

**IMPLEMENTATION OF COMMISSION MANDATES
RFA No. 0705141214**

INFORMATION CONFERENCE

Governor Nelson A. Rockefeller Empire State Plaza
Carol F. Huxley Theater
New York State Museum
Albany, New York

May 24, 2007
1:00 p.m.

APPEARANCES:

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Robert W. Reed, Deputy Commissioner for Administration

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1 MR. DELKER: Good afternoon. Could
2 everyone take their seats? We have a lot to do
3 this afternoon, and we need to get started.

4 Before we get to the formal agenda, I'd
5 just kind of like to give you a preview of what
6 we're going to do here today. You should all
7 have picked up copies of the agenda outside, and
8 so you can see the main subjects we're going to
9 cover. Essentially, those are the main areas of
10 the RFA, and we hope to elaborate on those and
11 clarify some things that may not come across
12 just in the reading of it. We'll talk about the
13 purposes, the activities and costs, the basis of
14 our award decision-making and the application
15 process, and then the procedure for submitting
16 applications.

17 Now we want to go through all of this
18 fairly quickly, because we recognize that all of
19 you are affected differently by the Commission's
20 mandates, and you all have your own distinctive
21 set of circumstances in your health care
22 facilities, and so your questions -- you know, I
23 know you all have a lot of questions to ask
24 about your particular circumstances, and it's
25 hard to generalize in a presentation about

1 things that are applicable for everybody, so we
2 want to move through the formal agenda fairly
3 quickly. To facilitate that, we ask that you
4 hold your questions until the formal question
5 and answer session. You will have an
6 opportunity to ask questions. We have
7 walk-around microphones that will be brought to
8 you, so when you need to ask a question you can
9 just stay where you are.

10 A couple of other statements. It's in
11 the nature of these conferences that, while we
12 do our best to present full and final
13 information, what we say here is not final until
14 we actually publish the formal written results
15 of it in the form of the questions and answers
16 posed and the main points we make in our
17 presentations. So I guess you can consider all
18 of what we say here today marked with a big
19 draft stamp, but I don't expect a lot of
20 uncertainty here. I think most of that will
21 come in the form of responses. We'll have to
22 get back to you on it, depending on the
23 circumstances of your particular facility. But
24 bear in mind that we are confident we know most
25 of what we need to tell you here. We may have

1 to issue some qualifications and clarifications
2 later.

3 So before proceeding, we'll all
4 introduce ourselves. I'm Chris Delker with the
5 Division of Health Facility Planning.

6 MR. VEINO: Bob Veino, DOH
7 counsel's office.

8 MS. PADEN: Deborah Paden,
9 counsel's office.

10 MR. CONWAY: Tom Conway, DOH
11 general counsel's office.

12 MR. CLYNE: Jim Clyne, Office of
13 Health Systems Management.

14 MS. LEFEBVRE: Lora Lefebvre,
15 portfolio management at DASNY.

16 MR. VOLK: Larry Volk, portfolio
17 management at DASNY.

18 MR. REED: Bob Reed, Department of
19 Health, Division of Administration.

20 MR. BENJAMIN: Neil Benjamin, OHSM.

21 MR. ABEL: Charles Abel, Health
22 Facilities Planning.

23 MR. SCHMIDT: Bob Schmidt, Health
24 Facilities Planning, Albany, New York.

25 MR. DELKER: Okay, to get started

1 I'd like to introduce our new Deputy
2 Commissioner for Health Systems Management, Jim
3 Clyne.

4 MR. CLYNE: Thanks, Chris. I want
5 to first thank everyone on this panel, our
6 friends from DASNY and the DOH staff, who have
7 really been going above and beyond the call of
8 duty to get this RGA out there so that we can
9 make the recommendations of the Berger
10 Commission happen in a timely reasonable way.

11 As everyone knows, the Commission did
12 the report on December of '06, and it's now law,
13 and we're using this opportunity, these dollars,
14 to implement that report.

15 Many people have already taken
16 significant steps, and we've met with --
17 literally hundreds of meetings, and many have
18 taken steps, already implemented commissions on
19 mandates, and we appreciate the effort that
20 you've put forward to do that and see this as an
21 opportunity to be able to do our part, which is
22 to contribute some dollars to make a successful
23 transition.

24 For others who have not begun to carry
25 out the Commission's mandate, this is a chance

1 to get some financial assistance that we're
2 talking about today. This is really a unique
3 opportunity. This is going to be the primary
4 vehicle by which the State can step forward and
5 partner with you to make the Commission's
6 recommendations move forward in a way that
7 improves the public health, reduces costs and
8 really allows the Commission's recommendations
9 to be implemented in a way that I think we all
10 want it to be. And, although, the \$550 million
11 seems like a lot of money in the discussions
12 that we've had with many of the providers who
13 have come forward, we know that there is a lot
14 of need out there. But as the Commission report
15 has said, the State dollars are going to be the
16 last dollars in.

17 Some of these facilities are going to
18 have to carry some debt forward. They're going
19 to have to take some responsibility for the
20 previous decisions that management has made, and
21 the 550 million has to go really to implement
22 quite a few recommendations when you look at the
23 entire report.

24 As Chris talked about, we're going to
25 try and answer as many questions as we can on a

1 facility-specific basis, but we are also going
2 to be available for meetings with individual
3 facilities from now through the application
4 process. To the extent that we can be helpful
5 to discuss particular issues that you have, we
6 would be happy to do so. Contact myself, Neil
7 Benjamin to set up meetings. I know some people
8 have already done that.

9 That's it for my presentation.

10 MR. DELKER: We'll move now to Neil
11 Benjamin and Bob Reed to talk about the general
12 purposes and the overview of the RFA. This
13 request for assistance is a little bit different
14 animal than what you're used to. It's not your
15 usual grant, nor is it the competitive
16 procurement activity that you may have
17 participated in in HEAL phase II or other
18 procurement activities in the past. So Neil and
19 Bob will explain that and how it fits in with
20 the purposes of the Commission and where we see
21 the mandates going ahead.

22 MR. BENJAMIN: Thank you, Chris.
23 Thank you, Jim. Again, I want to echo Jim's
24 compliments, both to the Dormitory Authority and
25 the Department staff, in terms of putting this

1 together and getting it out. I think it's
2 self-explanatory. I think this is a good segue
3 to one of the two background comments that I
4 think are important. One of them is, obviously,
5 you know, an understanding and, you know,
6 reading of the actual application, the
7 implementation of the Commission mandates, RFA,
8 and also, obviously, an understanding and
9 reading of the entire Commission report, you
10 know, because again this is targeted just to
11 facilities that are impacted by the Berger
12 Commission recommendations which are now law.

13 The purpose of this RGA -- or, I guess,
14 RFA, sorry, is really to provide financial
15 assistance for implementation of Commission
16 mandates for each facility in accordance with
17 compliance plans that are required by the
18 Commission legislation.

19 The Department did send out in late
20 January, early February, letters to each of the
21 Berger I'll call them "recommendee's," outlining
22 a series of deliverables and timeline that is
23 important for us to be able to work with
24 everyone who is the subject of a recommendation
25 as we move towards, again, mandatory

1 implementation of the recommendations. Those
2 letters could almost be considered as the
3 foundation for the compliance plans that must
4 accompany the response to this RFA. And I
5 can't -- we can't emphasize that enough, that
6 the compliance plan, the plan that you have for
7 complying with the Berger recommendations is the
8 foundation of the response to this RFA, because,
9 as Jim said, this really is the money to assist
10 in compliance with the Berger Law. Because, as
11 you know, and as the Department has been trying
12 to emphasize, Berger is now law, and these
13 recommendations according to -- and I'm quoting
14 the statute now. The Commissioner shall
15 implement the recommendations. And from our
16 perspective, these recommendations, the
17 Department will move to implement every one of
18 them, but this is an opportunity for you to get
19 some financial assistance in terms of
20 implementing those recommendations. This will
21 combine dollars that we have available to us
22 both under the HEAL New York statute as well as
23 the Federal State Health Reform Partnership,
24 more commonly known as F-SHRP. Those dollars
25 will both be available through this process, so

1 I think that's something else that is certainly
2 a matter of convenience and will be helpful to
3 all of us to eliminate the need for separate
4 RFPs or whatever, and it also gives us, and you,
5 the flexibility to determine, you know, the
6 elements of your proposal and where they might
7 fit in terms of what Bob Reed is going to talk
8 about in a couple of minutes.

9 So, again, this is something -- and I
10 just need to emphasize this. The compliance
11 plans for the Berger Law again are the most
12 critical part of this. The dollars we will
13 have -- you'll hear later on, you will have
14 people who are more than capable of assessing
15 the reasonableness of the use of the money as
16 well as the consistency of the compliance plans
17 with the Berger Law. So I'll be speaking more
18 on other pieces of this as we move forward, but
19 I would like to turn it over now to Bob Reed to
20 talk about some of the uses and restrictions
21 related to the State Finance Law as well as HEAL
22 and F-SHRP.

23 Mr. REED: Thanks, Neil. As Neil
24 pointed out, we're going to use two sets of
25 funding to meet the needs of this request for

1 application. The HEAL New York allocation is
2 strictly capital project fund dollars, and we
3 will use those dollars for aspects of your
4 compliance plan that meet the standards of
5 capital in generally accepted accounting
6 principles. Those dollars have been
7 reappropriated, and we continue to reappropriate
8 them as needed, as we receive additional
9 appropriations.

10 We also have available to us funds
11 provided through the Federal State Health Reform
12 Partnership, through CMS. Those dollars
13 potentially, over the five-year period, amount
14 to 1.5 billion dollars, 300 million dollars on
15 each of the demonstration years depending on a
16 number of conditions. Demonstration years are
17 federal fiscal years, if you're interested in
18 that. We will use these funds on sort of a mix
19 and match basis for funding various parts of the
20 project that meet whatever criteria we want to
21 adhere to with these funds. We have more
22 flexibility with F-SHRP funds than with HEAL New
23 York funds.

24 If and when you successfully negotiate a
25 contract with us for financial assistance, you

1 will be expected to sign a contract with New
2 York State and will have to be required to meet
3 the standards that New York State has set in its
4 contracts. A couple of points there that are
5 unique to HEAL, and these are reflected in the
6 RFA itself, and that is compliance is going to
7 be required with the WICKS Law, and we would
8 encourage you to take a look at that particular
9 section of the RFA. You'll have to sign and
10 adhere to that standard. One thing that I think
11 you ought to also take into consideration and
12 bear in mind, the Department of Health contracts
13 do have audible clauses in it. You will be
14 expected to submit a third-party audit to us
15 prepared in accordance with the Comptroller's
16 general standards. Those are reviewed annually.
17 Although, we have not formally done anything
18 along these lines, since significant funds are
19 going to be disbursed, one can expect various
20 control agencies, in the State and at the
21 federal government, are going to be interested
22 in how these funds are used. So I would expect
23 that there would be significant oversight of the
24 process, both by the Department of Health, by
25 the State Comptroller and potentially by the

1 centers for the Medicare and Medicaid services.
2 So just be aware of that in your planning and in
3 your administration of the program.

4 Another point to bear in mind, as Chris
5 mentioned at the outset, we're not viewing this
6 as a competitive process. You're not competing
7 one facility against another. You're competing
8 against a standard. The standard, if you will,
9 is that which is reflected through your
10 individual facility in the Berger Report.
11 That's the programmatic standard. The other
12 standard that is referenced in the Berger
13 report, as Jim pointed out, you're going to be
14 required to make a financial contribution to
15 this. Our analysis and thought process
16 throughout will be to get to the net lowest
17 public investment needed to ensure compliance
18 with the plan, and that's what our analytical
19 process of review is going to drive towards.

20 We don't have unlimited funds. These
21 are going to be -- our funds are going to be
22 last-dollar funds. Our contracts will have
23 language such that if you dispose of an asset at
24 the end of the process and realize a profit, the
25 State will expect that some of those funds, if

1 not all, will come back to the State to defray
2 the public investment. Those are some of the
3 highlights of what is expected in terms of the
4 funding streams and some of the Department's
5 requirements as we go forward. And I guess
6 Chris and Neil are going to go on about eligible
7 costs and activity.

8 MR. DELKER: Just to elaborate some
9 on what Bob said, I think it's worth, if you
10 have haven't already -- looking at the
11 Commission's report, the December 2006 report,
12 the principles that Bob referred to start on
13 page 230 of that report, and I think it gives a
14 very good, you know, description of the
15 principles, more of the whole philosophy, the
16 policy approach behind this endeavor where it's
17 both the State and the facilities, the health
18 care community that are seeking to make the
19 health care system more efficient, lower cost
20 and better oriented towards the health of the
21 patients and all of us. Okay.

22 That said, we're going to go into the
23 eligible costs and kind of give you some idea of
24 some of the things that are approval monitored.
25 First of all, though, we have to talk about

1 eligible applicants. The applicant must be an
2 Article 28 facility that is the subject of a
3 mandate in the Commission's Report, or an active
4 member thereof. Now we had some applications in
5 HEAL Phase 2. When we made this we had this
6 same requirement. We had several applications
7 that were disqualified because they were
8 submitted by these very nice 501 (c) 3
9 corporations that were affiliated with such and
10 such a health system, and they thought that
11 meant that they represented the Article 28
12 facility. Well, it didn't make it. The same
13 applies here. The Commission's mandates are
14 very explicit about pertaining to particular
15 facilities. So the applicant has to be the
16 facility itself or an active member thereof.
17 What do we mean by an active member? That's an
18 entity that had to receive establishment
19 approval under the Public Health Law. So if
20 that's not clear, speak to your attorneys about
21 it to make sure it's clear. A good check is
22 just to look at your operating certificate. If
23 the applicant's name is not on the operating
24 certificate, the applicant can't be an
25 applicant. So we just wanted to clarify that so

1 we don't have to filter out any right in front
2 like we did in Phase 2.

3 As Bob said and Neil said, generally
4 speaking, the activities and costs have to
5 relate directly to the implementation of the
6 Commission mandate. Now, there is some help in
7 this in the implementation outline that was sent
8 to you at the end of January, or thereabouts.
9 There may have been some variation in the date
10 to some of you. A letter from David Wollner to
11 all of the facilities affected by Commission
12 recommendations attached with what is called an
13 "implementation outline" for your facility. It
14 has certain dates and deliverables. Some of
15 them processed deliverables, some of them, you
16 know, activities. September 30 is a big day in
17 those letters for some of you, December 31 and
18 then June 30, 2008. So that's kind of the
19 framework for your application. What your
20 application is, is filling in the details on
21 that outline, putting in the meat, the details,
22 and how much it's going to cost and how much you
23 want us to help you with it. So if you keep
24 coming back to that implementation outline and
25 the OHSM letter as kind of your touchstone,

1 you'll probably be all right in what you're
2 asking for.

3 Did I skip one here? No, okay. As far
4 as what you can ask for, cost eligible, you can
5 ask for cost incurred all the way back to
6 January 1, 2007. Now, this doesn't mean you
7 load up with anything. It has to be something
8 under an audit, like Bob referred to, that could
9 be demonstrated to pertain directly to the
10 implementation of your mandate. But we realize
11 that many of you got started on your mandates as
12 soon as the report was issued, or some in
13 anticipation did it before, so those costs you
14 can build them all the way back. A significant
15 amount of grant moneys will be available for
16 costs that you can show incurred before
17 September 30, 2007. This has to do in part with
18 the federal fiscal year and the F-SHRP funds
19 being available according to the federal fiscal
20 year, which ends on September 30.

21 Bob, did you want to add anything to
22 that? Okay, I guess it was clear enough.

23 Now, as you know, one of the big
24 recommendations for a number of the
25 facilities -- the mandate, rather. They're not

1 recommendations anymore. -- is to enter into
2 mergers or affiliations between facilities, and
3 there are a lot of -- we recognize these are
4 complicated things. There a lot of costs
5 involved in these types of collaborative
6 arrangements, and I'd like to turn it over to
7 Lora Lefebvre for a few minutes to talk about
8 some of things in that.

9 MS. LEFEBVRE: Yeah, and I'll be
10 real brief. I mean you, probably, all know the
11 types of costs that are attended when two
12 institutions, or many institutions are trying to
13 get together either through a merger or an
14 affiliation. The nature of some of these costs
15 that we've seen in the past are facilitation of
16 a discussion in the first instance. Sometimes
17 you need people to help you facilitate that
18 discussion. We've seen expenses related to
19 infrastructure assessment. If two institutions
20 are trying to figure out how they're going to do
21 business as one or together, sometimes it makes
22 sense to have an assessment of both entities'
23 infrastructure on how you might deliver health
24 care better together. The other types of
25 expenses, there are certainly a lot of legal

1 expenses, first in the due diligence process,
2 and then certainly as you're trying to kind of
3 piece together what that relationship
4 contractually looks like. A lot of legal
5 expenses there. We've also seen both hired
6 financial consultants, outside consultants to do
7 due diligence on both of the sets of financial
8 statements and where the risks and opportunities
9 are for both institutions as they're coming
10 together. Cost of CON development is another
11 thing that we've seen expenses related around
12 this type of activity, and I don't think --
13 those are about the major costs that we've seen,
14 and I don't know if anybody else has any other
15 types of expenses that you might see.

16 MR. BENJAMIN: Just to emphasize,
17 Lora, that again this a little bit different
18 from the previous ones, in that previous
19 procurements under HEAL planning costs are
20 eligible.

21 MS. LEFEBVRE: I think that was it.
22 Chris.

23 MR. DELKER: Can everybody hear me?
24 Can you hear me? I get nervous standing at the
25 podium too. Whoops.

1 MR. BENJAMIN: You better stand at
2 the podium.

3 MR. DELKER: When I got -- there we
4 go. When I had lunch today, the total came to
5 6.66. And the young lady at the cashier said,
6 Oh, sir, you better get a cookie. I didn't buy
7 the cookie, so I'm dreading the question and
8 answer session.

9 Well, anyway, the eligible costs for
10 construction, construction is the kind of stuff
11 you're most familiar with in CON applications.
12 Renovations, buildings, knocking out walls,
13 expanding rooms, changing, converting space,
14 this is like the restructuring activities that
15 were under HEAL Phase 2. So this, generally,
16 the costs of renovation or expansion of
17 operating your facility to comport with the
18 Commission's mandates, those are acceptable.
19 Again, you must demonstrate that they are
20 directly related to the Commission mandate.
21 There are a number of the Commission mandate
22 recommendations for relocation between
23 facilities, particularly affiliating merging
24 facilities of beds or services. The cost
25 associated with that are acceptable. Medical

1 equipment associated with implementation of the
2 Commission mandate is also acceptable. Now, for
3 a list, you see on pages 5 and 6 of the RFA,
4 Section 1.7, a laundry list of eligible costs.
5 Note that it says "including but not limited
6 to," and the last one I believe is such costs as
7 deemed reasonable by the Commissioner. So we're
8 receptive to whatever you want to suggest. We
9 must emphasize, however, that you have to have
10 it related directly to the Commission mandate.
11 Don't try to take advantage of it for something
12 else. I mean you may have been thinking for
13 years about knocking out some walls, and, oh,
14 gee, we need a new MRI. We might as well throw
15 that in. So don't try to load up with things
16 that are not directly pertinent to the
17 Commission's mandate. That will slow down
18 consideration of your application, and it may
19 jeopardize the amount of funding you get. So
20 just keep that in mind.

21 Now, closures are a complicated thing,
22 and they certainly are ones that are a difficult
23 decision -- a difficult activity for a lot of
24 facilities in a lot of communities, and so there
25 are a number of things that we hope, and

1 financial assistance available here will kind of
2 soften some of the concerns around that and help
3 you absorb some of the costs associated with
4 that.

5 Neil, did you want to elaborate on
6 those?

7 MR. BENJAMIN: Yeah, just a little
8 bit, Chris. Thank you. I think this is where
9 it becomes most important, what Bob mentioned
10 earlier, in terms of the guiding principles as
11 to how we will view these applications,
12 particularly in the case of closures. And when
13 I say closures, it includes those that are
14 closing but converting to other types of
15 services, and that is the -- and we're guided by
16 the financing section. I think it's the last
17 section of the Berger Report. We are being
18 guided by those principles. The last dollar and
19 the institutions shall self-fund the cost of
20 closures to the extent possible. Now we know,
21 we know from, you know, years of dealing with
22 the industry on various different levels that
23 that is a lot easier said than done. We do
24 recognize that balance sheets contain many items
25 that, you know, when they go into a calculation

1 of whether there's a net equity position or a
2 deficit position, but within those asset and
3 liability items are many complications. We do
4 understand that. But to the extent, though,
5 possible we will be reviewing these, to the best
6 of our knowledge, as to whether or not assets
7 may be, number 1, currently available; number 2,
8 available by the time of the mandated
9 implementation date, and then, number 3, if
10 assets may become available after the
11 implementation date such as, as Bob indicated
12 earlier, from the sale of assets. Bob Veino
13 taught me this one. In other types of health
14 department issues and procurement, that's
15 commonly known as "claw-back provisions." And
16 so we will be vigilant of that as well, and we
17 certainly -- you know, we certainly will be
18 considering funding costs, net costs up front
19 that are necessary to realize those dollars down
20 the road, with the understanding, as Bob said,
21 that the State investment, you know, there can't
22 really be a profit made on the state investment
23 that is made up front. And there are many other
24 things, I know. You know, probably, on a lot of
25 your minds are costs such as accrued pension

1 liabilities, malpractice insurance liabilities
2 and those types of things. That's why it's very
3 important that we get with the application that
4 was requested, and that is sets of your audited
5 financial statements. And, again to quote
6 someone else earlier, why this one is different
7 is that we will be able to talk with all of you
8 during the review process, and we will be able
9 to use that for things ranging from just
10 clarification of eligible costs to how we may
11 view things, to ask you for more information,
12 any type of a thing. So it's going to be a --
13 we hope this would be a collaborative approach.
14 There are certainly items on income statements
15 and balance sheets that, you know, you may have
16 a better understanding that will help us in this
17 last dollar assessment, etcetera. So we, again,
18 will be, you know, reaching out and encouraging
19 that kind of a discussion as we go forward.

20 Before we leave the issue of closure
21 costs, I want to ask Lora, since the Dormitory
22 Authority has had some experience with closures,
23 from the financial side if you have anything to
24 add.

25 MS. LEFEBVRE: No. Neil, I think

1 you did a good job of characterizing of what we
2 would like to see. I think that in addition,
3 just to kind of give -- to the audited financial
4 statements, I think that when you look at the
5 RFA, it asks for a lot more detail too about the
6 nature of your assets and the nature of the
7 liabilities that may or may not show up
8 necessarily on your audited financial
9 statements. We're going to be wanting a little
10 bit more detail and breakdown of each one of
11 those kind of categories of assets and
12 liabilities also. And, unfortunately, yes, we
13 have had some experience in closure, and I think
14 this slide kind of details some of the larger
15 costs that attended to closure, but I think
16 there are also some other details on other
17 slides, I think, Chris, in the back that also
18 lay out a little bit more too.

19 MR. DELKER: Okay. One more thing
20 before we leave eligible costs, and certainly
21 not least, many of the Commission's
22 recommendation mandates call for expansion or
23 new services; for example, especially in the
24 long-term care area, reductions of inpatient
25 capacity in favor of things like long-term home

1 health care or adult-day health care, on the
2 acute care side, a lot of expanded ambulatory
3 care, or primary care, or things like that.
4 These certainly are eligible costs, and
5 certainly the funding here is available to
6 support that. Again, be guided by the same
7 principles. Show they are directly -- the costs
8 and activities are directly related to the
9 mandate.

10 All right, we want to move ahead now to
11 the basis of the awards sections of the RFA,
12 just kind of the rationale and thinking of what
13 we're going to bring to the basis of the awards.
14 Again, to reiterate this mantra, I guess it is,
15 you have to be fully compliant with the
16 Commission's mandate. The funding is for
17 implementation of the mandates, and that's what
18 your request should address. It would certainly
19 help funding for those applications that have a
20 few barriers to implementation. Propose
21 something that's practical that you can get done
22 within the context of implementing a mandate.
23 If it's something that is going to take a lot of
24 other things necessary to happen that are
25 outside it, it's probably not a good approach.

1 Rethink it and come back with something more
2 directly related. Be reasonable, cost
3 effective, financially feasible. You're used to
4 this with some of the CON reviews and other
5 activities or any funding endeavor where you try
6 to propose something that is credit worthy or
7 thought to be a sound approach. So just keep
8 those principles in mind. And again, as Bob
9 Reed said in his presentation, the minimum
10 public investment is what's going to guide our
11 decisions here. Okay? So keep that in mind.
12 And I think something that is certainly
13 distinctive to this process, and you certainly
14 won't find it in a procurement process, and very
15 few others, is that we will negotiate with you.
16 If you submit something that we don't think will
17 not get you to implementation of your mandate in
18 a timely way, or if you're proposing costs that
19 we don't think are pertinent, we will contact
20 you and work with you to try to get things on
21 track and focused. Okay? Now, obviously, the
22 better your application is initially the
23 sooner -- if we do deem it worth approving and
24 your financial effort is adequate, the sooner it
25 will get approved. So try to get it so you

1 don't have to be negotiated with, so to speak,
2 but try to get it right. Try to get it in, but
3 we do want to work with you. The burden is on
4 the Department to ensure that these mandates are
5 implemented, as well as on you, and so we want
6 to work together in getting things right.

7 And then, again, if you get it in by the
8 deadline and it's a good proposal, those three
9 criteria -- financially feasible, practical,
10 right on target with the mandate -- your chances
11 are better.

12 Now we're going to go through the
13 application. Now, as we said, the application
14 itself, especially the program part of it, is
15 your compliance plan. And then the financial
16 part of it is your costs of how you're going to
17 implement that plan. And some of this stuff
18 will look familiar from earlier procurements.
19 Some of it will look similar to restructuring,
20 but bear in mind it has to be directly related
21 to the mandate.

22 The first thing we need is a good
23 executive summary, and we do mean summary. In
24 some of the Phase 2 applications, we had
25 executive, quote, summaries that were ten pages

1 long, so please be concise. Be direct. Give us
2 a road map. It will make it a lot easier for us
3 to read and review your compliance plan and
4 associated financial application. We don't need
5 a lot of background. It may be all very
6 interesting that your facility was founded in
7 the early 19th century to meet the health needs
8 of a sailor ship-wrecked on Long Island Sound,
9 but we don't really need to know. One of the
10 Phase 2 applicants appended their proceedings
11 from their staff organizational development
12 retreat and their mission this, values. We
13 don't really need that. We're going to be
14 reading dozens of these things, and make it
15 direct and pertinent to the mandate and to how
16 you're going to get there, how you're going to
17 implement it, how much it's going to cost, how
18 much you want from us.

19 I think I'm going to introduce Bob
20 Schmidt, and take a good look at Bob, because
21 he's director of the HEAL Implementation Unit,
22 and that's the unit that really has most of the
23 responsibility for the receipt and
24 administration of these grants. He'll be the
25 man and the voice on the other end of the phone

1 and the guy on the other end of the e-mails, and
2 you ought to get to know him.

3 MR. SCHMIDT: Thanks, Chris. I
4 drew the short straw. That's why my name is on
5 the front of the RFA.

6 As Chris mentioned, I'm going to make
7 sure the executive summary is brief. If it's
8 more than one or two pages, it's not really a
9 summary, so keep it to about two pages.

10 The next section, just to reiterate,
11 Sections A through F are going to be considered
12 compliance plan, and this is where we're going
13 to get the details about how you are meeting the
14 mandate.

15 Impact on the institution. This is
16 where you're going to talk about the way you're
17 going to implement -- the mandate is going to
18 affect your institution. It's going to address
19 changes in inpatient, outpatient fee-based
20 services, how your physical plant is being
21 altered, your joint governing structure, how it
22 might change if you're in a merger or
23 affiliation and the benefits to your
24 institution.

25 In the case of some mergers, women's

1 health services could be affected. You might
2 want to make that clear that you're going to
3 assure access to all women's health services.

4 Okay, one more thing on impact of the
5 institution, you want to make sure that you've
6 demonstrated how you've engaged in outreach
7 efforts, that you're involved in the community
8 and how you're going to go about implementing
9 the mandate and that there has been community
10 input. And in the case of that, there could be
11 your border advisory group can have some input,
12 your work with community-based organizations or
13 the hospital community service plans, like how
14 that's been done to assure community buy-in with
15 how you're going to go about your application.

16 Okay, objectives, tasks and timelines.
17 This is really the same as we had in other grant
18 applications. You want to start with your major
19 milestones, and you want to have your
20 sub-objectives listed below that, and you want
21 it to be a sequential timeline that basically is
22 going to comply with the original OHSM timeline
23 that was sent earlier this year, the Dave
24 Wollner letter, so to make sure that you're not
25 planning something that's not going to dovetail

1 with what the original compliance plan was.

2 Okay, resources for compliance. You
3 want to have a narrative description of the
4 sources that you're going to use, your funding
5 sources, and how the HEAL money is going to work
6 with the funding sources you've secured, whether
7 it be your own sources, or the sources that
8 you're going to affiliate with, or anything else
9 that might be relevant. I don't know if anybody
10 from the panel wants to talk about sources,
11 other sources within HEAL, but -- not really.

12 MS. LEFEBVRE: Let me just say I
13 think it's important when you're providing the
14 application that you -- we're going to ask you
15 to outline what your liabilities are in pretty
16 great detail, but we really would like to also
17 see, you know, what other assets and other
18 potential sources of funding that you might tap
19 upon to get us down to that lowest net state
20 investment dollars, so add that on to the
21 assets.

22 MR. SCHMIDT: Great. Thanks, Lora.

23 MR. ABEL: Bob, just to tack on, we
24 want to make sure that you're specific with
25 respect to who will be funding equity

1 contributions, who would be borrowers of any
2 debt proposed to satisfy the condition, and
3 we're talking about not just the subject
4 facility but other related facilities --
5 foundations, related real estate entities,
6 corporate partners and parents.

7 MR. SCHMIDT: Thanks, Charlie. The
8 next area is the monitoring plan. Every RGA we
9 had before this has recorded the monitoring
10 plan, and we want you to include the method
11 you're going to use, using to track your
12 progress, and that I want to make sure that your
13 monitoring plan has a feedback mechanism, so
14 that if things don't go according to plan that
15 you have ways to correct it and make sure you
16 stay on track and on schedule. The tradition
17 monitoring portion of the applications has
18 always been the weakest, so we thought maybe we
19 can just spend a couple more minutes on how to
20 improve monitoring plans.

21 The next area is reporting requirements.
22 Because we have got a real tight turn-around
23 time to accomplish these projects, we're going
24 to be requiring monthly as well as quarterly
25 reports. That's the first time in the HEAL

1 process we're requiring a monthly report. But
2 the monthly report, the intention is to be brief
3 and just give us highlights of what's happening
4 at the end of each monthly period. And then the
5 quarterly reports would have more of the usual
6 required detail, a discussion of your milestones
7 achieved and your evaluation of the project
8 status, discussion of any delays or other
9 problems encountered, your plan of action for
10 addressing any delays or other issues
11 encountered, objectives for the next reporting
12 period, the remaining project period, and then
13 you'll have to each quarter include a report of
14 the project expenses and revenues, or a budget
15 expenditure report of that.

16 And then we get into the project budget.
17 Your project budget should include a detailed
18 discussion of the reasonableness of each budget
19 item, and the budgeted item should be directly
20 related to the mandate, the project involved,
21 the mandate, nothing extraneous or extra. As
22 Chris had mentioned, you don't want to overload
23 the project budget with unnecessary expenses.

24 All right, and the next area is
25 retirement, other liabilities. I would like to

1 defer that discussion to Larry and Lora of the
2 Dormitory Authority.

3 MS. LEFEBVRE: Yeah. This is kind
4 of repetitive, but I think we really are -- as
5 we're assessing these applications, it's going
6 to be very important for us to understand in
7 pretty great detail what your liabilities look
8 like, particularly with regard to closures and
9 with regard to mergers and affiliations, a
10 description of your -- in detail, a description
11 of your liabilities, the nature of the
12 liabilities, whether they're collateralized,
13 whether they're not, the amount of the
14 liability. With regard to payroll liabilities,
15 this is again pretty much directed at a closure
16 kind of application. A description of what the
17 work force is like, any collective bargaining
18 agreements that you might have with the
19 employees, severance policies. And also, in the
20 case of closure, if a Warren Act liability is
21 present, or if you think you're going to be
22 paying out under the Warren Act. Kind of the
23 flip side of the liability discussion is that,
24 to the degree that you have real property that
25 you have debt out on, we would like to be able

1 to also get in the application an appraisal of
2 that real property to accompany your application
3 so that we can kind of get a sense of what the
4 value is, vis-a-vis the debt, or the liability
5 that you're carrying on the asset.

6 Additionally, if we're talking about pension or
7 malpractice liabilities, it would be very
8 helpful to get, and we would like to see,
9 actuarial kind of accounting of the status of
10 both of those funds, both the pension
11 liabilities and the malpractice liabilities
12 along with your application.

13 MR. SCHMIDT: Thanks. Let's see
14 the next slide.

15 MS. LEFEBVRE: That is more related
16 to construction, or do you want me to keep
17 going?

18 Okay, so continuing on, the next slide
19 really kind of relates, as I see it, to
20 basically an application that would come in with
21 some type of construction activity or new stuff.
22 And basically if you've identified that you're
23 going to use debt, other types of debt aside
24 from F-SHRP or HEAL to do that project, we want
25 to know basically how that construction project

1 is going to contribute to your financial
2 feasibility going forward. Obviously, under a
3 closure it's not really relevant. Merger
4 acquisition or kind of a restructuring your
5 facility, that would make a huge amount of
6 sense. Also, if you're going to incur outside
7 debt to kind of assist the project along a
8 feasibility, kind of similar, I would suspect,
9 Charlie, to a CON project, show us how you're
10 going to be able to pay that back over time
11 after you get the project up and complete.
12 Again, all of the other data underneath that,
13 including supporting documentation, it's the
14 same. We need to see as much financial
15 information as we possibly can in detail. Okay,
16 thanks.

17 MR. SCHMIDT: Cost effectiveness.
18 There are a lot of ways to go from A to B in the
19 project mandate, where to look to justify your
20 approach would be the most effective.

21 Then the remaining narrative portion of
22 the application has these four sections.
23 Financial feasibility for non-closure projects,
24 the applicant's financial position, this is
25 pretty important. You have to, basically, give

1 us a full picture of what your financial
2 position is. We're requiring the two prior
3 annual audit financial statements, two prior
4 annual statements along with a year-to-date
5 financial statement. That wouldn't be an audit,
6 of course, and any other accompanying
7 documentation that would enable us to do a full
8 assessment of what your position is.

9 There's also certification that's in the
10 RFA. You have to sign off on, and then you have
11 to provide some other general corporate
12 information.

13 And there's a host of schedules that
14 have to be completed, and Charlie is going to
15 walk through those for you.

16 I think one thing I was going to mention
17 too that, unlike the prior applications, we're
18 requiring two complete signed originals, or hard
19 copies, and then also six copies on a CD in
20 Adobe. So I think Phase 3, we asked for 21
21 application copies which became very unruly, so
22 hopefully this will reduce the paperwork you
23 send in and make it easier for the reviewers.

24 Are there any other questions? Not yet,
25 not yet, all right. Okay, here you go, Chris.

1 MR. ABEL: I just want to go
2 through some of the principles that we'll be
3 looking for when we designed the forms for you
4 to complete with respect to this request for
5 assistance and how to go about completing them
6 from a principle perspective, because each
7 individual situation is going to be different,
8 I'm sure.

9 The first thing we want to do is make
10 the forms as simple as possible and as generic
11 as possible so that they will be useful across
12 the board, but at the same time provide as much
13 information as we think is going to be necessary
14 and keep them familiar. So the forms that you
15 see that we have as Schedule 2 will look very
16 similar to the Certificate of Need, Capital Cost
17 forms that you're all familiar with. They are
18 available, as are the instructions on the
19 Department of Health website, so they should be
20 pretty straight forward, and there is assistance
21 on the website for completion of those forms.
22 They are slightly modified from the CON
23 versions. Some elements are not pertinent here,
24 so they were deleted. Some additional elements
25 are pertinent here, so they've been added.

1 Among those things that have been added, or that
2 we would like to see in addition to what we
3 would ordinarily submit with a CON, would be a
4 detail of the multiple sources of funding that
5 may be available to you, and as I mentioned
6 earlier, different partners, related entities
7 that would also be able to contribute to this
8 effort.

9 We mentioned certified financial
10 statements. I think we'd like to get the last
11 two years certified statements and the latest
12 interims for all of the facilities involved.
13 Just as with the CON where you're expressing a
14 source of funding, we look for some level of
15 documentation or comfort that that source of
16 funding is willing and able to contribute here.
17 When it comes to cash equity, you know,
18 typically we look for the financial statements
19 to support that.

20 Borrowing, we look for letters of
21 interest, at a minimum, initially, commitment
22 letters, if you have them. For any capital
23 construction project, we're going to be
24 assessing the reasonableness of the equity to
25 debt ratio in the same manner that we take a

1 look at Certificate of Need applications for
2 capital construction projects. Typically what
3 we see is 90 percent debt, 10 percent equity.
4 That's not a given or a requirement in every
5 situation, because we want to make sure that
6 your projects work from a financially feasible
7 manner. But, again, the premise here, or the
8 principle is that the state dollars are the last
9 dollars in and only when necessary.

10 There are schedules developed
11 specifically for closing costs, something that
12 is outside of the CON process, of course, but
13 we've taken a shot at detailing the categories
14 of costs that would be attributed to closing
15 costs. We don't expect that this is all
16 inclusive, and you're welcome to add lines,
17 supplement these schedules with whatever
18 information you have that you feel necessary to
19 include so that we have a good picture of what
20 your plan is for achieving compliance with the
21 Berger Commission.

22 You have another schedule for
23 restructuring similar. Similarly, we've taken
24 our best shot at detailing the categories there.
25 Feel free to add. Just keep in mind that, just

1 as we do in Certificate of Need reviews, -- and
2 I may be repeating myself here, but it's
3 probably worth repeating -- you're going to
4 detail the costs. You're going to give us the
5 basis for those costs, and then you're going to
6 show, demonstrate to us the ability to fund
7 those costs. And where the shortfall is,
8 there's your request.

9 It's pretty much as simple as that. As
10 folks have already discussed, you know, this
11 will be a -- to the extent that we have
12 questions or concerns over the application, this
13 process doesn't prohibit us from engaging you in
14 a discussion over a modification or, for that
15 matter, if you have a question over the status
16 of a particular component of the project.
17 Whether that be a use or a source, we will give
18 you a call and engage you in that matter, make
19 modifications on an ongoing basis as needed.
20 Anything else?

21 MR. BENJAMIN: Thank you, Charlie.
22 I just wanted to add a little bit to one comment
23 that Charlie made. He gave an example of CON on
24 a 90 percent debt, 10 percent equity. That's
25 really just an example to talk about, you know,

1 how that may be applied in CON. In the cases at
2 hand, certainly, the amount of debt that may be
3 proposed and may be acceptable from other
4 sources would certainly depend upon a lot of
5 factors, you know, and also the category or the
6 type of Berger recommendation that's out there.
7 You know, it could be very well viewed
8 differently in a straight closure versus a
9 construction project versus -- it all depends
10 upon everything that we've talked about earlier
11 in terms of other available resources.

12 MR. DELKER: And the last comments
13 from the panel?

14 Okay, this ends our presentation part of
15 it, so we'll go to the questions and answers
16 now. Can we have the lights up a little bit?

17 A few procedural things before we start
18 the questions. First, when you pose a question,
19 identify yourself, your name and your
20 organization. And if you have a business card
21 when you leave, you can just leave it with the
22 stenographer on the desk there.

23 Because this is a very well attended
24 session, we want to be fair to everybody, so
25 each questioner will be able to ask one question

1 and an immediate follow-up and then we'll move
2 onto the next question. If anyone has multiple
3 questions, we'll get back to you if time
4 permits, but we do need to try to be fair and
5 even handed here in the amount of time we have
6 available. So one and a follow-up. Bob and
7 Kelly are moving around with microphones, so
8 raise your hand if you want to ask a question.

9 MR. ASPINALL: Ed Aspinall with the
10 Work Institute. You mentioned training. I
11 assume you mean incumbent training, the training
12 of incumbent workers as well as transitional
13 workers that might be affected? And just as a
14 follow-up, the facility will be able to hire
15 outside organizations or agencies to do that
16 training, both the incumbent workers and the
17 transitional workers; is that correct?

18 MR. BENJAMIN: To go backwards, as
19 many of you who know me know that's usually what
20 I do. I'll answer your second question first.
21 Yes, yes, those costs certainly, with assistance
22 from the outside in terms of that, would be an
23 eligible cost for consideration in here. The
24 whole issue of, you know, the costs of worker
25 retraining, yeah, certainly this -- I can't call

1 it procurement. -- this RFA should be viewed not
2 as the only mechanism that's available.
3 Certainly, all of the other Department's
4 activities and programs relative to providing
5 funding for worker retraining, you know, should
6 continue to be pursued by those Berger
7 recommendees, you know, who would still qualify.
8 So while we will certainly consider as an
9 eligible cost reasonable amounts of dollars for
10 that, by no means should this just be considered
11 the exclusive source of money for those types of
12 costs.

13 MR. VOLK: I would like to add just
14 one thing to that, which is and the retraining
15 must be in support of the Commission mandate.
16 This is not an opportunity to simply retrain
17 your staff.

18 MR. VALLET: Jean-Paul Vallet,
19 Orange Regional Medical Center. Schedule 1
20 seemed to imply it, but our particular mandate
21 includes a construction and closure component.
22 The focus of this go-around will be requesting
23 moneys only for the closure piece. Can I assume
24 that we will only need to submit these schedules
25 that are listed in the closure portion of this,

1 or would there be a need to submit information
2 on the construction piece as well?

3 MR. ABEL: The scope of the project
4 that you are proposing would need HEAL or F-SHRP
5 dollars. That's what you're going to be
6 requesting. So if you're looking at -- if
7 you've already gotten a construction portion
8 taken care of, or you're going to fund that
9 portion of your compliance mandate in some other
10 manner and you're concentrating on only the
11 closure piece, then those are the schedules,
12 only the schedules that you'll need to complete
13 the closure-related schedules.

14 MR. VALLET: Okay, and there is no
15 mention of matching funds; is that correct? I
16 assume that there will be no matching fund
17 requirement?

18 MR. ABEL: Matching funds from what
19 source?

20 MR. VALLET: From the applicant.

21 MR. ABEL: Oh, in every one of
22 these proposals we expect that to the extent
23 that the applicant can fund some of those costs,
24 or all of those costs, they will be detailed and
25 the applicant and all of the, as I said, related

1 facilities. So I think from the principle
2 that's been articulated a number of times here
3 that the State, the public dollars are the last
4 dollars to go into this project. That's the way
5 we're going to assess the review of each one of
6 these proposals. If the facility and related
7 facilities, or related entities, have sufficient
8 dollars to do the whole project, then there is
9 really no need for public dollars. But to the
10 extent that something falls short, the sources
11 of funding fall short from the reasonable costs,
12 then we're willing to contribute.

13 MS. LEFEBVRE: It's just different.
14 We didn't set -- like HEAL 1, 2 and 3, we didn't
15 set like a defined, kind of like a level of
16 expected matching. We expect in the first
17 instance that you're putting up your own
18 resources, and then we fill in the gap at the
19 back end.

20 MR. VALLET: Thank you.

21 MS. FRANZ: Yes, I'm Jean Franz.
22 I'm here representing the Suffolk Health Network
23 down in Suffolk. To the extent that the support
24 that these hospitals need is to do bed
25 reconfiguration and, therefore, are going to

1 require capital, if I understood it correctly,
2 it's better if you're getting funds that you can
3 expend by the end of September, and if that's
4 not possible how do we reconcile that?

5 MR. REED: As we said, there are
6 multiple sources of funds that the State has
7 available to meet these criteria. The September
8 deadline is for us -- and it's reflected by a
9 period in the financial schedules, is to help us
10 identify what source of funds is best for a
11 specific project that meet both our needs and
12 your needs. There's still significant capital
13 dollars, if you recall, in looking at the RFA.
14 What we're trying to get at is the total project
15 costs. We understand that any type of project
16 that does have a capital component may require a
17 multi-year commitment. We're looking for you to
18 outline that plan in as much detail as you can
19 so we get an idea of the full scope of the cost
20 of the project. We want to use this request for
21 application, and the ensuing contract is the
22 basis for continued assessment, if you will, as
23 more information, perhaps, becomes available
24 when a capital project is designed and that sort
25 of a thing, so we're looking at it as the

1 beginning of a longer process and so forth.

2 MS. FRANZ: Thank you.

3 MS. COOKE: Hello. I'm Jeanette
4 Cooke, Sound Shore Health System in Westchester
5 County. How would a project that we might seek
6 funds for, how would that relate to a submitted
7 CON in terms of our request for financial
8 support?

9 MR. BENJAMIN: Well, the CON, the
10 scope of the CON would have to be virtually
11 identical to the elements of the compliance
12 plan. In other words, there would have to be
13 consistency. That doesn't mean that, you know,
14 the rest of the CON would be disregarded or
15 whatever, but there would, at a minimum, have to
16 be full consistency with that and the element of
17 the compliance plan that you're seeking funds
18 for here.

19 MS. COOKE: I didn't quite express
20 myself clearly, and I apologize. What I was
21 trying to ask about is literally the financing
22 that is presented in the submitted, already
23 policed CON, and the Commission may have made
24 recommendation related to that already submitted
25 CON. Can we now submit or request grant funding

1 to support implementation of that
2 recommendation?

3 MR. ABEL: Yeah. To the extent
4 that you -- in your CON that was submitted, to
5 the extent that you have projected a need for
6 grant funding, whether it be from this source or
7 some other entity, we would take a look at that.
8 And assuming that it was very clearly indicated
9 that it was from HEAL or F-SHRP dollars, well,
10 then I see a consistency there, that your
11 application would be consistent with the CON
12 application. If your grant funding was from
13 some other source and in fact that other source
14 continues to wish to fund your CON project, then
15 I don't see the need for HEAL or F-SHRP funding
16 because you have your financing plan in place.
17 You have the ability to fund that project
18 already.

19 MS. COOKE: And what if, because
20 you have more than one recommendation for new or
21 expanded services, you begin to be stretched,
22 even though when you submitted the CON you
23 thought you could do one thing, now you're being
24 asked to do more than one thing, and so suddenly
25 the financing picture not change?

1 MR. ABEL: We would have to take a
2 look at the individual specific situation, the
3 individual Berger mandates, what you have in
4 house with respect to the CON, where the mandate
5 differs from the CON that was submitted, and
6 then all of the available funding sources for
7 the whole -- to achieve full compliance with the
8 Berger mandate.

9 MR. REED: However, if you're
10 trying to -- forgive the term -- gain the system
11 to substitute some of these state dollars for
12 other dollars, I think we take a very hard look
13 at that, and you would be subjected to quite a
14 lot of questioning about that.

15 MR. MURPHY: Charlie Murphy from
16 Cicero Consulting Associates. Neil, I think
17 this is for you, based on your introduction.
18 Several of the mandates involving closure of
19 downsizing called for alternative services to be
20 provided, quote, under new sponsorship or by,
21 quote, another sponsor. Could such a sponsor,
22 that is not one of the 81 named facilities,
23 apply for financial assistance under this round
24 of appeal of funding so as to complete the
25 implementation of the mandate?

1 MR. BENJAMIN: Chris' lead-in as to
2 eligible applicants, I think, has the answer to
3 that. As Chris mentioned, the keys to how far
4 we can go in terms of eligible applicants is
5 related to the Article 28 or article whatever
6 licensure status under the Public Health Law.
7 If in a situation you describe, we would expect
8 that the Berger recommendee would work out the
9 arrangements with those other groups, would work
10 out the financial arrangements so that
11 compliance is demonstrated, but we would be
12 limited to providing the dollars only to the
13 eligible applicant. So there would have to be
14 some discussion and project development, so to
15 speak, relationship contract, whatever it is,
16 among those parties. We are holding the Berger
17 recommendees accountable for compliance and
18 delivering on whatever elements are needed to
19 demonstrate compliance.

20 MR. MURPHY: Just a follow-up. So
21 a partner facility, so to speak, as long as it's
22 an Article 28, I think you're saying? Let me
23 put it another way. The named facility would be
24 the flagship name on the application, one of the
25 named 81, but they could have a partner facility

1 that is going to provide the alternative
2 services that go into the closed or downsized
3 shell of a building. Do you think that's
4 plausible?

5 MR. BENJAMIN: As long as, again
6 the party that we are holding accountable for
7 everything, as Bob said earlier, and responsible
8 for implementation again remains the subject of
9 the recommendation. I mean we've had -- as Jim
10 said, you know, it probably is about a hundred
11 meetings already we've had, and this question,
12 you know, maybe not in that context, comes up a
13 lot, you know, in terms of -- I think it needs
14 to be separated out. In our discussions it's
15 mostly what other types of entities will you
16 accept in your compliance plans that aren't
17 necessarily Article 28. I think that's one, but
18 here we're more narrowly bound and more narrowly
19 restricted in terms of who we deal with, so it's
20 kind of shifting the burden for developing the
21 appropriate relationships to effectuate that.
22 We're putting the burden on the Berger
23 recommendee and who would also, in this case, be
24 a recipient of the money.

25 MR. CLYNE: In many of these cases

1 it's long-term care. Also, we're coordinating
2 with Mark Kissinger in his efforts in reshaping
3 the long-term care system in New York, whether
4 it be subsequent, whether it's right-sizing
5 dollars -- alternatives, and some of these might
6 fit in better. I'm not saying that you couldn't
7 apply, particularly if it was the actual
8 physical plan and something had to happen to it,
9 that maybe some of the continuation of the
10 services that need to get up and going might
11 come to another RFP that is going to come out of
12 our shop, and we are coordinating them.

13 MS. DIAZ: Jose Diaz, director of
14 the 1199 Lead Training Unemployment Funds. I
15 have a follow-up question about the retraining
16 costs. You stated that it will be considered
17 retraining dollars if they're reasonable, and
18 you also said that they would be considered very
19 compliant with the Berger Commission Report.
20 However, my question is what do you envision as
21 being allowed under the training programs?
22 Short-term, long-term training programs? When
23 we talk about closures, we would be talking
24 about preparing workers to transition to new
25 jobs, perhaps within the health care industry or

1 outside of the health care industry, and that
2 would require support placement services,
3 etcetera, versus workers who would be moving
4 from incumbent workers who might be moving from
5 a facility to another one because of
6 restructuring or new services. So do you have
7 an idea of what type of training programs that
8 would be allowed in this program?

9 MR. BENJAMIN: Well, I think, and I
10 don't really mean to be flippant on this at all,
11 but I'm going to coin a phrase that people use
12 in a lot of aspects, we'll know it when we see
13 it, because I don't really think that there is
14 any one answer that we can give you now, because
15 it really would depend upon the overall broader
16 elements of your plan for compliance. So, you
17 know, without seeing that, I go back to what I
18 said earlier. You know, we will consider for
19 funding, you know, reasonable costs that relate
20 to implementing Berger. As Larry Volk from
21 DASNY said, you know, and to go along with what
22 Chris said, that is not an open invitation to
23 put everything but the kitchen sink into it
24 either. So we still have to make sure that the
25 very narrow interpretations of Berger and any

1 sort of discretion we may have, we have to make
2 sure that patient safety is assured throughout
3 this entire process. So to the extent that
4 there are costs related to assuring that,
5 whether it be worker retraining or other types
6 of costs attended to that, you know, we will
7 consider that.

8 MR. LAUZARONE: Rich Lauzarone,
9 Continuum Health Partners. I just want to ask a
10 question related to what Mr. Murphy had asked in
11 a little more direct way. There are
12 institutions which did not receive a letter
13 which have definitely -- however, were
14 definitely impacted financially in their
15 expected role in fulfilling the mandates. I'll
16 just give you an example. You have hospital A
17 and B, and the report states that hospital A is
18 expected to close and that the Commission relied
19 upon the ability of hospital B to expand a
20 service or services in reaching its
21 determination that hospital A was no longer
22 needed from a community-health standpoint. In
23 this case hospital B, in fulfilling the mandates
24 of the Commission, while not having received a
25 letter, is definitely being impacted

1 financially, either expressly or implied. And
2 we would like to know if such an institution
3 would be eligible.

4 MR. BENJAMIN: I would go back
5 to -- let me see now. This is the third
6 retraining question. The first one is that --
7 no, seriously, I just need to remind you of a
8 couple of things. Number 1, you know, these
9 dollars are not the only dollars that are out
10 there for worker retraining.

11 MR. LAUZARONE: This is not worker
12 retraining. This is related to construction.

13 MR. BENJAMIN: Oh, I'm sorry.

14 MR. LAUZARONE: This is
15 construction. So hospital B is, either
16 expressly or implied, expected to expand some
17 service involving cost.

18 MR. CLYNE: But that's not covered
19 by this application. There are going to be
20 subsequent efforts through HEAL and F-SHRP to
21 deal with the impacted facilities, you know, who
22 will be surrounded and expected to do, you know,
23 ED expansions or whatever type of expansions.
24 But many people look at the surrounding
25 facilities as the ones that should end up

1 financially healthier as a result of the
2 closures, and that was a lot of the thinking
3 behind the recommendations in the Report, but
4 you can expect the subsequent -- not only
5 focused on that but also primary care,
6 expansion, and, as I said, expansion of
7 community alternatives for long-term care. We
8 are already thinking about that and talking
9 about that, to have that ready to go in the next
10 round, also mixed in with another IT, so we have
11 not forgotten about it.

12 MR. RODAT: Hi, I'm John Rodat from
13 Albany County. I have a question. The
14 governance question goes back to your point that
15 the eligible applicant is either an Article 28
16 facility or a corporation established under the
17 Public Health Law, etcetera. Our Article 28
18 facility is -- well, we actually have two, the
19 county nursing home and the Manley Home, one of
20 those being closed. That's pretty clear. We,
21 however, for the Berger Commission Report, have
22 laid an additional mandate on us to expand
23 community-based services. We do not currently
24 have a certificate under the Public Health Law
25 relating to those sorts of services. Is the

1 implication of the way you structured this, that
2 the only way in which we could receive these
3 funds would be for the nursing home to be the
4 applicant to be operator of the community-based
5 services, or is there some other alternative?

6 MR. ABEL: Well, somebody can
7 correct me if I'm wrong, but I guess just to
8 answer this, that, and that question a little
9 more clearly, it's only the named facilities
10 that can be the applicants for this request for
11 assistance. They can partner with other
12 entities to achieve the Berger mandate, but the
13 funding and the entity we will hold accountable
14 will be the named facility or a co-operator.

15 MR. RODAT: Yeah, I think there's a
16 difference in the case that I just laid out from
17 the case that was laid out a moment ago, because
18 in this instance it's one governing authority,
19 namely, the county.

20 MR. BENJAMIN: John, I think --
21 correct me if I'm wrong, but the county, if the
22 county is the licensed operator then that would
23 cover a broad array of everything that it's
24 licensed to do.

25 MR. RODAT: So it would be the

1 county generally as opposed to the county
2 nursing home as the older --

3 MR. BENJAMIN: Well, if a Berger
4 recommendee is operated by a particular county,
5 okay, if that is the licensed operator, then in
6 that particular situation the county would be
7 the eligible applicant.

8 MR. RODAT: Thank you.

9 MR. BENJAMIN: Chris goes all the
10 way back. Well, what Chris said I think is very
11 important, going to the operating certificate.
12 And I know I didn't have my hand raised, but I
13 just wanted to follow up what I was going to say
14 earlier when I fell asleep to this gentleman's
15 question about retraining, because I was going
16 to go back to what I said earlier. Please don't
17 take this procurement as the only dollars that
18 may be available for retraining, because all of
19 the other Department's programs, I mean they're
20 not going to be suspended; they're not going to
21 be viewed any differently. Those programs are
22 available. Here we attempt to focus on the
23 costs of the retraining as they may be
24 reasonably related to implementation of these
25 specific recommendations.

1 MR. GORMLEY: Bill Gormley
2 representing Dutch Manor. We have a response
3 date of June 30 for preliminary plans. If we
4 submit the RFA around that time, does one negate
5 the need for the other?

6 MR. BENJAMIN: No.

7 MR. GORMLEY: So if we have a
8 June 30 preliminary plan due, that has to go in,
9 and then the RFA, if it comes in on June 15 or
10 July 16, both documents have to come in?

11 MR. BENJAMIN: Yeah. Bill, really,
12 remember, the plan is much more -- that's more
13 of a general outline.

14 MR. GORMLEY: I understand.

15 MR. BENJAMIN: Yeah, yeah, but, no,
16 yes, we will be expecting both.

17 MR. GORMLEY: Okay, and then just a
18 follow-up.

19 MR. CLYNE: They should be so close
20 together as to be practically indistinguishable.

21 MR. GORMLEY: Well, I'm insulted,
22 Jim.

23 MR. CLYNE: I'm sorry. You're so
24 detailed. I'm looking out for your clients.

25 MR. GORMLEY: Additionally, as

1 Charlie was talking before about the process,
2 and when you get done with an RFA that requires
3 you to go through the Schedule 2s, as you put
4 them forward, you're really almost going to have
5 a CON done except for the shortened schedules
6 and the things of that nature. Does it serve
7 any purpose to include some of those schedules?
8 I know it probably won't, in your mind, be
9 considered a CON, but it would almost all -- you
10 know, it would make it a more complete package.

11 MR. ABEL: We're looking for the
12 most complete picture that you can paint for us
13 for the scope of the project to ensure its
14 compliance with the Berger mandates, and to give
15 us good assurance that the costs are reasonable,
16 that the funding sources are available and that
17 all other available funding sources have been
18 tapped so that the requests for assistance is
19 the lowest possible dollar figure.

20 MR. GORMLEY: Thank you.

21 MR. RINALDI: Dan Rinaldi from
22 Benedictine Hospital. Actually, two questions.
23 The first, you know, many of these projects are
24 multi-year projects -- five years, six years
25 too -- you know, certainly the bed

1 reconfigurations and so forth. I'm assuming the
2 contracts are one-year contracts only, or are
3 they multi-year contracts? That's question one.
4 And then question two I think is for Lora. Is
5 there any thought given to being able to utilize
6 F-SHRP money to help us secure tax-exempt
7 financing to refinance the construct projects?

8 MR. REED: These contracts will not
9 necessarily be one, single-year contract. They
10 may be written as a single year, but they will
11 be renewable to the extent that is deemed
12 necessary in response to the application. If
13 you have a multi-year project, we would try to
14 get to a multi-year contract. As I said, we
15 want to use this as a vehicle to follow through
16 to avoid the cost and the expense on both of our
17 parts of this type of an effort and to get a
18 sound plan for compliance with the Berger
19 recommendation. And in part, before Lora talks
20 about bonding and so forth, you know, as I
21 mentioned at the outset, HEAL money is available
22 to support some of these projects. One
23 component of HEAL, in terms of the way funds are
24 provided by the State, is to allow funds -- is
25 to allow the Dormitory Authority to bond parts

1 of these projects. And I think we're still
2 interested in identifying parts of the project
3 that would meet our definitions for capital and
4 for bonding, and ultimately this may lead to a
5 Dormitory Authority debt; although, we don't
6 need the debt service in place right away to
7 complete a contract.

8 MS. LEFEBVRE: Yeah, and, I think,
9 Dan, your question is directed at another type
10 of DASNY bonding, perhaps, because our bonding
11 will go to support, you know, the grant, the
12 HEAL grant. I think your question is directed,
13 could that -- it's an interesting question --
14 could the HEAL or the F-SHRP contribution
15 qualify to assist an institution in to getting
16 into the bond market to meet another financing.
17 And I think I would say that probably to act as
18 security, probably not, but to act as your
19 equity contribution, you know, perhaps upping
20 the equity contribution. I think that it's
21 clear that DASNY bonding, aside from the HEAL
22 bonding that we'll do for your institution,
23 should be considered as any type of debt should
24 be considered as part of your package, your
25 financial package. And I would like to think

1 about it a little bit more before we answer it
2 real definitively, but I think that it doesn't
3 quite work as a security mechanism, the grant on
4 a bonding. I don't know. Debby, do you have
5 any --

6 MS. PADEN: I think you're going in
7 the right direction, Lora. I agree with Lora.
8 I think that it would be hard for your HEAL
9 grant to secure your loan, but it could
10 certainly supplement a loan.

11 MS. FRYE: I'm Dorothy Frye from
12 SUNY Downstate. I want to ask you about
13 something that Mr. Clyne said regarding the HEAL
14 in the next round for institutions that will be
15 impacted not because they're on the list, but
16 because they're assisting someone on the list.
17 And also you mentioned the long-term care round.
18 That's separate from the HEAL money that's being
19 proposed at this point?

20 MR. CLYNE: That's separate to the
21 extent that you have somebody who wants to reply
22 who is not mentioned as one of the Berger
23 mandates.

24 MS. FRYE: And that's above the
25 dollar amount?

1 MR. CLYNE: That would be a
2 separate -- something that we're discussing
3 internally right now is the next round, what do
4 we do after this with the recognition that there
5 are going to be facilities that are impacted,
6 and there are going to be policies that we want
7 to continue to push forward like building
8 primary care capacity, expanding
9 community-based -- and long-term care, and then
10 also looking at restructuring, not only the
11 impact on facilities but we've been approached
12 by other facilities who weren't mentioned in the
13 Berger Commission who want to restructure. And
14 had they also had the opportunity to apply for
15 dollars, they would be able to do Berger-like
16 opportunities of merging and downsizing. So we
17 want to create that opportunity in another
18 round.

19 MS. FRYE: Thank you.

20 MR. FINKELSTEIN: Harvey
21 Finkelstein, Glendale Home. As we downsize, we
22 will see considerable loss of revenue which will
23 not be equal by the expenses that will reduce
24 during that transition period. So the question
25 is, will that be a recognized cost that we can

1 apply for, the net loss between the revenue and
2 the expenses?

3 MR. ABEL: Well, Neil just said he
4 knows what he would say, so hopefully we're on
5 the same page. I would think so. It's a
6 reasonable and common phenomenon, that expenses
7 may not be reduced in the same proportion as
8 revenues; however, we would expect that in your
9 plan you are detailing, taking and giving us a
10 month-by-month cash flow, for instance, to
11 demonstrate that effect, quantify that effect,
12 and demonstrate to us what steps you are taking
13 to reduce expenses to the extent possible, so
14 that to the extent possible you're operating as
15 efficiently as possible. A lot of possibilities.

16 MS. LEFEBVRE: I would also add to
17 that too, though, that one would expect also to
18 see some balance sheet, you know, kind of give
19 also. I mean if you have things, assets, the
20 home has assets that are either related to the
21 home or around the home that you could possibly
22 monetize to assist you, those are the types of
23 things we would be looking at also to kind of
24 fill that gap. And then in the end, HEAL or
25 F-SHRP, kind of those, that would be the very,

1 very last piece.

2 MR. ABEL: Just a couple of
3 additional comments. It would be an eligible
4 cost to consider. The expenses that exceed
5 revenues for the interim period need to be
6 specific to achieving the Berger mandate. And
7 there's nobody here who is going to say we're
8 going to fund ongoing losses as a result of the
9 ultimate product. That needs to be demonstrated
10 to be feasible, frankly. I guess it would be
11 interesting to see what would happen if you can
12 not show feasibility of the ultimate outcome.

13 MR. MAHLER: Tony Mahler from
14 Westchester Medical Center. Could you talk a
15 little bit about expended -- what you mean by
16 the September 30 date? Is that's obligated? Is
17 that cash out the door? Is it on the books?
18 What kind of standard are you going to apply to
19 that?

20 MR. REED: A more precise term
21 might be the word "disbursed." That means cash
22 out the door by the facility.

23 MR. MERE: I'm Mohammed Mere,
24 Eastern Niagara Health. Just a question on this
25 last dollar issue. I don't mean to be beat a

1 dead horse, but if there's any liquidity on the
2 balance sheet, that should be used? Is that
3 what you're saying? That liquidity should be
4 used before any HEAL funds will be allocated?

5 MR. ABEL: We're not going to be
6 scratching the balance sheet for the last penny,
7 but the principle is there. You know, it makes
8 no sense to leave a facility out there penniless
9 at the end of the day. By the same token, if
10 there are resources available for this purpose,
11 they should be used.

12 MR. VOLK: I think it goes back to
13 the feasibility issue and what the particular
14 mandate is and what the institution is going to
15 look like after the mandate has been completed.
16 If the issue is a closure, then probably, yes,
17 we want you to use all of your liquid assets and
18 anything else you've got. If after you have met
19 the Commission mandate you're going to continue
20 as an operating entity, then you're going to
21 need some working capital and some ability to
22 make payroll the following week. So I think
23 that it's going to be a question of, really,
24 questions. And I think that there will be a
25 dialogue as that process goes on in trying to

1 understand what you've proposed, and understand
2 why you've proposed it, and the more detail you
3 can put into your application the better.

4 MR. CASEY: Dennis Casey from A. L.
5 Lee Memorial Hospital in Fulton. If you're
6 currently in discussion with the Department and
7 you have not fully completed your plans at this
8 point, is there the possibility of an extension
9 for an application under this round of the HEAL
10 grant applications?

11 MR. REED: I think you have two
12 options. One, we do recognize that some plans,
13 especially in complicated merger consolidation
14 issues, may not be completed by the July date.
15 There is a possibility, and a suggestion in the
16 RFA, that you provide a high level summary of
17 your plans and intent, identified by sources and
18 uses, and basically use that as a place-holder.
19 There's also the possibility that is reserved to
20 the State that, if deemed appropriate by the
21 Commissioner, in exceptional circumstances that
22 there would be an extension granted. I don't
23 think we're looking on using that terribly
24 frequently at this point, however.

25 MR. CASEY: Thank you.

1 MR. HOFFMAN: Jay Hoffman from
2 Ellis Hospital. I have a question with regard
3 to the funding of self-insurance trusts. If we
4 are taking over a service that is not provided
5 within our current operations, requiring an
6 additional funding of a self-insurance trust to
7 keep it actuarially solvent, is that an example
8 of a cost that would be submittable under this
9 grant application? And I have a follow-up
10 question after that.

11 MS. LEFEBVRE: Say it again.

12 MR. HOFFMAN: If we have a service
13 that is not currently provided within our
14 facility and our actuaries require additional
15 funding in order to provide adequate coverage
16 for that particular service, and that service is
17 required to be provided under the mandate, would
18 that actuarial funding be eligible for payment
19 under the grant?

20 MS. LEFEBVRE: I think so.

21 MR. ABEL: I think it is
22 reasonable, but I'll tell you, you better make
23 sure you explain that real well in your
24 application and identify that specific --

25 MR. HOFFMAN: I'll bring my

1 actuary.

2 MS. LEFEBVRE: Also, it goes back
3 to -- you will have to demonstrate how, going
4 into the future, this new organization with its
5 new services and malpractice is going to be able
6 to demonstrate feasibility also, so that's part
7 of the discussion also.

8 MR. HOFFMAN: Absolutely, a
9 mandate. And a follow-up question. With
10 organizations coming together there would be
11 naturally the retirement of malpractice coverage
12 from the predecessor organization with the
13 purchase of tail coverage also be an example of
14 an item that would be covered under the mandate?

15 MS. LEFEBVRE: Yeah, I would think
16 so.

17 MR. MERTENS: John Mertens from St.
18 Vincent's Midtown Hospital. If I submit my
19 application next week and it's perfect, when is
20 the earliest that I can expect to see any money?
21 Please be specific.

22 MR. ABEL: Well, I'll start this.
23 We will be reviewing the applications as they
24 come in. We will not be waiting for the
25 deadline and all of those applications to come

1 in before we begin reviewing them. So once the
2 application comes in, it will be deemed for
3 completeness and then sent to the reviewers for
4 review. One point just to keep in mind here,
5 this is going to happen on an ongoing basis.
6 Dollars are going to be committed, so the
7 earlier you get your applications in, the better
8 you have an opportunity to take advantage of
9 these funds. With respect to the timing then,
10 once we are in agreement that the plan is
11 achieving the Berger mandate and we've come to
12 an agreement on the way to fund those costs then
13 the timing is your --

14 MR. REED: I don't think there is a
15 black and white answer, frankly, because,
16 following up on what Charlie said, there will be
17 a period that the State will need to get an
18 understanding of the project.

19 MR. MERTENS: Could I make it
20 easier for you? Is there any chance that the
21 money is going to be disbursed before July 16?

22 MR. REED: I think that there is
23 about as much chance as the moon falling on us
24 right now.

25 MR. MERTENS: So you're going to

1 wait and assess them all together?

2 MR. REED: No, no. I'm thinking
3 about that in real pragmatic and in real world
4 terms, in terms the process that has to be gone
5 through; that is, a contract has to be
6 negotiated and signed. It will be subject to
7 review by the Attorney General of the State of
8 New York. These are going to be new, unique.
9 That may require some time there. The
10 Comptroller of the State of New York statutorily
11 has 90 days to review a contract before it acts.
12 I mean just those types of things that are
13 background processes of the State would make a
14 July 16 cash flow, assuming there were
15 disbursements on your part by that time,
16 probably out of reach. Real world answer.

17 MR. MERTENS: Yeah, I'm sorry. You
18 threw in a curve ball there with the 90 days
19 review by the State. Are you going to say
20 that's going to happen, so we're talking about
21 four or five months from now?

22 MR. REED: That may be the
23 realistic way. I'm just saying that under the
24 law the Comptroller has 90 days at his
25 discretion when they receive a contract.

1 MR. MERTENS: At a meeting with
2 Mr. Clyne, we were told that, you know, the
3 process is in place because four institutions
4 have already been down this pathway, and we're
5 led to believe that, you know, timing shouldn't
6 be an issue because everybody knows what they're
7 doing.

8 MR. CLYNE: Right, but we don't
9 control the State Comptroller's office. The
10 State Comptroller doesn't work for the health
11 department. We've talked to the Comptroller's
12 office. We're not anticipating long delays or
13 unnecessary delays, but in the abstract of not
14 knowing what the plan is, not knowing how
15 complicated the contract is, it's impossible for
16 us to say.

17 MR. MERTENS: Use one of the four
18 that have been approved. Have they seen any
19 money yet?

20 MR. CLYNE: One of the four --

21 MR. MERTENS: You said there were
22 four institutions that have been processed
23 already.

24 MR. CLYNE: No, we said we've gone
25 through four separate HEAL. This is HEAL number

1 four, as in the process of going through in how
2 we go through and analyze.

3 MR. MERTENS: We know the answer to
4 that. You haven't paid out any money on that,
5 but that wasn't what you were indicating. You
6 were indicating that -- I think it was the other
7 gentleman -- Manhattan I&E, for instance, had
8 been approved, so --

9 MR. SCHMIDT: That's Phase 2.

10 MS. LEFEBVRE: That was a Phase 2
11 project, John. It has been awarded. They just
12 got their CON application. Right, Neil?

13 MR. ABEL: Yes.

14 MR. DELKER: It's been awarded, but
15 to Bob's point, that contract is not yet
16 executed. Okay, it still needs approval by the
17 Comptroller's office. Pardon me?

18 MR. MERTENS: We're looking into
19 our own financing to keep this process moving
20 while you get around to it.

21 MR. DELKER: Well --

22 MS. LEFEBVRE: Well, John, I don't
23 think that is relative. I think that's a little
24 bit harsh. I think what we're saying -- I think
25 what Bob is trying to say is that there is some

1 expectation that it will take time for the
2 government to move through the regulatory
3 process, and he's saying it's a four- to
4 five-month process.

5 MR. VOLK: And the thing that would
6 make the most sense for you is to go out and
7 secure independent financing, spend the money
8 and collect it back from the State after the
9 fact.

10 MR. CLYNE: And there's also a big
11 difference between us being able to get back to
12 you and say yes we think your plan makes sense
13 and this is what we're going to go forward with
14 in the actual processing of all the papers. So
15 you're going to hear back well before five or
16 six months, but the actual dollar's flowing, and
17 us coming back saying we approve your plan with
18 this amount, you know, doesn't mean something in
19 the financial community.

20 MR. MERTENS: Thank you.

21 MR. ICKOWSKI: Mike Ickowski from
22 Mount St. Mary's Hospital in Niagara Falls.
23 Regarding the funding for long-term debt, you
24 look at certain financial ratios that you're
25 going to have thresholds or cut-offs that say

1 that you're not eligible for funds for long-term
2 debts if you exceed certain amounts?

3 MS. LEFEBVRE: Can you describe a
4 little bit more what you mean by funding for
5 long-term debt?

6 MR. ICKOWSKI: Reduction of what is
7 current long-term debt, would you be looking a
8 debt service coverage ratios, and say you're at
9 a certain level now, and it doesn't appear that
10 you would need that funding?

11 MS. LEFEBVRE: No, I don't think
12 so.

13 MR. BENJAMIN: We're not in a
14 position to answer that right now, because it
15 all depends upon all of the elements of the
16 compliance plan. I mean we would need to see,
17 you know, all of the parts of it. If you're
18 asking would a reduction in long-term debt to
19 make a mandatory recommendation be financially
20 feasible, yes, we would consider that. We would
21 also consider, you know, assisting with debt
22 service if that was the most efficient mechanism
23 to get there. So the issue of debt, yes, is
24 something that we would consider, but it's
25 really premature to speculate as to how. There

1 are several different ways. And, again, the
2 last thing we want is for, you know, to mandate
3 compliance and have the -- comes out the other
4 end not financially feasible and back knocking
5 on Lord's door next week.

6 MR. ICKOWSKI: Relating to that,
7 Neil, you have a definition of financial
8 feasibility. Is there a certain operating
9 margin, percentage, or some definition you have
10 that says going forward that's a good amount,
11 that's a right percent?

12 MR. BENJAMIN: Again, it's
13 difficult to say, because it all depends upon
14 the nature of all of the other pieces of the
15 proposal. I mean what Charlie said earlier, if
16 it was just a narrow, one project, if it was --
17 you know, I think there is one recommendation in
18 there that actually had beds, you know, the
19 feasibility of that particular project would be
20 the benchmark. But in cases where there are
21 unified governance, or whatever, it all depends
22 on how well the parts are presented to us and
23 how we assess them. I know that's maybe not the
24 answer you would want, but, you know, the
25 general assessment of financial feasibility

1 again isn't something I think that can be
2 generalized right now.

3 MR. CONWAY: Dennis Conway, Long
4 Beach Medical Center. I have two questions.
5 I'll give the first. The first question, on
6 this debt issue, because I think clearly --

7 MR. DELKER: Dennis, one question
8 and then a related follow-up, okay?

9 MR. CONWAY: Okay. Let's take --
10 I'm trying to clarify this whole issue about
11 debt, because clearly I think with the mandates
12 for many institutions, as we talk about making
13 changes, restructuring, closures, so forth, most
14 of these institutions carry a substantial amount
15 of debt which prevents them of having the
16 wherewithal to secure funding for themselves, so
17 I think I'm hearing -- I'm not sure, but I think
18 I'm hearing that there would be consideration
19 about using the HEAL or the F-SHRP moneys for
20 the purpose of helping to relieve the
21 institution of either long-term or current debt.
22 Is that correct?

23 MR. ABEL: Yes.

24 MR. CONWAY: Okay.

25 MS. LEFEBVRE: Within the context

1 of implementing the Berger recommendations, I
2 mean there are a lot of different
3 recommendations out there, and the nature of
4 them are all pretty different. I mean closures
5 are different than downsizing, you know
6 yourself, from a two-hundred bed facility to a
7 hundred-bed facility.

8 MR. CONWAY: My follow-up is that
9 if the organization that was identified in the
10 Berger Commission has a direct affiliated
11 relationship with another organization and a
12 change within that second organization in terms
13 of relieving debt could take place through some
14 contractual arrangement between the two
15 organizations, could that possibly be something
16 to consider?

17 MR. ABEL: You're saying that the
18 related entity would contribute to retiring debt
19 in the subject facility?

20 MR. CONWAY: And it could be
21 demonstrated that by doing so it has a direct
22 bearing on meeting the mandate for the
23 institution that was named in the Berger
24 Commission.

25 MR. ABEL: I think that is what we

1 expect, that if there is a related facility out
2 there to the -- related to the Berger specified
3 facility and they can contribute to retiring
4 debt, or in any other way contribute to
5 achieving the Berger mandates for the specified
6 facility, we are expecting that there is a
7 contribution there, yes.

8 MS. PADEN: Was that your question,
9 or was your question could you use HEAL money to
10 reduce the debt --

11 MR. CONWAY: I think that's what
12 we're here to talk about, using HEAL money or
13 F-SHRP money for the purpose of either relieving
14 debt or providing for some change within the
15 related organization so as to help meet the
16 mandate of the organization named in the Berger
17 Commission.

18 MS. PADEN: I think that is
19 different. I think we're talking about them
20 contributing.

21 MR. CONWAY: Even if it could be
22 demonstrated that the organization named in the
23 Berger Commission is dependent on the other
24 facility, that it has a direct -- two
25 organizations that are closely related.

1 MS. LEFEBVRE: Yup.

2 MR. ABEL: Well, okay, I understand
3 your question, and I'll try to paraphrase it,
4 but you're asking if HEAL or F-SHRP dollars
5 could be used to retire the debt of a related
6 facility, a facility that is related?

7 MR. CONWAY: Also with common
8 governance.

9 MR. ABEL: I guess we would have to
10 take a look at it and see why that would work
11 out, why that would be in the public's best
12 interest in achieving the Berger mandate.

13 MR. SEMINARO: Joseph Seminaro from
14 Cold Spring Hills. Good afternoon. My question
15 relates to disbursements of HEAL 2 grant funds
16 and conversations related to the GBA application
17 process. We became aware that there was a
18 distinction between for-profit and
19 not-for-profit entities in terms of disbursement
20 of the funds. I was wondering if the same
21 distinction would hold for the F-SHRP funds.

22 MR. BENJAMIN: I don't know if we
23 understand the question.

24 MR. REED: There is no distinction
25 between disbursement from a profit-making or a

1 non-profit-making.

2 MR. SEMINARO: Apparently, that's
3 what I was led to believe in conversations.
4 What was told to me was, for example, for a
5 not-for-profit you could just draw down from --
6 to be placed into --

7 MR. DELKER: Joe, I think what
8 you're referring to is the 25 percent advance
9 for not-for-profits?

10 MR. SEMINARO: Yes.

11 MR. DELKER: Yes, I think that's
12 what you mean. So your question is would
13 for-profits be eligible for the 25 percent
14 advance under F-SHFP? No, they would not.

15 MR. REED: At this point in this
16 phase of the procurement and in this request for
17 application we're not considering advances.

18 MR. SEMINARO: Thanks.

19 MR. BRONSTEIN: Hi. Jeff
20 Bronstein, New York Presbyterian. I can think
21 of at least one instance where the Berger
22 Commission recommendation wouldn't yield a CON,
23 Certificate of Need, from the impacted
24 institution, but might require, say, a transfer
25 and another applicant Certificate of Need, so it

1 wouldn't be a CON coming from the impacted
2 institution or a closure plan. So, number one,
3 I just want to make sure that there is a
4 requirement for -- and I haven't heard this.
5 I'm just asking for clarification, that if
6 you're applying for HEAL 4 that it would be a
7 commensurate CON required. And the second part
8 of that is that there might still be expenses
9 related to the institution that's being
10 impacted, meaning the Berger-listed institution,
11 to either for consultant costs, or some
12 operational, or cosmetic improvements that the
13 applicant taking over the facility might require
14 as part of the transaction. And so the
15 question, the second part, follow-up, would
16 those kinds of expenses be accepted as part of
17 the HEAL 4 part -- requests.

18 MR. BENJAMIN: Jeff, on your first
19 question about CON, you know, the Berger statute
20 did -- do I have this right, Tom? -- did not not
21 withstand CON. Is that right? Okay, so to the
22 extent CON is otherwise required, it has to be
23 submitted. I mean everybody in this room knows
24 that, for example, straight closure plans are
25 not the subject of the CON, but closures that

1 are converted to another level of care, you
2 know, the transition to the other level of care
3 may in itself may require an application. So
4 those rules and those regulations still apply,
5 and you just need to use your judgment on that.

6 On the second piece, I think I would go
7 back to what I tried to say earlier. You know,
8 expenses, reasonable expenses associated with
9 implementing Berger will be considered eligible
10 costs to the extent that they are incurred by
11 the Berger recommendee. So, there may need to
12 be some, you know, again sub, below the surface,
13 transactions or whatever between other parties
14 to get to that point, but the ultimate -- but
15 that doesn't change the nature of the costs that
16 we would be willing to consider.

17 MR. BRONSTEIN: Thank you.

18 MR. DELKER: There is one down
19 there.

20 MS. SULIK: Good afternoon, Liz
21 Sulik from Peninsula Hospital in Queens. The
22 Berger Commission in its recommendation used
23 three little words, "contingent upon financing,"
24 and directed a merger, an investigation of a
25 merger. So, in essence, there are two separate

1 and distinct costs that will be incurred --
2 obviously, the preliminary costs of
3 investigating the feasibility and the study for
4 the cost itself, and then, secondly, the cost of
5 a new facility. I know that Mr. Benjamin said
6 that he wanted to get kind of an idea of the
7 overall cost of what the recommendations of the
8 Berger Commission would be, but may we separate
9 the two costs in an application for this grant
10 money? In other words, just apply at this point
11 for the moneys, for the planning and the study
12 of it, and then at a certain point any other
13 attending cost for other moneys that may be
14 coming down the pike?

15 MR. BENJAMIN: Well, you certainly
16 can do that, but again, what I tried to say
17 earlier, you know, it's right in the RFP that
18 this is a -- you know, it doesn't say these
19 words, but these are my words. This is a golden
20 opportunity. In our view, this is the most
21 dollars that will be made available for Berger
22 implementation. It is certainly very
23 advantageous to -- because we're directing only
24 at Berger recommendees. There are several
25 pieces of this that incentivize coming in for

1 costs attended to compliance and implementation
2 of Berger. So in that scenario you certainly
3 would run the risk. You would run several
4 risks, you know, potentially in the future
5 potentially a small pool of money running into
6 potentially a purely competitive situation. And
7 so there are a lot of advantages to coming in
8 now for whatever you think you may need to fully
9 comply with Berger.

10 MR. BRONSTEIN: Thank you.

11 MS. KING: Barbara King, Continuum
12 Health Partners. I'm still confused about what
13 a Berger mandate hospital is. In the Berger
14 Commissioner Report it was stated that hospital
15 X has to assume X amount of beds from the
16 hospital down the block that's closing. Can the
17 hospital that's assuming the extra beds apply
18 for this, or is it the hospital that is closing?

19 MR. BENJAMIN: Yeah. I mean,
20 right, to the extent that the receiving facility
21 is named, named in the actual recommendation,
22 yes. If that institution is named in the actual
23 recommendation, yes.

24 MR. OSBORNE: Hi, Mike Osborne,
25 Catholic Health Services. If a facility

1 received money under HEAL 2 and now plans to
2 implement Berger under HEAL 4, during this
3 negotiation process you talk about is there an
4 ability to readdress what you previously
5 committed to under that negotiation? Because
6 they may contradict each other.

7 MR. BENJAMIN: I don't want to ever
8 be accused of being speechless. I mean, could
9 you just give a generic example?

10 MR. OSBORNE: Generically, a
11 facility agreed to, I don't know, convert
12 portions of its hospital. It may now need
13 portions of that hospital as it relates to the
14 conversion with closure of another facility. It
15 may need to expand, decrease services, whatever
16 it may be, but it may not agree with what they
17 previously agreed to. I guess the question
18 would be they may need to tweak that original
19 plan, whether it would be certificate services
20 or whatever, to now comply with Berger.

21 MR. BENJAMIN: My understanding is
22 that there is only a limited amount of
23 adjustment that can be made in prior HEAL award
24 through adjustments to the work plan. Okay, and
25 that is viewed in isolation from Berger. It has

1 to be viewed in isolation from Berger, because
2 that was a separate procurement under separate
3 rules under the State Finance Law. You know, as
4 I'm told by Bob and others, you know, the word
5 "materiality" comes in. So there is a window of
6 opportunity to modify that previous HEAL award
7 but the changes cannot be material. So I don't
8 think that there is -- we don't really have the
9 ability to connect the two, but we will be able
10 to consider modifications to the previous HEAL
11 awards to the extent it fits that definition.

12 MR. OSBORNE: The facility agreed
13 to HEAL 2, but then probably they had to walk
14 away from that now in order to comply with
15 Berger, is that possible?

16 MR. REED: That means that your
17 proposal is basically null and void because
18 you're no longer able to carry out that work
19 plan. What is implied then is the quid pro quo
20 is no longer in place. We would cancel the
21 contract and go forward.

22 MR. OSBORNE: And that's a decision
23 a facility could make?

24 MR. REED: I would think that it's
25 something certainly that could be considered,

1 yes.

2 MR. OSBORNE: Thank you.

3 MR. SCHMIDT: Any other questions?

4 MR. DELKER: Excuse me. Is there
5 anyone who has not yet asked a question who
6 wants to?

7 MR. LANG: I'm Terry Lang from A.
8 L. Lee Memorial Hospital, and this is probably
9 for the attorneys up front, so I'll go ahead and
10 ask. Could you explain how Article 8, 9 and 10
11 of the New York State Labor law is referenced in
12 this whole process and also this Article 15A,
13 the women and minorities business owners, is
14 going to affect the applicant in this process?

15 MR. VEINO: The short answer is
16 that you'll need to discuss the details of that
17 with your own attorneys. The reason being is
18 that, you know, these are provisions that are in
19 the statute, so they must be taken into account,
20 but we at this table are not labor lawyers.
21 We're not experts in the area of the Labor Law
22 provisions or the provisions regarding the
23 Article 15A, so this is something that, yes, you
24 are under law and by the contract must be in
25 compliance, have to certify being in compliance

1 with the provisions of those laws, but in terms
2 of detailing what that compliance will entail,
3 that is something that you will need to discuss
4 with qualified attorneys in those areas.

5 MR. DELKER: And I'm not a labor
6 lawyer either, but we had a little experience
7 with this with Phase 2. As a practical matter,
8 Article A requires paying the prevailing wages,
9 and DOL, as you probably know, has a schedule of
10 prevailing wages for, I think, every diligent
11 handler in the State. It runs 2,000 pages
12 literally. What we do when a contract becomes
13 ready to be executed, to go forward for approval
14 from OSC, we notify DOL, as the contracting
15 agency, of the names of the contractors by
16 county. It enters their database, and then
17 their inspectors, when they go out, know who is
18 under this contract which is governed by the
19 prevailing wage scales in that area. I've had a
20 couple of inspectors calling already, and so
21 then they check on, you know, what you're paying
22 and so on. That's that part of it. Other
23 parts, Article 15 and Article 9, I'm not that
24 familiar with, but we are in touch with DOL on
25 this on how to set it up from our part. And,

1 again, as Bob said, your own attorney should
2 explore that as it pertains to a particular
3 project.

4 MR. GORMLEY: Bill Gormley. Will
5 the retirement of commercial debt be considered?

6 MR. BENJAMIN: Yes.

7 MR. DELKER: Again, is there anyone
8 who has not yet asked a first question?

9 MS. SUSKO: Jenny Susko from Ellis
10 Hospital, Schenectady. In the monitoring plan
11 section of the application, please give examples
12 of the types of methodology or feedback
13 mechanisms that you would deem appropriate, or
14 what's expected.

15 MR. DELKER: Well, I think we look
16 at things that are going to -- as the project
17 goes on, find trouble spots, unforeseen
18 obstacles. For example, many organizations will
19 have weekly meetings of the project team --
20 perhaps the contract manager, the director of
21 medical services, and so on -- to monitor
22 weekly, biweekly, whatever, and to have a
23 response mechanism, so to speak, about how to
24 address problems and obstacles when they're not
25 going well, or it may be just to verify that

1 things are on schedule. It's those sorts of
2 manage-oriented things that we're looking for.

3 MR. SCARPINO: Dave Scarpino,
4 Kingston Hospital. I understand the IT costs
5 are not considered to be eligible costs for the
6 Berger piece of this. However, hospitals are
7 required to align -- efficiencies in reducing
8 the staff. Can you put that in as a cost or
9 offset in reductions in staff?

10 MR. DELKER: I don't think we would
11 say categorically they're not eligible. There
12 should not be an RFA for IT. There should not
13 be an application for IT. Again, it's your
14 mandate. What does your mandate say how do
15 these costs relate to implementation of your
16 mandate? You would have to demonstrate this it
17 is critical to it.

18 MR. SCARPINO: Exactly, so we said
19 X number of percentage of staff --

20 MR. DELKER: Does the Commission
21 mandate that you release staff --

22 MR. SCARPINO: Well, that's a
23 little --

24 MR. DELKER: The Commission
25 mandates are a little more specific than that.

1 Are you reducing beds for cost efficiency?

2 MR. SCARPINO: Yes.

3 MR. DELKER: Well, I think we would
4 look more to the pertinence of beds and those
5 associated reductions. These are principally
6 capital projects.

7 Is there anyone who has not yet asked a
8 first question? All right, is there anyone
9 besides Charles Murphy and Bill Gormley who want
10 to ask a question? I used to work with Charlie.
11 I know what he's like.

12 MR. CASEY: Dennis Casey again from
13 A. L. Lee Memorial in Fulton. Under Schedule 3,
14 you have listed costs such as just severance and
15 pension funds. I've not heard any mention at
16 any time, or in the write-up of the RFA, about
17 unemployment costs. And since hospitals
18 self-fund their unemployment costs and if staff
19 leave, will unemployment costs be eligible for
20 funding under the RFA?

21 MR. ABEL: Yeah. We've actually
22 had discussions with the State Labor Department,
23 and they have issues on their own with respect
24 to the potential for unemployment payments as a
25 result of what's happening with restructuring

1 the health care system. I don't believe the
2 intention for these funds would be to cover
3 unemployment costs in any -- well, I'll say in
4 the narrow or the broad sense.

5 MR. SCARPINO: Just as a follow-up
6 to that, unemployment costs can be significant,
7 both in terms of the scope and the scale of
8 them, for large numbers of people that would be
9 unemployed as a result of a closure and could
10 significantly impact the remaining assets that
11 you have moving forward.

12 MR. ABEL: I think that there are a
13 number -- well, it's not just the Labor
14 Department, but a number of state agencies that
15 are looking to fund initiatives to deal with,
16 you know, any negative fallout as a result of
17 restructuring. And, frankly, the Health
18 Department has a couple of initiatives separate
19 and apart from this HEAL opportunity, HEAL
20 F-SHRP opportunity, to deal with some of those
21 costs. So unless someone has been involved in
22 some discussions where unemployment costs in the
23 broadest sense would be funded, I would have to
24 think that this is not an opportunity for that.

25 MR. MURPHY: I only have -- Chris,

1 I cut it way down. I only have two more. Neil,
2 I think this is for you in regard to the
3 technical components of the application, A
4 through F. The application says that the
5 technical components will be deemed and reviewed
6 as a plan for compliance, and you spoke earlier
7 about this becoming the compliance plan. My
8 question is does this constitute the only
9 acceptable compliance plan available for the 81
10 facilities? In other words, must all 81 named
11 facilities complete sections A through F to be
12 compliant with the mandate even if financial
13 assistance is not being sought? And that would
14 include facilities that are challenging or
15 otherwise not thrilled with the mandate.

16 MR. BENJAMIN: Well, any Berger
17 recommendee that is seeking funding here has to
18 fill this out, and we will use that as the
19 complete -- as the submission of a complete
20 compliance plan. I mean that -- you know, that
21 in terms of that. In terms of other providers,
22 providers who are Berger recommendees who, you
23 know, may choose otherwise, I mean that's up to
24 them. As I said earlier, I tried to emphasize
25 that this is probably a once-in-a-lifetime,

1 golden opportunity for this level of financial
2 assistance, because in our view the Commissioner
3 shall, which means in our -- must implement the
4 recommendations. And, you know, so we view that
5 as the recommendation would be implemented with
6 our money or without our money. This is the
7 opportunity to do it with our money.

8 MR. SCARPINO: I guess a follow-up.
9 Are you linking Section A through F with the
10 January 31 OHSM letter? To be compliant with
11 the OHSM letter, is this the device you have
12 created to create a compliance plan that
13 contains all of the information you're looking
14 for? Do you have to do the compliance component
15 of this application, irrespective of whether
16 you're asking for money, to be in compliance or
17 to show compliance with the Berger mandate?

18 MR. BENJAMIN: No, no, no. Yes,
19 the answer is no.

20 MS. MASSET: My name is Margaret
21 Masset. I'm here representing Westfield
22 Memorial Hospital. I'll start by saying what I
23 do understand so we don't spend time talking
24 about that. I understand that there is federal
25 money and State money in the October 1 deadline

1 use of funds to cover expenditures that are
2 actually paid out before October 1. Is just an
3 issue as to which part of the money is used for
4 purposes of funding and approved -- so that I
5 understand, but in terms of -- and not to put
6 too fine a point under it, but I would imagine
7 that the State of New York has a little bit of a
8 fire lit under it to make sure it uses every
9 single last penny of the F-SHRP funds that are
10 available, I would assume. On the timing issue,
11 when it comes to -- a statement was made that
12 the trigger for saying kind of which pot of
13 money might be available is when the facility
14 actually pays out the expenses. The facility
15 pays an expense out, okay, as opposed to whether
16 it's recorded on the books or -- and I also
17 understand that you said that there is going to
18 be -- you will move as quickly, obviously, on
19 these applications as you can, but as far as
20 when, the question of when will cash actually be
21 forthcoming from this program, have to go
22 through the procedural elements, and comments
23 were made that, you know, four and five months
24 might not be out of the question. I'm getting
25 the impression, when you're looking at the

1 facilities paying dollars out the door before
2 October 1 to help you meet your goal by using as
3 much, if not all, the federal funds as you can,
4 we're going to have timing issues. Now here's
5 the question. Sorry about the big lead-up. Is
6 it anticipated that the facilities will go ahead
7 and self-fund a variety of the expenses that are
8 explained in the grant applications and actually
9 undertake those expenses prior to October 1, and
10 that the State will then get credit, even if the
11 funds aren't forthcoming until after October 1?
12 Or is it everything has to be done? The State
13 has to have approve it, the contract has to be
14 done, and the federal funds come over to pay the
15 expenses before --

16 MR. REED: I think your first --
17 our intent that as long -- if a facility makes
18 the disbursement, we will document that. We
19 will put a contract in place. Whenever the
20 contract is put in place, we have a two-year
21 window after the end of the fiscal year to
22 complete the financial transactions. The
23 contract vehicle would reflect that period, the
24 prior period back to January 1, to whatever the
25 end date of the particular project happened to

1 be.

2 You know, and just further, just to
3 supplement the earlier question, you know, we're
4 not contemplating advancing funds in this
5 process. So that means the facility has to have
6 made a disbursement before they can voucher
7 claimed funds from us.

8 MR. BRONSTEIN: Hi. Jeff
9 Bronstein, New York Presbyterian. Actually, as
10 I see people leaving, I realize the longer I
11 wait for my question, I just might end up with a
12 one-on-one with the A team.

13 I have a very specific question. One of
14 the facilities in the Berger Commission Report
15 was mandated to spin off their ambulatory care
16 clinics to a taker, and one of the exercises
17 that they are going through right now is for one
18 clinic -- which is operating in an area that is
19 not currently considered a medically
20 under-served area designated by the federal
21 government -- they're going to undertake that
22 analysis, and there is an appeal that it might
23 end up being an MUA which then, of course,
24 allows it to consider a transfer to FQHC. So
25 discussions with a potential provider can't

1 really begin until that analysis has been done.
2 And, obviously, going through that analysis and
3 then going through the federal government's
4 procedure to get it designated a FQHC will take
5 at least several months, and it certainly will
6 happen probably during or after the summer
7 period. So I guess the question that I have
8 specific to that example is if there are
9 expenses -- number 1, if there are expenses tied
10 to this analysis, I would guess that that would
11 be something that would qualify under the HEAL
12 4, but understanding that it wouldn't be a
13 commensurate application or a final plan that
14 would be submitted during that time period
15 because the end product of that analysis of
16 whether it would be designated as an MQAC or not
17 will dictate who that provider should go to, to,
18 actually, for the transfer of ownership. Does
19 the question make sense?

20 MR. BENJAMIN: Jeff, could we have
21 that discussion offline? Because I really don't
22 understand much of anything you just asked.
23 Seriously, I understand the issues that you have
24 in there, but we really -- no disrespect
25 intended, we really weren't intending to use

1 this forum as a discussion about specific
2 recommendations. I would love to have that
3 discussion with you offline, and we'll give you
4 as much guidance as we possibly can.

5 MR. BRONSTEIN: Thank you.

6 MR. VOLK: Can I just make one
7 observation sort of related to that? And that
8 is that the RFA includes a procedure for
9 essentially requesting a postponement, and
10 you're supposed to provide as much information
11 as you can now and an overview of what the whole
12 thing is going to be. And to the extent that
13 the whole thing is going to take place beyond
14 the term of this, I think that you can put all
15 of that in. You have keyed up your application
16 for this, what is going to be spent in the
17 immediate future, and you've also set the stage
18 for the future, would be my inclination.

19 MR. BRONSTEIN: Thank you.

20 MR. BENJAMIN: Call him.

21 MR. LANG: I'm Terry Lang again
22 from A. L. Lee Memorial Hospital, and I guess I
23 have to ask this question since we found out
24 about unemployment costs. How about in the
25 consulting fee category, how about the attorney

1 fees related to the renegotiation of human
2 contracts? That would ultimately have to happen
3 if your facility has to be reconfigured and
4 downsized. Would that be a reasonable cost?

5 MR. ABEL: We could consider
6 necessary and reasonable costs.

7 MR. WEILER: Chris Weiler from
8 Oppenheimer Funds. If a facility has been
9 placed on a closure list, what are the odds of
10 remaining open under different parent
11 organization? If it fails to make application
12 for the HEAL funds by the deadline, what
13 placement would there be for creditors to be
14 repaid in debt, you know, assuming they failed
15 to meet that deadline requirement?

16 MR. ABEL: The first part was if
17 the Berger mandate is for a facility to close
18 then how would we perceive an action to try to
19 keep it open under a different sponsorship?

20 MR. WEILER: That's correct.

21 MR. ABEL: There's a number of
22 parts of the Berger Commission Report that we,
23 the Department staff, have reviewed to determine
24 the amount of flexibility, if any, in every
25 recommendation for the closures, and there are

1 some specific closures. Unless it's modified
2 within that actual recommendation, the
3 expectation is that the facility would close.
4 That's the law as we interpret it today, and we
5 would not be able to fund any costs associated
6 with anything other than the closure.

7 MR. WEILER: Okay. If they failed
8 to make application for funds for debt or
9 payment by the deadline, how would creditors
10 have access to HEAL?

11 MR. ABEL: Creditors do not have
12 access to the HEAL dollars except through an
13 applicant that receives an award.

14 MR. WEILER: Okay, thank you.

15 MR. LAUZARONE: Rich Lauzarone,
16 Continuum Health Partners. When I look into the
17 opportunity, post-submission, to submit more
18 detailed information and perhaps revised
19 information, for example, we describe in high
20 level detail and use conceptual detail to
21 describe a project, and subsequent to that
22 during the planning phase we now have developed
23 a floor plan which would demonstrate, for
24 example, feasibility and the ability to get it
25 done rapidly and basically buttress the

1 application; that's number one. I presume that
2 you would receive that information
3 post-submission? A short follow-up.

4 MR. ABEL: We're open to receiving
5 information post-submission, but you should
6 really make every effort to submit all necessary
7 information so that we can just see the entire
8 scope, the reasonableness of the costs and the
9 sources of funding right up front, but there
10 will be an opportunity for us to engage the
11 applicant in follow-up.

12 MR. LAUZARONE: Okay, that kind of
13 answers my question. I guess we would take up
14 my next question during that phase.

15 MR. ABEL: Keep in mind, though,
16 that the goal here is to facilitate the Berger
17 recommendations which the timeframe -- the
18 timelines are not very long, and we do hope to
19 move forward with the review of these
20 applications in a very quick manner.

21 MR. BENJAMIN: Again, also to
22 emphasize, you know, the rolling application
23 process, so to the extent that your application
24 is thorough and complete, that gives you a
25 better chance to review and possibly funded in

1 an early stable, rather than run the risk that
2 maybe later on, you know, there is a different
3 set of circumstances and dollars that may be
4 available.

5 MR. MURPHY: Bob, this is Charlie
6 Murphy again. Bob, you draw the distinction
7 between the HEAL money and the F-SHRP money and
8 the use restrictions. Is that distinction
9 transparent to the applicant? Do they have to
10 worry about making that determination in their
11 submission, or really is the State going to do
12 that and make an award on the available money?

13 MR. REED: Ultimately, the State
14 will make that decision. To the extent that an
15 applicant can identify, and this was something
16 that was specifically asked for in the earlier
17 Phase 2 HEAL process, identifying capital funds,
18 that's of great assistance to us. So we would
19 tend to use -- we tend to apply the resources
20 that we have available opportunistically to meet
21 the greatest need that we can, to spread the
22 dollars, and maybe some reasons to use the more
23 flexible dollars in one case and more
24 restrictive dollars in another.

25 MR. SCHMIDT: Any other questions?

1 MR. CONWAY: Dennis Conway, Long
2 Beach Medical Center. Given that there seems to
3 be more flexibility to the F-SHRP moneys, is
4 there any potential that in presenting how an
5 organization will meet the mandate, within that
6 proposal would be included, say, a service that
7 regionally is necessary but not a specified
8 mandate, is there some way that F-SHRP moneys
9 can be directed towards the costs regarding that
10 particular service?

11 MR. ABEL: In this solicitation, or
12 whatever you want to call it, this opportunity
13 to access HEAL and F-SHRP dollars is limited to
14 achieving the Berger mandate. So to just put it
15 on the table very clearly, if your proposal that
16 you submit is going above and beyond or outside
17 of the Berger implementation requirements, we're
18 going to -- there's a very, very high
19 probability that's it's going to be rejected.
20 Those portions are going to be rejected. Will
21 there be other opportunities to access F-SHRP
22 dollars for reasonable restructuring? Yeah, I
23 would expect that there probably would be, but
24 we haven't made those decisions.

25 MR. REED: Just to amplify on that,

1 you know, F-SHRP has a number of conditions the
2 State must meet to earn those moneys from the
3 federal government. There are a number of
4 milestones that we have to achieve and report on
5 clearly to the federal government. Some of
6 those milestones are very onerous, so there is
7 really no guarantee as we go into year two that
8 additional funds out of F-SHRP will be
9 available. And the tests, in terms of the
10 milestones that we have to meet, get
11 progressively more difficult as the years go by.

12 MR. BENJAMIN: Dennis, to put it
13 another way, the further you stray the less
14 likely it is that we will pay.

15 MS. MCCARTHY: Sue McCarthy from
16 Erie County Medical Center. Is the issue with
17 spending money really more specific to the
18 F-SHRP dollars than the HEAL dollars? I'm
19 really having a hard time with this big lie in
20 terms of determining who might get what, what
21 plans might be accepted. I'm sure that's an
22 issue for almost everyone that is named in the
23 report. It almost feels like we're being
24 encouraged to spend all kinds of money, and then
25 the risk is, of course, that the State could

1 look at us and say, well, obviously -- and now
2 you don't need any funding, and obviously there
3 is not enough money to do everything in New York
4 State that, the thought is, might need to be
5 done here. So back to the easy question. Is
6 this really more the F-SHRP dollars and not the
7 whole aggregate pool?

8 MR. REED: Our intent is to use
9 expenditures that occur prior to 9/30/07,
10 disbursements by the facility, to the greatest
11 extent we can for using F-SHRP dollars.

12 MS. McCARTHY: Okay, but not the
13 HEAL funding.

14 MR. REED: We're not going to be
15 prohibited from doing that, you know, and
16 depending on what need is expressed by the
17 aggregate facilities, you know, maybe we'll have
18 a problem, maybe we won't.

19 MS. McCARTHY: I'm still not clear.
20 With regard to construction, specifically, I
21 mean these projects, as you've acknowledged, are
22 multi-year in many cases. Don't happen
23 overnight. Could be a function of CON stuck in
24 a pipeline right now. It's hard to see how,
25 practically speaking, how spending could occur

1 before bigger decisions are made.

2 MR. REED: That's correct. It's
3 highly unlikely that significant capital
4 disbursements would occur between the period
5 January 1, '07 and September 30, '07 in
6 compliance with the Berger mandates.

7 MS. MCCARTHY: Okay.

8 MR. RODAT: John Rodat, Albany
9 County. A follow-up to that question. How are
10 you defining capital in this particular context?
11 For example, if we are currently doing extra
12 maintenance, refurbishing physical plants in
13 order to transfer patients from one of our
14 facilities to another, what's the threshold --
15 but we didn't borrow money to do that, what's
16 your threshold to define that?

17 MR. BENJAMIN: John, how the
18 expenditure is paid for doesn't have anything to
19 do with it. It's whether it's the nature of the
20 expenditure. And if it's a capital expenditure
21 during that time period that is directly related
22 to complying with Berger, to complying with
23 implementation of Berger, then it clearly would
24 be considered as an allowable cost in here. I
25 mean I think that's -- you could pay for it with

1 cash. You could pay for it with county debt,
2 whatever. That's transparent to us. It's the
3 expenditure of the dollars and the purpose that
4 the dollars were expended for.

5 MR. REED: In the case that you
6 reference, John, I think you can make the clear
7 distinction between what could be construed as
8 routine maintenance and upkeep versus what is a
9 capital improvement to the facility. If you're
10 going to put a coat of paint down the hall and
11 in the rooms, I don't think it's going to
12 qualify as capital. But if there's significant
13 reconstruction or reconfiguration of the
14 footprint and things like that, then yeah.

15 MR. SCHMIDT: Any other questions?

16 MR. DELKER: As we said, we will
17 put the questions and answers out later in a
18 transcript of the meeting on the web, and we'll
19 clarify and follow-up anything that we need to.
20 Thank you all for coming.

C E R T I F I C A T E

I, Kyle Alexy, a Shorthand Reporter and Notary Public in and for the State of New York, do hereby certify that the foregoing record taken by me is a true and accurate transcript of the same, to the best of my ability and belief.

Kyle Alexy

DATE: May 28, 2007

\$	82/12 82/19 85/19 88/12 89/3 93/23 95/16 97/7 98/24 100/5 103/1 103/24 103/24 103/25 107/10	affiliate [1] 32/8 affiliated [2] 15/9 81/10 affiliating [1] 20/23 affiliation [2] 18/14 30/23 affiliations [2] 18/2 35/9 after [10] 23/10 37/11 66/4 69/15 69/18 71/10 77/8 100/11 100/21 102/6 afternoon [4] 2/1 2/3 83/14 86/20 again [31] 7/23 8/10 8/25 10/9 10/11 19/17 20/19 24/5 24/17 26/6 26/14 27/8 28/7 35/15 37/12 41/7 53/5 53/8 71/11 79/1 79/12 80/1 86/12 87/16 93/1 93/7 94/13 95/12 103/21 106/21 107/6 against [2] 13/7 13/8 agencies [3] 12/20 44/15 96/14 agency [1] 92/15 agenda [3] 2/4 2/7 3/2 aggregate [2] 110/7 110/17 ago [1] 59/17 agree [2] 65/7 89/16 agreed [3] 89/11 89/17 90/12 agreement [2] 73/10 73/12 agreements [1] 35/18 ahead [4] 7/21 26/10 91/9 100/6 Albany [4] 1/5 4/24 58/13 111/8 Alexy [2] 113/3 113/11 align [1] 94/7 all [56] 2/6 2/17 2/18 2/20 2/23 3/17 4/3 6/9 10/3 14/1 14/21 14/25 16/11 17/1 17/5 17/14 18/10 24/7 26/10 29/5 31/3 34/24 37/12 38/25 39/17 40/12 41/15 43/9 45/3 46/24 46/25 51/6 55/10 60/9 60/18 62/9 62/17 69/17 72/25 74/1 77/14 78/15 78/15 78/17 79/13 79/14 79/21 81/4 95/8 97/10 98/13 100/3 103/14 106/6 109/24 112/20 allocated [1] 69/4 allocation [1] 11/1 allow [2] 63/24 63/25 allowable [1] 111/24 allowed [2] 54/21 55/8 allows [2] 6/8 101/24 almost [5] 9/2 62/4 62/9 109/22 109/23 along [5] 12/18 36/12 37/7 38/4 55/21 already [14] 5/15 5/18 7/8 14/10 42/10 46/7 49/22 49/24 50/18 53/11 58/8 75/4 75/23 92/20 also [42] 7/1 8/8 10/4 11/10 12/11 19/5 21/2 25/12 25/16 25/17 32/16 35/19 36/1 37/6 38/9 38/19 40/7 43/5 53/23 54/1 54/18 58/5 58/10 65/17 66/10 66/14 67/16 67/17 67/19 67/23 70/19 72/2 72/6 72/7 72/13 77/10 78/21 83/7 91/12 99/16 103/17 106/21 altered [1] 30/21 alternative [3] 51/19 53/1 59/5 alternatives [2] 54/5 58/7 although [3] 6/10 12/17 64/5 always [1] 33/18 ambulatory [2] 26/2 101/15 among [2] 40/1 52/16 amount [14] 11/13 17/15 21/19 35/13 37/5 43/2 44/5 65/25 77/18 79/10 80/14 88/15 89/22 104/24 amounts [2] 45/9 78/2 amplify [1] 108/25 analysis [6] 13/15 101/22 102/1 102/2 102/10 102/15 analytical [1] 13/18 analyze [1] 76/2 animal [1] 7/14 annual [2] 38/3 38/4 annually [1] 12/16 another [19] 13/4 13/7 19/10 41/22 51/21
\$550 [1] 6/10		
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'07 [2] 111/5 111/5		
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0705141214 [1] 1/1		
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1.5 [1] 11/14		
1.7 [1] 21/4		
10 [2] 42/24 91/10		
10 percent [1] 41/3		
1199 [1] 54/14		
15 [2] 61/9 92/23		
15A [2] 91/12 91/23		
16 [3] 61/10 73/21 74/14		
19th [1] 29/7		
1:00 [1] 1/7		
2		
2,000 [1] 92/11		
2006 [1] 14/11		
2007 [4] 1/6 17/6 17/17 113/13		
2008 [1] 16/18		
21 [1] 38/20		
230 [1] 14/13		
24 [1] 1/6		
25 [1] 84/13		
25 percent [1] 84/8		
28 [8] 15/2 15/11 52/5 52/22 53/17 58/15 58/17 113/13		
2s [1] 62/3		
3		
30 [8] 16/16 16/18 17/17 17/20 61/3 61/8 68/16 111/5		
300 [1] 11/14		
31 [2] 16/17 98/10		
5		
501 [1] 15/8		
550 million [1] 6/21		
6		
6.66 [1] 20/5		
8		
81 [4] 51/22 52/25 97/9 97/10		
9		
9/30/07 [1] 110/9		
90 [4] 42/24 74/11 74/18 74/24		
90 percent [1] 41/3		
A		
Abel [2] 1/16 4/21		
ability [8] 42/6 50/17 56/19 69/21 89/4 90/9 105/24 113/7		
able [17] 5/21 8/23 24/7 24/8 35/25 37/10 40/7 40/16 43/25 44/14 63/5 66/15 72/5 77/11 90/9 90/18 105/5		
about [63] 2/12 2/24 2/25 6/2 6/24 7/11 10/8 10/20 14/6 14/25 15/14 15/20 18/7 19/13 21/13 25/5 30/9 30/13 30/16 31/8 31/15 32/10 33/3 36/6 39/5 42/25 43/10 49/21 51/14 53/10 54/15 54/23 54/24 58/8 58/9 58/11 60/15 62/1 63/20 65/1 65/12 68/15 73/23 74/3 74/20 80/10 80/12 80/19		

A		B
<p>another... [14] 52/23 54/11 55/5 58/10 64/9 64/16 66/17 81/11 84/25 86/1 89/14 107/24 109/13 111/14 answer [15] 3/5 6/25 20/8 44/20 52/2 55/14 59/8 65/1 73/15 74/16 76/3 78/14 79/24 91/15 98/19 answers [4] 3/15 43/15 106/13 112/17 anticipated [1] 100/6 anticipating [1] 75/12 anticipation [1] 17/13 any [39] 16/1 19/14 24/12 27/5 33/1 34/8 34/10 35/17 38/6 38/24 40/22 48/15 55/14 55/25 60/21 62/7 63/5 64/23 65/5 69/1 69/4 72/20 73/20 75/18 76/4 82/4 87/12 91/3 95/15 95/16 96/3 96/16 97/16 104/24 105/5 107/25 108/4 110/2 112/15 anybody [2] 19/14 32/9 anymore [1] 18/1 anyone [5] 44/2 91/5 93/7 95/7 95/8 anything [11] 12/17 17/7 17/21 24/23 32/8 42/20 69/18 102/22 105/6 111/18 112/19 anyway [1] 20/9 apart [1] 96/19 apologize [1] 49/20 Apparently [1] 84/2 appeal [2] 51/24 101/22 appear [1] 78/9 APPEARANCES [1] 1/9 appended [1] 29/10 applicable [1] 3/1 applicant [18] 15/1 15/15 15/24 15/25 46/20 46/23 46/25 52/13 58/15 59/4 60/7 84/25 85/13 91/14 105/13 106/11 107/9 107/15 applicant's [2] 15/23 37/24 applicants [5] 15/1 29/10 52/2 52/4 59/10 application [51] 2/14 7/3 8/6 11/1 16/19 16/20 21/18 24/3 27/22 28/13 28/13 29/4 31/15 32/14 35/16 36/1 36/2 36/12 36/20 37/22 38/21 42/12 48/21 50/11 50/12 52/24 57/19 63/12 70/3 70/9 71/9 71/24 72/19 73/2 76/12 83/16 84/17 86/3 87/9 93/11 94/13 97/3 97/4 98/15 102/13 103/15 104/11 105/8 106/1 106/22 106/23 applications [19] 2/16 15/4 15/6 20/11 22/11 26/19 28/24 31/18 33/17 35/5 38/17 41/1 70/10 72/23 72/25 73/7 99/19 100/8 106/20 applied [1] 43/1 applies [1] 15/13 apply [9] 51/23 54/7 66/14 67/1 68/18 86/4 87/10 88/17 107/19 applying [1] 85/6 appraisal [1] 36/1 appreciate [1] 5/19 approach [5] 14/16 24/13 26/25 27/7 37/20 approached [1] 66/11 appropriate [3] 53/21 70/20 93/13 appropriations [1] 11/9 approval [4] 14/24 15/19 76/16 92/13 approve [2] 77/17 100/13 approved [4] 27/25 75/18 76/8 99/4 approving [1] 27/23 are [162] area [8] 25/24 33/8 33/21 34/24 91/21 92/19 101/18 101/20 areas [2] 2/9 92/4 aren't [2] 53/16 100/11 around [9] 3/7 19/11 22/2 33/22 44/7 45/22 61/4 67/21 76/20 arrangement [1] 81/14</p>	<p>array [1] 59/23 arrangements [3] 18/6 52/9 52/10 article [14] 15/2 15/11 52/5 52/5 52/22 53/17 58/15 58/17 91/10 91/12 91/23 92/8 92/23 92/23 articulated [1] 47/2 as [179] aside [2] 36/23 64/21 ask [17] 2/23 3/3 3/6 3/8 17/4 17/5 24/11 24/21 32/14 43/25 44/8 49/21 56/9 65/12 91/10 95/10 103/23 asked [8] 38/20 50/24 56/10 91/5 93/8 95/7 102/22 107/16 asking [5] 17/2 78/18 83/4 85/5 98/16 asks [1] 25/5 asleep [1] 60/14 aspects [2] 11/3 55/12 Aspinnall [1] 44/9 assess [3] 47/5 74/1 79/23 assessing [3] 10/14 35/5 40/24 assessment [6] 18/19 18/22 24/17 38/8 48/22 79/25 asset [3] 13/23 23/2 36/5 assets [11] 23/6 23/10 23/12 25/6 25/11 32/17 32/21 67/19 67/20 69/17 96/10 assist [4] 9/9 37/7 64/15 67/22 assistance [15] 6/1 7/13 8/15 9/19 11/25 22/1 39/5 39/20 44/21 51/23 59/11 62/18 97/13 98/2 107/18 assisting [2] 65/16 78/21 Associate [1] 1/22 associated [7] 20/25 21/1 22/3 29/4 86/8 95/5 105/5 Associates [1] 51/16 assume [5] 44/11 45/23 46/16 88/15 99/10 assuming [5] 50/8 63/1 74/14 88/17 104/14 assurance [1] 62/15 assure [2] 31/3 31/14 assured [1] 56/2 assuring [1] 56/4 at [58] 4/15 4/17 6/22 12/8 12/20 13/5 13/23 14/10 15/22 16/8 19/24 20/1 20/5 25/4 29/20 34/4 35/15 39/12 40/21 41/1 41/13 41/24 43/1 46/6 47/18 48/13 48/14 48/25 49/15 50/7 51/2 51/13 55/10 57/24 63/21 64/9 65/19 66/10 67/23 69/9 70/7 70/24 74/24 75/1 77/24 78/8 83/10 84/15 84/21 87/10 87/12 87/24 91/20 93/16 95/15 99/25 102/5 110/1 attached [1] 16/12 attempt [1] 60/22 attended [5] 18/11 25/15 43/23 56/6 88/1 attending [1] 87/13 attorney [4] 1/22 74/7 93/1 103/25 attorneys [4] 15/20 91/9 91/17 92/4 attributed [1] 41/14 audible [1] 12/13 audit [4] 12/14 17/8 38/3 38/5 audited [3] 24/4 25/3 25/8 authority [6] 7/24 24/22 35/2 59/18 63/25 64/5 available [33] 7/2 9/21 9/25 11/10 17/15 17/19 22/1 23/7 23/8 23/10 26/5 39/18 40/5 43/11 44/6 45/2 48/7 48/23 51/6 60/18 60/22 62/16 62/17 63/21 69/10 87/21 97/9 99/10 99/13 107/4 107/12 107/20 109/9 avoid [1] 63/16 award [5] 2/14 89/23 90/6 105/13 107/12 awarded [2] 76/11 76/14 awards [3] 26/11 26/13 90/11 aware [2] 13/2 83/17</p>	<p>away [2] 64/6 90/14 back [26] 3/22 14/1 16/24 17/5 17/14 23/15 25/17 27/1 37/10 44/3 47/19 55/17 57/4 58/14 60/10 60/16 69/12 72/2 77/8 77/11 77/15 77/17 79/4 86/7 100/24 110/5 background [3] 8/3 29/5 74/13 backwards [1] 44/18 balance [5] 22/24 24/15 67/18 69/2 69/6 ball [1] 74/18 Barbara [1] 88/11 bargaining [1] 35/17 barriers [1] 26/20 based [6] 30/19 31/12 51/17 58/23 59/4 66/9 basically [8] 31/21 36/20 36/22 36/25 37/25 70/18 90/17 105/25 basis [9] 2/13 7/1 11/19 26/11 26/13 42/5 42/19 48/22 73/5 be [286] Beach [2] 80/4 108/2 bear [4] 3/24 12/12 13/4 28/20 bearing [1] 81/22 beat [1] 68/25 became [2] 38/21 83/17 because [35] 2/18 8/10 9/8 9/10 15/7 29/20 33/22 39/6 41/5 43/23 50/16 50/19 55/5 55/13 55/14 59/17 60/15 60/18 64/10 65/15 65/16 73/15 75/3 75/6 78/14 79/13 80/6 80/11 87/23 89/5 90/1 90/17 98/2 102/15 102/21 become [1] 23/10 becomes [3] 22/9 48/23 92/12 becoming [1] 97/7 bed [4] 47/24 62/25 81/6 81/7 beds [6] 20/24 79/18 88/15 88/17 95/1 95/4 been [23] 5/7 9/11 11/6 16/9 21/12 31/9 31/14 33/18 39/25 40/1 47/2 62/17 66/11 69/15 75/4 75/18 75/22 76/8 76/11 76/14 96/21 102/1 104/8 before [21] 2/4 4/3 17/13 17/16 24/20 25/20 33/9 43/17 62/1 63/19 65/1 69/4 73/1 73/21 74/11 77/15 99/2 100/1 100/15 101/6 111/1 begin [3] 50/21 73/1 102/1 beginning [1] 49/1 begun [1] 5/24 behind [2] 14/16 58/3 being [17] 17/19 22/17 30/20 50/23 54/21 56/25 58/20 63/5 65/18 77/11 85/9 89/8 91/17 91/25 97/13 101/23 109/23 belief [1] 113/7 believe [4] 21/6 75/5 84/3 96/1 below [2] 31/20 86/12 benchmark [1] 79/20 Benedictine [1] 62/22 benefits [1] 30/23 Benjamin [5] 1/11 4/20 7/7 7/11 87/5 Berger [71] 5/9 8/11 8/21 9/7 9/10 9/12 10/11 10/17 13/10 13/12 22/17 41/21 43/6 45/6 51/3 51/8 52/8 52/16 53/22 54/19 55/20 55/25 58/21 59/12 60/3 62/14 63/18 65/22 66/13 66/15 68/6 73/11 81/1 81/10 81/23 82/2 82/5 82/16 82/23 83/12 84/21 85/10 85/19 86/9 86/11 86/22 87/8 87/21 87/24 88/2 88/9 88/13 88/13 89/2 89/20 89/25 90/1 90/15 94/6 97/16 97/22 98/17 101/14 104/17 104/22 106/16 108/14 108/17 111/6 111/22 111/23 Berger-like [1] 66/15 Berger-listed [1] 85/10</p>

B	<p>besides [1] 95/9</p> <p>best [6] 3/12 23/5 41/24 48/10 83/11 113/6</p> <p>better [13] 14/20 18/24 20/1 20/6 24/16 27/22 28/11 48/2 54/6 70/3 71/22 73/7 106/25</p> <p>between [11] 18/2 20/22 67/1 77/11 81/14 83/18 83/25 86/13 107/7 111/4 112/7</p> <p>beyond [3] 5/7 103/13 108/16</p> <p>big [6] 3/18 16/16 17/23 77/10 100/5 109/19</p> <p>bigger [1] 111/1</p> <p>Bill [4] 61/1 61/11 93/4 95/9</p> <p>billion [1] 11/14</p> <p>bit [12] 7/13 19/17 22/8 25/10 25/18 42/22 43/16 65/1 68/15 76/24 78/4 99/7</p> <p>biweekly [1] 93/22</p> <p>black [1] 73/15</p> <p>block [1] 88/16</p> <p>board [1] 39/12</p> <p>Bob [27] 4/6 4/18 4/23 7/11 7/19 10/7 10/19 14/9 14/12 16/3 17/8 17/21 22/9 23/11 23/12 23/20 27/8 29/19 29/20 32/23 44/6 53/7 76/25 90/4 93/1 107/5 107/6</p> <p>Bob's [1] 76/15</p> <p>bond [2] 63/25 64/16</p> <p>bonding [7] 63/20 64/4 64/10 64/10 64/21 64/22 65/4</p> <p>books [2] 68/17 99/16</p> <p>border [1] 31/11</p> <p>borrow [1] 111/15</p> <p>borrowers [1] 33/1</p> <p>Borrowing [1] 40/20</p> <p>both [17] 7/24 9/22 9/25 12/24 14/17 18/22 19/5 19/7 19/9 36/10 36/10 44/16 48/11 61/10 61/16 63/16 96/7</p> <p>bound [1] 53/18</p> <p>breakdown [1] 25/10</p> <p>brief [3] 18/10 30/7 34/2</p> <p>bring [2] 26/13 71/25</p> <p>broad [2] 59/23 96/4</p> <p>broader [1] 55/15</p> <p>broadest [1] 96/23</p> <p>Bronstein [2] 84/20 101/9</p> <p>brought [1] 3/7</p> <p>budget [5] 34/14 34/16 34/17 34/18 34/23</p> <p>budgeted [1] 34/19</p> <p>build [1] 17/14</p> <p>building [2] 53/3 66/7</p> <p>buildings [1] 20/12</p> <p>burden [3] 28/3 53/20 53/22</p> <p>Bureau [1] 1/18</p> <p>business [3] 18/21 43/20 91/13</p> <p>but [91] 3/19 3/23 6/14 7/1 9/18 10/18 17/10 21/5 22/14 23/2 23/4 25/15 28/2 28/2 28/20 29/9 32/11 32/16 33/4 34/1 35/4 39/12 41/7 41/12 42/2 44/4 45/20 47/9 49/15 52/11 52/25 53/17 55/11 55/23 57/18 57/24 58/3 58/5 59/7 59/12 59/21 60/12 61/15 62/9 63/10 64/18 65/2 65/9 65/15 66/11 69/1 69/7 71/22 75/8 75/13 76/5 76/14 77/16 78/24 79/20 79/24 80/17 83/4 84/24 85/25 86/14 86/14 87/8 87/16 87/19 89/16 90/7 90/9 90/13 91/20 92/1 92/6 92/24 96/14 99/5 99/6 99/19 102/12 102/24 106/5 106/9 108/7 108/23 110/12 111/15 112/12</p> <p>buttness [1] 105/25</p> <p>buy [2] 20/6 31/14</p> <p>buy-in [1] 31/14</p>	<p>call [7] 5/7 8/21 25/22 42/18 44/25 103/20 108/12</p> <p>called [2] 16/12 51/19</p> <p>calling [1] 92/20</p> <p>came [1] 20/4</p> <p>can [59] 2/8 3/8 3/17 5/8 6/4 6/25 7/4 12/19 17/4 17/4 17/14 17/16 19/23 19/24 26/21 31/11 33/19 36/3 37/15 43/16 43/21 45/23 46/23 48/2 48/18 49/25 52/4 55/14 58/4 59/6 59/10 59/11 62/12 66/25 68/11 70/3 72/20 78/3 80/1 82/3 84/20 87/16 88/16 89/23 94/8 96/6 99/19 100/3 101/6 103/4 103/6 103/11 103/14 106/7 107/15 107/21 108/9 110/11 112/6</p> <p>can't [6] 9/5 9/5 15/24 23/21 44/25 101/25</p> <p>cancel [1] 90/20</p> <p>cannot [1] 90/7</p> <p>capable [1] 10/14</p> <p>capacity [2] 25/25 66/8</p> <p>capital [18] 11/2 11/5 39/16 40/22 41/2 48/1 48/12 48/16 48/24 64/3 69/21 95/6 107/17 111/3 111/10 111/20 112/9 112/12</p> <p>card [1] 43/20</p> <p>care [24] 2/21 14/18 14/19 18/24 25/24 26/1 26/1 26/2 26/3 26/3 46/8 54/1 54/3 54/25 55/1 58/5 58/7 65/17 66/8 66/9 86/1 86/2 96/1 101/15</p> <p>Carol [1] 1/4</p> <p>carry [4] 5/24 6/18 80/14 90/18</p> <p>carrying [1] 36/5</p> <p>case [10] 22/12 30/25 31/10 35/20 53/23 56/23 59/16 59/17 107/23 112/5</p> <p>cases [4] 43/1 53/25 79/20 110/22</p> <p>Casey [2] 70/4 95/12</p> <p>cash [7] 40/17 67/10 68/17 68/21 74/14 99/20 112/1</p> <p>cashier [1] 20/5</p> <p>categorically [1] 94/11</p> <p>categories [3] 25/11 41/13 41/24</p> <p>category [2] 43/5 103/25</p> <p>Catholic [1] 88/25</p> <p>CD [1] 38/19</p> <p>Center [5] 45/19 68/14 80/4 108/2 109/16</p> <p>centers [1] 13/1</p> <p>century [1] 29/7</p> <p>certain [6] 16/14 77/24 78/2 78/9 79/8 87/12</p> <p>certainly [26] 10/1 18/25 19/2 21/22 23/17 23/17 24/14 25/20 26/4 26/5 26/18 27/12 27/13 43/2 43/4 44/21 44/25 45/3 45/8 62/25 65/10 87/15 87/22 88/2 90/25 102/5</p> <p>certificate [10] 15/22 15/24 39/16 41/1 42/1 58/24 60/11 84/23 84/25 89/19</p> <p>certification [1] 38/9</p> <p>certified [2] 40/9 40/11</p> <p>certify [2] 91/25 113/5</p> <p>challenging [1] 97/14</p> <p>chance [4] 5/25 73/20 73/23 106/25</p> <p>chances [1] 28/10</p> <p>change [5] 30/22 50/25 81/12 82/14 86/15</p> <p>changes [3] 30/19 80/13 90/7</p> <p>changing [1] 20/13</p> <p>characterizing [1] 25/1</p> <p>Charles [3] 1/16 4/21 95/9</p> <p>Charlie [11] 33/7 37/9 38/14 42/21 42/23 51/15 62/1 73/16 79/15 95/10 107/5</p> <p>check [2] 15/21 92/21</p> <p>choose [1] 97/23</p> <p>Chris [19] 4/4 5/4 6/24 7/22 13/4 14/6 19/22 22/8 25/17 30/3 30/6 34/22 38/25 52/3 55/22 60/9 60/10 96/25 104/7</p> <p>Chris' [1] 52/1</p> <p>Christopher [1] 1/18</p>	<p>Cicero [1] 51/16</p> <p>circumstances [5] 2/21 2/24 3/23 70/21 107/3</p> <p>claimed [1] 101/7</p> <p>clarification [2] 24/10 85/5</p> <p>clarifications [1] 4/1</p> <p>clarify [4] 2/11 15/25 80/10 112/19</p> <p>clauses [1] 12/13</p> <p>claw [1] 23/15</p> <p>claw-back [1] 23/15</p> <p>clear [8] 15/20 15/21 17/22 31/2 58/20 64/21 110/19 112/6</p> <p>clearly [8] 49/20 50/8 59/9 80/6 80/11 108/15 109/5 111/23</p> <p>clients [1] 61/24</p> <p>clinic [1] 101/18</p> <p>clinics [1] 101/16</p> <p>close [4] 56/18 61/19 104/17 105/3</p> <p>closed [2] 53/2 58/20</p> <p>closely [1] 82/25</p> <p>closing [5] 22/14 41/11 41/14 88/16 88/18</p> <p>closure [21] 24/20 25/13 25/15 35/15 35/20 37/3 37/23 43/8 45/21 45/23 45/25 46/11 46/13 51/18 69/16 85/2 85/24 89/14 96/9 104/9 105/6</p> <p>closure-related [1] 46/13</p> <p>closures [13] 21/21 22/12 22/13 22/20 24/22 35/8 54/23 58/2 80/13 81/4 85/25 104/25 105/1</p> <p>Clyne [5] 1/10 4/12 5/3 65/13 75/2</p> <p>CMS [1] 11/12</p> <p>co [1] 59/14</p> <p>co-operator [1] 59/14</p> <p>coat [1] 112/10</p> <p>coin [1] 55/11</p> <p>Cold [1] 83/14</p> <p>collaborative [2] 18/5 24/13</p> <p>collateralized [1] 35/12</p> <p>collect [1] 77/8</p> <p>collective [1] 35/17</p> <p>combine [1] 9/21</p> <p>come [13] 2/11 3/21 6/13 14/1 27/1 36/20 54/11 54/11 61/10 72/24 72/25 73/11 100/14</p> <p>comes [7] 40/17 53/12 61/9 73/2 79/3 90/5 99/11</p> <p>comfort [1] 40/15</p> <p>coming [9] 16/24 19/9 72/10 77/17 85/1 87/14 87/25 88/7 112/20</p> <p>commensurate [2] 85/7 102/13</p> <p>comment [1] 42/22</p> <p>comments [4] 8/3 43/12 68/3 99/22</p> <p>commercial [1] 93/5</p> <p>COMMISSION [36] 1/1 5/10 5/11 6/14 7/20 8/7 8/9 8/12 8/15 8/18 16/6 16/11 20/20 20/21 21/2 21/10 41/21 45/15 49/23 54/19 56/18 56/24 58/21 66/13 69/19 81/10 81/24 82/17 82/23 84/22 86/22 87/8 94/20 94/24 101/14 104/22</p> <p>Commission's [11] 2/19 5/25 6/5 6/8 14/11 15/3 15/13 20/18 21/17 25/21 26/16</p> <p>Commissioner [8] 1/10 1/13 5/2 9/14 21/7 70/21 88/14 98/2</p> <p>commissions [1] 5/18</p> <p>commitment [2] 40/21 48/17</p> <p>committed [2] 73/6 89/5</p> <p>common [2] 67/6 83/7</p> <p>commonly [2] 9/24 23/15</p> <p>communities [1] 21/24</p> <p>community [12] 14/18 31/7 31/9 31/12 31/13 31/14 56/22 58/7 58/23 59/4 66/9 77/19</p> <p>community-based [4] 31/12 58/23 59/4</p>
C	<p>calculation [1] 22/25</p>		

<p>C</p> <p>community-based... [1] 66/9 community-health [1] 56/22 competing [2] 13/6 13/7 competitive [3] 7/15 13/6 88/6 complete [13] 37/11 38/18 39/4 46/12 51/24 62/10 62/12 64/7 97/11 97/19 97/19 100/22 106/24 completed [4] 38/14 69/15 70/7 70/14 completeness [1] 73/3 completing [1] 39/5 completion [1] 39/21 compliance [41] 8/17 9/3 9/6 9/10 10/10 10/16 11/4 12/6 13/17 28/15 29/3 30/12 32/1 32/2 41/20 46/9 49/11 49/17 51/7 52/11 52/17 52/19 53/16 55/16 62/14 63/18 78/16 79/3 88/1 91/25 91/25 92/2 97/6 97/7 97/9 97/20 98/12 98/14 98/16 98/17 111/6 compliant [4] 26/15 54/19 97/12 98/10 complicated [4] 18/4 21/21 70/13 75/15 complications [1] 23/3 compliments [1] 7/24 comply [4] 31/22 88/9 89/20 90/14 complying [3] 9/7 111/22 111/22 component [5] 42/16 45/21 48/16 63/23 98/14 components [2] 97/3 97/5 comport [1] 20/17 Comptroller [4] 12/25 74/10 74/24 75/10 Comptroller's [4] 12/15 75/9 75/11 76/17 CON [33] 19/10 20/11 27/4 37/9 39/22 40/3 40/13 41/12 42/23 43/1 49/7 49/9 49/10 49/14 49/23 49/25 50/4 50/11 50/14 50/22 51/4 51/5 62/5 62/9 76/12 84/22 85/1 85/7 85/19 85/21 85/22 85/25 110/23 concentrating [1] 46/10 conceptual [1] 105/20 concerns [2] 22/2 42/12 concise [1] 29/1 condition [1] 33/2 conditions [2] 11/16 109/1 CONFERENCE [1] 1/2 conferences [1] 3/11 confident [1] 3/24 confused [1] 88/12 connect [1] 90/9 consider [13] 3/17 45/8 55/18 56/7 68/4 78/20 78/21 78/24 81/16 86/16 90/10 101/24 104/5 considerable [1] 66/22 consideration [4] 12/11 21/18 44/23 80/18 considered [14] 9/2 30/11 45/10 54/16 54/18 62/9 64/23 64/24 86/9 90/25 93/5 94/5 101/19 111/24 considering [2] 23/18 84/17 consistency [4] 10/16 49/13 49/16 50/10 consistent [1] 50/11 consolidation [1] 70/13 constitute [1] 97/8 construct [1] 63/7 construction [14] 20/10 20/10 36/16 36/21 36/25 40/23 41/2 43/9 45/21 46/2 46/7 57/12 57/15 110/20 construed [1] 112/7 consultant [1] 85/11 consultants [2] 19/6 19/6 consulting [2] 51/16 103/25 contact [2] 7/6 27/19 contain [1] 22/24 contains [1] 98/13 contemplating [1] 101/4</p>	<p>context [4] 26/22 53/12 80/25 111/10 contingent [1] 86/23 continuation [1] 54/9 continue [4] 11/7 45/6 66/7 69/19 continued [1] 48/22 continues [1] 50/14 continuing [1] 36/18 Continuum [3] 56/9 88/11 105/16 contract [21] 11/25 12/1 48/21 52/15 63/9 63/14 64/7 74/5 74/11 74/25 75/15 76/15 90/21 91/24 92/12 92/18 93/20 100/13 100/19 100/20 100/23 contracting [1] 92/14 contractors [1] 92/15 contracts [8] 12/4 12/12 13/22 63/2 63/2 63/3 63/8 104/2 contractually [1] 19/4 contractural [1] 81/14 contradict [1] 89/6 contribute [8] 5/22 37/1 40/7 40/16 47/12 81/18 82/3 82/4 contributing [1] 82/20 contribution [5] 13/14 64/14 64/19 64/20 82/7 contributions [1] 33/1 control [2] 12/20 75/9 convenience [1] 10/2 conversations [2] 83/16 84/3 composition [1] 89/14 convert [1] 89/11 converted [1] 86/1 converting [2] 20/13 22/14 Conway [4] 1/14 4/10 80/3 108/1 Cooke [1] 49/4 cookie [2] 20/6 20/7 coordinating [2] 54/1 54/12 copies [4] 2/7 38/19 38/19 38/21 corporate [2] 33/6 38/11 corporation [1] 58/16 corporations [1] 15/9 correct [8] 33/15 44/17 46/15 59/7 59/21 80/22 104/20 111/2 correctly [1] 48/1 cosmetic [1] 85/12 cost [27] 14/19 16/22 17/4 17/5 19/10 20/24 22/19 27/2 29/17 37/17 39/16 44/23 45/9 48/19 57/17 63/16 66/25 68/4 71/8 87/4 87/4 87/7 87/13 94/8 95/1 104/4 111/24 costs [71] 2/13 6/7 14/7 14/23 16/4 17/13 17/16 18/4 18/11 18/14 19/13 19/19 20/9 20/16 21/4 21/6 22/3 23/18 23/18 23/25 24/10 24/21 25/15 25/20 26/4 26/7 27/18 28/16 41/11 41/14 41/15 42/4 42/5 42/7 44/21 44/24 45/12 46/23 46/24 47/11 48/15 54/16 55/19 56/4 56/6 60/23 62/15 73/12 85/11 86/10 86/15 87/1 87/2 87/9 88/1 94/4 94/5 94/15 95/14 95/17 95/18 95/19 96/3 96/6 96/21 96/22 103/24 104/6 105/5 106/8 108/9 could [36] 2/1 9/2 17/8 31/1 31/10 43/7 50/23 51/21 52/25 59/2 64/13 64/14 65/9 67/21 68/14 73/19 81/13 81/15 81/20 82/9 82/21 83/5 84/5 89/8 90/23 90/25 91/10 96/9 102/20 104/5 109/25 110/23 110/25 111/25 112/1 112/7 couldn't [1] 54/6 Counsel [2] 1/14 1/24 counsel's [3] 4/7 4/9 4/11 county [14] 49/5 58/13 58/19 59/19 59/21 59/22 60/1 60/1 60/4 60/6 92/16 109/16 111/9 112/1 couple [8] 3/10 10/8 12/4 33/19 57/8 68/2</p>	<p>92/20 96/18 course [4] 38/6 41/12 101/23 109/25 cover [4] 2/9 59/23 96/2 99/1 coverage [4] 71/15 72/11 72/13 78/8 covered [2] 57/18 72/14 create [2] 66/17 98/12 created [1] 98/12 credit [2] 27/6 100/10 creditors [3] 104/13 105/9 105/11 criteria [3] 11/20 28/9 48/7 critical [2] 10/12 94/17 current [3] 71/5 78/7 80/21 currently [6] 23/7 58/23 70/6 71/13 101/19 111/11 curve [1] 74/18 cut [2] 77/25 97/1 cut-offs [1] 77/25</p> <p>D</p> <p>Dan [2] 62/21 64/9 DASNY [9] 1/15 1/21 1/24 4/15 4/17 5/6 55/21 64/10 64/21 data [1] 37/12 database [1] 92/16 date [9] 16/9 23/9 23/11 38/4 61/3 68/16 70/14 100/25 113/13 dates [1] 16/14 Dave [2] 31/23 94/3 David [1] 16/10 day [3] 16/16 26/1 69/9 days [3] 74/11 74/18 74/24 dead [1] 69/1 deadline [7] 28/8 48/8 72/25 98/25 104/12 104/15 105/9 deal [4] 53/19 57/21 96/15 96/20 dealing [1] 22/21 Debby [1] 65/4 Deborah [2] 1/24 4/8 debt [35] 6/18 33/2 35/25 36/4 36/23 36/23 37/7 40/25 41/3 42/24 43/2 64/5 64/6 64/23 77/23 78/5 78/7 78/8 78/18 78/21 78/23 80/6 80/11 80/15 80/21 81/13 81/18 82/4 82/10 82/14 83/5 93/5 104/14 105/8 112/1 debts [1] 78/2 December [3] 5/12 14/11 16/17 December 2006 [1] 14/11 December 31 [1] 16/17 decision [4] 2/14 21/23 90/22 107/14 decision-making [1] 2/14 decisions [4] 6/20 27/11 108/24 111/1 decrease [1] 89/15 deem [2] 27/23 93/13 deemed [5] 21/7 63/11 70/20 73/2 97/5 defer [1] 35/1 deficit [1] 23/2 define [1] 111/16 defined [1] 47/15 defining [1] 111/10 definitely [3] 56/13 56/14 56/25 definition [3] 79/7 79/9 90/11 definitions [1] 64/3 definitively [1] 65/2 defray [1] 14/1 degree [1] 35/24 delays [4] 34/8 34/10 75/12 75/13 deleted [1] 39/24 deliver [1] 18/23 deliverables [3] 8/22 16/14 16/15 delivering [1] 52/18 Delker [2] 1/18 4/4 demonstrate [9] 20/19 42/6 52/19 67/11 67/12 72/3 72/6 94/16 105/23</p>
--	---	--

<p>D</p> <p>demonstrated [6] 17/9 31/6 52/11 68/9 81/21 82/22</p> <p>demonstration [2] 11/15 11/16</p> <p>Dennis [6] 70/4 80/3 80/7 95/12 108/1 109/12</p> <p>department [17] 1/14 4/18 7/25 8/19 9/11 9/17 12/12 12/24 23/14 28/4 39/19 70/6 75/11 95/22 96/14 96/18 104/23</p> <p>Department's [3] 14/4 45/3 60/19</p> <p>depend [2] 43/4 55/15</p> <p>dependent [1] 82/23</p> <p>depending [3] 3/22 11/15 110/16</p> <p>depends [4] 43/9 78/15 79/13 79/21</p> <p>Deputy [3] 1/10 1/13 5/1</p> <p>describe [4] 52/7 78/3 105/19 105/21</p> <p>description [5] 14/14 32/3 35/10 35/10 35/16</p> <p>designated [3] 101/20 102/4 102/16</p> <p>designed [2] 39/3 48/24</p> <p>desk [1] 43/22</p> <p>detail [13] 25/5 25/10 32/16 34/6 35/7 35/10 37/15 40/4 42/4 48/18 70/2 105/20 105/20</p> <p>detailed [4] 34/17 46/24 61/24 105/18</p> <p>detailing [4] 41/13 41/24 67/9 92/2</p> <p>details [6] 16/20 16/21 25/14 25/16 30/13 91/16</p> <p>determination [2] 56/21 107/10</p> <p>determine [2] 10/5 104/23</p> <p>determining [1] 109/20</p> <p>developed [2] 41/10 105/22</p> <p>developing [1] 53/20</p> <p>development [4] 1/15 19/10 29/11 52/14</p> <p>device [1] 98/11</p> <p>DHFP [3] 1/17 1/18 1/20</p> <p>dialogue [1] 69/25</p> <p>Diaz [1] 54/13</p> <p>dictate [1] 102/17</p> <p>did [11] 5/11 8/19 16/2 17/3 17/13 17/21 22/5 25/1 56/12 85/20 85/20</p> <p>didn't [7] 15/12 20/6 47/14 47/14 49/19 60/12 111/15</p> <p>difference [2] 59/16 77/11</p> <p>different [15] 7/13 19/17 22/22 24/6 39/7 40/6 47/13 79/1 81/2 81/4 81/5 82/19 104/10 104/19 107/2</p> <p>differently [3] 2/19 43/8 60/21</p> <p>differs [1] 51/5</p> <p>difficult [4] 21/22 21/23 79/13 109/11</p> <p>diligence [2] 19/1 19/7</p> <p>diligent [1] 92/10</p> <p>direct [6] 29/1 29/15 56/11 81/10 81/21 82/24</p> <p>directed [5] 35/15 64/9 64/12 86/24 108/9</p> <p>directing [1] 87/23</p> <p>direction [1] 65/7</p> <p>directly [11] 16/5 17/9 20/20 21/10 21/16 26/7 26/8 27/2 28/20 34/19 111/21</p> <p>director [9] 1/11 1/15 1/16 1/18 1/19 1/21 29/21 54/13 93/20</p> <p>disbursed [3] 12/19 68/21 73/21</p> <p>disbursement [4] 83/19 83/25 100/18 101/6</p> <p>disbursements [4] 74/15 83/15 110/10 111/4</p> <p>discretion [2] 56/1 74/25</p> <p>discuss [3] 7/5 91/16 92/3</p> <p>discussed [1] 42/10</p> <p>discussing [1] 66/2</p> <p>discussion [15] 18/16 18/18 24/19 34/6 34/8 34/18 35/1 35/23 42/14 52/14 70/6</p>	<p>72/7 102/21 103/1 103/3</p> <p>discussions [5] 6/11 53/14 95/22 96/22 101/25</p> <p>dispose [1] 13/23</p> <p>disqualified [1] 15/7</p> <p>disregarded [1] 49/14</p> <p>disrespect [1] 102/24</p> <p>distinct [1] 87/1</p> <p>distinction [6] 83/18 83/21 83/24 107/6 107/8 112/7</p> <p>distinctive [2] 2/20 27/13</p> <p>Division [4] 1/12 1/23 4/5 4/19</p> <p>do [57] 2/2 2/6 3/12 5/20 5/21 7/6 12/13 15/17 17/17 18/20 19/6 22/23 23/3 27/23 28/3 28/23 36/16 36/24 38/7 39/9 42/1 44/4 44/15 44/20 47/8 47/24 48/4 50/23 50/24 53/3 54/20 55/6 57/22 58/23 59/24 64/22 65/4 66/3 66/4 66/15 70/12 85/20 87/16 92/12 94/14 98/7 98/14 98/14 98/23 105/11 106/18 107/9 107/11 110/3 111/15 111/19 113/4</p> <p>document [1] 100/18</p> <p>documentation [3] 37/13 38/7 40/15</p> <p>documents [1] 61/10</p> <p>does [7] 48/16 61/4 62/6 94/14 94/20 97/8 102/18</p> <p>doesn't [10] 17/6 42/13 49/13 65/2 75/10 77/18 78/9 86/15 87/18 111/18</p> <p>DOH [3] 4/6 4/10 5/6</p> <p>doing [4] 75/7 81/21 110/15 111/11</p> <p>DOL [3] 92/9 92/14 92/24</p> <p>dollar [6] 13/22 22/18 24/17 62/19 65/25 68/25</p> <p>dollar's [1] 77/16</p> <p>dollars [51] 5/13 5/22 6/15 6/16 9/21 9/24 10/12 11/2 11/3 11/6 11/12 11/14 11/14 23/19 32/20 41/8 41/9 45/9 46/5 47/3 47/4 47/8 47/9 48/13 50/9 51/11 51/12 52/12 54/5 54/17 57/9 57/9 60/17 66/15 73/6 83/4 87/21 100/1 105/12 107/3 107/22 107/23 107/24 108/13 108/22 109/18 109/18 110/6 110/11 112/3 112/4</p> <p>don't [41] 3/19 13/20 16/1 19/12 19/14 21/11 21/15 27/16 27/19 28/1 29/4 29/9 29/13 32/9 33/14 34/22 41/15 50/15 55/10 55/13 60/16 64/5 65/4 68/25 70/22 73/14 75/8 76/22 78/11 83/22 89/7 89/11 90/7 90/8 94/10 96/1 98/23 102/21 110/2 110/22 112/11</p> <p>done [12] 7/8 12/17 22/23 26/21 31/14 62/2 62/5 100/12 100/14 102/1 105/25 110/5</p> <p>door [4] 68/17 68/22 79/5 100/1</p> <p>Dormitory [5] 7/24 24/21 35/2 63/25 64/5</p> <p>Dorothy [1] 65/11</p> <p>dovetail [1] 31/25</p> <p>down [11] 21/17 23/19 32/19 47/23 75/4 84/5 86/18 87/14 88/16 97/1 112/10</p> <p>downsize [1] 66/21</p> <p>downsized [2] 53/2 104/4</p> <p>downsizing [3] 51/19 66/16 81/5</p> <p>Downstate [1] 65/12</p> <p>dozens [1] 29/14</p> <p>draft [1] 3/19</p> <p>draw [2] 84/5 107/6</p> <p>dreading [1] 20/7</p> <p>drew [1] 30/4</p> <p>drive [1] 13/19</p> <p>due [3] 19/1 19/7 61/8</p> <p>during [8] 24/8 66/24 89/2 102/6 102/14 105/22 106/14 111/21</p> <p>Dutch [1] 61/2</p> <p>duty [1] 5/8</p>	<p>E</p> <p>e-mails [1] 30/1</p> <p>each [11] 8/16 8/20 11/15 25/10 34/4 34/13 34/18 39/6 43/25 47/5 89/6</p> <p>earlier [19] 22/10 23/12 24/6 28/18 31/23 40/6 43/10 53/7 55/18 60/14 60/16 73/7 79/15 86/7 87/17 97/6 97/24 101/3 107/16</p> <p>earliest [1] 72/20</p> <p>early [3] 8/20 29/7 107/1</p> <p>earn [1] 109/2</p> <p>easier [4] 22/23 29/2 38/23 73/20</p> <p>Eastern [1] 68/24</p> <p>easy [1] 110/5</p> <p>echo [1] 7/23</p> <p>Ed [2] 44/9 57/23</p> <p>effect [2] 67/11 67/11</p> <p>effective [2] 27/3 37/20</p> <p>effectiveness [1] 37/17</p> <p>effectuate [1] 53/21</p> <p>efficiencies [1] 94/7</p> <p>efficiency [1] 95/1</p> <p>efficient [2] 14/19 78/22</p> <p>efficiently [1] 67/15</p> <p>effort [5] 5/19 27/24 40/8 63/17 106/6</p> <p>efforts [3] 31/7 54/2 57/20</p> <p>either [10] 18/13 55/24 57/1 57/15 58/15 67/20 80/21 82/13 85/11 92/6</p> <p>elaborate [3] 2/10 14/8 22/5</p> <p>element [1] 49/16</p> <p>elements [8] 10/6 39/23 39/24 49/11 52/18 55/16 78/15 99/22</p> <p>eligible [26] 14/6 14/23 15/1 17/4 19/20 20/9 21/4 24/10 25/20 26/4 44/23 45/9 52/2 52/4 52/13 57/3 58/15 60/7 68/3 71/18 78/1 84/13 86/9 94/5 94/11 95/19</p> <p>eliminate [1] 10/3</p> <p>Ellis [2] 71/2 93/9</p> <p>else [7] 10/1 19/14 21/12 24/6 32/8 42/20 69/18</p> <p>emphasize [7] 9/5 9/12 10/10 19/16 21/9 97/24 106/22</p> <p>Empire [1] 1/4</p> <p>employees [1] 35/19</p> <p>enable [1] 38/7</p> <p>encountered [2] 34/9 34/11</p> <p>encourage [1] 12/8</p> <p>encouraged [1] 109/24</p> <p>encouraging [1] 24/18</p> <p>end [16] 13/24 16/8 29/25 30/1 34/4 47/19 48/3 57/25 67/24 69/9 79/4 100/21 100/25 101/11 101/23 102/15</p> <p>endeavor [2] 14/16 27/5</p> <p>ends [2] 17/20 43/14</p> <p>engage [2] 42/18 106/10</p> <p>engaged [1] 31/6</p> <p>engaging [1] 42/13</p> <p>enough [3] 9/5 17/22 110/3</p> <p>ensuing [1] 48/21</p> <p>ensure [3] 13/17 28/4 62/13</p> <p>entail [1] 92/2</p> <p>enter [1] 18/1</p> <p>enters [1] 92/16</p> <p>entire [4] 6/23 8/9 56/3 106/7</p> <p>entities [6] 33/5 40/6 47/7 53/15 59/12 83/19</p> <p>entities' [1] 18/22</p> <p>entity [5] 15/18 50/7 59/13 69/20 81/18</p> <p>envision [1] 54/20</p> <p>equal [1] 66/23</p> <p>equipment [1] 21/1</p> <p>equity [8] 23/1 32/25 40/17 40/24 41/3 42/24 64/19 64/20</p>
---	---	---

E	F	
<p>Erie [1] 109/16 especially [3] 25/23 28/14 70/13 essence [1] 86/25 essentially [2] 2/9 103/9 established [1] 58/16 establishment [1] 15/18 estate [1] 33/5 etcetera [3] 24/17 55/3 58/17 evaluation [1] 34/7 even [5] 44/5 50/22 82/21 97/12 100/10 ever [1] 89/7 every [8] 9/17 33/8 41/4 46/21 92/10 99/8 104/24 106/6 everybody [5] 3/1 19/23 43/24 75/6 85/23 everyone [5] 2/2 5/5 5/11 8/24 109/22 everything [6] 43/10 53/7 55/23 59/23 100/12 110/3 Exactly [1] 94/18 example [14] 25/23 42/23 42/25 56/16 71/7 72/13 84/4 85/24 89/9 93/18 102/8 105/19 105/24 111/11 examples [1] 93/11 exceed [2] 68/4 78/2 except [2] 62/5 105/12 exceptional [1] 70/21 exclusive [1] 45/11 Excuse [1] 91/4 executed [2] 76/16 92/13 executive [3] 28/23 28/25 30/7 exempt [1] 63/6 exercises [1] 101/16 expand [4] 56/19 57/16 58/22 89/15 expanded [2] 26/2 50/21 expanding [2] 20/13 66/8 expansion [4] 20/16 25/22 58/6 58/6 expansions [2] 57/23 57/23 expect [14] 3/19 12/19 12/22 13/25 41/15 46/22 47/16 52/7 58/4 67/8 67/17 72/20 82/1 108/23 expectation [2] 77/1 105/3 expected [9] 12/1 12/14 14/3 47/16 56/15 56/18 57/16 57/22 93/14 expecting [2] 61/16 82/6 expand [1] 48/3 expended [2] 68/15 112/4 expenditure [5] 34/15 111/18 111/20 111/20 112/3 expenditures [2] 99/1 110/9 expense [2] 63/16 99/15 expenses [23] 18/18 18/25 19/1 19/5 19/11 19/15 34/14 34/23 66/23 67/2 67/6 67/13 68/4 85/8 85/16 86/8 86/8 99/14 100/7 100/9 100/15 102/9 102/9 experience [3] 24/22 25/13 92/6 experts [1] 91/21 explain [3] 7/19 71/23 91/10 explained [1] 100/8 explanatory [1] 8/2 explicit [1] 15/14 explore [1] 93/2 express [1] 49/19 expressed [1] 110/16 expressing [1] 40/13 expressly [2] 57/1 57/16 extension [2] 70/8 70/22 extent [22] 7/4 22/20 23/4 42/11 46/22 47/10 47/23 50/3 50/5 56/3 63/11 65/21 67/13 67/14 85/22 86/10 88/20 90/11 103/12 106/23 107/14 110/11 extra [3] 34/21 88/17 111/11 extraneous [1] 34/21</p>	<p>F-SHFP [1] 84/14 F-SHRP [28] 9/24 10/22 11/22 17/18 36/24 46/4 50/9 50/15 57/20 63/6 64/14 67/25 80/19 82/13 83/4 83/21 96/20 99/9 107/7 108/3 108/8 108/13 108/21 109/1 109/8 109/18 110/6 110/11 facilitate [3] 3/3 18/17 106/16 facilitation [1] 18/15 facilities [33] 2/22 4/22 4/24 6/17 7/3 8/11 14/17 15/15 16/11 17/25 18/2 20/23 20/24 21/24 33/4 40/12 47/1 47/7 51/22 57/21 57/25 59/9 66/5 66/11 66/12 97/10 97/11 97/14 100/1 100/6 101/14 110/17 111/14 facility [54] 1/12 3/23 4/5 7/1 8/16 13/7 13/10 15/2 15/12 15/16 16/13 20/17 29/6 33/4 37/5 44/14 47/6 52/21 52/23 52/25 55/5 58/16 58/18 59/14 68/22 69/8 71/14 81/6 81/7 81/19 82/1 82/3 82/6 82/24 83/6 83/6 85/13 87/5 88/20 88/25 89/11 89/14 90/12 90/23 99/13 99/14 100/17 101/5 104/3 104/8 104/17 105/3 110/10 112/9 facility-specific [1] 7/1 fact [2] 50/13 77/9 factors [1] 43/5 failed [2] 104/14 105/7 fails [1] 104/11 fair [2] 43/24 44/4 fairly [2] 2/18 3/2 fall [1] 47/11 falling [1] 73/23 fallout [1] 96/16 falls [2] 47/10 77/22 familiar [5] 20/11 28/18 39/14 39/17 92/24 far [3] 17/3 52/3 99/19 favor [1] 25/25 feasibility [11] 37/2 37/8 37/23 68/12 69/13 72/6 79/8 79/19 79/25 87/3 105/24 feasible [6] 27/3 28/9 41/6 68/10 78/20 79/4 February [1] 8/20 federal [13] 9/23 11/11 11/17 12/21 17/18 17/19 98/24 100/3 100/14 101/20 102/3 109/3 109/5 fee [2] 30/19 103/25 fee-based [1] 30/19 feedback [2] 33/13 93/12 feel [2] 41/18 41/25 feels [1] 109/23 fees [1] 104/1 fell [1] 60/14 few [5] 6/22 18/7 26/20 27/15 43/17 figure [2] 18/20 62/19 fill [3] 47/18 67/24 97/18 filling [1] 16/20 filter [1] 16/1 final [3] 3/12 3/13 102/13 Finance [2] 10/21 90/3 financial [37] 1/17 6/1 8/14 9/19 11/25 13/14 19/6 19/7 22/1 24/5 24/23 25/3 25/8 27/24 28/15 29/4 37/1 37/14 37/23 37/24 38/1 38/3 38/5 40/9 40/18 48/9 49/7 51/23 52/10 64/25 77/19 77/24 79/7 79/25 97/12 98/1 100/22 financially [8] 27/3 28/9 41/6 56/14 57/1 58/1 78/19 79/4 financing [9] 22/16 49/21 50/16 50/25 63/7 64/16 76/19 77/7 86/23 find [2] 27/14 93/17 fine [1] 99/6 Finkelstein [1] 66/21 fire [1] 99/8</p>	<p>first [19] 5/5 14/25 18/16 19/1 28/22 33/25 39/9 43/18 44/20 47/16 57/6 62/23 80/5 80/5 85/18 93/8 95/8 100/16 104/16 fiscal [4] 11/17 17/18 17/19 100/21 fit [2] 10/7 54/6 fits [2] 7/19 90/11 five [6] 11/13 62/24 74/21 77/4 77/15 99/23 five-month [1] 77/4 five-year [1] 11/13 flagship [1] 52/24 flexibility [4] 10/5 11/22 104/24 108/3 flexible [1] 107/23 flip [1] 35/23 flippant [1] 55/10 floor [1] 105/23 flow [2] 67/10 74/14 flowing [1] 77/16 focus [2] 45/22 60/22 focused [2] 27/21 58/5 folks [1] 42/10 follow [19] 44/1 44/6 44/14 52/20 54/15 60/13 61/18 63/15 71/9 72/9 80/8 81/8 85/15 96/5 98/8 106/3 106/11 111/9 112/19 follow-up [17] 44/1 44/6 44/14 52/20 54/15 61/18 71/9 72/9 80/8 81/8 85/15 96/5 98/8 106/3 106/11 111/9 112/19 following [2] 69/22 73/16 footprint [1] 112/14 for-profit [1] 83/18 for-profits [1] 84/13 force [1] 35/17 foregoing [1] 113/5 forgive [1] 51/10 forgotten [1] 58/11 form [2] 3/15 3/21 formal [4] 2/4 3/2 3/4 3/14 formally [1] 12/17 forms [5] 39/3 39/10 39/14 39/17 39/21 forth [4] 49/1 63/1 63/20 80/13 forthcoming [2] 99/21 100/11 forum [1] 103/1 forward [18] 5/20 6/4 6/6 6/13 6/18 10/18 14/5 24/19 37/2 39/20 62/4 66/7 77/13 79/10 90/21 92/13 96/11 106/19 found [1] 103/23 foundation [2] 9/3 9/8 foundations [1] 33/5 founded [1] 29/6 four [10] 37/22 74/21 75/3 75/17 75/20 75/22 75/25 76/1 77/3 99/23 FQHC [2] 101/24 102/4 framework [1] 16/19 frankly [3] 68/10 73/15 96/17 Franz [1] 47/21 free [1] 41/25 frequently [1] 70/24 friends [1] 5/6 front [6] 16/1 23/18 23/23 30/5 91/9 106/9 Frye [1] 65/11 fulfilling [2] 56/15 56/23 full [6] 3/12 38/1 38/7 48/19 49/16 51/7 fully [3] 26/15 70/7 88/8 Fulton [2] 70/5 95/13 function [1] 110/23 fund [14] 11/2 22/19 42/6 46/8 46/16 46/23 50/14 50/17 68/8 73/12 95/18 96/15 100/7 105/5 funded [2] 96/23 106/25 funding [42] 10/25 11/19 14/4 21/19 23/18 26/5 26/16 26/19 27/5 32/4 32/6 32/18 32/25 40/4 40/14 40/16 45/5 47/11 49/25</p>

<p>F</p> <p>funding... [23] 50/6 50/12 50/15 51/6 51/24 55/19 59/13 62/16 62/17 71/3 71/6 71/15 71/18 77/23 78/4 78/10 80/16 95/20 97/17 99/4 106/9 110/2 110/13</p> <p>funds [44] 11/10 11/18 11/21 11/22 11/23 12/18 12/22 13/20 13/21 13/22 13/25 17/18 36/10 46/15 46/18 48/2 48/6 48/10 49/6 49/17 54/14 59/3 63/23 63/24 69/4 73/9 78/1 83/15 83/20 83/21 95/15 96/2 99/1 99/9 100/3 100/11 100/14 101/4 101/7 104/8 104/12 105/8 107/17 109/8</p> <p>further [2] 101/2 109/13</p> <p>future [4] 72/4 88/4 103/17 103/18</p>	<p>grant [16] 7/15 17/15 31/17 49/25 50/6 50/12 64/11 64/12 65/3 65/9 70/10 71/9 71/19 83/15 87/9 100/8</p> <p>granted [1] 70/22</p> <p>grants [2] 1/18 29/24</p> <p>great [4] 32/16 32/22 35/7 107/18</p> <p>greatest [2] 107/21 110/10</p> <p>group [1] 31/11</p> <p>groups [1] 52/9</p> <p>guarantee [1] 109/7</p> <p>guess [14] 3/17 8/13 14/5 17/22 26/14 59/7 68/10 83/9 89/17 98/8 102/7 102/10 103/22 106/13</p> <p>guidance [1] 103/4</p> <p>guide [1] 27/10</p> <p>guided [3] 22/15 22/18 26/6</p> <p>guiding [1] 22/10</p> <p>guy [1] 30/1</p>	<p>26/19 48/9 63/6 82/15 100/2</p> <p>helpful [3] 7/4 10/2 36/8</p> <p>helping [1] 80/20</p> <p>here [31] 2/6 3/13 3/18 3/20 3/25 15/13 17/3 22/1 26/5 27/11 38/25 39/23 39/25 40/16 41/7 42/2 44/5 44/23 47/2 47/22 49/18 53/18 60/22 68/7 73/4 82/12 97/17 98/21 106/16 110/5 111/24</p> <p>here's [1] 100/4</p> <p>hereby [1] 113/4</p> <p>Hi [4] 58/12 84/19 88/24 101/8</p> <p>high [3] 70/16 105/19 108/18</p> <p>highlights [2] 14/3 34/3</p> <p>highly [1] 111/3</p> <p>Hills [1] 83/14</p> <p>him [2] 30/2 103/20</p> <p>hire [1] 44/14</p> <p>hired [1] 19/5</p> <p>his [3] 27/9 54/2 74/24</p> <p>Hoffman [1] 71/1</p> <p>hold [3] 3/4 59/13 83/21</p> <p>holder [1] 70/18</p> <p>holding [2] 52/16 53/6</p> <p>home [9] 25/25 58/19 58/19 59/3 60/2 66/21 67/20 67/21 67/21</p> <p>hope [4] 2/10 21/25 24/13 106/18</p> <p>hopefully [2] 38/22 67/4</p> <p>horse [1] 69/1</p> <p>hospital [25] 31/13 56/16 56/17 56/19 56/21 56/23 57/15 62/22 70/5 71/2 72/18 77/22 86/21 88/13 88/14 88/16 88/17 88/18 89/12 89/13 91/8 93/10 94/4 98/22 103/22</p> <p>hospitals [3] 47/24 94/6 95/17</p> <p>host [1] 38/13</p> <p>house [1] 51/4</p> <p>how [49] 7/19 12/22 16/22 16/22 18/20 18/23 22/11 24/10 28/16 29/15 29/16 29/17 29/17 30/13 30/20 30/21 31/6 31/8 31/13 31/15 32/5 33/19 36/25 37/9 39/5 43/1 48/4 49/5 49/6 52/3 72/3 75/14 76/1 78/25 79/22 79/23 91/10 92/25 93/23 94/14 103/24 103/25 104/18 105/9 108/4 110/24 110/25 111/9 111/17</p> <p>however [8] 21/9 51/9 54/20 56/13 58/21 67/8 70/24 94/6</p> <p>huge [1] 37/5</p> <p>human [1] 104/1</p> <p>hundred [3] 53/10 81/6 81/7</p> <p>hundred-bed [1] 81/7</p> <p>hundreds [1] 5/17</p> <p>Huxley [1] 1/4</p>
<p>G</p> <p>gain [1] 51/10</p> <p>gap [2] 47/18 67/24</p> <p>gave [1] 42/23</p> <p>GBA [1] 83/16</p> <p>gee [1] 21/14</p> <p>general [9] 1/14 1/24 4/11 7/11 12/16 38/11 61/13 74/7 79/25</p> <p>generalize [1] 2/25</p> <p>generalized [1] 80/2</p> <p>generally [4] 11/5 16/3 20/15 60/1</p> <p>generic [2] 39/10 89/9</p> <p>Generically [1] 89/10</p> <p>gentleman [1] 76/7</p> <p>gentleman's [1] 60/14</p> <p>get [50] 2/3 2/4 3/22 4/25 5/8 6/1 9/18 13/16 18/13 19/24 20/6 21/19 24/3 26/21 27/17 27/20 27/25 27/25 28/2 28/2 28/7 29/16 30/2 30/13 32/19 34/16 36/1 36/3 36/8 37/11 40/10 44/3 48/14 48/19 54/10 62/2 63/14 63/17 73/7 73/17 76/20 77/11 78/23 86/14 87/6 100/10 102/4 105/24 109/10 109/20</p> <p>getting [5] 8/1 28/6 48/2 64/15 99/24</p> <p>give [16] 2/5 14/23 25/3 29/1 34/3 37/25 42/4 42/17 55/14 56/16 62/14 67/18 80/5 89/9 93/11 103/3</p> <p>given [3] 41/4 63/5 108/2</p> <p>gives [3] 10/4 14/13 106/24</p> <p>giving [1] 67/9</p> <p>Glendale [1] 66/21</p> <p>go [43] 2/17 6/21 14/5 14/6 14/22 20/4 22/25 24/19 28/12 31/8 31/15 33/14 37/18 38/25 39/1 39/5 43/15 44/18 45/22 47/4 52/4 53/2 55/17 55/21 57/4 58/9 60/16 61/8 62/3 64/11 76/2 77/6 77/13 86/6 90/21 91/9 92/13 92/17 99/21 100/6 102/17 109/7 109/11</p> <p>go-around [1] 45/22</p> <p>goal [2] 100/2 106/16</p> <p>goes [6] 58/14 60/9 69/12 69/25 72/2 93/17</p> <p>going [129]</p> <p>golden [2] 87/19 98/1</p> <p>gone [2] 74/4 75/24</p> <p>good [14] 2/1 8/2 14/14 15/21 25/1 26/25 28/8 28/22 29/20 41/19 62/15 79/10 83/14 86/20</p> <p>Gormley [3] 61/1 93/4 95/9</p> <p>got [5] 17/11 20/3 33/22 69/18 76/12</p> <p>gotten [1] 46/7</p> <p>governance [3] 58/14 79/21 83/8</p> <p>governed [1] 92/18</p> <p>governing [2] 30/21 59/18</p> <p>government [5] 12/21 77/2 101/21 109/3 109/5</p> <p>government's [1] 102/3</p> <p>Governor [1] 1/4</p>	<p>H</p> <p>had [24] 6/12 15/4 15/5 15/6 15/18 20/4 24/22 25/13 28/24 31/17 33/9 34/22 53/9 53/11 54/8 56/10 66/14 66/14 76/7 79/18 90/13 92/6 92/19 95/22</p> <p>hall [1] 112/10</p> <p>hand [3] 43/2 44/8 60/12</p> <p>handed [1] 44/5</p> <p>handler [1] 92/11</p> <p>happen [9] 5/10 26/24 54/8 68/11 73/5 74/20 102/6 104/2 110/22</p> <p>happened [1] 100/25</p> <p>happening [2] 34/3 95/25</p> <p>happy [1] 7/6</p> <p>hard [6] 2/25 38/18 51/12 65/8 109/19 110/24</p> <p>harsh [1] 76/24</p> <p>Harvey [1] 66/20</p> <p>has [51] 6/15 6/20 6/21 9/11 12/3 15/15 16/14 17/7 17/17 19/14 24/22 28/20 29/22 31/9 33/9 33/13 33/17 37/22 44/2 48/6 52/2 61/8 67/20 69/15 74/4 74/5 74/11 74/24 76/11 81/10 81/21 82/24 85/22 88/15 89/25 91/5 92/9 93/8 95/7 96/18 96/21 97/17 99/7 100/12 100/13 100/13 101/5 102/1 104/3 104/8 109/1</p> <p>have [164]</p> <p>haven't [4] 14/10 76/4 85/4 108/24</p> <p>having [3] 56/24 80/15 109/19</p> <p>he [4] 42/23 67/3 67/4 87/6</p> <p>He'll [1] 29/24</p> <p>he's [3] 29/21 77/3 95/11</p> <p>HEAL [57] 1/20 7/17 9/22 10/21 11/1 11/22 12/5 15/5 19/19 20/15 29/21 32/5 32/11 33/25 36/24 46/4 47/14 50/9 50/15 57/20 63/21 63/23 64/12 64/14 64/21 65/8 65/13 65/18 67/24 69/4 70/9 75/25 75/25 80/19 82/9 82/12 83/4 83/15 85/6 85/17 89/1 89/2 89/23 90/6 90/10 90/13 96/19 96/19 102/11 104/12 105/10 105/12 107/7 107/17 108/13 109/18 110/13</p> <p>health [44] 1/10 1/12 1/14 2/21 4/5 4/13 4/19 4/21 4/23 5/2 6/7 9/23 11/11 12/12 12/24 14/17 14/19 14/20 15/10 15/19 18/23 23/13 26/1 26/1 29/7 31/1 31/3 39/19 47/22 49/4 52/6 54/25 55/1 56/9 56/22 58/17 58/24 68/24 75/10 88/12 88/25 96/1 96/17 105/16</p> <p>healthier [1] 58/1</p> <p>hear [4] 10/13 19/23 19/24 77/15</p> <p>heard [2] 85/4 95/15</p> <p>hearing [2] 80/17 80/18</p> <p>Hello [1] 49/3</p> <p>help [10] 16/6 16/23 18/17 22/2 24/16</p>	<p>I</p> <p>I'd [3] 2/4 5/1 18/6</p> <p>I'll [13] 8/21 10/17 18/9 44/20 56/15 71/22 71/25 72/22 80/5 83/3 91/9 96/3 98/22</p> <p>I'm [40] 4/4 9/13 20/7 29/19 30/6 39/8 47/21 47/22 49/3 54/6 55/11 57/13 58/12 59/7 59/21 61/21 61/23 61/24 63/1 65/11 68/23 74/2 74/17 74/23 80/10 80/17 80/17 80/18 85/5 88/12 90/4 91/7 92/5 92/23 98/21 99/24 103/21 109/18 109/21 110/19</p> <p>I've [2] 92/19 95/15</p> <p>Ickowski [1] 77/21</p> <p>idea [4] 14/23 48/19 55/7 87/6</p> <p>identical [1] 49/11</p> <p>identified [3] 36/22 70/17 81/9</p> <p>identify [4] 43/19 48/10 71/24 107/15</p> <p>identifying [2] 64/2 107/17</p> <p>if [100] 11/17 11/24 13/8 13/23 13/25 14/9 15/19 15/22 16/23 18/19 19/14 23/9 24/23 26/23 27/16 27/18 27/23 28/7 30/7 30/22</p>

<p>if... [80] 32/9 33/14 35/20 35/21 36/6 36/22 37/6 40/22 42/15 43/20 44/2 44/3 44/8 46/6 46/6 47/6 48/1 48/2 48/3 48/13 48/22 50/12 50/19 51/9 52/7 54/7 54/17 57/2 59/7 59/21 59/21 60/3 60/5 61/3 61/7 61/9 63/12 67/19 68/11 69/1 69/9 69/16 69/18 70/5 70/20 71/3 71/12 72/18 78/2 78/17 78/22 79/15 79/16 81/9 82/1 82/21 83/4 83/20 83/22 85/5 88/22 88/25 95/18 97/12 100/3 100/10 100/17 102/8 102/9 104/3 104/8 104/11 104/16 104/24 105/7 108/15 111/11 111/20 112/9 112/12</p> <p>II [1] 7/17</p> <p>imagine [1] 99/6</p> <p>immediate [2] 44/1 103/17</p> <p>impact [4] 30/15 31/4 66/11 96/10</p> <p>impacted [9] 8/11 56/14 56/25 57/21 65/15 66/5 84/23 85/1 85/10</p> <p>implement [9] 5/14 6/21 9/15 9/17 28/17 29/17 30/17 89/2 98/3</p> <p>implementation [26] 1/1 1/20 8/7 8/15 9/1 16/5 16/7 16/13 16/24 17/10 21/1 23/9 23/11 26/17 26/20 27/17 29/21 50/1 51/25 53/8 60/24 87/22 88/1 94/15 108/17 111/23</p> <p>implemented [4] 5/18 6/9 28/5 98/5</p> <p>implementing [6] 9/20 26/22 31/8 55/20 81/1 86/9</p> <p>implication [1] 59/1</p> <p>implied [3] 57/1 57/16 90/19</p> <p>imply [1] 45/20</p> <p>important [8] 8/4 8/23 22/9 24/3 32/13 35/6 37/25 60/11</p> <p>impossible [1] 75/15</p> <p>impression [1] 99/25</p> <p>improve [1] 33/20</p> <p>improvement [1] 112/9</p> <p>improvements [1] 85/12</p> <p>improves [1] 6/7</p> <p>in [315]</p> <p>incentivize [1] 87/25</p> <p>inclination [1] 103/18</p> <p>include [6] 33/10 34/13 34/17 41/19 62/7 97/14</p> <p>included [1] 108/6</p> <p>includes [3] 22/13 45/21 103/8</p> <p>including [2] 21/5 37/13</p> <p>inclusive [1] 41/16</p> <p>income [1] 24/14</p> <p>incumbent [4] 44/11 44/12 44/16 55/4</p> <p>incur [1] 37/6</p> <p>incurred [4] 17/5 17/16 86/10 87/1</p> <p>independent [1] 77/7</p> <p>indicated [2] 23/11 50/8</p> <p>indicating [2] 76/5 76/6</p> <p>indicating that [1] 76/6</p> <p>indistinguishable [1] 61/20</p> <p>individual [5] 7/2 13/10 39/7 51/2 51/3</p> <p>industry [3] 22/22 54/25 55/1</p> <p>information [16] 1/2 3/13 24/11 37/15 38/12 39/13 41/18 46/1 48/23 98/13 103/10 105/18 105/19 106/2 106/5 106/7</p> <p>infrastructure [2] 18/19 18/23</p> <p>initially [2] 27/22 40/21</p> <p>initiatives [2] 96/15 96/18</p> <p>inpatient [2] 25/24 30/19</p> <p>input [2] 31/10 31/11</p> <p>inspectors [2] 92/17 92/20</p> <p>instance [6] 18/16 47/17 59/18 67/10 76/7 84/21</p> <p>Institute [1] 44/10</p>	<p>institution [15] 30/15 30/18 30/24 31/5 57/2 64/15 64/22 69/14 80/21 81/23 84/24 85/2 85/9 85/10 88/22</p> <p>institutions [11] 18/12 18/12 18/19 19/9 22/19 56/12 65/14 75/3 75/22 80/12 80/14</p> <p>instructions [1] 39/18</p> <p>insulted [1] 61/21</p> <p>insurance [3] 24/1 71/3 71/6</p> <p>intended [1] 102/25</p> <p>intending [1] 102/25</p> <p>intent [3] 70/17 100/17 110/8</p> <p>intention [2] 34/2 96/2</p> <p>interest [2] 40/21 83/12</p> <p>interested [3] 11/17 12/21 64/2</p> <p>interesting [3] 29/6 64/13 68/11</p> <p>interim [1] 68/5</p> <p>interims [1] 40/12</p> <p>internally [1] 66/3</p> <p>interpret [1] 105/4</p> <p>interpretations [1] 55/25</p> <p>into [17] 12/11 14/22 18/1 22/25 34/16 47/4 53/2 55/23 64/16 70/3 72/4 76/18 84/6 88/5 91/19 105/16 109/7</p> <p>introduce [3] 4/4 5/1 29/19</p> <p>introduction [1] 51/17</p> <p>investigating [1] 87/3</p> <p>investigation [1] 86/24</p> <p>investment [6] 13/17 14/2 23/21 23/22 27/10 32/20</p> <p>invitation [1] 55/22</p> <p>involved [5] 18/5 31/7 34/20 40/12 96/21</p> <p>involving [2] 51/18 57/17</p> <p>irrespective [1] 98/15</p> <p>is [304]</p> <p>Island [1] 29/8</p> <p>isn't [1] 80/1</p> <p>isolation [2] 89/25 90/1</p> <p>issue [14] 4/1 24/20 44/24 68/25 69/13 69/16 75/6 78/23 80/6 80/10 99/3 99/10 109/16 109/22</p> <p>issued [1] 17/12</p> <p>issues [7] 7/5 23/14 34/10 70/14 95/23 100/4 102/23</p> <p>it [185]</p> <p>it's [61] 2/24 3/10 5/12 7/14 8/1 14/9 14/16 15/21 16/22 22/16 24/2 24/12 26/23 26/25 28/8 29/17 30/7 30/8 30/18 32/13 35/5 37/3 37/13 42/2 42/9 47/13 48/2 48/8 52/21 53/14 53/19 54/1 54/4 59/9 59/18 59/23 64/13 64/20 67/5 69/23 72/19 75/15 76/14 77/3 78/24 79/12 87/17 90/24 94/1 94/13 96/13 99/16 105/1 108/19 110/24 111/2 111/19 111/19 111/20 112/2 112/11</p> <p>item [3] 34/19 34/19 72/14</p> <p>items [3] 22/24 23/3 24/14</p> <p>its [6] 12/3 56/20 62/13 72/4 86/22 89/12</p> <p>itself [5] 12/6 15/16 28/14 86/3 87/4</p>	<p>job [1] 25/1</p> <p>jobs [1] 54/25</p> <p>Joe [1] 84/7</p> <p>John [8] 58/12 59/20 72/17 76/11 76/22 111/8 111/17 112/6</p> <p>joint [1] 30/21</p> <p>Jose [1] 54/13</p> <p>Joseph [1] 83/13</p> <p>judgment [1] 86/5</p> <p>July [4] 61/10 70/14 73/21 74/14</p> <p>July 16 [3] 61/10 73/21 74/14</p> <p>June [4] 16/18 61/3 61/8 61/9</p> <p>June 15 [1] 61/9</p> <p>June 30 [3] 16/18 61/3 61/8</p> <p>just [68] 2/5 2/12 3/9 8/10 10/10 13/2 14/8 15/22 15/25 19/16 21/20 22/7 24/9 25/3 26/12 27/7 30/10 32/12 32/23 33/3 33/19 34/3 39/1 40/13 41/25 41/25 42/22 42/25 43/21 44/13 45/10 45/13 47/13 52/20 56/9 56/16 57/7 59/7 59/16 60/13 61/17 67/3 68/2 68/24 73/4 74/12 74/23 76/11 79/16 84/5 85/3 85/5 86/5 87/10 89/9 93/25 95/14 96/5 96/13 99/2 101/2 101/2 101/11 102/22 103/6 106/7 108/14 108/25</p> <p>justify [1] 37/19</p>
	<p>J</p> <p>James [1] 1/10</p> <p>January [6] 8/20 16/8 17/6 98/10 100/24 111/5</p> <p>January 1 [3] 17/6 100/24 111/5</p> <p>January 31 [1] 98/10</p> <p>Jay [1] 71/1</p> <p>Jean [2] 45/18 47/21</p> <p>Jean-Paul [1] 45/18</p> <p>Jeanette [1] 49/3</p> <p>Jeff [4] 84/19 85/18 101/8 102/20</p> <p>Jenny [1] 93/9</p> <p>jeopardize [1] 21/19</p> <p>Jim [7] 4/12 5/2 7/23 9/9 13/13 53/9 61/22</p> <p>Jim's [1] 7/23</p>	<p>K</p> <p>keep [13] 16/23 21/20 27/7 27/11 30/9 36/16 39/14 41/25 71/7 73/4 76/19 104/19 106/15</p> <p>Kelly [1] 44/7</p> <p>keyed [1] 103/15</p> <p>keys [1] 52/3</p> <p>kind [30] 2/5 14/23 16/18 16/25 19/2 20/10 22/1 24/19 25/3 25/11 25/14 26/12 35/3 35/16 35/22 36/3 36/9 36/19 37/4 37/7 37/8 47/15 53/20 67/18 67/23 67/25 68/18 87/6 99/12 106/12</p> <p>kinds [2] 85/16 109/24</p> <p>King [1] 88/11</p> <p>Kingston [1] 94/4</p> <p>Kissinger [1] 54/2</p> <p>kitchen [1] 55/23</p> <p>knocking [3] 20/12 21/13 79/4</p> <p>know [107] 2/22 2/23 3/24 6/13 7/7 8/5 8/5 8/10 9/11 10/5 14/14 16/16 17/23 18/10 19/14 22/20 22/21 22/21 22/25 23/17 23/21 23/24 23/24 24/15 24/18 29/9 30/2 32/9 32/17 36/25 40/17 42/10 42/25 43/5 43/7 44/19 44/19 44/24 45/5 45/7 49/13 53/10 53/12 53/13 55/12 55/17 55/18 55/19 55/21 56/6 57/2 57/8 57/21 57/22 60/12 62/8 62/10 62/23 62/25 63/20 64/11 64/19 65/4 67/18 69/7 75/2 75/5 76/3 77/18 78/17 78/21 79/2 79/17 79/18 79/23 79/24 81/5 83/22 85/19 86/2 86/7 86/12 87/5 87/17 87/18 88/4 89/11 90/3 90/4 91/18 92/9 92/17 92/21 95/11 96/16 97/20 97/23 98/4 99/23 101/2 101/3 104/14 106/22 107/2 109/1 110/15 110/17</p> <p>knowing [2] 75/14 75/14</p> <p>knowledge [1] 23/6</p> <p>known [2] 9/24 23/15</p> <p>knows [4] 5/11 67/4 75/6 85/23</p> <p>Kyle [2] 113/3 113/11</p>
		<p>L</p> <p>labor [6] 91/11 91/20 91/21 92/5 95/22 96/13</p> <p>lady [1] 20/5</p> <p>laid [3] 58/22 59/16 59/17</p> <p>Lang [2] 91/7 103/21</p> <p>language [1] 13/23</p> <p>large [1] 96/8</p>

<p>L</p> <p>larger [1] 25/14</p> <p>Larry [4] 1/21 4/16 35/1 55/20</p> <p>last [15] 6/16 13/22 21/6 22/16 22/18 24/17 40/10 41/8 43/12 47/3 68/1 68/25 69/6 79/2 99/9</p> <p>last-dollar [1] 13/22</p> <p>late [1] 8/19</p> <p>later [4] 4/2 10/13 107/2 112/17</p> <p>latest [1] 40/11</p> <p>laundry [1] 21/4</p> <p>Lauzarone [2] 56/8 105/15</p> <p>law [18] 5/12 8/12 9/10 9/12 10/11 10/17 10/21 12/7 15/19 52/6 58/17 58/24 74/24 90/3 91/11 91/21 91/24 105/4</p> <p>laws [1] 92/1</p> <p>lawyer [1] 92/6</p> <p>lawyers [1] 91/20</p> <p>lay [1] 25/18</p> <p>lead [4] 52/1 54/14 64/4 100/5</p> <p>lead-in [1] 52/1</p> <p>lead-up [1] 100/5</p> <p>least [3] 25/21 84/21 102/5</p> <p>leave [6] 24/20 25/20 43/21 43/21 69/8 95/19</p> <p>leaving [1] 101/10</p> <p>led [2] 75/5 84/3</p> <p>Lee [4] 70/5 91/8 95/13 103/22</p> <p>Lefebvre [3] 1/15 4/14 18/7</p> <p>legal [3] 1/23 18/25 19/4</p> <p>legislation [1] 8/18</p> <p>less [1] 109/13</p> <p>let [3] 32/12 52/22 57/5</p> <p>Let's [2] 36/13 80/9</p> <p>letter [7] 16/10 16/25 31/24 56/12 56/25 98/10 98/11</p> <p>letters [5] 8/20 9/2 16/17 40/20 40/22</p> <p>level [8] 40/14 47/15 70/16 78/9 86/1 86/2 98/1 105/20</p> <p>levels [1] 22/22</p> <p>liabilities [13] 24/1 24/1 25/7 25/12 32/15 34/25 35/7 35/11 35/12 35/14 36/7 36/11 36/11</p> <p>liability [5] 23/3 35/14 35/20 35/23 36/4</p> <p>licensed [3] 59/22 59/24 60/5</p> <p>licensure [1] 52/6</p> <p>lie [1] 109/19</p> <p>lifetime [1] 97/25</p> <p>lights [1] 43/16</p> <p>like [33] 2/5 5/1 6/11 10/19 16/2 17/8 18/6 19/4 20/14 25/2 25/25 26/3 31/13 32/16 34/25 35/8 35/17 35/25 36/8 40/2 40/10 45/13 47/14 47/15 47/15 57/2 64/25 66/7 66/15 69/15 95/11 109/23 112/14</p> <p>likely [1] 109/14</p> <p>limited [4] 21/5 52/12 89/22 108/13</p> <p>lines [2] 12/18 41/16</p> <p>linking [1] 98/9</p> <p>liquid [1] 69/17</p> <p>liquidity [2] 69/1 69/3</p> <p>list [5] 21/3 21/4 65/15 65/16 104/9</p> <p>listed [4] 31/20 45/25 85/10 95/14</p> <p>lit [1] 99/8</p> <p>literally [3] 5/17 49/21 92/12</p> <p>little [18] 7/13 19/17 22/7 25/9 25/18 42/22 43/16 56/11 59/8 65/1 68/15 76/23 78/4 86/23 92/6 94/23 94/25 99/7</p> <p>Liz [1] 86/20</p> <p>load [2] 17/7 21/15</p> <p>loan [2] 65/9 65/10</p> <p>long [23] 25/24 25/25 29/1 29/8 52/21 53/5 54/1 54/3 54/22 58/7 65/17 66/9 75/12</p>	<p>77/23 78/1 78/5 78/7 78/18 80/3 80/21 100/17 106/18 108/1</p> <p>long-term [14] 25/24 25/25 54/1 54/3 54/22 58/7 65/17 66/9 77/23 78/1 78/5 78/7 78/18 80/21</p> <p>longer [5] 49/1 56/21 90/18 90/20 101/10</p> <p>look [25] 6/22 12/8 15/22 25/4 28/18 28/19 29/20 35/7 37/19 39/15 40/14 40/18 40/20 41/1 50/7 51/2 51/12 57/24 69/15 77/24 83/10 93/15 95/4 105/16 110/1</p> <p>looking [17] 14/10 39/3 46/6 48/13 48/17 48/25 61/24 62/11 66/10 67/23 70/23 76/18 78/7 94/2 96/15 98/13 99/25</p> <p>looks [1] 19/4</p> <p>Lora [11] 1/15 4/14 18/7 19/17 24/21 32/22 35/1 63/4 63/19 65/7 65/7</p> <p>Lord's [1] 79/5</p> <p>loss [2] 66/22 67/1</p> <p>losses [1] 68/8</p> <p>lot [27] 2/2 2/23 3/19 6/11 6/13 18/3 18/4 18/25 19/4 21/23 21/24 22/23 23/24 25/5 26/2 26/23 29/2 29/5 37/18 43/4 51/14 53/13 55/12 58/2 67/15 81/2 88/7</p> <p>love [1] 103/2</p> <p>lower [1] 14/19</p> <p>lowest [3] 13/16 32/19 62/19</p> <p>lunch [1] 20/4</p>	<p>mantra [1] 26/14</p> <p>many [17] 5/15 5/17 6/12 6/25 17/11 18/12 22/24 23/3 23/23 25/21 44/19 53/25 57/24 62/23 80/12 93/18 110/22</p> <p>map [1] 29/2</p> <p>Margaret [1] 98/20</p> <p>margin [1] 79/9</p> <p>Mark [1] 54/2</p> <p>marked [1] 3/18</p> <p>market [1] 64/16</p> <p>Mary's [1] 77/22</p> <p>Masset [1] 98/21</p> <p>match [1] 11/19</p> <p>matching [4] 46/15 46/16 46/18 47/16</p> <p>material [1] 90/7</p> <p>materiality [1] 90/5</p> <p>matter [4] 10/2 42/15 42/18 92/7</p> <p>may [46] 1/6 2/11 3/25 7/16 16/9 21/12 21/18 23/7 23/10 24/10 24/15 25/7 25/7 29/5 40/5 42/2 43/1 43/2 43/3 48/16 49/23 56/1 60/18 60/23 63/10 64/4 67/7 70/14 74/9 74/22 86/3 86/3 86/11 87/8 87/13 88/8 89/6 89/12 89/15 89/16 89/16 89/18 93/25 97/23 107/3 113/13</p> <p>maybe [8] 33/18 53/12 54/9 79/23 107/2 107/22 110/17 110/18</p> <p>McCarthy [1] 109/15</p> <p>me [14] 19/23 19/24 23/13 32/12 36/16 44/19 52/22 57/5 59/7 59/21 76/17 84/4 91/4 113/5</p> <p>mean [28] 15/17 17/6 18/10 21/12 28/23 44/11 49/13 53/9 55/10 60/19 67/19 68/15 68/25 74/12 77/18 78/4 78/16 79/15 81/2 81/4 84/12 85/23 88/19 89/8 97/20 97/23 110/21 111/25</p> <p>meaning [1] 85/10</p> <p>means [5] 45/10 68/21 90/16 98/3 101/5</p> <p>meant [1] 15/11</p> <p>meat [1] 16/21</p> <p>mechanism [5] 33/13 45/2 65/3 78/22 93/23</p> <p>mechanisms [1] 93/13</p> <p>Medicaid [1] 13/1</p> <p>medical [7] 20/25 45/19 68/14 80/4 93/21 108/2 109/16</p> <p>medically [1] 101/19</p> <p>Medicare [1] 13/1</p> <p>meet [16] 10/25 11/4 11/20 12/2 29/7 48/7 48/11 64/3 64/16 82/15 100/2 104/15 107/20 108/5 109/2 109/10</p> <p>meeting [4] 30/13 75/1 81/22 112/18</p> <p>meetings [5] 5/17 7/2 7/7 53/11 93/19</p> <p>member [3] 15/4 15/16 15/17</p> <p>Memorial [5] 70/5 91/8 95/13 98/22 103/22</p> <p>mention [3] 38/16 46/15 95/15</p> <p>mentioned [12] 13/5 22/9 30/6 34/22 40/5 40/9 44/10 52/3 63/21 65/17 65/22 66/12</p> <p>Mere [1] 68/23</p> <p>merger [6] 18/13 30/22 37/3 70/13 86/24 86/25</p> <p>mergers [3] 18/2 30/25 35/9</p> <p>merging [2] 20/23 66/16</p> <p>Mertens [1] 72/17</p> <p>met [2] 5/16 69/18</p> <p>method [1] 33/10</p> <p>methodology [1] 93/12</p> <p>microphones [2] 3/7 44/7</p> <p>Midtown [1] 72/18</p> <p>might [25] 10/6 18/23 19/15 21/14 30/22 31/1 32/9 32/18 35/18 44/13 49/5 54/5 54/10 55/4 68/21 84/24 85/8 85/13 99/13 99/24 101/11 101/22 109/20 109/21 110/4</p> <p>Mike [2] 77/21 88/24</p>
	<p>M</p> <p>made [13] 6/20 15/5 23/22 23/23 42/23 49/23 87/21 89/23 99/11 99/23 101/6 108/24 111/1</p> <p>Mahler [1] 68/13</p> <p>mails [1] 30/1</p> <p>main [3] 2/8 2/9 3/16</p> <p>maintenance [2] 111/12 112/8</p> <p>major [2] 19/13 31/18</p> <p>make [42] 3/16 5/9 5/22 6/5 13/14 14/18 15/12 15/21 29/2 29/14 30/6 31/2 31/5 31/24 32/24 33/12 33/15 37/5 38/23 39/9 41/5 42/18 55/24 56/1 62/10 69/22 71/22 73/19 74/13 77/6 78/19 85/3 90/23 99/8 102/19 103/6 104/11 105/8 106/6 107/12 107/14 112/6</p> <p>makes [4] 18/21 69/7 77/12 100/17</p> <p>making [5] 2/14 80/12 83/25 84/1 107/10</p> <p>malpractice [5] 24/1 36/7 36/11 72/5 72/11</p> <p>man [1] 29/25</p> <p>manage [1] 94/2</p> <p>manage-oriented [1] 94/2</p> <p>management [7] 1/10 1/21 4/13 4/15 4/17 5/2 6/20</p> <p>manager [1] 93/20</p> <p>Managing [2] 1/15 1/24</p> <p>mandate [55] 5/25 15/3 16/6 17/10 17/25 20/20 20/21 21/2 21/10 21/17 26/9 26/16 26/22 27/17 28/10 28/21 29/15 30/14 30/17 31/9 34/20 34/21 37/19 45/15 45/20 46/9 51/4 51/8 51/25 58/22 59/12 68/6 69/14 69/15 69/19 71/17 72/9 72/14 73/11 79/2 81/22 82/16 83/12 88/13 94/14 94/14 94/16 94/21 97/12 97/15 98/17 104/17 108/5 108/8 108/14</p> <p>mandated [2] 23/8 101/15</p> <p>mandates [22] 1/1 2/20 5/19 7/21 8/7 8/16 15/13 17/11 20/18 25/22 26/17 28/4 51/3 51/18 56/15 56/23 62/14 65/23 80/11 82/5 94/25 111/6</p> <p>mandatory [2] 8/25 78/19</p> <p>Manhattan [1] 76/7</p> <p>Manley [1] 58/19</p> <p>manner [4] 40/25 41/7 46/10 106/20</p> <p>Manor [1] 61/2</p>	

M	103/18 106/13 106/14 113/6 myself [3] 7/6 42/2 49/20	95/7 95/15 96/13 96/24 97/13 97/15 99/5 99/24 100/3 101/4 101/19 102/16 105/5 105/11 106/18 108/7 110/3 110/6 110/12 110/14 110/19
<p>milestones [5] 31/19 34/6 109/4 109/6 109/10</p> <p>million [3] 6/10 6/21 11/14</p> <p>mind [11] 3/24 12/12 13/4 21/20 27/8 27/11 28/20 41/25 62/8 73/4 106/15</p> <p>minds [1] 23/25</p> <p>minimum [3] 27/9 40/21 49/15</p> <p>minorities [1] 91/13</p> <p>minutes [3] 10/8 18/7 33/19</p> <p>mission [1] 29/12</p> <p>mix [1] 11/18</p> <p>mixed [1] 58/10</p> <p>modification [1] 42/14</p> <p>modifications [2] 42/19 90/10</p> <p>modified [2] 39/22 105/1</p> <p>modify [1] 90/6</p> <p>Mohammed [1] 68/23</p> <p>moment [1] 59/17</p> <p>monetize [1] 67/22</p> <p>money [35] 6/11 9/9 10/15 32/5 45/11 53/24 63/6 63/21 65/18 72/20 73/21 75/19 76/4 77/7 82/9 82/12 82/13 87/10 88/5 89/1 98/6 98/6 98/7 98/16 98/25 98/25 99/3 99/13 107/7 107/7 107/12 109/17 109/24 110/3 111/15</p> <p>moneys [8] 17/15 45/23 80/19 87/11 87/13 108/3 108/8 109/2</p> <p>monitor [1] 93/21</p> <p>monitored [1] 14/24</p> <p>monitoring [6] 33/8 33/9 33/13 33/17 33/20 93/10</p> <p>month [3] 67/10 67/10 77/4</p> <p>month-by-month [1] 67/10</p> <p>monthly [4] 33/24 34/1 34/2 34/4</p> <p>months [4] 74/21 77/16 99/23 102/5</p> <p>moon [1] 73/23</p> <p>more [41] 9/24 10/14 10/17 11/21 14/15 14/19 24/11 25/5 25/10 25/18 25/19 27/1 30/8 31/4 33/19 34/5 36/15 48/23 50/20 50/24 53/18 53/18 56/11 59/9 61/12 61/12 62/10 65/1 68/20 70/2 78/4 94/25 95/4 97/1 105/17 107/22 107/23 108/3 109/11 109/17 110/6</p> <p>most [12] 3/20 3/24 10/11 20/11 22/9 29/22 37/20 62/12 77/6 78/22 80/13 87/20</p> <p>mostly [1] 53/15</p> <p>Mount [1] 77/22</p> <p>move [11] 3/2 6/6 7/10 8/25 9/17 10/18 26/10 44/1 77/2 99/18 106/19</p> <p>moving [5] 44/7 55/3 55/4 76/19 96/11</p> <p>MQAC [1] 102/16</p> <p>Mr [1] 56/10</p> <p>Mr. [3] 65/13 75/2 87/5</p> <p>Mr. Benjamin [1] 87/5</p> <p>Mr. Clyne [2] 65/13 75/2</p> <p>MRI [1] 21/14</p> <p>MUA [1] 101/23</p> <p>much [15] 16/22 16/22 29/17 29/18 35/15 37/14 39/12 42/9 48/18 61/12 73/23 100/3 102/22 103/4 103/10</p> <p>multi [6] 48/17 62/24 63/3 63/13 63/14 110/22</p> <p>multi-year [6] 48/17 62/24 63/3 63/13 63/14 110/22</p> <p>multiple [3] 40/4 44/2 48/6</p> <p>Murphy [4] 51/15 56/10 95/9 107/6</p> <p>Museum [1] 1/5</p> <p>must [10] 9/3 15/1 20/19 21/9 45/15 91/19 91/24 97/10 98/3 109/2</p> <p>my [17] 7/9 30/4 54/20 60/12 71/25 72/18 81/8 83/14 87/19 89/21 97/7 98/20 101/11</p>	<p>N</p> <p>name [5] 15/23 30/4 43/19 52/24 98/20</p> <p>named [13] 51/22 52/23 52/25 59/9 59/14 81/23 82/16 82/22 88/21 88/21 88/22 97/10 109/22</p> <p>namely [1] 59/19</p> <p>names [1] 92/15</p> <p>narrative [2] 32/3 37/21</p> <p>narrow [3] 55/25 79/16 96/4</p> <p>narrowly [2] 53/18 53/18</p> <p>naturally [1] 72/11</p> <p>nature [10] 3/11 18/14 25/6 25/6 35/11 62/6 79/14 81/3 86/15 111/19</p> <p>necessarily [3] 25/8 53/17 63/9</p> <p>necessary [9] 23/19 26/24 39/13 41/9 41/18 63/12 104/6 106/6 108/7</p> <p>need [49] 2/3 3/8 3/25 6/14 10/3 10/10 18/17 21/14 28/22 29/4 29/9 29/13 37/14 39/16 41/1 42/1 44/4 45/24 46/1 46/4 46/12 47/9 47/24 50/5 50/15 54/10 57/7 61/5 64/6 68/5 69/21 73/17 78/10 78/16 84/23 84/25 86/5 86/11 88/8 89/12 89/15 89/18 91/16 92/3 107/21 110/2 110/4 110/16 112/19</p> <p>needed [5] 11/8 13/17 42/19 52/18 56/22</p> <p>needs [7] 10/25 29/7 48/11 48/12 53/13 68/9 76/16</p> <p>negate [1] 61/4</p> <p>negative [1] 96/16</p> <p>negotiate [2] 11/24 27/15</p> <p>negotiated [2] 28/1 74/6</p> <p>negotiation [2] 89/3 89/5</p> <p>Neil [16] 1/11 4/20 7/6 7/10 7/18 10/23 10/23 14/6 16/3 22/5 24/25 51/16 67/3 76/12 79/7 97/1</p> <p>Nelson [1] 1/4</p> <p>nervous [1] 19/24</p> <p>net [5] 13/16 23/1 23/18 32/19 67/1</p> <p>Network [1] 47/22</p> <p>new [29] 1/5 1/5 4/24 5/1 9/22 11/1 11/22 12/1 12/3 21/14 25/23 36/21 50/20 51/20 54/3 54/24 55/6 72/4 72/5 74/8 74/8 74/10 84/20 87/5 91/11 99/7 101/9 110/3 113/4</p> <p>next [14] 30/10 33/8 33/21 34/11 34/24 36/14 36/18 44/2 58/9 65/14 66/3 72/19 79/5 106/14</p> <p>Niagara [2] 68/24 77/22</p> <p>nice [1] 15/8</p> <p>no [26] 1/1 17/3 24/25 45/10 46/14 46/16 47/9 56/21 57/7 61/6 61/15 69/8 74/2 74/2 75/24 78/11 83/24 84/14 90/18 90/20 98/18 98/18 98/18 98/19 102/24 109/7</p> <p>nobody [1] 68/7</p> <p>non [2] 37/23 84/1</p> <p>non-closure [1] 37/23</p> <p>non-profit-making [1] 84/1</p> <p>nor [1] 7/15</p> <p>not [111] 2/11 3/13 5/24 7/14 12/17 13/5 13/6 14/1 15/20 15/23 17/25 21/5 21/16 23/6 25/7 25/21 26/25 27/17 30/8 31/24 31/25 32/11 33/3 35/13 37/3 38/24 38/25 39/23 41/4 45/1 45/16 48/4 50/25 51/22 53/12 54/6 55/22 56/12 56/24 57/9 57/11 57/18 58/4 58/11 58/23 60/20 60/20 63/8 64/18 65/15 65/22 66/10 66/23 67/7 68/12 69/5 70/7 70/14 71/4 71/13 72/24 75/12 75/13 75/14 76/15 78/1 78/13 79/4 79/23 80/17 83/19 84/5 84/9 84/14 84/17 85/20 85/20 85/25 89/16 91/5 91/20 91/21 92/5 92/23 93/8 93/24 94/5 94/11 94/12 94/12</p>	<p>not-for-profit [2] 83/19 84/5</p> <p>not-for-profits [1] 84/9</p> <p>Notary [1] 113/3</p> <p>Note [1] 21/5</p> <p>nothing [1] 34/21</p> <p>notify [1] 92/14</p> <p>now [41] 2/17 5/12 7/3 7/10 8/12 9/12 9/14 10/19 15/4 16/6 17/6 17/23 21/2 21/21 22/20 26/10 27/21 28/12 28/13 43/16 49/25 50/23 55/14 57/5 66/3 73/24 74/21 78/9 78/14 80/2 88/8 89/1 89/12 89/20 90/14 100/4 101/17 103/11 105/22 110/1 110/24</p> <p>null [1] 90/17</p> <p>number [19] 11/16 17/24 20/21 21/25 23/7 23/7 23/9 47/2 57/8 75/25 85/2 94/19 96/13 96/14 102/9 104/21 106/1 109/1 109/3</p> <p>numbers [1] 96/8</p> <p>nursing [3] 58/19 59/3 60/2</p> <p>O</p> <p>objectives [3] 31/16 31/20 34/11</p> <p>obligated [1] 68/16</p> <p>observation [1] 103/7</p> <p>obstacles [2] 93/18 93/24</p> <p>obviously [9] 8/4 8/8 27/21 37/2 87/2 99/18 102/2 110/1 110/2</p> <p>occur [3] 110/9 110/25 111/4</p> <p>October [5] 98/25 99/2 100/2 100/9 100/11</p> <p>October 1 [5] 98/25 99/2 100/2 100/9 100/11</p> <p>odds [1] 104/9</p> <p>off [2] 38/10 101/15</p> <p>office [8] 1/10 4/7 4/9 4/11 4/12 75/9 75/12 76/17</p> <p>offline [2] 102/21 103/3</p> <p>offs [1] 77/25</p> <p>offset [1] 94/9</p> <p>oh [4] 20/6 21/13 46/21 57/13</p> <p>OHSM [5] 4/20 16/25 31/22 98/10 98/11</p> <p>okay [30] 4/25 14/21 17/3 17/22 25/19 27/11 27/21 31/4 31/16 32/2 36/18 37/15 38/25 43/14 46/14 60/5 61/17 76/16 80/8 80/9 80/24 83/2 85/21 89/24 99/15 105/7 105/14 106/12 110/12 111/7</p> <p>older [1] 60/2</p> <p>on [111] 2/10 3/22 3/22 5/5 5/12 5/18 6/25 10/13 10/18 11/14 11/15 11/18 14/6 14/9 14/12 15/23 16/20 17/11 17/20 18/23 19/7 21/3 22/5 22/22 23/22 23/24 24/14 25/8 25/16 26/1 27/20 28/3 28/5 28/10 29/8 29/25 30/1 30/4 30/15 31/4 32/20 32/23 33/16 33/16 33/19 35/25 36/5 36/18 38/10 38/19 39/18 39/21 42/19 42/23 43/22 46/2 46/10 51/17 52/18 52/24 53/22 55/10 58/5 58/22 60/22 61/9 63/16 65/3 65/15 65/16 66/11 67/4 68/17 68/24 69/1 69/25 70/23 73/5 73/12 73/16 73/23 74/15 76/4 79/5 79/22 80/5 81/22 82/23 85/18 86/5 86/6 92/21 92/22 92/24 92/25 93/17 93/21 94/1 95/23 99/10 99/16 99/18 101/12 104/9 107/2 107/12 108/15 108/25 109/4 110/16 112/18</p> <p>once [3] 73/1 73/10 97/25</p> <p>once-in-a-lifetime [1] 97/25</p> <p>one [61] 8/3 8/4 9/17 12/10 12/19 13/7 17/3 17/23 18/21 21/6 23/13 24/6 25/10 25/19 29/9 30/8 31/4 38/16 42/22 43/25</p>

<p>one... [41] 44/6 45/14 46/21 47/5 50/20 50/23 50/24 51/22 52/24 53/17 55/5 55/14 57/6 58/19 59/18 61/4 63/2 63/3 63/9 63/22 65/22 67/17 70/12 73/4 75/17 75/20 79/16 79/17 80/7 84/21 85/2 86/18 101/12 101/12 101/13 101/16 101/17 103/6 106/1 107/23 111/13 one-on-one [1] 101/12 one-year [1] 63/2 onerous [1] 109/6 ones [3] 19/18 21/22 57/25 ongoing [3] 42/19 68/8 73/5 only [19] 41/9 45/2 45/23 45/24 46/10 46/12 52/12 57/9 58/4 59/2 59/9 60/17 63/2 66/10 87/23 89/22 96/25 97/1 97/8 onto [1] 44/2 open [4] 55/22 104/10 104/19 106/4 operated [1] 60/4 operating [8] 15/22 15/23 20/17 60/11 67/14 69/20 79/8 101/18 operational [1] 85/12 operations [1] 71/5 operator [4] 59/4 59/14 59/22 60/5 Oppenheimer [1] 104/8 opportunistically [1] 107/20 opportunities [3] 19/8 66/16 108/21 opportunity [19] 3/6 5/13 5/21 6/3 9/18 45/16 66/14 66/17 73/8 87/20 90/6 96/19 96/20 96/24 98/1 98/7 105/17 106/10 108/12 opposed [2] 60/1 99/15 options [1] 70/12 or [118] Orange [1] 45/19 order [3] 71/15 90/14 111/13 ordinarily [1] 40/3 organization [11] 43/20 72/4 72/12 81/9 81/11 81/12 82/15 82/16 82/22 104/11 108/5 organizational [1] 29/11 organizations [6] 31/12 44/15 72/10 81/15 82/25 93/18 oriented [2] 14/20 94/2 original [3] 31/22 32/1 89/18 originals [1] 38/18 Osborne [1] 88/24 OSC [1] 92/14 other [65] 3/10 7/17 10/18 13/11 18/24 19/14 22/14 23/13 23/23 25/16 25/16 26/24 27/4 29/25 30/1 31/17 32/11 32/17 32/17 33/4 34/8 34/10 34/25 36/23 37/12 38/6 38/11 38/24 43/3 43/11 45/3 46/9 49/12 50/7 50/13 50/13 51/12 52/9 53/15 56/5 59/5 59/11 60/19 61/5 62/17 66/12 76/6 79/3 79/14 82/4 82/23 86/2 86/13 87/10 87/12 87/13 89/6 91/3 92/22 97/10 97/21 105/6 107/25 108/21 112/15 others [3] 5/24 27/15 90/4 otherwise [3] 85/22 97/15 97/23 ought [2] 12/11 30/2 our [38] 2/14 3/12 3/16 5/1 5/5 5/21 9/15 13/15 13/18 13/21 13/22 23/6 27/10 41/24 43/14 45/20 48/11 49/7 53/14 54/12 58/17 63/16 64/3 64/10 71/5 71/13 71/14 76/19 87/20 92/25 98/2 98/3 98/6 98/6 98/7 100/17 110/8 111/13 ourselves [1] 4/4 out [45] 5/8 5/25 6/14 8/1 8/19 10/24 13/13 16/1 18/20 20/12 21/13 24/18 25/18 35/22 35/25 43/6 52/8 52/10 53/14 54/11 57/9 59/16 59/17 61/24 68/17 68/22 69/8 74/16</p>	<p>76/4 77/6 79/3 81/3 82/1 83/11 90/18 92/17 97/18 99/2 99/14 99/15 99/24 100/1 103/23 109/8 112/17 outcome [1] 68/12 outline [7] 16/7 16/13 16/21 16/24 32/15 48/18 61/13 outlining [1] 8/21 outpatient [1] 30/19 outreach [1] 31/6 outset [2] 13/5 63/21 outside [9] 2/7 19/6 26/25 37/6 41/12 44/15 44/22 55/1 108/16 over [10] 10/19 11/13 18/6 37/10 42/12 42/14 42/15 71/4 85/13 100/14 overall [2] 55/15 87/7 overload [1] 34/22 overnight [1] 110/23 oversight [1] 12/23 overview [2] 7/12 103/11 own [7] 2/20 32/7 47/17 76/19 91/17 93/1 95/23 owners [1] 91/13 ownership [1] 102/18</p>	<p>percent [7] 41/3 41/3 42/24 42/24 79/11 84/8 84/13 percentage [2] 79/9 94/19 perfect [1] 72/19 perhaps [6] 48/23 54/25 64/10 64/19 93/20 105/18 period [14] 11/13 34/4 34/12 34/12 48/9 66/24 68/5 73/17 100/23 100/24 102/7 102/14 111/4 111/21 permits [1] 44/4 perspective [2] 9/16 39/6 pertain [1] 17/9 pertaining [1] 15/14 pertains [1] 93/2 pertinence [1] 95/4 pertinent [5] 21/16 27/19 29/15 39/23 39/25 phase [14] 7/17 15/5 16/2 20/15 28/24 29/10 38/20 76/9 76/10 84/16 92/7 105/22 106/14 107/17 phenomenon [1] 67/6 philosophy [1] 14/15 phone [1] 29/25 phrase [1] 55/11 physical [3] 30/20 54/8 111/12 picked [1] 2/7 picture [4] 38/1 41/19 50/25 62/12 piece [7] 19/3 45/23 46/2 46/11 68/1 86/6 94/6 pieces [3] 10/18 79/14 87/25 pike [1] 87/14 pipeline [1] 110/24 place [9] 50/16 64/6 70/18 75/3 81/13 90/20 100/19 100/20 103/13 place-holder [1] 70/18 placed [2] 84/6 104/9 placement [2] 55/2 104/13 plan [42] 9/6 9/6 11/4 13/18 28/15 28/17 29/3 30/12 32/1 33/8 33/10 33/13 33/14 34/9 41/20 48/18 49/12 49/17 50/16 54/8 55/16 61/8 61/12 63/18 67/9 73/10 75/14 77/12 77/17 78/16 85/2 89/19 89/24 90/19 93/10 97/6 97/7 97/9 97/20 98/12 102/13 105/23 planning [9] 1/12 4/5 4/22 4/24 13/2 19/19 31/25 87/11 105/22 plans [14] 8/17 9/3 10/11 10/16 31/13 33/20 53/16 61/3 70/7 70/12 70/17 85/24 89/1 109/21 plant [1] 30/20 plants [1] 111/12 plausible [1] 53/4 Plaza [1] 1/4 please [4] 29/1 60/16 72/21 93/11 podium [2] 19/25 20/2 point [12] 13/4 58/14 65/19 70/8 70/24 73/4 76/15 84/15 86/14 87/10 87/12 99/6 pointed [2] 10/24 13/13 points [2] 3/16 12/4 policed [1] 49/23 policies [2] 35/19 66/6 policy [2] 1/15 14/16 pool [2] 88/5 110/7 portfolio [3] 1/21 4/15 4/16 portion [5] 33/17 37/21 45/25 46/7 46/9 portions [3] 89/12 89/13 108/20 pose [1] 43/18 posed [1] 3/16 position [6] 23/1 23/2 37/24 38/2 38/8 78/14 possibility [3] 70/8 70/15 70/19 possible [10] 22/20 23/5 39/10 39/11 48/4 62/19 67/13 67/14 67/15 90/15</p>
	<p>P p.m [1] 1/7 package [3] 62/10 64/24 64/25 Paden [2] 1/24 4/8 page [2] 14/13 67/5 pages [5] 21/3 28/25 30/8 30/9 92/11 paid [3] 76/4 99/2 111/18 paint [2] 62/12 112/10 panel [3] 5/5 32/10 43/13 papers [1] 77/14 paperwork [1] 38/22 paraphrase [1] 83/3 Pardon [1] 76/17 parent [1] 104/10 parents [1] 33/6 part [19] 5/21 10/12 17/17 28/14 28/16 43/14 63/19 64/24 72/6 74/15 85/7 85/14 85/15 85/16 85/17 92/22 92/25 99/3 104/16 participated [1] 7/17 particular [16] 2/24 3/23 7/5 12/8 15/14 42/16 45/20 60/4 60/6 69/13 71/16 79/19 93/2 100/25 108/10 111/10 particularly [4] 20/23 22/12 35/8 54/7 parties [2] 52/16 86/13 partner [4] 6/5 52/21 52/25 59/11 partners [5] 33/6 40/6 56/9 88/12 105/16 Partnership [2] 9/23 11/12 parts [8] 11/19 63/17 63/25 64/2 78/17 79/22 92/23 104/22 party [2] 12/14 53/6 past [2] 7/18 18/15 pathway [1] 75/4 patient [1] 56/2 patients [2] 14/21 111/13 Paul [1] 45/18 pay [5] 37/10 100/14 109/14 111/25 112/1 paying [4] 35/22 92/8 92/21 100/1 payment [2] 71/18 105/9 payments [1] 95/24 payroll [2] 35/14 69/22 pays [2] 99/14 99/15 Peninsula [1] 86/21 penniless [1] 69/8 penny [2] 69/6 99/9 pension [4] 23/25 36/6 36/10 95/15 people [8] 5/15 7/7 10/14 18/17 55/11 57/24 96/8 101/10 perceive [1] 104/18</p>	

<p>P</p> <p>possibles [1] 67/15 possibly [5] 37/15 67/21 81/15 103/4 106/25 post [3] 105/17 106/3 106/5 post-submission [3] 105/17 106/3 106/5 postponement [1] 103/9 pot [1] 99/12 potential [4] 32/18 95/24 101/25 108/4 potentially [5] 11/13 12/25 88/4 88/5 88/6 practical [3] 26/21 28/9 92/7 practically [2] 61/20 110/25 pragmatic [1] 74/3 precise [1] 68/20 predecessor [1] 72/12 preliminary [3] 61/3 61/8 87/2 premature [1] 78/25 premise [1] 41/7 prepared [1] 12/15 preparing [1] 54/24 Presbyterian [2] 84/20 101/9 present [2] 3/12 35/21 presentation [4] 2/25 7/9 27/9 43/14 presentations [1] 3/17 presented [2] 49/22 79/22 presenting [1] 108/4 presume [1] 106/1 pretty [8] 32/15 35/7 35/15 37/25 39/20 42/9 58/20 81/4 prevailing [3] 92/8 92/10 92/19 prevents [1] 80/15 preview [1] 2/5 previous [5] 6/20 19/18 19/18 90/6 90/10 previously [2] 89/4 89/17 primary [4] 6/3 26/3 58/5 66/8 principally [1] 95/5 principle [4] 39/6 41/8 47/1 69/7 principles [8] 11/6 14/12 14/15 22/10 22/18 26/7 27/8 39/2 prior [7] 38/2 38/3 38/17 89/23 100/9 100/24 110/9 pro [1] 90/19 probability [1] 108/19 probably [17] 17/1 18/10 23/24 26/25 42/3 53/10 62/8 64/17 64/18 69/16 74/16 90/13 91/8 92/9 97/25 102/6 108/23 problem [1] 110/18 problems [2] 34/9 93/24 procedural [2] 43/17 99/22 procedure [3] 2/15 102/4 103/8 proceeding [1] 4/3 proceedings [1] 29/10 process [32] 2/15 7/4 9/25 12/24 13/6 13/15 13/19 13/24 19/1 24/8 27/13 27/14 34/1 41/12 42/13 49/1 56/3 62/1 69/25 74/4 75/3 76/1 76/19 77/3 77/4 83/17 89/3 91/12 91/14 101/5 106/23 107/17 processed [2] 16/15 75/22 processes [1] 74/13 processing [1] 77/14 procurement [9] 1/18 7/16 7/18 23/14 27/14 45/1 60/17 84/16 90/2 procurements [2] 19/19 28/18 product [2] 68/9 102/15 profit [7] 13/24 23/22 83/18 83/19 83/25 84/1 84/5 profit-making [1] 83/25 profits [2] 84/9 84/13 program [5] 1/15 13/3 28/14 55/8 99/21 programmatically [1] 13/11 programs [6] 45/4 54/21 54/22 55/7 60/19 60/21</p>	<p>progress [1] 33/12 progressively [1] 109/11 prohibit [1] 42/13 prohibited [1] 110/15 project [42] 11/2 11/20 34/7 34/12 34/14 34/16 34/17 34/20 34/23 36/24 36/25 37/7 37/9 37/11 37/19 40/23 42/16 43/9 46/3 47/4 47/8 48/11 48/14 48/15 48/20 48/24 49/5 50/14 50/17 52/14 62/13 63/13 64/2 73/18 76/11 79/16 79/19 93/3 93/16 93/19 100/25 105/21 projected [1] 50/5 projects [11] 33/23 37/23 41/2 41/6 62/23 62/24 63/7 63/22 64/1 95/6 110/21 property [2] 35/24 36/2 proportion [1] 67/7 proposal [6] 10/6 28/8 79/15 90/17 108/6 108/15 proposals [2] 46/22 47/6 propose [2] 26/20 27/6 proposed [5] 33/2 43/3 65/19 70/1 70/2 proposing [2] 27/18 46/4 provide [7] 8/14 38/11 39/12 53/1 70/16 71/15 103/10 provided [6] 11/11 51/20 63/24 71/4 71/13 71/17 provider [2] 101/25 102/17 providers [3] 6/12 97/21 97/22 providing [4] 32/13 45/4 52/12 82/14 provisions [5] 23/15 91/18 91/22 91/22 92/1 public [11] 6/7 13/17 14/2 15/19 27/10 47/3 47/9 52/6 58/17 58/24 113/4 public's [1] 83/11 publish [1] 3/14 purchase [1] 72/13 purely [1] 88/6 purpose [6] 8/13 62/7 69/10 80/20 82/13 112/3 purposes [4] 2/13 7/12 7/20 99/4 pursued [1] 45/6 push [1] 66/7 put [14] 5/20 52/23 55/23 62/3 70/3 94/8 99/5 100/19 100/20 103/14 108/14 109/12 112/10 112/17 putting [4] 7/25 16/21 47/17 53/22</p>	<p>quo [1] 90/19 quote [4] 24/5 28/25 51/20 51/21 quoting [1] 9/13</p> <p>R</p> <p>raise [1] 44/8 raised [1] 60/12 ranging [1] 24/9 rapidly [1] 105/25 rather [2] 17/25 107/1 ratio [1] 40/25 rationale [1] 26/12 ratios [2] 77/24 78/8 reach [1] 74/16 reaching [2] 24/18 56/20 read [1] 29/3 readdress [1] 89/4 reading [4] 2/12 8/6 8/9 29/14 ready [2] 58/9 92/13 real [10] 18/10 33/5 33/22 35/24 36/2 65/2 71/23 74/3 74/3 74/16 realistic [1] 74/23 realize [4] 13/24 17/10 23/19 101/10 really [37] 5/7 6/2 6/8 6/21 8/14 9/9 23/22 29/9 29/13 29/22 30/8 31/17 32/11 32/16 35/4 36/19 37/3 42/25 47/9 55/10 55/13 55/15 61/11 62/4 69/23 78/25 90/8 102/1 102/21 102/24 102/25 106/6 107/11 109/7 109/17 109/19 110/6 reappropriate [1] 11/7 reappropriated [1] 11/7 reason [1] 91/17 reasonable [14] 5/10 21/7 27/2 45/9 47/11 54/17 55/19 62/15 67/6 71/22 86/8 104/4 104/6 108/22 reasonableness [4] 10/15 34/18 40/24 106/8 reasonably [1] 60/24 reasons [1] 107/22 recall [1] 48/13 receipt [1] 29/23 receive [6] 11/8 15/18 56/12 59/2 74/25 106/2 received [2] 56/24 89/1 receives [1] 105/13 receiving [2] 88/20 106/4 receptive [1] 21/8 recipient [1] 53/24 recognition [1] 66/4 recognize [4] 2/18 18/3 22/24 70/12 recognized [1] 66/25 recommendation [17] 8/24 25/22 43/6 49/24 50/2 50/20 53/9 63/19 78/19 79/17 84/22 86/22 88/21 88/23 98/5 104/25 105/2 recommendations [23] 5/9 6/6 6/8 6/22 8/12 9/1 9/7 9/13 9/15 9/16 9/20 16/12 17/24 18/1 20/22 58/3 60/25 81/1 81/3 87/7 98/4 103/2 106/17 recommendee [5] 52/8 53/23 60/4 86/11 97/17 recommendee's [1] 8/21 recommendees [4] 45/7 52/17 87/24 97/22 reconcile [1] 48/4 reconfiguration [2] 47/25 112/13 reconfigurations [1] 63/1 reconfigured [1] 104/3 reconstruction [1] 112/13 record [1] 113/5 recorded [2] 33/9 99/16 reduce [4] 38/22 66/23 67/13 82/10 reduced [1] 67/7 reduces [1] 6/7</p>
	<p>Q</p> <p>qualifications [1] 4/1 qualified [1] 92/4 qualify [4] 45/7 64/15 102/11 112/12 quantify [1] 67/11 quarter [1] 34/13 quarterly [2] 33/24 34/5 Queens [1] 86/21 question [58] 3/4 3/8 20/7 42/15 43/18 43/25 44/2 44/8 44/20 53/11 54/15 54/20 56/10 57/6 58/13 58/14 59/8 60/15 63/3 63/4 64/9 64/12 64/13 66/24 68/24 69/23 71/2 71/10 72/9 80/5 80/7 82/8 82/9 83/3 83/14 83/23 84/12 85/15 85/19 89/17 91/5 93/8 95/8 95/10 97/8 99/20 99/24 100/5 101/3 101/11 101/13 102/7 102/19 103/23 106/13 106/14 110/5 111/9 questioner [1] 43/25 questioning [1] 51/14 questions [18] 2/22 2/23 3/4 3/6 3/15 6/25 38/24 42/12 43/15 43/18 44/3 62/22 69/24 80/4 91/3 107/25 112/15 112/17 quick [1] 106/20 quickly [3] 2/18 3/3 99/18 quid [1] 90/19 quite [4] 6/22 49/19 51/13 65/3</p>	

<p>R</p> <p>reducing [2] 94/7 95/1 reduction [2] 78/6 78/18 reductions [3] 25/24 94/9 95/5 Reed [6] 1/13 4/18 7/11 10/7 10/19 27/9 reference [1] 112/6 referenced [2] 13/12 91/11 referred [2] 14/12 17/8 referring [1] 84/8 refinance [1] 63/7 reflect [1] 100/23 reflected [3] 12/5 13/9 48/8 Reform [2] 9/23 11/11 refurbishing [1] 111/12 regard [6] 35/8 35/9 35/14 71/2 97/2 110/20 regarding [4] 65/13 77/23 91/22 108/9 Regional [1] 45/19 regionally [1] 108/7 regulations [1] 86/4 regulatory [1] 77/2 reiterate [2] 26/14 30/10 rejected [2] 108/19 108/20 relate [4] 16/5 49/6 55/19 94/15 related [37] 10/21 18/18 19/11 20/20 21/10 26/8 27/2 28/20 33/4 33/5 34/20 36/15 40/6 46/13 46/25 47/6 47/7 49/24 52/5 56/4 56/10 57/12 60/24 67/20 80/8 81/18 82/1 82/2 82/15 82/25 83/5 83/6 83/16 85/9 103/7 104/1 111/21 relates [3] 36/19 83/15 89/13 relating [2] 58/25 79/6 relationship [3] 19/3 52/15 81/11 relationships [1] 53/21 relative [2] 45/4 76/23 release [1] 94/21 relevant [2] 32/9 37/3 relief [1] 56/18 relieve [1] 80/20 relieving [2] 81/13 82/13 relocation [1] 20/22 remaining [4] 34/12 37/21 96/10 104/10 remains [1] 53/8 remember [1] 61/12 remind [1] 57/7 renegotiation [1] 104/1 renewable [1] 63/11 renovation [1] 20/16 Renovations [1] 20/12 repaid [1] 104/14 repeating [2] 42/2 42/3 repetitive [1] 35/4 reply [1] 65/21 report [26] 5/12 5/14 6/14 6/23 8/9 13/10 13/13 14/11 14/11 14/13 15/3 17/12 22/17 34/1 34/2 34/13 34/15 54/19 56/17 58/3 58/21 88/14 101/14 104/22 109/4 109/23 Reporter [1] 113/3 reporting [2] 33/21 34/11 reports [2] 33/25 34/5 represented [1] 15/11 representing [3] 47/22 61/2 98/21 request [10] 7/13 10/25 26/18 39/4 42/8 48/20 49/7 49/25 59/10 84/16 requested [1] 24/4 requesting [3] 45/22 46/6 103/9 requests [2] 62/18 85/17 require [8] 48/1 48/16 55/2 71/14 74/9 84/24 85/13 86/3 required [9] 8/17 12/2 12/7 13/14 34/6 71/17 85/7 85/22 94/7 requirement [5] 15/6 41/4 46/17 85/4</p>	<p>104/15 requirements [3] 14/5 33/21 108/17 requires [2] 62/2 92/8 requiring [5] 33/24 34/1 38/2 38/18 71/5 reserved [1] 70/19 reshaping [1] 54/2 resources [5] 32/2 43/11 47/18 69/10 107/19 respect [5] 32/25 39/4 51/4 73/9 95/23 response [5] 9/4 9/8 61/2 63/12 93/23 responses [1] 3/21 responsibility [2] 6/19 29/23 responsible [1] 53/7 rest [1] 49/14 restricted [1] 53/19 restrictions [2] 10/20 107/8 restrictive [1] 107/24 restructure [1] 66/13 restructuring [10] 20/14 28/19 37/4 41/23 55/6 66/10 80/13 95/25 96/17 108/22 result [5] 58/1 68/8 95/25 96/9 96/16 results [1] 3/14 Rethink [1] 27/1 retire [1] 83/5 retirement [3] 34/25 72/11 93/5 retiring [2] 81/18 82/3 retrain [1] 45/16 retraining [12] 44/25 45/5 45/14 54/15 54/17 56/5 57/6 57/10 57/12 60/15 60/18 60/23 retreat [1] 29/12 revenue [2] 66/22 67/1 revenues [3] 34/14 67/8 68/5 review [10] 13/19 24/8 29/3 47/5 73/4 74/7 74/11 74/19 106/19 106/25 reviewed [3] 12/16 97/5 104/23 reviewers [2] 38/23 73/3 reviewing [3] 23/5 72/23 73/1 reviews [2] 27/4 42/1 revised [1] 105/18 RFA [24] 1/1 2/10 7/12 8/7 8/14 9/4 9/8 12/6 12/9 21/3 25/5 26/11 30/5 38/10 45/1 48/13 61/4 61/9 62/2 70/16 94/12 95/16 95/20 103/8 RFP [2] 54/11 87/17 RFPs [1] 10/4 RGA [3] 5/8 8/13 33/8 Rich [2] 56/8 105/15 right [26] 16/1 17/1 26/10 28/2 28/6 28/10 34/24 38/25 54/4 64/6 65/7 66/3 73/24 75/8 76/12 78/14 79/11 80/2 85/20 85/21 87/17 88/20 95/8 101/17 106/9 110/24 right-sizing [1] 54/4 Rinaldi [1] 62/21 risk [3] 88/3 107/1 109/25 risks [2] 19/8 88/4 road [2] 23/20 29/2 Robert [3] 1/13 1/19 1/22 Rockefeller [1] 1/4 Rodat [2] 58/12 111/8 role [1] 56/15 rolling [1] 106/22 room [1] 85/23 rooms [2] 20/13 112/11 round [7] 51/23 58/10 65/14 65/17 66/3 66/18 70/9 routine [1] 112/8 rules [2] 86/4 90/3 run [3] 88/3 88/3 107/1 running [1] 88/5 runs [1] 92/11</p>	<p>said [25] 6/15 9/9 14/9 14/22 16/3 16/3 20/5 22/23 23/20 27/9 28/13 46/25 48/5 53/7 53/10 54/18 55/18 55/21 55/22 58/6 60/10 60/16 63/14 65/13 67/3 73/16 75/21 75/24 79/15 87/5 93/1 94/18 97/24 99/17 112/16 sailor [1] 29/8 sale [1] 23/12 same [12] 15/6 15/12 26/6 31/17 37/14 39/12 40/25 67/5 67/7 69/9 83/20 113/6 satisfy [1] 33/2 say [25] 3/13 3/18 22/13 32/12 60/13 64/17 67/4 68/7 71/11 74/19 75/16 76/25 77/12 77/25 78/8 79/13 84/24 86/7 87/16 87/18 94/11 94/14 96/3 108/6 110/1 saying [10] 52/22 54/6 69/3 74/23 76/24 77/3 77/17 81/17 98/22 99/12 says [3] 21/5 79/10 97/4 scale [1] 96/7 scales [1] 92/19 Scarpino [1] 94/3 scenario [1] 88/2 schedule [8] 33/16 39/15 41/22 45/19 62/3 92/9 94/1 95/13 schedules [10] 38/13 41/10 41/17 45/24 46/11 46/12 46/13 48/9 62/5 62/7 Schenectady [1] 93/10 Schmidt [3] 1/19 4/23 29/20 scope [6] 46/3 48/19 49/10 62/13 96/7 106/8 scratching [1] 69/6 seats [1] 2/2 second [5] 44/20 81/12 85/7 85/15 86/6 secondly [1] 87/4 section [7] 12/9 21/4 22/16 22/17 30/10 93/11 98/9 sections [4] 26/11 30/11 37/22 97/11 secure [4] 63/6 65/9 77/7 80/16 secured [1] 32/6 security [2] 64/18 65/3 see [27] 2/8 5/20 7/20 19/15 21/3 25/2 32/17 36/8 36/13 36/19 37/14 39/15 40/2 41/3 50/10 50/15 55/12 57/5 66/22 67/18 68/11 72/20 78/16 83/10 101/10 106/7 110/24 seeing [1] 55/17 seek [1] 49/5 seeking [3] 14/18 49/17 97/17 seemed [1] 45/20 seems [2] 6/11 108/2 seen [6] 18/15 18/18 19/5 19/11 19/13 75/18 segue [1] 8/2 self [6] 8/2 22/19 71/3 71/6 95/18 100/7 self-explanatory [1] 8/2 self-fund [3] 22/19 95/18 100/7 self-insurance [2] 71/3 71/6 Seminaro [1] 83/13 send [2] 8/19 38/23 sense [9] 18/22 36/3 37/6 69/8 77/6 77/12 96/4 96/23 102/19 sent [3] 16/7 31/23 73/3 separate [10] 10/3 65/18 65/20 66/2 75/25 86/25 87/8 90/2 90/2 96/18 separated [1] 53/14 September [7] 16/16 17/17 17/20 48/3 48/7 68/16 111/5 September 30 [4] 16/16 17/20 68/16 111/5 sequential [1] 31/21 series [1] 8/22 seriously [2] 57/7 102/23 serve [1] 62/6 served [1] 101/20</p>
	<p>S</p> <p>safety [1] 56/2</p>	

<p>S</p> <p>service [12] 31/13 56/20 57/17 64/6 71/4 71/12 71/16 71/16 78/8 78/22 108/6 108/10</p> <p>services [23] 1/17 13/1 20/24 22/15 25/23 30/20 31/1 31/3 50/21 51/19 53/2 54/10 55/2 55/6 56/20 58/23 58/25 59/5 72/5 88/25 89/15 89/19 93/21</p> <p>session [3] 3/5 20/8 43/24</p> <p>set [8] 2/21 7/7 12/3 47/14 47/15 92/25 103/17 107/3</p> <p>sets [3] 10/24 19/7 24/4</p> <p>several [6] 15/6 51/18 79/1 87/24 88/3 102/5</p> <p>severance [2] 35/19 95/14</p> <p>shall [3] 9/14 22/19 98/3</p> <p>sheet [3] 67/18 69/2 69/6</p> <p>sheets [2] 22/24 24/15</p> <p>shell [1] 53/3</p> <p>SHFP [1] 84/14</p> <p>shifting [1] 53/20</p> <p>ship [1] 29/8</p> <p>ship-wrecked [1] 29/8</p> <p>shop [1] 54/12</p> <p>Shore [1] 49/4</p> <p>short [6] 30/4 47/10 47/11 54/22 91/15 106/3</p> <p>Short-term [1] 54/22</p> <p>shortened [1] 62/5</p> <p>shortfall [1] 42/7</p> <p>Shorthand [1] 113/3</p> <p>shot [2] 41/13 41/24</p> <p>should [20] 2/6 26/18 34/17 34/19 39/19 45/1 45/5 45/10 57/25 61/19 64/23 64/23 69/2 69/3 69/11 93/1 94/12 94/12 102/17 106/5</p> <p>shouldn't [1] 75/5</p> <p>show [7] 17/16 25/7 26/7 37/9 42/6 68/12 98/17</p> <p>SHRP [28] 9/24 10/22 11/22 17/18 36/24 46/4 50/9 50/15 57/20 63/6 64/14 67/25 80/19 82/13 83/4 83/21 96/20 99/9 107/7 108/3 108/8 108/13 108/21 109/1 109/8 109/18 110/6 110/11</p> <p>side [3] 24/23 26/2 35/23</p> <p>sign [3] 12/1 12/9 38/10</p> <p>signed [2] 38/18 74/6</p> <p>significant [8] 5/16 12/18 12/23 17/14 48/12 96/6 111/3 112/12</p> <p>significantly [1] 96/10</p> <p>similar [4] 28/19 37/8 39/16 41/23</p> <p>Similarly [1] 41/23</p> <p>simple [2] 39/10 42/9</p> <p>simply [1] 45/16</p> <p>since [4] 12/18 24/21 95/17 103/23</p> <p>single [3] 63/9 63/10 99/9</p> <p>single-year [1] 63/9</p> <p>sink [1] 55/23</p> <p>sir [1] 20/6</p> <p>situation [6] 39/7 41/5 51/2 52/7 60/6 88/6</p> <p>six [3] 38/19 62/24 77/16</p> <p>sizing [1] 54/4</p> <p>skip [1] 17/3</p> <p>slide [3] 25/14 36/14 36/18</p> <p>slides [1] 25/17</p> <p>slightly [1] 39/22</p> <p>slow [1] 21/17</p> <p>small [1] 88/5</p> <p>so [137]</p> <p>soften [1] 22/2</p> <p>solicitation [1] 108/11</p> <p>solvent [1] 71/7</p>	<p>some [4] 2/11 4/1 5/22 6/1 6/17 6/18 6/19 7/7 9/19 10/20 13/25 14/2 14/4 14/8 14/23 14/24 15/4 16/6 16/9 16/10 16/14 16/15 16/17 17/12 18/8 18/14 21/13 22/2 22/3 24/22 25/13 25/14 25/16 27/4 28/17 28/19 28/24 30/25 31/11 36/21 38/11 39/2 39/23 39/24 40/14 46/9 46/23 50/7 50/13 51/11 52/14 54/5 54/9 57/16 59/5 62/7 63/22 67/18 69/21 69/21 70/12 74/9 76/25 79/9 81/13 82/14 85/11 86/12 96/20 96/22 105/1 107/22 108/8 109/5</p> <p>some of [1] 96/20</p> <p>somebody [2] 59/6 65/21</p> <p>someone [3] 24/6 65/16 96/21</p> <p>something [25] 10/1 10/9 17/7 21/11 26/21 26/23 27/1 27/6 27/12 27/16 31/25 41/11 47/10 54/8 65/13 66/2 77/18 78/24 80/1 81/15 90/25 91/23 92/3 102/11 107/15</p> <p>sometimes [2] 18/16 18/21</p> <p>soon [1] 17/12</p> <p>sooner [2] 27/23 27/24</p> <p>sorry [5] 8/14 57/13 61/23 74/17 100/5</p> <p>sort [4] 11/18 48/24 56/1 103/7</p> <p>sorts [2] 58/25 94/1</p> <p>sought [1] 97/13</p> <p>sound [4] 27/7 29/8 49/4 63/18</p> <p>source [9] 40/14 40/15 42/17 45/11 46/19 48/10 50/6 50/13 50/13</p> <p>sources [17] 32/4 32/5 32/6 32/7 32/7 32/10 32/11 32/18 40/4 43/4 47/10 48/6 51/6 62/16 62/17 70/17 106/9</p> <p>space [1] 20/13</p> <p>speak [5] 15/20 28/1 52/15 52/21 93/23</p> <p>speaking [3] 10/17 16/4 110/25</p> <p>specific [14] 7/1 32/24 48/11 51/2 60/25 68/6 71/24 72/21 94/25 101/13 102/8 103/1 105/1 109/17</p> <p>specifically [3] 41/11 107/16 110/20</p> <p>specified [3] 82/2 82/5 108/7</p> <p>speculate [1] 78/25</p> <p>speechless [1] 89/8</p> <p>spend [4] 33/19 77/7 98/23 109/24</p> <p>spending [2] 109/17 110/25</p> <p>spent [1] 103/16</p> <p>spin [1] 101/15</p> <p>spoke [1] 97/6</p> <p>sponsor [2] 51/21 51/21</p> <p>sponsorship [2] 51/20 104/19</p> <p>spots [1] 93/17</p> <p>spread [1] 107/21</p> <p>Spring [1] 83/14</p> <p>St [2] 72/17 77/22</p> <p>stable [1] 107/1</p> <p>staff [10] 5/6 7/25 29/11 45/17 94/8 94/9 94/19 94/21 95/18 104/23</p> <p>stage [1] 103/17</p> <p>stamp [1] 3/19</p> <p>stand [1] 20/1</p> <p>standard [6] 12/10 13/8 13/8 13/11 13/12 68/18</p> <p>standards [3] 11/4 12/3 12/16</p> <p>standing [1] 19/24</p> <p>standpoint [1] 56/22</p> <p>start [5] 14/12 31/18 43/17 72/22 98/22</p> <p>started [3] 2/3 4/25 17/11</p> <p>state [46] 1/4 1/5 6/4 6/15 9/23 10/21 11/11 12/2 12/3 12/20 12/25 13/25 14/1 14/17 23/21 23/22 32/19 41/8 47/3 48/6 51/11 63/24 70/20 73/17 74/7 74/10 74/13 74/19 75/9 75/10 77/8 90/3 91/11 92/11 95/22 96/14 98/25 99/7 100/10 100/12 107/11 107/13 109/2 109/25 110/4 113/4</p> <p>stated [2] 54/16 88/14</p>	<p>statement [2] 38/5 99/11</p> <p>statements [11] 3/10 19/8 24/5 24/14 25/4 25/9 38/3 38/4 40/10 40/11 40/18</p> <p>states [1] 56/17</p> <p>status [4] 34/8 36/9 42/15 52/6</p> <p>statute [4] 9/14 9/22 85/19 91/19</p> <p>statutorily [1] 74/10</p> <p>stay [2] 3/9 33/16</p> <p>stenographer [1] 43/22</p> <p>step [1] 6/4</p> <p>steps [3] 5/16 5/18 67/12</p> <p>still [9] 45/7 48/12 55/24 64/1 76/16 85/8 86/4 88/12 110/19</p> <p>straight [3] 39/20 43/8 85/24</p> <p>straw [1] 30/4</p> <p>stray [1] 109/13</p> <p>streams [1] 14/4</p> <p>stretched [1] 50/21</p> <p>strictly [1] 11/2</p> <p>structure [1] 30/21</p> <p>structured [1] 59/1</p> <p>stuck [1] 110/23</p> <p>study [2] 87/3 87/11</p> <p>stuff [3] 20/10 28/17 36/21</p> <p>sub [2] 31/20 86/12</p> <p>sub-objectives [1] 31/20</p> <p>subject [7] 8/24 15/2 33/3 53/8 74/6 81/19 85/25</p> <p>subjected [1] 51/13</p> <p>subjects [1] 2/8</p> <p>submission [5] 97/19 105/17 106/3 106/5 107/11</p> <p>submit [11] 12/14 27/16 40/3 45/24 46/1 49/25 61/4 72/18 105/17 106/6 108/16</p> <p>submittable [1] 71/8</p> <p>submitted [9] 15/8 49/6 49/22 49/24 50/4 50/22 51/5 85/23 102/14</p> <p>submitting [1] 2/15</p> <p>subsequent [4] 54/4 57/20 58/4 105/21</p> <p>substantial [1] 80/14</p> <p>substitute [1] 51/11</p> <p>successful [1] 5/22</p> <p>successfully [1] 11/24</p> <p>such [9] 13/23 15/9 15/10 21/6 23/11 23/25 51/21 57/2 95/14</p> <p>suddenly [1] 50/24</p> <p>Sue [1] 109/15</p> <p>sufficient [1] 47/7</p> <p>Suffolk [2] 47/22 47/23</p> <p>suggest [1] 21/8</p> <p>suggestion [1] 70/15</p> <p>Sulik [1] 86/21</p> <p>summaries [1] 28/25</p> <p>summary [5] 28/23 28/23 30/7 30/9 70/16</p> <p>summer [1] 102/6</p> <p>SUNY [1] 65/12</p> <p>supplement [3] 41/17 65/10 101/3</p> <p>support [10] 1/17 26/6 40/19 45/15 47/23 49/8 50/1 55/2 63/22 64/11</p> <p>supporting [1] 37/13</p> <p>supposed [1] 103/10</p> <p>sure [16] 15/21 30/7 31/5 31/24 32/24 33/12 33/15 39/8 41/5 55/24 56/2 71/23 80/17 85/3 99/8 109/21</p> <p>surface [1] 86/12</p> <p>surrounded [1] 57/22</p> <p>surrounding [1] 57/24</p> <p>Susko [1] 93/9</p> <p>suspect [1] 37/8</p> <p>suspended [1] 60/20</p> <p>system [6] 14/19 15/10 49/4 51/10 54/3 96/1</p> <p>Systems [3] 1/10 4/13 5/2</p>
--	--	---

<p>T</p> <p>table [2] 91/20 108/15</p> <p>tack [1] 32/23</p> <p>tail [1] 72/13</p> <p>take [20] 2/2 6/19 12/8 12/11 21/11 26/23 29/20 40/25 50/7 51/1 51/12 60/17 73/8 77/1 80/9 81/13 83/10 102/4 103/13 106/13</p> <p>taken [7] 5/15 5/18 41/13 41/23 46/8 91/19 113/5</p> <p>taker [1] 101/16</p> <p>taking [4] 67/9 67/12 71/4 85/13</p> <p>talk [15] 2/12 7/11 10/7 10/20 14/25 18/7 24/7 30/16 32/10 42/25 54/23 68/14 80/12 82/12 89/3</p> <p>talked [3] 6/24 43/10 75/11</p> <p>talking [9] 6/2 33/3 36/6 54/23 58/8 62/1 74/20 82/19 98/23</p> <p>talks [1] 63/19</p> <p>tap [1] 32/18</p> <p>tapped [1] 62/18</p> <p>target [1] 28/10</p> <p>targeted [1] 8/10</p> <p>tasks [1] 31/16</p> <p>taught [1] 23/13</p> <p>tax [1] 63/6</p> <p>tax-exempt [1] 63/6</p> <p>team [3] 1/20 93/19 101/12</p> <p>technical [2] 97/3 97/5</p> <p>tell [2] 3/25 71/22</p> <p>ten [1] 28/25</p> <p>tend [2] 107/19 107/19</p> <p>term [18] 25/24 25/25 51/10 54/1 54/3 54/22 54/22 58/7 65/17 66/9 68/20 77/23 78/1 78/5 78/7 78/18 80/21 103/14</p> <p>terms [23] 7/25 9/19 10/7 14/3 22/10 43/11 44/22 49/7 52/4 53/13 53/19 63/23 74/4 74/4 81/12 83/19 92/1 96/7 97/21 97/21 99/5 109/9 109/20</p> <p>terribly [1] 70/23</p> <p>Terry [2] 91/7 103/21</p> <p>tests [1] 109/9</p> <p>than [12] 7/14 10/14 11/22 22/23 30/8 50/20 50/24 81/5 94/25 105/6 107/1 109/18</p> <p>thank [19] 5/5 7/22 7/23 22/8 42/21 47/20 49/2 60/8 62/20 66/19 70/25 77/20 86/17 88/10 91/2 103/5 103/19 105/14 112/20</p> <p>thanks [8] 5/4 10/23 30/3 32/22 33/7 36/13 37/16 84/18</p> <p>that [620]</p> <p>that's [63] 7/9 10/1 13/11 13/18 15/17 15/20 16/18 23/14 24/2 26/17 26/21 29/22 30/4 31/14 31/25 33/25 38/9 41/4 42/24 43/6 44/19 45/2 46/5 47/2 47/4 48/3 53/3 53/17 57/18 58/20 61/12 63/3 65/18 65/18 65/20 65/24 68/16 72/6 74/20 76/9 76/23 79/10 79/11 79/23 82/11 84/2 84/11 85/9 88/16 88/17 90/22 92/22 94/22 97/23 104/20 105/4 106/1 107/18 108/19 109/21 111/2 111/25 112/2</p> <p>Theater [1] 1/4</p> <p>their [12] 2/2 29/10 29/11 29/12 56/14 76/12 92/16 92/17 95/18 95/23 101/15 107/10</p> <p>them [20] 8/4 8/21 9/18 11/8 16/15 16/15 17/14 39/5 39/14 40/22 54/12 62/4 73/1 74/1 79/23 80/15 81/4 82/19 96/8 97/24</p> <p>themselves [1] 80/16</p> <p>then [47] 2/15 16/18 19/2 23/9 28/7 28/15 34/4 34/12 34/16 37/21 38/10 38/19 42/5 44/1 46/11 47/8 47/12 47/18 50/10 50/14</p>	<p>51/6 59/22 60/5 61/9 61/17 63/4 66/9 67/24 69/16 69/20 73/3 73/9 73/12 80/8 87/4 87/12 90/13 90/19 92/16 92/21 100/10 101/23 102/3 104/18 109/24 111/23 112/14</p> <p>there [115]</p> <p>there's [13] 23/1 38/9 38/13 42/8 48/12 59/15 68/7 69/1 70/19 77/10 104/21 108/18 112/12</p> <p>thereabouts [1] 16/8</p> <p>therefore [1] 47/25</p> <p>thereof [2] 15/4 15/16</p> <p>these [52] 3/11 5/13 6/17 9/12 9/16 11/18 11/21 12/5 12/18 12/22 13/20 15/8 18/3 18/5 18/14 22/11 23/5 26/4 28/4 29/14 29/24 33/23 35/5 37/22 41/17 45/24 46/22 47/6 47/24 48/7 51/11 53/25 54/5 57/8 59/2 60/24 62/23 63/8 63/22 64/1 73/9 74/8 80/14 87/18 87/19 91/18 94/15 95/5 96/2 99/19 106/19 110/21</p> <p>they [45] 10/6 15/7 15/10 15/11 20/19 21/22 22/25 26/7 39/11 39/17 39/19 39/22 39/24 46/24 52/25 54/18 59/11 60/23 61/19 63/3 63/9 63/10 66/14 66/15 69/11 72/23 74/25 75/18 76/11 82/3 84/14 86/10 89/6 89/16 89/18 90/13 91/19 92/17 92/21 95/23 101/6 101/17 104/14 105/7 107/9</p> <p>they're [15] 6/18 17/25 18/20 19/9 35/12 35/13 54/17 60/19 60/20 65/15 65/16 75/6 93/24 94/11 101/21</p> <p>they've [1] 39/25</p> <p>thing [17] 12/10 19/11 21/21 24/12 25/19 28/22 31/4 38/16 39/9 45/14 48/25 50/23 50/24 77/5 79/2 103/12 103/13</p> <p>things [29] 2/11 3/1 14/24 18/4 18/8 21/15 21/25 23/24 24/2 24/9 24/11 25/25 26/3 26/24 27/20 28/6 29/14 33/14 40/1 43/17 57/8 62/6 67/19 67/23 74/12 93/16 94/1 94/2 112/14</p> <p>think [100] 3/20 6/9 8/1 8/2 8/4 10/1 12/10 14/9 14/13 19/12 19/21 22/8 22/16 24/25 25/2 25/4 25/13 25/15 25/17 27/12 27/16 27/19 29/19 32/13 35/4 35/21 38/16 38/20 39/13 40/10 47/1 51/12 51/16 52/2 52/22 53/3 53/13 53/17 55/9 55/13 59/15 59/20 60/10 63/4 64/1 64/8 64/12 64/17 64/20 64/25 65/2 65/6 65/8 67/5 69/12 69/22 69/24 70/11 70/23 71/20 71/21 72/15 73/14 73/22 76/6 76/23 76/23 76/24 76/24 77/12 78/11 79/17 80/1 80/6 80/11 80/17 80/17 81/25 82/11 82/18 82/19 84/7 84/11 84/20 86/6 88/8 90/8 90/24 92/10 93/15 94/10 95/3 96/12 96/24 97/2 100/16 103/14 111/25 112/6 112/11</p> <p>thinking [5] 21/12 26/12 58/2 58/8 74/2</p> <p>third [2] 12/14 57/5</p> <p>third-party [1] 12/14</p> <p>this [163]</p> <p>Thomas [1] 1/14</p> <p>thorough [1] 106/24</p> <p>those [61] 2/9 2/10 9/1 9/20 9/24 11/3 11/6 11/12 12/16 13/25 14/2 16/17 17/13 19/13 20/18 22/6 22/13 22/18 23/2 23/19 24/2 25/11 26/19 27/8 28/8 36/10 38/15 39/21 40/1 42/5 42/7 44/21 45/6 45/11 46/11 46/23 46/24 52/9 52/16 58/20 58/25 60/21 62/7 67/22 67/25 72/25 73/12 74/12 85/16 86/4 86/4 92/1 92/4 94/1 95/4 96/20 100/9 108/20 108/24 109/2 109/6</p> <p>though [5] 14/25 23/4 50/22 67/17 106/15</p> <p>thought [7] 13/15 15/10 27/7 33/18 50/23 63/5 110/4</p> <p>three [2] 28/8 86/23</p>	<p>threshold [2] 111/14 111/16</p> <p>thresholds [1] 77/25</p> <p>threw [1] 74/18</p> <p>thrilled [1] 97/15</p> <p>through [30] 2/17 3/2 7/3 9/25 11/11 11/12 13/9 18/13 28/12 30/11 38/15 39/2 57/20 62/3 63/15 74/5 75/25 76/1 76/2 77/2 81/13 89/24 97/4 97/11 98/9 99/22 101/17 102/2 102/3 105/12</p> <p>throughout [2] 13/16 56/2</p> <p>throw [1] 21/14</p> <p>tied [1] 102/9</p> <p>tight [1] 33/22</p> <p>time [16] 23/8 33/23 33/25 37/10 39/12 44/3 44/5 61/4 74/9 74/15 77/1 95/16 98/23 102/14 109/19 111/21</p> <p>timeframe [1] 106/17</p> <p>timeline [3] 8/22 31/21 31/22</p> <p>timelines [2] 31/16 106/18</p> <p>timely [2] 5/10 27/18</p> <p>times [1] 47/2</p> <p>timing [5] 73/9 73/13 75/5 99/10 100/4</p> <p>today [5] 2/6 3/18 6/2 20/4 105/4</p> <p>together [10] 8/1 18/13 18/21 18/24 19/3 19/10 28/6 61/20 72/10 74/1</p> <p>token [1] 69/9</p> <p>told [3] 75/2 84/4 90/4</p> <p>Tom [2] 4/10 85/20</p> <p>Tony [1] 68/13</p> <p>too [7] 19/25 25/5 25/18 38/17 62/25 67/17 99/6</p> <p>total [2] 20/4 48/14</p> <p>touch [1] 92/24</p> <p>touchstone [1] 16/25</p> <p>towards [4] 8/25 13/19 14/20 108/9</p> <p>track [3] 27/21 33/11 33/16</p> <p>tradition [1] 33/16</p> <p>training [8] 44/10 44/11 44/11 44/16 54/14 54/21 54/22 55/7</p> <p>transaction [1] 85/14</p> <p>transactions [2] 86/13 100/22</p> <p>transcript [2] 112/18 113/6</p> <p>transfer [4] 84/24 101/24 102/18 111/13</p> <p>transition [4] 5/23 54/24 66/24 86/2</p> <p>transitional [2] 44/12 44/17</p> <p>transparent [2] 107/9 112/2</p> <p>tried [3] 86/7 87/16 97/24</p> <p>trigger [1] 99/12</p> <p>trouble [1] 93/17</p> <p>true [1] 113/5</p> <p>trust [1] 71/6</p> <p>trusts [1] 71/3</p> <p>try [12] 6/25 21/11 21/15 27/5 27/20 27/25 28/2 28/2 44/4 63/13 83/3 104/18</p> <p>trying [10] 9/11 18/12 18/20 19/2 48/14 49/21 51/10 69/25 76/25 80/10</p> <p>turn [3] 10/19 18/6 33/22</p> <p>turn-around [1] 33/22</p> <p>tweak [1] 89/18</p> <p>two [24] 8/3 10/24 18/11 18/19 30/8 30/9 38/2 38/3 38/18 40/11 58/18 62/22 63/4 70/11 80/4 81/6 81/14 82/24 86/25 87/9 90/9 97/1 100/20 109/7</p> <p>two-hundred [1] 81/6</p> <p>two-year [1] 100/20</p> <p>type [10] 19/12 24/12 36/21 43/6 48/15 55/7 57/23 63/17 64/9 64/23</p> <p>types [14] 18/5 18/11 18/24 19/15 22/14 23/13 24/2 36/23 45/11 53/15 56/5 67/22 74/12 93/12</p> <p>typically [2] 40/18 41/2</p>
		<p>U</p> <p>ultimate [3] 68/9 68/12 86/14</p>

<p>U</p> <p>ultimately [3] 64/4 104/2 107/13 uncertainty [1] 3/20 under [35] 9/22 15/19 17/8 19/19 20/15 35/22 37/2 51/20 51/23 52/6 54/21 58/16 58/24 70/9 71/8 71/17 71/19 72/14 74/23 84/14 89/1 89/2 89/5 90/2 90/3 91/24 92/18 95/13 95/20 99/6 99/8 101/20 102/11 104/10 104/19 under-served [1] 101/20 underneath [1] 37/12 understand [15] 23/4 35/6 48/15 61/14 70/1 70/1 83/2 83/23 94/4 98/23 98/24 99/5 99/17 102/22 102/23 understanding [7] 8/5 8/8 23/20 24/16 73/18 89/21 102/12 understood [1] 48/1 undertake [2] 100/9 101/21 unemployed [1] 96/9 unemployment [9] 54/14 95/17 95/18 95/19 95/24 96/3 96/6 96/22 103/24 unforeseen [1] 93/17 unfortunately [1] 25/12 unified [1] 79/21 unique [3] 6/2 12/5 74/8 unit [2] 29/21 29/22 unless [2] 96/21 105/1 unlike [1] 38/17 unlikely [1] 111/3 unlimited [1] 13/20 unnecessary [2] 34/23 75/13 unruly [1] 38/21 until [4] 3/4 3/13 100/11 102/1 up [42] 2/7 7/7 17/7 21/15 23/18 23/23 25/7 37/11 43/16 44/1 44/6 44/14 47/17 52/20 53/12 54/10 54/15 57/25 60/13 61/18 71/9 72/9 73/16 80/8 81/8 85/15 91/9 92/25 95/16 96/5 97/23 98/8 100/5 101/11 101/23 103/15 106/3 106/9 106/11 106/13 111/9 112/19 upkeep [1] 112/8 upon [8] 32/19 43/4 43/10 55/15 56/19 78/15 79/13 86/23 upping [1] 64/19 us [40] 8/23 9/21 10/3 10/4 11/10 11/25 12/14 14/21 16/23 24/16 29/1 29/2 29/18 32/19 34/3 35/6 37/9 38/1 38/7 42/4 42/6 42/13 48/8 48/9 58/22 62/12 62/15 63/6 67/9 67/12 73/23 75/16 77/11 77/17 79/22 101/7 106/10 107/18 110/1 112/2 use [25] 10/15 10/24 11/3 11/18 24/9 32/4 33/11 36/23 42/17 48/20 55/11 63/15 69/17 70/18 75/17 82/9 86/5 97/18 99/1 102/25 105/20 107/8 107/19 107/22 110/8 used [10] 7/14 12/22 27/3 69/2 69/4 69/11 83/5 86/22 95/10 99/3 useful [1] 39/11 uses [3] 10/20 70/18 99/8 using [7] 5/13 33/11 70/23 80/19 82/12 100/2 110/11 usual [2] 7/15 34/5 usually [1] 44/19 utilize [1] 63/5</p>	<p>verify [1] 93/25 versions [1] 39/23 versus [4] 43/8 43/9 55/3 112/8 very [27] 14/14 15/8 15/14 24/2 27/14 29/5 35/6 36/7 38/21 39/15 43/7 43/23 50/8 51/12 54/18 55/25 60/10 67/25 68/1 87/22 101/13 106/18 106/20 108/15 108/18 108/18 109/6 view [5] 22/11 24/11 87/20 98/2 98/4 viewed [5] 43/7 45/1 60/21 89/25 90/1 viewing [1] 13/5 vigilant [1] 23/16 Vincent's [1] 72/18 virtually [1] 49/10 vis [2] 36/4 36/4 vis-a-vis [1] 36/4 voice [1] 29/25 void [1] 90/17 Volk [3] 1/21 4/16 55/20 voucher [1] 101/6</p>	<p>weekly [2] 93/19 93/22 Weiler [1] 104/7 welcome [1] 41/16 well [38] 9/22 10/16 10/21 15/12 20/9 21/14 23/16 28/5 33/24 43/7 43/23 44/12 46/2 49/9 50/9 55/9 58/18 59/6 60/3 60/10 61/21 67/3 71/23 72/22 76/21 76/22 77/15 79/22 83/2 87/15 93/15 93/25 94/22 95/3 96/3 96/13 97/16 110/1 were [14] 15/7 15/7 15/9 20/15 28/25 39/24 56/13 74/14 75/2 75/21 76/5 76/6 99/23 112/4 weren't [2] 66/12 102/25 Westchester [2] 49/4 68/14 Westfield [1] 98/21 what [95] 2/5 3/13 3/18 3/25 7/14 10/7 13/18 14/3 14/9 15/17 16/12 16/19 17/1 17/4 19/3 22/9 25/1 26/12 26/17 32/1 32/15 32/17 35/7 35/16 36/3 38/1 38/8 40/2 41/2 41/19 44/19 46/5 46/18 48/10 48/14 49/20 50/19 51/3 53/15 54/20 55/7 55/17 55/21 56/10 60/10 60/13 60/16 66/3 67/4 67/12 68/11 68/15 68/18 69/3 69/13 69/14 70/1 73/16 75/6 75/14 76/5 76/24 76/25 77/13 78/4 78/6 79/15 81/25 82/11 84/3 84/4 84/7 84/12 86/7 87/7 87/16 88/12 89/4 89/16 90/19 92/2 92/12 92/21 94/14 95/11 98/22 103/11 103/16 104/9 104/12 109/20 109/20 110/16 112/7 112/8 what's [6] 27/10 34/3 93/14 95/25 111/14 111/15 whatever [18] 10/4 11/20 21/8 41/17 49/15 52/5 52/15 52/18 57/23 79/21 86/13 88/8 89/15 89/20 93/22 100/24 108/12 112/2 when [33] 3/8 6/22 11/24 15/5 18/11 20/3 20/4 22/12 22/25 25/4 32/13 39/3 40/17 41/9 43/18 43/21 48/24 50/22 54/22 55/12 60/14 62/2 72/19 74/25 92/12 92/17 93/24 99/11 99/13 99/20 99/20 99/25 105/16 Whenever [1] 100/19 where [16] 3/9 7/20 10/6 14/16 19/8 22/8 27/5 30/12 30/16 37/19 40/13 42/7 51/4 79/20 84/21 96/22 wherewithal [1] 80/16 whether [15] 23/1 23/6 32/6 35/12 35/13 42/17 50/6 54/3 54/4 56/5 89/19 98/15 99/15 102/16 111/19 which [20] 5/21 6/4 8/12 13/9 17/20 38/21 45/14 56/12 56/13 59/2 66/22 80/15 92/18 98/3 99/3 99/12 101/18 101/23 105/23 106/17 while [4] 3/11 45/8 56/24 76/20 white [1] 73/15 who [29] 5/6 5/24 6/12 8/24 10/14 32/25 33/1 44/19 45/7 53/19 53/23 55/3 55/4 57/21 65/21 65/22 66/12 66/13 68/7 91/5 91/5 92/17 93/8 95/7 95/9 97/22 97/22 102/17 109/20 whole [9] 14/15 44/24 47/8 51/7 80/10 91/12 103/11 103/13 110/7 Whoops [1] 19/25 why [6] 24/2 24/6 30/4 70/2 83/10 83/11 WICKS [1] 12/7 will [105] 3/5 3/7 3/20 7/19 9/17 9/20 9/25 10/2 10/12 10/13 11/3 11/18 12/1 12/2 12/13 13/8 13/16 13/22 13/25 14/1 17/15 21/17 22/1 22/11 23/5 23/16 23/17 24/7 24/8 24/16 24/18 27/15 27/16 27/19 27/25 28/18 28/19 29/2 32/25 38/22 39/11 39/15 42/11 42/17 43/25 44/14 45/8 45/22 45/24 46/16 46/24 48/22 53/15 54/16 55/18 56/6 57/22 59/13 59/14 61/16 63/8 63/10 64/11 65/14 66/22 66/22 66/23 66/25 69/4 69/24</p>
<p>V</p> <p>Vallet [1] 45/18 value [1] 36/4 values [1] 29/12 variation [1] 16/9 variety [1] 100/7 various [3] 11/19 12/19 22/22 vehicle [3] 6/4 63/15 100/23 Veino [3] 1/22 4/6 23/12</p>	<p>W</p> <p>wage [1] 92/19 wages [2] 92/8 92/10 wait [2] 74/1 101/11 waiting [1] 72/24 walk [3] 3/7 38/15 90/13 walk-around [1] 3/7 walls [2] 20/12 21/13 want [46] 2/17 3/2 5/4 6/10 7/23 11/20 16/23 17/21 21/8 22/5 24/21 26/10 28/3 28/5 29/18 31/2 31/5 31/18 31/19 31/20 32/3 32/24 33/10 33/12 34/22 36/16 36/24 39/1 39/9 41/5 43/24 44/8 48/20 56/9 63/15 65/12 66/6 66/13 66/17 69/17 79/2 79/24 85/3 89/7 95/9 108/12 wanted [4] 15/25 42/22 60/13 87/6 wanting [1] 25/9 wants [3] 32/10 65/21 91/6 Warren [2] 35/20 35/22 was [43] 16/7 17/12 17/22 19/21 24/4 29/6 31/23 32/1 38/16 49/20 50/4 50/8 50/9 50/12 51/5 54/7 56/21 58/2 59/17 60/13 60/15 62/1 76/6 76/10 78/22 79/16 79/16 81/9 81/23 82/8 82/9 83/17 83/20 84/3 84/4 84/4 88/14 90/2 99/11 101/15 104/16 107/15 107/16 wasn't [1] 76/5 way [20] 5/10 6/6 6/9 17/5 17/14 27/18 30/16 47/4 52/23 56/11 59/1 59/2 60/10 63/23 73/12 74/23 82/4 97/1 108/8 109/13 ways [3] 33/15 37/18 79/1 we [271] we'd [1] 40/10 we'll [13] 2/12 3/21 4/3 7/10 39/2 43/15 44/1 44/3 55/12 64/22 103/3 110/17 112/18 we're [58] 2/6 2/8 5/13 6/1 6/24 10/24 13/5 14/22 21/7 22/15 25/9 26/13 28/12 29/13 30/12 32/14 33/3 33/23 34/1 35/5 36/6 38/2 38/17 40/23 47/5 47/12 48/14 48/17 48/25 53/18 53/22 54/1 62/11 64/1 66/2 67/4 68/7 69/5 70/23 74/20 75/4 75/12 76/18 76/24 77/13 78/13 82/12 82/19 84/17 87/23 91/21 94/2 100/4 101/3 106/4 108/17 109/23 110/14 we've [17] 5/16 6/12 18/15 18/18 19/5 19/11 19/13 41/13 41/23 43/10 53/9 53/11 66/11 73/11 75/11 75/24 95/21 weakest [1] 33/18 web [1] 112/18 website [2] 39/19 39/21 week [3] 69/22 72/19 79/5</p>	<p>weekly [2] 93/19 93/22 Weiler [1] 104/7 welcome [1] 41/16 well [38] 9/22 10/16 10/21 15/12 20/9 21/14 23/16 28/5 33/24 43/7 43/23 44/12 46/2 49/9 50/9 55/9 58/18 59/6 60/3 60/10 61/21 67/3 71/23 72/22 76/21 76/22 77/15 79/22 83/2 87/15 93/15 93/25 94/22 95/3 96/3 96/13 97/16 110/1 were [14] 15/7 15/7 15/9 20/15 28/25 39/24 56/13 74/14 75/2 75/21 76/5 76/6 99/23 112/4 weren't [2] 66/12 102/25 Westchester [2] 49/4 68/14 Westfield [1] 98/21 what [95] 2/5 3/13 3/18 3/25 7/14 10/7 13/18 14/3 14/9 15/17 16/12 16/19 17/1 17/4 19/3 22/9 25/1 26/12 26/17 32/1 32/15 32/17 35/7 35/16 36/3 38/1 38/8 40/2 41/2 41/19 44/19 46/5 46/18 48/10 48/14 49/20 50/19 51/3 53/15 54/20 55/7 55/17 55/21 56/10 60/10 60/13 60/16 66/3 67/4 67/12 68/11 68/15 68/18 69/3 69/13 69/14 70/1 73/16 75/6 75/14 76/5 76/24 76/25 77/13 78/4 78/6 79/15 81/25 82/11 84/3 84/4 84/7 84/12 86/7 87/7 87/16 88/12 89/4 89/16 90/19 92/2 92/12 92/21 94/14 95/11 98/22 103/11 103/16 104/9 104/12 109/20 109/20 110/16 112/7 112/8 what's [6] 27/10 34/3 93/14 95/25 111/14 111/15 whatever [18] 10/4 11/20 21/8 41/17 49/15 52/5 52/15 52/18 57/23 79/21 86/13 88/8 89/15 89/20 93/22 100/24 108/12 112/2 when [33] 3/8 6/22 11/24 15/5 18/11 20/3 20/4 22/12 22/25 25/4 32/13 39/3 40/17 41/9 43/18 43/21 48/24 50/22 54/22 55/12 60/14 62/2 72/19 74/25 92/12 92/17 93/24 99/11 99/13 99/20 99/20 99/25 105/16 Whenever [1] 100/19 where [16] 3/9 7/20 10/6 14/16 19/8 22/8 27/5 30/12 30/16 37/19 40/13 42/7 51/4 79/20 84/21 96/22 wherewithal [1] 80/16 whether [15] 23/1 23/6 32/6 35/12 35/13 42/17 50/6 54/3 54/4 56/5 89/19 98/15 99/15 102/16 111/19 which [20] 5/21 6/4 8/12 13/9 17/20 38/21 45/14 56/12 56/13 59/2 66/22 80/15 92/18 98/3 99/3 99/12 101/18 101/23 105/23 106/17 while [4] 3/11 45/8 56/24 76/20 white [1] 73/15 who [29] 5/6 5/24 6/12 8/24 10/14 32/25 33/1 44/19 45/7 53/19 53/23 55/3 55/4 57/21 65/21 65/22 66/12 66/13 68/7 91/5 91/5 92/17 93/8 95/7 95/9 97/22 97/22 102/17 109/20 whole [9] 14/15 44/24 47/8 51/7 80/10 91/12 103/11 103/13 110/7 Whoops [1] 19/25 why [6] 24/2 24/6 30/4 70/2 83/10 83/11 WICKS [1] 12/7 will [105] 3/5 3/7 3/20 7/19 9/17 9/20 9/25 10/2 10/12 10/13 11/3 11/18 12/1 12/2 12/13 13/8 13/16 13/22 13/25 14/1 17/15 21/17 22/1 22/11 23/5 23/16 23/17 24/7 24/8 24/16 24/18 27/15 27/16 27/19 27/25 28/18 28/19 29/2 32/25 38/22 39/11 39/15 42/11 42/17 43/25 44/14 45/8 45/22 45/24 46/16 46/24 48/22 53/15 54/16 55/18 56/6 57/22 59/13 59/14 61/16 63/8 63/10 64/11 65/14 66/22 66/22 66/23 66/25 69/4 69/24</p>

W

will... [35] 72/3 72/23 72/24 73/2 73/16
 73/17 74/6 77/1 86/9 87/1 87/21 90/9 92/2
 92/3 93/4 93/18 95/19 97/5 97/18 99/18
 99/20 100/6 100/10 100/18 100/19 102/4
 102/5 102/17 106/10 107/14 108/5 108/20
 109/8 109/14 112/16
 willing [3] 40/16 47/12 86/16
 window [2] 90/5 100/21
 wish [1] 50/14
 with the [1] 44/9
 within [11] 23/2 26/22 32/11 54/25 71/5
 71/13 80/25 81/12 82/14 105/2 108/5
 without [2] 55/17 98/6
 withstand [1] 85/21
 Wollner [2] 16/10 31/24
 women [1] 91/13
 women's [2] 30/25 31/3
 won't [3] 27/14 62/8 110/18
 wondering [1] 83/20
 word [2] 68/21 90/4
 words [6] 49/12 86/23 87/10 87/19 87/19
 97/10
 work [17] 8/23 27/20 28/3 28/6 31/12 32/5
 35/17 41/6 44/10 52/8 52/9 65/3 75/10
 83/10 89/24 90/18 95/10
 worker [5] 44/24 45/5 56/5 57/10 57/11
 workers [7] 44/12 44/13 44/16 44/17 54/24
 55/3 55/4
 working [1] 69/21
 world [2] 74/3 74/16
 worry [1] 107/10
 worth [3] 14/9 27/23 42/3
 worthy [1] 27/6
 would [152]
 wouldn't [4] 38/5 84/22 85/1 102/12
 wrecked [1] 29/8
 write [1] 95/16
 write-up [1] 95/16
 written [2] 3/14 63/10
 wrong [2] 59/7 59/21

73/25 77/15 77/24 78/1 78/8 78/17 81/17
 83/4 84/8 85/6 90/18 92/21 98/13 98/16
 99/25 103/10 112/9
 you've [11] 5/20 31/5 31/6 32/6 36/22 46/7
 69/18 70/1 70/2 103/17 110/21
 young [1] 20/5
 your [123]
 yourself [2] 43/19 81/6
 Yup [1] 83/1

Y

yeah [16] 18/9 22/7 35/3 44/25 50/3 59/15
 61/11 61/15 61/15 64/8 72/15 74/17 88/19
 95/21 108/22 112/14
 year [17] 11/13 17/18 17/20 31/23 38/4
 48/17 62/24 63/2 63/3 63/9 63/10 63/13
 63/14 100/20 100/21 109/7 110/22
 year-to-date [1] 38/4
 years [9] 11/15 11/16 11/17 21/13 22/21
 40/11 62/24 62/24 109/11
 yes [21] 25/12 44/21 44/21 47/21 61/16
 69/16 76/13 77/12 78/20 78/23 80/23 82/7
 84/10 84/11 88/22 88/23 91/1 91/23 93/6
 95/2 98/18
 yet [7] 38/24 38/25 75/19 76/15 91/5 93/8
 95/7
 yield [1] 84/22
 York [17] 1/5 1/5 4/24 9/22 11/1 11/23 12/2
 12/3 54/3 74/8 74/10 84/20 91/11 99/7
 101/9 110/3 113/4
 you [359]
 you'll [6] 10/13 12/9 17/1 34/13 46/12
 91/16
 you're [72] 7/14 11/17 13/6 13/7 13/13
 17/1 19/2 20/11 27/3 27/18 28/16 29/16
 29/16 30/16 30/16 30/22 31/2 31/7 31/8
 31/15 31/24 32/4 32/8 32/13 32/24 33/11
 35/21 36/5 36/22 37/6 37/9 39/17 40/13
 41/16 42/3 42/4 42/5 46/5 46/6 46/8 46/10
 47/17 48/2 49/17 50/23 51/9 52/22 61/23
 62/4 65/6 67/14 69/3 69/19 69/20 70/5