

**STATE OF NEW YORK**  
**PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**

**ANNUAL MEETING**

**AGENDA**

*February 13, 2014*

*Immediately following the Special Establishment and Project Review Committee Meeting  
(which is scheduled to begin at 9:45 a.m.)*

*90 Church Street  
4<sup>th</sup> Floor, Room 4A & 4B  
New York City*

**I. INTRODUCTION OF OBSERVERS**

Dr. William Streck, Chairman

**II. ELECTION OF OFFICERS**

**A. Election of Vice Chairperson**

**B. Announce Committee Chairpersons and Vice Chairpersons and  
Committee Membership**

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

**C. Discharge the Ad Hoc Advisory Committee on Environmental and  
Construction Standards**

**III. 2013 ANNUAL REPORT**

Public Health and Health Planning Council Annual Report

**Exhibit #1**

**IV. APPROVAL OF MINUTES**

December 12, 2013

**Exhibit #2**

January 7, 2014

V. **ADOPTION OF REVISED OBSERVER GUIDELINES**

Exhibit #3

A. **Adoption of the Revised Guidelines for Committee Observers**

James Dering, General Counsel

B. **Adoption of the Revised Guidelines for Observers for Full Public Health and Health Planning Council**

James Dering, General Counsel

VI. **REPORT OF DEPARTMENT OF HEALTH ACTIVITIES**

A. **Report of the Department of Health**

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

B. **Report of the Office of Primary Care and Health Systems Management Activities**

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

C. **Report of the Office of Health Insurance Programs Activities**

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

D. **Report of the Office of Public Health Activities**

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

VII. **PUBLIC HEALTH SERVICES**

**Report on the Activities of the Committee on Public Health**

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

VIII. **HEALTH POLICY**

**Report on the Activities of the Committee on Health Planning**

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

**IX. REGULATION**

**Report of the Committee on Codes, Regulations and Legislation**

**Exhibit #4**

Angel Gutiérrez, M.D., Chair

**For Emergency Adoption**

3-08 Amendment of Subpart 7-2 of Title 10 NYCRR - Children’s Camps

**For Adoption**

13-25 Section 405.4 of Title 10 NYCRR -Definition of Pediatric Sepsis Update

13-20 Amendment of Section 400.21 and Repeal of Sections 405.43 and 700.5 of Title 10 NYCRR – Advance Directives

**X. PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS**

**Report of the Committee on Establishment and Project Review**

Jeffrey Kraut, Chair of Establishment and Project Review Committee

**A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES**

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

**CON Applications**

**Residential Health Care Facilities - Construction**

**Exhibit #5**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1.	132267 C	Linden Center for Nursing and Rehabilitation (Kings County)	Contingent Approval

**CATEGORY 2:** Applications Recommended for Approval with the Following:

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

**CON Applications**

**Acute Care Services - Construction**

**Exhibit #6**

<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1. 132207 C	New York Presbyterian Hospital – Columbia Presbyterian Center (New York County) Dr. Boutin-Foster – Recusal Dr. Martin - Interest	Contingent Approval

**Ambulatory Surgery Centers - Construction**

**Exhibit #7**

<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1. 132199 C	NYU Hospitals Center (New York County) Dr. Brown – Recusal	Contingent Approval
2. 132205 C	Strong Memorial Hospital (Monroe County) Mr. Booth- Interest Ms. Hines – Recusal Mr. Robinson - Recusal	Contingent Approval
3. 132210 C	Cayuga Medical Center at Ithaca (Tompkins County) Mr. Booth - Interest	Contingent Approval

**Residential Health Care Facilities - Construction**

**Exhibit #8**

<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1. 131309 C	Jamaica Hospital Nursing Home Co. Inc. (Queens County) Mr. Fassler - Interest	Contingent Approval

**Upstate Request for Applications – Certified Home Health Agencies –  
Construction**

**Exhibit #9**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1.	132354 C	Alpine Home Health Care, LLC (Bronx County) Mr. Fensterman – Recusal	Contingent Approval

**CATEGORY 3:** Applications Recommended for Approval with the Following:

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

**CON Applications**

**Acute Care Services - Construction**

**Exhibit #10**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1.	132187 C	Winthrop-University Hospital (New York County) Dr. Brown – 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**

**Exhibit #11**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1.	132134 B	Moshenyat, LLC d/b/a Moshenyat Gastroenterology Center (Kings County)	Contingent Approval

**Diagnostic and Treatment Centers – Establish/Construct**

**Exhibit #12**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1.	131284 B	Lasante Health Center, Inc. (Kings County)	Contingent Approval
2.	132080 B	Broadway Community Health Center, Inc. (New York County)	Contingent Approval

**Residential Health Care Facility – Establish/Construct**

**Exhibit #13**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1.	132166 E	Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation (Kings County)	Contingent Approval

**Restated Articles of Organization**

**Exhibit #14**

	<b><u>Applicant</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
	The Plastic Surgery Center of Westchester , LLC	Approval

**Certificate of Incorporation**

**Exhibit #15**

**Applicant**

Montefiore Foundation, Inc.

**E.P.R.C. Recommendation**

Approval

**HOME HEALTH AGENCY LICENSURES**

**Exhibit #16**

**Number**

**Applicant/Facility**

**E.P.R.C. Recommendation**

1565 L

Anne M. Chambers d/b/a Health Beat  
(Nassau, Queens, and Westchester Counties)

Contingent Approval

1646 L

F & H Homecare, Inc. d/b/a Visiting Angels  
(Bronx County)

Contingent Approval

1657 L

Gentle Care Home Services of NY, Inc.  
(Bronx, Kings, New York, Queens, and Richmond Counties)

Contingent Approval

1709 L

Gentle Touch Home Care Agency, Inc.  
(Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester Counties)

Contingent Approval

2092 L

Igbans Home Care Services, Inc.  
(Bronx, Kings, Nassau, New York, Queens, and Richmond Counties)

Contingent Approval

1928 L

Marina Homecare Agency of NY, Inc.  
(Dutchess, Nassau, Orange, Putnam, Queens, Rockland, Suffolk, Sullivan, Ulster and Westchester Counties)

Contingent Approval

2139 L	Westchester Homecare, Inc. d/b/a FirstLight HomeCare of Westchester (Westchester County)	Contingent Approval
2224 L	Foster Nurses Agency USA, Inc. (Bronx, Kings, Nassau, New York, Queens and Richmond Counties)	Contingent Approval

**CATEGORY 2:** Applications Recommended for Approval with the Following:

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

**CON Applications**

**Residential Health Care Facility – Establish/Construct**

**Exhibit #17**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>E.P.R.C. Recommendation</u></b>
1.	131036 E	Little Neck Care Center (Queens County) Mr. Fensterman – Recusal	Contingent Approval
2.	131159 E	Morningside Acquisition I, LLC d/b/a Morningside House Nursing Home (Bronx County) Mr. Fassler – Interest Mr. Fensterman - Recusal	Contingent Approval
3.	131348 E	Shore View Nursing & Rehabilitation Center, LLC (Kings County) Mr. Fensterman – Recusal	Contingent Approval
4.	132071 E	Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare (Steuben County) Mr. Fensterman – Recusal	Contingent Approval

5.	131092 E	Shorefront Operating, LLC d/b/a Waterfront Rehabilitation and Health Care Center (Kings County) Mr. Fassler – Interest Mr. Fensterman - Recusal	Contingent Approval
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**Certified Home Health Agencies – Establish/Construct**

**Exhibit #18**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1.	132115 E	Visiting Nurse Service of New York Home Care (Kings County) Mr. Fassler – Interest Ms. Hines –Interest	Contingent Approval
2.	132264 E	Visiting Nurse Service of New York Home Care (Kings County) Mr. Fassler – Interest Ms. Hines - Interest	Contingent Approval

**Upstate Request for Applications – Certified Home Health Agencies –  
Establish/Construct**

**Exhibit #19**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1.	132353 E	Alpine Home Health Care, LLC (Erie County) Mr. Booth – Interest Mr. Fensterman - Recusal	Contingent Approval

**HOME HEALTH AGENCY LICENSURES**

**Exhibit #20**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
	2140 L	Hardings Beach, LLC d/b/a Home Instead Senior Care (Monroe County) Mr. Booth – Recusal Ms. Hines – Interest Mr. Robinson - Interest	Contingent Approval

2213 L	Genesee Region Home Care of Ontario County, Inc. d/b/a Home Care Plus (See exhibit for Counties to be served) Mr. Booth – Recusal Ms. Hines – Interest Mr. Robinson - Interest	Contingent Approval
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**CATEGORY 3:** Applications Recommended for Approval with the Following:

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

**NO APPLICATIONS**

**CATEGORY 4:** Applications Recommended for Approval with the Following:

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

**Ambulatory Surgery Centers – Establish/Construct**

**Exhibit #21**

<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1. 112086 B	1504 Richmond, LLC d/b/a Richmond Surgery Center (Richmond County) Mr. Fensterman – Recusal Mr. Kraut – Recusal Ms. Hines – Abstained at EPRC One Member Opposed	Contingent Approval

**Upstate Request for Applications – Certified Home Health Agencies – Establish/Construct**

**Exhibit #22**

<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1. 131224 E	Visiting Nurse Service of New York Home Care (Dutchess County) Ms. Hines – Interest Three Members Opposed at EPRC	Contingent Approval

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

**NO APPLICATIONS**

**CATEGORY 6:** Applications for Individual Consideration/Discussion

**Dialysis Services – Establish/Construct**

**Exhibit #23**

<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1. 132178 E	Big Apple Dialysis Management, LLC (Kings County) Dr. Bhat – Recusal Mr. Fensterman – Recusal Dr. Palmer - Recusal	To be presented at the Special Establishment/Project Review Committee on 2/13/14 No Recommendation

**Upstate Request for Applications – Certified Home Health Agencies – Establish/Construct**

**Exhibit #24**

<u>Number</u>	<u>Applicant/Facility</u>	<u>E.P.R.C. Recommendation</u>
1. 131225 E	Visiting Nurse Service of New York Home Care (Oneida County) Mr. Booth – Interest Ms. Hines – Interest Dr. Streck - Interest	No Recommendation

**XI. PROFESSIONAL**

**Executive Session - Report of the Committee on Health Personnel and Interprofessional Relations**

Dr. Jodumutt Bhat, Chair  
One Case arising under PHL 2801-b

**XII. NEXT MEETING**

March 27, 2014 - ALBANY  
April 10, 2014 – ALBANY

**XIII. ADJOURNMENT**

To Be Distributed Under Separate Cover

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

**Minutes**  
**December 12, 2013**

The meeting of the Public Health and Health Planning Council was held on Thursday, December 12, 2013, at the Century House, 997 New Loudon Road (Route 9), Main Ball Room Latham, New York 12110, Chairman, Dr. William Streck presided.

**COUNCIL MEMBERS PRESENT:**

Dr. William Streck, Chair	Ms. Ellen Rautenberg
Dr. Howard Berliner	Mr. Peter Robinson
Dr. Jodumatt Bhat	Dr. John Ruge
Dr. Lawrence Brown	Dr. Theodore Strange
Mr. Michael Fassler	Dr. Anderson Torres
Mr. Howard Fensterman	Dr. Patsy Yang
Dr. Angel Gutiérrez	
Mr. Robert Hurlbut	
Mr. Jeffrey Kraut	

**DEPARTMENT OF HEALTH STAFF PRESENT:**

Mr. Charles Abel	Ms. Sylvia Pirani
Dr. Guthrie Birkhead	Mr. Jeffrey Rothman
Mr. Alex Damiani	Ms. Linda Rush
Ms. Barbara DelCogliano	Mr. Robert Schmidt
Mr. Christopher Delker	Mr. Michael Stone
Dr. Barbara Dennison	Ms. Lisa Thomson
Mr. James Dering	Ms. Lisa Ullman
Ms. Alejandra Diaz	Ms. Rae Ann Vitale
Ms. Colleen Leonard	Mr. Robert Welch
Ms. Rebecca Fuller Gray	Ms. Karen Westervelt
Ms. Sandy Haff	Ms. Diana Yang
Ms. Diana Jones	Dr. Howard Zucker
Ms. Sue Kelly	
Ms. Ruth Leslie	
Ms. Lisa McMurdo	
Ms. Joan Cleary Miron	

**INTRODUCTION:**

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

**MEETING OVERVIEW:**

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

**RESOLUTION OF APPRECIATION:**

Dr. Streck noted that Dr. Sullivan resigned from the Council to serve as the Acting Commissioner of the Office of Mental Health. Dr. Streck read into the record on behalf of the Council a Resolution of Appreciation for Dr. Sullivan thanking her for her dedication and to the Council.

**REGULATION**

Dr. Streck introduced Dr. Gutiérrez to give his Report of the Committee on Codes, Regulations and Legislation. Due to the lack of a quorum Dr. Gutiérrez presented regulations that did not require Council action.

**For Information**

11-36 Amendment of Sections 700.2 and 717.3, Parts 793 and 794 of Title 10 NYCRR - Hospice Operational Rules

**For Discussion**

Part 405 of Title 10 NYCRR – Federal Conditions of Participation Amendments

Building Codes

Dr. Gutiérrez presented to the Council for Information 1-36 Amendment of Sections 700.2 and 717.3, Parts 793 and 794 of Title 10 NYCRR - Hospice Operational Rules and for Discussion Part 405 of Title 10 NYCRR – Federal Conditions of Participation Amendments and a regulation pertaining to Building Codes. To review the report, please see pages 4 through 7 of the attached transcript.

**REPORT OF DEPARTMENT OF HEALTH ACTIVITIES:**

Dr. Streck introduced Ms. Kelly to give the Report on the Department of Health Activities.

## **REPORT OF DEPARTMENT OF HEALTH:**

### Health Benefits Exchange

Ms. Kelly began her report by updating the Council on the official health plan marketplace for New York. There were more than 100,000 people enrolled through the Department's online marketplace. Starting January 1, 2014, they will have quality, low-cost health coverage. In all, more than 314,000 people have completed applications on the health plan marketplace and more than a quarter-million New Yorkers have received enrollment assistance from the customer service call center. More than 56,000 in-person assisters are trained and ready to assist New Yorkers throughout the state.

### Population Health Summit

Ms. Kelly announced that the Department held its first Population Health Summit which was well received and well attended. Participants had the chance to hear from leading authorities on public health, including Dr. Tom Frieden, the Director of the CDC, Dr. Tom Farley, Commissioner of the New York City Department of Health and Mental Hygiene; and Commissioner Shah. The Summit called attention to the critical role that public health will play in improving population health. It also showcased our own state's Prevention Agenda as the roadmap for achieving these goals.

### World AIDS Day

Ms. Kelly also noted that the Department celebrated and joined in the commemoration of World AIDS Day, with a 30th anniversary celebration of the New York State AIDS Institute and the AIDS Advisory Council.

### Code-a-thon

Ms. Kelly advised that the Department will be hosting the first ever New York State Health Code-a-Thon, as part of a larger event called New York Innovates. The code-a-thon is a two-day gathering that will be held at RPI in Troy. The event challenges developers, designers, and data enthusiasts to use open data from various sites, such as Health Data New York and Open Data New York, to create technology solutions that we hope will one day link New Yorkers to community resources that improve their health. The ultimate goal is to help New Yorkers lower their risk for obesity and diabetes and that is the focus of the Code-a-Thon.

## Prevention Agenda

Ms. Kelly stated that improving the health of our communities is a critical goal for the Health Department which can be achieved with help from various stakeholders, including local health departments and hospitals. As part of the Prevention Agenda, the Department is requiring hospitals and local health departments to meet to discuss ways to improve the health of their communities, and to submit plans for how they will do so. As of December 2013, more than 40 local health departments have submitted community health assessments and community health improvement plans to the Department of Health. The Department has also collected 125 community service plans from hospitals. Ms. Kelly further noted that the Department is continuing to work with the local health departments in remaining hospitals and hospital systems that will be submitting their respective plans. The Department has dedicated staff throughout the Department to review the documents, using an online tool, and it is anticipated that those reviews will be completed by January 2014. Every local health department and hospital will receive feedback, highlighting the strengths and opportunities for improvement, which they can share with their partners.

## Sepsis

Ms. Kelly noted that hospitals have been stepping up to meet requirements regarding sepsis. The state requires all hospitals in the state to adopt evidence-based sepsis protocols for children and adults treated in emergency rooms and on in-patient units. Hospitals are required to report their compliance with these practices and in the outcomes of these efforts. All hospitals have successfully submitted protocols for sepsis care. Adopting these protocols in New York has the potential to save thousands of lives per year and reduce other tragic and costly consequences of sepsis. With the assistance of the adopted rules for sepsis care, New York is leading the nation by ensuring that proven best-practices are implemented across the state. Measuring adherence to protocols and developing a standardized risk-adjusted mortality measure. Through these actions, New York will contribute to the evidence base nationally that continues to evaluate the impact of sepsis protocols on mortality.

## Health Data New York

Ms. Kelly explained that in early December 2013, the Department released hospital cost and charge data for all hospitalizations in New York State in the years 2009–2011. That information is now on Health Data New York, an open data platform. The intention is for consumers to know how much hospital care costs across different hospitals for various services. Until recently, the public did not know how much they or their insurance company were going to be charged for particular services or procedures. Now individuals will be able to make informed choices about their health care and the best place for treatment. The data has had more than 4,000 views and more than half of those views and requests coming from the media. In the week since its release, there have already been 480 downloads of the charge and cost data. The Department of Health, through the Office of Quality and Patient Safety are continuing to work with the provider community and the providers associations to improve the quality of the data.

## Flu

Ms. Kelly updated the members on the flu. The Department is always tracking the flu season. As of the date of the meeting, New York is at sporadic levels of flu and there was no determination that the flu has become prevalent in New York. A flu report is posted on the Department's website every Thursday.

## ISTOP

Ms. Kelly noted that the new prescription-monitoring program, ISTOP has been a resounding success. ISTOP, which created the new prescription monitoring program registry has been providing practitioners and pharmacists with a user-friendly system to access a patient's controlled substance history in a secure online website. Since its debut, the PMP has been accessed by more than 55,000 users who have performed more than 4.8 million searches for controlled substance dispensing data. Based upon a search of a patient's name, date of birth, and gender, the PMP registry provides a practitioner with a list of all of the controlled substances dispensed for a patient over the past six months. The information includes the types, strength, and quantity of a medication, the date it was prescribed and dispensed, as well as the name of the prescriber and dispensing pharmacy. The use of the data registry has not only thwarted doctor shopping, but it has also informed prescribers about their patient's history, improved clinical decisions, and prevented potential dangerous drug interactions.

## Vital Access Provider Safety Net Programs

Ms. Kelly announced that the Department announced awards for the vital access provider safety net programs, or VAP II. The funds, \$46 million in all in this first round, will go toward many improvements in community care to achieve specific financial, operational, and quality improvement goals. These include expanding access to ambulatory services through added services or expanded hours of operation, the opening of urgent care centers to reduce the use of ERs, expanded services in rural areas, reducing adverse events, to lower costs, and establishing care coordination between and among providers and levels of health care delivery. In the near future the Department will be making \$80 million available for VAP awards and the Department is hopeful to secure more funding through the Medicaid Redesign Team waiver.

## Empire Clinical Research Investigated Program

Ms. Kelly noted that in October 2013, the Department awarded \$17.2 million in the Empire Clinical Research Investigated, Investigator Program (ECRIP), which provide funds to teaching hospitals to train physicians in clinical research. ECRIP was revamped in 2013 to continue making individual awards to teaching hospitals, and to make larger team-based center awards for institutions doing more advanced biomedical research. These funds are important for attracting more federal research funds to New York State. It will also increase the number of clinical investigators in the state, which will put New York in a more competitive position to get federal funds.

## LEAN

Ms. Kelly stated that the Department is involved in an exciting new venture across state agencies called LEAN, or LEAN government, which is intended to reduce inefficiencies and improve the quality of our programs. The first item of focus is associated with CON and opening surveys to issue operating certificates or amended operating certificates.

## State Health Improvement Plan

Ms. Kelly noted that the Department is involved in submitting the State Health Improvement Plan (SHIP) to the federal government after revisions and taking into account the public comments. The intent is to achieve the Triple Aim for all New Yorkers—improved health, better health care quality, and consumer experience at lower cost. A draft of the SHIP, was posted to the Department’s website and the comment period ended on December 6, 2013. There were 32 individuals and organizations who submitted comments. The plan is being revised to reflect those comments and the Department expects the plans to be submitted to the Federal Government on or about December 20, 2013, and will be posted on the Department’s website. In January 2014, workgroups will be established to begin the work of developing programs and processes to implement the plan and to prepare for submitting a grant application to the Center for Medicare and Medicaid Innovation at CMS for a state innovation testing grant. The Department is anticipating that the final grant opportunity will be announced by the Federal Government in February or March of 2014.

Ms. Kelly concluded her report. Dr. Streck thanked Ms. Kelly for her report. To view the complete report with member’s questions and comments, please see pages 7 through 22 of the attached transcript.

## **REPORT OF THE OFFICE OF PRIMARY CARE AND HEALTH SYSTEMS MANAGEMENT ACTIVITIES**

Ms. Westervelt began her report and thanked Dr. Ruge, Council members the Health Planning Committee, and Department staff for all the work that they have done on the Ambulatory Services Oversight workgroup and will continue to do.

Ms. Westervelt stated that the health care delivery system throughout the North Country is under stress due to rapid changes in organization, delivery models, payment reforming, and aging population, workforce shortages, and shrinking funding. Rising rates of chronic disease are also jeopardizing quality of life, workforce, and the economy. There is a growing recognition in the North County of the socioeconomic, environmental, and behavioral health factors that contribute to good health, yet there has not been substantive collaborative transformation models developed, in large part, due to fiscal challenges. These multi-faceted challenges require multi-stakeholder interventions that are tailored to the regional, local needs. In November 2013, Commissioner Shah formed a North Country Health Systems Redesign Commission to engage a regional planning group to engage a group of health care facility stakeholders in a regional

planning process, with the goal of stabilizing essential community providers, integrating systems of care, to eliminate the risk of reduced access to essential community services, expand access to primary care and community behavioral health services, reduce workforce shortages, and achieve improved quality of care and better population health. The nine counties that comprise the North County are the counties of Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence, Warren, and Washington. The Commission's charge is: to assess the total scope of care in the nine counties—community and preventative care, secondary and tertiary care, and long-term care; assessing facility infrastructure in terms of population needs; managing capacity and insuring that essential providers survive or that, more appropriately, capacity is developed to replace failing providers; developing a restructuring, a recapitalization agenda; identifying opportunities for merger, affiliation, and/or partnership among providers that will maintain or improve, as we said, access and quality, financial viability, and promote integrated care; and making, also making specific recommendations that providers and communities can implement to improve access, coordination, outcomes, and quality of care, including preventable utilization and population health; and develop recommendations regarding distribution of reinvestment grants. The commission will hold its initial meeting on December 17 in Lake Placid and is charged with submitting its recommendations to the Commissioner of Health by March 31, 2014.

Dr. Streck thanked Ms. Westervelt for the report. To review the full report, please see pages 22 through 26 of the attached transcript.

### **REPORT OF THE OFFICE OF PUBLIC HEALTH ACTIVITIES**

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

Dr. Birkhead began his report by speaking on the topic of hospital acquired infections. The central line blood stream infections and selected surgical wound infections, as well as C-difficile infections are reportable by hospitals in the state, through the National Health Care Safety Network system. The Department publishes an annual report on the Department's website which includes trend data from previous reports. Over the past years there is reduction in central line blood stream infections reported through the system of 53 percent. Overall, in the selected surgical sites, the Department has seen a reduction of about 16 percent over the life of the program. There is a 14 percent surgical wound site infection reduction in colon surgery, 23 percent reduction in bypass surgery in the chest wound site, and 47 percent reduction in donor site. There has not been any change in hip surgery.

Dr. Birkhead also stated that the Department has been monitoring clustering difficile acquired infections in a hospital. It is difficult thing to track due to the fact that some patients may come into the hospital with it, so you have to distinguish between a community-acquired and hospital-acquired. In addition, patients may be discharged and then come back with c-difficile that was hospital related.

Dr. Birkhead noted that there are state funds that the Department gives each year for hospitals or groups of hospitals to do quality improvement, learning collaborative approaches,

those are underway now in the area of central line blood stream infections and MRSA infections.

Dr. Birkhead concluded his report. To view the complete report, see pages 26 through 31 of the attached transcript.

Dr. Streck thanked Dr. Birkhead for his report and moved to the Approval of the Minutes.

### **APPROVAL OF THE MINUTES OF OCTOBER 3, 2013 and OCTOBER 22, 2013:**

Dr. Streck asked for a motion to approve the October 3, 2013 and October 22, 2013 Minutes of the Public Health and Health Planning Council meeting. Dr. Gutiérrez motioned for approval which was seconded by Dr. Berliner. The minutes were unanimously adopted. Please refer to page 31 and 32 of the attached transcript.

### **APPROVAL OF THE REVISED 2014 MEETING SCHEDULE:**

Dr. Streck next moved to the approval of the revised 2014 meeting schedule. The members approved the revision. Please see page 32 of the transcript.

### **REGULATION**

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

#### **For Emergency Adoption**

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

Dr. Gutiérrez began his report by introducing and briefly describing regulation 13-08 Amendment of Subpart 7-2 of Title 10 NYCRR - Children's Camps. He motioned for emergency adoption. Dr. Berliner seconded the motion. The motion passed. Please see page 32 and 33 of the attached transcript.

#### **For Adoption**

13-02 Amendment of Part 405 of Title 10 NYCRR- Hospital Pediatric Care

13-13 Amendment to Section 12.3 of Title 10 NYCRR – Administration of Vitamin K to Newborn Infants

Dr. Gutiérrez described regulations that are on the agenda for adoption. The first, 13-02 Amendment of Part 405 of Title 10 NYCRR- Hospital Pediatric Care. Dr. Gutiérrez motioned to adopt the proposed regulation. Dr. Berliner seconded the motion. The motion carried. Please see pages 33 through 35 of the attached transcript.

Dr. Gutiérrez introduced regulation 13-13 Amendment to Section 12.3 of Title 10 NYCRR – Administration of Vitamin K to Newborn Infants and motioned for adoption. Dr. Berliner seconded the motion. The motion to adopt carried. Please see pages 35 through 37 of the attached transcript.

Dr. Gutiérrez concluded his report. Dr. Streck thanked Dr. Gutiérrez for the report.

## **PUBLIC HEALTH SERVICES**

Dr. Streck moved to the next item under Public Health Services and introduced Dr. Torres to give the Report of the Activities of the Committee on Public Health.

### **Report on the Activities of the Committee on Public Health**

Dr. Torres stated that the Public Health Committee is starting to review of the community service plans, the community health assessments and community health improvement plans submitted by hospitals and the local health departments as part of the Prevention Agenda. The Committee will have a report for the Council in February on this review.

Dr. Torres noted the topics from the Committee’s November meeting. The Committee continues its focus on reducing maternal mortality. Staff from the Department’s Division of Family Health spoke to the Committee to get a better understanding of some of the issues and programs focused on women’s health, including reproductive health and impact maternal mortality. The goal of the most recent discussion was to link past presentations to the Prevention Agenda and see what action steps there are moving forward. There is also a need to focus on health across the reproductive life of a woman, both preconception and interconception, to reduce unintended pregnancies and improve pre- and inter-conceptional care, we should consider the following: addressing the cross-cutting social determinants of health that underlie many health issues, including racism, poverty, and violence; providing comprehensive, evidence-based health education, including sexual health education for youth in all of our schools; think of how to promote norms of wellness through effective social marketing across the lifespan; identifying and implementing clinically oriented strategies, that would include integrating preconception and interconception care into routine primary and specialty care for women of reproductive age; implementing strategies to focus on access to pregnancy planning and family planning services to reduce unintended pregnancy among women with chronic conditions; also focusing on women who may have had an adverse birth outcome—low birth weight, et cetera.—and making sure that they are engaged in interconception care. The goal is to bring attention, hopefully sustained attention, to a problem that may or may not get the attention that it deserves.

Dr. Torres also advised that the committee will also discuss how to follow up on these very strong recommendations to keep the attention on this important issue and keep it in the forefront.

Dr. Streck thanked Dr. Torres. Please see pages 38 through 42 of the attached transcript.

## **HEALTH POLICY**

Dr. Streck introduced Dr. Rugge to give the report on the Committee on Health Planning.

### **Report on the Activities of the Committee on Health Planning**

Dr. Rugge concluded his report, to review in detail and the members comments, please refer to pages 43 through 4 through 58 and 106 through of the transcript.

Dr. Rugge began his report by stating the Commissioner charged the Health Planning Committee with taking a new look at ambulatory care services in New York. There are a number of drivers for this planning process which includes the development of new models of care that were not invented or conceived at the time of the regulatory structures we now live under, this includes retail clinics, urgent care centers, freestanding emergency departments, high-end imaging, radiation therapy on a freestanding basis.

Dr. Rugge gave background on the process of the preparing the recommendations. He also noted that Senator Hannon and Assemblyman Gottfried actively participated in the Committee discussions. Dr. Rugge noted that David Choksi helped the Committee and Department prepare a vision statement, opening statement, opening chapter of the paper.

Dr. Rugge explained that the Committee is presenting recommendations and proposed revisions to regulations or statute. He further explained that on the recommendations that are adopted it will be incorporated into a report that will be presented to the Council in February as a finished product.

Dr. Rugge introduced Mr. Delker to the Council recommendations on limited-services clinics.

Mr. Delker stated that throughout the process the Committee throughout the process first and foremost was insuring patient safety and quality, and transparency to consumers of all the services that will be provided in this setting.

Mr. Delker first presented retail clinic recommendations. A retail clinic provides limited set of services that is basically episodic and confined to the duration of the patient encounter. These are not meant to be continuing sources of care. The Committee recommends that these be defined through regulation or statute that these services are episodic and just provided in the duration of the patient encounter. The limited-service clinic cannot provide anything like surgical services, dental, rehab, mental health, substance abuse, or birth-related services, they cannot exercise or deliver anything having to do with venipuncture, nor can they prescribe controlled substances. The Committee also recommends that they would be prohibited from serving patients 24 months of age or younger. They could not deliver childhood immunizations, only flu vaccines for those up through pediatric and adolescent up to 18 years. To be transparent the Committee recommends that the retail clinics make clear to the consumer which services are and

are not offered through their signage and through their marketing information and advertising. The Committee also recommends that these providers be accredited through third-party accrediting organization recognized by the Department and that any loss of accreditation be communicated to the Department. There were several questions and comments from the members. Please see pages 50 through 75 of the attached transcript.

Dr. Ruge next moved to the urgent care recommendations and introduced Ms. Diaz.

Ms. Diaz began by giving the definition of urgent care. Urgent care is intended to treat episodic, acute illness, or minor traumas that are not life-threatening or permanently disabling. Urgent care is not intended to be a patient-centered medical home or source of continuing care, similar to limited-services clinics. Urgent care is not intended for emergency intervention for major trauma, life-threatening or potentially disabling conditions, for monitoring and on-going treatment of chronic conditions. Ms. Diaz stated that in terms of establishing a naming convention, the Committee wants to restrict the use of “urgent care” and its equivalents to those providers offering urgent care services. Urgent care providers cannot use the word “emergency” or its equivalent in their names. In terms of patient safety and quality, we’re requiring policies and procedures for referring patients whose needs exceed the services of an urgent care provider to ensure continuity of care.

Ms. Diaz explained that in terms of health information technology, it is identical to the recommendations in limited services clinics in terms of requiring utilization of certified electronic health records, providing a copy of medical records, requiring documentation, execution and ongoing management and requiring e-prescribing. In order to achieve this definition and the naming protections the Committee is recommending that there be statutory action. Only providers meeting the definition that we reviewed would be able to use the term ‘urgent care.’ To be approved to use the name providers will need to meet specified criteria demonstrated through certification for Article 28’s or through accreditation for Non-Article 28’s.

Ms. Diaz described Non-Article 28’s such as private practice offices including those that are affiliated with an article 28 that wish to call themselves an urgent care provider would be expected to obtain accreditation by an accrediting body approved by the Department of Health. No CON review would be required. For Article 28 urgent care providers, existing 28 hospitals or D&TCs wanting to provide urgent care services would be expected to go through a limited CON review to have urgent care listed on their operating certificates. Maintaining the flexibility that an Article 28 would have now to offer some services thorough private practices, they would still have that choice. Private practice that is affiliated with an Article 28 would still be able to establish. Their expectation would be that they seek accreditation and then for the establishment of any new Article 28 or D&TC that wishes to be an urgent care provider they would go through CON review. To see the complete discussion of urgent care please see pages 75 through 91 of the attached transcript.

Dr. Streck announced that he will be moving to the Report of the Establishment and Project Review Committee and will return to the completion of Dr. Ruge’s report. Dr. Streck introduced Mr. Kraut.

**PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS**

**B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES**

**CATEGORY 2:** Applications Recommended for Approval with the Following:

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

**CON Applications**

**Acute Care Services – Establish/Construct**

**Exhibit #16**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>Council Action</u></b>
1.	132195 E	Mount Sinai Hospitals Groups, Inc. (New York County) Dr. Bhat – Recusal Dr. Martin – Recusal (not present)	Contingent Approval

Mr. Kraut advised that in order to move applications in which there are recusals he will be taking applications out of order. Mr. Kraut introduced application 132195 and noted that Dr. Bhat declared a conflict and left the meeting room. Mr. Kraut noted for the record that Dr. Martin has a conflict however is not present at the meeting. Mr. Kraut motioned for approval. Dr. Gutiérrez seconded the motion. The motion to approve passed with Dr. Bhat’s noted recusal. Dr. Bhat re-entered the meeting room. Please see pages 91 through 93 of the attached transcript.

**Residential Health Care Facility – Establish/Construct**

**Exhibit #18**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>Council Action</u></b>
1.	131125 E	Ruby Care, LLC d/b/a Emerald North Nursing and Rehabilitation Center (Erie County) Mr. Fensterman - Recusal	Contingent Approval

- |    |          |  |                     |
|----|----------|--|---------------------|
| 2. | 131156 E | Opal Care, LLC d/b/a<br>Emerald South<br>Rehabilitation and Care Center<br>(Erie County)<br>Mr. Fensterman – Recusal                     | Contingent Approval |
| 3. | 131264 E | South Shore Rehabilitation, LLC<br>d/b/a South Shore Rehabilitation<br>and Nursing Center<br>(Nassau County)<br>Mr. Fensterman – Recusal | Contingent Approval |
| 4. | 132113 E | SGRNC LLC d/b/a King<br>David Nursing<br>and Rehabilitation Center<br>(Kings County)<br>Mr. Fassler – Recusal                            | Contingent Approval |

Mr. Kraut next moved to applications 131125, 131156, and 131264 and noted for the record that Mr. Fensterman has declared conflicts and has left the meeting room. Mr. Kraut motioned for approval, Dr. Gutiérrez seconded the motion. The motion to approve passed with Mr. Fensterman’s recusals. Mr. Fensterman returned to the meeting room. Please see pages 93 and 94 of the attached transcript.

Mr. Kraut introduced application 132113 and noted for the record that Mr. Fassler has declared a conflict and has left the meeting room. Mr. Kraut motioned to approve and Dr. Gutiérrez seconded the motion. The motion to approve carried with Mr. Fassler’s noted recusal. Mr. Fassler re-entered the meeting room. Please see pages 94 and 95 of the attached transcript.

**Certificate of Amendment of the Certificate of Incorporation**

**Exhibit #19**

**Applicant**

**Council Action**

Addiction Research and Treatment Corporation  
Dr. Brown – Recusal

Approval

Mr. Kraut moved to the consent to file the Certificate of Amendment of the Certificate of Incorporation of Addiction Research and Treatment Corporation and stated that Dr. Brown has declared a conflict and has left the meeting room. Mr. Kraut motioned for approval which was seconded by Dr. Gutiérrez. The motion to approve passed with Dr. Brown’s recusal. Dr. Brown returned to the meeting room. See page 95 of the attached transcript.

**CATEGORY 6:** Applications for Individual Consideration/Discussion

**Ambulatory Surgery Centers – Establish/Construct**

**Exhibit #21**

<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1. 112086 B	1504 Richmond, LLC d/b/a Richmond Surgery Center (Richmond County) Mr. Fensterman – Recusal Mr. Kraut - Recusal	Deferred

Mr. Robinson called application 112086 and stated that Mr. Fensterman and Mr. Kraut have declared a conflict and have left the meeting room. Mr. Robinson motioned for deferral of the application. Dr. Gutiérrez seconded the motion. Dr. Strange abstained. The motion failed due to the lack of quorum. Dr. Ruge motioned to reconsider once additional members returned to the meeting room. The motion to defer carried with Dr. Stranges' abstention and Mr. Fensterman and Mr. Kraut's recusals. Mr. Fensterman and Mr. Kraut returned to the meeting room. Please see pages 96 through 98 of the attached transcript.

**A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES**

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

**CON Applications**

**Ambulatory Surgery Center - Construction**

**Exhibit #5**

<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1. 122206 C	Griffiss Eye Surgery Center (Oneida County)	Contingent Approval

Mr. Kraut introduced the first project application 122206 and motioned for approval. Dr. Gutiérrez seconded the motion. The motion carried. Please see pages 98 and 99 of the attached transcript.

**Residential Health Care Facility - Construction**

**Exhibit #6**

<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
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- |    |          |  |                     |
|----|----------|--|---------------------|
| 1. | 122281 C | Meadowbrook Healthcare<br>(Clinton County) | Contingent Approval |
|----|----------|--|---------------------|

Mr. Kraut introduced application 122281 and motioned for approval which was seconded by Dr. Gutiérrez. The motion to approve carried. Please see pages 99 and 100 of the attached transcript.

**CATEGORY 2:** Applications Recommended for Approval with the Following:

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

**CON Applications**

**Acute Care Services - Construction**

**Exhibit #7**

<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1.	132009 C Hospital for Special Surgery (New York County) Dr. Boutin-Foster – Recusal (not present)	Contingent Approval
2.	131326 C Memorial Hospital for Cancer and Allied Diseases (New York County) Dr. Boutin-Foster – Recusal (not present)	Contingent Approval
3.	132037 C Memorial Hospital for Cancer and Allied Diseases (New York County) Dr. Boutin-Foster – Recusal (not present)	Contingent Approval
4.	132077 C Memorial Hospital for Cancer and Allied Diseases (Suffolk County) Dr. Boutin-Foster – Recusal (not present)	Contingent Approval

Mr. Kraut called applications 132009, 131326, 132037 and 132077 and noted for the record that Dr. Boutin-Foster has conflicts however is not present at the meeting. Mr. Kraut motioned for approval which was seconded by Dr. Berliner. The motion to approve carried.

Please see pages 100 and 101 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

**NO APPLICATIONS**

**B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES**

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

**CON Applications**

**Acute Care Services – Establish/Construct Exhibit #8**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>Council Action</u></b>
1.	132204 E	Mohawk Valley Health System (Oneida County)	Contingent Approval

**Ambulatory Surgery Centers – Establish/Construct Exhibit #9**

	<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>Council Action</u></b>
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1.	131069 E	Meadowbrook Endoscopy Center (Nassau County)	Contingent Approval
2.	131192 B	Abaco North, LLC d/b/a Manhattan Multi-Specialty Ambulatory Surgery Center (New York County)	Contingent Approval
3.	131296 B	Westmoreland ASC, LLC (Oneida County)	Contingent Approval
4.	132108 B	Niagara ASC, LLC d/b/a Ambulatory Surgery Center of Niagara (Niagara County)	Contingent Approval

**Diagnostic and Treatment Center – Establish/Construct**

**Exhibit #10**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1.	132011 B	Parkmed NYC, LLC (New York County)	Contingent Approval

**Dialysis Services– Establish/Construct**

**Exhibit #11**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1.	132034 B	Brooklyn United Methodist Church Continuum Services (Kings County)	Contingent Approval
2.	132067 B	Elizabethtown Center, LLC (Essex County)	

**Residential Health Care Facilities - Establish/Construct**

**Exhibit #12**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1.	131086 E	Autumn View Health Care Facility, LLC (Erie County)	Contingent Approval
2.	131087 E	Brookhaven Health Care Facility, LLC (Suffolk County)	Contingent Approval

3.	131088 E	Garden Gate Health Care Facility (Erie County)	Contingent Approval
4.	131089 E	Harris Hill Nursing Facility, LLC (Erie County)	Contingent Approval
5.	131090 E	North Gate Health Care Facility (Niagara County)	Contingent Approval
6.	131091 E	Seneca Health Care Center (Erie County)	Contingent Approval

**Certified Home Health Care Agency- Establish/Construct**

**Exhibit #13**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1.	132048 E	HCS Certified Home Care New York, Inc. d/b/a Girling Health Care of New York (Kings County)	Contingent Approval

**Certificate of Amendment of the Certificate of Incorporation**

**Exhibit #14**

Applicant

East Harlem Council for Human Services, Inc.

Council Action

Approval

**HOME HEALTH AGENCY LICENSURES**

**Exhibit #15**

	<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
	2143 L	Access to Home Care Services, Inc. (Cayuga, Onondaga, Cortland, Seneca, Tompkins, Oswego, and Jefferson Counties)	Contingent Approval
	2048 L	ACME Home Care, Inc. (Bronx, Kings, New York, Richmond, and Queens Counties)	Contingent Approval

2022 L	Big Apple Homecare Agency, Inc. (Kings, Richmond, Queens, Bronx, New York and Westchester Counties)	Contingent Approval
2117 L	Boomer Services Plus, Inc. d/b/a Comfort Keepers #786 (Nassau, Suffolk and Queens Counties)	Contingent Approval
2091 L	Elmy's Special Services, Inc. (Bronx, Richmond, Kings, Queens, Nassau and New York Counties)	Contingent Approval
2094 L	EP Home Care, LLC (Kings County)	Contingent Approval
2086 L	Irene A. Manolias d/b/a Executive Home Health Care (Nassau and Suffolk Counties)	Contingent Approval
2035 L	First Step Services, Inc. (Westchester and Bronx Counties)	Contingent Approval
2023 L	Kings Homecare Agency, Inc. (Bronx, Kings, New York, Queens and Richmond Counties)	Contingent Approval
2054 L	Lagora Health Services, Inc. (Kings, Nassau, Queens, Bronx, New York and Richmond Counties)	Contingent Approval
2115 L	NYC Pro Home Care, Inc. (New York, Bronx, Kings, Richmond, Queens and Nassau Counties)	Contingent Approval
1917 L	Polo Care, Inc. (Bronx, Queens, Kings, Richmond, Nassau, and New York Counties)	Contingent Approval

2098 L	RAMA Associates, LLC d/b/a Home Helpers and Direct Link of Amsterdam (Albany, Saratoga, Fulton, Schenectady, Montgomery and Schoharie Counties)	Contingent Approval
2040 L	Simpson Solutions, LLC d/b/a All Care Living Assistance Services (Westchester, Rockland, Bronx, New York, Queens, Richmond and Kings Counties)	Contingent Approval
2111 L	Berardino and Pfisterer, Inc. d/b/a Oxford Home Care Services (Oneida, Otsego and Herkimer Counties)	Contingent Approval
2032 L	RJG Consultants, Inc. d/b/a Providence Home Care Services (New York, Bronx, Kings, Richmond, Queens and Nassau Counties)	Contingent Approval

Mr. Kraut called all applications in Category One as listed above. He motioned for approval, Dr. Gutiérrez seconded the motion. The motion to approve carried. Please see pages 101 through 104 of the attached transcript.

**Hospice– Establish/Construct**

**Exhibit #17**

<u>Number</u>	<u>Applicant/Facility</u>	<u>Council Action</u>
1. 132063 E	Hospice of New York (Queens County) Mr. Fassler - Interest	Contingent Approval

Mr. Kraut called application 132063 and noted for the record that Mr. Fassler has an interest. Mr. Kraut motioned to approve. Mr. Gutiérrez seconded the motion. The motion to approve carried. Please pages 104 and 105 of the attached transcript.

**HOME HEALTH AGENCY LICENSURES**

**Exhibit #20**

<b><u>Number</u></b>	<b><u>Applicant/Facility</u></b>	<b><u>Council Action</u></b>
2363 L	Livingston County Board of Supervisors d/b/a Livingston County Department of Health (Livingston County) Ms. Hines - Interest	Contingent Approval
2041 L	NEC Care, Inc. d/b/a Home Instead Senior Care (Saratoga, Warren, and Washington Counties) Dr. Rugge – Interest/Abstaining	Contingent Approval
2109 L	Neighbors NY, Inc. (Warren, Washington, and Saratoga Counties) Dr. Rugge – Interest/Abstaining	Contingent Approval

Mr. Kraut moved to applications 2363, 2041 and 2109 and noted that Ms. Hines has an interest in application 2363 and Dr. Rugge has an interest and will be abstaining on applications 2041 and 2109. Mr. Kraut motioned to approve. Dr. Gutiérrez seconded the motion. The motion to approve carried. Please see pages 105 and 106 of the attached transcript.

**CATEGORY 3:** Applications Recommended for Approval with the Following:

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

**NO APPLICATIONS**

**CATEGORY 4:** Applications Recommended for Approval with the Following:

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

**NO APPLICATIONS**

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

## **NO APPLICATIONS**

Mr. Kraut concluded his report. Dr. Streck briefly adjourned. The Council reconvened and Dr. Streck introduced Dr. Rugge to continue the Report on the Activities of the Committee on Health Planning.

## **HEALTH POLICY**

Mr. Fensterman noted that given the members discussion it appears that there will not be a vote today on the recommendations. Dr. Strange, Dr. Bhat and Dr. Brown agreed with Mr. Fensterman as there are many details that need to be considered and vetted in a much broader conversation.

Next, Dr. Rugge introduced Ms. Vitale to present the emergency room department recommendations.

Ms. Vitale stated that currently New York has several providers operating emergency services outside of a traditional hospital environment. She noted that one recommendation is to establish a naming convention for these entities and a definition, and the name hospital-sponsored off-campus ED was proposed as the name to be used in regulation for an emergency department that is hospital-owned and geographically removed from a hospital campus. In terms of standards and scope of services, hospital-sponsored off-campus ED would be held to the same standards and requirements as a hospital-based ED with regard to the training of the providers, the staffing required, and the array of services provided. The general understanding that an off-campus ED may not be able to handle the full scope of trauma and life threatening conditions that a hospital-based ED would, and in those cases would need to possibly transfer patients that required surgery and patient admission and things like that. Off-campus EDs would need to demonstrate compliance with CMS hospital conditions of participation as well.

Ms. Vitale described the terms of hours of operation, typically hours of operation would be 24/7. The Committee decided that part-time operation would be allowed subject to CON approval with minimum operating hours of at least 12 hours a day, and consideration made for the distance to the nearest hospital-based ED when part-time operation is allowed. She explained terms of disclosures to consumers, an off-campus ED would be required to have clear nomenclature and signage and a communication plan for communicating not only to the public, also with regional emergency medical services about their capacity and their hours of operation to ensure that that is clear to the community.

Ms. Vitale noted the terms of patient safety and quality requirements, all off-campus EDs would need to have the capability of receiving ground ambulance patients and treating them, or if patient presented to the off-campus ED with a condition that required a higher level of care there would need to be EMS protocols in place for providing timely transfer for those patients to the nearest hospital-based ED.

Mr. Rothman explained that Freestanding EDs would require some regulatory amendments in various different areas including accreditation, definition, need, and standards or requirements. Proposed is that the Freestanding ED would require accreditation from a New York State recognized accrediting body. If a hospital loses its accreditation the hospital and accrediting body would be required to report such changes to the Department within a timely fashion and if the hospital is not accredited by a third party then as we do now with hospitals and as is referenced in our regulations, the Department then would do the survey and certification. There would be the need to amend 10 NYCRR Section 720.1 as it pertains to the existing accreditation regulations that are currently in place that address hospital requirements. 10 NYCRR Section 702 which defines hospital-sponsored off-campus emergency departments. It would restrict ownership only to hospitals. No other entity would be allowed to own a freestanding ED. Full CON would be required which would include PHHPC review for a new freestanding ED. Emergency approval by the Commissioner may be allowed in instances where there might be a hospital closing and it might be sudden and other resources could not be garnered and put into place in a timely fashion and the emergency approval part would have to coincide with Section 401.2.

Mr. Rothman stated that a need methodology for hospital-sponsored off-campus emergency departments would need to be articulated in 10 NYCRR Section 709, and 10 NYCRR Section 405.19 would have to be revised in the section for emergency services to include requirements that are specific to hospital-sponsored off-campus EDs. This would include the scope of service, minimum hours of operation, criteria for part-time operation, capacity to receive ground ambulance patients and transfer and referral protocols.

Mr. Rothman noted that the Committee and Department also wanted to address the considerations that would be in place for approval of a part-time operation. The criteria would also be in 10 NYCRR Section 405.19 which deals specifically with emergency services. Section 709 would include specific need criteria. Consideration will be made for the local and unique circumstances necessitating part-time operation in addition to what would be in the regulation. Full CON review would be required for a new off-campus ED that will operate part-time and would similarly require a full CON review for an existing full-time freestanding ED that wished to reduce it's hours. Emergency approval by the Commissioner may be allowed in instances where a hospital closing was precipitous and did not allow enough time to garner resources adequate to fill the voice consistent with Section 401.2.

There was much discussion and questions from the members. Dr. Streck stated there was a series of observations on all three recommendations and asked Dr. Ruge to hold a Health Planning Committee meeting and present the Committee's recommendation to the Full Council in February. Dr. Ruge advised that the Committee will meet on January 7, 2014.

To review the complete report please see pages 107 through 134 of the attached transcript.

**ADJOURNMENT:**

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

1 WILLIAM STRECK: Good morning, everyone. If I could ask  
2 you to take your seats and we'll begin this meeting of the  
3 Public Health and health Planning Council. I'm Dr. William  
4 Streck, the Chair of the Council. It, as is apparent, there are  
5 members who have not yet arrived, so that we will begin the  
6 meeting and go through some of the informational components and  
7 some of the reports and trust that by the time we are moving to  
8 areas that require discussion we will—and potential votes—we  
9 will have the necessary members here.

10 So I call the meeting to order. Welcome, Executive  
11 Commissioner Kelley, participants, and observers. And then just  
12 to go through some of the housekeeping as we do at each meeting,  
13 reminding councilmembers, staff, and the audience that the  
14 meeting is subject to the Open Meeting Law and is broadcast over  
15 the internet and the webcasts are available at the Department of  
16 Health website no later than seven days after the meeting, for a  
17 minimum of thirty days thereafter. Reminder, too, that there are  
18 ground rules. There is synchronized captioning, so we ask that  
19 everyone be thoughtful in their remarks, not speak while others  
20 are speaking; ask you to identify yourselves when you first  
21 speak; and the microphones are hot, so side conversations could  
22 be broadcast, which may not be preferred, you want to keep that  
23 in mind. There is a record of appearance form outside the room  
24 and it is required by the Joint Commission on Public Ethics, the

1 form is also posted on the website, so we ask guests and others  
2 to sign that form.

3 I next offer you an overview of today's meeting. We will  
4 begin with an adoption of the revised meeting schedule. Having  
5 handled that complex task we will move on to Department of  
6 Health reports. We will hear from Executive Deputy Commissioner  
7 Kelley, Ms. Westervelt will then give us an update on the  
8 Offices of Primary Care and Health Services, and Dr. Birkhead  
9 will give a report on the activities of the Office of Public  
10 Health. Under the category of "public health services," Dr.  
11 Torrez will update the Council on the work of that committee.  
12 Under "health policy," Dr. Rugge will present to the Council the  
13 ambulatory services recommendations, and they will also be  
14 presented for discussion. And then following that we will have  
15 project review recommendations and Establishment Committee  
16 actions; Mr. Kraut will chair that session. If there are  
17 conflicts, members of the Council are asked to have noted those  
18 conflicts and if some are recognized now, please notify the  
19 staff and make sure that the conflicts are noted. We do batch  
20 our applications in the project review process and we will have  
21 significant batching today, which will offer opportunity for  
22 more effective deliberations, and Mr. Kraut will oversee that.  
23 At this point I would like to move on to a resolution of  
24 appreciation to Dr. Sullivan. Dr. Sullivan has moved to the  
25 Office of Mental Health and in that role will no longer be a

1 member of this Council, so I would like to read the following. A  
2 Resolution of Appreciation:

3       "Whereas Ann Maria Teresa Sullivan, MD, has served with  
4 distinction on the New York State Public Health and Health  
5 Planning Council from May 24, 2011 to October 4, 2013, and  
6 whereas Dr. Sullivan during her tenure as a member of the Public  
7 Health and Health Planning Council was dedicated and served on  
8 the Committee of Establishment and Project Reviews and the  
9 Committee on Codes, Regulations, and Legislations. And whereas  
10 in serving in this capacity she has made countless contributions  
11 to improving New York State's health care delivery system and to  
12 furthering the improvement of public health for the citizens of  
13 New York State, and whereas members of the Public Health and  
14 Health Planning Council of the State of New York do hereby  
15 express and acknowledge her unstinting, selfless, and valuable  
16 service to the Council for two years. Now therefore be it  
17 resolved that members of the Public Health and Health Planning  
18 Council convey to Dr. Sullivan our esteem, admiration, and  
19 appreciation for her instrumental role in enhancing the health  
20 and wellbeing of all who reside in the State of New York and be  
21 it further resolved that members of the Public Health and Health  
22 Planning Council do hereby extend their gratitude to Ann Marie  
23 Teresa Sullivan for her committed service to the Council, and  
24 send her our best wishes for many years of health, happiness,

1 and professional achievement." And that resolution will be  
2 signed by myself and Mr. Kraut as Vice Chair.

3 So, we do extend our appreciation to her and our  
4 appreciation for her continued work for New York State. So, with  
5 that, I have gotten us to the adoption of minutes and I will  
6 ask, do we have enough people to adopt the minutes. We do not.  
7 All right. So we could not adopt the revised meeting dates, but  
8 we can at least discuss them, and so that complex task is to say  
9 that the meeting of September 11, 2014 has been moved to  
10 September 18, 2014 and we'll just say that there was a general  
11 acceptance of the group and those who were not here will have to  
12 adapt and we can vote on it at the next meeting if it's  
13 problematic. Dr. Gutierrez could proceed with our reports. I do  
14 with the informational parts. Certainly if we get to points  
15 where we have adoption required, we'll obviously have to defer  
16 that, so please, Dr. Gutierrez, codes, regulations.

17

18 ANGELO GUTIERREZ: Good morning. My name is Angel  
19 Gutierrez, I am the Chair of the Codes, Regulation, and  
20 Legislation Committee and for the purpose of moving this meeting  
21 along, I will present the information apart. On the agenda, for  
22 information was a proposal for— regarding Hospice operational  
23 standards. It is being updated to make state regulations  
24 consistent with the federal rules set forth in 47CFR, section  
25 418. They more accurately reflect the current operation,

1 operating state requirements for hospitals in New York State and  
2 are also consistent with chapter 441 of the New York State laws  
3 of 2001 and the Medicaid READY SIGN Initiative to expand the  
4 Hospice benefit. It was stated that the definitions of "terminal  
5 illness" is expanded from six-months to twelve-months life  
6 expectancy to allow individuals the benefit of Hospice care  
7 earlier in the illness to manage their symptoms on an ongoing  
8 basis, thereby reducing the need for costlier hospitalizations  
9 and emergency room visits. A section-by-section summary of the  
10 revisions was also provided. Discussion centered on the change  
11 from six months to twelve months and if there is risk to  
12 providers that they will not meet Medicare requirements for  
13 documentation and be at risk for pay- at risk for payment. It  
14 was explained that the standards are the same except for the  
15 change from six to twelve months and that they would not be able  
16 to be reimbursed for the services for Medicare, but they would  
17 be for Med- from Medicaid. It was further explained that the  
18 Medicaid statement amendment had been sent to CMS and is pending  
19 approval. For discussion on the agenda was an overview of part  
20 405 hospital changes proposed as a result of federal conditions  
21 of participation requirements. Changes were made to the  
22 governing body, administration, nursing services, medical  
23 records, and emergency service provisions. In addition to the  
24 federal conditions, changes were also made regarding  
25 telemedicine. There was discussion concerning removing certain

1 health status requirements from those— for those New York State  
2 physicians practicing from a remote location. The last item on  
3 the agenda pertained to the general construction site  
4 requirements specific to facilities located in a flood plain.  
5 This proposal was based on the work of the ad hoc committee on  
6 environmental and construction standards, under recommendations  
7 that were approved by the full Council on October 3rd. This  
8 measure changes references to the flood plain from a 100-year  
9 flood plain to a 500-year flood plain. Mitigation measures for  
10 new construction and projects undergoing substantial renovation  
11 are also added to these provisions. They include installing  
12 flood resisting emergency generators and fuel supplies;  
13 installation of generators and fuel pumps in a manner so they  
14 are readily accessible in the event of a flood; installation of  
15 external pre-connections and power systems for use in an event  
16 of an emergency power system failure; installation of pre-  
17 connections of HVAC systems for temporary boiler and chiller  
18 hookup; and insuring that power and emergency power generation  
19 capacity includes the powering, includes the powering of the  
20 HVAC systems, as well. And that's the informational part of my  
21 report.

22

23 WILLIAM STRECK: Thank you, Dr. Gutierrez. Are there  
24 action items that you would bring back later?

25

1 ANGEL GUTIERREZ: Yes.

2

3 WILLIAM STRECK: OK. Thank you. We'll return to those. I  
4 would then move to the Department of Health reports and assuring  
5 Executive Deputy Commissioner Kelley that her thoughts will be  
6 shared with our colleagues, by video if necessary, so we just  
7 want to make sure that the scanned crowd is not viewed as, in  
8 any way other than a chance event. So, with that, I would ask,  
9 Sue, for you to make your presentation.

10

11 SUE KELLEY: Thank you, Doc- Sorry, I'm an infrequent  
12 presenter here, so thank you. It's a pleasure to be here today to  
13 speak with you on behalf of Dr. Shah, who is unable to be here  
14 this morning. This is an opportunity to reflect on the year's  
15 activities and to look forward to the new year. It's been a very  
16 busy fall, as you know, especially with the debut of the New  
17 York State of Health, the official health plan marketplace for  
18 New York. Donna Frescatore, the Director of the Health Benefits  
19 Exchange, reports that as of this past Monday more than 100,000  
20 people enrolled through our online marketplace. That means that  
21 starting January 1st, they will have quality, low-cost health  
22 coverage. In all, more than 314,000 people have completed  
23 applications on the health plan marketplace and more than a  
24 quarter-million New Yorkers have received enrollment assistance  
25 from the customer service call center. More than 56,000 in-

1 person assisters are trained and ready to assist New Yorkers  
2 throughout the state. This is good news for New Yorkers and... who  
3 have gone without health insurance for too long. I'm really  
4 pleased and, as evidenced by the work of the New York State Her...  
5 Health, that we have a strong team in place who really have  
6 fulfilled and continue to fulfill their responsibilities. As you  
7 know, health insurance is a vital part of any effort to improve  
8 health and in our... in our constant efforts to help New Yorkers  
9 get healthier, the Department, with... with the assistance of  
10 members of the Council, held our first Population Health Summit  
11 last week, which was well received and well attended.  
12 Participants had the chance to hear from leading authorities on  
13 public health, including Dr. Tom Frieden, the Director of the  
14 CDC; Dr. Tom Farley, Commissioner of the New York City  
15 Department of Health and Mental Hygiene; and our own State  
16 Health Commissioner, Dr. Nirav Shah. The Summit called attention  
17 to the critical role that public health will play in improving  
18 population health. It also showcased our own state's Prevention  
19 Agenda as the roadmap for achieving these goals. At the same  
20 time, we also celebrated and joined in the commemoration of  
21 World AIDS Day, with a 30th anniversary celebration of the New  
22 York State AIDS Institute and the AIDS Advisory Council. Next  
23 week, we'll be hosting the first-ever New York State Health  
24 Code-a-Thon, as part of a larger event called New York  
25 Innovates. The code-a-thon is a two-day gathering that will be

1 held at RPI in Troy. The event challenges developers, designers,  
2 and data enthusiasts to use open data from various sites, such  
3 as Health Data New York and Open Data New York, to create  
4 technology solutions that we hope will one day link New Yorkers  
5 to community resources that improve their health. Our ultimate  
6 goal is to help New Yorkers lower their risk for obesity and  
7 diabetes and that is the focus of the Code-a-Thon. The intention  
8 is to create linkages to assist people to increase their level  
9 of physical activity, improving their food choices, and finding  
10 health innovations in their- and interventions in their  
11 communities. Improving the health of our communities is a  
12 critical goal for the State Health Department and, I know, for  
13 the Public Health Council, as well. A goal that will be achieved  
14 with help from various stakeholders, including local health  
15 departments and our hospitals. As part of the Prevention Agenda,  
16 this fall we began requiring hospitals and local health  
17 departments to meet to discuss ways to improve the health of  
18 their... their communities, and to submit plans for how they will  
19 do so. As of December, more than 40 local health departments  
20 have submitted community health assessments and community health  
21 improvement plans to the Department of Health. We've also  
22 collected 125 community service plans from hospitals and that  
23 number just so you know, includes hospital systems that  
24 incorporate multiple individual hospital providers. We are  
25 continuing to work with the local health departments in

1 remaining hospitals and hospital systems that will be submitting  
2 their respective plans.

3 DOH has dedicated 15 staff throughout the Department to  
4 review the documents, using an online tool, and we expect those  
5 reviews will be completed by January 2014. Every local health  
6 department and hospital will receive feedback, highlighting the  
7 strengths and opportunities for improvement, which they can  
8 share with their partners. From this review, we hope to get a  
9 better understanding of many factors, including the breadth of...  
10 of participating organizations and collaboration among partners.  
11 That, that's one thing we reflected upon during World AIDS Day  
12 was the importance of 30 years of collaboration. We were able to  
13 make a difference in communities through that, that model of  
14 collaboration and I think the same model is envisioned through  
15 the... the Prevention Agenda, because it matters that localities,  
16 local health departments, community hospitals, hospital systems  
17 are taking- take advantage of working with each other and  
18 working with stakeholders in the community, to achieve  
19 improvements in population health.

20 So the number of sites that, that we- we're looking at the  
21 number of sites that meet the Prevention Agenda criteria and  
22 that the plans are implementing evidence-based strategies. We'll  
23 have a better understanding of how these objectives will be  
24 measured, how plans will be disseminated, and what can be done  
25 to sustain community achieve engagement. These plans will reveal

1 the feasibility of implementing the Prevention Agenda process at  
2 the local level and the factors that will lead to success, as  
3 well the challenges we face in pursuing collaborative community  
4 health planning. We will use these plans to map out communities  
5 that are working on similar objectives statewide in an effort to  
6 promote peer learning. These are certainly very exciting and  
7 promising collaborations at a community level and we really are  
8 thankful to Dr. Birkhead's leadership in the Office of Public  
9 Health and to the work of this Council in moving the agenda  
10 forward. As you know, hospitals have been stepping up to meet  
11 our requirements regarding sepsis. As you know, this fall the  
12 state required all hospitals in the state to adopt evidence-  
13 based sepsis protocols for children and adults treated in  
14 emergency rooms and on in-patient units. Hospitals are required  
15 to report their compliance with these practices and in the  
16 outcomes of these efforts. All hospitals—I'm pleased to report—  
17 have successfully submitted protocols for sepsis care. Adopting  
18 these protocols in New York have the potential to save thousands  
19 of lives per year and reduce other tragic and costly  
20 consequences of sepsis. With the assistance of the adopted rules  
21 for sepsis care, New York is leading the nation by ensuring that  
22 proven best-practices are implemented across the state.  
23 Measuring adherence to protocols and developing a standardized  
24 risk-adjusted mortality measure. Through these actions, New York  
25 will contribute to the evidence base nationally that continues

1 to evaluate the impact of sepsis protocols on mortality. More...  
2 more importantly, for all of us, lives will be saved.

3 Earlier this month, as you know, we released hospital cost  
4 and charge data for all hospitalizations in New York State in  
5 the years 2009–2011. That information is now on Health Data New  
6 York, our open data platform. The intention is for consumers to  
7 know how much hospital care costs across different hospitals for  
8 various services. Until now, the public did not know how much  
9 they or their insurance company were going to be charged for  
10 particular services or procedures. Now individuals will be able  
11 to make informed choices about their health care and the best  
12 place for treatment. As you know, the data is already getting a  
13 lot of interest with more than 4,000 views and more than half of  
14 those views and requests coming from the media. In the week  
15 since its release, there have already been 480 downloads of the  
16 charge and cost data. The Department of Health, through the  
17 Office of Quality and Patient Safety—and I spoke with Pat Ruhan  
18 this morning about this—we are continuing to work with the  
19 provider community and the providers associations to improve the  
20 quality of the data, but the Commissioner insisted on beginning  
21 this process now. We really, one might say, well, could you have  
22 waited a little bit longer? Could we have had more discussions  
23 about it? Discussion will need to continue and improvements will  
24 be made through the publication of these data. DOH and Dr.  
25 Birkhead and his colleagues in the Office of Public Health are

1 always busy; they're also tracking this- the flu season. Gus may  
2 be reporting more about that. As of now, we are at sporadic  
3 levels of flu and there's no determination that the flu... that  
4 flu has become prevalent in New York State. A flu report is  
5 posted on our website every Thursday.

6 We have good news on another front-the new prescription-  
7 monitoring program, which was launched two months ahead of  
8 schedule in June, has been a resounding success. ISTOP, which  
9 created the new prescription monitoring program registry has  
10 been providing practitioners and pharmacists with a user-  
11 friendly system to access a patient's controlled substance  
12 history in a secure online website. Since its debut, the PMP has  
13 been accessed by more than 55,000 users who have performed more  
14 than 4.8 million searches for controlled substance dispensing  
15 data. To put this in perspective, the old online PMP saw only...  
16 less than a half-million requests from 5,000... more than 5,000  
17 users during the three-and-a-half years the program was  
18 available. Based upon a search of a patient's name, date of  
19 birth, and gender, the PMP registry provides a practitioner with  
20 a list of all of the controlled substances dispensed for a  
21 patient over the past six months. The information includes the  
22 types, strength, and quantity of of a medication, the date it  
23 was prescribed and dispensed, as well as the name of the  
24 prescriber and dispensing pharmacy. The use of the data registry  
25 has not only thwarted doctor shopping, but it has also informed

1 prescribers about their patient's history, improved clinical  
2 decisions, and prevented potential dangerous drug interactions.  
3 To decrease the burden on practitioners—because I know the  
4 startup was a challenge, not only for Department staff, but also  
5 for practitioners—to decrease the burden, the PMP registry  
6 allows practitioners to designate staff members to access the  
7 data on their behalf. Practitioners can review their previous  
8 PMP searches, as well as searches performed by their designated  
9 staff, insuring that this sensitive information is protected by  
10 a strong audit trail.

11 DOH has created a new data collection tool, which is making  
12 it easier for pharmacies and other dispensers to provide the  
13 data; it has received more than ten million records from  
14 pharmacies and institutions since it was made available. This  
15 function allows pharmacies to report data in an unintended  
16 unintended fashion, insuring that accurate data can be submitted  
17 in a timely manner. The feedback received from practitioners,  
18 pharmacists, and professional societies has been overwhelmingly  
19 positive. While there was a delay at the... at the outset, we've  
20 made progress in processing requests since August, which now  
21 we're able to successfully process almost 30,000 paper requests  
22 in a... in a month's period of time.

23 This has also been a busy time for the Department in  
24 announcing awards. Last week we announced awards for the vital  
25 access provider safety net programs, or VAP II. The funds, \$46

1 million in all in this first round, will go toward many  
2 improvements in community care to achieve specific financial,  
3 operational, and quality improvement goals. These include  
4 expanding access to ambulatory services through added services  
5 or expanded hours of operation; the opening of urgent care  
6 centers to reduce the use of ERs; expanded services in rural  
7 areas, reducing adverse events, to lower costs; and establishing  
8 care coordination between and among providers and levels of  
9 health care delivery.

10 As you know, qualified hospitals, nursing homes, diagnostic  
11 and treatment centers, and homecare providers are eligible for  
12 supplemental professional... financial assistance. In the near  
13 future we will be making another \$80 million available for VAP  
14 awards and we hope to secure more funding through the Medicaid  
15 redesign team waiver.

16 In October, we also awarded \$17.2 million in the Empire  
17 Clinical Research Investigated, Investigator Program or ECRIP  
18 grants, which provide funds to teaching hospitals to train  
19 physicians in clinical research. ECRIP was revamped this year to  
20 continue making individual awards to teaching hospitals, but  
21 also to make larger team-based center awards for institutions  
22 doing more advanced biomedical research. These funds are  
23 important for attracting more federal research funds to New York  
24 State. It will also increase the number of clinical

1 investigators in the state, which will put New York in a more  
2 competitive position to get federal funds.

3 I wanted to let you know that inside DOH we are involved in  
4 an exciting new venture across state agencies called LEAN, or  
5 LEAN government, intended to reduce inefficiencies and improve  
6 the quality of our programs. It's important to note that the  
7 first, actually, focus is actually associated with CON and  
8 opening surveys to issue operating certificates or amended  
9 operating certificates. We're taking advantage of experts in the  
10 field—we actually have a consultant from Toyota—working with our  
11 regional offices and central office to make improvements in the—  
12 in this process, and we hope to see that you'll see results in  
13 the near future.

14 DOH is involved in also submitting our state health  
15 improvement plan, which you know was cross-published for  
16 comment among stakeholders and other members of the public. The  
17 State Health Improvement Plan, or SHIP, which will be submitted  
18 to the federal government after revision, taking into account  
19 the public comment period, the intent is to achieve the Triple  
20 Aim for all New Yorkers—improved health, better health care  
21 quality, and consumer experience at lower cost. A draft of the  
22 SHIP, as I mentioned, was posted to the Department's website and  
23 the comment period ended on December 6th. We had 32 individuals  
24 and organizations who submitted comments. The plan is now being  
25 revised to reflect those comments and we expect to have a

1 revised plan ready for final review before we submit it to the  
2 federal government on or about December 20th. The revised plan  
3 and an overview of comments submitted will be available for  
4 review and posted to the public website. In January 2014, we  
5 will establish work groups to begin the work of developing  
6 programs and processes to implement the plan and to prepare for  
7 submitting a grant application to the Center for Medicare and  
8 Medicaid Innovation at CMS for a state innovation testing grant.  
9 We're anticipating that the final grant opportunity will be  
10 announced by the federal government in February or March of  
11 2014.

12 So, reflecting upon the year, we -I want to thank the  
13 Council very much for your support and for the adoption of regs  
14 that were very important for the implementation of many of the  
15 programs we discussed, as well as for your advice on guidelines  
16 and the improvement of our programs. No doubt we're heading into  
17 what will prove to be another exciting year in New York State,  
18 but before I end, Karen probably will also speak to the  
19 establishment of the North Country Health System's redesign  
20 commission that the Commissioner has charged to make  
21 improvements in the delivery system for preventive medical,  
22 behavioral, and long-term care services to all communities  
23 throughout New York's North County. I want to thank Karen for  
24 your leadership and you'll, I'm sure, be discussing more of  
25 these initiatives. I know I speak for Dr. Shah when I say thank

1 you to the Council, to Department staff, for all you are doing  
2 to improve access and quality of care in New York State. Thank  
3 you.

4

5 WILLIAM STRECK: Thank you. Quite a comprehensive list.  
6 Are there questions or comments for Ms. Kelley?

7

8 DR. BROWN: Thank you very much for, again, a  
9 comprehensive report and I apologize that I wasn't here at the  
10 outset. I am sure I missed some pearls that I could fully  
11 benefit from.

12 I have a just a few things that I would like... a few of them  
13 are questions. Frankly you mentioned about the flu vaccine. And  
14 how that's going and I commend you for the effort and the  
15 Department of Health's leadership in that respect. One of the  
16 issues that was raised previously, I think, with respect to  
17 adolescents who attend detention centers and the programs under  
18 in New York City, and how those providers are actually also  
19 included because, as you know, institutional settings are ripe  
20 environments for transmission and it does seem that that was a  
21 particular area of need that was not really addressed in terms  
22 of... because there was a number of questions about whether those  
23 providers are required or recommended flu vaccination.

24

1 SUE KELLEY: So, in the... in the justice system, are you  
2 saying? In the juvenile justice?

3

4 DR. BROWN: Yes, ma'am.

5

6 SUE KELLEY: Institutional setting? We would expect that,  
7 but I— you're sitting in the middle of two experts who could  
8 probably shed light on this, particularly in New York City. I  
9 would turn to Dr. Gus Birkhead, first of all, to clarify, and  
10 then, perhaps Patsy Yang would want to comment, particularly  
11 from the New York City Department of Health's perspective.

12

13 GUS BIRKHEAD: I think at this point, national  
14 recommendations are that everyone get a flu shot, and  
15 particularly those in settings, congregate settings as you are  
16 describing, so that's a universal recommendation. The  
17 regulations that we've adopted apply only to those State Health  
18 Department-regulated facilities, so we don't have, I don't  
19 think, authority in juvenile detention facilities at the moment.  
20 I don't believe, but we can go back and look at that.

21

22 SUE KELEY: Right. I think, I think it would be... Dr.  
23 Brown, you're observing and reflecting upon a gap in the  
24 delivery of the vaccines in those settings?

25

1 DR. BROWN: Particularly since we are, actually, as an  
2 agency that provides services there, as well as agencies that  
3 are covered by New York City and New York State regulations, so  
4 it seemed a bit of a disconnect that if you work in one of our  
5 sites you are required to, in fact, comply with the guidelines  
6 from the State, and others you are only... we offer the  
7 recommendations, but not required to comply.

8

9 GUS BIRKHEAD: So I think we just have to talk offline on  
10 what the circumstances are. I can't- it's not a blanket answer.

11

12 SUE KELLEY: But we do have opportunities, working with  
13 our Deputy Secretary for Health and our partner-colleagues state  
14 agencies, you know, to- we've shared the information with them  
15 through those meetings and discussions, but we could certainly  
16 follow up with those state agencies and, as Gus says, gather  
17 more information from you about it.

18

19 WILLIAM STRECK: Other questions, comments? Mr. Kraut?

20

21 JEFF KRAUT: I think there was a passing reference, but I  
22 wasn't sure, with the- is there any renewed optimism with the  
23 11-15 waiver?

24

1           SUE KELLEY:       Yes, well, Jason... I think, LIZ MESUM may be  
2 here today, too— no she's not going to make it. OK. So, if Jason  
3 were here, he would say, yes, there are still positive  
4 discussions occurring with CMS and there are further submissions  
5 that the Office of Health Insurance Programs are putting  
6 together, so there is— you know, optimism... there are some people  
7 that are always optimistic, so I work from someone who's very  
8 positive and very optimistic. I may not necessarily be of that  
9 nature, but I think there is reason to believe that we are going  
10 to make progress with respect to the federal government's  
11 responsiveness to the State of New York.

12

13           JEFF KRAUT:       You know, I only... I notice you are getting  
14 closer because they said "well this out of the waiver, that's  
15 out of the waiver," which means there is some negotiation going  
16 on.

17

18           SUE KELLEY:       Yes.

19

20           JEFF KRAUT:       So that's... that's... I would use the word  
21 "optimistic." OK, great. Thank you.

22

23           SUE KELLEY:       Thank you.

24

1 WILLIAM STRECK: Other questions or comments for Ms.  
2 Kelley? Thank you, Sue.

3

4 SUE KELLEY: Thank you.

5

6 WILLIAM STRECK: Long list, a lot of accomplishments.  
7 Karen, we'll turn to your report.

8

9 KAREN WESTERVELT: Thank you, Dr. Streck.

10

11 WILLIAM STRECK: Karen's over there behind the pillar  
12 for those who cannot recognize her immediately.

13

14 KAREN WESTERVELT: Thanks, Dr. Streck. Let me keep my  
15 remarks brief; I know you have a very robust agenda in front of  
16 you, but let me begin by thanking Dr. Ruge, council members,  
17 members of the planning committee, and Department staff for all  
18 the work that they have done on the Ambulatory Services  
19 Oversight workgroup and will continue to do. The work will be,  
20 you know, ongoing, as well, so thank you in that regard.

21 As Sue mentioned in her remarks, the health care delivery  
22 system throughout the North Country is under stress due to rapid  
23 changes in organization, delivery models, payment reforming, and  
24 aging population, workforce shortages, and shrinking funding.  
25 Rising rates of chronic disease are also jeopardizing quality of

1 life, workforce, and the economy. There's a growing recognition  
2 in the North County of the socioeconomic, environmental, and  
3 behavioral health factors that contribute to good health, yet  
4 there has not been substantive collaborative transformation  
5 models developed, in large part, due to fiscal challenges. These  
6 multi-faceted challenges require multi-stakeholder interventions  
7 that are tailored to the regional, local needs. Last month, the  
8 Commissioner formed a North Country Health Systems Redesign  
9 Commission to engage a regional planning group to... or to have  
10 the regional planning group engage a group of health care  
11 facility stakeholders in a regional planning process, with the  
12 goal of stabilizing essential community providers, integrating  
13 systems of care, to eliminate the risk of reduced access to  
14 essential community services, expand access to primary care and  
15 community behavioral health services, reduce workforce  
16 shortages, and achieve improved quality of care and better  
17 population health. And just to give you a little perspective,  
18 the nine counties that comprise the North County are the  
19 counties of Clinton, Essex, Franklin, Hamilton, Jefferson,  
20 Lewis, St. Lawrence, Warren, and Washington, and these counties  
21 encompass about 13,000 square miles and are home to a little  
22 under 600,000 people, a population density of 43 people per  
23 square mile and a lack of public transportation presents a  
24 difficult challenge for providers attempting to ensure access to  
25 high-quality services for all the North Country residents. The

1 region's difficulty in recruiting all types of practitioners,  
2 particularly physicians, adds to the struggle. As in other areas  
3 of the state, the North Country providers need to develop  
4 integrated delivery systems, adopt and build on the health home  
5 model, Medicaid managed care and care coordination across the  
6 continuum, including preventative and primary, acute,  
7 behavioral, and long-term care. Developing such a system will  
8 improve both patient outcomes, provider financial stability, and  
9 better population health. The Commission's charge is: to assess  
10 the total scope of care in the nine counties—community and  
11 preventative care, secondary and tertiary care, and long-term  
12 care; assessing facility infrastructure in terms of population  
13 needs; managing capacity and insuring that essential providers  
14 survive or that, more appropriately, capacity is developed to  
15 replace failing providers; developing a restructuring, a  
16 recapitalization agenda; identifying opportunities for merger,  
17 affiliation, and/or partnership among providers that will  
18 maintain or improve, as we said, access and quality, financial  
19 viability, and promote integrated care; and making, also making  
20 specific recommendations that providers and communities can  
21 implement to improve access, coordination, outcomes, and quality  
22 of care, including preventable utilization and population  
23 health; and last, but not least, develop recommendations  
24 regarding distribution of reinvestment grants. The commission  
25 will hold its initial meeting on December 17 in Lake Placid and

1 is charged with submitting its recommendations to the  
2 Commissioner of Health by March 31st of 2014. And with that,  
3 I'll turn it back and answer any questions you might have.

4

5 WILLIAM STRECK: Questions or comments? Reinvestment  
6 grants. I'm just-- that was the last thing that you were saying  
7 was going to be part of this?

8

9 KAREN WESTERVELT: Just making recommendations to the  
10 Department in that regard.

11

12 KAREN WESTERVELT: I see. OK. Other questions or comments?

13

14 DR. BROWN: None specifically really, to what you've  
15 shared with us, but I have been informed that you actually have  
16 some leadership with respect to the ISTOP program that was  
17 shared with us. I wanted to ask you if you could give some  
18 attention to a conundrum that is probably occurring, not because  
19 the program has not been able to meet some of its objectives,  
20 but in clinical practice, what happens is that in the program,  
21 because of confidentiality laws, providers do not have access to  
22 patients who are enrolled in MEDICATIONS, SUCH AS TREATMENT  
23 WITH methadone, and that could be really challenging with  
24 respect to both the providers providing primary care for the  
25 patient, and the providers who actually are providing the opiate

1 treatment for patients. So I was wondering if you could look  
2 into that and perhaps get back to us at another council meeting  
3 about how the state plans to meet that conundrum, because I can  
4 tell you that in a medical- that medical advisory panel for  
5 OASIS, this issue has come up because of patients who are using  
6 benzodiazepines at the same time that they are on methadone  
7 treatment, and that presents a major clinical problem.

8

9 KAREN WESTERVELT: We're definitely happy to look into  
10 that and we would also coordinate that would our Office of  
11 Alcoholism and Substance Abuse Services, as well, and we can  
12 have Terry O'Leary come to the next meeting, but in the interim  
13 get a response to your query.

14

15 WILLIAM STRECK: Other questions for Ms. Westervelt?  
16 Thank you. We'll now move to the report of the Office of Public  
17 Health. Dr. Birkhead.

18

19 GUS BIRKHEAD: Thanks very much. I wanted to report this  
20 morning on the release of another report from the Health  
21 Department this week that... on hospital acquired infections. I  
22 think, as you know, central line blood stream infections and  
23 selected surgical wound infections, as well as C-difficile  
24 infections are reportable by hospitals in the state, through the  
25 National Health Care Safety Network system. We publish an annual

1 report and just this week have released the report for the 2012  
2 data and, including trend data from the previous years in that  
3 report. You can see a copy of the report, it's linked on our  
4 Department of Health website, but I just wanted to highlight a  
5 few of the highlights of that report. Through the efforts, I  
6 think, of this reporting system and the— all the quality  
7 improvement that's gone around it over the last six years we've  
8 seen a reduction in central line blood stream infections  
9 reported through the system of 53 percent, so that's pretty  
10 significant reduction in what is largely, I think, a preventable  
11 clinical problem. We estimate that the savings from decreased  
12 length of stay, hospital stay, could range up, at the high end  
13 of the range, up to the \$70 million or so level from this  
14 reduction in central line blood stream infections. Overall, in  
15 the selected surgical sites, we've seen a reduction of about,  
16 over the life of the program, of about 16 percent, and the most,  
17 the biggest reduction has occurred— Well, look, in colon  
18 surgery, we've seen a 14 percent surgical wound site infection  
19 reduction, in bypass surgery in the chest wound site a 23  
20 percent reduction, in the donor site a 47 percent reduction in  
21 wound infections. In hip surgery we have not seen any change  
22 over time, so there's still work to be done there, but overall,  
23 again, we estimate the savings from the, this reduction in... in  
24 wound infections, it could range as high as 35—\$35 million in  
25 savings. We also, for the past several years, have been

1 monitoring clustering difficile acquired infections in a  
2 hospital. This is, as you know, a form of severe diarrhea caused  
3 by or exacerbated by antibiotic exposure and so we have been  
4 starting to track this. This is the second year that we've had  
5 hospital reporting of c-difficile. It's a difficult thing to  
6 track because some patients may come into the hospital with it,  
7 so you have to distinguish between a community-acquired and  
8 hospital-acquired. And in addition, patients may be discharged  
9 and then come back with c-difficile that was, in fact, hospital  
10 related. So the report goes into how we tried to count... count  
11 these cases. The other factor that's come into play is that  
12 there are now much more sensitive tests available for c-diff,  
13 and so in the 89 hospitals that have moved to the more sensitive  
14 testing, they have actually seen an increase, 14 percent in c-  
15 difficile infections, which probably reflects better detection  
16 of previous cases that were previously there but not found. In  
17 the 88 hospitals that continued for the two years using the same  
18 type of testing, there was a 15 percent reduction in the c-diff  
19 in those hospitals. So c-diff is a- is another condition  
20 acquired in the hospital that really can submit to protocol-  
21 driven care with patients, as with the surgical wound  
22 infections, to reduce the risk and have early detection if it is  
23 going to occur. So, this program, I think, over the next coming  
24 years, we'll hopefully begin to see significant reductions

1 across the board in c-difficile as we've seen in most of the  
2 other measures that we're looking at.

3 In addition, we have some state funds that we put out each  
4 year for hospitals or groups of hospitals to do quality  
5 improvement, learning collaborative approaches and those are  
6 underway right now in the area of central line blood stream  
7 infections and MRSA infections. And the report that we released  
8 this week highlights some of that work that's also being done.  
9 So, I think kudos to the hospitals around the state. Clearly  
10 people are looking at this in an- a quality improvement vein-it  
11 improves health care and I think that's the important thing,  
12 from my point of view. It also does reduce costs and that's,  
13 again, part of the Triple Aim that we're shooting for. So, I  
14 commend you to the website to look at the report if you are  
15 interested. It's a pretty comprehensive report and it does, for  
16 each hospital in the state, show the level of that hospital last  
17 year and this year for each of the types of infections, which I  
18 mentioned, with confidence limits. This program is pretty  
19 comprehensive in terms of our doing audits of every hospital or  
20 many hospitals each year to validate the data. So the data are  
21 statistically valid and we provide the statistical measures in  
22 the report, as well.

23 So, that's a highlight of some of the work that we've done  
24 out of the Office of Public Health and our hospital acquired

1 infection program, so I'd be happy to answer any questions about  
2 that.

3

4 WILLIAM STRECK: Mr. Fassler?

5

6 MICHAEL FASSLER: Just a question on the flu vaccination  
7 with employees. Have you seen any difference in rate for prior  
8 years now that we have regulation requiring it?

9

10 GUS BIRKHEAD: We're in the process of, as you know in the  
11 hospitals, we did an initial survey back in November and we're  
12 still compiling those data, so we'll have a report for you at  
13 the next meeting.

14

15 WILLIAM STRECK: I think it's been positive. Yeah... I  
16 think you'll find positive results in the hospitals. It's been  
17 pretty impressive. It LOOKED like the prior trial before, it was  
18 abandoned after the litigation, you know. There was... there was a  
19 response then and I think that we've seen the same response, but  
20 we'll wait for the data. We won't go on opinions here. Other  
21 thoughts. Dr. Bhat?

22

23 DR. BHAT: Dr. Bhat here. I had an opportunity to read the  
24 report yesterday--remarkable. The blood stream infection rate has  
25 gone down 51 percent. The results that you have, is it

1 QUANTITATED with CDC. They also have something similar to that  
2 tracking the hospital acquired infection.

3

4 GUS BIRKHEAD: We're- so we're actually using the CDC web-  
5 based system to collect these data-The National Healthcare Data  
6 Safety Network, NHSN. So, CDC has set up this system for any  
7 hospital to use; in New York we're- with this- with the law that  
8 we have, we require the hospitals to use that system. So it is,  
9 it is the CDC algorithms, the CDC definitions, the CDC's  
10 statistical piece and we add on our own auditing to... to validate  
11 the data and improve the data collection.

12

13 WILLIAM STRECK: Other questions or comments? Thank you.  
14 We're gonna do a brief u-turn here, now that we have our full  
15 contingent of councilmembers. We'll go back and I'll ask for  
16 approval of the minutes from the last council meeting. May I  
17 have a motion to that effect?

18

19 [Moved.]

20

21 [Second.]

22

23 WILLIAM STRECK: Moved and seconded. Any discussion?  
24 Those in favor, aye.

25

1 [Aye.]

2

3 WILLIAM STRECK: Opposed? Thank you. And then we also  
4 need approval for the change in the meeting date for September  
5 of '14 from September 11th to September the 18th. Is there  
6 concern, reservation, or requirement for action about that other  
7 than acceptance on the part of the Council? I'll interpret  
8 silence as unanimous concurrence. Thank you. And so that date is  
9 approved. And then we will return back to Dr. Gutierrez, who,  
10 for those who were not in attendance initially, gave just the  
11 informational aspect of the Codes and Regulation Committee  
12 report, but now will bring forth action items from that group.

13

14 ANGEL GUTIERREZ: Thank you, Dr. Streck. So the Committee  
15 on Codes, Regulations, and Legislation convened on November 21st  
16 and reviewed six regulations. On the agenda for a third  
17 emergency adoption, the previous adoption having ended since the  
18 90 days are up, was the children's camp regulation. This  
19 measure, amending subpart 7-2 of the New York State Sanitary  
20 Code has been continuously in effect since June 30th of this  
21 year. There is no change to the versions approved earlier; the  
22 emergency regulation is needed to ensure that safeguards remain  
23 in effect until a permanent regulation is adopted. When asked  
24 when the permanent version will be available, it was stated that  
25 the Department is working closely with the Justice Center staff

1 regarding additional concerns regarding significant incidents  
2 and clarification as to what mandated reporters will need to  
3 address and report. Additional safeguards beyond the mandated  
4 requirements of the Justice Center legislation are also being  
5 considered. Once finalized, the permanent regulation will be  
6 sent to the Committee for consideration for adoption and after  
7 motion and a second, the Committee unanimously approved and  
8 recommended adoption to the full Council and I so move.

9

10 WILLIAM STRECK: There's a motion. Is there a second?

11

12 [Second.]

13

14 Second. Is there discussion on the proposal Dr. Gutierrez  
15 has offered? Hearing none, those in favor, aye.

16

17 [Aye.]

18

19 Opposed? Thank you. That motion carries.

20

21 ANGEL GUTIERREZ: On the agenda for regular adoption was  
22 part 405 pediatric and other amendments regulation. This  
23 regulation provides a comprehensive approach to assure that  
24 hospitals are admitting children for whom it has the appropriate  
25 staff resources and equipment. There are also provision

1 effecting old patients, not just pediatrics, that needed to be  
2 addressed and updated, including surgery, anesthesia, radiology,  
3 nuclear medicine, pharmacy, and emergency medical services. Key  
4 provisions—require all patients to be weighed in metrics to help  
5 prevent medication errors; require hospitals to have policies  
6 and procedures in place for the timely transfer of patients for  
7 whom they do not have the capability to provide care, with the  
8 exception for disasters and search situations, to make sure that  
9 they have the capacity, equipment, and training necessary before  
10 accepting or trying to care for the patients; require policies  
11 and procedures in place to review and communicate to the lab  
12 AND/OR diagnostic test results for the emergency room or  
13 admitted patients, and communicate it to the patient's primary  
14 care provider if known; require that prior to discharge,  
15 critical value tests, ONE THAT represents a PATH of  
16 physiological state and such, and such variants WOULD BE NORMAL  
17 as to be potentially life threatening or would require immediate  
18 medical attention are completed and reviewed by a PA, nurse  
19 practitioner, or MD familiar with the patient's condition and  
20 communicate it to the patient, guardian, parent, or agent;  
21 require the discharge plan include information regarding  
22 completed and pending tests, medications, diagnosis, and follow-  
23 up care that are communicated to the patient, guardian, or  
24 health care agent; create a Parent's Bill of Rights that must be  
25 posted and also distributed to parents; require equipment to be

1 age and size appropriate; require policy and procedure for  
2 imaging studies for newborns and pediatric patients that include  
3 clinical appropriateness, dosage, beam CULMINATION, image  
4 quality, and shielding; require pediatric life support training  
5 when appropriate throughout the hospital; allow a parent or  
6 guardian to stay with the patient at all times to the extent  
7 possible given the patient's health and safety; and add  
8 requirements for pediatric intensive care units (PICUs). After a  
9 motion and a second, the Committee unanimously recommended  
10 adoption to the full Council, and I so move.

11

12 WILLIAM STRECK: There's a motion. Is there a second?

13

14 [Second.]

15

16 Is there discussion on this recommendation? Hearing none,  
17 those in favor, aye.

18

19 [Aye.]

20

21 Opposed? The motion carries. Thank you.

22

23 ANGEL GUTIERREZ: The next item on the agenda for regular  
24 adoption is a proposal concerning administration of vitamin K to  
25 newborn infants. Currently vitamin K to prevent bleeding is

1 required to be administered to newborn infants within the first  
2 hour of birth. This short time period is being identified as a  
3 barrier to ensure that new mothers and their infants have the  
4 recommend thirty to sixty minutes of uninterrupted time for  
5 mother to infant bonding and to complete the first breast  
6 feeding. This proposal will expand the timeframe for  
7 administration of vitamin K from within one hour of birth to  
8 within six hours of birth. After a motion and a second, the  
9 Committee unanimously recommended adoption to the full Council,  
10 and I so move.

11

12 WILLIAM STRECK: There's a motion, is there a second?  
13 Just out of curiosity, this one hour has been there for decades,  
14 is there, was there a rationale for the one hour? Never mind.  
15 OK, we'll call the vote. I'm just curious, I mean, it's been  
16 decades.

17

18 ANGEL GUTIERREZ: It was, it was I believe that with the  
19 increase in breastfeeding, they realized that this was  
20 interfering with that particular period and so...

21

22 WILLIAM STRECK: No, I understand that, but the idea  
23 that it had to be delivered within an hour has been like a  
24 tenant.

25

1           ANGEL GUTIERREZ:       When they looked... when they look at the  
2 existing data.

3

4           WILLIAM STRECK:        The data.

5

6           ANGEL GUTIERREZ:       The data didn't support the one hour.

7

8           WILLIAM STRECK:        It's those damnable facts. Just getting  
9 in the way of long traditions. OK, sorry, I just was curious. So  
10 we have a motion and a second. Is there any further discussion?  
11 Hearing none, those in favor of the motion, aye.

12

13 [Aye.]

14

15 Opposed? Thank you, the motion carries.

16

17           ANGEL GUTIERREZ:       I didn't have the script in front of  
18 me. That concludes my report.

19

20           WILLIAM STRECK:        Thank you, Dr. Gutierrez. So, that  
21 concludes the Codes and Regulation report and that brings us  
22 back on our published schedule here, so that we will now move to  
23 the Public Health Services report and I'll turn to Dr. Torres  
24 for that report. Thank you.

25

1 DR. TORRES: Good morning. Dr. Gutierrez, I'm happy I got  
2 a script. Thanks to my team, Ms. Pirani, and Dr. Jo Ivey  
3 Boufford. Two items I want to report on from the last Public  
4 Health Committee meeting. First, with Ms. Kelley reporting that  
5 we are starting to review of the community service plans and the  
6 community health assessments and community health improvement  
7 plans submitted by hospitals and the local health departments as  
8 part of the Prevention Agenda. We will have a report for the  
9 Council in February on what we've learned from this review. We  
10 are particularly interested in looking at how counties and  
11 hospitals are working together on the two Prevention Agenda  
12 priority areas, including one relating to health disparities.  
13 We're also want to look at how many different stakeholder  
14 sectors were brought to the table as part of the Prevention  
15 Agenda planning processes. A review would be used to provide  
16 feedback and provide data to track progress and to help New York  
17 State Health Foundation make its awards and grants to some  
18 counties to support the implementation of their Prevention  
19 Agenda plan. Second, I want to touch on the discussion we held  
20 at the most recent committee meeting in November. The topic was  
21 the committee's continuing focus on reducing maternal mortality.  
22 Staff from the Departments Division of Family Health spoke to  
23 the committee, including Dr. Rachel DeLong, Dr. Marilyn Cassica,  
24 and Christine Massler. The purpose of the discussion was to get  
25 a better understanding of some of the issues and programs

1 focused on women's health, including reproductive health and  
2 impact maternal mortality. At past meetings, we had several very  
3 substantive presentations and materials on the scope of the  
4 problem in New York supported by the Division of Family Health  
5 and the New York State Department of Health. The goal of the  
6 most recent discussion was to link these past presentations to  
7 the Prevention Agenda and see what action steps we might move  
8 forward on. Maternal mortality is defined by the World Health  
9 Organization as the death of woman while pregnant or within 42  
10 days of termination of pregnancy, irrespective of the duration  
11 and site of the pregnancy, from any cause related to or  
12 aggravated by pregnancy or its management, but not from  
13 accidental or incidental causes. The United States has abysmal  
14 statistics and we rank behind 40 other nations as far as  
15 maternal mortality. New York State is 47th out of 50 states, so  
16 there's a lot to be improved upon. New York State's rate of 23.1  
17 deaths per 100,000 live births... live births, is above the  
18 Healthy People 2020 goal, which is 11.4. We also know that there  
19 are dramatic disparities in maternal mortality with regard to  
20 race, ethnicity, socioeconomic status, and geography, in New  
21 York State and nationality [sic]. In New York State, we know  
22 that black women die at a rate of about four-times that of white  
23 women. Because of these reasons, we selected this goal as part  
24 of our Prevention Agenda. National research suggests that one  
25 actionable issue that would impact the maternal mortality

1 problem would be to reduce unintended pregnancies, especially in  
2 women who are in high-risk groups, including older women. We  
3 also need to focus on health across the reproductive life of a  
4 woman, both preconception and interconception, to reduce  
5 unintended pregnancies and improve pre- and inter-conceptual  
6 care, we should consider the following: addressing the cross-  
7 cutting social determinants of health that underlie many health  
8 issues, including racism, poverty, and violence; providing  
9 comprehensive, evidence-based health education, including sexual  
10 health education for youth in all of our schools; think of how  
11 to promote norms of wellness through effective social marketing  
12 across the lifespan; identifying and implementing clinically  
13 oriented strategies, that would include integrating  
14 preconception and interconception care into routine primary and  
15 specialty care for women of reproductive age; implementing  
16 strategies to focus on access to pregnancy planning and family  
17 planning services to reduce unintended pregnancy among women  
18 with chronic conditions; also focusing on women who may have had  
19 an adverse birth outcome—low birth weight, et cetera.—and making  
20 sure that they are engaged in interconception care. The goal is  
21 to bring attention, hopefully sustained attention, to a problem  
22 that may or may not get the attention that it deserves. We had a  
23 very lively discussion at the committee meeting. Suggestions  
24 were of interest to the group included the following: putting a  
25 team around those people who are at high risk; using models from

1 chronic illness and community care coordination; everything  
2 we're doing in Medicaid with the population right now to reduce  
3 utilization and cost and improve outcome and address the Triple  
4 Aim should be done here; focusing on pre-hospital maternity  
5 care; working very closely with the primary care setting, with  
6 doctors, to have the routinely ask women of childbearing age a  
7 simple question—do you want to be pregnant in the next year; and  
8 then at each clinical encounter and subsequent visit, the answer  
9 to this question will provoke one of two answer—are you on  
10 family planning or how can we get you healthy and make sure that  
11 women get prenatal care early; enrolling high-risk in... high-risk  
12 women in health homes (if you've got two or more chronic  
13 conditions and you are on Medicaid, you should be enrolled in a  
14 health home); need to work on how to make sure that good  
15 prenatal care and the contraception discussion is part of the  
16 expected outcome and expected service delivery in the health  
17 home concept. The committee could work on establishing criteria  
18 for advanced medical homes that include family planning,  
19 counseling, and contraception. The committee acknowledged that  
20 this was just the beginning of the discussion on a very complex  
21 and sensitive public health issue, perhaps even more sensitive,  
22 depending on a person's religious background and communities.  
23 The committee will also discuss how to follow up on these very  
24 strong recommendations to keep the attention on this important

1 issue and keep it in the forefront and not to forget it. And  
2 that concludes my report.

3

4 WILLIAM STRECK: Thank you. Are there questions or  
5 comments in regard to Dr. Torres' report? Dr. Bhat?

6

7 DR. BHAT: We had a very lively discussion at the committee  
8 last time. One question I did not ask in the committee, say that  
9 the same way when you are seeing a patient, when we are asking  
10 what allergies, new allergies, would you recommend the  
11 childbearing-age group ask the same questions, say that have you  
12 intended to become pregnant or are you on birth control? It  
13 would be one part of the encounter that we have in the office or  
14 any other setup.

15

16 DR. TORRES: I would definitely note that and I know that  
17 that would also generate addition discussion because of parents  
18 that may be accompanying children in doctor's visits, as well,  
19 and looking at culture and how that would play a role, because  
20 that would... that would spark up some debate.

21

22 WILLIAM STRECK: Thank you. Other questions or comments?  
23 All right. Thank you.

24 We'll now move to our Health Policy section and in this  
25 section Dr. Rugge's gonna present the Ambulatory Care Services

1 recommendations. This has been a very sustained and substantial  
2 effort to bring this report to the full Council. I've spoke to  
3 John before the meeting and though there may be a preference for  
4 adoption today, it is not a necessity, so I think it's important  
5 because these are very important, long-range- very important  
6 recommendations with long-term effects that the Council feel  
7 that we have had adequate time to discuss and review the  
8 recommendations and at the end of that period of time we can  
9 decide if we have enough information, if we want more  
10 information, and what actions we would like to take then, but I  
11 want to thank John and the Committee for the- and the staff to  
12 the Committee, in particular, for the many hours of work that  
13 have brought us to this point. John.

14

15 JOHN RUGGE: Thank you. Thank you, Bill. As everybody  
16 knows, Commissioner Shah charged the Planning Committee with  
17 taking a new look at ambulatory care services in New York. For  
18 this Council, a "new look" means either more regulation or less  
19 regulation, and so we've been struggling with that over a period  
20 of... of months. There are clearly a number of drivers for this  
21 planning process. They include the development of new models of  
22 care that were not invented or conceived at the time of the  
23 regulatory structures we now live under, this includes retail  
24 clinics, urgent care centers, freestanding emergency  
25 departments, high-end imaging, radiation therapy on a

1 freestanding basis. It also includes the enormous expansion of  
2 the role of ambulatory care vis-à-vis the health system, with so  
3 much in-patient care moving to the ambulatory care sector, all  
4 of which is now being framed through health policy  
5 considerations through the lens of the Triple Aim. Also driving  
6 this is the advent of health reform as expressed in the ACA,  
7 with the expectation, thanks to our new New York State of  
8 Health, more people being insured, but not necessarily more  
9 capacity to care for those people. And then at least develop the  
10 availability of data, like never before, and data systems enable  
11 the assessment of utilization, of quality, and the development  
12 of evidence-based standards for caregiving itself.

13       Also of note, the Committee was well-aware going in that  
14 there has been a bi-directional movement on the part of  
15 physicians, with more than half the physicians in New York State  
16 now being employed by a hospital or other institutional  
17 providers, leading to the development of highly integrated and  
18 comprehensive delivery systems. At the same time, a movement in  
19 the other direction of hundreds of physicians in certain groups  
20 aggregating into these so-called mega-groups, what they  
21 preferred to be called "high-performing medical groups," that  
22 represent the epitome of disruptive innovation—and I think as a  
23 premise this Committee in no way wants to suppress or discourage  
24 innovation, but there is a matter of taking a look disruption  
25 and the unintended consequences of being disruptive.



1           Also, a special note. There are two modes of practice of  
2 medicine in New York. One is the private practice of medicine  
3 with licensure and regulation through the State Education  
4 Department and the other, obviously, is institutional care  
5 provided under the auspices of article 28, with the regulation  
6 by the Department of Health. The committee took care in not to  
7 look to tilted the playing field in one direction or the other,  
8 certainly not trying to force providers into one mode or the  
9 other, but needing to have binocular vision, so as we considered  
10 each service, consider what are the implications for the.. for  
11 the two species of providers and trying to make equivalency and..  
12 and fairness and equity between those two modes knowing there is  
13 now such thing as a perfectly level playing field in a very  
14 bumpy world that is changing very fast, but have done our best  
15 to frame these issues so that we can give the very best care to  
16 the community and to our patients in whatever regulatory mode.

17           So, with that, the intention has been, just by way of  
18 background, we have prepared, with the help of Dave Choksi, a  
19 physician who was engaged with a services or the help of Dr.  
20 Shah, to help us prepare a vision statement, which will be our  
21 opening statement, our opening chapter of the paper, indicating  
22 how we see both the structure of care and the changes in that  
23 structure as we go forward and the principles by which we have  
24 been basing our current thinking and we believe will be  
25 necessary to apply as well to revisions, not in 30 or 40 years

1 we're doing now, but in two, three, or four years because the  
2 world changing so fast and understand that we cannot and do not  
3 wish to predict what our needs will be in only a few years.

4 A very preliminary draft narrative was prepared. That was  
5 the basis for developing a series of slides summarizing the  
6 recommendations that we hope to codify over time. The Committee,  
7 through the most two recent meetings, substantially revised  
8 those recommendations and we have not had time, staff has not  
9 had time, to re-draft the paper to reflect those  
10 recommendations.

11 What we are presenting today are the recommendations and  
12 regulations... and they're revisions in either regulation or  
13 statute that the Committee would choose to propose to the  
14 Council for consideration and adoption if you feel comfortable.  
15 We'd note that at the Committee, each recommendation was  
16 approved by unanimous vote with one exception, which passed by a  
17 vote of 8-to-1. I would not give away which item this was, to  
18 see if we can tease out in our discussion today what may require  
19 more discussion than other parts.

20 I think that the fairest way to proceed would be to ask the  
21 lead staff for each of our various chapters to present a brief  
22 overview of the slides, which have been distributed both the  
23 public and members of the Council prior to this meeting,  
24 leaving, hopefully, plenty of time for discussion and I think it  
25 will be, perhaps, helpful to use a more formal process. If

1 anyone would like to propose a change in the recommendations of  
2 the Committee, to move those changes and take that to a vote, as  
3 well, so that staff and Committee have the benefit of the  
4 thinking, both in terms of the summary recommendation and using  
5 our discussion today to inform the narrative, which we will be  
6 brought at our next meeting in early February in full form, so  
7 there will be one more chance to look at the fleshed-out,  
8 described version. In that narrative, I would predict there will  
9 be two subtexts, which do not appear on our slides because they  
10 are not changes in regulation or in statute. One is that we  
11 think that having developed this category of services, it's very  
12 important to not only put these into law and statute and  
13 regulation, but also to inform the public through a public-  
14 information campaign. It was pointed out to us that the National  
15 Health Service in the United Kingdom has an extensive  
16 advertising campaign, if you will, public service announcement,  
17 informing the public about what to use, when to use what  
18 services for what. So, when to go to the ER, when to go to your  
19 doctor, when to go to urgent care, when to stay home and put on  
20 a band aid, and in Britain, when to go to the pharmacy. So,  
21 clearly our notion is to go beyond the confines of simply this  
22 policy discussion, but to inform the public about the kinds of  
23 clarifications we're seeking for ourselves. As a second matter,  
24 implicit, I believe, in this discussion, is the value of  
25 categorizing services in addition to providing clarity to

1 stakeholders and to the public alike is to make it possible  
2 through another second-stage effort, not by this committee and  
3 not likely by this Council, but an effort to look at having  
4 categorized these services, how should we reimburse them? Once  
5 we have further clarification on what we are providing and where  
6 we are providing it, there should be additional clarity on how  
7 best to compensate providers for that effort. Doing this with  
8 awareness of these state health innovation plan, which makes  
9 explicit that there is, in this administration, increasing  
10 coordination across agencies, and so not only are we talking  
11 about Medicaid, but also the State Health Plan, through the  
12 Civil Service, and also through premium review by the Department  
13 of Financial Services for commercial payers. So the implications  
14 of what we were doing, as Dr. Streck has suggested, is more than  
15 simply making technical changes in how we're framing these and..  
16 in arcane places and under article 28, but also how in real life  
17 we're expected to provide the services, change over time, and  
18 how we to reimburse them, which will most likely determine where  
19 they reside, and a proportionality of one service to another. No  
20 small bit of business, but we think this Council will prove  
21 helpful in terms of policy as it evolves.

22 Before going into the slides, if there are any questions or  
23 comments or objections, this would be a good place to do it.

24

25 WILLIAM STRECK: I would go.

1

2           JOHN RUGGE:     Go. Go. We'll go. I think Mr. Delker,  
3 Chris, will lead with a discussion of slides on... on not retail  
4 clinics, but instead limited-services clinics.

5

6           CHRIS DELKER:  OK. Thank you. Before we get into the  
7 specifics, what the kind of guiding tenants for the discussion  
8 of the several types of care you'll see recommended here, are  
9 these that the Committee had in mind throughout the process—that  
10 is insuring patient safety and quality, and transparency to  
11 consumers of all the services that will be provided in this...  
12 these various settings of care. Also, stabilization of the  
13 medical home that none of the things being discussed are to  
14 substitute for the medical home, but they should have mechanisms  
15 for referral and linkage to the patient's medical home. These  
16 several types of care should also be supportive of the safety  
17 net, linkage to federally qualified health centers and other  
18 appropriate settings of care serving the underserved. And they  
19 should also use health information technology.

20           Just to describe how we're going to do this. We'll first  
21 define the service in each sector that's going to be discussed  
22 here, then present the recommendations and discuss the mechanism  
23 that the committee foresees for monitoring these. OK.

24           The first one is retail clinics. Now, retail clinics is  
25 kind of a catchy term, some are called "minute clinics" or

1 things like that, but what these really are limited-services  
2 clinics that provide, as the name says, a limited set of  
3 services that is basically episodic and confined to the duration  
4 of the patient encounter. These are not meant to be continuing  
5 sources of care, but just the ones that one might go to for  
6 an acute, just very minor sort of episode that needs some... some  
7 sort of medication or remediation.

8 In that vein, the Committee recommends that the term  
9 "limited-services clinics" be used and be required for any such  
10 clinic in a retail setting as part of the signage and the  
11 naming. Now, they may refer to them as minute clinics or  
12 whatever, but that would have to be followed by the statement  
13 "limited-services clinics" to emphasize that, indeed, this is  
14 not a place to get comprehensive care or a spectrum of care, but  
15 that it is, it is limited to certain types of care.  
16 Massachusetts has done this in their regulation of retail  
17 clinics with, so we're kind of taking a page from their book on  
18 that one.

19 And, again, the Committee recommends that these be defined  
20 through regulation or statute that these services are episodic  
21 and just provided in the duration of the patient encounter. And  
22 it's just as important to define what they are, is to define  
23 what they are not; in the last bullet there it will be made clear  
24 that a limited-service clinic cannot provide anything like  
25 surgical services, dental, rehab, mental health, substance

1 abuse, or birth-related services. And, again, this— they cannot  
2 exercise or deliver anything having to do with venipuncture, nor  
3 can they prescribe controlled substances. They are also pro...  
4 will also... the Committee also recommends that they would be  
5 prohibited from serving patients 24 months of age or younger  
6 because it is felt it's very important that these not be seen as  
7 a substitute for the regular pediatric care for infants and  
8 toddlers of this age—the well-child visits, the schedule  
9 immunizations, and other checkups that are vitally important.  
10 Similarly, they could not deliver childhood immunizations, only  
11 flu vaccines for those up through pediatric and adolescent up to  
12 18 years.

13

14 WILLIAM STRECK: Sorry, Chris, they could not do flu  
15 vaccinations?

16

17 CHRIS DELKER: No, they could give flu vaccinations.

18

19 WILLIAM STRECK: Oh, OK.

20

21 CHRIS DELKER: Just not other vaccinations, regular,  
22 scheduled vaccinations.

23

24 JEFF KRAUT: OK. And not draw blood? Do we get... they are  
25 not able to draw blood?

1

2           CHRIS DELKER: Venipuncture...

3

4           JEFF KRAUT:       Yeah, I'm just... I guess I escaped that when  
5 we... What was the rationale for that? I just don't recall. I  
6 know... I know it was in the previous drafts, but I didn't notice  
7 it until you just said it.

8

9           CHRIS DELKER: I'd have to defer to the committee members.

10

11          JEFF KRAUT:       Yeah, I just... I don't remember. Because, you  
12 know, given the nature of testing and... and the fact that a lot  
13 of clinical testing is... is going, you know, site-specific. You  
14 know, and obviously you did—you differentiate between a simple  
15 finger stick and venipuncture, I know that's a distinction.  
16 Just, I don't remember.

17

18          JOHN RUGGE:       I think you're right, Jeff, if we... not  
19 discussed that and that's to our disadvantage. I think the  
20 rationale is that we are not giving continuing care and  
21 therefore you would not be drawing blood and... in anticipation of  
22 a repeat visit. On the other hand, being able to do a finger  
23 stick to understand what the MEDIQUIT is might be entirely  
24 reasonable and open for discussion. That's the value of these  
25 meetings.

1

2 WILLIAM STRECK: That would open up another whole thing  
3 about state regulation of laboratory, on-site laboratory  
4 services. So...

5

6 JEFF KRAUT: I think LATER.

7

8 WILLIAM STRECK: It's have to be CLEA compliant.  
9 Which could be another... but that requires review. Yeah, Mr.  
10 Berliner. Doctor.

11

12 HOWARD BERLINER: A question about the 24-month rule. I  
13 mean, as a former professor of mine used to say, are people  
14 gonna be carrying around their passports to guarantee it's 24  
15 months or less? But more importantly, I think the real question  
16 is are we going to be shifting a lot of, you know, kind of ear  
17 infections, basic sore throats, little fevers to emergency rooms  
18 at a much higher cost and much less convenience, you know, by...  
19 by prohibiting very young kids from... from going to these places  
20 that... that have greater availability when a pediatrician or  
21 primary care provider isn't, isn't available.

22

23 JOHN RUGGE: Fair to say that... that these proposals are  
24 copycat, they're based on the Massachusetts experience and so  
25 just to say with a derivation, but they... their rationale is as

1 the children this young have vulnerabilities that may... may be  
2 failed to be recognized by mid-level providers in non-  
3 conventional clinical settings, and that every effort should be  
4 made to encourage that there is regular and continuous follow up  
5 by the pediatricians or the family doctors during that... that  
6 vulnerable period. Go... go for it, Chris.

7  
8 CHRIS DELKER: Moving along. In keeping with transparency...  
9 transparency, as we said at the beginning, the Committee  
10 recommends that these retail clinics make clear to the consumer  
11 which services are and are not offered through their signage and  
12 through their marketing information and advertising or whatever,  
13 and that this be prominently posted upon the entry to the  
14 clinic. These... these clinics, we say retail clinics, the... they  
15 are mostly located in pharmacies, but there also are in some  
16 other large retailers and other establishments, so that hence  
17 the name "retail," but they... it's important to emphasize that on  
18 those premises where these would operate, they do have the  
19 appropriate signage and information. It also has to be made  
20 clear to the consumer that he or she is not required to purchase  
21 any prescribed drugs or over-the-counter supplies from the  
22 retailer in which the retail clinic is... is located—that consumer  
23 choice remains paramount and there is not, there should not be  
24 any expectation that the purchase would have to be made at that  
25 premises.

1

2           JOHN RUGGE:     If I could go back to doc... Dr. Berliner's  
3 point as well, just to mention, I did speak with the National  
4 Medical Director of Minute Clinic, which is the leading  
5 provider, the leading provider of services in this mode, who...  
6 and his experience was that indeed they do not treat children  
7 under... under 24 months and he had no objection. Rather than  
8 limiting access to non-ED providers remember that this is  
9 opening up New York a whole... a whole range of services which  
10 currently do not exist, so I think it would be unfair to say the  
11 glass is half empty, implementing these set of recommendations  
12 would... would expand the availability of service for minor  
13 illness.

14

15           CHRIS DELKER:   And the Committee also recommends that these  
16 providers be accredited through third-party accrediting  
17 organization recognized by the Department and that any loss of  
18 accreditation be communicated to the Department. This is what  
19 we've been doing with office-based surgery for several years now  
20 in requiring accreditation, it's the same procedure. There is  
21 also a requirement, obviously, for patient safety and quality.  
22 Most of the retail clinics in other states are operated by nurse  
23 practitioners or physician assistants, and the Committee felt  
24 strongly that there should be a medical director, licensed... a  
25 New York State-licensed physician to oversee and monitor the

1 quality and safety of these entities which would... whatever  
2 corporation sponsors them. And also that there should be  
3 policies and procedures very clear for referring patients to  
4 more elaborate care, those who need it. Again, in terms of  
5 stabilization of the medical home, these clinics would maintain  
6 a roster of primary care physicians who are accepting new  
7 patients in the area, encourage the... the patient to connect with  
8 a primary care provider if they don't have a regular one, and  
9 this would include linkage to federally qualified health centers  
10 for underserved and... and Medicaid clients who may... who may use  
11 these clinics.

12

13 JEFF KRAUT: Chris, on... on this one, I thought we had  
14 modified this or maybe this is in the... the writing? Is that... the  
15 example was given that you work in Midtown Manhattan, you go to  
16 one of these clinics, and you live in Suffolk County. There's no  
17 expectation that that provider will have a roster of primary  
18 care providers in the area that... that this list will only be to  
19 the area in which the clinic is located. That we're not putting  
20 the onus on them... cause then they have to do it everywhere in  
21 the New York metropolitan area. And that was, I think that was  
22 brought up as an operating concern.

23

1 JOHN RUGGE: That... I think that's right, Jeff.

2 Absolutely. In addition there is some uncertainty about how best  
3 to generate this roster.

4

5 JEFF KRAUT: Right.

6

7 JOHN RUGGE: Is every limited-service clinic responsible  
8 for serving the neighborhood identifying, or will there be a... a  
9 state-based function that will enable not only the generation of  
10 a roster, but the updating of it periodically. Dr. Gutierrez.

11

12 ANGEL GUTIERREZ: If we are anticipating that the sites  
13 are going to have any kind of computer access, you can go to a  
14 computer and enter a zip code and you will find who will accept  
15 primary care. I don't think that that should limit our  
16 expectation that they will refer the patient or recommend that  
17 the patient secures primary care in the area near their zip  
18 code.

19

20 JEFF KRAUT: Right. I mean, it was brought up, I think,  
21 by Dan from...

22

23 JOHN RUGGE: Lowenstein.

24

1           JEFF KRAUT:       Lowenstein from PDCD, you know, ZocDoc or...  
2 there's a lot of programs that do this, but this is making an  
3 affirmative responsibility. It doesn't say through appropriate,  
4 you know... you know, we just have to be... I guess when you get to  
5 the writing you gotta be careful how it's written. I'm not  
6 making any other point than that.

7  
8           JOHN RUGGE:       I think the intent is... It has to be  
9 maintained and the mechanism by which that roster is generated  
10 will be evolving and will be explicated either in the report or  
11 through, through regulation.

12  
13          WILLIAM STRECK:     I must say, this—I'm sorry, Dr.  
14 Strange.

15  
16          DR. STRANGE:       There's been a few of issues...  
17 Came up under, even under the ACO, Jeff, snowbirds, for example,  
18 who go back and forth to Florida and are using these clinic,  
19 these minute clinics as their providers and even there you can't  
20 access, if they are in Florida, who are they going to see back  
21 in New York, how does that information get transmitted up here.  
22 We've had issues where we can't get the immunization schedule  
23 that was given down in Florida up here, patients forgot when did  
24 they get the pneumonia shot, when did they get ZOSTER vax. This  
25 is an issue of continuity of care, and especially as it relates

1 to a whole population-based health issue as we move into the  
2 whole ACO concept. This is a concern of mine as a geriatrician.

3

4 JOHN RUGGE: A fair point. And again, I think a  
5 recognition on the part of the Committee, we can't solve every  
6 problem, and yet for the... for the bulk of patients, we will have  
7 the beginning of a... of an approach that should prove workable.

8

9 WILLIAM STRECK: I would make the observation that we're  
10 taking a limited-service clinic, which is, by definition, a  
11 small enterprise and burdening it with a major social  
12 responsibility here, you know, and distributing primary care  
13 information and I'm just -I think it's a good idea, but I'm just  
14 not sure the patients who come into these clinics are looking  
15 for that, nor are... is the design of the clinic for that purpose.  
16 I mean, this-I... it's good idea, maybe, but I think from an  
17 operational viewpoint calling it "limited-service" and then  
18 giving it this kind of burden, I think is perhaps not...

19

20 JOHN RUGGE: And yet.

21

22 WILLIAM STRECK: Effective.

23

24 JOHN RUGGE: Yet, Dr. Streck, Dr. Sussman from Minute  
25 Clinic indicates that this is exactly what they now do by way of

1 issuing a plan of care and are looking to connect those... those  
2 enterprises to a primary care base.

3

4 WILLIAM STRECK: I wouldn't object to a clinic wanting  
5 to do that if that was there initiative, but I just—I must say  
6 it seems like a burden to impose on every clinic of this nature;  
7 if the design of the product that a company puts out or someone  
8 wants to run does that, I think that's great, but...

9

10 JOHN RUGGE: I think if the proprietors of existing  
11 centers are able to do it and we regard this as a social good,  
12 then requiring it is not such a huge leap, it's been proven to  
13 be possible, it's proven to be a standard of care by the leading  
14 provider, and therefore have— our having the expectation that  
15 these centers do connect to the rest of the system instead of  
16 being a one-off is a, at least in the Committee's view, is a  
17 reasonable expectation. Dr. Bhat.

18

19 DR. BHAT: Can I go back to one of the comments that was  
20 made earlier? In retail clinics that you have in these retail  
21 chains, the reason why they would like patients to come is they  
22 would like to get them in. And they're also going to have a  
23 pharmacy and who's going to be monitoring whether the  
24 prescriptions that are written (there couldn't be any kind of  
25 abuse), cause that's all there is. If this clinic were to be

1 next-door to the pharmacy, the chances are, and that's probably  
2 the reason why they would like to have this crowd coming in  
3 there.

4  
5 JOHN RUGGE: If I... and certainly we recognize the  
6 proximity may be the most important factor, but we are requiring  
7 public notice that there is no expectation, no requirement, and  
8 it should be no pressure other than convenience for the patient  
9 to utilize the retail services inside that facility.

10

11 DR. BHAT: But the situations you cannot. For example, a  
12 doctor in New York State simply cannot dispense medication, but  
13 you are going to go into one of these retail chains, somebody's  
14 gonna write the prescription and they are going to go next-door  
15 and purchase the prescription... medications, right?

16

17 JOHN RUGGE: Right, but as I understand it physicians are  
18 able to dispense medications if they want to go through the  
19 folderol, so there's no prohibition against physicians  
20 dispensing medications.

21

22 DR. BHAT: The retail pharmacy that's going to be able to  
23 (constrain), and I do agree with what Dr. Streck said, there's  
24 too much regulation they are going to be putting in, not in this  
25 particular context, maybe the next phase that you have, urgent

1 care centers, a lot of regulations that are putting in there,  
2 the product might drive up all the business going into the  
3 emergency rooms, which is going to cost maybe three to four  
4 times, maybe higher.

5

6 JOHN RUGGE: There's certainly recognition that, that  
7 there is a commercial incentive for retail establishments,  
8 especially pharmacies to establish these centers. The consensus  
9 of the Committee was that there is value, that with public  
10 notice we can ameliorate (at least to some degree) a perception  
11 that there is a need to use that particular facility.

12

13 WILLIAM STRECK: So, Chris, why don't you forge ahead  
14 here, because I think you're the, the format largely is going to  
15 apply to the urgent care discussions, too, as Dr. Bhat has  
16 alluded to. So, why don't we get through the final slides here.

17

18 CHRIS DELKER: OK.

19

20 WILLIAM STRECK: And move from there.

21

22 CHRIS DELKER: The other component of, to encourage  
23 stabilization of the medical home, would be to... for the  
24 committee recommends that these clinics have some policies and  
25 procedures to identify patients who might come back repeatedly

1 in short periods to kind of limit the number of visits or  
2 encounters they would have with them. Again, the committee  
3 recommends that these entities participate in electronic health  
4 records and e-prescribing. These would be, if approved, these  
5 retail clinics would be authorized under an amendment to article  
6 28 that would include allowing corporations to provide  
7 professional services, which is currently prohibited under state  
8 law. And it would also have language that would exempt them from  
9 CON; there would still be some sort of licensure or registration  
10 or certification process, but it would not be the review for  
11 public need, character, competence, and financial feasibility  
12 that is, you know, the standards of CON. OK, and that's retail  
13 clinics.

14

15 WILLIAM STRECK: Mr. Kraut and then Dr. Berliner.

16

17 HOWARD BERLINER: Chris, can you go back to that... that  
18 last recommendation?

19

20 CHRIS DELKER: The statute, you mean.

21

22 HOWARD BERLINER: Yeah.

23

24 CHRIS DELKER: Yeah.

25

1

2           HOWARD BERLINER:       So, would that mean each individual  
3 clinic would have to be, would have to get, would have to go  
4 through a process, or could a chain just put in for all of them?

5

6           (Right.)

7

8           JOHN RUGGE:       We did not consider the details of, if you  
9 will, registrational [sic] licensure, but remember this is a  
10 simple notification process and... and informational to the degree  
11 that there is a licensed physician in New York who is taking  
12 medical responsibility for the facilities, so we... we did not  
13 explicate whether one application would suffice for a chain or  
14 whether there would be a separate piece of paper for every  
15 individual site.

16

17           JEFF KRAUT:       Just a...

18

19           JOHN RUGGE:       Mr. Kraut.

20

21           JEFF KRAUT:       Just the... to make the point and... which we  
22 had discussed at the Committee, and the requirement of why this  
23 is statutory... just to recognize that we are recommending the  
24 corporate ownership of medicine. The corporate practice of  
25 medicine, which heretofore had been limited to the dialysis

1 centers for the reasons we're aware of, so the... that... and when  
2 we had probed that, that given some of the requirements that we  
3 were imposing and the practice model, one of the representatives  
4 from CVS said basically we can't do this in... and we can't really  
5 effectively manage these as little one-offs, with individual  
6 physicians or, you know, in practices in every location; that  
7 this very much was, putting aside the logistics of how this was  
8 done, but this was a corporate-wide or a state-wide policy, they  
9 wanted to run everything with a corporate umbrella, if you will,  
10 and that's why this is here, so this is beyond our ability to  
11 suggest a regulatory change. This will probably result in other  
12 conversation. And the concern was do we open the door and if it  
13 applies here it's one thing, you know, are we going to permit it  
14 to occur in other retail settings? Now, we had suggested, I  
15 think, pharmacies to try to restrict that, but the way that this  
16 is written, it could be in Lowman's, to use maybe not too an  
17 absurd example, any retail setting, this could be- So I think  
18 the statutory discussion will have to tighten that language.  
19 That's all I'm suggesting.

20

21 JOHN RUGGE: Just by... if I can go back also to the  
22 venipuncture discussion, just to SOLVE THIS and think about it.  
23 By precluding venipuncture, we are not precluding CLEA WAVE  
24 tests for pregnancy, HEMATIC REST blood sugar, and the rest,  
25 we're simply saying venipuncture implies sending the lab work

1 off to another laboratory, days later getting the response, and  
2 then having to contact the patient, which would imply continuity  
3 of care, and that's what we're trying to preclude. That's the  
4 rationale. It takes a while for the synapses to connect.

5

6 JEFF KRAUT: That's fine. I think that's appropriate.

7

8 [So, if I may, I just...]

9

10 JEFF KRAUT: Well, go ahead, I was just gonna... That's  
11 fine, but we also used the case, well what if this is part of a  
12 network of care where the provider is telling you to go to this  
13 location... I'll use our example, that we'll have a relationship  
14 with CVS. It will be integrated with our electronic systems and  
15 we may want the patient to go to that location for the care, and  
16 we may want a patient to have blood drawn there because it's  
17 convenient. We may, in fact, have our laboratory blood drawing  
18 in that location.

19

20 JOHN RUGGE: Then I would think you will seek to have  
21 within that retail establishment or in that retail clinic a  
22 venipuncture station, and simply be certified as you would for  
23 any other venipuncture station.

24

25 JEFF KRAUT: OK.

1

2           PETER ROBINSON:        I just want to underscore the point  
3 that Mr. Kraut made with regard to this exemption here for the  
4 corporate practice of medicine, which is, I think, potentially a  
5 very slippery slope, so while I think there was strong support  
6 for this exemption here for retail clinics and I support that,  
7 as well, I do think that we want to be careful to draw some  
8 lines here and do not recommend—very, very strongly—that this  
9 extend to other sectors of the delivery system. So, just a...

10

11           JOHN RUGGE:        My understanding is that staff has made due  
12 note, the paper will include that warning and caveat.

13

14           KAREN WESTERVELT:    I just want to have one point of  
15 clarification in that there was a comment made that there would  
16 just be a notification requirement; there would actually be a  
17 limited-licensure type LITE requirement, if you will. So there  
18 would be a process around that and the thinking is that it would  
19 be, you know, we would need to... we would need to approve each...  
20 each site, most likely, as opposed to just one general approval.

21

22           (DR. STRANGE:) Could I just comment to Jeff, to your point  
23 just now? I think in how you described it, in an integrated  
24 system, this makes a lot more sense than independent retailers  
25 being out there for purposes that may be altruistic or purposes

1 that may be not so altruistic, and I think the fragmentation of  
2 care, the potential for fragmentation of care, could be that  
3 much higher here if we don't let this, if we let this unvetted  
4 and allow this to just be freely open because we think somehow  
5 that we're going to allow for better access in... but in a very  
6 fragmented way. And we've already seen that. I mean, clearly  
7 I've seen that with geriatric population in little small segment  
8 of Staten Island, I'm hearing about that, and I think somehow as  
9 we evolve all of this, which I read through, into an integrated..  
10 an integrated systems, in the only way this is every going to  
11 work. Whether it's eventually done with IT, whether it's  
12 eventually done with some oversight that has to be where there  
13 is accountability and responsibility for whatever care is  
14 provided, but to continue to say that we're going to do this in  
15 a fragmented, piecemeal way just because it's a better way to  
16 have access, I think we need to be very careful there, because  
17 that's a very slippery slope.

18

19 JOHN RUGGE: I think that the impulse of the Committee  
20 was to say we indeed need integration, but integration can be  
21 vertical. I mean, some can be virtual. That we're requiring  
22 identification of a primary physician, where available, where  
23 appropriate; that records be transmitted; that licensure be  
24 mandated with... I think to say that retail clinics can be  
25 established only inside the context of large, integrated

1 systems, again, tilts the field toward one mode of care rather  
2 than saying what we're achieving is real integration where the  
3 care is coordinated and connected to primary care, with  
4 standards, and that's what these recommendations drive to.

5

6 DR. STRANGE: I'm sorry, just one more comment on that.  
7 Again, wearing my medical society for a second, but again, the  
8 physicians in this state, as a business, have... are a big  
9 business in this state as individual physicians and I understand  
10 where the... where the movement of health care is going, but as  
11 individuals... this, in another way, so taking away the whole  
12 integration with systems, but taking it as competing with the  
13 local doc on the corner. Again, that's an unfair advantage also.

14

15 WILLIAM STRECK: John, could I, under the health  
16 information technology, I'm going to return to this theme of  
17 overenthusiasm of goals here, because we're talking about these  
18 clinics now being responsible for a document that addresses  
19 ongoing management of a plan of care for every patient. I... I'm  
20 just trying to imagine trying to run one of these clinics. I  
21 mean, these people wander in with an earache and you... they  
22 have to leave with an ongoing plan of care, referral to a  
23 primary care practitioner. It's just- it just seems like a lot.

24

25 JOHN RUGGE: This... this is the core...

1

2 WILLIAM STRECK: It's not that it's not idealistically  
3 desirable, it just seems like a lot.

4

5 JOHN RUGGE: But as a practical matter what we're saying  
6 is the expectation is that these centers meet the criteria of  
7 meaningful use and, in the real world, with reimbursement  
8 tilting toward providers who are availing themselves of that  
9 technology and using it in that way, this is not inconsistent—  
10 and no new layer of requirement except as already available  
11 through the reimbursement system.

12

13 WILLIAM STRECK: Meaningful use applying, or applying  
14 meaningful use criteria to these little shops?

15

16 JOHN RUGGE: We did not say that, we said that... that  
17 we're requiring plans of care to be explicated, available to the  
18 patient, and available to the... that physician or provider giving  
19 continuing care, and those happen to be in accord with  
20 meaningful use and so rather than being yet one more feature  
21 that a provider is expected to do, it is... it is a reinforcement  
22 of another incentive system that is operative.

23

24 WILLIAM STRECK: Other questions or comments? Dr. Brown.

25

1 DR. BROWN: I must confess, I was really intrigued by  
2 reading a lot of this and I can certainly appreciate the issues  
3 about trying to enhance access. I am concerned, though, with the  
4 extent to which there could be abuse. That is that there may be  
5 excessive sessions that occur and the issue about also access to  
6 what populations, what is the oversight to say that, OK, this  
7 entity has the shop here in this community, that community, and  
8 maybe they have a shop where they are, I don't know, communities  
9 that can put better afford it or they are communities that, in  
10 fact, have fractured care, so they use this as a secondary way,  
11 in fact, to make sure that their care is adequately being met.  
12 And we also probably know from the literature that when patients  
13 seek care, it's what they believe that they need, as opposed to  
14 what is necessarily indicated by the data that may be presented  
15 to a physician. So, I'm- I must confess, I'm... I do appreciate  
16 the need for improved access, but I am concerned about the  
17 oversight and I do appreciate that I know the certificate of  
18 need is challenging for many health care systems to go through  
19 and, believe me, if there was another way that I could think off  
20 the top of my head I would certainly volunteer it, but it seems  
21 to me that this level of oversight in the name of access, and  
22 not to mention the burden that we're asking for this--on the one  
23 hand we're asking for a number of things that are all quite  
24 burdensome for a small entity, other than if you are a corporate  
25 center that you have a different satellite, you can be here and

1 there, they have economies of scale, they can do this quite  
2 easily, but for smaller practices it seems to me that this is  
3 over burdensome, and yet the issue about oversight, I'm also  
4 troubled by. So if it seems that I am irrational in my response,  
5 I must tell you, this as exciting as it presents in terms of  
6 trying to meet the answers to certain questions that have been  
7 long lasting, it seems to me it raises more than offers  
8 solutions.

9

10 JOHN RUGGE: Yeah, the Committee struggled with all these  
11 issues and you defined them very nicely. I mean, this is  
12 breaking some new ground for New York and it's trying to thread  
13 a needle of expanding access, but not having that disconnected  
14 from mainstream care. The proposals do several things. One is it  
15 does commit these providers to article 28 licensure, but no CON,  
16 there will be no CON requirement. With regard to repeat visits,  
17 the Committee absolutely shares that concern and is recommending  
18 that there be a limit. The suggested formula would be no more  
19 than three visits for the same condition. Well, how does one  
20 enforce this? My sense is the best way to enforce it is on the  
21 second phase and that is to say simply don't pay for it. There's  
22 no... there's no prohibition for a practitioner seeing that  
23 patient in that setting, to have the reimbursement formula  
24 indicate that there will be no payment for what could be  
25 regarded as an unnecessary, inappropriate visit. With regard

1 to some communities not having access to this service, it's  
2 absolutely the case, absolutely a concern, and yet, I think, no  
3 form of restructuring the delivery system by itself can hope to  
4 solve every problem; that we're not able to assure perfect  
5 access for everybody in this way, but at least it's, in the  
6 Committee's view, a modest step forward in terms of  
7 supplementing primary care without displacing and certainly not  
8 replacing it.

9

10 WILLIAM STRECK: Mr. Abel.

11

12 CHARLIE ABEL: Thank you. Just a point of clarification,  
13 because here we, in New York State, I think we, you know,  
14 associate, and for good reason, significant need approval with  
15 licensure. You know, in New York State, we have a parallel  
16 process, we have always had a parallel process. We've, based on  
17 CON reform recommendations and our implementation of those last  
18 year and here again, we're really pulling them apart as many  
19 other states have them apart, even CON states. So article 28  
20 facilities still need to licensed. They—we're saying that for  
21 these facilities they—we don't have to go through an evaluation  
22 of public need, an evaluation of whether the costs make sense,  
23 you know, given the health care industry, et cetera. The  
24 discussion, I think, around retail clinics are saying that we  
25 really don't need that, but we do need to have a licensure of

1 these facilities, as we would any article 28 facility, we need  
2 oversight. There needs to be someone in charge... we need to have  
3 an expectation of what these facilities can and can't do, and we  
4 need to have someone go in and survey these facilities and make  
5 sure that they are living up to their promises. So... so... the...  
6 the... the licensure component is still there. So, you know, I  
7 just... just to make sure that that's all out there. And, by the  
8 way, you know, we do have these facilities that are operating  
9 right now without that oversight, so the... you know, this...  
10 these... these sets of guidelines—and we've gotta develop all of  
11 the operational protocols around them, yet to be developed—the...  
12 these set of guidelines are really designed to ensure that... that  
13 these facilities operate within expectations, as discussed  
14 within the committees, and are providing a public good in  
15 exchange for the article 28 certification. Thank you.

16

17 WILLIAM STRECK: Should we move to urgent care, having  
18 broken ground with some of these ideas?

19

20 JOHN RUGGE: Just as a way of... way of preface, you'll  
21 begin to see repeating themes, and that is the issuance of a  
22 naming convention. In many ways, we're licensing the name, as  
23 well as, or even in lieu of licensing in a new, special way the  
24 provider. That we are looking for connection through referrals  
25 and notification and information sharing with the primary care

1 system, primary care provider. And we're also looking for  
2 connections to that HIT system as a modality. So, if you like it  
3 here, you'll- under retail clinic, you'll like it under urgent  
4 care. But we are trying to have a set of standard expectations  
5 for caregivers of episodic episodes of minor or acute illness.  
6 Going forward, our presenter is, ah-ha, Alejandra Diaz.

7  
8 ALEJANDRA DIAZ: Thank you. So, I'd like to start with  
9 the definition of "urgent care." There are three main points  
10 that we, that we cover in terms of the definition. Urgent care  
11 is intended to treat episodic, acute illness, or minor traumas  
12 that are not life-threatening or permanently disabling. Urgent  
13 care is not intended to be a patient-centered medical home or  
14 source of continuing care, similar to limited-services clinics.  
15 And similar to limited-services clinics, we also want to touch  
16 upon on what urgent care is not, which is it is not intended for  
17 emergency intervention for major trauma, life-threatening or  
18 potentially disabling conditions. It is not intended for  
19 monitoring and on-going treatment of chronic conditions. What  
20 we're really trying to do here is establish within the range of  
21 urgent care, or rather within the range of episodic acute  
22 illness where urgent care falls in terms of that spectrum of  
23 severity, and it would lie somewhere between limited-services  
24 clinics and an emergency department. In terms of defining urgent  
25 care scope of services, what we're trying to do here is

1 establish a minimum standard for what constitutes urgent care.  
2 So we have a list of services here, which I won't go into in  
3 detail, but we've worked with industry, as well as with the  
4 Council, to develop what this minimum standard, what these  
5 minimum services are that we would expect to be provided from  
6 any urgent care provider. In terms of establishing a naming  
7 convention, we want to restrict the use of "urgent care" and its  
8 equivalents to those providers offering urgent care services as  
9 we've defined and as we approve. Urgent care providers cannot  
10 use the word "emergency" or its equivalent in their names,  
11 again, helping to establish where urgent care falls within that  
12 spectrum of episodic care. The idea here is also to make sure  
13 that we're... making sure... making sure that the consumer  
14 understands who it is that they are going to for different types  
15 of services. Disclosures to consumers. Similar to limited-  
16 services clinics, we want to make sure that consumers can see  
17 what... what the types of services are that are provided by these  
18 providers, requiring signage to post the types of services  
19 provided, and also where applicable, similar to limited-service  
20 clinics, requiring signage that makes sure that people know that  
21 if there are ancillary services, pharmaceutical services that  
22 are nearby, that they have their choice for a provider for those  
23 services. In terms of patient safety and quality, we're  
24 requiring policies and procedures for referring patients whose  
25 needs exceed the services of an urgent care provider to ensure

1 continuity of care. So, making sure that there's a connection,  
2 either between an urgent care provider and an emergency  
3 department, if needed, but also making sure that there is a  
4 referral process in place to connect to primary care services.  
5 And that feeds into the next piece on stabilization of the  
6 medical home.

7         So, similar to the conversation we just had related to  
8 limited services clinics, there will be an expectation that if  
9 someone comes into an urgent care provider and does not have a  
10 primary care physician that there is a referral process in place  
11 to do the best to connect them to services in the most  
12 appropriate location.

13         We're also not trying to dictate how providers can achieve  
14 this, but asking that they have policies and procedures in place  
15 to limit the number of repeat encounters because, again, urgent  
16 care is not intended to be that sole provider for ongoing care,  
17 but rather to treat acute episodic cases.

18         In terms of health information technology, what you see  
19 here is identical to what we have with regard to limited  
20 services clinics in terms of requiring utilization of certified  
21 electronic health records, providing a copy of medical records,  
22 requiring documentation, execution and ongoing management and  
23 requiring e-prescribing. So I imagine that the conversation we  
24 had with regard to limited services clinics we might want to

1 think about how that applies specifically to urgent care as  
2 well.

3 In order to achieve this definition and the naming  
4 protections we want to establish statutory action. So only  
5 providers meeting the definition that we reviewed would be able  
6 to use the term 'urgent care.' So again, this isn't - this is  
7 really meant to be a protection of that name and a protection of  
8 that standard for urgent care which currently now is undefined  
9 in New York State. To be approved to use the name providers  
10 will need to meet specified criteria demonstrated through  
11 certification for article 28s or through accreditation for non-  
12 article 28s.

13 So, I'll start actually going into a little bit more detail  
14 with regard to the non-article 28s. So, private practice  
15 offices including those that are affiliated with an article 28  
16 that wish to call themselves an urgent care provider would be  
17 expected to obtain accreditation by an accrediting body approved  
18 by the Department of Health. No CON review would be required.  
19 For article 28 urgent care providers, existing 28 hospitals or  
20 D&TCs wanting to provide urgent care services would be expected  
21 to go through a limited CON review to have urgent care listed on  
22 their operating certificates. Currently that is not a service  
23 line listed on operating certificates. Maintaining the  
24 flexibility that an article 28 would have now to offer some  
25 services thorough private practices, they would also, they would

1 still have that choice. And so, as mentioned before a private  
2 practice that's affiliated with an article 28 would still be  
3 able to establish. Their expectation would be that they seek  
4 accreditation. And then for the establishment of any new  
5 article 28 or D&TC that wishes to be an urgent care provider  
6 they would go through CON review. So, nothing new there, but  
7 urgent care would be listed on their operating certificate  
8 through that process.

9 Additional accreditation requirements would be that if a  
10 non-article 28 provider loses it's accreditation both the  
11 accrediting body -

12

13 JOHN RUGGE: Dr. Berliner has a question.

14

15 WILLIAM STRECK: Yes, go ahead Dr. Berliner.

16

17 HOWARD BERLINER: Just a question on the last slide.

18 [mic, mic]

19 A physician practice affiliated with an article 28, well,  
20 any physician practice can provide urgent care services. You -  
21 I think you mean, can only use the term 'urgent care.'

22

23 ALEJANDRA DIAZ: Yes. Yes. So this is really in terms  
24 of creating that naming protection.

25

1           HOWARD BERLINER:     Right.  So it's a naming convention for  
2 a private practice affiliated - if a private practice wants to  
3 call itself an urgent care practice -

4

5           ALEJANDRA DIAZ:       Yes.

6

7           HOWARD BERLINER:     Right.  I don't think that's clear from  
8 - those people look at it, just make sure that that's what -

9

10          JOHN RUGGE:         Right.  Fair point.

11

12          ALEJANDRA DIAZ:     Any other questions?

13

14          WILLIAM STRECK:     Questions or comments?  Mr. Fassler.

15

16          MICHAEL FASSLER:    Yeah, just a question.  Seems like  
17 protecting the word 'urgent care' but if somebody ran a  
18 practice, did what an urgent care center did, advertised it as  
19 such, but didn't use the work 'urgent care' they can get around  
20 the regulations, I take it.

21

22          JOHN RUGGE:         They can do what they're doing now, and that  
23 is they can practice medicine.  We're not trying to infringe  
24 upon the practice of medicine or define it.  However we think  
25 there could be value both in terms of public recognition and

1 eventually in terms of reimbursement by being recognized and  
2 designated as an urgent care center.

3

4 MICHAEL FASSLER: But if someone called themselves  
5 'immediate care center' they'd be exempt from this then. They  
6 would not? It that one of the conventions tied in? Immediate  
7 Care, Quick Care, --

8

9 KAREN WESTERVELT: Do you want to address that? About the  
10 use of other terminology similar to urgent care?

11

12 JOAN: Yes, I believe the language that Alejandra, what  
13 page is it on, you can't use equivalent terminology either to  
14 try to get around it like, emergent care, derivatives of that,  
15 emergi-care. Alejandra, can you bring the slide of that has  
16 that?

17

18 ALEJANDRA DIAZ: Yeah, so we talk about protecting the  
19 term 'urgent care' and it's equivalents to those providers  
20 offering urgent care services.

21

22 JOHN RUGGE: We've not defined the equivalents, but the  
23 immediate care could well be an equivalent but decided not to  
24 try to tackle the English language in it's entirety and during

1 the committee deliberations. We'll leave that for the  
2 Department through the regulatory process.

3

4 MICHAEL FASSLER: But in the statutory part you'll tackle  
5 it then, in terms of what's equivalent.

6

7 JOHN RUGGE: Yes.

8

9 JEFF KRAUT: But, you know, it could be a doctor office  
10 and no appointments necessary. That's not what were talking  
11 about. That's absolutely permissible.

12

13 JOHN RUGGE: And once again, indicating if you're calling  
14 yourself urgent care then you will have service available, will  
15 have ACLS, will have a range of services that are assured. And  
16 the advantage is not to limit urgent care, but to categorize it  
17 and make it recognizable so the people can avoid unnecessary ED  
18 visits by knowing they have an alternative that would meet their  
19 needs. So this is really not intended to be a restriction on an  
20 urgent care, but rather a clarification so that appropriate  
21 utilization can take place, and inappropriate utilization in  
22 other parts of the system become unnecessary.

23

24 WILLIAM STRECK: Other comments or questions?

25

1 JOHN RUGGE: We have some over here.

2

3 WILLIAM STRECK: I'm sorry. Mr. Hurlbut.

4

5 ROBERT HURLBUT: We've had a couple of urgent care  
6 centers open in Rochester and the one question I ask the  
7 operator if he happened to be a national outfit. Is the fact -  
8 I asked him, I said, "Do you take Medicaid clients?" He said,  
9 absolutely not. So, one of my thoughts is why, have we talked  
10 at all about reforming any of these centers to accept Medicaid,  
11 because I'm looking at this as you well pointed out is to be  
12 able to avoid emergency room visits in the hospital. And I know  
13 that most of, a lot of these at least in Rochester are not  
14 necessarily in places where Medicaid clients reside, but I can  
15 see that happening in the future. And I'm just wondering if  
16 there has been any discussion about that, because if there  
17 hasn't been, there should be.

18

19 JOHN RUGGE: There was, indeed, discussion about  
20 Medicaid. Obviously under article 28 providers are to be  
21 expected and are compensated for Medicaid reimbursement. The  
22 initial recommendation, our initial slide did show requirement  
23 to accept Medicaid, but the committee decided to not make that  
24 requirement because of Medicaid reimbursement being so very low  
25 that we could jeopardize the viability of the whole mode of care

1 and then we would simply stifle development of these urgent care  
2 centers.

3

4 JEFF KRAUT: Well, we didn't leave it at that. We also  
5 expanded the fact that the expectation here is to encourage  
6 existing diagnostic and treatment centers and/or article 28  
7 entities to enter the urgent care business. They'd have to  
8 follow CON, they'd have to qualify for the rates. But remember,  
9 the difference between that is, could be you know, the  
10 difference between \$12 or \$20 and \$105. And the expectation  
11 here is almost all the urgent care development in the State have  
12 been in high income well-insured neighborhoods. And this is not  
13 addressing that need. But you have to stimulate that need. And  
14 that's why we're trying to draw the distinction here between -  
15 if you're going to serve Medicaid under an urgent care model,  
16 you're going to have to be a D&TC. In some way, shape, or form.  
17 That's the - thing.

18

19 JOHN RUGGE: Nicely put. And clarifying the structure of  
20 the delivery system does not help that aspect. That is left to  
21 the reimbursers to do. Dr. Bhat.

22

23 DR. BHAT: While I was reading through the slides, they  
24 appeared to me that there was two (intrusive) into the practice  
25 of medicine. Is urgent care system the state broken? That's

1 number one. And if it is not broken, what is it that we are  
2 trying to do here?

3

4 JOHN RUGGE: Well, clearly there is, there are hundreds  
5 of urgent care practices under that name currently, and there is  
6 no systematic way of identifying them except through their own  
7 association and some may not choose to affiliate. There is  
8 concern on part of certain committee members that in certain  
9 communities urgent care is coming to replace or displace primary  
10 care because of reimbursement advantages. There are concerns in  
11 other areas. There is simply no urgent care center available.  
12 What we do know is there are very significant numbers of  
13 patients going to emergency departments inappropriately. And  
14 therefore there is either a lack of recognition or lack of  
15 capacity on the urgent care side, and the committee's feeling is  
16 that by establishing this category, clarifying and standardizing  
17 the services provided we will legitimize and create a pathway  
18 for patients to go to the most appropriate location, which in  
19 many cases will be urgent care.

20

21 DR. BHAT: Would it discourage mom and pop kind of urgent  
22 care centers?

23

24 JOHN RUGGE: Mom and pop can do whatever they care to do  
25 under the practice of medicine. We're not restricting in any

1 way the private practice of medicine or limiting what private  
2 practitioners can do. We're saying, if you care to be labeling  
3 yourself, naming yourself as an urgent care provider there are  
4 certain expectations. You will have a defined service package  
5 and you will be accredited, and with that you have the benefits  
6 of reimbursement and eventually the publicity that goes with it  
7 as a way of directing patients to you as an appropriate  
8 caregiver.

9

10 DR. STRANGE: Just a question about 'specialty oriented  
11 urgent cares.' Orthopedics being the ones specifically. Does  
12 that fit under this model? Or they would have to call  
13 themselves Orthopedic Quick Care or something, because we have  
14 one that just opened on Staten Island that says come in if you  
15 fractured your ankle, you fell, we'll cast you and we'll refer  
16 you over to the orthopedist which happen to be the same people.

17

18 JOHN RUGGE: Yes. We did consider whether initially  
19 pediatric urgent care should require labeling if an urgent care  
20 center is doing pediatrics and merged. Orthopedics as well.  
21 And the judgment of the committee was if you're only going to do  
22 orthopedics, only going to do pediatrics, you will of course  
23 identify yourself as a pediatric and orthopedic urgent care  
24 center because you don't want to be bothered with people you're  
25 not going to care for. So we didn't think it was necessary to

1 regulate that, but that will shake out by itself. Nonetheless  
2 by meeting the standards that we've indicated in the accrediting  
3 by an external agency, one would be an urgent care center.

4

5 DR. STRANGE: You would still in those places require an  
6 EKG phlebotomy lab service in an orthopedic facility that's only  
7 casting or splinting?

8

9 JOHN RUGGE: Good question. Back to Joan.

10

11 JOAN: I think when our workgroup got together we felt  
12 that orthopedic urgent care would not fit under the urgent care  
13 name because it did not provide those minimum scope of services  
14 that they were in orthopedic after hours or some other kind of a  
15 name, but they didn't qualify providing these set of services.  
16 Pediatric may.

17

18 ALEJANDRA DIAZ: So I'd say very similar to a private  
19 practice offering primary care that has extended hours, maybe a  
20 few nights a week, they're able to do that under the current  
21 structure. And so if someone is specializing in orthopedics but  
22 has the extended hours it's very similar in their - they  
23 wouldn't like John said, fall under that, what we're considering  
24 in terms of urgent care.

25

1 DR. STRANGE: Just a symatic thing about the name.  
2 because they're currently calling themselves an orthopedic  
3 urgent care in the community. That's all I'm suggesting, and  
4 that name to the community suggests something that you can go to  
5 this 'orthopedic urgent care' as opposed to go to the ED, or if  
6 you had a simple fracture of a wrist that could be simply  
7 splinted and probably cost less and probably taken care of  
8 better by the orthopedists who are sitting there than maybe the  
9 emergency department. So we're going to have to recognize that  
10 and ask these physicians to change the name, and that pertains  
11 to what you just said, Dr. Rugge, about will that effect  
12 reimbursement via the providers? Will that present a different  
13 perspective to the community as it relates to what an urgi  
14 center is specifically for those specific populations.  
15 Pediatrics the same. Because again, you may not be doing EKGs  
16 in a pediatric urgent care center if you're taking care of sore  
17 throats, basically or earaches all day.

18

19 WILLIAM STRECK: So, we're going to conclude the urgent  
20 care discussion. Oh, I'm sorry Patsy. One more comment.

21

22 PATSY YANG: I may be misunderstanding this, but it  
23 almost seems that the applicability of CON requirements is not  
24 associated with the scope of an urgent care center because

1 that's standardized. It's more, it's relationship to an  
2 existing, a new, or none, or an affiliation to an article 28.

3

4 JOHN RUGGE: We're saying that in the article 28  
5 environment to call oneself an urgent care center would require  
6 a limited CON to have that added to the operating certificate.  
7 In the private practice environment it means receiving  
8 accreditation by a recognized agency, recognized by DOH. And  
9 would not involve a CON.

10

11 WILLIAM STRECK: How do you know if somebody's going to  
12 do this? They don't have to report it? You just have to hope  
13 that you see the sign? I mean, a private group that decides to  
14 call themselves an urgent center? There's no reporting  
15 relationship is their accreditation is separate, right? I'm  
16 just trying to imagine the tracking.

17

18 JOHN RUGGE: There are currently regulations regarding  
19 the word 'clinic' for example. And these may well not be  
20 enforced, but one cannot use the word 'clinic' in describing  
21 yourself unless you are article 28 accredited. So, there is  
22 certainly precedent for establishing naming conventions.  
23 Enforcement I think by the police is unlikely, but if indeed  
24 there is reimbursement to be attached to these centers, I think  
25 that will fall out rather naturally.

1

2 WILLIAM STRECK: Other comments on urgent care?

3

4 DR. STRANGE: One last one I'll make again. On the  
5 article 28 side, what some hospitals have gotten around is using  
6 other names like Fast Track, and really that was urgent care in  
7 another name and it doesn't meet - Fast Track doesn't mean  
8 anything.

9

10 JOHN RUGGE: And again, Dr. Strange, we've tried to wrap  
11 that around by saying "urgent care or equivalents." We have yet  
12 to define it. We're leaving staff to define how many words we  
13 can come up with that would not work. But in the same token, if  
14 somebody wants to have walk-in care, I don't know that we would  
15 want to preclude somebody from saying I'm a physician and you  
16 can come to - OK.

17

18 WILLIAM STRECK: So, confirmed one thing today and that  
19 is based on the number of coats that have been gathered, that  
20 keeping the temperature at this level in the room has kept  
21 everyone alert. So we appreciate of that. We're going to  
22 take an interlude here because we have our quorum threatened by  
23 other schedules, and so that we're going to pause this  
24 discussion and we're going to open discussion the project review  
25 committee for some items that must be addressed expeditiously in

1 view of the quorum consideration, so I'll turn this, the chair  
2 to Mr. Kraut for this discussion. Then we will circle back for  
3 our other items.

4

5 JEFF KRAUT: So I'm only going to call a few applications  
6 where we have recusals and could lose the quorum. OK? Cause if  
7 he leaves the room do I have to still - OK. Let's hope nobody  
8 else go to the bathroom. All right? So this is, I'm going to  
9 call to order the Establishment and Project Review Committee of  
10 November to report out the meeting. The first application I'm  
11 going to call the category two applications which are  
12 recommended approval where we have member recusals but there was  
13 no dissent by the Establishment and Project Review Committee.  
14 The first application is application 132195E, Mt. Sinai  
15 Hospitals Group in New York County. A conflict declared by Dr.  
16 Bhat who is leaving the room. Don't - and come back afterwards.  
17 Dr. Bhat has left the room. Both he and Dr. Martin had  
18 indicated a conflict. Dr. Martin is not here today.

19 This is to establish Mt. Sinai Hospitals Group as the  
20 active parent and co-operator of Mt. Sinai Hospital, Beth Israel  
21 Medical Center, St. Luke's Roosevelt Hospital Center and the New  
22 York Eye and Ear Infirmary. OHSM and the committee recommended  
23 approval with conditions and contingencies, and I so move.

24

25 Second.

1

2 WILLIAM STRECK: There is a motion and a second for this  
3 recommendation. Is there discussion? Hearing no discussion,  
4 those in favor of the motion as proposed, please say aye?

5

6 [Aye.]

7

8 Opposed? Thank you. The motion carries.

9

10 JEFF KRAUT: Can you ask Dr. Bhat to return please. Now  
11 I'll call - I'm going to group the following three applications  
12 where Mr. Fensterman has recused himself. These are  
13 applications 131125E, Ruby Care LLC, d/b/a Emerald North Nursing  
14 and Rehabilitation Center in Erie County. Application 131156E,  
15 Opal Care LLC, d/b/a Emerald South Rehabilitation and Care  
16 Center in Erie County. Application 131264E, South Shore  
17 Rehabilitation LLC, d/b/a South Shore Rehabilitation and Nursing  
18 Center in Nassau County. Mr. Fensterman has established a  
19 conflict on each of these applications and he has left the room.  
20 OHSM and the committee recommends approval with a condition and  
21 a contingency and I so move.

22

23 Second.

24

1 WILLIAM STRECK: A motion and a second. Is there  
2 discussion on the recommendation? Hearing none, those in favor,  
3 Aye?

4  
5 [Aye.]

6  
7 Opposed? The motion carries.

8  
9 JEFF KRAUT: Thank you. Could you ask Mr. Fensterman to  
10 return. And Dr. Bhat's back in the room too.

11 Next I'll call application 132113E, SGRNC LLC, d/b/a the  
12 King David Nursing and Rehabilitation Center in Kings County. A  
13 conflict has been declared by Mr. Fassler. Mr. Fassler has left  
14 the room. This is to establish SGRNC LLC d/b/a the King David  
15 Nursing and Rehabilitation Center as the operator of the  
16 Sephardic Nursing and Rehabilitation Center. OHSM and the  
17 committee recommend approval with condition and contingency and  
18 I so move.

19  
20 Second.

21  
22 WILLIAM STRECK: There's a motion and a second. Is  
23 there discussion? Hearing none, those in favor, aye?

24  
25 [Aye.]

1

2 Opposed? Thank you. The motion carries.

3

4 JEFF KRAUT: Could you ask Mr. Fassler to return.

5 Next, I'm calling a certificate of amendment of the

6 certificate of incorporation for Addiction Research and

7 Treatment Corporation with a name change to Star Treatment and

8 Recovery. A conflict has been declared by Dr. Brown who is

9 leaving the room. And he has left the room.

10 OHSM and the committee has recommended approval, and I so

11 move.

12

13 Second.

14

15 WILLIAM STRECK: Motion and a second. Is there

16 discussion? Hearing none, those in favor, aye?

17

18 [Aye.]

19

20 Opposed? Motion carries.

21

22 JEFF KRAUT: Dr. Brown's returning to the room and I'll

23 now turn over the report to Mr. Robinson.

24

1           PETER ROBINSON:        So we're calling application 112086B,  
2 1504 Richmond LLC, d/b/a Richmond Surgery Center in Richmond  
3 County. A conflict and recusal by Mr. Fensterman and Mr. Kraut  
4 who have both left the room. This is for the establishment and  
5 construction of a freestanding multi-specialty ambulatory  
6 surgery center. The project review committee has recommended a  
7 deferral of this application, and I so move.

8  
9 Second.

10

11           WILLIAM STRECK:        There's a motion and a second. Is  
12 there further discussion? Hearing none, those in favor, aye?

13

14 [Aye.]

15

16 Opposed? Thank you.

17

18           DR. STRANGE:        One abstention please.

19

20           WILLIAM STRECK:        Abstention noted, Dr. Strange. Dr.  
21 Berliner, yes.

22

23           HOWARD BERLINER:       Do we know if the issue in this  
24 application was the need to get a FOIL request from the

1 Department to certain other parties? Do we know if that's been  
2 done?

3

4 PETER ROBINSON: I'll turn to Mr. Abel for that.

5

6 CHARLIE ABEL: The divisions prepared the material  
7 submitted into our FOIL office, but I can't confirm if that  
8 material has made it to the hospitals that have sought that  
9 information.

10

11 WILLIAM STRECK: I must correct myself. With an  
12 abstention the motion does not carry. OK. Now I may correct  
13 myself again. So I'm - urgent care. Right. So, we had a  
14 motion that was made, seconded, and did not carry with majority,  
15 the necessary majority. Are there any other motions to be made?

16

17 JOHN RUGGE: Move to reconsider?

18

19 WILLIAM STRECK: That's the motion. Thank you. OK. So  
20 we'll move to reconsider. Is there a second?

21

22 [Second.]

23

24 Those in favor of the motion to reconsider, please say aye.

25

1 [Aye.]

2

3 Opposed? We may reconsider the motion. The motion is now  
4 being reconsidered. Those in favor of the motion, please say  
5 aye?

6

7 [Aye]

8

9 Opposed? With one abstention. The motion carries. Thank  
10 you.

11 OK. You can get Mr. Kraut back.

12

13 JEFF KRAUT: All right. So I'm going to now go back to  
14 the applications. I'm batching a fair number here. If there's  
15 anything that I call in the batch that any member of the council  
16 wishes to have removed from a batch just indicate so. You don't  
17 have to give a reason, just anybody has that right to remove it  
18 from a batch. But the first two are coming separately.

19 Application 122206C, Griffiths Eye Surgery Center, Oneida  
20 County. Certify a single-specialty ambulatory surgery as multi-  
21 specialty. OHSM and the committee recommends approval with  
22 conditions and contingencies and I so move.

23

24 [Second]

25

1 WILLIAM STRECK: A motion and a second. Discussion?

2 Those in favor, aye?

3

4 [Aye]

5

6 Opposed? Thank you. The motion carries.

7

8 JEFF KRAUT: Application 122281C, Meadowbrook Healthcare,  
9 Clinton County. To construct an extension and certify 87 new  
10 residential healthcare facility beds. OHSM and the committee  
11 recommends approval with conditions and contingencies, and Mr.  
12 Abel will provide an additional clarification, but I so move.

13

14 [Second]

15

16 JEFF KRAUT: Oh, do you want us not to vote until you do  
17 the clarification?

18

19 CHARLIE ABEL: It probably --

20

21 JEFF KRAUT: Yeah, go ahead.

22

23 CHARLIE ABEL: Just point of clarification; in our review  
24 we referenced that upon approval of this project and another  
25 project which was contingently approved for 210 bed nursing home

1 in Clinton County will be withdrawn and we have a contingency to  
2 that point. But just point of clarification that the members of  
3 the operator of Meadowbrook were also members of this 210 bed  
4 nursing home, James Mann which was approved a few years ago with  
5 discussion and consent by the Meadowbrook applicant  
6 representative who was also the representative of the James Mann  
7 application. Upon contingent approval of this application, the  
8 James Mann application project, 071088 will be withdrawn. Just  
9 want to make that clarification.

10

11 WILLIAM STRECK: With that clarification, there is a  
12 motion and a second, with a second on the floor. Is there  
13 further discussion? Hearing none, those in favor of the motion  
14 as proposed with the clarification, please say aye?

15

16 [Aye]

17

18 Opposed? The motion carries. Thank you.

19

20 JEFF KRAUT: I'm now going to move the special surgery  
21 and three Memorial Hospital applications as a batch. All of  
22 these applications, a conflict had been declared by Dr. Boutin-  
23 Foster who is not present at today's meeting. Application  
24 132009C, Hospital for Special Surgery, New York County.  
25 Application 131326C, Memorial Hospital for Cancer in New York

1 County. Application 132037, Memorial Hospital for Cancer and  
2 Allied Diseases in New York County. Application 132077C,  
3 Memorial Hospital for Cancer and Allied Diseases in Suffolk  
4 County. OHSM and the committee recommended approval with  
5 condition and a contingencies, and I so move.

6  
7 [Second]

8  
9 WILLIAM STRECK: A motion and a second. Discussion?  
10 Those in favor, aye?

11  
12 [Aye]

13  
14 Opposed? Thank you. The motion carries.

15  
16 JEFF KRAUT: Relax for a moment while I call the  
17 following batch of about 20 applications. These are  
18 applications recommended for approval with no issues, recusals,  
19 abstentions or interests were indicated.

20 Application 132204E, Mohawk Valley Health System in Oneida  
21 County.

22 Application 131069E, Meadowbrook Endoscopy Center in Nassau  
23 County. This one I'll have to indicate that we are approving it  
24 for a limited life extension of one year from the Public Health

1 and Health Planning approval with a condition and contingencies  
2 that are recommended.

3 Application 131192B, Abaco North LLC, d/b/a The Manhattan  
4 Multi-Specialty Ambulatory Surgery Center.

5 Application 132296B, West Morland ASC, LLC, in Oneida  
6 County.

7 Application 132108B, Niagara ASC, LLC, d/b/a the Ambulatory  
8 Surgery Center of Niagara County.

9 All three of these were recommended for conditional and  
10 contingent approval with an expiration of their operating  
11 certificate five years from the date of issuance is recommended.

12 Application 132011B, Park Med New York, LLC, New York  
13 County.

14 Application 132034B, Brooklyn United Methodist Church  
15 Continuum Services in Kings County.

16 Application 132067B, Elizabethtown LLC, Essex County.

17 Application 131086C, Autumn View Healthcare Facility, LLC,  
18 Erie County.

19 Application 131087E, Brookhaven Healthcare Facility, LLC,  
20 Suffolk County.

21 Application 131088E, Garden Gate Healthcare Facility in  
22 Erie County.

23 Application 131089E, Harris Hill Nursing Facility, LLC, in  
24 Erie County.

1 Application 131090E, North Gate Healthcare Facility,  
2 Niagara County.

3 Application 131091E, Seneca Healthcare Center in Erie  
4 County.

5 All of these applications above was noted  
6 for approval with condition and contingencies.

7 Application 132048E, HCS Certified Homecare New York, Inc.,  
8 d/b/a The Girling Healthcare of New York County. I would note  
9 for the record that the description section incorrectly lists  
10 Bronx County as one of the counties they will continue to serve.  
11 They will continue to serve Kings, New York, and Queens County.  
12 OHSM recommended, and the committee approval with condition and  
13 contingencies.

14 I now have certificate of amendment for the certificate of  
15 incorporation of the East Harlem Council for Human Services,  
16 Inc. Remove a reference to the specified address which a health  
17 related services are going to be provided and remove reference  
18 to it's assumed name. OHSM and the committee recommends  
19 approval.

20 I have a following licensed homecare agency applications.

21 2143L, 2048L, 2022L, 2117L, 2091L, 2094L, 2086L, 2035L,  
22 2023L, 2054L, 2115L, 1917L, 2098L, 2040L, 2111L, 2032L. OHSM  
23 and the committee recommend approval with contingencies, and I  
24 so move that batch.

25

1 [Second]

2

3 WILLIAM STRECK: There's motion and a second. An  
4 absolute affirmation of the batching process, so are there any  
5 discussions on the motion as presented? Certianly.

6

7 DR. PALMER: I have another point of information. Could  
8 he do that again?

9

10 WILLIAM STRECK: So we have a motion and a second  
11 encompassing a wide range of applications. Is there further  
12 discussion? Hearing none, those in favor, aye?

13

14 [Aye]

15

16 Opposed? Thank you. Those are all affirmed.

17

18 JEFF KRAUT: Application 13206E, Hospice of New York,  
19 Queens County. This is to transfer 19.97 percent ownership from  
20 one deceased member to two existing members. An interest had  
21 been declared by Mr. Fassler. We recommend approval with a  
22 contingency and contingency and I so move.

23 [Second]

24

25 JEFF KRAUT: CONDITION AND CONTINGENCY, and I so move.

1 WILLIAM STRECK: Moved and seconded. Discussion?

2 Hearing none, those in favor, aye?

3

4 [Aye]

5

6 Opposed? Carries. Thank you.

7

8 JEFF KRAUT: I'd now like to move the following licensed  
9 healthcare agency applications. 2363L, Livingston County Board  
10 of Supervisors d/b/a Livingston County Department of Health. An  
11 interest had been declared by Ms. Hines.

12 Application 2041L, NEC Care Inc., d/b/a Home Instead Senior  
13 Care for Saratoga, Warren, and Washington Counties. And  
14 interest had been declared by Dr. Rugge.

15 Application 2109L, Neighbors New York, Inc., Warren,  
16 Washington and Saratoga County. An interest had been declared  
17 by Dr. Rugge. OHSM and the committee recommend approval with  
18 contingencies and I so move.

19

20 [Second]

21

22 WILLIAM STRECK: Moved and seconded. Discussion?

23 Hearing none, those in favor, aye?

24

25 [Aye]

1

2 Opposed? Carries.

3

4 JEFF KRAUT: OK. The secretary of the council has  
5 indicated I have included everything that's in our agenda, and I  
6 therefore would like to adjourn the Project Review and  
7 Establishment Committee.

8

9 WILLIAM STRECK: Based entirely on her affirmation of  
10 that fact, we will accept your motion for adjournment. So we  
11 now adjourn that committee. Now, for the council we have work  
12 remaining ahead of us. We also have lunch as an option. So, I  
13 will offer you this alternative that we can break for lunch now,  
14 and return at 1:15, or we can continue the discussion and then  
15 break for lunch. So this is an instance where a hand vote is  
16 going to be required and a majority will rule. So, the option  
17 is continue, probably not past 1:15 in any case, or break now  
18 and return at 1:15. Your choice. So those who prefer to  
19 continue please raise your right hand. This is going to be a  
20 typical vote. One, two, three... and those who, let's see. We  
21 have, once again, one, two, three, four, five, six, seven,  
22 eight. And those who would prefer to break now and go to lunch?  
23 One, two...

24

25 [well, why don't they get their lunch and bring it in]

1

2 WILLIAM STRECK: Go get your lunch and you can join us  
3 while we work. OK, so. Can they get their lunch and come in?

4

5 JEFF KRAUT: Just take five minutes, get lunch and come  
6 in.

7

8 WILLIAM STRECK: OK. We'll take a few minutes, get  
9 lunch, and come back. That's it. Very few minutes. Well,  
10 we'll do it in shifts. We want to move.

11

12 So, we'll move on to the freestanding emergency department  
13 recommendations. And we'll set a goal of 1:30 to complete our  
14 deliberations on this today. Mr. Fensterman.

15

16 HOWARD FENSTERMAN: Yeah, I just, I want to make an  
17 observation, and I think that in view of the discussions we've  
18 had thus far, there are abundance of issues that have been  
19 raised. So it's pretty clear to me that I don't think we're  
20 going to be able to have a vote on this today, if that was our  
21 intention. So I just wanted to state that for the record. I  
22 think there has to be a little bit more vetting. And I don't  
23 think based upon what I heard, we're going to be able to vote on  
24 it today.

25

1 WILLIAM STRECK: OK. Thank you Mr. Fensterman. I  
2 probably should've asked if there were comments before we moved  
3 directly. Are there other comments about the discussion that  
4 has occurred thus far?

5  
6 DR. STRANGE: I'm going to agree with Mr. Fensterman if  
7 you don't mind, because I think this is a evolution in process  
8 that's going to play itself out, I think, over the next year,  
9 and I think there's a lot of questions and a lot of devil in the  
10 details, so to speak that need to be vetted out more than having  
11 a broad construct understanding that some oversight in terms of  
12 using the word for example 'urgent care' may be important but I  
13 think the definition of urgent care and then getting around that  
14 definition especially as it relates for example, to specialty  
15 services like pediatrics and orthopedists or this whole  
16 corporate practice of medicine as it relates to these  
17 freestanding clinics is of real concern, and I think needs to be  
18 vetted in a much more - just needs to be vetted in a much  
19 broader conversation.

20  
21 DR. BHAT: I agree with Mr. Fenstermand and with Dr.  
22 Strange. I think we probably need more time.

23  
24 WILLIAM STRECK: Mr. Fensterman, you had another  
25 comment.

1

2           HOWARD FENSTERMAN: Doc, just one other thing, Mr.  
3 Chairman, I believe also, and I didn't want to go into it today,  
4 there are a myriad of liability issues that I see that I could  
5 go on and on about, but I'm not going to, but I do think at some  
6 point we're going to have to address those, because this could  
7 be - some of the things I've heard could be a planktous  
8 attorney's field day.

9

10           WILLIAM STRECK: Other comments? Dr. Brown.

11

12           DR. BROWN: Chair, without going into detail in terms of  
13 my concerns, I think that we probably are not at the point that  
14 we can make a decision that we all feel that we adequately  
15 informed in so doing. At least for myself personally.

16

17           WILLIAM STRECK: Are there other comments? Well, that  
18 takes the pressure off the next presentation. So, we're not  
19 racing to a deadline nor must there be such a compelling  
20 presentation as to hurl us to such a deadline. So, John, who  
21 will be doing the emergency room department recommendations?

22

23           JOHN RUGE: RaeAnn Vitali. RaeAnn.

24

1           RAEANN VITALI: Yeah, to start out with freestanding  
2 emergency department recommendations, I just want to set a  
3 context for the discussion and for how the recommendations came  
4 about. Currently New York has several providers operating  
5 emergency services outside of a traditional hospital environment  
6 and so in coming up with these recommendations, several  
7 different scenarios were considered and discussed at length.  
8 The first being when a provider wishes to establish emergency  
9 services outside of a hospital environment due to a need,  
10 perceived need for emergency services in an area. The second is  
11 when an existing full-service hospital decides to downsize their  
12 services, but just retain the emergency services only. And a  
13 third situation where one hospital might close, and another  
14 provider would step in and in order to maintain some emergency  
15 services would take over emergency services in that same site.  
16 So as we go through these, just keep in mind that those three  
17 different scenarios were discussed in determining those  
18 recommendations.

19           As in the previous presentations we wanted to establish a  
20 naming convention for these entities and a definition, and the  
21 name hospital-sponsored off-campus ED was proposed as the name  
22 to be used in regulation for an emergency department that is  
23 hospital-owned and geographically removed from a hospital  
24 campus. And this is in line with the model that is supported by  
25 CMS, but since that is quite a mouthful the committee decided

1 that latitude would be given for the facility name that's held  
2 out to the public and recommended that the name of the hospital  
3 that owns the facility be used in the name along with the words  
4 satellite emergency department.

5 In terms of standards and scope of services, hospital-  
6 sponsored off-campus ED would be held to the same standards and  
7 requirements as a hospital-based ED with regard to the training  
8 of the providers, the staffing required, and the array of  
9 services provided. The general understanding that an off-campus  
10 ED may not be able to handle the full scope of trauma and life  
11 threatening conditions that a hospital-based ED would, and in  
12 those cases would need to possibly transfer patients that  
13 required surgery and patient admission and things like that.  
14 Off-campus EDs would need to demonstrate compliance with CMS  
15 hospital conditions of participation as well.

16 In terms of hours of operation, typically hours of  
17 operation would be 24/7. The committee decided that part-time  
18 operation would be allowed subject to CON approval with minimum  
19 operating hours of at least 12 hours a day, and consideration  
20 made for the distance to the nearest hospital-based ED when  
21 part-time operation is allowed.

22 This slide you see here is the same as in the previous two  
23 presentations in terms of connecting patients who present to an  
24 off-campus ED back with primary care provider.

1           In terms of disclosures to consumers, an off-campus ED  
2 would be required to have clear nomenclature and signage and a  
3 communication plan for communicating not only to the public, but  
4 also with regional emergency medical services about their  
5 capacity and their hours of operation to ensure that that is  
6 clear to the community.

7           In terms of patient safety and quality requirements, all  
8 off-campus EDs would need to have the capability of receiving  
9 ground ambulance patients and treating them, or if patient  
10 presented to the off-campus ED with a condition that required a  
11 higher level of care there would need to be EMS protocols in  
12 place for providing timely transfer for those patients to the  
13 nearest hospital-based ED.

14           With regard to information technology, this also is the  
15 same as the previous two presentations. I'll turn this over to  
16 Jeff.

17  
18           JEFF DENNISON: Freestanding EDs would require some  
19 regulatory amendments in various different areas including  
20 accreditation, definition, need, and standards or requirements.  
21 As far as accreditation goes, we would require accreditation  
22 from a New York State recognized accrediting body. If a  
23 hospital loses it's accreditation the hospital and accrediting  
24 body would be required to report such changes to the Department  
25 within a timely fashion and if the hospital is not accredited by

1 a third party then as we do now with hospitals and as is  
2 referenced in our regulations, the Department then would do the  
3 survey and certification. And the accrediting review would  
4 include a review of the freestanding ED which would be of course  
5 off the hospital campus. This would pertain specifically to  
6 section 720.1 of Title 10 and then that would pretty much be an  
7 addendum or an addition to the existing accreditation  
8 regulations that are currently in place that address hospital  
9 requirements.

10 As far as the definition goes that would be Title 10,  
11 section 702 which defines hospital-sponsored off-campus  
12 emergency departments. It would restrict ownership only to  
13 hospitals. No other entity would be allowed to own a  
14 freestanding ED. Full CON would be required which would include  
15 PHHPC review for a new freestanding ED. Emergency approval by  
16 the Commissioner may be allowed in instances where there might  
17 be a hospital closing and it might be sudden and other resources  
18 could not be garnered and put into place in a timely fashion and  
19 the emergency approval part would have to coincide with section  
20 401.2.

21 And a need methodology for hospital-sponsored off-campus  
22 emergency departments would need to be articulated in section  
23 709, and as far as the requirements go which are in 405.19 we  
24 would have to update and revise the section for emergency  
25 services to include requirements that are specific to hospital-

1 sponsored off-campus EDs. This would include the scope of  
2 service, minimum hours of operation, criteria for part-time  
3 operation, capacity to receive ground ambulance patients and  
4 transfer and referral protocols. We also wanted to address the  
5 considerations that would be in place for approval of a part-  
6 time operation. And the criteria would also be in section  
7 405.19 which deals specifically with emergency services.  
8 Section 709 would include specific need criteria. Consideration  
9 will be made for the local and unique circumstances  
10 necessitating part-time operation in addition to what would be  
11 in the regulation. Full CON review would be required for a new  
12 off-campus ED that will operate part-time and we would similarly  
13 require a full CON review for an existing full-time freestanding  
14 ED that wished to reduce it's hours. And to reiterate emergency  
15 approval by the Commissioner may be allowed in instances where a  
16 hospital closing was precipitous and did not allow enough time  
17 to garner resources adequate to fill the voice consistent with  
18 section 401.2. That's it.

19

20 WILLIAM STRECK: Are there now comments - Dr. Berliner.

21

22 HOWARD BERLINER: Would these facilities be required to  
23 abide by MTALA?

24

25 JOHN RUGGE: Yes.

1

2           RAEANN VITALI: Yes. We can add that for clarification.

3

4           WILLIAM STRECK: I'm sorry, go ahead.

5

6           HOWARD BERLINER: So, well, I'm a little bit confused  
7 because I thought there was a distinction between a hospital-  
8 based ED and then something else we were talking about which was  
9 the part-time ED. Is that just a -

10

11           JOHN RUGGE: Well, there was consideration as you know of  
12 having the provision or the possibility subject to full CON or  
13 emergency action by the Commissioner a full-time off-campus ED  
14 going part-time.

15

16           HOWARD BERLINER: So that's still on the table? Or off?

17

18           JOHN RUGGE: Yes.

19

20           HOWARD BERLINER: So what's the distinction between -  
21 that would fit into this set of regulations?

22

23           JOHN RUGGE: yeah, part-time ED consistent with CMS  
24 regulations could operate according to these provisions no less  
25 than 12 hours per day, seven days per week, would be subject to

1 MTALA so all patients would need to be accepted including  
2 Medicaid and uninsured, would be able to receive ambulances and  
3 would require an umbilical tie to the on-campus ED for oversight  
4 and physician supervision. Those are distinguishing marks as  
5 compared to an alternative which would be an urgent care center  
6 designation.

7

8 HOWARD BERLINER: Right, that's actually what I was just  
9 going to ask. Why not just call it an urgent care center and be  
10 less confusing to the public about everything.

11

12 JOHN RUGGE: Because of those three conditions.

13

14 JEFF KRAUT: Um, I think it's fair to say we had a  
15 spirited conversation about the appropriateness of a part-time  
16 ED in general, and there's a lot of pros and cons on that but  
17 recognizing it is in the CMS regulations and this is a, you  
18 know, it is a fact and we probably will have two of these coming  
19 before us in the not-to-distant future. The thing that I  
20 objected to was the requirement that if you had already gone  
21 through a CON and had been approved for a full time ED and you  
22 wish now to make the case to go to a part-time ED, whether or  
23 not you agree that there should be or not, but if the rules  
24 permit it that that should not require a full CON coming into  
25 this room, the public hearing, and I use the example that we

1 don't require that now when you close a service in a hospital.  
2 This is a service reduction, and what we require is the filing  
3 of a closure plan or, and you file it with the Department of  
4 Health, they review it, you have to file maybe a limited review,  
5 and it gets processed. And I just question the wisdom of  
6 requiring just this reduction to come into a full review  
7 environment. Typically these things occur, there may be other  
8 circumstances. It's part of the reason I also was emphatic that  
9 the Commissioner had the right to say you're a freestanding ED  
10 overnight if a hospital was in eminent danger of closing because  
11 you wanted to make sure that continuity and access remained in  
12 that community, that it didn't close down. Those are the best  
13 things. So, that was my perspective. I'm still uncomfortable  
14 with requiring a full CON for, to go from full-time to part-  
15 time. I think it's an administrative action the Department  
16 should review on a case-by-case basis.

17

18 JOHN RUGGE: I wouldn't try to provide a justification,  
19 but I think there is an explanation and that is a number of  
20 committee members had some level of reservation about whether a  
21 part-time ER is an oxymoron. How can you be part-time and yet be  
22 capable of doing full-time emergency services.

23

24 JEFF KRAUT: I acknowledge, that's a separate - I  
25 acknowledge that's a separate conversation.

1

2           JOHN RUGGE:       I think that's the connection of it was  
3 made, and that is well, there may indeed be a circumstance in  
4 one community or another especially those that are deeply rural  
5 that can only stay open 12 hours.  If they're going to stay open  
6 12 hours having MTALA, having the connection to ER, having the  
7 ambulance is important, but because of those reservations a  
8 feeling of well, perhaps, again, at least there should be a  
9 review in individual case by the council and that would entail a  
10 full CON.  So that's the explanation.  I'm not sure I would -

11

12           JEFF KRAUT:       I agree.  That is correct.  I just don't  
13 agree.  I don't think for the reasons I've stated, I really  
14 think this thing should be done administratively.  That's all.

15

16           WILLIAM STRECK:       Dr. Bhat.  You had a comment?

17

18           DR. BHAT:  These freestanding EDs, they still have to be by  
19 a hospital.  No private individuals cannot just  
20 somebody                       coming in and saying we are going to  
21 open an ED?

22

23           JOHN RUGGE:       That's right.  Yes.

24

25           PETER ROBINSON:       Dr. Streck...

1

2 WILLIAM STRECK: Yes, Mr. Robinson.

3

4 PETER ROBINSON: I just wanted to sort of build a little  
5 bit on Mr. Kraut's point and just address the rationale broadly  
6 for freestanding EDs so that we don't create the presumption  
7 that we want to become Texas and have a proliferation of these  
8 entities in the State. I think the major thrust of how these  
9 would evolve would be in settings where hospitals were closing  
10 and we were converting to a set of ambulatory services of which  
11 a freestanding ED is likely to be a core component, as opposed  
12 to thinking that we're expecting De novo applications. I'm not  
13 saying there can't be any, but I would suggest that the  
14 threshold and the review for something new that didn't exist  
15 before, rather than a restructuring in, for example, a  
16 downsizing hospital weren't the predominant thrust of where we  
17 were headed with this.

18

19 WILLIAM STRECK: I would have a question having I think  
20 done this the only time in the State in the last 40 years, there  
21 are some questions that we would need to be sure about, and they  
22 mainly relate to CMS, and that would be first of all, you  
23 mentioned separate accrediting body, but if this a hospital's  
24 freestanding ED, the hospital's going to be included in a Joint  
25 Commission review. So I don't think we need a freestanding, I

1 mean, an independent accreditation. The hospital accrediting  
2 group will take care of that. The 35 mile limit for Medicare on  
3 reimbursement would be a question in terms of a hospital being  
4 able to bill Part A because if you're within, it depends on  
5 whether they classify an emergency room as a clinic, and exactly  
6 how they would do that reimbursement would need to be clarified.  
7 Because if you're outside the 35 mile limit for a clinic, then  
8 you cannot bill Medicare Part A charges, the hospital cannot  
9 bill Medicare Part A charges. And let's see... well, those are  
10 two questions that I think - oh, and the third is I presume that  
11 the rates for the ED would be the same as the rates for the  
12 hospital, and is that a correct presumption? Because the cost  
13 base for a small freestanding ED maybe different. These are  
14 just logistical questions that would have a lot of impact on the  
15 financial sustainability of the freestanding ED.

16

17 JOHN RUGGE: The committee, once again, did not consider  
18 reimbursement. Simply looked at the categories of service that  
19 we thought could be appropriate leaving to others in the future  
20 to assign reimbursement levels.

21

22 WILLIAM STRECK: I think that's fine, but as a model,  
23 but the reimbursement's going to determine the feasibility.  
24 Charlie?

25

1 CHARLIE ABEL: Speaking to the reimbursement my expectation  
2 is that, and I haven't done a lot of research into this for  
3 satellite EDs, but my expectation is that the reimbursement  
4 would be the same as reimbursement in the host hospital ED. On  
5 the 35 mile piece, you're talking strictly with critical access  
6 hospitals, I'm presuming?

7

8 WILLIAM STRECK: No, any hospital that operates an  
9 article 28 clinic in New York State, you can operate an article  
10 28 clinic, but if the clinic is beyond 35 miles of the home base  
11 it cannot bill Medicare as a hospital-based clinic.

12

13 CHARLIE ABEL: You know what? I did not know that.

14

15 WILLIAM STRECK: Well, that's a first at the meeting  
16 here, but now we have to - it is a fact and it has a lot of  
17 implications on this kind of model. But depend on whether it's  
18 considered an ED a clinic.

19

20 RUTH LESLIE: And I'd like to respond to that if I might,  
21 it's Ruth Leslie. I don't, I do not believe that that rule  
22 would come into play here, at least as I understand this to be  
23 because if you set up a provider-based off-campus ED, it is  
24 considered a part of the hospital, the main site hospital. So,  
25 this CMS doesn't view this as being a clinic, per se, they

1 literally view it as a hospital that has two sites, or three, or  
2 however many sites the, the - because we would tuck that under  
3 the hospital's primary billing number. And so I would just be a  
4 one, a piece of the hospital that's off-campus.

5

6 WILLIAM STRECK: But if the clinic's more than 35 miles,  
7 even though it's under the hospital's billing number, it's  
8 different.

9

10 RUTH LESLIE: We can go ahead and you know, try to clarify  
11 that with CMS but I'm not sure that that applies. What I do  
12 know in my conversations with CMS is that there is a  
13 differential in reimbursement whether you are a full-time 24/7  
14 provider-based off-campus ED and a part-time. So there's a  
15 differential in billing. I don't pretend to know what it is  
16 exactly and what those numbers are, but I do know that there is  
17 a difference.

18

19 WILLIAM STRECK: Dr. Berliner then Dr. Bhat.

20

21 HOWARD BERLINER: I'm trying to think of the  
22 circumstances under which a hospital that wanted to convert to  
23 fewer hours of operation for an emergency room would want to  
24 have the emergency room called and emergency room and be subject

1 to MTALA and all the other regulations rather than just call it  
2 an urgent care center.

3

4 JOHN RUGGE: There are two grounds. One is I would  
5 presume the reimbursement would be higher for an ED than for an  
6 urgent care center, and secondly I think there are perceptual  
7 issues that as a, as we go from shrinking hospital - giving up  
8 inpatient beds to become a freestanding ED and then going from a  
9 full-time ED to a part-time ED, there's a matter of community  
10 acceptance, and also as a part matter the ability for  
11 ambulances to go to that center and not have burnout on the part  
12 of the volunteer rescue squads.

13

14 HOWARD BERLINER: Well, I mean, the perceptual, I mean,  
15 issue, I mean, I think is just a little bit absurd. People, I  
16 mean, we're quibbling over you know, how will people interpret  
17 different facets of primary care and will they understand the  
18 difference between urgent care and limited care and things like  
19 that. If there's one thing that everyone at least in this  
20 country understands it's what an emergency room is. So, the  
21 notion of a part-time emergency room I think is perceptually, is  
22 really problematic. It's like, I have to disagree with Charlie,  
23 and I think if you were going to have a limited hour emergency  
24 room, you're not going to be getting the same reimbursement  
25 rates as a full-time emergency room because in a full-time one,

1 in theory, you're being reimbursed for the 24-hour capacity and  
2 the full-time staffing and stuff like that. So, I think it  
3 would be a lower reimbursement rate, and I think in many cases  
4 you know, in Virginia, in a number of states in suburban areas  
5 there are hospitals that have set up freestanding emergency  
6 rooms, you know, but use that as a way of essentially gaining  
7 patient admissions at a later date. Only done in suburban areas  
8 that are well-insured, and things like that.

9

10 JOHN RUGGE: Right, right.

11

12 HOWARD BERLINER: So, the MTALA provision that I think is  
13 kind of critical, but you know, what does it matter if the  
14 place accepts them, is under the MTALA provisions if it's not  
15 open when you need it, and you're going to have to go someplace  
16 else anyway? It's a false premise.

17

18 JOHN RUGGE: Yeah, I think clearly -

19

20 HOWARD BERLINER: All this to say that I just want my  
21 audience of people in New York State and the international  
22 audience that watches this forum to know that I think this is a  
23 bad idea. We should not be recommending that emergency rooms  
24 operate for less than 24 hours.

25

1           JOHN RUGGE:        Thereby giving away the one negative vote.  
2   The - I think clearly in metropolitan New York will be  
3   misleading and dangerous to have a part-time ED. I think in a  
4   small town, let me pick Ticonderoga, where there is one patient  
5   per night going to that ED and giving up the ability for  
6   ambulances to come and the MTALA restrictions would be  
7   deleterious, and in a small town like this it seems like all you  
8   have to do is whisper for your neighbor once what the hours are  
9   and everybody knows it. So I think there's a very different  
10  level of perceptual awareness in deeply rural areas than more  
11  anonymous setting.

12

13           HOWARD BERLINER:        But just as a rejoinder to that, if I'm  
14  the one person who needs that service in the middle of the  
15  night, I'm not going to be real happy that the State Department  
16  of Health has said this is an OK thing to do. And more than  
17  that, I believe that as a tax payer in this state that if, in  
18  fact, institutions can't support their emergency rooms, then the  
19  State Department of Health has an obligation to find a way to  
20  help them do it other than saying OK, you don't have to be open  
21  for 24 hours. I think that's far more important than a lot of  
22  the other activities to which funding is given. But again,  
23  personal.

24

1 JOHN RUGGE: Not to go on and on but the most common  
2 diagnosis in the middle of the night is a sore throat. These  
3 are not highly emergent cases coming in at two in the morning.  
4

5 WILLIAM STRECK: Dr. Bhat, did you have a comment?  
6

7 DR. BHAT: ...35 mile rule, I never heard of it, but it's very  
8 interesting. One of my concerns, if it would allow hospitals to  
9 have a part-time emergency rooms, what is it that's going to be  
10 preventing most of these big mega hospitals that you have in  
11 Manhattan from going in and putting up a part-time emergency  
12 room in Brooklyn and destabilizing the hospitals that are  
13 already struggling there? And they could probably suck up all  
14 the good things like orthopedics and something else going into  
15 their own hospitals.  
16

17 JOHN RUGGE: The roadblock would be the wisdom and  
18 judgment of this council. I mean, this is the rationale for  
19 having a full CON so in individual circumstance unless there was  
20 a clear rationale not only would require departmental approval  
21 but also council approval.  
22

23 DR. BHAT: ...means if you're in Brooklyn I  
24 think only people that can have part-time emergency rooms are  
25 Brooklyn hospitals?

1

2           JOHN RUGGE:       No, we wouldn't expect any part-time hos -  
3 any part-time EDs in Brooklyn.

4

5 [inaudible]

6

7           DR. BHAT:...what's happening in Manhattan. Manhattan  
8 hospitals are encroaching into Brooklyn, Queens, they're even  
9 going into Suffolk County. And the only reason why they are  
10 there is because they probably are going to be getting in the  
11 high paying (DIGs) -- probably bringing it back to Manhattan.

12

13          JOHN RUGGE:       Right, right.

14

15          WILLIAM STRECK:     Dr. Gutierrez.

16

17          ANGEL GUTIERREZ:    Yes. Listening to Dr. Berliner's  
18 comments, I'd like to reflect a little on that because having  
19 lived and practiced in a small town that saw it's emergency room  
20 and it's hospitals closed, I lived that situation. I think that  
21 there is a semantic issue that needs to be at some point  
22 addressed. You don't need to turn very many nobs in your  
23 television or remote control if you will, to see what our armed  
24 forces are doing in Afghanistan. They are providing outstanding  
25 emergency services without emergency rooms. And we need to

1 somehow move away from latching on to the concept that good  
2 emergency services can be provided only in an emergency room.  
3 Emergency rooms in places like Salamanca New York are obsolete.  
4 They cannot survive. And you cannot keep an emergency room open  
5 24 hours a day because you have the eventual sore throat that  
6 may show at two o'clock in the morning. I don't know how we're  
7 going to get around this conundrum. But something needs to be  
8 done. I certainly do not see how small communities in rural  
9 areas could continue to support emergency rooms the way they  
10 have been supported until this point.

11

12 WILLIAM STRECK: Dr. Brown.

13

14 DR. BROWN: I have one question; I just want to be  
15 clear. Was the intent here to allow hospitals that have  
16 emergency rooms already, 24/7, to allow them to have a route to  
17 in fact go to less than 24/7?

18

19 JOHN RUGGE: Yes.

20

21 DR. BROWN: Was it, was there also consideration to  
22 allow hospitals who had full-time emergency rooms to have a  
23 part-time emergency room at another site?

24

1           JOHN RUGGE:       I think - bit of mind reading - there was no  
2   expectation of opening a new ED on a part-time basis. This is  
3   to accommodate communities faced with the possible loss of their  
4   ED and having a solution to keep those facilities open on a  
5   part-time basis.

6  
7           DR. BROWN:       Then based on that I must confess, I have  
8   the same concern Mr. Kraut had about why are we doing this to  
9   have, allow for a facility to reduce their size of operations  
10  because it's their business sense that they cannot operate a  
11  full-time emergency room? I have a little problem with that.

12  
13          WILLIAM STRECK:    So, we're approaching the self-imposed  
14  deadline for this discussion. But, what I would like to suggest  
15  is as follows; that we have offered a series of observations on  
16  all three recommendations. The group still has to write the  
17  definitive report, and so has been afforded the, I think, the  
18  pretty broad-based opinion and counsel from this council and we  
19  have another meeting in February, so I would ask John and I  
20  think you probably have meetings again, what should we expect in  
21  February in terms of a response to these issues, and how would  
22  you envision our coming to be supportive of this very, very  
23  impressive effort?

24

1           JOHN RUGGE:       At this point we are on - are scheduling a  
2 meeting on January 7, Tuesday January 7 in New York at 10 a.m.  
3 to reconvene. Obviously both staff and the committee will take  
4 into consideration all the comments and perceptions that have  
5 been expressed here today. I think the bigger question is how to  
6 proceed with this big a bundle of proposals with this group? It  
7 has taken our committee 10 months and many, many meetings,  
8 although not endless number of meetings, and the open question  
9 is will this council in another meeting or two or three or six,  
10 how many will be required to come to consensus and work through  
11 these issues? Raise the question, do we need a special meeting  
12 or should members of the council make a special effort to attend  
13 the committee meetings so that we can begin to work through and  
14 develop that consensus? I'm concerned. And again, I think this  
15 is a new level of complexity that we as a council are trying to  
16 deal with. I mean, this is not a one by one review of an  
17 application or one by one reg. This is looking at how do we go  
18 about redefining the delivery structure of healthcare in the  
19 State? A major enterprise. But also one that cannot - we  
20 cannot wait years for this because the world is overtaking us,  
21 and it should be. We have lots of innovation going, and the  
22 degree is to what - in what way can we intervene in a way that  
23 will be effective and will spare us complications of failing to  
24 address these issues? So I'm not sure how best to construct a  
25 time table. Howard.

1

2           HOWARD BERLINER:       Some of the - sorry Dr. Streck - some  
3 of the recommendations will require statutory change, right?

4

5           JOHN RUGGE:       Yes.

6

7           HOWARD BERLINER:       And some will just require regulatory  
8 change. We would get to approve the regulatory change through  
9 the codes committee?

10

11           JOHN RUGGE:       Is that - um, yes. I'm seeing nods of heads.  
12 In addition, I think the Governor will be hesitant to develop  
13 legislation and propose in the face of uncertainty on the part  
14 of this council. I mean, we are a gubernatorial council and we -  
15 and our advice and council is taking it extremely seriously.  
16 And yet, there is a felt need to look at these developments and  
17 respond in a reasonable timeframe.

18

19           WILLIAM STRECK:       I'm going to suggest that we do it this  
20 way; that John's committee continue it's work, prepare it's  
21 work; that we take an inventory of the items that were raised  
22 today; provide next to that those items, explanations and  
23 discussions, and bring those back to the group. I think the  
24 core element of the enterprise is not being questions, but some  
25 specifics and the, some important specifics need more detail or

1 a little more clarification. So, why don't we bring back the  
2 next iteration ---

3

4 JOHN RUGGE: I welcome that as a response. But I think  
5 if that's the consensus of the committee that we're going in the  
6 right direction, this is an important series of developments  
7 that we're undertaking, and each one of the points that have  
8 been raised will be - have been recorded will be reconsidered by  
9 the committee and will be elaborated upon in a narrative so that  
10 we can better capture than we can in a few bullets and a slide  
11 show. Is that a fair -

12

13 WILLIAM STRECK: Yes, yes I think you could modify the  
14 narrative based on it too. Just to be clear.

15

16 JOHN RUGGE: Absolutely.

17

18 DR. STRANGE: I understand this is an ambulatory strategy,  
19 there are some major differences between the urgent - between  
20 the medi clinics, the pharmacy clinics first and this emergency  
21 department discussion. It may be a thought, and again I  
22 understand it just prolongs it a little bit that for example,  
23 the emergency department discussion be taken out as a separate  
24 entity, discuss, voted on and moved on, where the other two  
25 urgi-care/medi-clinics really go closer together. Not that this

1 doesn't follow, but this, I think falls under having to change  
2 maybe some more codes and regulations and in some ways may be  
3 easier at the end of the day to vote on despite some of the  
4 concerns here at the end, as opposed to the other two where I  
5 think there's going to be - in my opinion - there may be just  
6 more discussion about how to get to the end result. So, again,  
7 my impression was that this may be an easier one to tackle  
8 first, understanding some of the recent, last concerns, and then  
9 get to the other two where I think we're going to spend a  
10 considerable amount of more time on. Just a thought.

11

12 JOHN RUGGE: I think those are very fair points. By the  
13 same token there are a number of applications about to come  
14 before the Health Department, and as it stands, there will be  
15 action, and the action will be taken by the Commissioner based  
16 on best judgment and that only means that council will not have  
17 had the opportunity to weigh in and develop the guidelines. No  
18 lines on the tennis court that we are drawing. Life will go on.  
19 And so the question is to what degree do we feel responsible to  
20 develop a program in concert with the efforts made up till now.

21

22 WILLIAM STRECK: Well, I think we feel collectively  
23 we're willing to assume the responsibility after we have  
24 discussed it to the point where we're comfortable. I think  
25 that's where we are as a group. And I think that next stage

1 will be our next meeting. The way we orchestrate our  
2 discussions may be an important consideration. There may be  
3 more effective ways to orchestrate it. I think certainly  
4 preparation by looking at any information provided particularly  
5 that information pertinent to points that have been raised by  
6 members of the group will facilitate our discussion, and so I  
7 think at this point I would ask if it would be acceptable to  
8 conclude today's discussion anticipating that we will receive  
9 more information. There will be more work. Those who can, can  
10 attend the meeting and we'll return in February with this on our  
11 agenda again. Is that acceptable to the group?

12

13 JOHN RUGGE: We're good. Yes.

14

15 WILLIAM STRECK: All right. That concludes that report.  
16 we've done project review. There are no other reports. So a  
17 motion for adjournment is in order. Made. Seconded. Any  
18 comments? We are adjourned.

19

20 [end of audio]

21

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

**Minutes**  
**January 7, 2014**

Dr. William Streck, Chair of the Public Health and Health Planning Council presided over the January 7, 2014 Special Meeting of the Public Health and Health Planning Council at the following locations:

- New York State Department of Health Offices at 90 Church Street, 4<sup>th</sup> Floor, Rooms 4A & 4B, NYC
- New York State Department of Health Offices at 584 Delaware Avenue, 2nd Floor Training Video Conference Room, Buffalo, NY 14202
- New York State Department of Health Offices, Corning Tower, 14<sup>th</sup> Floor, CR#1, Albany, NY 12237
- New York State Department of Health Offices, Triangle Building, 335 East Main Street, Rochester 4th Floor, NY 14604

**COUNCIL MEMBERS PRESENT:**

Dr. William Streck, Chair - Albany  
Dr. Jodumatt Bhat – NYC  
Dr. Howard Berliner - NYC  
Mr. Christopher Booth – Rochester  
Dr. Jo Ivey Boufford - NYC  
Dr. Lawrence Brown – NYC  
Mr. Michael Fassler - NYC  
Mr. Howard Fensterman - NYC  
Dr. Carla Boutin-Foster – NYC  
Mr. Arthur Levin - NYC  
Dr. Ellen Grant – Buffalo  
Dr. Angel Gutiérrez - Buffalo  
Ms. Victoria Hines -Rochester  
Mr. Jeffrey Kraut - NYC

Dr. Glenn Martin - NYC  
Dr. John Palmer - NYC  
Ms. Ellen Rautenberg – NYC  
Mr. Peter Robinson – Rochester  
Dr. John Ruge – Albany  
Dr. Theodore Strange - NYC  
Commissioner Shah – Albany

**DEPARTMENT OF HEALTH STAFF PRESENT:**

Mr. Charles Abel  
Ms. Nancy Agard  
Mr. Alex Damiani  
Mr. Christopher Delker  
Mr. James Dering  
Ms. Alehandra Diaz  
Ms. Sandy Haff  
Ms. Colleen Leonard  
Ms. Lisa McMurdo  
Ms. Joan Cleary Miron

Ms. Sylvia Pirani  
Mr. Jeffrey Rothman  
Mr. Michael Stone  
Ms. Lisa Thomson  
Ms. Lisa Ullman  
Ms. Rae Ann Vitale  
Ms. Karen Westervelt

## **INTRODUCTION:**

Dr. Streck called the meeting to order and introduced Dr. Rugge to present the Health Planning Committee's Report.

## **HEALTH PLANNING COMMITTEE REPORT**

Dr. Rugge explained that there is a list of recommendations of the Committee with reference to what would require regulatory action and what would require action by the legislature. Dr. Rugge introduced Dr. Shah.

Dr. Shah stated that there is an opportunity to shape the future of what these ambulatory care centers look like, the services that they provide the kind of care that patients can expect, and the role of these facilities in our evolving healthcare delivery system, that's becoming more integrated and more value-based. At the same time existing ambulatory care facilities are adopting new models of care such as the patient-centered medical home. Evolving models such as this PCMH model will guarantee high quality care for all patients and help us deal with some of our most challenging patients, among patients with multiple chronic conditions. The Department wants the same quality of care provided in all ambulatory care settings and attention to population health management. The management of high risk patients, rapid and judicious access to high quality specialty care, and integrated behavioral health therapy. The State and nation is trying to achieve the Triple Aim. If these goals are met, we can achieve that Triple Aim of improved population health, better care, and lower cost.

Dr. Shah stated that the recommendations will clarify exactly what these facilities are, what they provide, what services they will offer and not offer, and the measures that they have to take to ensure high quality care, patient safety, and even the signage that's required in these facilities. The recommendations are being presented so there is less confusion for the citizens of New York, to make sure that the operators of these ambulatory care facilities know they must report patient data, link in to regional and state health information technology and coordinate services across all the multiple state agencies. Most of all, we're doing it for the people of New York, so that all New Yorkers know what they're getting when they step into one of these outpatient settings, regardless of whether they're in Buffalo, Long Island, or the Adirondacks. Dr. Shah said that we are forging new ground and he appreciates all of your efforts in helping the Department advance the opportunities for outpatient care for all New Yorkers.

Dr. Rugge made a motion to approve the recommendations presented to the Council. Ms. Rautenberg seconded the motion.

### **A. Limited Services Clinics (Retail Clinics)**

There was discussion and questions from the members on the proposed Limited Services Clinics recommendations. Dr. Berliner made a motion to Require staff of Limited Services Clinics to participate in a State-designed and approved training program to support stabilization of the medical home. Training would include information to help staff understand the primary care system and how to direct patients through it. Dr. Levin seconded the motion. The motion carried with 17 affirmative votes. Please see pages 23 through 26 of the attached transcript.

## B. Urgent Care

Dr. Boufford made a motion for a minor edit for clarification to the Urgent Care Recommendation #3: Approval to be Called “Urgent Care” Provider to be edited to the clause “OR they can become an Article 28 through a full CON review” should be removed. Mr. Kraut seconded the edit. Dr. Streck agreed to the grammatical correction. Please see pages 37 through 41 of the attached transcript.

Dr. Berliner made a motion for an amendment to Urgent Care Recommendation #6: Stabilization of the Medical Home to Require staff of Urgent Care providers to participate in a State-designed and approved training program to support stabilization of the medical home. Training would include information to help staff understand the primary care system and how to direct patients through it. The motion was seconded by Mr. Levin. The motion carried with 19 affirmative votes. Please see pages 42 through 44 of the attached transcript.

## C. Freestanding Emergency Departments

Dr. Boufford motioned for an amendment to the Freestanding Emergency Department Recommendation #1: Establish Naming Convention and Definition Modify language from “It is recommended that Hospital-Sponsored Off-Campus EDs use...” to “Hospital-Sponsored Off-Campus EDs shall use...”. The motion was seconded by Mr. Levin. The motion passed with 19 votes. Please see pages 48 and 49 of the attached transcript.

Dr. Berliner motioned for an amendment to the Freestanding Emergency Department Recommendation #3: Define Hours of Operation to Remove 2<sup>nd</sup> bullet entirely to make no mention of the possibility of part-time operation of an emergency room. Dr. Strange seconded the motion. The discussion by the Council members centered around the argument that having some amount of emergency services available in a community may be preferred rather than having a hospital close entirely leaving the community without emergency care. Some communities, particularly in rural upstate, may not have the volume or resources to support full-time operation of an emergency department. Dr. Ruge clarified that the intent of the recommendation is that emergency departments will typically operate 24/7, except in cases where, due to unique and local circumstances, the Commissioner of Health grants an exception for part-time operation. The motion did not carry. Please see pages 51 through 64 of the attached transcript.

Mr. Fensterman requested a minor edit for clarification Mr. Fensterman under the Freestanding Emergency Department Recommendation #3: Define Hours of Operation to include in 2<sup>nd</sup> bullet the phrase “seven days per week” to express the intent that part-time free standing emergency departments must be in operation every day of the week. There was not vote taken and Dr. Ruge agreed to grammatical correction. Please see pages 59-60 of the transcript.

Mr. Kraut proposed an amendment proposed by Mr. Kraut under the Freestanding Emergency Department Recommendation #3: Define Hours of Operation to modify 3<sup>rd</sup> and 4<sup>th</sup> bullets to indicate that approval for full-time, or approval of a downgrade from full-time to part-time, will require administrative rather than full CON review. The motion was seconded by Mr. Fassler. A request was made by Mr. Levin and seconded by Mr. Fassler to separate the motion into two separate motions so that full-time operation and part-time operation would be

considered separately. Mr. Abel clarified that existing regulations require only a limited review when a hospital wishes to decertify all services except for the emergency department, effectively creating a free standing ED. Furthermore, an administrative review is required when a hospital is closing and another hospital proposes to operate an emergency department at that site as a way of preserving emergency services in that community. Similarly, when a brand new facility is proposed by an existing hospital that wishes to operate an emergency department at an off-campus location, that approval can be granted to the hospital through administrative review and the off-campus ED is considered a hospital extension site. Mr. Levin suggested that the 3<sup>rd</sup> and 4<sup>th</sup> bullets under discussion should be removed from Recommendation #3 which discusses hours of operation and would be more appropriately placed under Recommendation #4 which discusses need methodology and approval criteria. Mr. Robinson expressed concern about the potential for predatory practices through establishment of new free standing emergency department facilities in close proximity to other hospitals. Mr. Robinson sought clarification on the proposed amendments to verify that the motions made were intended to focus on situations in which existing providers would take over operations at existing emergency department sites. Mr. Kraut, seconded by Mr. Fassler, clarified the first proposed amendment stating “If an existing provider takes over an existing emergency department of another hospital, creating a satellite ED, they may do so through administrative CON review.” The motion carried. Please see pages 76 through 82.

Mr Kraut motioned to clarify the second proposed amendment stating “If an existing provider of a full-time free standing emergency department requests to move to part-time operation, an administrative CON review would be required.” The motion was seconded by Mr. Fassler. The motion carried with 6 members opposing. Please see pages 82 through 91.

- D.** Non-Hospital Surgery - Ambulatory Surgery Centers and Office Based Surgery  
No changes
  
- E.** Upgraded Diagnostic and Treatment Centers  
No changes

Dr. Streck stated that there is a motion to adopt the recommendations and had been seconded by Ms. Rautenberg. The motion is to adopt the recommendations with the agreed upon amendments. The motion carries. Please see pages 101 through 103 of the attached transcript.

**ADJOURNMENT:**

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

1 WILLIAM STRECK: Good morning everyone. I'm Dr. William  
2 Streck, the Chair of the Public Health and Health Planning  
3 Council. I welcome you to this special meeting. I welcome  
4 members, Commissioner Shah, participants, and observers. I'd  
5 like to remind council members that this is a meeting that is  
6 subject to the open meeting law. It is broadcast over the  
7 internet, and the webcast may be accessed at the Department of  
8 Health's website. These on-demand webcasts will be available no  
9 later than seven days after the meeting for a minimum of 30  
10 days. I would also point out that as a meeting of the full  
11 Public Health Council this is not a meeting that has a public  
12 comment period. This is a meeting that is limited to the  
13 discussion of the Council members. We will have some complexity  
14 because of the multiple sites which we will be trying to address  
15 these issues, so we will be courteous and adaptive in our  
16 process, trying to make sure that each individual at each site  
17 has adequate opportunity to express thoughts, comments, and  
18 opinions about this proposal, about the series of proposals  
19 today. We do ask that you identify yourself when speaking. I  
20 think that's be particularly important today. As a reminder for  
21 the audience, there is a form that needs to be filled out if you  
22 are here to observe the meetings. Did we have - is that form  
23 out there today? It's here. It's required by the Joint  
24 Commission on Public Ethics in accordance with Executive Law  
25 section 166.



1

2           JOHN RUGGE:       So, anyway, in summary, we have a digest  
3 that was circulated some time ago summarizing the context and  
4 also listing the recommendations of the committee with reference  
5 to what would require regulatory action and what would require  
6 action by the legislature. So to start the meeting I would like  
7 to move the recommendations contained in this report, but then  
8 also ask any comments of Dr. Shah.

9

10           NIRAV SHAH:       Thank you Dr. Rugge. I don't know if you  
11 remember the first time that you walked into a grocery store or  
12 a supermarket and saw a sign for a flu shot. You thought you  
13 were going to buy a loaf of bread but ended up getting  
14 vaccinated at the same time. That wasn't that long ago. And  
15 these days more and more patients are getting more and more care  
16 outside the traditional four walls of a hospital or clinic in  
17 different definitions of ambulatory care facilities. And today  
18 what we have is an opportunity to shape the future of what these  
19 ambulatory care centers look like, the services that they  
20 provide, the kind of care that patients can expect, and the role  
21 of these facilities in our evolving healthcare delivery system,  
22 that's becoming more integrated and more value-based.

23           At the same time existing ambulatory care facilities are  
24 adopting new models of care such as the patient-centered medical  
25 home. We know that evolving models such as this PCMH model will

1 guarantee high quality care for all patients and help us deal  
2 with some of our most challenging patients, among patients with  
3 multiple chronic conditions. We want the same quality of care  
4 provided in all ambulatory care settings. We expect a lot. We  
5 expect attention to population health management. The  
6 management of high risk patients, rapid and judicious access to  
7 high quality specialty care, and integrated behavioral health  
8 therapy. And that brings us to what we are trying to do as a  
9 state and as a nation which is to achieve the Triple Aim. If we  
10 can meet these goals, we can achieve that Triple Aim of improved  
11 population health, better care, and lower cost.

12 So, what are we seeing when we see various iterations of  
13 ambulatory practice? We're seeing retail clinics or sometimes  
14 called limited services clinics. We're seeing urgent care  
15 centers. We're seeing free-standing emergency departments. All  
16 of these are providing various flavors of primary care. Today  
17 our recommendations will clarify exactly what these facilities  
18 are, what they provide, what services they will offer and not  
19 offer, and the measures that they have to take to ensure high  
20 quality care, patient safety, and even the signage that's  
21 required in these facilities. Why are we doing this? We're  
22 doing this so we know there's less confusion for the citizens of  
23 New York. We're doing it so that as these centers grow and  
24 thrive in our evolving healthcare system (dictate) they're  
25 proper niche. We want to make sure that the operators of these

1 ambulatory care facilities know they must report patient data,  
2 link in to regional and state health information technology and  
3 coordinate services across all the multiple state agencies.  
4 Most of all, we're doing it for the people of New York, so that  
5 all New Yorkers know what they're getting when they step into  
6 one of these outpatient settings, regardless of whether they're  
7 in Buffalo, Long Island, or the Adirondacks. I hope you will  
8 give today's deliberation the same high level of substantive  
9 thought and careful attention to detail that you've given all  
10 throughout this process. I know we've spent a lot of time on  
11 these important issues. We're really forging new ground here,  
12 and I appreciate all of your efforts in helping us advance the  
13 opportunities for outpatient care for all New Yorkers. Thank  
14 you.

15

16 JOHN RUGGE: Just to be clear what we're looking at today  
17 I think is defining the taxonomy of ambulatory care.  
18 Chapter restates and reaffirms the necessity of robust primary  
19 care as a foundation of any healthcare system, and most of our  
20 time spent on looking at the proposed spectrum  
21 of episodic care given from very limited minor care to the most  
22 difficult and serious emergencies and trying to categorize this,  
23 we think we are setting ourselves up for a second stage  
24 activity, adopted somewhere by somebody, in terms of once we  
25 know what these services are and have defined them and

1 categorized them, how then should they be reimbursed and  
2 compensated relative to one another. As a committee we've  
3 decided to defer that conversation, thinking that the initial  
4 step is to look at the structure of care and update it,  
5 realizing as well that everything we do is tentative an  
6 environment that is so dynamic and so fast changing, so we are  
7 specifically recommending that rather than waiting another 30  
8 years for new fresh look, we suspect that another three years  
9 this body or an equivalent body will be taking a new look at  
10 innovations in the field and trying to refresh the role of  
11 public oversight for all these services.

12

13 WILLIAM STRECK: Thank you, John. Dr. Ruge's made a  
14 motion to approve the recommendation in total. And I would just  
15 like to offer some guidelines as to how we might go through this  
16 discussion. We will conclude this discussion today with a vote  
17 on the entire package as recommended by Dr. Ruge, presuming he  
18 gets a second of which I feel confident. But in this discussion  
19 process between that point and where we are at the moment, we  
20 will take each of these topics and we will discuss them, and we  
21 will discuss them to a level of comfort for the members of the  
22 Council. If there are to be votes other than the final vote,  
23 they would be amendments proposed by Council members to the  
24 language that is in the proposal as presented at this point. So  
25 just to get clear on our methods here. We will have full

1 discussion. If at the end of a discussion on one of these  
2 topics, an individual feels that an amendment to that component  
3 of the overall package is warranted, that individual may make  
4 that motion. If obtaining a second, we would discuss that  
5 motion and then that would be part if it passed, it would be  
6 part of the continuing accumulation of material for the final  
7 vote. Everyone clear on that? So, Dr. Ruge has made a motion  
8 on the full proposal. Is there a second? This could be a brief  
9 meeting.

10

11 JEFF KRAUT: We have a second by Ms. Rautenberg here in  
12 New York.

13

14 WILLIAM STRECK: So we have a motion and a second for  
15 the entire package, and with that we'll begin the discussion and  
16 we will begin that discussion with the first topic in the  
17 package which is limited service clinics. So the material has  
18 been presented previously. It is also before you in terms of  
19 naming conventions, scope of service, accreditation, disclosure,  
20 patient safety and quality, stabilization of the medical home,  
21 and information technology. The recommendation concludes with  
22 statutory action recommended for implementation. Is there  
23 discussion on the limited service clinic component of this  
24 proposal?

25

1           PETER ROBINSON:        Dr. Streck this is Peter Robinson in  
2 Rochester. I'd like to make a comment.

3

4           WILLIAM STRECK:        All right. Thank you Mr. Robinson.  
5 Proceed.

6

7           PETER ROBINSON:        Thank you. So, I -

8           The entire package but it is another step in, as proving  
9 the corporate practice of medicine in New York, and on that  
10 level, I have some concerns that we need to draw some boundaries  
11 around this. And so I am asking rather than making a  
12 recommendation for specific language about how the regulations  
13 are going to be written such that the corporate practice of  
14 medicine which this is is going to be limited to what we do here  
15 with retail clinics and what we have already done with regard to  
16 the dialysis program. And I don't know whether that's a  
17 response from counsel or whether anyone else can give me some  
18 feedback on that.

19

20           MICK STONE:        This is Mick Stone in Albany. Basically, I  
21 think what's contemplated and is part of the recommendation with  
22 respect to retail clinics anyway, it's going to be within  
23 article 28. Article 28 is already (in acceptance) of the  
24 corporate practice of medicine in that corporations are licensed  
25 to be, or established as hospitals, and hospitals being the

1 broad term clinics, and nursing homes. So  
2 the retail service clinic will be sort of subset, I think on the  
3 recommendations of diagnostic and treatment centers and able to  
4 be operated by corporations. The similarity to the end stage  
5 renal dialysis facilities is that they would presumably be  
6 exempt from the prohibition and corporate ownership of corporate  
7 stock of an article 28. So, to that extent that would have to  
8 be within statute. It would have to be done within statute to  
9 exempt this type of provider from that provision, much in the  
10 same way as end stage renal dialysis providers are.

11

12 JOHN RUGGE: So I would take it that any statute would be  
13 necessary to further expand upon this preci-

14

15 MICK STONE: yes.

16

17 PETER ROBINSON: So I am to be reass - so I - yeah, this  
18 is Peter Robinson again, so I'm getting reassurance that there  
19 are not loopholes to essentially create other venues in which  
20 the corporate practice of medicine can occur that the way this  
21 is structured the limitation will be solely to these particular  
22 services.

23

24 MICK STONE: That is correct. The defined set of  
25 services that are limited service clinics.

1

2           PETER ROBINSON:        Thank you.

3

4           CHIRS BOOTH:        This is Chris Booth, also in Rochester. My  
5 question would be, we have retail clinics now in New York and  
6 they operate without the corporate practice of medicine. What's  
7 the necessity for doing this?

8

9           JOHN RUGGE:        The rationale is that those existing retail  
10 clinics are operated as private practices and are essentially  
11 unlimited services, simply a matter of providing whatever  
12 services may be allowed through the practice of medicine that's  
13 defined by the State Education Department. We are aware that a  
14 number of retail establishments would like to use their  
15 experience in other states to put in New York a limited service  
16 package, generally staffed by nurse practitioners and PAs rather  
17 than physicians, but serving, if you will, a niche market for  
18 quick inexpensive care for minor illness that is self-limited,  
19 and this would allow for expansion of that kind of service  
20 across the state. That it's not possible to insert in private  
21 practices and retail stores.

22

23           CHRIS BOOTH:        Can I ask a question of clarification, if we  
24 pass this today and you have this new classification, could you

1 still have a pharmacy that has a private practice of medicine  
2 with a broader set of services in it go forward?

3

4 JOHN RUGGE: Yes. Yes. This does not preclude any of  
5 the activities already in place, and it does not impinge in any  
6 way on the practice of medicine and the prerogatives of  
7 physicians exercising that license.

8

9 CHRIS BOOTH: Thank you.

10

11 HOWARD FENSTERMAN: Dr. Rugge, it's Howard Fensterman. How  
12 are you.

13

14 JOHN RUGGE: Hi.

15

16 HOWARD FENSTERMAN: I have a question regarding following  
17 up on Peter's question regarding the corporate practice. One of  
18 my concerns is, and perhaps this is a question for counsel;  
19 corporations as we all know provide certain immunities from  
20 lawsuits and often times folks hide behind that corporate veil  
21 to protect themselves which is one of the objects of being a  
22 corporation in the first instance. One of my concerns here, and  
23 I'm wondering how we're addressing this is that as far as  
24 quality of care, which I know is a priority of the Department  
25 and the Commissioner, I would not want anyone hiding behind a

1 corporate veil and contemplating that they could get away, for  
2 lack of a better expression, with an inferior performance just  
3 because they're a corporation and in the event they were sued,  
4 they would find themselves as a shell and a prospective  
5 plaintiff would have no recourse, and I'm not as concerned about  
6 the plaintiffs as I am about having some leverage on the entity  
7 to understand that they have exposure in the event they don't -  
8 besides the exposure they would have from the Department, in the  
9 even that they don't provide the level of care that we're  
10 interested in, and I'd like counsel to comment on that if you  
11 would please.

12

13 MICK STONE: This is Mick Stone again, and essentially,  
14 again referring back to article 28 we already allow business  
15 preparations to be operators in New York State and with respect  
16 to end stage renal dialysis we allow more complex business  
17 appropriations to practice within New York State, and so, I  
18 guess the concern is always there that corporate structure could  
19 be used to shield presumably shareholders from liability in the  
20 event of some lawsuit or other action being taken  
21 (misappropriation). However, the appropriation itself has, is  
22 the holder of the license. The Department's action would be  
23 against the preparation, presumably the shareholders and the  
24 directors would be impacted by that with respect to any further  
25 action that they wanted to take towards establishment of any

1 other entities. And that's pretty much the structure as already  
2 exists with respect to article 28, I guess for better or for  
3 worse.

4

5 JOHN RUGGE: I would also add, Howard, I would think  
6 there's really two levels of responsibility; one is the  
7 corporate responsibility at the organizational level for  
8 suitable performance and procedures, but also there's individual  
9 responsibility on the part of the practitioner. And that  
10 practitioner would be responsible for maintaining community  
11 standards of care and would be subject to action by the OPMC and  
12 the education department in the event of less than adequate  
13 practice. We are further protecting the public.

14

15 HOWARD FENSTERMAN: I think that's a good point, doctor.  
16 And my concern is just in responding to Mick is what we did this  
17 with the dialysis centers, besides the issues that I had raised  
18 at that time with a couple of them as far as their character and  
19 competences regarding lawsuits that were existing. They  
20 generally, and that's a big distinction from here, they  
21 generally are very substantial entities who have financial  
22 wherewithal. My concern here - so that was less of a concern  
23 for me there because they were mostly national companies or  
24 multi-state companies that possess financial viability. Here,  
25 that's a distinction. And while I certainly appreciate the

1 individual practitioners having exposure, I'm just wondering if  
2 we would want to consider requiring some minimum amount of  
3 financial stability to be made by these corporations so that  
4 they at all times can demonstrate that they are not funneling  
5 all of their money out of the corporate entity and leaving a  
6 shell, because I not merely want the individual practitioners to  
7 have the leverage on the necessity to provide that quality care,  
8 but I'd like the operators and the licensees to understand that  
9 they similarly have exposure. Just a point I raise. Thank you.

10

11 JEFF KRAUT: Mr. Levin.

12

13 ART LEVIN: Morning John. So, I have some concerns and  
14 I apologize. As you all know, I've missed some meetings, so  
15 this may have been discussed previously, but, there are threads  
16 that run throughout the document, not just limited to retail  
17 clinics. Let me begin with consumer disclosure. I'm not a big  
18 believer in signage after sort of when somebody is already in a  
19 facility that that's the right time to educate them about what  
20 their - what's available where they are. So I really would urge  
21 that we think seriously about requiring the State to engage in a  
22 public service campaign with some vigor that attempts to educate  
23 the public in advance as to what these options are about. So  
24 before they go, some people at least may have availed themselves  
25 of this kind of information and know what they're going to.

1 Once you're there, it's not really great. First of all you have  
2 to look up and find the poster. And then you have to say, make  
3 a decision; is this the right place for me or not? So that's  
4 one thing. I'd really like to see the State invest in a very  
5 vigorous education program for all of these concerns.

6 The next thing is a question about the sort of optimization  
7 of the stabilization of the medical home and the preparation of  
8 this list. As I understand it, each facility, each entity is  
9 required to come up with a list. Seems to me that's a silly way  
10 to do it. A lot of duplicate energy. A lot of opportunity for  
11 mistakes and inaccuracies. I would like to charge the State  
12 with coming up with such a list that every one of these  
13 facilities could avail themselves of, a list that was current  
14 and real so that it had real meaning to people, because I think  
15 if we have every one of these entities come up with a list,  
16 they'll be useless lists. That's another point.

17 Third point is on the health information technology; I'm  
18 not sure what's meant in the first bullet: "All authorized  
19 clinicians and participation..." you know, could we be more  
20 specific there? Are we talking about the SHIN-NY for example?  
21 I'm not quite sure what we mean there. And then the third  
22 bullet I would like to urge us to include that patients should  
23 get a copy of the discharge plan. And those are sort of three  
24 threads of concern that run through this document.

25

1           JOHN RUGGE:       Thank you very much.  As a reminder, this is  
2 a digest of recommendations.  I think your comments and others  
3 will be reflected in the narrative report which will provide the  
4 music for the text.  Clearly there's an intent in a concluding  
5 chapter for this Council to recommend a very active public  
6 information campaign, so people know not only when or when not  
7 to use the minor services clinic, or limited services clinic,  
8 but also when to go to the ED, and as I see it this represents a  
9 significant enlargement of this Council, that instead of looking  
10 as simply regulatory issues, we're looking at the public health  
11 and what can be done in a broader way to influence behaviors  
12 that will be constructive.

13           We've got a list of referrals the committee recognized that  
14 there is currently no really good way and the language (is  
15 intended) to be quite open, so that as technologies evolve and  
16 the State has more access to data as it will through the all-  
17 payer database we'll be able to identify those practices which  
18 are open and available, and also those practices which are  
19 accepted as safetynet providers, Medicaid and uninsured  
20 patients, and see that as really a key maneuver.  It will be  
21 reflected in the language, but as currently we know we don't  
22 have all the exact ways and techniques for doing some.  
23 HIT, totally support what you're saying and the narrative will  
24 expand upon the responsibilities for providing information to  
25 patients as well as to other providers.

1

2           JEFF KRAUT:       We have two comments. One by Dr. Boutin-  
3 Foster first, then by Dr. Bhat.

4

5           CARLA BOUTIN-FOSTER:       Hi, good morning. This is a  
6 question regarding some of the scope of clinical work that's  
7 provided by these clinics. I assume that STD prevention would  
8 be covered also, would be within the scope of services provided.  
9 And if that is so, will such clinics be able to provide Gardasil  
10 as an immunization? Because it says that, I mean, they're going  
11 to see pediatrics 24 months and older and they cannot administer  
12 vaccination except for influenzas, but if they're providing STD  
13 prevention will there also be an exemption for Gardasil or  
14 consideration of that?

15

16           JOHN RUGGE:       Excellent point. That's an aspect we hadn't  
17 considered, but makes absolute sense and we can accept that as  
18 part of our narratives and the regs. Excellent point.

19

20           JEFF KRAUT:       I'm going to go Dr. Bhat and then Dr.  
21 Martin.

22

23           DR. BHAT: Dr. Bhat. This question is for Mick Stone. My  
24 understanding was in the dialysis industry corporations still  
25 could operate - could probably still operate in New York State

1 as long as their particular corporation is, it's approved by  
2 article 28, because the CON process they could go ahead and  
3 employ nurses or licensed individuals like maybe  
4 nurse practitioners or doctors. What in New York  
5 State was allowing publicly traded dialysis corporations coming  
6 in and doing business in New York State officially. There are  
7 certain differences between what we are talking about here and  
8 dialysis industry, dialysis is more federal  
9 program, that's number one; number two, there are a lot of  
10 checks and balances. Quality program and the collection of the  
11 data by the federal government is so robust and there's very  
12 little room for any kind of abuse, fraud and abuse kind of an  
13 issue because it's a highly regulated industry. Would we be  
14 having the same - if we are going to go along with this, what  
15 kind of regulations that you are going to be bringing in or  
16 looking at the quality and the utilization of these limited  
17 service clinics?

18

19 MICK STONE: Well I would agree with you that it's not  
20 built in to the extent that the dialysis clinics are subject to  
21 certain federal regulations. Not built in the limited service  
22 clinics don't have that, I guess, same regulatory oversight.  
23 However, then I think it becomes incumbent on the State through  
24 it's regulatory process to then come up with the, and  
25 I mean to include you the Public Health and Health Planning

1 Council, in adopting regulations that would get you to the  
2 comfort level to ensure that service is being provided  
3 adequately and appropriately.

4

5 JEFF KRAUT: Dr. Martin. And then Dr. Brown.

6

7 GLENN MARTIN: So I was going to talk about corporate  
8 practice of medicine but I'll hold off on that for a moment  
9 because Dr. Boutin-Foster raised an interesting question, and I  
10 think, actually underscores the whole, one of the major concerns  
11 I have with the whole retail clinic idea. Is as I understand  
12 that Gardasil requires, what, still currently three shots over a  
13 period of time? Over a period of time. I thought the whole  
14 point of the retail clinics was this was episodic, one shot, you  
15 walk - not one shot, bad pun - you walk in, you get your care,  
16 and allow me to editorialize, mainly for stuff that would go  
17 away anyway in a week or two and then life goes on. And our  
18 concern was exactly the public benefit of allow - of regulating  
19 this because we recognize that it's not really primary care and  
20 it doesn't really integrate extraordinarily well, and where  
21 patients should be being seen are in primary care clinics,  
22 physician's office, et cetera. So by doing this I think  
23 actually is exactly the opposite of what we're saying. As much  
24 as I would like and my kids actually got Gardasil and they also  
25 got Hepatitis vaccine which is sexually transmitted disease also

1 to a large extent, so we end up in a situation where I don't  
2 think that's a path we should go down by expanding it, even  
3 though I understand the public health issue that's being raised  
4 for the concerns that I raise, and I think it underscores the  
5 real problem of these whole clinics and how they fit in.

6

7 JOHN RUGGE: Excellent points, and I think this is  
8 another reason why we're going to need to be looking at it on a  
9 continuing basis at refreshing and keeping up with new care  
10 technologies. However many years ago, five years ago Gardasil  
11 did not exist. We didn't have this issue. There will no doubt  
12 be additional vaccines and additional modalities of care that  
13 we're going to consider. By the same token, the feeling of the  
14 Committee, I hope is that defining a set of minor services,  
15 limited services will be helpful, will provide an ecological  
16 niche within the system, and we will need to take a continuing  
17 look including now with Gardasil for both of those reasons.

18

19 JEFF KRAUT: Dr. Brown then Dr. Berliner.

20

21 DR. BROWN: Good morning. And I again would like to  
22 comment the Department of Health and our Committee for such  
23 great work in which they've been engaged in. I have only a  
24 couple of points, well, actually one point; I see in the scope  
25 of services regarding the retail clinics a phrase that says they

1 "include simple wellness and screening services for chronic  
2 conditions such as diabetes and hypertension." And I see later  
3 on that it excludes certain services, substance abuse services,  
4 and I can appreciate that. The question I have it to what  
5 extent that this process would include screening for behavioral  
6 health services? Why would they be excluded if you're screening  
7 for medical services?

8

9 JOHN RUGGE: They shouldn't be excluded. No, I think in  
10 any clinical study if a problem is screened and identified then  
11 what we have constructed as a system for referral to the  
12 appropriate level of care. For a limited services clinic that  
13 almost always means referral back to primary care. When it  
14 comes to urgent care as we'll get to it means really a  
15 bidirectional flow of information referrals to a higher level of  
16 acuity and also back to the foundation of the system of primary  
17 care. But there's certainly no intent to exclude identification  
18 behavioral health conditions in this list, and we can add that  
19 to the narrative.

20

21 JEFF KRAUT: Dr. Berliner. And then Mr. Kraut:

22

23 HOWARD BERLINER: Dr. Streck, is this an appropriate time  
24 to add to propose an amendment?

25

1 WILLIAM STRECK: Well I think that will - amendment, so  
2 you might as well start.

3  
4 JEFF KRAUT: Could I just ask for one second, because it  
5 may be on point to amendments. What might be helpful at this  
6 time is John, and you kind of touched upon it, by putting in  
7 some services, by definition we don't have everything, and there  
8 are things that are probably have left out which you know, other  
9 than for the thoughts that we just heard, if you gave us another  
10 day or two or a week or a month we'd come up with a much larger  
11 list possibly. Could we - I know; nobody wants to do that. But

12

13 JO BOUFFORD: Adding more isn't the point.

14

15 JEFF KRAUT: And that's my point. Could you just refresh  
16 our memory, I don't know who could do this best. This is going  
17 to require a statutory change. Just before we get too deep into  
18 some of the things, could you just go through a statutory change  
19 requires an act of the legislature and then coming back and  
20 writing more detailed regulations which ultimately also have to  
21 come back to the Council? Could you just - could somebody  
22 either affirm that or expand on that?

23

24 JOHN RUGGE: I think that's exactly the process. This is  
25 - we're at the starting gate for consideration by the executive

1 and by the legislature. And then it will, assuming the  
2 legislature does take action and comes back through the Codes  
3 Committee of this Council for further review and continued  
4 refinement. I think already what we've seen is rather than  
5 listing those conditions which would be screened which would  
6 indicate there should be screening services to include, for  
7 example, hypertension and diabetes, and that would be an  
8 improvement over the text as we now have it.

9

10 JEFF KRAUT: Dr. Berliner then Dr. Strange then Dr.  
11 Boufford.

12

13 HOWARD BERLINER: This is actually a friendly amendment  
14 so let me say that up front. I'd like to add to the  
15 recommendation particularly under stabilization of the medical  
16 home that all staff in these clinics be required to have a State  
17 designed and approved training program that helps them to  
18 understand the primary care system and how do direct people  
19 throughout it.

20

21 WILLIAM STRECK: OK. I'll take that as a motion. Does  
22 it have a second?

23

24 [Second]

25

1 JEFF KRAUT: Second by Dr. Levin.

2

3 WILLIAM STRECK: We have a motion on the floor to add  
4 training requirements to the primary care medical home step. Is  
5 there discussion on that amendment?

6

7 JEFF KRAUT: We're having discussion here but we're not  
8 including you.

9

10 HOWARD BERLINER: Sorry, Dr. Streck. This is not to the  
11 medical home staff. This is to the clinic staff, so that they  
12 understand how do direct people.

13

14 WILLIAM STRECK: OH, OK. I stand corrected. So the  
15 motion is for the limited services clinic staff approved  
16 training program. Is that close enough?

17

18 HOWARD BERLINER: Yes.

19

20 WILLIAM STRECK: And has a second. Is there further  
21 discussion on that proposal?

22

23 JOHN RUGGE: Just a point of information. Are you  
24 thinking in terms of a equivalent of the  
25 infectious disease course -

1

2 [Like a one hour CME?]

3

4 HOWARD BERLINER: Beyond my level of competence, but that  
5 sounds fine.

6

7 WILLIAM STRECK: Just a moment please. Could I just  
8 have clarification here. So we're talking about limited service  
9 clinics and undefined but somewhat to be defined training  
10 program and are there other comments on this proposal?

11

12 JEFF KRAUT: No one down here.

13

14 WILLIAM STRECK: I would now as - well, no, I won't ask.  
15 No further comments? Rochester? Buffalo? OK. So we have our  
16 first vote of the day on this amendment to add this training  
17 requirement. Those in favor raise your hand and be counted at  
18 your site. That should not be hard in Rochester. And we will  
19 see New York and here.

20

21 ANGEL GUTIERREZ: Buffalo is on, TWO votes.

22

23 WILLIAM STRECK: TWO votes.

24

25 JEFF KRAUT: We have TEN affirmative.

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WILLIAM STRECK: Which way?

ANGEL GUTIERREZ: Affirmative.

WILLIAM STRECK: All right. Jeff?

JEFF KRAUT: We have ELEVEN affirmative votes in New York.

WILLIAM STRECK: Eleven affirmative here. Rochester?

CHRIS BOOTH: THREE Affirmative in Rochester.

WILLIAM STRECK: THREE affirmative. So that's 16. Albany?, One, 17. 17 Affirmative votes. Those opposed? OK. So we have our first amendment to the proposal. Thank you. Is there other discussion on the limited service clinics?

JEFF KRAUT: Yes. Strange and then Dr. Boufford.

DR. STRANGE: Hi, good morning.

1 WILLIAM STRECK: I just - we're going to constrain our  
2 discussion on this within another 10 minutes on this particular  
3 topic. So if you have very critical thoughts, hone them.

4

5 DR. STRANGE: Good morning. Dr. Strange down here in New  
6 York. Excuse my voice from a little cold. Maybe I should go to  
7 a limited clinic, the health - exactly.

8

9 JOHN RUGGE: Not yet, Dr. Strange!

10

11 DR. STRANGE: So again, I want to commend the Commissioner  
12 and the Department and the Committee too for trying to get some  
13 oversight over a very difficult situation, and especially in the  
14 current times where primary care access is clearly an issue, and  
15 the whole issue of better health, higher quality, lower cost we  
16 all understand the Triple Aim. I am still concerned over  
17 however, though, better quality and better health may be an  
18 issue here. Clearly costs I think are probably improved here  
19 and I'm not sure for the better, and I'll explain in a second.

20 There are two subsets of patients that go to these limited  
21 services clinics. There are those that do it for convenience of  
22 net getting to their primary care doctor on an off time, on a  
23 weekend, and so on, and then there are those who just never see  
24 primary care doctors for whatever reason. In denial, not wanting  
25 to take care of themselves and whatever. Understanding that the

1 first group of patients may, may, be able to get back to  
2 whomever their primary care doctors are within a reasonable  
3 period of time is a good thing. My concern is on the second  
4 group of patients which is not an insignificant number of  
5 patients. And so the concern there would be for example in the  
6 screening, if I go in for my earache and somebody acknowledges  
7 that I have high blood pressure or may see a melanoma on my skin  
8 potentially or may need an immunization that is due, and I don't  
9 follow up with the primary doc, and I don't get treatment for my  
10 hypertension, and somehow a month or two or three later I end up  
11 with a stroke in an emergency room who is liable for that follow  
12 up? I know as a primary care doc if I find something in an  
13 office and I don't even go so far as a certified letter almost  
14 walking a patient down to the surgeon's office or to the  
15 mammogram, I'm fully liable for not fully engaging that patient  
16 in doing what he or she was supposed to do. Having seen a  
17 number of lawsuits in our one hospital where melanomas were  
18 missed, but not really missed. Were acknowledged, were told to  
19 the patient, but somehow just weren't gone to the full extent of  
20 what had to be done, where does that leave these limited service  
21 clinics, and what kind of quality did we really provide? And at  
22 what point are we abandoning the care? So when the patient  
23 comes back the second or third time to those clinics because  
24 that's the primary care provider they used, they don't go to  
25 anybody else despite our best efforts at getting them to any

1 other facility, they're going to come back a month or two or  
2 three later, and they're going to end up with the sequeli .  
3 Who's responsible for that, and how are we going to fix that,  
4 and how are we really improving the care with these limited  
5 clinics where this is still very fragmented piecemeal care? And  
6 then my last comment would be to the extent of the transmission  
7 of electronic data which must be connected, it has to be  
8 integrated, who's going to be responsible to pay for that? Is  
9 it going to be the primary care doctors office or facility to  
10 set up that interconnection which is a huge expense on the  
11 primary care doctor side, or is it going to be the limited  
12 liability - the limited service clinics who are going to be  
13 responsible to set up that interface which is not an inexpensive  
14 endeavor as we've learned with laboratories and X-ray facilities  
15 and other things, and those of us in the electronic world  
16 already. So I am very concerned. I understand the role and  
17 reason for these clinics. I understand access very well. As a  
18 primary care provider, however, I am concerned about the quality  
19 situations. You brought up one with the Gardisil situation. I  
20 don't see how somebody who doesn't have a provider but thinks  
21 they're going to keep going back to these clinics, how is that  
22 going to get reported? I can't get Zost - I'm a geriatrician.  
23 I don't know half the patients who get Zoster vacs right now.  
24 And that's reportable in my account - I'm part of an accountable  
25 care organization through Montefiore right now and I'm supposed

1 to report that and I don't even know who's getting it and who's  
2 not getting it because I'm not getting the information. And if  
3 Zoster vacs ever would be required a second or third time and we  
4 don't know that at this point in time, who's going to provide  
5 that Zoster vac? So I am very concerned about the extent of  
6 which this is going to lead to.

7

8 JOHN RUGGE: Dr. Streck, I think these are good points.  
9 Clearly the planning committee does not regard itself as  
10 perfection with establishing limited service clinics. What we  
11 are looking to create is a portal into the healthcare system.  
12 One that the patients will be encouraged to use and will be a  
13 ramp toward full service care. Clearly come patients may  
14 disregard the advice they are getting in the same way that a  
15 patient of a primary care physician may not follow up with a  
16 specialist and have a stroke because they didn't follow up on  
17 the TIA they received. At some level there is personal  
18 responsibility on that part of the patient, and there is no way  
19 in which we can be so paternalistic that every need is met on an  
20 insured basis without the engagement of the patient.

21

22 WILLIAM STRECK: are there other comments on the limited  
23 service clinics?

24

1           JEFF KRAUT:       Yeah, we have Dr. Boufford and then Mr.  
2 Fensterman.

3

4           WILLIAM STRECK:       Those will be the concluding comments.  
5 Thank you.

6

7           JO BOUFFORD:    I have one very specific and not very  
8 exciting comment, but somehow at the very last sentence in the  
9 limited service clinics says "requiring architectural review to  
10 assure health and safety requirements are met." I'm sure that  
11 found it's way in from another section. So it seems to me it  
12 probably out to be deleted. I don't recall ever discussing  
13 that. So, I think that belongs somewhere else. I guess the  
14 only other editorial thing I'd say, and it really speaks to some  
15 of the principles when we started out in this process, I think  
16 what we were - my recollection of how we started this is we were  
17 looking at the reality on the ground not creating things. And  
18 part of the effort to delimit without restricting the private  
19 practice of medicine some public information about what people  
20 can expect and some level of quality control over something over  
21 which we now know nothing is really what we've been about. Not  
22 trying to establish incentives to have more of these things. So  
23 it seems to me if we're willing to live with the fact that  
24 they're there, the only alternative I think -- and I totally  
25 take Dr. Strange's comments, I think they're important comments,

1 but the alternative would be to say they can't exist. They're  
2 not acceptable as forms of delivering healthcare. And I don't  
3 think I'm being extreme about this. As organized entities in  
4 terms of being existing in CVS's or these, the corporate  
5 practice of medicine that we're talking about, then we still  
6 have the problem of the private physician could set up in the  
7 same entity and be really unregulated. You know what I'm  
8 saying? So I think we've got a dilemma here and I just want to  
9 go back to first principles because I think the goal was to  
10 provide some public information about the expectations and to  
11 provide some level of oversight for things that were happening.  
12 And I think John put his finger on it which is, it's really  
13 going to be about the reimbursement system and whether what  
14 continues and flourishes and what doesn't, and the fundamental  
15 issue is how we pay for primary care. And that's, we're going  
16 to have to come back to that at some point. But I just thought  
17 it was important to remind ourselves of that. At least that's  
18 my sense of the effort. Thank you.

19

20 JEFF KRAUT: Mr. Fensterman.

21

22 HOWARD FENSTERMAN: I have - this is Howard. I want to go  
23 back and really following up with what Dr. Bhat and Dr. Strange  
24 said. I want to ask Dr. Rugge and perhaps the Commissioner if  
25 they think this would be a deterrent. On this liability issue

1 with the corporate practice of medicine, I wanted to ask the  
2 Commissioner and/or Dr. Ruge there may be a solution to this,  
3 which is requiring these corporations to maintain a liability  
4 insurance policy similar to what all of us who drive automobiles  
5 must do in this State, or alternatively to post a bond, because  
6 it seems to me that these clinics are not going through  
7 necessarily financial feasibility analysis nor an ongoing review  
8 of what their financial bona fides are. And I want to know if  
9 Dr. Ruge and/or the Commissioner thought that that might act as  
10 a deterrent to folks going into this clinic, in which case I'll  
11 withdraw my position. But if it does not, I wanted to know what  
12 your view was of imposing that on these corporate entities.

13

14 JEFF KRAUT: I think you've opened up an important issue,  
15 Howard, and that is something that can and will be addressed at  
16 the regulatory phase to include provision for funds  
17 to protect the public.

18

19 HOWARD FENSTERMAN: OK. Thank you.

20

21 WILLIAM STRECK: I'd like to offer two clarifications as  
22 we wrap up this phase, hopefully. First of all, Dr. Boufford,  
23 the architectural review is intrinsic to the article 28  
24 licensure so it's not an inadvertent sentence that crept in  
25 there. It is in fact part of the article 28 regulations. And

1 then for the group, I would just like to clarify what we are  
2 doing. There seems to be some question here; these are  
3 recommendations that the Public Health Council would be making.  
4 These recommendations are essentially to the Commissioner and to  
5 the legislature in recommending a change in statutory language.  
6 It is conceivable the legislature might not accept the  
7 recommendation of the Public Health and Health Planning Council  
8 on a statutory change. Should that occur, then all of these  
9 recommendations would essentially be captured in cyberspace  
10 until other approaches were discovered. So I think it's - we  
11 have to be realistic about what we are recommending. We are not  
12 in these proposals putting in place the regulations. That the  
13 point that John has been emphasizing throughout here. So these  
14 are directional recommendations and if the statutory change does  
15 not follow, these recommendations are essentially suspended. Is  
16 that clear? Does everybody make sense of what -

17

18 JEFF KRAUT: We have two questions; one Dr. Boufford,  
19 then Dr. Martin.

20

21 JO BOUFFORD: I just want to come back on the article 28 -  
22 I assume this would not mean applying article 28 standards to  
23 these clinics because that would put everyone out of business.

24

1 JOHN RUGGE: That's exactly right. This is manner of  
2 limiting the architectural standards to still be a compliant  
3 article 28.

4  
5 JO BOUFFORD: What does that mean, John, because article  
6 28 standards are article 28 standards. That's - as I understand  
7 it.

8  
9 JOHN RUGGE: ...for this category of article 28 provider  
10 there'll be a new set of standards which would be more, if you  
11 will, limited than for hospitals or clinics.

12  
13 CHRIS DELKER: There's some precedent for that in -  
14 Chris Delker in Albany. Division of Health Facility Planning.  
15 There's some precedent for that in part-time clinics. We have  
16 very minimal physical plant requirements for those  
17 the need for flexibility and the intent of those to be available  
18 on a less-structured or less-formal basis. I think the same  
19 would apply here.

20  
21 WILLIAM STRECK: One other comment? One other question?

22  
23 JEFF KRAUT: Dr. Martin.

24

1           GLENN MARTIN: Thank you. I'm just reacting to your  
2 comment that if the statutory change didn't go through this  
3 doesn't go anywhere, and I'm a little confused by that because  
4 during our - during testimony and the like, Mr. Kraut actually  
5 asked one of the pharmacy reps, I don't recall which chain, why  
6 we even had to talk about the corporate practice of medicine  
7 because there's nothing stopping me as a physician from setting  
8 up my own little corporation here and staffing CVS or Rite-Aid  
9 or whoever I want, if I wanted to cut a deal with them. So I  
10 don't understand that if the legislature in their wisdom should  
11 decide not to allow the expansion, why all this other work  
12 couldn't still move into regulatory not cyberspace, but real  
13 regulatory space and allow us to put some limits on these  
14 clinics in a way that would hopefully promote health. So I'm  
15 not sure if it's as tied together as you presented. And if you  
16 could explain that, I'd appreciate it.

17

18           WILLIAM STRECK: I think that's a critical question that  
19 needs to be clarified. Our attorneys to address that?

20

21           MICK STONE: Yeah, it depends on the model that  
22 you're looking at. With respect to the retail clinics if we're  
23 looking to expand it to allow certain providers to be able to  
24 come in and be licensed as retail services clinics then  
25 depending on who they are statutory change is necessary.

1 However, that does not preclude that if we allow existing  
2 providers who are already permitted to practice within the State  
3 to kind of define the scope of care that could be done perhaps  
4 regulatory process.

5

6 WILLIAM STRECK: That would be the article 28 providers  
7 though.

8

9 MICK STONE: Correct.

10

11 WILLIAM STRECK: Not the, none of the private practices  
12 and not these clinics.

13

14 MICK STONE: Right.

15

16 WILLIAM STRECK: So, the answer, Glenn, is these  
17 regulations could be made to apply to the current article 28  
18 providers if the statutory language was not passed. But it  
19 could not be applied to these clinics for which this whole  
20 process is directed.

21

22 GLENN MARTIN: And that would be - it would still be a  
23 private practice of medicine at that point and therefore you  
24 would have no particular regul - no regulatory authority to do  
25 anything about it? Is that basically what we're saying?

1

2 WILLIAM STRECK: That's correct.

3

4 GLENN MARTIN: OK.

5

6 WILLIAM STRECK: That is the gist of this discussion,  
7 one that we really need to be clear. So our recommendations are  
8 policy regulatory to the Commissioner through the Commissioner's  
9 statutory recommendations to the legislature as being proposed  
10 in this body of work.

11

12 GLENN MARTIN: Thank you for the clarification.

13

14 WILLIAM STRECK: OK, we'll now move to urgent care,  
15 where some of the ground has been well-trampled in our earlier  
16 discussions so we should be able to facilitate this discussion.  
17 Are there comments on the urgent care proposals?

18

19 ANGEL GUTIERREZ: Question from Dr. Boufford.

20

21 JO BOUFFORD: Yeah, I found the language seemed to get a  
22 little more convoluted than I recall from earlier drafts. I'm  
23 referring specifically to item point three. I'd like to  
24 understand the distinction or what at least at first reading  
25 seems to be a little bit inconsistent or contradictory between

1 the non-article 28 urgent care requirements and then dropping  
2 down are private physician practice affiliated with article 28,  
3 and then it says or they can become an article 28 through a full  
4 CON review. I thought we were trying to get out of the way of  
5 ambulatory care or provisions, so I'm a little bit confused by  
6 this whole -

7  
8 JEFF KRAUT: And I'd like to second that. Again, I don't  
9 think this language captures the discussion we had at the  
10 previous meetings that it's basically if you're an article 28  
11 you could choose to do this or choose not to do it, and if you  
12 choose to do it it should be done through a limited review  
13 because it's an extension clinic as an urgent care. That's the  
14 gist of it. And this gets a little too convoluted as to a  
15 private practice affiliated with an article 28, because it could  
16 be either way. And it shouldn't require a full CON review if  
17 we're not requiring it for the other group.

18

19 WILLIAM STRECK: Any comments about these suggestions?

20

21 [I can try to clarify. I think we were trying to respond  
22 to the Council. So if an existing article 28 wants to provide  
23 urgent care they do only have to go through a limited review to  
24 have it added to their operating certificate.]

25

1 JEFF KRAUT: Right.

2

3 [OK. A private physician office affiliated with an article  
4 28 can continue as private physician office and all they have to  
5 get is accreditation, or if they'd prefer, they could become an  
6 article 28. But if you go from a private physician office to an  
7 article 28 it does require a full CON review.]

8

9 JEFF KRAUT: But then you're becoming - you're becoming a  
10 D&TC then.

11

12 [correct]

13

14 JEFF KRAUT: So, why do we have to say that? We know  
15 that already. That's not - we don't need to say that. It  
16 contradicts the first bullet.

17

18 [OK. So we can strike the - so, OK, if a private physician  
19 office is affiliated with article 28 but just wants to remain  
20 private physician office, all they need is accreditation. We  
21 can --]

22

23 JEFF KRAUT: Which is what we said - which is the non-  
24 article 28 urgent care requirements.

25

1 [non-article 28 is only accreditation.]

2

3 JEFF KRAUT: Correct.

4

5 [For article 28 they will be accredited. Article 28s are  
6 required to be accredited and they have to add it to their  
7 operating certificate which only requires a limited review.]

8

9 JEFF KRAUT: Correct. And I think that's -

10

11 JOHN RUGGE: Dr. Streck agrees. I think that could be  
12 accepted simply as a grammatical correction. This is simply a  
13 matter of expressing the intent of the Committee, not an  
14 amendment to what the Committee is proposing. So we'll simply  
15 strike that last clause.

16

17 WILLIAM STRECK: The Chair is willing, unless there's a  
18 senatorial hold on this we will accept that amendment.

19

20 JEFF KRAUT: So, we're taking out the third bullet on -  
21 or they become - OK.

22

23 WILLIAM STRECK: Just the latter part of it. Other  
24 comments on urgent care?

25

1 JEFF KRAUT: Dr. Berliner.

2

3 HOWARD BERLINER: Dr. Streck, I'd like to offer a  
4 friendly amendment similar to the one that was approved for  
5 limited service clinics for the retail clinics under patient  
6 safety and - I'm sorry - under stabilization of the medical  
7 home, and that would also be for staff - and I think it's  
8 probably more important in this case, and that would be for  
9 staff to get training in order to better understand and help get  
10 people to appropriate primary care.

11

12 ANGEL GUTIERREZ: I didn't hear half of what Dr. Berliner  
13 said.

14

15 HOWARD BELINER: I'd like to offer a friendly amendment  
16 to recommendation five under patient safety - recommendation six  
17 to stabilization of the medical home. That would be the same as  
18 the one we added to limited service clinics that would require  
19 training of the staff of retail clinics in how to direct people  
20 through the primary care system and other appropriate venues of  
21 care.

22

23 WILLIAM STRECK: There's a motion. Is there a second?

24

25 ART LEVIN: Second.

1           ANGEL GUTIERREZ:       Second in Buffalo.

2

3           JEFF KRAUT:        There's a second by Mr. Levin.

4

5 [inaudible]

6

7           WILLIAM STRECK:       We already did that one I think. It's  
8 a friendly amendment. No objections. Could I - just one brief  
9 note; may I ask our colleagues in New York City, be sure and  
10 turn off your mics if you are not speaking because we're getting  
11 some extraneous noises throughout the rest of the network here.

12

13          JEFF KRAUT:        I'm going to mute, I'll mute the room until  
14 somebody wants to speak.

15

16          WILLIAM STRECK:       That's a great opportunity for us. So  
17 we have a motion and a second on that proposal to add the  
18 educational clause. We've already on the basis of a friendly  
19 unanimous consent amendment deleted the language. So this is  
20 the second amendment on the educational clause proposed by Dr.  
21 Berliner. Is there discussion on that amendment? Hearing none,  
22 and unaware if that's because you're on mute, I would ask for a  
23 vote on the amendments on those in favor at each site, please  
24 raise your hand to be counted. What's the count there Jeff?

25

1 JEFF KRAUT: We have 13 affirmative votes. Hopefully we  
2 have 13 people, hold on.

3

4 WILLIAM STRECK: Rochester? We need to hear from you?

5

6 CHRIS BOOTH: Three affirmative votes.

7

8 WILLIAM STRECK: Thank you. So the total - are there  
9 opposed individuals opposed to the amendment? None. OK. That  
10 amendment carries.

11

12 ANGEL GUTIERREZ: Just for the record, Buffalo was in  
13 favor.

14

15 WILLIAM STRECK: I beg your pardon?

16

17 ANGEL GUTIERREZ: Just for the record, Buffalo, two votes  
18 affirmative.

19

20 WILLIAM STRECK: We had counted you. We see you.

21 [inaudible]

22

23 JEFF KRAUT: Dr. Streck, Dr. Strange has a question.

24

1 DR. STRANGE: So, my question deals with bullet two,  
2 naming convention and consumer disclosure. We talked  
3 specifically about what urgi care centers must provide and must  
4 have in them in the first bullet, and then we talked about  
5 naming. So who's going to look at these naming of some of these  
6 facilities and how certain entities may try to get around the  
7 use of being or using urgi care, for example, treat and release  
8 or some of the new ones that are popping up in Manhattan right  
9 now Prime Med and others, and maybe not offering X-ray abilities  
10 or do you even need an X-ray ability in a geriatric urgi center?  
11 How are we - where is the - there seems to be some gray here as  
12 opposed to the black and white, which I understand in terms of  
13 who's going to monitor, if somebody says they're a treat and  
14 release for lack of a better term or a fast track, but are  
15 really offering urgi type of care, how are we monitoring that?  
16

17 JOHN RUGGE: I think the Committee recognizes we can't  
18 control the language. People will be very creative. What we  
19 can do is strongly recommend a program to increase or develop  
20 public awareness of urgent care and limit the use of urgent care  
21 to those centers that have been accredited and therefore  
22 recognized. In the course of this there would be a requirement  
23 that those urgent care centers to secure their designation  
24 label themselves as an urgent care center. So the key is not  
25 whether somebody calls themselves treat and release, but whether

1 there is urgent. There's urgent care, the public will know,  
2 hopefully, what the service packages is including and those  
3 expectations will be met.

4

5 WILLIAM STRECK: Other comments or questions on the  
6 urgent care component of the proposals?

7

8 [I have a question. ]

9

10 JEFF KRAUT: Dr. Boutin-Foster.

11

12 CARLA BOUTIN-FOSTER: this is more of a question in  
13 terms of following up health outcomes and making sure that we  
14 capture any unintended consequences, for instance, an increased  
15 number of patients going to urgent care centers as opposed to  
16 the emergency room with chest pain or signs and symptoms of  
17 stroke. So, are there any procedures in place for the  
18 Department to monitor this, whether it's looking at what are the  
19 diagnoses coming in, the number of patients with chest pain or  
20 symptoms of a TIA and whether or not there's a decrease in  
21 patients' - or an increase in patients going to the emergency  
22 room with missed strokes and MI. So these are some of these  
23 unintended consequences that may occur. Sorry to be a pessimist,  
24 but just putting it out there.

25

1 JOHN RUGGE: We've been assured by the urgent care  
2 providers that already there is good public recognition of when  
3 to go to the ED and when to go to urgent care. Clearly there  
4 will be times when people misinterpret the significance of their  
5 symptoms and there will need to be referral arrangements. At  
6 least currently we have no, I guess, big brother strategy to  
7 assure that every such event is captured or reported.

8

9 JEFF KRAUT: Dr. Bhat.

10

11 DR. BHAT: The urgent care centers which are operating at  
12 the present time if they do not want to come under this  
13 regulation they can continue to function. Only thing is they  
14 cannot use the word 'urgi center' or 'urgent care center.' On  
15 the other hand I think if somebody would like to go along with  
16 these recommendations, will there be additional revenue that  
17 they could collect for providing the service because now going  
18 to be additional cost with the providing the care,  
19 with a lot of regulations that are coming in. In there a  
20 provision to provide more incentivize for the use  
21 of the word 'urgi center', 'urgent care center' would they get  
22 more revenue?

23

24 NIRAV SHAH: So the question relates to if they are  
25 calling themselves urgent care center, they want to have that

1 level of care, they will also get appropriate rates and  
2 reimbursement because they're calling themselves urgent care  
3 centers?  
4

5 DR. BHAT: That was the question.  
6

7 JOHN RUGGE: That, Dr. Bhat, is phase II. I think once  
8 we develop the designation, then there can be further  
9 deliberation by appropriate body as to what is the appropriate  
10 compensation being provided. And the Committee has not  
11 addressed that issue as of yet.  
12

13 DR. BHAT: OK. Thank you.  
14

15 WILLIAM STRECK: Other comments on the urgent care  
16 center proposals? Going? We'll move on.  
17 Freestanding emergency departments.  
18

19 JEFF KRAUT: Dr. Streck, Dr. Boufford has a comment.  
20

21 JO BOUFFORD: I'd like to question the language of the  
22 second bullet under number one where it says it is recommended  
23 that the hospital sponsored off-campus ED use the name of the  
24 hospital. I thought that we had said that we wanted it to use  
25 the name of the hospital so that it would be in fact, must use,

1 rather than recommended. So, it speaks to the issue of patient  
2 information and clarity. So that's one question. And the  
3 second one was under the second bullet under three, I assume  
4 that maybe allowed with considerations, maybe allowed, and I  
5 remember this debate - I'm not going to go into it again, Howard  
6 will he says, but it's presumably there needs to be some process  
7 other than a local decision about whether an ER becomes part  
8 time, at least that was the conversa - that's where the strain  
9 was taking us in the last conversation. So I think that may need  
10 to be more explicit there than it is at this time. Thank you.

11

12 JEFF KRAUT: And - Howard do you want to say something?  
13 Because I want to take an opposing point of view, but go ahead.

14

15 JOHN RUGGE: Maybe just, let me address the first point.  
16 I think that Dr. Boufford, you've expressed the intent of the  
17 committee better than the document does, and I think we can make  
18 the same kind of grammatical correction say that the hospital-  
19 sponsored off-campus shall use the name of the sponsoring  
20 hospital in it's name. Does that comport?

21

22 WILLIAM STRECK: OK. Again, this is, proposes a  
23 friendly amendment. Can I have a second?

24

25 [Second.]

1

2           JEFF KRAUT:       Second by Mr. Levin.

3

4           WILLIAM STRECK:     Any further discussion on this  
5 wordsmithing amendment? Hearing none I would ask for a - well we  
6 have to have a vote, so those in favor raise your hand please  
7 for aye.

8

9           JEFF KRAUT:       We have 13 affirmative votes in New York.

10

11          WILLIAM STRECK:     Opposed? That amendment passes. I  
12 would remind the group in New York turn your mics off if you're  
13 not speaking please. We're hearing more than you want.

14

15          JEFF KRAUT:       Dr. Streck, I've been asked to qualify the  
16 statement, we have 13 affirmative notes in the County of  
17 Manhattan since we're all in New York.

18

19          WILLIAM STRECK:     OK. Other comments? Questions? We  
20 had the question about the, Dr. Boufford's second point - wish  
21 to address that.

22

23          JEFF KRAUT:       Dr. Berliner.

24

1           HOWARD BERLINER:       Yes, this is Dr. Berliner. I would  
2 like to make an amendment or move an amendment. This is  
3 regarding recommendation three, the second bullet, and I'd like  
4 to remove that bullet completely so that this report does not  
5 mention in any way the possibility part time operation for an  
6 emergency room. Let me explain why I say this, and I've said  
7 this before so one more time won't hurt. This is a report  
8 largely about promoting and protecting primary care. Emergency  
9 services are a critical component of primary care. The idea  
10 that we, the consumers don't understand what urgent care is or  
11 don't understand what convenient care is or the kinds of  
12 services they will get in a pharmacy or in a WalMart or in a  
13 place like that, that needs to be reaffirmed in statute and  
14 regulation and yet we will let a concept that everyone  
15 understands, the emergency room, switch to a part-time basis  
16 just seems to me to be completely inconsistent with the rest of  
17 this report and where it's going. I understand that there may  
18 be circumstances under which a hospital may feel the financial  
19 strains that make it difficult to operate an emergency  
20 department for 24 hours. I believe the Commissioner has enough  
21 emergency authority to allow this to happen, should that be the  
22 case in a particular example. But the fact is that we are a  
23 wealthy state and we should not allow any community to go  
24 without emergency services for any part of the day. Emergencies  
25 don't just happen, you know, when an emergency room is open. I

1 could go on with other reasons why I don't think this is a good  
2 recommended, but mostly I don't think a recommendation for part  
3 time emergency rooms should have the imprimatur of the Public  
4 Health and Health Planning Council of New York State. So, I  
5 again, move that that bullet be stricken from the  
6 recommendations.

7

8 WILLIAM STRECK: So we have a motion. Is there a  
9 second?

10

11 JEFF KRAUT: We have a second by Dr. Strange. We have a  
12 comment by Dr. Boufford and myself.

13

14 JO BOUFFORD: I'm just, I'm wondering Howard, because as you  
15 know my sentiments are sort of in that direction but I think I'm  
16 suggesting perhaps that if your amendment were passed and that  
17 bullet was deleted that in the first bullet where it says  
18 "generally" and in the third and fourth where it speaks, or the  
19 fourth where it speaks to "If there is a request for part-time,  
20 require full CON review." I know it doesn't respond to the  
21 urgency question that's been raised in these local  
22 conversations, but perhaps it leaves flexibility for exactly  
23 what you're talking about but doesn't encourage it.

24

1           HOWARD BERLINER:       If I can respond.  Yes.  If the second  
2 bullet remains in the draft then I believe the fourth bullet is  
3 absolutely important that this has to require a full Certificate  
4 of Need review.

5  
6           JO BOUFFORD:       All I'm saying is you could take the second  
7 bullet out and still with the word 'generally' in the first  
8 bullet and the last one then it sets up a process for part-time  
9 review, that speaks to the concern I had that it isn't sort of  
10 local decision.  But, anyway.  Just another thought about  
11 drafting.

12  
13          HOWARD BERLINER:       Let me amend my amendment to deal with  
14 the points that Dr. Boufford has raised.

15  
16          JEFF KRAUT:        Maybe we could come back in a second.  So I  
17 take a different point of view on this.  I think nobody wants to  
18 see a hospital close, but the fact is they do close.  In the  
19 wake of those closures what we want to ensure is where a  
20 community has depended on that hospital's emergency department  
21 as the front door to services, we now want to make it clearer on  
22 how to preserve that access to services.  Similarly we now have  
23 cases where a hospital has closed, where a community has, had a  
24 part time, had a full-time emergency department, freestanding,  
25 and now the community's healthcare needs have changed in that

1 they found different ways or those services are not being used  
2 in the same way and it's creating, frankly, an economic burden  
3 to some degree for the provider and for the services to be  
4 maintained. We're offering yet another option to try to  
5 maintain some degree of services, and that is a part time. Now,  
6 as distasteful and inappropriate as you may find that, it's  
7 still an option, and by eliminating that option we've  
8 essentially gone that if you're a provider or a freestanding ED  
9 and you no longer are economically able to do this or the  
10 community - which is because the community does not have the  
11 volume or support to provide that service, we're essentially  
12 saying you either stay open, or you close completely; that  
13 there's no middle ground. And I just, Jo, what I was going to  
14 suggest was something that would embrace that and frankly we  
15 recognize that we want these things to not so much to happen,  
16 but we want them to be available and the armamentarium on how  
17 healthcare is changing, and I wanted to remove the full-time - I  
18 wanted to make a friendly amendment to remove full-time  
19 requirement and basically saying a freestanding emergency  
20 department is essentially an extension clinic, and extension  
21 service of an existing article 28. The current regulations are  
22 that an existing - and extension clinic such as a satellite  
23 would be considered as an extension and then we could apply -  
24 and then we would classify that as a construction application  
25 and they're eligible for an administrative CON review (oh,

1 please) and therefore there would not be a need for a full  
2 review. It is the process of going through the full review that  
3 - again, we've said we want these things to be preserved. And I  
4 understand the thing and I would've made the same issue with  
5 somebody going from full-time to part-time, that it's an  
6 administrative, it's a notification to the Department and the  
7 Department should therefore just approve the plan and the  
8 timetable. And I understand these are hotbutton issues, but I  
9 wanted to amend that to remove administrative from part time and  
10 to go from full review to administrative for establishment.

11

12 WILLIAM STRECK: So we have two views on the table right  
13 now. Dr. Shah.

14

15 JEFF KRAUT: Dr. Boufford -

16

17 JO BOUFFORD: No, I just don't understand how -- it's not  
18 clear in the language.

19

20 WILLIAM STRECK: Pardon me. Manhattan. Turn off your  
21 mics if you're not using your mics. Dr. Shah.

22

23 NIRAV SHAH: I want to expand on what Jeff just said. I  
24 think that we realize that the need for high quality 24/7  
25 emergency care is real across the State. The financial

1 realities of some parts of the State north of Manhattan  
2 especially make it impossible to maintain such services in all  
3 circumstances in all places, and the reality of what we've seen  
4 in just the past year with three different places that I can  
5 talk about in detail where the opportunity to have a part-time  
6 ED versus no care was the only options. And so if it's all or  
7 part-time - there's three levels; all full-time ED, part-time  
8 ED, or none. Today that part-time ED doesn't work under our  
9 current rules and regulations. To explicitly state that under  
10 certain guidance, under certain terms we will allow some level  
11 of emergency care, can make a difference in a community between  
12 economic survival and slow but sure debt. We have a very good  
13 example in Lake Placid that people are very aware of where for  
14 example, we know that financially it is a big burden on the  
15 institution to maintain a full services emergency room 24/7 and  
16 yet with sports activities, with other planned events, the need  
17 for a real emergency room must be there to have an event occur  
18 in Lake Placid. That's one example where right now if there  
19 isn't an option the institutions involved have suggested that  
20 there will be nothing there, and so we're going from all to  
21 none. If there is an intermediate pathway it can help the  
22 community, it can still provide care for the vast majority of  
23 the potential injuries needed in an emergency room setting, and  
24 yet still facilitate building up that ecosystem. Remember, what  
25 we're talking about in this whole document is creating

1 additional niches. Of course they will need some sort of  
2 oversight and review. Of course that we will evolve our  
3 recommendations over time and we will have a second bite at the  
4 apple as we write the regulations. This is just setting the  
5 standard and saying we're looking to fill out the ecosystem.  
6 This is one model that we have to consider more explicitly. In  
7 the regulation phase we will talk about what specifics are  
8 needed and that's why we're promoting it explicitly in this  
9 document.

10

11 JOHN RUGGE: Just to build on what Dr. Berliner said, we  
12 are a wealthy state, but unfortunately we have some very poor  
13 communities that also happen to be very remote. And I think  
14 looking at the positive and that is by having a part-time ED you  
15 have the capacity to place, to establish a place of care that is  
16 able to receive ambulances, therefore relieving those rural  
17 very long drives when they may not be necessary during the day,  
18 and also EMTALA, so that all patients  
19 are assured of a local place of care that otherwise would not be  
20 available to them.

21

22 JEFF KRAUT: But we have several hands up down here. Is  
23 that -

24

1 WILLIAM STRECK: Before we proceed Jeff, could I just  
2 offer a little parliamentary GPS here? We have a motion on the  
3 table that has been seconded. That's Dr. Berliner's motion.  
4 That is an amendment to the initial motion and we have Mr. Kraut  
5 on the sideline holding a motion in his hand. So that's where  
6 we are at the moment. We should address the motion that is on  
7 the table first, try to resolve our thoughts about that so that  
8 we can progress through this sequence.

9

10 JEFF KRAUT: Could you just repeat -

11

12 WILLIAM STRECK: Comments are welcome.

13

14 JEFF KRAUT: Yes, we've asked first we have several hands  
15 up. The motion is to eliminate part-time - the second bullet.  
16 Part-time operation is to be eliminated. That's the motion.  
17 And we have Dr. Boufford, Mr. Fensterman, Dr. Martin. OK. and  
18 then - was there anybody else? Dr. Palmer, did you have your  
19 hand up?

20

21 DR. PALMER: I just want some clarification because, Jo,  
22 you made an addendum or a request for an addendum to the motion  
23 -

24

25 JO BOUFFORD: Just a clarification. It wasn't a -

1

2 DR. PALMER: I wanted to figure out how that just fit  
3 into what Jeff, you just said. So.

4

5 JEFF KRAUT: I think we're going to put my thing aside  
6 for the moment. Is that right Dr. Streck.

7

8 WILLIAM STRECK: Yes, we are on Dr. Berliner's motion  
9 right now.

10

11 JEFF KRAUT: Elimination of the part-time clinic. So,  
12 Mr. Fensterman and then anybody else.

13

14 HOWARD FENSTERMAN: My question is for Dr. Ruge. If you  
15 note in the first bullet in number three, it's generally 24  
16 hours a day 7 days a week. And in the second bullet it's 12  
17 hours a day, but it doesn't say 7 days a week. So for purposes  
18 of clarification for me, is this 12 hours a day 7 days a week?  
19 Is that the intention?

20

21 JOHN RUGGE: Yes.

22

23 HOWARD FENSTERMAN: OK. So that.

24

1 JOHN RUGGE: Yes. The intention is 7 days a week. And  
2 that will be made clear in the final document.

3  
4 HOWARD FENSTERMAN: OK. That's my first observation. My  
5 second one is is that if we were to sort of read one and two  
6 together and as a lawyer when I see the word 'generally' it  
7 gives me great concern because I don't know really what that  
8 means and who is going to interpret that, and I really don't  
9 want to put that in the hands of a Supreme Court judge at some  
10 point. So I'm suggesting that it seems that we are going in a  
11 direction here between 12 hours and 24 hours, and generally 24  
12 hours, does that really mean, was it the intention of the  
13 Committee to say that we are prepared to have these facilities  
14 operate between 12 hours a day and 24 hours a day, 7 days a  
15 week, because that seems to be what the use of the word  
16 generally means. That's my question, Dr. Ruge. Was that the  
17 intention of your Committee?

18  
19 JOHN RUGGE: The intention is to say that off-campus EDs  
20 would be generally working 24 hours per day and only by  
21 exception with authorization by the Commissioner would such an  
22 ED be allowed to operate on a less than 24/7 basis in which case  
23 it would be no less than 12 hours per day, 7 days per week.

24

1           HOWARD FENSTERMAN:   So, your usage of the word generally  
2 was to mean that they will be operating 24 hours a day unless  
3 the Commissioner takes a contrary position and gives basically a  
4 waiver.

5

6           JOHN RUGGE:       That's right.  
7 Circumstances of that particular community.   Yes.

8

9           JO BOUFFORD:    Yeah, that makes sense John, but I don't  
10 believe it's what this language says.   So in my original  
11 question had to do with who gets to opine on bullet two assuming  
12 that it is a part-time, and then it would seem to contradict  
13 bullet four which says reduce an existing full-time ED to part-  
14 time would require full CON review.   So I think the language is  
15 confusing and probably if it were clarified might solve people's  
16 concerns.

17

18           JOHN RUGGE:       Yeah, and I think that Mr. Kraut's amendment  
19 will be very helpful in terms of clarifying that once we work  
20 through the amendment that is now on the floor.

21

22   [I'm not sure John.]

23

1           JO BOUFFORD:    I'm think Jeff was going for admin versus  
2 full as an issue as I heard him which I think is not what this  
3 is. This is a second order conversation.

4  
5 [The conflict is whether this is within the discretion of the  
6 Commissioner, period, which is what you suggested. The  
7 Commissioner makes that decision, or it has to go through - the  
8 Commissioner makes that decision and/or it goes through a full  
9 CON review. Two different things. So we need to clarify.]

10

11           WILLIAM STRECK:       Thank you. Dr. Gutierrez.

12

13           ANGEL GUTIERREZ:    Yes, I think I was peripherally  
14 involved in the Lake Placid discussion, and a big difference  
15 came when people understood that there is a difference  
16 talking emergency room versus emergency service. Emergency  
17 service should be available 24 hours. An emergency room cannot  
18 stay open 24 hours. Not in some places in the state. And I  
19 semantics we're using may facilitate the understanding for  
20 people that need to digest this before they

21

22           WILLIAM STRECK:       Thank you. Are there additional  
23 comments on the amendment? Hearing none, then I would ask for a  
24 vote on the amendment as proposed by Dr. Berliner to strike  
25 bullet two under section three about part time operation.

1

2           ART LEVIN:           I just need a point of clarification.  Where  
3 are we with this sort of revised clarification on the authority  
4 issue.  In other words, everybody agrees that we sort of muddied  
5 the waters here where the Commissioner has the discretion to do  
6 this and/or a full CON review.  We need to clarify that because  
7 I think it's critical to how I would vote on the amendment.

8

9           WILLIAM STRECK:       OK.  You want to elaborate on that?

10

11          JO BOUFFORD:       If I can try.  If you strike bullet two, if  
12 the motion is to strike bullet two as written that it could go  
13 up or down and then we can go back to the issue of modifying it  
14 if it stays in.

15

16          WILLIAM STRECK:       Is that acceptable?  Mr. Levin?

17

18          ART LEVIN:           Yep.

19

20          WILLIAM STRECK:       All right.  So, we're back to the vote.  
21 So, the motion is to strike bullet two under section three.  
22 Those in favor of the motion as proposed please raise your hand  
23 to be counted.

24

1 JEFF KRAUT: There are three affirmative votes in New  
2 York. In Manhattan. Three affirmative votes on Church Street.

3

4 WILLIAM STRECK: Buffalo?

5

6 ANGEL GUTIERREZ: Zero.

7

8 WILLIAM STRECK: Rochester?

9

10 CHRIS BOOTH: Zero.

11

12 WILLIAM STRECK: Albany? The motion fails. Is there  
13 further discussion on the topic of freestanding emergency  
14 departments?

15

16 JEFF KRAUT: Could I make my amendment?

17

18 WILLIAM STRECK: You are welcome to, Mr. Kraut.

19

20 JEFF KRAUT: OK, but I'm going to make the amendment,  
21 make a motion and then Mr. Levin's going to ask for  
22 clarification on some of the authority issues. So what I'm  
23 suggesting is if you request - if you're an existing article 28  
24 provider that requests for a full-time off-campus ED that will  
25 require a limited review. It'll be treated as an extension

1 clinic. And we'll come back to how limited review authority is  
2 done in a second. If you're an existing - I'm sorry - yeah.

3

4 JOHN RUGGE: Do you mean limited review or administrative  
5 review?

6

7 JEFF KRAUT: I'm sorry, did I say -

8

9 CHARLIE ABEL: Currently the regulations would require an  
10 administrative review. This is Charlie Abel.

11

12 JEFF KRAUT: Yeah I - So, therefore, so that's going to  
13 be an administrative review, right? Because I'm changing it  
14 from full CON review to an administrative review. And then -  
15 oh, did I say limited? I'm sorry. I meant administrative. The  
16 request for a part-time operation of a new off-campus would  
17 basically be a limited review - I'm sorry, administrative review  
18 where the Department would essentially approve the plan and the  
19 time table for the reduction of hours. Neither of those would  
20 come to the Council.

21

22 WILLIAM STRECK: Is there a second to that motion?

23

24 JEFF KRAUT: We have a second by Mr. Fassler.

25

1 WILLIAM STRECK: Mr. Fassler, thank you.

2

3 ART LEVIN: I'd like to make a request of the maker of  
4 the motion to separate the two issues.

5

6 JEFF KRAUT: OK. Dr. Streck, which I'm fine.

7

8 WILLIAM STRECK: Please turn off your mics if you are  
9 not the one speaking please. Go ahead.

10

11 JEFF KRAUT: Mr. Levin asked me that he would like to  
12 have the discussion and those motions separated into two  
13 motions. He would like the first motion to be a full-time off-  
14 campus ED requires an administrative review. That's the motion.  
15 Let me just make that motion. Do I have a second? By Mr.  
16 Fassler.

17

18 WILLIAM STRECK: Motion made and seconded. Any  
19 discussion on that motion? Hearing none -

20

21 JEFF KRAUT: Hold on, we have Dr. Strange.

22

23 DR. STRANGE: On bullet four if you're a - Jeff, just  
24 clarify for me-

25

1           JEFF KRAUT:       We're not on four. We're only talking -  
2 we're not changing - we're only doing full-time ED.

3

4           DR. STRANGE:     So if you're a new - no not part time - so  
5 you're not talking about part-time?

6

7           JEFF KRAUT:       Not at all.

8

9           DR. STRANGE:     OK. Sorry.

10

11          JEFF KRAUT:       No discussion down here.

12

13          PETER ROBINSON:   This is Peter Robinson in Rochester.  
14 Just a clarification please. Does this motion apply to existing  
15 hospitals who are going to be closing their inpatient beds and  
16 therefore would have remaining a freestanding ED versus the de  
17 novo creation of a freestanding ED?

18

19          CHARLIE ABEL:     Yes, this is Charlie Abel. Currently the  
20 regulations that would actually require, would actually only  
21 require a limited review to decertify all services except for  
22 the emergency department or emergency services.

23

24          PETER ROBINSON:   OK, so what - I just want to be clear  
25 that what we're voting on here are existing hospitals that are

1 resizing and restructuring eliminating most or all of their  
2 inpatient services and want to retain in connection with another  
3 hospital a freestanding ED. No somebody who's coming in with a  
4 brand new application to plunk a freestanding ED in a community  
5 that doesn't have one. Yes. I just want to be clear that  
6 that's what we're voting on.

7

8 JEFF KRAUT: No, it's -

9

10 JOHN RUGGE: ...assigning responsibility to a new, to  
11 another hospital in lieu of the hospital that's closing it's  
12 inpatient beds, is that correct?

13

14 CHARLIE ABEL: Dr. Rugge's question was if -

15

16 JEFF KRAUT: That's not what I said.

17

18 CHARLIE ABEL: If the hospital is going to go essentially  
19 out of business but they want to retain emergency services at  
20 that site to be run by another hospital, that would be an  
21 administrative review by hospital B, operate an extension site  
22 for emergency services at that hospital A site.

23

24 PETER ROBINSON: I understand. That's what I was  
25 getting at. I just wanted to be clear that we were not going to

1 be creating this opportunity for you know, a rapid expansion of  
2 emergency rooms all over the State, but really a resizing to fit  
3 communities who have needed to restructure their services,  
4 particularly eliminating inpatient care. Is that, right?

5

6 JOHN RUGGE: That's right.

7

8 PETER ROBINSON: I just - the administrative review for  
9 me is a downsizing of a hospital and a restructuring. If we're  
10 going to the establishment of new EDs, even though they are  
11 connected to hospitals, I think that should be a CON. Non-  
12 administrative review.

13

14 WILLIAM STRECK: That's in that section four? Peter I  
15 think that's section four. Which has full CON review, at least  
16 in this proposal. I think that's the difference.

17

18 PETER ROBINSON: So you're affirming what I just said  
19 then? Is that right?

20

21 WILLIAM STRECK: I'm hoping I'm affirming but I do think  
22 your point is well taken. Section three is not clear as to  
23 exactly to whom this applies.

24

1 PETER ROBINSON: So then I'm asking for clarification of  
2 the motion to make that distinction.

3

4 KAREN WESTERVELT: So, Charlie restate it again.

5

6 CHARLIE ABEL: I mean, the prem - the understanding  
7 definition of a hospital-sponsored off-campus emergency  
8 department implies and includes that a hospital is running it.  
9 So, if a hospital is going to decertify itself as a hospital or  
10 essentially go out of business and another hospital is proposing  
11 to run an off-campus emergency department at that site, then  
12 obviously it would be the hospital that is going to have  
13 governance over that emergency department, it would require an  
14 administrative CON to be submitted and approved as currently, as  
15 the regulations current reside.

16

17 PETER ROBINSON: So, Charlie, yes I agree that that is  
18 the intent. What I am concerned about is not the hospital  
19 that's transitioning and another hospital taking it over. I am  
20 concerned about brand new freestanding EDs.

21

22 JOHN RUGGE: I think administrative review is understood  
23 to apply only to downsizing institutions where the hospital ER  
24 is being, changing it's of authority to another  
25 hospital.

1

2           PETER ROBINSON:       That's right. For that I would suggest  
3 administrative review is fine. For any other freestanding ED, I  
4 think that's full review.

5

6           CHARLIE ABEL: Well, OK, we have a couple of options.  
7 We've got a brand new emergency department, freestanding  
8 emergency department to be sponsored by, to be constructed where  
9 no healthcare facility currently is, to be constructed by an  
10 existing and established hospital. Right now that would be -  
11 right now the regulations would permit that through an  
12 administrative review as an extension site. We have in the past  
13 elevated those kinds of things to full review just for, just to  
14 advise the PHHPC but they don't require that and we've retained  
15 the authority to do that administratively. If you're talking  
16 about a brand new freestanding ED that is proposed to be  
17 operated by a non-established entity, the whole policy right now  
18 does not permit that to be established or approved.

19

20           PETER ROBINSON:       OK. I'm going to go -

21

22           JEFF KRAUT:       Hold it, hold it, Peter, Peter, let me just  
23 suggest - Charlie, Peter is making a point about predatory ED  
24 placement. He's basically saying if hospital A opens in their  
25 own hospital it's fine. But hospital B which is across town

1 can't open a freestanding ED across the street from them  
2 administratively. He's trying to show that distinction. It's a  
3 predatory placement issue. Mr. Levin has an issue.

4

5 ART LEVIN: I think we've got some confusion and  
6 conflict between section three which is purportedly titled  
7 "hours of operation" and therefore should be limited to that,  
8 and section four which talks about need methodology and CON  
9 process. And I think we have some work to do to be in  
10 conformance with what we're calling these sections and what  
11 we're discussing. Three is about hours. It doesn't, that title  
12 does not say to me this is relevant to hospitals that close  
13 their inpatient facilities and open an ED. So we need to clarify  
14 the language here because we're going to get nowhere today with  
15 this.

16

17 JEFF KRAUT: So if we focus on section four, that's the  
18 issue. Ignore three for a moment.

19

20 ART LEVIN: Let's clean up three which is about hours  
21 and I think we're, other than a defeat of Howie's amendment that  
22 we sort of have made some progress toward consensus on what that  
23 should be. If everybody agrees, limit that to the hours of  
24 operation issue and then take four and -

25 [inaudible]

1           JEFF KRAUT:        You heard what Mr. Levin said?

2

3           WILLIAM STRECK:       Yes, we did.    So, I guess the question  
4 is, is three ok now to move to four where we would address these  
5 two distinctions?

6

7           ART LEVIN:         No, no. I mean, I think we would take out  
8 bullets three and four. I think - the only thing that now  
9 speaks to hours is bullet one, as we've sort of modified it.

10

11          JEFF KRAUT:        Dr. Boufford.

12

13          JOHN RUGGE:        What I'm hearing, I think - let me say what  
14 I think I'm hearing is going from a full-time ED to part-time ED  
15 would be subject to administrative CON review that the  
16 downsizing or closure of a hospital but preservation of the ER  
17 by assigning sponsorship to another hospital will be subject to  
18 administrative review. And establishment of a new ED that  
19 doesn't exist at a new site would require full CON.

20

21          PETER ROBINSON:     That's correct Dr. Rugge. That's what  
22 I'm suggesting Dr. Rugge.

23

24          JOHN RUGGE:        And I think that is what Jeff is leading to,  
25 but his motion was only addressing part of that three part

1 approach. And we were getting mixed up about which one we're  
2 talking about.

3

4 JEFF KRAUT: OK. We have Dr. Boufford then Dr. Martin.

5

6 JO BOUFFORD: Just, I'm not going to comment on the last  
7 statement which sounded like it was a correct reflection of the  
8 conversation so far, but we did say that on bullet two of three,  
9 if we're focusing on hours, that a minimum of 12 hours a day, 7  
10 days a week I believe was to be added to number two as a minimum  
11 for a part-time operation.

12

13 JEFF KRAUT: Dr. Martin.

14

15 GLENN MARTIN: Thank you. So I guess I'm now responding to  
16 what I guess is still a motion, because it's not what was here  
17 and it did not reflect, I believe, what we originally voted on  
18 because we did have this discussion at the committee level,  
19 which was we at that point voted that if you were going from a  
20 full-time ED to a part-time ED that that required a CON that  
21 would come to this committee, and I understand the situation,  
22 and we discussed the fact that there may be emergency  
23 situations, it was already clear that the Commissioner has  
24 tremendous emergency powers that would allow him to deal with  
25 the situation if it occurred in an incredibly fast situation

1 that he needed to act. We also discussed the fact that a lot of  
2 times the need for quick decision is because there was long  
3 preparatory things that didn't get to the point of actually  
4 decision and then suddenly it's an emergency. It's like the  
5 Jacque Cousteau, suddenly the sun rose, and we reacted to it. I  
6 believe that this experiment in part-time EDs is something that  
7 we need to do for the reasons that Dr. Shah elucidated, excuse  
8 me, I agree with them, but I believe it is of sufficient  
9 importance and we have enough trepidation about how this is  
10 going to work that it requires a full CON if you are going from  
11 a full- to a part-time in a situation described. So I disagree  
12 with changing what we currently have, and which we had discussed  
13 before which was that requires full CON.

14

15 JEFF KRAUT: Dr. Bhat.

16

17 WILLIAM STRECK: So, thanks Glenn. You are disagreeing  
18 with Jeff who I believe I'm trying to backtrack our discussion  
19 here. Jeff did you get that, your discussion to a motion yet,  
20 or were you just discussing it?

21

22 JEFF KRAUT: I think I made a motion and I think Mr.  
23 Fassler seconded it.

24

1 WILLIAM STRECK: So we do have a motion and a second,  
2 and would you repeat your motion just so we can recalibrate.

3

4 JEFF KRAUT: I'm going to repeat my motion, but I think  
5 given what Mr. Robinson said it may need to be amended to be  
6 clear of the different situations. But what I said is if - and  
7 I'll be clearer - if an existing provider requests a new full-  
8 time off-campus ED, that would require an administrative review.  
9 Request for part-time operation of a new off-campus ED or to  
10 reduce existing full-time ED hours to part-time will also  
11 require an administrative review.

12

13 ART LEVIN: And how does that comport with four, Jeff?  
14 Section four?

15

16 JEFF KRAUT: This should be - both of those things apply  
17 to an existing provider, as far as I was concerned.

18

19 PETER ROBINSON: Mr. Kraut, can I just ask you to sort  
20 of tweak that motion a little bit -

21

22 JEFF KRAUT: Do what you want.

23

24 PETER ROBINSON: So that it distinguishes between an  
25 existing emergency department that's converting to a new

1 sponsor, if that's the way to describe it, versus an entirely  
2 new entity.

3

4 JEFF KRAUT: OK. I absolutely want that - whatever  
5 language needs to be clear as you propose this it should be an  
6 existing provider that is - exactly what you just said, because  
7 I'm not going to repeat it correct.

8

9 ART LEVIN: Would that mean that four would be a need  
10 methodology for new hospital-sponsored?

11

12 JEFF KRAUT: Yes. I think what you would need to prevent  
13 some of the concerns Mr. Robinson had, when we do a -- I don't  
14 believe you could do a need methodology, but let's say you can,  
15 we, I think the Committee was clear, they did not, they didn't  
16 want to see the proliferation of these freestanding EDs for a  
17 predatory purpose. What we wanted to see was these EDs to  
18 maintain access to services of hospitals that were imperiled or  
19 about to close or substantially change. That really was the  
20 intent.

21

22 WILLIAM STRECK: So, Jeff, if I may, an existing  
23 provider, assuming the sponsorship of an existing emergency room  
24 would require administrative approval.

25

1 JEFF KRAUT: That's correct.

2

3 WILLIAM STRECK: An existing provider that wish to  
4 establish a new freestanding emergency room or reduce services  
5 in an existing one, would also require administrative approval.  
6 That is what you're proposing.

7

8 JEFF KRAUT: That is correct.

9

10 PETER ROBINSON: NO, no, no, no. That last point, Dr.  
11 Streck. The new - I want to make sure we are clear about here  
12 is the administrative review for hours and the administrative  
13 review for transition of sponsorship of an existing ED in a  
14 downsizing or a closing hospital is one thing. For a new entity  
15 from an existing provider in a new location, that would require  
16 full review CON.

17

18 [Can you break it into three amendments? It's three different  
19 changes.]

20

21 JEFF KRAUT: Yes.

22

23 PETER ROBINSON: No, this is all clarification of the  
24 motion.

25

1 WILLIAM STRECK: That's fair. OK. Charlie.

2

3 CHARLIE ABEL: I just have to add this because I know it  
4 exists, and it will exist, is an emergency department is part of  
5 a hospital that closes and it so it's not an existing emergency  
6 department, but it's a site of a former emergency department  
7 that a new sponsor wants to come in and certify as an off-campus  
8 provider-sponsored ED. Administrative or full review?

9

10 PETER ROBINSON: That really depends. If we're talking  
11 a matter of a very short period in which the Department is doing  
12 some kind of an emergency transition then that would be an  
13 administrative review. But I don't know what the time gap is,  
14 but at some point services get redistributed, then you are  
15 actually establishing something very much new. So I would be  
16 careful not to sort of blur that line too much and put a very  
17 clear time limit on that transitional period.

18

19 JEFF KRAUT: And to that point.

20

21 NIRAV SHAH: I just want to remind everyone this is just  
22 recommendations and ultimately we will have opportunities in  
23 such instances to use the Commissioner's powers to make sure  
24 these transitions happen that maintain safety and quality.  
25 Obviously each case will be taken on one by one. If it's a

1 three month delay doesn't mean that it can't happen versus it  
2 might happen in some instances. So I would caution that we  
3 don't get too into the (weeds) while it is real. Remember, these  
4 are recommendations and at the end of the day there are  
5 emergency powers and emergency situations which will take all of  
6 this into account.

7

8 WILLIAM STRECK: Jeff, we still have your motion on the  
9 floor, as it exists in it's tattered state. Can you read what  
10 we think we have, again?

11

12 JEFF KRAUT: Could somebody up there from the attorneys  
13 restate my motion so nobody's going to debate it? I mean, you  
14 could debate it, I just want to be clear what I just said. I'm  
15 not stating it guys. One of you guys tell me what I said.

16

17 JOHN RUGGE: (it's like a pot of stew;) we'll know it  
18 when we see it.

19

20 JEFF KRAUT: Well, in all fairness, the Commissioner's  
21 comment was the most important which is that third bullet on  
22 item four. No matter what you're not going to prevent a  
23 hospital from clo - you want an emergency room to open the day a  
24 hospital closes, and you could follow CON 30, 60, 90 days later  
25 to take care of it, but let's just make sure that, you know,

1 nobody's debating that power, I think. So the issue here is for  
2 an existing provider to take over an existing emergency service  
3 department they may do so under an administrative review,  
4 period.

5

6 NIRAV SHAH: Yes.

7

8 JEFF KRAUT: For a existing provider to take over an  
9 emergency room on a part-time basis or an existing emergency  
10 provider to take over, to have an emergency room that they're  
11 running as a freestanding and to go from full-time to part-time,  
12 I'm also suggesting needs an administrative review for existing  
13 providers.

14

15 NIRAV SHAH: Yeah, why don't we take those and separate  
16 them. Do the first one first.

17

18 JEFF KRAUT: Yes. So, they want me to say it again so I  
19 mean it. So, it's an existing provider that takes over an  
20 existing emergency department or another hospital that has been  
21 running an emergency department and creates a satellite  
22 freestanding ED may do so through an administrative CON  
23 application. I'll leave it at that's the motion. And Dr.  
24 Berliner has a question.

25

1           HOWARD BERLINER:       So if a new provider - if a new  
2 hospital wanted to take over the emergency room of another  
3 hospital, could it, would it have to do it, could it do it as a  
4 part-time emergency room? Or would have to do it as a full-time  
5 emergency room?

6  
7           JEFF KRAUT:       I'm only making this motion for a full-time  
8 right now. Only for a full-time, so if somebody's going to take  
9 over Lich or INterfai-you know, they could do it right now  
10 through an administrative or the Commissioner's action.

11  
12          WILLIAM STRECK:       You want that as a separate motion?

13          JOHN RUGGE:       One at a time.

14  
15          JEFF KRAUT:       No, we're doing it one at a time.

16  
17          WILLIAM STRECK:       OK. So is there a second for that  
18 motion?

19  
20          [Second]

21  
22          JEFF KRAUT:       Second, Mr. Fassler.

23

1 WILLIAM STRECK: Motion and a second. Is there more  
2 discussion on that motion? Hearing none, those in favor of the  
3 motion as proposed, please raise your hand to be counted?

4

5 JEFF KRAUT: There's 13 on Church.

6

7 WILLIAM STRECK: OK. That motion carries. Is there  
8 anyone who wants to vote against it? Should've said that in  
9 reverse order. In any case, it does carry. All right.

10 Now, next, Mr. Kraut.

11

12 JEFF KRAUT: The second motion deals with the  
13 establishment of a part-time emergency department or the  
14 movement from a full-time freestanding emergency department to  
15 part-time. So that's what I'm talking - for an existing provider  
16 who is assuming control of an existing hospital or service to  
17 establish it as part-time would require an administrative CON.  
18 For an existing operating freestanding emergency department that  
19 goes from full-time to part-time would also require an  
20 administrative CON.

21

22 WILLIAM STRECK: is there a second?

23

24 [Second]

25

1 JEFF KRAUT: Second, Fassler.

2 Dr. Boutin -

3

4 WILLIAM STRECK: Is there discussion on this motion?

5

6 JEFF KRAUT: Yes. We have a couple of hands up. Dr.

7 Boutin-Foster.

8

9 CARLA BOUTIN-FOSTER: So, by saying that are we saying  
10 that it's OK for an emergency service to be established on a  
11 part-time basis at the outset as opposed to assuming it's going  
12 to be full-time and you know, if things happen then there would  
13 be consideration for a part-time? Because right now it says  
14 that an existing department can establish a part-time service,  
15 which goes back to, I think, what Dr. Berliner was saying that  
16 when you're talking about emergency services, should you start  
17 out talking about part-time. I recognize things will, may  
18 happen and conditions may change that we, that a full-time  
19 considers becoming part-time versus closing, but at the outset,  
20 at the outset should we say -

21

22 JEFF KRAUT: So, Dr. Streck, I think to move this along  
23 what I'm seeing people's head shaking, I should separate the  
24 motion. I should separate it to be, and if you'll forgive me,  
25 I'm going to separate the motion by saying for an existing

1 provider operating a full-time freestanding emergency department  
2 who wishes to go part-time off-campus - who wishes to go part  
3 time, that should be done by an administrative CON. So we're not  
4 talking about establishing a de novo part-time. We're going  
5 from full-time off-campus to part-time off-campus through an  
6 administrative CON. So if I could amend my amended motion,  
7 second by Mr. Fassler.

8

9 WILLIAM STRECK: So you've amended - OK, could I ask you  
10 again, turn off your mics if you're not using them in New York  
11 please. So the amendment is for an existing freestanding  
12 emergency room may reduce it's hours on the basis of an  
13 administrative CON. Is there a second. There was a second. Is  
14 there further discussion on this amendment?

15

16 JEFF KRAUT: Hold on. Dr. Boufford just wanted to - she  
17 was saying I don't think that's what I said. I wanted to clarify  
18 that it was an existing provider taking over. This is the -  
19 this is essentially - Dr. Boufford, it's somebody who's already  
20 been approved for a freestanding ED who moves to part-time hours  
21 whatever way they've been established. So it's not taking -  
22 because it would've been after the act occurred to establish a  
23 freestanding ED.

24

1           JO BOUFFORD:    But I think for those of us not in the  
2 hospital business, that needs to be clarified because it speaks  
3 to Dr. Boutin-Foster's concern.

4

5           JEFF KRAUT:      But that's why I'm trying to separate the  
6 two issues.

7

8           JO BOUFFORD:    But I thought you said sponsor take over.

9

10          JEFF KRAUT:      Nope.

11

12          JO BOUFFORD:    He didn't say that when you -

13

14          JEFF KRAUT:      I know. That's why I'm just saying. This  
15 is where we've - somebody has established a freestanding ED.  
16 Whatever means. Full review, whatever means. It's been  
17 established.

18

19          [Satellite?]

20

21          JEFF KRAUT:      It's a satellite - let me just use the term  
22 freestanding ED which encompasses a satellite. So the  
23 freestanding ED, it's been approved; they've been operating it.  
24 They now find that they want to reduce the number of hours.  
25 They apply now to go to part-time. I'm suggesting the

1 application to go to part-time should be considered an  
2 administrative CON action. So it's not a new, not necessarily -  
3 somebody that's been approved already, however they got  
4 approved. Only hospitals get established to do this. We've  
5 prevented that. So we're clear? Dr. Martin.

6

7 GLENN MARTIN: So I think this is the timely moment where I  
8 should speak against the amendment for the reasons that I had  
9 stated before that this is something that is probably not going  
10 to occur all that frequently. We have a needs methodology that  
11 doesn't exist yet, and which actually Mr. Kraut has already  
12 expressed some skepticism about whether or not we'll ever be  
13 able to come up with one, certainly not quickly. And I believe  
14 that there is enough concern; I certainly have enough concern  
15 about how this is going to work, if it is going to work, it's  
16 impact on the communities that are involved that I believe it is  
17 appropriate for us to give it a full CON review. It is quite  
18 possible that after a year or two or whatever this will be  
19 another one of those idiot things that has been said that wastes  
20 our time and I will lead the charge to say no, administrative is  
21 just fine, but for now I'm not comfortable with this and believe  
22 that the appropriate safeguard would be to have those changes  
23 from full to part-time come through a full CON and review by  
24 this committee. Thank you.

25

1           JEFF KRAUT:       Dr. Berliner.

2

3           HOWARD BERLINER:       Yeah, I concur with Dr. Martin on this.

4 It seems to me to exclude the community you know, from this kind  
5 of a discussion about the delivery of healthcare within their  
6 boundaries is just incompatible with where you know, this  
7 council should be. We've had some of our most vigorous  
8 discussions you know, prompted by community residents unhappy  
9 with these kinds of changes, and even if we apparently know of  
10 one community which is happy about giving up it's emergency  
11 services, I'm not sure that's the case for most other  
12 communities.

13

14          JEFF KRAUT:       Dr. Brown.

15

16          DR. BROWN:       I must confess, that I'm somewhat troubled  
17 by this. On the one hand, I certainly concur with the last two  
18 speakers about from the public health standpoint, but then the  
19 toehr side of the coin is that if a hospital has determined in  
20 it's own business operations that it cannot afford to be full  
21 standing and it needs to go part time, then are we saying that  
22 it is OK for the State of New York to put the remainder course  
23 that a hospital has to stay full operation?

24

1           JEFF KRAUT:       No, I think what we're saying here is the  
2 hospital will have two choices. They can go through a full  
3 review and go everything that's entailed with that or they  
4 simply close it and then there's no review. So, and recognize  
5 that you're applying a standard here to this service that does  
6 not apply to a hospital closure.

7

8           WILLIAM STRECK:       Is there further discussion on the  
9 amendment? Dr. Boufford, you might turn off your mic.

10

11          JO BOUFFORD:       I thought it was off. Sorry.

12

13          JOHN RUGGE:       One point of clarification; currently there  
14 is no freestanding off-campus ED in New York. Those EDs which  
15 appear to be freestanding are attached to one or two bed  
16 hospitals.

17

18          JEFF KRAUT:       That's not correct.  
19 Montefiore.

20

21          WILLIAM STRECK:       OK. So we have a motion. Is the  
22 motion clear to everyone what we are saying here?

23

24          [I'm sorry. It's not clear to everybody.]

25

1 WILLIAM STRECK: On the premise that it is clear, we  
2 will have a vote.

3  
4 [It's not clear]

5  
6 JEFF KRAUT: No, in all seriousness. Hold on, we have  
7 some skeptical faces here.

8  
9 JO BOUFFORD: We're not skeptical. We're not to  
10 it.

11  
12 JEFF KRAUT: I'm sorry. They're asking for me to restate  
13 it again. Where's the day when we had a stenographer? What I'm  
14 limiting this motion to is for a entity - I'm forgetting what  
15 I'm doing. Just freestanding administrative CON for going part  
16 time. OK. This is for an existing emergency dep - satellite  
17 emergency department that has been already approved and  
18 operational. It is now requesting to go from full-time to part-  
19 time. I am proposing that that action be reviewed by the  
20 Department of Health under an administrative CON.

21  
22 WILLIAM STRECK: That's fine. Stop right there. I  
23 think that's a coherent sentence. And we will call that the  
24 motion. Is there further discussion on the motion? All right.

1 Then we'll ask for a vote on the motion. Those in favor of the  
2 motion as proposed please raise your hand.

3

4 JEFF KRAUT: There are seven affirmative votes in New  
5 York.

6

7 WILLIAM STRECK: It may be hard to conceive of, but the  
8 motion passes and we have then approved that clause. So we've  
9 not taken care of two elements. I'm sorry, are there negative  
10 votes. I beg your pardon. Are there negative votes, and the  
11 negative votes are numbered -

12

13 JEFF KRAUT: There are six negative vote in New York  
14 City.

15 WILLIAM STRECK: 14-6. Thank you. OK. Are there other  
16 amendments, discussions, or comments about the freestanding  
17 emergency department proposals? Thank you for that extended and  
18 thoughtful discussion. We'll move on to non-hospital surgery,  
19 ambulatory surgery centers and office-based surgery. Are there  
20 comments or questions in regard to the proposals here?

21

22 ANGEL GUTIERREZ: I have a question.

23

24 WILLIAM STRECK: Yes, go ahead.

25

1           ANGEL GUTIERREZ:     yes, Gutierrez in Buffalo. I want to  
2 make sure that somehow the ability of a practitioner in rural  
3 communities, an isolated situation, will not be limited in any  
4 way, shape or form in it's ability to perform minor surgery in  
5 the office. By minor surgery I mean incision and drainage,  
6 biopsies, procedures that are currently being done in offices  
7 because in order for the patient to have the same thing done  
8 they need to travel 30 miles. I                   the language there.  
9 I just want to make sure that we are protecting that.

10

11           JOHN RUGE:           Duly noted, and I think the narrative can  
12 indicate there's no intent to restrict physicians from  
13 performing those procedures in the context of their routine  
14 practice.

15

16           WILLIAM STRECK:       I'm sorry John. What is - catch me up.

17

18           JOHN RUGGE:       Dr. Gutierrez was concerned that we're not  
19 limiting physicians in                   from doing INDS and  
20 lacerations. We'll note that in the report that we're not going  
21 to infringe upon that aspect of practicing medicine. That does  
22 not constitute office-based surgery.

23

24           WILLIAM STRECK:       Is there a clear line there? How are  
25 we going to - there is a clear line? OK.

1  
2 [Currently the situation in office-based surgery does not  
3 kick in until you are administering moderate sedation,  
4 sedation, general anesthesia. So if those procedures are  
5 generally are local or even minimal and they are, that's the way  
6 it currently is and these changes to not make any impact on  
7 that. ]

8  
9 JOHN RUGGE: Fine. Does that help you Dr. Gutierrez?

10  
11 ANGEL GUTIERREZ: Yes, I am satisfied with that.

12  
13 ART LEVIN: This is Art Levin. So, this is an old song  
14 for me, but we've got a number of years of data under our belt.  
15 I know initially the Department was rather stunned by the number  
16 of reports that they got from OBS when the legislation was  
17 passed and the severity of some of the mishaps that occurred.  
18 And I think this group would be well-served by seeing some sort  
19 of report from the Department that covers these couple of years  
20 of experience. I mean, I'm assuming that some of these changes  
21 in definitions of what's covered and what's reportable et  
22 cetera, are based on experience. We have not had the privilege  
23 of seeing that experience nor has the public, and we've had  
24 assurances that we would see it, but we have not seen it. And  
25 I'm particularly concerned because, as I said, the initial

1 reaction of the Department was somewhat shocked at the severity  
2 and volume, and I'd like to know, has that changed over time?  
3 Remain the same? Gotten worse? Is this sufficient or do we  
4 need to be looking in the future to do even more redefinition of  
5 office-based surgery and reporting.

6

7 WILLIAM STRECK: Other comments? I think we note that -  
8 other comments or questions?

9

10 JOHN RUGGE: (Jo may be able to help me) but we have  
11 heightened the requirements for reporting adverse events  
12 including ER follow-up visits. Isn't that the case?

13 Mr. Levin, we have tried to address those very concerns on  
14 the part of consumers.

15

16 ART LEVIN: The issue is whether the Council is educated  
17 by the experience.

18

19 JEFF KRAUT: I think, Mr. Levin is being a little polite.  
20 He's basically saying we want a report of the data. And we  
21 would like to have that included as well. It doesn't stop us  
22 from voting on the recommendation, but we need to - this is a  
23 side issue. We need the report of the data. What's been  
24 reported, the type, and the like. So -

25

1 JOHN RUGGE: [inaudible] deidentified basis to the Council  
2 or the Council could request the data from DOH.

3

4 JEFF KRAUT: We have requested it.

5

6 JOHN RUGGE:... data will be available.

7

8 JO BOUFFORD: Consider it requested.

9

10 JEFF KRAUT: Dr. Streck, I have to at the sake of getting  
11 your ire, there was an outstanding question left open on the  
12 freestanding emergency departments, and that is we did not  
13 address the issue, would we permit the establishment of a de  
14 novo part-time emergency off-site satellite? Did I get that  
15 correct?

16

17 WILLIAM STRECK: You are correct.

18

19 JEFF KRAUT: OK. Or, do you not want to - you may  
20 require - this is in section four and -

21

22 JO BOUFFORD: No, because four is hospital-sponsored off-  
23 campus.

24

1           JEFF KRAUT:       No, this would be a hospital-sponsored -  
2 would we allow a - let's say a hospital is about to close.  
3 Somebody wants to go in and operate it. Would you allow them to  
4 go in an operate it, to establish de novo part-time or would you  
5 require everybody who starts this must start full-time? That's  
6 the two issues?

7  
8           WILLIAM STRECK:       Isn't that addressed in the second  
9 amendment? (the IRA version.) The second amendment said that  
10 you could, that an existing entity could determine, essentially  
11 determine the hours of a freestanding emergency room.

12  
13          JO BOUFFORD:       That they're taking over.

14  
15          JEFF KRAUT:       If they're taking it over - I think the  
16 second amendment was they're taking over an emergency  
17 department, they've run it as a freestanding ED which would have  
18 meant they were running it full-time. They now want to go to  
19 part-time. And that required an action.

20  
21          WILLIAM STRECK:       That was the second one.

22  
23          JEFF KRAUT:       Right.

24

1 WILLIAM STRECK: So why would this not apply in the  
2 situation you're talking about?

3

4 JEFF KRAUT: This is asking a de novo. They've done in.  
5 they're now going in to operate a freestanding emergency  
6 department. They wish to start it off as part-time. Not to do  
7 it full-time.

8

9 [Jeff, that's bullet three of three. Look at bullet three  
10 under three and then tell me if that's now what you're asking  
11 for.]

12

13 JO BOUFFORD: But we modified that to existing providers.

14

15 JEFF KRAUT: I think we modified that.

16

17 [So, but it does say here, "request for a new full-time  
18 off-campus ED."]

19

20 JEFF KRAUT: No, we've dealt with this. This is not a  
21 full-time. This is going in day one and running it part-time.  
22 Mr. Levin.

23

24 [inaudible]

25

1           ART LEVIN:        It's asking whether under four one could  
2 make an application de novo and say we've already ascertained  
3 there's not enough volume or need; we want a part-time ED. So  
4 forget about taking over anything like that.

5  
6           JEFF KRAUT:       So would you allow that to go  
7 administratively? Is that what you're saying?

8  
9           ART LEVIN:        Well, I mean, I think the question is where  
10 does that fit? Is the assumption here that establishment of an  
11 off-campus ED will require full CON review, does that mean that  
12 you couldn't go in and ask for a 12-hour ED de novo? Because -

13  
14          JEFF KRAUT:        Let me - the Department.

15  
16          NIRAV SHAH:        I think we would, in our next iteration of  
17 this when we have a fuller document we will present case studies  
18 of four or five how many scenarios that try to capture the  
19 various combination, permutations of established operators and  
20 full-time to part-time. These are important issues that we  
21 should discuss. I would imagine that the cases are few enough  
22 that we could deal with it with the current authority granted to  
23 the Commissioner under existing statute, under emergency  
24 circumstances, unless there's a rush of these cases. So I would  
25 agree that it's important to clarify. I would argue that it may

1 not necessarily be important to clarify today because there are  
2 so many nuances and permutations involved.

3

4 ART LEVIN: OK. Fine.

5

6 JEFF KRAUT: Dr. Berliner.

7

8 HOWARD BERLINER: Question for the Commissioner. If a  
9 hospital operates a part-time emergency room, will their  
10 reimbursement be lowered?

11

12 NIRAV SHAH: Again, with payment reform being the next  
13 book of work that we're going to take up, I think those kinds of  
14 issues will be discussed in depth in our next iteration. So,  
15 this is phase one of two phases, remember, or more. Phase two  
16 will address the payment side of it.

17

18 KAREN WESTERVELT: And CMS billing rules do provide lower  
19 reimbursement for part-time EDs.

20

21 WILLIAM STRECK: May we return to the non-hospital  
22 surgery ambulatory surgery center and office-based surgery  
23 discussion? Is there any further discussion about these  
24 recommendations which I again, are dependent upon

1 amending existing statute? No further discussion? Could we  
2 move to upgraded diagnostic and treatment centers.

3

4 JOHN RUGGE: deregulation.

5

6 WILLIAM STRECK: We reserved a lot of time to debate  
7 this sentence, so.

8

9 JEFF KRAUT: Maybe we should break for lunch.

10

11 NIRAV SHAH: After a vote. Not before.

12

13 WILLIAM STRECK: Any comments on upgraded diagnostic and  
14 treatment centers? Hearing none, then let's go back to the  
15 beginning and review the proposals that we had gone through.  
16 I'm sorry?

17

18 JEFF KRAUT: Dr. Boufford has a comment.

19

20 JO BOUFFORD: I want to make a comment that's not on the  
21 action side but it's towards the end of the document, and I just  
22 want to point this out because I think as we move into a new  
23 world we need to think about it. The only stipulation for any  
24 CON review in this document of any kind has to do with  
25 increasing services or increasing by extension increasing cost

1 of care, increasing technology. There is no explicit statement  
2 in here about reduction of services or loss of services, and I'm  
3 not proposing any change in the way it's being done but it would  
4 seem to me for example, that in that last sentence on page 22  
5 where it says "referral to the Council on administrative  
6 review..." if they're all being done on administrative review,  
7 that there be something mentioned that if for example, a  
8 reduction in services is not seen by the Department to be in the  
9 interest of the community it would come to the council. I'm  
10 just concerned that there's no mention of reduction of services  
11 in any of this process which I think is not where we - we  
12 started out I think with a statement around CON that deal with  
13 that issue a little bit more, so I just suggest that there be  
14 some perhaps modification of that language. Because being on  
15 the record on this I think is, it's important.

16

17 WILLIAM STRECK: Thank you. Are there additional  
18 comments? So, we've gone through the limited service clinics  
19 with amendments, modifications, and clarifications, urgent care  
20 with language changes and amendments, freestanding emergency  
21 departments with a series of amendments for clarification, the  
22 non-hospital surgery recommendations, and the upgraded  
23 diagnostic and treatment center recommendations. Just to  
24 review, these are recommendations to the Commissioner. Some of  
25 these are dependent on statutory change for the recommendations

1 to have vitality. But with that, the initial motion from Dr.  
2 Rugge was for the approval of this package subject to any  
3 amendments of the proposed and accepted by the members of the  
4 Public Health and Health Planning Council. We have now arrived  
5 at that point. Is there any further discussion before I ask for  
6 a vote on the package as initially presented in the original  
7 motion? Hearing none, those in favor of the proposal as made by  
8 Dr. Rugge at the beginning of our discussions regarding  
9 oversight of ambulatory care services, please raise your hand If  
10 you are in favor? Aye.

11

12 ANGEL GUTIERREZ: Aye.

13

14 JEFF KRAUT: We have 12 votes in New York City. Dr.  
15 Brown has left the room.

16

17 WILLIAM STRECK: Rochester?

18

19 CHRIS BOOTH: Three yes.

20

21 WILLIAM STRECK: Buffalo?

22

23 ANGEL GUTIERREZ: Two affirmative.

24

1 WILLIAM STRECK: Two affirmative. One in Albany. Are  
2 there votes in opposition? Thank you. The oversight of the  
3 ambulatory care services proposal passes. This is a meeting, a  
4 special meeting. There are no other items on the agenda. With  
5 that I thank you.

6 Dr. Gutierrez, yes?

7

8 ANGEL GUTIERREZ: I want to congratulate and thank John  
9 Ruge for the work done.

10

11 [applause]

12

13 JEFF KRAUT: There are 12 people applauding you.

14

15 WILLIAM STRECK: Thank you.

16

17 [end of audio]

## **NEW YORK STATE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**

### **Guidelines for Committee Observers**

The Public Health and Health Planning Council welcomes interested observers at its Standing Committee's meeting, which are public meetings. However, in order to make these meetings as productive as possible for all concerned, the Council has established certain ground rules so as not to disrupt the business of the meetings.

1. All Press inquiries concerning Council or Department activities should be directed to the Director of Public Affairs at (518) 474-7354, and in the Director's absence, to the Executive Secretary.
2. The Chairman may excuse observers from portions of a meeting as appropriate (e.g. consideration of Section 2801-b allegations, pursuant to Public Officers Law Section §105).
3. Any interruption of the meeting for the taking of photographs by the news media will require approval of the Chairman before the start of the meeting.
4. Observers and participants will be accommodated within the physical limitations of the meeting room. Observers and participants will be identified and introduced to the Chairman of the Committee who may read their identification into the record of the meeting.
5. Discussion during the meeting is limited to the public who have signed up on the Speaker's list.
6. Staff to the Council members may be contacted by observers, generally before or after the meeting, for clarification of agenda items or discussion, interviews, general information on the Council, etc.
7. No written correspondence shall be distributed to the Council members the day of the meeting. All correspondence addressed to Council members shall be sent to the Council's Executive Secretary no later than 72 hours prior to the meeting in which the matter of the correspondence appears on the meeting agenda.

Executive Secretary, Public Health and Health Planning Council  
Empire State Plaza, Corning Tower, Room 1805  
Albany, New York 12237

Or via e-mail at [PHHPC@health.state.ny.us](mailto:PHHPC@health.state.ny.us)

Copies of Member listings and the schedule of Council meetings for the year are available on request.

Adopted 6/11  
Revised and Adopted

## **NEW YORK STATE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL**

### **Guidelines for Observers for Full Public Health and Health Planning Council**

The Public Health and Health Planning Council welcomes interested observers at its meetings of the whole body, which are public meetings. However, in order to make these meetings as productive as possible for all concerned, the Council has established certain ground rules so as not to disrupt the business of the meetings.

1. All Press inquiries concerning Council or Department activities should be directed to the Director of Public Affairs at (518) 474-7354, and in the Director's absence, to the Executive Secretary.
2. The Chairman may excuse observers from portions of a meeting as appropriate (e.g. consideration of Section 2801-b allegations, pursuant to Public Officers Law § 105).
3. Any interruption of the meeting for the taking of photographs by the news media will require approval of the Chairman before the start of the meeting.
4. Observers will be accommodated within the physical limitations of the meeting room. Observers will be identified and introduced to the Chairman of the Council who may read their identification into the record of the meeting.
5. Discussion during the meeting is limited to only the Council members (who may request information or reports from staff to the Council) unless prior approval to participate in a discussion has been granted by the Chairman.
6. Staff to the Council members may be contacted by observers, generally before or after the meeting, for clarification of agenda items or discussion, interviews, general information on the Council, etc.
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Adopted 6/11  
Revised and Adopted

## **SUMMARY OF EXPRESS TERMS**

The Department is amending 10 NYCRR Subpart 7-2 Children's Camps as an emergency rulemaking to conform the Department's regulations to requirements added or modified as a result of Chapter 501 of the Laws of 2012 which created the Justice Center for the Protection of Persons with Special Needs (Justice Center). Specifically, the revisions:

- amend section 7-2.5(o) to modify the definition of "adequate supervision," to incorporate the additional requirements being imposed on camps otherwise subject to the requirements of section 7-2.25
- amend section 7-2.24 to address the provision of variances and waivers as they apply to the requirements set forth in section 7-2.25
- amend section 7-2.25 to add definitions for "camp staff," "Department," "Justice Center," and "Reportable Incident"

With regard to camps with 20 percent or more developmentally disabled children, which are subject to the provisions of 10 NYCRR section 7-2.25, add requirements as follows:

- amend section 7-2.25 to add new requirements addressing the reporting of reportable incidents to the Justice Center, to require screening of camp staff, camp staff training regarding reporting, and provision of a code of conduct to camp staff
- amend section 7-2.25 to add new requirements providing for the disclosure of information to the Justice Center and/or the Department and, under certain circumstances, to make certain records available for public inspection and copying

- amend section 7-2.25 to add new requirements related to the investigation of reportable incidents involving campers with developmental disabilities
- amend section 7-2.25 to add new requirements regarding the establishment and operation of an incident review committee, and to allow an exemption from that requirement under appropriate circumstances
- amend section 7-2.25 to provide that a permit may be denied, revoked, or suspended if the camp fails to comply with the regulations, policies or other requirements of the Justice Center

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

**SUBPART 7-2**

**Children's Camps**

**(Statutory Authority: Public Health Law §§ 201, 225, 1390, 1394, 1395, 1399-a;**

**L. 2012, ch. 501)**

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

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

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

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

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

Section 7-2.24 is amended to read as follows:

Variance; waiver.

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

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

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

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

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

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

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

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

(i) Reporting.

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

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

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

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

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

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

(k) Disclosure of information

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

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

(1) Incident Management.

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

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

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

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

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

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

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

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

section, “complete” shall mean that all necessary information has been obtained to determine whether and how the incident occurred, and to complete the findings referenced in paragraph (1)(2)(iv) of this subdivision.

- (3) (i) The camp shall maintain a facility incident review committee, composed of members of the governing body of the children’s camp and other persons identified by the camp operator, including some members of the following: camp administrative staff, direct support staff, licensed health care practitioners, service recipients, the permit-issuing official or designee and representatives of family, consumer and other advocacy organizations, but not the camp director. The camp operator shall convene a facility incident review panel to review the timeliness, thoroughness and appropriateness of the camp's responses to reportable incidents; recommend additional opportunities for improvement to the camp operator, if appropriate; review incident trends and patterns concerning reportable incidents; and make recommendations to the camp operator to assist in reducing reportable incidents. The facility incident review panel shall meet at least annually, and also within two weeks of the completion of a written report and remedial plan for a reportable incident.
- (ii) Pursuant to paragraph (f) of subdivision one of section 490 of the Social Services Law and regulations of the Justice Center, a camp operator may seek an

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

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

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

## **Regulatory Impact Statement**

### **Statutory Authority:**

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

### **Legislative Objectives:**

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

**Needs and Benefits:**

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

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

that list, to also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment (SCR) to determine whether prospective employees are on that list.

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

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

**Compliance Costs:**

**Cost to Regulated Parties:**

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

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

Each camp will incur expenses for contacting the Justice Center to verify that potential employees, volunteers or others falling within the definition of “custodian” under section 488 of the Social Services Law (collectively “employees”) are not on the Staff Exclusion List (SEL). The effect of adding this consultation should be minimal. An entry level staff person earning the minimum wage of \$7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the Justice Center, within a few hours.

Similarly, each camp will incur expenses for contacting the Office of Children and Family Services (OCFS) to determine whether potential employees are on the State Central Registry of Child Abuse and Maltreatment (SCR) when consultation with the Justice Center shows that the prospective employee is not on the SEL. The effect of adding this consultation should also be minimal, particularly since it will not always be necessary. An entry level staff person earning the minimum wage of \$7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the OCFS, within a few hours. Assuming that each employee is subject to both screens, aggregate staff time required should not be more than six to eight hours. Additionally, OCFS imposes a \$25.00 screening fee for new or prospective employees.

Camps will be required to disclose information pertaining to reportable incidents to the Justice Center and to the permit issuing official investigating the incident. Costs

associated with this include staff time for locating information and expenses for copying materials. Using a high estimate of staff salary of \$30.00 an hour, and assuming that staff may take up to two hours to locate and copy the records, typical cost should be under \$100.

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

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

should be minimal, as it would be limited to copying and distributing the code, and to obtaining and filing the acknowledgments. Staff should need less than 30 minutes to review the code.

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

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

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

**Cost to State and Local Government:**

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

**Cost to the Department of Health:**

There will be routine costs associated with printing and distributing the amended Code. The estimated cost to print revised code books for each regulated children's camp in NYS is approximately \$1600. There will be additional cost for printing and distributing training materials. The expenses will be minimal as most information will be

distributed electronically. Local health departments will likely include paper copies of training materials in routine correspondence to camps that is sent each year.

**Local Government Mandates:**

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

**Paperwork:**

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

**Duplication:**

This regulation does not duplicate any existing federal, state, or local regulation. The regulation is consistent with regulations promulgated by the Justice Center.

**Alternatives Considered:**

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

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

**Federal Standards:**

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

**Compliance Schedule:**

The proposed amendments are to be effective upon filing with the Secretary of State.

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**Regulatory Flexibility Analysis**  
**for Small Business and Local Government**

**Types and Estimated Number of Small Businesses and Local Governments:**

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

**Compliance Requirements:**

**Reporting and Recordkeeping:**

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

**Other Affirmative Acts:**

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

**Professional Services:**

Camps with 20 percent or more developmentally disabled children are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

**Compliance Costs:****Cost to Regulated Parties:**

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

**Cost to State and Local Government:**

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in the

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

**Economic and Technological Feasibility:**

There are no changes requiring the use of technology.

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

**Minimizing Adverse Economic Impact:**

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

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

**Small Business Participation and Local Government Participation:**

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

## **Rural Area Flexibility Analysis**

### **Types and Estimated Number of Rural Areas:**

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

### **Reporting and Recordkeeping and Other Compliance Requirements:**

#### **Reporting and Recordkeeping:**

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

#### **Other Compliance Requirements:**

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

**Professional Services:**

Camps with 20 percent or more developmentally disabled children are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

**Compliance Costs:****Cost to Regulated Parties:**

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

**Economic and Technological Feasibility:**

There are no changes requiring the use of technology.

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

**Minimizing Adverse Economic Impact on Rural Area:**

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

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

**Rural Area Participation:**

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

## **Job Impact Statement**

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

## **Emergency Justification**

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

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

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

Promulgating the regulations on an emergency basis will ensure that campers with special needs promptly receive the coordinated protections to be provided to similar individuals cared for in other settings. Such protections include reduced risk of being cared for by staff with a history of inappropriate actions such as physical, psychological or sexual abuse towards persons with special needs. Perpetrators of such abuse often seek legitimate access to children so it is critical to camper safety that individuals who that have committed such acts are kept out of camps. The regulation provides an additional mechanism for camp operators to do so. The regulations also reduce the risk of incidents involving physical, psychological or sexual abuse towards persons with special needs by ensuring that such occurrences are fully and completely investigated, by ensuring that camp staff are more fully trained and aware of abuse and reporting obligations, allowing staff and volunteers to better identify inappropriate staff behavior and provide a mechanism for reporting injustice to this vulnerable population. Early detection and response are critical components for mitigating injury to an individual and will prevent a perpetrator from hurting additional children. Finally, prompt enactment of the proposed regulations will ensure that occurrences are fully investigated and evaluated by the camp, and that measures are taken to reduce the risk of re-occurrence in the future. Absent emergency adoption, these benefits and protections will not be available to campers

with special needs until the formal rulemaking process is complete, with the attendant loss of additional protections against abuse and neglect, including physical, psychological, and sexual abuse.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Sections 2800 and 2803 of the Public Health Law, Section 405.4 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subparagraph (ii) of paragraph (8) of subdivision (a) of Section 405.4 is amended to read as follows:

405.4 Medical staff.

(a) Medical staff accountability. The medical staff shall be organized and accountable to the governing body for the quality of medical care provided to all patients.

\* \* \*

(8) Definitions. For the purposes of this section, the following terms shall have the following meanings:

\* \* \*

(ii) for adults, severe sepsis shall mean sepsis plus at least one sign of hypoperfusion or organ dysfunction; for pediatrics, severe sepsis shall mean sepsis plus one of the following: cardiovascular organ dysfunction or acute respiratory distress syndrome (ARDS) or two or more organ dysfunctions [or acute respiratory distress syndrome]; and

## **REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

Public Health Law (“PHL”) Section 2800 provides that “hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state . . ., the department of health shall have the central, comprehensive responsibility for the development and administration of the state’s policy with respect to hospital related services . . .”

PHL Section 2803 authorizes the Public Health and Health Planning Council (“PHHPC”) to adopt rules and regulations to implement the purposes and provisions of PHL Article 28, and to establish minimum standards governing the operation of health care facilities.

### **Legislative Objectives:**

The legislative objectives of PHL Article 28 include the protection of the health of the residents of the State by promoting the efficient provision and proper utilization of high quality health services at a reasonable cost.

### **Needs and Benefits:**

Sepsis is a range of clinical conditions caused by the body’s systemic response to an infection and affects about 750,000 people in the U.S. each year. The mortality rate is alarming – between 20 percent and 50 percent – and the rate largely depends on how quickly patients are diagnosed

and treated with powerful antibiotics to battle the bacteria racing through their systems.

In New York State the number of **severe** sepsis cases increased from 26,001 in 2005 to 43,608 in 2011 - an increase of 68%. Similarly, the number of sepsis cases in New York State increased from 71,049 in 2005 to 100,073 in 2011, an increase of 41%. Sepsis mortality is significant and ranges widely from one hospital to another. In New York, sepsis mortality ranges between 15% and 37%. A patient may have a greater chance of dying from sepsis if care is provided by an institution ill-prepared to deal with this illness or from providers not thoroughly trained in identifying and treating sepsis.

In response to these alarming statistics regulations were enacted effective May 1, 2013 to require all hospitals licensed to operate in New York State to have in place and implement evidence-based protocols for the early identification and treatment of severe sepsis and septic shock.

The Sepsis regulations as originally drafted included a definition of pediatric severe sepsis that was not exactly consistent with the current international definition. This amendment will refine the definition to assure complete consistency. The original wording was as follows:

“for pediatrics, severe sepsis shall mean sepsis plus two organ dysfunctions or acute respiratory distress syndrome.”

Proposed revised wording is:

“for pediatrics, severe sepsis shall mean sepsis plus one of the following: cardiovascular organ dysfunction or acute respiratory distress syndrome (ARDS) or two or more organ dysfunctions”

There is no known opposition to this change. Physicians who specialize in pediatrics and pediatric critical care requested that this change be made to assure absolute consistency with established definitions and avoid any possible confusion on the part of hospitals and clinicians.

**COSTS:**

**Costs for the Implementation of and Continuing Compliance with these Regulations to the Regulated Entity:**

Existing Sepsis regulations that require all hospitals to submit evidence-based protocols for the early identification and treatment of sepsis to NYSDOH not later than December 31, 2013 are unchanged. There are no costs associated with this change. There is no impact on consumers or providers. This change assures consistency in definitions but in no way alters the intent or impact of the current regulations.

**Costs to Local and State Government:**

There is no fiscal impact to State or local government as a result of this regulation.

**Costs to the Department of Health:**

There will be no additional costs to the Department of Health associated with this definition change.

**Local Government Mandates:**

Hospitals operated by State or local government will be affected and be subject to the same requirements as any other hospital licensed under PHL Article 28.

**Paperwork:**

There is no additional paperwork associated with this change in wording.

**Duplication:**

These regulations do not duplicate any State or Federal rules and assure consistency with established and clinically accepted definitions in use throughout the Nation.

**Alternative Approaches:**

There are no viable alternatives. Physicians who specialize in pediatrics and pediatric critical care requested that this change be made to assure absolute consistency with established definitions and avoid any possible confusion on the part of hospitals and clinicians.

**Federal Requirements:**

Currently there are no federal requirements regarding the adoption of sepsis protocols or for reporting adherence to protocols or risk adjusted mortality.

**Compliance Schedule:**

These regulations will take effect upon publication of a Notice of Adoption in the New York *State Register*.

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**STATEMENT IN LIEU OF  
REGULATORY FLEXIBILITY ANALYSIS  
FOR SMALL BUSINESS AND LOCAL GOVERNMENTS**

No regulatory flexibility analysis is required pursuant to Section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

**STATEMENT IN LIEU OF  
RURAL AREA FLEXIBILITY ANALYSIS**

No rural area flexibility analysis is required pursuant to Section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas.

## **JOB IMPACT STATEMENT**

Pursuant to the State Administrative Procedure Act (SAPA) section 201-a(2)(a), a Job Impact Statement for this amendment is not required because it is apparent from the nature and purposes of the proposed rules that they will not have a substantial adverse impact on jobs and employment opportunities.

Pursuant to the authority vested in the Public Health and Health Planning Council and subject to approval by the Commissioner of Health by Sections 2803, 2993 and 2994-t of the Public Health Law, sections 405.43 and 700.5 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York are hereby repealed, and section 400.21 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York is hereby amended effective upon the publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 405.43 is repealed.

Section 700.5 is repealed.

Section 400.21 is amended to read as follows:

§ 400.21 Advance directives

(a) Statement of purpose. [Recent advances in medical technology have brought forth a multitude of choices about medical treatment. Advances in emergency medical services have expanded the capacity of the health care system to save the lives of victims who previously would not have survived acute trauma. New drugs and new surgical techniques may prolong life, but may not necessarily halt the spread of progressive or degenerative illness. Life support systems can maintain unconscious patients for months or even years. Decisions about medical treatment based on the availability of this burgeoning medical technology are deeply personal. They reflect basic values, personality traits and religious attitudes. An adult's capacity to tolerate pain, disfigurement or dependency must be considered.] The New York State Health Care Proxy Law allows an adult to designate another adult, such as a trusted friend or loved one who knows

the person and his/her wishes, to make [these] treatment decisions if the adult becomes incapacitated and is unable to do so. The Health Care Proxy Law guarantees an adult's right to self-determination and the expression of this right through another adult. Advance directives [like the Health Care Proxy] also allow an adult to express his or her preference regarding health care treatment, including a desire to continue or to refuse treatment and life supports. In the absence of a health care proxy, [adults who express their wishes orally or in writing concerning life-sustaining treatment in a clear and convincing manner are entitled, based on decisions of both the United States Supreme Court and the New York State Court of Appeals, to have those wishes recognized] the Family Health Care Decisions Act allows a surrogate (a family member or close friend) to make treatment decisions on behalf of a patient, in accordance with the patient's wishes, if known, or if the patient's wishes are not known, in accordance with the patient's best interests. Facilities must ensure that all adult patients/residents are informed of their rights and are supported and protected as they exercise their right to formulate written or oral instructions regarding their health care in the event such adults become incapacitated and are unable to direct their own health care.

(b) Definitions. The following words or phrases shall have the following meanings:

(1) An advance directive means a type of written or oral instruction relating to the provision of health care when an adult becomes incapacitated, including but not limited to a health care proxy, a consent [pursuant to Article 29-B of the Public Health Law] to the issuance of an order not to resuscitate or other medical orders for life-sustaining treatment (MOLST) recorded in a

patient's/resident's medical record, and a living will.

(2) A health care proxy means a document created pursuant to Article 29-C of the Public Health Law which delegates the authority to another adult known as a health care agent to make health care decisions on behalf of the adult when that adult is incapacitated.

(3) A living will means a document which contains specific instructions concerning an adult's wishes about the type of health care choices and treatments that an adult does or does not want to receive[, but which does not designate an agent to make health care decisions].

(4) A health care agent or agent means an adult to whom authority to make health care decisions is delegated under a health care proxy.

(5) An adult means any person who is 18 years of age or older, or is the parent of a child, or has married.

(6) Medical orders for life-sustaining treatment (MOLST) means medical orders to provide, withhold or withdraw life-sustaining treatment. The MOLST form is an alternative form authorized by the Commissioner under subdivision six of section twenty-nine hundred ninety-four-dd of the public health law. The MOLST form and guidance and checklists for using the MOLST form for any patient in any setting are posted on the department's website.

(c) Facility compliance. The facility shall ensure compliance with the requirements of law

governing advance directives, including but not limited to Articles [29-B and] 29-C, 29-CC and 29-CCC of the Public Health Law.

(d) Policies and procedures. The facility shall be responsible for developing, implementing and maintaining written policies and procedures addressing advance directives and shall:

(1) [furnish] make the following material available to each adult patient/resident, or if the adult patient/resident lacks capacity, to the family member or other adult who speaks on the patient's/resident's behalf at or prior to the time of admission to the facility as an inpatient or an outpatient and to each member of the facility's staff who provides patient/resident care. A facility need not provide these items more than once to an outpatient receiving services on a recurring basis:

(i) the description of State law prepared by the department entitled ["Planning in Advance for your Medical Treatment,"] "Deciding About Health Care: A Guide for Patients and Families," which summarizes the rights, duties and requirements of Articles [29-B and] 29-C, 29-CC and 29-CCC [and the right of an adult to formulate advance directives as expressed in final decisions of courts of competent jurisdiction]; and

(ii) the pamphlet prepared by the department entitled "Health Care Proxy: Appointing your Health Care Agent [-]in New York State[']s Proxy Law," containing a sample health care proxy form[; and

(iii) a summary of the facility's policy regarding the implementation of these rights];

(2) ensure that there is documentation in each adult's medical record indicating whether or not

the adult has executed a health care proxy under Article 29-C of the Public Health Law, or whether the adult has provided written or oral advance instructions about treatment to facility staff responsible for the patient's care or to facility employees upon admission;

(3) assess advance directives other than those described in Articles [29-B and] 29-C, 29-CC and 29-CCC of the Public Health Law. Nothing herein shall be construed to require that a facility must or may not seek a court determination that any individual advance directive has been expressed in a clear and convincing manner;

(4) provide in-service education to staff involved in the provision of care including medical staff concerning the facility's policies and procedures concerned with advance directives;

(5) provide (individually or with others) education to the community on issues concerning advance directives;

(6) ensure that an adult is not discriminated against in the provision of care or otherwise discriminated against based on whether or not the adult has executed an advance directive; and

(7) in addition, a nursing home shall:

(i) educate adult residents about the authority delegated under a health care proxy, what a proxy may include or omit, and how a proxy is created, revoked, or changed as requested by the resident;

(ii) ensure that each resident who creates a proxy while residing at the facility does so voluntarily; and

(iii) designate one or more individuals to educate the residents, respond to questions and assist residents in creating, revoking or changing a proxy.

(e) Medical orders for life-sustaining treatment (MOLST). To implement a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, facilities may, if appropriate, utilize the department approved MOLST form for patients with serious health conditions who:

(1) want to avoid or receive any or all life-sustaining treatment; or

(2) can reasonably be expected to die within one year.

(f) Rights to be publicized. The facility shall post in a public place in the facility the rights, duties and requirements of this section. Such statement may be included in any other statement of patient's/resident's rights required to be posted.

## **REGULATORY IMPACT STATEMENT**

### **Statutory Authority:**

The authority for the promulgation of this regulation is contained in Public Health Law (PHL) Sections 2803, 2993 and 2994-t. PHL Section 2803 authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner, to implement the purposes and provisions of Article 28 of the Public Health Law, and to establish minimum standards governing the operation of health care facilities. PHL Sections 2993 and 2994-t authorize the Commissioner in consultation with the Commissioners of the Offices of Mental Health (OMH) and People With Developmental Disabilities (OPWDD) to establish such regulations as may be necessary for the implementation of Article 29-C (Health Care Agents and Proxies) and Article 29-CC (Family Health Care Decisions Act) respectively.

### **Legislative Objectives:**

The legislative intent of PHL Article 28 is to provide for the protection and promotion of the health of the inhabitants of the State of New York by delivering high quality hospital and related services in a safe and efficient manner at a reasonable cost. The intent of PHL Article 29-C is to establish a decision making process to allow competent adults to appoint an agent to decide about health care treatment in the event they lose decision-making capacity. PHL Article 29-CC establishes a decision-making process applicable to decisions in general hospitals and nursing homes whereby a surrogate is selected and empowered to make health care decisions for patients who lack capacity to make their own health care decisions and who have not otherwise appointed an agent to make health care decisions pursuant to Article 29-C or provided clear and convincing

evidence of their treatment wishes.

**Needs and Benefits:**

While the Health Care Proxy Law in PHL Article 29-C outlines health care agent and proxy provisions to allow someone to designate another adult to make treatment decisions if he/she becomes incapacitated and is unable to do so, the Family Health Care Decisions Act in Article 29-CC would fill the gap by establishing a decision making process where a surrogate is selected and empowered to make such decisions for incapacitated individuals who have not otherwise appointed an agent pursuant to the Health Care Proxy Law, or provided clear and convincing evidence of their treatment wishes. This amendment will conform the regulations to the Public Health Law as amended by Chapter 8 of the Laws of 2010, which added the Family Health Care Decisions Act (FHCDA – Article 29-CC), made Article 29-B no longer applicable to PHL Article 28 facilities and added a new PHL Article 29-CCC, which provides authority for Medical Orders for Life-Sustaining Treatment (MOLST).

**Costs:**

This proposal will not increase costs to the Department or to the facilities required to comply. These amendments merely update the regulation to reflect current practice and to conform to statutory changes.

**Local Government Mandates:**

This regulation does not impose any new programs, services, duties, or responsibilities upon any county, city, town, village, school district, fire district or other special district.

**Paperwork:**

Facilities must be responsible for developing, implementing and maintaining written policies and procedures addressing advance directives and furnish to each adult patient/resident or family member or other adult who speaks on the patient's behalf if the patient/resident lacks capacity:

(1) the description of the State law "Deciding About Health Care: A Guide for Patients and Families," and (2) the pamphlet prepared by the Department entitled "Health Care Proxy: Appointing your Health Care Agent in New York State." Facilities must also ensure that there is documentation in each adult's medical record indicating whether or not the adult has executed a health care proxy under PHL Article 29-C, or whether the adult has provided written or oral advance instructions about treatment to facility staff responsible for the patient's care or to facility employees upon admission. Facilities may utilize the Department approved form for Medical Orders for Life-Sustaining Treatment (MOLST) to implement a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life sustaining treatment. Facilities must provide information about MOLST to patients with serious health conditions who: (1) want to avoid or receive any or all life-sustaining treatment, or (2) can reasonably be expected to die within one year.

**Duplication:**

This regulation does not duplicate any other state or federal law or regulation.

**Alternatives:**

The current regulation is out of date. This proposal updates the regulation to reflect current practice and statutory changes.

**Federal Standards:**

This regulatory amendment does not exceed any minimum standards of the federal government.

**Compliance Schedule:**

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

**Contact Person:**

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**REGULATORY FLEXIBILITY ANALYSIS**  
**FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS**

Pursuant to section 202-b of the State Administrative Procedure Act, a regulatory flexibility analysis is not required. The proposed rule will not impose an adverse economic impact on any of the facilities and will not impose a negative impact on local governments. These provisions will not impose any additional recordkeeping, reporting and other compliance requirements on any party since the proposal simply updates already existing advance directive requirements.

**Cure Period:**

Chapter 524 of the Laws of 2011 requires agencies to include a “cure period” or other opportunity for ameliorative action to prevent the imposition of penalties on the party or parties subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one was not included. This regulation creates no new penalty or sanction. Hence, a cure period is not necessary.

## **RURAL AREA FLEXIBILITY ANALYSIS**

Pursuant to section 202-bb of the State Administrative Procedure Act, a rural area flexibility analysis is not required. This measure implements provisions set forth in the Family Health Care Decisions Act (FHCDA) that establishes a decision making process, applicable to decisions in general hospitals and nursing homes, whereby a surrogate is selected and empowered to make health care decisions for patients who lack capacity to make their own health care decisions or provided clear and convincing evidence of their wishes.

The proposed rule will not impose an adverse economic impact on hospitals and diagnostic treatment centers located in rural areas in New York State and will not impose any additional recordkeeping, reporting and other compliance requirements since the proposal simply updates already existing advance directive requirements.

## **JOB IMPACT STATEMENT**

A Job Impact Statement is not included because it is apparent from the nature and purpose of these amendments that they will not have a substantial adverse impact on jobs and employment opportunities. This proposal merely updates the advance directive provisions in section 400.21 of 10 NYCRR to reflect current practice and statutory changes.



# Public Health and Health Planning Council

## Project # 132267 C Linden Center for Nursing and Rehabilitation

**County:** Kings County  
**Purpose:** Construction

**Program:** Residential Health Care Facility  
**Acknowledged:** November 14, 2013

### Executive Summary

#### Description

Alliance Health Associates, Inc., d/b/a Linden Center for Nursing and Rehabilitation (Linden), an existing proprietary corporation, is seeking approval to make permanent the temporary increase in RHCf beds granted after the devastation of Superstorm Sandy.

Linden was granted a temporary 40-bed increase on November 6, 2012, in order to relieve the decrease in available beds when numerous facilities were closed due to flood damage that forced evacuations and relocations. Linden has maintained a high level of occupancy since the temporary increase was granted. The 40 temporarily approved beds were initially occupied by displaced residents who were moved from their previous facilities due to the storm. These beds have since been occupied by residents from another facility, at the request of the Department, as well as newly admitted residents.

The members of Alliance Health Associates, Inc., d/b/a Linden Center for Nursing and Rehabilitation are as follows: Joel Landau (40%); Jack Basch (30%); Marvin Rubin (15%) and Solomon Rubin (15%). Alliance Health Associates, Inc. commenced operating the facility on May 28, 2013 through approval of CON number 112031.

DOH Recommendation  
Contingent Approval

#### Need Summary

Linden Center for Nursing and Rehabilitation's utilization was 78.5% in 2009, 87.8% in 2010, 94.1% in 2011, and 98.0% in 2012. The 40 temporary beds were initially granted to accommodate residents of other facilities who were displaced by Superstorm

Sandy. Since the storm, the facility has retained nearly full occupancy. The majority of surrounding facilities are at or above the 97 percent planning optimum capacity. Linden has also set up additional programs that will help ensure the continued utilization of the extra beds. If approved, the bed capacity would be at a permanent 280 beds.

#### Program Summary

The additional nursing unit contains all code required elements. The relatively modern design will result in an acceptable residential environment.

#### Financial Summary

There are no project costs.

#### Budget (280 beds):

Revenues	\$28,644,643
Expenses	<u>27,780,037</u>
Net Income	\$864,606

The applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

## Recommendations

Health Systems Agency

There will be no HSA recommendation for this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - a. Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b. Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c. Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - d. Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]

**Approval conditional upon:**

1. The project must be completed within one year from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The effective date for the certification of the additional beds will be determined by the MARO. [LTC]

Council Action Date

**February 13, 2014**

# Need Analysis

## Project Description

Alliance Health Associates, Inc. d/b/a Linden Center for Nursing and Rehabilitation seeks approval for permanent certification of 40 temporary beds authorized in the wake of Superstorm Sandy. Linden Center for Nursing and Rehabilitation is an existing 240-bed Article 28 residential health care facility, located at 2237 Linden Boulevard, Brooklyn, 11207, in Kings County. This bed capacity does not include the 40 temporary beds proposed in this application.

## Analysis

There is currently a need for 8,663 beds in the NYC Region as indicated in Table 1 below.

Table 1: RHCF Need – NYC Region

2016 Projected Need	51,071
Current Beds	42,330
Beds Under Construction	78
Total Resources	42,408
Unmet Need	8,663

Although a need for beds is indicated, Section 709.3 states that in such circumstances, there shall be a presumption of no need if the overall occupancy of RHCFs in the planning area is less than 97 percent. The average RHCF occupancy rate for New York City is 94.8%, and the average occupancy for Kings County is slightly lower, at 94.3%, as indicated in Table 2.

Table 2: Linden Center for Nursing and Rehabilitation/Kings County/NYC Region

Facility/County/Region	% Occupancy 2009	% Occupancy 2010
Linden Center for Nursing and Rehabilitation	78.5%	87.8%
Kings County	92.7%	95.0%
NYC Region	94.9%	95.4%

Facility/County/Region	% Occupancy 2011	% Occupancy 2012
Linden Center for Nursing and Rehabilitation	94.1%	95.6%
Kings County	94.3%	94.4%
NYC Region	94.8%	94.8%

Because New York City's overall RHCF utilization rate is below that of the 97% percent planning optimum, there is a presumption is no need for additional beds in the area, as set forth in 709.3(f). However, subdivision (f) also provides for a rebuttal of this presumption based on local factors in the facility's service area. Among such factors that may be considered are occupancy rates at other RHCFs. Although as noted in Table 2, the occupancy rate for RHCFs overall in the New York City planning area is below the planning optimum of 97 percent, facilities in the area of Brooklyn served by Linden Center show a higher rate, as indicated:

Facility	Certified Beds	2012 Occupancy
Atrium Center for Rehabilitation and Nursing	380	95.3%
Brooklyn United Methodist Church Home	120	100.0%
Brooklyn-Queens Nursing Home	140	95.0%
Bushwick Center for Rehabilitation and Health Care	225	96.0%
Four Seasons Nursing and Rehabilitation Center	270	99.5%

Linden Center for Nursing and Rehabilitation	240	98.0%
Schulman and Schachne Institute for Nursing And Rehabilitation	448	98.5%
Spring Creek Rehabilitation & Nursing Care Center	188	96.0%

As the chart indicates, the majority of facilities within a two-mile radius of Linden Center have occupancy rates above the 97 percent optimum. In addition, these occupancy rates are for the year 2012 and may have been lowered by the effects of Super Storm Sandy in the last quarter of that period. Nevertheless, even with some of these facilities falling below the 97 percent threshold, the overall RHCF utilization in the area of Linden Center is above 97 percent.

Linden Center has developed initiatives that respond to factors in the area's older population that affect RHCF utilization and which have contributed to the facility's rising rate of occupancy. These efforts include:

- A secure Alzheimer's unit, which has a wait list;
- A Diabetic Program, coordinated with the facility's dedicated Wound Care program;
- Total Parenteral Nutrition;
- Urology and bladder scans;
- Trachea tubes;
- Certified IV nurses and an in-house nurse practitioner;
- In-house, at-bedside FEES exams;
- Vestibular therapy

These programs for difficult-to-serve residents have contributed to an increase in Linden Center's case mix index (CMI), which has risen to 1.18. The facility has also been able to treat residents with a higher need without hospital assistance, as indicated by its low hospital readmission rate. The facility's census also typically includes few physical A and B residents, indicating that Linden Center's services are responsive to individuals in the local area who are fully appropriate for RHCF placement.

Linden Center has also developed working relationships with Brooklyn Hospital Center, Brookdale, and University Hospital Brooklyn (SUNY Downstate) that help ensure the prompt discharge of patients appropriate for RHCF care. The facility has also taken the initiative to enter into contracts with 22 Managed Long Term Care (MLTC) plans to ensure its full participation in the improvement of long-term care under Medicaid Redesign.

The applicant, Alliance Health Associates (Alliance), was the receiver of the facility, then known as Ruby Weston Manor, from late in 2011, through all of 2012 and until May, 2013. Significant financial losses, low utilization and operator instability at Ruby Weston caused the Department to approve Alliance Health Associates, Inc. as receiver in 2011 to stabilize operations and ensure quality oversight. The improvements wrought by Alliance during the receivership and maintained since its assumption of ownership of the facility in May, 2013, together with the active efforts of its operators to implement the aforementioned special programs and services, will likely sustain the higher occupancy rates that began in 2011, exceeded 97 percent by the end of 2012 and were sustained even with the 40 additional beds in 2013. These same measures and approach make it likely that the facility will maintain its high rate of occupancy after the permanent certification of the requested higher bed capacity.

#### Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, or of the Health Systems Agency area Medicaid admissions percentage, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid

patient's admissions is at least 75% of the planning area percentage or the Health Systems Agency percentage, whichever is applicable.

Linden Center for Nursing and Rehabilitation's Medicaid admissions of 62.6% in 2010 and 96.95% in 2011 far exceeded the Kings County 75% rates of 28.12% in 2010 and 30.92% in 2011.

**Conclusion**

Permanent certification of the additional 40 temporary beds awarded to the applicant is warranted, based on the following factors:

- A high overall occupancy rate in other facilities in the local area of Brooklyn served by the applicant;
- A high occupancy rate for the facility's complement of permanent and temporary beds, one that is likely to be sustained by the facility's operation of programs for hard-to-serve residents, its low rate of hospital readmissions, its working relationship with major hospitals in the area, and its active participation in multiple MLTC plans;
- A sustained high case mix index (CMI);
- Rates of Medicaid admissions well in excess of that for Kings County as a whole.

**Recommendation**

**From a need perspective, contingent approval is recommended.**

<h2>Programmatic Analysis</h2>
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**Facility Information**

	Existing	Proposed
Facility Name	Linden Center for Nursing and Rehabilitation	Same
Address	2237 Linden Boulevard Brooklyn, NY. 11207	Same
RHCF Capacity	240	280
ADHC Program Capacity	0	Same
Type Of Operator	Voluntary	Same
Class Of Operator	Corporation	Same
Operator	Alliance Health Associates, Inc.	Same

**Program Review**

Linden Center for Nursing and Rehabilitation (Linden Center), formerly Ruby Weston Manor, is a 240 bed nursing home located in Brooklyn. Originally approved as a 280 bed facility, Ruby Weston Manor opened in 2001 as a 240 bed nursing facility. For reasons that are unclear, the building was constructed to house 80 beds on the fourth floor, but the south nursing unit was left vacant and unoccupied. The nursing home continued to operate the 240 bed complement for the ensuing 12 years. In May, 2013 Ruby Weston Manor was purchased by Alliance Health Associates, Inc. d/b/a Linden Center for Nursing and Rehabilitation.

In October 2013 Superstorm Sandy flooded nursing homes in Brooklyn and Queens, and Linden Center offered the use of its vacant nursing unit to receive displaced individuals evacuated from the affected nursing facilities. Linden Center subsequently received emergency approval from DOH to open the vacant 40 bed unit to house the displaced residents. Linden Center is now requesting approval to certify the additional 40 beds, increasing the permanent bed capacity to 280 beds.

**Physical Environment**

The nursing unit to be certified is located on the south side of the fourth floor, and is a virtual mirror image of the existing 40 bed nursing unit situated on the northern side of the floor. The floor was designed as

an "H" shaped residential unit, with a large dining room located in the central common space serving both nursing units. The dining room looks out to a courtyard which separates the twin nursing units. The elevator lobby, on the opposite side of the corridor from the dining room, leads to a "C" shaped area which overlooks a four story atrium. Activity rooms and staff offices and lounges serving both units are arrayed around the atrium.

The nursing unit is a traditional linear design with double loaded corridor. Small activity rooms are located in either end of the corridor, adjacent to the stairwell. The unit consists of 18 double-bedded rooms and four single-bedded rooms. The majority of the doubles are configured in a toe-to-toe bed alignment with each bed adjacent to a window, offering ample light to both residents. The toilet rooms in all resident rooms are fully handicapped accessible. Entrance into the unit from the elevator bank passes the nurse's station, which is adjacent to the clean and soiled utility rooms. A shower is located adjacent to the soiled room. An additional tub and shower room is located on the other side of the nursing station, adjacent to the service corridor and exam room.

**Compliance**

Linden Center for Nursing and Rehabilitation is currently in substantial compliance with all applicable codes, rules and regulations.

**Conclusion**

The additional nursing unit contains all code required elements. The relatively modern design will result in an acceptable residential environment.

**Recommendation**

**From a programmatic perspective, approval is recommended.**

<h2>Financial Analysis</h2>
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**Operating Budget**

The applicant has submitted an operating budget for the 280 beds, in 2014 dollars, for the first and third years; summarized below:

	<u>Per Diem</u>	<u>Year One and Three</u>
<b>Revenues:</b>		
Medicaid Managed Care	\$221.69	\$15,542,385
Medicare Fee For Service	\$629.98	9,149,251
Commercial Fee For Service	\$253.13	3,802,773
Private Pay	\$299.87	<u>150,234</u>
<b>Total Revenues</b>		<b>\$28,644,643</b>
<b>Expenses:</b>		
Operating	\$222.46	\$22,280,209
Capital	<u>54.91</u>	<u>5,499,828</u>
<b>Total Expenses</b>	<b>\$277.37</b>	<b>\$27,780,037</b>
<b>Net Income</b>		<b>\$864,606</b>
<b>Utilization: (patient days)</b>		<b>100,156</b>
<b>Occupancy</b>		<b>98.00%</b>

Utilization broken down by payor source during the first and third years is as follows:

	<u>Year One and Year Three</u>
Medicaid Managed Care	70.00%
Medicare Fee For Service	14.50%
Commercial Fee For Service	15.00%
Private Pay	0.50%

Expense and utilization assumptions are based on the historical experience of the facility. Incremental expenses for the 40-bed unit during the first and third years are projected to be \$648,638. Incremental revenues for the 40-bed unit during the first and third years, which is the result of Medicare and Commercial utilization increasing, while Medicaid utilization is decreasing is projected at \$1,006,123. The applicant has indicated that they have been experiencing this shift in utilization.

#### Capability and Feasibility

There are no total project cost or working capital requirements associated with this application.

The submitted budget indicates a net income of \$864,606 for the 280 beds during the first and third year after the permanent certification of the 40 beds. Revenues are based on current reimbursement rates. Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

Since the current operator commenced operations on May 28, 2013, internal financial statements are only available. BFA Attachment A is the July 31, 2013 internal financial statement of Linden Center for Nursing and Rehabilitation. As shown, the entity had a positive working capital position and a positive net asset position through July 31, 2013. Also, the entity achieved a net income of \$720,160 through July 31, 2013.

The applicant has demonstrated the capability to proceed in a financially feasible manner.

#### Recommendation

**From a financial perspective, approval is recommended.**

## Attachments

BFA Attachment A	July 31, 2013 internal financial statements of Linden Center for Nursing and Rehabilitation.
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# Public Health and Health Planning Council

## Project # 132207 C New York Presbyterian Hospital – Columbia Presbyterian Center

**County:** New York County  
**Purpose:** Construction

**Program:** Hospital  
**Acknowledged:** October 11, 2013

### Executive Summary

#### Description

New York Presbyterian Hospital, a 2,298 bed, not-for-profit hospital system located in New York County, requests approval to create a new 16 single-bedded maternity unit located on the 10<sup>th</sup> floor of the Central Building at the Morgan Stanley Children’s Hospital at the New York Presbyterian Columbia University Medical Center campus. In order to create the new 16-bedded maternity unit, the applicant proposes to add 12 new maternity beds and relocate four existing high risk maternity beds located in the 10 Tower Labor and Delivery suite. The two existing double bedded high risk maternity inpatient rooms (four existing maternity beds) on 10 Tower will then be converted into two new Labor and Delivery rooms.

increase in maternity capacity is needed at the facility to accommodate its growth in maternity discharges and to operate its maternity beds within the desired planning occupancy optimum of 75 percent.

#### Program Summary

This facility has no outstanding Article 28 enforcement actions and is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations.

#### Financial Summary

Project costs of \$11,408,502 will be met via equity from operations.

DOH Recommendation  
Contingent Approval

#### Incremental Budget:

Revenues	\$11,519,520
Expenses	6,041,483
Excess of Revenues over Expenses	\$5,478,037

#### Need Summary

New York Presbyterian Hospital - Columbia Presbyterian Center seeks approval renovate space in order to create a new maternity unit and add 12 net new maternity beds to its operating certificate. The

The applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

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

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The applicant must adhere to the Construction Start (07/17/2014) and Completion Dates (08/26/2015) provided in the application. The Department understands that unforeseen circumstances may delay the start and completion of the project. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. [AES]

Council Action Date

**February 13, 2014**

## Need Analysis

### Background

New York Presbyterian Hospital - Columbia Presbyterian Center ("Columbia") is a 977-bed acute care hospital located at 622 West 168th Street, New York, 10032, in New York County. The applicant seeks CON approval to renovate space on its campus to create a new 16-bed maternity unit; by relocating 4 existing beds from another unit to the new unit and adding 12 net new maternity beds to its operating certificate. Upon project completion, the maternity beds at Columbia will increase from 58 to 70.

### Analysis

New York Presbyterian Hospital - Columbia Presbyterian Center has the following certified beds and services:

*Table 1: New York Presbyterian Hospital - Columbia Presbyterian Center: Certified Beds by Service. Source: HFIS, December 2015.*

<u>Bed Category</u>	<u>Existing Capacity</u>	<u>Requested Action</u>	<u>Capacity Upon Completion</u>
AIDS	14		14
Bone Marrow Transplant	4		4
Chemical Dependence - Detoxification	3		3
Coronary Care	18		18
Intensive Care	99		99
Maternity	58	12	70
Medical / Surgical	541		541
Neonatal Continuing Care	11		11
Neonatal Intensive Care	14		14
Neonatal Intermediate Care	33		33
Pediatric	100		100
Pediatric ICU	41		41
Physical Medicine and Rehabilitation	16		16
Psychiatric	25		25
<b>Total</b>	<b>977</b>	<b>12</b>	<b>989</b>

*Table 2: New York Presbyterian Hospital - Columbia Presbyterian Center: Certified Beds by Service. Source: HFIS, December 2015.*

AIDS	AIDS Center
Ambulatory Surgery - Multi Specialty	Audiology O/P
Cardiac Catheterization - Adult Diagnostic	Cardiac Catheterization - Electrophysiology (EP)
Cardiac Catheterization - Pediatric Diagnostic	Cardiac Catheterization - Pediatric Intervention Elective
Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)	Cardiac Surgery - Adult
Cardiac Surgery – Pediatric	Certified Mental Health Services O/P
Chemical Dependence – Detoxification	Clinical Laboratory Service
Comprehensive Psychiatric Emergency Program	Coronary Care
Dental O/P	Emergency Department
Epilepsy Comprehensive Services	Family Planning O/P
Health Fairs O/P	Intensive Care
Linear Accelerator	Lithotripsy
Magnetic Resonance Imaging	Maternity
Medical Social Services	Medical/Surgical
Neonatal Continuing Care	Neonatal Intensive Care
Neonatal Intermediate Care	Nuclear Medicine - Diagnostic
Nuclear Medicine – Therapeutic	Pediatric

*Table 2: New York Presbyterian Hospital - Columbia Presbyterian Center: Certified Beds by Service. Source: HFIS, December 2015.*

Pediatric Intensive Care	Pediatric O/P
Pharmaceutical Service	Physical Medical Rehabilitation
Physical Medicine and Rehabilitation O/P	Prenatal O/P
Primary Medical Care O/P	Psychiatric
Radiology – Diagnostic	Radiology-Therapeutic
Renal Dialysis – Acute	Renal Dialysis - Chronic
Respiratory Care	Therapy - Occupational O/P
Therapy - Physical O/P	Therapy - Speech Language Pathology
Transplant - Bone Marrow	Transplant - Heart - Adult
Transplant - Heart – Pediatric	Transplant - Kidney
Transplant – Liver	

New York Presbyterian Hospital - Columbia Presbyterian Center is a member of The New York & Presbyterian Hospitals Inc. The organization is authorized to operate five (5) hospitals and seventeen (17) extension clinics in the New York Metropolitan Area.

**New York State Designations:**

- AIDS Center;
- Regional Pediatric Trauma Center;
- Regional Pediatric Trauma Center;
- Regional Perinatal Center;
- Regional Perinatal Center;
- SAFE Center;
- Stroke Center.

New York Presbyterian Hospital - Columbia Presbyterian Center proposes to create a new 16-bed maternity unit and add 12 net new maternity beds to its operating certificate.

In 2007, New York Presbyterian Hospital - Columbia Presbyterian recorded 49,778 total inpatient discharges; by 2012, said discharges increased by 0.8 percent to 50,187. During the same period, Columbia’s obstetric/maternity discharges increased by 2.2 percent from 5,010 in 2007 to 5,119 in 2012 (Table 3).

During the period under review, New York Presbyterian Hospital - Columbia Presbyterian (excluding healthy newborns) experienced an overall average daily census (ADC) of 812 patients on any given day for an average occupancy rate of 83.1 percent. The hospital’s obstetric unit ADC averaged 51 patients on any given day for an average occupancy of 87.6 percent. Columbia’s obstetric occupancy rate was more than 10 percentage points higher than the NYSDOH desired planning optimum of 75.0 percent for urban counties.

*Table 3: New York Presbyterian Hospital - Columbia Presbyterian: Inpatient Utilization by Major Service Category. Source: SPARCS 2007 - 2012.*

Service	2007	2008	2009	2010	2011	2012	Current Beds
Discharges							
Medical/Surgical	32,679	31,967	33,519	34,088	33,813	33,836	
Pediatric	5,404	5,042	5,473	5,378	5,299	5,361	
Obstetric	5,010	4,857	5,017	4,993	5,034	5,119	
General Psychiatric	1,677	1,664	1,634	1,681	1,095	777	
Chemical Dependency	346	327	323	392	339	282	
High Risk Neonates	932	988	1,033	969	1,133	1,108	
Subtotal	46,048	44,845	46,999	47,501	46,713	46,483	
Healthy Newborns	3,730	3,470	3,663	3,610	3,525	3,704	

Table 3: New York Presbyterian Hospital - Columbia Presbyterian: Inpatient Utilization by Major Service Category. Source: SPARCS 2007 - 2012.

Service	2007	2008	2009	2010	2011	2012	Current Beds
Grand Total	49,778	48,315	50,662	51,111	50,238	50,187	
Average Daily Census							
Medical/Surgical	567	567	574	585	589	581	
Pediatric	92	94	93	87	92	87	
Obstetric	50	48	52	51	51	53	
General Psychiatric	29	30	29	30	28	25	
Chemical Dependency	6	5	5	7	6	3	
High Risk Neonates	53	60	62	56	64	62	
Subtotal	796	804	816	816	829	811	
Healthy Newborns	28	26	28	28	26	27	
Grand Total	824	830	844	844	855	838	
Occupancy Based on Current Beds							
Medical/Surgical	81.9	81.9	83.0	84.6	85.1	84.0	692
Pediatric	65.5	67.0	66.0	61.7	65.0	61.6	141
Obstetric	85.9	82.6	89.8	88.4	87.1	91.2	58
General Psychiatric	116.0	118.0	117.2	119.6	113.6	101.2	25
Chemical Dependency	186.7	163.3	170.0	223.3	190.0	113.3	3
High Risk Neonates	91.6	103.4	107.2	96.4	110.2	106.0	58
Total	81.5	82.3	83.5	83.5	84.8	83.0	977

New York Presbyterian Hospital - Columbia Presbyterian seeks to increase its obstetric beds in order to accommodate increased utilization due to physician recruitment, programmatic growth and to maintain occupancy rates within the desired obstetric planning optimum of 75.0 percent. The additional space will allow the hospital to meet the obstetric needs of its patients as well as, improve efficiencies and access to care.

Based on SPARCS discharge data, New York Presbyterian Hospital - Columbia Presbyterian obstetric unit occupancy has exceeded the desired planning optimum by more than 10 percentage points. In addition, the hospital's other inpatient units, except pediatric, have also exceeded the NYSDOH desired planning optimums. The renovations and addition of twelve (12) beds will provide the hospital with resources to appropriately treat its patients and to help with the growth in obstetric cases that the hospital is experiencing.

#### Conclusion

New York Presbyterian Hospital - Columbia Presbyterian seeks approval to expand its maternity unit and increase its maternity beds. The facility's maternity unit occupancy rate has consistently exceeded the desired planning optimum rate of 75.0 percent. In addition to the high occupancy rates, during the years under review, the hospital has experienced growth in its obstetric discharges. The expansion and additional beds will provide New York Presbyterian Hospital - Columbia Presbyterian with the space needed to meet the needs of its patients.

#### Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Project Proposal

New York-Presbyterian Hospital (NYP Hospital) proposes to create a new 16 single-bedded maternity unit located on the 10th floor of the Central Building at the Morgan Stanley Children's Hospital of New York-Presbyterian at the New York-Presbyterian/Columbia University Medical Center campus.

In order to create the new maternity unit, New York Presbyterian proposes to add 12 new maternity beds and relocate four existing high risk maternity beds located in the 10 Tower Labor and Delivery Suite. Two existing double-bedded high risk maternity inpatient rooms (four existing maternity beds) will be converted into two new Labor and Delivery Rooms. Specifically, the renovation will include 16 new inpatient single rooms, including six high risk single rooms, one isolation room and one bariatric room.

Staffing will increase by 30.8 FTEs in the first year after completion and is not anticipated to increase further by the third year of operation.

### Compliance with Applicable Codes, Rules and Regulations

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

### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Total Project Cost and Financing

Total project cost, which is for renovations and the acquisition of moveable equipment, is estimated at \$11,408,502, further itemized as follows:

Renovation and Demolition	\$6,625,713
Asbestos Abatement or Removal	54,500
Design Contingency	662,571
Construction Contingency	662,571
Planning Consultant Fees	35,000
Architect/Engineering Fees	689,100
Other Fees (Consultant)	1,058,209
Moveable Equipment	1,556,445
CON Fee	2,000
Additional Processing Fee	<u>62,393</u>
Total Project Cost	\$11,408,502

Project costs are based on a July 17, 2014 construction start date and a thirteen month construction period. The hospital will provide equity to meet the total project cost.

## Operating Budget

The applicant has submitted an incremental operating budget, in 2014 dollars, for the first and third years, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$9,909,024	\$11,519,520
Expenses:		
Operating	\$5,006,525	\$5,402,630
Capital	<u>732,932</u>	<u>638,853</u>
Total Expenses	\$5,739,457	\$6,041,483
Excess of Revenues over Expenses	\$4,169,567	\$5,478,037
Utilization: (Discharges)	886	1,030
Cost Per Discharge	\$6,477.94	\$5,865.52

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

	<u>Year One</u>	<u>Year Three</u>
Medicaid Managed Care	47.29%	47.28%
Medicare Fee For Service	.56%	.58%
Medicare Managed Care	.22%	.20%
Commercial Fee For Service	51.93%	51.94%

Expense assumptions are based on the historical experience of the hospital. Utilization assumptions are based on the following: an increase in deliveries and obstetric admissions are aligned with the expected growth in physician capacity by the Department of Obstetrics and Gynecology; volume will rise as physician practices in their specialty programs for high risk pregnancies gradually mature; and volume increases due to additional volume through outreach efforts in the community as the presence of the hospital's specialty fetal and high risk maternity programs are established over time.

## Capability and Feasibility

Project costs of \$11,408,502 will be met via equity from hospital operations. BFA Attachment A is the 2011 and 2012 certified financial statement of New York Presbyterian Hospital, which indicates the availability of sufficient funds to meet the total project cost.

The submitted budget indicates an excess of revenues over expenses of \$4,169,567 and \$5,478,037 during the first and third years, respectively. Revenues are based on current reimbursement methodologies for maternity services. The budget appears reasonable.

As shown on Attachment A, the hospital had an average positive working capital position and an average positive net asset position from 2011 through 2012. Also, the facility achieved an average operating excess of revenues over expenses of \$187,337,000 from 2011 through 2012.

BFA Attachment B is the September 30, 2013 internal financial statements of New York Presbyterian Hospital. As shown on Attachment B, the hospital had a positive working capital position and a positive net asset position through September 30, 2013. Also, the facility achieved an operating excess of revenues over expenses of \$125,820,000 through September 30, 2013.

The applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

## Recommendation

**From a financial perspective, approval is recommended.**

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## Attachments

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BFA Attachment A  
BFA Attachment B

Financial Summary- New York Presbyterian Hospital  
Internal financial statements - New York Presbyterian Hospital



# Public Health and Health Planning Council

Project # 132199 C

## NYU Hospitals Center

**County:** New York County  
**Purpose:** Construction

**Program:** Hospital  
**Acknowledged:** October 15, 2013

### Executive Summary

#### Description

New York University Hospitals Center (NYU), a 844-bed not-for-profit hospital located in New York County, requests approval to create the NYU Langone Center for ENT and Ophthalmologic Surgery, which will be located at its existing Ambulatory Care Center at 240 East 38<sup>th</sup> St. The ambulatory surgery unit will include 4 Class C Operating Rooms, 12 adult prep/recovery positions, 4 pediatric prep/recovery positions and an exam room. The location for this proposed newly created ENT and Ophthalmologic Surgery Unit will be an existing ambulatory facility with close proximity to other related programs.

There will be no changes in the operating certificate of New York University Hospitals Center as a result of this application.

#### DOH Recommendation Contingent Approval

#### Need Summary

The proposed project will relocate the ophthalmologic and otolaryngology services that are currently being provided at Tisch Hospital-NYU Hospitals Center. The number of projected cases is 2,700 cases in year 1 and 3,500 cases in year 3.

#### Program Summary

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations.

#### Financial Summary

Total projects cost for renovation and moveable equipment is \$20,075,273, which will be paid in equity.

Incremental Budget:	Revenues	\$31,728,832
	Expenses	<u>15,014,792</u>
	Excess Revenues	\$16,714,040

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

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

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. A time-limited waiver was granted specific to the requirements of NFPA 101-2000 20.4, 38.4.2, 11.8.2.1: "High-rise buildings shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." The waiver was based on the Waiver Determination signed by Stephen J. Rosenthal, A.I.A. dated December 31, 2013 and Request for Waiver dated December 30, 2013 with supporting documentation. This waiver expires July 30, 2019. [DAS]
7. The applicant is required to submit final construction documents, complying with requirements of 10NCYRR Part 710.7, to NYS DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) prior to start of construction. [DAS]

Council Action Date

**February 13, 2014**

## Need Analysis

### Background

NYU Hospitals Center is seeking approval to renovate the 3<sup>rd</sup> floor of the Ambulatory Care Center at 240 East 38<sup>th</sup> Street, Manhattan, 10016, in New York County and to certify ambulatory surgery services for ENT and ophthalmologic procedures. These procedures are currently performed on the 6<sup>th</sup> and 10<sup>th</sup> floors of the Tisch Hospital-NYU Hospitals Center. Upon approval, the Center will be known as the NYU Langone Center for ENT and Ophthalmologic Surgery.

### Analysis

The service area is New York County, which has a total of seven freestanding multi-specialty ASCs and eight freestanding single-specialty ASCs.

*Existing Ambulatory Surgery Centers: New York County (Source: SPARCS 2012)*

<b>ASC Type</b>	<b>Name</b>	<b>Total Patients 2012</b>
Gastroenterology	Carnegie Hill Endo, LLC	7,357
Multi-Specialty	Center for Specialty Care	4,585
Gastroenterology	East Side Endoscopy	8,811
Multi-Specialty	Fifth Avenue Surgery Center	2,051
Multi-Specialty	Gramercy Park Digestive Disease	8,577
Multi-Specialty	Gramercy Surgery Center, Inc	2,136
Endoscopy	Kips Bay Endoscopy Center LLC	9,401
Gastroenterology	Manhattan Endoscopy Ctr, LLC	9,857
Ophthalmology	Mid Manhattan Surgi-Center	3,888
Multi-Specialty	Midtown Surgery Center, LLC	2,860
Ophthalmology	Retinal Ambulatory Surgery Ctr	1,718
Multi-Specialty	Surgicare of Manhattan, LLC	3,993
Gastroenterology	West Side GI	3,652
Multi-Specialty	Roosevelt SC (Opened April 1, 2013)	N/A
Gastroenterology	Yorkville Endoscopy Center (Opened February 22, 2013)	N/A
<b>Total</b>		<b>68,886</b>

In addition there are two freestanding ASCs, one single-specialty ASC and one multi-specialty ASC, which have been approved, but are not yet operational.

The number of projected cases is 2,700 cases in Year 1 and 3,500 cases in Year 3.

### Conclusion

The proposed project will relocate ophthalmologic and otolaryngology surgery from a hospital site to an ambulatory care facility with close proximity to other related programs.

### Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Background

NYU Hospitals Center, requests approval to renovate space on the 3rd floor of its Ambulatory Care Center located at 240 East 38<sup>th</sup> Street, Manhattan and to certify multi-specialty ambulatory surgery for ENT and ophthalmologic procedures (which are currently performed on the 6<sup>th</sup> and 10<sup>th</sup> floors of the NYU Hospitals Center).

Upon approval, the Center will be known as the NYU Langone Center for ENT and Ophthalmologic Surgery. It will include four (4) Class C operating rooms, an exam room and 12 adult prep/recovery positions and four (4) pediatric prep/recovery positions.

It is anticipated the project will result in an additional 37.4 FTEs in the first year and 46.4 FTEs by year three.

### Site

NYU Langone Ambulatory Care Center  
240 East 38<sup>th</sup> Street, New York, NY 10016

### Services to be Approved

Ambulatory Surgery – Multi Specialty  
(Otolaryngology and Ophthalmology)

### Compliance with Applicable Codes, Rules and Regulations

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

### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Total Project Cost and Financing

Total project cost, which is for the renovation and moveable equipment is estimated at \$20,075,273, itemized as follows:

Renovation and Demolition	\$9,500,000
Asbestos Abatement	225,000
Design Contingency	1,000,000
Construction Contingency	1,000,000
Construction Manager Fees	500,000
Other Fees	700,000
Architect Fees	750,000
Moveable Equipment	5,688,474
Telecommunications	600,000
Application Fee	2,000
Additional Processing Fee	<u>109,799</u>
Total Costs	\$20,075,273

Project cost is based on a March, 2014 start date and a seven month construction period.

## Operating Budget

The applicant has provided a first and third year incremental budget, in 2013 dollars, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues:	\$24,476,527	\$31,728,832
Expenses:		
Operating	\$10,831,032	\$13,595,153
Capital	<u>709,820</u>	<u>1,419,639</u>
Total Expenses	\$11,540,852	\$15,014,792
Excess Revenues	<u>\$12,935,675</u>	<u>\$16,714,040</u>
Utilization/(Procedures)	2,700	3,500
Cost Per Procedure	\$4,274.38	\$4,289.94

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

<u>Payor Source</u>	<u>Year One/Three</u>
Medicaid Managed Care	10%
Medicare Fee-For-Service	19%
Medicare Managed Care	3%
Commercial Fee-For-Service	65%
Commercial Managed Care	2%
Other	1%

Utilization and expense assumptions are based on historical experience of the existing operation at NYU.

### Capability and Feasibility

The hospital will finance \$20,075,273 via cash equity. BFA Attachment A is a financial summary of NYU Hospital Center, which indicates the availability of sufficient funds to meet the equity contribution.

The submitted incremental budget projects excess revenues over expenses of \$12,935,675 and \$16,714,040 during the first and third years, respectively. The applicant's revenues reflect current reimbursement methodologies and rates of payment for ENT and ophthalmologic surgical services. The budget appears reasonable.

BFA Attachment A is a financial summary of New York University Hospitals Center. As shown in BFA Attachment A, NYU maintained an average positive working capital position and an average positive net asset position during the period shown. Also, the facility generated an average annual excess operating revenues over expenses of \$180,922,500 during the period shown. BFA Attachment B is the internal un-audited financial summary of New York University Hospitals Center. As shown in BFA Attachment B, NYU maintained a positive working capital position and a positive net asset position during the period shown. Also, the facility generated an excess of operating revenues over expenses of \$28,784,000 representing fiscal year January 1, 2013 thru October 31, 2013.

Based on the preceding, the applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

### Recommendation

**From a financial perspective, approval is recommended.**

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## Attachments

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BFA Attachment A      Financial Summary, NYU Hospital's Center  
BFA Attachment B      Internal Financial Summary, NYU Hospital Center



# Public Health and Health Planning Council

## Project # 132205 C Strong Memorial Hospital

**County:** Monroe County  
**Purpose:** Construction

**Program:** Hospital  
**Acknowledged:** October 9, 2013

### Executive Summary

#### Description

Strong Memorial Hospital, an 800-bed not-for-profit tertiary care teaching hospital located at 601 Elmwood Avenue, Rochester, NY (Monroe County), is requesting approval to establish an off-site ambulatory surgery center (ASC) within their article 28 extension clinic located at 156 West Avenue, Brockport, New York. Strong Memorial Hospital is a division of The University of Rochester.

As background, under CON 131231, Lakeside Memorial Hospital decertified all of their beds and services, and on April 27, 2013, they began operating as a diagnostic and treatment center with two extension clinics. Under CON 131333, Strong Memorial Hospital received approval to add the three sites as their own extension clinics. The extension clinics are located at: 156 West Avenue, Brockport, New York (formerly Lakeside Memorial Internal Medicine); 42 Nichols Street, Spencerport, New York (formerly Lakeside Urgent Care); and 8745 Lake Road, Leroy, New York (formerly Genesee Family Practice). Strong Memorial Hospital assumed the operations of these three locations on July 15, 2013.

The ambulatory surgery center will encompass 15,200 square feet on the first floor of the former Lakeside Memorial Hospital located at 156 West Avenue, Brockport, NY. The ambulatory surgery center will include: three operating rooms, five semi-private, and six private pre-operating and recovery bays/rooms, along with the requisite support areas.

The ambulatory surgery center expects to receive 1,200 surgical visits in its first year of operations and 3,000 visits by the third year. The applicant states that

the project will allow local residents, including SUNY Brockport students, to receive their care in a more convenient setting.

Under a companion application, CON 132125, Strong Memorial Hospital is seeking approval to establish a provider-based off-campus emergency department (ED) at this location.

#### DOH Recommendation Contingent Approval

#### Need Summary

Strong Memorial projects, that there will be 1,200 surgical procedures in year one and 3,000 in year three.

#### Program Summary

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations.

#### Financial Summary

The total project costs of \$1,990,960 will be provided from Strong Memorial Hospital's accumulated funds.

Incremental Budget:	Revenues:	\$8,247,800
	Expenses:	\$5,012,338
	Gain/ (Loss)	\$3,235,462

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency  
The HSA recommends approval of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. All devices producing ionizing radiation must be licensed by the New York State Department of Health -- Bureau of Environmental Radiation Protection. [HSP]
3. The approval of SHC drawings will require further reconfiguration and designation of surgical suite spaces as necessary to maintain circulation from OR's to post op recovery areas within semi-restricted spaces as defined by the 2010 FGI Guidelines, 3.7-1.3.4.1(2) requiring personnel to wear surgical attire and cover head and facial hair and limiting traffic in this area to authorized personnel and patients. [AER]
4. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
5. The applicant shall complete construction by May 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval may be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date  
**February 13, 2014**

## Need Analysis

### Background

Strong Memorial Hospital is seeking approval to certify multi-specialty ambulatory surgery services at an existing extension clinic at 156 West Avenue, Brockport 14420, in Monroe County.

In July 2013, Strong Memorial Hospital was approved to add three Article 28 Extension Clinics as follows:

- 156 West Avenue, Brockport, 14420, Monroe County (formerly Lakeside Hospital),
- 42 Nichols Street, Spencerport, 14559, Monroe County (formerly lakeside Urgent Care Center), and
- 8745 Lake Road, Leroy, 14482, Genesee County (formerly Genesee Family Practice)

Strong Memorial Hospital now plans to operate an off-site hospital-based ambulatory surgery center at the West Avenue site.

### Analysis

The service area is Monroe County. The proposed project will also serve communities in neighboring counties.

Monroe County has five freestanding multi-specialty ambulatory surgery centers.

<b>2012 Ambulatory Surgery Total Patients</b>		
<u>Type</u>	<u>Facility</u>	<u>Patients</u>
Multi-Specialty	Brighton Surgery Center LLC	4,745
Multi-Specialty	Lattimore Comm Surgicenter	3,616
Multi-Specialty	Linden Oaks Surg Ctr (AKA Unity Linden Oaks SC)	4,924
Multi-Specialty	Lindsay House Surgery Ctr Inc (AKA Rochester ASC)	599
Multi-Specialty	Westfall Surgery Center LLP	14,224

*SPARCS 2012*

Lakeside Memorial Hospital closed on April 26, 2013. In 2012, LMH provided 3,458 outpatient surgical procedures. The proposed project will preserve the services that were once provided by LMH.

The number of projected procedures is 1,200 in year one and 3,000 in year three.

### Conclusion

The proposed project will allow for the continuation of ambulatory surgical services in Brockport and the surrounding areas.

### Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Project Proposal

Strong Memorial Hospital (SMH) requests approval to certify an off-site ambulatory surgery center within the Article 28 extension clinic, Strong West (formerly Lakeside Hospital).

Site Name	Strong West Ambulatory Surgery Center
Site Address	156 West Avenue, Brockport, NY
Surgical Specialties	Multi-Specialty (including Ophthalmology, Orthopedic, Podiatry, and General Surgery)
Operating Rooms	3 (1 Class B & 2 Class C)

Procedure Rooms	1
Hours of Operation	Monday through Thursday, 7 AM to 6 PM
Staffing (1st Year/3rd Year)	24.7 FTEs / 37.0 FTEs
Medical Director(s)	Ryan Shelton, MD
Emergency , In-Patient and Backup Support Services Agreement and Distance	Strong Memorial Hospital 21.4 miles / 27 min.
On-Call Service	The surgeon's after-hours contact information/number will be provided to patients.

#### Compliance with Applicable Codes, Rules and Regulations

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

On August 5, 2004, Strong Memorial Hospital was fined \$20,000 for improperly computing patients' level of need which resulted in patients receiving liver transplants before other patients who would have scored higher.

#### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

#### Financial Analysis

Total project costs for the renovation and acquisition of moveable equipment is estimated at \$1,990,960, which is broken down as follows:

Renovation & Demolition	\$1,314,488
Design Contingency	62,708
Construction Contingency	62,708
Architect/Engineering Fees	54,467
Movable Equipment	483,710
CON Application Fee	2,000
CON Processing Fee	<u>10,879</u>
Total Project Cost	\$1,990,960

Total Project costs are based on an April 1, 2014 start date with a one month construction period. The applicant will fund the \$1,990,960 project from accumulated funds

## Operating Budget

The applicant has submitted first and third years operating budgets, in 2013 dollars:

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$2,887,200	\$8,247,800
Expenses:		
Operating	\$2,732,512	\$4,861,375
Capital	<u>150,963</u>	<u>150,963</u>
Total Expenses	\$2,883,475	\$5,012,338
Net Income or (Loss)	<u>\$3,725</u>	<u>\$3,235,462</u>

Utilization: (visits)	1,200	3,000
Cost Per Visit	\$2,402,90	\$1,670.78

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

Medicaid Managed Care	5.8%
Medicare Fee-For-Service	16.6%
Commercial Fee-For-Service	33.8%
Commercial Manage Care	18.7%
Private Pay	1.5%
All Other	21.6%
Charity	2.0%

Utilization assumptions were developed using Lakeside Memorial Hospital's historical experience in providing ambulatory surgery services at the 156 West Avenue campus. Expense assumptions were developed using the applicant's experiences in operating a multi-specialty off-site hospital ambulatory surgery center. The first year is expected to be close to breakeven, and by the third year the costs are expected to be covered at approximately 60.7% of projected volume or 1,821 visits.

The reasons for the operating surplus growing from \$3,725 in year 1 to \$3,235,462 by year 3 are as follows: In year 1 there is an assumption of approximately 1,200 visits based on a ramp up of operations, but an assumed baseline staffing component. By year 3, the facility is expecting to achieve 2.5 times the year 1 visits or approximately 3,000 visits with the expenses only growing by 1.7 times the year 1 expenses.

### Capability and Feasibility

Strong Memorial Hospital will satisfy the \$1,990,960 in total project cost from accumulated funds. BFA Attachment A is Strong Memorial Hospital's 2011-2012 certified financial summary, which indicates the availability of sufficient resources.

Working capital requirements are estimated at \$835,390 and will be provided from operations. Review of BFA Attachment A indicates working capital requirements can be met through operations.

The incremental budget projects positive results for the first and third years of \$3,725 and \$3,235,462, respectively. Revenues are based on prevailing reimbursement methodologies while commercial payers are based on experience. The budget appears reasonable.

As shown on BFA Attachment A, Strong Memorial Hospital has maintained an average working capital position of \$287,723,337, average net asset position of \$402,661,151, and for 2011 through 2012 generated an average excess of revenues over expenses of \$77,986,532.

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

### Recommendation

**From a financial perspective, approval is recommended.**

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## Attachments

BFA Attachment A  
BHFP Attachment

Financial Summary for 2011 and 2012, Strong Memorial Hospital  
Map



# Public Health and Health Planning Council

## Project # 132210 C Cayuga Medical Center at Ithaca

**County:** Tompkins County  
**Purpose:** Construction

**Program:** Ambulatory Surgery Center  
**Acknowledged:** October 11, 2013

### Executive Summary

#### Description

Cayuga Medical Center at Ithaca is proposing to construct and renovate new space for its outpatient gastroenterology services. Currently, endoscopy services are offered from its main campus location at 101 Dates Drive, Ithaca, NY and the Ambulatory Surgery Center located at 10 Arrowwood Drive, Ithaca, NY. This proposal would relocate the clinic to a new location at 2435 N. Triphammer Road, Ithaca, NY. Once approved, Cayuga Medical Center will cease to provide any outpatient gastroenterological endoscopic services from its current site at 10 Arrowwood Drive and would further shift approximately 75% of the outpatient gastroenterological volume from its current Ambulatory Surgery site.

The new clinic site will consist of four new endoscopy rooms and will accommodate all required ancillary spaces while consolidating the service to a central location.

There will be no changes in the operating certificate of Cayuga Medical Centers Center as a result of this application.

DOH Recommendation  
Contingent Approval

#### Need Summary

The proposed extension clinic is a relocation of outpatient endoscopy services as follows:

- a) Main Campus at 101 Dates Drive, Ithaca: approximately 75 percent of the outpatient services from this site will be shifted to the proposed new location on North Triphammer Road.

- b) Ambulatory Surgery Site at 10 Arrowwood Drive, Ithaca: operations at this site will discontinue.

The number of projected endoscopic procedure is 3,763 in year 1 and 3,801 in year 3.

#### 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 projects cost for construction and renovation is \$3,473,095, which will be paid in equity.

Budget:	Revenues	\$ 3,402,066
	Expenses	<u>1,868,530</u>
	Excess Revenues	\$ 1,533,536

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency  
Approval

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by September 1, 2014. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before the date, this may constitute abandonment of the approval and this approval may be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date  
**February 13, 2014**

## Need Analysis

### Project Description

Cayuga Medical Center at Ithaca is seeking approval to certify an extension clinic to provide single specialty ambulatory surgery services at 2435 North Triphammer Road, Ithaca, 14850, in Tompkins County.

### Analysis

The service area includes a total of 11 zip codes in Tompkins County and surrounding communities in Cayuga, Cortland, Tioga, Schuler, Seneca, and Chemung Counties.

Tompkins County does not have a freestanding single or multi-specialty ambulatory surgery center.

The proposed location is in Health Professional Shortage Areas (HPSAs) as follows:

- HPSA for Primary Care Services: Medicaid Eligible-Tompkins County
- HPSA for Mental Health Services: Medicaid Eligible-Tompkins County
- HPSA for Dental Health Services: Medicaid Eligible-Tompkins County

The number of projected endoscopic procedure is 3,763 in year 1 and 3,801 in year 3.

### Conclusion

This project will consolidate services that are currently being provided at the hospital and in another location in Ithaca that will be closed.

### Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Project Proposal

Cayuga Medical Center at Ithaca (CMC) requests approval to construct a single specialty gastroenterology ambulatory surgery extension clinic. With the construction of the new clinic, gastroenterological endoscopic services will longer be provided at CMC's ambulatory surgery location and approximately 75% of outpatient volume from the medical center's main campus will shift to the new clinic's location.

Site Name	Cayuga Medical Center Endoscopy Clinic
Site Address	2435 N. Triphammer Road, Ithaca
Surgical Specialties	Gastroenterology
Procedure Rooms	4
Hours of Operation	Monday through Friday, 7:30 am – 5:00 pm
Staffing (1 <sup>st</sup> Year/3 <sup>rd</sup> Year)	Current Staff of 12 FTEs will increase by 3.3 FTEs the 1 <sup>st</sup> year and are anticipated to increase by an additional 1.0 FTE in the 3 <sup>rd</sup> year of operation.
Medical Director(s)	Peter Brennan, MD
Emergency , In-Patient and Backup Support Services Agreement and Distance	Cayuga Medical Center 8.1 Miles / 15 Minutes
On-Call Service	The center will provide patient with the number of their 24/7 physician on-call service.

### Compliance with Applicable Codes, Rules and Regulations

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

Cayuga Medical Center was fined \$8,000 pursuant to a Stipulation and Order dated October 27, 2010 for an incident which occurred on April 8, 2009 in which a patient received a right-sided laminotomy and disc excision when the patient required and signed a consent for a left-sided procedure.

Cayuga Medical Center was fined \$26,000 pursuant to a recent Stipulation and Order dated December 15, 2013 for surveillance findings of July 21, 2010 related to a complaint investigation into the medical and nursing care rendered to a 21-year-old student admitted with pneumonia and dehydration. Failure to recognize the severity of the condition and a lack of monitoring led to the patient's death.

### Recommendation

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

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Lease Rental Agreement

The applicant has submitted an executed lease rental agreement for the site to be occupied, the terms of which are summarized below:

Premises:	8,960 square feet located at 2435 North Triphammer Road, Ithaca, NY. Currently the facility consists of 6,460 square feet and tenant will construct an additional 2,500 square feet in accordance with the lease terms at this location.
Lessor:	Triphammer Medical Realty, LLC
Lessee:	Cayuga Medical Center at Ithaca
Rental:	\$89,600 annually (\$10.00 per sq. ft.) Also, the annual increase in rent will be 3.5% per year over the ten year term.
Term:	15 years with yearly renewal options thereafter
Provisions:	Triple net lease whereby the Lessee shall pay landlord utilities, real estate taxes and miscellaneous expenses totaling approximately 58% of stated costs. Also, the landlord will pay \$58,000 toward the construction. Lessee will pay the Lessor an added \$4,833.33 for the first twelve months to reimburse the cost of construction.

The applicant has provided two letters indicating the rent reasonableness. The applicant has indicated that the lease agreement will be a non-arm's length lease agreement.

### Total Project Cost and Financing

Total project cost, which is for the renovation and construction, is estimated at \$3,473,095 is broken down as follows:

New Construction	625,000
Renovation and Demolition	1,555,000
Site Development	395,000
Design Contingency	218,000
Construction Contingency	186,750
Planning Consultant Fees	151,100
Architect/Engineering Fees	156,900

Moveable Equipment	164,358
Application Fee	2,000
Additional Processing Fee	<u>18,987</u>
Total Costs	\$3,473,095

#### Operating Budget

The applicant has provided a first and third year budget in 2013 dollars, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$3,402,066	\$3,402,066
Expenses:		
Operating	\$1,673,153	\$1,536,481
Capital	<u>332,049</u>	<u>332,049</u>
Total Expenses	\$2,005,202	\$1,868,530
Excess Revenues	<u>\$1,396,864</u>	<u>\$1,533,536</u>
Utilization/(Procedures)	3,763	3,801
Cost Per Procedure	\$532.87	\$491.58

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

<u>PAYOR SOURCE</u>	<u>YEAR ONE/THREE</u>
Medicaid Fee-For-Service	1%
Medicaid Managed Care	3%
Medicare Fee-For-Service	24%
Medicare Managed Care	4%
Commercial Fee-For-Service	67%
Private Pay	1%

Utilization and expense assumptions are based on historical experience of the existing operation at Cayuga Medical Center.

#### Capability and Feasibility

The hospital will finance \$3,473,095 via cash equity. BFA Attachment A is the financial summary of Cayuga Medical Center, which indicates the availability of sufficient funds for the equity contribution.

The submitted incremental budget projects excess revenues over expenses of \$1,396,864 and \$1,533,536 during the first and third years, respectively. The applicant's revenues reflect current reimbursement methodologies and rates of payment for gastroenterology services. The budget appears reasonable.

As shown on BFA Attachment A, Cayuga Medical Center maintained an average positive working capital position and an average positive net asset position during the period shown. Also, the facility generated an average annual excess operating revenues over expenses of \$7,239,141 during the period shown.

BFA Attachment B is the interim un-audited financial summary for Cayuga Medical Center. As shown on Attachment B, Cayuga Medical Center has maintained a positive working capital position and positive net asset position for the period shown. Also, the facility generated excess operating revenue over expenses of \$1,275,274 for the period January 1, 2013 through July 31, 2013.

Based on the preceding, the applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

#### Recommendation

**From a financial perspective, approval is recommended.**

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## Attachments

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BFA Attachment A  
BFA Attachment B

Financial Summary, Cayuga Medical Center  
(Internal) Financial Summary, Cayuga Medical Center



# Public Health and Health Planning Council

Project # 131309 C  
**Jamaica Hospital Nursing Home Co., Inc.**

**County: Queens County**  
**Purpose: Construction**

**Program: Residential Health Care Facility**  
**Acknowledged: June 11, 2013**

## Executive Summary

### Description

Jamaica Hospital Nursing Home Co., Inc., a 224-bed hospital-based, not-for-profit residential health care facility (RHCF) with two respite beds, located on the Jamaica Hospital Medical Center Campus, requests approval to renovate space and certify four additional RHCF beds, bringing the total beds to 228.

Jamaica Hospital Nursing Home Co., Inc. is sponsored by the Jamaica Hospital Medical Center and is a member of the Medisys Health Network, which also includes Flushing Hospital Medical Center, Medisys Family Health Centers, Advanced Center for Psychotherapy and James and Sarah Brady Institute for Traumatic Brain Injury. BFA Attachment A is the Medisys Health Network Organizational Chart.

DOH Recommendation  
Contingent Approval

### Need Summary

Jamaica Hospital Nursing Home has been above the 97 percent bed occupancy threshold for 2011 and is considered a safety-net facility for the local area. Jamaica Hospital Nursing Home has continued to see growth in their facility, partially due to their association

with Jamaica Hospital Medical Center and the Medisys network. The close association also allows them to provide palliative, hospice, and end of life care. The four additional beds and needed renovation will allow them to continue to operate as a safety-net facility and service their current residents.

### Program Summary

The addition of four nursing home beds at Jamaica Hospital Nursing Home Company will not have an adverse impact on the existing residents, since the remaining lounge and activity space is adequate to meet their needs.

### Financial Summary

Project costs will be met with \$64,341 in cash.

Incremental Budget:	Revenues:	\$446,023
	Expenses:	52,880
	Gain(Loss):	\$393,143

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

## Recommendations

Health Systems Agency

There will be no HSA recommendation for this application.

Office of Health Systems Management

**Approval contingent upon:**

1. 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 the CON fees. [PMU]
2. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
3. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - a) Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b) Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c) Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - d) Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
4. Submission of and programmatic review and approval of the final floor plans. [LTC]
5. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The effective date for the certification of the additional beds will be determined by the Metropolitan Area Regional Office. [LTC]
3. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
4. The applicant shall complete construction by May 16, 2014 in accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

**February 13, 2014**

## Need Analysis

### Project Description

Jamaica Hospital Nursing Home is an existing 224-bed not-for-profit facility located at 89-40 135th Street Jamaica, New York 11418 Queens County. They are seeking approval to add four net new beds and perform necessary renovations.

There is currently a need for 8,663 beds in the New York City Region as indicated in Table 1.

Table 1: RHCF Need – NYC Region

2016 Projected Need	51,071
Current Beds	41,895
Beds Under Construction	314
Total Resources	42,209
Unmet Need	8,862

Although a need for beds in New York City is indicated, section 709.3 states that in such circumstances, there shall be a presumption of no need if the overall occupancy of RHCFs in the planning area is less than 97 percent. The average RHCF occupancy rate for New York City is 94.8%, and the average occupancy for Queens County is slightly lower, at 94.4%, as indicated in Table 2. Occupancy at Jamaica Hospital Nursing Home was higher than that of Queens county for 2009, 2010 and 2011. It was also higher than that of New York City in 2009 and 2011, and slightly lower in 2010.

Table 2: RHCF Jamaica Hospital Nursing Home/Queens County

Facility/County/Region	2009	2010	2011	2012
Jamaica Hospital Nursing Home	95.8%	95.1%	97.9%	99.0%
Queens County	94.7%	94.7%	94.4%	94.2%
NYC	94.9%	95.4%	94.8%	95%*

\*NYC Region percentage not yet certified, but staff feels this number is fairly accurate.

Because New York City's overall RHCF utilization rate is below that of the 97% percent planning optimum, there is a presumption of no need for additional beds in the area, as set forth in 709.3(f). However, subdivision (f) also provides for a rebuttal of this presumption based on local factors in the facility's service area.

In describing local factors pertaining to bed need, the applicant states the following:

- Jamaica Hospital occupancy rose to over 103% during Hurricane Sandy. Since all flood zone facilities remain at risk through 2020, a similar circumstance could recur and additional capacity again be needed.
- Jamaica Hospital continues to have a 98% utilization rate through 2013.
- Jamaica Hospital is the only facility able to provide a full service nursing facility to the areas of Jamaica, Ozone Park, Woodhaven, Richmond Hill, and Howard Beach.
- The hospital nursing home is likely to experience an increase in demand due to the collaboration with Jamaica Hospital Medical Center and as a member of the Medisys Health Network.
- The alliance with Jamaica Hospital Medical Center allows the facility to provide palliative, hospice, and end of life care, which will help contribute to high occupancy.
- The facility is the only Queens facility to participate in the CMS bundled payment initiative.

### Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility

is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions or 75 percent of the Health Systems Agency area Medicaid admissions percentage, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage or of the Health Systems Agency percentage, whichever is applicable.

Jamaica Hospital Nursing Home was below the 75 percent of the planning average for both 2010 and 2011. The facility reported Medicaid admissions of 13.46 percent in 2010 and 11.78% in 2011. The 75 percent planning averages for Queens County for 2010 and 2011 were 28.46 percent (2010) and 30.41 percent (2011).

**Conclusion**

From a need perspective, approval is recommended. Jamaica Hospital Nursing Home is showing steady and maintained growth through the type and quality of its care, along with its extensive referral programs and singular location.

**Recommendation**

**From a need perspective, contingent approval is recommended.**

**Programmatic Analysis**

**Facility Information**

	EXISTING	PROPOSED
FACILITY NAME	Jamaica Hospital Nursing Home Company, Inc.	Same
ADDRESS	89-40 135 <sup>th</sup> Street Jamaica, NY. 11418	Same
RHCF CAPACITY	224	228
ADHC PROGRAM CAPACITY	N/A	Same
TYPE OF OPERATOR	Voluntary	Same
CLASS OF OPERATOR	Corporation	Same
OPERATOR	Jamaica Hospital Nursing Home Company, Inc.	Same

**Program Review**

Jamaica Hospital Nursing Home Company, Inc. (Jamaica) is a 224 bed residential health care facility located in Queens County. The applicant states that the nursing home has experienced a sustained increase in demand due to its new physical plant, close affiliation with Jamaica Hospital and its location within Queens County. To meet the current and future demand, Jamaica Hospital Nursing Home Company proposes to certify an additional four beds for a net total of 228 permanent RHCF beds.

**Physical Environment**

Jamaica Hospital Nursing Home Company proposes to accommodate the additional beds by converting two respite beds located on the second floor into a double bedroom, and renovating an underutilized lounge on the fourth floor into another double. The respite room is currently configured as a standard two bedded room and will require no modification. Renovations to the lounge include adding overbed lights, a nurse call device, electrical outlets, additional partition work, and ceiling light reconstruction. The floor area of the existing lounge is 256 square feet, which matches the area of a typical double bedroom.

There are two other lounges located on the fourth floor, which are of sufficient size to meet the needs of the residents. Additionally, there is 3,238 square feet of dedicated activity space on the first floor.

Compliance

Jamaica Hospital Nursing Home Company, Inc. is currently in substantial compliance with all applicable codes, rules and regulations.

Conclusion

The addition of four nursing home beds at Jamaica Hospital Nursing Home Company will not have an adverse impact on the existing residents, since the remaining lounge and activity space is adequate to meet their needs.

Recommendation

**From a programmatic perspective, contingent approval is recommended.**

<h2>Financial Analysis</h2>
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Total Project Cost and Financing

Total cost to renovate space is projected to be \$64,341 broken down as follows:

Renovation & Demolition	\$32,000
Architect/Engineering Fees	5,000
Other Fees(Consultant)	16,000
Movable Equipment	9,000
CON Application Fee	2,000
CON Processing Fee	<u>341</u>
Total Project Cost	<u>\$64,341</u>

Construction is anticipated to require one month for completion with a start date of April, 2014. Project costs will be financed through accumulated funds.

Operating Budget

The applicant has submitted an incremental operating budget, in 2013 dollars, for the first year subsequent to the addition of the four RHCf beds. The budget is summarized as follows:

	<u>Total</u>
Revenue:	
Medicaid	\$ 342,978
Medicare	103,045
Private Pay	<u>0</u>
Total	\$ 446,023
Expenses:	
Operating	\$ 45,780
Capital	<u>7,100</u>
Total	\$ 52,880
Net Income	\$ 393,143
Utilization: (patient days)	1,315
Occupancy	90.1%

The following is noted with respect to the incremental operating budget:

- The Medicaid capital component assumes reimbursement of interest and depreciation associated with total project cost.
- Medicare and private pay assume current rates of payment.
- Incremental Utilization by payor source is projected as follows:

Medicaid	76.9%
Medicare	23.1%

#### Capability and Feasibility

The facility will provide equity of \$64,341 from accumulated funds for total project costs. BFA Attachment B is the financial summary of Jamaica Hospital Nursing Home Co., Inc., showing sufficient funds available.

Working capital requirements for the RHCf incremental expenses are estimated at \$8,813. Review of BFA Attachment A, the financial summary, reveals sufficient resources to meet project cost equity and absorb additional working capital requirements.

The submitted incremental budget indicates that excess revenues of \$393,143 would be generated in the first year following renovations and the addition of four RHCf beds.

As shown on BFA Attachment B, the facility has experienced positive working capital and maintained negative net asset balances and an average net loss of \$2,072,722 as of July 31, 2013. Jamaica Hospital Nursing Home Co., Inc. is continuously working towards a break-even budget without interruption of patient care by decreasing and monitoring supply costs by approximately \$200,000, improving revenue cycles and payor mix, and increasing revenues by approximately \$600,000. BFA Attachment B shows a decrease in net losses from operations of approximately \$800,000 between 2012 and 2013 July cycles. BFA Attachment D shows that Jamaica Hospital Medical Center and Affiliates for 2012 experienced overall net income from operations of \$27,218,000.

Therefore, based on the preceding, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### Recommendation

**From a financial perspective, approval is recommended.**

## Attachments

BFA Attachment A	Organizational Chart of Medisys Health Network, Inc.
BFA Attachment B	Financial Summary, Jamaica Hospital Nursing Home Co. Inc., July 31, 2013
BFA Attachment C	Financial Summary, Jamaica Hospital Nursing Home Co. Inc., 2011-2012
BFA Attachment D	Financial Summary, Jamaica Hospital Medical Center and Affiliate, 2011-2012



# Public Health and Health Planning Council

Project # 132354 C  
**Alpine Home Health Care, LLC**

**County: Bronx County**  
**Purpose: Construction**

**Program: Certified Home Health Agency**  
**Acknowledged: December 30, 2013**

## Executive Summary

### Description

Alpine Home Health Care, LLC, an existing certified home health agency (CHHA) licensed to provide services in Bronx, Kings, New York, Queens, Richmond, Nassau and Suffolk counties, requests approval to expand its service area to include Rockland County. In another separate application, (CON 132353) Alpine is simultaneously seeking to establish a new CHHA to serve Erie and Niagara counties. Alpine is affiliated with Centers Plan for Health Living, LLC, which is an operational Managed Long Term Care Plan (MLTCP) that serves Bronx, New York, Kings, Queens, Richmond, Rockland, Niagara and Erie counties. Additionally, Centers Plan for Healthy Living, LLC plans to expand its proposed MLTCP to include Nassau and Suffolk counties. The applicant's sole member is Kenneth Rozenberg.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service area and/or approved population of existing CHHA's. Alpine Home Health Care, LLC submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

### DOH Recommendation Approval

### Program Summary

This proposal seeks approval for Alpine Home Health Care, LLC, a for-profit limited liability company which currently operates an Article 36 Certified Home Health Agency (CHHA) located in Bronx, New York, that serves Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, to expand its approved geographic service area to include Rockland County, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

### Financial Summary

There are no project costs associated with this application.

### Incremental Budget:

Revenues	\$1,986,555
Expenses	<u>1,671,818</u>
Net Income	\$314,737

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval conditional upon:**

1. Pursuant to 10 NYCRR 762.2(l), the applicant shall implement the project that is the subject of this application within 90 days of receipt of the Commissioner's approval of the application, and be providing services in the entire geographic area approved within one year of the Council's recommendation for approval. Failure to implement an approved application within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the Commissioner's approval. [CHA]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Alpine Home Health Care, LLC is an existing Article 36 Certified Home Health Agency with approval to serve Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk counties. The applicant has requested approval to expand into Rockland County.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

## Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17<sup>th</sup> and 27<sup>th</sup> were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

## Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17<sup>th</sup> and 27<sup>th</sup> letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

The applicant is partnered with an affiliated MLTCP in the proposed counties. They discussed how the CHHA expansion would directly support numerous MRT initiatives.

Alpine Home Health Care, LLC reported having existing contracts with 8 MLTCPs and is affiliated Centers Plan for Healthy Living which has recently been approved as a MLTCP. The CHHA will support the affiliated MLTCP by providing care management to high risk-enrollees of the MLTCP. They discuss how the CHHA is well suited to support the MRT initiatives through their disease management programs, HIT systems, relationships with MLTCPs, and technical expertise to meet the needs of patients with complex care needs.

The applicant provided detailed county specific data regarding NYSDOH disease specific incidences and death rates, CHHA and LTHHCP utilization, population, Cornell Univ. Program applied Demographic regarding persons living alone and PRI data. A GAP analysis was provided for each county based on the projected increase of CHHA visits due to transition of LTHHCP patients to MLTC. The applicant demonstrated a clear understanding of impact of implementing Managed Care transition (population currently serviced by LTHHCP providers) and the increase need for CHHA services. Analysis provided for each proposed county based on the projected increase of CHHA visits due to transition of LTHHCP patients and others to MLTC.

Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

Background

This proposal seeks approval for Alpine Home Health Care, LLC, a for-profit limited liability company which currently operates an Article 36 Certified Home Health Agency (CHHA) located in Bronx, New York, that serves Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, to expand its approved geographic service area to include Rockland County, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Also pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, the existing Alpine Home Health Care, LLC, Article 36 Certified Home Health Agency (CHHA) located in Bronx, New York, that currently serves Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, has submitted additional CON project # 132353-E requesting approval to establish a second additional (separate and distinct) Certified Home Health Agency (CHHA) located in Buffalo, New York, to serve the counties of Erie and Niagara. That CON construction project is also on the current agenda.

The existing CHHA in Bronx will continue to conduct business under the name of Alpine Home Health Care, LLC, and will continue to be located at 4260 Bronx Boulevard, Bronx, New York 10466, from which it will serve all its approved counties, including Rockland. There are no plans to operate an additional branch office in Rockland County at this time. The CHHA will continue to provide the same authorized services currently offered, which include: home health aide, medical social services, medical supplies/equipment/appliances, nursing, occupational therapy, physical therapy, and speech therapy.

The CHHA is currently in compliance with all applicable codes, rules, and regulations.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Operating Budget

The applicant has submitted an incremental budget, in 2014 dollars, for the first and third years, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues:		
Medicaid Managed Care	\$360,251	\$762,289
Medicare Fee For Service	319,468	875,992
Commercial Managed Care	<u>132,551</u>	<u>348,274</u>
Total Revenues	\$812,271	\$1,986,555
Total Expenses	\$764,078	\$1,671,818
Net Income	\$48,193	\$314,737
Utilization:		
Visits	2,638	7,033
Hours	18,091	40,655

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

	<u>Year One</u>	<u>Year Three</u>
Medicaid Managed Care	34.79%	34.90%
Medicare Fee For Service	29.81%	29.91%
Commercial Managed Care	33.40%	33.19%
Charity Care	2.00%	2.00%

Expense and utilization assumptions are based on the historical experience of the applicant's existing CHHA. Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment System.

### Capability and Feasibility

There are no total project costs associated with this application.

Working capital requirements are estimated at \$278,636, which is equivalent to two months of incremental third year expenses. The applicant has indicated the working capital requirement will be met via equity from the members of Alpine Home Health Care, LLC. BFA Attachment A is the personal net worth statement of the member of Alpine Home Health Care, LLC, which indicates the availability of sufficient funds for the working capital requirement.

The submitted budget indicates an incremental net income of \$48,193 and \$314,737 during the first and third years, respectively. Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment System. The submitted budget appears reasonable.

BFA Attachment B is the 2012 certified financial statements of Alpine Home Health Care, LLC. As shown, the facility had a positive working capital position and a positive net asset position during 2012. Also, the facility incurred a net loss of \$2,071,973 through 2012. The applicant has indicated that the reason for the loss was start-up costs for the subsidiary entity Centers Plan for Healthy Living's managed care program.

BFA Attachment C is the October 31, 2013 internal financial statements of Alpine Home Health Care, LLC. As shown, the facility had a negative working capital position and a positive net asset position through October 31, 2013. The applicant has indicated that the minor working capital deficit reflects a current year member draw, but as in the past, the member expects to end the year in a positive working capital position. Also, the facility achieved a net income of \$164,155 through October 31, 2013.

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

**From a financial perspective, approval is recommended.**

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## Attachments

BFA Attachment A	Personal Net Worth Statement
BFA Attachment B	2012 certified financial statements of Alpine Home Health Care, LLC
BFA Attachment C	October 31, 2013 internal financial statements of Alpine Home Health Care, LLC



# Public Health and Health Planning Council

Project # 132187 C  
**Winthrop University Hospital**

**County:** New York County  
**Purpose:** Construction

**Program:** Hospital  
**Acknowledged:** October 4, 2013

## Executive Summary

### Description

Winthrop University Hospital, a 591-bed, not-for-profit hospital, requests approval to certify an extension clinic in New York County, to provide linear accelerator services and stereotactic cyberknife services. The program will be located at an extension clinic located at 2150 Amsterdam Avenue, New York, New York, 10023.

### DOH Recommendation Contingent Approval

### Need Summary

Winthrop University Hospital seeks CON approval to certify an extension clinic with a linear accelerator service to provide stereotactic radiosurgery or stereotactic body radiotherapy through the use of a cyberknife to treat certain types of tumors and inoperable lesions in the body. This application seeks

to address the incidence of cancer patients in New York City that can be treated with cyberknife therapy.

### 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 \$10,951,532 will be met with equity of \$1,095,154 and an equipment loan in the amount of \$9,856,378 at a rate of 4% for a term of 7 years.

### Budget:

Revenues: \$8,046,439  
Expenses: \$5,439,779  
Gain/ (Loss) \$2,606,660

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

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

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. All devices producing ionizing radiation must be licensed by the New York State Department of Health -- Bureau of Environmental Radiation Protection. [HSP]

Council Action Date

**February 13, 2014**

## Need Analysis

### Background

Winthrop University Hospital (WUH) is a 591-bed acute care hospital located at 259 First Street Mineola, 11501, in Nassau County. WUH seeks approval to certify an extension clinic at 150 Amsterdam Avenue, New York, 10023, in New York County for linear accelerator service for the purpose of providing cyberknife treatment.

### Analysis

Winthrop University Hospital has the following certified beds and services:

*Table 1: Winthrop University Hospital: Certified Beds by Service.  
Source HFIS, December 2013*

<u>Bed Type</u>	<u>Certified Beds</u>
Coronary Care	20
Intensive Care	36
Maternity	63
Medical / Surgical	415
Neonatal Continuing Care	7
Neonatal Intensive Care	6
Neonatal Intermediate Care	14
Pediatric	22
Pediatric ICU	8
Total	591

*Table 2: Winthrop University Hospital: Certified Service.  
Source HFIS, December 2013*

Ambulatory Surgery - Multi Specialty	CT Scanner
Cardiac Catheterization - Adult Diagnostic	Cardiac Catheterization - Electrophysiology (EP)
Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)	Cardiac Surgery - Adult
Clinical Laboratory Service	Coronary Care
Emergency Department	Family Planning O/P
Health Fairs O/P	Intensive Care
Linear Accelerator	Magnetic Resonance Imaging
Maternity	Medical Social Services
Medical/Surgical	Neonatal Continuing Care
Neonatal Intensive Care	Neonatal Intermediate Care
Nuclear Medicine – Diagnostic	Nuclear Medicine - Therapeutic
Pediatric	Pediatric Intensive Care
Pharmaceutical Service	Poison Control Center
Primary Medical Care O/P	Psychiatric
Radiology – Diagnostic	Radiology-Therapeutic
Renal Dialysis – Acute	Therapy - Occupational O/P
Therapy - Physical O/P	

Winthrop University Hospital is authorized to operate 11 extension clinics and one Certified Home Health Agency (CHHA) in Nassau County. These clinics provide outpatient services such as dental O/P, diagnostic radiology, linear accelerator, medical social services, multi-specialty ambulatory surgery, occupational therapy, personal care, physical therapy, primary medical care, renal dialysis, speech language pathology, therapeutic radiology, and well child care.

Winthrop University Hospital has the following state designations:

- Regional Perinatal Center;
- Regional Trauma Center; and
- Stroke Center.

Winthrop University Hospital is the Primary Teaching Affiliate of Stony Brook University School of Medicine, a member of the Long Island Health Network and a member of New York-Presbyterian Health System.

Services to be certified at Winthrop University Hospital Cyberknife Center located at 150 Amsterdam Avenue, New York 10023:

- Linear Accelerator (cyberknife);
- Radiology – Therapeutic; and
- CT Scanner.

Winthrop University Hospital states that they receive referrals for cyberknife treatment from hospitals and physicians, including Memorial Sloan Kettering, New York-Presbyterian Hospital (Columbia and Weill Cornell Center), NYU Hospitals Center, and New York Eye and Ear Infirmary. The hospital indicates that it has administered over 60,000 cyberknife radiation doses since 2005 without a single radiation overdose.

The proposed facility will use the cyberknife to provide stereotactic radiosurgery therapy services. It is anticipated that the number of patients during the first and fifth year of operation will be 125 and 200, respectively. Based on the number of assumed cases, the clinic could expect to generate 625 treatments during the first year of operation and 1,000 by the fifth year. The cyberknife machine is expected to treat about 500 patients per year. Based on the projected number of cases, the facility will have capacity to accommodate additional cases.

Based on SPARCS data, Winthrop University Hospital primary inpatient and outpatient service area is Nassau County. Approximately 81.0 percent of its inpatients and 75.0 percent of its outpatients live in the county. The facility's secondary service area is comprised of Kings, New York, Queens and Suffolk Counties. Residents from these counties account for approximately 17.0 percent of the hospital's inpatient discharges and 24.0 percent of its outpatients visits. In 2000, the census count for the aforementioned counties was 8,985,813. By 2010, the census for the service area counties grew by 1.9 percent to 9,154,177 and is projected to reach 9,366,881 by 2020.

In 2007, the WUH recorded 34,702 total inpatient discharges. By 2008, these discharges increased by 0.4 percent to 34,832. Winthrop University Hospital continued to experience an increase in total inpatient discharges in 2009, 2010 and 2011; said discharges were 36,723; 36,848; and 36,933, respectively and stood at 34,795 in 2012 (Table 3).

<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>
34,702	34,832	36,723	36,848	36,933	34,795

Winthrop University Hospital seeks to provide therapeutic radiology services to the residents of New York City. During 2006 through 2010, the total new annual average cancer cases diagnosed in the five (5) Boroughs of New City was 38,194 residents. It is estimated that about 27.0 percent of these cases could be appropriate for cyberknife treatment.

**709.16 Radiation Oncology Need Methodology**

The factors for determining the public need for megavoltage (MEV) devices used in therapeutic radiology shall include, but not be limited to, the following:

1. No equipment other than four or more MEV or cobalt teletherapy units with a source axis distance of 80 or more centimeters and rotational capabilities will be considered appropriate as the primary unit in a multi-unit radiotherapy service or as the sole unit in a smaller radio therapeutic unit.
2. Ninety-five percent of the total population of each health region is within a one-hour mean travel time, adjusted for weather conditions, of a facility providing therapeutic radiology services.
3. The expected volume of utilization sufficient to support the need for an MEV machine shall be calculated as follows:
  - Each applicant and MEV machine shall provide a minimum of 5,000 treatments per year and have the capacity to provide 6,500 treatments per year. These volumes may be adjusted for the expected case-mix of a specific facility.
  - Sixty percent of the annual incidence of cancer cases in a service area will be candidates for radiation therapy.
  - Fifty percent of radiation therapy patients will be treated for cure with an average course of treatment of 35 treatments and fifty percent of patients will be treated for palliation with an average course of treatment of 15 treatments. These estimates may be adjusted based on the case-mix of a specific facility.

Radiation Oncology Need — New York City

New York City Therapeutic Radiology Need:	
Number of cancer cases per year (Average 2006 – 2010)	38,194
60% will be candidates for radiation therapy	22,916
50% of (2) will be curative patients	11,458
50% of (2) will be palliative patients	11,458
The course of treatment for curative patients is 35 treatments	401,037
The course of treatment for palliative patients is 15 treatments	171,873
The total number of treatments sum of (5 and 6)	572,910
Each MEV machine has a capacity for 6,500 treatments	88
<hr/>	
Need for Linacs in New York City	88
Existing and Approved Resource	73
Remaining Need	14

Conclusion

Based on the 709.16 need methodology for linear accelerators, there is a remaining need for 14 linear accelerators in New York City. This proposal will help to meet the need for the aforementioned service and lower the remaining need to 13.

Recommendation

**From a need perspective, approval is recommended.**

**Programmatic Analysis**

Project Proposal

Winthrop University Hospital (WUH), a not-for-profit teaching hospital in Nassau County, requests approval for certification of an extension clinic in New York County to bring its cyberknife robotic radiosurgery services program to the New York City region, thus enhancing access for individuals who require radiation therapy. Upon approval, the center will be known as the Winthrop University Hospital Cyberknife Center.

<u>Site</u>	<u>Approved Services</u>
Winthrop-University Hospital Cyberknife Center 150 Amsterdam Avenue New York, NY 10023	Radiology - Therapeutic CT Scanner

First year staffing will consist of 10.0 FTEs, including registered nurses and technicians, and is expected to remain at that level through the third year of operation.

#### Compliance with Applicable Codes, Rules and Regulations

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

#### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

#### Lease Rental Agreement:

The applicant has submitted a draft sublease agreement for the site that they will occupy; which is summarized below:

Premises: 6,300 Square feet located at 259 First Street, Mineola, New York  
Lessor: 150 Amsterdam Avenue Holdings, LLC  
Lessee: Winthrop University Hospital  
Term: 15 Years  
Rental: \$585,000 per year (\$92.85 per sq. ft.) with a stated escalation clause as follows:  
(Year 2 - \$598,162.50 or \$94.95 per square ft.)  
(Year 3 - \$611,621.16 or \$97.01 per square ft.)  
(Year 4 - \$625,382.63 or \$99.28 per square ft.)  
(Year 5 - \$639,453.74 or \$101.50 per square ft.)  
(Year 6 - \$712,341.45 or \$113.07 per square ft.)  
(Year 7 - \$728,369.13 or \$115.61 per square ft.)  
(Year 8 - \$744,757.44 or \$118.22 per square ft.)  
(Year 9 - \$761,514.48 or \$120.88 per square ft.)  
(Year 10 - \$778,648.56 or \$123.60 per square ft.)  
(Year 11 - \$860,518.15 or \$136.59 per square ft.)  
(Year 12 - \$879,879.81 or \$139.66 per square ft.)  
(Year 13 - \$899,677.10 or \$142.81 per square ft.)  
(Year 14 - \$919,919.84 or \$146.02 per square ft.)  
(Year 15 - \$940,618.03 or \$149.30 per square ft.)

Provisions: The lessee shall be responsible for maintenance, taxes and utilities utilized and proportioned for the space it occupies.

The applicant has submitted an affidavit indicating that there is no relationship between lessor and the lessee making this an arm's length agreement. Also, the applicant submitted two letters of rent reasonableness indicating that the lease amount is reasonable for the stated property.

Total Project Cost and Financing

Total project cost for renovations and the renovation and moveable equipment, is estimated at \$10,951,532, as indicated below:

Renovation & Demolition	\$4,664,000
Design Contingency	450,000
Construction Contingency	300,000
Fixed Equipment	4,344,000
Planning Consultant Fees	25,000
Architect Fees	358,000
Other Fees	65,000
Moveable Equipment	376,000
Financing Costs	98,564
Interim Interest Expense	209,075
Application Fee	2,000
CON Fees	<u>59,893</u>
Total Project Cost	\$10,951,532

Project costs are based on a March 1, 2014 start date and a seven month completion period.

Operating Budget

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

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$6,638,983	\$8,046,439
Expenses:		
Operating	\$ 2,719,000	\$2,997,000
Capital	<u>2,498,608</u>	<u>2,442,778</u>
Total Expenses	\$ 5,217,608	\$5,439,779
Excess of Revenues over Expenses	<u>\$1,421,375</u>	<u>\$2,606,660</u>
Outpatient: (Visits)	500	605
Cost Per Visit	\$10,435.21	\$8,991.37

Utilization by payor source, broken down by outpatient services for radiation cyberknife services for the first and third years is as follows:

	<u>Year One</u>	<u>Year Three</u>
Outpatient		
Medicaid Fee-for-Service	.4%	.3%
Medicaid HMO	7.2%	7.4%
Medicare Fee-for-Service	42.6%	42.6%
Medicare HMO	14.6%	14.5%
Commercial Fee-for-Service	.2%	.2%
Commercial Managed Care	32.8%	32.6%
Private Pay	.2%	.3%
Charity care	2.0%	2.1%

Expense and utilization assumptions are based on the historical experience of other clinics that operate cyberknife services.

### Capability and Feasibility

Project costs of \$10,951,532 will be met via equity of \$1,095,154 and a loan in the amount of \$9,856,378 at a rate of 4% for a term of 7 years. A letter of interest has been submitted via TD Bank. BFA Attachment A is the financial summary of Winthrop University Hospital, which indicates sufficient resources for equity contribution.

The submitted budget projects an excess of revenues over expenses of \$1,421,375 and \$2,606,660 during the first and third year of operation, respectively. Revenues are based on the hospital's current reimbursement rates and current reimbursement methodologies for the current services.

As shown on Attachment A, the hospital has maintained an average positive working capital and average net asset position. Also, the hospital achieved an average excess of operating revenue over operating expenses of \$19,051,987 for the period shown.

BFA Attachment B is the internal financial statement for the hospital for period ending September 31, 2013. The hospital has maintained an average positive working capital and average net asset position. Also, the hospital achieved an excess of operating revenue over expenses of \$7,736,624.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

### Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Financial Summary – Winthrop University Hospital
BFA Attachment B	Internal Financial Summary – Winthrop University Hospital



# Public Health and Health Planning Council

## Project # 132134 B Moshenyat, LLC d/b/a Moshenyat Gastroenterology Center

**County:** Kings County

**Program:** Ambulatory Surgery Center

**Purpose:** Establishment and Construction

**Acknowledged:** September 11, 2013

### Executive Summary

#### Description

Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center, a to-be-formed limited liability company (LLC), requests approval to establish and construct an Article 28 diagnostic and treatment center (D&TC) to be located in leased space located at 1958 Ocean Avenue, Brooklyn. Moshenyat Gastroenterology Center will be certified as a single-specialty freestanding ambulatory surgery center (FASC) in the discipline of gastroenterology.

The applicant will lease approximately 3,452 square feet on the ground and cellar levels of the recently constructed six story building. The site will include one procedure room, two pre-operating holding positions and one post-operating recovery position, along with the requisite support areas.

Yitzchak Moshenyat, M.D. is the proposed sole member of Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center. The FASC expects to have 2,740 visits during its first year, based on Dr.Yitzchak Moshenyat's current office based surgery practice.

#### DOH Recommendation

Contingent Approval with an expiration of the operating certificate five (5) years from the date of issuance.

#### Need Summary

Moshenyat Gastroenterology Center is located in the Midwood neighborhood and will serve Kings County. The center projects that there will be 2,740 visits in year one and 3,437 visits in year three.

#### Program Summary

The transfer and affiliation agreement is expected to be provided by Lutheran Medical Center.

Based on the information received, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

#### Financial Summary

Total project costs of \$1,093,503 will be provided by \$299,051 in personal investments (cash) from Yitzchak Moshenyat, M.D. with the remaining \$794,452 balance being financed through Capital One Bank for ten years at a 7% interest rate.

Budget:	Revenues:	\$1,790,536
	Expenses:	<u>\$1,226,777</u>
	Gain/ (Loss)	\$ 563,759

Subject to noted contingencies, it appears the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval with an expiration of the operating certificate five (5) years from the date of 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 of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the DOH beginning in the second year of operation. Said reports should include:
  - Data showing actual utilization including procedures;
  - Data showing breakdown of visits by payor source;
  - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - Data showing number of emergency transfers to a hospital;
  - Data showing percentage of charity care provided, and
  - Number of nosocomial infections recorded during the year in question. [RNR]
3. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
4. Submission 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]
5. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
6. Submission of a loan commitment, acceptable to the Department. [BFA]
7. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
8. Submission of a lease that contains the language set forth in 10 NYCRR 600.2(d), acceptable to the Department. [BFA, CSL]
9. Submission of executed copies of Articles of Organization and Operating Agreement. [CSL]
10. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

**Approval conditional upon:**

1. The project must be completed within three years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]

6. The review and approval of SHC drawings should include further evaluation of the remoteness of the first floor required exits and reconfiguration of smoke partitions to minimize the potential of both exits being blocked simultaneously as required by 2000 NFPA 101 LSC 7.5.1.3. [AER]
7. The applicant shall provide written approval from the New York City Fire Department, (FDNY) that the exiting arrangement and evacuation plans are acceptable at project completion. [AER]
8. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
9. The applicant shall complete construction by January 31, 2015. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval may be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

**February 13, 2014**

## Need Analysis

### Background

Moshenyat Gastroenterology Center is seeking approval to establish and construct an Article 28 diagnostic and treatment center to provide single specialty ambulatory surgery services at 1958 Ocean Avenue, Brooklyn, 11230, in Kings County. The proposed services are gastroenterology surgical services.

### Analysis

The service area is Kings County. The number of projected visits is 2,740 in year one and 3,437 in year three. These projections are based on the current practices of the participating surgeon. Kings County has a total of four freestanding multi-specialty ASCs and eight freestanding single-specialty ASCs.

<b>Ambulatory Surgery Patients in 2012</b>		<b>SPARCS</b>
<b>Type</b>	<b>Facility</b>	<b>2012 Patients</b>
Multi Specialty	All-City Family Hlthcare Ctr	3,345
Multi Specialty	ASC Brklyn (NY Center for Spec. Surgery)	2,025
Multi Specialty	Brklyn Endo & Amb Surg Ctr LLC <b>(Closed 5/1/13)</b>	5,628
Multi Specialty	Brook Plaza Amb Surgical Ctr	8,531
Ophthalmology	Brooklyn Eye Surgery Center	3,822
Gastroenterology	Digestive Diseases D & T C (South Brooklyn Endo-Center)	3,139
Endoscopy	Endoscopic Amb Specialty Ctr-Bay Ridge	1,078
Endoscopy	Endoscopic Diagnostic and Treatment Ctr LLC	2,815
Gastroenterology	Gastroenterology Care, Inc.	2,248
Endoscopy	Greater NY Endoscopy Surgical	7,085
Ophthalmology	Sheepshead Bay Surgery Center	2,398
Single-Specialty	Metro Center Digestive-Liver Diseases (Opened 2/6/2013)	n/a
Multi Specialty	Millennium ASC (Opened 6/8/2011)	n/a
<b>Total</b>		<b>42,114</b>

In addition there are eight freestanding ASCs, one single-specialty ASC and seven multi-specialty ASCs that have been approved, but which are not yet operational.

The applicant is committed to serving all persons without regard to their ability to pay or the source of payment.

### Conclusion

Approval of the proposed ASC would bring under Article 28 regulation an additional provider of ambulatory surgery to serve the communities of Brooklyn.

### Recommendation

**From a need perspective, contingent approval is recommended, with an expiration of the operating certificate five (5) years from the date of issuance.**

## Programmatic Analysis

### Project Proposal

Establish and construct a single specialty diagnostic and treatment center that will also be federally certified as an ambulatory surgery center.

<b>Proposed Operator</b>	Moshenyat, LLC
<b>Doing Business as</b>	Moshenyat Gastroenterology Center
<b>Site Address</b>	1958 Ocean Avenue, Brooklyn
<b>Surgical Specialties</b>	Single Specialty: Gastroenterology
<b>Operating Rooms</b>	0
<b>Procedure Rooms</b>	1
<b>Hours of Operation</b>	Monday through Friday from 8:00 am to 6:00 pm (Will be expanded to meet additional need, if necessary)
<b>Staffing (1<sup>st</sup> Year / 3<sup>rd</sup> Year)</b>	6.5 FTEs / 6.5 FTEs
<b>Medical Director(s)</b>	Moshenyat Yitzchak, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided by Lutheran Medical Center 7.3 miles/19 minute drive time
<b>On-call service</b>	Contact information for the surgeon, center, back-up hospital and the center's after-hours number will be provided to each patient with discharge instructions.

### Character and Competence

The sole member of Moshenyat, LLC is:

<b>Name</b>	
Moshenyat Yitzchak, MD	100%

Dr. Yitzchak is a practicing surgeons/board-certified gastroenterologist.

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.

### Integration with Community Resources

The Center will ensure that patients have access to primary care services through expansion of the Transfer and Affiliation Agreement with Lutheran Medical Center (LMC) to include primary and other specialty services, as needed. Outreach to the community will include participation in community health events and local religious institutions to increase awareness of services and relationship with the local hospital. Provisions will be made for those who cannot afford services, and charity care will be provided.

The applicant has made inquiries to LMC to establish a mutual network relationship and has expressed its interest in becoming a part of an Accountable Care Organization (ACO) and integrating into the regional health information organization (RHIO) and/or Health Information Exchange (HIE). Additionally, the applicant intends on utilizing an electronic medical record (EMR) and is reviewing programs but has not yet identified a specific EMR system.

### Recommendation

**From a programmatic perspective, contingent approval is recommended.**

## Financial Analysis

### Lease Rental Agreement

The applicant has submitted a draft lease for the proposed site:

Date:	May 1, 2013
Premises:	3,452 gross square feet on the ground and cellar levels of 1958 Ocean Avenue, Brooklyn, New York 11230
Landlord:	A & A 1958, LLC
Lessee:	Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center
Term:	10 year (1 <sup>st</sup> year sq. ft. rental rate is \$17.38) 1 <sup>st</sup> year at \$60,000                      2 <sup>nd</sup> year at \$62,400 3 <sup>rd</sup> year at \$64,866                      4 <sup>th</sup> year at \$67,461 5 <sup>th</sup> year at \$70,158                      6 <sup>th</sup> year at \$72,966 7 <sup>th</sup> year at \$75,876                      8 <sup>th</sup> year at \$ 78,918 9 <sup>th</sup> year at \$82,074                      10 <sup>th</sup> year at \$86,016 Renewal for (1) one 10-year term with a 4% rate increase
Provisions:	Utilities, Taxes, Maintenance and Insurance are all the responsibility of the tenant.

The applicant has provided an affidavit stating that the lease is a non-arm's length arrangement, as the applicant's sole member, Yitzchak Moshenyat, M.D., is also a member of the landlord A & A 1958, LLC. Realtor letters have been provided attesting to the rental rate being of fair market value.

### Total Project Cost and Financing

Total project costs for new construction and the acquisition of moveable equipment is estimated at \$1,093,503, which is broken down as follows:

Renovation & Demolition	\$543,002
Design Contingency	54,300
Construction Contingency	27,150
Architect/Engineering Fees	45,000
Other Fees	125,000
Movable Equipment	236,130
Financing Fee	31,780
Interim Interest Expense	23,171
CON Application Fee	2,000
CON Processing Fee	<u>5,970</u>
Total Project Cost	\$1,093,503

Project costs are based on a June 1, 2014 start date with an eight month construction period.

The applicant's financing plan appears as follows:

Cash Equity (Applicant)	\$299,051
Bank Loan (7% for a 10-year term)	<u>794,452</u>
Total	\$1,093,503

A letter of interest has been provided from Capital One Bank

## Operating Budget

The applicant has submitted the first and third years operating budgets, in 2014 dollars:

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$1,427,404	\$1,790,536
Expenses:		
Operating	\$862,316	\$956,578
Capital	<u>263,864</u>	<u>270,199</u>
Total Expenses	\$1,126,180	\$1,226,777
 Net Income or (Loss)	 \$301,224	 \$563,759
 Utilization: (visits)	 2,740	 3,437
Cost Per Visits	\$411.01	\$356.93

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

Medicaid Managed Care	12.0%
Medicare Fee-For-Service	40.0%
Commercial Fee-For-Service	23.0%
Commercial Manage Care	20.0%
Private Pay	3.0%
Charity	2.0%

Utilization and expense assumptions are based on similar single-specialty FASC, as well as the proposed operator's historical experience in operating an office based surgery center. The breakeven point is approximately 78.86% for the first year, or 2,161 visits, and 68.50% for the third year, or approximately 2,354 visits.

## Capability and Feasibility

The total project cost is \$1,093,503. The sole member, Yitzchak Moshenyat, M.D., will contribute \$299,051 from his personal liquid resources and the remaining balance of \$794,452 being finance through Capital One Bank at the above state terms.

Working capital requirements are estimated at \$204,463, which appears reasonable based on two months of third year expenses. The applicant has submitted a letter of interest from Capital One Bank to finance \$102,232 of the working capital with a three year payback period at an estimated 6% interest rate. The remaining \$102,231 in working capital will be provided from the sole member's own financial resources. BFA Attachment A is the applicant's personal net worth statements, which indicates there are sufficient liquid resources to meet both the equity and working capital requirements. BFA Attachment B is Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center pro-forma balance sheet that shows operations will start off with \$401,282 in equity

Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center projects an operating excess of \$301,224 and \$563,759 in the first and third years, respectively. Revenues for Medicare and Medicaid are based on current rates and commercial payers have been contacted for their current rate schedules. The applicant's budgets appear to be reasonable.

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

## Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Personal Net Worth Statement of Proposed Member of Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center
BFA Attachment B	Pro-forma Balance Sheet of Moshenyat, LLC d/b/a/ Moshenyat Gastroenterology Center
BHFP Attachment	Map

## Supplemental Information

### Outreach

Below are presented summaries of responses by hospitals to letters from the Department asking for information on the impact of the proposed ambulatory surgery center (ASC) in their service areas. There follows a summary of the applicant's response to DOH's request for information on the proposed facility's volume of surgical cases, the sources of those cases, and on how staff will be recruited and retained by the ASC.

**Facility:** Beth Israel Medical Center -- **No Response**  
Kings Highway Division  
3201 Kings Highway  
Brooklyn, NY 11212

**Facility:** New York Community Hospital of Brooklyn -- **No Response**  
2525 Kings Highway  
Brooklyn, NY 11215

**Facility:** Maimonides Medical Center -- **No Response**  
4802 Tenth Avenue  
Brooklyn, NY 11219

**Facility:** Lutheran Medical Center -- **No Response**  
150 55<sup>th</sup> Street  
Brooklyn, NY 11219

**Facility:** Coney Island Hospital -- **No Response**  
2601 Ocean Parkway  
Brooklyn, NY 11235

### Supplemental Information from Applicant

**Need and Source of Cases:** The applicant states that the projected volume of the proposed ASC is based on the actual experience of the proposed physician/sole member. The applicant also expects that ongoing and projected growth in ambulatory surgery in general will be a source of cases for the proposed facility, as will convenience in scheduling and the location of the ASC in an out-of-hospital setting.

**Staff Recruitment and Retention:** The applicant plans to recruit necessary staff through a hiring program. To the extent that additional staff may be needed, the proposed operators are committed not to seek to attract staff from local hospitals. The applicant will retain staff through competitive salary benefits and continuing education opportunities, elective work schedules within regular work hours and occasional long weekends or additional days off as rewards for hard work and efficiency.

**Office-Based Cases:** The applicant states that approximately 85 percent of the procedures projected for the proposed ASC are currently performed in the office-based setting. The remaining procedures, because of medical reasons, have been performed as inpatient procedures.

OHSM Comment

In the absence of comments from area hospitals, the Department finds no reason to consider reversal or modification of the recommendations for five-year limited life approval of the proposed ASC based on public need, financial feasibility and operator character and competence.

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 13th day of February, 2014, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish and construct a single-specialty ambulatory surgery center to be located at 1958 Ocean Avenue, Brooklyn, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:

132134 B

FACILITY/APPLICANT:

Moshenyat, LLC d/b/a Moshenyat  
Gastroenterology Center

APPROVAL CONTINGENT UPON:

**Approval with an expiration of the operating certificate five (5) years from the date of 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 of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the DOH beginning in the second year of operation. Said reports should include:
  - Data showing actual utilization including procedures;
  - Data showing breakdown of visits by payor source;
  - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - Data showing number of emergency transfers to a hospital;
  - Data showing percentage of charity care provided, and
  - Number of nosocomial infections recorded during the year in question. [RNR]
3. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
4. Submission 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]
5. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
6. Submission of a loan commitment, acceptable to the Department. [BFA]
7. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
8. Submission of a lease that contains the language set forth in 10 NYCRR 600.2(d), acceptable to the Department. [BFA, CSL]
9. Submission of executed copies of Articles of Organization and Operating Agreement. [CSL]
10. The submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within three years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The review and approval of SHC drawings should include further evaluation of the remoteness of the first floor required exits and reconfiguration of smoke partitions to minimize the potential of both exits being blocked simultaneously as required by 2000 NFPA 101 LSC 7.5.1.3. [AER]
7. The applicant shall provide written approval from the New York City Fire Department, (FDNY) that the exiting arrangement and evacuation plans are acceptable at project completion. [AER]
8. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
9. The applicant shall complete construction by January 31, 2015. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval may be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

Project #131284-B  
**Lasante Health Center, Inc.**

**County:** Kings County  
**Purpose:** Establishment and Construction

**Program:** Diagnostic and Treatment Center  
**Submitted:** May 22, 2013

## Executive Summary

### Description

Lasante Health Center, Inc., a proposed not-for-profit corporation requests approval for the establishment of a diagnostic and treatment center (D&TC) to provide primary medical care, pediatrics, well child care, dental, prenatal, psychology, ophthalmology, radiology, medical social services, nutritional services, health fairs and health education. While the center will focus on serving the Haitian community within the service area, it will be open to all patients who are in need of services. The existing building located at 672 Parkside Avenue in Brooklyn is a one-story structure that will be enlarged to four-stories. The center will be located in approximately 12,600 square feet of space on the 2<sup>nd</sup> floor of the building. The center will consist of thirty exam rooms, of which five will be dedicated to a separate dental suite with its own reception and waiting area. The facility will also have a main reception and waiting area, administrative and doctor's offices, conference room, a blood drawing room and laboratory, soiled utility room, staff locker room and lounge and appropriate support spaces. Upon CON approval the center will be applying for Federally Qualified Health Center designation.

Lasante Health Center will be managed and governed solely by a board of directors and will be under the medical direction of Rajat Mukherji, M.D.

DOH Recommendation  
Contingent Approval

### Need Summary

Lasante will be located in the Flatbush section of Brooklyn and will serve the Flatbush, Midwood and part of Borough Park neighborhoods.

Lasante will target the underserved Haitian population and is in a Health Professional Shortage Area for Primary Care and Dental Health Services. It is also in a Medically Underserved area/population. The number of projected visits is 24,819 in Year 1 and 36,639 in Year 3.

### Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

### Financial Summary

Total project costs of \$4,188,254, will be met with a \$3,769,428 bank loan and \$418,826 in equity.

Budget:	Revenues	\$3,130,817
	Expenses	<u>2,987,042</u>
	Net Income	\$ 143,775

Subject to noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation for this application

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of an executed transfer and affiliation agreement with a local acute care hospital, acceptable to the Department. [HSP]
3. Submission of an executed building sublease acceptable to the Department. [BFA, CSL]
4. Submission of an executed construction loan, acceptable to the Department. [BFA]
5. Submission of an executed working capital loan, acceptable to the Department. [BFA]
6. Submission of documentation of contributions to be used as a source of financing, acceptable to the Department. [BFA]
7. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

**Approval conditional upon:**

1. The project must be completed within three years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by April 1, 2015. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

**February 13, 2014**

## Need Analysis

### Project Description

Lasante Health Center, Inc. (LHC), a proposed New York State not-for-profit corporation, is seeking approval to establish and construct a diagnostic and treatment (D&TC) center to provide primary care, dental, ophthalmology, pediatrics, psychology, and well-child services. The proposed D&TC will be located at 672 Parkside Avenue, Brooklyn, 11226, in Kings County.

Upon approval of this CON, the applicant will apply for Federally Qualified Health Center status.

### Analysis

The primary service area includes zip codes 11226, 11225, 11203, 11210, 11230, and 11218 in the Flatbush area. The target population is the underserved Haitian population as well as all of the communities living in the service area, including those from other Caribbean Countries such as Jamaica, Trinidad, and Guyana.

The proposed site is in a Health Professional Shortage Area for Primary Care and Dental Health Services. It is also in a Medically Underserved Area/Population.

The number of projected visits is 24,819 in Year 1 and 36,639 in Year 3.

Prevention Quality Indicators (PQIs) are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

The table below provides information on the PQI rates for major condition categories. It shows that these rates are higher for 'All Circulatory,' 'All Diabetes,' and 'All PQIs' for three of the six service area zip codes combined than for the State.

PQI Rates-Hospital Admissions per 100,000 Adult, Source: NYSDOH-PQI

PQI Rates	Zip Codes 11226, 11225, 11203, Combined	NYS
All Circulatory	530	456
All Diabetes	374	224
All Above	1,618	1,563

The applicant is committed to serving all people in need regardless of their ability to pay or the source of payment.

### Conclusion

The proposed D&TC will improve access to needed services for the underserved Haitian population and other underserved groups in Brooklyn.

### Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Project Proposal

Lasante Community Services, Inc., a not-for-profit corporation, seeks to establish and construct a diagnostic and treatment center at 672 Parkside Avenue, Brooklyn. Upon approval, Lasante Community Services, Inc. intends to change its name to Lasante Health Center, Inc. The proposed health center's focus will be on the unmet needs of Brooklyn residents, particularly the local Haitian population.

<b>Proposed Operator</b>	Lasante Health Center, Inc.
<b>Site Address</b>	672 Parkside Avenue, Brooklyn
<b>Specialties</b>	Primary Medical    Pediatrics Dental                Well Child Care Prenatal                Psychology Ophthalmology        Radiology (Diagnostic) Nutritional             Medical Social Services Health Fairs            Health Education
<b>Hours of Operation</b>	Initially, the Center will be open 6 days/week (> 50 hours/week) and will provide expanded hours as determined by demand.
<b>Staffing (1<sup>st</sup> Year / 3<sup>rd</sup> Year)</b>	19.60 FTEs / 31.85 FTEs
<b>Medical Director(s)</b>	Rajat Mukherji, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided by University Hospital of Brooklyn (SUNY Downstate) 0.4 miles/3 minutes away
<b>On-call service</b>	24/7 call in center for referral to physicians, health care services, support groups and to register for health education and screening programs.

### Character And Competence

The Board of Directors is as follows:

<u>Name</u>	<u>Office Held</u>
(Rabbi) Yitzchok Halberstam	Chairperson
(Bishop) Guy Sansaricq	Vice-Chairperson
Kesler Dalmacy, MD	Secretary
Mendel Rottenberg	Treasurer
Marie Desruiiseau, RN	Board Member

The proposed board is comprised of religious leaders and individuals with extensive experience in public health and social services who have been involved in efforts to develop health programs and services for the Haitian community. The Board Chairperson, Rabbi Halberstam, owns a firm that offers comprehensive consulting services to health care facilities. In addition, he is the founder of a community-based, "One Stop" resource and referral center and a non-profit primary health care center in New Jersey. Mr. Rottenberg has worked for several years as an Assistant Administrator for a long-term care facility. Three native-born Haitians round out the Board. Bishop Sansaricq served the Diocese of Brooklyn for 22 years, during which time he was appointed as the coordinator of the Haitian Apostolate and he co-founded a service agency, Haitian-Americans for Progress. Dr. Dalmacy, a practicing physician in Brooklyn for over 28 years, with degrees in medicine and public health, has been active in Brooklyn's Haitian and Caribbean communities. Ms. Desruiiseau is a registered professional nurse with over 20 years of experience as a nursing supervisor in various health care facilities.

Disclosure information was similarly submitted and reviewed for the Medical Director. Dr. Mukherji, a practicing physician with over 35 years of experience, currently serves in a major metropolitan teaching hospital as Chief of Pulmonary Medicine and the Intensive Care Unit.

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.

The proposed Medical Director, Dr. Mukherji, disclosed one pending malpractice case.

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Recommendation

**From a programmatic perspective, contingent approval is recommended.**

## Financial Analysis

### Financial Analysis

The applicant will lease approximately 12,600 square feet on the second floor of a newly expanded four story building located at 672 Parkside Avenue, Brooklyn under the terms of the proposed sublease agreement summarized below:

Landlord:	672 Parkside, LLC
Lessee:	Harriman Properties, LLC
Sub Lessee:	Lasante Health Center, Inc.
Term:	15 years
Rental:	\$403,200/year (\$32/sq. ft.)
Provisions:	The lessee will be responsible for utilities, maintenance, insurance, and taxes.

The Landlord has agreed to defer the rent and accrue the rental cost to be paid only if the D&TC receives FQHC approval and only if there is a surplus readily available to meet this payment.

The applicant has indicated that the lease will be an arm's length agreement and three letters of opinion from Licensed Commercial Real Estate Brokers have been submitted indicating rent reasonableness. Other non-related parties occupy the remainder of the building.

### Total Cost and Financing

Total project costs for new construction and movable equipment are estimated at \$4,188,254, broken down as follows:

New Construction	\$2,161,271
Design Contingency	216,127
Construction Contingency	216,127
Architect/Engineering Fees	189,126
Construction Manager Fees	126,084
Consultant Fees	63,200
Movable Equipment	583,007
Telecommunications	210,667
Financing Costs	94,801
Interim Interest Expense	307,837
Application Fee	1,250
Additional Processing Fee	<u>18,757</u>
Total Project Cost	\$4,188,254

Project cost is based on a March 1, 2014 construction start date and a twelve month construction period. The applicant's financing plan appears as follows:

Bank Loan (7yrs, 6%)	\$3,769,428
Equity from Soloman Landau	\$418,826

A letter of interest from CapQuest Group, LLC has been submitted by the applicant. The applicant has submitted a letter indicating Solomon Landau will provide equity for project cost requirements with no repayment required. Mr. Landau is the owner of the landlord entity, 672 Parkside, LLC, and a local philanthropist. Lasante Health Center indicates that, with its focus on primary healthcare for the uninsured and underserved, it is a vehicle for Mr. Landau's vision of primary healthcare for all. Presented as BFA Attachment A, is the net worth statement of Soloman Landau, which shows sufficient funds available.

#### Operating Budget

The applicant has submitted an operating budget in 2014 dollars, for the first, second and third years of operation, summarized below:

	<u>Year One</u>	<u>Year Two</u>	<u>Year Three</u>
Revenues:	\$2,120,772	\$2,667,313	\$3,130,817
Expenses:			
Operating	\$1,718,351	\$2,211,409	\$2,541,680
Capital	<u>507,139</u>	<u>447,165</u>	<u>445,362</u>
Total Expenses:	\$2,225,490	\$2,688,574	\$2,987,042
Net Income (Loss):	\$(104,718)	\$(21,261)	\$143,775
Utilization: (visits)	24,819	31,215	36,639
Cost per visit:	\$89.67	\$86.13	\$81.52

Harriman Properties, LLC is providing the applicant with a deferment of the \$402,300 annual lease costs, which are thus not included in year one through year three budgets. The accrued rental cost will be paid only if the D&TC receives FQHC approval and only if there is a surplus readily available to meet this payment. DOH staff has reviewed the D&TC budgets under FQHC status and applicant can fully meet the annual lease costs, while maintaining feasible operating results.

The applicant has submitted statements from Kolel Beis Yacov, a congregation located in Brooklyn, from Mr. Sandor Oberlander, a local philanthropist and from Quality Diamond LLC, which is owned by Mr. Oberlander, stating they are willing to fund year one and year two budgeted losses with donations should FQHC designation not be granted. DOH staff has noted the availability of sufficient funds.

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

	<u>Year One and Three</u>
Commercial Fee for Service	2%
Commercial Managed Care	9%
Medicare Fee for Service	7%
Medicare Managed Care	3%
Medicaid Managed Care	72%
Private Pay/Other	5%
Charity Care	2%

Expenses and utilization assumptions are based on similar diagnostic and treatment centers in the geographic area.

### Capability and Feasibility

Total project costs of \$4,188,254 will be met through a loan from CapQuest Group, LLC for \$3,769,428 at stated terms, with the remaining \$418,826 from equity from Soloman Landau. BFA Attachment A is the net worth statement of Soloman Landau, which shows sufficient funds available.

Working capital needs are estimated at \$496,340 based on two months of third year expenses. The applicant will finance \$248,170 of working capital at an interest rate of 7% over 5 years, for which a letter of interest has been provided by CapQuest Group, LLC. The remaining \$248,170 will be provided as equity from Soloman Landau and Kolel Beis Yacov. Commitment letters have been provided stating they will provide equity for working capital requirements, which will not need to be repaid. BFA Attachment B is the pro-forma balance sheet of Lasante Health Center, Inc. as of the first day of operation, which indicates positive net assets of \$724,153.

The submitted budget indicates a net loss of \$104,718, and \$21,261 for the first and second years of operations, respectively, and a net income of \$143,775 for the third year of operation. DOH staff has reviewed the budget and it appears reasonable. Kolel Beis Yacov, Mr Sandor Oberlander and Quality Diamond, LLC have committed to funding the budgeted losses in year one and year two. Revenues are based on current reimbursement methodologies for diagnostic and treatment centers. The budget appears reasonable.

Based on the preceding, and subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

### Recommendation

**From a financial perspective, approval is recommended.**

## Attachments

BFA Attachment A  
BFA Attachment B

Net Worth Statement  
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 13th day of February, 2014, 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 diagnostic and treatment center at 672 Parkside Avenue, Brooklyn, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:

131284 B

FACILITY/APPLICANT:

Lasante Health Center, Inc.

APPROVAL CONTINGENT UPON:

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of an executed transfer and affiliation agreement with a local acute care hospital, acceptable to the Department. [HSP]
3. Submission of an executed building sublease acceptable to the Department. [BFA, CSL]
4. Submission of an executed construction loan, acceptable to the Department. [BFA]
5. Submission of an executed working capital loan, acceptable to the Department. [BFA]
6. Submission of documentation of contributions to be used as a source of financing, acceptable to the Department. [BFA]
7. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within three years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by April 1, 2015. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies  
(4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

Project # 132080 B  
**Broadway Community Health Center, Inc.**

**County:** New York County  
**Purpose:** Establishment and Construction

**Program:** Diagnostic and Treatment Center  
**Acknowledged:** August 9, 2013

## Executive Summary

### Description

Broadway Community Health Center, Inc., a to-be-formed, not-for-profit corporation, requests approval to establish and construct an Article 28 diagnostic and treatment center (DTC) to be located on floors three through six, consisting of approximately 10,302 square feet at 577 West 161<sup>st</sup> Street. The proposed services to be provided are as follows: Health Fairs, Medical Social Services/OP, Nutritional O/P, Ophthalmology O/P, Pediatrics O/P, Podiatry O/P, Prenatal O/P, Primary Medical Care O/P, Psychology O/P, Clinical Laboratory O/P, Dental O/P, Well Child and Radiology Diagnostic O/P. Upon approval and commencement of operations, the proposed center will seek approval to become a Federal Qualified Health Center (FQHC).

DOH Recommendation  
Contingent Approval

### Need Summary

Broadway Community Health Center, Inc. projects that there will be 25,525 visits in year one and 49,950 in year 3.

The proposed DTC will improve access to needed services for several communities in Manhattan and the Bronx.

### Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

A transfer and affiliation agreement is expected to be provided by St. Luke's Roosevelt Hospital.

### Financial Summary

There are no project costs associated with this application.

Budget:	Revenues:	\$ 6,747,496
	Expenses:	<u>5,909,955</u>
	Gain:	\$873,541

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
2. Submission of documentation of fundraising for working capital, acceptable to the Department. [BFA]
3. Submission of a loan commitment for working capital, acceptable to the Department. [BFA]
4. Submission of a photocopy of an executed amended Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of an amended Organizational Chart, acceptable to the Department. [CSL]
6. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by January 31, 2015 in accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval may be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Broadway Community Health Center, Inc. is seeking approval to establish and construct a diagnostic and treatment center to provide primary medical care and specialty services at 577 West 161<sup>st</sup> Street, New York, 10032, in New York County. Upon approval, Broadway Community Health Center will seek designation as a Federally Qualified Health Center Look-Alike status.

## Analysis

The number of projected visits is 25,525 in year one and 49,950 in year 3. In year one, the percent of primary care visits is projected to 62 percent and 72 percent by year 3.

The proposed primary service area includes the following neighborhoods:

- Washington Heights-Inwood neighborhood (zip codes 10031-34, 10040).
- Central Harlem-Morningside Heights neighborhood (zip codes 10026-27, 10030, 10037, 10039).
- Parts of the Upper West Side (zip code 10025).
- Kingsbridge-Riverdale (zip codes 10463 and 10471)
- East Harlem (zip codes 10029 and 10035).
- South Bronx (zip codes 10451-57, 10459-60, and 10474).

The proposed services are as follows:

- Clinical Laboratory Services O/P
- Dental O/P
- Health Fairs O/P
- Medical Social Services O/P
- Nutritional O/P
- Ophthalmology O/P
- Pediatrics O/P
- Podiatry O/P
- Prenatal O/P
- Primary Medical Care O/P
- Psychology O/P
- Radiology-Diagnostic O/P
- Well-Child

New York County has 49 freestanding DTCs that provide primary medical care services O/P; none is in zip code 10032, where the proposed DTC will be located. (HFIS)

The proposed site is in a Health Professional Shortage Area (HPSA) and in a Medically Underserved Area/Population according to HRSA:

- HPSA for Primary Care Services for Medicaid Eligible – Washington Heights/Inwood.
- HPSA for Mental Health Services for Medicaid Eligible – Washington Heights/Inwood.
- Medically Underserved Area/Population - Washington Heights/Inwood.

## Prevention Quality Indicators (PQIs)

PQIs are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

The table below provides information on the PQI rates for major condition categories. It shows that these rates are higher for all PQI categories for the 11 zip codes combined in the primary service area than those for the State.

*PQI Rates-Hospital Admissions per 100,000 Adult, Source: NYSDOH-PQI*

PQI Rates	Primary Service Area:	
	Zip Codes Combined:	NYS
All Acute	568	526
All Circulatory	655	456
All Diabetes	369	224
All Respiratory	478	357
All Above	2,071	1,563

**Conclusion**

The proposed DTC will improve access to needed services for several communities in Manhattan and the Bronx.

**Recommendation**

**From a need perspective, approval is recommended.**

**Programmatic Analysis**

**Project Proposal**

Establish and construct a diagnostic and treatment center providing primary and specialty care services

<b>Proposed Operator</b>	Broadway Community Health Services, Inc.
<b>Operator Type</b>	Not-for-Profit
<b>Site Address</b>	577 West 161 <sup>st</sup> Street, New York, NY
<b>Services</b>	Health Fairs Dental Nutritional Pediatrics Prenatal Psychology Well Child Clinical Laboratory Medical Social Services Ophthalmology Podiatry Primary Medical Care Radiology - Diagnostic
<b>Hours of Operation</b>	Monday through Friday from 8:00 am to 6:00 pm (Will add additional hours as need/demand requires)
<b>Staffing (1<sup>st</sup> Year / 3<sup>rd</sup> Year)</b>	23.5 FTEs / 41.2 FTEs
<b>Medical Director(s)</b>	Franz E. Goyzueta, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided by St. Luke's Roosevelt Hospital 2.5 miles/9 minutes

**Character and Competence**

The proposed Board of Directors is comprised of the following individuals:

<b>Name</b>	<b>Title/Position and Experience</b>
Franz E. Goyzueta, MD	President/Chairman; Physician in private practice with over 35 years of experience.
F. Sebastian Goyzueta	Vice President/Vice Chairman; Works for a private construction company in NYC.
Rosemary Goyzueta	Vice President/Vice Chairman/Treasurer; Office Manager of Goyzueta PC.

Lyudmilla Bloch	Secretary; Director of VP Programming at the Plaza Hotel and Marketing Director for various restaurants geared to tourists in NYC.
Jeanne Bunn	Director; Teacher/Assistant Principal at De La Salle Academy.
Daniel Cassidy	Director; Attorney.
Ivan Torres	Director; Full-time Law Student at Fordham Law School and community member.
Christopher Goff	Director; Chief Marketing Officer of a wholesale employee benefits firm.

Upon approval, the applicant has indicated a desire to seek authorization from the United States Department of Health Resources and Services Administration (HRSA) to become a Federally Qualified Health Center (FQHC); therefore, the composition of the governing board has been comprised of a majority of members who will be served by the center, and who, as a group, represent the individuals to be served in terms of demographic factors (i.e., race, ethnicity, sex).

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.

Recommendation

**From a programmatic perspective, contingent approval is recommended.**

<b>Financial Analysis</b>
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Lease Rental Agreement

The applicant will lease approximately 15,500 sq. ft. of space on the third through sixth floors and common area of 577 West 161<sup>st</sup> Street, New York, NY under the terms of the executed lease agreement summarized below:

Date:	June 7, 2013
Landlord:	SEB I Realty Corp
Tenant:	Broadway Community Health Center Inc.
Term:	10 Years with two five year renewal options.
Rental:	\$1,016,050(\$65.55 per sq. ft) per annum and increase 3.5% each year after.
Provisions:	Tenant responsible for maintenance, utilities, insurance and proportionate share of taxes.

The applicant has indicated that the lease will be a non- arm's length lease arrangement. Letters of opinion from license commercial real estate brokers have been submitted indicating rent reasonableness.

Total Project Cost and Financing

There are no project costs associated with this application. The Landlord will be doing all renovations and incorporating the expense into the lease payments.

The Landlord's construction start date is anticipated for April 1, 2014 with a ten month completion date.

### Operating Budget

The applicant has submitted an operating budget in 2013 dollars, for the first and third years of operation, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues:	\$3,448,045	\$6,747,496
Expenses:		
Operating	\$2,561,544	\$4,776,537
Depreciation and Rent	<u>1,056,050</u>	<u>1,133,418</u>
Total Expenses	\$3,617,594	\$5,909,955
Net Income	<u>\$(169,549)</u>	<u>\$873,541</u>
Utilization: (visits)	25,525	49,950
Cost Per Visit	\$141.73	\$118.32

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

	<u>First and Third Years</u>
Commercial Fee-For-Service	3.5%
Medicare Managed Care	12.0%
Medicaid Managed Care	80.0%
Self-Pay	2.5%
Charity Care	2.0%

Expense and utilization assumptions are based on the historical data of similar proposed D&TCs in the planning area.

### Capability and Feasibility

Working capital requirements, estimated at \$984,993, appear reasonable based on two months of third year expenses, which will be satisfied through a bank loan for \$492,496 with a 7% interest rate over three years, and the remaining \$492,497 through fundraising contributions. A letter of interest from Capital One Bank has been submitted by the applicant for the working capital loan. BFA Attachment A is the pro-forma balance sheet of Broadway Community Health Center, Inc. as of the first day of operation, which indicates positive fund balance of \$492,497.

The submitted budget indicates a net income of \$(169,549) and \$873,541 during the first and third years of operation, respectively. Revenues are based on prevailing reimbursement methodologies. FQHC status has not been taken into consideration under budgeted revenues. The budget appears reasonable.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

### Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A

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 13th day of February, 2014, 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 diagnostic and treatment center providing primary care and specialty services, 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:

132080 B

Broadway Community Health Center, Inc.

APPROVAL CONTINGENT UPON:

1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
2. Submission of documentation of fundraising for working capital, acceptable to the Department. [BFA]
3. Submission of a loan commitment for working capital, acceptable to the Department. [BFA]
4. Submission of a photocopy of an executed amended Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of an amended Organizational Chart, acceptable to the Department. [CSL]
6. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by January 31, 2015 in accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval may be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

**Project # 132166 E**  
**Williamsburg Services, LLC d/b/a Bedford Center for Nursing & Rehabilitation**

**County:** Kings County  
**Purpose:** Establishment

**Program:** Residential Health Care Facility  
**Acknowledged:** September 24, 2013

## Executive Summary

### Description

Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation, is seeking approval to become established as the new operator of Keser Nursing and Rehabilitation Center, Inc., an existing 200-bed voluntary residential health care facility (RHCF) located at 40 Heyward Street, Brooklyn. Keser Nursing and Rehabilitation Center, Inc. entered into an asset purchase agreement with Williamsburg Services, LLC, on April 1, 2013, for the sale and acquisition of the facility's operating interest. A separate real estate company, Aishel Avarham, Inc., currently owns the property and leases it to Keser; this lease will continue with the new operator.

BFA Attachment A presents a summary net worth statement of the proposed members. Several of the proposed members have ownership interest in additional RHCF facilities; the financial summaries are presented as BFA Attachments D through F for: Hamilton Park Nursing and Rehabilitation Center, Bezalel Rehabilitation and Elmhurst Care Center, respectively.

The applicants also have ownership in three other nursing homes: Linden Center for Rehabilitation and Nursing; Crown Heights Center for Rehabilitation and Nursing; and Hopkins Center for Rehabilitation and Nursing. These facilities were acquired by the members between March 2012 and May 2013, and therefore have not yet submitted full certified financial statements in which the members would have been associated with the facilities for an entire year.

		Operation	
		<u>Before</u>	<u>After</u>
Keser Nursing and Rehabilitation Center, Inc.			Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation
	<u>Percent Owned</u>		<u>Percent Owned</u>
<u>Name</u>		<u>Name</u>	
Keser Nursing and Rehabilitation Center, Inc.	100%	Solomon Rubin	30%
		Marvin Rubin	30%
		Joel Landau	20%
		Jack Basch	10%
		Zvi Klein	5%
		Sidney Greenberger	5%

### DOH Recommendation Contingent Approval

### Need Summary

The change in ownership will not result in any change in beds or services. Keser Nursing and Rehabilitation Center's utilization was 90.2% in 2009, 88.3% in 2010, and 92.6% in 2011. While utilization is below the Department's 97% planning optimum, the facility plans to increase utilization by creating new outreach programs in conjunction with other healthcare facilities and provider plans in its service area.

### Program Summary

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

#### Financial Summary

The facility's assets have been sold in accordance with the Asset Purchase Agreement effective April 1, 2013. There are no project costs associated with this proposal.

		<u>Year One</u>	<u>Year Three</u>
Budget	Revenues	\$19,418,860	\$19,527,060
	Expenses	<u>19,826,389</u>	<u>19,475,517</u>
	Gain/(Loss)	(\$407,529)	\$51,543

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, based on year three's projected budget.

## Recommendations

Health Systems Agency  
There will be no HSA review of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will:
  - a. Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b. Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c. Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - d. Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above;
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a photocopy of an executed Certificate of Assumed Name of Williamsburg Services, LLC, acceptable to the Department. [CSL]
4. Submission of a photocopy of an executed lease agreement and lease assignment agreement, acceptable to the Department. [BFA, CSL]
5. Submission of a photocopy of an executed Certificate of Amendment of the Articles of Organization of Williamsburg Services, LLC, acceptable to the Department. [BFA, CSL]
6. Submission of a photocopy of an executed Amended and Restated Operating Agreement of Williamsburg Services, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of an executed Certificate of Dissolution of Keser Nursing and Rehabilitation Center, Inc, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date  
**February 13, 2014**

# Need Analysis

## Project Description

Williamsburg Services, LLC, seeks approval to become the established operator of Keser Nursing and Rehabilitation Center, an 200-bed Article 28 residential health care facility, located at 40 Heyward Street, Brooklyn, 11249, in Kings County. Upon approval, the facility will be renamed Bedford Center for Nursing and Rehabilitation.

## Analysis

There is currently a need for 8,663 beds in the New York City Region as indicated in Table 1 below. However, the overall occupancy for the New York City Region is 94.8% for 2011 as indicated in Table 2.

Table 1: RHCF Need – New York City Region

2016 Projected Need	51,071
Current Beds	42,330
Beds Under Construction	78
Total Resources	42,408
Unmet Need	8,663

Keser Nursing and Rehabilitation Center's utilization was 90.2% in 2009, 88.3% in 2010, and 92.6% in 2011. The low utilization can be attributed to the facility's lack of outreach to surrounding healthcare facilities that would have better aligned the services that the facility offers with the needs of the area being serviced.

Table 2: Keser Nursing and Rehabilitation Center/Kings County/NYC Region Occupancy

Facility/County/Region	2009	2010	2011
Keser Nursing and Rehabilitation Center	90.2%	88.3%	92.6%
Kings County	92.7%	95.0%	94.3%
New York City Region	94.9%	95.4%	94.8%

## Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions or 75% of the Health Systems Agency area percentage, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patient's admissions is at least 75% of the planning area percentage or Health Systems Agency percentage, whichever is applicable.

Keser Nursing and Rehabilitation Center's Medicaid admissions for 2010 and 2011 was 55.47% and 67.08%, respectively, which exceeds the Kings County 75% rate of 28.12% in 2010 and 30.92% in 2011.

## Conclusion

Approval of this application will help maintain a needed RHCF facility for the community and for its Medicaid population.

## Recommendation

**From a need perspective, contingent approval is recommended.**

## Programmatic Analysis

### Facility Information

	<b>Existing</b>	<b>Proposed</b>
Facility Name	Keser Nursing and Rehabilitation Center, Inc.	Bedford Center for Nursing and Rehabilitation
Address	40 Heyward Street Brooklyn, NY. 11249	Same
RHCF Capacity	200	Same
ADHC Program Capacity	N/A	N/A
Type of Operator	Not-for-profit	Proprietary
Class of Operator	Corporation	Limited Liability Company
Operator	Keser Nursing and Rehabilitation Center, Inc.	Williamsburg Services, LLC  Members: Solomon Rubin           30.00% Marvin Rubin            30.00% Joel Landau              20.00% Jack Basch               10.00% Zvi Klein                 5.00% Sidney Greenberger     5.00%

### Character and Competence – Background

#### Facilities Reviewed

##### Nursing Homes

Linden Center for Rehabilitation and Nursing (previously known as Ruby Weston Manor)	05/2013 to present
Crown Heights Center for Nursing and Rehabilitation (previously known as Marcus Garvey Residential Rehabilitation Pavilion)	12/2012 to present
Hamilton Park Nursing and Rehabilitation Center	08/2009 to present
Hopkins Center for Rehabilitation and Healthcare	03/2012 to present
Elmhurst Care Center, Inc.	12/2003 to present
Bezalel Rehabilitation and Nursing Center	12/2003 to present

##### New Jersey Nursing Homes

AristaCare at Norwood Terrace	12/2003 to present
AristaCare at Alameda Center	08/2004 to present
AristaCare at Cedar Oaks	03/2007 to present
AristaCare at Whiting	06/2008 to present
AristaCare at Cherry Hill	01/2012 to present

##### Pennsylvania Nursing Homes

AristaCare at Meadow Springs	07/2006 to present
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##### Licensed Home Care Services Agency (LHCSA)

True Care, Inc.	03/2011 to present
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##### Diagnostic Laboratory

Shiel Medical Laboratory, Inc.	12/2003 to present
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### Individual Background Review

Solomon Rubin is the controller for the Grandell Rehabilitation and Nursing Center and the Beach Terrace Care Center. He is also a manager at Hamilton Park Nursing and Rehabilitation Center.

Solomon Rubin discloses the following ownership interests in health facilities:

Hamilton Park Nursing and Rehabilitation Center	08/2009 to present
Linden Center for Rehabilitation and Nursing	05/2013 to present
Crown Heights Center for Nursing and Rehabilitation	04/2013 to present
AristaCare at Norwood Terrace	2000 to present

Marvin Rubin is a manager at the Hamilton Park Nursing and Rehabilitation Center. Marvin Rubin discloses the following ownership interests in health facilities:

Linden Center for Rehabilitation and Nursing	05/2013 to present
Crown Heights Center for Nursing and Rehabilitation	04/2013 to present
Hopkins Center for Rehabilitation and Healthcare	03/2012 to present
Hamilton Park Nursing and Rehabilitation Center	12/2012 to present
True Care, Inc.	03/2011 to present

Joel Landau is the director of Care to Care, LLC, a radiology benefit management company. He is also the owner of The Intelimed Group, a medical contracting and credentialing company and E-Z Bill, a medical billing company. Joel Landau is a notary public, licensed by the Department of State in New York State. Mr. Landau discloses the following ownership interests in health facilities:

Linden Center for Rehabilitation and Nursing	05/2013 to present
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Jack Basch is the president of Shiel Medical Laboratory, Inc., a diagnostic test lab in Brooklyn, New York. He also serves as a consultant for the Elmhurst Care Center, Inc. Mr. Basch discloses the following ownership interests:

Elmhurst Care Center, Inc.	01/1999 to present
Bezalel Rehabilitation and Nursing Center	1989 to present
Linden Center for Rehabilitation and Nursing	05/2013 to present
Crown Heights Center for Nursing and Rehabilitation	12/2012 to present
Shiel Medical Laboratory	1994 to present

Zvi Klein is the president of AristCare, a nursing home management company located in South Plainfield, New Jersey. Mr. Klein discloses the following ownership interests in health facilities:

AristaCare at Meadow Springs	07/2006 to present
AristaCare at Cedar Oaks	03/2007 to present
AristaCare at Whiting	06/2008 to present
AristaCare at Cherry Hill	01/2012 to present

Sidney Greenberger is a licensed nursing home administrator in the states of New York and New Jersey, for which he is considered to be in good standing in both states. Mr. Greenberger is employed as the chief executive officer for AristaCare, a nursing home management company located in South Plainfield, New Jersey. Mr. Greenberger discloses the following ownership interests in health facilities:

AristaCare at Alameda Center	08/2004 to present
AristaCare at Meadow Springs	07/2006 to present
AristaCare at Cedar Oaks	03/2007 to present
AristaCare at Whiting	06/2008 to present
AristaCare at Cherry Hill	01/2012 to present

### Character and Competence Analysis

No negative information has been received concerning the character and competence of the applicants.

A review of operations for the Bezalel Rehabilitation and Nursing Center, Elmhurst Care Center, Inc., Linden Center for Rehabilitation and Nursing, Hopkins Center for Rehabilitation and Healthcare, Hamilton Park Nursing and Rehabilitation Center, and Crown Heights Center for Nursing and Rehabilitation, for the

periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

A review of operations of AristaCare at Norwood Terrace, AristaCare at Alameda Center, AristaCare at Cedar Oaks, AristaCare at Whiting, and AristaCare at Cherry Hill in the state of New Jersey for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

A review of operations of AristaCare at Meadow Springs in the state of Pennsylvania for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

A review of the licensed home care services agency True Care, Inc. reveals that a substantially consistent high level of care has been provided since there were no enforcements.

A review of the diagnostic test laboratory Shiel Medical Laboratory, Inc. indicates there are no issues with its license.

#### Project Review

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

#### Conclusion

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

#### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

#### Asset Purchase Agreement

The change in ownership will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized below:

Date:	April 1, 2013
Seller:	Keser Nursing and Rehabilitation Center, Inc.
Purchaser:	Williamsburg Services, LLC
Purchased Assets:	All of the seller's right, title and interest in and to all assets of Seller to the extent that such assets are (x) subject to assignment, (Y) owned by the Seller and (Z) related solely to the facility business, included without limitation the following , (1) the books and records, including, but not limited to patient records pursuant to the terms of a patient medical records transfer agreement, (2) computer software, (3) any permits and accreditations, (4) the tangible assets, (5) intellectual property, including, but not limited to, the name "Keser Nursing and Rehabilitation Center", (6) goodwill and (7) all current assets of the seller reflected on the balance sheet of the seller, including all cash and accounts receivable.
Liabilities Assumed :	All liabilities of the seller related to the facility, the facility business and the seller business assets, which are "current liabilities" as defined in accordance with generally accepted accounting principles, of seller (the " assumed liabilities"), including but not limited to the obligation to pay American Geri Care ("Geri Care") all amounts due relating to employee leasing services, which have been guaranteed

by the landlord and the \$150,000 working capital loan made by the landlord to the seller. Purchaser shall pay in full, all Assumed Liabilities or to the extent such obligations are not paid in full, Purchaser shall obtain Vendor Releases and deliver such Vendor releases to the seller. Notwithstanding the foregoing, purchaser shall not assume any ongoing contractual obligation of seller.

Purchase Price: Assumption of approximately \$12,000,000 in liabilities.  
Payment of Purchase Price: Liability assumption effective as of the closing date.

The applicant has submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. Currently, the facility has no outstanding Medicaid audit liabilities.

#### Lease Agreement

Facility occupancy will continue to be subject to a lease agreement that will be assigned from Keser to Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation, the terms of the lease are summarized as follows:

Premises:	200-bed Skilled nursing facility located at 40 Heyward Street, Brooklyn, New York, 11211 (County)	
Lessor:	Aishel Avraham, Inc.	
Lessee/Assignor:	Keser Nursing and Rehabilitation Center, Inc.	
Assignee/new Lessor:	Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation	
Term:	25 years starting September 2012 with 1 five year extension	
Rental:	Year 1 \$650,000	Year 14 \$780,000
	Year 2 \$660,000	Year 15 \$790,000
	Year 3 \$670,000	Year 16 \$800,000
	Year 4 \$680,000	Year 17 \$810,000
	Year 5 \$690,000	Year 18 \$820,000
	Year 6 \$700,000	Year 19 \$830,000
	Year 7 \$710,000	Year 20 \$840,000
	Year 8 \$720,000	Year 21 \$850,000
	Year 9 \$730,000	Year 22 \$860,000
	Year 10 \$740,000	Year 23 \$870,000
	Year 11 \$750,000	Year 24 \$880,000
	Year 12 \$760,000	Year 25 \$890,000
	Year 13 \$770,000	
Provisions:	Tenant pays for all utilities, taxes, repairs and maintenance	

The lease arrangement is an arm's length agreement.

Currently, Medicaid capital cost is reimbursed based on the interest and depreciation reimbursement methodology. After the change in the ownership, capital reimbursement will be based on the return of and return on equity methodology. Based on depreciable asset value, it appears that there is no real property reimbursable life remaining.

Operating Budget

Following is a summary of the submitted operating budget, presented in 2013 dollars, for the first and third year subsequent to change in ownership:

<u>Year One</u>	<u>Per Diem</u>	<u>Total</u>
Revenues:		
Medicaid	\$213.00	\$12,113,310
Medicare	\$735.00	5,608,050
Private Pay	\$350.00	<u>1,697,500</u>
Total		\$19,418,860
Expenses:		
Operating		\$17,442,983
Capital		<u>2,383,406</u>
Total		\$19,826,389
Net Income/(Loss)		(\$407,529)
Utilization: (patient days)		69,350
Occupancy		<u>94.74%</u>

<u>Year Three</u>	<u>Per Diem</u>	<u>Total</u>
Revenues:		
Medicaid	\$213.00	\$12,390,210
Medicare	\$735.00	5,666,850
Private Pay	\$350.00	1,470,000
Total		\$19,527,060
Expenses:		
Operating		\$17,094,125
Capital		<u>2,381,392</u>
Total		\$19,475,517
Net Income/(Loss)		\$51,543
Utilization: (patient days)		70,080
Occupancy		<u>96.00%</u>

Overall utilization is projected at 94.74% for year one and at 96.00% for year three, while utilization by payor source is expected as follows:

	<u>Year One</u>	<u>Year Three</u>
Medicaid	82.00%	83.01%
Medicare	11.00%	11.00%
Private Pay	7.00%	5.99%

- Breakeven utilization is projected at 96.73% for Year One
- Breakeven utilization is projected at 95.484% for Year Three.

### Capability and Feasibility

The purchase price and initiation of operations as a financially viable entity will be funded through the members' equity. Working capital requirements are estimated at \$3,304,398, based on two months of first year expenses, to be satisfied from the proposed members' equity. BFA Attachment A, the members' net worth statements, shows that some of the applicant's do not have sufficient liquid assets to cover all aspects of the application. Mr. Jack Basch, one of the applicant's, has provided a disproportionate share affidavit in order to cover the potential shortfalls of the other applicants

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with cost-based capital component payment methodology, to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

The submitted budget indicates a net loss of \$407,529 would occur during the first year following the change in ownership and a net gain of \$51,543 would be achieved by year three. The budget appears reasonable. BFA Attachment B is the pro-forma balance sheet of Willamsburg Services, LLC, which indicates positive working capital as well as negative members' equity of \$7,764,769 as of the first day of operations. It is noted that the negative member equity is a result of the assumption of approximately \$12,000,000 of sellers' liabilities.

BFA Attachment C is a financial summary of Keser Nursing and Rehabilitation Center, Inc. from 2010 through 2012. As shown, the facility had an average negative working capital position and an average negative net asset position. Also, the facility achieved an average net loss of \$2,166,703 from the period 2010 through 2012. The reason Keser incurred a loss in 2010 from operations is that its low occupancy did not permit the facility to cover their operating costs. The 2011 loss was due to low occupancy and because the facility received Medicaid and Medicare negative retroactive adjustments for the rate years 2009, 2010 and 2011. The facility again incurred a loss in 2012 due to low occupancy and a significant reduction in the Medicaid 2012 reimbursement rates.

In order to address the financial losses, the applicant will improve the outreach initiatives to surrounding health care facilities and managed long term care plans to better align the facility's services and programs with the needs of the residents in its service area. This initiative also includes the promotion of better working relationships with community and discharge planners at area health care facilities, modernization of the facility's Rehabilitation Department, including development of a specialized cardiac therapy program, and enhancement of the facility's ventilator unit and pulmonary department. These combined efforts to increase utilization coupled with better management control of operating costs, will permit the facility to realize an operating profit in Year Three.

BFA Attachment D is a financial summary of Hamilton Park Nursing and Rehabilitation Center from 2010 through 2012. As shown, the facility had an average negative working capital position and an average positive net asset position. The applicant indicates that the negative working capital is a temporary condition due to construction of 50 new beds approved through CON 102316. Once the new beds are fully operational, they expect to return to positive working capital. The facility achieved an average net income of \$1,030,503 from the period 2010 through 2012.

BFA Attachment E is the financial summary of Bezalel Nursing Home Company from 2010 through 2012. As shown on Attachment E, the facility had an average positive working capital position and an average positive net asset position. Also, the facility incurred an average net loss of \$442,280 during the period 2010 through 2012. The loss in both 2011 and 2012 was due to one-time only prior period adjustments; the adjustment in 2012 totaled \$575,000. Without this adjustment, the facility would have shown a net income of approximately \$330,000.

BFA Attachment F is the financial summary of Elmhurst Care Center, Inc. from 2010 through 2012. As shown, the facility had an average positive working capital position and an average positive net asset position. The facility incurred an average net income of \$106,652 during the period 2010 through 2012. The 2012 loss was caused by prior period one time only adjustments that totaled \$2,740,000. Without these adjustments, the facility would have had a profit from operations of approximately \$1,380,000.

Based on the preceding, and subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Net Worth of Proposed Members of Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation
BFA Attachment B	Pro-forma Balance Sheet Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation
BFA Attachment C	Financial Summary Keser Nursing and Rehabilitation Center, Inc. from 2010 through 2012
BFA Attachment D	Financial Summary, Hamilton Park Nursing and Rehabilitation Center from 2010 through 2012
BFA Attachment E	Financial Summary Bezalel Nursing Home Company from 2010 through 2012
BFA Attachment F	Financial Summary Elmhurst Care Center, Inc. from 2010 through 2012

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 13th day of February, 2014, 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 Williamsburg Services, LLC d/b/a Bedford Center for Nursing and Rehabilitation as the new operator of Keser Nursing and Rehabilitation Center, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:

132166 E

FACILITY/APPLICANT:

Williamsburg Services, LLC  
d/b/a Bedford Center for Nursing &  
Rehabilitation

APPROVAL CONTINGENT UPON:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will:
  - a. Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b. Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c. Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - d. Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above;
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]

3. Submission of a photocopy of an executed Certificate of Assumed Name of Williamsburg Services, LLC, acceptable to the Department. [CSL]
4. Submission of a photocopy of an executed lease agreement and lease assignment agreement, acceptable to the Department. [BFA, CSL]
5. Submission of a photocopy of an executed Certificate of Amendment of the Articles of Organization of Williamsburg Services, LLC, acceptable to the Department. [BFA, CSL]
6. Submission of a photocopy of an executed Amended and Restated Operating Agreement of Williamsburg Services, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of an executed Certificate of Dissolution of Keser Nursing and Rehabilitation Center, Inc, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies  
(4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



**STATE OF NEW YORK - DEPARTMENT OF HEALTH**

**M E M O R A N D U M**

**TO:** Colleen Frost, Executive Secretary  
Public Health and Health Planning Council

**FROM:** James E. Dering, General Counsel *JED*  
Division of Legal Affairs

**DATE:** October 30, 2013

**SUBJECT:** Restated Articles of Organization of The Plastic Surgery Center of Westchester, LLC. changing its name to "Surgical Specialty Center of Westchester, LLC."

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Attached is the Restated Articles of Organization of The Plastic Surgery Center of Westchester, LLC. This Article 28 limited liability company seeks approval to change its name to "The Surgical Specialty Center of Westchester, LLC." Public Health and Health Planning Council approval for a change of corporate name is required by 10 NYCRR § 600.11 (a) (4). Please be advised that Public Health Council approved a prior Restated Articles of Organization that changed the name of the applicant from "White Plains Surgeons Project, LLC" to The Plastic Surgery Center of Westchester, LLC.

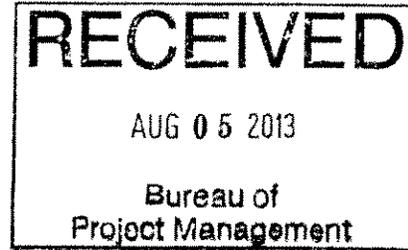
Also attached is a letter dated August 2, 2013 from Benjamin Malerba, the company's attorney. As explained in that letter, the company was converted from a single specialty to a multi-specialty ambulatory surgery center and it believes that the proposed name change more accurately reflects the services that it currently provides.

The Department has no objection to the name change, and the Restated Articles of Organization is in legally acceptable form.

Attachments

**BENJAMIN MALERBA**  
PARTNER  
(516) 357-3128  
[benjamin.malerba@rivkin.com](mailto:benjamin.malerba@rivkin.com)

August 2, 2013



**BY OVERNIGHT MAIL**

Barbara DeICogliano  
Director of Bureau of Project Management  
New York State Department of Health  
1842 Corning Tower  
Empire State Plaza  
Albany, NY 12237

Re: Request to Change the Name of The Plastic Surgery Center of Westchester, LLC to Surgical Specialty Center of Westchester, LLC  
Operating Certificate No.: 594520011R 5945200R  
Facility ID: 9231

Dear Ms. DeICogliano:

We represent The Plastic Surgery Center of Westchester, LLC (the "Center") and we write to you, on behalf of the Center, to request a change of name of the Center from "The Plastic Surgery Center of Westchester, LLC" to "Surgical Specialty Center of Westchester, LLC". The Center was converted from a single specialty to a multi-specialty ambulatory surgery center and it believes that the proposed name more accurately reflects the services that it currently provides. Provided that this request is approved, the Center will change its signage, letterhead and otherwise hold itself out to the public using the name "Surgical Specialty Center of Westchester, LLC".

Enclosed herewith is a copy of (i) a draft of the amended and restated Articles of Organization that we intend to file with the Department of State, which includes the name change (Exhibit A); and (ii) the filed Articles of Organization (Exhibit B). We also request that the Center's Operating Certificate be amended to reflect the new name (Exhibit C).

If you have any questions, please feel free to contact me.

Respectfully submitted,

RIVKIN RADLER LLP

*Benjamin P. Malerba*  
Benjamin P. Malerba

BPM/ic

cc: Samuel J. Beran, M.D.  
2819279 v1

**RESTATED**

**ARTICLES OF ORGANIZATION**

**OF**

**THE PLASTIC SURGERY CENTER OF WESTCHESTER, LLC**

**Under Section 214 of the Limited Liability Company Law of the State of New York**

The undersigned being an authorized person of the Limited Liability Company does hereby certify:

**FIRST:** The name of the limited liability company is THE PLASTIC SURGERY CENTER OF WESTCHESTER, LLC.

**SECOND:** The date when the articles of organization were filed by the Department of State is February 12, 2007. The name under which it formed was WHITE PLAINS SURGEONS PROJECT, LLC.

**THIRD:** The text of the articles of organization is hereby amended and restated to change the name, the purpose and address of the limited liability company and shall read as follows:

**ARTICLES OF ORGANIZATION**

**OF**

**SURGICAL SPECIALTY CENTER OF WESTCHESTER, LLC**

**Under Section 203 of the Limited Liability Company Law of the State of New York**

**FIRST:** The name of the limited liability company is SURGICAL SPECIALTY CENTER OF WESTCHESTER, LLC.

**SECOND:** The Company is organized and shall operate for the sole purpose of owning and operating a multi-specialty ambulatory surgery center under Article 28 of the New York Public Health Law which shall be located at (and the principal office of which shall be) 440 Mamaroneck Avenue, Harrison, New York 10528 in the county of Westchester, provided, however, that the Company shall not engage in such act or activity without first obtaining the consent or approval of the New York State Department of Health.

**THIRD:** The county within this State in which the office of the company is to be located is Westchester County.

**FOURTH:** The Company is not to have a specific date of dissolution in addition to the events of dissolution set forth in Section 701 of the LLCL.

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 13<sup>th</sup> day of February, 2014, approves the filing of the Restated Articles of Organization of The Plastic Surgery Center of Westchester, LLC dated as attached.



**STATE OF NEW YORK - DEPARTMENT OF HEALTH**

**M E M O R A N D U M**

**TO:** Public Health and Health Planning Council

**FROM:** James E. Dering, General Counsel *JED*  
Division of Legal Affairs

**DATE:** January 17, 2014

**SUBJECT:** Proposed Certificate of Incorporation of the Montefiore Foundation, Inc.  
(Foundation)

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The attached proposed Certificate of Incorporation of Montefiore Foundation, Inc. (“the Foundation”), dated November 22, 2013, is being submitted for Public Health and Health Planning Council approval. The Foundation’s Certificate includes in its purposes the solicitation and receipt of grants and contributions of every kind and description, wherever situated, within or without New York State without limitations to value for promoting and furthering the charitable, educational and scientific purposes of the tax-exempt entities within the Montefiore Health System, which includes entities that are licensed pursuant to Article 28 of the Public Health Law. Public Health and Health Planning Council approval is therefore required by Public Health Law § 2801-a(1) and (6).

The following documents and information are attached in support of the Foundation’s request for approval.

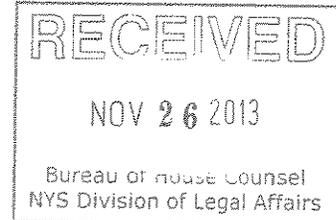
1. A letter dated November 22, 2013, from Jay E. Gerzog, requesting the creation of the Foundation and including a generalized description of the fundraising activities to be undertaken by the Foundation;
2. An Organizational Chart of Montefiore Health Systems, Inc.;
3. Information regarding the four members of the Foundation’s Initial Board of Directors;
4. The proposed Certificate of Incorporation of the Foundation;
5. The proposed bylaws for the Foundation;
6. A letter from the intended beneficiary acknowledging and approving of the Foundation’s proposed fund-raising activities on their behalf;

cc: Barbara DeICogliano

November 22, 2013

**VIA FEDEX**

Director, Bureau of House Counsel  
Division of Legal Affairs  
NYS Department of Health  
Corning Tower, Room 2484  
Empire State Plaza  
Albany, New York 12237



**Re: Request for Consent to the Filing of the Certificate of Incorporation of  
Montefiore Foundation, Inc.**

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Dear Sir/Madam:

I am writing to request the Department of Health's review and consent to the filing of the attached proposed Certificate of Incorporation of Montefiore Foundation, Inc. (the "Foundation").

The Foundation is being formed under the New York State Not-for-Profit Corporation Law to solicit charitable contributions to support the Section 501(c)(3) tax-exempt charitable organizations within the system of affiliated health care providers and related corporations and legal entities directly or indirectly controlled by Montefiore Health System, Inc., a New York not-for-profit corporation (hereinafter referred to collectively as the "Montefiore Health System"), including the following health care facilities licensed under the New York State Public Health Law ("PHL") as indicated below (hereinafter referred to collectively as the "Licensed Supported Organizations"):

- Montefiore Medical Center – licensed under Article 28 of the PHL as a hospital
- Montefiore New Rochelle Hospital – licensed under Article 28 of the PHL as a hospital
- Montefiore Mount Vernon Hospital – licensed under Article 28 of the PHL as a hospital
- Schaffer Extended Care Center – licensed under Article 28 of the PHL as a nursing home

The Foundation will also fundraise for other Section 501(c)(3) tax-exempt charitable organizations within the Montefiore Health System that are not licensed health care providers. The parent organization and sole member of the Foundation will be Montefiore Health System, Inc., which also serves as the parent organization of the Montefiore Health System as a whole. It is not presently anticipated that the Foundation will control any other organizations. A diagram of the Licensed Supported Organizations and other legal entities included within the Montefiore Health System and their respective relationships is attached as **Exhibit 1**.

The Foundation is being formed to centralize and streamline the fundraising efforts of the Montefiore Health System. The Foundation will be instrumental in obtaining additional financial resources for the continued operation of the Montefiore Health System and in fulfilling the health care needs of the patient population it serves. In order to fulfill its purposes, the Foundation will solicit and manage charitable contributions, gifts, grants and other forms of support for the benefit of the tax-exempt charitable affiliates of the Montefiore Health System. The Foundation will solicit funds for both the general purposes of the Licensed Supported Organizations and their affiliates and for any specific purposes as determined by the Foundation's Board of Trustees from time to time (e.g. renovation of the emergency department, breast cancer research, charity care, etc.). Forms of solicitation employed by the Foundation may include, but are not limited to, directed fundraising campaigns, galas, cocktail parties, dinners, golf and tennis outings, and solicitations by mail and telephone.

The following is information required by the New York State Department of Health regarding each of the four members of the Foundation's initial Board of Directors:

- **Steven M. Safyer, M.D.**
  - *Residential Address: 26 East 93rd Street, Apt 3CD, New York, NY 10128*
  - *Occupation: President and Chief Executive Officer*
  - *Employer Name and Address: Montefiore Medical Center*
  - *Past and present affiliations with other charitable or non-profit organizations: See **Exhibit 2a**.*
  
- **Philip O. Ozuah, M.D., Ph.D.**
  - *Residential Address: 8 Ronwood Road, Chestnut Ridge, NY 10977*
  - *Occupation: Executive Vice President and Chief Operating Officer*
  - *Employer Name and Address: Montefiore Medical Center*
  - *Past and present affiliations with other charitable or non-profit organizations: See **Exhibit 2b**.*

- **Christopher S. Panczner, Esq.**
  - *Residential Address: 531 East 20th Street, Apt. 10G, New York, NY 10010*
  - *Occupation: Senior Vice President and General Counsel*
  - *Employer Name and Address: Montefiore Medical Center*
  - *Past and present affiliations with other charitable or non-profit organizations: See **Exhibit 2c**.*
  
- **Lynn Richmond**
  - *Residential Address: 32-76 46th Street, Astoria, NY 11103*
  - *Occupation: Senior Vice President and Chief of Staff*
  - *Employer Name and Address: Montefiore Medical Center*
  - *Past and present affiliations with other charitable or non-profit organizations: See **Exhibit 2d**.*

The following documents required by the New York State Department of Health relating to the proposed incorporation of the Foundation are enclosed:

- 1) A copy of the signed and dated proposed Certificate of Incorporation of the Foundation (attached as **Exhibit 3**);
- 2) A copy of the proposed draft of the Foundation's Bylaws to be adopted following the incorporation of the Foundation (attached as **Exhibit 4**);
- 3) An original signed and dated letter from a duly-authorized representative of each of the Licensed Supported Organizations acknowledging that such Organizations will accept funds raised for them by the Foundation (attached as **Exhibit 5**).

If you have any questions or require any additional information, please call me directly at (212) 351-4940 at your earliest convenience. Thank you.

Very truly yours,



Jay E. Gerzog

Enclosures

## **Exhibit 1**

**Exhibit 2a**

**Steven M. Safyer, M.D.  
President and Chief Executive Officer  
Montefiore Medical Center**

Office of the President  
111 East 210th Street  
Bronx, NY 10467-2490

**Current Responsibilities**

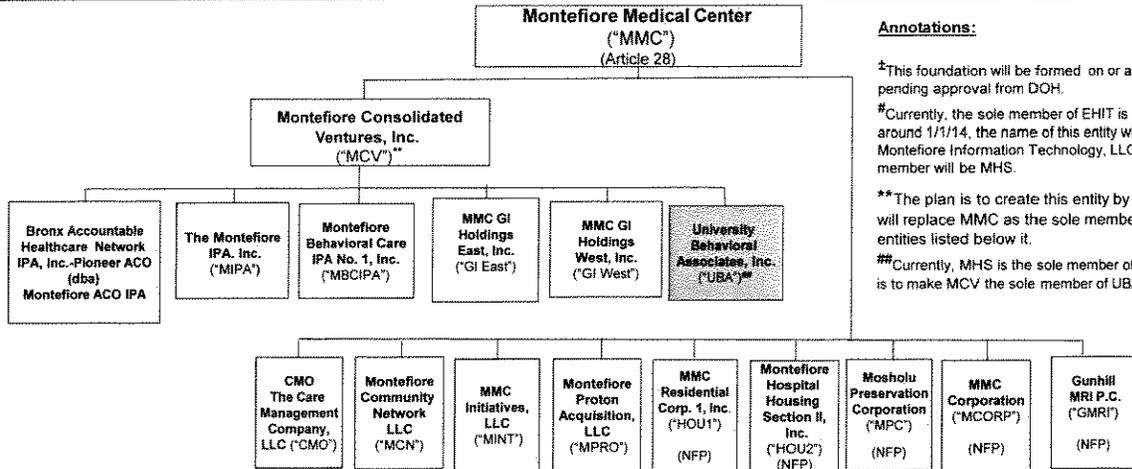
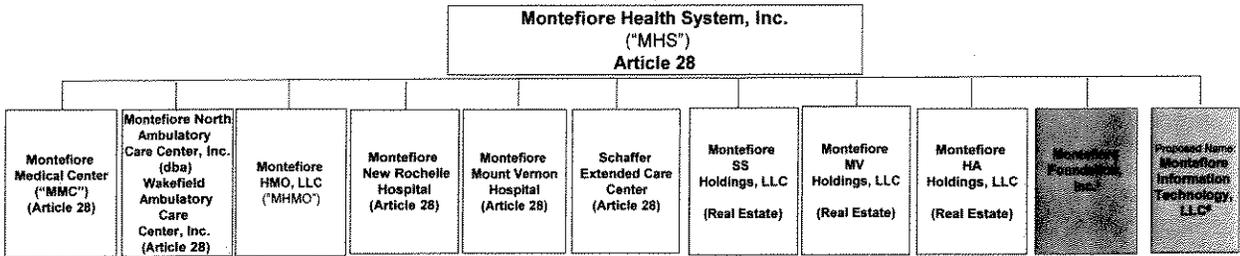
Steven M. Safyer, M.D., is president and chief executive officer of Montefiore in New York City. Montefiore is the University Hospital and Academic Medical Center for Albert Einstein College of Medicine and a full-service, integrated delivery system caring for patients from the New York metropolitan region. An accomplished physician leader and highly respected healthcare executive, Dr. Safyer has been at Montefiore since 1982, previously serving as senior vice president and chief medical officer.

**Prior Experience**

Throughout his medical career at Montefiore, Dr. Safyer has been a strong advocate for underserved populations, including those incarcerated and those affected by the public health crises of HIV and tuberculosis. He has built extensive primary care networks, developed innovative business and clinical strategies to manage care and assume risk, championed the adoption of cutting-edge clinical information systems and created nationally recognized quality and safety programs. He has nurtured a close relationship with Einstein which has resulted in superior, comprehensive specialty care being provided in Montefiore's Centers of Excellence in the areas of heart, transplant, cancer, The Children's Hospital at Montefiore and joint mobility.

**Education, Awards and Professional Affiliations**

Dr. Safyer received his Bachelor of Science degree from Cornell University and his medical degree from Albert Einstein College of Medicine. He completed his internship and residency in social medicine at Montefiore. He is board certified in internal medicine and a professor of medicine in the department of medicine and professor of epidemiology and population health in the department of epidemiology and population health at Einstein. Dr. Safyer currently serves as Chair of the League of Voluntary Hospitals and Homes and past chairman of the Board of Governors for the Greater New York Hospital Association (GNYHA). He is a board member of the Hospital Association of New York State (HANYS); Association of American Medical Colleges' Council of Teaching Hospitals (COH) Administrative Board; The Macy's Foundation; New York eHealth Collaborative (NYcE); Coalition to protect America's Health Care; and University HealthSystem Consortium (UHC). He is an active participant on committees for organizations such as the Association of American Medical Colleges; New York State Council on Graduate Medical Education; Medicaid Redesign Team; and Chase Regional Advisory Board. He was the previous Chair of the Bronx Regional Health Information Organization, an independent organization for health information sharing. A frequent lecturer on topics including population-based medicine, healthcare reform, and public health, Dr. Safyer has authored and co-authored numerous articles in peer-reviewed journals, covering subjects ranging from electronic medical records to managing the health of a population, to tuberculosis in prison populations.



**Annotations:**

‡ This foundation will be formed on or around 1/1/14, pending approval from DOH.

# Currently, the sole member of EHIT is MMC. On or around 1/1/14, the name of this entity will be changed to Montefiore Information Technology, LLC, and the sole member will be MHS.

\*\* The plan is to create this entity by 1/1/14. MCV will replace MMC as the sole member of the entities listed below it.

\*\*\* Currently, MHS is the sole member of UBA. The plan is to make MCV the sole member of UBA as of 1/1/14.

**Exhibit 2b**

**Philip O. Ozuah, MD, PhD**

**Executive Vice President  
Chief Operating Officer**

Dr. Ozuah is Executive Vice President and Chief Operating Officer of Montefiore. A nationally recognized physician, leader, executive, researcher, teacher and author, Dr. Ozuah completed his residency in social pediatrics at Montefiore. In addition to his medical degree, he also holds a Doctorate in Educational Leadership and Administration. He previously served as Professor and University Chairman of Pediatrics at Albert Einstein College of Medicine and Physician-in-Chief of the Children's Hospital at Montefiore (CHAM).

As the leader of CHAM and the Department of Pediatrics, he expanded access for underserved communities, recruited and cultivated outstanding talent, advanced programs of excellence, fostered innovations in medical education, quadrupled specialty case volumes and National Institutes of Health (NIH) funding, enhanced CHAM's regional and national reputation, and improved financial and operational performance. Under his leadership, the Department of Pediatrics became a Top-20 ranked NIH-funded department, and CHAM became one of "America's Best Children's Hospitals." He is also Professor of Pediatrics and Professor of Epidemiology and Population Health at Einstein.

**Exhibit 2c**

**Christopher S. Panczner, SR VP & General Counsel, Montefiore Medical Center**

Trustee, RESOLVE NYC, New York, NY – 1998-2001

Trustee, The Acorn School, New York, NY 2001 – 2004

Volunteer, Educational Alliance, New York, NY – 2004 – 2009

Member, Development Committee, Grace Church School, New York, NY - 2012-2013

Director, Barnes Landing Association, Amagansett, NY - 2012-present

Adjunct Professor, Pace University School of Law

**Exhibit 2d**

Lynn Richmond

Montefiore Medical Center  
Senior Vice President and Chief of Staff

- 2013 Bronx RHIO
- 2011 H-CAP
- 1994 Chair, Domestic Violence Task Force, Bellevue Hospital Center
- 1992 Staff Writer, NYC Task Force on Control of TB in Criminal Justice System, appointed by Commissioners of Health and Correction
- 1991 Chair, Addiction Committee, Montefiore Rikers Island Health Services

## **Exhibit 3**

**CERTIFICATE OF INCORPORATION**

**OF**

**MONTEFIORE FOUNDATION, INC.**

**Under Section 402 of the New York State Not-for-Profit Corporation Law**

The undersigned, a natural person over the age of eighteen years, for the purpose of forming a corporation under Section 402 of the New York State Not-for-Profit Corporation Law (the “NPCL”), hereby certifies as follows:

**FIRST:** The name of the corporation is Montefiore Foundation, Inc. (hereinafter referred to as the “Corporation”).

**SECOND:** The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 of the NPCL and shall be a Type B corporation as defined in Section 201 of the NPCL.

**THIRD:** (a) The Corporation shall be a corporation with members. The Corporation shall have one member and the the sole member of the Corporation shall be Montefiore Health System, Inc. (sometimes hereinafter referred as the “Member”), a New York Type B not-for-profit corporation qualifying under Section 501(c)(3) of the Code (as defined in Article FIFTEENTH below). The rights, powers, duties and obligations of the Member shall be as set forth in the By-Laws of the Corporation.

(b) The Corporation shall be a constituent entity of the “Montefiore Health System”, an integrated group of affiliated health care providers and related legal entities of which Montefiore Health System, Inc. is the direct or indirect parent corporation, which affiliated group includes, in addition to the Corporation: (i) Montefiore Medical Center, Montefiore New Rochelle Hospital, Montefiore Mount Vernon Hospital, Schaffer Extended Care Center, and Montefiore North Ambulatory Care Center, Inc., each being a New York not-for-profit corporation licensed under Article 28 of the New York State Public Health Law (“PHL”) and exempt from federal income tax under Section 501(a) of the Code as an organization described in Section 501(c)(3) of the Code and other than a private foundation by reason of their being described in Sections 509(a)(1) and 170(b)(i)(A)(iii) of the Code; and (ii) such other not-for-profit and for profit corporations and other legal entities as from time to time become constituent entities of the Montefiore Health System.

**FOURTH:** (a) The Corporation is organized, and shall be operated, exclusively for the charitable, educational and scientific purposes of promoting, facilitating and enhancing the delivery of quality, efficient, effective and economical health care and related services to, and improving and enhancing the general health and well being of, the communities served by the Montefiore Health System, by:

(1) soliciting, collecting, receiving and managing funds and other contributed assets to be received by gift, grant, donation, deed, purchase, legacy, bequest, devise or otherwise, and to otherwise acquire money and property (real or personal) of every kind and description, wherever situated, within or without the State of New York, and upon any terms and conditions, without limitations as to amount or value except such limitations, if any, as may now or hereafter be imposed by law, for use in furtherance of providing financial support to, and otherwise promoting and furthering the charitable, educational and scientific purposes of the Section 501(c)(3) tax-exempt entities within the Montefiore Health System and promoting the best interests of the patient populations served thereby; and

(2) subject to the limitations set forth herein, engaging in any and all other lawful acts or activities, and exercising all such powers, rights and privileges applicable to not-for-profit corporations organized under the NPCL, that are incidental to and in furtherance of accomplishing the foregoing charitable, educational and scientific purposes.

(b) The Corporation is organized, and shall be operated and shall engage in activities in furtherance of the purposes set forth in Paragraph (a) of this Article FOURTH, exclusively for charitable, educational and scientific purposes in the United States and abroad within the meaning of Section 170(c)(2)(B) and Section 501(c)(3) of the Code.

(c) Notwithstanding anything to the contrary in this Certificate, nothing herein shall authorize the Corporation, directly or indirectly, to engage in or to include among its purposes any of the activities mentioned in Section 404(a) through (v) of the NPCL, without the Corporation first having obtained the consent or approval from the appropriate governmental authority with respect thereto.

(d) Nothing in this Certificate of Incorporation shall authorize the Corporation within the State of New York to: (1) provide hospital services or health related services, as such terms are defined in the PHL; (2) establish, operate or maintain a hospital, a diagnostic and treatment center, a nursing home, or any facility providing health related services required to be licensed under Article 28 of the PHL; (3) establish, operate or maintain a home care services agency, a hospice, a managed care organization or a health maintenance organization, as provided for by Articles 36, 40 and 44, respectively, of the PHL and implementing regulations; (4) establish and operate an independent practice association; (5) establish, operate, construct, lease, or maintain an adult home, an enriched housing program, a residence for adults, or an assisted living program, as provided for by Article 7 of the New York State Social Services Law; or (6) establish, operate, construct, lease or maintain an assisted living residence, as provided for by Article 46-B of the PHL. Additionally, nothing in this Certificate of Incorporation shall authorize the Corporation within the State of New York, to (a) hold itself out as providing, or (b) provide any health care professional services that require licensure or registration pursuant to either Title 8 of the New York State Education Law, or the PHL, including, but not limited to, medicine, nursing, psychology, social work, occupational therapy, speech therapy, physical therapy, or radiation technology.

(e) The Corporation shall not operate for the purpose of carrying on a trade or business for profit.

**FIFTH:** In furtherance of its corporate purposes as set forth in Article FOURTH hereof, the Corporation shall have all of the general rights, powers and authority enumerated in the NPCL, including, in particular (a) Section 202 of the NPCL; (b) the power to solicit and receive grants, bequests and contributions for the purposes of the Corporation and the power to maintain a fund or funds of real or personal property in furtherance of the Corporation's purposes; provided, however, that notwithstanding any provision to the contrary set forth in Article FOURTH hereof or any other Article of this Certificate of Incorporation, the Corporation shall not have, and shall not be authorized to exercise, any right, power or authority in respect of any entity affiliated with the Montefiore Health System that is or may be licensed under Article 28, Article 28-A, or Article 36 of the PHL that would require establishment or licensure of the Corporation as an operator or active member of any such entity, including, but not limited to, any power or authority with regard to any of the matters set forth in 10 NYCRR Section 405.1(c).

**SIXTH:** No part of the Corporation's assets, net earnings, income or profits shall inure to the benefit of, or be distributable to, any trustee, director, officer or employee of the Corporation or other private person; provided, however, that the Corporation shall be authorized and empowered to pay reasonable compensation to any person for services rendered to or for the Corporation in furtherance of one or more of its purposes. No trustee, director, officer or employee of the Corporation or any private person shall be entitled to share in the distribution of any of the corporate assets on dissolution of the Corporation.

**SEVENTH:** No substantial part of the activities of the Corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation (except to the extent permitted by Section 501(h) of the Code if the Corporation makes an election thereunder), and the Corporation shall not participate in or intervene in (including the publishing or the distributing of statements in connection with) any political campaign on behalf of or in opposition to any candidate for public office.

**EIGHTH:** Notwithstanding anything to the contrary in this Certificate, the Corporation shall neither have nor exercise any power, nor shall it engage directly or indirectly in any activity, that would invalidate its status (a) as a corporation which is exempt from federal income taxation under Section 501(a) of the Code as an organization described in Section 501(c)(3) of the Code, or (b) as a corporation contributions to which are deductible under Sections 170(c)(2), 2055(a) or 2522(a) of the Code.

**NINTH:** The names and addresses of initial members of the Corporation's Board of Trustees, who shall serve as Trustees until the initial meeting of the Board of Trustees of the Corporation and until their successors are elected, are as follows:

Steven M. Safyer, M.D.  
111 East 210<sup>th</sup> Street  
Bronx, New York 10467-2490

Philip O. Ozuah, M.D., Ph.D.  
111 East 210<sup>th</sup> Street  
Bronx, New York 10467-2490

Christopher S. Panczner  
111 East 210<sup>th</sup> Street  
Bronx, New York 10467-2490

Lynn Richmond  
111 East 210<sup>th</sup> Street  
Bronx, New York 10467-2490

**TENTH:** In the event of dissolution of the Corporation, all of the remaining assets and property of the Corporation shall, after payment of or due provision for all necessary expenses and liabilities thereof, be distributed to:

(a) Montefiore Health System, Inc. and/or one or more affiliates or successors thereof, as are then in good standing and qualifying under Section 501(c)(3) of the Code, for use by such entities in furtherance of charitable, scientific and educational purposes substantially similar to those of the Corporation; or

(b) in the event that Montefiore Health System, Inc. and its affiliates and successors have ceased to exist or are not then qualifying under Section 501(c)(3) of the Code, then to one or more charitable, educational and/or scientific organizations as are then in existence and qualifying under Section 501(c)(3) of the Code, or to the Federal, State and/or local governments for a related public purpose, in such proportions as the Board of Trustees of the Corporation shall determine, for use by such entities in furtherance of charitable, scientific and educational purposes substantially similar to those of the Corporation,

in either case, subject to compliance with (i) the rules and regulations of the New York State Department of Health and any other applicable laws of the State of New York and (ii) an order of a Justice or the Supreme Court of the State of New York.

**ELEVENTH:** The office of the Corporation shall be located in Bronx County, New York.

**TWELTH:** In accordance with Section 508(e) of the Code, if in any taxable year the Corporation is a private foundation as defined in Section 509(a) of the Code, then in such year:

(a) The Corporation shall distribute such amounts for each taxable year at such time and in such manner so as not to subject the Corporation to tax on undistributed income under Section 4942 of the Code;

(b) The Corporation shall not engage in any act of self-dealing which is subject to tax under Section 4941(d) of the Code;

(c) The Corporation shall not retain any excess business holdings which are subject to tax under Section 4943(c) of the Code;

(d) The Corporation shall not make any investments in such manner so as to subject the Corporation to tax under Section 4944 of the Code; and

(e) The Corporation shall not make any taxable expenditures which are subject to tax under Section 4945 of the Code.

**THIRTEENTH:** No trustee, director or officer of the Corporation shall have any personal liability to the Corporation or its members for damage resulting from any breach of such trustee's, director's or officer's duties as a trustee, director or officer of the Corporation; provided, however, that this Article THIRTEENTH shall not eliminate or limit the liability of any trustee, director or officer: (a) if a judgment or other final adjudication adverse to such trustee, director or officer establishes that his or her acts or omissions (i) were in bad faith or involved intentional misconduct or a knowing violation of law or that such trustee, director or officer personally gained in fact a financial profit or other advantage to which he or she was not legally entitled, or (ii) violated Section 719 of the NPCL, unless the NPCL is amended or supplemented to so limit or eliminate such liability; or (b) to the extent that such personal liability is otherwise required by, or can not otherwise be eliminated in accordance with, the NPCL.

**FOURTEENTH:** (a) The Corporation shall, to the fullest extent permitted by the NPCL, indemnify any present or former trustee, director, officer, employee or agent of the Corporation or the personal representatives thereof, made or threatened to be made a party in any civil or criminal action or proceeding by reason of the fact that such trustee, director, officer, employee or agent, or his or her testator or intestate, is or was a member, trustee, director, officer, employee or agent of the Corporation or, at the request of the Corporation, served any other organization, entity or other enterprise in any capacity, to the full extent and in all such circumstances as shall be permitted under the NPCL, and all such indemnified costs and expenses incurred shall be advanced by the Corporation pending the final disposition of such action or proceeding.

(b) Such required indemnification shall be subject only to the exception that no indemnification may be made to or on behalf of any trustee, director, officer, employee or agent in the event and to the extent that a judgment or other final adjudication adverse to the trustee, director, officer, employee or agent establishes that such trustee's, director's, officer's, employee's or agent's acts were committed in bad faith or involved intentional misconduct or a knowing violation of law or that such trustee, director, officer, employee or agent personally gained in fact a financial profit or other advantage to which he or she was not legally entitled (provided, however, that indemnification shall be made upon any successful appeal of any such adverse judgment or final adjudication).

(c) The Corporation shall have the power to purchase and maintain insurance to indemnify the Corporation, its members, trustees, directors, officers, employees and agents of the Corporation, and other persons otherwise entitled to indemnification, to the full extent and in such circumstances as is permitted under the NPCL. No indemnification shall be made under this Article FOURTEENTH if such indemnification would be inconsistent with the provisions of the Corporation's By-Laws, a resolution of Corporation's member(s) or Board of Trustees or other proper corporate action, or, the provisions of Sections 4941 through 4945 or Section 4958 of the Code, as any such of the foregoing may be in effect at the time of the accrual

of the alleged cause of action asserted in the threatened or pending action or proceeding, which prohibits or otherwise limits such indemnification.

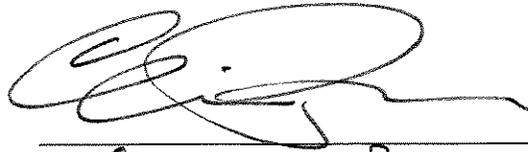
**FIFTEENTH:** All references herein to the Code are to the Internal Revenue Code of 1986, and shall be deemed to include both amendments thereto and corresponding statutory provisions of future United States Internal Revenue Laws which supercede the Code or particular provisions thereof.

**SIXTEENTH:** The Secretary of State of New York is hereby designated as agent of the Corporation upon whom process against it may be served. The post office address to which the Secretary of State shall mail a copy of any process against the Corporation which is served upon the Secretary of State is: Montefiore Foundation, Inc., Attn: Office of the General Counsel, 111 East 210<sup>th</sup> Street, Bronx, New York 10467.

**[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK.]**

**[SIGNATURE PAGE TO FOLLOW.]**

IN WITNESS WHEREOF this Certificate of Incorporation has been signed and the statements made herein affirmed as true under penalties of perjury this 21<sup>st</sup> day of November, 2013.



By: Christopher S. Panczner  
Sole Incorporator

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CERTIFICATE OF INCORPORATION  
OF  
MONTEFIORE FOUNDATION, INC.

Pursuant to Section 402 of the  
Not-For-Profit Corporation Law

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Jay E. Gerzog, Esq.  
EPSTEIN, BECKER & GREEN, P.C.  
250 Park Avenue  
New York, New York 10177-1211

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212.351.4500

**Exhibit 4**

DRAFT

**BYLAWS**  
**OF**  
**MONTEFIORE FOUNDATION, INC.**

**ARTICLE I.**

PURPOSE

Section 1.1 Principal Office. Montefiore Foundation, Inc. (the “Corporation”) shall have its principal office in the Bronx, New York or at such other place as may be determined by the Board of Trustees from time to time.

Section 1.2 Purposes. The Corporation shall at all times be operated exclusively for charitable, scientific, and educational purposes within the meaning of Section 170(c)(2)(B) and 501(c)(3) of the Internal Revenue Code of 1986, as amended (the “Code”), as set forth in the Corporation’s Certificate of Incorporation.

Section 1.3 Powers. The Corporation shall have all of the powers of a not-for-profit corporation provided for under the New York State Not-for-Profit Corporation Law (“NPCL”), subject to any limitations contained in its Certificate of Incorporation and these Bylaws, as such may be amended from time to time; provided, however, the Corporation shall exercise its powers only in furtherance of its charitable, scientific, and educational purposes as such terms are defined under Section 501(c)(3) of the Code and as further specified in the Corporation’s Certificate of Incorporation.

**ARTICLE II.**

MEMBERS

Section 2.1 Sole Member. The sole member of the Corporation shall be Montefiore Health System, Inc. (the “Member”), a New York not-for-profit corporation licensed as a hospital under Article 28 of the New York State Public Health Law that is exempt from federal income tax under Section 501(a) of the Code as an organization described in Section 501(c)(3) of the Code.

Section 2.2 Powers and Duties; Reserved Powers. In addition to its other powers and responsibilities established by law, by the Certificate of Incorporation of the Corporation and by these Bylaws, the Member shall have the following reserved powers:

(a) The power to elect the Trustees of the Corporation and to remove the Trustees of the Corporation subject to Section 3.3 of these Bylaws; and

(b) The power to authorize (i) the amendment and restatement of the Certificate of Incorporation and Bylaws of the Corporation; (ii) the merger or consolidation of the Corporation with any other entity; (iii) the sale, lease, exchange, mortgage, pledge or other disposition of all or substantially all the property and assets of the Corporation; and (iv) the voluntary dissolution of the Corporation, and the plan of distribution of assets upon dissolution and the revocation of voluntary dissolution proceedings.

Section 2.3 Meetings of the Member. The Member may hold regular or special meetings, either in or outside of the State of New York. Regular and special meetings of the Member may be held at such times and such places as determined by the Member and set forth in the notices of meeting. The Member, the Chair of the Board of Trustees, or the Board of Trustees may cause special meetings of the Member. The annual meeting of the Member shall be held at such time and place as shall be stated in the notice of meeting.

Section 2.4 Action by Member.

(a) The vote of a majority of the Members' Board of Trustees shall be deemed to constitute the vote and act of the Member, except as provided in Section 3.5 of these Bylaws for the removal of Trustees by the Member.

(b) The Annual Meeting of the Member's Board of Trustees shall be deemed to constitute the annual meeting of the Member of the Corporation required by Section 603(b) of the Not-For-Profit Corporation Law and as provided in Section 2.3 hereof.

(c) Each of the reserved powers set forth in Section 2.2 hereof, including without limitation: (i) the appointment of the Trustees of the Corporation, (ii) any amendment to the Corporation's Certification of Incorporation or these Bylaws, or (iii) the dissolution, merger, or sale of all or substantially all of the assets of the Corporation, shall require the affirmative action of the Member.

(d) Any action required or permitted to be taken at a meeting of the Member may be taken without a meeting if a duly authorized representative of the Member signs a written consent, setting forth the action.

### ARTICLE III.

#### BOARD OF TRUSTEES

Section 3.1 Powers. The property, affairs, and business of the Corporation shall be managed by its Board of Trustees. The Board of Trustees shall have, and may exercise, all of the powers of the Corporation except as may be limited or conferred by law, by the Certificate of Incorporation of the Corporation, or by these Bylaws.

Section 3.2 Number and Qualification. The number of Trustees constituting the entire Board shall be fixed from time to time by the Member; provided, however, that such number of Trustees shall not be less than three (3), or such other minimum required by the NPCL. No decrease in the number of Trustees shall shorten the term of any incumbent Trustee. Trustees shall be selected on the basis of a demonstrated record of dedication to community service, an interest in the objectives of the Corporation, as well as the ability of the candidates to participate effectively in fulfilling those objectives. Each Trustee shall be at least eighteen (18) years of age.

Section 3.3 Election and Term of Office of Trustees. All Trustees of the Corporation shall be elected by the Member for a term of one (1) year at each Annual Meeting of the Member or as determined from time to time by the Member. The terms of office of all Trustees shall expire at the next Annual Meeting of the Corporation following their election and, in any event, each elected Trustee shall continue in office until his or her successor shall have been elected and qualified, or until his or her death, resignation or removal.

Section 3.4 Vacancies. Any vacancy or vacancies in the Board because of death, resignation, removal, disqualification, increase in the number of Trustees, or any other cause, may be filled by the Member. Each person selected to fill a vacancy shall serve as a Trustee until the next Annual Meeting of Trustees at which the vacated position is up for election in the regular order of business, and until his or her successor is duly elected, appointed and qualified.

Section 3.5 Resignation and Removal. Any Trustee may resign at any time by giving written notice of such resignation to the Board of Trustees or to the Chairman or Secretary thereof, and such resignation shall take effect at the time stated therein, or if no time is stated, upon its delivery to the Board, the Chairman or Secretary. Any Trustee may be removed at any time for cause by the Member.

Section 3.6 Attendance. Trustees shall be expected to attend all meetings of the Board unless excused therefrom by the Chairman. Failure by any Trustee, without good cause as determined by the Chairman, to attend at least fifty percent (50%) of all such meetings in any calendar year shall be grounds for cause for removal from the Board.

Section 3.7 Annual and Regular Meetings. As soon as practical after each annual election of Trustees by the Member, the annual meeting of the Board of Trustees shall be held on such date, and at such time and at such place as the Board of Trustees shall determine for the purpose of election of Officers of the Corporation and the transaction of such other business as may be properly brought before such meeting. The Board of Trustees shall hold such number of other regular meetings at such times and at such places as may from time to time be determined by the Board of Trustees. At the annual meeting of the Board, the Board may fix the dates for its regular meetings during the upcoming year.

Section 3.8 Special Meetings. Special meetings of the Board of Trustees may be called at any time by the President or Chairman of the Board, by the Member, or by the Secretary upon written demand of a majority of the Board of Trustees, and shall be held at such time and place as shall be designated in the notice thereof.

Section 3.9 Notice of Meetings. Notice of the time and location of the annual meeting shall be given either personally, sent by certified or overnight mail, electronic mail, or facsimile to each Trustee at least five (5) days before the date of such meeting. Regular meetings of the Board of Trustees may be held without notice at such time and place as shall from time to time be determined as regular meeting dates and places by the Board. Notice of the time, place and purpose of each special meeting of the Board shall be given either personally, sent by certified or overnight mail, electronic mail or facsimile to each Trustee at least forty-eight (48) hours before the scheduled time of the meeting, or such shorter notice as the person or persons calling such meeting may deem necessary or appropriate under the existing circumstances. No business other than that specified in the notice of a special meeting shall be transacted thereat. At any meeting at which every member of the Board of Trustees shall be present, though held without notice, any business may be transacted which might have been transacted as if the meeting had been duly called.

Section 3.10 Waiver of Notice. Notice of the time, place and purpose of any meeting of the Board shall not be required to be given to any Trustee who submits a waiver of notice either before or after the meeting, or who attends the meeting without protesting the lack of notice to him prior thereto or at its commencement.

Section 3.11 Quorum. Except as may be otherwise specifically provided by the NPCL, the Certificate of Incorporation of the Corporation or these Bylaws, at all meetings of the Board of Trustees, the presence of a majority of the number of Trustees then in office who are entitled to vote shall constitute a quorum for the transaction of business at any meeting of the Board of Trustees. If a quorum shall not be present at any meeting of the Board of Trustees, the Trustees who are present may adjourn the meeting from time to time, until a quorum shall be present. A Trustee who is deemed to have a conflict of interest with respect to the approval of a contract, transaction or other arrangement pursuant to the Corporation's Conflict of Interest Policy, although not entitled to participate in the discussion nor vote on any matters with respect to which such Trustee has a conflict, may be counted in determining the presence of a quorum at a meeting of the Board of Trustees or committee that authorizes such contract, transaction or arrangement.

Section 3.12 Vote. Each Trustee shall be entitled to one (1) vote. The vote of a majority of the Trustees present at any meeting at which a quorum is present shall be the act of the Trustees, unless the act of a greater number or percentage of Trustees is required by the NPCL, the Certificate of Incorporation of the Corporation or these Bylaws.

Section 3.13 Action without a Meeting. Unless otherwise provided by the Certificate of Incorporation of the Corporation or these Bylaws, any action required or permitted to be taken at any meeting of the Board of Trustees or of any committee thereof may be taken without a meeting, if all the members of the Board of Trustees or committee, as the case may be, consent thereto in writing, and the writing or writings are filed with the minutes of proceedings of the Board of Trustees or committee.

Section 3.14 Teleconference. Any or all Trustees may participate in a meeting of the Board of Trustees by means of a conference telephone or similar telecommunications equipment by which all persons participating in the meeting are able to hear each other at any special

meeting of the Board of Trustees. Participation by such means at any special meeting of the Board of Trustees shall constitute presence in person at such meeting.

Section 3.15 Minutes. The Secretary or his or her designee shall maintain complete and accurate minutes of all Board meetings and shall retain all unanimous written consents executed by the Trustees. Said minutes and written consents shall be maintained in the permanent records of the Corporation.

Section 3.16 Entire Board of Trustees. For purposes of these Bylaws, the phrase “entire Board of Trustees” shall mean the total number of Trustees pursuant to Section 3.2 of these Bylaws including vacancies.

Section 3.17 Compensation. Trustees shall receive no compensation for their services as Trustees, but may be reimbursed for the expenses reasonably incurred by them in the performance of their duties in accordance with policies established by the Board of Trustees or the Member.

## ARTICLE IV.

### COMMITTEES

Section 4.1 Committees Generally. The Board of Trustees may designate such committees of the Board with such duties and responsibilities as it deems appropriate. All standing committees shall have at least three (3) trustees as members of the committee. There shall be a standing Executive Committee and an advisory Finance and Investment Committee, and, in addition, the Board of Trustees may, by resolution approved by a majority of the entire Board, designate one (1) or more additional committees of the Board (standing, special, advisory or otherwise) as may from time to time be deemed suitable, necessary, or convenient to aid in accomplishing the purposes of the Corporation. The Chairman shall have the right to appoint non-Trustees to serve on special and advisory committees, provided, however, that: (1) only Trustees may serve as the Chair of any committee; (2) Trustees shall, at all times, constitute a majority of the total membership of any committee; and (3) non-Trustee members of any committee shall not be counted toward the quorum or the votes of the committee if such committee is acting with regard to powers of the Board of Trustees that have been delegated to the committee by the Board of Trustees. Committees shall be required to maintain and submit minutes of their meetings to the full Board of Trustees. In addition, each Committee (through its chair, if any) shall be required to respond to inquiries made by the Chairman or the Board with regard to the activities of such Committee. The Chairman shall serve as an *ex officio* member of each Committee of which the Chairman is not otherwise a regular member. The President, if he/she is otherwise a Trustee, shall be an *ex officio* voting member of each Committee. Notwithstanding the foregoing, no committee shall have authority as to any of the following matters:

- (a) the power to appoint or remove Officers of the Corporation;
- (b) the filling of vacancies in the Board of Trustees or any committee thereof;

- (c) the amendment or repeal of any resolution of the Board of Trustees which by the terms thereof shall not be so amendable or repealable;
- (d) the fixing of compensation of the Trustees for serving on the Board of Trustees or on any committee;
- (e) causing the Corporation to incur debt, or pledging tangible or intangible assets of Corporation;
- (f) the authorization of indemnification for expenses incurred by Trustees, Officers or other persons in defending a civil or criminal action or proceeding under the applicable provisions of the NPCL pursuant to ARTICLE VI of these Bylaws;
- (g) the amendment or repeal of the Certificate of Incorporation of the Corporation or these Bylaws, or the adoption of new bylaws of the Corporation;
- (h) transferring, by sale or lease, any real property of the Corporation; and
- (i) the approval of a petition for non-judicial dissolution of the Corporation, a plan of merger or consolidation or the sale or other disposition of all or substantially all of the corporate assets.

Section 4.2 Executive Committee. The Executive Committee shall consist of the Chairman, President, Secretary and Treasurer. In order to provide continuity of governing body control, the Executive Committee shall exercise the authority of the Board of Trustees in the supervision and control of the affairs of the Corporation in the interval between the meetings of the Board. The Executive Committee shall have special charge of all matters not expressly assigned to some other Committee. The Executive Committee shall be considered always in session and the affirmative vote of a majority of the members of the Committee shall constitute valid action of such Committee. Except as otherwise prohibited by the NPCL, the Executive Committee shall and may exercise the powers of the Board of Trustees, provided such action is not inconsistent with the provisions of the Certificate of Incorporation of the Corporation, these Bylaws, any law or statute governing the Corporation or any limitations imposed by the Board. Any action taken by the Executive Committee shall be reported fully to the Trustees at the next regular or special meeting.

Section 4.3 Finance and Investment Committee. The Finance and Investment Committee shall review the proposed annual budget for the Corporation and shall recommend the adoption of the budgets to the Board and periodically review the actual fiscal operations of the Corporation. In relation to its approved budget, the committee shall recommend for approval by the Board any rules and regulations that may be necessary for the proper drawing of drafts and checks, upon the Treasury and for the prompt collection of all interest, dividends and rentals, as well as other monies due the Corporation. In addition, the committee shall examine as often as it may consider necessary, but at least once each fiscal year, the investments of the Corporation and make recommendations thereon to the Board. The Finance and Investment Committee shall consist of the Treasurer of the Board of Trustees, and not less than three (3) additional members. Subject to the limitations set forth in Section 4.1 hereof, the Chairman shall

have the right to appoint persons who are not members of the Board of Trustees, to the Committee.

Section 4.4 Tenure of Members of Committees of the Board. Each committee of the Board of Trustees and every member thereof shall serve at the pleasure of the Board and for such terms as the Board shall determine. The Board of Trustees shall have the power at any time to change the membership of any committee, to fill vacancies, and to discharge any such committees. The Board of Trustees may designate one or more Trustees as alternate members of any Committee, who may replace any absent or disqualified member at any meeting of any such Committee.

Section 4.5 Meetings. Meetings of committees, of which no notice shall be necessary, shall be held at such time and place as shall be fixed by the Chairman or President of the Corporation or the Chair of the committee or by a vote of a majority of all of the members of the committee.

Section 4.6 Quorum and Manner of Acting. Unless otherwise provided by resolution of the Board of Trustees, and subject to the limitations set forth in Section 4.1 hereof, a majority of all of the members of a committee shall constitute a quorum for the transaction of business. Except as otherwise set forth in these Bylaws, a vote by a majority of the members present at a meeting at which a quorum is present shall constitute valid action taken by the Committee in question. The procedures and manner of acting of the committees of the Board of Trustees shall be subject at all times to the directions of the Board of Trustees.

Section 4.7 Alternate Committee Members. The Board of Trustees may designate one or more Trustees as alternate members of any standing or special committee of the Board of Trustees who may replace any absent member or members at any meeting of such committee.

## ARTICLE V.

### OFFICERS

Section 5.1 Number. The Officers of the Corporation shall include: (i) a Chairman, (ii) a President, (iii) a Secretary, and (iv) a Treasurer. In addition, the Board of Trustees from time to time, may elect such other Officers and confer upon the Officers those powers and duties which it shall deem necessary or advisable for the conduct of the affairs of the Corporation. Any Officer may hold two or more offices except that the same person shall not be both President and Secretary.

Section 5.2 Election and Term of Office. The Officers shall be elected by the Trustees at the Annual Meeting of the Board unless otherwise determined by the Trustees, and shall serve until the next Annual Meeting, and until their successors are duly elected and qualified. The Chair must be a Trustee; all other Officers may be, but need not be, Trustees. Any Officer elected by the Trustees may be removed with or without cause by an affirmative vote of a majority of the Trustees then in office. Such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an officer shall not in and of itself create any contract rights.

Section 5.3 Resignation. Any Officer may resign at any time by giving written notice of such resignation to the Board, the Chairman or the Secretary. Such resignation shall take effect at the time specified therein or, if not so specified, upon its delivery to the Board, the Chairman, or the Secretary, as the case may be.

Section 5.4 Vacancies. A vacancy in any office by reason of death, resignation, removal or otherwise may be filled by the Board of Trustees for the unexpired portion of the term of such office. Every Officer so elected shall, unless sooner displaced, serve until the next Annual Meeting, and until such Officer's successor is duly elected and qualified.

Section 5.5 Duties of the Chairman. The Chairman shall preside at all meetings of the Board of Trustees. In the absence or disability of the Chairman, the President shall perform the duties and exercise all the powers of the Chairman.

Section 5.6 Duties of the President. The Board shall appoint a chief executive officer bearing the title of President who shall be its representative in the management and operation of the Corporation and shall have general care, supervision and direction of its affairs. Except as otherwise provided and subject always to control by the Board of Trustees, the President shall be responsible for the overall management of the Corporation. The President shall be accountable to the Board of Trustees for the management of the Corporation and shall report periodically to the Board of Trustees on the affairs of the Corporation as the Board of Trustees shall require. The President shall be responsible for supervising the day to day operations of the Corporation, may employ and discharge other employees of the Corporation, may approve ordinary and reasonable expenditures and contracts and sign such contracts and other documents, including, without limitation, documents and forms required by federal, state and local governments to be executed by the Corporation's officers, and shall have such other duties as may be assigned by the Board of Trustees. Consistent with the policies and directives of the Board of Trustees, the President may delegate or assign such management duties as are necessary and prudent to accomplish the objectives of the Board of Trustees.

Section 5.7 Duties of the Treasurer. The Treasurer shall maintain the books of account and shall have charge and custody of, and be responsible for, all funds and securities of the Corporation, and deposit all such funds in the name of and to the credit of the Corporation in such banks, trust companies, or other depositories as shall be selected by the Board of Trustees. The Treasurer shall ensure that a true and accurate accounting of the financial transactions of the Corporation is made and that reports of such transactions are presented to the Board of Trustees. The Treasurer shall also perform all other duties customarily incident to the office of Treasurer and such other duties as from time to time may be assigned by the Board of Trustees.

Section 5.8 Duties of the Secretary. The Secretary shall keep a record of all the meetings and proceedings of the Board of Trustees. Except as otherwise provided, the Secretary shall give or cause to be given notice, where required, of all meetings of the Trustees. The Secretary shall keep or cause to be kept a correct list of the Trustees of the Corporation, and shall perform the entire duties incident to the office of the Secretary. The Secretary shall be the custodian of the records and seal of the Corporation, and attest all acts of the Corporation when such attestation is required or deemed desirable. In the absence or disability of the Secretary, the

Secretary's duties shall be assumed by such other person or persons as the Chairman or the Board of Trustees may designate.

## ARTICLE VI.

### INDEMNIFICATION

Section 6.1 Indemnification of Employees, Officers, Trustees and Members of Committees. The Corporation shall indemnify to the fullest extent permitted by law every Trustee, employee, Officer and member of a committee or of the Corporation made a party to a proceeding by reason of such person being or having been a Trustee, employee, Officer, or member of a committee of the Corporation, against judgments, penalties, fines, settlements and reasonable expenses actually incurred, including those expenses actually incurred prior to the final disposition of such proceeding.

Section 6.2 Prohibited Indemnification. Notwithstanding Section 6.1 hereof, the Corporation 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 Trustees 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 6.3 Insurance. The Corporation is not required to purchase liability insurance for Trustees and Officers, but the Corporation may purchase such insurance if authorized and approved by the Board of Trustees. To the extent permitted by law, such insurance may insure the Corporation for any obligation it incurs as a result of this ARTICLE VI or operation of law and it may insure directly the Trustees, Officers, employees, or volunteers of the Corporation for liabilities against which they are not entitled to indemnification under this Article VI as well as for liabilities against which they are entitled or permitted to be indemnified by the Corporation.

## ARTICLE VII.

### GENERAL PROVISIONS

Section 7.1 Fiscal year. The fiscal year of the Corporation shall commence on January 1st and end as of December 31<sup>st</sup> of each year.

Section 7.2 Books and Records. There shall be kept at the office of the Corporation (i) correct and complete books and records of account; (ii) minutes of the proceedings of the Member, the Board of Trustees and any committee of the Board of Trustees; (iii) a current list of the Trustees, Officers and Member of the Corporation and their residential and business addresses; (iv) a copy of the Certificate of Incorporation of the Corporation and these Bylaws, (v) a copy of the Corporation's application for recognition of exempt status under Section 501(c)(3) of the Code (IRS Form 1023); and (vi) copies of the Foundation's past three (3) years' information returns (IRS Form 990).

Section 7.3 Corporate Seal. The Board of Trustees shall have the authority to select the inscription and form of the Foundation's corporate seal.

Section 7.4 Deposits, Checks and Notes. All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Trustees may select. All deposits shall be made in the name of the Corporation. Checks, notes, drafts, bills of exchange, acceptances, undertakings, or other instruments or orders for the payment of money shall be signed by such Officers or agents as the Trustees may from time to time designate or shall bear the facsimile signature of such Officers or agents as the Trustees may from time to time designate.

Section 7.5 Execution of Contracts. The President, Treasurer and Secretary shall have the authority, in the name of and on behalf of the Corporation, to enter into any contract or execute and deliver any instrument. The Board of Trustees, except as otherwise provided in these Bylaws, may authorize any Officer or Officers, agent or agents, in the name of and on behalf of the Corporation to enter into any contract or execute and deliver any instrument, and such authority may be general or confined to specific instances; but, unless so authorized by the Board of Trustees, or expressly authorized by these Bylaws, no Officer, agent or employee shall have any power or authority to bind the Corporation by any contract or engagement or to pledge its credit or to render it liable pecuniarily in any amount for any purpose.

Section 7.6 Conflict of Interest Policy. The Board of Trustees shall adopt, and shall cause the Corporation, the Board of Trustees and the Officers of the Corporation to adhere to, a Conflict of Interest Policy that is substantially consistent with prevailing principles and standards established for addressing conflicts of interest by applicable law, regulation and/or administrative guidance, including, but not limited to, the New York State Not-for-Profit Corporation Law and Internal Revenue Service guidance and policy.

Section 7.7 Loans. No loans shall be contracted on behalf of the Corporation unless specifically authorized by the Board of Trustees.

Section 7.8 Loans to Trustees and Officers. No loans, other than through the purchase of bonds, debentures, or similar obligations of the type customarily sold in public offerings, or through ordinary deposit of funds in a bank, shall be made by the Corporation to its Trustees or Officers, or to any other corporation, firm, association or other entity in which one or more of its Trustees or Officers are trustees, directors or officers or hold a substantial financial interest, except a loan by one Type B not-for-profit corporation to Type B not-for-profit corporation. A loan made in violation of this section shall be a violation of the duty to the Corporation of the Trustees or Officers authorizing it or participating in it, but the obligation of the borrower with respect to the loan shall not be affected thereby.

**ARTICLE VIII.**

**DIRECTION AND CONTROL OF DISPOSITION OF DONOR RESTRICTED FUNDS:  
RETAINED POWER**

Section 8.1 Notwithstanding any provision hereof to the contrary, the disposition of any donor-restricted funds or assets of the Corporation shall remain at all times under the exclusive direction and control of the Board of Trustees of the Corporation.

**ARTICLE IX.**

**AMENDMENTS**

Section 9.1 These Bylaws may be altered, amended or repealed solely by action of the Member.

\* \* \*

**Exhibit 5**

# Montefiore

THE UNIVERSITY HOSPITAL FOR  
ALBERT EINSTEIN COLLEGE OF MEDICINE

November 22, 2013

Director, Bureau of House Counsel  
Division of Legal Affairs  
NYS Department of Health  
Corning Tower, Rm 2484  
Empire State Plaza  
Albany, New York 12237

Re: Acceptance of Donations from Montefiore Foundation, Inc.

Dear Sir/Madam:

I am writing in connection with the request of Montefiore Foundation, Inc. (the “**Foundation**”) for the consent of the New York State Department of Health to the filing of the Foundation’s Certificate of Incorporation.

The Foundation is being formed to raise charitable contributions to support various affiliated Section 501(c)(3) tax-exempt charitable organizations, including, but not limited to, the following entities that are licensed health care facilities under Article 28 of the New York State Public Health Law (“**PHL**”), as indicated below (referred to collectively as the “**Licensed Supported Organizations**”):

- Montefiore Medical Center – licensed under Article 28 of the PHL as a hospital
- Montefiore New Rochelle Hospital – licensed under Article 28 of the PHL as a hospital
- Montefiore Mount Vernon Hospital – licensed under Article 28 of the PHL as a hospital
- Schaffer Extended Care Center – licensed under Article 28 of the PHL as a nursing home

In order to grant consent to the filing of a certificate of incorporation of a not-for-profit corporation that includes among its purposes the solicitation of funds to benefit a facility that is located in New York State and licensed under Article 28 of the PHL, the New York State Department of Health requires a letter from a duly-authorized representative of the intended supported organization, acknowledging that it will accept funds raised by the not-for-profit corporation. In compliance with such requirement, I hereby acknowledge, as the President of each of the Licensed Supported Organizations, that each of the Licensed Supported Organizations will accept grant funds and other distributions raised by the Foundation.

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Steven M. Safyer, MD  
President and CEO  
111 East 210th Street  
Bronx, New York 10467  
718-920-2001  
ssafyer@montefiore.org

If you have any questions or require additional information, please contact the Secretary of the Licensed Supported Organizations, Christopher Panczner, Esq., at (718) 920-7787. Thank you for your attention to this matter.

Sincerely,



Steven M. Safyer, M.D.  
President and CEO

## RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, on this 13th day of February, 2014, approves the filing of the Certificate of Incorporation of Montefiore Foundation, Inc., dated November 21, 2013.

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Anne M. Chambers d/b/a Health Beat  
Address: Inwood  
County: Nassau  
Structure: Sole Proprietorship  
Application Number: 1565L

Description of Project:

Anne M. Chambers d/b/a Health Beat, a sole proprietor, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The sole proprietor of Health Beat is the following individual:

Anne Marie Chambers, Nursing Assistant  
Privately employed

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located in Nassau County:

Nassau                      Westchester                      Queens

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Respiratory Therapy	Occupational Therapy
Speech-Language Pathology	Audiology	Medical Social Services
Nutrition	Homemaker	Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: December 10, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: F & H Homecare, Inc. d/b/a Visiting Angels  
Address: Bronx  
County: Bronx  
Structure: For-Profit Corporation  
Application Number: 1646-L

Description of Project:

F & H Homecare, Inc. d/b/a Visiting Angels, a for-profit corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

F & H Homecare, Inc. has proposed to operate as a Franchisee of Living Assistance Services, Inc. (Visiting Angels).

The applicant has authorized 1,000 shares of stock, which are owned as follows:

Fafa A. Mensah, RN – 500 shares Registered Nurse, Visiting Nurse Service of New York	Harris Cofie – 500 shares Retired
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The Board of Directors of F & H Homecare, Inc. d/b/a Visiting Angels comprises the following individuals:

Fafa A. Mensah, RN – Chairman/Treasurer (Previously Disclosed)	Harris Cofie – Vice Chairman/Secretary (Previously Disclosed)
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The Office of the Professions of the State Education Department indicates no issues with the licensure of the health professional associated with this application.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of Bronx and Queens Counties from an office to be located in Bronx County.

The applicant proposes to provide the following health care services:

Nursing	Personal Care	Home Health Aide
Housekeeper	Homemaker	

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: November 11, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Gentle Care Home Services of NY, Inc.  
Address: Staten Island  
County: Richmond  
Structure: For-Profit  
Application Number: 1657-L

Description of Project:

Gentle Care Home Services of NY, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock, which are owned as follows:

Mikhail Komissarenko, 150 shares Senior Chemist, Chanel	Evelina Tuers, RN (NY & NJ) – 50 shares Registered Nurse, St. Luke’s Roosevelt Hospital
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The board members of Gentle Care Home Services of NY, Inc. comprise the following individuals:

Mikhail Komissarenko – President (Previously Disclosed)	Evelina Tuers – Executive Director (Previously Disclosed)
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The Office of the Professions of the State Education Department indicates no issues with the licensure of the health professional associated with this application.

Evelina Tuers is licensed as a registered nurse in the state of New Jersey, license number 13300200. The New Jersey State Board of Examiners indicates Evelina Tuers’s license is currently active and there are no issues with the licensure of this health professional.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 1 Monroe Avenue, Staten Island, New York, 10301:

Bronx	Kings	New York	Richmond
Queens			

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Occupational Therapy	Speech-language Pathology
Homemaker	Personal Care	Physical Therapy	Medical Social Services
Housekeeper			

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: November 27, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Gentle Touch Home Care Agency, Inc.  
Address: Brooklyn  
County: Kings  
Structure: For-Profit Corporation  
Application Number: 1709-L

Description of Project:

Gentle Touch Home Care Agency, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock, which are owned as follows:

Khem C. Sharma – 100 shares  
Owner/President, Gemini Quality Care, Inc.

Jacques C. Antoine, MD – 100 shares  
President, East Brooklyn Medical

The Board of Directors of Gentle Touch Home Care Agency, Inc. comprises the following individuals:

Khem C. Sharma – President, Secretary  
(Previously Disclosed)

Jacques C. Antoine, MD – Vice President, Treasurer  
(Previously Disclosed)

The Office of the Professions of the State Education Department, the New York State Physician Profile and the Office of Professional Medical Conduct, where appropriate, indicate no issues with the licensure of the health professional associated with this application.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

The applicant proposes to serve the residents of the following counties from an office located at 1718 Pitkin Avenue, Brooklyn, New York 11212:

Bronx                      Kings                      New York                      Queens                      Richmond

The applicant proposes to establish a second site in Nassau County to service the residents of the following counties:

Nassau                      Suffolk                      Westchester

The applicant proposes to provide the following health care services:

Nursing                      Personal Care                      Home Health Aide                      Homemaker  
Housekeeper                      Physical Therapy                      Occupational Therapy                      Speech-Language Pathology  
Nutrition                      Medical Social Services                      Respiratory Therapy

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: November 13, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Igbans Home Care Services, Inc.  
Address: Queens  
County: Queens  
Structure: Not-For-Profit Corporation  
Application Number: 2092-L

Description of Project:

Igbans Home Care Services, Inc., a not-for-profit corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The Board of Directors of Igbans Home Care Services, Inc. comprises the following individuals:

Nelson U. Igbanugo, HHA – Director/CEO Case Manager, City of New York Director, Igbans Institute	Juliet Mogu, HHA, CNA – Vice President (Operations) Case Manager, City of New York
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Emmanuel Nwozuzu, Ph.D., RN,  
Vice President (Administration)  
Retired

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The New York State Home Care Registry revealed that Nelson Ugbanugo and Juliet Mofu are certified as a HHA's, and have no convictions or findings.

A search of the individual named above on the New York State Nurse Aide Registry revealed that Juliet Mogu is certified as a CNA, and has no convictions or findings.

The applicant proposes to serve the residents of the following counties from an office located at 216-19 Merrick Blvd, Queens, New York 11413:

Bronx	Kings	New York
Richmond	Queens	Nassau

The applicant proposes to provide the following health care services:

Nursing	Personal Care	Home Health Aide
Homemaker	Housekeeper	

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: December 31, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Marina Homecare Agency of NY, Inc.  
Address: Riverhead  
County: Suffolk  
Structure: For-Profit Corporation  
Application Number: 1928-L

Description of Project:

Marina Homecare Agency of NY, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned solely by Helene Korbin.

The Board of Directors of Marina Homecare Agency of NY, Inc. comprises the following individual:

Helene Korbin, Esq., President  
Partner, Hilgendorff & Korbin  
Owner, Comfort Keepers (companion care agency)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

A Certificate of Good Standing has been received for the attorney.

The applicant proposes to serve the residents of the following counties from an office located at 31 Main Road, Suite 9, Riverhead, New York 11901:

Nassau	Suffolk	Queens	Westchester
Rockland	Putnam	Dutchess	Orange
Ulster	Sullivan		

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Respiratory Therapy
Speech Language Pathology	Audiology	Medical Social Services
Nutrition	Homemaker	Housekeeper

Review of the disclosure information indicates that the applicant has no affiliations with other health care facilities.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: November 19, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Westchester Homecare, Inc.  
d/b/a FirstLight HomeCare of Westchester  
Address: Somers  
County: Westchester  
Structure: For Profit Corporation  
Application Number: 2139-L

Description of Project:

Westchester Homecare, Inc. d/b/a FirstLight HomeCare of Westchester, a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

Westchester Homecare, Inc. d/b/a FirstLight HomeCare of Westchester has authorized 200 shares of stock which are owned as follows: 101 shares of stock are owned by Laura McMahon, 98 shares of stock are owned by Vincent McMahon and 1 share of stock is owned by Therese Reilly, R.N.

The members of the Board of Directors of Westchester Homecare, Inc. d/b/a FirstLight HomeCare of Westchester comprise the following individuals:

Laura McMahon, Chairperson Retired	Vincent McMahon, Vice Chairperson Retired
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Therese Reilly, R.N., Board Member  
Patient Care Supervisor,  
FirstLight HomeCare of Westchester

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of Westchester County from an office located at 51 Stonehouse Road, Somers, New York 10589.

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care	Homemaker
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Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: December 16, 2013

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Foster Nurses Agency USA, Inc.  
Address: New York  
County: New York  
Structure: For Profit Corporation  
Application Number: 2224-L

Description of Project:

Foster Nurses Agency USA, Inc., a business corporation, requests approval for a change in ownership of a licensed home care services agency under Article 36 of the Public Health Law.

Nasreen Khan d/b/a Foster Nurses Agency was previously approved as a licensed home care services agency by the Public Health Council at its November 22, 1991 meeting and subsequently licensed as 9214L001. On June 6, 2012, the agency underwent a change of ownership from the sole proprietorship to Foster Nurses Agency USA, Inc. The corporation authorized and issued 200 shares of stock to Nasreen Khan as the sole shareholder.

Nasreen Khan and Foster Nurses Agency are currently excluded from participation in Medicaid by the Office of the Medicaid Inspector General. In March 2013 Nasreen Khan resigned her position as president of the corporation and transferred 90% of the shares to Anu Khan and 10% to Mahammed Akram Khan.

The applicant is now requesting approval for the change in ownership of this agency to Foster Nurses Agency USA, Inc. with Anu Khan owning 180 shares and Mohammad Akram Khan owning 20 shares.

The Board of Directors of Foster Nurses Agency USA, Inc. comprises the following individuals:

Anu Khan, L.P.N., Chairperson/Secretary Director of Patient Services, Foster Nurses Agency USA, Inc.	Mohammad Akram Khan, Vice Chairperson/Treasurer Bookeeping and Accounting Director, Foster Nurses Agency USA, Inc.
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A search of the Medicaid Disqualified Provider List and the OIG Exclusion List revealed no matches for Anu Khan and Mohammad Akram Khan.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 316 5<sup>th</sup> Avenue, Suite 404B, New York, New York 10001:

New York  
Kings

Bronx  
Queens

Richmond  
Nassau

The applicant proposes to provide the following health care services:

Nursing  
Physical Therapy  
Homemaker  
Nutrition

Home Health Aide  
Occupational Therapy  
Housekeeper  
Audiology

Personal Care  
Speech-Language Pathology  
Medical Social Services  
Respiratory Therapy

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: January 14, 2014

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 13th day of February, 2014, having considered any advice offered by the staff of the New York State Department of Health and the Establishment and Project Review Committee of the Council, and after due deliberation, hereby approves the following applications for licensure, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER:</u>	<u>FACILITY:</u>
1565 L	Anne M. Chambers d/b/a Health Beat (Nassau, Queens, and Westchester Counties)
1646 L	F & H Homecare, Inc. d/b/a Visiting Angels (Bronx County)
1657 L	Gentle Care Home Services of NY, Inc. (Bronx, Kings, New York, Queens, and Richmond Counties)
1709 L	Gentle Touch Home Care Agency, Inc. (Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester Counties)
2140 L	Hardings Beach, LLC d/b/a Home Instead Senior Care (Monroe County)

- 2092 L Igbans Home Care Services, Inc.  
(Bronx, Kings, Nassau, New York, Queens, and  
Richmond Counties)
- 1928 L Marina Homecare Agency of NY, Inc.  
(Dutchess, Nassau, Orange, Putnam, Queens,  
Rockland, Suffolk, Sullivan, Ulster and Westchester  
Counties)
- 2139 L Westchester Homecare, Inc. d/b/a FirstLight  
HomeCare of Westchester  
(Westchester County)
- 2224 L Foster Nurses Agency USA, Inc.  
(Bronx, Kings, Nassau, New York, Queens and  
Richmond Counties)
- 2213 L Genesee Region Home Care of Ontario County, Inc.  
d/b/a Home Care Plus  
(See exhibit for Counties to be served)



# Public Health and Health Planning Council

Project # 131036 E  
**Little Neck Care Center**

**County: Queens County**  
**Purpose: Establishment**

**Program: Residential Health Care Facility**  
**Acknowledged: January 25, 2013**

## Executive Summary

### Description

Little Neck Care Center, an existing proprietary LLC and a 120-bed Residential Health Care Facility (RHCF) located at 260-19 Nassau Blvd in Little Neck is seeking approval for an 82.5% transfer in ownership.

Ownership of the facility before and after the requested change is as follows:

#### Current

<u>Name</u>	<u>Percentages</u>
Bent Philipson	50%
Esther Farkovits	50%

#### Proposed

<u>Name</u>	<u>Percentages</u>
Bent Philipson	17.5%
Judy Landa	42.5%
David Rubenstein	15.0%
Leah Freidman	12.5%
Rochel David	12.5%

The transfer price is approximately \$12,060.25 per percentage; therefore, the total purchase price is \$994,930.31, which is broken down as follows:

<u>Transferee</u>	<u>Purchase Price</u>
Judy Landa	\$512,560.33
David Rubenstein	\$180,903.72
Leah Friedman	\$150,733.13
Rochel David	\$150,733.13

The transfer agreements have been executed between current members and proposed members at above stated prices, and the transfer of the interests will be

made when all necessary regulatory and lender approvals have been made.

Judy Landa currently has 25.75% membership interest in West Lawrence Care Center, a 215-bed RHCF in Far Rockaway.

The proposed members have submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring interest, without releasing the transferor of its liability and responsibility.

DOH Recommendation  
Contingent Approval

Need Summary  
Transfer of stock does not require a Need Review.

Program Summary  
No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

Financial Summary

There are no project costs associated with this application.

Budget:	Revenues:	\$11,757,119
	Expenses:	<u>11,418,610</u>
	Gain:	\$ 338,509

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

## Recommendations

Health Systems Agency

There is no HSA recommendation for this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of an operating agreement acceptable to the department. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date

**February 13, 2014**

## Need Analysis

### Recommendation

Transfer of stock does not require a Need Review.

## Programmatic Analysis

### Facility Information

	Existing	Proposed
Facility Name	Little Neck Care Center	Same
Address	260-19 Nassau Blvd. Little Neck, NY 11362	Same
RHCF Capacity	120	Same
ADHC Program Capacity	N/A	Same
Type of Operator	Limited Liability Company	Same
Class of Operator	Proprietary	Same
Operator	Little Neck Care Center, LLC  <u>Members:</u> Esther Farkovits      50.00% Bent Philipson        50.00%	Little Neck Care Center, LLC  <u>Existing Member:</u> Bent Philipson        17.50% <u>New Members:</u> Judy Landa            42.50% David Rubenstein    15.00% Leah Friedman        12.50% Rochel David <u>12.50%</u> 100.00%

### Character and Competence Background

#### Facilities Reviewed

Brookhaven Rehabilitation & Health Care Center LLC	04/2001 to 02/2009
Fort Tryon Center for Rehabilitation and Nursing	11/2002 to 01/2009
Franklin Center for Rehabilitation and Nursing	11/2002 to 01/2009
Highfield Gardens Care Center of Great Neck (formerly Wedgewood Care Center)	11/2003 to 11/2005
West Lawrence Care Center	09/2003 to present

### Individual Background Review

**Judy Landa** reports no employment during the past ten years. Ms. Landa has disclosed the following health care facility interests with dates of ownership, as follows:

Brookhaven Rehabilitation and Health Care Center	04/2001 to 02/2009
Fort Tryon Center for Rehabilitation and Nursing	11/2002 to 01/2009
Franklin Center for Rehabilitation and Nursing	11/2002 to 01/2009
Highfield Gardens Care Center of Great Neck (formerly Wedgewood Care Center)	01/1997 to 11/2005
West Lawrence Care Center	09/2003 to present

**David Rubenstein** is dually employed as administrator at Garden State Health Care Administrators and United Health Administrators, both in the insurance industry. Mr. Rubenstein discloses no ownership interests in health care facilities.

**Leah (Zahler) Friedman** lists her current employment in human resources/payroll with Confidence Management Systems LLC, which provides housekeeping and laundry facilities to the healthcare industry. Ms. Friedman discloses no ownership interests in health care facilities.

**Rochel (Zahler) David** lists her current employment in human resources/payroll with Confidence Management Systems LLC, which provides housekeeping and laundry facilities to the healthcare industry. Ms. David discloses no ownership interests in health care facilities.

### **Character and Competence Analysis**

No negative information has been received concerning the character and competence of the above applicants identified as new members.

A review of Brookhaven Rehabilitation & Health Care Center, LLC for the period identified above reveals the following:

- The facility was fined \$2,000 pursuant to a Stipulation and Order issued April 3, 2009 for surveillance findings on April 25, 2008. Deficiencies were found under 10 NYCRR 415.12 - Quality of Care: Accidents.

A review of Highfield Gardens Care Center of Great Neck for the period identified above reveals the following:

- The facility was fined \$1,000 pursuant to a Stipulation and Order issued August 16, 2005 for surveillance findings on August 27, 2004. Deficiencies were found under 10 NYCRR 415.12(c)(2) - Quality of Care: Pressure Sores.

A review of operations for Brookhaven Rehabilitation & Health Care Center, LLC and Highfield Gardens Care Center of Great Neck, for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no repeat enforcements.

A review of operations for the Fort Tryon Center for Rehabilitation and Nursing, Franklin Center for Rehabilitation and Nursing and West Lawrence Care Center for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

No changes in the program or physical environment are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Operating Budget

Following is a summary of the submitted operating budget, presented in 2013 dollars, for the first year subsequent to change in ownership:

Revenues:	
Medicaid	\$6,667,119
Medicare	3,200,000
Private Pay/Other	<u>1,890,000</u>
Total	\$11,757,119
Expenses:	
Operating	\$10,730,397
Capital	<u>688,213</u>
Total	\$11,418,610
Net Income	<u>\$ 338,509</u>

- Medicaid capital component is based on the return of and return on equity methodology.
- Medicare and private pay revenues are based on current payment rates.
- Overall utilization is projected at 95.9%.
- Payor mix is based on an average utilization between 2011 and 2012.
- Utilization by payor source is anticipated as follows:

Medicaid	73.1%
Medicare	11.9%
Private/Other	15.0%
- Breakeven utilization is projected at 93.1%.

### Capability and Feasibility

There are no project costs associated with this application. The total purchase price for the transfer of the 82.5% ownership is \$994,930.31. BFA Attachment A is the Net Worth Statements for proposed member, which shows sufficient equity.

Working capital requirements are estimated at \$1,903,102 based on two months' of first year expenses, and will be satisfied from proposed members' equity. Review of BFA Attachment A, net worth of proposed members, reveals sufficient resources to satisfy the working capital requirements.

The submitted budget indicates that a net income of \$338,509 would be maintained during the first year following change in ownership. DOH staff has noted a fluctuation in payor mix between 2012 and current 2013, and has therefore sensitized the budgets, which still show a net profit. BFA Attachment E is the sensitized budget based on August 31, 2013 historical census. BFA Attachment B presents the pro-forma balance sheet of Little Neck Care Center. As shown, the facility will initiate operation with \$568,000 members' equity. The budget appears reasonable.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology, to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

Review of BFA Attachment C, financial summary of Little Neck Care Center, shows a slight negative working capital in 2011, positive net equity, and a net loss from operations of \$1,267,902 due to a

Medicaid retroactive adjustment not accounted for. The 2012 certified financials show a \$249,709 net loss from operations due from a Medicaid recoupment adjustment and losses ceased as of 2013, showing a net income of \$1,301,044 as of August 31, 2013.

BFA Attachment D is the financial summary of West Lawrence Care Center. As shown, the facility had an average negative working capital position and an average positive net asset position from 2010 through 2012. The reason for the negative working capital position is that the facility experienced historical losses. Also, the facility incurred average historical losses of \$81,385 from 2010 through 2012. The applicant has indicated that the reasons for the losses are retroactive rate reductions of \$833,857 in 2011, and the losses in 2012 resulted from approximately \$40 per patient day reduction in the facility's Medicaid rate. The applicant implemented the following steps to improve operations: reevaluating staff patterns; decreasing excess staff without adversely effecting patient care; and aggressively restructuring contracts and insurance policies.

Based on the preceding, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendation

**From a financial perspective, approval is recommended.**

## Attachments

BFA-Attachment A	Net Worth of Proposed Members
BFA-Attachment B	Pro-forma Balance Sheet, Little Neck Care Center
BFA-Attachment C	Financial Summary, Little Neck Care Center
BFA-Attachment D	Financial summary , West Lawrence Care Center
BFA Attachment E	Sensitized Budget based on August 31, 2013 Historical Census

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 13th day of February, 2014, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to transfer 82.5 percent ownership to four new members, 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:

131036 E

Little Neck Care Center

APPROVAL CONTINGENT UPON:

1. Submission of an operating agreement acceptable to the department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 131159 E Morningside Acquisition I, LLC d/b/a Morningside House Nursing Home

**County:** Bronx County  
**Purpose:** Establishment

**Program:** Residential Health Care Facility  
**Acknowledged:** April 8, 2013

### Executive Summary

#### Description

Morningside Acquisition I, LLC, d/b/a Morningside House Nursing Home (Morningside House) requests approval to be established as the operator of Morningside House Nursing Home Company, Inc., a 362-bed not-for-profit residential health care facility (RHCF) located at 1000 Pelham Parkway South. Morningside House also has two offsite adult day health care programs (ADHCP) with a total of 70 slots, a long term home health care program (LTHHCP) serving Bronx County, and licensed home care services agency (LHCSA). A separate application will be filed for the change in ownership of the LHCSA. CON 131126 has been approved for the decertification of 48 beds and is pending finalization from the Regional Office; therefore the acquisition will be for 314 beds. Ownership of the operation and real estate before and after the requested change is as follows:

<b>CURRENT MEMBERSHIP</b>		<b>PROPOSED MEMBERSHIP</b>	
<u>Operation</u>		<u>Operation</u>	
Morningside House Nursing Home Company, Inc.	100%	Morningside Acquisition I, LLC d/b/a Morningside House Nursing Home:	
		Alex Solovey	35%
		Pasquale DeBenedictis	35%
		Soloman Rutenberg	20%
		Joseph F. Carrillo II	10%
<u>Real Property</u>		<u>Real Property</u>	
Morningside House Nursing Home Company, Inc.	100%	Morningside Acquisition II, LLC.	
		Alex Solovey	35%
		Pasquale DeBenedictis	35%
		Soloman Rutenberg	20%
		Joseph F. Carrillo II	10%

Joseph Carrillo, II, Pasquale DeBenedictis and Alex Solovey currently have membership interests in Petite Fleur Nursing Home, a 180-bed RHCF located in Sayville; Mills Pond Nursing and Rehabilitation Center, a 250-bed RHCF located in St. James; East Neck Nursing and Rehabilitation Center, a 300-bed RHCF

located in West Babylon; and Barnwell Nursing and Rehabilitation Center, a 236-bed RHCF located in Valatie.

Joseph Carrillo, II also currently has membership interest in Carillon Nursing and Rehabilitation Center, a 315-bed RHCF located in Huntington.

DOH Recommendation  
Contingent Approval

Need Summary  
The change in ownership will not result in any change in beds or services.

The facility has operated below the county average and the department's 97% planning optimum for 2009, 2010, and 2011. Utilization decreased due to patient displacement while the facility was being renovated.

Program Summary  
No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

Financial Summary  
The purchase price for the operating assets is \$6,349,040 and the real property is \$33,650,960, totaling \$40,000,000. The purchase price will be paid with a bank loan of \$32,000,000 for the real property and operations, and \$8,000,000 of member's equity.

There are no project costs associated with this application.

Budget:	Revenues:	\$47,618,580
	Expenses:	<u>46,484,585</u>
	Net Income:	\$ 1,133,995

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There is no HSA recommendation for this application.

Office of Health Systems Management

**Approval contingent upon:**

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - a) Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b) Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c) Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - d) Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]

3. Submission of an executed building lease, acceptable to the Department. [BFA, CSL]
4. Submission of a loan commitment for working capital, acceptable to the Department. [BFA]
5. Submission of a commitment, acceptable to the Department, for a permanent mortgage from a recognized lending institution at a prevailing rate of interest. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and old refinanced debt. [BFA]
6. Submission of a photocopy of the executed Certificate of Amendment of the Articles of Organization of Morningside Acquisition I, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of an executed amended Operating Agreement of Morningside Acquisition I, LLC, acceptable to the Department. [CSL]
8. Submission of a photocopy of an executed Certificate of Assumed Name of Morningside Acquisition I, LLC, acceptable to the department. [CSL]
9. Submission of a fully executed proposed Certificate of Amendment of the Certificate of Incorporation or Certificate of Dissolution of Morningside Nursing Home Company, Inc. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Morningside Acquisition I, LLC is seeking approval to become the new operator/owner of Morningside House Nursing Home Company, Inc., a 314 bed nursing home located at 1000 Pelham Parkway South, Bronx, 10461, in Bronx County.

## Analysis

There is currently an unmet need of 8,862 beds in the New York City region as shown in Table 1. However, overall occupancy is 94.8% as indicated in Table 2.

Table 1: RHCF Need – NYC Region

2016 Projected Need	51,071
Current Beds	41,895
Beds Under Construction	314
Total Resources	42,209
Unmet Need	8,862

Morningside Acquisition I, LLC utilization was lower than that of Bronx County for 2009, 2010, and 2011 as shown in Table 2.

Table 2: RHCF – Morningside House Nursing Home /Bronx County Occupancy

Facility/County/Region	2009	2010	2011
Morningside House Nursing Home	95.6%	93.0%	86.5%
Bronx County	96.0%	95.8%	94.3%
NYC	94.9%	95.4%	94.8%

From 2011 to August 2013, Morningside converted 48 RHCF beds to assisted living beds with the assistance of a HEAL grant. The decrease in RHCF bed utilization at Morningside during this period is the result of the construction associated with this conversion of RHCF bed space to ALP functions.

## Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage of health Systems Agency percentage, whichever is applicable.

Morningside House Nursing Home was above the 75 percent planning average for 2010 and 2011. The facility reported Medicaid admissions of 43.13 percent in 2010 and 48.25 percent in 2011. The 75 percent planning averages for Bronx County for 2010 and 2011 were 34.1 percent and 37.5 percent respectfully.

## Conclusion

The new owners will continue to make this RHCF an asset to local residents through an updated facility that will restore its occupancy to more optimum levels.

## Recommendation

**From a need perspective, contingent approval is recommended.**

## Programmatic Analysis

### Establishment Application Review

#### Character and Competence Background

##### Facility Information

	Existing	Proposed
Facility Name	Morningside House Nursing Home Company Inc	Morningside House Nursing Home
Address	1000 Pelham Parkway South Bronx, New York 10461	Same
RHCF Capacity	314	Same
ADHC Program Capacity	70	Same
Type of Operator	Not for Profit Corporation	Limited Liability Company
Class of Operator	Voluntary	Proprietary
Operator	Morningside House Nursing Home Company Inc	Morningside Acquisition I, LLC d/b/a Morningside House Nursing Home  Members: Pasquale DeBenedictis 35% Alex Solovey 35% Soloman Rutenberg 20% Joseph F. Carillo, II 10%

##### Facilities Reviewed

Carillon Nursing and Rehabilitation Center	05/2003 to present
Barnwell Nursing and Rehabilitation Center	10/2003 to present
East Neck Nursing and Rehabilitation Center	02/2006 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	05/2013 to present
Carillon Dialysis Center	10/2003 to present
Norwalk Acquisition I Nursing Home d/b/a Cassena Care at Norwalk (Connecticut)	08/2013 to present

##### Individual Background Review

**Pasquale DeBenedictis** is the director of finance at Carillon Nursing and Rehabilitation since 1997. Mr. DeBenedictis has disclosed ownership interest in the following health care facilities:

Barnwell Nursing and Rehabilitation Center	11/2003 to present
East Neck Nursing and Rehabilitation Center	02/2005 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	05/2013 to present
Norwalk Acquisition I Nursing Home d/b/a Cassena Care at Norwalk (Connecticut)	08/2013 to present

**Alexander Solovey** is a New York State licensed physical therapist in good standing. He is the director of rehabilitation at Theradynamics Physical Therapy Rehabilitation P.C. since 1999. Mr. Solovey disclosed ownership interest in the following health care facilities:

Barnwell Nursing and Rehabilitation Center	11/2003 to present
East Neck Nursing and Rehabilitation Center	02/2005 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	05/2013 to present
Norwalk Acquisition I Nursing Home d/b/a Cassena Care at Norwalk (Connecticut)	08/2013 to present

**Joseph F. Carillo II** holds an active New York Nursing Home Administrator's License in good standing. He is the Administrator at Carillon Nursing and Rehabilitation since 1986. He has disclosed ownership interest in the following health care facilities:

Carillon Nursing and Rehabilitation Center	01/1999 to present
Barnwell Nursing and Rehabilitation Center	10/2003 to present
East Neck Nursing and Rehabilitation Center	02/2006 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	05/2013 to present
Carillon Dialysis Center	10/2003 to present

**Soloman Rutenberg** is employed as CEO at Workmen's Circle Multicare Center (SNF) since 2006. He disclosed ownership interest in the following health care facility:

Workmen's Circle Multicare Center	07/2013 to present
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### **Character and Competence Analysis**

No negative information has been received concerning the character and competence of the above applicants identified as new members.

A review of operations for Barnwell Nursing & Rehabilitation Center, Carillon Nursing and Rehabilitation Center, East Neck Nursing and Rehabilitation Center, Mills Pond Nursing and Rehabilitation Center, Petite Fleur Nursing Home, and Workmen's Circle Multicare Center, for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Asset Purchase Agreement

The change in ownership will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized below:

Date:	February 4, 2013
Seller:	Morningside House Nursing Home Company, Inc.
Purchaser:	Morningside Acquisition I, LLC
Purchased Assets:	All rights, title and interest in all assets exclusively used in the operation of the business to include fixed equipment; non-fixed equipment; assigned contracts; all resident and patient records; all policy and procedural manuals related solely to the operation of the businesses; the Medicare and Medicaid provider numbers and provider agreements to the extent assignable; any and all permits; tax and accounting records and goodwill.
Excluded Assets:	All cash; cash equivalents; short term investments; accounts receivable or any amounts due from third parties prior to the closing date; resident prepayments; any credits prepaid expenses; deferred charges, advance payments, security deposits; benefits and rights to reimbursement available under insurance policies; any personnel records required by law to be retained; all tax losses, refunds, credits, or other similar benefits; any and all claims against third parties including, but not limited to all retroactive rate increases and lump sum or other payments prior to the closing date and certain items in the Chapel.
Assumed Liabilities:	All claims, liabilities and obligations of any kind or nature incurred in the conduct of the business from and after the closing date.

Excluded Liabilities: All claims, liabilities and obligation of any kind or nature incurred in the conduct of the business prior to the closing date.  
Purchase Price: \$6,349,040  
Purchase Terms: Paid in full at closing.

**Real Property Sale Agreement**

The change in real property will be effectuated in accordance with the executed real property sale agreement, the terms of which are summarized below:

Date: February 4, 2013  
Seller: Morningside House Nursing Home Company, Inc.  
Purchaser: Morningside Acquisition II, LLC  
Purchase Price: \$33,650,960  
Purchase Terms: \$2,000,000 down payment with the remaining \$31,650,960 paid in full at closing.  
Closing Date: Transactions to take place concurrently with the closing of the Asset Purchase Agreement.

The applicant has provided a letter of interest from Greystone stating available financing of \$32,000,000 at 6% for a term of thirty years, with the remaining balance of \$8,000,000 to be paid with equity from the proposed members. BFA Attachment B is the net worth statements of the proposed members, which indicates available resources. Each proposed member has submitted an affidavit stating he will contribute resources disproportionate to ownership percentages.

The applicant has submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility.

**Lease Agreement**

The applicant has submitted a draft lease agreement, the terms of which are summarized below:

Premises: A 362-bed RHCF located at 1000 Pelham Parkway South, Bronx  
Lessor: Morningside Acquisition II, LLC  
Lessee: Morningside Acquisition I, LLC  
Terms: 30 years with the option to renew for an additional 10 years.  
Rental: \$3,548,840/year  
Provisions: Lessee responsible for taxes, utilities, insurance and maintenance.

The lease arrangement is a non-arm's length agreement. The applicant has submitted an affidavit attesting to the relationship between the landlord and operating entity.

**Operating Budget**

The applicant has submitted an operating budget, in 2013 dollars, for the first and third year subsequent to change in ownership:

<u>RHCF</u>	<u>Year One</u>	<u>Year Three</u>
Revenues:		
Medicaid	\$28,813,125	28,426,817
Medicare	5,391,708	7,019,863
Private/Other	993,611	1,347,812
Total Revenues	\$35,198,444	\$36,794,492
Expenses:		
Operating	\$29,963,856	\$30,191,450
Capital	5,712,115	5,712,115
Total Expenses	\$35,675,971	\$35,903,565

Net Loss/Income:	\$(477,527)	\$890,927
Utilization (patient days):	111,172	112,318
Occupancy:	97.0%	98.0%

The following is noted with respect to the submitted RHC operating budget:

- The reduction of 48 beds increases the budgeted occupancy levels from historical and is based on historical 2012 occupancy.
- Medicare and private pay assume current rate of payment.
- Medicaid rates are based on 2013 Medicaid pricing rates with no trend.
- The capital component of the Medicaid rate is based on the return of and return on equity reimbursement methodology.
- Utilization by payor source for year one and three is expected as follows:

	<u>Year One</u>	<u>Year Three</u>
Medicaid	89.60%	87.50%
Medicare	8.44%	10.00%
Private/Other	1.96%	2.50%

- The slight shift in 2012 and budgeted Medicaid and Private Pay is based on past experience of the proposed operators as a result of meetings with local community leaders, local hospitals and local physicians to determine specific community needs and offer programs that are responsive to the need in the area.
- Breakeven occupancy is projected at 93.3%

#### ADHCP

Revenues:	<u>Year One</u>	<u>Year Three</u>
Medicaid	\$1,278,147	\$1,365,293
Private	<u>386,270</u>	<u>412,607</u>
Total Revenues	\$1,664,417	1,777,900
Expenses:	\$1,613,517	\$1,613,517
Net Income:	\$50,900	\$164,383
Visits:	13,728	14,664
Cost per Visit:	\$117.53	\$110.03

Utilization by payor source is as follows:

Medicaid	85%
Private	15%

#### LTHHCP

Revenues:	<u>Year One</u>	<u>Year Three</u>
	\$7,866,307	\$9,046,188
Expenses:	<u>8,349,395</u>	<u>8,967,503</u>
Net Loss/Income:	\$(483,088)	\$78,685

Utilization by payor source is as follows:

Medicare Fee for Service	8.5%
Medicaid Managed Care	89.5%
Charity Care	2.0%

Expenses and utilization are based on the historical experience of current services within the facility.

The combined revenues and expenses for the first and third years of operation are as follows:

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$44,729,168	\$47,618,580
Expenses:	<u>45,638,883</u>	<u>46,484,585</u>
Net Loss/Income:	\$(909,715)	\$1,133,995

#### Capability and Feasibility

The purchase price of \$6,349,040 for the operations and \$33,650,960 for the property will be financed with a total bank loan of \$32,000,000 at stated terms, with the remaining \$8,000,000 from proposed member's equity. BFA Attachment B, the net worth statements of the proposed members, indicates available resources.

Working capital requirements are estimated at \$7,606,481, based on two months of first year expenses. The applicant will finance \$3,803,240 of working capital at an interest rate of 6% over 5 years for which a letter of interest has been provided by Greystone. The remaining \$3,803,241 will be provided as equity from the proposed members. BFA Attachment C is the pro-forma balance sheet of Morningside House Nursing Home. As shown, the facility will initiate operation with \$3,803,241 member's equity.

The budget indicates a net loss of \$909,715 during the first year and a net income of \$1,133,995 during the third year subsequent to change in ownership. The budget appears reasonable. Following is a comparison of historical and projected third year revenues and expenses:

Projected Income	\$47,618,580
Projected Expense	<u>46,484,585</u>
Projected Net Profit	\$1,133,995
2012 Operating Revenues	\$46,192,545
2012 Operating Expense	<u>50,532,904</u>
2012 Net Loss	\$(4,340,359)
Incremental Net Income	\$5,474,354

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

Review of BFA Attachment D, financial summary of Morningside Nursing Home Company, Inc., indicates the facility experienced negative working capital, generated positive equity and experienced an average net loss of \$5,012,872 for the period shown between 2010 and 2012. The applicant has stated that the losses were due to years of the facilities cost of operations exceeding the allowable reimbursable rates and occupancy affected due to construction on the A-5 unit and the delay in issuance of the approval to decertify 48 RHCf beds and certify 40 assisted living beds. Between 2011 and 2012, the existing operator has reduced expenses by approximately \$3,400,000. To improve operations and further reduce expenses without interruption of patient services the proposed new owners will do the following:

- The proposed operators have a central business office that coordinates and handles all of the financial office and administrative support services, which will result in a decrease in expenses of approximately \$704,659.
- Reductions in administrative and direct nursing services will result in a decrease in expenses of approximately \$3,474,804.
- Services such as grounds/security, housekeeping, medical records and dietary services will be reduced further by approximately \$1,162,469.

Review of BFA Attachments E, F, G, and H, financial summaries of Barnwell Nursing and Rehabilitation Center, Carillon Nursing and Rehabilitation Center, East Neck Nursing and Rehabilitation Center, and Mills Pond Nursing and Rehabilitation Center, indicates these facilities have maintained average positive working capital and equity and generated average positive net income for 2011-2012. As of July 31, 2013, the facilities maintained positive working capital and equity and generated positive net income, with the exception of Mills Pond Nursing & Rehabilitation Center, which experienced negative working capital due to a misclassification on the balance sheet for a long term liability classified as current relating to Jopal Realty.

Review of BFA Attachment I, financial summary of Petite Fleur Nursing Home, which was acquired December 21, 2012, indicates the facility has maintained positive working capital and equity and generated a net income of \$2,043,741 as of July 31, 2013.

Based on the preceding, and subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

Recommendation

**From a financial perspective, approval is recommended.**

## Attachments

BFA Attachment A	Organization Chart
BFA Attachment B	Personal Net Worth Statement
BFA Attachment C	Pro-forma Balance Sheet
BFA Attachment D	Financial Summary, Morningside House Nursing Home Company, Inc.
BFA Attachment E	Financial Summary, Barnwell Nursing and Rehabilitation Center
BFA Attachment F	Financial Summary, Carillon Nursing and Rehabilitation Center
BFA Attachment G	Financial Summary, East Neck Nursing and Rehabilitation Center
BFA Attachment H	Financial Summary, Mills Pond Nursing Home and Rehabilitation Center
BFA Attachment I	Financial Summary, Petite Fleur Nursing and Rehabilitation Center

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 13th day of February, 2014, 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 Morningside Acquisition I, LLC as the new owner and operator of Morningside House Nursing Home Company, 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:

131159 E

FACILITY/APPLICANT:

Morningside Acquisition I, LLC  
d/b/a Morningside House Nursing Home

APPROVAL CONTINGENT UPON:

1. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning are average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - a) Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b) Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c) Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - d) Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period.

[RNR]

3. Submission of an executed building lease, acceptable to the Department. [BFA, CSL]
4. Submission of a loan commitment for working capital, acceptable to the Department. [BFA]
5. Submission of a commitment, acceptable to the Department, for a permanent mortgage from a recognized lending institution at a prevailing rate of interest. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and old refinanced debt. [BFA]
6. Submission of a photocopy of the executed Certificate of Amendment of the Articles of Organization of Morningside Acquisition I, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of an executed amended Operating Agreement of Morningside Acquisition I, LLC, acceptable to the Department. [CSL]
8. Submission of a photocopy of an executed Certificate of Assumed Name of Morningside Acquisition I, LLC, acceptable to the department. [CSL]
9. Submission of a fully executed proposed Certificate of Amendment of the Certificate of Incorporation or Certificate of Dissolution of Morningside Nursing Home Company, Inc. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies  
(4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 131348 E Shore View Nursing & Rehabilitation, LLC

**County:** Kings County  
**Purpose:** Establishment

**Program:** Residential Health Care Facility  
**Acknowledged:** July 19, 2013

### Executive Summary

#### Description

Shore View Acquisition I, LLC, to-be-renamed Shore View Nursing & Rehabilitation Center, LLC, requests approval to be established as the operator of Shoreview Nursing Home, a 320-bed proprietary skilled nursing facility located at 2865 Brighton 3<sup>rd</sup> Street, Brooklyn. The applicant will not be purchasing the real estate as part of this application. There will be no change in services provided. The applicant entered into a transfer agreement dated April 4, 2013 with Shoreview Nursing Home.

The current and proposed operator is as follows:

<u>Current</u>		<u>Proposed</u>	
Shoreview Nursing Home		Shore View Nursing & Rehabilitation Center, LLC	
<u>Partners:</u>		<u>Members:</u>	
Karen Boxer	0.75%	Pasquale Debenedictis	32.50%
Robin Chaney	0.75%	Alex Solovey	32.50%
Ann Castellucci	3.30%	Soloman Rutenberg	5.00%
Ernest Dicker	17.26%	Michael Schrieber	30.00%
Mark Dicker	33.20%		
Sheryl Dicker	33.20%		
Helene Fried	0.32%		
Steven Katzenstein	1.20%		
Norma Krupenie	0.24%		
Beth Mcgrath	1.27%		
Howard Present	2.55%		
Raymond Small	0.30%		
Reuben Taub	2.55%		
Richard Weisbrod	0.64%		
Frederick Turk	1.20%		
Jane O'Brien	1.27%		

BFA Attachments E and F are the financial summaries of the other skilled nursing facilities owned by the proposed members.

DOH Recommendation  
Contingent Approval

#### Need Summary

Shoreview's utilization was 90.6% in 2009, 92.6% in 2010, 90.7% in 2011, and 91.5% in 2012. Shoreview was damaged by Superstorm Sandy, necessitating closure until repairs and improvements could be made. The facility re-opened in March of 2013, and has seen approximately 80 – 100 admission requests each month since. To date the facility has a total of 302 patients which is a 94 percent utilization rate. The applicant expects the facility to be at near-optimum capacity shortly, because of new programs and services that meet the needs of a unique niche, a large Russian population. The change in ownership will not result in any change in beds or services.

#### Program Summary

No negative information has been received concerning the character and competence of the proposed applicant members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

#### Financial Summary

The purchase price of \$10 will be met via equity from the proposed members personal resources.

<b>Budget:</b>	
Revenues	\$34,580,200
Expenses	<u>34,089,600</u>
Net Income	\$490,600

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program.
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility.
  - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy.
  - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above.
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions.
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
4. Submission of an executed Certificate of Assumed name, acceptable to the Department. [CSL]
5. Submission of an executed Operating Agreement, acceptable to the Department. [CSL]
6. Submission of an Amendment of the Articles of Organization, acceptable to the Department. [CSL]
7. Submission of an Asset Purchase Agreement, acceptable to the Department. [CSL]
8. Submission of an executed Lease Agreement, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Shore View Acquisition 1, LLC, to-be-renamed Shore View Nursing & Rehabilitation Center, LLC, a newly formed entity, seeks approval to enter into an asset purchase agreement with Shoreview Nursing Home to be established as the new owner/operator. Shoreview Nursing Home is a 320-bed Article 28 residential health care facility located at 2865 Brighton 3<sup>rd</sup> Street, Brooklyn, 11235, in Kings County.

## Analysis

The RHCF bed need methodology set forth in 10 NYCRR 709.3 may be used in the evaluation of changes of RHCF ownership, even if no additional beds are requested. The applicant does not request additional beds in the proposed change of ownership, but in light of the facility's low occupancy rates of recent years, the Department evaluated the need for maintenance of Shoreview's current complement of 320 beds.

Table 1: RHCF Need – New York City Region

2016 Projected Need	51,071
Current Beds	42,330
Beds Under Construction	78
Total Resources	42,408
Unmet Need	8,663

There is currently a need for 8,663 beds in the New York City Region as indicated in Table 1. Although a need for beds is indicated, Section 709.3 states there shall be a presumption of no need if the overall occupancy of RHCFs in the planning area is less than 97 percent. The average RHCF occupancy rate for New York City is 94.8%, and the average occupancy for Kings County is slightly lower, at 94.3%, as indicated in Table 2.

Table 2: Shoreview Nursing Home/Kings County/New York City Region Occupancy

<u>Facility/County/Region</u>	<u>% Occupancy 2009</u>	<u>% Occupancy 2010</u>	<u>% Occupancy 2011</u>
Shoreview Nursing Home	90.6%	92.6%	90.7%
Kings County	92.7%	95.0%	94.3%
New York City Region	94.9%	95.4%	94.8%

## Local Factors

Section 709.3 also provides that the presumption of no need based on aggregate occupancy of less than 97 percent may be rebutted by consideration of factors that may affect access to and utilization of RHCF beds in the applicant's local area. It is the responsibility of the applicant to describe and document these factors.

In describing relevant local factors, the applicant first cited Superstorm Sandy, which damaged Shoreview in late 2012, causing the facility to close to make necessary repairs and renovations. The facility undertook these repairs and improvements and re-opened in March, 2013.

The applicants further describe a distinctive feature of the service area in the form of a large number of residents of Russian descent in the area surrounding the facility. In recognition of this niche population, the operators have recently recruited Russian-speaking staff and initiated service of Russian cuisine for residents. Since completing the aforementioned repairs and renovations and initiating these culturally targeted efforts, the facility has been receiving 80 – 100 admissions requests per month. Currently, 70 percent of Shoreview's residents are of Russian descent.

Recently, the facility has also set up a working relationship with area hospitals. Shoreview currently has 290 residents, with 12 in hospitals looking to be transferred to the facility, for a total of 302 individuals. With new relationships between Shoreview, Maimonides and Coney Island Hospitals, the applicant intends to expand the facility's services to include a new cardiac and wound care program, which is likely to attract additional residents.

Features of the renovated facility include:

- Expanded open spaces for residents to make the environment more comfortable and home-like;
- A cardiac rehabilitation unit to address the high prevalence of congestive heart failure in the service area's Russian population;
- A state-of-the-art rehabilitation center.

### Occupancy

The 290 current residents and 12 intended admissions from area hospitals as of mid-January, 2014 would total to a 94 percent operating utilization. The applicant stated that the facility's census is typically made up of approximately 100 shorter-term residents and approximately 200 longer-term residents. This relatively high proportion of shorter-term residents may cause the occupancy rate to fluctuate from time-to-time and hold it somewhat below the 97 percent optimum.

Shoreview Nursing Home's utilization was 90.6% in 2009, 92.6% in 2010, and 90.7% in 2011. The applicant stated the reason for the low utilization in previous years was because of the physical appearance of the building, along with the outdated services then being provided. In view of the increase in occupancy that has occurred since the renovated facility re-opened, this seems an accurate assessment.

### Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, or of the Health Systems Agency area Medicaid Admissions percentage, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patients' admissions is at least 75% of the planning area percentage or of the Health Systems Agency percentage, whichever is applicable.

Shoreview Nursing Home Medicaid admissions of 64.42% in 2010 and 60.81% in 2011 far exceeded the Kings County 75% rates of 28.12% in 2010 and 30.92% in 2011.

### Conclusion

Continued certification of Shoreview's currently certified capacity of 320 beds is warranted in view of the following factors:

- Renovations in physical plant that have made the facility more attractive to current and potential residents;
- Staffing and program initiatives that recognize the distinctive characteristics of the service area's population;
- Collaborative relationships with area hospitals;
- A state-of-the-art rehabilitation center to serve both longer-term and shorter-term residents;
- A cardiac rehabilitation program reflective of the health needs of the area's population;
- A steadily increasing occupancy rate, one which includes a high proportion of Medicaid clients.

Approval of this application will maintain a community resource that provides services to both the Medicaid patient population and the community demographic.

Recommendation

**From a need perspective, contingent approval is recommended.**

<h2 style="margin: 0;">Programmatic Analysis</h2>
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Facility Information

	Existing	Proposed
Facility Name	Shoreview Nursing Home	Shore View Nursing & Rehabilitation Center, LLC
Address	2865 Brighton 3 <sup>rd</sup> Street Brooklyn, New York 11235	Same
RHCF Capacity	320	Same
ADHC Program Capacity	n/a	Same
Type of Operator	Partnership	LLC
Class of Operator	Proprietary	Proprietary
Operator	Shoreview Nursing Home	Shore View Nursing & Rehabilitation Center, LLC  Members: Pasquale DeBenedictis 32.5% Alex Solovey 32.5% Soloman Rutenberg 5.0% Michael Schreiber <u>30.0%</u> . 100.0%

Character and Competence Background

Facilities Reviewed

Barnwell Nursing and Rehabilitation Center	01/2004 to present
East Neck Nursing and Rehabilitation Center	02/2006 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	07/2013 to present
Norwalk Acquisition I Nursing Home	08/2013 to present
d/b/a Cassena Care at Norwalk (Connecticut)	

Individual Background Review

**Pasquale DeBenedictis** is a certified public accountant (CPA) in good standing. He is the director of finance at Carillon Nursing and Rehabilitation Center since 1997. Mr. DeBenedictis discloses ownership interests in the following residential health care facilities:

Barnwell Nursing and Rehabilitation Center	11/2003 to present
East Neck Nursing and Rehabilitation Center	02/2005 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	07/2013 to present
Norwalk Acquisition I Nursing Home	08/2013 to present
d/b/a Cassena Care at Norwalk (Connecticut)	

**Alexander Solovey** is a New York State licensed physical therapist in good standing. He is the director of rehabilitation at Theradynamics Physical Therapy Rehabilitation P.C. since 1999. Mr. Solovey discloses ownership interests in the following residential health care facilities:

Barnwell Nursing and Rehabilitation Center	11/2003 to present
East Neck Nursing and Rehabilitation Center	02/2005 to present
Mills Pond Nursing and Rehabilitation Center	10/2010 to present
Petite Fleur Nursing Home	12/2012 to present
Workmen's Circle Multicare Center	07/2013 to present

Norwalk Acquisition I Nursing Home  
d/b/a Cassena Care at Norwalk (Connecticut)

08/2013 to present

**Michael Schreiber** holds an active New York Nursing Home Administrator's License in good standing. Mr. Schreiber is employed as a director at both Shoreview Nursing Home, since 2006, and Sea-Crest Health Care Center, since 2005. Mr. Schreiber discloses he served as an executive director for these facilities for the following time periods:

Sea Crest Health Care Center	01/2008 to 12/2012
Shoreview Nursing Home	01/2008 to 12/2012

**Soloman Rutenberg** has been employed as CEO at Workmen's Circle Multicare Center, a skilled nursing facility, since 2006. Prior employment has Mr. Rutenberg as the assistant administrator at Kingsbridge Heights, from 1998 to 2006. He discloses an ownership interest in the following health care facility:

Workmen's Circle Multicare Center	07/2013 to present
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#### Character and Competence - Analysis

No negative information has been received concerning the character and competence of the applicants.

A review of operations for Barnwell Nursing & Rehabilitation Center, Carillon Nursing and Rehabilitation Center, East Neck Nursing and Rehabilitation Center, Mills Pond Nursing and Rehabilitation Center, Petite Fleur Nursing Home, and Workmen's Circle Multicare Center for the periods identified above, results in a conclusion of substantially consistent high level of care since there were no enforcements.

#### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

#### Asset Purchase Agreement

The applicant has submitted an executed asset purchase agreement for the purchase of the nursing home, summarized below:

Date	April 4, 2013
Seller	Shoreview Nursing Home
Purchaser	Shore View Nursing & Rehabilitation Center, LLC
Assets Acquired	Business and operation of the Facility; all inventory, supplies and other articles of personal property; all contracts, agreements, leases, undertakings, commitments and other arrangements which Buyer agrees to assume at the Closing; the name "Shoreview Nursing Home" and any and all other trade names, logos, trademarks and service marks associated with the Facility; all security deposits and prepayments; all menus, policies and procedures manuals and computer software; all telephone numbers and telefax numbers used by the Facility; all resident/patient records relating to the Facility; goodwill in connection with the operation of the Facility; all accounts receivable relating to services rendered by the Facility on and after the Effective Date of March 15, 2013; all rate increases and/or lump payments resulting from rate appeals with respect to third party payments, which become effective or paid on or after the Effective Date; all cash, marketable securities, deposits and cash equivalents, and all accrued interest and dividends and all reimbursement made prior to, on or after the Closing Date by

Excluded Assets	Medicare, Medicaid or any third party payor, excluding insurance proceeds, for storm damage suffered by Seller and/or the Facility relating to or caused by Hurricane Sandy. All insurance policies and claims, and the proceeds thereof, relating to events occurring prior to the Effective Date; all retroactive rate increases, resulting from rate appeals, with respect to third party payments for services rendered at the Facility prior to the Effective Date of March 15, 2013 and all accounts receivable relating thereto and proceeds thereof, all claims, rights, causes of action, rights of recovery, rights of set off and recoup against and third parties; all amounts due from third parties related to Seller; all leasehold improvements, furniture, fixtures and equipment owned by Seller; all financial books and records of Seller; all accounts receivable related to services rendered by the Facility prior to the Effective Date; any assets of Seller not used in connection with the operation of the Seller and the real property and improvements thereon.
Assumed Liabilities	All liabilities and obligations relating to the Facility and/or Basic Assets arising on or after the Effective Date of March 15, 2013 or otherwise relating to services rendered by, or the operation of, the Facility on and after the Effective Date; all of Seller's Accounts Payable and other Liabilities and all healthcare, Medicaid and Medicare overpayments and assessments liabilities and all of Seller's Liabilities relating to the Transferred Employees for vacation, holiday time and personal days, all of which were earned but not yet taken or paid prior to the Effective Date.
Retained Liabilities	Seller is retaining and shall remain liable for the following liabilities: any liability relating to the Excluded Assets; any liability relating to or arising out of use, ownership or operation of the Facility prior to the Effective Date of March 15, 2013 other than the Assumed Liabilities; all of Seller's sick pay Liabilities existing on the day before the Effective Date and all of Seller's Accounts Payable existing on the day prior to the Effective Date, other than the Assumed Liabilities.
Purchase Price	\$10 and the assumption of the Assumed Liabilities.
Payment of Purchase Price	Cash at Closing

The applicant submitted an affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of the liability and responsibility. Currently, there are no outstanding liabilities.

#### Lease Rental Agreement

The applicant has submitted an executed lease rental agreement for the site that they will occupy, which is summarized below:

Date:	April 12, 2013
Premises:	The property located at 2865 Brighton 3 <sup>rd</sup> Street, Brooklyn, New York, which consists of a 320-bed residential nursing facility.
Lessor:	Shore View Real Estate Holding, LLC
Lessee:	Shore View Nursing & Rehabilitation Center, LLC
Term:	The lease will terminate on March 30, 2061.
Rental:	From Commencement Date through March 14, 2014; \$1,123,141 annually. From March 15, 2014 through March 14, 2019; \$1,500,000 annually. From March 15, 2019 through March 14, 2024; \$2,000,000 annually.

From March 15, 2024 through March 14, 2029; \$2,100,000 annually.  
 For every five year period subsequent to March 15, 2029, minimum annual rent shall be equal to the fair market value for the lease premises.  
 Provisions: The lessee shall be responsible for maintenance, utilities and real estate taxes.

**Operating Budget**

The applicant has submitted an operating budget, in 2013 dollars, for the first year after the change in operator, summarized below:

	<u>Per Diem</u>	<u>Total</u>
<b>Revenues:</b>		
Medicaid Managed Care	\$266.28	\$23,027,100
Medicare Fee For Service	\$571.63	7,112,800
Commercial Fee For Service	\$498.90	1,902,800
Private Pay	\$500.78	2,362,200
Non Operating Revenues		<u>175,300</u>
<b>Total Revenues</b>		<b>\$34,580,200</b>
<b>Expenses:</b>		
Operating	\$301.46	\$32,392,500
Capital	<u>15.79</u>	<u>1,697,100</u>
<b>Total Expenses</b>	<b>\$317.25</b>	<b>\$34,089,600</b>
<b>Net Income</b>		<b>\$490,600</b>
Utilization: (patient days)		107,453
Occupancy		91.99%

The breakeven occupancy for the facility is 90.63%. The applicant has provided the occupancy from December 18, 2013, through January 5, 2014, and the facility had an average occupancy of 91.54%. The projected occupancy during the first year is consistent with what the facility has been achieving since December 18, 2013.

Utilization for the RHCf beds, broken down by payor source during the first year after the change in operator is summarized as follows:

Medicaid Managed Care	80.48%
Medicare Fee For Service	11.58%
Commercial Fee For Service	3.55%
Private Pay	4.39%

The following expense categories are projected to decrease after the change in operator when compared with 2011 data:

- The new operator will not have the continued bad debt expense of \$539,593.
- The administrative fees and executive director costs have been removed as the expense already is included in the full administrative staff and totals \$597,321.

**Capability and Feasibility**

The purchase price of \$10 will be met via equity from the proposed members. The applicant will also assume some of the current operator's liabilities.

Working capital requirements are estimated at \$5,681,600, which is equivalent to two months of first year expenses. The applicant will finance \$2,000,000 at an interest rate of 1 month LIBOR + 275 basis points (approximately 2.92% as of 12/20/2013). The remainder, \$3,681,600, will be met via equity from the proposed members' personal resources. BFA Attachment A is the personal net worth statements of the proposed members of Shore View Nursing & Rehabilitation Center, LLC, which indicates the availability of sufficient funds for the equity contribution.

The applicant provided an affidavit indicating that the proposed members will provide equity disproportionate to their ownership percentages. BFA Attachment C is the pro-forma balance sheet of Shore View Nursing & Rehabilitation Center, LLC as of the first day of operation, which indicates a positive net asset position of \$2,993,208.

The submitted budget indicates a net income of \$490,600 during the first year after the change in operator. Revenues are increasing because the applicant is projecting utilization levels achieved prior to Superstorm Sandy in 2012. The submitted budget appears reasonable. Revenues are increasing from 2011 historical experience due to trending and additional occupancy projected from 2011 data. The applicant has indicated that due to Superstorm Sandy, the facility did repairs totaling \$3,354,286.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology, to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

BFA Attachment B is the financial summary of Shoreview Nursing Home from 2010 through 2012. As shown, the facility had an average negative working capital position and average negative net asset position from 2010 through 2012. The applicant has indicated that the reason for the average negative working capital position and the average negative net asset position is from prior year losses. The applicant has indicated that the reason for the 2010 loss was due to the facility not controlling expenses, of which the operator then controlled expenses. The applicant has indicated that the 2012 loss was due to Superstorm Sandy.

BFA Attachment D is the October 31, 2013 internal financial statements of Shoreview Nursing Home. As shown, the facility had a positive working capital position and a positive net asset position through October 31, 2013. Also, the facility achieved an income from operations of \$3,530,186 through October 31, 2013.

BFA Attachment E is the financial summary of Barnwell Nursing and Rehabilitation from 2010 through 2012. As shown, the facility had an average positive working capital position and an average positive net asset position. The applicant has indicated that the negative working capital position in 2010 and 2011 was due to a large liability due to a third party, which has been removed as of the 2012 financial statement leaving a positive working capital position in 2012. Also, the facility achieved an average net income of \$372,063 from 2010 through 2012.

BFA Attachment F is the financial summary of East Neck Nursing Home from 2010 through 2012. As shown, the facility had an average positive working capital position and an average positive net asset position from 2010 through 2012. Also, the facility achieved an average net income of \$720,923 from 2010 through 2012.

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Personal Net Worth Statement- Proposed Members
BFA Attachment B	Financial Summary- Shoreview Nursing Home
BFA Attachment C	Pro-forma Balance Sheet
BFA Attachment D	October 31, 2013 internal financial statements of Shoreview Nursing Home
BFA Attachment E	Financial Summary- Barnwell Nursing and Rehabilitation
BFA Attachment F	Financial Summary- East Neck Nursing Home

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 13th day of February, 2014, 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 Shoreview Acquisition 1, LLC as the new owner and operator of Shoreview Nursing Home, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:

131348 E

FACILITY/APPLICANT:

Shore View Nursing & Rehabilitation  
Center, LLC

APPROVAL CONTINGENT UPON:

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program.
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility.
  - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy.
  - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above.
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions.
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
4. Submission of an executed Certificate of Assumed name, acceptable to the Department. [CSL]
5. Submission of an executed Operating Agreement, acceptable to the Department. [CSL]
6. Submission of an Amendment of the Articles of Organization, acceptable to the Department. [CSL]
7. Submission of an Asset Purchase Agreement, acceptable to the Department. [CSL]
8. Submission of an executed Lease Agreement, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 132071 E Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare

**County:** Steuben  
**Purpose:** Establishment

**Program:** Residential Health Care Facility  
**Acknowledged:** August 6, 2013

### Executive Summary

#### Description

Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare, is seeking approval to become established as the new operator of Steuben County Infirmary, an existing 105-bed county-owned residential health care facility (RHCF) located at 7009 Rumsey Street Extension in Bath.

Steuben Operations Associates, LLC ownership as follows:

	<u>% Membership Interest</u>
Kenneth Rozenberg	63%
Jeffrey Strauss	29%
Jeffrey Sicklick	3%
David Greenberg	5%

The initial capital paid for proposed membership interest is \$20 per one percent for a total of \$2,000.

Kenneth Rozenberg, Jeffrey Strauss, and Jeffrey Sicklick have membership interests in multiple healthcare facilities. BFA Attachment B shows the proposed members interest in the affiliated facilities.

DOH Recommendation  
Contingent Approval

#### Need Summary

Utilization at Steuben County Infirmary has been steady from 2009 to 2011 but did see a slight decrease in 2012 to 90 percent. This decrease is assumed to be from patients being aware of the nursing home sale that would take place. The utilization for 2013 has increased back to 94.3% with only 6 vacancies in the

building. The new owners plan to bring their successful managed long term care environment and apply it to this facility which they feel with help them exceed the 97% planning optimum..

#### Program Summary

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with the CMS 2013 sprinkler mandate.

#### Financial Summary

The purchase price for the operating assets is \$6,987,500. The purchase price will be paid by \$698,750 in cash and a \$6,288,750 mortgage at 5.26% over a 10 year term with a 20 year amortization.

There are no project costs associated with this proposal.

Budget:	Revenues:	\$11,677,467
	Expenses:	\$ 11,343,211
	Gain:	334,256

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

The HSA recommends contingent approval of this application.

Office of Health Systems Management

### **Approval contingent upon:**

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a loan commitment for working capital, acceptable to the Department. [BFA]
4. Submission of a loan commitment for the purchase price, acceptable to the Department. [BFA]
5. Submission of a photocopy of an executed Assignment and Assumption Agreement, acceptable to the Department. (CSL)
6. The sponsor's signing a Medicaid access agreement. [FLA]
7. The sponsor's willingness to enter into an agreement with Steuben County which articulates how the sponsor will continue to provide a safety net function for the County. [FLA]
8. The sponsor's agreement to either develop an aide training program or enter into an arrangement with Corning Community College or others to insure a sufficient supply of aides. [FLA]

### **Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. With the condition that the sponsor, who will become the largest single provider of skilled nursing facility services in Steuben County and given the increasing prevalence of dementia with the aging of the population, actively engages with Steuben County authorities and other health care providers and facilities in the county to assess the unmet needs of people with dementia and their caregivers for both out-patient and inpatient best practice services. Further, the sponsor submits a report to FLHSA within a year of assuming operation of the facility indicating what role the sponsor is willing to assume to address identified needs of caregivers and people with dementia. [FLA]

Council Action Date

**February 13, 2013.**

# Need Analysis

## Background

Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare seeks approval to be established as the new operator of Steuben County Infirmary, a 105-bed residential health care facility located at 7009 Rumsey Street Extension, Bath, in Steuben County.

## Analysis

Steuben County has met its 2016 bed need. There is no remaining RHCf bed need in Steuben County, as shown in Table 1.

*Table 1: RHCf Need – Steuben County*

2016 Projected Need	691
Current Beds	691
Beds Under Construction	0
Total Resources	691
Unmet Need	0

Steuben Operations Associates did not exceed the Department's planning optimum of 97% RHCf occupancy for 2009, 2010, or 2011. Steuben Operations Associates did exceed the Steuben County average RHCf utilization for the same years. Occupancy was 94.1 % in 2009, 93.5% in 2010 and 93.9% in 2011, while Steuben County averaged 91.2% in 2009, 91.4% in 2010, and 91.9% in 2011.

*Table 2: Steuben Operations Associates/Steuben County*

<u>Facility/County/Region</u>	<u>% Occupancy 2009</u>	<u>% Occupancy 2010</u>
Steuben Operations Associates	94.1%	93.5%
Steuben County	91.2%	91.4%
<u>Facility/County/Region</u>	<u>% Occupancy 2011</u>	<u>% Occupancy 2012</u>
Steuben Operations Associates	93.9%	89.7%
Steuben County	91.9%	91.7%

## Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions or 75% of the Health Systems Agency area, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage or Health Systems Agency percentage, whichever is applicable.

Steuben County Infirmary did not exceed the Steuben County 75% Medicaid admission percentages of 17.97% in 2010 and 17.14% in 2011 with admissions of 16.89% and 5.08%, respectively.

## Conclusion

This transfer of ownership will not result in any capacity changes and will preserve a facility that is serving the community, with higher occupancy rates than other RHCf's in the county.

## Recommendation

**From a need perspective, contingent approval is recommended.**

## Programmatic Analysis

### Facility Information

	Existing	Proposed
Facility Name	Steuben County Infirmary	Steuben Center for Rehabilitation and Healthcare
Address	7009 Rumsey Street Extension Bath, NY 14810	Same
RHCF Capacity	105	Same
ADHC Program Capacity	N/A	Same
Type of Operator	County	Limited Liability Company
Class of Operator	Public	Proprietary
Operator	Steuben County Department of Social Services	Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare  Managing Member Kenneth Rozenberg           63.0%  Members: Jeremy Strauss               29.0% David Greenberg             5.0% Jeremy Sicklick              3.0%

### Character and Competence - Background

#### Facilities Reviewed

##### Nursing Homes

Boro Park Center for Rehabilitation and Healthcare	05/2011 to present
Bronx Center for Rehabilitation and Health Care	10/2003 to present
Brooklyn Center for Rehabilitation and Residential Health Care	03/2007 to present
Bushwick Center for Rehabilitation and Health Care	06/2008 to present
Chittenango Center for Rehabilitation and Health Care	07/2008 to present
Corning Center for Rehabilitation	07/2013 to present
Dutchess Center for Rehabilitation and Healthcare	08/2004 to present
Fulton Center for Rehabilitation and Healthcare	04/2012 to present
Holliswood Center for Rehabilitation and Healthcare	11/2010 to present
Queens Center for Rehabilitation and Residential Health Care	06/2004 to present
Richmond Center for Rehabilitation and Specialty Healthcare	04/2012 to present
Rome Center for Rehabilitation and Health Care	07/2008 to present
Suffolk Center for Rehabilitation and Nursing	05/2007 to 07/2011
University Nursing Home	10/2003 to present
Waterfront Center for Rehabilitation and Health Center	08/2011 to present
Williamsbridge Manor Nursing Home	10/2003 to present

##### Certified Home Health Agency

Alpine Home Health Care (CHHA)	07/2008 to present
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##### Licensed Home Care Services Agency

Amazing Home Care (LHCSA)	05/2006 to present
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##### Emergency Medical Services

Senior Care Emergency Ambulance Services, Inc. (EMS)	06/2005 to present
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Individual Background Review

**Kenneth Rozenberg** is a licensed nursing home administrator in good standing, and a licensed paramedic in good standing. He lists current employment as CEO at Bronx Center for Rehabilitation & Health Care since 1998. Mr. Rozenberg discloses extensive health care facility interests as follows:

Boro Park Center for Rehabilitation and Healthcare	05/2011 to present
Bronx Center for Rehabilitation and Health Care	10/1997 to present
Brooklyn Center for Rehabilitation and Residential Health Care	03/2007 to present
Bushwick Center for Rehabilitation and Health Care	05/2010 to present
Wartburg Lutheran Home Receivership	06/2008 to 05/2010
Wartburg Lutheran Home for the Aging Receivership	06/2008 to 05/2010
Chittenango Center for Rehabilitation and Health Care	05/2011 to present
Stonehedge–Chittenango Receivership	07/2008 to 05/2011
Corning Center for Rehabilitation (formerly Founders Pavilion)	07/2013 to present
Dutchess Center for Rehabilitation and Healthcare	08/2004 to present
Fulton Center for Rehabilitation and Healthcare	04/2012 to present
Holliswood Center for Rehabilitation and Healthcare	05/2013 to present
Holliswood Center Receivership	11/2010 to 05/2013
Queens Center for Rehabilitation and Residential Health Care	06/2004 to present
Richmond Center for Rehabilitation and Specialty Healthcare	04/2012 to present
Rome Center for Rehabilitation and Health Care	05/2011 to present
Stonehedge- Rome Receivership	07/2008 to 05/2011
University Nursing Home	08/2000 to present
Waterfront Center for Rehabilitation and Health Center	01/2013 to present
Waterfront Center Receivership	08/2011 to 01/2013
Williamsbridge Manor Nursing Home	11/1996 to present
Alpine Home Health Care (CHHA)	07/2008 to present
Amazing Home Care (LHCSA)	05/2006 to present
Senior Care Emergency Ambulance Services, Inc. (EMS)	05/2005 to present

**Jeremy B. Strauss** has been employed as Executive Director of Dutchess Center for Rehabilitation since 2003. Mr. Strauss discloses the following health facility interests:

Dutchess Center for Rehabilitation and Healthcare	08/2004 to present
Fulton Center for Rehabilitation and Healthcare	04/2012 to present
Holliswood Center for Rehabilitation	05/2013 to present
Queens Center for Rehabilitation and Residential Health Care	06/2004 to present
Richmond Center for Rehabilitation and Specialty Healthcare	04/2012 to present
Rome Center for Rehabilitation and Health Care	05/2011 to present
Senior Care Emergency Ambulance Services, Inc. (EMS)	04/2011 to present
Suffolk Center for Rehabilitation and Nursing	05/2007 to 07/2011
Waterfront Center for Rehabilitation	01/2013 to present

**Jeffrey N. Sicklick** is a nursing home administrator in good standing in the states of New York and New Jersey. Mr. Sicklick has been employed as Administrator at Bronx Center for Rehabilitation & Health Care since October, 1997. Mr. Sicklick discloses the following health facility interests:

Boro Park Center for Rehabilitation and Healthcare	05/2011 to present
Bushwick Center for Rehabilitation and Health Care	05/2011 to present
Chittenango Center for Rehabilitation and Health Care	05/2011 to present
Corning Center for Rehabilitation	07/2013 to present
Dutchess Center for Rehabilitation and Healthcare	08/2004 to present
Fulton Center for Rehabilitation and Healthcare	04/2012 to present
Holliswood Center for Rehabilitation	05/2013 to present
Queens Center for Rehabilitation and Residential Health Care	06/2007 to present
Richmond Center for Rehabilitation and Specialty Healthcare	04/2012 to present
Rome Center for Rehabilitation and Health Care	05/2011 to present
Waterfront Center for Rehabilitation	01/2013 to present

**David Greenberg** is a nursing home administrator in good standing in the states of New York and New Jersey. Mr. Greenberg has been employed as an Administrator at Boro Park Center Nursing Home since July 2010. Prior employment includes Administrator positions at both Wartburg Lutheran Nursing Home from November 2007 to July 2010, and Liberty House Nursing Home in Jersey City, NJ May 2002 to November 2007. Mr. Greenberg reports no health facility interests.

#### Character and Competence - Analysis

No negative information has been received concerning the character and competence of the above applicants identified as new members.

A review of operations of Bronx Center for Rehabilitation and Health Care for the period identified above reveals that the facility was fined \$2,000 pursuant to a Stipulation and Order issued October 23, 2007 for surveillance findings on April 27, 2007. Deficiencies were found under 10 NYCRR 415.12 Quality of Care and 415.12(i)(1), Quality of Care: Nutrition.

The facility was also fined \$4,000 pursuant to a Stipulation and Order issued August 25, 2011 for surveillance findings on April 16, 2010. Deficiencies were found under 10 NYCRR 415.12 (h)(2) Quality of Care: Accidents and Supervision and 415.26 Administration.

A review of the operations of Chittenango Center for Rehabilitation and Health Care (formerly known as Stonehedge Health & Rehabilitation Center - Chittenango) for the period identified above reveals that the facility was fined \$20,000 pursuant to a Stipulation and Order issued February 17, 2012 for surveillance findings on January 20, 2011. Deficiencies were found under 10 NYCRR 415.12(c)(1)(2) Quality of Care: Pressure Sores and NYCRR 415.12(d)(1) Quality of Care: Catheters.

The facility was also fined \$4,000 pursuant to a Stipulation and Order issued November 15, 2010 for surveillance findings on October 22, 2009. Deficiencies were found under 10 NYCRR 415.12(h)(1,2) Quality of Care: Accidents and Supervision, and 415.26(b)(3)(4) Governing Body.

A review of the operations of Waterfront Health Care Center for the period identified above reveals that the facility was fined \$2,000 pursuant to a Stipulation and Order issued April 24, 2013 for surveillance findings on September 27, 2011. Deficiencies were found under 10 NYCRR 415.12(h)(1)(2) Quality of Care: Accidents and Supervision.

A review of Williamsbridge Manor Nursing Home for the period identified above reveals that the facility was fined \$1,000 pursuant to a Stipulation and Order issued July 8, 2008 for surveillance findings of December 19, 2007. A deficiency was found under 10 NYCRR 415.12 Quality of Care.

The review of operations for Williamsbridge Manor Nursing Home, Bronx Center for Rehabilitation and Health Care, Waterfront Health Care Center, and Chittenango Center for Rehabilitation and Health Care for the time periods indicated above results in a conclusion of substantially consistent high level of care since there were no repeat enforcements.

The review of operations of University Nursing Home, Dutchess Center for Rehabilitation and Healthcare, Queens Center for Rehabilitation and Residential Health Care, Brooklyn Center for Rehabilitation and Residential Health Care, Bushwick Center for Rehabilitation and Health Care, Boro Park Center for Rehabilitation and Healthcare, Rome Center for Rehabilitation and Health Care, Holliswood Center for Rehabilitation and Healthcare, Fulton Center for Rehabilitation and Healthcare, Richmond Center for Rehabilitation and Specialty Healthcare, Suffolk Center for Rehabilitation and Nursing, and Corning Center for Rehabilitation for the time periods indicated above reveals that a substantially consistent high level of care has been provided since there were no enforcements.

A review of Alpine Home Health Care, LLC and Amazing Home Care reveals that a substantially consistent high level of care has been provided since there were no enforcements.

The review of Senior Care Emergency Ambulance Services, Inc. reveals that a substantially consistent high level of care has been provided since there were no enforcements.

#### Project Review

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application. The facility is in compliance with CMS 2013 sprinkler mandates.

#### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

#### Asset Purchase Agreement

The change in ownership will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized below:

Date:	June 3, 2013
Seller:	County of Steuben
Purchaser :	Steuben Operations Associates, LLC
Purchased Assets:	All assets used in operation of the facility. Facilities; equipment; supplies and inventory; prepaid expenses; documents and records; assignable leases, contracts, licenses and permits; telephone numbers, fax numbers and all logos; resident trust funds; deposits; accounts and notes receivable; cash, deposits and cash equivalents;
Excluded Assets:	Any security, vendor, utility or other deposits with any Governmental Entity; any refunds, debtor claims, third-party retroactive adjustments and related documents prior to closing, and personal property of residents.
Assumed Liabilities:	Those associated with purchased assets.
Purchase Price:	\$6,987,500 for the operating interest.
Payment of Purchase Price:	\$698,750 cash held in escrow as a deposit upon execution with the remaining \$6,288,750 at closing.

Concurrent with entering into the Asset Purchase Agreement, the County of Steuben entered into a Land Purchase Agreement with Steuben Land Associates, LLC for the sale and acquisition, respectively, of the real property interest of Steuben County Infirmery at a purchase price of \$3,762,500. The members of Steuben Land Associates, LLC are Daryl Hagler (99%) and Jonathan Hagler (1%).

The applicant members have submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring interest, without releasing the transferor of its liability and responsibility.

#### Lease Agreement

Facility occupancy is subject to an executed lease agreement, the terms of which are summarized as follows:

Date:	June 15, 2013
Premises:	A 105 bed RHCF located at 7009 Rumsey Street Extension, Bath
Landlord:	Steuben Land Associates, LLC

Tenant: Steuben Operations Associates, LLC  
 Terms: 30 years commencing on the execution of the lease  
 Rental: Base rent equal to the debt service payments of the mortgage covering the premises. \$316,406 per year plus \$250,000 per year.  
 Provisions: Tenant is responsible for taxes, insurance, utilities and maintenance

The lease arrangement is an arm's length agreement. The applicant has submitted an affidavit attesting to the relationship between landlord and tenant in that members of each company have previous business relationships involving real estate transactions of other nursing homes.

#### Operating Budget

Following is a summary of the submitted operating budget for the RHCF, presented in 2013 dollars, for the first and third year subsequent to change in ownership:

Revenues:	
Medicaid	\$6,941,932
Medicare	1,896,139
Private Pay	<u>2,839,396</u>
Total Revenues	\$11,677,467
Expenses:	
Operating	\$10,164,542
Capital	<u>1,178,669</u>
Total Expenses	<u>\$11,343,211</u>
Net Income	<u>\$334,256</u>
Utilization: (patient days)	38,284
Occupancy	99.9%

The following is noted with respect to the submitted RHCF operating budget:

- Expenses include lease rental.
- Medicaid revenues include assessment revenues.
- Medicaid rates are based on 2013 Medicaid pricing rates with no trend to 2014.
- Medicare and Private rates are based on the experience of the County and the applicant's experience in assuming operations of similar facilities.
- Overall utilization is projected at 99.9%, while utilization by payor source is expected as follows:
 

Medicaid	76.3%
Medicare	9.3%
Private Pay	14.4%
- Breakeven occupancy is projected at 97.0%.

#### Capability and Feasibility

The purchase price of the operations will be financed by a loan from Greystone of \$6,288,750 at an interest rate of 5.26% for 10 years, with a 20 year amortization, with the remaining \$698,750 from the members of Steuben Operations Associates, LLC. BFA Attachment A is the net worth statement of proposed members, which shows sufficient equity. A Letter of Interest has been submitted by Greystone.

The members of Steuben Operations Associates, LLC have submitted an affidavit stating that they will fund the balloon payment, should acceptable financing not be available at the time the loan comes due after the 10 year period. BFA Attachment E is the interest and amortization schedule for the ten year term.

Working capital requirements are estimated at \$1,890,535, based on two months of the first year expenses, of which \$945,268 will be satisfied from the proposed member's equity, and the remaining \$945,267 will be satisfied through a loan from Greystone at 5.26% over 5 years. A letter of interest has been supplied by the bank. BFA Attachment A is the net worth of proposed members, which shows sufficient equity.

The submitted budget indicates that a net income of \$334,256 would be maintained during the first year following change in ownership. DOH staff has reviewed the difference between the current 2012 net operating loss of \$2,881,322, as shown on BFA Attachment E, and the first year budgeted net income of \$334,256 and has concluded that the difference is mainly due to the reduction in employee fringe benefits of \$2,872,740. The facility will no longer participate in the County benefit plan. BFA Attachment G is the budget sensitivity analysis based on September 25, 2013 current utilization of the facility, which shows the budgeted revenues would decrease by \$183,076, resulting in a net income in year one of \$151,180. As of January 27, 2014, the facility has an occupancy level of 96.2% and is close to achieving a break-even occupancy level of 97.0%. BFA Attachment C is the pro-forma balance sheet of Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare, which indicates positive members' equity of \$2,020,268 as of the first day of operations. It is noted that assets include \$6,987,500 in goodwill, which is not an available liquid resource, nor is it recognized for Medicaid reimbursement purposes. Thus, members' equity would be negative \$4,967,232. The budget appears reasonable.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

As shown on BFA Attachment D, the facility maintained positive working capital in 2009-2010, experienced negative working capital in 2011, and maintained positive net assets and an average net loss from operations of \$2,137,607 for the period shown.

As shown on BFA Attachment E, the facility experienced negative working capital, net assets and a net operating loss of \$2,881,322 in 2012. The county cannot maintain its current operation due to reoccurring losses from year to year and has therefore decided to sell the facility.

BFA Attachment H is the financial summary of the proposed members' affiliated health care facilities and shows the facilities have maintained positive income from operations for the periods shown with one exception, Chittenango Center for Rehabilitation had loss due to a one-time audit recoupment.

#### Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Net Worth of Proposed Members
BFA Attachment B	Proposed Members Ownership Interest in Affiliated Homes
BFA Attachment C	Pro-forma Balance Sheet,
BFA Attachment D	Financial Summary, Steuben County Infirmary, 2009-2011
BFA Attachment E	Financial Summary, Steuben County Infirmary, 2012
BFA Attachment F	Interest and Amortization Schedule
BFA Attachment G	Budget Sensitivity Analysis
BFA Attachment H	Financial Summaries of Affiliated RHCs for proposed 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 13th day of February, 2014, 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 Steuben Operations Associates, LLC d/b/a Steuben Center for Rehabilitation and Healthcare as the new operator of Steuben County Infirmary, 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:

132071 E

FACILITY/APPLICANT:

Steuben Operations Associates, LLC  
d/b/a Steuben Center for Rehabilitation and  
Healthcare

APPROVAL CONTINGENT UPON:

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy; and
  - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period.

[RNR]

3. Submission of a loan commitment for working capital, acceptable to the Department. [BFA]
4. Submission of a loan commitment for the purchase price, acceptable to the Department. [BFA]
5. Submission of a photocopy of an executed Assignment and Assumption Agreement, acceptable to the Department. (CSL)
6. The sponsor's signing a Medicaid access agreement. [FLA]
7. The sponsor's willingness to enter into an agreement with Steuben County which articulates how the sponsor will continue to provide a safety net function for the County. [FLA]
8. The sponsor's agreement to either develop an aide training program or enter into an arrangement with Corning Community College or others to insure a sufficient supply of aides. [FLA]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. With the condition that the sponsor, who will become the largest single provider of skilled nursing facility services in Steuben County and given the increasing prevalence of dementia with the aging of the population, actively engages with Steuben County authorities and other health care providers and facilities in the county to assess the unmet needs of people with dementia and their caregivers for both out-patient and inpatient best practice services. Further, the sponsor submits a report to FLHSA within a year of assuming operation of the facility indicating what role the sponsor is willing to assume to address identified needs of caregivers and people with dementia. [FLA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

Project # 131092 E

**Shorefront Operating, LLC d/b/a Waterfront Rehabilitation and Health Care Center**

**County:** Kings County  
**Purpose:** Establishment

**Program:** Residential Health Care Facility  
**Acknowledged:** March 1, 2013

## Executive Summary

**Description**

Shorefront Operating, LLC, an existing limited liability company, is seeking approval to become the new operator of Shorefront Jewish Geriatric Center, a 360-bed not-for-profit residential health care facility (RHCF) with an offsite adult day health care program (ADHCP) located in Brooklyn. The RHCF is to be renamed Waterfront Rehabilitation and Health Care Center. The ADHCP is not being transferred to the applicant. The current operator is considering closure of that program.

The executed asset purchase agreement is between Shorefront Jewish Geriatric Center, Inc. and Shorefront Operating, LLC. The operation is being purchased for \$18,000,000. Ownership of the operation before and after the requested change is as follows:

Current

Shorefront Jewish Geriatric Center, Inc., not-for-profit corporation

Proposed

Shorefront Operating, LLC

<u>Name</u>	<u>% Ownership</u>
Leah Friedman	10.0%
Rochel David	10.0%
David Rubinstein	10.0%
Avi Philipson	10.0%
Esther Farkovits	10.0%
Deena Hersh	10.0%
Joel Zupnick	25.0%
Shaindy Berko	10.0%
Berish Rubinstein	2.5%
Bruchy Singer	2.5%

The executed real estate purchase agreement is between Shorefront Jewish Geriatric Center, Inc. and Shorefront Realty, LLC. The real property is being purchased for \$32,000,000. Ownership of the real property before and after the requested change is as follows:

Current

Shorefront Jewish Geriatric Center, Inc., not-for-profit corporation.

Proposed

Shorefront Realty, LLC

<u>Name</u>	<u>% Ownership</u>
Leah Friedman	10.0%
Rochel David	10.0%
David Rubinstein	10.0%
Benjamin Landa	20.0%
Philipson Family, LLC	10.0%
Cheskel Berkowitz	25.0%
Schlesinger Family Trust	10.0%
Berish Rubinstein	2.5%
Brucha Singer	2.5%

Esther Farkovits and Berish Rubenstein presently have ownership interests in the following Nursing Homes: Nassau Extended Care Facility, a 280-bed RHCF, located in Hempstead, New York; Park Avenue Extended Care Facility, a 240- bed RHCF, located in Long Beach, New York; Throgs Neck Extended Care Facility, a 205-bed RHCF, located in the Bronx; and Townhouse Extended Care Center, a 280-bed RHCF, located in Uniondale, New York.

Esther Farkovits also presently has ownership interest in Little Neck Care Center, a 120-bed RHCF, located in Little Neck, New York.

Berish Rubenstein also presently has ownership interest in Bay Park Center for Nursing and Rehab, a 480-bed RHCF, located in Bronx, New York.

DOH Recommendation  
Contingent Approval

#### Need Summary

Shorefront Jewish Geriatric Center's utilization was 97.63% in 2011, which exceeds that for both Kings County and the New York City region. The change in ownership will result in a name change, to Waterfront Rehabilitation and Health Care Center, upon project approval. There will be no change in beds or services.

#### Program Summary

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No administrative services or consulting agreements are proposed in this application.

#### Financial Summary

The purchase price for the operation is \$18,000,000 and the real estate purchase price is \$32,000,000. The applicant will provide equity of \$5,000,000 and a bank loan of \$45,000,000.

#### Budget:

Revenues	\$44,153,000
Expenses	<u>43,130,800</u>
Net Income	\$ 1,022,200

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner; and contingent approval is recommended.

# Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program.
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility.
  - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy.
  - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
3. Submission of a programmatic acceptable name for the facility. [LTC]
4. Submission of a photocopy of the applicant's executed Second Amendment to Amended and Restated Operating Agreement, acceptable to the Department. [CSL]
5. Submission of an original affidavit from the applicant, acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to the article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. [BFA]
6. Submission of an executed loan commitment for not more than 50% of the applicable working capital, acceptable to the Department. [BFA]
7. Submission of an executed promissory note, acceptable to the Department. [BFA]
8. Submission of a commitment, acceptable to the Department, for a permanent mortgage from a recognized lending institution at a prevailing rate of interest. Included with the submitted permanent mortgage commitment, must be a sources and uses statement and debt amortization schedule, for both new and refinanced debt. [BFA]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. Certification of the CMS mandated sprinkler system by the Metropolitan Area Regional Office. [LTC]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Shorefront Operating, LLC seeks approval to enter into an asset purchase agreement with Shorefront Jewish Geriatric Center, a 360-bed residential health care facility located at 3015 West 29th Street, Brooklyn, 11224, in Kings County. The new owners also propose to change the name to Waterfront Rehabilitation and Health Care Center.

## Analysis

Shorefront's utilization was higher than Kings County and the New York City region for 2009, 2010, and 2011, as shown in Table 1:

*Table 1: Shorefront Center for Rehabilitation and Nursing Care /Kings County/ NYC Region Occupancy*

<b>Facility/County/Region</b>	<b>2009</b>	<b>2010</b>
Shorefront Jewish Geriatric Center	97.92%	98.05%
Kings County	93.68%	93.55%
NYC region	95.01%	94.88%

<b>Facility/County/Region</b>	<b>2011</b>	<b>2012</b>
Shorefront Jewish Geriatric Center	97.63%	97.6%
Kings County	94.64%	94.4%
NYC region	94.76%	95%*

\*NYC Region percentage not yet certified, but staff feels this number is fairly accurate

There is currently an unmet need of 7,649 beds in the New York City region, but RHCF bed occupancy for the five boroughs remains below the 97 percent planning optimum. However, occupancy at Shorefront has consistently been above 97 percent.

*Table 2: RHCF Need – NYC*

<b>2016 Projected Need</b>	51,071
<b>Current Beds</b>	43,343
<b>Beds Under Construction</b>	79
<b>Total Resources</b>	43,422
<b>Unmet Need</b>	7,649

## Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay of 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, or 75 percent of the Health Systems Agency area Medicaid admissions percentage whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department. An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patients admissions is at least 75% of the planning area percentage or Health Systems Agency percentage, whichever is applicable.

Shorefront Jewish Geriatric Center was below the 75 percent planning average for 2009 and 2010. The facility reported Medicaid admissions of 6.82 percent and 14.30 percent in 2009 and 2010, respectively. The 75 percent planning averages for Kings County for these years were 14.97 percent (2009) and 27.7 percent (2010).

Conclusion

Shorefront's occupancy rate of 97.63% indicates that approval of this application will help maintain a needed resource for the Brooklyn community.

Recommendation

**From a need perspective, contingent approval is recommended.**

<b>Programmatic Analysis</b>
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Background

	<b>Existing</b>	<b>Proposed</b>
Facility Name	Shorefront Jewish Geriatric Center	Seagate Rehabilitation and Health Care Center
Address	3015 West 29th Street Brooklyn, NY. 11224	Same
RHCF Capacity	360	Same
ADHC Program Capacity	N/A	Same
Class of Operator	Not-For-Profit Corporation	Limited Liability Company
Operator	Shorefront Jewish Geriatric Center, Inc.	Shorefront Operating, LLC  <u>Managing Members:</u> Joel Zupnick 25.0% Esther Farkovits 10.0% Avi Philipson 10.0%  <u>Members</u> Leah Friedman 10.0% Rochel David 10.0% David Rubinstein 10.0% Deena Hersh 10.0% Shaindy Berko 10.0% Berish Rubinstein 2.5% Brucha Singer 2.5%

Character and Competence - Background

Facilities Reviewed

Nursing Homes

North Westchester Restorative Therapy and Nursing Center	12/2010 to 09/2011
Bay Park Center for Nursing and Rehabilitation	05/2007 to present
Little Neck Care Center	04/2011 to present
Nassau Extended Care Facility	07/2004 to present
Park Avenue Extended Care Facility	07/2004 to present
Throgs Neck Extended Care Facility	07/2004 to present
Townhouse Extended Care Center	07/2004 to present

Licensed Home Care Services Agency (LHCSA)

Pella Care, LLC	01/2005 to present
Parent Care Home Care, LLC	01/2005 to present

Individual Background Review

Joel Zupnick is employed as the vice president of HHCNY, Inc., a healthcare staffing agency, and as the vice president of Specialty Rx, Inc., a pharmaceutical company. Mr. Zupnick also serves as the

chief financial officer for Pella Care, LLC, a licensed home care services agency. He discloses the following health facility ownership interests:

North Westchester Restorative Therapy and Nursing Center	12/2010 to 09/2011
Pella Care, LLC (LHCSA)	01/2005 to present

Esther Farkovits is currently unemployed. She was previously a yoga instructor at the Lucille Roberts gym from February 2005 to October 2006. Ms. Farkovits discloses the following ownership interests in health facilities:

Little Neck Care Center	04/2011 to present
Nassau Extended Care Facility	07/2004 to present
Park Avenue Extended Care Facility	07/2004 to present
Throgs Neck Extended Care Facility	07/2004 to present
Townhouse Extended Care Center	07/2004 to present

Avi Philipson is currently unemployed and discloses no employment history. Avi Philipson discloses no ownership interests in health facilities.

Leah Friedman is employed in human resources at Confidence Management Systems, a housekeeping services company, located in Linden, New Jersey. Ms. Friedman discloses no ownership interests in health facilities.

Rochel David is employed in human resources at Confidence Management Systems, a housekeeping services company, located in Linden, New Jersey. Ms. David discloses no ownership interests in health facilities.

David Rubinstein lists his current employment as the administrator of Garden State Health Care Administrators, an insurance company based in Brooklyn, New York and as the owner/operator of United Health Administrators, an insurance company also based in Brooklyn, New York. Mr. Rubinstein discloses no ownership interests in health facilities.

Deena Hersh is currently unemployed and discloses no employment history. She discloses no ownership interests in health facilities.

Shaindy Berko is currently unemployed. She was previously an eighth grade teacher at the United Talmudical Academy of Boro Park from 2010 to 2011. Ms. Berko discloses no ownership interests in health facilities.

Berish Rubinstein lists his current employment as the Director of Human Resources at Prompt Nursing Employment, an employment agency located in Woodmere, New York. Berish Rubinstein discloses the following health facility ownership interest:

Bay Park Center for Nursing and Rehabilitation	05/2007 to present
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Brucha Singer lists her current employment as bookkeeper and accountant at County Agency of New York, Inc., a professional employer organization located in Brooklyn, New York. She is also employed in clerical duties at the Southside Agency, a staffing agency also located in Brooklyn, New York. Brucha Singer discloses the following ownership interest:

Parent Care Home Care LLC	01/2005 to present
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#### Character and Competence - Analysis

No negative information has been received concerning the character and competence of the applicants.

A review of the Bay Park Center for Nursing and Rehabilitation for the period identified above revealed the following:

- The facility was fined \$4,000 pursuant to a Stipulation and Order issued March 2, 2011 for surveillance findings on December 18, 2009. Deficiencies were found under 10 NYCRR 415.12 -Quality of Care: Highest Practicable Potential and 10 NYCRR 415.12(i)(1) – Quality of Care: Nutrition Status.
- The facility was fined \$18,000 pursuant to a Stipulation and Order issued May 30, 2012 for surveillance findings on February 16, 2011. Deficiencies were found under 10 NYCRR 415.4(b)(1)(i) – Definition Free From Abuse; 10 NYCRR 415.4(b) – Development of Abuse Policies; 10 NYCRR 415.12(h)(2) – Quality of Care: Accidents; 10 NYCRR 415.12(i)(1) – Quality of Care: Nutrition; and 10 NYCRR 415.26(c)(1)(iv) – Nurse Aide Competency.

It was determined by the Department of Health Nursing Home Surveillance staff that the citations under 10 NYCRR 415.12(i)(1) – Quality of Care: Nutrition, on the above stipulation and orders were not identical violations and were adequately resolved with the facility’s plan of correction.

A review of operations for Bay Park Center for Nursing and Rehabilitation for the time period identified above results in a conclusion of substantially consistent high level of care since there were no repeat enforcements.

A review of the North Westchester Restorative Therapy and Nursing Center, Little Neck Care Center, Nassau Extended Care Facility, Park Avenue Extended Care Facility, Throgs Neck Extended Care Facility, and the Townhouse Extended Care Facility for the time period identified above reveals that a substantially consistent high level of care has been provided since there were no enforcements.

A review of the licensed home care services agencies Pella Care, LLC and Parent Care Home Care, LLC for the time periods identified above reveals that a substantially consistent high level of care has been provided since there were no enforcements.

#### Project Review

No changes in the program or physical environment are proposed in this application. Shorefront Jewish Geriatric Center submitted a Certificate of Need in January 2011 to renovate and refurbish its nursing units along with the installation of a sprinkler system mandated by the Centers for Medicare and Medicaid Services (CMS). The project was approved by the Public Health and Health Planning Council in December 2011. Prior to the proposed change of ownership of the facility, the operating board determined it would not proceed and formally withdrew the project in August 2013. A separate notice of construction was submitted to the Department to complete the CMS mandated sprinkler system. It is recommended that the applicant should consider the need to renovate and refurbish areas of the nursing unit to create a more homelike environment that recognizes the characteristics of the nursing home residents.

As mentioned above, the facility has installed a sprinkler system in accordance to the CMS 2013 sprinkler mandate. However, the Department of Health’s surveillance unit will need to ensure that the installation of the sprinkler system has met CMS requirements.

#### Conclusion

No negative information has been received concerning the character and competence of the proposed applicants identified as new members.

No changes in the program or physical environment are proposed in this application. No consulting or administrative services agreements are proposed in this application.

#### Recommendation:

**From a programmatic perspective, contingent approval is recommended.**

## Financial Analysis

### Asset Purchase Agreement

The change in operational ownership will be effectuated in accordance with an executed asset purchase agreement, the terms of which are summarized below:

Date:	September 24, 2012
Seller:	Shorefront Jewish Geriatric Center, Inc.
Buyer:	Shorefront Operating, LLC
Assets Transferred:	The business and operation of the facility; the lease; furniture, fixtures and equipment; inventory and supplies; assignable contracts, licenses and permits; resident funds; security deposits and prepayments; menus, policies and procedure manuals, phone numbers, financial books and records; resident and employee records; Medicare and Medicaid provider numbers.
Excluded Assets:	Personal property; marketable securities; retroactive rate increases; appeal proceeds relating to periods prior to closing.
Assumed Liabilities:	Those relating to transferred assets.
Purchase Price:	\$18,000,000 with a \$2,000,000 down payment upon execution of agreement with the remainder at closing.

The applicant, as a contingency of approval, must provide an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. Currently, there are no outstanding Medicaid overpayment liabilities relating to HCRA surcharges and obligations.

### Lease Agreement

Facility occupancy is subject to an executed lease agreement, the terms of which follow:

Date:	February 19, 2013
Lessor:	Shorefront Realty, LLC
Lessee:	Shorefront Operating, LLC
Term:	35 years with one renewal term of 10 years
Rental:	Annual rent equal to debt service on lessee's mortgage plus \$2,450,000 per year supplemental rent to increase to \$2,695,000 on fifth anniversary date of lease and increase 2% each year after.
Other:	Lessee pays insurance, taxes, maintenance and utilities

### Operating Budget

Following is a summary of the submitted operating budget for the RHCF, presented in 2013 dollars, for the first year subsequent to change in ownership:

	<u>Total</u>
Revenues:	
Medicaid	\$28,128,000
Medicare	12,650,000
Private Pay/Other	<u>3,375,000</u>
Total Revenues	\$44,153,000

Expenses:	
Operating	\$38,496,000
Capital	<u>4,634,800</u>
Total Expenses	\$43,130,800

Net Income \$ 1,022,200

Utilization (patient days) 128,000  
Occupancy 97.4%

The following is noted with respect to the submitted RHCF operating budget:

- The capital component of the Medicaid rate is based on the return of, and return on, equity reimbursement methodology.
- Expenses include lease rental.
- Medicaid rates are based on 2013 Medicaid pricing rates with no trend.
- Medicare and private pay revenues are based on current payment rates.
- Breakeven occupancy is projected at 95.2%.
- Utilization by payor source is expected as follows:

Medicaid	75.0%
Medicare	18.0%
Private Pay	7.0%

#### Capability and Feasibility

The applicant will satisfy the purchase price of \$18,000,000 for the operation and \$32,000,000 for the reality from a \$45,000,000 bank loan at 4% over 30 years with the remaining \$5,000,000 in members' equity. A letter of interest has been submitted from Greystone on behalf of the applicant. A draft promissory note has been submitted by the applicant, whereas Shorefront Operating, LLC promises to pay Shorefront Realty, LLC \$16,000,000 at 4% interest over twenty years.

Working capital requirements are estimated at \$7,188,467, based on two months of the first year expenses, of which \$3,594,234 will be satisfied from the proposed members' net worth and the remaining \$3,594,233 from a bank loan (5 year term at 6%). A letter of interest has been supplied by Greystone for the working capital loan. An affidavit from each applicant member, which states that he or she is willing to contribute resources disproportionate to ownership percentages, has been provided by the proposed members. BFA Attachment A is the net worth of proposed members.

The submitted budget indicates that a net income of \$1,022,200 would be maintained during the first year following change in ownership. Staff has noted that the 2012 historical costs contain additional expenses of \$401,000 due to Hurricane Sandy and legal fees associated with the sale of Shorefront. It should also be noted that the first year budget does not reflect the current operator's administrative overhead paid to the parent company, Metropolitan Jewish Health System. The first year budget is more reflective of 2011 overall utilization with a conservative approach to increased Medicaid patients. The budget appears reasonable.

Staff notes that with the expected 2014 implementation of managed care for nursing home residents, Medicaid reimbursement is expected to change from a state-wide price with a cost-based capital component payment methodology to a negotiated reimbursement methodology. Facility payments will be the result of negotiations between the managed long term care plans and the facility. At this point in time, it cannot be determined what financial impact this change in reimbursement methodology will have on this project.

BFA Attachment B presents the pro-forma balance sheet of Shorefront Operating, LLC. As shown, the facility will initiate operation with \$5,063,000 members' equity. It is noted that assets include

\$16,500,000 in goodwill, which is not an available liquid resource, nor is it recognized for Medicaid reimbursement purposes. Thus, members' equity would be negative \$11,437,000.

Review of BFA Attachment C, financial summary of Shorefront Geriatric Center, indicates that the facility has maintained positive working capital and equity positions and has generated an average net loss of \$141,813 for the period shown. The facility has experienced an average occupancy of 97.87% for the period shown.

Review of BFA Attachment D, financial summary of affiliated RHCs, indicates the following facilities had operational losses in 2011 and/or 2012. Bay Park Center had a 2011 net operational loss due to the implementation of the new reimbursement methodology not accounted for by management. Little Neck Care Center had a 2011 and 2012 net operational loss due to costs associated with closing on the purchase of the facility from the prior owner. The facility has steadily improved operations since the new owners have improved census. Park Avenue Facility had a 2011 net operational loss due to a retroactive rate reduction in their adult day care. Throgs Neck had a 2011 net operational loss due to additional expenses for third party loans. Townhouse Extended care had 2012 and 2011 net operational losses due to a reserve for potential uncollectible accounts receivables.

Based on the preceding, and subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Net Worth of Proposed Members
BFA Attachment B	Pro-forma Balance Sheet, , LLC
BFA Attachment C	Financial Summary, Shorefront Geriatric Center
BFA Attachment D	Financial Summary of affiliated Nursing Homes

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 13th day of February, 2014, 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 Shorefront Operating, LLC, to become the new operator of Shorefront Jewish Geriatric Center, a 360-bed not-for-profit residential health care facility (RHCF) with an offsite adult day health care program (ADHCP) located in Brooklyn, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER:

131092 E

FACILITY/APPLICANT:

Shorefront Operating, LLC d/b/a Waterfront  
Rehabilitation and Health Care Center (Kings  
County)

APPROVAL CONTINGENT UPON:

1. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
2. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program.
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility.
  - Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility, and inform them about the facility's Medicaid Access policy.
  - Submit an annual report for two years to the DOH, which demonstrates substantial progress with the implementation of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above; and
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
    - Other factors as determined by the applicant to be pertinent.

The DOH reserves the right to require continued reporting beyond the two year period.  
[RNR]
3. Submission of a programmatically acceptable name for the facility. [LTC]
4. Submission of a photocopy of the applicant's executed Second Amendment to Amended and Restated Operating Agreement, acceptable to the Department. [CSL]
5. Submission of an original affidavit from the applicant, acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to the article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. [BFA]
6. Submission of an executed loan commitment for not more than 50% of the applicable working capital, acceptable to the Department. [BFA]
7. Submission of an executed promissory note, acceptable to the Department. [BFA]

8. Submission of a commitment, acceptable to the Department, for a permanent mortgage from a recognized lending institution at a prevailing rate of interest. Included with the submitted permanent mortgage commitment, must be a sources and uses statement and debt amortization schedule, for both new and refinanced debt. [BFA]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. Certification of the CMS mandated sprinkler system by the Metropolitan Area Regional Office. [LTC]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 132115 E Visiting Nurse Service of New York Home Care

**County:** Kings County  
**Purpose:** Establishment

**Program:** Certified Home Health Agency  
**Acknowledged:** August 27, 2013

### Executive Summary

#### Description

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care (VNSNY), a not-for-profit certified home health agency (CHHA) requests approval to acquire The Brooklyn Hospital Center's certified home health agency a/k/a Brooklyn Hospital Center Home Health Services Division (Brooklyn Hospital's CHHA), which serves Kings County. VNSNY will integrate Brooklyn Hospital's CHHA into its current home care operations that services the following counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, and Westchester. In addition, under CON 121313, VNSNY was approved on April 11, 2013, by the Public Health and Planning Council to service Suffolk County.

Concurrently, the VNSNY has three CON projects under review: CON 131224, which is requesting approval to service five additional counties in the Hudson Valley Region (Dutchess, Orange, Putnam, Sullivan, and Ulster); CON 131225, which is requesting approval to service eight additional counties in the Central Region (Delaware, Fulton, Hamilton, Herkimer, Montgomery, Oneida, Onondaga, and Otsego); CON 132264, requesting approval to acquire Brookdale Hospital's CHHA serving Bronx, Kings, New York, Queens, Richmond, Nassau and Suffolk Counties.

DOH Recommendation  
Contingent Approval

Need Summary  
There will be no Need recommendation for this application

#### Program Summary

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, a voluntary not-for-profit Article 36 CHHA and LTHHCP, proposes to purchase, acquire, and merge the Article 36 CHHA operated by Brooklyn Hospital Center Home Health Services Division, a voluntary not-for-profit Article 36 CHHA approved to serve Kings County. Upon transfer of ownership, VNSNY will merge all the operations of Brooklyn Hospital Center Home Health Services Division CHHA into its existing CHHA operations, resulting in the ultimate closure of the former Brooklyn Hospital Center Home Health Services Division CHHA.

#### Financial Summary

The purchase price is \$4,250,000, and will be funded from equity. There are no project costs associated with this application.

Incremental Budget:	Revenues:	\$10,002,594
	Expenses:	\$ 8,645,814
	Gain (Loss):	\$ 1,356,780

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation for this application

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of an executed building sub-lease acceptable to the Department. [BFA]
2. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
3. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
4. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Assumed Name, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date

**February 13, 2014**

## Programmatic Analysis

### Program Description

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care (VNSNY), a voluntary not-for-profit Article 36 CHHA and LTHHCP, proposes to purchase, acquire, and merge the Article 36 CHHA operated by Brooklyn Hospital Center Home Health Services Division, a voluntary not-for-profit Article 36 CHHA approved to serve Kings County. Upon transfer of ownership, VNSNY will merge the operations of Brooklyn Hospital Center Home Health Services Division CHHA into its existing CHHA operations, resulting in the ultimate closure of the former Brooklyn Hospital Center Home Health Services Division CHHA.

VNSNY has its main parent office practice location address in New York County, and six additional branch office practice location addresses in Bronx, Kings, Queens, Richmond, Nassau, and Westchester Counties. The CHHA currently serves Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, and Rockland Counties, and was approved by PHHPC on April 11, 2013, to expand into Suffolk County. The LTHHCP serves Bronx, Kings, New York, Queens, and Nassau Counties. The applicant also operates VNS Children and Adolescent Mental Health Clinic at FRIENDS, a mental health clinic licensed by NYS Office of Mental Health.

VNSNY CHHA will continue to provide the following home health care services:

Nursing	Home Health Aide	Medical Social Services
Physical Therapy	Occupational Therapy	Speech Language Pathology
Medical Supplies, Equipment, and Appliances		

VNSNY has as its member (parent) corporation Visiting Nurse Service of New York, a not-for-profit corporation. Visiting Nurse Service of New York is also the member (parent) corporation of the following not-for-profit corporations: Visiting Nurse Service of New York Hospice Care, an Article 40 hospice; New Partners, Inc., d/b/a Partners in Care Services, an Article 36 licensed home care services agency (LHCSA); Family Care Services, an Article 36 LHCSA and home attendant program; and VNS Continuing Care Development Corporation. The latter corporation is the member (parent) corporation of VNS Choice, d/b/a VNSNY Choice, a Managed Care Organization which includes a Managed Long Term Care Plan, a Medicaid Advantage Plan, and a Medicaid Advantage Plus Plan; and VNS Choice Community Care, an Article 36 LHCSA.

The governing body of the applicant, Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, is as follows:

Jon Mattson, Chairperson  
Partner, Trilantic Capital Partners (Private Equity Partnership)  
Affiliations: VNSNY

Anne Bick Ehrenkranz, Vice Chairperson  
Retired  
Affiliations: VNSNY; New Partners, Inc., d/b/a Partners in Care

Margaret A. Bancroft, Esq.  
Of Counsel, Dechert, LLP (Law Firm)  
Affiliations: VNSNY

Alice Cooney Frelinghuysen  
Curator, Metropolitan Museum of Art  
Affiliations: VNSNY

Elisabeth Gotbaum  
Partner, Bedford Grove (Political Fundraising Firm)  
Affiliations: VNSNY

Clare Gregorian  
Retired  
Affiliations: VNSNY

Valerie S. Peltier, Esq.  
Managing Director, Tishman Speyer Properties, Inc. (Real Estate Development)  
Affiliations: VNSNY

Carl H. Pforzheimer, III  
Manager, Carl H. Pforzheimer & Co., LLC (Investment Firm)  
Affiliations: VNSNY

John P. Rafferty, CPA  
Retired Partner, Ernst and Young, LLP (Accounting Firm)  
Affiliations: VNSNY

Ira S. Rimerman  
Retired Senior Executive, Citigroup (Banking)  
Affiliations: VNSNY; Continuum Health Partners, Inc. (Beth Israel Medical Center, Inc. – Petrie Campus, Manhattan, and Kings Highway Division, Brooklyn; St. Lukes Roosevelt Hospital Center, Inc. – Roosevelt Hospital Division and St. Lukes Hospital Division; Long Island College Hospital; New York Eye and Ear Infirmary, Inc. (all Hospitals); Beth Israel Ambulatory Care Services Corp. (D&TC); Robert Mapplethorpe Residential Treatment Facility (RHCF); Jacob Perlow Hospice Corp. (Hospice)

The governing body of the member (parent) corporation, Visiting Nurse Service of New York, is as follows:

Douglas D. Broadwater, Esq., Chairperson  
Retired Partner, Cravath, Swaine & Moore, LLP (Law Firm)

Frank S. Vigilante  
Retired Senior V.P., AT&T  
Affiliations: VNA of Central Jersey, Inc. (Hospice), VNA of Central Jersey Health Group, Inc. (CHHA); VNSNY Hospice Care

Margaret A. Bancroft, Esq.  
Disclosed above

Bobbie Berkowitz, RN (WA)  
Senior VP, Columbia University Medical Center  
Dean, Columbia University School of Nursing  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Group Health Cooperative, Seattle, WA (NFP Health Care Plan); Qualis Health, Seattle, WA (NFP Healthcare Quality Consulting Organization)

Carmen Beauchamp Ciparick, Esq.  
Of Counsel, Greenberg Traurig, LLP (Law Firm)  
Retired Associate Judge, NYS Court of Appeals  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Robert C. Daum  
Retired CEO, DFMC, Inc., d/b/a Growth Capital Partners (Investments)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

E. Mary C. Davidson  
VP, Maxwell Davidson Gallery (Art Dealer)  
Affiliations: VNSNY Hospice Care

Jose M. de Lasa, Esq.  
Of Counsel, Baker and MacKenzie (Law Firm)

Edith M. Dupuy, RN  
Retired  
Claire M. Fagin, R.N., Ph.D.  
Retired Self-Employed Consultant  
Elisabeth Gotbaum  
Disclosed above

Anne Bick Ehrenkranz  
Disclosed above  
Alice Cooney Frelinghuysen  
Disclosed above  
Clare Gregorian  
Disclosed above

Mary R. (Nina) Henderson  
Managing Partner, Henderson Advisory (Consulting Firm)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Peter L. Hutchings  
Retired Exec. V.P. & CFO, Guardian Life Insurance Co.  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Public Health Solutions, d/b/a MIC Women's Health Services, formerly Medical and Health Research Association of NYC (D&TC), NY Organ Donor Network, Empire Health Choice (HMO)

Robert M. Kaufman, Esq.  
Partner, Proskauer Rose, LLP (Law Firm)  
Board Director, Old Westbury Funds (Mutual Funds)  
Affiliations: VNSNY Hospice Care; Public Health Solutions, d/b/a MIC Women's Health Services, formerly Medical and Health Research Association of NYC (D&TC)

Michael Laskoff  
CEO, Managing Partner, Abilto, LLC (Behavioral Health Consulting)  
Affiliations: New Partners, Inc., d/b/a Partners in Care

Arthur Lindenauer, CPA  
Retired CFO, Schlumberger Limited (Oil Field Services)  
Affiliations: New Partners, Inc., d/b/a Partners in Care

Kwan-Lan (Tom) Mao  
Retired V.P., Citigroup (Banking)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Joseph D. Mark  
Retired President, Aveta, Inc. (Health Insurance Company)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Jon Mattson  
Disclosed above

Mathy Mezey, R.N., Ed.D.  
Professor, NYU College of Nursing  
Affiliations: VNSNY Hospice Care

Phyllis J. Mills, R.N.  
Trustee, Mary Flagler Charitable Trust  
Affiliations: VNS Continuing Care Development Corporation; VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Valerie S. Peltier, Esq.  
Disclosed above

Carl H. Pforzheimer, III  
Disclosed above

John P. Rafferty, CPA  
Disclosed above

Corinne H. Rieder, Ed.D.  
Executive Director, Treasurer, The John A. Hartford Foundation (Charitable Foundation)  
Affiliations: VNSNY Hospice Care  
Andrew N. Schiff, M.D.  
Partner, Aisling Capital (Investments/Finance)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Ira S. Rimerman  
Disclosed above

Albert L. Siu, MD  
Chairman / Professor, Mount Sinai School of Medicine's Brookdale Department of Geriatrics and Palliative Medicine  
Director, Bronx VA Medical Center's Geriatric Research, Education, and Clinical Center  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Senior Health Partners (MLTCP); Mount Sinai Care, LLC (ACO)

Kenneth G. Standard, Esq.  
Partner, Epstein Becker & Green, PC (Law Firm)  
Affiliations: Family Care Services

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A search of all of the above named board members, employers, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the Office of the Inspector General's Provider Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile, the Office of Professional Medical Conduct, the NYS Unified Court System, and the Washington State Department of Health Professional Licensing, where appropriate, indicate no issues with the licensure of the health professionals and other licensed professionals associated with this application. In addition, the attorneys have all submitted current Certificates of Good Standing.

The Division of Hospitals and Diagnostic and Treatment Centers reviewed the compliance history of all affiliated hospitals and diagnostic and treatment centers for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following facility was the subject of enforcement actions:

St. Lukes Roosevelt Hospital Center, Inc. was the subject of an enforcement action in 2006 based on violations citing improperly delayed treatment due to financial considerations. The hospital paid a \$4,000 civil penalty to resolve this matter. The hospital has been in compliance since that time.

It has been determined that the affiliated hospitals and diagnostic and treatment centers have provided a substantially consistent high level of care.

The Division of Residential Services reviewed the compliance history of the affiliated residential health care facility for the time period specified as the affiliation. It has been determined that the residential health care facility has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The Division of Home and Community Based Services reviewed the compliance history of all affiliated long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following provider was the subject of an enforcement action:

Jacob Perlow Hospice Corporation, now d/b/a MJHS Hospice and Palliative Care (formerly d/b/a Continuum Hospice Care / Jacob Perlow Hospice / Harlem Community Hospice) was cited with condition-level deficiencies in the areas of Governing Authority; Contracts; Administration; Staff and Services; Personnel; Patient / Family Rights; Plan of Care; and Medical Records Systems / Charts, as a result of a November 29, 2006 survey. An enforcement action was resolved with an October 1, 2007 stipulation and order, which included payment of a \$24,000 civil penalty. The agency has been in compliance since that time.

It has been determined that the long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices have exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations. When code violations did occur, it was determined that the operators investigated the circumstances surrounding the violation and took steps appropriate to the gravity of the violation that a reasonably prudent operator would take to promptly correct and prevent the recurrence of the violation.

The Office of Health Insurance Programs Division of Managed Care reviewed the compliance history of the affiliated managed long term care plans and health maintenance organizations for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied.

The Office of Health Insurance Programs Division of Managed Care reports that the Medicaid Advantage Plan operated by VNS Choice, d/b/a VNSNY Choice, has no enforcement history and is currently in substantial compliance. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, had a suspension on all new enrollments imposed in April 2013, which was lifted by the Department and new enrollments were allowed to resume, effective November 1, 2013. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, are therefore now in substantial compliance. The New York State Office of the Attorney General reports that, although it has a continuing investigation involving this same provider at this time, the Office of the Attorney General no longer requests that the Department hold off the review and approval of the current applications, since the provider has executed an interim agreement to resolve in principle certain aspects of their investigation.

It has therefore been determined that the affiliated managed long term care plans and health maintenance organizations are currently in substantial compliance with all applicable codes, rules, and regulations.

The New York State Office of Mental Health has reviewed the compliance history of the affiliated mental health clinic, for the time period 2008 (initial licensure) to 2013, and has determined the mental health clinic has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The State of New Jersey has reviewed the compliance histories of the health care facilities operated under VNA of Central Jersey, Inc., and VNA of Central Jersey Health Group, Inc., for the time period specified as the affiliation, and has determined the health care facilities have been in substantial compliance with all applicable codes, rules, and regulations.

The State of Washington has reviewed the compliance history of the health care plan administered by Group Health Cooperative, for the time period specified as the affiliation, and has determined the health care plan has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

A review of all personal qualifying information indicates there is nothing in the background of the board members of Visiting Nurse Service of New York Home Care II and Visiting Nurse Service of New York to adversely affect their positions on the boards. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Purchase and Sale Agreement

The applicant has submitted an executed agreement to purchase the CHHA operating interest, the terms of which are summarized below:

Date:	August 14, 2013
Seller:	The Brooklyn Hospital Center
Purchaser:	Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care
Assets Transferred Operations:	Rights, title and interest in assets of the business including: copies of records used in the business, personnel records, patients files and medical records, technical and nontechnical data relating to operations. All permitted licenses, operating certifies, permits waivers and consents relating to the operations. Goodwill.
Excluded Assets:	Cash, cash equivalents, and accounts receivable prior to midnight of the closing date.
Assumed Liabilities:	Obligations and liabilities arising subsequent to the closing date.
Purchase Price:	\$4,250,000
Payment:	\$4,250,000 due at closing

The purchase price will be satisfied through equity

BFA Attachment A is the 2011 and 2012 certified financial summary for Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, which reveals sufficient resources to meet the equity requirements.

The applicant has submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 36 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. There are no outstanding Medicaid and Assessment liabilities as of September 19, 2013.

#### Interim Management Agreement

The applicant has entered in interim management agreement with The Brooklyn Hospital Center to manage their CHHA's day-to-day operation until the transfer is consummated. The hospital will pay a monthly fee of \$13,750. On September 5, 2013, the Department of Health approved this arrangement.

#### Operating Budget

The applicant has submitted the first and third year's incremental operating budgets, in 2013 dollars:

	<u>First Year</u>	<u>Third Year</u>
Revenues		
Medicaid	\$ 884,449	\$857,732
Medicare	5,260,398	5,113,113
Commercial	3,705,795	3,880,591
Other	<u>144,651</u>	<u>151,158</u>
Total Revenues	\$9,995,293	\$10,002,594
Total Expenses	<u>\$8,480,737</u>	<u>\$8,645,814</u>
Net Income or (Loss)	<u>\$1,514,556</u>	<u>\$1,356,780</u>

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

	<u>First Year</u>	<u>Third Year</u>
Medicaid-Episodic	6.3%	6.3%
Medicare-Episodic	43.2%	42.9%
Commercial-Managed Care	44.5%	44.2%
Charity Care	6.0%	6.6%

Patient utilization and expense projections are based on the applicant's analysis of data from Brooklyn Hospitals CHHA, along with their historical experience.

As a conservative measure, the applicant is projecting a 2% reduction from the 2012 Medicaid episodic payment base rate, starting in the first year and compounding through the third year. Thus, the average Medicaid episodic payment in the first and third years is expected to be \$6,032 and \$5,793, respectively, after taking into consideration the average case mix of 1.100 and adjusting for New York City Wage Index Factor of 0.991433. The average case mix of 1.100 was based on Brooklyn Hospital's CHHA experience

As a conservative measure, the applicant is projecting a 2% reduction from the 2012 Medicare episodic payment base rate starting in the first year and compounding through the third year. Thus the average Medicare episodic payment in the first and third years is expected to be \$3,235 and \$3,107, respectively after taking into consideration the average case mix of 1.2500 and adjusting for New York City Wage Index Factor of 1.3052. The average case mix of 1.2500 is based upon the applicant's analysis of the population to be served, which is slightly higher than Brooklyn Hospital's CHHA case mix of 1.1706. Commercial rates were based on VNSNY existing contract rates.

### Capability and Feasibility

The applicant will provide \$4,250,000 in equity to purchase The Brooklyn Hospital's CHHA. Review of BFA Attachment A, VNSNY's 2011 and 2012 certified financial summary, indicates the availability of sufficient resources for the equity contribution. Additionally, the financial statement stated that the VNSNY transfers substantially all of its excess cash to Visiting Nurse Service of New York, its sole member, for cash management and investment purposes. BFA Attachment B is Visiting Nurse Service of New York and Subsidiaries 2011 and 2012 certified financial summary, which shows average investments of \$1,002,658,000.

The working capital requirement is estimated at \$1,440,969, which appears reasonable based upon two months of third year expenses, and will be provided from the applicant. BFA Attachment A, VNSNY's 2011 and 2012 certified financial summary, shows sufficient resources to meet the working capital requirements as well.

The budget projects a first and third years' surplus of \$1,514,556 and \$1,356,780, respectively. Revenues are based on current payment methodologies. The submitted budget appears reasonable.

A review of BFA Attachment A shows VNSNY recorded an Asset Impairment charge of \$32,778,000. The applicant has determined that in 2012 programmatic and reimbursement changes to New York's Long Term Home Health Program (LTHHCP) limited the functionality on a prospective basis on several of their previously acquired licenses and rights. Thus, in 2012, they recognized an impairment loss on those affected non-amortized intangible assets.

As shown in BFA Attachment A, the applicant has maintained a positive working capital position, had a positive net equity, and experienced net losses in 2011 and 2012 of \$15,842,000 and \$6,814,000, respectively. Losses are related to declines in volume, as well as rate reductions in both Medicare and Medicaid. VNSNY is planning to implement significant operational improvements to reach break-even financial operating results by 2015. They include the following:

- Significant cost savings in reaching best practice benchmarks in utilization, productivity and administrative cost efficiencies.
- To mitigate losses, the organization is reviewing expenses and overhead including administrative position eliminations, productivity, call center redesign, streamlining of contract administration, and office space consolidation.
- In addition, Visiting Nurse Service of New York Home Care II will be investing in new information technology that will facilitate the achievement of cost efficiency improvements. These technologies will enable more real-time utilization controls, caseload optimization and streamlined administrative functions.

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

### Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Financial Summary for 2011 and 2012, Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care
BFA Attachment B	Financial Summary for 2011 and 2012, Visiting Nurse Service of New York and Subsidiaries

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 13th day of February, 2014, 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 Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Care as the new operator of Brooklyn Hospital Center's Certified Home Health Agency, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER

APPLICANT/FACILITY

132115 E

Visiting Nurse Services of New York  
Home Care

APPROVAL CONTINGENT UPON:

1. Submission of an executed building sub-lease acceptable to the Department. [BFA]
2. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
3. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
4. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Assumed Name, acceptable to the Department. [CSL]

APPROVAL CONDITIONED UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 132264 E Visiting Nurse Service of New York Home Care

**County:** Kings County  
**Purpose:** Establishment

**Program:** Certified Home Health Agency  
**Acknowledged:** November 15, 2013

### Executive Summary

#### Description

Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care (VNSNY), a not-for-profit corporation, is requesting approval to acquire Brookdale Hospital Medical Center's CHHA, which serves Bronx, Kings, New York, Queens, Richmond, Nassau and Suffolk counties. VNSNY will integrate Brookdale Hospital Medical Center's CHHA into its current home care operations that service the following counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, and Westchester. VNSNY was approved on April 11, 2013 by the Public Health and Planning Council, to service Suffolk County as well.

Concurrently, the VNSNY has three CON projects under review: CON 131224, requesting approval to service five additional counties in the Hudson Valley Region (Dutchess, Orange, Putnam, Sullivan and Ulster); CON 131225, requesting approval to service eight additional counties in the Central Region (Delaware, Fulton, Hamilton, Herkimer, Montgomery, Oneida, Onondaga and Otsego); CON 132115, requesting approval to acquire The Brooklyn Hospital Center's certified home health agency a/k/a Brooklyn Hospital Center Home Health Services Division (Brooklyn Hospital's CHHA), which serves Kings County.

DOH Recommendation  
Contingent Approval

Need Summary  
There will be no Need recommendation of this application.

#### Program Summary

VNSNY, a voluntary not-for-profit Article 36 CHHA and LTHHCP, proposes to purchase, acquire, and merge the Article 36 CHHA operated by Brookdale Hospital Medical Center Home Health Agency, a voluntary not-for-profit Article 36 CHHA and LTHHCP, whose CHHA is approved to serve Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, and whose LTHHCP is approved to serve Kings County only. Upon transfer of ownership, VNSNY will merge the operations of Brookdale Hospital Medical Center Home Health Agency CHHA into its existing CHHA operations, resulting in the ultimate closure of the former Brookdale Hospital Medical Center Home Health Agency CHHA.

The Brookdale Hospital Medical Center Home Health Agency LTHHCP will not be a part of this proposed transaction. Accordingly, the Brookdale Hospital Medical Center Home Health Agency CHHA-based LTHHCP will be required to either close, or convert to a Brookdale Hospital Medical Center hospital-based LTHHCP. Either transaction must occur at the same time as, or prior to, the sale and closure of the Brookdale Hospital Medical Center Home Health Agency CHHA.

#### Financial Summary

The purchase price is \$1,250,000 and will be funded from equity. There are no project costs associated with this application.

Incremental Budget:	Revenues:	\$16,913,299
	Expenses:	<u>16,035,578</u>
	Gain (Loss):	\$877,721

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of an executed building sub-lease, acceptable to the Department. [BFA]
2. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
3. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
4. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Assumed Name, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Council Action Date

**February 13, 2014**

## Programmatic Analysis

### Background

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care (VNSNY), a voluntary not-for-profit Article 36 CHHA and LTHHCP, proposes to purchase, acquire, and merge the Article 36 CHHA operated by Brookdale Hospital Medical Center Home Health Agency, a voluntary not-for-profit Article 36 CHHA and LTHHCP, whose CHHA is approved to serve Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, and whose LTHHCP is approved to serve Kings County only. Upon transfer of ownership, VNSNY will merge the operations of Brookdale Hospital Medical Center Home Health Agency CHHA into its existing CHHA operations, resulting in the ultimate closure of the former Brookdale Hospital Medical Center Home Health Agency CHHA.

The Brookdale Hospital Medical Center Home Health Agency LTHHCP will not be a part of this proposed purchase, acquisition, and merger transaction. Accordingly, the Brookdale Hospital Medical Center Home Health Agency CHHA-based LTHHCP will be required to either close, or convert to a Brookdale Hospital Medical Center hospital-based LTHHCP. Either transaction must occur at the same time as, or prior to, the sale and closure of the Brookdale Hospital Medical Center Home Health Agency CHHA.

VNSNY, has its main parent office practice location address in New York County, and six additional branch office practice location addresses in Bronx, Kings, Queens, Richmond, Nassau, and Westchester Counties. VNSNY currently serves Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, and Rockland Counties, and was approved by PHHPC on April 11, 2013, to expand into Suffolk County. The Visiting Nurse Service of New York Home Care LTHHCP serves Bronx, Kings, New York, Queens, and Nassau Counties. The applicant also operates VNS Children and Adolescent Mental Health Clinic at FRIENDS, a mental health clinic licensed by NYS Office of Mental Health.

VNSNY will serve the patients transferred from Brookdale Hospital Medical Center Home Health Agency CHHA, predominantly from its existing branch office practice location addresses located in Kings and Nassau Counties. VNSNY will continue to provide the following approved home health care services:

Nursing	Home Health Aide	Medical Social Services
Physical Therapy	Occupational Therapy	Speech Language Pathology
Medical Supplies, Equipment, and Appliances		

VNSNY, has as its member (parent) corporation Visiting Nurse Service of New York, a not-for-profit corporation. Visiting Nurse Service of New York is also the member (parent) corporation of the following not-for-profit corporations: Visiting Nurse Service of New York Hospice Care, an Article 40 hospice; New Partners, Inc., d/b/a Partners in Care Services, an Article 36 licensed home care services agency (LHCSA); Family Care Services, an Article 36 LHCSA and home attendant program; and VNS Continuing Care Development Corporation. The latter corporation is the member (parent) corporation of VNS Choice, d/b/a VNSNY Choice, a Managed Care Organization which includes a Managed Long Term Care Plan, a Medicaid Advantage Plan, and a Medicaid Advantage Plus Plan; and VNS Choice Community Care, an Article 36 LHCSA.

The governing body of the applicant, Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, is as follows:

Jon Mattson, Chairperson Partner, Trilantic Capital Partners (Private Equity Partnership) Affiliations: VNSNY	Anne Bick Ehrenkranz, Vice Chairperson Retired Affiliations: VNSNY; New Partners, Inc., d/b/a Partners in Care
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Margaret A. Bancroft, Esq. Of Counsel, Dechert, LLP (Law Firm) Affiliations: VNSNY	Alice Cooney Frelinghuysen Curator, Metropolitan Museum of Art Affiliations: VNSNY
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Elisabeth Gotbaum  
Partner, Bedford Grove (Political Fundraising Firm)  
Affiliations: VNSNY

Clare Gregorian  
Retired  
Affiliations: VNSNY

Valerie S. Peltier, Esq.  
Managing Director, Tishman Speyer Properties, Inc. (Real Estate Development)  
Affiliations: VNSNY

Carl H. Pforzheimer, III  
Manager, Carl H. Pforzheimer & Co., LLC (Investment Firm)  
Affiliations: VNSNY

John P. Rafferty, CPA  
Retired Partner, Ernst and Young, LLP (Accounting Firm)  
Affiliations: VNSNY

Ira S. Rimerman  
Retired Senior Executive, Citigroup (Banking)  
Affiliations: VNSNY; Continuum Health Partners, Inc. (Beth Israel Medical Center, Inc. – Petrie Campus, Manhattan, and Kings Highway Division, Brooklyn; St. Lukes Roosevelt Hospital Center, Inc. – Roosevelt Hospital Division and St. Lukes Hospital Division; Long Island College Hospital; New York Eye and Ear Infirmary, Inc. (all Hospitals); Beth Israel Ambulatory Care Services Corp. (D&TC); Robert Mapplethorpe Residential Treatment Facility (RHCF); Jacob Perlow Hospice Corp. (Hospice)

The governing body of the member (parent) corporation, Visiting Nurse Service of New York, is as follows:

Douglas D. Broadwater, Esq., Chairperson  
Retired Partner, Cravath, Swaine & Moore, LLP (Law Firm)

Frank S. Vigilante  
Retired Senior V.P., AT&T  
Affiliations: VNA of Central Jersey, Inc. (Hospice), VNA of Central Jersey Health Group, Inc. (CHHA); VNSNY Hospice Care

Margaret A. Bancroft, Esq.  
Disclosed above

Bobbie Berkowitz, RN (WA)  
Senior VP, Columbia University Medical Center  
Dean, Columbia University School of Nursing  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Group Health Cooperative, Seattle, WA (NFP Health Care Plan); Qualis Health, Seattle, WA (NFP Healthcare Quality Consulting Organization)

Carmen Beauchamp Ciparick, Esq.  
Of Counsel, Greenberg Traurig, LLP (Law Firm)  
Retired Associate Judge, NYS Court of Appeals  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Robert C. Daum  
Retired CEO, DFMC, Inc., d/b/a Growth Capital Partners (Investments)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

E. Mary C. Davidson  
VP, Maxwell Davidson Gallery (Art Dealer)  
Affiliations: VNSNY Hospice Care

Jose M. de Lasa, Esq.  
Of Counsel, Baker and MacKenzie (Law Firm)

Edith M. Dupuy, RN  
Retired

Anne Bick Ehrenkranz  
Disclosed above

Claire M. Fagin, R.N., Ph.D.  
Retired Self-Employed Consultant

Alice Cooney Frelinghuysen  
Disclosed above

Elisabeth Gotbaum  
Disclosed above

Clare Gregorian  
Disclosed above

Mary R. (Nina) Henderson  
Managing Partner, Henderson Advisory  
(Consulting Firm)  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

Peter L. Hutchings  
Retired Exec. V.P. & CFO, Guardian Life  
Insurance Co.  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care; Public  
Health Solutions, d/b/a MIC Women's Health  
Services, formerly Medical and Health  
Research Association of NYC (D&TC), NY  
Organ Donor Network, Empire Health Choice  
(HMO)

Robert M. Kaufman, Esq.  
Partner, Proskauer Rose, LLP (Law Firm)  
Board Director, Old Westbury Funds (Mutual  
Funds)  
Affiliations: VNSNY Hospice Care; Public  
Health Solutions, d/b/a MIC Women's Health  
Services, formerly Medical and Health  
Research Association of NYC (D&TC)

Michael Laskoff  
CEO, Managing Partner, Abilto, LLC  
(Behavioral Health Consulting)  
Affiliations: New Partners, Inc., d/b/a Partners  
in Care

Arthur Lindenauer, CPA  
Retired CFO, Schlumberger Limited (Oil Field  
Services)  
Affiliations: New Partners, Inc., d/b/a Partners  
in Care

Kwan-Lan (Tom) Mao  
Retired V.P., Citigroup (Banking)  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

Joseph D. Mark  
Retired President, Aveta, Inc. (Health  
Insurance Company)  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

Jon Mattson  
Disclosed above

Mathy Mezey, R.N., Ed.D.  
Professor, NYU College of Nursing  
Affiliations: VNSNY Hospice Care

Phyllis J. Mills, R.N.  
Trustee, Mary Flagler Charitable Trust  
Affiliations: VNS Continuing Care  
Development Corporation; VNS Choice, d/b/a  
VNSNY Choice; VNS Choice Community Care

Valerie S. Peltier, Esq.  
Disclosed above

Carl H. Pforzheimer, III  
Disclosed above

John P. Rafferty, CPA  
Disclosed above

Corinne H. Rieder, Ed.D.  
Executive Director, Treasurer, The John A.  
Hartford Foundation (Charitable Foundation)  
Affiliations: VNSNY Hospice Care

Ira S. Rimerman  
Disclosed above

Andrew N. Schiff, M.D.  
Partner, Aisling Capital (Investments/Finance)  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

Albert L. Siu, MD  
Chairman / Professor, Mount Sinai School of  
Medicine's Brookdale Department of  
Geriatrics and Palliative Medicine  
Director, Bronx VA Medical Center's Geriatric  
Research, Education, and Clinical Center  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care; Senior  
Health Partners (MLTCP); Mount Sinai Care,  
LLC (ACO)

Kenneth G. Standard, Esq.  
Partner, Epstein Becker & Green, PC (Law  
Firm)  
Affiliations: Family Care Services

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A search of all of the above named board members, employers, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the Office of the Inspector General's Provider Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile, the Office of Professional Medical Conduct, the NYS Unified Court System, and the Washington State Department of Health Professional Licensing, where appropriate, indicate no issues with the licensure of the health professionals and other licensed professionals associated with this application. In addition, the attorneys have all submitted current Certificates of Good Standing.

The Division of Hospitals and Diagnostic and Treatment Centers reviewed the compliance history of all affiliated hospitals and diagnostic and treatment centers for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following facility was the subject of enforcement actions:

St. Lukes Roosevelt Hospital Center, Inc. was the subject of an enforcement action in 2006 based on violations citing improperly delayed treatment due to financial considerations. The hospital paid a \$4,000 civil penalty to resolve this matter. The hospital has been in compliance since that time.

It has been determined that the affiliated hospitals and diagnostic and treatment centers have provided a substantially consistent high level of care.

The Division of Residential Services reviewed the compliance history of the affiliated residential health care facility for the time period specified as the affiliation. It has been determined that the residential health care facility has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The Division of Home and Community Based Services reviewed the compliance history of all affiliated long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following provider was the subject of an enforcement action:

Jacob Perlow Hospice Corporation, now d/b/a MJHS Hospice and Palliative Care (formerly d/b/a Continuum Hospice Care / Jacob Perlow Hospice / Harlem Community Hospice) was cited with condition-level deficiencies in the areas of Governing Authority; Contracts; Administration; Staff and Services; Personnel; Patient / Family Rights; Plan of Care; and Medical Records Systems / Charts, as a result of a November 29, 2006 survey. An enforcement action was resolved with an October 1, 2007 stipulation and order, which included payment of a \$24,000 civil penalty. The agency has been in compliance since that time.

It has been determined that the long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices have exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations. When code violations did occur, it was determined that the operators investigated the circumstances surrounding the violation and took steps appropriate to the gravity of the violation that a reasonably prudent operator would take to promptly correct and prevent the recurrence of the violation.

The Office of Health Insurance Programs Division of Managed Care reviewed the compliance history of the affiliated managed long term care plans and health maintenance organizations for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied.

The Office of Health Insurance Programs Division of Managed Care reports that the Medicaid Advantage Plan operated by VNS Choice, d/b/a VNSNY Choice, has no enforcement history and is currently in substantial compliance. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, had a suspension on all new enrollments imposed in April 2013, which was lifted by the Department and new enrollments were allowed to resume, effective November 1, 2013. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, are therefore now in substantial compliance. The New York State Office of the Attorney General reports that, although it has a continuing investigation involving this same provider at this time, the Office of the Attorney General no longer requests that the Department hold off the review and approval of the current applications, since the provider has executed an interim agreement to resolve in principle certain aspects of their investigation.

It has therefore been determined that the affiliated managed long term care plans and health maintenance organizations are currently in substantial compliance with all applicable codes, rules, and regulations.

The New York State Office of Mental Health has reviewed the compliance history of the affiliated mental health clinic, for the time period 2008 (initial licensure) to 2013, and has determined the mental health clinic has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The State of New Jersey has reviewed the compliance histories of the health care facilities operated under VNA of Central Jersey, Inc., and VNA of Central Jersey Health Group, Inc., for the time period specified as the affiliation, and has determined the health care facilities have been in substantial compliance with all applicable codes, rules, and regulations.

The State of Washington has reviewed the compliance history of the health care plan administered by Group Health Cooperative, for the time period specified as the affiliation, and has determined the health care plan has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

A review of all personal qualifying information indicates there is nothing in the background of the board members of Visiting Nurse Service of New York Home Care II and Visiting Nurse Service of New York to adversely affect their positions on the boards. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

Total Project Cost and Financing

There are no project costs associated with this application.

Purchase and Sale Agreement

The applicant has submitted an executed agreement to purchase the CHHA operating interest of Brookdale Hospital Medical Center, the terms of which are summarized below:

Date:	November 4, 2013
Seller:	Brookdale Hospital Medical Center
Purchaser:	Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care
Assets Transferred Operations:	Rights, title and interest in assets of the business including: copies of records used in the business, personnel records, patients files and medical records, technical and nontechnical data relating to operations. All permitted licenses, operating certificates, permits, waivers, and consents relating to the operations, and Goodwill.
Excluded Assets:	Cash, cash equivalents, and accounts receivable prior to midnight of the closing date.
Assumed Liabilities:	Obligations and liabilities arising subsequent to the closing date.
Purchase Price:	\$1,250,000
Payment:	\$1,250,000 due at closing

The purchase price will be satisfied through equity.

BFA Attachment A is the 2011 and 2012 certified financial summary for VNSNY, which reveals sufficient resources to meet the equity requirements.

The applicant has submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 36 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility.

### Interim Management Agreement

The applicant has entered into an interim management agreement with Brookdale to manage their CHHA's day-to-day operations until the transfer is consummated. Brookdale will pay a monthly fee of \$3,000. The Department of Health approved this arrangement on December 3, 2013.

### Lease Rental Agreement

The applicant has submitted a draft sublease for the proposed site; the terms are summarized below:

Premises:	58,387 sq. ft. aggregate in the building known as 1630 and 1642 East 15 <sup>th</sup> Street, Brooklyn, NY
Landlord:	Kingswood Partners, LLC
Lessee/sublessor:	Visiting Nurse Service of New York
Sublessee	VNSNY Home Care II
Term:	5 years starting at \$1,867,590.60 per year commencing on the commencement date (\$31.99 per sq. ft.) and increasing to \$2,060,539.32 per annum (\$35.29 per sq. ft.) commencing on November 7, 2016.
Provisions:	Utilities, Insurance and Maintenance to be paid by sublessee for their portion of these costs.

The applicant states the lease is an arm's length arrangement between Kingswood Partners, LLC and Visiting Nurse Service of New York, which are not related parties. The proposed sublease is a non-arm's length agreement between related parties, Visiting Nurse Service of New York and VNSNY Home Care II.

### Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues:		
Medicaid	\$6,673,082	\$7,935,471
Medicare	3,921,015	7,053,617
Commercial	<u>1,019,184</u>	<u>1,924,211</u>
Total Revenues	\$11,613,281	\$16,913,299
Expenses	<u>\$11,037,921</u>	<u>\$16,035,578</u>
Net Gain(Loss)	\$575,360	\$877,721

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

<u>Payor</u>	<u>Year One</u>	<u>Year Three</u>
Commercial	20.19%	25.79%
Medicare	66.46%	57.62%
Medicaid	10.88%	14.19%
Charity Care	2.47%	2.40%

Patient utilization and expense projections were based on the applicant's analysis of data from Brookdale Hospital CHHA, along with their historical experience and similarly located CHHA's.

As a conservative measure, the applicant is projecting a 2% reduction from the 2012 Medicaid episodic payment base rate starting in the first year and compounding through the third year. Thus, the average Medicaid episodic payment in the first and third years is expected to be \$6,032.32 and \$5,793.44, respectively, after taking into consideration the average case mix of 1.100 and adjusting for New York

City Wage Index Factor of 0.991433. The average case mix of 1.100 was based on the experience of similarly located CHHA's due to the very small census of the Brookdale Hospital CHHA.

As a conservative measure, the applicant is projecting a 2% reduction from the 2012 Medicare episodic payment base rate starting in the first year and compounding through the third year. Thus the average Medicare episodic payment in the first and third years is expected to be \$3,235.98 and \$3,107.83, respectively, after taking into consideration the average case mix of 1.2500 and adjusting for New York City Wage Index Factor of 1.3052. The average case mix of 1.2500 is based upon the applicant's analysis of the population to be served, which is slightly higher than Brookdale Hospital CHHA case mix of 1.0700.

Commercial rates were based on VNSNY existing contract rates.

#### Capability and Feasibility

There are no project costs associated with this application. The \$1,250,000 purchase price for the CHHA will be funded from the applicant's equity. Review of BFA Attachment A, VNSNY 2011 and 2012 certified financial summary, indicates the availability of sufficient resources for the equity contribution. Additionally, the financial statement states that VNSNY transfers substantially all of its excess cash to Visiting Nurse Service of New York, its sole member, for cash management and investment purposes. BFA Attachment B is Visiting Nurse Service of New York and Subsidiaries 2011 and 2012 certified financial summary, which shows average investments of \$1,002,658,000.

Working capital requirements are estimated at \$2,672,596, which appears reasonable based upon two months of third year expenses, and will be provided from the applicant. Review of BFA Attachment A, VNSNY 2011 and 2012 certified financial summary, shows sufficient resources to meet the working capital requirements as well.

The submitted budget indicates that the applicant will achieve incremental net revenue in the first and third years of operations of \$575,360 and \$877,721, respectively. Revenue is based on current payment rates for Certified Home Health Agencies. The budget appears reasonable.

A review of BFA Attachment A shows VNSNY recorded an Asset Impairment charge of \$32,778,000. The applicant determined in 2012, that programmatic and reimbursement changes to New York's Long Term Home Health Program (LTHHCP) limited functionality on a prospective basis of their previously acquired licenses and rights. Thus, in 2012, they recognized an impairment loss on those affected non-amortized intangible assets.

As shown in BFA Attachment A, the applicant has maintained a positive working capital position, had a positive net equity, and experienced net operating losses in 2011 and 2012 of \$15,842,000 and \$6,814,000, respectively. Losses in 2011 and 2012 are related to declines in volume, as well as rate reductions in both Medicare and Medicaid. VNSNY is planning to implement significant operational improvements to reach break-even financial operating results by 2015. They include the following:

- Significant cost savings in reaching best practice benchmarks in utilization, productivity and administrative cost efficiencies.
- To mitigate losses, the organization is reviewing expenses and overhead, including administrative position eliminations, productivity, call center redesign, streamlining of contract administration, and office space consolidation.
- In addition, Visiting Nurse Service of New York Home Care II will be investing in new information technology that will facilitate the achievement of cost efficiency improvements. These technologies will enable more real-time utilization controls, caseload optimization and streamlined administrative functions.

Based on the preceding, it appears that the applicant has demonstrated the financial capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

**From a financial perspective, contingent approval is recommended.**

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## Attachments

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BFA Attachment A	Financial Summary for 2011 and 2012, Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care
BFA Attachment B	Financial Summary for 2011 and 2012, Visiting Nurse Service of New York and Subsidiaries

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 13th day of February, 2014, 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 Visiting Nurse Service of New York Home Care II as the new operator of Brookdale Hospital medical Center Home Care Agency, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER

APPLICANT/FACILITY

132264 E

Visiting Nurse Service of New York  
Home Care

APPROVAL CONTINGENT UPON:

1. Submission of an executed building sub-lease, acceptable to the Department. [BFA]
2. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
3. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
4. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Assumed Name, acceptable to the Department. [CSL]

APPROVAL CONDITIONED UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

Project # 132353 E  
**Alpine Home Health Care, LLC**

**County:** Erie County  
**Purpose:** Establishment

**Program:** Certified Home Health Agency  
**Acknowledged:** December 30, 2013

## Executive Summary

### Description

Alpine Home Health Care, LLC, an existing certified home health agency (CHHA) licensed to provide services in Bronx, Kings, New York, Queens, Richmond, Nassau and Suffolk Counties, requests approval to establish a CHHA to serve Erie and Niagara counties. In another separate application, Alpine is simultaneously seeking to expand its service area to include Rockland County. Alpine is affiliated with Centers Plan for Health Living, LLC, which is an operational Managed Long Term Care Plan (MLTCP) that serves Bronx, New York, Kings, Queens, Richmond, Rockland, Niagara and Erie Counties. Additionally, Centers Plan for Healthy Living, LLC plans to expand its proposed MLTCP to include Nassau and Suffolk Counties. The applicant's sole member is Kenneth Rozenberg.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service area and/or approved population of existing CHHA's. Alpine Home Health Care, LLC submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

### DOH Recommendation

Contingent Approval

### Program Summary

This proposal seeks approval for Alpine Home Health Care, LLC, a for-profit limited liability company which currently operates an Article 36 Certified Home Health Agency (CHHA) located in Bronx, New York, that serves Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, to establish a second additional (separate and distinct) Certified Home Health Agency (CHHA) located in Buffalo, New York, to serve the counties of Erie and Niagara, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

### Financial Summary

There are no project costs associated with this application.

### Incremental Budget:

Revenues	\$2,891,262
Expenses	<u>2,743,649</u>
Net Income	\$ 147,613

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of an executed lease rental agreement, acceptable to the Department. [BFA]

**Approval conditional upon:**

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council.  
[CHA]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Alpine Home Health Care, LLC is requesting approval to establish a new Certified Home Health Agency to serve Erie and Niagara Counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

## Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17<sup>th</sup> and 27<sup>th</sup> were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

## Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17<sup>th</sup> and 27<sup>th</sup> letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

The applicant is partnered with an affiliated MLTCP in the proposed counties. They discussed how the CHHA expansion would directly support numerous MRT initiatives.

Alpine Home Health Care, LLC reported having existing contracts with MLTCPs and is affiliated Centers Plan for Healthy Living. The CHHA will support the affiliated MLTCP by providing care management to high risk-enrollees of the MLTCP. They discussed how the CHHA is well suited to support the MRT initiatives through their disease management programs, HIT systems, relationships with MLTCPs, and technical expertise to meet the needs of patients with complex care needs.

The applicant provided detailed county specific data regarding NYSDOH disease specific incidences and death rates, CHHA and LTHHCP utilization, population, Cornell Univ. Program applied Demographic regarding persons living alone and PRI data. A GAP analysis was provided based on the projected increase of CHHA visits due to transition of LTHHCP patients to MLTC. The applicant demonstrated a clear understanding of impact of implementing Managed Care transition (population currently serviced by LTHHCP providers) and the increase need for CHHA services. Analysis provided for each proposed county based on the projected increase of CHHA visits due to transition of LTHHCP patients and others to MLTC.

Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Background

Alpine Home Health Care, LLC, a for-profit limited liability company, currently operates an Article 36 certified home health agency (CHHA) located in Bronx, New York, that serves Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties. The current proposal seeks approval to establish a second additional (separate and distinct) Certified Home Health Agency (CHHA) located in Buffalo, New York, to serve the counties of Erie and Niagara, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Also pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties, the existing Alpine Home Health Care, LLC, Article 36 Certified Home Health Agency (CHHA) located in Bronx, New York, that currently serves Bronx, Kings, New York, Queens, Richmond, Nassau, and Suffolk Counties, has submitted additional CON project # 132354-C requesting the addition of Rockland County to its geographic service area. That CON construction project is also on the current agenda.

This proposed new CHHA in Buffalo will conduct business under the name of Alpine Home Health Care, LLC, and will be located at 200 Seventh Avenue, Buffalo, New York 14201, in office space leased from Waterfront Health Care Center, Inc., an Article 28 nursing home. The Alpine Home Health Care, LLC, CHHA to be located in Buffalo, New York, will continue to provide the same authorized services currently offered by the Alpine Home Health Care, LLC, CHHA located in Bronx, New York, which include: home health aide, medical social services, medical supplies/equipment/appliances, nursing, occupational therapy, physical therapy, and speech therapy.

The sole member and manager of Alpine Home Health Care, LLC, is Kenneth Rozenberg, with 100% membership interest. Mr. Rozenberg is currently licensed as both a nursing home administrator and an emergency medical technician in New York State. Mr. Rozenberg has been employed as the Chief Executive Officer of Bronx Center for Rehabilitation and Health Care since 1998. His ownership interests in health care facilities encompass the following nineteen (19) providers:

- Williamsbridge Manor Nursing Home (Nursing Home) – 1997 to present
- Bronx Center for Rehabilitation and Health Care (Nursing Home) – 1998 to present
- University Nursing Home (Nursing Home) – 2000 to present
- Dutchess Center for Rehabilitation and Health Care (Nursing Home) – 2004 to present
- Queens Center for Rehabilitation and Health Care (Nursing Home) – 2004 to present
- SeniorCare EMS (Ambulance Company) – 2005 to present

- Amazing Home Care, Inc. (Licensed Home Care Services Agency) – 2006 to present
- Brooklyn Center for Rehabilitation and Residential Health Care (Nursing Home) – 2007 to present
- Alpine Home Health Care, LLC (CHHA) – 2008 to present
- Rome Center for Rehabilitation and Health Care, formerly Stonehedge Health and Rehabilitation Center – Rome (Nursing Home) – 2008 to present
- Chittenango Center for Rehabilitation and Health Care, formerly Stonehedge Health and Rehabilitation Center – Chittenango (Nursing Home) – 2008 to present
- Bushwick Center for Rehabilitation and Health Care, formerly Wartburg Lutheran Home for the Aging (Nursing Home) – 2008 to present
- Holliswood Center for Rehabilitation, formerly Holliswood Care Center (Nursing Home) – 2010 to present
- Boro Park Center for Rehabilitation and Health Care (Nursing Home) – 2011 to present
- Waterfront Health Care Center (Nursing Home) – 2011 to present
- Fulton Center for Rehabilitation and Health Care (Nursing Home) – 2012 to present
- Richmond Center for Rehabilitation and Specialty Healthcare (Nursing Home) – 2012 to present
- The Centers Plan for Healthy Living (Managed Long Term Care Plan) – 2013 to present
- Corning Center for Rehabilitation (Nursing Home) – 2013 to present

A search of the above named member, manager, employer, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the Office of the Inspector General's Provider Exclusion List.

The New York State Department of Health's Bureau of Professional Credentialing and Bureau of Emergency Medical Services indicate that Mr. Rozenberg's professional licenses and certifications are both in good standing.

The Division of Quality and Surveillance for Nursing Homes and ICF/MRs reviewed the compliance history of the affiliated nursing homes for the time periods specified as the affiliations.

An enforcement action was taken against Bronx Center for Rehabilitation and Health Care in 2007 based on the findings of an April, 2007, survey. Deficiencies were cited in Quality of Care: Highest Practicable Potential; and Quality of Care: Nutrition. A \$2,000 civil penalty was assessed.

An additional enforcement action was taken against Bronx Center for Rehabilitation and Health Care in 2011 based on the findings of an April, 2010, survey. Deficiencies were cited in Quality of Care: Accidents and Supervision; and Administration. A \$4,000 civil penalty was assessed.

An enforcement action was taken against Williamsbridge Manor Nursing Home in 2008 based on the findings of a December, 2007, survey. Deficiencies were cited in Quality of Care. A \$1,000 civil penalty was assessed.

An enforcement action was taken against Stonehedge Health and Rehabilitation Center – Chittenango (now Chittenango Center for Rehabilitation and Health Care) in 2010 based on the findings of an October, 2009, survey. Deficiencies were cited in Quality of Care: Accidents and Supervision; and Governing Body. A \$4,000 civil penalty was assessed.

An additional enforcement action was taken against Chittenango Center for Rehabilitation and Health Care (formerly Stonehedge Health and Rehabilitation Center – Chittenango) in 2012 based on the findings of a January, 2011, survey. Deficiencies were cited in Quality of Care: Pressure Sores; and Quality of Care: Catheters. A \$20,000 civil penalty was assessed.

An enforcement action was taken against Waterfront Health Care Center in 2013 based on the findings of a September, 2011, survey. Deficiencies were cited in Quality of Care: Accidents and Supervision. A \$2,000 civil penalty was assessed.

It has been determined that the affiliated nursing homes are operating in substantial compliance with all applicable codes, rules and regulations.

The Division of Home and Community Based Care reviewed the compliance history of the affiliated certified home health agency and licensed home care services agency for the time period specified as the affiliation. It has been determined that the affiliated certified home health agency and licensed home care services agency have exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations.

The Bureau of Emergency Medical Services reviewed the compliance history of the affiliated ambulance company for the time period specified as the affiliation. It has been determined that the affiliated ambulance company has operated in substantial compliance with all applicable codes, rules and regulations.

The Office of Health Insurance Programs Division of Managed Care reviewed the compliance history of the affiliated managed long term care plan for the time period specified as the affiliation. It has been determined that the affiliated managed long term care plan has operated in substantial compliance with all applicable codes, rules and regulations.

A review of all personal qualifying information indicates there is nothing in the background of the member and manager of Alpine Home Health Care, LLC, to adversely effect his position in the organization. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Lease Rental Agreement

The applicant has submitted a draft lease rental agreement for the site that they will occupy:

Premises: 3,500 square feet located at 200 Seventh Street, Buffalo, New York  
 Lessor: Waterfront Health Care Center, Inc.  
 Lessee: Alpine Home Health Care, LLC  
 Term: Five years with a renewable five year term.  
 Rental: \$52,000 annually (\$14.85 per sq. ft.)  
 Provisions: The leasee shall be responsible for real estate taxes, maintenance and utilities.

### Operating Budget

The applicant has submitted an incremental budget, in 2014 dollars, for the first and third years, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues:		
Medicaid Managed Care	\$630,603	\$1,169,979
Medicare Fee For Service	559,214	1,037,528
Commercial Managed Care	<u>259,417</u>	<u>683,755</u>
Total Revenues	\$1,449,234	\$2,891,262
 Total Expenses	 \$1,401,154	 \$2,743,649
 Net Income	 \$48,080	 \$147,613
Utilization:		
Visits	5,191	13,980
Hours	32,246	72,503

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

	<u>Year One</u>	<u>Year Three</u>
Medicaid Managed Care	34.88%	34.94%
Medicare Fee For Service	29.90%	29.95%
Commercial Managed Care	33.22%	33.11%
Charity Care	2.00%	2.00%

Expense and utilization assumptions are based on the historical experience of the applicant's existing CHHA. Revenues are reflective of current payment rates including the implementation of the Medicaid Episodic Payment System.

#### Capability and Feasibility

There are no total project costs associated with this application.

Working capital requirements are estimated at \$457,274, which is equivalent to two months of the incremental third year expenses. The applicant has indicated the working capital requirement will be met via equity from the members of Alpine Home Health Care, LLC. BFA Attachment A is the personal net worth statement of the sole member of Alpine Home Health Care, LLC, which indicates the availability of sufficient funds for the working capital requirement.

The submitted budget indicates an incremental net income of \$48,080 and \$147,613 during the first and third years, respectively. Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment System. The submitted budget appears reasonable.

BFA Attachment B is the 2012 certified financial statements of Alpine Home Health Care, LLC. As shown, the facility had a positive working capital position and a positive net asset position during 2012. Also, the facility incurred a net loss of \$2,071,973 through 2012. The applicant has indicated that the reason for the loss was start-up costs for the subsidiary entity, Centers Plan for Healthy Living's managed care program.

BFA Attachment C is the October 31, 2013 internal financial statements of Alpine Home Health Care, LLC. As shown, the facility had a negative working capital position and a positive net asset position through October 31, 2013. The applicant has indicated that the minor working capital deficit reflects a current year member draw, but, as in the past, the member expects to end the year in a positive working capital position. Also, the facility achieved a net income of \$164,155 through October 31, 2013.

Subject to the noted contingency, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

#### Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Personal Net Worth Statement
BFA Attachment B	2012 certified financial statements of Alpine Home Health Care, LLC
BFA Attachment C	October 31, 2013 internal financial statements of Alpine Home Health Care, LLC

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 13th day of February, 2014, 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 Certified Home Health Agency to serve Erie and Niagara Counties, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER

APPLICANT/FACILITY

132353 E

Alpine Home Health Care, LLC

APPROVAL CONTINGENT UPON:

1. Submission of an executed lease rental agreement, acceptable to the Department. [BFA]

APPROVAL CONDITIONED UPON:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Hardings Beach, LLC d/b/a Home Instead Senior Care  
Address: Pittsford  
County: Monroe  
Structure: Limited Liability Company  
Application Number: 2140L

Description of Project:

Hardings Beach, LLC d/b/a Home Instead Senior Care, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law. The applicant has entered into a franchise agreement with Home Instead, Inc. The applicant currently operates a companion care agency.

The members of Hardings Beach, LLC d/b/a Home Instead Senior Care consist of:

Vesna Herbowy, Manager/Member– 51% Co-owner/operator, Home Instead Senior Care (companion care)	Christopher Parks, Member– 49% Co-owner, Home Instead Senior Care (companion care) Director, Channel Expansion Strategy, Xerox Corporation
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A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of Monroe County from an office located at 1159 Pittsford-Victor Road, Suite 125, Pittsford, New York 14534

The applicant proposes to provide the following health care services:

Nursing	Home Health Aide	Personal Care
Homemaker	Housekeeper	

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: January 13, 2014

Division of Home & Community Based Services  
Character and Competence Staff Review

Name of Agency: Genesee Region Home Care of Ontario County, Inc.  
d/b/a Home Care Plus  
Address: Buffalo  
County: Erie  
Structure: Not-For-Profit Corporation  
Application Number: 2213-L

Description of Project:

Genesee Region Home Care of Ontario County, Inc. d/b/a Home Care Plus, a not-for-profit corporation, requests approval for a change in ownership of a licensed home care services agency under Article 36 of the Public Health Law.

Excellus Acquisition, Inc. d/b/a Sibley Nursing Personnel Services was previously approved as a home care services agency by the Public Health Council at its November 11, 2003 meeting and subsequently licensed as 1200L002, 1200L003, 1200L005 and 1200L007.

The purpose of this application is the purchase of the Sibley LHCSA by Home Care Plus pursuant to the terms of an Asset Purchase Agreement.

The sole corporate member of Genesee Region Home Care of Ontario County, Inc. is North Star Home Health Management, Inc., a not-for-profit corporation. The sole corporate member of North Star Home Health Management, Inc. is Excellus Health Plan, Inc., a not-for-profit corporation. The sole corporate member of Excellus Health Plan, Inc. is Lifetime Healthcare, Inc., a not-for-profit holding company.

Genesee Region Home Care of Ontario County, Inc. d/b/a Home Care Plus and North Star Home Health Management, Inc. have a mirror Board of Directors. The Board of Directors consists of the following individuals:

Joseph F. Kurnath, M.D. – Chairman  
Physician/Partner, Partners in Internal  
Medicine

Affiliations:

- Director, Genesee Region Home Care of Ontario County, Inc.
- Director, Excellus Health Plan, Inc.
- Director, Genesee Region Home Care Association, Inc.

Dorothy A. Coleman, CPA – President & CEO  
EVP and CFO, Excellus Health Plan

Affiliations:

- Director, Genesee Valley Group Health Association.
- Director, Sibley Nursing Personnel Services, Inc.

Charles H. Stuart – Vice Chairman  
Financial Advisor, Morgan Stanley Smith Barney

Affiliations:

- Director, Genesee Region Health Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.

Jordon I. Brown – Treasurer  
Executive VP, Lifetime Assistance, Inc.  
(Human Services)

Affiliations:

- Director, Genesee Region Health Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.

Deborah Minor, RN – Director  
Director of Public Health, Director of Patient Services, Early Intervention Official, Yates County Public Health

Affiliations:

- Director, Genesee Region Health Care Association, Inc. (3/13 – Present)
- Director, Genesee Region Health Care of Ontario County, Inc. (3/13 – Present)

Mordecai J. Kolko – Director  
Retired

Elane M. Daly, RN – Director  
Director of Health and Human Services, Cayuga County Health and Human Services Department

Affiliations:

- Director Genesee Region Health Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.
- Board Member, Auburn Community Hospital (2005 – January 2014)

Jagat S. Mehta, M.D. – Director  
Physician, Self-employed

Affiliations:

- Director, Genesee Region Home Care Association, Inc.
- Director, Genesee Region Home Care of Ontario County, Inc.

Hilda Rosario-Escher – Director  
Vice President, Ibero American Action League

Affiliations:

- Board Member, Huther-Doyle (substance abuse) (2009-present)
- Director, Genesee Region Home Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.
- Board Member, Rochester Psychiatric Center (1992-2010)
- Member, Executive Director's Committee, Office of Mental Health

Marilyn L. Dollinger, RN, FNP – Director  
Associate Dean, St. John Fisher College

Affiliations:

- Board Member, St. Johns Senior Services (Senior Services) (2005-present)
- Board Member, St. John's Health Care Corporation (2000-2010)
- Director, Genesee Region Home Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.

Alfred D. Matt – Director  
President and CEO, F.X. Matt Brewing Company

John J. Mahoney – Director  
Founder/Principal, Summit Business Group, LLC (consulting)

Affiliations:

- Director, Genesee Region Health Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.

David D. Reh – Director  
President, The Raytec Group, Inc. (administrative services)

Affiliations:

- Director, Excellus Health Plan, Inc.
- Director, Genesee Region Home Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.

Manuel M. Matos, M.D. – Director  
Division Chief, Unity Health System

Affiliations:

- Director, Genesee Region Home Care Association, Inc.
- Director, Genesee Region Health Care of Ontario County, Inc.

Excellus Health Plan, Inc. and Lifetime Healthcare, Inc. have a mirror Board of Directors. The Board of Directors consists of the following individuals:

Randall L. Clark – Chairman  
Chairman, Dunn Tire, LLC

Austin T. Hildebrandt, CPA – Vice Chairman  
President, Hillside Children’s Foundation

Thomas E. Rattmann – Vice Chairman  
Chairman, CEO, President, Columbian  
Financial Group

Christopher C. Booth, Esq. – President & CEO  
President and CEO, President and COO; Executive VP and  
COO; Executive MP, Commercial Markets and Health Care  
Affairs; Executive VP, Chief Administrative Officer, and  
General Counsel, Excellus Health Plan, Inc.

Affiliations:

- Director, Genesee Valley Group Health Association  
(2004 – Present)
- Director, Sibley Nursing Personnel Services, Inc.  
(2005 – Present)

John G. Doyle, Jr. – Director  
President, Doyle Security Systems, Inc.

Thomas Y. Hobart, Jr. – Director  
Retired

Hermes L. Ames, III – Director  
Retired

Natalie L. Brown – Director  
Executive Director, YWCA Mohawk Valley

Affiliations:

- Director, Well Choice, Inc. (Empire  
BCBS) (1999-2005)

Affiliations:

- Board Chair, Faxton-St. Luke’s Healthcare (2001-  
2004)

Dennis P. Kessler – Director  
Owner, The Kessler Group, Inc.  
Owner, The Kessler Family, LLC  
Professor, University of Rochester

Charles H. Stuart – Director  
(Previously Disclosed)

Affiliations:

- Director, Genesee Region Home  
Care Association, Inc.
- Director, Genesee Region Health  
Care of Ontario County, Inc.
- Member, University of Rochester  
Medical Center (1/04–2/12)

Alfred D. Matt – Director  
(Previously Disclosed)

Joseph F. Kurnath, M.D. – Director  
(Previously Disclosed)

Patrick A. Mannion – Director  
Chairman, President, CEO, COO, EVP &  
SVP, Unity Mutual Life Insurance Company

George F.T. Yancey, Jr. – Director  
Managing Director, Delta Point Capital

Colleen E. O’Leary, M.D. – Director  
Professor, SUNY Upstate Medical University  
Member/Vice President, Upstate Medical  
Anesthesiology Group

Jennifer C. Balbach – Director  
Partner, Summer Street Capital Partners, LLC

William H. Goodrich – Director  
Chief Executive Officer/President, LeChase  
Construction

Marianne W. Gaige, CPA – Director  
President and CEO, Cathedral Corporation

Affiliations:

- Director, Upstate Cerebral Palsy (2005-present)
- Director, St. Elizabeth Medical Center (2005-2011)

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile, and the Office of Professional Medical Conduct, where appropriate, indicate no issues with the licensure of the health professionals associated with this application.

A Certificate of Good Standing has been received for all attorneys.

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A seven year review of the operations of the agencies/facilities listed below was performed as part of this review (unless otherwise noted):

Genesee Region Home Care of Ontario County, Inc. d/b/a Home Care Plus (LHCSA)  
Genesee Region Home Care Association, Inc. (hospice)  
Genesee Region Home Care Association, Inc. d/b/a Lifetime Care (CHHA)  
Genesee Region Home Care Association, Inc. d/b/a Lifetime Care (LTHHCP)  
Sibley Nursing Personnel Services, Inc. (LHCSA)  
Genesee Valley Group Health Association, Inc. d/b/a Lifetime Health Medical Group (D&TC)  
Excellus Health Plan, Inc. d/b/a Finger Lakes HMO, Upstate HMO & Univera Health Care (HMO)  
University of Rochester Medical Center (2006 – 2/2012)  
St. John's Health Care Corporation (2006-2010)  
Huther-Doyle (substance abuse) (2009-present)  
Rochester Psychiatric Center (2006-2010)  
Upstate Cerebral Palsy (2006-present)  
St. Elizabeth Medical Center (2006-2011)  
Auburn Community Hospital (2005 – January 2014)

**St. John's Health Care Corporation** was fined ten thousand dollars (\$10,000.00) pursuant to a stipulation and order dated June 20, 2011 for surveillance findings of September 27, 2010. Deficiencies were found under 10 NYCRR 415.12 – Quality of Care: Highest Practicable Potential.

The Information provided by the Bureau of Quality Assurance for Nursing Homes has indicated that the residential health care facilities reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Division of Home and Community Based Services has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

**Auburn Community Hospital** was fined twelve thousand dollars (\$12,000.00) pursuant to a stipulation and order settled in 2012 for surveillance findings of July 19, 2010 and April 14, 2011. Deficiencies were found under 10 NYCRR 400.21(a) – Advance Directives, 405.3 – Administration, 405.6(a)(2)(v) – Quality Assurance Program, 405.7 – Patients' Rights, 405.2(a) – Governing Body and 405.6 – Quality Assurance Program.

The information provided by the Division of Hospitals and Diagnostic & Treatment Centers has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Office of Mental Health has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Office for People With Developmental Disabilities has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Office of Alcoholism and Substance Abuse Services has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Bureau of Managed Care Certification and Surveillance has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The applicant proposes to continue to serve the residents of the following counties from an office located at 150 Empire Drive, Buffalo, New York 14224.

Erie	Orleans	Genesee	Niagara
Wyoming	Cattaragus	Chautauqua	Allegany

The applicant proposes to continue to serve the residents of the following counties from an office located 282 North St., Suite G, Auburn, New York 13021.

Tompkins	Cayuga	Madison	Onondaga
Cortland	Oneida	Herkimer	Schuyler

The applicant proposes to continue to serve the residents of the following counties from an office located at 21107 State Route 12F, Watertown, New York 13601.

St. Lawrence	Jefferson	Lewis	Oswego
Herkimer			

The applicant proposes to continue to provide the following health care services:

Nursing	Home Health Aide	Personal Care	Homemaker	Housekeeper
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Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval  
Date: January 14, 2014

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 13th day of February, 2014, having considered any advice offered by the staff of the New York State Department of Health and the Establishment and Project Review Committee of the Council, and after due deliberation, hereby approves the following applications for licensure, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER:</u>	<u>FACILITY:</u>
1565 L	Anne M. Chambers d/b/a Health Beat (Nassau, Queens, and Westchester Counties)
1646 L	F & H Homecare, Inc. d/b/a Visiting Angels (Bronx County)
1657 L	Gentle Care Home Services of NY, Inc. (Bronx, Kings, New York, Queens, and Richmond Counties)
1709 L	Gentle Touch Home Care Agency, Inc. (Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester Counties)
2140 L	Hardings Beach, LLC d/b/a Home Instead Senior Care (Monroe County)

- 2092 L Igbans Home Care Services, Inc.  
(Bronx, Kings, Nassau, New York, Queens, and  
Richmond Counties)
- 1928 L Marina Homecare Agency of NY, Inc.  
(Dutchess, Nassau, Orange, Putnam, Queens,  
Rockland, Suffolk, Sullivan, Ulster and Westchester  
Counties)
- 2139 L Westchester Homecare, Inc. d/b/a FirstLight  
HomeCare of Westchester  
(Westchester County)
- 2224 L Foster Nurses Agency USA, Inc.  
(Bronx, Kings, Nassau, New York, Queens and  
Richmond Counties)
- 2213 L Genesee Region Home Care of Ontario County, Inc.  
d/b/a Home Care Plus  
(See exhibit for Counties to be served)



# Public Health and Health Planning Council

Project #112086-B  
**1504 Richmond, LLC d/b/a Richmond Surgery Center**

**County:** Richmond

**Program:** Ambulatory Surgery Center

**Purpose:** Establishment and Construction

**Acknowledged:** August 15, 2011

## Executive Summary

### Description

1504 Richmond, LLC d/b/a Richmond Surgery Center, a to-be-formed proprietary limited liability company, requests approval for the establishment of a multi- specialty ambulatory surgery center to serve the residents of Richmond County. The Center will provide the following surgical services in two operating rooms; plastic surgery, gastroenterology, gynecology, ophthalmology, orthopedics, otolaryngology and urology. The space will be leased space located at 1504 Richmond Road, Staten Island, New York.

The proposed members of Richmond Surgery Center, and their ownership percentages, are as follows:

Scott Vitolo	35%
Todd Vitolo	35%
Noreen Vitolo	25%
Michael Costes, M.D.	5%

This project was originally presented to the Establishment and Project Review Committee on March 22, 2012, and proceeded to the Public Health and Health Planning Council on April 5, 2012. The Committee recommended, and the Council approved, a deferral of the project due to questions from the Committee about the lack of health care facility experience of the proposed members. After the deferral, the applicant revised the proposed members to include a physician and a member with health facility experience, as well as explained more fully the qualifying experiences of the original members.

The project was brought back to the Committee and Council on November 21, 2013 and December 12, 2013, respectively. The proposal was again deferred, this time to allow area hospitals time to FOIL and review the CON file.

At this time, after reviewing the revised material and considering information submitted by area hospitals, the Department is again forwarding the project for consideration.

### DOH Recommendation

Contingent Approval with an expiration of the operating certificate five (5) years from the date of issuance.

### Need Summary

The number of projected procedures is 1,980 in year 1 and 2,183 in year 3. These projections are based on the actual experience of the proposed surgeons who will be utilizing the proposed center. The procedures are currently done in out-of-hospital settings or at area hospitals.

### Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely on the applicant's character and competence or standing in the community.

A transfer and affiliation agreement is expected be provided by North Shore/Staten Island University Hospital.

### Financial Summary

Budget: Revenues:	\$ 2,376,790
Expenses:	\$ 1,858,376
Gain/(Loss):	\$ 518,414

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval with an expiration of the operating certificate five (5) years from the date of issuance contingent upon:**

1. Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the DOH beginning in the second year of operation. Said reports should include:
  - Data showing actual utilization including procedures;
  - Data showing breakdown of visits by payor source;
  - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - Data showing number of emergency transfers to a hospital;
  - Data showing percentage of charity care provided, and
  - Number of nosocomial infections recorded during the year in question. [RNR]
2. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
3. Submission by the governing body of the ambulatory surgery center of an organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
5. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
6. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
7. Submission of a signed and dated first page of Schedule 1A, acceptable to the Department. [CSL]
8. Submission of a photocopy of the applicant's Articles of Organization, acceptable to the Department. [CSL]
9. Submission of a photocopy of a fully executed and dated Certificate of Amendment to the applicant's Articles of Organization, acceptable to the Department. [CSL]
10. Submission of a photocopy of a fully executed and dated amendment to the applicant's Operating Agreement, acceptable to the Department. [CSL]
11. Submission of a photocopy of the applicant's revised Certificate of Doing Business under an Assumed Name, acceptable to the Department. [CSL]
12. Submission of a photocopy of a fully executed, dated and revised Lease Agreement, acceptable to the Department. [BFA, CSL]
13. Submission of documentation verifying the list of the applicant's managers, acceptable to the Department. [CSL]
14. Submission of documentation regarding the relocation or dissolution of Landmark Surgical, PLLC (Landmark PLLC) as applicable, acceptable to the Department. [CSL]
15. Submission of a signed statement from the applicant, acceptable to the Department, that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate. [CSL]
16. Submission of a photocopy of any and all fully executed and dated documents pursuant to which the applicant will acquire the operating assets of Landmark PLLC, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. (PMU)
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by March 30, 2015 in accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Council Action Date

**February 13, 2014**

## Need Analysis

### Background

1504 Richmond, LLC d/b/a Richmond Surgery Center is seeking approval to establish and construct a diagnostic and treatment center to provide multi-specialty ambulatory surgery services. The proposed freestanding ambulatory surgery center will be located at 1504 Richmond Road, Staten Island, 10304, in Richmond County and will provide plastic surgery, gastroenterology, gynecology, ophthalmology, orthopedics, otolaryngology, and urology surgical procedures.

### Analysis

The primary service area of the proposed project is Richmond County. Richmond County does not have any single specialty or multi-specialty freestanding ASCs. There are four hospitals in Richmond County that provide multi-specialty ambulatory surgical services.

The table below provides data on the number of total ambulatory patients in Richmond County hospitals.

<u>Ambulatory Surgery Patients</u>	<u>Total Patients 2012</u>
Richmond University Medical Center	3,764
Staten Island Hospital-North	12,754
Staten Island Hospital-South	4,030
Staten Island Hospital-Concord Div.	0

*SPARCS 2012*

The number of projected procedures is 1,980 in year 1 and 2,183 in year 3.

The applicant is committed to serving all persons in need of surgical care without regard to their ability to pay or the source of payment.

### Conclusion

The proposed ASC will provide residents of the borough with access to ambulatory surgery in a freestanding, non-hospital Article 28 setting; and will bring some procedures performed in non-Article 28 settings into an Article 28 environment.

### Recommendation

**From a need perspective, contingent approval with an expiration of the operating certificate five (5) years from the date of its issuance, is recommended.**

## Programmatic Analysis

### Background

Establish a diagnostic and treatment center that will also be federally certified as an ambulatory surgery center.

Proposed Operator	1504 Richmond, LLC
Doing Business As	Richmond Surgery Center
Site Address	1504 Richmond Road, Staten Island
Surgical Specialties	Multi-Specialty, including: Plastic Surgery Gastroenterology Gynecology Ophthalmology Orthopedics Otolaryngology Urology
Operating Rooms	2
Procedure Rooms	0
Hours of Operation	Monday through Friday from 8:00 am to 6:00 pm (Extended as necessary to accommodate additional procedures).
Staffing (1 <sup>st</sup> Year / 3 <sup>rd</sup> Year)	15.75 FTEs / 16.50 FTEs
Medical Director(s)	Michel Costes
Emergency, In-Patient and Backup Support Services Agreement and Distance	Expected to be provided by North Shore/Staten Island University Hospital 8.15 miles/14 minutes
On-call service	Patients will be provided with surgeon contact information as well as the facility's on-call service during hours when the facility is closed.

### Character and Competence

The members of the LLC are:

Todd Vitolo	35%
Scott Vitolo	35%
Noreen Vitolo	25%
Michel Costes, MD	5%

Todd Vitolo is an attorney currently employed as a licensed associate broker for a real estate company. He worked four years as a medical malpractice and health care litigation attorney and, besides general liability and product liability cases, he was involved in every aspect of medical malpractice defense litigation for both physicians and hospitals. He feels that this experience has allowed him to learn the inner workings of the health care system, including hospital and physician practices. Additionally, he feels it has allowed him to define the line between good and inadequate care and the processes which hospitals and physicians should have in place to insure the delivery of the necessary standard of care to the public. Mr. Vitolo feels he has developed a solid understanding and respect for the ethics, rules, regulations and laws that define the standard of care and conduct for patient care. In 2004, he started another career in residential real estate sales where he founded the Columbia Group which manages the sale and purchase of multi-million dollar properties. Mr. Vitolo feels this business experience will be useful as the operator of an ambulatory surgery center.

Scott Vitolo is currently the practice manager and administrator for an office based surgical (OBS) practice. Previously, he was a certified Emergency Medical Technician (EMT) who worked as a New York City Emergency Medical Service 911 EMT. He has also worked in the construction field. Mr. Vitolo is now, and has been, a medical practice manager for over 19 years, overseeing the planning, construction, and opening of an office based surgery center accredited by a national accrediting organization.

Mr. Vitolo acted as the general contractor and project manager for not only the OBS practice, but has also been involved in the development of several restaurant projects. He feels his intimate involvement in the construction and initiation of the OBS practice gave him extensive experience and knowledge of the Life Safety aspect of health care facilities. He also feels his experience as a practice manager and OBS administrator has given him an understanding of the ethical, moral, health and procedural standards required to operate an ambulatory surgery center. Mr. Scott Vitolo will be the center's administrator.

Noreen Vitolo, a licensed esthetician, is the owner/operator of a skin care business. She previously worked in a multi-location medical practice in the areas of operations, sales and customer service. She had also worked at an advertising agency prior to founding her own company which specialized in medical marketing. Her firm focused primarily on consumer medical education for physicians and hospitals in the tri-state area and her firm won a Telly award. Ms. Vitolo has traveled to Armenia to produce awareness videos for a children's open heart surgery center staffed by American volunteer surgeons, nurses and physicians in an effort to raise money for this charitable cause. Additionally, Ms. Vitolo actively fundraises for the American Cancer Society, and she is a member of the Staten Island Mental Health Society, the Women's Guild Committee and the Staten Island Chamber of Commerce. She opened her current business in 2003 and feels that her extensive experience running small businesses will be beneficial to the operation of the center. While Ms. Vitolo's role in the center will be all encompassing, she will act as Chief Business Officer and Director of Community Outreach and Education. She intends on ensuring that the center provides charitable care to the uninsured and reduced fees to those in need, especially those in traditionally underserved populations.

Dr. Michel Costes is a practicing physician who will serve as the facility's medical director.

It should be noted that Dr. Robert Vitolo, the father of Todd, Scott, and Noreen, is the current owner of an office based surgery practice at the proposed location. The proposal does not include any reference to Dr. Vitolo being a member of the applicant nor being in any management position at the center. He has signed an affidavit indicating he will have no ownership, managerial, or operational role in the center. Dr. Vitolo's only role will be as a participating/practicing surgeon.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

#### Integration with Community Resources

Should any patients present themselves at the center in need of primary care services, the center hopes to work with Staten Island University Hospital (SIUH) to provide such services. The proposed operators indicate that they have reached out to SIUH in an effort to establish a mutual network relationship. Additionally, the operators intend to participate in community health events and local religious institution events to make sure the community is aware of their services.

The center intends on utilizing electronic medical records and hopes to integrate in the regional health information organization (RHIO) or health information exchange (HIE). A sliding fee scale will be in place for those without insurance, and provisions will be made for those who cannot afford services.

#### Recommendation

**From a programmatic perspective, contingent approval is recommended.**

## Financial Analysis

### Lease Rental Agreement

The applicant has submitted a draft lease rental agreement for the site to be occupied. The terms of which are summarized below:

Premises: 5,760 square feet located at 1504 Richmond Road, Staten Island, New York, Richmond County  
 Lessor: Landmark 1504, LLC  
 Lessee: 1504 Richmond, LLC d/b/a Richmond Surgery Center  
 Rental: \$96,000 annually/\$8,000 monthly (\$16.67 per sq. ft.)  
 Term: (5) year term  
 Provisions: The lessee is responsible for paying 100% of the property taxes.

The applicant has provided two letters indicating the rent reasonableness. The applicant has indicated that the lease agreement will be an arms length lease agreement and provided an affidavit indicating the disclosure.

### Operating Budget

The applicant has submitted an operating budget, in 2013 dollars, for the first and third years of operation, summarized below:

	<u>Year One</u>	<u>Year Three</u>
Revenues	\$2,163,352	\$2,376,790
Expenses:		
Operating	\$1,562,995	\$1,750,376
Capital	<u>108,000</u>	<u>108,000</u>
Total Expenses	\$1,670,995	\$1,858,376
 Net Income	 \$492,357	 \$518,414
Utilization: (Procedures)	1,980	2,183
Cost Per Visit	\$843.94	\$851.29

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

Commercial Fee-for-Service	20.11%	20.18%
Commercial Managed Care	19.15%	19.22%
Medicare Fee-for-Service	38.31%	38.44%
Medicaid Fee-for-Service	5.27%	5.29%
Medicaid Managed Care	10.06%	10.09%
Charity Care	3.94%	3.60%
Private Pay	3.16%	3.18%

Expense and utilization assumptions are based on projected need study by the applicant and current reimbursement methodologies.

### Capability and Feasibility

There is no project cost associated with this application.

Working capital requirements, estimated at \$309,730, which appear reasonable based on two months' of third year expenses. The proposed members will provide equity in the amount of \$154,865 to meet the working capital requirement. BFA Attachment A is a summary net worth statement of the proposed members of Richmond Surgery Center, LLC, which indicates the availability of sufficient funds for the stated equity levels. The residual \$154,865 will be provided by a bank to 1504 Richmond, LLC at a rate of 7% for a term of (5) years. A letter of interest from Capital One Bank has been submitted.

BFA Attachment B is the pro-forma balance sheet of Richmond Surgery Center, which indicates a positive shareholders' equity position of \$154,865 as of the first day of operation.

The submitted budget projects a net income of \$492,357 and \$518,414 during the first year and third year of operation, respectively. Revenues are based on current reimbursement methodologies for ambulatory surgery services.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Personal Net Worth Statement- 1504 Richmond, LLC
BFA Attachment B	Pro-forma Balance Sheet- Richmond Surgery Center
BFA Attachment C	Detailed Budget of Richmond Surgery Center
BHFP Attachment	Map

## Supplemental Information

### Outreach

Below are presented summaries of responses by hospitals to letters from the Department asking for information on the impact of the proposed ambulatory surgery center (ASC) in their service areas. There follows a summary of the applicant's response to DOH's request for information on the proposed facility's volume of surgical cases, the sources of those cases, and on how staff will be recruited and retained by the ASC.

**Facility:** Richmond University Medical Center  
355 Bard Avenue  
Staten Island, NY 10310

Operating room utilization at Richmond University Medical Center (RUMC):

Current OR Use	Surgery Case Proportion <sup>1</sup>		Ambulatory Surgery Cases by Applicant Physicians	Reserved OR Time for Applicant Physicians
	Ambulatory	Inpatient		
70%	75%	25%	130	Not specified

RUMC opposes the application, stating that the proposed ASC presents "a grave financial risk" to the ongoing operation of RUMC's ambulatory program. The hospital does not attach a dollar amount to any expected loss of ambulatory surgical volume to the ASC. The hospital states that its current surgical revenues help support vital services, such as its 911 ambulance system and its Level 1 Trauma services in its ED. The hospital does not quantify the impact that a loss of surgical revenues to the proposed ASC would have on these or any other of its services or operations.

<sup>1</sup> Number of cases not specified.

RUMC had a working capital ratio of 0.98 in 2011 and 1.24 in 2012. In 2011, RUMC had an operating loss of \$17.1 million on revenues of \$283.1 million. In 2012, the facility had an operating loss of \$7.1 million on revenues of \$285.5 million. In 2011, RUMC provided charity care of \$5.3 million and experienced bad debt of \$14.8 million. In 2012, the facility provided \$6.2 million in charity care and had \$18.1 million in bad debt.

**Facility:** Staten Island University Hospital  
475 Seaview Avenue  
Staten Island, NY 10305

Operating room utilization at Staten Island University Hospital:

Current OR Use	Surgery Case Proportion <sup>2</sup>		Amb. Surg. Cases by Applicant Physicians	Reserved OR Time for Applicant Physicians
	Ambulatory	Inpatient		
North Campus OR: 69% (inpatient only) South Campus OR: 55% Ctr. for Ambulatory Surgery: 72%	S. Campus: 87%  Ctr. for Amb. Surgery: 99%	S. Campus: 13%  Ctr. for Amb. Surgery: 1%	354	Yes

The hospital opposes the application, based on its assumption that all 354 cases performed by applicant physicians at SIUH in 2012 would be transferred to the proposed ASC. The hospital projects that this would result in a loss of \$1,259,760 in revenues, which would adversely affect the ability of SIUH to provide necessary community services, such as health education events, chronic disease screening, flu vaccinations, smoking cessation programs, and similar activities. The hospital does not specify the specific impact that the projected loss would have on any individual service.

SIUH is reported under the North Shore-LIJ Health System's combined financial statement filing. The NSLIJ system had a working capital ratio of 1.7 in both 2011 and 2012. In 2011, NSLIJ system had an operating gain of \$134.2 million on operating revenue of \$6.2 billion. In 2012, the NSLIJ system's operating gain was \$97.9 million on operating revenue of \$6.7 billion. SIUH provided uncompensated care at established charges of approximately \$82,986,000 and \$69,916,000 in 2013 and 2012, respectively. This amount consisted of charity care of \$75,286,000 and \$63,116,000 in 2013 and 2012, respectively, and uncollectible charges written off as bed debt of \$7,700,000 and \$6,800,000 for 2013 and 2012, respectively.

Supplemental Information from Applicant

**Need and Source of Cases:** The applicant states that the projected volume of cases is based on the actual experience of the physicians who have expressed an interest in performing procedures at the proposed facility. The vast majority of these cases (85 percent) are currently performed in office-based settings. The applicant also expects the demand for ambulatory surgical services to continue to grow. The applicant further expects that patients will be attracted to the proposed ASC because of its convenience in scheduling and the fact that it will be located in an out-of-hospital setting.

**Staff Recruitment and Retention:** The applicant expects to employ existing staff of the current office-based practice. To the extent that additional staff is needed, the proposed operators are committed to not actively seeking staff from local hospitals.

**Office-Based Cases:** As noted, 85 percent of the cases projected for the proposed ASC are currently performed in an office-based setting.

<sup>2</sup> The hospital did not furnish the number of surgical cases. The percentages show the distribution of cases between inpatient and ambulatory surgery at each site.

#### OHSM Comment

The two hospitals that oppose this application assume that all the current cases performed by applicant physicians who practice at their facilities would be transferred to the proposed ASC. However, the applicant states that 85 percent of the cases projected for the proposed ASC are currently performed in an office-based setting, not in hospitals or hospital-based ambulatory surgery centers. In addition, neither hospital furnished information on its current annual number of ambulatory surgery cases, and one did not specify the actual dollar value of the revenues it expected to lose to the proposed ASC. The Department does not find the comments of the two hospitals sufficient to warrant reversal or modification of the recommendation for five-year limited life approval of the proposed ASC based on public need, financial feasibility and operator character and competence.

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 13th day of February, 2014, 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 free standing multi-speciality ambulatory surgery center to be located at 1504 Richmond Road, 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:

112086 B

FACILITY/APPLICANT:

1504 Richmond, LLC  
d/b/a Richmond Surgery Center

APPROVAL CONTINGENT UPON:

**Approval with an expiration of the operating certificate five (5) years from the date of issuance contingent upon:**

1. Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the DOH beginning in the second year of operation. Said reports should include:
  - Data showing actual utilization including procedures;
  - Data showing breakdown of visits by payor source;
  - Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - Data showing number of emergency transfers to a hospital;
  - Data showing percentage of charity care provided, and
  - Number of nosocomial infections recorded during the year in question. [RNR]
2. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
3. Submission by the governing body of the ambulatory surgery center of an organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
4. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
5. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
6. Submission of State Hospital Code (SHC) Drawings, acceptable to the Department, as described in BAEFP Drawing Submission Guidelines DSG-01. [AER]
7. Submission of a signed and dated first page of Schedule 1A, acceptable to the Department. [CSL]
8. Submission of a photocopy of the applicant's Articles of Organization, acceptable to the Department. [CSL]
9. Submission of a photocopy of a fully executed and dated Certificate of Amendment to the applicant's Articles of Organization, acceptable to the Department. [CSL]
10. Submission of a photocopy of a fully executed and dated amendment to the applicant's Operating Agreement, acceptable to the Department. [CSL]
11. Submission of a photocopy of the applicant's revised Certificate of Doing Business under an Assumed Name, acceptable to the Department. [CSL]
12. Submission of a photocopy of a fully executed, dated and revised Lease Agreement, acceptable to the Department. [BFA, CSL]
13. Submission of documentation verifying the list of the applicant's managers, acceptable to the Department. [CSL]
14. Submission of documentation regarding the relocation or dissolution of Landmark Surgical, PLLC (Landmark PLLC) as applicable, acceptable to the Department. [CSL]

15. Submission of a signed statement from the applicant, acceptable to the Department, that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate. [CSL]
16. Submission of a photocopy of any and all fully executed and dated documents pursuant to which the applicant will acquire the operating assets of Landmark PLLC, acceptable to the Department. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. (PMU)
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. The submission of Final Construction Documents, signed and sealed by the project architect, as described in BAEFP Drawing Submission Guidelines DSG-01, prior to the applicant's start of construction. [AER]
7. The applicant shall complete construction by March 30, 2015 in accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 131224 E Visiting Nurse Service of New York Home Care

**County:** Dutchess County  
**Purpose:** Establishment

**Program:** Certified Home Health Agency  
**Acknowledged:** April 26, 2013

### Executive Summary

#### Description

Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care (VNSNY), a not-for-profit corporation, is requesting to establish a new Certified Home Health Agency (CHHA) into Dutchess, Orange, Putnam, Sullivan and Ulster Counties. VNSNY's CON 131225 is concurrently being reviewed, requesting eight additional upstate counties. VNSNY currently serves Kings, Bronx, Queens, New York, Nassau, Westchester, Richmond and Rockland Counties. VNSNY was approved by the Public Health and Health Planning Council for Suffolk County as of April 11, 2013.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Visiting Nurse Service of New York Home Care submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation  
Contingent Approval

Program Summary  
This proposal seeks to establish a new Certified Home Health Agency (CHHA) to serve the upstate counties of Dutchess, Orange, Putnam, Sullivan, and Ulster, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

Financial Summary  
There are no project costs associated with this application.

Incremental Budget:	
Revenues:	\$11,252,813
Expenses:	<u>11,139,966</u>
Gain (Loss):	\$112,847

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. The Department of Health reserves the right to re-evaluate the incremental budgets for feasibility if all counties for establishment or expansion are not approved. [BFA]
2. Submission of an executed sublease building agreement, acceptable to the Department. [BFA]
3. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
4. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
6. Submission of a photocopy of the applicant's full executed Certificate of Assumed Name, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Visiting Nurse Service of New York Home Care II, Inc. d/b/a Visiting Nurse Service of New York Home Care is requesting approval to establish a new Certified Home Health Agency to serve the upstate counties of Dutchess, Orange, Putnam, Sullivan and Ulster counties.

On December 8, 2011 the Public Health and Health Planning Council adopted an amendment to Section 750.5 of Title 10, NYCRR authorizing the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies (CHHAs) or expand existing CHHAs. Public need was based on established criteria in section 709.1(a) of Title 10 and that approval of the application will facilitate implementation of Medicaid Redesign Initiatives to shift Medicaid beneficiaries from traditional fee-for-service programs to managed care, managed long term care systems, integrated health systems or similar care coordination models or that approval will ensure access to CHHA services in counties with less than 2 existing CHHAs.

## Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17<sup>th</sup> and 27<sup>th</sup> were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

## Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17<sup>th</sup> and 27<sup>th</sup> letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

The applicant provided a thorough analysis of the home health care needs and demonstrated knowledge of the issues surrounding home health care in the counties requested. The applicant also demonstrated how its organizational capacity including disease management and care management programs will produce quality and efficient home health care.

VNSNY demonstrated support of Medicaid Redesign initiatives and elaborated on transitioning patients into MLTCPs; reducing utilization while improving outcomes; managing high risk complex cases; extensive experience in care management programs and existing utilization control programs; health home initiatives; behavioral health programs; and their HIT system that utilizes a variety of tools that will enhance care coordination and improve health outcomes.

The applicant has existing proven care management programs such as their Congregate Care program, SPARK program, ESPIRIT, and Centers of Excellence. These programs provide outreach to the community and/or improve care management for high-risk cases. The applicant has existing utilization control programs and has an HIT system that utilizes a variety of tools that will enhance care coordination and improve health outcomes. The applicant also discussed how the CHHA will produce operating efficiencies within the health care system through clinical innovation and economies of scale.

Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Background

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, is an existing not-for-profit corporation currently operating an Article 36 CHHA and LTHHCP, with its main parent office located in New York County, and six branch offices located in Bronx, Kings, Queens, Richmond, Nassau, and Westchester Counties. The CHHA serves Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, and Rockland Counties, and was approved by PHHPC on April 11, 2013, to expand into Suffolk County. The LTHHCP serves Bronx, Kings, New York, Queens, and Nassau Counties. The applicant also operates VNS Children and Adolescent Mental Health Clinic at FRIENDS, a mental health clinic licensed by NYS Office of Mental Health.

This CON application # 131224-E has been submitted by Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, to request approval to establish a new additional CHHA in New York State, under Article 36 of the Public Health Law, with approval to serve the upstate counties of Dutchess, Orange, Putnam, Sullivan, and Ulster, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties. A companion CON application # 131225-E has also been submitted by Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, to request approval to establish a second new additional CHHA in New York State, under Article 36 of the Public Health Law, with approval to serve the upstate counties of Hamilton, Fulton, Montgomery, Otsego, Delaware, Herkimer, Oneida, and Onondaga, also pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties. That companion CON application is also being presented to the PHHPC at this time under separate cover.

The applicant proposes to operate the new CHHA proposed in this CON application # 131224 from a main parent office practice location at 300 Westage Business Center Drive, Suite 225, Fishkill (Dutchess County), New York 12524, to serve Dutchess, Orange, Putnam, Sullivan, and Ulster Counties.

The applicant proposes to provide the following home health care services:

Nursing	Home Health Aide	Medical Social Services
Physical Therapy	Occupational Therapy	Speech Language Pathology
Medical Supplies, Equipment, and Appliances		

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, has as its member (parent) corporation Visiting Nurse Service of New York, a not-for-profit corporation. Visiting Nurse Service of New York is also the member (parent) corporation of the following not-for-profit corporations: Visiting Nurse Service of New York Hospice Care, an Article 40 hospice; New Partners, Inc., d/b/a Partners in Care Services, an Article 36 licensed home care services agency (LHCSA); Family Care Services, an Article 36 LHCSA and home attendant program; and VNS Continuing Care Development Corporation. The latter corporation is the member (parent) corporation of VNS Choice, d/b/a VNSNY Choice, a Managed Care Organization which includes a Managed Long Term Care Plan, a Medicaid Advantage Plan, and a Medicaid Advantage Plus Plan; and VNS Choice Community Care, an Article 36 LHCSA.

The governing body of the applicant, Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, is as follows:

Jon Mattson, Chairperson  
Partner, Trilantic Capital Partners (Private  
Equity Partnership)  
Affiliations: VNSNY

Anne Bick Ehrenkranz, Vice Chairperson  
Retired  
Affiliations: VNSNY; New Partners, Inc., d/b/a  
Partners in Care

Margaret A. Bancroft, Esq.  
Of Counsel, Dechert, LLP (Law Firm)  
Affiliations: VNSNY

Alice Cooney Frelinghuysen  
Curator, Metropolitan Museum of Art  
Affiliations: VNSNY

Elisabeth Gotbaum  
Partner, Bedford Grove (Political Fundraising  
Firm)  
Affiliations: VNSNY

Clare Gregorian  
Retired  
Affiliations: VNSNY

Valerie S. Peltier, Esq.  
Managing Director, Tishman Speyer  
Properties, Inc. (Real Estate Development)  
Affiliations: VNSNY

Carl H. Pforzheimer, III  
Manager, Carl H. Pforzheimer & Co., LLC  
(Investment Firm)  
Affiliations: VNSNY

John P. Rafferty, CPA  
Retired Partner, Ernst and Young, LLP  
(Accounting Firm)  
Affiliations: VNSNY

Ira S. Rimerman  
Retired Senior Executive, Citigroup (Banking)  
Affiliations: VNSNY; Continuum Health  
Partners, Inc. (Beth Israel Medical Center, Inc.  
– Petrie Campus, Manhattan, and Kings  
Highway Division, Brooklyn; St. Lukes  
Roosevelt Hospital Center, Inc. – Roosevelt  
Hospital Division and St. Lukes Hospital  
Division; Long Island College Hospital; New  
York Eye and Ear Infirmary, Inc. (all Hospitals);  
Beth Israel Ambulatory Care Services Corp.  
(D&TC); Robert Mapplethorpe Residential  
Treatment Facility (RHCF); Jacob Perlow  
Hospice Corp. (Hospice)

The governing body of the member (parent) corporation, Visiting Nurse Service of New York, is as follows:

Douglas D. Broadwater, Esq., Chairperson  
Retired Partner, Cravath, Swaine & Moore,  
LLP (Law Firm)

Frank S. Vigilante  
Retired Senior V.P., AT&T  
Affiliations: VNA of Central Jersey, Inc.  
(Hospice), VNA of Central Jersey Health  
Group, Inc. (CHHA); VNSNY Hospice Care

Margaret A. Bancroft, Esq.  
Disclosed above

Bobbie Berkowitz, RN (WA)  
Senior VP, Columbia University Medical Center  
Dean, Columbia University School of Nursing  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care; Group  
Health Cooperative, Seattle, WA (NFP Health  
Care Plan); Qualis Health, Seattle, WA (NFP  
Healthcare Quality Consulting Organization)

Carmen Beauchamp Ciparick, Esq.  
Of Counsel, Greenberg Traurig, LLP (Law  
Firm)  
Retired Associate Judge, NYS Court of  
Appeals  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

Robert C. Daum  
Retired CEO, DFMC, Inc., d/b/a Growth Capital  
Partners (Investments)  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

E. Mary C. Davidson  
VP, Maxwell Davidson Gallery (Art Dealer)  
Affiliations: VNSNY Hospice Care

Jose M. de Lasa, Esq.  
Of Counsel, Baker and MacKenzie (Law Firm)

Edith M. Dupuy, RN  
Retired

Anne Bick Ehrenkranz  
Disclosed above

Claire M. Fagin, R.N., Ph.D.  
Retired Self-Employed Consultant

Alice Cooney Frelinghuysen  
Disclosed above

Elisabeth Gotbaum  
Disclosed above

Clare Gregorian  
Disclosed above

Mary R. (Nina) Henderson  
Managing Partner, Henderson Advisory  
(Consulting Firm)  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care

Peter L. Hutchings  
Retired Exec. V.P. & CFO, Guardian Life  
Insurance Co.  
Affiliations: VNS Choice, d/b/a VNSNY  
Choice; VNS Choice Community Care; Public  
Health Solutions, d/b/a MIC Women's Health  
Services, formerly Medical and Health  
Research Association of NYC (D&TC), NY  
Organ Donor Network, Empire Health Choice  
(HMO)

Robert M. Kaufman, Esq.  
Partner, Proskauer Rose, LLP (Law Firm)  
Board Director, Old Westbury Funds (Mutual Funds)  
Affiliations: VNSNY Hospice Care; Public Health Solutions, d/b/a MIC Women's Health Services, formerly Medical and Health Research Association of NYC (D&TC)

Michael Laskoff  
CEO, Managing Partner, Abilto, LLC  
(Behavioral Health Consulting)  
Affiliations: New Partners, Inc., d/b/a Partners in Care

Arthur Lindenauer, CPA  
Retired CFO, Schlumberger Limited (Oil Field Services)  
Affiliations: New Partners, Inc., d/b/a Partners in Care

Kwan-Lan (Tom) Mao  
Retired V.P., Citigroup (Banking)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Joseph D. Mark  
Retired President, Aveta, Inc. (Health Insurance Company)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Jon Mattson  
Disclosed above

Mathy Mezey, R.N., Ed.D.  
Professor, NYU College of Nursing  
Affiliations: VNSNY Hospice Care

Phyllis J. Mills, R.N.  
Trustee, Mary Flagler Charitable Trust  
Affiliations: VNS Continuing Care Development Corporation; VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Valerie S. Peltier, Esq.  
Disclosed above

Carl H. Pforzheimer, III  
Disclosed above

John P. Rafferty, CPA  
Disclosed above

Corinne H. Rieder, Ed.D.  
Executive Director, Treasurer, The John A. Hartford Foundation (Charitable Foundation)  
Affiliations: VNSNY Hospice Care

Ira S. Rimerman  
Disclosed above

Andrew N. Schiff, M.D.  
Partner, Aisling Capital (Investments/Finance)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Albert L. Siu, MD  
Chairman / Professor, Mount Sinai School of Medicine's Brookdale Department of Geriatrics and Palliative Medicine  
Director, Bronx VA Medical Center's Geriatric Research, Education, and Clinical Center  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Senior Health Partners (MLTCP); Mount Sinai Care, LLC (ACO)

Kenneth G. Standard, Esq.  
Partner, Epstein Becker & Green, PC (Law Firm)  
Affiliations: Family Care Services

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A search of all of the above named board members, employers, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the Office of the Inspector General's Provider Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile, the Office of Professional Medical Conduct, the NYS Unified Court System, and the Washington State Department of Health Professional Licensing, where appropriate, indicate no issues with the licensure of the health professionals and other licensed professionals associated with this application. In addition, the attorneys have all submitted current Certificates of Good Standing.

The Division of Hospitals and Diagnostic and Treatment Centers reviewed the compliance history of all affiliated hospitals and diagnostic and treatment centers for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following facility was the subject of enforcement actions:

St. Lukes Roosevelt Hospital Center, Inc. was the subject of an enforcement action in 2006 based on violations citing improperly delayed treatment due to financial considerations. The hospital paid a \$4,000 civil penalty to resolve this matter. The hospital has been in compliance since that time.

It has been determined that the affiliated hospitals and diagnostic and treatment centers have provided a substantially consistent high level of care.

The Division of Residential Services reviewed the compliance history of the affiliated residential health care facility for the time period specified as the affiliation. It has been determined that the residential health care facility has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The Division of Home and Community Based Services reviewed the compliance history of all affiliated long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following provider was the subject of an enforcement action:

Jacob Perlow Hospice Corporation, now d/b/a MJHS Hospice and Palliative Care (formerly d/b/a Continuum Hospice Care / Jacob Perlow Hospice / Harlem Community Hospice) was cited with condition-level deficiencies in the areas of Governing Authority; Contracts; Administration; Staff and Services; Personnel; Patient / Family Rights; Plan of Care; and Medical Records Systems / Charts, as a result of a November 29, 2006 survey. An enforcement action was resolved with an October 1, 2007 stipulation and order, which included payment of a \$24,000 civil penalty. The agency has been in compliance since that time.

It has been determined that the long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices have exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations. When code violations did occur, it was determined that the operators investigated the circumstances surrounding the violation and took steps appropriate to the gravity of the violation that a reasonably prudent operator would take to promptly correct and prevent the recurrence of the violation.

The Office of Health Insurance Programs Division of Managed Care reviewed the compliance history of the affiliated managed long term care plans and health maintenance organizations for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied.

The Office of Health Insurance Programs Division of Managed Care reports that the Medicaid Advantage Plan operated by VNS Choice, d/b/a VNSNY Choice, has no enforcement history and is currently in substantial compliance. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, had a suspension on all new enrollments imposed in April 2013, which was lifted by the Department and new enrollments were allowed to resume, effective November 1, 2013. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, are therefore now in substantial compliance. The New York State Office of the Attorney General reports that, although it has a continuing investigation involving this same provider at this time, the Office of the Attorney General no longer requests that the Department hold off the review and approval of the current applications, since the provider has executed an interim agreement to resolve in principle certain aspects of their investigation.

It has therefore been determined that the affiliated managed long term care plans and health maintenance organizations are currently in substantial compliance with all applicable codes, rules, and regulations.

The New York State Office of Mental Health has reviewed the compliance history of the affiliated mental health clinic, for the time period 2008 (initial licensure) to 2013, and has determined the mental health clinic has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The State of New Jersey has reviewed the compliance histories of the health care facilities operated under VNA of Central Jersey, Inc., and VNA of Central Jersey Health Group, Inc., for the time period specified as the affiliation, and has determined the health care facilities have been in substantial compliance with all applicable codes, rules, and regulations.

The State of Washington has reviewed the compliance history of the health care plan administered by Group Health Cooperative, for the time period specified as the affiliation, and has determined the health care plan has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

A review of all personal qualifying information indicates there is nothing in the background of the board members of Visiting Nurse Service of New York Home Care II and Visiting Nurse Service of New York to adversely effect their positions on the boards. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

#### Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

#### Sublease Agreement

The applicant has submitted a proposed sublease agreement for 3780 square feet on the second floor of 300 Westage Business Center Drive, Suite 225, located in Fishkill (Dutchess County), the terms of which are summarized below:

Premises:	300 Westage Business Center Drive, Suite 225, Fishkill, New York 12524
Lessor:	Samson Westage, LLC
Lessee, Sublessor:	VNS Choice
Sublessee:	VNSNY Home Care II
Rental:	\$7,560 /mo. (\$24.00/sq.ft.)
Term:	5 years with an additional 5 year renewal option.
Provisions:	The Lessee shall be responsible for insurance, taxes, maintenance and utilities.

The sublease arrangement is a non-arm's length agreement and the applicant has submitted letters from licensed real estate brokers attesting to the reasonableness of the per square foot rental.

#### Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars:

	<u>Year One</u>	<u>Year Three</u>
Revenues:		
Commercial Managed Care	\$339,221	\$600,274
Medicare Fee-for-Service	2,564,581	4,139,086
Medicare Managed Care	329,244	582,619
Medicaid Managed Care	<u>5,328,469</u>	<u>5,930,834</u>
Total Revenues	\$8,561,515	\$11,252,813
Expenses	<u>\$8,440,269</u>	<u>\$11,139,966</u>
Net Gain (Loss)	\$121,246	\$112,847

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

<u>Pavor</u>	<u>Year One</u>	<u>Year Three</u>
Commercial Managed Care	4.8%	6.2%
Medicare Fee-for-Service	27.2%	34.5%
Medicare Managed Care	4.7%	6.1%
Medicaid Managed Care	61.3%	51.2%
Charity Care	2.0%	2.0%

Expense and utilization assumptions are based on the provider's historical experience. Revenues are reflective of current payment rates as well as the implementation of the Medicaid Episodic Payment system.

#### Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at \$1,856,661, appear reasonable based on two months of third year expenses and will be provided through the existing operation. BFA Attachment A is the financial summary for Visiting Nurse Service of New York Home Care.

The submitted budget indicates that the applicant will achieve a \$121,246 and \$112,847 incremental net revenue in the first and third years of operations, respectively. Revenue is based on current payment rates for Certified Home Health Agencies. The submitted budget appears reasonable.

BFA Attachment A is the 2012 audited and 2011 audited financial summary of VNSNY, which shows the applicant has maintained positive working capital, net equity and experienced net loss from operations of \$6,814,000 and \$15,842,000 for 2012 and 2011, respectively. Losses in 2011 and 2012 are related to declines in volume, as well as rate reductions in both Medicare and Medicaid. VNSNY plans to implement significant operational improvements to reach break-even financial operating results by 2015. Over the course of the next three years VNSNY intends:

- Significant cost savings in reaching best practice benchmarks in utilization, productivity and administrative cost efficiencies.
- To mitigate losses, the organization is reviewing expenses and overhead including administrative position eliminations, call center redesign, streamline of contract administration, and office space consolidation.
- In addition, VNSNY will be investing in new information technology that will facilitate the achievement of cost efficiency improvements. These technologies will enable more real-time utilization controls, caseload optimization and streamlined administrative functions.

Based on proceeding, it appears that the applicant has demonstrated the financial capability to proceed in a financially feasible manner, and contingent approval is recommended.

Recommendation

**From a financial perspective, contingent approval is recommended.**

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## Attachments

BFA Attachment A

Financial Summary for 2011 audited and 2012 audited Visiting Nurse  
Service of New York Home Care

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 13th day of February, 2014, 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 certified home health agency operated by Visiting Nurse Services of New York Home Care to serve Dutchess, Orange, Putnam, Sullivan and Ulster Counties, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER

APPLICANT/FACILITY

131224 E

Visiting Nurse Service of New York  
Home Care

APPROVAL CONTINGENT UPON:

1. The Department of Health reserves the right to re-evaluate the incremental budgets for feasibility if all counties for establishment or expansion are not approved. [BFA]
2. Submission of an executed sublease building agreement, acceptable to the Department. [BFA]
3. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
4. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
6. Submission of a photocopy of the applicant's full executed Certificate of Assumed Name, acceptable to the Department. [CSL]

APPROVAL CONDITIONED UPON:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 132178 E Big Apple Dialysis Management, LLC

**County:** Kings County  
**Purpose:** Establishment

**Program:** Diagnostic and Treatment Center  
**Acknowledged:** October 4, 2013

### Executive Summary

#### Description

Big Apple Dialysis Management, LLC (Big Apple) requests approval to become the established operator of four chronic renal dialysis programs, which are currently operated by New York City Health & Hospitals Corporation at the following locations:

- Kings County Hospital Center located at 451 Clarkson Avenue, Dialysis Unit Room C6210, Brooklyn, to be renamed Big Apple Dialysis at Kings County Hospital
- Lincoln Hospital Center located at 234 East 149<sup>th</sup> Street, Hemodialysis Unit, Bronx, to be renamed Big Apple Dialysis at Lincoln Hospital
- Metropolitan Hospital Center, located at 1901 First Avenue, Dialysis Unit, New York to be renamed Big Apple Dialysis at Metropolitan Hospital Center
- Harlem Hospital located at 506 Lenox Avenue-Room 18-107 Dialysis Unit, New York, to be renamed Big Apple Dialysis at Harlem Hospital

Currently the Kings County Hospital location, which will become Big Apple's main site, is approved for 26 stations, located within the confines of the hospital. The Lincoln Hospital Center location is approved for eight dialysis stations, located within the confines of the hospital. The Metropolitan Hospital location is approved for 12 dialysis stations, located within the confines of the hospital. The Harlem Hospital Center location is approved for 11 dialysis stations, located within the confines of the hospital.

Upon the proposed change in ownership, there will not be a change in the number of approved stations or a modification to the existing physical environment

where the stations are located. Big Apple will enter into a license agreement with the New York City Health and Hospital Corporation for the right to continue to provide the ESRD services upon the change in ownership. There will be no disruption of services to the existing patients who receive dialysis services.

The members of Big Apple Dialysis Management, LLC and their ownership percentages are as follows:

<u>Owner</u>	<u>Percentage</u>
Jodumutt G. Bhat, M.D.	50%
Nirmal Mattoo, M.D.	50%

DOH Recommendation  
Contingent Approval

#### Need Summary

All three counties serve a total population of 5,593,198 with a total of 1674 stations, including approval of not-yet-operational stations. There continues to be need in all three counties. These stations are necessary to provide continued service to patients in the service areas.

#### Program Summary

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

Financial Summary

The purchase price is \$1,137,380.88, based on the estimated current fair market value of the equipment within the centers. The purchase price will be met by \$113,738.88 in equity from the proposed members and a \$1,023,642 loan with a five year term at a 3.16% interest rate from JPMorgan Chase Bank, N.A. The rate is based on the 30 day Libor plus 3.00%. The current 30 day Libor per the Wall Street Journal published January 15, 2014 is 0.16%. There are no project costs associated with this CON.

Total Budget Year-One-All Sites

Revenues	\$15,090,828
Expenses	<u>\$12,021,686</u>
Gain	\$3,069,142

Year One Budget by Individual Site:

**Big Apple Dialysis @ Kings County Hospital**

	<u>Year One</u>
Revenues	\$5,102,345
Expenses	<u>\$4,235,617</u>
Gain	\$866,728

**Big Apple Dialysis @ Lincoln Hospital Center**

	<u>Year One</u>
Revenues	\$3,214,988
Expenses	<u>\$2,520,020</u>
Gain	\$694,968

**Big Apple Dialysis @ Metropolitan Hospital Center**

	<u>Year One</u>
Revenues	\$2,694,082
Expenses	<u>\$2,377,667</u>
Gain	\$316,415

**Big Apple Dialysis @ Harlem Hospital**

	<u>Year One</u>
Revenues	\$4,079,413
Expenses	<u>\$2,888,382</u>
Gain	\$1,191,031

Subject to the noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There will be no HSA recommendation of this application.

Office of Health Systems Management

**Approval contingent upon:**

1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital for each of the four sites. [HSP]
2. Submission of a Medical Director Agreement, acceptable to the Department. [HSP]
3. Submission of a loan commitment, acceptable to the Department. [BFA]
4. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
5. The submission of existing conditions schematic floor plans and architects letter of certification for existing buildings, for review and approval. [AER]
6. Submission of a completed Schedule 3. [CSL]
7. Submission of an executed Certificate of Assumed Name, acceptable to the Department and clarification regarding whether each location requires a Certificate of Assumed Name – if they are all operating under different names. [CSL]
8. Submission of an executed Certificate of Amendment of the Articles of Organization, acceptable to the Department. [CSL]
9. Submission of an executed Operating Agreement (and Joinder), acceptable to the Department. [CSL]
10. Submission of an executed Administrative Services Agreement for all four (Harlem, Kings, Lincoln and Metropolitan) locations, acceptable to the Department. [BFA, CSL]
11. Submission of an executed building license agreement for all four (Harlem, Kings, Lincoln and Metropolitan) sites, acceptable to the Department. [BFA, CSL]
12. Submission of an executed Purchase and Sale Agreement. [CSL]

**Approval conditional upon:**

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. To provide Transfusion Services, licensure by the New York State Department of Health- Wadsworth Center is required. [HSP]

Council Action Date

**February 13, 2014**

# Need Analysis

## Background

Big Apple is seeking approval to be established as the new operator of four existing dialysis centers. These centers are as follows:

- Kings County Hospital Center, a 26-station chronic dialysis facility located at 451 Clarkson Avenue in Brooklyn, 11203;
- Lincoln Medical and Mental Health, an 8-station chronic dialysis facility located at 234 East 149<sup>th</sup> Street in the Bronx, 10451;
- Metropolitan Hospital Center, a 12-station chronic dialysis facility located at 1901 First Avenue in Manhattan, 10029 ;
- Harlem Hospital, an 11-station chronic dialysis unit located at 506 Lenox Ave Room 18-107 in Manhattan,10037.

There is need in Kings, Bronx, and New York Counties for additional chronic dialysis stations. Retaining these existing facilities is necessary for community residents and patients. There will not be any changes in the number of stations or the services offered at the facilities.

## Analysis

The service area for Big Apple and the facilities they are purchasing is Kings, Bronx, and New York Counties.

### Kings Population - 2,565,635

Ages 65 and Over:	11.7%	State Average:	14.1%
Nonwhite:	64.2%	State Average:	42.4%

### Bronx Population - 1,408,473

Ages 65 and Over:	10.9%	State Average:	14.1%
Nonwhite:	89.2%	State Average:	42.4%

### New York County Population - 1,619,090

Ages 65 and Over:	13.9%	State Average:	14.1%
Nonwhite:	52.4%	State Average:	42.4%

Source: U.S. Census 2012

The non-white and elderly groups are target groups for needing dialysis services, thus the reason we focus on the above percentage comparisons.

## Capacity

The Department's methodology to estimate capacity for chronic dialysis stations is specified in Part 709.4 of Title 10 and is as follows:

- One free standing station represents 702 treatments per year. This is based on the expectation that the center will operate 2.5 patient shifts per day at 6 days per week, which can accommodate 15 patients per week (2.5 x 6 x 15 x 52 weeks). This projected 702 treatments per year is based on a potential 780 treatments x 52 weeks x 90% utilization rate = 702. The estimated average number of dialysis procedures each patient receives per year is 156.
- One hospital based station is calculated at 499 treatments per year per station. This is the result of 2.0 shifts per day x 6 days per week x 52 weeks x 80% utilization rate. One hospital based station can treat 3 patients per year.
- Per Department policy, hospital-based stations can treat fewer patients per year. Statewide, the majority of stations are free standing, as are the majority of applications for new stations. As such, when calculating the need for additional stations, the Department bases the projected need on establishing additional free standing stations.

Existing Stations

Kings – 585 current stations and 132 in pipeline  
 Bronx- 389 current stations and 93 in pipeline  
 New York- 380 current stations and 95 in pipeline

Based upon DOH methodology, Kings County could treat 3227 patients with the operational stations and pipeline stations combined. Bronx County could treat 2169 patients with the operational stations and pipeline stations combined. New York County could treat 2138 patients with the operational stations and pipeline stations combined.

Projected Need

	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated
Kings County	3954	4507	4584	5073
Free Standing Stations Needed	879	1002	1019	1128
Existing Stations	585	585	585	585
Total Stations (Including Pipeline)	717	717	717	717
Net new stations from this project	0	0	0	0
Unmet Need With Approval	162	285	302	411

	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated
Bronx County	2616	2739	3033	3083
Free Standing Stations Needed	582	609	674	686
Existing Stations	389	389	389	389
Total Stations (Including Pipeline)	482	482	482	482
Net new stations from this project	0	0	0	0
Unmet Need With Approval	100	127	192	204

	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated
New York County	1917	2756	2223	3102
Free Standing Stations Needed	426	613	494	690
Existing Stations	380	380	380	380
Total Stations (Including Pipeline)	475	475	475	475
Net new stations from this project	0	0	0	0
Unmet Need With Approval	-49	138	19	215

\*\*FS – Free Standing

\*\*\*Based upon a estimate of a three percent annual increase

The data in the first row, "Free Standing Stations Needed," comes from the DOH methodology of each station being able to treat 4.5 patients, and each hospital station being able to treat 3 patients annually. The data in the next row, "Existing Stations," comes from the Department's Health Facilities Information System (HFIS). "Unmet Need" comes from subtracting needed stations from existing stations. "Total Patients Treated" is from IPRO data from 2011.

Recommendation

**From a need perspective, approval is recommended.**

<b>Programmatic Analysis</b>
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Background

Establish Big Apple Dialysis Management, LLC as the new operator of four dialysis programs/centers that are currently being operated by the New York City Health & Hospital Corporation. The center in Kings Hospital will be designated as the main site and three remaining centers, located in Lincoln Hospital, Metropolitan Hospital and Harlem Hospital, will be designated as extension sites. The applicant does not anticipate any physical changes or changes to the number of stations.

<b>Proposed Operator</b>	Big Apple Dialysis Management, LLC
<b>Doing Business As</b>	Big Apple Dialysis at Kings County Hospital
<b>Site #1 Address</b>	451 Clarkson Avenue, Brooklyn
<b>Approved Services</b>	Chronic Renal Dialysis (26 Stations)
<b>Shifts/Hours/Schedule</b>	Open 6 days per week, nearly 3 shifts per day.
<b>Staffing (1<sup>st</sup> Year/3<sup>rd</sup> Year)</b>	28.0 FTEs and will remain at that level by the third year of operation.
<b>Medical Director(s)</b>	Gary Briefel, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided onsite by Kings County Hospital.

<b>Proposed Operator</b>	Big Apple Dialysis Management, LLC
<b>Doing Business As</b>	Big Apple Dialysis at Lincoln Hospital
<b>Site #2 Address</b>	234 East 149 <sup>th</sup> Street, Bronx
<b>Approved Services</b>	Chronic Renal Dialysis (8 Stations)
<b>Shifts/Hours/Schedule</b>	Open 6 days per week, nearly 3 shifts per day.
<b>Staffing (1<sup>st</sup> Year/3<sup>rd</sup> Year)</b>	14.1 FTEs and will remain at that level by the third year of operation.
<b>Medical Director(s)</b>	Isaiarasi Gnanasekaran, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided onsite by Lincoln Hospital.

<b>Proposed Operator</b>	Big Apple Dialysis Management, LLC
<b>Doing Business As</b>	Big Apple Dialysis at Metropolitan Hospital
<b>Site #3 Address</b>	1901 First Avenue, Manhattan
<b>Approved Services</b>	Chronic Renal Dialysis (12 Stations)
<b>Shifts/Hours/Schedule</b>	Open 6 days per week, nearly 3 shifts per day.
<b>Staffing (1<sup>st</sup> Year/3<sup>rd</sup> Year)</b>	13.0 FTEs and will remain at that level by the third year of operation.
<b>Medical Director(s)</b>	Ashok P. Chaudhuri, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided onsite by Metropolitan Hospital

<b>Proposed Operator</b>	Big Apple Dialysis Management, LLC
<b>Doing Business As</b>	Big Apple Dialysis at Harlem Hospital
<b>Site #4 Address</b>	506 Lenox Avenue, Manhattan
<b>Approved Services</b>	Chronic Renal Dialysis (11 Stations)
<b>Shifts/Hours/Schedule</b>	Open 6 days per week, nearly 3 shifts per day.
<b>Staffing (1<sup>st</sup> Year/3<sup>rd</sup> Year)</b>	15.7 FTEs and will remain at that level by the third year of operation.
<b>Medical Director(s)</b>	LeRoy Herbert, MD
<b>Emergency, In-Patient and Backup Support Services Agreement and Distance</b>	Expected to be provided onsite by Harlem Hospital

The document entitled "Medical Director Agreement" submitted with the application delegates more authority to the contractor, Physicians Affiliate Group of New York, then is provided for in regulation. Specifically, it is an employment contract for the provision of multiple, unnamed, Medical Directors at four separate sites. As drafted, it constitutes an unacceptable management contract because the established operator is not retaining direct independent authority to appoint and discharge the Medical Directors as required by regulation. Therefore, a contingency has been placed on the recommendation regarding the submission of an acceptable Medical Director Agreement.

#### Character and Competence

The members of the LLC are:

<u>Name</u>	<u>Percent</u>
Jodumutt G. Bhat, MD	50.0%
Nirmal Mattoo, MD	50.0%

Drs. Bhat and Mattoo are both local physicians, board-certified in Internal Medicine. Dr. Mattoo holds a subspecialty in Nephrology.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

#### Recommendation

**From a programmatic perspective, contingent approval is recommended.**

## Financial Analysis

### Asset Purchase Agreement

The applicant has submitted a draft asset purchase agreement, which is summarized as follows:

Date:	September 4, 2013
Seller:	New York City Health and Hospitals Corporation
Purchaser:	Big Apple Dialysis Management, LLC
Acquired Assets:	The physical assets relating to the facilities including All equipment without limitation, reverse osmosis system, dialysis machines and recliners, telephone, fax and computer P.C.s, all furniture, all inventory and supplies located at such facility (collectively, the Inventory), All rights and interest in and to claims made or to be made by seller against the party from whom seller purchased the assets relating thereto, and its principals and any recoveries or proceeds therefrom.
Excluded Assets:	Cash deposits and cash equivalents of each facility as of the date immediately preceding such facility's closing date, all accounts receivable, regardless of when billed, including promissory notes, liens, mortgages, negotiable instruments and other claims, rights and causes of action against third parties, relating to services rendered by each facility prior to such facility's closing date, all retroactive rate increases and/or lump sum or other payments, resulting from rate appeals, audits or otherwise with respect to third party payments from any source which may be paid on or after the closing date from services rendered by each facility prior to such facility's closing date, all payments or cash equivalent credits relating to each facility resulting from claims, insurance premium rate reductions or insurance or other dividends paid or accruing for periods prior to such facility's closing date, subject to buyers rights hereunder, the rights of seller under this agreement and the proceeds payable to seller hereunder or in connection with the transactions contemplated hereby, Seller's Medicare and Medicaid provider numbers and provider agreements, all refunds and deposits with respect to income tax liabilities for all periods ending prior to each closing date, all original governance documents and records of seller, all goodwill and other intangible assets used by seller in connection with the operations of the facilities, all original tax and accounting records, subject to applicable law and any real property or the improvements to any real property being used in the operation of the facilities, it being acknowledged that seller will retain the ownership of such real property and improvements and will license to buyer their use under the license agreement.
Assumed Liabilities:	None
Excluded Liabilities:	None
Purchase Price:	\$1,137,380.88 which is allocated as follows: (1) Kings County Medical Center \$655,104.84, (2) Lincoln Hospital Center \$35,800, (3) Metropolitan Center \$353,676.04 and (4) Harlem Hospital Center \$92,000.
Payment:	\$113,738.88 in members equity \$1,023,642 at closing, through a loan from JPMorgan Chase Bank, N.A, with a five year term at a rate based on the 30 day Libor plus 3.00%. The current 30 day Libor per the Wall Street Journal published on January 15, 2014 is 0.16%. As of January 15, 2014 the rate would be 3.16%.

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 and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments, or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility.

#### Administrative Services Agreements

The applicant has submitted four draft administrative services agreements for each site, which are summarized as follows:

##### Big Apple Dialysis @ Kings County Hospital

Provider: Atlantic Dialysis Management Services, LLC (ADMS)  
Facility: Big Apple Dialysis Management, LLC d/b/a Big Apple Dialysis @ Kings County Hospital

Services Provided: Billing and collection services which includes reviewing all bills for items and services provided by the dialysis center, advising Big Apple in connection with administering controls and systems for the recording and collection of the revenues of the dialysis center as follows: perform billing and collection services on behalf of and in the name of the Dialysis Center. They however, will not bill for physician professional services on behalf of and in the name of the Physicians. They shall review Big Apple's collection policies for the Dialysis center to assure that they are reasonable, appropriate and consistent with all applicable laws, regulations, and agreements with third party payors, as applicable, it being understood that ADMS has no control over the adoption of such policies on behalf of Big Apple. Accounting and financial services. ADMS shall assist Big Apple in developing and annual budget for the dialysis Center for the upcoming fiscal year. At least 30 days prior to the end of each fiscal year of ADMS, commencing with the first full fiscal year after the commencement date, ADMS shall submit to Big Apple a proposed Budget for the Dialysis Center. Big Apple will have the sole right to reject, revise or adopt the Budget proposed by ADMS. Quality and Utilization Controls. ADMS shall advise and assist Big Apple in performing such medical record audits and in conducting utilization review and quality assurance/control review for the Dialysis center and other related activities as are necessary and appropriate for the operation of the Dialysis center as permitted under applicable law. ADMS shall provide a coordinator to work full time on site at the Dialysis center to fulfill its obligations under the agreement. ADMS shall provide and install a dialysis clinical information system software program (Dialysis System) to support the clinical and billing operations of the dialysis center which is licensed to ADMS. The system is proprietary and confidential and shall be return to ADMS upon termination of this agreement. ADMS shall advise Big Apple as to all necessary equipment and hardware required to ensure the operability of the Dialysis System. At the option and request of Big Apple, ADMS shall order for in and the name of the Dialysis center, all supplies, inventory and drugs necessary for the Dialysis center's operations under national and regional supply agreements or purchase contracts on terms identical to what ADMS and its affiliates receive provided Big Apple promptly pays the vendor for the supplies. The dialysis center shall be responsible for and pay directly to the laboratory any lab services ordered for the patients treated at the Dialysis Center.

Term: 3 Years with unlimited renewal terms of 1 year each.  
Compensation: \$300,000 year one paid in bi weekly installments of \$11,538.46, \$350,000 year two paid in bi weekly installments of \$13,461.54 and \$400,000 year three paid in bi weekly installments of \$15,384.62.

Big Apple Dialysis @ Lincoln Hospital Center

Provider: Atlantic Dialysis Management Services, LLC (ADMS)  
Facility: Big Apple Dialysis Management, LLC d/b/a Big Apple Dialysis @ Lincoln Hospital Center  
Services Provided: Billing and collection services which includes reviewing all bills for items and services provided by the dialysis center, advising Big Apple in connection with administering controls and systems for the recording and collection of the revenues of the dialysis center as follows: perform billing and collection services on behalf of and in the name of the Dialysis Center. They however, will not bill for physician professional services on behalf of and in the name of the Physicians. They shall review Big Apple's collection policies for the Dialysis center to assure that they are reasonable, appropriate and consistent with all applicable laws, regulations, and agreements with third party payors, as applicable, it being understood that ADMS has no control over the adoption of such policies on behalf of Big Apple. Accounting and financial services. ADMS shall assist Big Apple in developing and annual budget for the dialysis Center for the upcoming fiscal year. At least 30 days prior to the end of each fiscal year of ADMS, commencing with the first full fiscal year after the commencement date, ADMS shall submit to Big Apple a proposed Budget for the Dialysis Center. Big Apple will have the sole right to reject, revise or adopt the Budget proposed by ADMS. Quality and Utilization Controls. ADMS shall advise and assist Big Apple in performing such medical record audits and in conducting utilization review and quality assurance/control review for the Dialysis center and other related activities as are necessary and appropriate for the operation of the Dialysis center as permitted under applicable law. ADMS shall provide a coordinator to work full time on site at the Dialysis center to fulfill its obligations under the agreement. ADMS shall provide and install a dialysis clinical information system software program (Dialysis System) to support the clinical and billing operations of the dialysis center which is licensed to ADMS. The system is proprietary and confidential and shall be return to ADMS upon termination of this agreement. ADMS shall advise Big Apple as to all necessary equipment and hardware required to ensure the operability of the Dialysis System. At the option and request of Big Apple, ADMS shall order for in and the name of the Dialysis center, all supplies, inventory and drugs necessary for the Dialysis center's operations under national and regional supply agreements or purchase contracts on terms identical to what ADMS and its affiliates receive provided Big Apple promptly pays the vendor for the supplies. The dialysis center shall be responsible for and pay directly to the laboratory any lab services ordered for the patients treated at the Dialysis Center.

Term: 3 Years with unlimited renewal terms of 1 year each.  
Compensation: \$200,000 year one paid in bi weekly installments of \$7,692.31, \$250,000 year two paid in bi weekly installments of \$9,615.38 and \$300,000 year three paid in bi weekly installments of \$11,538.46.

Big Apple Dialysis @ Metropolitan Hospital Center

Provider: Atlantic Dialysis Management Services, LLC (ADMS)  
Facility: Big Apple Dialysis Management, LLC d/b/a Big Apple Dialysis@Metropolitan Hospital Center

Services Provided: Billing and collection services which includes reviewing all bills for items and services provided by the dialysis center, advising Big Apple in connection with administering controls and systems for the recording and collection of the revenues of the dialysis center as follows: perform billing and collection services on behalf of and in the name of the Dialysis Center. They however, will not bill for physician professional services on behalf of and in the name of the Physicians. They shall review Big Apple's collection policies for the Dialysis center to assure that they are reasonable, appropriate and consistent with all applicable laws, regulations, and agreements with third party payors, as applicable, it being understood that ADMS has no control over the adoption of such policies on behalf of Big Apple. Accounting and financial services. ADMS shall assist Big Apple in developing and annual budget for the dialysis Center for the upcoming fiscal year. At least 30 days prior to the end of each fiscal year of ADMS, commencing with the first full fiscal year after the commencement date, ADMS shall submit to Big Apple a proposed Budget for the Dialysis Center. Big Apple will have the sole right to reject, revise or adopt the Budget proposed by ADMS. Quality and Utilization Controls. ADMS shall advise and assist Big Apple in performing such medical record audits and in conducting utilization review and quality assurance/control review for the Dialysis center and other related activities as are necessary and appropriate for the operation of the Dialysis center as permitted under applicable law. ADMS shall provide a coordinator to work full time on site at the Dialysis center to fulfill its obligations under the agreement. ADMS shall provide and install a dialysis clinical information system software program (Dialysis System) to support the clinical and billing operations of the dialysis center which is licensed to ADMS. The system is proprietary and confidential and shall be return to ADMS upon termination of this agreement. ADMS shall advise Big Apple as to all necessary equipment and hardware required to ensure the operability of the Dialysis System. At the option and request of Big Apple, ADMS shall order for in and the name of the Dialysis center, all supplies, inventory and drugs necessary for the Dialysis center's operations under national and regional supply agreements or purchase contracts on terms identical to what ADMS and its affiliates receive provided Big Apple promptly pays the vendor for the supplies. The dialysis center shall be responsible for and pay directly to the laboratory any lab services ordered for the patients treated at the Dialysis Center.

Term: 3 Years with unlimited renewal terms of 1 year each.  
Compensation: \$200,000 year one paid in bi weekly installments of \$7,692.31, \$250,000 year two paid in bi weekly installments of \$9,615.38 and \$300,000 year three paid in bi weekly installments of \$11,538.46.

Big Apple Dialysis @ Harlem Hospital

Provider: Atlantic Dialysis Management Services, LLC (ADMS)  
Facility: Big Apple Dialysis Management, LLC d/b/a Big Apple Dialysis @ Harlem Hospital

Services Provided: Billing and collection services which includes reviewing all bills for items and services provided by the dialysis center, advising Big Apple in connection with administering controls and systems for the recording and collection of the revenues of the dialysis center as follows: perform billing and collection services on behalf of and in the name of the Dialysis Center. They however, will not bill for physician professional services on behalf of and in the name of the Physicians. They shall review Big Apple's collection policies for the Dialysis center to assure that they are reasonable,

appropriate and consistent with all applicable laws, regulations, and agreements with third party payors, as applicable, it being understood that ADMS has no control over the adoption of such policies on behalf of Big Apple. Accounting and financial services. ADMS shall assist Big Apple in developing and annual budget for the dialysis Center for the upcoming fiscal year. At least 30 days prior to the end of each fiscal year of ADMS, commencing with the first full fiscal year after the commencement date, ADMS shall submit to Big Apple a proposed Budget for the Dialysis Center. Big Apple will have the sole right to reject, revise or adopt the Budget proposed by ADMS. Quality and Utilization Controls. ADMS shall advise and assist Big Apple in performing such medical record audits and in conducting utilization review and quality assurance/control review for the Dialysis center and other related activities as are necessary and appropriate for the operation of the Dialysis center as permitted under applicable law. ADMS shall provide a coordinator to work full time on site at the Dialysis center to fulfill its obligations under the agreement. ADMS shall provide and install a dialysis clinical information system software program (Dialysis System) to support the clinical and billing operations of the dialysis center which is licensed to ADMS. The system is proprietary and confidential and shall be return to ADMS upon termination of this agreement. ADMS shall advise Big Apple as to all necessary equipment and hardware required to ensure the operability of the Dialysis System. At the option and request of Big Apple, ADMS shall order for in and the name of the Dialysis center, all supplies, inventory and drugs necessary for the Dialysis center's operations under national and regional supply agreements or purchase contracts on terms identical to what ADMS and its affiliates receive provided Big Apple promptly pays the vendor for the supplies. The dialysis center shall be responsible for and pay directly to the laboratory any lab services ordered for the patients treated at the Dialysis Center.

Term: 3 Years with unlimited renewal terms of 1 year each.  
 Compensation: \$300,000 year one paid in bi weekly installments of \$11,538.46, \$350,000 year two paid in bi weekly installments of \$13,461.54 and \$400,000 year three paid in bi weekly installments of \$15,384.62.

There is common ownership between the administrative services agreement provider and the applicant; both entities are owned by the same two individuals with the same ownership percentage.

#### License Agreement

The applicant has submitted a draft license agreement for the proposed sites, as summarized below:

Premises: Kings County Hospital Site 6<sup>th</sup> floor "C" building, Metropolitan Hospital Center Site 14<sup>th</sup> floor Main hospital building, Harlem Hospital Center site 4<sup>th</sup> floor New Patient Pavilion, Lincoln Hospital Center site interim location 9<sup>th</sup> floor and permanent location 7<sup>th</sup> floor  
 Licensor: New York City Health and Hospitals Corporation  
 Licensee: Big Apple Dialysis Management, LLC  
 Fees: Kings County site \$484,380 annually (\$54.00 per sq. ft.), Metropolitan Hospital Center site \$250,750 annually (\$50.00 per sq. ft.), Harlem Hospital Center site \$463,000 annually (\$50.00 per sq. ft.), Lincoln interim site \$239,920 annually (\$40.00 per sq. ft.) and Lincoln permanent site \$296,800 annually (\$40.00 per sq. ft.) On the fifth anniversary of the commencement date the fees will increase 10% based on the original fees.  
 Term: Five-year term with one additional four-year extension  
 Provisions: Licensor will provide utilities and maintenance services

The applicant has stated that the proposed lease is an arm's length arrangement.

Operating Budget

The applicant has submitted separate first year operating budgets, in 2013 dollars:

Big Apple Dialysis @ Kings County Hospital

	<u>Year One</u>
Total Revenues	\$5,102,345
Expenses	
Operating	\$3,464,585
Capital	<u>771,032</u>
Total Expenses	\$4,235,617
 Excess of Revenues over Expenses	 <u>\$866,728</u>
 Utilization (treatments)	 18,307
Cost Per Treatment	\$231.37
*Includes pharmaceuticals	

Utilization by payor source for the first year subsequent to the change in operator is summarized below:

	<u>Year One</u>
Medicaid Fee-For-Service	10.51%
Medicare Fee-For-Service	78.98%
Commercial Fee-For-Service	10.51%

Utilization estimates were based on existing volumes at the Kings County Hospital program site. Expense projections were based on the historical experiences of Big Apple Dialysis Management, LLC in operating dialysis clinics. The number of procedures required to breakeven in the first year is approximately 15,211 treatments, or 83.09% of the budgeted treatments.

Big Apple Dialysis @ Lincoln Hospital Center

	<u>Year One</u>
Total Revenues	\$3,214,988
Expenses	
Operating	\$2,178,154
Capital	<u>341,866</u>
Total Expenses	\$2,520,020
 Excess of Revenues over Expenses	 <u>\$694,968</u>
 Utilization: (treatments)	 11,544
Cost Per Treatment	\$218.30
*Includes pharmaceuticals	

Utilization by payor source for the first year subsequent to the change in operator is summarized below:

	<u>Year One</u>
Medicaid Fee-For-Service	10.81%
Medicare Fee-For-Service	78.38%
Commercial Fee-For-Service	10.81%

Utilization estimates were based on existing volumes at the Lincoln Hospital Center program site. Expense projections were based on the historical experiences of Big Apple Dialysis Management, LLC in operating dialysis clinics. The number of procedures required to breakeven in the first year is approximately 9,051 treatments, or 78.40% of the budgeted treatments.

Big Apple Dialysis @ Metropolitan Hospital Center

	<u>Year One</u>
Total Revenues	\$2,694,082
Expenses	
Operating	\$1,972,286
Capital	<u>405,381</u>
Total Expenses	\$2,377,667
 Excess of Revenues over Expenses	 <u>\$316,415</u>
 Utilization (treatments)	 9,984
Cost Per Treatment	\$238.15
*Includes pharmaceuticals	

Utilization by payor source for the first year subsequent to the change in operator is summarized below:

	<u>Year One</u>
Medicaid Fee-For-Service	10.94%
Medicare Fee-For-Service	78.12%
Commercial Fee-For-Service	10.94%

Utilization estimates were based on existing volumes at the Metropolitan Hospital Center program site. Expense projections were based on the historical experiences of Big Apple Dialysis Management, LLC in operating dialysis clinics. The number of procedures required to breakeven in the first year is approximately 8,811 treatments, or 88.25% of the budgeted treatments.

Big Apple Dialysis @ Harlem Hospital

	<u>Year One</u>
Total Revenues	\$4,079,413
Expenses	
Operating	\$2,523,281
Capital	<u>365,101</u>
Total Expenses	\$2,888,382
 Excess of Revenues over Expenses	 <u>\$1,191,031</u>
 Utilization (treatments)	 14,352
Cost Per Treatment	\$201.26
*Includes pharmaceuticals	

Utilization by payor source for the current year, and the first year subsequent to the change in operator, is summarized below:

	<u>Year One</u>
Medicaid Fee-For-Service	10.65%
Medicare Fee-For-Service	78.70%
Commercial Fee-For-Service	10.65%

Utilization estimates were based on existing volumes at the Harlem Hospital program site. Expense projections were based on the historical experiences of Big Apple Dialysis Management, LLC in operating dialysis clinics. The number of procedures required to breakeven in the first year is approximately 10,161 treatments, or 70.80% of the budgeted treatments.

Note, as these are currently HHC facilities, the applicant was not able to provide the current year information due to HHC having consolidated reporting for all of their facilities.

### Capability and Feasibility

Total purchase price is \$1,137,380.88, which is allocated as follows: (1) Kings County Medical Center \$655,104.84, (2) Lincoln Hospital Center \$35,800, (3) Metropolitan Center \$353,676.04 and (4) Harlem Hospital Center \$92,000. Big Apple Dialysis Management, LLC will meet the \$1,137,380.88 purchase price by \$113,738.88 in equity from the proposed members and a loan allocated to the project in the amount of \$1,023,642 at the above stated terms. There are no project costs associated with this CON.

Working capital requirements are estimated at \$2,222,500, which appears reasonable based upon two months of third year expenses. The proposed members will provide \$1,111,250 of the working capital from their personal resource and entered into a \$1,111,250 1-year working capital line of credit with JPMorgan Chase Bank, N.A., at a 3.25 % interest rate based on the current prime rate, which as of January 15, 2014 is 3.25%, as published in the Wall Street Journal. BFA Attachment A is the applicant personal net worth statements. Review of Attachment A indicates there are sufficient liquid resources to meet the equity and working capital requirements.

BFA Attachment B is the pro-forma balance sheet for Big Apple Dialysis Management, LLC, which shows operations will start off with \$1,224,988 in equity. BFA Attachment C is the pro-forma balance sheet for Big Apple Dialysis Management, LLC @ Kings Hospital site specific, which shows operations will start off with \$396,103 in equity. BFA Attachment D is the pro-forma balance sheet for Big Apple Dialysis Management, LLC @ Lincoln Hospital site specific, which shows operations will start off with \$232,228 in equity. BFA Attachment E is the pro-forma balance sheet for Big Apple Dialysis Management, LLC @ Metropolitan Hospital site specific, which shows operations will start off with \$219,766 in equity. BFA Attachment F is the pro-forma balance sheet for Big Apple Dialysis Management, LLC @ Harlem Hospital site specific, which shows operations will start off with \$263,153 in equity.

Year One shows net income of \$866,728 for Big Apple Dialysis @ Kings County Hospital, net income of \$694,968 for Big Apple Dialysis @ Lincoln Hospital Center, net income of \$316,415 for Big Apple Dialysis @ Metropolitan Hospital Center and net income of \$1,191,031 for Big Apple Dialysis @ Harlem Hospital. The combined Year One net income is \$3,069,142. Revenues reflect current reimbursement methodologies for Medicaid and Medicare and commercial revenues based on Big Apple Dialysis Management, LLC experience in operating centers throughout New York State. The budget appears reasonable.

### Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A	Net Worth Statements For the members of Big Apple Dialysis Management, LLC
BFA Attachment B	Pro-forma Balance sheet for Big Apple Management, LLC
BFA Attachment C	Pro-forma Balance Sheet for Big Apple Dialysis @ Kings County Hospital
BFA Attachment D	Pro-forma Balance Sheet for Big Apple Dialysis @ Lincoln Hospital Center
BFA Attachment E	Pro-forma Balance Sheet for Big Apple Dialysis @ Metropolitan Hospital Center
BFA Attachment F	Pro-forma Balance Sheet for Big Apple Dialysis @ Harlem Hospital

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 13th day of February, 2014, 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 Big Apple Dialysis Management, LLC as the operator of a chronic renal dialysis diagnostic and treatment center and three extension clinics currently operated by the New York City Health and Hospitals Corporation, 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:

132178 E

Big Apple Dialysis Management, LLC

APPROVAL CONTINGENT UPON:

1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital for each of the four sites. [HSP]
2. Submission of a Medical Director Agreement, acceptable to the Department. [HSP]
3. Submission of a loan commitment, acceptable to the Department. [BFA]
4. Submission of a working capital loan commitment, acceptable to the Department. [BFA]
5. The submission of existing conditions schematic floor plans and architects letter of certification for existing buildings, for review and approval. [AER]
6. Submission of a completed Schedule 3. [CSL]
7. Submission of an executed Certificate of Assumed Name, acceptable to the Department and clarification regarding whether each location requires a Certificate of Assumed Name – if they are all operating under different names. [CSL]
8. Submission of an executed Certificate of Amendment of the Articles of Organization, acceptable to the Department. [CSL]
9. Submission of an executed Operating Agreement (and Joinder), acceptable to the Department. [CSL]
10. Submission of an executed Administrative Services Agreement for all four (Harlem, Kings, Lincoln and Metropolitan) locations, acceptable to the Department. [BFA, CSL]
11. Submission of an executed building license agreement for all four (Harlem, Kings, Lincoln and Metropolitan) sites, acceptable to the Department. [BFA, CSL]
12. Submission of an executed Purchase and Sale Agreement. [CSL]

APPROVAL CONDITIONAL UPON:

1. The project must be completed within two years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
5. The clinical space must be used exclusively for the approved purpose. [HSP]
6. To provide Transfusion Services, licensure by the New York State Department of Health-Wadsworth Center is required. [HSP]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237



# Public Health and Health Planning Council

## Project # 131225 E Visiting Nurse Service of New York Home Care

**County:** Oneida County  
**Purpose:** Establishment

**Program:** Certified Home Health Agency  
**Acknowledged:** April 26, 2013

### Executive Summary

#### Description

Visiting Nurse Service of New York Home Care II d/b/a Visiting Nurse Service of New York Home Care (VNSNY), a not-for-profit corporation, is requesting to establish a new Certified Home Health Agency (CHHA) to serve Delaware, Fulton, Hamilton, Herkimer, Montgomery, Oneida, Onondaga and Otsego Counties. VNSNY currently serves Kings, Bronx, Queens, New York, Nassau, Westchester, Richmond and Rockland Counties. VNSNY's CON 131224 is concurrently being reviewed, and is requesting five additional upstate counties. VNSNY was approved by the Public Health and Health Planning Council for Suffolk County on April 11, 2013.

On December 8, 2011, the Public Health and Health Planning Council adopted an amendment to section 760.5 of Title 10, NYCRR. This emergency regulation authorized the Commissioner of Health to issue a request for applications (RFA) to establish new certified home health agencies, or expand the approved geographic service areas and/or approved population of existing CHHA's. Visiting Nurse Service of New York Home Care submitted an application in response to the competitive RFA, and was awarded RFA approval. This CON application is in response to the RFA approval.

DOH Recommendation  
Contingent Approval

#### Program Summary

This proposal seeks to establish a new Certified Home Health Agency (CHHA) to serve the upstate counties of Hamilton, Fulton, Montgomery, Otsego, Delaware, Herkimer, Oneida, and Onondaga, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties.

#### Financial Summary

There are no project costs associated with this application.

#### Incremental Budget:

Revenues:	\$20,723,126
Expenses:	<u>20,487,317</u>
Gain (Loss):	\$ 235,809

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Recommendations

Health Systems Agency

There is no HSA recommendation for this application.

Office of Health Systems Management

**Approval contingent upon:**

1. The Department of Health reserves the right to re-evaluate the incremental budgets for feasibility if all counties for establishment or expansion are not approved. [BFA]
2. Submission of an executed building lease agreement, acceptable to the Department. [BFA]
3. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
4. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
6. Submission of a photocopy of the applicant's fully executed Certificate of Assumed Name, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Council Action Date

**February 13, 2014**

## Need Analysis

### Background

Visiting Nurse Service of New York Home Care II, Inc. d/b/a Visiting Nurse Service of New York Home Care is requesting approval to establish a new Certified Home Health Agency to serve the upstate counties of Delaware, Otsego, Montgomery, Fulton, Hamilton, Onondaga, Oneida and Herkimer counties.

### Solicitation

The RFA for the establishment of new or expansion of existing CHHAs was released on January 25, 2012 with RFA applications due on March 9, 2012 and CON applications due on April 20, 2012. Applicants were permitted to submit questions to the Department to seek additional clarification regarding this process. The Department's answers were provided to all applicants prior to the submission deadline, to ensure consistent information was shared regarding the process.

Applicants that were not presented to the Public Health and Health Planning Council with a recommendation for approval at either the August 2012 or October 2012 meetings were considered deferred. The department notified RFA applicants that we are exercising our authority under the RFA Section VII.D.5 to seek clarifications and revisions of applications from those applicants whose applications have been deferred. Letters dated September 17<sup>th</sup> and 27<sup>th</sup> were sent to these applicants through NYSECON and included information related to the review and evaluation criteria and characteristics of approved applicants.

Additionally, the opportunity to arrange a meeting or phone conference with the Division of Home and Community Based Services to discuss the RFA criteria that was used to evaluate each application was made available to each applicant

### Competitive Review

The applications, including any supplemental information submitted, are being reviewed by the Department and recommendations are being made to the Public Health and Health Planning Council.

The CON determination of need was based on the applicant's response to the RFA which includes any additional information submitted by the applicant in response to the aforementioned September 17<sup>th</sup> and 27<sup>th</sup> letters. The applications were reviewed on criteria that included, but were not limited to:

- Organizational capacity to successfully implement the MRT initiatives and potential of the proposal to support the goals of the Department in advancing MRT initiatives;
- Knowledge and experience in the provision of home health services;
- Demonstration of public need based on 709.1(a) as well as a description of community need and the health needs of the community supported by data;
- Potential of the approved application to produce efficiencies in the delivery of home care services to the home care population;
- Comprehensive and effective quality assurance plan which described how the agency will use data to implement an ongoing quality assessment and performance improvement program that leads to measurable and sustained improvement in performance.

The applicant provided a thorough analysis of the home health care needs and demonstrated knowledge of the issues surrounding home health care in the counties requested. The applicant also demonstrated how its organizational capacity including disease management and care management programs will produce quality and efficient home health care.

VNSNY demonstrated support of Medicaid Redesign initiatives and elaborated on transitioning patients into MLTCPs; reducing utilization while improving outcomes; managing high risk complex cases; extensive experience in care management programs and existing utilization control programs; health

home initiatives; behavioral health programs; and their HIT system that utilizes a variety of tools that will enhance care coordination and improve health outcomes.

The applicant has existing proven care management programs such as their Congregate Care program, SPARK program, ESPIRIT, and Centers of Excellence. These programs provide outreach to the community and/or improve care management for high-risk cases. The applicant has existing utilization control programs and has an HIT system that utilizes a variety of tools that will enhance care coordination and improve health outcomes. The applicant also discussed how the CHHA will produce operating efficiencies within the health care system through clinical innovation and economies of scale.

Recommendation

**From a need perspective, approval is recommended.**

## Programmatic Analysis

### Review Summary

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, is an existing not-for-profit corporation currently operating an Article 36 CHHA and LTHHCP, with its main parent office located in New York County, and six branch offices located in Bronx, Kings, Queens, Richmond, Nassau, and Westchester Counties. The CHHA serves Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, and Rockland Counties, and was approved by PHHPC on April 11, 2013, to expand into Suffolk County. The LTHHCP serves Bronx, Kings, New York, Queens, and Nassau Counties. The applicant also operates VNS Children and Adolescent Mental Health Clinic at FRIENDS, a mental health clinic licensed by NYS Office of Mental Health.

This CON application # 131225-E has been submitted by Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, to request approval to establish a new additional CHHA in New York State, under Article 36 of the Public Health Law, with approval to serve the upstate counties of Hamilton, Fulton, Montgomery, Otsego, Delaware, Herkimer, Oneida, and Onondaga, pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties. A companion CON application # 131224-E has also been submitted by Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, to request approval to establish a second new additional CHHA in New York State, under Article 36 of the Public Health Law, with approval to serve the upstate counties of Dutchess, Orange, Putnam, Sullivan, and Ulster Counties, also pursuant to the recent Request for Applications (RFA) for the establishment of new CHHAs or the expansion of existing CHHAs into additional counties. That companion CON application is also being presented to the PHHPC at this time under separate cover.

The applicant proposes to operate the new CHHA proposed in this CON application # 131225 from a main parent office practice location at 2 Ellinwood Drive, Suite 6, Lower Level, New Hartford (Oneida County), New York 13413, to serve Hamilton, Fulton, Montgomery, Otsego, Delaware, Herkimer, Oneida, and Onondaga Counties. The applicant is also willing to establish one or two additional branch office practice locations, if warranted by New York State Department of Health.

The applicant proposes to provide the following home health care services:

Nursing	Home Health Aide	Medical Social Services
Physical Therapy	Occupational Therapy	Speech Language Pathology
Medical Supplies, Equipment, and Appliances		

Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, has as its member (parent) corporation Visiting Nurse Service of New York, a not-for-profit corporation. Visiting Nurse Service of New York is also the member (parent) corporation of the following not-for-profit corporations: Visiting Nurse Service of New York Hospice Care, an Article 40 hospice; New Partners,

Inc., d/b/a Partners in Care Services, an Article 36 licensed home care services agency (LHCSA); Family Care Services, an Article 36 LHCSA and home attendant program; and VNS Continuing Care Development Corporation. The latter corporation is the member (parent) corporation of VNS Choice, d/b/a VNSNY Choice, a Managed Care Organization which includes a Managed Long Term Care Plan, a Medicaid Advantage Plan, and a Medicaid Advantage Plus Plan; and VNS Choice Community Care, an Article 36 LHCSA.

The governing body of the applicant, Visiting Nurse Service of New York Home Care II, d/b/a Visiting Nurse Service of New York Home Care, is as follows:

Jon Mattson, Chairperson  
Partner, Trilantic Capital Partners (Private Equity Partnership)  
Affiliations: VNSNY

Anne Bick Ehrenkranz, Vice Chairperson  
Retired  
Affiliations: VNSNY; New Partners, Inc., d/b/a Partners in Care

Margaret A. Bancroft, Esq.  
Of Counsel, Dechert, LLP (Law Firm)  
Affiliations: VNSNY

Alice Cooney Frelinghuysen  
Curator, Metropolitan Museum of Art  
Affiliations: VNSNY

Elisabeth Gotbaum  
Partner, Bedford Grove (Political Fundraising Firm)  
Affiliations: VNSNY

Clare Gregorian  
Retired  
Affiliations: VNSNY

Valerie S. Peltier, Esq.  
Managing Director, Tishman Speyer Properties, Inc. (Real Estate Development)  
Affiliations: VNSNY

Carl H. Pforzheimer, III  
Manager, Carl H. Pforzheimer & Co., LLC (Investment Firm)  
Affiliations: VNSNY

John P. Rafferty, CPA  
Retired Partner, Ernst and Young, LLP (Accounting Firm)  
Affiliations: VNSNY

Ira S. Rimerman  
Retired Senior Executive, Citigroup (Banking)  
Affiliations: VNSNY; Continuum Health Partners, Inc. (Beth Israel Medical Center, Inc. – Petrie Campus, Manhattan, and Kings Highway Division, Brooklyn; St. Lukes Roosevelt Hospital Center, Inc. – Roosevelt Hospital Division and St. Lukes Hospital Division; Long Island College Hospital; New York Eye and Ear Infirmary, Inc. (all Hospitals); Beth Israel Ambulatory Care Services Corp. (D&TC); Robert Mapplethorpe Residential Treatment Facility (RHCF); Jacob Perlow Hospice Corp. (Hospice)

The governing body of the member (parent) corporation, Visiting Nurse Service of New York, is as follows:

Douglas D. Broadwater, Esq., Chairperson  
Retired Partner, Cravath, Swaine & Moore, LLP (Law Firm)

Frank S. Vigilante  
Retired Senior V.P., AT&T  
Affiliations: VNA of Central Jersey, Inc. (Hospice); VNA of Central Jersey Health Group, Inc. (CHHA); VNSNY Hospice Care

Margaret A. Bancroft, Esq.  
Disclosed above

Bobbie Berkowitz, RN (WA)  
Senior VP, Columbia University Medical Center  
Dean, Columbia University School of Nursing  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Group Health Cooperative, Seattle, WA (NFP Health Care Plan); Qualis Health, Seattle, WA (NFP Healthcare Quality Consulting Organization)

Carmen Beauchamp Ciparick, Esq.  
Of Counsel, Greenberg Traurig, LLP (Law Firm)  
Retired Associate Judge, NYS Court of Appeals  
Affiliations: VNS Choice, d/b/a VNSNY Choice;

Robert C. Daum  
Retired CEO, DFMC, Inc., d/b/a Growth Capital Partners (Investments)  
Affiliations: VNS Choice, d/b/a VNSNY Choice;

VNS Choice Community Care

E. Mary C. Davidson  
VP, Maxwell Davidson Gallery (Art Dealer)  
Affiliations: VNSNY Hospice Care

Edith M. Dupuy, RN  
Retired  
Claire M. Fagin, R.N., Ph.D.  
Retired Self-Employed Consultant  
Elisabeth Gotbaum  
Disclosed above

Mary R. (Nina) Henderson  
Managing Partner, Henderson Advisory (Consulting Firm)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Robert M. Kaufman, Esq.  
Partner, Proskauer Rose, LLP (Law Firm)  
Board Director, Old Westbury Funds (Mutual Funds)  
Affiliations: VNSNY Hospice Care; Public Health Solutions, d/b/a MIC Women's Health Services, formerly Medical and Health Research Association of NYC (D&TC)

Arthur Lindenauer, CPA  
Retired CFO, Schlumberger Limited (Oil Field Services)  
Affiliations: New Partners, Inc., d/b/a Partners in Care

Joseph D. Mark  
Retired President, Aveta, Inc. (Health Insurance Company)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Mathy Mezey, R.N., Ed.D.  
Professor, NYU College of Nursing  
Affiliations: VNSNY Hospice Care

Valerie S. Peltier, Esq.  
Disclosed above

John P. Rafferty, CPA  
Disclosed above

Ira S. Rimerman  
Disclosed above

VNS Choice Community Care

Jose M. de Lasa, Esq.  
Of Counsel, Baker and MacKenzie (Law Firm)

Anne Bick Ehrenkranz  
Disclosed above  
Alice Cooney Frelinghuysen  
Disclosed above  
Clare Gregorian  
Disclosed above

Peter L. Hutchings  
Retired Exec. V.P. & CFO, Guardian Life Insurance Co.  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care; Public Health Solutions, d/b/a MIC Women's Health Services, formerly Medical and Health Research Association of NYC (D&TC), NY Organ Donor Network, Empire Health Choice (HMO)

Michael Laskoff  
CEO, Managing Partner, Abilto, LLC (Behavioral Health Consulting)  
Affiliations: New Partners, Inc., d/b/a Partners in Care

Kwan-Lan (Tom) Mao  
Retired V.P., Citigroup (Banking)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Jon Mattson  
Disclosed above

Phyllis J. Mills, R.N.  
Trustee, Mary Flagler Charitable Trust  
Affiliations: VNS Continuing Care Development Corporation; VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Carl H. Pforzheimer, III  
Disclosed above

Corinne H. Rieder, Ed.D.  
Executive Director, Treasurer, The John A. Hartford Foundation (Charitable Foundation)  
Affiliations: VNSNY Hospice Care

Andrew N. Schiff, M.D.  
Partner, Aisling Capital (Investments/Finance)  
Affiliations: VNS Choice, d/b/a VNSNY Choice; VNS Choice Community Care

Albert L. Siu, MD  
Chairman / Professor, Mount Sinai School of  
Medicine's Brookdale Department of Geriatrics and  
Palliative Medicine  
Director, Bronx VA Medical Center's Geriatric  
Research, Education, and Clinical Center  
Affiliations: VNS Choice, d/b/a VNSNY Choice;  
VNS Choice Community Care; Senior Health  
Partners (MLTCP); Mount Sinai Care, LLC (ACO)

Kenneth G. Standard, Esq.  
Partner, Epstein Becker & Green, PC (Law Firm)  
Affiliations: Family Care Services

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

A search of all of the above named board members, employers, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the Office of the Inspector General's Provider Exclusion List.

The Office of the Professions of the State Education Department, the New York State Physician Profile, the Office of Professional Medical Conduct, the NYS Unified Court System, and the Washington State Department of Health Professional Licensing, where appropriate, indicate no issues with the licensure of the health professionals and other licensed professionals associated with this application. In addition, the attorneys have all submitted current Certificates of Good Standing.

The Division of Hospitals and Diagnostic and Treatment Centers reviewed the compliance history of all affiliated hospitals and diagnostic and treatment centers for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following facility was the subject of enforcement actions:

St. Lukes Roosevelt Hospital Center, Inc. was the subject of an enforcement action in 2006 based on violations citing improperly delayed treatment due to financial considerations. The hospital paid a \$4,000 civil penalty to resolve this matter. The hospital has been in compliance since that time.

It has been determined that the affiliated hospitals and diagnostic and treatment centers have provided a substantially consistent high level of care.

The Division of Residential Services reviewed the compliance history of the affiliated residential health care facility for the time period specified as the affiliation. It has been determined that the residential health care facility has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The Division of Home and Community Based Services reviewed the compliance history of all affiliated long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied. The review revealed that the following provider was the subject of an enforcement action:

Jacob Perlow Hospice Corporation, now d/b/a MJHS Hospice and Palliative Care (formerly d/b/a Continuum Hospice Care / Jacob Perlow Hospice / Harlem Community Hospice) was cited with condition-level deficiencies in the areas of Governing Authority; Contracts; Administration; Staff and Services; Personnel; Patient / Family Rights; Plan of Care; and Medical Records Systems / Charts, as a result of a November 29, 2006 survey. An enforcement action was resolved with an October 1, 2007 stipulation and order, which included payment of a \$24,000 civil penalty. The agency has been in compliance since that time.

It has been determined that the long term home health care programs, certified home health agencies, licensed home care service agencies, and hospices have exercised sufficient supervisory responsibility to protect the health, safety and welfare of patients and to prevent recurrent code violations. When code violations did occur, it was determined that the operators investigated the circumstances surrounding the violation and took steps appropriate to the gravity of the violation that a reasonably prudent operator would take to promptly correct and prevent the recurrence of the violation.

The Office of Health Insurance Programs Division of Managed Care reviewed the compliance history of the affiliated managed long term care plans and health maintenance organizations for the time period 2006 to 2013, or for the time periods specified as the affiliations, whichever applied.

The Office of Health Insurance Programs Division of Managed Care reports that the Medicaid Advantage Plan operated by VNS Choice, d/b/a VNSNY Choice, has no enforcement history and is currently in substantial compliance. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, had a suspension on all new enrollments imposed in April 2013, which was lifted by the Department and new enrollments were allowed to resume, effective November 1, 2013. The Managed Long Term Care Plan, and Medicaid Advantage Plus Plan, operated by VNS Choice, d/b/a VNSNY Choice, are therefore now in substantial compliance. The New York State Office of the Attorney General reports that, although it has a continuing investigation involving this same provider at this time, the Office of the Attorney General no longer requests that the Department hold off the review and approval of the current applications, since the provider has executed an interim agreement to resolve in principle certain aspects of their investigation.

It has therefore been determined that the affiliated managed long term care plans and health maintenance organizations are currently in substantial compliance with all applicable codes, rules, and regulations.

The New York State Office of Mental Health has reviewed the compliance history of the affiliated mental health clinic, for the time period 2008 (initial licensure) to 2013, and has determined the mental health clinic has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

The State of New Jersey has reviewed the compliance histories of the health care facilities operated under VNA of Central Jersey, Inc., and VNA of Central Jersey Health Group, Inc., for the time period specified as the affiliation, and has determined the health care facilities have been in substantial compliance with all applicable codes, rules, and regulations.

The State of Washington has reviewed the compliance history of the health care plan administered by Group Health Cooperative, for the time period specified as the affiliation, and has determined the health care plan has been in substantial compliance with all applicable codes, rules, and regulations, with no enforcement or administrative action imposed.

A review of all personal qualifying information indicates there is nothing in the background of the board members of Visiting Nurse Service of New York Home Care II and Visiting Nurse Service of New York to adversely effect their positions on the boards. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

Recommendation

**From a programmatic perspective, approval is recommended.**

## Financial Analysis

### Lease Agreement

The applicant has submitted a proposed lease agreement, the terms of which are summarized below:

Premises: 2,400 square feet at 1256 Albany Street, Utica, New York 13501  
 Landlord: Parkway Drugs Holding, LLC  
 Tenant: VNSNY Home Care II  
 Rental: \$2,100 /mo. (\$10.50/sq.ft.)  
 Term: 5 years with an additional 5 year renewal option.  
 Provisions: The Lessee shall be responsible for insurance, taxes, maintenance and utilities.

The lease arrangement is an arm's length agreement and the applicant has submitted letters from licensed real estate brokers attesting to the reasonableness of the per square foot rental.

### Operating Budget

The applicant has submitted an incremental operating budget for the first and third years, in 2013 dollars, which is summarized below:

	<u>YearOne</u>	<u>YearThree</u>
<u>Revenues:</u>		
Commercial Managed Care	\$ 719,878	\$ 1,157,411
Medicare Fee-for-Service	5,650,217	8,317,507
Medicare Managed Care	698,705	1,123,369
Medicaid Managed Care	<u>8,920,808</u>	<u>10,124,839</u>
Total Revenues	\$15,989,608	\$20,723,126
Expenses	<u>15,783,485</u>	<u>20,487,317</u>
Net Gain(Loss)	\$ 206,281	\$ 235,809

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

<u>Payor</u>	<u>Year One</u>	<u>Year Three</u>
Commercial Managed Care	5.3%	6.3%
Medicare Fee-for-Service	32.0%	36.5%
Medicare Managed Care	5.2%	6.1%
Medicaid Managed Care	55.5%	49.1%
Charity Care	2.0%	2.0%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates, as well as the recent implementation of the Medicaid Episodic Payment system.

### Capability and Feasibility

There are no project costs associated with this application.

Working capital requirements, estimated at \$3,414,553, appear reasonable based on two months of third year expenses and will be provided through the existing operation. BFA Attachment A is the financial summary for Visiting Nurse Service of New York Home Care.

The submitted budget indicates that the applicant will achieve a \$206,281 and \$235,809 incremental net revenue in the first and third years of operations, respectively. Revenue is based on current payment rates for Certified Home Health Agencies. The submitted budget appears reasonable.

BFA Attachment A is the 2012 audited and 2011 audited financial summary of VNSNY, which shows the applicant has maintained positive working capital, net equity and experienced net loss from operations of \$6,814,000 and \$15,842,000 for 2012 and 2011, respectively. Losses in 2011 and 2012 are related to declines in volume, as well as rate reductions in both Medicare and Medicaid. VNSNY is planning to implement significant operational improvements to reach break-even financial operating results by 2015. Over the course of the next three years VNSNY intends:

- Significant cost savings in reaching best practice benchmarks in utilization, productivity and administrative cost efficiencies.
- To mitigate losses, the organization is reviewing expenses and overhead including administrative position eliminations, call center redesign, streamline of contract administration, and office space consolidation.
- In addition, VNSNY will be investing in new information technology that will facilitate the achievement of cost efficiency improvements. These technologies will enable more real-time utilization controls, caseload optimization and streamlined administrative functions.

Based on the preceding, it appears that the applicant has demonstrated the financial capability to proceed in a financially feasible manner.

Recommendation

**From a financial perspective, contingent approval is recommended.**

## Attachments

BFA Attachment A    Financial Summary for 2011 Audited and 2012 Audited Visiting Nurse Service of New York Home Care

RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 13th day of February, 2014, 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 Certified Home Health Agency operated by Visiting Nurse Service of New York Home Care to serve Delaware, Fulton, Hamilton, Herkimer, Montgomery, Oneida, Onondaga and Otsego Counties, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER

APPLICANT/FACILITY

131225 E

Visiting Nurse Service of New York  
Home Care

APPROVAL CONTINGENT UPON:

1. The Department of Health reserves the right to re-evaluate the incremental budgets for feasibility if all counties for establishment or expansion are not approved. [BFA]
2. Submission of an executed building lease agreement, acceptable to the Department. [BFA]
3. Submission of a photocopy of the applicant's fully executed Bylaws, acceptable to the Department. [CSL]
4. Submission of a photocopy of the resolution of the applicant's Board of Directors, acceptable to the Department. [CSL]
5. Submission of a photocopy of the applicant's fully executed Certificate of Incorporation, acceptable to the Department. [CSL]
6. Submission of a photocopy of the applicant's fully executed Certificate of Assumed Name, acceptable to the Department. [CSL]

APPROVAL CONDITIONED UPON:

1. Pursuant to 10 NYCRR 760.8, the applicant shall be providing services in the entire geographic area approved by the Council within one year of the Council's approval. The failure, neglect or refusal of an applicant for the establishment of a new certified home health agency to commence operation of the certified home health agency within one year of issuance of the Council's approval or contingent approval of the application shall constitute an abandonment of the application by the applicant, with any such approval to be deemed cancelled and withdrawn without further action by the Council. [CHA]

Documentation submitted to satisfy the above-referenced contingencies (4 copies) should be submitted within sixty (60) days to:

Barbara DelCogliano  
Director  
Bureau of Project Management  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1842  
Albany, New York 12237