STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

AGENDA

June 6, 2013

10:00 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

April 11, 2013 **Exhibit #1**

III. REGULATION

Report of the Committee on Codes, Regulations and Legislation **Exhibit #2**

Angel Gutiérrez, M.D., Chair

For Emergency Adoption

13-08 Amendment of Subpart 7-2 of Title 10 NYCRR - Children's Camps

For Discussion

13-08 Amendment of Subpart 7-2 of Title 10 NYCRR – Children's Camps

Repeal of Sections 708.2 and 708.5 and addition of a new Section 405.33 Trauma Centers

Repeal of Subdivision (g) in Section 405.19and addition of a new Section 405.32 of Title 10 NYCRR – Observation Services

Repeal of Sections 405.43 and 700.5 and Amendment of Section 400.21 of Title 10 NYCRR Advance Directives

13-12 Amendment of Section 1.31 of Title 10 NYCRR - Disclosure of Confidential Cancer Information

IV. 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

Karen Westervelt, Deputy Commissioner, Office of Health Systems Management and Office of Primary Care

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

Elizabeth Misa, Medicaid Deputy Director, Office of Health Insurance Programs

E. Report of the Office of Public Health Activities

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

V. PUBLIC HEALTH SERVICES

Report on the Activities of the Committee on Public Health

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

VI. HEALTH POLICY

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

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

VII. PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Report of the Committee on Establishment and Project Review

Jeffrey Kraut, Chair of Establishment and Project Review Committee

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 #3**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122216 C	University Hospital (Suffolk County)	Contingent Approval
2.	122303 C	Northern Dutchess Hospital (Dutchess County)	Contingent Approval
3.	131101 C	Montefiore Med Center – Jack D Weiler Hosp of A Einstein College Div (Bronx County)	Contingent Approval

Cardiac Services – Construction **Exhibit #4**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	131114 C	Brookhaven Memorial Hospital Medical Center, Inc. (Suffolk County)	Contingent Approval

Upstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #5**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121238 C	Visiting Nurse Service of Schenectady and Saratoga (Schenectady County)	Approval
2.	121317 C	VNA of Albany VNA of Saratoga VNA of Rensselaer (Albany County)	Approval
3	121443 C	Hudson Valley Long Term Home Health Care Program (Ulster County)	Approval

4.	131184 C	Calvary Hospital (Bronx County)	Approval

Downstate Dear Administrator Letters – Long Term Home Health Care Program – Construction **Exhibit #6**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121290 C	Park Gardens Rehabilitation & Nursing Center, LLC (Bronx 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 #7**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121069 C	St Johns Episcopal Hospital So Shore (Queens County) Dr. Bhat - Recusal	Contingent Approval

Upstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #8**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121139 C	Visiting Nurse Association of Central New York Inc (Onondaga County) Mr. Booth - Interest	Approval
2.	121170 C	Rosa Coplon Jewish Home and Infirmary (Erie County) Mr. Booth – Interest Dr. Gutiérrez - Recusal	Approval

3.	121304 C	Twin Tier Home Health, Inc. (Broome County) Mr. Booth Interest	Approval
4.	121319 C	Schofield Residence (Erie County) Mr. Booth - Interest	Approval
5.	131185 C	Bethel Nursing Home Co Inc (Westchester County) Mr. Fensterman – Recusal	Approval

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #9**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121221 C	Gazmel, NY, Inc. d/b/a, Revival Home Health Care (Kings County) Dr. Bhat – Recusal Mr. Fensterman - Recusal	Approval

Upstate Dear Administrator Letters – Long Term Home Health Care Program – Construction **Exhibit #10**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121437 C	Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital (Fulton County) Mr. Booth - Interest	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

Upstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #11**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121322 C	Lutheran Long Term Home Health Care Program (Suffolk County) Ms. Hines – Abstained at EPRC	Approval

CATEGORY 4: Applications Recommended for Approval with the Following:

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

Acute Care Services - Construction **Exhibit #12**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122205 C	Women and Children's Hospital of Buffalo (Erie County) Mr. Booth - Interest Mr. Robinson – Opposed at EPRC	Contingent Approval

Downstate Dear Administrator Letters – Long Term Home Health Care Program – Construction **Exhibit #13**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121456 C	Fort Tryon Center for Rehabilitation and Nursing (New York County) Mr. Fensterman – Recusal Ms. Hines – Abstained at EPRC	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

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

Acute Care Services – Establish/Construct **Exhibit #14**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122271 E	St. Peter's Health Partners (Albany County)	Contingent Approval

Ambulatory Surgery Centers – Establish/Construct **Exhibit #15**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122207 E	Center for Specialty Care Inc (New York County)	Contingent Approval
2.	131050 B	New York Center for Ambulatory Surgery, LLC (New York County)	Contingent Approval
3.	131056 B	The Endoscopy Center of Queens (Queens County)	Contingent Approval
4.	131064 E	Midtown Surgery Center (New York County)	Contingent Approval

Residential Health Care Facility – Establish/Construct **Exhibit #16**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	131054 E	Cortlandt Operations, LLC d/b/a Cortlandt Healthcare (Westchester County)	Contingent Approval
2.	131068 B	Judson Meadows Residential Health Care Center, Inc. (Schenectady County)	Contingent Approval

3.	131100 E	Cosden, LLC d/b/a Palatine Nursing Home (Montgomery County)	Contingent Approval

Certified Home Health Agencies – Establish/Construct **Exhibit #17**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	131103 E	Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified (Kings County)	Approval

Upstate Request for Applications - Certified Home Health Agencies – Establish/Construct **Exhibit #18**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121213 E	Fort Hudson Certified Home Health Agency, Inc. (Washington County)	Contingent Approval

Certificate of Amendment of the Certificate of Incorporation **Exhibit #19**

Applicant	E.P.R.C. Recommendation
North Country Children's Clinic, Inc.	Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #20**

Number	Applicant/Facility	E.P.R.C. Recommendation
2080L	Nix JT Corporation d/b comfort Keepers #685 (Tompkins, Cortland, and Schuyler Counties)	Contingent Approval
2243L	Washington County Public Health Nursing Service (Washington 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

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

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122311 E	Endoscopy Center of Long Island, LLC (Nassau County) Mr. Kraut – Recusal	Contingent Approval

Dialysis Services – Establish/Construct **Exhibit #22**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112210 B	New York Regional Services, LLC d/b/a New York Regional Dialysis Center (Kings County) Dr. Bhat - Interest	Contingent Approval

Upstate Request for Applications - Certified Home Health Agencies – Establish/Construct **Exhibit #23**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121266 E	Guthrie Home Care (Chemung County) Mr. Booth - Interest	Contingent Approval

Downstate Request for Applications - Certified Home Health Agencies – Establish/Construct **Exhibit #24**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121233 E	United Hebrew of New Rochelle Certified Home Health Agency, Inc. (Westchester County) Mr. Fassler - Interest	Contingent Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #25**

Number	Applicant/Facility	E.P.R.C. Recommendation
2077L	GTD Services, Inc. dba BrightStar of North Shore Nassau County (Nassau and Suffolk Counties) Ms. Regan - Interest	Contingent Approval
1788L	Sunrise Home Care, Inc. (Putnam, Westchester and Dutchess Counties) Ms. Regan - Interest	Contingent Approval
2263L	Wyoming County Health Department (Wyoming County) Mr. Booth – Interest Ms. Hines – Interest Mr. Robinson - Interest	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

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

Residential Health Care Facility – Establish/Construct **Exhibit #26**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122312 E	VDRNC, LLC s/b/a Van Duyn Center for Rehabilitation and Nursing (Onondaga County) Mr. Booth – Interest Mr. Fensterman – Abstained at EPRC	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

NO APPLICATIONS

VIII. NEXT MEETING

July 18, 2013 – ROCHESTER
August 1, 2013 – ROCHESTER

IX. ADJOURNMENT

State of New York
Public Health and Health Planning Council

Minutes
April 11, 2013

The meeting of the Public Health and Health Planning Council was held on Thursday, April 11, 2013, at the Century House, 997 New Loudon Road (Route 9, Main Ball Room Latham, New York 12110, Chairman, Dr. William Streck presided.

COUNCIL MEMBERS PRESENT:

Dr. William Streck, Chair
Dr. Howard Berliner
Dr. Jodumatt Bhat
Mr. Christopher Booth
Dr. Jo Ivey Boufford
Mr. Michael Fassler
Mr. Howard Fensterman
Dr. Carla Boutin-Foster
Dr. Ellen Grant
Dr. Angel Gutiérrez
Ms. Victoria Hines
Mr. Robert Hurlbut
Mr. Jeffrey Kraut
Dr. Glenn Martin
Ms. Ellen Rautenberg
Mr. Peter Robinson
Dr. John Rugge
Dr. Theodore Strange
Dr. Ann Marie Sullivan
Dr. Patsy Yang

DEPARTMENT OF HEALTH STAFF PRESENT:

Ms. Sue Kelly
Mr. Charles Abel
Dr. Guthrie Birkhead
Ms. Rachel Block
Ms. Elsie Chun
Ms. Barbara DelCogliano
Mr. Christopher Delker
Ms. Colleen Frost
Dr. Foster Gesten
Ms. Rebecca Fuller Gray
Ms. Sandy Haff
Mr. Michael Heeran
Ms. Karen Lipson
Ms. Karen Madden
Mr. Justin Pfeifer
Ms. Sylvia Pirani
Ms. Hope Plavin
Ms. Linda Rush
Mr. Douglas Sackett
Mr. Robert Schmidt
Mr. Michael Shay
Mr. Michael Stone
Ms. Lisa Thomson
Ms. Karen Westervelt

INTRODUCTION:

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

MEETING OVERVIEW:

Dr. Streck gave a brief overview of the Council meeting agenda.

RESOLUTION OF APPRECIATION FOR KAREN LIPSON

Dr. Streck presented on behalf of the Council a Resolution of Appreciation to Ms. Lipson for her countless hours and time she dedicated to improving the health care and delivery systems of New York State.

RESOLUTION OF APPRECIATION FOR DOUGLAS SACKETT

Dr. Streck next acknowledges that this is Mr. Sackett's last Council meeting as he is retiring from state service this month and presented on behalf of the Council a Resolution of Appreciation to Mr. Sackett for the important work he undertook to keep New York's children's camp, drinking water and spray parks safe.

APPROVAL OF THE MINUTES OF FEBRUARY 7, 2013:

Dr. Streck asked for a motion to approve the February 7, 2013 Minutes of the Public Health and Health Planning Council meeting. Dr. Berliner motioned for approval which was seconded by Dr. Gutiérrez. The minutes were unanimously adopted. Please refer to page 38 of the attached transcript.

REGULATION

Dr. Streck introduced Dr. Gutiérrez to give his Report of the Committee on Codes, Regulations and Legislation.

For Adoption

13-01 Amendment of Sections 405.2 and 405.4 of Title 10 NYCRR (Hospital Sepsis Protocols)

13-05 Amendment of Sections 2.59, 405.3, 415.19, 751.6, 763.13, 766.11 and 793.5 of Title 10 NYCRR (Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel)

Dr. Gutiérrez introduced Amendment of Sections 405.2 and 405.4 of Title 10 NYCRR (Hospital Sepsis Protocols) and briefly described the proposed regulation and motioned for adoption. Dr. Berliner seconded the motion. The proposed regulation passed. Please see pages 39 and 40 of the attached transcript.

Dr. Gutierrez next introduced Amendment of Sections 2.59, 405.3, 415.19, 751.6, 763.13, 766.11 and 793.5 of Title 10 NYCRR (Prevention of Influenza Transmission by Healthcare and Residential Facility and Agency Personnel). After describing the proposed regulation Dr. Gutiérrez motioned for adoption, which was seconded by Dr. Berliner. The motion to adopt the regulation carried. Please see pages 40 and 41 of the attached transcript.

For Discussion

Subpart 7-2 of 10 NYCRR (Children's Camps)

Lastly, Dr. Gutiérrez described for discussion Subpart 7-2 of 10 NYCRR (Children's Camps). To review the brief description please refer to pages 41 and 42 of the transcript.

Dr. Gutiérrez concluded his report. Dr. Streck thanked Dr. Gutiérrez for the report and introduced Ms. Kelly to give the Department of Health Activities.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES:

Ms. Kelly began by giving a brief report on the enactment of the 2013-14 State budget.

2013-14 State Budget Overview

Ms. Kelly advised that New York adopted its budget for the new fiscal year prior to April 1, 2013 the start of the new fiscal year. Among the highlights are temporary operator legislation, authorization of additional assisted living beds, and redesign of general public, the general public health work program. Starting with temporary operator legislation which will permit the health commissioner to appoint a temporary operator of a general hospital, diagnostic and treatment center or adult care facility licensed by the Department when it is determined that the operator is experiencing serious financial difficulty that jeopardizes access to care in the community or if patient safety may be in danger because of conditions in the facility. In addition, a current operator may also make a request to the Commissioner to appoint a temporary operator. The appointment of such operator will generally be limited to a term of no more than one year. The Department endorsed this initiative and had been working to achieve this initiative to allow us to work with individual facilities to address severe financial problems. It is the Department's hope that a temporary operator can help to stabilize the fiscal situation as the Department works with the facility on strategies to strengthen its finances and to address any quality or patient safety issues.

Ms. Kelly further stated that another budget initiative supported by the Department and adopted as part of the budget authorizes the Commissioner to add up to 4500 assisted living program beds which will increase access to care for many people who will benefit from being in an assisted living program. To be eligible to apply for additional beds, an adult home must have a bed capacity of 80 or more beds with at least 25 percent residents having a serious mental illness. The budget supports this increased capacity to assist in the transition of residents to more independent housing and also provides capital cost reimbursement to these adult homes for facility renovations to meet future residents or health system needs.

Ms. Kelly explained that the adopted budget includes the redesign of the general public health work program, the first redesign of this program in several decades. In light of the fact that an increasing number of New Yorkers are expected to become insured, the redesign will focus on population based public health interventions, rather than clinical services. Core public health services are also redefined to include chronic disease prevention and emergency preparedness response for the first time. Beginning in 2014 counties will receive increases in their base grant awards for these core services. In addition the program includes a performance incentive payment component. And I must say, you know, around the table are members of the Department, colleagues who worked through the night, many evenings, many months, sometimes many years working towards achievement of these initiatives, and we were so pleased that they were enacted during the legislative budget session.

Ms. Kelly described a few major initiatives related to Medicaid and health insurance programs that were approved in the final budget. The budget supports of course, care management for all so that within three years all Medicaid members and services will be effectively managed and patient care will be integrated. As a result, initiatives such as health home establishment grants and behavioral health integration efforts will move forward contingent on funding being available, of course. In addition, the budget preserves the global spending cap which is unique to New York. The spending cap has proven highly effective in bringing greater fiscal responsibility and transparency to Medicaid in our state. Since Governor Cuomo initiated Medicaid redesign and reform, we've made great strides to make the program more efficient, bend the cost curve, and of course develop new models of care to improved services and health outcomes. As a result of that success, this year's budget also sets the stage for restoring the two percent across the board rate reduction as early as April 2014, just one year from now.

Ms. Kelly noted that while some major health initiatives as were adopted in this year's budget, there's some key programs that were not adopted in the final plan. One of them was certificate of need, CON redesign. She recognized and appreciated the Council's hard work and tireless efforts over the past year to create an effective plan. While the legislature did not approve the budget language for the redesign, we have a commitment from key legislators to continue discussions off budget, which we will proceed to do. CON redesign remains a priority of the Department and we will continue to work to build support for these valuable recommendations and will keep you updated on our progress.

Ms. Kelly mentioned the legislature did not include a pilot program to allow the formation of business corporations with access to investor capital and expanded debt financing opportunities to operate hospitals. This is an issue that raised some concerns among legislators and stated that we expect continued discussion and deliberation. Ms. Kelly noted that the Department will continue to work closely with the Governor and the legislature throughout the year to promote programs and strategies we view as critical to the future of healthcare delivery and public health in New York State.

Health Benefits Exchange

Ms. Kelly noted there have been some exciting developments in New York's efforts to develop a health benefits exchange. In mid-February a request for applications was issued for the in-person assistor and navigator program; a valuable tool to help people understand their options and provide direct assistance in applying for coverage. The deadline to submit applications was this past Monday. In-person assistors will guide people through the enrollment process and help them access the federal tax credits that will help make New York health insurance affordable in New York. There remains plenty of work to be done on the exchange, including launching a large coordinated outreach and marketing campaign to inform and educate people about the exchange and how they can use it as a tool to obtain affordable health insurance. New York continues to make significant process in the development of the state run exchange and will be set to begin enrollment on October – begin the enrollment process on October 1, 2013 with coverage starting January 2014. So the process will begin this coming October with coverage to start at the beginning of the year, next year. The Department will continue to update the Council on the exchange progress of future meetings.

Medicaid

Ms. Kelly a forum was held the last week in March, the National Committee for Quality Assurance, NCQA, and the New York Health Foundation recognized New York for the high quality of healthcare provided by health plans in the state including the excellent performance of Medicaid health plans. Each year the NCQA issues a state of health quality report to highlight specific health plan performance data on key measures. These include chronic condition management, health prevention measures such as weight assessments and cancer screenings, specific measures targeted to protecting the health of children and older adults, and general wellness of membership in health plans. This independent analysis allows healthcare quality trends and it identifies healthcare quality trends and tracks performance of health plans and overall results were individual states. The 2010 analysis demonstrates that care management, the cornerstone of Medicaid redesign, is working well in New York to improve healthcare quality and lower healthcare costs. NCQA recognized New York for having the most NCQA patient centered medical homes of any state. Ms. Kelly stated that she was sure that attributed to Dr. Gesten's work over the many years, and twice the number of patient centered medical home sites and clinicians of the next highest state in the country. Overall, 40 percent of Medicaid patients with patient centered medical home which improved the delivery of primary care including increased care coordination and access, and that's attribute to all the providers who participate in the program and of course all the efforts of folks in the Department who initiated the program and the support of members around the table.

2013-17 Prevention Agenda

Ms. Kelly explained that another area where the Council has been actively involved has been the development of the 2013-2017 prevention agenda. The first week in April, Commissioner Shah joined New York City Health Commissioner Farley, Dr. Boufford, and representatives from HANYS, the Greater New York Hospital Association and NYU at the Charles B. Wang Community Health Center in New York City to officially launch the plan and highlight its key priorities. The prevention agenda is the framework to guide out public health efforts in a number of areas including the prevention of chronic diseases, HIV, sexually transmitted diseases, vaccine preventable diseases, substance abuse and healthcare associated infections. It also focuses on strategies and interventions to promote healthy and safe environments, healthy woman, infants, and children, and better mental health. The efforts moving forward will build on the work of our partners including this council and 140 other organizations who worked on the agenda and are committed to making New York a healthier state. Ms. Kelly thanked the Council for their hard work in this endeavor

Ms. Kelly recognized Ms. Lipson and Mr. Sackett and the Council's contributions for the betterment for the population in New York State.

Ms. Kelly concluded her report. Dr. Streck asked if members had questions. To review Ms. Kelly's complete report and comments from the members, please refer to pages 42 through 53 of the attached transcript. Dr. Streck thanked Ms. Kelly and introduced Ms. Westervelt to give the Report of the Activities of the Office of Health Systems Management.

REPORT OF THE OFFICE OF HEALTH SYSTEMS MANAGEMENT ACTIVITIES

Mr. Westervelt began her report by echoing the Council's sentiments upon Karen Lipson's departure. Ms. Lipson is an esteemed and respected colleague, and wished her well.

Ms. Westervelt introduced Ms. Chun who is serving as Acting Director of the Division of Policy within the Office of Health Systems Management. Ms. Chun comes from the executive office and has worked in both the Assembly and the Senate and in prior capacities. Ms. Chun has expertise in the mental hygiene arena

Ms. Westervelt advised the Department is imposing a moratorium on healthcare facilities that are going to be doing new construction or major construction in flood prone plane areas. The Department consulted with the Chairman and is now requesting that the Establishment and Project Review Committee to put together a workgroup to consider new construction standards that can put in place in a reasonable amount of time so we can do this in an expeditious way so that we do not unnecessarily cause any impediments or delays in projects that would normally be coming before the Council.

Ms. Westervelt advised that CON reform is high on the Department's list of priorities and the Department will be reengaging in conversations with the legislature about to try to move forward those reform agendas. Ms. Westervelt also noted that critically important is a status update on the SUNY Downstate situation and legislation was passed that the SUNY chancellor has been tasked with putting together a sustainability plan by June 1, 2013 that has to be submitted to the legislature and approved by the Department of Health and the Division of budget prior to June 1, 2013. Ms. Westervelt discussed the Long Island Community Hospital, and the state is constrained from doing anything to act on that closure plan. We do have a Temporary Restraining Order, so discussions between the Department and SUNY are nonexistent really at that point in that regard.

Ms. Westervelt concluded her report and asked if members had questions. To review the members questions and Ms. Westervelt's full report please see pages 54 through 60 of the attached transcript.

REPORT OF THE OFFICE OF HEALTH INFORMATION TECHNOLOGY TRANSFORMATION ACTIVITIES

Dr. Streck introduced Ms. Block to give the report of the Office of Health Information Technology Transformation activities.

Ms. Block updated that Council on meaningful use payments. There continues to be significant increases in both the Medicare and Medicaid payments nationally. There is a continued increase in both Medicaid and Medicare meaningful use out of station and certification and significant growth in the dollars going out. Our current estimate is that we are probably at about 80 to 90 percent of the eligible hospitals, and somewhere in the neighborhood of 60 percent of the eligible physicians. It could be a little bit higher. With the physicians it is hard to establish a clear denominator because of the patient volume requirements. So it is not just somebody who is an eligible professional, but they have to have that minimum patient volume for Medicare or Medicaid. But conservatively 60 percent of those were eligible and probably something a bit higher than that. The Department is very pleased with the continued results of that.

Ms. Block explained the recent award of a CMS grant for what they are calling the State Innovation Model Pretesting Assistance Award. The State Innovation Model Initiative was established last year by CMS as part of the overall efforts of the Centers for Medicare and Medicaid – the Center for Medicare and Medicaid innovation within CMS, and this is obviously the area that has awarded many grants and many demonstration programs implementing those provisions of the ACA that really were emphasizing improvements in payment systems and delivery systems. This one in particular was focused on states providing the leadership to really coordinate and organize those efforts in their states.

Ms. Block summarized the announcements that were made about a month or six weeks ago, six states with model testing awards, these are very large scale efforts in those states to implement multi-payer healthcare transformation strategies. New York was one of three states to get a pretesting award. These are incremental efforts to build state capacity to help CMS implement these healthcare information models.

Ms. Blocked advised that New York had originally applied for one of the testing awards, which was the largest grant category back in September, 2012. The Department was notified in January 2013 that while CMS felt that we made a very good effort in the application, they were not giving us that award. They requested that the Department submit a request for a pretesting assistance award, and then we were rather promptly included in the announcements of all the grant awards, subsequently. This involves a six month period over which the Department is to do further data analysis and stakeholder outreach to develop a new state innovation plan and that then would position us later in the year to apply for the next round of large grants which CMS will be announcing sometime before the end of the year. They are looking for the Department to use all of our policy levers and strategies that are available in the State. They have put particular emphasis on multi-payer engagement; to engage providers and delivery system transformation; to look at how we implement the triple aim. One of the areas that we are asked to focus on and I think we have some very strong initiatives to highlight here in New York around integration of behavioral health and other community services, new delivery payment models as well as new care models are also points of emphasis for this plan, and health IT. Ms. Block wanted to underscore that what they want to see is something which will move 80 percent of the state's population to value-based payment and service delivery models over a five-year period. The plan needs to address how the Department would do that, but the grant application to be submitted later this year would need to have specific models and strategies identified that quantifiably would get us in New York State to that goal.

Ms. Block stated that April 1, 2013 was the kickoff date for this process, and the Department is working on developing further analysis to describe our healthcare environment. The legal regulatory policy issues that we want to address and in particular engaging stakeholders across regions and across specific areas of expertise to offer input into this plan. There are three levels of consultation such as reaching out to leaders across New York State, reaching out to regional organizations who have already made some efforts that we will want to complement and include in the plan and then also reaching out to stakeholder verticals, the hospital associations, physician organizations, consumer groups, employers and so forth who will have their own perspective to bring into the effort, as well as Council members to ask how the Department can incorporate the work that has already been done through the respective committees of this council and how we can integrate the planning and hopefully the implementation of this program into the future efforts of those committees.

Ms. Block concluded her report. To see the complete report, please refer to pages 60 through 66 of the attached transcript. Dr. Streck thanked Ms. Block for her report and moved to the Report of the Office of Public Health Activities and introduced Dr. Birkhead.

REPORT OF THE OFFICE OF PUBLIC HEALTH ACTIVITIES

Dr. Streck introduced Dr. Birkhead to give the Report of the Office of Public Health activities.

Dr. Birkhead began his report by thanking Mr. Sackett for his many years of work with the Department.

Dr. Birkhead updated the Council on the H7N9 influenza outbreak happening in China. China historically has been a place where new influenza strains originate and over the last couple of months there has been a cluster which now amounts to 33 cases. These are in four contiguous provinces in China around Shanghai. The influenza cases have been very severe, 28 of the 33 cases have been hospitalized severely ill, and there have been 9 deaths among the 33. So, over roughly 30 percent fatality rate. The other interesting feature is that these cases have occurred in elderly patients primarily, we compared the H5N1 which is the strain that we've been reading about now for five years periodically around the world related to poultry exposure. So this virus is acting a little bit differently. This is a newly emerged concern. There is no real clusters of people in households or close contact have been identified, and so no person-to-person transmission has been identified, so these may simply be people acquiring flu infection from bird contact, primarily chickens, but if it doesn't spread from human to human it doesn't present a problem for example, for a pandemic type situation or a SARS type of situation. However, it is concerning because of the high severity and hospitalization rate and death rate that's occurred with this. It is also not clear how many other milder cases might be occurring. This could just be the tip of the iceberg. It is obviously occurring in four provinces so it's somewhat wide-spread already. One of the other concerning features is that it doesn't appear to make the birds sick, and in previous pandemic. If it is making the birds ill then it's evident that it is there and you can take steps to destroy poultry flocks. If the birds are not ill, then you do not really know where to go to try and prevent this. The CDC has issued an alert here which the Department forwarded on to healthcare providers to basically be on the lookout for persons with flu-like illness with a recent travel history to this part of the world. The quarantine stations at U.S. airports are not yet screening people because we do not have person-to-person transmission but are certainly on alert. There are seven non-stop flights from China a day into JFK airport for example. So, this virus could be here very quickly. We also do not have flu testing available in this country. These viruses would show up as influenza untypable, and so CDC has asked all the public health labs including our own to forward any untypable flu samples to them within 24 hours so they can test them very quickly. And CDC is also working on a test kit that our public health labs could use to actually diagnose the H7N9 directly. So, hopefully there will be nothing more to report on this, but this is an example of a couple of things. One, it is an example of the public health network that is out there around the world for flu and other emerging diseases, and it's also an example, I think, of our, the effort we put into preparedness that we and the city health department and other public health agencies are able to get alerts out to hospital emergency departments and other clinical settings where patients might be seen. This is with only 30 cases known in the world, all in China. CDC does have reports of three people in the United States with flu-like illness after travel history who have turned out not to have flu, so obviously lots of other things cause flu-like illness. This is an example of the type of preparedness that we need to have in the public health world because these kinds of emerging threats seemingly can appear at anytime and anywhere.

Dr. Birkhead next advised the Council on chronic disease and tobacco prevention, cigarette smoking cessation, a number of years back in the previous, under the previous health commissioner the state health department submitted a petition to FDA to get them to change the way in which nicotine replacement therapy can be marketed and sold. Currently nicotine replacement therapy is available only in pharmacy type settings, and only packaged for one or two week supplies which can cost up to $20 to $30. The idea with our petition was that we wanted the FDA to allow nicotine replacement therapy to be sold anywhere where cigarettes can be sold, and also to be sold in packaging that would allow for a one day or a two day supply, in other words, much cheaper. Right now, if you are a smoker trying to quit and you have five dollars in your pocket and you walk into a gas station all you can buy is cigarettes. The idea here would be that you in the future, could buy nicotine replacement therapy with your five dollars, a one or two day supply to tide you over. The petition was submitted a number of years ago. The Department inquired of FDA and we are told that while they are considering petitions, they will not talk publicly about their deliberations. But just this past week, the FDA did send us a letter ruling that they were going to allow nicotine replacement therapy to be sold in now up to about 20,000 different settings, retail type settings in New York, and also allow it's packaging in much smaller unit doses. So this will require nicotine – the pharmaceutical companies that make nicotine replacement therapy to actually produce it in a new packaging form and also to try to market it in these other settings. There still are other additional steps to go, however this is an example of an idea which finally came around and which seems to make sense and that we hope will prevent, or help smokers really to quit. There were some additional parts of our petition that FDA did not approve. For example, the Department asked that the large package insert on the nicotine replacement therapy with lots of alarming information about the potential side effects of nicotine be reduced or eliminated since a package of cigarettes may have a simple phrase warning on it. It does not have a large booklet with all the dangers of cigarettes. So trying to balance, again, make them more equivalent in people's minds. FDA did not go along with that because nicotine is a registered pharmaceutical product and so the package insert has to remain. This is an example of a success.

Dr. Birkhead concluded his report. To review the complete report and members questions please refer to pages 66 through 76 of the attached transcript.

PUBLIC HEALTH SERVICES

Next, Dr. Streck asked Dr. Boufford to report on the Activities of the Committee on Public Health.

Report on the Activities of the Committee on Public Health

Dr. Boufford thanked Ms. Lipson for work and stated that Ms. Lipson has been really invaluable in the connection between the work of the Health Planning Committee and the Public Health Committee. Dr. Boufford also added that she had not had the pleasure to work with Mr. Sackett but it sounds like he was doing important work as well.

Dr. Boufford noted that the State Health Improvement Plan called the prevention agenda was adopted in December 2012. The guidance did go out in January 2013. To local hospitals and local health departments who have obligations to the state to present their plans, and in this instance they are being asked to do that together with stakeholders in the community, and that process is underway. The New York State website which includes all of the work done over the summer with the sort of 140-odd people that were referenced earlier and the multiple working groups, all of that material is now on the website and it's easily available. There is a large blue button on the home page which is wonderful. You do not have to navigate to find it, so we appreciate the communication staff for doing that. And the work of the last couple of months has really been focusing very much on communication and technical assistance support for local action. Efforts that could be done, would be done at the State to really support local partnerships in communities. Much of this effort is being made possible by grants from the Robert Wood Johnson Foundation in support of New York State's accreditation application, and there are in parallel activities going on in the health department trying to identify other sources of financial support.

Dr. Boufford next discussed the updated maternal mortality report. The Public Health Committee has picked this topic to try to "move the needle" in addition to the State Health Improvement Plan. Dr. Boufford showed a slide presentation in which it outlines elements of the communication strategy that the Committee has been undertaking. Communication strategy, one, is that we want to have multiple stakeholders involved in this activity. An important item on communication is how do people in these sectors think about health, public health prevention so we know how to have a conversation in a way that sort of gives them a sense to say I can really identify with this discussion, and I can see why I should participate in these activities in my community. And then the second part of it is the issue of knowing that there are vulnerable populations, and we are working with Minority Health Council chaired by Dr. Boutin-Foster to really try to have also a set of materials for addressing health disparities by being able to have clear communications with different vulnerable populations at the community level. So those are the big foci of the broader communication strategy in addition to just what gets people to pay attention when you start talking about prevention.

Ms. Pirani noted that the Robert Wood Johnson Foundation has been supporting the effort. They have given a grant directly to this Rabin Martin firm in New York City that helped us organize all the people that helped us develop the prevention agenda and is now developing a communications plan, and they started that with interviewing about 15 representatives; a small group but important people in various sectors including community-based organizations, hospitals, health plans, education, criminal justice as one of the areas because as someone asked before about gun control we do have violence prevention in our prevention agenda, and businesses to see what interests them, what do they think about when we mention the word 'prevention,' what interests them, what might motivate them to come to the table in these communities. These are the various pieces of the communications plan that they are working on, coming up with a tool kit, coming up with media spokesperson training once they come up with these messages, so that'll be helpful, and then some suggestions for our web content and media materials. They have interviewed several representatives from business, education, and health plans to try and figure out what might motivate those people, so, certainly businesses, how we need to talk in a better way, in a clear way about savings and benefits to businesses, need to bring, inform, better educate businesses about wellness programs; seems to be something

businesses are interested in. They have talked to some school representatives. These people are interested in linking up better mental health services to schools, something that schools are facing. And then they have interviewed several representatives from the health plans that have indicated they would like to be involved in this planning process at the beginning. These are some of the other communications efforts. Ms. Pirani advised that she and Dr. Boufford had participated in a public health live webcast that was aired March 28, 2013 and encouraged the members to watch the video. Dr. Shah was featured in public health activities going on in Schenectady County. Jim Connelly from Ellis Hospital, for example, has led this effort and has gotten a grant from the Schenectady Foundation to do a door to door survey to find out what is affecting people's health including the community that they live in. There was a press conference that had great participation from a wide range of participants including members of our ad-hoc committee. The Robert Wood Johnson Foundation was blogging from the event and did an interview with Dr. Shah. Ms. Pirani continued through the slide sets describing future efforts and collaborations.

Dr. Boufford noted a distinction between the first round of the prevention agenda and this round is funding entities who will provide support to local communities at the regional level, rather than funding the entities directly for their own work. That was a shift in concept, because it was realized as is not uncommon as those who are the most proficient at writing good grant proposals get money, and they're happen to usually be the people that are doing this anyway. The effort here was to try to take advantage of the expertise that was identified the last round, and then ask them to then provide that support to local communities.

Dr. Boufford identified the next steps. They are hoping to begin a website to develop the capacity for communities to interact with each other, share experiences on the website. Each of the communities picks the issues they are going to work on, they will be able to know which groups are working on maternal mortality for example, which groups are working on obesity prevention, ,and then they can really develop a sort of learning network across the state. Dr. Boufford noted that she is very pleased to be invited by Ms. Westervelt to talk with Primary Care and Office of Health Systems Management staff as part of their strategic planning. The Ad Hoc Committee which is our sort of intersectoral group that is numbering almost 30 now which I think is where the business community, professional associations, community organizations, health departments come together will be meeting on May 22, 2013 and will be designing a meeting there, sort of an extended meeting that will both celebrate the folks that are off and running, but also brief this group on what's been done and try to really get them activated, so part of the goal for the state level organizations is that they have members and constituencies and chapters at local levels, and we want to get them to the table while these conversations are going on. The plans are due November 2013 across the board, and so that is our goal is really to try to find resources and assure support to get as many communities as possible effectively through the planning, implementation and evaluation stages.

Dr. Boufford suggested that as a Council we might begin to think about the Prevention Agenda as a very critical element in the third part of the triple aim which is cost, quality, and achieving health.

Dr. Boufford concluded her report. See pages 76 through 88 of the attached transcript.

HEALTH POLICY

Report on the Activities of the Committee on Health Planning

Under the Category Health Policy, Dr. Streck introduced Dr. Rugge to update the Council on the work of the Committee on Health Planning.

Dr. Rugge advised that there are two prescribed activities and reviews that we are required to do. Parts 709.3 and parts 709.16, this represents a review of the nursing home bed methodology which is up for a five year review, and also review of methodology for therapeutic radiology. Most likely these will take place in the course of our regular committee meetings, and we will depend absolutely on staff to help us to be sure that we're meeting all requirements. Likewise, it'd be very important for us to monitor the progress of the implementation of the CON recommendations we made, especially since most of them did not make it through the legislature this year, but will be actively discussed and hopefully approved in the upcoming session.

Dr. Rugge stated that since we are a Planning Committee are the activities around future planning with the regulations that we proposed, and the fact that we have Ms. Block's SIM, State Innovation Model activities, need for planning to develop an innovation model, everything seems to be coming together very nicely including her million dollar budget which might allow for coffee at our planning committee meetings, and we can only induce her to make us a formal part of that discussion.

Dr. Rugge advised that that Health Planning Committee will undertake a series of special all day committee meetings on another topic for us to undertake and review and digest and recommend by September for consideration by the full council. That being a new look at the ways in which medical practices and providers of institutional services are really converging with a whole new set of sophisticated and advanced ambulatory care services noting that many physician practices have been coalescing into groups of hundreds of physicians mobilized especially with ACOs, and at the same time many hospitals are finding that their ambulatory work and those revenues are over balancing what was traditionally the center piece, the inpatient care, being provided by those institutions. So, with these movements if you will, coming together and looking so much alike, there are a series of questions in terms of how to recognize these activities and understand them as we do our reviews for CON and other approvals moving forward. All remembering the difficulty we had with a certain radiology therapeutic radiation centers and not even being able to do a count of how many private practices were doing radiation in Westchester County some time ago. In addition, considerations about what kind of expectations we as a public should have in terms of service to vulnerable populations as new activities are engendered and huge groups of physicians come together. And along with that, what kind of contribution to the HICRA pools will be made by various organizations doing much of the same work but coming from two different placed; the private practice world versus the institutional world. So, we are charged with taking a look and doing evaluation of these phenomena and trying to understand to wrap that into the oversight regulatory process for this Council and for this State.

Dr. Rugge stated at the committee session, managed to say all this without uttering the words 'leveling the playing field.' The time table really began with a kickoff on February 25, 2013 with a letter drafted by Ms. Lipson and others looking to stakeholders, vertical and otherwise, for input which hopefully has been and is being received as we speak and this committee will find it very important. It is important to understand their perspectives and views and recommendations of hospitals, physicians, health centers, and many others in terms of how to proceed with this analysis.

Dr. Rugge stated that having concluded that bit of work by September are looking in the fall at another series of activities and that is we are being charged by the Commissioner and by the Executive, we are taking a look at what I consider to be the continuum of care looking at the mini-clinics, the retail clinics that have proposed by the Governor and will be considered again by the legislature. Consideration of the explosion of interest in freestanding EDs, especially with the receding of certain inpatient services with the opportunity represented by upgraded D&T centers and by the possibility of actually implementing tele-medicine in areas of the State and communities that otherwise are going without services, and trying to identify a smooth continuum so we can have an appropriate setting and provision of healthcare community by community, population by population, in ways now that have been attempted through pilots and through fracturing and through phantom beds and the rest with the idea that that discussion will carry us through the fall for presentation of recommendations to the Council in time for the legislative session and doings of 2014. The Planning Committee is really counting on the participation of it's members.

Dr. Rugge concluded his report. To review the report, please refer to pages 89 through 95 of the attached transcript.

ROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Dr. Streck introduced Mr. Booth to give the Report of the Committee on Establishment and Project Review

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 #3**

	Number	Applicant/Facility	Council Action
1.	122190 C	John T Mather Memorial Hospital of Port Jefferson (Suffolk County)	Contingent Approval

122229 C	Montefiore Medical Center – North Division (Bronx County)	Contingent Approval

Residential Health Care Facility – Construction **Exhibit #4**

	Number	Applicant/Facility	Council Action
1.	122294 C	Alice Hyde Medical Center (Franklin County) Mr. Booth - Interest	Contingent Approval

Mr. Kraut introduced applications 122190, 122229 and 122294 and motioned for approval. The motion to approve was seconded by Dr. Berliner. The motion carried with Mr. Booth's noted interest in application 122294. Please refer to pages 96 and 97 of the 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 – Construction **Exhibit #5**

	Number	Applicant/Facility	Council Action
1.	112363 C	Mount Sinai Hospital (Queens County) Dr. Bhat – Recusal Dr. Martin – Recusal Dr. Sullivan – Interest	Contingent Approval

Mr. Kraut noted for the record that Dr. Bhat and Dr. Martin have exited the meeting room for application 112363. Mr. Kraut motioned for approval which was seconded by Dr. Berliner. The motion to approve carried with Dr. Sullivan's interest, Dr. Bhat and Dr. Martin's recusal. Dr. Bhat and Dr. Martin re-entered the meeting room. Please see page 97 and 98 of the attached transcript.

Acute Care Services – Construction **Exhibit #5**

	Number	Applicant/Facility	Council Action
2.	122297 C	New York Presbyterian Hospital – Columbia Presbyterian Center (New York County) Ms. Regan – Interest Dr. Boutin-Foster – Recusal	Contingent Approval
3.	122306 C	New York Presbyterian Hospital – Columbia Presbyterian Center (New York County) Ms. Regan - Interest Dr. Boutin-Foster – Recusal	Contingent Approval
4.	122314 C	New York Presbyterian Hospital – New York Weill Cornell Center (New York County) Ms. Regan - Interest Dr. Boutin-Foster – Recusal Dr. Boutin-Foster – Recusal	Contingent Approval
5.	122316 C	New York Presbyterian Hospital – New York Weill Cornell Center (New York County) Ms. Regan – Interest Dr. Boutin-Foster – Recusal	Contingent Approval

Mr. Kraut stated that Dr. Boutin-Foster is exiting the meeting room as she declared a conflict for applications 122297, 122306, 122314, and 122316. Mr. Kraut briefly described the applications and motioned for approval. Mr. Fassler seconded the motion. The motioned carried with Dr. Boutin-Foster's recusal and Ms. Regan's noted interest. Dr. Boutin-Foster re-entered the meeting room. Please see pages97 through 99 of the transcript.

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #6**

	Number	Applicant/Facility	Council Action
1.	121201 C	Alpine Home Health Care, LLC (Bronx County) Mr. Fassler – Recusal Mr. Fensterman - Recusal	Contingent Approval

Mr. Kraut announced that Mr. Fassler and Mr. Fensterman have declared a conflict on application 121201 and have both exited the meeting room. Mr. Kraut described the application and motioned for approval which was seconded by Dr. Gutiérrez. The motion carried with Mr. Fassler's and Mr. Fensterman's recusals. Mr. Fassler and Mr. Fensterman returned to the meeting room. Please see pages 99 and 100 of the 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

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #7**

	Number	Applicant/Facility	Council Action
1.	121229 C	Calvary Hospital (Bronx County) Ms. Hines – Abstained	Contingent Approval
2.	121241 C	Prime Home Health Services, LLC (Kings County) Ms. Hines – Abstained	Approval
3.	121289 C	Winthrop-University Hospital Home Health Agency (Nassau County) Ms. Hines – Abstained	Approval
4.	121312 C	Good Samaritan Hospital Home Care Department (Rockland County) Ms. Hines – Abstained	Approval
5.	121323 C	St Cabrini Nursing Home (New York County) Mr. Booth -Opposed Ms. Hines – Abstained	Approval

Mr. Kraut introduced applications 121229, 121241, 121289, 121312, and 121323. Mr. Kraut motioned for approval which was seconded by Dr. Gutiérrez. Ms. Hines expressed her concerns with the processing of the application. Staff and members engaged in dialogue regarding the general process. The motion to approve carried with one member opposing and Ms. Hines abstaining. Please see pages 100 through 124 of the attached transcript to view the complete discussion.

Long Term Home Health Care Program – Construction **Exhibit #8**

	Number	Applicant/Facility	Council Action
1.	131109 C	Health Services of Northern New York, Inc. (St. Lawrence County) Ms. Hines – Opposed	Contingent Approval

Mr. Kraut introduced application 131109 and motioned for approval. Dr. Berliner seconded the motion. Ms. Hines briefly explained why she is opposed to the application. The motion to approve carried with Ms. Hines opposed vote. Please see pages 124 though 126 of the attached transcript.

CATEGORY 4: Applications Recommended for Approval with the Following:

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

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #9**

	Number	Applicant/Facility	Council Action
1.	121214 C	New York Congregational Nursing Center LTHHCP (Kings County) Mr. Fassler – Interest Ms. Hines – Abstained	Contingent Approval
2.	121287 C	Gurwin Jewish Nursing and Rehabilitation Center LTHHCP (Suffolk County) Mr. Fassler – Interest Ms. Hines – Abstained	Approval

Mr. Kraut batched applications 121214 and 121287 and briefly described the application and motioned for approval. Dr. Berliner seconded the motion. The motion to approve carried with Mr. Fassler's noted interest and Ms. Hines abstaining. Please see page 127 of the attached transcript.

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #9**

	Number	Applicant/Facility	Council Action
3.	121313 C	Visiting Nurse Service of New York Home Care (New York County) Mr. Fassler – Interest Ms. Regan – Recusal Ms. Hines – Abstained	Approval

Mr. Kraut noted for the record that Ms. Regan exited the meeting room as she declared a conflict on application 121313. Mr. Kraut described the application and motioned for approval which was seconded by Dr. Gutiérrez. The motion to approve carried with Ms. Regan's recusal, Mr. Fassler's interest and Ms. Hines abstention. Ms. Regan re-entered the meeting room. See page 127 and 128 of the transcript.

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #9**

	Number	Applicant/Facility	Council Action
4.	121217 C	Bethel Nursing Home Co Inc (Westchester County) Mr. Fensterman – Recusal Ms. Hines – Abstained	Contingent Approval
5.	121231 C	Parker Jewish Institute for Health Care and Rehabilitation (Nassau County) Mr. Fassler – Interest Mr. Fensterman – Recusal Ms. Hines – Abstained	Approval

Downstate Dear Administrator Letters – Certified Home Health Agencies – Construction **Exhibit #10**

	Number	Applicant/Facility	Council Action
1.	121421 C	Four Seasons Nursing and Rehabilitation Center LTHHCP (Kings County) Mr. Fensterman – Recusal Ms. Hines – Abstained	Approval
2.	121440 C	Hillside Manor Nursing Center (Queens County) Mr. Fensterman – Recusal Ms. Hines – Abstained	Approval

Mr. Kraut stated that Mr. Fensterman has a conflict on applications 12121, 121331, 121421 and 121440 and has exited the meeting room. Mr. Kraut motioned for approval. Dr. Gutiérrez seconded the motion. The motion to approve the applications carried with Mr. Fensterman's noted recusal and Ms. Hines abstention. Mr. Fensterman returned to the meeting room. Please see pages 128 and 129 of the transcript.

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

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

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

CON Applications

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

	Number	Applicant/Facility	Council Action
1.	122213 E	Catholic Health Ministry Services, Inc. (Erie County) Mr. Booth - Interest	Contingent Approval

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

	Number	Applicant/Facility	Council Action
1.	122104 B	GoldStep Ambulatory Surgery Center, LLC (Kings County)	Contingent Approval
2.	122223 E	Hudson Valley Endoscopy Center, Inc. (Dutchess County)	Contingent Approval
3.	122280 B	Cortland ASC, LLC d/b/a Cortland Surgical Center (Cortland County) Mr. Booth - Interest	Contingent Approval

Diagnostic and Treatment Center – Establish/Construct **Exhibit #13**

	Number	Applicant/Facility	Council Action
1.	122013 B	The New York Foundling Bronx Health Care Center (Bronx County)	Contingent Approval

Dialysis Services – Establish/Construct **Exhibit #14**

	Number	Applicant/Facility	Council Action
1.	122181 E	Dialysis Newco, Inc. d/b/a DSI Renal (Dutchess County) Dr. Bhat – Interest	Contingent Approval
2.	122319 E	St. Joseph's Dialysis – Regional (Onondaga County) Dr. Bhat – Interest Mr. Booth - Interest	Contingent Approval

Residential Health Care Facilities – Establish/Construct **Exhibit #15**

	Number	Applicant/Facility	Council Action
1.	122233 E	Batavia Health Care Center, LLC (Genesee County) Mr. Booth – Interest Mr. Hurlbut – Interest	Contingent Approval
2.	122276 E	Livingston Hills Nursing and Rehabilitation Center, LLC (Columbia County)	Contingent Approval
3.	122298 E	Golden Hill Planning Corporation d/b/a Golden Hill Nursing and Rehabilitation Center (Ulster County)	Contingent Approval

Certificate of Dissolution **Exhibit #16**

Applicant	Council Action
Community General Hospital of Greater Syracuse	Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #17**

Number	Applicant/Facility	Council Action
2128-L	Achieve-ALP, LLC d/b/a Achieve Assisted Living Program (Sullivan County)	Contingent Approval

Mr. Kraut introduced all applications in Category One and motioned for approval. Dr. Gutiérrez seconded the motion. All applications in Category One were approved with the above listed interests. Please see pages 130 through 135 of the 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

HOME HEALTH AGENCY LICENSURES **Exhibit #18**

Number	Applicant/Facility	Council Action
1940-L	Allcare Homecare Agency, Inc. (Bronx, Richmond, Kings, Westchester, New York and Queens Counties) Ms. Regan - Interest	Contingent Approval
2053-L	Lavin Home Care, Inc. d/b/a Home Instead Senior Care (Suffolk, Nassau and Queens Counties) Ms. Regan - Interest	Contingent Approval
2043-L	Bushwick Economic Development Corp. (Kings, New York, Queens, and Richmond Counties) Ms. Regan - Interest	Contingent Approval
2084-L	Renewal Care Partners, LLC (Bronx, Westchester, Kings, Queens, New York and Richmond Counties) Ms. Regan - Interest	Contingent Approval

2027-L	Westchester Family Care, Inc. (Westchester, Rockland, Putnam and Dutchess Counties) Ms. Regan - Interest	Contingent Approval

Mr. Kraut introduced applications 1940, 2053, 2043, 2084 and 2027 and noted for the record that Ms. Regan has an interest. Mr. Kraut motioned for approval. Dr. Berliner seconded the motion. The motion to approve carried with Ms. Regan's noted interest. Please see page 135 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

Residential Health Care Facilities – Establish/Construct **Exhibit #19**

	Number	Applicant/Facility	Council Action
1.	122215 E	Excel at Woodbury for Rehabilitation and Nursing, LLC (Nassau County) Mr. Fensterman – Recusal	Contingent Approval
2.	122251 E	Rosewood Rehabilitation and Nursing Center (Rensselaer County) Mr. Fensterman – Recusal	Contingent Approval

Mr. Kraut noted for the record that Mr. Fensterman has declared a conflict on application 122215 and 122251 and has exited the meeting room. Mr. Kraut described the applications and motioned for approval. Dr. Gutiérrez seconded the motion. The motion to approve passed with Mr. Fensterman's noted recusals. Mr. Fensterman returned to the meeting room. Please see page 136 of the attached transcript.

Downstate Request for Applications – Certified Home Health Agencies – Establish/Construct **Exhibit #20**

	Number	Applicant/Facility	Council Action
1.	121232 E	Amber Court at Home, LLC (Nassau County) Ms. Hines- Abstained	Contingent Approval

Mr. Kraut described application 121232, motioned for approval and Dr. Berliner the seconded the motion. The motion to approve carried with Ms. Hines abstention. Please see pages 137 and 138 of the attached transcript.

Downstate Request for Applications – Certified Home Health Agencies – Establish/Construct **Exhibit #20**

	Number	Applicant/Facility	Council Action
2.	121260 E	Constellation Home Care (Nassau County) Ms. Hines – Opposed	Contingent Approval

Mr. Kraut described application 121260, motioned for approval and Dr. Berliner the seconded the motion. The motion to approve carried with Ms. Hines opposing vote. Please see page 138 and 139 of the transcript.

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

CON Applications

Residential Health Care Facility – Establish/Construct **Exhibit #21**

	Number	Applicant/Facility	Council Action
1.	122261 E	St. Marks Brooklyn Associates LLC d/b/a Crown Heights Center for Nursing and Rehabilitation (Kings County)	Contingent Approval

Lastly, Mr. Kraut described application 122261 and motioned for approval which was seconded by Dr. Gutiérrez. The motion to approve carried. Please see page 139 and 140 of the transcript.

ADJOURNMENT:

Dr. Streck hearing not further business of the Council adjourned the meeting.

ANGEL GUTIERREZ: Good morning. It is 10:15, and you're welcome to the meeting of the Codes, Regulations, and Legislation Committee. We have three regulations on the agenda. Two are for adoption, and one is for discussion, and the first item on the agenda concerns hospital sepsis protocols. Dr. Gesten from the Office of Quality and Patient Safety will conduct the presentation. Dr. Gesten, please go ahead.

FOSTER GESTEN: Thank you so much, and good morning to everybody. We came before you at the last meeting, and went through and introduced the sepsis regulations. During that period of time we had an open comment period, and I'm going to report briefly on the comments that we received in our response to them, and I'd be happy to entertain any comments or questions.

We received about 13 comments from different organizations regarding the proposed sepsis regulations. And I would way that there were essentially there things that we made modifications to of a relatively minor nature. The first one had to do with the timeframe of the implementation. We did hear from multiple parties that, concerns about the timeframe and what was perceived to be a fairly tight timeframe to respond to regulations, as well as to put the protocols in place. We made modifications to the regulations to move the date of submission of protocols from July 1 to September 3 giving the hospitals an

extra two months to submit those protocols to us. The second timeframe that we moved was related to implementation. While hospitals could start implementation at any time after submission after they've been reviewed by the Department and found to be consistent with the guidance document. They have until December 31, 2013 to put those protocols in place, rather than 45 days following receipt of a letter of approval. So, this will end up giving hospitals at least at the maximum 90 days to implement rather than 45 days provided they submit them as late as September 3.

Couple of other, just clean up on definitions. We clarified some of the terms that we had in terms of severe sepsis and septic shock, and then the last change that we made was a clarification to the definitions of severe sepsis and septic shock, clarifying the definition for pediatrics. We got some comments that there's a couple of words that were a little bit off or needed to be added to fully clarify those definitions for kids versus adults, and we made those changes.

Just briefly, we had a number of other comments. Some of them included issues related to ongoing protocols or definitions of time zero related to measurement, and we plan to address most of those questions and issues will be clarified in our guidance document which we are developing and which will help create more specificity to some of the wording in the requirements in the regulations.

There were some questions about applicability of the regulations. The intention is that it relates to ED and inpatient settings and article 28 acute care facilities. There were some questions about seeking clarification or concern about the the regulations were requiring the use of an invasive protocol, specifically use of a central line, and that we clarified that that is not so, and that be further clarifications of that in the guidance document as well. I mentioned about times zero essentially definitions of when the clock starts in terms of the protocols which have a times portion to it, and in terms of the measurement, we plan to have multiple times there since there are a number of different issues we want to capture in that measure.

There were some questions about timing of submission or starting to submit data and there was one response that asked us to delay that for a year or so to get, have hospitals begin the protocols, but we feel strongly that we can start piloting their receipt and collection of that data, essentially this year understanding that it’s going to be process and it will take probably sometime before we have data that we believe is completely valid accurate, so on.

There was some questions about the placement of the regulations. Medical staff versus hospital administration, but we got some feedback as we were putting this together that it was specifically important to place regulations both under the

hospital board as well as medical staff and that's where we decided to keep the regulations.

We had a couple of comments from manufacturers or industry representatives about various products that they thought could be useful or helpful related to prevention of sepsis, and were urging us to put in specific components related to prevention. We felt that the scope of the regulations were really not focused on prevention – sort of opened up a pretty big door in terms of thinking about prevention. Worthy of consideration, a topic that we're going to be working on but not right for these specific regulations.

There was questions about the reporting of the measures and whether this was going to be part of future hospital reporting. I would say the short answer is yes, but not right away. Again, as we've done with other sorts of reporting, public reporting, some time will need to take place, we feel, until we have data that we think we can publicly report.

So that's the quick high-level summary of comments and our responses to them, and I'm happy to answer any questions that folks may have.

ANGEL GUTIERREZ: Thank you very much. Any discussion from the Committee or the Council? I don't have anybody having called to talk. Anybody from the audience that wishes to

address this topic? Please, go ahead. Identify yourself and your affiliation please.

FRED HIEGLE: Good morning, thanks. My name if Fred Hiegle.

ANGEL GUTIERREZ: You have three minutes.

FRED HIEGLE: I won't take that long. I'll be quick. You know, I'm really here – I'm Fred Hiegle and I'm from HANYS and I'm here to lend our support to the regulations as modified and to thank the Department for hearing our comments and responding to those comments. HANYS has always been supportive of the goals of addressing sepsis. We've conducted a very extensive outreach to our members. We included consultations with national experts and we have a sincere desire to make this work. We had a very positive dialog with the Department of Health which we appreciate very much. It led to several of these modifications. We do trust that the Department recognizes that there's important value in implementing the sepsis protocols in the emergency department first. And we appreciate the additional time to do that. We hope the Department will respond quickly to review of protocols once they are submitted within the timeframes, and we very much look forward to continuing to

work with the sepsis advisory workgroup as time goes on, and as this all evolves.

Again, thank you very much for the modifications and responding positively to our comments.

ANGEL GUTIERREZ: Thank you very much. Any other comments or questions from the committee? If not, I entertain a motion. I'm sorry. Is there anybody else that wishes to speak besides – OK. Please identify yourself.

DEBORAH BROWN: Good morning. I'm Deborah Brown from the Greater New York Hospital Association. Very briefly we too wish to offer our support and our thanks. This is obviously an issue that is of great importance to greater New York. We've worked on UHF on our Stop Sepsis collaborative for some time now, working closely with the Department, and I know my colleagues will continue to do so. We too are thankful for thoughtful consideration of our comments, some of the changes that were made, and we look forward to addressing this issue together going forward.

ANGEL GUTIERREZ: Thank you very much. I will now entertain a motion. Mr. Hurlbut, second. OK. Any further discussion? All in favor on the committee?

"Aye."

ANGEL GUTIERREZ: Anybody opposed? Any abstentions? The motion is carried.

I will ask several members of the audience who have asked to speak on the following motion to approach the table and get themselves ready to talk when the time comes.

Next on the agenda, the provisions regarding the prevention of influenza transmission by healthcare residential facilities and agency personnel. Dr. (Luterlo) from the office of public health will present this regulation and the people that will be first in line to talk will be Fred Hiegle, Deborah Brown, and Jill Goldstein. If they would approach the table so we can gain some time. We have a long day today please. Dr. Luterlo, please.

DR. LUTERLO: Thank you. This regulation was previously presented to codes committee on February 7, briefly requires healthcare workers in designated facilities and agencies to wear surgical masks during influenza season if they haven't received the influenza vaccine.

ANGEL GUTIERREZ: Is your mic on?

DR. LUTERLO: Thank you. So, this regulation was previously presented at codes committee on February 7, and

briefly it requires healthcare workers in designated facilities and agencies to wear surgical masks during influenza season if they haven't received a flu vaccine that year. And it requires the facilities and agencies to report influenza vaccination rates to the Department of Health.

For the past two decades the Centers for Disease Control and Prevention has strongly recommended that healthcare personnel be vaccinated against influenza, and some healthcare and residential facilities and agencies have voluntarily implemented strategies to increase influenza vaccination rates among their personnel, but these efforts have met with limited success. During the 2011 and 2012 flu season, an average of only 48 percent of healthcare workers in hospitals and 45 percent of workers in nursing homes were vaccinated. As you know, this past influenza season was severe in many respects, not the least of which was the number of outbreak reports for influenza inquired in hospitals and nursing homes. This season there were 107 reports from hospitals, and 439 reports from nursing homes. The severe influenza season highlighted the need to take additional steps to protect patients which is the intent of this regulation. We received 13 comments from the public; 10 of them were opposed to the regulation; two were supportive, and one didn't address the key components of the regulation, but rather expressed support for mandated influenza vaccination of healthcare personnel. Eleven of the comments were from

professional organizations. One was from a health department and one was from a private citizen.

So, the comments could be categorized in five groups, and a miscellaneous category. The first category addressed approach and evidence. Several commenters stated that there was a lack of evidence that masked whereby unvaccinated healthcare workers would decrease transmission to patients, and while it's true that a study that directly addresses this question has never been conducted, logistic and also ethical considerations essentially would prevent such a study from ever being conducted. And accordingly the Department has analyzed related evidence and drawn reasonable inferences to formulate it's policy and that policy is that in the absence of vaccination requiring healthcare workers and others who are in close proximity to patients to wear masks is the best additional step we can take to prevent the transmission of influenza.

Although masks might not be as effective as vaccination, evidence does indicate that they may lessen transmission of influenza. CDC recommends the use of masks by potentially infectious persons to help contain the respiratory secretions. For the purposes of this regulation, we would consider that recommendation to apply to healthcare workers who are either infected and potentially contagious but not yet symptomatic or who are working with a mild illness that's not recommended as influenza. Additionally the infectious diseases society of

America recommends that healthcare personnel, who aren't vaccinated for influenza, wear masks.

Some comments in this category also suggested that different approaches to the problem such as mandatory influenza immunization education programs and emphases on hand hygiene and cough etiquette would be better. However, we know that despite many efforts over the years to educate healthcare personnel, influenza immunization rates remain unaccepted low. These efforts are ongoing and the messaging is ubiquitous before and during the flu season, but it just hasn't worked.

So, the next category of comments addressed the burdens that the regulation would impose on facilities and agencies. Although there was general agreement that the cost per mask is quite low, several commenters calculated higher cost for mask use for their personnel than was estimated by DOH. However, in most settings we would expect the cost to be less than $1 per shift per unvaccinated worker, which really is a tiny proportion of the budget of the covered facilities and agencies. And furthermore, from the perspective of the health system as a whole, fewer cases of influenza among healthcare workers and fewer instances of transmission to patients would actually decrease costs.

There was also concern about excessive documentation requirements. The regulation includes requirements that covered facilities and agencies report immunization rates to DOH. All

of the parties covered by this regulation already must maintain a health record for their employees that contains information like rubella status and TB testing results. So we don't think it's too much additional burden to add influenza immunization status.

One commenter was concerned about the requirement for name, address, and date of immunization as proof of vaccination if a healthcare worker was immunized by an outside provider. But these data elements are typically provided on the immunization cards that are given to patients after immunization. So it shouldn't be difficult for healthcare workers to provide, and really those data elements are needed to ensure that the vaccination was really obtained.

The third category dealt with concerns about worker safety. There was some concern about the physiologic burden of wearing masks for persons with lung problems or claustrophobia. But we have to remember that we're talking about a simple surgical mask. They're very lightweight, the don't form a tight seal, they're the type that are worn in hospitals every day for hours at a time such as in operating rooms. We're not talking about N95 respirators which could potentially form a physiologic barrier. Also, personnel covered by this regulation already would have to wear masks for a number of other reasons. It's just the nature of the work.

There were also some concerns that masks might pose a safety issue for healthcare workers because of increased communication barriers or negative reactions to personnel wearing masks. And there was some speculation that they can increase workplace violence as a result. In situations when this is a concern, we would expect the facilities and agencies to use the same procedures as are used now when masks are required for other reasons. We don't think this regulation increases the risk of workplace violence, and the regulations requirement to wear a mask does not violate the New York State public employer violence regulations as two commenters suggested. The Department notes that again, currently healthcare personnel might be required to wear a mask for a variety of reasons not related to these regulations.

Finally, there was concerns that the regulation would require each facility to conduct an OSHA hazard analysis. OSHA regulations require that all employees evaluate their workplaces for hazards and take appropriate measures. The regulation – excuse me, this regulation does not require any additional hazard analysis beyond what's already required under OSHA regulations nor does it violate OSHA laws or regulations in any way.

The fourth category of comments dealt with worker rights, with some commenter saying that the regulation was coercive and punitive rather than preventative, and that it would violate the

privacy of healthcare workers. However, the Department maintains that this regulation is designed to give healthcare workers a choice in how they protect their vulnerable patients from influenza, either immunization or mask wear, and while neither one is perfect, both would be expected to provide some level of protection for patients. Furthermore, a state regulation requiring that unvaccinated personnel wear masks does not violate HIPPA as was suggested by one commenter.

The fifth category is enforceability. This seemed to be a concern mostly for homecare agencies when staff are out in the community and might not be easily monitored. The Departments position is that the agencies will need to develop policies and a means of assessing compliance, just as they currently do for other regulations that effect care in the home.

So, given the comments received and summarized here, the Department has not made any changes to the regulation, and we ask that the Council consider it in its current form. Thank you.

ANGLE GUTIERREZ: Thank you very much. Any questions or comments from Committee or Council members? All right. We have speakers that have asked to be included in the discussion. I would like to ask you, because the session is being recorded, that you state, again, your name and affiliation, speak close to the microphone. Mr. Hiegle, please.

FRED HIEGLE: Good morning. Thank you. Fred Hiegle from HANYS, and I'm here today speaking on behalf of HANYS state-wide membership and our strong commitment to providing the highest quality care and services to the patients we service.

We well recognize the need to protect patients from flu and protect the staff that serves them, and candidly we applaud the Department for its efforts to bring about these protections through these regulations, and we support these regulations. Thank you.

ANGLE GUTIERREZ: Thank you very much. Ms. Brown.

DEBORAH BROWN: Good morning. I'm Deborah Brown from the Greater New York Hospital Association. We too are here today to support this measure. We thank the Department, the Council, the Committee for their leadership on this issue. We believe that this advances the goal which should be our most important goal of protecting the health and wellbeing of our patients and of our healthcare workers. This is a sensible way to address this problem, and we look forward to working with you as we go forward.

ANGLE GUTIERREZ: Thank you Ms. Brown.

JILL GOLDSTEIN: Good morning, my name is JILL Goldstein. I'm from the Visiting Nurse Service of New York. I want to thank you for having us here and to this proposal. I'm here on behalf of Mary Anne Christopher, the president and CEO of the Visiting Nurse Service of New York and many of you do know that the VNSNY is the provider of healthcare services in the homes and the communities of thousands of New Yorkers, and many of the most vulnerable. We treat many of the most vulnerable populations. As an employer of over 18,000 employees who deliver and support this care, VNSNY is dedicated to this proposal. And we will work, we continue to work closely with the Governor and the Commissioner and our policy makers, community leaders and lobbyists to improve the response of the home care health workers and the vulnerable communities, despite some of the challenges that you've outlined. They're very real, but not extenuating that we can't overcome them. Again, we are in absolute support of the roll up and mask up process.

ANGEL GUTIERREZ: Thank you very much. Next in line, Helen Tooley and Wendy Saunders. Please approach the table.

HELEN TOOLEY: From 1199 SEIU United Healthcare Workers East. Tanya Grant is going to deliver our comments.

TANYA GRANT: Good morning. My name is Tanya Grant. I am a member of 1199 SEIU and I'm also a licensed practical nurse in the capital region. I'm delivering this testimony on behalf of the 270,000 members of 1199 SEIU United Healthcare Workers East in New York State. Our members include registered nurses, respiratory therapists, licensed practical nurses, certified nursing assistants and home health aides and many others who direct patient care to millions of New Yorkers each year. The first sentence of our organization's constitution states, we are healthcare workers devoted to our patients. It is for this reason that we support the proposed regulations regarding the influenza vaccine. The work we do and the care we have for our patients. As healthcare workers we are at risk of occupationally acquired influenza, vaccination is the best method available of preventing transmission of disease. In addition to protecting healthcare workers, vaccination of workers can prevent transmission to patients especially those who are not able to receive vaccinations or who respond poorly to them. We encourage all of our members with direct patient care responsibilities to be vaccinated as recommended by the Centers for Disease Control. For example, this past flu season together with our benefit fund we held a number of health fairs for our homecare worker members to increase the rates of vaccination. For those who have not, who are not vaccinated, the requirement to wear a mask is a sensible alternative. Taken

together, these common sense regulations protect both the patients and our workers. We believe this will prevent illness and potentially save lives.

ANGEL GUTIERREZ: Thank you very much. Next.

KATE TULLY: Good morning. My name is Kate Tully. I'm a senior policy advisor at the New York State Association of Healthcare Providers. We are a trade association representing LHCSAs, CHHAs, long term home healthcare programs, hospices, and related health organizations. First of all, I want to thank you for the opportunity to comment on the proposed regulation requiring unvaccinated personnel in healthcare and residential facilities and agencies to wear a surgical or procedure masks during the time that the Commissioner determines the influenza is prevalent. HCP has submitted a letter to the members of the Council during your informative session, and also submitted detailed comments to the regulations.

I just want to highlight a few issues that HCP members are very concerned about. HCP and its members are certainly concerned for the health and safety of the homecare workers and the patients they serve. We appreciate and support the efforts of the commissioner and the Department of Health to inform the public of the seriousness of influenza and its impact on New Yorkers, especially the elderly and the young. Our homecare

providers have been actively involved in these efforts, instructing staff on the benefits of healthy behaviors, strongly recommending vaccinations and encouraging staff to stay home when they are sick. Now, the CDC has strongly recommended that all healthcare personnel be vaccinated against influenza as the most effective means of mitigating and reducing transmission of the virus. The documentation on best practices does not provide any assurance other than precautionary as is hand-washing that wearing of a mask will prevent the spread of the virus. The CDC website discusses spreading of illness in community settings where patients are compromised such as hospitals, nursing homes, and long term care facilities. This is distinguishable from the homecare delivery setting where appropriate precautionary measures can and are used to protect the health and safety of the individual patients and their aids. The homecare setting is just that; a home. Aides spend hours with the patient and to require a mask in such a setting is unreasonable, especially when the mask effectively diminishes rapidly upon use. These proposed regulations do raise many questions including how long should the mask be worn, how often should it be changed, is it solely for direct contact? What if the aide is transporting the patient in the car, running errands? Must the aide wear the mask when they go to Price Chopper? What is the disposal protocol? Is this medical waste? These regulations also pose problems from the patient’s perspective. How will the patient

wish dementia or developmentally disabled person react when the caretaker is wearing a mask? These patients are comfortable and feel safe in their home, but when confronted with a masked worker in their home, who knows how they may react the intent of the proposed regulation is laudable and important, however the additional cost administrative burdens go beyond the cost of masks and are anything but nominal. Documenting vaccinations, developing policies and procedures for a process that begins when the Commissioner determines the influenza season has begun is difficult to plan for and is cost measure. Home care providers are financially struggling with many unfunded mandates and would now be required to assume financial responsibility for this mandate as well.

ANGEL GUTIERREZ: Please wrap it up.

KATE TULLY: Yes. Homecare setting is just that; a home. Homecare urges the withdrawal of the proposal or in the alternative promulgate general guidelines and recommendations that the homecare communities can continue best practices and determine when masks are necessary for quality and preventive care. Thank you very much for your time.

ANGEL GUTIERREZ: Thank you. I have Wendy Saunders.

WENDY SAUNDERS: Thank you. I'm Wendy Saunders. I'm an assistant vice president for intergovernmental relations with the New York City Health and Hospitals Corporation or HHC. HHC is the largest municipal healthcare delivery system in the country. We serve 1.4 million patients each year. More than 70 percent of our patients are Medicaid beneficiaries and 480,000 of them are uninsured. HHC is an integrated healthcare system that provides comprehensive medical and behavioral health services through 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers and more than 70 community-based clinics. Our system includes a health plan, Metro Plus, that has more than 420,000 members. We also operate a certified home health agency, HHC Health and Homecare.

I'm speaking today in support of the regulations. Influenza, as you've heard, poses a serious threat to the health and safety of our patients, employees, and their families as well as the community at large. In addition to the health impact of the flu and all who work in healthcare settings and especially on our patients, there are other costs; lost work time reduces our ability to deliver patient care, healthcare workers may have to pick up slack for sick colleagues, and increased episodes of flu mean that all over the community people miss work, school, and family activities. Without question, vaccination against the flu is the essential safeguard for our staff and patients. Vaccination, as you've heard, is a

safe and effective and we view obtaining vaccination as a personal, professional, and public health responsibility for all of our healthcare workers. HHC has taken a comprehensive approach in our efforts to vaccinate our employees. We strive to make it as easy as possible for employees to get vaccinated. For example, we deploy flu coordinators who are charged with getting as many staff vaccinated as possible. We offer vaccinations at convenient locations and times throughout all of our facilities and corporate offices. For example, for two weeks in the fall of 2012, every HHC facility deployed vaccination teams that made rounds offering flu shots on all tours and all shifts. We have also endeavored to raise awareness of the importance and safety of flu vaccination through the use of posters, flyers, information on pay stubs and messaging through our internet. We've held small group discussions among employees to inform them about the benefits of vaccination and to address misconceptions and mythology. We tried providing cash and merchandise incentives to promote employee vaccination. With all of the above, we've made some progress. However, while vaccination rates vary by year and by facility, on average, less than half of our employees get vaccinated in any year. As of March 19 of this year, only 38.9 percent of our 38,000 full and part time workers have gotten flu vaccines, and that's not good enough.

ANGEL GUTIERREZ: Please wrap it up Ms. Saunders.

WENDY SAUNDERS: Yep. Given the deadly nature of the virus and a risk in safety of our patients, we strongly support the proposed regulations. As you've heard, for personnel unable or unwilling to get vaccinated, the use of masks has been shown to lessen transmission and limit our patients and other employees' exposure to the virus. Anything that the healthcare community and policy makers can do to lessen the transmission of influenza is a step in the right direction. In conclusion, we urge you to approve the adoption of these regulations. Thank you.

ANGEL GUTIERREZ: Thank you. Members of the Committee, I'd like to hear a motion in favor of this proposal? OK, second. OK. Any further discussion? All in favor?

"Aye."

Anybody opposed? Any abstentions? The motion is carried.

The last item on the agenda is a presentation for discussion concerning the children's camp provisions. Mr. Shea from the Bureau of Community and Environmental Health will lead the discussion. Please, Mr. Shea, go ahead.

MR. SHEA: Good morning. Thank you. As indicated, I'm here today to discuss some proposed amendments of subpart 7-2 of the state sanitary code, which are the regulations that pertain to children's camp. These proposed amendments are necessary to implement recent legislation that established a New York State Justice Center for the protection of people with special needs and intended to strengthen and standardize a safety net for vulnerable people that receive care from New York State Human Services agencies and programs.

The legislation identifies children's camps for children with developmental disabilities as a type of program to be within oversight of the Justice Center and requires the Department of Health to promulgate regulations that are consistent with the legislation and approved by the Justice Center pertaining to staffing requirements and incident management. The existing regulations define camps for the disabled to be those that have at least 20 percent or more children with developmental disabilities. Some of our camps are fully cater to these types of clientele. Others only a small portion of the camp is dedicated to children with disabilities. The regulations were only pertained to camps with 20 percent or more of a population.

Currently only 37 of approximately 300 regulated children's camps – sorry, 3000 regulated children's camps are identified as being for the developmentally disabled. There are 13 overnight

camps and 24 summer day camps. Existing regulations also already contain special requirements for camps for disabled campers including medical oversight, special staffing, activity safety, and accessibility requirements. These regulations did not apply to other camps that don't have at least 20 percent or more of its population for the disabled. The Justice Center legislation requires the Department to enhance staff screening, staff training, and incident management procedures for these camps only and do not apply to camps without 20 percent or more of the population. I'm going to address a few of the specific requirements of the regulation pertaining to staff screening. First, camp administration will now be required to verify that any potential employee or any camp staff is not contained on the Justice Center staff exclusion list. The Justice Center, it will be establishing and maintaining a state-wide database of names of individuals that have been substantiated as a subject of a reported, reportable incident.

Just a point of clarification; when I say 'camp staff,' that includes any employees or volunteers that will have contact with campers.

Next, all camp staff will now be categorized as mandated reporters and will be required to obtain mandated reporter training. As mandated reporters, camp staff must report allegations of abuse, neglect, and other significant incidents to the Justice Center vulnerable persons central registry and to

the Department of Health. The proposed amendments also include some additional mandates for reporting that have not historically been required of camps. Typically camps operators have been required to report incidents of physical and sexual abuse in addition to certain injuries and illnesses. This new legislation will require camps for the disabled to additionally report psychological abuse, neglect, the deliberate and inappropriate use of restraints, the use of aversive conditioning, certain medication errors, and any incidents where somebody was obstructed from reporting a reportable incident.

In addition to the mandated reporting requirements, camp staff are now required to review and acknowledge an understanding of the Justice Center code of conduct. This information will be provided to camps so they can have all their staff do this acknowledgment.

Pertaining to incident management, camps are required to cooperate fully with reportable incident investigation and provide and disclose all necessary information and access to conduct investigations by local health departments and the Justice Center. This has always been our expectation. This requirement just codifies it in the regulation at this time.

And last obligation for the children camp that I want to highlight, the camps will be required to convene a facility incident and review panel for review a camps response to reportable incidents. The panel’s responsibility will include

making recommendations for improvements to the camps response and to reduce reportable incidents. Also is some potential for reviewing trends and patterns of anything that have been appearing at the camp. There is an opportunity for a children's camp to receive an exemption for this incident review panel upon application to the Department. These applications are considered necessary because there could be some undue hardship of burden placed on the camps because of the small nature of the camps and the short duration that they may operate. Some camps may only operate a few weeks a year. Waivers or exemptions from this requirement will be based, will be issued when there is no unreasonable risk or health safety of the campers at the camp.

Finally the proposed regulations also specify reportable incidents investigation procedures and written incident report requirements for investigations conducted by both the Justice Center and those delegated to local health department. Currently the Justice Center will be investigating all incidents of abuse and neglect and the responsibility for investigating other types of incidents will be determined on a case by case basis by the Justice Center. The requirements require – the new proposal required no capital improvements and will only require changes in policy procedures of the camp. Thank you.

ANGEL GUTIERREZ: Thank you Mr. Shea. Any questions or comments by members of the committee? Dr. Boufford.

JO BOUFFORD: Yeah, I have a basic question; what is the governmental – what's the nature of the Justice Center? Is it a governmental entity? Is it an NGO created by government? I'm not familiar with it.

MR. SHEA: I believe it's an agency inside what the legislation says is the executive department. So I don't know how to clarify that any more. It's a brand new established with this legislation that was enacted in 2012 and will become effective in July 30 of this year.

JO BOUFFORD: Thank you. And then, just one more question; I mean, one of the, you alluded to it but I think it may be one of the issues that you since we're discussing this, I don't know that one can predict, but I guess you would be worried of losing providers for a fairly high needs population because of the regulations. I'm sure that's being considered. You mentioned it, but it strikes me if there are, you said you would provide waivers assuming there were protections, but there aren't that many and I know folks with disabled kids, it's hard to find camps like Camp Opportunity, so I just mention it in that context.

ANGEL GUTIERREZ: [inaudible]

JEFF KRAUT: There are special requirements for reporting incidents with children of developmental disabilities, so I'm clear at a special needs camp, the ones I'm familiar with where it's very clear. There's no definition in the reg of developmental disability, and maybe there isn't in state, but could this possibly apply to camps that have children who maybe on the spectrum? And they would have the same reporting requirements as here?

MR. SHEA: The state sanitary code subpart 7-2 does contain a definition of developmental disability. I could read that for you if you choose. It does.

JEFF KRAUT: (Does)this apply in a more broadly defined – I guess, is that definition broadly include maybe what some people may not consider a developmental disability but for the sake of the law – you know, kids with Asperger's or autism, but that are mainstream, so to speak, or in more typical populations.

MR. SHEA: Typically, no. Would not be – this is, the definition includes wording such as 'severe' and 'chronic' disability. That wording of that nature.

ANGEL GUTIERREZ: Any other comments or questions? Yes.

DR. SULLIVAN: I just have a question about the 20 percent. While this may seem burdensome to some camps, I mean, when children are vulnerable, they're vulnerable. I'm just wondering where the thinking comes, I mean, perhaps there could be some modifications, so it'd be easier for those with smaller populations, but to have that kind of arbitrary cut off is interesting. So where did that come from?

MR. SHEA: That's a good question. The regulation has been in effect for many years. Because it imposes an additional requirement for certain campus, I believe they thought that a threshold would need to be achieved in order to balance those additional requirements with the needs of the campers. I can't really – it's a long standing requirement and something that the Department has discussed looking further into on how we can better protect the children.

DR. SULLIVAN: Just might be interesting to look into some – there might be modifications for ones that have smaller - but things like checking certain people's background would seem to be something you should do.

MR. SHEA: The existing regulations have certain background check requirements -- sex offender registry requirements. Through diligent and reasonable searches that apply to all camps in addition. This will just impose the additional vulnerable person registry check that is being currently developed and will be brand new this summer.

ANGEL GUTIERREZ: Any other questions or comments?

MR. SHEA: I'd like to just correct one statement that I made. I said the legislation will become effective in July of this year. It's actually June 30 of this year. Thank you.

ANGEL GUTIERREZ: Thank you again. While nobody has called ahead to speak on this regulation, is there any member of the public that wishes to comment? If not, I will entertain a motion from the Committee. Yes, Dr. Bhat. Second? Any further discussion? Is there any questions? OK. All in favor? Anybody opposed? I'm sorry.

(What is the motion for?)

ANGEL GUTIERREZ: My apologies. It's just for discussion. Thank you. That concludes – I need a motion to adjourn. A motion to adjourn. So we are done. Thank you.

WILLIAM STRECK: With the conclusion of the Codes and Regulations Committee, we can begin the Public Health and Health Planning Council meeting for today. I'm Dr. William Streck, Chair of the Council. And I have the privilege of calling the meeting to order. We have executive deputy commissioner Kelly here as a participant and our other guests. Going through the housekeeping rules, I'd remind everyone that this meeting is subject to the open meeting law. It is broadcast over the internet. The webcasts may be accessed at the Department of Health's website and they are available no later than 7 days after the meeting for a minimum of 30 days. There are some suggestions or ground rules for our discussion. There is synchronized captioning here, so it's important that people do not talk over each other. The first time you speak please identify yourself as a Council member or DOH staff. And please note that the microphones are hot, they pick up every sound including the rustling of papers and unintended comments. There's a record of appearance form outside for the audience that needs to be filled out before you enter the meeting room. It's required by the Joint Commission on Public Ethics in accordance with executive law 166.

Next, I'd like to give you a brief overview of what we will cover in today's meeting. We'll return to the Codes and Regulations Committee's work when that committee reports. We will have the Department of Health reports, first from Ms.

Kelly, then Ms. Westervelt will give an update on the Offices of Primary Care and Health Systems. Ms. Block will report on the activities of the health information technology transformation endeavor. We will defer the office of health insurance program activities report that had been originally scheduled, and we will conclude with Mr. Burke – Dr. Birkhead's report on the Office of Public Health. We will then move to public health services. Under that category Dr. Boufford will update the Council on the important work on the Committee on Public health, and under the category of health policy, Dr. Rugge will update members on the next phase on the Committee on Health Planning. We will then move to project review recommendations and establishment actions. That committee's work will be shared and presented by Mr. Kraut.

The meeting today for council members will conclude with a required executive session. If there are conflicts for members of the Council or guests, they need to be noted and recorded. We do batch our CON applications so you can review any conflicts or interests that need to be noted. If those have not been so noted, please bring those to the attention of the staff.

I would then like to proceed to two special recognition moments here. First a resolution of appreciation for Karen Lipson. This is Karen's last meeting with us as she has decided to gracefully depart state service. The Council is very grateful to Ms. Lipson for her countless hours and the time she

dedicated to improving the healthcare and delivery systems of New York State. On behalf of the Council, Mr. Kraut, Dr. Rugge and myself have signed a resolution of appreciation which I will now read.

"Whereas Karen Lipson has served the citizens of the State of New York over the past five years, beginning her state service in January 2008, as Director of the newly created division of policy within the Office of Health Systems Management where she was charged with coordinating policy developments in legislation, budget initiatives, regulations, and policy directives. Her work in the Department of Health spanned the administrations of Commissioner of Health Richard F. Daines, and Nirav Shah. Ms. Lipson contributed to countless successful initiatives and many facets of healthcare, always with patient safety and quality of care at the forefront. Notably, Ms. Lipson worked with the Council's Health Planning Committee to streamline the Certificate of Need process and develop a regulatory and health planning framework that drives health system improvement and population health. During her tenure with the Department of Health, Ms. Lipson was instrumental in moving New York State forward in providing innovative healthcare opportunities such as working on the team that assessed the efficacy, safety, and cost-effectiveness of and need for proton beam therapy in New York State through a medical technology demonstration project. Ms. Lipson also

managed planning grants under HEAL phase 9 where she worked to encourage collaborative health planning models that could inform the state regarding local community needs, priority areas and strategies.

Therefore, whereas members of the Public Health and Health Planning Council recognize that during her years with the Department, she has demonstrated a strong commitment to the development of innovative programs, new services, and an efficient and high quality healthcare system, a positive difference in the lives of all New Yorkers and whereas Ms. Lipson’s expert advice and her dedication to strengthening the healthcare system has furthered the Council’s endeavors to improve the health for the citizens of New York State, and whereas Ms. Lipson’s integrity, resourcefulness, diplomacy, work ethic and professional demeanor under all circumstances has garnered the much deserved respect of the Council and her colleagues. Now, therefore be it resolved that members of the New York State Public Health and Health Planning Council with to convey their appreciation to Karen Lipson for her dedication, diplomacy, and for her selfless service to the citizens of our state, and be it further resolved that members of the New York Public Health and Health Planning Council feel privileged to have been able to serve the citizens of New York State with Karen Lipson whom they hold in the highest esteem as both a

friend and a colleague and offer best wishes for her future health, happiness, and professional achievements.”

[applause]

WILLIAM STRECK: We’re providing a copy of that resolution for all your job applications. If you’d like to make some comments.

KAREN LIPSON: It’s very hard to maintain my professional demeanor under these circumstances, but I do want to say that this is a bitter sweet moment, and that it’s really been a privilege to work with all of you and serve as staff to this council, and the people of New York are very lucky to have a group of professionals with such knowledge and expertise helping to guide state health policy. So, I thank all of you.

WILLIAM STRECK: Thank you Karen. I now have to move to the fact that we have compounded loss today because Mr. Douglas Sackett is retiring from the Department of Health, and I have a resolution in appreciation of his work. This is his last Council meeting, as he is retiring. The Council express our appreciation to Mr. Sackett for the important work he undertook to keep children’s camps, drinking water, and spray parks safe. The members of the Public Health Council may recall that Mr.

Sackett was one meeting short of becoming an honorary Public Health Council member since he spent so many council meetings presenting regulations relative to the notorious aquatic spray parks, and those who participated in Doug's education of us about that endeavor will not forget it. So, on behalf of the Council, Mr. Kraut and I have signed a resolution of appreciation for Mr. Sackett, and it goes as follows.

"Whereas Douglas Sackett has served the citizens of the State of New York over the past 38 years his work in the Department of Health spanned the administration of Commissioners of Health Robert Whalen, David Axelrod, Mark Chasen, Barbara DiBono, Antonio Novello, Richard Daines, and Nirav Shah. Mr. Sackett has displayed expertise in many facets of public health in which he was instrumental in the adoption of state regulations to safeguard swimming pools, beaches, children's camps, and temporary residences in New York State. During his tenure with the Department of Health, Mr. Sacket provided excellent guidance to the Council relative to the State's sanitary code. In 1999 in response to the outbreak of E-coli 015787, he played a major role in establishing the agricultural fairground regulation. In addition Mr. Sackett was also part of the team that revised countless campground regulations. Most notably Mr. Sackett assisted in the adoption of environmental health regulations to assure a sanitary, healthful and safe

environment for the public when using recreational aquatic spray ground.

Whereas members of the Public Health Council and Health Planning Council recognize that during his years with the Department he has demonstrated a strong commitment to public health and safety, which has made a positive difference in the lives of all New Yorkers. And whereas Mr. Sackett's expert advice and knowledge of environmental matters has furthered the Council's endeavors to improve the health for citizens of New York State, and whereas Mr. Sackett's integrity, resourcefulness, diplomacy, work ethic and professional demeanor under all circumstances has garnered the much deserved respect of the Council and his colleagues.

Now, therefore, be it resolved that members of the New York State Public Health and Health Planning Council wish to convey their appreciation to Douglas Sackett for his dedication, diplomacy, and for his selfless service to the citizens of our state. And be it further resolved that members of the New York State Public Health and Health Planning Council feel privileged to have been able to serve the citizens of New York State with Douglas Sackett whom they hold in the highest esteem as both a friend and colleague, and offer best wishes for his future health, happiness, and professional achievement."

Thank you Doug.

[applause]

DOUG SACKETT: Thank you very much, and as Ms. Lipson said, it is bitter sweet and I did enjoy the opportunity to work with all you fine folks and the colleagues out in the field and across the country in public health, and wish everybody well and continue the good work. Thank you.

WILLIAM STRECK: Well, thank you, and we are most appreciative that you have really traversed the long tenure of many commissioners here in this state. I think it's quite a remarkable achievement, and we are appreciative.

So with those honorific and expressions of our appreciation, we'll now return to our work, and begin with adoption of the minutes, so I would ask as a first order of business a motion for adoption of the February 7, 2013 minutes.

(so moved)

Moved and seconded. Is there correction, alteration, discussion? Hearing none, those in favor, aye?

"Aye."

WILLIAM STRECK: OK. Thank you. Now, in a quick reprise. We're going to have Dr. Gutierrez to give the report on the Codes, Regulations, and Legislation Committee.

ANGEL GUTIERREZ: Thank you very much, Mr. Chairman. Earlier today the Committee met in special meeting to review three regulations, two for adoption and one for discussion. The first proposal concerned hospital sepsis protocols. This proposal will require general hospitals to have in place evidence-based protocols for the early recognition and treatment of patients with severe sepsis and septic shock that are based on generally accepted standards of care. The medical staff must adopt, implement, periodically update, and submit to the Department such evidence-based protocols and also ensure that professional staff are periodically trained to implement the protocols. Sepsis protocols must include components specific to the identification, care, and treatment of adults and of children, and must clearly identify where and when components will differ for adults and for children. Hospitals will be responsible for the collection, use, and reporting of quality measures related to the recognition and treatment of severe sepsis for purpose of internal quality improvement and reporting to the Department. After a motion and a second, the Committee unanimously recommended adoption to the full Council, and I so move.

WILLIAM STRECK: There has been a motion. Is there a second? Second. Is there further discussion on the motion from

the Codes Committee? Hearing none, I would ask for those in favor of the motion as presented to say aye?

"Aye."

WILLIAM STRECK: Opposed? Thank you. The motion carries.

ANGEL GUTIERREZ: The next item on the agenda was a proposal regarding prevention of influenza transmission by healthcare, residential facility and agency personnel. This measure will require all unvaccinated personnel in healthcare and residential facilities and agencies to wear a surgical or procedure masks while in areas where patients or residents may be present and at the time when the Commissioner determines that influenza is prevalent. All healthcare and residential facilities and agencies must document the influenza status of all personnel for the current influenza season in each individual's personnel record or other appropriate record. Upon the request of the Department, the healthcare residential facility or agency must report the number and percentage of personnel that have been vaccinated against influenza for the current influenza season. Several speakers addressed the Committee regarding this proposal, and after a motion and a

second the Committee unanimously recommended adoption to the full Council, and I so move.

WILLIAM STRECK: A motion has been presented and seconded. Is there further discussion on the motion as presented by the Committee? Hearing no further discussion, I would ask for those in favor of the motion as presented to say aye.

“Aye.”

WILLIAM STRECK: Those opposed? Thank you. The motion carries.

ANGEL GUTIERREZ: The last item on the agenda was a discussion of a regulation that amends the children’s camps provisions. This proposal was developed as a result of new legislation creating a Justice Center for the protection of people with special needs. The regulation adds new definitions of camp staff, Justice Center and reportable incidents that makes clear the reportable incidents are to be reported to the Justice Center as well as to the Health Department. The regulation clarifies that adequate supervision of campers includes protecting campers from any unreasonable risks to experiencing a reportable incident, adds language specifically

addressing the investigation of reportable incidents, and obligates camps to cooperate with investigations and disclose information to the Health Department and Justice Center relevant to reportable incident and investigation. It adds a requirement that camps consult to the Justice Center's staff exclusion list with respect to prospective employees and requires camp staff to obtain mandated reporter training and acknowledge that they have reviewed and understood the Justice Center code of conduct.

That, Mr. Chairman, concludes my report.

WILLIAM STRECK: Thank you. We will now move to our various reports. Ms. Kelly is here in lieu of Dr. Shah today to provide an update from the Commissioner's office. I will turn the microphone to her.

SUE KELLY: Thank you, Dr. Streck. Good morning members of the Council and members of the public, observers here this morning. As Dr. Streck said, Commissioner Shah is unable to attend the meeting. He's in New York City attending the taskforce on life and the law meeting today, but I'm pleased to be here in his place.

I'll start with a brief report on the enactment of the 2013-14 State budget, and some of the recent activities of the Department. As you're all aware, New York State adopted its budget for the new fiscal year prior to April 1, the start of

the new fiscal year. And I wanted to go over some of the highlights of enactments as part of the budget. Among the highlights are temporary operator legislation, authorization of additional assisted living beds, and redesign of general public, the general public health work program.

Starting with temporary operator legislation which will permit the health commissioner to appoint a temporary operator of a general hospital, diagnostic and treatment center or adult care facility licensed by the Department when it is determined that the operator is experiencing serious financial difficulty that jeopardizes access to care in the community or if patient safety may be in danger because of conditions in the facility. In addition, a current operator may also make a request to the Commissioner to appoint a temporary operator. The appointment of such operator will generally be limited to a term of no more than one year.

The Department endorsed this initiative and had been working to achieve this initiative to allow us to work with individual facilities to address severe financial problems. It is our hope that a temporary operator can help to stabilize the fiscal situation as the Department works with the facility on strategies to strengthen its finances and to address any quality or patient safety issues.

Another budget initiative as I mentioned supported by the Department and adopted as part of the budget authorizes the

Commissioner to add up to 4500 assisted living program beds which will increase access to care for many people who will benefit from being in an assisted living program. To be eligible to apply for additional beds, an adult home must have a bed capacity of 80 or more beds with at least 25 percent residents having a serious mental illness. The budget supports this increased capacity to assist in the transition of residents to more independent housing and also provides capital cost reimbursement to these adult homes for facility renovations to meet future residents or health system needs.

With regard to public health, the adopted budget includes the redesign of the general public health work program, the first redesign of this program in several decades. In light of the fact that an increasing number of New Yorkers are expected to become insured, the redesign will focus on population based public health interventions, rather than clinical services. Core public health services are also redefined to include chronic disease prevention and emergency preparedness response for the first time. Beginning in 2014 counties will receive increases in their base grant awards for these core services. In addition the program includes a performance incentive payment component. And I must say, you know, around the table are members of the Department, colleagues who worked through the night, many evenings, many months, sometimes many years working

towards achievement of these initiatives, and we were so pleased that they were enacted during the legislative budget session.

Let me mention a few major initiatives related to Medicaid and health insurance programs that were approved in the final budget. The budget supports of course, care management for all so that within three years all Medicaid members and services will be effectively managed and patient care will be integrated. As a result, initiatives such as health home establishment grants and behavioral health integration efforts will move forward contingent on funding being available, of course. In addition, the budget preserves the global spending cap which is unique to New York. The spending cap has proven highly effective in bringing greater fiscal responsibility and transparency to Medicaid in our state.

Since Governor Cuomo initiated Medicaid redesign and reform, we've made great strides to make the program more efficient, bend the cost curve, and of course develop new models of care to improved services and health outcomes. As a result of that success, this year's budget also sets the stage for restoring the two percent across the board rate reduction as early as April 2014, just one year from now. Now, while some major health initiatives as we've noted were adopted in this year's budget, there's some key programs that were not adopted in the final plan. One of them was certificate of need, CON redesign. We all know the hard work and tireless efforts and we

appreciate the Council's work over the past year to create an effective plan. While the legislature did not approve the budget language for the redesign, we have a commitment from key legislators to continue discussions off budget, which we will proceed to do. CON redesign remains a priority of the Department and we will continue to work to build support for these valuable recommendations and will keep you updated on our progress.

I also want to mention another initiative that did not make it into the enacted budget. The legislature as you know, did not include a pilot program to allow the formation of business corporations with access to investor capital and expanded debt financing opportunities to operate hospitals. This is an issue that raised some concerns among legislators, but we expect it will be debated in the future. So we expect continued discussion and deliberation. Overall, we think there were many positive health initiatives in the 2013-14 budget plan, and we will continue to work closely with, obviously the Governor and the legislature throughout the year to promote programs and strategies we view as critical to the future of healthcare delivery and public health in New York State.

I wanted to mention there have been some exciting developments in New York's efforts to develop a health benefits exchange. In mid-February a request for applications was issued for the in-person assistor and navigator program; a valuable

tool to help people understand their options and provide direct assistance in applying for coverage. The deadline to submit applications was this past Monday. We're pleased with the response and have started to review the applications. In-person assistors will guide people through the enrollment process and help them access the federal tax credits that will help make New York health insurance affordable in New York.

As you know, there remains a lot of work to be done on the exchange, including launching a large coordinated outreach and marketing campaign to inform and educate people about the exchange and how they can use it as a tool to obtain affordable health insurance. New York continues to make significant process in the development of the state run exchange and will be set to begin enrollment on October – begin the enrollment process on October 1, 2013 with coverage starting January 2014. So the process will begin this coming October with coverage to start at the beginning of the year, next year. We will continue to update the Council on the exchange progress of future meetings.

I also want to briefly mention recent recognition of efforts undertaken by the Medicaid program since we won't have a report today from OHIP. At a forum held the last week in March, the National Committee for Quality Assurance, NCQA, and the New York Health Foundation recognized New York for the high quality of healthcare provided by health plans in the state including the excellent performance of Medicaid health plans. Each year,

as you know, the NCQA issues a state of health quality report to highlight specific health plan performance data on key measures. These include chronic condition management, health prevention measures such as weight assessments and cancer screenings, specific measures targeted to protecting the health of children and older adults, and general wellness of membership in health plans. This independent analysis allows healthcare quality trends and it identifies healthcare quality trends and tracks performance of health plans and overall results were individual states. The 2010 analysis demonstrates that care management, the cornerstone of Medicaid redesign, is working well in New York to improve healthcare quality and lower healthcare costs. NCQA recognized New York for having the most NCQA patient centered medical homes of any state, and I'm sure that attributed to Dr. Gesten's work over the many years, and twice the number of patient centered medical home sites and clinicians of the next highest state in the country. Overall, 40 percent of Medicaid patients with patient centered medical home which improved the delivery of primary care including increased care coordination and access, and that's attribute to all the providers who participate in the program and of course all the efforts of folks in the Department who initiated the program and the support of members around the table.

We're very proud of the progress and of course the Commissioner would be here extolling the praises of all of these

achievements. We recognize the Council as a strong partner in this effort, and we will continue to look to you for both guidance and support.

Another area where the Council has been actively involved has been the development of the 2013-2017 prevention agenda. Last week Commissioner Shah joined New York City Health Commissioner Farley, Dr. Boufford, and representatives from HANYS, the Greater New York Hospital Association and NYU at the Charles B. Wang Community Health Center in New York City to officially launch the plan and highlight its key priorities. The prevention agenda is the framework to guide out public health efforts in a number of areas including the prevention of chronic diseases, HIV, sexually transmitted diseases, vaccine preventable diseases, substance abuse and healthcare associated infections. And it also focuses on strategies and interventions to promote healthy and safe environments, healthy woman, infants, and children, and better mental health. Our efforts moving forward will build on the work of our partners including this council and may I note, 140 other organizations who worked on the agenda and are committed to making New York a healthier state.

I want to thank the Council for your hard work in this endeavor and at future meetings we will share information, of course, Dr. Boufford, on the progress of various prevention agenda initiatives.

Before I conclude my report today, I want to reiterate the bitter sweet change as Karen noted and others noted. I won't repeat the statements from the Council Chair, but I do note that the contributions of Karen Lipson and Doug Sackett really represent the whole range of activities, responsibilities, and the role of the Department, but also reflect the contributions of the Public Health and Health Planning Council. All for the betterment for the population in New York State. And we are so grateful, obviously, for the Council's support and grateful for our colleagues who serves our state so well, and I'm so proud to be here today to join in the recognition of your work. Thank you.

WILLIAM STRECK: Thank you Sue. Are there questions? There are indeed. Ellen, you want to begin.

ELLEN RAUTENBERG: Sue, I'm surprised to not hear you mention the across the board cuts in the budget to prevention programs. Can you tell the Council about those cuts and how they'll be implemented and what the rationale was for that?

SUE KELLY: The rationale for across the board cuts –

ELLEN RAUTENBERG: (As proposed by the Governor?)

SUE KELLY: Well, I mean, cuts are always difficult to, you know, receive to see proposed, to see enacted, but we are dealing with constrained resources. So the Department worked very closely with the Governor's office, with the division of the budget. I – cuts are always painful, but we're making every effort in the implementation of those cuts to reduce pain to the extent possible. But when we are faced with gaps in the budget, when we're faced with changes that obviously some of those changes are interacting with our Medicaid program and closing gaps in our budget as we much achieve a balanced budget, we needed to work with the budget division, with the Governor's office and obviously with the legislature in that public forum and the legislative budget making process. I agree. It's a painful process. I think, I haven't known a year that isn't painful, and we're going through some very difficult times, but we are working with the office of public health, and other offices in the agency to administer the new budget in a way that can reduce pain to the extent possible, but preserve core and evidence-based services and programs through the implementation of that budget.

Gus will be, in his report will probably reflect upon it, but I can't hide the fact that it's always difficult to deal with, you know, budget changes and reductions. But we have to work to implement the legislative budget and try to preserve the programs that we know matter to people. Yes.

(FASSLER:) With the growth of managed care, the long term managed care program, we're seeing now sprouting up of social daycares, and of course, it's been in the paper recently certain problems, are there any plans for the Department to either license and regulate the social daycare programs?

SUE KELLY: I'm not aware of specific plans at this point. We of course, are monitoring the situation, and as you know with the implementation of managed long term care we will see more evidence of these programs, and so we'll, we're constantly doing environmental scanning and we may come back, obviously to the Council or explore with our Governor's office any appropriate changes, whether it be in legislation or in regulation. But I can't predict to you at this moment exactly what will happen other than to make a commitment as we do in the implementation of all of our programs that we're going to monitor the impact on our beneficiaries and the public.

ELLEN GRANT: I just want to compliment the Department again. In my spare time, I'm also an NCQA surveyor, so when we go to our meetings in Washington talking about what the other states are doing, I can speak to and underscore the work that how New York is doing in terms of advancing and achieving the

triple aim with the primary care home and other models. So, congratulations and keep up the good work.

SUE KELLY: Thank you so much.

CARLA BOUTIN-FOSTER: Thank you Ms. Kelly. This is maybe a departure from what we've been talking about budgets but along the lines of patient safety and quality. In recent months we've heard a lot from both the Governor and the Mayor about making New York a model state for gun safety policies. Do you know if there are plans to bring this discussion to the Council and seeing what role we can play in terms of policy for you know, pediatricians asking their patients about safety and things like that? So are there plans to bring this to the Council as we discuss other issues?

SUE KELLY: I will follow up with the Commissioner and others within the Department about this. In the lead up to the gun safety legislation, the Department of Health did provide input to the Governor's office with respect to hospitalizations, emergency room visits, gun related information that spoke to gun related violence. So I think it would be appropriate to report back to the Council. It might be appropriate within other appropriate committees because we're going to be monitoring to see the results of the new gun safety legislation. Thank you.

WILLIAM STRECK: Other comments or questions for Ms. Kelly? Thank you, Sue. We'll now move to the OHSM report with Ms. Westervelt.

KAREN WESTERVELT: Good morning everybody. I just wanted to echo the Council sentiments, and two sentiments upon Karen Lipson's departure. Karen is an esteemed and respected colleague, and I know all of her colleagues, I know HSM want to wish her well. We're going to miss her dearly, but we wish her well. We're sure she's going to be terrific in whatever new position she decides to take. You know, and while that's a sad note, on a happier note we have the occasion today to introduce Elsie Chung who is going to be serving and acting director of division of policy capacity. So we're happy to welcome Elsie. Elsie comes to us recently from the executive office. She previously prior to the executive office has worked in both the Assembly and the Senate and in prior capacities, and she has a lot of expertise in the mental hygiene arena and actually Elsie, I think you actually had a short stint, I think, in the Department of Health for a period of time in governmental affairs if memory serves me correctly at one point in time. So, we're very excited to have Elsie joining us in that regard.

So, the other thing that I wanted to request of the Council after hearing all the wonderful things that you've done, we

don’t want to let a good opportunity pass and task you with potentially another assignment and one of the things that we’re asking the Department, we’re going to be imposing a moratorium on healthcare facilities that are going to be doing new construction or major construction in flood prone plane areas. So therefore we’ve consulted with the Chairman and we’re requesting that the Establishment Committee and if Mr. Kraut would be so kind, putting together a workgroup to consider you know, new construction standards that we can put in place in a reasonable amount of time so we can do this in an expeditious way so that we don’t unnecessarily cause any impediments or delays in projects that would normally be coming before us. However, we would ask also on that workgroup that you know, the Mayor’s office, the New York City Mayor’s office of resiliency and recovery also have a representative on that workgroup as well as our State Office of Emergency Management. They have some expertise in that office, and they’re interested in joining us in that capacity, and we’ve also had HHS that’s indicated that they will make available to us FEMA experts in this regard. So I think there’s a body of work that’s already been put together. I think that we can act quickly on, but if provided you have no objections to that, we would ask that we convene that workgroup and start our work relatively quickly moving forward.

And the other thing that I want to mention is that it was a very busy executive budget session, and as Sue mentioned in her remarks, I won't – you know, we have a number of things yet to go but CON reform is high on our priority list. It is something that we will be reengaging in conversations with the legislature about to try to move forward those reform agendas. It's critically important and the only other thing I wanted to mention is the project review committee at the last meeting had asked for a status update on the SUNY Downstate situation and legislation was passed which many of you are probably aware that the SUNY chancellor has been tasked with putting together a sustainability plan by June 1 that has to be submitted to the legislature and approved by the Department of Health and the Division of budget prior to June 1. So, more to come in that regard. You know, currently with regard to the Long Island Community Hospital, the state is constrained from doing anything to act on that closure plan. We do have a TRO, so discussions between the Department and SUNY are nonexistent really at that point in that regard. But happy to take any questions that you may have.

HOWARD BERLINER: Karen, about the moratorium; is that a moratorium going forward or does that apply to recently approved projects as well?

KAREN WESTERVELT: So it's a moratorium going forward. You know, we've done a quick assessment with respect to projects that are on the agenda today, and don't believe that there's an impact on today's agenda.

HOWARD BERLINER: No, I understand that, my concern is really we approved a very large project just before the storm right in the flood zone, NYU. I mean, I just wanted to know what the status of that would be.

KAREN WESTERVELT: Right, so, one of the things with NYU and some of these impacted facilities, another facility that will potentially be impacted that'll be part of this is Long Beach Medical Center, for example, that still isn't opened, but we do NYU for the most part has already, you know, mostly come online. We don't think it's going to have a major impact insofar as NYU is concerned with the moratorium. But we would want to entertain the flexibility to make sure we're not necessarily unduly restricting a major provider from moving forward necessarily. So –

HOWARD BERLINER: Thank you.

DR. SULLIVAN: Little bit tangential but just to bring up as these hospitals become unstable in various places, one of the

impacts is on the emergency rooms in those areas and in New York City the emergency rooms not just of HHC but all the hospitals are really feeling the impact of this intense kind of disruption, and we have increases of 10, 15, 20 percent sometimes in overcrowded emergency rooms and people waiting for beds. So I just think it's something the State needs to take a look at when these things happen, because there are these consequences that happen immediately in the community as soon as there's some instability in the hospital systems, and we're all getting a little bit used to it, but it keeps coming. So, I'm just saying I think it would be something that it would be really important to really look at so there's some understanding of what the impact of what these changes really are.

KAREN WESTERVELT: So, just for clarification, the impact of the changes when we have disaster and emergency or –

DR. SULLIVAN: No, I'm talking about when our hospitals close.

KAREN WESTERVELT: Oh, when a hospital closes.

DR. SULLIVAN: Or when there's talk of hospitals closing. It doesn't take much to happen in a community before there's an increased use of emergency rooms. I'm going to talk about the

hospital codes, LICH issue in Brooklyn and what we've already experienced in Queens and with some of the closures in Manhattan, I just think that there needs to be an appreciation of that. When that instability happens, what happens in the care in the emergency rooms throughout the City.

KAREN WESTERVELT: So, that's a very good point, and one of the things, you know, any time any hospital closes, one of the things that we do in the Department is a disruption analysis or an absorption analysis as it relates to other facilities and that would be factored into our closure plan so that we make sure that patients will have access and access to quality care. You know, I think in, you know, with the situation right now with hospitals currently we may have more hospital systems potentially in this circumstance and I think there's going to have to be heightened sensitivity to that issue.

DR. SULLIVAN: And just one follow up; I think that while we all submit such – not sure there's any follow up as to what the actual results of that are too clearly over time and space. What happens a year later? What happens six months later? And I think that those are done with good intentions, but often they're not quite as smooth as the initial closure plan looks.

KAREN WESTERVELT: So, you're looking for analysis post-closure.

DR. SULLIVAN: Yes, thank you.

KAREN WESTERVELT: OK.

WILIAM STRECK: Other comments or questions? Thank you. We'll now move to Ms. Bloch's presentation. The Office of Health Information Technology Transformation.

RACHEL BLOCK: Thank you Mr. Chairman. Two items to report on today. It's not quite up there with the Letterman Top 10 List, but I know you all look forward to our updates for the meaningful use payments. We continue to see significant increases in both the Medicare and Medicaid payments nationally, but in particular we like to report on what's going on here in New York, and this is in part a result of our efforts in the Department and also many efforts at the community level. And you can see continued increases in both Medicaid and Medicare meaningful use out of station and certification and significant growth in the dollars going out. Our current estimate is that we're probably at about 80 to 90 percent of the eligible hospitals, and somewhere in the neighborhood of 60 percent of the eligible physicians. It could be a little bit higher. With

the physicians it's hard to establish a clear denominator because of the patient volume requirements. So it's not just somebody who is an eligible professional, but they have to have that minimum patient volume for Medicare or Medicaid. But conservatively 60 percent of those were eligible and probably something a bit higher than that. So we're very pleased with the continued results of that. And as you can see, $743 million coming into New York State. We always like to celebrate that and recognize that these are real dollars for both physicians and hospitals who really could use this additional help.

But my main item for today is to tell you a little bit about our recent award of a CMS grant for what they're calling the State Innovation Model Pretesting Assistance Award. The State Innovation Model Initiative was established last year by CMS as part of the overall efforts of the Centers for Medicare and Medicaid – the Center for Medicare and Medicaid innovation within CMS, and this is obviously the area that has awarded many grants and many demonstration programs implementing those provisions of the ACA that really were emphasizing improvements in payment systems and delivery systems. This one in particular was focused on states providing the leadership to really coordinate and organize those efforts in their states.

Just to summarize the announcements that were made about a month or six weeks ago, six states with model testing awards, these are very large scale efforts in those states to implement

multi-payer healthcare transformation strategies. We were one of three states to get a pretesting award. I'll explain a little bit of how that came about in a moment. And then there are a number of state – I apologize, the map is not correct, but the narrative underneath, and we'll give staff the corrected map – 16 states that received design funding. So, these are really incremental efforts to build state capacity to help CMS implement these healthcare information models.

Going back, we had originally applied for one of the testing awards, which was the largest grant category back in September. We were notified in January that while CMS felt that we made a very good effort in our application, they were not giving us that award, but they wanted us to submit a request for a pretesting assistance award, and then we were rather promptly included in the announcements of all the grant awards, subsequently. And basically what this involves is a six month period over which we are to do further data analysis and stakeholder outreach to develop a new state innovation plan and that then would position us later in the year to apply for the next round of large grants which CMS will be announcing sometime before the end of the year.

There's quite a lot of narrative here. I'm not going to read all of this to you, but just to highlight a few of the requirement. They're looking for us to really be using all of our policy levers and strategies that are available in the

State. They have put particular emphasis on multi-payer engagement, and as you, I think, all appreciate that is a very important thing but also very complicated thing to do in a state like New York; to engage providers and delivery system transformation; to look at how we implement the triple aim and of course this is the broad theme under which all of these things are being implemented. One of the areas that we are asked to focus on and I think we have some very strong initiatives to highlight here in New York around integration of behavioral health and other community services, new delivery payment models as well as new care models are also points of emphasis for this plan. And health IT of course, that's the one area where we certainly have a lot to build on and as we've discussed with Karen Westervelt workforce issues which CMS is also interested in seeing us address.

So this is, there are many individual items here, but just to pull out a few, and I just want to underscore this one point that what they want to see is something which will move 80 percent of the state's population to value-based payment and service delivery models over a five-year period. So, ultimately the plan needs to address how we would do that, but the grant application that we would plan to submit later this year would need to have specific models and strategies identified that quantifiably would get us in New York State to that goal. So, a

big challenge, but also I think an enormously exciting opportunity.

So, we have started as of April 1 was the kickoff date for this process, and we are working on developing further analysis to describe our healthcare environment. The legal regulatory policy issues that we want to address and in particular engaging stakeholders across regions and across specific areas of expertise to offer input into this plan. I thought I had one more….

So, what we are engaged in right now are really three levels of consultation reaching out to leaders across New York State, reaching out to regional organizations who've already made some efforts that we will want to complement and include in the plan and then also reaching out to what I'm calling stakeholder verticals, the hospital associations, physician organizations, consumer groups, employers and so forth who will have their own perspective to bring into the effort, and obviously we have already reached out to both Dr. Rugge and Dr. Boufford to ask how we can incorporate the work that has already been done through the respective committees of this council and how we can integrate the planning and hopefully the implementation of this program into the future efforts of those committees. And so we will be very much looking forward to working with the Council directly in that respect and of course

reporting our progress on the development of this plan as we go forward.

WILLIAM STRECK: Thank you. Are there questions for Ms. Block? I have two. 'Stakeholder verticals.' It's an interesting term. I just want to make note of that. I don't know where each of us will qualify in the vertical versus horizontal assessments.

RACHEL BLOCK: You know, in the health IT world we are always making up new acronyms, so I figured that –

WILLIAM STRECK: Well, just keep us up to date so we can stay with you. That's always a concern. I did have a question about the 80 percent participation; is that all payers?

RACHEL BLOCK: It's intended to be 80 percent of the population. So, what we need to then step back and look at the particular payer mix both broadly across New York State, but as we know there are extreme differences at a regional level in terms of the payer mix as well. So we really need to be looking at both calculations, but it is really more of a population measure than specifically a payer measure.

WILLIAM STRECK: Thank you. Other questions? Thank you very much. We will now move to Dr. Birkhead's report.

GUS BIRKHEAD: Thanks very much. I wanted to update the Council today on two topical public health issues. Before I do that though, I'd be remiss if I didn't also acknowledge Doug Sackett's many years of work with the Department. I didn't realize you began your work under Commissioner Whalen, so that's quite an accomplishment Doug. Thank you.

The two topical areas, one, people have been reading in the press I think about the H7N9 influenza outbreak happening in China. China historically has been a place where new influenza strains originate and over the last couple of months there has been a cluster which now amounts to 33 cases. This slide here shows you when the known cases have occurred. And I'll quickly go through a couple of additional slides. These are in four contiguous provinces in China around Shanghai which is seen here and the other I think interesting – it's not going to advance; there's one other slide – the other interesting feature of this influenza – these cases have been very severe; 28 of the 33 cases have been hospitalized severely ill, and 9, there have been 9 deaths among the 33. So, over roughly 30 percent fatality rate. The other interesting feature is that these cases have occurred in elderly patients, primarily, so the green bars on this graph which shows age are the new strain, compared

the H5N1 which is the strain that we've been reading about now for five years periodically around the world related to poultry exposure. So this virus is acting a little bit differently.

So this is a newly emerged concern. How big a concern is it? Well, there are a couple of things which are positive about this. One is that no real clusters of people in households or close contact have been identified, and so no person-to-person transmission has been identified, so these may simply be people acquiring flu infection from bird contact, primarily chickens, but if it doesn't spread from human to human it doesn't present a problem for example, for a pandemic type situation or a SARS type of situation. However, it is concerning because of the high severity and hospitalization rate and death rate that's occurred with this. It's also not clear how many other milder cases might be occurring. This could just be the tip of the iceberg. It's obviously occurring in four provinces so it's somewhat wide-spread already. One of the other concerning features is that it doesn't appear to make the birds sick, and in previous pan – you know, concerns with – if it's making the birds ill then it's evident that it's there and you can take steps to destroy poultry flocks. If the birds aren't ill, then you don't really know where to go to try and prevent this.

So, there are a number of – this has basically got the public health community on alert in China, obviously, but also around the world. CDC has issued an alert here which we

forwarded on to healthcare providers to basically be on the lookout for persons with flu-like illness with a recent travel history to this part of the world. The quarantine stations at U.S. airports are not yet screening people because we don't have person-to-person transmission but are certainly on alert. I was interested to learn that we have seven non-stop flights from China a day into JFK airport for example. So, this virus could be here very quickly.

We also do not have flu testing available in this country. These viruses would show up as influenza untypable, and so CDC has asked all the public health labs including our own to forward any untypable flu samples to them within 24 hours so they can test them very quickly. And CDC is also working on a test kit that our public health labs could use to actually diagnose the H7N9 directly. So, hopefully there will be nothing more to report on this, but this is an example of a couple of things. One, it's an example of the public health network that is out there around the world for flu and other emerging diseases, and it's also an example, I think, of our, the effort we put into preparedness that we and the city health department and other public health agencies are able to get alerts out to hospital emergency departments and other clinical settings where patients might be seen. And this is with only 30 cases known in the world, all in China. CDC does have reports of three people in the United States with flu-like illness after travel history

who’ve turned out not to have flu, so obviously lots of other things cause flu-like illness. This is an example of the type of preparedness that we need to have in the public health world because these kinds of emerging threats seemingly can appear at anytime and anywhere.

So that was one public health update. And then a second, shifting gears completely here to the world of chronic disease and tobacco prevention, cigarette smoking cessation, a number of years back in the previous, under the previous health commissioner the state health department submitted a petition to FDA to get them to change the way in which nicotine replacement therapy can be marketed and sold. Currently nicotine replacement therapy is available only in pharmacy type settings, and only packaged for one or two week supplies which can cost up to $20 to $30. The idea with our petition was that we wanted the FDA to allow nicotine replacement therapy to be sold anywhere where cigarettes can be sold, and also to be sold in packaging that would allow for a one day or a two day supply, in other words, much cheaper. Right now, if you’re a smoker trying to quit and you have five dollars in your pocket and you walk into a gas station all you can buy is cigarettes. The idea here would be that you in the future, could buy nicotine replacement therapy with your five dollars, a one or two day supply to tide you over.

(WILLIAM STRECK:) Gus, where can anybody buy cigarettes for only $5 in New York State?

GUS BIRKHEAD: Sorry. $10 then. If you have $5 you can buy half a pack. Right. So, this petition was submitted a number of years ago. We didn't hear anything. We inquired of FDA and we're told that while they're considering petitions, they won't talk publicly about their deliberations. But just this past week, the FDA did send us a letter ruling that they were going to allow nicotine replacement therapy to be sold in now up to about 20,000 different settings, retail type settings in New York, and also allow it's packaging in much smaller unit doses. So this will require nicotine – the pharmaceutical companies that make nicotine replacement therapy to actually produce it in a new packaging form and also to try to market it in these other settings. And so, there still are other additional steps to go, but I think this is an example of an idea which finally came around and which seems to make sense and that we hope will prevent, or help smokers really to quit.

We had some additional parts of our petition that FDA did not approve. For example, we asked that the large package insert on the nicotine replacement therapy with lots of alarming information about the potential side effects of nicotine be reduced or eliminated since a package of cigarettes may have a simple phrase warning on it. It doesn't have a large booklet

with all the dangers of cigarettes. So trying to balance, again, make them more equivalent in people's minds. FDA did not go along with that because nicotine is a registered pharmaceutical product and so the package insert has to remain.

But this is an example of a success. I think we're not thinking how we can reach out and assist for the companies that may want to market this and package it in this way to we hope some of them will take this up and actually market the product in that way, and we're prepared to evaluate how that will, how that will impact the smoking epidemic in the state.

So I think with those two comments, I'll stop there and see if there are questions on those or anything else.

WILLIAM STRECK: Questions or comments for Dr. Birkhead? Dr. Berliner.

HOWARD BERLINER: Dr. Birkhead, not to be facetious but how does the plan to have more exposure for the nicotine replacements jive with Mayor Bloombers proposal to hide all the tobacco products out of site?

GUS BIRKHEAD: Well, I think they're both sort of the same idea. If you're trying to quite, trying to eliminate the triggers to prompt you to want to smoke and certainly going through the checkout line and seeing the cigarettes lined up

there is another trigger to do that. So, -- I don't think the City's proposal, it relates to cigarettes so you're raising an interesting question, but we're not trying to necessarily hide the nicotine. We'd like it to replace the cigarettes at the checkout line and them maybe people would use it more readily. More readily. Right.

WILLIAM STRECK: Mr. Kraut.

JEFF KRAUT: Just returning to the flu, just a question. Since the disease is not manifesting itself in the birds apparent, so how do they know which bird, they have this wholesale destruction of poultry, pigeons and other birds. Does that, in fact, stop transmission? Or is that – I'm just trying to understand how that relates to managing the disease.

GUS BIRKHEAD: I'm not sure of the details here. I know they have isolated the virus from domestic flocks of chickens and also from a pigeon and looking at the virus genetically, it appears to be a flu virus that's a mix of wild bird and chicken flu virus. There are many different strains of flu in the world with different animal predilections, so this one unlike the H1N1 we saw a few years ago has no pig or swine genetic material that would suggest that.

JEFF KRAUT: But killing off hundreds of thousands stops, breaks a chain?

GUS BIRKHEAD: I don't – it's a good question. I don't know the evidence. It is a standard pra – has been a standard practice with other flu, particularly the H5N1 strains which have been around the world now for five years or so that when you find there the flocks do get sick and I think if you step in quickly and eradicate the flocks, you can prevent. But this virus seems to be out there quite widespread, at least in these four provinces right now, so I'm not sure how, what they're doing will have that impact or not.

WILLIAM STRECK: Other comments or questions? Dr. Bhat.

DR. BHAT: Can't this virus mutate? At the present time it's only bird to human. Can it become human to human at a later time?

GUS BIRKHEAD: Well, that's always the concern with these emerging viruses. If there is human flu also in the same population and a person gets infected with both, you could have a virus that comes out that's a mixture of the two that might have characteristics that would allow it to be transmitted. So, flu viruses are constantly not only evolving but mixing when two

different strains infect the same animal or person, and that is the source of the concern.

CARLA BOUTIN-FOSTER: Along the lines of surveillance and looking at the impact of policy change, are there plans to monitor the – I believe now emergency contraceptions are available at stores and regardless of age anyone can purchase that? Is that –

GUS BIRKHEAD: There was a court case just this past week where the judge I think said yes, you're right. The age limitation the FDA had put on emergency contraception was lifted.

CARLA BOUTIN-FOSTER: Are there plans by the Department to monitor the impact of this whether unintended pregnancies go down or STDs go up or –

GUS BIRKHEAD: That's a good question. I haven't thought about it, but we can certainly take that back. It is, the whole area of teen, particularly teen pregnancy prevention is one where we have a lot of programmatic effort going on, so we'll give some thought to how, what the impact of this will be. I'm not sure whether practice has actually changed out there just as a result of reading about a court case in the newspaper. I'm

not sure whether FDA needs to communicate with the world about what's now allowable or not. So, we'll go back and take a look at that. But it's a good question.

CARLA BOUTIN-FOSTER: And also an opportunity for packaging, like as Ellen said, put a condom in it, or, I mean, something.

GUS BIRKHEAD: Well, we have certainly had an effort to educate people, women about the availability of emergency contraception and also the other things that you need to think about if you're having to access emergency contraception, how can you avoid getting yourself in that circumstance the next time? So that is part of our messaging and our educational effort, for sure.

HOWARD BERLINER: Just to add on to that, I mean, studies that were done by the New York City Council found that large numbers of pharmacies did not provide you know, availability for those products. And so it might be –

GUS BIRKHEAD: For emergency contraception over the counter, you mean? At all? I wasn't aware of that.

HOWARD BERLINER: It might be nice to kind of just mention that as well.

GUS BIRKHEAD: I think we can certainly take this as an example to go back and educate people again about the issue.

WILLIAM STRECK: Other comments or questions for Dr. Birkhead? OK. I just want to take a moment to clarify some logistics which may dash some hopes of departure here. But what we're going to do is our next two reports, then we're going to break for lunch for 30 minutes. So, those of you who are here for project review, that is the way we will – gonna have to do it today. And I'm sorry if that has prolonged your day in beyond what you had hoped. We will now move to the public health services report. Dr. Boufford.

JO BOUFFORD: Thank you. And I just want to add a voice of thanks to Karen Lipson. The word 'population health' appeared in her salutation a couple of times. She's been really invaluable in the connection between the work of the health planning committee and the public health committee, so I just want to add my voice. I haven't had the pleasure of working with Mr. Sackett, but it sounds like he was doing important things as well.

Let me just, to briefly remind everybody where we are. I get confused by all the meetings, which one we've talked to you about when. But we did the guidance on the – you did approve the state health improvement plan called the prevention agenda in December. The guidance did go out in January. This is to local hospitals and local health departments who have obligations to the state to present their plans, and in this instance they're being asked to do that together with stakeholders in the community, and that process is underway. The New York State website which includes all of the work done over the summer with the sort of 140-odd people that were referenced earlier and the multiple working groups, all of that material is now on the website and it's easily available. There's a large blue button on the home page which is wonderful. You don't have to navigate to find it, so we appreciate the communication staff for doing that. And the work of the last couple of months has really been focusing very much on communication and technical assistance support for local action, and that's what we want to talk to you about a little bit today, and this would be hopefully efforts that could be done, would be done at the State to really support local partnerships in communities. Much of this effort is being made possible by grants from the Robert Wood Johnson Foundation in support of New York State's accreditation application, and there are in parallel activities going on in the health department trying to

identify other sources of financial support. This is just a plug for the public health side of the house, to really support primarily the activities in the local communities as this project moves forward. So Sylvia and I are going to do a tag team, but before we start this I just want to, do mention you did have at your places I believe maternal mortality report and to say that at the last meeting of the Public Health Committee we had this update; this has been revised since that time for members of the committee, but a very nice update. This was put together by Gus Birkhead and his colleagues to tell us, sort of, what's going on in the State around maternal mortality, and the discussion at the Public Health Committee, this is the issue we've picked to try to "move the needle" in addition to the State Health Improvement Plan. So, we will be hopefully having some suggestions for the committee at our next meeting on added value activities where the Committee could really support the work of the staff and health department. So that is still very much on our agenda.

So, this slide, I'm going to hand it over to Sylvia when it gets complicated in just a minute or two. This gives you an outline of the elements of the communication strategy that we've been undertaking, and you're going to hear about each of those a little bit in the next moments. Next one. And this is just to remind you what I just said before that one of the two real issues in the communication strategy, one, is that we want to –

we have multiple stakeholders involved in this activity. People from other sectors like, we hope, increasingly, or certainly we know business, professional associations, and we hope in some communities actually transportation, housing, environment, agriculture and others depending on the issues that they take up. So one of the really important things on communication is how do people in these sectors think about health, public health prevention so we know how to have a conversation in a way that sort of gives them a sense to say I can really identify with this discussion, and I can see why I should participate in these activities in my community. And then the second part of it is the issue of knowing that there are vulnerable populations, and we are working with Minority Health Council chaired by Dr. Boutin-Foster to really try to have also a set of materials for addressing health disparities by being able to have clear communications with different vulnerable populations at the community level. So those are the big foci of the broader communication strategy in addition to just what gets people to pay attention when you start talking about prevention. So, Sylvia, do you want to pick up from here?

SYLVIA PIRANI: Sure. So, as Jo mentioned the Robert Wood Johnson Foundation has been supporting our effort. They have given a grant directly to this Rabin Martin firm in New York City that helped us organize all the people that helped us

develop the prevention agenda and is now developing a communications plan, and they started that with interviewing about 15 representatives; a small group but important people in various sectors including community-based organizations, hospitals, health plans, education, criminal justice as one of the areas because as someone asked before about gun control we do have violence prevention in our prevention agenda, and businesses to see what interests them, what do they think about when we mention the word ‘prevention,’ what interests them, what might motivate them to come to the table in these communities. These are the various pieces of the communications plan that they will -- that they’re working on, coming up with a tool kit, coming up with media spokesperson training once they come up with these messages, so that’ll be helpful, and then some suggestions for our web content and media materials.

They have interviewed several representatives from business, education, and health plans to try and figure out what might motivate those people, so, certainly businesses, how we need to talk in a better way, in a clear way about savings and benefits to businesses, need to bring, inform, better educate businesses about wellness programs; seems to be something businesses are interested in. They’ve talked to some school representatives. These people are interested in linking up better mental health services to schools, something that schools are facing. And then they have interviewed several

representatives from the health plans that have indicated they would like to be involved in this planning process at the beginning. I know Gus is going to join Foster at upcoming meeting of the health plans again to get some more involvement, and we'll try and focus on this regionally as well.

All right? These are some of the other communications efforts. Dr. Boufford and I participated in a public health live webcast that was aired March 28 and in your spare time you could watch us on video. We – the interesting part of this was, I mean, if you've seen a lot of it certainly at previously meetings, but we did have some roll-ins from Dr. Shah, and then some featured public health activities going on in Schenectady County. Jim Connelly from Ellis Hospital, for example, has led this effort and has gotten a grant from the Schenectady Foundation to do a door to door survey to find out what is affecting people's health including the community that they live in. So, that was discussed on this video. And then we had our press conference that Sue Kelly mentioned. We had great participation from a wide range of participants including members of our ad-hoc committee. This clip, which we were hoping to show you today but is not going to work on this computer, is a great, just one minute clip from NY1 on prevention, and we think it's a good way to learn for people who don't know how prevention is important in improving public health. Here's some press from the China Town coverage. The

illustrious group of people that joined us. And then the Robert Wood Johnson Foundation, Dr. Farley there with Dr. Shah, Perry Pong, and Ken Rasky at the event.

JO BOUFFORD: Can I – I just want to interrupt here for one minute, about the launch. The locus at the Charles P. Wang Center was picked on purpose to emphasize the importance of primary care and community partnerships. This is a community health center in China Town in Manhattan that has really one of the really successful community health centers, but lots of community partners were there as well, and obviously in important support relationships, back up relationships with NYU and Bellevue, so it was kind of representing what we're trying – the message we're trying to get across as far as what these local partnerships must involve.

And then the other thing, couple of pictures back the group shot includes – back, that one – Dan Sisto and Ken Rasky from the State Hospital, HANYS and Greater New York Hospital Association with the Commissioner of Health of the City and the State standing together all speaking from the same playbook without notes was very impressive, I have to say, and very gratifying, and we really appreciate the support of HANYS and Greater New York on this. I do have a little copy of the – Greater New York has prepared a brochure about the prevention agenda which they sent out to all of their members, and the

HANYS group you'll hear about later has, in fact, will in fact, be very involved in state-wide prevention; have done a lot of work on webcasting to their members to get the hospitals involved. So the goal of being really getting these core partnerships at the local level activated, so they can bring others in. Sorry, Sylvia.

SYLVIA PIRANI: We did have the Robert Wood Johnson Foundation. They're blogging from the event, so they've written this nice story and did an interview with Dr. Shah that's on their website. And then there is some local video coverage going on in communities as they launch their community-wide assessments.

So, we do have some money left over from Robert Wood Johnson Foundation to provide technical support. It was one of the things we learned from the first prevention agenda that groups needed help. Not so much in working together to identify priorities but to do more after that; to actually implement them. So we are contracting with HANYS and then five regional planning groups learning from the work that the health planning committee did to provide support to local coalitions. There's going to be three webinars on some key issues that we've identified, and then this group is going to be talking monthly along with some groups that weren't funded, so the group, the health planning group in Nassau/Suffolk, Greater New York is

participating as well as NYSECHA and some others to make sure that we're all coordinating our support on this issue. So it's sort of the beginning from the ground up, I think, of this regional health improvement efforts that Karen and John have been working on.

This is the map of the groups that we're funding. The Adirondack Health Institute, the Central New York HSA which is now called Health-E Connections I think, the Steuben, Allegheny, Yates2 network in the Finger Lakes and the P2 Collaborative, and the Healthy Capital District initiative here. There is not group – there is one slowly emerging in the Hudson Valley that we hope to connect to and have them participate in the call. Nassau/Suffolk, as I said, will be participating. We're not really focusing on New York City immediately with this technical assistance, but their representatives will participate.

JO BOUFFORD: If I could just add another, just a distinction between the first round of the prevention agenda and this round is funding entities who will provide support to local communities at the regional level, rather than funding the entities directly for their own work. That was a shift in concept, because it was realized as is not uncommon as those who are the most proficient at writing good grant proposals get money, and they're happen to usually be the people that are doing this anyway. So the effort here was to try to take

advantage of the expertise that was identified the last round, and then ask them to then provide that support to local communities.

SYLVIA PIRANI: And then, Jo, I don't know if you want to finish up.

JO BOUFFORD: Yeah, these are next steps. The website we're hoping to begin to develop the capacity for communities to interact with each other, share experiences on the website. That's an ambitious goal, but we hope to do that, so that eventually when each of the communities picks the issues they're going to work on, they'll be able to know, you know, which groups are working on maternal mortality for example, which groups are working on obesity prevention, ,and then they can really develop a sort of learning network across the state. The health disparities resources, I've already discussed. A lot of presentations going on. Conversations; we're very pleased to be invited by Karen Westervelt to talk with primary care and Office of Health Systems Management staff as part of their strategic planning thinking on this, and Sylvia, Gus, and others have been very active, and I think people are asking proactively for these briefings, which is great. The ad-hoc committee which is our sort of intersectoral group that is numbering almost 30 now which I think is where the business community, professional

associations, community organizations, health departments come together will be meeting on May 22 and will be designing a meeting there, sort of an extended meeting that'll both celebrate the folks that are off and running, but also brief this group on what's been done and try to really get them activated, so part of the goal for the state level organizations is that they have members and constituencies and chapters at local levels, and we want to get them to the table while these conversations are going on. The plans are due November 2013 across the board, and so that's our goal is really to try to find resources and assure support to get as many communities as possible effectively through the planning, implementation and evaluation stages. Time is kind of slowing down when they really need to put things in place, and hopefully we'll be doing more of that work.

The last thing I just wanted to say is that I'm going forward, especially with John's group, activating, again, I say I now have all these meetings on my calendar, with the health planning exercise is to try to – I'm just going to suggest that as a council we might begin to think about the prevention agenda as a very critical element in the third part of the triple aim which is cost, quality, and achieving health. It gets presented as there's all this healthcare reform work and the waiver and there's also the prevention agenda, and we try to sort of identify this in the course of the conversations that are going

forward. But I think the really conceptual thing here is if we can start seeing the work of the triple aim connecting more closely with the work of the MRT going forward, the work Rachel's doing and others, we really appreciate her reaching out on that, and it is really an integral part of the waiver and not sort of an end of the prevention agenda. So that's our challenge, I think, for everybody, and I look forward to further conversations on that going forward. So that's the end of my report.

WILLIAM STRECK: Questions or comments? Yes, Dr. Grant.

ELLEN GRANT: Just quickly, I know that the goal is by 2017 to reduce the infant mortality rate by 10 percent, but I'd be interesting in knowing in view of the fact that there's such a disparate percentage between White and Blacks in terms of the deaths, what the Department is doing to help alleviate you know, around that State. What kind of prevention, what kind of options you're doing to be more of a watchdog in these communities?

GUS BIRKHEAD: Thank you. That's a good question. And I'll just highlight what you're speaking from should be at everybody's desk, is a summary of our maternal mortality review process at the State. This was shared at the Public Health

Committee at it's last meeting. But this gives you, I think in one place, sort of a summary of the data that we're collecting, what some of the data are telling us, and we are using this process very much to identify steps. So, for example, one concrete step that we're doing is in analyzing the data, it's clear that hypertension during pregnancy is one of the causes of these maternal deaths, untreated or unrecognized or inadequately treated hypertension. So we have brought together a panel of experts. We have a protocol that we are about ready to finalize, and we will be out in the healthcare community basically trying to get teams within healthcare settings to pay attention specifically to hypertension as an issue. Previously we had looked at maternal hemorrhage as another factor, and I think one of the things we'd like to work with the Council on is sort of identifying additional steps that we can take. Some of this obviously happens in healthcare settings, preventing maternal mortality, but some of it also happens out in the community, getting women access to birth control, to timed pregnancies, to have preconception care. Obesity epidemic is probably a factor here as well. So a number of our programs impact on those, but how do we pull that together into a comprehensive program focused on reducing maternal mortality. That's what we would like to engage the Council in getting further help with. So, to be continued.

WILLIAM STRECK: Other questions or comments? Thank you. We'll turn to Dr. Rugge and the health planning report.

JOHN RUGGE: Just by way of an editorial comment, this is more of a report on upcoming activities rather than the activities. But looking back just for a moment, I think for all of us on the Council, it's hard to imagine a time when there was not a division of planning, a division of policy at DOH. It is equally hard to remember a time when there wasn't Karen Lipson as Director of Policy. And of course, that's the case. She is the first and only Director or Policy for the Department of Health, and we can only hope that the Planning Committee did not somehow contribute to her decision to depart. In the meantime, we welcome Elsie Chung very much, and hope that she brought her track shoes because our long winter rest is over and we are about to start again.

There are two prescribed activities and reviews that we are required to do. Parts 709.3 and parts 709.16 for those of you who aren't keeping track of the numbers, this represents a review of the nursing home bed methodology which is up for a five year review, and also review of methodology for therapeutic radiology. Most likely these will take place in the course of our regular committee meetings, and we will depend absolutely on staff to help us to be sure that we're meeting all requirements.

Likewise, it'd be very important for us to monitor the progress of the implementation of the CON recommendations we made, especially since most of them did not make it through the legislature this year, but will be actively discussed and hopefully approved in the upcoming session.

Very important among those, since we are a Planning Committee are the activities around future planning with the regs that we proposed, and the fact that we have Rachel Blocks SIM, State Innovation Model activities, need for planning to develop an innovation model, everything seems to be coming together very nicely including her million dollar budget which might allow for coffee at our planning committee meetings, and we can only induce her to make us a formal part of that discussion.

I'm not sure, I think you covered very nicely the activities that you are doing and we are glad to provide both air cover and balance and input into the process that you're looking for, and this does represent a significant source of potential funding for the kinds of innovations we clearly need to do to improve healthcare in New York.

Having said all this, once again, we are about to undertake a series of special all day committee meetings on another topic for us to undertake and review and digest and recommend by September for consideration by the full council. That being a new look at the ways in which medical practices and providers of

institutional services are really converging with a whole new set of sophisticated and advanced ambulatory care services noting that many physician practices have been coalescing into groups of hundreds of physicians mobilized especially with ACOs, and at the same time many hospitals are finding that their ambulatory work and those revenues are over balancing what was traditionally the center piece, the inpatient care, being provided by those institutions. So, with these movements if you will, coming together and looking so much alike, there are a series of questions in terms of how to recognize these activities and understand them as we do our reviews for CON and other approvals moving forward. All remembering the difficulty we had with a certain radiology therapeutic radiation centers and not even being able to do a count of how many private practices were doing radiation in Westchester County some time ago. In addition, considerations about what kind of expectations we as a public should have in terms of service to vulnerable populations as new activities are engendered and huge groups of physicians come together. And along with that, what kind of contribution to the HICRA pools will be made by various organizations doing much of the same work but coming from two different placed; the private practice world versus the institutional world. So, we are charged with taking a look and doing evaluation of these phenomena and trying to understand to

wrap that into the oversight regulatory process for this Council and for this State.

Once again, as I did at our committee session, managed to say all this without uttering the words 'leveling the playing field.' The time table really began with a kickoff on February 25 with a letter drafted by Karen and others looking to stakeholders, vertical and otherwise, for input which hopefully has been and is being received as we speak and this committee will find it very important, I'm sure, to understand their perspectives and views and recommendations of hospitals, physicians, health centers, and many others in terms of how to proceed with this analysis.

Concurrently as I understand it, there is an internal workgroup within DOH developing either recommendations or options which will be unveiled to us at one or another of our committee meetings, the next one being held on May 21 and followed by a meeting on June 18 with a wrap up meeting for all day consideration in September.

And having concluded that bit of work by September are looking in the fall at another series of activities and that is we are being charged by the Commissioner and by the Executive, we're taking a look at what I consider to be the continuum of care looking at the mini-clinics, the retail clinics that have proposed by the Governor and will be considered again by the legislature. Consideration of the explosion of interest in

freestanding EDs, especially with the receding of certain inpatient services with the opportunity represented by upgraded D&T centers and by the possibility of actually implementing tele-medicine in areas of the State and communities that otherwise are going without services, and trying to identify a smooth continuum so we can have an appropriate setting and provision of healthcare community by community, population by population, in ways now that have been attempted through pilots and through fracturing and through phantom beds and the rest with the idea that that discussion will carry us through the fall for presentation of recommendations to the Council in time for the legislative session and doings of 2014. So, we are coming back alive. Planning Committee is really counting on the participation of it's members. Obviously we welcome the support of Elsie and staff and also the participation of other council members, all members of the public are really important to make this a successful enterprise.

WILLIAM STRECK: Thank you, John. We need to make a note to allow an extra 15 minutes for your reports when you complete all this work in September. The next big step it sounds like is an unveiling, and so that unveiling will obviously guide a lot of your work through the September project. When do you think the unveiling is expected?

JOHN RUGGE: Well, we will have a meeting on May 21, and I think – this is very preliminary but, I think to start not so much with options and recommendations but to really understand the perspectives of the stakeholders that have been queried and others that may want to step forward to address these issues, and we may look at more specific invitations to people that we really need to hear from. And along the way in the course of this, obviously recommendations as they've been engendered by DOH will be important to the committee.

WILLIAM STRECK: Other questions or comments? Ellen.

ELLEN RAUTENBERG: In terms of the legislation not approving the CON recommendations, was that just too much – in terms of the legislation not approving the CON recommendations was it just too much too soon, or was there organized opposition? What was the flavor of that?

JOHN RUGGE: It was a huge budget, and I think these were items that were recognized as not having a direct financial impact and therefore could be deferred for a few weeks and digested further.

WILLIAM STRECK: Other questions or comments? Hearing none we will adjourn the meeting for now. Council will resume at 1:15.

[BREAK]

WILLIAM STRECK: …meeting here today, so if you would all please take your seats, we will begin.

So, we'll now move to the Project Review and Establishment Committee report, and I'll turn the microphone over to Mr. Kraut.

JEFF KRAUT: Thank you Dr. Streck. Since I have the mic and I'm chairing the meeting, chairing this report, I also just want to add my comments about Karen and as a health planner I have to tell you, you know excellence when you see it, and Karen, without being repetitive, what was in the resolution, you touched a historic body of work. If you look over the history of restructuring and giving focus and meaning to health planning in this State that probably no one else can claim as far as I've been involved with the Department of Health, and I have to tell you as a health professional, as a planner, as somebody who manages a lot of facilities, I think the impact that you've had is extensive in getting us to keep moving forward and doing it

swiftly and trying to focus on those issues which are critical to the State. So I just want to add my word of thanks, and you know, we can't have enough superlatives when it comes to your work. But thank you so much, Karen.

OK. I am going to – this is the largest batch of applications we've had since the Council was merged and we dealt with a backlog. We have an opportunity to group a lot of the applications, and where I – I'm going to do so. If any member wants to remove anything out of the group, please let me know, and I obviously will do so.

The first is categoryI applications. These are for acute care services for construction. I'm calling the following applications.

122190C, John Mather Memorial Hospital, Port Jefferson. To certify an extension clinic with Cyberknife service to provide sterotactic radio surgery. OHSM recommends approval with conditions and contingencies.

122229C, Montefiore Medical Center. To certify a 25 bed inpatient unit at the Wakefield Hospital Campus. OHSM recommends approval with conditions and contingencies.

Application 122294C, Alice Hyde Medical Center, Franklin County. Interest has been declared by Mr. Booth. To certify 80 residential healthcare facility beds from Franklin Nursing Home and construct 135 bed facility on the medical campus, decertifying 20 residential beds. I make a motion that OHSM to

approve, and I recommend the Establishment Committee recommend approval with conditions and contingencies, and I so move.

WILLIAM STRECK: There is a motion and a second. Is there discussion? Hearing none, those in favor of the motion as presented, please say aye?

“Aye.”

WILLIAM STRECK: Opposed? The motion carries. Thank you.

JEFF KRAUT: Now, I’ll call application 112363C, Mt. Sinai Hospital of Queens. I have a conflict, recusal, Dr. Martin and Dr. Bhat who are leaving the room and an interest and abstaining from Dr. Sullivan and Dr. Boufford is not here. Am I correct? And Dr. Boutin-Foster? No. Not on this one. OK. So this is to modernize Mt. Sinai Hospital, Queens, through a construction of a new building for emergency ambulatory and surgical care on the campus. The new building will have an expanded emergency department with 36 treatment bays and eight observation beds, and will further include 10 operating rooms. OHSM and the Establishment Committee recommend approval with conditions and contingencies, and I so move.

(Second.)

WILLIAM STRECK: There is a motion that has been seconded. Is there discussion? Hearing none, those in favor, aye.

“aye.”

WILLIAM STRECK: Opposed? The motion carries. Thank you.

JEFF KRAUT: Could you have Dr. Martin and Dr. Bhat please return into the room. Now I’ll call the next 1, 2, 3, 4 applications for New York Presbyterian Hospital, Columbia Presbyterian Medical Center. I have Dr. Boutin-Foster recusing herself on these applications, and an interest declared by Ms. Reagan.

The first is 122297C, to renovate the emergency department creating 66 acute care treatment areas and 22 rapid medical evaluation areas.

The second is application 122306C for renovating and upgrading 10 existing inpatient units located in the Millstein Hospital building on the campus of New York Presbyterian Hospital in the uptown.

Application 122314, New York Presbyterian Hospital. To construct a new ambulatory care center to be located at 1283 York Avenue and certify PET scanning services.

And application 12231C for New York Presbyterian Hospital to acquire New York Downtown Hospital and certify it as a new division of New York Presbyterian Hospital. OHSM and the Establishment Review Committee has recommended approval with conditions and contingencies on each of these applications, and I so move.

(Second.)

WILLIAM STRECK: We have a motion and a second. Is there discussion on the motion? Hearing none, those in favor, aye?

“Aye.”

WILLIAM STRECK: Opposed? Thank you. Motion carries.

JEFF KRAUT: Thank you. Could I have Dr. Boutin-Foster return to the room please.

Then I have application 121201C, Alpine Home Healthcare, LLC, Bronx County. They have a conflict declared by Mr. Fassler and Mr. Fensterman who are leaving the room. They have left the room. This application is to expand the service are and

existing CHHA to include Kings, Queens, Richmond, New York, Rockland, Niagara, Erie, Nassau, and Suffolk Counties. OHSM recommended disapproval as proposed and contingent and conditional approval as amended, as did the Establishment and Project Review Committee, and I so move.

(Second.)

WILLIAM STRECK: Motion and a second. Discussion? Hearing none, those in favor aye?

“Aye.”

WILLIAM STRECK: Opposed? Thank you. The motion carries.

JEFF KRAUT: Thank you. Could we have Mr. Fassler and Mr. Fensterman to return to the room. They’re back. Now, I’m going to put the following – just want to make sure – the following applications of which Ms. Hines has abstained at the Establishment Committee and has indicated she’ll probably be abstained in this group as well, so I’ll read the application. We don’t have a choice here. I’m grouping them because there was an abstention in the establishment. Usually we don’t but since our understanding is the abstain is going to occur. I hope you understood that.

Application 121229C, Calvary Hospital, the Bronx. I just have to read this description. Calvary Hospital Inc., is an existing article 36 certified home health agency which operates a special needs CHHA in Westchester and New York Counties, and a general purpose CHHA in Bronx and Queens Counties. The applicant is proposing to convert their special needs CHHA into a general purpose CHHA and to expand their service area into the downstate counties of Richmond, Kings, and Nassau. They've also requested approval to expand into the upstate counties of Rockland, Putnam, which is going to be presented to the Public Health and Health Planning Council at a future meeting. Therefore, OHSM recommended disapproval as proposed, but contingent and conditional approval as amended by the Department with the same recommendation being adopted by the Establishment and Project Review Committee.

Application 121241C, Prime Health – excuse me, Prime Home Health Services, LLC, Kings County. Establish a certified CHHA to include Bronx, Nassau, Richmond, and Westchester Counties, and certify nutritional services.

Application 121289C, Winthrop University Hospital Home Health Agency to expand existing CHHA to serve Queens and Suffolk Counties.

Application 121312C, Good Samaritan Hospital Home Care Department in Rockland County. To expand their existing CHHA to include the Bronx, Westchester, and New York Counties.

Application 121323C, St. Cabrini Nursing Home, New York County. To expand the existing long term home health care program by establishing a CHHA to serve New York, Bronx, and Westchester Counties.

OHSM and the Establishment and Review Committee recommend approval with conditions and with one member abstaining on each of these applications, and I so move.

(Second.)

WILLIAM STRECK: The motion has been made and seconded. Is there discussion? Ms. Hines.

VICKY HINES: Thanks. I do want to, and I made some of these comments at the Establishment Committee. I appreciate the opportunity to do it again. I want to raise concern about what I have come to see as a flawed process, but I say that in the constructive understanding of the process we approved. So, we had a very rigorous debate a little more than 18 months ago about this RFA. We did approve it and we now have what we asked for. I have to really commend the Department because I think they have done a yeoman’s effort over the last 18 months in reviewing almost 200, I think, applications, and have brought forth each of them independently, most of which we’ve approved that have come forth. But I think in terms of describing my concern about the flaw, I want to describe what we’ve done, at

least in the six downstate counties that have additional applications on the agenda for today. So, in those counties we have gone from originally 104 CHHAs to we now have 240 CHHAs approved with the action that we've taken over the last several months. So we've increased it by 136 in just those six counties. And that's at a time when we have moved -- things changed rapidly since we originally approved this RFA process, but we have moved to managed care and part, and we've moved rapidly downstate, part of the value of managed care, the incentive in managed care is to reduce utilization. That has actually happened, but in addition MLTCs rely much more on licensed agencies than they do on CHHAs, and I think that's also evidenced by the number of licensed agencies that we've approved in the last many months. Since the RFA was distributed, CHHA utilization has reduced pretty significantly. The DOH January Medicaid global cap report shows that home health spending is actually $144 million below the projection for that spending. So we have reduced CHHA utilization at a time when we have more than doubled CHHA access in those six counties.

So we've created capacity at a time when demand is shrinking. We've added administrative infrastructure at a time when capacity – I'm sorry, at a time when demand is shrinking, and I think at best what that does is that destabilizes the existing structure and certainly will destabilize these new CHHAs, and at worst it really creates an atmosphere where fraud

could be possible. I think we made these comments during our original debate, that if you take a look at Florida and California that have had unfettered growth in CHHAs, it's the place we are, those are the two states we're most concerned about in terms of overutilization. And I think we run the risk of doing the same thing here.

In terms of the applications themselves, we have considered each of them independently, and that was the process we established, but each of those if you just take the Bronx applications as an example, so we had 11; we now I think have approved 21 new ones in the Bronx. Each of those 21 applications use the same need projections and access projections in putting their application, and frankly their financial projections together. So, their world has changed. So we reviewed and adopted them independently, but those 21 new agencies are all vying for exactly the same supposed unmet need that each of their competitive applications included. So, automatically we have financial projections that now I would really call into question.

And then I guess finally to me the whole process is counterintuitive to our commitment to do regional planning. So, as we have looked at these independently and without a view to overall need and a competitive review of overall need, as I said, I think we've just created unfettered growth that will have a lot of unintended consequences. I don't have a remedy.

Part of the reason that I abstained at Establishment and I will abstain from all of them today is because I voted yes until we sort of got to this point where I feel like we've gotten way too many on the docket. It doesn't seem fair to me to vote no when the applications that are before us today are no more worthy or less worthy than the applications that I have already voted yes to approve, so sort of my best remedy is to abstain because I feel like we don't have a good ultimate solution. But I just, I'm very concerned about it.

WILLIAM STRECK: Mr. Booth.

CHRIS BOOTH: I agree with many of the comments that were just made and I won't repeat any of them, but I do agree with them. Unfortunately I wasn't able to go to the Committee meeting day, but my comment I'm going to make relates to the comments I made at the first round, and that was we had some significant discomfort with the analysis that we were being provided on each of those applications, in essence the need methodology descriptions in the first round were deficient and hard to really assess, and we had some conversation about that and an agreement that that would be improved going forward. In fact, the need analysis this time is even less than what was in the first round, and they're almost word for word in every single one of these. And on that basis I don't know how we

exercise appropriate judgment in these applications, and therefore, from my perspective, I don't think they should be approved and I'm going to want to disapprove them and hope a deferral is the next motion. I'm not sure I'll have any support for that, but I don't feel comfortable going forward when what we said after the first round hasn't been addressed for the second round.

WILLIAM STRECK: Are there other comments? I guess I would just pose the question for the Council, and that is if we do make a decision that in hindsight proved incorrect or had consequences that were not considered advantageous as outlined by Ms. Hines, do we have any recourse? Any means to address this? Or how should we approach this should that come up? It seems to me that question is the benefit by at least being asked here before the group today.

KAREN WESTERVELT: Dr. Streck, if I may, I think it might be helpful to review the process. You know, Becky, I think, if you can talk about the process and specifically about the need issue and respectfully I think with the number of applications, you know, I think my recollection is we have not approved that number of applications. Is that correct, Becky?

BECKY FULLER-GRAY: Hi, can you hear me? Just to do a little bit of explanation here Vicky, and to, I think your numbers are – can you hear me? Is that better? To be able to explain the numbers that I think Ms. Hines has been using today, her numbers reflect the number of approved applicants who have been allowed to expand or establish in each of those counties, and not necessarily new organizations that have been approved. Throughout this entire process we have actually approved four brand new organizations to provide certified home health agencies in the State to date. We have approved long term home health care programs to convert, we have approved some special needs CHHAs to convert to general purpose CHHAs, but for the most part the expansions have been for existing certified home health agencies that are providing services within the areas in which they have asked to expand into. So the numbers that Vicky has talked to today reflect the number of agencies that have basically been providing certified home health agency services that have expanded into maybe contiguous counties in the metropolitan area, for the most part. They do not reflect brand new organizations providing home health services.

The purpose of the RFA and this process in general came about because of Medicaid redesign and the need for us to look at how we were going to improve access, improvement management of high cost in complex cases, improve care coordination in the provision of home health services generally in the State of New

York. The moratorium that had been in effect since 1996 had not allowed any new certified home health agencies to be established other than through purchasing of home health agencies. At the time, back in January, there were 32 county operated CHHAs of the 130 approved certified home health agencies. Of those, 16 were sole providers in their counties. At the time of the RFA, 18 county operated CHHAs had indicated that they were about to close, thereby decreasing access to home health agency services at a time when managed long term care and managed care was being implemented.

We ask applicants to give us a comprehensive analysis of what the existing healthcare delivery system is in the region that they want to expand into. We ask them to identify existing health services, health status indicators and factors that impact healthcare access and patient services. We also asked them to demonstrate how they, their organization will enhance care coordination, increase quality and efficiency, improve patient choice and access and improve quality outcomes. Those discussions that they present to us are reviewed by a team of reviewers who basically rate based on our criteria how well they address those issues. There are seven specific criteria that we ask the applicants to address and each of those criteria are reviewed comprehensively.

WILLIAM STRECK: Ms. Hines.

VICKY HINES: Becky, thank you. Because I think your clarification about the number that are new versus expansion are really important. I should have made that point myself. And I think what that does in my view is it does take off the table my worry about duplicating or expanding administrative costs because I would imagine most of those are not going to add administrative infrastructure just to expand. But it doesn't alleviate my concern about, you know, vying for the same staff, vying for the same referral base, you know, when utilization has actually gone down.

I also would say I completely agree that in the counties where there is a sole provider or that sole provider is the county that's then choosing to sell is a place where we have to do something. We haven't actually addressed those yet, I don't think. I don't think these six counties fall into – the six counties that I just talked about in terms of the growth that we've seen so far, I don't think we've addressed any of those yet.

BECKY FULLER-GRAY: No, the county providers are typically upstate providers.

VICKY HINES: Yeah, yeah. And I do completely agree that we need to do something in those cases. And as I said, the

seven criteria that were addressed in the RFA, those were the criteria that we all agreed to, and I'm not arguing that they were wrong at the time that we agreed to them. I think the world has changed, and one of the concerns that I had originally was based on those criteria alone create more capacity than we needed, and of course there are unintended consequences that go with excess capacity. So my point is simply is I think we're there. I think we have reached the unintended consequence, and not that these seven criteria are wrong, it's just a part of the puzzle. So I just wanted to make that point.

GLENN MARTIN: I guess what I'm looking for is a metric that would help me understand this, because I understand the pent up demand but in fact there are only four new things that came online. There were a bunch of counties that want to get out of the business and we probably have a need to increase competition and availability in certain counties, and then there are a whole bunch of people who have expanded. But the expansion means what in a metric? These are X – how many new, I don't know, homes? How many new patients? How many new people have we approved people to be now serviced that weren't before, since apparently the number the Vicky mentioned probably isn't the best way of looking at it. Is there a better number to look at it? Because, and I certainly share the concern that if we're dumping a bunch of excess capacity into the system, that's not

the best way to do it either. So, is there another number that would answer that? You know what I'm saying? Somebody does.

BECKY FULLER-GRAY: I think I know what you're saying. I think when you look at the metropolitan region of New York and the number of people that – is this better? Sorry. When you look at the metropolitan region of New York and the number of people that are receiving home health services and the number of agencies, about 2/3 of all home health services are provided in the major metropolitan region of New York City. And to look at it by the number of providers by county that are approved is probably reasonable. That's how it has historically been looked at. Need is based on the county. More to the point, I think your question is how many more additional individuals will be receiving home health services. I cannot answer that question.

KAREN WESTERVELT: I think with a movement towards managed long term care the intention is to move more of these patients into a community-based setting so the goal is to create more opportunities for patients to go into those community-based settings, and this is consistent with the goals of MRT and competition will drive down the costs, frankly, per patient moving forward as well, so, and one of the things I'm concerned about as well is the fairness test and that we have approved applications both upstate and downstate based on the same

criterion, and to now hold these applications to a different standard would be concerning.

GLENN MARTIN: No, I'm not proposing that. Again, it's more and probably should've brought it up in committee, it's just trying to better understand it. When somebody wanted to open one of these up in the Finger Lakes, Rochester, and somebody actually objected, there was the interesting discussion or actual real numbers were mentioned and the number of employees that were available and how this was going to quite possibly increase cost because there would be bidding wars to get competent people to be able to work for them and the like, and it was a very interesting discussion. None of that ever happens downstate. I mean, it's as if everyone just sort of said, OK. It's an interesting phenomena, and I just – I've just, I'm resonating to the discomfort that Ms. Hines raised without a solution to it. I just understand what's being said.

KAREN WESTERVELT: And I think to Ms. Hines point, I think she has a very good point, I think hence the reason that we would like to try to ultimately promote regional planning and the (RICS) in New York because we're going to be addressing this as we move forward and under healthcare reform, so I think the sooner we can get there, the better, but that is going to be a process that's going to take some time to get to that point.

JEFF KRAUT: When we go – to your point, let's just focus this on downstate because it's a little easier because there are different dynamics, different markets. So, and I'll tell you how my thinking has evolved, and when we started I just thought it was fundamentally unfair that there was a moratorium here. that it was ridiculous that a facility – for some geographic county line that you have 50 percent of your patients coming from another county but for whatever quirk on when you were approved, you were prevented from serving those patients. And combined with the advent of the managed long term care plans the theory behind that was these plans, if there was more competition in the market, they would be negotiating with the home care agencies to, for taking care of their patients. that'll be all in managed care, a lot of – and then we'll deal with the dual eligible and stuff. So, the issue now is we thought we put out the RFP and there would be some expansion in the marketplace. I don't think we ever anticipated that everybody who had been requested to expand would meet the test. But at some level, what does it matter? Is there going to – I think Vicky raises a valid issue, is this going to be supply-driven activity? Will this – they'll go out and do it, and I don't think I ever anticipated this many would be approved, but I certainly anticipated within a market place that there probably be a doubling of the number of people who were

qualified, not necessarily agencies, but certainly a number. A practical issue here is, I could only speak from the hospital side which is also dwindling in it's business is you're dealing and trying to coordinate access for four or five agencies, and that doubles now. And there is a practical issue here on how you do that, and at the same time balance the federal requirement of patient choice. And that will manifest itself in strange ways, I'm sure. But, you know, the point you raised, if we would've gone through this with the hindsight, we would've said let's just approve X or expand market and stop and wait, see what happens, and come back a year or two later and see if we had to do that, and unfortunately as, and I'm not going to restate, you know, we find ourselves in today's position. That's it.

WILLIAN STRECK: Dr. Sullivan.

DR. SULLIVAN: Clarify; the RFP went out, and are these the sum total of the ones that are going to keep coming before us? Or are there more applications that are going to come? I mean, was it a time limited RFP, I thought? So there must – what are the total numbers? Is this it, what we're going to approve today? Or are there more?

KAREN WESTERVELT: So, the RFP was time limited, so, however, what you have before you today is not the remainder of the applications. You have the applications that have gone, that have met our criterion as far as meeting the high scores in the RFP, basically. So, a decision is going to have to be made for those applications that are in a deferred status, if you will, right now moving forward, and then the other issue that we're going to have to address moving forward as well, and this gets to Ms. Hines point I think, you know, once we have the advent of these particular facilities into the market place, we're going to have to determine what our need methodology is moving forward for, you know, so we have a need methodology as opposed to just having a moratorium and having this type of situation where you have this bottleneck in the future. So, there are – how many applications pending, approximately?

BECKY FULLER-GRAY: For today this is the majority of the downstate applications that we are going to present. Although there are a few that had issues in getting us material for their CON application that we will come back in May and June. We have upstate applications that we have scheduled for May and June as well. So, after the June agenda we should be almost complete, I would suspect.

WILLIAM STRECK: So, if I might summarize, this has been a good discussion of the origin of this policy, our intent, the outcome, and our discomfort with the Darwinism we have launched on this enterprise, but I'm not sure that we can devolve what we have created at this point, and there will be outcomes presumably largely market driven from this point forward. Mr. Booth.

CHRIS BOOTH: The only thing I would say is I don't even get to some of the issues that we're discussing because in my mind we're supposed to have some judgment and look at some of the details here, and we're not even provided with the details to do that.

WILLIAM STRECK: Are there other comments? Dr. Gutierrez.

ANGEL GUTIERREZ: As Dr. Martin asked for specific measurements, I am still confused with the capacity issue. However you measured it from Ms. Hines, or from the Department, have we achieved the situation in this specific area where we have excess capacity?

VICKY HINES: I'm not sure. I don't know the answer to that question. What I do know is that the data show that CHHA

utilization downstate has reduced at the same time that we have expanded the number of CHHAS that we have. I absent a rational need methodology and I agree completely, we need a rational one. I just don't know what it is. So, the data would say that we have no need for further expansion because the market's actually been contracting. But, I also agree with Karen that it doesn't make sense for us to just sort of draw a line today and say we're not going to do any more because we are, we agree to a methodology, that methodology has been applied to the applications that are here today, and I think we just have a much bigger problem that we have to solve. I don't have an answer to how we solve it.

ANGEL GUTIERREZ: But the game changed, didn't it.

VICKY HINES: Um, yes.

ANGEL GUTIERREZ: We're playing football with the rules from two years ago and now the game has changed.

VICKY HINES: Yes. The game has changed a lot I think.

WILLIAM STRECK: Capacity was not one of our criteria when we started out.

VICKY HINES: It was not.

WILLIAM STRECK: I think that's Vicky's point. So you're right. That's our conundrum. Capacity was not a criteria. Capacity is the question. That's independent of Chris's point which is just the quality of the information for decision making.

ANGEL GUTIERREZ: So what's other than fairness, which I understand, what's the rush to act?

WILLIAM STRECK: Dr. Sullivan.

DR. SULLIVAN: It's just not even clear to me that there have been these fluctuations and there's been less use, what that means. Does that mean there's less use because places have kind of slimmed down because they couldn't afford to provide the services? I don't know that we're clear about any of this, to tell you the truth. So I don't know that there's a cause and effect here between what's been approved and the decrease in utilization, unless you can show it. And so, I do think the fairness thing holds a fair amount of weight at this point. This is my opinion. I mean, we've gone this far down the road. It is a time-limited thing. These are expansions, and I think they're – not many of them are expansions anyway. The market

will probably drive to some extent whether or not you end up expanding into all these counties that these various CHHAs put in, but I just think you're a little bit in trouble trying to change the rules of the game in the middle of the game, especially if you don't know that these adverse, possible adverse consequences really have anything to do with what you've done so far. I mean you can suggest it, but you don't know.

WILLIAM STRECK: Mr. Hurlbut. Thank you.

ROBERT HURLBUT: Well, I guess speaking as a for-profit guy, I think I'm the only one here, that I think it's not fair to the applicants to change the rules on them. They followed it. And I think with the advent of managed care coming for Medicaid even for nursing homes in the next three to four years, I'm looking at it as the market's going to control a lot of this. And if there's expansions of certain CHHAs, doesn't matter if you're talking about the nursing home industry, the hospitals, or home healthcare, people are going to go where they're going to go, and if there's too much capacity then some of these CHHAs just won't be in business. Or, like with the hospitals, look how many hospitals have merged. I think that's what's going to happen, and I think that yes, there is a little bit of an issue about the capacity, but capacity is, it's like, it's very fluid. And I don't think it's right if someone has

spent the time and the effort to go in front of this council and then we shut them off because we're sort of like nefarious in our decisions. That to me will get us in trouble. I think the one thing we have to be is consistent.

WILLIAM STRECK: Dr. Martin.

GLENN MARTIN: So, since it appears that we didn't have a rational need methodology in place, do we have a rational monitoring methodology in place going forward? Because yes, it is true, the market will probably prevail, but I mean, downstate has seen what happens when the market prevails and hospitals close abruptly or the like and how it disrupts services in healthcare provision and safety, that it would be nice to make sure that we, again, things may merge, things may not expand, things may collapse and in inappropriate and poor ways. I'm just asking – do we have a ration – do we have the ability to monitor what's going forward prospective – obviously prospectively, well, so that we can intervene and do things from it, or are we not even prepared for that because we're just focusing on filling, getting through the RFA process and dealing with this. I guess I'm concerned with that.

WILLIAM STRECK: Is there anyone who wants to attempt to respond. Karen, do you want to –

KAREN WESTERVELT: So, just to get to Dr. Gutierrez's earlier question about you know, why the need to act, many of these entities have contracts with managed long term care plans. Right now we are trying to advance the managed long term care agenda as well. So just to your earlier point, and with respect to monitoring, we survey, you know, these facilities, you know, certainly, and you know, if they, is there a standard Becky, as far as the volume?

BECKY FULLER-GRAY: All home health agencies that are certified home health agencies are monitored, surveyed, at a minimum of every 36 months. We respond to complaints more frequently than that, patient care complaints. We also have a mechanism to monitor their outcome data as frequently as we desire, basically, as it's uploaded. So we do have a monitoring mechanism in place that we utilize.

KAREN WESTERVELT: And I think the other thing is because we're not dealing with bricks and mortar here necessarily, I think if a CHHA was to close if you will, you know, it's easier to make arrangements for that patient to be affiliated with another CHHA.

WILLIAM STRECK: Mr. Fensterman.

HOWARD FENSTERMAN: Yeah, I want to echo what Bob said, because I, you're not the only for-profit guy here. But, actually I am. In any event, I just want to refresh everyone's recollection as to historically what transpired here when Rick Cook was here when we went over the criteria and he put it up on the screen and he set forth very clearly and numerated the various criteria by which these RFPs were going to be evaluated. And at that time, we approved that. Applicants have not come forward. They've submitted their applications to the Department, and they've fulfilled those criteria that were enumerated that we approved. So, I think at this juncture, I agree with Bob that it would be patently, not only unfair, but wrong to not approve applicants who have met those criteria. And I have to say that I think there's tremendous merit to what Vicky has said, there's tremendous merit to what Chris has said. I think that we need to look at this on a prospective basis, hence forth. I think there is clearly problems that have been raised today such as capacity, and we need to look at that. But as far as the applications that are here before us today, these folks apparently in the Department's view have fulfilled those factors that were enumerated that we have approved, and I think that it is entirely appropriate that so long as, I think the establishment recommended approval of them, that we should be doing the same.

WILLIAM STRECK: Are there other comments? Ms. Regan.

SUSAN REGAN: I think I have a partial answer for Dr. Martin, and I think the way we decide or figure out as we go forward if it's working is we're going to look at how the managed long term care programs are succeeding. And the old system, the moratorium system assured that it would fail, because what you had was a managed long term care plan having to put together a continuum of services to handle a population and they couldn't do business with a CHHA because the CHHA fell off after. So we had to fix that. And I think that's what we've done by these applications, and maybe the only way to do it in terms of, I mean, again, CHHAs are very fluid, so maybe you need to have a form of Darwinism where those CHHAs that successfully can deal with managed care will have their contracts in place, arrangements with the various hospitals and everyone else, and that will work out. And those that don't will not just get Medicaid patients. So, in a way, we have to wait for time to show us what's working. And we'll know because we'll know if managed long term care is working.

WILLIAM STRECK: OK. I think everyone for this robust discussion. I do just want to clarify that the credibility of an observation and the power of a vote is not weighted here

based on for-profit or not-for-profit status as we move ahead. OK. So we have a motion and we have a second. And we've had the discussion. So, those in favor of the motion as presented, please signify by raising your hands in this instance please. The motion carries. Are there those who wish to cast a vote against? One. OK. Thank you. Abstentions? Vote against, and then I'm asking abstentions? Are there those who are abstaining? One. Thank you. Thank you for that discussion. Mr. Kraut.

JEFF KRAUT: Application 131109C, Health Services of Northern New York, St. Lawrence County. An interest declared by Mr. Booth. To certify a long term home healthcare program in Lawrence County. OHSM recommends approval with contingency. The Establishment Committee recommend approval with a contingency with one member opposing. And I so move. (Second.)

WILLIAM STRECK: A motion and a second. Is there discussion? Ms. Hines.

VICKY HINES: Yeah, this one I am opposed to for the simple reason and actually since this was approved at Establishment Committee the State has received approval from CMS to require mandatory enrollment of patients enrolled in the long

term home healthcare program into long term managed care. So, at the time I originally opposed it that was pending, but had not been received, and it just doesn't make sense to me to establish a new long term home healthcare program when ultimately that structure will disappear.

WILLIAM STRECK: Are there additional comments or questions?

KAREN WESTERVELT: Becky, do you just want to talk about this being an interim solution?

BECKY FULLER-GRAY: Yes. St. Lawrence County is a certified home health agency that also has a long term home healthcare program providing services to about 130 Medicaid recipients at the moment. St. Lawrence County would like to close both their certified home health agency and their long term home healthcare program. There are no other long term home healthcare program providers or options for these individuals at this time. This is being recommended for approval as an option for those individuals to be able to continue to receive services until such time they can be transitioned to managed long term care.

VICKY HINES: Just one question; I think I had understood at Establishment that there was at least the nursing home transition diversion waiver option and personal care, but is that not the case? Available in St. Lawrence?

BECKY FULLER-GRAY: The nursing home transition diversion waiver is a viable option for those individuals who elect to use that option to transition. Typically the number of providers are not robust enough to be able to provide a seamless transition, especially in the upstate rural counties. We've had issues previously when long terms have closed trying to transition small numbers of patients into the nursing home transition diversion waiver just because of the number of available providers that are available for those individuals to access services.

WILLIAM STRECK: Are there other comments or questions? Hearing none, I would ask since we have a motion and a second for those in favor of the motion to say aye?

"Aye."

WILLIAM STRECK: Opposed? One. The motion carries. Thank you.

JEFF KRAUT: Going to batch the following two applications. Application 121214C, New York Congregational Nursing Center Long Term Home Healthcare program to expand it's program by certifying a CHHA to serve Kings County. And application 121287C, Gurwin Jewish Nursing and Rehabilitation Center Long Term Home Healthcare program in Suffolk County to expand it's program by establishing a CHHA to serve Nassau and Suffolk County. OHSM recommended approval with a condition as did the Establishment and Project Review Committee with one member abstaining and I so move.
(Second.)
And an interest had been declared by Mr. Fassler on these two applications.

WILLIAM STRECK: We have a motion and a second. Is there discussion? Hearing none, those in favor, aye.

"Aye."

WILLIAM STRECK: Opposed? Thank you. The motion carries. I'm sorry? Noting Ms. Hines abstention. Thank you.

JEFF KRAUT: I'm going to call application 121313C, Visiting Nurse Service of New York Home Care in New York County.

Ms. Regan is recusing herself and an interest has been declared by Mr. Fassler. Ms. Regan's leaving the room.

OHSM and the Committee recommended approval with a condition with one member abstaining, and I so move. (Second.)

WILLIAM STRECK: I have a motion and a second. Is there discussion? Hearing none, those in favor aye?

"Aye."

WILLIAM STRECK: Opposed? Abstaining? Ms. Hines. Thank you.

JEFF KRAUT: Could we have Ms. Regan return. I'll call the next four applications where Mr. Fensterman has declared a conflict and is recusing himself.

Application 121217C Bethel Nursing Home Company in Westchester. Mr. Fensterman is out of the room. This is to expand the long term home healthcare program by certifying a CHHA to serve Bronx, New York, Putnam, Queens, and Westchester Counties.

Application 121231C, -- isn't this the same one we just did? Oh, no, no, this is Parker. Parker Jewish Institute for Healthcare and Rehabilitation in Nassau County. Expand a

current long term home healthcare program to certify a CHHA service Brooklyn, Queens, Nassau, Suffolk, New York, Bronx and Westchester Counties.

Application 121421C, Four Seasons Nursing and Rehabilitation Center, long term home healthcare program in Kings County. Convert the long term home healthcare program into a full service CHHA per the DHCBSDAL to provide services in Bronx, Kings, Queens, and Richmond Counties.

Application 121440C, Hillside Manor Nursing Center in Queens. To expand it’s CHHA to serve Queens, Bronx, Kings, New York, and Richmond Counties.

OHSM recommended approval with conditions. The Committee recommended likewise with one member abstaining on these applications. And I so move.

(Second.)

WILLIAM STRECK: We have a motion and a second. Is there discussion on this recommendation? Hearing none, I would ask those in favor to say aye?

“Aye.”

WILLIAM STRECK: Opposed? Abstaining? Ms. Hines. Thank you.

JEFF KRAUT: We have Mr. Fensterman return please. Now, I'll move to application 122213E, Catholic Health Ministry Services of Erie County with an interest declared by Mr. Booth. To merge the current constituent corporations of Catholic Health System into a single surviving corporation for the Sisters of Charity in Buffalo New York, and to be called the Catholic Health Ministry Services Inc. I'm going to be, I'm going to read each one, but I'm going to group all of these. Approval with contingencies was recommended by both OHSM and the Establishment Committee.

Application 122104B – did I say Mr. Booth had an interest in the previous application? Yeah, OK. Application 122104B, Gold Step Ambulatory Surgery Center in Kings County. To establish and construct a multi-specialty am-surg center to be located at 3007 Farragut Road in Brooklyn. The services that will be provided, it'll be gastroenterology, podiatry, general surgery, urology, and GYN. OHSM recommended conditional contingent approval with expiration of the operating certificate five years from the date of it's issuance as recommended, and this recommendation was adopted by the Establishment and Project Review Committee.

Application 122223E, Hudson Valley Endoscopy Center in Dutchess County. To certify for an indefinite life for a change in stock ownership of Hudson Valley Endoscopic Center which was

referenced in CON number 082050. OHSM and the Committee recommend approval with contingencies.

Application 122280B, Cortland ASC, LLC, d/b/a the Cortland Surgical Center in Cortland County. Interest declared by Mr. Booth. To establish and construct an am-surg center to provide otolaryngology procedures, located at 64 Pomeroy Street in Cortland. Conditional and contingent approval with the expiration of the operating certificate five years from the date of it’s issuance was recommended.

Application 122013B, the New York Foundling Bronx Healthcare Center in Bronx County. To establish and construct an article 28 D&TC center at 170 Brown Place in the Bronx and an extension clinic in Staten Island. OHSM and the Committee recommend approval with conditions and contingencies.

Application 122181E, Dialysis Newco Inc., d/b/a DSI Renal in Dutchess County. To establish Dialysis Newco as the new owner of the Dutchess Dialysis Center currently operating as an extension clinic of FMS Southern Manhattan Dialysis Center with an interest declared by Dr. Bhat. This is approval was recommended by OHSM and the Committee with contingencies.

Application 122319E, St. Joseph’s Dialysis Center, Regional Onondaga County. Interest declared by Mr. Booth. To transfer 25 percent of existing member Liberty Syracuse, LLC to a new member, New York Dialysis Services, Inc,. with an interest

declared by Dr. Bhat. OHSM and the Committee recommend approval with contingencies.

122233E, Batavia Healthcare Center, LLC in Genesee County. Interest – Batavia. I got the other one right. I got Onondaga right. Batavia Health Center. Just kidding. Batavia Health Center, LLC in Genesee County. Interest declared by Mr. Booth and Mr. Hurlbut who is an expert in that county. Transfer 100 percent ownership of the nursing home to Batavia Healthcare Center LLC. Approval with contingencies is recommended by the OHSM and the Council.

Application 122276E, Livingston Hills Nursing and Rehabilitation in Columbia County, to establish the Livingston S&V Operations LLC. d/b/a the Livingston Hills Nursing and Rehabilitation Center as the operator of Livingston Hills Nursing and Rehabilitation Center. OHSM and the Committee recommend approval with conditions and contingencies.

Application 122298E, Golden Hill Planning Corporation d/b/a the Golden Hill Nursing and Rehabilitation Center in Ulster County. To establish the Golden Hill Planning Corporation d/b/a the Golden Hill Nursing and Rehabilitation Center as the operator of Golden Hill Healthcare Center. OHSM and the Committee recommend approval with contingencies.

Then we have a certificate of dissolution of the Community General Hospital of Greater Syracuse. OHSM and the Committee recommended approval, and the health homecare licensure of 2128-

L, Achieve ALP, LLC., d/b/a Achieve Assisted Living in Sullivan County. Approval was recommended with a contingency by OHSM and the Committee, and I so move.

(Second.)

WILLIAM STRECK: All of these applications have been recommended for approval. They have been seconded. Is there discussion? Dr. Berliner.

HOWARD BERLINER: I have a question about the two dialysis applications.

JEFF KRAUT: Sure.

HOWARD BERLINER: And the question is really these are as I understand it, one is basically a sale by Fresenius and one is a purchase by Fresenius, and I'm wondering are we monitoring the quality of care and a variety of other things about how this firm is doing given it's had some national problems? And are we making sure that the quality of care in New York meets our standards?

CHARLIE ABEL: Well, I can let you know that the, that dialysis providers are monitored very closely. They get monitored once every three years minimum. The – we do monitoir

what's happening with the large publicly traded dialysis entities from a global perspective because clearly what happens in California or Texas may have implications for us. But at least with respect to the quality issues that we've seen in other parts of the country, we don't see that as systemic to the organization, at least not at this point. So we continue to monitor these services in New York State. With respect to the two applications specifically, just to add clarity, the dialysis Newco application is a divestiture of the Fresenius entity. There was a court order and agreement to, for Fresenius to sell off parts of it's organization and so this is actually a sale to a new corporate entity to provide dialysis services in New York State. It's part of a national acquisition of part of the Fresenius network. And with respect to the St. Joseph's Dialysis application, this is actually the Fresenius New York entity, New York Dialysis Services assuming responsibility for, or assuming ownership that was previously held by the straw man that Fresenius had put in through a representative governance arrangement. So this is actually, from a compliance perspective and being able to hold Fresenius responsible for the operations of that facility, it's a stronger and better governance structure from our perspective. Thank you.

WILLIAM STRECK: Other questions or comments on the motions? Hearing none, those in favor, aye?

"Aye."

WILLIAMS STRECK: Opposed? Abstaining? Passed. Thank you.

JEFF KRAUT: Going to group the following home health agency licensures together.

Application 1940-L, All Care Home Care Agency, Inc.

2053-L, Lavin Home Care d/b/a Home Instead Senior Care.

2043-L, Bushwick Economic Development Corporation

2084-L, Renewal Care Partners, LLC.

2027-L, Westchester Family Care, Inc.

OHSM and the Committee recommends approval with contingencies, and I so move.

(Second.)

WILLIAM STRECK: Moved and seconded. Discussion? Hearing none, those in favor, Aye?

"aye."

WILLIAM STRECK: Opposed? Thank you. Passes.

JEFF KRAUT: I have next group is application – I'm going to put the next two together where Mr. Fensterman has a conflict.

Application 122215E, Excel at Woodbury for Rehabilitation and Nursing, LLC, in Nassau County. Mr. Fensterman – I'm sorry. Howard, you abstained. You did not have a – you're going to leave? OK. Mr. Fensterman has left the room. Transfer ownership of Woodbury Center for Healthcare to Excel at Woodbury for Rehabilitation and Nursing, LLC.

Application 122251E, Rosewood Rehabilitation and Nursing Center, Rensselaer County. To establish Rosewood Care, d/b/a Rosewood Rehabilitation and Nursing Center as the operator of Rosewood Rehabilitation Center.

OHSM and the Committee recommend approval with contingencies with one member abstaining, and I so move. (Second.)

WILLIAM STRECK: Moved and seconded. Discussion? Hearing none, those in favor aye?

"Aye."

WILLIAM STRECK: Opposed? Abstaining? Thank you. The motion carries.

JEFF KRAUT: I have now the last batch I'll batch together. Mr. Fensterman has returned to the room. 121232E, Amber Court at Home, LLC, Nassau County. Establish a CHHA to serve all five boroughs of New York City, Nassau, and Suffolk County.
Application 121260E, Constellation Homecare in Nassau County. Establish a CHHA to serve Bronx, Queens, New York, Nassau, Suffolk, and Westchester Counties.
Application 122261E, St. Mark's Brooklyn Associates, LLC. d/b/a Crown Heights Center for Nursing and Rehabilitation, Kings County. To establish St. Mark's Brooklyn Associates, LLC, d/b/a Crown Heights Center for Nursing and Rehabilitation as the new operator of the Marcus Garvey Nursing Home Company. OHSM and the Committee recommended approval with contingencies with one member abstaining, and I so move.
(Second.)

WILLIAM STRECK: Motion and a second. Is there discussion? Ms. Hines.

VICKY HINES: I probably should've stopped you, because I actually am going to vote differently on each of the three. I apologize.

JEFF KRAUT: Let me call them back. Could you just tell me I have to remove from the batch? Do you just want me to go in order?

VICKY HINES: Would you go in order? That would be easier for me.

JEFF KRAUT: OK. Disregard.

Application 121232E, Amber Court at Home, LLC, Nassau County. Establish a CHHA to serve the five boroughs of New York City. OHSM and the Committee recommend approval with condition and contingencies with one member abstaining, and I so move. (Second.)

WILIAM STRECK: Moved and seconded. Is there discussion? Hearing none, those in favor, aye.

“Aye.”

WILLIAM STRECK: Opposed? Abstaining? Ms. Hines. Thank you.

JEFF KRAUT: Application 121260E, Constellation Home Care Nassau County. To establish a CHHA to serve Bronx, Queens, New York, Nassau, Suffolk and Westchester County. OHSM and the Committee recommend approval with condition and contingencies, with one member abstaining, and I so move. (Second.)

WILLIAM STRECK: Moved and seconded. Discussion? Those in favor, Aye?

“Aye.”

WILLIAM STRECK: Opposed? Ms. Hines. Abstaining. The motion carries.

JEFF KRAUT: Application 12261E, St. Mark’s Brooklyn Associates, d/b/a the Crown Heights Center for Nursing and Rehabilitation. To establish St. Mark’s Associates d/b/a Crown Heights Center for Nursing and Rehabilitation as the new operator or Marcus Garvey Nursing Home Company. OHSM and the Committee recommend approval with contingencies and with one member abstaining, and I so move.
(Second.)

WILLIAM STRECK: Moved and seconded. Is there discussion? Those in favor aye?

“Aye.”

WILLIAM STRECK: Opposed? Abstaining. The motion passes. Thank you.

JEFF KRAUT: That, Mr. Chairman, concludes the report of the Committee and I'm happy to let you know, Mr. Hurlbut, I have been invited in the summer to visit Batavia, and from a hospital colleague who just sent me an email saying come up and we'll teach you how to say the world. There you go. Dr. Streck, that is the end of our committee report.

WILLIAM STRECK: And that gratefully appreciated conclusion. Thank you. That concludes the public portion of the Public Health and Health Planning Council. I would remind members of the Council that we have an executive session to follow immediately, and by immediately we mean within a minute. So we'll ask our guests if they could please excuse themselves, and then we will resume. Thank you very much for everyone's attention. We will begin our meeting…

[end of audio]

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

June 6, 2013

REGULATION

Report of the Committee on Codes, Regulations and Legislation **Exhibit #2**

Angel Gutiérrez, M.D., Chair

For Emergency Adoption

13-08 Amendment of Subpart 7-2 of Title 10 NYCRR - Children's Camps

For Discussion

13-08 Amendment of Subpart 7-2 of Title 10 NYCRR – Children's Camps

Repeal of Sections 708.2 and 708.5 and addition of a new Section 405.33 Trauma Centers

Repeal of Subdivision (g) in Section 405.19and addition of a new Section 405.32 of Title 10 NYCRR – Observation Services

Repeal of Sections 405.43 and 700.5 and Amendment of Section 400.21 of Title 10 NYCRR Advance Directives

13-12 Amendment of Section 1.31 of Title 10 NYCRR - Disclosure of Confidential Cancer Information

Pursuant to the authority vested in the Public Health and Health Planning Council by Section 225 of the Public Health Law, subject to the approval by the Commissioner of Health, Subpart 7-2 of the State Sanitary Code, as contained in Chapter 1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended as follows, to be effective on June 30, 2013.

SUBPART 7-2

Children's Camps

(Statutory Authority: Public Health Law §§ 201, 225, 1390, 1394, 1395, 1399-a; L. 2012, ch. 501)

Subdivision (o) of section 7-2.5 is amended to read as follows:

(o) The camp operator shall provide adequate supervision. *Adequate supervision* shall mean:

(1) supervision such that a camper is protected from any unreasonable risk to his or her health or safety, including physical or sexual abuse or any public health hazard; [and]

(2) as a minimum, there shall exist visual or verbal communications capabilities between camper and counselor during activities and a method of accounting for the camper's whereabouts at all times[.]; and

(3) at camps required to comply with section 7-2.25 of this Subpart, protection from any unreasonable risk of experiencing an occurrence which would constitute a reportable incident as defined in section 7-2.25(h)(4) of this Subpart.

Section 7-2.24 is amended to read as follows:

Variance; waiver.

(a) *Variance* - i[I]n order to allow time to comply with certain provisions of this Subpart, an operator may submit a written request to the permit-issuing official for a variance from a specific provision(s) when the health and safety of the children attending the camp and the public will not be prejudiced by the variance, and where there are practical difficulties or unnecessary hardships in immediate compliance with the provision. An operator must meet all terms of an approved variance(s) including the effective date, the time period for which the variance is granted, the requirements being varied and any special conditions the permit-issuing official specifies. The permit-issuing official shall consult with the State Department of Health and shall obtain approval from the State Department of Health for the proposed decision, prior to granting or denying a variance request for requirements in section 7-2.25 of this Subpart.

(b) *Waiver* - i[I]n order to accept alternative arrangements that do not meet certain provisions of this Subpart but do protect the safety and health of the campers and the public, an operator may submit a written request to the permit-issuing official for a

waiver from a specific provision of this Subpart. Such request shall indicate justification that circumstances exist that are beyond the control of the operator, compliance with the provision would present unnecessary hardship and that the public and camper health and safety will not be endangered by granting such a waiver. The permit-issuing official shall consult with a representative of the State Department of Health prior to granting or denying a waiver request. An operator must meet all terms of an approved waiver(s), including the condition that it will remain in effect indefinitely unless revoked by the permit-issuing official or the facility changes operators. The permit-issuing official shall consult with the State Department of Health, and shall obtain the approval of the State Department of Health for the proposed decision, prior to granting or denying a waiver request related to the requirements in section 7-2.25 of this Subpart.

New subdivisions (h)-(m) of section 7-2.25 are added to read as follows:

(h) Definitions. The following definitions apply to Section 7-2.25 of this Subpart.

(1) *Camp Staff* shall mean a director, operator, employee or volunteer of a children's camp; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a children's camp pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the children's camp.

(2) *Department* shall mean the New York State Department of Health.

(3) *Justice Center* shall mean the Justice Center for the Protection of People with Special Needs, as established pursuant to Section 551 of the Executive Law.

(4) *Reportable Incident* shall include those actions incorporated within the definitions of "physical abuse," "sexual abuse," "psychological abuse," "deliberate inappropriate use of restraints," "use of aversive conditioning," "obstruction of reports of reportable incidents," "unlawful use or administration of a controlled substance," "neglect," and "significant incident" all as defined in Section 488 of the Social Services Law.

(i) Reporting.

(1) In addition to the reporting requirements of section 7-2.8(d), a camp operator subject to section 7-2.25 of this Subpart and all camp staff falling within the definition of "mandated reporter" under section 488 of the Social Services Law shall immediately report any reportable incident as defined in section 7-2.25(h)(4) of this Subpart and Section 488 of the Social Services Law, where such incident involves a camper with a developmental disability, to the permit-issuing official and to the Justice Center's Vulnerable Persons' Central Register. Such report shall be provided in a form and manner as required by the Justice Center.

(j) Employee Screening, Training, and Code of Conduct

(1) Prior to hiring anyone who will or may have direct contact with campers, or approving credentials for any camp staff, the operator shall follow the procedures established by the Justice Center in regulations or policy, to verify that such person is not on the Justice Center's staff exclusion list established pursuant to section 495 of the Social Services Law. If such person is not on the Justice Center's staff exclusion list, the operator shall also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment as required by section 424-a of the Social Services Law. Such screening is in addition to the requirement that the operator similarly verify that a prospective camp staff is not on the sexual abuse registry, as required by section 7-2.5(l) of this Subpart.

(2) A camp operator must ensure that camp staff, and others falling within the definition of mandated reporter under Section 488 of the Social Services Law who will or may have direct contact with campers having a developmental disability, receive training regarding mandated reporting and their obligations as mandated reporters. A camp operator shall ensure that the telephone number for the Justice Center's hotline for the reporting reportable incidents is conspicuously displayed in areas accessible to mandated reporters and campers.

(3) The camp operator shall ensure that all camp staff and others falling within the definition of “custodian” under Section 488 of the Social Services Law are

provided with a copy of the code of conduct established by the Justice Center pursuant to Section 554 of the Executive Law. Such code of conduct shall be provided at the time of initial employment, and at least annually thereafter during the term of employment. Receipt of the code of conduct must be acknowledged, and the recipient must further acknowledge that he or she has read and understands such code of conduct.

(k) Disclosure of information

(1) Except to the extent otherwise prohibited by law, the camp operator shall be obliged to share information relevant to the investigation of any incident subject to the reporting requirements of this Subpart with the permit-issuing official, the State Department of Health, and the Justice Center. The permit-issuing official, the department and the Justice Center shall, when required by law, or when so directed by the department or the Justice Center and except as otherwise prohibited by law, be permitted to share information obtained in their respective investigations of incidents subject to the reporting requirements of section 7-2.25 (i) of this Subpart.

(2) Except as otherwise prohibited by law, the operator of a camp not otherwise subject to Article Six of the Public Officers Law shall make records available for public inspection and copying to the extent required by subdivision six of Section 490 of the Social Services Law and regulations of the Justice Center.

(l) Incident Management.

(1) The camp operator shall cooperate fully with the investigation of reportable incidents involving campers with developmental disabilities and shall provide all necessary information and access to conduct the investigation. The camp operator shall promptly obtain an appropriate medical examination of a physically injured camper with a developmental disability. The camp operator shall provide information, whether obtained pursuant to the investigation or otherwise, to the Justice Center and permit-issuing official upon request, in the form and manner requested. Such information must be provided in a timely manner so as to support completion of the investigation subject to the time limits set forth in this subdivision.

(2) Unless delegated by the Justice Center to a delegate investigatory agency as defined in subdivision six of Section 488 of the Social Services Law, incidents of abuse or neglect, as defined in subdivision eleven of Section 488 of the Social Services Law, shall be investigated by the Justice Center. With regard to all other reportable incidents, as defined in Section 488 of the Social Services Law, the permit-issuing official shall initiate a prompt investigation of an allegation of a reportable incident, which shall commence no later than five business days after notification of such an incident, unless the Justice Center agrees that it will undertake such investigation. Additional time for completion of the investigation

may be allowed, subject to the approval of the department, upon a showing of good cause for such extension. At a minimum, the investigation of any reportable incident shall comply with the following:

(i) Investigations shall include a review of medical records and reports, witness interviews and statements, expert assessments, and the collection of physical evidence, observations and information from care providers and any other information that is relevant to the incident. Interviews should be conducted by qualified, objective individuals in a private area which does not allow those not participating in the interview to overhear. Interviews must be conducted of each party or witness individually, not in the presence of other parties or witnesses or under circumstances in which other parties or witnesses may perceive any aspect of the interview. The person alleging the incident, or who is the subject of the incident, must be offered the opportunity to give his/her version of the event. At least one of the persons conducting the interview must have an understanding of, and be able to accommodate, the unique needs or capabilities of the person being interviewed The procedures required by this Subparagraph (i) may be altered if, and only to the extent necessary to, comply with an applicable collective bargaining agreement.

(ii) All evidence must be adequately protected and preserved.

(iii) Any information, including but not limited to documents and other materials, obtained during or resulting from any investigation shall be kept confidential, except as otherwise permissible under law or regulation, including but not limited to Article 11 of the Social Services Law.

(iv) Upon completion of the investigation, a written report shall be prepared which shall include all relevant findings and information obtained in the investigation and details of steps taken to investigate the incident. The results of the investigation shall be promptly reported to the department, if the investigation was not performed by the department, and to the Justice Center.

(v) If any remedial action is necessary, the permit-issuing official shall establish a plan in writing with the camp operator. The plan shall indicate the camp operator's agreement to the remediation and identify a follow-up date and person responsible for monitoring the remedial action. The plan shall be provided, and any measures taken in response to such plan shall be reported, to the department and to the Justice Center.

(vi) The investigation and written report shall be completed and provided to the department and the Justice Center within 45 days of when the incident was first reported to the Justice Center. For purposes of this

section, “complete” shall mean that all necessary information has been obtained to determine whether and how the incident occurred, and to complete the findings referenced in paragraph (l)(2)(iv) of this subdivision.

(3) (i) The camp shall maintain a facility incident review committee, composed of members of the governing body of the children’s camp and other persons identified by the camp operator, including some members of the following: camp administrative staff, direct support staff, licensed health care practitioners, service recipients, the permit-issuing official or designee and representatives of family, consumer and other advocacy organizations, but not the camp director. The camp operator shall convene a facility incident review panel to review the timeliness, thoroughness and appropriateness of the camp's responses to reportable incidents; recommend additional opportunities for improvement to the camp operator, if appropriate; review incident trends and patterns concerning reportable incidents; and make recommendations to the camp operator to assist in reducing reportable incidents. The facility incident review panel shall meet at least annually, and also within two weeks of the completion of a written report and remedial plan for a reportable incident.

(ii) Pursuant to paragraph (f) of subdivision one of section 490 of the Social Services Law and regulations of the Justice Center, a camp operator may seek an

exemption from the requirement to establish and maintain an incident review committee. In order to obtain an exemption, the camp operator must file an application with the permit-issuing official, at least sixty days prior to the start of the camp operating season, or at any time in the case of exemptions sought within the first three months following the effective date of this provision. The application must provide sufficient documentation and information to demonstrate that that compliance would present undue hardship and that granting an exemption would not create an undue risk of harm to campers' health and safety. The permit-issuing official shall consult with the State Department of Health (department), and shall not grant or deny an application for an exemption unless it first obtains department approval for the proposed decision. An operator must meet all terms of an approved exemption(s), including the condition that it will remain in effect for one year unless revoked by the permit-issuing official, subject to department approval, or the facility changes operators. Any application for renewal shall be made within 60 days prior to the start of the camp's operating season. The procedure set forth in this Subparagraph (ii) shall be used instead of the general procedures set forth in section 7-2.24 of this Subpart.

(m) In addition to the requirements specified by subdivisions (d) and (g) of section 7-2.4 of this Subpart, a permit may be denied, revoked, or suspended if the children's camp fails to comply with regulations, policies, or other requirements of the Justice Center. In

considering whether to issue a permit to a children's camp, the permit-issuing official shall consider the children's camp's past and current compliance with the regulations, policies, or other requirements of the Justice Center.

Regulatory Impact Statement

Statutory Authority:

The Public Health and Health Planning Council is authorized by Section 225(4) of the Public Health Law (PHL) to establish, amend and repeal sanitary regulations to be known as the State Sanitary Code (SSC), subject to the approval of the Commissioner of Health. Article 13-B of the PHL sets forth sanitary and safety requirements for children's camps. PHL Sections 225 and 201(1)(m) authorize SSC regulation of the sanitary aspects of businesses and activities affecting public health including children's camps.

Legislative Objectives:

In enacting to Chapter 501 of the Laws of 2012, the legislature established the New York State Justice Center for the Protection of People with Special Needs (Justice Center) to strengthen and standardize the safety net for vulnerable people that receive care from New York's Human Services Agencies and Programs. The legislation includes children's camps for children with developmental disabilities as a type of facility within the oversight of the Justice Center and requires the Department of Health to promulgate regulations approved by the Justice Center pertaining to incident management. The proposed amendments further the legislative objective of protecting the health and safety of vulnerable children attending camps in New York State (NYS).

Needs and Benefits:

The legislation amended Article 11 of Social Services law as it pertains to children's camps as follows:

- It included overnight, summer day and traveling summer day camps for children with developmental disabilities as facilities required to comply with the Justice Center requirements.
- It defined the types of incident required to be reported by children's camps for children with developmental disabilities to the Justice Center Vulnerable Persons' Central Registry.
- It mandated that the regulations pertaining to children's camps for children with developmental disabilities are amended to include incident management procedures and requirements consistent with Justice Center guidelines and standards.
- It required that children's camps for children with developmental disabilities establish an incident review committee, recognizing that the Department could provide for a waiver of that requirement under certain circumstances
- It required that children's camps for children with developmental disabilities consult the Justice Center's staff exclusion list (SEL) to ensure that prospective employees are not on that list and to, where the prospective employee is not on

that list, to also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment (SCR) to ensure that prospective employees are not on that list.

- It required that children's camps for children with developmental disabilities publicly disclose certain information regarding incidents of abuse and neglect if required by the Justice Center to do so.

The children's camp regulations, Subpart 7-2 of the SSC are being amended in accordance with the aforementioned legislation.

Compliance Costs:
Cost to Regulated Parties:

The amendments impose additional requirements on the children's camp operator for reporting and cooperating with Department of Health investigations at children's camps for children with developmental disabilities (hereafter "camps"). The cost to affected parties is difficult to estimate due to variation in salaries for camp staff and the amount of time needed to investigate each reported incident. Reporting an incident is expected to take less than half an hour; assisting with the investigation will range from several hours to two staff days. Using a high estimate of staff salary of $30.00 an hour, total staff cost would range from $120 to $1600 for each investigation. Expenses are nonetheless expected to be minimal statewide as between 40 and 50 children's camps for children with developmental disabilities operate each year, with combined reports of zero

to two incidents a year statewide. Accordingly, any individual camp will be very unlikely to experience costs related to reporting or investigation.

Each camp will incur expenses for contacting the Justice Center to verify that potential employees are not on the staff exclusion list. The effect of adding this consultation should be minimal. An entry level staff person earning the minimum wage of $7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the Justice Center, within a few hours.

Similarly, each camp will incur expenses for contacting the Office of Children and Family Services (OCFS) to verify that potential employees are not on the State Central Registry of Child Abuse and Maltreatment (SCR) when consultation with the Justice Center shows that the prospective employee is not on the Staff Exclusion List (SEL). The effect of adding this consultation should also be minimal. An entry level staff person earning the minimum wage of $7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the OCFS, within a few hours. Although OCFS need not be consulted in every case, assuming that each employee is subject to both screens, the consultations with the Justice Center and the OCFS, combined, should not total more than six to eight hours of staff time.

Camps will be required to disclose information pertaining to reportable incidents to the Justice Center and to the permit issuing official investigating the incident. Costs associated with this include staff time for locating information and expenses for copying materials. Using a high estimate of staff salary of $30.00 an hour, and assuming that staff

may take up to two hours to locate and copy the records, typical cost should be under $100.

Camps must also assure that camp staff, and certain others, who fall within the definition of mandated reporters under section 488 of the Social Services Law receive training related to mandated reporting to the Justice Center, and the obligations of those staff who are required to report incidents to the Justice Center. The costs associated with such training should be minimal as it is expected that the training material will be provided to the camps and will take about one hour to review during routine staff training. Camps must also ensure that the telephone number for the Justice Center reporting hotline is conspicuously posted for campers and staff. Cost associated with such posting is limited, related to making and posting a copy of such notice in appropriate locations.

The camp operator must also provide each camp staff member, and others who may have contact with campers, with a copy of a code of conduct established by the Justice Center pursuant to Section 554 of the Executive Law. The code must be provided at the time of initial employment, and at least annually thereafter during the term of employment. Receipt of the code of conduct must be acknowledged, and the recipient must further acknowledge that he or she has read and understands it. The cost of providing the code, and obtaining and filing the required employee acknowledgment, should be minimal, as it would be limited to copying and distributing the code, and to obtaining and filing the acknowledgments. Staff should need less than 30 minutes to

review the code.

Camps will also be required to establish and maintain a facility incident review committee to review and guide the camp's responses to reportable incidents. The cost to maintain a facility incident review committee is difficult to estimate due to the variations in salaries for camp staff and the amount of time needed for the committee to do its business. A facility incident review committee must meet at least annually, and also within two weeks after a reportable incident occurs. Assuming the camp will have several staff members participate on the committee, an average salary of $50.00 an hour and a three hour meeting, the cost is estimated to be $450.00 dollars per meeting. However, the regulations also provide the opportunity for a camp to seek an exemption, which may be granted subject to Department approval based on the duration of the camp season and other factors. Accordingly, not all camps can be expected to bear this obligation and its associated costs.

Camps are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Finally, the regulations add noncompliance with Justice Center-related requirements as a ground for denying, revoking, or suspending a camp operator's permit.

Cost to State and Local Government:

State agencies and local governments that operate children’s camps for children

with developmental disabilities will have the same costs described in the section entitled "Cost to Regulated Parties." Currently, it is estimated that five summer day camps that meet the criteria are operated by municipalities. The regulation imposes additional requirements on local health departments for receiving incident reports and investigations of reportable incidents, and providing a copy of the resulting report to the Department and the Justice Center. The total cost for these services is difficult to estimate because of the variation in the number of incidents and amount of time to investigate an incident. However, assuming the typically used estimate of $50 an hour for health department staff conducting these tasks, an investigation generally lasting between one and four staff days, and assuming an eight hour day, the cost to investigate an incident will range $400.00 to $1600. Zero to two reportable incidents occur statewide each year, so a local health department is unlikely to bear such an expense. The cost of submitting the report is minimal, limited to copying and mailing a copy to the Department and the Justice Center.

Cost to the Department of Health:

There will be routine costs associated with printing and distributing the amended Code. The estimated cost to print revised code books for each regulated children's camp in NYS is approximately $1600. There will be additional cost for printing and distributing training materials. The expenses will be minimal as most information will be distributed electronically. Local health departments will likely include paper copies of training materials in routine correspondence to camps that is sent each year.

Local Government Mandates:

Children's camps for children with developmental disabilities operated by local governments must comply with the same requirements imposed on camps operated by other entities, as described in the "Cost to Regulated Parties" section of this Regulatory Impact Statement. Local governments serving as permit issuing officials will face minimal additional reporting and investigation requirements, as described in the "Cost to State and Local Government" section of this Regulatory Impact Statement. The proposed amendments do not otherwise impose a new program or responsibilities on local governments. City and county health departments continue to be responsible for enforcing the amended regulations as part of their existing program responsibilities.

Paperwork:

The paperwork associated with the amendment includes the completion and submission of an incident report form to the local health department and Justice Center. Camps for children with developmental disabilities will also be required to provide the records and information necessary for LHD investigation of reportable incidents, and to retain documentation of the results of their consultation with the Justice Center regarding whether any given prospective employee was found to be on the SEL or the SCR.

Duplication:

This regulation does not duplicate any existing federal, state, or local regulation.

The regulation is expected to be consistent with a regulation expected to be promulgated by the Justice Center.

Alternatives Considered:

The amendments to the camp code are mandated by law. No alternatives were considered.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

Federal Standards:

Currently, no federal law governs the operation of children's camps.

Compliance Schedule:

The proposed amendments are to be effective on June 30, 2013.

Contact Person:

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Regulatory Flexibility Analysis

for Small Business and Local Government

Types and Estimated Number of Small Businesses and Local Governments:

There are between 40 and 50 regulated children's camps for children with development disabilities (38% are expected to be overnight camps and 62% are expected to be summer day camps) operating in New York State, which will be affected by the proposed rule. About 30% of summer day camps are operated by municipalities (towns, villages, and cities). Typical regulated children's camps representing small business include those owned/operated by corporations, hotels, motels and bungalow colonies, non-profit organizations (Girl/Boy Scouts of America, Cooperative Extension, YMCA, etc.) and others. None of the proposed amendments will apply solely to camps operated by small businesses or local governments.

Compliance Requirements:

Reporting and Recordkeeping:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties," "Local Government Mandates," and "Paperwork" sections of the Regulatory Impact Statement. The obligations imposed on local government as the permit issuing official is described in "Cost to State and Local Government" and "Local Government Mandates" portions of the Regulatory Impact Statement.

Other Affirmative Acts:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" "Local Government Mandates," and "Paperwork" sections of the Regulatory Impact Statement.

Professional Services:

Camps for the disabled are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Compliance Costs:

Cost to Regulated Parties:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

Cost to State and Local Government:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in the "Cost to Regulated Parties" section of the Regulatory Impact Statement. The obligations

imposed on local government as the permit issuing official is described in “Cost to State and Local Government” and “Local Government Mandates” portions of the Regulatory Impact Statement.

Economic and Technological Feasibility:

There are no changes requiring the use of technology.

The proposal is believed to be economically feasible for impacted parties. The amendments impose additional reporting and investigation requirements that will use existing staff that already have similar job responsibilities. There are no requirements that that involve capital improvements.

Minimizing Adverse Economic Impact:

The amendments to the camp code are mandated by law. No alternatives were considered. The economic impact is already minimized.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department’s ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

Small Business Participation and Local Government Participation:

No small business or local government participation was used for this rule development. The amendments to the camp code are mandated by law. Ample opportunity for comment will be provided as part of the process of promulgating the regulations, and training will be provided to affected entities with regard to the new requirements.

Rural Area Flexibility Analysis

Types and Estimated Number of Rural Areas:

There are between 40 and 50 regulated children's camps for children with development disabilities (38% are expected to be overnight camps and 62% are expected to be summer day camps) operating in New York State, which will be affected by the proposed rule. Currently, there are seven day camps and ten overnight camps operating in the 44 counties that have population less than 200,000. There are an additional four day camps and three overnight camps in the nine counties identified to have townships with a population density of 150 persons or less per square mile.

Reporting and Recordkeeping and Other Compliance Requirements:

Reporting and Recordkeeping:

The obligations imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

Other Compliance Requirements:

The obligations imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

Professional Services:

Camps for the disabled are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Compliance Costs:

Cost to Regulated Parties:

The costs imposed on camps in rural areas are no different from those imposed on camps generally, as described in “Cost to Regulated Parties” and “Paperwork” sections of the Regulatory Impact Statement.

Economic and Technological Feasibility:

There are no changes requiring the use of technology.

The proposal is believed to be economically feasible for impacted parties. The amendments impose additional reporting and investigation requirements that will use existing staff that already have similar job responsibilities. There are no requirements that that involve capital improvements.

Minimizing Adverse Economic Impact on Rural Area:

The amendments to the camp code are mandated by law. No alternatives were considered. The economic impact is already minimized, and no impacts are expected to be unique to rural areas.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

Rural Area Participation:

No rural area participation was used for this rule development. The amendments to the camp code are mandated by law. Ample opportunity for comment will be provided as part of the process of promulgating the routine regulations, and training will be provided to affected entities with regard to the new requirements.

Job Impact Statement

No Job Impact Statement is required pursuant to Section 201-a (2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment that it will have no impact on jobs and employment opportunities, because it does not result in an increase or decrease in current staffing level requirements. Tasks associated with reporting new incidents types and assisting with the investigation of new reportable incidents are expected to be completed by existing camp staff, and should not be appreciably different than that already required under current requirements.

Emergency Justification

Chapter 501 of the Laws of 2012 established the Justice Center for the Protection of People with Special Needs ("Justice Center"), in order to coordinate and improve the State's ability to protect those persons having various physical, developmental, or mental disabilities and who are receiving services from various facilities or provider agencies. The Department must promulgate regulations as a "state oversight agency." These regulations will assure proper coordination with the efforts of the Justice Center, which will be operational after June 30, 2013.

Among the facilities covered by Chapter 501 are children's camps having enrollments of 20 percent or more developmentally disabled campers. These camps are regulated by the Department and, in some cases, by local health departments, pursuant to Article 13-B of the Public Health Law and 10 NYCRR Subpart 7-2. Given the effective date of Chapter 501 and its relation to the start of the camp season, these implementing regulations must be promulgated on an emergency basis in order to assure the necessary protections for vulnerable persons at such camps during the upcoming camp season. Absent emergency promulgation, such persons would be denied initial coordinated protections until the 2014 camp season. Promulgating these regulations on an emergency basis will provide such protection, while still providing a full opportunity for comment and input as part of the parallel formal rulemaking

process required by the State Administrative Procedures Act. The Department is authorized to promulgate these rules pursuant to sections 201 and 225 of the Public Health Law.

Promulgating the regulations on an emergency basis will ensure that campers with special needs promptly receive the coordinated protections to be provided to similar individuals cared for in other settings. Such protections include reduced risk of being cared for by staff with a history of inappropriate actions such as physical, psychological or sexual abuse towards persons with special needs. Perpetrators of such abuse often seek legitimate access to children so it is critical to camper safety that individuals who that have committed such acts are kept out of camps. The regulation provides an additional mechanism for camp operators to do so, The regulations also reduce the risk of incidents involving physical, psychological or sexual abuse towards persons with special needs by ensuring that such occurrences are fully and completely investigated, by ensuring that camp staff are more fully trained and aware of abuse and reporting obligations, allowing staff and volunteers to better identify inappropriate staff behavior and provide a mechanism for reporting injustice to this vulnerable population. Early detection and response are critical components for mitigating injury to an individual and will prevent a perpetrator from hurting additional children. Finally, prompt enactment of the proposed regulations will ensure that occurrences are fully investigated and evaluated by the camp, and that measures are taken to reduce the risk of re-occurrence in the future. Absent

emergency adoption, these benefits and protections will not be available to campers with special needs for the upcoming camp season, with the attendant loss of additional protections against abuse and neglect, including physical, psychological, and sexual abuse.

Pursuant to the authority vested in the Public Health and Health Planning Council by Section 225 of the Public Health Law, subject to the approval by the Commissioner of Health, Subpart 7-2 of the State Sanitary Code, as contained in Chapter 1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended as follows, to be effective upon publication of a Notice of Adoption in the State Register.

SUBPART 7-2

Children's Camps

(Statutory Authority: Public Health Law §§ 201, 225, 1390, 1394, 1395, 1399-a; L. 2012, ch. 501)

Subdivision (o) of section 7-2.5 is amended to read as follows:

(o) The camp operator shall provide adequate supervision. *Adequate supervision* shall mean:

(1) supervision such that a camper is protected from any unreasonable risk to his or her health or safety, including physical or sexual abuse or any public health hazard; [and]

(2) as a minimum, there shall exist visual or verbal communications capabilities between camper and counselor during activities and a method of accounting for the camper's whereabouts at all times[.]; and

(3) at camps required to comply with section 7-2.25 of this Subpart, protection from any unreasonable risk of experiencing an occurrence which would constitute a reportable incident as defined in section 7-2.25(h)(4) of this Subpart.

Section 7-2.24 is amended to read as follows:

Variance; waiver.

(a) *Variance* - i[I]n order to allow time to comply with certain provisions of this Subpart, an operator may submit a written request to the permit-issuing official for a variance from a specific provision(s) when the health and safety of the children attending the camp and the public will not be prejudiced by the variance, and where there are practical difficulties or unnecessary hardships in immediate compliance with the provision. An operator must meet all terms of an approved variance(s) including the effective date, the time period for which the variance is granted, the requirements being varied and any special conditions the permit-issuing official specifies. The permit-issuing official shall consult with the State Department of Health and shall obtain approval from the State Department of Health for the proposed decision, prior to granting or denying a variance request for requirements in section 7-2.25 of this Subpart.

(b) *Waiver* - i[I]n order to accept alternative arrangements that do not meet certain provisions of this Subpart but do protect the safety and health of the campers and the public, an operator may submit a written request to the permit-issuing official for a

waiver from a specific provision of this Subpart. Such request shall indicate justification that circumstances exist that are beyond the control of the operator, compliance with the provision would present unnecessary hardship and that the public and camper health and safety will not be endangered by granting such a waiver. The permit-issuing official shall consult with a representative of the State Department of Health prior to granting or denying a waiver request. An operator must meet all terms of an approved waiver(s), including the condition that it will remain in effect indefinitely unless revoked by the permit-issuing official or the facility changes operators. The permit-issuing official shall consult with the State Department of Health, and shall obtain the approval of the State Department of Health for the proposed decision, prior to granting or denying a waiver request related to the requirements in section 7-2.25 of this Subpart.

New subdivisions (h)-(m) of section 7-2.25 are added to read as follows:

(h) Definitions. The following definitions apply to Section 7-2.25 of this Subpart.

(1) *Camp Staff* shall mean a director, operator, employee or volunteer of a children's camp; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a children's camp pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the children's camp.

(2) *Department* shall mean the New York State Department of Health.

(3) *Justice Center* shall mean the Justice Center for the Protection of People with Special Needs, as established pursuant to Section 551 of the Executive Law.

(4) *Reportable Incident* shall include those actions incorporated within the definitions of "physical abuse," "sexual abuse," "psychological abuse," "deliberate inappropriate use of restraints," "use of aversive conditioning," "obstruction of reports of reportable incidents," "unlawful use or administration of a controlled substance," "neglect," and "significant incident" all as defined in Section 488 of the Social Services Law.

(i) Reporting.

(1) In addition to the reporting requirements of section 7-2.8(d), a camp operator subject to section 7-2.25 of this Subpart and all camp staff falling within the definition of "mandated reporter" under section 488 of the Social Services Law shall immediately report any reportable incident as defined in section 7-2.25(h)(4) of this Subpart and Section 488 of the Social Services Law, where such incident involves a camper with a developmental disability, to the permit-issuing official and to the Justice Center's Vulnerable Persons' Central Register. Such report shall be provided in a form and manner as required by the Justice Center.

(j) Employee Screening, Training, and Code of Conduct

(1) Prior to hiring anyone who will or may have direct contact with campers, or approving credentials for any camp staff, the operator shall follow the procedures established by the Justice Center in regulations or policy, to verify that such person is not on the Justice Center's staff exclusion list established pursuant to section 495 of the Social Services Law. If such person is not on the Justice Center's staff exclusion list, the operator shall also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment as required by section 424-a of the Social Services Law. Such screening is in addition to the requirement that the operator similarly verify that a prospective camp staff is not on the sexual abuse registry, as required by section 7-2.5(l) of this Subpart.

(2) A camp operator must ensure that camp staff, and others falling within the definition of mandated reporter under Section 488 of the Social Services Law who will or may have direct contact with campers having a developmental disability, receive training regarding mandated reporting and their obligations as mandated reporters. A camp operator shall ensure that the telephone number for the Justice Center's hotline for the reporting reportable incidents is conspicuously displayed in areas accessible to mandated reporters and campers.

(3) The camp operator shall ensure that all camp staff and others falling within the definition of “custodian” under Section 488 of the Social Services Law are

provided with a copy of the code of conduct established by the Justice Center pursuant to Section 554 of the Executive Law. Such code of conduct shall be provided at the time of initial employment, and at least annually thereafter during the term of employment. Receipt of the code of conduct must be acknowledged, and the recipient must further acknowledge that he or she has read and understands such code of conduct.

(k) Disclosure of information

(1) Except to the extent otherwise prohibited by law, the camp operator shall be obliged to share information relevant to the investigation of any incident subject to the reporting requirements of this Subpart with the permit-issuing official, the State Department of Health, and the Justice Center. The permit-issuing official, the department and the Justice Center shall, when required by law, or when so directed by the department or the Justice Center and except as otherwise prohibited by law, be permitted to share information obtained in their respective investigations of incidents subject to the reporting requirements of section 7-2.25 (i) of this Subpart.

(2) Except as otherwise prohibited by law, the operator of a camp not otherwise subject to Article Six of the Public Officers Law shall make records available for public inspection and copying to the extent required by subdivision six of Section 490 of the Social Services Law and regulations of the Justice Center.

(l) Incident Management.

(1) The camp operator shall cooperate fully with the investigation of reportable incidents involving campers with developmental disabilities and shall provide all necessary information and access to conduct the investigation. The camp operator shall promptly obtain an appropriate medical examination of a physically injured camper with a developmental disability. The camp operator shall provide information, whether obtained pursuant to the investigation or otherwise, to the Justice Center and permit-issuing official upon request, in the form and manner requested. Such information must be provided in a timely manner so as to support completion of the investigation subject to the time limits set forth in this subdivision.

(2) Unless delegated by the Justice Center to a delegate investigatory agency as defined in subdivision six of Section 488 of the Social Services Law, incidents of abuse or neglect, as defined in subdivision eleven of Section 488 of the Social Services Law, shall be investigated by the Justice Center. With regard to all other reportable incidents, as defined in Section 488 of the Social Services Law, the permit-issuing official shall initiate a prompt investigation of an allegation of a reportable incident, which shall commence no later than five business days after notification of such an incident, unless the Justice Center agrees that it will undertake such investigation. Additional time for completion of the investigation

may be allowed, subject to the approval of the department, upon a showing of good cause for such extension. At a minimum, the investigation of any reportable incident shall comply with the following:

(i) Investigations shall include a review of medical records and reports, witness interviews and statements, expert assessments, and the collection of physical evidence, observations and information from care providers and any other information that is relevant to the incident. Interviews should be conducted by qualified, objective individuals in a private area which does not allow those not participating in the interview to overhear. Interviews must be conducted of each party or witness individually, not in the presence of other parties or witnesses or under circumstances in which other parties or witnesses may perceive any aspect of the interview. The person alleging the incident, or who is the subject of the incident, must be offered the opportunity to give his/her version of the event. At least one of the persons conducting the interview must have an understanding of, and be able to accommodate, the unique needs or capabilities of the person being interviewed The procedures required by this Subparagraph (i) may be altered if, and only to the extent necessary to, comply with an applicable collective bargaining agreement.

(ii) All evidence must be adequately protected and preserved.

(iii) Any information, including but not limited to documents and other materials, obtained during or resulting from any investigation shall be kept confidential, except as otherwise permissible under law or regulation, including but not limited to Article 11 of the Social Services Law.

(iv) Upon completion of the investigation, a written report shall be prepared which shall include all relevant findings and information obtained in the investigation and details of steps taken to investigate the incident. The results of the investigation shall be promptly reported to the department, if the investigation was not performed by the department, and to the Justice Center.

(v) If any remedial action is necessary, the permit-issuing official shall establish a plan in writing with the camp operator. The plan shall indicate the camp operator's agreement to the remediation and identify a follow-up date and person responsible for monitoring the remedial action. The plan shall be provided, and any measures taken in response to such plan shall be reported, to the department and to the Justice Center.

(vi) The investigation and written report shall be completed and provided to the department and the Justice Center within 45 days of when the incident was first reported to the Justice Center. For purposes of this

section, “complete” shall mean that all necessary information has been obtained to determine whether and how the incident occurred, and to complete the findings referenced in paragraph (l)(2)(iv) of this subdivision.

(3) (i) The camp shall maintain a facility incident review committee, composed of members of the governing body of the children’s camp and other persons identified by the camp operator, including some members of the following: camp administrative staff, direct support staff, licensed health care practitioners, service recipients, the permit-issuing official or designee and representatives of family, consumer and other advocacy organizations, but not the camp director. The camp operator shall convene a facility incident review panel to review the timeliness, thoroughness and appropriateness of the camp's responses to reportable incidents; recommend additional opportunities for improvement to the camp operator, if appropriate; review incident trends and patterns concerning reportable incidents; and make recommendations to the camp operator to assist in reducing reportable incidents. The facility incident review panel shall meet at least annually, and also within two weeks of the completion of a written report and remedial plan for a reportable incident.

(ii) Pursuant to paragraph (f) of subdivision one of section 490 of the Social Services Law and regulations of the Justice Center, a camp operator may seek an

exemption from the requirement to establish and maintain an incident review committee. In order to obtain an exemption, the camp operator must file an application with the permit-issuing official, at least sixty days prior to the start of the camp operating season, or at any time in the case of exemptions sought within the first three months following the effective date of this provision. The application must provide sufficient documentation and information to demonstrate that that compliance would present undue hardship and that granting an exemption would not create an undue risk of harm to campers' health and safety. The permit-issuing official shall consult with the State Department of Health (department), and shall not grant or deny an application for an exemption unless it first obtains department approval for the proposed decision. An operator must meet all terms of an approved exemption(s), including the condition that it will remain in effect for one year unless revoked by the permit-issuing official, subject to department approval, or the facility changes operators. Any application for renewal shall be made within 60 days prior to the start of the camp's operating season. The procedure set forth in this Subparagraph (ii) shall be used instead of the general procedures set forth in section 7-2.24 of this Subpart.

(m) In addition to the requirements specified by subdivisions (d) and (g) of section 7-2.4 of this Subpart, a permit may be denied, revoked, or suspended if the children's camp fails to comply with regulations, policies, or other requirements of the Justice Center. In

considering whether to issue a permit to a children's camp, the permit-issuing official shall consider the children's camp's past and current compliance with the regulations, policies, or other requirements of the Justice Center.

Regulatory Impact Statement

Statutory Authority:

The Public Health and Health Planning Council is authorized by Section 225(4) of the Public Health Law (PHL) to establish, amend and repeal sanitary regulations to be known as the State Sanitary Code (SSC), subject to the approval of the Commissioner of Health. Article 13-B of the PHL sets forth sanitary and safety requirements for children's camps. PHL Sections 225 and 201(1)(m) authorize SSC regulation of the sanitary aspects of businesses and activities affecting public health including children's camps.

Legislative Objectives:

In enacting to Chapter 501 of the Laws of 2012, the legislature established the New York State Justice Center for the Protection of People with Special Needs (Justice Center) to strengthen and standardize the safety net for vulnerable people that receive care from New York's Human Services Agencies and Programs. The legislation includes children's camps for children with developmental disabilities as a type of facility within the oversight of the Justice Center and requires the Department of Health to promulgate regulations approved by the Justice Center pertaining to incident management. The proposed amendments further the legislative objective of protecting the health and safety of vulnerable children attending camps in New York State (NYS).

Needs and Benefits:

The legislation amended Article 11 of Social Services law as it pertains to children's camps as follows:

- It included overnight, summer day and traveling summer day camps for children with developmental disabilities as facilities required to comply with the Justice Center requirements.
- It defined the types of incident required to be reported by children's camps for children with developmental disabilities to the Justice Center Vulnerable Persons' Central Registry.
- It mandated that the regulations pertaining to children's camps for children with developmental disabilities are amended to include incident management procedures and requirements consistent with Justice Center guidelines and standards.
- It required that children's camps for children with developmental disabilities establish an incident review committee, recognizing that the Department could provide for a waiver of that requirement under certain circumstances
- It required that children's camps for children with developmental disabilities consult the Justice Center's staff exclusion list (SEL) to ensure that prospective employees are not on that list and to, where the prospective employee is not on

that list, to also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment (SCR) to ensure that prospective employees are not on that list.

- It required that children's camps for children with developmental disabilities publicly disclose certain information regarding incidents of abuse and neglect if required by the Justice Center to do so.

The children's camp regulations, Subpart 7-2 of the SSC are being amended in accordance with the aforementioned legislation.

Compliance Costs:
Cost to Regulated Parties:

The amendments impose additional requirements on the children's camp operator for reporting and cooperating with Department of Health investigations at children's camps for children with developmental disabilities (hereafter "camps"). The cost to affected parties is difficult to estimate due to variation in salaries for camp staff and the amount of time needed to investigate each reported incident. Reporting an incident is expected to take less than half an hour; assisting with the investigation will range from several hours to two staff days. Using a high estimate of staff salary of $30.00 an hour, total staff cost would range from $120 to $1600 for each investigation. Expenses are nonetheless expected to be minimal statewide as between 40 and 50 children's camps for children with developmental disabilities operate each year, with combined reports of zero

to two incidents a year statewide. Accordingly, any individual camp will be very unlikely to experience costs related to reporting or investigation.

Each camp will incur expenses for contacting the Justice Center to verify that potential employees are not on the staff exclusion list. The effect of adding this consultation should be minimal. An entry level staff person earning the minimum wage of $7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the Justice Center, within a few hours.

Similarly, each camp will incur expenses for contacting the Office of Children and Family Services (OCFS) to verify that potential employees are not on the State Central Registry of Child Abuse and Maltreatment (SCR) when consultation with the Justice Center shows that the prospective employee is not on the Staff Exclusion List (SEL). The effect of adding this consultation should also be minimal. An entry level staff person earning the minimum wage of $7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the OCFS, within a few hours. Although OCFS need not be consulted in every case, assuming that each employee is subject to both screens, the consultations with the Justice Center and the OCFS, combined, should not total more than six to eight hours of staff time.

Camps will be required to disclose information pertaining to reportable incidents to the Justice Center and to the permit issuing official investigating the incident. Costs associated with this include staff time for locating information and expenses for copying materials. Using a high estimate of staff salary of $30.00 an hour, and assuming that staff

may take up to two hours to locate and copy the records, typical cost should be under $100.

Camps must also assure that camp staff, and certain others, who fall within the definition of mandated reporters under section 488 of the Social Services Law receive training related to mandated reporting to the Justice Center, and the obligations of those staff who are required to report incidents to the Justice Center. The costs associated with such training should be minimal as it is expected that the training material will be provided to the camps and will take about one hour to review during routine staff training. Camps must also ensure that the telephone number for the Justice Center reporting hotline is conspicuously posted for campers and staff. Cost associated with such posting is limited, related to making and posting a copy of such notice in appropriate locations.

The camp operator must also provide each camp staff member, and others who may have contact with campers, with a copy of a code of conduct established by the Justice Center pursuant to Section 554 of the Executive Law. The code must be provided at the time of initial employment, and at least annually thereafter during the term of employment. Receipt of the code of conduct must be acknowledged, and the recipient must further acknowledge that he or she has read and understands it. The cost of providing the code, and obtaining and filing the required employee acknowledgment, should be minimal, as it would be limited to copying and distributing the code, and to obtaining and filing the acknowledgments. Staff should need less than 30 minutes to

review the code.

Camps will also be required to establish and maintain a facility incident review committee to review and guide the camp's responses to reportable incidents. The cost to maintain a facility incident review committee is difficult to estimate due to the variations in salaries for camp staff and the amount of time needed for the committee to do its business. A facility incident review committee must meet at least annually, and also within two weeks after a reportable incident occurs. Assuming the camp will have several staff members participate on the committee, an average salary of $50.00 an hour and a three hour meeting, the cost is estimated to be $450.00 dollars per meeting. However, the regulations also provide the opportunity for a camp to seek an exemption, which may be granted subject to Department approval based on the duration of the camp season and other factors. Accordingly, not all camps can be expected to bear this obligation and its associated costs.

Camps are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Finally, the regulations add noncompliance with Justice Center-related requirements as a ground for denying, revoking, or suspending a camp operator's permit.

Cost to State and Local Government:

State agencies and local governments that operate children’s camps for children

with developmental disabilities will have the same costs described in the section entitled "Cost to Regulated Parties." Currently, it is estimated that five summer day camps that meet the criteria are operated by municipalities. The regulation imposes additional requirements on local health departments for receiving incident reports and investigations of reportable incidents, and providing a copy of the resulting report to the Department and the Justice Center. The total cost for these services is difficult to estimate because of the variation in the number of incidents and amount of time to investigate an incident. However, assuming the typically used estimate of $50 an hour for health department staff conducting these tasks, an investigation generally lasting between one and four staff days, and assuming an eight hour day, the cost to investigate an incident will range $400.00 to $1600. Zero to two reportable incidents occur statewide each year, so a local health department is unlikely to bear such an expense. The cost of submitting the report is minimal, limited to copying and mailing a copy to the Department and the Justice Center.

Cost to the Department of Health:

There will be routine costs associated with printing and distributing the amended Code. The estimated cost to print revised code books for each regulated children's camp in NYS is approximately $1600. There will be additional cost for printing and distributing training materials. The expenses will be minimal as most information will be distributed electronically. Local health departments will likely include paper copies of training materials in routine correspondence to camps that is sent each year.

Local Government Mandates:

Children's camps for children with developmental disabilities operated by local governments must comply with the same requirements imposed on camps operated by other entities, as described in the "Cost to Regulated Parties" section of this Regulatory Impact Statement. Local governments serving as permit issuing officials will face minimal additional reporting and investigation requirements, as described in the "Cost to State and Local Government" section of this Regulatory Impact Statement. The proposed amendments do not otherwise impose a new program or responsibilities on local governments. City and county health departments continue to be responsible for enforcing the amended regulations as part of their existing program responsibilities.

Paperwork:

The paperwork associated with the amendment includes the completion and submission of an incident report form to the local health department and Justice Center. Camps for children with developmental disabilities will also be required to provide the records and information necessary for LHD investigation of reportable incidents, and to retain documentation of the results of their consultation with the Justice Center regarding whether any given prospective employee was found to be on the SEL or the SCR.

Duplication:

This regulation does not duplicate any existing federal, state, or local regulation.

The regulation is expected to be consistent with a regulation expected to be promulgated by the Justice Center.

Alternatives Considered:

The amendments to the camp code are mandated by law. No alternatives were considered.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

Federal Standards:

Currently, no federal law governs the operation of children's camps.

Compliance Schedule:

The proposed amendments are to be effective upon publication of a Notice of Adoption in the State Register.

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Regulatory Flexibility Analysis

for Small Business and Local Government

Types and Estimated Number of Small Businesses and Local Governments:

There are between 40 and 50 regulated children's camps for children with development disabilities (38% are expected to be overnight camps and 62% are expected to be summer day camps) operating in New York State, which will be affected by the proposed rule. About 30% of summer day camps are operated by municipalities (towns, villages, and cities). Typical regulated children's camps representing small business include those owned/operated by corporations, hotels, motels and bungalow colonies, non-profit organizations (Girl/Boy Scouts of America, Cooperative Extension, YMCA, etc.) and others. None of the proposed amendments will apply solely to camps operated by small businesses or local governments.

Compliance Requirements:

Reporting and Recordkeeping:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties," "Local Government Mandates," and "Paperwork" sections of the Regulatory Impact Statement. The obligations imposed on local government as the permit issuing official is described in "Cost to State and Local Government" and "Local Government Mandates" portions of the Regulatory Impact Statement.

Other Affirmative Acts:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" "Local Government Mandates," and "Paperwork" sections of the Regulatory Impact Statement.

Professional Services:

Camps for the disabled are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Compliance Costs:

Cost to Regulated Parties:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

Cost to State and Local Government:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in the "Cost to Regulated Parties" section of the Regulatory Impact Statement. The obligations

imposed on local government as the permit issuing official is described in “Cost to State and Local Government” and “Local Government Mandates” portions of the Regulatory Impact Statement.

Economic and Technological Feasibility:

There are no changes requiring the use of technology.

The proposal is believed to be economically feasible for impacted parties. The amendments impose additional reporting and investigation requirements that will use existing staff that already have similar job responsibilities. There are no requirements that that involve capital improvements.

Minimizing Adverse Economic Impact:

The amendments to the camp code are mandated by law. No alternatives were considered. The economic impact is already minimized.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department’s ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

Small Business Participation and Local Government Participation:

No small business or local government participation was used for this rule development. The amendments to the camp code are mandated by law. Ample opportunity for comment will be provided as part of the process of promulgating the regulations, and training will be provided to affected entities with regard to the new requirements.

Rural Area Flexibility Analysis

Types and Estimated Number of Rural Areas:

There are between 40 and 50 regulated children's camps for children with development disabilities (38% are expected to be overnight camps and 62% are expected to be summer day camps) operating in New York State, which will be affected by the proposed rule. Currently, there are seven day camps and ten overnight camps operating in the 44 counties that have population less than 200,000. There are an additional four day camps and three overnight camps in the nine counties identified to have townships with a population density of 150 persons or less per square mile.

Reporting and Recordkeeping and Other Compliance Requirements:

Reporting and Recordkeeping:

The obligations imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

Other Compliance Requirements:

The obligations imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

Professional Services:

Camps for the disabled are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Compliance Costs:

Cost to Regulated Parties:

The costs imposed on camps in rural areas are no different from those imposed on camps generally, as described in “Cost to Regulated Parties” and “Paperwork” sections of the Regulatory Impact Statement.

Economic and Technological Feasibility:

There are no changes requiring the use of technology.

The proposal is believed to be economically feasible for impacted parties. The amendments impose additional reporting and investigation requirements that will use existing staff that already have similar job responsibilities. There are no requirements that that involve capital improvements.

Minimizing Adverse Economic Impact on Rural Area:

The amendments to the camp code are mandated by law. No alternatives were considered. The economic impact is already minimized, and no impacts are expected to be unique to rural areas.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

Rural Area Participation:

No rural area participation was used for this rule development. The amendments to the camp code are mandated by law. Ample opportunity for comment will be provided as part of the process of promulgating the routine regulations, and training will be provided to affected entities with regard to the new requirements.

Job Impact Statement

No Job Impact Statement is required pursuant to Section 201-a (2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment that it will have no impact on jobs and employment opportunities, because it does not result in an increase or decrease in current staffing level requirements. Tasks associated with reporting new incidents types and assisting with the investigation of new reportable incidents are expected to be completed by existing camp staff, and should not be appreciably different than that already required under current 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 sections 2800, 2803, 3063, 3064, 3066, 3074 and 3075 of the Public Health Law, Part 405 and Part 708 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, are hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, as follows:

Subparagraph (8) of subdivision (b) of Section 708.2 is hereby repealed.

Subparagraph i of section 708.5 is hereby repealed.

A new section, 405.33, is added to Part 405 as follows:

405.33 Trauma Centers

(a) *Definitions*. For purposes of this section, the following terms shall have the following meanings.

(1) Trauma means a variety of physical injuries due to mechanical, thermal, electrical, or corrosive causes.

(2) Trauma care means health care provided to patients at high risk of death or disability from multiple and severe injuries.

(3) Trauma center shall mean a facility capable of providing definitive trauma care.

(4) A Level I trauma center shall mean a facility verified by the American College of Surgeons Committee on Trauma (ACS-COT) as capable of providing definitive treatment to the full range of trauma patients, including a commitment to trauma research and education, and designated by the Department to provide such care.

(5) A Level II trauma center shall mean a facility verified by the ACS-COT as capable of providing comprehensive trauma care and designated by the Department to provide such care.

(6) A Level III trauma center shall mean a facility verified by the ACS-COT as capable of providing prompt assessment, resuscitation, emergency operations and stabilization of traumatically injured patients and having transfer agreements for patients whose needs exceed their resources and designated by the Department to provide such care.

(7) A Level IV trauma center shall mean a facility located in a rural area and verified by the ACS-COT as capable of providing initial evaluation and stabilization of injured patients prior to transfer to a higher level trauma center and designated by the Department to provide such care.

(8) A pediatric trauma center shall mean a facility verified by the ACS-COT as capable of providing comprehensive pediatric trauma care to the most severely injured children and designated by the Department to provide such care.

(b) *General Provisions*.

(1) Only those hospitals designated as trauma centers by the Department shall provide trauma care, except during conditions of disaster and/or emergency surge that may temporarily require undesignated hospitals to provide trauma care. No hospital shall state that it has trauma center status unless so designated by the Department.

(2) To be designated by the Department as a trauma center, a hospital must first be verified by the American College of Surgeons Committee on Trauma (ACS-COT) as capable of providing Level I, II, III, or IV trauma care. The verification review is to be conducted by 2 surgeons and a nurse reviewer. Following the Department's receipt of the final verification report by the ACS - COT confirming a hospital's capability to provide trauma care, the Department will designate such hospital as a Level I, II, III or IV trauma center.

(i) A hospital shall submit to the Department a copy of any verification report and verification certificate issued by the ACS – COT within seven days of receipt.

(ii) A hospital shall submit to the Department any statement of deficiencies, interim reports of focused surveys or notices of noncompliance issued by the ACS-COT immediately upon receipt.

(iii) A designated trauma center shall notify the Department immediately upon receipt of notice of failure to be verified or re-verified by the ACS - COT. Such notification must be made in writing to the Department by the hospital's Chief administrative official.

(iv) A designated trauma center must notify the Department immediately of any inability to meet the requirements of its current designation between verification visits. Such notification must be made in writing to the Department by the hospital's Chief administrative official.

(v) The Department may participate in any verification visit scheduled by ACS - COT.

(4) All hospitals shall have transfer agreements with the nearest designated Level I, Level II, Level III and pediatric trauma center as appropriate to assure the timely transfer of patients to the appropriate level of trauma care. Patients requiring trauma care will be transported in accordance with Department-approved EMS protocols. Under conditions of disasters and/or emergency surge, all hospitals may provide trauma care to those patients who require emergency care and admission notwithstanding the lack of trauma center designation.

(5) All hospitals, regardless of any trauma designation, must have age and size appropriate resuscitation equipment as set forth in this Part.

(6) Each designated trauma center and every hospital which admits trauma patients shall submit trauma data to the New York State Trauma Registry for those patients meeting the definition of trauma as detailed in the registry's Data Dictionary. The Data Dictionary defines those patients to be included in the registry and the data elements to be submitted to the registry. This

information must be submitted at least quarterly. The hospital shall have in place appropriate measures to ensure the confidentiality of the information contained in the registry.

(7) Performance improvement

(i) Each designated trauma center shall participate with other hospitals and healthcare facilities, EMS agencies and emergency/disaster management programs in regional trauma performance improvement activities which shall include:

(*a*) evaluation of the quality and appropriateness of care provided;

(*b*) analysis of data from the trauma registry, PCR database and other sources to identify potential problems and opportunities for improvement;

(*c*) work with regional stakeholders to make changes that will optimize care and monitor the effectiveness of those changes;

(*d*) development of trauma protocols, procedures, guidelines and policies;

(*e*) assessment of the regional trauma system;

(*f*) utilization of trauma and EMS data sources to guide public education and injury prevention efforts;

(*g*) provision of trauma-related/injury prevention education to allied healthcare providers; and

(*h*) participation in emergency and disaster planning including incorporation of resources and capabilities into mass casualty and disaster plans.

(ii) Trauma centers will provide feedback to those hospitals that have referred patients to them regarding patient outcome.

(iii) The Department will select a Level I trauma center in each region to coordinate regional trauma performance improvement activity. The selected Level I trauma center shall:

(*a*) Review quarterly all of the following incidents that occur in their region: pediatric trauma deaths; delays of 4 hours or more in transferring traumatically injured patients to a higher level of trauma care (excluding single system injuries with an Injury Severity Score of less than 9); and transport or admission of trauma patients to a non-trauma center. The selected Level I trauma center will have the authority to request and review all associated medical records and documents. Notwithstanding any other provisions of law, none of the medical records, documentation or regional discussion/actions shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as here-in-after provided or as provided in any other provision of law.

(*b*) Submit to the Department on a quarterly basis a brief synopsis of each event, any issues identified, the plan implemented to affect necessary change and the plan for monitoring effectiveness.

(*c*) At the Department's request, investigate potential issues identified by the Department during routine analysis of regional State trauma registry data and provide written information to the Department documenting its investigation.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The authority for the promulgation of these regulations is contained in Public Health Law (PHL) Sections 2800 and 2803 (2). PHL Article 28 (Hospitals), Section 2800 specifies that "Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, pursuant to section three of article seventeen of the constitution, the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services, and all public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition or for the rendering of health-related service shall be subject to the provisions of this article."

PHL Section 2803(2) authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner, to implement the purposes and provisions of PHL Article 28, and to establish minimum standards governing the operation of health care facilities.

Legislative Objectives:

The legislative objective of PHL Article 28 includes the protection of the health of the residents of the State by assuring the efficient provision and proper utilization of health services, of the highest quality at a reasonable cost.

Needs and Benefits:

The number and complexity of injuries sustained in a traumatic event, the health of the patient at the time of the event, and the trauma care available to that patient after the event, determine the threat or risk of death, loss of limb, disability, and other permanent harm that may result. As hospitals vary in the amount and scope of resources they can provide to treat trauma patients, a goal of the State trauma system is to assure that trauma patients receive high quality trauma care at hospitals that can provide the resources needed to maximize the patient's chances for a good outcome.

These new regulations are promulgated to update Part 708 pertaining to the provision of trauma care and the designation of trauma centers. The provisions contained in Part 708 were originally promulgated in 1990, and were modeled after the trauma standards of the American College of Surgeons Committee on Trauma (ACS-COT) published in *Resources for Optimal Care of the Injured Patient* of the time. The regulations have remained unchanged since that time and are currently outdated.

The State Trauma Advisory Committee (STAC), as defined by PHL Article 30B, advises the Department and Commissioner regarding trauma and disaster care. Since 2006 members of

the STAC have considered revisions to Sections 708.2 and 708.5 following the publication of updated ACS standards. STAC then explored the possibility of directly adopting the ACS-COT standards and having the ACS survey and verify trauma centers in New York State. Commissioner Shah met with STAC leadership in 2012 and determined that New York State should move to adopting ACS-COT standards and verification process for trauma centers in order to strengthen the State trauma system and improve patient care.

Trauma care has become much more sophisticated and requires significant resources and highly trained staff with expertise in the particular requirements for caring for severely injured patients. The ACS has set the standard for caring for trauma patients since 1922 when the ACS' Committee on Trauma (COT) was created, and actively and routinely updates the standards to reflect current trends and evidence-based practice. The ACS-COT standards are national standards which are updated every five years. Surveillance is conducted in three-year cycles.

Adopting ACS-COT standards allows for four levels of trauma center. Current 708 regulations allow for only two levels of trauma center; Regional (comparable to ACS Level I) and Area (comparable to ACS Level II or III). The addition of two more levels of trauma care in areas that are currently underserved will serve to strengthen the State's trauma system.

Costs for the Implementation of and Continuing Compliance with these Regulations to the Regulated Entity:

Trauma center designation is a voluntary process. Only those hospitals desiring to care for trauma patients will incur the additional costs that may be required to meet ACS-COT

standards. Costs that will be incurred by the regulated parties include the cost of a consultative visit, should the facility determine this is a prudent first step in working towards successful verification, and the verification visit itself. The cost for a consultative visit is $15,000 while the cost for a verification visit is $13,000. The proposed regulation would require the addition of a nurse reviewer to the verification team to ensure a thorough review, and would add an additional cost of $3000 to the cost of a verification visit. Additional costs that may be incurred by the regulated parties could include the costs associated with the hiring of appropriate staff, such as additional trauma surgeons, trauma registrars and an injury prevention coordinator.

Per Jobs-Salary.com the "average" salary of a board certified trauma surgeon is approximately $304,500. Those hospitals seeking trauma designation for the first time will need to hire a full time trauma program manager. The "average" salary of a nurse manager is $62,840. The "average" salary for an injury prevention coordinator ("health educator") is $47,812. Review and update of the various policies and procedures related to trauma could be accomplished with existing staff imposing little or no additional cost to the regulated parties.

The 40 currently designated trauma centers in the state are required to maintain a trauma registry. The ACS-COT standards currently require one registrar for every 750-1000 patients entered in to the registry. Many currently designated centers will be required to hire an additional registrar to meet this standard. The "average" salary for a "registrar" is $37,828. Per Digital Innovations, one of the vendors currently supporting the New York State trauma registry, for those facilities pursuing designation as a trauma center for the first time, the average cost of

purchasing the software necessary to begin a trauma registry is approximately $5-$10,000, and the annual cost for maintaining a registry is approximately $2-3,000.

Emergency Medical Services (EMS) protocols dictate that trauma patients must be transported to the highest level of trauma center in a region. The goal of the New York State Trauma Registry is to capture all data for trauma patients cared for in the state. For those unverified and undesignated hospitals who occasionally receive trauma patients not transported by ambulance, there will be a mechanism for capturing this data. Per Image Trend, the vendor currently serving as the State's repository for the New York State Trauma Registry, the cost for submitting an abbreviated subset of trauma data will be free of charge. For the small numbers of trauma patients expected at these facilities, entry of trauma data can be accomplished by existing staff and should not require additional hiring.

Those regulated parties who will also be caring for traumatically injured children must ensure that their equipment is age and size appropriate.

Cost to State and Local Government:

There are no additional costs to state and local government to implement this regulation. Existing staff will be utilized to conduct surveillance of the regulated parties and monitor compliance with these provisions.

Cost to the Department of Health:

As stated above, there are no additional costs to state and local government to implement this regulation. Existing staff will be utilized to conduct surveillance of the regulated parties and monitor compliance with these provisions.

Local Government Mandates:

There are no additional programs, services, duties or responsibilities imposed by this rule upon any county, city, town, village, school district, fire district or any other special district.

Paperwork:

This measure will require some facilities to develop various written policies and procedures which may include: trauma activation criteria and procedures, a massive transfusion protocol, a difficult airway management policy, trauma diversion policy, performance improvement processes and activities, transfer agreements and trauma data analysis. Facilities will also be required to complete an application for their consultative and verification visits, along with a pre-review questionnaire.

Duplication:

This regulation will not conflict with any state or federal rules.

Alternative Approaches:

Suitable alternatives to the proposed changes have been explored and found to be unsustainable.

Federal Requirements:

This regulation will not conflict with any state or federal rules.

Compliance Schedule:

This proposal will go into effect upon a Notice of Adoption in the New York *State Register*.

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REGULATORY FLEXIBILITY ANALYSIS

FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect of Rule:

This regulation will apply to the 228 general hospitals in New York State who seek trauma center designation. Currently there are 40 designated trauma centers in New York State.

Compliance Requirements:

The ACS has set the standard for caring for trauma patients since 1922 when the ACS' Committee on Trauma (COT) was created, and actively and routinely updates the standards to reflect current trends and evidence-based practice. The ACS-COT standards are national standards which are updated every five years. ACS-COT standards require: all staff that care for trauma patients, or who manage trauma programs, to have current CME in trauma care; adequate surgical staff to ensure prompt attention is given to those patients who are most critically injured. For level I and II facilities this will require that an attending surgeon be present within 15 minutes of the most critically injured patient's arrival. For a level III trauma center this time frame is 30 minutes; prompt neurosurgical availability for level I and II trauma centers; prompt orthopedic surgical availability for all levels of trauma center; a trauma registry be maintained and be current within 60 days of a patient's discharge; a developed performance improvement process; engagement in public and professional education; and participation in injury prevention activities.

Cure Period:

Chapter 524 of the Laws of 2011 requires agencies to include a "cure period" or other opportunity for ameliorative action to prevent the imposition of penalties on the party or parties subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one was not included. Trauma center designation is a voluntary process. The STAC advised the Department in May of 2012 to set a deadline of May 10, 2013 for those hospitals currently designated as trauma centers to contact the ACS-COT to schedule a consultative visit. The STAC further advised that all currently designated trauma centers request their verification visit no later than two years from the date of receipt of the final report of the consultative visit. This timeline was subsequently adopted by the Department and was disseminated to all the currently designated trauma centers.

For those hospitals seeking trauma center designation for the first time, they were advised in March of 2013 that they would need to contact the ACS-COT by May 10, 2015 to schedule their consultative visit, and two years from receipt of their final consultative visit report to request their verification visit. These facilities have also been advised that prior to having their consultative visit, they need to have in place: a trauma service, a trauma medical director, a trauma program manager, a trauma registry, 9-12 months of trauma data and a performance improvement process of some kind. Trauma center designation is voluntary.

Professional Services:

The majority of currently designated trauma centers employ an adequate number of trauma surgeons, have a trauma program manager, a registrar and some employ an injury

prevention coordinator. Most currently designated trauma centers will need to hire additional trauma registrars to be compliant with the ACS-COT standards regarding data submission. Some facilities may need to hire additional surgeons. Newly designated trauma centers will in all likelihood need to hire a trauma program manager and trauma registrar.

Compliance Costs:

The cost for a consultative visit is $15,000 while the cost for a verification visit is $16,000. The "average" salary of a board certified trauma surgeon is approximately $304,500, the "average" salary of a nurse manager is $62,840, the "average" salary for a "registrar" is $37,828 and the "average" salary for an injury prevention coordinator ("health educator") is $47,812. For those newly designated facilities the average cost of purchasing the software necessary to begin a trauma registry is approximately $5-$10,000 and the annual cost for maintaining a registry is approximately $2-3,000. For those hospitals who continue to care for trauma patients without undergoing verification and designation, per Image Trend, the vendor currently serving as the State's repository for the New York State registry, the cost for submitting an abbreviated subset of trauma data will be free of charge. For the small numbers of trauma patients expected at these facilities, entry of trauma data can be accomplished by existing staff and should not require additional hiring.

Economic and Technological Feasibility:

This proposal is economically and technically feasible.

Minimizing Adverse Impact:

Currently designated trauma centers were advised in May of 2012 that they would have to contact the ACS-COT to schedule a consultative visit by May 10, 2013. Following receipt of their final consultative visit report, currently designated trauma centers have two years in which to schedule their verification visit. For those hospitals seeking trauma center designation for the first time, they were advised in March of 2013 that they would need to contact the ACS-COT by May 10, 2015 to schedule their consultative visit, and two years from receipt of their final consultative visit report to request their verification visit. These facilities have also been advised that prior to having their consultative visit, they need to have in place: a trauma service, a trauma medical director, a trauma program manager, a trauma registry, 9-12 months of trauma data and a performance improvement process of some kind. Trauma center designation is voluntary. Those hospitals that do not wish to care for trauma patients will not need to comply with this regulation.

Small Business and Local Government Participation:

Outreach to the affected parties has and is being conducted. This proposal has been discussed and reviewed by the STAC during open, webcast meetings and with the Greater New York Hospital Association (GNYHA) and the Healthcare Association of New York State (HANYS). Organizations that represent the affected parties are also given notice of this proposal by its inclusion on the agenda of the Codes and Regulations Committee of the Public Health and Health Planning Council (PHHPC). This agenda and the proposal will be posted on the Department's website. The public, including any affected party, is invited to comment during the Codes and Regulations Committee meeting.

RURAL AREA FLEXIBILITY ANALYSIS

No Rural Area Flexibility Analysis is required pursuant to section 202-bb (4)(a) of the State Administrative Procedure Act (SAPA). It is apparent, from the nature of the proposed amendment that it will not impose any adverse impact on rural areas, and the rule does not impose any reporting, recordkeeping or other compliance requirements on public or private entities specific to rural areas as participation in the trauma system is voluntary

JOB IMPACT STATEMENT

Nature of Impact:

These provisions will not have a significant impact on jobs. Currently designated trauma centers have been required to have a trauma program director, trauma program manager, trauma registrar and an injury prevention coordinator. Many will be required to hire an additional trauma registrar to maintain ACS-COT standards regarding data abstraction and submission and some will need to hire additional trauma surgeons to manage their current trauma census and performance improvement responsibilities.

Categories and Numbers Affected:

There are currently 40 hospitals in New York State designated as trauma centers.

Regions of Adverse Impact:

There are no regions of adverse impact.

Minimizing Adverse Impact:

Currently designated trauma centers were advised in May of 2012 that they would have to contact the ACS-COT to schedule a consultative visit by May 10, 2013. Following receipt of their final consultative visit report, currently designated trauma centers have two years in which to schedule their verification visit. For those hospitals seeking trauma center designation for the first time, they were advised in March of 2013 that they would need to contact the ACS-COT by May 10, 2015 to schedule their consultative visit, and two years from receipt of their final

consultative visit report to request their verification visit. These facilities have also been advised that prior to having their consultative visit, they need to have in place: a trauma service, a trauma medical director, a trauma program manager, a trauma registry, 9-12 months of trauma data and a performance improvement process of some kind. Trauma center designation is voluntary. Those hospitals that do not wish to care for trauma patients will not need to comply with these regulations.

EXPRESS TERMS

Pursuant to the authority vested in the Public Health and Health Planning Council and subject to the approval by the Commissioner of Health pursuant to Sections 2803 and 2805-v of the Public Health Law, paragraph (2) of subdivision (e) of Part 405.19 is amended, subdivision (g) of Section 405.19 is repealed and a new Section 405.32 is added to Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York to be effective upon publication of a Notice of Adoption in the New York State Register to read as follows:

Paragraph (2) of subdivision (e) of Section 405.19 is amended to read as follows:

(2) Every person arriving at the emergency service for care shall be promptly examined, diagnosed and appropriately treated in accordance with triage and transfer policies and protocols adopted by the emergency service and approved by the hospital. Such protocols must include written agreements with local emergency medical services (EMS) in accordance with subparagraph (b) (1) (i) of this section. All patient care services shall be provided under the direction and control of the emergency services director or attending physician. In no event shall a patient be discharged or transferred to another facility, unless evaluated, initially managed, and treated as necessary by an appropriately privileged physician, physician assistant, or nurse practitioner. No later than eight hours after presenting in the emergency service, every person shall be admitted to the hospital, or assigned to observation services in accordance with

[subdivision (g) of this] section 405.32 of this part, or transferred to another hospital in accordance with paragraph (6) of this subdivision, or discharged to self-care or the care of a physician or other appropriate follow-up service. Hospitals which elect to use physician assistants or nurse practitioners shall develop and implement written policies and treatment protocols subject to approval by the governing body that specify patient conditions that may be treated by a registered physician assistant or nurse practitioner without direct visual supervision of the emergency services attending physician.

Section 405.19 of Part 405 is amended to repeal Subdivision (g) of such section.

A new Section 405.32 is added to read as follows:

405.32 Observation services.

(a) General.

(1) Observation services are post-stabilization services appropriate for short-term treatments, assessment, and re-assessment of those patients for whom diagnosis and a determination concerning inpatient admission, discharge, or transfer can reasonably be expected within forty-eight hours.

(2) If observation services are provided the service shall be provided in a manner which protects the health and safety of the patients in accordance with generally accepted standards of medical practice.

(3) Direct referral is defined as a patient referred by a community, hospital outpatient clinic, or diagnostic and treatment center physician or appropriately licensed practitioner to the hospital for observation services without receiving emergency room or critical care services on the day observation care begins. The referring practitioner must have admitting privileges and must have conducted a physical exam of the patient within the previous eight hours from the referral.

(4) Patients may be assigned to the observation service only by order of a physician or appropriately licensed practitioner.

(5) Patients may be assigned to observation services only through the Emergency Department or by direct referral in accordance with hospital policies, procedures and bylaws, in conformance with applicable statutes and regulations.

(b) Organization and Notice.

(1) The medical staff shall develop and implement written policies and procedures, approved by the Governing Body, that are based on the clinical needs of the patient, that shall specify:

(i) the organizational structure of the observation service, including the specification of authority and accountability of the services,

(ii) the proper clinical location for the care of a patient requiring observation services,

(iii) the appropriate medical and administrative oversight of observation services

(iv) clinical criteria for observation assignment and discharge,

(v) assignment of a physician, nurse practitioner, or physician assistant who will be responsible for the care of the patient and timely discharge from observation services, and

(vi) integration with related services and quality assurance activities of the hospital.

(2) The observation service, in conjunction with the discharge planning program of the hospital, shall establish and implement written criteria and guidelines specifying the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post observation treatment or services but not in need of inpatient hospital care.

(3) Patients in observation shall be cared for by staff appropriately trained and in sufficient numbers to meet the needs of the patients.

(4) Patients being assigned to the observation services, or the patient representative, shall:

(i) receive verbal and written notice which explains clearly that observation services are an outpatient service and thus subject to outpatient rules and co-payments of their medical insurance provider, and

(ii) have included in their medical record a signed acknowledgement of receipt of the verbal and written notice.

(c) *Locations.* Hospitals may provide observation services in the following locations:

(1) Inpatient beds;

(2) Distinct Observation Units; and

(3) In a hospital designated as a critical access hospital pursuant to subpart F of part 485 of Title 42 of the Code of Federal Regulations or a sole community hospital pursuant to section 412.92 of Title 42 of the Code of Federal Regulations or any successor provisions, observation services may be provided in the emergency department.

(d) Distinct Observation Units.

(1) Physical Standards

(i) The observation unit shall comply with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011, except that the unit need not be adjacent to the emergency department.

(ii) Observation unit beds shall not be counted within the state certified bed capacity of the hospital and shall be exempt from the public need provisions of Part 709.

(iii) The observation unit shall be marked with a clear and conspicuous sign that states: This is an observation unit for visits of up to 48 hours. Patients in this unit are not admitted for inpatient services.

(2) Any hospital seeking to establish an distinct observation unit shall, not less than 90 days prior,:

(i) if no construction, as defined in subdivision 5 of section 2801 of the Public Health Law, will be needed, no construction waivers are being requested, and no service will be eliminated, notify the Department in writing of the general location of the unit and the number of beds; and submit a certification from a licensed architect or engineer, in the form specified by the Department, that the space complies with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011; or

(ii) if construction, as defined in subdivision 5 of section 2801 of the Public Health Law, will be needed, or construction waivers are being requested, or a service will be eliminated,

(a) submit a request for limited review under 710.1(c)(5) of this Title, provided that for purposes of Part 710, a construction project involving only the creation of an observation unit and the addition of observation unit beds shall not be subject to review under section 710.1(c)(2) or (3) of this Title, unless the total project cost exceeds $15 million or $6 million respectively; and

(b) comply with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011.

(3) Any hospital operating an observation unit pursuant to a waiver granted by the Department shall be required to comply with the provisions of this subdivision within 12 months of its effective date.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The authority for the proposed revision to Title 10 NYCRR Part 405 is section 2803 of the Public Health Law (PHL), which authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner of Health, to effectuate the provisions and purposes of Article 28 of the PHL with respect to minimum standards for hospitals.

Legislative Objectives:

While observation services have been widely used, it wasn't until 2011 a Medicaid rate was implemented and 2012 regulations were adopted creating operational standards for observation units, pursuant to a recommendation adopted by Governor Cuomo's Medicaid Redesign Team. In January 2013 Governor Cuomo signed legislation creating section 2805-v of the Public Health Law in relation to hospital observation services which differ from the current regulations.

The proposed changes are designed to make the regulations consistent with the law, as well as make modifications based on the experiences of hospitals and the desire to bring the regulations more in line with Medicare rules, while still assuring patient safety and quality of care.

Current Requirements:

Current regulations require that observation services be rendered in a discrete unit, under the direction and control of the emergency services. Additionally, observation services are currently limited to twenty-four hours, at which time the hospital must either discharge or admit the patient. Observation services have been identified as a means of improving patient care and relieving overcrowding in emergency departments by increasing efficiency and patient through-put. However, the current regulations differ significantly from legislation and from Medicare rules.

Needs and Benefits:

The proposed regulations repeal 405.19(g) and create a new section, 405.32. In response to the recent legislation, the new regulations will allow observation services to be rendered in a distinct unit or in inpatient beds, with no limit on the number of observation beds. The facility will be able to determine the appropriate oversight, and the maximum observation stay will increase to forty-eight hours.

Additionally, proposed changes would allow hospitals to accept direct referrals to observation by properly privileged and credentialed community providers, following appropriately adopted policies and procedures. The new regulations will also require both verbal and written notice be given to patients explaining that observation services are considered an outpatient service with all concurrent applicable insurance rules.

These regulatory changes incorporate the statutory changes and take into account the desire for appropriate consistency with Medicare rules and operational experiences over the past year, while maintaining proper safeguards and attention to patient safety and quality of care.

COSTS

Costs to Private Regulated Parties:

This regulation creates no additional burdens or costs to regulated parties. It will eliminate the requirement for discrete units which may have required construction costs to be in compliance with construction standards.

Costs to Local Government:

There are no costs to local government.

Costs to the Department of Health:

The proposed amendment would impose no new costs on the Department.

Costs to Other State Agencies:

There are no costs to other State agencies or offices of State government.

Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

This regulation requires no additional paperwork other than written notice to patients about their assignment to observation services.

Duplication:

There are no relevant State regulations which duplicate, overlap or conflict with the proposed amendment. Federal Medicare payment rules set forth standards for reimbursement of observation services. These proposed regulations provide clear and consistent operating standards for observation services. The regulations do not conflict with Medicare payment rules.

Alternatives:

The Department considered not requiring verbal and written notice to patients regarding their assignment to observation services. Based on the literature and recent newspaper articles, the Department determined that such information was important for patients to know.

Federal Standards:

The proposed amendment does not exceed any minimum operating standards for health care facilities imposed by the Federal government.

Compliance Schedule:

The proposed amendment will be effective 90 days after publication of a Notice of Adoption in the New York State Register. Facilities operating observation units pursuant to a waiver approved by the Department will have 12 months to comply with these regulations.

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REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas. The regulation includes an exemption from for critical access hospitals and sole community hospitals, allowing them to utilize emergency room beds.

STATEMENT IN LIEU OF

JOB IMPACT STATEMENT

No Job Impact Statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment, that it will not have an adverse impact on jobs and employment opportunities.

Pursuant to the authority vested in the Public Health and Health Planning Council and subject to approval by the Commissioner of Health by Sections 2803, 2993 and 2994-t of the Public Health Law, sections 405.43 and 700.5 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York are hereby repealed, and section 400.21 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York is hereby amended effective upon the publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 405.43 is repealed.

Section 700.5 is repealed.

Section 400.21 is amended to read as follows:

§ 400.21 Advance directives

(a) Statement of purpose. [Recent a]Advances in medical technology have brought forth a multitude of choices about medical treatment. Advances in emergency medical services have expanded the capacity of the health care system to save the lives of victims who previously would not have survived acute trauma. New drugs and new surgical techniques may prolong life, but may not necessarily halt the spread of progressive or degenerative illness. Life support systems can maintain unconscious patients for months or even years. Decisions about medical treatment based on the availability of this burgeoning medical technology are deeply personal. They reflect basic values, personality traits and religious attitudes. An adult's capacity to tolerate pain, disfigurement or dependency must be considered. The New York State Health Care

Proxy Law allows an adult to designate another adult, such as a trusted friend or loved one who knows the person and his/her wishes, to make these treatment decisions if the adult becomes incapacitated and is unable to do so. The Health Care Proxy Law guarantees an adult's right to self-determination and the expression of this right through another adult. Advance directives like the Health Care Proxy also allow an adult to express his or her preference regarding health care treatment, including a desire to continue or to refuse treatment and life supports. In the absence of a Health Care Proxy, adults who express their wishes orally or in writing concerning life-sustaining treatment in a clear and convincing manner are entitled, based on decisions of both the United States Supreme Court and the New York State Court of Appeals, to have those wishes recognized. Facilities must ensure that all adult patients/residents are informed of their rights and are supported and protected as they exercise their right to formulate written or oral instructions regarding their health care in the event such adults become incapacitated and are unable to direct their own health care.

(b) Definitions. The following words or phrases shall have the following meanings:

(1) An advance directive means a type of written or oral instruction relating to the provision of health care when an adult becomes incapacitated, including, but not limited to a health care proxy, a consent [pursuant to Article 29-B of the Public Health Law] to the issuance of an order not to resuscitate or other medical order for life-sustaining treatment recorded in a patient's/resident's medical record, and a living will.

(2) A health care proxy means a document created pursuant to Article 29-C of the Public Health Law which delegates the authority to another adult known as a health care agent to make health care decisions on behalf of the adult when that adult is incapacitated.

(3) A living will means a document which contains specific instructions concerning an adult's wishes about the type of health care choices and treatments that an adult does or does not want to receive, but which does not designate an agent to make health care decisions.

(4) A health care agent or agent means an adult to whom authority to make health care decisions is delegated under a health care proxy.

(5) An adult means any person who is 18 years of age or older[, or is the parent of a child,] or has married.

(c) Facility compliance. The facility shall ensure compliance with the requirements of law governing advance directives including but not limited to Articles [29-B and] 29-C , 29-CC and 29-CCC of the Public Health Law.

(d) Policies and procedures. The facility shall be responsible for developing, implementing and maintaining written policies and procedures addressing advance directives and shall:

(1) furnish the following material to each adult patient/resident, or if the adult patient/resident lacks capacity, to the family member or other adult who speaks on the patient's/resident's behalf at or prior to the time of admission to the facility as an inpatient or an outpatient and to each member of the facility's staff who provides patient/resident care. A facility need not provide these items more than once to an outpatient receiving services on a recurring basis:

(i) the description of State law prepared by the department entitled ["Planning in Advance for your Medical Treatment,"] "Deciding About Health Care: A Guide for Patients and Families," which summarizes the rights, duties and requirements of Articles [29-B and]

29-C, 29-CC and 29-CCC [and the right of an adult to formulate advance directives as expressed in final decisions of courts of competent jurisdiction]; and

(ii) the pamphlet prepared by the department entitled "Appointing your Health Care Agent - New York State's Health Care Proxy Law," containing a sample health care proxy form[; and

(iii) a summary of the facility's policy regarding the implementation of these rights].

(2) ensure that there is documentation in each adult's medical record indicating whether or not the adult has executed a health care proxy under Article 29-C of the Public Health Law, or whether the adult has provided written or oral advance instructions about treatment to facility staff responsible for the patient's care or to facility employees upon admission;

(3) assess advance directives other than those described in Articles [29-B and] 29-C, 29-CC and 29-CCC of the Public Health Law.

Nothing herein shall be construed to require that a facility must or may not seek a court determination that any individual advance directive has been expressed in a clear and convincing manner;

(4) provide in-service education to staff involved in the provision of care including medical staff concerning the facility's policies and procedures concerned with advance directives;

(5) provide (individually or with others) education to the community on issues concerning advance directives;

(6) ensure that an adult is not discriminated against in the provision of care or otherwise discriminated against based on whether or not the adult has executed an advance

directive; and

(7) in addition, a nursing home shall:

(i) educate adult residents about the authority delegated under a health care proxy, what a proxy may include or omit, and how a proxy is created, revoked, or changed as requested by the resident;

(ii) ensure that each resident who creates a proxy while residing at the facility does so voluntarily; and

(iii) designate one or more individuals to educate the residents, respond to questions and assist residents in creating, revoking or changing a proxy.

(e) To implement a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, facilities may utilize the department approved form for medical orders for life-sustaining treatment (MOLST) and must provide information about MOLST to patients with serious health conditions who:

(1) want to avoid or receive any or all life-sustaining treatment; or

(2) can reasonably be expected to die within one year.

(f) Rights to be publicized. The facility shall post in a public place in the facility the rights, duties and requirements of this section. Such statement may be included in any other statement of patient's/resident's rights required to be posted.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Subdivision 4 of Section 225, and by Section 2402 of the Public Health Law, the section heading and subdivision (a) of Section 1.31 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, are hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

1.31 Disclosure of confidential cancer information [for research purposes].

(a) The identity of any person contained in a report of cancer made pursuant to the provisions of Section 2401 of the Public Health Law, or cancer data collected for other specific research studies, shall not be disclosed except [to governmental or government-sponsored research projects]:

(1) for the purpose of scientific studies and research when the State Commissioner of Health determines that substantial knowledge may be gained by such disclosure leading toward the reduction of morbidity and mortality[.]; or

(2) for surveillance or evaluation activities that are government sponsored at the federal or state (including Canadian province) level, when the State Commissioner of Health determines that the proposed activity is of significant public health importance and that release of identifiable information is necessary for the proposed activity.

The recipient shall limit the use of such information to the specific research study or [research] purpose for which such disclosure is made, shall not further disclose such information (except when the recipient is a central cancer registry), and shall satisfy the State Commissioner of Health that the confidentiality of [the] patient['s] identity will be

maintained. If the recipient of the data is a central cancer registry, the information released to the recipient shall be subject to the laws, regulations and policies governing release of confidential cancer data of the recipient's jurisdiction.

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

June 6, 2013

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 #3**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122216 C	University Hospital (Suffolk County)	Contingent Approval
2.	122303 C	Northern Dutchess Hospital (Dutchess County)	Contingent Approval
3.	131101 C	Montefiore Med Center – Jack D Weiler Hosp of A Einstein College Div (Bronx County)	Contingent Approval

Cardiac Services – Construction **Exhibit #4**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	131114 C	Brookhaven Memorial Hospital Medical Center, Inc. (Suffolk County)	Contingent Approval

Upstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #5**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121238 C	Visiting Nurse Service of Schenectady and Saratoga (Schenectady County)	Approval

2.	121317 C	VNA of Albany VNA of Saratoga VNA of Rensselaer (Albany County)	Approval
3	121443 C	Hudson Valley Long Term Home Health Care Program (Ulster County)	Approval
4.	131184 C	Calvary Hospital (Bronx County)	Approval

Downstate Dear Administrator Letters – Long Term Home Health Care Program – Construction **Exhibit #6**

	Number	**Applicant/Facility**	**E.P.R.C. Recommendation**
1.	121290 C	Park Gardens Rehabilitation & Nursing Center, LLC (Bronx County)	Contingent Approval

Public Health and Health Planning Council

Project # 122216

University Hospital

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

Program: **Acute Care Services**
Submitted: **July 19, 2010**

Executive Summary

Description

Stony Brook University Hospital (SBUH) a state affiliated 599-bed Academic Medical Center located in Suffolk County, requests approval to construct a structure on the southeastern sector of its medical campus; this structure will be two towers extended from a single base. The towers are a 240,000 square foot Medicine and Research Translation Tower (MART) and a 225,000 square foot bed tower. The total project cost for the clinical and non-clinical portions of the building is approximately $418.9 million. The combined clinical portion (Article 28) of the MART, which is approximately 42,130 sq. ft. (or 17.55% of the overall MART) and new bed tower has a project cost of approximately $263.5 million. The remaining portion of the project is academic and research (non-Article 28) space and its cost is approximately $155.4 million.

The proposed building represents continued redevelopment and growth at SBUH. The new towers will be able to be expanded in the future with the bed tower being able to expand vertically/upward by an additional eleven stories, which will allow this facility to potentially house additional replacement patient rooms. The MART has been designed to expand horizontally.

The proposed construction will create the following: a 10-level bed tower, which will be comprised of:

- SBUH newly created Children's Hospital (a sub unit of the proposed new tower) which will include a newly built Pediatric Intensive Care Unit (PICU), medical/surgical units, adolescent unit, procedure suite and modern patient and family amenities.
- New critical care and cardiac care units
- An expanded imaging department to improve clinical flow, support growth, provide adequately sized treatment/imaging rooms, and provide necessary support spaces.
- Newly built support departments to balance growth of support space throughout the hospital including a new loading dock, dietary expansion, connectors to the existing building, mechanical space, site improvement and new access roadways.
- The bed configuration of the bed tower will be configured as follows:
    - 16 bed Neuro ICU (Intensive Care Unit)
    - 20 bed SICU (Surgical Intensive Care Unit)
    - 40 bed Cardiology Unit
    - 18 bed Adolescent unit
    - 8 bed Pediatric Hematology Oncology Unit
    - 16 bed General Pediatrics unit
    - 12 bed PICU (Pediatric Intensive Care Unit)
    - 20 bed Adult Medical/Surgical Unit
    - -Pediatric Procedure suite
    - Expanded Radiology area

All beds are replacement beds with no change to total certified beds.

The proposed construction will also create the Medicine and Research Translation Tower. This tower's main components are:

- Cancer biology oriented wet laboratories for cell, tissue and other cancer Biology research
- Dry labs for statistical research
- Biomedical informatics
- Clinical study
- Conference Center
- Educational Space

- Administrative office suite
- Multi-disciplinary exam space for medical and surgical oncology
- Infusion center with private and open bays
- Pediatric Hematology and oncology including pediatric infusion
- Patient amenities and support space

The MART tower will house the following clinical services and clinical support functions in approximately 42,130 sq.ft of the building:

- Adult and Pediatric infusion
- Oncology Based Outpatient Facility
- MART lobby
- Materials Management
- Oncology Program's Administrative Area

The MART and its programs are intended to achieve several important purposes:

- Establish a collaborative research hub in Stony Brook's School of Medicine
- Fulfill a significant medical need on Long Island
- Accelerate the advancement of biomedical imaging
- Boost medical education and clinical/research collaborations

The project is scheduled for a completion of construction date of May 2017. The MART unit however, is expected to be completed and ready for preoccupancy inspection by April 2016. The facility is requesting that the project be allowed to phase in the operations of the MART unit prior to the bed tower being open for occupancy.

DOH Recommendation

Contingent approval.

Need Summary

The proposed new structure will update University Hospital as a facility and eliminate the operational inefficiencies associated with SBUH's outmoded and aging physical structure. The proposed project will also involve the conversion of 10 pediatric beds to 10 medical/surgical beds in order to reduce the facility's unduly high medical/surgical occupancy rate and to raise its low pediatric bed utilization to a rate closer to an optimum level.

Program Summary

From a programmatic perspective, approval is recommended.

Financial Summary

Article 28 project costs of $263,579,465 will be met via fundraising in the amount of $24,200,000, $68,070,475 in accumulated funds, $38,108,990 in TELP financing at 2% for 5 years and $133,200,000 in a DASNY tax exempt construction loan at 4% for 30 years**.**

Incremental Budget:

Revenues	$71,980,409
Expenses	64,833,622
Excess of Revenues over Expenses	$ 7,146,787

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency
There will be no HSA review of this project.

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 hundreths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]

2. Submission of documentation of receipt of Public Authorities Control Board approval of the TELP financing that is acceptable to the Department of Health. [BFA]

3. Submission of documentation that is acceptable to the Department of Health, of contributions to be used as the source of financing. [BFA]

4. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest that is determined to be acceptable by the Department of Health. This is to be provided within 120 days of receipt from the Department of Health, Bureau of Architectural and Engineering Facility Planning of approval of final plans and specifications and before the start of construction. Included with the submitted permanent mortgage commitment must be a source and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]

5. The applicant is required to submit design development drawings, complying with requirements of 10NYCRR Part 710.4, for review and approval by DASNY. [AER]

6. The applicant is required to submit final construction documents, complying with requirements of 10NCYCC Part 710.7, to NYS DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) prior to start of construction. [AER]

Council Action Date
June 6, 2013.

Need Analysis

Project Description

University Hospital (UH) is a 593-bed acute care facility located at Health Sciences Center SUNY, Stony Brook, 11794, in Suffolk County. The facility seeks approval to construct a structure on its campus consisting of two (2) towers. The larger of the two towers will be designated as the Medicine and Research Translation Tower (MART) and the smaller one will be a bed tower. In addition, University Hospital will convert 10 pediatric beds to 10 medical/surgical beds.

Background

University Hospital Stony Brook has the following certified beds and services:

Table 1: University Hospital Stony Brook : Certified beds

Bed Category	Certified Capacity	Requested Action	Certified Capacity Upon Completion
Bone Marrow Transplant	6		6
Burns Care	6		6
Coronary Care	10		10
Intensive Care	50		50
Maternity	36		36
Medical / Surgical	355	+10	365
Neonatal Continuing Care	8		8
Neonatal Intensive Care	18		18
Neonatal Intermediate Care	14		14
Pediatric	38	-10	28
Pediatric ICU	12		12
Psychiatric	40		40
Total	593	0	593

Table 2: University Hospital Stony Brook : Certified Services

Ambulance	Ambulatory Surgery - Multi Specialty
Audiology O/P	Burn Center
Burns Care	Cardiac Catheterization (Adult)
Cardiac Catheterization (Pediatric)	Certified Mental Health Services O/P
Clinical Laboratory Service	Comprehensive Psychiatric Emergency Program
Coronary Care	CT Scanner
Emergency Department	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	Open Heart Surgery (Adult)
Open Heart Surgery (Pediatric)	Pediatric
Pediatric Intensive Care	Pharmaceutical Service
Primary Medical Care O/P	Psychiatric
Radiology - Diagnostic	Renal Dialysis - Acute
Renal Dialysis Home Training O/P	Therapy - Occupational O/P
Therapy - Physical O/P	Therapy - Speech Language Pathology
Transplant - Bone Marrow	Transplant - Kidney

University Hospital Stony Brook is authorized to operate 17 hospital extension clinics; these clinics provide services such as occupational and physical therapy, primary medical care, diagnostic radiology, outpatient surgery, mental health services, and well child care.

UHSB has the following State designations:

- AIDS Center;
- Burn Center ;
- Regional Perinatal Center;
- Regional Trauma Center;
- Safe Center; and
- Stroke Center.

UHSB states that there are actively working to develop affiliation relationships with area community hospitals as it prepares to meet the health care reform challenges.

UHSB specifies that it has implemented a number of initiatives aimed at improving quality while increasing operational efficiencies. These efforts fall into three (3) major areas:

- Medical error prevention and quality improvement;
- Avoidable hospitalizations and readmissions; and
- Improved hospital efficiency and patient flow.

Analysis

University Hospital is the largest acute care hospital in Suffolk County. In addition to its acute care status, the hospital serves as the Regional Perinatal Center and Regional Trauma Center. An average of 96 percent of the hospital's total inpatient discharges are residents of Suffolk County. In 2000, the census for the county was 1,419,369 residents; by 2010 it increased by 5.2 percent to 1,493,350 and is projected to reach 1,530,550 by 2020.

From 2009 – 2011, University Hospital recorded an average of 34,171 total inpatient discharges; of these, 22,413, or 66.0 percent, were allocated to the major service category medical/surgical and 2,515, or 7.0 percent, to the major service category pediatrics. The associated average daily census for the aforementioned services were 361 and 23 patients, respectively. The average occupancy rate for medical/surgical patients was 86.0 percent and for pediatrics was 45.0 percent.

In 2011, University Hospital's experienced a marked increase in its medical/surgical ADC; it went from 357 patients on any given day in 2010 to 372 in 2011. The hospital's marked increase in medical/surgical ADC in 2011 resulted in an occupancy rate of 88.8 percent.

Throughout the review period, University Hospital's medical/surgical occupancy rate was slightly over the desire planning optimum of 85.0 percent; while its pediatric occupancy rate was well below the pediatric planning optimum of 70.0 percent (Table 3). A review of the hospital's 2012 partial SPARCS inpatient utilization statistics shows that the facility's medical/surgical occupancy rate is positioned to exceed the desired planning optimum rate of 85.0 percent.

To help ameliorate its high medical/surgical occupancy rate, UHSB proposes to convert 10 pediatric beds to 10 medical/surgical beds.

Table 3: University Hospital: Inpatient Utilization by Major Service Category.
Source: SPARCS 2009 - 2011

Service	2009	2010	2011	Current Beds
Discharges				
Medical/Surgical	21,634	22,623	22,981	
Pediatric	2,623	2,359	2,564	
Obstetric	4,370	4,263	3,993	
General Psychiatric	1,031	1,009	847	
Chemical Dependency	185	212	210	
High Risk Neonates	601	700	654	

Table 3: University Hospital: Inpatient Utilization by Major Service Category. Source: SPARCS 2009 - 2011				
Service	2009	2010	2011	Current Beds
Subtotal	30,444	31,166	31,249	
Healthy Newborns	3,376	3,201	3,077	
Grand Total	33,820	34,367	34,326	
Average Daily Census				
Medical/Surgical	353	357	372	
Pediatric	24	21	23	
Obstetric	40	39	37	
General Psychiatric	41	39	37	
Chemical Dependency	3	3	3	
High Risk Neonates	28	32	30	
Subtotal	489	491	503	
Healthy Newborns	24	22	22	
Grand Total	513	513	525	
Occupancy Based on Current Beds				
Medical/Surgical	84.2	85.2	88.8	419
Pediatric	47.6	42.6	46.4	50
Obstetric	111.4	109.2	103.9	36
General Psychiatric	103.3	96.8	92.5	40
Chemical Dependency	0.0	0.0	0.0	0
High Risk Neonates	70.8	80.0	75.0	40
Total	83.6	83.9	86.0	585

Emergency Department Visits and Ambulatory Surgery Procedures

In 2007, University Hospital recorded 68,326 total Emergency Department (ED) visits; by 2011, these visits increased by 31.0 percent to 89,478. Over the period, between 20.3 to 21.5 percent of the facility's ED visits resulted in an inpatient admission. During the period under review, the number of amb/surg procedures performed at UHSB increased significantly, from 17,007 in 207 to 39,823 in 2011 (Table 4).

Table 4: University Hospital Stony Brook: Emergency Department Visits and Ambulatory Surgery Statistics. Source: ICR 2007 -2011.

Year	*Total ED Visits*	*% of ED Visits Resulting in Inpt Admission*	*Amb/Surg Procedures*
2007	68,326	21.5	17,007
2008	73,591	20.5	17,503
2009	81,601	20.3	20,533
2010	85,069	20.9	37,550
2011	89,478	20.7	39,823

Conclusion

University Hospital seeks approval to construct new health care space on its campus and to convert 10 pediatric beds to 10 medical/surgical beds. This project will allow the facility to address key problems such as an outmoded and aging physical structure, which creates operational inefficiencies.

The request by University Hospital to convert 10 pediatric beds to 10 medical beds is supported by the facility's occupancy statistics over the last 24 months. The increase in medical/surgical beds will allow the hospital to operate closer to the planning optimum for that bed category (85 percent) and increase the pediatric occupancy rate to the mid-50 percent range.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

University Hospital (Stony Brook) requests approval to construct a building on its campus, comprised of two towers, to include both clinical and non-clinical space. What is being referred to as the Bed Tower will include a newly built pediatric intensive care unit, medical/surgical units, an adolescent unit, a procedure suite, pediatric patient and family amenities, critical care and cardiac care units, an expanded imaging department and expanded support departments. What is being referred to as the Medicine and Research Translation Tower will include cancer biology oriented wet labs, dry labs, a conference center, educational space, administrative offices, multi-disciplinary exam space for oncology services, an infusion center, pediatric hematology and oncology, and patient amenities and support space.

In conjunction with the proposed construction, Stony Brook proposes to convert ten pediatric beds to ten medical/surgical beds, maintaining a total bed count of 599. Staffing is expected to increase by 162 FTEs in year one of the completed project, and to increase by a total of 235 FTEs by year three of the completed project.

Compliance with Applicable Codes, Rules and Regulations

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.

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

Article 28 total project cost, which is for new Construction, renovations and the acquisition of moveable equipment, is estimated at $263,579,465, itemized as follows:

New Construction	$159,889,107
Renovation and Demolition	846,221
Site Development	4,195,262
Temporary Utilities	1,489,161
Asbestos Abatement	893,496
Design Contingency	16,731,325
Construction Contingency	8,452,648
Architect/Engineering Fees	16,680,262
Construction Manager Fees	4,465,430
Other Fees (Consultant)	854,989
Moveable Equipment	34,911,208
Telecommunications	3,197,782
Interim Interest Expense	9,528,828
CON Fee	2,000
Additional Processing Fee	1,441,746
Total Project Cost	$263,579,465

Project costs are based on a December 1, 2013 construction start date and a forty-one month construction period.

The applicant's financing plan appears as follows:

Fundraising	$24,200,000
Accumulated Funds(Hospital Revenue funds and Renamed Appropriations)	68,070,475
TELP Equipment Loan (2% for 5 years)	38,108,990
DASNY Loan (4% for 30 years)	133,200,000
Total for Clinical portion of the project	$263,579,465

* The Non-clinical (non-Article 28) space cost is approximately $155.4 million.
This cost is to be satisfied by $20,000,000 for an Urban Development Corp grant, $50,000,000 in Philanthropy; $20,000,000 in School of Medicine funds, $40,392,122 in renamed Appropriations (Children's Hospital educational space), $15,000,000 in a SUNY Match grant and $10,000,000 in indirect cost recoveries.

Indirect cost recoveries include general administration costs of the institution (including salaries and operational costs of the offices of President, Provost, Deans, Purchasing, Grants Management, Sponsored Programs, and Human Resources), building or space use, including depreciation of facilities and debt service costs, equipment, operations and maintenance costs, including utilities, repairs, custodial, environmental health and safety, general facilities management, and library costs.

Operating Budget

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first and third years of operation; summarized below:

Total Operating Budget Inpatient and Outpatient:

	Year One	Year Three
Revenues:	$49,688,963	$71,980,409
Expenses:		
Operating	$31,485,051	$46,663,045
Capital	12,322,361	18,170,577
Total Expenses:	$43,807,412	$64,833,622
Excess of Revenues over Expenses:	$5,881,551	$7,146,787

Inpatient:	Year One	Year Three
Revenues:	$45,314,718	$61,432,640
Expenses:		
Operating	$28,126,847	$39,325,966
Capital	11,008,796	15,314,162
Total Expenses:	$39,135,643	$54,640,128
Excess of Revenues over Expenses:	$6,179,074	$6,792,512
Utilization: (Discharges)	817	1,583
Operating - Cost per Discharge	$34,426.99	$24,842.68
Capital - Cost per Discharge	$13,474.66	$9,674.14
Total - Cost Per Discharge	$47,901.65	$34,516.82

Outpatient:	Year One	Year Three
Revenues:	$4,374,245	$10,547,769
Expenses:		
Operating	$3,234,982	$7,337,079

Capital	1,436,787	2,856,415
Total Expenses:	$4,671,769	$10,193,494
Excess of Revenues over Expenses:	($297,524)	$354,275
Utilization: (Visits)	3,108	7,481
Operating - Cost per Visit	$1,040.86	$980.76
Capital - Cost per Visit	$462.29	$381.82
Total - Cost Per Visit	$1,503.15	$1,362.58

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

Inpatient:	Year One	Year Three
Medicaid Fee-for-Service	9.56%	9.55%
Medicaid Managed Care	13.66%	13.67%
Medicare Fee-for-Service	31.90%	31.79%
Medicare Managed Care	6.06%	6.09%
Commercial Fee-for-Service	20.19%	20.22%
Commercial Managed Care	9.69%	9.69%
Private Pay/Other*	8.94%	8.99%

Outpatient:	Year One	Year Three
Medicaid Fee-for-Service	6.69%	6.67%
Medicaid Managed Care	19.02%	18.97%
Medicare Fee-for-Service	0.19%	0.19%
Medicare Managed Care	8.46%	8.45%
Commercial Fee-for-Service	5.66%	5.67%
Commercial Managed Care	12.36%	12.34%
Private Pay/Other*	47.62%	47.71%

*Other: includes revenues derived from Disproportionate Share Hospital (DSH) payments.

Expense assumptions are based on the current and historical experience of Stony Brook University Hospital. Utilization assumptions are based on the incremental volume growth based on historical growth levels as well as programmatic growth initiatives, which include higher acuity cardiac discharges due to the addition of two cardiac surgeons to the hospital as of September 2012.

In Year 1, the facility projects ramping up their cardiac discharges; therefore their blended incremental revenue per case is higher than in Year 3, when some of their incremental discharges are non-cardiac med/surg cases.

The facility's average rates for non-cardiac discharges can range from $16,000-$25,000 per discharge for medicine and $25,000 - $30,000 for surgery. One of the facility's highest revenue generating types of cases is cardiac/open heart, with average revenue of $56,000 per case.

Case Type	Non-Cardiac		Cardiac/Open Heart
	Medicine	Surgery	
Average Revenue Per Case	$16,000-$25,000	$25,000 - $30,000	$56,000

The facility is also currently working on reducing the average length of stay for both Years 1 and 3, by approximately 0.2 days in Year 1 and by 0.35 days in Year 3. The ALOS is decreasing primarily because the facility is implementing quality and operational efficiencies. For example, the facility is using electronic medical record systems to facilitate the delivery of more reliable, evidence based care, which is allowing for a higher prevention rate of surgical infections and complications. This helps reduce the overall length of stay, by allowing patients to recover faster and therefore, be discharged sooner. By implementing these efficiencies the facility is expecting to increase overall discharges going forward.

Capability and Feasibility

Project costs for the clinical portion of the project, which is $263,579,465, will be met via fundraising in the amount of $24,200,000, $68,070,475 in accumulated funds (cash and assets whose use is limited), $38,108,990 in TELP financing and $133,200,000 from a DASNY tax-exempt loan at the above stated terms. As shown in BFA Attachment B, 2012 internal financial statement for Stony Brook University Hospital Stony Brook University, shows that they have sufficient funds to meet the project equity.

Working capital requirements are estimated at $10,805,604, which appears reasonable based on two months of third year incremental expenses. The applicant will provide equity from operations to meet the working capital requirement.

As shown on BFA Attachments A and B, the applicant has sufficient funds to cover both the working capital requirement as well as the capital equity requirement.

The submitted incremental budget indicates an excess of revenues over expenses of $5,881,551 and $7,146,787 during the first and third years, respectively. Revenues are based on current reimbursement methodologies. The budget appears reasonable.

As shown on Attachment A, the certified 2010-2011 financial statement, Stony Brook University Hospital had a positive working capital position and a positive net asset position through 2011. Also, the hospital achieved an average excess of revenues over expenses of $18,139,500 through 2011. This excess of revenues over expenses is due to the facility receiving state appropriations in both 2010 and 2011 in the amount of $36,587,000 and $63,337,000, respectively. This money reflects expenditures of the hospital which have been or will be paid by the state at no charge to the Hospital's designated accounts with the university.

	2010	*2011*
Malpractice Liability Claims	($18,833,000)	$19,783,000
Debt Service	($4,094,000)	($662,000)
Transfers for costs of State Sponsorship	$59,190,000	$43,930,000
Net Indirect Costs allocated to the Hospital	$324,000	$286,000
Total	$36,587,000	$63,337,000

2009-2012 Inpatient Volume by Payer (Provided by Applicant)

	2009	*2009 %*	*2010*	*2010 %*	*2011*	*2011 %*	*2012*	*2012 %*
Medicaid	2,992	8.80%	2,551	7.37%	2,473	7.13%	1,818	5.19%
Medicaid HMO	5,314	15.62%	5,806	16.77%	5,899	17.00%	6,425	18.35%
Medicaid HMO-CHP	211	.62%	207	.60%	267	.77%	273	.78%
Medicare	8,530	25.08%	8,958	25.88%	9,381	27.03%	9,552	27.28%

Medicare HMO	1,726	5.07%	1,936	5.59%	1,873	5.40%	2,057	5.87%
Negotiated Payors	12,722	37.41%	12,486	36.07%	12,502	36.03%	12,605	36.00%
No Fault	521	1.53%	562	1.62%	455	1.31%	462	1.32%
Other	98	.29%	106	.31%	148	.43%	179	.51%
Self-Pay	1,483	4.36%	1,603	4.63%	1,308	3.77%	1,238	3.54%
Tricare	145	.43%	151	.44%	136	.39%	131	.37%
Workers Comp	269	.79%	253	.73%	261	.75%	275	.79%
Total	34,011		34,619		34,703		35,015	

2009-2012 Outpatient Volume by Payer (Provided by Applicant)								
	2009	*2009 %*	*2010*	*2010 %*	*2011*	*2011 %*	*2012*	*2012 %*
Medicaid	22,808	7.03%	20,734	6.36%	22,697	6.43%	19,135	5.24%
Medicaid HMO	33,336	10.27%	35,790	10.98%	44,758	12.68%	52,965	14.51%
Medicare	67,268	20.73%	69,274	21.25%	76,502	21.68%	81,144	22.23%
Medicare HMO	11,370	3.50%	11,519	3.53%	11,153	3.16%	11,919	3.27%
Commercial/. HMO	149,021	45.92%	146,923	45.08%	155,081	43.94%	156,935	43.00%
No Fault/ Workers Comp	13,537	4.17%	13,309	4.08%	12,665	3.59%	12,734	3.49%
Self-Insured/Other	27,195	8.38%	28,379	8.71%	30,065	8.52%	30,163	8.26%
Total	324,535		325,928		352,921		364,995	

The growth in outpatient volume between 2010 and 2011 was driven primarily by

- Referred Amb (which includes EKG, lab, echo, radiology) +12,301
- Emergency department visits +3,652
- Chemo Clinic (hired additional MDs) +5,352
- Clinic Visits +2,853
- Ambulatory Surgery +2,186

The growth in outpatient volume between 2011 and 2012 was driven primarily by

- Clinic visits + 4,876
- Emergency Department visits +3,266
- Ambulatory Surgery +2,205
- Referred Amb +1,797

Presented as BFA Attachment B are the 2012 draft financial statements of Stony Brook University Hospital. As shown, the hospital had a positive working capital position and a positive net asset position during 2012. Also, the hospital achieved an excess of revenues over expenses of $12,474,000 during 2012. This excess of revenues over expenses is due to the facility receiving state appropriations in 2012 in the amount of $47,273,000. This money reflects expenditures of the hospital which have been or will be paid by the state at no charge to the Hospital's designated accounts with the university.

Presented as BFA Attachment C are the 2012 and 2011 certified financial statements of Stony Brook Foundation, Inc. and Affiliate. As shown, they had an average positive working capital position and an average positive net asset position from 2011 through 2012. Also, they achieved an average income of $71,274,976 from 2011 through 2012. This is where the Philanthropic gift for the non-article 28 portion of the overall project, is to be derived.

Presented as BFA attachment D is the 2011-2020 current and projected financial statements of Stony Brook University Hospital. As shown, the hospital has projected to maintain an average positive working capital position and an average positive net asset position during the period 2013-2020. Also, the hospital projects to achieve an average excess of revenues over expenses of $12,400,250 during the period 2013-2020. This appears reasonable based on the prior years' operations, which included the facility receiving state appropriations. This money is not guaranteed and is only a projection of what will be provided by the State of New York in the future and what will be needed by the facility in the future to remain financially feasible.

Based on the preceding, and subject to the noted contingency, 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 contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary- certified 2010-2011 financial statement for Stony Brook University Hospital Stony Brook University
BFA Attachment B	Financial Summary- Internal 2012 - Stony Brook University Hospital Stony Brook University
BFA Attachment C	Financial Summary- 2011-2012 certified financial statement for Stony Brook Foundation, Inc. and Affiliate
BFA Attachment D	Financial Summary-2011-2020 historical and projected financial statements of Stony Brook University Hospital Stony Brook University
BFA Attachment E	MART and Bed Tower Project Unit Breakout by Floors
BFA Attachment F	Financing Breakout for the Article 28 and Non-Article 28 Sections of the Project

Public Health and Health Planning Council

Project # 122303-C

Northern Dutchess Hospital

County: **Dutchess County (Rhinebeck)**
Purpose: **Construction**

Program: **Hospital**
Submitted: **December 21, 2012**

Executive Summary

Description

Northern Dutchess Hospital (NDH), a 68-bed not-for-profit hospital in Rhinebeck, requests approval to construct a new four-story building to replace 40 Medical-Surgical beds and six replacement operating rooms. Significant project components include:

- Add new four-level, 81,500 square foot building.
- Ground floor will act as a link to the loading dock of the existing NDH building allowing for the transfer of clean and soiled materials.
- First floor will house non-Article 28 leased medical office space.
- Second floor will hold 40 medical-surgical beds. All beds will be in single-bedded rooms.
- Third floor will hold an operating suite containing six operating rooms, eight recovery bays, one isolation bay and fifteen prep/recovery bays with associated staff and support space.

The financing of this project will be through Kirchhoff Medical Properties, LLC (KMP), a developer company that will lease the underlying land from the Hospital and construct the new building. The Hospital will lease the ground, second and third floors from the developer/ owner of the building. Both leases will have a 35 year period. Beginning in year 26 of the lease term and over a 10 year period, Kirchhoff Medical properties, LLC will gift the entire entity to NDH at 10% per year and at the end of the 35 year term, will be owned by NDH.

DOH Recommendation

Contingent approval.

Need Summary

Because this project will involve no change in the hospital's beds or services, no Need recommendation is required.

Program Summary

From a programmatic perspective, approval is recommended.

Financial Summary

The project costs of $40,383,894 associated with this application will be met with $9,100,000 equity from Health Quest, $6,283,894 equity from Kirchhoff Medical Properties, LLC, the developer, and a $25,000,000 developer loan that Kirchhoff Medical Properties, LLC will incur.

Budget:	$76,683,691
	72,368,381
	$4,315,310

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA review of this project.

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 an executed ground lease that is acceptable to the Department of Health. [BFA]
3. Submission of an executed lease agreement that is acceptable to the Department of Health. [BFA]

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 or be disrupted by 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, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction [AER].
6. The applicant shall complete construction by August 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

June 6, 2013.

Programmatic Analysis

Program Description

Northern Dutchess Hospital requests approval for a new building, to be connected to the existing building, to house medical surgical beds, operating rooms and surgery prep/recovery space, and staff and support space. The building is to be constructed by a developer. The first floor of the building will be leased out by the developer and will not include any hospital services, but is intended to be leased to private physician practices.

There proposal does not include any additional beds or services but will update space to best serve patients under current medical practice. However, the hospital anticipates staffing will increase by 16 FTEs after the first year of occupancy.

Compliance with Applicable Codes, Rules and Regulations

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.

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

Ground Lease

The applicant has submitted a proposed ground lease agreement, the terms of which are summarized below:

Premises:	Land located at Montgomery Street and Springbrook Ave.,Rhinebeck, New York 12571
Landlord:	Northern Dutchess Hospital
Tenant:	Kirchhoff Medical Properties, LLC
Rental:	Years 1-5, $100,000 annually with 10% escalation each five year increments.
Term:	35 Year Lease
Provisions:	Tenant is responsible for taxes and general liability insurance.

Lease Agreement

The applicant has submitted a proposed lease agreement, the terms of which are summarized below:

Premises:	Building to be constructed on land located at Montgomery Street and Springbrook Ave., Rhinebeck, New York 12571
Landlord:	Kirchhoff Medical Properties, LLC
Tenant:	Northern Dutchess Hospital
Rental:	Years 1-5, $1,800,000 annually with 10% escalation each five year increments.
Term:	35 Year Lease
Provisions:	Tenant is responsible for maintenance, insurance and utilities.

Total Project Cost And Financing

Total project cost for the new construction and moveable equipment is estimated at $40,383,894, broken down as follows:

New Construction	$21,295,539
Site Development	2,045,728
Design Contingency	2,334,125
Construction Contingency	1,889,751
Planning Consultant Fees	40,000
Architect/Engineering Fees	1,816,500
Construction Manager Fees	1,121,077
Other Fees	2,327,161
Moveable Equipment	5,791,640
Telecommunications	400,000
Financing Costs	642,763
Interim Interest Expense	490,000
CON Application Fee	2,000
CON Additional Processing Fee	187,610
Total Project Costs	$40,383,894

The Bureau of Architectural and Engineering Facility Planning has determined that this project includes non-Article 28 space costs for physician medical offices of $6,083,451. As a result, the total approved project cost for reimbursement purposes shall be limited to $34,300,443.

Project cost is based on construction start and completion dates of June 1, 2013 and August 1, 2014, respectively.

The applicant's financing plan is as follows:

Equity-Northern Duchess Hospital	$9,100,000
Equity-Developer	$6,283,894
Developer's Financing (3%, 1.5 years)	$25,000,000

The financing of this project will be through Kirchhoff Medical Properties, LLC (KMP), a developer company that will lease the underlying land from the Hospital and construct the new building. The Hospital will lease the ground, second and third floors from the developer/ owner of the building. Both leases will have a 35 year period. Beginning in year 26 of the lease term and over a 10 year period, Kirchhoff Medical properties, LLC will gift the entire entity to NDH at 10% per year and at the end of the 35 year term, will be owned by NDH.

The developer has submitted current bank statements attesting to sufficient equity funds and has provided a certified public accountants' statement for net worth purposes to back-up the financing. A letter of interest from M&T bank has been submitted for a construction loan and the financing will then be converted to a term loan or taxable 30 year bonds @ 5.5% interest.

Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, for the first and third years of operation. The budget is summarized below:

	Year One	*Year Three*
Revenues:		
Patient Revenues	$74,003,508	$74,304,552
Other Revenues*	2,379,139	2,379,139
Total Revenues	$76,382,647	$76,683,691
Expenses:		
Operating	$64,786,911	$64,818,523
Capital	7,549,858	7,549,858
Total Expenses:	$72,336,769	$72,368,381
Excess Revenues:	$4,045,878	$4,315,310

Utilization: Discharges	16,029	16,049
Outpatient Visits	71,772	71,852

*Other Revenues represent Cafeteria Sales, rental Income from Wellness Center and Affiliate revenues.

Utilization by payor source for the first and third year of operation is anticipated as follows:

	Inpatient Services	Outpatient Services
Commercial Fee-for-Service	15.6	23.0
Commercial Managed Care	20.5	22.6
Medicare Fee-for-Service	46.7	25.3
Medicare Managed Care	6.0	5.0
Medicaid Fee-for-Service	1.4	2.7
Medicaid managed Care	7.0	9.0
Private Pay/Other	2.8	12.4

Expense and utilization assumptions are based on the historical experience of the Hospital.

Capability and Feasibility

Total project cost will be funded by $25,000,000 financing by the developer and the remainder, $15,383,894 will be provided as equity from the hospital and the developer. Health Quest has stated that they will help provide the $9,100,000 equity portion for this project. Presented as BFA Attachment B, is a financial summary of Health Quest and Northern Duchess Hospital, which indicates the availability of sufficient resources for this project.

Excess revenues for year one and year three are projected at $4,045,878 and $4,315,310, respectfully. DOH staff has sensitized third year budgets to reflect lease payment based on a 3% present value, therefore increasing net income by an additional $111,938. Revenues reflect current payment rates, adjusted for volume increases. Presented as BFA Attachment D, is the summary of the detailed budgets. The budget appears reasonable.

As shown on BFA Attachment A and B, the hospital has maintained positive working capital and net asset positions, and generated an average annual net operating revenue excess of $8,978,000 in 2011 and $4,565,000 as of September 30, 2012.

Subject to the noted contingencies, it appears the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary – Northern Dutchess Hospital-2011
BFA Attachment B	Financial Summary – Northern Dutchess Hospital-Health Quest, September 30,2012
BFA Attachment C	Financial Summary- Health Quest- 2011
BFA Attachment D	Summary of Detailed Budgets

Public Health and Health Planning Council

Project # 131101-C

Montefiore Medical Center - Jack D Weiler Hospital of A Einstein College Division

County: **Bronx County (Bronx)**
Purpose: **Construction**

Program: **Hospital**
Submitted: **February 20, 2013**

Executive Summary

Description

Montefiore Medical Center Weiler Hospital (Weiler), which is part of the overall Montefiore Medical Center, a 1,491-bed not-for-profit hospital has submitted a CON requesting approval to renovate and recertify an inpatient medical/surgical unit comprised of 21 beds, which will be located on the 7th Floor at the Weiler Hospital. Currently, the space is a closed medical/surgical inpatient unit that will require recommissioning and capital renovations and the relocation of the current occupants, who are using the space as offices. The facility is requesting permission to renovate and recertify this space in the existing building in order to house this new unit, due to the closure of Westchester Square's Medical/Surgical Inpatient beds, which was contingently approved by PHHPC on February 21, 2013 per CON 131015.

The closure of Westchester Squares' 140 medical surgical beds means that the patients that would have been seen there need to be seen at other hospital facilities in the area. As Weiler is in close proximity to Westchester Square, and due to the overlap of medical staff between Montefiore and Westchester Square, Montefiore expects to receive about half of these inpatient admissions for the year, which is approximately 2,500 admissions or 500 inpatient surgeries based on an average length of stay of 5.1 days. Currently, The Weiler hospital has 264 Medical /Surgical beds and the Montefiore Medical Center in totality has 1,039 Medical/Surgical beds. With this project, Weiler will increase from 264 medical surgical beds to 285 medical surgical beds and Montefiore Medical Center in totality will increase from 1,039 medical surgical beds to 1,060 medical surgical beds. Weiler's total bed capacity will increase from 403 to 424 beds, while the total bed capacity of Montefiore Medical Center as a whole will increase from 1,491 to 1,512 beds.

This project will involve the renovation of 7,800 square feet of space on the north end of the 7th floor of Weiler. This space was formerly an inpatient medical/surgical unit that is currently used as office space

DOH Recommendation

Contingent approval

Need Summary

The request to add additional beds at Montefiore Medical Center - Jack D Weiler Hospital of Einstein College is supported by the high occupancy rates exhibited at the hospital over the last three years. The additional beds will allow the hospital's medical/surgical unit to operate closer to the optimum planning level and provide capacity to absorb some of the patients that Montefiore expects to inherit due to the closure of New York Westchester Square Medical Center.

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 of $4,717,795 will be met entirely from equity from Montefiore Medical Center.

Incremental Budget:	Revenues:	$ 17,070,160
	Expenses:	9,956,237
	Gain:	$ 7,113,923

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

Recommendations

Health Systems Agency

There will be no HSA recommendation of 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. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

Approval conditional upon:

1. Per 711.9 approval of waiver with justification for existing two-bedded rooms or revision of project scope and cost to eliminate or revise bed locations as necessary. [AER]
2. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's 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

June 6, 2013.

Need Analysis

Background

Montefiore Medical Center – Jack D Weiler Hospital of Einstein College, a 403-bed acute care facility located at 1825 Eastchester Road, Bronx, 10461, in Bronx County, seeks approval to renovate and certify a 21-bed inpatient medical/surgical unit and to add 21 net new beds to its operating certificate. When this CON is completed, the total number of certified inpatient beds at Montefiore Weiler will be 424.

Need Summary

Montefiore Medical Center – Jack D Weiler Hospital of Einstein College is a member of Montefiore Health System, Inc., which includes two (2) other acute care facilities, Montefiore Medical Center - Henry & Lucy Moses Division and Montefiore Medical Center - North. Montefiore Weiler seeks CON approval to add an additional 21 medical/surgical beds, bringing its total number of certified inpatient beds to 424. These beds are being requested in order to address the high occupancy rates that the hospital has been experiencing.

Montefiore Medical Center – Jack D Weiler Hospital of Einstein College has the following certified beds and services:

Table 1: Montefiore Medical Center – Jack D Weiler Hospital of Einstein College: Certified Beds by Service

Bed Category	Certified Capacity	Requested Action	Certified Capacity Upon Completion
Coronary Care	10		10
Intensive Care	22		22
Maternity	50		50
Medical / Surgical	264	+21	285
Neonatal Continuing Care	9		9
Neonatal Intensive Care	11		11
Neonatal Intermediate Care	15		15
Physical Medicine and Rehabilitation	22		22
Total	403	+21	424

Table 2: Montefiore Medical Center – Jack D Weiler Hospital of Einstein College: Certified Services. Source: HFIS, April 2013.

Ambulatory Surgery - Multi Specialty	CT Scanner
Cardiac Catheterization - Adult Diagnostic	Cardiac Catheterization - Electrophysiology (EP)
Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)	Cardiac Surgery - Adult
Clinical Laboratory Service	Coronary Care
Emergency Department	Health Fairs O/P
Intensive Care	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	Pharmaceutical Service
Physical Medical Rehabilitation	Radiology - Diagnostic
Radiology-Therapeutic	Renal Dialysis - Acute
Renal Dialysis - Chronic	Therapy - Speech Language Pathology
Transplant - Kidney	

New York State Designation:

- Regional Perinatal Center; and
- Stroke Center.

Montefiore Medical Center seeks to add 21 additional inpatient medical/surgical beds to its Weiler campus in order to reduce the high occupancy rates that the hospital has been experiencing. The hospital also expects to use the additional beds to absorb a portion of the anticipated inpatient

admissions/discharge it will receive due to the closure of inpatient services at New York Westchester Square Medical Center.

Analysis/Discussion

Since 2010, Montefiore Weiler has discharged an average of 27,794 total inpatient discharges a year. On average, about 91.0 percent of these discharges originated in Bronx County. In 2000, the total census for Bronx County was 1,332,650. By 2010, the census increased by 3.9 percent to 1,385,108. The county's total population estimates for 2012 is 1,408,473 residents. By the next census period, Bronx County's total population is projected to increase by 5.0 percent over the 2010 census period, to 1,453,970.

Seventy nine percent of Montefiore Weiler's inpatient beds are allocated to the major service category medical/surgical. Over the last three years, an average of 18,647 patients received inpatient medical/surgical services at the hospital. In 2010, these patients generated an average daily census (ADC) of 282 patients on any given day; by 2011, the ADC increased to 296 and stood at 299 in 2012. The accompanying average length of stay (ALOS) was 5.4 days in 2010 and increased to 5.7 and 6.0 days in 2011 and 2012, respectively.

In 2010, Montefiore Weiler's occupancy rate for the major service category of medical/surgical was 88.7 percent. By 2011, it increased to 93.1 percent and in 2012 it stood at 94.1 percent. During the same period, the hospital's overall occupancy rates were 89.3 percent, 91.7 percent and 92.0 percent, respectively (Table 3). This is consistently higher than the planning optimum of 85 percent.

Table 3: Montefiore Medical Center - Jack D Weiler Hospital of A Einstein College: Inpatient Utilization by Major Service Category.
*Source: SPARCS 2010 - 2012**

Service	2010	2011	2012	Current Beds
Discharges				
Medical/Surgical	18,945	18,821	18,175	
Obstetric	5,037	4,841	4,643	
High Risk Neonates	463	472	492	
Subtotal	24,549	24,231	23,425	
Healthy Newborns	3,802	3,346	3,453	
Grand Total	28,351	27,577	26,878	
Average Daily Census				
Medical/Surgical	282	296	299	
Obstetric	46	44	43	
High Risk Neonates	30	28	27	
Subtotal	360	370	371	
Healthy Newborns	28	24	28	
Grand Total	388	393	398	
Average Length of Stay				
Medical/Surgical	5.4	5.7	6.0	
Obstetric	3.4	3.3	3.3	
High Risk Neonates	23.3	21.5	20.3	
Subtotal	5.3	5.6	5.8	
Healthy Newborns	2.7	2.6	2.9	
Grand Total	5.0	5.2	5.4	
Occupancy Based on Current Beds				

Table 3: Montefiore Medical Center - Jack D Weiler Hospital of A Einstein College: Inpatient Utilization by Major Service Category.
*Source: SPARCS 2010 - 2012**

Service	2010	2011	2012	Current Beds
Medical/Surgical	88.7	93.1	94.1	318
Obstetric	92.6	88.2	85.0	50
High Risk Neonates	84.3	79.7	78.0	35
Total	89.3	91.7	92.0	403

Montefiore Weiler also provided a substantial amount of Emergency Department (ED) care. In 2010, the hospital recorded 71,429 total ED visits; in 2012, ED visits increased by 3.9 percent to 74,212. During the period, approximately 21.0 percent of the hospital's total ED visits resulted in an inpatient admission (Table 4).

Table 4: Montefiore Medical Center - Jack D Weiler Hospital of A Einstein College: Emergency Department Visits. Source: SPARCS 2010 - 2012

Year	Total Emergency Department Visits	Percent of ED Visits Resulting in an Inpatient Admission
2010	71,429	20.9
2011	71,756	20.8
2012	74,212	20.5

SPARCS inpatient data for the years under review show that the facility's medical/surgical occupancy rates exceeded the desired planning optimum level of 85.0 percent. In 2010, Montefiore's medical/surgical occupancy rate was 3.7 percentage points above the desired planning optimum rate. By 2012, the hospital's medical/surgical occupancy rate was 9.1 points above the planning optimum level.

Conclusion

The proposed addition of 21 medical/surgical beds would help to lower the unduly high medical/surgical bed occupancy rate at the Montefiore Weiler facility and bring it closer to the 85 percent planning optimum.

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Background

Renovate and recertify an inpatient medical/surgical unit comprised of 21 beds located on campus. This project is the first phase of a plan to expand the acute medical/surgical bed capacity at the Weiler Hospital. The unit will include seven (7) semi-private rooms and three (3) single bed isolation rooms, with one isolation room outfitted for a bariatric patient.

Staffing will consist of 86.4 FTEs, including registered nurses and technicians, under the supervision of the Center's medical director. Staffing has been projected to remain at 86.4 FTEs by the third year of operation.

Compliance with Applicable Codes, Rules and Regulations

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

Project Cost and Financing

Total project cost, which is for Renovations and the acquisition of movable equipment, is estimated at $4,717,795, further itemized as follows:

Renovation & Demolition	$2,500,000
Design Contingency	125,000
Construction Contingency	125,000
Architect/Engineering Fees	120,000
Other Fees	100,000
Movable Equipment	1,600,000
Telecommunications/IT	120,000
CON Fees	2,000
CON Additional Fees	25,795
Total Project Cost	$4,717,795

The facility intends to fund total project cost with equity from existing resources.

Equity	$4,717,795

The construction start date is July 1, 2013 with an 8 month construction period.

Operating Budget

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first and third years of operation, summarized below:

	Year One and Three
Revenues:	$17,070,160
Expenses:	
Operating:	$9,584,384
Capital:	$ 371,853
Total Expenses:	$9,956,237
Excess Revenues:	$7,113,923
Utilization: (Discharges)	1,270
Cost Per Discharge:	$7,839.56

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

	Years One and Three
Commercial Fee-for-Service	9.45%

Commercial Managed Care	7.40%
Medicare Fee-for-Service	32.05%
Medicare Managed Care	28.11%
Medicaid Fee-for-Service	9.05%
Medicaid Managed Care	12.28%
Other	0.47%
Charity Care	1.19%

Expense and utilization assumptions are based on the experience of the present operator.

Capability and Feasibility

The issue of capability centers on the applicant's ability to meet the total project cost. Presented as BFA Attachment A, is the 2010-2011 financial summary of Montefiore Medical Center, which indicates the availability of sufficient resources.

The working capital requirement is estimated at $1,659,373, based on two months' of third year expenses. The facility will provide the full amount through equity. As presented on BFA Attachment A, the 2010-2011 financial summary for Montefiore Medical Center, the facility has sufficient resources to fund both the project and the required working capital.

The issue of feasibility is centered on the applicant's ability to meet expenses with revenue and maintain a viable operating entity. The submitted budget indicates an excess of Revenues over Expenses of $7,113,923 during both the first and third years of operation.

BFA Attachment A is comprised of the 2010-2011 certified financial statements of Montefiore Medical Center. As shown, the facility has maintained an average positive working capital position and has maintained an average positive net asset position and has had a positive average net operating revenue of $83,252,000 for the period shown.

BFA Attachment B is comprised of the1/1/2012-11/30/2012 internal financial statements for Montefiore Medical Center. As shown, the facility has maintained an average positive working capital position and has maintained an average positive net asset position and has positive net operating revenue of $93,150,000 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- 2010-2011 Montefiore Medical Center
BFA Attachment B	Financial Summary –Internal 1/1/2012-11/30/2012 Montefiore Medical Center

Public Health and Health Planning Council

Project # 131114-C

Brookhaven Memorial Hospital Medical Center, Inc.

County: **Suffolk County (Patchogue)** ***Program:*** **Hospital**
Purpose: **Construction** ***Submitted:*** **February 26, 2013**

Executive Summary

Description

Brookhaven Memorial Hospital Medical Center (BMHMC), a 30-bed not-for-profit acute care facility located at 101 Hospital Road, Patchogue, requests approval for the construction of an addition to the main hospital building and additional renovations to provide a suite to centralize the PCI/EPS cardiac catheterization labs (Cath Labs), and provide new space for a new four room operating suite and Post Anesthesia Care Unit (PACU), to be named The Knapp Cardiac Center. BMHMC has been approved to provide diagnostic cardiac catheterization services through CON 021189 and the need for the cath labs has already been approved by the Department under CON 111326 to include PCI/EPS cath lab services. The current application will combine these services into one permanent suite for a long-term solution for enhanced, efficient and improved patient care.

The newly constructed addition will be on the north side of BMHMC's Emergency Department and will be a three-story building with a mechanical penthouse. The first floor will consist of new storage, mechanical, electrical and engineering rooms. The new Knapp Cardiac Center will be on the second floor, along with shell space for two PCI/EPS labs in the future and a new lobby and common area. The third floor will consist of the four-room Operating Suite and Post Anesthesia Care Unit.

DOH Recommendation

Contingent approval

Need Summary

Brookhaven Memorial Hospital Medical Center is certified to provide Cardiac Catheterization - Adult Diagnostic services. Via Project 111326, the hospital received permission to expand its licensed cardiac services and added adult PCI emergency and adult PCI elective services to its operating certificate, as well as adult intervention and adult diagnostic cardiac electrophysiology study services. The completion of this CON project # 131114 will allow BMHMC to create a permanent centralized suite for its cardiac services.

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 be met with $18,555,640 in cash, $4,800,000 in fundraising, $2,700,000 in HEAL Grant-Phase 4 and a $35,000,000 mortgage over 20 years @ 5.5% .

Incremental Budget:	Revenues:	$16,004,753
	Expenses:	12,462,578
	Gain:	$ 3,542,175

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

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 a commitment for a permanent mortgage for the project to be provided from a recognized lending institution, at a prevailing rate of interest, determined to be acceptable by the Department of Health. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment, must be a Sources and Uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
3. Submission of the executed HEAL Phase 4 Grant amended contract acceptable to the Department of Health. [BFA]
4. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

Approval conditional upon:

1. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
2. The applicant shall complete construction by March 7, 2016 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

June 6, 2013.

Need Analysis

Background

Brookhaven Memorial Hospital Medical Center (BMHMC) is a 306-bed acute care hospital located at 101 Hospital Road, Patchogue, 11772, in Suffolk County. The facility seeks approval to construct an addition to the hospital's main building in order to create a centralized suite for cardiac services and four (4) net new operating rooms (ORs).

Brookhaven Memorial Hospital Medical Center has the following certified beds and services:

Table 1: Brookhaven Memorial Hospital Medical Center: Certified Beds. Source: HFIS, April 2013.

Bed Category	Certified Capacity
Coronary Care	7
Intensive Care	17
Medical / Surgical	252
Pediatric	10
Psychiatric	20
Total	306

Table 2: Brookhaven Memorial Hospital Medical Center: Certified Services. Source: HFIS, April 2013.

Ambulatory Surgery - Multi Specialty	CT Scanner
Cardiac Catheterization - Adult Diagnostic	Certified Mental Health Services O/P
Clinical Laboratory Service	Coronary Care
Emergency Department	Health Fairs O/P
Intensive Care	Lithotripsy
Magnetic Resonance Imaging	Maternity
Medical Social Services	Medical/Surgical
Nuclear Medicine - Diagnostic	Nuclear Medicine - Therapeutic
Pediatric	Pharmaceutical Service
Primary Medical Care O/P	Psychiatric
Radiology - Diagnostic	Renal Dialysis - Acute
Renal Dialysis - Chronic	Therapy - Speech Language Pathology

Brookhaven Memorial Hospital Medical Center is authorized to operate seven (7) hospital extension clinics whose services include Renal Dialysis - Chronic O/P, Home Peritoneal Dialysis Training and Support, Physical Medicine and Rehabilitation O/P, Radiology - Diagnostic O/P, CT scanner, Magnetic Resonance Imaging, Primary Medical Care O/P, Certified Mental Health Services O/P and Chemical Dependence - Rehabilitation O/P.

The hospital also has the following State designations:

- Area Trauma Center; and
- Stroke Center.

Analysis

SPARCS inpatient data for 2010 - 2012 showed that Brookhaven Memorial Hospital Medical Center discharged an average of 15,372 patients a year. Of these, approximately 98.0 percent were residents of Suffolk County. The 2000 census for Suffolk County was 1,419,369 residents; by 2010, this increased by 5.2 percent, to 1,493,350. The county is projected to reach 1,530,550 residents by 2020. The 2012 estimates for Suffolk County are 1,499,273 residents or 5.6 percent above the 2000 census.

The hospital is licensed to operate 306 total beds; of these, 90 percent are allocated to the major service category medical/surgical. The average daily census (ADC) for this bed category was 213 patients on any given day, for an average occupancy rate of 77.3 percent.

In 2012, BMHMC performed 291 catheterization procedures. The hospital indicates that 88 of those cases required PCI. BMHMC states that 42 percent of the PCI procedures were performed at Winthrop University Hospital, its cardiac surgery affiliate.

BMHMC's inpatient surgical cases and Ambulatory Surgery procedures performed from 2009 – 2011 averaged 13,780 procedures per year using its seven ORs. Based on the NYSDOH standard of 800 – 1,200 procedures per operating room per year the BMHM request for four additional ORs is reasonable.

The hospital indicates that the implementation of this project will result in the following:

- Capacity to accommodate the latest operating room equipment and provide state-of-the-art care for all surgical patients.
- A permanent, centralized suite for BMHMC's PCI/EPS cardiac catheterization laboratories;
- Enhanced access to PCI and diagnostic catheterization laboratory and EPS procedures for all residents in the service area;
- Improved cardiac health outcomes for Suffolk County residents;
- Gain in efficiency of BMHMC's cardiac services via the consolidation of the hospital's catheterization laboratories into a single contiguous suite;

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Brookhaven Memorial Hospital Medical Center Inc., a hospital, requests approval to construct an addition to the main building creating a centralized suite for cardiac services and four (4) new operating rooms. The center will have two (2) catheterization labs and one (1) EPS lab (that will also be able to provide catheterization procedures). There will also be two (2) shell spaces for future PCI/EPS labs, as the need arises (to be utilized upon subsequent application for approval).

Staffing will increase by 16.67 FTEs the first year after completion and by 31.67 FTEs by the third year of operation.

Compliance with Applicable Codes, Rules and Regulations

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 cost for new construction, renovations and the acquisition of moveable equipment is estimated at $61,055,640 itemized as follows:

New Construction	$27,516,112
Renovation and Demolition	5,841,888
Site Development	1,482,000
Design Contingency	3,120,000
Construction Contingency	1,950,000
Fixed Equipment	11,686,111
Architect/Engineering Fees	2,704,000
Moveable Equipment	260,668
Construction Manager Fees	2,815,339
Telecommunications	741,052
Other Professional Fees	10,400
Financing Costs	350,000
Interim Interest Expense	2,245,833
CON Application Fee	2,000
CON Processing Fee	330,237
Total Project Cost	$61,055,640

Project costs are based on a January 1, 2014 construction start date and an approximate twenty-six month construction period. The applicant's financing plan is as follows:

Equity	$ 18,555,640
Fundraising	4,800,000
HEAL GRANT- Phase 4	2,700,000
Mortgage @ 5.5%, 20 years	35,000,000

A letter of interest from TD Bank, N.A. has been submitted by Brookhaven Memorial Hospital Medical Center.

The Bureau of Architectural and Engineering Facility Planning has determined that this project includes shell space costs of $680,378 for future expansion.
As a result, the total approved project cost for reimbursement purposes shall be limited to $60,375,262 until such time as the shell space is approved for use (under a future CON) by the Department.

Operating Budget

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first and third years, summarized below:

	YEAR ONE	YEAR THREE
	$11,475,912	$16,004,753
Revenues		
Expenses:		
Operating	$ 5,765,414	$ 8,192,914
Capital	4,383,116	4,269,664
Total Expenses	$10,148,530	$12,462,578
Net Income(Loss)	$1,327,382	$3,542,175
Utilization:		
Inpatient (Discharges)	624	866
Outpatient (Visits)	854	1,277

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

INPATIENT	YEAR ONE	YEAR THREE
Commercial Fee for Service	9%	6%
Commercial Managed Care	9%	12%
Medicare Fee for Service	28%	22%
Medicare Managed Care	19%	25%
Medicaid Managed Care	14%	13%
Charity Care	6%	5%
Other*	15%	17%

OUTPATIENT	YEAR ONE	YEAR THREE
Commercial Fee for Service	10%	6%
Commercial Managed Care	10%	13%
Medicare Fee for Service	24%	20%
Medicare Managed Care	20%	26%
Medicaid Managed Care	9%	10%
Charity Care	4%	3%
Other*	23%	22%

*Other utilization includes Self-Pay and Blue Cross.

Expense and utilization assumptions are based on the hospital's historical experience in the operation of its existing cath labs and operating rooms.

Capability and Feasibility

Project cost of $61,055,640 will be met with $18,555,640 in accumulated funds, $4,800,000 in fundraising from the BMH Foundation's temporarily restricted funds, $2,700,000 from the HEAL Grant-Phase 4 and the remaining $35,000,000 from a mortgage at stated terms. A letter of interest from TD Bank, N.A. has been submitted by Brookhaven Memorial Hospital Medical Center. Presented as BFA Attachment A is the financial summary for BMHMC, which indicates the availability of sufficient equity funds.

The submitted incremental budget projects an excess of revenues over expenses for the first and third years of $1,327,382 and $3,542,175, respectively. Revenues reflect the hospital's current payment rates. The budget appears reasonable.

BFA Attachment A, financial summary of BMHMC shows that the facility has maintained positive working capital and net asset positions and generated an annual gain from operations of $43,359 in 2012 and a loss from operations of $4,236,445 in 2011. The 2011 operational loss is due to the $3,100,000 in additional expense of a health care consulting firm to improve hospital operations and a one-time accounting error from 2005 booked in 2011. The applicant indicates that the remaining $1,136,445 was due to deficient cost controls and over spending. As a result of the consulting firm's analysis, BMHMC implemented cost reductions and turned around the Hospital's operating position in 2012.

Based on the proceeding, and subject to noted contingencies, it appears the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary, Brookhaven Memorial Hospital Medical Center, 2011/2012
BFA Attachment B	Detailed Budgets

Public Health and Health Planning Council

Project # 121238-C
Visiting Nurse Service of Schenectady and Saratoga Counties

County: **Schenectady County (Schenectady)** ***Program:*** **Certified Home Health Agency**
Purpose: **Construction** ***Submitted:*** **April 18, 2012**

Executive Summary

Description
Visiting Nurse Service of Schenectady and Saratoga Counties (VNS), an existing not-for Profit Corporation located at 108 Erie Boulevard, Schenectady, NY, which operates a full service Certified Home Health Agency (CHHA), is requesting to expand their existing certified home health agency (CHHA) into Albany, Schoharie, Warren, Franklin and Essex Counties. Ellis Hospital d/b/a Ellis Medicine is the sole corporate member of the Visiting Nurse Services of Schenectady and Saratoga Counties (VNS).

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. VNS submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval

DOH Recommendation
Approval

Program Summary
This proposal seeks approval to expand the existing Certified Home Health Agency (CHHA) operated by Visiting Nurse Service Association of Schenectady County, Inc., d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties, which has current approval to serve Schenectady and Saratoga Counties, to include approval to serve Albany, Schoharie, Warren, Essex, and Franklin Counties, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:	Revenues:	$9,121,152
	Expenses:	5,713,701
	Gain(Loss):	$3,407,451

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Visiting Nurse Service Association of Schenectady County, Inc., d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties is an existing not-for-profit corporation that operates an Article 36 Certified Home Health Agency and a Long Term Home Health Care Program with approval to serve Schenectady and Saratoga counties. The applicant is requesting approval to expand the service area of their Certified Home Health Agency to include Albany, Essex, Franklin, Schoharie and Warren counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;

Knowledge and experience in the provision of home health services;

Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;

Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Visiting Nurse Service of Schenectady and Saratoga Counties is part of a hospital-based integrated health care system that provides services in the counties currently served by the applicant and the proposed expanded service area. The applicant is a component corporation of Ellis Medicine of Schenectady, which includes acute care hospitals, a residential health care facility, a CHHA, a LTHHCP, and multiple ambulatory care sites.

Visiting Nurse Service of Schenectady and Saratoga Counties currently operates a Medicaid Health Home that serves Saratoga and Schenectady counties. They implemented care transition programs with local insurers; provide care management and enrollment services for VNSNY Choice MLTCP and they have contracts with several existing MLTCPs. They also discussed partnering with other CHHAs, LTHHCPs and hospitals to form an IPA to coordinate health services; and collaborating with Ellis Hospital and The Community Hospice to provide cost effective palliative care services.

The applicant provided demographic statistical data on age, ethnicity, gender, income, and diagnoses/health status indicators. They discussed in-and out-migration of services to participants in the proposed counties and how Ellis Hospital serves patients in these counties.

The applicant has an understanding of the cultural and socioeconomic characteristics of the Capital Region's diverse population. They discussed the development of culturally sensitive outreach programs and bilingual/bicultural programs that will be offered for patients in the expanded CHHA service area. The applicant has a strong history of serving low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly.

The applicant will utilize a Health Information Technology system, including electronic charting, reporting, and networking and communication tools. The CHHA is currently in discussions with the HIXNY system, which is a collaboration of health plans, hospitals, physician practices and other entities in a 17-county geographic area comprising the Capital Region and Northern New York. HIXNY has built an interoperable network to electronically share patient medical information more efficiently for the benefit of healthcare consumers. This will assist with the transmittal of information in real time. Communication with a variety of providers will reduce fragmentation and allow for continuity of care, which will improve quality and reduce acute admissions.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Visiting Nurse Service Association of Schenectady County, Inc., d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties, is an existing not-for-profit corporation that operates a CHHA and a LTHHCP located at 108 Erie Boulevard, Schenectady, New York 12305 (Schenectady County). Both the CHHA and LTHHCP are currently approved to serve Schenectady and Saratoga Counties from the Schenectady practice location. Pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, Visiting Nurse Service Association of Schenectady County, Inc., d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties, seeks approval to expand its CHHA only, by adding approval to serve Albany, Schoharie, Warren, Essex, and Franklin Counties. The CHHA will continue to be located at its current main parent office practice location of 108 Erie Boulevard, Schenectady, New York 12305 (Schenectady County) to serve Schenectady, Saratoga, Albany, and Schoharie Counties, and plans to establish a new additional branch office practice location in Essex County to serve Warren, Essex, and Franklin Counties.

Visiting Nurse Service Association of Schenectady County, Inc., d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties, will continue to provide the following home health care services: home health aide; medical social services; medical supplies, equipment, and appliances; nursing; nutritional services; occupational therapy, personal care; physical therapy, and speech language pathology.

Visiting Nurse Service Association of Schenectady County, Inc., d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties, is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Revenues:		
Medicaid	$436,142	$1,418,551
Medicare	2,071,762	6,738,384
Commercial	296,454	964,217
Total Revenues	$2,804,358	$9,121,152
Expenses	$2,028,379	$5,713,701
Net Gain(Loss)	$775,979	$3,407,451

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

Payor	**Years One and Three**
Commercial	9.40%
Medicare	54.01%
Medicaid	34.50%
Charity Care	2.10%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates, as well as the implementation of the Medicaid Episodic Payment system.

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at $952,284, which appears reasonable based on two months of third year expenses and will be provided through the existing operation. Based on the review of BFA Attachment A, it appears that VNS does not have enough capital to cover their incremental working capital requirements. However ,based on review of BFA Attachment B, the financial statements for the sole corporate member of VNS, Ellis Hospital d/b/a Ellis Medicine, it appears that Ellis Hospital has the capital necessary to fund the working capital requirements. The Department has received a letter of support in which Ellis Hospital has agreed to furnish any needed additional working capital for VNS.

The submitted budget indicates that the applicant will achieve incremental net revenue in the first and third years of operations of $775,979 and $3,407,451, respectively. Revenue is based on current payment rates for Certified Home Health Agencies.

Presented as BFA Attachment A, is the audited financial summary of the Visiting Nurse Service Association of Schenectady County, d/b/a Visiting Nurse Service of Schenectady and Saratoga counties for 2011-2012. The financial statements show that the applicant has maintained a positive working capital position and a negative net asset position and achieved an average net loss of $55,504 for the period 2011 through 2012. The loss is from 2012 and is due to the new operation called Care Central, which is a Health Home that opened in 2012.

The initial operating outlay for the facility was $625,000. Care Central is the DOH awarded Health Home, part of the State Plan Amendment (#11-56) filed in 2011 by the state to take advantage of the Federal Affordable Care Act. Care Central, a d/b/a of the VNS, was licensed in January of 2012. This program is administratively recorded on the financial statements of the VNS, while it is a partnership of over 50 health and health plan partners. It is unrelated to the operations of the CHHA and LTHHCP. It is also noted this is not a cash loss, as the employees of Care Central are Ellis Hospital employees. Therefore, without this extraordinary one-time event, the facility would have had a net income of $369,257 for 2012.

BFA Attachment B is the audited financial summary of Ellis Hospital (d/b/a Ellis Medicine) for 2011-2012. The financial statements show that the applicant has maintained a positive working capital position and a positive net asset position and achieved an average net income of $8,644,758 for the period 2011-2012.

Based on the preceding, it appears that the applicant has demonstrated the financial 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 for Visiting Nurse Service Association of Schenectady County d/b/a Visiting Nurse Service of Schenectady and Saratoga Counties for 2011-2012
BFA Attachment B	Financial Summary for Ellis Hospital (d/b/a Ellis Medicine) for 2011-2012

Public Health and Health Planning Council

Project # 121317--C
VNA of Albany VNA of Saratoga VNA of Rensselaer

County: **Albany County (Albany)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 20, 2012**

Executive Summary

Description
Visiting Nurse Association of Albany Inc. d/b/a VNA of Albany VNA of Saratoga VNA of Rensselaer, an existing voluntary, not-for-profit Certified Home Health Agency (CHHA), is requesting to expand services to Columbia, Fulton Greene, Montgomery, Schenectady, Schoharie, Warren and Washington counties.
On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. VNA of Albany VNA of Saratoga VNA of Rensselaer submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation
Approval

Program Summary
This proposal seeks approval to expand the geographic service area of Visiting Nurse Association of Albany, Inc. d/b/a VNA of Albany/VNA of Saratoga/VNA of Rensselaer beyond its current service area of Albany, Saratoga and Rensselaer counties into the following eight additional counties: Columbia, Fulton, Greene, Montgomery, Schenectady, Schoharie, Warren and Washington, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:	Revenues:	$4,220,090
	Expenses:	3,935,169
	Gain(Loss):	$ 284,921

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

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Visiting Nurse Association of Albany, Inc., dba VNA of Albany/VNA of Saratoga/VNA of Rensselaer, currently operates an Article 36 certified home health agency and a long term home health care program with approval to serve Albany, Saratoga and Rensselaer counties. The applicant is requesting approval to expand the service area of the CHHA into Columbia, Fulton, Greene, Montgomery, Schenectady, Schoharie, Warren and Washington counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

The Visiting Nurse Association of Albany, Inc. has an affiliation with Albany Medical Center that was established to create program interfaces and ensure clinical competencies in serving the most complex patients in the region treated and discharged home to the community from Albany Medical Center.

The application detailed how the applicant has aligned with MRT goals for improved care coordination, and enhanced efficiency through initiatives that will strengthen care coordination model with primary care practices and development of clinical initiatives that will promote improved outcomes. In addition, the applicant indicated that they have existing contracts with several MLTCPs.

The applicant has developed multiple clinical specialty programs to align with the clinical needs of patients discharged from Albany Medical Center, including specialty programs for the treatment of wound care, diabetes, cardio-pulmonary diseases and mental health conditions. They discussed their Transition Coach Program, which they state has proven successful in reducing the risk of re-hospitalization, and are centered on executing an effective transition process from the hospital to the community. This program teaches self-management, understanding of medication regimes, and connection with the physician timely after discharge.

The applicant described the linkages and existing relationships with other community service and health care providers. The applicant used point of care information system Health Information System since 2006. They state that the system improves patient outcomes and care coordination and monitoring and enhances effective communication.

The applicant demonstrated need in each county by providing detailed county-specific profiles for each of the requested counties that included socio-economic factors, health indicators, health status of home care discharges and patients returning to the community from Albany Medical Center.

The applicant described the patterns of in-and out-migration for specific services and patient preferences. The proposal noted that individuals are out-migrating from their county of residence to obtain hospital services from Albany Medical Center.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Visiting Nurse Association of Albany, Inc. d/b/a VNA of Albany/VNA of Saratoga/VNA of Rensselaer is an Article 36 certified home health agency (CHHA) and long term home health care program serving Albany, Saratoga and Rensselaer counties. The applicant is requesting approval to expand the current geographic service area of its CHHA into the following eight additional counties: Columbia, Fulton, Greene, Montgomery, Schenectady, Schoharie, Warren and Washington. The applicant will continue to have its main office at 35 Colvin Avenue, Albany, New York 12206 with branch offices in Fulton, Montgomery, Schoharie, Washington and Greene counties.

The applicant will continue to provide the following home health services: home health aide, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, physical therapy and speech language pathology.

Visiting Nurse Association of Albany, Inc. is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Revenues:		
Commercial Fee-For-Service	$1,251,046	$1,862,275
Commercial Managed Care	58,313	255,143
Medicare Managed Care	1,116,421	1,229,589
Medicaid Managed Care	891,514	771,419
Private Pay	81,443	101,664
Total Revenues	$3,398,737	$4,220,090
Expenses	3,102,755	3,935,169
Net Gain(Loss)	$ 295,982	$ 284,921

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

Payor	**Year One**	**Year Three**
Commercial Fee-for-Service	35.0%	38.0%
Commercial Managed Care	1.0%	5.0%
Medicare Managed Care	35.0%	28.0%
Medicaid Managed Care	26.0%	26.0%
Private Pay	1.0%	1.0%
Charity Care	2.0%	2.0%

Medicaid Managed Care revenues show an incremental decrease between year one and year three due to bad debts being offset against Medicaid patients.

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates as well as the Medicaid Episodic Payment system.

Capability and Feasibility

There are no project costs associated with this application.

The submitted budget indicates that the applicant will achieve a net gain of $295,982 and $284,921in the first and third years of operations, respectively. Revenue is based on current payment rates for Certified Home Health Agencies. The submitted budget appears reasonable.

Presented as BFA Attachment A is the audited 2012 and 2011 financial summary of VNA of Albany and Affiliates which shows the applicant has maintained positive working capital, net assets and a net profit from operations of $643,486 and $466,294, respectively.

Based on preceeding, it appears that the applicant has demonstrated the financial 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 for of VNA of Albany & Affiliates, 2012 and 2011

Public Health and Health Planning Council

Project # 121443-C
Hudson Valley Long Term Home Health Care Program

County: **Ulster County (Highland)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **June 20, 2012**

Executive Summary

Description
Hudson Valley Care Partners, LLC d/b/a Hudson Valley Long Term Home Health Care Program, a proprietary limited liability company, requests approval to convert its existing Long Term Home Health Care Program (LTHHCP) to a Certified Home Health Agency (CHHA) to serve Ulster County. The applicant is affiliated through common ownership with Hudson Valley Rehabilitation & Extended Care Center, a 203-bed residential health care facility (RHCF) located at 260 Vineyard Avenue, Highland, NY (Ulster County).

Chapter 56 of the Laws of 2012 authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Plan (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHA's in New York State.

DOH Recommendation
Approval.

Need Summary
From a need perspective, approval is recommended.

Program Summary
This proposal seeks approval to convert Hudson Valley Long Term Home Health Care Program into a general purpose certified home health agency (CHHA), Hudson Valley Certified Home Health Agency, to serve the residents of Ulster County pursuant to the Dear Administrator Letter (DAL) HCBS 12-04, LTHHCP Opportunity to Become a General Purpose CHHA.

Financial Summary
There are no project costs associated with this proposal.

Budget	Revenues:	$ 2,551,405
	Expenses:	$ 1,859,905
	Gain:	$691,500

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

Recommendations

Health Systems Agency

There will be no HSA review of this project.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval.[CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Hudson Valley Care Partners, LLC is requesting approval to convert their long term home health care program into a certified home health agency to serve the residents of Ulster County.

Chapter 56 of the Laws of 2012 authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Plan (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State.

Solicitation

On May 10, 2012, the Department issued a Dear Administrator Letter (DAL) outlining the process for LTHHCPs who were eligible for the expedited review process authorized by Chapter 56 of the Laws of 2012.

A June 11, 2012 clarification letter to the May 10, 2012 DAL letter informed potential applicants that the process to establish or expand existing CHHAs in NYS is based on the demonstration of need and or the ability of the organization to facilitate Medicaid Redesign Initiatives. The applicant was expected to address these criteria in their responses to the questions in CON Schedule 21.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August, 2012 or October, 2012 meetings were considered deferred. The department notified applicants that were deferred of the opportunity to submit supplemental information for the Department to consider in the review of these CONs.

Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's responses to CON Schedule 21 and any supplemental information requested by the Department. From this review, applicants were recommended in each county proposed based on how well their proposal addressed the review criteria.

Hudson Valley Care Partners, LLC currently operates Hudson Valley Rehabilitation and Extended Care Center, a 203 bed residential health care facility in Ulster County, and a long term home health care program that serves the residents of Ulster County.

Hudson Valley Care Partners, LLC has the organizational capacity and existing infrastructure to implement Medicaid redesign. The applicant discussed various MRT initiatives, including initiatives to control utilization and reduce costs, transition to MLTCP mandatory enrollment, and home care worker parity. The applicant will emphasize care coordination, disease management and prevention with the goal of reducing avoidable hospital and nursing home admissions and readmissions.

Hudson Valley Care Partners, LLC named their referral sources including hospitals, nursing homes, and physician offices. They state that their CHHA services will be highly coordinated with other providers and insurers such as MLTCPs to ensure high-quality care and the seamless transition of patients from institutional care to the home care. They express their existing and strong relationships with local health and social services departments and describe their working relationship as collaborative because of the interdependency between the municipal entities for referrals case management, service delivery and systems accountability in serving as a LTHHCP in Ulster County.

The applicant discussed the electronic health record (EMR) system they are currently using, and they plan to incorporate additional functions into its quality improvement data collection process. Their CHHA will maximize the utilization of tele-health and other similar technologies to bring resources to patients throughout the county.

The applicant provided demographics for Ulster County by 2010 service area population by age group, as well as the projected 65 plus age group growth rate from 2010 through 2020. They provided demographics for the service population by racial/ethnic minority; defined disabilities; and poverty/income statistics. In addition, they provided data on health status indicators reflected in Preventive Quality Indicators (PQI) total for all admissions and breakdown by the specified PQI conditions and included an analysis stating a higher than expected hospital admission rate for diagnoses that represent a high percent of all admissions in Ulster County. They described how the growth of home care will be required to reduce admission and readmissions in addition to the MLTCPs influencing admissions rates and RHCF utilization, all of which will increase the need for CHHA services.

They discussed their outreach programs to inform community entities about the existence of their services and provision of feedback to these referral sources concerning the progress of patients referred to the agency. They will provide specific marketing plans to include community presentations, along with written materials when they become a general purpose CHHA. They will place a strong emphasis on the development of culturally sensitive outreach programs for their community's diverse population.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Program Description

Hudson Valley Care Partners, LLC currently operates an Article 36, 100 slot long term home health care program (LTHHCP), Hudson Valley LTHHCP, serving the residents of Ulster County and an Article 28, 203 bed residential health care facility (RHCF), Hudson Valley Rehabilitation and Extended Care Center, located at 260 Vineyard Avenue in Highland, New York 12528. The applicant proposes to convert its LTHHCP into Hudson Valley Certified Home Health Agency, a general purpose certified home health agency (CHHA) to serve Ulster County. The CHHA will be located at 266 Vineyard Avenue in Highland.

Hudson Valley Certified Home Health Agency will provide the following home health care services: home health aide, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, physical therapy and speech language pathology.

Hudson Valley Care Partners, LLC is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, conditional approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted the first and third year's operating budgets, in 2013 dollars, as summarized below:

Description	First Year	Third Year
Medicaid	$509,953	$999,510
Medicare	688,935	1,350,310
Commercial	102,849	201,585
Total Revenues	$1,301,737	$2,551,405
Total Expenses	$951,105	$1,859,905
Net Income or (Loss)	$350,632	$691,500

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

Medicaid – Manage Care	34%
Medicare – Episodic	54%
Commercial – Manage Care	10%
Charity Care	2%

Projected utilization is based upon the applicant's analysis, which took into consideration the need for additional CHHA services in Ulster County as the system transitions to Managed Long Term Care Plans (MLTCP) and the projected reduction of LTHHCP services in Ulster County. The expense projections are based upon the applicant's experience in providing LTHHCP services in the community and similarly sized CHHA's in the upstate region.

The average Medicaid episodic payment is expected to be $4,934.92 after taking into consideration the average case mix of .798765 and adjusting for the Hudson Valley Wage Index Factor of 1.125693. The applicant expects to have approximately 103.3 Medicaid episodes in the first year and 202.5 episodes by the third year.

Medicare average episodic payment of $4,196.10 was based on the applicant's historical LTHHCP payment experience trended to 2013 dollars. The applicant expects to have approximately 164 Medicare episodes in the first year and 321.8 Medicare episodes in the third year. Commercial revenue projections were based on historical payment rates

Capability and Feasibility

There are no project costs associated with this application.

Additional working capital is expected to be minimal as the project is a conversion from an existing LTHHCP to a CHHA. Any additional working capital will be provided from Hudson Valley Care Partners, LLC accumulated funds. Presented as BFA Attachment A and B is Hudson Valley Care Partners, LLC, 2010 and 2011 certified financial summary and their December 31, 2012 internal financial summary, respectively, which shows sufficient resources for this purpose.

The budget projects a first year and third year operating surplus of $350,632 and $691,500, respectively. Revenues are based on current payment methodologies. The submitted budget appears reasonable.

A review of Attachment A and B shows Hudson Valley Care Partners, LLC had a positive average working capital position and a positive average net asset position. Hudson Valley Care Partners, LLC had an average operating loss of $237,721 for the period 2010-2011. The 2010 loss was due to their Medicaid rate being below expenses and inappropriate cost control measures.

In 2011, the applicant implemented cost control measures and obtained a revised Medicaid rate, which enabled Hudson Valley Care Partners, LLC to generate an operating surplus in 2011 and 2012. The operating gain for 2012 was $146,194.

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 for 2010 and 2011, Hudson Valley Care Partners, LLC
BFA Attachment B	Internal Financial Summary for 2012, Hudson Valley Care Partners, LLC d/b/a Hudson Valley Rehabilitation and Extended Care Center

Public Health and Health Planning Council

Project # 131184-C

Calvary Hospital

County: **Bronx County (Bronx)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 3, 2013**

Executive Summary

Description

Calvary Hospital Inc., a not-for-profit corporation requests approval to expand its existing Certified Home Health Agency (CHHA) to serve Rockland and Putnam counties. Earlier, on April 11, 2013, the Public Health and Health Planning Council (PHHPC) contingently approved the applicant's request under CON 121229 to expand its CHHA service into Richmond, Kings and Nassau counties and to convert its New York and Westchester counties special need CHHAs to service the general population.

Calvary Hospital is a long term acute care hospital providing palliative end-of-life care and is a subsidiary of ArchCare, which is the health care ministry of the Archdiocese of New York.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Calvary Hospital, Inc., submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval

DOH Recommendation

Approval

Program Summary

This proposal seeks approval to expand the service area of the general purpose CHHA into the additional upstate counties of Rockland and Putnam, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary

There are no project costs associated with this proposal.

Budget	Revenues:	$ 162,790
	Expenses:	$ 118,011
	Gain:	$44,779

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

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Calvary Hospital, Inc. is an existing not-for-profit voluntary corporation that operates an Article 36 certified home health agency (CHHA) approved to provide services in Bronx, Queens, New York, Richmond, Kings, Westchester and Nassau Counties. This application requests approval for expansion of the CHHA into the Upstate counties of Rockland and Putnam.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;

Knowledge and experience in the provision of home health services;

Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;

Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Calvary Hospital, Inc. provided detailed data that demonstrated their ability support the goals of the Department in advancing Medicaid Redesign Initiatives. The applicant also demonstrated community need and public need using the criteria specified in Section 709.1(a) of Title 10. The applicant demonstrated throughout their proposal their ability and capacity to expand their existing CHHA.

The applicant is a subsidiary of ArchCare who operates a MLTCP. ArchCare is a large continuing care system with a broad array of services including a Program of All-inclusive Care for the Elderly (PACE), Medicare Advantage Special Needs Plan, home care, hospice, a long-term acute care hospital, adult day health care and seven nursing homes located throughout the greater New York metropolitan area. In addition, the applicant indicated that they have contracts with seven other MLTCPs.

They identify their Palliative Home Care Services which provide a more coordinated, forward-thinking approach oriented towards better outcomes, higher satisfaction and lower costs in line with MRT initiatives. Their organization is an end-of-life health provider offering coordinated care through a full spectrum of care modalities including, clinics, CHHA, hospice and acute care hospitals. They state they can operate in a more integrated manner between modalities.

They provided an extensive list of referral sources throughout the proposed counties. Throughout the application they demonstrate that they have the support and organizational capacity to facilitate Medicaid Redesign initiatives.

The applicant provided data and analysis that demonstrated community need and the health needs of the community, current and projected. They described how they will meet the unmet needs of the community they propose to serve and their ability to effectively and efficiently provide services to meet the growing needs of each community. Calvary states that they have proven outreach capabilities in minority communities. They have outreach mechanisms throughout the New York Metro area including East/Central Harlem, Bushwick/East New York, and Yonkers/Mt. Vernon among other neighborhoods.

The applicant provided information that addressed actual utilization of home care services in the geographic service area proposed to be served to the capacity in that service area with names of providers in the proposed service area. They provided data and analysis on the current number/rates of hospital discharges to homecare providers, or on the actual utilization rates/visits/patients served by the existing and proposed counties.

They described specific strategies that they will use to manage high risk cases. The applicant discussed streamlining operations and reducing operating cost within the home health care system. The proposal provided specific strategies and controls that the proposed CHHA will use to monitor and control utilization and cost of home care services.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Calvary Hopsital, Inc. is an existing not-for-profit voluntary corporation that operates an Article 36 certified home health agency (CHHA) originally certified to provide general purpose CHHA services in Bronx and Queens Counties and special needs CHHA services in Westchester and New York Counties.

Pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, Calvary Hospital, Inc. received approval to convert its special needs CHHA into a general purpose CHHA in Westchester and New York counties and to expand its service area into the downstate counties of Richmond, Kings and Nassau (CON #121229).

Through this CON Project #131184-C Calvary Hospital, Inc. is requesting approval to serve the upstate counties of Rockland and Putnam. Calvary Hospital Inc. proposes to offer the following health care services : nursing, home health aide, physical therapy, occupational therapy, speech language pathology, medical social services, nutrition, physician and medical supply, equipment and appliances. Calvary Hospital, Inc. is not proposing to establish any new branches at this time and will serve the counties from its existing office located at 1740 Eastchester Road, Bronx, New York 10461.

The CHHA operated by Calvary Hospital, Inc. is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted the first and third year's operating budgets, in 2013 dollars, as summarized below:

Description	**First Year**	**Third Year**
Medicaid	$60,440	$152,151
Medicare	3,913	9,411
Commercial	511	1,228
Total Revenues	$64,864	$162,790
Total Expenses	$24,745	$118,011
Net Income or (Loss)	$40,119	$44,779

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

	First Year	*Third Year*
Medicaid Fee-for-Service	10.7%	5.1%
Medicaid Episodic	70.0%	83.7%
Medicare Episodic	14.5%	7.2%
Medicare Manage Care	.1%	.6%
Commercial Manage Care	2.7%	1.4%
Charity Care	2.0%	2.0%

Utilization was based upon serving as the primary CHHA for its parent's (ArchCare) Managed Long Term Care Plan (MLTCP). In addition, Calvary Hospital currently covers Rockland County with its hospice service and will utilize its existing relationships to develop its CHHA business. The expense projections were based on historical experience and reflect a pro rata share of costs as shown on CON 121229.

The average Medicaid episodic payment is expected to be $8,948 after taking into consideration the average case mix of 1.599 and adjusting for the New York City Wage Index Factor of .991433. Their case mix of 1.599 was determined by Medicaid in 2012 and reflects their patients' severity of illness. Medicaid Fee-for-Service reflects a small portion of revenue that may continue to be carved out from the shift to manage care.

Medicare average episodic payment of $3,400 is the actual rate received by the applicant. The Medicare average case mix of 1.2354 was determined by Centers for Medicare & Medicaid Services (CMS) in 2012. Commercial revenue projections were based on historical payment rates

Capability and Feasibility

There are no project costs associated with this application.

The working capital requirement is estimated at $19,669, which appears reasonable based upon two months of third year expenses and will be provided through the existing operations. Presented as BFA Attachment A and B is Calvary Hospital, Inc. 2010 and 2011 certified financial summary and their December 31, 2012 internal financial summary, which shows sufficient resources for this purpose.

The budget projects a first year and third year operating surplus of $40,119 and $44,779, respectively. Revenues are based on current payment methodologies. The submitted budget appears reasonable

A review of Attachments A and B shows Calvary Hospital, Inc. has maintained a positive working capital position and a positive net asset position during years ending 2010, 2011 and 2012; the facility also experienced a net operating loss of $8,010,200 and 8,210,800 for 2010 and 2011 respectively, which represents 8.3% of gross operating revenue for both years. For the years ending 2010 and 2011 the Hospital shows average negative change in net assets of $1,850,950 of which $1,741,750 was from pension related adjustments and unrealized investment losses. The applicant states that the Hospital provides a great deal of care and family services that are not accounted for under current reimbursement methods, which is essentially covered through an extensive network of donors.

The 2012 internal financial statements also show that the facility experienced a net operating loss of $31,384,000 as of December 31, 2012, which represents 31% of gross operating revenue. A review of the 2012 internal financial summary (Attachment B) shows Calvary Hospital, Inc. had a negative change in net assets of $20,442,000, which is the result of a decision to incur a $21,000,000 one-time charge to buy out its pension obligation with the Archdiocese of New York. Their pension plan will now be managed by a third party, which they expect will save several million dollars annually, which will strengthen the organization's financial performance.

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 for 2010 and 2011, Calvary Hospital, Inc.
BFA Attachment B	Internal Financial Summary for 2012, Calvary Hospital, Inc.

Public Health and Health Planning Council

Project # 121290-C
Park Gardens Rehabilitation & Nursing Center, LLC

County: **Bronx County (Bronx)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 20, 2012**

Executive Summary

Description
Park Gardens Rehabilitation & Nursing Center, LLC, an existing Long Term Home Health Care Program (LTHHCP) currently operating in Bronx County, requests approval to convert the LTHHCP to a CHHA that would serve Bronx, New York (Manhattan) and Westchester Counties. The CHHA would provide the following services: Nursing, physical therapy, speech therapy, occupational therapy, medical social services, and home health aides.

DOH Recommendation
Approval

Program Summary
This proposal seeks approval to convert the long term home health care program (LTHHCP) operated by Park Gardens Rehabilitation & Nursing Center, LLC into a certified home health agency in Bronx County and to expand the service area into New York and Westchester counties, pursuant to the Dear Administrator Letter (DAL) HCBS 12-04, LTHHCP Opportunity to Become a General Purpose CHHA.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:

Revenues:	$8,252,911
Expenses:	8,166,108
Gain (Loss)	$ 86,803

Recommendations

Health Systems Agency

There will be no HSA recommendation for this application.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Park Gardens Rehabilitation and Nursing Center, LLC currently operates an Article 28 residential health care facility (RHCF) and an Article 36 long term home health care program (LTHHCP) with approval to serve Bronx County. The applicant is requesting approval to convert the LTHHCP into a certified home health agency (CHHA) to serve Bronx County and to expand their service area into New York and Westchester counties.

Chapter 56 of the Laws of 2012 authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Plan (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State.

Solicitation

On May 10, 2012, the Department issued a Dear Administrator Letter (DAL) outlining the process for LTHHCPs who were eligible for the expedited review process authorized by Chapter 56 of the Laws of 2012.

A June 11, 2012 clarification letter to the May 10, 2012 DAL letter informed potential applicants that the process to establish or expand existing CHHAs in NYS is based on the demonstration of need and or the ability of the organization to facilitate Medicaid Redesign Initiatives. The applicant was expected to address these criteria in their responses to the questions in CON Schedule 21.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified applicants that were deferred of the opportunity to submit supplemental information for the Department to consider in the review of these CONs.

Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's responses to CON Schedule 21 and any supplemental information requested by the Department. From this review, applicants were recommended in each county proposed based on how well their proposal addressed the review criteria.

Park Gardens Rehabilitation and Nursing Center LLC currently operates a long term home health care program in Bronx County. They are requesting approval to convert their LTHHCP into a CHHA and to expand their service area to include New York and Westchester counties to improve care coordination, care quality and home healthcare delivery while at the same time reducing Medicaid costs and increasing efficiency.

The applicant addressed MRT initiatives by describing their plan to use resources and technology such as Telehealth to reduce and control utilization of CHHA services. Those resources will reduce actual nursing visits while maintaining patient monitoring to allow assessment of real time information. The applicant will facilitate mandatory enrollment into MLTCPs by identifying patients who may require community based long term care services beyond 120 days and who meet other MLTCP criteria. They will provide information regarding MLTCPs and mandatory enrollment and assist in arranging enrollment in a MLTCP. They named three existing relationships with Fidelis; GuildNet; and Independence Care Systems. They state that their relationships with the MLTCPs will be expanded upon with the approval of the CHHA expansion.

The applicant provided demographic data by population, race and age and health status indicators for each county proposed. They discussed the growth in the elderly population, along with the need for more efficient healthcare expenditures throughout the nation, and the evolution of healthcare services as technology and research become more advanced. They provided statistical data regarding the statewide projected growth of the elderly population and the projected growth in each county proposed from 2010 through 2030.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Program Description

Park Gardens Rehabilitation and Nursing Center, LLC currently operates an Article 28 residential health care facility (RHCF) and an Article 36 long term home health care program (LTHHCP) with approval to serve Bronx County. The applicant is requesting approval to convert the LTHHCP into a certified home health agency (CHHA) to serve Bronx County and to expand their service area into New York and Westchester counties. This CHHA proposes to establish no branch offices and will serve the proposed service area from an office located at 6585 Broadway, Riverdale, New York 10471.

Park Gardens Rehabilitation & Nursing Center, LLC proposes to provide the following home health care services in its CHHA: audiology, home health aide, homemaker, housekeeper, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, personal care, physical therapy, respiratory therapy and speech language pathology.

The residential health care facility and long term home health care program operated by Park Gardens Rehabilitation & Nursing Center, LLC are currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, conditional approval is recommended.

Financial Analysis

Background

Chapter 56 of the Laws of 2012, authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Program (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State.

Effective May 1, 2012, a new Episodic Payment System (EPS) reimbursement methodology to reimburse CHHA providers for services provided to Medicaid patients receiving home care services took effect. The EPS is based on a price for 60 day episodes, which will be adjusted by patient acuity and regional wage differences. The EPS was recommended by the Medicaid Redesign Team (MRT proposal #5) and authorized in the 2011-2012 enacted budgets. The EPS is designed to address the issue of rapid growth in Medicaid costs per patient by better aligning payments with needed services and is part of a broad effort to promote the development of care management arrangements for Medicaid recipients.

Operating Budget

The applicant has submitted an incremental operating budget, in 2012 dollars, during the first and third years; which are summarized below:

	Year One	Year Three
Medicaid Managed Care	826,640	1,878,730
Medicare Managed Care	1,336,500	3,037,500
Charity Care	(77,408)	(163,319)
Other	1,540,000	3,500,000
Total Revenues	$3,625,732	$8,252,911
Expenses	$3,870,366	8,166,108
Net Gain (Loss)	($244,634)	$86,803

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

	Year One	Year Three
Medicaid Managed Care	20%	22%
Medicare Managed Care	40%	36%
Other	38%	40%
Charity Care	2%	2%

Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment System. Expense assumptions are based on salaries in the area for CHHA services. Utilization assumptions are based on the applicant's discussions with former nurses currently employed by the applicant's long term home heath team.

CAPABILITY AND FEASIBILITY

There are no project costs associated with this application.

Working capital requirements, estimated at $703,702, appear reasonable based on two months of first year expenses. Presented as BFA Attachment A is the certified 2012 draft financial statement and 2011 certified financial statement of Park Gardens Rehabilitation & Nursing Center, LLC, which indicates the availability of sufficient funds for the equity contribution to meet the working capital requirements.

The submitted budget indicates that the applicant has revenues over expenses of ($244,634) and $86,803 for the first year and third year of operation, respectively. Revenues are based on current payment rates including the implementation of the Medicaid Episodic Payment System. The submitted budget appears reasonable.

Presented as BFA Attachment A are the 2012 unaudited-financial statements which indicate negative working capital position and positive net asset position. The reason for the negative working capital position was due to an account called due to third party payors allocated to short term rather than long term liabilities.

The applicant aggressively decreased this commitment from the previous year which totaled $2,578,117. Also, the applicant achieved an average operating income of $11,010.

Presented as BFA Attachment B is the 2011 year end audited financial statement for the stated facility. As shown on Attachment B, the entity has a negative working capital position and positive net asset position. The reason for the negative working capital position was due to accounts payable not being collected in a timely manner and an account due to third party payors in the amount of $2,578,117 which is current and being paid down aggressively by the applicant. Also, the applicant incurred an operating loss of $82,423 due to plant maintenance expense coming in over budget. The members made an equity contribution of $106,501 to offset the loss and in 2012 were able to materially reduce the plant maintenance expense.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A- Un-audited Financial Summary- Park Gardens Rehabilitation & Nursing Center
BFA Attachment B- Audited Financial Summary – Park Gardens Rehabilitation & Nursing Center

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

June 6, 2013

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 #7**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121069 C	St Johns Episcopal Hospital So Shore (Queens County) Dr. Bhat - Recusal	Contingent Approval

Upstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #8**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121139 C	Visiting Nurse Association of Central New York Inc (Onondaga County) Mr. Booth - Interest	Approval
2.	121170 C	Rosa Coplon Jewish Home and Infirmary (Erie County) Mr. Booth – Interest Dr. Gutiérrez - Recusal	Approval

3.	121304 C	Twin Tier Home Health, Inc. (Broome County) Mr. Booth Interest	Approval
4.	121319 C	Schofield Residence (Erie County) Mr. Booth - Interest	Approval
5.	131185 C	Bethel Nursing Home Co Inc (Westchester County) Mr. Fensterman – Recusal	Approval

Downstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #9**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121221 C	Gazmel, NY, Inc. d/b/a, Revival Home Health Care (Kings County) Dr. Bhat – Recusal Mr. Fensterman - Recusal	Approval

Upstate Dear Administrator Letters – Long Term Home Health Care Program – Construction **Exhibit #10**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121437 C	Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital (Fulton County) Mr. Booth - Interest	Contingent Approval

Public Health and Health Planning Council

Project # 121069-C
St Johns Episcopal Hospital So Shore

County: **Queens County (Queens)**
Purpose: **Construction**

Program: **Acute Care Services**
Submitted: **February 7, 2012**

Executive Summary

Description
St. John's Episcopal Hospital (SJEH) is a 257-bed not-for-profit hospital located at Far Rockaway, Queens, New York. SJEH is affiliated with Episcopal Health Services, Inc. and Subsidiaries. SJEH seeks approval to permanently certify 4 Intensive Care Unit beds for which the hospital received temporary emergency approval. The ICU beds are situated on the 3rd floor of the hospital, which is located at 327 Beach 19th Street, Far Rockaway, Queens, N.Y. SJEH is currently licensed to operate 8 ICU beds (excluding the 4 ICU beds operated under temporary emergency approval) and will operate 12 ICU beds upon implementation of this project.

DOH Recommendation
Contingent approval

Need Summary
St. John's Episcopal Hospital South Shore received temporary emergency approval to operate 4 additional intensive care unit (ICU) beds to accommodate an expected influx of patients due to the anticipated closure of Peninsula Hospital Center. With the additional beds, the hospital's interim ICU occupancy is 88.9 percent. The ICU occupancy rate would exceed 100 percent without the additional beds.

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
The total project cost of $1,230,428 will be funded entirely through existing cash equity of the hospital.

Incremental Budget:	Revenues:	$1,722,000
	Expenses:	$1,634,883
	Gain:	$ 87,117

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation of 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. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

Approval conditional upon:

1. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
2. The applicant shall complete construction by March 1, 2016. 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

June 6, 2013.

Need Analysis

Background

St. John's Episcopal Hospital South Shore (SJEHSS) is a 257 bed acute care hospital located at 327 Beach 19th Street, Far Rockaway in Queens County. The facility seeks to permanently certify 4 ICU beds, for which the hospital was granted temporary emergency approval. Upon completion, the hospital's ICU capacity will be 12 beds.

St. John's Episcopal Hospital South Shore (SJEHSS) has the following certified beds and services:

Table 1: St. John's Episcopal Hospital South Shore: Certified Beds by Service.

Bed Category	Certified Capacity	Requested Change	Capacity Upon Completion
Medical-Surgical	144		144
Intensive Care	8	+4	12
Coronary Care	8		8
Maternity	12		12
Pediatric	6		6
Neonatal Intermediate Care	4		4
Drug Detoxification	32		32
Psychiatric / Mental	43		43
Total	257	+4	261

Table 2: St. John's Episcopal Hospital South Shore: Certified Services.

Ambulatory Surgery - Multi Specialty	Audiology O/P
Certified Mental Health Services O/P	Chemical Dependence - Detoxification
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
Family Planning O/P	Intensive Care
Lithotripsy	Maternity
Medical Social Services	Medical/Surgical
Neonatal Intermediate Care	Nuclear Medicine - Diagnostic
Pediatric	Pediatric O/P
Pharmaceutical Service	Physical Medicine and Rehabilitation O/P
Primary Medical Care O/P	Psychiatric
Radiology - Diagnostic	Renal Dialysis - Acute
Renal Dialysis - Chronic	Therapy - Occupational
Therapy - Occupational O/P	Therapy - Physical O/P
Therapy – Speech Language Pathology	

SJEHSS is authorized by NYSDOH to provide outpatient care at 3 other locations in Queens County. These clinics provide primary medical care, outpatient surgery, medical social services and certified mental health services.

SJEHSS has the following State Designation:
Level 2 Perinatal Center; and
Stroke Center.

The hospital is affiliated with the State University of New York Health Science Center, Brooklyn. SJEHSSS currently trains interns and residents in a number of specialties. The facility also trains medical students, psychologists, and physician assistants at Creedmoor Psychiatric Center.

Analysis

In 2007, SJEHSS recorded 9,982 total inpatient discharges. By 2010, these discharges increased by 3.9 percent to 10,374. In 2011 and 2012, inpatient discharges stood at 9,373 and 8,645, respectively. On average,approximately 60.0 percent of the hospital's inpatient discharges were allocated to the major service category medical/surgical. In 2007, med/surg patients generated an average length of stay (ALOS) of 8.2 days. By 2010, the ALOS for these patients declined significantly by 14.6 percent, to 7.0 days. Over the period, the hospital's med/surg patients average daily census ranged from 109 to 128 patients (Table 3).

Table 3: St. John's Episcopal Hospital South Shore: Major Service Category Medical/Surgical Inpatient Utilization. Source: SPARCS 2007- 2012.*

Category	**2007**	**2008**	**2009**	**2010**	**2011***	**2012***
Medical/Surgical	5,684	5,666	5,924	6,177	5,578	5,958
Total	9,982	9,779	10,288	10,374	9,373	8,645
M/S - Average Length of Stay	8.2	7.9	7.5	7.0	6.9	6.7
M/S - Average Daily Census	128	123	122	118	106	109
Medical/Surgical Occupancy	79.8	77.0	76.4	74.0	65.9	68.1

**Reporting for 2011 and 2012 is incomplete*

To evaluate the hospital's need for ICU beds, ICU utilization statistics were obtained from the hospital and the Institutional Cost Reports. From 2007 to 2011, SJEHSS's ICU patients' ADC ranged between 7 to 8 patients on any given day. This resulted in occupancy rates that fluctuated from 88.0 percent to 97.8 percent (Table 4). The hospital's peek period interim ICU occupancy statistics for 2012, with 12 beds, showed a utilization rate of 88.9 percent. If the facility did not have the additional 4 beds, then the occupancy rate, with 8 beds, would have been 133.3 percent.

Table 4: Intensive Care Unit Utilization Statistics.
Source: St Johns Episcopal Hospital South Shore, 2007 – 2010 and ICR, 2011.

ICU Utilization	**2007**	**2008**	**2009**	**2010**	**2011**
Average Daily Census	8	7	7	7	8
Beds	8	8	8	8	8
Occupancy Percent	94.4	92.0	89.2	88.0	97.8

Conclusion

SJEHSS's interim ICU occupancy statistics with the additional beds requested for permanent certification in this application show the unit operating at 88.9 percent. Occupancy in this unit would have been 133.3 percent without the additional beds.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

St. John's Episcopal Hospital South Shore requests approval to permanently certify four intensive care beds that were temporarily approved under an emergency approval.

There will be no changes to staffing or services concurrent with approval of this application.

Compliance with Applicable Codes, Rules and Regulations

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 of $1,230,428 are itemized as follows:

Renovation & Demolition	$ 824,000
Architect/Engineering Fees	82,400
Design Contingency	82,400
Construction Contingency	82,400
Other Fees	15,450
Movable Equipment	135,059
CON Application Fee	2,000
CON Processing Fee	6,719
Total Project Cost	$1,230,428

Project costs were completed as required under the Temporary Emergency Approval.
The applicant's financing plan appears as follows:

Cash Equity (Applicant)	$1,230,428

Operating Budget

The applicant has submitted an incremental operating budget, in 2013 dollars, as summarized below:

	Year One	**Year Three**
Revenues:		
Inpatient	$1,505,000	$1,642,000
Expenses:		
Operating	$1,531,151	$1,534,847
Capital	100,036	100,036
Total Expenses	$1,631,188	$1,634,883
Excess Revenue over Expenses	($ 126,188)	$ 7,117
Utilization:		
Discharges	113	123
Operating Cost per Discharge	$ 13,550	$ 12,478
Capital Cost per Discharge	885	813
Total Cost per Discharge	$ 14,435	$ 13,291

Inpatient utilization by payor source for the first and third year:

Payor	Year One	Year Three
Medicaid Managed Care	54.0%	53.6%
Medicare Fee-for-Service	30.1%	30.1%
Medicare Managed Care	5.3%	5.7%
Commercial Fee-for-Service	4.4%	4.9%
Commercial Managed Care	4.4%	4.1%
Other	1.8%	1.6%

The budget is based on the hospital's current experience in operating its Intensive Care unit, adjusted for additional volume.

Capability and Feasibility

St. John's Episcopal Hospital has satisfied the project costs of $1,230,428 from accumulated funds.

Working capital requirements are estimated at $271,865, which appears reasonable based on two months of first year expenses. Working capital needs will be funded through existing cash equity and ongoing operations. Review of Attachment B shows the facility has adequate resources to provide the working capital.

St. John's Episcopal Hospital projects first and third year incremental revenues over expenses to be $(126,188) and $7,117, respectively. Revenues are based on current reimbursement experience of SJEH in providing ICU services. The budget appears to be reasonable.

Review of BFA Attachment A indicates the applicant achieved average positive working capital and net assets as well as average net operating revenue of ($4,738,500) during 2010 and 2011.

Review of BFA Attachment B, the Episcopal Health Services Inc. and subsidiaries internal financial statements for 2012 indicate that the applicant has achieved negative working capital and positive net assets. Working capital as of December 31, 2012 was ($14,044,000). Net operating revenue of ($5,130,000) was realized for 2012.

The applicant indicates the reason for the losses were that volume in the fourth quarter of 2011 was lower than expected, while staffing in certain areas of the hospital needed to be increased. Also, the hospital expended approximately $1,500,000 in anticipation of the closure of Peninsula General Hospital. SJEH has taken, and continues to take, numerous steps to address these losses, including: review and adjustment of `appropriate staffing levels; development of a financial system to analyze service lines; updating its Charge Description Master; revamping its patient accounts department to enhance billing and collections. Also, the applicant indicates that through late October 2012, the hospital was experiencing positive net income, until the impact of Hurricane Sandy impeded operations, and increased expenses.

The applicant has begun to review underperforming services, and to control salary and benefit packages. Part of the review consists of divesting SJEHSS itself of its two nursing homes, which when sold, will eliminate over $5,000,000 in annual support and leave the consolidated hospital system with only $1,487,000 in long term debt, as of 12/31/2012.

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 – Episcopal Health Services Inc. and Subsidiaries (2010 and 2011 - audited)
BFA Attachment B -	Financial Summary – Episcopal Health Services Inc. and Subsidiaries (January 1 through December 31, 2012- unaudited)
DHFP Attachment	Map

Public Health and Health Planning Council

Project # 121139
Visiting Nurse Association of Central New York Inc.

County: **Onondaga County (Syracuse)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **March 20, 2012**

Executive Summary

Description
Visiting Nurse Association of Central New York (VNACNY), is an existing not-for profit corporation located at 1050 West Genesee Street, Syracuse, NY (Onondaga County), which operates a full service Certified Home Health Agency (CHHA) as well as a long term home health program. VNACNY is requesting to expand their existing certified home health agency (CHHA) into the surrounding Central New York regional counties, which include Cayuga, Jefferson, Oneida and Oswego.

The sole corporate member of VNACNY is VNA Homecare, which was founded in 2011, and is comprised of CCH Home Care and Palliative Services, Inc., VNACNY, and Independent Health Services, Inc. VNA Homecare provides comprehensive, cohesive home care for all stages of life-from prenatal care to care for young families to rehabilitation, long term and end-of-life care.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. VNACNY submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation
Approval

Program Summary
This proposal seeks approval to expand the service area of Visiting Nurse Association of Central New York, Inc., an existing Certified Home Health Agency (CHHA). Visiting Nurse Association of Central New York Inc. is currently approved to serve Onondaga County and is requesting approval to expand into Cayuga, Jefferson, Oneida and Oswego counties pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:	Revenues:	$5,103,369
	Expenses:	4,760,596
	Gain(Loss):	$342,773

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

Recommendations

Health Systems Agency

The HSA has no comment on the recommendation of this application.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Visiting Nurse Association of Central New York, Inc., an existing Certified Home Health Agency (CHHA), approved to serve Onondaga County is requesting approval to expand into Cayuga, Jefferson, Oneida and Oswego counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;

Knowledge and experience in the provision of home health services;

Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;

Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

This CON application is to expand Visiting Nurse Association of Central New York, Inc.'s existing Certified Home Health Agency (CHHA), approved to serve Onondaga County, into Cayuga, Jefferson, Oneida and Oswego counties.

The applicant provided detailed descriptions of strategies they will use to meet specific MRT goals and how they are well positioned to be successful. They have established contracts with Fidelis Care at Home MLTCP in Onondaga county, which serves to facilitate care management, care coordination, and transitioning MA patients from fee for service to managed care. In addition, they have partnered with Upstate University Hospital on their designated Health Home model. The applicant has working partnerships with Upstate University Hospital, Crouse Hospital, and St Joseph's Medical Center. Both hospitals have expressed difficulty in securing home care for the patients they discharge to the proposed counties. Approval to add the 4 additional counties to its existing CHHA will enhance the applicant's ability of to provide home care to 90% of Upstate University Hospital's patients in need of home care.

The applicant specializes in pediatric services, maternal and child health, wound and ostomy care, diabetic services, and chronic care. They are the preferred provider for pediatric home care services for Upstate University Hospital, being the only CHHA in Onondaga County with a dedicated pediatric team. The applicant indicated that they have repeatedly received approval from DOH Regional Office on an as-needed case by case basis to provide their specialized pediatric and maternal and child health services and expertise in the counties they are requesting. They also described their experience and success in treating highly complex medical, behavioral, and long term care needs. In addition, they have proven that they can control costs by the fact that they achieved a 22% risk adjustment hospitalization rate versus statewide average of 31% and Federal average of 27%. They currently utilize Electronic Medical Records and Telehealth that enhance communication with other providers to reduce ER visits and hospitalizations, and with the patients themselves to promote medication management, home safety, and self management. The applicant describes how they will continue these services through each of the proposed counties.

The Department received several letters of support, including from Elderserve/Home First and Fidelis. Throughout the application, the applicant addressed both public and community need. The applicant demonstrated public need using the criteria of 709.1(a) and provided supporting data. They provided both current and projected basic demographic statistical data on population projections, age, income/poverty levels, diagnoses/health status indicators, insurance status/MA eligibility, employment status and described how this information demonstrates need in each of the counties. They also provided a detailed analysis of health status risk for each county using specific data.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Visiting Nurse Association of Central New York, Inc. is an existing not-for-profit corporation currently operating an Article 36 CHHA currently serving Onondaga County. This application has been submitted by Visiting Nurse Association of Central New York, Inc., to request approval to expand the service area of their existing CHHA currently serving Onondaga County into Cayuga, Jefferson, Oneida and Oswego counties, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties. Visiting Nurse Association of Central New York Inc. also sponsors a long term home health care program (LTHHCP) currently authorized to serve patients in Onondaga County.

Visiting Nurse Association of Central New York, Inc. proposes to serve the residents of Onondaga, Cayuga, Jefferson, Oneida and Oswego counties from their existing office located at 1050 West Genesee Street, Syracuse, New York 13204.

The applicant proposes to provide the following home health care services:

home health aide	medical social services	physical therapy
nursing	occupational therapy	medical supply equipment, and appliances
nutritional	speech language pathology	respiratory therapy
personal care	physician services	

The certified home health agency and long term home health care program operated by Visiting Nurse Association of Central New York, Inc. are currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a program perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Revenues:		
Medicaid	$1,556,760	$1,720,576
Medicare	2,363,439	2,679,091
Commercial	622,095	703,702
Private Pay	48,883	54,744
Charity Care	0	0
Bad Debt	(48,883)	(54,744)
Total Revenues	$4,542,294	$5,103,369
Expenses	$4,433,086	$4,760,596
Net Gain(Loss)	$109,208	$342,773

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

Payor	**Year One and Year Three**
Commercial	15.00%
Medicare	48.50%
Medicaid	32.00%
Private Pay	1.00%
Charity Care	2.50%
Bad Debt	1.00%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment system

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at $793,433, which appears reasonable based on two months of third year expenses and will be provided through the existing operations investment accounts.

Based on the review of BFA Attachment A, it appears that the VNACNY does have enough capital to cover their working capital requirements.

The submitted budget indicates that the applicant will achieve incremental net revenue in the first and third years of operations of $109,208and $342,773, respectively. Revenue is based on current payment rates for Certified Home Health Agencies.

Presented as BFA Attachment A, is the audited financial summary of the Visiting Nurse Service Association of Central New York, Inc. for 2011-2012. The financial statements show that the applicant has maintained a positive working capital position and a positive net asset position, and achieved a net loss of $743,852 for the period 2012. The loss is due to the facility losing market share in 2010, but still keeping the same administrative staffing level as before the loss of market share. In order to rectify this, the facility has been working on recapturing the market share lost in 2010, by securing preferred provider agreements.

BFA Attachment B is the audited financial summary of Visiting Nurse Service Association of Central New York, Inc. for 2010-2011. The financial statements show that the applicant has maintained a positive working capital position and a positive net asset position and achieved an average net loss of $942,794 for the period 2010-2011. The loss is due to the facility losing market share in 2010 but still keeping the same administrative staffing level as before the loss of market share. In order to rectify this, the facility has been working on recapturing the market share lost in 2010 by securing preferred provider agreements

Based on the preceding, it appears that the applicant has demonstrated the financial 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 for Visiting Nurse Service Association of Central New York, Inc. for 2011-2012
BFA Attachment B	Financial Summary for Visiting Nurse Service Association of Central New York, Inc. for 2010-2011.

Public Health and Health Planning Council

Project # 121170-C
Rosa Coplon Jewish Home and Infirmary

County: **Erie County (Getzville)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **March 30, 2012**

Executive Summary

Description
The Rosa Coplon Jewish Home and Infirmary, an operating entity of Menorah Campus, Inc. d/b/a The Harry and Jeanette Weinberg Campus, an existing Long Term Home Health Care Program, seeks approval to change their Long Term Home Health Care Program (LTHHCP) to a Certified Home Health Agency (CHHA) with a service area of Erie County. The CHHA will provide the following services: home health aide, medical social services, Medical supplies, equipment, nursing, nutritional, personal care, occupational therapy, physical therapy, respiratory therapy, speech language pathology and audiology.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Rosa Coplon Jewish Home and Infirmary submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation
Approval

Program Summary
This proposal seeks approval to convert the existing Rosa Coplon Jewish Home and Infirmary Long Term Home Health Care Program with current approval to serve Erie County, into Rosa Coplon Jewish Home and Infirmary Certified Home Health Care Agency (CHHA), with approval to serve Erie County, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:

Revenues	$1,278,117
Expenses	1,204,874
Excess of Revenues over Expenses	$73,243

The applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Rosa Coplon Jewish Home and Infirmary Long Term Home Health Care Program (LTHHCP), approved to serve Erie County is requesting approval to convert the existing into Rosa Coplon Jewish Home and Infirmary to a Certified Home Health Care Agency (CHHA), with approval to serve Erie County.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

This CON application is to convert the existing Rosa Coplon Jewish Home and Infirmary Long Term Home Health Care Program (LTHHCP), approved to serve Erie County into Rosa Coplon Jewish Home and Infirmary Certified Home Health Care Agency (CHHA), with approval to serve Erie County.

The Rosa Coplon Jewish Home and Infirmary RHCF, LTHHCP, and ADHCP are under the corporate umbrella of Menorah Campus, Inc., d/b/a Harry and Jeanette Weinberg Campus, which also includes Menorah Campus Adult Home, Inc. operators of Dosberg Manor Adult Home, Dosberg Manor Assisted Living Program, and Menorah Licensed Home Care Services Agency, Menorah Campus Independent Senior Living Apartments, Inc. operators of six named independent senior living apartment buildings, one of which is for their Managed Long Term Care Plan enrollees, Greenwood Residences, Inc. (OMH-certified), Amherst Towne Senior Apartments (HUD), Amherst Glen Senior Apartments (HUD), Menorah Social Adult Day Care Center, Total Aging in Place Program, Inc., a Medicaid Managed Long Term Care Plan, and Menorah Campus Health Services, Inc., a Diagnostic & Treatment Center.

The applicant indicated that the Weinburg campus became part of the largest HMO provider in WNY and emphasized how failure to approve the application would jeopardize the negotiation with the provider. The application indicated how their program offers continuity of care due to operating a PACE program as well as a MLTCP Total Aging in Place Program in Erie County. The applicant has indicated that they have entered into contractual arrangements with the "Supportive Medical Partners" who will provide physician services to the entities on the Weinburg Campus. The MLTCP has entered into a consulting contract with Health Dimensions Group to operate a PACE program which will address the dual eligible population. The applicant has indicated the entity will transition from the Consumer Directed Personal Assistance Program to Managed Care.

Rosa Coplon LTHHCP's health information technology (HIT) is already licensed and in operation with "AllScripts" as their practice management system provider. The plan of care is utilized to provide the necessary structure for documentation, for tracking and monitoring services, tests, referrals, and the required follow-up. Each client has an RN case manager responsible for their care coordination and communication with the interdisciplinary team including case conferencing with all services to achieve the optimal patient outcome. The applicant is currently evaluating a "point of care" system available through AllScripts which would make use of laptops by the clinicians thereby generating more timely information with greater efficiency. They are also evaluating the electronic health record component, which would include client history, clinical charting, e-prescribing, diagnostic testing and results, and patient follow-up.

Rosa Coplan states that converting the LTHHCP into a CHHA will ensure access and accessibility in the Weinberg integrated network of senior services that will provide integrated senior care on their campus. The CHHA will promote patient choice by offering additional Managed Care options to the Erie County through education and communication with relationships with providers in the community.

The applicant provided an analysis that demonstrates how all of the factors listed in Section 709.1(a) of Title 10 translate into need Erie County and how they will meet the health needs of members of medically underserved groups which have traditionally experience difficulties in obtaining equal access to health services.
The applicant also provided information and an analysis for Erie County based on age, income, race, chronic disease and census needs to the Managed Care and dually eligible population. They indicated that the socio-economic status and chronic conditions correlates to hospital admissions. The proposal indicated a lack of access, community based services and primary care services needed to meet the need of the medically underserved population as well as people with chronic conditions. There is also the issue of geographic disparity in Erie County, which causes coordination of care difficulties. The gap analysis analyzed the need for frail seniors, low income, and the disabled population. The analysis also analyzed the growth in the aged population and how this is changing how care is being delivered. The data provided indicated the through the coordination of care through involving community resources and linkages home care services will prevent unnecessary hospitalizations. Rosa Coplan currently provides an education program for chronic diseases and conditions to improve patient outcomes. These programs offer an array of supportive services, technology and coordination of care to allow people to live safely in the community.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Rosa Coplon Jewish Home and Infirmary is an existing not-for-profit nursing home located at 2700 North Forest Road, Getzville, New York 14068, which currently operates Rosa Coplon Jewish Home and Infirmary Long Term Home Health Care Program (LTHHCP). Pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, the applicant seeks approval to convert their LTHHCP into a CHHA, and serve Erie Couny. The new CHHA will ultimately replace the existing LTHHCP, will be named Rosa Coplon Jewish Home and Infirmary Certified Home Health Care Agency, and will be located at the LTHHCP's current location of 2700 North Forest Road, Getzville, New York 14068.

The applicant proposes to provide the following home health care services:

home health aide	medical social services	physical therapy
nursing	occupational therapy	respiratory therapy
nutritional	speech language pathology	medical supply equipment, and appliances
personal care	audiology	homemaker
housekeeper		

Rosa Coplon Jewish Home and Infirmary Long Term Home Health Care Program, is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first and third years, summarized below:

	Year One	**Year Three**
Revenues:		
Medicaid Managed Care	$341,684	$493,573
Medicare Managed Care	436,147	657,869
Commercial Fee-for-Service	72,140	125,425
Private Pay	1,000	1,250
Total Revenues	$850,971	$1,278,117
Expenses:		
Operating	$818,739	$1,174,657
Capital	28,510	30,217
Total Expenses	$847,249	$1,204,874
Excess of Revenues over Expenses	$3,722	$73,243

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

	Year One	Year Three
Medicaid Managed Care	57.58%	60.11%
Medicare Managed Care	34.87%	32.80%
Commercial Fee-for-Service	5.52%	5.06%
Private Pay	.03%	.03%
Charity Care	2.00%	2.00%

Expense and utilization assumptions are based on the applicant's historical experience in providing LTHHCP services in the community and similarly sized CHHA's. Revenues are reflective of current payment rates, as well as the recent implementation of the Medicaid Episodic Payment System.

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements are estimated at $200,812, which appears reasonable based on two months of third year expenses. The applicant will provide equity from operations to meet the working capital requirement. Presented as BFA Attachment A are the 2011 and 2012 certified financial statements of Rosa Coplon Jewish Home & Infirmary, which indicates the availability of sufficient funds to meet the working capital equity contribution.

The submitted budget indicates an excess of revenues over expenses of $3,722 and $73,243 during the first and third years, respectively. Revenues are reflective of current payment rates as well as the recent implementation of the Medicaid Episodic Payment System. The budget appears reasonable.

As shown on Attachment A, Rosa Coplon Jewish Home & Infirmary had an average negative working capital position and an average negative net asset position from 2011 through 2012. The negative positions are attributed to prior year losses. Also, Rosa Coplon Jewish Home and Infirmary incurred a loss of operations of $1,278,422 and $1,602,766 from 2011 through 2012. The applicant has indicated that the reasons for the losses are the result of the following: high staffing levels; the use of purchased contract services; overtime costs and reduction in reimbursement. The applicant worked to reduce overtime and the need for purchased services; negotiated union contracts and improved accounts receivable management to improve days in AR and delinquent accounts.

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- 2011 and 2012 certified financial statements of Rosa Coplon Jewish Home & Infirmary

Public Health and Health Planning Council

Project # 121304-C

Twin Tier Home Health, Inc.

County: **Broome County (Vestal**)
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 20, 2012**

Executive Summary

Description

Twin Tier Home Health (Twin Tier), an existing voluntary not-for-profit, comprehensive certified home health agency (CHHA) located in Vestal, NY (Broome County), is requesting to expand its existing certified home health agency (CHHA) service area from Broome County to include Chenango, Delaware and Tioga Counties as well. The applicant will provide the following services: skilled nursing, Home Health Aide, Medical Social Workers, Registered Dietician, Occupational Therapy, Physical Therapy and Speech therapy services. Twin Tier also has specialty programs including an in home and community based fall prevention program, a cardiac disease management program, an orthopedic rehab program, a wound program and a COPD disease management program that is under development.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Twin Tier Home Health, Inc. submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

Twin Tier is a member of UHSH health system that has hospitals in Broome, Chenango and Delaware counties, as well as physician practices in Broome, Chenango, Delaware and Tioga counties.

DOH Recommendation

Approval

Program Summary

This proposal seeks approval to expand Twin Tier Home Health, Inc.'s geographic service area beyond its current service area of Broome County to include the contiguous counties of Chenango, Delaware and Tioga pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary

There are no project costs associated with this application.

Incremental Budget:

Revenues:	$10,546,460
Expenses:	10,148,214
Gain(Loss):	$398,246

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

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Twin Tier Home Health, Inc. is an existing Article 36 certified home health agency with approval to serve Broome County. The applicant is requesting approval to expand their service area into Chenango, Delaware and Tioga counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Twin Tier Home Health (Twin Tier) is a member of the UHS Health System that includes hospitals in Broome, Chenango, and Delaware Counties, as well as physician practices located in Broome County and the three counties they propose to serve. Additionally, Twin Tier partners with UHS Home Care, a division of UHS that includes Professional Home Care, Inc., a LHCSA providing infusion and DME services in the proposed counties of Chenango, Delaware, and Tioga; and Ideal Senior Living Center Housing Corporation, a LHCSA providing private duty nursing and aide service, including an aide training program in Broome, Chenango and Tioga counties.

The applicant provided demographic information specific to each county proposed as well as a market study that outlines 760.5(c)(2) of title 10. In addition, they presented other relevant data and provided an analysis of the data to demonstrate need. They presented normative criteria for age and sex specific utilization rates to correct for unnecessary utilization of health care services. They discussed how the CHHA would serve the traditionally medically underserved groups. The applicant's determination of need is based on the limited number of providers in each of the counties they propose to serve.

The applicant demonstrated knowledge of the home care services area for the proposed counties. They discussed the need for CHHA services in the proposed counties. The applicant provided data as well as an analysis of the proposed services area taking into account the demographics of the population, the needs of the community as well as the current and proposed increase in need of CHHA utilization.

Twin Tier offers a full range of service in addition to specialty programs which include an in-home and community based fall prevention program (In Balance), a cardiac disease management program (Heart at Home), an orthopedic rehab program (Rehab at Home), a wound program under the supervision of a certified wound ostomy continence nurse (CWOCN), and a COPD disease management program in development.

Twin Tier emphasis is on their integrated health care system and begins with intake personnel that partner with community agencies, physician practices, and hospitals to ensure a safe initiation of services at home. Over 85% of admissions are completed within 24 hours of referral or discharge from the inpatient facility with 25% of all admission on the weekend. They state their ability to achieve the high level of access is by recruiting and retaining a stable work force. They claim a low staff turnover with 10.1% in 2011 across disciplines.

They further describe their support of the MRT initiatives with active participation with the UHS health system members on the following projects: Medical Home; care coordination; reducing hospital readmissions; and Medicaid Health Home. Their connection with UHS enables Twin Tier to support the proposed UHS Medicaid Health Home and Medical Home models of care in Broome, Chenango, Delaware and Tioga counties. Twin Tier expounds on Enhanced Care Coordination with their UHS system initiatives that focus on improved outcomes and reduced utilization of acute care services, and includes development of the Medicaid Health Home, Care Coordination Models, and the Gold STAMP collaborative.

Twin Tier demonstrated their ability to work within the managed care environment and to improve efficiencies and quality of care. Twin Tier has longstanding community partnerships and plans to develop additional partnerships to foster the quality patient care.

Recommendation

From a need perspective, approval is recommended

Programmatic Analysis

Background

Twin Tier Home Health, Inc. is an Article 36 certified home health agency (CHHA) serving Broome County. Twin Tier Home health, Inc. is requesting approval to expand its current geographic service area into the contiguous counties of Chenango, Delaware and Tioga. Twin Tier Home Health, Inc. proposes to serve all counties from its current practice location of 4401 Vestal Parkway East, Vestal, New York 13850.

Twin Tier Home Health, Inc. will continue to provide the following home health services: home health aide, medical social services, medical supplies, equipment and appliances, nursing, nutrition, occupational therapy, personal care, physical therapy and speech language pathology.

Twin Tier Home Health, Inc. is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Revenues:		
Medicare Fee-for-Service	$5,746,903	$7,108,127
Medicare Managed Care	1,150,503	1,423,774
Medicaid Managed Care	259,983	317,382
Commercial Fee-for- Service	1,305,580	1,614,537
Private *Pay/Other	82,640	82,640
Charity Care	0	0
Total Revenues	$8,545,609	$10,546,460
Expenses	$8,650,006	$10,148,214
Net Gain(Loss)	($104,397)	$398,246

*Private Pay / Other is co-pay revenue, therefore no visits are included, as it would distort the actual visits shown.

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

Payor	**Year One**	**Year Three**
Commercial Fee-for-Service	18.90%	19.37%
Medicare Fee-for-service	61.83%	61.47%
Medicare Managed Care	13.83%	13.76%
Medicaid Managed Care	3.30%	3.34%
Charity Care	2.14%	2.05%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates, as well as the recent implementation of the Medicaid Episodic Payment system.

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at $1,691,369, which appears reasonable based on two months of third year expenses and will be provided through the existing operation.

As shown on BFA Attachment A, the 2010-2011 certified financial statement for Twin Tier Home Health, Inc., the facility has sufficient resources to meet working capital requirements.

The submitted budget indicates that the applicant will achieve incremental net loss in the first year of $104,397, and an incremental net income in the third year of operations of $398,246. Revenue is based on current payment rates for Certified Home Health Agencies. The first year loss will be covered through existing operations. The submitted budget appears reasonable.

Presented as BFA Attachment A is the audited financial summary of Twin Tier Home Health, Inc. for 2010 and 2011, which shows the applicant has maintained a positive working capital position, a positive net asset position, and achieved an average net income of $23,319 from operations for the period 2010 through 2011. In 2011, the facility had a loss of $117,267, which was caused by a volume decrease in which revenue did not meet the fixed costs. Prior to 2011, and thereafter, the facility has been able to post a profit. The facility regained a positive net income in 2012 of $203,362.

Presented as BFA Attachment B is the audited financial summary for UHSH for 2010 and 2011, which shows the facility has maintained a positive working capital position and a positive net asset position, and achieved an average net income of $21,084,756 from operations for the period 2010 through 2011. Attachment C, is the internal financial summary for Twin Tier Home Health, Inc. for 2012, which shows that the applicant has maintained a positive working capital position, a positive net asset position, and achieved a net income from operations for 2012 of $201,454.

Presented as BFA Attachment D is the internal financial summary for UHSH for 2012, which shows the facility has maintained a positive working capital position and a positive net asset position and achieved a net income of from operations for 2012 of $9,999,703.

Based on the preceding, it appears that the applicant has demonstrated the financial 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 for Twin Tier Home Health, Inc. (2010- 2011)
BFA Attachment B	Financial Summary for UHSH 2010-2011
BFA Attachment C	Internal Financial Summary for Twin Tier Home Health, Inc. 2012
BFA Attachment D	Internal Financial Summary for UHSH for 2012

Public Health and Health Planning Council

Project # 121319-C

Schofield Residence

County: **Erie County (Kenmore)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 20, 2012**

Executive Summary

Description

Wheel Chair Home, Inc. d/b/a Schofield Residence, a not-for-profit corporation, requests approval to establish a Certified Home Health Agency (CHHA) to serve Erie and Niagara counties. The applicant operates a 120-bed residential health care facility (RHCF) located at 3333 Elmwood Avenue, Kenmore, New York (Erie County). They also operate an offsite 60-slot Adult Day Health Care Program (ADHCP) in Erie County, and a 300-slot Long Term Home Health Care Program (LTHHCP), which includes an AIDS Home Care Program, in Erie County. Through Schofield Home Health Care Services Inc., they operate a Licensed Home Care Services Agency (LHCSA). The applicant expects that the proposed CHHA will be known as Schofield Residence CHHA.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Wheel Chair Home, Inc. d/b/a Schofield Residence, submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation

Approval

Program Summary

This proposal seeks approval to convert the long term home health care program currently operated by Wheel Chair Home, Inc. d/b/a Schofield Residence, into a certified home health agency (CHHA) to serve Erie County and Niagara County, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary

There are no project costs associated with this proposal.

Budget	Revenues:	$2,950,304
	Expenses:	$ 2,950,305
	Gain (Loss):	$ (1)

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

Recommendations

Health Systems Agency

There will be no HSA recommendation for this application

Office of Health Systems Management

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Wheel Chair Home, Inc. dba Schofield Residence currently operates a residential health care facility and a long term home health care program with approval to serve the residents of Erie County. The applicant is requesting approval to convert their LTHHCP into a CHHA to serve the residents of Erie County and Niagara County.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Schofield Residence provided data and an analysis that demonstrated how the factors listed in Section 709.1(a) of Title 10 translate into need for each county proposed and how they will meet the health needs of members of medically underserved groups which have traditionally experience difficulties in obtaining equal access to health services. In addition, the applicant provided information that addressed actual utilization of home care services in the proposed geographic service area.

The applicant described specific strategies that they will use to manage high risk cases and discussed the streamlining of operations and a reduction of operating costs within the home health care system. The applicant provided specific strategies and controls that the proposed CHHA will use to monitor and control the utilization and cost of home care services.

The applicant's LTHHCP has existing contracts with Independent Health, Blue Cross and Blue Shield, and Univera, and provides services to the dually eligible population and is currently negotiating contracts other MLTCPs. They described their relationship with Erie County's Community Alternative Systems Agency and the TBI/NHTD Regional Resource Development Specialist.

The applicant has established community linkages in Erie County, specifically with TBI and HIV/AIDS community organizations, and proposes to establish relationships with specific community organizations in Niagara County, such as the Health Association of Niagara County, the Dale Association, the Coalition of Agencies in Service to the Elderly, and the Coalition for Older Adults in Niagara County. In addition, the applicant described specific primary sources of referrals for the CHHA services, including community hospitals, health homes, and managed care organizations.

The applicant also has the infrastructure and capacity to operate a CHHA because they currently operate a LTHHCP. They have the technology to transfer current patient records through Point of Care. The system enables providers to complete electronic record findings, enter orders, and review information.

Recommendation

From a need perspective, approval is recommended

Programmatic Analysis

Background

Wheel Chair Home, Inc. d/b/a Schofield Residence, an Article 28 residential health care facility (RHCF) and an Article 36 long term home health care program (LTHHCP) with approval to serve Erie County is requesting approval to convert the LTHHCP into a CHHA to serve Erie County and to expand their service area into Niagara County. The applicant proposes to operate the CHHA under the assumed name Schofield Residence CHHA which will be located at 2757 Elmwood Avenue, Kenmore, New York 14217.

Schofield Residence CHHA proposes to offer the following home health services: audiology, home health aide, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, personal care, physical therapy, respiratory therapy and speech language pathology.

The residential health care facility and long term home health care program operated by Wheel Chair Home, Inc. are currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted the first and third year's operating budgets, in 2013 dollars, as summarized below:

Description	First Year	Third Year
Medicaid	$554,734	$1,770,183
Medicare	286,715	1,180,121
Total Revenues	$841,449	$2,950,304
Total Expenses	$843,149	$2,950,305
Net Income or (Loss)	$(1,700)	$(1)

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

	First Year	Third Year
Medicaid - Episodic	7.3%	57.8%
Medicaid - Manage Care	65.4%	.0%
Medicare - Episodic	20.3%	30.2%
Medicare - Manage Care	5.0%	10.0%
Charity Care	2.0%	2.0%

Patient utilization projections were based on the applicant's analysis of need, projected changes in area population, and anticipated need for additional CHHA services as the Medicaid system transitions to managed care and Managed Long Term Care (MLTC). Expense projections were based on the applicant's historical LTHHCP experience, as well as on a planned seeking of competitive bids for services currently not offered (example: telehealth).

The average Medicaid episodic payment is expected to be $3,877 after taking into consideration the average case mix of .745467 and adjusting for Western New York Wage Index Factor of .903208. The average case mix of .745467 was based on an analysis of Clinical and Functional data taken from their LTHHCP patients. The applicant expects the census to be 55 patients in the first year and 165 patients in the third year.

Medicare average episodic payment of $2,960 is the actual rate received in 2012 by the applicant's LTHHCP. The Medicare average case mix of 1.37 was determined by the Centers for Medicare & Medicaid Services (CMS) in 2012.

Capability and Feasibility

There are no project costs associated with this application.

The working capital requirement is estimated at $491,718, which appears reasonable based upon two months of third year expenses and will be provided from Board Designated Fund Assets. Presented as BFA Attachment A, is Wheel Chair Home, Inc. d/b/a Schofield Residence and Affiliate 2011 and 2012 certified financial summary, which shows the Board Designated Fund Assets amount to $6,777,028 under the heading of "Investments".

The budget projects a small first year loss of $1,700 and breaking even in the third year with a $1 loss. Revenues are based on current payment methodologies. The submitted budget appears reasonable

A review of Attachment A Wheel Chair Home, Inc. d/b/a Schofield Residence and Affiliate has maintained a positive working capital position and a positive net asset position during years ending 2011 and 2012. For the years ending 2011 and 2012, Wheel Chair Home, Inc. d/b/a Schofield Residence and Affiliate incurred operating losses of $253,970 and $1,537,041, respectively. When taking into consideration non-operating income, the 2011 excess of revenues over expenses turns into a small surplus of $23,987, and

the 2012 operating loss is reduced by $582,373, bringing the excess of revenues over expenses to a negative $954,668.

The applicant states that the reason for the 2011 operating loss of $253,970 is primarily from the following: elimination of LTHHCP HIV Nursing rate and Cash Receipts Assessment payment in lieu of 2% cross aboard cut for SNF, ADHCP and LTHHCP rates; additional funding for Workers Compensation claims; and added costs associated with the implementation of LTHHCP transition to Point of Care field devices. The applicant implemented the following steps to improve operations: Wage and Salary freeze; non-direct care open positions left unfilled; negotiated better terms with vendor and service providers; and negotiated a financially prudent union contract.

The applicant states that the reason for the 2012 operating loss of $1,537,041 is primarily from the following: $134,390 in Medicaid reimbursement reductions; $496,000 in added Workers Compensation Claims; $601,784 in extraordinary operational losses for ADHCP program. This occurred because their landlord, Sheehan Health Network, closed and filed bankruptcy and Schofield had to assume all of the building expenses, along with depreciating the balance of its leasehold improvements; and the balance for building repairs and miscellaneous items. The applicant implemented the following steps to improve operations: Reductions in non-direct care work force and converting some full time positions to part time; restructuring non-union 401K Retirement Plan and reducing the employer contribution; negotiation of better terms with vendor and service providers; hiring of a new Workers Compensation broker, who provides proactive approach to reducing workplace injuries; and restructured LTHHCP service delivery model by transitioning staff to Point of Care field Devices over 2011 and 2012.

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 for 2011 and 2012, Wheel Chair Home, Inc. d/b/a Schofield Residence and Affiliate

Public Health and Health Planning Council

Project # 131185-C

Bethel Nursing Home Co., Inc.

County: **Westchester County (Ossining)** ***Program:*** **Certified Home Health Agency**
Purpose: **Construction** ***Submitted:*** **April 3, 2013**

Executive Summary

Description

Bethel Nursing Home Co., Inc., an existing not-for-profit Long Term Home Health Care Program (LTHHCP) provider, is requesting to expand the current LTHHCP to include a Certified Home Health Agency to serve Putnam County. The LTHHCP currently serves Westchester County.

On January 25, 2012, the Department issued a Request for Applications (RFA) to establish new or expand existing certified home health agencies (CHHA) in New York State. LTHHCPs were informed to submit a response to the RFA if they were interested in expanding the population they serve. Subsequently, on May 10, 2012 the Department issued a letter stating that Chapter 56 of the Laws of 2012-13 authorized the Commissioner of Health to grant an expedited review of a certificate of need application (CON) submitted by an existing LTHHCP requesting approval to become a general purpose CHHA. This CON is in response to the DOH letter.

DOH Recommendation

Approval

Program Summary

This proposal seeks approval to expand the existing Bethel Nursing Home Company, Inc., Long Term Home Health Care Program (LTHHCP), with current approval to serve Westchester County, by adding Bethel Nursing Home Company, Inc., Certified Home Health Agency (CHHA), with approval to serve the downstate counties of Bronx, New York, Queens, and Westchester, and the upstate county of Putnam, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties. The downstate counties of Bronx, New York, Queens, and Westchester, were already approved by PHHPC at its April 11, 2013 meeting, pursuant to CON project 121217-C. This current CON project 131185-C seeks approval for the upstate county of Putnam.

Financial Summary

There are no project costs associated with this application.

Incremental Budget	Revenues:	$1,008,890
	Expenses:	792,003
	Net Income:	$216,887

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

Recommendations

Health Systems Agency

Office of Health Systems Management
Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [LTC]

Council Action Date
June 6, 2013.

Need Analysis

Background

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Bethel Nursing Home Company, Inc. presented data in support of the criteria in 709.1(a) from numerous sources and described how they would meet the needs of the underserved. They utilized GAP analysis and presented normative criteria for age specific utilization rates; described patterns of in and out migration; described how they will conduct outreach and health education programs; and described the availability of home care services within the proposed areas for each county, in addition to how the CHHA would support the goals of MRT initiatives.

The applicants discussed their LTHHCP personalized plans of care focused on specific patient needs to reduce preventable admissions and readmissions to hospital and nursing homes. They discussed their disease centered plans of care which they support through specialized programs which include CHF; COPD; Diabetes; and all common conditions affecting elderly individuals. These programs are overseen by nurses specializing in these fields. They describe how their use of IT systems effectively supports their patients with specific diseases and conditions.

The applicants elaborate on the streamlining of operations and monitoring/controlling utilization and costs in home care through their Health IT systems and collaboration and sharing of patient information with MLTCPs and healthcare providers, including their own affiliates. They discuss their electronic charting, reporting, networking and communication tools in addition to their data analyses functions, clinical management and strategic benchmarking functions. They discuss controlling utilization through their existing systems and their Quality Assurance and Performance Improvement Programs in place to review utilization and referrals to determine if services are medically necessary or appropriate to meet the patient's needs.

The applicant identified well established relationships with healthcare institutions, social service agencies and other entities that will ensure their CHHA program is well-utilized and that it will provide high quality and coordinated care.

Recommendation

From a need perspective, approval is recommended

Programmatic Analysis

Program Description

Bethel Nursing Home Company, Inc., is an existing not-for-profit voluntary corporation which operates a nursing home located at 17 Narragansett Avenue, Ossining, New York 10562 (Westchester County). The nursing home currently operates Bethel Nursing Home Company, Inc., Adult Day Health Care Program (ADHCP), and Bethel Nursing Home Company, Inc., Long Term Home Health Care Program (LTHHCP), located at 19 Narragansett Avenue, Ossining, New York 10562 (Westchester County). The LTHHCP is approved to serve Westchester County only.

Pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, Bethel Nursing Home Company, Inc., Long Term Home Health Care Program seeks approval to expand its LTHHCP by adding Bethel Nursing Home Company, Inc., Certified Home Health Agency (CHHA), with approval to serve the downstate counties of Bronx, New York, Queens, and Westchester, and the upstate county of Putnam. The new CHHA will be located at the LTHHCP's current location of 19 Narragansett Avenue, Ossining, New York 10562 (Westchester County). The proposed CHHA plans to serve all five requested counties from this practice location in Westchester County.

Bethel Nursing Home Company, Inc., Certified Home Health Agency will provide the following home health care services: home health aide; medical social services; medical supplies, equipment, and appliances; nursing; nutritional services; occupational therapy; personal care; physical therapy; respiratory therapy; and speech language pathology.

Bethel Nursing Home Company, Inc., and Bethel Nursing Home Company, Inc., Long Term Home Health Care Program, are currently in compliance with all applicable codes, rules and regulations.

This CON project 131185-C is requesting approval to serve the following upstate county: Putnam County. CON project 121217-C already received PHHPC approval on April 11, 2013 for the proposed CHHA to serve the following downstate counties: Bronx, New York, Queens, and Westchester Counties.

Recommendation

From a programmatic perspective, conditional approval is recommended.

Financial Analysis

Background

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first and third years, summarized below:

	Year One	Year Three
Revenues:		
Commercial	$25,347	$105,010
Medicaid	142,787	591,547
Medicare	75,392	312,333
Total Revenues:	$243,526	$1,008,890
Expenses:	$193,022	$792,003
Net Income:	$50,504	$216,887

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

	Year One and Three
Commercial Managed Care	10%
Medicare Fee-for-Service	54%
Medicaid Managed Care	34%
Charity Care	2%

Expenses and utilization assumptions are based on the historical experience of Bethel Nursing Home Co., Inc. Revenues are reflective of current payment rates.

CAPABILITY AND FEASIBILITY

There are no project costs associated with this application.

Working capital requirements are estimated at $132,001 based on two months of third year expenses and will be provided from the proceeds of its sale of 35 residential health care facility beds for $2,113,340. Presented as BFA Attachment A, is the closing payment statement, indicating the receipt of sufficient funds.

The submitted budget indicates a net income of $50,504 and $216,887 for the first and third years of operations, respectively. Revenue is based on current payment rates for certified home health agencies and the Medicaid episodic payment rates. The budget appears reasonable.

Presented as BFA Attachment B, a financial summary of Bethel Nursing Home Co., Inc. indicates that the facility has experienced negative working capital and negative net assets and generated a net income of $210,749 for 2011.
Presented as BFA Attachment C, a financial summary of Bethel Nursing Home Co., Inc. indicates that the facility has experienced negative working capital and a net loss of $58,076 as of December 31, 2012. The applicant has stated that the operating loss was due to prior year open workers compensation cases

and the negative working capital is due to Related Party being listed as current liabilities. The applicant indicates that these are discretionary liabilities owed to the facility's related parties and are not immediately due within the fiscal year. To improve operations Bethel Nursing Home Co., Inc. has decertified 35 residential health care facility beds under approved CON 122138. The certification of the CHHA will also improve financial performance and contribute to a positive working capital position in the future.

Recommendation

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Closing payment statement
BFA Attachment B	Financial Summary 2011, Bethel Nursing Home Co., Inc.
BFA Attachment C	Internal Financial Summary as of December 31, 2012, Bethel Nursing Home Co., Inc.

Public Health and Health Planning Council

Project # 121221-C
Gazmel, NY, Inc. d/b/a Revival Home Health Care

County: **Kings (Brooklyn)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 16, 2012**

Executive Summary

Description

Gamzel NY, Inc. d/b/a Revival Home Care, an existing proprietary business corporation certified as a special needs Certified Home Health Agency (CHHA) is requesting to expand their existing CHHA into Suffolk and Richmond Counties and to serve the general public. Revival Home Care currently serves Kings, Bronx, Queens, New York, Nassau, Westchester, Sullivan, Rockland and Orange counties as a special need CHHA serving the Hasidic and Orthodox Jewish population, Russian immigrants and Holocaust survivors.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Revival Home Health Care submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation

Contingent Approval.

Program Summary

This proposal seeks approval to convert the applicant's Special Needs Population Certified Home Health Agency (CHHA) into a general population CHHA, and to add Richmond and Suffolk Counties to its approved geographic service areas, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary

There are no project costs associated with this application.

Incremental Budget:	Revenues:	$13,036,068
	Expenses:	7,715,804
	Gain(Loss):	$ 5,320,264

Subject to noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

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

Office of Health Systems Management
Approval Contingent upon:

1. The Department of Health reserves the right to re-evaluate the incremental budgets for feasibility if all counties for establishment or expansion are not approved.[BFA]

Approval Conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval.[CHA]

Council Action Date
June 6, 2013.

Need Analysis

Background

Gamzel NY, Inc. dba Revival Home Health Care currently operates a special needs Certified Home Health Agency approved to serve the special needs population of the Hasidic and Orthodox Jewish population, Russian immigrants and Holocaust survivors in the counties of Bronx, Kings, New York, Queens, Nassau, Westchester, Rockland Orange and Sullivan. The applicant is requesting approval to convert to a CHHA serving the general population in these counties and to expand into Richmond and Suffolk counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Gamzel NY, Inc. d/b/a Revival Home Health Care (Revival) detailed their initiatives in support of the goals of the Department in advancing Medicaid Redesign Initiatives. The applicant's experience providing home care services to a special needs population gives them the clinical and technical expertise to meet the needs of patients with complex care needs in the most efficient manner. Revival described specialized strategies to manage high risk cases with a comprehensive spectrum of services ranging from post-acute care to chronic disease management and a palliative care program. They described their disease management protocols designed to promote cost efficient patient care and improved health outcomes. These programs include rehabilitation services for many chronic diseases.

In addition to the application to sponsor a partially capitated MLTCP called Revival Choice which is under review by the Department, they named existing contracts in place with 14 MLTCPs. Revival stated that the MLTCPs currently under contract utilize the CHHAs targeted disease management programs for its enrolled patients, several of which have also been developed in collaboration with leading hospitals in Revival's service area.

They detailed strategies to manage high risk cases, streamlining operations and reducing operating costs. Additionally, they address strategies and controls to monitor and control utilization and cost of home care services and expound on their Re-Hospitalization Prevention Program; Infusion Program; Joint Replacement Program; Wound Management Program; Chronic Disease Management Program, Palliative Care Program and Diabetic Management Program.

The applicant provided data to support need for each county they are proposing to serve and performed an analysis of the data to support public and community need. The applicant described projected population characteristics of the service area including relevant health status indicators and socio-economic conditions and how they will meet the health needs of members of underserved groups which have traditionally experienced difficulties in obtaining access to health services. The applicant described normative criteria for age and sex specific utilization rates to correct for unnecessary utilization of health care services

Recommendation:
From a need perspective, approval is recommended

Programmatic Analysis

Background

Gamzel NY, Inc., d/b/a Revival Home Health Care, is an existing for-profit corporation whose corporate office is located at 5377 Kings Highway, Brooklyn, New York 11203. Previous CON Project 122145-E recently received Public Health and Health Planning Council all contingencies satisfied approval, by letter dated March 18, 2013, to transfer 100% of the stock ownership of Gamzel NY, Inc., d/b/a Revival Home Health Care, from Suzanne Faye Zakheim to Isaac Soskin, the corporation's Chief Executive Officer and the CHHA's Administrator. The final legal sale transaction of all 200 shares of the corporation's issued stock, making Mr. Soskin the sole stockholder, director, and officer of Gamzel NY, Inc., d/b/a Revival Home Health Care, occurred effective March 29, 2013.

Gamzel NY, Inc., d/b/a Revival Home Health Care, currently operates a Certified Home Health Agency (CHHA) approved to serve the special needs population of the Hasidic and Orthodox Jewish Population, Russian Immigrants, and Holocaust Survivors, in the counties of Bronx, Kings, New York, Queens, Nassau, Westchester, Rockland, Orange, and Sullivan Counties. Pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, the applicant seeks approval to convert its Special Needs Population CHHA into a general population CHHA, and to add Richmond and Suffolk Counties to its approved geographic service areas. Gamzel NY, Inc., d/b/a Revival Home Health Care, will continue to serve all counties from the CHHA's existing practice location office at 5350 Kings Highway, Brooklyn, New York 11203. The CHHA does not have any additional branch office practice locations approved at this time.

Gamzel NY, Inc., d/b/a Revival Home Health Care, will continue to provide the following home health care services: home health aide; medical social services; medical supplies, equipment, and appliances; nursing; nutritional services; occupational therapy, physical therapy, and speech language pathology.

Although this agency received conditional approval to operate their CHHA as a special needs CHHA limited to the Hasidic and Orthodox Jewish Population, Russian Immigrants, and Holocaust Survivors they have not been fully compliant with this requirement. Revival Home Health Care has made progress toward becoming compliant with the condition. They have increased the percentage of their patients served that fall within the special needs population from 30% in the January to June 2009 semi-annual reporting period to 47% in the January to June 2012 semi-annual reporting period.

Gamzel NY, Inc., d/b/a Revival Home Health Care, is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	Year Three
Revenues:		
Medicaid	$5,580,586	$11,431,201
Medicare	725,836	1,486,793
Commercial	57,642	118,075
Total Revenues	$6,364,064	$13,036,068
Expenses	3,888,910	7,715,804
Net Gain(Loss)	$2,475,154	$ 5,320,264

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

Payor	Year One and Year Three
Commercial Managed Care	1.3%
Medicare Fee-for-Service	12.9%
Medicaid Managed Care	83.8%
Charity Care	2.0%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates as well as the recent implementation of the Medicaid Episodic Payment system.

Capability and Feasability

There are no project costs associated with this application.

Working capital requirements, estimated at $1,285,967, appear reasonable based on two months of third year expenses and will be provided through the existing operation.

The submitted budget indicates that the applicant will achieve a $2,475,154 and $5,320,264 incremental net revenue in the first and third years of operations, respectively. Revenue is based on current payment rates for Certified Home Health Agencies. The submitted budget appears reasonable.

Presented as BFA Attachment A is the audited financial summary of Revival Home Health Care, which shows the applicant has experienced negative working capital and net equity and achieved net revenue of $8,519,616 from operations for 2011. The negative working capital and net equity in 2011 was due to cash withdrawals for dividends but was replaced in 2012. BFA Attachment B, draft 2012 financial summary for Revival Home Health Care, shows the applicant has experienced negative working capital, maintained positive net assets and maintains a net profit from operations of $6,557,548 in 2012. Revival Home Health Care received final approval from the Public Health and Health Planning Council on March 18, 2013, for a 100% transfer of shareholder interest from Suzanne Zakheim to Isaac Soskin under CON 122145. As part of this transfer agreement, the negative working capital was corrected effective with the closing on March 22, 2013.

Based on the proceeding, it appears that the applicant has demonstrated the financial capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary for Revival Home Health Care 2011
BFA Attachment B	Financial Summary for Revival Home Health Care, draft 2012

Public Health and Health Planning Council

Project # 121437-C
Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital

County: **Fulton County (Johnstown)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **June 19, 2012**

Executive Summary

Description
Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital, request approval to expand the service area of its CHHA from Fulton and Montgomery counties to include Hamilton, Herkimer, Saratoga, Schoharie and Warren counties. The CHHA will provide the following services: nursing, physical therapy, speech therapy, occupational therapy, medical social services, and home health aide services.

The applicant is a CHHA that currently operates a 330-slot long term home health care program (LTHHCP) serving the residents of Fulton and Montgomery County.

Chapter 56 of the Laws of 2012 authorizes the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Plan (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State. This CON application is in response to Chapter 56 of the Laws of 2012.

DOH Recommendation
Contingent approval

Program Summary
This proposal seeks approval to expand the service area of Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital's certified home health agency (CHHA) by adding Hamilton, Herkimer, Saratoga, Schoharie and Warren Counties to its present service area of Fulton and Montgomery counties, pursuant to the Dear Administrator Letter (DAL) 12-04, LTHHCPs Opportunity to Become a General Purpose CHHA.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:

Revenues	$4,579,681
Expenses	4,019,684
Excess of Revenues over Expenses	$559,997

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval contingent upon:

1. Submission of executed leases for Saratoga and Herkimer counties that is acceptable to the Department of Health. [BFA]

Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital currently operates a certified home health agency and long term home health care program that serves Fulton and Montgomery counties. The applicant is requesting approval to expand the service area of their CHHA to Hamilton, Herkimer, Saratoga, Schoharie and Warren counties.

Chapter 56 of the Laws of 2012 authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Plan (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State.

Solicitation

On May 10, 2012, the Department issued a Dear Administrator Letter (DAL) outlining the process for LTHHCPs who were eligible for the expedited review process authorized by Chapter 56 of the Laws of 2012.

A June 11, 2012 clarification letter to the May 10, 2012 DAL letter informed potential applicants that the process to establish or expand existing CHHAs in NYS is based on the demonstration of need and or the ability of the organization to facilitate Medicaid Redesign Initiatives. The applicant was expected to address these criteria in their responses to the questions in CON Schedule 21.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified applicants that were deferred of the opportunity to submit supplemental information for the Department to consider in the review of these CONs.

Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's responses to CON Schedule 21 and any supplemental information requested by the Department. From this review, applicants were recommended in each county proposed based on how well their proposal addressed the review criteria.

Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital is an existing CHHA and LTHHCP, serving Fulton and Montgomery counties, and is submitting this CON to request approval to expand the service area of their CHHA to Hamilton, Herkimer, Saratoga, Warren, and Schoharie counties. This applicant is also a provider of services under the Nursing Home Transition and Diversion (NHTD) Medicaid Waiver.

The applicant has joined the Visiting Nurse Service of Schenectady and Saratoga Counties, Inc. Community-based Care Transition Program. The care transition program is a partnership of six community-based organizations and eight acute care hospitals to deliver care transition services in upstate NY. The goal of the program is to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.

The applicant has also entered into contracts with three MLTCPs in the proposed service area: Fidelis, United HealthCare and VNSNY Choice. They reported having relationships with commercial insurance plans in the proposed service area such as CDPHP and Empire Blue Cross.

They stated that approval of the CHHA will result in cost savings; expanded access and improved administrative efficiencies related to the provision of home health services. The applicant stated that in order to meet these goals their CHHA will implement an innovative disease centered management program for all patients, including high cost and complex cases, that emphasize care coordination, prevention and performance with the goal of reducing costly and avoidable hospital and nursing home admissions and readmissions and managing/improving patient health. The applicant will offer enhanced access to community-based services aimed at keeping residents in their home; a comprehensive continuum of services for a growing elderly population; and a cost-efficient, and thereby cost-saving, integrated system of care that emphasizes care coordination, prevention and performance.

The applicant provided a list of referral sources, and described how their existing community linkages are of value to their current patients. They discussed their capability to partner with other organizations, which has been enhanced by the partnerships it has established with MLTCPs. This will result in a strengthened capacity of the CHHA to excel in fostering the implementation of Medicaid Redesign Initiatives.

The applicant provided detailed data on the demographics of the current and projected population characteristics of the entire service area and break down by age groups; insurance, institutionalization, disabilities, poverty/income; mortality rates, preventive quality indicators categories and disabilities per each county proposed. The applicant currently operates a CHHA and LTHHCP in rural counties. Their experience in serving these counties will benefit the proposed counties, which are rural in nature.

They discussed patterns of in and out migration and discuss how in a rural setting, patients must travel long distances to receive needed healthcare services. They state that as a result, some patients choose to delay needed healthcare services or forgo healthcare altogether, and ultimately seek care late in an acute care episode, resulting in costly hospital or nursing home admissions that could have been prevented. They state that by adding home care services to these rural areas, they can reduce costs and result in a high quality of life by enabling these patients to remain at home. They described how approval of their application will address the factors listed in Section 709.1(a) of Title 10 through their analysis and how the data they provided demonstrates need in each county they propose to serve.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital is an Article 36 certified home health agency (CHHA) and a 330 slot long term home health care program (LTHHCP) serving the residents of Fulton and Montgomery counties. Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital is requesting approval to expand the service area of its CHHA to Hamilton, Herkimer, Saratoga, Schoharie and Warren counties. Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital currently serves Fulton and Montgomery Counties from an office located at 2-8 West Main Street, Johnstown, New York 12095. The applicant is in the process of determining the need for one or two branch offices as it expands services to Hamilton, Herkimer, Saratoga, Schoharie and Warren counties

Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital will provide the following home health services: home health aide, homemaker, housekeeper, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, personal care, physical therapy, respiratory therapy and speech language pathology.

Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital is currently in compliance with all applicable codes, rules and regulations.

Recommendation

From a programmatic perspective, conditional approval is recommended.

Financial Analysis

Lease Rental Agreement

The applicant has indicated that they plan to enter into leases in Saratoga and Herkimer counties. As of this date, they have not entered into any agreements. As a contingency of approval, the applicant must submit executed leases.

Operating Budget

The applicant has submitted an incremental budget, in 2013 dollars, for the first and third years, summarized below:

	Year One	Year Three
Revenues:		
Medicaid Managed Care	$1,166,897	$1,627,208
Medicare Fee-for-Service	1,775,934	2,476,490
Commercial Managed Care	341,336	475,983
Total Revenues	$3,284,167	$4,579,681
Expenses:		
Operating	$2,757,389	$3,839,471
Capital	180,213	180,213
Total Expenses	$2,937,602	$4,019,684
Excess of Revenues over Expenses	$346,565	$559,997

Utilization broken down by payor source during the first and third years is as follows:

	Year One	Year Three
Medicaid Managed Care	27.00%	27.00%
Medicare Fee-for-Service	61.00%	65.61%
Commercial Managed Care	10.00%	5.39%
Charity Care	2.00%	2.00%

Expense and utilization assumptions are based on the applicant's historical experience in providing LTHHCP services in the community and similarly sized CHHA's in the upstate region, including the applicant's own CHHA. Revenues are reflective of current payment rates, as well as the recent implementation of the Medicaid Episodic Payment System.

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements are estimated at $669,947, which appears reasonable based on two months of third year expenses. The applicant will provide equity to meet the working capital requirement. Presented as BFA Attachment A, is the December 31, 2012 internal financial statements for Community Health Center of St. Mary's Healthcare, and Nathan Littauer Hospital, which indicates the availability of sufficient funds to meet the working capital requirement.

The submitted budget indicates an excess of revenues over expenses of $346,565 and $559,997 during the first and third years, respectively. Revenues are reflective of current payment rates, as well as the recent implementation of the Medicaid Episodic Payment System. The budget appears reasonable.

As shown on Attachment A, the applicant had a positive working capital position and a positive net asset position. Also, the applicant achieved an excess of revenues over expenses of $166,567 through December 31, 2012.

Presented as BFA Attachment B is the 2010 and 2011 certified financial statements of Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital, Inc. As shown, the applicant had an average positive working capital position and an average positive net asset position from 2010 and 2011. Also, the applicant incurred an average loss of operations of $147,574 from 2010 and 2011. The applicant has indicated that the reason for the losses was the result of high staffing levels and the use of purchased/contract services. The applicant worked to reduce staffing levels and the need for purchased services, which resulted in positive operations in 2012.

Subject to the noted contingency, 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, contingent approval is recommended.

Attachments

BFA Attachment A-	December 31, 2012 internal financial statements of Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital
BFA Attachment B-	Financial Summary- 2010 and 2011 certified financial statements of Community Health Center of St. Mary's Healthcare and Nathan Littauer Hospital

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

June 6, 2013

A. APPLICATIONS FOR 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 HSA

Upstate Request for Applications – Certified Home Health Agencies – Construction **Exhibit #11**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121322 C	Lutheran Long Term Home Health Care Program (Suffolk County) Ms. Hines – Abstained at EPRC	Approval

Public Health and Health Planning Council

Project # 121322-C
Lutheran Long Term Home Health Care Program

County: **Suffolk (Hauppauge)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **April 20, 2012**

Executive Summary

Description
Lutheran Center at Poughkeepsie, Inc. d/b/a Lutheran Long Term Home Health Care Program an existing not-for-profit Long Term Home Health Care Program (LTHHCP) provider is requesting to expand the current LTHHCP to include a Certified Home Health Agency to serve Suffolk and Dutchess counties. The LTHHCP currently serves Suffolk County.

On January 25, 2012, the Department issued a Request for Applications (RFA) to establish new or expand existing certified home health agencies (CHHA) in New York State. LTHHCPs were informed to submit a response to the RFA if they were interested in expanding the population they serve. Subsequently, on May 10, 2012, the Department issued a letter stating that Chapter 56 of the Laws of 2012-13 authorized the Commissioner of Health to grant an expedited review of a certificate of need application (CON) submitted by an existing LTHHCP requesting approval to become a general purpose CHHA. This CON is in response to the DOH letter.

Need Summary
Lutheran Center at Poughkeepsie, Inc. currently operates a residential health care facility and a long term home health care program that serves Suffolk County. The applicant is seeking approval to add a CHHA to their continuum of services that will operate under the assumed name TLCN Home Care and serve Suffolk and Dutchess counties.

From a need perspective, approval is recommended.

DOH Recommendation
Approval

Program Summary
Lutheran Center at Poughkeepsie, Inc. is requesting approval to add a certified home health agency (CHHA) to their continuum of services, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
There are no project costs associated with this application.

Incremental Budget	Revenues:	$3,225,733
	Expenses:	2,881,808
	Net Income:	$343,925

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

Recommendations

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

Office of Health Systems Management
Approval conditional upon:

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval.[CHA]

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Council Action Date
June 6, 2013.

Need Analysis

Background

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Lutheran Center at Poughkeepsie, Inc. currently operates a residential health care facility and a long term home health care program that serves Suffolk County. The parent corporation of the Lutheran Center at Poughkeepsie, Inc. is The Lutheran Care Network. The applicant provided information regarding organizational capacity and how adding a CHHA to their continuum of services will meet the goals of Medicaid Redesign Initiatives.

The applicant demonstrated an understanding of how the proposal will support the goals of the MRT initiatives by describing how the CHHA will enhance patient choice by allowing patients needing CHHA services to remain within their own family of service providers. They plan to partner with several MLTCPs as well as promote transition from fee for service to managed care organizations for the dually eligible patients.

A description of the strategies that will manage high risk patients, streamline cost and reduce costs was provided. The applicant participates in the NYSDOH telehealth initiative. The Telehealth program has shown a decrease in readmission to hospitals. In addition, the LTHHCP currently utilizes an electronic medical record system as well as the Allscripts program that enhances communication and reporting. This reduces duplication of employee efforts in recording patient care. The application provided specific strategies and controls that the proposed CHHA will use to monitor and control utilization and cost of home care services.

The applicant provided information describing community need and the health needs of the community both current and projected. They also described how they will meet the need of medically underserved groups in obtaining access to health services. The applicant provided the health status indicators that relate to the medically underserved population in Suffolk and Dutchess counties and also provided demographic date related to age, income and census needs to the Managed Care and dually eligible population.

The Lutheran Center at Poughkeepsie, Inc. has an existing QA/QI plan that provides specific actions and procedures that demonstrate their efforts, issues identification, root cause analysis, and outcomes that are benchmarked against current provider and performance improvement.

Recommendation:
From a need perspective, approval is recommended

Programmatic Analysis

Lutheran Center at Poughkeepsie, Inc. is a not-for-profit corporation that currently operates a residential health care facility and a long term home health care program that serves Suffolk County. The applicant is seeking approval to add a CHHA to their continuum of services. The CHHA will operate under the assumed name TLCN Home Care and serve Suffolk and Dutchess counties. The agency will have offices located in Suffolk and Dutchess counties.

TLCN Home Care proposes to offer the following home health care services: home health aide, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, physical therapy and speech language pathology.

The residential health care facility and long term home health care program operated by the Lutheran Center at Poughkeepsie, Inc. are currently in compliance with all applicable codes, rules and regulations.

Recommendation:
From a programmatic perspective, approval is recommended.

Financial Analysis

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first and third years, summarized below:

	Year One	Year Three
Revenues:		
Commercial	$108,365	$134,720
Medicaid	1,112,723	1,740,258
Medicare	1,181,556	1,350,755
Total Revenues:	$2,402,644	$3,225,733
Expenses:	$2,273,446	$2,881,808
Net Income:	$129,198	$343,925

Expenses and utilization assumptions are based on the historical experience of Lutheran Center at Poughkeepsie, Inc. Revenues are reflective of current payment rates.

	Years One and Three
Commercial Fee for Service	4%
Medicare Fee for Service	59%
Medicaid Managed Care	35%
Charity Care	2%

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements are estimated at $480,301 based on two months of third year expenses and will be provided by the parent company, The Lutheran Care Network. Presented as BFA Attachment A is the financial summary of The Lutheran Care Network indicating sufficient funds.

The submitted budget indicates incremental net income of $129,198 and $343,925 for the first and third years of operations, respectively. Revenue is based on current payment rates for certified home health agencies including the Medicaid episodic payment rates. The budget appears reasonable.

Presented BFA Attachment B, a financial summary of Lutheran Center at Poughkeepsie, Inc. the facility has experienced negative working capital and net assets and has generated a net loss from operations of $902,453 for 2011. As of December 31, 2012 the facility has experienced negative working capital and net assets and generated a net loss from operations of $384,927.
The negative working capital is due to the entire balance of bonds payable being classified as current liabilities because a waiver for covenant violations has not yet been received. The applicant has stated that the losses from operations were due to a major worker's compensation claim and issues with the water distribution system at Lutheran Center at Poughkeepsie, Inc. The cost to correct these issues were not anticipated in the budget and caused financial shortfalls. The applicant indicates that negative equity is a result of historical mismanagement of billing and collections on receivables. Management has implemented the following strategies to improve operations:

- Recent negotiations with the union have brought about significant changes in the cost structure of the fringe benefits and compensation for union employees resulting in an approximate savings of $300,000.
- Reduction of hours for non-union employees.
- Renegotiation of food contracts.
- Reduction of fringe benefits by shifting more of the cost to employees.
- Close monitoring of overtime.

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	Internal Financial Summary as of December 31, 2012, The Lutheran Care Network
BFA Attachment B	Financial Summary, Lutheran Center at Poughkeepsie, Inc.
BFA Attachment C	Internal Financial Summary as of December 31, 2012, Lutheran Center at Poughkeepsie, Inc.

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

June 6, 2013

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

Acute Care Services - Construction **Exhibit #12**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122205 C	Women and Children's Hospital of Buffalo (Erie County) Mr. Booth - Interest Mr. Robinson – Opposed at EPRC	Contingent Approval

Downstate Dear Administrator Letters – Long Term Home Health Care Program – Construction **Exhibit #13**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121456 C	Fort Tryon Center for Rehabilitation and Nursing (New York County) Mr. Fensterman – Recusal Ms. Hines – Abstained at EPRC	Contingent Approval

Public Health and Health Planning Council

Project # 122205-C
Women and Children's Hospital of Buffalo

County: **Erie County (Buffalo)**
Purpose: **Construction**

Program: **Hospital**
Submitted: **November 2, 2012**

Executive Summary

Description
Women and Children's Hospital of Buffalo,(WCHOB), a 200-bed not-for-profit hospital located at 219 Bryant Street, Buffalo (Erie County), requests approval to construct a replacement facility and relocate its operations to the Buffalo Niagara Medical Campus (BNMC) located at 818 Ellicott Street, Buffalo (Erie County).

The proposed new facility will replace the Women and Children's Hospital of Buffalo current aged infrastructure that dates back to 1927. The size of the current facility is 608,000 square feet, which will be downsized under the proposed project to 410,400 square feet, yielding greater operational efficiencies with respect to resources and energy usage. The eleven-story replacement facility will be physically linked to the A-Tower of Buffalo General Medical Center (BGMC) by a two-story bridge spanning Ellicott Street.

The new facility will be downsized in most areas to adjust to shifting demands from ongoing demographic changes in Western New York, as well as projected operational trends in healthcare delivery. The replacement hospital will have 174 licensed inpatient beds, 26 fewer than the 200 beds presently certified at WCHOB. The proposed 26-bed reduction at WCHOB will be transferred to other Kaleida facilities in advance of the hospital's move, and will be the subject of a separate CON application.

Kaleida Health is an integrated healthcare delivery system that includes: Buffalo General Medical Center, DeGraff Memorial Hospital, Gates Vascular Institute, Millard Fillmore Suburban Hospital, Women and Children's Hospital of Buffalo, two long-term care facilities, Visiting Nursing Association of WNY, and several other subsidiaries, along with two charitable foundations.

DOH Recommendation
Contingent Approval

Need Summary
Kaleida Health Women and Children's Hospital of Buffalo seeks to consolidate and relocate its existing hospital onto the Buffalo Niagara Medical Campus. The number of total inpatient beds will be reduced by 26 resulting in a new certified capacity of 174. In addition, several certified cardiac catheterization services will be removed from WCHB's operating certificate and transferred to Buffalo General Medical Center's operating certificate. The relocation and downsizing of the hospital will allow WCHB to benefit from the efficiencies of the new site. In addition, WCHB will be in a better position to adapt to a projected declining population base of women of childbearing age.

Program Summary
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.

Financial Summary

The total project cost, excluding shell space, is $237,214,362 and will be funded as follows: $13,108,533 from The Women and Children's Hospital of Buffalo Foundation; $30,000,000 in fund raising; $43,312,881 from an equipment loan; and the remaining balance of $150,792,948 from a FHA-insured mortgage, at a 4.45% interest rate with a 25 year term.

Incremental Budget	Revenues	$20,019,321
	Expenses	16,387,800
	Gain (Loss)	$3,631,521

Subject to the noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

Office of Health Systems Management
Approval contingent upon:

1. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest, determined to be acceptable by the Department of Health. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]

2. Submission of an equipment loan commitment that is acceptable to the Department of Health. [BFA]

3. Submission of documentation of fundraising to be used as a source of financing that is acceptable to the Department of Health. [BFA]

4. The applicant is required to submit design development drawings, complying with requirements of 10NCYRR Part 710.4, for review and approval by DASNY.[AER]

5. The applicant is required to submit final construction documents, complying with requirements of 10NCYRR Part 710.7, to NYS-DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) prior to start of construction. [AER]

Council Action Date
June 6, 2013.

Need Analysis

Project Description

Kaleida Health Women and Children's Hospital of Buffalo (WCHB) is a 200-bed acute care hospital located at 219 Bryant Street, Buffalo, 14222, in Erie County. The facility seeks to replace its existing 200-bed hospital and relocate it to the Buffalo Niagara Medical Campus (BNMC) at 818 Ellicott Street, Buffalo, 14203, in Erie County. In addition, the hospital proposes to downsize its maternity and pediatric services by 26 inpatient beds and transfer several of its unused/under-utilized services to Buffalo General Medical Center. When this CON is completed, the number of inpatient beds at WCHB will be reduced by 26 and will total 174.

Background

Kaleida Health Women and Children's Hospital of Buffalo has the following certified beds and services:

Certified Beds: Kaleida Health Women and Children's Hospital of Buffalo			
Certified Beds	Certified Capacity	Requested Action*	Certified Capacity Upon Completion
Maternity	40	-10*	30
Neonatal Continuing Care	18		18
Neonatal Intensive Care	28		28
Neonatal Intermediate Care	18		18
Pediatric	68	8*	60
Pediatric ICU	28	-8*	20
Total	200	-26*	174

*Will be retained by Kaleida Health and redistributed to other facilities in the system.

Certified Services: Kaleida Health Buffalo General Medical Center			
Service	Certified Service	Requested Action	Certified Service Upon Completion
AIDS Center	√		√
Ambulatory Surgery - Multi Specialty	√		√
Audiology O/P	√		√
Burn Program	√	Remove	
CT Scanner	√		√
Cardiac Catheterization - Pediatric Diagnostic	√	Trans. Buff. Gen	
Cardiac Catheterization - Pediatric Intervention Elective	√	Trans. Buff. Gen	
Cardiac Surgery - Pediatric	√		√
Certified Mental Health Services O/P	√		√
Chemical Dependence - Rehabilitation O/P	√		√
Clinic Part Time Services	√		√
Clinical Laboratory Service	√		√
Dental O/P	√		√
Emergency Department	√		√
Epilepsy Comprehensive Services	√		√
Family Planning	√		√
Health Fairs O/P	√		√
Home Peritoneal Dialysis Training and Support	√		√

Certified Services: Kaleida Health Buffalo General Medical Center			
Service	Certified Service	Requested Action	Certified Service Upon Completion
Intensive Care	√		√
Magnetic Resonance Imaging	√		√
Maternity	√		√
Medical Social Services	√		√
Neonatal Continuing Care	√		√
Neonatal Intensive Care	√		√
Neonatal Intermediate Care	√		√
Nuclear Medicine - Diagnostic	√		√
Pediatric	√		√
Pediatric Intensive Care	√		√
Pediatric O/P	√		√
Pet Scanner	√	Add	√
Prenatal	√	Add	√
Pharmaceutical Service	√		√
Physical Medicine and Rehabilitation O/P	√		√
Primary Medical Care O/P	√		√
Psychology		Add	√
Radiology - Diagnostic	√		√
Regional Perinatal Center	√	Add	√
Renal Dialysis - Acute	√		√
Renal Dialysis - Chronic	√		√
Respiratory Care	√		√
Therapy - Occupational O/P	√		√
Therapy - Physical O/P	√		√
Therapy - Respiratory O/P	√	Add	√
Therapy - Speech Language Pathology	√		√
Therapy - Vocational Rehabilitation O/P	√		√
Transplant - Heart - Pediatric	√		√
Transplant – Kidney	√	Remove	
Trauma Center - Pediatric	√	Add	√
Well Child Care	√	Add	√

Kaleida Health Women and Children's Hospital of Buffalo has the following state designations:

- AIDS Center;
- Regional Pediatric Trauma Center; and
- Regional Perinatal Center.

The relocation of the facility will allow WCHB to streamline its inpatient services and maximize efficiencies; thus allowing their patients access to the full continuum of care on the BNMC. To support the service consolidation, pediatric diagnostic and elective interventional cardiac catheterization services will be removed from WCHB's operating certificate and transferred to Buffalo General Medical Center's operating certificate.

According to mapquest.com the distance between the old site and new site is 1.26 miles, 4 minutes travel time.

Services to be added and/or removed from Kaleida Health Buffalo General Medical Center's operating certificate:

Certified Services: Kaleida Health Buffalo General Medical Center, 100 High Street, Buffalo, 14203			
Service	Certified Service	Requested Action	Certified Service Upon Completion
Burn Program	√	Remove	
Cardiac Catheterization - Pediatric Diagnostic		Trans. Buff. Gen	√
Cardiac Catheterization - Pediatric Intervention Elective		Trans. Buff. Gen	√

Analysis

In 2009 – 2011, an average of 79 percent and 10 percent of WCHB inpatient discharges originated from Erie and Niagara Counties, respectively. In 2000, the total census for these two (2) counties was 1,170,111; by 2010, it declined by 3.0 percent to 1,135,509. Projections for 2020 indicate that the population of Erie and Niagara Counties will continue to experience further declines. Between 2010 and 2020, the population is likely to decline by 4.3 percent, to 1,086,627.

The population of women of childbearing age is also experiencing a similar downward trend. Between 2000 and 2010, the population of this cohort declined by 11.7 percent, from 284,240 to 252,969. The downward trend for this age group is projected to decline an additional 7.7 percent, from 252,969 in 2010 to 233,368 in 2020.

Census and Population Projections: Erie and Niagara Counties Source: Census Bureau 2000 and 2010; Cornell Program on Applied Demographics 2020 projections.			
	Erie County	Niagara County	Total
Total Population			
2000	950,265	219,846	1,170,111
2010	919,040	216,469	1,135,509
2020	878,075	208,552	1,086,627
% Change 00 vs. 20	(7.6)	(5.1)	(7.1)
Females 10 - 44			
2000	230,311	53,929	284,240
2010	206,251	46,718	252,969
2020	190,565	42,803	233,368
% Change 00 vs. 20	(17.3)	(20.6)	(17.9)

Over the last five (5) years, Kaleida Health Women and Children's Hospital of Buffalo total inpatient discharges have fluctuated between 13,900 and 15,200 patients. The average daily census (ADC) of these patients ranged from 170 to 185 patients on any given day, and the associated occupancy rates ranged from the high 70s to the mid-80s.

Kaleida Health Women and Children's Hospital of Buffalo will reduce its major service pediatric and obstetric beds by 16 beds and 10 beds, respectively. During the period under review, the facility averaged 5,738 pediatric and 3,700 obstetric discharges. The average pediatric and obstetric occupancy rates for the interval were 59.0 percent and 79.5 percent, respectively. WCHB's average pediatric occupancy rate during the period under review was about 11 percentage points below the urban planning optimum of 70.0 percent. However, its average obstetric occupancy rate was almost 5 percentage points beyond the obstetric planning standard of 75.0 percent.

The hospital plans to reduce its inpatient pediatric capacity by 16 beds. When the hospital's past experienced is reanalyzed using the proposed reduced capacity, the revised occupancy rate increased to 70.8 percent. This exceeds the pediatric planning optimum by less than one (1) percentage point.

WCHB also plans to reduce its inpatient obstetric capacity. Currently, the hospital operates 40 obstetric beds; the average occupancy rate was 79.5 percent. The hospital indicates that it will reduce its obstetric capacity by 10 beds. Based on its historic utilization, the reduction in beds would result in a revised occupancy rate in excess of 100.0 percent. Because of this likely high occupancy, the hospital plans to shift its appropriate gynecological patients to Buffalo General Medical Center. This will allow WCHB to stay within the obstetric planning optimum.

Kaleida Health Women and Children's Hospital of Buffalo: Inpatient Utilization by Major Service Category. Source: SPARCS 2007 – 2011.

Service	2007	2008	2009	2010	2011	Current Beds
Discharges						
Medical/Surgical	1,588	1,609	1,718	1,455	1,463	
Pediatric	6,149	5,257	6,250	5,634	5,402	
Obstetric	3,589	3,615	3,793	3,842	3,661	
General Psychiatric	58	69	62	60	49	
Chemical Dependency	10	5	9	17	9	
High Risk Neonates	800	847	805	816	885	
Subtotal	12,194	11,402	12,637	11,824	11,469	
Healthy Newborns	2,617	2,538	2,578	2,650	2,413	
Grand Total	14,811	13,940	15,215	14,474	13,882	
Average Daily Census						
Medical/Surgical	19	17	17	15	16	
Pediatric	64	53	61	53	52	
Obstetric	32	32	32	32	31	
General Psychiatric	1	2	1	1	1	
Chemical Dependency	0	0	0	0	0	
High Risk Neonates	51	55	52	54	55	
Subtotal	166	159	163	155	154	
Healthy Newborns	19	18	18	18	16	
Grand Total	185	177	181	173	170	
Average Length of Stay						
Medical/Surgical	4.3	3.8	3.5	3.7	3.9	
Pediatric	3.8	3.7	3.5	3.4	3.5	
Obstetric	3.2	3.3	3.1	3	3.1	
General Psychiatric	6.8	9.4	6.5	5.9	5.9	
Chemical Dependency	4.1	2.8	3.6	2.5	1.1	
High Risk Neonates	23.1	23.5	23.6	24.1	22.7	
Subtotal	5	5.1	4.7	4.8	4.9	
Healthy Newborns	2.6	2.6	2.6	2.5	2.5	
Grand Total	4.6	4.6	4.3	4.4	4.5	
Occupancy Based on Current Beds						
Medical/Surgical	0.0	0.0	0.0	0.0	0.0	0
Pediatric	66.9	55.0	63.0	55.1	53.8	96
Obstetric	79.8	81.0	80.8	80.3	77.0	40
General Psychiatric	0.0	0.0	0.0	0.0	0.0	0
Chemical Dependency	0.0	0.0	0.0	0.0	0.0	0
High Risk Neonates	79.1	85.3	81.3	84.2	85.9	64
Total	83.2	79.3	81.3	77.5	76.9	200

Conclusion

Kaleida Health Women and Children's Hospital of Buffalo intends to restructure the facility to meet the demand for its services as well as to adjust to the projected population declines in its two core counties for inpatient admissions. The hospital will rightsize its inpatient beds and services and relocate to the Buffalo Niagara Medical Campus next to Buffalo General Medical Center. The reduction in pediatric capacity will allow the hospital to operate closer to the pediatric planning optimum, with capacity for surges in its utilization. However, the reduction of obstetric capacity pushes the hospital well beyond the obstetric planning optimum. The hospital is aware of this and intends to shift its appropriate gynecological cases to Buffalo General Medical Center. The shift in cases will provide WCHB with the room to operate within the obstetric planning optimum.

Recommendation

From a need perspective, approval is recommended

Programmatic Analysis

Project Proposal

Kaleida Health requests approval to build a replacement facility for the Women and Children's Hospital in Buffalo. This division of Kaleida Health will move to the Buffalo Niagara Medical Campus, adjacent to the Buffalo General division. Concurrent with the construction of a replacement facility, Kaleida Health will restructure Women and Children's by building a smaller physical plant and reducing the number of licensed beds by 26. However, Kaleida will request, via a separate CON, the 26 beds be transferred to other divisions in advance of the completion of this project. Additionally, Women and Children's will no longer provide cardiac catheterization services at their division. Instead, due to the proximity, the pediatric catheterization program will be relocated to Buffalo General. Also on the Buffalo Niagara Medical Campus is a Kaleida medical office building, which will house Women and Children's ambulatory programs, including outpatient clinics, infusion services, and dialysis. The replacement Women and Children's division is proposed to be physically attached to both Buffalo General and the medical office building.

The reconfiguration of beds and services will not result in a net reduction in Kaleida Health staff over the first three years of occupancy.

Compliance with Applicable Codes, Rules and Regulations

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

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.

From a programmatic perspective, approval is recommended.

Financial Analysis

Total Project Cost and Financing

Total project cost for new construction and equipment is estimated at $244,413,082 itemized as follows:

	Total	Shell Space	Approved Project Cost
New Construction	$144,466,359	($5,580,981)	$138,885,378
Asbestos Abatement and Removal	967,924		967,924
Design Contingency	14,446,636	(557,640)	13,888,996
Construction Contingency	7,945,650	(306,702)	7,638,948
Fixed Equipment	18,366,853		18,366,853
Architect/Engineering Fees	9,367,016	(361,567)	9,005,449
Construction Manager Fees	4,890,651	(188,779)	4,701,872
Other Fees (Consultant)	4,240,278	(163,675)	4,076,603
Movable Equipment	14,255,027		14,255,027
Telecommunications	10,691,000		10,691,000
Financing Costs	7,374,021		7,374,021
Interim Interest Expense	6,062,759		6,062,759
Con Application Fee	2,000		2,000
Additional CON Processing Fee	1,336,908	(39,376)	1,297,532
Total Project Cost	$244,413,082	($7,198,720)	$237,214,362

Total costs are based on a July 1, 2013 start date with a thirty-two month construction period.

Note, at this time, the eleventh floor is considered to be shell space. The applicant states that Roswell Park Cancer Institute (RPCI) expects to use this space to build a physician-led, unified pediatric hematology-oncology program. RPCI has provided WCHOB a Memorandum of Understanding in regards to this project. RPCI is in the process of preparing a CON for this program. Note the Bureau of Architectural & Engineering Facility has approved Subproject 1 only for $237,214,362. Subproject 2 is for the shell space.

The applicant's financing plan appears as follows:

Equity from The Women and Children's Hospital of Buffalo Foundation	$13,108,533
Fund Raising (Pledge total is $26.5 million)	30,000,000
Equipment Loan (EB-5 NYS, LLC (7 years @3%)	43,312,881
FHA-Insured Mortgage (25 year term @4.45%)	150,792,948
Total	$237,214,362

A letter of interest has been provided by Gavin and LaVigne, Inc., for the FHA-insured mortgage. Also as state above, a letter of interest has been provided by EB-5 New York State, LLC for the equipment financing.

Operating Budget

The applicant has submitted the first and third year's incremental operating budgets, in 2012 dollars, as summarized below:

	First Year	Third Year
Revenue- Inpatient	$24,534,795	$19,241,976
Revenues-Outpatient:	1,656,339	1,059,184
Other Operating Income *	(281,839)	(281,839)
Total Revenues	$25,909,295	$20,019,321
Expenses:		
Operating	$6,212,437	$(1,012,010)
Capital	17,415,785	17,399,810
Total Expenses	$23,628,222	$16,387,800

Excess Revenue over Expenses	$2,281,073	$ 3,631,521
Utilization: - Inpatient discharges	1,956	1,259
- Outpatient Visits	1,894	999
Total Increase in Utilization	3,850	2,258
Cost per Utilization	$6,137.20	$7,257.66

*The reduction in "Other Operating Revenues" is the result of not leasing space in the new facility to private practices.

Inpatient and outpatient utilization by payor source for the first and third years is as follows:

	Inpatient	Outpatient
Medicaid Fee-for-Service	6.78%	8.90%
Medicaid Managed Care	16.89%	25.90%
Medicare Fee-for-Service	19.17%	12.56%
Medicare Managed Care	20.34%	14.68%
Commercial Fee-for-Service	3.11%	2.94%
Commercial Manage Care	29.82%	29.39%
Private & All Other	3.30%	4.70%
Charity	.59%	.93%

Expenses are based upon historical experience after adjusting for volume and investment. First year expenses contain additional staffing cost associated with the relocation process. The applicant expects operational savings in the first year of $10,500,000 and by the second year the annual savings are expected to be $12,400,000 coming from savings in utilities, supplies, salaries, professional fees, and purchased services.

The applicant expects Inpatient discharges to increase by 14% over 2011. A large portion of this increase or 11% is from a 5% increase in market share coming from obstetrics and obstetrics-non delivery (with a corresponding increase in normal newborn and neonatology), and a 3% increase in select pediatric service lines. WCHOB plans to achieve its projected volume growth through the following tactics:

- Expansion of OB/GYN services through the opening of three suburban OB/GYN sites in the following; Hamburg, NY, Lockport, NY and Lancaster, NY.
- Expansion of OB/GYN services at the Eastside Women's Health Center and Westside Women's Health Center.
- Increase services at Regional Perinatal Center through increased Maternal Fetal Medicine availability.
- Increase outreach and telemedicine in Southern Tier to decrease outmigration of patients to Pennsylvania.
- Focus on adolescent market for subspecialties.
- Increase assess of neurology and epilepsy services.

The applicant expects a net 2% increase in pediatric ambulatory surgery, outpatient imaging, and outpatient rehabilitation. The applicant states that for 2011 the total outpatient visits totaled 202,941 and when compared to the expected incremental change of 1,894 outpatient visits, the percentage increase was under 1% or .009.

Capability and Feasibility

The total project costs, excluding shell space, is $237,214,362 will be funded as follows: $13,108,533 from The Women and Children's Hospital of Buffalo Foundation; $30,000,000 in fund raising (of which $26.6 million has been pledged); $43,312,881 from an equipment loan; and the remaining balance of $150,792,948 coming from a FHA-insured mortgage, at the above stated terms. Letters of interest have been provided for the equipment loan and the mortgage.

Working capital requirements are estimated at $2,731,300, which appear reasonable based on two months of third year budgeted expenses. Presented as Attachments A and B is Kaleida Health 2010 and 2011 certified financial summary and their December 31, 2012 internal financial summary which indicates working capital requirements can be met from accumulated funds.

The incremental budget for the first year and third years' of operations projects an operational surplus of $2,281,073 and $3,631,521, respectively. Inpatient reimbursement rates were modeled at the DRG level by payer, assuming no inflation. Projections assumed an increase in capital add-on due to the increase cost of capital associated with the project. Outpatient reimbursements rates were modeled from existing rates at WCHOB assuming no inflationary increase. The budget appears reasonable.

As shown on BFA Attachments A, Kaleida Health had an average positive working capital of $180,265,500, an average excess of revenues over expenses of $7,729,000 and net assets totaling $194,424,000 as of December 31, 2011**.** For 2011 Kaleida Health experienced a $26,968,000 loss which consists of a $20,062,000 loss from operations and a $6,906,000 net loss in other income, primarily from restructuring charges, loss on impairment and disposal of assets. Kaleida Health states the Western New York Market has seen a significant downturn in impatient volume, about 5% or 10,000 inpatient cases, since the third quarter of 2010 and continuing through 2011. According to the SPARCS data inpatient utilization by Major Service category at WCHOB declined from 14,474 inpatient discharges in 2010 to 13,882 in patient discharges in 2011, a drop of 592 discharges or about 4%. The reduction in inpatients volume along with the downward reimbursement pressure from state and federal governments has driven down net patient service revenue. In early 2011 Kaleida Health mandated a focus around cost reduction and volume growth and has implemented the following initiatives to improve operating results: productivity improvements, labor cost control, portfolio and service line review and integration, corporate and fixed cost review and reductions, community benefit analysis, and the disposition of Waterfront Health Care

As shown on BFA Attachments B, Kale Ida Health had a positive working capital of $222,342,000, an excess of revenues over expenses of $42,846,000 and net assets totaling $251,821,000 as of December 31, 2012. It is noted that the financial results shown on the December 31, 2012 internal financial summary indicates the above initiatives appear to be working.

Presented as BFA Attachments C is The Women and Children's Hospital of Buffalo Foundation 2010 and 2011 certified financial summary. The facility has a positive average working capital of $47,044,173, an average excess of revenues over expenses of $3,695,016 and net assets totaling $68,098,120 as of December 31, 2011. The Women and Children's Hospital of Buffalo Foundation has provided a letter stating it will provide $20,307,253 for the project, including the shell space. It appears that the Foundation has sufficient resources.

Presented as BFA Attachments D is The Women and Children's Hospital of Buffalo Foundation December 31, 2012 internal financial summary, the facility had a positive working capital of $51,170,703, an excess of revenues over expenses of $8,640,787 and net assets totaling $78,901,450 as of December 31, 2012.

From a programmatic perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Financial Summary for 2010 and 2011, Kaleida Health
BFA Attachment B	Internal Financial Summary for December 31, 2012, Kaleida Health
BFA Attachment C	Financial Summary for 2010 and 2011, The Women and Children's Hospital of Buffalo Foundation
BFA Attachment D	Internal Financial Summary for December 31, 2012, The Women and Children's Hospital of Buffalo Foundation
BFA Attachment E	Detail Budget

Public Health and Health Planning Council

Project # 121456-C
Fort Tryon Center for Rehabilitation and Nursing

County: **New York (New York)**
Purpose: **Construction**

Program: **Certified Home Health Agency**
Submitted: **June 22, 2012**

Executive Summary

Description
Fort Tryon Rehabilitation & Health Care Facility, LLC, a proprietary limited liability company, requests approval to establish a Certified Home Health Agency (CHHA, to serve Bronx, Queens and New York counties. The applicant operates a 205-bed residential health care facility (RHCF) located at 801 West 190th Street in New York County, and a 100-slot Long Term Home Health Care Program (LTHHCP). Fort Tryon Rehabilitation & Health Care Facility, LLC is a member of Tri-Care, LLC, which is affiliated with: Split Rock Rehabilitation and Health Care Center, LLC a 240-bed RHCF with a 100-slot LTHHCP located in Bronx Count, and New Franklin Rehabilitation & Health Care Facility, LLC a 320-bed RHCF located in Queens County with an offsite ADHCP that is also located in Queens County.

It should be noted that Split Rock Rehabilitation and Health Care Center, LLC d/b/a Split Rock Rehabilitation and Health Care Center, an affiliate of the applicant through common ownership, is concurrently filing CON 121457 seeking to establish a CHHA to serve Bronx and Westchester Counties.

Chapter 56 of the Laws of 2012, authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Program (LTHHCP), requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State.

The applicant expects that the CHHA will be known as Fort Tryon Certified Health Agency, but this has not been determined as of yet.

DOH Recommendation
Approval.

Need Summary
Fort Tryon Center for Rehabilitation and Nursing currently operates a residential health care facility and a long term home health care program. They are requesting approval to add a certified home health agency to serve Bronx, New York and Queens counties to their continuum of services.

From a need perspective, approval is recommended.

Program Summary
This proposal seeks approval to add a general purpose certified home health agency (CHHA) to Fort Tryon Center for Rehabilitation and Nursing's residential health care facility (RHCF) and long term home health care program (LTHHCP), pursuant to the Dear Administrator Letter (DAL) HCBS 12-04, LTHHCP Opportunity to Become a General Purpose CHHA.

Financial Summary
There are no project costs associated with this proposal.

Budget	Revenues:	$7,443,609
	Expenses:	7,241,937
	Gain:	$ 201,672

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

Recommendations

Health Systems Agency

There will be no HSA recommendation for this application.

Office of Health Systems Management

Approval conditional upon

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval.[CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Chapter 56 of the Laws of 2012 authorized the Commissioner of Health to grant an expedited review of a certificate of need (CON) application submitted by an existing Long Term Home Health Care Plan (LTHHCP) requesting approval as a general purpose Certified Home Health Agency (CHHA). This authorization was subsequent to the Department issuing a Request for Applications (RFA) on January 25, 2012, to establish new or expand existing CHHAs in New York State.

Solicitation

On May 10, 2012, the Department issued a Dear Administrator Letter (DAL) outlining the process for LTHHCPs who were eligible for the expedited review process authorized by Chapter 56 of the Laws of 2012.

A June 11, 2012 clarification letter to the May 10, 2012 DAL letter informed potential applicants that the process to establish or expand existing CHHAs in NYS is based on the demonstration of need and or the ability of the organization to facilitate Medicaid Redesign Initiatives. The applicant was expected to address these criteria in their responses to the questions in CON Schedule 21.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified applicants that were deferred of the opportunity to submit supplemental information for the Department to consider in the review of these CONs.

Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's responses to CON Schedule 21 and any supplemental information requested by the Department. From this review, applicants were recommended in each county proposed based on how well their proposal addressed the review criteria.

Fort Tryon Center for Rehabilitation & Nursing wishes to establish a CHHA to serve New York, Bronx and Queens Counties. The applicant currently operates a 205 bed residential health care facility, an adult day health care program and a long term home care program.

They are a member of the Tri-Care, LLC system of 3 residential health care facilities that serve the New York City region. Fort Tryon is strategically positioned as a health care provider to implement CHHA services. The Tri-Care group has expertise and successful experience in LTHHC and ADHC programs and contractual relationships with several MLTCPs. This enhances continuity of care and patient choice.

A detailed list of referrals, by county, for Tri-Care was provided. As part of resident care and discharge process Fort Tryon Rehabilitation refers resident to local CHHAs. If approved, the residents will remain within the continuum of care provided by the applicant resulting in a seamless transition.

The applicant will provide case management services to advocate, refer, link and access other programs to enhance services and ensure maximum benefits and supports. The applicant currently has several contractual relationships with managed care organizations in place and in the process of developing additional relationships with several MLTCPs which are expanding into the proposed service areas. The applicant will work collaboratively with MLTCPs to reduce and control costs by participation in the provision of case management for its patients enrolled in MLTCs. If a patient requires more than short-term CHHA services, Fort Tryon will work with the patient and the MLTC to ensure mandatory enrollment into the MLTCP for the continuation of services.

The proposed CHHA will deal aggressively with acute illnesses to assure that the patient will remain in their own home and avoid hospitalizations. The CHHAs medical team will provide education, medical/nursing support in close contact with the physician and caregiver support to minimize the need for hospitalization. The CHHA will educate patients and their families on the subject of wound care, safety assessment of the home to prevent falls and fractures, education on prevention of chronic disease and dietary training.

Efficiency will be maintained and costs contained through development and monitoring of the care plan and the costs of the services provided. Services will be provided in accordance with the patients' needs and monitored on an ongoing basis and fee sources will be determined prior to service delivery. The exiting LTHHCP has demonstrated a clear efficiency in service by decreasing the need for institutionalization and maintaining people in their own homes. The CHHA will be able to duplicate this model and utilize LTHHCP staff for support resulting in cost effectiveness as the staff can serve in dual roles. The CHHA will utilize effective linkages that are already in place to support all efforts in the continuum of care model.

The applicant provided a detailed market gap analysis supporting the projected need for home care services in each proposed county. They discussed the projected increase of home care utilization. They provided statistics describing the CHHA service visits utilization by county supporting the likely increase in home care utilization in the mandatory enrollment environment. They provided hospital discharge and utilization rates by sex, age and county and the projected increase over the total service area. They provided statistics for Medicare & Medicaid eligibility and insurance status by sex and over the age of 75 representing the increase in the eligible Medicaid managed care population that were previously exempt. They also included the projected population numbers by county and gap analysis which supports the need.

The applicant will provide community education to patients and their family members. They have outreach programs in place throughout the community. The CHHA will develop initiatives specific to the community it serves to ensure the needs of the community are addressed. The proposed CHHA will fit into the community's long-range plan by implementing the MRT initiatives. The applicant's management team has experience, knowledge and expertise in the home health care setting.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Fort Tryon Center for Rehabilitation and Nursing currently operates a residential health care facility and a long term home health care program which serves New York County. The applicant is requesting approval to add a CHHA to their continuum of services. The new CHHA will use the assumed name Fort Tryon Certified Home Health Agency and will serve Bronx, New York and Queens counties. The applicant proposes to establish branch offices in each of the counties it plans to serve.

Fort Tryon Certified Home Health Agency proposes to provide the following home health care services: audiology, home health aide, homemaker, housekeeper, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, personal care, physical therapy, respiratory therapy and speech language pathology.

Fort Tryon Center for Rehabilitation and Nursing (RHCF) and Fort Tryon Long Term Home Health Care Program are currently in compliance with all applicable codes, rules and regulations.

CONDITION:

Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval.

From a programmatic perspective, conditional approval is recommended.

Financial Analysis

Operating Budget

The applicant has submitted the first and third year's operating budgets, in 2013 dollars, as summarized below:

Revenue Description	First Year	Third Year
Medicaid	$2,641,976	$5,399,465
Medicare	938,957	2,001,562
Private	20,630	42,582
Total Revenues	$3,601,563	$7,443,609
Total Expenses	$3,595,141	$7,241,937
Net Income or (Loss)	$6,422	$201,672

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

Payor	Year One and Year Three
Medicaid	72.4%
Medicare	24%
Private	.3%
Charity Care	3.3%

Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment System. Expense assumptions are based on salaries in the area for CHHA services. Utilization assumptions are based on the historical experience of the applicant's long term home health care program.

Capability and Feasibility

There are no project costs associated with this application.

The working capital requirement is estimated at $1,206,990, which appears reasonable based upon two months of third year expenses. It is anticipated that working capital can be provided from operations, but as a backup plan, Helen Webster, the applicant's major member, has provided an affidavit stating that she would contribute any needed working capital, up to the total amount of $1,300,000.

Presented as BFA Attachment A is Helen Webster's net worth statement, which shows sufficient liquid resources for this purpose. Presented as BFA Attachments B and C, are Fort Tryon Rehabilitation & Health Care Facility, LLC 2010 and 2011 certified financial summary and their internal financial summary for the period ending December 31, 2012, respectively.

The budget projects a first year and third year operating surplus of $6,422 and $201,672, respectively. Revenues are based on current payment methodologies. The submitted budget appears reasonable.

A review of Attachment B shows Fort Tryon Rehabilitation & Health Care Facility, LLC has maintained an average negative working capital position, a positive net asset position and generated average positive operating results of $2,918,089 for the period 2010-2011. The applicant states that working capital will turn positive in 2013.

A review of Attachment C shows Fort Tryon Rehabilitation & Health Care Facility, LLC has maintained an average negative working capital position, a positive net asset position and generated average positive operating results of $3,773,120.

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	Net Worth Statement
BFA Attachment B	Financial Summary for 2010 and 2011, Fort Tryon Rehabilitation & Health Care Facility, LLC
BFA Attachment C	Internal Financial Summary for 2012, Fort Tryon Rehabilitation & Health Care Facility, LLC

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

June 6, 2013

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

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

CON Applications

Acute Care Services – Establish/Construct **Exhibit #14**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122271 E	St. Peter's Health Partners (Albany County)	Contingent Approval

Ambulatory Surgery Centers – Establish/Construct **Exhibit #15**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122207 E	Center for Specialty Care Inc (New York County)	Contingent Approval
2.	131050 B	New York Center for Ambulatory Surgery, LLC (New York County)	Contingent Approval
3.	131056 B	The Endoscopy Center of Queens (Queens County)	Contingent Approval
4.	131064 E	Midtown Surgery Center (New York County)	Contingent Approval

Residential Health Care Facility – Establish/Construct **Exhibit #16**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	131054 E	Cortlandt Operations, LLC d/b/a Cortlandt Healthcare (Westchester County)	Contingent Approval

2.	131068 B	Judson Meadows Residential Health Care Center, Inc. (Schenectady County)	Contingent Approval
3.	131100 E	Cosden, LLC d/b/a Palatine Nursing Home (Montgomery County)	Contingent Approval

Certified Home Health Agencies – Establish/Construct **Exhibit #17**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	131103 E	Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified (Kings County)	Approval

Upstate Request for Applications - Certified Home Health Agencies – Establish/Construct **Exhibit #18**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121213 E	Fort Hudson Certified Home Health Agency, Inc. (Washington County)	Contingent Approval

Certificate of Amendment of the Certificate of Incorporation **Exhibit #19**

Applicant	E.P.R.C. Recommendation
North Country Children's Clinic, Inc.	Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #20**

Number	Applicant/Facility	E.P.R.C. Recommendation
2080L	Nix JT Corporation d/b comfort Keepers #685 (Tompkins, Cortland, and Schuyler Counties)	Contingent Approval
2243L	Washington County Public Health Nursing Service (Washington County)	Contingent Approval

Public Health and Health Planning Council

Project # 122271-E

St. Peter's Health Partners

County: **Albany County (Troy)**
Purpose: **Establishment**

Program: **Hospital**
Submitted: **December 7, 2012**

Executive Summary

Description

St. Peter's Health Partners (SPHP), a New York not-for-profit corporation, is seeking approval to become the active parent and co-operator for all of the SPHP providers and to co-establish each Article 28 Hospital within the SPHP health care system for purposes of forming an Obligated Group and joint co-establishment among all members of the Obligated Group, for the limited purpose of financing debt. Presented as BFA Attachment A is a listing of all the SPHP providers. Presented as BFA Attachment B, is the organizational chart for the SPHP providers under the Active Parent. Presented as BFA Attachment C, is the organizational chart for SPHP Obligated Group.

DOH Recommendation

Contingent approval

Need Summary

St. Peter's Health Partner's seeks CON approval to accomplish the following:

- Establishment as the active parent and co-operator of the licensed health care organizations in its system; and
- Co-establishment of each of the Article 28 hospitals within SPHP health care system in order to form an Obligated Group for the limited purpose of financing debt through the Obligated Group.

Approval is recommended.

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

Designation as an active parent and the formation of the obligated group is expected to enhance SPHP health care facilities and contribute to a greater marketing presence for the System and its providers. It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendations

Health Systems Agency

There will be no HSA review for this project.

Office of Health Systems Management

Approval contingent upon:

1. Submission of an executed Supplemental Master Trust Indenture that is acceptable to the Department of Health. [BFA]
2. Submission of a photocopy of each of the executed Restated Certificates of Incorporation of St. Peter's Health Partners; Beverwyck, Inc.; Eddy Licensed Home Care Agency, Inc.; Heritage House Nursing Center, Inc.; Home Aide Service of Eastern New York, Inc.; Memorial Hospital, Albany, N.Y.; Our lady of Mercy Life Center; Samaritan Hospital of Troy, New York; Senor Care Connection, Inc.; Seton Health at Schuyler Ridge Residential Healthcare; Seton Health System, Inc.; St. Peter's Hospital of the City of Albany; Sunnyview Hospital and Rehabilitation Center; The Capital Regional Geriatric Center, Inc.; The James A. Eddy Memorial Geriatric Center, Inc.; and Villa Mary Immaculate, acceptable to the Department. [CSL]

Council Action Date

June 6, 2013.

Need Analysis

Project Description

St. Peter's Health Partners (SPHP) seeks approval to be established as the active parent and co-operator of each of the existing entities within St. Peter's Health Care services, Northeast Health, Inc., and Seton Health system. In addition, SPHP seeks to co-establish each of the Article 28 hospitals within the system as an Obligated Group and to joint co-establish among all members of the Obligated Group for the purpose of financing debt through the Obligated Group.

Background

Currently, St. Peter's Hospital is the sole member of St. Peter's Health Partner's Obligated Group, along with St. Peter's Hospital. The following hospitals will become members:

- Albany Memorial Hospital – 165-beds;
- Samaritan Hospital – 212-beds;
- St. Mary's Hospital – 196-beds; and
- Sunnyview Hospital and Rehabilitation Center – 115-beds
- The Capital Region Geriatric Center, Inc. d/b/a Eddy Village Green.

The hospitals in SPHP have a total of 1,170 inpatient beds. Collectively, the majority of the patients served in the system hospitals reside in Albany, Rensselaer, Saratoga and Schenectady Counties. In 2000, the combined census for these counties was 794,293 residents; by 2010 it increased by 5.5 percent to 837,967. By 2020, the resident population is projected to increase to 862,052.

In 2010 and 2011, these hospitals averaged about 46,900 total inpatient discharges and 167,000 total Emergency Department visits. Sunnyview Hospital is not licensed for Emergency Department services.

As an active parent, SPHP intends to do the following for all of its providers:

- implement consistent corporate policies and procedures across the system;
- implement a consistent approach to regulatory compliance, standards of care and medical staff credentialing;
- organize the network of providers in an efficient and accessible continuum of care that is responsive to community needs;
- collaborate and conserve resources such as joint purchasing;
- facilitate clinical integration and use of best practices;
- share resources; and
- exhibit common mission, philosophy, values and purpose.

St. Peter's Health Partners expects the following benefits from the Obligated Group:

- each member will have access to capital that is necessary to preserve critical assets and support projects that are needed to maintain quality of care and a competitive position;
- some members will gain access to capital on more favorable terms than they can achieve on their own; and
- each member will be able to accept, utilize, transfer and share in the assets, revenues and incomes of the other members as needed or desirable to carry out the obligations under the master trust indenture.

Recommendation

From a need perspective, approval is recommended

Programmatic Analysis

Program Description

Establish St. Peter's Health Partners (SPHP) as the active parent of the licensed health care facilities operated by St. Peter's Health Care Services, Northeast Health, and Seton Health Systems, Inc. and co-establish each of the hospitals and Eddy Village Green as part of an obligated group. SPHP is currently the passive parent over the licensed entities. Being established as the active parent will allow SPHP to exercise powers reserved for licensed operators. SPHP will be the active parent over:

St. Peter's Health Care Services
St. Peter's Hospital
Our Lady of Mercy Life Center
St. Peter's Nursing and Rehabilitation Center

Northeast Health
Samaritan Hospital of Troy, New York
Memorial Hospital, Albany NY
Sunnyview Hospital and Rehabilitation Center
The James A. Eddy Memorial Geriatric Center
Eddy Village Green
Heritage House Nursing Center
Eddy SeniorCare
Eddy Visiting Nurses Associates
Eddy Village Green at Beverwyck
Eddy Licensed Home Care Agency

Seton Health System
St. Mary's Hospital
Seton Health at Schuyler Ridge Residential Healthcare

Character and Competence

The Board of Trustees of St. Peter's Health Partners is:

Name	
Robert J. Bylancik	
Barbara Cottrell	
Susan Dake	
Ann DiSarro	
Fr. Kenneth Doyle	
John D. Filippone, MD	
Harold d. Gordon, Esq	2nd Vice Chair
Ronald L. Guzior	
George Hearst III	
Sr. Phyllis Herbert	
Robert W. Johnson, III, Esq	Chair
Sydney Tucker Jones, III	
Beverly Karpiak	
Michael Keegan	Treasurer
John M. Lang	
Norman Massry	
Sr. Kathleen Natwin	
George Philip	1st Vice Chair
Curtis Powell	
James K. Reed, MD	President
Alan Sanders, MD	

James Slavin, MD
Anthony P. Tartaglia, MD Secretary
Lisa Thorn, MD
Sr. Kathleen Turley

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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

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.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Background

Effective October 1, 2011, SPHP became the sole member of St. Peter's Health Care Services and Northeast Health, Inc. and a class A member of Seton Health System, Inc., whereas SPHP was given passive parent powers. SPHP's sole member is Catholic Health East. As active parent and co-operator, SPHP will have the power and authority to make decisions for its affiliates as stated in its certificate of incorporation and bylaws, and the active parent powers as described in 10 NYCRR 405.1(c) as follows:

> (1) appointment or dismissal of hospital management level employees and medical staff, except the election or removal of corporate officers by the members of a not-for-profit corporation;
>
> (2) approval of hospital operating and capital budgets;
>
> (3) adoption or approval of hospital operating policies and procedures;
>
> (4) approval of certificate of need applications filed by or on behalf of the hospital;
>
> (5) approval of hospital debt necessary to finance the cost of compliance with operational or physical plant standards required by law;
>
> (6) approval of hospital contracts for management or for clinical services; and,
>
> (7) approval of settlements of administrative proceedings or litigation to which the hospital is party, except approval by the members of a not-for-profit corporation of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.

SPHP's exercise of its powers will allow SPHP to do the following for all SPHP providers:

- Formulate consistent corporate policies and procedures across the SPHP system;
- Ensure a consistent approach to regulatory compliance, standards of care, and medical staff credentialing;
- Organize the network providers into an efficient and accessible continuum of care responsive to community needs;

- Collaborate in areas designed to conserve resources, such as joint purchasing;
- Facilitate clinical integration and the use of best practices;
- Share resources; and,
- Reflect common mission, philosophy, values and purposes.

St. Peter's Hospital is currently the sole member of the St. Peter's Hospital Obligated Group and was formed before the SPHP Health System. Memorial Hospital of Albany, Samaritan Hospital of Troy, Seton Health System, Inc. d/b/a St. Mary's Hospital, Sunnyview Hospital and Rehabilitation Center of Schenectady and the Capital Region Geriatric Center, Inc., who are part of Northeast Health, want to become co-established with SPHP and each other for the limited purpose of obligated group financings. On January 1, 200, St. Peter's Hospital entered into a Master Trust Indenture (MTI), which enables the Hospital to execute supplemental Master Trust Indentures, admitting new entities to the Obligated Group. Each member of the Obligated Group will be jointly and severally liable for payment of all obligations under the MTI and will be required to pledge their gross revenues to secure Obligations. Membership in the Obligated Group will offer the following benefits:

- Each member will have access to capital necessary to preserve critical assets and support projects necessary to maintain quality of care and a competitive position.
- Some members may have access to capital on more favorable terms than such Member could achieve on its own.
- Each Member may accept, utilize, transfer and share in the assets, revenues and incomes of the other Members as necessary or desirable to carry out the obligations under the MTI or similar instruments.

The current SPHP obligated group credit ratings are as follows: Moody's Investors Service has an A3 rating with a stable outlook; Standard and Poor's and Fitch Ratings have a BBB+ rating with a positive outlook.

The existing debt of approximately $263,145,000 within the Obligated Group which belongs to St. Peter's Hospital will not be refinanced through the Group. The existing debt of Albany Memorial and Seton-St. Mary's as of December 31, 2012, was approximately $37,814,538 and may be refinanced as part of the expansion of the Obligated Group.

Capability and Feasibility

The applicant has stated that upon approval of this application by the Public Health and Health Planning Council, SPHP will obtain consent for the proposed changes from necessary lenders, insurers and trustees. There will be no change in the daily operations of each health care facility, although each facility is expected to experience cost benefits from the active parent and obligated group designations.

Presented as Attachments D, is the consolidated internal financial summaries of SPHP. Each system has maintained positive working capital, net assets and a net profit from operations as of December 31, 2012. Presented as BFA Attachment E-G are the 2011 financial summaries for each system. Again, each has shown positive working capital, net assets and a net profit from operations.

The flexibility to address any individual entity's liquidity needs by drawing on the resources of the health system as needed is a key benefit of belonging to the health system and of becoming a member of the obligated group.

Designation as an active parent and the formation of the obligated group is expected to enhance SPHP health care facilities and contribute to a greater marketing presence for the System and its providers.

Recommendation

From a financial perspective, contingent approval is recommended

Attachments

BFA Attachment A- Listing of SPHP Providers

BFA Attachment B- Proposed Organizational Chart for St. Peter's Health Partners-Active parent

BFA Attachment C- Proposed Organizational Chart for St. Peter's Health Partners-Obligated Group

BFA Attachment D- Financial Summary, SPHP Consolidated 2012

BFA Attachment E- Financial Summary, St. Peter's Health Care Services and related Entities, 2011

BFA Attachment F- Financial Summary, Seton Health System, Inc., 2011

BFA Attachment G- Financial Summary, Northeast Health, Inc. and Affiliates, 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 6th day of June, 2013, 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 become the active parent and co-operator for all of the SPHP providers and to co-establish each Article 28 hospital within the SPHP health care system for purposes of forming an Obligated Group, 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:
122271 E	St. Peter’s Health Partner

APPROVAL CONTINGENT UPON:

1. Submission of an executed Supplemental Master Trust Indenture that is acceptable to the Department of Health. [BFA]

2. Submission of a photocopy of each of the executed Restated Certificates of Incorporation of St. Peter's Health Partners; Beverwyck, Inc.; Eddy Licensed Home Care Agency, Inc.; Heritage House Nursing Center, Inc.; Home Aide Service of Eastern New York, Inc.; Memorial Hospital, Albany, N.Y.; Our lady of Mercy Life Center; Samaritan Hospital of Troy, New York; Senor Care Connection, Inc.; Seton Health at Schuyler Ridge Residential Healthcare; Seton Health System, Inc.; St. Peter's Hospital of the City of Albany; Sunnyview Hospital and Rehabilitation Center; The Capital Regional Geriatric Center, Inc.; The James A. Eddy Memorial Geriatric Center, Inc.; and Villa Mary Immaculate, 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 122207-E

Center for Specialty Care Inc

County: **New York County (New York)**
Purpose: **Establishment**

Program: **Diagnostic and Treatment Center**
Submitted: **November 5, 2012**

Executive Summary

Description

Center for Specialty Care (CSC) is an existing, New York State business corporation, which has operated a freestanding multi-specialty ambulatory surgery center at 50 East 69th Street, New York, New York since becoming operational in 1988. In June 2012, Mrs. Nancy K. Smith, then the sole shareholder, transferred 2% of her ownership interest, by gift, to each of her following four adult children; Lucinda Smith Hay, James Walter Smith, III, Peter Frederick Smith, and Constance Smith Plimpton. The transaction proposed through this application would increase each of her four adult children's ownership membership percentage from 2% to 15%. There are no proposed or expected changes in the operation of the freestanding surgery center as a result of this change in stock ownership.

The current and proposed membership interest of CSC is as follows:

Current		Proposed	
Member	Percent	Member	Percent
Nancy K. Smith	92%	Nancy K. Smith	40%
James W. Smith, III	2%	James W. Smith, III	15%
Lucinda S. Hay	2%	Lucinda S. Hay	15%
Constance S. Plimpton	2%	Constance S. Plimpton	15%
Peter F. Smith	2%	Peter F. Smith	15%

Each of the four individuals purchasing additional shares have entered into an executed stock sale agreement, the terms of which are summarized below.

DOH Recommendation

Contingent Approval.

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 project costs associated with this application.

The purchase price of $200,000 each will be met by each of the four adult children purchasing additional shares. Each of the four purchasing members will increase their present membership interest from 2% of the outstanding shares, to 15% membership interest.

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

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application

Office of Health Systems Management

Approval contingent upon:

1. Submission of stockholder affidavits, acceptable to the Department. [CSL]
2. Submission of an amended stock certificate, acceptable to the Department. [CSL]

Council Action Date

June 6, 2013.

Programmatic Analysis

Background

Transfer an additional 52% of the shares of the Center for Specialty Care, Inc., an operational ambulatory surgery center, to the four adult children of the current majority shareholder. The four adult children are already 2% shareholders via a transaction earlier this year, as allowed under Public Health Law for business corporations. There will be no changes to the operation of the facility as a result of this project.

Character and Competence

The current majority shareholder is Nancy K. Smith (92%). Following approval the stock ownership will be as follows:

Name	
Nancy K. Smith	40%
James W. Smith III	15%
Lucinda S. Hay	15%
Constance S. Plimpton	15%
Peter F. Smith	15%

James Smith is a real estate investment manager. Ms. Hay is currently the director in charge of the day-to-day operations of the Center. Ms. Plimpton is a homemaker and volunteer. Peter Smith is a software engineer/architect.

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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

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.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Stock Sale Agreement

Nancy K. Smith has entered into an executed stock sale agreement dated October 23, 2012 with each of the four purchasing members listed below:

James W. Smith, III
Lucinda S. Hay
Constance S. Plimpton
Peter F. Smith

Each purchasing member is purchasing an additional 13% membership interest in Center for Specialty Care for $200,000 each. Each membership interest of the four purchasing members will increase from 2% to 15% of total stock membership interest.

Capability and Feasibility

There are no project costs associated with this application.

The $200,000 purchase price for each of the four members purchasing additional shares will be met from each of their available personal net assets. Presented as BFA Attachment D, is the net worth statement for the members purchasing additional shares for Center for Specialty Care, which show sufficient funds for the purchase. Nancy K. Smith, mother of Constance Plimpton, has submitted a letter attesting that the $200,000 purchase money was gifted to Ms. Constance Plimpton.

BFA Attachments A is the 2010 and 2011 financial summaries for Center for Specialty Care, Inc. operations, which shows the facility has maintained positive working capital, members' equity and achieved average net income from operations of $132,264, during this period. The applicant indicates that the loss for 2010 was primarily the result of inefficient medical supply management. The center made personnel changes to improve that department.

BFA Attachments B is the 2012 unaudited profit and loss statement for Center for Specialty Care, Inc., which shows the facility has achieved a net income from operations of $200,136.

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 of Center for Specialty Care, Inc. 2011 and 2010
BFA Attachment B -	Profit and loss statement of Center for Specialty Care, Inc. 2012- Unaudited
BFA Attachment C -	Center for Specialty Care Inc. - Membership Percentage: Pre and Post PHHPC Approval.
BFA Attachment D -	Net Worth Statement – Purchasing Members.

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 6th day of June, 2013, 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 transfer 52 percent of stock from a majority shareholder to four exiting minority shareholders, 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:
122207 E	Center for Specialty Care Inc

APPROVAL CONTINGENT UPON:

1. Submission of stockholder affidavits, acceptable to the Department. [CSL]

2. Submission of an amended stock certificate, 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131050-B
New York Center for Ambulatory Surgery, LLC

County: **New York County (New York)** ***Program:*** **Ambulatory Surgery Center**
Purpose: **Establishment and Construction** ***Submitted:*** **January 31, 2013**

Executive Summary

Description
New York Center for Ambulatory Surgery, LLC, an existing limited liability company, requests approval for the establishment and construction of a multi-specialty Freestanding Ambulatory Surgical Center (FASC) to provide orthopedic surgery, urology, gastroenterology, vascular surgery, gynecology, including gynecologic oncology, plastic and cosmetic surgery, colorectal surgery, and general surgery. The center will be located in leased space on the fifth floor of an existing building at 309 East 94th Street, New York. The center will consist of four operating rooms, four pre-op holding rooms, 14 recovery spaces, sterilization and soiled workrooms and appropriate support space. The center will be staffed with twenty-two physicians consisting of; two board certified orthopedic surgeons, two board certified gastroenterologists, three board certified gynecological oncologists, five board certified general surgeons, three board certified urologists, two board certified plastic surgeons, two board certified colorectal surgeons, one board certified gynecologic physician and two board certified vascular surgeons.

The sole proposed member of New York Center for Ambulatory Surgery, LLC is Mark Reiner, M.D. Dr. Reiner is board certified in general surgery.

DOH Recommendation
Contingent approval for a limited life of five years.

Need Summary
New York Center for Ambulatory Surgery proposes to provide ambulatory surgery services in orthopedic, urology, gynecology including gynecologic oncology, gastroenterology, vascular, plastic and cosmetic, colorectal, and general surgical procedures. The number of projected surgical procedures is 4,420 in the first year of operation.

Contingent approval is recommended for a limited period of five years.

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
Total project costs of $6,421,991 will be met with a $5,779,792 bank loan and $642,199 of member's equity.

Budget	Revenues:	$7,397,335
	Expenses:	5,030,592
	Net Income:	$2,366,743

Subject to noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this project.

Office of Health Systems Management

Approval with an expiration of the operating certificate five years from the date of its issuance 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 DOH beginning in the second year of operation. Said reports should 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 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)
4. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
5. Submission of an executed bank loan for project costs acceptable to the Department of Health. [BFA]
6. Submission of an executed working capital loan that is acceptable to the Department of Health. [BFA[
7. Submission of an executed building lease agreement that is acceptable to the Department of Health. [BFA, CSL]
8. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
9. Submission of a photocopy of the applicant's finalized and executed Operating Agreement acceptable to the Department. [CSL]
10. Submission of a photocopy of the applicant's executed Certificate of Amendment of Article of Organization 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, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]

6. The applicant shall complete construction by February 1, 2016. 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
June 6, 2013.

Need Analysis

Background

New York Center for Ambulatory Surgery, LLC is seeking approval to establish and construct a freestanding ambulatory surgery center to provide multi-specialty surgery services at 309 East 94th Street, New York, 10128, in New York County.

Analysis

New York Center for Ambulatory Surgery projects to perform approximately 4,420 surgical procedures in the first year of operation and 4,689 surgical procedures in the third year. These projections are based on the current practices of participating surgeons. The service area is New York County.

New York County has a total of six freestanding multi-specialty ASCs and seven freestanding single-specialty ASCs.

Existing Ambulatory Surgery Centers: New York County
Source: SPARCS 2011

ASC Type	Name of the Facility with Zip Codes	Total Patients 2011
Multi-Specialty	Center for Specialty Care, 10021	4,757
Gastroenterology	East Side Endoscopy, 10010	9,059
Multi-Specialty	Fifth Avenue Surgery Center, 10028	1,494
Endoscopy	Kips Bay Endoscopy Center LLC, 10016	9,504
Gastroenterology	Manhattan Endoscopy Center, LLC, 10017	617
Ophthalmology	Mid-Manhattan Surgi-Center, 10010	3,661
Multi-Specialty	Midtown Surgery Center, LLC, 10017	2,867
Multi-Specialty	Surgicare of Manhattan, LLC, 10017	3,350
Multi-Specialty	Gramercy Park Digestive Disease Center, 10003	8,215
Multi-Specialty	Gramercy Surgery Center, Inc., 10010	1,876
Gastroenterology	Carnegie Hill Endo, LLC (Opened March 2, 2012), 10029	N/A
Ophthalmology	Retinal ASC of NY, Inc., 10075	1,857
Gastroenterology	West Side GI (Opened June 15, 2012), 10019	N/A
Total		47,257

In addition there are three freestanding ASCs (two single-specialty ASCs in zip codes 10021 and 10011), and one multi-specialty ASC in zip code 10019) that have been approved, but are not yet operational.

New York Center for Ambulatory Surgery has provided a mission statement and a statement that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws with consultation of the legal counsel. These statements are acceptable to the Department.

New York Center for Ambulatory Surgery is committed to serving all persons without regard to ability to pay or source of payment.

Conclusion

Approval of the proposed ASC would bring under Article 28 regulation an additional provider of ambulatory surgery to serve the communities of New York County.

Recommendation

From a need perspective, contingent approval is recommended for a limited period of five years.

Programmatic Analysis

Program Description

Establish and construct an Article 28 diagnostic and treatment center that will be certified as a multi-specialty ambulatory surgery center.

Proposed Operator	New York Center for Ambulatory Surgery, LLC
Site Address	309 East 94th Street, New York NY 10128
Surgical Specialties	Multi-Specialty, including: orthopedic, urology, gynecology, gastroenterology, vascular, plastic, colorectal and general.
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 and physician needs)
Staffing (1st Year / 3rd Year)	21.25 FTEs /24.0 FTEs
Medical Director(s)	Mark Reiner, MD
Emergency, In-Patient and Backup Support Services Agreement and Distance	Expected to be provided by Lenox Hill Hospital 1.5 miles/7 minutes
On-call service	Access to the facility's 24/7 physician on-call service during hours when the facility is closed.

Character and Competence

The sole member of the LLC is:

Name	
Mark Reiner, MD	100%

Dr. Reiner is a board-certified practicing surgeon.

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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

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.

Integration with Community Resources

The Center plans to work with its patients to educate them on the availability of, and services offered by, local primary care physicians and community hospitals and the surgical services offered by the Center. The Center will work to build partnerships in order to educate the community about the services offered at the Center. A sliding fee scale will be developed for patients without health insurance.

The applicant indicates that it will become a network provider in the provider-led health homes designated by the Department for New York County and the surrounding counties as the Department phases in the implementation of health homes. The Center will consider joining any Accountable Care Organization (ACO) that forms to provide services to New York County residents, and will make a decision regarding joining such as ACOs in accord with its operating agreement.

The applicant plans to implement an electronic medical record system and will investigate the potential of joining a RHIO.

Recommendation

From a programmatic perspective, contingent approval is recommended

Financial Analysis

Lease Rental Agreement

The applicant will lease approximately 13,333 square feet on the fifth floor of an existing building at 309 East 94th Street, New York under the terms of the proposed lease agreement summarized below:

Landlord:	Karten Realty Corporation
Lessee:	New York Center for Ambulatory Surgery, LLC
Term:	10 years with the option to renew for three additional terms of five years
Rental:	$456,655 the first year increasing 2% yearly ($34.25 per sq. ft.)
Provisions:	The lessee will be responsible for utilities, maintenance, taxes, and insurance.

The applicant has indicated that the lease will be an arm's length agreement and letters of opinion from Licensed Commercial Real Estate Brokers have been submitted indicating rent reasonableness. Other non-related parties occupy the remainder of the building.

Total Project Cost and Financing

Total project costs for renovations and moveable equipment are estimated at $6,421,991, broken down as follows:

Renovation & Demolition	$4,276,250
Design Contingency	427,625
Construction Contingency	427,625
Architect/Engineering Fees	342,100
Consultant Fees	24,000
Movable Equipment	624,840
Financing Costs	61,223
Interim Interest Expense	201,211
Application Fees	2,000
Additional Processing Fees	35,117
Total Project Cost	$6,421,991

Project cost is based on an August 1, 2013 construction start date and a six month construction period. The applicant's financing plan appears as follows:

Bank Loan (10yrs, 6%)	$5,779,792
Member's Equity	$642,199

A letter of interest from Capital One has been submitted by the applicant.

Operating Budget

The applicant has submitted an operating budget in 2013 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues:	$6,972,697	$7,397,335
Expenses:		
Operating	$3,470,602	$3,748,875
Capital	1,321,319	1,281,716
Total Expenses:	$4,791,920	5,030,592
Net Income:	$2,180,777	$2,366,743
Utilization: (procedures)	4,420	4,689
Cost per procedure:	$1,084	$1,073

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

	Year One & Three
Commercial Fee-for-Service	24.5%
Commercial Managed Care	24.5%
Medicare Fee-for-Service	39.5%
Medicaid Managed Care	6.0%
Private Pay	3.3%
Charity Care	2.2%

Expenses and utilization assumptions are based on the historical experience of the physicians' private practices. Upon CON approval the physicians will continue to operate their private practices. Each physician has provided a referral letter in support of utilization projections.

Capability and Feasibility

Total project costs of $6,421,991 will be met through a loan from Capital One for $5,779,792 at stated terms, with the remaining $642,199 from proposed member's equity. Presented as BFA Attachment A, is the net worth statement of the proposed member, which indicates the availability of sufficient funds.

Working capital needs are estimated at $838,432 based on two months of third year expenses. The applicant will finance 419,216 of working capital at an interest rate of 8% over 5 years for which a letter of interest has been provided by Capital One. The remaining $419,216 will be provided as equity by the proposed member.
Presented as BFA Attachment B, is the pro-forma balance sheet of New York Center for Ambulance Surgery, LLC as of the first day of operation, which indicates positive member's equity of $1,061,415.

The submitted budget indicates a net income of $2,180,777 and $2,366,743 during the first and third years of operation, respectively. Revenues are based on current reimbursement methodologies for ambulatory surgery centers. The budget appears reasonable.

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	Net Worth Statements of Proposed Members
BFA Attachment B	Pro-forma Balance Sheet

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: Mount Sinai Hospital
One Gustave Levy Place
New York, NY 10029

No response.

Facility: Lenox Hill Hospital
100 East 77th Street
New York, NY 10021

No response.

Facility: New York Presbyterian Hospital
New York Weill Cornell Center
525 East 68th Street
New York, NY 10021

No response.

Facility: Hospital for Special surgery
535 East 70th Street
New York, NY 10021

No response.

Supplemental Information from Applicant

Need and Sources of Cases: The applicant states that the utilization projected for the proposed facility is based on the current caseload of the 22 physicians who have committed to perform cases at the proposed ASC. The applicant estimates that 75 percent of these cases are currently being performed in the participating physicians' offices or at other non-hospital based ASCs. The applicant also expects that consumers' and third-party payers' preferences for utilizing freestanding ASC's will contribute to use of the facility, as will expected continued growth in the utilization of ambulatory surgical procedures in New York County. The applicant also believes that performing cases in a freestanding facility that is

responsive to the needs of the participating physicians will result in greater convenience and efficiency for patients and physicians, which will contribute further to utilization of the proposed ASC.

Staff Recruitment and Retention: The applicant states that initial recruitment will be of selected staff currently employed by the member physicians in their private practices, 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, 75 percent of the cases projected for the facility are currently being performed in the participating physicians' offices or at other non-hospital based ASCs. The remainder are expected to come from modest growth in the physicians' current cases and from local area hospitals.

OHSM Comment

The absence of any comments in opposition to this application 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 6th day of June, 2013, 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 ambulatory surgery center to be located at 309 East 94th Street, New York, 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:
131050 B	New York Center for Ambulatory Surgery, LLC

APPROVAL CONTINGENT UPON:

Approval with an expiration of the operating certificate five years from the date of its issuance 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 DOH beginning in the second year of operation. Said reports should 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 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)
4. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
5. Submission of an executed bank loan for project costs acceptable to the Department of Health. [BFA]
6. Submission of an executed working capital loan that is acceptable to the Department of Health. [BFA[
7. Submission of an executed building lease agreement that is acceptable to the Department of Health. [BFA, CSL]
8. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
9. Submission of a photocopy of the applicant's finalized and executed Operating Agreement acceptable to the Department. [CSL]
10. Submission of a photocopy of the applicant's executed Certificate of Amendment of Article of Organization 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, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
6. The applicant shall complete construction by February 1, 2016. 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131056-B
The Endoscopy Center of Queens

County: **Queens County (Astoria)** ***Program:*** **Ambulatory Surgery Center**
Purpose: **Establishment and Construction** ***Submitted:*** **February 1, 2013**

Executive Summary

Description
TFCQ, Inc., an existing proprietary corporation, requests approval to establish and construct an Article 28 diagnostic and treatment center (the Center) to be certified as a single specialty freestanding ambulatory surgery center. The facility will be certified as a single specialty freestanding ambulatory surgery center in the discipline of gastroenterology. The Center, which will have three procedure rooms, will be located on the second floor at 23-27 31st Street, Astoria, New York. The private practice will be in the same building but on a different floor (which floor is still to be determined). The ASC will be on its own floor, with nothing else on that floor.

The Center will be known as The Endoscopy Center of Queens. All of the procedures projected for the Center are currently being performed in the private practice offices of the sponsoring physicians.

The proposed ownership of TFQC, Inc. is as follows:

Steven Ackerman	10%
Nicholas Roditis, MD.	40%
Barry Obadiah, MD.	40%
Brian Marmor	10%

DOH Recommendation
Contingent approval is recommended for a limited life of five years.

Need Summary
The Endoscopy Center of Queens proposes to provide single-specialty ambulatory surgery services in gastroenterology surgical procedures and projects that 9,900 surgical procedures will be performed in the first year of operation. All the procedures are currently being performed in the private practice offices of the participating physicians.

Contingent approval is recommended for a limited life of five years.

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
Total project cost, which is $3,421,312, will be met via equity from the shareholders personal resources.

Budget:

Revenues	$4,976,337
Expenses	4,136,987
Net Income	$839,350

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this project.

Office of Health Systems Management

Approval with an expiration of the operating certificate five years from the date of its issuance 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 DOH beginning in the second year of operation. Said reports should 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 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]
4. Submission of an assumed name or DBA, if applicable, acceptable to the Department. [HSP]
5. Submission of an executed lease rental agreement that is acceptable to the Department of Health. [BFA, CSL]
6. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
7. Submission of an organizational chart showing the applicant's legal structure. [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, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
6. The applicant shall complete construction by April 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

June 6, 2013.

Need Analysis

Background

The Endoscopy Center of Queens is seeking approval to establish and construct an Article 28 diagnostic and treatment center to provide single-specialty ambulatory surgery services. The proposed freestanding ambulatory surgery center will be located at 23-25 31st Street, Astoria, 11105, in Queens County.

Analysis

The Endoscopy Center of Queens projects to perform approximately 9,900 surgical procedures in the first year of operation and 10,503 surgical procedures in the third year and will serve Queens County. These projections are based on the current practices of the participating physicians.

Queens County has a total of five freestanding multi-specialty ASCs and one freestanding single-specialty ASC. Additionally, there are four freestanding single-specialty ASCs (three GI and one ophthalmology) and four multi-specialty ASCs that are approved but not yet operational in Queens County.

Existing Ambulatory Surgery Centers: Queens County
Source: SPARCS 2011

ASC Type	Name of the Facility with Zip Codes	Total Patients 2011
Multi-Specialty	Choices Women's Medical Center, Inc., 11435	8,225
Multi-Specialty	Hillside D & TC, LLC, 11423	2,303
Ophthalmology	The Mckool Eye Institute, LLC, 11103	7,119
Multi-Specialty	New York Surgery Center Queens, LLC (Boulevard Surgical Center), 11103	1,353
Multi-Specialty	Physicians Choice Surgicenter, 11414	723
Multi-Specialty	Queens Surgi-Center, 11385	4,970
Total		24,693

The Endoscopy Center has provided a Mission Statement that is acceptable to the Department.
The Endoscopy Center has also provided a statement that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws with consultation of legal counsel. This statement is acceptable to the Department.

The Endoscopy Center is committed to serving all persons in need of surgery regardless of their ability to pay or the source of payment.

Conclusion

Approval of this project would bring the affected procedures into a regulated Article 28 setting and subject them to the associated surveillance and quality controls.

Recommendation

From a need perspective, contingent approval is recommended for a limited life of five years.

Programmatic Analysis

Background

The applicant proposes to establish and construct a single specialty diagnostic and treatment center in gastroenterology that will also be federally certified as an ambulatory surgery center.

Proposed Operator	TECQ, Inc. (upon approval will change name to The Endoscopy Central of Queens, Inc.)
Site Address	23-25 31st Street, Astoria NY 11105
Surgical Specialties	Single Specialty: Gastroenterology
Operating Rooms	0
Procedure Rooms	3
Hours of Operation	Monday through Friday from 9:00 am to 5:00 pm (Extended as necessary to accommodate patient needs).
Staffing (1st Year / 3rd Year)	24.05 FTEs / 24.05 FTEs
Medical Director(s)	Nicholas Roditis, MD
Emergency, In-Patient and Backup Support Services Agreement and Distance	Will be provided by Mount Sinai Hospital of Queens 0.8 miles/2 minute drive time
On-call service	24/7 on-call service to connect patients to the facility's on-call physician during hours when the facility is closed.

Character and Competence

The members of the Corporation are:

Name	
Brian Marmor (President)	10%
Steven Ackerman (Vice President)	10%
Nicholas Roditis, MD (Secretary)	40%
Barry Obadiah, MD (Treasurer)	40%

Two of the members are practicing surgeons/board-certified gastroenterologists. Of the remaining two members, one is the CEO and the other is the COO/Administrator of an operational ambulatory surgery 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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases, as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

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.

Integration with Community Resources

The Center plans to work with its patients to educate them on the availability of, and services offered by, local primary care physicians and community hospitals. The Center will work to build partnerships with local physicians and primary medical care providers in the local community (including those providers who are expected to be in the same building with TECQ) in an effort to educate the community about the services offered at the Center. Additionally, patients will not be excluded based on ability to pay, as a sliding fee scale will be developed for patients without health insurance and charity care will be provided.

The applicant indicates interest in becoming a part of an Accountable Care Organization (ACO), including that of Mount Sinai Hospital, and will be exploring all available options.

The applicant is working collaboratively with Mount Sinai Hospital of Queens to develop an electronic medical record (EMR) system for the Center and is investigating the potential of affiliating with a regional health information organization (RHIO) in the area (i.e. Interborough RHIO or the New York Clinical Information Exchange (NYCLIX)).

Recommendation

From a programmatic perspective, contingent approval is recommended

Financial Analysis

Lease Rental Agreement

The applicant has submitted a draft lease rental agreement for the site that they will occupy, which is summarized below:

Premises:	8,500 square feet located at 23-27 31st Street, Astoria, New York
Lessor:	Pali Realty, LLC
Lessee:	TFCQ, Inc.
Term:	20 years
Rental:	$323,000 annual rent ($38.00 per sq. ft.)
Provisions:	The lessor shall be responsible for utilities, sewer services and maintenance services.

The applicant has indicated that the lease agreement will be a non-arms length lease agreement, since Nicholas Roditis, MD., and Barry Obadiah, MD. are members of the landlord.

Total Project Cost And Financing

Total project cost, which is for renovations and the acquisition of moveable equipment, is estimated at $3,421,312, itemized as follows:

Renovation and Demolition	$1,891,917
Design Contingency	189,192
Construction Contingency	189,192
Architect/Engineering Fees	189,192
Other Fees	90,000
Moveable Equipment	851,116
CON Fee	2,000
Additional Processing Fee	18,703
Total Project Cost	$3,421,312

Project costs are based on a December 1, 2013 construction start date and a four-month construction period. The applicant will provide equity to meet the total project cost.

Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, for the first and third years of operation, summarized below:

	Year One	Year Three
Revenues	$4,686,311	$4,971,707
Expenses:		
Operating	$3,426,800	$3,502,164
Capital	615,934	634,823
Total Expenses	$4,042,734	$4,136,987
Net Income	$643,577	$834,720
Utilization: (procedures)	9,900	10,503
Cost Per Procedure	$408.36	$393.89

Utilization, itemized by payor source, during the first and third years is as follows:

	Year One and Three
Medicaid Managed Care	5.00%
Medicare Fee-for-Service	45.00%
Medicare Managed Care	5.00%
Commercial Fee-for-Service	5.00%
Commercial Managed Care	37.00%
Private Pay	1.00%
Charity Care	2.00%

Expense and utilization assumptions are based on the historical experience of the private physicians. The applicant has submitted physician referral letters in support of utilization projections.

Capability and Feasibility

Total project cost of $3,421,312 will be met via equity from personal resources of the shareholders of TFCQ, Inc.

Working capital requirements are estimated at $689,498, which is equivalent to two months of third year expenses. The applicant will provide equity from their personal resources. Presented as BFA Attachment A are the personal net worth statements for the shareholders of TFQC, Inc., which indicates the availability of sufficient funds to meet the total project cost and the working capital requirement. The applicant submitted an affidavit indicating that they will contribute, as needed, resources disproportionate to ownership percentages. Presented as BFA Attachment B, is the pro-forma balance sheet of TFQC, Inc. as of the first day of operation, which indicates a positive shareholders equity position of $4,110,809.

The submitted budget indicates a net income of $643,577 and $834,720 during the first and third years of operation, respectively. Revenues are based on current reimbursement rates for ambulatory surgery services.

Subject to the noted contingency, 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, contingent approval is recommended

Attachments

BFA Attachment A - Personal Net Worth Statement
BFA Attachment B - Pro-forma Balance Sheet

Supplemental Information

The Endoscopy Center of Queens, LLC
CON #131056

Supplemental Information

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: Mount Sinai Hospital of Queens
25-10 30th Avenue
Long Island City, NY 11102

No response.

Facility: City Hospital Center at Elmhurst
79-01 Broadway
Elmhurst, NY 11373

No response.

Facility: Forest Hills Hospital
102-01 66th Road
Forest Hills, NY 11375

No response.

Supplemental Information from Applicant

Need and Sources of Cases: The applicant states that all of the procedures projected for the ASC are currently being performed in the private practice offices of the participating physicians. The projected caseload for the third year reflects a modest allowance for growth from the first year of operations. The applicant also intends to put in place a charity care initiative to ensure that at least two percent of all cases at the ASC will be for the uninsured, underinsured and other underserved groups in Queens County. The applicant further expects that the growing preference of consumers and third party payers for the services of ASCs will also help achieve and maintain the caseload projected for the proposed facility.

Staff Recruitment and Retention: The applicant states that initial recruitment will be of selected staff currently employed by the member physicians in their private practices, 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. Finally, the applicant expects that the existing staff of the private practices will, for the most part, meet the needs of the proposed ASC, which will minimize or eliminate any concern regarding loss of staff by hospitals to the facility.

Office-Based Cases: As noted, all of the procedures projected for the proposed ASC are currently being performed in the private practice offices of the participating physicians.

OHSM Comment

The absence of any comments in opposition to this application 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 6th day of June, 2013, 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 single-specialty ambulatory surgery center specializing in gastroenterology to be located at 23-25 31st Street, Astoria, 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:
131056 B	The Endoscopy Center of Queens

APPROVAL CONTINGENT UPON:

Approval with an expiration of the operating certificate five years from the date of its issuance 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 DOH beginning in the second year of operation. Said reports should 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 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]
4. Submission of an assumed name or DBA, if applicable, acceptable to the Department. [HSP]
5. Submission of an executed lease rental agreement that is acceptable to the Department of Health. [BFA, CSL]
6. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
7. Submission of an organizational chart showing the applicant's legal structure. [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, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
6. The applicant shall complete construction by April 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131064-E

Midtown Surgery Center

County: **New York County (New York)**
Purpose: **Establishment**

Program: **Ambulatory Surgery Center**
Submitted: **February 11, 2013**

Executive Summary

Description

Midtown Surgery Center, LLC, an existing limited liability company, requests approval for the establishment of new members of this multi-specialty ambulatory surgery center. The applicant is proposing a change in membership interest of 76.505%. From a historical perspective, the applicant submitted a 90 day notification for a change in membership interest, whereas a total of 24.90% has been distributed to new members. Presented as BFA Attachment A, is the spreadsheet of the current and proposed owners of Midtown Surgery Center, LLC.

The applicant will consist of two types of members, which are as follows:

Non operating members:	
(Robert Haar, Glen Lau, Douglas Chin, Charles Thorne and Nolan Karp)	40%
Surgeon members (remaining people)	60%

DOH Recommendation

Contingent approval

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 purchase prices will be financed proportionately based on ownership percentages through proposed members equity.

Budget:

Revenues	$47,613,618
Expenses	22,362,490
Net Income	$25,251,128

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval contingent upon:

1. Submission of executed transfer agreements for the purchase of membership interests that is acceptable to the Department of Health. [BFA, CSL]
2. Submission of a photocopy of an executed and dated Operating Agreement of Midtown Surgery Center, LLC, acceptable to the Department. [CSL]

Council Action Date

June 6, 2013.

Programmatic Analysis

Background

Establish several new members of the ASC and remove three members who have sold their shares

Character and Competence

The new proposed members of the LLC are:

Proposed	*Already Approved*	
Orrin Sherman	Robert Haar	Douglas Schottenstein
Edward Kwak	Glen Lau	Dimitry Nesen
S. Steven Yang	Douglas H. L. Chin	Mark Reiner
John A. Frachhia	Charles H. Thorne	Brian Jacob
David Pereira	Nolan Karp	Brian Katz
Thomas Youm	Jeffrey Kaplan	Anthony Vine
Timothy Reish	Alton Barron	Cary B. Chapman
Steven Struhl	Steven Glickel	Garrett Bennett
James Gladstone	Louis Catalano	Robert Guida
Bradford Parsons	Adam Cohen	Jonathan Glashow
Andrew Jurtel	Daveed Frazier	Ron Noy
Craig Radnay	Stuart Mogul	Joseph Iraci
Donald Rose	Andrew Rosen	Sergei Dolgopolov
Fabian Bitan	Edmond Cleeman	Mark Zoland
James Pacholka	Richard Gilbert	A. Douglas Heymann
Charles Kimmelman	Mark Klion	Steven Sheskier
Samieh Rizk	Francis Mendoza	*Michael Loshigan
Yolanda Ragland	Vijay Anand	*Laurence Orbuch
Guy Lin	Darren Friedman	*Salvatore Lenzo
Evan Goldstein	Darius Kohan	
Alexa Lessow	Kenneth McCulloch	*Redeeming membership
Lisa Libertore	Andrew Feldman	
3636 Assoc, LLC	Kevin Wright	
Corinne Horn	Francis Cuomo	
Michael Burnett	Jonathan Stieber	
Neil Sperling	Joel Kreitzer	
Lane Krevitt	Gordon Friedman	
Robert Pincus	Vinoo Sebastian Thoras	
Scott Gold	Kenneth Chapman	

All of the proposed members are practicing surgeons or podiatrists.

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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Drs. Frachhia and Parsons each disclosed 1 pending malpractice case. Drs. Sherman and Pereira each disclosed 2 pending malpractice cases. Dr. Bitan disclosed 5 pending malpractice cases. Dr. Radnay disclosed 6 pending malpractice cases. Additionally, Dr. Kimmelman disclosed 4 settled malpractice cases with payouts ranging from $10,000 to $2.3 M dollars.

None of the proposed members disclosed ownership in any health care facilities.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Membership Interest Purchase Agreement

The applicant has submitted a draft membership interest purchase agreement, the terms of which are summarized below, of which each unit will be purchased for $25,000.

Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, for the first year subsequent to the change in membership interests, summarized below:

Revenues:	
Medicaid Managed Care	$ 2,486,385
Medicare Fee-for-Service	2,185,299
Commercial Fee-for-Service	26,671,826
Commercial Managed Care	8,206,623
Self Pay	9,035,563
Total Revenues	$48,585,396
Less Charity Care	971,708
Net Revenues	$47,613,688

Utilization, itemized by payor source, during the first year of subsequent to the change in membership interests, is as follows:

Medicaid Managed Care	8.00%
Medicare Fee-for-Service	5.00%
Commercial Fee-for-Service	52.00%
Commercial Managed Care	16.00%
Self Pay	17.00%
Charity Care	2.00%

Utilization assumptions are based on the applicant's historical experience. Expenses are decreasing, as a result of the surgeons who previously were compensated as contract surgeons, who are now recognized members/owners of the surgery center. Until the additional surgeons were approved by the State Health Department under the original 90 day notification, the surgeons were compensated as independent contractors.

Capability and Feasibility

The purchasers will purchase the membership interests for $25,000 for each membership unit acquired.

Working capital requirements are estimated at $3,727,081, which is equivalent to two months of first year expenses.

The applicant will meet the working capital requirement from a personal net worth statement of the members. Staff has reviewed the personal net worth statements and indicates that they have sufficient resources to pay the purchase price for the acquired interests and the working capital requirement. Also, the applicant provided an affidavit indicating that if needed, they will provide equity disproportionate to ownership interests.

The submitted budget indicates a net income of $25,251,128 during the first year subsequent to the change in membership interests. Revenues are based on current reimbursement methodologies of the facility.

Presented as BFA Attachment B, is the 2011 certified financial statements of Midtown Surgery Center. As shown on Attachment A, the facility had a positive working capital position and a positive net asset position. Also, the facility achieved a net income of $12,945,692 during 2011.

Presented as BFA Attachment C, is the 2012 internal financial statements of Midtown Surgery Center. As shown, the facility had a negative working capital position and a positive net asset position through December 31, 2012. The applicant has indicated that the negative working capital position is the result of a temporary bank overdraft. The applicant has indicated that that liability has since been paid to the bank and as a result, the facility has a positive working capital position through January 31, 2013. Also, the facility achieved a net income of $25,640,273 during 2012.

Subject to the contingency, 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, contingent approval is recommended.

Attachments

BFA Attachment A-	Spreadsheet of the current owners and proposed owners of Midtown Surgery Center
BFA Attachment B-	Financial Summary- 2011 certified financial statements of Midtown Surgery Center
BFA Attachment C-	Financial Summary- 2012 internal financial statements of Midtown Surgery Center

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 6th day of June, 2013, 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 several new members of the multi-specialty ambulatory surgery center located at 305 East 47th Street, 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:
131064 E	Midtown Surgery Center

APPROVAL CONTINGENT UPON:

1. Submission of executed transfer agreements for the purchase of membership interests that is acceptable to the Department of Health. [BFA, CSL]

2. Submission of a photocopy of an executed and dated Operating Agreement of Midtown Surgery Center, 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131054-E
Cortlandt Operations, LLC d/b/a Cortlandt Healthcare

County: **Westchester County (Peekskill)** ***Program:*** **Residential Health Care Facility**
Purpose: **Establishment** ***Submitted:*** **February 1, 2013**

Executive Summary

Description

Cortlandt Operations, LLC, d/b/a Cortlandt Healthcare, an existing limited liability company, requests approval to be established as the operator of Cortlandt Healthcare, LLC, a120-bed proprietary residential health care facility (RHCF) located in Peekskill. Ownership of the operation before and after the requested change is as follows:

Current		Proposed	
Cortlandt		Cortlandt	
Healthcare, LLC		Operations, LLC	
Members:		Members:	
Steven Croopnick	25%	Devorah Friedman	36.5%
Mark Gorstein	25%	Sharon Einhorn	36.5%
Robert Schlundt	25%	Israel Minzer	9.0%
Steven Rubin	25%	Benjamin Einhorn	5.0%
		Naftali Minzer	2.0%
		Dov Minzer	2.0%
		Rivka Sussman	2.0%
		Eliezer Schwartz	2.0%
		Shaindl Shur	2.0%
		Yossie Zucker	2.0%
		Steven Sax	1.0%

Cortlandt Operations, LLC will enter into a lease agreement with Westchester Realty Associates, LLC, which will continue to be owned equally by Steven Croopnick, Mark Gorstein, Robert Schlundt and Steven Rubin.

Rivka Sussman, Dovie Minzer, Devorah Friedman, Israel Minzer, Sharon Einhorn and Naftali Minzer have ownership interests in the following RHCFs: St. James Rehabilitation and Healthcare Center, a 230-bed RHCF located in St. James, the Grand Pavilion for Rehabilitation and Nursing at Rockville Center, a 158-bed RHCF located in Rockville Center, Bellhaven Center for Rehabilitation and Nursing Center, a 240-bed RHCF located in Brookhaven and Dumont Center for Rehabilitation a 196-bed RHCF located in New Rochelle. Yossie Zucker has ownership interests in The Grand Pavilion for Rehabilitation and Nursing at Rockville Center, a 158-bed RHCF located in Rockville Center and St. James Rehabilitation and Healthcare Center, a 230-bed RHCF located in St. James. Benjamin Einhorn has membership interest in the Grand Pavilion for Rehabilitation and Nursing at Rockville Center, a 158-bed RHCF located in Rockville Center. Steven Sax has ownership interest in St. James Rehabilitation and Healthcare Center, a 230-bed RHCF located in St. James. Rivka Sussman, David Minzer, Naftali Minzer and Devorah Friedman have ownership interests in San Souci Rehabilitation and Nursing Center, a 120-bed RHCF located in Yonkers. Sharon Einhorn, Israel Minzer and Devorah Frieman have ownership interests in Ramapo Manor Center for Rehabilitation and Nursing, a 20-bed RHCF located in Suffern.

DOH Recommendation

Contingent approval

Need Summary

Cortlandt Healthcare's bed utilization increased from 93.7% in 2009 and 2010 to 94.1% in 2011 and was higher than that for Westchester County as a whole for each of these years. This project involves no change in beds or services.

Program Summary

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

Financial Summary

Total asset purchase price of $4,500,000 will be met with a bank loan of $3,600,000 with the remaining $900,000 from proposed members' equity.

Budget:	Revenues:	$14,750,528
	Expenses:	14,061,344
	Net Income:	$689,184

Subject to noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval contingent upon:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
   - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
   - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
   - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
   - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
     - Information on activities relating to a-c above; and
     - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
     - Other factors as determined by the applicant to be pertinent.

   The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a programmatically acceptable name for the facility. [LTC]
4. Submission of an executed bank loan for the purchase price that is acceptable to the Department of Health. [BFA]
5. Submission of an executed working capital loan that is acceptable to the Department of Health. [BFA]
6. Submission of the applicant's fully executed proposed Restated Articles of Organization, acceptable to the Department. [CSL}
7. Submission of the applicant's fully executed proposed Operating Agreement, acceptable to the Department. [CSL]
8. Submission of the Certificate of Dissolution or the Certificate of Amendment of the Articles of Organization of Cortlandt Healthcare, LLC, acceptable to the Department. [CSL]

Council Action Date

June 6, 2013.

Need Analysis

Background

Cortlandt Operations LLC, doing business as Cortlandt Healthcare, seeks approval to be established as the new operator of Cortlandt Healthcare LLC, a 120 bed residential health care facility located at 110 Oregon Road, Peekskill, 10566, in Westchester County.

Analysis

Cortlandt Healthcare's utilization rate was higher than that of Westchester County for 2009, 2010 and 2011, as shown in Table 1. Cortlandt Healthcare's utilization increased from 93.7% in 2009 and 2010 to 94.1% in 2011. A snapshot of Cortlandt's recent utilization indicates a utilization rate of 95.8 % in February 2013.

Table 1: RHCF – Cortlandt Healthcare /Westchester County

Facility/County/Region	% Occupancy 2009	% Occupancy 2010	% Occupancy 2011
Cortlandt Healthcare	93.7%	93.7%	94.1%
Westchester County	93.3%	92.8%	92.3%

There is currently a need for 224 beds in Westchester County.

Table 2: RHCF Need – Westchester

2016 Projected Need	6,716
Current Beds	6,539
Beds Under Construction	-47
Total Resources	6492
Unmet Need	224

Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department.
An applicant will be required to make appropriate adjustments in its admission polices and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage of health Systems Agency percentage, whichever is applicable.

Cortlandt Healthcare was below the 75 percent planning average for 2009 and 2010. The facility reported Medicaid admissions of 7.60 percent and 9.7 percent in 2009 and 2010, respectively. The 75 percent planning averages for Westchester County for these years were 11.48 percent (2009) and 20.24 percent (2010).

Conclusion

Cortlandt Healthcare is committed to continuing the increasing occupancy rate that has occurred for the last three years and to maintaining this facility as a viable community resource.

Recommendation

From a need perspective, contingent approval is recommended

Programmatic Analysis

Facility Information

	Existing	**Proposed**
Facility Name	Cortlandt Healthcare LLC	Cortlandt Healthcare
Address	110 Oregon Road Peekskill, NY. 10566	Same
RHCF Capacity	120	Same
ADHC Program Capacity	N/A	Same
Type of Operator	Proprietary	Proprietary
Class of Operator	Limited Liability Company	Limited Liability Company
Operator	Cortlandt Healthcare LLC	Cortlandt Operations LLC Members: Devorah Friedman 36.5% Sharon Einhorn 36.5% Israel Minzer 9.0% Benjamin Einhorn 5.0% Naftali Minzer 2.0% Dov Minzer 2.0% Rivka Sussman 2.0% Eliezer Schwartz 2.0% Shaindl Shur 2.0% Yossie Zucker 2.0% Steve Sax 1.0%

Character and Competence - Background

Facilities Reviewed

Nursing Homes

Sans Souci Rehabilitation & Nursing Center	10/2009 to present
Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present
Ramapo Manor Center for Rehabilitation & Nursing	07/2012 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Individual Background Review

Devorah Friedman holds a New York State speech language pathologist license, in good standing. Ms. Friedman discloses the following ownership interests:

Sans Souci Rehabilitation & Nursing Center	10/2009 to present
Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present
Ramapo Manor Center for Rehabilitation & Nursing	07/2012 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Sharon Einhorn discloses no employment history over the last 10 years. Ms. Einhorn discloses the following ownership interests:

Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present

Ramapo Manor Center for Rehabilitation & Nursing	07/2012 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Israel Minzer is the president of Healthcare Equipment and Parts, a diagnostic medical equipment supplier in Brooklyn, NY. Mr. Israel Minzer discloses the following ownership interests:

Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present
Ramapo Manor Center for Rehabilitation & Nursing	07/2012 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Benjamin Einhorn is a New York State certified public accountant with his license currently inactive. He is employed as the assistant administrator at the Liberty House Nursing Home in Jersey City, New Jersey, and as the vice president of the Romerovski Corporation, a clothing exporter in Roselle Park, New Jersey. Mr. Einhorn discloses the following ownership interests:

The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Naftali Minzer is the executive vice president of Dermarite Industries LLC, a manufacturer of wound and skin care products in Paterson, New Jersey. Mr. Naftali Minzer discloses the following ownership interests:

Sans Souci Rehabilitation & Nursing Center	10/2009 to present
Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Dovie Minzer is the vice president of sales at Healthcare Equipment and Parts, a diagnostic medical equipment supplier in Brooklyn, NY. Mr. Minzer discloses the following ownership interests:

Sans Souci Rehabilitation & Nursing Center	10/2009 to present
Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Rivka Sussman discloses no employment history over the last 10 years. Ms. Sussman discloses the following ownership interest:

Sans Souci Rehabilitation & Nursing Center	10/2009 to present
Dumont Center for Rehabilitation	08/2010 to present
Bellhaven Center for Rehabilitation and Nursing Center	03/2010 to present
St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Eliezer Schwartz is a sales executive at Qualmax Supplies, a janitorial supply company in Linden, New Jersey. Mr. Schwartz discloses no ownership interest in health facilities.

Shaindl Shur is the president of Comprehensive Healthcare Solutions LLC, a medical billing company in Lakewood New Jersey. Ms. Shur discloses no ownership interests in health facilities.

Yossie Zucker is a New York State certified public accountant with license is currently inactive. Mr. Yossie Zucker is the owner and president of CareRite Services LLC, a financial consulting firm for nursing homes in Lakewood, New Jersey. He discloses ownership interest in the following facilties:

St. James Rehabilitation & Healthcare Center	08/2012 to present
The Grand Pavilion for Rehabilitation at Rockville Center	08/2012 to present

Steven Sax has been the Director of Clinical Reimbursement and Development at CareRite Services, LLC for the last nine months. Previously, Mr. Sax was the assistant administrator to the Sans Souci Rehabilitation and Nursing Center in Yonkers, New York. Steven Sax discloses the following ownership interest in health facilities:

St. James Rehabilitation & Healthcare Center	08/2012 to present

Character and Competence - Analysis

No negative information has been received concerning the character and competence of the applicants.

A review of Sans Souci Nursing Home for the period reveals that the facility was fined $10,000 pursuant to a Stipulation and Order for surveillance findings on February 11, 2011. Deficiencies were found under 10 NYCRR 415.12(j): Quality of Care – Hydration.

A review of operations for the Sans Souci Rehabilitation and Nursing Center for the period results in a conclusion of substantially consistent high level of care since there were no repeat enforcements.

A review of Bellhaven Center for Rehabilitation and Nursing, Dumont Center for Rehabilitation and Nursing, Ramapo Manor Center for Rehabilitation & Nursing, St. James Rehabilitation and Healthcare Center, and The Grand Pavilion for Rehabilitation at Rockville Center reveals that a substantially consistent high level of care has been provided since there were no enforcements for the time period reviewed.

Project Review

No changes in the program or physical environment are proposed in this application.

Conclusion

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

The proposed name “Cortlandt Healthcare” does not adequately represent the facility as a nursing home, and is potentially misleading to the public. As a contingency of approval, the applicant will be required to submit a revised name, subject to DOH approval.

Recommendation

From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Asset Purchase Agreement

The change in ownership of the operations will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized below:

Date:	December 28, 2012
Seller:	Cortlandt Healthcare, LLC
Buyer:	Cortlandt Operations, LLC
Assets Transferred:	All rights, title and interest in the business and operation of the Facility and to the tenant's position in the leases; all contracts; the name Cortlandt Healthcare and any and all other trade names, logos, trademarks and service marks associated with the facility; all menus, policy and procedure manuals; all telephone numbers, fax numbers and domain names used in the operation of the Facility; copies of all financial books and records; all resident/patient records; all employee and payroll records; goodwill; copies of all other books and records; all plans; Medicare and Medicaid provider agreements and numbers; all licenses and permits; all resident funds held in trust; all computer software; all prepaid expenses and deposits related to the assumed contracts; all leasehold improvements, furniture, fixtures and equipment; all inventory, supplies, and other articles of personal property; closing date accounts receivable, all security deposits and prepayments and all prepaid expenses.
Excluded Assets:	All cash and cash equivalents, post-closing rate increases for periods prior to the closing date, net of unreimbursed cash receipts assessment liabilities, initial date accounts receivable, amounts due from related parties, True2Life Trademark, Scott Wheeler's personal computers.
Assumed Liabilities:	All accounts payable; all accrued payroll and taxes payable; all monies due to employees; all payables to third party and private payors; all payables to others and the ongoing obligations under the assumed contracts arising on and before closing date
Excluded Liabilities:	All liabilities of seller other than the assumed liabilities.
Purchase Price:	$4,500,000 paid in full at closing.

The applicant has provided a letter of interest from M&T Bank stating available financing of $3,600,000 at 5.26% for a term of ten years, with a 20 year amortization with the remaining balance of $900,000 to be paid with equity from proposed members. The applicant has submitted an affidavit stating the resulting balloon payment at the end of the ten year term will be funded by members should acceptable financing not be available. Presented as BFA Attachment A, is the net worth statements of the proposed members, which indicates available resources. Sharon Einhorn has submitted an affidavit stating she will contribute resources disproportionate to ownership percentages.

The applicant has submitted 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.

Lease Agreement

The applicant submitted an executed lease agreement, the terms of which are summarized below:

Date:	December 28, 2012
Landlord:	Westchester Realty Associates, LLC
Lessee:	Cortlandt Operations, LLC
Premises:	All buildings, structures, fixtures, equipment and tract of land located at 110 Oregon Road, Cortlandt
Term:	26 years with the option to renew for an additional term of 23 years
Rental:	$684,324/year plus supplemental rent of $500,000/year with a 1% annual

increase for lease years 1-8, 2% annual increase for lease years 9-18 and 3% annual increase for years 19-26.

Provisions: The lessee will be responsible for taxes, utilities, insurance and maintenance.

The lease agreement is between unrelated parties and is therefore an arm's length agreement.

Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, for the first year subsequent to change in ownership:

Revenues:	$14,750,528
Expenses:	
Operating	12,703,156
Capital	1,358,188
Total Expenses:	$14,061,344
Net Income:	$689,184
Utilization: (patient days)	41,218
Occupancy:	94.1%

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 facilities 2012 Medicaid rate with no trend to 2013.
- The capital component of the Medicaid rate is based on the return of and return on equity reimbursement methodology.
- Utilization by payor source for year one is expected as follows:

Medicare	21.8%
Medicaid	57.4%
Private Pay	20.8%

- Utilization is based on 2011 payor mix.
- Breakeven occupancy is projected at 89.7%

Capability and Feasibility

There are no project costs associated with this application.

The total purchase price of $4,500,000 will be met with a bank loan of $3,600,000 at stated terms, with the remaining $900,000 from proposed members' equity. As shown on BFA Attachment A, the net worth statements of the proposed members indicate available resources.

Working capital requirement are estimated at $2,343,557, based on two months of first year expenses. The applicant will finance $1,171,778 of working capital at an interest rate of 5.26% over five years for which a letter of interest has been provided by M&T Bank. The remaining $1,171,779 will be provided as equity from the proposed members. Presented as BFA Attachment B, is the pro-forma balance sheet of Cortlandt Operations, LLC as of the first day of operation. As shown, the facility will initiate operation with $2,071,779 member's equity. It is noted that assets include $4,148,240 in goodwill, which is not an available liquid resource, nor is it recognized for Medicaid reimbursement purposes. Thus members' equity would be a negative $2,076,461.

The submitted budget indicates a net income of $689,184 for the first year subsequent to change in ownership. The budget appears reasonable.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

Review of BFA Attachment C, financial summary of Cortlandt Healthcare, LLC indicates the facility maintained average positive working capital and equity and generated a net income of $169,651 and $381,860 for 2010 and 2011, respectively. As of December 31, 2012 the facility has maintained positive working capital and equity and generated a net income of $253,225.

Review of BFA Attachment D, financial summary of Bellhaven Center for Rehabilitation and Nursing indicates the facility experience negative working capital, maintained positive equity and generated a net income of $130,674 and $2,059,049 for 2010 and 2011, respectively. As of December 31, 2012 the facility experienced negative working capital, maintained positive equity and generated a net income of $2,690,542. The applicant has stated the negative working capital in 2010 was due to the facility being acquired March 2010 and was assessed with a $1,747,000 Medicaid rate change.

In 2011, the facility had $672,441 in Medicare Part B liabilities as current liabilities but are payable upon future audit and in 2012, accrued expenses represent vacation and sick days accrued by staff but not payable until such time as the staff actually use those benefits.

Review of BFA Attachment E, financial summary of Dumont Center for Rehabilitation and Nursing Care indicates the facility experience negative working capital, maintained positive equity and generated net income of $801,205 and $2,078,997 in 2010 and 2011, respectively. As of December 31, 2012, the facility maintained positive working capital and equity and generated a net income of $1,007,870. The applicant has stated the negative working capital was due to the facility being acquired in 2010, and incurred third party payor liabilities and related party liabilities from the prior operator.

Review of BFA Attachment F, financial summary of San Souci Rehabilitation and Nursing Center indicates the facility experienced negative working capital, maintained positive equity and generated a net income of $816,218 and $928,772 in 2010, and 2011, respectively. As of December 31, 201, the facility experienced negative working capital, maintained positive equity and generated a net income of $1,777,371.

The applicant has stated the 2010 negative working capital was due to the facility being acquired in 200, and was awaiting a rebasing rate from the prior operator's base year. Consequently, the facility's accounts payable during 2010 increased and the facility had to get a short term note. In 2011 and 2012, the facility accrued Medicare Part B liabilities, which are payable upon future audit.

Review of BFA Attachment G, financial summary of Ramapo Manor Center for Rehabilitation and Nursing, which was acquired July 2012, indicates the facility experienced positive working capital and equity and generated a positive net income of $4,563,889 as of December 31, 2012.

Review of BFA Attachment H, financial summary of The Grand Pavilion for Rehabilitation and Nursing, which was acquired August 2012, indicates the facility has generated negative working capital, experienced positive equity and generated a net income of $559,894 as of December 31, 2012. The applicant has stated the negative working capital was due to the facility still being in its transition period and used a line of credit of $2,290,000 to fund renovations.

Review of BFA Attachment I, financial summary of St. James Rehabilitation and Healthcare Center, which was acquired August 2012, indicates the facility has generated negative working capital, experienced positive equity and generated a net income of $2,032,024 as of December 31, 2012. The applicant has stated the negative working capital was due to the facility still being in its transition period and has a demand loan of $4,000,000 to fund renovations.

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, Cortlandt Healthcare, LLC
BFA Attachment D	Financial Summary, Bellhaven Center for Rehabilitation and Nursing
BFA Attachment E	Financial Summary, Dumont Center for Rehabilitation and Nursing Care
BFA Attachment F	Financial Summary, Sans Souci Rehabilitation and Nursing Center
BFA Attachment G	Financial Summary, Ramapo Manor Center for Rehabilitation and Nursing
BFA Attachment H	Financial Summary, The Grand Pavilion for Rehabilitation and Nursing
BFA Attachment I	Financial Summary, St. James Rehabilitation and Healthcare Center

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 6th day of June, 2013, 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 Cortland Operations, LLC d/b/a Cortland Healthcare, 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:
131054 E	Cortlandt Operations, LLC d/b/a Cortlandt Healthcare

APPROVAL CONTINGENT UPON:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
    - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
    - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
    - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
    - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
        - Information on activities relating to a-c above; and
        - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
        - Other factors as determined by the applicant to be pertinent.

    The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a programmatically acceptable name for the facility. [LTC]
4. Submission of an executed bank loan for the purchase price that is acceptable to the Department of Health. [BFA]
5. Submission of an executed working capital loan that is acceptable to the Department of Health. [BFA]
6. Submission of the applicant's fully executed proposed Restated Articles of Organization, acceptable to the Department. [CSL}
7. Submission of the applicant's fully executed proposed Operating Agreement, acceptable to the Department. [CSL]
8. Submission of the Certificate of Dissolution or the Certificate of Amendment of the Articles of Organization of Cortlandt Healthcare, 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131068-B
Judson Meadows Residential Health Care Center, Inc.

County: **Schenectady County (Glenville)** ***Program:*** **Residential Health Care Facility**
Purpose: **Establishment and Construction** ***Submitted:*** **February 11, 2013**

Executive Summary

Description
Judson Meadows Residential Health Care Center, Inc., a to-be-formed subsidiary of Baptist Health Nursing and Rehabilitation Center Inc. (BHNRC), a 262 bed residential health care facility (RHCF), proposes to construct a 192 bed replacement residential health care facility on Swaggertown Road, Glenville, approximately half a mile from the current BHNRC location. A portion of the existing building, known as Baptist Health Nursing and Rehabilitation Center, Inc., will be used for 43 short term rehabilitation and transitional care beds and most administrative and support services, resulting in a total of 235 licensed beds for BHNRC and a net decrease of 27 beds.

The remainder of the building will be demolished to make room for new low-income housing for seniors and the developmentally disabled when additional funds become available.

The proposed construction would involve building a community building and eight single story units of 24 residents in two wings of 12 residents each with a dedicated hearth room, dining room and den, with the kitchen and spa/tub room being shared among the 24 residents. One wing of the facility will be a 12-bed Alzheimer's unit.

Baptist Health Nursing and Rehabilitation Center, Inc. will be the active parent and co-operator of Judson Meadows Residential Health Care Center, Inc. Presented as BFA Attachment A, is the organizational chart.

DOH Recommendation
Contingent approval

Need Summary
Schenectady County is currently has an excess of 183 residential health care facility beds. The approval of this project will result in the reduction of 27 beds and will increase the overall utilization rate for RHCF beds in Schenectady County. Baptist Health Nursing and Rehabilitation had an occupancy rate of 96.7% in 2011, while Schenectady County as a whole had a rate of 94.7%.

Program Summary
The establishment and construction of Judson Meadows Residential Health Care Center, Inc. will replace an obsolete nursing home with a modern, generously sized residence offering a home-like ambiance. The choice of an all-single configuration and the application of green house concepts of care will result in a pleasant living arrangement. No adverse information has been received concerning the character and competence of any of the proposed board members.

Financial Summary
Project costs of $36,390,062 will be met with land equity of $1,630,800, Heal NY Phase 21 grant of $5,647,232 and a mortgage of $29,112,030.

Budget:	Revenues:	$19,913,287
	Expenses:	18,276,885
	Net Income:	$1,636,402

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency
There will be no HSA recommendation of 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. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
3. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
    - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
    - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
    - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
    - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
        - Information on activities relating to a-c above; and
        - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
        - Other factors as determined by the applicant to be pertinent.

    The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
4. Submission of, and acceptable programmatic review and approval of final floor plans which respond to the noted design issues. [LTC]
5. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest that is determined to be acceptable by the Department of Health. This is to be provided within 120 days of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
6. Submission of a land appraisal by a member of the Members Appraisal Institute that is acceptable to the Department of Health. [BFA]
7. The applicant is required to submit design development drawings, complying with requirements of 10NCYRR Part 710.4, for review and approval by DASNY. [AER]
8. The applicant is required to submit final construction documents, complying with requirements of 10NCYRR Part 710.7, to NYS DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) prior to start of construction. [AER]
9. Submission of evidence of site control, acceptable to the Department. [CSL]

Approval conditional upon:

1. The approval of the decertification of 219 RHCF beds to occur by the time the new nursing home opens. [BFA]

Council Action Date
June 6, 2013.

Need Analysis

Background

Judson Meadows Residential Health Care Center, the operator of Baptist Health Nursing and Rehabilitation Center, Inc (BHNRC), a 262-bed voluntary not-for-profit nursing home located at 297 North Ballston Avenue, Scotia, 12302, in Schenectady County, seeks approval to decertify 219 beds and build a 192 bed replacement facility. This will result in a net decrease of 27 residential health care beds. The remaining 43 beds will be kept at the original campus and used as short term rehabilitation beds until the facility can finance the removal of the building and construction of supportive housing.

Analysis

Baptist Health Nursing and Rehabilitation Center's utilization rate was higher than that of Schenectady County for 2009, 2010, and 2011, as shown in Table 1 below:

Table 1: RHCF – Judson Meadows Residential Health Care Center /Schenectady County

Facility/County/Region	**% Occupancy 2009**	**% Occupancy 2010**	**% Occupancy 2011**
Baptist Health Nursing and Rehabilitation	96.9%	96.2%	96.7%
Schenectady County	94.2%	94.2%	94.7%

Schenectady County has an excess of 183 residential health care facility beds. This project will reduce this excess by 27 beds.

Table 2: RHCF Need – Schenectady County

2016 Projected Need	889
Current Beds	986
Beds Under Construction	86
Total Resources	1072
Unmet Need	-183

Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, whichever is less. In calculating such percentages, the Department will use the most current data received and analyzed by the Department.

An applicant will be required to make appropriate adjustments in its admission polices and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage of health Systems Agency percentage, whichever is applicable.

Baptist Health Nursing and Rehabilitation was above the 75 percent planning average for 2009 and 2010. The facility reported Medicaid admissions of 8.89 percent and 24.31 percent in 2009 and 2010, respectively. The 75 percent planning averages for Schenectady County for these years were 5.5 percent in 2009 and 10.10 percent in 2010.

Conclusion

Approval of this application is expected to improve the quality of care at Baptist Health Nursing and Rehabilitation Center and to reduce excess RHCF beds in Schenectady County.

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Facility Information

	Existing	**Proposed**
Facility Name	Baptist Health Nursing and Rehabilitation Center, Inc.	Judson Meadows Residential Health Care Center, Inc.
Address	297 North Ballston Avenue Scotia, NY 12302	39 Swaggertown Road Glenville, New York 12302
RHCF Capacity	262	192
ADHC Program Capacity	N/A	N/A
Type of Operator	Voluntary	Voluntary
Class of Operator	Corporation	Corporation
Operator	Baptist Health Nursing and Rehabilitation Center, Inc.	Judson Meadows Residential Health Care Center, Inc. (JM) Sole Corporate Member Baptist Health Nursing and Rehabilitation Center, Inc. (BH) Board Members (JM and BH) Timothy W. Bartos President/CEO Harry Wood Chairperson William Dorr Vice-Chairperson Alan Freestone Treasurer Anita Parker Secretary Darlene Truax Walter McKay Mark Dorr Howard Sheffey William Sweet

Character and Competence-Background

Facilities Reviewed

Residential Health Care Facilities
Baptist Health Nursing and Rehabilitation Center, Inc. 4/2003 to present

Diagnostic and Treatment Centers
Family Medical Care, Inc. 4/2003 to present

Adult Care Facilities
Baptist Health Enriched Housing Program, Inc.

Individual Background Review:

Timothy W. Bartos is the President and CEO since July, 1983 of Baptist Health Nursing and Rehabilitation Center, an existing 262 bed nursing home. BH is also the sole corporate member of Judson Meadows Residential Health Care Facility, Inc. Mr. Bartos holds a nursing home administrator license and a notary public license in good standing. Mr. Bartos is also the President/ CEO, of Family Medical Care, Inc., an Article 28 diagnostic and treatment center, and Baptist Health Enriched Housing Program, Inc. an approved enriched housing program/assisted living program.

Harry M. Wood, is the chairperson of the Board, and is employed as an Associate Broker by Realty USA in Clifton Park, since March 1992. Mr. Wood holds a real estate broker license in good standing. Mr. Wood is also the Chairman of the Boards of Family Medical Care, Inc. a diagnostic and treatment center, and Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

William Dorr is the vice-chairperson of the Board, and is retired, previously employed by the New York State Office of Children and Family Services. Mr. Dorr serves on the Boards of Family Medical Care, Inc., a diagnostic and treatment center, and Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

Allan Freestone is the treasurer of the Board, and is employed by Coburg Village in Rexford as Director of Facilities and Operations, since August 2006. Mr. Freestone has no additional health facility interests or board associations.

Anita T. Parker is the secretary of the Board. Ms. Parker serves on the Boards of Family Medical Care, Inc., a diagnostic and treatment center, and Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

Darlene J. Truax is employed as a secretary at the First Baptist Church in Rexford. Ms. Truax serves on the Board of Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

Walter McKay is the Technology Manager at Bank of America in Albany. Mr. McKay serves on the Board of Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

Mark Dorr is the Vice-President of the New York State Hospitality and Tourism Association in Albany. Mr. Dorr serves on the Board of Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

Howard L. Sheffey is retired, and serves on the Board of Baptist Health Enriched Housing Program, Inc., an approved enriched housing program/assisted living program.

William Sweet is the Vice-President for Construction and Engineering at the Golub Corporation in Schenectady. Mr. Sweet holds a real estate broker license in good standing. Mr. Sweet has no additional health facility interests or board associations.

Character and Competence-Analysis

No adverse information has been received concerning the character and competence of any of the proposed board members.

A review of the operations of Baptist Health Nursing and Rehabilitation Center for the period reveals the following:

- The facility was fined $300 pursuant to a Stipulation and Order issued November 26, 2004 for surveillance findings on multiple dates. Deficiencies were found under 10 NYCRR 415.12(h)(2) Quality of Care: Accidents and 10 NYCRR 415.15(b)(2)(iii) Physician Services.
- The facility was fined $1,000 pursuant to a Stipulation and Order issued July 11, 2006 for surveillance findings on July 21, 2005. Deficiencies were found under 10 NYCRR 415.4(b)(1)(i) Resident Behavior and Facility Practices: Staff Treatment of Residents.
- The facility was fined $2,000 pursuant to a Stipulation and Order issued February 13, 2007 for surveillance findings on August 4, 2006. Deficiencies were found under 10 NYCRR 415.12(h)(2) Quality of Care: Accidents.

The review of operations of Baptist Health Nursing and Rehabilitation Home results in a conclusion of substantially consistent high level of care since there were no repeat enforcements. The review of operations for Family Medical Care, Inc. and Baptist Health Enriched Housing Program, Inc. for the time periods indicated reveals that a substantially consistent high level of care has been provided since there were no enforcements.

Program Review

Baptist Health Nursing and Rehabilitation Center, Inc. (BH) is the voluntary operator of a 262 bed nursing home located in Scotia, New York. In 2012 BH was awarded a HEAL 21 grant to construct a replacement nursing home, to be located at a site approximately one mile from the existing nursing home. Baptist had acquired the large site, which is just north of the current Baptist site on Route 50, to construct an assisted living facility. The sponsor will create a separately established not-for-profit corporation to construct a 192 bed nursing home, which will employ "Small House" design concepts. BH will retain 43 beds at the current site, resulting in a net decertification of 27 beds. An 80 unit enriched housing program, currently under construction, will also be located on the Judson Meadows campus and will include 10 assisted living beds.

The existing Baptist Health Nursing and Rehabilitation Center nursing home will continue to operate; however, it will be downsized into a single 43 bed short term rehabilitation nursing unit located in the "N" Building. The kitchen, located in the "H" and "S" Buildings, will continue to serve this nursing unit. The overall plan for the site is to demolish the "H" and "S" Buildings to make room for low income housing units for seniors and the developmentally disabled. The future plans for meal service at the BH site have not been determined at this time.

JM, the proposed operator of the new nursing home, will be a not-for-profit corporation with BH as sole corporate member and co-operator. The Boards of Directors of JM and BH are identical.

Physical Environment

The proposed nursing facility will consist of four single story buildings arrayed in a rectangle, totaling 128,728 square feet of space, surrounding a community/commons building providing an additional 2,606 square feet. The commons building will provide a central meeting place for residents and a larger area for religious and special events. The applicant has indicated that it plans to expand the building to accommodate administrative offices in the near future. A central storage building adjacent to the resident buildings will afford greatly needed storage space for the nursing home, and serve as the maintenance center for the entire site. The individual residential buildings will contain 48 beds in a double "H" configuration. The resident rooms are aligned in a conventional linear placement with a courtyard between the two parallel nursing units. The courtyards will be enclosed outside areas with gardens and pathways available for resident interaction. Public areas and service functions are located in the crosswise hallway links. Each "H" shaped unit will be referred to as a house, with two houses per building. The houses are joined together by a corridor on one side which is also utilized for administrative offices.

Houses are further sub-divided into two 12 bed small houses. The Small House concept is similar to the trademarked Green House care model, with certain differences. Small houses incorporate many of the green house features including the central living area with the hearth room and dining room adjacent to the open kitchen. Small houses also utilize multi-purpose workers, who are certified nurse assistants with expanded duties and responsibilities. Meals are shared family style at a common table, but the small house model utilizes the kitchen to serve multiple resident units, with some meals arriving pre-cooked from a central kitchen. The principal difference in the small house model is the size of the resident units, with small houses containing 12 or 13 beds, compared to the 10 bed maximum in the traditional green house.

Entry to the small house leads into the hearth room, which is located in the center of the residential unit. The hearth room comprises the main living and activity area where residents congregate, and includes a fireplace and a porch, which is adjacent to the entry vestibule. A corridor-like space leads into the dining area, with a short corridor connecting to the dining area for the neighboring small house. A den opens off the hallway to offer another lounging alternative. The kitchen, which will prepare most of the meals for

the entire house, also serves as the divider between the twin small houses. A door from the dining area leads out to a porch allowing additional outside access to the residents. On the other side of the corridor opposite the kitchen the spa room and personal care area serves both small houses. Adjacent to the spa room the resident laundry affords residents the opportunity to wash their own personal clothing.

12 single occupancy bedrooms are arrayed on both sides of the hearth room. Four bedrooms in each small house are sized as bariatric rooms. The bariatric rooms have approximately 15% greater square footage, and include wider doors and beds. Resident bedrooms will include a private bathroom with European-type shower. The bathrooms include fold-down grab bars for easier access to staff assisting the resident, and a personal belongings cabinet. The two bariatric rooms closest to the entry will include a lift system which greatly enhances access to the bathrooms.

The houses will include all required areas, although consistent with green house design, office space tends to be limited. Offices 151 and 152 in the household link will function as the director of nursing and nursing home administrator offices. Scheduling, charting and other nursing activities will take place in an office located across the central living area from the den. Rehabilitation services will take place in the resident bedrooms and the den. It is the intention of the applicant to segregate residents requiring more significant rehabilitation at the existing BH campus down Route 50, thereby reducing the demand for these services at JM.

One house of 24 beds will be programmed as a dementia care unit, although the design will not diverge from the other small houses.

Project Review- Analysis

The establishment and construction of Judson Meadows will replace an obsolete nursing home at BHNRC with a modern, generously sized residence offering a homelike ambiance. While some of the proposed layout retains an institutional flavor, such as the use of the parallel nursing units that are central to the building design, enhancements to the current program could mitigate these effects. For example, the relocation of administrative offices into the expanded community building would reduce congestion within the small houses, and heighten the residential character of the surroundings. The installation of lifts in all resident rooms would also enhance the independence of the residents. And the exclusive preparation of meals in the small houses, rather than leaving some still to be prepared in the central kitchen, could contribute further to the homelike environment. Nevertheless, the proposed employment of an all-single configuration and the application of green house concepts of care will result in a pleasant living arrangement, and one much improved over the current facility and traditional institutional models.

Recommendation

From a programmatic perspective, contingent approval is recommended.

Financial Analysis

Total Project Cost and Financing

Total cost for the replacement facility and movable equipment is estimated at $36,390,062 itemized as follows:

Land Acquisition	$1,630,800
New Construction	20,789,764
Site Development	4,063,380
Temporary Utilities	50,000
Design Contingency	1,293,302
Construction Contingency	1,293,302
Planning Consultant Fees	154,235
Architect/Engineering Fees	1,374,487
Construction Manager Fees	618,519
Consultant Fees	520,461

Decommissioning, Moving and Startup Costs	300,000
Movable Equipment	1,824,328
Telecommunications	993,000
Financing Costs	355,676
Interim Interest Expense	927,768
Application Fee	2,000
Additional Fee	199,040
Total Project Cost	36,390,062

Project cost is based on a September 1, 2013 construction start date and an eighteen month construction period. Project cost for the RHCF, excluding CON fees is $36,189,022 for new construction.

The Bureau of Architectural and Engineering Facility Planning has determined that the cost per bed of $268,000 for new construction is within applicable geographic project cost per bed limitations.

The applicant's financing plan is as follows:

HEAL NY Phase 21	$5,647,232
Land Equity	1,630,800
Bank Mortgage (4.5% 27yrs)	29,122,030

The Department is reducing the recommended equity contribution to 20% in exchange for the 27 RHCF beds to be decertified and project costs below applicable RHCF bed caps.

Operating Budget

The applicant has submitted an operating budget for the replacement RHCF in 2013 dollars, for the first and third years of operation, summarized below:

	Year One	**Year Three**
Revenues:		
Patient Revenue	$14,415,666	$19,220,887
Other Revenue*	519,300	692,400
Total Revenue:	$14,934,966	$19,913,287
Expenses:		
Operating	$12,063,223	$16,084,296
Capital	1,644,442	2,192,589
Total Expenses:	$13,707,665	$18,276,885
Net Income:	$1,227,301	$1,636,402
Utilization: (days)	51,510	68,678
Occupancy:	73.5%	98.0%

*Other revenue represents meal sales, donations, beauty and gift shop and vending machines.

The following is noted with respect to the submitted RHCF operating budget:

- Medicare and private pay are based on current rates of payment.
- The facility's Medicaid rate is based on 2012 Medicaid Statewide Pricing with adjusted capital for a new facility with no trend to 2013.
- The first year patient days are prorated based on moving the patients into the replacement facility from the first day until historical occupancy levels are achieved by the second year.

- Overall utilization for year one and three are projected at 73.5% and 98.0%, while utilization by payor source for year one is expected as follows:

	Year One and Year Three
Commercial	5%
Medicare	6%
Medicaid	61%
Private Pay	28%

- Breakeven occupancy in the third year is projected at 89.9%.

Capability and Feasibility

The applicant will finance total project costs of $36,390,062 with land equity of $1,630,800, HEAL NY Phase 21 grant of $5,647,232 and the remainder will be a mortgage of $29,112,030 over a 5 year term, 27 year amortization with interest only for the first two years and monthly amortization beginning in year three on a 25 year basis at 4.5%. Before the end of five years, the applicant will pursue HUD financing and if not available, the bank will facilitate a 30 year non-rated bond deal at 7%. A bank letter of interest from M&T Bank has been submitted by the applicant at stated terms. DOH staff has noted that if HUD financing should not be available net income for the future periods of operations would decrease approximately $41,500 due to additional interest expense.

Working capital requirements are estimated at $3,046,148 based on two months of third year expenses and will be provided through the existing operation of BHNRC. Presented as BFA Attachment B, is the financial summary of BHNRC, which indicates the availability of sufficient funds. Cash ($2,135,512) plus accounts receivable ($3,398,861) minus accounts payable ($1,316,356) equals $4,218,017).

The submitted budget indicates a net income of $1,227,301 and $1,636,402 for the first and third years of operations, respectively. DOH staff has sensitized the first and third year budgets based on historical occupancy levels for 2012 and notes that the first and third year will maintain a net gain of approximately $424,233 and $565,568, respectively. Presented as BFA Attachment C, is the sensitized budget. The budget appears reasonable.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology, to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

Review of BFA Attachment B, financial summary of Baptist Health Nursing and Rehabilitation Center, indicates that the facility has maintained average positive working capital and net assets and experienced a net loss of $1,243,052 and 693,736 for 2010 and 2011, respectively. The applicant has stated the 2010 losses were due to a reduction in net resident income of approximately $740,000, a long term care overpayment review, which resulted in a recoupment of $111,000, retroactive Medicaid rate adjustments totaling $100,000, and expenses were approximately $300,000 greater than anticipated. The 2011 losses were due to a bad debt allowance adjustment of approximately $650,000. As of December 31, 2012, the applicant maintained positive working capital and net assets and generated a net income of $1,413,403.

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	Organizational Chart
BFA Attachment B	Financial Summary, Baptist Health Nursing and Rehabilitation Center, Inc.
BFA Attachment C	Sensitized Budgets

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 6th day of June, 2013, 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 construct a 192 bed nursing home to partially replace the existing Baptist Health Nursing and Rehab Center and establish Judson Meadows Residential Health Care Center as a co-operator, 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:
131068 B	Judson Meadows Residential Health Care Center, Inc.

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. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
3. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
    - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
    - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
    - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
    - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
        - Information on activities relating to a-c above; and
        - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
        - Other factors as determined by the applicant to be pertinent.

    The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
4. Submission of, and acceptable programmatic review and approval of final floor plans which respond to the noted design issues. [LTC]
5. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest that is determined to be acceptable by the Department of Health. This is to be provided within 120 days of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
6. Submission of a land appraisal by a member of the Members Appraisal Institute that is acceptable to the Department of Health. [BFA]
7. The applicant is required to submit design development drawings, complying with requirements of 10NCYRR Part 710.4, for review and approval by DASNY. [AER]
8. The applicant is required to submit final construction documents, complying with requirements of 10NCYRR Part 710.7, to NYS DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) prior to start of construction. [AER]
9. Submission of evidence of site control, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The approval of the decertification of 219 RHCF beds to occur by the time the new nursing home opens. [BFA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131100-E
Cosden, LLC d/b/a Palatine Nursing Home

County: **Montgomery County (Palatine Bridge)**
Program: **Residential Health Care Facility**
Purpose: **Establishment**
Submitted: **February 20, 2013**

Executive Summary

Description
Cosden, LLC, a to-be-formed limited liability company, requests approval to be established as the new operator of Palatine Nursing Home, a 70-bed proprietary residential healthcare facility located at 154 Lafayette Street, Palatine Bridge, New York. Also, Dencos, LLC, a newly formed corporate entity, will purchase the building from Glessing & Salzman, LLC pursuant to the proposed Purchase and Sale Agreement.

The current and proposed ownership of Palatine Nursing Home is as follows:

Current	Proposed
Palatine Nursing Home, Inc.	Cosden, LLC
Charles Glessing 100%	Member:
	Cosimo Mastropierro 100%

The sole member of the real estate entity, Dencos, LLC, will be Mastropierro Living Trust. Cosimo Mastropierro is the appointed trustee of the Mastropierro Living Trust.

The sole member of Cosden, LLC has ownership interests in the following facilities: New East Side Nursing Home; Berkshire Nursing Home and Pontiac Nursing Home. Presented as BFA Attachment D through F are the financial summaries of these facilities.

DOH Recommendation
Contingent approval

Need Summary
Palatine Nursing Home's occupancy was 95.1% in 2011. This change in ownership will not result in any change in the facility's beds or services.

Program Summary
No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

Financial Summary
The purchase price for the real estate portion is $2,100,000, and the operation portion is $400,000. The real estate purchase price will be met as follows: $5,000 paid with the execution of this Agreement; $1,300,000 paid by the Realty Buyer and the Realty Closing at or prior to the Realty Closing; $450,000 paid three months after the Realty Closing takes place, via a promissory note, and $350,000 paid by the Realty Buyer by bank or cashier bank at or prior to the due date of such payment. The Operation purchase price will be met via equity from the proposed member.

Budget:

Revenues	$4,320,016
Expenses	3,642,046
Net Income	$ 677,970

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.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval contingent upon:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
   - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
   - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
   - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
   - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
     - Information on activities relating to a-c above; and
     - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
     - Other factors as determined by the applicant to be pertinent.

   The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of an executed lease agreement between the Applicant and Dencos, LLC, the landlord that is acceptable to the Department of Health. [BFA, CSL]
4. Submission of an executed promissory note that is acceptable to the Department of Health. [BFA]
5. Submission of a photocopy of the Amendment of the Operating Agreement of Cosden, LLC, acceptable to the Department. [CSL]
6. Submission of a photocopy of the Certificate of Amendment to the Articles of Organization of Cosden, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of the Certificate of Assumed Name of Cosden, LLC, acceptable to the Department. [CSL]
8. Submission of a completed and signed Schedule 4B, acceptable to the Department. [CSL]
9. Submission of a photocopy of a Certificate of Dissolution or Certificate of Amendment of the Certificate of Incorporation of Palatine Nursing home, Inc., acceptable to the Department. [CSL]

Council Action Date

June 6, 2013.

Need Analysis

Background

Palatine Nursing Home, a 70 bed proprietary business corporation located at Upper Lafayette Street Palatine Bridge, 13428, in Montgomery County, seeks approval to enter into an asset purchase agreement with Cosden LLC.

Analysis

Palatine Nursing Home's utilization was higher than that for Montgomery County as a whole for 2009, 2010, and 2011, as shown in Table 1 below:

Table 1: Palatine Nursing Home/Montgomery County

Facility/County	% Occupancy 2009	% Occupancy 2010	% Occupancy 2011
Palatine Nursing Home	98.1%	97.3%	95.1%
Montgomery County	96.7%	93.9%	88.7%

There is currently an excess of 75 beds in Montgomery County.

Table 2: RHCF Need – Montgomery County

2016 Projected Need	515
Current Beds	590
Beds Under Construction	0
Total Resources	590
Unmet Need	-75

Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department.
An applicant will be required to make appropriate adjustments in its admission polices and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage of health Systems Agency percentage, whichever is applicable.

Palatine Nursing Home was above the 75 percent planning average for 2009 and 2010. The facility reported Medicaid admissions of 31.94 percent and 41.46 percent in 2009 and 2010, respectively. The 75 percent planning averages for Columbia County for these years were 16.0 percent (2009) and 31.40 percent (2010).

Conclusion

Approval of this application will improve the financial viability of Palatine Nursing Home, which will enable the facility to continue to be an important resource for Montgomery County, as indicated by its high rate of Medicaid admissions.

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Facility Information

	Existing	**Proposed**
Facility Name	Palatine Nursing Home	Same
Address	Upper Lafayette Street Palatine Bridge NY 13428	Same
RHCF Capacity	70	Same
ADHC Program Capacity	N/A	Same
Type of Operator	Corporation	Limited Liability Company
Class of Operator	Proprietary	Proprietary
Operator	Palatine Nursing Home, Inc.	Cosden, LLC Shareholders: Cosimo Mastropierro 100.00%

Character and Competence - Background

Facilities Reviewed:

Nursing Homes

New East Side Nursing Home	05/2003 to present
Berkshire Nursing Home	05/2003 to present
Pontiac Nursing Home	05/2003 to present

Individual Background Review:

Cosimo Mastropierro lists his current occupation as consultant for the nursing homes in which he maintains an ownership interest. Mr. Mastropierro discloses the following ownership interests.

New East Side Nursing Home	08/1996 to present
Berkshire Nursing Home	03/2001 to present
Pontiac Nursing Home	01/2000 to present

Character and Competence - Analysis

No negative information has been received concerning the character and competence of the above applicants identified as new members.

A review of New East Side Nursing Home for the indicated period reveals that the facility was fined $12,000 pursuant to a Stipulation and Order issued August 25, 2011 for surveillance findings on January 29, 2010. Deficiencies were found under 10 NYCRR 415.11 (c)(1) – Comprehensive Care Plans and 415.12 (h)(2) - Quality of Care: Accidents and Supervision.

A review of operations for New East Side Nursing Home for the period identified above, results in a conclusion of a substantially consistent high level of care, since there were no repeat enforcements.

A review of operations for Berkshire Nursing Home and Pontiac Nursing Home for the periods identified above, results in a conclusion of a substantially consistent high level of care, since there were no enforcements.

Project Review

No changes in the program or physical environment are proposed in this application.

Conclusion

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

Recommendation:
From a programmatic perspective, approval is recommended.

Financial Analysis

Agreement of Purchase and Sale
The applicant has submitted an executed asset purchase agreement for the operations and the real estate, which is summarized below:

Date:	December 11, 2012
Seller:	Palatine Nursing Home, Inc. (Operations Seller) and Glessing & Salzman, LLC (Realty Seller)
Purchaser:	Dencos, LLC (Realty Buyer) and Cosden, LLC (Operations Buyer)
Purchased Assets:	The Realty Seller agrees to sell and Realty Buyer agrees to purchase all of Seller's right, title and interest in and to all of the Real Property. The Purchaser agrees to purchase all of Seller's and Glessing's right, title and interest in and to the Tangible Personal Property and Intangible Personal Property used in the operation of the Facility. The acquired assets of the operation will include the following: the business and operation of the Facility, except for the Excluded Assets; Seller's right, title and interest in and to all furniture, fixtures, equipment, furnishings, appliances, tools, instruments, machinery, computers, computer equipment and hardware, which are used in connection with the operation of the facility; all inventory, supplies and other articles of personal property; all of Seller's and Glessing interests in the Assumed Contracts; patient and resident funds held in trust; the Name; all security deposits and prepayments, if any, for future services held by Seller and Glessing; all telephone numbers, fax numbers, email addresses and websites used by the Facility; copies of all business records in the Seller's and Glessing's possession relating to the Facility, except general ledgers; all resident and patient records relating to the Facility; copies of all employee and payroll records; all goodwill in connection with the business of the Facility and Seller and Glessing and copies of all plans; Seller's and Glessing Medicare and Medicaid provider numbers and the Facility has 70 skilled nursing beds.
Excluded Assets:	The following assets will be retained by the Seller: All cash, cash equivalents, accounts receivable, deposits and investments with respect to the Facility are excluded. All Excluded Assets of the Seller shall be first be used to pay Seller's and Glessing's current accounts payable and accrued expenses, excluding rent payable that exist as of the Operation Closing Date. Notwithstanding the forgoing, if the Excluded Assets exceed each payables, then so long as Seller's and Glessing's creditors for the Payables have not commenced an action to collect the same, the Operations Buyer may utilize such Excluded Assets for Cash Flow.
Excluded Liabilities:	Seller, Glessing and Realty Seller shall retain all liabilities and obligations of any kind or nature.
Purchase Price:	The real property purchase price is $2,100,000 and the operational purchase price is $400,000.

Payment of Purchase Price: The real property purchase price will be met as follows: $5,000 paid upon the execution of this Agreement; $1,300,000 paid by the Realty Buyer at the Realty Closing; $450,000 paid three months after the Realty Closing takes place via a promissory note and $350,000 paid by the Realty Buyer by bank or cashier check at or prior to the due date of such payment, upon the earlier of the Operations Closing or termination of this Agreement. The purchase price of $400,000 for the operational purchase price will be met as follows:

The purchase price for the real estate portion is $2,100,000 and for the operation portion will be $400,000. The real estate purchase price will be met as follows: $5,000 paid with the execution of this Agreement; $1,300,000 paid by the Realty Buyer at or prior to the Realty Closing; $450,000 paid three months after the Realty Closing takes place via a promissory note and $350,000 paid by the Realty Buyer by bank or cashier bank at or prior to the due date of such payment.

The Operation purchase price will be met via equity from the proposed member.

The applicant has submitted an affidavit from the applicant, 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, the facility has no outstanding liabilities.

Lease Rental Agreement

The applicant has submitted a draft lease rental agreement for the site that they will occupy, which is summarized below:

Premises:	The nursing home located at 154 Lafayette Street, Palatine Bridge, New York
Landlord:	Dencos, LLC
Tenant:	Cosden, LLC d/b/a Palatine Nursing Home
Rental:	$268,800 annually / ($22,400 monthly)
Term:	10 years
Provisions:	The tenant shall be responsible for maintenance, utilities and real estate taxes.

Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, for the first year subsequent to the change in operator, which is summarized below:

	Per Diem	Year Three
Revenues:		
Medicaid Managed Care	$154.86	$3,075,040
Medicare Fee-for-Service	324.55	630,198
Private Pay	253.29	614,778
Total Revenues		$4,320,016
Expenses:		
Operating	$148.02	$3,592,849
Capital	2.03	49,197
Total Expenses	$150.05	$3,642,046
Net Income		$677,970
Utilization: (patient days)		24,272
Occupancy		95.00%

Utilization broken down by payor source during the first year subsequent to the change in operator is as follows:

Medicaid Managed Care	82.00%
Medicare Fee-for-Service	8.00%
Private Pay	10.00%

The applicant projected an increase in occupancy from 2012 (90%) due to the applicant planning to increase quality of care, capital investments and providing physical therapy services. Medicare utilization is increasing due to the current operator's having begun to offer physical therapy services necessary for short term rehabilitation treatment to Medicare beneficiaries. The transition would include the hiring of a full time physical therapist to provide these services to Medicare beneficiaries that would otherwise not have been referred by a hospital. Utilization is expected to increase as a result of these new services provided. The applicant projects that occupancy will exceed occupancy levels that were achieved from 2009 through 2011.

Capability and Feasibility

The purchase price for the real estate portion is $2,100,000 and for the operation portion will be $400,000. The real estate purchase price will be met as follows: $5,000 paid with the execution of this Agreement; $1,300,000 paid by the Realty Buyer at or prior to the Realty Closing; $450,000 paid three months after the Realty Closing takes place via a promissory note and $350,000 paid by the Realty Buyer by bank or cashier bank at or prior to the due date of such payment. The Operation purchase price will be met via equity from the proposed member.

Working capital requirements are estimated at $607,007, which is equivalent to two months of third year expenses. The proposed member will provide equity to meet the working capital from his personal resources. Presented as BFA Attachment A is the personal net worth statement of the sole member, which indicates the availability of sufficient funds for the equity contribution to meet the working capital requirement and the purchase of the real estate and the operation. Presented as BFA Attachment C is the pro forma balance sheet for Cosden, LLC as of the first day of operation, which indicates a positive net asset position of $3,021,007 as of the first day of operation.

The submitted budget indicates a net income of $677,970 during the first year subsequent to the change in operator. Staff notes that with the expected 2014 implementation of managed care for nursing home residents. Medicaid reimbursement is expected to change from a state-wide price with a cost based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point of time it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

Presented as BFA Attachment B is the financial summary of Palatine Nursing Home during the period 2009 through 2011. As shown, the facility had an average negative working capital position and an average negative net asset position from 2009 through 2011. Also, the facility incurred an average net loss of $76,830 from 2009 through 2011. The applicant has indicated that the reason for the loss in 2010 and 2011 was the result of the nursing home being overstaffed and the costs of overtime. The applicant reduced overtime to improve operations. The facility incurred a loss in 2012 of $161,808.

Presented as BFA Attachment D is the financial summary of Pontiac Nursing Home from the period 2010 through November 30, 2012. As shown on Attachment D, the facility had an average positive working capital position and an average positive net asset position. Also, the facility achieved an average net income of $984,413 during the period 2010 through November 30, 2012.

Presented as BFA Attachment E is the financial summary of New East Side Nursing Home. As shown, the facility had an average negative working capital position and an average positive net asset position during the period 2010 through November 30, 2012. Also, the facility achieved an average net income of $1,855,057 during the period 2010 through November 30, 2012.

Presented as BFA Attachment F is the financial summary of Berkshire Nursing Home. As shown, the facility had an average positive working capital position and an average positive net asset position from the period 2010 through November 30, 2012. Also, the facility achieved an average net income of $1,855,057 during the period 2010 through November 30, 2012.

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, contingent approval is recommended

Attachments

BFA Attachment A-	Personal Net Worth Statement
BFA Attachment B-	Financial Summary for Palatine Nursing Home
BFA Attachment C-	Pro-forma Balance Sheet
BFA Attachment D-	Financial Summary for Pontiac Nursing Home
BFA Attachment E-	Financial Summary for New East Side Nursing Home
BFA Attachment F-	Financial Summary for Berkshire Nursing Home

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 6th day of June, 2013, 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 Cosden, LLC d/b/a Palatine Nursing Home as the new owner and operator of Palatine 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:
131100 E	Cosden, LLC d/b/a Palatine Nursing Home

APPROVAL CONTINGENT UPON:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
   - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
   - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
   - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
   - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
     - Information on activities relating to a-c above; and
     - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
     - Other factors as determined by the applicant to be pertinent.

   The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of an executed lease agreement between the Applicant and Dencos, LLC, the landlord that is acceptable to the Department of Health. [BFA, CSL]
4. Submission of an executed promissory note that is acceptable to the Department of Health. [BFA]
5. Submission of a photocopy of the Amendment of the Operating Agreement of Cosden, LLC, acceptable to the Department. [CSL]
6. Submission of a photocopy of the Certificate of Amendment to the Articles of Organization of Cosden, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of the Certificate of Assumed Name of Cosden, LLC, acceptable to the Department. [CSL]
8. Submission of a completed and signed Schedule 4B, acceptable to the Department. [CSL]
9. Submission of a photocopy of a Certificate of Dissolution or Certificate of Amendment of the Certificate of Incorporation of Palatine Nursing home, Inc., 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 131103-E

Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified

County: **Kings County (Brooklyn)**
Purpose: **Establishment**

Program: **Certified Home Health Agency**
Submitted: **February 21, 2013**

Executive Summary

Description

Tri-Borough Certified Health Systems of New York, LLC is requesting to become the new operator of Family Aides Certified Services of Brooklyn/Queens, a proprietary business corporation located at 405 91st street in Brooklyn. The current operator is Family Aides Certified Services of NYC, Inc.

Family Aides Certified Services of New York City, Inc. was established in April of 1989 to service Kings County, and in 1999, Queens County was added to its service area. There are no project costs associated with this application.

Mr. Kenrick Cort is the sole member of Tri-Borough Certified Health Systems of New York, LLC. Tri-Borough Certified Home Care, LTD is a solely owned asset of Tri-Borough Certified Health Systems of New York, LLC where there is common ownership. Kenrick Cort is the sole stockholder, director and officer of Tri-Borough Home Care, Ltd., a proprietary corporation operating a certified License Home Care Service Agency. Presented as BFA Attachment A, is the organizational chart of Tri-Borough Certified Health Systems of New York, LLC.

DOH Recommendation

Approval

Program Summary

Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified proposes to become the new owner and operator of the CHHA currently operated by Family Aides Certified Services of NYC, Inc. d/b/a Family Care Certified Services of Brooklyn & Queens.

Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified received PHHPC to become the new owner and operator of the CHHA and LTHHCP operated by Family Aides Certified Services of Nassau/Suffolk, Inc. at the February 7, 2013 PHHPC meeting.

Financial Summary

There are no project costs associated with this application. The CHHA will be purchased for $700,000.

Budget:	Revenues:	$12,060,919
	Expenses:	11,296,429
	Gain:	$ 764,490

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

Recommendations

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

Office of Health Systems Management
Approval.

Council Action Date
June 6, 2013.

Programmatic Analysis

Background

Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified is a limited liability company. Tri-Borough Certified Health Systems of New York seeks approval to purchase and become the new operator of the Family Aides Certified Services of NYC, Inc. d/b/a Family Care Certified Services of Brooklyn & Queens CHHA which is approved to serve patients in Kings and Queens Counties.

Tri-Borough Certified Health Systems of New York, LLC d/b/a Tri-Borough Certified Health Systems of New York received PHHPC to become the new owner and operator of the CHHA and LTHHCP operated by Family Aides Certified Services of Nassau/Suffolk, Inc. at the February 7, 2013 PHHPC meeting.

Tri-Borough Home Care Ltd. has proposed to enter into a management agreement with Family Aides Certified Services of NYC, Inc. d/b/a Family Care Certified Services of Brooklyn & Queens which is currently under review by the Department of Health. Tri-Borough Home Care Ltd is related to the applicant by common ownership.

The applicant proposes to operate the CHHA from an office located at 1414 Utica Avenue, Brooklyn, New York 11203 and to serve Kings and Queens Counties.

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Medical Supplies, Equipment, and Appliances
Physical Therapy	Occupational Therapy	Speech Language Pathology
Personal Care	Respiratory Therapy	Medical Social Services
Nutrition	Homemaker	Housekeeper

The sole member and sole manager of Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified is:

Kenrick L. Cort – President/CEO

Affiliations:

- President/CEO, Tri-borough Home Care, Ltd.
- President/CEO, ISIS Home Health Care, Inc., Fort Myers, FL (2005 – Present)
- President/CEO, ISIS Home Health Care, Inc., Sunrise, FL (2008 – Present)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

A ten year review of the operations of the following facilities was performed as part of this review for the time periods specified (unless otherwise specified):

Tri-borough Home Care, Ltd.
ISIS Home Health Care, Inc., Fort Myers, FL (2005 – Present)
ISIS Home Health Care, Inc., Sunrise, FL (2008 – Present)

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.

ISIS Home Health Care, Inc., Fort Myers, FL was fined eleven thousand dollars ($11,000.00) resulting from two survey deficiencies; one thousand dollars ($1,000.00) for not following the Plan of Treatment

and ten thousand dollars ($10,000.00) for not following the Plan of Care, 10 patients total. ISIS Home Health Care, Inc. resolved the fine September 6, 2012.

ISIS Home Health Care, Inc., Fort Myers, FL was fined ten thousand dollars ($10,000.00) resulting from not completing their quarterly reports for the 3rd and 4th quarter in 2008. ISIS Home Health Care, Inc. resolved the fine October 6, 2009.

The information provided by the State of Florida regulatory agency has indicated that facilities affiliated with this application 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 appropriate character and competence under Article 36 of the Public Health Law.

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 below:

Date:	October 17, 2012
Seller:	Family Aides Certified Services of New York City, Inc. d/b/a Family Care Certified Services of Brooklyn and Queens
Buyer:	Tri-Borough Certified Health Systems of New York, LLC
Assets Purchased:	The operating assets of the business such as furniture, fixtures, all seller's rights, title and interests, assignable contracts, patient list ,telephone number and goodwill.
Excluded Assets:	Personal property; marketable securities; equipment leased by seller; accounts receivable relating to periods prior to closing and name.
Assumed Liabilities:	Those relating to transferred assets.
Purchase Price:	$700,000 with $100,000 currently held in escrow and another $100,000 to be paid in escrow after six months of the executed agreement. The purchase price will be reduced prior to closing if Medicare and Medicaid Recoupments occur between November 1, 2012 and the closing date. If Recoupments exceed purchase price then Seller pays Purchaser a maximum of $350,000.

As of April, 18, 2013, there have been no Medicare or Medicaid recoupments.

The applicant has submitted an affidavit, which states that the applicant agrees 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 36 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.

Management Agreement

On October 17, 2012, in accordance with the Asset Purchase Agreement, a Management Agreement was executed by Seller and Purchaser in the form of an Administrative and Consulting Agreement to permit Tri-Borough Home Care, LTD (TBHC), who shares common ownership with Tri-Borough Health Systems of New York, LLC to consult with Seller and manage the operations of the business prior to DOH approval. The compensation for such services is $33,333.33 per month.

Lease Agreement

The applicant has submitted an executed lease agreement for 1414 Utica Avenue, Brooklyn, New York, for 2,848 square feet of its administrative offices, the terms of which are summarized below:

Date:	November 1, 2012
Premises:	The second floor of building located at 1414 Utica Avenue, Brooklyn.
Landlord:	Tri-Borough Home Care, LTD
Lessee:	Family Aides Certified Services of New York City, Inc. d/b/a Family Care Certified Services of Brooklyn and Queens
Rental:	$6,211.56/month ($26.17 per sq. ft.)
Term:	Month to month until the change in operator is approved by the Department of Health.
Provisions:	Lessee is responsible for insurance and maintenance.

The lease arrangement is an arm's length agreement. Family Aides Certified Services of New York City, Inc. has submitted letters from real estate brokers attesting to the reasonableness of the rent.

Assignment and Assumption of Lease

The applicant has submitted an executed Assignment and Assumption of the lease agreement for 1414 Utica Avenue, Brooklyn, New York, for its administrative offices, the terms of which are summarized below:

Date:	February 20, 2013
Premises:	The second floor of building located at 1414 Utica Avenue, Brooklyn.
Assignor:	Tri-Borough Home Care, LTD
Assignee:	Tri-Borough Certified Health Systems of New York, LLC

Operating Budget

The applicant has submitted an operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Total Revenue	$9,595,050	$12,060,919
Total Expenses	8.367,551	11,296,429
Net Income	$1,227,499	$ 764,490

Utilization by payor source for years one and three is as follows:

Medicare	70.0%
Medicaid	20.0%
Commercial	8.0%
Charity Care	2.0%

Expense and utilization assumptions are based on the historical experience of Family Aides Certified Services of Brooklyn/Queens.

Capability and Feasibility

There are no project costs associated with this application. The purchase price of $700,000 will be satisfied with proposed member's equity. The balance due as of to-date is $600,000, since $100,000 has already been paid and held in escrow until closing. Presented as BFA Attachment B, is the net worth of the proposed member, which shows sufficient equity.

The working capital requirement is estimated at $1,882,738, based on two months of third year expenses. Working capital will be provided from Tri-Borough Home Care, LTD as an inter-company expense.

Presented as BFA Attachment C, is the financial summary of Tri-Borough Home Care LTD, which shows positive working capital, net equity and a net profit from operations of $537,478 as of December 31, 2012. Presented as BFA Attachment E, is the Pro- forma Balance Sheet of Brooklyn/Queens regarding the change in operator of the CHHA, which indicates positive equity of $1,882,738.

The submitted budget projects a net income of $1,227,499 and $764,490 for the first and third years, respectively. Revenue is based on current payment rates for home health care services. The budget appears reasonable.

Presented as BFA Attachment D is the financial summary of Family Aides Certified Services of New York City, Inc., which shows the facility experienced negative working capital, negative net equity and a loss from operations. This was due to cases relating to long term patients receiving services for over 120 day periods which were 80% Medicaid. On April 1, 2011, the Medicaid CHHA program came under a Managed Care model brought on by an MRT recommendation which created a drastic decline in revenues. The program could not reduce its expenses quickly enough, resulting in the possible closure of the operation and surrendering of its license. In 2012, Tri-Borough Home Care, LTD proposed a management contract to take over the services.

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 for Tri-Borough Health Services of New York, LLC
BFA Attachment B	Net Worth Statement of Proposed Member
BFA Attachment C	Financial Summary- Tri-Borough Home Care, LTD, unaudited 2012
BFA Attachment D	Financial Summary-Family Aides Certified Services of New York City, Inc.2012draft and 2011certified
BFA Attachment E	Pro-forma Balance Sheet

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 6th day of June, 2013, 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 Tri-Borough Certified Health Systems of New York, LLC as the new operator of Family Care Certified Services of Brooklyn/Queens Certified Home Health Agency, 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
131103 E	Tri-Borough Certified Health Systems of New York, LLC d/b/a Family Care Certified

APPROVAL CONTINGENT UPON:

N/A

APPROVAL CONDITIONED UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 121213-E
Fort Hudson Certified Home Health Agency, Inc.

County: **Washington County (Fort Edward)** ***Program:*** **Certified Home Health Agency**
Purpose: **Establishment** ***Submitted:*** **April 16, 2012**

Executive Summary

Description
Fort Hudson Certified Home Health Agency, Inc. a proposed not-for-profit corporation, requests approval to establish a Certified Home Health Agency (CHHA) to serve Warren and Washington counties. The applicant's sole member is Fort Hudson Health System, Inc., whose corporate membership includes: Fort Hudson Nursing Center, Inc., a196-bed residential health care facility (RHCF) with an on-site medical adult day health care (ADHC) program; Fort Hudson Home Care, Inc., which offers personal care services, and several other entities that provides housing and a foundation that assists and sponsors programs.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Fort Hudson Certified Home Health Agency, Inc. submitted an application in response to the competitive RFA and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation
Contingent approval

Program Summary
This proposal seeks to establish a Certified Home Health Agency (CHHA) to serve the counties of

Warren and Washington pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
Total project costs of $364,483 will be met with $40,033 in equity and a five year loan for $324,450 from Glens Fall National Bank and Trust Company at a 3.75% interest rate.

Budget	Revenues:	$ 3,369,621
	Expenses:	$ 3,247,800
	Gain:	$121,821

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this project.

Office of Health Systems Management

Approval contingent upon:

1. Submission of a loan commitment that is acceptable to the Department of Health. [BFA]
2. Submission of a working capital loan commitment that is acceptable to the Department of Health. [BFA]
3. Submission of an executed building lease that is acceptable to the Department of Health. [BFA]
4. Submission of a photocopy of the executed and dated proposed Certificate of Incorporation of Fort Hudson Certified Home Health Agency, Inc., acceptable to the Department. [CSL]

Approval conditional upon:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Fort Hudson Certified Home Health Agency, Inc. is requesting approval to establish a new Certified Home Health Agency to serve Warren and Washington counties. On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;

Knowledge and experience in the provision of home health services;

Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;

Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Fort Hudson Certified Home Health Agency, Inc. is a community based organizations that is mission driven and currently operates a Licensed Home Care Service Agency (LHCSA), 196 Bed Skilled Nursing Facility (SNF), an Adult Day Health Care Program, and Independent Senior Retirement Housing. As they already have a presence in the proposed service area, they are familiar with the population they propose to serve and currently provide health care in the counties they propose to serve.

The applicant has the support of Saratoga Hospital demonstrated by a letter of support and plans to directly collaborate with Glens Falls Hospital. These three facilities make up the major health care systems in the proposed service area. Through partnership with Glens Falls Hospital's Medical Health Home they will be able to provide care management in rural areas of the proposed counties through the use telehealth in the proposed counties which are mostly rural areas. As they are an existing organization they will reduce operating costs and provide administrative efficiencies to the health care system through the use of shared resources.

The applicant has a diversified and integrated network of health care services and will be able to provide a full range of community based programs. They have established disease management programs for tobacco use, heart disease, diabetes, and high blood pressure which have been proven to reduce costly hospital admissions and readmissions. As part of their program they will work efficiently to move clients out of higher cost services into more efficient home care services and to coordinate care across the health care spectrum also reducing hospital readmission.

The applicant provided relevant data and data analysis regarding health status indicators and demographics of the aging population for the counties they propose to serve to demonstrate community need. The applicant provided a marker study demonstrating a need for CHHA services in the proposed counties. They also included a Health Assessment and Community Service Plan from the Adirondack Rural Health Network that identified a need for additional home care services in the region. The applicant described how they would operate to fill these identified gaps in service. They discussed the need to move chronic conditions into care management models and how they could work in remote areas of the counties. In addition, the applicant demonstrated public need using the criteria of 709.1(a) and provided supporting data.

Recommendation

From a need perspective, approval is recommended

Programmatic Analysis

Background

Fort Hudson Certified Home Health Agency, Inc. is a proposed not-for-profit corporation requesting approval to become established as a CHHA under Article 36 of the Public Health Law, with approval to serve the counties of Warren and Washington.

The applicant proposes to operate the CHHA from an office located at 319 Broadway, Fort Edward, New York 12828. The applicant proposes to provide the following health care services:

Nursing	Home Health Aide
Physical Therapy	Occupational Therapy
Speech Language Pathology	Medical Social Services
Nutrition	Medical Supplies, Equipment, and Appliances
Audiology	Respiratory Therapy
Personal Care	Homemaker
Housekeeper	

The Board of Directors of Fort Hudson Certified Home Health Agency, Inc. will be as follows:

Judith S. Bulova – Director/President
Retired

David E. Kisselback – Director/Vice President
CEO, YMCA

Keith Laake, CPA – Director/Treasurer
President, Cost Control Associates, Inc.

Claire M. Murphy – Director/Secretary
Office for the Aging Director, Warren County

All of the members of the Board of Directors of Fort Hudson Certified Home Health Agency, Inc. also sit on the Board of Directors of parent organization, Fort Hudson Health System.

The Board of Directors of Fort Hudson Health System is as follows:

David E. Kisselback – President
(Previously Disclosed)

Gretchen Steffan – Vice President
Managing Partner, Grove Associates

Keith Laake, CPA – Treasurer
(Previously Disclosed)

G. Neil Roberts, NHA – Secretary
Research and Analyst, Next Wave

David J. Capron – Director
Sr. Manager of Facilities/EH&S, Navilyst Medical, Inc.

Andrew E. Lemery – Director
Retired

John Matochik, Jr., DVM – Director
Retired

Stanley W. Maziejka – Director
School Superintendent, Stillwater School District

Robert J. Miles – Director
Retired

Dean A. Reali, MD – Director
Physician, Glens Falls Hospital

Judith S. Bulova – Director
(Previously Disclosed)

Claire M. Murphy – Director
(Previously Disclosed)

Tori J.E. Riley – Director
Director Member Services Economic Development Specialist, SEDC

Mark W. Miller – Director
President, Americlean

All of the members of the Board of Directors of Fort Hudson Health System also sit on the Board of Directors of the Residential Health Care Facility, Fort Hudson Nursing Center, Inc., and the Licensed Home Care Service Agency, Fort Hudson Home Care, Inc.

A search of the individuals named above revealed no matches on either the NYS OMIG Medicaid Disqualified Provider List, or the US DHHS Office of the Inspector General 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.

The Bureau of Professional Credentialing has indicated that Garry Neil Roberts, NHA license #03805 holds a NHA license in good standing and the Board of Examiners of Nursing Home Administrators has never taken disciplinary action against this individual or his license.

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:

Fort Hudson Nursing Center, Inc.
Fort Hudson Home Care, Inc. (April 2008 – Present)

The information provided by the Bureau of Quality Assurance and Surveillance for Nursing Homes has indicated that the nursing home reviewed 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 patients and to prevent recurrent code violations.

A review of all personal qualifying information indicates there is nothing in the background of the principals listed above to adversely effect their positions in the proposed organizational structure. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Total Project Cost and Financing

Total project cost for the acquisition of moveable equipment is estimated at $364,483, broken down as follows:

Movable Equipment	$360,500
CON Application Fee	2,000
CON Processing Fee	1,983
Total Project Cost	$364,483

Project costs are based on a July 1, 2013 start date, with a five month construction period.

The applicant's financing plan appears as follows:

Cash Equity	$40,033
Loan (3.75%, 5-year term)	324,450
Total	$364,483

A letter of interest has been provided from Glens Falls National Bank and Trust Company, at the above stated terms.

Lease Rental Agreement

The applicant has submitted a draft lease for the proposed site; the terms are summarized below:

Premises:	1,200 gross sq. ft. located at 319 Broadway, Fort Edward, New York 12828
Landlord:	Fort Hudson Nursing Center, Inc.
Lessee:	Fort Hudson Certified Home Health Agency, Inc.
Term:	5 years ($7,400 per year or $6.17 per sq. ft.)
Provisions:	All included in rent

The proposed lease is a non- arm's length arrangement. The square footage rental rate is based on the capital cost per square, calculated according to Medicare/Medicaid cost allocation (step-down) principals, as described in New York State Residential Health Care Facilities Accounting and Reporting Manual.

Operating Budget

The applicant has submitted the first and third year's operating budgets, in 2013 dollars, as summarized below:

Description	First Year	Third Year
Medicaid	$520,261	$948,325
Medicare	724,883	1,321,306
Commercial & All Other	603,468	1,099,990
Total Revenues	$1,848,612	$3,369,621
Total Expenses	$2,296,325	$3,247,800
Net Income or (Loss)	$(447,713)	$121,821

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

Medicaid Episodic	11%
Medicare Episodic	41%
Commercial Fee-for-Service	42%
All Other	4%
Charity Care	2%

Utilization and payor mix assumptions are based the applicant's recent market study, and input from several consultants, along with reviewing the area providers, filed 2010 and 2011 cost reports. The expense projections are based upon the applicant's experience in providing services to the community and reviewing the cost reports from similarly sized CHHA's in the upstate region.

The average Medicaid episodic payment is expected to be $4,109.58 after taking into consideration the average case mix of .8 and adjusting for the Capital Region Wage Index Factor of .911944. The applicant expects to have approximately 227 Medicaid episodes by the third year.

The Medicare average episodic payment is expected to be $2,091.39 after taking into consideration the average case mix of 1.15 and adjusting for a wage index of .8504. The applicant expects to have approximately 620 Medicare episodes by the third year. Commercial revenue projections were based on historical payment rates.

Capability and Feasibility

The total project cost of $364,483 will be provided as follows: $40,033 from Fort Hudson Health System Inc. long term investment account with the balance of $324,450 being financed through the Glens Falls National Bank and Trust Company at the above stated terms.

The working capital requirement is estimated at $541,300, which appears reasonable based upon two months of third year expenses. Half of the working capital or $270,650 will be provided from the Fort Hudson Health System, Inc. long term investment account with the remaining $270,650 being provided from a line of credit through the Glens Falls National Bank and Trust Company at a 4.25% rate of interest. Presented as BFA Attachment A is Fort Hudson Health System, Inc. and Related Entities 2011 and 2012 certified financial summary, which shows sufficient resources for this purpose. Presented as BFA Attachment B is a pro-forma balance sheet showing operations will start off with $310,683 in equity.

The budget projects a first year loss of $447,713 and third year operating surplus of $121,821. The applicant states that the first year loss is the result of a very conservative estimate of utilization and billable services, while expenses reflect new agency startup costs. The applicant states "given our recent experience in starting new programs and the existing geographical presence in the counties to be served, it is the goal to outperform the projections." Revenues are based on current payment methodologies. The submitted budget appears reasonable.

A review of Attachment A shows Fort Hudson Health System, Inc. and Related Entities Valley Care Partners, LLC had a positive average working capital position, a positive average net asset position and has $509,039 in Long Term Investments. For the periods shown, Fort Hudson Health System, Inc. and Related Entities generated a positive average net increase in assets of $635,895.

It appears 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	Financial Summary for 2011 and 2012, Fort Hudson Health System, Inc. and Related Entities
BFA Attachment B	Pro-forma Balance Sheet

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 6th day of June, 2013, 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 a certified home health agency program to serve Warren and Washington 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
121213 E	Fort Hudson Certified Home Health Agency, Inc.

APPROVAL CONTINGENT UPON:

1. Submission of a loan commitment that is acceptable to the Department of Health. [BFA]
2. Submission of a working capital loan commitment that is acceptable to the Department of Health. [BFA]
3. Submission of an executed building lease that is acceptable to the Department of Health. [BFA]
4. Submission of a photocopy of the executed and dated proposed Certificate of Incorporation of Fort Hudson Certified Home Health Agency, Inc., acceptable to the Department. [CSL]

APPROVAL CONDITIONED UPON:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

STATE OF NEW YORK - DEPARTMENT OF HEALTH

MEMORANDUM

TO: Public Health and Health Planning Council

FROM: James E. Dering, General Counsel

DATE: May 7, 2013

SUBJECT: Proposed Certificate of Amendment of the Certificate of Incorporation of North Country Children's Clinic, Inc.

Attached is the proposed Certificate of Amendment of the Certificate of Incorporation of North Country Children's Clinic, Inc. The Corporation seeks approval to change its name to "North Country Family Health Center, Inc.," and to amend the original Certificate of Incorporation to include additional purposes. As set forth in the attached letter from Lucy Gerviss, attorney for the corporation, the reason for the change is to expand the scope of practice to include the treatment of adults as well as children. The requested name change corresponds with this expanded scope of practice.

North Country Children's Clinic, Inc. is a type B not-for-profit corporation that was established pursuant to Article 28 of the Public Health Law. Therefore, Public Health and Health Planning Council approval for a change of corporate name and purposes is required by Not-for-Profit Corporation Law § 804 (a) and 10 NYCRR § 600.11 (a) (1).

Attached are the duly executed Certificate of Amendment of the Certificate of Incorporation and an additional resolution of the Clinic's board of directors making amendments to the Certificate of Amendment as required by the State Education Department.

The Department has no objection to the change of name or purposes, and the Certificate of Amendment is in legally acceptable form.

JED: JCL
Attachments

SCHWERZMANN & WISE, P.C.
ATTORNEYS AT LAW
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ANN E. PHILLIPS
GEORGE E. MEAD III
LUCY M. GERVISS*

*ALSO ADMITTED IN FLORIDA

RICHARD F. SCHWERZMANN
(1918-2000)

LESLIE H. DEMING
OF COUNSEL

November 26, 2012

Via Certified Return Receipt Requested Mail to:
NYS Department of Health
Public Health and Health Planning Council
ATTN: Colleen M. Frost, Executive Secretary
Health Planning Facility
433 River St., 6th Floor
Troy, NY 12180

Re: North Country Children's Clinic, Inc.
Watertown, NY 13601

Dear Ms. Frost,

Our office represents the North Country Children's Clinic, Inc. located in Watertown, New York (hereinafter the "Clinic"). The Clinic desires to change its corporate name to "North Country Family Health Center, Inc." as well as expand its corporate scope and powers to allow for the treatment of adults in accordance with a federal grant that the Clinic recently received. In accordance with NY Not-For-Profit Law ("NPL") Sections 804(a) and 404, we believe that the consent of the Public Health and Health Planning Council (hereinafter the "PHHPC") is a necessary prerequisite to filing the Certificate of Amendment with the Department of State.

To obtain the PHHPC's consent, enclosed herein for consideration are copies of the following:

1) Proposed "Certificate of Amendment";
2) Minutes of the Clinic Board meeting held on October 20, 2011 showing an acceptance of proposed amendments of the Articles of Incorporation to expand powers, and associated Certificate of Amendment;
3) Minutes of the Clinic Board meeting held on August 2, 2012 showing an approval of a change of the Clinic's name to "North Country Family Health Center," and associated Certificate of Amendment;
4) Resolution dated November 19, 2012 approving the addition of corporate indicator "Inc." to the previously approved name as changed (proposed Certificate of Amendment included in number one, above); and

5) Certificate of Incorporation filed January 13, 1975 and Amended Certificate of Incorporation filed August 4, 1983 with consents.

Please forward these documents to the necessary committe for review. **We request to be placed on the agenda of the PHHPC committee meeting scheduled for January 24, 2013 in anticipation of the full PHHPC Board meeting on February 7, 2013.**

If the attorney assigned to this matter has any questions or concerns, or is in need of additional documentation, please do not hesitate to contact me. Your anticipated prompt attention to this matter is appreciated. Thank you.

Very Truly Yours,

SCHWERZMANN & WISE, P.C.

Lucy M. Gerviss

Encs.

cc: Janice Charles, Interim Executive Director – North Country Children's Clinic, Inc.

CERTIFICATE OF AMENDMENT
OF THE
CERTIFICATE OF INCORPORATION
OF THE
NORTH COUNTRY CHILDREN'S CLINIC, INC.

Under Section 803 of the Not-for-Profit Corporation Law

FIRST: The name of the Corporation is: NORTH COUNTRY CHILDREN'S CLINIC, INC. (the "Corporation").

SECOND: The Certificate of Incorporation was filed by the Department of State on January 13, 1975.

THIRD: The law the Corporation was formed under is Section 402 of the Not-for-Profit Corporation Law.

FOURTH: The Corporation is a corporation as defined in Section 102(a)(5) of the Not-for-Profit Corporation Law.

FIFTH: The Corporation is a Type B corporation and shall remain Type B after filing of this Certificate of Amendment which among other things, enlarges the purposes of the Corporation.

SIXTH: The amendments effected by this Certificate of Amendment are as follows:

Paragraph 1 of the Certificate of Incorporation relating to the name of the Corporation is hereby amended to read in its entirety as follows:

" The name of the Corporation is NORTH COUNTRY FAMILY HEALTH CENTER, INC."

Paragraph 3 of the Certificate of Incorporation relating to the purposes for which the Corporation is formed is hereby amended to read in its entirety as follows:

"The purposes for which the Corporation is to be formed is to provide family and individual health care, education and development, to screen for growth and development in children, provide family counseling, family planning, family immunization, preventative dental advice, and to do any other act or thing incidental to or connected with the foregoing purposes

or advancement thereof, but not for the pecuniary profit or financial gain of its members, directors, or officers except as permitted by Article 5 of the Not-for-Profit Corporation Law."

Paragraph 4 of the Certificate of Incorporation relating to the powers granted to the Corporation to further its corporate purposes is hereby amended to read in its entirety as follows:

"To the extent permitted under the statutes of the State of New York, and in furtherance of its corporate purposes, the corporation shall have the power:

(a) To establish and operate multi-physician screening facilities for children and adults of all ages within the definition of hospital as defined by Article 28 of the Public Health Law, provided, however, that before each screening facility is opened or operated the corporation shall first receive prior appropriate approval by the New York State Department of Health or agency designated thereunder.

(b) To purchase, receive, take by grant, gift devise, bequest or otherwise acquire, own, hold, improve, employ or otherwise deal in and with, real or personal property, or any interest therein, wherever situated.

(c) To have a corporate seal, and to alter such seal at pleasure, and to use it by causing it or a facsimile to be affixed or impressed or reproduced in any other manner.

(d) To sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, all or any of its property, or any interest therein, wherever situated.

(e) To purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, land, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use and otherwise deal in and with, bonds or other obligations, shares or other securities or interest issued by others, whether engaged in similar or different business, governmental or other activities.

(f) To make capital contributions or subventions to other not-for-profit corporations.

(g) To accept subventions from other persons or unit of government.

(h) To make contracts, give guarantees and incur liabilities, borrow money at such rates of interest as the corporation may determine, issue its notes, bonds and other obligations, and secure any of its obligations by mortgage or pledge of all or any of its property or any interest therein, wherever situated.

(i) To lend money, invest and reinvest its funds, and to take and hold real and personal property as security for the payments of funds so loaned or invested.

(j) To carry on its operations, and have offices and exercise its powers in any jurisdiction within or without the United States.

(k) To elect or appoint officers, employees and other agents of the corporation, define their duties, fix their reasonable compensation and the reasonable compensation of directors, and to indemnify corporate personnel. Such compensation shall be commensurate with services performed.

(l) To adopt, amend or repeal by-laws.

(m) To make donations, irrespective of corporate benefit, for the public welfare or for community fund, hospital, charitable, educational, scientific, civic or similar purposes.

(n) To be a member, associate or manager of other non-profit activities or to the extent permitted in any other jurisdiction to be an incorporator of other corporations.

(o) To have and exercise all powers necessary to effect any or all of the purposes for which the corporation is formed.

Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on by a corporation exempt from Federal Income Tax under section 501(c)(3) of the Internal Revenue Code of 1986 (or any other corresponding provisions of any future United States Internal Revenue Law)."

Paragraph 6 of the Certificate of Incorporation relating to the location of the Corporation's office is hereby amended to read in its entirety as follows:

"The Corporation's office is to be located in the County of Jefferson, State of New York."

Paragraph 9 of the Certificate of Incorporation relating to the location to where notice should be sent by the Secretary of State is hereby deleted in its entirety.

Paragraph 12 of the Certificate of Incorporation relating to the designation of agent is hereby amended to read in its entirety as follows:

"The Secretary of State is designated as agent of the Corporation upon whom process against it may be served. The address to which the Secretary of State shall forward copies of process accepted on behalf of the Corporation is: 238 Arsenal Street, Watertown, NY 13601."

SEVENTH: The Certificate of Amendment was authorized by a vote of a majority of the entire Board of Directors. The Corporation has no members.

Signature: Margaret E. Sorensen

Printed Name: Margaret E. Sorensen

Title: President, Board of Directors

Date: 11-5-12

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 6th day of June, 2013, approves the filing of the Certificate of Amendment of Certificate of Incorporation of North Country Children's Clinic, Inc., dated November 5, 2012.

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Nix JT Corporation d/b/a Comfort Keepers #685
Address:	Ithaca
County:	Tompkins
Structure:	For-Profit Corporation
Application Number:	2080-L

Description of Project:

Nix JT Corporation d/b/a Comfort Keepers #685, a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law. Nix JT Corporation d/b/a Comfort Keepers #685 is an existing companion care agency and a franchise.

The applicant has authorized one share of common stock which is owned as follows:
Teresa L. Nix owns one half share and Jeffrey A. Nix owns one half share.

The Board of Directors of Nix JT Corporation d/b/a Comfort Keepers #685 comprises the following individuals:

Teresa L. Nix, President, Secretary	Jeffrey A. Nix, Vice President, Treasurer
General Manager, Comfort Keepers #685	Conference Service Supervisor, Cornell University

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 179 Graham Road, Suite F, Ithaca, New York 14850:

Tompkins	Cortland	Schuyler

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
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: May 8, 2013

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Washington County Public Health Nursing Service
Address:	Hudson Falls
County:	Washington
Structure:	Public
Application Number:	2243L

Description of Project:

Washington County Public Health Nursing Service requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The county currently operates a certified home health agency and long term home health care program which they are planning on selling. Washington County Public Health Nursing Service is requesting approval to open a licensed home care services agency to enable the county to continue to provide essential public health nursing services in the event the CHHA and LTHHCP are sold.

The applicant proposes to serve the residents of Washington County from an office located at 415 Lower Main Street, Hudson Falls, New York 12839.

The applicant proposes to provide Nursing Services.

Washington County Public Health Nursing Service currently operates a Diagnostic and Treatment Center, Certified Home Health Agency, Long Term Home Health Care Program and Hospice.

The information provided by the Division of Certification and Surveillance indicated that the Diagnostic and Treatment Center 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 indicated that the Certified Home Health Agency, Long Term Home Health Care Program and Hospice have provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

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:	April 1, 2013

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 6th day of June, 2013, 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:
2077L	GTD Services, Inc. dba BrightStar of North Shore Nassau County (Nassau and Suffolk Counties)
2080L	Nix JT Corporation d/b comfort Keepers #685 (Tompkins, Cortland, and Schuyler Counties)
1788L	Sunrise Home Care, Inc. (Putnam, Westchester and Dutchess Counties)
2243L	Washington County Public Health Nursing Service (Washington County)
2263L	Wyoming County Health Department (Wyoming County)

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

June 6, 2013

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

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

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122311 E	Endoscopy Center of Long Island, LLC (Nassau County) Mr. Kraut – Recusal	Contingent Approval

Dialysis Services – Establish/Construct **Exhibit #22**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	112210 B	New York Regional Services, LLC d/b/a New York Regional Dialysis Center (Kings County) Dr. Bhat - Interest	Contingent Approval

Upstate Request for Applications - Certified Home Health Agencies – Establish/Construct **Exhibit #23**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121266 E	Guthrie Home Care (Chemung County) Mr. Booth - Interest	Contingent Approval

Downstate Request for Applications - Certified Home Health Agencies – Establish/Construct **Exhibit #24**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	121233 E	United Hebrew of New Rochelle Certified Home Health Agency, Inc. (Westchester County) Mr. Fassler - Interest	Contingent Approval

HOME HEALTH AGENCY LICENSURES **Exhibit #25**

Number	Applicant/Facility	E.P.R.C. Recommendation
2077L	GTD Services, Inc. dba BrightStar of North Shore Nassau County (Nassau and Suffolk Counties) Ms. Regan - Interest	Contingent Approval
1788L	Sunrise Home Care, Inc. (Putnam, Westchester and Dutchess Counties) Ms. Regan - Interest	Contingent Approval
2263L	Wyoming County Health Department (Wyoming County) Mr. Booth – Interest Ms. Hines – Interest Mr. Robinson - Interest	Approval

Public Health and Health Planning Council

Project # 122311-E
Endoscopy Center of Long Island, LLC

County: **Nassau County (Garden City)**
Purpose: **Establishment**

Program: **Diagnostic and Treatment Center**
Submitted: **December 27, 2012**

Executive Summary

Description

Endoscopy Center of Long Island, LLC, (ECLI), an existing diagnostic and treatment center (D&TC) that is certified as a single specialty freestanding ambulatory surgical center (FASC) for Gastroenterology and is also certified to provide Clinical Laboratory Service for Outpatients, is requesting approval to add North Shore-LIJ Ventures, LLC as a member of ECLI. The sole member of North Shore-LIJ Ventures, LLC is North Shore University Hospital, a voluntary not-for-profit 804-bed tertiary care hospital located in Manhasset. North Shore University Hospital will serve as the backup hospital.

The current and proposed membership interest of ECLI is as follows:

Current Member	% Interest	Proposed Member	% Interest
KLG,LLC	36.8843%	KLG,LLC	11.0653%
Endoscopy Associates, LLC	33.4815%	Endoscopy Associates, LLC	10.0444%
S&T Associates, LLC	27.1342%	S&T Associates, LLC	8.1403%
DM&MK,LLC	1.5000%	DM&MK,LLC	0.4500%
JC&EH,LLC	1.0000%	JC&EH,LLC	0.3000%
		North Shore-LIJ Ventures, LLC	70.0000%

North Shore-LIJ Ventures, LLC will enter into a Membership Interest Purchase Agreement to acquire 70% membership interest in ECLI for $28.4 million. Presented as BFA Attachment B, is the financial summary for North Shore-Long Island Jewish Health System, who will fund this transaction for North Shore-LIJ Ventures, LLC and shows sufficient funds for the purchase.

In 2012, Endoscopy Center of Long Island (ECLI) performed 9,297 procedures. From January 1, 2013 through April 30, 2013, ECLI performed 3,117 procedures. Per the applicant, the change in ownership will not result in any change in the services being provided or the capacity.

DOH Recommendation

Contingent Approval

Program Summary

Endoscopy Center of Long Island, LLC, an existing ambulatory surgery center, requests permission transfer 70% of its membership interest from existing members to a new member, North Shore-LIJ Ventures, LLC (NSLIJ Ventures). No staffing or programmatic changes will occur due to this membership change.

Financial Summary

There are no project costs associated with this application.

The purchase price of $28,400,000 will be met with accumulated funds from North Shore-Long Island Jewish Health System.

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

Office of Health Systems Management

Approval contingent upon:

1. Submission of an executed Membership Interest Purpose Agreement that is acceptable to the Department of Health. [BFA]
2. Submission of documentation demonstrating that the applicant has obtained or will obtain site control. [CSL]
3. Submission of a signed statement that the proposed financial and referral structure has been assessed in light of the anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate. [CSL]
4. For each facility identified in Contingency #3, the applicant must submit documentation reflecting the facility's current and past compliance with the applicable regulations in the state in which it operates. [CSL]
5. Submission of evidence of an Administrative Services Agreement acceptable to the Department. [CSL]
6. Submission of an executed operating agreement for the LLC, acceptable to the Department. [CSL]
7. Submission of a list of all managers of the second-level LLC-member. [CSL]
8. Submission of executed articles of organization for the second-level LLC-member, acceptable to the Department. [CSL]
9. Submission of an executed operating agreement for the second-level LLC-member, acceptable to the Department. [CSL]

Council Action Date

June 6, 2013.

Programmatic Analysis

Project Proposal

Endoscopy Center of Long Island, LLC, an existing ambulatory surgery center, requests permission transfer 70% of its membership interest from existing members to a new member, North Shore-LIJ Ventures, LLC (NSLIJ Ventures). No staffing or programmatic changes will occur due to this membership change.

Character and Competence

The new 70% member is NSLIJ Ventures, whose sole member is North Shore University Hospital (NSUH). NSUH 's active parent is North Shore Long Island Jewish Health System (NSLIJHS). The Department reviewed the board of trustees of NSLIJHS as well as the individuals who will be the managers of NSLIJ Ventures. The managers of NSLIJ Ventures, all current employees of NSLIJHS, are:

Name
Dennis Dowling
Sharon Joy
Laurence Kraemer
John McGovern
Ira Nash, MD
Robert Scoskie
John Steel, Jr.

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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Mr. Steel disclosed a pending misdemeanor DWI charge. Michael Aschner disclosed two settled lawsuits. Michael Slade disclosed two settled lawsuits.

There was also disclosure regarding several investigations and legal proceedings involving Staten Island University Hospital, which is part of NSLIJHS. They include monetary settlements and a five-year Corporate Integrity Agreement related to the operation of part-time clinics, Medicare and Medicaid billing for stereotactic radiosurgery, the provision of detoxification services above licensed capacity, the graduate medical education program, and the provision of psychiatric services above licensed capacity.

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.

Recommendation

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

From a programmatic perspective, approval is recommended.

Financial Analysis

Financial Analysis

MEMBERSHIP INTEREST PURCHASE AGREEMENT

North Shore-LIJ Ventures, LLC will enter into a Membership Interest Purchase Agreement with Endoscopy Center of Long Island, LLC. The applicant has submitted a proposed agreement, which is summarized below:

Purchaser:	North Shore-LIJ Ventures, LLC
Seller:	KGL,LLC, Endoscopy Associates, LLC, S&T Associates, LLC, DM & MK, LLC and JC & EH,LLC
Purchase Price:	$28,400,000 for 70% membership interest with $100,000 to be held in escrow with the remaining balance due at closing.

CAPABILITY AND FEASIBILITY

There are no project costs associated with this application.

The purchase price of $28,400,000 will be met with accumulated funds from North Shore-Long Island Jewish Health System. Presented as BFA Attachment B, is the financial summary for North Shore-Long Island Jewish Health System, who will fund this transaction for North Shore-LIJ Ventures, LLC and shows sufficient funds for the purchase.

BFA-Attachments A is the 2011 and as of September 30, 2012 financial summaries for Endoscopy Center of Long Island, LLC currently in operation, which shows the facility has maintained positive working capital, members' equity and a net income from operations of $5,456,125 and $6,198,694, respectively.

BFA-Attachments B is the 2011 and as of September 30, 2012 financial summaries for North Shore-Long Island Jewish Health System, Inc., which shows the facility has maintained positive working capital, net assets and a net income from operations of $92,946,000 and $96,284,000, respectively.

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

From a financial perspective, approval is recommended.

Attachments

BFA Attachment A	Financial Summary of Endoscopy Center of Long Island, LLC-2011 and as of September 30, 2012
BFA Attachment B	Financial Summary of North Shore-Long Island Jewish Health System, Inc.-2011 and as of September 30, 2012

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 6th day of June, 2013, 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 add North Shore-LIJ Ventures, LLC as a member of Endoscopy Center of Long Island, 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:
122311 E	Endoscopy Center of Long Island, LLC

APPROVAL CONTINGENT UPON:

1. Submission of an executed Membership Interest Purpose Agreement that is acceptable to the Department of Health. [BFA]
2. Submission of documentation demonstrating that the applicant has obtained or will obtain site control. [CSL]
3. Submission of a signed statement that the proposed financial and referral structure has been assessed in light of the anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate. [CSL]
4. For each facility identified in Contingency #3, the applicant must submit documentation reflecting the facility's current and past compliance with the applicable regulations in the state in which it operates. [CSL]
5. Submission of evidence of an Administrative Services Agreement acceptable to the Department. [CSL]
6. Submission of an executed operating agreement for the LLC, acceptable to the Department. [CSL]
7. Submission of a list of all managers of the second-level LLC-member. [CSL]
8. Submission of executed articles of organization for the second-level LLC-member, acceptable to the Department. [CSL]
9. Submission of an executed operating agreement for the second-level LLC-member, 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:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 112210-B

New York Regional Services, LLC
d/b/a New York Regional Dialysis Center

County: **Kings (Brooklyn)** ***Program:*** **Dialysis Services**
Purpose: **Establishment and Construction** ***Submitted:*** **October 7, 2011**

Executive Summary

Description

New York Regional Services, LLC, is submitting this project revision to change the location of the proposed site, change the number of proposed dialysis stations (from 25 stations to 24) and reflect the updated ownership of the LLC. The new proposed site will be located at 843 Lexington Avenue, Brooklyn, New York and is close proximity to the old site, so there will be no change to the service area as a result of this revision.

The new proposed ownership of New York Regional Services, LLC will be as follows:

Leah Olshwang	90.00%
Moses Gross	5.00%
Abraham Klein	5.00%

DOH Recommendation

Contingent approval.

Need Summary

The Department has determined there is additional need for chronic dialysis stations in Kings County. The addition of these 24 stations will help Kings County residents receive treatment in the county. The facility is projecting 18,720 visits within its first full year of operation. The facility will be operating close to 100% occupancy using the Department's standard.

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 via equity of $303,948, a bank loan of $2,125,965, and an equipment lease of $609,567.

Budget:	*Revenues:*	*$ 6,244,097*
	Expenses:	*6,002,842*
	Gain/(Loss):	*$ 241,293*

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Architectural Summary

The applicant is requesting approval to construct a new 24-station chronic renal dialysis center in Brooklyn. The proposed 9,580 SF center will occupy the entire first floor of an existing one-story, fully-sprinklered, commercial building and will entail interior alterations.

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 a bank loan that is acceptable to the Department of Health. [BFA]
3. Submission of an executed equipment lease that is acceptable to the Department of Health. [BFA]
4. Submission of a photocopy of an executed Amendment to the Lease Agreement between the applicant and Cheyenne Realty, LLC, acceptable to the Department. [BFA, CSL]
5. Submission of a photocopy of the executed Certificate of Amendment of the Articles of Organization of New York Regional Services, LLC, acceptable to the Department. [CSL]
6. Submission of a photocopy of an executed amendment to the Operating Agreement of New York Regional Services, LLC, acceptable to the Department. [CSL]
7. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submissions Guidelines DSG-01. [AER]

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 the start of construction. [AER]
6. The applicant shall complete construction by September 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

June 6, 2013.

Need Analysis

Background

New York Regional Services, LLC d/b/a New York Regional Dialysis Center is seeking approval to establish and construct a 24-station dialysis facility located at 843 Lexington Avenue, Brooklyn.

Analysis

Service Area: The service area for this application is Kings County.

Population:

2010:	2,504,700		
Ages 65 and Over:	11.5%	State Average:	13.5%
Nonwhite:	64.3%	State Average:	41.7%

Source: U.S. Census 2010

The Department tracks statistics on populations with a higher probability of contracting End Stage Renal Disease (ESRD), which requires dialysis.

The cohort representing those over the age of 65 represents the largest group of users of dialysis services. In Kings County, the 65+ age group represents 11.5% of the population, slightly lower than the statewide average of 13.5%.

Minority groups are also at a greater risk of developing Type II Diabetes, which is the leading cause of ESRD. In Kings County, the non-white population is 64.3%, which is higher than the statewide average of 41.7%.

Capacity

The Department's methodology to estimate capacity for chronic dialysis stations is specified in Part 709.4 of Title 10 and is as follows:

- One freestanding station represents 702 treatments per year. This is based on the expectation that the center will operate 2.5 patient shifts per day at 6 days per week, which can accommodate 15 patients per week (2.5 x 6 x 15 x 52 weeks). This projected 702 treatments per year is based on a potential 780 treatments x 52 weeks x 90% utilization rate = 702.

- One hospital based station is calculated at 499 treatments per year per station. This is the result of 2.0 shifts per day x 6 days per week x 52 weeks x 80% utilization rate. One hospital based station can treat 3 patients per year.

- Per Department policy, hospital-based stations can treat fewer patients per year. Statewide, the majority of stations are freestanding, as are the majority of applications for new stations. As such, when calculating the need for additional stations, the Department bases the projected need on the establishment of additional freestanding stations.

- There are currently 683 dialysis stations and 108 pipeline stations for a total of 791 stations in Kings County. This project proposes to add 24 net new freestanding stations to the system.

- Based upon the DOH methodology, the existing 791 approved stations could treat a total of 3,560 patients annually.

- Based upon an estimate of three percent annual increase in patients treated, the current number of 791 chronic stations in Kings County is not sufficient to meet the current needs of patients and residents. Considering the current and projected increase in patients, there is a need for additional stations by 2016.

Table 1	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated
	3954	4507	4584	5225
Free Standing Stations Needed	879	1002	1019	1162
Existing Stations	683	683	683	683
Total Stations (Including Pipeline)	791	791	791	791
Net new stations from this project	24	24	24	24
Total Stations After Approval (Including Pipeline)	817	817	817	817
Unmet Need With Approval	62	185	202	345

**FS – Free Standing
***Based upon an estimate of a three percent annual increase

The data in the first row, "Free Standing Stations Needed," comes from the DOH methodology of each station being able to treat 4.5 patients, and each hospital station being able to treat 3 patients annually. The data in the next row, "Existing Stations," comes from the Department's Health Facilities Information System (HFIS). "Unmet Need" comes from subtracting needed stations from existing stations. "Total Patients Treated" is from IPRO data from 2011.

Conclusion

The facility currently accommodates a population in need of access to dialysis stations in the service area. The 683 operating stations in Kings County currently serve a population of 2,565,635. Currently there are not enough stations to treat the 4,507 residents that need treatment in Kings County; nor will the additional 108 pipeline stations suffice to meet the county's need for dialysis in 2016. The approval of these 24 additional stations is recommended.

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Background
Establish a diagnostic and treatment center to provide chronic renal dialysis services. Amends and supercedes CON 091037.

Proposed Operator	New York Regional Services, LLC
Doing Business As	New York Regional Dialysis Center
Site Address	843 Lexington Avenue, Brooklyn
Stations	24
Staffing (1st Year / 3rd Year)	31.25 FTEs / 33.25 FTEs
Medical Director(s)	Marie-Alex Michel
Emergency, In-Patient and Backup Support Services Agreement and Distance	Will be provided by Woodhull Medical & Mental Health Center < 1 mile and 3 minutes

Character and Competence

The members of the LLC are:

Name	
Leah Olshwang (Manager)	90%
Moses Gross	5%
Abraham Klein	5%

Leah Olshwang is a speech language pathologist. Moses Gross and Abraham Klein are mortgage brokers.

Ms. Olshwangm and Messrs. Gross and Abraham believe that their combined experiences and strengths create a team with the capability to operate the proposed health care facility. As a direct provider of health care services, Ms. Olshwang indicates her strong committment in the delivery of high-quality care to patients and plans to make the development of quality oversight systems and programs a focus of the Center, both pre-operationally and on a continuing basis upon opening. She believes in the importance of hiring and retaining experienced and capable staff. The Center has already recruited Dr. Michel, a board-certified nephrologist, to serve as Medical Director and is committed to hiring an Administrator with strong experience in dialysis care. Additionally, Messrs. Gross and Abraham have extensive experience in managing the financial aspects of a business. Their involvement is for the purpose of providing that fiscal and business management experience and oversight to 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 ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

None of the applicants disclosed any association with other licensed health care facilities.

Compliance with Applicable Codes, Rules and Regulations

The facility must comply at all times with applicable state, federal and local codes, rules and regulations and must conform to generally accepted standards of practice.

Recommendation

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

Lease Rental Agreement

The applicant has submitted a draft lease rental agreement, which is summarized below:

Premise:	10,000 square feet located at 843 Lexington Avenue, Brooklyn, New York
Lessor:	843 Lexington Avenue, LLC
Lessee:	New York Regional Services, LLC
Term:	10 years
Rental:	$235,000 Year One and a 3% increase per year over the base rent.
Provisions:	The lessee shall be responsible for maintenance and utilities.

The applicant has indicated that the lease agreement will be a non-arm's length lease arrangement.

Total Project Cost and Financing

Total project cost, which is for renovations and the acquisition of moveable equipment, is estimated at $3,039,480, further broken down as follows:

Renovation and Demolition	$1,665,004
Design Contingency	166,500
Construction Contingency	166,500
Architect/Engineering Fees	166,500
Other Fees (Consultant)	36,867
Moveable Equipment	642,077
Financing Costs	27,355
Interim Interest Expense	148,818
CON Fee	3,250
Additional Processing Fee	16,608
Total Project Cost	$3,039,480

Project costs are based on a September 1, 2013 construction start date and a twelve month construction period.

The applicant's financing plan appears as follows:

Equity	$303,948
Equipment Lease (7.50% for a five year term)	609,567
Loan (6.00% for a five year term)	2,125,965

Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, during the first and third years, summarized below:

	Year One	Year Three
Revenues	$5,750,405	$6,244,097
Expenses:		
Operating	$4,901,469	$5,390,568
Capital	661,351	612,236
Total Revenues	$5,562,820	$6,002,804
Net Income	$187,585	$241,293
Utilization: (treatments)	18,720	20,448
Cost Per Treatment	$297.16	$293.56

Utilization broken down by payor source during the first and third years is as follows:

	Year One	Year Three
Medicare Fee For Service	73.00%	73.00%
Medicaid Managed Care	4.00%	4.00%
Commercial Managed Care	12.00%	12.00%
CAPD Medicare	11.00%	11.00%

Expense and utilization assumptions are based on historical experience of other facilities in the geographical area.

Capability And Feasibility

Total project cost of $3,039,480 will be met as follows: Equity of $303,948; Equipment Lease of $609,567 at an interest rate of 7.75% for a five year term and a bank loan of $2,125,965 at an interest rate of 6.00% for a five year term.

Working capital requirements are estimated at $1,000,467, which is equivalent to two months of third year expenses. The applicant will provide equity to meet the working capital requirement via personal funds from the proposed members. Presented as BFA Attachment A are the personal net worth statements of the proposed members of New York Regional Services, LLC, which indicates the availability of sufficient funds for the equity contribution. The

applicant submitted affidavits indicating that they will provide equity disproportionate to ownership percentages. Presented as BFA Attachment B, is the pro-forma balance sheet of New York Regional Services, LLC as of the first day of operation, which indicates a positive net asset position of $1,304,415.

The submitted budget indicates a net income of $187,585 and $241,297 during the first and third years, respectively. Revenues are based on the current reimbursement methodologies for dialysis services. 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 contingent approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Architectural Analysis

Background

The first floor will consist of 9,580 sf of renovation and will include the dialysis center treatment area along with all required support services. The dialysis center treatment area consists of approximately 5,500 sf and contains twenty-four stations, one of which is an isolation station; soiled and clean utility rooms; staff and patient toilet rooms; two nurses' stations; five prep areas; stretcher and wheelchair alcove; and storage. The support services on the floor include the entrance vestibule; reception area; waiting area; staff and public toilet rooms; exam room; conference room; offices; medical records room; men's and women's locker rooms with showers; staff lounge; storage rooms; and mechanical equipment room.

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 Statements of the Proposed Members
BFA Attachment B	Pro-forma Balance Sheet
BHFP Attachment	Map

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 6th day of June, 2013, 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 freestanding 24 station chronic renal dialysis center at 843 Lexington Avenue, Brooklyn, 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:
112210 B	New York Regional Services, LLC d/b/a New York Regional Dialysis Center

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 a bank loan that is acceptable to the Department of Health. [BFA]
3. Submission of an executed equipment lease that is acceptable to the Department of Health. [BFA]
4. Submission of a photocopy of an executed Amendment to the Lease Agreement between the applicant and Cheyenne Realty, LLC, acceptable to the Department. [BFA, CSL]
5. Submission of a photocopy of the executed Certificate of Amendment of the Articles of Organization of New York Regional Services, LLC, acceptable to the Department. [CSL]
6. Submission of a photocopy of an executed amendment to the Operating Agreement of New York Regional Services, LLC, acceptable to the Department. [CSL]
7. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submissions Guidelines DSG-01. [AER]

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 the start of construction. [AER]
6. The applicant shall complete construction by September 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]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 121266-E

Guthrie Home Care

County: **Chemung County (Horseheads)** ***Program:*** **Certified Home Health Agency**
Purpose: **Establishment** ***Submitted:*** **April 19, 2012**

Executive Summary

Description

Guthrie Home Care is requesting to establish a Certified Home Health Agency (CHHA) to service Tioga, Steuben and Chemung Counties. The site locations for all three Guthrie Home Care offices are as follows: Guthrie Clinic at 29 North Chemung St. in Waverly, Guthrie Clinic Centerway at 130 Centerway in Corning and 31 Arnot Rd. in Horseheads.

Guthrie Healthcare System is an integrated health system located in north central Pennsylvania and Upstate New York, serving patients from an 11-county service area. Guthrie Healthcare System is comprised of a research institute, home care/hospice, hospitals in Sayre, Pa., Corning, N.Y., and Troy, Pa., as well as a multi-specialty group practice of more than 260 physicians and 130 mid-level providers in a regional office network encompassing sub-specialty and primary care sites in 23 communities throughout Pennsylvania and New York. Guthrie Health offers a wide range of services and programs designed to enhance the health and well-being of those it serves. Guthrie Healthcare System is the sole member of Guthrie Home Care. Presented as BFA Attachment D, is the organizational chart of the Guthrie Corporate structure.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Guthrie Home Care submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation

Contingent approval

Program Summary

This proposal seeks to establish a new Certified Home Health Agency (CHHA) to serve the upstate counties of Tioga, Steuben, and Chemung, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary

There are no project costs associated with this application.

Incremental Budget:	Revenues:	$ 951,283
	Expenses:	1,073,196
	Gain(Loss):	$ (121,913)

Subject to the noted contingency, with the financial support commitment of the Guthrie Healthcare System, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

The HSA recommends approval of this application.

Office of Health Systems Management

Approval contingent upon:

1. Submission of an executed building lease(s) that is acceptable to the Department of Health. [BFA]

Approval conditional upon:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

Guthrie Home Care, a not-for-profit corporation, requests approval to establish a Certified Home Health Agency to serve the counties of Chemung, Steuben and Tioga.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;

Knowledge and experience in the provision of home health services;

Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;

Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

Guthrie Healthcare System, based in Sayre, Pennsylvania, is an integrated health system that includes primary care and specialty physicians, community hospitals, a research institute, a hospice as well as a CHHA providing homecare service in northern Pennsylvania. Corning Hospital in Corning, NY has been affiliated with Guthrie Healthcare System since 1999 and in 2004 became a permanent member of the system. Recently, the Guthrie Healthcare System and Guthrie Clinic have formed an affiliation with the St. James Mercy Health System in Hornell, NY.

The applicant described the current availability of CHHA providers in each of the proposed counties and indicates that there is limited patient choice in these counties. The applicant discussed the difficulty the existing providers have had in maintaining staff to provide services and states that they are able to offer recruiting resources that allow full staffing of services so that reliable care can be provided on an ongoing basis, which will ensure access to services.

The applicant states that they have strong working relationships in place with the local Department of Social Services in the proposed service area in addition to strong linkages with community service organizations and healthcare providers. The applicant has also indicated that they use several different types of Health Information Technology that enhance care coordination.

The applicant indicated that they will work closely with other providers and MLTCPs to implement an individualized disease-centered plan of care for each patient. Supported by the use of evidence-based medicine and standards for disease management, they will focus on the core health issues surrounding each patient to provide a unique solution that will enable each patient to maintain/improve health and remain in his/her home.

The applicant indicated they will be able to facilitate Medicaid Redesign by supporting the several MRT initiatives. The applicant specifically discussed each MRT initiative and provided details regarding programs they have or will implement to facilitate the goals of each initiative. The applicant further indicated they are supporting Medicaid redesign by constructing an Accountable Care Organization.

The applicant provided demographic statistical data for each of the proposed counties and provided an explanation of how the demographic data provided demonstrates need They provided statistical data for health-related outcomes and compared the age-adjusted mortality, incidence or hospitalization rates to NYS, and concluded they were worse in the proposed counties. They provided PQI data for each of the proposed counties that they state reflect certain ambulatory care sensitive conditions where early interventional care could possibly prevent inpatient hospitalization. They state they will focus efforts on preventing hospitalizations due to bacterial pneumonia, chronic obstructive pulmonary disease, dehydration and short term complications of diabetes. The applicant states that they will also focus their efforts on reversing the high hospitalization and mortality rates from COPD through targeted health education efforts and COPD management. They will place a strong emphasis on the conditions represented by higher-than-expected PQI statistics as part of their disease management program.

Recommendation

From a need perspective, approval is recommended.

Programmatic Analysis

Background

Guthrie Home Care is an existing not-for-profit corporation requesting approval to become established as a CHHA in New York State, under Article 36 of the Public Health Law, with approval to serve the upstate counties of Tioga, Steuben, and Chemung. Guthrie Home Care currently operates the following, all in the State of Pennsylvania:

- Guthrie Home Care, d/b/a Guthrie Home Health, a certified home health agency,
- Guthrie Home Care, d/b/a Guthrie Private Care, a licensed home care services agency, and
- Guthrie Home Care, d/b/a Guthrie Hospice, a hospice agency.

The sole member corporation of Guthrie Home Care is Guthrie Healthcare System, a not-for-profit corporation.

Guthrie Healthcare System is also the member corporation of:

- Corning Hospital, Inc., which operates a hospital, two outpatient extension clinics, and a clinical laboratory, all in New York State,
- Guthrie Same Day Surgery Center, Inc., operational in New York State, which became an extension clinic of Corning Hospital, Inc., in January, 2013,
- Robert Packer Hospital, which operates a hospital, diagnostic and treatment center, dialysis centers, and the Robert Packer Hospital School of Nursing, all in Pennsylvania,
- Troy Community Hospital, Inc., a critical access inpatient hospital and outpatient treatment center in Pennsylvania,
- Sayre House of Hope, a temporary overnight residence for families of critically ill hospital patients in Pennsylvania,
- Twin Tier Management Corporation Med Supply Depot, a durable medical equipment company in Pennsylvania, and
- Donald Guthrie Foundation, a charitable fundraising entity in Pennsylvania.

The sibling corporation of Guthrie Healthcare System is Guthrie Clinic, Ltd., is a medical practice group of primary care physicians and health care specialists operating in both Pennsylvania and New York State. Pursuant to a 2001 Alignment Agreement entered into by sibling corporations Guthrie Healthcare System and Guthrie Clinic, Ltd., broad parental authority over both corporations has been delegated to Guthrie Health, a not-for-profit corporation. Although Guthrie Health is not the member corporation of either Guthrie Healthcare System or Guthrie Clinic, Ltd., both the 2001 Alignment Agreement and the Guthrie Health Corporate By-Laws state that Guthrie Health shall have the power to control the operational, legal, financial, budgetary, strategic, and procedural powers and functions of Guthrie Clinic, Ltd., Guthrie Healthcare System, and all the health provider entities under the Guthrie Healthcare System.

The entire Guthrie Health organization of health care providers plans to undergo an organizational restructuring beginning on or about July, 2013, whereby sibling corporations Guthrie Healthcare System and Guthrie Clinic, Ltd. will both be dissolved, and all their functions will be merged into the surviving Guthrie Health. Guthrie Health will then be renamed Guthrie Clinic, and by virtue of its acquisition and merger of Guthrie Healthcare System and Guthrie Clinic, Ltd., will become the sole member (parent) corporation of all the individual health care providers in the Guthrie family of providers identified above, including the applicant Guthrie Home Care. The enclosed organizational chart represents the current structure in Figure 1, and the proposed restructure in Figure 2.

The applicant proposes to operate Guthrie Home Care from a main parent office practice location at 31 Arnot Road, Horseheads, New York 14845 (Chemung County), and from two branch office additional practice locations at 29 North Chemung Street, Waverly, New York 14892 (Tioga County), and at 130 Centerway, Corning, New York 14830 (Steuben County). Guthrie Home Care will be leasing office space at all three of those locations from Guthrie Clinic, Ltd., which has current practice locations existing at each of those New York State addresses cited above.

The applicant proposes to provide the following home health care services:

Nursing	Home Health Aide	Medical Social Services
Physical Therapy	Occupational Therapy	Speech Language Pathology

Medical Supplies, Equipment, and Appliances

The Board of Directors of Guthrie Home Care is identified below:

Kenneth Levitzky, Esq. (PA), Chairperson Self-Employed, Kenneth R. Levitzky Law Office Affiliations: Guthrie Health, Guthrie Healthcare System, Troy Community Hospital		Joseph Scopelliti, MD (NY and PA) CEO, Guthrie Health Affiliations: Guthrie Health, Guthrie Healthcare System, Guthrie Clinic, Ltd .
Marie Droege President and COO, Guthrie Health President, Robert Packer Hospital Affiliations: Guthrie Health, Guthrie Healthcare System, Robert Packer Hospital, Corning Hospital, Inc.		Staci Covey, RN (NY and PA) VP Post-Acute Care, Guthrie Health President and Administrator, Troy Community Hospital Administrator, Guthrie Home Care Affiliations: Troy Community Hospital
Richard McIntyre Retired CEO, Martha Lloyd School, Inc. (Services for the Developmentally Disabled)		David Morris Retired Minister, Church of Christ (Religious Organization)
Vance Good, MD (NY and PA) Staff Physician, Guthrie Clinic, Ltd. (Physician Practice Group) Affiliations: Troy Community Hospital		William Miller President and CEO, Martha Lloyd School, Inc. (Services for the Developmentally Disabled)
Bernard Smith VP Finance, Guthrie Healthcare System CFO, Guthrie Home Care		Meade Murtland Station Manager, WATS Broadcasting (Radio Station)
Janet Lewis, Secretary / Treasurer Retired Commissioner, Bradford County (County Government) Affiliations: Troy Community Hospital, Bradford County Manor Nursing Home		Jerry Carr Director of Dining and Nutrition, Kendal at Ithaca Life Care Community (Continuing Care Retirement Community)
Edward Jones, MD (NY and PA) Regional Medical Director, Guthrie Clinic, Ltd. (Physician Practice Group) Affiliations: Guthrie Health, Guthrie Healthcare System, Guthrie Clinic, Ltd.		Richard Robinson Retired Certified Educator (Elementary, Reading, and Special Education Certifications)

The Board of Directors of Guthrie Healthcare System is identified below:

William Ransom III, Chairperson Retired VP Management and Commercial Sales, Henry Dunn, Inc. (Insurance Agency) Affiliations: Guthrie Health		Joseph Scopelliti, MD (NY and PA) Disclosed above
Marie Droege Disclosed above		Kenneth Levitzky, Esq. (PA) Disclosed above
Edward Jones, MD (NY and PA) Disclosed above		Susan Storch Substitute Teacher, Troy Area School District, PA County Auditor, Bradford County, PA Co-Owner / Manager, Storch Family Dairy Farm
Francis Belardi, MD (NY and PA) President and CEO, Guthrie Clinic, Ltd. (Physician Practice Group)		Jay Chadwick Contract President and CEO, Lebanon Valley Insurance Company President and CEO, Tuscarora Wayne Insurance Company
David LaRue Gibbs Retired Affiliations: Robert Packer Hospital, Guthrie Same Day Surgery Center, Inc.		David Iocco, PE (NY) Self Employed Engineering Consultant Affiliations: Corning Hospital, Inc.
Joseph Joyce, Jr. Business Development and Relationship Manager, Valuation Consultant, Murphy McCormack Capital Advisors (Investment Banking/Mergers and Acquisitions) Affiliations: Guthrie Health		Andrew Ripic III Associate VP, General Manager, Cargill, Inc. (Manufacturing)
Philip Roche, Esq. (NY) Partner, Attorney, Yorlo and Roche Law Office Affiliations: Guthrie Health, Corning Hospital		Judith Rowe Sales Engineer, Corning Incorporated (Industrial Manufacturing)
Richard Rynone President and CEO, Rynone Manufacturing Corporation (Manufacturing) Affiliations: Robert Packer Hospital		

The Board of Directors of Guthrie Health is identified below:

Michael Donnelly, Chairperson Corporate VP Business Services, Corning Incorporated (Industrial Manufacturing) Affiliations: Corning Hospital		Terence Devine, MD (NY and PA), Vice Chairperson Chief, Opthalmology Department, Guthrie Clinic, Ltd. (Physician Practice Group)
Edward Jones, MD (NY and PA), Treasurer Disclosed above		William Ransom III, Secretary Disclosed above
Kenneth Levitzky, Esq. (PA) Disclosed above		Joseph Scopelliti, MD (NY and PA) Disclosed above
Joseph Joyce, Jr. Disclosed above		Philip Roche, Esq. (NY) Disclosed above
Ethan Arnold, MPH Managing Director, The Chartis Group (Health Care Consulting)		Kyra Bannister, MD (NY and PA) Anesthesia Associate, Guthrie Clinic, Ltd. Medical Director, Guthrie Same Day Surgery Center, Inc.
Donald Hartman Self Employed Business Consultant Affiliations: St. Joseph's Hospital, Elmira, NY		Douglas Hastings, Esq. (NY and DC) Shareholder, Board Chairman, Epstein Becker Green, PC, Law Offices, Washington, DC
Harold Eugene Lindsey, MD (MA) President and CEO, Atrius Health, Auburndale, MA (Physician Practice Group) President and CEO, Harvard Vanguard Medical Associates, Newton, MA (Physician Practice Group)		David Pfisterer, MD (NY and PA) Family Practice Physician, Guthrie Clinic, Ltd. (Physician Practice Group) Affiliations: Guthrie Clinic, Ltd.
Douglas Trostle, MD (NY and PA) Chairman of Surgery, Guthrie Clinic, Ltd. (Physician Practice Group) Affiliations: Guthrie Clinic, Ltd., Fairgrounds Surgical Center, Allentown, PA		

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 NYS Education Department, NYSDOH Office of Professional Medical Conduct, NYSDOH Physician Profile, NYS Unified Court System, Pennsylvania Supreme Court Disciplinary Board, Pennsylvania Department of State Bureau of Occupational and Professional Affairs, Pennsylvania Department of Education, District of Columbia Court of Appeals, and Massachusetts Board of Registration in Medicine all indicate no issues with the licensure of the health professionals and other licensed professionals associated with this application. In addition, the attorneys have all submitted Certificates of Good Standing.

The NYSDOH Division of Hospitals and Diagnostic and Treatment Centers has reviewed the compliance history of all the affiliated hospitals, extension clinics, diagnostic and treatment centers, and surgical center operating in New York State, and has indicated that have all provided sufficient supervision to prevent harm to the health, safety and welfare of patients and to prevent recurrent code violations. There were no enforcement actions within the previous ten years.

The Pennsylvania Department of Health Division of Home Health reviewed the compliance history of the affiliated certified home health agency, licensed home care services agency, and hospice operating in Pennsylvania, and indicates no adverse compliance findings and/or enforcements actions were cited against the providers.

The Pennsylvania Department of Health Division of Nursing Care Facilities reviewed the compliance history of the affiliated nursing home operating in Pennsylvania for the time period 2003 to 2008, the time period specified as the affiliation.

An enforcement action was taken against Bradford County Manor Nursing Home based on the findings of an April, 2006, survey. Deficiencies leading to enforcement were cited in Quality of Care: Pressure Sores; Quality of Care: Nutrition; and Quality of Care: Hydration. A $12,250 civil monetary penalty was assessed and paid.

It has been determined that the nursing home is in substantial compliance with all applicable codes, rules and regulations.

At this time, neither the Pennsylvania Department of Health Division of Acute and Ambulatory Care, nor the Pennsylvania Department of Health Division of Intermediate Care Facilities, have submitted responses to requests for the compliance history of the affiliated hospitals, diagnostic and treatment centers, dialysis centers, surgical centers, or developmental disabilities service provider operating in Pennsylvania.

A review of the personal qualifying information indicates there is nothing in the background of the board members to adversely effect their positions on the boards. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

From a programmatic perspective, approval is recommended.

Financial Analysis

Lease Agreements

The applicant has submitted proposed lease agreements for each site, the terms of which are summarized below:

Chemung County Site:

Premises:	300 sq. ft. located at 31 Arnot Rd, Horseheads, New York
Landlord:	Guthrie Clinic LTD (Big Flats)
Tenant:	Guthrie Home Care
Rental:	$4,500/year ($15.00/sq. ft.)
Term:	5 years with an additional 5 year renewal option.
Provisions:	The Lessee shall be responsible for insurance, maintenance and utilities.

Tioga Site:

Premises:	300 sq. ft. located at 29 North Chemung Street, Waverly, New York
Landlord:	Guthrie Clinic LTD (Waverly)
Tenant:	Guthrie Home Care
Rental:	$4,500/year ($15.00/sq. ft.)
Term:	5 years with an additional 5 year renewal option.
Provisions:	The Lessee shall be responsible for insurance, maintenance and utilities.

Steuben Site:

Premises:	300 sq. ft. located at 130 Centerway, Corning, New York
Landlord:	Guthrie Clinic LTD (Corning)
Tenant:	Guthrie Home Care
Rental:	$4,500/year ($15.00/sq. ft.)
Term:	5 years with an additional 5 year renewal option.
Provisions:	The Lessee shall be responsible for insurance, maintenance and utilities.

The lease arrangement is a non-arm's length agreement, and the applicant has submitted letters from licensed real estate brokers attesting to the reasonableness of the per square foot rental.

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Revenues:		
Medicaid Managed Care	$ 40,372	43,681
Medicare Fee-for-Service	550,815	595,962
Medicare Managed Care	42,426	45,925
Commercial Fee-for-Service	219,549	249,873
Private Pay	13,281	15,842
Total Revenues	$866,443	$951,283
Expenses	$944,664	$1,073,196
Net Gain(Loss)	$(78,221)	$(121,913)

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

Payor	**Year One and Year Three**
Medicaid Managed Care	10.0%
Medicare Fee-for-Service	58.0%
Medicare Managed Care	5.0%
Commercial Fee-for-Service	24.0%
Private Pay	1.0%
Charity Care	2.0%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates as well as the Medicaid Episodic Payment system.

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at $158,547, appear reasonable based on two months of third year expenses and will be provided through the existing Guthrie Healthcare System, which has stated that $1,000,000 of investment funds will be provided for start-up costs.

Presented as BFA Attachment C, is the pro-forma balance sheet, which shows net

The submitted budget indicates that the applicant will experience a net loss of $78,221 and $121,913 in the first and third years of operations, respectively. The operating losses would be incurred while Guthrie Healthcare System is developing the Home Health program in New York State and anticipates the loses to turn positive over time as they expand and build a larger market base. The losses would be supported by the equity of the Guthrie Healthcare System (attachment B), which includes current home healthcare services, Guthrie Home Care. As shown on BFA Attachment A, Guthrie Home Care has positive net assets of $5,366,797 with an investments portfolio of $5,519,972. These funds would be available to support the New York operations through equity transfers until such time when the New York operations could stand on their own. Revenue is based on current payment rates for Certified Home Health Agencies. The submitted budget appears reasonable.

Presented as BFA Attachment A is the audited 2012 financial summary of Guthrie Home Care Services, which shows the applicant has experienced negative working capital, maintained positive net equity and a net profit of $576,335 from operations. The negative working capital was due to the result of a significant change in bad debt reserves brought on by the turnover in the billing and collection staffing, along with upgrades to their 3-M billing system. Subsequently they have trained the new staff on the system through the use of a 3-M consultant, along with adding staff to help support this process. They have also engaged a consultant, McBee Associates, Inc., to review the overall office operation and collection process to help reallocate resources and streamline the process. The result has been to reduce the bad debt reserve by approximately 45% as of December 31, 2012.

Presented as BFA Attachment B is the financial summary of Guthrie Healthcare System, which shows the applicant has maintained positive working capital, net equity and a net profit of $3,268,289 from operations for 2012.

Based on preceding and subject to noted contingency, it appears that the applicant has demonstrated the financial 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	Financial Summary for Guthrie Home Care, June 30, 2012
BFA Attachment B	Financial Summary for Guthrie Healthcare System, June 30, 2012
BFA Attachment C	Pro-forma Balance Sheet
BFA Attachment D	Organizational Chart- Guthrie Health Corporate Structure
DHFP Attachment	Figure 1, Figure 2

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 6th day of June, 2013, 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 a certified home health agency to serve Tioga, Steuben and Chemung 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
121266 E	Guthrie Home Care

APPROVAL CONTINGENT UPON:

1. Submission of an executed building lease(s) that is acceptable to the Department of Health. [BFA]

APPROVAL CONDITIONED UPON:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Public Health and Health Planning Council

Project # 121233-E
United Hebrew of New Rochelle Certified Home Health Agency, Inc.

County: **Westchester County (New Rochelle)** ***Program:*** **Certified Home Health Agency**
Purpose: **Establishment** ***Submitted:*** **April 17, 2012**

Executive Summary

Description
United Hebrew of New Rochelle Certified Home Health Agency, Inc., an existing not-for-profit corporation, is requesting to establish a Certified Home Health Agency (CHHA) to serve Westchester County with short-term health care and support services in the home. The new program will assist in the transition of dual eligibles to managed long-term care programs.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. United Hebrew of New Rochelle Certified Home Health Agency, Inc. submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation
Contingent approval

Program Summary
This proposal seeks approval to establish a new certified home health agency, United Hebrew of New Rochelle Certified Home Health Agency, Inc., pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary
There are no project costs associated with this application.

Incremental Budget:	Revenues:	$13,155,616
	Expenses:	12,594,808
	Gain(Loss):	$ 560,808

Subject to noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

Approval contingent upon:

1. Submission of an executed building lease that is acceptable to the Department of Health. [BFA]
2. Submission of an executed proposed Certificate of Incorporation of United Hebrew of New Rochelle Certified Home Health Agency, Inc., acceptable to the Department. [CSL]

Approval conditional upon:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Council Action Date

June 6, 2013.

Need Analysis

Background

United Hebrew of New Rochelle Certified Home Health Agency, Inc., a not-for-profit corporation, is requesting approval to establish a certified home health agency to serve Westchester County.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17th and 27th were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17th and 27th letters. The applications were reviewed on criteria that included, but were not limited to:

Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;

Knowledge and experience in the provision of home health services;

Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;

Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;

Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.
United Hebrew of New Rochelle Certified Home Health Agency, Inc. is proposing to establish a certified home health agency to serve Westchester County.

The parent corporation of the applicant is United Hebrew Geriatric Center, which operates a 294 bed residential health care facility and a Long Term Home Health Care Program (LTHHCP). A licensed home care agency and an assisted living program are operated by a related entity. The parent also has an established relationship with Elderplan MLTCP and has begun transitioning qualified LTHHCP patients into Elderplan MLTCP.

The applicant listed community hospitals that they have existing relationships with and who will be a key source of their referrals, including the number of referrals expected from each. They also described the referrals that will come from within the United Hebrew System. The LHCSA that is operated by a related entity has contractual relationships with Centerlight and VNS Choice to provide home health aide services.

The applicant has developed working relationships with Sound Shore Medical Center, White Plains Hospital Center, and Lawrence Hospital. They were awarded a HEAL 20 grant to expand their senior housing offering additional Special Needs Assisted Living Residence and independent living to their campus. Additionally, United Hebrew LTHHCP has the experience in provision of care management under a cost capped basis.

The applicant provided statistics on the dual eligible population and described the population characteristics of Westchester County. They discussed meeting the needs of the medically underserved population and identified specific medically underserved communities in the county. Additionally they elaborated on community outreach and education efforts.

The applicant projected an increase in the future CHHA visit need based on current CHHA utilization patterns, statistics on the dually eligible population and population growth estimates. The application provided population demographics and discussed specifics on discharges and how those discharge statistics translated into need. In addition, the applicant described the internal demand for CHHA services within its organization. The applicant estimated that their programs will have approximately 500 patients annually who will be in need of CHHA services.

The applicant provided statistics on preventable hospital readmissions and discussed their care management protocols to minimize hospital readmissions. They name their working relationships with Sound Shore Medical Center, White Plains Hospital Center and Lawrence Hospital to continue their collaboration to provide care management for their patients in the CHHA and assist transition into MLTCPs, as appropriate. They discuss their growing telehealth program to augment their robust care management program for those with diabetes, congestive heart failure, and COPD with monitoring of patients at home through technology, increasing the quality of care and reducing the cost of delivery.

They have demonstrated innovation to reach high standards of care while providing cost effective and efficient care supporting the MRT initiatives. This is demonstrated by their institution of a Comprehensive RN Case Management Model to decrease the volume of visits for RN and other skilled disciplines. Additionally, they have introduced the Telehealth Electronic Patient Monitoring Program to monitor patients with chronic health diseases to decrease re-hospitalization; and they have decreased the length of stay in the United Hebrew's Short Stay Rehab Unit via Transitioning/Diversion Program, and to MLTCPs.

Recommendation
From a need perspective, approval is recommended.

Programmatic Analysis

Background

United Hebrew of New Rochelle Certified Home Health Agency, Inc., a not for profit corporation, is seeking approval to establish a new certified home health agency (CHHA) to serve Westchester County. This CHHA proposes to establish no branch offices and will serve Westchester County from an office located at 40 Willow Drive, New Rochelle, New York 10805. The parent of United Hebrew of New Rochelle Certified Home Health Agency, Inc. is United Hebrew Geriatric Center.

The members of the Board of Directors of United Hebrew of New Rochelle Certified Home Health Agency, Inc. comprise the following individuals:

Michael R. Rozen, Chairperson
Retired
Affiliation: United Hebrew Geriatric Center

Malcolm H. Lazarus, Esq., Vice Chairperson
Chairman, Polished Metals Ltd., Inc.
Affiliation: United Hebrew Geriatric Center

Rita C. Mabli, NHA, Director
President/CEO, United Hebrew Geriatric Center

The members of the Board of Directors of United Hebrew Geriatric Center comprise the following individuals:

Michael R. Rozen, Chairperson
(disclosed above)

Malcolm H. Lazarus, Senior Chairperson
(disclosed above)

Donald Duberstein, Chairperson Elect
President, The Duberstein Organization, Ltd. (investments)

Harrin K. Platzner, Vice Chairperson
COO, Platzner International Group (real estate)

Peter A. Tomback, Esq., Vice Chair
Retired

Mark A. Hartman, Esq., Secretary
Senior Counsel, NYC Health & Hospitals Corporation
Affiliation: Willow Towers

Pearl A. Quarles, Treasurer
Retired

David A. Alpert, Director
Manager Community Development, Riverside Memorial Chapel

Robert H. Baker, M.D., Director
Self-employed physician

Fr. Martin J. Biglin, Director
Pastor, Holy Name of Jesus Church

Jeffrey I. Citron, Esq., Director
Managing Partner, Davidoff, Hutchen & Citron

Frank Corvino, R.Ph., Director
President/CEO, Yale New Haven Health
Affiliations: Yale New Haven Health (CT)
Greenwich Hospital (CT)

Bruce Frank, CPA, Director
Partner, Ernst & Young, LLP

Albert Lefkowitz, Director
President, Joe-Anne Company International (mfg.)

Rosemary G. McLaughlin, Director
SVP, Signature Bank

Rita C. Mabli, NHA, Director
(disclosed above)

Arnold Miller, Director
Retired

Anthony J. Nardozzi, Director
Owner, New York Connecticut (real estate)

Gregg Seidner, Director
COO, Bronx Park Rehabilitation
and Nursing Center
Affiliation: Agewell NY (MLTCP),
Match One Staffing,
CV Staffing, (MA)
HRL Associates
(Recruitment)

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, indicate no issues with the license of the medical professional associated with this application.

A Certificate of Good Standing has been received for the attorneys.

The Bureau of Professional Credentialing has indicated that Rita C. Mabli, NHA license #03628, holds a NHA license in good standing and the Board of Examiners of Nursing Home Administrators has never taken disciplinary action against this individual or her license.

United Hebrew of New Rochelle Certified Home Health Agency, Inc. proposes to provide the following home health care services: audiology, home health aide, medical social services, medical supply, equipment and appliances, nursing, nutritional, occupational therapy, personal care, physical therapy, respiratory therapy and speech language pathology.

A review of the following agencies/facilities was performed as part of this review:

United Hebrew Geriatric Center
Willow Towers Assisted Living Residence
AZOR Home Care, Inc.
United Hebrew Geriatric Center Long Term Home Health Care Program
Yale New Haven Health (CT)
Greenwich Hospital (CT)
Agewell NY (MLTCP)
Match One Staffing
HRL Associates (recruitment)

The information provided by the Bureau of Quality Assurance and Surveillance for Nursing Homes has indicated that the nursing home reviewed 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 assisted living residence reviewed 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 home health care agencies reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of patients and to prevent recurrent code violations.

The information provided by the Bureau of Managed Care Certification and Surveillance has indicated that the MLTCP reviewed has provided sufficient supervision to prevent harm to the health, safety and welfare of the insured and to prevent recurrent code violations.

The information provided by the New York City Consumer Affairs has indicated that the staffing agencies reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of employees and to prevent recurrent code violations.

Requests have been sent to the State of Connecticut for a report on the compliance histories of the health care facilities operated for the time period specified as the affiliation. At this time, the New York State Department of Health has not received a response.

Recommendation

From a programmatic perspective, conditional approval is recommended.

Financial Analysis

Lease Agreements

The applicant has submitted a draft lease agreement, the terms of which are summarized below:

Premises:	3,300 gross square feet located on the first floor at 40 Willow Dr., New Rochelle, New York
Sub landlord:	Soundview Apartments Low Savin Residence
Subtenant:	United Hebrew Long Term Home Health Care Program
Rental:	$2,667 per month ($9.70/sq. ft.)
Term:	Five years.
Provisions:	The Lessee shall be responsible for insurance.

The lease arrangement is a non-arm's length agreement. United Hebrew Long Term Home Health Care Program has submitted letters from real estate brokers attesting to the reasonableness of the rent.

Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	Year One	**Year Three**
Revenues:		
Medicaid Managed Care	$2,755,397	$9,335,086
Medicare Fee-for-Service	926,454	3,396,330
Medicare Managed Care	98,725	357,480
Other	18,690	66,720
Total Revenues	$3,799,266	$13,155,616
Expenses	3,841,527	12,594,808
Net Gain(Loss)	$(42,261)	$560,808

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

Payor	**Year One**	**Year Three**
Medicaid Managed Care	44.4%	44.5%
Medicare Fee-for-Service	44.6%	44.3%
Medicare Managed Care	7.1%	7.3%
Other	1.4%	1.4%
Charity Care	2.5%	2.5%

Expense and utilization assumptions are based on the existing LTHHCP Program's historical experience. Revenues are reflective of current payment rates as well as the Medicaid Episodic Payment system.

Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at $2,192,603, appear reasonable based on two months of third year expenses and will be provided through the existing operations of United Hebrew Geriatric Center. Presented as BFA Attachment B is the financial summary of United Hebrew Geriatric Center showing sufficient funds.

The submitted budget indicates that the applicant will achieve a net loss of $42,216 and a net gain of $560,808 incremental net revenue in the first and third years of operations, respectively. Revenue is based on current payment rates for Certified Home Health Agencies. The submitted budget appears reasonable.

Presented as BFA Attachment B is the audited 2011 and draft 2012 financial summary of United Hebrew Geriatric Center, which shows the applicant has maintained positive working capital, net equity and experienced a net loss from operations of $1,694,494 and $1,713,173, respectively. The applicant indicates that the operational losses are due to the 2011 Medicare cuts amounting to $800,000 and the change in Medicaid rates under appeal due to the increase in bed capacity between the Skalet Pavilion and Gitner Pavilion.

Based on proceeding, it appears that the applicant has demonstrated the financial capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

From a financial perspective, contingent approval is recommended.

Attachments

BFA Attachment A	Organizational Chart for United Hebrew
BFA Attachment B	Financial Summary for United Hebrew Geriatric Center, 2011 audited and 2012 draft

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 6th day of June, 2013, 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 a certified home health agency to serve Westchester County, 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
121233 E	United Hebrew of New Rochelle Certified Home Health Agency, Inc.

APPROVAL CONTINGENT UPON:

1. Submission of an executed building lease that is acceptable to the Department of Health. [BFA]
2. Submission of an executed proposed Certificate of Incorporation of United Hebrew of New Rochelle Certified Home Health Agency, Inc., acceptable to the Department. [CSL]

APPROVAL CONDITIONED UPON:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	GTD Services, Inc. d/b/a BrightStar of North Shore Nassau County
Address:	Woodbury
County:	Nassau
Structure:	For-Profit Corporation
Application Number:	2077-L

Description of Project:

GTD Services, Inc., d/b/a BrightStar of North Shore Nassau County, a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law. GTD Services, Inc. d/b/a BrightStar of North Shore Nassau County is an existing companion care agency and a franchise.

The applicant has authorized 200,000 shares of stock which are owned as follows:

Donald W. Nickel, 62,500 shares Owner, BrightStar of North Shore Nassau County	Maureen B. Nickel, 62,500 shares Owner, BrightStar of North Shore Nassau County

The remaining 75,000 shares of stock are unissued.

The Board of Directors of GTD Services, Inc. d/b/a BrightStar of North Shore Nassau County comprises the following individuals:

Donald W. Nickel, President (disclosed above)	Maureen B. Nickel, Vice President, Secretary (disclosed above)

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 136 Woodbury Road, Suite 203, Woodbury, New York 11797:

Nassau	Suffolk

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	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: May 9, 2013

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Sunrise Home Care, Inc.
Address:	Brewster
County:	Putnam
Structure:	For-Profit Corporation
Application Number:	1788-L

Description of Project:

Sunrise 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 solely by Elsa Silva.

The Board of Directors of Sunrise Home Care, Inc. comprises the following individuals:

Elsa Silva, Chairperson, Treasurer	David Silva, Vice Chairperson, Secretary
Self-employed Home Health Aide	US Postal Service, Postal Carrier

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 15 Cooledge Drive, Brewster, New York 10509:

Putnam	Westchester	Dutchess

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: April 30, 2013

Division of Home & Community Based Services
Character and Competence Staff Review

Name of Agency:	Wyoming County Health Department
Address:	Silver Springs
County:	Wyoming
Structure:	Public
Application Number:	2263L

Description of Project:

Wyoming County Health Department requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The county currently operates a certified home health agency (CHHA) which they have authorized an Asset Purchase Agreement to sell the CHHA. Wyoming County Health Department is requesting approval to open a licensed home care services agency to enable the county to continue to provide essential public health nursing services.

The applicant proposes to serve the residents of Wyoming County from an office located at 5362 Mungers Mill Road, Silver Springs, New York 14550.

The applicant proposes to provide Nursing and Nutritional services.

Wyoming County Health Department currently operates a Hospital, Diagnostic and Treatment Center, Residential Health Care Facility and Certified Home Health Agency.

The information provided by the Division of Certification and Surveillance indicated that the Hospital and Diagnostic and Treatment Center has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Wyoming County Community Hospital SNF was fined ten thousand dollars ($10,000) in ten monthly installments of one thousand dollars ($1,000) each pursuant to a stipulation and order dated May 24, 2011 for surveillance findings of March 19, 2009. Deficiencies were found under 10 NYCRR 415.12(h)(2) Quality of Care: Accidents.

Wyoming County Community Hospital SNF was fined two thousand dollars ($2,000) pursuant to a stipulation and order dated October 15, 2008 for surveillance findings of February 27, 2008. Deficiencies were found under 10 NYCRR 415.12(c)(1)(2) Quality of Care: Pressure Sores.

Wyoming County Community Hospital SNF was fined two thousand dollars ($2,000) pursuant to a stipulation and order dated February 11, 2008 for surveillance findings of February 1, 2007. Deficiencies were found under 10 NYCRR 415.12(h)(1) Quality of Care: Accidents.

The Information provided by the Bureau of Quality Assurance for Nursing Homes has indicated that the residential health 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 indicated that the Certified Home Health Agency has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Recommendation: Approval
Date: April 29, 2013

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 6th day of June, 2013, 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:
2077L	GTD Services, Inc. dba BrightStar of North Shore Nassau County (Nassau and Suffolk Counties)
2080L	Nix JT Corporation d/b comfort Keepers #685 (Tompkins, Cortland, and Schuyler Counties)
1788L	Sunrise Home Care, Inc. (Putnam, Westchester and Dutchess Counties)
2243L	Washington County Public Health Nursing Service (Washington County)
2263L	Wyoming County Health Department (Wyoming County)

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

June 6, 2013

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 4: Applications Recommended for Approval with the Following:

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

Residential Health Care Facility – Establish/Construct **Exhibit #26**

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	122312 E	VDRNC, LLC s/b/a Van Duyn Center for Rehabilitation and Nursing (Onondaga County) Mr. Booth – Interest Mr. Fensterman – Abstained at EPRC	Contingent Approval

Public Health and Health Planning Council

Project # 122312-E
VDRNC, LLC d/b/a Van Duyn Center for Rehabilitation and Nursing

County: **Onondaga County (Syracuse)**
Program: **Residential Health Care Facility**
Purpose: **Establishment**
Submitted: **December 27, 2012**

Executive Summary

Description
VDRNC, LLC, doing business as Van Duyn Center for Rehabilitation and Nursing, requests approval to be established as the operator of Van Duyn Home and Hospital, a 513-bed county owned residential healthcare facility located at 5075 West Seneca Turnpike, Syracuse, New York.

The County of Onondaga entered into an Operational Asset Purchase Agreement on December 21, 2012, with VDRNC, LLC for the sale and acquisition, respectively, of the operating interests of Van Duyn Home and Hospital, which will be discussed in a subsequent section. Concurrent with entering into the Operational Asset Purchase Agreement, the County of Onondaga entered into a Facility Acquisition Agreement with the County of Onondaga Civic Development Corporation (OCDC) to transfer the real property interests of the Van Duyn Home and Hospital to the OCDC, in anticipation of OCDC entering into a Facility Sale Agreement with 5075 West Seneca, LLC for the sale and acquisition of the real property interest of Van Duyn Home and Hospital. The ownership of the real estate entity is Efraim Steif 50% and Uri Koenig 50%. These agreements will be discussed in subsequent sections.

The proposed members of VDRNC, LLC with ownership percentages are as follows:

Uri Koenig	60.00%
Efraim Steif	39.90%
David Camerota	00.10%

Presented as BFA Attachment D through E are the financial summaries of Bridgewater Center for Rehabilitation & Nursing and Pine Valley Center, in which the proposed members of VDRNC, LLC have ownership interests. Also, the proposed members have recently acquired ownership interests in other residential healthcare facilities but financial data is not available.

DOH Recommendation
Contingent approval

Need Summary
Van Duyn Home and Hospital is operating at 94 percent occupancy, which equates to 483 beds. This is slightly lower than the utilization rate for Onondaga County as a whole, which is 94.6%. This project will not involve a change in beds or services.

Program Summary
No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

Financial Summary
The purchase price for the acquisition of the operating interests of Van Duyn Home and Hospital is $50,000, which will be paid in cash.

The purchase price for the real property interest of the facility is $4,950,000, of which a $50,000 deposit has been paid in escrow to the Seller, and 5075 West Seneca, LLC will pay the balance of the purchase price ($4,900,000) to OCDC over a 60 month period.

Budget:

Revenues	$44,808,547
Expenses	44,268,632
Net Income	$539,915

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.

Recommendations

Health Systems Agency

The HSA has no comment on the recommendation of this application

Office of Health Systems Management

Approval contingent upon:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]

2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
   - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
   - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
   - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
   - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
     - Information on activities relating to a-c above; and
     - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
     - Other factors as determined by the applicant to be pertinent.

   The DOH reserves the right to require continued reporting beyond the two year period. [RNR]

Council Action Date

June 6, 2013.

Need Analysis

Background

VDRNC, LLC, doing business as Van Duyn Center for Rehabilitation and Nursing, is seeking to be established as the operator of Van Duyn Home and Hospital, a 513 bed residential health care facility located at 5075 West Seneca Turnpike, Syracuse 13215, in Onondaga County.

Analysis

Van Duyn Home and Hospital's utilization rate was higher than that for Onondaga County as a whole for 2009, but was lower in 2010, and 2011 as shown in Table 1 below:

Table 1: Van Duyn Home and Hospital /Onondaga County Occupancy Rates

Facility/County	*2009*	*2010*	*2011*
Van Duyn Home and Hospital	96.2%	95.3%	94.0%
Onondaga County	96.0%	96.2%	94.6%

There is currently an excess of 600 beds in Onondaga County.

Table 2: RHCF Need – Onondaga County

2016 Projected Need	2,416
Current Beds	2,986
Beds Under Construction	30
Total Resources	2,986
Unmet Need	-600

Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department.
An applicant will be required to make appropriate adjustments in its admission polices and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage of health Systems Agency percentage, whichever is applicable.

Van Duyn Home and Hospital was above the 75 percent planning average for both 2009 and 2010. The facility reported Medicaid admissions of 10.7 percent and 21.07 percent in 2009 and 2010, respectively. The 75 percent planning averages for Onondaga County for these years were 5.23 percent (2009) and 7.54 percent (2010).

Conclusion

Approval of this application is expected to improve the financial stability and quality of care at this facility, which is a necessary community resource, as indicated by its high percentage of Medicaid admissions.

Recommendation

From a need perspective, contingent approval is recommended.

Programmatic Analysis

Facility Information

	Existing	**Proposed**
Facility Name	Van Duyn Home and Hospital	Van Duyn Center for Rehabilitation and Nursing
Address	5075 West Seneca Turnpike Syracuse, NY 13215	Same
RHCF Capacity	513	Same
ADHC Program Capacity	N/A	Same
Type of Operator	County	Limited Liability Company
Class of Operator	Public	Proprietary
Operator	County of Onondaga	Van Duyn Center for Rehabilitation and Nursing Members: Uri Koenig 60.00% Efraim Steif 39.90% David Camerota 0.10%

Character and Competence - Background

Facilities Reviewed

Nursing Homes

Bridgewater Center for Rehabilitation & Nursing, LLC	02/2005 to present
Capstone Center for Rehabilitation and Nursing	03/2012 to present
Central Park Rehabilitation and Nursing Center	11/2008 to present
Chestnut Park Rehabilitation and Nursing Center	06/2011 to present
Colonial Park Rehabilitation and Nursing Center	06/2011 to present
Cortland Park Rehabilitation and Nursing Center	06/2011 to present
Highland Park Rehabilitation and Nursing Center	06/2011 to present
Hudson Park Rehabilitation and Nursing Center	06/2011 to present
Pine Valley Center for Rehabilitation and Nursing	12/2004 to present
Riverside Center for Rehabilitation and Nursing	03/2012 to present
Vestal Park Rehabilitation and Nursing Center	06/2011 to present
Westchester Center for Rehabilitation and Nursing	05/2003 to 12/2006

Adult Care Facilities

Riverside Manor Adult Care (closed)___	09/2009 to 07/2010

Individual Background Review

Uri Koenig is a CPA in good standing and owner of JK Koenig & Co., an accounting firm located in Spring Valley, NY. Mr. Koenig discloses the following health facility interests.

Bridgewater Center for Rehabilitation & Nursing	08/2006 to present
Pine Valley Center for Rehabilitation and Nursing	01/2008 to present
Central Park Rehabilitation and Nursing Center	03/2012 to present

Receiverships

Highland Park Rehabilitation and Nursing Center	06/2011 to present
Hudson Park Rehabilitation and Nursing Center	06/2011 to present
Vestal Park Rehabilitation and Nursing Center	06/2011 to present
Chestnut Park Rehabilitation and Nursing Center	06/2011 to present
Cortland Park Rehabilitation and Nursing Center	06/2011 to present
Colonial Park Rehabilitation and Nursing Center	06/2011 to present
Riverside Center for Rehabilitation and Nursing	03/2012 to present
Capstone Center for Rehabilitation and Nursing	03/2012 to present

Efraim Steif is a licensed nursing home administrator in good standing in the States of New York and New Jersey. Mr. Steif is the President of FRS Healthcare Consultants, Inc., and formerly served as Administrator of Record at Forest View Center for Rehab and Nursing in Forest Hills from 2000 to 2005. Mr. Steif discloses the following health care facilities interests.

Bridgewater Center for Rehabilitation & Nursing, LLC	02/2005 to present
Pine Valley Center for Rehabilitation and Nursing	12/2004 to present
Central Park Rehabilitation and Nursing Center	11/2008 to present
Riverside Manor Adult Care (closed)	09/2009 to 07/2010

Receiverships

Westchester Center for Rehabilitation and Nursing	01/2003 to 12/2006
Chestnut Park Center for Rehabilitation and Nursing	06/2011 to present
Cortland Park Center for Rehabilitation and Nursing	06/2011 to present
Colonial Park Center for Rehabilitation and Nursing	06/2011 to present
Highland Park Center for Rehabilitation and Nursing	06/2011 to present
Hudson Park Center for Rehabilitation and Nursing	06/2011 to present
Vestal Park Center for Rehabilitation and Nursing	06/2011 to present
Riverside Center for Rehabilitation and Nursing	03/2012 to present
Capstone Center for Rehabilitation and Nursing	03/2012 to present

David Camerota is a licensed nursing home administrator in good standing currently employed as Administrator of Record at Central Park Rehabilitation and Nursing Center. Mr. Camerota has served nearly continuously as administrator for the past eleven years, including service at Heritage Health Care Center in Utica, Sunnyside Care Center in Syracuse and Valley View Manor Nursing Home in Norwich. Mr. Camerota has disclosed the following nursing home ownership interests.

Pine Valley Center for Rehabilitation and Nursing	06/2011 to present
Central Park Rehabilitation and Nursing Center	02/2012 to present

Character and Competence - Analysis

No negative information has been received concerning the character and competence of the above applicants.

A review of Central Park Rehabilitation and Nursing Center for the period identified above reveals that the facility was fined $2,000 pursuant to a Stipulation and Order NH-10-064 issued December 6, 2010 for surveillance findings on May 26, 2009. Deficiencies were found under 10 NYCRR 415.19(a) Quality of Care: Infection Control.

A review of operations for Central Park Rehabilitation and Nursing Center for the period identified above results in a conclusion of substantially consistent high level of care, since there were no repeat enforcements.

A review of operations for the Bridgewater Center for Rehabilitation and Nursing, LLC, Capstone Center for Rehabilitation and Nursing, Chestnut Park Rehabilitation and Nursing Center, Colonial Park Rehabilitation and Nursing Center, Cortland Park Rehabilitation and Nursing Center, Highland Park Rehabilitation and Nursing Center, Hudson Park Rehabilitation and Nursing Center, Pine Valley Center

for Rehabilitation and Nursing, Riverside Center for Rehabilitation and Nursing, Vestal Park Rehabilitation and Nursing Center, and Westchester Center for Rehabilitation and Nursing, and Riverside Manor Adult Care for the periods identified above results in a conclusion of substantially consistent high level of care since there were no enforcements.

Project Review

No changes in the program or physical environment are proposed in this application.

Conclusion

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

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:	December 21, 2012
Seller:	Onondaga County
Purchaser:	VDRNC, LLC
Assets Acquired:	All licenses, certificates and permits held or owned by Seller relating to the ownership or operation of the Facility and the Assets; inventory, and supplies subject to depletions, replacements or additions there to in the ordinary course of business of the Facility; copies of the financials and other books, records, information and title documents necessary for the Buyer to operate the Facility on and after the Closing Date; books, records, medical charts and information pertaining to the residents; any payments made by Payors for goods and services rendered on and after the Closing; books, records, and information pertaining to the Facility's Service Providers; copies of all financial, accounting and operating data and records; Seller's Medicare and Medicaid provider numbers and provider agreements; all resident funds held in trust for the residents; and all retroactive rate increases; cash on hand and accounts receivable.
Excluded Assets:	Leased or licensed property; Seller's right to use the name "Van Duyn Home and Hospital"; the Seller's rights, title and interests in the insurance policies covering the Seller; the Seller's rights, title and interest in claims against third parties, not related to payment for services rendered by the Seller or any person to the residents of the Facility; the Seller's rights, title and interest in and to any rebates, refunds, settlements from class actions or other legal proceedings due to the Seller; all payments or cash equivalent credits relating to the Facility resulting from claims, insurance premium rate reductions or insurance or other dividends paid or accruing for periods prior to the Closing Date; all insurance policies not transferred to Buyer; all rights and interests of Seller under and pursuant to this Agreement and any documents executed in connection with the Closing; all employee benefit plans and all assets being transferred or sole pursuant to the term of the Facility Sale Agreement.
Assumed Liabilities:	The purchase will not assume any liabilities.
Excluded Liabilities:	All accounts and loans payable; any other liabilities or obligations related

	to the Assets, the ownership or operation of the Facility; arising from or relating to any period prior to the Closing Date, other than the Assumed Liabilities; any and all liabilities arising from employment by Seller prior to the Closing Date, including COBRA claims, relating to the termination of employment of any Employee employed prior to the Closing Date; any contracts of the Seller; any gain on sale and any recapture that may be recognized under the Medicare or the New York Medicaid program and any other third party payor programs; the liabilities of Seller relating to the retention of professionals with respect to the transaction; except with respect to those Accounts Receivable being transferred or paid to Buyers, any reimbursement overpayment liabilities and obligations of Seller to Medicaid or Medicare arising out of or related to payment for services rendered prior to the Closing Date; all liabilities or claims relating to Intergovernmental Transfers and all liabilities or claims pertaining to Seller's of OCDC's demolition, disposal and remediation of the Structure.
Purchase Price:	$50,000
Payment of Purchase Price:	A deposit of $50,000 to be held in escrow. The Deposit shall be released to Seller at Closing. The balance will be paid over a 60 month period.

The applicant has submitted an affidavit from the applicant, 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, the facility has no outstanding liabilities.

Real Estate Purchase Agreement

The applicant has submitted an executed real estate purchase agreement, which is summarized below:

Date:	December 21, 2012
Seller:	Onondaga Civic Development Corporation
Purchaser:	5075 West Seneca LLC
Purchase Price:	$4,950,000
Payment of Purchase Price:	Deposit of $50,000 Balance of $4,900,000 due at Closing

The purchaser, 5075 West Seneca LLC, will pay the balance of the purchase price ($4,900,000) to OCDC over a 60 month period with 60 equal monthly installments.

Lease Rental Agreement

The applicant has submitted a draft lease rental agreement for the site that they will occupy; which is summarized below:

Premises:	The nursing home located at 5075 West Seneca Turnpike
Landlord:	5075 West Seneca, LLC
Tenant:	VDRNC,LLC
Rental:	The net rent shall be equal to the greater of all debt service (interest and principal) arising out of any mortgage or financing used to purchase or refinance and debt related to the real property and the furniture, fixtures and equipment that exist on the Commencement Date plus any out of pocket administrative costs or five hundred thousand dollars. The estimated lease rental payments are $980,000 from years 1 through 5 and $500,000 from years 6 through 10.
Provisions:	The tenant shall be responsible for maintenance, utilities and real estate taxes.

Operating Budget

The applicant has submitted an operating budget, in 2012 dollars, for the first year subsequent to the change in operator; which is summarized below:

	Per Diem	*Total*
Revenues:		
Medicaid Fee-for-Service	$229.35	$31,914,135
Medicaid Managed Care	$229.35	172,700
Medicare Managed Care Fee-for-Service	$438.37	4,861,959
Private Pay	$314.30	7,859,753
Total Revenues		$44,808,547
Expenses:		
Operating	$244.11	$42,963,476
Capital	7.42	1,305,156
Total Expenses	$251.53	44,268,632
Net Income		$539,915
Utilization: (patient days)		176,000
Occupancy		93.99%

Utilization itemized by payor source during the first year subsequent to the change in operator is as follows:

Medicaid Fee-for-Service	79.06%
Medicaid Managed Care	0.42%
Medicare Fee-for-Service	6.30%
Private Pay	14.22%

Utilization assumptions are based on the historical experience of the nursing home.

Capability and Feasibility

The purchase price for the acquisition of the operating interests is $50,000, which will be paid in cash. The purchase price for the real property interest of the facility is $4,950,000, of which a $50,000 deposit has been paid in escrow to the Seller and the remainder, $4,900,000, will be paid to OCDC over a 60 month period. Presented as BFA Attachment A are the personal net worth statements of the proposed members of VDRNC, LLC, which indicates the availability of sufficient funds for the equity contribution.

Working capital requirements are estimated at $7,378,105, which is equivalent to two months of first year expenses.
The applicant will be acquiring the accounts receivable and working capital cash as part of the assets acquired from Van Duyn Home and Hospital. These acquired assets are in excess of the needed working capital requirement. Presented as BFA Attachment C, is the pro-forma balance sheet of VDRNC, LLC as of the first day of operation, which indicates a positive net asset position of $8,192,186 as of the first day of operation. Presented as BFA Attachment F, is the pr- forma balance sheet for the real estate entity, which indicates a positive net asset position of $50,000.

The submitted budget indicates a net income of $539,915 during the first year subsequent to the change in operator. The applicant reduced revenues from the current year (2011) to the first year after the change in operator due to the 2011 rate consisted of prior period adjustments that inflate the revenue for 2011. Staff notes that with the expected 2014 implementation of managed care for nursing home residents. Medicaid reimbursement is expected to change from a state-wide price with a cost based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

The applicant projected changes in the following expense and revenue assumptions:

The reduction in administrative and general expenses is the county allocation of overhead to the nursing home. It goes away with the new operator, as it represents $11,051,591 of allocated county expenses compared to a budget of $4,593,257. (From applicant) Comparable administrative and general expenses at facilities larger than Van Duyn were at $4,300,000 so there is no rational reason for the $11,000,000 county allocation.

*Fringe benefits are being reduced by $5,300,000. The fringe benefit reduced from 62% to 35%, which is the high end of other nursing homes fringe benefits in the area. The administrative and general expense reductions of $6,458,334 and fringe benefit reductions of $5,300,000 comprise the entire $11,700,000 reduction in total expenses.

*Overall, the facility will hire an additional 14.25 FTE's during the first year. Salary expenses are projected to increase overall for the facility by $704,369 as the result of hiring additional RNs, five additional LPN's and 16 additional aides. (From applicant) Review of comparably sized facilities and case mix warrant the addition of this staff.

*Revenues decreased from 2011 to first year because due to the 2011 rate consisted of prior period adjustments that inflate the revenues for 2011.

Presented as BFA Attachment B, is the financial summary of Van Duyn Extended Care Facility from 2009 through 2011. As shown on Attachment B, the facility had an average positive working capital position and an average negative net asset position from 2009 through 2011. The negative net asset position is due to historical losses. Also, the facility incurred average losses of $7,213,857 from 2009 through 2011. The applicant indicated that the reason for the losses is the fact that the facility's operating expenses are a combination of direct and indirect expenses incurred by the county in the operation of the facility, of which many of the operation expenses such as the facility's administration does not have direct control over. Consequently, the County offsets the facility operating losses with annual tax revenue that allows the County to maintain a balanced budget for the nursing home and the County as a whole. Due to restrictions on property tax increases, the County, similar to other counties in New York State, has determined that continued reliance on tax revenue to offset County nursing home operations is no longer feasible and has decided to sell the facility.

Presented as BFA Attachment D, is the financial summary of Bridgewater Center for Rehabilitation from 2009 through 2011. As shown on Attachment D, the facility had an average positive working capital position and an average positive net asset position. Also, the facility achieved an average net loss of $194 from 2009 through 2011. The applicant incurred a net loss of $261,940 from operations in 2011, which were the result of expenses included of $207,004 of pharmacy expenses from the prior operator's ownership period.

Presented as BFA Attachment E, is the financial summary of Pine Valley Center from 2009 through 2011. As shown on Attachment E, the facility had an average negative working capital position and an average positive net asset position. Also, the facility had an average net income of $449,541 from 2009 through 2011. The facility had an operating loss in 2011 due to the facility advancing payments on an approved capital project, which will be reimbursed to the facility through its HEAL NY Phase 12 grant.

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
BFA Attachment B	Financial Summary- Van Duyn Extended Care Facility
BFA Attachment C	Pro-forma Balance Sheet- Operating Entity
BFA Attachment D	Financial Summary- Bridgewater Center
BFA Attachment E	Financial Summary- Pine Valley Center
BFA Attachment F	Pro Forma Balance Sheet-Real Estate Entity

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 6th day of June, 2013, 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 VDRNC, LLC d/b/a Van Duyn Center for Rehabilitation and Nursing as the new operator of Van Duyn Home and Hospital, 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:
122312 E	VDRNC, LLC d/b/a Van Duyn Center for Rehabilitation and Nursing

APPROVAL CONTINGENT UPON:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]

2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
   - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
   - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
   - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
   - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
     - Information on activities relating to a-c above; and
     - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
     - Other factors as determined by the applicant to be pertinent.

   The DOH reserves the right to require continued reporting beyond the two year period. [RNR]

APPROVAL CONDITIONAL UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano
Director
Bureau of Project Management
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1842
Albany, New York 12237