

**NEW YORK STATE DEPARTMENT OF HEALTH**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**  
**SPECIAL ESTABLISHMENT AND PROJECT REVIEW COMMITTEE MEETING**  
**June 18, 2025, 9:00 AM**  
**90 CHURCH STREET, 4TH FLOOR, CONFERENCE ROOMS 4A AND 4B, NYC**  
**TRANSCRIPT**

**Mr. Robinson** Good morning, everyone. I'm Peter Robinson, Chair of the Establishment and Project Review Committee. I'm calling to order a special meeting of the committee to consider two applications. Mr. Holt has gone through all the admonitions and guidelines, so I won't repeat those unless anybody would like me to.

**Mr. Robinson** Two applications to consider. The first is an application for transplant services. 241258C, NYU Langone Hospital in Brooklyn in Kings County, noting a conflict and recusal by Dr. Kalkut, who's left the room. Dr. Lim has also declared an interest. This application is to certify kidney transplant for that hospital. The department is recommending approval with conditions and a contingency.

**Mr. Robinson** Motion by Dr. Torres.

**Mr. Robinson** Second by Mr. Thomas.

**Mr. Robinson** I have Ms. Agard here for that application.

**Ms. Agard** Good morning. I'm up here in Albany. My name is Nancy Agard. I work with the Bureau of Organ Donation and Transplant. As you just said, the department is recommending approval of this application with a contingency and multiple conditions. To let you know, the department and external reviewers took a look at the CON and reviewed pretty carefully. Based on those recommendations, the department is making this recommendation. I just wanted to talk a little bit about the application and who the parties were involved. This application is filed by the NYU Langone Hospital System, which as all of you are very familiar with. It's a quaternary care teaching at the hospital that has four inpatient hospital facilities in Manhattan, Brooklyn, Long Island and four emergency departments associated with it. NYU Langone Hospital in Manhattan is kind of the flagship that anchors this system. They are very much involved in this application as it relates to the Brooklyn facility. I'm going to take a little bit of time to talk about the Manhattan facility. NYU Langone in Manhattan has 813 beds. It's affiliated with an academic medical center, NYU Grossman School of Medicine. The Manhattan facility, the NYU Manhattan facility is a certified transplant center. They currently provide transplant care for hearts, livers, lungs, kidneys, and pancreas programs. They transplant both children as well as adults. They have been up and functioning for quite some time. NYU, as part of its sort of growth in the arena of transplant care established a transplant institute in 2016. The function and the role of the transplant institute was really to facilitate and foster access to transplant care for New Yorkers, and especially in their service area. They have focused on trying to reduce the barriers to transplantation, as well as improve the quantity and quality of care that are provided. NYU Langone has

established a very strong relationship with Live On New York, which is the organ procurement organization for that geographic area. Live On New York is responsible for Metropolitan New York City, Long Island, and right up to the lower Hudson Valley. They've also established a Donor Care Unit, which has helped facilitate the increase and improvement in donor care, increases the number of organs per donor that have been able to be recovered and transplanted into other patients. Along that same line, they also have a very active program to try to facilitate living donation. Although their numbers of living donors don't end up being as many as some other facilities, it's because their wait time for deceased donors is actually much shorter than other facilities. They are both active at trying to facilitate donation at the deceased donors as well as living donors. Lastly, NYU Manhattan has been extremely active in contributing to the science of organ donation and transplant. They have multiple projects going on, but the one that you may be familiar with is the facilitation, actually the clinical and preclinical research being done on xenotransplantation, trying to reduce make available more organs so that we don't have so many people sitting on waiting lists living with organ failure. If I swing a little bit to talk about the Brooklyn facility itself, it's a 444-bed Article 28 hospital that is part of the NYU Langone Hospital system. It provides a variety of services, emergency, cardiac, nephrology, general medicine, med search, stroke care, et cetera. It's a full-fledged Article 28 facility. Since becoming part of the NYU hospital system, this Brooklyn facility has benefited from the resources that the system has invested in it, and that those investments from the hospital system have actually increased their standing and number of quality measures as compared with other facilities in the region and even in the state as far as that goes. The NYU system has investments have resulted in over 115 Care sites within the borough of Brooklyn, which includes the establishment of the first FFQHC in the Brooklyn area. The hospital system has partnered with One Brooklyn Health, again, as part of their outreach trying to reach underserved populations and establish programs such as Building Bridges to facilitate patient access to care and not just kidney care, but care across the board that's needed. One of the established, one of the things that they've established in Brooklyn is a transplant evaluation clinic. Currently, the Manhattan facility cares for a number of patients who are migrating their nephrology care, their chronic kidney care from Brooklyn where they live into Manhattan. They still need ongoing evaluations and care after their transplant is received. The system has established a transplant evaluation and care clinic in Brooklyn already. The system has committed to continued outreach to providers, to dialysis centers who are often key to identifying patients who should at least be referred for a transplant evaluation and if they're deemed appropriate to be listed by the facility. If I talk a little bit about the application itself, as we said already, NYU Brooklyn is seeking to certify an adult kidney transplant program. They're projecting conservatively forty transplants to be done during the first year and up to one hundred in the third year since they opened. They are identifying that they're going to be pulling these or identifying these people that they are going to waitlisting and transplanting from the current population that's being served by the Manhattan facility since there's been such an out migration looking for transplant care into their facility as well as through outreach efforts that they have already established as I said through connections with One Brooklyn Health and other activities that they will be undertaking. The application does provide data that supports the need for another transplant center,

another kidney transplant center in the borough of Brooklyn, and they address, and they provide data on both health and social determinants of health. They identify that clearly the borough of Brooklyn has a large population, that their mean household income is actually less than the mean household of income of the other boroughs in the city, as well as that of the state. They also have identified that 20% of the population in Brooklyn has a household income of less than \$20,000. Those who are served by the FQHC as part of their system, actually about 60% of them have an income of less than 200% of their poverty level. Additional data that's provided in support of the application includes the fact that they're quoted DOH reports, so I guess we can't fault them too much, that identify that both hypertension and diabetes are much higher in the Brooklyn population, both of which are well known to lead to end stage renal disease and the need for transplants. They've identified that the percentage of Brooklyn residents who are receiving dialysis care for end-stage renal disease is actually higher than those percentages in the other boroughs in the city. The percent of those on dialysis who are getting transplanted who reside in Brooklyn are actually less than those who are receive dialysis and reside in other boroughs of the city. There's a fair amount of support there for the need for an additional program in Brooklyn. Clearly, the application evidence is that the Brooklyn facility will benefit from being associated with the Transplant Institute at the Manhattan facility. They actually plan on moving staff who are currently in place and staff and leadership positions in the Manhattan facility over to Brooklyn once the application is approved and they receive approval from the Organ Procurement Transplant Network, here to after referred to as OPTN, because it's too many words for me to say. It used to be that you could refer to the OPTN as UNOS, which was the United Network for Organ Sharing. People were more familiar with that language. However, there have been some changes at the federal level, so it's not referred to as UNOS anymore. I wanted to talk a little bit about the transplant programs that are in New York and specifically around the city. There are fifteen transplant centers currently in New York, fourteen of which are licensed by New York state. Six of those are located within the boroughs, New York City boroughs and there are three more on the island. Not inconsistent with the growth and transplant across the board in New York State, there's been a 30% increase in kidney transplants since 2020 through the end of 2024, which is about the same increase in transplantation overall. However, kidneys drive that. One should know that the wait list for New York generally is about 8,000 people. 7,000 of those people are waiting for kidneys. The kidney transplant wait list and transplantation rates are all driven by the kidney, those who are needing a kidney. I did put information for those of you who are data geeks in the exhibit about all of how many transplants each of the transplant facilities are carrying out are performing throughout from 2020 through 2025. It should be noted that NYU Langone in Manhattan, as well as Weill Cornell and Mount Sinai consistently perform more kidney transplants a year than the other facilities. There are some really high performing facilities in that their volume of transplants is a lot. There's sort of a mid-range. There's sort of lower or smaller lower volume programs. The NYU Manhattan facility performs the most kidney transplants in the state. They're fairly close to being the most in the country. SUNY Downstate, there is another transplant program in Brooklyn, and it is at SUNY Downstate otherwise known as SUNY Brooklyn. They have an active program. Since 2021, they have transplanted about forty kidneys a year. They're one of the lower volume program. They

have had sort of ups and downs in the volume that they've transplanted per year. 2020 was an off year for them. It was kind of an off year for everybody from the perspective of COVID, but also an off year in that program was inactive for a period of time. Thus, they did not do a lot of transplants. They list somewhere between 90 and 120/130 patients a year. They have about 225 people on their wait list right now. There is an existing program that does serve the residents of Brooklyn. However, it's a relatively low volume program compared to the others. If we want to look at quality measures that the transplant programs are evaluated on, the exhibit also spoke a little bit about those. The first one I just want to highlight is the median time on the wait list. You always hear about patients who are on the wait list for such a long time waiting for an organ for a kidney. What I can tell you when you look at the data is that NYU Manhattan has the shortest median time on the wait list before receiving a kidney, followed by Columbia and Weill Cornell, which are also significantly below the national average as far as wait time. As far transplant rates, Mount Sinai and SUNY Brooklyn are the only two facilities in the state whose observed versus expected transplant rate is lower than what is expected. The last, and perhaps the most important quality measure has to do with one-year graft survival. That again, like everything else sort of exists on a continuum with each facility having somewhat different performance on that. Performance on one-year post-transplant graft survival, as well as one-year graft survival hazard ratio for NYU, Columbia, Mount Sinai, and North Shore is actually better than the national average, while there are some people that are just hanging out around the national average. SUNY Brooklyn unfortunately has a less than average one-year graft survival, which means that their graft failure rate is a little higher than the national average. Again, if you wanted specifics these details are in the exhibit. I don't really want to go on forever in a day, although I could. I think in summary, the department is recommending approval of this application because of the fact that NYU Brooklyn will be supported by a very successful program at NYU Manhattan location, and with the support of the Transplant Institute, policies, procedures, staff, leadership, we expect that this program would be successful, not only in volume but in quality performance. I think the one thing we haven't said out loud here, and so I guess I will be that what impact will be opening this second program in Brooklyn have on the existing program at SUNY Downstate? Unfortunately, I don't have a good answer for that because I don't know. What I can tell you is somewhat contrary to what you might think. Every time we've opened a new transplant program in the state, you worry about the impact that it's going to have on the other programs. You worry the fact that it will make less organs available for the people who are already listed at those programs. That just hasn't happened, oddly enough. Every single time we've opened a new program it's actually brought more organs in and increased the number of people who are transplanted in the state. It's very possible, especially given where the NYU Brooklyn facility is saying they're going to identify their patients from that this will have little to no impact on Downstate. My crystal ball is kind of cloudy at the moment, so I can't tell you what the impact will be. All of that put together, the department recommends approval of this application with, as I said a contingency and multiple conditions.

**Mr. Robinson** Thank you for that very thorough presentation. Appreciate that.

**Mr. Robinson** Any questions from the members of the committee or the rest of the council?

**Mr. Kraut** I just want to make one comment. Nancy, thank you for your typically thorough report. As a data geek, I appreciate the abundance of information you provided. It was really good to read. I just want to remind people in the room that Lutheran many years ago was a hospital teetering on survivability. You come back over the years we've approved projects at Lutheran, a heart surgery and other things. You just see this is a kind of a natural progression of a partner that's invested in a place and has built up services to the point where we're actually going to, if we approve this application, which I would advocate we should. We are now establishing a precedent. It just shows you how hospitals can be strengthened. This will be the first transplant program approved in New York State in a hospital that's not an academic medical center that really evolved as a community hospital and a weak one at that that has strengthened itself. There's an investment of programs here. It just shows you what is possible when there's focus on something. It may, as said every time the arguments in the past have been you approve another application. It has a deleterious effect on organ procurement, programs, and that's never been the case. That's why I suspect we have not received a letter in opposition. That would be valid. I just basically applaud the precedent, and we may see more of these elsewhere in the state if they can meet the same quality standards that I think we have in front of us. Not saying anything against it.

**Mr. Lawrence** Harvey Lawrence, council member. Mr. Kraut, I agree with you that this is terrific. They have additional program coming to Brooklyn and serving the population. I'm just a little concerned about not knowing the impact on SUNY Downstate's program. A great collaboration would also result in SUNY Downstate performance being enhanced by this new program coming. I guess this is sort of a general question. Any way of NYU Langone collaborating also with SUNY Downstate? It's also working with One Brooklyn. Is there an opportunity there for shared learning that would elevate, help to elevate SUNY Downstate's performance and program?

**Mr. Robinson** Let me just ask the applicant to come forward.

**Mr. Kraut** Yeah, but I would also suggest that question be directed at SUNY Downstate, because they have had multiple opportunities to partner with other programs and chose not to.

**Mr. Lawrence** Okay, I understand that, but I also understand that SUNY Downstate is a state-funded institution and we all know the ups and downs sometimes of it.

**Mr. Kraut** Yes, I don't disagree.

**Mr. Robinson** I agree. We just want just some general observations on the comments by Mr. Lawrence rather than probing you about the project itself.

**Mr. Robinson** Mr. Cicero, if you could introduce your colleagues.

**Mr. Cicero** Frank Cicero, a consultant to the applicant.

**Mr. Rudy** Bret Rudy, Executive Vice President, Chief of Hospital Operations, NYU Brooklyn.

**Ms. Sullivan** Bridget Sullivan, Transplant Administrator at NYU Langone.

**Mr. Montgomery** I'm Robert Montgomery. I'm the Director of the Transplant Institute.

**Ms. Sullivan** I would just like to say that currently, NYU Langone takes the fellows of the SUNY Downstate program, the nephrology fellows. They rotate through our transplant fellowship. There's good collaboration there. Also, in the past six years, they've had to deactivate their program two times. In both of those times, NYU Langone took patients that were waiting on their waiting list and adopted them into our program so that we could continue to give them opportunities for transplantation. We do already have several bridges set up for collaboration with them, and that will not stop with the opening of this new program.

**Mr. Lawrence** Any chance of actually sort of enhancing the relationship?

**Ms. Sullivan** We'd be very open to talking to them and finding out what might be of interest.

**Mr. Lawrence** Would you be also open to reaching out to them?

**Ms. Sullivan** Absolutely, we're good colleagues.

**Mr. Robinson** Good probing.

**All** (Laughing)

**Mr. Robinson** Thank you.

**Mr. Robinson** Dr. Soffel.

**Dr. Soffel** Good morning. Denise Soffel, council member. My question, I don't know if this is actually for the folks in Albany or for you guys. My understanding is that the challenge for a transplant is not a lack of transplant centers, but rather a lack of organs to transplant. Are there costs affiliated with maintaining a transplant center that is underutilized?

**Mr. Montgomery** I mean, I think there are costs to the greater health, you know, funding of transplantation. I don't think there are necessarily costs that would compromise the number of transplants that are done. Transplant centers that are not functioning at a high level still do transplants and still have reasonable outcomes, as

you can see from the table that you have in front of you. More to the point, this isn't a zero-sum game. As already mentioned several times whenever a new transplant center is opened, it tends to just enhance I guess, through competition, but also through best practices, the other transplant programs in the area. I'm quite confident that that's to happen in Brooklyn. We're very open to collaborating about those best practices. Obviously, the biggest problem in transplantation right now is the lack of organs. Obviously, we're working on that from a research perspective. There's also a real big problem in the geographic distribution of organs, so there are areas like New York that, and particularly Brooklyn that have very high rates of end-stage kidney disease, but our donation rate in New York is quite low. About 70 percent of our kidneys that we use come from other parts of the country where they have higher numbers of organs per patients on dialysis. We're already very involved in this sort of redistribution of organs. Part of it is that we get patients on the list, we compete for those organs, and also probably a more important part of it is we have relationships with the organ procurement organizations throughout the country. They know that we're good stewards of those organs. I know them by name. If they have an organ that they're having trouble placing that is at risk for discard we'll go look at that organ or bring it in and in most cases we end up transplanting it.

**Mr. Robinson** I was really mainly concerned about getting the answer to Mr. Lawrence's question as well. Thank you very much for your comments.

**Mr. Robinson** I'm just going to open this up and see if there's anybody from the public that wishes to speak on this application?

**Mr. Robinson** Hearing none, and remember the motion is for approval with conditions and contingencies. I'll call the question.

**Mr. Robinson** All in favor?

All Aye.

**Mr. Robinson** Any opposed?

**Mr. Robinson** Any abstentions?

**Mr. Robinson** The motion carries.

**Mr. Robinson** Thank you very, very much.

**Mr. Robinson** This application is for a residential health care facility establishment. Application 231213E, Silvercrest Acquisition 1, LLC doing business as Silvercrest Nursing and Rehabilitation Center. This is in Queens County. I'll note an interest by Mr. La Rue. This is to establish Silvercrest Acquisition 1 LLC as the new operator of Silvercrest Nursing and Rehabilitation Center, a 320-bed residential health care facility

currently operated by Silvercrest at 144-4587th Avenue in Jamaica. Department is recommending approval with a condition and contingencies.

**Mr. Robinson** Motion by Dr. Berliner.

**Mr. Robinson** Second by Dr. Torres.

**Mr. Robinson** Here we have Mr. Heeran to run us through this application

**Mr. Heeran** Thank you.

**Mr. Heeran** Michael Heeran with the New York State Department of Health Office of Aging and Long-Term Care.

**Mr. Heeran** Silvercrest is an existing 320-bed not-for-profit residential health care facility located in Jamaica, Queens. This facility has eighty licensed ventilator beds in the 320-licensed bed count. The current operator, Silvercrest is a not-for-profit corporation with a passive corporate member, New York Presbyterian Health Care System. This application is for the establishment of Silvercrest Acquisition 1 LLC as the new operator of the facility under the name of Silvercrest Nursing and Rehabilitation Center. Excuse me. The relationship between New York Presbyterian and the facility would end upon transfer of the operations. The members of Silvercrest Acquisition 1 are Pasquale DeBenedictis at 40 percent membership, Alex Solovey at 40% membership, Joseph Carillo, II at 10 percent membership, and Michael Schrieber at 10% membership. This application has common members between the real property entity and the operating entity with all members of the proposed operating LLC being members of the real property LLC. The members of proposed operating entity have considerable health care facility ownership experience which includes nursing homes, assisted living facilities, diagnostic and treatment centers, certified home health agencies, and licensed home care services agencies. All members of the proposed operating LLC have nursing home ownership portfolios that pass the Section 600.2 health regulation requirement for less than 40% nursing home ownership with below average star ratings. They meet the character and competency requirements. There'll be no changes to the beds or services as a result of this application. Reported occupancy at the facility over the past three years has been between 95% and 98% of licensed beds. As of April 15th, 2025, 100% of staff beds were occupied. Queens County as a whole has 95.6% of staff beds occupied. The combined purchase price for this facility is \$96 million, \$93 million for the real property, and \$3 million for operations. The purchase price for operations will be paid from the member equity. The purchase for real property will be paid with \$11.4 million from member equity, and \$81.6 million from a three-year bridge loan with estimated interest from 7.96 percent. The borrowers intend to refinance the mortgage to a long-term permanent financing program prior to the end of the bridge loan. The proposed members provided affidavits confirming their willingness to use personal resources in the event that refinancing is not available by the end-of-the-bridge loan term. The applicant will lease the premises from the real property LLC Silvercrest Acquisition II through a non-arms-length agreement due to the common membership



between the LLCs. The lease is for a twenty-year term with rent payments starting at \$800,000 per month, which is \$9.6 million annual, with 2% annual increases throughout the term. The tenant is responsible for payment of taxes, insurance, and utilities related to the lease premises. The applicant submitted and executed non-arms-length administrative consulting services agreement with CasitaCare LLC, which will be effective upon issuance of a new operating certificate to the applicant. The agreement will cover back-office services such as plant and maintenance consulting, billing and collection consulting, accounting, financial services, payroll and accounts payable, clinical policies and procedures review and implementation, service contracts, excuse me, and purchasing. The fee paid for services provided under the contract is \$125,000 per month, which is \$1.5 million annual. CasitaCare is a privately held LLC managed by Pasquale DeBenedictis, Alex Solovey and Joseph Carillo, II, who are also members of the proposed operating LLC. I just want to add here that we have asked and received assurances that this agreement is not in place now and they're not providing administrative or consulting services to the current operator. This facility has been incurring operational losses. As detailed within the exhibit for the year ended December 31st, 2024, Silvercrest reported a negative working capital position, a negative equity position, and reported an at-loss of \$6.26 million. The applicant submitted a business plan outlining measured end initiatives to improve the facility's financial position that includes census and revenue management with increased ventilator bed referrals, expense management with a focus on a cost structure aligned with community best practices. The applicant notes additional initiatives that include streamlining and optimizing of services, reducing operational costs by reducing overtime usage, outside contracting, managing transfers, and physician oversight. The submitted budget indicates an income of approximately \$1.5 million in year one and \$1,700,000 in year three. The budget appears reasonable. The working capital requirement is estimated at \$10.2 million and will be funded with equity from the proposed members. The proposed members demonstrated a net worth that is sufficient to cover acquisition costs and working capital needs. The Bureau of Financial Analysis has concluded that the applicant has demonstrated the capability to proceed in a financially feasible manner. The long-term care ombudsman has reviewed the application, has no objections. Based on the review of materials submitted with the application and representations made by the applicant during the review, the department is recommending approval with conditions their contingencies.

**Mr. Robinson** Thank you for that report.

**Mr. Robinson** Questions from members of the committee or members of council?

**Mr. Robinson** Hearing none, I do note that we have two people have signed up to speak in opposition. I am going to call Robin. I apologize. I don't have the name.

**Mr. Kraut** Robert.

**Mr. Robinson** Thank you.

**Mr. Robinson** Please come forward and introduce yourself. As Mr. Holt mentioned, we limit these remarks to three minutes. Please continue. Please go ahead.

**Mr. Gallimore** My name is Robert Gallimore. I live in Silvercrest. I'm proof of them doing their jobs from the beginning. I was on the vent. I was the trach. I've been through all of it. Non-for-profit is the best way to go. For profit, for new people coming in, there's no guarantee that people aren't going to get the services needed. Already, they've cut in services, staffing, and everything for all residents. 320 people live there because they have no place else to go. How can you change everything so drastically and not realize you're dealing with lives? I'm living proof things can be done. Otherwise, I wouldn't be here, be able to talk to you. There's no oxygen. There's no nothing. I've done all the work because they did the work. Now, you're cutting staff, nursing, environmental services. They're not even cleaning the rooms properly anymore. They're doing the bare minimum. That's it. You come in there. The place stinks now. It should not be like that. Healthcare facilities should be clean and properly maintained. We've had flooding in there that have not been repaired. We have shower rooms that benches broke. They went and got plastic benches. They have not fixed the patio for people to get fresh air in the facility because they're not safe to use. They're not maintaining everything like they used to. There's no programs or anything. We have resident council. We do all of it. The answer is we're just going to do the bare minimum. That's unacceptable for lives.

**Mr. Robinson** We thank you for your comments.

**Mr. Gallimore** Thank you.

**Mr. Robinson** Mr. Oscar Roman.

**Mr. Roman** Good morning, everyone. My name is Oscar Roman. Pardon me if I'm a little nervous. It's my first time. I'm a resident at Silvercrest facility as well as the President of the Resident Council. We are a skilled facility where we require additional care. We have significant concerns regarding the quality of care that we are currently receiving. When I first arrived, it was a non-profit and they were tending to our needs. As they came in, they cut our CNA staff down. They're cutting our nurses down. They're changing the food. We don't have options. We don't have rights to speak up. We don't have the recreation. Like Mr. Gallimore stated, they cut our ES services, which is environmental services that does the cleaning. I understand that this might be good for certain people, but as the 320 residents that were there.. This is not great for us. We have concerns. We have lived that matter. We're really in a tight situation. Again, we do go to resident council meetings. We do voice our opinions. Nothing gets done. The decisions that they make are done without us. We don't find out half of the time until everything's already done. For instance, we had two nurses on each side dealing with twenty patients apiece. They cut that down to the point where they have one nurse dealing with forty patients, forty residents. It's hard to give the medication and the care and provide the services that's needed and required. Again, we are a skilled facility. We have ventilation. We have people going in and out. We have a womb care for our patients. We handle a lot of stuff. With all the cuts that they're making, it's making it very

difficult and very dangerous for us as the residents at the facility. I mean, I can't speak like everyone else cause I'm a little bit eh, but the truth of the matter is we need people that's going to help us, and Presbyterian was doing their job as a nonprofit. We were a 4.5-to-5-star residential home. Now, they're talking about we're great because we're a 3.5. That's like saying that your child can go to school and come home with grades of a D Plus and a C and you accept that. That's not good for us. We are residents and at least give us a B Plus or at least confirm or talk with us and let us know what's going on. We're not asking for much. We're residents. We do pay our insurances. We do require certain needs. Everyone's different. We have ventilation. We have just therapy. Every situation is different. By them cutting down the services and the staffing, and this is going to affect us in a lot of different ways. We have these things called codes, rapid response, code 99.

**Mr. Roman** Yes, Sir.

**Mr. Roman** We have this codes, and as of lately, the past year, year and a half, these codes have gone up. People going out. Unfortunately, people were expiring. It's not good. We need this. We need the assistance. We can't let them take over our facility and make it a three-star place. We need help.

**Mr. Robinson** We thank you very much for the comments. Thank you. I appreciate it.

**Mr. Robinson** Can we have the applicant come forward please?

**Mr. Kraut** I have a question just to focus the initial conversation. My understanding is we have not approved the new ownership group to take over the institution. The two gentlemen who just described what has occurred, I want to be clear, it's not under the new ownership group. This is the existing ownership is what they were addressing. Could you just speak to that issue, please, so I can understand it. Thank you.

**Mr. Robinson** Please introduce yourselves first.

**Ms. Sanchez** Good morning. Kim Roldan Sanchez, President at Silvercrest Center for Nursing and Rehab.

**Mr. Robinson** Could you introduce your colleagues?

**Mr. Blatt** Good morning. Andrew Blatt. I'm consulting to the applicant. We have Michael Schrieber, who's one of the members of the applicant and Pasquale DeBenedictis.

**Ms. Sanchez** I'll start by reiterating.

**Mr. Robinson** Just put the mic right in front of your mouth.

**Ms. Sanchez** I will start by re-iterating what Mr. Kraut said. The operator of Silvercrest Nursing Center is me under the New York Presbyterian as the passive parent. We have

not transitioned. I understand that the residents have this perception that it is consented. We regularly clarify that for them at different forums. I do want to respond to the comments that were just said related to the current operations. Understandably, change is not easy for anyone, particularly the residents who live there. This is their home. We have been transparent about this transition from the beginning. We've had three formal communications with the residents where there are opportunities, as the two gentlemen indicated, for them to share issues, concerns that they have throughout. That would exist regardless of a proposed sale that's underway right now. I do want to go to a couple of the comments there. Staffing. I'll begin with that there. As everyone knows, the mandate for staffing and nursing homes is 3.5. We exceed that. We are currently, for the past four weeks at 3.77. We've always been in that range. We've never been penalized related to being under that and something that we are proud of. We take a lot of pride in doing that. We monitor our staffing on all of the units regularly. We have plans in place for when there are call-outs from team members. We have a Vent Unit, as was indicated. Those patients have a higher acuity and more needs. The staffing on the Vent Unit is higher than it would be on the other long-term care and rehab units. We have our nursing team, who is hands-on. Our leadership that is always at the forefront, working with the units, rounding, getting communication from the staff about any needs that they have related to staffing, ensuring at times when we don't have those staffing needs on the unit because of call outs or others, we have agencies at hand that we immediately turn to ensure that we have full staffing on each of those floors. As it relates to the star ratings, we believe strongly that the proposed future operator is a stellar organization and that they will bring quality care as we are providing today, that it will be consistent and seamless to our residents. I do also want to address just the communications again. The residents do have access to me as the President, to the administrator, to the executive team regularly to communicate any of their concerns that they have. We plan to continue having this open dialog with them as we transition here. There are, though, perceptions from the residents that are not accurate. We want to make sure that they have the information that they need to feel comfortable. They live here, and it is really important that we continue our mission of being patient-centric and focused on their needs.

**Mr. Robinson** I do think that, based on the comments that we've gotten from the two residents who came here, there is at least a concern that there will be reductions in staffing and services as a result of the transition. Could we have the new owner's comment on that?

**Mr. Schrieber** My name is Michael Schrieber, proposed new operator. We've received information from Kim, as she has discussed here in regard to what those changes are. We do know that during the last annual survey, they received a deficiency for insufficient staffing, which was based upon the code regarding your facility assessment. Their facility assessment was extremely high, well over 3.5. In fact, I believe it was a 4.27. They had reduced it just through overtime with assurances to the union, both on their part as well as our own that there will be no reductions in staff. The union is fully on board with that, that being 1199.

**Mr. Robinson** Thank you for that response.

**Mr. Robinson** Open it up to the committee or members of the council for questions.

**Mr. Robinson** Dr. Boufford.

**Dr. Boufford** I think just to response to the concerns of the residents, might there be their perception of reduction in staff support, et cetera, being preparing for reducing expenses in order to make a takeover by another owner more attractive? Sorry to be cynical, but I just wanted to raise that. I think it's a really important issue relative to the potential for the new owners investing to address some of the shortfalls that have been identified by the residents, rather than maintaining what they at least have expressed to us is a reduction in services from what they have experienced in the past at the facility.

**Mr. Schrieber** The plan that we have in place again is not to reduce for what it is that we had looked at and this is information provided to us by the current operator. It was high usage of overtime. That overtime didn't necessarily provide much of anything beyond what would be potentially necessary as Kim had mentioned for call outs or whatnot. We would propose and we had look with this current operator that new software would put in place to actually manage. The hours that are being provided instead of over utilizing hours and provide what would be pertinent to. Thus, we would not be looking to reduce and jeopardize any care to any of the residents within the facility.

**Dr. Boufford** I think that really wasn't my question. I was just trying to get a sense of willingness to review the situation against higher quality standards to respond to some of the concerns in terms of making more of an investment rather than continuing to reduce expenses in the takeover process.

**Mr. DeBenedictis** We have experience that goes back to, believe it or not 1990. We take patient complaints and patient family complaints very seriously. We have systems in place that address these complaints. We also believe in a high quality of care. What we do is we assess everything. We listen to the complaints, which they have. We ensure that we're going to be providing the proper care, which we do across all of our facilities. We haven't been in there to actually change anything yet, but our intention is when we go into any building is we do make investments in the building. We make investments both in the physical plant, we make investments and the quality of care. We have new procedures and policies that we put in place. We invest in technology. We make investment throughout the entire facility. If we see areas that need improvement, our intention is to make investments in those specific areas.

**Ms. Monroe** Ann Monroe, member of the council and committee. Thank you.

**Ms. Monroe** I have a question for Presbyterian. You're a passive parent. That means you're not operating the facility today. Is that accurate?

**Ms. Sanchez** That's correct. However, there is a board, and the board does have New York Presbyterian leadership that sit there. They're involved in any key decisions.

**Ms. Monroe** If you're the passive parent who's the operator today?

**Ms. Sanchez** Silvercrest.

**Ms. Monroe** Silvercrest is in there?

**Ms. Sanchez** Yes.

**Ms. Monroe** When the gentleman said we're not in there yet or whatever. That was my question was this is not a case of a brand-new person. We approve the sale today. Tomorrow, there's brand new people coming in. These are the people that have been operating it under your passive parenthood.

**Ms. Sanchez** Today, Silvercrest operates it, and the team that is there is employed by Silvercrest.

**Mr. Robinson** I think there's confusion in terms of the names. There's Silvercrest that's the current operator and Silvercrest Acquisition, which is the new operator.

**Ms. Monroe** Are you different?

**Mr. Kraut** New York Presbyterian, as a passive parent appoints the board at Silvercrest who operates it today. There is a board. That board oversees management. Assume that New York Presbyterian delegates powers to that board. That board is responsible for operating the facility, hiring management, setting policy and running the facility. What we're being asked is that entity, Silvercrest Nursing Home today is going to transfer ownership to a group considering. It's called Silvercrest Acquisition, and that is the confusion is Mr. DeBenedictis, Alex Solovey, Joe Carillo and Michael Schrieber, two of which of the owners are in front of us.

**Ms. Monroe** Well, thank you for clarifying that for me, Jeff. That leads to my last question, which is what did the passive parent, the Presbyterian, how did you go about selecting Silvercrest Acquisitions to buy your facility? What process did you through? Did you have other bidders? What made this the most appropriate choice for you?

**Ms. Rike** Yes, Miriam Rike. I'm Chair of the Board of Directors.

**Ms. Monroe** Please speak into the mic.

**Ms. Rike** Oh, sorry.

**Ms. Rike** Is that better?

**Mr. Kraut** Yes.

**Ms. Rike** I am Chair of board for Silvercrest, the Board of Directors, and we did go through an extensive process of evaluating alternatives. We interviewed. We had a request for proposals. We had a number of proposals and interviewed a number of operators for this transaction. We selected based on their quality, their experience, their commitment to the community. That was a fairly extensive process.

**Mr. Robinson** Thank you for that.

**Mr. Robinson** Mr. Lawrence.

**Mr. Lawrence** Harvey Lawrence, member of the council. I guess in the communication here, I sort of got in loss for me. Why are you disposing or selling the asset at this point?

**Ms. Rike** Yes, so Silvercrest, a very important asset, but not core to the New York Presbyterian operations. Given the economies of scale of an operator that will allow them to operate this facility at a different level than we're able to as where it's one facility outside of our core hospital care.

**Mr. Lawrence** They will bring greater management capabilities or greater financial capabilities to the operation?

**Ms. Rike** And the systems, they have standard systems.

**Mr. Lawrence** I guess I'm trying to sort of compare that to some of the comments that I've heard from the residents who suggest that services have been diminished or are diminishing. Is that part of the rationale for your sale at this juncture that you are not able to or haven't been the services have diminished over time?

**Ms. Rike** I would say the board has been committed to high level of services and respond to residents' input and complaints. And so, in terms of, as Kim noted, our staffing levels and our commitment to improvements to the facility have continued, certainly over the last three years since I've been board Chair.

**Dr. Kalkut** A question for the applicant. You had mentioned that the two-star rating is the current rating for the facility. You mentioned that some of that related to the survey was staffing. Yet the staffing, you get four stars for staffing there. Is it just the time difference with the survey and either added staffing or use of overtime, as you mentioned, was one of the ways that staffing was increased? How did that work?

**Mr. DeBenedictis** Well, staffing plays a part in the five-star rating. Ultimately, it's the care that you provide that really, really computes what the five star is. Although you might have four stars in staffing, you might other deficiencies elsewhere, which would result in a two-star reading. That's the answer to that specific question. We have

averages of three to five stars. In our facilities currently. We're anticipating, like Kim had said, our expertise is in skilled care. We're anticipated by implementing the policies and the procedures that we've literally learned over the last twenty years that we're going to see an improvement in care and improvement in the current star rating.

**Dr. Kalkut** I think that does answer my question. The reduction of overtime and better efficiency of staffing hopefully would maintain a four-star rating with staffing, four- or five-star ratings. That's really my point.

**Mr. DeBenedictis** Yes, yeah, efficient scheduling definitely will help.

**Mr. Robinson** Thank you very much.

**Mr. Kraut** Guys, if you could just be focused on the questions, because we have a large meeting today, and I've got to get to it.

**Mr. Kraut** Go ahead.

**Mr. La Rue** Just quickly, Scott La Rue, member of the council. This points out one of the flaws of the staffing legislation that was passed by the legislature is it's not tied to acuity of the residents in the building. We heard the applicant say, maybe not as direct as the question you just asked, that even though their staffing is at 3.77 per patient per day, they have eighty ventilator units in the facility, which is going to require a higher level of staffing than the staffing mandate suggests, which is what I believe the applicant said their intentions was to raise the staffing level because the acuity in the building is higher than a traditional nursing home which is exactly what they should be doing and points out the flaw of the 3.5 mandate.

**Mr. Robinson** Thanks for the comments.

**Mr. Robinson** I'm going to let you guys leave the table and ask if there's anybody else from the public that wishes to speak on this application.

**Mr. Robinson** Hearing none, I'll now call the question.

**Mr. Robinson** All in favor?

All Aye.

**Mr. Robinson** Any opposed?

**Mr. Robinson** Any abstentions?

**Mr. Robinson** That motion carries.



**Mr. Robinson** This concludes the special Establishment and Project Review committee.

**Mr. Robinson** I turn it over to Mr. Kraut for the full council.

**Mr. Robinson** Anybody leave glasses and room keys down at the front desk? They're with Ms. Leonard.

**Mr. Kraut** It's a Marriott.

**All** (Laughing)