STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

AGENDA

April 18, 2023
10:00 a.m.

90 Church Street, Conference Rooms 4 A/B, NYC

I. INTRODUCTION OF OBSERVERS

Jeffrey Kraut, Chair

II. 2022 ANNUAL REPORT

2022 Public Health and Health Planning Council Annual Report
*****For Informational Purposes*****

III. APPROVAL OF MINUTES

December 8, 2022 PHHPC Meeting Minutes

January 26, 2023 Special PHHPC Meeting Minutes

February 9. 2023 PHHPC Meeting Minutes

IV. REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

A Report of the Department of Health

James V. McDonald, M.D., M.P.H., Acting Commissioner of Health

B Report of the Office of Aging and Long Term Care

Adam Herbst, Deputy Commissioner, Office of Aging and Long Term Care

C Report of the Office of Health Equity and Human Rights

Johanne Morne, Deputy Commissioner, Office of Health Equity and Human Rights

D Report of the Office of Primary Care and Health Systems Management

John Morley, M.D., Deputy Commissioner, Office of Primary Care and Health Systems Management

E Report of the Office of Public Health

Ursula Bauer, Ph.D., MPH, Deputy Commissioner, Office of Public Health

V. PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

A. Report of the Committee on Establishment and Project Review

Gary Kalkut, Vice Chair of the Establishment and Project Review Committee

APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

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

CON Application

Acute Care Services - Construction

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	221082 C	Jamaica Hospital Medical Center (Queens 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

NO APPLICATIONS

CATEGORY 3: Applications Recommended for Approval with the Following:

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

CON Application

Ambulatory Surgery Centers - Construction

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	222234 C	Atlantic Surgery Center (Suffolk County) Dr. Berliner – Abstained at EPRC	Contingent Approval

CATEGORY 4: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

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

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

Ambulatory Surgery Centers – Establish/Construct

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	212260 B	Surgicore Suffolk, LLC (Suffolk County)	Contingent Approval
2.	222181 B	Bronx Vascular Surgical Center, LLC (Bronx County)	Contingent Approval
3.	222227 B	Southern Tier Surgery Center, LLC (Broome County)	Contingent Approval

Home Health Agency Licensures – Establish/Construct

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	222086 E	Aimer Home Care Corp. (Geographical Service Area: Rensselaer, Columbia, Greene, Washington, and Schenectady Counties)	Approval
2.	222156 E	Right At Home Nassau North Shore (Geographical Service Area: Nassau, Suffolk, and Queens Counties)	Approval

Certificate of Amendment of the Restated Certificate of Incorporation

Applicant	E.P.R.C. Recommendation
Glens Falls Hospital Foundation, Inc.	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

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	222213 B	Staten Island GSC, LLC d/b/a Ambulatory Surgery Center of Staten Island (Richmond County) Mr. Kraut – Interest/Abstaining Dr. Strange – Interest/Abstaining	Contingent Approval

Diagnostic and Treatment Centers – Establish/Construct

	Number	Applicant/Facility	E.P.R.C. Recommendation
1.	221123 E	Community Inclusion, Inc. d/b/a TRC Community Health Center of Western New York (Chautauqua County) Mr. Holt - Interest	Contingent Approval

Certificate of Dissolution

Applicant	E.P.R.C. Recommendation
St. Teresa's Nursing Home, Inc. Mr. LaRue – Recusal	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 and Project Review Committee Dissent, or
- ❖ Contrary Recommendation by HAS

NO APPLICATIONS

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

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

NO APPLICATIONS

VI. REGULATION

Report of the Committee on Codes, Regulations and Legislation

Thomas Holt, Chair of the Committee on Codes, Regulations and Legislation

For Emergency Adoption

20-22 Amendment of Sections 405.11 and 415.19 of Title 10 NYCRR (Hospital and Nursing Home Personal Protective Equipment (PPE) Requirements)

20-06 Amendment of Part 2, Section 405.3 and Addition of Section 58-1.14 to Title 10 NYCRR (Investigation of Communicable Disease)

For Information

20-06 Amendment of Part 2, Section 405.3 and Addition of Section 58-1.14 to Title 10 NYCRR (Investigation of Communicable Disease)

23-05 Addition of Section 400.26 to Title 10 NYCRR & Amendment of Sections 600.1 & 710.2 of Title 10 NYCRR (Inclusion of a Health Equity Impact Assessment as Part of the Certificate of Need (CON) Process)

VII. NEXT MEETINGS

June 15, 2023 (NYC)
June 29, 2023(NYC)

VIII. ADJOURNMENT

******Agenda items may be called in an order that differs from above******

Public Health and Health Planning Council
2022 Annual Report

I. General Council Activities in 2022

The Public Health and Health Planning Council (PHHPC) held a total of 16 meetings.

Meeting Dates	Meeting	PHHPC Meeting Location
1/11/2022	Special Committee on Codes, Regulations and Legislation Special Full Council	Albany Zoom
1/27/2022	Committee Day: Establishment and Project Review Committee	Albany Zoom
2/10/2022	Committee on Codes, Regulations and Legislation Annual Full Council	Albany Zoom
3/1/2022	Joint Health Planning Committee and Public Health Committee	Albany Zoom
3/2/2022	Special Establishment and Project Review Committee Special Full Council	Albany Zoom
3/17/2022	Special Committee on Codes, Regulations and Legislation Special Full Council	Albany Zoom
3/24/2022	Committee Day: Establishment and Project Review Committee	Albany Zoom
4/15/2022	Committee on Codes, Regulations and Legislation Full Council	Albany Zoom
5/19/2022	Committee Day: Establishment and Project Review Committee	Albany Zoom
6/2/2022	Committee on Codes, Regulations and Legislation Full Council	Albany NYC Zoom

7/14/2022	Committee Day: Establishment and Project Review Committee	Albany
7/28/2022	Committee on Codes, Regulations and Legislation Full Council	Albany NYC
9/15/2022	Special Committee on Codes, Regulations and Legislation Special Full Council Establishment and Project Review Committee	Albany NYC
10/6/2022	Committee on Codes, Regulations and Legislation Full Council	Albany NYC
11/17/2022	Special Committee on Codes, Regulations and Legislation Special Full Council Committee Day: Establishment and Project Review Committee	Albany NYC
12/8/2022	Committee on Codes, Regulations and Legislation Full Council	Albany NYC

II. Membership

Jeffrey Kraut, Chair
Jo Ivey Boufford, M.D., Vice Chair
John Bennett, Jr., M.D., F.A.C.C., F.A.C.P.
Howard Berliner, SC.D.
Angel Alfonso Gutiérrez, M.D.
Thomas Holt
Gary Kalkut, M.D.
Scott La Rue
Harvey Lawrence
Roxanne Lewin, M.D.
Sabina Lim, M.D.
Ann Monroe
Mario Ortiz, R.N., Ph.D., F.A.A.N.
Ellen Rautenberg, M.H.S. (served until 5/31/2022)
Peter Robinson
John Rugge, M.D., MPP
Denise Soffel, Ph.D. (appointed 6/2/2022)
Nilda Soto, MS Ed
Theodore Strange, M.D.
Hugh Thomas, Esq.
Anderson Torres, Ph.D., LCSW-R
Kevin Watkins, M.D., M.P.H.
Patsy Yang, Dr.P.H.
Dr. Mary Bassett, Commissioner of Health, Ex-Officio

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

- Committee on Codes, Regulations and Legislation
- Committee on Establishment and Project Review
- Committee on Health Planning
- Committee on Public Health
- Ad Hoc Committee to Lead the Prevention Agenda

III. Major Accomplishments of Committees in 2022

A. Committee on Codes, Regulations and Legislation

Members

Angel Alfonso Gutiérrez, M.D., Chair (6/2011 – 1/2022) Vice Chair (2/2022 – 12/31/2022)	Thomas Holt, Vice Chair (6/2011 – 1/2022) Chair (2/2022 – present)
Jeffrey Kraut	Kevin Watkins, M.D., M.P.H.
Roxanne Lewin, M.D.	Patsy Yang, Dr.P.H.
John Rugge, M.D., MPP	

Work Conducted in 2022

EMERGENCY ADOPTION

In 2022, the Codes Committee recommended, and the Council subsequently approved, the following 8 regulations amending Titles 10 and 18 of the New York Codes, Rules and Regulations (NYCRR) for emergency adoption. These emergency regulations addressed critical public health concerns.

20-22 Amendment of Sections 405.11 and 415.19 of Title 10 NYCRR (Hospital and Nursing Home Personal Protective Equipment (PPE) Requirements): In order for hospital and nursing home staff to safely provide care for COVID-19 positive patients and residents, or patients and residents infected with another communicable disease, while ensuring that they themselves do not become infected with COVID-19 or any other communicable disease, personal protective equipment (PPE), including masks, gloves, respirators, face shields and gowns, must be readily available and used. Therefore, these regulations ensure that hospitals and nursing homes have sufficient PPE stockpiles in the event of a communicable disease outbreak, should supply chain issues arise, to ensure each facility is adequately prepared to protect its staff and patients or residents, without needing to rely on the State's emergency stockpile. The regulations set forth two distinct calculations for hospitals and nursing homes to calculate the requisite 60-day PPE supply and set forth the specific types of PPE required in the stockpile. **This regulation was on the Codes agenda on January 11, 2022, April 5, 2022, June 2, 2022, September 15, 2022, and November 17, 2022.**

21-06 Addition of Subpart 66-4 to Title 10 NYCRR (COVID-19 Vaccinations of Nursing Home and Adult Care Facility Residents and Personnel): These regulations seek to prevent the spread of COVID-19 in nursing homes and adult care facilities (ACFs) and to help protect the health and life of residents of nursing homes and ACFs by requiring such congregate care facilities to offer or arrange for consenting residents and personnel to receive the COVID-19 vaccine. This requirement was established by regulation to help ensure residents are less likely to suffer a COVID-related death or severe illness and that fewer staff test positive for COVID-19. **This regulation was on the Codes agenda on January 11, 2022, April 5, 2022 and June 2, 2022.**

20-24 Addition of Sections 1.2, 700.5 and Part 360 to Title 10 NYCRR; Amendment of Sections 400.1, 405.24 & 1001.6 of Title 10 NYCRR and Sections 487.3, 488.3 and 490.3 of Title 18 NYCRR (Surge and Flex Health Coordination System): These regulatory amendments permit the State Commissioner of Health or their designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by state or federal law. The Commissioner's authority to suspend or modify certain regulations, as set forth in these regulations, are intended to ensure that the State has the most efficient regulatory tools to facilitate the State's and regulated parties' response efforts to Surge and Flex the healthcare system statewide. The regulation also permits the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute. The regulatory amendments also require hospitals to: develop disaster emergency response plans; maintain a 60-day supply of personal protective equipment (PPE); ensure that staff capable of working remotely are equipped and trained to do so; and report data as requested by the Commissioner. **This regulation was on the Codes agenda on January 11, 2022, April 5, 2022, June 2, 2022, September 15, 2022 and November 17, 2022.**

21-14 Addition of Section 2.61 to Title 10 NYCRR, Amendment of Sections 405.3, 415.19, 751.6, 763.13, 766.11, 794.3 & 1001.11 of Title 10 NYCRR & Sections 487.9, 488.9 and 490.9 of Title 18 NYCRR (Prevention of COVID-19 Transmission by Covered Entities): These regulations require certain covered entities to ensure their personnel are fully vaccinated against COVID-19, and to document evidence thereof in appropriate records. Such covered entities are also required to review and make determinations on medical exemption requests and provide reasonable accommodations thereof to protect the wellbeing of the patients, residents and personnel in such facilities. These regulations further require documentation and information regarding personnel vaccinations, as well as approved exemption requests, to be provided to the Department immediately upon request. **This regulation was on the Codes agenda on January 11, 2022 and March 17, 2022.**

20-06 Amendment of Part 2, Section 405.3 and Addition of Section 58-1.14 to Title 10 NYCRR (Investigation of Communicable Disease): These regulations update, clarify and strengthen the Department's authority, as well as that of local health departments, to take specific actions to control the spread of disease, including actions related to investigation and response to a disease outbreak, as well as the issuance of isolation and quarantine orders. **This regulation was on the Codes agenda on February 10, 2022, April 5, 2022, June 2, 2022, July 28, 2022, October 6, 2022 and December 8, 2022.**

20-07 Amendment of Section 2.60 of Title 10 NYCRR & Repeal of Subpart 66-3 of Title 10 NYCRR (Face Coverings for COVID-19 Prevention): These regulations provide that masking may be required under certain circumstances, as determined by the Commissioner based on COVID-19 incidence and prevalence, as well as any other public health and/or clinical risk factors related to COVID-19 disease spread. **This regulation was on the Codes agenda on February 10, 2022, April 5, 2022, June 2, 2022, July 28, 2022, October 6, 2022 and December 8, 2022.**

21-15 Addition of Sections 2.9 and 2.62 to Title 10 NYCRR (COVID-19 Reporting and Testing): Empowers Commissioner to issue determinations requiring the immediate implementation of heightened COVID-19 testing protocols for population segments that may be at increased risk of transmission due, in part, to their employment or residential circumstances. These regulations also permit the Department to require reporting of testing and positive reports among school students, teaching staff, and any other employees or volunteers. **This regulation was on the Codes agenda February 10, 2022 and April 5, 2022.**

22-21 Amendment of Section 23.1 of Title 10 NYCRR (Mpox Virus to the List of Sexually Transmitted Diseases (STDs)): This amendment adds the Mpox virus (formerly known as "Monkeypox" until redesignation by the World Health Organization) to Group B of the existing list of STDs. County local health departments (LHDs) have an existing legal obligation to control the spread of Mpox under Public Health Law Article 6 communicable disease guidance. Consistent with such guidance, this regulation requires STD clinics operated by LHDs or providing services through contractual arrangements to provide diagnosis and treatment, including prevention services, to persons diagnosed or at risk for 3 Mpox, either directly or through referral. Further, this regulation allows minors to consent to their own Mpox testing, prevention services (including vaccine), and treatment. **This regulation was on the Codes agenda on October 6, 2022.**

ADOPTION

In 2022, the Codes Committee recommended, and the Council subsequently approved, the following 7 regulations amending Titles 10 and 18 of the NYCRR for permanent adoption. These regulations were designed to promote health and safety, expand access to services, and align state policies with transformative changes in health care.

21-19 Amendment of Sections 600.1 and 600.2 of Title 10 NYCRR (Article 28 Nursing Homes; Establishment; Notice and Character and Competence Requirements): These regulations were amended to codify the procedure for the notification to the Long-term care ombudsman (LTCO), residents, staff, and others of an application for the establishment of a nursing home operator.

21-14 Addition of Section 2.61 to Title 10 NYCRR, Amendment of Sections 405.3, 415.19, 751.6, 763.13, 766.11, 794.3 & 1001.11 of Title 10 NYCRR & Sections 487.9, 488.9 and 490.9 of Title 18 NYCRR (Prevention of COVID-19 Transmission by Covered Entities): These regulations require certain covered entities to ensure their personnel are fully vaccinated against COVID-19, and to document evidence thereof in appropriate records. Such covered entities are also required to review and make determinations on medical exemption requests and provide reasonable accommodations thereof to protect the wellbeing of the patients, residents and personnel in such facilities. These regulations further require documentation and information regarding personnel vaccinations, as well as approved exemption requests, to be provided to the Department immediately upon request.

21-06 Addition of Subpart 66-4 to Title 10 NYCRR (COVID-19 Vaccinations of Nursing Home and Adult Care Facility Residents and Personnel): These regulations were implemented to help prevent the spread of COVID-19 in nursing homes and adult care facilities (ACFs) and to help protect the health and life of residents of nursing homes and ACFs by requiring such congregate care facilities to offer or arrange for consenting residents and personnel to receive the COVID-19 vaccine. This requirement was established by regulation to help ensure residents are less likely to suffer a COVID-related death or severe illness and that fewer staff test positive for COVID-19.

20-24 Addition of Sections 1.2, 700.5 and Part 360 to Title 10 NYCRR; Amendment of Sections 400.1, 405.24 & 1001.6 of Title 10 NYCRR and Sections 487.3, 488.3 and 490.3 of Title 18 NYCRR (Surge and Flex Health Coordination System): These regulatory amendments permit the State Commissioner of Health or their designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by state or federal law. The Commissioner's authority to suspend or modify certain regulations, as set forth in these regulations, are intended to ensure that the State has the most efficient regulatory tools to facilitate the State's and regulated parties' response efforts to Surge and Flex the healthcare system statewide. The regulation also permits the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor

temporarily suspends or modifies a controlling state statute. The regulatory amendments also require hospitals to: develop disaster emergency response plans; maintain a 60-day supply of personal protective equipment (PPE); ensure that staff capable of working remotely are equipped and trained to do so; and report data as requested by the Commissioner.

21-13 Addition of Section 415.34 to Title 10 NYCRR (Nursing Home Minimum Direct Resident Care Spending): These regulations implement the statutory directive of Public Health Law section 2828. Specifically, pursuant to the statute, the regulations (1) set forth how facilities that fail to meet the statutory minimum spending requirements must pay the State, (2) provide exceptions from the minimum spending requirements for residential health care facilities that serve certain specialized populations, (3) set forth factors the Department will use to determine whether to waive the spending requirements for facilities unable to comply due to "unexpected or exceptional circumstances that prevented compliance," and (4) provide factors the Department will use to determine whether to exclude extraordinary revenues and capital expenses from the calculations to determine whether a facility has met its minimum spending requirements. Requiring nursing homes to spend an appropriate amount of revenue on the direct care of residents and resident-facing staffing will reduce errors, complications, and adverse resident care incidents. It will also improve the safety and quality of life for all long-term care residents in New York State.

21-20 Amendment to Sections 415.2 and 415.13 of Title 10 NYCRR (Minimum Staffing Requirements for Nursing Homes): These regulations implement the statutory directive of Public Health Law section 2895-b. Specifically, pursuant to the statute, the regulations: (1) set forth minimum nurse staffing standards; (2) provide for the imposition of penalties for failure to meet minimum staffing standards; (3) provide for mitigating factors for failure to meet the minimum staffing requirements; and (4) set forth a process for the Department to determine facilities that are in need of assistance to meet the staffing requirements. Research has demonstrated that as nurse turnover increases in nursing homes, the quality of resident care declines. Therefore, having adequate nurse staffing levels provides residents with the highest quality of care. Requiring these facilities to meet this minimum level of staffing will help ensure patient safety and improve the quality of care received by the residents of the nursing home.

22-11 Amendment of Subpart 5-1 of Title 10 NYCRR (Public Water Systems): Amendments were made to Title 10, Subpart 5-1 to correct typographical errors and inconsistencies with the Code of Federal Regulations to retain the Department's primacy enforcement authority under the Safe Drinking Water Act. These regulatory amendments were adopted by consensus rulemaking.

REGULATORY PROPOSALS FOR INFORMATION

In 2022, the following 4 proposals to amend Title 10 NYCRR were presented to the Codes Committee and the Council for information after a Notice of Proposed Rulemaking was filed in the *State Register*.

21-06 Addition of Subpart 66-4 to Title 10 NYCRR (COVID-19 Vaccinations of Nursing Home and Adult Care Facility Residents and Personnel): These regulations seek to prevent the spread of COVID-19 in nursing homes and adult care facilities (ACFs) and to help protect the health and life of residents of nursing homes and ACFs by requiring such congregate care facilities to offer or arrange for consenting residents and personnel to receive the COVID-19 vaccine. This requirement was established by regulation to help ensure residents are less likely to suffer a COVID-related death or severe illness and that fewer staff test positive for COVID-19.

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22-21 Amendment of Section 23.1 of Title 10 NYCRR (MpoxVirus to the List of Sexually Transmitted Diseases (STDs)): This amendment adds the Mpox virus (formerly known as "Monkeypox" until redesignation by the World Health Organization) to Group B of the existing list of STDs. County local health departments (LHDs) have an existing legal obligation to control the spread of Mpox under Public Health Law Article 6 communicable disease guidance. Consistent with such guidance, this regulation requires STD clinics operated by LHDs or providing services through contractual arrangements to provide diagnosis and treatment, including prevention services, to persons diagnosed or at risk for 3 Mpox, either directly or through referral. Further, this regulation allows minors to consent to their own Mpox testing, prevention services (including vaccine), and treatment.

22-16 Amendment of Subpart 5-1 of Title 10 NYCRR (Maximum Contaminant Levels (MCLs)): These regulations are proposed for adoption pursuant to Public Health Law (PHL) section 1112, which requires the Department to adopt Emerging Contaminants Monitoring Requirements (ECMR). Specifically, PHL section 1112 requires that Notification Levels (NLs) be established for 23 PFAS designated as "emerging contaminants." The first category is a sum of 6 compounds to 0.0000300 mg/L (30 ppt) with a 10 ppt notification level for hexafluoropropylene oxide-dimer acid (HFPO-DA/GenX) and the second category is a sum of 13 compounds to 0.000100 mg/L (100 ppt). Decisions on each PFAS chemical's notification category were made based on an evaluation of liver toxicity effect levels, human half-lives,

established reference doses, and chemical structure similarities. The 30 ppt notification levels applies to the sum of six (6) PFAS compounds and the 100 ppt NL applies to the sum 13 PFAS compounds. Confirmed sample results that are at or above either NL will prioritize evaluations of the public water system, allow for exposure reduction recommendations based on those evaluations, and provide advanced communication to the community served by the water system.

B. Committee on Establishment and Project Review

Members

Peter Robinson, Chair
Gary Kalkut, M.D., Vice Chair
John Bennett, Jr., M.D.
Howard Berliner
Angel Gutierrez, M.D.
Thomas Holt
Jeffrey Kraut
Scott LaRue
Harvey Lawrence
Sabina Lim, M.D.
Ann Monroe
Hugh Thomas, Esq.
Anderson Torres, Ph.D.

Project Review 2022

The following projects were reviewed by the Establishment and Project Review Committee and forwarded to the Public Health and Health Planning Council in 2022.

HOSPITALS

Hospital Mergers

212223 C New York-Presbyterian Hospital - New York Weill Cornell Center
Certify NewYork-Presbyterian Brooklyn Methodist Hospital as a new division of The New York and Presbyterian Hospital

Hospital Modernizations or Expansions

212282 C Auburn Community Hospital $ 14,127,057
Construct a radiation oncology center with a linear accelerator on the hospital campus and certify Radiology-Therapeutic O/P

221218 C United Memorial Medical Center $ 33,776,631
Certify a new extension clinic at 8103 Oak Orchard Road, Batavia providing primary care, other medical specialties, and single-specialty ambulatory surgery (gastroenterology) services

212135 C University Hospital SUNY Health Science Center $ 3,086,375
Certify a new division to be called Upstate University Hospital at Hutchings to provide inpatient behavioral health services to adolescents and children to be located at 620 Madison Avenue, Syracuse, and certify 29 psychiatric beds

212174 C Westchester Medical Center $ 165,800,164
Construct a five-story inpatient bed tower on the main campus to house 96 beds (41 ICU and 55 Medical/Surgical), and with shell space on the 5th Floor, with no change in total certified beds

Cardiac Surgery

211094 C New York-Presbyterian Hospital - New York Weill Cornell Center $ 8,352,970
Certify Adult Heart Transplant Services and acquire requisite equipment

Hospital Ambulatory Surgery Centers

221248 C NYU Langone Hospital-Long Island $ 18,219,372
Certify a new single-specialty ambulatory surgery center extension clinic on the 7th floor of 211 Station Road, Mineola

212212 C NYU Langone Orthopedic Center $ 189,297,119
Certify ambulatory surgery - multi-specialty and perform renovations to add an 18-OR ambulatory surgery center in the extension clinic located at 333 East 38th Street, New York

Hospital Beds

221054 C Canton-Potsdam Hospital $ 71,795,281
Certify 15 additional Medical/Surgical beds, construct a four-story addition to include 60 single-bedded rooms, an expansion of the emergency department and shell space, and renovate the existing emergency department

212113 C North Shore University Hospital $ 560,705,671
Construct an 8-story addition to include new surgical suites and intensive care units (ICU) and certify 38 additional ICU beds, 20 via an intra-network bed transfer from LIJ Valley Stream (Companion to 212127) (Amends and Supersedes 172212)

212259 C Sisters of Charity Hospital - St. Joseph Campus $ 7,885,120
Perform renovations to create an addiction treatment unit and convert 40 medical/surgical beds to 40 chemical dependence rehabilitation beds

221105 C Strong Memorial Hospital $ 557,250,894
Construct an inpatient bed tower, certify 9 Intensive Care beds and 35 Medical/Surgical beds, and perform renovations to expand and modernize the emergency department

RESIDENTIAL HEALTH CARE FACILITIES

RHCF Establishments

192228 E Betsy Ross Operations, LLC d/b/a Betsy Ross Rehabilitation and Nursing
Establish Betsy Ross Operations, LLC as the new operator of the 120-bed residential health care facility located at 1 Elsie Street, Rome

192027 E Crest Opco LLC d/b/a Crest Manor Living and Rehabilitation Center
Establish Crest Opco LLC as the new operator of the 80-bed residential health care facility (RHCF), located at 6745 Pittsford-Palmyra Road, Fairport

192336 E DURNC Operating, LLC d/b/a Dunkirk Rehabilitation & Nursing Center
Establish DURNC Operating, LLC as the new operator of the 40-bed residential health care facility located at 447-449 Lake Shore Drive West, Dunkirk, currently operated by Absolut Center for Nursing and Rehabilitation at Dunkirk, LLC

192026 E Eastside Opco LLC d/b/a East Side Nursing & Rehab
Establish Eastside Opco LLC as the new operator of the 80-bed residential health care facility located at 62 Prospect Street, Warsaw currently operated as East Side Nursing Home

192332 E EDRNC Operating, LLC d/b/a Eden Rehabilitation & Nursing Center
Establish EDRNC Operating, LLC as the new operator of the 40-bed residential health care facility located at 2806 George Street, Eden currently operated by Absolut Center for Nursing and Rehabilitation at Eden, LLC

202054 E Forest View Center for Rehabilitation & Nursing
Transfer of 12.5% ownership interest from one (1) withdrawing stockholder to one (1) new stockholder

211233 E Glen Island Center for Nursing and Rehabilitation
Transfer 90.01 percent interest from one withdrawing shareholder to the remaining shareholder

192204 E Highland Nursing Home, Inc. d/b/a North Country Nursing & Rehabilitation Center
Transfer 100 percent shareholder interest to ten new shareholders

221084 E Hilaire Farm Skilled Living & Rehabilitation Center, LLC d/b/a Hilaire Rehab & Nursing
Transfer 33.3% ownership interest from one deceased member to one new member

192333 E HORNC Operating, LLC d/b/a Houghton Rehabilitation & Nursing Center
Establish HORNC Operating, LLC as the new operator of the 100-bed residential health care facility located at 9876 Luckey Drive, Houghton currently operated by Absolut Center for Nursing and Rehabilitation at Houghton, LLC

211276 E J&H Operations, LLC d/b/a Swan Lake Nursing & Rehabilitation
Establish J&H Operations, LLC d/b/a Swan Lake Nursing & Rehabilitation as the new operator of Suffolk Center for Rehabilitation and Nursing an existing 120-bed residential health care facility at 25 Schoenfeld Boulevard Patchogue

202203 E Kingsway Arms Nursing Center, Inc.
Transfer 19.0826 percent ownership to an existing member

202084 E Lawrence Nursing Care Center, Inc.
Transfer of 90.1% ownership interest from four (4) withdrawing stockholders to four (4) remaining stockholders, each of whom will own 25% ownership interest

202106 E Montgomery Operating Co., LLC d/b/a Montgomery Nursing and Rehabilitation Center
Transfer a total of 99% ownership interest from four withdrawing members and one existing member to six new members

202066 E New Vanderbilt Rehabilitation and Care Center, Inc.
Transfer 30.2% interest from one withdrawing member to the three remaining members

201024 E Optima Care Brentwood, LLC d/b/a Maria Regina Rehabilitation and Nursing
Establish Optima Care Brentwood, LLC as the operator of the 188-bed residential health care facility located at 1725 Brentwood Road, Brentwood currently operated by Maria Regina Residence, Inc.

202122 E Providence Rest, Inc.
Establish Catholic Health Care System as the active parent/co-operator of Providence Rest, a 200-bed residential health care facility located at 3304 Waterbury Avenue, Bronx

202269 E Ross OPCO LLC d/b/a Ross Center for Nursing and Rehabilitation
Establish Ross OPCO LLC as the new operator of Ross Center for Nursing and Rehabilitation, an existing 120 bed skilled nursing facility located at 839 Suffolk Avenue, Brentwood

192335 E SARNC Operating, LLC d/b/a Salamanca Rehabilitation & Nursing Center
Establish SARNC Operating, LLC as the new operator of the 120-bed residential health care facility located at 451 Broad Street, Salamanca currently operated by Absolut Center for Nursing and Rehabilitation at Salamanca, LLC

211087 E The Premier Center for Rehabilitation of Westchester, LLC d/b/a Springvale Nursing and Rehabilitation Center
Establish The Premier Center for Rehabilitation of Westchester, LLC as the new operator of Bethel Nursing and Rehabilitation Center, a 200-bed residential health care facility located at 67 Springvale Road, Croton-On-Hudson

202034 E Ulster NH Operations LLC d/b/a Golden Hill Center for Rehabilitating and Nursing
Establish Ulster NH Operation LLC as the new operator of the 280-bed residential health care facility located at 99 Golden Hill Drive, Kingston, currently operated as Golden Hill Nursing and Rehabilitation Center

211139 E Village Acquisition I, LLC d/b/a Lower West Side Rehabilitation and Nursing Center
Establish Village Acquisition I, LLC as the new operator of VillageCare Rehabilitation and Nursing Center, a 105-bed residential health care facility located at 214 West Houston Street, New York

RHCF Modernizations or Expansions

221065 C Elizabeth Seton Children's Center $ 118,000,000
Certify a 96-bed residential health care facility for a Young Adult Demonstration Program to be constructed at 315 North Street, White Plains

212105 C Rutland Nursing Home, Inc. $ 43,039,119
Certify an 80-bed Young Adult Demonstration Program, with no change in total certified beds, and perform requisite renovations - OBH

DIAGNOSTIC AND TREATMENT CENTERS

Diagnostic and Treatment Center Establishments

221224 E 21 Reade Place ASC, LLC d/b/a Bridgeview Endoscopy
Transfer 41.6665% ownership interest to five new members of the sole member LLC

221231 B A Friendly Face Akademy, Corp. $ 466,082
Establish and construct a new diagnostic and treatment center for primary care and other medical specialties at 1887 Richmond Avenue, Staten Island

221267 E Advanced Endoscopy LLC d/b/a Advanced Endoscopy Center
Transfer of 10.71213% ownership interest from three withdrawing Class B members to one new member LLC

212079 E Ambulatory Surgery Center of Western New York LLC
Transfer 77% ownership interest from 23 existing members to one new member

211143 E AMSC, LLC d/b/a Downtown Bronx ASC
Transfer 100% of membership interest in AMSC, LLC d/b/a Downtown Bronx ASC

221115 E	Apex Surgical Center Transfer a total of 48.87% ownership interest from three withdrawing members and four existing members to two new individual members, one new member LLC comprised of multiple individual members, and two existing members		
221145 B	Apple Care Health Establish and construct a new diagnostic and treatment center at 1578 Fulton Street, Brooklyn	$	1,202,557
192211 B	Beach Channel D&TC, LLC d/b/a Beach Channel Diagnostic and Treatment Center Establish and construct a diagnostic and treatment center to be located at 50-15 Beach Channel Drive, Far Rockaway, in Peninsula Nursing and Rehabilitation Center	$	1,276,882
212219 B	Bronx Community Health Network, Inc. Establish and construct a Diagnostic and Treatment Center at 3763 White Plains Road, Bronx with a mobile van extension clinic to provide primary care and dental services - Safety Net	$	5,031,392
221268 E	Carnegie Hill Endoscopy, LLC Transfer of 18.66% ownership interest from three withdrawing Class B members to one new member LLC		
212176 B	Columbia/NewYork-Presbyterian Advanced Imaging, Inc. Establish and construct a diagnostic and treatment center at 710 West 168th Street, New York, and an extension clinic at 722 West 168th Street, New York; both specializing in radiology and imaging services	$	53,289,721
212213 B	East 180 Operating, LLC d/b/a East 180th Street Health and Treatment Center Establish and construct a diagnostic and treatment center located at 870 East 180th Street, Bronx	$	11,660,135
221269 E	East Side Endoscopy, LLC d/b/a East Side Endoscopy and Pain Management Center Transfer 41.926% ownership interest from three withdrawing members to a new member LLC; 83.3333% interest from two withdrawing members to existing members within two member LLCs and 9.306% from an existing member to a new member within a member LLC		
221270 E	Endoscopy Center of Niagara, LLC Transfer 49% ownership interest from one withdrawing Class A member LLC to two new Class A member LLCs		
221271 E	Endoscopy Center of Western New York, LLC Transfer 100% ownership interest from 15 withdrawing members to two new member LLCs		
221272 E	Island Digestive Health Center Transfer 10% ownership interest from three withdrawing members to one new member LLC		

221265 B	JAL 28 LLC d/b/a A Merryland Health Center Establish JAL 28 LLC as the new operator of A Merryland Health Center, a diagnostic and treatment center at 2873 West 17th Street, Brooklyn, currently operated by A Merryland Operating LLC, and certify Medical Services - Other Medical Specialties		
211085 B	KD Hudson Ventures, LLC d/b/a Avalon Medical Group Establish and construct a Diagnostic and Treatment Center to be located at 121 Executive Drive, New Windsor for primary and specialty care through the relocation, consolidation, and conversion of multiple private practices	$	2,361,979
212182 E	Main Street Radiology at Bayside LLC Transfer ownership interest in a member LLC from ten withdrawing members to the remaining members and seven new members		
221206 E	Northern Westchester Facility Project LLC d/b/a Yorktown Center for Specialty Surgery Transfer 20.044% from sixteen existing members to eleven new members and seek PHHPC approval of eight existing members		
212057 B	NY Med South Bronx, LLC Establish and construct a Diagnostic and Treatment Center to be located at 2825 Third Avenue, Bronx	$	1,576,267
221227 B	Parkchester DTC LLC d/b/a Parkchester Diagnostic and Treatment Center Establish and construct a diagnostic and treatment center at 1879 Gleason Avenue, Bronx, perform renovations, and construct new space adjoining the existing building - CRFP	$	4,648,617
211226 E	Perry Avenue Family Medical, Inc. Transfer 100 percent ownership from the existing members to two new members at 85 percent and 15 percent respectively		
221070 B	Pinpoint Medical, LLC Establish and construct a diagnostic and treatment center at 649 39th Street, Brooklyn	$	2,494,577
212258 B	Rego Park Counseling, LLC d/b/a Rego Park Diagnostic and Treatment Center Establish and construct a Diagnostic and Treatment Center at 63-36 99th Street, Rego Park, co-located with mental health and substance use disorder services	$	418,480
221212 E	Smile New York Outreach, LLC Transfer of 100% ownership interest from one withdrawing member to a new member within the sole member LLC		
211151 B	W Medical, LLC d/b/a W Health Center Establish and construct a diagnostic and treatment center to be located at 70 Lee Avenue, Brooklyn	$	558,082
212208 B	World Health Clinicians, Inc. d/b/a Circle Care Center - Westchester Establish and construct an Article 28 diagnostic and treatment center to be located at 34 South Broadway, White Plains	$	141,030

221199 B	Yaldeinu Health Inc. Establish and construct a new diagnostic and treatment center at 1600 63rd Street, Brooklyn, to provide Primary Care and Other Medical Specialties services	$	547,295

Freestanding Ambulatory Surgery Centers

212271 C	Ambulatory Surgery Center of Niagara Convert from single-specialty (ophthalmology) ambulatory surgery to multi-specialty ambulatory surgery and perform requisite renovations	$	158,468
212177 C	Buffalo Surgery Center, LLC Relocate the GI Suite to an adjacent building on the same campus with requisite renovations, renovate and expand existing space to create additional operating rooms, and convert to multispecialty ambulatory surgery	$	6,243,756
221095 B	Empire CSS, LLC d/b/a Empire Center for Special Surgery Establish and construct a new multi-specialty ambulatory surgery center at 4855 Hylan Boulevard, Staten Island	$	6,676,577
221191 B	Maxillofacial Ambulatory Surgery Center, LLC Establish and construct a single-specialty freestanding ambulatory surgery center (FASC) at 400 Townline Road, Hauppauge, specializing in oral and maxillofacial surgical procedures	$	3,719,676
201004 B	Pelham Parkway SC, LLC d/b/a Pelham Parkway Surgery Center Establish and construct a new multi-specialty ambulatory surgery center to be located at 1000 Pelham Parkway South, Bronx in currently vacant space in a multi-use building that includes Morningside Nursing and Rehabilitation Center	$	8,393,727
221213 E	Performance Surgical Center, LLC d/b/a Performance Surgical Center Establish Performance Surgical Center, LLC as the new operator of Millenium Ambulatory Surgery Center, a multi-specialty freestanding ambulatory surgical center at 1408 Ocean Avenue, Brooklyn		
202057 B	Premier SC, LLC t/b/k/a Premier Ambulatory Surgery Center of New York, LLC Establish and construct a new multi-specialty freestanding ambulatory surgery center with four (4) operating rooms to be located at 176-60 Union Turnpike, Fresh Meadows	$	10,576,961

Establishment of New Dialysis Providers (Change of Ownership)

211201 E	MVNY Partners I, LLC d/b/a U.S. Renal Care Faxton Dialysis Establish MVNY Partners I, LLC as the new operator of the 36-station chronic renal dialysis center located at 1676 Sunset Avenue, Utica, currently operated by Faxton-St. Lukes Healthcare.		
211202 B	MVNY Partners II, LLC d/b/a U.S. Renal Care St. Luke's Home Dialysis Establish MVNY Partners II, LLC as the operator of the 8-station dialysis center located at 1650 Champlin Ave, Utica, currently operated by Faxton-St. Luke's Healthcare and certify Home Hemo and Home Peritoneal Dialysis Training & Support Services		

211203 B MVNY Partners III, LLC d/b/a U.S. Renal Care Masonic Care Community Dialysis
Establish MVNY Partners III, LLC as the operator of the 20-station dialysis center located at 2150 Bleeker St., Utica, currently operated by Faxton-St. Lukes Healthcare and certify Home Hemo and Home Peritoneal Dialysis Training & Support services.

211204 B MVNY Partners IV, LLC d/b/a U.S. Renal Care Rome Dialysis
Establish MVNY Partners IV, LLC as the operator of the 16-station dialysis center located at 91 Perimeter Rd, Rome currently operated by Faxton-St Lukes Healthcare and certify Home Hemodialysis and Home Peritoneal Dialysis Training & Support services

211205 B MVNY Partners V, LLC d/b/a U.S. Renal Care Herkimer Dialysis
Establish MVNY Partners V, LLC as the operator of the 8-station dialysis center located at 201 E State St, Herkimer currently operated by Faxton-St Lukes Healthcare and certify Home Hemo and Home Peritoneal Dialysis Training & Support services

211206 B MVNY Partners VI, LLC d/b/a U.S. Renal Care Hamilton Dialysis
Establish MVNY Partners VI, LLC as the operator of the 8-station dialysis center located at 10 Easton St, Hamilton currently operated by Faxton-St Lukes Healthcare and certify Home Hemo and Home Peritoneal Dialysis Training & Support services

211207 B MVNY Partners VII, LLC d/b/a U.S. Renal Care Oneida Dialysis
Establish MVNY Partners VII, LLC as the operator of the 8-station dialysis center located at 131 Main St., Oneida currently operated by Faxton-St. Luke's Healthcare and certify Home Hemo and Home Peritoneal Dialysis Training & Support Services

CERTIFIED HOME HEALTH AGENCIES

Certified Home Health Agencies

221184 E Emerest Certified Home Health Care of NY LLC d/b/a Royal Care Certified Home Health Care of NY
Establish Emerest Certified Home Health Care of NY LLC as the new operator of Cabrini Certified Home Health Agency, a Certified Home Health Agency currently operated by Cabrini of Westchester and relocate it to 798 Southern Boulevard, Bronx

202185 E Wellbound II LLC
Establish Wellbound II LLC as the new operator of Bethel Nursing Home Company Certified Home Health Agency

Hospices

212251 C Hospice Care Network d/b/a Hospice Care of Long Island, Queens South Shore
Acquire the assets of Hospice of Westchester - Putnam (HWP), add Westchester and Putnam as approved counties, close HWP's 540 White Plains Road, Tarrytown office, and use a new assumed name in the expanded service area

212149	C	Hospice of Jefferson County/Palliative Care of Jefferson County Certify four additional residence beds and decertify two inpatient certified beds, for a total certified capacity of 12 residence beds and perform requisite renovations to accommodate the new beds	$ 2,207,196

TABLE I

Median Processing Times

(Acknowledgement to Director Action in Days)

	Admin	Full	LHCSA	Ltd
2018	65	150	586	21
2019	87	148	186	28
2020	84	216	165	52
2021	98	152	0	62
2022	83	193	0	63

TABLE I (A)

Historical Project Volume and Values

	Number of Actions						Value of Actions *(in thousands)*					Average Value *(in thousands)*			
Year	Admin	Full	LHCSA	Ltd	Notice	Total	Admin	Full	Ltd	Notice	Total	Admin	Full	Ltd	Notice
2018	148	97	35	283	332	895	759,184	2,393,107	527,475	608,464	4,288,229	5,130	24,671	1,864	1,833
2019	97	101	18	305	399	920	492,504	657,505	528,747	1,080,223	2,758,980	5,077	6,510	1,734	2,707
2020	86	56	2	189	295	628	346,232	1,561,724	359,591	586,177	2,853,724	4,026	27,888	1,903	1,987
2021	101	42	0	217	359	719	433,342	562,628	404,613	414,448	1,815,031	4,291	13,396	1,865	1,154
2022	108	82	0	165	329	684	607,503	1,888,166	411,429	872,998	3,780,095	5,625	23,026	2,494	2,653

TABLE I (B)

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

2022

	Number of Projects				Value of Projects *(in thousands)*			
	Admin	Full	Ltd	Total	Admin	Full	Ltd	Total
Region								
Western	11	11	8	30	10,980	14,232	25,343	50,555
Finger Lakes	13	3	18	34	79,112	591,512	33,538	704,163
Central	7	13	10	30	18,199	91,309	13,065	122,574
NY Penn	2	0	3	5	2,797	0	1,227	4,024
Northeast	5	1	17	23	18,255	0	16,770	35,025
Hudson Valley	13	11	16	40	91,202	286,381	19,542	397,126
New York City	37	34	74	145	324,685	320,555	266,823	912,063
Long Island	20	9	19	48	62,272	584,177	35,120	681,569
Total	108	82	165	**355**	$607,503	$1,888,166	$411,429	**$2,907,098**

2021

	Number of Projects				Value of Projects *(in thousands)*			
	Admin	Full	Ltd	Total	Admin	Full	Ltd	Total
Region								
Western	17	3	13	33	69,825	70,834	18,901	159,560
Finger Lakes	10	1	29	40	20,585	6,730	47,617	74,932
Central	11	8	19	38	12,321	74,562	36,889	123,772
NY Penn	3	1	2	6	10,392	2	1,411	11,806
Northeast	9	1	15	25	8,346	0	15,267	23,614
Hudson Valley	12	2	33	47	67,073	16,837	75,341	159,252
New York City	32	18	81	131	180,734	302,232	160,072	643,037
Long Island	7	8	25	40	64,065	91,431	49,115	204,611
Total	101	42	217	**360**	$433,342	$562,628	$404,613	**$1,400,583**

TABLE II (A)
Disapprovals
2022

None

TABLE II (B)
Withdrawals
2022

Withdrawals by Applicant		29
Withdrawals by Department		22
	Total	51

TABLE III

Bed Changes by Facility Type by Region
2022

HOSPITALS	Western	Finger Lakes	Central	NY-Penn	North East	Hudson Valley	NYC	Long Island	TOTAL
Bed Category									
AIDS	0	0	0	0	0	0	-13	0	-13
Bone Marrow Transplant	0	0	0	0	0	0	0	0	0
Chemical Dependence, Detox	0	0	0	0	0	0	-62	0	-62
Chemical Dependence, Rehab	40	0	0	0	0	0	-11	0	29
Coma Recovery	0	0	0	0	0	0	-2	0	-2
Coronary Care	0	0	0	0	0	0	0	0	0
Intensive Care	0	9	0	0	0	0	0	38	47
Maternity Beds	12	0	0	0	-6	0	2	0	8
Medical/Surgical	-52	35	15	20	0	0	-24	-20	-26
Neonatal Intensive Care	0	0	0	0	0	0	7	0	7
Neonatal Intermediate Care	0	0	0	0	0	0	2	0	2
Neonatal Continuing Care	0	0	0	0	0	0	0	0	0
Pediatric	0	0	0	0	0	0	-10	0	-10
Pediatric ICU	0	0	0	0	0	0	0	0	0
Physical Medicine & Rehabilitation	0	0	0	0	0	0	0	0	0
Prisoner	0	0	0	0	0	0	0	0	0
Psychiatric	0	0	29	0	0	0	-23	0	6
Transitional Care	0	-26	0	-20	0	0	-16	0	-62
Traumatic Brian Injury	0	0	0	0	0	0	-18	0	-18
New York State Total	0	18	44	0	-6	0	-168	18	**-94**

RESIDENTIAL HEALTH CARE FACILITIES	Western	Finger Lakes	Central	NY-Penn	North East	Hudson Valley	NYC	Long Island	TOTAL
Bed Category									
AIDS	0	0	0	0	0	0	-50	0	-50
RHCF	0	0	0	0	0	92	50	0	142
Behavioral Intervention	0	0	0	0	0	0	0	0	0
Neurodegenerative	0	0	0	0	0	0	0	0	0
Pediatric	0	0	0	0	0	0	0	0	0
Tramatic Brain Injury	0	0	0	0	0	0	0	0	0
Ventilator, Adult	0	0	0	0	0	0	0	0	0
Ventilator, Pediatric	0	0	0	0	0	0	0	0	0
New York State Total	0	0	0	0	0	92	0	0	**92**

TABLE IV

Approved Projects by Facility Type
2022

TABLE IV (A)
Administrative Review Projects

Region	CHHA	DTC	HOSPICE	HOSPITAL	RHCF	TOTAL
Western	0	6	0	5	0	11
Finger Lakes	0	3	0	10	0	13
Central	0	1	0	5	1	7
NY-Penn	0	0	0	2	0	2
Northeastern	0	2	0	3	0	5
Hudson Valley	0	10	0	3	0	13
New York City	0	21	0	14	2	37
Long Island	0	9	0	11	0	20
New York State Total	0	52	0	53	3	**108**

TABLE IV (B)
Full Review Projects

Region	CHHA	DTC	HOSPICE	HOSPITAL	LHCSA	RHCF	TOTAL
Western	0	5	0	1	0	5	11
Finger Lakes	0	0	0	2	0	1	3
Central	0	8	1	3	0	1	13
NY-Penn	0	0	0	0	0	0	0
Northeastern	0	0	0	0	0	1	1
Hudson Valley	1	4	0	1	0	5	11
New York City	1	24	0	3	0	6	34
Long Island	0	2	1	2	0	4	9
New York State Total	2	43	2	12	0	23	**82**

TABLE IV (C)
Limited Review Projects

Region	DTC	HOSPITAL	RHCF	TOTAL
Western	2	5	1	8
Finger Lakes	2	13	3	18
Central	2	6	2	10
NY-Penn	0	3	0	3
Northeastern	1	15	1	17
Hudson Valley	5	10	1	16
New York City	6	66	2	74
Nassau-Suffolk	3	11	5	19
New York State Total	21	129	15	**165**

TABLE V

Public Health and Health Planning Council
Establishment Projects Reviewed by Facility Type
2022

	Current Year				2021	2020	2019
	Approval	Disapproval	Deferral	Total	Total	Total	Total
Facility Type							
Hospitals	0	0	0	0	2	2	3
Residential Health Care Facilities	21	0	1	22	0	1	15
Diagnostic and Treatment Centers	41	0	2	43	21	24	40
Certified Home Health Agencies	2	0	0	2	5	2	11
Hospices	0	0	0	0	0	0	1
Licensed Home Care Services Agency	0	0	0	0	0	2	18
New York State Total	64	0	3	67	28	31	88

C. Health Planning Committee

Members

John Rugge, M.D. MPP - Chair
John Bennett, Jr., M.D.
Howard Berliner
Jo Ivey Boufford, M.D.
Jeffrey Kraut
Scott LaRue
Harvey Lawrence
Roxanne Lewin, M.D.
Ann Monroe
Mario Ortiz, R.N., Ph.D., F.A.A.N.
Ellen Rautenberg (served until 5/31/2022)
Peter Robinson
Denise Soffel, Ph.D. (6/2022)

D. Public Health Committee

Members

Jo Ivey Boufford, M.D., Chair
Anderson Torres, Ph.D., Vice Chair
John Bennett, Jr., M.D.
Angel Gutiérrez, M.D.
Sabina Lim, M.D.
Ann Monroe
Mario Ortiz, R.N., Ph.D., F.A.A.N.
Ellen Rautenberg (served until 5/31/2022)
Denise Soffel, Ph.D. (6/2022)
Nilda Soto
Theodore Strange, M.D.
Kevin Watkins, M.D., M.P.H.
Patsy Yang, Dr.P.H.

Work Conducted in 2022

The Public Health Committee and the Health Planning Committee convened a joint meeting on March 1, 2022 to discuss how the Council, the Public Health Committee and the Health Planning Committee can begin to work together to advance their shared agenda. The joint meeting was developed with the assistance of the Office of Public Health Practice and the Commissioner's Office to put a marker down for future joint Public Health Committee and Health Planning Committee meetings.

The main focus of the meeting was on the topics of the Prevention Agenda, public health successes at the local level, Health Across All Policies and Healthy Aging, and the Office of Health Insurance Programs (OHIP) 1115 Waiver proposal, public health workforce, and maternal mortality. The committee's heard presentations from a panel of public health directors, commissioners from Onondaga, Otsego and Orange County on their work on COVID and on their work on the broader public health agenda during COVID. The Department of Health and the NYS Office of the Aging provided updates on the implementation for the Executive Order issued in 2018 on Health Across All Policies and Healthy Aging in the State. The State agencies that have been involved in the ealth Across All Policies structure and meetings have continued to be active throughout 2022. The committee's also heard presentations on the public health workforce, which largely focused on the Public Health Service Corps. There was an update on maternal mortality and the committee heard an update on the progress of the Governor's Commission on Maternal Mortality. The last topic on the agenda was OHIP providing an update on the 1115 waiver.

E. Committee on Health Personnel and Interprofessional Relations

Members

Hugh Thomas, Esq.	Thomas Holt
Angel Gutiérrez, M.D.	Mario Ortiz, R.N., Ph.D., F.A.A.N.

The Committee reviewed and decided on one health personnel cases in Executive Session.

Adopted

NYS Department of Health (DOH)

Public Health and Health Planning Council (PHHPC)

Deputy Commissioner Executive Report

I. OFFICE OF AGING & LONG TERM CARE (OALTC)

Executive Budget Update

- At the time of this writing, the Executive Budget negotiations are still ongoing. As I have indicated before, Governor Hochul's strong commitment to our aging population aligns with OALTC's vision and mission of helping aging and disabled New Yorkers live healthy, fulfilling lives with dignity and independence in the communities of their choice. The Governor's Executive budget includes initiatives that broaden access to aging services, improve quality and transparency in long-term care settings, provide funding for home care teams to serve low-income older adults in their communities, and providing respite care for caregivers. I will provide a detailed update to you in future PHHPC cycles once the budget is finalized and approved.

Safe Staffing

Nursing Home Direct Resident Spending Requirements (70/40 Spend)

- OALTC is working to finalize the compliance review process, including cross-functional components within DOH and specifically our partners within the Medicaid program, including Long-Term Care Reimbursement.

- We are happy to report that in late March, a total of $87.9 million was distributed to 419 nursing homes, as designated in the FY 2023 Enacted Budget. The remaining $5.6 million of the non-federal share will be distributed when the Department has received and assessed the required financial information from the 39 remaining nursing homes. The federal share will be distributed after CMS approval of the Medicaid State Plan Amendment. The $187 million was appropriated in last year's Enacted Budget to assist eligible nursing homes with staffing compliance.

- The Department will rely, in part, on the submission of the annual nursing home cost reports (RHCF 4) to determine compliance in 2022. Since the cost reports are due to DOH close to the end of July 2023, compliance reviews will begin when those cost reports are received and the data analyzed.

- We have also identified a tentative solution to address the concerns that were raised about hospital-based nursing homes and the fact that, in many instances, but not all, their annual cost reports do not align with the expense cost centers defined in the regulation. We have developed a survey to capture applicable revenue and expense data that will include a certification form and we engaged stakeholders prior to implementation. The survey and DAL (Dear Administrator Letter) were distributed to hospital-based nursing homes on April 11, 2023.

In addition, we would like to recognize and provide our appreciation for the input provided by our partner hospital associations.

Nursing Home Minimum Staffing Requirements (3.5 hours per resident per day (HPRD))

- DOH consulted with the Department of Labor (DOL) on the DOH Commissioner's Determination of an Acute Labor Supply Shortage for the 2022 quarterly review periods (Q2, Q3, Q4). The recommended determination has been advanced for agency review. Nursing homes will be notified when the determinations are publicly available.

- This month OALTC will be finalizing and circulating policies, procedures, forms and communications necessary to begin enforcement of minimum staffing compliance determinations. Training material has been finalized, with the plan to begin compliance assessments this month.

Master Plan for Aging (MPA)

- In February, we held our third meeting with the Master Plan for Aging Council, composed of the heads of state agencies (19 state agencies, 1 New York City agency, and 2 Governor's Office representatives) and their designees. As the membership of this group is evolving, additional agencies will undoubtedly be invited to participate. We also held our second meeting with the Stakeholder Advisory Committee (29 members), which is composed of private, not-for-profit and research sector leaders in aging and long- term care. To strengthen our path moving forward, we established Guiding Principles and Key Considerations, which will further guide the operations and substantive content of the Council and Committee work.

- We have also begun the process of socializing the work with the MPA Council and Stakeholder Advisory Committee, including building cohesion by: (1) soliciting input from state agency leads on the challenges their programs face in reaching and helping the aging population of New York; (2) selecting subcommittee topics to focus Master Plan deliberations with various subcommittee members, including asking for feedback from subcommittee members on identifying focus areas and corresponding issues; and (3) assembling a comprehensive reference guide on the aging and long term care landscape of programs and services for subcommittee members to reference when making recommendations for improvements in these service systems.

- Subcommittee meetings are scheduled to start in late April, and members of the subcommittees have been given written assignments to help frame their thoughts on the content of the Master Plan for Aging and to help guide meeting planning. Members continue to be added to the subcommittees, ensuring that the process is representative of the many different communities of the state, particularly along ethnic and geographic lines. Pursuant to the milestones in Executive Order 23, the subcommittees will prepare a preliminary report to the Governor in the beginning of July.

- Stakeholders and members of the public have had and will continue to have multiple opportunities to provide feedback and to engage in the development of the Master Plan for Aging. Those opportunities include participating in statewide stakeholder engagement sessions, which will include town halls, and other public forums, to ensure we have heard from as many New Yorkers as possible. To date, we have held informational webinars with various

stakeholders in the aging and disability communities, including local health departments (LHDs), Area Agencies on Aging (AAAs) and Regional Economic Development Councils (REDC) members. Additionally, a survey was sent to community providers and over 900 responses were received.

- We successfully launched a website for the Master Plan, which has been updated with recordings and minutes from the stakeholder committee and state agency council meetings. We will be building out the website with additional content as town halls are scheduled, the preliminary report is released, and survey results have been analyzed.

- We will continue to build and sustain our momentum through our subcommittees, public engagement at town halls across the state and presentations to a wide variety of stakeholder groups. We will also continue our work with the Public Health and Health Planning Council (PHHPC) to address the health and long-term care needs of aging New Yorkers.

PACE Reform

- As I have indicated previously, Governor Hochul chaptered into law the *Program of All-Inclusive Care for the Elderly* (PACE) reforms. The new law will streamline the regulation of PACE programs by developing a uniform authorization process, encompassing all program requirements into a singular license and survey which will improve oversight of PACE organizations. These changes will maintain the same level of oversight of all PACE programs that exist today across all program areas.

- The Department is in the process of drafting the new regulations associated with the new PACE law and expects to present these to PHHPC for information and discussion at the June PHHPC cycle.

Processing Licensed Home Care Service Agency (LHCSA) applications

- The Department is now accepting LHCSA applications after a two-year moratorium. At today's PHHPC meeting the first two LHCSA applications will be considered after the lifting of the moratorium.

- At the most recent Establishment and Project Review Committee (EPRC), PHHPC members asked the Department to consider workforce issues as a factor when reviewing new LHCSA applications. As a result, going forward all new LHCSA applicants will be asked to present their workforce strategy as part of the application process. OALTC will then report their workforce plans and strategies as part of the PHHPC project summaries for consideration on whether to approve an application.

- At the same EPRC meeting, the Department was asked to provide an overview of the status of LHCSA surveillance, which we will be reporting on for the next meeting.

II. OFFICE OF HEALTH EQUITY AND HUMAN RIGHTS (OHEHR)

Advisory Bodies: Implementation Update

The Office of Health Equity and Human Rights will oversee three advisory bodies:

1. Internal NYSDOH Health Equity and Diversity Equity and Inclusion (DEI) Advisory Committee (launched)
2. Community Stakeholder Council on Health Equity and Human Rights (launched)
3. Inter-Agency Health Equity and Diversity, Equity and Inclusion Committee (launch end of April)

- Internal NYSDOH Health Equity and DEI Advisory Committee
  - Purpose is to convene Department staff across all disciplines to identify how best to advance efforts addressing health equity as well as efforts to improve diversity, equity, and inclusion within the Department, consisting of employees from across all offices, bureaus and divisions.
  - Meeting Frequency: Monthly
  - Goals:
    - Partner DOH programmatic areas, and senior leadership, to ensure that organizational culture, practice, and leadership development are clearly reflected in the Department's vision for health equity and diversity, equity, and inclusion.
    - Improve health equity, reduce health disparities, and better support marginalized and underserved communities by providing a structured, focused, small group structure to provide recommendations to the Department.
- Community Stakeholder Council on Health Equity and Human Rights
  - Purpose is to create a forum where the Department and community stakeholders can share and discuss recommendations on how to advance health equity and human rights across New York State. Stakeholders participating in this Community Stakeholder Council informs the work of the Department through recommendations to advance health equity, uplift human rights, and better support marginalized and underserved communities. The committee consists of organizations from the community that can provide valuable insight into issues on the ground and help the Department identify ways to advance health equity and human rights across the state.
  - Meeting Frequency: 3x/year
  - Goals:
    - Create a structured, focused space and structure where community stakeholders can discuss ways to improve health equity, reduce health disparities, and better support marginalized and underserved communities and offer recommendations to the Department on work related to health equity and human rights.
    - Ensure that community voices are directly included and accurately represented in conversations in health equity and human rights
    - Increase the community's knowledge and awareness of the Department's efforts related to health equity and human rights.

- Inter-Agency Health Equity and Diversity, Equity and Inclusion Committee
  - Purpose: convene New York State leadership across all disciplines to identify how best to advance efforts addressing health equity as well as efforts to improve diversity, equity, and inclusion. It is projected to start in quarter one of 2023 and will convene multiple State executive agencies and offices. The intent is that the committee will have at least one representative from agency/office that are responsible for advancing efforts in the areas of equity, diversity, equity, and inclusion , and/or human rights.
  - Meeting Frequency: 3-4 times/year
  - Goals:
    - Foster inter-agency collaboration at the State level
    - Provide key updates
    - Create a space for shared learning

Congenital Syphilis Elimination Strategic Planning Group

- As a strategy to stem increases of congenital syphilis and support equitable access and care to potentially eliminate congenital syphilis, the AIDS Institute in the Office of Health Equity and Human Rights is convening a Congenital Syphilis Elimination Strategic Planning Group with external partners.

- The Congenital Syphilis Elimination Strategic Planning Group initially convened on March 31st with 51 members across New York State who responded to a widespread "Call for Membership" letter sent by the AIDS Institute director. Providers, community-based organizations, persons impacted by congenital syphilis, and the general community were all encouraged to join the committee. The overall goal is to collaboratively develop a comprehensive Congenital Syphilis Elimination Framework and Action Plan through a health equity lens. The next meeting is scheduled for May, 2023.

- Members will serve on one of seven subcommittees with the following anticipated areas of focus:
  - Prevention
  - Education
  - Community-Based Programming
  - Surveillance and Research
  - Medical Care and Treatment
  - Policy and Planning
  - Marketing and Advocacy.

- The newly appointed Commissioner was the keynote speaker at the Department's Congenital Syphilis Elimination Strategic Planning Group Orientation Meeting on March 31st, 2023.

Community COVID-19 Vaccination Sites:

- To enhance vaccine efforts in response to the COVID-19 pandemic, the New York State Department of Health worked towards the goal of vaccinating all New Yorkers against COVID-19.

- Previously, the only State-operated source of COVID-19 vaccinations were State-run Mass Vaccination Site but there were still areas of need.

- Marci McCall and a dedicated team of DOH staff developed a pop-up vaccination site program to further target communities of need.

- The goals of the pop-up vaccination program:
    - Provided increased access to the vaccine in communities that may otherwise have limited access due to socioeconomic factors
    - Expanded outreach to encourage vaccinations in communities that have higher rates of skepticism towards the vaccine

- The Department utilized the Social Vulnerability Index at the zip code level to determine areas of vaccine need.

- The Department's team provide technical assistance and troubleshooting.

- There were over 1,700 pop-up vaccination sites and over 162,000 shots administered across the ten regions of the state.

- Although the pop-ups are ending, the relationships built remain and further community trust has been established. The intention is to remain involved with the communities to maintain those relationships.
    - Especially helpful working with the LHDs and Federally Qualified Health Centers (FQHCs) across the state, as well as faith-based and community-based organizations.

- The team is still working on final evaluations of the programs to develop new trainings and document lessons learned from the work of the points of dispensing (pods) in smaller communities across the state.

- Community vaccination sites have ended as of March 31st, 2023.

Runaway and Homeless Youth Legislation:

- The New York State Legislature recently passed new provisions of section 2504 of the Public Health Law, expanding minor consent for medical treatment to runaway and homeless youth. This means that those who are homeless or receiving services from a runaway and homeless youth program under the age of 18 can legally consent to all medical and dental care.

- The Governor signed the legislation into law December 23, 2022.

- The Office of Health Equity and Human Rights has been working with the Division of Legal Affairs and Office of Public Health in the Department of Health, as well as our colleagues in the New York State Office of Children and Family Services (OCFS), and in partnership with advocates and runaway and homeless youth programs to develop guidance for both medical providers and runaway and homeless youth programs across the state. DOH and OCFS have developed a Dear Provider Letter, guidance for youth, and an FAQ that will be shared with providers and programs.

- The law took effect on March 23rd, 2023, with guidance to follow.

MPOX Dear Colleague Letter

- The AIDS Institute prepared and distributed a Dear Colleague Letter on MPOX to providers on March 23rd, 2023, introducing a robust sexual health communication and engagement plan to promote vaccine uptake in hard-to-reach communities and individuals.

- Currently, there is not a concern regarding vaccine availability and the Department recommends the subcutaneous route of administration with 0.5ml injection volume.

- MPOX has been added to the regulated list of Sexually Transmitted Infections (STIs) to ensure adolescents under 18 can access MPOX related services without parental consent.

Health Equity Impact Assessment

- The Office of Health Equity and Human Rights is overseeing the implementation of the Health Equity Impact Assessment requirement tied to the state's Certificate of Need (CON) process, which will go into effect June 22, 2023.

- Background: State legislation was passed requiring the inclusion of a Health Equity Impact Assessment for Article 28 health care facilities submitting a Certificate of Need application to the Department for proposed facilities projects. The intent is for the Health Equity Impact Assessment to be a demonstration of how a facility's proposed projects impacts the accessibility and delivery of services. The purpose is to understand the health equity impacts of a facility's proposed project, with a particular focus on impacts to medically underserved groups.

- The proposed regulation will be presented to the Public Health and Health Planning Council for information, with the request for the Department to publish the proposed regulation in the Central Register for a 60-day comment period before the law goes into effect. The proposed regulation is aimed to provide guidance on the Health Equity Impact Assessment requirement starting June 22, 2023.

- The Office of Health Equity and Human Rights, in close collaboration with the Office of Primary Care and Health Systems Management and the Division of Legal Affairs, has been regularly meeting with hospital associations, nursing home associations, and consumer advocates.

- Additional guidance documents are being developed by the Department.

- We welcome public comment on the proposed regulation, which will help inform the language of the final regulation and supporting documents, all of which will be brought back to the Public Health and Health Planning Council later this summer.

Racial Equity Working Group: Implementation Update

- OHEHR convened the first meeting of the Racial Equity Working Group on March 3, 2023.
    - Background: State Bill A.5679-A/S.2987-A (Darling/Parker) declared that racism is a public health crisis in NYS, and established the Racial Equity Working Group within DOH which is charged with studying racism's impact on public health and making recommendations for legislative or other actions to reduce or eliminate racial and ethnic disparities.

- Since the launch, the Racial Equity Working Group has convened several times to "set up" the group by going over governance (aka by-laws) and related logistics.

- The Racial Equity Working Group is in the process of identifying the preliminary areas of focus to address per the legislation. Once these have been confirmed, subcommittees may be created to further address those areas of focus.

III. OFFICE OF PRIMARY CARE AND HEALTH SYSTEMS MANAGEMENT

Executive Budget Update

- Executive Budget negotiations are ongoing. We have several initiatives we are hoping to see supported related to the workforce challenges we are all facing.

Center for Health Care Policy & Resource

- The Doctors Across New York (DANY) Physician program received 162 applications. Contracts are expected to begin July 1st, 2023.

- Nurses Across New York (NANY) – applications were accepted through Wednesday, April 12th. New contracts are expected to begin on August 1st, 2023.

- DOH released a Solicitation of Interest titled "**Increasing Training Capacity in Statewide Healthcare Facilities**." The total available funding is $22,500,000. Awards will provide up to $1,000,000 per year for two years to eligible healthcare facilities and the two year contract period is anticipated to begin October 1st 2023. DOH received 144 questions and will be releasing the answers on or about 4/12/23. The questions, for the most part, seek further guidance with regards to what types of training and titles are eligible and the specific use of funds. The Application due date is May 3rd, 2023.The opportunity can be found at the following link: https://www.health.ny.gov/funding/soi/20298/docs/soi.pdfopportunity Eligible organizations are:

- A General Hospital certified or licensed under Article 28 of the Public Health Law (PHL); OR
- Diagnostic and Treatment Centers (D&TCs) certified or licensed under Article 28 of the Public Health Law (PHL); OR
- Residential Health Care Facility (Nursing Home) certified or licensed under Article 28 of PHL

Bureau of Narcotic Enforcement (BNE)

- On February 24, 2023, the Drug Enforcement Administration (DEA) proposed permanent rules for the prescribing of controlled substance medications via telemedicine beyond the scheduled end of the COVID-19 public health emergency on May 11, 2023. The public was able to comment for 30 days on the proposed rules.

- The proposed rules would allow a medical practitioner that has never conducted an in-person evaluation of a patient to prescribe a 30-day supply of Schedule III-V non-narcotic controlled medications or a 30-day supply of buprenorphine for the treatment of opioid use disorder without an in-person evaluation or referral from a medical practitioner that has conducted an in-person evaluation, as long as the prescription is otherwise consistent with any applicable Federal and State laws. No refills may be issued on the prescription.

- Patients will be required to attend at least one in-person consultation to obtain prescriptions of Schedule II controlled medications such as many opioid pain medications (e.g., hydrocodone, oxycodone) and stimulants (e.g., Adderall) to treat attention deficit disorder.

- In addition, the DEA has proposed to add a definition of the term "telemedicine relationship established during the COVID-19 public health emergency." Such a relationship would exist if the practitioner has not conducted an in-person medical evaluation of the patient and has prescribed one or more controlled medications based on telemedicine encounters during the federal COVID-19 public health emergency. In this situation, a six-month transition period of doctor-patient relationships based on telehealth prescribing flexibilities would be allowed.

- The New York State Department of Health is pursuing pathways to align with DEA telemedicine rules when finalized.

Bureau of Emergency Management Services (BEMS)

- The rural EMS task force met for the first time on February 28th, 2023 The members discussed the problems facing their own agencies, the rural EMS community, as well as the system as a whole. Four subcommittees were created -
  - Systems
  - Standards
  - Funding
  - Staffing

- Each subcommittee will explore their topic and will also collaborate on why those challenges exist and methods to address them.

- The Department regrets to inform PHHPC that Dr. Patricia ("Trish") O'Neill, the Vice Chair of the STAC, passed away as the result of an MVA on Long Island on Feb. 17th. Dr. O'Neill was the Vice Chair of Surgery and Chief of the division of trauma and Acute Care Surgery at One Brooklyn Health.

Health Care Transformation

- $658 million in Statewide Health Care Transformation III awards were announced in February and we are working to finalize contracts as quickly as possible.

Center for Provider Services and Oversight

Safe Nurse Staffing

- The safe nurse staffing law regulations were published in the state register for public comment on March 1st. The 60 day comment period ends on May 1st. Once comments are received and reviewed a determination will be made on whether reviews will be necessary.

PHHPC

- **Membership**
    - There are 25 seats on the council. At present there are four vacant seats. We are, at present, advancing four applicants for the Governor's consideration.
- **Planning Committee**
    - As you are aware from the last PHHPC council the Planning committee met on the day prior to that meeting. Since that time there has been several planning discussions for the next meeting. The speakers and the members were able to identify multiple areas that had potential to impact in a positive way the situation in Emergency Departments that would reduce the delays affecting EMS crews.

    - The next step is a workgroup video call prior to the June PHHPC meeting. Topics for the workgroup and presentations will relate to dental care and mental health care in the emergency department (ED) and alternatives. We are working closely with the Office of Dental Directors in the Office of Health Insurance Programs (OHIP), the Center for Community Health within the Office of Public Health and our colleagues at the Office of Mental Health (OMH).

IV. OFFICE OF PUBLIC HEALTH

Executive Budget Update

- The FY 2024 Executive Budget included many proposals aimed at improving the public health of New Yorkers. Some of the proposals included would increase access to safe abortions, expand Medicaid doula coverage, implement a registry of residential dwellings to help track and remediate lead-based paint hazards, and ban flavored tobacco products to safeguard young people and those who have been addicted to flavored products at alarmingly high rates. The Executive Budget also proposed an increase to the tobacco tax, acknowledging that tobacco use remains the leading cause of preventable death in New York and the United States. The Office of Public Health plans to establish a new Division of Vaccine Excellence, with a focus on improving immunization rates in the State and increasing awareness of the importance of childhood vaccines, in particular. Budget negotiations are ongoing, and the Office of Public Health looks forward to an enacted state budget that addresses public health concerns and improves the Office of Public Health's capacity to improve health outcomes for all New Yorkers.

Center for Community Health:

New Director for the Center for Community Health (CCH)

- Travis O'Donnell was appointed to the position of Director of CCH beginning March 16, 2023. In this position Travis leads four large, complex Divisions that have broad programmatic, policy and fiscal portfolios that are critical to NYSDOH achieving its overarching mission of improving the health, productivity and well-being of all New Yorkers. The four Divisions are: Chronic Disease Prevention, Family Health, Epidemiology, and Nutrition.

Advancing Health Equity and Racial Justice in the Division of Chronic Disease Prevention (DCDP)

- **Request for Applications (RFAs):** The Division of Chronic Disease Prevention (DCDP) has incorporated racial justice and health equity in its Request For Applications (RFAs) to fund: services for Breast Cancer Survivors Who are Black; Breastfeeding, Chestfeeding, and Lactation Friendly Services (BFF-NY); Peer Education, Outreach, and Shared Decision Making for Persons at High Risk for Prostate Cancer; Breast, Cervical and Colorectal Cancer Services Screening Program (CSP).

- **Protecting Youth and People of Color through DCDP's Bureau of Tobacco Control**: The DCDP Bureau of Tobacco Control is working in support of the Governor's proposed Tobacco Control Measures announced as part of the State of the State Address this year. An excerpt from *Lead the Way for a Tobacco-Free Generation* section of the State of the State Book reads:

  Solidifying New York's leadership in ensuring a tobacco-free generation, Governor Hochul will introduce legislation to expand upon the State's ban on the sale of flavored vaping products by prohibiting the sale of all flavored tobacco products. In addition, Governor Hochul will propose to increase the cigarette tax from $4.35 to $5.35 per pack.

  NYS continues to be a national leader by proposing to prohibit the sale of menthol cigarettes and flavored tobacco products and has the strongest cigarette tax in the nation.

Ensuring Access to Abortion Services in the State

- The Division of Family Health (DFH) has successfully awarded a total of $24.1M to support access to abortion services through the Expanding Safe and Supportive Medical and Procedural Abortion Access (ESSMAA) Program. The remaining dollars are in the process of being awarded.

Improving the State's Maternal Mortality Rates

- The Maternal Mortality Review Board (MMRB) examines information related to pregnancy-associated deaths and to issue findings and recommendations to advance the prevention of maternal mortality. The Board's multidisciplinary members volunteer to review maternal deaths and develop recommendations to improve maternal outcomes to present future deaths.

- New York State Maternal Mortality & Morbidity Advisory Council (MMMAC): The MMMAC reviews the findings and reports from the MMRB to identify the associated social determinants and environmental issues known to impact maternal health outcomes. The MMMAC includes both professionals and community members. The MMMAC has been meeting to develop their own recommendations on how to prevent maternal mortality and morbidity in NYS.

- New York State Perinatal Quality Collaborative (NYSPQC) Project is a set of projects focused on providing the best and safest care for women and infants in New York State by collaborating with birthing hospitals, perinatal care providers and other key stakeholders to prevent and minimize harm.

- Perinatal and Infant Community Health Collaborative (PICHC): This initiative supports the development, implementation, and coordination of collaborative community-based strategies to improve perinatal health outcomes and eliminate racial, ethnic, and economic disparities in those outcomes. A total of $68M, ($13.6M annually) is available to support the PICHC program for a five-year period from 7/1/22 – 6/30/27. There are 26 programs across the state.

Infectious Diseases Update

- Invasive Group A Streptococcal Infection (iGAS): In December 2022, the Centers for Disease Control and Prevention (CDC) issued a Health Advisory to notify clinicians and public health authorities of an increase in pediatric iGAS infections in several states. At that time, an increase in iGAS was not observed in New York State (NYS). However, recent surveillance data in NYS, including New York City, demonstrate an increase in iGAS infections during 2023 primarily among persons aged 65 and older, though small increases have been seen in children. Statewide, including NYC, there have been over 450 cases of iGAS infections reported during the first three months of 2023. Individual reports from NYC and NYS providers have indicated severe outcomes of iGAS including necrotizing fasciitis, streptococcal toxic shock syndrome, and death.

- ***Candida auris*** **(C. auris):** As of March 21, 2023, public health surveillance has identified 1,454 persons with clinical infection and 1870 persons colonized with *C. auris*.

Elevating the Bureau of Immunization to a Division

- The Division of Epidemiology and the Office of Public Health have reorganized the Immunization Bureau elevating it to a division. This change will accommodate the State's growing vaccine needs.

Increasing Participation in the Women Infant and Children (WIC) Program

- **Meet Wanda, the WIC Chatbot:**

  The NYS WIC Program launched Wanda, the WIC Chatbot, in April 2021. Wanda is an interactive electronic program that was developed to enable families to learn about WIC and to assess their eligibility to participate using an electronic device. Since launching Wanda, more than 13,000 users have completed the chatbot experience with more than 11,000 referrals sent to WIC local agencies. You can find Wanda on the NYSDOH website under WIC.

  https://www.health.ny.gov/prevention/nutrition/wic/

Center for Environmental Health:

- The Center for Environmental Health (CEH) is advancing several initiatives involving legislative or regulatory changes that will better safeguard NYS's drinking water from contaminants and prevent children from being exposed to lead paint hazards in their homes. CEH is also administering important new federal funding via the Bipartisan Infrastructure Law that targets the removal of Lead Service Lines, the removal of emerging contaminants from drinking water, and the upgrading of aging and inadequate water supply infrastructure. After Public Health Law 1112 was revised in December 2022 to require the Department to regulate additional per- and polyfluorinated compounds (PFAS), CEH hosted two meetings with the New York State Drinking Water Quality Council, which provided recommendations that guided the Department to propose revisions to Part 5 Drinking Water Regulations in fall 2022. More than 1,500 comments were submitted and the Department is evaluating these in conjunction with the United States Environmental Protection Agency's proposed National Drinking Water regulations for several PFAS compounds that were posted to the Federal Register in March 2023. Other revisions to Public Health Law also lowered the action level for lead in school drinking water from 15 parts per billion (ppb) to 5 ppb and increased the frequency of lead testing from every 5 years to every 3 years (effective in January 2023). The Department has been working with partners in the State Education Department to operationalize these changes and the New York State Department of Environmental Conservation, which administers the Clean Water Infrastructure Act funds that were identified as the funding source for schools to remediate their lead-containing water infrastructure. Lastly, the federal Bipartisan Infrastructure Law provided New York State with significant additional funding for water infrastructure projects, enhancing the existing Drinking Water State Revolving Loan Fund and including funding for two new programs: Lead Service Line Replacement and Emerging Contaminants. In 2022, the Department published Draft Intended Use Plans for all three of these Bipartisan Infrastructure Law programs, incorporating the requirements to prioritize Disadvantaged Communities, and will be administering the funds in coordination with the New York State Environmental Facilities Corporation.

Prevention Agenda Update:

- Planning for the 2025 – 2030 NYS Prevention Agenda is now in full-swing. As previously reported, the planning process had a soft kickoff at the February 8, 2023, Public Health Committee (PHC) meeting where committee members were briefed on the current Prevention Agenda cycle, given a progress update on key indicators, and the planning process was proposed. Following the PHC meeting, NYSDOH convened an internal steering committee to orient key leaders and stakeholders across the Department to the state health improvement plan and formulate first-draft thoughts on the current priorities, and whether they still served the needs of New Yorkers. Two initial workgroups were formed to look at the current structure of priorities within the Prevention Agenda, and to explore options for evaluating the utility of the Prevention Agenda as an effective framework to advance the state's public health goals.

- On April 3, 2023, the Ad Hoc Committee to Support the NYS Prevention Agenda was reconvened as a next step in the planning process by bringing together stakeholders from across New York. The convening of the committee was the culmination of several months of organization and recruitment of over 100 diverse stakeholders from state agencies, advocacy groups and academia, among others. The Ad Hoc Committee meeting was held in Albany, NYC and Buffalo and virtually on Zoom. Multiple recurring themes emerged during the committee meeting, such as suggestions to revisit existing priorities; establish clearer priorities around social determinants of health and health equity, including poverty and housing; other priorities include healthy aging, and data access and sharing. The Ad Hoc Committee will continue to meet quarterly, with the next meeting tentatively planned for this summer. The discussion from the initial meeting is being reviewed, and highlights will be distributed to the internal steering committee and workgroups to be used in their work and in establishing additional workgroups as needed.

Wadsworth Center:

Division of Infections Disease:

- The spread of drug-resistant Trichophyton indotineae, a novel dermatophyte species that causes significant morbidity in Asia, Europe, and Canada, is a concern. Recently, a collaboration between Wadsworth Center Mycology Laboratory, a NYC hospital and Centers for Disease Control and Prevention has confirmed the emergence of T. indotineae in the United States, particularly in New York City. The findings of this study will soon be published in the Morbidity and Mortality Weekly Report. Public health surveillance efforts and increased testing could help detect and monitor the spread of T. indotineae. The Wadsworth Center Mycology Laboratory is well-equipped to undertake surveillance efforts for NY.

- The Diagnostic Immunology Laboratory has developed a novel test to detect antibodies to Orthopoxvirus (the virus genus that includes smallpox and mpox). Antibody detection is useful for surveillance of disease prevalence and can also complement other tests, to aid in diagnoses. While smallpox has been eradicated due to a successful vaccination program, that very vaccination program promoted antibodies that react with both smallpox and mpox. What this means is that people who have had a childhood smallpox vaccine (e.g., most people who are

over 50 years old) have antibodies. Also, the same type of vaccine used to protect people from smallpox was deployed during the mpox outbreak of 2022, so those people also have antibodies. What makes the Diagnostic Immunology Laboratory test unique is that it can detect antibodies that were elicited by actual mpox infection and not be influenced by prior vaccination. For surveillance and diagnoses purposes, this is impactful because true infections are identified, whereas other mpox antibody tests cannot tell if the antibodies were caused by infection or vaccination. Funding has been provided by a CDC ELC grant, and the test is in the Wadsworth Center catalogue and available for order now.

- The Diagnostic Immunology Laboratory will be adding Chagas serology testing into the Wadsworth testing catalogue. Chagas Disease is caused by a parasite, Trypanosoma cruzi, which is transmitted through an insect bite. While Chagas disease is not endemic to NYS, a fair number of cases are present in NYS due to travel, immigration, or even transplantation with infected organs. Serology (measurement of antibodies to Trypanosoma cruzi) aids in diagnoses. Chagas serology testing requires the use of two independent antibody tests. Commercial laboratories may use one test, but currently the only facility that uses two tests, and thus fully confirms Chagas disease by serology, is the Centers for Disease Control (CDC). With permission from the CDC, the Wadsworth Center Diagnostic Immunology Laboratory has verified two FDA-approved antibody tests that can be used together to confirm the presence of antibodies to Trypanosoma cruzi. Implementation of Chagas Disease serology will be impactful to NYS by providing an alternative for testing and easing the testing burden of CDC. Chagas testing at Wadsworth may also have some benefit to other states, in the event that CDC is not able to perform their testing or reaches capacity. The lab expects to be ready for full capacity testing in 2-3 weeks.

Division of Genetics:

- First baby treated for cerebral adrenoleukodystrophy (CALD) using a Food and Drug Administration approved gene therapy. This baby was detected by the NYS NBSP with possible disease in March of 2017 and received the gene therapy on March 17, 2023.

- On December 30, 2013, New York became the first state in the country to screen newborns for adrenoleukodystrophy (ALD). ALD is an X-linked disease affecting about 1:17,000 people. The cerebral form of disease (CALD) is the most severe form with symptoms presenting in boys generally between 4 and 7 years of age. Boys that develop CALD disease and are not treated generally will die within a year or two of the symptoms. Newborn screening is necessary to detect boys with ALD in the absence of a family history or other screening. On March 3, 2017, the Newborn Screening Program detected very elevated C26:0-lysophosphatidylcholine (C26:0-LPC) in a dried blood spot sample taken from Connor Hess. C26:0-LPC is the marker used to screen babies for ALD. Ever since Connor was referred for ALD his family worked with physicians to ensure he was monitored for the earliest signs of CALD. This is done by using magnetic resonance imaging (MRI) to detect active brain lesions that are indicative of CALD. Not all boys that screen positive for ALD will develop the cerebral form, but when active lesions are detected early enough, the boy can receive a stem cell transplant to treat the disease prior to the onset of the irreversible damage to myelin that occurs in the brain without early detection. Unfortunately, Connor had MRI imaging that showed his brain had developed active lesions.

Connor wasn't the first boy detected by the Newborn Screening Program to develop CALD, however he was the first to receive Food and Drug Administration approved gene therapy using Skysona, which is one of six gene therapies cleared since 2017. The story of Connor was recently reported in the Boston Globe if you would like to read more on this historic event. (https://www.bostonglobe.com/2023/04/01/business/young-boys-nightmare-diagnosis-3-million-one-time-treatment-that-will-likely-save-his-life/).

- First newborn detected through Newborn Screening with mucopolysaccharidosis type I (MPS I)

- Newborn screening for Mucopolysaccharidosis Type I (MPS I) began in NYS on October 1, 2018.

- Now, after nearly 1 million babies screened, the program detected its first case of severe MPS I on March 23, 2023. The Newborn Screening Program is uncertain why more cases of MPS I haven't been detected since the incidence is reported to be 1 in 100,000 individuals. MPS I is an autosomal recessive inherited lysosomal disorder and patients present with a spectrum of severity. Most patients are affected with severe MPS I and will develop symptoms in the first year of life. Early symptoms may include umbilical or inguinal hernias, and/or frequent respiratory tract infections. Later manifestations are more severe affecting the skeletal system, heart, growth rate, and intellectual ability. Without treatment, death usually occurs within the first ten years of life. A cord blood transplant is required to prevent the onset of symptoms. Like all other disorders on the newborn screening panel, early detection is necessary to prevent irreversible damage to organ systems.

Division of Environmental Health Sciences:

- NIH Human Health and Exposure Analysis Resource (HHEAR) at Wadsworth

- The Division of Environmental Health Sciences (DEHS) submitted a continuing application for $1.4 million to support year 5 of the Wadsworth HHEAR lab. This resource has been continually funded by NIH since 2015 to support targeted analyses for environmental contaminants in biospecimens collected by NIH-funded investigators, where an environmental aspect has been identified meriting these types of analyses. The HHEAR team at Wadsworth maintains expertise for measurements of organic and inorganic contaminants in blood, urine and tissues. The funding supports a development core charged with developing new assays.

- The funding supports a total of eight staff across two laboratory units in DEHS.

State of New York
Public Health and Health Planning Council

Minutes
December 8, 2022

The meeting of the Public Health and Health Planning Council was held on Thursday, December 8, 2022 at the Empire State Plaza, Concourse Level, Meeting Room 6, Albany, New York, and 90 Church Street, 4th Floor CR 4 A/B, NYC. Jeffrey Kraut, Chair presided.

COUNCIL MEMBERS PRESENT

Dr. John Bennett - Albany	Dr. John Rugge – Albany
Dr. Howard Berliner – NYC	Dr. Denise Soffel - NYC
Dr. Jo Boufford - NYC	Ms. Nilda Soto – NYC
Dr. Angel Gutiérrez – Albany	Dr. Theodore Strange - NYC
Mr. Thomas Holt – NYC	Mr. Hugh Thomas – NYC
Dr. Gary Kalkut – NYC	Dr. Anderson Torres - NYC
Mr. Jeffrey Kraut - NYC	Dr. Kevin Watkins – Albany
Mr. Scott LaRue – NYC	Commissioner Bassett Ex-Officio - Albany
Mr. Harvey Lawrence - NYC	
Dr. Sabina Lim – NYC	
Ms. Ann Monroe – Albany	

DEPARTMENT OF HEALTH STAFF PRESENT

Dr. Ursula Bauer - Albany
Ms. Valerie Deetz - Albany
Mr. Kenneth Evans - Albany
Mr. Mark Furnish – Albany
Ms. Shelly Glock – Albany
Mr. Michael Heeran – Albany
Mr. Adam Herbst – NYC
Dr. Eugene Heslin - Albany
Mr. Jonathan Karmel - Albany
Ms. Colleen Leonard- NYC
Mr. George Macko – Albany
Ms. Kathy Marks – NYC
Dr. James McDonald - Albany
Dr. John Morley - Albany
Ms. Johanne Morne - Albany
Mr. Travis O'Donnell - Albany
Mr. Jason Riegert - Albany
Mr. William Sacks - Albany
Ms. Jaclyn Sheltry - Albany
Mr. Michael Stelluti - NYC
Ms. Jennifer Treacy - Albany
Ms. Christine Wheeler - Albany

INTRODUCTION

Mr. Kraut called the meeting to order and welcomed Council members, Commissioner Bassett, meeting participants and observers.

APPROVAL OF THE MEETING MINUTES OF OCTOBER 6, 2022

Mr. Kraut asked for a motion to approve the October 6, 2022 Minutes of the Public Health and Health Planning Council meeting. Dr. Berliner motioned for approval. Dr. Torres seconded the motion. The minutes were unanimously adopted. Please refer to page 2 of the attached transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Mr. Kraut introduced Dr. Bassett to give the Report on the Activities of the Department.

Dr. Bassett began her report by recognizing the importance of this committee. The fact that the ddpartment can rely on the external expertise of this body is crucial to the work that we do. She thanked all of the members for their commitment and acknowledged the hard work that they do on a voluntary basis. She noted that when she assumed leadership of the Department of Health about a year ago we were in the midst of a surge in COVID cases due to the Omicron variant. Hospitalizations topped 11,000 statewide for the first time since the early months of the COVID crisis. This crisis consumed her first month as Health Commissioner, but little did she know that we would be facing multiple imminent threats in 2022 with MPox and the polio outbreaks. Moving into Winter, New York was dealing with the triple threat of flu, which we have a really marked increase in the number of flu cases and hospitalizations, respiratory syncytial virus and COVID. It has been, without a doubt, a challenging year for public health. As I always say to members of the Department and anyone who wants to talk about public health, we didn't go into this field because it's easy. In the midst of these ongoing crises, we managed to get a lot done. Looking back on this year, there's a lot to be proud of. We launched a rebuild of the health department, the purpose of which is not just to move towards a more efficient, sustainable way of working, but to increase and improve the staff morale. The Department of Health is and must remain a great place to work. I'm also very proud of our launch this Summer of two new offices, the Office of Health Equity and Human Rights. You can all see Joanne Morne on the screen and the Office of Aging and Long Term Care. The Office of Health Equity and Human Rights places equity at the core of everything that we do. This office supports all of Department and setting and implementing an overarching vision and framework of diversity, equity and inclusion. Its ultimate goal is to reduce statewide health disparities, and in particular, the enduring racial ethnic disparities, but all of the disparities that are unjust and preventable. The OALTC, that's the Office of Aging and Long-Term Care, was created in recognition of our aging population and the specific needs of elderly New Yorkers, whether they choose to age in their homes or require long term care facilities. It's also helping to implement the State Master Plan on Aging, which will lay the foundation for changing the landscape of aging and long term care in our state. We have strengthened our relationships with local health departments, recognizing their expertise and the critical role that they play in managing crises and delivering prevention services to all New Yorkers. I felt particularly fortunate to travel throughout the state to see our local health departments in action, noting their challenges and the creative ways in which they are addressing them. Each local health department faces its own budget constraints, health issues, staffing needs, but they are all united in the need to provide preventative care and make New Yorkers safer and healthier. Having worked in public health for nearly forty years, I believe that there is no reward greater than the work that we do every day. Judging from your

commitment, I suspect that all of the members agree with me. I know that our work is never done. Equity is the North Star of what we do. We must keep it at the center of our work. If the last year has taught us anything, it's that another public health crisis may be lurking around the next corner. We can't let the crisis of the moment interrupt our vision for making New York a safer and healthier place to live.

Dr. Bassett concluded her report. To review the complete report and members questions and comments please see pages 2 through 4 of the transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Report on the Activities of the Office of Health Equity and Human Rights

Mr. Kraut introduced Ms. Morne to give the Report on the Activities of the Office of Health Equity and Human Rights.

Ms. Morne introduced herself as the Deputy Commissioner for the Office of Health Equity and Human Rights. She acknowledged the many accomplishments that Dr. Bassett was able to lead us through over the last year, the department's reorganization creating this office has definitely stood out and been a part of the legacy that will be left for us to continue.

Ms. Morne talked about some of the key activities that have happened within the office since the last time that we met. She acknowledged the work of the State Department of Health AIDS Institute and the recent hosting of the 2022 Ending the Epidemic Summit, as well as the World AIDS Day event. Recognizing World AIDS Day as a day for us to remember those who have passed and those certainly who continue to do the essential work as we move forward in ending the epidemic. The gathering was a virtual one. It was titled Collaborating for Change Partnering for Health Equity. We had attendance of over 1,800 registered participants and the opportunity to discuss both evidence based and grassroots actions that have been taken to reduce disparities related to HIV diagnosis, treatment and health related outcomes. As background related to data, and this data is from 2021, I asked that we take into consideration the impact of COVID, but I also think it's important to understand where we are in New York State as it relates to HIV. In 2021, there were over 2,000 individuals, just over 2,000 individuals that were newly diagnosed with HIV. This is a 30% decrease since the state initiated ending the epidemic in 2015. At that time, you may recall that a three point plan with the intention of achieving the first ever decrease in HIV prevalence in New York State was accepted and put into motion. In 2019, New York State did achieve the ability or did achieve the goal of achieving HIV prevalence in which we saw that the number of deaths of individuals was less than the number of individuals who were newly diagnosed. In spite of that achievement, we still recognize that we have significant areas for us to focus on in our progress to ending the epidemic in New York State, specifically as it relates to disparities, ongoing disparities, particularly within communities of color.

Ms. Morne acknowledged that New York State continues to have the highest percent of pre-exposure prophylaxis coverage in the nation, with more people receiving prescriptions than in any other jurisdiction. In 2021, there were more than 44,000 New Yorkers who filled at least one prescription for pre-exposure prophylaxis, which is thirteen times more than the number of

prescriptions that were filled in 2014. Going back to the point of disparities, we continue to see persistent challenges as it relates to unequal access related to care, social determinants of health as well as stigma. Hispanic and non-Hispanic Black populations account for 34% of the state population, yet 74% of new HIV diagnoses are among the same individuals. Racial disparities have accounted for over 50,000 new HIV diagnoses in the state in the past decades. From 2020 to 2021, the percentage of people living with HIV who received medical care also increased to 88%, which is certainly a success. We continue to do work with our partners to ensure that individuals who are newly diagnosed are linked to and engage in care within thirty days of a diagnosis. Critical first step to achieving viral suppression for an individual. We continue to move forward in our efforts of ending the epidemic. You may recall that the original goal of ending the epidemic was by the end of 2020. As I stated, we achieved the goal of HIV prevalence. However, recognizing the disparities and the commitment to leaving no community behind. In addition to the impact of COVID, that 2020 has been extended to the end of 2024. More updates will be provided. I want to acknowledge the expansion of sexual health clinics to improve access to equitable sexual health services. Again, within the AIDS Institute, the Office of the Medical Director expanded sexual health services from four regions to ten regions throughout rest of state. That includes areas outside of New York City. Recently awarded contracts for sexual health clinical services began on October 1st of this year. We continue to prioritize access to sexual health services with the expansion of these clinics. Our intention is to create environments that are inclusive, stigma free, sex positive and safe. Transgender Equity Wellness Fund, the Office of LGBTQ Services, as well as the Office of Administration are working collaboratively to initiate contracts under this fund focused on transgender equity wellness. Ms. Morne stated the Office will continue to provide an update on the outcomes of that funding.

Mr. Morne acknowledged the work of the New York State Opioid Settlement Board. The Department of Health, as part of the New York State Settlement Board, herself as designee for Dr. Bassett, as a voting member. As background on the board, if you're not familiar, it was created via Chapter 171 of the laws of 2022 pursuant to Mental Hygiene Law 2518. The Settlement Fund Advisory Board was established under OASIS, our partner agency, Office of Addiction Services and supports to provide recommendations on health funding received by the Settlement Fund should be allocated. The board is charged with annually producing a written report with recommendations for allocations by November 1st, which was completed for this year. In summary, in this past year there were ten meetings held in which the board deliberated regarding areas of priority. The board identified and recommended ten priority areas for consideration, including harm reduction, treatment, investments across service, continuance, priority populations, housing recovery prevention, transportation, public awareness and research. The work of the board continues as we move forward. Our next meeting is on December 14. Many of you have had discussion and certainly have great interest as it relates to the Health Equity Assessment Initiative. The Office of Health Equity and Human Rights is working collaboratively with the Office of Primary Care and Health Systems under the direction of Dr. Morley on the development of regulations that would support the original Senate Bill. The bill was signed into law and becomes effective June of next year. The bill relates to requiring a health equity assessment to be filed with an application for construction or change to a hospital or health related service. In addition to finalizing draft regulations, priority actions include meeting with community stakeholders for both input and recommendation, development of

assessment, guidance and frequently asked questions document. These drafts along with other priority points on the integration and application of this health equity assessment will be made formally to the council, I believe, at the next meeting. I also wanted to share because priority work is being taken related to aging and HIV, in addition to the other work that's being done across the department related to the priority of addressing aging in health care. A pilot prioritizing individuals who are diagnosed with HIV as well as aging will provide case management, health, education, risk reduction as well as insurance navigation for individuals who are eligible.

Ms. Morne discussed within the AIDS Institute, we have created an entire bureau that's focused on aging with the hire of an Aging Coordinator to work across state. As we continue to receive input from individuals across the community related to their desire for a more streamlined and efficient access and system related to their medical as well as mental health care. In closing, I just want to acknowledge that tomorrow we will have the New York State Health Equity Council meeting. It will be held at 90 Church Street and beginning at 10:00am. This gives us the opportunity to speak with members of the council to receive input as well as discussion related to health equity actions taken across the state. What I've provided today are simply some of the priority areas in which we are focused in addition to the other day to day areas. I hope that the information I've provided has been useful to you. We will continue to provide update as well as provide detail as the Office of Health Equity and Human Rights continues to expand in response to the needs of New York.

Ms. Morne concluded her report. To view the complete report and Members comments and questions, please see pages 5 through 8 of the transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Report on the Activities of the Office of Public Health

Mr. Kraut introduced Dr. Bauer to give the Report on the Activities of the Office of Public Health.

Dr. Bauer began her report by giving an update on the Office of Public Health's (OPH). Dr. Bauer stated In October, I reviewed with you the application that the Office of Public Health submitted to the CDC to strengthen public health, workforce foundational capabilities and data systems. I'm pleased to share with you that earlier this month we received our notice of award $137,000,000 over five years for strengthening public health, workforce and foundational capabilities. We were approved, but unfunded for the data systems component of that application. However, because data modernizing our data systems is essential to the other two components strengthening public health, workforce and foundational capabilities. We do plan to continue with our data modernization work at the Department using some of the resources from this opportunity. What I'll review with you today are the ways in which this new grant program aligns with and can help advance the work of the prevention agenda. Of course, the prevention agenda and the strengthening public health grant are both focused on improving the health and well-being of New Yorkers and promoting health equity across our populations.

Dr. Bauer stated the new CDC grant prioritizes the public health workforce and supporting local health departments to reach deeply into communities of need to address longstanding health inequities. While not explicitly framed as a grant to strengthen the prevention agenda, the timing of the grant aligns with the planning for the next six year cycle of the prevention agenda and allows us to put in place a strong infrastructure to support a robust next cycle, and specifically to lift up the health equity thrust of the prevention agenda and the department. With 86 new positions and the establishment of two new units, one for training and partnerships, and one to investigate the root causes of health inequities, we will be well-positioned to support local health departments and their health care and community partners in making progress toward prevention agenda goals. Regional offices, too, will be better staffed to play a critical role. In the next six year cycle, I'd like to use the prevention agenda more overtly as an organizing framework for OPH and Department activities. For example, how we support the prevention agenda, priority areas and specific, the specific work of communities to advance those areas around the department's policy, budget and state of the state initiatives. Improvements in public health generally require a wraparound strategy, sort of a full court press approach from the policy side, the programmatic side, the culture change side, and there are certainly policies, laws, regulations, funding, training, media and communications, even the bully pulpit that can be mobilized to focus on ensuring even greater progress on prevention agenda priorities.

Dr. Bauer discussed preventing communicable diseases is a current priority area in the prevention agenda. Within that priority area, improving uptake of child and adult vaccines is critical to our current and future health and the ability of our health care system to deliver services. Improving our childhood and adult immunization rates will require that full court press, that wrap around strategy bringing all the department's pressure points and resources to bear. I do see this as a critical area of focus for the next six-year prevention agenda cycle. Within the CDC grant, we have a disease agnostic staffing and other resources across OPH, including to the regional offices and the local health department, to build out our training, our partnerships, our outreach, our community engagement and our communications capabilities. We have the opportunity with this grant and with the focused approach from the Department to make the six-year cycle of the next six-year cycle of the prevention agenda particularly productive and impactful.

Dr. Bauer concluded her report. To view the complete report and Members comments and questions, please see pages 8 through 11 of the transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Report on the Activities of the Office of Primary Care and Health Systems Management

Mr. Kraut introduced Dr. Morley to give the Report on the activities of the Office of Primary Care and Health Systems Management.

Dr. Morley began his report by stating the Department is actively reaching out to key identified stakeholders, including nursing home and hospital associations, labor unions and medical societies in New York State to explore alternative methods for hospitals and nursing homes to ensure an adequate PPE stockpile in the event of another pandemic should supply

chains be disrupted. Number two, Prescription Drug Regulations. To implement public health laws Section 280 B, the Department is currently developing regulations to instruct hospitals how to register as a donor or recipient entity for unused prescription drugs. These regulations will help indigent patients access and afford needed medications. Number three, nurses across New York, the NANY program, will continue to work towards publishing the request for applications prior to the end of this month, December 31st. From the Bureau of Emergency Medical Services, the World University Games for 2023 will be taking place in Lake Placid. World University Games, also known as WUG 23. It's an eleven day international festival and competition that combines high level sports with educational and cultural events. It'll be in Lake Placid and nearby towns between January the 12th, 2023 and January 22nd, 2023. The department, along with other agencies of the New York State WUG Commission and the organizing committee, have been participating in monthly planning calls since the Fall of 2021. The Department determined early on that the organizing committee would be required to obtain a Part 18 permit for the event.

Dr. Morley noted the federal DEA is permitting telemedicine practitioners to prescribe controlled substances without the usual prerequisite of an in-personal physical examination. To ensure the continued availability of medically necessary access to controlled substance medications, the Commissioner of Health has determined that it's necessary to permit controlled substance prescribing by telemedicine in the same manner that the DEA permits limited to the duration of the COVID-19 federal public health emergency. This determination will sustain access to controlled substance medications and provide consistency for telemedicine practitioners, pharmacists and patients. The Department intends to finalize and post this termination online for the duration of the COVID-19 federal public health emergency.

Dr. Morley stated the Safe Nurse Staffing Bill, the work group met three weeks ago and reviewed the draft annual report as required by statute. We very much appreciate their input on that report. We continue to work on regulations for safe nurse staffing with the unions, with the hospital associations and with the Governor's Office. As you did hear from the Commissioner, there is a plethora of virus activity in the communities. These viruses are having a very clear and direct impact, not just on individual patient level, but on the system level. Hospitals are full and the long standing issue of crowding in the emergency departments of hospitals continues unabated. The ED issue is having an impact on more than patients in the hospitals. It's affecting the EMS system. CMAC, the State Emergency Medical Advisory Committee and SEMSCO, the State Emergency Medical Services Council, have both raised concerns about this impact on EMS. Where an EMS crew could transfer a patient to the care of the hospital, be ready for their next emergency call, be it a motor vehicle accident, a gunshot wound, heart attack, stroke or whatever the emergency is that relate to the activation of the 911 system. It was being done in under thirty minutes. It's now not unusual, not rare for it to take over two hours to transfer a patient to the care of the hospital staff. This is having a very significant time on response times. The times that it takes for the ambulance to arrive at the motor vehicle accident, at the scene of whatever event has occurred or wherever the emergency is necessary. The Chair of CMAC recently met with our own Chair of the council and Dr. Rugge.

Dr. Morley concluded his report. To see the complete report please see pages 12 through 17 of the transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Report on the Activities of the Office of Aging and Long Term Care

Mr. Kraut introduced Mr. Herbst to give the Report on the activities of the Office of Aging and Long Term Care.

Mr. Herbst began his report by providing some high priority activities occurring in his office since his last report in October. OALTC will continue to spearhead the implementation and execution of this New York State's master plan for aging. This is intended when the Governor signed the Executive Order two months ago now. This master plan that intended to create a blueprint of strategies for government, the private sector and nonprofits support older New Yorkers. It's also intended to address challenges related to communication, coordination, caregiving, long term financing and innovative care, and ensure that state policy and programs are coordinated and aligned to ensure that all New Yorkers can age in our state with freedom, dignity and independence for as long as possible. Today, I am proud to report that yesterday, December 7th, we launched the first meeting of New York's Master Plan for Aging. The council is comprised of heads of New York State agencies and all commissioners. The council will not only be responsible for receiving recommendations from the Stakeholder Advisory Committee and providing a final report.

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Mr. Herbst noted our charge is to deliver to the Governor a final master plan set of recommendations in late 2024. At the convening of the agency, council was only a first step. Our next step will be to convene a master plan stakeholder advisory committee that will bring together approximately twenty-five aging experts from across the different sectors in New York State to gather feedback and input through a series of stakeholder engagement sessions and will support the creation of the master plan in collaboration with the Agency Council. Beyond the Council and Stakeholder Committee, stakeholders and members of the public will have multiple opportunities to provide feedback and to engage in the development of our states master plan for aging.

Mr. Herbst explained OALTC has already initiated some very important work, one of which is the processing of the applications. As you may be aware, the Department released the new licensure application process in mid-August. Although we expected a steady of applications you would be asked to approve that is not necessary occurred. To date we have received a total of fifteen applications acknowledged by the Department to review since the lifting of the moratorium. Staff are currently reviewing on a first come, first served basis. That said, I did commit to looking at the various licensure processes to determine if we could streamline the process without compromising quality. This work is very much underway. I am pleased to report that under the leadership of Mark Furnish processes are being examined and work is developing right now on a management agreement consolidation plan. This process should be in place by November of 2023.

Mr. Herbst stated both the 7040 direct care spending regulation and the minimum nurse staffing regulations were the direct result of two prescriptive statutes that specifically required

the Department of Health to draft and adopt regulations. At the November 17th meeting, I explained in detail the procedural history of both the 7040 direct care spending and the minimum staffing statutes. Again, to be transparent and clear with you all, I want to give a very brief synopsis today. The 7040 direct resident care spending statute was enacted by the legislature as Chapter 57 of the law as of 2021. The law was slated to go into effect on January 1st, 2022. However, the Governor declared a state of emergency suspending the implementation date from January 1st, 2022 through March 31st, 2022 based on the workforce shortage facing our state and the nation. The minimum nurse staffing statute was enacted by the Legislature and became Chapter 156 of the laws of 2021. This law was slated to go into effect on January 1st, 2022 as well. However, the statute, like the 7040 direct care spending was suspended by the Governor's state of emergency from January 1st, 2022 through March 31st, 2022. Therefore, both statutes went into effect and have been the law in New York since April 1st, 2022.

Mr. Herbst discussed that the legislature placed the responsibility on the Department that set up guidepost to enforce these regulations. We at the Department have tried to put notice of standards and provide the flexibility to grant waivers and to ensure the industry knows how to document the evidence needed for the waivers. Approval of these regulations allows the Department to establish the process for applying for waivers and for exclusions of revenue under the 7040 direct resident care spending statute, as well as the processes for demonstrating the existence of mitigating factors under the nursing home staffing level statute. The regulations are needed to ensure that everyone is on notice of the standards, provide the flexibility to grant waivers and to ensure the industry knows how to document the evidence needed for the waivers. Approval of the regulations allows the Department to establish the process for applying for waivers and for the exclusions of revenue under the 7040 direct care spending statute, as well as the process for demonstrating the existence of the mitigating factors, the nursing home staffing levels statute.

Mr. Herbst concluded his report. To see the complete report please see pages 17 through 22 of the transcript.

REGULATION

Mr. Kraut introduced Mr. Holt to give his Report of the Committee on Codes, Regulations and Legislation.

Report of the Committee on Codes, Regulation and Legislation

For Emergency Adoption

20-06 Amendment of Part 2, Section 405.3 and Addition of Section 58-1.14 to Title 10 NYCRR
(Investigation of Communicable Disease)

20-07 Addition of Section 2.60 to Title 10 NYCRR
(Face Coverings for COVID-19 Prevention)

Mr. Holt introduced for Emergency Adoption of Amendment of Part 2, Section 405.3 and Addition of Section 58-1.14 to Title 10 NYCRR (Investigation of Communicable Disease) and motioned for adoption. Dr. Strange seconded the motion. The motion carried. Please see pages 26 and 27 of the transcript.

20-07 Addition of Section 2.60 to Title 10 NYCRR
(Face Coverings for COVID-19 Prevention)

Mr. Holt introduced For Emergency Adoption of Addition of Section 2.60 to Title 10 NYCRR (Face Coverings for COVID-19 Prevention). Mr. Holt motions for approval. Mr. LaRue seconded the motion. The motion carried. Please see page 27 of the transcript.

22-21 Amendment of Section 23.1 of Title 10 NYCRR
(Mpox to the List of Sexually Transmitted Diseases (STDs))

Mr. Holt introduced For Emergency Adoption of Amendment of Section 23.1 of Title 10 NYCRR (Mpox to the List of Sexually Transmitted Diseases (STDs)). Mr. Holt motions for approval. Dr. Strange seconded the motion. The motion carried. Please see pages 27 and 28 of the transcript.

For Information

22-16 Amendment of Subpart 5-1 of Title 10 NYCRR
(Maximum Contaminant Levels (MCLs))

For Adoption

22-11 Amendment of Subpart 5-1 of Title 10 NYCRR
(Public Water Systems)

Mr. Holt introduced For Information Amendment of Subpart 5-1 of Title 10 NYCRR (Maximum Contaminant Levels (MCLs)) and for Adoption Amendment of Subpart 5-1 of Title 10 NYCRR (Public Water Systems) Mr. Holt motions for approval. Mr. LaRue seconded the motion. The motion carried. Please see page 28 of the transcript.

Mr. Holt concluded his report. Mr. Kraut thanked Mr. Holt for his report

PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Mr. Kraut introduced Dr. Kalkut to give the Report of the Committee on Establishment and Project Review.

PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Report of the Committee on Establishment and Project Review

Gary Kalkut, M.D. Vice Chair, 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

NO APPLICATIONS

CATEGORY 2: Applications Recommended for Approval with the Following:

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

CON Applications

Acute Care Services - Construction

Number	Applicant/Facility	Council Action
221248 C	NYU Langone Hospital – Long Island (Nassau County) Dr. Kalkut - Recusal	Contingent Approval

Mr. Kraut called application 221248 and noted for the record that Dr. Kalkut has a conflict and has exited the meeting room. Dr. Strange motioned for approval and Dr. Torres seconded the motion. The motion to approve carried with Dr. Kalkut's recusal. Dr. Kalkut returned to the meeting room. Please see page 25 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

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

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

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

Ambulatory Surgery Centers – Establish/Construct

Number	Applicant/Facility	Council Action
221191 B	Maxillofacial Ambulatory Surgery Center, LLC (Suffolk County)	Contingent Approval
221206 E	Northern Westchester Facility Project LLC d/b/a Yorktown Center for Special Surgery (Westchester County)	Contingent Approval
221213 E	Performance Surgical Center, LLC d/b/a Performance Surgical Center (Kings County)	Contingent Approval

Dr. Kalkut called applications 221191, 221206, and 221213. Dr. Kalkut motioned for approval. Dr. Torres seconded the motion. The motion to approve carried. Please see pages 28 and 29 of the attached transcript

Diagnostic and Treatment Centers – Establish/Construct

Number	Applicant/Facility	Council Action
221145 B	Apple Care Health (Kings County)	Contingent Approval
221227 B	Parkchester DTC LLC d/b/a Parkchester Diagnostic and Treatment Center (Bronx County)	Contingent Approval

221231 B	A Friendly Face Akademy, Corp. (Richmond County)	Contingent Approval
221265 B	JAL 28 LLC d/b/a A Merryland Health Center (Kings County)	Contingent Approval

Dr. Kalkut called applications 221145, 221227, 221231 and 221265. Dr. Kalkut motioned for approval. Dr. Berliner seconded the motion. The motion to approve carried. Please see page 28 30 of the attached transcript

Residential Health Care Facilities – Establish/Construct

Number	**Applicant/Facility**	**Council Action**
192204 E	Highland Nursing Home, Inc. d/b/a North County Nursing & Rehabilitation Center (St. Lawrence County) (Deferred at Department's Request)	Deferred at the Department's Request
202034 E	Ulster NH Operations LLC d/b/a Golden Hill Center for Rehabilitation and Nursing (Ulster County)	Contingent Approval
211087 E	The Premier Center for Rehabilitation of Westchester, LLC d/b/a Springvale Nursing and Rehabilitation Center (Westchester County)	Contingent Approval

Dr. Kalkut next called application 192204 and noted this application has been deferred at the department's request. Lastly, Dr. Kalkut called applications 202034 and 211087. Dr. Kalkut motioned for approval. Mr. Thomas seconded the motion. The motion to approve carried. Please see pages 30 and 31 of the attached transcript.

CATEGORY 2: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

CATEGORY 3: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the following:

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

NO APPLICATIONS

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

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

NO APPLICATIONS

Dr. Kalkut concluded his report.

ADJOURNMENT:

Mr. Kraut announced the upcoming PHHPC meetings and adjourned the public portion of the meeting.

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MEETING
DEECMBET 8, 2022 (IMMEDIATELY FOLLOWING CODES AT 10:00 AM)
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

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Mr. Kraut I'm now going to call to order the December 8th, 2022 meeting of the Public Health and Health Planning Council. I'm Jeff Kraut. I Chair the council.

Mr. Kraut I call it to order.

Mr. Kraut I want to welcome Commissioner Bassett, participants and observers. As a reminder for all audience viewing the public meeting via the webcast, there is a form that needs to be filled out which records your attendance at this meeting. It's required in order to comply with the Commissioner of Ethics and Lobbying Law 166. We also have posted this form on the Department of Health's website on the www.NYHealth.Gov under Certificate of Need. Please email the completed forms to Colleen.Leonard@Health.NY,Gov. We appreciate your cooperation having us fulfill our responsibilities and duties. I want to remind the council members, staff and the audience that this meeting is subject to the Open Meeting Law and is being broadcast over the internet. We want to make sure that we're on mute while others are speaking, avoid the rustling of papers. We are synchronizing captioning. Let's be sure not to talk over one another. The first time an individual speaks, please identify your name and identify yourself as a council member or DOH staff. This will be really helpful. I'm going to encourage the members, staff and public to join the department's Certificate of Need Listserv. The unit regularly sends out important council information via that listserv and give notices about our agenda, the dates, the topics, material that we're going to be seeing. There's instructions on the table outside of the rooms on how to join that listserv, or you can find that online. I'm going to change up the agenda today slightly to accommodate some of our speakers. We're going to hear first from Dr. Bassett to give a report on the Department of Health Activities, then followed by Ms. Morne, who's going to attend via Zoom in order to accommodate her schedule. We'll be going into Executive Session. We'll then return from Executive Session and go through the rest of the reports from Dr. Bauer, from the Office of Public Health, Dr. Morley for the Office of Primary Care and Health Systems Management and Mr. Herbst from the Office of Aging and Long Term Care. We will come back for committee reports from the various chairs to conclude our meeting.

Mr. Kraut It's now my honor to introduce Dr. Bassett, who has served as our Commissioner for the past year. As you may have heard, I'm sure she'll share her news. She is going to be leaving the department. I have a kind of a notice of appreciation, a resolution, Commissioner, but I'd like you know, I think it's best if you speak first and then we'll express our sentiments.

Mr. Kraut Commissioner, welcome.

Dr. Bassett Thank you very much.

Dr. Bassett Let me begin with my remarks since this is my last meeting as Health Commissioner. I want to start out by recognizing the importance of this committee. The fact that the department can rely on the external expertise of this body is crucial to the work that we do. I want to thank all of the members for your commitment and acknowledge the hard work that you do on a voluntary basis. When I assumed leadership of the Department of Health about a year ago we were in the midst of a surge in COVID cases due to the Omicron variant. Hospitalizations topped 11,000 statewide for the first time since the early months of the COVID crisis. This crisis consumed my first month as Health Commissioner, but little did I know that we would be facing multiple imminent threats in 2022 with MPox and the polio outbreaks. Moving into Winter, we are dealing with the triple threat of flu, which we have a really marked increase in the number of flu cases and hospitalizations, respiratory syncytial virus and COVID. It has been, without a doubt, a challenging year for public health. As I always say to members of the department and anyone who wants to talk about public health, we didn't go into this field because it's easy. In the midst of these ongoing crises, we managed to get a lot done. Looking back on this year, there's a lot to be proud of. We launched a rebuild of the health department, the purpose of which is not just to move towards a more efficient, sustainable way of working, but to increase and improve the staff morale. The Department of Health is and must remain a great place to work. I'm also very proud of our launch this Summer of two new offices, the Office of Health Equity and Human Rights. You can all see Joanne Morne on the screen and the Office of Aging and Long Term Care. The Office of Health Equity and Human Rights places equity at the core of everything that we do. This office supports all of the health department and setting and implementing an overarching vision and framework of diversity, equity and inclusion. Its ultimate goal is to reduce statewide health disparities, and in particular, the enduring racial ethnic disparities, but all of the disparities that are unjust and preventable. The OALTC, that's the Office of Aging and Long-Term Care, was created in recognition of our aging population and the specific needs of elderly New Yorkers, whether they choose to age in their homes or require long term care facilities. It's also helping to implement the State Master Plan on Aging, which will lay the foundation for changing the landscape of aging and long term care in our state. We have strengthened our relationships with local health departments, recognizing their expertise and the critical role that they play in managing crises and delivering prevention services to all New Yorkers. I felt particularly fortunate to travel throughout the state to see our local health departments in action, noting their challenges and the creative ways in which they are addressing them. Each local health department faces its own budget constraints, health issues, staffing needs, but they are all united in the need to provide preventative care and make New Yorkers safer and healthier. Having worked in public health for nearly forty years, I believe that there is no reward greater than the work that we do every day. Judging from your commitment, I suspect that all of the members agree with me. I know that our work is never done. Equity is the North Star of what we do. We must keep it at the center of our work. If the last year has taught us anything, it's that another public health crisis may be lurking around the next corner. We can't let the crisis of the moment interrupt our vision for making New York a safer and healthier place to live.

Dr. Bassett With those comments, I thank you all and return to you, Chairman.

Mr. Kraut Thank you very much, Dr. Bassett.

Mr. Kraut We certainly appreciate the kind words about the council and our partnership with the department. We really appreciate your leadership over this past year and as a member of the council, you've put some of the issues that we have struggled with front and center, particularly, as you said, on health equity, human rights, a focus on aging, the

prevention agenda and public health. Obviously, you arrived at a time of tremendous change in the state that continues to reverberate. We do have a resolution, and I'm not going to read everything, but we want to acknowledge that wonderful partnership we had with you and how you just seamlessly took over the leadership of the department navigating the state through still occurring COVID and a tripartite kind of public health challenges that we're now in the midst of, but protecting against COVID-19, against MPox and the really the focus that you had in restructuring the strategy of the Department of Health, optimize its talent and increasing the diversity as part of its overall mission to build a healthier and more equitable New York for all of its residents. We very much want to express to you for our affection, our respect, our admiration for your leadership. Dr. Boufford and I have signed a resolution on behalf of the council memorializing those thoughts. Again, we want to thank you for the service, but we want to leave you with questions from the council as we began.

Mr. Kraut I'll turn it over to the council. If you have questions for the Commissioner, this is the best time to ask.

Mr. Kraut Yes, Dr. Boufford.

Dr. Boufford I don't really have a question, but I want to add comments to Jeff's. Dr. Bassett, we will miss you deeply and also want to thank you very sincerely, as Jeff has done for what you have managed to do over the last year. I think inheriting a health department that where people have really been running flat out for the last two and a half years on a national crisis played out in the state was a very difficult challenge. I think you have been a fantastic role model in public health to show that you have to manage the crises, as you say, that are inevitable, but also look under the infrastructure that really has to be allowed to stay strong and capable for the daily work of Departments of Health. Congratulate you on that sort of management style, leadership style, which is really, really important. Just to touch on a couple of things that Jeff said, similarly. I think you, as he mentioned, I think laying the blueprint for rebuilding the department, especially on the public health side, has been really important. I was looking at the minutes of the last meeting and Dr. Bauer's discussion really of all the steps that have been taken to build new offices, connect the dots, link with the local health departments. I encourage my colleagues to take a look at that section of the report, because I think it sort of lays the agenda for us in terms of supporting the department in that work. Similarly, the appointment of Dr. Morne and creating of that office to address health equity both structurally as well as operationally, will be very, very important. The connection of a master plan on aging and the experience, life experience of older people in addition to the long term care delivery system, again connects areas that this council has been very concerned about for a very long time. Finally, of course, I would end with the prevention agenda, but I think your support of it again, your comments at our last meeting and the fact that it really is a vehicle for connecting the department with the Office of Mental Health, with the Office on Aging, with our colleagues in the Department of State who have been very supportive on the planning side. Similarly, local health departments is really something you really helped begin laying the groundwork for that revision over the next year. We're very grateful. We will miss you, but, obviously, as always, we wish you well and thank you for your contributions.

Mr. Kraut Dr. Rugge.

Dr. Rugge Proving the importance of sitting position, I have the honor of presenting you with the official proclamation and signed by Jeff and Jo.

Dr. Rugge Thank you very much.

Dr. Bassett Thank you.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence Thank you.

Dr. Bassett Since I still have a live mic, let me thank all of you for your kind words and take advantage of the fact that many members of the department are here to thank them on the record for having welcomed me and supported me weary as they were from the two and a half years of a all out COVID response. I know that you continue this work so aptly framed by both Chair and our Vice Chair.

Dr. Bassett Thank you all.

Dr. Bassett Best wishes to the ever, ever onwards work that lies ahead.

Dr. Bassett Thank you.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence Dr. Bassett, I would like to thank you for your leadership, not only at the state level, but also when you served as Commissioner at New York City. Thank you for your focus on primary care and for community care, for looking at health disparities and bringing that to the forefront. I'm saddened by your departure, because when we look forward and look at the horizon for public health and for community health in our neighborhoods, we need champions and warriors like you to advance those those issues. I'm hoping that whoever comes in to replace you will have the same level of commitment to primary care and to advancing health equity across the state. I would welcome any parting words of wisdom given the perch that you're leading, that you might offer to us that are really taking on much of the challenges at the grassroots street level, trying to make a difference in the lives of people that have been suffering from health disparities.

Dr. Bassett I've turned my mic on again.

Dr. Bassett Mr. Lawrence, thank you for those kind words. I think that you've heard very well described both the kind of infrastructure and the road map that lies ahead. I am confident that the next Commissioner will encounter a health department that is not quite as weary and is as ever and always ready to take up the challenges that have been so well outlined. I don't know who this person will be, but I do know that they will have a full four years under the leadership of Governor Hochul to tackle that agenda. You have other avenues I expect to express your desires on who that person might be. I'm sure that the search is actively underway.

Mr. Kraut Thank you very much, Dr. Bassett.

Mr. Kraut Again, we, on behalf of a grateful council, thank you for your partnership. Thank you for your leadership. We wish you well. Who knows? One day you could return to sit with us. Except you're in Massachusetts, but you never know. We wish you well.

Mr. Kraut Thank you.

Mr. Kraut I'm now going to turn to Ms. Morne, who will give us a report on the OHEHR. We love acronyms here. The Office of Health Equity and Human Rights. Dr. Bauer, I think what I'll do is I'll also have you follow her. We'll kind of take the public health portion of the meeting and then we'll go into Executive Session after that.

Mr. Kraut Ms. Morne.

Ms. Morne Thank you so much.

Ms. Morne Good morning, everyone. I am Johanne Morne, Deputy Commissioner for the Office of Health Equity and Human Rights.

Ms. Morne Can I just check to make sure that my volume is adequate?

Ms. Morne Wonderful. Wonderful.

Ms. Morne Certainly, also in acknowledging the many accomplishments that Dr. Bassett was able to lead us through over the last year, the department's reorganization creating this office has definitely stood out and been a part of the legacy that will be left for us to continue.

Ms. Morne Thank you.

Ms. Morne I'd like to take my next few minutes to talk about some of the key activities that have happened within the office since the last time that we've met. I'd like to start first by acknowledging the work of the State Department of Health AIDS Institute and the recent hosting of the 2022 Ending the Epidemic Summit, as well as the World AIDS Day event. Recognizing World AIDS Day as a day for us to remember those who have passed and those certainly who continue to do the essential work as we move forward in ending the epidemic. The gathering was a virtual one. It was titled Collaborating for Change Partnering for Health Equity. We had attendance of over 1,800 registered participants and the opportunity to discuss both evidence based and grassroots actions that have been taken to reduce disparities related to HIV diagnosis, treatment and health related outcomes. As background related to data, and this data is from 2021, I asked that we take into consideration the impact of COVID, but I also think it's important to understand where we are in New York State as it relates to HIV. In 2021, there were over 2,000 individuals, just over 2,000 individuals that were newly diagnosed with HIV. This is a 30% decrease since the state initiated ending the epidemic in 2015. At that time, you may recall that a three point plan with the intention of achieving the first ever decrease in HIV prevalence in New York State was accepted and put into motion. In 2019, New York State did achieve the ability or did achieve the goal of achieving HIV prevalence in which we saw that the number of deaths of individuals was less than the number of individuals who were newly diagnosed. In spite of that achievement, we still recognize that we have significant areas for us to focus on in our progress to ending the epidemic in New York State, specifically as it relates to disparities, ongoing disparities, particularly within communities of color. I want to acknowledge that New York State continues to have the highest percent of pre-exposure prophylaxis coverage in the nation, with more people receiving prescriptions than in any other jurisdiction. In 2021, there were more than 44,000 New Yorkers who filled at least one prescription for pre-exposure prophylaxis, which is thirteen times more than the number of prescriptions that were filled in 2014. Going back to the point of

disparities, we continue to see persistent challenges as it relates to unequal access related to care, social determinants of health as well as stigma. Hispanic and non-Hispanic Black populations account for 34% of the state population, yet 74% of new HIV diagnoses are among the same individuals. Racial disparities have accounted for over 50,000 new HIV diagnoses in the state in the past decades. From 2020 to 2021, the percentage of people living with HIV who received medical care also increased to 88%, which is certainly a success. We continue to do work with our partners to ensure that individuals who are newly diagnosed are linked to and engage in care within thirty days of a diagnosis. Critical first step to achieving viral suppression for an individual. We continue to move forward in our efforts of ending the epidemic. You may recall that the original goal of ending the epidemic was by the end of 2020. As I stated, we achieved the goal of HIV prevalence. However, recognizing the disparities and the commitment to leaving no community behind. In addition to the impact of COVID, that 2020 has been extended to the end of 2024. More updates will be provided. I want to acknowledge the expansion of sexual health clinics to improve access to equitable sexual health services. Again, within the AIDS Institute, the Office of the Medical Director expanded sexual health services from four regions to ten regions throughout rest of state. That includes areas outside of New York City. Recently awarded contracts for sexual health clinical services began on October 1st of this year. We continue to prioritize access to sexual health services with the expansion of these clinics. Our intention is to create environments that are inclusive, stigma free, sex positive and safe. Transgender Equity Wellness Fund, the Office of LGBTQ Services, as well as the Office of Administration are working collaboratively to initiate contracts under this fund focused on transgender equity wellness. Sixteen transgender and gender nonconforming organizations have been identified to receive this funding. It's intended to increase the capacity of grassroots organizations working at a local level to ensure investments for organizations that are led and serving transgender, gender nonconforming, non-binary and intersex individuals, as well as address inequities in current resource allocation. We'll continue to provide an update on the outcomes of that funding. I want to acknowledge the work of the New York State Opioid Settlement Board. The Department of Health, as part of the New York State Settlement Board, myself as designee for Dr. Bassett, as a voting member. As background on the board, if you're not familiar, it was created via Chapter 171 of the laws of 2022 pursuant to Mental Hygiene Law 2518. The Settlement Fund Advisory Board was established under OASIS, our partner agency, Office of Addiction Services and supports to provide recommendations on health funding received by the Settlement Fund should be allocated. The board is charged with annually producing a written report with recommendations for allocations by November 1st, which was completed for this year. In summary, in this past year there were ten meetings held in which the board deliberated regarding areas of priority. The board identified and recommended ten priority areas for consideration, including harm reduction, treatment, investments across service, continuance, priority populations, housing recovery prevention, transportation, public awareness and research. The work of the board continues as we move forward. Our next meeting is on December 14. I know many of you have had discussion and certainly have great interest as it relates to the Health Equity Assessment Initiative. The Office of Health Equity and Human Rights is working collaboratively with the Office of Primary Care and Health Systems under the direction of Dr. Morley on the development of regulations that would support the original Senate Bill. The bill was signed into law and becomes effective June of next year. The bill relates to requiring a health equity assessment to be filed with an application for construction or change to a hospital or health related service. In addition to finalizing draft regulations, priority actions include meeting with community stakeholders for both input and recommendation, development of assessment, guidance and frequently asked questions document. These drafts along with other priority points on the integration and application of this health equity assessment will be made formally to the council, I

believe, at the next meeting. I also wanted to share because priority work is being taken related to aging and HIV, in addition to the other work that's being done across the department related to the priority of addressing aging in health care. A pilot prioritizing individuals who are diagnosed with HIV as well as aging will provide case management, health, education, risk reduction as well as insurance navigation for individuals who are eligible. Our goal here certainly is to provide support for the purpose of obtaining optimal health, while not limiting the focus to only the achievement of viral suppression. We're looking to improve management of co-morbidities and improve perceptions of social connectedness. In general within the AIDS Institute, we have created an entire bureau that's focused on aging with the hire of an Aging Coordinator to work across state. As we continue to receive input from individuals across the community related to their desire for a more streamlined and efficient access and system related to their medical as well as mental health care. In closing, I just want to acknowledge that tomorrow we will have the New York State Health Equity Council meeting. It will be held at 90 Church Street and beginning at 10:00am. This gives us the opportunity to speak with members of the council to receive input as well as discussion related to health equity actions taken across the state. What I've provided today are simply some of the priority areas in which we are focused in addition to the other day to day areas. I hope that the information I've provided has been useful to you. We will continue to provide update as well as provide detail as the Office of Health Equity and Human Rights continues to expand in response to the needs of New York.

Ms. Morne Thank you.

Mr. Kraut Thanks so much, Ms. Morne.

Mr. Kraut Are there any questions?

Mr. Kraut Dr. Kalkut.

Dr. Kalkut Mr. Morne, thank you for your comments. I look forward to working with you. Many health systems big and small have established structures that deal with health equity and disparities. I think working with your office and these health care providers would be beneficial on both sides. I invite you to reach out to organisations that have these structures. I think this is a time and it's moved rapidly, not nearly far enough, but rapidly to work on health equity and try to make changes both internally and in the larger system and in the communities.

Dr. Kalkut Thank you.

Ms. Morne Thank you.

Ms. Morne Certainly, we would welcome the opportunity to speak with any of the health care systems and administrations that really have prioritized health equity as central to the work and the daily practice. We have been fortunate. We have had the opportunity to meet with many representatives from the community, both from a community based perspective, as well as a hospital based perspective. We welcome every opportunity to gain a better understanding. What we wanted to do is enhance what's existing, not undo anything that's in place and working well.

Ms. Morne Thank you.

Mr. Kraut Any questions up in Albany?

Mr. Kraut I thank you for coming to the council. Obviously, the regulations that are going to deal with certificate of need and health equity and disparities have long been a focus of this council. We've had numerous conversations about having a framework that is consistent to look at that and I know we'll look forward to a discussion about those draft regulations before they actually are circulated beyond the council. This is something I had indicated to Ms. Morne and that before they get filed, we do want to look at them to get our input early in that process. We'll look forward to the next committee meeting where you'd probably, I guess, in Codes. We do it for information.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence I'm not very familiar with the structure of the department, but I just wanted to ask about the staffing level, whether you're fully staffed and what's the staffing level when you are fully staffed?

Ms. Morne Thank you.

Ms. Morne We are in the process of becoming fully staffed. I should acknowledge that we are fortunate to have just brought on a Deputy Director for the office who has significant background, both in health equity as well as in hospital systems and working in government. That would be Tina Kim. In addition to that, we are hiring both on state as well as through Health Research Inc to fill the positions that have been made available to the office. I think one of the benefits of the fact that the office is made up of existing offices, such as the Office of Minority Health and Health Disparities Prevention, as well as the AIDS Institute, has provided us with a level of staffing that a new office does not always have the benefit of, but certainly we are looking to bring on additional colleagues that have specific background and experience in health equity, as well as in workforce development for diversity, equity and inclusion. All that to say that we're almost there. We're in the interview process. At this time I'm very grateful for the level of support that has been received in making sure that the staffing resources of the office need.

Mr. Kraut Thank you very much.

Mr. Kraut Thank you, Ms. Morne. Thank you for making yourself available. I know you had multiple commitments at this time. We appreciate the effort you made. We really do. We look forward to our next conversation.

Ms. Morne Yes.

Mr. Kraut I'm going to now ask Dr. Bauer, who provide a report on the activities of the Office of Public Health and then following that, we will go into Executive Session.

Dr. Bauer Thank you.

Dr. Bauer Good morning, members. I'm Ursula Bauer, Deputy Commissioner for Public Health. In October, I reviewed with you the application that the Office of Public Health submitted to the CDC to strengthen public health, workforce foundational capabilities and data systems. I'm pleased to share with you that earlier this month we received our notice of award $137,000,000 over five years for strengthening public health, workforce and foundational capabilities. We were approved, but unfunded for the data systems

component of that application. However, because data modernizing our data systems is essential to the other two components strengthening public health, workforce and foundational capabilities. We do plan to continue with our data modernization work at the department using some of the resources from this opportunity. What I'll review with you today are the ways in which this new grant program aligns with and can help advance the work of the prevention agenda. Of course, the prevention agenda and the strengthening public health grant are both focused on improving the health and well-being of New Yorkers and promoting health equity across our populations. The new CDC grant prioritizes the public health workforce and supporting local health departments to reach deeply into communities of need to address longstanding health inequities. While not explicitly framed as a grant to strengthen the prevention agenda, the timing of the grant aligns with the planning for the next six year cycle of the prevention agenda and allows us to put in place a strong infrastructure to support a robust next cycle, and specifically to lift up the health equity thrust of the prevention agenda and the department. With 86 new positions and the establishment of two new units, one for training and partnerships, and one to investigate the root causes of health inequities, we will be well-positioned to support local health departments and their health care and community partners in making progress toward prevention agenda goals. Regional offices, too, will be better staffed to play a critical role. In the next six year cycle, I'd like to use the prevention agenda more overtly as an organizing framework for OPH and department activities. For example, how we support the prevention agenda, priority areas and specific, the specific work of communities to advance those areas around the department's policy, budget and state of the state initiatives. Improvements in public health generally require a wraparound strategy, sort of a full court press approach from the policy side, the programmatic side, the culture change side, and there are certainly policies, laws, regulations, funding, training, media and communications, even the bully pulpit that can be mobilized to focus on ensuring even greater progress on prevention agenda priorities. I'm a chronic disease epidemiologist by training. To me, one of the biggest takeaways from the COVID pandemic is that our poor COVID outcomes, worse than other wealthy nations, are due in large part to our high rates of chronic disease, our poor population health status going into the pandemic. Turning that tide will be critical to our future pandemic readiness. All of our counties in New York have chosen at least one chronic disease prevention agenda activity in the current prevention agenda cycle. However, in addition to the COVID pandemic over the past nearly three years, as Dr. Bassett noted, we're struggling with other respiratory viruses, including RSV and flu and other vaccine preventable diseases, including MPox and polio. Our vaccination rates here in New York are surprisingly low in specific areas and across the state. I think we're number twenty-five among US states. Preventing communicable diseases is a current priority area in the prevention agenda. Within that priority area, improving uptake of child and adult vaccines is critical to our current and future health and the ability of our health care system to deliver services. Improving our childhood and adult immunization rates will require that full court press, that wrap around strategy bringing all the department's pressure points and resources to bear. I do see this as a critical area of focus for the next six year prevention agenda cycle. Within the CDC grant, we have a disease agnostic staffing and other resources across OPH, including to the regional offices and the local health department, to build out our training, our partnerships, our outreach, our community engagement and our communications capabilities. We have the opportunity with this grant and with the focused approach from the department to make the six year cycle of the next six year cycle of the prevention agenda particularly productive and impactful. I look forward to working with Dr. Boufford with the Public Health Committee and with you to do just that. Finally, I am pleased to share with you that with Dr. Boufford, we have a tentative date for the next meeting of the Public Health Committee. We're looking at Wednesday, February 8th, for the next meeting in conjunction with the next full meeting on

February 9th. Dr. Boufford and I are preparing an agenda to tentatively include an in-depth review of the prevention agenda result from 2021, a presentation by Ms. Morne to help us more meaningfully incorporate improving health equity and decreasing health disparities into the prevention agenda and a discussion of DOH priorities for the new cycle. Ideally, we'll set these with the new Commissioner, but certainly with the Public Health Committee, the Ad Hoc Leadership Committee and members and then finally outlining the process and timeline for developing that six year prevention agenda plan. While change and uncertainty are unfortunately upon us in the department with Dr. Bassett's departure, I am very optimistic for our future and grateful for Dr. Bassett's leadership and support of our efforts to rebuild the department, our commitment to equity, our drive toward a manageable and sustainable way of working, and our strengthened partnership with the local health departments. Thank you, Dr. Bassett. We'll continue to make progress in each of these areas with rebuilding as a top priority.

Dr. Bauer Thank you.

Mr. Kraut Thank you much, Dr. Bauer.

Mr. Kraut I'm going to hand it over to Dr. Boufford.

Dr. Boufford Thank you, Dr. Bauer. I thank you so much for your comments. I'm very excited about your commitment to using the platform of the prevention agenda to move us all forward. I know the council and especially the Public Health Committee of the council are very eager to work with you starting in the New Year. Thanks for that.

Dr. Boufford I also wanted to emphasize for my colleagues, and I think you did in your statement, which is very important, the inclusion of Ms. Morne and early on in the thinking about the prevention agenda revision, because we realize that the area of disparities each local health department takes two of the five goals and one area of disparity to work on is an area our colleagues have identified as needing more technical assistance, more support, more guidance. The fact that her office now exists and has that charge to really bring together those pieces in the department will be really, really helpful in the collaboration. Again, thank you for including her as well and also outreach to our colleagues in mental health and OASIS and Ageing, which are all important components of the prevention agenda going forward. I just want to ask you specifically only because as I mentioned, I've sort of commended your great comments from the last meeting to my colleagues to take a look, especially those in the Public Health Committee. You mentioned the grant from the federal government, does there continue to be financial support for filling vacancies from the state within the state budget for, especially, the Office of Public Health Practice and your own office, in addition to the federal funding? I'd like to just ask you about the status of that.

Dr. Bauer Yes.

Dr. Bauer Thank you.

Dr. Bauer We do have support to fill positions. We have been on a hiring spree for the last year or more. I think, as Dr. Bassett mentioned at the last meeting, it's hard to get ahead of the curve because with every new hire, we seem to create a new vacancy. We are working very hard to try to fill vacancies and to expand. We do have a number of budget initiatives in place submitted to help us do that. We'll see what happens with the budget this year.

Mr. Kraut Thank you.

Mr. Kraut Any other questions for Dr. Bauer in New York?

Mr. Kraut Up in Albany?

Mr. Kraut I'll wait a second.

Mr. Kraut Thank you, Dr. Bauer.

Mr. Kraut We look forward to the next set of committee meetings. We know they'll be very productive. Appreciate your partnership and support of your team.

Mr. Kraut We're going to go into an Executive Session of the Public Health and Health Planning Council to discuss a legal issue. I'm going to ask members of the public in New York and in Albany to please exit the room.

Mr. Kraut Making a motion.

Mr. Kraut To have a second to go into Executive Session.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Up in Albany?

All Aye.

Mr. Kraut We are going into Executive Session.

Mr. Kraut Will members of the public please exit. This session is limited to members and DOH staff.

Mr. Kraut While the room is getting reset, welcome back. We're now back in session having ended the Executive Session.

Mr. Kraut I now like to have a motion to approve the minutes of October 6th, 2022 of the meeting minutes.

Mr. Kraut I have a motion, Dr. Berliner. A second, Dr. Torres.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Kraut I'm now going to turn it over to Dr. Morley to give the report of the Office of Primary Care and Health Systems Management.

Dr. Morley Thank you, Mr. Kraut.

Dr. Morley Can you hear me?

Mr. Kraut Yes, we can.

Dr. Morley I'm Dr. John Morley. I'm the Deputy Commissioner for the Office of Primary Care and Health Systems Management. Beginning my report with the Center for Health Care Policy and Resources, the PPE Stockpile Methodology. The department is actively reaching out to key identified stakeholders, including nursing home and hospital associations, labor unions and medical societies in New York State to explore alternative methods for hospitals and nursing homes to ensure an adequate PPE stockpile in the event of another pandemic should supply chains be disrupted. Number two, Prescription Drug Regulations. To implement public health laws Section 280 B, the department is currently developing regulations to instruct hospitals how to register as a donor or recipient entity for unused prescription drugs. These regulations will help indigent patients access and afford needed medications. Number three, nurses across New York, the NANY program, will continue to work towards publishing the request for applications prior to the end of this month, December 31st. From the Bureau of Emergency Medical Services, the World University Games for 2023 will be taking place in Lake Placid. World University Games, also known as WUG 23. It's an eleven day international festival and competition that combines high level sports with educational and cultural events. It'll be in Lake Placid and nearby towns between January the 12th, 2023 and January 22nd, 2023. The department, along with other agencies of the New York State WUG Commission and the organizing committee, have been participating in monthly planning calls since the Fall of 2021. The department determined early on that the organizing committee would be required to obtain a Part 18 permit for the event. The Bureau of EMS staff continue to work with the organizers on completing the Emergency Management Report. From the Bureau of Narcotic Enforcement, as I'm certain you're aware, the COVID-19 pandemic accelerated the evolution of some segments of health care delivery system to New Yorkers. The practice of telemedicine expanded greatly, preserving and extending access to care. The federal government and New York State have both recognized that telemedicine continues to play a vital role while the federal public health emergency due to the COVID-19 persists. The federal DEA is permitting telemedicine practitioners to prescribe controlled substances without the usual prerequisite of an in-personal physical examination. To ensure the continued availability of medically necessary access to controlled substance medications, the Commissioner of Health has determined that it's necessary to permit controlled substance prescribing by telemedicine in the same manner that the DEA permits limited to the duration of the COVID-19 federal public health emergency. This determination will sustain access to controlled substance medications and provide consistency for telemedicine practitioners, pharmacists and patients. The department intends to finalize and post this termination online for the duration of the COVID-19 federal public health emergency. There has been a cybersecurity events at a large hospital system in New York City. The system suffered a cyber incident on approximately 11/21/22, which resulted in the disabling of their electronic health record. All sites are currently using read only access to information. I remind folks that the events that are taking place in Eastern Europe and in Russia have led to significant increases in hacking events. There's a great deal of susceptibility to this problem in the United States. Our health care transformation group, Statewide Health Healthcare Transformation Three is in the final stages and we anticipate

announcements of awards very shortly. We aim to have out the request for applications for statewide for in early 2023. The Center for Provider Services and Oversight. I'm happy to report that there are no significant workforce actions also known as strikes in New York State at this time. The Safe Nurse Staffing Bill, the work group met three weeks ago and reviewed the draft annual report as required by statute. We very much appreciate their input on that report. We continue to work on regulations for safe nurse staffing with the unions, with the hospital associations and with the Governor's Office. As you did hear from the Commissioner, there is a plethora of virus activity in the communities. These viruses are having a very clear and direct impact, not just on individual patient level, but on the system level. Hospitals are full and the long standing issue of crowding in the emergency departments of hospitals continues unabated. The ED issue is having an impact on more than patients in the hospitals. It's affecting the EMS system. CMAC, the State Emergency Medical Advisory Committee and SEMSCO, the State Emergency Medical Services Council, have both raised concerns about this impact on EMS. Where an EMS crew could transfer a patient to the care of the hospital, be ready for their next emergency call, be it a motor vehicle accident, a gunshot wound, heart attack, stroke or whatever the emergency is that relate to the activation of the 911 system. It was being done in under thirty minutes. It's now not unusual, not rare for it to take over two hours to transfer a patient to the care of the hospital staff. This is having a very significant time on response times. The times that it takes for the ambulance to arrive at the motor vehicle accident, at the scene of whatever event has occurred or wherever the emergency is necessary. The Chair of CMAC recently met with our own Chair of the council and Dr. Rugge. I will leave to Mr. Kraut further details on the discussion that took place between the Chair of CMAC and himself and the outcome from that discussion. That's the end of my report. I'll be happy to take any questions. Again, I'll look for any additional information from the Chair of this committee related to the CMAC request.

Mr. Kraut Let me just comment before we open up for questions. As we all are aware, the challenge of staffing our facilities throughout the state, particularly in our Upstate in a rural areas, has had numerous unintended consequences beyond the walls of the institution. One of the things the SEMSCO had pointed out is we're experiencing an issue with ambulances in rural areas who are coming to the ED, are being asked to wait many times in the ED, but more often outside of the day with their patient to keep the patient on a stretcher because of the inability of the hospital or the ED staff to accommodate that patient. There's insufficient staff. There's sufficient beds. There's insufficient resources. As you could expect, that backs up. Particularly in a rural area where they don't have a lot of ambulance services, you can't get that crew back out on the road if they can't drop off a patient on the stretcher that they have. That has repercussions for the amount of time it takes for the ambulance crews to respond to the next call if they can't do it. One of the things both Dr. Ruggie and I, in discussing this, we believe this is an issue to that it has serious ramifications. We want Dr. Ruggie and the planning committee to kind of have a discussion about it, to shine light on it and make the administrative and the regulatory and the community people aware in the state of this problem and to try to work out potential solutions that might be beneficial in doing this. This is where I think a good role of the committee. John, I think you've already kind of have discussions that you plan to schedule that at the next cycle. Is that correct?

Dr. Morley Yes.

Mr. Kraut I'll leave it up to you, John, if you could add anything.

Dr. Rugge Thanks to Dr. Morley, there have been very preliminary discussions about how to organize an approach to this particular problem of system stress. I think there can be some early on ways to address it and also may open up a broader discussion about how do we deal with system stress overall. Looking at convening a meeting within the next month or two of the Planning Committee and the hope of developing both an agenda and a series of proposals for consideration by the council and the department.

Mr. Kraut It's another indication, as we talked before, about health equity, the prevention agenda, public health, it's the interconnectedness of all these different offices within the department and the need to have alignment within. Essentially, even as we try to pivot away from some more mundane activities to focus in on public health and strategy and policy for the state. This is a good example that we could use this venue to do so.

Mr. Kraut With that, if there's any other questions for Dr. Morley, I'll give it to Dr. Berliner, Dr. Boufford, then Dr. Kalkut, then I'll go to Albany.

Dr. Rugge Dr. Bennett has a comment.

Dr. Bennett Could I just have a comment? I think this kind of gridlock in the system is obviously multifactorial. What it's causing is gridlock everywhere. I believe, as I look at it, the single most important feature in the gridlock right now is workforce. It's workforce, workforce, workforce. If you look at the hospitals in Upstate New York, particularly in this region, they don't have enough staff. Private practices are starting to feel the same thing. That's why the ambulances are waiting to unload their patients. It's workforce, workforce, workforce.

Dr. Berliner What that's led to is an interconnectedness in terms of problems. As we've heard, difficulties with staffing the nursing homes lead to back up in terms of hospital capacity, which leads to backup of ED capacity, which leads to our ambulances with patients in the parking lots for hours. It's unacceptable. We can't solve all the problems at once, but at least we can begin as a planning entity to look at how to address the issue of those access problems for the ambulances in the ED. That may lead to some broader discussion about what can we do for the health system in general.

Mr. Kraut Thank you.

Mr. Kraut Howard.

Dr. Strange John, this is one of my favorite topics. Many years ago, we approved the dissolution of evening operations for the emergency room at the Lake Placid Hospital, but it was our understanding at the time that if there was an international competition, they would have to go back to twenty-four hour operation. In light of your comments about the problems with workforce and staffing, when do they cut back to twenty-four hour operation? When does that end again?

Dr. Rugge Others in the department may know more about this than I, but as I understand it, the parent organization, Adirondack Medical Center, Adirondack Health.

Mr. Kraut Hold on.

Mr. Kraut Howard asked the question. He's basically giving you an agenda item for the committee meeting.

Dr. Rugge Fine.

Mr. Kraut Let's get that into the agenda of the committee, because I got to move the meeting along. That's all. I just wanted to let you know this is a topic that we're going to be taking up. It's multifactorial. If you have questions or comments, please direct them to Dr. Rugge, so we make sure it's part of the agenda of that committee.

Mr. Kraut I now called on Dr. Boufford, then Dr. Kalkut, and I'll go back up to Albany.

Dr. Boufford Thanks.

Dr. Boufford I just want to change topics. I have sort of three questions. One has to do with your very helpful report on the authority you have over, if you will, non hospitals around the surge and flex question. One of the points in the minutes that I wanted to raise is not so much... I appreciate the fact that you cannot include entities over which the department has no authority in any surge and flex regulation. Part of their request repeatedly, which I was making every time this regulation came forward, was the fact that and again, to the degree that you can be Article 28 institutions, ambulatory care institutions, primary care institutions that you do regulate and the local health department had not been involved in, perhaps not been used to the full extent they could have in the initial COVID response, but importantly, that they be involved in planning for the next one. I think your response was, we will turn to them when the next one comes along. If necessary, we'll use them more. The request I think, or I would make at least would be that we would talk about how they would be involved in developing the plan for the next response. Because right now on the regulatory side, we've looked at the only folks involved in their planning our hospital. That's that one comment. The second one I wanted to raise is that I had previously also requested that the council be provided with and this can be in the next meeting, the current language that's being used to link the prevention agenda performance with the CON link. I know we're going to be looking at CON's with equity and other things, but I think it'll be really... I'd like to reopen that conversation and see where we might take it forward with other entities when that happens. Finally, this is a little bit off, but colleagues of mine that are very involved in primary care were concerned about the Governor's veto of a set of commission that had been proposed by the legislature, one of which was a commission to oversee the new primary care initiative to bring more attention to primary care in the state of New York. I appreciate there are lots of complex reasons why not to have a lot of other bodies that have to be staffed and worked on. I wondered if your office has a plan B relative to the idea of a primary care initiative that really looked at the sector of the health care delivery system in a way that is very badly needed, I think, especially as we move into our next wave.

Dr. Boufford Thank you.

Mr. Kraut John, I'll just let you respond.

Dr. Rugge In terms of the Article 28, we are talking to the folks. The FQHC's and other groups are very anxious actually to help and to participate. We have not come to concrete mechanisms in terms of what they will do, but we are talking with them about that and they're willing and interested.

Mr. Kraut Local health departments as well.

Dr. Rugge Thank you.

Dr. Rugge Yes.

Dr. Rugge We talked to the local health departments on a monthly basis.

Dr. Boufford John, I appreciate you're in touch with these folks. I'm really talking about a very specific agenda item and I think perhaps would be great to work with them around how they could be incorporated into appropriately into planning for the next COVID response.

Dr. Rugge Those are things that we are talking to them about. We just don't have an outcome yet that I can speak for them in terms of what they will be doing. this is something that has been a conversation with them. the issue of current language on the CoN and the prevention agenda, we will get that to you before the end of the week, which ends tomorrow so that gives us twenty-four hours.

Mr. Kraut Take a week.

Dr. Rugge We're overdue on that. I apologize. We will get that to you as soon as we can.

Dr. Rugge In terms of the private practice issue, we have not been focusing on that so far, but that is something that we will be working on in January of 2023.

Mr. Kraut John, you may have misspoke. You meant not private practice, primary care.

Dr. Rugge Sorry. Primary care. You're right.

Mr. Kraut Go ahead.

Dr. Boufford To clarify, the legislature proposed a commission on primary care that would oversee an initial primary care initiative broadly drawn. That was my question.

Dr. Rugge I'm not familiar with that legislation at all.

Mr. Kraut You might want to look at the language of what was proposed because I suspect it'll be subsumed.

Dr. Rugge Was that the last session that that was something that was proposed?

Mr. Kraut Yes.

Dr. Boufford They were vetoed. There was a bucket of commissions. Among those was the primary care commission that was to have initiated the primary care initiative.

Dr. Rugge Thank you.

Dr. Rugge It didn't make it onto my list at all, so it will now.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut John, thanks for your report. I wanted to make a comment. I'm assuming it came out of your office, which is the laboratory guidance for Ebola virus disease testing for hospitals and off campus emergency departments. Our people and I assume it's not the first time you've heard some of this. The people will not or do not want to use the main laboratory to do routine laboratory testing for people under investigation, patients under investigation in the emergency department for Ebola, CBC, patients with potential Ebola for CBCs liver function tests and the like. They feel they would have to take their machine that does thousands of tests a day offline and would disrupt the hospital flow because a major piece of equipment is out of service until it's decontaminated. There are other issues, obviously, with point of care testing, which is the other option that the guidance offers. It probably is more feasible, but obviously there is expense and having to do laboratory tests like this for twenty-four hours other issues, staffing, space, etc. Again, very difficult to implement. I understand the urgency of identifying a case of a patient with Ebola. The outbreak in Uganda has continued, but the difficulty in implementation of this guidance is really, I think, a major issue across the hospital community.

Dr. Morley It did not come from OPCHSM. is not part of our office. It is in public health. Having said that, I've participated in conversations about this topic. I'm not sure what the difficulty is. This is not like a prion where you have to burn equipment that gets used. This is a virus like other viruses. Yes, it is a serious virus that causes serious illness, But I've been told by the laboratory folks there is no reason to take equipment off line if it's been used for Ebola. It's just like any other virus in terms of the systems that they use and the protections. As long as you're following the usual protections, you're fine.

Dr. Kalkut I'd argue that there are viruses in blood where many specimens our people feel that the machines need to be decontaminated before putting back into service. Let's not dispute one way or the other here. That's an issue that we're hearing.

Mr. Kraut Can we take it back to Office of Public Health and particularly the Director of the Wadsworth Laboratories, maybe to follow up with Dr. Kalkut and his associates. I'm sure from what I understand, it's a little more broad based than just Dr. Kalkut's institution.

Dr. Morley We'll be happy to have the Wadsworth folks contact you.

Mr. Kraut Thank you, John.

Mr. Kraut There are no other questions for Dr. Morley, I'd like to move on and get a report from the Office of Aging and Long Term Care.

Mr. Kraut Adam.

Mr. Herbst Adam Herbst, Deputy Commissioner for the Aging and Long Term Care. I'd like to refer to my October remarks and I'll go into some detail towards the end of my comments to consider to address some of the concerns raised regarding the safe staffing regulations that were discussed and considered at the November 17th meeting. First, I'd like to describe some high priority activities in my office since my last report in October. I previously reported, OALTC will continue to spearhead the implementation and execution of this New York State's master plan for aging. This is intended when the Governor signed the Executive Order two months ago now. This master plan that intended to create a blueprint of strategies for government, the private sector and nonprofits support older New Yorkers. It's also intended to address challenges related to communication, coordination, caregiving, long term financing and innovative care, and ensure that state policy and

programs are coordinated and aligned to ensure that all New Yorkers can age in our state with freedom, dignity and independence for as long as possible. Today, I am proud to report that yesterday, December 7th, we launched the first meeting of New York's Master Plan for Aging. The council is comprised of heads of New York State agencies and all commissioners. The council will not only be responsible for receiving recommendations from the Stakeholder Advisory Committee and providing a final report.

Mr. Kraut We're going to ask you to sit. We need to see the screen. We need to communicate with our folks in Albany.

Mr. Kraut Thank you.

Mr. Kraut Just don't block the screen so we can communicate.

Mr. Kraut Thank you.

Mr. Herbst Our charge is to deliver to the Governor a final master plan set of recommendations in late 2024. At the convening of the agency, council was only a first step. Our next step will be to convene a master plan stakeholder advisory committee that will bring together approximately twenty-five aging experts from across the different sectors in New York State to gather feedback and input through a series of stakeholder engagement sessions and will support the creation of the master plan in collaboration with the Agency Council. Beyond the Council and Stakeholder Committee, stakeholders and members of the public will have multiple opportunities to provide feedback and to engage in the development of our states master plan for aging. These opportunities to include participating in stakeholder engagement sessions, town halls and other public forums and serve on subcommittees so we can hear from everybody and it's fully inclusive. As I stated back in October, I look forward to continuing to work with the Public Health and Health Planning Council as a partner in addressing the health and long term care needs of our aging population in New York. At a quick glance, OALTC has already initiated some very important work, one of which is the processing of the applications. As you may be aware, the department released the new licensure application process in mid-August. Although we expected a steady of applications you would be asked to approve that is not necessary occurred. To date we have received a total of fifteen applications acknowledged by the Department to review since the lifting of the moratorium. Staff are currently reviewing on a first come, first served basis. That said, I did commit to looking at the various licensure processes to determine if we could streamline the process without compromising quality. This work is very much underway. I am pleased to report that under the leadership of Mark Furnish processes are being examined and work is developing right now on a management agreement consolidation plan. This process should be in place by November of 2023. I look forward to updating this group at our next public conversation with a next step. Another important initiative that my office is working on is the nursing home quality, which remains at the forefront of everyone's mind. We will continue efforts to improve nursing home quality, leveraging our toolbox of resources within the department, which include the legislative and regulatory processes, the executive budget and thoughtful policy development that we are very much working on as we end this calendar year. We look forward to partnering with you on some very important policy initiatives in the next year for nursing and quality. One additional initiative that I'd like to highlight today is the PACE reform. We continue our discussions and planning on structural alternatives for the program of all inclusive care for the elderly, also known as the PACE program. As previously mentioned, we will continue to work with our partners in the Medicaid office, external stakeholders and this body on these alternatives. That being said, I'd like to go on

relatively quickly, but like to go to my my final comments with respect to the safe staffing regulations. I first want to thank you for the thoughtful and engaging discussion on the two safe staffing regulations on November 17th. I want to take some time now to address some concerns that have been raised since that time. I want to assure you that the department did not mislead this body. Both the 7040 direct care spending regulation and the minimum nurse staffing regulations were the direct result of two prescriptive statutes that specifically required the Department of Health to draft and adopt regulations. At the November 17th meeting, I explained in detail the procedural history of both the 7040 direct care spending and the minimum staffing statutes. Again, to be transparent and clear with you all, I want to give a very brief synopsis today. The 7040 direct resident care spending statute was enacted by the legislature as Chapter 57 of the law as of 2021. The law was slated to go into effect on January 1st, 2022. However, the Governor declared a state of emergency suspending the implementation date from January 1st, 2022 through March 31st, 2022 based on the workforce shortage facing our state and the nation. The minimum nurse staffing statute was enacted by the Legislature and became Chapter 156 of the laws of 2021. This law was slated to go into effect on January 1st, 2022 as well. However, the statute, like the 7040 direct care spending was suspended by the Governor's state of emergency from January 1st, 2022 through March 31st, 2022. Therefore, both statutes went into effect and have been the law in New York since April 1st, 2022. The enacted laws mandate the drafting and adoption of regulations by the Department. Further, public health law mandates that you approve any regulation related to Article 28 nursing home facilities before the department can proceed to adopt a regulation by publishing them in the state register. On November 17th, I also outlined the procedural reasons why both regulations were coming before you, as they did. If the regulations had not been approved on November 17, it would have led to, at the very least, another sixty day delay in complying with the statutory mandate to adopt these regulations because of the required re-issuing and associated public comment period. As I stated to you all on November 17th, the department is in a unique position. The two regulations presented are legislative mandates placed on the department. I said on November 17th that to properly enforce the legislative mandate and to ensure uniformity and consistency across the industry regulations must be in place. I want to be clear that the two laws are in fact and have been since April 1st, 2022. In other words, the requirement that every residential health care facility spend a minimum of 70% of revenue on direct resident care and 40% of revenue on resident facing staffing, as well as the requirement that every nursing home maintain daily average staffing hours equal to 3.5 hours of care per resident per day by a certified nurses aid, licensed nurse or a nurse aide had been in place, once again, since April 1st, 2022. These are statutory requirements. The Legislature placed the responsibility on the Department of Health to set up a guidepost to the notice of standards and provide flexibility to grant waivers.

Mr. Herbst Excuse me.

Mr. Herbst Let me say that again.

Mr. Herbst The legislature placed the responsibility on the department that set up guidepost to enforce these regulations. We at the department have tried to put notice of standards and provide the flexibility to grant waivers and to ensure the industry knows how to document the evidence needed for the waivers. Approval of these regulations allows the department to establish the process for applying for waivers and for exclusions of revenue under the 7040 direct resident care spending statute, as well as the processes for demonstrating the existence of mitigating factors under the nursing home staffing level statute. The regulations are needed to ensure that everyone is on notice of the standards,

provide the flexibility to grant waivers and to ensure the industry knows how to document the evidence needed for the waivers. Approval of the regulations allows the department to establish the process for applying for waivers and for the exclusions of revenue under the 7040 direct care spending statute, as well as the process for demonstrating the existence of the mitigating factors, the nursing home staffing levels statute. Somewhat redundant. I cannot speak to the specifics of pending litigation today. However, a letter recently sent by the New York State Health Facilities Association and the New York State Center for Assisted Living indicates the department misinformed you as to what your options were in deciding whether to approve these mandated regulations. According to an interpretation by both of these associations, the statutes cannot be enforced first adopted the regulations. I want to reiterate that the two laws are in effect and have been in effect since April 1st. It is the department's responsibility, once again, to set up the guidepost to enforce through regulations, and thus failure to adopt the regulations would not have nullified the statutes. Rather, it would leave the industry to operate in a vacuum, resulting in a widespread confusion with respect to both statutes. Such a result would create an ethical responsibility and should be rejected. in fact, in response to questions about what members could do to express its displeasure at the situation, it would suggest the department should reach out through formal communication. I know that you all take your role as members very seriously. You were presented the scenario now in front of the state of New York due to these two legislative mandates. You asked tough and reasonable questions. The department has outlined the scenarios as to what would happen if you did not approve these regulations. Everything done on November 17th by the department was transparent. I hope this discussion today clarifies the situation for you all. As always, I encourage everyone to feel free to reach out to me on this and any other issue that related to aging and long term care. I must end my conversation before I open up to remarks acknowledging Dr. Bassett, who obviously has spoken already today. I want to thank Dr. Bassett, who has only helped our Department of Health in many ways. Dr. Bassett helped us lay the foundation for change and the landscape in the state of New York for aging and long term care. She helped build the foundation that will help us with respect to the long term care community for the long haul. Dr. Bassett helped us begin the process setting very important priorities to better serve all New Yorkers. She is specifically focused and has worked and partnered with me on the needs of aging New Yorkers. I really hope we all can agree and thank Dr. Bassett together in terms of all of her wonderful work over the course of the last year.

Mr. Herbst Thank you.

Mr. Kraut There are two issues here. There's just questions you want to raise. I just want everybody to be aware of the time. We can be losing our quorum if we don't move. Just to be very clear about the questions. Mr. La Rue then Mr. Holt and then Dr. Berliner.

Mr. La Rue Good afternoon, Scott La Rue, member of the council. Thank you for your comment. We appreciate the work that the department has done to really implement legislation that they did not write. We know how complicated it is. We all want more staffing. There's no doubt about that, but it needs to be funded. Even though the legislation did not fully fund what this is going to cost, there was some dollars in the state budget. Could you share with us the timeline or when you think the methodology for distribution will be and when you think they'll be able to start distributing the funds?

Mr. La Rue Thank you.

Mr. Herbst Very important question. We have been actively discussing this actually as recently as this morning. We hope to come back at the next meeting with some very specific indication of a timeline. We hope to distribute that as soon as possible.

Mr. Kraut Mr. Holt.

Mr. Holt Couple of questions. You were discussing the process for waiver in the department to determine the criteria. Can you give us an idea where you're at in that process and when we can expect to see what those criteria would look like?

Mr. Herbst Sure.

Mr. Herbst Thank you.

Mr. Herbst Mark, can you speak to that one moment? I'm just trying to catch my breath here.

Mr. Furnish Yes.

Mr. Kraut The question was about process and timing on the waivers.

Mr. Furnish We are in the process. On December 15th, we are meeting with the Department of Labor to discuss defining acute labor shortages. Once we develop that protocol, we will issue guidance that will be distributed in the form of a dear administrator letter to the industry and to the public at large with that.

Mr. Furnish Thank you.

Mr. Holt Adam, just one other comment, I guess, as much as anything. Appreciate the fact that the department is developing a plan on aging that's forward looking. Have to say, I'm greatly concerned, particularly Upstate, about what the future looks like for us in the long term care sector. It's one thing to be forward looking. It's another thing to get there. From my perspective, I don't know of a colleague provider who's not facing really extreme financial stress right now. I know you know that, but I just want to make sure I said that for the record.

Mr. Herbst I appreciate that. We're very much aware of that.

Mr. Kraut Is the subject for Adam?

Mr. Kraut Why don't you go ahead.

Dr. Berliner I'm wondering if you could say something about the Upstate nursing home that was cited by the Attorney General and specifically the role of the Department of Public Health. Did they raise it? Did they bring it to the Attorney General? And also, I think this council approved a whole bunch of homes by the same ownership. What is the department doing in that regard?

Mr. Herbst I turn to my colleague, the general counsel.

General Counsel I think all I can say is that the case was referred by the department. There was the referral letter to the AG and we have been working in cooperation with the Attorney General on the investigation.

Dr. Berliner Thank you.

Mr. Kraut I think Mark wants to respond to that.

General Counsel Can you repeat your question?

Mr. Kraut The other homes this ownership group may own or have an interest in. Is there surveillance? I guess Howard's asking, are you taking a closer look at those?

General Counsel I don't want to comment on the investigation that's ongoing.

Mr. Herbst I will just say that we, like all surveillance activity, we are ensuring that there's quality of care at every facility. We're very astute to this. My team is working very hard across the state.

Mr. Kraut Before I move on to the next item, is there any questions for Mr. Herbst from Albany?

Mr. Kraut At the conclusion of the meeting in which we adopted the regulations, the council made a resolution to direct the Chair to prepare a letter to send to the Health Chair Leadership. In that letter, which we had shared with all of you for comment, we acknowledged and in fact commended both the legislature and the Governor and promulgating these regulations, being clear that the objectives of high quality care, appropriate staffing and resources in the nursing homes are a goal that we all share. In addition, we had many suggestions we felt that could actually strengthen that statute and improve it for its objective. In doing so, we then drafted a letter for you that everyone had reviewed. We received everybody's comments. We sent it to you for draft. I'd now like a motion authorizing the sending of that letter to the legislature.

Mr. Kraut I have a motion for Mr. Thomas. I have a second, Dr. Kalkut.

Mr. Kraut Any conversation?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

General Counsel Can you please do a roll call vote.

Mr. Kraut Okay.

Mr. Kraut Go ahead.

Mr. Kraut We're going to do a roll call vote.

General Counsel Dr. Bennett?

Dr. Bennett Yes.

General Counsel Dr. Berliner?

General Counsel Dr. Boufford?

Dr. Boufford Yes.

General Counsel Dr. Gutierrez?

Dr. Gutierrez Yes.

General Counsel Mr. Holt?

Mr. Holt Yes.

General Counsel Dr. Kalkut?

Dr. Kalkut Yes.

General Counsel Mr. La Rue?

General Counsel Mr. Lawrence?

General Counsel Dr. Lim?

General Counsel Ms. Monroe?

Ms. Monroe Yes.

General Counsel Dr. Rugge?

Dr. Rugge Yes.

General Counsel Dr. Strange?

Dr. Strange Yes.

General Counsel Dr. Torres?

General Counsel Dr. Watkins?

Dr. Watkins Yes.

General Counsel And the Chair?

Mr. Kraut Yes.

General Counsel Passes.

Mr. Kraut Thank you very much.

Mr. Kraut Before I go to the committee report, I don't know if all of you are aware, but Dr. Gutierrez has made a very difficult decision to resign from the council at the end of this month. Throughout his eleven years of service, I don't think words on a resolution are going to be appropriate for me to reply. I'll just kind of do it. The role, the dedication that he's done to ensuring that every New Yorker has access to quality health care, supporting the prevention agenda. He has literally weathered storms to attend and manage the Codes Committee meeting, assist with obtaining a quorum. I just cannot begin to tell you how much we all appreciate your perspective, your wisdom, your support this many years. You've not only been a strong pillar for others to look up on, lean on for advice and direction, you have been a soul in the conscious of this body. The first day you served here you have taken on some of the most difficult challenges that not only chairing codes, but in reviewing actions against licenses. When you speak, your sense of commitment to always try to do what is right and in the best interests of health care of New Yorkers is an enormous example. You are what every member should aspire to be and to act. I don't understand how I can actually express the words about the privilege it's been to serve with you. We're so grateful for the integrity, your dedication, your contributions, and your enduring commitment to patient care. On behalf of all of us, I thank you. We have a resolution for you. I am not reading it. I would like to turn the mic over to you and to share with us your parting thoughts with us. Again, I wish I was there. I'd be hugging you.

Dr. Gutierrez Thank you, Jeff.

Dr. Gutierrez Thank you, everybody here today and all those that were along the way. I feel that the challenges that we are going through now will demonstrate the metal of this group. Were it not for the virus and the other things that to come, we would be in better shape, but we are not. I think our actions have been correct. Our actions have been sincere.

Mr. Kraut You may have hit the button. It may be off, but we can't hear you. Your mic may be off.

Dr. Gutierrez Mic is on.

Mr. Kraut Just bring it closer.

Dr. Gutierrez I think that the discussions that we had today.

Dr. Gutierrez Can you hear me now?

Mr. Kraut Yes.

Dr. Gutierrez Discussions that we had today were very robust.

Mr. Kraut We're going to ask you to change the mic, because we are not hearing you at all.

Mr. Kraut I'm not going to let this moment pass without hearing your words.

Dr. Gutierrez Is this better?

Mr. Kraut A little bit.

Mr. Kraut It's a little fuzzy.

Ms. Monroe Jeff is too.

Ms. Monroe You are too, Jeff.

Total Webcasting The Zoom sessions audio is failing, so that's what's happening right now. We would have to reset the Zoom session to correct it. We were hoping to move along, I guess. I don't know. It's up to you.

Mr. Kraut What if I call you on the phone and then I'll play it through the mic here.

Dr. Gutierrez That's what we need to be able to switch techniques and switch approaches so we succeed. We are all suffering the results of three horrible years. We have survived that. I think that we'll go forward and succeed. I'm sorry I have to leave now. I would love to stay and learn some more because I've been learning for eleven years. It's time for me to give somebody else a chance to work at the council. Is a last thing that I'll do as a physician today. I had a great life, a great experience with the council. I thank you all for the opportunity to have been able to do this. Stay well, stay healthy. Go forward. You're doing the right thing. We are doing the right thing.

Dr. Gutierrez Thank you.

Mr. Kraut Thank you.

Mr. Kraut You're certainly hearing us. We're all standing up. We have about forty members of the public who are doing likewise here. Thank you so much. We can't say enough. People come and go, but this guy really hits hard. You're going to be missed.

Mr. La Rue I've got to leave, unfortunately.

Mr. Kraut We're going to move right now to the voting.

Mr. Kraut Is that okay?

Mr. La Rue Okay.

Mr. La Rue There's a couple of things. I wanted to mention.

Mr. Kraut Because we're going to lose quorum.

Mr. La Rue Yeah, I'm part of the quorum you're going to lose.

Mr. La Rue Just a quick question. On the nursing home applications that are coming up today that were approved at the previous committee meeting. I don't know if the department had an opportunity to review those for the issues that were laid out in the AG's report and not just specifically to the ownership, but the whole issue of a realty company holding the real estate and whether the amount being paid or the rent is reasonable,

because it seemed like in the allegation that the AG made that that was the way that they were tightening allegedly funds out of the home.

General Counsel Good afternoon. I'm an attorney at the Department of Health. We have reviewed those kinds of things in the project that will be presented. One of them is going to be deferred at the department's request.

General Counsel Thank you.

Mr. Kraut Can we start with Establishment Project Review, please?

Mr. Kraut I'm going to call the first application given to me here because Dr. Kalkut is away and Mr. Robinson is unavailable.

Mr. Kraut I call application 2 2 1 2 4 8 C, NYU Langone Hospital, Long Island to certify a new single Specialty Ambulatory Surgery Extension Clinic on the seventh floor of 211 Station Road, Mineola. Conflict recusal declared by Dr. Kalkut, who's out of the room. DOH and DRC issues. Approvals with contingents and conditions were recommended.

Mr. Kraut May I have a motion?

Mr. Kraut I have a motion, Dr. Strange. I have a second, Dr. Torres.

Mr. Kraut Any comments from the department?

Mr. Kraut Any questions from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Kraut Call Dr. Kalkut in, please.

Mr. Kraut You want me to stop and go to Codes, because if we miss Codes, we got to keep a quorum for Codes.

Mr. Kraut I'm suspending the establishment of Project Review.

Mr. Kraut I'm now going to ask Mr. Holt to give us the Codes.

Mr. Holt Good afternoon. At today's meeting of the Committee on Codes, Regulations and Legislation, the committee reviewed and voted the recommended after the following regulation for approval before the full council. First, investigation of communicable diseases. Members of the Health Department here. They presented the regulation for emergency adoption. They're available for any other questions.

Mr. Holt I move the acceptance of this regulation.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Strange.

Mr. Kraut Any questions from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Holt Second was face coverings for COVID-19 protection. Members of the Health Department presented this regulation for emergency adoption to the committee. They're available if you have any questions.

Mr. Holt I move the acceptance of this regulation.

Mr. Kraut I have a motion from Mr. Holt, a second by Mr. LaRue.

Mr. Kraut Any questions from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut No opposed.

Mr. Kraut Go ahead.

Mr. Holt Third, impact virus on the list of sexually transmitted diseases. Again, the Health Department presented information on its regulation for emergency adoption. They're here should there be any questions.

Mr. Holt I so move.

Mr. Kraut I have the motion from Mr. Holt. I have a second by Dr. Strange.

Mr. Kraut Any questions from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut Motion carries.

Mr. Holt Next, we had maximum prepayment levels that was presented for information only.

Mr. Holt Finally, we had the public water systems. Again, the Health Department presented information to the committee during that meeting.

Mr. Holt I so move the adoption.

Mr. Kraut I have the motion to adopt. I have a second, Mr. LaRue.

Mr. Kraut Any questions from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposition?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Holt That concludes my report.

Mr. Kraut Thank you very much, Mr. Holt.

Mr. Kraut I'll now turn it back to Dr. Kalkut to provide the report of the project review recommendations and establishment actions.

Mr. Kraut Thank you.

Dr. Kalkut Application 2 2 1 1 9 1 B, Maxillofacial Ambulatory Surgery Center, LLC in Suffolk County. This is to establish and construct a single specialty freestanding ambulatory surgery center at 100 Townline Road and Apple, specializing in oral and maxillofacial surgical procedure. Both the department and the committee recommend approval with conditions and contingencies with a recommendation of the operating certificate five years from the date of issuance.

Dr. Kalkut Next is 2 2 1 2 0 6 E, Northern Westchester Facility Project LLC doing business as Yorktown Center for Specialty Surgery. That's in Westchester County. This is a transfer of 20.04% from sixteen existing members to eleven new members and seek Public Health Council approval of eight existing members. Both the department and the committee recommend approval and a contingency.

Dr. Kalkut 2 2 1 1 2 1 3 E, Performance Surgical Center, LLC doing business as Performance Surgical Center in Kings County. This is to establish a Performance Surgical Center LLC as the new operator of Millennium Ambulatory Surgery Center, a multi-specialty freestanding Surgical Center at 1408 Ocean Avenue in Brooklyn. Please note

that on Page 3 of the exhibit, contingency number one has been removed due to being placed on the application in error. Both the department and the committee recommend approval with conditions and contingencies for an exploration of the operating system to get five years from the date of issuance.

Dr. Kalkut I so move.

Mr. Kraut I have the motion to move those applications.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Torres.

Mr. Kraut Any questions on any of those applications?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Ms. Monroe Yes, it's quick.

Ms. Monroe When we have looked at other ambulatory surgery centers in the past, one of our concerns has been whether or not they take Medicaid at their center. If not, that that will add undue burden to the local safety net hospital. Can the department just tell me whether or not these three, whether they will take Medicaid. If not, if we could approach them for reconsideration of that.

Mr. Kraut The establishment committee did look at that and discussed it the data within the court, but I'll give it to the department to answer it directly. That was the question we did resolve a committee meeting.

General Counsel We did take a look at that. The Medicaid revenues, the projected Medicaid revenues are always part of the operating budget submitted. They are part of the exhibit. These three facilities have submitted Medicaid projections that meet what we have historically approved. Also, as noted, there are a limit to life put on the operating certificate and they'll be coming back to the department for us to take a look at what was actually delivered in terms of charity care and Medicaid for indefinite life.

Mr. Kraut Any other questions?

Mr. Kraut Are we okay to proceed?

Mr. Kraut I'll take no answer as no answer.

Mr. Kraut Dr. Kalkut.

Dr. Kalkut 2 2 1 1 4 5 B, Apple Care helped in Kings County to establish and construct a new diagnostic and treatment center at 1570 Fulton Street in Brooklyn. The department and committee recommended approval with condition and contingencies.

Dr. Kalkut 2 2 1 2 2 7 B, Parkchester DTC LLC doing business as Parkchester Diagnostic and Treatment Center in the Bronx, which is to establish and construct a diagnostic treatment center at 1879 Gleason Avenue in the Bronx. Perform renovations and construct new space adjoining existing building. The department and the committee recommend approval with condition and contingencies.

Dr. Kalkut 2 2 1 2 3 1 B, A Friendly Face Academy Corporation in Richmond County. Establish and construct a new diagnostic and treatment center for primary care and other medical specialties at 1887 Richmond Avenue in Staten Island. The department and the committee recommended approval with conditions and contingencies.

Dr. Kalkut 2 2 1 2 6 5 , JAL 28 LLC doing business as A Merryland Health Center in Kings County. This is to establish JAL 28 LLC as the new operator of A Merryland Health Center, a diagnostic treatment center at 2873 West 17th Street in Brooklyn. Currently operated by A Merryland operating LLC and Certified Medical Services and other medical specialties. A note from the department on Page 2 of the exhibit. Contingency number one has been removed due to being placed on this application in error. The separtment and committee recommend approval with conditions and contingencies.

Dr. Kalkut I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner.

Mr. Kraut Any questions on any of these applicants?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Dr. Kalkut 1 9 2 2 0 4 E, Highland Nursing Home. I believe this says North County Nursing and Rehabilitation Center in St. Lawrence County. This application has been deferred at the department's request.

Dr. Kalkut Next is 2 0 2 0 3 4 E, Ulster Nursing Home Operations, LLC doing business as Golden Health Center for Rehabilitation and Nursing in Ulster County. This is to establish Ulster Nursing Home Operation LLC as the new operator of the 280 bed residential health care facility located at 99 Golden Hill Drive in Kingston currently operated as Golden Hill Nursing and Rehab Location Center. The department and committee recommended approval with conditions and contingencies.

Dr. Kalkut 2 1 0 1 0 8 7 E, the Premier Center for Rehabilitation of Westchester, LLC, DBA, Springvale Nursing and Rehabilitation Center in Westchester County to establish the Premier Center for Rehabilitation of Westchester LLC as the new operator of Bethel Nursing and Rehabilitation Center, a 200 bed residential healthcare facility located at 67 Springvale Road. The department and committee recommend approval with condition and contingencies.

Dr. Kalkut I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Second, Mr. Thomas.

Mr. Kraut Any questions?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Kraut We have to repeat one number.

Dr. Kalkut Ulster Nursing Home Operations, LLC doing business as Golden Hill Center for Rehab and Nursing.

Dr. Kalkut Thank you.

Mr. Kraut Just before we conclude, I also want to take the time to recognize that Lisa Thompson, who retired a short while ago, has been with us from the very beginning. She was instrumental in developing a lot of the policies and procedures and the successful operation that we have done. She always was a volunteer, a friendly face. Dr. Boufford and I have issued a resolution for her. She started in the department when Dr. Axelrod, Dr. Chase and Dr. De Bono, Dr. Novello, Dr. Dames, Dr. Shah, Dr. Zucker, Dr. Bassett. She had a phenomenal career starting back in June of 1987, I think. Working with the Public Health Council, the Establishment Committee first, then working as the Assistant Executive Secretary to us. You know how dedicated she was. She was exceptional, nice person, always volunteering to do things. She allowed our counsel to move forward with the work. We want to thank her for her integrity, resourcefulness, ethic, professional demeanor, and most importantly, her sense of humor under all circumstances.

Mr. Kraut Lisa, I don't have the resolution with me, but I'm sure in Albany we'll give it to you. We'll have it framed and everything. Thank you for coming back. See, alumni day.

Mr. Kraut Lisa, we wanted to thank you so much.

Mr. Kraut Our next meeting is going to be on January 26th in Albany. There is a committee meeting February 9th in Albany and New York City both.

Mr. Kraut May I may have a motion to adjourn the Public Health and Health Planning Council meeting.

Mr. Kraut We are adjourned.

Mr. Kraut Thank you.

State of New York
Special Public Health and Health Planning Council

Minutes
January 26, 2023

The meeting of the Public Health and Health Planning Council was held on Thursday, January 26, 2023 at the Empire State Plaza, Concourse Level, Meeting Room 6, Albany, and 90 Church Street, 4th Floor CR 4A/B, New York City. Chairman Jeffrey Kraut presided.

COUNCIL MEMBERS PRESENT

Dr. John Bennett - Albany	Mr. Peter Robinson – NYC
Dr. Howard Berliner – NYC	Dr. Denise Soffel - NYC
Dr. Jo Ivey Boufford - NYC	Mr. Hugh Thomas - NYC
Mr. Jeffrey Kraut – NYC	Dr. Kevin Watkins - Albany
Mr. Scott LaRue – NYC	Dr. Patsy Yang – NYC
Mr. Harvey Lawrence - NYC	Acting Commissioner McDonald –
Dr. Roxanne Lewin - Albany	Ex-Officio Member
Dr. Sabina Lim – NYC	
Ms. Ann Monroe – NYC	

DEPARTMENT OF HEALTH STAFF PRESENT

Mr. Jason Corvino - Zoom
Ms. Valarie Deetz - Zoom
Mr. Vince DiCocco - Albany
Ms. Shelly Glock – NYC
Mr. Ken Evans - Albany
Mr. Mark Furnish - Albany
Mr. Michael Heeran – NYC
Mr. Adam Herbst - Zoom
Dr Eugene Heslin – Albany
Ms. Celeste Johnson - NYC
Mr. Jonathan Karmel - Albany
Ms. Tina Kim - Zoom
Ms. Colleen Leonard- Albany
Mr. George Macko - Albany
Ms. Karen Madden - Zoom
Ms. Kathy Marks – NYC
Dr. John Morley - Albany
Ms. Johanne Morne - Zoom
Ms. Marthe Ngwashi - NYC
Mr. Jason Riegert - Zoom
Mr. Mark Schweitzer - Albany
Ms. Jaclyn Sheltry - Albany
Ms. Angela Smith - Albany
Mr. Michael Stelluti - NYC
Ms. Jennifer Treacy - Albany

INTRODUCTION

Mr. Kraut called the meeting to order and welcomed Council members, meeting participants and observers.

COMMITTEE ON CODES, REGULATIONS AND LEGISLATION ACTIONS

Mr. Kraut introduced Dr. Yang to give the Report of the Committee on Codes, Regulations and Legislation.

Report of the Committee on Codes, Regulations and Legislation
Dr. Patsy Yang, Vice Chair, Committee on Codes, Regulations and Legislation

For Emergency Adoption

20-22 Amendment of Sections 405.11 and 415.19 of Title 10 NYCRR
(Hospital and Nursing Home Personal Protective Equipment (PPE) Requirements)

Dr. Yang introduced for Emergency Adoption of Amendment of Sections 405.11 and 415.19 of Title 10 NYCRR (Hospital and Nursing Home Personal Protective Equipment (PPE) Requirements). Dr. Yang motioned for adoption. Mr. Thomas seconded the motion. The motion carried. Please see page 1 of the transcript.

Dr. Yang concluded her report.

ADJOURNMENT:

Mr. Kraut announced the upcoming PHHPC meetings and adjourned the meeting.

NEW YORK STATE DEPARTMENT OF HEALTH
SPECIAL PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MEETING
JANUARY 26, 2023 10:00 AM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Mr. Kraut I would like to call to meeting the Special Public Health and Health Planning Council of January 26, 2023. I welcome our members, participants and observers. You heard the kind of the rules of the road from Mr. Robinson when he opened the Establishment and Project Review. I'll now call on Dr. Yang, who I might also add has graciously agreed to serve as the new Vice Chair of the Codes Committee. Welcome. Thank you for agreeing to do so. I'd also like to also announce the Dr. Soto has been appointed to serve on the Codes Committee, and we welcome you as well.

Mr. Kraut Dr. Yang, I turn the meeting over to you to give the report on the actions of the Committee of Codes, Regulations and Legislation.

Dr. Yang Thank you, Mr. Kraut.

Dr. Yang Good morning. This morning's meeting of the Committee on Codes, Regulations and Legislation, the committee reviewed and voted to recommend adoption of the Emergency Regulation for approval before the full council. That regulation is hospital and nursing home personal protective equipment requirements. As Jaclyn Sheltry and Jonathan Karmel up in Albany in the State Health Department presented the regulation to the committee. They are available here on camera to answer any questions.

Mr. Kraut Thank you.

Mr. Kraut Do any members of the council have questions for the department?

Mr. Kraut I have a motion from Dr. Yang. I have a second from Mr. Thomas.

Mr. Kraut I'll call for a vote.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion passes unanimously.

Mr. Kraut I'll now adjourn the meeting of the Public Health and Health Planning Council.

Mr. Kraut Thank you very much.

Mr. Kraut I just want to remind everybody, and I'll do this twice. Our next meeting is on Wednesday, February 8th beginning at 10:00am, the Public Health Committee will convene, followed by the Health Planning Committee at 1:30 in both Albany and New York City. On February 9th, the Codes Committee will meet at 10:00am, followed by the annual full meeting of the council in both Albany and New York City.

Mr. Kraut We are adjourned.

Mr. Kraut I will now turn it back to Mr. Robinson.

State of New York
Public Health and Health Planning Council

Minutes
February 9, 2023

The meeting of the Public Health and Health Planning Council was held on Thursday, February 9, 2023 at the Empire State Plaza, Concourse Level, Meeting Room 6, Albany, New York, and 90 Church Street, 4th Floor CR 4 A/B, NYC. Jeffrey Kraut, Chair presided.

COUNCIL MEMBERS PRESENT

Dr. Howard Berliner – NYC	Dr. Mario Ortiz - Albany
Dr. Jo Boufford - Albany	Mr. Peter Robinson – NYC
Mr. Thomas Holt – Albany	Dr. John Rugge – Albany
Dr. Gary Kalkut – NYC	Dr. Theodore Strange - NYC
Mr. Jeffrey Kraut - NYC	Mr. Hugh Thomas – Albany
Mr. Scott LaRue – NYC	Dr. Anderson Torres - NYC
Mr. Harvey Lawrence – NYC	Dr. Kevin Watkins – Albany
Dr. Roxanne Lewin - Albany	Dr. Patsy Yang – NYC
Dr. Sabina Lim – NYC	Acting Commissioner McDonald –
Ms. Ann Monroe – Albany	Ex-Officio - Albany

DEPARTMENT OF HEALTH STAFF PRESENT

Dr. Ursula Bauer - Albany
Mr. Jason Corvino - Zoom
Ms. Valarie Deetz – Zoom
Ms. Ann Foley - Zoom
Mr. Mark Furnish – NYC
Ms. Shelly Glock – Albany
Mr. Michael Heeran – Albany
Mr. Adam Herbst – NYC
Dr Eugene Heslin – Albany
Ms. Celeste Johnson - NYC
Mr. Jonathan Karmel - Albany
Mr. Michael Kharfen - Albany
Ms. Colleen Leonard- NYC
Ms. Karen Madden - Zoom
Mr. George Macko – Albany
Ms. Kathy Marks – NYC
Ms. Marthe Ngwashi - NYC
Dr. John Morley - Albany
Ms. Johanne Morne - Albany
Mr. Travis O'Donnell - Zoom
Ms. Dorothy Persico - Zoom
Mr. Jason Riegert - Albany
Dr. Shane Roberts - Zoom
Ms. Claudette Royal - Zoom
Mr. William Sacks - Zoom
Ms. Kimberly Scott - Zoom
Ms. Angela Smith - Albany
Mr. Michael Stelluti - Zoom
Ms. Jennifer Treacy - Albany

INTRODUCTION

Mr. Kraut called the meeting to order and welcomed Council members, Dr. McDonald, meeting participants and observers.

ELECTION OF OFFICERS

Election of Vice Chairperson

Mr. Kraut nominated Dr. Jo Ivey Boufford to serve as the Council's Vice Chair. The motion was seconded by Dr. Berliner. The motion to appoint Dr. Boufford to serve as Vice Chair passed. Please see page 2 of the attached transcript.

Standing Committee

M. Kraut announced the standing committee's chair and vice chairs. He stated that he recently appointed Dr. Yang to serve as Vice Chair of the Committee on Codes. Regulations and Legislation as well as appointing Dr. Soffel as a member of the Codes Committee. Mr. Kraut also announced that he appointed Ms. Monroe to serve as the Vice Chair of the Health Planning Committee. Mr. Kraut thanked the Council members for their continued dedication. Please see page 2 of the transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Mr. Kraut introduced Dr. McDonald to give the Report on the Activities of the Department.

Dr. McDonald began his report by introducing himself and giving some background about himself. He noted that the work of the PHHPC is very important and thanked the members for many hours they volunteer for the Council.

Dr. McDonald noted that the one of the emergency regulations the PHHPC adopted addressed the statewide face mask requirement for health care facilities, which that statewide face mask requirement, healthcare says has served New York well. He underscored the pandemic is not over and New York is in a period of transition. It is generally recognized COVID is a treatable and preventable disease. We are in a time of transition where the state of emergency nationally is winding down. We see now more than ever the need for organizational and personal responsibility as our persistent way forward. Masking is effective and has kept many people very safe throughout the federal public health emergency. Dr. McDonald encouraged people to not throw away their facemask and to keep one with them. However, we do see our COVID infections as a state decreasing and the hospitalization levels decreasing. It allows New York to shift from blanket mandates to approach in which the Department provide people with the information and tools they need to protect themselves and their families and their organizations. The Department has given health care facilities and general public the information they need to protect themselves from the spread of COVID, not just masking, but ventilation requirements and ventilation advice, vaccinations and handwashing and other non-pharmacological public health measures have been very helpful.

Dr. McDonald stated that one thing that is not on your agenda today is the Department asking the Public Health and Health Planning Council committee to renew the emergency regulation on masking in health care settings. It will expire on February 12, 2023. New York is shifting their request to hospitals and other health care facilities to follow the Centers for Disease

Control and Prevention guidance and to come up with their own plan for when masking may be required for their staff based on community cases, not on vaccine status. When and where masking should be required facilities, already have infection prevention staff to implement, monitor and enforce.

Dr. McDonald explained the COVID numbers steadily dropping since the start of the year. There were 14,541 cases in January 2023 that we knew of admitting there are limitations with the numbers we know from testing, but it's a consistent number. 4,094 on February 6, 2023. There was a decrease in deaths, hospital admissions and decreases in resident cases in nursing homes. He stated the Department is looking to that moment when COVID boosters are as routine as the flu shot.

Dr. McDonald then spoke on the topic of the flu. The flu was hard on New York. It came early this year and hit us hard. The numbers were declining significantly. The week of February 6, 2023 there was a decline in cases which is the seventh week in a row of declining. Dropping 34% over the previous week. There was one pediatric death reported in the first week of February raising the number of children lost to flu this year to nine.

Dr. McDonald stated that Polio and mpox have been significant issues in New York State and the Department has responded with agility and now the State has entered a new phase of recovery in preparation of both those while the Department is preparing for what we could see in the Spring. As this emergency unwinds, the Department continues forward. The Department is asking to make permanent the designation of mpox as a sexually transmitted infection to ensure that everyone is protected including underage, sexually active people. There are resources, staffing and budget to increase awareness, distribute vaccines and provide treatments.

Dr. McDonald noted another important public health issue, which is that of emergency department wait times. They are problematic in New York. Backlogs of patients have forced some people to wait hours or even days for care. The backlog extends to hospital parking lots, where ambulances with patients are detained and have to help care for people until there's room in the emergency department. A very complex and multifactorial issue. Dr. McDonald thaned Department staff as well as the PHHPC's Health Planning Committee for the work they are doing in this complex issue. One step forward resolving this issue is the emergency triage, treat and transport model (ET3). The emergency triage treats, and transport model is voluntary. It is a five-year payment model from the Center for Medicare and Medicaid Services that allows for greater flexibility for ambulance care teams to address the emergency health needs of the Medicare fee for service beneficiaries. Under this pilot, ambulances will be reimbursed to take patients to an alternate destination other than an emergency department so they could go to a primary care office, maybe an urgent care clinic, or a community mental health center. The emergency medical services team is also authorized to initiate treatment in a place with a qualified health care partner early either at the scene or at the 911 emergency responder or via telehealth. This kind of flexibility can not only help ease the backlog emergency departments by redirecting patients who do not need to go to the hospital, but it also sees patients and their families time resulting in significantly lower out-of-pocket costs. New York needs to keep going

forward with developing a statewide disaster response system capable of rapidly deploying emergency medical services resources, as well as establish a program that integrates health care systems and community care medicine to increase patient care.

Dr. McDonald concluded his report by stating that he looks forward to collaborating with the Council. To review the complete report and members questions and comments please see pages 2 through 6 of the transcript.

Report on the Activities of the Office of Public Health

Mr. Kraut introduced Dr. Bauer to give the Report on the Activities of the Office of Public Health.

Dr. Bauer began her report by sharing with the members the launch of the planning process for the next six-year cycle of the Prevention Agenda, New York's Health Improvement Plan. The kickoff was February 8th at the meeting of the Public Health Committee, joined by the Health Planning Committee. Thank you to Dr. Boufford and Dr. Rugge for chairing that meeting and committee members for the robust dialogue and guidance as we begin the planning process. The Department provided members with a high-level overview of the prevention agenda, including state aid to localities. Members noted that the lion's share almost 50% of state aid reimbursements to local health departments supports activities to control communicable diseases. That was true before COVID in 2019 as well as during COVID in 2021 and 2022. Article 6 State aid does not include the additional resources that local health departments received for the COVID response specifically. The Office of Public Health's Deputy Director for Science then presented the midpoint progress for the current 2019 to 2024 cycle. Specifically, trends in prevention agenda indicators from the 2019 to 2021 period. Across 99 public health indicators, 32 were unchanged over the three-year period. 29 targets were met. 19 worsened during that period. 18 improved even though targets were unmet. This 99 prevention agenda indicators are dispersed across six priority areas, in addition to the overarching priority area of improving health status and reducing health disparities. We have priority areas focused on preventing chronic diseases, promoting healthy and safe environments, promoting healthy women, infants and children and promoting well-being and preventing mental and substance use disorders. Finally, preventing communicable diseases. Within the preventing communicable diseases priority, 50% of the indicator targets were met which this is the area that receives the most state aid reimbursement. While the preventing chronic disease priority which receives the least state aid reimbursement had only 16% of indicators met. Committee members noted this association. It also may be the case that the more indicators within a priority, the less likely the indicator targets will be met. For example, the preventing communicable disease priority has 10 indicators while preventing chronic diseases has 25. This issue of considering how to strategically focus the work of the prevention agenda in order to create the greatest impact was raised during the conversation and will continue to be a point of discussion throughout the planning period. How do we balance the breadth and the depth of prevention agenda priorities?

Dr. Bauer also explained that the committee's also heard from Deputy Commissioner Joanne Morne, who introduced us to the work of the Office of Health Equity and Human Rights and offered some guiding principles to address health disparities and more effectively build health equity into the prevention agenda. These include investing in neighborhoods, amplifying community voices, addressing social determinants, the essential role that meaningful work plays in improving lives and the importance of investing in youth. Committee members raised questions about how we engage and empower community voices and the role of the Ad Hoc Leadership Committee in lifting up diverse perspectives as well as mobilizing community action. While community engagement and action were recognized as essential to the success of the prevention agenda, members also recognized the levers that state agencies and state government can bring to bear on both social determinants and public health.

Dr. Bauer noted that the committee's discussed the need to better understand the value the prevention agenda brings to the state and our represent and our residents. Last year, 2022 was the 15th year of the prevention agenda. The Department does not yet have a rich understanding of whether the existence of the prevention agenda has actually contributed to public health improvements. Is it a framework that galvanizes action and accelerates improvements in public health outcomes. Is it a framework that simply tracks the impact of the vital work that we are doing everyday. It may be time over this 18-month planning period to assess this approach to public health improvement and explore ways to tweak, to modify, to advance the approach. The prevention agenda relies on robust partnerships and is largely a voluntary undertaking. Are there ways to strengthen the investment in public health improvement? For example, by leveraging community benefit requirements, by reordering the priorities of Article 6 state aid reimbursement or even by shifting to a further upstream approach of focusing on strengthening the conditions that allow people to achieve their highest level of health rather than on mitigating the adverse effects that occur when those conditions are poor.

Dr. Bauer concluded her report by stating she is grateful for the rich discussion that we had with the Public Health Committee and Health Planning Committee members and looking forward to the continuing partnership as we explore these and other questions and plan the next cycle for the prevention agenda. To view the complete report and Members comments and questions, please see pages 6 through 8 of the transcript.

Report on the Activities of the Office of Health Equity and Human Rights

Mr. Kraut introduced Ms. Morne to give the Report on the Activities of the Office of Health Equity and Human Rights.

Ms. Morne announced the Department is ready to launch the Health Equity Leadership Institute in the month of March. This a 12-month virtual learning collaborative that is prioritizing physicians, advanced practice nurses and health facility administrators. This has been a project that has been in the works for some time. In addition to providing the actual education as it relates to health equity, it is also the opportunity for the Department to evaluate the actual application of the competencies that are being reviewed. She advised that she will have more updates on that as we look at the individuals who are participating and the outcomes that the

Department anticipates as they continue to look for those opportunities to integrate and leverage equitable practices across our service delivery platform.

Ms. Morne then shared that the 2021 New York State LGBTQIA Plus Health and Human Services Needs Assessment has now been published. She stated that the first thing is that the Department noted was a generational shift. This came up in the Public Health Committee discussion as far as looking at the needs and the continuing emerging issues, both from the perspective of youth as well as from the perspective of those who are aging. With the shift, what we find is that community members over the age of 35 and those under 35, as one can imagine, are having very unique, nuanced experiences, expectations and needs. As a result of that, the Department has to work in partnership with New York State's LGBT Health and Human Services Network to assess the services that are currently available and determine the additional services that we need to develop in order to effectively respond to the presenting needs. The Department has found in terms of disparities as far as the needs, the access and the outcomes within the LGBTQ Plus community is that it strongly replicates very strongly with the racial and ethnic health disparities that we see as far as patterns across our nation and in the majority of the needs and issues that have been examined within this survey consistent with other health disparities we see that individuals who identify as Black, Indigenous or other people of color certainly are reporting a higher level of need and lower needs as far as the actual service access available to them. As far as patterns related to privilege and health inequities, we see the patterns that mirror across our nation and in New York State, as much as we are such a progressive state and we have done diligent work to ensure access to services throughout every region of our state. What the needs assessment would tell us is that we have additional work to do, especially as it relates to access for physical health, mental health and other psychosocial points of support.

Ms. Morne move onto an item that was raised at the February 8th Public Health Committee that was specific to the data collection for individuals who identify as Asian or Pacific Islander. She noted that she very briefly touched on the fact that there is current law that speaks to the data collection and the steps that we need to take in order to ensure that there is specific data and reflection of individuals who identify as Asian and Pacific Islander. Ms. Morne gave some background, the legislation that was passed and signed into law requires that every state, agency, board or commission that directly collects data on ethnic origin for residents of the State of New York use separate categories for a number of Asian and Pacific Islander groups. That would include but isn't necessarily limited to individuals who identify as Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan or Taiwanese. Since the bill passage, the Office of Minority Health and Health Disparities Prevention and Office of the Office of Health Equity and Human Rights has been working collectively and in partner with community to develop the next steps as far as operationalizing the intent to this legislation. Ms. Morne advised that there is an existing draft of an implementation plan that is currently under review. The implementation plan includes the Department's phased approach in implementing the changes as needed, as well as identifying some of the practices that can be used universally and the challenges that exist. The challenges as it relates to data and data collection in a consistent manner across not only the Department or all state agencies was a discussion point from yesterday as well. The Department looks forward to the opportunity to use

this legislation and exercise as an opportunity to show how in fact we can collect data that is more informative and more reflective of the individuals being served.

Ms. Morne moved to the topic of the Racial Equity Working Group. This may be a new working group for some. In December of 2021, a bill that was signed into law focuses on the fact that in New York State we have declared racism as a public health crisis, posing a threat to health, safety and overall quality of life. With that, the law mandates that a racial equity working group be developed within the New York State Department of Health. The intent or charge of this group is to study racism's impact on public health while making recommendations for actions that are necessary to reduce or eliminate racial and ethnic disparities. There will be a planning meeting with the membership. The membership is to represent individuals with lived experience from across New York State. That planning meeting will help to create the framework which will be utilized as we move forward with the intent of providing a report to the legislature by the end of the year December 31st. Additionally, as it relates to the long-standing Health Equity Council previously referred to as the Minority Health Council, their next meeting will be March 24th in New York City.

Ms. Morne also noted more recent points of concern that the Department has been working on across the Department. First is an increased number of HIV diagnosis among people who use drugs in Broome County of New York State. The Department has found an increase in the number of individuals who are diagnosed with HIV as compared to past years. The preliminary number of new HIV cases among individuals who report a history of injection drug use diagnosed in the second half of 2022 within Broome County, has been elevated. Most of the diagnoses have occurred in individuals who identify as white, female and between the ages of 30 to 39. When asked the risk factors that were reported included unsuppressed viral load, a lack of recent HIV treatment, multiple sexual as well as injection partners and transactional sex. The Department is also looking at the preliminary data, which at this time indicates an increase in the number of individuals diagnosed with both Hepatitis C and syphilis coinfection. When the Department identifies clusters such as this, there is a policy and guidance that goes into effect. The state works very closely with the local health department, in this case within Broome County, as well as with our funded and non-funded partners in those regions. In order for there to be an immediate response as well as points of outreach, education and intervention in an effort, number one, to collect this information to help us know how to prioritize the Department's response and also to help eliminate any further transmissions.

Ms. Morne stated that as of February 9th a release should have been issued as it relates to the identification of resistant gonorrhea. There was a reported novel strain in Massachusetts of highly resistant gonorrhea. January 20th, Massachusetts issued a clinical alert to make sure that providers were aware of this. Together with the AIDS Institute and our Wadsworth Laboratories, a health advisory has been sent that includes a briefing on these novel cases. The guidance that providers should be using if there is a suspected case of multidrug resistant gonorrhea, as well as the instructions on how to send specimens to Wadsworth Laboratories for processing. In a situation such as this, there is an infrastructure in place to monitor susceptibility. That includes enhanced testing, enhanced case surveillance, sentinel surveillance and partner services.

Ms. Morne advised that the latest County Overdose Quarterly Report was released in January 2023. There is an increase as it relates to opioid related death as well as overdose. We had a 14% increase reflected for 2021 as compared to 2020. That's about a little less than 5,000 individuals that were lost. There's about a 13% increase in outpatient emergency department visits, a 30% increase in outpatient emergency department visits for opioid overdose, also including fentanyl presence and a 12% increase in emergency medical naloxone administration. The Department has a very significant history as it relates to harm reduction and intervention. The recent opioid increases that we are seeing not only in New York State, but across our nation is also largely due to the presence of fentanyl, as well as other illicit drugs that are being placed within the opioids. The history of harm reduction, which begins from the 1990's, includes access across New York State to syringe exchange programs, the distribution of naloxone, drug user health hubs, which act as a point of contact directly for an individual, for example, that is being released for an emergency department, as well as increased access and training for medication assisted treatments such as Suboxone. Ms. Morne noted that when we talk about equity and when we talk about the reduction of disparities, as well as stigma and discrimination, we have to look at these areas across the board. It is very important to understand the infrastructure that New York State maintains in responding to this critical issue.

Ms. Morne concluded her report. To view the complete report and Members comments and questions, please see pages 8 through 11 of the transcript.

Report on the Activities of the Office of Aging and Long Term Care

Mr. Kraut introduced Mr. Herbst to give the Report on the activities of the Office of Aging and Long Term Care.

Mr. Herbst began his report by stating that New York State is the fourth largest population of older adults in the United States, with 3.2 million New Yorkers over the age of 65, a number that is projected to grow to 5.3 million by the year 2030. Caring for these older New Yorkers is expensive. The state spends more on long term care services annually, which is about $32 Billion than any other service. To address the needs of the state's aging population Governor Kathy Hochul signed Executive Order 23 last Fall, which directs the state to develop a master plan for aging. The urgency is clear. New York is facing a tidal wave of aging New Yorkers here in New York State. The Office of Aging and Long Term Care has spent an enormous amount of time in the last few months developing the master plan with our partners in state government, the Office of Aging and other state partners. Planning out the intricate network of government and health care systems dedicated to designing the road map and how New York will provide the necessary care and resources to ensure people can age in place for as long as possible. The Department’s goal is to create a blueprint of public health in age friendly strategies for government, the private sector and the nonprofit sector to support older New Yorkers to remain in their home or to remain in New York for as long as possible. The executive order has directed the Department to provide the Governor with a specific set of recommendations that address the challenges related to communication, coordination, caregiving, long term care services and finances and innovative care. The Department also wants to ensure that state policy and programmers are coordinated and aligned to ensure that New Yorkers can age in our state with freedom, dignity and independence for as long as possible.

Mr. Herbst stated the Department has launched the Master Plan for Aging Council, which is comprised of the heads of many state agencies and the commissioners and experts and leaders from across the aging and long term care ecosystem, including some members here. To strengthen our path moving forward the Department has proposed a set of guiding principles and key considerations that will help guide the operations and substantive content of the council and the committee work. The work has begun to solicit input from state agency leads on the challenges that their programs face in reaching and helping the aging population in New York. Subcommittees have selected two topics to focus on the master plan deliberations, and with various subcommittee members participating.

Mr. Herbst announced that the Department has launched a new public website that is going to provide information and updates on all the work that the Master Plan for Aging will be trying to accomplish. He expressed that his hope is that the stakeholders and members of the public will have multiple opportunities to provide feedback and to engage in the development of the master plan. These opportunities will include participating in statewide stakeholder engagement sessions, which will include town halls and other public forums to help ensure that we've heard from as many New Yorkers as possible. Lastly, the Department will continue to build and sustain our momentum through our subcommittees and public engagement with different venues and work with the Public Health and Health Planning Council as a partner in addressing the health and long-term care needs within the master plan's processes. He noted that the Master Plan is a large initiative and there will be many updates over the next couple of years.

Mr. Herbst stated that the Department released a new licensure application process in mid-August. Since that time, OALTC has hired a significant number of staff to process and review these applications and has worked to streamline and improve the application review process. There are currently 36 pending applications. Starting in the March cycle, the applications will go to the Council for review. OALTC team continues to work on reforming and consolidating the looks of management agreement policy to help reduce the continuing backlog that has occurred in processing and improving management agreements.

Mr. Herbst mentioned that the Department knows the importance of ensuring high quality nursing home quality of care and to remain at the forefront for all of us. Nursing home quality care is very important and OALTC has taken the first steps to reform the quality review and with the recent statutory changes to character and competence. The 40% CMS star rating test for nursing homeowners who own five or more nursing homes over the course of 48 months, and the input of the long-term care to the CON and process has made the process clearer and has served as a quality gatekeeper on several pending applications. There is still much work to be done. OALTC will help start a process of reviewing the rent payments for inter-connected ownership structures, for the reasonableness for such rents. Once developed, OALTC will include this review in all nursing homes and exhibits presented. OALTC will also review all outstanding CON applications and move towards disapproval of CON applications that have languished sometimes for years due to the poor ownership quality history. The Department will continue to improve the process with the Council’s assistance and guidance. He stated that he looks forward to working with Health Planning Committee and the Establishment and Project Review Committee to discuss ways to help improve nursing home quality in the CON process.

Mr. Herbst mentioned that parenthetical to the nursing homes are adult care facilities acts, which falls within the licensure and surveillance of OALTC. ACF's provide long term non-medical residential services to adults who are substantively unable to live independently due to physical, mental or other limitations associated with age and other factors. Residents in these settings do not require the continuing medical and nursing services provided in acute care hospitals, inpatient psych facilities, or skilled nursing facilities. Unlike Article 28 nursing homes or hospitals, Article 36, CHAS and Article 40 hospices and unlike the component of the Medicaid Assisted Living Program, they are not subject to the approval or recommendation. He noted that due to the importance of ACF's in the long term care continuum, the OALTC is dedicated to bringing updates to you surrounding our work in OALTC to ensure access, promote quality of care in perpetuity. Governor Hochul has proposed legislation in this year's executive budget, which creates a system of quality reporting metrics as a first step towards establishing consumer transparency in ACF's. The proposal includes an annual collection and reporting of quality measures for each ACF. These quality measures will be established by my office in consultation with stakeholders and will be made available to the public, along with additional information that might be helpful.

Mr. Herbst next spoke on the topic of PACE reform. The Department continues discussions and planning on structural alternatives for the program of all-inclusive care for the elderly, better known as PACE. On December 28th, the Governor captured into law PACE reforms, Chapter A 12 of the Laws of 2022 seeking to streamline the regulation of PACE programs by developing uniform authorization and encompassing all program requirements into singular licensure improve oversight of PACE organizations. These changes maintain the same level of oversight of all PACE programs that exist today from all across the program areas. This new PACE reform becomes effective in June of this year. OALTC will continue to keep this body posted on all new developments with respect to PACE.

Mr. Herbst thanked the Council for their thoughtful and engaging discussion on the two safe staffing regulations that we discussed in November and December. Mr. Herbst provided updates on the progress. First, with respect to the nursing home minimum staffing requirements 3.5HPRD, the Department consulted with the on the Department of Health determination of an acute labor supply shortage for the 2022 quarterly review periods of Q2, Q3 and Q4. The recommendation has been advanced for agency review. Nursing homes will soon be notified once the determination is publicly available. OALTC is in the process of finalizing and circulating policies, procedures, forms and communications necessary to begin enforcement of the minimum staffing, compliance, determination. As discussed previously, Mr. Herbst noted that OALTC staff will be available to assess facilities as needed once finalized within the industry. The goal is to begin compliance assessments around April 1, 2023.

Mr. Herbst stated that next is the nursing home direct resident spending requirement, also known as the 70/40 spend. This is another area where OALTC is working to finalize the compliance review process, which is very complicated, as you can imagine and includes the cross functional components within the Department of Health and specifically our partners within the Medicaid program, including the long-term care reimbursement team. Please keep in

mind that to assess compliance, the Department will rely in part on the submission of the annual Nursing Home Cost Reports to determine compliance in 2022. Cost reports are due to the Department of Health approximately at the end of July 2023. Compliance reviews begin when nursing homes submit these cost reports. Mr. Herbst advised that the Department is confident that we have identified a tentative solution to address any concerns that were raised about hospital-based nursing homes and the fact that in many instances not all their annual cost reports do not align with the expense cost centers defined in the regulation. The Department has developed a survey to capture applicable revenue and expense data that will include an attestation form and will engage stakeholders prior to the implementation. The goal is to disseminate the administrator letter to hospital-based nursing homes in early April, so they may prepare for completing the survey on a timely basis.

Lastly Mr. Herbst gave a brief update on the executive budget. Governor Hochul released the executive budget which includes many exciting new initiatives directly related to aging and long-term care. These items showcase Governor Hochul's strong commitment to our aging population and align with OALTC's mission and vision of helping older New Yorkers live healthy, meaningful lives with dignity and independence in the least restrictive setting. The Governor's State of the State and executive budget did invest quite a bit in areas which are going to be very important for OALTC, specifically expanding access to primary care, investing in provider reimbursement, providing for provisions for staffing, investing in veterans nursing homes and subsidizing comprehensive health insurance eligible workers. Importantly. In addition, the executive budget is providing for managed care plan integration and other reforms, the expansion of the Medicaid buys in program, increasing supportive housing funding and providing for the pharmacy benefit actions. It is felt that these budget items will help broaden access to aging services, improve quality and transparency in long term care settings, and provide funding for home care teams to help serve lower income older New Yorkers in their communities in addition to providing respite care for caregivers who need to rest. We applaud the Governor for her ongoing efforts to provide for a livable, safe and healthy New York for all aging New Yorkers.

Mr. Herbst concluded his report. To see the complete report please see pages 12 through 16 of the transcript.

REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Report on the Activities of the Office of Primary Care and Health Systems Management

Mr. Kraut introduced Dr. Morley to give the Report on the activities of the Office of Primary Care and Health Systems Management.

Dr. Morley began his report by stating the Center for Health Care Policy and Resources, the Doctors Across New York Program, the Physician Loan Repayment and Physician Practice Support Program, the solicitation of interest for Cycle 9 was released January 18th. The enacted budget for fiscal year 2223 provides funding in the amount of $15, 800,000 and is expected to result in approximately 132 three-year awards. Previously funded cycles provided $9,000,000 in funding and we appreciate the increase. Awards will provide up to $120,000 in total funding to a

physician who agrees to practice in an underserved area for a period of three years of service. Individual physicians and health care facilities are eligible to apply. Applications were being accepted up until February 8th at 4:00pm. The solicitation of interest is posted on the Department's web page. The NANY, the Nurses Across New York program, the solicitation of interest is expected to go out later this month.

Dr. Morley updated the Council on the work of the Bureau of Emergency Medical Services. EMS for Children Program is starting to roll out the National Pediatric Emergency Care Coordination Program for emergency departments. This is a voluntary program. It is designed to help emergency departments to be well prepared to handle pediatric emergencies by following national best practices for both equipment and training. Trauma in New York State is seeing an uptick in level three applications from hospitals who feel they're already treating many trauma patients and would like to elevate the care and recognition by becoming verified Level 3 trauma centers. The State EMS Council recently completed an EMS sustainability whitepaper that was released and is available on the Bureau of the EMS web page under the meeting section as part of the Council Public Documents.

Dr. Morley stated that the Department's Bureau of Narcotic Enforcement (BNE) drug takeback program that was passed and established in 2018 mandates that drug manufacturers establish, fund and manage an approved drug takeback program for the safe collection and disposal of unused covered drugs. There are currently two approved program operators in New York State with over 1600 kiosks and 214 mail back locations available to the public. Over 71,000 of medications have been collected since June of 2022. Additional information is available on the Bureau of Narcotic Enforcement website as part of the DOH website. On January the 31st, Dr. McDonald issued a determination concerning the use of telemedicine. This guidance ensures the continued availability of medically necessary access to controlled substance medications by allowing the use of telemedicine for patient evaluations and prescribing to the same extent that the Drug Enforcement Administration permits for the duration of the federal COVID-19 emergency. Registered practitioners can prescribe Schedule 2-4 controlled substance medications to patients for whom they have not conducted an in-person or medical evaluation, provided that the prescription is issued for legitimate medical purposes by the practitioner acting in the usual course of professional practice. The practitioner is acting in accordance with applicable state and federal laws, and that telemedicine communication is conducted using audio, visual, real time two-way interactive communication system. I must point out that healthcare providers may initiate buprenorphine for the treatment of opioid use disorder with a telephone evaluation only, which expands access to this lifesaving medication to assist combatting the opioid epidemic in New York. The determination Letter can be found on the BNE website with the New York State Department of Health website.

Dr. Morley stated that there is a considerable interest in statewide health care transformation. The Department is in the final stages of moving this through the process and expect to announce the winners of that before the end of February. That will be immediately followed by the RFA for State Health Care Transformation program for again, immediately after three is released.

Dr. Morley highlighted the Center for Providers Services and Oversight's work. The draft regulations for Safe Nurse Staffing were presented to the Codes Committee on February 9th. Adirondack Health, Lake Placid has submitted a closure plan for their freestanding emergency department in October. The purpose of the closure is described by Adirondack is to provide financial relief as more long-term plans are established. Currently, it is open from 8:00am to 8:00pm seven days a week. The plan requests permanent closure. The CON is being requested or being processed to remove the ED service. Adirondack Medical Center Emergency Department is located in Saranac Lake, 11 miles away and will remain open 24/7. Also from the Center for Provider Services and Oversight. Dr. Morley also noted that One Brooklyn Health had a substantial, significant cyber event that was in the press. They suffered an interruption in normal I.T. operations in late 2022. OPCHSM worked with them to help ensure the critical capacity information was continuing to be collected during the time period where OBH was unable to do that, provide that information. OBH resumed full operation in early January. Cyber events are increasingly happening. Dr. Morley asked the Council to remind as many folks as they can of the importance of following just the basic rules of cyber security in addition to having the usual protections at a higher level. Dr. Morley advised that four New York City hospitals went on strike in January from the Mount Sinai system and Montefiore system. OPCHSM staff performed monitoring activities and collected data from the facilities to assure patients that were remaining in the facilities were receiving appropriate levels of care. The strike, fortunately resolved in a matter of days.

Dr. Morley noted that the Buffalo blizzard was a substantial event and OPCHSM staff responded and helped staff operations to respond to the Buffalo blizzard in late December. Teams from the Bureau of EMS staffed the Erie County Emergency Operations Center during the duration of the storm. Other staff created situational awareness reports and helped to mitigate the difficulties at the facilities.

Dr. Morley updated the Council on the 2023 State of the State approval process of health care projects. In 2023, Governor Hochul directed the Department of Health to review and amend the CON process, including raising the cost threshold for projects that need to file a CON and revisiting the definition of, quote, public need, end quote. These and other CON reforms are intended to reduce administrative burden and approval times for more rapid modernization of the state health care infrastructure. The Department last updated CON requirements in 2017 and will be looking at you to recommend changes in recent discussions as well as feedback we have received from providers and stakeholders. The Department looks forward to working with the Council that will be proposing some recommendations to them in the coming months. Finally, the Planning Committee met yesterday.

Lastly, Dr. Morley advised that some members of the State Emergency Medical Advisory Committee and the State Emergency Medical Services Council joined the February 8th Health Planning Committee meeting to discuss concerns they felt had a public health impact and to make recommendations to this body for help with the issue of delays impacting EMS and 911 response times. The meeting brought in health care experts from across the continuum, from primary care and from hospitals through EMS. Speakers from Heaney's Greater New York,

Iroquois, the New York College of Emergency Physicians, Mt. Sinai and many other entities addressed the committee as well as provided written reports. Several potential responses were identified by the participants. There will be follow up. There will be a more detailed report forthcoming

Dr. Morley concluded his report. To see the complete report please see pages 17 through 20 of the transcript.

HEALTH POLICY

Report on the Activities of the Public Health Committee and Health Planning Committee

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

Dr. Rugge stated that Dr. Morley was approached by the past Chair of the State Emergency Services Council regarding concerns over offloading delays at the E.R. ramp. Dr. Morley kindly referred this to this Council and the Health Planning Committee. Dr. McDonald then also enlisted first Deputy Commissioner Heslin to help and partner with us. The first initial meeting was held on February 8th. Very preliminary data indicates a stable census among the emergency departments, but a significant increase in the number of ambulance ride. Likewise, there has been a increase in offloading times, certainly across the middle part of the state capital district, Finger Lakes, Central New York. This is complicated by the fact there's been a notable decrease in the number of squads and an even more significant decrease in available EMT staff. As Dr. Morley indicated, we had had presentations by key stakeholders of across the state and elaborate data presentations by Dr. Heslin from the Department. The upshot is everyone acknowledges significant stresses bouncing back and forth across the system, not only offloading problems but over boarding in the ED, overloading of the hospitals inability to access long term care for discharges. This has resulted in our developing a whiteboard of necessary areas for further research opportunities for improvements and hopefully eventually suggestions for reform and specific actions recommended by the council. Dr. Rugged noted that the Health Planning Committee will be working through all the issues raised yesterday and bring in a more detailed report to the Council and hopefully have suggestions for first steps in reform.

Dr. Rugge concluded his report. To see the complete report please see pages 20 and 21 of the transcript.

PUBLIC HEALTH SERVICES

Report on the Activities of the Health Planning Committee

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

Dr. Boufford thanked Dr. Bauer's and her team for their work putting together a Public Health Committee meeting, especially adding new analytic staff who have replaced retirements for continue to analyze and update the data that is coming in on the Prevention Agenda. She noted that connecting to the Deputy Director for Sciences Office, the capacity to really update the evidence base can lead to informed streamlining of the prevention agenda and also a better opportunity to integrate the equity elements and monitoring and evaluation. Dr. Boufford stated that she is delighted to hear about budget opportunities because this has been the most cost effective initiative that New York has ever undertaken in public health. There has been zero funding of this effort from the beginning, she noted that it is very exciting to see the commitment to replacing staff. Dr. Boufford also thanked Mr. Morne for joining as part of a core group and going forward Dr. Bauer's commitment to bringing in the Commissioner of the Office of Mental Health and OASAS who have been core members of the prevention agenda from the beginning and really very important efforts to have objectives in ageing and also priority area in mental health and wellbeing added. Observations around the complementarity of the Prevention Agenda to statewide initiatives. Mr. Herbst mentioned is the Master Plan for Aging. This can be a way to address many of the population health, community conditions, elements of the master plan, as a lot of work will have to go unnecessarily on the service side in the work that OALTC's taken on. Similarly, complementing the waiver on the prevention agenda effort is very aligned with the Plan for Heroes going forward, which will add planning. Activities are supposed to be multistakeholder. New York has those platforms already at local level and similarly the SDN networks.

Dr. Boufford lastly stated that the Public Health Committee members flagged issues that have been of ongoing concerns which the committee hopes to take up in future meetings. These issues are the public health workforce, an update on the maternal mortality initiative, which the Council has been very interested in for about 4 to 5 years now, and similarly engaging again on community benefit as a potential source for alignment of hospital engagement in their community prevention agenda coalitions with their dollar commitments to improving health in their communities. She also noted that the Public Health Committee have been taking on the issue of violence in the Prevention Agenda before COVID and they hope that they that can come back in the fullness of time as we move forward for the revision process.

Dr. Boufford concluded her report. To see the complete report please see pages 21 and 22 of the transcript.

REGULATION

Mr. Kraut introduced Mr. Holt to give his Report of the Committee on Codes, Regulations and Legislation.

Report of the Committee on Codes, Regulation and Legislation

For Adoption

22-21 Amendment of Section 23.1 of Title 10 NYCRR (Monkeypox Virus to the List of Sexually Transmitted Diseases (STDs)

Mr. Holt introduced for Adoption of Amendment of Part 2, Section 405.3 and Addition of Section 58-1.14 to Title 10 NYCRR (Investigation of Communicable Disease) and motioned for adoption. Dr. Berliner seconded the motion. The motion carried. Please see pages 22 and 23 of the transcript.

For Discussion

21-17 Amendment of Parts 400 and 405 of Title 10 (Clinical Staffing in General Hospitals)

20-28 Amendment of Sections 12.2 & 405.21, and Parts 721, 754 & 795 of Title 10 NYCRR (Perinatal Services, Perinatal Regionalization, Birthing Centers and Maternity Birthing Centers)

Mr. Holt noted that the also on the agenda For Discussion was the Amendment of Parts 400 and 405 of Title 10 (Clinical Staffing in General Hospitals and Amendment of Sections 12.2 & 405.21, and Parts 721, 754 & 795 of Title 10 NYCRR (Perinatal Services, Perinatal Regionalization, Birthing Centers and Maternity Birthing that will be coming back to the Council at a later date for adoption. Please see page 23 of the transcript.

Mr. Holt concluded his report. Mr. Kraut thanked Mr. Holt for his report

PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Mr. Kraut introduced Mr. Robinson to give the Report of the Committee on Establishment and Project Review.

PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

Report of the Committee on Establishment and Project Review

Peter Robinson, Chair, Establishment and Project Review Committee

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 6: Applications for Individual Consideration/Discussion

CON Applications

Dialysis Services – Establish/Construct

		Council Action
201222 E	True North III DC, LLC d/b/a Grand Boulevard Dialysis (Suffolk County) Mr. Kraut – Recusal Dr. Strange – Recusal	Contingent Approval
211244 E	True North VI DC, LLC d/b/a Peconic Bay Dialysis (Suffolk County) Mr. Kraut – Recusal Dr. Strange - Recusal	Contingent Approval

Mr. Robinson first called application 201222 and noted for the record that Mr. Kraut and Dr. Strange have declared conflicts and have exited the meeting room. Mr. Robinson motioned for approval. Mr. Holt seconded the motion. The motion to approve carried with the noted recusals. Please see pages 23 and 24 of the transcript.

Mr. Robinson introduced application 211244 and noted for the record that Mr. Kraut and Dr. Strange have declared conflicts and have remained outside the meeting room. Mr. Robinson motioned for approval. Mr. Holt seconded the motion to approve. The motion carried with the noted recusals. Please see page 25 of the attached transcript.

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

Cardiac Services - Construction

Number	Applicant/Facility	Council Action
182144 C	Nassau University Medical Center (Nassau County) Mr. Kraut – Recusal Dr. Strange – Recusal Dr. Lim - Interest	Contingent Approval

Mr. Robinson introduced application 182144 and noted for the record that Mr. Kraut and Dr. Strange have declared conflicts and have remained outside the meeting room. He also noted for the record that Dr. Lim has an interest. Mr. Robinson motioned for approval. Dr. Torres seconded the motion to approve. The motion carried with the noted recusals. Mr. Kraut and Dr. Strange returned to the meeting room. Please see page 25 through 27 of the attached transcript for members questions and comments.

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

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

CON Applications

Ambulatory Surgery Centers – Establish/Construct

Number	Applicant/Facility	Council Action
222011 B	Flushing Endoscopy Center, LLC (New York County) Dr. Lim – Interest/Abstaining	Contingent Approval
222024 B	787 Ortho ASC LLC d/b/a Peakpoint Midtown West ASC (New York County) Dr. Lim – Recusal	Contingent Approval
222089 B	Peakpoint Flatiron LLC (New York County) Dr. Lim – Recusal	Contingent Approval

Mr. Robinson called application 222011 and noted for the record that Dr. Lim has declared an interest and will abstain. Mr. Robinson motioned for approval. Dr. Strange seconded the motion. The motion carried with Dr. Lim's abstention. Please see page 27 of the transcript.

Mr. Robinson then called application 222024 and noted for the record that Dr. Lim has declared a conflict and has exited the meeting room. Mr. Robinson motioned for approval, Dr. Berliner seconds the motion. The motion carries with Dr. Lim's recusal. Please see pages 27 and 28 of the transcript.

Mr. Robinson then called application 222089 and noted for the record that Dr. Lim has declared a conflict and has remained outside the meeting room. Mr. Robinson motioned for approval, Dr. Berliner seconds the motion. The motion carries with Dr. Lim's recusal. Please see page 28 of the transcript.

CATEGORY 6: Applications for Individual Consideration/Discussion

Certificates

Certificate of Amendment of the Certificate of Incorporation

Applicant	Council Action
Beth Israel Medical Center Dr. Lim - Recusal	Approval

Mr. Robinson then moves to the Certificate of Amendment of the Certificate of Incorporation and notes for the record that Dr. Lim has declared a conflict and has remained outside the meeting room. Mr. Robinson motions for approval and Dr. Berliner seconds the motion. The motion to approve carried with Dr. Lim's recusal. Dr. Lim returns to the meeting room. Please see page 29 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

Ambulatory Surgery Centers – Establish/Construct

Number	Applicant/Facility	Council Action
221252 B	Upstate Endoscopy Associates, LLC d/b/a Upstate Endoscopy Center (Rensselaer County) Dr. Bennett – Recusal (not present at meeting)	Contingent Approval

Mr. Robinson then called application 221252 and noted for the record that Dr. Bennet has declared a conflict of interest but was not present at the meeting. Mr. Robinson motioned for approval, Dr. Strange seconded the motion. The motion to approve passed. Please see pages 29 and 30 of the transcript.

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

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

CON Applications

Diagnostic and Treatment Center - Construction

Number	Applicant/Facility	Council Action
221257 C	Open Door Family Medical Center, Inc. (Westchester County)	Contingent Approval

Mr. Robinson called application 221257 and motioned for approval. Dr. Torres seconded the motion. The motion to approve carried. Please see page 30 of the attached transcript.

CATEGORY 2: Applications Recommended for Approval with the Following:

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

Ambulatory Surgery Center - Construction

Number	Applicant/Facility	Council Action
222012 C	The New York Eye Surgical Center (Saratoga County) Dr. Bennett – Interest (not present at meeting)	Contingent Approval

Mr. Robinson next introduced application 222012 and noted for the record that Dr. Bennet has declared an interest but is not present at the meeting. Mr. Robinson motions for approval, Dr. Berliner seconds the motion. The motion passes. Please see pages 30 and 31 of the attached transcript.

CATEGORY 3: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

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

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

CON Applications

Cardiac Services - Construction

Number	Applicant/Facility	Council Action
222087 C	Mount Sinai Beth Israel (New York County) Dr. Lim - Recusal	No Recommendation

Next, Mr. Robinson called application 222087 and motions for approval. Dr. Berliner seconds the motion. After a lengthy discussion, Mr. Kraut called the question, a roll call vote was conducted. The motion failed with no further motions from members. Dr. Lim returned to the meeting room. Please see pages 31 through 41 for the complete discussion.

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 3: Applications Recommended for Approval with the Following:

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

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the following:

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

NO APPLICATIONS

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

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

CON Applications

Midwifery Birthing Center – Establish/Construct

Number	Applicant/Facility	Council Action
202086 B	Coit House, LLC (Erie County)	Disapproval

Mr. Robinson called application 202086 and motioned for disapproval. Dr. Berliner seconded the motion. After a lengthy discussion the members voted on the disapproval, the motion to disapprove carried with two members opposing. Please see pages 41 through 47 of the transcript.

Residential Health Care Facilities – Establish/Construct

Number	Applicant/Facility	Council Action
192237 E	JAG Operating LLC d/b/a FoltsBrook Center for Nursing and Rehabilitation (Herkimer County)	Contingent Approval
212117 E	Livingston Two Operations LLC d/b/a Livingston Hills Nursing and Rehabilitation Center (Columbia County)	Contingent Approval
222124 E	Woodcrest Rehabilitation & Residential Health Care Center (Queens County)	Contingent Approval

Mr. Robison called application 192237 and motioned for approval. Dr. Berliner seconded the motion. The motion to approve carried. Please see pages 47 and 48 of the transcript.

Mr. Robinson then called application 212117 and motioned for approval. Dr. Berliner seconds the motion. The motion carries. Please see page 48 of the transcript.

Mr. Robinson introduced application 222124 and motioned for approval. Dr. Berliner seconds the motion. The motion to approve carries. Please see page 48 of the transcript.

Certificates

Restated Certificate of Incorporation

Applicant	Council Action
Cayuga Health System, Inc.	Approval

Mr. Robinson called the Restated Certificate of Incorporation of Cayuga Health System, Inc. and motioned for approval. Dr. Berliner seconded the motion. The motion carried. Please page 49 of the transcript.

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

CON Applications

Ambulatory Surgery Centers – Establish/Construct

Number	Applicant/Facility	Council Action
221280 E	Specialists' One-Day Surgery Center, LLC (Onondaga County)	Approval
222036 B	Excelsior ASC LLC d/b/a Excelsior Ambulatory Surgery Center (Kings County)	Contingent Approval

Diagnostic and Treatment Centers – Establish/Construct

Number	Applicant/Facility	Council Action
221281 B	Integrity Care Services (Kings County)	Contingent Approval
222032 B	Mount Valley Care LLC (Rockland County)	Contingent Approval

Residential Health Care Facilities – Establish/Construct

Number	Applicant/Facility	Council Action
222123 E	The Knolls at Goshen, Inc. (Orange County)	Contingent Approval

Mr. Robinson called applications 221280, 222036, 221281, 222032 and 222123 and motioned for approval. Dr. Berliner seconded the motion. The motion to approve carried. Please see pages 49 and 50 of the transcript.

Mr. Robinson concluded his report.

ADJOURNMENT:

Mr. Kraut thanked Mr. Robinson. He then announced the upcoming PHHPC meetings and adjourned the meeting.

NEW YORK STATE DEPARTMENT OF HEALTH
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
ANNUAL FULL COUNCIL COMMITTEE MEETING
FEBRUARY 9, 2023 10:00 AM
ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC
TRANSCRIPT

Mr. Kraut Thank you, Mr. Holt and the committee members, members of the council. I'm Jeffrey Kraut. I have the privilege to call to order the February 9th, 2023, meeting of the annual Public Health and Health Planning Committee Council Meeting. I want to welcome members, participants and observers. As a reminder for all our audience, by now you know that you need to fill out a form which records your attendance at this meeting in accordance with Executive Law 166. We post this form on www.NYHealth.Gov under the Certificate of Need. The email a completed form should all be sent to Colleen.Leonard@Health.NY.Gov. We appreciate your support in us meeting the law. Obviously, we are subject to the Open Meeting Law. Broadcast after the internet. Make sure you're on mute. Don't move around papers. We're doing synchronized captioning, so let's not talk over each other. Again, please identify yourselves when you first speak. I want to encourage members, staff and the public to join the Department of Health's Certificate of Need Listserv. This unit regularly sends out important council information, notices, our agenda, all the material that's included in the agenda, meeting dates and other policy matters not only for the full meeting but for all of our committee meetings. There are printed instructions at the reference table how to join listserv. You can contact Ms. Leonard for assistance. During the course of the meeting, I'll make this mention out for the public and members of the public who are observing us. You're going to see computers, iPads, phones open in front of members. That is not because they're distracted or playing solitaire. That's because today's agenda contains 637 pages. When you include yesterday's planning meeting and other letters and communications we received from public and other interested parties, we have over 850 pages of documentation that's supporting today's agenda. The most efficient way and environmentally appropriate way for us to consult our notes and the information being discussed and provided is by looking at a computer screen in front of us. It does not mean we're not engaged. It does not mean we're not listening. Before I go through today's meeting, I want to just be clear for the record, who's attending. In Albany, we have Dr. Boufford, Mr. Holt, Dr. Lewin, Ms. Monroe, Dr. Ortiz, Dr. Rugge, Dr. Soffel, Dr. Torres, Dr. Watkins. In New York, we have Dr. Berliner, Dr. Kalkut, Mr. La Rue, Mr. Lawrence, Dr. Lim, Mr. Robinson, Ms. Soto, Dr. Strange, Mr. Thomas, Dr. Yang and myself. I believe the Commissioner is joining us as well in Albany. For today's meeting, there's going to be a vote on the appointment of the council's Vice Chair. We're going to hear reports. First, let me just say that it is my pleasure that we are welcoming Acting Commissioner Dr. James McDonald, who is joining us today. I'll call on him in a moment. I just want to just acknowledge and congratulate you on your appointment. I've had the pleasure of having a brief conversation with Dr. McDonald about the council's work and the efforts. He's very aware of it. I think you saw a lot of evidence of that at yesterday's meeting of the Public Health and Health Planning committees and the engaged conversations and the support we receive from department staff in those meetings and will continue to do so. You'll hear from the Office of Public Health, the Office of Health Equity and Human Rights, the Office of Aging and Long-Term Care and the Office of Primary Care and Health Systems Management. We'll get a report for adoption and discussion from the Codes Committee. Mr. Robinson will present recommendations of the Establishment and Project Review Committee. We'll also hear in addition under the reports, and I will move these up before the Establishment Committee

of Dr. Boufford to give us a brief report on the activities of yesterday's meeting for both the Public Health Committee and the Health Planning committees. Members of the Council and most of our guests understand we've organized our agenda, particularly for Establishment and Project Review, which captures the roles and responsibilities of the council. We're going to be batching certificates of need. I hope you've all looked at our agenda. If there's any objection to how we batched those things, please let us know. I now want to move to the election of the council's Vice Chair.

Mr. Kraut I make a motion to re-elect Dr. Boufford to serve as Vice Chair.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner, thank you.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut I'm assuming in Albany it's all affirmative, with the possible exception of Dr. Boufford.

Mr. Kraut Everybody should get a hug for a variety of different reasons. I've recently appointed Dr. Patsy Yang to serve as the Codes Committee Vice Chair and Ms. Ann Monroe as Vice Chair of the Planning Committee. I'd like to thank both of them for serving as well as Dr. Denise Soffel to serve as a member of the Codes Committee. We agree. Thank you for giving us that work. With the exceptions that I've made, there's no other changes to the standing committee. Mr. Robinson will Chair and Dr. Kalkut is Vice Chair of Establishment and Project Review. Dr. Boufford as Chair and Dr. Torres as Vice Chair for Public Health. Dr. Rugge is Chair. Ms. Monroe is Vice Chair of Health Planning. Mr. Holt as Chair. Dr. Yang as Vice Chair of Codes, Committees, Regulations and Legislation. Mr. Thomas has agreed to take on the tremendous task of chairing the Health Personnel and Interprofessional Relations Committee Activities. Dr. Boufford will continue to chair and lead the Ad Hoc Committee to lead the State Health Improvement Plan. I'd like to thank all the members of the council for their hard work and dedication. We look forward to a very productive year, keeping in mind our goals and our service in maintaining and improving the health of New Yorkers. As I said, it's my pleasure to welcome Dr. James McDonald, who's going to update the council about the department's activities since our last meeting.

Mr. Kraut Welcome, Dr. McDonald.

Mr. Kraut Thank you so much for joining us.

Dr. McDonald Thank you, Chairman.

Dr. McDonald It's great to be here today. Just to tell you a little bit about myself for just a moment, because I think most of you probably haven't met me before. I am actually board certified in pediatrics as well as board certified in general preventive medicine and public health. I actually grew up just a few miles North of where I'm sitting right now in a little town in Albany County called Cohoes, New York. I did join the New York State Department of Health in July of 2022 as a Medical Director of the Office of Public Health. I've been to this

meeting twice before in that role. I just want to underscore; I am beyond happy to be back home. I can tell you, as someone who graduated from Siena College in June of 1986, I had no idea it wouldn't be until June of 2022 before I would permanently return home. It has really just been thrilling for my wife and my kids to be back where we've come to know as home forever. My career has been more of an adventure than I ever really thought it would have been. I served as an active-duty pediatrician for six years in the United States Navy. The Navy was very generous in moving me around the country, as it often is. I've had a chance to serve in many parts of the United States. I also got to serve in Okinawa, Japan for two years as a pediatrician, which was just, again, a wonderful lifetime experience here. I enjoyed that. I've practice, I guess, on my own volition, a lot of other parts of the United States as well. I've always been attracted to underserved parts of the United States. That brought me to an underserved area in Pennsylvania for some time after the Navy. I also worked on the Navajo Reservation for two and a half years in Chinle, Arizona, which is just a delightful part of the area. The Navajo people have affected me deeply and profoundly for the better in so many ways. I've also practiced in rural Tennessee. I've spent the last fourteen years in Rhode Island, the last ten plus years serving in various leadership roles of the Rhode Island Department of Health, culminating in January of 22, serving as the Acting Director of the Rhode Island Department of Health. Here we call it Commissioner. There, it's called Director. It's really thrilled to be here as the Acting Commissioner of the New York State Department Health as I now enter my sixth week on the job here. It is fun to follow in the footsteps of Dr. Bassett. However, I really got a chance to know her and respect her very deeply. She's laid a beautiful groundwork for the work that we, quite frankly, must continue to do to strengthen the department and the health and the well-being of everyone who calls New York home. I am really happy to be here for the full council meeting of the Public Health and Health Planning Council. I think it's important, you know, the work you do really is important work. I'm beyond thankful for all the work you've done. It's not lost to me how many hours I volunteered for this council, not just in coming to the meetings, but, you know, Chairman Kraut, you talked about the 800 plus pages that committee members have to review ahead of time. There's an enormous amount of commitment and time you make to this. I just want to make sure it's really clear. I'm very thankful for all the work you do. I recognize the service that is involved in being a member of this great council, which really quite substantially. You've adopted many, many emergency regulations during the pandemic. You've done a lot of things outside the pandemic as well that have been very critical in the state’s role in us with the pandemic. One of the emergency regulations you addressed was the statewide face mask requirement for health care facilities, which that statewide face mask requirement, health care says has served us well. I want to underscore; the pandemic is not over. It's not lost on me that twenty days from now we're going to be at the three-year mark since patient number one in the State of New York. We are in a period of transition. It's generally recognized COVID is a treatable and preventable disease. We're in a time of transition where the state of emergency nationally is winding down. We see now more than ever the need for organizational and personal responsibility as our persistent way forward. I know and we know at the State Department health that masking is effective and has kept many people very safe throughout the federal public health emergency. We're quite frankly, not in the same place we were in 2020. Neither 2021 nor the 2022 where Omnicom really did just sort of just overtake us in many ways. I want to make sure it's clear to you, you know, I am not throwing away my facemask and I keep one with me and I encourage you to do the same as well. However, we do see our COVID infections as a state decreasing. We see our hospitalization levels more importantly, decreasing. It allows us to shift from blanket mandates to approach in which we provide people with the information and tools they need to protect themselves and their families and their organizations. We've given health care facilities and general public the information they need to protect themselves from the

spread of COVID, not just masking, but ventilation requirements and ventilation advice, vaccinations and handwashing and other non-pharmacological public health measures have been very helpful. One of the things that's not on your agenda today, and this is something maybe unusual about what's not on your agenda, is we're not asking the Public Health and Health Planning Council committee to renew the emergency regulation on masking in health care settings. It will expire on February 12th, 2023. Not that I expect you to remember this, but when Jason Riegert and I were here at the last meeting, that's what we asked you to do, is renew it one more time. We're not asking you to renew that today. What we're doing now is we're shifting our request to hospitals and other health care facilities to follow the Centers for Disease Control and Prevention guidance and to come up with their own plan for when masking may be required for their staff based on community cases, not on vaccine status. When and where masking should be required facilities, already have infection prevention staff to implement, monitor and enforce. I think this transition is an important step forward moving beyond the public health emergency. COVID numbers steadily dropping since the start of the year, which I'm very thankful for. Just to give you a few numbers, because we are the State Department of Health. We love to give people numbers. We had 14,541 cases in January 2023 that we knew of admitting there are limitations with the numbers we know from testing, but it's a consistent number. We had 4,094 on February 6. We see decreases in deaths. More importantly, we see decreases in hospital admissions. We also see decreases in resident cases in nursing homes that are also declining as well. As the COVID numbers drop, you know, we do look forward to May 11th at the end of the federal public health emergency. We're not there yet. We are looking to that moment when COVID boosters are as routine as you get your your flu shot. I do think it's important to state this, is that the Bivalent COVID booster, you know, it is safe and effective. I think it's one of those things where we should all use our agency in our role to be helpful, just to encourage our friends and neighbors and others to just get the Bivalent COVID vaccine as much as possible. I certainly got mine back in September when I was able to. Highly encourage others to do the same as well. I want to shift a little bit to a conversation a little bit about flu vaccine and flu season. Flu was a hard year for New York. It came early this year. It hit us hard. We're seeing those numbers declining significantly. This week we saw another week of declining cases. It's the seventh week in a row of declining. We dropped 34% over the previous week. That said, flu is still widespread across the state. We did have one pediatric death last week reported that raised the number of children lost to flu this year to nine. I want to talk a little bit about another public health emergency that's kind of unwinding a little bit. Polio and mpox have been significant issues in New York State in particular. The department has responded, you know, with quite frankly, agility and quite frankly quite well to both polio and to mpox and quite effective work in both cases here. We've entered a new phase of recovery in preparation of both those and working course at the department, being prepared for what we could see in the Spring. As this emergency unwinds, the department continues forward and we're preparing for what the future could give us. We're asking to make permanent the designation of mpox as a sexually transmitted infection to ensure we're protecting all those at risk, including underage, sexually active people. We have the resources, staffing and budget to increase awareness, distribute vaccines and provide treatments. I want to shift to just another topic, you know, another important public health issue, which is that of emergency department wait times. They are problematic in New York. Backlogs of patients have forced some people to wait hours or even days for care. The backlog extends to hospital parking lots, where ambulances with patients, quite frankly, are detained and have to help care for people until there's room in the emergency department. A very complex and multifactorial issue. I'm very thankful for the people department as well as the Public Health and Health Planning Committee for the work they're doing in this complex issue. It's working together on issues like this that we're going to make a difference in this. These

issues didn't crop up overnight. They won't go away overnight. I'm very confident about working together, which is really what public health is. It's collaboration towards really helping the population. We're going to overcome this. One step forward resolving this issue is the emergency triage, treat and transport model. It's sometimes called ET3. The emergency triage treats, and transport model is voluntary. It's a five-year payment model from the Center for Medicare and Medicaid Services, also known as CMS, that allows for greater flexibility for ambulance care teams to address the emergency health needs of the Medicare fee for service beneficiaries. Under this pilot, will be reimbursed to take patients to an alternate destination other than an emergency department so they could go to a primary care office, maybe an urgent care clinic, or a community mental health center. The emergency medical services team is also authorized to initiate treatment in a place with a qualified health care partner early either at the scene or at the 911 emergency responder or via telehealth. This kind of flexibility can not only help ease the backlog emergency departments by redirecting patients who do not need to go to the hospital, but it also sees patients and their families time resulting in significantly lower out-of-pocket costs. We do need to keep going forward with developing a statewide disaster response system capable of rapidly deploying emergency medical services resources, as well as establish a program that integrates health care systems and community care medicine to increase patient care. I want to underscore, looking ahead, I am hopeful. I am optimistic, which is something I haven't really been able to say quite a bit in the last three years. I think a lot of us will say that. The pandemic is not over, but I am optimistic. I don't want to sound too optimistic, but I just want to underscore the moments that I really feel we're in here right now. It's a preventable, treatable disease. We deal with COVID in particular. It is a time of transition. One of the things I think about with the pandemic is how much it affected all of us deeply. It affected us all personally. It still does. Although it's not over, we do have the tools we need to live with this. We have a great vaccine. We have effective treatment. There's masking. There are other strategies we can all do that we can live with this. I think we're just transitioning to a time where organizational and personal responsibility really do become more of where I see our future. I do look forward to collaborating with you in the future.

Dr. McDonald Thank you.

Mr. Kraut Commissioner, thank you so much and appreciate those remarks.

Mr. Kraut Does anybody have any questions for the Commissioner?

Mr. Kraut It's like parliament, you know, as the Prime Minister.

Mr. Kraut Anything in Albany?

Mr. Kraut Ms. Monroe.

Ms. Monroe Thank you.

Ms. Monroe It's very nice to meet you, Commissioner.

Ms. Monroe I'm hoping that the next time we get together, which I guess would be April, you'll be able to share a little more with us about what the Governor and the department's priorities are in the new budget and how that impacts the work of the department in its variety of areas and suggestions about how we might think of some things differently. I very much appreciate the update on COVID and all of that, and I think that's important for

us to know, but I would ask that you kind of broaden your view next time to talk about priorities and areas that need investment that are supported by the Governor and the legislature, or perhaps not as supported as you would have hoped. Is that too much to ask?

Dr. McDonald It's not too much to ask. We'll just plan on it. We'll make a date. Let's just do it. I'll be here and we'll be happy to talk about that. You bet.

Mr. Kraut I have another question from Dr. Kalkut in New York.

Mr. Kraut Thank you.

Dr. Kalkut I thank you very much for the remarks. I think the announcement about lapsing of the emergency mask regulations will be met with a lot of satisfaction and I think is a reflection of how well we have done over a long period of time with COVID treatment, prevention and prevention of health care workers. Just to clarify, with the lapsing of the regulations on Sunday, decisions about mask use in individual facilities, hospitals and skilled nursing facilities will return to an institutional decision. Is that the correct interpretation?

Dr. McDonald Yes.

Dr. Kalkut Thank you, Sir.

Mr. Kraut Well, Commissioner, again, thank you. We appreciate the time. We look forward to the next and continuing conversations. Again, you know, personally, I just want to thank you for your support of the council. We got off to a great start these last six weeks.

Mr. Kraut Thank you very much.

Dr. McDonald Thank you, Chairman.

Mr. Kraut Thank you.

Mr. Kraut Now, I'm going to introduce Dr. Bauer to give a report on the activities of the Office of Public Health.

Mr. Kraut Dr. Bauer.

Dr. Bauer Thank you, Chairman.

Dr. Bauer Good morning. Ursula Bauer, Deputy Commissioner for Public Health. Today, I am pleased to share with you the launch of the planning process for the next six-year cycle of the prevention agenda, New York's Health Improvement Plan. The kickoff was yesterday at the meeting of the Public Health Committee, joined by the Health Planning Committee. Thank you to Dr. Boufford and Dr. Rugge for chairing that meeting and committee members for the robust dialogue and guidance as we begin the planning process. We provided members with a high-level overview of the prevention agenda, including state aid to localities. Members noted that the lion's share almost 50% of state aid reimbursements to local health departments supports activities to control communicable diseases. That's true before COVID in 2019 as well as during COVID in 2021 and 2022. Article 6 State aid does not include the additional resources that local

health departments received for the COVID response specifically. OPH's Deputy Director for Science then presented the midpoint progress for the current 2019 to 2024 cycle. Specifically, trends in prevention agenda indicators from the 2019 to 2021 period. Across 99 public health indicators, 32 were unchanged over the three-year period. 29 targets were met. 19 worsened during that period. 18 improved even though targets were unmet. This 99 prevention agenda indicators are dispersed across six priority areas, in addition to the overarching priority area of improving health status and reducing health disparities. We have priority areas focused on preventing chronic diseases, promoting healthy and safe environments, promoting healthy women, infants and children and promoting well-being and preventing mental and substance use disorders. Finally, preventing communicable diseases. Within the preventing communicable diseases priority, 50% of the indicator targets were met. Recall this is the area that receives the most state aid reimbursement. While the preventing chronic disease priority which receives the least state aid reimbursement had only 16% of indicators met. Committee members noted this association. It also may be the case that the more indicators within a priority, the less likely the indicator targets will be met. For example, the preventing communicable disease priority has 10 indicators while preventing chronic diseases has 25. This issue of considering how to strategically focus the work of the prevention agenda in order to create the greatest impact was raised during the conversation and will continue to be a point of discussion throughout the planning period. How do we balance the breadth and the depth of prevention agenda priorities? We also heard from Deputy Commissioner Joanne Morne, who introduced us to the work of the Office of Health Equity and Human Rights and offered some guiding principles to address health disparities and more effectively build health equity into the prevention agenda. These include investing in neighborhoods, amplifying community voices, addressing social determinants, the essential role that meaningful work plays in improving lives and the importance of investing in youth. Committee members raised questions about how we engage and empower community voices and the role of the Ad Hoc Leadership Committee in lifting up diverse perspectives as well as mobilizing community action. While community engagement and action were recognized as essential to the success of the prevention agenda, members also recognized the levers that state agencies and state government can bring to bear on both social determinants and public health. We discussed the need to better understand the value the prevention agenda brings to the state and our represent and our residents. Last year, 2022 was the 15th year of the prevention agenda. We don't yet have a rich understanding of whether the existence of the prevention agenda has actually contributed to public health improvements. Is it a framework that galvanizes action and accelerates improvements in public health outcomes? Is it a framework that simply tracks the impact of the vital work that we are doing every day? It may be time over this 18-month planning period to assess this approach to public health improvement and explore ways to tweak, to modify, to advance the approach. The prevention agenda relies on robust partnerships and is largely a voluntary undertaking. Are there ways to strengthen the investment in public health improvement? For example, by leveraging community benefit requirements, by reordering the priorities of Article 6 state aid reimbursement or even by shifting to a further upstream approach of focusing on strengthening the conditions that allow people to achieve their highest level of health rather than on mitigating the adverse effects that occur when those conditions are poor. I'm grateful for the rich discussion that we had yesterday with Public Health Committee and Health Planning Committee members and looking forward to the continuing partnership as we explore these and other questions and plan the next cycle for the prevention agenda.

Dr. Bauer Thank you.

Mr. Kraut Thank you very much, Dr. Bauer.

Mr. Kraut Are there questions for Dr. Bauer?

Mr. Kraut Any in Albany?

Mr. Kraut I have some in New York.

Mr. Kraut I'll go to New York.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence Harvey Lawrence, a member of the council. Unfortunately, I was not able to make the meeting yesterday, but I did have a question regarding leveraging the impending 1115 waiver. The resources of that to support many of those initiatives. Did that come up during your conversation yesterday?

Dr. Bauer That absolutely did come up. It's been a topic that we've been thinking about and are eager to explore with our local health department colleagues with the Ad Hoc Leadership Council, so definitely we see opportunities there.

Dr. Bauer Thank you.

Mr. Kraut Any other questions?

Mr. Kraut Dr. Bauer, I just have one.

Mr. Kraut It's just really a comment. Look at it from the resources of the state. You acknowledge it's hard to measure impact. It's very difficult to get accurate measures here. I think part of it is, you know, we may not be using the most contemporary tools and all the data. This is going to be a broken record to somebody. The department is sitting on an all-payer database that has identified data that is able to measure at small areas, movements in in utilization, in health status and utilization of care. We have yet to get that in the hands of researchers, think tanks, policy makers, where I suspect that we can create a new generation of tools because the data is so much richer, we have so much better data. I would just leave it at that, that that would be something we have been trying to liberate. Good data presented and analyzed in a neutral way will drive good policy. We're going to come back to this issue when we talk about health equity in the impact statements, because if the state can't measure it, how is any one provider going to be held accountable for movement there? It's just not going to happen unless we have a good basic, simple set of data and not end up with just information that doesn't really answer the question. I'll just leave it at that. It doesn't need a response. For everybody who sat in your seat, I have made this statement, unfortunately, for many, many years. I hope you will help us liberate that information and get it outside of the department into the academic circles and think tanks. That's all I would say.

Mr. Kraut Dr. Bauer, thank you very much.

Mr. Kraut Somewhat on a related topic, it's now my pleasure to introduce Ms. Morne to give us a report on the activities of the Office of Health Equity and Human Rights.

Ms. Morne Well, thank you very much, Chairman.

Ms. Morne Good morning, everyone. For those who heard some of my remarks from yesterday, I apologize, but I'm back. Sometimes repetition is good. Let me start with the good news that I can offer. I'm really excited to announce that we are ready to launch our Health Equity Leadership Institute that will be launching in the month of March. What this is, is a 12-month virtual learning collaborative that is prioritizing physicians, advanced practice nurses and health facility administrators. This has been a project that has been in the works for some time. In addition to providing the actual education as it relates to health equity, it's also the opportunity for us to evaluate the actual application of the competencies that are being reviewed. I'll be sure to have more updates on that as we look at the individuals who are participating and certainly the outcomes that we anticipate as we continue to look for those opportunities to integrate and leverage equitable practices across our service delivery platform. The next point of good news I want to share is that the 2021 New York State LGBTQIA Plus Health and Human Services Needs Assessment has now been published. Just quickly, if I could review some of the takeaways that we've gained from that health assessment. The first thing is that we certainly have noted a generational shift. This came up yesterday in the Public Health Committee discussion as far as looking at the needs and the continuing emerging issues, both from the perspective of youth as well as from the perspective of those who are aging. With the shift, what we find is that community members over the age of 35 and those under 35, as one can imagine, are having very unique, nuanced experiences, expectations and needs. As a result of that, we have to work in partnership with New York State's LGBT Health and Human Services Network to assess the services that are currently available and determine the additional services that we need to develop in order to effectively respond to the presenting needs. What we find in terms of disparities as far as the needs, the access and the outcomes within the LGBTQ Plus community is that it strongly replicates very strongly with the racial and ethnic health disparities that we see as far as patterns across our nation and in the majority of the needs and issues that have been examined within this survey consistent with other health disparities we see that individuals who identify as Black, Indigenous or other people of color certainly are reporting a higher level of need and lower needs as far as the actual service access available to them. As far as patterns related to privilege and health inequities, again, we see the patterns that mirror across our nation and in New York State, as much as we are such a progressive state and we have done diligent work to ensure access to services throughout every region of our state. What the needs assessment would tell us is that we have additional work to do, especially as it relates to access for physical health, mental health and other psychosocial points of support. I'm going to move onto an item that was raised yesterday during the Public Health Committee. That was specific to the data collection for individuals who identify as Asian or Pacific Islander. I very briefly touched on the fact that there is current law that speaks to the data collection and the steps that we need to take in order to ensure that there is specific data and reflection of individuals who identify as Asian and Pacific Islander. For background, the legislation that was passed and signed into law requires that every state, agency, board or commission that directly collects data on ethnic origin for residents of the State of New York use separate categories for a number of Asian and Pacific Islander groups. That would include but isn't necessarily limited to individuals who identify as Chinese, Japanese, Filipino, Korean, Vietnamese, Cambodian, Indonesian, Pakistani, Sri Lankan or Taiwanese. Since the bill passage, the Office of Minority Health and Health Disparities Prevention and Office of the Office of Health Equity and Human Rights has been working collectively and in partner with community to develop the next steps as far as operationalizing the intent to this legislation. There is an existing draft of an implementation plan that is currently under review. The implementation plan includes the department's phased approach in implementing the changes as needed, as well as

identifying some of the practices that can be used universally and the challenges that exist. The challenges as it relates to data and data collection in a consistent manner across not only the department, but I would suggest other, or all state agencies was a discussion point from yesterday as well. We look forward to the opportunity to use this legislation and exercise as an opportunity to show how in fact we can collect data that is more informative and more reflective of the individuals being served. I'd like to talk for a moment on the Racial Equity Working Group. This may be a new working group for some. Essentially, as background, in December of 2021, a bill that was signed into law focuses on the fact that in New York State we've declared racism as a public health crisis, posing a threat to health, safety and overall quality of life. With that, the law mandates that a racial equity working group be developed within the New York State Department of Health. The intent or charge of this group is to study racism's impact on public health while making recommendations for actions that are necessary to reduce or eliminate racial and ethnic disparities. There will be a planning meeting with the membership. The membership is to represent individuals with lived experience from across New York State. That planning meeting will help to create the framework which will be utilized as we move forward with the intent of providing a report to the legislature by the end of the year December 31st. Additionally, as it relates to the long-standing Health Equity Council previously referred to as the Minority Health Council, their next meeting will be March 24th. That meeting will be held in New York City. I also want to bring some of the more recent points of concern that we have been working on across the department. First is an increased number of HIV diagnosis among people who use drugs in Broome County of New York State. What we have found is an increase in the number of individuals who are diagnosed with HIV as compared to past years. The preliminary number of new HIV cases among individuals who report a history of injection drug use diagnosed in the second half of 2022 within Broome County, has been elevated. Most of the diagnoses have occurred in individuals who identify as white, female and between the ages of 30 to 39. When asked the risk factors that were reported included unsuppressed viral load, a lack of recent HIV treatment, multiple sexual as well as injection partners and transactional sex. We are also looking at the preliminary data, which at this time indicates an increase in the number of individuals diagnosed with both Hepatitis C and syphilis coinfection. When we identify clusters such as this, there is a policy and guidance that goes into effect. The state works very closely with the local health department, in this case within Broome County, as well as with our funded and non-funded partners in those regions. In order for there to be an immediate response as well as points of outreach, education and intervention in an effort, number one, to collect this information to help us know how to prioritize our response and also two, of course, to help eliminate any further transmissions. At this point by this morning, a release should have been issued as it relates to the identification of resistant gonorrhea. As background, there was a reported novel strain in Massachusetts of highly resistant gonorrhea. January 20th, Massachusetts issued a clinical alert to make sure that providers were aware of this. Together with the AIDS Institute and our Wadsworth Laboratories, a health advisory has been sent that includes a briefing on these novel cases. The guidance that providers should be using if there is a suspected case of multidrug resistant gonorrhea, as well as the instructions on how to send specimens to Wadsworth Laboratories for processing. In a situation such as this, there is an infrastructure in place to monitor susceptibility. That includes enhanced testing, enhanced case surveillance, sentinel surveillance and partner services. Along those lines, I also want to make note of the fact that the latest County Overdose Quarterly Report was released. This is in January of this year. No surprise that based on what you see, based on data that's available as well as media report, we continue to see an increase as it relates to opioid related death as well as overdose. We had a 14% increase reflected for 2021 as compared to 2020. That's about a little less than 5,000 individuals that were lost. There's about a 13%

increase in outpatient emergency department visits, a 30% increase in outpatient emergency department visits for opioid overdose, also including fentanyl presence and a 12% increase in emergency medical naloxone administration. My reason for raising this here is to speak for a moment and ensure that everyone on the committee and council is aware of the fact that New York State Department of Health has a very significant history as it relates to harm reduction and intervention. The recent opioid increases that we're seeing not only in New York State, but across our nation is also largely due to the presence of fentanyl, as well as other illicit drugs that are being placed within the opioids. The history of harm reduction, which begins from the 1990's, includes access across New York State to syringe exchange programs, the distribution of naloxone, drug user health hubs, which act as a point of contact directly for an individual, for example, that is being released for an emergency department, as well as increased access and training for medication assisted treatments such as Suboxone. I think that's a very important point to be raised. When we talk about equity and when we talk about the reduction of disparities, as well as stigma and discrimination, I think we have to look at these areas across the board. I think it's very important to understand the infrastructure that New York State maintains in responding to this critical issue.

Ms. Morne Thank you.

Mr. Kraut Thank you very much.

Mr. Kraut Are there any questions?

Mr. Kraut Ms. Soto.

Ms. Soto My comment is that amongst the people who were at the meeting on Monday, yesterday, excuse me. I want to say that I appreciated your quick response. Some of it like within 24 hours regarding some of our comments and issues, namely that we wanted more specification on the collection of Asian-American data and also attention and reporting of the Asian population. You make reference to that group with the LGBT group. I want to commend you of listening to us and like I said, within 24 hours responding.

Ms. Morne Thank you.

Mr. Kraut Thank you.

Mr. Kraut Any other questions in Albany?

Dr. Soffel I have one very, very quick question. I'm sorry, Jeff. I just was wondering; do you have a listing of who's on the Racial Equity Working Group and what their agenda will be? Because I just was quickly looking at the Department of Health website and couldn't find it.

Ms. Morne Yes.

Ms. Morne No, it's not up yet. The website has to be updated as we continue to put the finishing touches on the upcoming planning meeting. We do have a list of individuals that will be on the group and I'm happy to share that outside of the meeting. I'll send that to Ms. Leonard.

Ms. Morne You're welcome.

Mr. Kraut Thank you again.

Mr. Kraut We are looking forward to more reports. I know we'll come back with a code change, hopefully in the March meeting. We'll see a little more of you. I neglected when Dr. Bauer spoke. We touched on the laboratory and that to make people aware that the state has started rebuilding and consolidating probably the nation's premier public health laboratory outside of the CDC is the Wadsworth Lab. To Ms. Monroe's comments about, you know, ask our help. That is a vital resource. I'm sure everybody on this panel will be strong and loud advocates for funding for our laboratory to see it maintains that leading edge science and accessibility to New Yorkers. I just wanted to mention that.

Mr. Kraut I'd like to turn to Mr. Herbst to give a report on the activities of the Office of Aging and Long-Term Care.

Mr. Herbst Thank you, Chairman.

Mr. Herbst Good morning. My name is Adam Herbst, Deputy Commissioner for the Office of Aging and Long-Term Care. I'd like to begin by describing something that my office spent a great deal of time on and we will for the next few years. New York State is the fourth largest population of older adults in the United States, with 3.2 million New Yorkers over the age of 65, a number that is projected to grow to 5.3 million by the year 2030. Caring for these older New Yorkers is expensive. The state spends more on long term care services annually, which is about $32 Billion than any other service. To address the needs of the state's aging population Governor Kathy Hochul signed Executive Order 23 last Fall, which directs the state to develop a master plan for aging. The urgency is clear. We're facing a tidal wave of aging New Yorkers here in New York State. My office, the Office of Aging and Long-Term Care has spent an enormous amount of time in the last few months developing the master plan with our partners in state government, the Office of Aging and other state partners, which I'll mention in a few moments. Planning out the intricate network of government and health care systems dedicated to designing the road map and how New York will provide the necessary care and resources to ensure people can age in place for as long as possible, which is our goal. Our goal is to create a blueprint of public health in age friendly strategies for government, the private sector and the nonprofit sector to support older New Yorkers to remain in their home or to remain in New York for as long as possible. The executive order has directed us to provide the Governor with a specific set of recommendations that address the challenges related to communication, coordination, caregiving, long term care services and finances and innovative care. We also want to ensure that state policy and programmers are coordinated and aligned to ensure that New Yorkers can age in our state with freedom, dignity and independence for as long as possible. Since our last meeting, we've launched the Master Plan for Aging Council, which is comprised of the heads of many state agencies and the commissioners and experts and leaders from across the aging and long-term care ecosystem, including some members here. To strengthen our path moving forward, I've proposed a set of guiding principles and key considerations that will help guide the operations and substantive content of the council and the committee work. We've also begun the process of soliciting input from state agency leads on the challenges that their programs face in reaching and helping the aging population in New York. We've selected subcommittees two topics to focus on the master plan deliberations, and with various subcommittee members participating on that. Finally, we've launched a new public website that is going to provide information and updates on all the work that the Master Plan for Aging will be trying to accomplish. My hope is that the stakeholders and members

of the public will have multiple opportunities to provide feedback and to engage in the development of the master plan. These opportunities will include participating in statewide stakeholder engagement sessions, which will include town halls and other public forums to help ensure that we've heard from as many New Yorkers as possible. Lastly, we will continue to build and sustain our momentum through our subcommittees and public engagement with different venues and work with the Public Health and Health Planning Council as a partner in addressing the health and long-term care needs within the master plan's processes. As you may be aware, the master plan is a large initiative and there will be many updates over the next couple of years. I look forward to partnering with all of you on this. Next, I'd like to provide a quick glance at some work that my office, the Office of Aging Long-Term Care, has been initiating recently. As you may be aware, we released a new licensure application process in mid-August. Since that time, OALTC has hired a significant number of staff to process and review these applications and has worked to streamline and improve the application review process. There are currently 36 pending applications. Starting in the March cycle, I look forward to bringing these applications to this body for review. Further, my team continues to work on reforming and consolidating the looks of management agreement policy to help reduce the continuing backlog that has occurred in processing and improving management agreements. I believe, and I hope that the policy will go into effect later this month. Very important to this body and to our state is ensuring high quality nursing home quality of care and to remain at the forefront for all of us. Nursing home quality care is very important, clearly. We have taken the first steps in OALTC to reform the quality review and with the recent statutory changes to character and competence. The 40% CMS star rating test for nursing homeowners who own five or more nursing homes over the course of 48 months, and the input of the long-term care to the CON and process has made the process clearer and has served as a quality gatekeeper on several pending applications. However, there is still much work to be done. To that end, my team will help start a process of reviewing the rent payments for inter-connected ownership structures, for the reasonableness for such rents. Once developed, OALTC will include this review in all nursing homes and exhibits presented. OALTC will also review all outstanding CON applications and move towards disapproval of CON applications that have languished sometimes for years due to the poor ownership quality history. As we continue to improve the process with your assistance and guidance in the coming months, I look forward to working with Health Policy and Planning Committee and the Establishment and Review Committee at upcoming meetings to discuss and explore additional ways to help improve nursing home quality in the CON process. Parenthetical to the nursing homes are adult care facilities acts, which falls within the licensure and surveillance of OALTC. ACS provide long term non-medical residential services to adults who are substantively unable to live independently due to physical, mental or other limitations associated with age and other factors. Residents in these settings do not require the continuing medical and nursing services provided in acute care hospitals, inpatient psych facilities, or skilled nursing facilities. Unlike Article 28 nursing homes or hospitals, Article 36, CHAS and Article 40 hospices and unlike the component of the Medicaid Assisted Living Program, they are not subject to the approval or recommendation. That being said, because of the importance of ACF's in the long-term care continuum, I am dedicated to bringing updates to you surrounding our work in OALTC to ensure access, promote quality of care in perpetuity. Governor Hochul has proposed legislation in this year's executive budget, which creates a system of quality reporting metrics as a first step towards establishing consumer transparency in ACF's. The proposal includes an annual collection and reporting of quality measures for each ACF. These quality measures will be established by my office in consultation with stakeholders and will be made available to the public, along with additional information that might be helpful. I look forward to speaking with you all about ACF's going forward. I'd like to briefly mention

PACE reform. We continue our discussions and planning on structural alternatives for the program of all-inclusive care for the elderly, better known as PACE. I'm pleased to announce that on December 28th, the Governor captured into law PACE reforms, Chapter A 12 of the Laws of 2022 seeking to streamline the regulation of PACE programs by developing uniform authorization and encompassing all program requirements into singular licensure improve oversight of PACE organizations. These changes maintain the same level of oversight of all PACE programs that exist today from all across the program areas. This new PACE reform becomes effective in June of this year. OALTC will continue to keep this body posted on all new developments with respect to PACE. I look forward to speaking with you all on that. I want to next thank you for the continued, thoughtful and engaging discussion on the two safe staffing regulations that we discussed in November and December. As promised, I wanted to update you on the progress made at this time. First, with respect to the nursing home minimum staffing requirements 3.5HPRD. DOH consulted with the on the Department of Health determination of an acute labor supply shortage for the 2022 quarterly review periods of Q2, Q3 and Q4. The recommended has been advanced for agency review. Nursing homes will soon be notified once the determination is publicly available. My team is in the process of finalizing and circulating policies, procedures, forms and communications necessary to begin enforcement of the minimum staffing, compliance, determination. As discussed previously, my staff will be available to assess facilities as needed once finalized within the industry. Although we are not yet at the finish line, our goal is to begin compliance assessments around April 1st, 2023. Next is the nursing home direct resident spending requirement, also known as the 7040 spend. This is another area where my team is working to finalize the compliance review process, which is very complicated, as you can imagine and includes the cross functional components within the Department of Health and specifically our partners within the Medicaid program, including the long-term care reimbursement team. Please keep in mind that to assess compliance, the department will rely in part on the submission of the annual Nursing Home Cost Reports to determine compliance in 2022. Cost reports are due to the Department of Health approximately at the end of July 2023. Compliance reviews begin when nursing homes submit these cost reports. I look forward to updating you at that particular time. We're confident that we have identified a tentative solution to address any concerns that were raised about hospital-based nursing homes and the fact that in many instances not all their annual cost reports do not align with the expense cost centers defined in the regulation. We have developed a survey to capture applicable revenue and expense data that will include an attestation form and will engage stakeholders prior to the implementation. Our goal is to disseminate the administrator letter to hospital-based nursing homes in early April, so they may prepare for completing the survey on a timely basis. Finally, I'd like to give you all a brief update on the executive budget. Governor Hochul released the executive budget. There have been many exciting new initiatives directly related to aging and long-term care. These items showcase Governor Hochul's strong commitment to our aging population and align with my teams, and OALTC's mission and vision of helping older New Yorkers live healthy, meaningful lives with dignity and independence in the least restrictive setting. The Governor's state of the state and executive budget did invest quite a bit in areas that I think are going to be very important for OALTC, specifically expanding access to primary care, investing in provider reimbursement, providing for provisions for staffing, investing in veterans nursing homes and subsidizing comprehensive health insurance eligible workers. Importantly. In addition, the executive budget is providing for managed care plan integration and other reforms, the expansion of the Medicaid buys in program, increasing supportive housing funding and providing for the pharmacy benefit actions. We believe that these budget items will help broaden access to aging services, improve quality and transparency in long term care settings, and provide funding for home care teams to help serve lower income

older New Yorkers in their communities in addition to providing respite care for caregivers who need to rest. We applaud the Governor for her ongoing efforts to provide for a livable, safe and healthy New York for all aging New Yorkers. As always, please do not hesitate to reach out to me and my team with questions or concerns you have as we partner together to enhance the New York's aging and long-term care agenda going forward.

Mr. Herbst Thank you very much.

Mr. Kraut Thank you very much for that report.

Mr. Kraut Any questions?

Mr. Kraut Mr. La Rue.

Mr. La Rue Good morning. I want to start out first by again expressing how enthusiastic I am that the Governor and the Department of Health is so focused on the issues of long-term care and the aging population. We've been talking about this for a number of years at this council and to see the momentum and the movement is really positive and greatly appreciated. In terms of the budget or the staffing legislation, first, is there any indication yet when the funds are going to be released that were in the prior year's budget to pay for the increased staffing? I know a number of providers without that cash aren't able to achieve the 3.5 requirement.

Mr. Herbst Thank you, Scott. Thank you for those comments. I appreciate that greatly.

Mr. Herbst We are actively moving this process forward and I hope with our partners in the Medicaid office, in the department legal team and our partners in the chamber, that we can advance these funds imminently and as soon as possible. I can't give a specific timeline yet, but it is certainly something we're working very hard on right now.

Mr. La Rue In the budget proposal that was submitted is the 5% replacing the additional funding that was being put forth for the staffing, the 5% Medicaid increase? Does it have any impact on the prior year's allocations as it was presented?

Mr. Herbst It's not replacing. Last year is last year. This year is this year. The 5% should go forward. We're very hopeful that 5% will have an impact. I know that you've been very active in advocating for this increased funding. I'm looking forward to making those funds available. We are making those funds available. We think we'll have a great impact in this year's budget.

Mr. La Rue Thank you.

Mr. Kraut Are there any questions in Albany?

Mr. Holt Jeff, a comment?

Mr. Kraut Go ahead, Tom.

Mr. Holt Thanks, Jeff.

Mr. Holt Adam, thank you also, as Scott indicated for all the work that your office is doing. Again, more and more of a comment than a question and just want to speak specifically to

what we're experiencing Upstate. I think that the applications that we've had before us at project review last cycle and then again, this cycle really point out how incredibly challenging our staffing situation is. I'm appreciative of all that's been put into the budget in terms of additional support proposals for the Medicaid reimbursement for us, but it's a long way to go. You were talking earlier in your comments about a multiyear approach to dealing with aging services in New York State, which obviously we understand we need to approach it that way, but we also have to get the existing provider community to that point. I'm just greatly concerned about what's happening Upstate now. Again, I think some of the applications that we're seeing in front of us now before Project Review speak to those challenges. I think it's even much more dire when we talk about smaller rural communities where we don't have redundant capacity. I think, you know, we've been challenged at the committee level around approvals for some of these applications because we're being presented with choices that aren't ideal for us. We just need to continue to focus not only on the long term but also getting there between then and now.

Mr. Holt Thank you.

Mr. Herbst Appreciate that thought. I look forward to partnering. My team looks forward to partnering with you on this.

Mr. Kraut Thank you.

Mr. Kraut Any other questions?

Mr. Kraut Mr. Thomas.

Mr. Thomas Very quickly, Hugh Thomas, member of council. Good morning, Mr. Herbst. I just wanted to clarify in terms of your statewide Committee on the Aging and the various committee members, will you be looking at the entire Medicaid program or just focus exclusively on long term care? The reason I ask is just because the public data has been announced over the last number of days that the Medicaid program overall not just lives in your control has exceeded 8 million people now. That 32 billion may be light. I just wanted to ask the question and hopefully there'll be an interdisciplinary conversation as you're going through your work.

Mr. Herbst Well, I appreciate the question. My friend and colleague, the Medicaid Director, is a participant on the Master Plan for Aging, very much aware of the driver of the aging and long-term care costs in the Medicaid program and certainly something that will be a relevant conversation.

Mr. Kraut Well, to your point, I think a little over 30% of New Yorkers now are insured through Medicaid. It's no longer an entitlement program for the poor. We've expanded it in very practical ways.

Mr. Thomas In important ways, Mr. Kraut. When you layer in the Medicare enrollment, well, you've got about 12 million people in the state that are on some kind of government insurance, leaving aside the public health well, well regarded decisions. It's just the economics.

Mr. Kraut Hence why government is the major player, not payer and not a major payer.

Mr. Kraut Thank you so much.

Mr. Kraut I'm now going to call on Dr. Morley to give a report on the activities of the Office of Primary Care and Health Systems Management.

Dr. Morley Good afternoon, Mr. Chairman. Thank you very much. I'm Dr. John Morley. I'm the Deputy Commissioner for OPCHCM. From our Center for Health Care Policy and Resources, our Doctors Across New York Program, the Physician Loan Repayment and Physician Practice Support Program, the solicitation of interest for Cycle 9 was released January 18th. The enacted budget for fiscal year 2223 provides funding in the amount of $15, 800,000 and is expected to result in approximately 132 three-year awards. Previously funded cycles provided $9,000,000 in funding and we appreciate the increase. Awards will provide up to $120,000 in total funding to a physician who agrees to practice in an underserved area for a period of three years of service. Individual physicians and health care facilities are eligible to apply. Applications were being accepted up until yesterday, the 8th at 4:00pm. The solicitation of interest is posted on the department web page. NANY, the nurses across New York program, the solicitation of interest is expected to go out later this month. From our Bureau of Emergency Medical Services, EMS for Children Program is starting to roll out the National Pediatric Emergency Care Coordination Program for emergency departments. This is a voluntary program. It is designed to help emergency departments to be well prepared to handle pediatric emergencies by following national best practices for both equipment and training. Trauma in New York State is seeing an uptick in level three applications from hospitals who feel they're already treating many trauma patients and would like to elevate the care and recognition by becoming verified Level 3 trauma centers. The State EMS Council recently completed an EMS sustainability whitepaper that was released and is available on the Bureau of the EMS web page under the meeting section as part of the Council Public Documents. From our Bureau of Narcotic Enforcement, the drug takeback program that was passed and established in 2018 mandates that drug manufacturers establish, fund and manage an approved drug takeback program for the safe collection and disposal of unused covered drugs. There are currently two approved program operators in New York State with over 1600 kiosks and 214 mail back locations available to the public. Over £71,000 of medications have been collected since June of 2022. Additional information is available on the Bureau of Narcotic Enforcement website as part of the DOH website. Telemedicine, and this is still under BNE, Bureau of Narcotic Enforcement. On January the 31st, the New York State Acting Commissioner, Dr. James McDonald, issued a determination concerning the use of telemedicine. This guidance ensures the continued availability of medically necessary access to controlled substance medications by allowing the use of telemedicine for patient evaluations and prescribing to the same extent that the Drug Enforcement Administration permits for the duration of the federal COVID-19 emergency. Registered practitioners can prescribe Schedule 2-4 controlled substance medications to patients for whom they have not conducted an in-person or medical evaluation, provided that the prescription is issued for legitimate medical purposes by the practitioner acting in the usual course of professional practice. The practitioner is acting in accordance with applicable state and federal laws, and that telemedicine communication is conducted using audio, visual, real time two-way interactive communication system. I must point out that health care providers may initiate buprenorphine for the treatment of opioid use disorder with a telephone evaluation only, which expands access to this lifesaving medication to assist combatting the opioid epidemic in New York. The determination Letter can be found on the BNE website with the New York State Department of Health website. Health Care Transformation, there's considerable interest in statewide health care transformation. We're aware of that. We're in the final stages of moving this through the process. We expect to announce the winners of that before the end of this month. We're working to get

it out as soon as we possibly can. That will be immediately followed by the RFA for State Health Care Transformation program for again, immediately after three is released. From the Center for Providers Services and Oversight, I'm very happy to say that the draft regulations for Safe Nurse Staffing were presented to the Codes Committee just a couple of hours ago. On a different note, from the same Center for Service Providers, Providers Services. Adirondack Health, the Lake Placid has submitted a closure plan for their freestanding emergency department in October. The purpose of the closure is described by Adirondack is to provide financial relief as more long-term plans are established. Currently, it is open from 8:00am to 8:00pm seven days a week. The plan requests permanent closure. The CON is being requested or being processed to remove the ED service. Adirondack Medical Center Emergency Department is located in Saranac Lake, 11 miles away and will remain open 24/7. From our Center for Provider Services and Oversight, One Brooklyn Health had a substantial, significant cyber event that was in the press. They suffered an interruption in normal I.T. operations in late 2022. OPCHSM worked with them to help ensure the critical capacity information was continuing to be collected during the time period where OBH was unable to do that, provide that information. OBH resumed full operation in early January. Cyber events are increasingly happening. We wish this committee to remind as many folks as they can of the importance of following just the basic rules of cyber security in addition to having the usual protections at a higher level. Hospital strikes, four New York City hospitals went on strike in January from the Mount Sinai system and Montefiore system. OPCHSM staff performed monitoring activities and collected data from the facilities to assure patients that were remaining in the facilities were receiving appropriate levels of care. The strike, fortunately resolved in a matter of days. The Buffalo blizzard was a substantial event that occurred weeks ago. OPCHSM staff responded and helped staff operations to respond to the Buffalo blizzard in late December. Teams from the Bureau of EMS staffed the Erie County Emergency Operations Center during the duration of the storm. Other staff created situational awareness reports and helped to mitigate the difficulties at the facilities. The 2023 State of the State approval process of health care projects. In 2023, Governor Hochul directed the Department of Health to review and amend the CON process, including raising the cost threshold for projects that need to file a CON and revisiting the definition of, quote, public need, end quote. These and other CON reforms are intended to reduce administrative burden and approval times for more rapid modernization of the state health care infrastructure. The department last updated CON requirements in 2017 and will be looking at you to recommend changes in recent discussions as well as feedback we have received from providers and stakeholders. We wish to work in partnership with all of these folks. We look forward to working with this council that will be proposing some recommendations to them in the coming months. Finally, the Planning Committee met yesterday. I'll leave some additional details to the Chair of that committee, Dr. Rugge, but I would just like to say the meeting was the result of a request from Simec and Semco to discuss concerns they felt had a public health impact and to make recommendations to this body for help with the issue of delays impacting EMS and 911 response times. The meeting brought in health care experts from across the continuum, from primary care and from hospitals through EMS. Speakers from Heaney's Greater New York, Iroquois, the New York College of Emergency Physicians, Mt. Sinai and many other entities addressed the committee as well as provided written reports. Several potential responses were identified by the participants. There will be follow up. There will be a more detailed report coming to this committee. As it was only just yesterday, it was hard to get a collection of data for a detailed report, but we will have one at the next committee meeting.

Dr. Morley If you have any questions, Mr. Chairman, or members of the committee, I'd be happy to take them at this time.

Mr. Kraut We have some questions in New York; Dr. Kalkut and then Dr. Berliner.

Dr. Kalkut Thank you for your report.

Dr. Kalkut I wanted to ask if you could update the council on the status of the 1115 Medicaid waiver, the health equity reform submission.

Dr. Morley That would come under it. I'm not able to do that. That would come under a different office, but we'd be happy to obtain that for the next meeting or to get you information between now and then.

Dr. Kalkut Thank you.

Mr. Herbst It is progressing right now. We don't have much of an update just yet that we can go into, but we can certainly, as John just said, we can provide one, but it is progressing. If you have specific questions, we can take that back.

Dr. Kalkut It really was where it stands in the pipeline. I think the whole council is interested in that.

Dr. Kalkut Thank you.

Mr. Kraut Dr. Berliner, then Ms. Soto, then I'll go to Albany.

Dr. Berliner Dr. Morley, we thank you for your report, which was quite comprehensive. As you know, I have an inexplicable interest in the state of emergency services in Lake Placid. If I understood what you were.... I'll tell you why. As you know that in Lake Placid, they've closed the emergency room for the night, except when there's an international event. There was a romcom on Netflix around Christmas time where someone gets sick at night and ends up going to a vet because there's no emergency room. I thought, my God, this is what we did. We allowed this to happen. Netflix owes us money. The real question is, if this other urgent care center is not going to be operating, does that really mean that there is no emergency service within a reasonable distance from Lake Placid in the winter months when transportation might not be too good?

Dr. Morley I'm not sure how you would define a reasonable distance, but I'd just like to highlight that this is a very, very large state and there are many, many residents that don't have EMS services available or a hospital in some areas. In terms of Lake Placid, 11 miles away in Saranac Lake, is a hospital with a 24/7 emergency room.

Dr. Berliner I mean, no question there are lots of areas that suffer from a lack of nearby emergency services. This is a particular tourist area. It's an area where people are doing what some might consider to be relatively dangerous activities, some into the night. Given the...Maybe not this year, but given the the typical weather conditions, it might be more difficult to get from Lake Placid to Saranac than it might be in some other areas.

Dr. Morley We are in conversation with them about their request about their interest in still providing care in the area, just not labeling it a freestanding emergency department, but they would potentially still have providers that would be seeing patients.

Mr. Kraut Hold on. Hold on. I'm going to lose quorum again today.

Mr. Kraut Let's just get the questions.

Ms. Soto I have three I think sort of short questions. I'm familiar with Doctors Across New York. These are already licensed physicians. The Nurses Across New York, already licensed nurses? That's the first question. The second is, is there any discussion anywhere in between the state whether it's the department or not about increasing the class size in terms of the health professions? New York City Council about four, six years ago provided salary support for about five nurses to become faculty in the CUNY system, because they have more qualified applicants than they had openings. Part of the problem is not enough faculty. The last one sort of related is, are there any initiatives going on to increase individuals entering the health professions? One of the incentives could be loan forgiveness along the lines of your loan is forgiven if you work in an underserved area, which keeps being brought up. The challenges for some of these are having and reaching the optimum or required staffroom. Again, is Nurses Across New York already licensed nurses? Discussion about increasing the class size in the health professions. Any initiatives like a loan forgiveness to encourage people to enter the health professions?

Dr. Morley Thank you for your questions.

Dr. Morley The first question, yes. They must be licensed. This is an incentive intended to get them to work in an underserved area. They would be graduates and we would be helping them with loan repayments. It's a number similar to the Doctors Across New York Program. We're hoping that this grows in terms of the amount of money that we are able to offer them. Second in terms of there's a great deal of discussion about the issue you described about class size. We've raised it with state education as well. The Governor and the legislature have indicated and are financing the initiation of the, quote, Center for Workforce Innovation. We've identified what we believe is going to be an excellent director for that center that we hope to have starting in the next month or two. The first responsibility will be to hire additional staff. The Center for Workforce Innovation will then coordinate with other state agencies the O agencies, OASIS, OMD, Office of Children and Families, other services that provide health care services as well as state education, looking to find as many ways as we can to encourage people to enter health care professions. Nurses get the most attention and appropriately so, because the need is so great and because we depend so heavily upon them, but they're not the only area that we have a significant shortage of. We're going to be looking for laboratory technicians, imaging experts. We're looking for people to get into the health care arena in multiple different areas. We want to do anything that we can to support that.

Mr. Kraut Thank you.

Mr. Kraut We're going to lose quorum again. I have members that are having to leave. Cannot stay. I have to move the agenda.

Mr. Kraut If there's any other questions for Mr. Morley, please talk to him after the meeting. Dr. Rugge, Dr. Boufford, I know you want to give you a report. A lot of the people were there yesterday. Some of us viewed it. Can you give us a few minutes of a report? If anybody has questions, if they would contact them directly so I can move the agenda. Again, unfortunately, we've just been informed members have to leave and I will not be able to have any votes today.

Dr. Rugge This is John Rugge. Let me try to go fast. As we've already heard from Dr. Morley, he was approached by the past Chair of the State Emergency Services Council regarding concerns over offloading delays at the E.R. ramp. Dr. Morley kindly referred this to this council and the planning committee. Commissioner MacDonald then also enlisted first Deputy Commissioner Heslin to help and partner with us. We had our initial meeting yesterday. Very preliminary data indicates a stable census among the emergency departments, but a significant increase in the number of ambulance ride. Likewise, there has been a increase in offloading times, certainly across the middle part of the state capital district, Finger Lakes, Central New York. This is complicated by the fact there's been a notable decrease in the number of squads and an even more significant decrease in available EMT staff. As Dr. Morley indicated, we had had presentations by key stakeholders of across the state and elaborate data presentations by Dr. Heslin from the department. The upshot is everyone acknowledges significant stresses bouncing back and forth across the system, not only offloading problems but over boarding in the ED, overloading of the hospitals inability to access long term care for discharges. This has resulted in our developing a whiteboard of necessary areas for further research opportunities for improvements and hopefully eventually suggestions for reform and specific actions recommended by the council. Since this meeting happened only yesterday, we will be working through all the issues raised yesterday and bring in a more detailed report and a proposed workplan to the council on April 18, and then this committee will go back to work with the schedule and hopefully have suggestions for first steps in reform.

Mr. Kraut Thanks very much.

Dr. Rugge Thank you.

Mr. Kraut Dr. Boufford.

Dr. Boufford Thanks.

Dr. Boufford In the spirit of quickness, I just want to make a couple of extra comments on top of Ursula's excellent report for us to thank her and her team for putting a meeting, a very rich meeting together, especially adding new analytic staff who have replaced retirements for continue to analyze and update the data that is coming in on the prevention agenda. I think connecting to the Deputy Director for Sciences Office. We'll have a capacity to really update the evidence base that I think can lead to informed streamlining, as Ursula mentioned, of the prevention agenda and also a better opportunity to integrate the equity elements and monitoring and evaluation. I want everybody to remember. I am so delighted to hear about budget opportunities because this has been the most cost-effective initiative that the state has ever undertaken in public health. There has been zero funding of this effort from the beginning. It's very exciting to see the commitment to replacing staff. Similarly thanking Joanne Morne for joining as part of a core group and I think going forward Dr. Bauer's commitment to bringing in the Commissioner of Mental Health, Oasis who have been core members of the prevention agenda from the beginning and really very important efforts to have objectives in ageing and also priority area in mental health and wellbeing added. We're delighted to have that happen. Observations around the complementarity of the prevention agenda to statewide initiatives. One Adam Herbst mentioned is the master Plan for Aging. We see it as a way to address a lot of the population health, community conditions, elements of the master plan, as a lot of work will have to go unnecessarily on the service side in the work that Adam's taken on. Similarly, complementing the waiver on the prevention agenda effort is very aligned with the Plan for

Heroes going forward, which will add planning. Activities are supposed to be multi-stakeholder. We have those platforms already at local level and similarly the SDN networks, we got into a discussion of the role of CBOs and addressing broader determinants of health. Finally, for the Public Health Committee members, we did flag issues that have been of ongoing concern to the Public Health Committee, which we hope to take up in future meetings. One is on the public health workforce, which was mentioned. The other is an update on the maternal mortality initiative, which the council has been very interested in for about 4 to 5 years now, and similarly engaging again on community benefit as a potential source for alignment of hospital engagement in their community prevention agenda coalitions with their dollar commitments to improving health in their communities. Finally, the Public Health Committee have been taking on the issue of violence in the prevention agenda before COVID. Hopefully, that can come back in the fullness of time as we move forward for the revision process.

Dr. Boufford I'll stop there.

Dr. Boufford Thank you.

Mr. Kraut Thank you very much, Dr. Boufford.

Mr. Kraut I'd like to have a motion to move into an Executive Session. The purpose is to confer with counsel on an attorney client privilege matter.

Mr. Kraut May I have a motion?

Mr. Kraut I have a motion, Dr. Berliner.

Mr. Kraut I have a second, Dr. Strange.

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Motion carries.

Mr. Kraut Will the public please exit the room. You'll be in the hearing room one. We'll call you back in when we are ready.

Mr. Kraut Our call to order back the meeting, I would report of the Committee on Codes, Regulation and Legislation.

Mr. Kraut Mr. Holt.

Mr. Holt Thank you, Mr. Kraut.

Mr. Holt At today's meeting and Codes, Regulations and Legislation, the committee reviewed and recommended for adoption one regulation, and we heard two proposals for information. The regulation that is before us for adoption relates to mpox virus adding it to the list of sexually transmitted diseases. We did receive a report from the department on this regulation.

Mr. Holt I move the acceptance of this regulation.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Unknown Speaker Here in Albany.

Mr. Kraut Any questions from the council?

Mr. Kraut All those in favor?

All Aye.

Mr. Kraut Same thing in Albany, assume everybody voted affirmatively.

Mr. Kraut Anybody opposed?

Mr. Kraut Abstentions?

Mr. Kraut Motion carries.

Mr. Holt There were two items, as I indicated, that were on for discussion only clinical staffing in general, hospitals and perinatal services, perinatal regionalization, birthing centers and maternity birthing centers. Those regulations will be coming back before the council at some point in the future.

Mr. Holt That concludes today's meeting of the Codes.

Mr. Kraut Thank you very much, Mr. Holt, and thank the council members for doing that.

Mr. Kraut I now turn it over to Mr. Robinson for the report of the Committee on Establishment of Project Review.

Mr. Robinson Thank you, Mr. Kraut.

Mr. Robinson As he mentioned, we're going to be taking these out of the order of the agenda and focusing on those applications that have recusals. We'll begin by asking Mr. Kraut and Dr. Strange to leave the room and Dr. Boufford, we will be making the motions on these applications to you as the Vice Chair.

Dr. Boufford I am in position to accept them.

Mr. Robinson Thank you.

Mr. Robinson I'm bringing forward application 2 0 1 2 2 E, True North 3DC LLC doing business as Grand Boulevard Dialysis in Suffolk County, again noting the conflict and recusal by Mr. Kraut and Dr. Strange. This is to establish True North 3DC LLC as the new operator of the 20 station Chronic Renal Dialysis Center located at 860 Grand Boulevard Deer Park that is currently operated as an extension clinic of the Bronx Dialysis Center. The department recommended approval with conditions and contingencies. The

committee did vote for approval with conditions and contingencies, with two members opposing at the May 19th meeting, so a cycle earlier. I want to bring to the attention of the council members a letter that was distributed from the applicant, which I think and I'm going to actually turn to my colleagues on the council, particularly Mr. Lawrence and Dr. Berliner. Unfortunately, Dr. Gutierrez is no longer with us, but also Dr. Gutierrez had some very specific questions. After reading that letter and understanding where things are going, I believe that those concerns have been very well addressed, in particular with DaVita now moving to less than 50% ownership and the decision making around quality of care, the formulary and other issues that have been a real concern of several members of this council, that those have been addressed. Therefore, I am making a motion to approve the application.

Dr. Boufford Motion to approve.

Dr. Boufford Is there a second?

Dr. Boufford Second from Mr. Holt.

Dr. Boufford Is there any discussion or questions from staff or members of the council?

Dr. Boufford Any in New York City?

Mr. Robinson Mr. Lawrence has a comment or a question.

Mr. Lawrence I reviewed the letter and it does satisfy the concerns with regard to ownership and also around the quality issues that were raised at the time.

Mr. Robinson Thank you, Sir.

Dr. Boufford Thank you.

Dr. Boufford Any other comments from New York City?

Dr. Boufford None here in Albany.

Dr. Boufford All in favor?

All Aye.

Dr. Boufford Any opposed?

Dr. Boufford Any abstention?

Mr. Robinson Unanimous here in New York.

Dr. Boufford Any abstentions?

Dr. Boufford The motion passes.

Mr. Robinson Thank you.

Mr. Robinson A sister application 2 1 1 2 4 4 E, True North 4DC LLC doing business as Peconic Bay Dialysis in Suffolk County. Again, Mr. Kraut and Doctor Strange in recusal. This is to establish Peconic Bay Dialysis as the new operator Peconic Bay Dialysis, a 13-station chronic renal dialysis facility at 700 Old County Road Suite 4 Riverhead, currently operated by Knickerbocker Dialysis Inc. The department recommends approval with conditions and contingencies. As with the earlier application, the committee recommend approval with conditions and contingencies with two members opposing at that same May 19th meeting. The letter that I referenced for the previous application applies to this one as well.

Mr. Robinson I make a motion to approve the application.

Dr. Boufford Is there a second?

Dr. Boufford Mr. Holt.

Dr. Boufford Any questions or concerns from council members?

Dr. Boufford Any in New York City?

Dr. Boufford Peter any in New York City? I can't see the group.

Mr. Robinson None in New York.

Dr. Boufford In that case, we'll vote on the motion.

Dr. Boufford All in favor say, aye.

All Aye.

Dr. Boufford Any opposed?

Dr. Boufford Any abstentions?

Dr. Boufford I see none in Albany.

Dr. Boufford Any in New York City, Peter?

Mr. Robinson None in New York.

Dr. Boufford The motion passes.

Mr. Robinson Thank you very much.

Mr. Robinson Can we have Mr. Kraut and Dr. Strange back in the room.

Dr. Boufford I think it's the same people.

Mr. Robinson I'm sorry. We're taking this out of order, my confusion. Keep them away.

Mr. Robinson Application 1 8 2 1 4 4 C, Nassau University Medical Center in Nassau County. Also, a conflict and recusal by Mr. Kraut and Dr. Strange and an interest by Dr.

Lim. This is to certify cardiac catheterization and electrophysiology and cardiac catheterization, percutaneous coronary intervention or PCI services with requisite renovations. This is being processed as a full review. The department recommends approval with conditions and contingencies, as did the committee.

Mr. Robinson I so move.

Dr. Boufford Is there a second?

Dr. Boufford Dr. Torres.

Dr. Boufford Any questions?

Dr. Soffel I have a question about this one.

Dr. Boufford Dr. Soffel.

Dr. Soffel I never call myself Dr. Soffel, but that's okay. My question was around need for this application because as I read the application, I saw that there are many other cardiac catheterization facilities on Long Island that are relatively close to where this one is being operated. I just wanted to understand why the department determined that there was a need for additional services.

Ms. Glock Thanks for the question.

Dr. Boufford Please identify yourself, so people in New York City know who's talking.

Ms. Glock I'm sorry. Shelly Glock from the department.

Ms. Glock Thanks for the question.

Ms. Glock As stated in the staff report, the cardiac services regs under 709.14, which were adopted in September of 2019, requires facilities to project a minimum of 36 emergency PCI procedures in year one of operation. An emergency PCI is anything that's not elective or scheduled. In this application they are referring approximately 50 PCI and EP cases out each year. That referral out of that number of cases indicates that they are able to meet the 36. The other programs in the area are there and this reduces the transfer of those patients who might need that service showing up at the door. That's how the regulations read. You have to show a need of 36. This application has demonstrated that they meet that regulation for public need.

Dr. Boufford Any other questions or comments from members of the council?

Dr. Boufford Let's move to a vote.

Dr. Boufford All in favor, aye.

All Aye.

Dr. Boufford Any opposed?

Dr. Boufford Any abstentions?

Dr. Boufford None in Albany.

Mr. Robinson All in favor in New York.

Dr. Boufford Therefore, the motion is passed.

Dr. Boufford You can now invite Mr. Kraut and Dr. Strange back.

Mr. Robinson We will do just that.

Mr. Robinson Apologies, but continuing out of order on the agenda.

Mr. Robinson This is application 2 2 2 0 1 1 B, Flushing Endoscopy Center, LLC in New York County. An abstention by Dr. Lim. This is to certify a three single specialty ambulatory surgery center extension Clinic for Gastroenterology, Otolaryngology and Urology at 168 Center Street in New York and transfer 38.65% ownership interest from three members to two existing and four new members. The department recommend approval with conditions and contingencies with an expiration of the operating certificate five years from the date of issuance. The committee made a similar recommendation.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut I have a second, Dr. Strange.

Mr. Kraut Any comments?

Mr. Kraut Any questions for the department?

Mr. Kraut All those in favor, aye?

All Aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Application 2 2 2 0 2 4 B, 787 Ortho ASC LLC doing business as Peakpoint Midtown West ASC in New York County. Again, a conflict in recusal by Dr. Lim. Establish and construct a new multi-specialty ambulatory surgery center at 787 11th Avenue in New York. Please note that the hours of operation were corrected in the exhibit to state that they were open Monday through Friday, not Thursday and Friday. With that modification, the department has recommended approval with conditions and contingencies, with an

expiration of the operating certificate five years from the date of issuance. The committee made a similar recommendation.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Thank you, Dr. Berliner.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Application 2 2 2 0 8 9 B, Peakpoint Flatiron LLC in New York County. Again, a conflict and recusal by Dr. Lim. Establish and construct the dual single specialty Ambulatory Surgery Center at 1115 Broadway, New York for Ophthalmology and Otolaryngology, head and neck surgical services. Again, note that the DBA has been removed from the application. The facility name will remain Peakpoint Flatiron LLC. Also, the hours of operation were corrected in the exhibit. The state open Monday through Friday and not Monday and Friday. With that, the department has recommended approval with conditions and contingencies, with an expiration of the operating certificate five years from the date of issuance, as did the committee.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Kraut Just do the certificate and get it out of the way.

Mr. Robinson Beth Israel Medical Center Certificate of Amendment to the Certificate of Incorporation. This is not the application on New York Eye and Ear. To change the purposes of the application. Dr. Lim, again, a conflict in refusal. The department and the committee recommend approval.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions?

Ms. Monroe Excuse me. Which one are we on?

Ms. Monroe Which application are we on?

Mr. Kraut The certificate of incorporation for Beth Israel Medical Center for their nursing school.

Ms. Monroe Thank you.

Mr. Kraut We're just getting rid of the ones with recusals, that's why. I know we're jumping around, but we're just trying to make sure we have enough votes when we have to.

Mr. Kraut Are there any questions about the certificate of incorporation?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Application 2 1 2 2 5 2 B, Upstate Endoscopy Associates LLC doing business as Upstate Endoscopy Center in Rensselaer County. A conflict and recusal by Dr. Bennett. I don't believe he's here today. Establish and construct a single specialty ambulatory surgery center for Gastroenterology at 112 McChesney Avenue in Troy. Department recommending approval with conditions and contingencies and an expiration of the operating certificate five days from the date of issuance, as did the committee.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Strange.

Mr. Kraut Is there any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstention?

Mr. Kraut The motion carries.

Mr. Robinson For those of you watching from home, we're now going back to the regular order of the agenda, and we'll just go down the ones that we haven't covered.

Mr. Robinson Application 2 2 1 2 5 7 C, Open Door Family Medical Center Inc in Westchester County. This is to certify an extension clinic at 2 Church Street, Ossining to provide medical services, primary care and medical services and other medical specialties as a safety net. The department is recommending approval with conditions and contingencies, as did the committee.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second by Dr. Torres.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Thank you.

Mr. Robinson Application 2 2 2 0 1 2 C, New York Eye Surgical Center in Saratoga County. An interest by Dr. Bennett who is not present. Convert from single specialty ophthalmology ambulatory surgery to multi-specialty able to secretary surgery with no construction. Department recommending approval with conditions and a contingency as did the committee.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Application 2 2 2 0 8 7 C, Mount Sinai, Beth Israel in New York County. I want to note a conflict in recusal by Dr. Lim on this application. This is to certify New York Eye and Ear Infirmary of Mt. Sinai as a new division of Mt. Sinai Beth Israel with no change to beds or services. The department has recommended approval with a condition and contingency. A lengthy conversation at the committee level, resulting in no recommendation coming forward.

Mr. Robinson I move the approval of this application.

Mr. Kraut I have a motion to approve.

Mr. Kraut I have a second by Dr. Berliner.

Mr. Kraut A second by Dr. Torres.

Mr. Kraut Are there any comments or questions from the council members on this application?

Ms. Monroe Could you repeat the condition, Mr. Robinson, that has been added to this application approval?

Mr. Robinson I don't believe there was a condition added from the original application that was presented by the department. Do you have anything that is different than what the department included in its original condition and contingencies?

Ms. Glock Nothing has been added.

Ms. Monroe Did I misunderstand you, Mr. Robinson?

Mr. Robinson I said that there was a considerable debate at the committee meeting and we could not develop a recommendation as a result of that. The application was brought forward to the full council without a recommendation.

Mr. Kraut Dr. Berliner, Mr. Lawrence.

Dr. Berliner When the comprehensive health planning law was developed in 1964, it created the categories of providers and consumers. The reason for that was because the federal government was going to be putting so much money into the health care system through what became Medicare and Medicaid the next year. It was thought it was important for people and communities to have some say in what hospitals and other institutions did, that it was no longer just going to be, well, the money is out there so we can do whatever we want. We can build what we want. We can shop what we want. We can add any equipment that we want. We're still stuck with providers and consumers for better or worse. We get divided up that way when we're put on councils such as this. In this particular case, we find a provider who has had almost no communication with the public. It is very rare to find the long list of elected officials who were saying, you didn't talk to us. We don't know what you're doing. It is very rare to find somewhat differently a long

list of staff that work at the hospital saying, we don't know what you're doing. This is not a good thing. Talk to us. Let us have a debate about this. I mean, for this, I'm just amazed at the lack of public communication about what they want to do. This is not switching six beds out of a unit someplace that should be within the purview of the administration. This is affecting, I mean, a major institution in New York City. The fact that it's been around for a long time is less important than the fact that it serves large numbers of underserved people. I have no idea what the institution intends to do going forward except that nothing will change, which somehow doesn't sound satisfying. It's also worth noting that the reason why this has to be rushed through, according to the applicants, is that if the hospital was below 2% occupancy or two patients per day occupancy, it will lose its CMS certification as a hospital. Well, that sounds bad until you try to think about what does that actually mean? I mean, is there someone sitting at a desk with their finger over the button and as soon as the number drops to 1.9, they go, you're gone? Is this going to take a year or two until someone studies it, see if it goes up again and stuff like that? I might add, as a former professor of health administration at a number of institutions that if a institution can increase the occupancy by 1%. We're talking about what I would consider to be really poor administration. For those reasons, I don't think this should be approved.

Dr. Berliner Thank you.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence I was initially going to respond to whether there were contingencies. I don't think they were official contingencies from the council, but I believe that the applicant made a pledge that there would be no change in the operations of New York Eye and Ear. That pledge was, as I understood it, was unequivocal that there. I think hopefully that's in the record. I had similar concerns about what is the rush and what is the need, especially, since I believe Mount Sinai is already the sole member in New York Eye and Ear. What would be the difference? What I understood was that the difference would be that this would allow New York Eye and Ear to continue as a functioning hospital and that otherwise that may not be the case. That was, I thought, a pretty compelling argument. If that argument is valid, then I think we have an obligation to take that on either face value or to hear that there's some other compelling reason not to proceed with this. I don't know if the applicant is here and whether we can get that pledge again.

Mr. Kraut I think the pledge is part of the record, but let's just get all the comments out on the ground and we'll talk to the department.

Mr. Kraut Are there any comments in Albany?

Mr. Kraut Dr. Boufford.

Dr. Boufford I was having a flashback on this discussion of community consultation, shall we say, around the one of the last times when the obituary care facilities. I think it was at the Beth Israel and Mount Sinai. There was a similar problem, I guess. I wanted to ask a question about this. I mean, A, I think it's just kind of unimaginable that an institution as sophisticated as this would have this problem. I wondered if in the conversation with them, because they are the sole owner, it sounds like I may have misstated the actual term of art. Perhaps they did not think that they needed to do that. They're saying, there are not going to be any changes. They're just continuing in charge and they're going to continue to do what they've been doing. I just wondered if that came out at the committee, because I wasn't there. I'm not a member of the committee.

Mr. Kraut Yes, it did.

Mr. Kraut What I'm going to do at the conclusion of these questions for the purpose of some of the members who weren't there, I'm going to recount some of the facts going back to actually that 2020 application that you just referenced when Beth Israel was looking to move to the New York Eye and Ear site. I'll come back to that, and I'll touch on that.

Dr. Boufford Thank you.

Mr. Kraut Any other questions?

Dr. Rugge Yes.

Dr. Rugge This is John Rugge.

Mr. Kraut Yes.

Dr. Rugge My concern is that there was significant opposition from both their own staff members, members of the community and elected officials, and apparently no meaningful engagement by a senior administration making the proposal. There was no back and forth, no ability for me in any case to assess who's right here. Without being able to make that determination, I cannot find a way to support the application. I'm also concerned that the pledge of no further changes will be totally unenforceable. This is not something that will come back to us. Therefore, they could say no changes. If they need changes, they're going to have to make them. Therefore, that's not a basis for me to make a determination.

Dr. Rugge Thank you.

Mr. Kraut Okay.

Mr. Kraut Denise, I think you had your hand up.

Dr. Soffel Yes, I do.

Dr. Soffel Thank you.

Dr. Soffel I want to raise for those who weren't at committee a point that I raised during the committee meeting, which is that this question of the hospital being at risk of losing its CMS authorization to operate as a facility is not mentioned at all in the application materials. It was only brought up after the fact in his presentation and his correspondence after the application had been submitted. When I asked about why this had not been part of their original application, the answer was we forgot to mention it or something to that effect, which I found a rather disingenuous response to what I thought was a pretty straightforward question. I would also like to support Dr. Berliner's comments. I think that the fact that we got so much correspondence from elected officials, from community member, from the hospital, residents and staff and former residents and trainees is really troubling to me that the hospital did not do its necessary stakeholder communication engagement conversations so that there was a mutual understanding of why this was being done and how it was of benefit to consumers, to the community, to health equity issues, to the sort of agenda that we as a council should be thinking about. I share the concerns that this is not a well-presented application.

Mr. Kraut Would you like to make another comment, Mr. Lawrence and then I'd like to do a summary here.

Mr. Lawrence I guess my question then, what is the consequence of not acting them as a sole member? The institution will then step back and if in fact they then have the option without any input from the council or anyone else to do whatever they wish.

Mr. Kraut That's correct.

Mr. Kraut Let's just put this in context for those of you who were not present, I just want to recount some of the history. I pulled the previous applications, all the letters from the 2020. Just to remind everybody, we or our predecessor councils approved the merger with Beth Israel as part of its formation with Continuum in 1999. We approved the merger of Continuum into the Mount Sinai Hospital Group again in 2013. We affirmed that. We have in an addendum to the application that the Mt. Sinai Hospital Group, Mt. Sinai, Beth Israel, St. Luke's, New York Eye and Ear, South Nassau, the other hospital in Brooklyn. They are all boxes. They all have a common governance, common management oversight. The active parent is the Mount Sinai Hospital Group board. There is no oversight or board change here. What we're being asked to do is to move a box under Beth Israel Medical Center, something we have approved numerous times for many hospitals. We had done so without any real conversation or community input. That might explain, but does not forgive the terrible, the inadequate conversations given the history of this application and what had done. We are being asked to do so is because of this low occupancy. Those of us who run hospitals, CMS doesn't sit and wait to do a budget to push a button. They walk into the hospital and on the day, you walk in, if you don't have the two patients, they just walk in and say, that's it. Here's the letter. There are things you do. Let's be honest. No government action is absolutely what you call it. Just because opponents say they weren't engaged by the hospital doesn't mean the hospitals didn't engage with some, but not the ones here, which is problematic because they were very engaged in the previous application. This was a serious thing. Now, we have also raised that there was a historic low occupancy here. 2016 it was 1.8 average daily census; 2017 it was 1.8. 2019 was 2.2. The plan to avert the CMS issue was the application in 2020. Let's come back to that. Just so you know, we know from the document they actually increased their average daily census over the year to 2.2 post COVID. On 96 days we were given information. There were zero patients there. On 41% of the days, there were less than 2%. In 2020, we were given another application to have a bed reduction at Beth Israel Medical Center and to move it to the site of New York Eye and Ear. Now, just for those of you who are not in New York City, we're talking two blocks. 13th and 14th Street sits New York Eye and Ear. I think 1516 through 17th is Beth Israel. It's not 11 miles in the Adirondacks. It's two city, three city blocks. Five-minute walk. Just put that the context here of what they're trying to do. We approved the establishment of the construction of a 70-bed hospital at a cost of $700,000,000 that would have averted this low occupancy thing in New York Eye and Ear. We intentionally we already approved the merger between New York Eye and Ear and Beth Israel, but a physical merger of physical relocation, $600,000,000. Now, we understood there was significant community opposition and some of the same issues that we had today that you just spoke about we had then. You think you'd learned from that, right? Post-COVID, Mt. Sinai now comes to us and abandons that plan and says we're not doing it. They come to us and say, now we're not moving ahead with that. In order to preserve the mission and activities now requests us to protect against that possibility with CMS to simply move the operating system. Now, they said in writing, no closure of any clinical program. They did mention the gender affirming surgery was moving to, I think, the

Amsterdam location on Morningside. No change in access. No change in bed availability. No change in union jobs or the status of the union jobs. No change in GME. No change in oversight or governance. This is, in their mind, was an administrative movement to essentially do that. There was a consequence of not approving that. Now, we've received a lot of letters and communication. We heard from the voice from community residents that expressed concern about a loss of service, reduced access to care. Some, they view this as a merger. That's a technical detail. Some people would call it a merger. We just call it an operating certificate movement. A lot of this has already occurred. Some of the things that people expressed fear of... Merging into Beth Israel has already occurred as a practical matter. I reviewed the correspondence in January 2020. The same concerns about reduction here. I think what we've learned from the issue here is you need to communicate with those that you know are going to oppose. I think the point that Dr. Berliner and Mr. Lawrence and Denice and the others said. There's no question here that they did a poor job. They might not have thought they had to do it because they thought it was a simple movement of an operating certificate. They believe, I think now. I'm not naive. I don't think the outcome would have been different. I think many issues about health care, this is really about trust. We have an institution. We have a community. I made this point at the Project review committee. When Mount Sinai says no change just don't trust them. It's an element of trust. It's so hard. If they did have those communications, I don't think Mount Sinai necessarily would have changed its position because all it's doing is trying to preserve the mission. The fact of the matter is the most likely outcome of those conversations would be agreement on one central point. We disagree. They'll agree to disagree. I expressed my disappointment at Sinai for the reasons you said, but also the community who frankly celebrated Beth Israel in Mount Sinai just a short two years ago. This is about change. Denise remembered; we were talking about Saint Vincent. Part of the reason Saint Vincent couldn't get a project approved is because every project it proposed, there was somebody opposing it. It got into this vicious cycle where it ended up and we'd all agree, should never have closed, never have closed. They couldn't get any agreement with the community. They couldn't get the level of support. Here we are. In the past, we've not only approved, but we also have encouraged the movement of inpatient care into ambulatory surgery. We approved multiple CONs, many of them from New York Eye and Ear to take their inpatient care, moving into ambulatory care centers. Almost eight centers I think we approved that are owned by New York Eye and Ear and now the group. We've approved consolidation of operating certificates to move one hospital as an operating division of another. In 2000, we approved Manhattan Eye and Ear to go into Lenox. There was a big fight with the same issue. The medical staff, they went into court. We approved New York, NYU, Brooklyn to go into the NYU. We approved Syosset to go into North Shore. I can keep going on and on with a list of hospitals that we've done. Now, how do you know that there's no change? How do you do that? I guess it is a matter of the record. If there is a change, if there's a change to any license programs there, it has to come back to us because a change in any other additional change in the operating certificate requires at least discussion. I take a look at this, and I look at three criteria, and I know there's a four; need, financial feasibility and because it's an existing provider, character and competence is not an issue here. On this basis of need, there's no question about the need. The community says it's needed. The hospital's committed to doing it. The financial feasibility. The community has identified the financial losses that have been in that hospital. This provides stability since it's now going to be consolidated on the financials of Beth Israel and as part of the Mount Sinai Hospital Group, as it always was. That's why, you know, I think at this juncture, I wanted to call for a revote, but I wanted to recount the history of what we were trying to do here. Now, coming back down to the trust, it is going to be an issue. I get it. Other than we put requirements in here, but we can't say to an institution, you can never change. In this day

and age, it's impossible. I'm just trying to say, let's look at what we're being asked to do. I know there's a lot of other activities around what we're being asked to do but take it down to the essence that we are preserving a hospital. We are preserving access to that care, and we are preserving essentially an institution that is simply saying the sponsors saying we're going to support it.

Mr. Kraut Dr. Berliner.

Dr. Berliner Jeff is our Chair because he's incredibly politic and well-spoken, but I don't think what he said is entirely accurate or to the point. We have closed institutions, taken away their operating certificates when they were going out of business. The place that we're talking about Eye and Ear has internal reserves of over $150,000,000. It's not going out of business financially. What no one has spent any time talking about and it's hard to discuss this because there is no evidence one way or the other is that if I was a real estate developer, you know, I would be drooling at the prospect of getting the New York Eye and Ear site in the East Village, probably one of the hottest markets in New York City. Two years ago, or three years ago, we heard from Mount Sinai that they were going to basically close Beth Israel and talked about all the money they were investing in it without saying how much money they were going to get from selling the Beth Israel property, which is larger and therefore probably even more valuable. I don't think you can just say that, well, we've taken away operating certificates before, so this is not any different. I think it's incredibly different.

Mr. Kraut If they were motivated by the real estate, they would have been approved to do it.

Dr. Berliner Well, you know, okay.

Mr. Kraut But they didn't.

Dr. Berliner Well, they didn't. Again, never explained to our counsel. That's okay. We understand they're going to take a 650-bed hospital and shrink it to 40 and then COVID happened a month later. It didn't make as much logical sense as it might have then. I think what the community, I think what the elected officials, I think what the hospital staff is asking for is give us a plan. Tell us how you're going to do this. This is a distinguished institution, not that other place that have closed haven't been distinguished in their own ways. But tell us, how are you going to preserve the legacy and what some might say the greatness of New York Eye and Ear in a place which no longer has the name New York Eye and Ear. I don't think that means that they can never come back with an application. I think people just want to hear give us a plan that makes sense.

Mr. Kraut I just pulled up the transcript of what Mr. Lawrence was asking about. This is a direct quote. They gave us a plan. It's very important question. It's an unqualified commitment. As everybody knows exactly what we're committing to. There will not be any closures of New York Eye and Ear inpatient beds. There will not be any closures of New York Eye and Ear clinical programs. There will be no change in local access. It is true that some we are, as I've said, over ten years, we've made adjustments to improve access to our communities and made investments. It doesn't mean everything will happen where it is today, but we're not closing a single program. We are going to ensure that access, particularly for our most disadvantaged patients are there. There will be no change to the board that governs our operations. There is no change for the graduate. There's going to be no change to the union status for our unionized employees as well. We commit to all of

those things. It's in the record. What more do you want them to do? Well, I'm just saying, we keep saying things. Our job is to help facilitate and guide change in the state. Change is not easy. Nobody likes change. Every time something happens. Do you believe him or not? That's a fundamental issue. I get that. I can only say that I know what the record is. The Department of Health knows this. There has to be accountability by the department on these actions.

Mr. Kraut Ms. Soto and then Dr. Strange and Dr. Rugge.

Ms. Soto Could you repeat what you read from? Something about the location of where some of these services are may change.

Mr. Kraut Well, I think over the last ten years, they said they've made multiple adjustments to improve access. It doesn't mean that everything happens where it is today, but we don't close a single program. I think what he was also referring to is the gender affirming surgery had been moved out of the hospital. In one of the letters we received, it was indicated they did so because they just felt they wanted to have it in a more full-service environment because the risks that accompany surgery of that nature.

Mr. Kraut Dr. Strange and then Dr. Kalkut.

Dr. Strange A point of clarification. Approving this in my mind, is protecting us more and protecting the community more in a sense because of the conditions that you just read. What does disapproval mean to us?

Mr. Kraut I don't know. They'll have come up with another plan, but CMS could walk it. I mean it's been in the paper. If I was CMS, I'd walk in there.

Dr. Strange Disapproval could mean they close it and they make it a real estate deal.

Mr. Kraut I can't speak for the applicant, so I don't know.

Dr. Strange What I'm saying is approving it protects the hospital base and everything that they're currently.

Mr. Kraut I'd like to believe that.

Mr. Kraut Dr. Kalkut and then I'll go to Albany.

Mr. Kraut I think it's hard to be more eloquent on two opposing positions than what we've heard just now. I don't know. Well, I do know. Acknowledged that the communication was terrible. They didn't speak to people or if one believes sort of the volume of emails and conversations that have taken place. I also think you can't stand in the way of change. Preserving services in a neighborhood, in a community has to be paramount. The risk of closing, the risk of of losing GME and hospital rates I think is real and will be disruptive or destructive to services provided in that community. I personally have had experience at Long Island College Hospital. I was in a room with physicians. I'm a physician. Who were trained, started out their practices and were going to finish their practices? They said, and it was the same thing that the I don't remember the census. This is a group of physicians, some whom I trained with, said we can admit 50 patients to this hospital. I said, do they need to be in the hospital? What do you mean you can admit 50 people as if it's a whim or a fill the beds? It was closed. There's been a freestanding ED there since then. It has 100

visits, 95 visits a day. In a month, there'll be 180,000 square feet of ambulatory care and a freestanding ED in a new place. There's change in the system, right? We are stewards of that change to a degree. I think the argument about trust, I think, is, as Jeff and Howard said is one of the keys here. If we're not keeping up with the move towards ambulatory, the move to bigger rooms, the move to modernization, then we're not doing our job.

Mr. Kraut Any comments in Albany?

Dr. Rugge Yes, John Rugge.

Mr. Kraut Go ahead, John.

Dr. Rugge I'm very sensitive and aware of the arguments just made by Dr. Kalkut. By the same token, rather than our job protecting the future. Well, we heard in executive session is our job is assessing need. In this case, the management of this facility did not describe the need to its own community, to its own stakeholders, and also has not been forthcoming to us in terms of what's driving this until late, oh, we forgot that we're going to be decertified. It just seems like it's establishing a bad precedent for us to be approving something when there's not been true adequate communication with either its own community or with us. That puts me in a very difficult position in terms of where to go, in terms of making a vote.

Dr. Rugge Thank you.

Mr. Kraut I'd like to call a vote unless there are any comments or questions just to see where we end up and then we could take it from there.

Mr. Kraut We have a motion to approve.

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut We have a delay. We're going to have to do a roll call.

Ms. Leonard Dr. Boufford?

Dr. Boufford Yes.

Ms. Leonard Mr. Holt?

Mr. Holt Yes.

Ms. Leonard Dr. Kalkut?

Ms. Leonard Mr. La Rue?

Ms. Leonard Mr. Lawrence?

Ms. Leonard Dr. Lewin?

Dr. Lewin Yes.

Ms. Leonard Ms. Monroe?

Ms. Monroe No.

Ms. Leonard Dr. Ortiz?

Dr. Ortiz No.

Ms. Leonard Mr. Robinson?

Dr. Ortiz Ortiz is yes.

Ms. Leonard Mr. Robinson was yes.

Ms. Leonard Dr. Rugge?

Dr. Rugge No.

Ms. Leonard Dr. Soffel?

Dr. Soffel No.

Ms. Leonard Ms. Soto?

Ms. Leonard Dr. Strange?

Dr. Strange Yes.

Ms. Leonard Dr. Torres?

Dr. Torres No.

Ms. Leonard Dr. Watkins?

Ms. Monroe He says no.

Ms. Leonard Please repeat that for the record. We couldn't hear.

Dr. Watkins No.

Dr. Ortiz This is Dr. Ortiz. My vote was yes.

Ms. Leonard Your vote was yes?

Dr. Ortiz Yes.

Ms. Leonard Okay.

Ms. Leonard 11 affirmative. 11/6.

Ms. Leonard Motion fails.

Mr. Kraut We have the motion failing.

Mr. Kraut Let's talk about what we can do. We can add conditions on here that we'll address. We can add additional conditions now. What additional conditions would be satisfactory? We can add a condition that if there is any type of change. What would work to make this affirmative, do you want to add conditions on to the application that what they stated is part of the approval process? Just so I know what I'm talking about and I'm not misrepresenting, what are the consequences of doing that? Does that give it great... The statements made are not statements they are now part of it that they can't make changes? What are the ramifications of doing that? I just need some guidance.

Ms. Ngwashi Good afternoon. I'm an attorney at the department.

Ms. Ngwashi Is someone in New York City talking?

Mr. Kraut You can go ahead. We're trying to understand if we add conditions to the application, what kind of conditions would address the concern that, you know, this is what they said, but to give it greater, I guess, regulatory levers.

Ms. Ngwashi First, I'd like to address the fact that we do need to keep in mind that the application as it is presented is what the council is considering and preparing its motion for a vote. I'd like to emphasize that. When you are thinking about potentially adding for this project, which is a construction project where the Public Health and Health Planning Council offers its recommendation to the Commissioner who renders the final determination.

Mr. Kraut This is not an establishment, this is a construction.

Ms. Ngwashi This is a construction project.

Mr. Kraut Oh, I'm sorry. I misunderstood.

Dr. Rugge What's being constructed?

Mr. Kraut We let it go.

Dr. Rugge What's being constructed?

Mr. Kraut I didn't realize that. I'm sorry. We have a vote, and the vote would move on to the Commissioner.

Dr. Rugge Excuse me. What makes this a construction project?

Ms. Ngwashi Any projects that are not establishment projects are categorized as construction projects. These are already established entities.

Mr. Kraut This is a currently established provider. That's why character and competence wasn't a component. It was only need and financial feasibility. If that's the case, we do not have a vote or nor a recommendation to the Commissioner. We will pass it on to the Commissioner for action.

Mr. Kraut Yes.

Dr. Rugge I'm wondering if we can be notified when the Commissioner makes a decision?

Mr. Kraut Yes.

Mr. Kraut We now require when the Commissioner acts on anything that we have not recommended that we're notified. The Commissioner will make the final determination in that respect.

Mr. Kraut Thank you.

Mr. Kraut Mr. Robinson.

Mr. Robinson Thank you.

Mr. Kraut I gave us an option.

Mr. Lawrence We lost the opportunity to impact on this?

Mr. Kraut That's correct.

Mr. Lawrence Thank you.

Mr. Kraut You had an opportunity to make a motion to amend. Nobody did.

Mr. Kraut Here we go.

Mr. Robinson This is an application for midwifery birthing services. This is an establish and construct. To be sure people are clear, this is an establishment application. This is application 2 0 2 0 8 6, the Coit House LLC, located in Erie County. This is to establish and construct a midwifery birthing center to be located at 414 Virginia Street in Buffalo. The department recommended disapproval. As with the previous application, there was a lengthy conversation and I think a very informative one in which, among other things, we had significant debate about the character and competence. I also want to point out that because the department's recommendation stopped at the point of looking at character and competence, the rest of the application, the facilities requirements, the financial feasibility, the other things that are looked at by the department was not conducted. The application right now is only coming to us with that element of the review process done. It essentially came to a halt. That's where we stand.

Mr. Robinson With that and the no recommendation from the committee, I make a motion to support the department's recommendation for disapproval.

Mr. Kraut I have a motion to disapprove.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Berliner seconds it.

Mr. Kraut Dr. Torres as well.

Mr. Kraut Let's open this up for discussion.

Mr. Kraut Does the department wish to make a statement before we do?

Dr. Morley I would like to make a statement. This is Dr. John Morley, the Deputy Commissioner.

Dr. Morley Thanks very much.

Dr. Morley Out of respect for the committee's time, I will abbreviate remarks that were a little longer earlier. At the time of this application comes, we're presenting revised regulations for paternity birthing centers which articulate the regional perinatal system in New York. Additionally, we have engaged and are engaged in ongoing conversations to ensure standards are attainable for applicants to meet industry standards that are necessary to serve low risk patients. We strongly support the growth of midwifery birthing centers. The Coit House application was initiated over two years ago. The department spent well over 100 hours in dealing with this application, including over 20 hours of my time over the last 9 months. As was stated, we have only one other instance in the last 10 years where the department recommended disapproval of an application for establishment. Multiple reasons for this were presented by Ms. Glock for this disapproval. The committee is in receipt of a letter from the County Medical Examiner, as well as a pediatrician in the community. Both letters recommended against approval. It's highly significant to us that a County Medical Examiner would write such a letter. I would like to highlight some of what was written in that letter. Quote, I would like to alert you to two deaths that occurred due to gross negligence on the part of the midwives in this facility. There is no doubt with adequate medical care both of these children would be alive today. These deaths are currently under investigation by the Office of Professional Discipline. In both of these cases, the practitioners of this midwifery showed careless disregard for human life and two lives were lost because of it. I would ask that you do not expand their license, as I am certain that this will lead to more unnecessary deaths. That's from the letter of the Medical Examiner. I did call the Medical Examiner at their suggestion and spoke with them. It was very clear as to why she came to the conclusion she did. I'd like to state for the record that our requests for additional information, specifically what steps were taken in response to the two infants were not supported by any evidentiary documentation or proof. Many meetings and a great deal of time went into the review of this application. We do not make the recommendation lightly. We move this application forward as it is the right of the applicant to request so. We do not have an outcome from the State Education Office of Professional Discipline. Given that the process is confidential, we have no way of knowing when it will be complete. It is possible it could be years from now. As has been the case in the past the Coit House project is not an application the Department would have brought forward to prepare for its consideration as the individual applicant is the subject of an open and active investigation by a licensing entity which puts at potential jeopardy the practice license that the applicant has submitted an application for consideration. Those are my comments. If anyone has any questions to me, I'd be happy to take them.

Mr. Kraut Does anybody have questions for Dr. Morley?

Mr. Kraut None in New York.

Mr. Kraut Any up in Albany?

Mr. Kraut There's nobody in Albany have any questions about this?

Ms. Monroe We may have comments.

Mr. Kraut Comments is fine.

Mr. Kraut Anybody have comments in Albany, please?

Ms. Monroe I do.

Ms. Monroe This is Ann.

Mr. Kraut Okay.

Ms. Monroe First of all, I have great respect for the work of the department. In the years that I've been on the council, we have seen things the same way and where we didn't, we were able to handle them through contingencies that the council would put on applications that managed to address our needs. It's been very strong work, but I just can't support this recommendation and I'll give you four reasons. There's too much disagreement between the applicant and her attorneys and the department about what was provided and what was not provided. These are very respected attorneys in Western New York, and they provided emails and specifics about things that they had provided the department. I'm not saying they're right and the department is wrong, but with this great difference between what the applicant is saying was provided and what the department says is not provided just raises a lot of questions for me. The second is we have no regulations. If this had come before us at a later point, I would feel perhaps differently about it. I agree with Dr. Morley that two deaths and a very serious letter from the Medical Examiner belong in the investigation of her liability. She was not one of the midwives that were quoted from the Medical Examiner. While she is a director and has accountability, we don't know whether she's going to be found responsible or vindicated by this investigation. To me that creates a real question of ambiguity that to me, needs to be considered. I'm glad that Mr. Robinson talked about architectural review, because that took up a lot of time at our committee meeting when the department had made it very clear that they did not look at architectural because they stopped at character incompetence. My preference, frankly, is that the applicant would have withdrawn their application. I think it's terrible that we've gotten to this point and to withdraw it and bring it back under regulations would have made a lot of sense, but she didn't do that. We don't have the option, as I understand it, at the council, to pend or defer or whatever happened to the two that we looked at today who had been deferred since May. We don't have that option. In that respect, since it's not been withdrawn and I have strong concerns about the collective work that was done on this application and the importance of midwifery, as talked about in terms of the regulations, I just can't support the department's recommendation and I will be voting no.

Ms. Ngwashi Chair, I would just like to make a comment.

Mr. Kraut Hold on. We have Dr. Strange here for a minute.

Mr. Kraut Go ahead.

Dr. Strange I appreciate your comments, but as a physician, as a practicing physician, as a Chair of a department, somebody who sits on the board of OPMC also when I hear that kind of a quality raised by a Deputy Commissioner coming from a public official in Erie

County and local people. As you clearly stated, there has to be accountability whether or not that practitioner was actively involved or not. She was a leader. She was an overseer. She was an administrator. We owe that community. I agree midwifery is important and it's something we all need to continue to strive to get, especially into our communities of need in our communities that have access issues. We also should never, never ever allow us to compromise quality or even think about the potential of compromising quality. I think, Jeff, what you said at the beginning about character and competence coming back to potentially bite us both as a collective body and personally, although we are protected, so I'm not worried about my personal liability. There is no way that I cannot state that the Department of Health did the right thing here and we must...as a practitioner, I can know in no other way in my heart and soul does not support what the Department of Health has put forth. This person, this group of people want to come back again with another application somewhere down the road when they've cleared themselves if that so happens. We have an obligation to this community and to the State of New York not to ever even think about allowing some sort of care that potentially is dangerous.

Mr. Kraut Dr. Kalkut and Mr. Lawrence.

Dr. Kalkut I completely agree with Dr. Strange. It's hard not to think as a physician taking care of patients. I've worked a lot with birthing centers. I have a lot of respect for them and the work they do and the professionalism that's been evident to me. The patient group that they take care of, low risk patients, predominantly, and for good reason. You have two deaths in a relatively short period of time to give our approbation to that operator, I think sends a terrible message and puts us in a compromised position. I think the department has done a good job here. The reasoning is sound, and I don't see how I can vote for this.

Mr. Kraut Mr. Lawrence.

Mr. Lawrence I think at the committee meeting I indicated that I supported birthing centers and would like to see many more of them. I also would, I guess, ask and push that maybe the applicant would reconsider and withdraw the application. My vote at that time was to encourage that to happen. I think the applicant is well intended, but I think at this point, you know, it would have been in the applicant's best interest to withdraw the application. My vote is going to be with the department this time.

Mr. Kraut Did you want to make a statement?

Ms. Ngwashi Yes.

Ms. Ngwashi Thank you.

Ms. Ngwashi I just wanted to state that it is reasonable for an applicant to defend their character and competence and present information in a way that achieve the goal of illustrating that the applicant is of good moral character and competence. The department also has a responsibility to conduct reviews to address any apparent or anticipated inquiry about a proposed project. That is what happened here with this project application. That is what happens with all project applications. Ms. Monroe, to some of the things that you said, I would just like to add some clarity. Number one, there are midwifery birth center regulations in place currently. The regulations that were presented today are amendments to those regulations that are already in place. Any of those amendments would not have had any impact on the project application as it has been presented. I want to make sure that people are clear on that. There are regulations in place. Number two, the architectural

review. Please note this for the record. The architectural review is not at issue with this project application. It was done, as were other reviews, like legal, like financial. However, as Ms. Glock indicated when she presented this project application, those reviews and recommendations for other things; architectural, legal, financial were not concluded because there was an issue with character and competence. Character and competence is a statutory requirement. If you do not meet that, then you fail for establishment purposes. The last thing that I would like to mention is whenever there is an investigation that we are alerted to either by a licensing entity or a District Attorney's Office, the US Attorney's Office, the Attorney General's Office, any law enforcement agency. We do not move applications forward with a favorable recommendation because we are not able to make a recommendation based on a pending outcome where there has been no resolution. That is the case for any application that we have brought forward in the past. This is a policy of the department that we're not intending to change.

Ms. Ngwashi Thank you.

Mr. Kraut Thank you.

Ms. Monroe May I just make a quick response?

Mr. Kraut Yes.

Mr. Kraut Go ahead.

Ms. Monroe I agree with you. I don't understand why after 22 months of being with the department, we have to bring it forward right now. I don't understand why it can't either continue dialogue with the applicant and or proceed later with an investigation.

Mr. Kraut That was the applicant's choice. That was their right. We offered that. They chose not to do it. Y

Ms. Monroe We offered what?

Mr. Kraut We offered to remove the application. Not remove the application. We had asked the applicant to essentially take the application away from consideration.

Ms. Monroe I understand that, but what I'm saying is, if the department has had this application for 22 months, but there's been no resolution on the litigation or whatever you call it as a legal thing, why did the department have to bring it forward right now? I don't need to have an answer and I don't want to get into a debate with you. I made my point. I made what I wanted to where my vote is, and I think we should hear from others and then take it to a vote.

Ms. Ngwashi I really do need to clarify. I really need to clarify this for the record. It is the applicant's right to bring a project forward. It is not the department bringing projects forward to respond to it just on our own, just because we want to. When projects are ready to move forward, we bring them to the council for consideration. That is what happened here. The applicant wanted to move this project forward despite the fact that we had conversations about some deficiencies moving forward. The project is here because it's an establishment project, and the Public Health and Health Planning Council is the one that renders a final determination. The department makes the recommendation. That being said, that's what we would like to be able to accomplish here.

Mr. Kraut Is there any other comments in Albany?

Dr. Soffel Hi. This is a very troubling application. I was reminded that the application had been denied based on the fact that the operator had not demonstrated a substantially consistent high level of care as being rendered. I was told that that that when Ms. Glock gave her presentation about the application at the committee meeting two weeks ago, that she laid out the reasons. I actually went back and watched it again because I didn't see it the first time. I think that the thing that was flagged as the challenge in this application was that when these sentinel events happened, that there was not a response on the part of the applicant that demonstrated that there had been a root cause analysis and a review of what had happened and what had gone on and a review of policies and procedures within the operation that would reflect a responsiveness to the concerns that have been raised. As I read then all of the correspondence from the applicant and went back and watched her testimony as well, it sounded like she tried to be responsive and that there was some lack of responsiveness on both sides and lack of transparency in the whole process. Dragging out over 28 months is it seems... I don't quite know what was going on and I would say that I believe that the department absolutely operates in good faith and works really hard at what they do. It seems like when I read all of the correspondence that somehow some things didn't do these didn't quite come together and I don't quite know why. I also was quite troubled by an allegation in one of the letters that the letter from the Medical Examiner had actually been solicited by the department, which was quite a startling statement for someone to make. I think that there was a enough questions about the process that I am not comfortable supporting the department's recommendation.

Mr. Kraut We're about to lose a quorum because people have to leave. All I would say to the rest of you is we need to vote. We have never in the years I've been in this council had a statement that we just had about an applicant like Dr. Morley and whether you want to give that weight or not I'm just suggesting to you never in our history has the department made a statement as Dr. Morley just made about an applicant.

Mr. Kraut With that, I'd like to call a vote.

Mr. Kraut All those in favor of the recommendation.

Mr. Kraut Hold on.

Mr. Kraut Go ahead.

Mr. Kraut That's what I was just about to do.

Mr. Kraut A yes vote is a vote to disapprove the application. Now, if we disapprove the application, the applicant has an appellate right. They can go to get an Article 78 hearing. if any of the issues that were raised by Ms. Monroe, Dr. Soffel may have any merit it'll go before an administrative law judge. They may return the application to us. They may resubmit it. It's done without prejudice. They can come back in at any time and reapply.

Mr. Kraut Am I correct?

Mr. Kraut There's no prejudice in the vote, but it gives them the right to go and do that.

Mr. Kraut If you're voting yes, you're voting to disapprove. If you're voting no, you're not voting to disapprove.

Mr. Kraut All those in favor of the motion to disapprove the application if you would raise your hand.

Mr. Kraut In New York, it's unanimous.

Mr. Kraut Dr. Boufford and Dr. Rugge.

Mr. Kraut If you're voting opposed, please raise your hand.

Ms. Leonard Two opposed.

Mr. Kraut We have two opposed.

Mr. Kraut The motion carries.

Mr. Kraut The application is disapproved.

Mr. Kraut Mr. Robinson.

Mr. Robinson It's really a privilege to be a part of this council and this committee and to have a conversation like we had. I just commend you all and the department.

Mr. Robinson Application 1 9 2 2 3 7 E, JAG Operating LLC doing business as Foltsbrook Center for Nursing and Rehabilitation. This is in Herkimer County. This is to establish JAG Operating LLC as the new operator of Foltsbrook Center for Nursing and Rehabilitation. A 163-bed skilled nursing facility located at 104 North Washington Street in Herkimer. Please note that an amendment was added to the exhibit of a map displaying nursing homes within ten miles of the current facility. The department recommended approval with contingencies. There is no recommendation from the committee.

Mr. Robinson I make a motion to approve the application with contingencies, as the department did.

Mr. Kraut I have a motion to approve.

Mr. Kraut I have a second by Dr. Berliner.

Mr. Kraut Are there any comments?

Mr. Kraut Yes, Mr. La Rue.

Mr. La Rue Yes.

Mr. La Rue At the committee meeting I opposed the application but based on the information the department provided and the letters that we received from the community, I'm going to be changing my vote today.

Mr. Kraut Thank you very much, Mr. La Rue.

Mr. Kraut Are there any questions in Albany?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut The motion carries.

Mr. Robinson Application 2 1 2 1 1 7 E, Livingston to Operations LLC doing business as Livingston Hills Nursing and Rehabilitation Center. This is in Columbia County. This is to establish Livingston Two Operations LLC as the new operator of Livingston Hills Nursing and Rehabilitation Center, a 120-bed residential health care facility at 2781 Route 9 in Livingston. The department recommended approval with contingencies, as did the committee earlier today.

Mr. Kraut I have a motion.

Mr. Kraut May I have a second?

Mr. Kraut Dr. Strange.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson Application 2 2 2 1 2 4 E, Woodcrest Rehabilitation and Residential Health Care Center in Queens County. Transfer 20% ownership interest from one withdrawing member to one new member. The department recommends approval with a condition. The committee voted similarly this morning.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions on this application?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Kraut We didn't do a Cayuga.

Mr. Robinson Did I miss Cayuga?

Mr. Kraut Cayuga, the certificate of incorporation.

Mr. Robinson Oh.

Mr. Kraut And then you got to go back and do the category once, right? You can batch those.

Mr. Robinson This is a certificate of incorporation of incorporation for Cayuga Health Care System. A name change. You'll recall this was in relation to services that were already approved. This is just aligning the bylaws and the corporate structure to confirm that as opposed to us approving those programs. We did that already. The department recommends approval, as did the committee earlier today.

Mr. Robinson I so move.

Mr. Kraut I have a motion.

Mr. Kraut I have a second, Dr. Berliner.

Mr. Kraut Any questions?

Mr. Kraut All those in favor, aye.

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Dr. Boufford Excuse me. Dr. Ortiz has left.

Mr. Kraut Thank you.

Mr. Robinson I'm going to batch the remaining applications.

Dr. Boufford Excuse me. Dr. Ortiz and Dr. Watkins have left.

Mr. Kraut Nobody else can leave until these last applications are done, because then we lose the quorum.

Mr. Kraut Go ahead.

Mr. Robinson 2 2 1 2 8 0 Specialist One day Surgery LLC transferring 100% ownership interest to a new member LLC comprised of the current members and one new member, and then immediately transfer 25% ownership interest to a new not for profit corporate member. Note that a revised staff report has been distributed and posted which corrects the proposed membership table. Application 2 2 2 0 3 6 B, Excelsior ASC LLC doing business as Excelsior Ambulatory Surgery Center in Kings County. This is to establish and

construct a new multi-specialty ambulatory surgery center at 8 33/65th Street in Brooklyn. This one involves the approval with conditions and contingencies and an expiration of the operating certificate five years from the date of issuance. Application 2 2 1 2 8 1 B, Integrated Care Services in Kings County Establishing construct a new diagnostic and treatment center at 14 26/39th Street in Brooklyn. Application 2 2 2 0 3 2 B, Mount Valley Care LLC in Rockland County establish and construct a new diagnostic and treatment center at 290 Route 59 in Spring Valley. Application 2 2 2 1 2 3 E, The Knolls at and Inc in Orange County, establishing the notification as the new operator of the 40-bed residential health care facility, which is part of a continuing care retirement community of 214 Herriman Drive, Goshen, currently operated by Glenn Arden Inc. In all instances, the department and the committee recommend approval with conditions, contingencies, and in the one instance, a five-year limitation on the application.

Mr. Robinson I move those applications.

Mr. Kraut I have a motion.

Mr. Kraut I have a second by Dr. Berliner.

Mr. Kraut Any questions on any of these applications?

Mr. Kraut All those in favor, aye?

Mr. Kraut Opposed?

Mr. Kraut Abstentions?

Mr. Kraut The motion carries.

Mr. Robinson That concludes the report of the Establishment of Project Review.

Mr. Kraut Thank you.

Mr. Kraut That was a very disjointed agenda. We really appreciate everybody's communication. I just want to let you know that the next regularly scheduled committee day is on March 30th. The full council will be on Tuesday, April 18th. We've gotten a request from some of the members to stop by preceding the meeting to get everybody together in one location. I think given some of the nature of the discussions, we'd be better off if we're in a room. On the next cycle, those meetings will be held in New York City and only in New York City. We're going back to essentially one site per cycle. We need to get back together. It's just challenging us, I think. We'll see how that goes. We are trying to get changes in the Open Meeting Law for extraordinary circumstances to participate by Zoom for members, but so far, we haven't been successful, but we're going to try. The next meeting cycle will be only in New York City.

Mr. Kraut I have motion to adjourn.

Mr. Kraut So moved.

Mr. Kraut We are adjourned.

Mr. Kraut Thank you, everybody.

Mr. Kraut Thank you for this and the committee days and the work and thank the department.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 221082-C
Jamaica Hospital Medical Center

Program: **Hospital**
Purpose: **Construction**

County: **Queens**
Acknowledged: **March 22, 2022**

Executive Summary

Description
Jamaica Hospital Medical Center (JHMC), a 416-bed voluntary not-for-profit Article 28 acute care hospital located at 89th Avenue & Van Wyck Expressway, Jamaica (Queens County), requests approval to expand and modernize its Emergency Department (ED) and add 22 new critical care beds and an interventional suite. Upon completion of this project, JHMC will have 48 ICU beds and 438 total beds. JHMC is the only Level 1 Trauma Center in South Queens.

The expansion and modernization of the ED will address current design and infrastructure deficiencies at JHMC, improving infection control and patient care. The new ED will be expanded into the ground floor of a new 48,534 square foot 3-story plus basement addition on adjacent available property currently utilized as a Doctor's Parking Lot. The 2nd and 3rd floors will house two new critical care units with 22 new critical care beds. In addition to the new construction, renovations will be performed to the existing ED and adjacent areas. The ED project will increase ambulance bays from four (4) to five (5), trauma bays from one (1) to four (4) major and four (4) minor trauma bays, and isolation spaces from one (1) to six (6) with four (4) additional treatment rooms available as step down units.

Medisys Health Network, Inc. (Medisys), a New York not-for-profit corporation, is JHMC's sole voting member. It is also the sole voting member of Flushing Hospital Medical Center, Jamaica Hospital Nursing Home, and other healthcare organizations. Medisys was formed to support and benefit these organizations by providing planning and consulting services and improving service coordination.

OPCHSM Recommendation
Contingent Approval is recommended.

Need Summary
The applicant projects ED visits of 99,400 in Year One and 125,000 in Year Three.

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
Total project costs of $155,270,341 will be met with a Statewide Health Care Facility Transformation Program IV (SHCFTP IV) grant award of $150,000,000 and $5,270,341 from ongoing operations of JHMC.

Incremental Budget:	Year One (2026)	Year Three (2028)
Revenues	$27,998,423	$46,146,403
Expenses	37,367,403	43,799,851
Net Income/(Loss)	($9,368,981)	$2,346,552

The Enterprise Budget (in 000's) is as follows:

	Current Year (2021)	Year One (2026)	Year Three (2028)
Revenues	$663,882	$691,880	$710,028
Expenses	$662,354	$699,721	$706,153
Net Income	$1,528	($7,841)	$3,875

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management

Approval contingent upon:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of documentation confirming final approval of the Statewide Health Care Facility Transformation Program IV executed grant contract, acceptable to the Department of Health. [BFA]
3. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of Mechanical, Electrical, and Plumbing (MEP) Drawings acceptable to the Department, as described in BAER Drawing Submission Guidelines DSG-01. [AER]

Approval conditional upon:

1. This project must be completed by **April 18, 2027**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **September 18, 2023,** and construction must be completed by **January 18, 2027**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]

Council Action Date

April 18, 2023

Need and Program Analysis

Background and Analysis

Jamaica Hospital Medical Center (JHMC), a 416-bed not-for-profit, tertiary care hospital located at 89th Avenue & Van Wyck Expressway in Jamaica (Queens County), seeks approval to construct an addition to expand and modernize its Emergency Department (ED), add 22 critical care beds, and add an interventional suite. The expansion and modernization of the ED will address current design and infrastructure deficiencies at JHMC, improving infection control and patient care. The new total certified bed capacity, including all bed types, will be 438 beds.

The expansion and improvements will be achieved through the construction of a new 48,534 square-foot three-story building with a basement in a parking lot adjacent to the current hospital. The 15,571 square foot ground floor will be used for the new Emergency Department. The second and third floors will provide 8,696 square feet for each of the two new critical care units consisting of 22 new critical care beds. The 15,571-square-foot basement area will provide space for hospital functions being displaced by the expanded ED. Beyond the new construction, approximately 36,265 square feet of renovations will be performed in the existing ED and adjacent areas.

The current ED was built 30 years ago and has a capacity for 60,000 visits. JHMC is the only Level 1 Trauma Center in South Queens and had 2,007 trauma activations in 2021. Occupancy of the existing 26 Intensive Care beds has consistently been in the high 90s in recent years. Direct admissions from the ED to the ICU have ranged from 1,300 to 1,600 per year.

Other improvements include adding one (1) ambulance bay, going from one (1) trauma bay to four (4) major trauma bays and four (4) minor trauma bays with four (4) additional treatment rooms, increase from one (1) to six (6) isolation rooms, and replacing curtained treatment bays with 57 enclosed treatment areas. In addition, it will address air filtration, increase air changes, increase exhaust capabilities, and negative air pressure space allocations. This project will also modernize the Pediatric ED space and seven (7) enclosed geriatric treatment rooms, as well as modernize the ICU rooms.

Staffing is expected to increase as a result of this construction/expansion project by 191.0 FTEs at Year One of the completed project, with no additional increases by Year Three.

The tables below show the current and proposed changes to treatment spaces and beds.

ED Treatment Spaces		
Treatment Spaces	**Current**	**Proposed**
Trauma Bays	1	8
Step Down Treatment	0	4
Isolation	1	6
Treatment Bays	27 curtained	57 enclosed
Total	**29**	**75**

Source: Applicant

Beds		
Bed Type	**Current**	**Proposed**
Coronary Care	4	0
Intensive Care	22	48
Maternity	40	40
Medical / Surgical	228	228
Neonatal Continuing Care	4	4
Neonatal Intensive Care	5	5
Neonatal Intermediate Care	10	10
Pediatric	24	24
Physical Medicine and Rehabilitation	16	16
Psychiatric	56	56
Transitional Care	7	7
Certified Beds Total	**416**	**438**

Source: Applicant

The hospital is in Queens County. The population of Queens County, according to 2021 US Census population estimates, was 2,331,143. The population is expected to increase to 2,544,231 by 2028, according to Cornell PAD estimates, a 9.1% increase.

According to Data USA, in 2018, 89.5% of the population in Queens County had health coverage as follows.

Employer Plans	43.2%
Medicaid	25.9%
Medicare	9.8%
Non-Group Plans	10.3%
Military or VA	0.302%

Based on the market share analysis below, the primary service area is Southwest Queens, Jamaica, and East New York neighborhoods. JHMC is the only Level I trauma center in South Queens with proximity to JFK airport.

Market Share Analysis for Jamaica Hospital Medical Center Service Area: 85% of hospital discharges based on patient Zip codes of origin, including the facility with the biggest share in each zip code						
Patient Zip Code	**City**	**Annual average discharges**	**Percent of facility's total discharges**	**Cumulative Percent**	**Facility's Share of Zip Code**	**Facility with the biggest share of this zip code (%)**
11208	Brooklyn	1,289	8.5	8.5	12.7	1629:Jamaica Hospital Medical Center (13%)
11419	Jamaica	1,143	7.5	16	23.8	1629:Jamaica Hospital Medical Center (24%)
11420	Jamaica	1,083	7.1	23.1	22.5	1629:Jamaica Hospital Medical Center (23%)
11434	Jamaica	1,047	6.9	30	13.2	1630:Long Island Jewish Medical Center (24%)
11435	Jamaica	1,022	6.7	36.7	17	1629:Jamaica Hospital Medical Center (17%)
11418	Jamaica	979	6.4	43.1	26.4	1629:Jamaica Hospital Medical Center (26%)
11421	Jamaica	736	4.8	47.9	20.5	1629:Jamaica Hospital Medical Center (21%)
11433	Jamaica	735	4.8	52.8	16.3	1630:Long Island Jewish Medical Center (20%)
11416	Jamaica	668	4.4	57.1	25.3	1629:Jamaica Hospital Medical Center (25%)
11417	Jamaica	616	4	61.2	20.4	1629:Jamaica Hospital Medical Center (20%)

Market Share Analysis for Jamaica Hospital Medical Center Service Area: 85% of hospital discharges based on patient Zip codes of origin, including the facility with the biggest share in each zip code						
Patient Zip Code	**City**	**Annual average discharges**	**Percent of facility's total discharges**	**Cumulative Percent**	**Facility's Share of Zip Code**	**Facility with the biggest share of this zip code (%)**
11432	Jamaica	500	3.3	64.5	6.8	1633:Queens Hospital Center (26%)
11436	Jamaica	486	3.2	67.7	20.8	1629:Jamaica Hospital Medical Center (21%)
11414	Jamaica	399	2.6	70.3	13.2	1630:Long Island Jewish Medical Center (22%)
11207	Brooklyn	322	2.1	72.4	3	1286:Brookdale Hospital Medical Center (14%)
11412	Jamaica	267	1.8	74.2	5.8	1630:Long Island Jewish Medical Center (33%)
11415	Jamaica	238	1.6	75.7	12.4	1630:Long Island Jewish Medical Center (18%)
11413	Jamaica	216	1.4	77.1	4.6	1630:Long Island Jewish Medical Center (27%)
11691	Far Rockaway	199	1.3	78.4	2.3	1635:St Johns Episcopal Hospital So Shore (38%)
11423	Jamaica	182	1.2	79.6	5.1	1630:Long Island Jewish Medical Center (34%)
11354	Flushing	129	0.8	80.5	2.2	1637:Newyork-Presbyterian/Queens (38%)
11422	Jamaica	119	0.8	81.3	3.4	1630:Long Island Jewish Medical Center (28%)
11355	Flushing	104	0.7	81.9	1.4	1637:Newyork-Presbyterian/Queens (47%)
11692	Far Rockaway	97	0.6	82.6	3.7	1635:St Johns Episcopal Hospital So Shore (38%)
11368	Flushing	95	0.6	83.2	0.9	1626:Elmhurst Hospital Center (25%)
11385	Flushing	95	0.6	83.8	1.1	1318:Wyckoff Heights Medical Center (27%)
11429	Jamaica	86	0.6	84.4	2.8	1630:Long Island Jewish Medical Center (39%)
11212	Brooklyn	78	0.5	84.9	0.7	1286:Brookdale Hospital Medical Center (19%)

Source: SPARCS inpatient data (April 1, 2021-March 31, 2022) Data updated 11/03/2022

The applicant states that the current ED was designed to accommodate 60,000 visits per year; however, prior to the COVID-19 pandemic, the ED volume significantly exceeded this volume, with patients facing significant wait times due to high volume and limited space.

The expected ED outcomes of the application include:

- Modernization of the ED to address design and infrastructure deficiencies to better address infection control and improve patient care by adding appropriately sized space with sufficient trauma bays, isolation rooms, and single-occupancy treatment rooms. This will streamline patient and staff flow and improve ventilation.
- Reductions in waiting time, improve staff efficiency, and patient and staff safety and comfort.

According to the applicant, the expanded ED will add to the need for additional critical care beds to accommodate direct admissions from the ED. From 2019 to 2021, there was a 21.3% decrease in ED

visits. The applicant expects ED volume to exceed pre-pandemic levels by year three, seeing 99,400 visits by Year One and 125,000 visits by Year Three.

ED Volume, Historically and Projected Source: Applicant								
Year	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022***	**2025***
Total ED Visits	119,398	113,284	110,387	113,777	77,996	89,553	99,400	125,000
Volume for 29 Treatment Spaces	4,117	3,906	3,806	3,923	2,690	3,088	3,428	4,310
Volume with 75 Treatment Spaces	1,592	1,510	1,472	1,517	1,040	1,194	1,325	1,667

** Projected data*

Prevention Agenda

This project will address current design and infrastructure deficiencies that will allow the ED to be better equipped to prevent the spread of infection and improve patient care.

The applicant has identified the primary and secondary service areas. A quantitative and qualitative description of the population to be served, including a sociodemographic breakdown, was provided.

The hospital's efforts will contribute to the state's goals to "reduce communicable diseases" through a modernized ED and improved ED practices. Specifically,

1. The applicant has provided information about the need for additional critical care beds to accommodate direct admissions from the ED.
2. The project will result in added ambulance bays, trauma bays, and isolation rooms and will replace current curtained treatment bays with 57 enclosed treatment areas. In addition, it will address air filtration, increased air changes, increased exhaust capabilities, and negative air pressure space allocations.
3. The hospital states it is "implementing interventions to expand cancer control services that support local public health priorities." However, the hospital did not specify how these enhancements are consistent with the facility's Community Service Implementation Plan. Specifically, However, no examples are provided, nor does the applicant describe activities that support the local Community Health Improvement Plan. Of particular interest is how the hospital has engaged partners in its efforts to address local public health priorities.
4. The application reports $200,980,553 in community benefit spending, with $1,827,901 in spending in the Community Health Improvement Services and Community Benefit Operations category.

Compliance with Applicable Codes, Rules, and Regulations

The medical staff will continue to ensure that the procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and expertise. The Facility's admissions policy includes anti-discrimination provisions regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures are performed in accordance with all applicable federal and state codes, rules, and regulations.

Conclusion

Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law. Through this project, the applicant will expand and modernize their ED and enhance other hospital treatment areas to serve Queens and surrounding neighborhoods.

Financial Analysis

Total Project Cost and Financing

The total project cost for new construction and the acquisition of moveable equipment is estimated at $155,270,341 and is broken down as follows:

New Construction	55,519,200
Renovation & Demolition	36,265,000
Site Development	5,337,150
Design Contingency	9,678,420
Construction Contingency	9,678,420
Architect/Engineering Fees	5,323,131
Construction Manager Fees	2,419,605
Capitalized Licensing Fees	1,162,850
Moveable Equipment	29,035,260
CON Application Fee	2,000
CON Processing Fee	849,305
Total Project Cost	155,270,341

The applicant's financing plan appears as follows:

Cash	$5,270,341
Statewide Health Care Facility Transformation Program IV Grant	$150,000,000
Total	$155,270,341

Operating Budget

	Current Year (2021)		Year One (2026)		Year Three (2028)	
	Per Disch.	Total	Per Disch.	Total	Per Disch.	Total
Inpatient Revenues:						
Commercial MC	$17,818.92	$43,798,911	$18,053.96	$47,337,496	$18,197.20	$49,696,552
Medicare FFS	$26,404.40	50,432,405	$25,544.20	53,617,270	$25,051.92	55,740,513
Medicare MC	$20,420.68	66,877,729	$19,977.81	70,961,165	$19,717.27	73,683,456
Medicaid FFS	$17,483.71	28,865,607	$17,432.64	31,204,421	$17,408.94	32,763,631
Medicaid MC	$13,109.28	86,311,525	$13,783.95	96,653,038	$14,188.46	103,547,380
All Other [1]	$29,116.19	6,172,633	$28,814.35	6,483,229	$26,492.07	6,172,654
Inpatient Revenues [2]		$282,458,810		$306,256,619		$321,604,186
Expenses: (Inpatient)						
Operating	$21,361.80	$347,684,626	$20,761.71	$364,077,420	$19,941.66	$366,447,900
Capital	$613.55	9,986,177	$648.95	11,379,965	$695.13	12,773,752
Inpatient Expenses	$21,975.35	$357,670,803	$21,410.66	$375,457,385	$20,636.79	$379,221,653
Impatient Income/(Loss)		($75,211,993)		($69,200,766)		($57,617,467)
Utilization (Discharges):		16,276		17,536		18,376

Outpatient Revenues:						
Commercial MC	$571.05	$37,787,869	$583.99	$39,322,131	$592.37	$40,344,972
Medicare FFS	$461.47	$6,774,348	$463.61	$6,949,272	$464.98	$7,065,888
Medicare MC	$312.98	$17,082,822	$313.07	$17,257,823	$313.14	$17,374,491
Medicaid FFS	$391.70	$5,978,881	$388.63	$6,172,691	$386.71	$6,301,897
Medicaid MC	$231.63	$54,731,229	$236.35	$56,689,449	$239.43	$57,994,929
All Other [1]	$687.98	$3,053,269	$677.69	$3,217,667	$671.63	$3,327,265
Outpatient Revenues [2]		$125,408,418		$129,609,033		$132,409,442
Expenses: (Outpatient)						
Operating	$716.67	$296,175,784	$744.29	$313,351,586	$735.89	$313,614,746
Capital	20.58	8,506,742	25.92	$10,911,759	31.25	13,316,779
Outpatient Expenses	$737.25	$304,682,524	$770.21	$324,263,345	$767.14	$326,931,525
Outpatient Income/(Loss)		($179,274,106)		($194,654,312)		($194,522,083)
Utilization: (Visits)		413,269		421,009		426,169
Net Income Loss		($254,486,099)		($263,855,078)		($252,139,550)
Other Op. Rev.		$222,816,686		$222,816,686		$222,816,686
Total Op. Loss		(31,669,413)		(41,038,392)		(29,322,864)
Non-Oper. Rev.		33,198,000		33,198,000		33,198,000
Total Income/(Loss) [3]		$1,528,587		($7,840,392)		$3,875,136

[1] All Other revenue includes workers comp, no-fault Insurance, and minimal self-pay revenue.
[2] Other Operating Revenues include grant awards, physician billing and professional components, and other income.
[3] Total revenues and expenses, as presented, exclude approximately $265,342,000 in capitation revenues and $218,586,000 in costs related to capitation revenue.

The following is noted with respect to the submitted budget:

- Current Year revenues and expenses are reflective of JHMC's 2021 audited financial statements.
- Projected volume is based on current community need, emergency department walkout rates attributed to wait times, current level of ambulance diversion at JHMC, as well as additional capacity created as a result of this project.
- Volume by payor is modeled based on JHMC's existing payor mix.
- Rates by payor are based on JHMC's current reimbursement levels and are projected to remain constant.
- The proposed staff mix is based on current and expected future contract staffing levels and the projected staff needed to accommodate the projected increased patient utilization based on the new capacity. Additional staff will be added as needed to ensure quality of care.

Utilization by payor source for inpatient and outpatient services is as follows:

Inpatient:	Current Year	Year One	Year Three
Commercial MC	15.10%	14.95%	14.86%
Medicare FFS	11.74%	11.97%	12.11%
Medicare MC	20.12%	20.26%	20.34%
Medicaid FFS	10.15%	10.21%	10.24%
Medicaid MC	40.45%	39.98%	39.71%
Charity Care	1.14%	1.35%	1.47%
All Other	1.30%	1.28%	1.27%
Total	100.00%	100.00%	100.00%

Outpatient:	Current Year	Year One	Year Three
Commercial MC	16.01%	16.00%	15.98%
Medicare FFS	3.55%	3.56%	3.57%
Medicare MC	13.21%	13.09%	13.02%
Medicaid FFS	3.69%	3.77%	3.82%
Medicaid MC	57.18%	56.97%	56.84%
Charity Care	5.28%	5.48%	5.61%
All Other	1.08%	1.13%	1.16%
Total	100.00%	100.00%	100.00%

Capability and Feasibility

Total project costs of $155,270,341 will be met with a Statewide Health Care Facility Transformation Program IV (SHCFTP IV) grant award of $150,000,000 and $5,270,341 from ongoing operations of JHMC. Working capital needs, estimated at $6,227,901, are based on two months of first-year incremental expenses and will be funded by JHMC's ongoing operations. The submitted budget projects an incremental net loss of $11,510,667 and an incremental net income of $722,501 in Years One and Three, respectively. The projected gain in Year 3 is driven by an increase in the number of Treat and Release (T&R) visits and a reduction in ED walkouts, currently estimated to be 5,500 during 2022. Moreover, an additional ambulance bay will help eliminate diversions, estimated at 500 patients per year, and allow for incremental ambulance throughput. The submitted budget appears reasonable.

As shown in BFA Attachment A, Certified Financial Statements as of December 31, 2021, JHMC reported $30,119,000 in positive working capital, positive net assets of $14,541,000, and a $15,086,000 gain from operations. During the period, JHMC received approximately $94,559,000 in Value-Based Payment Quality Improvement Program (VBPQIP) funding intended to assist facilities in severe financial distress and enable the continuation of operations while allowing the distressed facility to work on long-term sustainability. During 2021, JHMC also received $1,745,000 in Provider Relief Funds intended to reimburse eligible healthcare providers for eligible expenditures attributable to COVID-19 and revenue loss. While Jamaica maintained a positive working capital and net asset position for the year ended December 31, 2021, these results are primarily attributable to grant funding the facility received during the year. In 2022, the VBPQIP program transitioned to the Directed Payment Template (DPT) model designed to support qualifying Safety Net hospitals through enhanced Medicaid Managed Care rates. These DPT rates are assumed to be applied to the incremental volume for this project. The revenue projections do not assume the additional impact of these rates when applied to all of JHMC's projected utilization, which will provide additional operating support across JHMC's inpatient and outpatient lines.

BFA Attachment B presents JHMC's Internal Financial Statements for the year ending December 31, 2022. During this period, JHMC reported $8,984,043 in negative working capital, a negative net asset position of $4,787,077, and an operating loss of $3,648,293, which was further offset by $17,058,143 in other non-operating expenses, and $1,377,962 grant for capital purposes resulting in a net loss of $19,328,475. The facility's negative financial position is attributable to challenges resulting from the high-need population served, the majority of which are governmental payors. Uncompensated care to the uninsured and patients with coverage who cannot pay their co-pays and deductibles also contribute to financial distress. The closure of six (6) hospitals in Queens within the past several years resulted in a significant strain on Jamaica Hospital, specifically the ED, which was not designed to accommodate the current demand for emergency services.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BFA Attachment A	Jamaica Hospital Medical Center – 2021 Certified Financial Statements
BFA Attachment B	Jamaica Hospital Medical Center – December 31, 2022, Internal Financial Statements

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 222234-C
Atlantic Surgery Center

Program: **Diagnostic and Treatment Center** ***County:*** **Suffolk**
Purpose: **Construction** ***Acknowledged:*** **December 23, 2022**

Executive Summary

Description
Atlantic SC, LLC d/b/a Atlantic Surgery Center, currently certified as a single-specialty Article 28 freestanding ambulatory surgery center (FASC) specializing in gastroenterology services, requests approval to add a second single specialty for pain management and install a C-Arm machine. The facility has been operating at 1145 Montauk Highway, West Islip (Suffolk County) since April 2022.

Dr. Nitin Mariwalla is the owner/operator of the Atlantic Surgery Center and serves as its Medical Director. Dr. Mariwalla, a neurosurgeon with a medical practice in West Islip, and Dr. Raymond Baule will perform the pain management services at the facility. Both physicians are board-certified and have admitting privileges at Good Samaritan Hospital Medical Center, where the applicant has a Transfer and Affiliation Agreement for backup and emergency services. Good Samaritan Hospital Center is located 0.4 miles from the proposed facility.

OPCHSM Recommendation
Contingent Approval

Need Summary
The applicant projects 1,098 pain management procedures in Year One and 1,331 in Year Three with 12.02% Medicaid and 1.95% Charity Care in the third year.

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
Total project costs of $135,229 will be funded from equity.

Budget:	Year One (2023)	Year Three (2025)
Revenues:	$591,092	$715,221
Expenses:	$505,563	$554,878
Net Income	$85,529	$160,343

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Primary Care and 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 signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
   a. Data displaying actual utilization, including procedures;
   b. Data displaying the breakdown of visits by payor source;
   c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
   d. Data displaying the number of emergency transfers to a hospital;
   e. Data displaying the percentage of charity care provided;
   f. The number of nosocomial infections recorded during the year reported;
   g. A list of all efforts made to secure charity cases; and
   h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]

Approval conditional upon:

1. This project must be completed by **one year from the date of the recommendation letter**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. The submission of annual reports to the Department as prescribed by the related contingency each year for the duration of the limited life approval of the facility. [RNR]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]

Council Action Date

April 18, 2023

Need Analysis

Background and Analysis

The center was approved under CON 191212 and began operations in April 2022, providing gastroenterology surgery services in five procedure rooms. The primary service area is Suffolk County. The population of Suffolk County in 2021 was 1,526,344, according to the latest US Census data population estimates, and is projected to decrease to 1,492,157 by 2028. According to Data USA, in 2020, 95.8% of the population of Suffolk County had health coverage as follows:

Employer Plans	58.3%
Medicaid	11.6%
Medicare	13.0%
Non-Group Plans	12.4%
Military or VA	0.501%

The applicant projects 1,098 pain management procedures in Year One and 1,331 in Year Three. These projections are based on the current practices of participating surgeons. The applicant has also been approached by physicians currently performing pain management procedures in hospitals who would like to bring them to Atlantic Surgery Center. The table below shows the projected payor source utilization for Years One and Three for just the pain management procedures.

	Year One		Year Three	
Payor	**Volume**	**%**	**Volume**	**%**
Commercial FFS	330	30.05%	399	29.98%
Commercial MC	198	18.03%	240	18.03%
Medicare FFS	330	30.05%	399	29.98%
Medicare MC	55	5.01%	67	5.03%
Medicaid FFS	22	2.00%	27	2.03%
Medicaid MC	110	10.02%	133	10.00%
Private Pay	33	3.01%	40	3.00%
Charity Care	20	1.83%	26	1.95%

The applicant anticipates their projections from their original CON for gastroenterology procedures to remain (7,500 gastroenterology procedures in Year One and 10,352 in Year Three.

The center is current with its SPARCS reporting through December 2022.

PrecisionCare Surgery Center, a single-specialty ASC providing orthopedic procedures, is also requesting to add pain management at its location (222270 on this agenda). This center opened in April 2021 and is 26.2 miles and 35 minutes away from Atlantic Surgery Center.

The table below shows the number of patient visits for relevant ASCs within Suffolk County for 2019 through 2021. 2020 visits were significantly impacted by the COVID-19 pandemic.

Specialty Type	Facility Name	Patient Visits		
		2019	2020	2021
Gastroenterology/ Pain Management	Advanced Surgery Center of Long Island	8,447	6,287	8,932
Gastroenterology	Digestive Health Center of Huntington	4,038	3,489	4,591
Gastroenterology	Great South Bay Endoscopy Center	6,720	5,305	7,056
Gastroenterology	Island Digestive Health Center	6,964	4,672	6,142
Gastroenterology	Island Endoscopy Center	11,757	7,020	8,286
Multi	Long Island Ambulatory Surgery Center	14,642	9,270	12,057
Multi	Melville Surgery Center	5,917	4,611	4,273
Gastroenterology/ Pain Management	North Fork Surgery Center (opened 2/14/20)	N/A	1,298	2,968
Multi	North Shore Surgi-Center	7,226	6,364	6,215
Gastroenterology	Northeast Endoscopy (opened 7/14/21) [1]	N/A	N/A	0
Multi	Port Jefferson ASC [1]	2,570	3,037	0
Multi	Progressive Surgery Center	2,886	1,510	2,092
Multi	South Shore Surgery Center	4,828	3,389	3,856
Multi	Suffolk Surgery Center	5,724	3,655	3,953
Multi	Center for Advanced Spine & Joint Surgery (opened 8/30/21) [1]	N/A	N/A	0
Total Visits		**81,719**	**50,907**	**70,421**

[1] *No data located for 2021*

The center has Medicaid Managed Care contracts with the following: Affinity Health, Health First PHSP, Health Insurance Plan of Greater NY, Neighborhood Health Provider, NYS Catholic Health, and United Healthcare of NY. The center will work collaboratively with local Federally Qualified Health Centers such as Hudson River Healthcare-Wyandanon, Long Island Select Healthcare, and Damian Family Health Care Centers to provide services to the under-insured in their service area.

Conclusion

Approval of this project will enhance access to pain management surgery services for the residents of Suffolk County.

Program Analysis

Project Proposal

Atlantic SC, LLC d/b/a Atlantic Surgery Center, an existing single specialty gastroenterology Ambulatory Surgery Center (ASC) located at 1145 Montauk Highway in West Islip (Suffolk County), seeks approval for the addition of a second single specialty for the provision of pain management and addition of a C-arm.

The Applicant reports that since the proposed ASC filed for initial licensure in 2019, his practice of pain medicine has increased the overall utilization and need to provide pain medicine services has increased. Also, several other physicians have approached the Applicant to provide pain management services because they feel hospitals are understaffed and patients prefer an ASC setting.

Staffing is expected to be increased by 2.00 FTEs at Year One and 2.00 FTEs at Year Three of the completed project.

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.

Compliance with Applicable Codes, Rules, and Regulations

The medical staff will continue to ensure that the procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and expertise. The Facility's admissions policy includes anti-discrimination provisions regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures are performed in accordance with all applicable federal and state codes, rules, and regulations.

Conclusion

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

Financial Analysis

Total Project Costs and Financing

Total project costs for construction, fit-out, and the acquisition of moveable equipment are estimated at $135,229, distributed as follows:

Architect/Engineering Fees	$7,500
Other Fees	$25,000
Movable Equipment	$100,000
CON Application Fee	$2,000
Additional CON Processing Fee	$729
Total Project Cost	$135,229

The applicant will fund the project through equity.

BFA Attachment A presents the applicant's personal Net Worth Statement, which indicates sufficient liquid resources exist to fund the equity requirement for project costs.

Operating Budget

The applicant has submitted their first (2023) and third (2025) year operating budget for the pain management services only, in 2023 dollars, summarized below:

	Year One (2023)		Year Three (2025)	
Revenues:	Per Procedure	Revenues	Per Procedure	Revenues
Commercial FFS	$ 675.91	$223,049	$676.41	$269,889
Commercial MC	644.50	116,010		$140,372
Medicare FFS	$482.79	$159,321	$483.15	$192,778
Medicare MC	$470.13	$25,857	$466.97	$31,287
Medicaid FFS	470.14	$10,343	$463.52	$12,515
Medicaid MC	$482.79	53,107	$483.15	$64,259
Private Pay	$468.73	15,468	$467.90	$18,716
Bad Debt		($12,063)		($14,595)
Total Revenues		$591,092		$715,221
Expenses:				
Operating Expense	$449.73	$493,802	$408.05	$543,117
Capital Expense	$10.71	$11,761	$8.84	$11,761
Total Expense:	$460.44	$505,563	$416.89	$554,878
Net Income:		$85,529		$160,343
Total Procedures		1,098		1,331

Utilization by payor sources for the pain management services only is anticipated as follows:

	Year One (2023)		Year Three (2025)	
Payor	Volume	%	Volume	%
Commercial FFS	330	30.05%	399	29.98%
Commercial MC	198	18.03%	240	18.03%
Medicare FFS	330	30.05%	399	29.98%
Medicare MC	55	5.01%	67	5.03%
Medicaid FFS	22	2.00%	27	2.03%
Medicaid MC	110	10.02%	133	10.00%
Private Pay	33	3.01%	40	3.00%
Charity Care	20	1.83%	26	1.95%

The following assumptions were considered for the operating budget:

- Volume is based on the historical experience of pain management cases of the two physicians that will be performing procedures at the FASC. These two physicians, Dr. Mariwalla and Dr. Baule, have provided a letter of intent to perform pain management services at Atlantic Surgery Center.
- Medicare and Medicaid revenues are based on the 2022 CMS fee schedule. Commercial FFS revenues are based on 140% of the 2022 CMS Fee schedule, and Commercial MC revenues are based on 125% of the CMS fee schedule.
- Expenses are based on similar ambulatory surgery centers of similar size as well as the experience to date of the existing FASC.

Capability and Feasibility

Total project costs of $135,229 will be funded by the applicant's equity. As shown in BFA Attachment A, the applicant's personal Net Worth Statement indicates sufficient liquid resources to fund the equity requirement for project costs.

Working capital requirements are estimated at $92,480 based on two months of third-year expenses. The applicant will fund the working capital needs from equity. The summary of the member's Net Worth Statement in BFA Attachment A indicates sufficient funds for the required working capital.

BFA Attachment B is the 4/1/2022 - 12/31/2022 internal financial statements for Atlantic SC, LLC d/b/a Atlantic Surgery Center. The facility has generated a negative working capital position of $3,226,196 and a positive net asset position of $235,233 and generated a net loss of $364,840 for the period. The loss is due to the FASC receiving its operating certificate in April 2022 but not being approved for enrollment in the NYS Medicaid Program until January 23, 2023, which limited the applicant's ability to bill and collect revenue.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BHFP Attachment	Map
BFA Attachment A	Net Worth Statement of the Proposed Member of Atlantic SC, LLC d/b/a Atlantic Surgery Center
BFA Attachment B	4/1/2022-12/31/2022 Internal Financial Statements for Atlantic SC, LLC d/b/a Atlantic Surgery Center

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 212260-B
SurgiCore Suffolk, LLC

Program: **Diagnostic and Treatment Center** ***County:*** **Suffolk**
Purpose: **Establishment and Construction** ***Acknowledged:*** **February 11, 2022**

Executive Summary

Description

SurgiCore Suffolk, LLC (The Center), an existing Limited Liability Company, is seeking approval to establish and construct an Article 28 multi-specialty ambulatory surgery center (ACS) specializing in pain management, orthopedic, and podiatry services. The proposed Center will be in leased space owned by APR Community Realty, LLC, at 1050 Old Nichols Road, Islandia, and serve central Suffolk County.

SurgiCore Suffolk, LLC is a collaboration between SurgiCore Eastern Long Island, LLC, and Community Medical Wellness, an existing private pain management practice. Community Medical Wellness is comprised of three (3) partners who currently operate a pain management practice in Suffolk County; Aman Deep, M.D., Robert Antoniou, M.D., and Paul Cella, P.A. SurgiCore Eastern Long Island, LLC, an affiliate of SurgiCore surgical centers, comprises 11 independent ambulatory surgery centers in the Tri-State area.

Ownership of the operations after PHHPC approval is as follows:

SurgiCore Suffolk, LLC	
Member	Membership % in SurgiCore Suffolk, LLC
Direct Members:	49%
Paul Cella, P.A. 16.33%	
Robert Antoniou, M.D. 16.33%	
Aman Deep, M.D. 16.33%	
SurgiCore Eastern Long Island, LLC	51%
Anthony DeGradi 25%	
Wayne Hatami 25%	
Feliks Kogan 25%	
Leonid Tylman 25%	
Total Surgicore Suffolk, LLC	100%

BFA Attachment B presents the organizational chart showing the proposed membership interest of the Center. The Medical Director of the proposed facility is Robert Antoniou, M.D. The applicant has submitted an executed transfer and affiliation agreement with St. Charles Hospital located at 200 Belle Terre Rd., Port Jefferson, NY 11777, approximately 15 miles away.

OPCHSM Recommendation

Contingent approval with an expiration of the operating certificate five years from the date of its issuance.

Need Summary

The applicant projects 3,738 procedures in Year One and 4,650 in Year Three, with Medicaid at 4% and Charity Care at 2%.

Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a (3).

Financial Summary

Total project costs of $6,629,110 will be met with equity from the proposed members of SurgiCore Eastern Long Island, LLC.

Budget:	Year One 2024	Year Three 2026
Revenues	$6,703,340	$8,289,521
Expenses	$6,579,189	$8,131,924
Net Income	$124,151	$157,597

Recommendations

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

Office of Primary Care and Health Systems Management
Approval with an expiration of the operating certificate five years from the date of its issuance, 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 by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
3. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]
4. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
5. Submission of Mechanical, Electrical, and Plumbing (MEP) Drawings acceptable to the Department, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]

Approval conditional upon:

1. This project must be completed by **December 18, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **September 18, 2023,** and construction must be completed by **September 18, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

5. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
6. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]

Council Action Date

April 18, 2023

Need Analysis

Background and Analysis

This project is a collaboration between Surgicore Eastern Long Island, LLC, and Community Medical Wellness, an existing pain management practice in Port Jefferson Station. According to the applicant, this long-standing practice needs an additional location to handle the volume of patients. The proposed site will allow the practice to better serve its existing patient base, as a substantial portion falls within the catchment area of the proposed ASC.

The service area consists of Suffolk County. The population of Suffolk County in 2021 was 1,526,344, according to the latest US Census data, and is projected to decline slightly to 1,492,157 by 2028. According to Data USA, in 2020, 95.8% of the population of Suffolk County had health coverage as follows:

Employer Plans	58.3%
Medicaid	11.6%
Medicare	13%
Non-Group Plans	12.4%
Military or VA	0.501%

The number of projected procedures is 3,738 in Year One and 4,650 in Year Three with Medicaid at 4.02% and Charity Care at 2.00%. These projections are based on the current practices of participating surgeons. According to the applicant, the projections are conservatively reflected due to the anticipated engagement from Managed Care Plans in both Year 1 and Year 3. The applicant states that all of the procedures moving to this center are currently being performed in other ASCs. The table below shows the projected payor source utilization for Years One and Three.

	Year One		Year Three	
Payor	**Volume**	**%**	**Volume**	**%**
Commercial FFS	1,977	52.89%	2,452	52.73%
Commercial MC	645	17.26%	821	17.66%
Medicare FFS	75	2.01%	89	1.91%
Medicare MC	151	4.04%	183	3.94%
Medicaid FFS	83	2.22%	96	2.06%
Medicaid MC	72	1.93%	91	1.96%
Private Pay/Other	660	17.66%	825	17.74%
Charity Care	75	2.01%	93	2.00%

The center initially plans to obtain contracts with the following Medicaid Managed Care plans: Fidelis Care and Healthfirst. The center will work collaboratively with local Federally Qualified Health Centers such as Dolan Family Health Center, Suffolk County Health Center at Riverhead, Greenport Health Center, and others to provide service to the under-insured in their service area. The center has developed a financial assistance policy with a sliding fee scale to be utilized when the center is operational.

The table below shows the number of patient visits for relevant ASCs in Suffolk County for 2019 through 2021. The number of patient visits for 2020 was significantly impacted by COVID-19.

Specialty Type	Facility Name	Patient Visits		
		2019	2020	2021
Gastroenterology/ Pain Management	Advanced Surgery Center of Long Island	8,447	6,287	8,932
Multi	Long Island Ambulatory Surgery Center	14,642	9,270	12,053
Orthopedics	Long Island Hand & Orthopedic Surgery Center	666	595	659
Multi	Melville Surgery Center	5,917	4,611	4,273
Gastroenterology/ Pain Management	North Fork Surgery Center (opened 2/14/20)	N/A	1,298	2,968
Multi	North Shore Surgi-Center	7,226	6,364	6,215
Multi	Port Jefferson ASC [2]	2,570	3,037	0
Orthopedics	PrecisionCare Surgery Center (opened 4/21/21)	N/A	N/A	628
Multi	Progressive Surgery Center, LLC [1]	2,886	1,510	2,092
Multi	South Shore Surgery Center	4,828	3,389	3,856
Multi	Suffolk Surgery Center	5,724	3,655	3,953
Multi	The Center for Advanced Spine & Joint Surgery (opened 8/30/21) [2]	N/A	N/A	0
Total Visits		**52,906**	**40,016**	**45,629**

[1] *SPARCS 2020 & 2021 data is for a partial year.*
[2] *No SPARCS data located for 2021.*

For the first six months of 2022, there have been approximately 24,900 total visits of the above ASCs, which would annualize to approximately 49,800 visits, an increase of 9% over 2021 for the relevant ASCs in Suffolk County.

Letters of opposition have been received from two ASCs that opened in 2021 in Suffolk County; The Center for Advanced Spine and Joint Surgery and PrecisionCare Surgery. Both centers expressed concerns that this proposed ASC will create an over-saturation of the market for ambulatory surgery services. Suffolk County currently has a ratio of 84,773 patients per ASC, a relatively high number that does not indicate over-saturation.

The table below shows the time and distance from the newly proposed center for the relevant ASCs in Suffolk County.

Name	Specialty Type	Time/Distance
The Center for Advanced Spine & Joint Surgery	Multi	4.6 miles / 8 minutes
Long Island Ambulatory Surgery Center	Multi	5.3 miles / 15 minutes
North Shore Surgi-Center	Multi	7.0 miles / 14 minutes
PrecisionCare Surgery Center	Orthopedics	8.8 miles / 21 minutes
South Shore Surgery Center	Multi	8.9 miles / 18 minutes
Port Jefferson ASC	Multi	14.8 miles / 24 minutes
Advanced Surgery Center of Long Island	Gastroenterology/ Pain Management	14.8 miles / 24 minutes
Melville Surgery Center	Multi	15.6 miles / 19 minutes
Suffolk Surgery Center, LLC	Multi	15.9 miles / 19 minutes
Long Island Hand and Orthopedic Surgery Center, LLC	Orthopedics	17 miles / 30 minutes
Progressive Surgery Center	Multi	18.5 miles / 25 minutes
North Fork Surgery Center	Gastroenterology/ Pain Management	46.2 miles / 52 minutes

Conclusion

Approval of this project will provide increased access to podiatry, orthopedic, and pain management surgery services in an outpatient setting for the residents of Suffolk County.

Program Analysis

Project Proposal

SurgiCore Suffolk, LLC, an existing New York State limited liability company, seeks approval to establish and construct a multi-specialty freestanding ambulatory surgery center specializing in Orthopedic Surgery, Podiatric Surgery, and Pain Management to be located at 1050 Old Nichols Road in Islandia (Suffolk County).

Proposed Operator	SurgiCore Suffolk, LLC
Doing Business As	SurgiCore Suffolk, LLC
Site Address	1050 Old Nichols Road Islandia, New York 11749 (Suffolk County)
Surgical Specialties	Multi-Specialty: Orthopedic Surgery Podiatry Pain Management
Operating Rooms	4
Procedure Rooms	3
Hours of Operation	Monday through Friday, 6:00 am to 5:00 pm Saturdays as demand warrants
Staffing (1st Year / 3rd Year)	34.79 FTEs / 42.35 FTEs
Medical Director(s)	Robert Antoniou, M.D.
Emergency, In-Patient and Backup Support Services Agreement and Distance	Is expected to be provided by: St. Charles Hospital 15.9 Miles / 30 minutes
On-call Service	Patients who require assistance during off-hours will engage the 24-hour answering service to reach the on-call surgeon during hours when the facility is closed.

Character and Competence

The ownership of SurgiCore Suffolk, LLC is:

Member Name	**Proposed Interest**
Surgicore Eastern Long Island, LLC *Anthony DeGradi (25%)* *Wayne Hatami (25%)* *Feliks Kogan (25%)* *Leonid Tylman (25%)*	**51.00%**
Robert Anoniou, M.D.	**16.33%**
Paul Cella, P.A.	**16.33%**
Aman Deep, M.D.	**16.33%**
TOTAL	**100%**

Dr. Robert Antoniou is the proposed Medical Director. He is a Pain Management Physician and Owner of Community Medical Wellness, PC for over three (3) years. He was the former Director of Anesthesiology/Pain Management and an Interventionalist at EMU Health Surgery Center for over two (2) years. He was an Anesthesiologist/Pain Management Interventionalist at North American Partners in Anesthesia for over one (1) year. He received his medical degree from SUNY Upstate Medical University. He completed his residency in Anesthesiology and fellowship in Pain Management at Tufts University. Dr. Antoniou discloses ownership interest in the following healthcare facilities:

EMU Health *2018-present*

Mr. Paul Cella, PA-C, is the CEO and Co-Founder of Community Medical Wellness, PC for over three (3) years. He administrates and manages the day-to-day operations and EMR system. He has established and set up over 20 new locations throughout Long Island. He is the owner of Long Island Physician Assistant Services PC. He is responsible for providing physician assistants on an as-needed basis to physician practices in all specialties. He is a practicing Physician Assistant at DRD Medical for over seven (7) years. He was a practicing Physician Assistant in the Critical Care program at St. Charles Hospital for five (5) years. He was a practicing Physician Assistant in the House Staff and Vascular Access/PICC Line Service at Mather Hospital for over four (4) years. He was a practicing Physician Assistant in the Neurological Department at Southside Hospital for two (2) years. He was a practicing Physician Assistant in the Neurosurgery Department at Winthrop Hospital for four (4) years. He received his Physician Assistant degree from Hofstra University.

Dr. Aman Deep is the Medical Director of Community Medical Wellness for over three (3) years. He was an Attending Physician-Hospitalist at St. Charles Hospital for over four (4) years. He received his medical degree from the American University of Antiqua. He completed his residency in Internal Medicine at Flushing Hospital Medical Center and Icahn School of Medicine at Mount Sinai. He is board certified in Internal Medicine.

Mr. Anthony DeGradi is a Managing Partner and Co-Owner of New Horizon Surgical Center for over 14 years. He is responsible for management of the facility through work with the executive team, ensuring compliance with the applicable regulations, and investing in the Center. This work with the executive team allows for additional procedures and focus to constantly improve patient care and the overall patient experience. He is the Managing Partner of Surgicore Management Inc. for over three (3) years. He is responsible for management of operations and affairs. He is a Managing Partner of Surgicore Management NY LLC for over two (2) years. He is responsible for management and operations. Mr. DeGradi disclosed ownership interest in the following healthcare facilities:

Fifth Avenue Surgery Center	*12/2017-present*
All City Family Healthcare Center	*11/2017-present*
Empire State ASC	*11/2019-present*
North Queens Surgical Center	*11/2019-present*
Surgicore of Jersey	*09/2016-present*
Surgicore Surgical Center	*02/2016-present*
Rockland and Bergen Surgery Center	*03/2020-present*
New Horizon Surgical Center	*02/2012-present*

Mr. Wayne Hatami is a Managing Partner of Surgicore Management Inc. for over three (3) years. He is responsible for management and affairs. He is a Managing Partner for Surgicore Management LLC for over two (2) years. He is responsible for management and operations. He is the Owner and Physical Therapist of NY Spine Physical Therapy for 18 years. He was responsible for the day-to-day management of the office as well as teaching patients how to prevent or manage their conditions so that they achieved their long-term health benefits. This included examining each patient, developing a plan of care, using treatment techniques to promote their ability to move, reduce pain, restore function, and prevent disability. Mr. Hatami discloses ownership interest in the following healthcare facilities:

Fifth Avenue Surgery Center	*12/2017-present*
All City Family Healthcare Center, Inc	*11/2017-present*
Empire State ASC	*11/2019-present*
North Queens Surgical Center	*11/2019-present*
New Horizon Surgical Center	*02/2012-present*
Surgicore of Jersey City	*09/2016-present*
Surgicore Surgical Center	*02/2016-present*
Rockland and Bergen Surgery Center	*03/2020-present*

Mr. Feliks Kogan is the Owner and President of Aleste Corp for over eight (8) years. He is responsible for operations and affairs. He is also the Partner and Co-Owner of Manalapan Surgery Center for over nine (9) years. He is responsible for the management of the facility through work with the executive team to ensure compliance with applicable regulations. He also works with the executive team to provide investment in the center which allows for additional procedures and focus on improving patient care and the overall patient experience. He is the Managing Partner of Surgicore Management Inc. for over two (2)

years. He is responsible for operations and management. He is the Managing Partner of Surgicore Management NY LLC for over one (1) year. He is responsible for operations and management. He was the President and Owner of Syrus Corp. for five (5) years. He was responsible for medical and healthcare marketing for physicians and surgeons and patient acquisition services while providing proprietary sentiment analysis tools to physicians and healthcare providers. Mr. Kogan discloses ownership interest in the following healthcare facilities:

Fifth Avenue Surgery Center	*12/2017-present*
All City Family Healthcare Center	*11/2017-present*
Empire State ASC	*11/2019-present*
North Queens Surgical Center	*11/2019-present*
Surgicore of Jersey City	*09/2016-present*
Surgicore Surgical Center	*02/2016-present*
Manalapan Surgery Center	*02/2012-present*
Rockland and Bergen Surgery Center	*03/2020-present*

Mr. Leonid Tylman is the CEO of Lenco Diagnostics Laboratory, Inc for over 18 years. He is responsible for the management of the facility, including working with medical staff and the executive team to certify the facility complies with federal, state, and local statutes and regulations. He also works with the medical staff and executive team to invest in new equipment. The team also makes decisions on what additional testing capabilities to add to provide an additional level of care to patients. Mr. Tylman discloses ownership interest in the following healthcare facilities:

Fifth Avenue Surgery Center	*12/2017-present*
All City Family Healthcare Center	*11/2017-present*
Empire State ASC	*11/2019-present*
North Queens Surgical Center	*11/2019-present*
Surgicore of Jersey City	*09/2016-present*
Surgicore Surgical Center	*02/2016-present*
Manalapan Surgery Center, Inc	*02/2012-present*
New Horizon Surgical Center	*02/2012-present*
Rockland and Bergen Surgery Center	*03/2020-present*
Lenco Diagnostic Laboratories, Inc	*01/2002-present*

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

For those patients who do not identify a primary care provider (PCP), the Applicant plans to refer patients to primary care providers. This can be done by any of the clinic's providers, staff, clinicians, or other persons. The Applicant is committed to serving all persons in need without regard to race, sex, age, religion, creed, sexual orientation, source of payment, ability to pay, or other personal characteristic. The Applicant is committed to the development of a formal outreach program directed to the members of the local community. The purpose of the program will be to inform the community of the benefits derived from and the latest advances made in pain management, orthopedic surgery, and podiatry. The Applicant plans to contact FQHCs within the proposed catchment area. The Applicant will also develop customized outreach materials and resources to connect with targeted populations. The Applicant will engage experienced consultants for professional managed care contracting support. The Applicant will develop

and implement an outreach strategy to secure contracts for participation in both Medicaid and national Medicare Managed Care Organization networks and other related activities.

The Center intends on using an Electronic Medical Record (EMR) program. The EMR platform the Applicant will use does support New York's RHIO and/or Health Information Exchange, but when it becomes available in the future, the Applicant will evaluate the service.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Analysis

Total Project Costs

The total project cost for the renovations and acquisition of movable equipment is $6,629,110, presented in 2023 dollars and distributed as follows:

Renovation and Demolition	$4,426,500
Design Contingency	442,650
Construction Contingency	442,650
Architect/Engineer Fees	300,000
Moveable Equipment	979,060
Application Fee	2,000
Processing Fee	36,250
Total Project Costs	$6,629,110

Operating Budget

The applicant has submitted their first and third-year operating budgets. Summarized below:

	Year One 2024		Year Three 2026	
Revenues:	Per Proc.	Total	Per Proc.	Total
Comm. FFS	$1,871	$3,699,552	$1,865	$4,571,749
Comm. MC	$1,454	$937,645	$1,448	$1,189,020
Medicare FFS	$1,379	$103,432	$1,386	$123,379
Medicare MC	$1,723	$260,206	$1,738	$318,095
Medicaid FFS	$425	$35,300	$447	$42,900
Medicaid MC	$616	$44,353	$532	$57,476
Other/Private	$2,459	$1,622,852	$2,408	$1,986,902
Total Revenues		$6,703,340		$8,289,521
Expenses:				
Operating	$1,512,48	$5,653,640	$1,539.67	$7,159,462
Capital	$247.61	$925,549	$209.13	$972,462
Total Expenses:	$1,760.09	$6,579,189	$1,748.80	$8,131,924
Net Income:		$124,151		$157,597
Utilization (Procedures)		3,738		4,650
Cost Per Procedure		$1,760.08		$1,748.80

The following is noted with respect to the submitted budget:

- The revenues, expense, and utilization assumptions are based on the current physician practices in the area, using 2022 Medicare rates, 90% of Medicare and Medicaid rates, and 110% for commercial rates.
- Growth projections are based on other independent entities under the SurgiCore umbrella; their labor costs, benefits, utilities, supplies, and other soft costs (marketing, computers, paper, vendors) are all projected to increase with increased utilization. According to the applicant, their labor costs are subject to substantial inflation, especially since their increased labor costs are for specialists and nurses. Likewise, medical supply costs have had significant increases. As operations ramp up and their facility becomes established, they believe the current shortage of physicians and services in the region will drive increased utilization at the ASC.

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

	Year One 2024	Year Three 2026
Commercial FFS	52.89%	52.73%
Commercial MC	17.26%	17.66%
Medicare FFS	2.01%	1.91%
Medicare MC	4.04%	3.94%
Medicaid FFS	2.22%	2.06%
Medicaid MC	1.93%	1.96%
Other/Private Pay	17.66%	17.74%
Charity Care	2.01%	2.00%
Total Procedures	100%	100%

Administrative Service Agreement:

The applicant has submitted an executed Administrative Service Agreement between SurgiCore Suffolk, LLC and Surgicore Management NY, LLC, which is summarized as follows:

Date:	Date TBA. Effective upon PHHPC approval.
Administrator:	SurgiCore Suffolk, LLC
Service Provider:	Surgicore Management NY LLC
Services:	Development of policies and procedures; computer access to new employees; assistance with workers' compensation; coordinated management, maintenance, and administration of applications related to hardware; information technology support; assistance with budget preparations and benefits.
Term:	5-year term with another additional 5-year renewal.
Fee:	$25,000 per month prorated for any partial months.

Surgicore Management NY LLC will be performing the above services. The Licensed Operator retains ultimate authority, responsibility, and control in all the final decisions associated with the services. There is common ownership between the applicant and the administrative services agreement provider. Surgicore Management NY is made up of the same members who own SurgiCore Suffolk, LLC.

Lease Rental Agreement

The applicant has submitted an executed Lease Rental Agreement for the proposed site, the terms of which are summarized below:

Premises:	1050 Old Nichols Road, Islandia, Suffolk County – Approximately (14,622 sq. ft.)
Landlord:	APR Community Realty, LLC
Lessee:	SurgiCore Suffolk, LLC
Term:	20 years with two (2) consecutive renewal 10-year terms.
Rental:	$53,275.00 monthly, and in year three (3) increases to $54,562 monthly.
Provisions:	The lessee will pay all the expenses of the property, including utilities, taxes, and maintenance, per the agreement.

The lease is a non-arm's length agreement. There is a relationship between SurgiCore Suffolk, LLC and the proposed tenant of the premises, and APR Community Realty, LLC as the owner of the premises and members of the facility. In addition, the applicant has submitted two (2) real estate letters indicating rent reasonableness from NYS Licensed realtors. The lease is a triple-net lease.

Capability and Feasibility

Project costs are $6,629,110 and will be paid with member equity. BFA Attachment A is the net worth statement of the members who will provide equity for this facility. Members Leonid Tylman, Anthony DeGradi, and Feliks Koganeach submitted disproportionate share affidavits if other members did not have enough equity to fund project costs.

The working capital requirement is estimated at $1,355,321, based on two (2) months of third-year expenses. SurgiCore Suffolk, LLC will fund the working capital requirement through members' equity contributions. BFA Attachment A shows that Surgicore Suffolk, LLC members have sufficient equity to cover this contribution. Additionally, members Leonid Tylman, Anthony DeGradi, and Feliks Kogan submitted disproportionate share affidavits should other members not have enough equity to fund working capital requirements.

The submitted budget indicates a net income of $124,151 and $157,597 during the first and third years of operation, respectively. Revenues and expenses are based on current reimbursement methodologies. BFA Attachment C presents the Pro Forma Balance Sheet SurgiCore Suffolk, LLC. The pro forma balance sheet indicates a positive members' equity position of $7,984,431 on the first day of operations. The budget appears reasonable.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BHFP Attachment	Map
BFA Attachment A	Net worth Statements of all proposed members
BFA Attachment B	Organizational Chart of Surgicore Suffolk, LLC
BFA Attachment C	Pro Forma - Surgicore Suffolk, LLC

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 18th day of April 2023, 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 at 1050 Old Nichols Road, Islandia, 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:
212260 B	SurgiCore Suffolk, LLC

APPROVAL CONTINGENT UPON:

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
3. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]
4. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
5. Submission of Mechanical, Electrical, and Plumbing (MEP) Drawings acceptable to the Department, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]

APPROVAL CONDITIONAL UPON:

1. This project must be completed by **December 18, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **September 18, 2023,** and construction must be completed by **September 18, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]
5. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
6. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 222181-B
Bronx Vascular Surgical Center, LLC

Program: **Diagnostic and Treatment Center** ***County:*** **Bronx**
Purpose: **Establishment and Construction** ***Acknowledged:*** **November 29, 2022**

Executive Summary

Description

Bronx Vascular Surgical Center, LLC (to be renamed from Bronx VS, LLC) (the center), an existing limited liability company, requests approval to establish and construct a single-specialty Article 28 ambulatory surgery center (ASC) to be located at 1733 Eastchester Road, Suite 3, Bronx (Bronx County).

The ASC will have two (2) operating rooms and provide end-stage renal disease (ESRD) related vascular access services. The purpose of the ASC is to improve access to service patients with (ESRD) and peripheral vascular disease necessary to achieve maximum efficient care. The ASC will be housed in leased space.

This project is a partnership between an existing, non-article 28 physician group, Advanced Access Medical Care (AAMC), and specific individuals affiliated with RMS Lifeline Inc. d/b/a Lifeline Vascular Care, which will combine to create Bronx Vascular Surgical Center, LLC under one ASC. In addition, AAMC will dissolve, and their two (2) physicians will move their procedures to the newly established Bronx Vascular Surgical Center, LLC.

The proposed members of Bronx Vascular Surgical Center, LLC are listed below.

Member	% Interest
Zaher Hanadeh, M.D.	50.000%
Amit Shah, M.D.	15.000%
Jeffery Peo	13.125%
Linda Raham	13.125%
Margaret Anderson	4.375%
Barry Brostoff	4.375%

Zaher Hamedeh, M.D., will serve as Medical Director. The applicant entered into a Transfer and Affiliation Agreement with Montefiore Medical Center (Epstein Campus). The applicant also entered into an administrative services agreement with RMS Lifeline Inc. d/b/a/ Lifeline Vascular Care to provide administrative functions for the center.

OPCHSM Recommendation

Contingent Approval with an expiration of the operating certificate five years from the date of its issuance.

Need Summary

The applicant projects 2,092 procedures in Year One and 2,831 in Year Three, with Medicaid at 18.58% and Charity Care at 2.30% by the third year of operations.

Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a (3).

Financial Summary

Total cost for this project is $3,764,200, including $1,750,000 for an Asset Purchase Agreement (APA). A letter of interest has been provided by Panacea Financial at an interest rate of 7.66% for a 10-year term. The cost of renovations and moveable equipment is $2,426,989, to be funded by member equity of $276,989 and a loan of $2,150,000. Panacea Financial has provided a letter of interest for this loan at 7.16% interest and a 10-year term.

Budget	Year One (2023)	Year Three (2025)
Revenues	$5,533,808	$7,815,038
Expenses	4,268,196	5,171,261
Net Income	$1,265,612	$2,643,777

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of an executed working capital loan commitment acceptable to the Department of Health. [BFA]
5. Submission of an executed building lease acceptable to the Department of Health. [BFA]
6. Submission of an executed loan for construction and renovations commitment acceptable to the Department of Health. [BFA]
7. Submission of an executed asset purchase agreement acceptable to the Department. [BFA]
8. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include a commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
9. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]

Approval conditional upon:

1. This project must be completed by **July 15, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]

2. Construction must start on or before **October 15, 2023,** and construction must be completed by **April 15, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]
6. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

Council Action Date

April 18, 2023

Need Analysis

Background and Analysis

The service area consists of Bronx County. The population of Bronx County in 2021 was 1,424,948, according to the latest US Census data population estimates, and is projected to increase to 1,590,942 by 2028. The percentage of residents aged 65 and over was 14.0% which is slightly lower than the New York State percentage of 17.5%. The non-while population percentage was 55.7% which is significantly higher than the New York State percentage of 30.9%. These are two population groups most in need of end-stage renal dialysis services. Based on a review of existing dialysis stations in Bronx County, there is a large presence of patients requiring dialysis services. Currently, there are 827 existing dialysis stations, with 58 stations under construction within the county, concluding that many could require vascular surgery services.

According to Data USA, in 2020, 92% of the population of Bronx County had health coverage as follows:

Employer Plans	30.8%
Medicaid	41.8%
Medicare	6.79%
Non-Group Plans	12.1%
Military or VA	0.417%

The number of projected procedures is 2,092 in Year One and 2,831 in Year Three, with Medicaid at 18.58% and Charity Care at 2.30% by the third year of operations. These projections are based on the current practices of participating surgeons. The applicant states that all the procedures moving to this center are currently being performed in an office-based setting. The table below shows the projected payor source utilization for Years One and Three.

	Year One		Year Three	
Payor	**Volume**	**%**	**Volume**	**%**
Commercial FFS	673	32.17%	916	32.36%
Medicare FFS	982	46.94%	1,324	46.77%
Medicaid FFS	387	18.50%	526	18.58%
Charity Care	50	2.39%	65	2.30%

The center initially plans to obtain contracts with the following Medicaid Managed Care plans: Affinity, Amida Care, Emblem Health, HIP, Empire Blue Cross, Metro Plus, MVP, United Health Care, Health First, VNS, and WellCare. The center will work collaboratively with local Federally Qualified Health Centers such as Urban Health Plan, Park Tree Community Health Center, Plaza Del Castilo Health Center, and BronxCare Dr. Martin Luther King Jr. Health Center to provide service to the under-insured in their service area. The center has developed a financial assistance policy with a sliding fee scale to be utilized when the center is operational.

The table below shows the number of patient visits for relevant ASCs in Bronx County for 2019 through 2021. The number of patient visits for 2020 was significantly impacted by COVID-19.

Specialty Type	Facility Name	Patient Visits		
		2019	2020	2021
Multi	Ambulatory Surgery Ctr of Greater NY	8,836	4,939	10,821
Multi	Avicenna ASC, Inc.	6,200	4,516	4,407
Multi	Crotona Parkway ASC (opened 6/10/22)	N/A	N/A	N/A
Multi	Downtown Bronx ASC	3,508	1,097	1,714
Multi	East Tremont Medical Center [1]	0	0	0
Multi	Empire State Ambulatory Surgery Center	5,633	5,062	7,868
Multi	Triborough Ambulatory Surgery Center (opened 12/24/20) [2]	N/A	N/A	0
Total Visits		**24,177**	**15,615**	**24,810**

[1] No data located for 2019,2020, & 2021 for this facility

[2] No data located for 2021 for this facility

Conclusion

Approval of this project will provide increased access to vascular access surgery services in an outpatient setting for the residents of Bronx County.

Program Analysis

Program Description

Proposed Operator	Bronx Vascular Surgical Center, LLC
Doing Business As	Bronx Vascular Surgical Center, LLC
Site Address	1733 Eastchester Road, Suite 2 Bronx, New York 10461 (Bronx County)
Surgical Specialties	Single Specialty-Vascular
Operating Rooms	2
Procedure Rooms	0
Hours of Operation	Monday to Friday, 7:30 am to 3:30 pm
Staffing (1st Year / 3rd Year)	15.8 FTEs / 19.1 FTEs
Medical Director(s)	Zaher Hamedeh, MD
Emergency, In-Patient and Backup Support Services Agreement and Distance	Is provided by: Montefiore Medical Center 0.6 Miles / 4 minutes
On-call Service	Patients who require assistance during off-hours will be provided a phone number for a 24-hour/day, seven (7) days/week on-call service to immediately refer the patient to the Center's on-call physician.

Character and Competence

The ownership of Bronx Vascular Surgical Center, LLC is as follows:

Member Name	Proposed Interest
Zaher Hamadeh, M.D.	50.000%
Amit Shah, M.D.	15.000%
Jeffrey Peo	13.125%
Linda Rham	13.125%
Margaret Anderson	4.375%
Barry Brostoff	4.375%
TOTAL	**100.00%**

Bronx Vascular Surgical Center, LLC is managed by its members through a Board of Managers comprised of managers appointed by the members of Bronx Vascular. The initial managers will be the following members:

Margaret Anderson *Manager*
Barry Brostoff *Manager*
Jeffrey Peo *Manager*
Linda Rahm *Manager*

Dr. Zaher Hamadeh is a Member and the Proposed Medical Director. He is the Medical Director of Advanced Access Medical Care for over nine (9) years. He is a Diagnostic Nephrologist at Kidney Medical Associates for over six (6) years. He was an Assistant Professor of Medicine at Jacobi Medical Center for two (2) years. He was a Hospitalist at Deaconess Medical Center for three (3) years. He received his medical degree from the University of Damascus. He completed his Internal Medicine residency at the University of Texas Medical Branch. He completed his Nephrology fellowship at Albert Einstein College of Medicine Jacobi Medical Center. He is board certified in Internal Medicine with a subceritfication in Nephrology.

Dr. Amit Shah is on the Medical Advisory Board of Azura Vascular Care. He is a Vascular Surgeon at American Access Care Physician, PLLC, for nine (9) years. He is the Chief of Vascular Surgery at North Bronx Health Network for 12 years. He is the Medical Director of the Vascular Laboratory at Jacobi

Medical Center for 12 years. He received his medical degree from SUNY Downstate Medical Center College of Medicine. He completed his General Surgery residency at Montefiore Medical Center and his Vascular Surgery fellowship. He is board certified in General Surgery and Vascular Surgery.

Jeffrey Peo is the Managing Partner of RMS Lifeline for two (2) years. He is responsible for the oversight of business development, Information Technology, and finance. He was the CEO of The OBL Group for two (2) years. He was responsible for optimizing patient satisfaction, reducing costs to the patient, maximizing profitability, and scheduling compression to recover lost time from less efficient venues. He was the Chief Development Officer of Ambulatory Surgical Centers of America. He was responsible for developing profitable ASCs through acquisition, de novo development, and joint ventures with hospital systems. Prior to his experience in healthcare, he worked in IT as an Executive Consultant for Xerox Connect. He partnered with Fortune 100 companies to design and implement Knowledge Management solutions. Mr. Peo discloses ownership interest in the following healthcare facilities:

Select OBS	*04/2020-present*
Lifeline Vascular Care	*05/2020-present*
Vascular Health and Wellness, LLC	*05/2020-present*
Lifeline Vascular & Interventional Center-Niceville	*05/2020-present*
Coastal Vascular & Interventional Center	*05/2020-present*
VASCON Vascular Care Center	*04/2020-present*
Pittsburg North Surgical Center	*01/2022-present*

Linda Rahm is an Owner, Managing Partner, and COO of Select OBS, LLC and RMS Lifeline Vascular Care, Inc. for two (2) years. She manages the daily business operations and administrations of the company, working closely with department heads and supervisor heads to support day to day activities of the company. This includes working with executives, compiling company financial reports, implementing business strategies, optimizing the company's operational capabilities, and establishing policies that promote company culture and vision. She was the Vice President of Operations for the northeast region for Ambulatory Surgery Centers of America for five (5) years. She was responsible for overseeing eight multispecialty ASCs, including growth and development, clinical operations, regulatory compliance, financial operations, and joint venture partner relations. She was the Administrator of Pioneer Valley Surgicenter for 11 years. She was responsible for the overall administration and organization of the surgery center, planning and directing all business, financial, and clinical activities. She was the Director of Operations of Connecticut Multispecialty for two (2) years. She was responsible for the general operations of the multispecialty division of Hartford Hospital, including startups, budgeting, expense control, contract development, and relations. She was the CEO of Olympus Specialty Hospital for two (2) years. She was responsible for the executive functioning of a 346-bed rehabilitative hospital and skilled nursing facility. She was the Director of Operations of the Chiron Rehabilitative Division for two (2) years. She was the Regional and Clinical Director of Operations of Sun Healthcare Group for nine (9) years. She was a Staff Therapist at New Medico Pioneer Valley TBI Center for three (3) years. Ms. Rahm discloses ownership interest in the following healthcare facilities:

Select OBS	*04/2020-present*
Lifeline Vascular Care	*05/2020-present*
Vascular Health and Wellness, LLC	*05/2020-present*
Lifeline Vascular & Interventional Center-Niceville	*05/2020-present*
Coastal Vascular & Interventional Center	*05/2020-present*
VASCON Vascular Care Center	*04/2020-present*
Pittsburg North Surgical Center	*01/2022-present*

Margaret Anderson is a Partner and Board Member of Lifeline Vascular Care for one (1) year. She acquired and carved out $50M in revenue from ASC and office-based lab businesses from DaVita. She was the Senior Vice President of DaVita. She was responsible for $1B in profits and losses, 275 dialysis centers, 140 home programs, and 115 hospitals in 13 states. She assumes additional enterprise responsibilities and expanded leadership overseeing standalone national businesses providing practice management to vascular surgeons. Under her leadership, the facilities surpassed their goals, built 67 de novo, and acquired 25 centers with improved lead times from 27 to 18 months. There was service line diversification resulting in cost-effectiveness and improved clinical results. She was the President of the 3i Dental Division of Biomet for three (3) years. She was responsible for developing and executing strategic plans to reignite growth in an underperforming $270M global business with below-market growth. She

helped improve revenue growth from 2% below market to at market globally and 2% above market in critical North American markets. She helped increase new product revenue from 3% to 20%. She was the Director of Operations at TPG for four (4) years. She was responsible for diligence, deal negotiations, transactions, transition service, management team recruiting, and chief of staff. She improved time to market by 60% by driving implementation of disciplined portfolio management processes and leveraging differential technologies. She was the Director of Performance of Alixpartners for four (4) years. She served as the Interim Executive to perform turnaround and restructuring services for multiple companies. She was the Principal of Caledonia Group for three (3) years. She developed private equity practice, assessed potential deals for quantifiable opportunities in due diligence, validated operating plans, and capitalized on opportunities through LEAN implementation. She held multiple roles at General Motors Powertrain Division for over 10 years, including Manufacturing Superintendent, Supply Chain & Quality Superintendent. Lean Manufacturing Manager, Senior Project Manager, and Manufacturing Supervisor & Reliability Engineer. Ms. Anderson discloses ownership interest in the following healthcare facilities:

Lifeline Dialysis Access Center	*12/2005-05/2018*
Lifeline Vascular Center Fort Lauderdale	*06/2012-03/2018*
Open Access Lifeline Inc.	*05/2008-09/2018*
Lifeline Vascular Center Altamonte Springs	*12/2012-02/2018*
Lifeline Vascular Center of So. Orlando	*12/2012-02/2018*
Lifeline Vascular Center Tampa	*04/2012-01/2017*
Lifeline Valley Access Center	*03/2015-12/2021*
Select OBS	*04/2020-present*
RMS Lifeline Vascular Care	*05/2020-present*
Vascular Health and Wellness	*05/2020-present*
Lifeline Vascular and Intervention Center Niceville	*05/2020-present*
Coastal Vascular and Intervention Center	*05/2020-present*
VASCON Vascular Care Center	*04/2020-present*
Pittsburg North Surgical Center	*01/2022-present*

Barry Brostoff is the Chief of Strategy at Lifeline Vascular for one (1) year. He was the previous Vice President of Strategy and Business Development of Lifeline Vascular Care for one (1) year. He was the previous Transaction Director of DaVita for four (4) years. He developed the overall strategy for the existing portfolio post-separation from DaVita. He negotiated and closed two joint ventures in the first-year post-separation from DaVita and negotiated and executed 14 development and management service agreements. He drove the development of a database to identify potential physician partners to supplement the existing portfolio, as well as DeNovo opportunities. He held multiple roles at DCP Midstream LLC and DCP Midstream Partners LP for over eight (8) years, including Manager of Business Development for one (1) year, Manager of Corporate Development and Mergers & Acquisitions for three (3) years, Manager of Technical Accounting, and Manager of Control & Operations Accounting for one (1) year. In these roles, he was responsible for determining the strategy and drafting responses to Requests for Proposals based on the results of financial modeling and consultation with operations and engineering. He negotiated gas gathering and processing agreements that optimized and organically expanded the existing asset base. He facilitated all aspects of the due diligence process on cross-functional teams of up to 40 individuals, reporting directly to the CEO and VP of Business Development. He conducted the due diligence process, created an Excel-based financial model to evaluate numerous third-party buy side and sell side transactions, identifying critical deal issues, escalating and resolving them as appropriate. He also supervised, reviewed, and appraised a group of nine corporate associates responsible for the monthly ledger closing, annual regulatory filing process, and accounts receivable. The process included reviewing over 200 monthly account reconciliations in the area, such as stock-based compensation, purchase price allocation, payroll, legal, environmental, accounts receivable, debt, and cash. Lastly, he performed technical research in accounting pronouncements and prepared memos formally documenting the basis for conclusions on various topics, including revenue and expense recognition, derivative issues, capitalization and expense determination, and purchase and liquidation accounting. He was an Accounting Research Manager for The Coca-Cola Company for five (5) years. He supported worldwide field locations with technical accounting advice on various topics, including consolidation of variable interest entities and optimal merger and acquisition structure. He researched the impact of new accounting guidance and anchored company policies and procedures. He was the Principal/Senior Domestic Auditor at The Coca-Cola Company for two (2) years. He planned, supervised, and executed operational internal audits of various functional units to assess the adequacy of the internal

control structure in place and compliance with established company standards and US GAAP. He was a Senior and Staff Accountant at Deloitte & Touche, LLP for three (3) years. He planned, supervised, and executed quarterly and annual financial statement audits in accordance with GAAP as well as performed full and limited-scope audits of employee benefit plans. Mr. Brostoff discloses ownership interest in the following healthcare facilities:

Select OBS	*04/2020-present*
RMS Lifeline Vascular Care	*05/2020-present*
Vascular Health and Wellness, LLC	*05/2020-present*
Lifeline Vascular & Interventional Center	*05/2020-present*
Coastal Vascular & Interventional Center	*05/2020-present*
VASCON Vascular Care Center	*04/2020-present*
Pittsburg North Surgical Center	*01/2022-present*

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.

- *Dr. Hamadeh disclosed a malpractice suit that was filed in April 2018. The plaintiff was the patient and alleged negligence. Specifically, the patient alleged negligence in an attempt to retrieve a migrated stent during the procedure to open a vein for dialysis access. The case was settled in July 2018 for $215,000.*

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

For those patients who do not identify a primary care provider (PCP), the Center plans to work closely with its patients to educate them regarding the availability of primary care services offered by local providers, including a broad array of outpatient primary care services offered by Montefiore Medical Center. Prior to leaving the facility, each patient will be provided information concerning the local availability of primary care services.

The Center commits that all patients without discrimination due to personal characteristics or ability to pay. The Center commits to providing charity care for persons without the ability to pay and to utilize a sliding scale for persons who are unable to pay the full charge or are uninsured. The proposed budget projects 2% charity care, and 18% will be Medicaid recipients.

The Center plans to utilize an Electronic Medical Record (EMR) system and to fully integrate and exchange information with an established RHIO with the capability for clinical referral and event notification. The Applicant will consider joining any Accountable Care Organization (ACO).

Conclusion

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a (3).

Financial Analysis

Total Project Costs

The total project cost in 2023 dollars for renovations and the acquisition of moveable equipment is estimated at $2,426,989, further broken down as follows:

Renovation & Demolition	$1,618,760
Design Contingency	161,876
Construction Contingency	161,876
Architect/Engineering Fees	137,595
Construction Manager Fees	40,470
Other Fees (Consultant)	24,835
Moveable Equipment	215,000
Interim Interest Costs	51,313
CON Fee	2,000
Additional Processing Fee	13,264
Total Project Cost	$2,426,989

Operating Budget

The applicant has submitted an operating budget, in 2023 dollars, during the first and third years of operations, summarized as follows:

	Year One 2024		Year Three 2026	
Commercial FFS	$2,530.60	$1,703,092	$2,625.73	$2,405,166
Medicare FFS	$3,524.47	$3,461,031	$3,691.68	$4,887,790
Medicaid FFS	$955.26	$369,685	$992.55	$522,082
Total		$5,533,808		$7,815,038
Expenses:				
Operating	$1,759.68	$3,681,244	$1,625.15	$4,600,804
Capital	$280.57	$586,952	$201.50	$570,457
Total Expenses	$2,040.25	$4,268,196	$1,826.66	$5,171,261
Net Income		$1,265,612		$2,643,777
Procedures/Visits		2,092		2,831
Cost/Procedures		$2,040.25		$1,826.66

The following is noted with respect to the submitted operating budget:

- Revenue assumptions are based upon the current cases that the M.D.s are performing at AAMC's existing private surgical practice that will be moved to the Center. Two M.D.s submitted their procedures with reimbursement CPT codes for each physician.
- Reimbursement rates reflect current and projected Federal and State Government rates with adjustments based on the region.
- Expense and utilization assumptions are based upon the current operations of AAMC office-based surgery practice.
- Charity care is estimated to be at 2.30% in the third year of operations, and Medicaid is estimated to be at 18.58%.

Utilization broken down by payor source, during the first and third years is as follows:

	Year One 2024		Year Three 2026	
Payor Source	Volume	%	Volume	%
Commercial FFS	673	32.17%	916	32.36%
Medicare FFS	982	46.94%	1,324	46.77%
Medicaid FFS	387	18.50%	526	18.58%
Charity Care	50	2.39%	65	2.30%

Lease Rental Agreement

The applicant has submitted a draft lease letter of intent agreement summarized below:

Date:	3/31/2024 commencement date
Premises:	6,663 total sq. ft. (Ground Floor)
Lessor:	1733 Eastchester, LLC and Eastchester Road Realty, LLC
Lessee:	Bronx Vascular Surgical Center, LLC
Term:	10 years
Rental:	$42.50 per square ft. totaling $283,177.50 annually during the first year and increasing 3% the base rent by 3% every year after.
Provisions:	The lessee shall be responsible for utilities, maintenance, and real estate taxes.

The applicant has submitted an affidavit attesting that the lease will be an arm's length agreement as there is no relationship between the principals of the Landlord. The applicant has submitted two letters from two New York State real estate brokers attesting to the reasonableness. Simone Development Companies, the building owner's property management company, has submitted a letter of intent.

Asset Purchase Agreement

The applicant has submitted a draft APA summarized below:

Date:	February 21, 2023
Buyer:	RMS Lifeline, Inc.
Seller:	Advanced Access Medical Care, LLC
Term:	120 Months (10-Years)
Assets Assumed:	Goodwill from the book of business and the services of (2) doctors who will join the practice.
Fees:	$1,750,000
Payment Terms:	$262,500 down payment with the remaining $1,487,500 to be paid upon receipt of the notice for NEWCO, payment through wire transfer or certified check.
Provisions:	Closing is to occur on or before December 31, 2023

The applicant has submitted an executed letter of intent as Advanced Access Medical Care is going to dissolve. Dr. Zaher Hamadeh and Dr. Amit. Shah, who owns AAMC, will transfer their book of business and practice to Bronx VSC, LLC.

Administrative Service Agreement
The applicant has submitted an executed Administrative Service Agreement, which is summarized below:

Date:	February 17, 2023
Administrator:	RMS Lifeline, Inc.
Company:	Bronx Vascular Surgical Center, LLC
Term:	(5) Five Years with a (5) Five Year renewal unless agreed otherwise.
Services Provided:	Staff Recruiting; Personnel Administration; Non-Clinical Staff Training; Clinical Staff Training approved by the governing body; Communications with Patients; Lease administration assistance; Property Administration; Contract Support Services; Purchasing and Inventory Administration; Benchmarking; Licenses; Outreach & Education; Joint Commission Accreditation; Clinical Reporting; Quality Assurance Improvement; Accounts payable: Financial Reporting and Information System Support.
Fees:	$500,000 for the first three years and $575,000 each year thereafter, paid monthly.
Provisions:	The company shall be responsible solely for any liabilities not stated in the agreement and expenses for operations and maintenance. Termination of this agreement will require 120 days' notice by the administrator.

Bronx Vascular Surgical Center, LLC will retain all the direct authority and decisions related to the day-to-day business and retain all authority and responsibility. The established operator retains all authority and responsibility for the obligations of the organization and governing documents.

Capability and Feasibility
The total cost for this project is $3,764,200, including an Asset Purchase Agreement (APA) from a non-Article 28 facility. The Total Project Cost for construction is $2,426,989. Project costs will be met by a bank loan of $2,150,000 for ten (10) years at an estimated interest rate of 7.16%. A letter of interest from Panacea Financial was submitted. Attachment A indicates sufficient members' equity to cover the contribution of $276,989. The asset purchase agreement to acquire the non-Article 28 private practice of AAMC is $1,750,000. Panacea Financial has provided the letter of interest for a term of ten (10) years at an interest rate of 7.66%, which will be fully funded with a bank loan and secured by Bronx Vascular Surgical Center, LLC.

Working capital requirements are estimated at $861,877, equivalent to two months of third-year expenses. The applicant will finance $400,000 at a rate of 7.66%% for a five-year term. A bank letter of interest has been submitted. The remaining $465,877 will be provided by members' equity contributions. Attachment A presents the personal net worth statements of the proposed Bronx Vascular Surgical Center, LLC members, indicating sufficient funds to meet their equity contribution. BFA Attachment B is the pro forma showing equity of $738,866 as of the first day of operation.

Conclusion
The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BHFP Attachment	Map
BFA Attachment A	Personal net worth statements of proposed members of Renal Focus ASA, LLC
BFA Attachment B	Pro Forma Balance Sheet
BFA Attachment C	Organizational Chart (after PHHPC approval)

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 18th day of April 2023, 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 new single-specialty ambulatory surgery diagnostic and treatment center for vascular surgery at 1733 Eastchester Road, Bronx, 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:
222181 B	Bronx Vascular Surgical Center, LLC

APPROVAL CONTINGENT UPON:

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of an executed working capital loan commitment acceptable to the Department of Health. [BFA]
5. Submission of an executed building lease acceptable to the Department of Health. [BFA]
6. Submission of an executed loan for construction and renovations commitment acceptable to the Department of Health. [BFA]
7. Submission of an executed asset purchase agreement acceptable to the Department. [BFA]
8. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include a commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
9. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]

APPROVAL CONDITIONAL UPON:

1. This project must be completed by **July 15, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **October 15, 2023,** and construction must be completed by **April 15, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]
6. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 222227-B
Southern Tier Surgery Center, LLC

Program: **Diagnostic and Treatment center** ***County:*** **Broome**
Purpose: **Establishment and Construction** ***Acknowledged:*** **December 28, 2022**

Executive Summary

Description

Southern Tier Surgery Center, LLC (to be renamed from Binghamton Project, LLC), an existing New York limited liability company, requests approval to establish and construct an Article 28 diagnostic and treatment center (D&TC) to be certified as a dual single-specialty freestanding ambulatory surgery center (FASC) specializing in orthopedics (including spine and podiatric) and pain management procedures. The applicant will lease space in an existing one-story building located at 601 Harry L. Drive, Johnson City (Broome County), New York. The FASC will include four (4) operating rooms.

Present below and as BFA Attachment C is the organizational chart and proposed members of Southern Tier Surgery Center, LLC.

Southern Tier Surgery Center, LLC		
Class A - Physician Members		49%
Mohamed Ali Al-Saied, M.D.	2.00%	
Brandon Ewald, D.P.M.	4.00%	
Ian Hutchinson, M.D.	3.00%	
Dana Klush, D.P.M.	3.00%	
Colin McDonald, D.O.	3.00%	
Dermont Reynolds, M.D.	4.88%	
Joseph Romani, D.P.M.	4.88%	
Khalid Sethi, M.D.	4.88%	
Brian Timm, D.P.M.	3.50%	
Robert Van Gorder, M.D.	4.50%	
Thomas Van Gorder, M.D.	4.50%	
Darren J. Weinheimer, D.P.M.	2.00%	
Mark Wilson, M.D.	4.88%	
Class B Members - New York Holdco, LLC		51%
Jeffrey Andrews (35%)	17.85%	
Binghamton Health Corp. (65%)	33.15%	
Total Class A and B Ownership		100%

Dr. Mohamed Ali Al-Saied, who is currently a physician at Our Lady of Lourdes Memorial Hospital, will be a practicing physician and serve as Medical Director. There will be an additional twelve (12) practicing physicians; all are Board-Certified physicians. Our Lady of Lourdes Memorial Hospital is the sole, passive member of Binghamton Health Corporation.

Each physician member has provided a letter estimating the number of ambulatory procedures currently performed elsewhere that can be appropriately performed at a FASC. The letters attest to providing approximately 2,112 procedures in Year One and 3,717 procedures by Year Three.

The ASC will enter into a Transfer and Affiliation Agreement with Our Lady of Lourdes Memorial Hospital

OPCHSM Recommendation

Contingent Approval with an expiration of the operating certificate five years from the date of its issuance.

Need Summary

The applicant projects 2,112 procedures in Year One and 3,717 in Year Three, with Medicaid at 12.89% and Charity Care at 1.99% by the third year.

Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

Financial Summary

Total project costs of $13,065,769 will be met through members' equity of $1,292,325, a lease tenant improvement allowance of $2,792,125, and $8,981,319 to be provided by Bank of America via a bank loan with a 7-year term and 7.13% interest rate.

Budget:	Year One (2024)	Year Three (2026)
Revenues	$5,932,540	$11,475,925
Expenses	6,034,448	8,502,781
Net Income	($101,908)	$2,973,144

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of an executed loan commitment acceptable to the Department of Health. [BFA]
5. Submission of an executed working capital loan commitment acceptable to the Department of Health. [BFA]
6. Submission of an executed building lease acceptable to the Department of Health. [BFA]
7. Submission of an updated net worth statement from Dr. Colin McDonald showing sufficient liquid resources for his portion of the equity and working capital requirement. [BFA]
8. Submission of a copy of a Lease agreement that is acceptable to the Department. [CSL]
9. Submission of a copy of an Operating Agreement of the proposed Operator that is acceptable to the Department. [CSL]
10. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include a commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
11. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]

Approval conditional upon:

1. This project must be completed by **September 15, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]

2. Construction must start on or before **September 15, 2023,** and construction must be completed by **June 15, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
1. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]
5. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

Council Action Date
April 18, 2023

Need Analysis

Background and Analysis

The service area consists of Broome County. The population of Broome County in 2021 was 197,240, according to the latest US Census data, and is projected to decrease to 187,884 by 2028. According to Data USA, in 2020, 96.1% of the population of Broome County had health coverage as follows:

Total Health Care Coverage	96.1%
Employer Plans	45.3%
Medicaid	22.5%
Medicare	14.8%
Non-Group Plans	12.5%
Military or VA	1.03%

Currently, only one ASC, Greater Binghamton Eye Surgery Center, is operating in Broome County. This center provides ophthalmology services and is currently requesting approval to add otolaryngology surgical services. This center opened in May of 2021 and is located just one mile and four minutes away from the proposed new ASC. The applicant states that the volume of ambulatory surgery is expected to grow in the future, and the new center will help ensure that appropriate cases are performed in an out-of-hospital setting. The proposed center represents an attempt by Our Lady of Lourdes Memorial Hospital and local physicians to enhance access to outpatient surgical services, lessening the need for patients and physicians to travel to the hospital for ambulatory surgery services.

The table below shows the number of patient visits for area hospitals and hospital extension clinics in Broome County for 2019 through 2021. The number of patient visits for 2020 was significantly impacted by COVID-19.

Specialty Type	Facility Name	Patient Visits		
		2019	2020	2021
Multi	UHS-Binghamton General Hospital	9,502	8,568	7,975
Multi	Our Lady of Lourdes Hospital	17,843	16,168	17,511
Multi	UHS-Wilson Medical Center	11,085	8,322	7,636
Multi	Wilson Place ASC (extension clinic)	6,009	4,394	4,199
Total Visits		**44,439**	**37,452**	**37,321**

Source: SPARCS

The number of projected procedures is 2,112 in Year One and 3,717 in Year Three, with Medicaid at 12.89% and Charity Care at 1.99% by the third year. These projections are based on the current practices of participating surgeons. The applicant states that 90% of procedures moving to this center are currently being performed in a hospital setting. The table below shows the projected payor source utilization for Years One and Three.

	Year One		Year Three	
Payor	Volume	%	Volume	%
Medicaid FFS	60	2.84%	107	2.88%
Medicaid MC	210	9.94%	372	10.01%
Medicare FFS	410	19.41%	772	19.42%
Medicare MC	378	17.90%	665	17.89%
Commercial FFS	581	27.51%	1,023	27.52%
Commercial MC	258	12.22%	453	12.19%
Other	129	6.10%	227	6.11%
Private Pay	43	2.04%	74	1.99%
Charity Care	43	2.04%	74	1.99%

The center initially plans to obtain contracts with the following Medicaid Managed Care plans Atena Health, CDPHP, Excellus Health, MVP Health, and United Healthcare of NY. The center will work collaboratively with local Federally Qualified Health Centers to provide service to the under-insured in their service area. The center has developed a financial assistance policy with a sliding fee scale to be utilized when the center is operational.

Conclusion

Approval of this project will provide increased access to orthopedic and pain management surgery services in an outpatient setting for the residents of Broome County.

Program Analysis

Program Description

Proposed Operator	Binghamton Project, LLC
Doing Business As	Southern Tier Surgery Center
Site Address	601 Harry L. Drive Johnson City, New York 13790 (Broome County)
Surgical Specialties	Single Specialty Orthopedics Pain Management
Operating Rooms	4
Procedure Rooms	0
Hours of Operation	Monday to Friday, 7:00 am to 5:00 pm
Staffing (1st Year / 3rd Year)	14.24 FTEs / 19.50 FTEs
Medical Director(s)	Mohammed Ali Al Saied, MD
Emergency, In-Patient and Backup Support Services Agreement and Distance	Is provided by: Our Lady of Lourdes Memorial Hospital 3.7 Miles / 10 minutes
On-call Service	Patients who require assistance during off-hours will be provided a phone number for a 24-hour/day, seven (7) days/week on-call service to immediately refer the patient to the Center's on-call physician.

Character and Competence

The ownership of Binghamton Project, LLC is:

Member Name		Proposed Interest
Class A Members		**49.00%**
Mohamed Ali Al-Saied, M.D.	(2.000%)	
Brandon Ewald D.P.M.	(4.000%)	
Ian Hutchinson, M.D.	(3.000%)	
Dana Klush, D.P.M.	(3.000%)	
Colin McDonald, D.O.	(3.000%)	
Dermot Reynolds, M.D.	(4.875%)	
Joseph Romani, D.P.M.	(4.875%)	
Khalid Sethi, M.D.	(4.875%)	
Brian Timm, D.P.M.	(3.500%)	
Robert Van Gorder, M.D.	(4.500%)	
Thomas Van Gorder, M.D.	(4.500%)	
Darren Weinheimer, D.P.M.	(2.000%)	
Mark Wilson, M.D.	(4.875%)	
Class B Members		**51.00%**
Jeffrey Andrews	(33.150%)	
Binghamton Health Corp.	(17.850)	
	TOTAL	**100.00%**

Dr. Mohamed Al Saied is the Proposed Medical Director and an Orthopedic Surgeon at Our Lady of Lourdes Hospital for over three (3) years. He was an Orthopedic Surgeon at St. Mary's Regional Medical Center for four (4) years. He was a Locums Orthopedic Surgeon at Humber River Regional Hospital for over four (4) years. He was a General Practitioner for one (1) month at Melville. He was a General Practitioner at Notre Dame Bay Memorial Hospital Health Center for two (2) years. He was a General practitioner at Gaser Ben Gasher Poly Clinic for over one (1) year. He was a General Practitioner at Ebn

El Nafis clinic for six (6) months. He was a General Practitioner at the Tripoli Central Hospital for over one (1) year. He was a General Practitioner in the Trauma and Emergency Department at Tripoli Central Hospital for two (2) months. He was a General Practitioner at the Alhadba Poly-Clinic for one (1) year. He received his medical degree from Al-Fatah University in Tripoli. He completed his Orthopedic Surgery residency at the University of Toronto. He completed his Foot and Ankle Surgery fellowship at Western Hospital and his Hip and Ankle Arthroplasty fellowship at McMaster University. He is board certified in Orthopedic Surgery.

Mr. Jeffery Andrews is the Chief Operating Officer and Executive Vice president of Compassus Home Health and Hospice for seven (7) months. He provided operational leadership in a multistate, privately backed organization with annual revenues of $800M. He created organizational management systems for the consistent execution of operational metrics. He developed a plan for evolving organizational structure to ensure scalability, including the new clinical team to allow for value-based care. He directed an organic growth strategy with a focus on Ascension relationship development and improving new growth opportunities and customer relations. He designed recruitment and retention strategies specific to clinical onboarding and mentoring. He was the COO and Interim President of Sequel Youth and Family Services for nine (9) months. He was responsible for operations management for an organization with annual revenues of $300M, developed strategic plans and an organizational road map to position the company for future industry changes, restructured the organization to leverage regional relationships and improve decision-making, including establishing operational metrics. He led and coordinated customer care development teams with a focus on lean referral management, directed growth strategy, led enterprise-wide cost savings initiatives, and led and directed a clinical philosophy redesign. He was the Market President, Regional Vice President, and CEO of United Surgical Partners International for over 10 years. He led joint venture relationships with key health system partners, actively collaborated with system executives to improve quality, performance, and outcomes, and facilitated communication of market strategy in collaboration with physician leaders. He guided financial negotiations and debt restructure, facilitated the acquisition and merger of three (3) surgery centers, and directed the implementation of hospital gainsharing programs resulting in $4M of annual savings. He guided regional marketing and recruitment plans in collaboration with regional teams, directed regional staffing initiatives focused on reducing agency staffing, decreased turnover by 25%, designed a campus expansion, and recruited 20 physicians. He was an Administrator at Banner Thunderbird and Banner Estrella Surgery Centers for over one (1) year. He was responsible for $3M in budget at each center. He led the financial and operational turnaround at Banner Thunderbird and increased volume by 10% in nine (9) months. He recruited four (4) new surgeons. He completed a $6M new facility construction project. He was the Administrator at Surgis, Inc for over one (1) year. He prepared, monitored, and controlled a $2M operating budget and provided leadership to 20 employees. He strategized and negotiated managed care contracts to bolster the bottom line resulting in improved operating margins. He was the Network Account Manager of UnitedHealthcare for over one (1) year. He was a Business Analyst at Sun Health for over one (1) year. He was a Pharmaceutical Sales Representative for one (1) year for Johnson and Johnson.

Susan Bretscher is the Chief Mission Integration Officer and Chief Operating Officer at Our Lady of Lourdes Memorial Hospital for two (2) years. She defines the strategic direction and accountabilities for infrastructures, resources, and capabilities in collaboration with the senior management team and department directors for the organization. She also participates in the development, implementation, and accountability for the organization's vision, policies, and objectives; collaborates with senior management on setting strategic initiatives, develops plans, and implements processes for Mission Integration. She was the Vice President and Chief Mission Integration Officer at Our Lady of Lourdes Memorial Hospital for four (4) years. She collaborated with senior management in setting strategic initiatives, developing plans, and implementing processes for Mission Integration and supported the ministry's ecclesiastical relationship with the local Diocesan Ordinaries and the larger Catholic communities. She also held shared strategic ownership and leadership accountability for creating a Model Community culture. She was the Director of Community Outreach and Mission Integration for one (1) year. She collaborated with senior management and department directors in the development of specific strategies, tactics, and tasks that are aligned with the mission, vision, and core values. She managed the implementation of the mission integration and strategic initiatives while also directing youth services to meet individual and program goals. She directed the Lourdes Medical Mission at Home and other institution-wide services. She was the Director of Learning Services for one (1) year. She worked in partnership with Human Resources to assess the needs and develop, recommend, and implement solutions to meet organizational

development and effectiveness needs. She worked in partnership with the Manager of Community Relations to plan, develop, implement, and evaluate community health education. She set and controlled the budget for Learning Services and the library. She oversaw the administrative management of the podiatry residency program, family medicine residency program, continuing medical education program, and the library/archives. She was a Health Sciences Information Specialist at Our Lady of Lourdes Memorial Hospital for 22 years. She managed the hospital library and archives and provided library services to hospital staff, coordinated with the continuing medical education program and maintained the program accreditation, developed and maintained a broad spectrum of library services, supervised library/archive staff and volunteers, and implemented and maintained databases for circulation and control of library materials.

Katheryn Connerton is the President and CEO of Ascension Lourdes for over eight (8) years. She has led a $440M net revenue healthcare system with a 220-bed acute care hospital, an over 280-person physician network, and 3,400 associates. She transformed the health system to ambulatory care with 75% outpatient revenue, led value-based care redesign, initiated cohort management formalizing relationships between community-based organizations and primary care, engineered quality review infrastructure for the health system, and led entry into the largest Clinically Integrated Network in the upstate. She was the Vice President of Internal Consulting of Bon Secours Health System for over eight (8) years. She implemented all facets of EMR, achieved the system's highest revenue performance for post-install, realized $100M in benefits, led a 300-person staff in implementing and support of EHR operations in 14 hospitals, five LTCs, and an 800-person physician network, and partnered with executive management to start A Medicare Shared Savings Program. She was the Chief Operating Officer of Bon Secours Venice Healthcare for two (2) years. She implemented operational improvements increasing EBIDTA as percent net revenue by 8.5%, obtained $5M in grant funding for a surgical center of excellence, reduced salary and wage expense by 20% with top decile performance to benchmark metrics, increased service acuity leading to increased Medicare case mix, and doubled medical staff size. She was the Vice President of Quality and Risk at Bon Secours Venice Healthcare for four (4) years. She built a cardiovascular program including interventional cath and interventional radiology, outpaced projections for open heart surgery by 10%, doubled interventional caths, and exceeded the contribution margin by 10%. Ms. Connerton discloses membership interest in the following healthcare facilities:
Our Lady of Lourdes Memorial Hospital *12/2014-present*

Dr. Brandon Ewald is a Podiatrist at Lourdes Foot and Ankle for over four (4) years. He was a Podiatrist at Southern Tier Associates in Podiatric Medicine and Surgery for approximately one (1) year. He received his medical degree from the New York College of Podiatric Medicine. He completed his Podiatric Medicine and Surgical Residency at Our Lady of Lourdes Memorial Hospital. He completed his Podiatric Surgery Residency at the Rubin Institute for Advanced Orthopedics-International Center for Limb Lengthening at Sinai Hospital. He is board certified in Podiatric Medicine.

Dr. Ian Hutchinson is an Attending Orthopedic Surgeon at Ascension Medical Group/Our Lady of Lourdes Hospital for five (5) months. He received his medical degree from the Royal College of Surgeons in Ireland. He completed his Orthopedic Surgery residency at Albany Medical Center. He completed his Orthopedic Surgery/Sports Med at the Sports Medicine Institute at the Hospital for Special Surgery.

Dr. Dana Klush is a Podiatric Medicine and Surgery Practice Associate at LaPorta and Associates for 12 years. He received his medical degree from Temple University School of Podiatric Medicine. He completed his Podiatric Medicine and Surgery Residency at Community Medical Center. He is board certified in Podiatric Medicine.

David Mannes is the Chief Financial Officer of Ministry Markets at Ascension for over one (1) year. He leads the finance function, including financial reporting, planning, revenue cycle, capital planning, and financial integrity for Our Lady of Lourdes Memorial Hospital. He was the previous Vice President of Finance MWF at Ascension for three (3) years. He led the finance planning, forecasting, capital planning, financial integrity, and consolidation of 10 hospitals in Wisconsin. He was the Controller of Ascension for over nine (9) years. He led the financial reporting and accounting function for Ascension Wisconsin, including accounting, payroll, time and attendance, consolidation, accounts payable, cash management, and audit. Mr. Mannes discloses membership interest in the following healthcare facilities:
Horizon Homecare and Hospice *10/2009-06/2021*

Dr. Colin McDonald is an Attending Orthopedic Surgeon at Ascension Medical Group/Our Lady of Lourdes Hospital for six (6) months. He completed his Orthopedics and Sports Medicine fellowship at the University of Buffalo. He completed his Orthopedic Surgery residency at the Orthopedic Residency of York, Wellspan. He received his medical degree from Lake Erie College of Osteopathic Medicine.

Alexandra Reyes is the Vice President of Operations at Regent Surgical Health for over three (3) years. She works with the center Administrator and Operating Board and provides hands-on management and support for day-to-day center activities that promote growth and desired financial performance. The key areas of focus are strategic planning, partner relations, staff development, and accountability. She is the primary operations contact for inquiries for the Center staff and physician partners. She delegates authority and responsibility to department heads, develops and improved management techniques and practices, and provides leadership, vision, and strategic direction. She reviews and supports negotiations for quotes for equipment, supplies, and ancillary service agreements. She was the Vice president of Operations at Physician Endoscopy for over two (2) years. She functions as the primary liaison between Physician Endoscopy (PE) and multiple ASCs. She interacted and influenced cross-functionally within PE departments and also worked collaboratively with the Centers to develop initiatives that promote center growth, cost containment, and operational improvement, provided onsite support and project oversight, developed key contacts within the center community, and kept current on regional and national industry related events that may impact the Centers. She was the Senior Vice President of Operations of Frontier Healthcare for two (2) years. She provided the Centers with a recommended program for managing efficient ongoing operations. She submitted the Medical Director, Quality Assurance and Performance Improvement Committee, and Board of Manager medical staff bylaws, a quality program, and departmental policies and procedures for review and modification. She provided support to the Administrator and Medical Director, who are responsible for familiarizing the facility staff with the policies and procedures. She completes periodic audits of the Center's operations and provides feedback to the Board of Managers on the Center's adherence to programs, and contributes feedback on quality and risk programs for QAPI for the Board to consider in internal reviews. She provides operational insights on best practices and tools gained from experiences working in other ASCs. She was the ASC Regional Director of Prospira Pain Care/National Surgical Centers of America for two (2) years. She directed daily operations of the surgery center, personnel supervision, cost control, inventory management, risk management, and quality improvement. She also recruited, oriented, trained, and directed staff, conducted performance evaluations, assisted with recruiting qualified physicians, and directed the daily operations of four surgery centers. She was the Operating Room Manager of Memorial Same Day Surgery Center for 10 months. She directed the daily operations of the surgery center, personnel supervision, cost control, inventory management, risk management, and quality improvement. She prepared the facility to successfully meet The Joint Commission Inspection and monitored payroll and benefits for accuracy, timeliness, cost-effectiveness, and adherence to state and federal requirements. She was an Administrator at Weston Outpatient Surgical Center for over one (1) year. She spearheaded a full-scope facility operation inclusive of policy and procedure development and implementation, goal setting, strategy planning, budgeting, and collaboratively supporting the total perioperative process. She steered strict compliance with OSHA rules and regulations, fostered transparent communication between business offices, patient care areas, and physician practices, monitored payroll and benefits, conducted cost analysis and prepared reports, negotiated contracts and maintained cooperative relationships, and played an active role in developing and optimizing the Quality Management Program. She was an Administrator at Treasure Coast Center for Surgery for two (2) years. She was a Nurse Manager at Palms West Surgicenter for over two (2)years. She was a Staff Nurse in the Operating Room at North Shore University Hospital at Glen Cove Orthopedic and Rehab Institute for two (2) years. She was a Director of Nursing at the Rehab Institute for two (2) years.

Dr. Dermot Reynolds is an Associate in Orthopedic Surgery, Hip and Knee Reconstruction at Ascension Lourdes Hospital for seven (7) months. He was an Associate in Orthopedic Surgery Hip and Knee Reconstruction and Orthopedic Trauma at St. Joseph Health for two (2) years. He was an Associate in Orthopedic Surgery, Hip and Knee Reconstruction and Orthopedic Trauma at Robert Packer Hospital for over 16 years. He was an Assistant Professor in Orthopedics at the University of Manitoba for one (1) year. He was the Service Chief in Trauma at the University of Manitoba for one (1) year. He received his medical degree from the University of Toronto. He completed his Orthopedic Surgery residency at the Memorial University of Newfoundland. He completed his Orthopedic Adult Joint Reconstruction fellowship

at the University of Manitoba. He completed his Orthopedic Trauma fellowship at the University of Calgary. He is board certified in Orthopedic Surgery.

Dr. Joseph Romani is a Podiatric Surgeon at Ascension Lourdes for over four (4) years. He was a Podiatric Surgeon at LaPorta and Associates, PC, for two (2) years. He received his medical degree from Kent State University College of Podiatric Medicine. He completed his Podiatric and Orthopedic residency at Sinai Hospital. He completed his Podiatric Medicine and Surgery with Reconstructive Rearfoot and Ankle residency at Our Lady of Lourdes Memorial Hospital.

Dr. Khalid Sethi is the Director of Neurosurgery a UHS Medical Group for over six (6) years. He is the Co-Director of Surgical Services at UHSH for over four (4) years. He is a Member of the UHSH Medical Executive Committee for over four (4) years. He was an Elected Board member of UHS Medical Group for six (6) years. He is the Director of Neurosciences, Quality Optimization, and Performance Improvement at UHSH for 15 years. He is the Chief of Neurosurgery at UHSH for 20 years. He is the Chief of Neurosurgery at Lourdes Hospital for 21 years. He is an Investigator at Regional Clinical Research, Inc. for 17 years. He is a Neurosurgeon at UHS for over six (6) years. He was a Partner at Southern New York Neurosurgical, PC, for 14 years. He received his medical degree from the Indianan University School of Medicine. He completed his Neurological Surgery residency at the University of Minnesota Hospitals and Clinics. He completed his Complex Adult Spinal Deformity fellowship at VA Medical Center Minnesota. He completed his Trauma/Cerebrovascular Neurosurgery fellowship at Hennepin County Medical Center.

Dr. Brian Timm is a Podiatrist at Ascension Lourdes for over seven (7) years. He was a Podiatrist at Family Foot and Leg Center for six (6) years. He received his medical degree from Dr. William Schooll College of Podiatric Medicine. He completed his residency at Our Lady of Lourdes Hospital. He is board certified in Foot and Ankle Surgery and Reconstructive Rearfoot and Ankle Surgery.

Dr. Robert Van Gorder is an Orthopedic Surgeon at Our Lady of Lourdes Hospital for over five (5) years. He was an Orthopedic Surgeon at Tier Orthopedic Associates for two (2) years. He received his medical degree from SUNY Upstate Medical Center. He completed his Orthopedic residency at the University of Vermont. He completed his Orthopedic Sports Fellowship at the University of Rochester. He is board certified in Orthopedics.

Dr. Thomas Van Gorder is an Orthopedic Surgeon at Ascension, Our Lady of Lourdes Hospital, and Lourdes Orthopedics for over five (5) years. He was an Orthopedic Surgeon for Tier Orthopedic Associates for 20 years. He received his medical degree from SUNY Buffalo Medical University. He completed his Orthopedic Surgery residency at SUNY Buffalo.

Dr. Darren Weinheimer is a Podiatrist at the Foot Care Center and Primary Foot Care for 25 years. He is a Podiatric Attending Physician at Lourdes Hospital and Binghamton Hospital Medicaid Clinics for 25 years. He was a Board Member of the Arthritis Foundation of Broome County for five (5) years. He is an Assistant Residency Director at Lourdes Hospital for 13 years. He is Core Teaching Faculty at Binghamton General Hospital for 15 years. He received his medical degree from the Ohio College of Podiatric Medicine. He completed his Rotating Podiatric Residency and his Podiatric Surgical Residency at St. Francis Central Hospital. He is board certified in Podiatric Surgery and Reconstructive Rearfoot and Ankle.

Dr. Mark Wilson is an Orthopedic Surgeon at Lourdes Orthopedics Riverside for over five (5) years. He was a Physician and Partner at Tier Orthopedic Associates, PC, for 12 years. He received his medical degree from SUNY Upstate. He completed his Orthopedic residency at SUNY Upstate. He completed his Sports Medicine Fellowship at Southern California Center for Sports Medicine. He is board certified in Orthopedic Surgery.

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

For those patients who do not identify a primary care provider (PCP), the Center, in cooperation with Our Lady of Lourdes Hospital, plans to work with its patients to educate them regarding the availability of services offered by local primary care physicians and Our Lady of Lourdes Hospital. The Applicant is committed to serving all persons in need without regard to race, sex, age, religion, sexual orientation, ability to pay, source of payment, or other personal characteristics. A sliding scale fee based on Federal Poverty Income Guidelines and family size will be developed for patients without health insurance coverage. The operating budget projects 2.0% for charity care, 2.0% for private pay, with private pay patients paying reduced fees based on their ability to pay, and 12.9% for Medicaid. The Center will contract with two or more Medicaid-managed care plans and will seek to participate in one of the provider-led designated health homes for Broome County to develop referral and other collaborative arrangements to enhance access to ambulatory surgery services to Medicaid and charity care patients. The Applicant plans to contract with Medicaid-managed Care Plans such as Aetna Health Inc., Capital District Physicians' Health Plan, Inc., Excellus Health Plan, Inc., MVP Health Plan, Inc., and United Healthcare of New York, Inc. The Applicant plans to outreach to the following FQHC, Cornerstone Family Healthcare, and other community-based providers.

The Center plans to utilize an Electronic Medical Record (EMR) system and to fully integrate and exchange information with an established RHIO with the capability for clinical referral and event notification. The Applicant will consider joining any Accountable Care Organization (ACO).

Conclusion

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

Financial Analysis

Total Project Costs and Financing

Total project costs, estimated at $13,065,769, are as follows:

Renovation & Demolition	$6,113,782
Design Contingency	611,378
Construction Contingency	611,378
Architect/Engineering Fees	405,439
Other Fees	123,000
Movable Equipment	4,573,694
Interim Interest Expense	533,640
CON Application Fee	2,000
CON Processing Fee	71,458
Total Project Cost	$13,065,769

The applicant's financing plan appears as follows:

Cash Equity (Applicant)	$1,292,325
Lease Tenant Improvement Allowance	$2,792,125
Bank Loan (7.13% interest, 7-year term)	$8,981,319
Total	$13,065,769

Bank of America has provided a letter of interest at the above-stated terms for the bank loan. Bank of America has also provided a letter of interest for the working capital loan at 7.13% interest for a 3-year term.

Operating Budget

The applicant submitted their first- and third-year operating budgets, in 2023 dollars, summarized below:

	Year One 2024		Year Three 2026	
	Per Proc.	Total	Per Proc.	Total
Revenues:				
Medicaid FFS	$944.10	$56,646	$947.10	$101,340
Medicaid MC	$947.37	$198,947	$944.87	$351,491
Medicare FFS	$1,834.36	$752,086	$2,034.18	$1,468,677
Medicare MC	$1,741.97	$658,463	$1,934.07	$1,286,155
Commercial FFS	$4,768.34	$2,770,407	$5,291.17	$5,412,863
Commercial MC	$4,397.85	$1,134,646	$4,885.23	$2,213,007
Private Pay	$1,188.49	$51,105	$1,321.32	$97,778
Other	$2,404.96	$310,240	$2,399.18	$544,614
Total Revenues		$5,932,540		$11,475,925
Expenses:				
Operating	$1,770.98	$3,740,319	$1,705.21	$6,338,247
Capital	$1,086.24	$2,294,129	$582.33	$2,164,534
Total Expenses	$2,857.22	$6,034,448	$2,287.54	$8,502,781
Net Income or (Loss)		($101,908)		$2,973,144
Utilization: (procedures)		2,112		3,717

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

Medicaid FFS	2.84%
Medicaid MC	9.94%
Medicare FFS	19.41%
Medicare MC	17.90%
Commercial FFS	27.51%
Commercial MC	12.22%
Other	6.10%
Private Pay	2.04%
Charity	2.04%
Total	100%

The following is noted with respect to the submitted budget:

- Revenue assumptions are based on current and projected Federal and State government reimbursement rates, with private pay payor rates reflecting adjustments based on experience in the region.
- Utilization projections are based on the current caseloads of the participating physicians appropriate to a FASC setting. Each physician has submitted a letter in support of their utilization projections.
- Expense assumptions are based upon staffing, operating, and capital costs as determined based on the experience of the participating physicians as well as the experience of other FASCs in New York State in providing similar service patient care.
- The breakeven, based on the projected utilization, is approximately 101.75% or 2,149 procedures in year one and 77.80% or 2,892 procedures in year three.

The budgets are reasonable.

Lease Rental Agreement

The applicant submitted a draft lease for the proposed site. The terms are summarized below:

Premises:	Approximately 15,995 rentable square feet in an existing building located at 601 Harry L. Drive, Johnson City (Broome County), NY
Landlord:	Spark JC, LLC
Lessee:	Binghamton Project, LLC
Term:	15 years with 2 5-year renewal terms
Rent:	$591,815 annually ($49,317.92 monthly or $37 per square foot.) with a 2.5% annual increase from year 2 going forward.
Provisions:	Triple Net lease

The applicant provided an affidavit stating that the lease is an arm's length arrangement. The applicant submitted letters from two NYS licensed realtors attesting to the rent being of fair market value.

Administrative Services Agreement

The applicant submitted an executed administrative services agreement. The terms are summarized below:

Date	April 5, 2022
Operator:	Binghamton Project, LLC
Contractor:	Regent Surgical Management, LLC
Services of contractor:	Assistance to established Operator's administrator, consulting/advisory services related to administration and operational functions, regulatory monitoring, compliance, and quality assurance, oversight of all functions related to accounts receivables, develop and implement a marketing plan, and operate, supervise, and oversee all functions related to billing and preparation of health facility assessments, review rate sheets and assisting with filing necessary appeals.
Term:	7 years with infinite 3-year renewals
Compensation	$310,107.96 annually ($25,842.33 monthly)

The agreement provides that the facility operator will retain ultimate control in all the final decisions associated with the facility. The applicant has submitted an executed attestation stating that the applicant understands and acknowledges that there are powers that must not be delegated, the applicant will not willfully engage in any illegal delegation, and understands that the Department will hold the applicant accountable.

Capability and Feasibility

The total project cost of $13,065,769 will be satisfied by the proposed members' equity contribution of $1,292,325, a lease tenant improvement allowance of $2,792,125, and an $8,981,319 bank loan.

Working capital requirements are estimated at $1,417,130 based on two months of third-year expenses. The applicant is, however, budgeting a working capital need of $1,607,675 to address the applicant's understanding of typical start-up issues with a new ASC, including covering the projected loss from operations in Year One. The applicant has submitted a letter of interest from Bank of America to finance $400,000 of the working capital for a 3-year term at 7.13% interest. The remaining $1,207,605 will be provided by the members. BFA Attachment A presents the net worth statement of the proposed physician members, the individual member of New York Holdco, LLC, and the internal financial statements through the 6/30/22 fiscal year of Binghamton Health Corporation, the corporate member of New York Holdco, LLCBFA. Attachment A indicates that only New York Holdco, LLC members have sufficient liquid resources to meet their portion of the equity and working capital requirements. Some of the physician members need to demonstrate more liquid resources to fund the equity requirement for this project. These members have resolved this issue through prepayment of equity and personal financing. Based on this information, the physician members will have sufficient liquid resources to fund their portion of this project's equity and working capital requirement.

BFA Attachment B provides the pro-forma balance sheet showing operations will start with $5,292,125 in equity. Southern Tier Surgery Center, LLC projects a net loss of $101,908 for the first year and a net income of $2,973,144 in the third year. Reimbursement rates reflect current and projected Federal and State government rates, with private payers reflecting adjustments based on experience in the region.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BHFP Attachment	Map
BFA Attachment A	Personal Net Worth Statement and certified financial statements of members of Southern Tier Surgery Center, LLC
BFA Attachment B	Pro Forma Balance Sheet of Southern Tier Surgery Center, LLC
BFA Attachment C	Organizational Chart and List of 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 18th day of April 2023, 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 dual single-specialty ambulatory surgery diagnostic and treatment center for Orthopedics and Pain Management at 601 Harry L Drive, Johnson City, 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:
222227 B	Southern Tier Surgery Center, LLC

APPROVAL CONTINGENT UPON:

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of an executed loan commitment acceptable to the Department of Health. [BFA]
5. Submission of an executed working capital loan commitment acceptable to the Department of Health. [BFA]
6. Submission of an executed building lease acceptable to the Department of Health. [BFA]
7. Submission of an updated net worth statement from Dr. Colin McDonald showing sufficient liquid resources for his portion of the equity and working capital requirement. [BFA]
8. Submission of a copy of a Lease agreement that is acceptable to the Department. [CSL]
9. Submission of a copy of an Operating Agreement of the proposed Operator that is acceptable to the Department. [CSL]
10. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include a commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
11. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]

APPROVAL CONDITIONAL UPON:

1. This project must be completed by **September 15, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **September 15, 2023,** and construction must be completed by **June 15, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]
6. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 222086-E
Aimer Home Care Corp.

Program: **LHCSA**
Purpose: **Establishment**

County: **Rensselaer**
Acknowledged: **December 7, 2022**

Executive Summary

Description

Aimer Homecare Corp., a for-profit corporation, seeks approval for initial licensure as a Licensed Home Care Service Agency (LHCSA) under Article 36 of the Public Health Law.

The applicant proposes to serve the residents of the following counties from an office located at 5 Springfield Avenue, East Greenbush, New York 12601:

- Rensselaer
- Greene
- Schenectady
- Columbia
- Washington

The applicant proposes to provide the following healthcare services:

- Nursing
- Home Health Aide
- Personal Care
- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
- Speech-Language Pathology
- Audiology
- Medical Social Services
- Nutrition
- Homemaker
- Housekeeper
- Medical Equipment, Supplies, and Appliances

OALTC Recommendation

Approval is recommended.

Need Summary

This CON meets the need requirements set forth in 10 NYCRR Section 765-1.16 as all counties requested have a presumed need.

Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §3606(2).

Recommendations

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

Office of Aging and Long-Term Care
Approval is recommended.

Council Action Date
April 18, 2023

Program Analysis

Program Description

Aimer Homecare Corp., a for-profit corporation, seeks approval for initial licensure as a Licensed Home Care Service Agency (LHCSA) under Article 36 of the Public Health Law.

The applicant proposes to serve the residents of the following counties from an office located at 5 Springfield Avenue, East Greenbush, New York 12601:

Columbia, Greene, Rensselaer, Schenectady, and Washington Counties.

The applicant proposes to provide the following healthcare services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Respiratory Therapy
Speech-Language Pathology	Audiology	Medical Social Services
Nutrition	Homemaker	Housekeeper
Medical Equipment, Supplies, and Appliances		

Character and Competence Review

The applicant has authorized 10,000 shares, which are owned by Agustin Prado Guevara and Luisa Puello de Leon.

Agustin Prado Guevara - 5,000 shares
Chief Marketing Officer, Amor Homecare Inc.

Luisa Puello de Leon – 5,000 Shares
Director of Intake Department, Trivium of New York, LLC

The Board of Directors of Aimer Homecare, Corp. comprises the following individuals:

Agustin Prado Guevara
Disclosed above

Luisa Puello de Leon
Disclosed above

Misael Cabrera Prado
Director of Marketing/Business Development Department, Amor Homecare Inc. of Pennsylvania, Connecticut, and North Carolina

Paola Prado Guevara
Director of the Intake Department, Amor Homecare Inc. of Pennsylvania, Connecticut, and North Carolina

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

Need Review

This CON meets the need requirements set forth in 10 NYCRR Section 765-1.16 as all counties requested have a presumed need.

Financial Review

In accordance with 10 NYCRR 765-1.2(b)3, the applicant has submitted financial documents prepared by a Certified Public Accountant (CPA) demonstrating the financial feasibility of the agency. See Attachment A.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Attachments

OALTC	Financial Attachment

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 18th day of April, 2023, 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 new licensed home care services agency at 5 Springfield Avenue, East Greenbush, 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
222086 E	Aimer Home Care Corp.

APPROVAL CONTINGENT UPON:

N/A

APPROVAL CONDITIONAL UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in th*e Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 222156-E
Right At Home Nassau North Shore

Program: **LHCSA**
Purpose: **Establishment**
County: **Nassau**
Acknowledged: **November 25, 2022**

Executive Summary

Description
EQ Health, Inc., d/b/a Right at Home Nassau North Shore, a business corporation, requests approval to become the new operator of Right at Home North Shore LI, a Licensed Home Care Services Agency, under Article 36 of the Public Health Law.

Funzalo & Canteet, Inc. d/b/a Right at Home North Shore LI (current operator) was approved by the Public Health and Health Planning Council at its June 7, 2012, meeting. The agency was subsequently licensed under license number 1939L001. On August 24, 2022, they entered a management contract with EQ Health, Inc.,

Right at Home North Shore LI currently serves Queens, Nassau, and Suffolk counties from an office located at 400 Post Avenue, Suite 302, Westbury, NY 11590. There will be no changes to the counties served or services provided as a result of this project. Upon completion of this application, the agency will be known as Right at Home Nassau North Shore. EQ Health, Inc. proposes to operate as a Franchisee of Right at Home, LLC.

OALTC Recommendation
Approval is recommended.

Need Summary
In accordance with 10 NYCRR 765-1.16(c)2, this application is exempt from Public Need review as the agency is actively serving over 25 patients, as attested to by the current operator.

Program Summary
The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §3606(2).

Recommendations

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

Office of Aging and Long-Term Care
Approval is recommended.

Council Action Date
April 18, 2023

Program Analysis

Program Description

EQ Health, Inc., d/b/a Right at Home Nassau North Shore, a business corporation, requests approval to become the new operator of Right at Home North Shore LI, a Licensed Home Care Services Agency under Article 36 of the Public Health Law.

The agency currently operates as Funzalo & Canteet, Inc. d/b/a Right at Home North Shore LI and serves Queens, Nassau, and Suffolk counties from an office located at 400 Post Avenue, Suite 302, Westbury, NY 11590. There will be no changes to the counties served or services provided as a result of this project. Upon completion of this application, the agency will be known as Right at Home Nassau North Shore. EQ Health, Inc. proposes to operate as a Franchisee of Right at Home, LLC.

Character and Competence

The applicant has authorized 200 shares of stock which are owned as follows:

Zubin Kapadia, Esq. (President, Right at Home North Shore LI) - 200 shares

The applicant has 14 years of healthcare industry experience, including positions in executive management.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

A search of the individuals and entities named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

Need Review

In accordance with 10 NYCRR 765-1.16(c)2, this application is exempt from Public Need review as the agency is actively serving over 25 patients, as attested to by the current operator.

Financial Review

In accordance with 10 NYCRR 765-1.2(b)3, the applicant has submitted financial documents prepared by a Certified Public Accountant (CPA) demonstrating the financial feasibility of the agency.

Conclusion

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §3606(2).

Attachments

OALTC	Financial Attachment

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 18th day of April, 2023, 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 EQ Health, Inc. as the new operator of Right at Home Nassau North Shore, a Licensed Home Care Services Agency currently operated by Funzalo & Canteet, Inc., 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
222156 E	Right At Home Nassau North Shore

APPROVAL CONTINGENT UPON:

N/A

APPROVAL CONDITIONAL UPON:

N/A

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in th*e Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

MEMORANDUM

To: Kathy Marks
General Counsel
Division of Legal Affairs

From: Jason W. Riegert, Deputy Director
Bureau of Program Counsel
Division of Legal Affairs

Date: March 3, 2023

Subject: Certificate of Amendment of the Restated Certificate of Incorporation of Glens Falls Hospital Foundation, Inc.

The attached package was prepared by Vincent DiCocco for the Division of Legal Affairs. Relevant background material has been included.

I have reviewed the package and find it acceptable.

If you approve, please sign the memorandum and kindly return the package to Vincent DiCocco for further processing.

Thank you.

NEW YORK STATE OF OPPORTUNITY. Department of Health

MEMORANDUM

To: Colleen Leonard, Executive Secretary
Public Health and Health Planning Council

From: Vincent DiCocco, Senior Attorney
Bureau of Program Counsel
Division of Legal Affairs

Date: March 3, 2023

Subject: Certificate of Amendment of the Restated Certificate of Incorporation of Glens Falls Hospital Foundation, Inc.

Please include this matter on the next Establishment and Project Review Public Health and Health Planning Council agenda.

The attachments relating to the matter include the following:

1) A Memorandum to the Public Health and Health Planning Council (PHHPC) from Kathy Marks, Department of Health General Counsel.

2) A May 18, 2022 email to Colleen Leonard and Lisa Thomson requesting approval to amend the purposes and powers stated in Glens Falls Hospital Foundation, Inc.'s Restated Certificate of Incorporation from Richard J. Krainin.

3) The Corporate Bylaws of Glens Falls Hospital Foundation, Inc.

4) The resolution authorizing the proposed Certificate of Amendment of the Restated Certificate of Incorporation by the Sole Member of Glens Falls Hospital board of governors and by the directors of Albany Med Health System (the sole member of Glens Falls Hospital.)

5) The current Restated Certificate of Incorporation of Glens Falls Hospital Foundation, Inc. as well proposed amendment of the Restated Certificate of Incorporation of Glens Falls Hospital Foundation, Inc.

NEW YORK STATE OF OPPORTUNITY. Department of Health

MEMORANDUM

To: Public Health and Health Planning Council

From: Kathy Marks, General Counsel

Date: March 3, 2023

Subject: Certificate of Amendment of the Restated Certificate of Incorporation of Glens Falls Hospital Foundation, Inc.

Glens Falls Hospital Foundation, Inc. ("GFHF") requests Public Health and Health Planning Council ("PHHPC") approval of a proposed Restated Certificate of Amendment of its Certificate of Incorporation.

GFHF is a New York not-for-profit corporation incorporated on September 25, 1995, with the purpose "[t]o establish and maintain a program to solicit, receive and manage inter vivos and testamentary gifts, life income gifts and other split-interest gifts to support the work of the medical, charitable, scientific, research or educational purposes of Glens Falls Hospital and related organizations." The Public Health Council ("PHC") consented to the filing of the Certificate of Incorporation of GFHF on January 26, 1996.

Presently, GFHF wishes to amend Section 4(b) of its Restated Certificate of Incorporation to correct a scrivener's error. Section 4(b) authorizes GFHF to engage in any lawful activity in furtherance of its support of the Hospital, except for activities specified in Section 404(b-v) of the Not-For-Profit Corporation Law. However, Sections 404(o) and 404(t) of the Not-For-Profit Corporation Law refer to the purposes of soliciting contributions for a hospital or facility providing health related services, which are activities that are rooted in the purposes of GFHF. As such, the proposed Amendment corrects references to Section 404 of the Not- For-Profit Corporation Law to allow GFHF to continue providing services to Glens Falls Hospital and related organizations.

Attached is a May 18, 2022, request e-mail from Richard J. Krainin on behalf of GFHF to the Department, the Bylaws of GFHF, the Resolutions of the Board of Trustees of GFHF on April 7, 2022, approving the amendment, the current Restated Certificate of Incorporation of GFHF as well as the proposed Certificate of Amendment of the Restated Certificate of Incorporation of GFHF.

There is no legal objection to the proposed Certificate of Amendment of the Certificate of Incorporation.

Attachments

From:	Krainin, Richard
To:	DiCocco, Vincent (HEALTH)
Subject:	FW: Request for PHHPC Approval to Amending the Restated Certificate of Incorporation of Glens Falls Hospital Foundation
Date:	Friday, November 18, 2022 8:14:15 AM
Attachments:	image001.png image002.png GFH Foundation CoA (003).pdf Glens Falls Hospital Foundation - NY - Certified Articles (5.3.22).PDF

This is the 5/18 email to Ms. Leonard and Ms. Thomson.

Richard J. Krainin
PARTNER | ARENTFOX SCHIFF LLP
(HE/HIM/HIS)

richard.krainin@afslaw.com | 212.484.3918 DIRECT | 516.662.4285 MOBILE
Bio | My LinkedIn | Subscribe
1301 Avenue of the Americas, 42nd Floor, New York, NY 10019

From: Krainin, Richard
Sent: Wednesday, May 18, 2022 6:52 PM
To: Colleen.Leonard@health.ny.gov; Lisa.Thomson@health.ny.gov
Subject: Request for PHHPC Approval to Amending the Restated Certificate of Incorporation of Glens Falls Hospital Foundation

Greetings Ms. Leonard and Ms. Thomson.

On behalf of my clients, Glens Falls Hospital Foundation (**Foundation**) and Glens Falls Hospital (**Hospital**), I would appreciate your guidance in obtaining PHHPC approval of a corrective amendment to the Foundation's Restated Certificate of Incorporation. [First Attachment]

The Foundation was formed to solicit, receive and manage gifts to support the work of the Hospital, an Article 28 Hospital. [See Section 4(a) of the 2nd attachment—a certified copy of the Foundation's Restated Certificate of Incorporation]

The amendment corrects a scrivener's error in Section 4(b) of the Foundation's Restated Certificate of Incorporation. 4(b) authorizes the Foundation to engage in any lawful activity in furtherance of its support of the Hospital, other than activities described in specified subsections of Section 404 of the Not-For-Profit Corporation Law. The Amendment corrects the subsections of Section 404 of the Not-For-Profit Corporation Law whose activities are to be excluded.

Please let me know what additional information I can provide and to whose attention I should send it.

Thank you very much in advance for your guidance.

--Richard Krainin

Richard J. Krainin
PARTNER | ARENTFOX SCHIFF LLP
(HE/HIM/HIS)

richard.krainin@afslaw.com | 212.484.3918 DIRECT | 516.662.4285 MOBILE
Bio | My LinkedIn | Subscribe
1301 Avenue of the Americas, 42nd Floor, New York, NY 10019

BY-LAWS

OF

GLENS FALLS HOSPITAL FOUNDATION

100 PARK STREET

GLENS FALLS, NEW YORK 12801

Adopted 7/24/95

Amended 12/1/95

Amended 12/5/00

Amended 9/15/04

Amended 6/16/05

Amended 9/29/15

Amended 7/1/20

Amended 3/3/21

TABLE OF CONTENTS

ARTICLE I

NAME AND LOCATION

The corporation shall be known as GLENS FALLS HOSPITAL FOUNDATION (hereinafter the "CORPORATION") and shall be located in or near the City of Glens Falls, County of Warren, State of New York.

ARTICLE II

PURPOSES AND POWERS

The purposes for which this corporation has been organized shall be as set forth in the corporation's Certificate of Incorporation, as in effect from time to time. The CORPORATION shall not enter into any Related Party Transaction, unless such transaction is approved in accordance with the CORPORATION's Conflict of Interest Policy.

ARTICLE III

MEMBERSHIP

1. MEMBERSHIP CORPORATION. The CORPORATION shall be a membership corporation. The sole member of the CORPORATION shall be the GLENS FALLS HOSPITAL ("HOSPITAL"), existing as a type B Charitable Corporation under the New York Not-For-Profit Corporation Law.

2. ANNUAL MEETING. The Annual Meeting of the membership of the CORPORATION shall be held in the second quarter of each fiscal year of the CORPORATION for the purpose of approval by the Board of Trustees of the CORPORATION, as such place and time, and upon such notice as shall be fixed by the member.

3. OTHER MEETINGS. Regular and special meetings of the member shall be held at such times, places and upon such notice as the member shall fix.

ARTICLE IV

BOARD OF TRUSTEES

1. RESPONSIBILITY AND AUTHORITY. Corporate powers shall be vested in a BOARD which shall be responsible for the property, finances, and affairs of the CORPORATION and which shall, through its officers and organization, authorize all acts necessary to maintain and enhance the interest and welfare of the CORPORATION and its programs. The use of the phrase, "entire board", herein refers to the total number of Trustees which the CORPORATION would have if there were no vacancies.

2. QUALIFICATIONS AND NUMBERS. Each Trustee shall be at least eighteen (18) years of age. The initial BOARD shall consist of at least six (6) persons. Thereafter, the number of the Trustees constituting the entire BOARD shall be at least five (5) and no more than thirty

(30), inclusive of the President of the CORPORATION, the President of the Medical Staff of the HOSPITAL and the Chairperson of the Corporation ad hoc Guild Committee, if such Committee exists. The President of the Medical Staff and the Chairperson of the Corporation ad hoc Guild Committee shall be non-voting members. The number of Trustees may be increased or decreased by action of the Trustees, provided that any action of the Trustees to effect such increase or decrease shall require the vote of a majority of the entire BOARD. No decrease shall shorten the term of any incumbent Trustee. BOARD members shall be chosen for their ability to contribute to and support the objectives of the CORPORATION through their wisdom, wealth, and work. Members shall be chosen from as wide a cross section of the community as is feasible as determined by the BOARD. Each member should possess basic qualities of honesty, integrity, a sense of justice and sound moral character. Membership on the Board should reflect a breadth of diversity in keeping with the broadened role of GLENS FALLS HOSPITAL in the community.

3. ATTENDANCE. Failure to maintain an active role in BOARD matters as evidenced by absence from 25% or more BOARD meetings and assigned committee meetings during any fiscal year of a TRUSTEE's term is cause for ineligibility for re-election.

4. VACANCIES. Vacancies occurring on the BOARD may be filled by the BOARD, provided that candidates shall be subject to the approval of the Board of Governors of the HOSPITAL. A Trustee elected on an interim basis shall hold office for the unexpired term of the Trustee who originally created the interim vacancy.

5. CONFLICTS OF INTEREST.

(a.) The BOARD shall adopt written policies regarding conflicts of interest. Such policies shall relate to disclosure of transactions where conflict of interest is a possibility and the responsibility of each TRUSTEE to be alert to possible conflict of interest to him or her or other TRUSTEES. See Appendix A for the current Conflict of Interest Policy.

(b.) Any new members of the BOARD shall be advised of this policy upon assuming the duties of office, and must complete the Conflict of Interest Statement.

(c.) All TRUSTEES must complete the Conflict of Interest Statement annually.

6. REMOVAL AND RESIGNATION. Any Trustee may be removed for cause by vote of the remaining members of the BOARD. A Trustee may resign at any time by giving written notice to the Secretary of the BOARD. Unless otherwise specified in the notice, the resignation shall take effect upon receipt thereof by the BOARD, and the acceptance of the resignation shall not be necessary to make it effective.

7. COMPENSATION. Trustees shall serve without compensation except for reimbursement for reasonable expenses. In keeping with the Not-For-Profit status of the CORPORATION, no Trustee shall benefit financially from his position as a Trustee.

8. AUDIT. The Audit Committee shall oversee an annual audit of the

CORPORATION'S financial statements. Only Independent Trustees of the BOARD shall deliberate and vote on such audit functions.

ARTICLE V

OFFICERS

1. OFFICERS OF THE CORPORATION.

(a.) President of the Corporation. The President/CEO of the CORPORATIOIN (hereinafter "President") shall be the President/CEO of the HOSPITAL and shall represent the BOARD of the CORPORATION in all corporate matters not reserved to the BOARD or its Officers by these By-Laws. The President shall be a voting member of the BOARD and of all committees of the BOARD. The President shall be responsible to the BOARD for the planning, organization, programming, and the control, coordination, and execution of all corporate policies and activities. The President shall have the necessary authority to discharge the above responsibilities subject only to such policies as may be adopted or directives issued by the BOARD or the Executive Committee thereof.

(b.) Administrative Officers of the Corporation. The President may appoint such Administrative Officers as may be necessary and desirable to manage adequately and efficiently the operations of the CORPORATION and such other activities of the CORPORATION as may be deemed appropriate by the BOARD. Such Administrative Officers shall include, but not be limited to, an Executive Vice President.

2. OFFICERS OF THE BOARD.

(a.) Officers and Term of Office. The Officers of the BOARD shall be a Chair, Vice Chair, and a Secretary, each of whom shall serve a term of two (2) years. No Officer shall serve more than two (2) consecutive terms.

(b.) Chair. The Chair shall preside at the Annual Meeting and at all regular and special meetings of the BOARD and of the Executive Committee, and shall perform such other duties as pertain to that office. The Chair shall be a voting member of all committees. The Chair may not be an employee of the CORPORATION.

(c.) Vice Chair. In the event of absence or disability of the Chair, the Vice Chair shall assume all of the duties of the Chair.

(d.) Secretary. The Secretary shall be responsible for minutes of the meetings of the BOARD and the Executive Committee.

ARTICLE VI

ELECTIONS

1. TRUSTEES. Trustees shall be elected or reelected at the Annual Meeting of the CORPORATION by a majority of the BOARD. Upon election by the BOARD, the Trustees shall then be approved by the Board of Governors of the HOSPITAL. Members of the Board of Trustees are elected to a three-year (3) term, with the possibility of being elected to serve three (3) additional three-year (3) terms. Should a Trustee resign before a term is completed, a successor may, at any time, be elected by majority vote to serve the remainder of the unexpired term; this newly elected Trustee may serve four (4) full three-year (3) terms in addition to serving the unexpired term.

To provide for a smooth transition from December Annual Meetings to Annual Meetings taking place in the second quarter of the Corporation's fiscal year, one term of each Board Member may be extended by six (6) months.

2. OFFICERS OF THE BOARD. Officers of the BOARD shall be elected at the Annual Meeting of the CORPORATION from among those persons nominated by the Governance Committee and shall serve for a term of two (2) years. No Trustee shall hold the office of Chair for more than two (2) consecutive terms.

ARTICLE VII

MEETINGS

1. ANNUAL MEETING. The Annual Meeting of the Board of Trustees shall be held in the second quarter of each fiscal year. Written notice of the Annual Meeting shall be mailed thirty (30) days in advance thereof to each member of the BOARD. At the Annual Meeting a report regarding activities during the preceding year and the financial status of the CORPORATION for the preceding year shall be submitted by the President or the President's designees.

2. REGULAR MEETINGS. The BOARD shall meet at least annually and may hold such additional meetings as it may set.

3. QUORUMS. A majority shall constitute a quorum for the transaction of all business except for amendments to the By-Laws. Except as otherwise provided by the Not-For-Profit Corporation Law and except as in these By-Laws otherwise provided, the vote of a majority of the Trustees present at the time of the vote, if a quorum is present at such time, shall be the act of the BOARD. All votes of TRUSTEES must be in person or by conference telephone, video or similar communications equipment.

4. MEETINGS. Any TRUSTEE may participate in a meeting of the BOARD or any committee thereof by means of a conference telephone, video, or similar communications equipment allowing all persons participating in such meeting to hear each other at the same time, and allowing each TRUSTEE to participate in all matters before the Board, including, without limitation, the ability to propose, object to, and vote upon a specific action to be taken by the BOARD or Committee.

5. UNANIMOUS WRITTEN CONSENT. Any action required or permitted to be taken by the board or any committee thereof may be taken without a meeting if all members of the BOARD or the committee consent in writing or through electronic means to the adoption of a resolution authorizing such action. The resolution and the written consent or consents shall be filed with the minutes of the proceedings of the BOARD. Such action by written consent shall have the same force and effect as the unanimous vote of the TRUSTEES. Any certificate or other document filed under any provision of law that relates to action so taken shall state that the action was taken by unanimous written consent of the BOARD without a meeting.

6. MINUTES. The minutes of each meeting of the Board of Trustees shall reflect all business conducted, including findings, conclusions, and recommendations.

ARTICLE VIII

COMMITTEES

1. AUTHORITY TO CREATE COMMITTEES. Whenever the BOARD shall consist of five (5) or more members, the BOARD may designate from their number three (3) or more Trustees to constitute an Executive Committee, a Finance Committee, a Governance Committee, an Audit Committee and other Standing Committees. Ad hoc Committees may be created for such special purposes as the BOARD shall deem appropriate. Each committee, to the extent provided in the resolution designating it, shall have the authority of the BOARD with the exception of any authority the delegation of which is prohibited by Section 712 of the Not-For-Profit Corporation Law.

The chairs of committees are encouraged to recommend to the Chair of the BOARD, non-board members who have special knowledge, expertise, and/or experience valuable to any Board committee. The Chair of the BOARD may appoint persons who are not members of the Board to serve on committees, other than the Executive Committee and the Audit Committee, with full voting rights.

2. STANDING COMMITTEES. The Chair of the BOARD shall appoint annually committees as provided below.

(a.) Executive Committee. The voting membership of the Executive Committee shall consist of (i) the Chair, Vice Chair, Secretary, and immediate past Chair of the BOARD, (ii) the President of the CORPORATION, and (iii) the Chairs of the Standing Committees as specified herein. The Executive Vice President of the CORPORATION shall serve as non-voting members. Actions of the Executive Committee are binding on the BOARD and the CORPORATION for matters considered in the normal course of business. If the BOARD meets no more often than annually, the Executive Committee shall meet at least quarterly.

(b.) Finance Committee. There shall be a Finance Committee consisting of a Committee Chair and at least two (2) Trustees at large appointed by the Chair of the BOARD. The CORPORATION'S finance staff shall be non-voting members of the Finance Committee, and shall provide support to the Finance Committee. This Committee shall provide policy direction to the

CORPORATION'S finance staff on the following matters: (i) the discharge of responsibility for management of corporate assets, (ii) the provision of proper trust of endowment funds; and (iii) the receipt and review of reports of investments and income and disbursements of operating funds. The Committee shall receive from the President an annual budget which the Committee shall review, approve, and transmit to the BOARD for its approval no later than at the last full BOARD meeting prior to the beginning of the fiscal period covered by the budget.

(c.) Governance Committee. The Governance Committee shall consist of at least five (5) Trustees. It shall be Chaired by the Vice-Chairman of the Board. The purpose of the Governance Committee shall be to coordinate, evaluate, plan, and design the organizational and governing structure of the Board of Trustees. To fulfill this purpose, the Committee shall:

(1.) Continually seek to identify new potential members and leaders to and for the Board of Trustees.

(2.) Nominate at the Annual Meeting of the Board of Trustees, and at other times as vacancies occur, candidates for Officers in accordance with these By-Laws. The slate of nominations shall be sent with the agenda at least one (1) month prior to the meeting at which the election will occur.

(3.) Be responsible for developing an orderly progression of Officers, particularly the Chairman, to ensure the continuity of leadership of the BOARD.

(4.) Recommend to the BOARD at its Annual Meeting, or at other times as vacancies occur, candidates for membership to the BOARD. Be responsible for evaluating and recommending modifications to these By-Laws.

(5.) Be responsible for the development of an on-going orientation and continuing education program for the Board of Trustees. Be responsible for monitoring BOARD member participation in these programs.

(6.) Set standards for and review the performance of the BOARD and report thereon to members of the BOARD. As part of this, the Committee shall develop a program and procedure for ongoing assessment of the BOARD and Trustee effectiveness.

(d.) Audit Committee. The Audit Committee shall be comprised entirely of Independent Trustees. Independent Trustees are those Trustees who: (a) are not, and have not been within the last three years, an employee of the CORPORATION or an affiliate of the CORPORATION, and do not have a relative who is, or has been within the last three years, a key employee of the

CORPORATION or an affiliate of the CORPORATION; (b) have not received, and do not have a relative who has received, in any of the last three fiscal years, more than $10,000 in direct compensation from the CORPORATION or an affiliate of the CORPORATION; and (c) are not a current employee of or do not have a substantial financial interest in, and do not have a relative who is a current officer of or has a substantial financial interest in, any entity that has made payments to, or received payments from, the CORPORATION for property or services in an amount which, in any of the last three fiscal years, exceeds the lesser of $25,000 or two percent of such entity's consolidated gross revenues. The CORPORATION'S finance staff shall be non-voting members of the Audit Committee, and shall provide support to the Audit Committee. The Audit Committee shall:

(1.) Review and maintain the annual conflict of interest statements of the Trustees.

(2.) Oversee all audit functions, which shall include reviewing with the independent auditor the scope and planning of the audit prior to the audit's commencement; upon completion of the audit, reviewing and discussing with the independent auditor: (A) any material risks and weaknesses in internal controls identified by the auditor; (B) any restrictions on the scope of the auditor's activities or access to requested information; (C) any significant disagreements between the auditor and management; and (D) the adequacy of the corporation's accounting and financial reporting processes; and annually considering the performance and independence of the independent auditor.

3. OTHER COMMITTEES. Other Committees may be appointed by the Chair of the BOARD on a regular, or Ad hoc basis, as deemed necessary.

ARTICLE IX

INDEMNIFICATION

Every Trustee or Officer of the CORPORATION and his or her personal representatives shall be indemnified by the CORPORATION against all costs and expenses reasonably incurred by or imposed upon him or her in connection with any action to which he or she was a party by reason of his or her being a Trustee or Officer, except if he or she was finally adjudicated to have acted in bad faith and to be liable by reason of willful misconduct in the performance of his or her duties as such Trustee or Officer. "Costs and expenses" shall include, but without limiting the generality thereof, attorneys' fees, damages, and reasonable amounts paid in settlement. The CORPORATION is hereby authorized to purchase and maintain insurance for such indemnification of its Trustees and Officers to the maximum extent permitted by law.

ARTICLE X

CORPORATE SEAL

The Corporate Seal, if any, shall be in such form as the Board of Trustees shall prescribe.

ARTICLE XI

TAX YEAR

The Tax Year of the CORPORATION shall be the calendar year.

ARTICLE XII

DISSOLUTION

Subject to and in accordance with the provisions contained in the Not-For-Profit Corporation Law, a majority of the BOARD may petition a court of competent jurisdiction for dissolution of the CORPORATION.

Upon dissolution of the CORPORATION, any assets after the payment of debts shall be turned over to the HOSPITAL as a fund to be held for such specific purposes as the Board of Governors of the HOSPITAL shall direct.

ARTICLE XIII

AMENDMENT OF BY-LAWS AND
CERTIFICATE OF INCORPORATION

By-Laws may be adopted, amended or repealed by the BOARD at any annual, regular or special meeting, provided that the notice of such meeting shall contain a concise statement of the proposed amendments and shall be given at least seven (7) days prior to the scheduled date of such meeting. Any proposed adoption, amendment or repeal of these By-Laws or to the Certificate of Incorporation will not become effective until approved by the Board of Governors of the HOSPITAL.

Two-thirds of the membership of the BOARD shall constitute a quorum for adoption, amendment or repeal of the By-Laws or Certificate of Incorporation and such adoption, amendment or repeal shall be by a vote of two-thirds of those present.

Notwithstanding anything in these By-Laws to the contrary, the provisions of Article II and this Article XIII shall not be amended without the prior written consent of Albany Medical Center, a New York not-for-profit corporation.

ARTICLE XIV

EMERITUS MEMBERSHIP

1. PURPOSES.

   (a.) To recognize long, faithful and especially distinctive service of Glens Falls Hospital Foundation Trustees.

   (b.) To engage retired Glens Falls Hospital Foundation Board of Trustees in the

on-going work of the Foundation and Glens Falls Hospital.

2. STRUCTURE & MEMBERSHIP. The Emeritus category of membership of the Glens Falls Hospital Foundation is an honorary designation to recognize exemplary service, and is a non-voting membership on the Board of Trustees. Election to Emeritus status is by recommendation of the Governance Committee and majority vote of the Glens Falls Hospital Foundation Board of Trustees. There is no term of office or mandatory retirement date. Emeritus Trustees will be invited to attend Foundation meetings, will receive regular updates including advance mailings for meetings of the Glens Falls Hospital Foundation Board of Trustees, and will be invited to special events of/for the Glens Falls Hospital Foundation Board of Trustees.

3. NOMINATIONS. Retired members of the Glens Falls Hospital Foundation Board of Trustees are eligible to participate as Members Emeritus of the Foundation Board.

RESOLUTIONS
of the

BOARD OF TRUSTEES

of
GLENS FALLS HOSPITAL FOUNDATION

April 7, 2022

WHEREAS, Glens Falls Hospital Foundation (the "Foundation") is a supporting corporation of Glens Falls Hospital, its sole member (the "Hospital");

WHEREAS, paragraph 4(a) of the Foundation's Restated Certificate of Incorporation ("Incorporation Certificate") provides that the Foundation is formed to establish and maintain a program to solicit, receive and manage gifts to support the work of the Hospital and related organizations;

WHEREAS, paragraph 4(b) of the Incorporation Certificate authorizes the Foundation to engage in any and all lawful activities incidental to its paragraph 4(a) purpose, but not those activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(v);

WHEREAS, the Board of Trustees of the Foundation (the "Board") deems it reasonable, necessary, desirable, and appropriate, and in the best interests of the Foundation to amend paragraph 4(b) of the Incorporation Certificate to remove activities mentioned in Sections 404(o) and (t) from the activities that the Foundation is excluded from engaging in;

NOW, THEREFORE, IT IS HEREBY RESOLVED THAT:

1. The Board authorizes, subject to approval of the Hospital and Albany Medical Center, that paragraph 4(b) of the Incorporation Certificate be amended to read as follows:

> "To engage in any and all lawful activities incident to the foregoing. Nothing herein shall authorize the corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(n), (p) through (r), (u) or (v)."

2. Each Officer of the Board and the President/CEO of the Foundation, are each hereby designated an "Authorized Officer" of the Foundation for purposes of these resolutions.

3. Each Authorized Officer is hereby authorized, empowered and directed to take all actions necessary to effectuate the amendment of the Incorporation Certificate.

The foregoing resolutions were duly adopted by the Board of Trustees of the Foundation on April 7, 2022.

Secretary

APPROVAL AND CONSENT
OF THE SOLE MEMBER OF
GLENS FALLS HOSPITAL FOUNDATION

Glens Falls Hospital, as the sole member of Glens Falls Hospital Foundation, hereby ratifies, approves, authorizes and consents to the matters and transactions described on Schedule I attached hereto.

This instrument shall become effective as of the 28 day of April, 2022.

Glens Falls Hospital, as the sole member of Glens Falls Hospital Foundation

By: Paul Sarnacki

Title: Interim President/CEO

RESOLUTIONS
of the

BOARD OF TRUSTEES

of
GLENS FALLS HOSPITAL FOUNDATION

April 7, 2022

WHEREAS, Glens Falls Hospital Foundation (the "Foundation") is a supporting corporation of Glens Falls Hospital, its sole member (the "Hospital");

WHEREAS, paragraph 4(a) of the Foundation's Restated Certificate of Incorporation ("Incorporation Certificate") provides that the Foundation is formed to establish and maintain a program to solicit, receive and manage gifts to support the work of the Hospital and related organizations;

WHEREAS, paragraph 4(b) of the Incorporation Certificate authorizes the Foundation to engage in any and all lawful activities incidental to its paragraph 4(a) purpose, but not those activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(v);

WHEREAS, the Board of Trustees of the Foundation (the "Board") deems it reasonable, necessary, desirable, and appropriate, and in the best interests of the Foundation to amend paragraph 4(b) of the Incorporation Certificate to remove activities mentioned in Sections 404(o) and (t) from the activities that the Foundation is excluded from engaging in;

NOW, THEREFORE, IT IS HEREBY RESOLVED THAT:

1. The Board authorizes, subject to approval of the Hospital and Albany Medical Center, that paragraph 4(b) of the Incorporation Certificate be amended to read as follows:

> "To engage in any and all lawful activities incident to the foregoing. Nothing herein shall authorize the corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(n), (p) through (r), (u) or (v)."

2. Each Officer of the Board and the President/CEO of the Foundation, are each hereby designated an "Authorized Officer" of the Foundation for purposes of these resolutions.

3. Each Authorized Officer is hereby authorized, empowered and directed to take all actions necessary to effectuate the amendment of the Incorporation Certificate.

The foregoing resolutions were duly adopted by the Board of Trustees of the Foundation on April 7, 2022.

Secretary

APPROVAL AND CONSENT
OF ALBANY MED HEALTH SYSTEM

Albany Med Health System hereby ratifies, approves, authorizes and consents to the amendment of Paragraph 4(b) of Glens Falls Hospital Foundation's Restated Certificate of Incorporation pursuant to the resolutions of the board of trustees of Glens Falls Hospital Foundation described on Schedule I attached hereto.

This instrument shall become effective as of the 4th day of May, 2022.

Albany Med Health System

By: _____

Title: Pres + CEO

Schedule I

Resolutions of the Board of Trustees of Glens Falls Hospital Foundation
Presented at the April 7, 2022 meeting of the
Glens Falls Hospital Foundation Board of Trustees
(see attached Resolutions)

RESOLUTIONS
of the

BOARD OF TRUSTEES

of
GLENS FALLS HOSPITAL FOUNDATION

April 7, 2022

WHEREAS, Glens Falls Hospital Foundation (the "Foundation") is a supporting corporation of Glens Falls Hospital, its sole member (the "Hospital");

WHEREAS, paragraph 4(a) of the Foundation's Restated Certificate of Incorporation ("Incorporation Certificate") provides that the Foundation is formed to establish and maintain a program to solicit, receive and manage gifts to support the work of the Hospital and related organizations;

WHEREAS, paragraph 4(b) of the Incorporation Certificate authorizes the Foundation to engage in any and all lawful activities incidental to its paragraph 4(a) purpose, but not those activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(v);

WHEREAS, the Board of Trustees of the Foundation (the "Board") deems it reasonable, necessary, desirable, and appropriate, and in the best interests of the Foundation to amend paragraph 4(b) of the Incorporation Certificate to remove activities mentioned in Sections 404(o) and (t) from the activities that the Foundation is excluded from engaging in;

NOW, THEREFORE, IT IS HEREBY RESOLVED THAT:

1. The Board authorizes, subject to approval of the Hospital and Albany Medical Center, that paragraph 4(b) of the Incorporation Certificate be amended to read as follows:

> "To engage in any and all lawful activities incident to the foregoing. Nothing herein shall authorize the corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(n), (p) through (r), (u) or (v)."

2. Each Officer of the Board and the President/CEO of the Foundation, are each hereby designated an "Authorized Officer" of the Foundation for purposes of these resolutions.

3. Each Authorized Officer is hereby authorized, empowered and directed to take all actions necessary to effectuate the amendment of the Incorporation Certificate.

The foregoing resolutions were duly adopted by the Board of Trustees of the Foundation on April 7, 2022.

Secretary

200701000328

RESTATED CERTIFICATE OF INCORPORATION
OF
GLENS FALLS HOSPITAL FOUNDATION

(UNDER SECTION 805 OF THE NEW YORK STATE NOT-FOR-PROFIT CORPORATION LAW)

The undersigned, being the Chief Executive Officer of Glens Falls Hospital Foundation (the "Corporation"), in accordance with Section 805 of the Not-for-Profit Corporation Law of the State of New York ("NPCL"), does hereby certify as follows:

1. The name of the Corporation is Glens Falls Hospital Foundation.

2. The Certificate of Incorporation of the Corporation was filed by the Department of State on March 12, 1996, under Section 402 of the Not-For-Profit Corporation Law of the State of New York.

3. The Certificate of Incorporation is hereby amended to effect the following amendments:

   A. Paragraph THREE of the Certificate of Incorporation, which provides for the corporation's status as a charitable corporation, is hereby amended to read in its entirety as follows:

      "THREE: The corporation shall be a charitable corporation under Section 201 of the Not-For-Profit Corporation Law of the State of New York."

   B. Paragraph SIX of the Certificate of Incorporation, which paragraph sets forth the names and addresses of the initial directors of the Corporation, is hereby omitted in its entirety, as such information is not required to be set forth in a restated certificate of incorporation in accordance with Section 805(c) of the NPCL.

   C. Paragraphs SEVEN, EIGHT and NINE of the Certificate of Incorporation are hereby re-numbered as Paragraphs SIX, SEVEN and EIGHT, respectively.

   D. Paragraph EIGHT(c) of the Certificate of Incorporation (formerly Paragraph NINE(c)), having to do with the dissolution of the Corporation, is hereby amended to read in its entirety as follows:

      "(c) Upon the dissolution, final liquidation, or winding up of the corporation, the Board of Directors shall, subject to any requisite approval and jurisdiction of the Supreme Court of the State of New York, after paying or making provision for the payment of all of the corporation's liabilities, dispose of all of the assets of the corporation exclusively for the purposes of Glens Falls Hospital, or any of Glens Falls Hospital's affiliates as are then organized and

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operated exclusively for the same or similar not-for-profit charitable purposes as shall at the time qualify as exempt organizations under Section 501(c)(3) of the Code (or the corresponding provision of any subsequent federal tax laws), as the Board of Directors shall determine."

E. The following new Paragraph NINE is hereby added to the Certificate of Incorporation:

"NINE: Notwithstanding anything to the contrary in this Certificate of Incorporation, the provisions of Paragraphs FOUR and EIGHT(c) and this Paragraph NINE shall not be amended without the prior written consent of Albany Medical Center, a New York not-for-profit corporation."

4. This Restated Certificate of Incorporation was unanimously authorized by the members of the Board of Directors of the Corporation and the sole member of the Corporation, Adirondack Health Services, Inc.

5. The text of the Certificate of Incorporation of the Corporation, as amended hereby, is restated to read in its entirety as follows:

ONE: The name of the corporation is Glens Falls Hospital Foundation.

TWO: The corporation is a corporation as defined in Section 102(a)(5) of the Not-For-Profit Corporation Law of the State of New York.

THREE: The corporation shall be a charitable corporation under Section 201 of the Not-For-Profit Corporation Law of the State of New York.

FOUR: The corporation is formed for the following reasons and for the following purposes:

(a) To establish and maintain a program to solicit, receive and manage inter vivos and testamentary outright gifts, life income gifts and other split-interest gifts to support the work of the medical, charitable, scientific, research or educational purposes of Glens Falls Hospital and related organizations.

(b) To engage in any and all lawful activities incidental to the foregoing. Nothing herein shall authorize the corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Not-For-Profit Corporation Law, Section 404(b)-(v).

FIVE: The office of the corporation is to be located in Warren County in the State of New York.

SIX: The duration of the corporation is to be perpetual.

SEVEN: The Secretary of State, pursuant to Section 402(a)(6), is hereby designated as agent of the corporation upon whom process against it may be served. The post office address to which the Secretary shall mail a copy of any process against the corporation served upon him is: 100 Park Street, Glens Falls, NY 12801.

EIGHT: For the regulation of the internal affairs of the corporation, it is hereby provided:

(a) No part of the assets, income, profits or net earnings of the corporation shall inure to the benefit of, or be distributable to, its member, directors, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article FOUR hereof. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. Notwithstanding any other provisions of this Certificate of Incorporation, the corporation shall not carry out 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 the corresponding provision of any future United States Internal Revenue law).

(b) The corporation shall, to the extent applicable, comply with the provisions of Section 4947 and 508 of the Internal Revenue Code of 1986 (or the corresponding provisions of any subsequent Federal tax laws), insofar as such sections: (i) Require the corporation to distribute income for each taxable year allocable to charitable purposes in such manner as not to subject the corporation to tax under Section 4942 of the Code; (ii) Prohibit the corporation, its directors, or its members, from engaging in any act of self-dealing as defined in Section 4941 of the Code; (iii) Prohibit the corporation from retaining any excess business holdings as defined in Section 4943 of the Code; (iv) Prohibit the corporation from making investments which jeopardize charitable purposes as specified in Section 4944 of the Code; or (v) Prohibit the corporation from making taxable expenditures as defined in Section 4945 of the Code.

(c) Upon the dissolution, final liquidation, or winding up of the corporation, the Board of Directors shall, subject to any requisite approval and jurisdiction of the Supreme Court of the State of New York, after paying or making provision for the payment of all of the corporation's liabilities, dispose of all of the assets of the corporation exclusively for the purposes of Glens Falls Hospital, or any of Glens Falls Hospital's affiliates as are then organized and operated exclusively for the same or similar not-for-profit charitable purposes as shall at the time qualify as exempt organizations under Section 501(c)(3) of the Code (or the corresponding

provision of any subsequent federal tax laws), as the Board of Directors shall determine.

(d) Nothing contained in this Certificate of Incorporation shall authorize the Corporation to establish or operate a hospital or to provide hospital service or health-related service, or to operate a home care service health agency, a hospice, a health maintenance organization, or a comprehensive health services plan, as provided for by Articles 28, 36, 40 and 44, respectively, of the Public Health Law.

NINE: Notwithstanding anything to the contrary in this Certificate of Incorporation, the provisions of Paragraphs FOUR and EIGHT(c) and this Paragraph NINE shall not be amended without the prior written consent of Albany Medical Center, a New York not-for-profit corporation.

[*Remainder of this page intentionally left blank*]

IN WITNESS WHEREOF this Restated Certificate of Incorporation has been signed and the statements made herein affirmed as true under penalties of perjury this 8th day of June, 2020:

By: Dianne Shugrue
Title: Chief Executive Officer

CERTIFICATE OF AMENDMENT OF THE RESTATED CERTIFICATE OF INCORPORATION OF GLENS FALLS HOSPITAL FOUNDATION

(UNDER SECTION 803 OF THE NOT-FOR-PROFIT CORPORATION LAW)

FILED BY:

ARENTFOX SCHIFF LLP
1301 Avenue of the Americas
New York, NY 10019

CERTIFICATE OF AMENDMENT OF THE RESTATED CERTIFICATE OF INCORPORATION OF GLENS FALLS HOSPITAL FOUNDATION

(UNDER SECTION 803 OF THE NOT-FOR-PROFIT CORPORATION LAW)

The undersigned, being the Interim President/CEO of Glens Falls Hospital Foundation (the "Corporation"), in accordance with Section 803 of the Not-For-Profit Corporation Law of the State of New York (the "Not-For Profit Corporation Law"), does hereby certify as follows:

1. The name of the Corporation is Glens Falls Hospital Foundation.

2 The Restated Certificate of Incorporation of the Corporation was filed by the State of New York Department of State on July 1, 2020 under Section 805 of the Not-For-Profit Corporation Law, restating the Certificate of Incorporation of the Corporation that was filed by the State of New York Department of State on March 12, 1996 under Section 402 of the Not-For-Profit Corporation Law.

3. The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 (Definitions) of the Not-For-Profit Corporation Law.

4. Paragraph FOUR(b) of the Restated Certificate of Incorporation, which provides for the purposes for which the Corporation is formed, is hereby amended to read in its entirety as follows:

> "(b) To engage in any and all lawful activities incidental to the foregoing. Nothing herein shall authorize the corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Not-For-Profit Corporation Law, Sections 404(b) through (n), (p) through (r), (u) or (v)."

5. The above certificate amendment was authorized by the trustees of the Corporation and approved by the board of governors of Glens Falls Hospital (the sole member of the Corporation) and by the directors of Albany Med Health System (the sole member of Glens Falls Hospital) in accordance with each such organization's respective bylaws.

6. The Secretary of State of the State of New York, pursuant to Section 803(a)(6) of the Not-For-Profit Corporation Law, is hereby designated as agent of the Corporation upon whom process against the Corporation may be served. The post office address to which the Secretary of State

shall mail a copy of any process against the Corporation served upon the Secretary is: 100 Park Street, Glens Falls, NY 12801.

[*Remainder of this page intentionally left blank*]

IN WITNESS WHEREOF this Certificate of Amendment of the Restated Certificate of Incorporation of Glens Falls Hospital Foundation has been signed and the statements made herein affirmed as true under penalties of perjury this 16th day of May, 2022:

Paul Scimeca

Name: Paul Scimeca
Title: Interim President/CEO

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 18th day of April 2023 approves the filing of the Certificate of Amendment of the Restated Certificate of Incorporation of Glens Falls Hospital Foundation, Inc., dated June 8, 2020.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 222213-B
Staten Island GSC, LLC d/b/a Ambulatory Surgery Center of Staten Island

Program: **Diagnostic and Treatment Center** ***County:*** **Richmond**
Purpose: **Establishment and Construction** ***Acknowledged:*** **December 14, 2022**

Executive Summary

Description
Staten Island GSC, LLC, an existing limited liability company, requests approval to establish and construct a single specialty ambulatory surgery diagnostic and treatment center (D&TC) whose single specialty is gastroenterology services. Ambulatory Surgery Center of Staten Island will be located on the ground floor of an existing two-story office building at 2043 Richmond Avenue, Staten Island (Richmond County), New York. The primary service area is Richmond County, centered on the zip code 10314, in which the proposed Ambulatory Surgery Center (ASC) will reside.

The proposed members of Staten Island GSC, LLC are as follows:

Alexander Brun, MD.	30%
Igor Grosman, MD.	30%
Staten Island GSC MSO, LLC	40%
	100%

The members of Staten Island GSC MSO, LLC are Alexander Brun, MD. (50%) and Igor Grosman, MD. (50%).

The applicant has been in discussion with Staten Island University Hospital for referral of patients if necessary. Alexander Brun, M.D., will serve as the Medical Director of the Center.

OPCHSM Recommendation
Contingent Approval with an expiration of the operating certificate five years from the date of its issuance.

Need Summary
The applicant projects 7,150 procedures in Year One and 12,711 in Year Three, with Medicaid at 24% and Charity Care at 2% each year.

Program Summary
The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

Financial Summary
The total project cost of $3,742,864 will be met as follows: Equity of $1,042,864 and a bank loan of $2,700,000 at an interest rate of 4.40% for a 10-year term.

Budget	Year One (2025)	Year Three (2027)
Revenues	$4,305,517	$7,657,047
Expenses	3,983,370	5,679,378
Net Income	$322,147	$1,977,669

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of a bank loan commitment that is acceptable to the Department of Health. [BFA]
5. Submission of an executed lease rental agreement that is acceptable to the Department of Health. [BFA]
6. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
7. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
8. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]
9. Submission of a copy of a sublease that is acceptable to The Department. [CSL]
10. Submission of a copy of a Certificate of Assumed Name that is acceptable to The Department. [CSL]
11. Submission of a copy of a Delaware LLC Certificate of Formation of Staten Island GSC MSO LLC that is acceptable to The Department. [CSL]
12. Submission of a copy of an Operating Agreement of Staten Island GSC MSO LLC that is acceptable to The Department. [CSL]
13. Submission of a copy of a Delaware LLC Certificate of Formation or Application for Authority of Staten Island GSC, LLC that is acceptable to The Department. [CSL]
14. Submission of a copy of an Operating Agreement of Staten Island GSC, LLC that is acceptable to The Department. [CSL]

Approval conditional upon:

1. This project must be completed by **January 18, 2025**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **October 18, 2023,** and construction must be completed by **October 18, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]
6. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

Council Action Date

April 18, 2023

Need Analysis

Background and Analysis

The service area is Richmond County. The population of Richmond County in 2021 was 493,494, according to the latest US Census population estimates data, and is estimated to decline slightly to 487,631 by 2028. According to Data USA, in 2020, 95.9% of the population of Richmond County had health coverage as follows:

Employer Plans	56.6%
Medicaid	16.7%
Medicare	12.7%
Non-Group Plans	9.53%
Military or VA	0.336%

Richmond Pain Management ASC is the only operating ASC in Richmond County. The center opened in 2016, and under CON 202093, it was granted approval to convert to a multi-specialty ASC. This center had visits of 4,370 in 2019, 2,897 in 2020, and 2,615 in 2021. Two other ASCs, Specialty Surgery Center of Staten Island (multi-specialty) and Empire Center for Special Surgery (multi-specialty), are approved but not yet operational.

The applicant projects 7,150 procedures in Year One and 12,711 in Year Three with Medicaid at 24% and Charity Care at 2% each year. These projections are based on the current practices of participating surgeons. The applicant states that the procedures moving to the proposed center are currently being performed in an office-based setting. The table below shows the projected payor source utilization for Years One and Three.

	Year One		Year Three	
Payor	**Volume**	**%**	**Volume**	**%**
Commercial FFS	3,861	54.00%	6,864	54.00%
Medicare FFS	858	12.00%	1,525	12.00%
Medicare MC	572	8.00%	1,1017	8.00%
Medicaid FFS	143	2.00%	254	2.00%
Medicaid MC	1,573	22.00%	2,797	22.00%
Charity Care	143	2.00%	254	2.00%

The Center initially plans to obtain contracts with the following Medicaid Managed care plans: Healthfirst PHSP, Health Plus, United Health Care of NY, NYS Catholic Health Plan, and Health Insurance Plans of Greater NY. The Center will work collaboratively with local Federally Qualified Health Centers (FQHC) such as Beacon Christian Community Health Center, Bay Street Health Center, Metro Community Health Center, and Community Health Care of Richmond to provide service to the under-insured in their service area.

Conclusion

Approval of this project will provide increased access to gastroenterology surgery services in an outpatient setting for the residents of Richmond County.

Program Analysis

Project Proposal

Staten Island GSC LLC d/b/a Ambulatory Surgery Center of Staten Island, an existing limited liability company, seeks approval to establish and construct a single specialty freestanding ambulatory surgery center specializing in Gastroenterology to be located at 2043 Richmond Avenue in Staten Island (Richmond County).

Proposed Operator	Staten Island GCS LLC
Doing Business As	Ambulatory Surgery Center of Staten Island
Site Address	2043 Richmond Avenue Staten Island, New York 10314 (Richmond County)
Surgical Specialties	Single Specialty ASC Gastroenterology
Operating Rooms	0
Procedure Rooms	4
Hours of Operation	Monday to Friday, 8:00 am to 6:00 pm The Center will modify the hours or add Saturday, 8:30 am to 6:00 pm, as volume dictates.
Staffing (1st Year / 3rd Year)	9.20 FTEs / 14.20 FTEs
Medical Director(s)	Alexander Brun, MD
Emergency, In-Patient and Backup Support Services Agreement and Distance	Is provided by: Staten Island University Hospital 7.5 Miles / 19 minutes
On-call Service	Patients who require assistance during off-hours will be provided an after-hours contact number so that patients and /or families can make contact with a clinical staff person of the Center.

Character and Competence

The ownership of Staten Island GCS LLC is:

Member Name	Proposed Interest
Alexander Brun, M.D.	**30.00%**
Igor Grosman, D.O.	**30.00%**
Staten Island GSC MSO LLC *Alexander Brun, M.D. (50.00%)* *Igor Grosman, D.O. (50.00%)*	**40.00%**
TOTAL	**100%**

Dr. Alexander Brun is the Director and Physician at Triborough GI, an office-based endoscopy practice, for over one (1) year. He is a Physician at Triborough GI PLLC for over five (5) years. He was a Physician at SLC Associates LLC for three (3) years. He was a Physician at Alexander Brun, P.C. for over one (1) year. He was a Physician at Be Well Primary Health Care Center for over four (4) years. He was a Physician at Century Medical and Dental for two (2) years. He received his medical degree from SUNY Downstate. He completed his Internal Medicine residency at Rutgers Robert Wood Johnson Medical School. He completed his Gastroenterology fellowship at Hofstra North Shore LIJ School of Medicine.

Dr. Igor Grosman is a Physician at Triborough GI for over 13 years. He is the Medical Director at Digestive Disease Diagnostic Treatment Center for over five (5) years. He received his medical degree from the New York College of Osteopathic Medicine. He completed his Internal Medicine residency and Gastroenterology fellowship at North Shore LIJ Hospital. He is board certified in Gastroenterology. Dr. Grosman discloses ownership interest in the following healthcare facilities:
South Brooklyn Endoscopy Center *12/2009-present*

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 will provide services to all patients regardless of payor source. The Applicant plans to reach out to the following FQHCs in their catchment area in an effort to advise them of the services being offered and how those services can be a benefit to the respective FQHCs. Those FQHCs include Bay Street Health Center (part of Sun River Health, Inc.), Community Health Center of Richmond, Inc., Metro Community Health Center, Inc., and Beacon Christian Community Health Center, Inc. The Applicant plans to contract with multiple Medicaid Managed Care Plans, including Health First Health Plan/Healthfirst PHSP, Inc., United Health Care of New York, New York State Catholic Health Plan, Inc., and Health Plus, LLC, Health Insurance Plans of Greater New York.

The Applicant plans to utilize an Electronic Medical Record (EMR) system. The Applicant has not determined if they plan to integrate into a Regional Health Information Organization and/or Health Information Exchange.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Analysis

Total Project Cost and Financing

The total project cost, which is for renovations and the acquisition of moveable equipment, is estimated at $3,742,864 and is further broken down as follows:

Renovation and Demolition	$1,847,016
Design Contingency	92,351
Construction Contingency	92,351
Architect/Engineering Fees	147,761
Other Fees (Consultant)	204,000
Moveable Equipment	1,180,125
Financing Costs	57,017
Interim Interest Expense	99,781
CON Fees	2,000
Additional Processing Fees	20,462
Total Project Cost	$3,742,864

The applicant's financing plan appears as follows:

Equity	$1,042,864
Bank Loan (4.40% interest rate for a ten-year term)	$2,700,000
Total	$3,742,684

Operating Budget

The applicant has submitted an operating budget, in 2023 dollars, for the first and third years, summarized below:

	Year One 2025 Per Procedure	Total	Year Three 2027 Per Procedure	Total
Revenues:				
Commercial FFS	$737.35	$2,846,913	$737.44	$5,061,812
Medicare FFS	$491.57	421,765	$491.74	$749,898
Medicare MC	$491.57	281,177	$493.05	$501,432
Medicaid FFS	$491.57	70,294	$493.54	$125,358
Medicaid MC	$491.57	773,236	$491.53	$1,374,813
Gross Revenues		$4,393,385		$7,813,313
Less Bad Debt		87,868		$156,266
Net Revenues		$4,305,517		$7,657,047
Expenses:				
Operating	$375.97	$2,688,153	$342.39	$4,352,104
Capital	$181.15	$1,295,217	$104.42	$1,327,274
Total Expenses	$557.11	$3,983,370	$446.81	$5,679,378
Net Income		$322,147		$1,977,669
Utilization: (Procedures)		7,150		12,711

The following is noted with respect to the submitted budget:

- Expense assumptions are based on the historical experience of other ambulatory surgery centers in the geographical area. The doctors and referring physicians currently provide services in other areas of New York City, including Brooklyn and the Bronx, and it is factored in some patients may travel to this center for a needed procedure.

- Reimbursement is based on current reimbursement methodologies for ambulatory surgery services.
- The applicant has submitted physician referral letters in support of utilization projections.

Utilization, broken down by payor source, during the first and third years, is summarized as follows:

	Year One 2025	Year Three 2027
Commercial FFS	54.00%	54.00%
Medicare FFS	12.00%	12.00%
Medicare MC	8.00%	8.00%
Medicaid FFS	2.00%	2.00%
Medicaid MC	22.00%	22.00%
Charity Care	2.00%	2.00%
Total	100.00%	100.00%

Lease Rental Agreement

The applicant has submitted a draft sublease agreement for the site that they will occupy, which is summarized below:

Premises	4,024 square feet located at 2043 Richmond Avenue, Staten Island, New York.
Sublessor	Triborough GI, PLLC
Sublessee	Staten Island GSC, LLC
Term	10 years
Rental	$600,000 annually ($149.11 per sq.ft.)
Provisions	The sublessee shall be responsible for real estate taxes, maintenance, and utilities.

The applicant has submitted an affidavit indicating that there is no relationship between the sublessor and the sublessee. The applicant has submitted two real estate letters attesting to the reasonableness of the per-square-foot rental.

Capability and Feasibility

Total project costs of $3,742,864 will be met with $1,042,864 of equity through the proposed members and a bank loan of $2,700,000 at an interest rate of 7% for a ten-year term. In addition, the applicant has submitted a bank letter of interest concerning the financing.

Working capital requirements are estimated at $946,563, equivalent to two months of third-year expenses. The applicant will provide equity through the proposed members' resources to meet the working capital requirement. Presented as BFA Attachment A are the personal net worth statements of the proposed members of Staten Island GSC, LLC, indicating the availability of sufficient funds for their equity contribution. Presented as BFA Attachment B is the pro forma balance sheet of Staten Island GSC, LLC, which indicates a positive net asset position of $1,989,427.

The submitted budget indicates a net income of $322,147 and $1,977,669 during the first and third years, respectively. Revenues are based on current reimbursement methodologies for gastroenterology services. The submitted budget appears reasonable.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BHFP Attachment	Map
BFA Attachment A	Personal Net Worth Statement- Proposed Members
BFA Attachment B	Pro Forma Balance Sheet

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 18th day of April 2023, 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 diagnostic and treatment center for Gastroenterology to be constructed at 2043 Richmond Avenue, Staten 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:
222213 B	Staten Island GSC, LLC d/b/a Ambulatory Surgery Center of Staten Island

APPROVAL CONTINGENT UPON:

Approval with an expiration of the operating certificate five years from the date of its issuance, 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 for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of a bank loan commitment that is acceptable to the Department of Health. [BFA]
5. Submission of an executed lease rental agreement that is acceptable to the Department of Health. [BFA]
6. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
7. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations, and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
8. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include:
    a. Data displaying actual utilization including procedures;
    b. Data displaying the breakdown of visits by payor source;
    c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery;
    d. Data displaying the number of emergency transfers to a hospital;
    e. Data displaying the percentage of charity care provided;
    f. The number of nosocomial infections recorded during the year reported;
    g. A list of all efforts made to secure charity cases; and
    h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]
9. Submission of a copy of a sublease that is acceptable to The Department. [CSL]
10. Submission of a copy of a Certificate of Assumed Name that is acceptable to The Department. [CSL]
11. Submission of a copy of a Delaware LLC Certificate of Formation of Staten Island GSC MSO LLC that is acceptable to The Department. [CSL]

12. Submission of a copy of an Operating Agreement of Staten Island GSC MSO LLC that is acceptable to The Department. [CSL]
13. Submission of a copy of a Delaware LLC Certificate of Formation or Application for Authority of Staten Island GSC, LLC that is acceptable to The Department. [CSL]
14. Submission of a copy of an Operating Agreement of Staten Island GSC, LLC that is acceptable to The Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. This project must be completed by **January 18, 2025**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **October 18, 2023,** and construction must be completed by **October 18, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date, this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]
6. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. Department of Health

Public Health and Health Planning Council

Project # 221123-E
Community Inclusion, Inc. d/b/a TRC Community Health Center of Western New York

Program:	**Diagnostic and Treatment Center**	***County:***	**Chautauqua**
Purpose:	**Establishment**	***Acknowledged:***	**December 5, 2022**

Executive Summary

Description

Community Inclusion Inc. d/b/a TRC Community Health Center of Western NY, a New York-based not-for-profit corporation, is seeking approval to become the operator of two extension clinics and a school-based extension clinic currently operated by the Chautauqua County Chapter of NYSARC serving the developmentally disabled community. The extension clinics are located at 890 East Second Street, Jamestown, and 186 Lakeshore Drive West, Dunkirk. The Jamestown site will be certified for Medical Services-Primary Care, Dental O/P, and Podiatry O/P. The Dunkirk site will be certified for Dental O/P and Podiatry O/P services. The school-based clinic will be certified for School-Based Health and Dental services.

Community Inclusion, Inc. was originally incorporated in 1999 as a Community Housing Development Organization (CHDO). The Certificate of Incorporation will be amended to change the purpose from that of a CHDO to a purpose consistent with the operation of a federally qualified health center look-a-like (FQHC LAL), a designation Community Inclusion will pursue once operational.

Adnan Munir, M.D., will serve as the Center's Medical Director. The applicant will have an Affiliation Agreement for backup and emergency services with UPMC Chautauqua, located 1.2 miles (3 minutes travel time) from the Center.

OPCHSM Recommendation

Contingent Approval

Need Summary

The number of projected visits for both sites combined is 19,172 in Years One and Three, with Medicaid utilization projected at 54.75%.

Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

Financial Summary

There are no project costs or compensation associated with this application.

Budget:	Year One 2023	Year Three 2025
Revenues	$3,617,385	$3,760,465
Expenses	$3,558,925	$3,699,083
Net Income/(Loss)	$58,460	$61,382

Recommendations

Health Systems Agency

There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management

Approval contingent upon:

1. Submission of an executed lease at 880-896 East Second Street, acceptable to the Department of Health. [BFA]
2. Submission of an executed lease at 186 Lake Shore Drive, acceptable to the Department of Health. [BFA]
3. Submission of an executed facilities uses agreement at 350 East Second Street, acceptable to the Department of Health. [BFA]
4. Submission of an executed Services Agreement acceptable to the Department of Health. [BFA]
5. Submission of a photocopy of the lease for the property located at 186 Lake Shore Drive, acceptable to the Department. [CSL]
6. Submission of a photocopy of the lease for the property located at 890 East 2nd Street, Jamestown, acceptable to the Department. [CSL]
7. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital for the Jamestown and Dunkirk sites. [HSP]

Approval conditional upon:

1. This project must be completed by **one year from the date of this letter**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
3. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]

Council Action Date

April 18, 2023

Need Analysis

Background and Analysis

The service area is Chautauqua County. The population of Chautauqua County in 2021 was 126,807, according to the latest US Census data, and is projected to decrease to 121,953 by 2028. According to Data USA, in 2020, 94.5% of the population in Chautauqua County had health coverage as follows:

Employer Plans	43.8%
Medicaid	22.3%
Medicare	14.4%
Non-Group Plans	12.3%
Military or VA	1.6%

The number of projected visits for both sites combined is 19,172 in Years One and Three. The table below shows the payor utilization for Years One and Three.

Projected Payor Mix		
Payor	**Year One**	**Year Three**
Medicaid FFS	11.27%	11.27%
Medicaid MC	43.47%	43.47%
Commercial	13.19%	13.19%
Medicare FFS	20.58%	20.58%
Medicare MC	5.12%	5.12%
Private Pay/Other	6.37%	6.37%

TRC Community Health Center was originally established to meet the unique needs of TRC's core population, individuals with intellectual and developmental disabilities, who have been underserved by existing providers. With this project, NYSARC, Inc. d/b/a The Resource Center is planning to convert portions of their existing Article 28 clinics to an entity that would qualify for Federally Qualified Health Center look-alike status. Health-Related services (such as physical therapy, occupational therapy, and speech-language pathology services will continue to be provided by NYSARC. NYSARC will transfer the school-based program at Jamestown High School to Community Inclusion as well. Both proposed extension clinics are in a Health Professional Shortage Area for Primary Care as well as for Dental Care and a Medically Underserved Area.

Conclusion

Approval of this project allows TRC Community Health Center of Western NY to provide primary care, dental, and podiatry services to individuals with developmental disabilities within Chautauqua County.

Program Analysis

Project Proposal

Community Inclusion, Inc. d/b/a TRC Community Health Center of Western New York seeks approval to become the new operator of the Article 28 Diagnostic and Treatment Centers located at 890 East 2nd Street in Jamestown (Chautauqua County) from its previous operator Chautauqua County Chapter of NYSARC, Inc d/b/a The Resource Center. The applicant also wishes to certify a new extension clinic to be located at 186 Lakeshore Drive in Dunkirk (Chautauqua County). Upon approval of the project, Community Inclusion, Inc. will qualify for FQHC look-alike status. The health-related services of PT, OT, and SLP will continue to be provided by Community Inclusion, Inc. under the Article 28 license. There will be no change in services at the main site. The extension site will be certified to provide Dental O/P and podiatry. Upon approval of the project, the extension site will be named TRC Community Health Center.

Proposed Operator	Community Inclusion, Inc.
Doing Business As	TRC Community Health Center of Western Center
Site Address	Main Site: 890 East 2nd Street Jamestown, New York 14701 (Chautauqua County) Extension Site: 186 Lakeshore Drive Dunkirk, New York 14048 (Chautauqua County)
Shift/Hours/Schedule	Jamestown Site: 8 am to 4:30 pm Dunkirk Site: 8 am to 4:30 pm
Approved Services	Main Site: Medical Services-Primary Care Dental O/P Podiatry O/P Extension Site: Dental O/P Podiatry O/P
Staffing (1st Year/3rd Year)	76.2 FTES/76.2 FTEs
Medical Director	Adnan Munir, MD
Emergency, In-Patient and Backup Support Services Agreement and Distance	Is expected to be provided by Jamestown Site-UPMC Chautauqua, 1.2 mile/3 min Dunkirk site-Brooks TLC Hospital System, 1.1 miles/4 min

Character and Competence

The proposed members of Community Inclusion, Inc. are:

Member Name	Board Office Held
Todd Jacobson, M.D.	Treasurer
Richard Erickson	Vice President
Patricia Perlee	President
Dawn Columbare	Secretary

Dr. Adnan Munir is the proposed Medical Director. He is a Primary Care Physician at The Resource Center for over 14 years. He is the Medical Director of LSS Nursing Home for over 16 years. He was a Primary Care Physician at WCA Hospital for over nine (9) years. He received his medical degree from the Universidad Tech De Santiago School of Medicine in the Dominican Republic. He completed his Internal Medicine Residency at the Hoboken University Medical Center. He is Board Certified in Internal Medicine.

Dr. Todd Jacobson is an Occupational Health Physician at UPMC Chautauqua for over 38 years. He is the Occupational Health Director for over 28 years. He was the Interim Hospital Medical Director of WCA Hospital for one (1) year. He was a part-time Physician at The Resource Center Clinic for three (3) years.

He was an Internal Medicine Physician in private practice for 10 years. He received his medical degree from SUNY Buffalo. He completed his Internal Medicine Residency at Millard Fillmore Hospital.

Dawn Columbare is a Nursing Education Consultant for seven (7) years. She assists community colleges in achieving national nursing accreditation. The colleges she has contracts with are New River Community College and Virginia Western College. She was the Director of Nursing and a Professor of Nursing at Jamestown Community College for 16 years.

Richard Erickson is the Director of Accounting at the Chautauqua Institution-Ames Avenue for over 17 years. He oversees the accuracy and regulatory compliance of financial operations. He facilitates strategic planning, develops financial policies and procedures, and manages all aspects of the budgetary process. He has also served on the Advisory Committee of the Southwest Chapter of the American Red Cross.

Patricia Perlee retired in 2011. She was the Executive Director of the Joint Neighborhood Project for six (6) years. She was a Case Manager of Independent Health for seven (7) years. She was responsible for the care management of the members enrolled in all commercial and Medicare insurance plans in three counties in Western New York. She identified and managed high-risk and high-cost members to desired outcomes and implemented case management for members requiring out-of-area care. She ensured proper care by conducting reviews of medical records and the appropriateness and continued stay of hospitalized members. She was a Branch Manager at the VNA Healthcare Group for 10 years. She was responsible for all aspects of the interdisciplinary home health care support services team. She managed up to 100 RNs, LPNs, and HHCAs. She handled all aspects of recruitment, staff training, in-service program delivery, performance reviews, and disciplinary procedures. She also assisted with the development of the operating budget.

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.

Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Analysis

Operating Budget

The applicant has provided 2022 current-year results and first and third-year operating budgets in 2023 dollars, summarized as follows:

	Current Year 2022		Year One 2023		Year Three 2025	
Revenues:	Per Visit	Total	Per Visit	Total	Per Visit	Total
Medicaid-FFS	$276.62	$410,226	$138.86	$299,930	$144.75	$312,659
Medicaid-MC	$107.46	464,224	$138.88	1,157,737	$144.78	1,206,872
Medicare-FFS	$82.06	278,096	$89.47	353,042	$93.08	367,305
Medicare-MC	$101.71	114,928	$96.63	94,794	$100.53	98,624
Commercial-FFS	$158.46	291,246	$162.47	410,735	$172.37	435,749
Private Pay	$152.75	105,551	$218.21	266,436	$231.50	282,662
Other Operating Revenue		697,299		1,073,450		1,097,152
Bad Debt		-48,735		-38,739		-40,558
Total		$2,312,835		$3,617,385		$3,760,465
Expenses:						
Operating	$236.77	$3,042,720	$174.28	$3,341,276	$181.32	$3,476,263
Capital	$23.43	301,123	$11.35	217,649	$11.62	222,820
Total	$260.20	$3,343,843	$185.63	$3,558,925	$192.94	$3,699,083
Net Income (Loss)		($1,031,008)		$58,460		$61,382
Total Visits		12,851		19,172		19,172
Cost per Visits		$260.20		$185.63		$192.94

* *Current Year Other Operating Revenues include a D&TC Medicaid enhancement of $228,029, Federal & State Grants of $335,186, and Other Income of $134,084. Year One Other Operating Revenue includes a D&TC Medicaid enhancement of $259,181, Federal & State Grants of $550,186, Other Income of $134,084, and Medical Oversight of Resource Center revenue of $130,000. Year Three Other Operating Revenues include similar revenue sources as Year One.*

The following is noted with respect to the submitted budget:

- Current year utilization was based on actual visits from January through November 2022 and then annualized for an entire year. For the first and third years, utilization was based on the average of 2020-2022, plus an increase in dental units.
- Medicaid rate for the first year was based on the prospective payment system (PPS) rate from NYSARC's 2021 AHCF report. Annual increases of 2.1% are based on DOH's 2022 Medicare Economic Index (MEI). Medicaid Managed Care was increased by 2% each year based on the average 2020-2022 rate.
- The Medicare rate was increased by 2% each year based on the average 2020-2022 rate.
- Commercial and Private rates were increased by 3% each year based on the average 2020-2022 rate.
- Salaries were projected based on budgeted FTEs and salaries for 2022 plus 2%. Benefits were in relation to payroll expenses. The other costs were based on actuals adjusted for utilization plus 2% per year.
- Rent expense based on lease obligations.

Utilization broken down by payor source for the Current, Year One, and Year Three is as follows:

	Current Year 2021		Year One 2023		Year Three 2025	
Payor:	Visits	%	Visits	%	Visits	%
Medicaid-FFS	1,483	11.54%	2,160	11.27%	2,160	11.27%
Medicaid-MC	4,320	33.62%	8,336	43.47%	8,336	43.47%
Medicare-FFS	3,389	26.37%	3,946	20.58%	3,946	20.58%
Medicare-MC	1,130	8.79%	981	5.12%	981	5.12%
Commercial-FFS	1,838	14.30%	2,528	13.19%	2,528	13.19%
Private Pay*	691	5.38%	1,221	6.37%	1,221	6.37%
Total	12,851	100%	19,172	100%	19,172	100%

** Charity Care is included in Private/Self Pay, where sliding fee scale patients are reported.*

The applicant has submitted an affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement, or understanding between the applicant and transferor to the contrary, to be liable for any Medicaid overpayments made to the facility and surcharges, assessments, or fees due from the Seller under Article 28 of the Public Health Law concerning the period before the applicant acquiring its interest, without releasing the Seller of its ability and responsibility. As of February 1, 2023, the facility had no outstanding Medicaid audit liabilities or assessments.

Lease Agreements

The applicant has submitted two draft lease agreements; the terms are summarized below:

Lease Agreement #1

Premises:	7,028 sq. ft. located at 880-896 East Second Street, Jamestown, NY
Landlord:	Chautauqua Resources, Inc.
Lessee/Tenant:	Community Inclusion, Inc.
Term:	15 years, renewal two (2), 5-year term
Rental:	$92,000 per year ($13.09 per sq. ft.) 2% yearly increase
Provisions:	Tenant will be responsible for maintenance, utilities, insurance, and real estate taxes.

The applicant has provided an affidavit stating that the lease is a non-arms-length arrangement. Two letters from NYS licensed realtors have attested that the rental rate is fair market value.

The applicant has submitted a draft lease agreement; the terms are summarized below:

Lease Agreement #2

Premises:	2,507 sq. ft. located at 186 Lakeshore Drive West, Dunkirk
Landlord:	Chautauqua County Chapter of NYSARC, Inc.
Lessee/Tenant:	Community Inclusion, Inc
Term:	15 years, renewal two (2), 5-year term
Rental:	$36,000 per year ($14.36 per sq. ft.) – 2% yearly increase
Provisions:	Tenant will be responsible for maintenance, utilities, insurance, and real estate taxes.

The lease is a non-arms-length arrangement. Two letters from NYS licensed realtors have attested that the rental rate is fair market value.

Facilities Use Agreement

The applicant has submitted a draft Facilities Use Agreement; the terms are summarized below:

Premises:	Space in Jamestown High School at 350 East Second Street, Jamestown, NY 14701
Grants right to use:	Jamestown City School District
Recipient of the right to use	Community Inclusion, Inc.
Term:	Three (3) years
Payment:	$1

Services Agreement

The applicant has submitted a draft services agreement; the terms are summarized below:

Facility:	Community Inclusion, Inc.
Contractor:	Chautauqua County Chapter of NYSARC, Inc
Services Provided:	Oversight for finance and accounting, purchasing, risk management, and employee benefits coordination. Oversight to ensure compliance with laws and regulations. Oversight of Privacy Programs. Provide legal advice. Assist with information systems. Assist with payroll, accounts payable, budgets, and fiscal filings. Assist human resources. Provide housekeeping and property maintenance.
Term:	One (1) year
Fee:	Chief Finance Officer $2,800 per month, Chief Compliance Officer tracked at $100 per hour; Chief Privacy Officer tracked at $55 per hour, General Counsel tracked at $100 per hour, Employee Benefit Coordination tracked at $80 per hour, Information Systems $8,500 per month, Property and Risk Management at $1,400 per month, Maintenance tracked at $75 per hour, Payroll and accounting at $25,000 per month, and Staff training tracked at $80 per hour.

The applicant has submitted an executed attestation stating that the applicant understands and acknowledges that there are powers that must not be delegated, the applicant will not willfully engage in any illegal delegation, and understands that the Department will hold the applicant accountable.

Capability and Feasibility

There are no project costs or compensation associated with this application. According to the Chief Operating Officer of the Chautauqua County Chapter of NYSARC, Inc., they will support Community Inclusion, Inc., from start-up until profitability via a $1M line of credit. The terms are 3.25% (first-year interest only) with a five-year amortization period. BFA Attachment A, Chautauqua County Chapter of NYSARC, Inc's September 30, 2022, Financial Statements showed $12.3M in working capital with a 1.94 current ratio. According to the cash flow analysis, the need for $500 thousand occurs in the first three months of operation, with repayment starting in the twelfth month, as seen in BFA Attachment B.

Working capital is estimated at $616,514 based on two months of third-year expenses. BFA Attachment C presents Community Inclusion, Inc.'s pro-forma balance sheet showing operations will start with $962,203 in equity. The submitted budget projects a net income of $58,460 in the first year and $61,382 in the third year. The proposed budget is reasonable.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

Attachments

BFA Attachment A	Chautauqua County Chapter of NYSARC, Inc., September 30, 2022, Financial Statements
BFA Attachment B	Community Inclusion, Inc, Cash Flow Analysis
BFA Attachment C	Community Inclusion, Inc, Pro Forma Balance Sheet
BFA Attachment D	Community Inclusion, Inc., Post-Transaction Organization Chart

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 18th day of April 2023, 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 Community Inclusion, Inc. as the operator of an extension clinic currently operated by NYSARC, Inc. at 890 East 2nd Street, Jamestown, and certify a new extension clinic at 186 Lakeshore Drive West, Dunkirk - Safety Net, 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:
221123 E	Community Inclusion, Inc. d/b/a TRC Community Health Center of Western New York

APPROVAL CONTINGENT UPON:

1. Submission of an executed lease at 880-896 East Second Street, acceptable to the Department of Health. [BFA]
2. Submission of an executed lease at 186 Lake Shore Drive, acceptable to the Department of Health. [BFA]
3. Submission of an executed facilities uses agreement at 350 East Second Street, acceptable to the Department of Health. [BFA]
4. Submission of an executed Services Agreement acceptable to the Department of Health. [BFA]
5. Submission of a photocopy of the lease for the property located at 186 Lake Shore Drive, acceptable to the Department. [CSL]
6. Submission of a photocopy of the lease for the property located at 890 East 2nd Street, Jamestown, acceptable to the Department. [CSL]
7. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital for the Jamestown and Dunkirk sites. [HSP]

APPROVAL CONDITIONAL UPON:

1. This project must be completed by **one year from the date of this letter**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
3. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON.*

NEW YORK STATE OF OPPORTUNITY. | Department of Health

MEMORANDUM

To: Colleen Leonard, Executive Secretary
Public Health and Health Planning Council

From: Mark A. Schweitzer, Associate Attorney
Bureau of Program Counsel
Division of Legal Affairs

Date: March 15, 2023

Subject: Proposed Dissolution of St. Teresa's Nursing Home, Inc.

Please include this matter on the next Establishment and Project Review Public Health and Health Planning Council agenda.

The attachments relating to the matter include the following:

1) A Memorandum to the Public Health and Health Planning Council from Kathy Marks, General Counsel;

2) Letter from applicant's consultant requesting approval of the proposed Certificate of Dissolution of St. Teresa's Nursing Home, Inc.;

3) An executed, proposed Certificate of Dissolution and Plan of Dissolution of St. Teresa's Nursing Home, Inc.;

4) The Resolution of the Board of Trustees of St. Teresa's Nursing Home, Inc., approving and authorizing the dissolution;

5) The Resolution of the Board of Trustees of Catholic Health Care System, the sole member of St. Teresa's Nursing Home, Inc., approving and authorizing the dissolution;

6) The Resolution of the Board of Trustees of Providence Health Services, the sole member of Health Care System, approving and authorizing the dissolution

7) Certificate of Incorporation of St. Teresa's Nursing Home, Inc., dated January 30, 1968, Certificate of Amendment of Certificate of Incorporation dated June 18,1987, and associated corporate documents and consents.

8) The Amended and Restated Bylaws of St. Teresa's Nursing Home, Inc., adopted June 25, 2008.

9) A proposed verified petition seeking the Attorney General's approval of the filing of the Certificate of Dissolution of St. Teresa's Nursing Home, Inc.

Attachments.

NEW YORK STATE OF OPPORTUNITY. Department of Health

MEMORANDUM

To: Public Health and Health Planning Council

From: Kathy Marks, General Counsel

Date: March 15, 2023

Subject: Proposed Dissolution of St. Teresa's Nursing Home, Inc.

St. Teresa's Nursing Home, Inc. requests Public Health and Health Planning Council ("PHHPC") approval of its proposed dissolution in accordance with the requirements of Not-For-Profit Corporation Law § 1002(c) and § 1003, as well as 10 NYCRR Part 650.

St. Teresa's Nursing Home, Inc. is a New York not-for-profit corporation that received approval from the New York State Department of Social Services to establish and operate an Article 28 facility on December 19, 1967, and filed its Certificate of Incorporated on January 30, 1968. A Restated Certificate of Incorporation to enlarge the corporate purposes, to establish and operate a diagnostic and treatment center to provide for Comprehensive Outpatient Rehabilitation Facility Services (CORF), was approved by the Public Health Council on April 8, 1988.

St. Teresa's Nursing Home, Inc. was the licensed operator of a Nursing Home located at 120 Highland Avenue in the City of Middletown, NY, County of Orange, until January 31, 2013, when it transferred its operations and assets to HRNC Operating, LLC, d/b/a Highland Rehabilitation and Nursing Center, as approved in Certificate of Need Application Number 121103. Because St. Teresa's Nursing Home, Inc. has ceased operations and gone dormant, its Board of Trustees and the Boards of Trustees of its member believe it is in the best interests of St. Teresa's Nursing, Inc. to dissolve. St. Teresa's Nursing Home, Inc. has no assets or liabilities.

The Board of Trustees of St. Teresa's Nursing Home, Inc. approved and authorized dissolution and authorized the filing of the Certificate of Dissolution on September 27, 2021. The Board of Trustees of Catholic Health Care System, as sole corporate member of St. Teresa's Nursing Home, Inc., approved and authorized the dissolution of St. Teresa's Nursing Home, Inc. on September 27, 2021. The Board of Trustees of Providence Health Services, as sole corporate member of Catholic Health Care System, approved and authorized the dissolution of St. Teresa's Nursing Home, Inc. on December 14, 2021.

The required documents: a proposed Verified Petition to the Attorney General, a Plan of Dissolution, and a proposed Certificate of Dissolution, with supporting organizational documents of St. Teresa's Nursing Home, Inc. and resolutions of the board of trustees of St. Teresa's Nursing Home, Inc., the board of trustees of Catholic Health Care System, as the sole corporate member of St. Teresa's Nursing Home, Inc., and the board of trustees of Providence Health Services, as the sole corporate member of Catholic Health Care System, authorizing the dissolution, are included for PHHPC's review. A letter from the consultant for St. Teresa's Nursing Home, Inc. advocating for dissolution, is also enclosed.

There is no legal objection to the proposed Verified Petition, Plan of Dissolution, and the Certificate of Dissolution.

Attachments.

White Plains Unit
Frank M. Cicero
Charles F. Murphy, Jr.
James Psarianos
Michael D. Ungerer
Noelia Chung
Brian Baldwin
Michael F. Cicero
Karen Dietz
Evelyn Branford
Michael C. Maiale
Patrick Clemente

Cicero Consulting Associates
VCC, Inc.

925 Westchester Ave. · Suite 201 · White Plains, NY 10604
Tel: (914) 682-8657 · Fax: (914) 682-8895
cicero@ciceroassociates.com

Albany Unit
William B. Carmello
Joseph F. Pofit
Albert L. D'Amato
Mark Van Guysling
Rosemarie Porco
Daniel Rinaldi, Jr.
Mary Ann Anglin

Emeritus Consultants
Nicholas J. Mongiardo
Joan Greenberg
Martha H. Pofit
Frank T. Cicero, M.D.
Rose Murphy

Michael P. Parker, Sr.
(1941-2011)
Anthony J. Maddaloni
(1952-2014)

January 24, 2022

Ms. Colleen M. Leonard, Executive Secretary
Public Health and Health Planning Council
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1805
Empire State Plaza
Albany, New York 12237

RE: Dissolution of St. Teresa's Nursing Home, Inc.

Dear Ms. Leonard:

On behalf of our client, St. Teresa's Nursing Home, we are writing to seek approval from the Public Health and Health Planning Council (PHHPC) for the dissolution of St. Teresa's Nursing Home, which is a New York State not-for-profit corporation whose Amended Certificate of Incorporation was approved by PHHPC on August 25, 2006. In 2013, the assets of St. Teresa's Nursing Home, until that time a certified nursing home, were transferred to a new owner/operator. St. Teresa's Nursing Home has no assets or liabilities and has been financially dormant for a number of years. St. Teresa's Nursing Home hopes to formally dissolve as soon as possible.

In furtherance of this request, please find the following documents:

1. Proposed Certificate of Dissolution;
2. Restated Certificate of Incorporation;
3. Amended and Restated Bylaws; and
4. Board Resolutions authorizing the dissolution.

Please feel free to call me if you require other information. Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero

Frank M. Cicero

cc: Sarah D. Strum, Esq., Senior Vice President of Compliance, ArchCare

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of the Archdiocese of New York

CERTIFICATE OF DISSOLUTION

OF

ST. TERESA'S NURSING HOME, INC.

Under Section 1003 of the Not-for-Profit Corporation Law

1) The name of this corporation is St. Teresa's Nursing Home, Inc.

2) The Certificate of Incorporation of St. Teresa's Nursing Home, Inc. was filed by the Department of State of the State of New York on January 30, 1968.

3) The names and addresses of each of the officers and directors of the corporation are as follows:

Francis J. Serbaroli, Chairman- One Vanderbilt Avenue, New York, NY 10017
Thomas E. Alberto- 35 Prospect Park West Apt. 13A Brooklyn, NY 11215
Steve Bujno – 246 West End Avenue, Apt 4A, New York, NY 10023
John Cahill- 1011 First Avenue 20th Floor New York, NY 10022
Dr. Tara A. Cortes- 433 First Avenue, 5th Floor New York, NY 10016
John T. Dunlap- 230 Park Avenue 21st Floor New York, NY 10177
Monsignor Charles J. Fahey- Nottingham, 1301 Nottingham Rd, Jamesville, NY 13078
Thomas J. Fahey, Jr., M.D.- 300 East 66th Street New York, NY 10065
Eric P. Feldmann- 16 Hampshire Road Rockville Centre, NY 11570
Sister Seline Flores, Providence Rest, 3304 Waterbury Avenue, Bronx, NY 10465
John Gleason, 250 Park Avenue, New York, NY 10017
Karen Gray- 235 East 45th Street New York, New York 10017
George Irish- 300 West 57th Street, 26th Floor New York, NY 10019
Clarion E. Johnson, MD- 5504 Dorset Avenue Chevy Chase, Maryland 20815
Rory Kelleher- 1165 Fifth Avenue New York, NY 10029
Monsignor Joseph LaMorte- 1011 First Avenue, 19th Floor New York, NY 10022
Scott LaRue, ex-officio- 205 Lexington Avenue New York, NY 10016
Thomas M. O'Brien, Vice-Chair- PO Box 2326 Bonita Springs FL. 34133
Kathryn Rooney- 1475 Hylan Boulevard Staten Island, NY 10305
Joseph Saporito, 43 Somerset Place, Matawan, NJ 07747
G.T. Sweeney- 100 Church Street New York, NY 10007
Gennaro (Jerry) Vasile, Ph.D., 21908 Masters Circle Estero, FL 33928-6949
Bishop Gerald Walsh- 1011 First Avenue New York, NY 10022

4) The corporation is a charitable corporation.

5) At the time of authorization of the corporation's Plan of Dissolution as provided in Not-for-Profit Corporation Law §1002, the corporation holds no assets which are legally required to be used for a particular purpose.

6) The corporation elects to dissolve.

7) Dissolution of the corporation was authorized by the majority vote of the board of directors, followed by two-thirds vote of the members.

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8) Prior to the delivery of the Certificate of Dissolution to the Department of State for filing the Plan of Dissolution was approved by the Attorney General. A copy of the approval of the Attorney General is attached.

X Frank Serbaroli
5B87D899CB31C2DE11E9FC57F917FEAC contractworks
(Signature)

Frank Serbaroli
(Print or Type Name of Signer)

Chairman of the Board of Directors
(Capacity of Signer)

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of the Archdiocese of New York

Plan of Dissolution

Of

St. Teresa's Nursing and Rehabilitation Center

The Board of Trustees of St. Teresa's Nursing and Rehabilitation Center, The Board of Trustees of Catholic Health Care System and Providence Health Services have all considered the advisability of voluntarily dissolving the corporation and have determined that dissolution is in the best interest of the corporation.

1. The Corporation has no assets or liabilities.

2. In addition to Attorney General approval, the following governmental approvals of the Plan are required and copies of the approvals will be attached to the Verified Petition submitted to the Attorney General.

   New York State Public Health and Health Planning Council

3. A Certificate of Dissolution shall be signed by an authorized director or officer and all required approvals shall be attached thereto.

Francis J. Serbaroli
Chair

September 27, 2021
Date

RESOLUTION OF THE

BOARD OF TRUSTEES

OF

ST. TERESA'S NURSING AND REHABILITATION CENTER

(Dissolution of St. Teresa's Nursing and Rehabilitation Center)

WHEREAS, St. Teresa's Nursing and Rehabilitation Center (the "Corporation" or "Nursing Home") is a not-for-profit corporation organized and existing under the Not-for-Profit Corporation Law and Article 28 of the Public Health Law of the State of New York.

WHEREAS, St. Teresa's Nursing and Rehabilitation Center previously operated a Nursing Home located at 120 Highland Avenue Middletown, NY 10940. St. Teresa's Nursing and Rehabilitation Center last operated on or about January 31, 2013, when it was transferred to The Highland Rehabilitation and Nursing Center and currently has no assets or liabilities.

WHEREAS, the Board of Trustees of St. Teresa's Nursing and Rehabilitation Center have considered the advisability of voluntarily dissolving the corporation.

WHEREAS, pursuant to Article III of St. Teresa's Nursing and Rehabilitation Center's bylaws, St. Teresa's Nursing and Rehabilitation Center shall make a recommendation to Catholic Health Care System and to Providence Health Services with respect to any dissolution for the Nursing Home.

WHEREAS, the Board of Trustees of St. Teresa's Nursing and Rehabilitation Center after due consideration, have deemed it advisable and in the best interests of the Corporation to approve and recommend for approval to the Catholic Health Care System Board of Trustees and Providence Health Services a Plan of Dissolution and authorize the filing of a Certificate of Dissolution with the New York State Department of State subject to the approval of the Attorney General of the State of New York, and any other necessary governmental authority, to dissolve.

NOW THEREFORE, BE IT:

RESOLVED, that the Corporation shall dissolve voluntarily; and it is further

RESOLVED. that the Board of Trustees of St. Teresa's Nursing and Rehabilitation Center hereby approves and recommends for approval to the Catholic Health Care System Board of Trustees and Providence Health Services the dissolution of St. Teresa's Nursing and Rehabilitation Center; and it is further

RESOLVED, that the Board of Trustees of St. Teresa's Nursing and Rehabilitation Center hereby approves and recommends for approval to the Catholic Health Care System Board of Trustees and Providence Health Services the Plan of Dissolution in the form attached hereto and the authorizing of the filing of a Certificate of Dissolution with the New York State Department

of State subject to the approval of the Attorney General of the State of New York, and any other necessary governmental authority, to dissolve.

Adopted at a duly noticed meeting of the St. Teresa's Nursing and Rehabilitation Center Board of Trustees on September 27, 2021.

Francis J. Serbaroli
Chair

RESOLUTION OF THE

BOARD OF TRUSTEES

OF

CATHOLIC HEALTH CARE SYSTEM

(Dissolution of St. Teresa's Nursing and Rehabilitation Center)

WHEREAS, St. Teresa's Nursing and Rehabilitation Center (the "Corporation" or "Nursing Home") is a not-for-profit corporation organized and existing under the Not-for-Profit Corporation Law and Article 28 of the Public Health Law of the State of New York.

WHEREAS, St. Teresa's Nursing and Rehabilitation Center previously operated a Nursing Home located at 120 Highland Avenue Middletown, NY 10940. St. Teresa's Nursing and Rehabilitation Center last operated on or about January 31, 2013, when it was transferred to The Highland Rehabilitation and Nursing Center and currently has no assets or liabilities.

WHEREAS, the Board of Trustees of St. Teresa's Nursing and Rehabilitation Center has approved and recommended for approval to the Catholic Health Care System Board of Trustees for the voluntarily dissolution of the corporation and have determined that dissolution is in the best interest of the corporation.

WHEREAS, pursuant to St. Teresa's Nursing and Rehabilitation Center's bylaws, Catholic Health Care System is the sole member of the Nursing Home, and shall make a recommendation to Providence Health Services with respect to any dissolution for the Nursing Home.

WHEREAS, the Board of Trustees of Catholic Health Care System have considered the advisability of voluntarily dissolving the corporation.

WHEREAS, the Board of Trustees of Catholic Health Care System after due consideration, have deemed it advisable and in the best interests of the Corporation to adopt and approve a Plan of Dissolution and authorize the filing of a Certificate of Dissolution with the New York State Department of State subject to the approval of the Attorney General of the State of New York, and any other necessary governmental authority, to dissolve.

NOW THEREFORE, BE IT:

RESOLVED that the Corporation shall dissolve voluntarily; and it is further

RESOLVED, that the Board of Trustees of Catholic Health Care System herby approves and recommends for approval to Providence Health Services the dissolution of St. Teresa's Nursing and Rehabilitation Center; and it is further

RESOLVED that the Board of Trustees of Catholic Health Care System hereby approves and recommends for approval to Providence Health Services the Plan of Dissolution in the form attached hereto and the authorizing of the filing of a Certificate of Dissolution with the New York State Department of State subject to the approval of the Attorney General of the State of New York, and any other necessary governmental authority, to dissolve.

Adopted at a duly noticed meeting of the Catholic Health Care System Board of Trustees on September 27, 2021.

Francis J. Serbaroli
Chair

RESOLUTION
OF THE MEMBERS OF
PROVIDENCE HEALTH SERVICES

(Dissolution of St. Teresa's Nursing and Rehabilitation Center)

WHEREAS, Providence Health Services ("Providence") is the sole corporate member of the Catholic Health Care System ("CHCS") and as such has certain reserved powers; and

WHEREAS, St. Teresa's Nursing and Rehabilitation Center (the "Nursing Home") is a not-for-profit corporation organized and existing under the Not-for-Profit Corporation Law and Article 28 of the Public Health Law of the State of New York; and

WHEREAS, CHCS is the sole corporate member of the Nursing Home and as such has certain reserved powers to approve the plan of dissolution of the Nursing Home; and

WHEREAS, the Nursing Home previously operated an Article 28 residential health care facility at 120 Highland Avenue Middletown, NY 10940, which ceased operations on or about January 31, 2013 following an asset purchase by The Highland Rehabilitation and Nursing Center, and currently has no assets or liabilities; and

WHEREAS, the Board of Directors of the Nursing Home has approved and recommended for approval to Providence Health Services for the voluntarily dissolution of the Nursing Home and have determined that dissolution is in the best interest of the Nursing Home; and

WHEREAS, the CHCS Board of Trustees has approved and recommended for approval to Providence Health Services the voluntarily dissolution of the Nursing Home and have determined that dissolution is in the best interest of the Nursing Home; and

WHEREAS, the bylaws of the Nursing Home grant the authority to Providence Health Services as the Sponsor of the Nursing Home sole authority to approve any dissolution of the Nursing Home; and

WHEREAS, the Providence Health Services has considered the advisability of voluntarily dissolving the Nursing Home; and

WHEREAS, the Providence Health Services, after due consideration, have deemed it advisable and in the best interests of the Nursing Home to adopt and approve a Plan of Dissolution and authorize the filing of a Certificate of Dissolution with the New York State Department of State subject to the approval of the Attorney General of the State of New York, and any other necessary governmental authority, to dissolve.

NOW THEREFORE, it is

RESOLVED, that the Nursing Home shall dissolve voluntarily; and it is further

RESOLVED, that the Providence Health Services does hereby adopt and approve the Plan of Dissolution in the form attached hereto; and it is further

RESOLVED, that the Providence Health Services hereby authorizes the filing of a Certificate of Dissolution with the New York State Department of State, subject to the consent of the Attorney General of the State of New York; and it is further

RESOLVED, that the officers of the Corporation are hereby authorized and empowered to execute such documents, to make any necessary, nonmaterial amendments to such documents and to do any and all acts necessary to effectuate the foregoing resolutions.

Adopted at a duly constituted meeting of the Providence Health Services Board of Trustees on December 14, 2021.

Msgr. Joseph LaMorte
Vice President

ST. TERESA'S NURSING HOME, INC.

ATTACHMENT 7

CERTIFICATE OF INCORPORATION OF ST. TERESA'S NURSING HOME, INC., AND ALL AMENDMENTS AND ASSOCIATED DOCUMENTS

CERTIFICATE OF INCORPORATION

OF

ST. TERESA'S NURSING HOME, INC.

PURSUANT TO THE MEMBERSHIP CORPORATION LAW AND THE PUBLIC HEALTH LAW

66358

We, the undersigned, for the purpose of forming a nursing home company pursuant to the Membership Corporations Law and the Public Health Law of the State of New York hereby certify:

I

The name of the proposed corporation is ST. TERESA'S NURSING HOME, INC. (hereinafter referred to as the "Company").

II

The purposes for which the Company is to be formed are to provide nursing home accommodations for sick, invalid, infirm, disabled or convalescent persons of low income, and to this end to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, maintain and operate a nursing home project pursuant to the terms and provisions of the Public Health Law.

III

The territory in which the operations of the Company will be principally conducted is the State of New York.

IV

The principal office of the Company is to be located in the City of Middletown, County of Orange, State of New York.

V

The number of directors of the Company shall be not less than three nor more than fifteen. Directors shall be elected by the members of the Company. One additional director may be designated by the Commissioner of Health of the State of New York (hereinafter referred to as the "Commissioner"). In the absence of fraud or bad faith said additional director appointed by the Commissioner shall not be personally liable for the debts, obligations or liabilities of the Company.

VI

The names and residences of the directors of the Company until the first annual meeting are:

Name	Address
Mary Grace Muha (Name in Religion: Sister Mary Grace)	Middletown, N. Y. 130 Highland Ave.
Josephine Grace (Name in Religion: Sister Helena Dolores)	130 Highland Ave. Middletown, N. Y.
Emerentiana Pouliot (Name in Religion: Sister Emerentiana)	130 Highland Ave. Middletown, N. Y.
Rose Marie Burke (Name in Religion: Sister Ann Dolores)	Middletown, N. Y. 130 Highland Ave.
Edward A. Munns	20 South Broadway Yonkers, N. Y.

VII

The names and residences of the subscribers to this Certificate of Incorporation are:

Name	Address
Mary Grace Muha (Name in Religion: Sister Mary Grace)	130 Highland Ave. Middletown, N. Y.
Josephine Grace (Name in Religion: Sister Helena Dolores)	130 Highland Ave. Middletown, N. Y.
Emerentiana Pouliot (Name in Religion: Sister Emerentiana)	130 Highland Ave. Middletown, N. Y.
Edward A. Munns	20 South Broadway Yonkers, N. Y.
Richard N. Goldwater, Esq.	60 East 42nd St. New York, N. Y.

VIII

The duration of the Company is for a period of two years from the date of the filing of this Certificate by the Secretary of State.

IX

The real property of the Company shall not be sold, transferred, encumbered or assigned except as permitted by the provisions of the Public Health Law.

X

The Company has been organized exclusively to serve a public purpose and it shall be and remain subject to the supervision and control of the Commissioner pursuant to the provisions of the Public Health Law.

XII

XI.

All income and earnings of the Company shall be used exclusively for its corporate purposes.

XII

No part of the net income or net earnings of the Company shall inure to the benefit or profit of any private individual, firm or corporation.

XIII

All of the subscribers to this Certificate of Incorporation are of full age. At least two-thirds of them are citizens of the United States and at least one of them is a resident of the State of New York. At least one of the persons named as a director of the Company is a citizen of the United States and a resident of the State of New York.

IN WITNESS WHEREOF, we have made, subscribed and acknowledged this Certificate of Incorporation, in quadruplicate, this 4th day of December, 1967.

Mary Grace Muha

Josephine Grace

Emerentiana Poulfot

Edward A. Munns

Richard N. Goldwater

XI

STATE OF NEW YORK)
SS.:
COUNTY OF Orange)

On this 15th day of December, 1967 before me personally came MARY GRACE MUHA, JOSEPHINE GRACE and EMERENTIANA POULIOT, to me known and known to me to be the persons described in and who executed the foregoing Certificate of Incorporation of ST. TERESA'S NURSING HOME, INC. and they duly acknowledged to me that they executed the same.

ANNA L. GIBBONS
Notary Public in the State of New York
Orange County Clerk's No. 321
Commission Expires March 30, 19 69

Anna L. Gibbons
Notary Public

STATE OF NEW YORK)
SS.:
COUNTY OF Westchester)

On this 4th day of December, 1967 before me personally came EDWARD A. MUNNS to me known and known to me to be the person described in and who executed the foregoing Certificate of Incorporation of ST. TERESA'S NURSING HOME, INC. and he duly acknowledged to me that he executed the same.

ADELINE A. LOFSTEDT
NOTARY PUBLIC
IN THE STATE OF NEW YORK
Appointed for Westchester County

Adeline A. Lofstedt
Notary Public

STATE OF NEW YORK)
SS.:
COUNTY OF New York)

On this 15th day of December, 1967 before me personally came RICHARD M. GOLDWATER, to me known and known to me to be the person described in and who executed the foregoing Certificate of Incorporation of ST. TERESA'S NURSING HOME, INC. and he duly acknowledged to me that he executed the same.

Notary Public

LEON LINER
Notary Public, State of New York
No. 60-2369565
Qualified in Westchester County
Term Expires March 30, 1969

CONSENT TO INCORPORATION BY
COMMISSIONER OF HEALTH

I, HOLLIS S. INGRAHAM, M.D., Commissioner of Health of the State of New York, do this 26 day of December, 1967, pursuant to Article 28-A of the Public Health Law hereby certify that I consent to the filing of the foregoing Certificate of Incorporation of ST. TERESA'S NURSING HOME, INC. with the Secretary of State of the State of New York.

Hollis S. Ingraham, M.D.
Commissioner of Health
By: Robert P. Whalen
Robert P. Whalen, M.D.
Deputy Commissioner

The undersigned, a Justice of the Supreme Court of the Ninth Judicial District, wherein is located the principal office of St. Teresa's Nursing Home, Inc. hereby approves the within Certificate of Incorporation of St. Teresa's Nursing Home, Inc. and the filing thereof.

Dated: ~~December~~ January 15, 1968 1967.
Goshen, N.Y.

Justice of the Supreme Court

State of New York — Department of Social Services

State Board of Social Welfare

Albany

Know all Men by These Presents:

At a meeting of the State Board of Social Welfare, held on the nineteenth day of December, 1967, due inquiry and investigation having been made, the Board approved the application of ST. TERESA'S NURSING HOME, INC., No. 5-92, a membership corporation, for approval of the proposed certificate of incorporation pursuant to Section 35 of the Social Services Law and Article 28-A of the Public Health Law, empowering it to establish, maintain and operate an 80 bed nursing home in the City of Middletown, County of Orange, State of New York.

In Witness Whereof, the State Board of Social Welfare has caused these presents to be signed in accordance with the provisions of the statutes and its by-laws, and the official seal of the Board and of the Department to be hereunto affixed, this twentieth day of December, in the year one thousand nine hundred and sixty-seven.

Secretary

Form WL-103 (Rev. 7/67)

663358

CERTIFICATE OF
INCORPORATION
OF
ST. TERESA'S NURSING HOME,
INC.

PURSUANT TO THE MEMBER-
SHIP CORPORATION LAW AND
THE PUBLIC HEALTH LAW

Dated: December , 1967.

GOLDWATER & FLYNN
COUNSELLORS AT LAW
60 EAST 42nd STREET
NEW YORK

1130

STATE OF NEW YORK
DEPARTMENT OF STATE
FILED JAN 30 1968
TAX $
FILING FEE $ 50

John P. Lomenzo
Secretary of State
By

State of New York — Department of Social Services

State Board of Social Welfare

Albany

#759168

Know all Men by These Presents:

At a meeting of the State Board of Social Welfare, held on the fifteenth *day of* April, 1969 *, due inquiry and investigation having been made,* the Board approved the proposed Certificate of Extension of Existence of ST. TERESA'S NURSING HOME, INC., No. 5-92 pursuant to Section 45 of the General Corporation Law of the State of New York.

In Witness Whereof, the State Board of Social Welfare has caused these presents to be signed in accordance with the provisions of the statutes and its by-laws, and the official seal of the Board and of the Department to be hereunto affixed, this sixteenth *day of* April *, in the year one thousand nine hundred and* sixty-nine.

Secretary

Form 055-824 16 68

CERTIFICATE OF EXTENSION OF

EXISTENCE OF

ST. TERESA'S NURSING HOME, INC.

(a Membership corporation)

Pursuant to Section 45 of the General Corporation Law

We, the undersigned, MARY GRACE MUHA, President, and RICHARD M. GOLDWATER, Secretary, of ST. TERESA'S NURSING HOME, INC., HEREBY CERTIFY:

1. The name of the corporation is St. Teresa's Nursing Home Inc.

2. The Certificate of Incorporation was filed in the office of the Secretary of State on January 30, 1969.

3. The term of existence specified in the original Certificate of Incorporation will expire on January 30, 1970.

4. The duration of the corporation shall be perpetual.

IN WITNESS WHEREOF, we have executed this Certificate this [illegible] day of February, 1969.

Mary Grace Muha, President

Richard M. Goldwater, Secretary

STATE OF NEW YORK)
COUNTY OF [illegible]) ss.:

On the [illegible] day of [illegible], 1969, before me personally came Mary Grace Muha and Richard M. Goldwater, to me known and known to me to be the persons described and who executed the foregoing Certificate of Extension of Existence and they thereupon

severally duly acknowledged to me that they executed the same.

Notary Public

STATE OF NEW YORK)
COUNTY OF ORANGE) ss.:

Mary Grace Muha and Richard M. Goldwater, being severally duly sworn, depose and say, each for himself deposes and says that she, Mary Grace Muha is the President of St. Teresa's Nursing Home, Inc. and he, Richard M. Goldwater is the Secretary of said Corporation, that they were duly authorized to execute and file the foregoing Certificate of Extension of Existence of said Corporation by the votes, cast in person or by proxy, of a majority of the members of record of said Corporation, at a meeting of the members called for that purpose upon like notice as that required for the annual meetings of the Corporation, the said meeting having been held at 130 Highland Avenue, Middletown, on February 26, 1969.

Mary Grace Muha, President

Richard M. Goldwater, Secretary

SWORN to before me this
day of
1969.

Notary Public

CONSENT TO FILING CERTIFICATE OF EXTENSION
OF EXISTENCE BY COMMISSIONER OF HEALTH

I, HOLLIS B. INGRAHAM, M.D., Commissioner of Health of the State of New York, do this 27 day of May, 1969, pursuant to Article 28-A of the Public Health Law, hereby certify that I consent to the filing of the foregoing Certificate of Extension of Existence of St. Teresa's Nursing Home, Inc. with the Secretary of State of the State of New York.

Hollis B. Ingraham, M.D.
Commissioner of Health

By: Donald G. Dickson
Donald G. Dickson, M.D.
Deputy Commissioner

CERTIFICATE OF EXTENSION

OF EXISTENCE OF

ST. TERESA'S NURSING HOME, INC.

(a Membership Corporation)

Pursuant to Section 45 of the General Corporation Law

Dated: February 26, 1969.

GOLDWATER & FLYNN
COUNSELLORS AT LAW
60 EAST 42ND STREET
NEW YORK

DEPARTMENT OF STATE
FILED MAY 28 1969
TAX $

State of New York — Department of Social Services

State Board of Social Welfare

Albany

Know all Men by These Presents:

At a meeting of the State Board of Social Welfare, held on the fifteenth *day of* April, 1969 *, due inquiry and investigation having been made,* the Board approved the proposed Certificate of Amendment Relating to the Disposition of Assets Upon Dissolution and Non-Profit Character of ST. TERESA'S NURSING HOME, INC., No. 7-92, pursuant to Section 30 of the Membership Corporations Law, Section 35 of the Social Services Law, and Article 28-A of the Public Health Law of the State of New York.

In Witness Whereof, *the State Board of Social Welfare has caused these presents to be signed in accordance with the provisions of the statutes and its by-laws, and the official seal of the Board and of the Department to be hereunto affixed, this* twenty-sixth *day of* May *, in the year one thousand nine hundred and* sixty-nine.

Secretary

Form DSS-824 (6/68) (Formerly W-103)

CERTIFICATE OF AMENDMENT

RELATING TO THE DISPOSITION OF ASSETS

UPON THE DISSOLUTION AND NON-PROFIT

CHARACTER OF

ST. TERESA'S NURSING HOME, INC.

(a Membership Corporation)

Pursuant to Section Thirty of The Membership Corporation Law

We, the undersigned, MARY GRACE MUHA, President and RICHARD M. GOLDWATER, Secretary, of ST. TERESA'S NURSING HOME, INC. a membership corporation duly organized and existing pursuant to the Membership Corporations Law and the Public Health Law of the State of New York, for the purpose of amending the Certificate of Incorporation of St. Teresa's Nursing Home Inc. relating to the disposition of the assets upon dissolution and the non-profit character of St. Teresa's Nursing Home Inc. pursuant to Section 30 of the Membership Corporations Law, do hereby make, sign and acknowledge this Certificate and do certify as follows:

1. The name of this Corporation is ST. TERESA'S NURSING HOME, INC.
2. The Certificate of Incorporation was approved by the State Board of Social Welfare on December 19, 1967, consented to by the Commissioner of Health on December 26, 1967, and filed in the office of the Secretary of State of the State of New York on January 30, 1968.
3. The provision of the Certificate of Incorporation to be eliminated by the execution and filing of this Certificate of Amendment is -

XII. No part of the net income or net earnings of the company shall inure to the benefit or profit of any

private individual, firm or corporation.

4. The provision to be substituted for the foregoing is -

"XII. The Company is organized and shall be operated as a non-profit organization, shall not have power to issue certificates of stock or to declare or pay dividends, and shall be operated exclusively for the purposes enumerated in Article II hereof, thereby to lessen the burdens of government and promote social welfare. No part of the net income or net earnings of the Company shall inure to the benefit or profit of any private individual, firm or corporation. No officer or employee of the Company shall receive or be lawfully entitled to receive any pecuniary benefits from the operation thereof except as reasonable compensation for services. No member or director of the Company shall receive any salary, other compensation or pecuniary profit of any kind for services as such member or director other than reimbursement of actual and necessary expenses incurred in the performance of his duties.

Upon the dissolution of the Company the Board of Directors shall, after paying or making provisions for the payment of all of the liabilities of the Company, distribute all of the remaining assets of the Company exclusively for the purposes of the Corporation or for a similar public use or purpose, to such organization or organizations organized and operating exclusively for charitable purposes as shall at the time qualify as an exempt organization or organizations under Section 501 (c) (3) of the Internal Revenue Code of 1954 as the same shall then be in force, or the corresponding provision of any future United States Internal Revenue Law, or to the United States of America, the State of New

York, or a local government within the State of New York, as the Board of Directors shall determine, or in the absence of such determination by the Board of Directors such assets shall be distributed by the Supreme Court of the State of New York to such other qualified exempt organization or organizations as in the judgment of the Court will best accomplish the general purposes or a similar public use or purpose of this Company. In no event shall the assets of this Company upon dissolution be distributed to a director, officer, employee or member of this Company.

The dissolution of this Company and any distribution of the assets of this Company incident thereto shall be subject to such law, if any, then in force as may require the approval or consent thereto by any Court or Judge thereof having jurisdiction or by any governmental department or agency or official thereof."

IN WITNESS WHEREOF, we have made, signed and acknowledged this Certificate the 26th day of February, 1969.

Mary Grace Muha, President

Richard M. Goldwater, Secretary

STATE OF NEW YORK)
COUNTY OF ORANGE) ss.:

MARY GRACE MUHA and RICHARD M. GOLDWATER, being severally duly sworn, depose and say, and each for himself deposes and says that she Mary Grace Muha is the President of St. Teresa's Nursing

Home, Inc. and he, Richard M. Goldwater, is the Secretary thereof, that they were duly authorized to execute and file the foregoing Certificate of Amendment relating to the disposition of assets upon the dissolution and non-profit character of St. Teresa's Nursing Home, Inc. pursuant to Section 30 of the Membership Corporations Law; by the concurring vote of a majority of the members of the Corporation present at a special meeting held at 130 Highland Avenue, Middletown, on the 26th day of February, 1969, upon notice pursuant to Section 43 of the Membership Corporations Law and that they subscribed such Certificate by virtue of such authority.

Mary Grace Muha, President

Richard M. Goldwater, Secretary

SWORN to before me this

26th day of February,

1969.

Notary Public

MARIA H. GOLDWATER
NOTARY PUBLIC, State of New York
No. 31-4496025
Qualified in New York County
Commission Expires, March 30, 1969

STATE OF NEW YORK) ss:
COUNTY OF ORANGE)

On this 26th day of February, 1969, before me personally came MARY GRACE MUHA and RICHARD M. GOLDWATER, to me known and known to me to be the persons described in and who executed the foregoing Certificate of Amendment relating to the disposition of assets upon the dissolution and non-profit character of St. Teresa's Nursing Home, Inc., and they severally acknowledged to me that they executed the same.

Notary Public

DONALD DAVIDOFF
Notary Public, State of New York
Commission Expires March 30, 1970

CONSENT TO FILING CERTIFICATE OF AMENDMENT RELATING TO THE DISPOSITION OF ASSETS UPON THE DISSOLUTION AND NON-PROFIT CHARACTER OF ST. TERESA'S NURSING HOME, INC. BY THE COMMISSIONER OF HEALTH

I, HOLLIS B. INGRAHAM, M.D., Commissioner of Health of the State of New York, do this 27 day of May 1969, pursuant to Article 28-A of the Public Health Law, hereby certify that I consent to the filing of the foregoing Certificate of Amendment Relating to the Disposition of Assets Upon the Dissolution and Non-Profit Character of St. Teresa's Nursing Home, Inc. with the Secretary of State of the State of New York.

Hollis B. Ingraham, M.D.
Commissioner of Health

By Donald G. Dickson
Donald G. Dickson, M.D.
Deputy Commissioner

759869 - P

CERTIFICATE OF AMENDMENT

RELATING TO THE DISPOSITION OF ASSETS UPON THE DISSOLUTION

AND NON-PROFIT CHARACTER OF

ST. TERESA'S NURSING HOME, INC.

(a Membership Corporation)

Pursuant to Section 30 of the Membership Corporation Law

Dated: February 26, 1969

GOLDWATER & FLYNN
COUNSELLORS AT LAW
60 EAST 42ND STREET
NEW YORK

(2) Memb
1/30/68 663318-8
Orange Co.
5/27

FILED MAY 28 1969
TAX $ none
FILING FEE $ 30
John P. Lomenzo
SECRETARY OF STATE
BY
36 Orange

CERTIFICATE OF TYPE OF NOT-FOR-PROFIT CORPORATION

OF

ST. TERESA'S NURSING HOME, INC.

(Under Section 113 of the Not-For-Profit Corporation Law)

873684

We, the undersigned, President and Secretary of ST. TERESA'S NURSING HOME, INC., certify:

1. The name of the corporation is ST. TERESA'S NURSING HOME, INC.

2. The name under which the corporation was originally incorporated was ST. TERESA'S NURSING HOME, INC.

3. The Certificate of Incorporation of the corporation was filed with the Department of State on January 30, 1960 and the corporation was formed pursuant to the Membership Corporation Law and the Public Health Law.

4. The post office address within the State of New York to which the Secretary of State shall mail a copy of any notice required by law is 130 Highland Avenue, Middletown, New York 10940.

5. Under Section 201 (Purposes) of the Not-For-Profit Corporation Law, St. Teresa's Nursing Home, Inc. is a Type D Not-For-Profit Corporation as defined in this chapter.

IN WITNESS WHEREOF, we have executed this Certificate this 3rd day of December, 1970.

S. Mary [illegible]
President

[illegible]
Secretary

STATE OF NEW YORK)
COUNTY OF ORANGE) ss.:

MOTHER MARY GRACE, being duly sworn, deposes and says, that she is the President of St. Teresa's Nursing Home, Inc.; that she has read the foregoing Certificate of Type of Not-For-Profit Corporation of St. Teresa's Nursing Home, Inc., under Section 113 of the Not-For-Profit Corporation Law and knows the contents thereof; that the same is true to her own knowledge, except as to matters therein stated to be alleged upon information and belief, and that as to those matters she believes it to be true.

SISTER HELENA DOLORES
Notary Public - State of New York
Residing in Orange County Com-
mission expires March 30, 19..

Mother Mary Grace, President

Sworn to before me this
2nd day of December, 1970.

Sister Helena Dolores
Notary Public

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

RICHARD M. GOLDWATER, being duly sworn, deposes and says, that he is the Secretary of St. Teresa's Nursing Home, Inc.; that he has read the foregoing Certificate of Type of Not-For-Profit Corporation of St. Teresa's Nursing Home, Inc., under Section 113 of the Not-For-Profit Corporation Law and knows the contents thereof; that the same is true to his own knowledge, except as to matters therein stated to be alleged upon information and belief, and that as to those matters he believes it to be true.

Richard M. Goldwater, Secretary

Sworn to before me this
1st day of December, 1970.

Notary Public

Notary Public, State of New York
No. 31-2635270
Qualified in New York County
Commission Expires March 30, 1971

1/30/68 .6633-5

873664-8

CERTIFICATE OF TYPE

OF

NOT-FOR-PROFIT CORPORATION

OF

ST. TERESA'S NURSING HOME, INC.

(Under Section 113 of the Not-For-Profit Corporation Law)

DATED: December , 1970.

GOLDWATER & FLYNN
COUNSELLORS AT LAW
60 EAST 42ND STREET
NEW YORK

STATE OF NEW YORK
DEPARTMENT OF STATE
FILED DEC 7 1970
FEES $ None
FILING FEE $ 10

Secretary of State
By MB

330

Type D

C F S CERTIFICATE OF AMENDMENT OF CERTIFICATE OF INCORPORATION C F S

OF ST. TERESA'S NURSING HOME, INC.

Pursuant to the Provisions of Section 803 of the Not-For-Profit Corporation Law

B646346

We, the undersigned, James J. Murray, President, and Richard M. Goldwater, Secretary, of ST. TERESA'S NURSING HOME, INC., a Not-For-Profit Corporation, duly organized and existing under the Not-For-Profit Corporation Law and the Public Health Law of the State of New York for the purposes of amending the Certificate of Incorporation relating to the enlargement of the powers of the Corporation pursuant to the Provisions of Section 803 of the Not-For-Profit Corporation Law, do hereby make, sign and acknowledge this Certificate and do certify as follows:

1. The name of this Corporation is St. Teresa's Nursing Home, Inc.

B646346

2. a. The Certificate of Incorporation was filed in the Office of the Secretary of the State of New York on January 30, 1968, after approval and consent by the Commissioner of Health on December 26, 1967, and the State Board of Welfare on December 19, 1967, and a Justice of the Supreme Court on January 15, 1968;

b. A Certificate of Extension of the Existence of St. Teresa's Nursing Home, Inc. was filed in the Office of the Secretary of State on May 28, 1969, pursuant to Section 45 of the General Corporation Law after approval by the State Board of Social Welfare on April 15, 1969, and the Commissioner of Health

of the State of New York on May 27, 1969;

c. A Certificate of Amendment relating to the Disposition of Assets upon the Dissolution and Non-Profit Character of St. Teresa's Nursing Home, Inc. was filed on May 28, 1969, pursuant to Section 30 of the Membership Corporations Law, Section 35 of the Social Services Law and Article 28-A of the Public Health Law after approval of the Commissioner of Health on May 27, 1969, and the State Board of Social Welfare on April 15, 1969;

d. A Certificate of Type of Not-For-Profit Corporation of St. Teresa's Nursing Home, Inc. was filed on December 7, 1970, under Section 113 under the Not-For-Profit Corporation Law.

3. The Corporation is a corporation as defined in Sub-paragraph A-5 of Section 102 of the Not-For-Profit Corporation Law and is, and will continue to be, a Type D Corporation after the filing of the within Amendment enlarging its purposes under Section 201.

4. The purposes of the Corporation are to be enlarged by amending Section II of the Certificate of Incorporation to read as follows:

II

The purposes for which the Company is to be formed are as follows:

a. To provide nursing home accommodations for sick, invalid, infirm, disabled or convalescent persons of low income, and to this end to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own,

income, and to this end to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, maintain and operate a nursing home project pursuant to the terms and provisions of Article 28-A of the Public Health Law;

b. To operate a diagnostic and treatment center to provide for Comprehensive Outpatient Rehabilitation Facility Services (CORF).

5. The Secretary of State of the State of New York is designated as agent of the Corporation upon whom process against it may be served, and the post office address within the State to which the Secretary of State shall mail a copy served upon such Secretary is c/o Richard M. Goldwater, 60 E. 42nd Street, New York, NY 10165.

6. This amendment to the Certificate of Incorporation was authorized by a vote of a majority of all members entitled to vote thereon of a meeting of members.

IN WITNESS WHEREOF, we have executed this Certificate of Incorporation this 18 day of June, 1987.

James J. Murray, President

Richard M. Goldwater, Secretary

STATE OF NEW YORK)
}ss:
COUNTY OF ORANGE)

JAMES J. MURRAY and RICHARD M. GOLDWATER, being severally duly sworn, depose and say, and each for himself deposes and says that he, James J. Murray, is the President of St. Teresa's Nursing Home, Inc. and he, Richard M. Goldwater, is the Secretary thereof, that they were duly authorized to execute and file the foregoing Certificate of Amendment relating to the Enlargement of Powers of the Corporation of St. Teresa's Nursing Home, Inc., pursuant to the Provisions of Section 803 of the Not-For-Profit Corporation Law, by the concurring vote of a majority of the members of the Corporation present at a special meeting held at 120 Highland Avenue, Middletown, New York on the 18th day of June, 1987, upon notice pursuant to Section 43 of the Membership Corporation Law and that they subscribed such Certificate by virtue of such authority.

James J. Murray, President

Richard M. Goldwater, Secretary

Sworn to before me this
18 day of June, 1987.

Notary Public

MARIE T. DUNLEAVY
Notary Public, State of New York
No. 01DU1044635
Qualified in Kings County
Commission Expires April 30, 1989

4

0088 0255

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

DAVID AXELROD, M.D.
COMMISSIONER

CONSENT

TO FILING A CERTIFICATE OF AMENDMENT

OF A CERTIFICATE OF INCORPORATION

BY THE

COMMISSIONER

I, DAVID AXELROD, M.D., Commissioner of Health of the State of New York, do this 24th day of July, 1987, consent to the filing with the Secretary of State of the Certificate of Amendment of the Certificate of Incorporation of St. Teresa's Nursing Home, Inc., as executed on the 12th day of June, 1987 pursuant to Section 104(e) of the Not-for-Profit Corporation Law and Section 2854 of the Public Health Law.

David Axelrod, M.D.
Commissioner of Health

3088 0256

STATE OF NEW YORK
DEPARTMENT OF HEALTH
CORNING TOWER BUILDING
ALBANY, N.Y. 12237

PUBLIC HEALTH COUNCIL

CORRECTION LETTER

April 8, 1988

Sister Mary Grace
Administrator
St. Teresa's Nursing Home, Inc.
120 Highland Avenue
Middletown, NY 10940

Re: Application No. 840842 - St. Teresa's Nursing Home (Orange Co.)

Dear Sister Mary Grace:

I HEREBY CERTIFY THAT AFTER INQUIRY and investigation, the application of St. Teresa's Nursing Home is APPROVED; the contingencies having now been fulfilled satisfactorily. The Public Health Council had considered this application and imposed the contingencies at its meeting of July 25, 1986.

Public Health Council approval is not to be construed as approval of property costs or the lease submitted in support of the application. Such approval is not to be construed as an assurance or recommendation that property costs or lease amounts as specified in the application will be reimbursable under third party payor reimbursement guidelines.

To complete the requirements for certification approval, please contact the New Rochelle Area Office of the New York State Office of Health Systems Management, 145 Huguenot Street, 6th Floor, New Rochelle, NY 10801, (914) 632-3701 within 30 days of receipt of this letter.

Karen S. Westervelt
Executive Secretary

6

8888 0259

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

CESAR A. PERALES
Commissioner

DAVID EMIL
Deputy Commissioner
and General Counsel

July 21, 1987

Richard M. Goldwater
Attorney at Law
60 East 42nd Street
New York, New York 10165

Re: St. Teresa's Nursing Home, Inc.

Dear Mr. Goldwater:

The draft certificate of amendment of the above which you submitted has been given careful consideration and I am of the opinion that an executed original certificate containing the same statement of purposes as those submitted in the draft would not require the approval of the State Department of Social Services under the provisions of applicable statutes. If otherwise in proper form, such an executed original certificate should be received for filing by the Secretary of State.

The proposed wording of the purposes is set forth in your draft certificate as follows:

The purposes for which the Company is to be formed are as follows:

a. To provide nursing home accommodations for sick, invalid, infirm, disabled or convalescent persons of low income, and to this end to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, income, and to this end to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, maintain and operate a nursing home project pursuant to the terms and provisions of Article 28-A of the Public Health Law;

b. To operate a diagnostic and treatment center to provide for Comprehensive Outpatient Rehabilitation Facility Services (CORF).

This letter is not to be construed as an approval by the State Department of Social Services, or any officer of the Department, but as a statement that the approval of the State Department of Social Services would not be required for a certificate of amendment containing the foregoing statement of purposes. When it is apparent on the face of a certificate that approval of the Department is not required under the provisions of the statutes, it has been the policy of the Department to indicate neither approval nor disapproval.

You may send the executed original certificate of amendment to the Secretary of State together with this letter.

If your organization intends to solicit contributions in this State, please contact the Charities Registration Section of the Department of State. That office will advise you whether or not the organization is required t register with the Secretary of State pursuant to Article 7-A of the Executive Law.

Sincerely,

Yvette Kitchen

Yvette Kitchen
Assistant Counsel
Bureau of Child Welfare
Services Law

Enclosure
YK:rj

STATE OF NEW YORK
DEPARTMENT OF LAW
ALBANY 12224

ROBERT ABRAMS
ATTORNEY GENERAL

JAMES G. McSPARRON
DEPUTY FIRST ASSISTANT
ATTORNEY GENERAL

Telephone: (518) 474-7206

July 21, 1987

Richard M. Goldwater, Esq.
60 East 42nd Street
New York, New York 10165

Dear Mr. Goldwater:

RE: ST. TERESA'S NURSING HOME, INC.

Due and timely service of the notice of application for the approval of the proposed certificate of amendment to the certificate of incorporation of the above-entitled organization is hereby admitted.

The Attorney General does not intend to appear at the time of application. Approval is contingent upon your seeking the approval of the Departments of Health and Social Services pursuant to Section 404 of the Not-For-Profit Corporation Law.

Very truly yours,

ROBERT ABRAMS
Attorney General

By

RICHARD S. REDLO
Assistant Attorney General

9

0000 0262

CONSENT

Pursuant to the Provisions of Section 801 of the Not-For-Profit Corporation Law, the undersigned, Acting Justice of the Supreme Court, Ninth Judicial District, wherein is located the principal office of St. Teresa's Nursing Home, Inc., hereby approves the within Certificate of Amendment of the Certificate of Incorporation of St. Teresa's Nursing Home, Inc. and the filing thereof.

Dated: May 18, 1988
Goshen, New York

Acting Justice of the Supreme Court

Hon. Joseph G. Owen
~~Acting Supreme Court Justice~~

70

B646346

CERTIFICATE OF AMENDMENT
OF THE
CERTIFICATE OF INCORPORATION
OF
ST. TERESA'S NURSING HOME, INC.
TO PERMIT THE OPERATION OF A
DIAGNOSTIC AND TREATMENT
CENTER TO PROVIDE FOR
COMPREHENSIVE OUTPATIENT
REHABILITATION FACILITY
SERVICES.

FILED

(A Not-For-Profit Corporation)

Pursuant to the Provisions
of Section 803.

Dated: May , 1988.

Richard M. Goldwater
COUNSELLOR AT LAW
60 EAST 42ND STREET #3122
NEW YORK

CFS

STATE OF NEW YORK
DEPARTMENT OF STATE
FILED JUN 1 - 1988
AMT. OF CHECK $ 40
FILING FEE $ 30
TAX $
COUNTY FEE $
COPY $
CERT $
REFUND $
SPEC HANDLE $ 10
BY:

Orange
Type D

NFP type D
1/30/62 Orange
LF 873664-81
663358-8

83849

HKF
not sold 130 Highland Ave
Middletown NY

3/21

RECEIVED

September 26, 2006
(the "Effective Date")

AMENDED AND RESTATED BYLAWS

OF

ST. TERESA'S NURSING HOME, INC.

ARTICLE 28 CO-ESTABLISHMENT

ARTICLE I
Purposes

Section 1. Certificate of Incorporation. The name and purposes of the St. Teresa's Nursing Home, Inc. (the "Nursing Home") shall be as set forth in its Certificate of Incorporation. These Bylaws, the powers of the Nursing Home and of its Member and directors and officers, and all matters concerning the conduct and regulation of the affairs of the Nursing Home shall be subject to such provisions in regard thereto, if any, as are set forth in the Certificate of Incorporation.

Section 2. Location. The principal office of the Nursing Home in the State of New York shall initially be located at the place set forth in the Certificate of Incorporation of the Nursing Home.

Section 3. Corporate Seal. The Board of Directors may adopt and alter the seal of the Nursing Home.

Section 4. Purpose of the Nursing Home. The Nursing Home is devoted to caring for the sick and disabled with compassion in the tradition of Catholic Health Care. It seeks to deliver high quality care, to treat all patients with dignity, and to provide a caring environment for patients at the Home. As a participating member of the Catholic Health Care System, the Nursing Home is also committed to furthering the System's ability to promote high quality care, to enhance its services, and to operate effectively as a Health Care System.

ARTICLE II
Membership in the Catholic Health Care System

Section 1. Participation in the Catholic Health Care System ("CHCS" or the "System"). The Nursing Home is a full participating member of CHCS, a health care delivery system composed of hospitals, nursing homes and other entities located in the metropolitan New York area and the Hudson Valley (each hospital, nursing home and other entity, including the Nursing Home, is

referred to herein as a "CHCS Institution"). Providence Health Services ("Providence") is the sponsors (the "Sponsor") of the System.

Section 2. Multiple Levels of Authority. Providence is the sponsor (the "Sponsor") of the Nursing Home and its related entities, and as such exercises certain powers set forth in Article III of these Bylaws. CHCS is the sole corporate member (the "Member") of the Nursing Home. It holds powers as Member and as an organization co-established with the Nursing Home pursuant to Article 28 of the New York Public Health Law. The Board of the Nursing Home oversees the operation of the facility in accordance with the powers and procedures set forth in these Bylaws and the Nursing Home's Certificate of Incorporation.

Section 3. Purpose of CHCS. The CHCS Institutions, including the Nursing Home, have come together through CHCS and Providence to fulfill the Catholic mission common to each, to promote a commitment to high quality patient care throughout the System, to create efficiencies by streamlining management and operations, and to enhance the financial strength of the CHCS Institutions and the System as a whole.

Section 4. Ethical and Religious Directives. The purposes and operations of the Nursing Home shall be carried out in conformity with the values and teachings of the Roman Catholic Church and with the Ethical and Religious Directives for Catholic Health Care Services of the National Conference of Catholic Bishops as interpreted by the Archbishop of New York.

ARTICLE III
Sponsor: Reserved Powers of Providence

Section 1. General. Providence shall hold and exercise certain reserved powers related to mission, governance and property matters as the Sponsor of the Nursing Home and Related Entities.

Section 2. Approvals by Providence related to Mission and Corporate Identity. Approval by Providence, taking into consideration a recommendation by CHCS, shall be required for:

(i) Any amendments to the Bylaws of the Nursing Home or any Related Entity that change the powers reserved to Providence in such Bylaws;

(ii) A change in the mission of CHCS, the Nursing Home, or any Related Entity; and

(iii) Any merger, joint venture, dissolution, bankruptcy filings, or change in the corporate member of the Nursing Home or any Related Entity.

Approvals by Providence for actions set forth in (ii) and (iii) of this Section, shall also take into consideration the recommendation of the Nursing Home or Related Entity which shall make a recommendation to Providence and to CHCS about the action.

Section 3. Approvals by Providence for Property Matters. In order to preserve the mission and philosophy of the Nursing Home, approval by Providence, taking into consideration a recommendation by CHCS, shall be required for the following matters:

(i) Any Nursing Home or Related Entity real property transaction or capital projects involving the sale, pledge, transfer or other encumbrance of real property or other fixed assets of the Nursing Home or Related Entity equal to or above a value of $400,000;

(ii) Any lease of real property for a period equal to or greater than 9 years;

(iii) Any debt incurrence by any one of or group of the CHCS Institutions, including the Nursing Home or any Related Entity in an amount equal to or greater than $400,000 secured by the property, revenues, or other assets of the Nursing Home or Related Entity, and any unsecured debt incurrence by any one of or group of the CHCS Institutions, including the Nursing Home or any Related Entity, in an amount greater than $3,000,000; and

(iv) Any disposition of artifacts of significant historical or artistic value.

For purposes of these Bylaws, "Related Entity" means any individual, partnership, joint venture, association, corporation, trust, estate, limited liability company, limited liability partnership, or any other legal entity that directly or through one or more intermediaries is controlled by the Nursing Home. As used in this definition, the term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a Related Entity, whether through corporate membership, ownership of voting securities, by contract or otherwise. Ownership of ten percent (10%) or less of the voting securities, member units, or other equitable interest of any entity shall not constitute control for purposes of this Section. Providence, CHCS and other CHCS member Nursing Homes and Hospitals shall not be considered a Related Entity of the Nursing Home for purposes of these Bylaws.

ARTICLE IV
Member: CHCS Reserved Powers

Section 1. General. CHCS is the sole member of the Nursing Home. As long as the Nursing Home has only one Member, the terms "Members," "any Member," "Majority of Members," "quorum of Members" and similar expressions contained in these Bylaws shall be deemed to mean the sole Member. CHCS shall take action and exercise the powers reserved hereunder in accordance with the provisions of its bylaws and Certificate of Incorporation.

Section 2. Powers and Rights. CHCS shall have such powers and rights as are vested in CHCS by law, the Certificate of Incorporation of the Nursing Home, and these Bylaws.

Section 3. Limited Liability. CHCS, in accordance with Section 517 of the New York Not-for-Profit Corporation Law, shall not be personally liable or responsible for the debts, liabilities or obligations of the Nursing Home.

Section 4. Reserved Powers of CHCS. Approval or action by CHCS shall be required with respect to the following matters pertaining to the Nursing Home or any Related Entity of the Nursing Home.

(a) CHCS Recommendations to Providence; Property Matters and Corporate Identity. CHCS shall make a recommendation to Providence with respect to the matters set forth below. In making its recommendation, CHCS shall take into consideration the recommendation or approval by the Board of the Nursing Home or the Related Entity in each case:

(i) Any Nursing Home or Related Entity real property transactions or capital projects involving the sale, pledge, transfer or other encumbrance of real property or other fixed assets of the Nursing Home or Related Entity equal to or greater than $400,000 in value;

(ii) Any lease of real property for a period equal to or greater than nine (9) years;

(iii) Debt incurrence by any one of or group of the CHCS Institutions, including the Nursing Home or any Related Entities, secured by the property, revenues, or other assets of the Nursing Home or Related Entity in an amount equal to or greater than $400,000, and of any unsecured debt incurrence by any one of or group of the CHCS Institutions, including the Nursing Home or any Related Entity, in an amount greater than $3,000,000;

(iv) Any disposition of artifacts of significant historic or artistic value, and

(v) Any merger, joint venture, dissolution, or bankruptcy filing, or change in the corporate member, for the Nursing Home or any Related Entity.

(b) Corporation Governance. Subject to the powers reserved to Providence in Article II of these Bylaws, the CHCS Board of Trustees shall have sole authority for the following matters related to governance:

(i) Amendment to the Bylaws and Certificate of Incorporation of the Nursing Home; and

(ii) Appointment and removal of the members of the Board of Directors and the Chairman of the Board of Directors of the Nursing Home.

(c) Administrative and Property Matters. Approval by the CHCS Board of Trustees, after taking into consideration the recommendation of the Nursing Home Board of Directors, shall be required for the following actions by the Nursing Home:

(i) Adoption of the operating and capital budgets of the Nursing Home or Related Entity;

(ii) Adoption or amendment of the business and strategic plan for the Nursing Home or any Related Entity;

(iii) Formation or purchase of an entity that is a Related Entity of the Nursing Home;

(iv) Any real estate transaction involving the sale, pledge or transfer of real property with a value above $30,000 and below $400,000 or any capital project involving the sale, pledge or transfer of fixed assets with a value above $30,000 and below $400,000;

(v) Approval of management contracts or contracts above $1 million in remuneration;

(vi) Program or services changes by the Nursing Home or a Related Entity that result in: (a) closure or establishment of a licensed service or program; or (b) change in location of a licensed service or licensed program outside the service area of Nursing Home or Related Entity; and

(vii) Approval of any merger, purchase, joint operating agreement or other affiliation (each an "Affiliation") with a third party, or withdrawal from, disposition of an interest in or dissolution of any such Affiliation.

(d) CHCS Approvals: Consultation with Facilities. CHCS shall have the authority to approve the following actions, after consultation with the Nursing Home:

(i) Adopt criteria or guidelines for manage care contracting;

(ii) Adopt system-wide benefit program or plans, including but not limited to health, dental and other medical benefits, severance and pension;

(iii) Adopt system-wide measures, standards and initiatives to improve health care quality; and

(iv) Changes to the facility's IT infrastructure, platform, operating systems, or applications so that the Nursing Home can participate in the IT operating platform, infrastructure and/or system and shared applications of CHCS.

(e) Joint Authority: Facility President and Executive Director.

(i) The CHCS Executive Vice President for Continuing Care ("the CHCS EVP for Continuing Care) shall serve as the President of the Nursing Home. After consulting with the Board of Directors of the Nursing Home, the CHCS CEO shall have the authority to hire and remove the CHCS EVP for Continuing Care, to set the annual compensation and benefits for the EVP for Continuing Care, and the conduct an annual performance evaluation.

(ii) The CHCS EVP for Continuing Care and the Board of Directors of the Nursing Home shall have joint authority to hire the Executive Director of the Nursing Home. Accordingly, the approval of both the CHCS EVP for Continuing Care and the Nursing Home Board of Directors shall be required to hire the Nursing Home Executive Director, to set annual compensation and benefits for the Executive Director, and to conduct an annual evaluation of the Executive Director. The CHCS EVP for Continuing Care and the Board of Directors of the Nursing Home shall each have the authority to remove the Executive Director, provided that the CHCS EVP for Continuing Care shall consult with the Board of Directors and the Board of Directors shall consult with the EVP for Continuing Care before taking such action.

(f) Conflict Resolution. Any disagreement between the Nursing Home Board of Directors and CHCS regarding a decision to hire, set annual compensation and benefits for, conduct an annual evaluation of, or fire the Executive Director of the Nursing Home shall be referred to the CHCS Board of Trustees which shall review the matter and make a recommendation regarding resolution to both parties.

ARTICLE V
Board of Directors of the Nursing Home

Section 1. In General. The governance of the Nursing Home shall be vested in a Board of Directors (the "Board"), except as otherwise provided in these Bylaws. The Board shall have and shall execute all powers and perform all the duties relating to oversight of the Nursing Home, its property, and the conduct of its affairs as specified in these Bylaws.

Section 2. Number. The Board of Directors shall consist of not less than three (3) nor more than fifteen (15) Directors. The Chairman of the Board of CHCS shall at all times be an *ex officio* Director without vote.

Section 3. Emeritus Directors. Emeritus Directors may be elected from time to time by CHCS. An Emeritus Director may serve in an advisory capacity, but shall not be entitled to vote or count toward a quorum at any meeting.

Section 4. Election. The Directors of the Nursing Home other than the *ex-officio* Director shall be appointed by CHCS, taking into consideration candidates for the Board recommended by the Nursing Home Board of Directors. Directors other than the *ex-officio* Director shall be divided as nearly as possible into three (3) classes of equal numbers.

Section 5. Term of Office. The members of the Board of Directors shall be divided into three (3) classes of as nearly equal number as possible, with each class serving a staggered term of three (3) years. Directors other than the *ex-officio* Director may not serve (in addition to any term for which they may have been elected by CHCS pursuant to Section 7 of this Article) more than three (3) consecutive three (3) year terms. However, following absence from office of one (1) year, a person who has previously served three (3) consecutive terms in office as a Director may be re-elected.

Section 6. Resignation; Removal. Any Director may resign at any time by giving written notice of such resignation to the Secretary. Unless otherwise specified therein, such resignation shall take effect upon receipt thereof by the Secretary. Any or all of the Directors may be removed without cause by CHCS.

Section 7. Vacancies. In case of a vacancy in the Board of Directors, a successor for the balance of the term of such vacancy shall be appointed by CHCS.

Section 8. Qualification. The Board of Directors shall consist only of persons who are dedicated to assuring the Nursing Home's provision of high quality of health care consistent with its missions. Among other persons, the Board shall include persons (i) who are at least eighteen (18) years of age; (ii) who are knowledgeable and skilled in the area of health care; (iii) who are from the community served by the Nursing Home; (iv) who are knowledgeable in financial and business affairs and (v) who are willing to accept responsibilities placed by law upon Nursing Home Directors. At least one (1) licensed physician shall be a member of the Board of Directors. No person shall serve as a Director unless, in the judgment of CHCS, such person is able to make a positive contribution to the management or direction of the affairs of the Nursing Home.

Section 9. Orientation and Education. A comprehensive orientation program and a continuing education program shall be provided for members of the Board of Directors. These programs shall reference the Nursing Home's Corporate Compliance Program.

ARTICLE VI
Meetings of Directors

Section 1. Annual Meeting. The annual meeting of the Board of Directors shall be held on a day in the second quarter, to be selected by the Chairman of the Board, at the Nursing Home or some other suitable place for the election of Officers, the appointment of an Executive Committee and other standing and special committees, and for action on such other matters as may be brought before the meeting. The annual report of the Nursing Home shall be presented to the Directors at this meeting, shall be filed with the records of the Nursing Home and shall be entered in the minutes of the meeting.

Section 2. Regular Meetings. Regular meetings shall be held in January, March, July and November of each year or at such times as the Board may designate.

Section 3. Special Meetings. Special meetings may be held whenever the Chairman of the Board shall deem the same necessary or advisable, or upon written request of one-third (1/3) of the Directors to the Secretary, the Secretary then being required to send immediately notice of such meeting, which shall take place no later than twelve (12) days from the date upon which the Directors made such request to the Secretary. The notice shall state the purpose for which the meeting is being called. No other business shall be transacted except such as is stated in the notice.

Section 4. Notice. Notice of the date, time, place and purpose of each meeting of Directors shall be given by telegram, facsimile, first class mail or delivering a written notice thereof personally to the Directors not less than ten (10) days prior to the date of the meeting. Notice need not be given to any Director who submits a signed waiver of notice before or after the annual meeting or any special meeting. Attendance of a Director at any meeting shall constitute a waiver unless the Director protests during the meeting that such notice was not properly given.

Section 5. Minutes. Minutes of meetings of the Board of Directors shall reflect pertinent business conducted and shall be regularly distributed to all Directors.

Section 6. Quorum and Voting. Except as may otherwise be required by law or by these Bylaws, in order to constitute a quorum for the transaction of business at a meeting of Directors, there shall be present in person a majority of the Directors. The act of a majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except as otherwise provided in these Bylaws.

Section 7. Presence through Communication Equipment. Any one (1) or more Directors may participate in a meeting of the Board or any committee thereof by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.

Section 8. Voting. Each Director shall be entitled to one (1) vote. There shall be no voting by proxy.

Section 9. Action by Written Consent. Any action required or permitted to be taken by the Board or any committee thereof may be taken without a meeting if all Directors or all Directors serving on any committee as the case may be, consent in writing to a resolution authorizing the action. Any such action shall be filed with the minutes of the Board or committee.

ARTICLE VII
Duties and Powers of Board of Directors

Section 1. Standard of Care; No Compensation. The Directors shall discharge their duties in good faith and with that degree of diligence, care and skill ordinarily prudent persons would exercise under similar circumstances. A Director shall not receive compensation for services

performed in his capacity as Director, but shall be entitled to reimbursement for reasonable expenses incurred in the performance of his or her duties as Director.

Section 2. Role of the Board. Subject to powers vested elsewhere in these Bylaws and the Nursing Home's Certificate of Incorporation, the Board of Directors shall serve as the governing board of the Nursing Home, shall oversee its property and affairs, develop and preserve the assets of the Nursing Home, and oversee the quality of care of patients through the appointment of a qualified medical staff. The Board shall have power to hold meetings, appoint committees, appoint an Advisory Council, employ necessary medical and administrative staff and employees and to suspend, censure or expel any of them subject to the personnel policies of the Nursing Home and without prejudice to their contract rights, if any. The Board shall authorize expenditures to carry out the purposes of the Nursing Home and promote its best interests. The Board of Directors shall report on a regular basis to CHCS on the current status of the Nursing Home and its affairs.

Subject to the powers vested in CHCS by these Bylaws and the Nursing Home's Certificate of Incorporation, the Board of Directors shall establish policies for the management and operation of the Nursing Home and shall determine its objectives and goals and shall annually, reexamine such policies, objectives and goals. The Board also shall be responsible for the approval of settlements of administrative proceedings or litigation to which the Nursing Home is a party; the oversight of the Nursing Home's quality improvement processes, including but not limited to policies and procedures and physician credentialing; the management of the Nursing Home's facilities; and oversight of corporation compliance and audit functions.

Section 3. Chairman. The Chairman of the Board of Directors shall preside at meetings of the Board and shall be a member *ex-officio* of all committees. In the absence of the Chairman, one of the Vice Chairmen of the Board shall preside at meetings of the Board. The Chairman shall verify reports of the Board and have power to exercise all such acts as may be incident to his office or as provided by law.

Section 4. Vice Chairman. The Vice Chairmen of the Board shall act as deputies of the Chairman. Each Vice Chairman shall perform such duties and shall have and exercise such powers as from time to time may be assigned to him by the Chairman of the Board or the Board of Directors.

Section 5. Advisory Council. The Board of Directors may at any time designate persons who are not Directors as members of an Advisory Council. The members of the Advisory Council may upon invitation attend meetings of the Board of Directors or of any committee of the Board. Members of the Advisory Council shall not be entitled to vote either at meetings of the Board or of any committee of the Board.

Section 6. Annual Evaluation. The Board of Directors shall evaluate its own process of governance annually.

ARTICLE VIII
Officers

Section 1. Principal Officers. At each annual meeting of the Board of Directors, the Board shall elect by a majority vote the following principal Officers of the Nursing Home who shall serve for a term of one (1) year or until their successors have been elected:

(i) One (1) or more Vice Chairmen of the Board,

(ii) a Treasurer, and

(iii) a Secretary.

Section 2. Other Officers. The Board of Directors shall elect from time to time, one (1) or more Vice Presidents, and a Medical Director and may elect one (1) or more Assistant Secretaries and/or Assistant Treasurers, such Officers to have the powers and duties hereinafter prescribed and to serve at the pleasure of the Board. Such Officers need not be Directors except as otherwise provided in these Bylaws. In the event of the disability of, or vacancy in the office of, the Secretary, the Assistant Secretary shall perform all the duties of the Secretary pending the election of a new Secretary. In the event of the disability of, or vacancy in the office of, the Treasurer, the Assistant Treasurer shall perform all the duties of the Treasurer pending the election of a new Treasurer.

Section 3. President. The President shall be an Officer of the Nursing Home and of CHCS. CHCS shall have sole authority to appoint and remove the President, to set annual compensation and benefits for the President and to conduct an annual performance evaluation of the President, after consulting with the Nursing Home Board of Directors. The Board of Directors shall delegate to the President the power to appoint additional agents and employees of the Nursing Home and to prescribe their respective authorities and duties.

Section 4. Chairman of the Board. The Chairman of the Board of Directors shall be appointed by CHCS for a term of three (3) years and shall be eligible to serve two (2) additional three (3) year terms as Chairman of the Board of Directors regardless of the number of years served as a Director.

Section 5. Vacancies. In the event that a vacancy shall occur in the office of Chairman of the Board or the President, the Board of Directors or, the Executive Committee, may appoint an Acting Chairman of the Board or Acting President to fill such vacancy pending appointment of a successor by CHCS. The Member shall be promptly notified of such appointment. In the event that there is a vacancy in the office of Treasurer or Secretary of the Board, the Board may appoint an Acting Treasurer or Acting Secretary pending election of a successor.

ARTICLE IX
Duties and Powers of Officers

Section 1. President/CEO. The President/CEO shall be an *ex-officio*, non-voting member of the Board of Directors, and an *ex-officio* non-voting member of all Board Committees, with the

exception of the Executive Committee. He or she shall be responsible for carrying into effect the policies, programs and resolutions approved or adopted by the Board of Directors for the Nursing Home, including preparation of annual operating plans, budget and longer term objectives. He or she shall act as the duly authorized representative of the Board of Directors in all matters in which the Board of Directors has not formally designated some other person to so act and shall keep the Board informed at its regular meetings of matters related to Board policies and programs and such other information as the Board needs to fulfill its duties as specified in these Bylaws. The President shall also keep the Board of Trustees of CHCS informed of administrative, fiscal and other matters necessary for CHCS to fulfill its responsibilities specified in these Bylaws.

Section 2. Executive Director/Administrator. The Executive Director shall be the chief operating officer of the Nursing Home. The Executive Director shall be and shall employ a qualified Nursing Home Administrator pursuant to the laws of the State of New York and responsible for management of the Nursing Home. He or she shall manage the day-to-day operations, staff and provision of services at the Nursing Home, subject to such policies as may be adopted by the Board of Directors, the CHCS Board of Directors and directives as given by the President. The Executive Director shall keep the Board of Directors informed at its regular meetings of the Nursing Home operations affecting quality of care, corporate compliance, service delivery, facility operations, and employee relations. He or she shall act as the duly authorized representative of the Board of Directors on all matters for which the Board delegates him or her as such.

Section 3. Medical Director. The Medical Director shall be a physician licensed to practice medicine in the State of New York and shall, subject to the authority of the President, and the Executive Director, have authority over and responsibility for the functioning of the Medical Staff.

Section 4. Secretary. The Secretary shall, subject to these Bylaws and the direction of the Board:

(i) Keep the Minutes of the meetings of the Board of Directors and the Executive Committee.

(ii) Perform such other duties as may from time to time be prescribed by the Board of Directors.

Section 5. Treasurer. The Treasurer shall have custody of all funds of the Nursing Home and shall be responsible for all receipts and reimbursements. He shall see that a true and accurate accounting of the financial transactions of the Nursing Home is made and shall render to the President and Directors, whenever requested and at least annually, an account of the financial condition of the Nursing Home and of his transactions as Treasurer.

ARTICLE X
Committees

Section 1. In General. The Board, by resolution adopted by a majority of the entire Board, shall designate from among its members an Executive Committee, and shall approve establishment of a Finance Committee, an Audit and Compliance Committee, a Planning Committee, a Governance Committee, and a Quality Committee. The Board may from time to time designate such other ad hoc or standing committees as the Board may deem appropriate. Where appropriate, the Board may appoint non-Board members to Board committees.

Section 2. Special Committees. The Board may also appoint and specify the duties of special committees of the Board. Special committees shall be discharged upon the completion of their function.

Section 3. Meetings; Quorum and Voting. Each standing and special committee shall hold regular meetings at least annually if not otherwise specified. A special meeting of any committee shall be called by the Secretary in accordance with Article VI, Section 3 upon the request of the Chairman of the Board, the President or a majority of the members of such committee. In order to constitute a quorum for the transaction of business at a meeting of a standing or special committee, there shall be present in person a majority of the committee members unless otherwise specifically provided in these Bylaws. The act of a majority of the committee members at a meeting at which a quorum is present shall constitute the act of the committee. A written record of the proceedings, recommendations and actions of each standing and special committee shall be maintained. Standing committees shall report to the Board of Directors as specified in Sections 4 through 8 of this Article. Special committees shall report to the Board of Directors at least annually.

Any committee member may resign by giving written notice of such resignation to the Chairman of the Board or any member may be removed from committee membership by the same authority by which he was appointed. In the case of a vacancy on a standing or special committee, the Board, by resolution adopted by a majority of its members, shall elect a successor for the balance of the term of such vacancy.

Section 4. Executive Committee. The Executive Committee shall consist of the Chairman of the Board, each Vice Chairman of the Board, if any, the Chairman of the Finance Committee, the Chairman of the Quality Committee, the Chairman of the Planning Committee and additional Directors not exceeding three (3), selected by the Board. The Chairman of CHCS may serve ex-officio without vote on the Executive Committee. The Executive Committee shall meet as needed and shall have authority to transact regular business of the Nursing Home between meetings of the Board; provided, however, that the Executive Committee is not empowered to act with respect to any reserved powers described in these Bylaws; and provided that no action so taken shall be beyond the authority of the Board or in conflict with the expressed policies of the Board. The presence of a majority of the members of the Committee shall constitute a quorum for the transaction of business at any meeting. The authority of the Executive Committee shall be subject to the limitations set forth in the New York Not-For-Profit Corporation Law and the New York Public Health Law and Regulations. Any action taken by

the Executive Committee shall be reported to the Board at the next meeting of the Board. It shall be the obligation of the Executive Committee to conduct at least annually an evaluation of the President.

Section 5. Finance Committee. The Finance Committee shall consist of a Vice Chairman of the Board, if any, the Treasurer, and at least two (2) other Directors selected by the Board of Directors who shall have experience in the area of business and finance. The Board of Directors shall select the Chairman of the Finance Committee. The Finance Committee may include members who are not Directors, if such members are duly appointed by majority vote of the Board. The Finance Committee shall meet at least quarterly and shall report to the Board of Directors in relation to the financial operation of the Nursing Home. This shall include, without limitation, review and recommendation to the Nursing Home Board of Directors and the CHCS Board of Trustees regarding approval of the annual budget and any revisions thereto; recommendation to the Nursing Home Board of Directors and the CHCS Board of Trustees as to approval of the annual audit by independent public accountants; recommendations to the Board as to the financial feasibility of proposed new construction, major renovations, new programs, etc.; periodic reports to the Board as to performance against financial goals; and supervision of investment of operating and endowment funds.

Section 6 Audit and Compliance Committee. The Audit and Compliance Committee shall consist of at least three (3) Directors with expertise in corporate compliance and audit. All three Directors shall be independent Directors of the Nursing Home Board of Directors. The Audit and Compliance Committee shall meet at least three (3) times annually and shall report to the full Board of the Nursing Home in relation to compliance and audit:

(i) Review and recommend to the Board policies and procedures for Corporate Compliance;

(ii) Recommend a Compliance Officer to the Board for appointment;

(iii) Receive and review regular reports from the Compliance Officer and others as appropriate on:

--overall implementation of the Compliance Program;
--compliance monitoring results;
--audits or evaluations of high-risk areas;
--follow-up investigations of alleged violations of the compliance program; including any disciplinary or corrective actions taken; and
--training of employees on compliance;

(iv) At least annually, assess the effectiveness of the Nursing Home's compliance program and plan and recommend modifications in organizational structure, and policies and procedures to the Board where necessary to assure compliance;

(v) Review and recommend to the Board approval of the annual audit by independent public accountants and periodically receive and review internal audit reports.

Section 7. Planning Committee. The Planning Committee shall consist of at least four (4) Directors with diverse backgrounds. The Board of Directors shall select the Chairman and members of the Planning Committee. The Committee shall meet semi-annually and, subject to the powers vested elsewhere by these Bylaws, shall be responsible for the development and annual review of a long-range plan for the Nursing Home. The planning process shall define and analyze the areas of need, establish general goals and specific objectives relative to each need, identify and select alternative courses of action, provide for implementation of the plan of action and for evaluation of the effect of program activities in the context of the health needs of the community. The long-range plan shall include a capital plan developed in consultation with the Finance Committee. The Planning Committee shall also review all new services lines proposed for the Nursing Home. The Planning Committee shall then make recommendations to the Board with respect to the long-range plan of the Nursing Home.

Section 8. Governance Committee. The Governance Committee shall have three (3) or more members who shall be selected by the Board of Directors on the basis of their experience and interest. The Governance Committee shall have the duty to

(i) Recommend to the full Board candidates for election by CHCS to the Nursing Home Board;

(ii) Review the Bylaws on an annual basis;

(iii) Conduct an annual performance evaluation of the Board of Directors and how well it has fulfilled its duties as set forth in these Bylaws and general fiduciary duties; and

(iv) Make such other recommendations to improve facility governance as it deems appropriate.

Section 9. Quality Committee. The Quality Management/Performance Improvement Committee shall fulfill the responsibility of the Board of Directors in monitoring and supporting a program to assess and improve the quality of care in the Nursing Home. The Quality Committee shall consist of at least three (3) members of the Board of Directors selected by the Board of Directors which shall also select the Chairman of the Committee. The Committee shall meet at least quarterly and report to the full Board at each regularly scheduled Board meeting. The Committee shall:

(i) Develop and recommend to the full Board an annual plan to assess and continuously improve quality;

(ii) Receive and review regular reports from the Nursing Home's quality and medical staff summarizing the findings, actions and results of the Nursing

Home's program to assess and improve health care quality, including all actions taken in response to state or federal surveys of health care quality;

(iii) Review quality indicators generated for public reporting or by the Nursing Home for quality improvement purposes and examine all findings by public bodies regarding the quality of care at the Nursing Home;

(iv) Review and, as appropriate, recommend to the Board required changes in the procedures, methods and systems for gathering, analyzing and using data to assess and improve the quality of care; and

(v) At least annually, assess the effectiveness of the Nursing Home's quality program and recommend modifications in organizational structure, staffing patterns, and care delivery where necessary to promote high quality, compassionate care.

ARTICLE XI
Procedure for Meeting

All meetings of the Board of Directors and committees of the Nursing Home shall be conducted in accordance with procedures and rules of order as shall be acceptable to the Board.

ARTICLE XII
Medical Staff

Section 1. Appointment. The Board of Directors shall appoint the members of the Medical Staff in accordance with the provisions of these Bylaws and the Bylaws of the Medical Staff. Medical Staff members shall be appointed to terms of two (2) years only, with such terms being renewable by the Board and the Medical Board as described in these Bylaws and the Bylaws of the Medical Staff.

Section 2. Bylaws of Medical Staff. The organization, appointments, selection of officers and committees, determination of privileges, meetings and procedures of the Medical Staff shall be set forth in the Bylaws of the Medical Staff, which are subject to the approval of the Board of Directors. The Board of Directors, acting directly or by delegation to a Committee of the Board, shall make a determination within ninety (90) days after the Medical Board transmits its recommendation concerning these issues to the Board or Committee of the Board.

ARTICLE XIII
Dissolution

Upon the dissolution of the Nursing Home, the Board of Directors of the Nursing Home shall, after paying or making provision for the payment of all of the liabilities of the Nursing Home, distribute all of the remaining assets of the Nursing Home exclusively for the purposes of the Nursing Home or for a similar use or purpose, to such organization or organizations operated,

supervised or controlled by or in connection with Providence and organized and operated exclusively for charitable purposes.

ARTICLE XIV
Conflicts of Interest

Conflicts of interest are those circumstances in which personal, financial or professional interests may conflict with the interests of the Corporation. Members of the Board of Directors, officers, senior management, and members of committees with board delegated powers shall be required to provide full disclosure of conflicts in conformance with the Nursing Home's Conflicts of Interest Policy and Procedure (the "Conflicts Policy"). The Board of Directors shall furnish to members of the Board of Directors, officers, senior management and members of committees with Board-delegated powers a copy of such policy, as revised from time to time. Each Board member, officer, senior manager and members of committees with board delegated powers shall file with the Nursing Home a Conflict of Interest Statement at such times as such filing is required by the Conflicts Policy.

ARTICLE XV
Indemnification

Section 15.1 Authorized Indemnification. Unless clearly prohibited by law or Section 15.2 of these Bylaws, the Nursing Home shall indemnify, any person ("Indemnified Person") made, or threatened to be made, a party in any action or proceeding, whether civil, criminal, administrative, investigative or otherwise, including any action by or in the right of the Nursing Home, by reason of the fact that he or she (or his or her testator or intestate), whether before or after adoption of this Section, (a) is or was a Director or officer of the Nursing Home or (b) in addition is serving or served in any capacity, at the request of the Nursing Home, including as a member of a committee of the Board of Directors of the Nursing Home, or as director or officer of any other Nursing Home, or any partnership, joint venture, trust, employee benefit plan or other enterprise. The indemnification shall be against all judgments, fines, penalties, amounts paid in settlement (provided the Nursing Home shall have consented to such settlement) and reasonable expenses, including attorneys' fees, and costs of investigation, incurred by an Indemnified Person with respect to any such threatened or actual action or proceeding, and any appeal thereof.

Section 15.2 Prohibited Indemnification. The Nursing Home shall not indemnify any person if a judgment or other final adjudication adverse to the Indemnified Person (or to the person whose actions are the basis for the action or proceeding) establishes, or the Board of Directors in good faith determines, that such person's acts were committed in bad faith or were the result of active and deliberate dishonesty and were material to the cause of action so adjudicated or that he or she personally gained in fact a financial profit or other advantage to which he or she was not legally entitled.

Section 15.3 Advance of Expenses. The Nursing Home shall, on request of any Indemnified Person who is or may be entitled to be indemnified by the Nursing Home, pay or promptly reimburse the Indemnified Person's reasonably incurred expenses in connection with a

threatened or actual action or proceeding prior to its final disposition. However, no such advancement of expenses shall be made unless the Indemnified Person makes a binding, written commitment to repay the Nursing Home, with interest, for any amount advanced for which it is ultimately determined that he or she is not entitled to be indemnified under the law or Section 15.2 of these Bylaws. An Indemnified Person shall cooperate in good faith with any request by the Nursing Home that common legal counsel be used by the parties to such action or proceeding who are similarly situated unless it would be inappropriate to do so because of actual or potential conflicts between the interests of the parties.

Section 15.4 Indemnification of Others. Unless clearly prohibited by law or Section 15.2 of these Bylaws, the Board of Directors may approve Nursing Home indemnification as set forth in Section 15.1 of these Bylaws or advancement of expenses as set forth in Sections 15.1 and 15.3 of these Bylaws, to a person (or the testator or intestate of a person) who is or was employed by the Nursing Home or who is or was a volunteer for the Nursing Home, and who is made, or threatened to be made, a party in any action or proceeding, by reason of the fact of such employment or volunteer activity, including actions undertaken in connection with service at the request of the Nursing Home in any capacity for any other corporation, partnership, joint venture, trust, employee benefit plan or other enterprise.

Section 15.5 Determination of Indemnification. Indemnification mandated by a final order of a court of competent jurisdiction will be paid. After termination or disposition of any actual or threatened action or proceeding against an Indemnified Person, if indemnification has not been ordered by a court the Board of Directors shall, upon written request by the Indemnified Person, determine whether and to what extent indemnification is permitted pursuant to these Bylaws. Before indemnification can occur, the Board of Directors must explicitly find that such indemnification will not violate the provisions of Section 15.2 of these Bylaws. No director with a personal interest in the outcome, or who is a party to such actual or threatened action or proceeding concerning which indemnification is sought, shall participate in this determination. If a quorum of disinterested directors is not obtainable, the Board of Directors shall act only after receiving the opinion in writing of independent legal counsel that indemnification is proper in the circumstances under then applicable law and these By-laws.

Section 15.6 Binding Effect. Any person entitled to indemnification under these Bylaws has a legally enforceable right to indemnification which cannot be abridged by amendment of these Bylaws with respect to any event, action or omission occurring prior to the date of the amendment.

Section 15.7 Insurance. To the extent permitted by law, directors' and officers' liability insurance may inure the Nursing Home for any obligation it incurs as a result of this Article XV or operation of law and it may insure directly the directors, officers, employees, or volunteers of the Nursing Home for liabilities against which they are not entitled to indemnification under this Article XV as well as for liabilities against which they are entitled or permitted to be indemnified by the Nursing Home.

Section 15.8 Nonexclusive Rights. The provisions of this Article XV shall not limit or exclude any other rights to which any person may be entitled under law or contract. The Board of

Directors is authorized to enter into agreements on behalf of the Nursing Home with any directors, officer, employee or volunteer providing them rights to indemnification or advancement of expenses in connection with potential indemnification in addition to the provisions therefore in this Article XV subject in all cases to the limitations of Section 15.2 of these Bylaws.

ARTICLE XVI
Volunteers and Auxiliaries.

Groups interested in rendering services and undertaking activities designed to promote the best interest of the Nursing Home may be approved by the Board of Directors and shall function under their own bylaws and rules, subject in each instance to the prior approval of the Board of Directors before the same are effective.

ARTICLE XVII
Authority to Contract for Internal Management

Subject to any applicable provisions of law, the Board of Directors shall have authority to contract for the internal management of the Nursing Home's facilities with a Roman Catholic Religious Order or Community approved by Providence. In the event such a contract is entered into, such Roman Catholic Religious Order or Community shall have the right to nominate from among its members persons who are Administrators licensed by the State of New York to serve as Administrator of the Nursing Home.

ARTICLE XVIII
Gender

As used in these Bylaws, all references to the masculine gender shall be deemed to include the feminine.

APPROVED BY THE BOARD OF TRUSTEES OF
THE CATHOLIC HEALTH CARE SYSTEM

DATE: September 8, 2004

_____
Francis J. Serbaroli, Chair of the Board of Trustees

Dated: September 28, 2022

ST. TERESA'S NURSING HOME, INC.

ATTACHMENT *9*

PETITION FOR DISSOLUTION

----------X

In the Matter of the Application of :

ST. TERESA'S NURSING HOME, INC. : VERIFIED PETITION

For Approval of Certificate of Dissolution :

pursuant to Section 1002 of the :

Not-for -Profit Corporation Law :

----------X

TO:

THE ATTORNEY GENERAL OF THE STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
Charities Bureau, Transactions Section
28 Liberty Street
New York, New York 10004

Petitioner, ST. TERESA'S NURSING HOME, INC. by Francis J. Serbaroli, Chairman, Board of Directors, of the corporation, for its Verified Petition alleges:

1. ST. TERESA'S NURSING HOME, INC., whose principal address is located in the county of New York, was incorporated pursuant to New York's Not-for-Profit Corporation Law on December 1, 1967. A copy of the Certificate of Incorporation (and all amendments) and the complete and current By-laws are attached as Exhibit A.

2. The names, addresses and titles of the corporation's directors and officers are as follows:

Francis J. Serbaroli, Chairman- One Vanderbilt Avenue, New York, NY 10017
Thomas E. Alberto- 35 Prospect Park West Apt. 13A Brooklyn, NY 11215
Steve Bujno – 246 West End Avenue, Apt 4A, New York, NY 10023
John Cahill- 1011 First Avenue 20th Floor New York, NY 10022
Dr. Tara A. Cortes- 433 First Avenue, 5th Floor New York, NY 10016
John T. Dunlap- 230 Park Avenue 21st Floor New York, NY 10177
Monsignor Charles J. Fahey- Nottingham, 1301 Nottingham Rd, Jamesville, NY 13078
Thomas J. Fahey, Jr., M.D.- 300 East 66th Street New York, NY 10065
Eric P. Feldmann- 16 Hampshire Road Rockville Centre, NY 11570
Sister Seline Flores, Providence Rest, 3304 Waterbury Avenue, Bronx, NY 10465
John Gleason, 250 Park Avenue, New York, NY 10017
Karen Gray- 235 East 45th Street New York, New York 10017
George Irish- 300 West 57th Street, 26th Floor New York, NY 10019
Clarion E. Johnson, MD- 5504 Dorset Avenue Chevy Chase, Maryland 20815
Rory Kelleher- 1165 Fifth Avenue New York, NY 10029

Monsignor Joseph LaMorte- 1011 First Avenue, 19th Floor New York, NY 10022
Scott LaRue, ex-officio- 205 Lexington Avenue New York, NY 10016
Thomas M. O'Brien, Vice-Chair- PO Box 2326 Bonita Springs FL. 34133
Kathryn Rooney- 1475 Hylan Boulevard Staten Island, NY 10305
Joseph Saporito, 43 Somerset Place, Matawan, NJ 07747
G.T. Sweeney- 100 Church Street New York, NY 10007
Gennaro (Jerry) Vasile, Ph.D., 21908 Masters Circle Estero, FL 33928-6949
Bishop Gerald Walsh- 1011 First Avenue New York, NY 10022

3. The purposes for which the corporation was organized are set forth in its Certificate of Incorporation at paragraph three thereof and are as follows:

> II. the purposes for which the Company is to be formed are to provide nursing home accommodations for sick, invalid, infirm, disabled or convalescent persons of low income, and to this end to plan, construct, erect, build, acquire, alter, reconstruct, rehabilitate, own, maintain and operate a nursing home project pursuant to the terms and provisions of the Public Health Law.

4. The corporation is a charitable corporation.

5. The corporation plans to dissolve in accordance with the Plan of Dissolution attached hereto as Exhibit B (the "Plan").

6. The corporation is dissolving because the corporation, which owned and operated a skilled nursing facility, sold its assets at 120 Highland Avenue Middletown, NY 10940 and its operating certificate which transaction closed on or about January 31, 2013. The corporation is not aware of any ongoing or completed audit or inquiry by the Internal Revenue Service ("IRS") in the past three years or if the corporation paid any excise taxes or disclosed an excess benefit transaction or diversion of assets on its information returns to the IRS.

7. The Board of Directors of ST. TERESA'S NURSING HOME, INC., met at a duly called meeting on proper notice on September 27, 2021 at which a quorum of 19 directors out of 23 total directors was present, and unanimously approved resolutions adopting the Plan, and authorizing the filing of a Certificate of Dissolution. Such resolution, certified by the Secretary or other duly authorized officer is attached hereto as Exhibit C.

8. After the Board of Directors of ST. TERESA'S NURSING HOME, INC., approved the Plan, the Board of Trustees of Catholic Health Care System, at a duly called meeting on proper notice on September 27, 2021 at which a quorum of 19 trustees out of 23 total trustees was present, and unanimously approved resolutions adopting the Plan, and authorizing the filing of a Certificate of Dissolution. Such resolution, certified by the Secretary or other duly authorized officer is attached hereto as Exhibit D.

9. After the Board of Directors of ST. TERESA'S NURSING HOME, INC., and the Board of Trustees of Catholic Health Care System approved the Plan, the sole member, Providence Health Services, received and reviewed it and at a duly called meeting on proper

notice on December 14, 2021 at which a quorum of 4 trustees out of 4 total trustees was present, and unanimously approved resolutions adopting the Plan, and authorizing the filing of a Certificate of Dissolution. Such resolution, certified by the Secretary or other duly authorized officer is attached hereto as Exhibit E.

10. The corporation has no assets or liabilities as of the date hereof.

11. The corporation is not required to file a final financial report with the Charities Bureau because the organization is exempt from registration with the Charities Bureau.

12. A copy of the Public Health and Health Planning Council approval to the Plan is attached to the Certificate of Dissolution.

13. With this Petition, the original Certificate of Dissolution is being submitted to the Attorney General for approval pursuant to Not-for-Profit Corporation Law Section 1003.

WHEREFORE, Petitioner requests that the Attorney General approve the Certificate of Dissolution of ST. TERESA'S NURSING HOME, INC., a not-for-profit corporation, pursuant to Not-for-Profit Corporation Law Section 1003.

IN WITNESS WHEREFORE, the corporation has caused this Petition to be executed this __ day of April, 2022.

Frank Serbaroli

5B87D899CB31C2DE11E9FC57F917FEAC contractworks

Signature

_____

Francis J. Serbaroli, Chairman

VERIFICATION AND CERTIFICATION

STATE OF NEW YORK)

ss.:

COUNTY OF NEW YORK)

Francis J. Serbaroli, being duly sworn, deposes and says:

I am the Chairman of the Board of Directors of ST. TERESA'S NURSING HOME, INC., the corporation named in the above Petition, and make this verification and certification at the direction of its Board of Directors. I have read the foregoing Petition and (i) I know the contents thereof to be true of my own knowledge, except those matters that are stated on information and belief, and as to those matters I believe them to be true and (ii) I hereby certify under penalties of perjury that the Plan was duly authorized and adopted by the Board of Directors and by the corporation's sole member.

_____

Signature

Sworn to before me this

____day of _____, 20__.

_____

Notary Public

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 18th day of April 2023, approves the filing of the Certificate of Dissolution of St. Teresa's Nursing Home, Inc., dated September 27, 2021.

Pursuant to the authority vested in the Commissioner of Health by Section 2803 of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended by amending sections 405.11 and 415.19, to be effective upon filing with the Secretary of State, to read as follows:

Section 405.11 is amended by adding a new subdivision (g) as follows:

(g) (1) The hospital shall possess and maintain a supply of all necessary items of personal protective equipment (PPE) sufficient to protect health care personnel, consistent with federal Centers for Disease Control and Prevention guidance, for at least 60 days, by August 31, 2021.

(2) The 60-day stockpile requirement set forth in paragraph (1) of this subdivision shall be determined by the Department as follows for each type of required PPE:

(i) for single gloves, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 550;

(ii) for gowns, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 41;

(iii) for surgical masks, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 21; and

(iv) for N95 respirator masks, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 9.6.

(3) A hospital shall be considered to possess and maintain the required PPE if:

(i) it maintains all PPE on-site; or

(ii) it maintains PPE off-site, provided that the off-site storage location is within New York State, can be accessed by the hospital within at least 24 hours, and the hospital maintains at least a 10-day supply of all required PPE on-site, as determined by the calculations set forth in paragraph (2) of this subdivision. A hospital may enter into an agreement with a vendor to store off-site PPE, provided that such agreement requires the vendor to maintain unduplicated, facility-specific stockpiles; the vendor agrees to maintain at least a 60-day supply of all required PPE, or a 90-day supply in the event the Commissioner increases the required stockpile amount pursuant to this subdivision (less the amount that is stored on site at the facility); and the PPE is accessible by the facility 24 hours a day, 7 days a week, year round. In the event the Department finds a hospital has not maintained the required PPE stockpile, it shall not be a defense that the vendor failed to maintain the supply.

(iii) Any PPE stored outside of New York State shall not count toward the facility's required 60-day stockpile.

(4) The Commissioner shall have discretion to increase the stockpile requirement set forth in paragraph (1) of this subdivision from 60 days to 90 days where there is a State or local public health emergency declared pursuant to Section 24 or 28 of the Executive Law. Hospitals shall possess and maintain the necessary 90-day stockpile of PPE by the deadline set forth by the Commissioner.

(5) The Department shall periodically determine the number of staffed beds in each hospital. Hospitals shall have 90 days to come into compliance with the new PPE stockpile requirements, as set forth in paragraph (2) of this subdivision, following such determination by the Department. Provided further that the Commissioner shall have discretion to determine an applicable bed

calculation for a hospital which is different than the number of staffed beds, if circumstances so require.

(6) In order to maximize the shelf life of stockpiled inventory, providers should follow the appropriate storage conditions as outlined by manufacturers, and providers are strongly encouraged to rotate inventory through regular usage and replace what has been used in order to ensure a consistent readiness level and reduce waste. Expired products should be disposed of when their expiration date has passed. Expired products shall not be used to comply with the stockpile requirement set forth in paragraph (1) of this subdivision.

(7) Failure to possess and maintain the required supply of PPE may result in the revocation, limitation, or suspension of the hospital's license; provided, however, that no such revocation, limitation, or suspension shall be ordered unless the Department has provided the hospital with a fourteen-day grace period, solely for a hospital's first violation of this section, to achieve compliance with the requirement set forth herein.

(8) In the event a new methodology relating to PPE in hospitals is developed, including but not limited to a methodology by the U.S. Department of Health & Human Services, and the Commissioner determines that such alternative methodology is appropriate for New York hospitals and will adequately protect hospital staff and patients, the Commissioner shall amend this subdivision to reflect such new methodology.

Section 415.19 is amended by adding a new subdivision (f) as follows:

(f) (1) The nursing home shall possess and maintain a supply of all necessary items of personal protective equipment (PPE) sufficient to protect health care personnel, consistent with federal Centers for Disease Control and Prevention guidance, for at least 60 days, by August 31, 2021.

(2) The 60-day stockpile requirement set forth in paragraph (1) of this subdivision shall be determined by the Department as follows for each type of required PPE:

(i) for single gloves, the applicable positivity rate, multiplied by the nursing home's average census as determined annually by the Department, multiplied by 24;

(ii) for gowns, the applicable positivity rate, multiplied by the nursing home's average census as determined annually by the Department, multiplied by 3;

(iii) for surgical masks, the applicable positivity rate, multiplied by the nursing home's average census as determined annually by the Department, multiplied by 1.5; and

(iv) for N95 respirator masks, the applicable positivity rate, multiplied by the nursing home's average census as determined annually by the Department, multiplied by 1.4.

(v) For the purposes of this paragraph, the term "applicable positivity rate" shall mean the greater of the following positivity rates:

(a) The nursing home's average COVID-19 positivity rate, based on reports made to the Department, during the period April 26, 2020 through May 20, 2020; or

(b) The nursing home's average COVID-19 positivity rate, based on reports made to the Department, during the period January 3, 2021 through January 31, 2021; or

(c) 20.15 percent, representing the highest Regional Economic Development Council average COVID-19 positivity rate, as reported to the Department, during the periods April 26, 2020 through May 20, 2020 and January 3, 2021 through January 31, 2021.

(3) A nursing home shall be considered to possess and maintain the required PPE if:

(i) it maintains all PPE on-site; or

(ii) it maintains PPE off-site, provided that the off-site storage location is within New York State, can be accessed by the nursing home within at least 24 hours, and the nursing home maintains at least a 10-day supply of all required PPE on-site, as determined by the calculations set forth in paragraph (2) of this subdivision. A nursing home may enter into an agreement with a vendor to store off-site PPE, provided that such agreement requires the vendor to maintain unduplicated, facility-specific stockpiles, the vendor agrees to maintain at least a 60-day supply of all required PPE (less the amount that is stored on-site at the facility), and the PPE is accessible by the facility 24 hours a day, 7 days a week, year round. In the event the Department finds a nursing home has not maintained the required PPE stockpile, it shall not be a defense that the vendor failed to maintain the supply.

(iii) Any PPE stored outside of New York State shall not count toward the facility's required 60-day stockpile.

(4) The Department shall determine the nursing home's average census annually, by January 1st of each year, and shall communicate such determination to each facility. Nursing homes shall have 90 days to come into compliance with the new PPE stockpile requirements, as set forth in paragraph (2) of this subdivision, following such determination by the Department.

(5) In order to maximize the shelf life of stockpiled inventory, providers should follow the appropriate storage conditions as outlined by manufacturers, and providers are strongly encouraged to rotate inventory through regular usage and replace what has been used in order to ensure a consistent readiness level and reduce waste. Expired products should be disposed of when their expiration date has passed. Expired products shall not be used to comply with the stockpile requirement set forth in paragraph (1) of this subdivision.

(6) Failure to possess and maintain the required supply of PPE may result in the revocation, limitation, or suspension of the nursing home's license; provided, however, that no such revocation, limitation, or suspension shall be ordered unless the Department has provided the nursing home with a fourteen day grace period, solely for a nursing home's first violation of this section, to achieve compliance with the requirement set forth herein.

(7) In the event a new methodology relating to PPE in Residential Health Care Facilities is developed, including but not limited to a methodology by the U.S. Department of Health & Human Services, and the Commissioner determines that such alternative methodology is appropriate for New York nursing homes and will adequately protect facility staff and patients, the Commissioner shall amend this subdivision to reflect such new methodology.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Section 2803 of the Public Health Law (PHL) authorizes the promulgation of such regulations as may be necessary to implement the purposes and provisions of PHL Article 28, including the establishment of minimum standards governing the operation of health care facilities, including hospitals and nursing homes.

Legislative Objectives:

The legislative objectives of PHL Article 28 include the protection and promotion of the health of the residents of the State by requiring the efficient provision and proper utilization of health services, of the highest quality at a reasonable cost.

Needs and Benefits:

The 2019 Coronavirus (COVID-19) is a disease that causes mild to severe respiratory symptoms, including fever, cough, and difficulty breathing. People infected with COVID-19 have had symptoms ranging from those that are mild (like a common cold) to severe pneumonia that requires medical care in a general hospital and can be fatal, with a disproportionate risk of severe illness for older adults and/or those who have serious underlying medical health conditions.

On January 30, 2020, the World Health Organization (WHO) designated the COVID-19 outbreak as a Public Health Emergency of International Concern. On a national level, the Secretary of Health and Human Services determined on January 31, 2020 that as a result of confirmed cases of COVID-19 in the United States, a public health emergency existed and had existed since January 27, 2020, nationwide. Thereafter, the situation rapidly evolved throughout

the world, with many countries, including the United States, quickly progressing from the identification of travel-associated cases to person-to-person transmission among close contacts of travel-associated cases, and finally to widespread community transmission of COVID-19.

In order for hospital and nursing home staff to safely provide care for COVID-19 positive patients and residents, or patients and residents infected with another communicable disease, while ensuring that they themselves do not become infected with COVID-19 or any other communicable disease, it is critically important that personal protective equipment (PPE), including masks, gloves, respirators, face shields and gowns, is readily available and are used. Therefore, as a result of global PPE shortages at the outset of the State of Emergency, New York State provided general hospitals, nursing homes, and other medical facilities with PPE from the State's emergency stockpile from the beginning of the COVID-19 outbreak. However, hospitals and nursing homes must ensure sufficient PPE stockpiles exist for any future communicable disease outbreaks to ensure each facility is adequately prepared to protect its staff and patients or residents, without needing to rely on the State's emergency stockpile.

Based on the foregoing, the Department has made the determination that this emergency regulation is necessary to ensure that all general hospitals and nursing homes maintain a 60-day supply of PPE to ensure that sufficient PPE is available in the event of a continuation or resurgence of the COVID-19 outbreak or another communicable disease outbreak.

COSTS:

Costs to Regulated Parties:

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each facility. However, the

Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are strongly encouraged to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to balance facility expenditures over time and reduce waste. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). As such, this regulation imposes no long-term additional costs to regulated parties.

Costs to Local and State Governments:

This regulation will not impact local or State governments unless they operate a general hospital or nursing home, in which case costs will be the same as costs for private entities.

Costs to the Department of Health:

This regulation will not result in any additional operational costs to the Department of Health.

Paperwork:

This regulation imposes no addition paperwork.

Local Government Mandates:

General hospitals and nursing homes operated by local governments will be affected and will be subject to the same requirements as any other general hospital licensed under PHL Article 28.

Duplication:

These regulations do not duplicate any State or federal rules.

Alternatives:

The Department believes that promulgation of this regulation is the most effective means of ensuring that general hospitals and nursing homes have adequate stockpiles of PPE necessary to protect hospital staff from communicable diseases, compared to any alternate course of action.

Federal Standards:

No federal standards apply to stockpiling of such equipment at hospitals.

Compliance Schedule:

The regulations will become effective upon filing with the Department of State.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower Building, Room 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488

(518) 473-2019 (FAX)
REGSQNA@health.ny.gov

REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Business and Local Government:

This regulation will not impact local governments or small businesses unless they operate a general hospital or a nursing home. Currently there are five general hospitals in New York that employ less than 100 staff and qualify as small businesses, and there are 79 nursing homes in New York qualify as small businesses given that they employ less than 100 staff.

Compliance Requirements:

These regulations require all general hospitals and nursing homes to purchase and maintain adequate stockpiles of PPE, including but not limited to masks, respirators, face shields and gowns.

Professional Services:

It is not expected that any professional services will be needed to comply with this rule.

Compliance Costs:

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each covered facility. However, the Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are strongly encouraged to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby

helping to balance facility expenditures over time and reduce waste. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). As such, this regulation imposes no long-term additional costs to regulated parties.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

The Department anticipates that any adverse impacts will be minimal, as both hospitals and nursing homes have already mobilized their stockpiling efforts since early 2020, when the spread of the COVID-19 virus was first recognized in New York State, including through two surges of the COVID-19 pandemic. As such, the continuance of these stockpiling requirements is not expected to create any additional adverse impact on hospitals or nursing homes. Moreover, for nursing homes, these PPE regulations are consistent with the existing directive in Public Health Law section 2803(12) to maintain a two-month PPE supply.

Small Business and Local Government Participation:

The Department contacted hospital and nursing home associations, individual hospitals and health systems, and health care labor unions for input regarding these regulations and the

underlying methodology. Input from these stakeholders has been incorporated into the regulations.

RURAL AREA FLEXIBILITY ANALYSIS

Type and Estimated Numbers of Rural Areas:

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

Allegany County	Greene County	Schoharie County
Cattaraugus County	Hamilton County	Schuyler County
Cayuga County	Herkimer County	Seneca County
Chautauqua County	Jefferson County	St. Lawrence County
Chemung County	Lewis County	Steuben County
Chenango County	Livingston County	Sullivan County
Clinton County	Madison County	Tioga County
Columbia County	Montgomery County	Tompkins County
Cortland County	Ontario County	Ulster County
Delaware County	Orleans County	Warren County
Essex County	Oswego County	Washington County

Franklin County	Otsego County	Wayne County
Fulton County	Putnam County	Wyoming County
Genesee County	Rensselaer County	Yates County
	Schenectady County	

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

Albany County	Monroe County	Orange County
Broome County	Niagara County	Saratoga County
Dutchess County	Oneida County	Suffolk County
Erie County	Onondaga County	

There are 47 general hospitals located in rural areas as well as several licensed nursing homes.

Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:

These regulations require all general hospitals and nursing homes, including those in rural areas, to purchase and maintain adequate stockpiles of PPE, including but not limited to masks, respirators, face shields and gowns.

Compliance Costs:

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each facility. However, the Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as

part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to balance facility expenditures over time and reduce waste. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). Therefore, this regulation imposes no long-term additional costs to regulated parties.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

The Department anticipates that any adverse impacts will be minimal, as both hospitals and nursing homes have already mobilized their stockpiling efforts since early 2020, when the spread of the COVID-19 virus was first recognized in New York State, including through two surges of the COVID-19 pandemic. As such, the continuance of these stockpiling requirements is not expected to create any additional adverse impact on hospitals or nursing homes. Moreover, for nursing homes, these PPE regulations are consistent with the existing directive in Public Health Law section 2803(12) to maintain a two-month PPE supply.

Rural Area Participation:

The Department contacted hospital and nursing home associations, individual hospitals and health systems, and health care labor unions for input regarding these regulations and the underlying methodology, including associations representing facilities in rural areas of the State. Input from these stakeholders has been incorporated into the regulations.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

EMERGENCY JUSTIFICATION

These regulations are needed on an emergency basis to ensure hospital and nursing home staff, as well as the patients and residents for whom they provide care, are adequately protected during the 2019 Coronavirus (COVID-19) or another communicable disease outbreak. These regulations are specifically meant to address the lessons learned in New York State from 2020 to 2021 during the COVID-19 pandemic with respect to PPE. Notwithstanding the end of the State disaster emergencies relating to COVID-19, infections in nursing homes across the state persist and hospitals remain at the front lines of response. Further, a possible resurgence of COVID-19 or another communicable disease outbreak, and possible interruptions to the PPE supply chain again as seen during the COVID-19 pandemic, necessitates that hospitals and nursing homes continue to have an adequate supply of PPE to protect these vulnerable populations and the staff who provide care.

New York State first identified COVID-19 cases on March 1, 2020 and thereafter became the national epicenter of the outbreak. However, as a result of global PPE shortages, many hospitals and nursing homes in New York State had difficulty obtaining adequate PPE necessary to care for their patients and residents. New York State provided general hospitals, nursing homes, and other medical facilities with PPE from the State's emergency stockpile from the beginning of the COVID-19 outbreak.

These regulations are needed on an emergency basis to ensure that hospitals and nursing homes Statewide do not again find themselves in need of PPE from the State's stockpile should another communicable disease outbreak occur, COVID-19 or otherwise. It is critically important that PPE, including masks, gloves, respirators, face shields and gowns, is readily available and used when needed, as hospital and nursing home staff must don all required PPE to safely

provide care for patients and residents with communicable diseases, while ensuring that they themselves do not become infected with a communicable disease.

Based on the foregoing, the Department has made the determination that this emergency regulation is necessary to ensure that all general hospitals and nursing homes maintain a 60-day supply of PPE to ensure that sufficient PPE is available in the event of a resurgence of COVID-19 or another communicable disease outbreak.

Of note, the regulations, although effective for 60 days by law, include an early termination provision requiring the Commissioner to amend the regulations to follow an alternative PPE stockpile methodology, in the event a new methodology relating to PPE in hospitals and/or Residential Health Care Facilities is developed and the Commissioner determines that such alternative methodology is appropriate for New York hospitals and nursing homes and will adequately protect facility staff and patients.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Sections 225, 576, and 2803 of the Public Health Law, Sections 2.1 and 2.5 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended, Section 2.6 is repealed and a new Section 2.6 is added, Section 405.3 is amended and a new Section 58-1.14 is added, to be effective upon filing with the Secretary of State, to read as follows:

Subdivision (a) of section 2.1 is amended to read as follows:

(a) When used in the Public Health Law and in this Chapter, the term infectious, contagious or communicable disease, shall be held to include the following diseases and any other disease which the commissioner, in the reasonable exercise of his or her medical judgment, determines to be communicable, rapidly emergent or a significant threat to public health, provided that the disease which is added to this list solely by the commissioner's authority shall remain on the list only if confirmed by the Public Health and Health Planning Council at its next scheduled meeting:

* * *

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* * *

Section 2.5 is amended to read as follows:

A physician in attendance on a person affected with or suspected of being affected with any of the diseases mentioned in this section shall submit to an approved laboratory, or to the laboratory

of the State Department of Health, for examination of such specimens as may be designated by the State Commissioner of Health, together with data concerning the history and clinical manifestations pertinent to the examination:

* * *

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* * *

Section 2.6 is repealed and replaced as follows:

2.6 Investigations and Response Activities.

(a) Except where other procedures are specifically provided in law, every local health authority, either personally or through a qualified representative, shall immediately upon receiving a report of a case, suspected case, outbreak, or unusual disease, investigate the circumstances of such report at any and all public and private places in which the local health authority has reason to believe, based on epidemiological or other relevant information available, that such places are associated with such disease. Such investigations and response activities shall, consistent with any direction that the State Commissioner of Health may issue:

(1) Verify the existence of a disease or condition;

(2) Ascertain the source of the disease-causing agent or condition;

(3) Identify unreported cases;

(4) Locate and evaluate contacts of cases and suspected cases, as well as those reasonably expected to have been exposed to the disease;

(5) Collect and submit, or cause to be collected or submitted, for laboratory examination such specimens as may furnish necessary or appropriate information for determining the

source of disease, or to assist with diagnosis; and furnish or cause to be furnished with such specimens pertinent data on forms prescribed by the State Commissioner of Health, including but not limited to the history of cases, physical findings and details of the epidemiological investigation;

(6) With the training or assistance of the State Department of Health, examine the processes, structures, conditions, machines, apparatus, devices, equipment, records, and material within such places that may be relevant to the investigation of disease or condition;

(7) Instruct a responsible member of a household or entity, as applicable, to implement appropriate actions to prevent further spread of a disease; and

(8) Take any other steps to reduce morbidity and mortality that the local health authority determines to be appropriate.

(b) When a case or suspected case of a disease, condition, outbreak, or unusual disease occurs in any business, organization, institution, or private home, the person in charge of the business, organization, institution or the home owner, as well as any individuals or entities required to report pursuant to sections 2.10 and 2.12 of this Part, shall cooperate with the State Department of Health and local health authorities in the investigation of such disease, condition, outbreak, or unusual disease.

(c) Investigation Updates and Reports.

(1) Upon request of the State Department of Health, the local health authority shall submit updates and reports on outbreak investigations to the State Department of Health. The

content, timeframe, and manner of submission of such updates shall be determined by the State Department of Health.

(2) The local health authority shall complete investigation reports of outbreaks within 30 days of the conclusion of the investigation in a manner prescribed by the State Commissioner of Health, unless the State Commissioner of Health prescribes a different time period.

(d) Commissioner authority to lead investigation and response activities.

(1) The State Commissioner of Health may elect to lead investigation and response activities where:

(i) Residents of multiple jurisdictions within the State are affected by an outbreak of a reportable disease, condition, or unusual disease; or

(ii) Residents in a jurisdiction or jurisdictions within the State and in another state or states are affected by an outbreak of a reportable disease, condition, or unusual disease; or

(iii) An outbreak of an unusual disease or a reportable disease or condition involves a single jurisdiction with the high potential for statewide impact.

(2) Where the State Commissioner of Health elects to lead investigation and response activities pursuant to paragraph (1) of this subdivision, local health authorities shall take all reasonable steps to assist in such investigation and response, including supply of personnel, equipment or information. Provided further that the local health authority shall take any such action as the State Commissioner of Health deems appropriate and that is within the jurisdiction of the local health authority. Any continued investigation or

response by the local health authority shall be solely pursuant to the direction of the State Commissioner of Health, and the State Commissioner of Health shall have access to any investigative materials which were heretofore created by the local health authority.

Paragraph (11) of subdivision (d) of section 405.3 is amended, paragraph (12) is renumbered paragraph (13), and a new paragraph (12) is added, to read as follows:

(d) Records and reports. Any information, records or documents provided to the department shall be subject to the applicable provisions of the Public Health Law, Mental Hygiene Law, Education Law, and the Public Officers Law in relation to disclosure. The hospital shall maintain and furnish to the Department of Health, immediately upon written request, copies of all documents, including but not limited to:

* * *

(11) written minutes of each committee's proceedings. These minutes shall include at least the following:

(i) attendance;

(ii) date and duration of the meeting;

(iii) synopsis of issues discussed and actions or recommendations made; [and]

(12) whenever the commissioner determines that there exists an outbreak of a highly contagious communicable disease pursuant to Part 2 of this Title or other public health emergency, such syndromic and disease surveillance data as the commissioner deems appropriate, which the hospital shall submit in the manner and form determined by the commissioner; and

(13) any record required to be kept by the provisions of this Part.

* * *

Section 405.3 is amended by adding a new subdivision (g) as follows:

(g) Whenever the commissioner determines that there exists an outbreak of a highly contagious communicable disease pursuant to Part 2 of this Title or other public health emergency, the commissioner may direct general hospitals, as defined in Article 28 of the public health law, and consistent with the federal Emergency Medical Treatment and Labor Act (EMTALA), to accept patients pursuant to such procedures and conditions as the commissioner may determine appropriate.

New section 58-1.14 is added to read as follows:

Section 58-1.14 Reporting of certain communicable diseases.

(a) The commissioner shall designate those communicable diseases, as defined by section 2.1 of the Sanitary Code, that require prompt action, and shall make available on the Department's website a list of such communicable diseases.

(b) Laboratories performing tests for screening, diagnosis or monitoring of communicable diseases requiring prompt action pursuant to subdivision (a) of this section, for New York State residents and/or New York State health care providers, shall:

(i) immediately report to the commissioner all positive results for such communicable diseases in a manner and format as prescribed by the commissioner; and

(ii) report all results, including positive, negative and indeterminate results, to the commissioner in a time and manner consistent with Public Health Law § 576-c.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for the regulatory amendments to Part 2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is Section 225 of the Public Health Law (PHL), which authorizes the Public Health and Health Planning Council (PHHPC), subject to the approval of the Commissioner of Health (Commissioner), to establish and amend the State Sanitary Code (SSC) provisions related to any matters affecting the security of life or health or the preservation and improvement of public health in the State of New York. Additionally, Section 2103 of the PHL requires all local health officers to report cases of communicable disease to the New York State Department of Health (Department).

The statutory authority for the proposed amendments to section 405.3 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is section 2803 of the PHL, which authorizes 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.

The statutory authority for the proposed new section 58-1.14 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is section 576 of the PHL, which authorizes the Department to adopt regulations prescribing the requirements for the proper operation of a clinical laboratory, including the methods and the manner in which testing or analyses of samples shall be performed and reports submitted.

Legislative Objectives:

The legislative objective of PHL § 225 is, in part, to protect the public health by authorizing PHHPC, with the approval of the Commissioner, to amend the SSC to address public health issues related to communicable disease.

The legislative objective of PHL § 2803 includes, among other objectives, authorizing PHHPC, with the approval of the Commissioner, to adopt regulations concerning the operation of facilities licensed pursuant to Article 28 of the PHL, including general hospitals.

The legislative objective of PHL § 576 is, in part, to promote public health by establishing minimum standards for clinical laboratory testing and reporting of test results, including to the Department for purposes of taking prompt action to address outbreaks of disease.

Needs and Benefits:

These regulations update, clarify and strengthen the Department's authority as well as that of local health departments to take specific actions to monitor the spread of disease, including actions related to investigation and response to a disease outbreak.

The following is a summary of the amendments to the Department's regulations:

Part 2 Amendments:

- Amend sections 2.1 and 2.5 to reflect The World Health Organization's (WHO) decision to change the name of "monkeypox" to "Mpox" in an effort to reduce the stigma that monkeypox comes with and deal with possible misinformation falsely suggesting that monkeys are the main source of spreading the virus.
- Repeal and replace current section 2.6, related to investigations, to clarify existing local health department authority.

- Sets forth specific actions that local health departments must take to investigate a case, suspected case, outbreak, or unusual disease.
- Requires individuals and entities subject to a public health investigation to cooperate with the Department and local health departments.
- While the Department works collaboratively with local health departments on a variety of public health issues, including disease control, this regulation clarifies the authority for the Commissioner to lead disease investigation activities under certain circumstances (i.e., where there is potential for statewide impact, multiple jurisdictions impacted, or impact on one or more New York State jurisdictions and another state or states), while working collaboratively with impacted local health departments. In all other situations, local health departments retain the primary authority and responsibility to control communicable disease within their respective jurisdictions, with the Department providing assistance as needed.
- Codify in regulation the requirement that local health departments send reports to the Department during an outbreak.

Part 405 Amendments

- Mandates hospitals to report syndromic surveillance data during an outbreak of a highly contagious communicable disease.
- Permits the Commissioner to direct hospitals to take patients during an outbreak of a highly contagious communicable disease, which is consistent with the federal Emergency Medical Treatment and Labor Act (EMTALA).

Part 58 Amendments

- New section 58-1.14 added clarifying reporting requirements for certain communicable diseases
    - Requires the Commissioner to designate those communicable diseases that require prompt action, and to make available a list of such diseases on the State Department of Health website.
    - Requires clinical laboratories to immediately report positive test results for communicable diseases identified as requiring prompt attention, in a manner and format identified by the Commissioner.
    - Requires clinical laboratories to report all test results, including negative and indeterminate results, for communicable diseases identified as requiring prompt attention, via the Electronic Clinical Laboratory Reporting System (ECLRS).

COSTS:

Costs to Regulated Parties:

Although there are costs associated with disease investigation and response for any outbreak, these regulations clarify and strengthen the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations.

The requirement that hospitals submit syndromic surveillance reports when requested during an outbreak is not expected to result in any substantial costs. Hospitals are already regularly and voluntarily submitting data to the Department, and nearly all of them submit such reports electronically. With regard to the Commissioner directing general hospitals to accept

patients during an outbreak of a highly contagious communicable disease, hospitals are already required to adhere to the federal Emergency Medical Treatment and Labor Act (EMTALA). Accordingly, both of these proposed amendments will not impose any substantial additional cost to hospitals.

Clinical laboratories must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102. The regulation simply clarifies existing requirements and is not anticipated to imposes any substantial additional costs beyond those costs that laboratories would incur in the absence of these regulations.

Costs to Local and State Governments:

Although there are costs associated with disease investigation and response for any outbreak, these regulations clarify and strengthen the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations. Further, making explicit the Department's authority to lead investigation activities will result in increased coordination of resources, likely resulting in a cost-savings for State and local governments.

Any clinical laboratories operated by a local government must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102. The regulation simply clarifies existing requirements and is not anticipated to imposes any substantial additional costs beyond those costs that laboratories would incur in the absence of these regulations.

Paperwork:

Some hospitals may be required to make additional syndromic surveillance reports that they are not already making. Otherwise, these regulations do not require any additional paperwork.

Local Government Mandates:

Under existing regulation, local health departments already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties.

Duplication:

There is no duplication in existing State or federal law.

Alternatives:

The alternative would be to leave in place the current regulations on disease investigation. However, many of these regulatory provisions have not been updated in fifty years and should be modernized to ensure appropriate response to a disease outbreak, such as COVID-19.

Federal Standards:

States and local governments have primary authority for controlling disease within their respective jurisdictions. Accordingly, there are no federal statutes or regulations that apply to disease control within NYS.

Compliance Schedule:

These emergency regulations will become effective upon filing with the Department of State and will expire, unless renewed, 90 days from the date of filing. As the COVID-19 pandemic is consistently and rapidly changing, it is not possible to determine the expected duration of need at this point in time. The Department will continuously evaluate the expected duration of these emergency regulations throughout the aforementioned 90-day effective period in making determinations on the need for continuing this regulation on an emergency basis or issuing a notice of proposed rulemaking for permanent adoption. This notice does not constitute a notice of proposed or revised rule making for permanent adoption.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower Building, Room 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.ny.gov

REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Business and Local Government:

Under existing regulation, local health departments already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties.

Compliance Requirements:

Under existing regulation, local health departments already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties. With respect to mandating syndromic surveillance reporting during an outbreak of a highly infectious communicable disease, hospitals are already reporting syndromic surveillance data regularly and voluntarily. With respect to clinical laboratories, they must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102. The regulation simply clarifies existing requirements and is not anticipated to imposes any substantial additional costs beyond those costs that laboratories would incur in the absence of these regulations.

Professional Services:

It is not expected that any professional services will be needed to comply with this rule.

Compliance Costs:

Although there are costs associated with disease investigation and response for any outbreak, these regulations clarify and strengthen the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations.

Further, making explicit the Department's authority to lead investigation activities will result in increased coordination of resources, likely resulting in a cost-savings for State and local governments.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

As the proposed regulations largely clarify existing responsibility and duties among regulated entities and individuals, any adverse impacts are expected to be minimal. The Department, however, will work with regulated entities to ensure they are aware of the new regulations and have the information necessary to comply.

Small Business and Local Government Participation:

Due to the emergent nature of COVID-19, small business and local governments were not consulted. If these regulations are proposed for permanent adoption, all parties will have an opportunity provided comments during the notice and comment period.

RURAL AREA FLEXIBILITY ANALYSIS

Type and Estimated Numbers of Rural Areas:

While this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 44 counties have a population of less than 200,000 based upon 2020 United States Census data:

Allegany County
Broome County
Cattaraugus County
Cayuga County
Chautauqua County
Chemung County
Chenango County
Clinton County
Columbia County
Cortland County
Delaware County
Essex County
Franklin County
Fulton County
Genesee County
Greene County
Hamilton County
Herkimer County
Jefferson County
Lewis County
Livingston County
Madison County
Montgomery County
Ontario County
Orleans County
Oswego County
Otsego County
Putnam County
Rensselaer County
Schenectady County
Schoharie County
Schuyler County
Seneca County
St. Lawrence County
Steuben County
Sullivan County
Tioga County
Tompkins County
Ulster County
Warren County
Washington County
Wayne County
Wyoming County
Yates County

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

Albany County	Monroe County	Orange County
Dutchess County	Niagara County	Saratoga County
Erie County	Oneida County	Suffolk County
	Onondaga County	

Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:

As the proposed regulations largely clarify existing responsibilities and duties among regulated entities and individuals, no additional recordkeeping, compliance requirements, or professional services are expected. With respect to mandating syndromic surveillance reporting during an outbreak of a highly infectious communicable disease, hospitals are already reporting syndromic surveillance data regularly and voluntarily. Additionally, the requirement for local health departments to continually report to the Department during an outbreak is historically a practice that already occurs. With respect to clinical laboratories, they must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102.

Compliance Costs:

As the proposed regulations largely clarify existing responsibility and duties among regulated entities and individuals, no initial or annual capital costs of compliance are expected above and beyond the cost of compliance for the requirements currently in Parts 2, 405 and 58.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

As the proposed regulations largely clarify existing responsibility and duties among regulated entities and individuals, any adverse impacts are expected to be minimal. The Department, however, will work with local health departments to ensure they are aware of the new regulations and have the information necessary to comply.

Rural Area Participation:

Due to the emergent nature of COVID-19, parties representing rural areas were not consulted. If these regulations are proposed for permanent adoption, all parties will have an opportunity provided comments during the notice and comment period.

JOB IMPACT STATEMENT

The Department of Health has determined that this regulatory change will not have a substantial adverse impact on jobs and employment, based upon its nature and purpose.

EMERGENCY JUSTIFICATION

Where compliance with routine administrative procedures would be contrary to public interest, the State Administrative Procedure Act (SAPA) § 202(6) empowers state agencies to adopt emergency regulations necessary for the preservation of public health, safety, or general welfare. In this case, compliance with SAPA for filing of this regulation on a non-emergency basis, including the requirement for a period of time for public comment, cannot be met because to do so would be detrimental to the health and safety of the general public.

New York continues to experience significant community levels of COVID-19 disease. The levels of COVID-19 illness that hospitals are still experiencing is the equivalent of a regular flu season, but for more than 36 months in a row. New York still has a 7-day average of over 1,300 cases per day, and over 1,700 people in the hospital affected by COVID each day. Regrettably, New York still averages about 20 deaths per day associated with COVID-19.

Severe Acute Respiratory Syndrome Coronavirus -2 (SARS-CoV2) still mutates, although the current dominant strain is BQ1, a subvariant of Omicron, new more contagious variants continue to emerge. The threat from emerging variants includes their unknown virulence affecting morbidity and mortality. It is also unknown how well existing vaccines or pharmacotherapeutics will protect against emerging variants. Several monoclonal antibody treatments are no longer authorized for use by FDA, because they do not work against new Omicron strains.

In fall and early winter of 2022-23, New York experienced large increases in COVID-19, influenza, and respiratory syncytial virus (RSV) that taxed the healthcare system. While this "tripledemic" has since eased, COVID continues to cause significant morbidity and mortality to New Yorkers.

New York is also uniquely subject to rare diseases, due to its size, congestion, and status as a major international travel hub. Earlier this year, as part of an Ebola virus outbreak in Uganda, travelers from the country were funneled to five airports in the US, with JFK and Newark airports being two of those. If individuals with contacts to known cases were identified, measures would need to be taken to protect the public health. Similarly, an outbreak of Marburg virus is currently taking place in Equatorial Guinea. Marburg is similar to Ebola and outbreaks like this highlight the ongoing outsized roles that New York may have in international infectious disease cases and outbreaks.

Furthermore, a polio outbreak has affected multiple counties in the State of New York, with one paralytic case and detections of genetically related virus in six counties, indicating circulation and transmission of the virus likely in hundreds of people. Currently, four polio infections have been identified in Israel, with at least one of those resulting in a case of paralytic polio. There is significant regular travel that takes place between New York and Israel, and with spring break and religious holidays, that amount of travel between the two areas is expected to increase, which may put more of the population at risk of becoming to exposed to poliovirus.

The emergency regulations are needed to continue requiring clinical laboratories to report all test results, including negative and indeterminate results, for communicable diseases such as COVID-19, polio and other communicable infections; mandate hospitals to report syndromic surveillance data; and permit the Commissioner to direct hospitals to take patients during a disease outbreak such as COVID-19 or Ebola.

Based on the ongoing burden of multiple outbreaks seen across the state, the Department has determined that these regulations are necessary to promulgate on an emergency basis to control the spread of highly contagious communicable diseases in New York State.

Accordingly, current circumstances necessitate immediate action, and pursuant to the State Administrative Procedure Act Section 206(6), a delay in the issuance of these emergency regulations would be contrary to public interest.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Sections 225, 576, and 2803 of the Public Health Law, Sections 2.1 and 2.5 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended, Section 2.6 is repealed and a new Section 2.6 is added, Section 405.3 is amended and a new Section 58-1.14 is added, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivision (a) of section 2.1 is amended to read as follows:

(a) When used in the Public Health Law and in this Chapter, the term infectious, contagious or communicable disease, shall be held to include the following diseases and any other disease which the commissioner, in the reasonable exercise of his or her medical judgment, determines to be communicable, rapidly emergent or a significant threat to public health, provided that the disease which is added to this list solely by the commissioner's authority shall remain on the list only if confirmed by the Public Health and Health Planning Council at its next scheduled meeting:

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Section 2.5 is amended to read as follows:

A physician in attendance on a person affected with or suspected of being affected with any of the diseases mentioned in this section shall submit to an approved laboratory, or to the laboratory of the State Department of Health, for examination of such specimens as may be designated by

the State Commissioner of Health, together with data concerning the history and clinical manifestations pertinent to the examination:

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* * *

Section 2.6 is repealed and replaced as follows:

2.6 Investigations and Response Activities.

(a) Except where other procedures are specifically provided in law, every local health authority, either personally or through a qualified representative, shall immediately upon receiving a report of a case, suspected case, outbreak, or unusual disease, investigate the circumstances of such report at any and all public and private places in which the local health authority has reason to believe, based on epidemiological or other relevant information available, that such places are associated with such disease. Such investigations and response activities shall, consistent with any direction that the State Commissioner of Health may issue:

(1) Verify the existence of a disease or condition;

(2) Ascertain the source of the disease-causing agent or condition;

(3) Identify unreported cases;

(4) Locate and evaluate contacts of cases and suspected cases, as well as those reasonably expected to have been exposed to the disease;

(5) Collect and submit, or cause to be collected or submitted, for laboratory examination such specimens as may furnish necessary or appropriate information for determining the source of disease, or to assist with diagnosis; and furnish or cause to be furnished with

such specimens pertinent data on forms prescribed by the State Commissioner of Health, including but not limited to the history of cases, physical findings and details of the epidemiological investigation;

(6) With the training or assistance of the State Department of Health, examine the processes, structures, conditions, machines, apparatus, devices, equipment, records, and material within such places that may be relevant to the investigation of disease or condition;

(7) Instruct a responsible member of a household or entity, as applicable, to implement appropriate actions to prevent further spread of a disease; and

(8) Take any other steps to reduce morbidity and mortality that the local health authority determines to be appropriate.

(b) When a case or suspected case of a disease, condition, outbreak, or unusual disease occurs in any business, organization, institution, or private home, the person in charge of the business, organization, institution or the home owner, as well as any individuals or entities required to report pursuant to sections 2.10 and 2.12 of this Part, shall cooperate with the State Department of Health and local health authorities in the investigation of such disease, condition, outbreak, or unusual disease.

(c) Investigation Updates and Reports.

(1) Upon request of the State Department of Health, the local health authority shall submit updates and reports on outbreak investigations to the State Department of Health. The content, timeframe, and manner of submission of such updates shall be determined by the State Department of Health.

(2) The local health authority shall complete investigation reports of outbreaks within 30 days of the conclusion of the investigation in a manner prescribed by the State Commissioner of Health, unless the State Commissioner of Health prescribes a different time period.

(d) Commissioner authority to lead investigation and response activities.

(1) The State Commissioner of Health may elect to lead investigation and response activities where:

(i) Residents of multiple jurisdictions within the State are affected by an outbreak of a reportable disease, condition, or unusual disease; or

(ii) Residents in a jurisdiction or jurisdictions within the State and in another state or states are affected by an outbreak of a reportable disease, condition, or unusual disease; or

(iii) An outbreak of an unusual disease or a reportable disease or condition involves a single jurisdiction with the high potential for statewide impact.

(2) Where the State Commissioner of Health elects to lead investigation and response activities pursuant to paragraph (1) of this subdivision, local health authorities shall take all reasonable steps to assist in such investigation and response, including supply of personnel, equipment or information. Provided further that the local health authority shall take any such action as the State Commissioner of Health deems appropriate and that is within the jurisdiction of the local health authority. Any continued investigation or response by the local health authority shall be solely pursuant to the direction of the State Commissioner of Health, and the State Commissioner of Health shall have access to any

investigative materials which were heretofore created by the local health authority.

Paragraph (11) of subdivision (d) of section 405.3 is amended, paragraph (12) is renumbered paragraph (13), and a new paragraph (12) is added, to read as follows:

(d) Records and reports. Any information, records or documents provided to the department shall be subject to the applicable provisions of the Public Health Law, Mental Hygiene Law, Education Law, and the Public Officers Law in relation to disclosure. The hospital shall maintain and furnish to the Department of Health, immediately upon written request, copies of all documents, including but not limited to:

* * *

(11) written minutes of each committee's proceedings. These minutes shall include at least the following:

(i) attendance;

(ii) date and duration of the meeting;

(iii) synopsis of issues discussed and actions or recommendations made; [and]

(12) whenever the commissioner determines that there exists an outbreak of a highly contagious communicable disease pursuant to Part 2 of this Title or other public health emergency, such syndromic and disease surveillance data as the commissioner deems appropriate, which the hospital shall submit in the manner and form determined by the commissioner; and

(13) any record required to be kept by the provisions of this Part.

* * *

Section 405.3 is amended by adding a new subdivision (g) as follows:

(g) Whenever the commissioner determines that there exists an outbreak of a highly contagious communicable disease pursuant to Part 2 of this Title or other public health emergency, the commissioner may direct general hospitals, as defined in Article 28 of the public health law, and consistent with the federal Emergency Medical Treatment and Labor Act (EMTALA), to accept patients pursuant to such procedures and conditions as the commissioner may determine appropriate.

New section 58-1.14 is added to read as follows:

Section 58-1.14 Reporting of certain communicable diseases.

(a) The commissioner shall designate those communicable diseases, as defined by section 2.1 of the Sanitary Code, that require prompt action, and shall make available on the Department's website a list of such communicable diseases.

(b) Laboratories performing tests for screening, diagnosis or monitoring of communicable diseases requiring prompt action pursuant to subdivision (a) of this section, for New York State residents and/or New York State health care providers, shall:

(i) immediately report to the commissioner all positive results for such communicable diseases in a manner and format as prescribed by the commissioner; and

(ii) report all results, including positive, negative and indeterminate results, to the commissioner in a time and manner consistent with Public Health Law § 576-c.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for the regulatory amendments to Part 2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is Section 225 of the Public Health Law (PHL), which authorizes the Public Health and Health Planning Council (PHHPC), subject to the approval of the Commissioner of Health (Commissioner), to establish and amend the State Sanitary Code (SSC) provisions related to any matters affecting the security of life or health or the preservation and improvement of public health in the State of New York. Additionally, Section 2103 of the PHL requires all local health officers to report cases of communicable disease to the New York State Department of Health (Department).

The statutory authority for the proposed amendments to section 405.3 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is section 2803 of the PHL, which authorizes 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.

The statutory authority for the proposed new section 58-1.14 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is section 576 of the PHL, which authorizes the Department to adopt regulations prescribing the requirements for the proper operation of a clinical laboratory, including the methods and the manner in which testing or analyses of samples shall be performed and reports submitted.

Legislative Objectives:

The legislative objective of PHL § 225 is, in part, to protect the public health by authorizing PHHPC, with the approval of the Commissioner, to amend the SSC to address public health issues related to communicable disease.

The legislative objective of PHL § 2803 includes, among other objectives, authorizing PHHPC, with the approval of the Commissioner, to adopt regulations concerning the operation of facilities licensed pursuant to Article 28 of the PHL, including general hospitals.

The legislative objective of PHL § 576 is, in part, to promote public health by establishing minimum standards for clinical laboratory testing and reporting of test results, including to the Department for purposes of taking prompt action to address outbreaks of disease.

Needs and Benefits:

These regulations update, clarify and strengthen the Department's authority as well as that of local health departments to take specific actions to monitor the spread of disease, including actions related to investigation and response to a disease outbreak.

The following is a summary of the amendments to the Department's regulations:

Part 2 Amendments:

- Amend sections 2.1 and 2.5 to reflect The World Health Organization's (WHO) decision to change the name of "monkeypox" to "Mpox" in an effort to reduce the stigma that monkeypox comes with and deal with possible misinformation falsely suggesting that monkeys are the main source of spreading the virus.
- Repeal and replace current section 2.6, related to investigations, to clarify existing local health department authority.

- Sets forth specific actions that local health departments must take to investigate a case, suspected case, outbreak, or unusual disease.
- Requires individuals and entities subject to a public health investigation to cooperate with the Department and local health departments.
- While the Department works collaboratively with local health departments on a variety of public health issues, including disease control, this regulation clarifies the authority for the Commissioner to lead disease investigation activities under certain circumstances (i.e., where there is potential for statewide impact, multiple jurisdictions impacted, or impact on one or more New York State jurisdictions and another state or states), while working collaboratively with impacted local health departments. In all other situations, local health departments retain the primary authority and responsibility to control communicable disease within their respective jurisdictions, with the Department providing assistance as needed.
- Codify in regulation the requirement that local health departments send reports to the Department during an outbreak.

Part 405 Amendments

- Mandates hospitals to report syndromic surveillance data during an outbreak of a highly contagious communicable disease.
- Permits the Commissioner to direct hospitals to take patients during an outbreak of a highly contagious communicable disease, which is consistent with the federal Emergency Medical Treatment and Labor Act (EMTALA).

Part 58 Amendments

- New section 58-1.14 added clarifying reporting requirements for certain communicable diseases
    - Requires the Commissioner to designate those communicable diseases that require prompt action, and to make available a list of such diseases on the State Department of Health website.
    - Requires clinical laboratories to immediately report positive test results for communicable diseases identified as requiring prompt attention, in a manner and format identified by the Commissioner.
    - Requires clinical laboratories to report all test results, including negative and indeterminate results, for communicable diseases identified as requiring prompt attention, via the Electronic Clinical Laboratory Reporting System (ECLRS).

COSTS:

Costs to Regulated Parties:

Although there are costs associated with disease investigation and response for any outbreak, these regulations clarify and strengthen the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations.

The requirement that hospitals submit syndromic surveillance reports when requested during an outbreak is not expected to result in any substantial costs. Hospitals are already regularly and voluntarily submitting data to the Department, and nearly all of them submit such reports electronically. With regard to the Commissioner directing general hospitals to accept

patients during an outbreak of a highly contagious communicable disease, hospitals are already required to adhere to the federal Emergency Medical Treatment and Labor Act (EMTALA). Accordingly, both of these proposed amendments will not impose any substantial additional cost to hospitals.

Clinical laboratories must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102. The regulation simply clarifies existing requirements and is not anticipated to imposes any substantial additional costs beyond those costs that laboratories would incur in the absence of these regulations.

Costs to Local and State Governments:

Although there are costs associated with disease investigation and response for any outbreak, these regulations clarify and strengthen the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations. Further, making explicit the Department's authority to lead investigation activities will result in increased coordination of resources, likely resulting in a cost-savings for State and local governments.

Any clinical laboratories operated by a local government must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102. The regulation simply clarifies existing requirements and is not anticipated to imposes any substantial additional costs beyond those costs that laboratories would incur in the absence of these regulations.

Paperwork:

Some hospitals may be required to make additional syndromic surveillance reports that they are not already making. Otherwise, these regulations do not require any additional paperwork.

Local Government Mandates:

Under existing regulation, local health departments already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties.

Duplication:

There is no duplication in existing State or federal law.

Alternatives:

The alternative would be to leave in place the current regulations on disease investigation. However, many of these regulatory provisions have not been updated in fifty years and should be modernized to ensure appropriate response to a disease outbreak, such as COVID-19.

Federal Standards:

States and local governments have primary authority for controlling disease within their respective jurisdictions. Accordingly, there are no federal statutes or regulations that apply to disease control within NYS.

Compliance Schedule:

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

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower Building, Room 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.ny.gov

REGULATORY FLEXIBILITY ANALYSIS

Effect on Small Business and Local Government:

Under existing regulation, local health departments already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties.

Compliance Requirements:

Under existing regulation, local health departments already have the authority and responsibility to take actions to control the spread of disease within their jurisdictions. The proposed amendments clarify these existing authorities and duties. With respect to mandating syndromic surveillance reporting during an outbreak of a highly infectious communicable disease, hospitals are already reporting syndromic surveillance data regularly and voluntarily. With respect to clinical laboratories, they must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102. The regulation simply clarifies existing requirements and is not anticipated to imposes any substantial additional costs beyond those costs that laboratories would incur in the absence of these regulations.

Professional Services:

It is not expected that any professional services will be needed to comply with this rule.

Compliance Costs:

Although there are costs associated with disease investigation and response for any outbreak, these regulations clarify and strengthen the existing authorities and responsibilities of local governments. As such, these regulations do not impose any substantial additional costs beyond what local health departments would incur in the absence of these regulations.

Further, making explicit the Department's authority to lead investigation activities will result in increased coordination of resources, likely resulting in a cost-savings for State and local governments.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

As the proposed regulations largely clarify existing responsibility and duties among regulated entities and individuals, any adverse impacts are expected to be minimal. The Department, however, will work with regulated entities to ensure they are aware of the new regulations and have the information necessary to comply.

Small Business and Local Government Participation:

Due to the emergent nature of COVID-19, small business and local governments were not consulted. If these regulations are proposed for permanent adoption, all parties will have an opportunity provided comments during the notice and comment period.

RURAL AREA FLEXIBILITY ANALYSIS

Type and Estimated Numbers of Rural Areas:

While this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 44 counties have a population of less than 200,000 based upon 2020 United States Census data:

Allegany County
Broome County
Cattaraugus County
Cayuga County
Chautauqua County
Chemung County
Chenango County
Clinton County
Columbia County
Cortland County
Delaware County
Essex County
Franklin County
Fulton County
Genesee County
Greene County
Hamilton County
Herkimer County
Jefferson County
Lewis County
Livingston County
Madison County
Montgomery County
Ontario County
Orleans County
Oswego County
Otsego County
Putnam County
Rensselaer County
Schenectady County
Schoharie County
Schuyler County
Seneca County
St. Lawrence County
Steuben County
Sullivan County
Tioga County
Tompkins County
Ulster County
Warren County
Washington County
Wayne County
Wyoming County
Yates County

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

Albany County	Monroe County	Orange County
Dutchess County	Niagara County	Saratoga County
Erie County	Oneida County	Suffolk County
	Onondaga County	

Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:

As the proposed regulations largely clarify existing responsibilities and duties among regulated entities and individuals, no additional recordkeeping, compliance requirements, or professional services are expected. With respect to mandating syndromic surveillance reporting during an outbreak of a highly infectious communicable disease, hospitals are already reporting syndromic surveillance data regularly and voluntarily. Additionally, the requirement for local health departments to continually report to the Department during an outbreak is historically a practice that already occurs. With respect to clinical laboratories, they must already report communicable disease testing results using the ECLRS and must also immediately report communicable diseases pursuant to PHL § 2102.

Compliance Costs:

As the proposed regulations largely clarify existing responsibility and duties among regulated entities and individuals, no initial or annual capital costs of compliance are expected above and beyond the cost of compliance for the requirements currently in Parts 2, 405 and 58.

Economic and Technological Feasibility:

There are no economic or technological impediments to the rule changes.

Minimizing Adverse Impact:

As the proposed regulations largely clarify existing responsibility and duties among regulated entities and individuals, any adverse impacts are expected to be minimal. The Department, however, will work with local health departments to ensure they are aware of the new regulations and have the information necessary to comply.

Rural Area Participation:

Due to the emergent nature of COVID-19, parties representing rural areas were not consulted. If these regulations are proposed for permanent adoption, all parties will have an opportunity provided comments during the notice and comment period.

JOB IMPACT STATEMENT

The Department of Health has determined that this regulatory change will not have a substantial adverse impact on jobs and employment, based upon its nature and purpose.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Section 2803 of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended by adding a new section 400.26, and amending sections 600.1 and 710.2, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

A new section 400.26 is added, to read as follows:

Section 400.26. Health Equity Impact Assessments.

(a) In accordance with Public Health Law § 2802-b, applications under Article 28, meeting the criteria set forth in this section, shall include a health equity impact assessment. The purpose of the health equity impact assessment is to demonstrate how a proposed project affects the accessibility and delivery of health care services to enhance health equity and contribute to mitigating health disparities in the facility's service area, specifically for medically underserved groups.

(b) Definitions. For the purposes of this section the following terms shall have the following meaning:

(1) "*Independent entity*" means individual or organization with demonstrated expertise and experience in the study of health equity, anti-racism, and community and stakeholder engagement, and with preferred expertise and experience in the study of health care access or delivery of health care services, able to produce an objective written assessment using a standard format of whether, and, if so, how, the facility's proposed project will impact access to and delivery of health care services, particularly for members of medically underserved groups.

(2) "*Conflict of Interest*" means having a financial interest in the approval of an application or assisting in drafting any part of the application on behalf of the facility, other than the health equity assessment.

(3) "*Stakeholders*" shall include individuals or organizations currently or anticipated to be served by the facility, employees of the facility including facility boards or committees, public health experts including local health departments, residents of the facility's service area and organizations representing those residents, patients of the facility, community-based organizations, and community leaders.

(4) "*Meaningful engagement*" shall mean providing advance notice to stakeholders and an opportunity for stakeholders to provide feedback concerning the facility's proposed project, including phone calls, community forums, surveys, and written statements. Meaningful engagement must be reasonable and culturally competent based on the type of stakeholder being engaged (for example, people with disabilities should be offered a range of audiovisual modalities to complete an electronic online survey).

(c) In accordance with Public Health Law 2802-b, applications for the construction, establishment, change in establishment, merger, acquisition, elimination or substantial reduction, expansion or addition of a hospital service or health-related service of a hospital that require review or approval by the public health and health planning council or the commissioner, shall include a health equity impact assessment; provided, however, that a health equity impact assessment shall not be required for the following:

(1) projects that do not require prior approval but instead only require a written notice to be submitted to the Department prior to commencement of a project pursuant to Part 710 of this Title;

(2) minor construction and equipment projects subject only to limited review pursuant to Part 710 of this Title, unless such project would result in the elimination, reduction, expansion or addition of beds or services;

(3) establishment (new or change in ownership) of an operator, including mergers and acquisitions, unless such establishment would result: (i) the elimination of a hospital service or health-related service; (ii) a 10 percent or greater reduction in the number of certified beds, certified services, or operating hours or (iii) a change of location of a hospital service or health-related service; and

(4) applications made by a diagnostic and treatment center whose patient population is over fifty percent combined patients enrolled in Medicaid or uninsured, unless the application includes a change in controlling person, principal stockholder, or principal member of the facility.

(d) A health equity impact assessment shall be performed by an independent entity without a conflict of interest, using a standard format provided by the Department, and shall include:

(1) meaningful engagement of stakeholders commensurate to the size, scope and complexity of the facility's proposed project and conducted throughout the process of developing the health equity impact assessment, to incorporate and reflect community voices;

(2) a description of the mechanisms used to conduct meaningful engagement;

(3) a documented summary of statements received from stakeholders through meaningful engagement as submitted to, or prepared by, the facility or independent entity. The Department reserves the right to request and review individual statements as submitted, or prepared by the facility or independent entity, while reviewing the health equity impact assessment.

(4) documentation of the contractual agreement between the independent entity and the facility;

(5) a signed attestation from the independent entity that there is no conflict of interest; and

(6) a description of the independent entity's qualifications.

(e) When submitting an application to the Department requiring a health equity impact assessment, the application must include:

(1) a full version of the application and a version with proposed redactions, if any, to be shared publicly; and

(2) a signed written acknowledgment that the health equity impact assessment was reviewed by the facility, including a narrative explaining how the facility has or will mitigate potential negative impacts to medically underserved groups identified in the health equity impact assessment. The narrative must also be made available to the public and posted conspicuously on the facility's website until a decision on the application is rendered by the public health and health planning council or the commissioner.

Paragraph (5) of subdivision (b) of section 600.1 is amended to read as follows:

(b) Applications to the council shall contain information and data with reference to: (5) the following documents shall be filed:

* * *

(5) the following documents shall be filed:

* * *

(iii) <u>a health equity impact assessment, if applicable, pursuant to section 2802-b of the Public Health Law and section 400.26 of this Title;</u>

(iv) such additional pertinent information or documents necessary for the council's consideration, as requested.

Subdivision (b) of section 710.2 is amended to read as follows:

(b) The application setting forth the scope and concept of the project shall include the following if applicable:

* * *

(11) a health equity impact assessment, if applicable, pursuant to section 2802-b of the Public Health Law and section 400.26 of this Title.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (PHL) § 2803(2)(a) 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 (Commissioner), to effectuate the provisions and purposes of Article 28 of the PHL. Chapter 766 of the Laws of 2021 and Chapter 137 of the Laws of 2022 amended Article 28 of the PHL by adding a new Section 2802-b, requiring health equity impact assessments to be submitted to the Department of Health (Department) for certain applications requiring review or approval by PHHPC or the Commissioner.

Legislative Objectives:

The legislative objective of PHL § 2802-b is to ensure the establishment, ownership, construction, renovation, and change in service of health care facilities defined in Article 28 (including general hospitals, nursing homes, diagnostic and treatment centers, and midwifery birth centers) do not adversely impact the public health of, service delivery to, or access to hospital and health-related services for medically underserved groups. Applications for select projects will be required to include a health equity impact assessment as part of the application process. The purpose of the assessment is to ensure community members, including members of medically underserved groups, are meaningfully engaged and considered in the development of proposed facility projects, encourage facilities to understand the health equity impacts of proposed projects and mitigate potential negative impacts from proposed projects, and allow the Department and PHHPC to consider how proposed projects will impact medically underserved groups when approving or denying applications. The intended impact of this legislation is to embed equity into structural decision-making processes, which will help New York's health care facilities stay accountable to enhancing health equity in their communities.

Needs and Benefits:

These regulations are necessary to implement PHL § 2802-b. Specifically, the regulations set forth criteria that: (1) qualifies an independent entity to conduct an objective health equity impact assessment; (2) defines a conflict of interest such that it would prevent an otherwise independent entity from performing an objective health equity impact assessment; (3) specifies requirements for meaningful engagement with stakeholders as part of the health equity impact assessment; (4) defines the type of applications for which a health equity impact assessment is and is not required; and (5) clarifies standards for completion of the health equity impact assessment, including the use of a template issued by the Department and inclusion of a narrative statement from the facility in response to the findings of the assessment.

In addition, the regulations require facilities to integrate health equity into their decision making and planning processes to promote the maximum utilization of resources and ensure that medically underserved groups are not negatively impacted by proposed establishment, ownership, construction, renovation, and/or change in service applications. Requiring a demonstration of meaningful engagement with stakeholders will ensure that the people whom the health care facilities serve have a voice in proposed projects. This assessment is critical for Article 28 facilities to consider when making changes to their services, facilities and ownership. The regulations ensure that a facility reviews the findings of the health equity impact assessment and develops a narrative statement for how it will mitigate potential for exacerbating health inequities in underserved communities.

Costs:

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

The proposed regulation will require a health equity impact assessment to be completed with the submission of certain applications and will therefore require health care facilities to pay

for such an assessment to be performed. Facilities are required to utilize an independent entity without a conflict of interest to complete the health equity impact assessment. The projected costs associated with performing such an assessment are not easily identifiable, as they will vary greatly depending on the size, scope and complexity of a facility's proposed project. However, the Department anticipates these costs could range anywhere from $500 to upwards of $30,000. These costs are unavoidable in the regulations, as PHL § 2802-b requires health equity impact assessments to be performed by independent entities.

Costs to State and Local Governments:

There is no impact on costs to state and local governments associated with this regulation unless they operate an Article 28 health care facility, in which case they may be required to submit a health equity impact assessment pursuant to the proposed regulations. The proposed regulations also define "stakeholders" to include local health departments, so local health departments may be asked to comment as part of a facilities' meaningful engagement of stakeholders. In this instance, local health departments may bear minimal costs associated with staff time but there are no major operational costs to local governments.

Costs to the Department of Health:

This regulation will result in an operational cost to the Department of Health due to the hiring of staff responsible for reviewing and analyzing data from health equity impact assessments submitted to the Department.

Local Government Mandates:

There is no impact on local government mandates associated with this regulation.

Paperwork:

This regulation will require Article 28 health care facilities to conduct a health equity impact assessment as part of their application. These facilities will need to contract with an independent entity to conduct a health equity impact assessment and document such agreement in appropriate records. Facilities also must submit documentation of their agreements with independent entities conducting health equity impact assessments.

In addition, the proposed regulation will require facilities to review their health equity impact assessments and develop a narrative on how they intend to mitigate potential harms to medically underserved groups. Facilities must submit this narrative along with their health equity impact assessments as part of the application.

Duplication:

This regulation does not have any duplications in state or federal law. There is some overlap between the health equity impact assessment and some of the required content for the certificate of need (CON) process. Specifically, Schedules 16-24 of the CON [excluding Schedule 23] application include questions for facilities to answer regarding the community need and impact on certain populations for changes in health care facilities. However, these questions are minimal and do not require "meaningful community engagement" to complete. This regulation is a means of ensuring "meaningful community engagement" and a full impact assessment focused on health equity for facilities participating in the certificate of need process.

Alternatives:

One alternative to the proposed regulation the Department considered was requiring all CON applications under Article 28 of the Public Health Law to be subject to the health equity

impact assessment requirement. However, this alternative was ultimately not incorporated into the regulation because the Department decided to focus on the potential health equity impacts of proposed projects that involve access to or delivery of health services, and to exempt proposed projects such as routine repairs or maintenance. Another alternative the Department considered was to articulate more stringent requirements on the types of individuals or organizations that qualify to serve as independent entities for purposes of conducting health equity impact assessments. However, this alternative was not incorporated into the proposed regulation because the Department did not want to limit the types of individuals or organizations with expertise and qualification that may prove to offer invaluable insight through their assessments.

Federal Standards:

There are no federal statutes or standards with respect to health equity impact assessments as a component of the CON process for facilities.

Compliance Schedule:

This regulation will become effective after publication of Notice of Adoption in the New York State Register.

Contact Person:
Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.ny.gov

REGULATORY FLEXIBILITY ANALYSIS
FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect of Rule:

Local governments and small businesses will not be affected by this rule, unless they operate a general hospital. Where a local government or small business operates a general hospital, they will be similarly affected as any other regulated entity under the rule. There are over 150 Article 28 health care facilities owned by municipalities and local governments in the State. The Department does not anticipate a change in establishment applications by such applicants as a result of the proposed regulation.

Compliance Requirements:

Pursuant to Public Health Law (PHL) § 2802-b, health care facilities regulated under Article 28 of the PHL will be required to have a health equity impact assessment performed by an independent entity when submitting certain applications to the Department for approval by the Public Health and Health Planning Council (PHHPC) or the Commissioner of Health (Commissioner). The regulations will help to further define what an independent entity is for purposes of performing a health equity impact assessment, the types of applications requiring such an impact assessment and the documentation required to be submitted to the Department.

Professional Services:

The regulations require a health equity impact assessment to be performed by an independent entity without a conflict of interest.

Compliance Costs:

The proposed regulation will require a health equity impact assessment to be completed with the submission of certain applications and will therefore require local governments and

small businesses operating health care facilities regulated under Article 28 of the PHL to pay for such an assessment to be performed. Facilities are required to utilize an independent entity without a conflict of interest to complete the health equity impact assessment. The projected costs associated with performing such an assessment are not easily identifiable, as they will vary greatly depending on the size, scope and complexity of a facility's proposed project. However, the Department anticipates these costs could range anywhere from $500 to upwards of $30,000. These costs are unavoidable in the regulations, as PHL § 2802-b requires health equity impact assessments to be performed by independent entities.

Economic and Technological Feasibility:

This proposal is economically and technically feasible, as it does not require any special technology and does not impose an unreasonable financial burden on anyone.

Minimizing Adverse Impact:

Minimal flexibility exists to minimize impact since these new requirements are statutory and apply to all Article 28 of the PHL health care facility operators.

Small Business and Local Government Participation:

The Department has taken steps to notify stakeholders about the effects of this regulation and has provided the opportunity for them to comment on the proposed regulations. In addition, the regulation will be presented to PHHPC on March 30, 2023, where there will be an opportunity for public comment prior to being published in the State Register and subject to a 60-day public comment period.

RURAL AREA FLEXIBLITY ANALYSIS

Type and Number of Rural Areas:

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 44 counties have an estimated population of less than 200,000 based upon the 2020 United States Census:

Allegany County	Greene County	Schoharie County
Broome County	Hamilton County	Schuyler County
Cattaraugus County	Herkimer County	Seneca County
Cayuga County	Jefferson County	St. Lawrence County
Chautauqua County	Lewis County	Steuben County
Chemung County	Livingston County	Sullivan County

Chenango County	Madison County	Tioga County
Clinton County	Montgomery County	Tompkins County
Columbia County	Ontario County	Ulster County
Cortland County	Orleans County	Warren County
Delaware County	Oswego County	Washington County
Essex County	Otsego County	Wayne County
Franklin County	Putnam County	Wyoming County
Fulton County	Rensselaer County	Yates County
Genesee County	Schenectady County	

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon 2019 United States Census population projections:

Albany County	Niagara County	Saratoga County
Dutchess County	Oneida County	Suffolk County
Erie County	Onondaga County	
Monroe County	Orange County	

Reporting, recordkeeping, and other compliance requirements; and professional services:

Pursuant to Public Health Law (PHL) § 2802-b, health care facilities regulated under Article 28 of the PHL will be required to have a health equity impact assessment performed by an independent entity when submitting certain applications to the Department for approval by the Public Health and Health Planning Council (PHHPC) or the Commissioner of Health (Commissioner).

Compliance Costs:

Per SAPA § 202-bb(3)(c), it is not anticipated that there will be any significant variation in cost for different types of public and private entities in rural areas.

Economic and Technological Feasibility:

This proposal is economically and technically feasible, as it does not require any special technology and does not impose an unreasonable financial burden in rural areas.

Minimizing Adverse Impact:

Minimal flexibility exists to minimize impact since these new requirements are statutory and apply to all Article 28 of the PHL health care facility operators.

Rural Area Participation:

The Department has taken steps to notify stakeholders on the effects of this regulation and has provided the opportunity for them to comment on the proposed regulations. In addition, the regulation will be presented to PHHPC on March 30, 2023, where there will be an opportunity for public comment prior to being published in the State Register and subject to a 60-day public comment period.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these proposed regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs or employment opportunities.