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

***COMMITTEE DAY***

***AGENDA***

***November 17, 2022***
***10:15 a.m.***

- ***90 Church Street, Conference Rooms 4 A/B, NYC***
- ***Empire State Plaza, Concourse Level, Meeting Room 6, Albany***

## I. SPECIAL COMMITTEE ON CODES, REGULATIONS, AND LEGISLATION

Thomas Holt, Chair

**For Emergency Adoption**

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

**For Adoption**

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

**For Emergency Adoption**

20-24 Addition of Sections 1.2, 700.5 and Part 360 to Title 10 NYCRR; Amendment of Sections 400.1, 405.24 & 1001.6 of Title 10 NYCRR and Sections 487.3, 488.3 and 490.3 of Title 18 NYCRR (Surge and Flex Health Coordination System)

**For Adoption**

20-24 Addition of Sections 1.2, 700.5 and Part 360 to Title 10 NYCRR; Amendment of Sections 400.1, 405.24 & 1001.6 of Title 10 NYCRR and Sections 487.3, 488.3 and 490.3 of Title 18 NYCRR (Surge and Flex Health Coordination System)

21-13 Addition of Section 415.34 to Title 10 NYCRR (Nursing Home Minimum Direct Resident Care Spending)

21-20 Amendment to Sections 415.2 and 415.13 of Title 10 NYCRR (Minimum Staffing Requirements for Nursing Homes)

## II. COMMITTEE ON ESTABLISHMENT AND PROJECT REVIEW

Peter Robinson, Chair

### A. Applications for Construction of Health Care Facilities/Agencies

**Acute Care Services- Construction** **Exhibit # 1**

| | Number | Applicant/Facility |
|---|---|---|
| 1. | 221248 C | NYU Langone Hospital – Long Island<br>(Nassau County) |

### B. Applications for Establishment and Construction of Health Care Facilities/Agencies

**Ambulatory Surgery Centers- Establish and Construct** **Exhibit # 2**

| | Number | Applicant/Facility |
|---|---|---|
| 1. | 221191 B | Maxillofacial Ambulatory Surgery Center, LLC<br>(Suffolk County) |
| 2. | 221206 E | Northern Westchester Facility Project LLC d/b/a Yorktown Center for Special Surgery<br>(Westchester County) |
| 3. | 221213 E | Performance Surgical Center, LLC d/b/a Performance Surgical Center<br>(Kings County) |

**Diagnostic and Treatment Centers - Establish/Construct** **Exhibit # 3**

| | Number | Applicant/Facility |
|---|---|---|
| 1. | 221145 B | Apple Care Health<br>(Kings County) |
| 2. | 221227 B | Parkchester DTC LLC d/b/a Parkchester Diagnostic and Treatment Center<br>(Bronx County) |
| 3. | 221231 B | A Friendly Face Akademy, Corp.<br>(Richmond County) |
| 4. | 221265 B | JAL 28 LLC d/b/a A Merryland Health Center<br>(Kings County) |

**Residential Health Care Facilities - Establish/Construct** **Exhibit # 4**

| | Number | Applicant/Facility |
|---|---|---|
| 1. | 192204 E | Highland Nursing Home, Inc. d/b/a North Country Nursing & Rehabilitation Center (St. Lawrence County) |
| 2. | 202034 E | Ulster NH Operations LLC d/b/a Golden Hill Center for Rehabilitating and Nursing (Ulster County) |
| 3. | 211087 E | The Premier Center for Rehabilitation of Westchester, LLC d/b/a Springvale Nursing and Rehabilitation Center (Westchester County) |

Pursuant to the authority vested in the Commissioner of Health by Section 2803 of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended by amending sections 405.11 and 415.19, to be effective upon filing with the Secretary of State, to read as follows:

Section 405.11 is amended by adding a new subdivision (g) as follows:

(g) (1) The hospital shall possess and maintain a supply of all necessary items of personal protective equipment (PPE) sufficient to protect health care personnel, consistent with federal Centers for Disease Control and Prevention guidance, for at least 60 days, by August 31, 2021.

(2) The 60-day stockpile requirement set forth in paragraph (1) of this subdivision shall be determined by the Department as follows for each type of required PPE:

(i) for single gloves, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 550;

(ii) for gowns, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 41;

(iii) for surgical masks, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 21; and

(iv) for N95 respirator masks, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 9.6.

(3) The Commissioner shall have discretion to increase the stockpile requirement set forth in paragraph (1) of this subdivision from 60 days to 90 days where there is a State or local public

health emergency declared pursuant to Section 24 or 28 of the Executive Law. Hospitals shall possess and maintain the necessary 90-day stockpile of PPE by the deadline set forth by the Commissioner.

(4) In order to maximize the shelf life of stockpiled inventory, providers should follow the appropriate storage conditions as outlined by manufacturers and inventory should be rotated through regular usage and replace what has been used in order to ensure a consistent readiness level, and expired products should be disposed of when their expiration date has passed. Expired products shall not be used to comply with the stockpile requirement set forth in paragraph (1) of this subdivision.

(5) Failure to possess and maintain the required supply of PPE may result in the revocation, limitation, or suspension of the hospital's license; provided, however, that no such revocation, limitation, or suspension shall be ordered unless the Department has provided the hospital with a fourteen day grace period, solely for a hospital's first violation of this section, to achieve compliance with the requirement set forth herein.

Section 415.19 is amended by adding a new subdivision (f) as follows:

(f) (1) The nursing home shall possess and maintain a supply of all necessary items of personal protective equipment (PPE) sufficient to protect health care personnel, consistent with federal Centers for Disease Control and Prevention guidance, for at least 60 days, by August 31, 2021.

(2) The 60-day stockpile requirement set forth in paragraph (1) of this subdivision shall be determined by the Department as follows for each type of required PPE:

(i) for single gloves, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 24;

(ii) for gowns, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 3;

(iii) for surgical masks, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 1.5; and

(iv) for N95 respirator masks, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 1.4.

(v) For the purposes of this paragraph, the term "applicable positivity rate" shall mean the greater of the following positivity rates:

*(a)* The nursing home's average COVID-19 positivity rate, based on reports made to the Department, during the period April 26, 2020 through May 20, 2020; or

*(b)* The nursing home's average COVID-19 positivity rate, based on reports made to the Department, during the period January 3, 2021 through January 31, 2021; or

*(c)* 20.15 percent, representing the highest Regional Economic Development Council average COVID-19 positivity rate, as reported to the Department, during the periods April 26, 2020 through May 20, 2020 and January 3, 2021 through January 31, 2021.

(3) In order to maximize the shelf life of stockpiled inventory, providers should follow the appropriate storage conditions as outlined by manufacturers and inventory should be rotated through regular usage and replace what has been used in order to ensure a consistent readiness

level, and expired products should be disposed of when their expiration date has passed. Expired products shall not be used to comply with the stockpile requirement set forth in paragraph (1) of this subdivision.

(4) Failure to possess and maintain the required supply of PPE may result in the revocation, limitation, or suspension of the nursing home's license; provided, however, that no such revocation, limitation, or suspension shall be ordered unless the Department has provided the nursing home with a fourteen day grace period, solely for a nursing home's first violation of this section, to achieve compliance with the requirement set forth herein.

## REGULATORY IMPACT STATEMENT

**Statutory Authority:**

Section 2803 of the Public Health Law (PHL) authorizes the promulgation of such regulations as may be necessary to implement the purposes and provisions of PHL Article 28, including the establishment of minimum standards governing the operation of health care facilities, including hospitals and nursing homes.

**Legislative Objectives:**

The legislative objectives of PHL Article 28 include the protection and promotion of the health of the residents of the State by requiring the efficient provision and proper utilization of health services, of the highest quality at a reasonable cost.

**Needs and Benefits:**

The 2019 Coronavirus (COVID-19) is a disease that causes mild to severe respiratory symptoms, including fever, cough, and difficulty breathing. People infected with COVID-19 have had symptoms ranging from those that are mild (like a common cold) to severe pneumonia that requires medical care in a general hospital and can be fatal, with a disproportionate risk of severe illness for older adults and/or those who have serious underlying medical health conditions.

On January 30, 2020, the World Health Organization (WHO) designated the COVID-19 outbreak as a Public Health Emergency of International Concern. On a national level, the Secretary of Health and Human Services determined on January 31, 2020 that as a result of confirmed cases of COVID-19 in the United States, a public health emergency existed and had existed since January 27, 2020, nationwide. Thereafter, the situation rapidly evolved throughout

the world, with many countries, including the United States, quickly progressing from the identification of travel-associated cases to person-to-person transmission among close contacts of travel-associated cases, and finally to widespread community transmission of COVID-19.

In order for hospital and nursing home staff to safely provide care for COVID-19 positive patients and residents, or patients and residents infected with another communicable disease, while ensuring that they themselves do not become infected with COVID-19 or any other communicable disease, it is critically important that personal protective equipment (PPE), including masks, gloves, respirators, face shields and gowns, is readily available and are used. Therefore, as a result of global PPE shortages at the outset of the State of Emergency, New York State provided general hospitals, nursing homes, and other medical facilities with PPE from the State's emergency stockpile from the beginning of the COVID-19 outbreak. However, hospitals and nursing homes must ensure sufficient PPE stockpiles exist for any future communicable disease outbreaks to ensure each facility is adequately prepared to protect its staff and patients or residents, without needing to rely on the State's emergency stockpile.

Based on the foregoing, the Department has made the determination that this emergency regulation is necessary to ensure that all general hospitals and nursing homes maintain a 60-day supply of PPE to ensure that sufficient PPE is available in the event of a continuation or resurgence of the COVID-19 outbreak or another communicable disease outbreak.

**COSTS:**

**Costs to Regulated Parties:**

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each facility. However, the

Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to balance facility expenditures over time. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). As such, this regulation imposes no long-term additional costs to regulated parties.

**Costs to Local and State Governments:**

This regulation will not impact local or State governments unless they operate a general hospital or nursing home, in which case costs will be the same as costs for private entities.

**Costs to the Department of Health:**

This regulation will not result in any additional operational costs to the Department of Health.

**Paperwork:**

This regulation imposes no addition paperwork.

**Local Government Mandates:**

General hospitals and nursing homes operated by local governments will be affected and will be subject to the same requirements as any other general hospital licensed under PHL Article 28.

**Duplication:**

These regulations do not duplicate any State or federal rules.

**Alternatives:**

The Department believes that promulgation of this regulation is the most effective means of ensuring that general hospitals and nursing homes have adequate stockpiles of PPE necessary to protect hospital staff from communicable diseases, compared to any alternate course of action.

**Federal Standards:**

No federal standards apply to stockpiling of such equipment at hospitals.

**Compliance Schedule:**

The regulations will become effective upon filing with the Department of State. These regulations are expected to be proposed for permanent adoption at a future meeting of the Public Health and Health Planning Council.

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## REGULATORY FLEXIBILITY ANALYSIS

**Effect on Small Business and Local Government:**

This regulation will not impact local governments or small businesses unless they operate a general hospital or a nursing home. Currently there are five general hospitals in New York that employ less than 100 staff and qualify as small businesses, and there are 79 nursing homes in New York qualify as small businesses given that they employ less than 100 staff.

**Compliance Requirements:**

These regulations require all general hospitals and nursing homes to purchase and maintain adequate stockpiles of PPE, including but not limited to masks, respirators, face shields and gowns.

**Professional Services:**

It is not expected that any professional services will be needed to comply with this rule.

**Compliance Costs:**

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each covered facility. However, the Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to

balance facility expenditures over time. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). As such, this regulation imposes no long-term additional costs to regulated parties.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

The Department anticipates that any adverse impacts will be minimal, as both hospitals and nursing homes have already mobilized their stockpiling efforts since early 2020, when the spread of the COVID-19 virus was first recognized in New York State, including through two surges of the COVID-19 pandemic. As such, the continuance of these stockpiling requirements is not expected to create any additional adverse impact on hospitals or nursing homes. Moreover, for nursing homes, these PPE regulations are consistent with the existing directive in Public Health Law section 2803(12) to maintain a two-month PPE supply.

**Small Business and Local Government Participation:**

Small business and local governments were not directly consulted given the urgent need to ensure hospital patients and nursing home residents are adequately protected in the event of a resurgence of COVID-19 or another communicable disease outbreak. However, the Department

plans to issue an advisory to hospital CEOs and nursing home administrators alerting them to the anticipated proposed rulemaking on these regulations and opportunity to submit public comments.

## RURAL AREA FLEXIBILITY ANALYSIS

**Type and Estimated Numbers of Rural Areas:**

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Allegany County | Greene County | Schoharie County |
| Cattaraugus County | Hamilton County | Schuyler County |
| Cayuga County | Herkimer County | Seneca County |
| Chautauqua County | Jefferson County | St. Lawrence County |
| Chemung County | Lewis County | Steuben County |
| Chenango County | Livingston County | Sullivan County |
| Clinton County | Madison County | Tioga County |
| Columbia County | Montgomery County | Tompkins County |
| Cortland County | Ontario County | Ulster County |
| Delaware County | Orleans County | Warren County |
| Essex County | Oswego County | Washington County |

| | | |
|---|---|---|
| Franklin County | Otsego County | Wayne County |
| Fulton County | Putnam County | Wyoming County |
| Genesee County | Rensselaer County | Yates County |
| | Schenectady County | |

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Albany County | Monroe County | Orange County |
| Broome County | Niagara County | Saratoga County |
| Dutchess County | Oneida County | Suffolk County |
| Erie County | Onondaga County | |

There are 47 general hospitals located in rural areas as well as several licensed nursing homes.

**Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:**

These regulations require all general hospitals and nursing homes, including those in rural areas, to purchase and maintain adequate stockpiles of PPE, including but not limited to masks, respirators, face shields and gowns.

**Compliance Costs:**

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each facility. However, the Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as

part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to balance facility expenditures over time. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). Therefore, this regulation imposes no long-term additional costs to regulated parties.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

The Department anticipates that any adverse impacts will be minimal, as both hospitals and nursing homes have already mobilized their stockpiling efforts since early 2020, when the spread of the COVID-19 virus was first recognized in New York State, including through two surges of the COVID-19 pandemic. As such, the continuance of these stockpiling requirements is not expected to create any additional adverse impact on hospitals or nursing homes. Moreover, for nursing homes, these PPE regulations are consistent with the existing directive in Public Health Law section 2803(12) to maintain a two-month PPE supply.

**Rural Area Participation:**

Parties representing rural areas were not directly consulted given the urgent need to ensure hospital patients and nursing home residents are adequately protected in the event of a resurgence of COVID-19 or another communicable disease outbreak. However, the Department plans to issue an advisory to hospital CEOs and nursing home administrators alerting them to the anticipated proposed rulemaking and opportunity to submit public comments.

## STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

## EMERGENCY JUSTIFICATION

These regulations are needed on an emergency basis to ensure hospital and nursing home staff, as well as the patients and residents for whom they provide care, are adequately protected during the 2019 Coronavirus (COVID-19) or another communicable disease outbreak. These regulations are specifically meant to address the lessons learned in New York State from 2020 to 2021 during the COVID-19 pandemic with respect to PPE. Notwithstanding the end of the State disaster emergencies relating to COVID-19, infections in nursing homes across the state persist and hospitals remain at the front lines of response. Further, a possible resurgence of COVID-19 or another communicable disease outbreak necessitates that hospitals and nursing homes continue to have an adequate supply of PPE to protect these vulnerable populations and the staff who provide care.

New York State first identified COVID-19 cases on March 1, 2020 and thereafter became the national epicenter of the outbreak. However, as a result of global PPE shortages, many hospitals and nursing homes in New York State had difficulty obtaining adequate PPE necessary to care for their patients and residents. New York State provided general hospitals, nursing homes, and other medical facilities with PPE from the State's emergency stockpile from the beginning of the COVID-19 outbreak.

These regulations are needed on an emergency basis to ensure that hospitals and nursing homes Statewide do not again find themselves in need of PPE from the State's stockpile should another communicable disease outbreak occur, COVID-19 or otherwise. It is critically important that PPE, including masks, gloves, respirators, face shields and gowns, is readily available and used when needed, as hospital and nursing home staff must don all required PPE to safely

provide care for patients and residents with communicable diseases, while ensuring that they themselves do not become infected with a communicable disease.

Based on the foregoing, the Department has made the determination that this emergency regulation is necessary to ensure that all general hospitals and nursing homes maintain a 60-day supply of PPE to ensure that sufficient PPE is available in the event of a resurgence of COVID-19 or another communicable disease outbreak.

Of note, a Notice of Proposed Rule Making was published in the *State Register* on June 8, 2022, with a public comment period that ended on August 8, 2022. The Department intends these emergency regulations to be in effect only until such time as the Assessment of Public Comment and Final Rule can be published in the State Register, which would make the Proposed Rule permanent.

Pursuant to the authority vested in the Commissioner of Health by Section 2803 of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended by amending sections 405.11 and 415.19, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Section 405.11 is amended by adding a new subdivision (g) as follows:

(g) (1) The hospital shall possess and maintain a supply of all necessary items of personal protective equipment (PPE) sufficient to protect health care personnel, consistent with federal Centers for Disease Control and Prevention guidance, for at least 60 days, by August 31, 2021.

(2) The 60-day stockpile requirement set forth in paragraph (1) of this subdivision shall be determined by the Department as follows for each type of required PPE:

(i) for single gloves, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 550;

(ii) for gowns, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 41;

(iii) for surgical masks, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 21; and

(iv) for N95 respirator masks, fifteen percent, multiplied by the number of the hospital's staffed beds as determined by the Department, multiplied by 9.6.

(3) The Commissioner shall have discretion to increase the stockpile requirement set forth in paragraph (1) of this subdivision from 60 days to 90 days where there is a State or local public

health emergency declared pursuant to Section 24 or 28 of the Executive Law. Hospitals shall possess and maintain the necessary 90-day stockpile of PPE by the deadline set forth by the Commissioner.

(4) In order to maximize the shelf life of stockpiled inventory, providers should follow the appropriate storage conditions as outlined by manufacturers and inventory should be rotated through regular usage and replace what has been used in order to ensure a consistent readiness level, and expired products should be disposed of when their expiration date has passed. Expired products shall not be used to comply with the stockpile requirement set forth in paragraph (1) of this subdivision.

(5) Failure to possess and maintain the required supply of PPE may result in the revocation, limitation, or suspension of the hospital's license; provided, however, that no such revocation, limitation, or suspension shall be ordered unless the Department has provided the hospital with a fourteen day grace period, solely for a hospital's first violation of this section, to achieve compliance with the requirement set forth herein.

Section 415.19 is amended by adding a new subdivision (f) as follows:

(f) (1) The nursing home shall possess and maintain a supply of all necessary items of personal protective equipment (PPE) sufficient to protect health care personnel, consistent with federal Centers for Disease Control and Prevention guidance, for at least 60 days, by August 31, 2021.

(2) The 60-day stockpile requirement set forth in paragraph (1) of this subdivision shall be determined by the Department as follows for each type of required PPE:

(i) for single gloves, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 24;

(ii) for gowns, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 3;

(iii) for surgical masks, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 1.5; and

(iv) for N95 respirator masks, the applicable positivity rate, multiplied by the number of certified nursing home beds as indicated on the nursing home's operating certificate, multiplied by 1.4.

(v) For the purposes of this paragraph, the term "applicable positivity rate" shall mean the greater of the following positivity rates:

*(a)* The nursing home's average COVID-19 positivity rate, based on reports made to the Department, during the period April 26, 2020 through May 20, 2020; or

*(b)* The nursing home's average COVID-19 positivity rate, based on reports made to the Department, during the period January 3, 2021 through January 31, 2021; or

*(c)* 20.15 percent, representing the highest Regional Economic Development Council average COVID-19 positivity rate, as reported to the Department, during the periods April 26, 2020 through May 20, 2020 and January 3, 2021 through January 31, 2021.

(3) In order to maximize the shelf life of stockpiled inventory, providers should follow the appropriate storage conditions as outlined by manufacturers and inventory should be rotated through regular usage and replace what has been used in order to ensure a consistent readiness

level, and expired products should be disposed of when their expiration date has passed. Expired products shall not be used to comply with the stockpile requirement set forth in paragraph (1) of this subdivision.

(4) Failure to possess and maintain the required supply of PPE may result in the revocation, limitation, or suspension of the nursing home's license; provided, however, that no such revocation, limitation, or suspension shall be ordered unless the Department has provided the nursing home with a fourteen day grace period, solely for a nursing home's first violation of this section, to achieve compliance with the requirement set forth herein.

## REGULATORY IMPACT STATEMENT

**Statutory Authority:**

Section 2803 of the Public Health Law (PHL) authorizes the promulgation of such regulations as may be necessary to implement the purposes and provisions of PHL Article 28, including the establishment of minimum standards governing the operation of health care facilities, including hospitals and nursing homes.

**Legislative Objectives:**

The legislative objectives of PHL Article 28 include the protection and promotion of the health of the residents of the State by requiring the efficient provision and proper utilization of health services, of the highest quality at a reasonable cost.

**Needs and Benefits:**

The 2019 Coronavirus (COVID-19) is a disease that causes mild to severe respiratory symptoms, including fever, cough, and difficulty breathing. People infected with COVID-19 have had symptoms ranging from those that are mild (like a common cold) to severe pneumonia that requires medical care in a general hospital and can be fatal, with a disproportionate risk of severe illness for older adults and/or those who have serious underlying medical health conditions.

On January 30, 2020, the World Health Organization (WHO) designated the COVID-19 outbreak as a Public Health Emergency of International Concern. On a national level, the Secretary of Health and Human Services determined on January 31, 2020 that as a result of confirmed cases of COVID-19 in the United States, a public health emergency existed and had existed since January 27, 2020, nationwide. Thereafter, the situation rapidly evolved throughout

the world, with many countries, including the United States, quickly progressing from the identification of travel-associated cases to person-to-person transmission among close contacts of travel-associated cases, and finally to widespread community transmission of COVID-19.

In order for hospital and nursing home staff to safely provide care for COVID-19 positive patients and residents, or patients and residents infected with another communicable disease, while ensuring that they themselves do not become infected with COVID-19 or any other communicable disease, it is critically important that personal protective equipment (PPE), including masks, gloves, respirators, face shields and gowns, is readily available and are used. Therefore, as a result of global PPE shortages at the outset of the State of Emergency, New York State provided general hospitals, nursing homes, and other medical facilities with PPE from the State's emergency stockpile from the beginning of the COVID-19 outbreak. However, hospitals and nursing homes must ensure sufficient PPE stockpiles exist for any future communicable disease outbreaks to ensure each facility is adequately prepared to protect its staff and patients or residents, without needing to rely on the State's emergency stockpile.

Based on the foregoing, the Department has made the determination that this regulation is necessary to ensure that all general hospitals and nursing homes maintain a 60-day supply of PPE to ensure that sufficient PPE is available in the event of a continuation or resurgence of the COVID-19 outbreak or another communicable disease outbreak.

**COSTS:**

**Costs to Regulated Parties:**

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each facility. However, the

Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to balance facility expenditures over time. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). As such, this regulation imposes no long-term additional costs to regulated parties.

**Costs to Local and State Governments:**

This regulation will not impact local or State governments unless they operate a general hospital or nursing home, in which case costs will be the same as costs for private entities.

**Costs to the Department of Health:**

This regulation will not result in any additional operational costs to the Department of Health.

**Paperwork:**

This regulation imposes no addition paperwork.

**Local Government Mandates:**

General hospitals and nursing homes operated by local governments will be affected and will be subject to the same requirements as any other general hospital licensed under PHL Article 28.

**Duplication:**

These regulations do not duplicate any State or federal rules.

**Alternatives:**

The Department believes that promulgation of this regulation is the most effective means of ensuring that general hospitals and nursing homes have adequate stockpiles of PPE necessary to protect hospital staff from communicable diseases, compared to any alternate course of action.

**Federal Standards:**

No federal standards apply to stockpiling of such equipment at hospitals.

**Compliance Schedule:**

The regulations will become effective upon publication of a Notice of Adoption in the New York State Register. These regulations are expected to be proposed for permanent adoption at a future meeting of the Public Health and Health Planning Council.

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## REGULATORY FLEXIBILITY ANALYSIS

**Effect on Small Business and Local Government:**

This regulation will not impact local governments or small businesses unless they operate a general hospital or a nursing home. Currently there are five general hospitals in New York that employ less than 100 staff and qualify as small businesses, and there are 79 nursing homes in New York qualify as small businesses given that they employ less than 100 staff.

**Compliance Requirements:**

These regulations require all general hospitals and nursing homes to purchase and maintain adequate stockpiles of PPE, including but not limited to masks, respirators, face shields and gowns.

**Professional Services:**

It is not expected that any professional services will be needed to comply with this rule.

**Compliance Costs:**

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each covered facility. However, the Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to

balance facility expenditures over time. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). As such, this regulation imposes no long-term additional costs to regulated parties.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

The Department anticipates that any adverse impacts will be minimal, as both hospitals and nursing homes have already mobilized their stockpiling efforts since early 2020, when the spread of the COVID-19 virus was first recognized in New York State, including through two surges of the COVID-19 pandemic. As such, the continuance of these stockpiling requirements is not expected to create any additional adverse impact on hospitals or nursing homes. Moreover, for nursing homes, these PPE regulations are consistent with the existing directive in Public Health Law section 2803(12) to maintain a two-month PPE supply.

**Small Business and Local Government Participation:**

Small business and local governments were not directly consulted given the urgent need to ensure hospital patients and nursing home residents are adequately protected in the event of a resurgence of COVID-19 or another communicable disease outbreak. However, the Department

plans to issue an advisory to hospital CEOs and nursing home administrators alerting them to the anticipated proposed rulemaking on these regulations and opportunity to submit public comments.

## RURAL AREA FLEXIBILITY ANALYSIS

**Type and Estimated Numbers of Rural Areas:**

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Allegany County | Greene County | Schoharie County |
| Cattaraugus County | Hamilton County | Schuyler County |
| Cayuga County | Herkimer County | Seneca County |
| Chautauqua County | Jefferson County | St. Lawrence County |
| Chemung County | Lewis County | Steuben County |
| Chenango County | Livingston County | Sullivan County |
| Clinton County | Madison County | Tioga County |
| Columbia County | Montgomery County | Tompkins County |
| Cortland County | Ontario County | Ulster County |
| Delaware County | Orleans County | Warren County |
| Essex County | Oswego County | Washington County |

| | | |
|---|---|---|
| Franklin County | Otsego County | Wayne County |
| Fulton County | Putnam County | Wyoming County |
| Genesee County | Rensselaer County | Yates County |
| | Schenectady County | |

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Albany County | Monroe County | Orange County |
| Broome County | Niagara County | Saratoga County |
| Dutchess County | Oneida County | Suffolk County |
| Erie County | Onondaga County | |

There are 47 general hospitals located in rural areas as well as several licensed nursing homes.

**Reporting, Recordkeeping, and Other Compliance Requirements; and Professional Services:**

These regulations require all general hospitals and nursing homes, including those in rural areas, to purchase and maintain adequate stockpiles of PPE, including but not limited to masks, respirators, face shields and gowns.

**Compliance Costs:**

The purpose of this regulation is to require general hospitals and nursing homes to maintain adequate stockpiles of PPE. The initial cost to facilities as they establish stockpiles of PPE will vary depending on the number of staff working at each facility. However, the Department anticipates that hospitals and nursing homes will routinely use stockpiled PPE as

part of their routine operations; while facilities must maintain the requisite stockpile at all times in the event of an emergency need, facilities are expected to rotate through their stockpiles routinely to ensure the PPE does not expire and is replaced with new PPE, thereby helping to balance facility expenditures over time. Further, in the event of an emergency need, hospitals and nursing homes are expected to tap into their stockpiles; as such, hospitals and nursing homes will ultimately use equipment which would have been purchased had a stockpile not existed, thereby mitigating overall costs. Moreover, nursing homes are statutorily obligated to maintain or contract to have at least a two-month supply of PPE pursuant to Public Health Law section 2803(12). Therefore, this regulation imposes no long-term additional costs to regulated parties.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

The Department anticipates that any adverse impacts will be minimal, as both hospitals and nursing homes have already mobilized their stockpiling efforts since early 2020, when the spread of the COVID-19 virus was first recognized in New York State, including through two surges of the COVID-19 pandemic. As such, the continuance of these stockpiling requirements is not expected to create any additional adverse impact on hospitals or nursing homes. Moreover, for nursing homes, these PPE regulations are consistent with the existing directive in Public Health Law section 2803(12) to maintain a two-month PPE supply.

**Rural Area Participation:**

Parties representing rural areas were not directly consulted given the urgent need to ensure hospital patients and nursing home residents are adequately protected in the event of a resurgence of COVID-19 or another communicable disease outbreak. However, the Department plans to issue an advisory to hospital CEOs and nursing home administrators alerting them to the anticipated proposed rulemaking and opportunity to submit public comments.

## STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

## SUMMARY OF EXPRESS TERMS

Although the Governor retains authority to issue Executive Orders to temporarily suspend or modify regulations pursuant to the Executive Law, these regulatory amendments provide an expedient and coherent plan to implement quickly the relevant temporary suspensions or modifications. The regulatory amendments permit the State Commissioner of Health or designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by statute or federal law. These amendments also permit the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute.

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

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Sections 225, 2800, and 2803 of the Public Health Law; and in the Commissioner of Health by Sections 576 and 4662 of the Public Health Law and Section 461 of the Social Services Law, Title 10 (Health) and Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended to be effective upon filing with the Secretary of State, to read as follows:

A new Part 360 is added to Title 10, to read as follows:

Part 360 Surge and Flex Health Coordination System Activation During a State Disaster Emergency Declaration

Part 360. Surge and Flex System

Section 360.1. Administrative Purpose, Application and Scope

(a) Administrative purpose.

Hospitals across New York State, prior to the COVID-19 pandemic, rarely worked together or coordinated as a unified system. But a pandemic on the scale of the COVID-19 crisis demonstrated that hospitals could not meet the demand of the moment unless a new and innovative system was put into place requiring unprecedented coordination, cooperation, and agility. The New York State Department of Health takes note of the successful implementation of the Surge and Flex System by New York State's hospitals and offers these regulations as an additional way to strengthen the pandemic response. Surge and Flex Health Coordination System Activation has helped hospitals respond to the COVID-19 state disaster emergency, and New

York's hospitals have made commendable efforts to coordinate their response to the pandemic, to direct patients to the hospitals with the capacity to treat them, and to increase capacity as needed, during each wave of the pandemic.

The COVID-19 crisis demanded a new coordinated approach to ensure no one hospital was overwhelmed by COVID-19 patients or needed more ventilators, while a hospital nearby had capacity for more patients and excess equipment. It was imperative for government to coordinate and organize all hospitals under the umbrella of one unified system, and efficiently use all the resources available in the state to attempt to meet the significant demands of the crisis.

The "Surge and Flex" system is designed to create a single, coordinated statewide system to prevent a disaster from overwhelming any one hospital in the state. The purpose of this NYSDOH regulation is to institutionalize Surge and Flex operation, giving hospitals the time and guidance to adequately prepare for a potential future activation of Surge and Flex. This regulation provides the Department of Health with the necessary tools to enact Surge and Flex operation during another wave of COVID-19, or a future public health emergency. Further, this regulation is designed to help each hospital prepare for this contingency in order to ensure a straightforward transition from standard operating procedures to "Surge and Flex."

(b) Application and Scope. In the event of a State disaster emergency declared pursuant to section 28 of the Executive Law, the Commissioner may exercise the authorities granted in this Part, thereby maximizing the efficiency and effectiveness of the State's hospital systems and mitigating the threat to the health of the people of New York. Further, this Part establishes certain ongoing emergency planning requirements, called the Surge and Flex Health Care Coordination System, for facilities and agencies regulated by the Department.

To the extent that any provision of this Part conflicts with any other regulation of the Department, this Part shall take precedence. All authorities granted to the Commissioner shall be subject to any conditions and limitations that the Commissioner may deem appropriate. The Commissioner may delegate activation of the authorities provided by this Part to appropriate executive staff within the Department. In the event that there are inconsistent statutes, which would preclude effectiveness of such regulation, such regulation shall be effective upon the suspension of such inconsistent statute by the Governor pursuant to authority in Article 2-B of the Executive Law, and such regulation shall immediately be effective.

Section 360.2. Surge and Flex Health Care Coordination System Requirements.

(a) In the event of a declared State disaster emergency, the Commissioner shall have all necessary authority and procedures to activate the Surge and Flex Health Care Coordination System (hereinafter "Surge and Flex System"), including the following:

(1) Increase Bed Capacity. At the Commissioner's direction, which shall be incremental and geographically targeted, health care facilities shall increase by up to 50% the number of acute care beds and/or change the service categories of beds certified or otherwise approved in any entity regulated by the Department. At the Commissioner's direction, health care facilities shall postpone up to 100% of non-essential elective procedures or allow such procedures only pursuant to such conditions as the Commissioner may determine. The Department shall establish procedures to approve temporary changes at regulated health care facilities to physical plants, to facilitate the increased capacity and shall expedite review of construction applications related to temporary locations, provided that schematics are filed with the Department and patient safety is maintained.

(2) Enhanced Staffing Capacity. Health care facilities shall establish plans to meet enhanced staffing levels sufficient to ensure that the increased bed capacity has adequate staffing. The Commissioner may further expand or modify criteria for staffing. Health care facilities shall have access to a State-run portal for staffing needs identifying both volunteers and available staff; whether licensed or registered in New York State, or authorized or licensed to practice in any other state or Canada.

(3) Availability of Supplies and PPE. Health care facilities shall maintain and actively manage a supply of personal protective equipment (PPE) appropriate for use during a declared health emergency that could last at least 60-days pursuant to Section 405.11(g) of this Title. The Commissioner shall have all necessary authority to re-distribute the resources of a regulated entity if there is a determination that such resources are limited and in order to preserve the health and safety of New Yorkers, including:

(i) Requiring that any medical or other equipment that is held in inventory by any entity in the State, or otherwise located in the State, be reported to the Department, in a form and with such frequency as the Commissioner may determine.

(ii) Requiring that the patient census be reported to the Department, in a form and with such frequency as the Commissioner may determine.

(iii) For any infectious and communicable disease, ensuring that testing results are reported immediately if positive, and as determined by the Commissioner if such testing results are negative, via the electronic clinical laboratory reporting system or as the Commissioner may determine.

(iv) Suspending or restricting visitation, in accordance with the need to conserve PPE, and subject to such conditions or limitations as the Commissioner may determine.

(4) Statewide Coordination.

(i) Discharging, transfer, and receiving of patients. Health care facilities regulated by the Department shall, if directed to do so by the Commissioner, rapidly discharge, transfer, or receive patients, while protecting the health and safety of such patients and residents, and consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA). The Department shall coordinate with health care facilities to balance individual facility patient load, and may promulgate further directives to specify the method and manner of transfer or discharge.

(ii) Designating Health Care Facilities as Trauma Centers. The Department is authorized to designate an entity as a trauma center; extend or modify the period for which an entity may be designated as a trauma center; or modify the review team for assessment of a trauma center; or change the level of acuity designation or health services of a facility or other determination about patient care as appropriate, including restricting admission or treatment to patients with a particular diagnosis.

(iii) Maintaining a Statewide Health Care Data Management System. Health care facilities or health systems shall report as directed by the Department any information necessary to implement the Surge and Flex System (e.g. available hospital beds, equipment available and in use) and the Department shall use that health facility or health system data in order to monitor, coordinate, and manage during the emergency.

Section 360.3. Hospital emergency Surge and Flex Response Plans.

(a) Every general hospital (hereinafter, “hospital”) shall adopt a detailed emergency Surge and Flex Response Plan (hereinafter, “plan”) that, at a minimum, includes the following elements:

(1) Bed surge plan. The plan shall explain how the hospital will increase the number of current staffed acute care operational beds to a number set by the Commissioner, which shall be up to a 50% increase of such beds within seven days from the date of the declaration of the state disaster emergency. For the purposes of this Part, an “acute care operational bed” means a bed that is staffed and equipped with appropriate infrastructure such that it can be used to deliver health care services to a patient. The Commissioner may further define the type of acute care operational beds for a given state disaster emergency, which may include isolation beds, intensive care (ICU) beds, pediatric and/or acute care beds. The plan shall contain scenarios for increases of current staffed acute care operational beds in phased increments, detailing the associated considerations for PPE, staffing, and other supplies and equipment, including whether the hospital can meet those requirements using internal resources and capabilities, as well as intra-system load balancing and postponement of some or all non-essential elective procedures. These plans shall inform the Commissioner’s directives, which shall be incremental and geographically tailored at the Statewide, regional, or community level, as dictated by infection rate data.

(2) PPE surge plan. The plan shall explain how the hospital will increase its supply of personal protective equipment (PPE) appropriate for use in a pandemic to achieve continuous maintenance of its required 60-day supply of PPE, pursuant to section 405.11(g) of this Title. The plan shall list the contracted entities or other supply chain agreements executed by the hospital. Such plan shall further include, as appropriate,

how the hospital will repurpose existing equipment, replenish the inventory from other areas of the health system, and establish cooperative agreements to obtain PPE to accommodate supply chain interruptions. A PPE surge plan may provide for hospital utilization of some, but not all, of the stockpile reserves during a State disaster emergency, provided that within 30 days of the end of the State disaster emergency, the stockpile reserve is fully restored.

(3) Mass casualty plan. The plan shall explain how the hospital will receive and treat mass casualty victims, in the event of a secondary disaster arising from the interruption of normal services resulting from an epidemic, earthquake, flood, bomb threat, chemical spills, strike, interruption of utility services, nuclear accidents and similar occurrences, while addressing the continued need for surge capacity for the underlying state disaster emergency declaration.

(4) Staffing plan. The plan shall explain how the hospital will: identify and train backups for employees who may be unable to report to work during a pandemic; institute employee overtime protocols; and increase staffing by inter- and intra-system loan, cross-training, and volunteer programs, which would be operational on seven days' notice.

(5) Capital plan. The plan shall explain how the hospital shall ensure continuous operation of facilities and access to utilities, materials, electronic devices, machinery and equipment, vehicles, and communication systems. The plan shall ensure that the hospital routinely performs all required maintenance and peak load testing of its infrastructure systems, including: electrical, heating, ventilation and air conditioning (HVAC), and oxygen supply.

(b) The Chief Executive Officer (CEO) of the hospital, or system if authorized by the Commissioner to report on a system-wide basis, shall certify to the review and approval of the plan, including an attestation that it can be implemented and achieved in the event of a declared disaster emergency. The CEO shall be responsible for ensuring that the plan is reviewed and updated, as necessary, periodically as specified by the Commissioner and shall re-certify that it is able to be implemented and achieved upon each review.

(c) The Department may require the hospital to submit its disaster emergency response plan and history of semi-annual certifications for review, and may require the hospital to make such amendments to the plan as the Commissioner deems appropriate, to ensure that the plan will achieve the requirements established in subdivision (a) of this section, including increases in bed capacity.

(d) In the event of a declared state disaster emergency, any or all hospitals shall execute their plans immediately upon the direction of the Commissioner.

(e) Additional preparedness requirements.

(1) PPE. Every hospital shall, at all times, continue to maintain the required 60-day supply of PPE appropriate for use in a disaster emergency including a pandemic, pursuant to section 405.11(g) of this Title.

(2) Information technology. Every hospital shall ensure that non-essential staff who are capable of working remotely in the event of an emergency are equipped and trained to do so, and that infrastructure is in place to allow for the repurposing of existing workspaces as needed when activating the Surge and Flex System.

(f) Reporting requirements during the activation of the Surge and Flex System.

(1) In the event of a declared state disaster emergency, upon the Commissioner's direction, hospitals or health systems shall report to the Department all data requested by the Commissioner, in a manner determined by the Commissioner under Section 306.2. Such data may include, but shall not be limited to:

(i) Bed availability, both in total and by designated service.

(ii) Bed capacity, meaning acute care operational beds as defined in paragraph (a)(1) of this Section.

(iii) Patient demographics.

(iv) Other health statistics, including deaths.

(v) PPE and other supplies, in stock and ordered.

(vi) PPE and other supply usage rates.

(2) Such reports shall be submitted periodically as determined by the Commissioner, except and unless otherwise directed by the Department.

Section 360.4 Clinical laboratory testing

(a) In the event of a declared state disaster emergency, the Commissioner shall have all necessary authority to:

(1) Authorize clinical laboratories to operate temporary collecting stations to collect specimens from individuals.

(b) In addition, and to the extent consistent with any Executive Order issued by the Governor, the Commissioner shall have all necessary authority to:

(1) Waive permit requirements for clinical laboratories and establish minimum qualifications to allow non-permitted clinical laboratories to accept and test

specimens from New York State, provided that such laboratories must meet any federal requirements.

(2) Establish minimum qualifications of individuals that may perform clinical laboratory tests, provided that such persons meet federal requirements.

(3) Allow clinical laboratories to accept specimens without an order, subject to a plan approved by Commissioner to ensure the result of any tests are reported to the patient or the patient's personal representative and there will be appropriate follow up with the patient based on the results.

(4) Authorize licensed pharmacists to order clinical laboratory tests, consistent with federal law, including certificate of waiver requirements.

(5) Permit licensed pharmacists to be designated as qualified healthcare professionals for the purpose of directing a limited service laboratory, pursuant to Section 579 of the Public Health Law.

(6) Permit licensed pharmacists to order and administer clinical tests.

(c) Prioritization of clinical laboratory tests. In the event the declared state disaster emergency requires utilization of clinical laboratory testing at a rate that exceeds available capacity, no laboratory shall perform such test unless the test has been ordered consistent with the testing prioritization published by the Commissioner.

(d) Reporting of results of any communicable disease during a Surge and Flex period shall be made immediately via the Electronic Clinical Laboratory Reporting system, if positive, and on a schedule as determined by the Commissioner if negative.

Subdivision (g) of section 405.24 of 10 NYCRR is amended to read as follows:

Emergency and disaster preparedness. The hospital shall have a written plan, rehearsed and updated at least twice a year, with procedures to be followed for the proper care of patients and personnel, including but not limited to the reception and treatment of mass casualty victims, in the event of an internal or external emergency or disaster arising from the interruption of normal services resulting from earthquake, flood, bomb threat, chemical spills, strike, interruption of utility services, nuclear accidents and similar occurrences. Personnel responsible for the hospital's accommodation to extraordinary events shall be trained in all aspects of preparedness for any interruption of services and for any disaster. This shall be in addition to the Surge and Flex Plan that is required pursuant to Part 360 of the Title.

Section 400.1 of 10 NYCRR is amended to read as follows:

(a) This Subchapter shall be known and may be cited as "Medical Facilities--Minimum Standards," and shall apply to medical facilities defined as hospitals within article 28 of the Public Health Law. The standards within a particular article shall constitute the minimum standards for the identified medical facility in addition to those standards that may apply to such facilities as set forth in Articles 1 and 3 of this Subchapter as applicable.

(b) During the period of a state disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Subchapter, that is not otherwise required by state statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of

regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a state disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new section 700.5 of 10 NYCRR is added to read as follow:

700.5 Commissioner authority to suspend and modify regulations

During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Subchapter, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the State disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies State statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or

modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (8) is added to subdivision (e) of section 1001.6 of 10 NYCRR, to read as follows:

(8) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new section 1.2 of 10 NYCRR is added to read as follows.

1.2 Commissioner authority to suspend and modify regulations

During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Title, that is not otherwise required by state statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (4) subdivision (g) of section 487.3 of 18 NYCRR is added to read as follows:

(4) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the

Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (6) subdivision (f) of section 488.3 of 18 NYCRR is added to read as follows:

(6) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by state statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the State disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies State statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (5) subdivision (g) of section 490.3 of 18 NYCRR is added to read as follows:

(5) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the State disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a state disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies State statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

## REGULATORY IMPACT STATEMENT

**Statutory Authority:**

The authority for the promulgation of these regulations with respect to facilities subject to Article 28 of the Public Health Law (PHL) is contained in PHL sections 2800 and 2803(2). PHL Article 28 (Hospitals), section 2800, specifies: "Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, pursuant to section three of article seventeen of the constitution, the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services, and all public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition or for the rendering of health-related service shall be subject to the provisions of this article." PHL section 2801 defines the term "hospital" as also including residential health care facilities (nursing homes) and diagnostic and treatment centers (D&TCs). PHL section 2803 (2) authorizes PHHPC to adopt and amend rules and regulations, subject to the approval of the Commissioner, to implement the purposes and provisions of PHL Article 28, and to establish minimum standards governing the operation of such health care facilities.

PHL section 4662 authorizes the Commissioner to issue regulations governing assisted living residences. Social Services Law (SSL) section 461(1) authorizes the Commissioner to promulgate regulations establishing standards applicable to adult care facilities. PHL section 576 authorizes the Commissioner to regulate clinical laboratories.

PHL section 225 authorizes the Public Health and Health Planning Council (PHHPC) and the Commissioner to establish and amend the State Sanitary Code (SSC) provisions related to any matters affecting the security of life or health or the preservation and improvement of public health in the State of New York.

Upon the future declaration of any disaster emergency, any further authorization by the Governor pursuant to article 2-B of the Executive Law, if it should suspend any statutes which otherwise conflict with these regulations, will establish the immediate effectiveness of these provisions.

**Legislative Objectives:**

The objectives of PHL Article 28 include protecting the health of New York State residents by ensuring that they have access to safe, high-quality health services in medical facilities, while also protecting the health and safety of healthcare workers. Similarly, PHL Articles 36 and 40 ensure that the Department has the tools needed to achieve these goals in the home care and hospice spaces, and PHL section 4662 and SSL section 461 likewise ensure that the Department has appropriate regulatory authority with respect to assisted living residences and adult care facilities. PHL section 576 ensures that the Commissioner has appropriate regulatory authority over clinical laboratories. Finally, PHL section 225 ensures that the State Sanitary Code includes appropriate regulations in the areas of communicable disease control and environmental health, among others.

By permitting the Commissioner to temporarily suspend or modify regulatory provisions in each these areas, where not required by state statute or federal law, or where authorized by a

gubernatorial Executive Order, these amendments provide crucial flexibility for this and future emergency response efforts.

**Needs and Benefits:**

During a state disaster emergency, Section 29-a of the Executive Law permits the Governor to, among other things, "temporarily suspend specific provisions of any statute, local law, ordinance, or orders, rules or regulations, or parts thereof, of any agency during a state disaster emergency, if compliance with such provisions would prevent, hinder, or delay action necessary to cope with the disaster."

Although the Governor retains authority to issue Executive Orders to temporarily suspend or modify regulations pursuant to the Executive Law, these proposed regulatory amendments would provide an expedient and coherent plan to implement quickly the relevant temporary suspensions or modifications. The proposed regulatory amendments would permit the State Commissioner of Health or designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by statute or federal law. These proposed amendments would also permit the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute.

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

During a state disaster emergency with significant public health impact, and where compliance with certain regulations may prevent, hinder or delay action necessary to cope with the disaster, as is the case with COVID-19, this authority will ensure that the State has the most efficient regulatory tools to facilitate the State's and regulated parties' response efforts to Surge and Flex the healthcare system statewide. Additionally, this authority will also ensure that the Department has the flexibility to impose additional requirements, where necessary, to ensure effective response to a declared state disaster emergency. Accordingly, these tools will help ensure the health and safety of patients and residents in New York State.

**Costs:**

**Costs to Regulated Parties:**

As demonstrated during the COVID-19 pandemic emergency, significant provider costs, as well as local, regional and state costs, were incurred as a result of the need to respond to the demand for urgent healthcare and related services. These costs had significant impact throughout the state. It is anticipated there would be similar types of costs in a widespread emergency that would need to be addressed through both appropriate preparedness as well as within, and as part of, a coordinated response to a specific situation.

To the extent that additional requirements are imposed on regulated parties by these proposed regulatory amendments, most requirements would be in effect only for the duration of a declared state disaster emergency, with the hope of limiting costs to the extent possible.

**Costs to Local Governments:**

As demonstrated during the COVID-19 pandemic emergency, significant provider costs, as well as local, regional and state costs, were incurred as a result of the need to respond to the demand for urgent healthcare and related services. These costs had significant impact throughout the state. It is anticipated there would be similar types of costs in a widespread emergency that would need to be addressed through both appropriate preparedness as well as within and as part of a coordinated response to a specific situation.

To the extent additional requirements are imposed on local governments that operate facilities regulated by the Department, most requirements would be in effect only for the duration of a declared state disaster emergency, with the hope of limiting costs to the extent possible.

**Cost to State Government:**

The administration and oversight of these planning and response activities will be managed within the Department's existing resources.

**Paperwork:**

It is not anticipated that the proposed regulatory amendments will impose any significant paperwork requirements. Although these proposed amendments require additional reporting,

these reports can be submitted electronically using the current platforms that facilities are already using. Moreover, such reporting requirements would only be activated during a declared state disaster emergency, thereby limiting the burden.

**Local Government Mandates:**

Facilities operated by local governments will subject to the same requirements as any other regulated facility, as described above.

**Duplication:**

These proposed regulatory amendments do not duplicate state or federal rules.

**Alternatives:**

The alternative would be to not promulgate the regulation. However, this alternative was rejected, as the Department believes that these regulatory amendments are necessary to facilitate response to a state disaster emergency.

**Federal Standards:**

42 CFR 482.15 establishes emergency preparedness minimum standards in four core areas including emergency planning, development of applicable policies and procedures, communications plan, and training and testing. These proposed amendments would complement the federal regulation and further strengthen hospitals' emergency preparedness and response programs.

**Compliance Schedule:**

These regulatory amendments will become effective upon filing with the Department of State.

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## REGULATORY FLEXIBILITY ANALYSIS

**Effect on Small Business and Local Government:**

The proposed regulatory amendments would primarily affect health care professionals, licensed health care facilities, permitted clinical laboratories, emergency medical service personnel, providers, and agencies, and pharmacies.

**Compliance Requirements:**

A significant portion of these regulatory amendments are designed to provide regulatory relief during a declared state disaster emergency. Where the regulatory amendments would impose requirements, most of them would only be applicable when there is a declared state disaster emergency. An example of a requirement that may be implemented during a declared state disaster emergency is reporting of data and inventory as requested by the Commissioner (i.e. medical supplies and equipment, as well as hospital bed capacity, bed utilization, patient demographics, etc.). There are certain ongoing requirements proposed by this regulatory amendments, which would apply regardless of whether there is a declared state disaster emergency, in which hospitals would be required to: (1) maintain minimum levels of PPE; (2) ensure work from home capabilities; and (3) develop disaster emergency response plans.

**Professional Services:**

It is not expected that any professional services will be required to comply with the proposed regulatory amendments.

**Compliance Costs:**

As demonstrated during the COVID-19 pandemic emergency, significant provider costs, as well as local, regional and state costs, were incurred as a result of the need to respond to the demand for urgent healthcare and related services. These costs had significant impact throughout the state. It is anticipated there would be similar types of costs in a widespread emergency that would need to be addressed through both appropriate preparedness as well as within and as part of a coordinated response to a specific situation.

To the extent additional requirements are imposed on small businesses and local governments by these proposed regulatory amendments, most requirements would only be in effect for the duration of a declared state disaster emergency, with the hope of limiting costs to the extent possible. Ongoing costs requiring hospitals to maintain a minimum PPE supply and ensure work from home capabilities should have been addressed throughout the ongoing COVID-19 pandemic, thereby limiting costs of continued implementation. Ongoing costs related to hospital development of disaster emergency response plan will complement and build upon existing planning documents that hospitals are already required to have, which also limits costs.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the proposed regulatory amendments.

**Minimizing Adverse Impact:**

Although the proposed regulatory amendments impose some additional requirements on regulated parties, most of these requirements are only triggered during a declared state disaster

emergency.  Proposed amendments that would impose ongoing requirements would only apply to hospitals, and as noted above, will largely be a continuation of the efforts already being employed by these entities.

**Small Business and Local Government Participation:**

The Surge and Flex Health Care Coordination System was activated during the COVID-19 State disaster emergency which was first declared on March 7, 2020, and it has been used throughout the COVID-19 pandemic. The public has been permitted to comment at the public meetings during which the Public Health and Health Planning Council has approved this regulation on an emergency basis. A Notice of Proposed Rule Making was published in the *State Register* on February 16, 2022, with a public comment period that ended on April 18, 2022, and the Department will publish an Assessment of Public Comment before a Final Rule is adopted.

## RURAL AREA FLEXIBILITY ANALYSIS

**Type and Number of Rural Areas:**

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein." The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Allegany County | Greene County | Schoharie County |
| Cattaraugus County | Hamilton County | Schuyler County |
| Cayuga County | Herkimer County | Seneca County |
| Chautauqua County | Jefferson County | St. Lawrence County |
| Chemung County | Lewis County | Steuben County |
| Chenango County | Livingston County | Sullivan County |
| Clinton County | Madison County | Tioga County |
| Columbia County | Montgomery County | Tompkins County |
| Cortland County | Ontario County | Ulster County |
| Delaware County | Orleans County | Warren County |
| Essex County | Oswego County | Washington County |
| Franklin County | Otsego County | Wayne County |
| Fulton County | Putnam County | Wyoming County |

| | | |
|---|---|---|
| Genesee County | Rensselaer County | Yates County |
| | Schenectady County | |

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

| | | |
|---|---|---|
| Albany County | Monroe County | Orange County |
| Broome County | Niagara County | Saratoga County |
| Dutchess County | Oneida County | Suffolk County |
| Erie County | Onondaga County | |

**Reporting, recordkeeping, and other compliance requirements; and professional services:**

A significant portion of these regulatory amendments are designed to provide regulatory relief during a declared state disaster emergency. Where the regulatory amendments would impose requirements, most of them would only be applicable when there is a declared state disaster emergency. An example of a requirement that may be implemented during a declared state disaster emergency is reporting of data and inventory as requested by the Commissioner (i.e. medical supplies and equipment, hospital bed capacity, bed utilization, patient demographics, etc.). There are certain ongoing requirements proposed by this regulatory amendments, regardless of whether there is a declared state disaster emergency, in which hospitals would be required to: (1) maintain minimum levels of PPE; (2) ensure work from home capabilities; and (3) develop disaster emergency response plans. This regulation provides that the Commissioner's directives shall be incremental and geographically tailored and targeted at the Statewide, regional, or community level, as dictated by infection rate data.

It is not expected that any professional services will be required to comply with the proposed regulatory amendments.

**Compliance Costs:**

As a large part of these regulatory amendments would give the State Commissioner of Health authority to temporarily suspend or modify certain regulations within Titles 10 and 18 during a state disaster emergency, these regulatory amendments are not expected to result in any significant costs to public and private entities in rural areas.

To the extent additional requirements are imposed on public and private entities in rural areas by these proposed regulatory amendments, such requirements would only be in effect for the duration of a declared state disaster emergency.

Lastly, per SAPA § 202-bb(3)(c), it is not anticipated that there will be any significant variation in cost for different types of public and private entities in rural areas.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

Although the proposed regulatory amendments impose additional requirements on regulated parties, including those in rural areas, most of these requirements are only triggered during a declared state disaster emergency. Proposed amendments that would require disaster emergency preparedness planning on the part of regulated parties will complement and build upon existing state and federal planning requirements.

**Rural Area Participation:**

The Surge and Flex Health Care Coordination System was activated during the COVID-19 State disaster emergency which was first declared on March 7, 2020, and it has been used throughout the COVID-19 pandemic. The public has been permitted to comment at the public meetings during which the Public Health and Health Planning Council has approved this regulation on an emergency basis. A Notice of Proposed Rule Making was published in the *State Register* on February 16, 2022, with a public comment period that ended on April 18, 2022, and the Department will publish an Assessment of Public Comment before a Final Rule is adopted.

## JOB IMPACT STATEMENT

The Department of Health has determined that these regulatory changes will not have a substantial adverse impact on jobs and employment, based upon its nature and purpose.

## EMERGENCY JUSTIFICATION

During a state disaster emergency with significant public health impact, and where compliance with certain regulations may prevent, hinder or delay action necessary to cope with the disaster, as has been the case with COVID-19, these proposed regulations will ensure that the State has the most efficient regulatory tools to facilitate the State's and regulated parties' response efforts to Surge and Flex the healthcare system statewide. Additionally, this authority will also ensure that the Department has the flexibility to impose additional requirements, where necessary, to ensure effective response to a declared state disaster emergency. Accordingly, these tools will help ensure the health and safety of patients and residents in New York State.

The Surge and Flex Health Care Coordination System was activated during the COVID-19 State disaster emergency which was declared by Governor Cuomo under Executive Orders No. 202 through 202.111 (March 7, 2020 to June 15, 2021; see 9 NYCRR §§8.202 through 8.202.111), the State disaster emergency which was declared by Governor Hochul under Executive Orders No. 4 through 4.14 (September 27, 2021 to November 26, 2022; see 9 NYCRR §§ 9.4 through 9.4.14), and the State disaster emergency which was declared by Governor Hochul under Executive Orders No. 11 through 11.9 (November 26, 2021 to September 12, 2022; see 9 NYCRR §§9.11 through 9.11.9).

Of note, a Notice of Proposed Rule Making was published in the *State Register* on February 16, 2022, with a public comment period that ended on April 18, 2022. The Department intends these emergency regulations to be in effect only until such time as the Notice of Adoption is published in the *State Register*, which will make the Proposed Rule permanent.

## SUMMARY OF EXPRESS TERMS

Although the Governor retains authority to issue Executive Orders to temporarily suspend or modify regulations pursuant to the Executive Law, these proposed regulatory amendments would provide an expedient and coherent plan to implement quickly the relevant temporary suspensions or modifications. The proposed regulatory amendments would permit the State Commissioner of Health or designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by statute or federal law. These proposed amendments would also permit the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute.

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

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Sections 225, 2800, and 2803 of the Public Health Law; and in the Commissioner of Health by Sections 576 and 4662 of the Public Health Law and Section 461 of the Social Services Law, Title 10 (Health) and Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

A new Part 360 is added to Title 10, to read as follows:

Part 360 Surge and Flex Health Coordination System Activation During a State Disaster Emergency Declaration

Part 360. Surge and Flex System

Section 360.1. Administrative Purpose, Application and Scope

(a) Administrative purpose.

Hospitals across New York State, prior to the COVID-19 pandemic, rarely worked together or coordinated as a unified system. But a pandemic on the scale of the COVID-19 crisis demonstrated that hospitals could not meet the demand of the moment unless a new and innovative system was put into place requiring unprecedented coordination, cooperation, and agility. The New York State Department of Health takes note of the successful implementation of the Surge and Flex System by New York State's hospitals and offers these regulations as an additional way to strengthen the pandemic response. Surge and Flex Health Coordination System

Activation has helped hospitals respond to the COVID-19 state disaster emergency, and New York's hospitals have made commendable efforts to coordinate their response to the pandemic, to direct patients to the hospitals with the capacity to treat them, and to increase capacity as needed, during each wave of the pandemic.

The COVID-19 crisis demanded a new coordinated approach to ensure no one hospital was overwhelmed by COVID-19 patients or needed more ventilators, while a hospital nearby had capacity for more patients and excess equipment. It was imperative for government to coordinate and organize all hospitals under the umbrella of one unified system, and efficiently use all the resources available in the state to attempt to meet the significant demands of the crisis.

The "Surge and Flex" system is designed to create a single, coordinated statewide system to prevent a disaster from overwhelming any one hospital in the state. The purpose of this NYSDOH regulation is to institutionalize Surge and Flex operation, giving hospitals the time and guidance to adequately prepare for a potential future activation of Surge and Flex. This regulation provides the Department of Health with the necessary tools to enact Surge and Flex operation during another wave of COVID-19, or a future public health emergency. Further, this regulation is designed to help each hospital prepare for this contingency in order to ensure a straightforward transition from standard operating procedures to "Surge and Flex."

(b) Application and Scope. In the event of a State disaster emergency declared pursuant to section 28 of the Executive Law, the Commissioner may exercise the authorities granted in this Part, thereby maximizing the efficiency and effectiveness of the State's hospital systems and mitigating the threat to the health of the people of New York. Further, this Part establishes

certain ongoing emergency planning requirements, called the Surge and Flex Health Care Coordination System, for facilities and agencies regulated by the Department.

To the extent that any provision of this Part conflicts with any other regulation of the Department, this Part shall take precedence. All authorities granted to the Commissioner shall be subject to any conditions and limitations that the Commissioner may deem appropriate. The Commissioner may delegate activation of the authorities provided by this Part to appropriate executive staff within the Department. In the event that there are inconsistent statutes, which would preclude effectiveness of such regulation, such regulation shall be effective upon the suspension of such inconsistent statute by the Governor pursuant to authority in Article 2-B of the Executive Law, and such regulation shall immediately be effective.

Section 360.2. Surge and Flex Health Care Coordination System Requirements.

(a) In the event of a declared State disaster emergency, the Commissioner shall have all necessary authority and procedures to activate the Surge and Flex Health Care Coordination System (hereinafter "Surge and Flex System"), including the following:

(1) Increase Bed Capacity. At the Commissioner's direction, which shall be incremental and geographically targeted, health care facilities shall increase by up to 50% the number of acute care beds and/or change the service categories of beds certified or otherwise approved in any entity regulated by the Department. At the Commissioner's direction, health care facilities shall postpone up to 100% of non-essential elective procedures or allow such procedures only pursuant to such conditions as the Commissioner may determine. The Department shall establish procedures to approve temporary changes at regulated health care facilities to physical plants, to facilitate the increased capacity and shall expedite review of construction applications related to

temporary locations, provided that schematics are filed with the Department and patient safety is maintained.

(2) Enhanced Staffing Capacity. Health care facilities shall establish plans to meet enhanced staffing levels sufficient to ensure that the increased bed capacity has adequate staffing. The Commissioner may further expand or modify criteria for staffing. Health care facilities shall have access to a State-run portal for staffing needs identifying both volunteers and available staff; whether licensed or registered in New York State, or authorized or licensed to practice in any other state or Canada.

(3) Availability of Supplies and PPE. Health care facilities shall maintain and actively manage a supply of personal protective equipment (PPE) appropriate for use during a declared health emergency that could last at least 60-days pursuant to Section 405.11(g) of this Title. The Commissioner shall have all necessary authority to re-distribute the resources of a regulated entity if there is a determination that such resources are limited and in order to preserve the health and safety of New Yorkers, including:

(i) Requiring that any medical or other equipment that is held in inventory by any entity in the State, or otherwise located in the State, be reported to the Department, in a form and with such frequency as the Commissioner may determine.

(ii) Requiring that the patient census be reported to the Department, in a form and with such frequency as the Commissioner may determine.

(iii) For any infectious and communicable disease, ensuring that testing results are reported immediately if positive, and as determined by the Commissioner if such testing results are negative, via the electronic clinical laboratory reporting system or as the Commissioner may determine.

(iv) Suspending or restricting visitation, in accordance with the need to conserve PPE, and subject to such conditions or limitations as the Commissioner may determine.

(4) Statewide Coordination.

(i) Discharging, transfer, and receiving of patients. Health care facilities regulated by the Department shall, if directed to do so by the Commissioner, rapidly discharge, transfer, or receive patients, while protecting the health and safety of such patients and residents, and consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA). The Department shall coordinate with health care facilities to balance individual facility patient load, and may promulgate further directives to specify the method and manner of transfer or discharge.

(ii) Designating Health Care Facilities as Trauma Centers. The Department is authorized to designate an entity as a trauma center; extend or modify the period for which an entity may be designated as a trauma center; or modify the review team for assessment of a trauma center; or change the level of acuity designation or health services of a facility or other determination about patient care as appropriate, including restricting admission or treatment to patients with a particular diagnosis.

(iii) Maintaining a Statewide Health Care Data Management System. Health care facilities or health systems shall report as directed by the Department any information necessary to implement the Surge and Flex System (e.g. available hospital beds, equipment available and in use) and the Department shall use that health facility or health system data in order to monitor, coordinate, and manage during the emergency.

Section 360.3. Hospital emergency Surge and Flex Response Plans.

(a) Every general hospital (hereinafter, “hospital”) shall adopt a detailed emergency Surge and Flex Response Plan (hereinafter, “plan”) that, at a minimum, includes the following elements:

(1) Bed surge plan. The plan shall explain how the hospital will increase the number of current staffed acute care operational beds to a number set by the Commissioner, which shall be up to a 50% increase of such beds within seven days from the date of the declaration of the state disaster emergency. For the purposes of this Part, an “acute care operational bed” means a bed that is staffed and equipped with appropriate infrastructure such that it can be used to deliver health care services to a patient. The Commissioner may further define the type of acute care operational beds for a given state disaster emergency, which may include isolation beds, intensive care (ICU) beds, pediatric and/or acute care beds. The plan shall contain scenarios for increases of current staffed acute care operational beds in phased increments, detailing the associated considerations for PPE, staffing, and other supplies and equipment, including whether the hospital can meet those requirements using internal resources and capabilities, as well as intra-system load balancing and postponement of some or all non-essential elective procedures. These plans shall inform the Commissioner’s directives, which shall be incremental and geographically tailored at the Statewide, regional, or community level, as dictated by infection rate data.

(2) PPE surge plan. The plan shall explain how the hospital will increase its supply of personal protective equipment (PPE) appropriate for use in a pandemic to achieve continuous maintenance of its required 60-day supply of PPE, pursuant to section 405.11(g) of this Title. The plan shall list the contracted entities or other supply chain

agreements executed by the hospital. Such plan shall further include, as appropriate, how the hospital will repurpose existing equipment, replenish the inventory from other areas of the health system, and establish cooperative agreements to obtain PPE to accommodate supply chain interruptions. A PPE surge plan may provide for hospital utilization of some, but not all, of the stockpile reserves during a State disaster emergency, provided that within 30 days of the end of the State disaster emergency, the stockpile reserve is fully restored.

(3) Mass casualty plan. The plan shall explain how the hospital will receive and treat mass casualty victims, in the event of a secondary disaster arising from the interruption of normal services resulting from an epidemic, earthquake, flood, bomb threat, chemical spills, strike, interruption of utility services, nuclear accidents and similar occurrences, while addressing the continued need for surge capacity for the underlying state disaster emergency declaration.

(4) Staffing plan. The plan shall explain how the hospital will: identify and train backups for employees who may be unable to report to work during a pandemic; institute employee overtime protocols; and increase staffing by inter- and intra-system loan, cross-training, and volunteer programs, which would be operational on seven days' notice.

(5) Capital plan. The plan shall explain how the hospital shall ensure continuous operation of facilities and access to utilities, materials, electronic devices, machinery and equipment, vehicles, and communication systems. The plan shall ensure that the hospital routinely performs all required maintenance and peak load testing of its

infrastructure systems, including: electrical, heating, ventilation and air conditioning (HVAC), and oxygen supply.

(b) The Chief Executive Officer (CEO) of the hospital, or system if authorized by the Commissioner to report on a system-wide basis, shall certify to the review and approval of the plan, including an attestation that it can be implemented and achieved in the event of a declared disaster emergency. The CEO shall be responsible for ensuring that the plan is reviewed and updated, as necessary, periodically as specified by the Commissioner and shall re-certify that it is able to be implemented and achieved upon each review.

(c) The Department may require the hospital to submit its disaster emergency response plan and history of semi-annual certifications for review, and may require the hospital to make such amendments to the plan as the Commissioner deems appropriate, to ensure that the plan will achieve the requirements established in subdivision (a) of this section, including increases in bed capacity.

(d) In the event of a declared state disaster emergency, any or all hospitals shall execute their plans immediately upon the direction of the Commissioner.

(e) Additional preparedness requirements.

(1) PPE. Every hospital shall, at all times, continue to maintain the required 60-day supply of PPE appropriate for use in a disaster emergency including a pandemic, pursuant to section 405.11(g) of this Title.

(2) Information technology. Every hospital shall ensure that non-essential staff who are capable of working remotely in the event of an emergency are equipped and trained to do so, and that infrastructure is in place to allow for the repurposing of existing workspaces as needed when activating the Surge and Flex System.

(f) Reporting requirements during the activation of the Surge and Flex System.

(1) In the event of a declared state disaster emergency, upon the Commissioner's direction, hospitals or health systems shall report to the Department all data requested by the Commissioner, in a manner determined by the Commissioner under Section 306.2. Such data may include, but shall not be limited to:

(i) Bed availability, both in total and by designated service.

(ii) Bed capacity, meaning acute care operational beds as defined in paragraph (a)(1) of this Section.

(iii) Patient demographics.

(iv) Other health statistics, including deaths.

(v) PPE and other supplies, in stock and ordered.

(vi) PPE and other supply usage rates.

(2) Such reports shall be submitted periodically as determined by the Commissioner, except and unless otherwise directed by the Department.

Section 360.4 Clinical laboratory testing

(a) In the event of a declared state disaster emergency, the Commissioner shall have all necessary authority to:

(1) Authorize clinical laboratories to operate temporary collecting stations to collect specimens from individuals.

(b) In addition, and to the extent consistent with any Executive Order issued by the Governor, the Commissioner shall have all necessary authority to:

(1) Waive permit requirements for clinical laboratories and establish minimum qualifications to allow non-permitted clinical laboratories to accept and test specimens from New York State, provided that such laboratories must meet any federal requirements.

(2) Establish minimum qualifications of individuals that may perform clinical laboratory tests, provided that such persons meet federal requirements.

(3) Allow clinical laboratories to accept specimens without an order, subject to a plan approved by Commissioner to ensure the result of any tests are reported to the patient or the patient's personal representative and there will be appropriate follow up with the patient based on the results.

(4) Authorize licensed pharmacists to order clinical laboratory tests, consistent with federal law, including certificate of waiver requirements.

(5) Permit licensed pharmacists to be designated as qualified healthcare professionals for the purpose of directing a limited service laboratory, pursuant to Section 579 of the Public Health Law.

(6) Permit licensed pharmacists to order and administer clinical tests.

(c) Prioritization of clinical laboratory tests. In the event the declared state disaster emergency requires utilization of clinical laboratory testing at a rate that exceeds available capacity, no laboratory shall perform such test unless the test has been ordered consistent with the testing prioritization published by the Commissioner.

(d) Reporting of results of any communicable disease during a Surge and Flex period shall be made immediately via the Electronic Clinical Laboratory Reporting system, if positive, and on a schedule as determined by the Commissioner if negative.

Subdivision (g) of section 405.24 of 10 NYCRR is amended to read as follows:

Emergency and disaster preparedness. The hospital shall have a written plan, rehearsed and updated at least twice a year, with procedures to be followed for the proper care of patients and personnel, including but not limited to the reception and treatment of mass casualty victims, in the event of an internal or external emergency or disaster arising from the interruption of normal services resulting from earthquake, flood, bomb threat, chemical spills, strike, interruption of utility services, nuclear accidents and similar occurrences. Personnel responsible for the hospital's accommodation to extraordinary events shall be trained in all aspects of preparedness for any interruption of services and for any disaster. This shall be in addition to the Surge and Flex Plan that is required pursuant to Part 360 of the Title.

Section 400.1 of 10 NYCRR is amended to read as follows:

(a) This Subchapter shall be known and may be cited as "Medical Facilities--Minimum Standards," and shall apply to medical facilities defined as hospitals within article 28 of the Public Health Law. The standards within a particular article shall constitute the minimum standards for the identified medical facility in addition to those standards that may apply to such facilities as set forth in Articles 1 and 3 of this Subchapter as applicable.

(b) During the period of a state disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Subchapter, that is not otherwise required by state statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay

action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a state disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new section 700.5 of 10 NYCRR is added to read as follow:

700.5 Commissioner authority to suspend and modify regulations

During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Subchapter, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the State disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies State statutes pursuant to the Governor's authority

under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (8) is added to subdivision (e) of section 1001.6 of 10 NYCRR, to read as follows:

(8) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new section 1.2 of 10 NYCRR is added to read as follows.

1.2 Commissioner authority to suspend and modify regulations

During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Title, that is not otherwise required by state statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (4) subdivision (g) of section 487.3 of 18 NYCRR is added to read as follows:

(4) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the state disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the

Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies state statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (6) subdivision (f) of section 488.3 of 18 NYCRR is added to read as follows:

(6) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by state statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the State disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a State disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies State statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

A new paragraph (5) subdivision (g) of section 490.3 of 18 NYCRR is added to read as follows:

(5) During the period of a State disaster emergency declared pursuant to section 28 of the Executive Law, the State Commissioner of Health or their designee may suspend or modify any provision, of parts thereof, of this Part, that is not otherwise required by State statute or federal law, if compliance with such provisions, or parts thereof, would prevent, hinder, or delay action necessary to cope with the State disaster emergency, or if necessary to assist or aid in coping with such disaster. Such suspension or modifications may include any modifications of regulation, exceptions, limitations or other conditions as the Commissioner or their designee deems appropriate and necessary to respond to the disaster emergency. Provided, further, that should the Governor declare a state disaster emergency pursuant to section 28 of the Executive Law, which suspends or otherwise modifies State statutes pursuant to the Governor's authority under section 29-a of the Executive Law, the Commissioner or their designee may suspend or modify any provision of any regulation that is consistent with the statutory authority as modified or suspended, for the period of such suspension or modification.

## REGULATORY IMPACT STATEMENT

**Statutory Authority:**

The authority for the promulgation of these regulations with respect to facilities subject to Article 28 of the Public Health Law (PHL) is contained in PHL sections 2800 and 2803(2). PHL Article 28 (Hospitals), section 2800, specifies: "Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the state, pursuant to section three of article seventeen of the constitution, the department of health shall have the central, comprehensive responsibility for the development and administration of the state's policy with respect to hospital and related services, and all public and private institutions, whether state, county, municipal, incorporated or not incorporated, serving principally as facilities for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition or for the rendering of health-related service shall be subject to the provisions of this article." PHL section 2801 defines the term "hospital" as also including residential health care facilities (nursing homes) and diagnostic and treatment centers (D&TCs). PHL section 2803 (2) authorizes PHHPC to adopt and amend rules and regulations, subject to the approval of the Commissioner, to implement the purposes and provisions of PHL Article 28, and to establish minimum standards governing the operation of such health care facilities.

PHL section 4662 authorizes the Commissioner to issue regulations governing assisted living residences. Social Services Law (SSL) section 461(1) authorizes the Commissioner to promulgate regulations establishing standards applicable to adult care facilities. PHL section 576 authorizes the Commissioner to regulate clinical laboratories.

PHL section 225 authorizes the Public Health and Health Planning Council (PHHPC) and the Commissioner to establish and amend the State Sanitary Code (SSC) provisions related to any matters affecting the security of life or health or the preservation and improvement of public health in the State of New York.

Upon the future declaration of any disaster emergency, any further authorization by the Governor pursuant to article 2-B of the Executive Law, if it should suspend any statutes which otherwise conflict with these regulations, will establish the immediate effectiveness of these provisions.

**Legislative Objectives:**

The objectives of PHL Article 28 include protecting the health of New York State residents by ensuring that they have access to safe, high-quality health services in medical facilities, while also protecting the health and safety of healthcare workers. Similarly, PHL Articles 36 and 40 ensure that the Department has the tools needed to achieve these goals in the home care and hospice spaces, and PHL section 4662 and SSL section 461 likewise ensure that the Department has appropriate regulatory authority with respect to assisted living residences and adult care facilities. PHL section 576 ensures that the Commissioner has appropriate regulatory authority over clinical laboratories. Finally, PHL section 225 ensures that the State Sanitary Code includes appropriate regulations in the areas of communicable disease control and environmental health, among others.

By permitting the Commissioner to temporarily suspend or modify regulatory provisions in each these areas, where not required by state statute or federal law, or where authorized by a

gubernatorial Executive Order, these amendments provide crucial flexibility for this and future emergency response efforts.

**Needs and Benefits:**

During a state disaster emergency, Section 29-a of the Executive Law permits the Governor to, among other things, "temporarily suspend specific provisions of any statute, local law, ordinance, or orders, rules or regulations, or parts thereof, of any agency during a state disaster emergency, if compliance with such provisions would prevent, hinder, or delay action necessary to cope with the disaster."

Although the Governor retains authority to issue Executive Orders to temporarily suspend or modify regulations pursuant to the Executive Law, these proposed regulatory amendments would provide an expedient and coherent plan to implement quickly the relevant temporary suspensions or modifications. The proposed regulatory amendments would permit the State Commissioner of Health or designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by statute or federal law. These proposed amendments would also permit the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute.

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

During a state disaster emergency with significant public health impact, and where compliance with certain regulations may prevent, hinder or delay action necessary to cope with the disaster, as is the case with COVID-19, this authority will ensure that the State has the most efficient regulatory tools to facilitate the State's and regulated parties' response efforts to Surge and Flex the healthcare system statewide. Additionally, this authority will also ensure that the Department has the flexibility to impose additional requirements, where necessary, to ensure effective response to a declared state disaster emergency. Accordingly, these tools will help ensure the health and safety of patients and residents in New York State.

**Costs:**

**Costs to Regulated Parties:**

As demonstrated during the COVID-19 pandemic emergency, significant provider costs, as well as local, regional and state costs, were incurred as a result of the need to respond to the demand for urgent healthcare and related services. These costs had significant impact throughout the state. It is anticipated there would be similar types of costs in a widespread emergency that would need to be addressed through both appropriate preparedness as well as within, and as part of, a coordinated response to a specific situation.

To the extent that additional requirements are imposed on regulated parties by these proposed regulatory amendments, most requirements would be in effect only for the duration of a declared state disaster emergency, with the hope of limiting costs to the extent possible.

**Costs to Local Governments:**

As demonstrated during the COVID-19 pandemic emergency, significant provider costs, as well as local, regional and state costs, were incurred as a result of the need to respond to the demand for urgent healthcare and related services. These costs had significant impact throughout the state. It is anticipated there would be similar types of costs in a widespread emergency that would need to be addressed through both appropriate preparedness as well as within and as part of a coordinated response to a specific situation.

To the extent additional requirements are imposed on local governments that operate facilities regulated by the Department, most requirements would be in effect only for the duration of a declared state disaster emergency, with the hope of limiting costs to the extent possible.

**Cost to State Government:**

The administration and oversight of these planning and response activities will be managed within the Department's existing resources.

**Paperwork:**

It is not anticipated that the proposed regulatory amendments will impose any significant paperwork requirements. Although these proposed amendments require additional reporting,

these reports can be submitted electronically using the current platforms that facilities are already using. Moreover, such reporting requirements would only be activated during a declared state disaster emergency, thereby limiting the burden.

**Local Government Mandates:**

Facilities operated by local governments will subject to the same requirements as any other regulated facility, as described above.

**Duplication:**

These proposed regulatory amendments do not duplicate state or federal rules.

**Alternatives:**

The alternative would be to not promulgate the regulation. However, this alternative was rejected, as the Department believes that these regulatory amendments are necessary to facilitate response to a state disaster emergency.

**Federal Standards:**

42 CFR 482.15 establishes emergency preparedness minimum standards in four core areas including emergency planning, development of applicable policies and procedures, communications plan, and training and testing. These proposed amendments would complement the federal regulation and further strengthen hospitals' emergency preparedness and response programs.

**Compliance Schedule:**

These regulatory amendments will become effective upon publication of a Notice of Adoption in the New York State Register.

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## REGULATORY FLEXIBILITY ANALYSIS

**Effect on Small Business and Local Government:**

The proposed regulatory amendments would primarily affect health care professionals, licensed health care facilities, permitted clinical laboratories, emergency medical service personnel, providers, and agencies, and pharmacies.

**Compliance Requirements:**

A significant portion of these regulatory amendments are designed to provide regulatory relief during a declared state disaster emergency. Where the regulatory amendments would impose requirements, most of them would only be applicable when there is a declared state disaster emergency. An example of a requirement that may be implemented during a declared state disaster emergency is reporting of data and inventory as requested by the Commissioner (i.e. medical supplies and equipment, as well as hospital bed capacity, bed utilization, patient demographics, etc.). There are certain ongoing requirements proposed by this regulatory amendments, which would apply regardless of whether there is a declared state disaster emergency, in which hospitals would be required to: (1) maintain minimum levels of PPE; (2) ensure work from home capabilities; and (3) develop disaster emergency response plans.

**Professional Services:**

It is not expected that any professional services will be required to comply with the proposed regulatory amendments.

**Compliance Costs:**

As demonstrated during the COVID-19 pandemic emergency, significant provider costs, as well as local, regional and state costs, were incurred as a result of the need to respond to the demand for urgent healthcare and related services. These costs had significant impact throughout the state. It is anticipated there would be similar types of costs in a widespread emergency that would need to be addressed through both appropriate preparedness as well as within and as part of a coordinated response to a specific situation.

To the extent additional requirements are imposed on small businesses and local governments by these proposed regulatory amendments, most requirements would only be in effect for the duration of a declared state disaster emergency, with the hope of limiting costs to the extent possible. Ongoing costs requiring hospitals to maintain a minimum PPE supply and ensure work from home capabilities should have been addressed throughout the ongoing COVID-19 pandemic, thereby limiting costs of continued implementation. Ongoing costs related to hospital development of disaster emergency response plan will complement and build upon existing planning documents that hospitals are already required to have, which also limits costs.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the proposed regulatory amendments.

**Minimizing Adverse Impact:**

Although the proposed regulatory amendments impose some additional requirements on regulated parties, most of these requirements are only triggered during a declared state disaster

emergency.  Proposed amendments that would impose ongoing requirements would only apply to hospitals, and as noted above, will largely be a continuation of the efforts already being employed by these entities.

**Small Business and Local Government Participation:**

Due to the emergency nature of COVID-19, small businesses and local governments were not consulted.

## RURAL AREA FLEXIBILITY ANALYSIS

**Type and Number of Rural Areas:**

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein." The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Allegany County | Greene County | Schoharie County |
| Cattaraugus County | Hamilton County | Schuyler County |
| Cayuga County | Herkimer County | Seneca County |
| Chautauqua County | Jefferson County | St. Lawrence County |
| Chemung County | Lewis County | Steuben County |
| Chenango County | Livingston County | Sullivan County |
| Clinton County | Madison County | Tioga County |
| Columbia County | Montgomery County | Tompkins County |
| Cortland County | Ontario County | Ulster County |
| Delaware County | Orleans County | Warren County |
| Essex County | Oswego County | Washington County |
| Franklin County | Otsego County | Wayne County |
| Fulton County | Putnam County | Wyoming County |

| | | |
|---|---|---|
| Genesee County | Rensselaer County | Yates County |
| | Schenectady County | |

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

| | | |
|---|---|---|
| Albany County | Monroe County | Orange County |
| Broome County | Niagara County | Saratoga County |
| Dutchess County | Oneida County | Suffolk County |
| Erie County | Onondaga County | |

**Reporting, recordkeeping, and other compliance requirements; and professional services:**

A significant portion of these regulatory amendments are designed to provide regulatory relief during a declared state disaster emergency. Where the regulatory amendments would impose requirements, most of them would only be applicable when there is a declared state disaster emergency. An example of a requirement that may be implemented during a declared state disaster emergency is reporting of data and inventory as requested by the Commissioner (i.e. medical supplies and equipment, hospital bed capacity, bed utilization, patient demographics, etc.). There are certain ongoing requirements proposed by this regulatory amendments, regardless of whether there is a declared state disaster emergency, in which hospitals would be required to: (1) maintain minimum levels of PPE; (2) ensure work from home capabilities; and (3) develop disaster emergency response plans. This regulation provides that the Commissioner's directives shall be incremental and geographically tailored and targeted at the Statewide, regional, or community level, as dictated by infection rate data.

It is not expected that any professional services will be required to comply with the proposed regulatory amendments.

**Compliance Costs:**

As a large part of these regulatory amendments would give the State Commissioner of Health authority to temporarily suspend or modify certain regulations within Titles 10 and 18 during a state disaster emergency, these regulatory amendments are not expected to result in any significant costs to public and private entities in rural areas.

To the extent additional requirements are imposed on public and private entities in rural areas by these proposed regulatory amendments, such requirements would only be in effect for the duration of a declared state disaster emergency.

Lastly, per SAPA § 202-bb(3)(c), it is not anticipated that there will be any significant variation in cost for different types of public and private entities in rural areas.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

Although the proposed regulatory amendments impose additional requirements on regulated parties, including those in rural areas, most of these requirements are only triggered during a declared state disaster emergency. Proposed amendments that would require disaster emergency preparedness planning on the part of regulated parties will complement and build upon existing state and federal planning requirements.

**Rural Area Participation:**

Due to the emergency nature of COVID-19, parties representing rural areas were not consulted in the initial draft. However, parties representing rural may submit comments during the notice and comment period for the proposed regulations.

## JOB IMPACT STATEMENT

The Department of Health has determined that these regulatory changes will not have a substantial adverse impact on jobs and employment, based upon its nature and purpose.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Section 2828 of the Public Health Law, Part 415 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is hereby amended by adding a new Section 415.34, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

415.34. Minimum Direct Resident Care Spending.

(a) Purpose. This Section sets forth the requirements of the minimum direct resident care spending law set forth in Section 2828 of the Public Health Law and applies to all residential health care facilities licensed pursuant to this Part, except as provided in subdivision (c) of this Section.

(b) Definitions. The definitions of this Section shall have the same meaning as those terms set forth in subdivision (2) of Section 2828 of the Public Health Law. Additionally, the following terms shall have the following meanings:

(1) “Contracted out” shall mean services provided by registered professional nurses, licensed practical nurses, or certified nurse aides who provide services in a residential health care facility through contractual or other employment agreement, whether such agreement is entered into by the individual practitioner or by an employment agency on behalf of the individual practitioner. Such agreement may be oral or in writing.

(2) “Direct resident care” shall mean the following cost centers in the residential health care facility cost report:

(i) Nonrevenue Support Services - Plant Operation & Maintenance, Laundry and Linen, Housekeeping, Patient Food Service, Nursing Administration, Activities Program,

Nonphysician Education, Medical Education, Medical Director's Office, Housing, Social Service, Transportation;

(ii) Ancillary Services - Laboratory Services, Electrocardiology, Electroencephalogy, Radiology, Inhalation Therapy, Podiatry, Dental, Psychiatric, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy, Pharmacy, Central Services Supply, Medical Staff Services provided by licensed or certified professionals including and without limitation Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant; and

(iii) Program Services - Residential Health Care Facility, Pediatric, Traumatic Brain Injury (TBI), Autoimmune Deficiency Syndrome (AIDS), Long Term Ventilator, Respite, Behavioral Intervention, Neurodegenerative, Adult Care Facility, Intermediate Care Facilities, Independent Living, Outpatient Clinics, Adult Day Health Care, Home Health Care, Meals on Wheels, Barber & Beauty Shop, and Other similar program services that directly address the physical conditions of residents. Direct resident care does not include, at a minimum and without limitation, administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, and fiscal services.

(3) “Resident-facing staffing” shall mean all staffing expenses in the ancillary and program services categories on Exhibit H of the residential health care facility cost reports.

(4) “Revenue” shall mean the total operating revenue from or on behalf of residents of the residential health care facility, government payers, or third-party payers, to pay for a resident's occupancy of the residential health care facility, resident care, and the operation of the residential

health care facility as reported in the residential health care facility cost reports submitted to the Department; provided, however, that revenue shall exclude:

(i) the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years;

(ii) funding received as reimbursement for the assessment under Public Health Law section 2807-d(2)(b)(vi), as reconciled pursuant to Public Health Law section 2807-d(10)(c);

(iii) the capital per diem portion of the reimbursement rate for nursing homes; provided, however, that such exclusion shall not apply:

(*a*) for nursing homes that have an overall one-, two-, or three-star rating assigned pursuant to the inspection rating system of the U.S. Centers for Medicare and Medicaid Services (CMS rating); or

(*b*) to any amount of the capital per diem portion of the reimbursement rate that is attributable to a capital expenditure made to a corporation, other entity, or individual, with a common or familial ownership to the operator or the facility as reported under Public Health Law section 2803-x(1); and

(iv) any grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, including, but not limited to, funds received from the federal emergency management agency or health resources and services administration.

(c) Applicability.

(1) For the purposes of this Section, residential health care facilities shall not include:

(i) facilities that are authorized by the Department to primarily care for medically fragile children or young adults, people with HIV/AIDS, persons requiring behavioral

intervention, or persons requiring neurodegenerative services. For the purposes of this subparagraph, a facility shall be considered to primarily care for such specialized populations if at least 51 percent of certified beds are designated for persons with such specialty health care needs; or

(ii) continuing care retirement communities licensed pursuant to Article 46 or 46-A of the Public Health Law.

(iii) A facility may apply to the Commissioner for a waiver of applicability of this Section on the basis of providing specialty care services if such facility primarily provides care to a specialized population other than one listed in subparagraph (i) of this paragraph. Such application shall detail what specialty services the facility provides, the percentage of the resident population needing such specialty services, and whether any other residential health care facilities licensed by the Department provide such specialty services. The Commissioner shall have discretion to approve or reject applications submitted pursuant to this subparagraph, and shall provide the facility with the basis for the Commissioner's determination within a reasonable timeframe upon receipt of a complete application. Factors the Commissioner will assess in determining whether to grant or deny a waiver application based on provision of services to a specialty population include, but are not limited to, the following:

*(a)* the number of other residential health care facilities licensed by the Department that provide the services identified by the facility as specialized services;

*(b)* whether a majority of current facility residents have special health care needs as identified by the facility; and

*(c)* the unique training or licensing required of facility staff to provide services to the identified specialized population.

(iv) In the event a facility no longer provides care for a specialty population, as identified under subparagraphs (i) and (iii) of this paragraph, the facility shall comply with this Section by January first of the first year following the date on which the facility ceased operating as a specialty residential health care facility, as determined by the Commissioner.

(2) Additional Waivers. A facility may apply to the Commissioner for a waiver of applicability of this Section on the basis of unexpected or exceptional circumstances that prevented compliance. Such application shall detail the specific unexpected or exceptional circumstance experienced by the facility; when the facility first learned of such circumstances; why the facility could not have anticipated such circumstances arising; actions the facility took to address such circumstances; expenses incurred as a result of addressing such circumstances; when the facility expects such circumstances to be resolved; and what preventive steps the facility is taking to ensure that such circumstances do not unexpectedly arise in the future. The Commissioner shall have discretion to approve or reject applications submitted pursuant to this paragraph, and shall provide the facility with the basis for the Commissioner's determination within a reasonable timeframe upon receipt of a complete application. Factors the Commissioner will assess in determining whether to grant or deny a waiver application based on unexpected or exceptional circumstances include, but are not limited to, the following:

(i) whether the facility should have anticipated such events occurring;

(ii) whether any other residential health care facilities licensed by the Department experienced similar circumstances but have not applied for a waiver under this paragraph;

(iii) whether the facility has implemented sufficient policies and procedures to ensure such events do not recur.

(d) Minimum Spending Requirements. By January 1, 2022, residential health care facilities shall comply with the following minimum expenditures:

(1) 70 percent of revenue shall be spent on direct resident care; and

(2) 40 percent of revenue shall be spent on resident-facing staffing.

(i) All amounts spent on resident-facing staffing shall be included as a part of amounts spent on direct resident care; and

(ii) 15 percent of costs associated with resident-facing staffing that are contracted out by a facility for services provided by registered professional nurses, licensed practical nurses, or certified nurse aides shall be deducted from the calculation of the amount spent on resident-facing staffing and direct resident care.

(3) For the purposes of assessing whether a facility has met the minimum spending requirements, a facility may apply to the Commissioner to have certain revenues and expenses excluded from the calculation of the facility's total revenue and total expenditures, where the facility has satisfactorily demonstrated to the Commissioner that such revenues and expenses were incurred due to the following circumstances:

(i) a natural disaster, where a federal, State, or local declaration of emergency has been issued; or

(ii) the facility has received extraordinary, non-recurring revenue which, in the discretion of the Commissioner, does not accurately reflect operating revenue for the purposes of this rule, including but not limited to revenue received through insurance or legal settlements.

(e) Recoupment.

(1) A residential health care facility shall be subject to recoupment for excessive total operating revenue if:

(i) the facility's total operating revenue exceeds total operating and non-operating expenses by more than five percent of total operating revenue; or

(ii) the facility fails to spend the minimum amount necessary to comply with the minimum spending standards for resident-facing staffing or direct resident care, as set forth in subdivision (d) of this Section, as calculated on an annual basis, or for 2022, on a pro-rata basis for April 1, 2022 through December 31, 2022.

(2) Remission of excess revenue.

(i) The Department shall issue a notice of noncompliance to a facility subject to recoupment for excessive total operating revenue, which indicates the amount to be remitted based on the amount of excess revenue or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as applicable, as well as acceptable forms of payment.

(ii) Upon receipt of a notice of noncompliance pursuant to subparagraph (i), the facility shall remit the total amount indicated in the notice of noncompliance by November first in the year following the year in which the expenses are incurred.

(3) Penalties. Failure to remit the total required fee by the due date may result in adverse action by the Department, including but not limited to: bringing suit in a court of competent jurisdiction, taking deductions or offsets from payments made pursuant to the Medicaid program, and imposition of penalties pursuant to Section 12 of the Public Health Law.

(4) Recouped funds shall be deposited by the Department into the Nursing Home Quality Pool, pursuant to Section 2808(2-c)(d) of the Public Health Law.

(f) Residential Health Care Facility Cost Reports.

(1) The Department shall, no less frequently than annually, audit the residential health care facilities' cost reports for compliance in accordance with this Section.

(2) If a facility did not report data in the 2019 residential health care facility cost report, they must promptly provide the Department with data on the facility's direct resident care and resident facing staffing expenses in accordance with this Section and Section 2828 of the Public Health Law. This data must be submitted with a written certification by the operator, officer, or public official responsible for the operation of the facility, in a form and format determined acceptable by the Department, attesting that all data reported by the facility is complete and accurate. If the data is not submitted within a reasonable timeframe, as determined by the Department, the Department shall use the previous available cost report data applicable to such facility.

## REGULATORY IMPACT STATEMENT

**Statutory Authority:**

The statutory authority is provided under section 2828 of the Public Health Law (PHL), which directs the Department of Health (Department) to promulgate regulations governing the disposition of revenue in excess of expenses permitted under PHL § 2828 for residential health care facilities. Specifically, PHL § 2828 directs that, as of January 1, 2022, every residential health care facility shall spend a minimum of 70 percent of revenue on direct resident care and 40 percent of revenue on resident-facing staffing, wherein amounts spent on resident-facing staffing are included in the amount spent on direct resident care.

Laws of 2022, Chapter 57, Part M, § 1, amended the definition of "revenue" in PHL § 2828.

In general, PHL § 2828 provides that remission of excess revenue is calculated on an annual basis. Laws of 2022, Chapter 57, Part M, § 4, provides that in 2022, the remission of excess revenue shall be on a pro-rata basis for only that portion of the year during which the failure of a residential health care facility to spend a minimum of seventy percent of revenue on direct resident care, and forty percent of revenue on resident-facing staffing, may be held to be a violation of the Public Health Law, i.e., April 1, 2022, through December 31, 2022, the portion of 2022 after Executive Order 4.4 expired. See 9 NYCRR §9.4.4, which was in effect from January 1, 2022, through March 31, 2022.

**Legislative Objectives:**

The legislative objective of PHL § 2828 is to ensure that residential health care facilities spend a majority of their revenue on direct resident care (70 percent), with 40 percent of such

expenses focused on paying for resident-facing staffing. The goal of these minimum spending requirements is to help ensure a high quality of resident care.

**Needs and Benefits:**

These regulations are necessary to implement the statutory directive of PHL § 2828. Specifically, pursuant to the statute, the regulations (1) set forth how facilities that fail to meet the statutory minimum spending requirements must pay the State, (2) provide exceptions from the minimum spending requirements for residential health care facilities that serve certain specialized populations, (3) set forth factors the Department will use to determine whether to waive the spending requirements for facilities unable to comply due to "unexpected or exceptional circumstances that prevented compliance," and (4) provide factors the Department will use to determine whether to exclude extraordinary revenues and capital expenses from the calculations to determine whether a facility has met its minimum spending requirements.

Requiring nursing homes to spend an appropriate amount of revenue on the direct care of residents and resident-facing staffing will reduce errors, complications, and adverse resident care incidents. It will also improve the safety and quality of life for all long-term care residents in New York State.

**COSTS:**

**Costs to Regulated Parties:**

The purpose of this regulation is to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall

expenditures to meet the minimum spending thresholds. While the Department anticipates that costs will be borne by residential health facilities, and that those costs may create financial challenges for some organizations, compliance with these minimum spending requirements is mandated by statute (PHL § 2828), and as such these regulatory amendments are necessary. Moreover, any recouped funds from residential health care facilities that fail to comply with PHL § 2828 will be deposited into the Nursing Home Quality Pool to benefit high-quality residential health care facilities, thereby helping to offset any costs for high-performing facilities while also encouraging the provision of quality resident care.

**Costs to Local and State Governments:**

This regulation will not impact local or State governments unless they operate a residential health care facility, in which case the costs will be the same as for privately-operated facilities. Currently, there are 21 residential health care facilities operated by local governments (counties and municipalities) and 6 residential health care facilities operated by the State.

**Costs to the Department of Health:**

This regulation will not result in any additional operational costs to the Department of Health.

**Paperwork:**

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit revenue and expense information through an annual cost report submitted to the Department, such costs reports are current required pursuant to PHL §§

2805-e and 2808-b. If a facility has not submitted a cost report for 2019, the regulation requires the expense and revenue data to instead be submitted with a written certification by the operator, officer, or public official responsible for the operation of the facility, in a form and format determined acceptable by the Department, attesting that all data reported by the facility is complete and accurate. Although this data form would be a new requirement, because it is merely a temporary measure to substitute for a missing 2019 cost report, the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities subject to this new paperwork requirement.

**Local Government Mandates:**

Residential health care facilities operated by local governments will be affected and will be subject to the same requirements as any other residential health care facility licensed under PHL Article 28.

**Duplication:**

These regulations do not duplicate any State or federal rules.

**Alternatives:**

These regulations are mandated pursuant to PHL § 2828. Accordingly, the alternative of not issuing these regulations was rejected.

**Federal Standards:**

No federal standards apply.

**Compliance Schedule:**

The regulations will become effective upon publication of a Notice of Adoption in the New York State Register.

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## REGULATORY FLEXIBILITY ANALYSIS

**Effect on Small Business and Local Government:**

This regulation will not impact local governments or small businesses unless they operate a residential health care facility. Currently, there are 21 residential health care facilities operated by local governments (counties and municipalities) and 6 residential health care facilities operated by the State. Additionally, to date, 79 residential health care facilities in New York qualify as small businesses given that they have 100 or fewer employees.

**Compliance Requirements:**

This regulation seeks to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. In accordance with this statute, residential health care facilities will be required to meet these aforementioned minimum spending requirements, unless they meet certain exceptions as detailed in both PHL § 2828 and these regulations, including facilities that provide care to Commissioner-designated specialty populations and facilities that are unable to comply with the minimum spending requirements due to natural disaster or other "unexpected or exceptional circumstances that prevented compliance."

Facilities that fail to meet the minimum spending requirements of PHL § 2828 and these regulations will be required to remit a penalty payment in the amount of the facility's excessive total operating revenue, based on the amount of excess revenue or the difference between the minimum spending requirement and the actual amount of spending on resident-facing staffing or direct care staffing, as applicable.

**Professional Services:**

No professional services are required by this regulation.

**Compliance Costs:**

This regulation seeks to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum spending thresholds. While the Department anticipates that costs will be borne by residential health facilities, and that those costs may create financial challenges for some organizations, compliance with these minimum spending requirements is mandated by statute (PHL § 2828), and as such these regulatory amendments are necessary. Moreover, any recouped funds from residential health care facilities that fail to comply with PHL § 2828 will be deposited into the Nursing Home Quality Pool to benefit high-quality residential health care facilities, thereby helping to offset any costs for high-performing facilities while also encouraging the provision of quality resident care.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

This regulation is mandated pursuant to PHL § 2828 and necessary to ensure that direct resident care is prioritized by setting forth minimum spending requirements for such care. Therefore, any adverse impacts are outweighed by the regulation's health and safety benefits to residents as well as the legal mandate for promulgation.

**Small Business and Local Government Participation:**

Health care provider organizations, individual institutions, local health departments and the public are invited to comment during the Codes and Regulations Committee of the Public Health and Health Planning Council (PHHPC). Interested parties and members of the general public will be notified and provided in advance of the PHHPC meeting the time and place of the meeting, the text of the regulation for their review and a chance to submit oral and written comments. All written comments will be sent to PHHPC members 72 hours in advance of the meeting.

Further, the Department will engage in active discussions and dialogue with all interested parties, including industry associations directly impacted by this regulation, to inform them of their need to comply, to answer questions and listen to comments they may have on this regulation. Specifically, the Department will issue a *Dear Administrator Letter (DAL)* to each effected nursing home, either operated by a local government, or privately, which will outline the date such regulation will go into effect, the specific requirements outlined in the regulation and the penalties for non-compliance. Further, the Department will formally solicit questions from each effected party and will prepare a *Frequently Asked Questions*, (*FAQ*) which will be updated regularly and publicly posted on the Department's website for review and feedback.

**Cure Period:**

This regulation does not include a cure period given that compliance is required by January 1, 2022 per PHL § 2828.

## RURAL AREA FLEXIBILITY ANALYSIS

**Type and Estimated Numbers of Rural Areas:**

Although this rule applies uniformly throughout the state, including rural areas, for the purposes of this Rural Area Flexibility Analysis (RAFA), "rural area" means areas of the state defined by Exec. Law § 481(7) (SAPA § 102(10)). Per Exec. Law § 481(7), rural areas are defined as "counties within the state having less than two hundred thousand population, and the municipalities, individuals, institutions, communities, and programs and such other entities or resources found therein. In counties of two hundred thousand or greater population 'rural areas' means towns with population densities of one hundred fifty persons or less per square mile, and the villages, individuals, institutions, communities, programs and such other entities or resources as are found therein."

The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010:

Allegany County
Cattaraugus County
Cayuga County
Chautauqua County
Chemung County
Chenango County
Clinton County
Columbia County
Cortland County
Delaware County
Essex County
Franklin County
Fulton County
Genesee County
Greene County
Hamilton County
Herkimer County
Jefferson County
Lewis County
Livingston County
Madison County
Montgomery County
Ontario County
Orleans County
Oswego County
Otsego County
Putnam County
Rensselaer County
Schenectady County
Schoharie County
Schuyler County
Seneca County
St. Lawrence County
Steuben County
Sullivan County
Tioga County
Tompkins County
Ulster County
Warren County
Washington County
Wayne County
Wyoming County
Yates County

The following counties of have population of 200,000 or greater, and towns with population densities of 150 person or fewer per square mile, based upon the United States Census estimated county populations for 2010:

| | | |
|---|---|---|
| Albany County | Monroe County | Orange County |
| Broome County | Niagara County | Saratoga County |
| Dutchess County | Oneida County | Suffolk County |
| Erie County | Onondaga County | |

Licensed residential health care facilities are located in these identified rural areas.

**Reporting, recordkeeping, and other compliance requirements; and professional services:**

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit revenue and expense information through an annual cost report submitted to the Department, such costs reports are currently required pursuant to PHL §§ 2805-e and 2808-b. If a facility has not submitted a cost report for 2019, the regulation requires the expense and revenue data to instead be submitted with a written certification by the operator, officer, or public official responsible for the operation of the facility, in a form and format determined acceptable by the Department, attesting that all data reported by the facility is complete and accurate. Although this data form would be a new requirement, because it is merely a temporary measure to substitute for a missing 2019 cost report, the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities subject to this new paperwork requirement.

**Compliance Costs:**

This regulation seeks to implement PHL § 2828, which requires residential health care facilities to spend a certain percentage of revenue (70 percent) on direct resident care, with 40 percent of such revenue focused on resident-facing staffing. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum spending requirements, but rather may appropriately manage expenditures to balance overall expenditures

to meet the minimum spending thresholds. While the Department anticipates that costs will be borne by residential health facilities, and that those costs may create financial challenges for some organizations, compliance with these minimum spending requirements is mandated by statute (PHL § 2828), and as such these regulatory amendments are necessary. Moreover, any recouped funds from residential health care facilities that fail to comply with PHL § 2828 will be deposited into the Nursing Home Quality Pool to benefit high-quality residential health care facilities, thereby helping to offset any costs for high-performing facilities while also encouraging the provision of quality resident care.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

This regulation is mandated pursuant to PHL § 2828 and necessary to ensure that direct resident care is prioritized by setting forth minimum spending requirements for such care. Therefore, any adverse impacts are outweighed by the regulation's health and safety benefits to residents as well as the legal mandate for promulgation.

**Rural Area Participation:**

The Department will notify all residential health care facilities, including those located in rural areas, of the existence of these regulations and the opportunity to submit public comments or questions to the Department.

## STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

Pursuant to the authority vested in the Public Health and Health Planning Council and Commissioner of Health by sections 2803 and 2895-b of the Public Health Law, Sections 415.2 and 415.13 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivision (h) of Section 415.2 is amended to read as follows:

(h) Nurse aide (see section [415.13(c)(1)] 415.13(d)(1) of this Part).

Section 415.13, and the title thereof, are amended to read as follows:

Section 415.13 Nursing Services and Minimum Nursing Staff Requirements.

(a) Staffing standards. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility shall further assure that staffing levels enable each resident to receive[s] treatments, medications, diets and other health services in accordance with individual care plans. At a minimum, the facility shall ensure its daily nursing staff levels comply with paragraph (2) of subdivision (b) of this Section; provided, however, that compliance with paragraph (2) of subdivision (b) of this Section shall not serve as a defense where the facility has failed to provide sufficient nursing care to residents in accordance with their resident assessment and individual plans of care, or the facility failed to ensure residents received ordered treatments, medications, diets or other health services consistent with the residents' individual plans of care and in accordance with federal and State law and regulations.

[(a)] (b) Sufficient staff.

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) registered professional nurses or licensed practical nurses;

(ii) certified nurse aides, meaning any person included in the nursing home nurse aide registry pursuant to Section 2803-j of the Public Health Law; and

(iii) other nursing personnel.

(2) Minimum Nursing Staff Requirements. At a minimum, the facility shall employ certified nurse aides, registered professional nurses, licensed practical nurses, or nurse aides sufficient to maintain the following daily staffing hours per resident:

(i) From January first, two thousand twenty-two through December thirty-first, two thousand twenty-two, the facility shall maintain daily average staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, registered professional nurse, licensed practical nurse, or nurse aide. Out of such 3.5 hours, no less than 2.2 hours of care per resident per day shall be provided by a certified nurse aide or a nurse aide, and no less than 1.1 hours of care per resident per day shall be provided by a registered professional nurse or licensed practical nurse.

(ii) Beginning January first, two thousand twenty-three and thereafter, every nursing home shall maintain daily average staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, registered professional nurse, or licensed practical nurse. Out of such 3.5 hours, no less than 2.2 hours of care per resident per day shall be provided by a certified nurse aide, and no less than 1.1 hours of care per resident per day shall be provided by a registered professional nurse or licensed practical nurse.

[(2)] (3) The facility shall designate a registered professional nurse or licensed practical nurse to serve as a charge nurse on each tour of duty who is responsible for the supervision of total nursing activities in the facility. Alternatively, as necessitated by resident care needs, the facility may designate one charge nurse for each tour of duty on each resident care unit or on proximate nursing care units in the facility provided that each nursing care unit in the facility is under the supervision of a charge nurse.

[(b)] (c) Registered professional nurse.

(1) The facility shall use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week, or more often as necessary to comply with the minimum staffing requirements set forth in paragraph (2) of subdivision (b) of this Section.

* * *

[(c)] (d) Nurse aide.

(1) For the purpose of this section and section 415.26(d) of this Part, nurse aide shall mean any person [who provides direct personal resident care and services including, but not limited to, safety, comfort, personal hygiene or resident protection services, for compensation, under the supervision of a registered professional nurse or licensed practical nurse in the facility] who is included in the nurse aide hour component of the federal Centers for Medicare and Medicaid Services payroll based journal for long-term care facilities but has not yet been certified as a certified nurse aide, including individuals who are in the first four months of employment and who are receiving training in a Department-approved nurse aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse, or individuals, other than a licensed professional, who have been approved by the Department to

administer medications to residents. For the purposes of this section and section 415.26(d) of this Part, a nurse aide does not include volunteers or [except for] those individuals who furnish services to residents only as feeding assistants as defined in Section [415.13(d)] 415.13(e) of this Part. Certification of such nurse aide shall be in accordance with the provisions of section 415.26(d) of this Part.

* * *

[(d)] (e) Feeding Assistant.

* * *

(f) Non-Compliance with Staffing Standards.

(1) Compliance with the minimum nursing staff requirements set forth in paragraph (2) of subdivision (b) of this Section shall be determined on a quarterly basis, as determined by the Department, by comparing the daily average of the number of hours provided per resident, per day, using the most recent data available from the federal Centers for Medicare and Medicaid Services payroll based journal and the facility's average daily census on a daily basis.

(i) The Department shall initially determine whether a facility is compliant or non-compliant with the minimum nursing staff requirements by conducting the following three assessments:

*(a)* Assessing whether the total daily staffing hours provided per resident by nurse aides (only from January first, two thousand twenty-two through December thirty-first, two thousand twenty-two), certified nurse aides, licensed practical nurses, or registered nurses fell below 3.5 hours of care per resident on average over the course of the quarter; and

*(b)* Assessing whether at least 2.2 hours of care per resident per day was provided by a certified nurse aide or a nurse aide (only from January first, two thousand twenty-two through December thirty-first, two thousand twenty-two) on average over the course of the quarter; and

*(c)* Assessing whether at least 1.1 hours of care per resident per day was provided by a registered professional nurse or licensed practical nurse on average over the course of the quarter.

(ii) A facility that, on average over the course of the quarter, fell below the hourly requirements set forth in clauses (a) through (c) of subparagraph (i) will be considered non-compliant for the purposes of this Section. Any facility that the Department finds non-compliant shall have progressive penalties assessed based upon the number of days per quarter in which the daily staffing hours provided per resident fell below the minimum hourly requirements set forth in paragraph (2) of subdivision (b) of this Section.

(iii) For the purposes of determining compliance, an individual shall not be counted while performing administrative services, as defined in the Centers for Medicare and Medicaid Services payroll based journal for long-term care facilities. Further, individuals who are attending training, either onsite or offsite, and are not available to perform their primary job duties shall not be counted for purposes of determining compliance with the minimum daily staffing hours.

(2) Penalties.

(i) The Department shall impose a penalty of up to two thousand (2,000) dollars per day for each day in a quarter that a facility fails to comply with the minimum nursing staff requirements set forth in paragraph (2) of subdivision (b) of this Section, unless mitigating or aggravating factors exist.

(ii) Mitigating Factors. The Department may reduce penalties in a quarter that a facility is non-compliant, if the Department determines, in its sole discretion, that any of the following mitigating circumstances existed during the period of non-compliance:

*(a)* Extraordinary circumstances faced the facility. For the purposes of this clause, extraordinary circumstances shall mean that the facility experienced a natural disaster; a national emergency affecting the facility has been officially declared; a State or municipal emergency affecting the facility has been declared pursuant to Article 2-B of the Executive Law; or the facility experienced a catastrophic event that caused physical damage to the facility or impaired the ability of facility personnel to access the facility. Provided, however, that the facility must first demonstrate, to the satisfaction of the Department, that such extraordinary circumstances could not have been prevented or mitigated through effective implementation of the facility's pandemic emergency plan, prepared pursuant to Section 2803(12) of the Public Health Law, and that the facility complied with the disaster and emergency preparedness requirements set forth in Section 415.26(f) of this Part; or

*(b)* An acute labor supply shortage of nurse aides, certified nurse aides, licensed practical nurses, or registered nurses exists in the Metropolitan and Nonmetropolitan Area in which the facility is located, as such areas are defined by the federal Bureau of Labor Statistics.

(*1*) For the purposes of determining whether a facility was located in an area experiencing an acute labor supply shortage during the period of non-compliance, the Commissioner shall issue a determination on a quarterly basis as to whether an acute labor supply shortage of nurse aides, certified nurse aides, licensed practical nurses, or registered nurses exists in any Metropolitan or Nonmetropolitan Area of New York State. Such determination shall be made in consultation with the New York State Department of Labor and shall take into account job availability metrics developed by the New York State Department of Labor, which may include but is not limited to the list of job openings in New York State.

(*2*) The fact that the facility is located in an area experiencing an acute labor supply shortage pursuant to this clause shall not serve as a mitigating factor unless the facility has demonstrated, to the satisfaction of the Department, reasonable attempts to procure sufficient staffing during the period of non-compliance, notwithstanding the acute labor supply shortage. Reasonable attempts may include, but not be limited to, incentivizing new personnel through increased wage and benefit offers and searching for personnel outside of the Metropolitan and Nonmetropolitan Area in which the facility is located;

(*3*) The fact that the facility is located in an area experiencing an acute labor supply shortage pursuant to this clause shall not serve as a mitigating factor unless the facility has demonstrated, to the satisfaction of the Department, that it has taken steps over the course of the quarter to ensure resident health and safety notwithstanding any labor supply shortage, including but not limited to discontinuing admissions or transferring residents to another appropriate facility; or

*(c)* A verifiable union dispute exists between the facility and nurse aides, certified nurse aides, licensed practical nurses, or registered nurses employed or contracted by such facility, resulting in a labor shortage at the facility.

(g) Eligibility for Funding to Comply with Minimum Nursing Staff Requirements.

The Department shall determine which nursing homes are anticipated to be in compliance with Section 2828 of the Public Health Law based on the most current, available Residential Health Care Facility cost report data, or such other source of cost information as the Department shall identify. Pursuant to methodology set forth in the current Medicaid State Plan Amendment, the Department shall determine whether such nursing homes must expend additional funds to comply with this Section, beyond any costs necessary to comply with Section 2828 of the Public Health Law. Any such nursing home that the Department finds will be required to expend

additional funds to comply with this Section shall be eligible to receive from the Department additional funds, subject to availability from the New York State Division of the Budget, to hire nursing staff necessary to achieve the minimum nursing staff requirements set forth in paragraph (2) of subdivision (b) of this Section.

## REGULATORY IMPACT STATEMENT

**Statutory Authority**:

The statutory authority is provided under sections 2803 and 2895-b of the Public Health Law, which provides that the Commissioner of Health enact regulations establishing standard nursing home staffing levels.

**Legislative Objectives**:

The legislative objective of PHL section 2895-b is to ensure safe and appropriate levels of nurse staffing in nursing homes in order to improve the care for residents of nursing homes.

**Needs and Benefits**:

These regulations are necessary to implement the statutory directive of PHL section 2895-b. Specifically, pursuant to the statute, the regulations: (1) set forth minimum nurse staffing standards; (2) provide for the imposition of penalties for failure to meet minimum staffing standards; (3) provide for mitigating factors for failure to meet the minimum staffing requirements; and (4) set forth a process for the Department to determine facilities that are in need of assistance to meet the staffing requirements.

Research has demonstrated that as nurse turnover increases in nursing homes, the quality of resident care declines. Therefore, having adequate nurse staffing levels provides residents with the highest quality of care. Requiring these facilities to meet this minimum level of staffing will help ensure patient safety and improve the quality of care received by the residents of the nursing home.

**Costs:**

**Costs for the Implementation of, and Continuing Compliance with the Regulation to the Regulated Entity:**

This regulation seeks to implement standard minimum nursing home staffing levels. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum staffing requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum staffing thresholds. In any event, if costs are borne by residential health care facilities, compliance with these minimum staffing requirements is mandated by Public Health Law section 2895-b, and as such these regulatory amendments are necessary.

C**osts to State and Local Governments:**

This regulation will not impact local or State governments unless they operate a residential health care facility, in which case the costs will be the same as for privately-operated facilities. Currently, there are 21 residential health care facilities operated by local governments (counties and municipalities) and 6 residential health care facilities operated by the State.

**Costs to the Department of Health:**

This regulation will not result in any additional operational costs to the Department of Health.

**Local Government Mandates:**

Residential health care facilities operated by local governments will be affected and will be subject to the same requirements as any other residential health care facility licensed under PHL Article 28.

**Paperwork:**

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit staffing and care information through the facility's average daily census on a daily basis, such reporting is already required. Therefore, the submission of this data does not create a new requirement, and the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities.

**Duplication:**

These regulations do not duplicate any State or federal rules.

**Alternatives:**

These regulations are mandated pursuant to PHL section 2895-b. Accordingly, the alternative of not issuing these regulations was rejected. The Department considered different alternatives for the imposition of civil penalties and determined that penalties need to be high enough to prevent facilities from simply paying the penalty as a cost of doing business rather than complying with the law.

**Federal Standards:**

No federal standards apply.

**Compliance Schedule:**

The regulations incorporate the compliance dates contained in the Public Health Law section 2895-b, which requires a certain level of staffing by January 1, 2022, and a certain level by January 1, 2023.

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## REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES AND LOCAL GOVERNMENTS

**Effect of Rule:**

This regulation implements PHL Section 2895-b, which provides the Commissioner of Health authority to establish minimum staffing standards for nursing homes and impose civil penalties for nursing homes that fail to adhere to the minimum standards. These minimum standards, which take effect January 1, 2022, require every nursing home to maintain daily staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide (CNA), licensed practical nurse, or registered nurse with at least 2.2 hours of care per resident per day being provided by a CNA and at least 1.1 hours of care per resident per day provided by a licensed nurse. The nursing home must post information regarding nurse staffing at the facility. Penalties may not be assessed against nursing homes until April 1, 2022, and the Commissioner may take into consideration several mitigating factors when issuing penalties including declared disaster emergencies, the frequency of non-compliance, and regional labor supply shortages.

Currently, there are 21 residential health care facilities operated by local governments (counties and municipalities) and there are 115 providers that reported 100 or fewer employees according to recently filed cost data reports.

**Compliance Requirements:**

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit staffing and care information through the facility's average daily census on a daily basis, such reporting is already required. Therefore, the submission of this

data does not create any new requirement, and the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities.

**Professional Services:**

No professional services are required by this regulation.

**Compliance Costs:**

This regulation seeks to implementing standard minimum nursing home staffing levels. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum staffing requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum staffing thresholds. In any event, if costs are borne by residential health care facilities, compliance with these minimum staffing requirements is mandated by Public Health Law section 2895-b, and as such these regulatory amendments are necessary.

**Economic and Technological Feasibility:**

There are no economic or technological impediments to the rule changes.

**Minimizing Adverse Impact:**

This regulation is mandated pursuant to PHL section 2895-b and necessary to ensure that direct resident care is prioritized by setting forth minimum staffing requirements for such care. Therefore, any adverse impacts are outweighed by the regulation's health and safety benefits to residents as well as the legal mandate for promulgation.

Additionally, regulations provide that the Department shall determine whether nursing homes must expend additional funds to comply, and nursing homes that the Department finds will be required to expend additional funds to comply may be eligible to receive from the Department additional funds, subject to availability from the New York State Division of the Budget, to hire nursing staff necessary to achieve the minimum nursing staff requirements.

Further, regulations establishing the civil penalties include mitigating factors to account for: (1) extraordinary circumstances facing the facility such as officially declared emergencies or natural disasters; (2) the frequency of the violations of the facility; and (3) the existence of a nurse labor shortage in the area of the nursing home.

**Small Business and Local Government Participation:**

The Department will notify such entities of the existence of these regulations and the opportunity to submit comments or questions to the Department. The Department will engage in active discussions and dialogue with all interested parties, including industry associations directly impacted by this regulation, to inform them of their need to comply, to answer questions and listen to comments they may have on this regulation.

The Department has already taken several steps to notify the nursing home industry on the effects of this regulation and has provided the opportunity for public comment. On October 7, 2021, at the Public Health and Health Planning Council (PHHPC), the Department presented this regulation for information and discussion purposes. At that meeting the regulation was reviewed and discussed by PHHPC members. In addition, the public, including the effected parties to this regulation, were afforded and opportunity to ask questions and provide comments.

In addition, there were conference calls made to the various associations representing the nursing home industry to inform them of the regulation and to provide an opportunity to ask questions.

Further, the regulation will be filed in the State Register, providing another opportunity for public comments and review. Once completed, the regulation will again go to PHHPC where there will be another opportunity for public comment.

**For Rules That Either Establish or Modify a Violation or Penalties Associated with a Violation:**

The governing statute directs the Commissioner of Health to establish civil penalties for those facilities that fail to comply with the minimum staffing requirements. However, there are several mitigating factors set forth in the regulation to potentially reduce the fine amount; additionally, the regulation provides for a progressive system of penalties depending on the number of days per quarter the facility was out of compliance with the minimum staffing requirements.

## Rural Area Flexibility Analysis

**Types and Estimated Numbers of Rural Areas:**

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010 (https://www.census.gov/quickfacts/). Approximately 17% of small health care facilities are located in rural areas.

| | | |
|---|---|---|
| Allegany County | Greene County | Schoharie County |
| Cattaraugus County | Hamilton County | Schuyler County |
| Cayuga County | Herkimer County | Seneca County |
| Chautauqua County | Jefferson County | St. Lawrence County |
| Chemung County | Lewis County | Steuben County |
| Chenango County | Livingston County | Sullivan County |
| Clinton County | Madison County | Tioga County |
| Columbia County | Montgomery County | Tompkins County |
| Cortland County | Ontario County | Ulster County |
| Delaware County | Orleans County | Warren County |
| Essex County | Oswego County | Washington County |
| Franklin County | Otsego County | Wayne County |
| Fulton County | Putnam County | Wyoming County |
| Genesee County | Rensselaer County | Yates County |
| | Schenectady County | |

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

| | | |
|---|---|---|
| Albany County | Monroe County | Orange County |
| Broome County | Niagara County | Saratoga County |
| Dutchess County | Oneida County | Suffolk County |
| Erie County | Onondaga County | |

Licensed residential health care facilities are located in these identified rural areas.

**Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:**

This regulation generally imposes no additional paperwork requirements. Although facilities will be required to submit staffing and care information through the facility's average daily census on a daily basis, such reporting is already required. Therefore, the submission of this data does not form any new requirement, and the Department does not anticipate that this requirement will be unduly burdensome for the residential health care facilities.

**Costs:**

This regulation seeks to implementing standard minimum nursing home staffing levels. Residential health care facilities are not necessarily required to expend additional resources to meet these minimum staffing requirements, but rather may appropriately manage expenditures to balance overall expenditures to meet the minimum staffing thresholds. In any event, if costs are borne by residential health care facilities, compliance with these minimum staffing requirements is mandated by Public Health Law section 2895-b, and as such these regulatory amendments are necessary.

**Minimizing Adverse Impact:**

This regulation is mandated pursuant to PHL section 2895-b and necessary to ensure that direct resident care is prioritized by setting forth minimum staffing requirements for such care. Therefore, any adverse impacts are outweighed by the regulation's health and safety benefits to residents as well as the legal mandate for promulgation.

Additionally, regulations provide that the Department shall determine whether nursing homes must expend additional funds to comply, and nursing home that the Department finds will be required to expend additional funds to comply may be eligible to receive from the Department additional funds, subject to availability from the New York State Division of the Budget, to hire nursing staff necessary to achieve the minimum nursing staff requirements.

Further, regulations establishing the civil penalties include mitigating factors to account for: (1) extraordinary circumstances facing the facility such as officially declared emergencies or natural disasters; (2) the frequency of the violations of the facility; and (3) the existence of a nurse labor shortage in the area of the nursing home

**Rural Area Participation:**

The Department will notify all residential health care facilities, including those located in rural areas, of the existence of these regulations and the opportunity to submit public comments or questions to the Department. The Department will engage in active discussions and dialogue with all interested parties, including industry associations directly impacted by this regulation, to inform them of their need to comply, to answer questions and listen to comments they may have on this regulation.

## STATEMENT IN LIEU OF JOB IMPACT STATEMENT

A Job Impact Statement for these regulations is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities. To the contrary, given the minimum requirements for nursing staff, including nurse aides, certified nurse aides, licensed practical nurses, and registered nurses, the Department anticipates that these regulations will have a positive impact on nursing jobs throughout the State, to the extent these regulations will help incentivize hiring in these professions.

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221248-C
## NYU Langone Hospital-Long Island

***Program:*** **Hospital**
***Purpose:*** **Construction**

***County:*** **Nassau**
***Acknowledged:*** **July 26, 2022**

## Executive Summary

### Description
NYU Langone Hospital- Long Island (NYULH-LI) requests approval to certify an extension clinic to provide single specialty (gastroenterology) ambulatory surgery services on the 7th floor of 211 Station Drive, Mineola. The project will allow NYULH-LI to address capacity issues at the main hospital.

The hospital also has approval for an extension clinic on the 6th floor of the building to provide wound care services, which is currently under construction.

### OPCHSM Recommendation
Contingent Approval is recommended.

### Need Summary
Currently, patients needing outpatient endoscopies at NYU Langone Hospital-Long Island have a three-month wait time. The applicant projects 3,373 visits in the first year and 3,655 in the third with Medicaid utilization of 16.4%.

### Program Summary
Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

### Financial Summary
The total project cost of $18,219,372 will be met through equity from hospital operations. The budget projects Year One net income of $3,304,223 and $4,511,830 by Year Three.

| Budget | Year One (2023) | Year Three (2025) |
|---|---|---|
| Revenues | $11,977,013 | $13,769,697 |
| Expenses | 8,672,790 | 9,257,867 |
| Net Income | $3,304,223 | $4,511,830 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. The submission of Design Development and State Hospital Code (SHC) Drawings, as described in BAER Drawing Submission Guidelines DSG-1.0 Required Schematic Design (SD) and Design Development (DD) Drawings, and 3.20 LSC Chapter 20, New Ambulatory Healthcare Public Use, for review and approval. [DAS]

**Approval conditional upon:**

1. This project must be completed by **June 1, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **June 1, 2023,** and construction must be completed by **March 1, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]

## Council Action Date

December 8, 2022

# Need and Program Analysis

## Proposal

NYU Langone Hospital-Long Island is seeking approval to certify an extension clinic to provide single specialty (gastroenterology) ambulatory surgery services on the 7th floor of 211 Station Drive, Mineola, NY 11501, in Nassau County.

## Analysis

Currently, inpatients and outpatients receive their care in the same endoscopy suite which is located within the adjacent hospital. The wait for outpatient endoscopy procedures has been up to three months. This project will relieve pressure on the in-hospital endoscopy rooms by performing surgeries that meet appropriate criteria for the proposed extension clinic. The current hospital endoscopy suite has six procedure rooms. This extension clinic will have four procedure rooms for immediate use and two shelled procedure rooms for future growth. Approval of this project will allow more timely appointments leading to improved outcomes and patient satisfaction.

The primary service area is Nassau County, the secondary service area includes Suffolk and Queens Counties. According to Data USA, in 2019, 95.7% of the population in Nassau County has health coverage as follows.

| | |
|---|---|
| Employer Plans | 58.9% |
| Medicaid | 10.4% |
| Medicare | 13.7% |
| Non-Group Plans | 12.4% |
| Military or VA | 0.19% |

The applicant projects 3,373 visits in the first year and 3,655 in the third with Medicaid utilization of 16.4%. Staffing is expected to increase by 32.2 FTEs as a result of this project.

The table below shows the number of patient visits at relevant ambulatory surgery centers in Nassau County for the years 2019 through 2021.

| **Facility Name** | **Specialty** | **Patient Visits** | | |
|---|---|---|---|---|
| | | **2019** | **2020** | **2021** |
| Day OP of North Nassau [3] | Multi | 860 | 619 | 0 |
| East Hills Surgery Center | Multi | 3,001 | 3,964 | 4,886 |
| Endoscopy Center of LI | Gastroenterology | 8,547 | 6,874 | 8,696 |
| Garden City Surgi Center | Multi | 7,109 | 5,628 | 7,066 |
| LI Center for Digestive Health | Gastroenterology | 6,508 | 4,267 | 5,605 |
| Lynbrook Surgery Center [2] | Multi | 7,325 | 5,647 | 4,736 |
| Meadowbrook Endoscopy | Gastroenterology | 10,088 | 7,850 | 9,553 |
| New Hyde Park Endoscopy | Gastroenterology | 4,900 | 4,859 | 6,350 |
| Pro Health ASC, Inc [3] | Multi | 11,203 | 11,031 | 0 |
| ProHealth Day Op ASC [1,3] | Multi | 5,377 | 985 | 0 |
| Star Surgical Suites (opened 10/20/20) | Gastroenterology | N/A | N/A | 807 |
| Syosset SurgiCenter (opened 1/15/19) | Multi | 709 | 3,886 | 4,993 |
| **Totals** | | **65,627** | **55,610** | **52,692** |

*[1] 2020 SPARCS data is for a partial year*
*[2] 2021 SPARCS data is for a partial year*
*[3] No SPARCS data found for 2021*

### Compliance with Applicable Codes, Rules, and Regulations

The medical staff will continue to ensure that the procedures performed at the facility conform to generally accepted standards of practice and that privileges granted are within the physician's scope of practice and expertise. The Facility's admissions policy includes anti-discrimination provisions regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures are performed in accordance with all applicable federal and state codes, rules, and regulations.

### Conclusion

Approval of this project will result in improved care times and increased patient satisfaction for residents of Nassau, Queens, and Suffolk Counties needing gastroenterology surgery services through NYU Langone Hospital-LI. Based on the results of this review, a favorable recommendation can be made regarding the facility's current compliance pursuant to 2802-(3)(e) of the New York State Public Health Law.

## Financial Analysis

### Lease Rental Agreement

The applicant has submitted an executed lease rental agreement for the site that they are currently occupying, which is summarized below. The following lease includes space in the lobby and space on the fifth through the seventh floor.

| | |
|---|---|
| Premises | 81,500 square feet located at 211 Station Road, Mineola, New York. The lessee shall lease 2,000 square feet on the lobby,26,500 square feet on the fifth floor, 26,500 square feet on the sixth, and 26,500 square feet on the seventh floor. |
| Lessor | Steel Station RD, LLC |
| Lessee | NYU Langone Hospitals |
| Term | 30-year term with two (2) options to extend the term of the lease for five years each. |
| Rental | $1,915,250. For the seventh floor alone, this comes to $622,750. |
| Provisions | The lessee shall be responsible for real estate taxes, maintenance, and utilities. |

The applicant provided an affidavit indicating that there is no relationship between the lessor and the lessee.

### Total Project Cost and Financing

The total project cost, which is for renovations and the acquisition of moveable equipment, is estimated at $18,219,372 and will be financed from equity from operations.

| | |
|---|---|
| Renovation and Demolition | $8,040,000 |
| Design Contingency | 88,259 |
| Construction Contingency | 804,000 |
| Planning Consultant Fees | 40,212 |
| Architect/Engineering Fees | 588,396 |
| Construction Manager Fees | 2,721,863 |
| Moveable Equipment | 3,996,127 |
| Telecommunications | 1,838,868 |
| CON Fee | 2,000 |
| Additional Processing Fee | 99,647 |
| Total Project Cost | $18,219,372 |

## Operating Budget

The applicant has submitted an operating budget, in 2022 dollars, for the first and third years of the extension clinic, summarized below:

| | Year One (2023) | | Year Three (2025) | |
|---|---|---|---|---|
| | Per Visit | Total | Per Visit | Total |
| Revenues | | | | |
| Commercial MC | $2,088 | $446,751 | $2,214 | $513,619 |
| Commercial FFS | $6,036 | $8,994,274 | $6,403 | $10,340,512 |
| Medicare FFS | $1,645 | $1,232,036 | $1,747 | $1,416,443 |
| Medicare MC | $1,661 | $594,636 | $1,762 | $683,639 |
| Medicaid FFS | $950 | $12,350 | $1,014 | $14,198 |
| Medicaid MC | $1,178 | $634,931 | $1,248 | $729,966 |
| Private Pay | $860 | $4,299 | $988 | $4,942 |
| Other | $9,623 | $57,736 | $11,063 | $66,378 |
| Total Revenues | | $11,977,013 | | $13,769,697 |
| | | | | |
| Expenses | | | | |
| Operating | $2,386.61 | $8,050,040 | $2,362.55 | $8,635,117 |
| Capital | $184.63 | 622,750 | 170.38 | 622,750 |
| Total Expenses | $2,571.24 | $8,672,790 | $2,532.93 | $9,257,867 |
| | | | | |
| Net Income | | $3,304,223 | | $4,511,830 |
| | | | | |
| Utilization (Visits) | | 3,373 | | 3,655 |
| Cost Per Visit | | $2,571 | | $2,533 |

Utilization broken down by payor source during the first and third years is as follows:

| Payor | Year One (2023) | Year Three (2025) |
|---|---|---|
| Commercial FFS | 6.34% | 6.35% |
| Commercial MC | 44.14% | 44.19% |
| Medicare FFS | 22.21% | 22.16% |
| Medicare MC | 10.61% | 10.62% |
| Medicaid FFS | 0.39% | 0.38% |
| Medicaid MC | 15.98% | 16.01% |
| Private Pay | 0.15% | 0.14% |
| Other | 0.18% | 0.16% |
| Total | 100.00% | 100.00% |

## Capability and Feasibility

Total project costs of $18,219,372 will be met with equity. BFA Attachment A is the August 31, 2020, and August 31, 2021, certified financial statements of NYU Langone Hospital, which indicate the availability of sufficient funds for the equity contribution.

The submitted budget indicates an excess of revenues over expenses of $3,304,223 and $4,511,830 during the first and third years, respectively. Revenues are based on current reimbursement methodologies for endoscopy services. The submitted budget appears reasonable.

As shown in BFA Attachment A, the entity had an average positive working capital position and an average positive net asset position for the years ending August 31, 2020, and August 31, 2021. The entity achieved an average excess of revenues over expenses of $549,800,000 for the years ending August 31, 2020, and August 31, 2021.

### Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BFA Attachment A | Financial Summary- August 31, 2020, and August 31, 2021, certified financial statements of NYU Langone Hospital. |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221191-B
## Maxillofacial Ambulatory Surgery Center, LLC

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Suffolk**
***Purpose:*** **Establishment and Construction** ***Acknowledged:*** **July 7, 2022**

## Executive Summary

### Description

Maxillofacial Ambulatory Surgery Center, LLC, a New York limited liability company, is requesting approval to establish and construct an Article 28 diagnostic and treatment center (D&TC) to be certified as a single-specialty freestanding ambulatory surgery center (FASC) for oral and maxillofacial surgical procedures. Currently, the facility is named Oral Maxillofacial S.C., LLC, which was formed to plan the development of the surgery center. Upon approval of this application, the LLC will amend its Articles of Organization to change its name to Maxillofacial Ambulatory Surgery Center, LLC. The facility will be located in leased space at 400 Townline Road, Hauppauge (Suffolk County).

| Proposed Operator | |
|---|---|
| Maxillofacial Ambulatory Surgery Center, LLC | |
| Members | % |
| Lynn Pierri, DDS, MS | 95% |
| Thomas DeNapoli | 5% |

Lynn Pierri DeNapoli uses her maiden name professionally. Dr. Pierri is Board Certified in Oral and Maxillofacial Surgery and will be the Center's Medical Director. The applicant expects to enter into a Transfer Agreement for backup and emergency services with St. Catherine of Siena Hospital, located 4.4 miles and 11 minutes travel time from the proposed Center.

All procedures projected are currently being performed in Lynn Pierri, DDS, MS office-based surgery practice.

### OPCHSM Recommendation

Contingent approval with an expiration of the operating certificate five years from the date of its issuance.

### Need Summary

The center will provide oral and maxillofacial surgery services in three procedure rooms. The number of projected procedures is 1,100 in Year One and 1,553 in Year Three with Medicaid at 5.00% and Charity Care at 2.00%.

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3)(b).

### Financial Summary

The total project costs of $3,719,676 will be funded via members' equity.

| Budget | Year One (2024) | Year Three (2026) |
|---|---|---|
| Revenues | $2,199,235 | $3,494,455 |
| Expenses | 1,836,972 | 2,561,297 |
| Gain | $362,263 | $933,158 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval with an expiration of the operating certificate five years from the date of its issuance, contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of an executed lease agreement, acceptable to the Department of Health. [BFA]
5. Submission of a photocopy of an amended and executed Articles of Organization, acceptable to the Department. [CSL]
6. Submission of a photocopy of an amended and executed Operating Agreement, acceptable to the Department. [CSL]
7. Submission of a photocopy of an amended and executed Lease Agreement, acceptable to the Department. [CSL]
8. Submission of an executed transfer and affiliation agreement, acceptable to the Department. [HSP]
9. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women, and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
10. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based upon the calendar year. Submission of annual reports will begin after the first full or, if greater or equal to six months after the date of certification, partial year of operation. Reports should include: a. Data displaying actual utilization including procedures; b. Data displaying the breakdown of visits by payor source; c. Data displaying the number of patients who needed follow-up care in a hospital within seven days after ambulatory surgery; d. Data displaying the number of emergency transfers to a hospital; e. Data displaying the percentage of charity care provided; f. The number of nosocomial infections recorded during the year reported; g. A list of all efforts made to secure charity cases; and h. A description of the progress of contract negotiations with Medicaid managed care plans. [RNR]

**Approval conditional upon:**

1. This project must be completed by **April 1, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **July 1, 2023,** and construction must be completed by **January 1, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date this shall constitute abandonment of the approval. [PMU]

3. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]
4. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
5. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
6. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https:www.health.ny.gov/facilites/hospitals/docs/hcs_access_forms_new_clinics. pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov [HSP]

Council Action Date
December 8, 2022

# Need Analysis

The service area consists of Suffolk County. The population of Suffolk County in 2020 was 1,525,920 and is projected to decline slightly to 1,494,816 by 2025.

The table below shows the number of patient visits for relevant ambulatory surgery centers in Suffolk County for 2019 through 2021. 2020 visits were significantly impacted by COVID-19.

| Spec Type | Facility Name | Patient Visits | | |
|---|---|---|---|---|
| | | 2019 | 2020 | 2021 |
| Multi | Long Island Ambulatory Surgery Center | 14,642 | 9,270 | 12,053 |
| Multi | Melville Surgery Center | 5,917 | 4,611 | 4,273 |
| Multi | North Shore Surgi-Center | 7,226 | 6,364 | 6,215 |
| Multi | Port Jefferson ASC [2] | 2,570 | 3,037 | 0 |
| Multi | Progressive Surgery Center, LLC [1] | 2,886 | 1,510 | 2,092 |
| Multi | South Shore Surgery Center | 4,828 | 3,389 | 3,856 |
| Multi | Suffolk Surgery Center | 5,724 | 3,655 | 3,953 |
| Multi | The Center for Advanced Spine & Joint Surgery (opened 8/30/21) [2] | N/A | N/A | 0 |
| **Total Visits** | | **43,793** | **31,836** | **32,442** |

[1] *SPARCS 2020 & 2021 data is for a partial year.*

[2] *No SPARCS data located for 2021.*

According to Data USA, in 2019, 95.7% of the population of Suffolk County has health coverage as follows:

| | |
|---|---|
| Employer Plans | 58.7% |
| Medicaid | 10.8% |
| Medicare | 13.6% |
| Non-Group Plans | 12.1% |
| Military or VA | 0.542% |

The applicant projects 1,100 procedures in the first year and 1,553 by the third. These projections are based on the current practices of participating surgeons. The applicant states that all of the procedures moving to this center are currently being performed in an office-based setting. The table below shows the projected payor source utilization for Years One and Three.

| | Year One | | Year Three | |
|---|---|---|---|---|
| **Payor** | **Procedures** | **%** | **Procedures** | **%** |
| Medicaid FFS | 5 | 0.45% | 7 | 0.45% |
| Medicaid MC | 50 | 4.55% | 71 | 4.57% |
| Medicare FFS | 165 | 15.00% | 233 | 15.00% |
| Medicare MC | 110 | 10.00% | 156 | 10.05% |
| Comm FFS | 246 | 22.36% | 347 | 22.34% |
| Comm MC | 193 | 17.55% | 273 | 17.58% |
| Private Pay | 309 | 28.09% | 434 | 27.95% |
| Charity Care | 22 | 2.00% | 32 | 2.06% |
| Total | 1,100 | 100.00% | 1,553 | 100.00% |

The Center plans to obtain contracts with the following Medicaid Managed care plans: Affinity, Healthfirst, and United Healthcare. The Center will work collaboratively with local Federally Qualified Health Centers (FQHC) and others to provide service to the under-insured in their service area. The Center has developed a financial assistance policy with a sliding fee scale to be utilized when the Center is operational.

Conclusion

Approval of this project will allow for continued access to oral and maxillofacial surgery services in an outpatient setting for the residents of Suffolk County.

# Program Analysis

Program Description

| | |
|---|---|
| **Proposed Operator** | Oral Maxillofacial S.C, LLC |
| **Doing Business As** | Maxillofacial Ambulatory Surgery Center, LLC |
| **Site Address** | 400 Townline Road<br>Hauppauge, New York 11788 (Suffolk County) |
| **Surgical Specialties** | Single-Specialty-Oral and Maxillofacial Surgery |
| **Operating Rooms** | 0 |
| **Procedure Rooms** | 3 |
| **Hours of Operation** | Thursday and Friday 7:00 am to 3 pm |
| **Staffing (1st Year / 3rd Year)** | 7.20 FTEs / 12.35 FTEs |
| **Medical Director(s)** | Lynn Pierri, DDS, MDS |
| **Emergency, In-Patient, and Backup Support Services Agreement and Distance** | Is expected to be provided by:<br>St. Catherine of Siena Hospital<br>4.4 Miles / 11 minutes |
| **On-call service** | Patients who require assistance during off-hours will engage the 24-hour answering service to reach the on-call surgeon during hours when the facility is closed. |

Character and Competence

The ownership of Maxillofacial Ambulatory Surgery Center, LLC is:

| Member Name | Interest |
|---|---|
| Lynn Pierri, DDS | 95.00% |
| Thomas DiNapoli | 5.00% |
| **Total** | **100%** |

**Lynn Pierri** is the proposed Medical Director and member. She is the CEO, President, and Owner of Lynn Pierri DDS, MS, P.L.L.C, the CEO and President of Suffolk Oral & Maxillofacial Ambulatory Surgery Facility, P.C., an office-based surgical practice, and the CEO and President at Dental Implants of Long Island, P.C. She was the CEO and President at Voxel Imaging USA, LLC and the CEO and President of Living Well Essentials, LLC d/b/a American Hair Solutions. She is an Attending Surgeon at Long Island Community Hospital and was previously a Clinical Assistant Professor at SUNY Stony Brook and an Attending Surgeon at North Shore Surgical Center. She received her dental degree at SUNY Stony Brook. She received her medical degree at the University Health Sciences of Antigua School of Medicine in the West Indies. She received her New York teaching certificate at C.W. Post University. She completed her residency in Oral and Maxillofacial Surgery at Bellevue Hospital Center. She completed her fellowship in Oral and Maxillofacial Surgery at the Royal Infirmary of Edinburgh in Scotland.

**Thomas DeNapoli** is the CFO of Suffolk and Oral Maxillofacial Center. He assists Dr. Pierri with the day-to-day facility and property operations management. He has created a portfolio of strategic investments in both short and long-term residential rental properties. He was previously the President and Co-founder of Jet Drive General Marine Contracting Co. Inc. which was a company specializing in residential and small municipal projects that became a subcontracting company responsible for major infrastructure, residential development, and commercial projects with an annual gross revenue of $20M.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health

care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Dr. Pierri disclosed two malpractice suits.

- *A malpractice suit was filed on February 16, 2021, by a patient against Dr. Pierri and the prosthodontist. The patient underwent extractions, bone graft, and implants by Dr. Pierri uneventfully but claimed the prosthodontist took an excessive amount of time to create the prosthesis. The case is pending.*

- *A malpractice suit was filed on October 31, 2019, by the patient and alleged pain and suffering. The patient received a partial odontectomy (extraction of an impacted tooth) where the root tip that was on the nerve was intentionally left behind on the molar to prevent paresthesia (numbness) at the patient's advanced age. Years after the procedure, the patient had an infection in the back of her mouth and alleged that it was the root tip. The patient was seen over two years after the procedure by Dr. Pierri and the healing was within normal limits. The case is still pending.*

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

### Integration with Community Resources

For those patients who do not identify a primary care provider (PCP), the Applicant will work with the patient to educate them on the availability of primary care services offered by local providers, including the services offered by the Center's backup hospital, St. Catherine of Siena. Prior to leaving the Center, each patient will be provided information concerning the local availability of primary care services. This can be done by any of the clinic's providers, staff, clinicians, or other persons.

The Applicant is committed to serving all persons in need without regard to race, sex, age, religion, creed, sexual orientation, source of payment, ability to pay, or other personal characteristics. The Applicant is committed to the development of a formal outreach program directed to the members of the local community. The purpose of the program will be to inform the community of the benefits derived from, and the latest advances made in pain management, orthopedic surgery, and podiatry. The Applicant plans to contact FQHCs within the proposed catchment area. The Applicant will also develop customized outreach materials and resources to connect with targeted populations. As part of the Center's commitment to enhance access for underserved populations, the Center will contract with two or more Medicaid managed care plans and will see to work collaboratively with other Article 28 providers to develop referral and other collaborative arrangements to enhance access to ASC services to Medicaid and charity care patients.

The Center also plans to coordinate its services with inpatient and or specialty ambulatory facilities to which a patient is referred. The Applicant will also develop a Quality Assurance Program that will include an analysis of the effectiveness of the coordination efforts. The Applicant also commits to providing charity care for persons without the ability to pay and to utilize a discounted fee scale for persons unable to pay the full amount or are uninsured. The proposed budget includes a projected charity care allowance of 2% and projects Medicaid patients at 5%. Self-pay patients projected as 28% of the budget will be offered the discounted rates depending on their ability to pay. However, admission for surgery will be based solely on medical need and ability to pay will not be a factor.

The Center intends to use an Electronic Medical Record (EMR) program that is compatible with New York's RHIO and/or Health Information Exchange. The Applicant commits to becoming a network provider in the provider-led health homes designated by the Department for Suffolk County. The Applicant will consider joining any Accountable Care Organization (ACO) that includes dental care as part of its ACO

contract. The Applicant will make a decision regarding joining ACOs in keeping with its operating agreement.

### Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicants' character and competence or standing in the community.

## Financial Analysis

### Total Project Cost and Financing

The total project cost for renovations and movable equipment is estimated at $3,719,676 and will be financed with equity.

| | |
|---|---|
| Renovation & Demolition | $2,223,000 |
| Design Contingency | 222,300 |
| Construction Contingency | 222,300 |
| Architect/Engineering Fees | 220,087 |
| Construction Manager Fees | 174,958 |
| Other Fees | 390,000 |
| Movable Equipment | 244,696 |
| Application Fees | 2,000 |
| Additional Processing Fees | 20,335 |
| Total Project Cost | $3,719,676 |

BFA Attachment A is the net worth summary for the members of Maxillofacial Ambulatory Surgery Center, LLC, which shows sufficient resources to meet the construction equity requirement.

### Operating Budget

The applicant has submitted the first and third year projected operating budgets, as summarized below:

| | Year One 2024 | | Year Three 2026 | |
|---|---|---|---|---|
| Revenues | Per Visit. | Total | Per Visit. | Total |
| Medicaid FFS | $1,334.20 | $6,671 | $1,335.14 | $9,346 |
| Medicaid MC | $1,200.66 | 60,033 | $1,191.32 | 84,584 |
| Medicare FFS | $2,187.04 | 360,862 | $2,466.87 | 574,780 |
| Medicare MC | $1,964.97 | 216,147 | $2,216.04 | 345,703 |
| Commercial FFS | $2,731.20 | 671,874 | $3,018.61 | 1,047,459 |
| Commercial MC | $2,484.11 | 479,434 | $2,892.34 | 789,609 |
| Private Pay | $1,308.14 | 404,214 | $ 1,481.51 | 642,974 |
| Total Revenues | | $2,199,235 | | $3,494,455 |
| | | | | |
| Expenses | | | | |
| Operating | $1,320.04 | $1,452,048 | $1,393.59 | $2,164,248 |
| Capital | $349.93 | 384,924 | $255.67 | 397,049 |
| Total Expenses | $1,669.97 | $1,836,972 | $1,649.26 | $2,561,297 |
| | | | | |
| Net Income (Loss) | | $362,263 | | $933,158 |
| | | | | |
| Procedures | | 1,100 | | 1,553 |
| Cost Per Procedure | | $1,669.97 | | $1,649.26 |

The following is noted with respect to the submitted ASC budget.

- The Medicaid Fee-for-Service (FFS) rate is based on the ambulatory patient group (APG) for the downstate region multiplied by APG weight. Medicaid Managed Care (MC) rate is estimated at approximately 90% of the Medicaid FFS rate.
- Medicare FFS rate is projected at the Federal government rate for FASC with the Medicare MC rate estimated at approximately 90% of the Medicare FFS rate.
- The Commercial FFS and MC rates are based on approximately 125% and 114% of the Medicare FFS rate with private payers reflecting a 60% adjustment to the Medicare FFS rate.
- Utilization by payor is based on the member physician's existing office-based surgical practice payer mix and adjustments for community outreach.
- The number and mix of staff were determined by the experience of Lynn Pierri, DDS, MS in providing outpatient oral and maxillofacial surgery services.
- Expenses are based upon the experience of Lynn Pierri, DDS, MS in providing outpatient oral and maxillofacial surgical services in an office-based surgical practice.
- Utilization by payor source for Years One and Three are summarized below:

| | Year One | | Year Three | |
|---|---|---|---|---|
| Payor | Procedures | % | Procedures | % |
| Medicaid FFS | 5 | 0.45% | 7 | 0.45% |
| Medicaid MC | 50 | 4.55% | 71 | 4.57% |
| Medicare FFS | 165 | 15.00% | 233 | 15.00% |
| Medicare MC | 110 | 10.00% | 156 | 10.05% |
| Commercial FFS | 246 | 22.36% | 347 | 22.34% |
| Commercial MC | 193 | 17.55% | 273 | 17.58% |
| Private Pay | 309 | 28.09% | 434 | 27.95% |
| Charity Care | 22 | 2.00% | 32 | 2.06% |
| Total | 1100 | 100% | 1553 | 100% |

## Lease Rental Agreement

The applicant has submitted a draft Lease Agreement, the terms are summarized below:

| | |
|---|---|
| Premises: | 4,732 rentable square feet at 400 Townline Road, Hauppauge, NY 11788 |
| Landlord: | 400 Townline LLC and Townline 400 LLC |
| Lessee: | Maxillofacial Ambulatory Surgery Center, LLC |
| Term: | 5 Years with a renewal of one (1) 5-year term |
| Rental: | $118,302 1st year ($25 per sq. ft.); 5% annual increase; renewal 3.5% annual rent increase |
| Provisions: | Maintenance and increases in taxes, insurance, and utilities. |

The lease arrangement is a non-arms-length agreement. The applicant has submitted an affidavit attesting to the common members between the landlord and the operator. Letters from two NYS licensed realtors have been provided attesting to the rental rate being of fair market value.

## Capability and Feasibility

Total project costs of $3,719,676 will be funded via members' equity. The working capital requirement is estimated at $426,883 based on two months of third-year expenses and will be financed via members' equity. BFA Attachment A is the members' net worth, which shows sufficient resources to meet the project and working capital equity requirements. BFA Attachment B is Maxillofacial Ambulatory Surgery Center, LLC's pro forma balance sheet, which shows operations will start with $4,146,559 in equity. Maxillofacial Ambulatory Surgery Center estimates a first and third-year operating surplus of $362,263 and $933,158, respectively. The budget appears reasonable.

## Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

| Attachments |
|---|

| | |
|---|---|
| BHFP Attachment | Map |
| BFA Attachment A | Members' Net Worth Summary |
| BFA Attachment B | Maxillofacial Ambulatory Surgery Center, LLC., Pro Forma Balance Sheet |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221206-E
## Northern Westchester Facility Project LLC
## d/b/a Yorktown Center for Specialty Surgery

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Westchester**
***Purpose:*** **Establishment** ***Acknowledged:*** **July 8, 2022**

## Executive Summary

### Description

Northern Westchester Facility Project LLC d/b/a Yorktown Center for Specialty Surgery (Yorktown or the Center), a Delaware Limited Liability Company Article 28 multi-specialty ambulatory surgery center (ASC) at 2651 Strang Boulevard Suite 100 in Yorktown Heights (Westchester County) is requesting to transfer ownership interest to eleven new members and seeking approval for eight members previously admitted under Transfer Notice 191079. Yorktown's current ownership consists of 15 Class A member physicians that own 91.0% of membership units and one Class B member, Merritt Healthcare Holdings Westchester, LLC that owns 9.0% of membership units.

There will be no change in services as a result of this application. George Pazos, MD, who is Board-certified in Otolaryngology, will serve as the Medical Director. The Center maintains a Transfer Agreement for emergency and backup services with Westchester Medical Center, 16.2 miles (19 minutes travel time) from The Center.

### OPCHSM Recommendation

Contingent Approval is recommended.

### Need Summary

There will be no need review per Public Health Law §2801-a (4)

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

### Financial Summary

There are no project costs for this application. The total purchase price for the 20.044% ownership interest is $627,622.07 and will be funded with proposed new member equity. The submitted budget for Yorktown indicates an excess of revenues over expenses of $1,061,585 and $1,537,479 during the first and third years of operations, respectively.

| Budget | Current Year (2020) | Year One (2023) | Year Three (2025) |
|---|---|---|---|
| Revenues | $7,922,257 | $9,513,335 | $10,940,336 |
| Expenses | $7,918,770 | $8,451,750 | $9,402,857 |
| Net Income | $3,487 | $1,061,585 | $1,537,479 |

# Recommendations

Health Systems Agency
There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management
**Approval contingent upon:**
1. Submission of the Operator's Operating Agreement that is acceptable to the Department. [CSL]

**Approval conditional upon:**
1. This project must be completed by **June 1, 2023**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. The continued submission of annual reports to the Department as prescribed in the approval of CON 151277 for the duration of the limited life approval of the facility. (RNR)

Council Action Date
December 8, 2022

# Program Analysis

## Background

Northern Westchester Facility Project, LLC d/b/a Yorktown Center for Special Surgery, an existing freestanding multi-specialty Ambulatory Surgery Center (FASC) seeks approval to transfer 20.044% ownership interest from 16 existing members to 11 new members and seeks approval for eight current members who were previously admitted as a result of a Transfer Notice 191079. The existing FASC is located at 2651 Strang Boulevard in Yorktown Heights (Westchester County). There will be no change in services or Medical Director as a result of this application. Staffing will increase by 1.77 FTEs in Year One and 1.00 FTEs in Year Three.

## Character and Competence

The proposed membership Northern Westchester Facility Project, LLC is provided in the chart below.

| **Member Name/Title** | **Current** | **Proposed** |
|---|---|---|
| **CLASS A MEMBERS** | | |
| Arthur Pidoriano, M.D. | 7.3428% | 5.7652% |
| George Pazos, M.D. | 7.0298% | 5.5195% |
| Gabriel Brown, M.D. | 6.7619% | 5.2738% |
| Gregg Cavaliere, M.D. | 6.7619% | 5.2738% |
| George Pianka, M.D. | 6.7619% | 5.2738% |
| Michael Bergstein, M.D. | 6.1411% | 4.8217% |
| Yanir Rubinstein, M.D. | 6.7179% | 5.2738% |
| Donato Perretta, M.D. | 6.7179% | 5.2738% |
| Barry Krosser, M.D. | 5.4040% | 4.2430% |
| John Angelino, M.D. | 5.4040% | 4.2430% |
| Scott Russinoff, M.D. | 5.4040% | 4.2430% |
| Robert Parks, M.D. | 4.9408% | 3.8793% |
| William Losquadro, M.D. | 5.4040% | 4.2430% |
| Kathy Ma, M.D. | 5.4040% | 4.2430% |
| Deborah Reich, M.D. | 4.9408% | 3.8793% |
| ***Neil Dunleavy, M.D. | 0.0000% | 3.1857% |
| ***Jason Hochfield, M.D. | 0.0000% | 3.1857% |
| ***Erich Braun, M.D. | 0.0000% | 3.1857% |
| ***Paul Mignone, M.D. | 0.0000% | 1.3361% |
| ***Opeyemi Daramola, M.D. | 0.0000% | 1.3361% |
| ***Deya Jourdy, M.D. | 0.0000% | 1.3361% |
| ***Rafael Axen, M.D. | 0.0000% | 3.0567% |
| ***Steven Cataldo, M.D. | 0.0000% | 2.1917% |
| ***Gabriel Pitta, M.D. | 0.0000% | 0.8767% |
| ***Kevin Lee, M.D. | 0.0000% | 0.8767% |
| ***Jay Bhangoo, M.D. | 0.0000% | 0.8767% |
| | | |
| **CLASS B MEMBER** | | |
| Merritt Healthcare Holdings Westchester, LLC<br>Matthew Searles (45%)<br>Richard Searles (20%)<br>William Mulhall (35%) | 9.0000% | 8.5067% |
| **Total** | **100%** | **100%** |

****Members Subject to Character and Competence*

**Dr. Giovanni "John" Angelino** is an Interventional Pain Management Physician at Northern Westchester Hospital, an Attending Anesthesiologist at Hudson Valley Hospital, a Partner, Attending Anesthesiologist, and Pain Management Physician at Mount Kisco, and the President of Giovanni Angelino, M.D., P.C. He received his medical degree from Universidad Del Noreste. He completed his residency in Anesthesiology at SUNY Downstate. He completed his fellowship in Pain Management at Emory University. He is board certified in Pain Management.

**Dr. Rafael Axen** is the Chair of the Department of Anesthesiology and the Site Medical Director of Caremount. He was previously the Chief of Anesthesiology at Bedford Anesthesia, the Medical Director and President of the Medical Staff of the Ambulatory Surgery Center of Westchester, and an Anesthesiologist at Kaiser Permanente. He received his medical degree from Rutgers Medical School. He completed his residency in Anesthesiology at New York Presbyterian Weill Cornell Medical Center. He is board certified in Anesthesiology.

**Dr. Jatinder Bhangoo** is a Medical Director of Dutchess Ambulatory Surgery Center and the Chairman of Anesthesia of the Northern Division of Caremount. He was previously the Director of Anesthesia at Mid-Hudson Regional Hospital, an Anesthesiologist at Anesthesia Associates of St. Francis, a member of the St. Francis Hospital Performance Improvement Committee, and an Assistant Professor at Stony Brook University Hospital. He received his medical degree from the Ross University School of Medicine in the West Indies. He completed his residency in Anesthesia at Stony Brook University Hospital.

**Dr. Erich Braun** is a Surgeon and Senior Partner at Caremount Medical Group. He is a Volunteer Firefighter in the Town of Katonah. He received his medical degree from the University of Pennsylvania Medical School. He completed his residency in Ophthalmology at NYU. He completed his Cornea fellowship at UC Irvine.

**Dr. Steven Cataldo** is an Anesthesiologist at Caremount Medical P.C. . He was an Anesthesiologist at Vyaire Medical Inc. and an Anesthesiologist at Revolutionary Medical Devices, Inc. He received his medical degree from SUNY Downstate Medical Center. He completed his Anesthesia residency at SUNY Downstate Medical Center. He is board eligible.

**Dr. Opeyemi Daramola** is a Surgeon in Otolaryngology at Caremount, an Attending Physician at Northern Westchester Hospital, and an Adjunct Instructor at Northwestern University. He was a Surgeon at Crystal Run Healthcare, a Surgeon at Penn Medicine Becker ENT & Allergy, an Attending Physician at Nyack Montefiore Hospital, an Attending Physician at the University Medical Center of Princeton, and a Clinical Instructor at Northwestern University. He received his medical degree from the University of Minnesota Medical School. He completed his residency in Otolaryngology at the Medical College of Wisconsin Affiliated Schools. He completed his fellowship in Rhinology at Northwestern University. He is board certified in Otolaryngology.

**Dr. Neil Dunleavy** is an Orthopedist at Caremount Medical, PC. He was an Orthopedist at Orthopaedic Specialty Group, PC and a Partner at KSF Orthopaedic Center. He received his medical degree from Georgetown University School of Medicine. He completed his residency in Orthopedic Surgery at St. Luke's Roosevelt Hospital Center, Columbia University. He completed his fellowship in Sports Medicine at the University of Chicago Medical Center. He is board certified in Orthopedic Surgery. Dr. Dunleavy discloses ownership interest in the following healthcare facilities:

*Tops Surgical Specialty Hospital* *2005-2018*

**Dr. Jason Hochfelder** is a Partner at Hudson Valley Bone and Joint and an Independent Medical Examiner at First Choice Evaluations. He received his medical degree from New York University School Of Medicine. He completed his residency in Orthopedics at NYU Hospital for Joint Diseases. He completed his fellowship in hip and knee surgery at Insall Scott Kelly Institute. He is board certified in Orthopedic Surgery.

**Dr. Deya Jourdy** is an Attending Surgeon and Director of Rhinology at Phelps Memorial Hospital and a Business Partner and Attending Surgeon at ENT and Allergy Associates, LLC. He was a Business Partner, Associate Faculty, an Attending Surgeon at ENT Faculty Practice, LLP, a Clinical Faculty and Attending Surgeon at the University of Miami Hospital, and a Clinical Instructor at the Department of

Otolaryngology. He received his medical degree from Weill Medical College at Cornell University. He was the Research Coordinator at Weill Cornell School of Medicine. He completed his residency in Otolaryngology-Head and Neck Surgery at New York Presbyterian Hospital-Columbia and Cornell and Memorial Sloan Kettering Cancer Center. He completed his fellowship in Rhinology-Endoscopic Sinus and Skull Base Surgery at University of Miami Miller School of Medicine. He is board certified in Otolaryngology.

**Dr. Kevin Lee** is a Cardiac Anesthesiologist at North American Partners in Anesthesia. He was the Chief of Cardiac Anesthesia and Ambulatory Vascular Surgery at North American Partners in Anesthesia, a Clinical Coordinator and Research Assistant in the Department of Anesthesia at New York Presbyterian Hospital, a Teaching Assistant at Columbia University in the Department of Biology, and a Metallurgical Process Engineer. He received his medical degree from Pennsylvania State University College of Medicine. He completed his residency and fellowship in Anesthesia at New York Presbyterian Hospital-Cornell. He is board certified in Anesthesia.

**Dr. William Losquadro** is a Plastic Surgeon at Caremount Medical P.C. and the owner of William D. Losquadro, MD Facial Plastic, and Reconstructive Surgery. He is affiliated with the Institute of Aesthetic Surgery and Medicine at Northern Westchester Hospital. He received his medical degree from SUNY Upstate. He completed his residency in Otolaryngology-Head and Neck Surgery at SUNY Upstate Medical University. He completed his fellowship in Facial Plastic and Reconstructive Surgery at University of Illinois at Chicago. He is board certified in Facial Plastic Surgery and Reconstructive Surgery as well as Otolaryngology-Head and Neck Surgery.

**Dr. Katherine Ma** is an Attending Orthopedic Surgeon at Caremount Medical Group. She was previously a Physical Therapist at Oxford Health Plans, Mount Sinai Sports Therapy Center, the Department of Veteran Affairs, and a private medical practice. She was an Adjunct Faculty Member at the Division of Physical Therapy and a Research Assistant at the New York Medical College Lyme Disease Clinic. She received her medical degree from New York Medical College. She completed her fellowship in Orthopedic Surgery-Foot and Ankle at University of Rochester Medical Center. She is board certified in Orthopedic Surgery.

**Dr. Paul Mignone** is an Associate and Ophthalmologist at Caremount Medical and Optum Health. He is an Owner and Partner at Mignone Medical Eye Care. He received his medical degree from New York Medical College. He completed his residency in Ophthalmology and his fellowship in Medical Retina at St. Luke's Roosevelt Hospital Center. He is board certified in Ophthalmology.

**Dr. Robert Parks** is an ENT/Otolaryngologist at Caremount Medical PC, an affiliated ENT with the Ambulatory Surgery Center of Westchester, and an affiliated ENT at New York Presbyterian/Hudson Valley Hospital. He was previously an ENT at Valley ENT. He received his medical degree from Columbia University. He completed his residency in ENT and Otolaryngology at Mount Sinai School of Medicine and Columbia University College of Physicians and Surgeons. He completed his fellowship as a Research Fellow at New York Presbyterian-Columbia University Medical Center. He is board certified in Otolaryngology.

**Dr. Donato Perretta** is an Orthopedic and Hand Surgeon at Caremount Medical, an Attending Surgeon at the Ambulatory Surgery Center of Westchester, an Attending Surgeon at Northern Westchester Hospital, an Attending Surgeon at Yorktown Center for Special Surgery. He received his medical degree from the New York University School of Medicine. He completed his residency in Orthopedics at NYU Hospital for Joint Diseases. He completed his fellowship in Hand and Upper Extremity Surgery at Massachusetts General Hospital. He is board certified in Orthopedics with a sub-certification in Hand Surgery.

**Dr. Arthur Pidoriano** is an Orthopedic Surgeon at Caremount Medical PC. He was President of the Medical Staff of NYY Hudson Valley and also served on the Board of Hudson Valley Hospital.

**Dr. Gabriel Pitta** is an Adult and Pediatric Anesthesiologist at East Manhattan Anesthesia Partners. He was a Staff Anesthesiologist at Northwest Anesthesia Partners. He received his medical degree from Weill Cornell Medical College. He completed his residency in Anesthesia at Yale New Haven Hospital. He

completed his fellowship in Pediatric Anesthesia at Columbia Presbyterian Hospital. He is board certified in Anesthesia.

**Dr. Yair Rubinstein** is an Orthopedic Surgeon at Caremount Medical, PC. He received his medical degree from the Albert Einstein College of Medicine. He completed his residency in Orthopedics at Montefiore Medical Center. He completed his fellowship in Sports Medicine at Long Beach Memorial Hospital.

**Dr. Scott Rusinoff** is an Orthopedic Surgeon at Caremount Medical, P.C. and an affiliated Surgeon with New York Presbyterian/Hudson Valley Hospital. He was an Orthopedic Surgeon at Community Orthopedic Associates, an Orthopedic Surgeon at University Orthopedics, and was previously affiliated with Westchester County Medical Center. He received his medical degree from SUNY Downstate Medical Center. He completed his residency in Orthopedics at New York Medical College. He completed his fellowship in Orthopedic Surgery at the Florida Orthopedic Institute. He is board certified in Orthopedic Surgery.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

## Conclusion

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

# Financial Analysis

## Operating Budget

| | Current Year (2020) | | Year One (2023) | | Year Three (2025) | |
|---|---|---|---|---|---|---|
| | Per Proc. | Total | Per Proc. | Total | Per Proc. | Total |
| Revenues | | | | | | |
| Commercial MC | $5,442.34 | $5,736,222 | $5,988.64 | $6,940,829 | $633.99 | $7,981,953 |
| Medicare FFS | $1,508.44 | 988,025 | $1,658.13 | 1,195,510 | $504.13 | 1,374,837 |
| Medicare MC | $1,729.50 | 242,130 | $1,902.45 | 292,977 | $834.00 | 336,924 |
| Medicaid MC | $1,492.15 | 140,262 | $1,647.74 | 169,717 | $524.70 | 195,175 |
| Private Pay | $2,546.65 | 50,933 | $2,801.32 | 61,629 | $632.88 | 70,873 |
| All Other[1] | $2,782.89 | 701,289 | $3,063.39 | 848,560 | $1,322.34 | 975,844 |
| Total Patient Rev. | | $7,858,860 | | $9,509,221 | | $10,935,605 |
| Other Income[2] | | 63,397 | | 4,114 | | 4,731 |
| Total Revenue | | $7,922,257 | | $9,513,335 | | $10,940,336 |
| | | | | | | |
| Expenses | | | | | | |
| Operating | $2,700.61 | $6,073,672 | $2,671.69 | $6,607,101 | $2,657.16 | $7,559,623 |
| Capital | 820.41 | 1,845,098 | 745.92 | 1,844,649 | 647.89 | 1,843,234 |
| Total Expenses | $3,521.02 | $7,918,770 | $3,417.61 | $8,451,750 | $3,305.05 | $9,402,857 |
| | | | | | | |
| Net Income | | $3,487 | | $1,061,586 | | $1,537,479 |
| | | | | | | |
| Visits | | 2,249 | | 2,473 | | 2,845 |
| Cost/Visit | | $3,521.02 | | $3,417.61 | | $3,305.05 |

[1] *All Other includes Workers' Compensation and No-Fault.*

[2] Other Income includes interest income of $3,740 and $59,657 in Provider Relief Funds distributions YCSS received from the U.S. Department of Health Human Services under the CARES Act.

Utilization by payor source during the first and third years is broken down as follows:

| | Current Year | Year One | Year Three |
|---|---|---|---|
| Commercial MC | 46.87% | 46.87% | 46.85% |
| Medicare FFS | 29.12% | 29.15% | 29.14% |
| Medicare MC | 6.22% | 6.23% | 6.22% |
| Medicaid MC | 4.18% | 4.16% | 4.18% |
| Private Pay | 0.89% | 0.89% | 0.88% |
| Charity Care | 1.51% | 1.50% | 1.51% |
| All Other | 11.20% | 11.20% | 11.21% |
| Total | 100.00% | 100.00% | 100.00% |

The following is noted with respect to the submitted budget:

- The current year reflects the facility's 2020 revenues and expenses.
- Staffing mix is based on the operations of the existing Article 28 ambulatory surgery center and the experience of the operator.
- Utilization in Year One and Three is based on an increase in the number of participating surgeons at the center.
- Expenses are based on the historical experience of the current operations.
- As of October 12, 2022, the facility had no outstanding Medicaid overpayment liabilities.

### Executed Lease Agreement

The applicant has submitted an executed lease agreement for the existing site, the terms of which are summarized below:

| | |
|---|---|
| Date: | January 15, 2016 |
| Premises: | 2651 Strang Boulevard, Suite 100, Yorktown Heights, New York, 10598 |
| Landlord: | GHP Strang, LLC |
| Tenant: | Northern Westchester Facility Project, LLC |
| Term: | 15 Years, with an option to renew for one 10-year term. |
| Rent: | Base rent is $365,400 ($30,450.00 per month) for the first three years, with 3% increase of base rent thereafter. Additional rent includes an estimated monthly electric payment of $4,567.50. Security deposit of $375,840 is due upon execution of the lease. |
| Provisions: | Tenant is responsible for insurance, utilities, and property taxes. |

The applicant submitted an affidavit stating the lease agreement is an arm's length arrangement.

### Executed First Amendment to Lease Agreement

The applicant has submitted an executed first amendment to the lease agreement for the existing site between GHP Strang, LLC and Northern Westchester Facility Project, LLC, the terms of which are summarized below:

| | |
|---|---|
| Date: | January 18, 2017 |
| Premises: | 2651 Strang Boulevard, Suite 100, Yorktown Heights, New York, 10598 |
| Landlord: | GHP Strang, LLC |
| Tenant: | Northern Westchester Facility Project, LLC |
| Term: | 15 Years, with an option to renew for one 10-year term |
| Rent: | Base rent is $365,400 ($30,450.00 per month) for the first three years, with 3% increase of base rent thereafter. Additional rent includes an estimated monthly electric payment of $4,567.50 Security deposit of $375,840 due upon execution of the lease. |
| Provisions: | Tenant is responsible for insurance, utilities, and property taxes. |

The applicant submitted an affidavit stating the lease agreement is an arm's length arrangement.

### Second Amendment to the Administrative Services Agreement

The applicant has submitted a Second Amendment to the Administrative Services Agreement (ASA), summarized as follows:

| | |
|---|---|
| Date: | August 7, 2021 |
| Company: | Northern Westchester Facility Project, LLC |
| Consulting Company: | Merritt Healthcare Holdings Westchester LLC |
| Term: | 7 years with 1 additional 2-year term. |
| Consulting Services Provided: | Organizing, coordinating, and monitoring the construction of additional procedure and operating rooms, organizing and overseeing the process of securing third-party financing, assisting with business planning, reviewing and modifying policies and procedures, overseeing accreditation and licensure process, assisting with financial management including preparation of annual financial statements and provision of data required for tax and government filings, coordinating and managing bookkeeping, accounting and data processing, negotiating with vendors for equipment, supplies, and IT services, administering benefit or insurance plans, human resource management, billing and collections, assisting with administration of utilization, cost and quality management systems, maintain agreed upon insurance coverage, legal services and credentialing support services. |
| Developmental Services: | Prepare pro formas, ROI, and financial projections, assist in obtaining financing for the project, recommend a site, an architect and builder, and |

| | |
|---|---|
| | manage the design and construction process, attend construction meetings and oversee construction, other tasks as mutually agreed upon by the parties. |
| Development Fee: | $200,000 paid in two installments of $50,000 and $150,000. |
| Consulting Fee: | $325,000 ($27,083.33/month) |

### Capability and Feasibility

There are no project costs associated with this application. The submitted budget indicates an excess of revenues over expenses of $1,061,586 and $1,537,479 during the first and third years of operations, respectively. Utilization in Year One and Three is based on an increase in the number of participating surgeons at the center. The total purchase price for the 20.044% membership units is $627,622.07 and will be funded with proposed member equity. BFA Attachment A presents the physician members' personal net worth statements, which indicate sufficient resources overall to fund the equity requirements.

A summary of the 2020 Certified Financial Statements for Yorktown Center for Specialty Surgery is included in BFA Attachment C. For the year ending December 31, 2020, Yorktown reported negative working capital and member's deficit of $584,614 and $2,048,186, respectively. The reported negative working capital was driven by post-COVID-19 ramp-up of operations and higher operational costs, negative members' deficit was impacted by accelerated depreciation and first-year losses. During 2020, Yorktown reported income from operations of $311,776, which was offset by $371,686 in interest expense, interest income of $3,740, and grant income of $59,657, resulting in a net income of $3,487.

A summary of the Internal Financial Statements for Yorktown Center for Specialty Surgery for the year ended December 31, 2021, is included in BFA Attachment D. These statements show a positive working capital position, a positive net asset position, and a positive operating income of $1,695,463, which was offset by $300,731 in other income, and $787,087 in other expenses resulting in net income of $1,209,107.

BFA Attachments E is a summary of internal Financial Statements for Yorktown Center for Specialty Surgery for period-ended June 30, 2022, which shows a negative working capital and negative net asset positions, and a positive operating income of $1,082,609 which was offset by $457,157 in other expenses, resulting in net income of $625,452 for the period. Negative working capital and net asset position is due to financial statements being presented on a cash basis and excluding approximately $1.5M in accounts receivable.

### Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BFA Attachment A | Proposed Members' Net Worth Statements |
| BFA Attachment B | 2020 Certified Financial Statements |
| BFA Attachment C | December 2021 Internal Financial Statements |
| BFA Attachment D | 2022 Internal Financial Statements |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221213-E
## Performance Surgical Center, LLC d/b/a Performance Surgical Center

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Kings**
***Purpose:*** **Establishment** ***Acknowledged:*** **July 11, 2022**

## Executive Summary

### Description

Performance Surgical Center, LLC (PSC), an existing New York limited liability company, requests approval to be established as the new operator of Millennium Ambulatory Surgery Center (Center), an Article 28, multi-specialty freestanding ambulatory surgery center (FASC). The Center is in leased space at 1408 Ocean Avenue, Brooklyn, Kings County. The center provides orthopedic, vascular, podiatric, plastic/hand, spine, gynecologic, and pain management surgery services

On September 21, 2020, Millennium Ambulatory Surgery Center, LLC entered into a purchase agreement (PA) with Performance Surgical Center, LLC., for the sale and acquisition of certain assets for $2,500,000. The transaction will be finalized upon Public Health and Health Planning Council (PHHPC) approval. Concurrently, 1408 Ocean Avenue, LLC entered into a purchase and sale agreement (PSA) with 1408 Partners LLC. for the sale and acquisition of the real property for $10,000,000. According to the real property deed, the transaction closed on December 28, 2020.

There is an existing Consulting Services Agreement between Performance Surgical Center, LLC, and Millennium Ambulatory Surgery Center, LLC, that has been in place since September 21, 2020. The Consulting Services Agreement will terminate upon the Department's approval of this application.

| Proposed Operator<br>Performance Surgical Center, LLC | |
|---|---|
| Members | % |
| Sandro Starna | 95% |
| Jonathan Phillips, M.D. | 5% |

Jonathan Phillips, M.D., is board certified in Family and Sports Medicine and will be the Center's Medical Director. The Center has an existing Transfer and Affiliation Agreement for backup and emergency services with New York Community Hospital, which is located 1.5 miles (7 minutes travel time) from the Center. The Center also has a Transfer and Affiliation Agreement with Maimonides Medical Center, which is 4.0 miles (15 minutes travel time) from the Center. These Transfer and Affiliation Agreements will be assigned to the new operator of the Center.

### OPCHSM Recommendation

Contingent approval with an expiration of the operating certificate five years from the completion of the application.

### Need Summary

Anticipating new physicians joining the center, the projected number of procedures is 3,750 in Years One and Three with 25.33% Medicaid and 10.00% Charity Care. The center is current with their SPARCS reporting.

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

### Financial Summary

The $2,500,000 purchase price for the FASC operations has been funded via a loan from 1408 Partners LLC (the landlord), with no interest and no repayment terms. The FASC's real property was

acquired by 1408 Partners LLC. for $10,000,000 and closed on December 28, 2020. The real property transaction was funded via $3,000,000 in members' equity and a $7,000,000 bank loan with a 10-year term and 30-year amortization at 3.875% interest from Connection bank. There are no project costs associated with this transaction.

| Budget | Year One 2023 | Year Three 2025 |
|---|---|---|
| Revenues | $8,511,765 | $8,551765 |
| Expenses | $6,202,895 | $6,202,895 |
| Net Income | $2,308,870 | $2,305,219 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval with an expiration of the operating certificate five years from the date of its issuance, contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of an executed lease agreement acceptable to the Department of Health. [BFA]
3. Submission of a signed agreement with an outside, independent entity satisfactory to the Department to provide annual reports to DOH. Reports are due no later than April 1st for the prior year and are to be based on the calendar year. Reports should include:
   a. Data displaying actual utilization including procedures;
   b. Data displaying the breakdown of visits by payor source;
   c. Data displaying the number of patients who needed follow-up care in a hospital within
   d. seven days after ambulatory surgery;
   e. Data displaying the number of emergency transfers to a hospital;
   f. Data displaying the percentage of charity care provided;
   g. The number of nosocomial infections recorded during the year reported;
   h. A list of all efforts made to secure charity cases; and
   i. A description of the progress of contract negotiations with Medicaid Managed Care plans. [RNR]

**Approval conditional upon:**

1. This project must be completed by **one year from the date of this letter**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https:www.health.ny.gov/facilites/hospitals/docs/hcs_access_forms_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov [HSP].
3. The submission of annual reports to the Department as prescribed by the related contingency, each year, for the duration of the limited life approval of the facility. [RNR]

## Council Action Date

December 8, 2022

# Need and Program Analysis

Project Proposal

| | |
|---|---|
| **Proposed Operator** | Performance Surgical Center, LLC |
| **Doing Business As** | Performance Surgical Center |
| **Site Address** | 1408 Ocean Avenue<br>Brooklyn, NY 11230 (Kings County) |
| **Shift/Hours/Schedule** | Monday through Friday 7:15 am to 5:00 pm |
| **Services** | Ambulatory Surgery-Multi Specialty<br>Orthopedic<br>Vascular<br>Podiatry<br>Plastic/Hand<br>Spine<br>Gynecology<br>Pain Management |
| **Staffing (1st Year/3rd Year)** | 35.3 FTEs/35.3 FTEs |
| **Medical Director** | Jonathan Phillips, MD |
| **Emergency, In-Patient, and Backup Support Services Agreement and Distance and Time** | New York Community Hospital<br>1.5 miles/7 minutes<br><br>Maimonides Medical Center<br>4.0 miles/15 minutes |

Background and Analysis

The service area of Kings County had a population of 2,736,074 in 2020 which is projected to grow to 2,810,876 by 2025. According to Data USA, in 2019, 93.3% of the population of Kings County has health coverage as follows:

| | |
|---|---|
| Employer Plans | 41.1% |
| Medicaid | 32.2% |
| Medicare | 8.01% |
| Non-Group Plans | 11.8% |
| Military or VA | 0.327% |

This facility is located within a Health Professional Shortage Area for primary care and is also designated within a Medically Underserved Area.

The following table shows the Center's Medicaid and charity care utilization for the past two years and projections going forward:

| | 2020 | 2021 | Years One & Three |
|---|---|---|---|
| Procedures | 531 | 436 | 3,750 |
| Medicaid | 0.0% | 32.4% | 25.33% |
| Charity Care | 0.0% | 0.0% | 10.00% |

The increase in the center's Medicaid utilization in 2021 was due to three new physicians performing procedures at the center. The center is projecting 3,750 procedures in Years One and Three with Medicaid utilization being 25.33% and Charity Care being 10.00%. This is based upon the expectation that ten new physicians will be performing surgeries at the center after approval of this project. The center has four operating rooms.

The center currently has contracts with the following Medicaid Managed Care plans Fidelis, HealthFirst, and HIP. The center has a referral agreement with The Family Centers at NYU Langone to provide service to the under-insured in their service area. The center participates in a "Second Chance" program whereby the center reaches out to convicted felons who have no insurance and require surgical services. Staff members also attend Alcoholics Anonymous and drug rehabilitation meetings to reach out to this vulnerable population. The center has a Financial Assistance policy with a sliding fee scale for those patients who need assistance. The center is current with their SPARCS reporting.

## Character and Competence

The proposed membership of Performance Surgical Center, LLC are:

| Name | Interest |
|---|---|
| Sandro Starna | 95.0% |
| Jonathan Phillips | 5.00% |
| Total | 100.0% |

Sandro Starna is the President of The Starna Group where he is responsible for managing financial and accounting aspects with a specialty in medical practices and ambulatory surgery centers. He communicates with all staff to ensure relevant information and significant changes in data are issued, and manages credit lines and loans, reviews monthly credit activity, monitors for fraud. He was the previous Vice President of Finance at Dream Wate where he was responsible for the preparation of the quarterly consolidated financial statements, reconciliation of all accounts, monthly accrual entries, commission reports, cash management reports based on accounts receivable collections, overhead cost analysis, meeting with executive staff and other teams to review metrics, meeting with shareholders to explain the quarterly results and providing daily cash reports and weekly reports. He was a Tax Senior Associate at J.Gittleson & Associates

Jonathan Phillips is a proposed member and the proposed Medical Director. He is an Owner of JWP, LLC, and is a Sports and Regenerative Medicine Physician at Performance Health. He is the Chairman of the Physician Operations Council which manages operations of the physician group throughout five Florida hospital locations in the Tampa area. He is a Member of the Physicians Group Board of Directors, and he updates board members on the operations and processes of the group and manages physician concerns. He was the Medical Director of S.O.A.R Medicine, a Sports and Family Medicine Physician at a Florida Hospital, a Founder of the Concussion Center at Florida's Wesley Hospital, the Medical Director of the Tampa Bay Storm Football Team, a Consultant Physician for the Tampa Bay Lightning hockey team, the Medical Director of an amateur boxing and MMA league, a Sports Medicine and Family Physician at Suncoast Medical Clinic, a Physician at New Tampa Urgent Care. He received his medical degree from the Medical University of the Americas. He completed his residency in Family Medicine at Latrobe Area Hospital in Pennsylvania. He completed his fellowship in Sports Medicine at the University of South Florida. He is board certified in family medicine with a sub-certification in sports medicine.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

## Conclusion

Approval of this project will provide for enhanced access to orthopedic, vascular, podiatry, plastic/hand, spine, gynecology (not abortions), and pain management surgery services in a community-based setting for the residents of Kings County. Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

# Financial Analysis

## Operating Budget

The applicant has submitted the current year (2020) and the first and third year projected operating budgets in 2022 dollars, as summarized below:

| | Current 2020 | | Year One 2023 | | Year Three 2025 | |
|---|---|---|---|---|---|---|
| | Per Proc. | Total | Per Proc. | Total | Per Proc. | Total |
| Revenues | | | | | | |
| Medicaid – MC | | $0 | $361.98 | $343,884 | $361.98 | $343,884 |
| Medicare - FFS | $974.83 | 214,463 | $973.53 | 979,375 | $973.53 | 979,375 |
| Medicare – MC | $969.74 | 83,402 | $974.08 | 380,866 | $974.08 | 380,866 |
| Commercial - FFS | $6,792.59 | 1,426,443 | $6,792.55 | 6,514,059 | $6,792.55 | 6,514,059 |
| Commercial – MC | $7,200.00 | 14,400 | $6,576.00 | 65,760 | ,$6,576.00 | 65,760 |
| Other | $3,837.54 | 49,888 | $3,861.37 | 227,821 | $3,861.37 | 227,821 |
| Total Revenues | | $1,788,596 | | $8,511,765 | | $8,511,765 |
| | | | | | | |
| Expenses | | | | | | |
| Operating | $2,773.07 | $1,472,501 | $1,549.37 | $5,810,131 | $1,550.34 | $5,813,782 |
| Capital | $739.67 | $392,764 | $104.74 | $392,764 | $104.74 | 392,764 |
| Total Expenses | $3,512.74 | $1,865,265 | $1,654.11 | $6,202,895 | $1,655.08 | $6,206,546 |
| | | | | | | |
| Net Income (Loss) | | ($76,669) | | $2,308,870 | | $2,305,219 |
| | | | | | | |
| Utilization | | 531 | | 3,750 | | 3,750 |
| Cost Per Procedure | | 3,512.74 | | $1,654.11 | | $1,655.08 |

Utilization by the payor for the current, first, and third years is summarized below:

| | Current Year 2020 | | Year One 2023 | | Year Three 2025 | |
|---|---|---|---|---|---|---|
| Payor | Procedures | % | Procedures | % | Procedures | % |
| Medicaid – MC | 0 | 0% | 950 | 25.33% | 950 | 25.33% |
| Medicare - FFS | 220 | 41.42% | 1,006 | 26.83% | 1006 | 26.83% |
| Medicare – MC | 86 | 16.20% | 391 | 10.43% | 391 | 10.43% |
| Commercial - FFS | 210 | 39.55% | 959 | 25.57% | 959 | 25.57% |
| Commercial - MC | 2 | 0.38% | 10 | 0.27% | 10 | 0.27% |
| Other | 13 | 2.45% | 59 | 1.57% | 59 | 1.57% |
| Charity | 0 | 0 | 375 | 10.00% | 375 | 10.00% |
| Total | 531 | 100% | 3,750 | 100% | 3,750 | 100% |

The following is noted concerning the submitted operating budget:

- Breakeven utilization is 2,733 procedures in the first and third years or approximately 73% of the expected volume.
- Medicare Fee for Service rates reflect the current 2020 rates, while Commercial and Private Pay rates have been adjusted based on experience at the Center.
- Medicare Managed Care rates are based on the facility's current year, 2020, while Medicaid Managed Care rates are based on the Center's average Medicaid Managed Care rate during 2021.
- Utilization and revenue projections are based on the Center's additional capacity of 4 operating rooms as of March 25, 2021. Only 2 operating rooms were available prior to the expansion.
- Projections are supported by letters from ten physicians.
- The projected increase in Medicaid Managed Care is due to three new physicians that will perform procedures covered by Medicaid.

## Purchase Agreement (PA)

The applicant submitted an executed PA to acquire certain assets associated with the FASC, which will become effective upon PHHPC approval. The terms are summarized below:

| | |
|---|---|
| Date: | September 21, 2020 |
| Seller: | Millennium Ambulatory Surgery Center, LLC |
| Buyer: | Performance Surgical Center, LLC previously known as Performance Practice, LLC |
| Asset Acquired: | Rights, title, and interest in the sellers' assets free of liens used in the FASC. Includes tangible personal property, inventory, real property lease, intellectual property, legally transferrable records, phone numbers, email addresses, and goodwill. |
| Excluded Assets | Cash and equivalents, account receivables (before the effective date for the Consulting Agreement), contracts (including provider agreements and provider numbers), and organization documents. |
| Assumption of Liabilities: | Surgery Center lease between the applicant and the 1408 Ocean Avenue, LLC, as of September 21, 2020, |
| Purchase Price | $2,500,000 |
| Payment of the Purchase Price | $1,500,000 paid into escrow on September 14, 2020<br>500,000 paid into escrow on September 22, 2020<br>500,000 paid into escrow on February 1, 2022 |

The $2,500,000 purchase price for the FASC operations has been funded through a loan from 1408 Partners LLC (the landlord), with no interest and no repayment terms.

The applicant has submitted an original affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement, or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and surcharges, assessments or fees due from the transferor under Article 28 of the Public Health Law concerning the period before the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. As of October 22, 2022, the facility had no outstanding Medicaid liabilities.

## Purchase And Sale Agreement

As summarized below, the applicant has submitted an executed PSA to acquire the FASCs real property.

| | |
|---|---|
| Date: | September 21, 2020 |
| Realty Owners: | 1408 Ocean Avenue, LLC |
| Buyer: | 1408 Partners, LLC |
| Premises Real Property: | Land, buildings, and improvements located at 1408 Ocean Avenue, New York, New York – Block 6712, lot 62 |
| Payments by Buyer: | $10,000,000<br>$3,000,000 down payment<br>$7,000,000 loan |

The real property purchase closed on December 28, 2020, and was paid as follows:

| | |
|---|---|
| Members Equity | $3,000,000 |
| A loan from Connection Bank (10-year term, interest at 3.875%, 30-year amortization) | $7,000,000 |

## Lease Agreement

The applicant has submitted a draft Lease Agreement; terms are summarized below:

| | |
|---|---|
| Premises: | 10,000 sq. ft. on the first floor and cellar level at 1408 Ocean Avenue, Brooklyn, NY 11361 |
| Landlord: | 1408 Partners, LLC |
| Tenant: | Performance Surgical Center, LLC |

| | |
|---|---|
| Term: | Ending September 30, 2032. Plus (1) 5-year renewal with a 3% yearly increase |
| Payment: | $360,000 ($36 per sq. ft.) with a 3% yearly increase |
| Provisions: | Taxes, insurance utilities, and maintenance |

The applicant has provided an affidavit stating the lease is a non-arm length agreement. There is common ownership between the landlord and the applicant. Letters from two NYS licensed realtors have been provided attesting to the rental rate being fair market value.

### Capability and Feasibility

The $2,500,000 purchase price for the FASC operations will be funded via a loan from 1408 Partners LLC (the landlord) with no interest or repayment terms. The FASC's real property was acquired by 1408 Partners LLC. for $10,000,000 and funded through $3,000,000 in members' equity and a $7,000,000 bank loan at stated terms from Connection bank. There are no project costs associated with this transaction.

The working capital requirement is estimated at $1,033,816 based on two months of first-year expenses and will be funded with members' equity. BFA Attachments A shows sufficient resources to meet the working capital equity requirement. Additionally, Jonathan Phillips, M.D. has provided an affidavit stating his willingness to contribute resources disproportionate to his ownership interest for working capital, if necessary. BFA Attachment B is Performance Surgical Center, LLC. pro forma balance sheet that shows operations will start with $1,033,816 in equity. Equity includes $2,200,000 in goodwill, which is not a liquid resource nor recognized for Medicaid reimbursement. Performance Surgical Center, LLC projects an operating surplus of $2,308,870 and $2,305,219 in the first and third years. The budget appears reasonable.

### Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BFA Attachment A | Performance Surgical Center, LLC. Members' net worth summary |
| BFA Attachment B | Pro Forma Balance Sheet of Performance Surgical Center, LLC |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221145-B
## Apple Care Health

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Kings**
***Purpose:*** **Establishment and Construction** ***Acknowledged:*** **May 18, 2022**

## Executive Summary

### Description

Apple Care Health, LLC, a New York limited liability company, requests approval to establish and construct an Article 28 Diagnostic and Treatment Center (D&TC) to provide Primary Medical Care, Other Medical Specialties, and Podiatry services.

The applicant plans to provide comprehensive care to individuals living in Brooklyn, with specific emphasis on residents in Crown Heights/ Prospect Heights, with a goal to reduce preventable admissions for patients with medical conditions.

The D&TC will be in leased space on the first floor and basement level of an existing four-story mixed-use building located at 1587 Fulton Street, Brooklyn (Kings County).

The proposed ownership is as follows:

| Apple Care Health, LLC | |
|---|---|
| Members | % |
| All Care Tele Health Corp. | 90% |
| *Joel Kaufman (100%)* | |
| Jeffrey Berman, M.D. | 10% |

Jeffrey Berman, M.D., is board certified in Psychiatry, Addiction Medicine, and Anesthesiology, and will serve as the Center's Medical Director. The applicant expects to enter into a Transfer and Affiliation Agreement for backup and emergency services with Interfaith Medical Center, located 0.3 miles (2 minutes travel time) from the Center.

### OPCHSM Recommendation

Contingent Approval

### Need Summary

The center will be located in an area designated as a Health Professional Shortage Area for Primary Care. The number of projected visits is 6,528 in Year One and 12,920 in Year Three. Medicaid utilization is projected at 65% and Charity Care at 2%.

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

### Financial Summary

Total project costs of $1,202,557 will be met through member equity of $120,256, with the remaining $1,082,301 balance being financed over ten years through Hudsonshine Capital at the firm's five-year cost of funds with an indicative rate of 5%. The projected budget is as follows:

| Budget | Year One 2024 | Year Three 2026 |
|---|---|---|
| Revenues | $910,753 | $1,802,722 |
| Expenses | 898,942 | $1,416,534 |
| Gain/(Loss) | $11,811 | $386,188 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0 [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0 [AER]
4. Submission of an executed loan commitment, acceptable to the Department of Health. [BFA]
5. Submission of an executed working capital loan commitment, acceptable to the Department of Health. [BFA]
6. Submission of an executed copy of the Articles of Organization of Apple Care Health, LLC that are acceptable to the Department. [CSL]
7. Submission of an executed copy of Operating Agreement of Apple Care Health, LLC that is acceptable to the Department. [CSL]
8. Submission of a copy of Bylaws of All Care Tele Health Corp that are acceptable to the Department. [CSL]
9. Submission of an executed Certificate of Incorporation of All Care Tele Health Corp that is acceptable to the Department. [CSL]
10. Submission of a list of board members and directors of All Care Tele Health Corp that is acceptable to the Department. [CSL]
11. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]

**Approval conditional upon:**

1. This project must be completed by **September 1, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **June 1, 2023,** and construction must be completed by **June 1, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]

5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov [HSP]

Council Action Date
December 8, 2022

# Need and Program Analysis

Background

| | |
|---|---|
| **Proposed Operator** | Apple Care Health, LLC |
| **To Be Known As** | Apple Care Health |
| **Site Address** | 1578 Fulton Street<br>Brooklyn, New York 11213 (Kings County) |
| **Specialties** | Medical Services-Primary Care<br>Medical Services-Other Medical Specialties<br>Cardiology<br>Endocrinology<br>Gastroenterology<br>Oncology<br>Orthopedics<br>Urology<br>Podiatry O/P |
| **Hours of Operation** | Sunday through Thursday 9 am to 8 pm<br>Fridays 9 am to 2 pm |
| **Staffing (1st Year / 3rd Year)** | 8.60 FTEs / 14.07 FTEs |
| **Medical Director(s)** | Dr. Jeffrey Berman, M.D. |
| **Emergency, In-Patient, and Backup Support Services Agreement and Distance** | Expected to be provided by<br>Interfaith Medical Center<br>0.3 miles / 2 minutes away |

The primary service area is the neighborhood of Crown Heights in Kings County. The center will be located in a HRSA-designated Primary Care Health Profession Shortage Area as well as a Medically Underserved Area. The population of Kings County was 2,736,074 in 2020 and is expected to grow to 2,810,876 by 2025. According to Data USA, in 2019 93.7% of the population in Kings County has health coverage as follows:

| | |
|---|---|
| Employer Plans | 41.7% |
| Medicaid | 33.2% |
| Medicare | 8.05% |
| Non-Group Plans | 10.5% |
| Military or VA | 0.222% |

The applicant projects 6,528 visits in the first year and 12,920 by the third with 65% Medicaid utilization and 2% Charity Care. The applicant states a commitment to serving all persons in need without regard to ability to pay or source of payment.

Prevention Quality Indicators (PQIs) are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The table below provides information on the PQI rates for the overall PQI condition. It shows that the PQI rate for the primary service area (zip code 11213) is significantly higher than the New York State rate.

| **Hospital Admissions per 100,000 Adults for Overall PQIs** | | |
|---|---|---|
| PQI Rates: 2017 | Zip Code-11213 | New York State |
| All PQI's | 1,889 | 1,431 |

Conclusion

The new diagnostic and treatment center will provide additional services to a federally recognized underserved area.

## Character and Competence

The members of Apple Health Care, LLC are:

| Name | Interest |
|---|---|
| All Care Tele Health Corp<br>*Joel Kaufman (100%)* | 90.00 % |
| Jeffrey Berman, MD | 10.00% |
| Total | 100.00% |

**Jeffrey Berman, MD** is a Member and the proposed Medical Director. He is the Director of Behavioral Medicine at the Discovery Institute in New Jersey, an addiction and behavioral health treatment center, the Director of Psychiatry at SOBA College Recovery in New Jersey, an in- and outpatient mental health and addiction treatment center, an Addiction Psychiatry Consultant at North Jersey Recovery Center, and a Clinical Assistant Professor of Psychiatry. He was the Associate Medical Director of Behavioral Health for Bergen Regional Medical Center and the Medical Director of Summit Oaks Hospital in New Jersey. He completed his medical degree at SUNY Upstate Medical Center. He completed his residency in Psychiatry at New Jersey Medical School. He completed his fellowship in Psychiatry at Robert Wood Johnson Medical School in New Jersey. He also completed a residency in Anesthesiology at Maimonides Medical Center and Massachusetts General Hospital. He completed his fellowship in Anesthesiology at Montefiore Medical Center. He is board certified in Psychiatry, Addiction Medicine, and Anesthesiology.

**Joel Kaufman** is a Licensed General Contractor for Unique Developers Corp. He has successfully completed numerous ground up and gut renovation projects and is a Corporate Real Estate Broker for Realty Guardian Inc. He was previously a Real Estate Agent for Microsoft Realty, King County Realty, and Exit Reality. He was a Volunteer Community Organizer at Cong Shaar Hatfilah where he arranged community affairs and coordinated daily member services.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

- *Dr. Berman pled no contest that he voluntarily surrendered his license in New Jersey in 1999 for being a habitual user of drugs and practicing medicine while impaired by drugs. In New York State, Dr. Berman had his license suspension lifted with probation for five years with the condition that he is permanently prohibited from practicing clinical anesthesia except for pain management and cannot prescribe medication for himself or his family members.*

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

## Conclusion

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

# Financial Analysis

## Total Project Cost and Financing

Total project costs for renovations and the acquisition of moveable equipment are estimated at $1,202,557, broken down as follows:

| | |
|---|---|
| Renovation & Demolition | $822,380 |
| Design Contingency | 82,238 |
| Construction Contingency | 82,238 |
| Architect/Engineering Fees | 15,000 |
| Other Fees | 75,000 |
| Movable Equipment | 57,907 |
| Financing Costs | 21,537 |
| Interim Interest Expense | 37,690 |
| CON Application Fee | 2,000 |
| CON Processing Fee | 6,567 |
| Total Project Cost | $1,202,557 |

The applicant's financing plan appears as follows:

| | |
|---|---|
| Cash Equity (Applicant) | $120,256 |
| Bank Loan (5% interest, 10-year term) | 1,082,301 |
| Total | $1,202,557 |

BFA Attachment A is the members' net worth which shows sufficient resources to meet the equity requirement. Hudsonshine Capital has provided a letter of interest.

## Operating Budget

The applicant has submitted first and third-year operating budgets, in 2022 dollars, as summarized below:

| | Year One 2024 | | Year Three 2026 | |
|---|---|---|---|---|
| | Per Visit | Total | Per Visit | Total |
| Revenues | | | | |
| Medicaid-FFS | $171.56 | $55,927 | $171.56 | $110,825 |
| Medicaid-MC | $137.24 | 537,586 | $137.24 | 1,063,917 |
| Medicare-FFS | $150.00 | 146,850 | $150.00 | 290,700 |
| Medicare-MC | $120.00 | 39,120 | $120.00 | 77,520 |
| Commercial-FFS | $150.00 | 68,550 | $150.00 | 135,600 |
| Commercial-MC | $130.00 | 25,480 | $130.00 | 50,440 |
| Private Pay | $190.00 | 37,240 | $190.00 | 73,720 |
| Total | | $910,753 | | $1,802,722 |
| Expenses | | | | |
| Operating | $99.45 | $649,196 | $91.33 | $1,179,995 |
| Capital | $38.26 | 249,746 | $18.31 | 236,539 |
| Total | $137.71 | $898,942 | $109.64 | $1,416,534 |
| Net Income | | $11,811 | | $386,188 |
| Total Visits | | 6,528 | | 12,920 |
| Cost per Visits | | $137.71 | | $109.64 |

Utilization broken down by payor source during Year One and Year Three is as follows:

| | Year One 2024 | | Year Three 2026 | |
|---|---|---|---|---|
| Payor | Visits | % | Visits | % |
| Medicaid-FFS | 326 | 4.99% | 646 | 5.00% |
| Medicaid-MC | 3,917 | 60.01% | 7,752 | 60.00% |
| Medicare-FFS | 979 | 15.00% | 1,938 | 15.00% |
| Medicare-MC | 326 | 4.99% | 646 | 5.00% |
| Commercial-FFS | 457 | 7.00% | 904 | 7.00% |
| Commercial-MC | 196 | 3.00% | 388 | 3.00% |
| Private Pay | 196 | 3.00% | 388 | 3.00% |
| Charity | 131 | 2.01% | 258 | 2.00% |
| Total | 6,528 | 100% | 12,920 | 100% |

The following is noted with respect to the submitted budget:

- Medicaid Fee for Service (FFS) rate is based upon the basic per-visit rate plus cost of capital obtained from the Bureau of D&TC Reimbursement. Medicaid Managed Care is assumed to be 80% of the Medicaid FFS's basic rate.
- Medicare FFS rate is based on the Medicare Part B fee schedule with the Medicare Managed Care assumed to be at 80% of the Medicare FFS rate. The rate for Commercial Fee for Service is based on the Medicare Part B fee schedule while the Commercial managed care rate is approximately 86% of the Medicare Part B fee schedule.
- Staffing and expenses were based on the specific staff requirements to properly and efficiently operate the D&TC along with a review of similar type and size diagnostic and treatment center cost reports.
- Utilization by payor source is based on the demographic of the service area which includes Crown Heights, Prospect Heights, and Weeksville located in Brooklyn Community District 8. Which is a medically underserved area, mental health professional shortage area (MHPSA), and health professional shortage area (HPSA).
- Utilization is expected to grow from an increase in demand, community network relationships, hospital affiliations, and marketing. Discussions have already taken place with a representative of Interfaith Medical Center/One Brooklyn Health system, the proposed hospital for backup and emergency services, to receive patients at the center who are in need of outpatient services and help to minimize the readmission of patients to the hospital by providing an available source of primary and other outpatient care.
- Breakeven utilization for the first year is 6,444 visits.

## Lease Rental Agreement

The applicant has submitted an executed lease for the proposed site, the terms of which are summarized below:

| | |
|---|---|
| Date: | April 1, 2022 |
| Premises: | 3,400 square feet located at 1587 Fulton Street, Brooklyn, NY 11213 |
| Landlord: | Fulton Unique Residence, LLC |
| Lessee: | Apple Care Health, LLC. |
| Term: | 11 years, base rent at $108,000 in year one ($31.77 per sq. ft.) |
| Provisions: | Utilities, Maintenance, Insurance and Taxes |

The applicant has provided an affidavit attesting that the lease is a non-arms-length agreement because Joel Kaufman is the sole member of the landlord and a member of the operator. Letters from two NYS licensed realtors have been provided attesting to the rental rate being of fair market value.

## Capability and Feasibility

Total project costs of $1,202,557 will be met through member equity of $120,256, with the remaining $1,082,301 balance being financed over ten years through Hudsonshine Capital at the above-stated terms.

Working capital requirements are estimated at $236,088, based on two months of third-year expenses. Funding will be as follows: $118,044 from member equity with the remaining $118,044 satisfied through a three-year loan from Hudsonshine Capital at the firm's five-year cost of funds with an indicative interest rate of 5%. Hudsonshine Capital has provided a letter of interest. Review of BFA Attachments A reveals Joel Kaufman has sufficient resources to meet all the equity requirements. BFA Attachment B is Apple Care Health LLC's pro forma balance sheet that shows operations will start with $238,300 equity. The Center projects an operating surplus of $11,811 and $386,188 in the first and third years. The applicant's budgets appear to be reasonable.

### Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BHFP Attachment | Map |
| BFA Attachment A | Net Worth Statements of Proposed Members of Apple Care Health, LLC |
| BFA Attachment B | Pro Forma Balance Sheet of Apple Care Health, LLC |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221227-B
## Parkchester DTC LLC d/b/a
## Parkchester Diagnostic and Treatment Center

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Bronx**
***Purpose:*** **Establishment and Construction** ***Acknowledged:*** **August 11, 2022**

## Executive Summary

### Description

Parkchester DTC LLC is requesting approval to establish and construct a new Article 28 Diagnostic and Treatment Center (D&TC) through the conversion of a private practice. The D&TC will be located in two adjoining leased spaces at 1879 Gleason Avenue and 1211 White Plains Road, Bronx, with the entrance on Gleason Avenue. The applicant proposes to provide primary care, physical therapy, podiatry, and other medical specialties.

The private practice, 1211 WPR Medical Services, PC, is owned by David Weiss, MD and managed by Neal and Amy Polan, the proposed medical director and proposed members of Parkchester DTC LLC respectively.

St. Barnabas Hospital will serve as the backup hospital for the Center. Upon approval of this application, the site will be known as Parkchester Diagnostic and Treatment Center.

### OPCHSM Recommendation

Contingent Approval

### Need Summary

The applicant projected 53,375 visits in Year One and 72,790 in Year Three. Medicaid utilization is projected at 55% and Charity Care at 2% in both Year One and Year Three. The converted DTC will increase services in a Medically Underserved Area where Prevention Quality Indicators evidence a possible lack of preventative care services.

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3)(b).

### Financial Summary

Total project costs of $4,648,617 will be met through members' equity of $1,649,817 and grant awards of $2,988,800 (Statewide Transformation Grant Award (SW) of $2,700,000 and Capital Restructuring Financing Program (CRFP) of $288,000) awarded to 1211 WPR Medical Services PC, a private medical practice. Upon approval of this CON, 1211 WPR Medical Service PC will cease operations but exist as a business, and maintain the grant awards received.

| Budget | Year One | Year Three |
|---|---|---|
| Revenues | $6,604,238 | $9,006,541 |
| Expenses | 6,445,977 | 8,642,377 |
| Net Income | $158,261 | $364,164 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
3. The submission of Engineering (MEP) Drawings for review and approval, as described in BAER Drawing Submission Guidelines DSG-1.0. [AER]
4. Submission of documentation confirming final approval of the Capital Restructuring Financing Program executed grant contract, acceptable to Department of Health. [BFA]
5. Submission of documentation confirming final approval of the Statewide Health Care Transformation Program executed grant contract, acceptable to Department of Health. [BFA]
6. Submission of an executed lease rental agreement that is acceptable to the Department of Health. [BFA]
7. Submission of an executed sublease agreement that is acceptable to the Department of Health. [BFA]
8. Submission of a working capital loan that is acceptable to the Department of Health. [BFA]
9. Submission of an Operating Agreement that is acceptable to the Department. [CSL]
10. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]

**Approval conditional upon:**

**1.** This project must be completed by **September 1, 2024**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]

1. Construction must start on or before **June 1, 2023,** and construction must be completed by **June 1, 2024**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a), if construction is not started on or before the approved start date this shall constitute abandonment of the approval. [PMU]
2. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
3. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
4. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov [HSP]

## Council Action Date

December 8, 2022

# Need and Program Analysis

## Program Description

| | |
|---|---|
| **Proposed Operator** | Parkchester DTC |
| **To Be Known As** | Parkchester Diagnostic and Treatment Center |
| **Site Address** | 1879 Gleason Avenue<br>Bronx, New York 10472 (Bronx County) |
| **Specialties** | Medical Services-Primary Care<br>Medical Services-Other Medical Specialties<br>Cardiology<br>Dermatology<br>Gastroenterology<br>Ophthalmology<br>Orthopedic<br>Psychiatry<br>Urology<br>Physical Therapy O/P<br>Podiatry O/P |
| **Hours of Operation** | Monday through Friday 8 am to 7 pm<br>Saturday 8 am 2 pm |
| **Staffing (1st Year / 3rd Year)** | 55.58 FTEs / 81.79 FTEs |
| **Medical Director(s)** | David Weiss, M.D. |
| **Emergency, In-Patient, and Backup Support Services Agreement and Distance** | Expected to be provided by<br>St. Barnabas Hospital<br>5.8 miles / 16 minutes away |

## Background

The primary service area encompasses the Parkchester and Soundview neighborhoods in Bronx County. The proposed site is in an HRSA-designated Medically Underserved Area for primary care.

According to Data USA, in 2019 92% of the population in Bronx County has health coverage as follows.

| | |
|---|---|
| Employer Plans | 30.8% |
| Medicaid | 41.8% |
| Medicare | 6.79% |
| Non-Group Plans | 12.1% |
| Military or VA | 0.417% |

The applicant projected 53,375 visits in Year One and 72,790 in Year Three.

| **Projected Payor Source** | | |
|---|---|---|
| **Insurance Type** | **Year One** | **Year Three** |
| Commercial | 20.00% | 20.00% |
| Medicare | 20.00% | 20.00% |
| Medicaid | 55.00% | 55.00% |
| Private Pay/Other | 3.00% | 2.00% |
| Charity Care | 2.00% | 2.00% |

Converting the primary care practice to a D&TC will allow for greater access to medical personnel, including increased staffing, without the need for prior appointments. The applicant anticipates this will reduce patient wait times, provide more immediate access to care, and have fewer emergency room visits.

A significant percentage of the area's residents were born outside of the United States and have limited

English proficiency. Parkchester will ensure staff are fluent in the language of the community, and materials will be available in English and Spanish, with accommodations for other dominant languages as needed. The applicant plans to provide services in a culturally sensitive manner. Examples provided include focusing on the availability of same-sex providers and extended hours on holy days.

The goal of this project is to reduce avoidable emergency room visits and increase the overall health of the service area by increasing access to health care. According to the applicant, the proposed service area is comprised of low-income families who often lack knowledge about health options and prevention with limited or no access to care.

Prevention Quality Indicators (PQIs) are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The table below provides information on the PQI rates for the overall PQI condition.

| **Hospital Admissions per 100,000 Adults for Overall PQIs** | | |
|---|---|---|
| PQI Rates: 2017 | Bronx County | New York State |
| All PQI's | 2,196 | 1,431 |

Character and Competence
The members of Parkchester DTC LLC. are:

| **Name** | **Interest** |
|---|---|
| Neal Polan | 95.00% |
| Amy Polan | 5.00% |
| **Total** | **100.00%** |

**Neal Polan** is the President and Principal Shareholder of Insight Management Corp. where he provides services in strategic acquisition, reorganizations, and operating solutions for small to middle-market companies in healthcare. He is a Partner and Principal Owner of PMC Medical Management, LLC, and KABAET 4, LLC where he is responsible for the day-to-day operating healthcare and ancillary healthcare services for five multi-specialty healthcare facilities. Mr. Polan serves on the Board of Directors of the Dr. Ramon Tallaj Foundation which offers grants, scholarships, and awards for students committed to the study of medicine and healthcare-related fields. He led the successful acquisition and management reorganization of Sterling Optical, which was in bankruptcy at the time of acquisition. He became a Joint Venture Partner/Operating Partner in Bronxdocs, a system of multi-specialty medical facilities in the Bronx. He was a Strategic Advisor to Corinthian Medical IPA for over five years.

**Amy Polan** is the Administrative Manager for PMC Medical Management PC where she is responsible for the involvement, implementation, supervision, and review of all facets and decisions made that impact daily operations. She is accountable for decisions that directly affect patient care, the medical office environment, compliance, and staffing. She interacts with the Office Manager, Human Resources, the Director of Operations, and the protocol advisor.

**David Weiss, MD** is the proposed Medical Director. He is the Owner of 1211 WPR Medical Services PC. He received his medical degree from New York Medical College. He completed his residency in Internal Medicine at Lenox Hill Hospital. He completed his fellowship in Pulmonary Disease at Norwalk Hospital. He is board certified in Internal Medicine and Pulmonology.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

### Conclusion

The new DTC will increase access to services in a medically underserved area, where high PQI rates evidence a possible lack of preventive care services. The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3)(b).

## Financial Analysis

### Operating Budget

The applicant has submitted an operating budget, in 2022 dollars, during the first and third years of operation, summarized below:

| | Year One | | Year Three | |
|---|---|---|---|---|
| | Per Visit | Total | Per Visit | Total |
| Revenues | | | | |
| Commercial FFS | $125.00 | $800,625 | $125.00 | $1,091,875 |
| Commercial MC | $105.00 | 448,245 | $105.00 | $611,415 |
| Medicare FFS | $125.00 | 867,375 | $125.00 | $1,182,875 |
| Medicare MC | $100.00 | 373,600 | $100.00 | $509,500 |
| Medicaid FFS | $167.76 | 451,114 | $169.02 | $615,064 |
| Medicaid MC | $126.76 | 3,383,104 | $126.76 | $4,613,612 |
| Private Pay | $175.00 | 280,175 | $175.00 | $382,200 |
| Total Revenues | | $6,604,238 | | $9,006,541 |
| | | | | |
| Expenses | | | | |
| Operating | $95.66 | $5,106,056 | $100.89 | $7,343,857 |
| Capital | $25.10 | $1,339,921 | $17.84 | $1,298,520 |
| Total Expenses | $120.77 | $6,445,977 | $118.73 | $8,642,377 |
| | | | | |
| Net Income | | $158,261 | | $364,164 |
| Utilization (Visits) | | 53,375 | | 72,790 |

Expense and utilization assumptions are based on the actual experience of the existing multispecialty medical practice.

Utilization broken down by payor source for the first and third years are as follows:

| Payor | Year One | Year Three |
|---|---|---|
| Commercial FFS | 12.00% | 12.00% |
| Commercial MC | 8.00% | 8.00% |
| Medicare FFS | 13.00% | 13.00% |
| Medicare MC | 7.00% | 7.00% |
| Medicaid FFS | 5.00% | 5.00% |
| Medicaid MC | 50.00% | 50.00% |
| Private Pay | 3.00% | 3.00% |
| Charity Care | 2.00% | 2.00% |
| Total | 100.00% | 100.00% |

## Total Project Cost and Financing

The total project cost, which is for new construction and the acquisition of moveable equipment, is estimated at $4,648,617, further broken down as follows:

| | |
|---|---|
| New Construction | $2,800,000 |
| Design Contingency | 50,000 |
| Construction Contingency | 420,000 |
| Planning Consultant Fees | 216,200 |
| Architect/Engineering Fees | 505,000 |
| Other Fees (Consultant) | 150,000 |
| Moveable Equipment | 480,000 |
| CON Fee | 2,000 |
| Additional Processing Fee | 25,417 |
| Total Project Cost | $4,648,617 |

The applicant's financing plan appears as follows:

| | |
|---|---|
| Equity (Members) | $1,649,817 |
| Transformation Grants: | |
| Statewide | $2,700,000 |
| CRFP | $288,800 |

## Lease Rental Agreements

The applicant has submitted a signed proposed sublease rental agreement for the space at 1211 White Plains Road that they will occupy:

| | |
|---|---|
| Proposed Date: | May 1, 2023 |
| Premises | 4,184 square feet located at 1211 White Plains Road, Bronx, New York. |
| Sublessor | PMC Medical Management, LLC |
| Sublessee | Parkchester DTC, LLC |
| Term | The sublessee shall commence on May 1, 2023 and expire on December 31, 2026. |
| Rental | From May 1, 2023 and ending on December 31, 2023, the rent shall be $146,400 ($34.99 per sq. ft.) |
| | Commencing on January 1, 2024, Base Rent shall be increased by 2.5%. |
| Provisions | The fixed rent shall include all water charges, utility, and real estate taxes. |

The applicant has submitted an affidavit stating that this lease will be a non-arm's length lease arrangement in that there is a relationship. Also, the applicant submitted two real estate letters attesting to the reasonableness of the per-square-foot rental.

The applicant has submitted a draft lease agreement for the space at 1897 Gleason Avenue that they will occupy:

| | |
|---|---|
| Premises | 9,060 square feet located at 1897 Gleason Avenue, Bronx, New York. |
| Lessor | Kabaet 3RE, LLC |
| Lessee | Parkchester DTC, LLC |
| Term | 15 years |
| Rental | Year 1-5: $320,000 annually ($35.32 per sq.ft.). Every five-year anniversary the annual rent shall be increased by Consumer Price Index for Wage Earners and Clerical Workers. |
| Provisions | The lessee shall be responsible for real estate taxes, maintenance, and utilities. |

The applicant has submitted an affidavit indicating that the lease agreement will be a non-arm's length lease arrangement in that there is a relationship between the lessor and the lessee. Furthermore, the

applicant has submitted two real estate letters attesting to the reasonableness of the per-square-foot rental.

### Capability and Feasibility

Total project costs of $4,648,617 will be met through members' equity of $1,649,817 and grant awards of $2,988,800 (Statewide Transformation Grant Award (SW) of $2,700,000 and Capital Restructuring Financing Program (CRFP) of $288,000) awarded to 1211 WPR Medical Services PC. The private practice, 1211 WPR Medical Services PC, is the awardee of the SW and CRFP grant awards. Upon approval of this CON, 1211 WPR Medical Service PC will cease operations.

Working capital requirements are estimated at $1,440,396, equivalent to two months of third-year expenses. The applicant will finance $720,198 at an interest rate of 6% for a three-year term. The remainder, $720,198, will be provided as equity via the proposed members' resources. BFA Attachment A, the personal net worth statements of the proposed members of Parkchester DTC LLC, indicates the availability of sufficient funds for the equity contribution. BFA Attachment B is the pro forma balance sheet of Parkchester DTC, LLC, indicating a positive net asset position of $5,368,815 as of the first day of operation.

The submitted budget indicates a net income of $158,261 and $364,164 during the first and third years, respectively. Revenues are based on current reimbursement methodologies for diagnostic and treatment center services. The submitted budget appears reasonable.

### Conclusion

Subject to the noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BHFP Attachment | Map |
| BFA Attachment A | Personal Net Worth Statement of Proposed Members |
| BFA Attachment B | Pro Forma Balance Sheet |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221231-B
## A Friendly Face Akademy, Corp.

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Richmond**
***Purpose:*** **Establishment and Construction** ***Acknowledged:*** **July 22, 2022**

## Executive Summary

### Description

A Friendly Face Akademy, Corp., an existing New York domestic business corporation, requests approval to establish and construct an Article 28 diagnostic and treatment center (D&TC) in renovated space at 1887 Richmond Avenue, Staten Island (Richmond County). The proposed center requests certification for primary care, other medical specialties, and physical therapy, serving both the pediatric and adult populations.

| Proposed Operator | |
|---|---|
| A Friendly Face Akademy, Corp. | |
| Shareholders | % |
| Ella Goldin | 50% |
| Anna Marie Dorelien | 50% |

Leonid Goldin, M.D., who is board certified in Internal Medicine will serve as Medical Director. The Center is negotiating a Transfer and Affiliation Agreement for emergency and backup services with Richmond University Medical Center 2.4 miles and 6 minutes travel time from the proposed Center.

### OPCHSM Recommendation

Contingent Approval

### Need Summary

The applicant projects 8,837 visits in Year One and 17,480 in Year Three. Medicaid utilization is projected at 60% and Charity Care at 2% in both years.

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

### Financial Summary

Total project costs of $466,082 are proposed to be met with $46,608 members' equity and a $419,474 bank loan for a five-year term with a 6% interest rate. Hudson Shine Capital has provided a letter of interest for the loan at the stated terms.

| Budget | Year One (2023) | Year Three (2025) |
|---|---|---|
| Revenues | $1,232,927 | $2,438,730 |
| Expenses | 1,069,482 | 1,692,541 |
| Net Income | $163,445 | $746,189 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of an executed loan commitment for total project costs, acceptable to the Department of Health. [BFA]
3. Submission of an executed loan commitment for working capital, acceptable to the Department of Health. [BFA]
4. Submission of copies of stock certificates that are acceptable to the Department. [CSL]
5. Submission of a copy of Bylaws that are acceptable to the Department. [CSL]
6. Submission of a copy of a Certificate of Incorporation that is acceptable to the Department. [CSL]
7. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]

**Approval conditional upon:**

1. This project must be completed by **December 1, 2023**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. Construction must start on or before **July 1, 2023,** and construction must be completed by **September 1, 2023**, presuming the Department has issued a letter deeming all contingencies have been satisfied prior to commencement. It is the responsibility of the applicant to request prior approval for any changes to the start and completion dates. In accordance with 10 NYCRR Section 710.10(a) if construction is not started on or before the approved start date this shall constitute abandonment of the approval. [PMU]
3. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, is required prior to the applicant's start of construction. [AER]
4. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose; and the entrance must not disrupt any other entity's clinical program space. [HSP]
5. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https://www.health.ny.gov/facilities/hospital/docs/hcs_access_form_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov. [HSP]

## Council Action Date

December 8, 2022

# Need Analysis

## Background and Analysis

The primary service area encompasses the South Beach and Willowbrook communities in Staten Island. The following services will be provided: primary care, physical therapy, and other medical specialties. The number of projected visits for the facility is 8,837 in Year One and 17,480 in Year Three.

According to Data USA, in 2019 95.9% of the population in Richmond County had health coverage as follows:

| | |
|---|---|
| Employer Plans | 56.6% |
| Medicaid | 16.7% |
| Medicare | 12.7% |
| Non-Group Plans | 9.53% |
| Military or VA | 0.336% |

The applicant projects the following payor mix:

| Payor | Year One | Year Three |
|---|---|---|
| Commercial | 14.99% | 15.00% |
| Medicare | 20.00% | 20.00% |
| Medicaid | 60.00% | 60.00% |
| Private Pay/Other | 3.00% | 3.00% |
| Charity Care | 2.00% | 2.00% |
| Total Visits | 8,837 | 17,480 |

Prevention Quality Indicators (PQIs) are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The table below provides information on the PQI rates for the overall PQI condition. It shows that the PQI rate for Richmond County is higher than the New York State rate.

| **Hospital Admissions per 100,000 Adults for Overall PQIs** | | |
|---|---|---|
| PQI Rates: 2017 | Richmond County | New York State |
| All PQI's | 1,525 | 1,431 |

With the establishment of A Friendly Face Academy, Corp. the applicant proposes to address preventable admissions through treatment and education. The applicant cited a 2019 Richmond University Medical Center Needs Assessment for Richmond County finding that county residents had a slightly higher premature death rate. Contributing factors included relatively higher rates of smoking and death due to drug overdose. Staten Island represents a large smoking population (24%), while the Take Care New York Goal 2020 is 12% or fewer smokers. The applicant plans to provide outreach programs with community leaders, church groups, and schools to help educate members of the community on the causes of diseases and identify symptoms to help them receive earlier treatment.

## Conclusion

The new center will increase access to services where elevated PQI rates indicate a possible lack of preventive care services.

# Program Analysis

## Program Description

| | |
|---|---|
| **Proposed Operator** | A Friendly Face Akademy, Corp |
| **To Be Known As** | A Friendly Face Akademy |
| **Site Address** | 1887 Richmond Avenue<br>Staten Island, New York 10314 (Richmond County) |
| **Services** | Medical Services-Primary Care<br>Medical Services-Other Medical Specialties<br>Neurology<br>Orthopedics<br>Cardiology<br>Pulmonology<br>Physical Therapy O/P |
| **Hours of Operation** | Sunday through Thursday 9 am to 8 pm<br>Fridays 9 am to 2 pm |
| **Staffing (1st Year / 3rd Year)** | 11.60 FTEs / 18.49 FTEs |
| **Medical Director(s)** | Leonid Goldin, M.D. |
| **Emergency, In-Patient, and Backup Support Services Agreement Distance and Time** | Expected to be provided by<br>Richmond University Medical Center<br>2.4 miles / 6 minutes away |

**Character and Competence**
The members of A Friendly face Akademy, Corp. are:

| Name | Interest |
|---|---|
| Ella Goldin | 50% |
| Anna Marie Dorelein | 50% |
| **Total** | **100%** |

**Anna Marie Dorelein** is the CEO, Clinical Director, and Founder of A Friendly Face (AFF), a treatment center for pediatric patients with autism, where she is responsible for training staff to assess the clients and build treatment plans and work with providers on carrying out treatment plans, conducting workshops and continuous trainings on various topics related to autism, conduct assessments, and generate related behavior plans to ensure effective implementation of all treatment and programs for all staff. She also facilitates meetings with administrators to ensure appropriate support and services are rendered to each client, she supervises and trains interventionists to ensure effective implementation of treatment plans and adherence to professional and legal requirements are demonstrated. She directly provides instruction, training, and support to students, interventionists, and family members during home and community visits.

**Ella Goldin** is the CFO and Founder of A Friendly Face (AFF). She established and operated four AFF treatment centers in New York City and New Jersey. She established partnerships with hospitals and providers who treat patients with autism and provide specialized training to ER doctors and medical professionals who serve special needs children. She advocates for the special needs population with a strong tie to the local community, providing pro bono trainings to the families affected and to professionals who provide educational services. She contracts and credentials all AFF board-certified providers and facilities into the 13 largest medical insurance carriers in New York City and New Jersey. She oversees Patient Management, Payroll, Billing, Human Resources, Quality Assurance, and Training Departments. She is an Independent P&C Insurance Broker at Capital Insuring Group. She was a Founder and Independent Broker Owner at EG Realty, an Analyst in the Asset Backed Securities Department at Morgan Stanley, and a Junior Analyst in the Equities Management Department.

**Leonid Goldin** is the proposed Medical Director. He is a Family Practice Physician at 21st Century Medical PC. He was previously an Attending Physician and Emergency Room Physician at Kingsbrook Jewish Medical Center, an Attending Physician at Park Nursing Home, and an Attending Physician at Resort Nursing Home. He was the Founder and Independent P&C Insurance Broker of Capital Insuring Group, the Founder and Independent Broker Owner of EG Realty, an Analyst of the Asset Backed Securities Department, and a Junior Analyst at Goldman Sachs. He received his medical degree from Pavlov First State Medical University and Kursk State Medical University. He completed his residency in Internal Medicine at Kingsbrook Jewish Medical Center and Woodhull Medical and Mental Health Center.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

Additionally, the staff from the Division of Certification & Surveillance reviewed the ten-year surveillance history of all associated facilities. Sources of information included the files, records, and reports found in the Department of Health. Included in the review were the results of any incident and/or complaint investigations, independent professional reviews, and/or comprehensive/focused inspections. The review found that any citations were properly corrected with appropriate remedial action.

### Conclusion

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

## Financial Analysis

### Total Project Cost and Financing

The total project cost for leasehold improvements, renovations, and moveable equipment is $466,082:

| | |
|---|---|
| Renovation & Demolition | $206,000 |
| Design Contingency | 20,600 |
| Construction Contingency | 20,600 |
| Architect /Engineering Fees | 31,000 |
| Other Fees | 55,000 |
| Moveable Equipment | 115,849 |
| Financing Costs | 9,996 |
| Interim Interest Expense | 2,499 |
| CON Fee | 2,000 |
| Additional Processing Fee | 2,538 |
| Total Project Cost | $466,082 |

The applicant's financing plan is as follows:

| | |
|---|---|
| Member's Equity | $46,608 |
| Bank loan (6% interest, 5-year term) | $419,474 |
| Total Financing | $466,082 |

Joseph Fuchs, a loan originator, has provided a letter of interest for the loan at the stated terms. BFA attachment A is the net worth statement of the members of A Friendly Face Akademy, Corp. which indicates sufficient resources to meet the equity requirements of this application.

## Operating Budget

The applicant has submitted their first-and third-year operating budget, in 2021 dollars, as shown below:

| | Year One (2023) | | Year Three (2025) | |
|---|---|---|---|---|
| | Per Visit | Total | Per Visit | Total |
| Revenues | | | | |
| Commercial FFS | $165 | $145,860 | $165 | $288,420 |
| Commercial MC | $120 | 52,920 | $120 | 104,880 |
| Medicare FFS | $150 | 198,900 | $150 | 393,300 |
| Medicare MC | $120 | 53,040 | $120 | 104,880 |
| Medicaid FFS | $169 | 74,707 | $169 | 147,723 |
| Medicaid MC | $135 | 657,150 | $135 | 1,299,967 |
| Private Pay | $190 | 50,350 | $190 | 99,560 |
| Total Revenues | | 1,232,927 | | $2,438,730 |
| | | | | |
| Expenses | | | | |
| Operating | $103 | $909,986 | $88 | $1,540,298 |
| Capital | $21 | 159,496 | $9 | 152,243 |
| Total Expenses | $124 | $1,069,482 | $97 | $1,692,541 |
| | | | | |
| Net Income | | $163,445 | | $746,189 |
| | | | | |
| Visits | | 8,837 | | 17,480 |

Utilization by payor source during the first and third years is broken down as follows:

| | Year One (2023) | | Year Three (2025) | |
|---|---|---|---|---|
| | Visits | % | Visits | % |
| Commercial FFS | 884 | 10.00% | 1,748 | 10.00% |
| Commercial MC | 441 | 4.99% | 874 | 5.00% |
| Medicare FFS | 1,326 | 15.01% | 2,622 | 15.00% |
| Medicaid MC | 442 | 5.00% | 874 | 5.00% |
| Medicaid FFS | 442 | 5.00% | 874 | 5.00% |
| Medicaid MC | 4,860 | 55.00 | 9,614 | 55.00% |
| Private Pay | 265 | 3.00% | 524 | 3.00% |
| Charity Care | 177 | 2.00% | 350 | 2.00% |
| Total | 29,545 | 100.0% | 44,956 | 100.0% |

The following is noted with respect to the submitted budget:

- The Medicaid Fee for Service reimbursement rate is based on the base rate plus the cost of capital as obtained from the NYSDOH, Bureau of D&TC Reimbursement.
- Medicaid Managed Care is assumed to be 80% of the Medicaid APG Fee for service rate.
- Commercial Insurance and Medicare Fee for Service rates are based on the Medicare part B fee schedule.
- Medicare Managed Care and Commercial Managed Care are based on 80% of the Medicare Part B Fee schedule.

## Lease Agreement

The applicant has submitted an executed lease agreement for site control of the facility, the terms of which are summarized below:

| | |
|---|---|
| Date: | May 1, 2022 |
| Premises: | 1887 Richmond Avenue, Lower Level & Suite I on the first floor, Staten Island NY |
| Landlord: | AFF Holding LLC |
| Tenant: | A Friendly Face Akademy, Corp. |

| | |
|---|---|
| Rental: | Base rent $84,000 annually ($7,000 per month) for year one, 4.8% increase thereafter. |
| Term: | 10 years |
| Provisions: | Real estate taxes, maintenance, personal property insurance, and pro rata share of electricity, water, and gas. |

The applicant submitted an affidavit that the lease is a non-arm's length agreement as the landlord and tenant have parties in common. Letters from two New York real estate brokers were submitted attesting to the reasonableness of the rent.

### Capability and Feasibility

The total project cost is $466,082 and will be met with $46,608 proposed members' equity and a $419,474 bank loan for a five-year term with a 6% interest rate. Working capital requirements are estimated at $282,090 based on two months of third-year expenses and will be met with $141,045 proposed member's equity, and a $141,045 bank loan for a three-year term with a 6% interest rate. BFA Attachment A is the net worth of the proposed members which indicates the availability of sufficient funds for stated levels of equity. Joseph Fuchs, a loan originator from Hudson Shine Capital, has provided a letter of interest for both the project cost and working capital loans at the stated terms. BFA Attachment C, the pro forma balance sheet for the applicant, indicates that the facility will initiate operations with members' equity of $748,172.

The submitted budget indicates the facility will generate net income of $163,445 and $746,189 in the first and third years, respectively. Revenues are based on prevailing reimbursement methodologies for D&TCs. The budget appears reasonable.

### Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BHFP Attachment | Map |
| BFA Attachment A | Net Worth Statement of A Friendly Face Akademy, Corp |
| BFA Attachment B | Pro Forma Balance Sheet, A Friendly Face Akademy, Inc. |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 221265-B
## JAL 28 LLC d/b/a A Merryland Health Center

***Program:*** **Diagnostic and Treatment Center** ***County:*** **Kings**
***Purpose:*** **Establishment** ***Acknowledged:*** **July 15, 2022**

## Executive Summary

### Description

JAL 28 LLC d/b/a A Merryland Health Center (Center), an Article 28 licensed Diagnostic & Treatment Center (D&TC), requests approval to be established as the operator of A Merryland Health Center, currently operated by A Merryland Operating LLC. A Merryland Health Center is located at 2873 West 17th Street, Brooklyn, New York, and is certified to provide primary care, optometry, podiatry, and therapy - physical O/P. As part of this application, the applicant is seeking to add other medical specialties to the Center's operating certificate.

On October 28, 2019, A Merryland Operating LLC filed a petition for reorganization under Chapter 11 of the Bankruptcy Code. As a result, BNBN Management, LLC entered into an Asset Purchase Agreement (APA), dated July 30, 2021, for the sale of assets of A Merryland Operating LLC. The parties subsequently entered into an Amended and Restated APA dated November 1, 2021., The Amended APA has been assigned to JAL 28, LLC, the applicant, through an assignment agreement.

The sole member of JAL 28, LLC is Jonathan Liebermann. The applicant will have a transfer and affiliation agreement with Coney Island Hospital. The medical director will be Leonid Ischov, MD.

### OPCHSM Recommendation

Contingent Approval is recommended

### Need Summary

The Center is located in a HRSA designated Medically Underserved Area and a Health Professional Shortage Area for Primary Care. The applicant projects 20,354 visits in the first year and 33,300 in the third with Medicaid utilization at 45% and Charity Care at 2%.

### Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

### Financial Summary

The purchase price for the facility is $1,600,000 and will be paid with equity by the proposed member.

| Budget | Year One 2023 | Year Three 2025 |
|---|---|---|
| Revenues | $2,664,282 | $4,427,522 |
| Expenses | 1,990,163 | 2,884,622 |
| Net Income | $674,119 | $1,542,900 |

# Recommendations

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
2. Submission of an executed lease assignment that is acceptable to the Department of Health. [BFA]
3. Submission of a photocopy of an amended and executed Lease Agreement, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. This project must be completed by **one year from the date of the recommendation letter**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]
2. The staff of the facility must be separate and distinct from the staff of other entities; the signage must clearly denote the facility is separate and distinct from other entities; the clinical space must be used exclusively for the approved purpose, and the entrance must not disrupt any other entity's clinical program space. [HSP]
3. The applicant must ensure registration for and training of facility staff on the Department's Health Commerce System (HCS). The HCS is the secure web-based means by which facilities must communicate with the Department and receive vital information. Upon receipt of the Operating Certificate, the Administrator/director that has day-to-day oversight of the facility's operations shall submit the HCS Access Form at the following link to begin the process to enroll for HCS access for the first time or update enrollment information as necessary: https:www.health.ny.gov/facilites/hospitals/docs/hcs_access_forms_new_clinics.pdf. Questions may be directed to the Division of Hospitals and Diagnostic &Treatment Centers at 518-402-1004 or email: hospinfo@health.ny.gov [HSP]

## Council Action Date

December 8, 2022

# Need and Program Analysis

## Program Description

| | |
|---|---|
| **Proposed Operator** | JAL 28 LLC |
| **Doing Business As** | A Merryland Health Center |
| **Site Address** | 2873 West 17th Street<br>Brooklyn, NY 11224 (Kings County) |
| **Shift/Hours/Schedule** | Monday through Friday 8:30 am to 5:00 pm<br>Saturday 10:00 am to 4:00 pm |
| **Services** | Medical Services-Primary Care<br>Medical Service-Other Medical Specialties<br>Optometry O/P<br>Podiatry O/P<br>Physical Therapy O/P |
| **Staffing (1st Year/3rd Year)** | 10.85 FTEs/18.95 FTEs |
| **Medical Director** | Leonid Isakov, MD |
| **Emergency, In-Patient, and Backup Support Services Agreement and Distance and Time** | Coney Island Hospital<br>2.0 miles/7 minutes |

The primary service area is the neighborhood of Coney Island in Kings County. The Center is located in a HRSA designated Medically Underserved Area and a Health Professional Shortage Area for Primary Care.

The population of Kings County was 2,736,074 in 2020 and is expected to grow to 2,810,876 by 2025. According to Data USA, in 2019, 93.7% of the population in Kings County had health coverage as follows:

| | |
|---|---|
| Employer Plans | 41.7% |
| Medicaid | 33.2% |
| Medicare | 8.05% |
| Non-Group Plans | 10.5% |
| Military or VA | 0.222% |

The applicant projects 20,354 visits in the first year and 33,300 in the third with Medicaid utilization at 45% and Charity Care at 2%. The applicant is committed to serving all persons in need without regard to the ability to pay or source of payment.

Prevention Quality Indicators (PQIs) are rates of admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. The table below provides information on the PQI rates for the overall PQI condition. It shows that the PQI rate for the primary service area (zip codes 11214, 11223, and 11224) is significantly higher than the New York State rate.

| **Hospital Admissions per 100,000 Adults for Overall PQIs** | | |
|---|---|---|
| **PQI Rates: 2017** | **Zip Codes-11214, 11223, 11224** | **New York State** |
| All PQI's | 1,533 | 1,431 |

## Character and Competence

The proposed sole member of JAL 28, LLC is **John Liebermann**. John Liebermann is the Operations Manager of Omega Health Inc. where he plans, organizes, and manages activities for physicians, clinics, and other health programs, liaises with staff and board members to ensure consistent delivery of care, and stays abreast of changing laws and regulations and notifies staff. He also oversees areas of financial

planning including accounting budgets, reporting, and expenditures, and maintains operational records for internal and external audiences. He oversees the recruitment, hiring, scheduling, and training of staff. He develops and implements strategies for quality assessment of treatment services and general operations. Previously, he was the CEO of SafeGuard Staffing and the Operations Manager of Williamsburg Pediatrics

**Leonid Isakov, MD** is the proposed Medical Director. He is an owner of Ocean Medical PC. Previously, he was a part-time Staff Physician at Staten Island University Hospital, a part-time Physician at Pediatric Private Offices in different locations in Brooklyn and Queens, and a Pediatric Hospitalist at St. Luke's Roosevelt. He received his medical degree from Central Asia Medical Pediatric Institute in Russia. He completed his residency in Pediatrics at Maimonides Medical Center. He is board certified in Pediatrics.

Staff from the Division of Certification & Surveillance reviewed the disclosure information submitted regarding licenses held, formal education, training in pertinent health and/or related areas, employment history, a record of legal actions, and a disclosure of the applicant's ownership interest in other health care facilities. Licensed individuals were checked against the Office of Medicaid Management, the Office of Professional Medical Conduct, and the Education Department databases as well as the US Department of Health and Human Services Office of the Inspector General Medicare exclusion database.

### Conclusion

Approval of this project will allow for continued access to a variety of medical services for the residents of Coney Island and the surrounding communities in Kings County. Based on the information reviewed, staff found nothing that would reflect adversely upon the applicant's character and competence or standing in the community.

## Financial Analysis

### Operating Budget

The applicant has submitted an operating budget, in 2022 dollars, for the first and third years as follows:

| | Year One | | Year Three | |
|---|---|---|---|---|
| | Per Visit | Total | Per Visit | Total |
| Revenues | | | | |
| Commercial FFS | $140.00 | $712,320 | $142.80 | $1,188,810 |
| Medicare FFS | $175.00 | $106,925 | $178.50 | $178,322 |
| Medicare MC | $140.00 | $569,800 | $142.80 | $951,048 |
| Medicaid FFS | $149.83 | $609,808 | $149.93 | $997,868 |
| Medicaid MC | $117.86 | $599,672 | $120.22 | $1,000,808 |
| Private Pay | $200.00 | $203,600 | $204.00 | $339,660 |
| Less Bad Debt | | ($137,843) | | ($228,994) |
| Total Revenues | | $2,664,282 | | $4,427,522 |
| | | | | |
| Expenses | - | - | - | - |
| Operating | $78.64 | $1,600,569 | $74.75 | $2,489,249 |
| Capital | $19.14 | 389,594 | $11.87 | 395,373 |
| Total Expenses | $97.78 | 1,990,163 | $86.63 | $2,884,622 |
| | | | | |
| Net Income | | $674,119 | | $1,542,900 |
| | | - | | - |
| Utilization: | | 20,354 | | 33,300 |

The following is noted with respect to the submitted operating budget:

- This entity is currently in bankruptcy and revenue and expense assumptions are based on the historical experience of the current operator.
- Their current Medicare and Medicaid Managed Care contracts are providing reimbursement at a level below their actual costs. They are in the process of renegotiating these rates to provide for higher reimbursement. Due to ongoing bankruptcy proceedings, they have incurred additional expenses not typically associated with daily operations.
- The Center relocated operations at the end of 2021, and as a result, they incurred significant one-time costs related to the move.

Utilization broken down by payor source for the first and third year are as follows:

| Payor | Year One | Year Three |
|---|---|---|
| Commercial FFS | 25.00% | 25.00% |
| Medicare FFS | 3.00% | 3.00% |
| Medicare MC | 20.00% | 20.00% |
| Medicaid FFS | 20.00% | 20.00% |
| Medicaid MC | 25.00% | 25.00% |
| Private Pay | 5.00% | 5.00% |
| Charity Care | 2.00% | 2.00% |
| Total | 100.00% | 100.00% |

Amended and Restated Asset Purchase Agreement (APA)

The applicant has submitted an executed Amended and Restated Asset Purchase Agreement. The Amended APA has been assigned to JAL 28, LLC, the applicant, through an assignment agreement.

| | |
|---|---|
| Date | November 1, 2021 |
| Purpose | The sale of the D&TC licensed under Article 28 of the New York State Public Health Law located at 1704-06 Mermaid Avenue, Brooklyn, New York. |
| Seller | A Merryland Operating LLC |
| Purchaser | BNBN Management, LLC, or its designee, with an address at 4403 15th Avenue Brooklyn, New York 11224. |
| Purchase Price | $1,600,000 |
| Payment of Purchase Price | $50,000 of the purchase price was previously paid by the Purchaser of the Seller upon the execution of a letter of intent for this transaction, $110,000 shall be placed in escrow and $1,440,000 will be paid at closing. |
| Assets Acquired | Furniture and equipment, supplies, goodwill the debtor's domain name, together with all other domain names owned by Debtor, telephone numbers and fax numbers of the Seller, custody of the patient records of the Seller for those patients treated by the Seller, all books and records relating to the operation of the business prior to the Closing, all of debtor's cash and accounts receivable due to Debtor resulting from the conduct of the Business prior to the Closing Date and security deposits pertaining to any assigned leases. |
| Excluded Assets | Employee Benefit Plans and all causes of action, including, bankruptcy avoidance claims, together with insurance refunds and tax refunds. |
| Assumed Liabilities | None |

The applicant has submitted an affidavit, acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement, or understanding between the applicant and the transferor

to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments, or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor, of its liability and responsibility.

### Lease Rental Agreement

The applicant has provided an executed lease assignment for the site they will occupy.

| | |
|---|---|
| Date | October 1, 2020 |
| Premises | The premises located at 2873 West 17th Street, Brooklyn, New York. |
| Lessor | 1256 Ocean Avenue, LLC |
| Lessee | A Merryland Operating LLC |
| Term | 10 years |
| Rental | Year One through Year Two: $126,000 annually<br>Year Three: $131,040 annually<br>Year Four: $136,281 annually<br>Year Five: $147,402 annually<br>Year Six: $153,298 annually<br>Year Seven: $159,470 annually<br>Year Eight: $153,807 annually<br>Year Nine: $172,439 annually<br>Year Ten: $179,337 annually |
| Provisions | The tenant shall be responsible for real estate taxes, utilities, and maintenance. |

### Sub-Lease Assignment and Assumption

The applicant has submitted a draft Assignment and Assumption of the standing lease agreement, as detailed below:

| | |
|---|---|
| Date | Effective November 18, 2022 |
| Premises | The premises located at 2873 West 17th Street, Brooklyn, New York. |
| Assignor | BNBN Management, LLC |
| Assignee | JAL 28, LLC |
| Term | 10 years |
| Rental | Year One through Year Two: $126,000 annually<br>Year Three: $131,040 annually<br>Year Four: $136,281 annually<br>Year Five: $147,402 annually<br>Year Six: $153,298 annually<br>Year Seven: $159,470 annually<br>Year Eight: $153,807 annually<br>Year Nine: $172,439 annually<br>Year Ten: $179,337 annually |
| Provisions | The tenant shall be responsible for real estate taxes, utilities, and maintenance. |

### Capability and Feasibility

There are no project costs associated with this application. The purchase price for the facility is $1,600,000 to be met with equity by the proposed member.

Working capital requirements are estimated at $480,770, which is equivalent to two months of third-year expenses. The proposed member will provide equity to meet the working capital requirement. BFA

Attachment A indicates that the proposed member has sufficient funds to meet the purchase price and the working capital requirement. BFA Attachment C, the pro forma balance sheet of the applicant, indicates a positive net asset position of $3,175,347 on the first day of operations.

The submitted budget indicates a net income of $674,119 and $1,542,900 during the first and third years, respectively. Revenues are based on current reimbursement methodologies for primary care services. The submitted budget appears reasonable.

BFA Attachment B is the 2021 certified financial statements of A Merryland Operating, LLC. As shown, the entity had a negative working capital position, net asset position, and incurred a loss of ($31,481) in 2021. The applicant has indicated the reason for losses stems from the current Medicare and Medicaid managed care contracts, which are currently at a reimbursement rate below actual costs. The current operator has been unable to attract a sufficient number of patients, and due to minimal marketing efforts, the operations relocated at the end of 2021. As a result, there were high one-time costs that the center incurred as a result.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| BFA Attachment A | Net Worth Statement of proposed member |
| BFA Attachment B | 2021 certified financial statement of A Merryland Operating |
| BFA Attachment C | Pro Forma Balance Sheet |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 192204-E
## Highland Nursing Home, Inc. d/b/a
## North Country Nursing & Rehabilitation Center

***Program:*** **Residential Health Care Facility** ***County:*** **St. Lawrence**
***Purpose:*** **Establishment** ***Acknowledged:*** **October 24, 2019**

## Executive Summary

### Description

Highland Nursing Home, Inc., the current operator of a 140-bed, proprietary, Article 28 residential health care facility (RHCF) located at 182 Highland Road, Massena (Saint Lawrence County), requests approval to transfer 100% ownership of its capital stock (200 shares) to ten new shareholders (collectively the "Buyers"). Lea Sherman, Jeffrey Goldstein, and Alexander Sherman are the current shareholders of the RHCF (collectively the "Sellers"). 182 Highland Road, LLC, a separate entity, owns the facility's real property.

On November 30, 2018, Lea Sherman, Jeffrey Goldstein, and Alexander Sherman entered into a Stock Purchase Agreement (SPA) (the Agreement) to sell all issued and outstanding capital stock in the Corporation to David Landa and Menajem (Mark) Salamon or their designees. There were two subsequent amendments to the SPA resulting in the following proposed ownership:

| Proposed Operator Highland Nursing Home, Inc. | | |
|---|---|---|
| Shareholders: | Shares | % |
| Menajem Salamon | 60 | 30.0% |
| Mordejai Salamon | 34 | 17.0% |
| Joshua Landa | 22 | 11.0% |
| Joseph Landa | 22 | 11.0% |
| David Landa | 21 | 10.5% |
| Suri Reich | 10 | 5.0% |
| Yossi Mayer | 10 | 5.0% |
| Blimie Perlstein | 10 | 5.0% |
| Hellen Majerovic | 9 | 4.5% |
| Tirtza Salamon | 2 | 1.0% |

The purchase price for the shares is $1,863,461, which represents the balance due on a $2,050,000 Promissory Note (10-year term at 3% interest) made between 182 Highland Road, LLC (as Lender) to the current shareholders (Lea Sherman, Jeffrey Goldstein, and Alexander Sherman as Borrowers) to enable their purchase of the shares in Highland Nursing Home, Inc. in 2016. The proposed new shareholders will assume repayment of the Promissory Note to 182 Highland Road, LLC.

Highland Nursing Home, Inc. leases the premises from 182 Highland Road, LLC for 30 years. There is a relationship between the proposed new shareholders of Highland Nursing Home, Inc. and the members of 182 Highland Road, LLC in that ownership is overlapping but not identical.

### OPCHSM/OALTC Recommendation

Contingent Approval is recommended.

### Need Summary

There will be no need review per Public Health Law §2801-a (4).

### Program Summary

There will be no change in beds or services provided. The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

## Financial Summary

The purchase price of the stock is $1,863,461 funded through the assumption of a 10-year Promissory Note at 3% interest. The $1,863,461 Promissory note balance will be canceled upon the closing of the stock purchase agreement, per note seven in the 2021 certified financial statement of Highland Nursing Home, Inc. There are no project costs associated with this application.

| Budget | Year One 2023 | Year Three 2025 |
|---|---|---|
| Revenues | $15,057,577 | $15,432,907 |
| Expenses | 14,905,708 | 15,074,618 |
| Net Income | $151,869 | $358,289 |

# Recommendations

## Long Term Care Ombudsman Program

The LTCOP recommends Approval. (See LTCOP Attachment A)

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a photocopy of the Certificate of Assumed Name, acceptable to the Department. [CSL]
2. Submission of a photocopy of a list of the Board of Directors, acceptable to the Department. [CSL]
3. Submission of a photocopy of an executed Resolution of the Board of Directors, acceptable to the Department. [CSL]
4. Submission of a photocopy of executed Shareholder Stock Certificates, acceptable to the Department. [CSL]
5. Submission of a photocopy of an amended and executed Lease Agreement, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. This project must be completed by **June 1, 2023**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]

## Council Action Date

December 8, 2022

# Program Analysis

## Facility Information

| | Existing | Proposed |
|---|---|---|
| Facility Name | North Country Nursing and Rehabilitation Center | North Country Nursing and Rehabilitation Center |
| Address | 182 Highland Road<br>Massena, NY 13662 | Same |
| RHCF Capacity | 140 | Same |
| ADHCP Capacity | N/A | N/A |
| Type of Operator | Business Corporation | Business Corporation |
| Class of Operator | Proprietary | Proprietary |
| Operator | Highland Nursing Home Inc. | Highland Nursing Home Inc.<br><br>Menajem Salamon* 30.0%<br>Mordejai Salamon** 17.0%<br>Joshua Landa 11.0%<br>Joseph Landa 11.0%<br>David Landa 10.5%<br>Suri Reich 5.0%<br>Yossi Mayer 5.0%<br>Blimie Perlstein 5.0%<br>Helen Majerovic 4.5%<br>Tirtza Salamon 1.0%<br><br>**President and Chief Executive Officer*<br>*** Vice President* |

## Character and Competence

**Experience**

**Menajem (Mark) Salamon** is a Licensed New York State, and New Jersey nursing home administrator. He lists concurrent employment at Gold Crest Care Center located in Bronx, NY as a Licensed Nursing Home Administrator since 2011, and the Chief Executive Officer of Highland Nursing Home Inc. (the subject facility) since May 2019. He holds a bachelor's degree with additional coursework. He discloses the following healthcare facility ownership interest:

| | | |
|---|---|---|
| Advanced Center for Nursing and Rehabilitation (CT) | (2.5%) | 10/16 – present |
| West Haven Center for Nursing and Rehab (CT) | (41.5%) | 11/21—present |
| Southport Center for Nursing and Rehab (CT) | (41.5%) | 11/21—present |
| New Haven Center for Nursing and Rehab (CT) | (41.5%) | 11/21—present |
| Waterbury Center for Nursing and Rehab (CT) | (41.5%) | 11/21—present |
| Torrington Center for Nursing and Rehab (CT) | (41.5%) | 11/21—present |

**Mordejai Salamon** lists employment as Director of Business Development at Gold Crest Care Center since 2014. His responsibilities include marketing, implementation of new strategic initiatives, and optimizing occupancy. He indicates no previous employment. He holds a bachelor's degree. He discloses the following healthcare facility ownership interest:

| | | |
|---|---|---|
| Advanced Center for Nursing and Rehabilitation (CT) | (10%) | 10/16 – present |
| West Haven Center for Nursing and Rehab (CT) | (7%) | 11/21—present |
| Southport Center for Nursing and Rehab (CT) | (7%) | 11/21—present |
| New Haven Center for Nursing and Rehab (CT) | (7%) | 11/21—present |
| Waterbury Center for Nursing and Rehab (CT) | (7%) | 11/21—present |
| Torrington Center for Nursing and Rehab (CT) | (7%) | 11/21—present |

**Joshua Landa** is currently a student at Yeshiva Tiferes Yisrael in Brooklyn, NY. He discloses the following healthcare facility interest:

| | | |
|---|---|---|
| Advanced Center for Nursing and Rehabilitation (CT) | (15%) | 10/16 – present |
| Torrington Center For Nursing and Rehabilitation (CT) | (36.5%) | 11/21 – present |

**Joseph Landa** is currently a financial supervisor at Hollis Park Nursing Home. He has held this position since February 2021, prior to this he was a student. He holds a bachelor's degree/. He discloses the following healthcare facility interests:

| | | |
|---|---|---|
| Advanced Center for Nursing and Rehabilitation (CT) | (15%) | 10/16 – present |
| Waterbury Center For Nursing And Rehabilitation (CT) | (36.5%) | 11/21 – present |

**David Landa** lists employment as an owner of = Dividends and Nursing Homes. He holds a high school diploma. He discloses the following health care facility ownership interests:

| | | |
|---|---|---|
| Windsor Park Nursing Home | (22.5%) | 6/86 – present |
| Sunrise Manor | (28.5%) | 2/93 – present |
| Gold Crest Care Center | (40%) | 2/96 – present |
| Fieldston Lodge Care Center | (26%) | 9/03 – present |
| Affinity Skilled Living & Rehabilitation Center | (15.66%) | 12/05 – present |

**Suri Reich** discloses employment at Wellsville Manor Care Center Social Services Department remotely since 2016 from her home in Brooklyn, NY. Previously her employment was Beth Jacob of Boro Park as a teacher between 2007 and 2016. Ms. Reich has a high school diploma and discloses the following ownership interests:

| | | |
|---|---|---|
| Oak Hill Rehab and Nursing | (10%) | 2/19 – present |
| River View Rehab and Nursing | (10%) | 2/19 – present |

**Yossi Mayer** discloses employment at Fieldstone Lodge Skilled Nursing Facility located in Bronx, NY in the Maintenance Department since 2017. He has a bachelor's degree. Mr. Mayer discloses the following ownership interests:

| | | |
|---|---|---|
| Oak Hill Rehab and Nursing | (10%) | 2/19 – present |
| River View Rehab and Nursing | (10%) | 2/19 – present |
| West Haven Center for Nursing and Rehab (CT) | (1.25%) | 11/21 – present |
| Southport Center for Nursing and Rehab (CT) | (1.25%) | 11/21 – present |
| Waterbury Center for Nursing and Rehab (CT) | (1.25%) | 11/21 – present |
| Torrington Center for Nursing and Rehab (CT) | (1.25%) | 11/21 – present |

**Blimie Perlstein** discloses that she is the owner of P&G brokerage, Inc. since 1994. P&G is an insurance brokerage located in Brooklyn, NY. Ms. Perlstein has a high school diploma and discloses no ownership interest in any healthcare facilities.

**Helen Majerovic** discloses employment at Flawless Dental as a receptionist. She has a high school diploma. Ms. Majerovic discloses the following ownership interests:

| | | |
|---|---|---|
| Oak Hill Rehab and Nursing | (5%) | 2/19 – present |
| River View Rehab and Nursing | (10%) | 2/19 – present |

**Tirtza Salamon** discloses no employment history for the past ten years. Ms. Salamon discloses no ownership interest in any healthcare facilities.

Quality Review

| | CMS Star Rating Criteria - 10 NYRRC 600.2(b)(5)(iv) | | | | |
|---|---|---|---|---|---|
| | | Duration of Ownership | | | |
| | | < 48 Months | | 48 months or more | |
| Proposed Owner | Total Nursing Homes | Number of Nursing Homes | Percent of Nursing Homes With a Below Average Rating | Number of Nursing Homes | Percent of Nursing Homes With a Below Average Rating |
| Joseph Landa | 2 | 1 | 100% | 1 | 100% |
| Joshua Landa | 1 | 0 | n/a | 1 | 100% |
| David Landa | 5 | 0 | n/a | 5 | 40% |
| Suri Reich | 1 | 1 | 100% | 0 | n/a |
| Yossi Mayer | 6 | 6 | 83.33% | 0 | n/a |
| Helen Majerovic | 2 | 2 | 50% | 0 | n/a |
| Blimie Perlstein | 0 | n/a | n/a | n/a | n/a |
| Mordejai Salamon | 5 | 4 | 100% | 1 | 100% |
| Menajem Salamon | 6 | 5 | 100% | 1 | 100% |
| Tirtza Salamon | 0 | n/a | n/a | n/a | n/a |

*Duration of Ownership as of 12/08/2022*
*Data Date: 09/2022*

**New York:** Four of the applicants own seven New York facilities. Oak Hill Rehab and Nursing and Fieldston Lodge Care Center are 1-star overall rated facilities. Affinity Skilled Living is a 2-star overall rated facility. Regarding Oak Hill Rehab and Nursing, one of the three health inspection surveys which were used to calculate the health inspection rating occurred while the proposed owners had operational control. The 1-star staffing rating is wholly attributable to the proposed owners. Regarding Fieldston Lodge Care Center and Affinity Skilled Living and Rehabilitation Center, the applicant states:

> *This facility's Overall rating was impacted by the staffing rating, which decreased from two (2) stars to one (1) star as a result of a change in the CMS staffing calculation, which provides for a higher value being attributed to Registered Nurses versus Licensed Practical Nurses. Since the COVID-19 pandemic began, the facility has had difficulties with hiring and retaining qualified Registered Nurses and has instead hired multiple Licensed Practical Nurses in order to provide the best-possible nursing coverage in a difficult labor market…*

As for the subject facility, Menajem (Mark) Salamon, a member of the proposed ownership group, entered into an employment agreement on May 31, 2019, with Highland Nursing Center, Inc. The May 2019 CMS Star Ratings indicate the facility had a 2-star overall, 1-star health inspection, 3-star quality, and 4-star staffing ratings at the time Mr. Salamon initiated his affiliation. The October 2022 Ratings indicate the overall, health inspection, quality measure, and staffing ratings are all now 1 star. Per the applicant:

> *Mr. Salamon has extensive experience with operating skilled nursing facilities, and it is expected that his experience will result in improved Star Ratings at the facility going forward.*

**Connecticut**: Four of the applicants own six Connecticut facilities, all of which are rated below average. Advanced Center for Nursing and Rehabilitation is a 2-star overall rated facility. As per the applicant:

> *The operator is working with clinical and operational leaders to achieve higher quality standards, which should improve this facility's Overall Star Rating to three…" The facility also has a below-average, 1-star staffing rating. Regarding the other facilities, the applicants state "The proposed new shareholders became affiliated with this facility in November 2021 and are in the process of making operational improvements...*

CMS Star Ratings

| *Facility* | *Ownership Since* | *Overall* | *Health Inspection* | *Quality Measure* | *Staffing* |
|---|---|---|---|---|---|
| **New York** | | | | | |
| Highland Nursing Center | Subject Facility | * | * | * | * |
| Gold Crest Care Center | Current | ***** | **** | ***** | ** |
| | 02/1996** | * | * | **** | * |
| Windsor Park Nursing Home | Current | ***** | ***** | *** | *** |
| | 06/1986** | *** | **** | ** | * |
| River View Rehabilitation and Nursing Center | Current | *** | *** | ***** | * |
| | 01/2019 | * | * | ** | *** |
| Sunrise Manor | Current | *** | **** | **** | * |
| | 02/1993** | *** | *** | * | **** |
| Affinity Skilled Living | Current | ** | ** | ***** | * |
| | 12/2005** | * | * | *** | * |
| Oak Hill Rehab and Nursing | Current | * | ** | ** | * |
| | 01/2019 | * | ** | *** | * |
| Fieldston Lodge Care Center | Current | * | * | **** | ** |
| | 09/2003** | ** | * | *** | **** |
| **Connecticut** | | | | | |
| Advanced Center for Nursing and Rehabilitation | Current | ** | *** | **** | * |
| | 10/2016 | * | * | *** | *** |
| West Haven Center For Nursing & Rehabilitation | Current | ** | ** | ***** | * |
| | 11/2021 | *** | ** | ***** | *** |
| Waterbury Center For Nursing And Rehab | Current | ** | * | ***** | * |
| | 11/2021 | ** | * | *** | **** |
| Regalcare At New Haven † | Current | * | * | *** | * |
| | 11/2021 | * | * | ** | *** |
| Torrington Center for Nursing & Rehabilitation | Current | * | * | *** | * |
| | 11/2021 | * | * | **** | *** |

| Facility | Ownership Since | Overall | Health Inspection | Quality Measure | Staffing |
|---|---|---|---|---|---|
| Southport Center For Nursing & Rehabilitation | Current | * | * | ** | ** |
| | 11/2021 | * | * | ** | ** |

† Special Focus Facility Candidate
***Earliest data as of 12/2009*
*Data date: 09/2022*

**Enforcement History**

**River View Rehabilitation and Nursing Care Center:**

- A federal CMP in the amount of $3,250 was assessed on 10/23/2020

**Oak Hill Rehab and Nursing**:

- A federal CMP in the amount of $655 was assessed on 12/7/2020
- A federal CMP in the amount of $975 was assessed on 12/14/2020
- A federal CMP in the amount of $1,310 was assessed on 11/15/2021
- A federal CMP in the amount of $1,965 was assessed on 11/22/2021

**Fieldston Lodge Care Center:**

- A federal CMP in the amount of $5,000 was assessed on 3/2/2022

**Advanced Center for Nursing and Rehabilitation (CT):**

- A federal CMP in the amount of $9,750 was assessed for 10/31/18 surveillance findings
- A federal CMP in the amount of $4,274 was assessed for 8/23/17 surveillance findings
- Federal CMPs in the amounts of $54,645 and $17,209 were assessed for 1/19/2017 surveillance findings.

**Torrington Center for Nursing and Rehabilitation (CT):**

- A federal CMP in the amount of $650 was issued on 1/3/2022

## Program Review

No changes in the program or physical environment are proposed in this application. The applicant states that it does plan to utilize staffing agencies and may utilize Five Star Staffing Inc. or any other suitable staffing provider for its staffing needs in the future. The applicant indicates that the facility does currently utilize P&G Insurance Brokers and the applicant plans to continue utilizing the services of P&G Insurance brokers in the future.

## Conclusion

The individual background review indicates the applicants have met the standard for approval as set forth in Public Health Law §2801-a(3).

# Financial Analysis

## Operating Budget

The applicant has provided the current year (2021) operations and an operating budget, in 2023 dollars, for the first and third years of operations after the change in ownership. The budget is summarized below:

| | Current Year 2021 | | Year One 2023 | | Year Three 2025 | |
|---|---|---|---|---|---|---|
| | Per Diem | Total | Per Diem | Total | Per Diem | Total |
| Revenues | | | | | | |
| Medicaid-FFS | $203.33 | $4,925,361 | $203.32 | $5,861,180 | $203.33 | $6,007,709 |
| Medicaid-MC | $177.04 | 343,465 | $177.04 | 343,465 | $177.00 | 352,052 |
| Medicare-FFS | $584.71 | 6,172,741 | $584.70 | 7,345,561 | $584.70 | 7,529,200 |
| Medicare-MC | $584.71 | 349,069 | $585.06 | 415,393 | $584.86 | 425,777 |
| Private Pay | $300.97 | 880,337 | $300.95 | 1,047,601 | $300.95 | 1,073,792 |
| All Other* | | 44,377 | | 44,377 | | 44,377 |
| Total Revenue | | $12,715,350 | | $15,057,577 | | $15,432,907 |
| | | | | | | |
| Expenses | | | | | | |
| Operating | $162.81 | $6,552,025 | $224.33 | $10,660,342 | $222.33 | $10,829,252 |
| Capital | $211.02 | 8,492,144 | $89.34 | 4,245,366 | $87.16 | 4,245,366 |
| Total Expense | $373.83 | $15,044,169 | $313.67 | $14,905,708 | $309.49 | $15,074,618 |
| | | | | | | |
| Oper Income | | ($2,328,819) | | $151,869 | | $358,289 |
| | | | | | | |
| Patient Days | | 40,243 | | 47,521 | | 48,709 |
| Utilization (%) | | 78.75% | | 93.00% | | 95.32% |

** Includes Investment income and vending machine revenues*

Notes concerning the submitted RHCF operating budget follow:

- The operating loss of ($2,328,819) is before considering $2,518,368 from the Medicare Relief Grant of $1,180,732 and Employee Retention Credit of $1,337,636, which brings Net Income to $189,549.
- The current year reflects the facility's 2021 revenues and expenses.
- Medicaid revenue is based on the facility's current 2021 Medicaid Regional Pricing rate. The per diems for Medicaid Manage Care is the daily rate experienced by the facility during 2021.
- The current year Medicare rate is the actual daily rate experienced by the facility during 2021. The forecasted year one and year three Medicare rate is based on the average daily rate experienced during 2021. The forecasted Private Pay rate is based on the average daily rate experienced during 2021.
- Projected expenses are based on the current operator's 2021 costs, adjusted to include inflation and increased volume. The incremental cost consists primarily of increased labor costs related to hiring additional clinical, aides/orderlies, housekeeping, and food service staff (53.30 FTEs in year one) to accommodate the increased patient volume.
  - The projected percentage of direct care staffing costs to projected facility revenues is 40.39% in year one and year three, exceeding the 40% requirement in Public Health Law 2808.
  - The percentage of direct resident care costs to projected facility revenue is 70.75% in year one and 71.70% in year three, exceeding the 70% requirement in Public Health Law 2808.
  - The facility's projected profit percentage is forecasted to be 1.01% in year one and 2.32% in year three, less than the 5% maximum outlined in Public Health Law 2808.
- The facility's projected utilization is 93% in year one and 95.32% in year three. Occupancy at 97.9% as of August 17, 2022, exceeds these projections and is a significant recovery from the pandemic impact when the utilization in the last three years averaged 63.9% and was 78.75% at year-end 2021. The breakeven utilization is projected at 92.33% for the first year.

- Current year staffing is based on 2021 staffing levels and a 78.75% occupancy rate. Staffing in years one and three are based on a planned increase in utilization. The facility currently has 96 FTEs. Additional staffing will be sourced from multiple area nursing staffing agencies.
- Projected utilization by payor source for the first and third year after the change in ownership is:

| | Current Year 2021 | | Year One 2023 | | Year Three 2025 | |
|---|---|---|---|---|---|---|
| Payor | Days | % | Days | % | Days | % |
| Medicaid -FFS | 24,224 | 60.19% | 28,827 | 60.66% | 29,547 | 60.66% |
| Medicaid-MC | 1,940 | 4.82% | 1,940 | 4.08% | 1,989 | 4.08% |
| Medicare-FFS | 10,557 | 26.23% | 12,563 | 26.44% | 12,877 | 26.44% |
| Medicare-MC | 597 | 1.48% | 710 | 1.49% | 728 | 1.49% |
| Private Pay | 2,925 | 7.27% | 3,481 | 7.33% | 3,568 | 7.33% |
| Total | 40,243 | 100.% | 47,521 | 100.% | 48,709 | 100% |
| | | | | | | |

Stock Purchase Agreement (SPA)

The applicant submitted an executed SPA to acquire the operating entity's corporate stock. The terms are summarized below:

| | |
|---|---|
| Date: | November 30, 2018 |
| Operator: | Highland Nursing Home, Inc. |
| Seller: | Lea Sherman, Jeffrey Goldstein, Alexander Sherman |
| Buyers: | David Landa, Menajem (Mark) Salamon, or their designees |
| Asset Acquired: | 100% of the issued and outstanding corporate stock in Highland Nursing Home, Inc. |
| Purchase Price: | $2,050,000 |
| Payment of Purchase Price: | $300,000 * paid upon execution, held in escrow;<br>$1,750,000 balance due at closing |

**This amount was held in escrow, and all interest accrued thereon was refunded to the Buyers at the Real Estate closing (May 31, 2019).*

First Amendment to Stock Purchase Agreement:

The applicant submitted an executed First Amendment to assign David Landa and Menajem Salamon's rights under the original Agreement to ten new shareholders. The terms are summarized below:

| | |
|---|---|
| Date: | July 10, 2019 |
| Sellers: | Lea Sherman, Jeffrey Goldstein, Alexander Sherman |
| Original Buyers: | David Landa and Menajem Salamon and their designees |
| New Buyers: | Joseph Landa, (13.75%, 27.5 shares); Joshua Landa, (13.75%, 27.5 shares); Menashe Eisen, (5%, 10 shares); Suri Reich, (5%, 10 shares); Yossi Mayer, (5%, 10 shares); Hellen Majerovic, (4.50%, 9 shares); Blimie Perlstein, (5%, 10 shares); Mordejai Salamon, (17%, 34 shares); Menajem Salamon, (30%, 60 shares); Tirtza Salamon, (1%, 2 shares). |
| Provision: | Acquisition of stocks in Highland Nursing Home, Inc. The Original Buyers assign, transfer, and release their right, title, and interest as Buyers under the Stock Purchase Agreement dated November 30, 2018, to New Buyers. |
| Price: | $1,863,461 (balance due on a $2,050,000 Promissory Note between Lea Sherman, Jeffrey Goldstein, and Alexander Sherman as borrowers and 182 Highland Road, LLC as Lender) |
| Payment of Purchase Price: | $1,863,461 via assumption of a 10-year Promissory Note at 3% interest between the current shareholders (Sellers, Borrowers) and 182 Highland Road, LLC (Lender) |

### Second Amendment to Stock Purchase Agreement:

The applicant submitted an executed Second Amendment whereby Menashe Eisen withdraws as Buyer. David Landa will replace Menashe Eisen as one of the ten proposed shareholders of Highland Nursing Home, Inc. The terms are summarized below:

| | |
|---|---|
| Date: | July 1, 2022 |
| Sellers: | Lea Sherman, Jeffrey Goldstein, Alexander Sherman |
| Original Buyers: | David Landa and Menajem Salamon and their designees |
| New Buyers: | Joseph Landa, (11%, 22 shares); Joshua Landa, (11%, 22 shares); David Landa, (10.5%, 21 shares); Suri Reich, (5%, 10 shares); Yossi Mayer, (5%, 10 shares); Hellen Majerovic, (4.50%, 9 shares); Blimie Perlstein, (5%, 10 shares); Mordejai Salamon, (17%, 34 shares); Menajem Salamon, (30%, 60 shares); Tirtza Salamon, (1%, 2 shares). |

The $1,863,461 purchase price for the operations' corporate stock will be satisfied by the assumption of the balance due on a Promissory Note (original principal valued at $2,050,000) between Lea Sherman, Jeffrey Goldstein, and Alexander Sherman (Borrowers) and 182 Highland Road LLC (Lender). Sellers' expenses of $416,640 related to the original SPA and Real Estate Contract were refunded at the Real Estate closing. Per note seven in the 2021 certified financial statement, the $1,863,461 note balance will be canceled upon the closing of the stock purchase agreement.

### Original Real Estate Purchase Agreement:

The applicant submitted a copy of the original real property purchase agreement and original lease agreement, the terms of which were summarized below:

| | |
|---|---|
| Date: | June 23, 2016 |
| Seller: | Highland Nursing Home, Inc. |
| Buyer: | Highland Realty Co, LLC (proposed initially, rights later assigned) |
| Asset Transferred: | Real property located at 182 Highland Road, Massena, NY 13662 |
| Purchase Price: | $4,950,000 |
| Payment of Purchase Price: | $4,950,000 cash at closing |

### Original Lease Agreement and First Amendment

The applicant has submitted an executed original lease agreement, and first amendment, the terms of which were summarized below:

| | |
|---|---|
| Date: | August 10, 2016, and First Amended on December 4, 2018 |
| Premises: | 140-bed RHCF located at 182 Highland Road, Massena, NY 13662 |
| Owner/Landlord: | Highland Realty Co., LLC (proposed initially, rights later assigned) |
| Lessee: | Highland Nursing Home, Inc. |
| Term: | 30 years (amended to start with the closing of the Real Property Contract and terminate 30 years later) |
| Rent: | $360,000 plus annual debt repayment (principal + interest estimated at $501,866 per year), totaling approx. $861,866 per year ($71,822 per month). |
| Provisions: | Triple Net |

On November 30, 2018, Highland Realty Co, LLC assigned its rights under the agreement for the sale of real property dated June 23, 2016, and the facility's lease agreement dated August 10, 2016, as amended December 4, 2018, to 182 Highland Road, LLC.

### Assignment of Agreement for sale of Real Property and Lease

The applicant has submitted an executed agreement for the assignment of the sale of real property agreement and the facility's lease agreement:

| | |
|---|---|
| Date: | November 30, 2018 |
| Assignor: | Highland Realty Co, LLC |
| Assignee: | 182 Highland Road, LLC |
| Assignment: | Assignor assigns all its rights, title, and interest to and under the real property sale agreement and the lease. |

The applicant confirms that the closing for the real property occurred on May 31, 2019. 182 Highland Road LLC leases the facility to Highland Nursing Home, Inc. for a term of 30 years.

The purchase price of the real property was satisfied as follows:

| | |
|---|---|
| Equity – 182 Highland Road LLC Members | $742,500 |
| Loan (M&T Bank, assumed outstanding realty loan debt, five years at 4% one-month Libor or 5.74%, (as of December 18, 2019) and one 5-year extension at 5.50% plus one-month Libor, 25-year amortization) | $4,207,500 |
| Total | $4,950,000 |

### Second Amendment to Lease

The applicant has submitted an executed second amendment to the lease agreement, the terms of which are summarized below:

| | |
|---|---|
| Date: | March 26, 2018 |
| Lessor | 182 Highland Road, LLC |
| Lessee: | Highland Nursing Home, Inc. |
| Term: | 30 years |
| Rental: | $360,000 plus annual debt repayment obligations (principal + interest estimated at $501,866 per year), totaling approx. $861,866 per year ($71,822 per month). |
| Provisions: | Triple Net |

The lease arrangement is a non-arm's length agreement. The applicant has submitted an affidavit attesting to the relationship between the landlord and tenant.

### Capability and Feasibility

The proposed new shareholders will acquire 100% of Highland Nursing Home, Inc.'s corporate stock for $1,863,461, to be funded via a 10-year Promissory Note at a 3% interest rate (original principal of $2,050,000) between the current shareholders (Borrowers) and 182 Highland Road, LLC (Lender). The $1,863,461 Promissory note balance will be canceled upon the closing of the stock purchase agreement, per note seven in the 2021 certified financial statement of Highland Nursing Home, Inc. 182 Highland Road LLC is the current property owner and has leased the facility to Highland Nursing Home, Inc. for a term of 30 years. There is a relationship between the proposed shareholders of Highland Nursing Home, Inc. and the members of 182 Highland Road, LLC in that ownership is overlapping but not identical. There are no project costs associated with this application.

The working capital requirement is estimated at $2,484,285, based on two months of Year One expenses. Funding will be provided from the entity's ongoing operations. BFA Attachment A is the net worth summaries for the proposed Buyers of Highland Nursing Home, Inc.'s corporate stock, and indicates they have sufficient resources to meet equity requirements. BFA Attachment C is Highland Nursing Home, Inc.'s pro forma balance sheet, which shows the entity will start with $3,617,174 in equity. Equity includes $1,359,817 in goodwill, which is not a liquid resource nor recognized for Medicaid reimbursement. If goodwill were eliminated, the total net assets would become $2,257,357.

The submitted budget projects a net income of $151,869 and $358,289 in the first and third years. Operating revenues are estimated to increase by approximately $2,342,227 from the Current Year to

Year One. This revenue increase is primarily from growing patient days and utilization to 93% in the first year. Overall expenses are projected to decrease by $138,461 by the first year following the approval of this project. Reductions in rent of $4,246,778 drive this decrease in overall expenses. However, decreases in capital expenses are offset by an increase in operating expenses of $4,108,317. The budget appears reasonable.

BFA Attachment D is a Financial Summary of Highland Nursing Home, Inc. for 2019 through 2021. The RHCF had average positive working capital, average positive net assets, and average positive net income. BFA Attachment E is the Internal Financials as of May 31, 2022, which show positive working capital, net assets, and an operating profit of $1,702,680.

BFA Attachment F is the proposed members' ownership interest in New York nursing homes. New York State-affiliated nursing homes on a combined basis had average positive working capital, average positive net assets, and average positive net income for the period from 2019 through 2021. In 2021 each affiliated nursing home maintains positive working capital, positive net assets, and positive net income.

### Conclusion

Based on the preceding, the applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| LTCOP Attachment | Long Term Care Ombudsman Program Recommendation |
| BFA Attachment A | Highland Nursing Home, Inc. - Proposed Stockholders' Net Worth |
| BFA Attachment B | Current Owners of the Real Property |
| BFA Attachment C | Pro Forma Balance Sheet |
| BFA Attachment D | 2019-2021 Financial Summary of Highland Nursing Home, Inc and 2021 certified financial statement. |
| BFA Attachment E | Internal Financials Highland Nursing Home, Inc. May 31, 2022. |
| BFA Attachment F | Proposed members' ownership interest in Affiliated RHCFs |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 202034-E
## Ulster NH Operations LLC d/b/a
## Golden Hill Center for Rehabilitating and Nursing

***Program:*** **Residential Health Care Facility** ***County:*** **Ulster**
***Purpose:*** **Establishment** ***Acknowledged:*** **August 18, 2020**

## Executive Summary

### Description

Ulster NH Operation, LLC, an existing limited liability company, requests approval to be established as the new operator of Golden Hill Nursing and Rehabilitation Center, a 280-bed residential health care facility (RHCF) at 99 Golden Hill Drive, Kingston (Ulster County).

Golden Hill Planning Corporation, Inc. is the current operator of the facility. Pursuant to the Asset Purchase Agreement (APA) dated November 22, 2019, Ulster NH Operation, LLC agreed to purchase the RHCF from Golden Hill Planning Corporation, Inc for $3,000,000 plus assumption of liabilities. Upon approval, the facility will be named Golden Hill Center for Rehabilitation and Nursing.

On November 22, 2019, Ulster NH Realty, LLC and Golden Hill Acquisition, LLC entered into a Contract of Sale for the real estate whereby Ulster NH Realty, LLC agreed to purchase the real estate associated with the facility. Upon approval of this application, Ulster NH Realty, LLC will lease the RHCF to Ulster NH Operation, LLC for a term of 40 years.

Ownership of the RHCF before and after the requested change is as follows:

| **Current** | |
|---|---|
| **Golden Hill Planning Corporation, Inc.** | |
| Orly Lieberman | 9.54% |
| Tibor Lebovich | 28.10% |
| Alex Berger | 8.33% |
| Edward Farbenblum | 44.13% |
| Solomon Klein | 9.90% |

| **Proposed** | |
|---|---|
| **Ulster NH Operation, LLC** | |
| CW Kingston Operating, LLC<br>Chava Wolofsky (100%) | 48.50% |
| KF Kingston Operating, LLC<br>Solomon Klein (100%) | 17.00% |
| ES Kingston Operating, LLC<br>Ernest Schlesinger (100%) | 17.00% |
| ED Kingston Operating, LLC<br>Ezriel Drebin (100%) | 9.50% |
| SE Kingston Operating, LLC<br>Shoshana Markovitz (100%) | 8.00% |

### OPCHSM/OALTC Recommendation

Contingent Approval

## Need Summary

There will be no changes to beds or services as a result of this application. Occupancy as of July 27, 2022, was 86.1% for the facility and 82.8% for Ulster County.

## Program Summary

The individual background review indicates the proposed members have met the standard for approval as set forth in Public Health Law §2801-a(3).

## Financial Summary

The purchase price for the operation is $3,000,000 to be met via equity from the proposed members. The purchase price for the real estate is $37,600,000 to be met via equity of $3,008,000 from the proposed members of the realty entity and a loan of $34,592,000 at an interest rate of 6% for a 30-year term.

The submitted budget indicates a projected net income of $1,555,859 and $1,683,131 in the first and third years of operations, respectively.

| | **Year One** | **Year Three** |
|---|---|---|
| Revenues | $33,759,867 | $34,502,563 |
| Expenses | 32,204,008 | 32,819,432 |
| Net Income | $1,555,859 | $1,683,131 |

# Recommendations

## Long Term Care Ombudsman Program

The LTCOP recommends Approval. (See LTCOP Attachment A)

## Health Systems Agency

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management

**Approval contingent upon:**

1. Submission of a loan commitment for the real estate, that is acceptable to the Department of Health. [BFA]
2. Submission of an executed lease agreement, that is acceptable to the Department of Health. [BFA]
3. Submission of an executed asset purchase agreement that is acceptable to the Department of Health. [BFA]
4. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
5. Submission of a photocopy of the Certificate of Assumed Name, acceptable to the Department. [CSL]
6. Submission of a photocopy of an amended and executed Lease Agreement, acceptable to the Department. [CSL]
7. Submission of a photocopy of an amended and executed Administrative Services Agreement, acceptable to the Department. [CSL]
8. Submission of a photocopy of the Application for Authority for CW Kingston Operations LLC, acceptable to the Department. [CSL]
9. Submission of a photocopy of an amended and executed Operating Agreement for CW Kingston Operations LLC, acceptable to the Department. [(CSL]
10. Submission of a photocopy of the Application for Authority for ED Kingston Operations LLC, acceptable to the Department. [CSL]
11. Submission of a photocopy of an amended and executed Operating Agreement for ED Kingston Operations LL, acceptable to the Department. [CSL]
12. Submission of a photocopy of an amended and executed Articles of Organization for KF Kingston Operations, LLC, acceptable to the Department. [CSL]
13. Submission of a photocopy of an amended and executed Operating Agreement for KF Kingston Operations, LLC, acceptable to the Department. [CSL]
14. Submission of a photocopy of an amended and executed Articles of Organization for ES Kingston Operations LLC, acceptable to the Department. [CSL]
15. Submission of a photocopy of an amended and executed Operating Agreement for ES Kingston Operations LLC, acceptable to the Department. [CSL]
16. Submission of a photocopy of an amended and executed Articles of Organization for SE Kingston Operations, LLC, acceptable to the Department. [CSL]
17. Submission of a photocopy of an amended and executed Operating Agreement for SE Kingston Operations, LLC, acceptable to the Department. [CSL]
18. Submission of a photocopy of an amended and executed Operating Agreement, acceptable to the Department. [CSL]
19. Submission of a photocopy of an amended and executed Partial Assignment of Membership Interests, acceptable to the Department. [CSL]

**Approval conditional upon:**

1. This project must be completed by **one year from the date of the recommendation letter**, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and an expiration of the approval. It is the responsibility of the applicant to request prior approval for any extension to the project approval expiration date. [PMU]

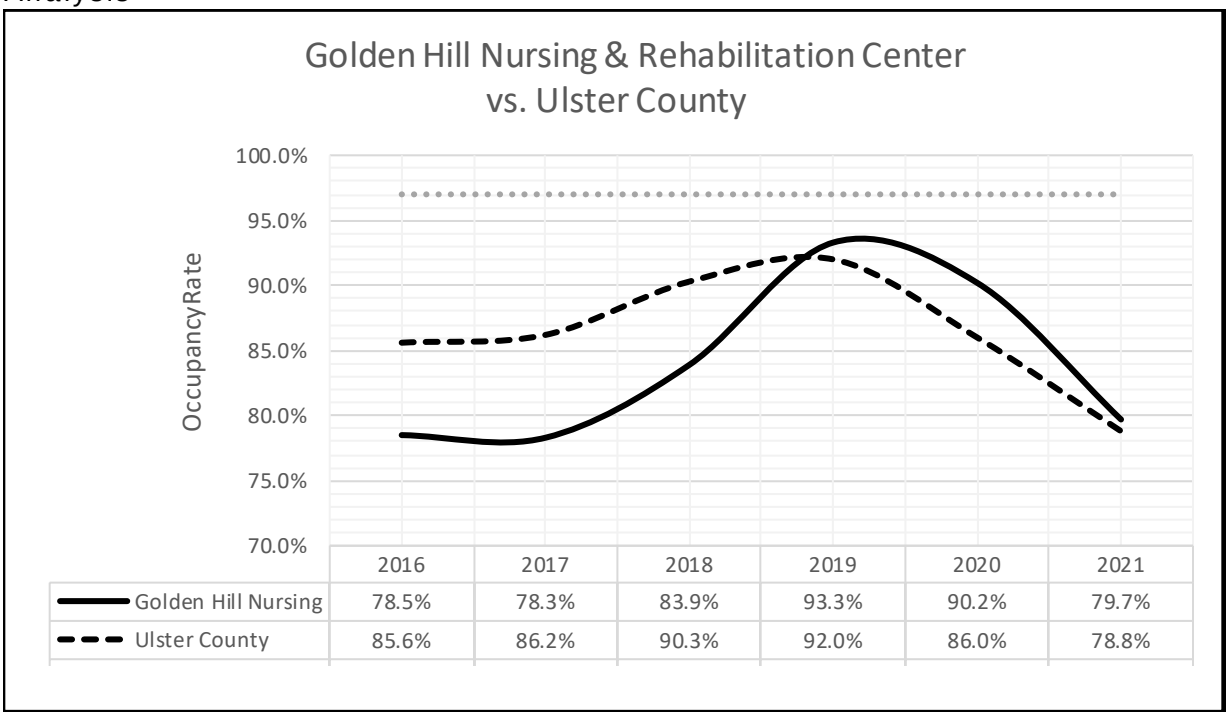
Council Action Date
December 8, 2022

# Need Analysis

## Project Description

Ulster NH Operation LLC is requesting approval to become the established operator of Golden Hill Nursing & Rehabilitation Center, a 280-bed Article 28 residential health care facility (RHCF) located at 99 Golden Hill Drive, Kingston, 12401 in Ulster County.

## Analysis




| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|
| Golden Hill Nursing | 78.5% | 78.3% | 83.9% | 93.3% | 90.2% | 79.7% |
| Ulster County | 85.6% | 86.2% | 90.3% | 92.0% | 86.0% | 78.8% |

Occupancy, as of September 21, 2022, was 88.9% for the facility and 85.5% for Ulster County.

## Medicaid Access

To ensure that the Residential Health Care Facility needs of the Medicaid population are met, 10 NYCRR §670.3 requires applicants to accept and admit a reasonable percentage of Medicaid residents in their service area. The benchmark is 75% of the annual percentage of residential health care facility admissions that are Medicaid-eligible individuals in their planning area. This benchmark may be increased or decreased based on the following factors:

- the number of individuals within the planning area currently awaiting placement to a residential health care facility and the proportion of total individuals awaiting such placement that are Medicaid patients and/or alternate level of care patients in general hospitals;
- the proportion of the facility's total patient days that are Medicaid patient days and the length of time that the facility's patients who are admitted as private paying patients remain such before becoming Medicaid eligible;
- the proportion of the facility's admissions who are Medicare patients or patients whose services are paid for under provisions of the federal Veterans' Benefit Law;
- the facility's patient case mix based on the intensity of care required by the facility's patients or the extent to which the facility provides services to patients with unique or specialized needs;
- the financial impact on the facility due to an increase in Medicaid patient admissions.

An applicant will be required to make appropriate adjustments in its admission policies and practices to meet the resultant percentage. The facility's Medicaid admissions rate was above the threshold of 75% of the Ulster County rate.

| Medicaid Access | 2019 | 2020 | 2021 |
|---|---|---|---|
| Ulster County Total | 27.1% | 21.6% | 22.7% |
| Ulster Threshold Value | 20.3% | 16.2% | 17.0% |
| Golden Hill Nursing | 34.1% | 27.3% | 26.9% |

### Conclusion

There will be no changes to beds or services as a result of this project. Based upon weekly census data, current occupancy, as of July 27, 2022, was 86.1% for the facility and 82.8% for Ulster County.

## Program Analysis

### Facility Information

| | Existing | Proposed |
|---|---|---|
| Facility Name | Golden Hill Nursing and Rehabilitation Center | Golden Hill Center for Rehabilitating and Nursing |
| Address | 99 Golden Hill Drive<br>Kingston, NY 12401 | Same |
| RHCF Capacity | 280 | Same |
| ADHCP Capacity | N/A | Same |
| Type of Operator | Business Corporation | Limited Liability Company |
| Class of Operator | Proprietary | Proprietary |
| Operator | Golden Hill Planning Corporation, Inc.<br>Shareholders<br>Solomon Klein 9.90%<br>Orly Lieberman 9.54%<br>Tibor Lebovich 28.10%<br>Alex Berger 8.33%<br>Edward Farbenblum 44.13% | Ulster NH Operation, LLC<br>Members<br>CW Kingston Operating, LLC 48.5%<br>Chava Wolofsky (100%)<br>KF Kingston Operating, LLC 17.0%<br>Solomon Klein* (100%)<br>ES Kingston Operating, LLC 17.0%<br>Ernest Schlesinger (100%)<br>ED Kingston Operating, LLC 9.5%<br>Ezriel Drebin (100%)<br>SE Kingston Operating, LLC 8.0%<br>Shoshana Markovitz (100%)<br><br>*Managing Member |

No changes in the program or physical environment are proposed in this application.

### Character and Competence

**Experience**

**Chava Wolofsky** indicates no employment history for the last ten years. Chava Wolofsky has a diploma from Bais Yaakov Academy and discloses the following interests in health care facilities.

Out-of-State Nursing Homes

| | |
|---|---|
| Alaska Gardens Health and Rehabilitation (19.70%) [WA] | 01/2021 to present |
| Hawthorne Center for Rehabilitation and Healing of Ocala (17.5%) [FL] | 08/2021 to present |
| Hawthorne Center for Rehabilitation and Healing of Brandon (17.5%) [FL] | 08/2021 to present |
| Hawthorne Center for Rehabilitation and Healing of Sarasota (17.5%) [FL] | 08/2021 to present |
| Forest Hill Center Health Care (19%) [NJ] | Pending |
| The Place at Pepper Hill 22.75% [SC] | Pending |
| Solaris Healthcare Lake Bennet (19%) [FL] | Pending |
| Solaris Healthcare Palatka (19%) [FL] | Pending |

Out-of-State Independent Living Facilities

| | |
|---|---|
| Hawthorne Estates of Ocala (17.50%) [FL] | 04/2021 to present |
| Hawthorne Estates of Brandon (17.5%) [FL] | Pending |

Out-of-State Assisted Living Facilities

| | |
|---|---|
| Hawthorne Inn of Brandon (17.50%) [FL] | 08/2021 to present |
| Hawthorne Inn of Lakeland (17.50%) [FL] | 08/2021 to present |

**Solomon Klein** indicates current employment at Sightrite an eyecare business since February 2013. Solomon Klein has an associate degree from Touro College and discloses the following interests in health care facilities:

Nursing Homes

| | |
|---|---|
| Ten Broeck Center for Rehabilitation & Nursing (10%) [NY] | 10/2018 to present |
| Clove Lakes Healthcare and Rehabilitation Center (9.9%) [NY] | 02/2020 to present |
| Golden Hill Nursing and Rehabilitation Center (9.9%) [NY] | 09/2020 to present |

Out-of-State Nursing Homes

| | |
|---|---|
| TimberRidge Center for Rehab & Healing (28.5%) [FL] | 09/2019 to present |
| Century Health & Rehabilitation Center (25%) [FL] | 03/2020 to present |
| Northbrook Center for Rehabilitation and Healing (25%) [FL] | 03/2020 to present |
| Santa Rosa Center for Rehabilitation and Healing (25%) [FL] | 03/2020 to present |
| Ybor City Healthcare & Rehabilitation (25%) [FL] | 03/2020 to present |
| Sandy Ridge Health & Rehabilitation (25%) [FL] | 03/2020 to present |
| Hawthorne Center for Rehabilitation and Healing of Ocala (41%) [FL] | 04/2021 to present |
| Hawthorne Center for Rehabilitation and Healing of Brandon (44%) [FL] | 08/2021 to present |
| Hawthorne Center for Rehabilitation and Healing of Sarasota (44%) [FL] | 08/2021 to present |
| The Place at Pepper Hill (45%) [SC] | Pending |
| Solaris Healthcare Lake Bennet (57%) [FL] | Pending |
| Solaris Healthcare Palatka (57%) [FL] | Pending |
| Forest Hill Center Rehabilitation and Healing (43%) [NJ] | Pending |

End Dated Ownership

| | |
|---|---|
| Abbey Woods Center for Rehab & Healing (6%) [MO] | 04/2017 to 6/2019 |

Out-of-State Independent Living Facilities

| | |
|---|---|
| Hawthorne Estates of Ocala (44%) [FL] | 07/2021 to present |
| Hawthorne Estates of Brandon (44%) [FL] | 07/2021 to present |

Out-of-State Assisted Living Facilities

| | |
|---|---|
| Hawthorne Inn of Ocala (41%) [FL] | 04/2021 to present |
| Hawthorne Inn of Brandon (44%) [FL] | 08/2021 to present |
| Hawthorne Inn of Lakeland (44%) [FL] | 08/2021 to present |

**Ernest Schlesinger** discloses employment as the Chief Executive Officer of Sightrite, an eyecare business since January 2013. Ernest Schlesinger has a diploma from Yeshiva Taras Chesed and discloses the following health facility interests:

Nursing Homes

| | |
|---|---|
| Dumont Center for Rehabilitation and Nursing Care (2.5%) [NY] | 07/2010 to present |
| St James Rehabilitation & Healthcare Center (10%) [NY] | 08/2012 to present |
| Bellhaven Center for Rehabilitation & Nursing Care (5%) [NY] | 03/2010 to present |
| The Grand Pavilion at Rockville Centre (5%) [NY] | 08/2012 to present |
| Westhampton Care Center (17%) [NY] | 02/2018 to present |
| Ten Broeck Center for Rehabilitation & Nursing (13%) [NY] | 10/2018 to present |

Out-of-State Nursing Homes

| | |
|---|---|
| Big Bend Woods Healthcare Center (10%) [MO] | 01/2016 to present |
| Washington Square Healthcare Center (6%) [OH] | 01/2014 to present |
| Greenery Center for Rehab and Nursing (15%) [PA] | 06/2016 to present |
| TimberRidge Center for Rehab & Healing (13%) [FL] | 09/2019 to present |

End Dated Ownership

| | |
|---|---|
| Abbey Woods Center for Rehabilitation and Healing (50%) [MO] | 04/2017 to 06/2019 |

**Ezriel Drebin** indicates self-employment in healthcare management and acquisitions. The applicant also indicates the position of Director of Operations at Infinite Care since September 2019. Ezriel Drebin has a diploma from Yeshiva Gedolah Toronto and discloses the following health facility ownership interests:

Out-of-State Nursing Homes

| | |
|---|---|
| Century Center Health & Rehabilitation Center (8%) [FL] | 03/2019 to Present |
| Northbrook Health & Rehabilitation (8%) [FL] | 03/2019 to Present |
| Santa Rosa Health & Rehabilitation Center (8%) [FL] | 03/2019 to Present |
| Ybor City Healthcare & Rehabilitation (8%) [FL] | 03/2019 to Present |
| Sandy Ridge Health & Rehabilitation (8%) [FL] | 03/2019 to Present |
| TimberRidge Center for Rehab & Healing (10%) [FL] | 09/2019 to Present |
| Hawthorne Center for Rehabilitation and Healing of Ocala 5% [FL] | 04/2021 to Present |
| Hawthorne Center for Rehabilitation and Healing of Brandon 2% [FL] | 07/2021 to Present |
| Hawthorne Center for Rehabilitation and Healing of Sarasota 2% [FL] | 07/2021 to Present |
| Forest Hill Center for Rehabilitation and Healing (3%) [NJ] | Pending |

Out-of-State Independent Living Facilities

| | |
|---|---|
| Hawthorne Estates of Brandon 2% [FL] | 07/2021 to Present |
| Hawthorne Estates of Ocala 2% [FL] | Pending |

Out-of-State Assisted Living Facilities

| | |
|---|---|
| Hawthorne Inn of Ocala 5% [FL] | 04/2021 to Present |
| Hawthorne Inn of Brandon 2% [FL] | 07/2021 to Present |
| Hawthorne Inn of Lakeland 2% [FL] | 07/2021 to Present |

**Shoshana Markovitz** is licensed as a Registered Nurse License in New Jersey. The applicant discloses employment as Registered Nurse and VFC (Vaccine for Children) Coordinator at Dr. Neil Gittleman located in Lakewood, NJ since 2/2018. Shoshana Markovitz has an M.S.N in Pediatric Primary Care Nurse Practitioner from Seton Hall University School of Nursing and a master's in science and Nursing from John Hopkins University. Shoshana Markovitz discloses no health facility ownership interests.

**Quality Review**

The proposed owners have been evaluated, in part, on the distribution of CMS Star ratings for their portfolios. For all proposed owners the distribution of CMS star ratings for their facilities meet the standard described in state regulations.

| CMS Star Rating Criteria - 10 NYCRR 600.2(b)(5)(iv) | | | | | |
|---|---|---|---|---|---|
| | | Duration of Ownership | | | |
| | | < 48 Months | | 48 months or more | |
| Proposed Owner | Total Nursing Homes | Number of Nursing Homes | Percent of Nursing Homes with a Below Average Rating | Number of Nursing Homes | Percent of Nursing Homes with a Below Average Rating |
| Chava Wolofsky | 4 | 4 | 75% | 0 | n/a |
| Ernest Schlesinger | 10 | 1 | 0 | 9 | 22% |
| Ezriel Drebin | 9 | 9 | 44.44% | 0 | n/a |
| Solomon Klein | 12 | 11 | 45.45% | 1 | 0 |
| Shoshana Markovitz | 0 | n/a | n/a | n/a | n/a |

*Duration of Ownership as of 12/8/2022*

*Data as of 09/2022*

The CMS Special Focus Facility (SFF) program includes nursing homes that have a history of serious quality issues or are included in a special program to stimulate improvements in their quality of care.

**New York**: The proposed owner's portfolio includes ownership in eight New York facilities. Seven of the New York facilities in the ownership portfolio have CMS overall quality ratings of average or higher. The remaining facility, Golden Hill Nursing and Rehabilitation Center, has a CMS overall quality rating of below average or lower. When asked to explain the low overall CMS ratings for Golden Hill Nursing and Rehabilitation Center the applicants indicated the following:

*The two-star rating in the Overall category was due primarily to the fact that the facility's staffing rating went from two stars to one star. Since the COVID-19 pandemic began, the facility has experienced difficulties in hiring and retaining qualified Registered Nurses. As a result, the facility has hired Licensed Practical Nurses in order to provide the best possible nursing coverage to its residents despite these difficult circumstances in the labor market.*

**Florida:** The proposed owner's portfolio includes ownership in nine Florida facilities. Five of the Florida facilities have CMS overall quality ratings of average or higher. The remaining four Florida facilities have CMS overall quality ratings of below average or lower. When asked to explain the low overall CMS ratings for the four facilities (Santa Rosa Center for Rehabilitation and Healing, Hawthorne Center for Rehabilitation and Healing of Brandon, Northbrook Center for Rehabilitation & Healing, and Hawthorne Center for Rehabilitation and Healing of Sarasota) the applicants indicated the following:

*Prior to Ezriel Drebin and Solomon Klein becoming members of Santa Rosa Center for Rehabilitation and Healing in March of 2020, the facility received an Immediate Jeopardy (IJ) violation. This violation has since been remedied by the facility, but the violation is still impacting the facility's Overall Star Rating. It is expected that the facility's Overall Rating will improve within the near term, as this violation ages and has a lesser impact on scoring.*

*The low rating at Hawthorne Center for Rehabilitation and Healing of Brandon was a result of a survey conducted on February 17, 2022, the facility received a G-level violation, along with three (3) IJ violations: F600 (Free from Abuse and Neglect); F609 (Reporting of Alleged Violations); and F610 (Investigate / Prevent / Correct Alleged Violation). Although three (3) IJ violations were received, these violations all related to one (1) incident and one (1) resident. All three (3) of these IJ violations have since been removed and the facility's Plan of Correction has been approved. Due to the above citation for resident harm or potential harm for abuse or neglect at Hawthorne Center for Rehabilitation and Healing of Brandon, CMS has indicated on the facility profile an icon of a red circle with a hand in it on the Nursing Home Compare website. Hawthorne Center for Rehabilitation and Healing of Brandon is also designated by CMS as a Special Focus Facility Candidate, which is a program that includes nursing homes that have a history of serious quality issues or are included in a special program to stimulate improvements in their quality of care.*

*The applicant states that the reason for the low star rating (2 stars in the Overall category) at Northbrook Center for Rehabilitation & Healing was due to two (2) Immediate Jeopardy (IJ) deficiencies that were received by the facility on April 13, 2022. These deficiencies have since been corrected and the fines associated with these deficiencies have also been paid. As such, it is expected that the facility's Overall star rating will increase to three (3) stars within the near term.*

*The applicant states the reason for the low overall star rating at Hawthorne Center for Rehabilitation and Healing of Ocala is the facility's staffing rating was adjusted from two (2) stars down to one (1) star. This is a result of a recent Payroll Based Journal report submission that contained an error that resulted in CMS reducing the facility's staffing rating to one (1) star for a period of six months. The facility has corrected this error and expects the overall staffing rating to return to three (3) stars in the overall category.*

**Missouri:** The proposed owner's portfolio includes ownership in one Missouri facility. When asked to explain the low overall CMS rating at Big Bend Woods, the applicant indicated:

*The rules in Missouri regarding whether a member has control of a facility are different than those in New York State. As such, although Ernest Schlesinger is a 10% member of this facility, he indicates*

*that he does not exercise control over the day-to-day operations of the facility. This facility is designated by CMA as a Special Focus Facility Candidate, which is a program that includes nursing homes that have a history of serious quality issues or are included in a special program to stimulate improvements in their quality of care.*

**Ohio:** The proposed owner's portfolio includes ownership in one Ohio facility. The Ohio facility currently has a CMS overall quality rating of average or higher.

**Pennsylvania:** The proposed owner's portfolio includes ownership in one Pennsylvania facility. The Pennsylvania facility currently has a CMS overall quality rating of below average or lower. When asked to explain the low overall CMS rating at The Greenery the applicant indicated:

*The rules in Pennsylvania regarding whether a member has control of a facility are different than those in New York State. As such, although Ernest Schlesinger is a 15% member of this facility, he indicates that he does not exercise control over the day-to-day operations of the facility.*

**Washington:** The proposed owner's portfolios include ownership in one Washington facility. The Washington facility currently has a CMS overall quality rating of below average. When asked to explain the low overall CMS rating at Alaska Gardens Health and Rehabilitation, the applicant indicated:

*Staffing has been an issue. The facility has hired a recruiter, contracted with several staffing agencies, and increased their presence on internet job boards related to open positions. Regarding the low health inspection rating, the facility attributes this to several deficiencies that were cited during surveys conducted at the facility in prior years. However, recent surveys conducted during 2022 have resulted in fewer deficiencies than in prior years. The applicant states that this reflects the facility's focus on improvement in this area and expects the health inspection rating will increase to three stars in the near term.*

CMS Star Ratings

**Currently Owned Nursing Homes**

| *Facility* | *Ownership Since* | *Overall* | *Health Inspection* | *Quality Measure* | *Staffing* |
|---|---|---|---|---|---|
| **New York** | | | | | |
| Golden Hill Nursing and Rehabilitation Center | Subject Facility | ** | *** | **** | * |
| | 09/2020 | ***** | **** | ***** | ** |
| Dumont Center for Rehabilitation and Nursing Care | Current | ***** | ***** | ***** | *** |
| | 07/2010 Data as of 11/2010 | * | * | *** | *** |
| The Grand Pavilion at Rockville Centre | Current | ***** | **** | ***** | ** |
| | 08/2012 | ** | ** | *** | ** |
| Westhampton Care Center | Current | *** | *** | ***** | * |
| | 02/2018 | **** | *** | ***** | *** |
| St James Rehabilitation & Healthcare Center | Current | ***** | **** | ***** | ** |
| | 08/2012 | ** | *** | **** | * |
| Bellhaven Center for Rehabilitation & Nursing Care | Current | *** | *** | **** | ** |
| | 03/2010 | * | ** | *** | * |
| Ten Broeck Center for Rehabilitation & Nursing | Current | *** | *** | ***** | * |
| | 10/2018 | ***** | **** | ***** | ** |

| *Facility* | *Ownership Since* | *Overall* | *Health Inspection* | *Quality Measure* | *Staffing* |
|---|---|---|---|---|---|
| Clove Lakes Healthcare and Rehabilitation Center | Current | *** | **** | **** | * |
| | 02/2020 | ***** | ***** | **** | *** |
| **Florida** | | | | | |
| Hawthorne Center for Rehab & Healing of Sarasota | Current | *** | *** | *** | **** |
| | 08/2021 | *** | ** | ** | **** |
| Hawthorne Center for Rehabilitation and Healing of Brandon † | Current | * | * | **** | *** |
| | 08/2021 | ** | * | **** | ***** |
| Hawthorne Center for Rehabilitation and Healing of Ocala | Current | ** | *** | **** | * |
| | 04/2021 | **** | ** | ***** | **** |
| Century Center for Rehabilitation and Healing | Current | **** | **** | *** | **** |
| | 03/2020 | **** | *** | ** | **** |
| Northbrook Center for Rehabilitation & Healing | Current | ** | ** | **** | **** |
| | 03/2020 | ***** | *** | ***** | **** |
| Sandy Ridge Center for Rehabilitation and Healing | Current | ***** | ***** | *** | **** |
| | 03/2020 | **** | **** | *** | **** |
| TimberRidge Center for Rehab & Healing | Current | **** | **** | ** | **** |
| | 09/2019 | *** | **** | *** | * |
| Santa Rosa Center for Rehabilitation and Healing | Current | * | * | **** | **** |
| | 03/2020 | **** | *** | *** | **** |
| Ybor City Healthcare & Rehabilitation Center | Current | **** | **** | **** | *** |
| | 03/2020 | **** | **** | **** | **** |
| **Missouri** | | | | | |
| Big Bend Woods Healthcare Center † | Current | * | * | *** | * |
| | 01/2016 | * | * | **** | *** |
| **Ohio** | | | | | |
| Washington Square Healthcare Center | Current | **** | ***** | **** | * |
| | 01/2014 | ** | ** | **** | *** |

| Facility | Ownership Since | Overall | Health Inspection | Quality Measure | Staffing |
|---|---|---|---|---|---|
| **Pennsylvania** | | | | | |
| Greenery Center for Rehab and Nursing | Current | ** | ** | **** | ** |
| | 06/2016 | * | * | * | * |
| **Washington** | | | | | |
| Alaska Gardens Health and Rehabilitation | Current | * | ** | *** | * |
| | 01/2021 | ** | ** | **** | *** |

***Data date:*** *09/2022*
*† Special Focus Facility Candidate*

**End-Dated Nursing Homes**

| Facility | Ownership Since | Overall | Health Inspection | Quality Measure | Staffing |
|---|---|---|---|---|---|
| **Missouri** | | | | | |
| Abbey Woods Center for Rehabilitation and Healing | 06/2019 | * | * | ** | * |
| | 04/2017 | *** | ** | ** | **** |

**Enforcement History**

**Clove Lakes Healthcare and Rehabilitation Center, NY:**

- The facility was fined $2,000 pursuant to Stipulation and Order NH-21-104 issued on June 2, 2021, for surveillance findings on February 24, 2021. A federal CMP in the amount of $5,000 was also assessed on 2/24/2021. The facility failed to establish and maintain an Infection Control Program to ensure the health and safety of residents to help prevent the transmission of COVID.
- The facility was assessed a federal CMP of $650.00 on 9/11/2021 for failure to report COVID data.

**Golden Hill Nursing and Rehabilitation Center, NY:**

- The facility was fined $2,000 pursuant to Stipulation and Order NH-21-234 issued on 12/16/2021, for surveillance findings on August 31, 2021. Deficiencies were found under Quality of Care.
- The facility was assessed a federal CMP of $655.14 on 1/4/2021 for failure to report COVID data.

**Westhampton Care Center, NY:**

- The facility was fined $14,000 pursuant to Stipulation and Order NH-22-116 for surveillance findings on January 18, 2022, under 10 NYCRR 415.19(a)(1)(2) Infection Control and 10 NYCRR 415.12 (H)(2) Quality of Care. A federal CMP in the amount of $11,435.00 was also assessed on 1/18/2022. The facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection. The facility also failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination.
- The facility was fined $10,000 pursuant to Stipulation and Order NH-19-003 issued on January 3, 2019, for surveillance findings on September 10, 2018. A federal CMP in the amount of $7,036 was also assessed on 9/10/2018. The facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of residents, and misappropriation of resident property.

**Sandy Ridge Health & Rehabilitation:**

- The facility was assessed federal CMPs of $650.00 on 8/3/2020, $975.00 on 10/12/2020, $1300.00 on 10/19/2020, and $1625.00 on 10/26/2020 for failure to report COVID data.

**Northbrook Center for Rehabilitation and Healing:**

- The facility was assessed federal CMPs of $650.00 on 12/28/2020 and $975.00 on 01/10/2022 for failure to report COVID data.
- The facility was assessed a federal CMP of $13,490.00 on 4/13/2022 from two J level deficiencies related to prevention of abuse and neglect (F600) and Cardio-Pulmonary Resuscitation (CPR) (F678).

**TimberRidge Center for Rehab & Healing:**

- The facility was assessed a federal CMP of $20,635 on 4/3/2020 for failure to ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.
- The facility was assessed federal CMPs of $655.00 on 5/10/2021 for failure to report COVID data.

**Century Health & Rehabilitation Center:**

- The facility was assessed federal CMPs of $650.00 on 6/21/2021 for failure to report COVID data.

**Hawthorne Center for Rehabilitation and Healing of Brandon:**

- The facility was assessed a federal CMP of $359,085.00 on 12/10/2021 from a G level deficiency and three IJ level deficiencies related to prevention of abuse and neglect (F600), reporting of abuse (F609), and investigation of abuse (F610).
- The facility was assessed a federal CMPs of $650.00 on 1/11/2021, $983.00 on 1/18/2021, $1,300.00 on 6/28/2021, $1,625.00 on 7/5/2021, and $1,950 on 8/16/2021 for failure to report COVID data.

**Big Bend Woods Healthcare Center:**

- The facility was assessed a federal CMP of $84,240 on 5/24/2021 the facility must provide appropriate pressure ulcer care and prevent new ulcers from developing.
- On 5/24/2021 the facility was cited for failure to provide appropriate treatment and care according to orders, resident's preferences, and goals Federal Tag 684 at a G level.
- The facility was assessed a federal CMP of $44,782 on 1/4/2021 the facility must provide appropriate treatment and care according to orders, resident's preferences, and goals.
- The facility was assessed federal CMPs of $655.00 on 6/7/2021, $983.00 on 6/21/2021, $1300.00 on 6/28/2021, and $1625.00 on 7/5/2021 for failure to report COVID data.
- On 3/18/2020 Big Bend Woods Healthcare Center was cited for failure to provide basic life support, including CPR, prior to the arrival of emergency medical personnel, subject to physician orders and the resident's advance directives Federal Tag 678 at a J level.
- The facility was assessed a federal CMP of $19,910 on 1/28/2020 the facility must provide appropriate treatment and care according to orders, resident's preferences, and goals.
- The facility was assessed a federal CMP of $11,443 on 3/3/2017 the facility must give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.

**Greenery Center for Rehab and Nursing:**

- The facility was assessed a federal CMP of $27,688.00 on 9/27/2019 the facility must ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.
- On 9/27/2019, the facility was cited for failure to provide appropriate treatment and care according to orders, residents' preferences, and goals. Federal Tag 684 at a G level.

**Bellhaven Center for Rehabilitation and Nursing Care:**

- The facility was fined $2,000.00 pursuant to Stipulation and Order NH-22-066 issued for surveillance findings on October 19, 2021, under 10 NYCRR 415.19(a) Infection Control. The facility was also assessed a federal CMP of $5,000.00 on 10/19/2021 for failure to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

- The facility was assessed federal CMPs of $650.00 on 3/22/2021, $975.00 on 6/14/2021, $1300.00 on 6/28/2021, $1300.00 on 6/28/2021, $1625.00 on 8/23/2021, $1,950.00 on 9/13/2021, $2,275.00 on 9/20/2021, $4,000.00 on 11/15/2021, and $5000.00 on 11/29/2021 for failure to report National Health Safety data.

### Conclusion

All health care facilities are in substantial compliance with all rules and regulations. The individual background review indicates the applicants have met the standard for approval as set forth in Public Health Law §2801-a(3).

## Financial Analysis

### Operating Budget

The applicant has submitted an operating budget, in 2022 dollars, during the first and third year:

| | **Current Year 2021** | | **Year One 2023** | | **Year Three 2025** | |
|---|---|---|---|---|---|---|
| | **Per PD** | **Total** | **Per PD** | **Total** | **Per PD** | **Total** |
| Revenues | | | | | | |
| Medicare FFS | $562.24 | $8,000,658 | $562.22 | $9,200,756 | $562.22 | $9,403,173 |
| Medicare MC | $562.24 | 1,468,005 | $562.17 | 1,688,206 | $562.19 | 1,725,347 |
| Medicaid FFS | $263.92 | 13,643,397 | $263.92 | 15,689,906 | $263.92 | 16,035,084 |
| Medicaid MC | $263.92 | 1,786,481 | $263.93 | 2,054,454 | 263.91 | 2,099,652 |
| Private Pay | $726.96 | 4,456,996 | $726.92 | 5,125,545 | $726.94 | 5,238,307 |
| Cares Act Rev | | 1,576,550 | | 0 | | 0 |
| Misc. Rev | | 965 | | 1,000 | | 1,000 |
| Total Revenues | | $30,933,052 | | $33,759,867 | | $34,502,563 |
| | | | | | | |
| Expenses | - | - | - | - | - | - |
| Operating | $313.25 | $25,510,075 | $293.52 | $27,488,856 | $293.63 | $28,104,280 |
| Capital | $57.90 | 4,715,152 | $50.35 | 4,715,152 | $49.26 | 4,715,152 |
| Total Expenses | $371.15 | $30,225,227 | $343.87 | 32,204,008 | $342.90 | $32,819,432 |
| | | | | | | |
| Net Income | | $707,825 | | $1,555,859 | | $1,683,131 |
| | | - | | - | | - |
| Utilization (Days) | | 81,436 | | 93,651 | | 95,712 |
| Occupancy | | 79.68% | | 91.64% | | 93.65% |

The following is noted with respect to the submitted budget:

- The Medicare and Private Pay rates are projected from the current market rates.
- The current year's Medicaid rate is based on the facility's Medicaid rate per 2019 RHCF-4 cost report information.
- The current occupancy rate of Golden Hill Nursing and Rehabilitation Center was 85.4% as of August 17, 2022, as tracked in the New York State Health Commerce System. The applicant has indicated that the projected increase in patient days and recovery to exceed pre-pandemic utilization will result from the applicant's plan to continue effectively marketing the facility to prospective residents. The facility's marketing campaign will continue to focus on communication and relationship building with the area doctors, hospitals, and resident family members regarding improvements being made at the facility. In addition, the applicant plans to invest further in the facility by upgrading and beautifying resident rooms, as well as the gymnasium and resident dining rooms.

Utilization detailed by payor source for the current year, year one, and year three are as follows:

| Payor | Current Year 2021 | Year One 2023 | Year Three 2025 |
|---|---|---|---|
| Medicare FFS | 17.47% | 17.47% | 17.47% |
| Medicare Managed Care | 3.21% | 3.21% | 3.21% |
| Medicaid FFS | 63.48% | 63.48% | 63.48% |
| Medicaid Managed Care | 8.31% | 8.31% | 8.31% |
| Private Pay | 7.53% | 7.53% | 7.53% |
| **Total** | **100.00%** | **100.00%** | **100.00%** |

Asset Purchase Agreement

The applicant has submitted a draft asset purchase agreement for the purchase of the operation:

| | |
|---|---|
| Purpose | Seller desires to sell, and Buyer desires to purchase, certain assets ofSeller relating to the Facility. |
| Purchaser | Ulster NH Operation, LLC |
| Seller | Golden Hill Planning Corporation |
| Assets Acquired | Business and operation of the Facility, all inventory, supplies, and other articles of personal property, all Facility contracts, agreements, leases,undertakings, commitments, and other arrangements which Buyer elects to assume, the name “Golden Hill Nursing and Rehabilitation Center” and any other trade names, logos, trademarks and service marks associated with the Facility, all security deposits and prepayments, if any, for future services held by the Seller, all menus, policies and procedures manuals and computer software, all telephone numbers and telefax numbers used by the Facility, copies of all books and records in the possession of Seller, all resident/patient records relating to the Facility, good will in connection to the Facility, all accounts receivable related to services rendered by the Facility and all cash, marketable securities, deposits and cash equivalents in the New Operating account and new payroll account. |
| Excluded Assets | All insurance, policies, and claims relating to events occurring before the Effective Date, all retroactive rate increases, regulation from rate appeals, audits or otherwise, concerning third party payments, all amounts due from parties related to Seller, all financial books and records of Seller, including, but not limited to organizational and other corporate type records, all accounts receivable relating to services rendered by the Facility before the Effective Date and the real property, and improvements thereon, and any rights relating to the ownership thereof. |
| Assumed Liabilities | Buyer shall assume at the Closing, all liabilities and obligations to the Facility arising on or after the Effective Date, all of Sellers’s Accounts Payable and other liabilities accruing on or after the Effective Date, and all healthcare, Medicare, and Medicaid overpayment and assessments liabilities. |
| Purchase Price | $3,000,000 plus assumption of liabilities. |
| Payment | Cash at Closing |

The applicant has submitted an affidavit, acceptable to the Department, in which the applicant agrees, notwithstanding any agreement, arrangement, or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments, or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor, of its liability and responsibility. Currently, there are no outstanding overpayment liabilities.

## Real Estate Purchase Agreement

The applicant has submitted an executed real estate purchase agreement:

| | |
|---|---|
| Date | November 22, 2019 |
| Premises | The premises located at 99 Golden Hill Dr, Kingston, New York. |
| Seller | Golden Hill Acquisition, LLC |
| Purchaser | Ulster NH Realty, LLC |
| Purchase Price | $37,600,000 |
| Payment of Purchase Price | $400,000 Initial Deposit to Escrowee<br>$400,000 additional deposit upon the expiration of the Due Diligence Period<br>$36,800,000 at Closing |

The applicant will finance the purchase price as follows:

| | |
|---|---|
| Equity | $3,000,000 |
| Bank Loan (6% for a30-year term) | $34,592,000 |

## Lease Rental Agreement

The applicant has submitted a draft lease agreement:

| | |
|---|---|
| Premises | The site located at 99 Golden Hill Dr, Kingston, New York |
| Lessor | Ulster NH Realty LLC |
| Lessee | Ulster NH Operation LLC |
| Term | 25 years |
| Rental | Year One: $3,760,000 with a 2% increase thereafter. |
| Provisions | The lessee shall be responsible for maintenance, real estate taxes, utilities, and insurance. |

The applicant has indicated that the lease agreement will be a non-arm's length lease arrangement in that there is a relationship between the landlord and the tenant.

## Capability and Feasibility

The purchase price for the operation is $3,000,000 and will be met via equity from the proposed members' personal resources. The purchase for the real estate is $37,600,000 and will be met via equity of $3,008,000 from the proposed members of the realty entity and a loan of $34,592,000 at an interest rate of 6% for a 30-year term. BFA Attachment A shows the members of the realty entity have sufficient funds to meet the equity requirements.

Working capital requirements are estimated at $5,469,905, which is equivalent to two months of third-year expenses. The proposed members of the operating entity will provide equity from their personal resources to meet the working capital needs. Mr. Solomon Klein has submitted a disproportionate share affidavit attesting that he is willing to contribute personal resources disproportionate to his ownership interest in the entity. BFA Attachment A is the net worth statements of the proposed members of Ulster NH Operation, LLC, which indicates the availability of sufficient funds for the working capital requirement.

The submitted budget indicates a net income of $1,555,859 and $1,683,131 during the first and third years, respectively. Revenues are based on current reimbursement methodologies. The submitted budget appears reasonable.

As shown in BFA Attachment C, Golden Hill Nursing and Rehabilitation Center had an average positive working capital position and an average positive net asset position from 2019 through 2021. Also, the entity achieved an average net income of $1,651,508 from 2019 through 2021.

BFA Attachment D is the financial summaries for the other facilities owned by the proposed members. As shown in BFA Attachment E, all the affiliated nursing homes had an average positive working capital position and an average positive net asset position during the period shown except for Westhampton and

Clove Lakes. Westhampton had a negative working capital position in 2019 and Clove Lakes had a negative working capital position, negative net asset position, and losses in 2019 and 2020. All the other facilities that the proposed members own achieved an average net income for the period shown except for Clove Lake.

Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| LTCOP Attachment | Long Term Care Ombudsman Program Recommendation |
| BFA Attachment A | Net Worth Statement of Proposed Members of Operating Entity |
| BFA Attachment B | Ownership of the Realty Entity |
| BFA Attachment C | Financial Summary - Golden Hill Nursing |
| BFA Attachment D | Financial Summary - Other Owned Nursing Facilities |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# Public Health and Health Planning Council

## Project # 211087-E
## The Premier Center for Rehabilitation of Westchester, LLC d/b/a Springvale Nursing and Rehabilitation Center

***Program:*** **Residential Health Care Facility** ***County:*** **Westchester**
***Purpose:*** **Establishment** ***Acknowledged:*** **April 6, 2021**

## Executive Summary

### Description

The Premier Center for Rehabilitation of Westchester, LLC, an existing New York limited liability company, requests approval to be established as the new operator of Bethel Nursing and Rehabilitation Center, an existing 200-bed, Article 28 Residential Health Care Facility (RHCF) at 67 Springvale Road, Croton-On-Hudson (Westchester County), currently operated by The Bethel Springvale Hursing Home, Inc. Once approved by PHHPC, the facility will be named Springvale Nursing and Rehabilitation Center.

On October 30, 2020, Bethel Springvale Nursing Home Inc. entered a Purchase and Sale Agreement for the realty whereby 67 Springvale Road, LLC agreed to purchase the realty associated with the facility and lease the space to The Premier Center for Rehabilitation of Westchester, LLC. The Asset Purchase Agreement is for The Premier Center for Rehabilitation of Westchester, LLC (operations). An Adult Day Health Care Program (ADHDP) associated with Bethel Nursing and Rehabilitation Center will close and therefore is not part of this application.

The proposed ownership of the nursing home is as follows:

| **The Premier Center for Rehabilitation of Westchester, LLC** | |
|---|---|
| **Members** | **Interest** |
| Bethel Op Holdings, LLC | 42.5% |
| *Leah Sod (99%)* | |
| *Zahava Bobker (1%)* | |
| JSB Bethel Holdings, LLC | 42.5% |
| *Sorah Bleier (80%)* | |
| *Aharon Bleier (20%)* | |
| Joel Schwartz | 10% |
| Lisa Safia | 5% |
| **Total** | **100%** |

The Proposed realty owner is 67 Springvale Road, LLC whose members are listed below:

| **67 Springvale Road, LLC** | |
|---|---|
| **Members** | **Interest** |
| JLS Equities, LLC | 45% |
| *Jacob Sod (100%)* | |
| JSB Holdco, LLC | 45% |
| *Jonathan Bleier (100%)* | |
| Joel Schwartz | 10% |
| **Total** | **100%** |

### OPCHSM/OALTC Recommendation

Contingent Approval

## Need Summary

There will be no changes to beds or services as a result of this project. Occupancy, as of May 18, 2022, was 52.0% for the facility and 84.6% for Westchester County.

## Program Summary

The individual background review indicates the applicants have met the standard for approval as set forth in Public Health Law §2801-a(3)

## Financial Summary

The total purchase price is $40,000,000, allocated as follows: $8,000,000 for the operations and $32,000,000 for the realty interests. The Premier Center for the Rehabilitation of Westchester, LLC secured a loan with a payout period of 36 months at a rate of 6% amortized over 25 years for the operations. 67 Springfield Road, LLC submitted a letter of interest for $32,000,000 at a 6% interest rate for term 25-year term for the realty.

| Budget | Year One | Year Three |
|---|---|---|
| Revenues | $19,965,600 | $23,010,200 |
| Expenses | $19,711,929 | $22,427,429 |
| Net Income | $253,671 | $582,771 |

# Recommendations

**Long Term Care Ombudsman Program**
The LTCOP recommends Approval. (See LTCOP Attachment A)

Health Systems Agency
There will be no HSA recommendation for this project.

Office of Primary Care and Health Systems Management
**Approval contingent upon:**
1. Submission of an executed commitment for the purchase of the realty, acceptable to the Department of Health. [BFA]
2. Submission of an executed commitment for the purchase of the operations, acceptable to the Department of Health. [BFA]
3. Submission of an executed lease agreement acceptable to the Department. [BFA]
4. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR].
5. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will: a. Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program; b. Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility; and identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility and inform them about the facility's Medicaid Access policy, and c. Identify community resources that serve the low-income and frail elderly population who may eventually use the nursing facility and inform them about the facility's Medicaid Access policy. [RNR]
6. Submission of a photocopy of an executed Certificate of Amendment of the Articles of Organization of The Premier Center for Rehabilitation of Westchester, LLC, acceptable to the Department. [CSL]
7. Submission of a photocopy of an executed Certificate of Amendment of the Articles of Organization of Bethel Op Holdings LLC, acceptable to the Department. [CSL]
8. Submission of a photocopy of an executed Certificate of Amendment of the Articles of Organization of JSB Bethel Holdings LLC, acceptable to the Department. [CSL]
9. Submission of photocopy of an amended and executed Second Amendment of the Operating Agreement of The Premier Center for Rehabilitation of Westchester, LLC, acceptable to the Department. [CSL]
10. Submission of an executed Lease Agreement between 67 Springvale Road LLC and The Premier Center for Rehabilitation of Westchester, LLC, acceptable to the Department. [CSL]

**Approval conditional upon:**
1. This project must be completed by one year from the date of the recommendation letter, including all pre-opening processes, if applicable. Failure to complete the project by this date may constitute an abandonment of the project by the applicant and the expiration of the approval. It is the responsibility of the applicant to request prior approval for any extensions to the project approval expiration date. [PMU]

Council Action Date
December 8, 2022

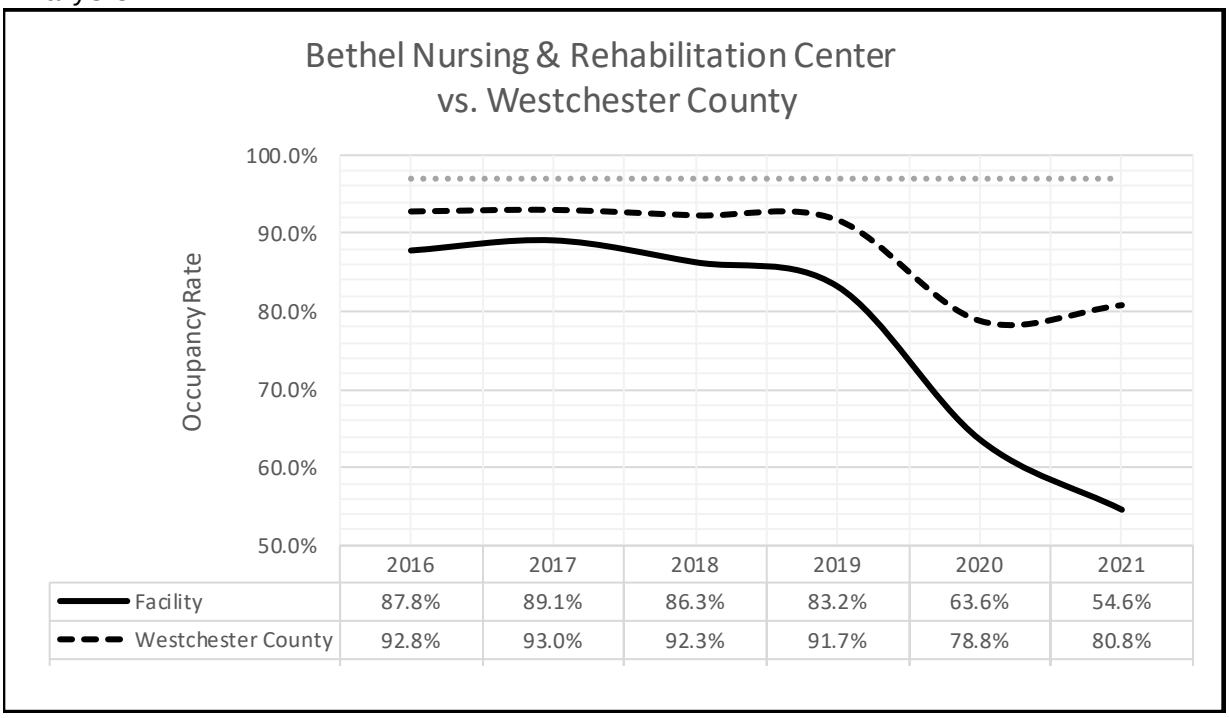
# Need and Program Analysis

Program Information

| | Existing | Proposed |
|---|---|---|
| **Facility Name** | Bethel Nursing & Rehabilitation Center | Springvale Nursing and Rehabilitation Center |
| **Address** | 67 Springvale Road<br>Croton-On-Hudson, NY 10520 | Same |
| **RHCF Capacity** | 200 beds | Same |
| **ADHCP Capacity** | Offsite – 25 | None |
| **Type of Operator** | Not-for-profit corporation | Limited Liability Company |
| **Class of Operator** | Voluntary | Proprietary |
| **Operator** | Bethel Springvale Nursing Home, Inc. | The Premier Center for Rehabilitation of Westchester, LLC<br><br>Members<br>Bethel Op Holdings LLC 42.5%<br>*Leah Sod* (99%)*<br>*Zahava Bobker (1%)*<br>JSB Bethel Holdings LLC 42.5%<br>*Sorah Bleier* (80%)*<br>*Aharon Bleier (20%)*<br>Joel Schwartz 10.0%<br>Lisa Sofia 5.0%<br><br>**Managing Member* |

The ADHCP is not included in the sale of this facility and is an excluded asset. No administrative services or consulting agreements are proposed in this application. The applicant does not intend to utilize any staffing agencies upon their assumption of ownership.

Analysis



2020 occupancy was impacted by COVID-19. Recently, the current operator has sent most new residents to two related facilities, Bethel Nursing Home Company and the Knolls.

In order to improve occupancy, the new operator intends to implement a new marketing plan to reposition the facility in the community, to promote the skills of the new operator, and to have a dedicated admissions team that will reach out to local hospitals and physicians to coordinate the continuation of patient care. Per the weekly census data, the occupancy, as of September 21, 2022, was 54.5% for the facility and 85.5% for Westchester County

Medicaid Access

To ensure that the Residential Health Care Facility needs of the Medicaid population are met, 10 NYCRR §670.3 requires applicants to accept and admit a reasonable percentage of Medicaid residents in their service area. The benchmark is 75% of the annual percentage of residential health care facility admissions that are Medicaid-eligible individuals in their planning area. An applicant will be required to make appropriate adjustments in its admission policies and practices to meet this benchmark which can be adjusted by the following factors:

- the number of individuals within the planning area currently awaiting placement to a residential health care facility and the proportion of total individuals awaiting such placement that are Medicaid patients and/or alternate level of care patients in general hospitals;
- the proportion of the facility's total patient days that are Medicaid patient days and the length of time that the facility's patients who are admitted as private paying patients remain such before becoming Medicaid eligible;
- the proportion of the facility's admissions who are Medicare patients or patients whose services are paid for under provisions of the federal Veterans' Benefit Law;
- the facility's patient case mix based on the intensity of care required by the facility's patients or the extent to which the facility provides services to patients with unique or specialized needs;
- the financial impact on the facility due to an increase in Medicaid patient admissions.

The facility's Medicaid admissions rate was below the threshold of 75% of the Westchester County rate for 2019 and 2020.

| Medicaid Access | 2019 | 2020 | 2021 |
|---|---|---|---|
| Westchester County Total | 28.4% | 31.3% | 27.2% |
| Westchester Threshold Value | 21.3% | 23.5% | 20.4% |
| Bethel Nursing & Rehab Center | **20.6%** | **19.6%** | 40.3% |

Character and Competence - Assessment

**Leah Sod** holds a bachelor's degree in psychology from Queens College and reports employment as a real estate consultant. They disclose the following health facility ownership interest:

New York Facilities

Massapequa Center Rehabilitation and Nursing Center (5%) 11/2017 to Present

**Zahava Bobker** is an Administrative Assistant at Premier Healthcare Management LLC in Great Neck, NY, with previous employment listed as a Customer Service Assistant at Fairmont Insurance Brokers Ltd. in Brooklyn, NY. They do not disclose any licenses or degrees. Zahava Bobker discloses the following health facility interests:

Maryland Facilities

Sterling Care at Frostburg Village (0.12%) 01/2018 to present
Sterling Care at South Mountain (0.12%) 01/2018 to present
Sterling Care Harbor Pointe (Asst. Living) (0.12%) 01/2018 to present

Pending

CON 192237 JAG Operating LLC d/b/a Foltsbrook Center for Nursing and Rehabilitation

**Aharon Bleier** is the current Director of Operations for Wym Op Holdings, and he indicates previous employment at Highfield Gardens Care Center as Accounts Receivable/ Accounts Payable Manager. Aharon Bleier holds a Rabbinical degree from Tiferes Israel. He discloses the following health facility interests:

New York Facilities
Massapequa Center for Nursing (5%) 11/2017 to present
Sunset Nursing & Rehabilitation (9.9%) 02/2019 to present

Pennsylvania Facilities
Wyomissing Health and Rehabilitation Center (80%) 10/2019 to present

Pending
CON 192237 JAG Operating LLC d/b/a Foltsbrook Center for Nursing and Rehabilitation

**Sorah Bleier** discloses employment at Peer Bais Yaacov of Rockland as a teacher, and previously she was a teacher at Beth Rochelle. She holds a teaching degree from BJJ Seminary. Sorah Bleier discloses the following health facility ownership interest:

New York Facilities
Highfield Gardens Care Center (9%) 09/2010 to present

**Lisa Sofia** discloses employment as a CEO/Consultant at BHO Services, the Executive Director at Deer Meadows Retirement Community (CCRC), and the CEO at Premier Healthcare Management LLC concurrently. She has a Master's Degree in Public Health Education from Saint Joseph's University. Lisa Sofia discloses the following health facility ownership interest:

Pennsylvania Facilities
Pleasant Acres (3%) 10/2018 to present
Willow TerraceWT Operating LLC (5%) 05/2018 to present

**Joel Schwartz** discloses employment at The Schwartz Group NY, LLC, as a healthcare investor, and previously he was employed as the General Manager for Medfast Billing, Inc., a medical billing company. He has a high school diploma. Joel Schwartz discloses the following health facility ownership interests:

New York Facilities
Leroy Village Green Residential Healthcare Facility (10%) 02/2019 to present
Sunset Nursing and Rehab Center (9%) 01/2019 to present

Florida Facilities
Manatee Springs Rehab and Nursing Center (7%) 04/2017 to present
Page Rehabilitation and Healthcare Center (10%) 01/2019 to present

Quality Review

| | CMS Star Rating Criteria - 10 NYCRR 600.2(b)(5)(iv) | | | | |
|---|---|---|---|---|---|
| | | Duration of Ownership | | | |
| | | < 48 Months | | 48 months or more | |
| **Proposed Owner** | **Total Nursing Homes** | **Number of Nursing Homes** | **Percent of Nursing Homes With a Below Average Rating** | **Number of Nursing Homes** | **Percent of Nursing Homes With a Below Average Rating** |
| Aharon Bleier | 3 | 2 | 50% | 1 | |
| Sorah Bleier | 1 | 0 | | 1 | 100% |
| Zahava Bobker | 2 | 0 | | 2 | 100% |
| Joel Schwartz | 4 | 3 | 66.66% | 1 | |
| Leah Sod | 1 | 0 | | 1 | |
| Lisa Sofia | 2 | 0 | | 2 | 100% |

*Duration of Ownership as of 12/8/2022*
*Data as of: 09/2022*

The proposed owners' portfolio includes ownership in four New York facilities. Two of the New York facilities have a CMS overall quality rating of average or higher.

Sunset Nursing and Rehabilitation Center currently has a one-star overall category. The applicant states: *Since Aharon Bleier and Joel Schwartz joined as shareholders of the facility in 2019, several steps have been taken to address quality and improve operations. These steps include implementing a new Electronic Medical Record system (in March 2019), which has improved efficiency and outcomes across all disciplines. Furthermore, the facility retained the services of an on-site consultant (in May 2021) to review quality and overall operations. These shareholders have also aligned the facility's policies and procedures with the shareholders' larger affiliated facilities to take advantage of best practices. This was a key factor in helping the facility maintain quality operations throughout the COVID-19 pandemic. Furthermore, the shareholders have implemented additional recruiter positions at the facility and throughout the organization to focus on interviewing and hiring high-quality staff members. Finally, the shareholders have strengthened the facility's clinical team by supplying regional Quality Assurance Nurses who provide routine audits of regulatory requirements.*

Highfield Gardens Care Center has a two-star overall category. The applicant states:
*The facility has hired a new administration team to achieve and maintain these improvements. Since the change in the senior management team, the facility has maintained five (5) stars in the Quality Measures rating. This rating has been maintained by conducting monthly Quality Measure meetings with the clinical and medical teams to review each resident's goal of care and to ensure that residents' needs are being met. The facility's last two (2) health inspections under the new leadership resulted in only two (2) minor, D-level tags. This facility was the first facility in New York State to have an annual, post-COVID-19 survey. Since that time, the facility improved from four (4) stars to five (5) stars in the Quality Measures rating, from one (1) star to three (3) stars in the Staffing rating and from one (1) star to three (3) stars in the Overall rating. However, the most-recent star rating calculation, which was based on May 2022 information, resulted in a decrease in the Staffing and Quality Measures categories based on an isolated nursing incident, which resulted in a loss of one (1) Health Inspection rating star, which then resulted in the facility receiving two (2) stars in the Overall category.*

The proposed owners' portfolio includes ownership in three Pennsylvania facilities, all of which are below average. Pleasant Acres Rehabilitation and Nursing is on the Special Focus Facility Candidate List. According to the applicant, this was the result of poor survey results from 2019. As such, the applicant is expecting that the facility will drop off the list within the next 90 days based on results from the last three annual surveys. Looking ahead, the facility is pleased to report that it had a very positive health inspection survey during the first quarter of 2022, and it is expected that the Health Inspection star rating will improve, as should the facility's overall star rating. In addition, the facility is in the process of hiring additional Registered Nurses and other staff, which should also serve to enhance the facility's staffing rating and the overall rating.

Willow Terrace Rehabilitation and Nursing Center currently shows two stars in the overall category. According to the applicant, the facility graduated from the Special Focus Facility program in 2020. The facility is expecting to receive the results of its most-recent survey any day and it is expected that this survey will result in minimal negative findings. As such, the applicant expects that this facility will have three stars in the near term.

The proposed owner's portfolio includes two Maryland facilities, two of which are below average. Sterling Care at Frostburg Village currently has a two-star rating overall rating. The applicant states: *This facility has not had a health inspection survey in more than three (3) years. However, the facility is pleased to report that it has moved from having one (1) star in the Overall category during 2018, 2019, 2020 and 2021 to having two (2) stars in the Overall category as of April 2022, due to its four (4) stars in the Quality Measures rating. The facility also reports that its Quality Measures rating is very close to becoming five (5) stars. As a result, it is expected that this facility's Overall rating will move up to three (3) stars within the near term.*

Sterling Care at South Mountain shows two (2) stars in the Overall category with five (5) stars in Quality Measures. The applicant states: *This facility was purchased in 2018 and the facility's last full recertification survey was in November of 2019, in which the facility received four (4) D-level (no harm*

*with the potential for minimal harm) deficiencies. The facility has not had a recertification survey in almost three (3) years. The Overall rating has been negatively impacted by the facility's Staffing rating of one (1) star. Over the past several years, the facility has experienced difficulties in hiring and retaining qualified RNs. As a result, the facility has hired Licensed Practical Nurses (LPNs) to provide the nursing coverage for its residents, despite the difficult circumstances in the labor market. Since the newly updated CMS staffing calculation provides for a higher value to be attributed to RNs versus LPNs, the facility's Staffing rating has decreased during 2022. To mitigate the effects of this situation, the facility utilizes the services of multiple nursing staffing agencies and continuously works to fill any gaps the facility may experience due to the shortage of qualified RNs.*

The proposed owner's portfolio includes two Florida facilities, one of which is below average. Page Rehabilitation and Healthcare Center currently has a two-star overall rating. The applicant states: T*he facility recently had its annual survey and the results were very positive and resulted in minimal deficiencies. As a result, the facility's overall star rating is expected to increase once these survey results are reflected in CMS records.*

| *Facility* | *Ownership Since* | *Overall* | *Health Inspection* | *Quality Measures* | *Staffing* |
|---|---|---|---|---|---|
| **New York** | | | | | |
| Bethel Nursing & Rehabilitation Center | Subject Facility | ** | ** | *** | ** |
| Highfield Gardens Care Center Of Great Neck | Current | **** | *** | ***** | ** |
| | 09/2010 | **** | *** | **** | **** |
| Leroy Village Green | Current | *** | *** | **** | *** |
| | 08/2019 | *** | ** | ***** | ** |
| Massapequa Center Rehabilitation and Nursing Center | Current | ** | ** | ***** | * |
| | 11/2017 | *** | ** | ***** | *** |
| Sunset Nursing and Rehab Center | Current | * | * | *** | * |
| | 01/2019 | ** | *** | *** | * |
| **Pennsylvania** | | | | | |
| Willow Terrace | Current | ** | *** | *** | * |
| | 05/2018 | ** | * | ***** | *** |
| Wyomissing Health And Rehabilitation Center | Current | *** | *** | **** | * |
| | 05/2016 | **** | *** | ***** | *** |
| Pleasant Acres Nursing And Rehabilitation Center † | Current | * | * | ** | * |
| | 10/2018 | ** | * | *** | **** |
| **Maryland** | | | | | |
| Sterling Care At South Mountain | Current | ** | ** | **** | ** |
| | 11/2018 | ** | ** | ** | ** |

| Facility | Ownership Since | Overall | Health Inspection | Quality Measures | Staffing |
|---|---|---|---|---|---|
| Sterling Care At Frostburg Village | Current | ** | ** | **** | * |
| | 11/2018 | * | * | *** | *** |
| **Florida** | | | | | |
| Manatee Springs Rehab and Nursing Center | Current | **** | *** | ***** | *** |
| | 04/2017 | * | * | *** | *** |
| Page Rehabilitation and Healthcare Center | Current | ** | * | ***** | *** |
| | 01/2019 | ** | * | ***** | **** |

***Data as of:*** *09/2022*

Enforcement History

Page Rehabilitation and Healthcare Center (Florida):

- The facility was assessed federal CMP's on 4/18/2022 in the amount of $3,618
- The facility was assessed federal CMP's on 4/11/2022 in the amount of $3,289
- The facility was assessed federal CMP's on 4/4/2022 in the amount of $2,960
- The facility was assessed federal CMP's on 3/28/2022 in the amount of $2,631
- The facility was assessed federal CMP's on 3/21/2022 in the amount of $3,542
- The facility was assessed federal CMP's on 3/14/2022 in the amount of $1,973
- The facility was assessed federal CMP's on 3/7/2022 in the amount of $1,645
- The facility was assessed federal CMP's on 2/28/2022 in the amount of $1,316
- The facility was assessed federal CMP's on 2/28/2022 in the amount of $987
- The facility was assessed federal CMP's on 2/14/2022 in the amount of $658
- The facility was assessed federal CMPs on 01/30/2020 in the amount of $92,563 and $92,564 for failing to honor the residents' right to request, refuse and or discontinue treatment and administer the facility in a manner that enables it to use its resources effectively and efficiently respectively.

Willow Terrace Nursing and Rehabilitation Center (Pennsylvania):

- The facility was assessed federal CMP's on 6/28/2021 in the amount of $650
- The facility was assessed federal CMP's on 4/28/2021 in the amount of $9,750
- The facility was assessed federal CMPs of $143,579 on 09/20/19 for not providing appropriate treatment and care according to orders, resident's preferences, and goals; and $16,544 on 10/31/18 for not ensuring food and drink are palatable, attractive, and at a safe and appetizing temperature.
- They also received a G level tag on 06/19/19 for not ensuring that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

Pleasant Acres (Pennsylvania):

- The facility was assessed a federal CMP of $111,813 on 09/03/21 for not developing and implementing a complete care plan that meets all the resident's needs, with timetables and actions that can be measured and protecting each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. The latter of these resulted in physical harm for one of three residents reviewed.
- The facility was assessed federal CMP's on 7/19/2021 in the amount of $650
- The facility was assessed federal CMP's on 3/30/2021 in the amount of $15,289
- The facility was assessed federal CMP's on 10/29/2020 in the amount of $22,750
- The facility was assessed federal CMP's on 7/15/2020 in the amount of $13,000
- The facility received a G tag on 02/01/19 for not ensuring that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents

- K tag on 08/29/19 for not providing appropriate treatment and care according to orders, resident's preferences and goals.

Sterling Care at Forstburg Village (Maryland):
- The facility was assessed federal CMP's on 4/11/2022 in the amount of $658
- They received a J level tag on 06/06/2019 for not providing appropriate treatment and care according to orders, residents' preferences, and goals.

Massapequa Center Rehabilitation and Nursing (New York):
- The facility was assessed a federal CMP on 2/21/2022 in the amount of $658.
- The facility was assessed a federal CMP on 5/4/2021 in the amount of $5,000 on 5/4/2021
- The facility was assessed a federal CMP of $7,036 on 03/01/19 for not protecting each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.
- The facility was fined $2,000 pursuant to Stipulation and Order NH 20-041 issued on 9/14/2020 for surveillance findings on 8/14/2020. Deficiencies were found under 10 NYCRR 415.19 (a) (1), (a)(2), and (b)(1) Isolation/social distancing.
- The facility was fined $10,000 pursuant to Stipulation and Order NH19-027 issued on 7/3/2019 for surveillance findings on 3/1/2018

Sunset Nursing and Rehab Center (New York):
- The facility was fined $2,000 pursuant to Stipulation and Order NH-21-206 issued on 11/17/2021 for surveillance findings on 7/21/2021. Deficiencies were found under 10 NYCRR sections 415.19 (a) and 415.19(b)(4) Infection control.
- The facility was assessed a federal CMP of $6,923 on 07/21/21 for not ensuring that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents, and not protecting each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

Highfield Gardens Care Center of Great Neck (New York):
- The facility was fined $2,000 pursuant to Stipulation and Order NH-21-222 issued on 11/23/2021 for surveillance findings on 9/21/2021. Deficiencies were found under 10 NYCRR 415.19(a) Infection Control
- The facility was fined $8,000 pursuant to Stipulation and Order NH21-050 issued on 3/13/2021 for surveillance findings on 1/7/2021. Deficiencies were found under 10 NYCRR sections 415.19(a) (1-2), 415.19 (b)(4), and 400.2 and Governors Executive Order 202.11. Deficiencies are for Infection Control, PPE, and Handwashing.
- The facility was fined $2,000 pursuant to Stipulation and Order NH20-071 issued on 9/15/2020 for surveillance findings on 8/13/2020. Deficiencies were found under 10NYCRR sections 419.19(a)(1), 415.19(a)(2) Infection Control – Facemask.

## Conclusion

The individual background review indicates the applicants have met the standard for approval as set forth in Public Health Law §2801-a(3). There will be no changes to beds or services as a result of this project.

# Financial Analysis

## Operating Budget

The applicant has provided an operating budget, in 2022 dollars, for the first and third years after the change of ownership. The budget is summarized below:

| | Current Year (2020) | | Year One (2023) | | Year Three (2025) | |
|---|---|---|---|---|---|---|
| | **Per Diem** | **Total** | **Per Diem** | **Total** | **Per Diem** | **Total** |
| Inpatient Revenues | | | | | | |
| Commercial FFS | $310.00 | $17,360 | $312.15 | $1,936,900 | $355.83 | $2,207,900 |
| Medicare FFS | $742.15 | 3,140,759 | $728.32 | 4,039,268 | $860.11 | 4,770,185 |
| Medicare MC | $712.43 | 1,077,196 | $728.28 | 1,383,732 | $742.85 | 1,411,415 |
| Medicaid FFS | $225.41 | 6,238,562 | $239.83 | 6,094,942 | $385.42 | 11,725,416 |
| Medicaid MC | $225.41 | 2,135,084 | $239.89 | 4,323,058 | $23.90 | 430,684 |
| Private Pay | $390.78 | 1,404,865 | $390.19 | 1,936,900 | $395.19 | 2,207,900 |
| Other* | | 278 | | 1,200 | | 1,200 |
| Medicare Part B | | 0 | | 249,600 | | 255,500 |
| Total Inpatient Rev. | | $14,014,104 | | $19,965,600 | | $23,010,200 |
| | | | | | | |
| ADHCP Revenues | | | | | | |
| Commercial FFS | $153.11 | $23,732 | | | | |
| Medicaid FFS | $152.47 | 128,071 | | | | |
| Private Pay | $128.00 | 1,024 | | | | |
| Total Outpt Rev. | | $152,827 | | | | |
| | | | | | | |
| Non-Oper. Rev. | | 3,352,235 | | | | |
| Total Revenues | | $17,519,166 | | $19,965,600 | | $23,010,200 |
| | | | | | | |
| Expenses | | | | | | |
| Operating Exp. | | $17,526,520 | | $14,039,397 | | $16,254,298 |
| Capital Exp. | | 1,089,774 | | 5,672,532 | | 6,273,131 |
| Total Exp. | | $18,616,194 | | $19,711,929 | | $22,427,429 |
| | | | | | | |
| Net Income/(Loss) | | ($1,097,028) | | $253,671 | | $582,771 |
| | | | | | | |
| Total Patient Days | | 46,543 | | 62,050 | | 69,350 |
| Total ADHCP Visits | | 1,003 | | 0 | | 0 |
| Occupancy (RHCF) | | 63.76% | | 85.00% | | 94.94% |

**Other revenue is Investment income, contributed services, and general contributions.*

The following is noted concerning the submitted budget:

- The Medicare and Private Pay rates are projected based on current market rates.
- ADCHP revenue and expenses are not included in Years One and Three as this will not be part of the future operation of the RHCF.
- Medicare utilization is expected to increase significantly in Years One and Three as the applicant plans to provide short-term rehabilitation resident service.
- The current year's Medicaid rate is based on the facility's current Medicaid experience.
- The budget indicates a plan to increase occupancy by working with hospitals, and community-based organizations and implementing a 24-hour-per-day admissions protocol to ensure easy access for discharge planners.

- The current year's occupancy is 63.76% due to the negative effects of COVID-19, but the facility is taking steps to increase occupancy. Pre-COVID-19 the facility's occupancy was at 83.2%, and the average occupancy for Westchester County was 84.6% as of 6/1/22.
- The applicant will add experienced staff to the facility to stabilize operations. The new operator will invest significant resources to market the facility effectively. This proposed marketing campaign will focus on communication and relationship building with area doctors, hospitals, and residents' family members regarding improvements made at the facility. The applicant states that similar marketing plans have been successful at the applicant's members' affiliated facilities.

Utilization by payor source is as follows:

| Payor | RHCF Current Yr. | RHCF Year 1 | RHCF Year 3 |
|---|---|---|---|
| Commercial FFS | .12% | 10.00% | 8.95% |
| Medicare FFS | 9.09% | 8.94% | 8.00% |
| Medicare MC | 3.25% | 3.06% | 2.74% |
| Medicaid FFS | 59.46% | 40.96% | 47.17% |
| Medicaid MC | 20.35% | 29.04% | 25.99% |
| Private Pay | 7.72% | 8.00% | 7.16% |
| Total | 100% | 100% | 100% |

Asset Purchase Agreement

The applicant has submitted a draft Asset Purchase Agreement (APA) for the RHCF's operating interest. The terms of the agreement are summarized below:

| | |
|---|---|
| Date: | October 30, 2020 |
| Seller: | The Bethel Springvale Nursing Home, Inc. (Operations) |
| Buyer: | The Premier Center for Rehabilitation of Westchester, LLC (Operations) |
| Rate: | 6% Letter of interest has been submitted from Capital Funding, LLC |
| Purchased Assets: | Operational Assets: Operations seller's rights, title, and interest in every kind, nature, and description owned or leased in connection with the business; sellers rights to deposits relating to prepayments or prepaid expenses; complete copies of all personnel records and payroll information; any insurance claims and rights concerning injury, damage or loss related or arising from the Purchased Assets; rights, title, and interest in regards to providing services and proprietary information agreements related to the business; all the seller's books and records relating to the operations of the business and medical records; any funds held in trust by the seller in connection with the resident's funds. |
| Excluded Assets: (Operational & Real Property) | Contracts of Seller that are not assigned or assumed; Seller's Medicaid provider number or provider status; the Adult Day Care Program operated by Seller; Vehicles that the seller currently owns; retroactive reimbursements concerning Medicaid, or settlements and or adjustments. |
| Purchase Price: | $8,000,000 for the operations. |
| Payment of Purchase Price: | The payout period is 36 months amortized over 25 years. A letter of interest has been provided to the Department for the purchase price. |

The applicant submitted a Medicaid affidavit, acceptable to the Department, where the applicant agrees, notwithstanding any agreement, arrangement, or understanding between the applicant and the transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor under Article 28 of the Public Health Law concerning the period before the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. As of June 5, 2022, the facility has outstanding Medicaid liabilities totaling $18,561, which will be added to working capital and, per the pro forma, paid out of operations.

## Purchase and Sale Agreement (Realty)

The applicant has submitted an executed (Purchase and Sale Agreement) for the RHCF's Realty Purchase Agreement. The terms of the agreement are summarized below:

| | |
|---|---|
| Seller: | The Bethel Springvale Nursing Home, Inc. |
| Buyer: | 67 Springvale Nursing Home, LLC |
| Purchase Price: | $32,000,000 |
| Rate: | 6% |
| Term: | 25 years. |
| Payment of Purchase Price: | Capital Funding, LLC has submitted a letter of interest. |
| Provisions: | Expected to be permanently refinanced through HUD 232/223F. If funding is not favorable, Sorah Bleier has provided an affidavit stating she will provide a balloon payment for the residual amount owed. |

This is a non-arm's length agreement between the parties as listed above in the narrative.

## Lease Agreement

The applicant submitted a draft lease agreement for the RHCF, the terms are summarized as follows:

| | |
|---|---|
| Date: | To-Be-Determined |
| Premises: | 200-bed RHCF 67 Springvale Road, Croton-On-Hudson (Westchester County). |
| Landlord: | 67 Springvale Road, LLC |
| Tenant: | The Premier Center for Rehabilitation of Westchester, LLC |
| Term: | 10-year term |
| Rental: | $4,500,000 annually, subject to an increase of 2% of the prior year's base rent, on each anniversary of the commencement date. |
| Provisions: | Lessee at its sole cost and expense will maintain, repair, or replace and restore the property to its original condition if necessary. Lessee shall not make alterations in the demised premises without the permission of Lessor. |

The Premier Center for rehabilitation of Westchester (Operations) has entered into a non-arm's length agreement with 67 Springfield Road, LLC (Realty), and The Premier Center for Rehabilitation of Westchester, LLC does have common ownership.

## Capability and Feasibility

There are no project costs associated with this application. The total purchase price for the operating interest and realty acquisition is $40,000,000; $32,000,000 for the Real Estate, and $8,000,000 for the operations. The Real Estate portion of the transaction will be met with a loan of $32,000,000 over 25 years at a 6% interest rate, for which Capital Funding, LLC provided a letter of interest. The purchase price for acquiring the operating interests is $8,000,000. The applicant submitted a draft APA for the purchase price of the facility operations at a rate of 6% for a 36-month term amortized over 25 years.

The working capital requirement is $3,627,738, based on two months of first-year expenses. BFA Attachment A shows that the members have sufficient funds via member equity to satisfy the funding requirement. In addition, Sorah Bleier has submitted a disproportionate share affidavit to any member of The Premier Center for Rehabilitation of Westchester, LLC that cannot meet the equity requirements.

BFA Attachment B is the 2019-2020 certified financial statements and the November 30, 2021 Internal financial statements for the facility. The facility experienced a negative working capital and equity position for both periods. The facility showed an operating loss of $1,776,120 in 2019 and $1,097,028, in 2020. The internal financial statements show negative working capital, net asset positions, and an operating loss of $161,708. These losses were driven by the negative effects of the COVID-19 pandemic. Before the pandemic, the facility planned to increase occupancy by working with providers seeking facility admissions, a robust marketing program that will also work with local hospitals, and a dedicated admissions team who will work with physician groups and groups to coordinate the continuation of patient care.

The submitted budget shows a projected net income of $253,671 and $582,771 for the first and third years. The budget appears reasonable. BFA Attachment C is the pro forma to the financial position on the first day of operations showing members' equity of $3,657,000.

Attachment D is a financial summary using the certified financial statements for the affiliated facilities. Massapequa Center for Rehabilitation and Nursing (2021); Wedgewood Care Center, Inc (2020); and Leroy Village Green Residential Health Care Facility (2021) had positive working capital, working capital, and net income position. Sunset Nursing and Rehabilitation (2020) had negative working capital and net asset position and incurred an operating loss of $1,250,219 due to the COVID-19 pandemic and increasing operating expenses.

### Conclusion

The applicant has demonstrated the capability to proceed in a financially feasible manner.

## Attachments

| | |
|---|---|
| LTCOP Attachment A | Long Term Care Ombudsman Program Recommendation |
| BFA Attachment A | Net Worth-Operations - The Premier Center for Rehabilitation of Westchester<br>Net Worth- Realty- 67 Springvale Road, LLC, (Realty Interest) |
| BFA Attachment B | Bethel Springvale Nursing Home Inc. 2019-2020 Certified Financial Statements and 2021 Internal Financial Statement |
| BFA Attachment C | Pro Forma Balance Sheet |
| BFA Attachment D | Affiliated Residential Health Care Facilities. |