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

#### ANNUAL MEETING

#### <u>AGENDA</u>

February 12, 2015

10:00 a.m.

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

#### I. <u>INTRODUCTION OF OBSERVERS</u>

Jeffrey Kraut

## II. <u>ELECTION OF OFFICERS</u>

- A. Election of Vice Chairperson
- B. Announce Committee Chairpersons and Vice Chairpersons and Committee Membership
  - Committee on Codes, Regulations and Legislation
  - Committee on Establishment and Project Review
  - Committee on Health Planning
  - Committee on Public Health
  - Ad Hoc Committee to Lead the State Health Improvement Plan

## III. APPROVAL OF MINUTES

Exhibit #1

December 4, 2015

#### IV. REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

#### A. Report of the Department of Health

Howard A. Zucker, M.D., J.D., Acting Commissioner of Health

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

Daniel Sheppard, Deputy Commissioner, Office of Primary Care and Health Systems Management

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

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

#### D. Report of the Office of Quality and Patient Safety

Patrick Roohan, Director, Office of Quality and Patient Safety

#### V. PUBLIC HEALTH SERVICES

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

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

#### VI. REGULATION

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

Exhibit #2

Angel Gutiérrez, M.D., Chair

#### For Emergency Adoption

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

#### For Adoption

11-02 Amendment of Section 415.3(h) of Title 10 NYCRR (Nursing Home Transfer and Discharge Rights)

#### VII. PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

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

Jeffrey Kraut, Chair of Establishment and Project Review Committee

## A. <u>APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES</u>

<u>CATEGORY 1</u>: Applications Recommended for Approval – No Issues or Recusals,

Abstentions/Interests

#### **CON Applications**

#### **Acute Care Services - Construction**

	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142181 C	Orange Regional Medical Center (Orange County)	Contingent Approval

## **Ambulatory Surgery Centers - Construction**

Exhibit #4

	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142134 C	Mohawk Valley Eye Surgery Center (Montgomery County)	Contingent Approval

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

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

## **CON Applications**

#### **Acute Care Services - Construction**

	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142081 C	Huntington Hospital (Suffolk County) Mr. Kraut - Recusal	Contingent Approval
2.	142168 C	Westchester Medical Center (Westchester County) Dr. Berliner – Interest	Contingent Approval
3.	142083 C	Southside Hospital (Suffolk County) Mr. Kraut – Recusal	Contingent Approval
4.	142185 C	New York Presbyterian Hospital – New York Weill Cornell Center (New York County) Dr. Brown – Recusal	Contingent Approval
5.	142228 C	Strong Memorial Hospital (Monroe County) Ms. Hines – Recusal	Contingent Approval

#### **Residential Health Care Facilities - Construction**

Exhibit #6

	<u>Number</u>	Applicant/Facility	<b>E.P.R.C. Recommendation</b>
1.	132305 C	Jewish Home of Rochester (Monroe County) Ms. Hines - Interest	Contingent Approval

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

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

#### **NO APPLICATIONS**

**<u>CATEGORY 4</u>**: Applications Recommended for Approval with the Following:

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

#### NO APPLICATIONS

**CATEGORY 5**: Applications Recommended for Disapproval by OHSM or

Establishment and Project Review Committee - with or without

Recusals

NO APPLICATIONS

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

#### NO APPLICATIONS

B. <u>APPLICATIONS FOR ESTABLISHMENT AND</u> CONSTRUCTION OF HEALTH CARE FACILITIES

<u>CATEGORY 1</u>: Applications Recommended for Approval – No Issues or Recusals,

Abstentions/Interests

#### **CON Applications**

**Ambulatory Surgery Centers – Establish/Construct** 

	<u>Number</u>	Applicant/Facility	<b>E.P.R.C. Recommendation</b>
1.	141253 E	South Brooklyn Endoscopy Center (Kings County)	Contingent Approval
		4	

Diagnostic and Treatment Centers – Establish/Construct			Exhibit #8
	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142152 E	Odyssey Community Services, Inc. (New York County)	Contingent Approval
Resid	ential Health Care Fac	ility – Establish/Construct	Exhibit #9
	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142195 B	Delhi Rehabilitation & Nursing Center (Delaware County)	Contingent Approval
Certif	fied Home Health Agen	Exhibit #10	
	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142193 E	Kindred Healthcare (Saratoga County)	Contingent Approval
<b>HOM</b>	IE HEALTH AGENCY	Exhibit #11	
	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
	2276 L	1 <sup>st</sup> Class Care Services, Inc. (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)	Contingent Approval
	2178 L	All Heart Homecare Agency, Inc. (New York, Richmond, Kings, Bronx, Queens, and Westchester Counties)	Contingent Approval
	2292 L	Angels of Mercy Counseling Center, Inc. (Nassau Suffolk Queens and Westchester Counties)	Contingent Approval

2272 L	A Plus Homecare Agency, Inc. (Queens, Bronx, New York, Kings, Richmond, and Nassau Counties)	Contingent Approval
2037 L	Bright Home Care, Inc. (New York, Bronx, Kings, Richmond, Queens and Westchester Counties)	Contingent Approval
2266 L	Central Westchester Home Health Services, LLC (Westchester County)	Contingent Approval
2268 L	Chinatown Home Health Care, Inc. (New York, Bronx, Kings, Queens, Richmond and Nassau Counties)	Contingent Approval
2395 L	Ciambella Home Care, Inc. d/b/a FirstLight Home Care of East Buffalo (Erie and Niagara Counties) Deferred at the Department's Request	
2218 L	Comprehensive Elder Care, LLC (Bronx, Richmond, Kings, New York, Queens, and Nassau Counties)	Contingent Approval
2285 L	Elite Home and Community Care Service, Inc. (Rockland, Putnam, Westchester, Orange and Bronx Counties)	Contingent Approval
2254 L	Ellison Home Care Companion Agency, Inc. (Nassau, Westchester, Rockland, Queens, and Suffolk Counties)	Contingent Approval

2247 L	Grupp KK, Inc. (Bronx, Richmond, New York, Queens, Kings, Westchester Counties)	Contingent Approval
2152 L	Guiding Angels Home Care, LLC (Bronx, Kings, New York, Richmond, Queens and Nassau Counties)	Contingent Approval
2138 L	Home at Last Home Care Services, LLC (Kings, Bronx, Queens, Richmond, and New York Counties)	Contingent Approval
2175 L	Human First Community Health Care, LLC (Nassau, Suffolk and Queens Counties)	Contingent Approval
2215 L	La'Dorch Homecare, Inc. (Bronx, Richmond, Kings, New York, Queens, and Westchester Counties)	Contingent Approval
2261 L	Marabi Homecare Agency, Inc. (New York, Richmond, Kings, Bronx, Queens, and Nassau Counties)	Contingent Approval
2274 L	Masih Home Care Incorporated (Queens, Kings, Richmond, New York, Bronx, and Nassau Counties)	Contingent Approval
2202 L	MY Care Health Services, Inc. (Queens, New York, Bronx, Richmond, Kings, and Nassau Counties)	Contingent Approval

2244 L	New Hope Services, Inc. (Bronx, Richmond, New York, Queens, Kings and Westchester Counties)	Contingent Approval
2259 L	NMC Homecare Agency of NY, Inc. (New York, Richmond, Kings, Bronx, Queens, and Westchester Counties)	Contingent Approval
2176 L	Augusta Osinowo d/b/a Nightingale Care Services (Bronx, Queens, New York, Richmond, Kings, and Nassau Counties)	Contingent Approval
2157 L	Passion for Seniors of NY, Inc. (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)	Contingent Approval
2299 L	Premium Home Services, LLC (Queens, Kings, Bronx, New York, Richmond, and Nassau Counties)	Contingent Approval
2279 L	Scope Healthcare Services, Inc. (Suffolk, Nassau and Queens Counties)	Contingent Approval
2163 L	Global Private Home Care LLC (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)	Contingent Approval
2461 L	Alice Hyde Medical Center (Franklin County)	Contingent Approval
2295 L	Hyde Park Assisted Living Facility, Inc. d/b/a Hyde Park Licensed Home Care Agency (Dutchess County)	Contingent Approval

2319 L	Acare HHC, Inc. d/b/a Four Seasons Home Care (Bronx, Queens, Kings, Richmond, Nassau and New York Counties)	Contingent Approval
2281 L	Anchor Home Care LLC (Allegany, Erie, Orleans, Cattaraugus, Genesee, Wyoming, Chautauqua and Niagara Counties) Deferred at the Department's Request	
2389 L	Crown of Life Care NY, LLC (Bronx, Queens, Kings, Richmond, Nassau and New York Counties)	Contingent Approval
2342 L	Elite HHC, LLC (Bronx, Richmond, Kings, Westchester, New York and Queens Counties)	Contingent Approval
2401 L	Prestige LHCSA Management, Inc. (Bronx, Richmond, Kings, Westchester, New York and Queens Counties)	Contingent Approval
2556 L	Quality Care – USA, Inc. d/b/a Gentiva Health Services (See exhibit for counties served)	Contingent Approval

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

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

## **CON Applications**

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

	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	142218 E	NYU Lutheran Medical Center (Kings County) Dr. Kalkut – Recusal	Contingent Approval
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### **CATEGORY 3:** Applications Recommended for Approval with the Following:

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

#### NO APPLICATIONS

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

- **❖** PHHPC Member Recusals
- **Second Second S**
- Contrary Recommendation by HSA

#### **CON Applications**

## Residential Health Care Facility – Establish/Construct

Exhibit #13

	<u>Number</u>	Applicant/Facility	<b>E.P.R.C.</b> Recommendation
1.	142115 E	Pure Life Renal of Buffalo, Inc. (Erie County) Dr. Bhat – Interest Dr. Martin – Abstained at EPRC	Contingent Approval

#### **CATEGORY 5**: Applications Recommended for Disapproval by OHSM or

Establishment and Project Review Committee - with or without

Recusals

#### NO APPLICATIONS

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

#### **Dialysis Services – Establish/Construct**

	<u>Number</u>	Applicant/Facility	E.P.R.C. Recommendation
1.	132178 E	Big Apple Dialysis Management, LLC (Kings County) Dr. Bhat – Recusal Dr. Boufford - Recusal Dr. Martin – Recusal Dr. Yang - Recusal	No Recommendation

## VIII. PROFESSIONAL

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

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

## IX. <u>NEXT MEETING</u>

March 26, 2015 - ALBANY April 16, 2015 - ALBANY

## X. ADJOURNMENT

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

## Minutes December 4, 2014

The meeting of the Public Health and Health Planning Council was held on Thursday, December 4, 2014, at the Century House 997 New Loudon Road (Route 9), Main Ball Room, Latham, New York. Council member Mr. Peter Robinson presided.

#### **COUNCIL MEMBERS PRESENT**

Dr. Howard Berliner	Dr. Gary Kalkut
Dr. Jodumatt Bhat	Dr. Arthur Levin
Mr. Christopher Booth	Dr. Glenn Martin
Dr. Carla Bouton-Foster	Ms. Ellen Rautenberg
Dr. Lawrence Brown	Dr. John Rugge
Ms. Kathleen Carver-Cheney	Mr. Peter Robinson
Mr. Michael Fassler	Dr. Anderson Torres
Ms. Kim Fine	Dr. Patsy Yang
Dr. Angel Gutierrez	
Ms. Vicky Hines	
Mr. Thomas Holt	

#### DEPARTMENT OF HEALTH STAFF PRESENT

Mr. Charles Abel Ms. Nancy Agard Ms. Karen Madden Mr. Udo Ammon Ms. Lisa McMurdo Ms. Anna Colello Ms. Joan Cleary Miron Ms. Barbara DelCogliano Ms. Elizabeth Misa Mr. Christopher Delker Ms. Lakia Rucker Mr. James Dering Ms. Linda Rush Ms. Alejandra Diaz Mr. Keith Servis Mr. James Horan Mr. Michael Stone Ms. Yvonne Lavoie Ms. Lisa Ullman Ms. Colleen Leonard Ms. Diana Yang

Ms. Ruth Leslie

#### **INTRODUCTION**

Mr. Robinson called the meeting to order and welcomed Council members, meeting participants and observers. He mentioned that Mr. Sheppard would provide the Report on the Department of Health Activities in Commissioner Zucker's absence and that the Dr. Birkhead would provide an update on the Office of Public Health activities at the next meeting.

#### APPROVAL OF THE MINUTES OF OCTOBER 2, 2014

Mr. Robinson asked for a motion to approve the October 2, 2014 Minutes of the Public Health and Health Planning Council meeting. Dr. Gutierrez motioned for approval which was seconded by Dr. Berliner. The minutes were unanimously adopted. Please refer to page 34 of the attached transcript.

#### REPORT OF DEPARTMENT OF HEALTH ACTIVITIES

Mr. Robinson turned the floor over to Mr. Sheppard to give the Report on the Department of Health Activities.

#### **EBOLA**

Mr. Sheppard reported that New York had its first Ebola patient, Dr. Craig Spencer, in mid-October. Dr. Craig Spencer was working in Guinea for Doctors without Borders when he contracted the virus. Six days after his return he came down with Ebola symptoms and went to Bellevue Hospital Center where he was isolated and treated for three weeks. His discharge from Bellevue was a much celebrated event that demonstrated New York's ability to successfully treat this disease. Since claiming its first victim last December, Ebola has effected more than 16,900 people in eight countries of which more than 6,000 people have died. The collective preparedness efforts by the health departments and hospitals kept others from getting sick, including the healthcare workers who took care of Dr. Spencer.

Mr. Sheppard advised that New York began preparing for an Ebola patient long before Dr. Spencer got sick. New York is a State with more than 19 million people and we are home to a city that is an international travel hub, with more than 8 million people. We have one of five major U.S. Airports, JFK New York City, which allows flights from countries where Ebola has become widespread. Since October, travelers from effected countries have gone through an initial health screening. They are then referred to state and local public health authorities for active monitoring of Ebola symptoms. The monitoring goes on for 21 days following their last day of potential exposure to Ebola. Since the program began, health officials have monitored over 3,000 travelers more than 30,000 times.

Mr. Sheppard stated that knowing the risk for having a patient with Ebola was high, New York was the first state in the nation to designate hospitals for the care of patients with Ebola. At the Governor's request, 10 hospitals across the State agreed to serve as designated centers for treating people with confirmed cases of Ebola. He was pleased to announce that five of New York's designated hospitals have been approved by the CDC for inclusion on a list of U.S. facilities that will serve as Ebola treatment centers. The five CDC approved hospitals are the North Shore System in Glen Cove, New York; New York City Montefiore Health System; New York Presbyterian Hospital, the Allen Pavilion; Bellevue Hospital Center and Mt. Sinai Hospital. These five centers are among 35 hospitals in the country designated by the U.S. Department of Health and Human services as having the capabilities, training, and resources to provide the complex and extensive treatment that an Ebola patient requires while minimizing the risk to healthcare workers. They have undergone an intensive assessment by the CDC's Rapid Ebola Preparedness Team. The Department has requested the CDC to survey the other five hospitals in New York State so that they may also be added to the federal list. The remaining five hospitals are Erie County Medical Center in Buffalo, SUNY Stony Brook University Hospital on Long Island, SUNY Upstate Medical University in Syracuse, University

of Rochester Medical Center, and the Women's and Children's Hospital of Buffalo.

Mr. Sheppard noted that the Department continues to work with CDC and local health departments to ensure that these centers maintain the necessary state of readiness with respect to facilities, workforce, training, labs, and waste management, all of which are required to safely and effectively treat a patient with Ebola. The rapid Ebola response teams have assessed each facility on all infection control aspects of caring for a patient with Ebola from the use of personal protective equipment or PPE to details like how trash is removed from a patient's room. They also ensure that staff involved in the caring for a patient with Ebola has been appropriately trained. That means that the staff involved have demonstrated that they know how to put on and take off PPE, they know the appropriate protocols for proper waste management, they know how to do infection control, they know how to safely transport lab specimens, and that these designated hospitals also have processes in place to support the physical and emotional wellbeing of the staff providing care for someone with Ebola. It's important to note the hospital staff caring for patients with Ebola will not be providing care to other patients which will limit potential exposure to other patients.

Mr. Sheppard advised that at Governor Cuomo's request, Dr. Zucker issued a Commissioner's order on October 16, 2014, that outlined hospital preparation protocols. The order required hospitals to develop protocols, training, and drills, provide personal protective equipment and identify a care setting to ensure that early recognition safe handling a suspect Ebola patients is possible. The Commissioner's order also required all hospitals and clinics in the State to be ready to evaluate, isolate, and transport a person suspected of having Ebola. Additionally, the Department has begun to do readiness assessments for nearly 1,000 clinics; meet with state EMS providers to review their protocols for safe transportation; spoken with community health centers and other providers to ensure they were also ready for an Ebola patient or suspect Ebola patient; amassed its own stockpile of PPE for hospitals who are unable to replenish their supplies in the midst of treatment; and done practice drills for early identification and isolation of suspect Ebola patients in an emergency department.

Mr. Sheppard mentioned that as of November 21, 2014, there have been eight cases in Mali, six of which have died. As a result, both the CDC and Department of Homeland Security have added Mali to the list of Ebola affected nations and they're screening all travelers coming into the U.S. each day from Mali, as well as those from Liberia, Sierra Leone, and Guinea. Although there are no direct flights between the U.S. and Mali, approximately 15 to 20 residents of Mali do arrive in the United States every day by way of other countries. Most of these people are U.S. citizens coming home to America. In light of this possibility, we started enhancing our screening for travelers who originated in Mali. They'll be subject to the same 21 day monitoring and movement protocols now in effect for travelers from Guinea, Liberia, and Sierra Leone. That means twice daily temperature checks as well as check-ins with the state and local public health authorities.

#### WOLRD AIDS DAY

Mr. Sheppard reported that the Department held its annual World Aids Day event on December 1, 2014, at the Empire State Plaza. It was an event that galvanized the AIDS community in our resolve to combat this disease and help us to remember those we have lost to it. New York is at a turning point where we can actually envision a future without AIDS. It has

been a long and difficult journey due to the fact that New York has been at the epicenter of this epidemic since it began in the 80s. In our darkest days the early 90s, New York had as many as 15,000 new diagnoses a year. Today we are down to 3,000 new diagnoses a year. Many factors played a role in what has happened: better prevention strategies such as free syringe distribution programs for the injectable drug users, more education and awareness such as our mandated offers of HIV testing, and improvements in healthcare including the newly approved use of antiretroviral medications for people who are HIV negative and want to stay that way. When we talk about the end of the epidemic, we are talking about bringing down the number of new infections to just 750. Last month, Governor Cuomo announced the creation of the ending the epidemic task force. To help us achieve our goals, this group will support his three point plan which includes identifying persons with HIV who remain undiagnosed and linking them to healthcare, linking and retaining persons diagnosed with HIV in healthcare to maximize virus suppression so they remain healthy and prevent further transmission, and providing access to pre-exposure prophylaxis or PREP for high-risk persons to keep them HIV negative. The plan will alter the future of AIDS in New York State. It will also demonstrate the power of public health and good healthcare and showcases what we've achieved in New York.

#### NY STATE OF HEALTH

Mr. Sheppard advised that the Council that New York State of Health, the marketplace healthcare exchange, is currently in its second year. To date, more than 960,000 New Yorkers were enrolled during the first enrollment period which puts the Department well-ahead of its one million people insured by 2016 goal. The enrollment process began November 15<sup>th</sup> and ends February 15, 2015. The premiums for the 2015 plans will continue to be more than 50 percent lower than they were before the marketplace was created. Nearly 75 percent of the people enrolled received financial assistance that helped further lower their monthly costs. The Exchange is also enhancing its outreach efforts by providing some of the informational materials in 10 languages including Arabic, Hindu and Yiddish. Additionally, the website has been enhanced and a new Spanish version was created. Consumers in many counties will have more health plan options to choose from in 2015. Many new features were added such as a compare guide that lets consumers see all available plans in their county before they begin their application. Consumers will also get a personalized premium quote without entering personal information and completing the application.

#### DISASTER PREPAREDNESS

In closing, Mr. Sheppard stated that Dr. Zucker wanted to express thanks to the people in Western New York and all those who assisted in recovery from the recent series of snow storms. These people worked hard to ensure the health and safety of people affected by the recent storms was protected. Dr. Zucker was personally there for several days and saw how hard people were working to keep communities safe from all the snow and subsequent potential for flooding.

Mr. Sheppard concluded the report. Mr. Robinson thanked him and inquired if members had questions or comments. To see the complete report and comments from members, please see pages 34 through 50 of the attached transcript.

## Report of the Office of Health Insurance Programs Activities

Next, Mr. Robinson introduced Ms. Misa to give Report of Activities of the Office of Health Insurance Programs.

#### DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

Ms. Misa reported that the Department is on track with its year one deliverables. There are currently 25 PPSs statewide. On October 1, 2014, the final DSRIP plan application was released, and on December 1, 2014, LEAD submitted their final partner lists within the network tool. Project plan applications must be completed and submitted by the PPS lead on December 22, 2014, and will be posted to the website on December 24, 2014. The public comment period will be held from December 24 to January 26, 2015. In early February, the independent assessor will make recommendations to the public. The DSRIP project approval and oversight team will begin public meetings in mid-February and will make their final recommendations to the state in March. DSRIP year one will begin on April 1, 2015. There is a lot of work to be accomplished within a very tight timeline, but the Department is on track. All information can be found on the Department's DSRIP website.

Ms. Misa concluded the report. Mr. Robinson thanked her and inquired if members had questions or comments. To see the complete report and comments from members, please see pages 50 through 55 of the attached transcript.

#### Report on the Office of Quality and Patient Safety Activities

Mr. Robinson introduced Mr. Roohan to give the report of Activities of the Office of Quality and Patient Safety.

Mr. Roohan advised that the Office of Quality and Patient Safety is made up of four core areas: quality improvement in patient safety, evaluation measurement reporting and transparency, data system enhancement and development, and healthcare transformation. Under quality improvement and patient safety, one of the projects is to improve sepsis care in New York State. Regulations have given the Department authority to review evidence-based protocols from hospitals, measure process measures of sepsis care, and develop a risk-adjusted mortality model to compare hospitals. Much of the project's success is a combination of hospitals participation and an incredible workgroup of stakeholders. The first review of the evidence-based protocols were in by December 31, 2013, and have all been approved. Additionally, two quarters have been collected thus far and once the data is cleaned up, the stakeholder workgroup will develop a data dictionary. The goal is to continue to evaluate the data and eventually evaluate the impact on mortality. Staff will continue to work diligently on this project as sepsis mortality is a serious condition and the number one cause of inpatient mortality in New York State.

Mr. Roohan reported that staff have been the lead on quality measurement of health plan reporting for the Department for over 20 years. Staff have been collecting data on quality assurance reporting requirements (QARR) from various managed care plan types; measurement and alignment; collection reporting for health homes and proposed fully integrated duals (FIDA) program; DSRIP; HARP – the health and recovery plans, Medicaid behavioral health plans; managed long term care programs; and the cardiac data reporting system.

Mr. Roohan stated that staff are developing an all-payer database (APD) for processing claims throughout the state. The process will begin with what public payers, such as Medicaid, Child Health Plus and the New York State of Health. The data intake system which collects data for the public payers began this fall. Medicare data will be added in 2015 and commercial insurance data collection will begin in late 2015. Funds were made available in the 2014-2015 budget to create the APD. The procurement process has been initiated to procure a vendor to do data storage and analytics from the system. Staff anticipate the system to be cost approximately \$1.1 to \$1.5 billion for a billion rolls of data yearly. APD regulations are in development which will address the submission requirements and process, data access levels, and what information can and cannot be released. Additionally, revised regulations were issued last year regarding the state's health planning and research cooperative systems (SPARCS). These revisions included clarification on how data is collected, a streamlined approval process, and a reduced waiting time for retrieving SPARCS data.

Mr. Roohan mentioned that his office has been heavily involved in healthcare transformation. One featured program is the State Health Innovation Plan which was submitted to the federal government last year which produced a four-year model grant for \$10 million. Staff have been working very closely with Medicaid and all the measurement activities related to DSRIP including measures, specifications, reporting, and interaction with CMS. Additionally, staff have worked very closely with OHIP staff to include a lot of data on publicly available data, and DSRIP core metrics which are preventable, prevention quality indicators (PQIs) and potentially preventable readmissions (PPRs).

#### OFFICE BASED SURGERY

Dr. Gesten reported that an Ad Hoc Office Based Surgery Advisory Committee was created in August and briefly listed the names of its members. The major objectives of the Committee are to review adverse event data with a focus on office-based surgery related deaths to identify potential systemic and preventable issues, make recommendations to enhance data collection, and improve patient safety for those individuals who are having office-based surgery procedures. The committee held a conference call on September 30, 2014, and met on November 13, 2014, in New York City. More meetings have been scheduled for 2015. It is anticipated that the work of the group in terms of concluding its recommendations and report should take between six to ten months.

Dr. Gesten advised that the Committee had done an additional analysis of the office-based surgery adverse event data that was received from 2010 to 2013 which focused on deaths, particularly those involving vascular and GI procedures. The majority of the office-based surgery deaths involve end stage renal disease patients who are on dialysis and receiving various kinds of surgical interventions to correct shunt abnormalities and/or deal with shunt dysfunction.

Dr. Gesten stated that future plans include reviewing data on 2014 deaths and those going forward with external experts, matching the adverse event data to vital statistics death data, and examining the data collection protocols from the office-based surgery accrediting bodies. The Committee is also continuing to pursue electronic submissions as a method of reporting adverse events to try to decrease the barriers or the burden of making adverse events reports to the Department. The ultimate goal is to resubmit the amendments to OBS legislation that were supported and submitted by PHHPC last year.

Mr. Robinson thanked both Dr. Gesten and Mr. Roohan, and inquired if members had questions or comments. To see the complete report and comments from members, please see pages 56 through 77 of the attached transcript.

## **PUBLIC HEALTH SERVICES**

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

Mr. Robinson introduced Ms. Rautenberg to give her Report of the Committee on Public Health.

Ms. Rautenberg reported that the Prevention Agenda is now two years old and the local planning activities are ending year one. Due to the decreased traction from the implementation cycle to the implementation cycle, members are now highly focused on the implementation of the local plans between local health departments, hospitals, and their community partners.

Ms. Rautenberg informed members that a work group was created to address health disparities which met in September. The discussion highlighted disparities within the five prevention goals and what the attendees respective organizations are doing to try to tackle the issue of health disparities. The Office of Minority Health and Health Disparities will be issuing a statutorily required report on health equity in the near future. The Committee offered to help them communicate the findings of the report throughout the state and make sure that the local partnerships are aware of and have access to data on health disparities.

Ms. Rautenberg mentioned that a meeting was held for localities that are working on promoting mental health and the prevention of substance abuse, the second most chosen priority within the Prevention Agenda. The New York State Health Department, along with the New York State Office of Mental Health, the Office of Alcohol and Substance Abuse, and the New York State Association of County Health Officials, the Conference of Local Mental Health Agencies, and the New York Academy of Medicine hosted a one-day meeting to provide training and technical assistance to communities that selected this particular Prevention Agenda item as one of their top two. There were approximately 29 counties in attendance, along with their government counterparts, hospital partners, and community partners. The discussion focused on evidence-based interventions in areas around suicide prevention, prescription drug prevention, tobacco cessation for those with mental illness, and ESBERT. The meeting was an opportunity for communities to share what they were doing and learn from each other.

Ms. Rautenberg advised that department staff will be sending out surveys to the local health departments and hospitals to measure their progress on Prevention Agenda items since plan submissions in 2013. The workgroup plans to meet in early February to analyze the survey results and provide a summary at a future Council meeting.

Ms. Rautenberg concluded her report. Mr. Robinson thanked her and inquired if members had questions or comments. To see the complete report and comments from members, please see pages 78 through 80 of the attached transcript.

#### **HEALTH POLICY**

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

Mr. Robinson introduced Dr. Rugge to give the Report on the Activities of the Health Planning Committee.

Dr. Rugge reported that two sessions were held on development criteria for the approval of off-campus EDs, where there has been no ED previously. There is a mechanism in place for recognition of off-campus EDs when a hospital closes but the ED continues. Through committee discussion, the determination was to focus on both the distance from the nearest available existing emergency department and the size of the population. The Department is now working on a proposal to present to the full Council at a later date.

Dr. Rugge stated that the Committee discussed a proposal to designate Nicholas Noyes Memorial Hospital as a stroke center. There was a brief discussion on the specifics of the application, specifically its contingencies. Dr. Rugge then motioned to approve the designation of Nicholas Noyes Hospital as a stroke center pending fulfillment of the last contingency. The motion was seconded by Dr. Gutierrez; the motion was approved.

Dr. Rugge concluded his report. Mr. Robinson thanked him and inquired if members had questions or comments. To see the complete report and comments from members, please see pages 81 through 80 of the attached transcript.

#### Report of the Committee on Codes, Regulation and Legislation

Mr. Robinson introduced Dr. Gutierrez to give his Report of the Committee on Codes, Regulations and Legislation.

#### For Adoption

12-03 - Section 710.1 of Title 10 NYCRR - Certificate of Need Requirements

Dr. Gutierrez described Amendment of Section 710.1 of Title 10 NYCRR (Certificate of Need Requirements) and motioned to adopt this regulation. Dr. Berliner seconded the motion. The adoption carried. Please see pages 83 through 84 of the attached transcript.

14-16 - Part 404 of Title 10 NYCRR – Integrated Outpatient Services

Dr. Gutierrez described Amendment of Part 404 of Title 10 NYCRR (Integrated Outpatient Services) and motioned to adopt this regulation. Mr. Fassler seconded the motion. The adoption carried. Please see pages 84 through 94 of the attached transcript.

#### **For Information**

11-02 - Sections 415.3 of Title 10 NYCRR – Nursing Home Transfers and Discharge Rights

Dr. Gutierrez described the proposed Amendment of Sections 415.3 of Title 10 NYCRR (Nursing Home Transfers and Discharge Rights) for discussion. Please see pages 94 to 95 of the attached transcript.

Dr. Gutierrez concluded his report. Mr. Robinson thanked him and moved to the next item on the agenda.

## Report on the Activities of the Ad Hoc Advisory Committee on Free-Standing Ambulatory Surgery Centers and Charity Care

Mr. Robinson thanked Mr. Delker for his work in staffing the Committee, and the members of the Council who have been participating. Mr. Robinson noted that he would not read the report due to time constraints but requested that it be put into the record for the minutes. He mentioned that the Committee made significant progress in working through the various criteria and would be drafting their own criteria soon.

Mr. Robinson concluded his report. To see the complete report and comments from members, please see pages 95 to 96 of the attached transcript.

#### PROJECT REVIEW RECOMMENDATIONS AND ESTABLISHMENT ACTIONS

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

Christopher Booth, Vice Chair, Establishment and Project Review Committee

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

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

Abstentions/Interests

#### **NO APPLICATIONS**

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

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

#### **CON Applications**

#### **Acute Care Services - Construction**

Exhibit #3

	<u>Number</u>	<u>Applicant/Facility</u>	Council Action
1.	142157 C	United Memorial Medical Center North Street Campus (Genesee County) Mr. Booth – Interest Ms. Hines – Recusal Mr. Robinson – Recusal	Contingent Approval

Mr. Booth described application 142157C. He noted for the record that Ms. Hines and Mr. Robinson had both declared a conflict and left the meeting room. Mr. Booth motioned for approval, Dr. Gutierrez seconded. The motion to approve carried. Ms. Hines and Mr. Robinson returned to the meeting room. Please see pages 96 and 97 of the transcript.

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142079 C	CareFirst/Southern Tier Hospice and Palliative Care/ Southern Tier Hospice (Steuben County) Mr. Booth - Interest	Contingent Approval

Mr. Booth described application 142079C and motioned for approval. Dr. Berliner seconded and the motion to approve carried. Please see pages 97 and 98 of the transcript.

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

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

#### NO APPLICATIONS

## <u>CATEGORY 4</u>: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- **Second Second Project Review Committee Dissent, or**
- Contrary Recommendation by HSA

#### **NO APPLICATIONS**

**CATEGORY 5**: Applications Recommended for Disapproval by OHSM or

Establishment and Project Review Committee - with or without

Recusals

**NO APPLICATIONS** 

<u>CATEGORY 6</u>: Applications for Individual Consideration/Discussion

**NO APPLICATIONS** 

## B. <u>APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES</u>

<u>CATEGORY 1</u>: Applications Recommended for Approval – No Issues or Recusals,

Abstentions/Interests

#### **CON Applications**

Acute	Care Services – Establ Number	ish/Construct <u>Applicant/Facility</u>	Exhibit #5 Council Action
1.	142140 E	NYP Community Programs, Inc. (Westchester County) Dr. Boutin-Foster - Recusal	Contingent Approval

Mr. Booth described application 142140E. He noted for the record that Dr. Boutin-Foster had declared a conflict and left the meeting room. Mr. Booth motioned for approval, Dr. Berliner seconded. The motion to approve carried. Dr. Boutin-Foster returned to the meeting room. Please see pages 98 and 99 of the transcript.

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

Exhibit #6

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	132340 B	Richmond ASC, LLC d/b/a Richmond Pain Management (Richmond County)	Contingent Approval
2.	142077 E	Island Digestive Health Center (Suffolk County)	Contingent Approval
Reside	ential Health Care Facil	Exhibit #7	
	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142056 E	Hope Center Operations, LLC d/b/a Hope Center For HIV and Nursing Care (Bronx County)	Contingent Approval
2.	142090 E	L&A Operations LLC d/b/a Adira at Riverside Rehabilitation (Westchester County)	Contingent Approval
Certif	ied Home Health Agend	Exhibit #8	

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142060 E	Dominican Sisters Family Health Service, Inc. (Nassau County)	Contingent Approval
2.	142068 E	Royal Care Certified Home Health Care, LLC (Queens County)	Contingent Approval
3.	142100 E	A & T Certified Home Care, LLC (Rockland County)	Contingent Approval

Mr. Booth described applications 132340B, 142077E, 142056E, 142090E, 142060E, 142068E and 142100E. Mr. Booth motioned for approval, Dr. Berliner seconded. The motion to approve carried. Please see pages 99 and 101 of the transcript.

## **Certificate of Amendment of the Application of Authority**

Exhibit #9

**Applicant** Council Action

Fletcher Allen Partners, Inc. Approval

The Debutante Cotillion and Christmas Ball, Inc.

Approval

#### **Restated Certificate of Incorporation**

Exhibit #10

**Applicant** Council Action

The Health Science Center Foundation at Syracuse, Inc. Approval

Mr. Booth then called applications Fletcher Allen Partners, Inc.; The Debutante Cotillion and Christmas Ball, Inc.; and The Health Science Center Foundation at Syracuse, Inc. Mr. Booth motioned for approval, Dr. Gutierrez seconded. The motion to approve the applications carried. Please see pages 101 through 102 of the attached transcript.

## **HOME HEALTH AGENCY LICENSURES**

<u>Number</u>	Applicant/Facility	<b>Council Action</b>
2162L	24/7 Homecare Agency of NY, Inc. (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)	Contingent Approval
2172L	Able Body Homecare Agency of NY, Inc. (Bronx, Kings, New York, Richmond, Queens and Westchester Counties)	Contingent Approval
2191L	Agincare Homecare Services, Inc. (Bronx, New York, Kings, Richmond, Queens, and Nassau Counties)	Contingent Approval
2161L	Allied Partners Home Care, LLC (Nassau and Queens Counties)	Contingent Approval
2236L	Anderson Care, LLC d/b/a Home Helpers/Direct Link (Albany and Schenectady Counties)	Contingent Approval

2187L	Angel Home Care Agency, Inc. (Kings, Richmond, New York, Queens, and Bronx Counties)	Contingent Approval
2174L	Angel's Touch Home Care, LLC (Kings, Richmond, Queens, Bronx, New York and Westchester Counties)	Contingent Approval
2252L	Axzons Health System Corporation (Nassau, Westchester, Suffolk and Queens Counties)	Contingent Approval
2207L	Blissful Healthcare, Inc. (Bronx, New York, Kings, Richmond and Queens Counties)	Contingent Approval
2060L	Compassionate Home Health Care, LLC (New York, Bronx, Kings, Richmond, Queens, and Westchester Counties)	Contingent Approval
2257L	Customize Care, LLC (Bronx, Queens, Kings, Richmond, New York and Westchester Counties)	Contingent Approval
2164L	Eva Homecare Agency, Inc. (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)	Contingent Approval
2230L	First Baana Corp. (New York, Bronx, Kings, Richmond, Queens and Westchester Counties)	Contingent Approval

2232L	Fun & Fit, LLC d/b/a Home Instead Senior Care (Westchester, Putnam, Dutchess and Bronx Counties)	Contingent Approval
2189L	Janette Homecare of NY, Inc. (New York, Bronx, Kings, Richmond, Queens and Nassau Counties)	Contingent Approval
2087L	Long Beach Home Care Services, Inc. (Bronx, Richmond, New York, Nassau, Kings, and Queens Counties)	Contingent Approval
2182L	Safe and Prudent, LLC (New York, Bronx, Kings, Richmond, Queens, and Nassau Counties)	Contingent Approval
2201L	SafeCare Home Care Agency, Inc. (Nassau, Suffolk and Queens Counties)	Contingent Approval
2208L	SHARE of New Square, Inc. (Rockland, Sullivan, Putnam, Westchester, Dutchess, Bronx, Orange and Ulster Counties)	Contingent Approval
2159L	Skilled Home Care Services of New York, LLC d/b/a Skilled Home Care Services of New York (Bronx, Queens, Kings, Richmond, New York and Westchester Counties)	Contingent Approval
1728L	Supreme Generation, Inc. (Bronx, Queens, Kings, New York and Richmond Counties)	Contingent Approval
2183L	The Heinlein Group, Inc. d/b/a Synergy HomeCare of Westchester (Westchester and Bronx Counties)	Contingent Approval

2197L	Visiting Nurse Service Care at Home, Inc. (Albany, Montgomery, Warren, Clinton, Rensselaer, Washington, Essex, Saratoga, Franklin, Schenectady, Fulton and Schoharie Counties)	Contingent Approval
2055L	Golden Eagle Homecare Agency, Inc. (Bronx, Queens, Kings, Nassau, New York, and Richmond Counties)	Contingent Approval
2391L	JS Homecare Agency of NY, Inc. (Bronx, Richmond, Kings, Nassau, New York and Queens Counties)	Contingent Approval
2127L	Premier Home Health Care Services, Inc. (Kings, New York, Queens, Richmond, and Bronx Counties)	Contingent Approval
2256L	Premier Home Health Care Services, Inc. (Westchester, Putnam, Rockland, and Bronx Counties)	Contingent Approval

Mr. Booth next called applications 2162L, 2172L, 2191L, 2161L, 2236L, 2187L, 2174L, 2252L, 2207L, 2060L, 2257L, 2164L, 2230L, 2232L, 2189L, 2087L, 2182L, 2201L, 2208L, 2159L, 1728L, 2183L, 2197L, 2055L, 2391L, 2127L, and 2256L. Mr. Booth made a motion to approve and Dr. Bhat seconded. The motion passed. Please refer to pages 102 to 104 of the transcript.

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

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

#### **CON Applications**

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

Exhibit 12

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142108 E	Long Island Jewish Medical Center (Queens County) Br. Bhat – Interest Dr. Martin – Interest	Contingent Approval

2.	142105 E	Mount St Marys Hospital and	Contingent Approval
		Health Center	
		(Niagara County)	
		Mr Booth - Interest	

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

Exhibit #13

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142039 E	North Country Orthopaedic Ambulatory Surgery Center, LLC (Jefferson County) Mr. Booth - Interest	Contingent Approval
2.	142073 E	Buffalo Surgery Center, LLC (Erie County) Mr. Booth – Interest	Contingent Approval

## **Dialysis Services – Establish/Construct**

Exhibit #14

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	141210 B	Peninsula Continuum Services, LLC d/b/a Cassena Care Dialysis at Peninsula (Queens County) Dr. Bhat – Interest	Contingent Approval
2.	141280 E	Liverpool LD, LLC d/b/a FMS- Liverpool Dialysis Center (Onondaga County) Dr. Bhat – Interest Mr. Booth – Interest	Contingent Approval

Mr. Booth described applications 152108E, 142105E, 142039E, 142073E, 141210B, and 141280E. Mr. Booth made a motion to approve, Dr. Brown seconded. The motion to approve carried. Please refer to pages 103 to 105 of the transcript.

# Residential Health Care Facilities – Establish/Construct Number Applicant/Facility Council Action

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	132128 B	DOJ Operations Associates, LLC d/b/a Triboro Center for Rehabilitation and Specialty Healthcare (Bronx County) Dr. Bhat - Recusal	Contingent Approval

Mr. Booth called application 132128B. He advised that Dr. Bhat had a recusal and had left the room. Mr. Booth made a motion to approve which Mr. Fassler seconded. The motion to approve carried and Dr. Bhat returned to the room. Please refer to pages 105 to 106 of the transcript.

2. 141213 E Comprehensive at Williamsville, Contingent Approval LLC d/b/a Comprehensive Rehabilitation and Nursing Center at Williamsville (Erie County)

Mr. Booth - Interest

Mr. Booth then called application 141213E and informed members that he had declared an interest. Mr. Booth made a motion to approve; Dr. Boutin-Foster seconded. The motion to approve carried. Please refer to pages 106 to 107 of the transcript.

## **HOME HEALTH AGENCY LICENSURES**

<u>Number</u>	Applicant/Facility	<b>Council Action</b>
2226L	Beech Development Corp. d/b/a ComForcare Senior Services – Rochester East (Monroe, Livingston, Ontario and Wayne Counties) Mr. Booth – Interest Ms. Hines - Interest	Contingent Approval
2241L	New York Congregational Licensed Home Care Services Agency, Inc. (Bronx, Queens, Kings, Richmond, New York and Nassau Counties) Mr. Fassler – Interest	Contingent Approval
2316L	Rehekah Rehab Licensed Home Care Services Agency, Inc. (Bronx County) Mr. Fassler - Interest	Contingent Approval
2449L	The Gardens by Morningstar, LLC (Oswego, Onondaga and Cayuga Counties) Mr. Booth - Interest	Contingent Approval

2211L	UCSL, LLC d/b/a focus Home Care of Central New York (Herkimer, Oswego, Lewis, Oneida, Madison, and Onondaga Counties) Mr. Booth – Interest	Contingent Approval
2331 L	Shire Senior Living LLC (Monroe, Ontario, Schuyler, Yates, Chemung, Wayne, Seneca, Livingston, Genesee, and Steuben Counties) Ms. Hines - Interest	Contingent Approval

Mr. Booth next called applications 2226L, 2241L, 2316L, 2449L, 2211, and 2331. Mr. Booth made a motion to approve, Dr. Torres seconded. The motion to approve carried. Please refer to pages 107 to 108 of the transcript.

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

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

None

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

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

#### **CON Applications**

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

Exhibit #17

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	141290 B	SOW Westside, LLC d/b/a Surgicare of Westside (New York County) Dr. Martin – Recusal Dr. Brown – Opposed at EPRC Dr. Torres – Opposed at EPRC	Contingent Approval

Mr. Booth described application 141290B and noted that Drs. Martin and Kalkut both had declared conflicts and left the room. Mr. Booth made a motion to approve which was seconded by Dr. Gutierrez. The motion passed and Drs. Martin and Kalkut returned to the room. Please refer to pages 108 to 109 of the transcript.

## <u>CATEGORY 5</u>: Applications Recommended for Disapproval by OHSM or

Establishment and Project Review Committee - with or without

Recusals

#### **NO APPLICATIONS**

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

## **CON Applications**

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

Exhibit #18

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142061 E	East Side Endoscopy (New York County) Dr. Brown – Abstained at EPRC Mr. Levin – Opposed at EPRC	Contingent Approval

Mr. Booth called application 142061E and motioned to approve. Ms. Fine seconded; the motion to approve carried. Please refer to pages 109 to 110 of the transcript.

#### **Dialysis Services – Establish/Construct**

Exhibit #19

	<u>Number</u>	Applicant/Facility	<b>Council Action</b>
1.	142058 E	Massena Center, LLC d/b/a Massena Dialysis Center (St. Lawrence County)	Contingent Approval

Mr. Booth then called application 142058E and motioned to approve. Dr. Gutierrez seconded; the motion carried. Please refer to pages 110 to 111 of the transcript.

Mr. Booth concluded his report and Mr. Robinson thanked him.

#### **ADJOURNMENT:**

Mr. Robinson reminded members of the dates and location of the next meeting cycle. He then made a motion to adjourn. The motion was seconded and passed.

- 1 ANGEL GUTIERREZ: Good morning. My name is Angel
- 2 Gutierrez, I'm the chair of the Codes, Regulation, and
- 3 Legislation Committee and I'm told that we do have a quorum. So
- 4 we're going to call the meeting to order.
- 5 There are three sets of regulations in the agenda today.
- 6 For adoption we have an amendment of certificate of need
- 7 requirements. The Department is proposing an amendment to
- 8 section 710.1 of title 10 NYCRR regarding simplifying the
- 9 Certificate of Need process for certain projects. And Chris
- 10 Delker of the Department is here to present this proposal. Dr.
- 11 Delker.

12

- 13 CHRIS DELKER: Thank you. These regulations were issued
- 14 pursuant to legislation that passed in 2011 and took effect in
- 15 January of 2012, almost three years ago now, and what that
- 16 legislation did was eliminate requirements for limited review or
- 17 other types of CON review for projects that were confined to
- 18 non-clinical infrastructure in healthcare facilities, repair and
- 19 maintenance and one for one equipment replacement, all
- 20 regardless of cost. So, in place of the limited review of CON
- 21 application the operator would have to submit only a notice to
- 22 the Department describing the project and any construction or
- 23 equipment purchases involved accompanied by any applicable
- 24 architecture or engineering certification, and if applicable a
- 25 patient safety plan during construction.

- 1 We received one comment on these regulations from
- 2 Healthcare Association of New York State HANYS expressing
- 3 concern that the statute as we administered it was being
- 4 interpreted in a manner that for any project that might effect a
- 5 clinical space, even though it involved non-clinical
- 6 infrastructure, a CON review might be required. We have not
- 7 generally administered the project that way but we think that
- 8 the regulations that we think that these regulations will
- 9 clarify that and by emphasizing that the CON or limited review
- 10 would apply only if an infrastructure project involved the
- 11 modification or alteration of clinical space services or
- 12 equipment, and that's what the regulation says. So we think
- 13 that that will make it possible for any infrastructure project
- 14 that does not involve clinical space to be subject only to note
- 15 of submission, and indeed that had been the case throughout the
- 16 almost three years we've been administering it. We have had a
- 17 number of projects where, that involved an entire facility. For
- 18 example, an HVAC replacement or an electrical system replacement
- 19 that obviously effected clinical and non-clinical space but
- 20 because those projects did not involve the alteration or
- 21 modification of clinical space they were accepted as notice
- 22 submissions. We think that specifying very clearly in
- 23 regulation that only if modification or alteration of clinical
- 24 space is involved would any limited review apply will prevent
- 25 any possible misadministration if you will, of the law, and

- 1 perhaps in error requiring limited review where clinical space
- 2 is not effected, if that's clear. Any questions?

3

- 4 ANGEL GUTIERREZ: Thank you Mr. Delker. Questions from
- 5 the Committee? Questions from members of the Council? Are there
- 6 any members of the public who would like to comment on this
- 7 proposal? If not, we have a motion to approve this? Dr. Bhat.
- 8 Second? OK. Let's vote. All in favor? Anybody opposed? Any
- 9 abstentions? The motion carries.
- 10 For adoption also is integrated services licensure. We
- 11 have this for adoption of proposed regulations on the
- 12 integration of primary care and behavioral health services. Ms.
- 13 Ullman from the Department is here to explain the regulations.

14

- 15 LISA ULLMAN: Thank you. The Department has worked
- 16 together with the Office of Mental Health and the Office of
- 17 Alcoholism and substance abuse services on these joint
- 18 regulations which are designed to facilitate the integration of
- 19 primary care and behavioral healthcare services, and the idea is
- 20 that they would apply to providers that have already had dual
- 21 licensure at one site which will allow them to get expedited
- 22 approval to add services at a second site. So, for example that
- 23 means for an article 28 facility that has multiple sites that
- 24 are licensed by the Department of Health and they have approval,
- 25 for example, from OMH to provide mental health services at one

- 1 site, if they want to add mental health services at a second
- 2 site they ordinarily would have to undergo another licensure
- 3 process from OMH. They will not have to do that under the
- 4 regulations. They would have the ability to seek an expedited
- 5 approval in order to do that, and that should certainly
- 6 facilitate their ability to move forward. The regulations also
- 7 set forth some physical plant standards which may actually be
- 8 easier for some of the providers to meet than the existing
- 9 standards, so for example, some of the behavioral health
- 10 providers, they might offer you know, services in a clinic
- 11 setting in an existing space that it would be very difficult and
- 12 expensive to renovate, so these regulations offer some
- 13 flexibility with those standards so that they can meet, you
- 14 know, the level that still supports the provision of safe and
- 15 hygienic services. The regulations also set forth operating
- 16 standards which you know, address things that you know, make
- 17 sure that the services are provided in a way that is of quality
- 18 and that supports all of the elements that you would expect to
- 19 see on both the behavioral and the primary care side, so they
- 20 will address things such as making sure there is appropriate
- 21 admission criteria, discharge planning, treatment planning,
- 22 other items such as that. And I think that, you know, there are
- 23 certainly another benefit to the providers that will come from
- 24 these regulations as the idea that once they are approved to
- 25 move forward as an integrated services provider, they will not

- 1 need to be licensed I'm sorry, be inspected by more than one
- 2 agency. They will be able to just be approved just be
- 3 inspected and overseen by one agency. Of course the agencies
- 4 will work very closely together as that gets expedited. So, we
- 5 think that overall this process will really help the providers
- 6 do a better job at integrating their services so they can
- 7 approach to co-occurring needs of their populations. The
- 8 regulations and ours were published in the State registrar on
- 9 October 15 as well as virtually identical regulations that were
- 10 put forth by the other two agencies, OMH and OASAS. The comment
- 11 period expired on the first. We have looked at those comments
- 12 that were received. We made some changes to the regulations.
- 13 Other changes we thought we could not make. For example, one
- 14 item that I think we heard from some of the commenters was that
- 15 the regulations didn't necessarily go far enough, that we were
- 16 still requiring that there be licensure by that second agency
- 17 and some viewed that as an obstacle. I think our response to
- 18 that is that this is one model of integrating care. It's
- 19 something that is important to us and there will be other
- 20 models, for example, as I think some of the commenters
- 21 acknowledged. We are proceeding under the DSRIP program with
- 22 some regulatory flexibility which we do anticipate will be used
- 23 to help some of the providers integrate their services. So,
- 24 this is simply one model, and the way that it was structured, it
- 25 was designed to you know, allow some flexibility and exchange

- 1 for that make sure that because there is that existing licensure
- 2 by the second agency that that just assures us that the provider
- 3 is in good standing and it gives us some comfort that you know,
- 4 the flexibility is appropriate.

5

- 6 ANGEL GUTIERREZ: Is that it? Thank you very much Ms.
- 7 Ullman. Any questions from members of the Committee? I have a
- 8 question, a couple. If you all have the copy of the summary of
- 9 expressed terms, I would like you to refer to page 24, third
- 10 paragraph from the top. Primary care services shall not include
- 11 prenatal care, dental services, ambulatory surgery, blah, blah,
- 12 blah. I'm concerned about that because a place like this will
- 13 attract hopefully young people with either mental or substance
- 14 abuse problems. A pregnant young woman in that situation may
- 15 have the only opportunity to get prenatal care. I do not know
- 16 why prenatal care is excluded.

17

- 18 LISA ULLMAN: It's a very legitimate question and again,
- 19 one of our overall goals here was to, you know, make sure that
- 20 we're helping expand access to necessary services, and I think
- 21 that it is something that we will look at closer in the future.
- 22 I think the idea now was that we wanted to make sure that you
- 23 know, the prenatal care was provided, you know, sort of as part
- 24 of a more comprehensive sort of opportunity that wouldn't
- 25 necessarily be provided in these, so we just thought that this

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1
    wasn't the right opportunity for that, but again, I think it's
2
    something that we'll talk about in the future.
3
4
         ANGEL GUTIERREZ: The next concern has to
5
    page 30 - I'm sorry, yes.
6
7
         LAWRENCE BROWN:
                             Good morning. And I want to thank you
8
    for raising the concern. Thank you for the response from the
9
    Department of Health. I do agree that given that these are
10
    sites where access to care becomes so critical and for a woman
11
    who is in the beginning of a pregnancy, I find it very less than
12
    proactive thinking about how we can make sure that we improve
13
    access to care by that limitation. That one is really when
14
    that's kind of challenging from a public health standpoint.
15
16
         LISA ULLMAN: Yeah, I appreciate that, and again, I think
17
    our focus really was on primary care, and I think obstetrical
    care starts to sort of head into you know, more of a specialty
18
19
    area, but certainly those patients can be seen and provided with
20
    what we think of traditionally as primary care. But again, it's
21
    something we can certainly look at expanding in the future.
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23
         LAWRENCE BROWN: I look forward to hearing that,
24
    hopefully not too distant in the future.
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1
         ANGEL GUTIERREZ: I have a question on procedure here.
2
    if in fact the feeling for that particular issue is strong
3
    enough, do we ask for modification now, removing that clause, or
4
    do we move it because we by virtue of how the schedule is, we're
5
    going to be proposing to the Full Council something that we have
6
    some questions about.
7
8
         LISA ULLMAN: My recommendation would be that we do go
9
    ahead because I think that there are a lot of providers that are
10
    very eager to move forward with what we've structured and we can
11
    certainly take that up and certainly answer your concerns more
12
    thoroughly, see if there is something else that we can do, but I
13
    think we are, again, very eager as I believe the community is
14
    too for us to move forward and get the structure put into place.
15
16
         ANGEL GUTIERREZ: The next -
17
18
         JOHN RUGGE: Just, Dr. Gutierrez,
19
20
         ANGEL GUTIERREZ: I'm sorry. Go ahead please.
21
22
         JOHN RUGGE: Lisa, would you be able to commit to a time
23
    table for that?
24
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LISA ULLMAN: For?

JOHN RUGGE: Bringing the issue back?

3

- 4 LISA ULLMAN: I can certainly come back, discuss it more
- 5 thoroughly with you at the next meeting if that's OK, and you
- 6 know, let you know that either we've talked about it and I can
- 7 give you more substantive reasons about why we don't think
- 8 prenatal care necessarily falls into the primary care and is
- 9 suitable for this, or whether it is appropriate for us to expand
- 10 that at this time. Again, the focus was to be more on primary
- 11 care, but you know, I'm recognizing your concerns as something
- 12 that we really should explore. So if you'd like, I could come
- 13 back at the next meeting.

14

- JOHN RUGGE: I think the risk is that one or the other is
- 16 going to fall away, either that person is going to receive
- 17 behavioral healthcare or receive prenatal care but ot both. So
- 18 I think bring the proposal back for an up and down consideration
- 19 rather than simply more information would be helpful.

20

21 LISA ULLMAN: Sure.

22

23 ANGEL GUTIERREZ: Dr. Martin.

1 So I certainly understand and applaud the GLEN MARTIN: 2 enthusiasm for this, but it, just thinking that prenatal care 3 covers a large range of severity, illness interventions, and 4 concerns. I mean, simply weighing somebody and ordering an 5 outside ultrasound and you know checking blood sugar, blood 6 pressure, and the like is something that could easily be done here. if it gets more complicated it's not, so I suspect that 7 8 there may be some definitional issues and the like that are 9 going to have to come into this that may not be quite as easy as 10 simply saying, yes, prenatal care should be in these clinics, 11 because certainly knowing the psych clinics that I've run that would be somewhat frightening. Not the easy part. I mean, 12 13 certainly in the beginning, but at some point it would have to 14 be a lot different than just saying a physical exam room is what 15 I'm thinking. I can understand a little bit of hesitancy to say 16 yes, we can simply remove that word and we're done. I'm expressing sympathy for the Department's desire to study. 17 There's a little bit, but also agree that it should be done 18 19 expeditiously and with the idea that we should allow it to be 20 integrated to the extent possible, as quickly as possible. 21 22 Spoken like a behavioral health provider, I JOHN RUGGE: 23 might say.

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ANGEL GUTIERREZ: So, why can't we as committee not be 1 2 able to just strike that particular item from that particular 3 page? Primary care services shall not include dental services 4 or ambulatory surgery, blah, blah, blah? So we take that 5 prenatal care out. 6 7 I do think it implements the concerns that LISA ULLMAN: 8 were raised that this can go beyond primary care, but again, a 9 basic level of services that do fall within the primary care 10 realm is what's anticipated. So, again, I do think it does 11 warrant further discussion because these are legitimate 12 reasonable concerns , and we do want to have that dialog with you further. I think we would prefer, if we could, to move forward 13 with the regulations as drafted, so that we're comfortable with 14 15 what we're adding are primary care services, and we can move 16 forward expeditiously. 17 18 MR. DERING: If I could add in too from a process 19 standpoint what Lisa's mentioning makes sense to go forward, 20 then we're moving forward but address the other concerns as we 21 move along. 22 23 ANGEL GUTIERREZ: OK. Any further discussion on this 24 particular part of the proposal? Then I'll ask you to go to page 30 at the top where it says, "program space except medical 25

- 1 examination and treatment rooms may be shared between certified
- 2 patient services pursuant,..." blah, blah, blah. And my question
- 3 is why are we keeping an examination room from being used for
- 4 counseling purposes? I don't see I mean it happens all the
- 5 time and for instance, article 28 facilities? I have a problem
- 6 with a patient and I ask either mental health or substance abuse
- 7 staff to come and help me with a patient and I leave the
- 8 examination room and they carry the interview right then and
- 9 there. What is there about an examination room that excludes it
- 10 from being used for counseling purposes?

- 12 LISA ULLMAN: I think in part the thinking was just the
- 13 way that the room is structured probably would not be conducive
- 14 to some types of counseling, you know, certainly of a group
- 15 counseling couldn't be held in a smaller exam room. I think we
- 16 can certainly flesh this out a little bit more potentially in
- 17 guidance, but the idea wasn't to, you know, completely prohibit
- 18 the use of space, you know, for multiple purposes if it's
- 19 appropriate. It's just that we want to make sure certainly
- 20 those things aren't happening in the same space at the same time
- 21 and it would have to be a structurally appropriate space for the
- 22 particular service. So we can, again, certainly make sure that
- 23 the providers have sufficient and understanding of what that
- 24 means and we can put that in guidance.

1 ANGEL GUTIERREZ: My last concern on page 53 at the top 2 where it mentions AIDS and HIV information "shall only be 3 disclosed in accordance where article 27F of the public health 4 law..." I found in my review no mention of a similar restriction 5 to substance abuse information which is just as restrictive or 6 more, and I wonder, that said, and look from the standpoint of a practicing physician who wants to find out more about my patient 7 8 being seen at that facility, the wall that one finds regarding 9 information about HIV or substance abuse is formidable. I don't 10 know how to negotiate that. I don't know how to, shall we 11 include substance abuse in here if we're going to take that 12 (tag) number one; number two, if it is known in the community 13 that this particular article 28 facility there are services 14 provided which include mental health and substance abuse, it is 15 almost implied that questions about Joe Smith attending that 16 clinic means not just his diabetes, he's having other things being taken care of, that I am implicitly aware of. How do we 17 negotiate that? I would like to hear Dr. Brown's opinion on 18 this. 19 20 21 LAWRENCE BROWN: As an internist and addiction medicine 22 specialist I must share with you, Mr. Chair, that I continue to 23 find a conundrum with respect to the issue of having sufficient 24 information available to providers, irrespective of what that 25 clinical discipline. And the real concern about issues about

- 1 confidentiality. I, on the one hand I see the comment that
- 2 you're making with respect to the top of page 53. The issue
- 3 with respect to (sub-use) confidential information will still
- 4 stand. A state cannot reverse what a federal relation is,
- 5 42CFR. So, but I do believe that many primary care providers
- 6 may not know about the significance of those federal
- 7 regulations. So, somehow or another would seem to me that the
- 8 New York State Department of Health actually does make sure that
- 9 any providers who choose to do this understand that there
- 10 significance of separation, and even though, I must tell you,
- 11 I'm troubled by it in some ways because as even with our iStop
- 12 program in New York State, as a person who's providing care for
- 13 a patient as a (substance abuse treatment) program, I know every
- 14 medication that is prescribed to my patient that is a
- 15 prescription narcotic. However, a provider who is not an
- 16 addiction treatment program and does not now that his patient or
- 17 her patient that they're treating with the same prescription
- 18 narcotic is enrolled in a medication assisted treatment program.
- 19 They're not allowed to get that information. That information is
- 20 not available to them in iStop. I only use that as an example
- 21 that the issue you raise is very complicated. I'm not sure in a
- 22 context of this committee meeting that we're going to be able to
- 23 have enough time to really flesh them out, but I would recommend
- 24 that we do so at some point that is convenient in the schedule.

1 ANGEL GUTIERREZ: Thank you very much, Dr. Martin. I'm 2 sorry. 3 4 ART LEVIN: I'm his other arm. So, I guess my guestion 5 is why one doesn't suffice? In other words that introductory 6 paragraph which basically says you've got to follow state and 7 federal regulations, I think we create the problem by the 8 exceptionalism and then putting in a specific reference to the 9 state AIDS law on privacy and confidentiality, but why? I mean, 10 doesn't the first paragraph, number one, do it? Says you've got 11 to pay attention to what state and federal law say you have to 12 pay attention to. 13 14 ANGEL GUTIERREZ: I can appreciate that, but I'm trying 15 to imagine what is going to happen if a practitioner from 16 outside the facility asks for information about a patient being 17 taken care of. If it is truly an integrated system, I can picture that in some history and physical done from the medical 18 standpoint, there will be pertinent information of HIV and 19 20 substance abuse, that, how'd you take that out in our 21 communications with the community, medical care community? Dr. 22 Martin. 23 24 GLENN MARTIN: So, having lived this all my life and living 25 it now in health information exchange environments in the like,

- 1 the answer is it's real tough. But I'm not saying that the laws
- 2 as they currently state make a huge amount of sense, but all
- 3 this reads to me that these are the laws and you've got to
- 4 follow them. There's also interestingly in two, mentioned
- 5 something that usually gets forgotten most of these
- 6 conversations, but just ask the patient's permission. They get
- 7 consent, you know, you then have that information available.
- 8 And in our experience both with health information exchange
- 9 consenting and in terms of asking patients in collaborative care
- 10 models to consent to have that information shared, they will
- 11 frequently be happy to do so. So, it is annoying, it is
- 12 difficult operationally do deal with it. It would be nice if it
- 13 got straightened out, but it is a question of both federal regs
- 14 and state regs and I understand your concern, but I think that's
- 15 just what it is. So this doesn't make it any worse. This just
- 16 recognizes the issue and tells people you have to follow the
- 17 rules, as much as I'd like them to be changed.
- 19 ANGEL GUTIERREZ: Thank you Dr. Martin. Are there any
- 20 other questions from committee members or counsel members? We
- 21 have a request from Mr. Heigel from HANYS to speak on the matter
- 22 please.

- 24 FRED HEIGEL: Good morning. Thank you. I'm Fred Heigel
- 25 from HANYS, and we did share these very detailed new regulations

- 1 with our membership. Got a lot of feedback, and frankly much of
- 2 the feedback came from the behavioral health side of the article
- 3 28 provider community. I'm not going to go through our lengthy
- 4 comments although many of them were addressed in the discussion
- 5 you just had within the Committee itself, and we appreciate that
- 6 recognition, and I think in general most practitioners agree
- 7 that treating mental health and physical health conditions in
- 8 conjunction with one another just benefits the patient.
- 9 Initially we thought, and Lisa described it this way really,
- 10 that the intent of these regulations was to facilitate
- 11 integration and even incentivize it in some cases. However, the
- 12 feedback we've got from our membership is that we fear it's
- 13 going to have just the opposite effects on article 28 providers;
- 14 that it's going to make it more complicated than it is right
- 15 now. And remember many of them already provide integrated
- 16 services up to a threshold level and I do appreciate Lisa's
- 17 description earlier of the approach from DSRIP to potentially
- 18 relieve that threshold cap. You know, we believe that is an
- 19 incentive approach. But given the concerns that have been
- 20 raised by our membership and the fact that many at least view
- 21 this as creating additional hurdles, not incentives, we urge the
- 22 committee to consider our comments very carefully and modify the
- 23 regulations accordingly. Thank you.

1 ANGEL GUTIERREZ: Thank you very much. Any other comments 2 from the public? If not, I will entertain a motion to approve 3 this for adoption. Dr. Bhat. Second? OK. All in favor? 4 [Aye] 5 Anybody against? Any abstentions? The motion is carried. 6 The next item is for information only and deals with 7 nursing home transfers and discharge rights. The final item on 8 the agenda is a discussion of proposed amendments to section 9 415.3 of title 10 NYCRR to clarify the requirements for transfer 10 and discharge of patients from nursing homes as mandated by 11 federal law. The amendments more clearly define what constitutes 12 a transfer of discharge, specify the elements that must be 13 include in a notice of transfer or discharge the residence and 14 deadlines for service of notice and clarify the rights of a 15 resident at a hearing should one be requested. James Horan from 16 the Department is here to explain the proposal. Mr. Horan, good 17 morning. 18 19 JAMES HORAN: The federal nursing home guidelines require 20 that the states provide due process hearings when a nursing home 21 proposes to discharge a resident involuntarily. The Department 22 was found out about 10 years ago that the Department standards 23 were out of compliance with the federal regulations, and it was 24 also, there were also complaints about how the hearings were

done. The Department entered into a stipulation to settle that

- 1 lawsuit, and agree as part of the stipulation that the
- 2 Department would come into compliance with the federal
- 3 regulations, and in the meantime would adopt an interim policy
- 4 that would reflect the federal regulations and that would be the
- 5 policy that and that the Department's administrative law
- 6 judges would take over the hearings, they had been previously
- 7 been done by Department surveyors. That's my office. I'm the
- 8 Chief for the Department. So for the last 10
- 9 years we had been operating under the interim policy in
- 10 compliance with the federal regulations.
- 11 So these amendments would change the nursing home code, but
- 12 they would have no change over how the hearings have been
- 13 conducted these last 10 years under the stipulation under the
- 14 interim policy...

- 16 ANGEL GUTIERREZ: Thank you very much. Any questions
- 17 from members of the committee? Any questions from members of
- 18 the Council? Any comments from the public? This is only for
- 19 information so this concludes the meeting and the Codes
- 20 Committee is closed.
- 22 CHRIS BOOTH: Good morning. I'm Chris Booth. I'd like to
- 23 call a special Establishment and Project Review Committee
- 24 meeting. We have one application for this morning. It's ar
- 25 application that was on our last meeting which some issues were

1 raised and some information requested. I'm going to read the 2 application and put it on the table, take the motion and the 3 second, and then open it up to the Department to provide some 4 information. So the application is 142058E, Messina Center LLC, 5 d/b/a Messina Dialysis Center. An interest declared by Mr. Booth. Establish Messina Center LLC, d/b/a Messina Dialysis 6 7 Center as the new operator of an eight station dialysis center 8 located at 290 Main Street, Messina, currently operated as an 9 extension clinic of Messina Memorial Hospital. The Department 10 recommended approval with conditions and contingencies. Can I 11 have a motion? And a second? Motion and second. Mr. Abel. 12 13 CHARLIE ABEL: Thank you. So, this project was deferred 14 from the meeting three weeks ago now, establishment and project 15 review committee meeting primarily because of the interest by 16 members of a particular member of the applicant entity who was a 17 subject of disciplinary action. For folks who have seen my November 25 member to the members, you'll note that that 18 19 individual has had a medical incident and has been removed by 20 the applicant from the applicant entity. Essentially removing 21 the concern by members. We've revised the exhibit. It was sent 22 out to everyone. It is still financially feasible. Character

and competence is fine with the applicant, and the need is

demonstrated so we can recommend, we can continue to recommend

23

1 approval and I believe the concern of the committee members has 2 been resolved. 3 4 CHRIS BOOTH: Thank you Mr. Abel. Any questions of the 5 Department? Yes, Dr. Berliner. 6 7 Yeah, Charlie, I think to correctly HOWARD BERLINER: 8 reflect the position of the Council, concern wasn't a specific 9 incident. Thing is we didn't know what that specific incident 10 was and therefore couldn't make a judgment. So, it wasn't -11 just to be clear about that. 12 13 CHRIS BOOTH: Thank you. Any other questions? Any members 14 of the public wish to speak on this application? Please come forward. Please identify yourself, thank you. 15 16 17 18 SEAN BRALEY: My name is Sean Braley. I'm a representative 19 from the New York State Nurses Association. The New York State 20 Nurses Association represents 37,000 registered nurses 21 throughout New York State and is a leading advocate for quality 22 patient care and universal access and care for all New York 23 residents. We are here to express our opposition to the pending 24 application by Messina Center, LLC, to receive approval to

purchase and operate the existing eight station chronic

- 1 outpatient dialysis facility currently owned and operated by
- 2 Messina Memorial Hospital. We note at the outset that the
- 3 proposed transfer will not result in the loss of employment of
- 4 any of the current public employees who work for Messina
- 5 Memorial Hospital in the dialysis clinic as the terms of the
- 6 agreement appear to maintain the current staff as public sector
- 7 employees of the hospital, and that they will be assigned to the
- 8 hospital to work in the clinic once the new owner has assumed
- 9 control of the operations. We wish to state however, that we
- 10 continue to oppose the privatization of public hospital systems
- 11 in general in a public dialysis facility in particular. Our
- 12 concerns regarding the privatization of public health systems
- 13 are based on issues regarding quality of and access to care
- 14 particularly for vulnerable populations that are uninsured or
- 15 underinsured. We also believe that for profit healthcare
- 16 ownership and delivery is a threat to both access to care and
- 17 quality as for-profit owners have a direct incentive to dilute
- 18 the quality of care in pursuit of profits. This tenancy is even
- 19 more pronounced in cases where the for-profit owner is a
- 20 corporation that has a direct duty to maximize the returns of
- 21 shareholders or that the corporate entity is closely held or
- 22 publicly traded.
- 23 There's ample evidence of the threat to patient care and to
- 24 access to care in cases where dialysis clinics are transferred
- 25 from public to -public or non-profit owners to for-profit

- 1 ownership. Studies have shown that for-profit dialysis
- 2 operators tend to seek to reduce costs in order to generate
- 3 profits to seek other ways to generate more income. This
- 4 financial incentive increases the risk to patients and increases
- 5 negative outcomes. It also negatively impacts access to care or
- 6 the quality of care for uninsured patient populations. The
- 7 threats to care resulting from private for-profit ownership and
- 8 operation of dialysis facilities include the following: one,
- 9 for-profit dialysis facilities have a 13 percent higher risk of
- 10 patient mortality than non-profit dialysis facilities after
- 11 adjusting for an array of socio-demographic risk factors.
- 12 Patient disease severity, comorbid conditions and facility
- 13 characteristics. Two; the evidence suggests a number of
- 14 possible explanations for the higher death rates that are
- 15 observed with for-profit dialysis providers. These explanations
- 16 include responding to financial pressures for prioritizing
- 17 stakeholder returns over implementing the necessary conditions
- 18 to insure high quality of care, the lower equipment usage and
- 19 shorter duration of each dialysis session that produces a lower
- 20 average cost per dialysis session and also the lower staff skill
- 21 mix and fewer registered nurse patient care hours provided for
- 22 by the for-profit dialysis services providers. Three; in
- 23 addition to higher risk of patient mortality, the research
- 24 reveals that patients receive their care from for-profit
- 25 dialysis providers spend more days in the hospital than those

- 1 who are cared for by non-profit providers. In fat, research
- 2 shows patients treated in for-profit dialysis facilities
- 3 experience 17 percent more risk adjusted hospital delays,
- 4 hospital days than their non-profit counterparts. Preventing
- 5 infections and other complications that lead to hospitalizations
- 6 for dialysis patients are potentially costly activities that
- 7 require adequate levels of professional staff and also require a
- 8 willingness to implement the necessary conditions to insure high
- 9 quality of care. As Lee (turtow) and (Zineos) explain patients
- 10 treated in for-profit dialysis providers will have higher
- 11 hospital days per year because the cost of any intervention that
- 12 would prevent lengthy hospital admissions are greater than the
- 13 financial rewards. Four; patients who are uninsured or
- 14 underinsured in for-profit dialysis centers are less likely to
- 15 receive critical information about transplantation options.
- 16 The application by Messina Center LLC, raises concerns
- 17 related to quality of care and access that are noted in the
- 18 research cited, that I just cited. We note first that Messina
- 19 Center will be an LLC which, in which 60 percent of the
- 20 ownership will reside with American Renal Associates. American
- 21 Renal operates or has an ownership share in more than 23 states
- 22 and we believe that they operate in excess of 100 facilities.
- 23 We were unable to analyze the quality of their various
- 24 facilities because the company does not list specific sites on
- 25 it's website. We do note however, that it does not appear that

- 1 the Department of Health made any analysis of this multistate
- 2 operators quality track record. With respect to the data that
- 3 is provided in the CON document issued by the DOH, it appears
- 4 that ARA operates three sites in New York State. A comparison
- 5 of the current Messina Hospital operated site and the three
- 6 sites operated by ARA, that's Elizabeth Town Center LLC, Mohawk
- 7 Valley Dialysis Center LLC, and Plattsburgh Associates, LLC,
- 8 raises serious concerns about the quality of care provided by
- 9 ARA. According to the data produced by the November meeting of
- 10 the Committee, and that should be exhibits 84 through 86, the
- 11 Messina Hospital Clinic outperformed the ARA clinics in many
- 12 areas.
- 13 The applicant provided data only for two facilities in New
- 14 York State. Of the two facilities for which information was
- 15 available to compare, Messina greatly outperformed the
- 16 Elizabethtown facility and was equal or better in every
- 17 category. The Mohawk Valley slightly outperformed the hospital
- 18 facility in two categories, but the hospital greatly out
- 19 performed that ARA facility in fistula formation, use of
- 20 catheters, and calcium levels. It is thus fair to conclude that
- 21 the level of care provided by the current Messina Hospital
- 22 Operation of the clinic is of higher quality than that of the
- 23 proposed buyer. This is without taking into account more
- 24 detailed analysis of the 100+ other facilities operated by ARA
- 25 which was not reviewed by the DOH it would appear.

2 CHRIS BOOTH: Could you wrap up soon please.

3

- 4 SEAN BRALEY: I am. Finally, we are concerned about the
- 5 impact of the conversion of the facility to for-profit ownership
- 6 upon access to care for uninsured patients and whether there
- 7 would be a tendency to displace underinsured and uninsured
- 8 patients currently receiving services in order to increase the
- 9 number of commercially insured patients being treated. This
- 10 issue was not apparently examined by the DOH staff.
- In conclusion, based on the foregoing, the New York State
- 12 Nurses Association believes that the application should be
- denied.

14

- 15 CHRIS BOOTH: Thank you very much. Any questions of this
- 16 speaker? Hearing none, any other comments or questions? Yes.
- 17 Please identify yourself. Thank you.

- 19 SUE (BOLUE): Yes. Good morning. Sue (Bolue) Chief Nurse
- 20 Executive for Messina Memorial Hospital. Messina Hospital
- 21 developed the dialysis unit as a request from the community with
- 22 the need of having access to dialysis care in Messina, the
- 23 closest area was 37 miles which is a long drive for them during
- 24 our winter months three times a week. We did create the
- 25 dialysis unit and we have been very successful in that, however

- 1 we have been experiencing losses of approximately \$500,000 a
- 2 year. Messina Hospital is overall losing money. We cannot
- 3 continue at that rate and the question of whether we'll be able
- 4 to maintain the dialysis unit was why we sought out an
- 5 organization to purchase the unit so that we could continue the
- 6 life saving and vital care of dialysis to our community. So I
- 7 ask the committee to make that part of your consideration.
- 8 Thank you.

10 CHRIS BOOTH: Thank you very much. Yes, Mr. Levin.

- 12 ART LEVIN: I know I sound like a broken record, but on
- 13 this one, but it seems to me that we have more and more evidence
- 14 that there may be problems out there in the land of large for
- 15 profit change. I mean, we have Devita now with an immense fine
- 16 for kickbacks and self-referrals and stuff. So, not specific to
- 17 this application, but the question is really what do we do?
- 18 What's our responsibility now that we have systems that measure
- 19 performance and where we seem to have some evidence that bad
- 20 things may happen in the large chain environment, how do we deal
- 21 with it here and what's the relationship between what happens in
- 22 the larger chain to what's happening in our state and in our
- 23 localities. So I think at some point the council really needs
- 24 to take, and the department need to really take a closer look at
- 25 this.

2 CHRIS BOOTH: Charlie, is that something that you could 3 take on and bring back to this group? 4 5 CHARLIE ABEL: Well, couple things. one, you know, I think 6 it may be an issue to extrapolate from a certain national 7 provider that those kinds of problems exist across all national 8 providers. I will say that one of the comments presented by the 9 individual from the Nurses Association we did review out-of-10 state providers as we do all out-of-state providers that are 11 related to applicants. Didn't find any issues that would be a 12 problem with character and competence. And of course we present 13 all of the detailed quality information for all of the New York 14 facilities that have operational experience and with this 15 provider two of the three that they have in operation have been 16 in operation long enough to have actual experience to be able to 17 provide to you. And that information you know, I our opinion isn't necessarily better or worse than the current provider, but 18 19 the underlying question that I think is begged by the discussion 20 is and I don't have a good answer but I'll throw it out, what 21 does that really mean if the proposed provider, the applicant 22 entity has a reasonable quality history that is not 23 representative of a problematic provider, but the, may score 24 some marginal less in terms of quality indicators than the 25 person, than the entity that is operating now? Does that really

- 1 mean that we're going to stop a sale transaction between two
- 2 willing partners that fall, that fall within the norm for the
- 3 industry in terms of quality? That's a real issue I think for
- 4 us for staff to be able to understand where the Council is
- 5 going. So, we can, to get more direct question, we can
- 6 certainly do some research on the national facilities, national
- 7 dialysis providers and bring folks up to date in terms of you
- 8 know lawsuits and things like that. It's not a trivial task
- 9 because as we know, some of the providers have facilities in
- 10 almost all the states. This provider, subject provider here has
- 11 facilities in many states, not in most of the states but we can
- 12 do that, and I'm not going to be able to promise you that it'll
- 13 be next cycle, but we will do our best to get you something in
- 14 terms of that kind of an assessment.
- 16 CHRIS BOOTH: And Charlie, I'm not sure that the council
- 17 has a perspective on terms of where it's going, but it'd be nice
- 18 to have some data to relate to some of the allegations that are
- 19 brought forth. So, to the extent there's data that shows that
- 20 the quality of for-profit just making it up was significantly
- 21 below that of the not-for-profits or that the quality is
- 22 significantly lower than it was before the for-profit was
- 23 allowed to take it over. That's information would be good to
- 24 have. We don't know that that's true, but we have, you know,
- 25 situations like we had this morning where it comes forward with

- 1 the allegations. And it would be good to be comfortable with
- 2 the information as to whether we think in general and it's true
- 3 or not true or it's significant or not significant.

- 5 CHARLIE ABEL: And in the attachment at least well we've
- 6 provided you got the quality indicators for comparison for the
- 7 facilities that the applicant has had operational experience in
- 8 New York versus the current facilities. Hopefully, at least
- 9 that's a start in the right direction.

10

- 11 CHRIS BOOTH: OK. Thank you. We have one more person
- 12 that wishes to speak. Can you introduce yourself?

- 14 Yes. Thank you. Michael Cost. I'm the Vice President and
- 15 general counsel for American Renal Associates and I appreciate
- 16 your time here today in looking at our application, and I
- 17 respect your time sensitivity on all your other applicants, but
- 18 I did feel it would be appropriate for me to address just some
- 19 of the comments.
- Number one, American Renal Associates owns and operates, as
- 21 of today, 163 dialysis centers in 25 states and the District of
- 22 Columbia. We actually service over 13,000 patients, and some of
- 23 our quality indicators which are available on the CMS website,
- 24 the (QUIPS) website, we meet and exceed quality indicators in
- 25 more of all the categories. I think one of the important things

- 1 to note is when we initially approached Messina Hospital as part
- 2 of this transaction, our main emphasis was to improve quality of
- 3 care, number one. Number two to keep the union employees and
- 4 public employees in their positions and not displace them and
- 5 not to disrupt the union. And thirdly, just to make sure that
- 6 this critical most important access to services remains viable
- 7 to people in these counties. I mean, it's critically accessed
- 8 to make sure that this dialysis center remains operational. So
- 9 I don't want to debate for-profit versus not-for-profit
- 10 healthcare. I think that's been debated in much literature.
- 11 What I did want to just mention is that it's important for us,
- 12 and I felt the council to know that American Renal Associates is
- 13 dedicated to improving the quality of care for not only the
- 14 patients at Messina Dialysis Center, but for all of our patients
- 15 throughout the country. Thank you.
- 17 CHRIS BOOTH: Thank you very much. Any further comments
- 18 or questions? If not, I'll call the question. All those in
- 19 favor say aye.
- 20 [aye.]

- 21 Are there any opposed? One opposed. Any abstentions? One
- 22 abstention. Motion passes and we are adjourned.
- 24 PETER ROBINSON: OK. We're done with the preliminaries.
- 25 Good morning. I'm Peter Robinson, member of the Council and

- 1 I'll be presiding over this meeting in Mr. Kraut's absence. I
- 2 welcome you all, in particular Mr. Shepard who is here instead
- 3 of Dr. Zucker. Welcome Mr. Shepard and members of the staff.
- 4 So, just a few little preliminaries before we get going.
- 5 First I'd like to remind council members, staff, and the
- 6 audience that this meeting is subject to the open meeting law
- 7 and is broadcast over the internet. For those of you that are
- 8 interested the webcasts are accessed at the Department of Health
- 9 website Nyhealth.gov. The on-demand webcast will be available
- 10 no later than seven days after the meeting for a minimum of 30
- 11 days, and then a copy will be retained in the Department for
- 12 four months. As a reminder for the members of our audience,
- 13 there is a form that needs to be filled out before you enter the
- 14 meeting room or now if you haven't done it yet which records you
- 15 attendance at meetings. That form is required by the joint
- 16 commission on public ethics in accordance with executive law
- 17 section 166. So thank you all for your cooperation to ensure
- 18 that we're complying with the law. Let me just briefly go over
- 19 how we're going to conduct today's meeting. We'll begin with the
- 20 Department of Health reports, and Mr. Shepard will be reporting
- 21 both for himself as well as for the commissioner. We're going to
- 22 blend those two reports together. Ms. (Misa) will give a report
- 23 on the activities of the Office of Health Insurance Programs.
- 24 And as I understand it Mr. Rohan and Mr. Gestin will give an
- 25 update on the activities on the Office of Quality and Patient

- 1 Safety and the recent work of the ad-hoc office-based surgery,
- 2 committee on office surgery.
- 3 Dr. Birkhead too has been at the last moment called away,
- 4 and so he will not be available to give his report. We're going
- 5 to defer that until the next meeting of the Council. Ms.
- 6 Rautenberg will give a report on the activities of the Committee
- 7 on Public Health, and then Dr. Rugge will give his report on the
- 8 Committee on Health Planning and present for approval and
- 9 application for a stroke designation center. Dr. Gutierrez who
- 10 recently adjourned the Codes Committee will give his report from
- 11 the Codes Committee from this morning. And then I'll give a very
- 12 brief report on the activities of the ad-hoc committee on
- 13 freestanding ambulatory surgery and charity care. And then
- 14 last, but certainly not least the project review recommendations
- 15 and establishment actions which will be presented by Mr. Booth.
- 16 So that's what we have coming up.
- 17 A word about conflicts; members of the Council and most of
- 18 our guests who regularly attend the meeting are now familiar
- 19 with the reorganization of the agenda by topics or categories,
- 20 and that caps the roles and responsibilities of the Council.
- 21 This reorganization includes the batching of certificate of need
- 22 applications and turning to the members here, I hope you've
- 23 taken the time to review the batched applications and have
- 24 thought about whether you would like a project moved to a
- 25 different category. If not, we will proceed as it's currently

- 1 been scheduled. So, everybody OK with the way we've got it
- 2 structured? Good.
- 3 OK. So, next, or first on the agenda is the approval of
- 4 the minutes of our last meeting. May I have a motion? Dr.
- 5 Gutierrez. Dr. Berliner, second. Any comments, corrections?
- 6 Hearing none, all in favor.

- 8 [Aye.]
- 9 Any opposed? That's carried. Thank you. So let me turn
- 10 to Mr. Shepard who will be giving two reports in one.

- DAN SHEPPARD: Good morning. Again, I'm here on behalf of
- 13 Dr. Zucker. He does send his regrets but there was an
- 14 unscheduled and high priority meeting that he had to attend this
- 15 morning. So, I'll present his remarks and again, his apologies
- 16 and good wishes.
- 17 So, first of all, hope everybody had a very happy
- 18 Thanksgiving and on behalf of Dr. Zucker wishing you a joyous
- 19 upcoming holiday season. I'd like to begin by discussing the
- 20 biggest public health issue today which is Ebola. As you know,
- 21 a lot has happened on Ebola since last we met. For starters,
- 22 New York had its first Ebola patient in mid-October. Dr. Craig
- 23 Spencer was working in Guinea for Doctors without Borders when
- 24 he contracted the virus. Six days after his return he came down
- 25 with Ebola symptoms and went to Bellevue Hospital Center where

- 1 he was isolated and treated for three weeks. His discharge from
- 2 Bellevue was a much celebrated event that demonstrated New
- 3 York's ability to successfully treat this disease. It has given
- 4 us hope that we do have the capacity to manage Ebola which has
- 5 inflicted so much pain and suffering mostly in West Africa.
- 6 Since claiming its first victim last December, Ebola has
- 7 effected more than 16,900 people in eight countries. More than
- 8 6,000 people have died. Luckily Dr. Spencer was not one of
- 9 them, and the collective preparedness efforts by the health
- 10 departments and hospitals kept others from getting sick,
- 11 including the healthcare workers who took care of Dr. Spencer.
- 12 New York began preparing for an Ebola patient long before Dr.
- 13 Spencer got sick. We knew that we had to be ready for what
- 14 seemed like an inevitability. Afterall, New York is a State
- 15 with more than 19 million people and we're home to a city that's
- 16 international travel hub, a bustling metropolis with more than 8
- 17 million people. We have one of five major U.S. Airports, JFK
- 18 New York City, and that follows flights from countries where
- 19 Ebola has become widespread. The other airports in the U.S.
- 20 that have traffic from countries where Ebola is present are
- 21 Newark, Washington-Dulles, Ohare in Chicago and Hartsfield in
- 22 Atlanta.
- 23 So let me start by saying that the vast majority of
- 24 travelers arriving in the U.S. who have a fever or any other
- 25 suspicious symptoms do not have Ebola. So, even so, we have to

- 1 take precautions. Since October, travelers from effected
- 2 countries have gone through an initial health screening. They
- 3 are then referred to state and local public health authorities
- 4 for active monitoring of Ebola symptoms. The monitoring goes on
- 5 for 21 days following their last day of potential exposure to
- 6 Ebola. Since the program began, health officials have monitored
- 7 over 3000 travelers more than 30,000 times. Knowing our risk
- 8 for having a patient with Ebola was high, New York was the first
- 9 state in the nation to designate hospitals for the care of
- 10 patients with Ebola. At the Governor's request, 10 hospitals
- 11 across the State agreed to serve as designated centers for
- 12 treating people with confirmed cases of Ebola. Today I'm
- 13 pleased to announce that five of New York's designated hospitals
- 14 have been approved by the CDC for inclusion on a list of U.S.
- 15 facilities that will serve as Ebola treatment centers. The five
- 16 CDC approved hospitals are the North Shore System in Glen Cove,
- 17 New York; New York City Montefiore Health System; New York
- 18 Presbyterian Hospital, the Allen Pavilion; Bellevue Hospital
- 19 Center and Mt. Sinai Hospital. These five centers are among 35
- 20 hospitals in the country designated by the U.S. Department of
- 21 Health and Human services as having the capabilities, training,
- 22 and resources to provide the complex and extensive treatment
- 23 that an Ebola patient requires while minimizing the risk to
- 24 healthcare workers. They've undergone an intensive assessment by
- 25 the CDC rapid Ebola preparedness team, the REP team, and we are

- 1 also importantly asking CDC to survey the other five hospitals
- 2 in New York State that have worked so hard to be prepared, kind
- 3 of agreed to be designated as treatment centers and may also be
- 4 added to the federal list. And these remaining five hospitals
- 5 are Erie County Medical Center in Buffalo, SUNY Stony Brook
- 6 University Hospital on Long Island, SUNY Upstate Medical
- 7 University in Syracuse, University of Rochester Medical Center,
- 8 and the Women's and Children's Hospital of Buffalo. The
- 9 Department continues to work with CDC and local health
- 10 departments to ensure that these centers maintain the necessary
- 11 state of readiness with respect to facilities, workforce,
- 12 training, labs, and waste management, all of which are required
- 13 to safely and effectively treat a patient with Ebola. The rapid
- 14 Ebola response teams have assessed each facility on all
- 15 infection control aspects of caring for a patient with Ebola
- 16 from the use of personal protective equipment or PPE to details
- 17 like how trash is removed from a patient's room. And they also
- 18 ensure that staff involved in the caring for a patient with
- 19 Ebola has been appropriately trained. That means that the staff
- 20 involved have demonstrated that they know how to put on and take
- 21 off PPE, they know the appropriate protocols for proper waste
- 22 management, they know how to do infection control, they know how
- 23 to safely transport lab specimens, and that these designated
- 24 hospitals also have processes in place to support the physical
- 25 and emotional wellbeing of the staff providing care for someone

- 1 with Ebola. And that includes monitoring the staff for fever or
- 2 other early symptoms so they can properly assess and treated.
- 3 It's important to note the hospital staff caring for patients
- 4 with Ebola will not be providing care to other patients. It's a
- 5 dedicated activity for the course of the disease. So, this is
- 6 obviously very important to limit potential exposure to other
- 7 patients. CDC is working with state and local authorities as
- 8 well as domestic and global manufacturers to make sure we have
- 9 enough PPE supplies for the Ebola response. Hospitals that have
- 10 Ebola treatment centers must have enough PPE for at least seven
- 11 days. But CDC also has strategic national stock pile of PPE
- 12 that can be deployed to the hospitals if necessary. The CDC
- 13 stock pile currently has enough PPE to support 50 days of Ebola
- 14 care. They've ordered enough PPE to support 250 days of care
- 15 and can deliver supplies in less than 24 hours to any hospital
- 16 in New York in the U.S., I apologize. And what about the
- 17 other five hospitals in New York that have agreed to serve as
- 18 Ebola treatment centers? While the designation by state or
- 19 federal governments indicates facility has undergone special
- 20 preparedness protocols, the reality is that all hospitals must
- 21 be ready to handle a potential Ebola patient. All hospitals
- 22 must be ready to assess patients with Ebola-like symptoms for
- 23 the recent travel history and determine whether they were
- 24 exposed to people sick with Ebola in the last 21 days. To
- 25 assist us, the Greater New York Hospital Association in

- 1 collaboration with the Hospital Association of New York State
- 2 hosted a meeting on November 19 to discuss Ebola care for these
- 3 designated hospitals and other tertiary care hospitals that
- 4 wanted to attend. The presenters discussed everything from the
- 5 importance of teamwork in treating Ebola, to the ethical
- 6 challenges of treating an Ebola patient when treatment like CPR
- 7 for example, could potentially jeopardize the life of healthcare
- 8 workers. The sessions were very informative and helped hospitals
- 9 to better understand the intricacies involved in caring for
- 10 someone with Ebola. These sessions were among the many
- 11 collaborative efforts to help hospitals stay on top of the Ebola
- 12 threat. And just something I'm sure the Commissioner would have
- 13 mentioned when he hit this point, I think one of the most,
- 14 having been through this for the past couple of months, I think
- 15 one of the most notable things during Ebola crisis in New York
- 16 or the preparation was how closely the State, the local health
- 17 departments in particular, the City of New York and the
- 18 hospitals and the provider associations worked together. It was
- 19 really something. I was very honored to be part of, and I know
- 20 the Commissioner would've said the same, would say the same.
- 21 The Department of Health has been preparing hospitals to
- 22 treat Ebola all fall and have been in constant contact with the
- 23 hospitals to make sure they've taken appropriate steps. The
- 24 Department staff have visited 211 hospitals throughout the state
- 25 and I'm very pleased to say that most of the facilities are

- 1 fully ready to handle a suspect Ebola patient. The Department
- 2 is working with the few very few hospitals that are not ready to
- 3 ensure that they get there quickly. But as I mentioned earlier
- 4 all hospitals in New York must achieve some degree of readiness.
- 5 At Governor Cuomo's request, Dr. Zucker issued a
- 6 Commissioner's order on October 16 that outlines what hospitals
- 7 must do to be prepared. The order required hospitals to develop
- 8 protocols, training, and drills, provide personal protective
- 9 equipment and identify a care setting to ensure that early
- 10 recognition safe handling a suspect Ebola patients is possible.
- 11 The Commissioner's order also requires all hospitals and clinics
- 12 in the State to be ready to evaluate, isolate, and transport a
- 13 person suspected of having Ebola. In addition, the Department
- 14 has begun to do readiness assessments for nearly 1000 clinics.
- 15 We've also met with state EMS providers to review their
- 16 protocols for safe transportation. We've spoke with community
- 17 health centers and other providers to ensure they were also
- 18 ready for an Ebola patient or suspect Ebola patient. In
- 19 addition, the Department amassed it's own stockpile of PPE for
- 20 hospitals who are unable to replenish their supplies in the
- 21 midst of treatment. We've also done practice drills for early
- 22 identification and isolation of suspect Ebola patients in an
- 23 emergency department, and these drills have taught us a great
- 24 deal about what we're doing right and what we're doing wrong and
- 25 helped us to prepare for that first patient, Dr. Spencer.

- 1 Whether there will be others besides Dr. Spencer remains to be
- 2 seen. But we do know that in Africa the virus is spreading.
- 3 Ebola has recently affected another country, this time the
- 4 nation of Mali. As of November 21, there have been eight cases
- 5 in Mali and six patients died. As a result, CDC and the
- 6 Department of Homeland Security have added Mali to the list of
- 7 Ebola affected nations and they're screening all travelers
- 8 coming into the U.S. each day from Mali as well as those from
- 9 Liberia, Sierra Leone, and Guinea. Although there are no direct
- 10 flights between the U.S. and Mali, approximately 15 to 20
- 11 residents of Mali do arrive in the United States every day by
- 12 way of other countries. Most of these people are U.S. citizens
- 13 coming home to America. In light of this possibility, we started
- 14 enhancing our screening for travelers who originated in Mali.
- 15 They'll be subject to the same 21 day monitoring and movement
- 16 protocols now in effect for travelers from Guinea, Liberia, and
- 17 Sierra Leone. That means twice daily temperature checks as well
- 18 as check-ins with the state and local public health authorities.
- 19 So as you can see, preparations for Ebola have escalated
- 20 significantly in the last two months.
- 21 President Obama's emergency funding request for \$6.2
- 22 billion that's now before Congress will help our nation grow the
- 23 response capability to this international public health threat.
- 24 It will help us maintain our hospital preparedness efforts,
- 25 enable us to work towards development of vaccines, drugs, and

- 1 diagnostic tools, and fund our response in West Africa and other
- 2 vulnerable countries while strengthening our global health
- 3 security. I'm pleased to say that New York has played a major
- 4 role and demonstrated to the nation that we can treat a patient
- 5 with Ebola without compromising the health and safety of those
- 6 providing that care.
- 7 So, the Commissioner also wanted to provide you with an
- 8 update on World AIDS Day. In particular to acknowledge the
- 9 commemoration of worlds AIDS day that took place the other day
- 10 at the Empire State Plaza. It was an event that galvanized the
- 11 AIDS community in our resolve to combat this disease and help us
- 12 to remember those we have lost to it. As you know, today in New
- 13 York we are at a turning point where we can actually envision a
- 14 future without AIDS. It's been a long and difficult journey.
- 15 New York has been at the epicenter of this epidemic since it
- 16 began in the 80s. In our darkest days the early 90s, New York
- 17 had as many as 15,000 new diagnoses a year. Today we're down to
- 18 3000 new diagnoses a year. Many factors played a role in what's
- 19 happened; better prevention strategies like free syringe
- 20 distribution programs for the injectable drug users, more
- 21 education and awareness such as our mandated offers of HIV
- 22 testing, improvements in healthcare including the newly approved
- 23 use of antiretrovirals for people who are HIV negative and want
- 24 to stay that way all these initiatives have had a hand in
- 25 driving down infection rates of HIV. When we talk about the end

- 1 of the epidemic, we're talking about not wiping out HIV
- 2 altogether -- only a vaccine would enable us to do that --
- 3 Rather, we're talking about bringing down the number of new
- 4 infections to just 750. Last month, Governor Cuomo announced the
- 5 creation of the ending the epidemic task force. To help us
- 6 achieve our goals, this group will support his three point plan
- 7 which includes identifying persons with HIV who remain
- 8 undiagnosed and linking them to healthcare, linking and
- 9 retaining persons diagnosed with HIV in healthcare to maximize
- 10 virus suppression so they remain healthy and prevent further
- 11 transmission, and providing access to pre-exposure prophylaxis
- 12 or PREP for high-risk persons to keep them HIV negative. The
- 13 plan will alter the future of AIDS in New York State. We'll go
- 14 from a state where the history of the worst HIV epidemic in the
- 15 country to one where new infections are rare and those living
- 16 with the disease will have normal lifespans with few
- 17 complications. The fact that we can even contemplate this
- 18 possibility demonstrates the power of public health and good
- 19 healthcare and showcases what we've achieved in New York.
- One other topic that the Commissioner, Dr. Zucker wanted to
- 21 bring you up to speed on was the New York State of Health.
- 22 We're now in the second year of the New York State of Health,
- 23 our marketplace healthcare exchange. We enrolled more than
- 24 960,000 New Yorkers in the first enrollment period and we're
- 25 well-ahead of our goal of insuring more than one million people

- 1 are insured by 2016. The premiums for the 2015 plans will
- 2 continue to be more than 50 percent lower than they were before
- 3 the marketplace was created. Nearly 75 percent of the people
- 4 enrolled received financial assistance that helped further lower
- 5 their monthly costs. And the Exchange is also enhancing it's
- 6 outreach efforts. Some of the informational materials will now
- 7 be available in 10 languages including Arabic, Hindu and
- 8 Yiddish. We've also enhanced the website and created a new
- 9 Spanish version. Consumers in many counties will have more
- 10 health plan options to choose from in 2015. We've added a plan
- 11 and compare guide that lets consumers see all available plans in
- 12 their county before they begin their application. Consumers
- 13 will also get a personalized premium quote without entering
- 14 personal information and completing the application. And we've
- 15 literally assisted thousands of people, New Yorkers, in the
- 16 enrollment process which began November 15 and ends on February
- 17 15 of next year.
- In closing, Dr. Zucker wanted to express thanks to the
- 19 people in Western New York and all those who assisted in
- 20 recovery from the recent series of snow storms. These people
- 21 worked hard to ensure the health and safety of people affected
- 22 by the recent storms was protected. Dr. Zucker was personally
- 23 there for several days and saw how hard people were working to
- 24 keep communities safe from all the snow and subsequent potential
- 25 for flooding. It was truly a testament to the human spirit and

for that again, he just wanted to convey his thanks. End of Dr. 1 2 Zucker's report. 3 4 PETER ROBINSON: Thank you. Any questions for Mr. 5 Sheppard? Dr. Gutierrez? 6 7 Two questions. I wonder at what point ANGEL GUTIERREZ: 8 we'll find it appropriate to start calling the Ebola a pandemic, 9 number one. Number two is I appreciate the celebration about 10 the HIV situation. When, what the position of the Department? 11 What role is the Department playing regarding the lifting of the 12 restrictions from blood transfusions by certain populations 13 groups? 14 15 DAN SHEPPARD: So, I'm probably not going to satisfy 16 neither question, and I, on the pandemic, unless another member 17 of the Department has the background to answer that, I don't 18 feel I'm in a position to answer that question. I apologize. 19 And on your second question I, we'll have to get back to you 20 with an answer. 21 22 PETER ROBINSON: So, those were good guestions then. 23

DAN SHEPPARD: Very good questions. And I wish there were

25 a physician from the Department here to help answer them.

- 2 ANGEL GUTIERREZ: I'm concerned because I believe that
- 3 there is a mental change that occurs when you stop using
- 4 epidemic and you start using pandemic. It happened with the
- 5 flu, but we have two other pandemics that we deal with every
- 6 day. One is the multiple drug resistant tuberculosis. We don't
- 7 talk about it that way. But the other one is HIV. It's a
- 8 pandemic. And I think that is a differential a change in the
- 9 attitude if we change the nomenclature we use to refer to it.
- 10 The second item deals with something that is up front in the
- 11 press today. There is some restriction that keeps homosexuals,
- 12 for instance, from giving blood and the red cross, and that
- 13 restriction is an entry point level restriction. We have tests
- 14 for blood obtained for transfusions that determines whether the
- 15 person is positive or not. The original restriction goes to the
- 16 early times of the pandemic, and it was justifiable then. It
- 17 appears to be less justifiable today. And it's upfront in the
- 18 press I think we need to respond.

19

DAN SHEPPARD: Both very good questions.

21

- 22 PETER ROBINSON: So, could we ask the Department to look
- 23 into that? I think that's a very appropriate question. Thank
- 24 you. Dr. Bhat.

1 DR. BHAT: Thank you Mr. Sheppard. Maybe I'll ask you a 2 question that you can answer. 3 4 DAN SHEPPARD: I hope so. 5 6 DR. BHAT: Ebola is going to be there in Africa for a long 7 period of time. As long as Ebola is in Africa we are 8 prepared here. Does it cost anything more? All the 9 all the hospitals that have to prepare for it. Is there - it 10 goes on for years. Is there any mechanism of funding either at 11 the federal level or the state level to defer the cost? 12 13 DAN SHEPPARD: As I mentioned in Dr. Zucker's remarks, the 14 President has put forward to Congress the \$6.2 billion request. 15 We would hope that federal government, given the national and 16 international nature of the situation would provide some support 17 to states for, to cover the cost of not just the set up to be prepared, but then also the extraordinary ongoing costs to treat 18 19 someone with the disease. 20 21 PETER ROBINSON: And actually the ongoing cost of 22 training. Because you can't remain static. It's not a one-time 23 thing. You actually have to take people off line and 24 continuously rehearse them if you're going to keep them current

and active.

- 2 DAN SHEPPARD: What's extraordinary when you start looking,
- 3 breaking down the course of treatment is the cost of not just
- 4 the staffing levels it takes but the disposal of waste and just
- 5 right down the line it's quite staggering.

6

7 PETER ROBINSON: Dr. Brown

8

- 9 LAWRENCE BROWN: Will you be able to come back to the
- 10 Council to share with us the data you have in terms of the Ebola
- 11 preparedness of the providers that have been reviewed by the
- 12 Department? It would be useful to know.

13

- 14 DAN SHEPPARD: I'd be happy to do that. We're in the midst
- 15 of completing all the visits and happy to give you statistics on
- 16 that. Sure.

17

18 PETER ROBINSON: Hello behind the pole there.

19

20 [it's like the old Yankee Stadium. Hard to see.]

21

22 PETER ROBINSON: It is. Could you identify yourself.

- 24 GARY KALKUT: Dr. Kalkut. Hi. Just a comment. The arch
- 25 of the AIDS epidemic from '81, I actually saw a patient in 1980

at Boston City Hospital who in retrospect had toxoplasmosis and 1 2 AIDs and what had happened with the disease in terms of 3 treatment, public health, community involvement, and the privacy 4 of New York, New York State, and particularly the AIDS Institute 5 in New York State in moving this along, I think is dramatic and 6 incredible effort, and should be commended. And again, from 7 1981 till now when I was around the AIDS program at Montefiore 8 we had an inpatient unit with 110 patients, was the census, that 9 was closed. Bellevue closed their inpatient unit. There are 10 plenty of problems that still exist, and it is a global issue 11 for sure. But what's happened in New York State is quite 12 remarkable. 13 14 DAN SHEPPARD: Thank you. I know the past couple months as 15 I've gotten to know the Department much more in depth than I had 16 before I came here in June, seeing visiting and meeting with some folks who work in the AIDS Institute and seeing the level 17 18 of dedication and just the longevity of how long many of them 19 had worked there, how dedicated they are is quite inspiring. 20 Thank you. I'll certainly make sure people are aware of your 21 comments. 22

Yes.

PETER ROBINSON:

23

CARLA BOUTIN-FOSTER: I just wanted to go back to Dr. 1 2 comments and just for the records that reasons to remove the 3 restrictions it sends the wrong message. If there's a missed 4 opportunity for identifying new cases, gay men or women are not 5 necessarily the fastest growing new infections and also it 6 really raises the question of how safe the blood supply is. 7 I think these are reasons when you go back to the Department to 8 mention why we should reconsider this. 9 10 Thank you. OK. So, now we turn to -PETER ROBINSON: 11 thank Mr. Sheppard for his report and the responses to those questions that we were able to get answers to, and the rest will 12 13 be forthcoming. Absolutely. 14 DAN SHEPPARD: Thanks for being gentle everybody. 15 16 17 And now for an update from the office PETER ROBINSON: 18 of Health Insurance Programs. Ms. Misa. Did I pronounce that 19 properly? 20 21 MS. MISA: It's Misa. Thank you. So thank you and good 22 morning. I just wanted to provide a brief update on our work 23 with DSRIP. So we are still on track with our DSRIP year one

deliverables, and currently we have 25 PPSs statewide, and a

detailed list of the 25 PPSs is available on the Department's

24

- 1 website for anyone looking for additional detail. I also today
- 2 wanted to briefly highlight some of the key DSRIP dates that
- 3 staff have been working on, and I wanted to mention that an
- 4 updated DSRIP timeline was circulated earlier this week and is
- 5 also available on the Department's website. So, in the
- 6 beginning of October on October 1, the final DSRIP plan
- 7 application was released, and earlier this week on December 1
- 8 LEAD submitted their final partner lists within the network
- 9 tool. at the end of this month on December 22 project plan
- 10 applications must be completed and submitted by the PPS lead and
- 11 two days later on December 24 applications will be posted to the
- 12 website and public comment on those applications will begin. We
- 13 will receive public comment until January 26. In early February
- 14 the independent assessor will make recommendations to the public
- 15 and in mid-February the DSRIP project approval and oversight
- 16 team will begin public hearings and meetings and they will make
- 17 their final recommendations to the state and members of the
- 18 DSRIP project approval and oversight team should be announced
- 19 over the next four weeks. And then on April 1 DSRIP year one
- 20 begins. So there is a lot of work in a very tight timeline, but
- 21 I'm happy to announce that we are on track and there's a ton of
- 22 information on DSRIP on the Department's website for anyone
- 23 that's interested. So, thank you, and that concludes my report.

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         PETER ROBINSON: Can you provide an update on the
2
    capital plan that's linked to DSRIP?
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4
         MS. MISA: Yeah, and I would defer to OHSM. I don't know,
5
    Lisa, if you have an update on -
6
7
         CHARLIE ABLE: Peter, I can respond to that.
8
    released the application last month. We had an applicant
9
    conference as well, and the original due date for applications
10
    which had been concurrent with the DSRIP application due date of
11
    December 22 has been pushed back to February 20. So that as the
12
    DSRIP PPSs come together and they're doing their final work now
13
    of this month they'll have a little more time once that work is
14
    settled to be able to compose the necessary information and
15
    documentation to support their capital requests. So, it's $1.2
16
    billion statewide, and two processes, one specifically for DSRIP
17
    PPS participants and one for those facilities that are outside
    of a PPS. The processes will remain essentially the same.
18
19
    details will be forthcoming on the website on the capital
20
    restructuring financing program website in the near future.
21
22
         PETER ROBINSON: Thank you. Questions for Ms. Misa or
23
    Mr. Abel? Dr. Martin.
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2 interesting presentation about regulatory relief as part of 3 DSRIP and I'm just curious how that aspect of the process is 4 going along. It may be too early for people to be asking for 5 it, but I'm not sure. I figured I would just ask. 6 7 Yeah, I think that we had had some further LISA ULLMAN: 8 discussions after we had posted to the web out document on 9 regulatory flexibility, which really outlined the areas that we 10 thought there would be potential for flexibility. We certainly 11 wanted to make all the providers aware that we were interested 12 in hearing from them, if they had ideas or questions about the 13 types of flexibility that they might need, and that's what 14 culminated in that document. We do anticipate making additional 15 information available as we get it. The requests for regulatory 16 flexibility waivers are to be submitted along with the project 17 plan applications which as states would be later this month. However, and I think we made this point in the presentation when 18 19 we were before this body last time, that if a provider, a PPS 20 recognizes a need for potentially additional waivers that hadn't 21 been requested in that application, they will have the 22 opportunity to request that as well. So we are sort of looking 23 forward to a continued ongoing dialog with the providers as they 24 move forward considering what waivers they need to request, and 25 we will make information available to them as we become, you

GLENN MARTIN: I think it was last cycle we had gotten an

- 3 hrs. 1 know, more able to sort of articulate specific regulatory 2 provisions where it looks like waivers might be available. So I 3 think we'll probably be posting more information on an ongoing 4 basis. 5 6 PETER ROBINSON: Dr. Kalkut. 7 8 GARY KALKUT: Thanks. Thank you. Question about 9 partners, the partner list was submitted, finalized I think on 10 Monday. There was some communication in the week just prior to 11 Thanksgiving about an audit and review process for those partner 12 lists. I was wondering if you'd comment on that, what that 13 process will be to audit the list, what opportunity for the 14 individual performing provider systems to review the lists. 15 Then I have a specific issue I want to ask about. 16 I don't have detail on the exact audit process, but I can 17 certainly go back to individuals who are working on that and get 18 19 back to you if that's helpful. 20 21 GARY KALKUT: It would be. 22
- 24

25 Peter?

[OK]

2 Dr. Rugge.

3

- 4 JOHN RUGGE: Just with regard to capital is providers all
- 5 around the state are looking at five year needs for new
- 6 investment. I think there is a consensus that \$1.2 billion is
- 7 not going to suffice. Curious in terms of how the Department
- 8 may be approaching this and what kinds of recommendations may be
- 9 forthcoming.

10

- 11 CHARLIE ABEL: Well, I'm aware that there is that concern,
- 12 and I've heard that there are discussions taking place, but
- don't have any progress to report.

14

15 PETER ROBINSON: OK then. Thank you very much.

16

JOHN RUGGE: You've heard it from us, that's all.

18

- 19 PETER ROBINSON: So I think we are now turning to an
- 20 update on the activities of the Office of Quality and Patient
- 21 Safety, and also I think the ad-hoc committee on office-based
- 22 surgery. Is that correct? Is that Mr. Roohan and Dr. Gestin?

23

24 [that's correct]

1 Thank you.

- 3 PAT ROOHAN: So, thank you for allowing me to speak
- 4 today. I'm going to give a general overview of the office since
- 5 we haven't really presented to this group of what we're doing
- 6 and what our core functions are.
- 7 Basically we divided up into four core areas. The first
- 8 quality improvement in patient safety, second evaluation
- 9 measurement reporting and transparency. The third, data system
- 10 enhancement and development, and the fourth healthcare
- 11 transformation. I'm going to give a couple examples of what
- 12 we're working on and Foster can elaborate on office-based
- 13 surgery for example.
- 14 So under quality improvement and patient safety one of the
- 15 projects we've been working on is to improve sepsis care in New
- 16 York State. Regulations has given us authority to review
- 17 evidence-based protocols from hospitals. That's the first part
- 18 of the regulation. The second part is to measure process
- 19 measures of sepsis care, and the third is develop a risk-
- 20 adjusted mortality model to compare hospitals. We have been
- 21 successful with the help of the hospitals, the hospitals'
- 22 participation, and this has been tremendous that the first
- 23 review of the evidence-based protocols were in and approved,
- 24 were in by December 31, 2013, and all have been approved are in
- 25 play right now.

- 1 We have a very incredible workgroup of stakeholders that
- 2 have been involved in developing data dictionary and how to
- 3 collect data on this, and we have begun to successfully collect
- 4 data. We are on our second data collection. We have two
- 5 quarters of data, second quarter was in as of last week. We're
- 6 still fairly in the early stages of that. A lot of data to
- 7 clean up. Working with stakeholders to improve that. Our goal
- 8 is to continue to evaluate this and to eventually get to
- 9 evaluate the impact on mortality. Sepsis mortality, sepsis
- 10 shock and severe sepsis mortality, serious condition and the
- 11 number one cause of inpatient mortality in New York State and we
- 12 will continue to work diligently on that.
- 13 Secondly under evaluation measurement reporting and
- 14 transparency, the Office of Quality and Patient safety is the
- 15 lead on quality measurement of healthplan reporting for the
- 16 Department for over 20 years. We've been doing, Foster, myself,
- 17 and many of our staff have been collecting what we call QARR,
- 18 the Quality Assurance Reporting Requirements. That system now
- 19 collects data from various managed care plan types including
- 20 commercial managed care, commercial PPO, Medicaid managed care,
- 21 child health plus, Medicaid special need plans, and beginning
- 22 this year the New York State of Health, healthplans for the
- 23 exchange population. And all we have measurement on
- 24 approximately 12 million people in the system.

- 1 Our staff also have been the lead in measurement and
- 2 alignment, collection reporting for health homes, proposed
- 3 (FIDA) program, the fully integrated duals program, DSRIP, HARP
- 4 the health and recovery plans, Medicaid behavioral health
- 5 plans which are being implemented in the future. We are also
- 6 the lead on measuring quality for the managed long term care
- 7 program as well.
- 8 Other measurement activities include the New York State
- 9 cardiac data reporting system. It's been a powerful resource
- 10 for quality improvement to improve the quality of care related
- 11 to cardiac surgery and PCI in New York State. Providing
- 12 hospitals and cardiac surgeons as well as cardiologists with
- 13 data about their own outcomes for these procedures allows them
- 14 to examine the quality of their own care, of the care they're
- 15 delivering and improve on that care.
- 16 The second area that we're working in and Anna has
- 17 presented to this group on is stroke. Stroke care in New York
- 18 in July of 2012 received a grant from CDC to
- 19 quality improvement initiative to approve in-hospital care for
- 20 acute stroke. With this grant, New York State has engaged a
- 21 statewide quality improvement activities that expand and
- 22 strengthen programs currently, the stroke designation program.
- 23 In addition, we're working with others in the Department in
- 24 collaborating a focus QI program that will do the following
- 25 things; one, increase the use and report of data on indicators

- 1 of stroke care collected from the stroke designated hospitals;
- 2 develop both aggregate and hospital-specific reports on stroke
- 3 outcomes collected through SPARCS data, the inpatient data
- 4 system and provide TA, technical assistance to support data
- 5 quality in hospital stroke care quality assurance.
- 6 Our third major area is what we call data system
- 7 enhancements and developments. We are the lead in developing an
- 8 all-payer database. An all-payer database will be claims,
- 9 beginning with claims data across all payers in New York. We
- 10 will begin this process with what we're calling public payers,
- 11 Medicaid, Child Health Plus and the New York State of Health.
- 12 We already have what we call a data intake system to collect
- 13 that data for the public payers that has begun this fall, and we
- 14 will go into production in beginning January 2015. Medicare data
- 15 will be added in 2015 in commercial insurance data collection
- 16 will begin in late '15. Funds were made available in the '14-
- 17 '15 budget to create the APD. We are currently developing
- 18 procurement to procure a vendor to do data storage in analytics
- 19 from the system. Serious considerations of the APD in terms of
- 20 the IP side of this as we anticipate the system to be about \$1.1
- 21 to \$1.5 Billion with a B rolls of data a year. APD regs are in
- 22 development. The Regs will address the submission requirements,
- 23 who submits what to us and most importantly access to the data
- 24 at what level who gets access to what, what could we release,
- 25 what we can't release. The second under data system

- 1 enhancements is a success story on SPARCS, the State health
- 2 planning and research cooperative systems. We have revised regs
- 3 presented to this group I believe last year. Some of those regs
- 4 clarified how we collect the data and also streamlined the
- 5 approval process and some of our data and processing. Through
- 6 some efficiencies we have posted data efficiencies as well as
- 7 posting data on the Healthdata.ny website that completely
- 8 deidentified. We have reduced the queue for getting SPARCS data
- 9 from I believe it was around 90 to 100 requests in a gueue that
- 10 would take almost a year to less than five today, and often that
- 11 queue is empty. Now our timeline is usually within a month we
- 12 can get data from SPARCS.
- 13 Lastly on data system enhancement and development is the
- 14 increase adoption utilization of the SHIN-NY, the State Health
- 15 Information Network of New York. The SHIN-NY is a network of
- 16 network that is connecting the regional health information
- 17 organizations, aka RHIOs across the state with patient consent,
- 18 electronic health records, can be exchanged instantaneously with
- 19 the system. Adoption of (EHRs) by provider the key to success
- 20 of the SHIN-NY as well as the ability of the EHRs to communicate
- 21 to the RHIOs. The New York State appropriate of [\$]55 million
- 22 in the current budget as well as a federal match of another 28
- 23 million will fund the SHIN-NY and the RHIOs. The funding will
- 24 create a standardized expectation across all RHIOs. For
- 25 example, what we call a patient alert when a patient actually

- 1 goes to the ER or the hospital, primary care doctor for example
- 2 will know that instantaneously.
- 3 Lastly, our office has been heavily involved in what we
- 4 call healthcare transformation and under that is both the State
- 5 Health Innovation Plan, aka SHIP which was submitted to the
- 6 federal government last year. We are also the lead on the State
- 7 Innovation model grant. That grant is a four-year grant for \$10
- 8 million. We should hear any day to have fund parts of the SHIP.
- 9 The SHIP dovetails very nicely with DSRIP. The SHIP is across
- 10 the State plan to transform healthcare, but our staff has been
- 11 the lead working very closely with Medicaid and all the
- 12 measurement activities related to DSRIP including measures,
- 13 specifications, reporting, and interaction with CMS.
- 14 And finally we have worked very closely with OHIP, the
- 15 staff, to include a lot of data on publicly available data,
- 16 things we haven't put out publicly before under healthdata.ny as
- 17 well as the DSRIP website including some of the core metrics of
- 18 DSRIP which are preventable, prevention quality indicators which
- 19 are called PQIs which are the preventable, potentially
- 20 preventable inpatient events. PPRs, potentially preventable
- 21 readmissions, and soon potentially preventable and avoidable ER
- 22 use.
- 23 That concludes my report.

1 PETER ROBINSON: Well, I thank you very much. I'd like 2 to sort of kick off maybe a couple of questions that I'm sure 3 I'm gonna maybe steal Mr. Levin's thunder a little bit here, but 4 the - it's just amazing the amount of data you apparently have 5 access to and the populations that you're able to capture 6 information on. And the question is, is that capability, can 7 that be delivered in such a way that we can evaluate the 8 efficacy of policies or practices that the council has purview 9 over? So, for example, the earlier discussion about dialysis 10 that resulted in the approval of that transaction, well the 11 whole question of how dialysis centers are performing 12 comparatively in New York State and whether or not there is a difference between, in New York, the for-profits and the not-13 14 for-profits, and what quality metrics should we be looking at 15 and can we make some kind of judgment about whether we're making 16 the right decision or not? I think that's sort of the kind of 17 question that the council would be interested in. Because it's very difficult to deal with that when you're dealing with an 18 19 individual application, yet we kind of are somewhat ill informed 20 when we're making judgments about those individual transactions 21 because we don't have that context. 22 23 PAT ROOHAN: I would say in an ideal state an all-payer 24 database will be able to answer those questions. And your

particular question given that it's Medicare data predominantly,

- 1 there will be additional access rules in terms of who gets what.
- 2 Part of the design feature of (RAPD) that is still under
- 3 development is how do we provide there's a catch 22 here how
- 4 do we provide detailed patient-level data for research
- 5 evaluation purposes in this case. We have to do everything we
- 6 can to protect the integrity of the patient's identifiable
- 7 information. So, we are working with that in general on the APD
- 8 and we will have to work with CMS on what can be released and
- 9 not released, but certainly this kind of data could help you
- 10 answer those questions.

- 12 PETER ROBINSON: Well, I'm actually thinking that we
- 13 could be a little bit more proactive in that, meaning that if
- 14 there could be over the course of a year two or three topics
- 15 that you would bring forward and present to the council on an
- 16 evaluative basis that would allow us to inform us better about
- 17 how we deal with some of the more controversial applications
- 18 that we deal with here, dialysis and the for-profit chains is
- 19 one issue that keeps coming up, ambulatory surgery has certainly
- 20 been an area where there's been a fair amount of controversy.
- 21 Some of that does relate to the questions of quality and access
- 22 that we have no basis I mean, we're almost reacting
- 23 subjectively or anecdotally to that rather using a broader set
- 24 of data that might more appropriately inform policy judgments or
- 25 transactional judgments that the council makes. So, just a...

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- FOSTER GESTEN: If I could respond specifically to the
- 4 dialysis issue, one of the things that the Committee should be
- 5 aware of is that CMS does post publicly data on quality for
- 6 dialysis centers. It's available on their websites, so there is
- 7 currently publicly available information on the quality of
- 8 healthcare at dialysis centers. What is not on that website is
- 9 a detailed analysis looking at for profit versus not-for-profit,
- 10 although those sorts of analyses are certainly in the
- 11 literature. And as some of you may be aware of there are
- 12 articles and studies back and forth about whether previous
- 13 studies have sufficiently adjusted for patient risk factors to
- 14 do that analysis. But, to some degree, some of that information
- 15 relative to quality is currently available.

16

- 17 PETER ROBINSON: Right, and although I think what we're
- 18 talking about here is obviously a New York State focused look at
- 19 that data, and that seems to be something that you may be in a
- 20 better position to do for us.
- 21 Are we going to continue with the ad-hoc committee report
- 22 on surgery? Are there further questions from the Council? Ah,
- 23 Dr. Berliner.

1 HOWARD BERLINER: Two questions. One, is there any 2 timeline or any kind of date that you can give us for when the 3 all-payer database would be available? And the second question 4 is, is the State Department of Health going to be releasing a 5 report on Yorkville Endoscopy given that CMS released one two 6 weeks ago. 7 8 PAT ROOHAN: I'll answer the first question on APD. So, 9 we are fairly down the line building the front end, what we call 10 the front end systems. Basically how to get the data into the 11 system collected from the carriers starting with the public 12 payers. So that system will be, like I mentioned, will be up 13 and running in January. We have to get regulations through for 14 the commercial carriers so we don't have regulations, we're in 15 that pre-vetting process right now, so once we get the 16 commercial - once we get the regulations in we anticipate that 17 commercial data will be hopefully submitted by the late this year - late '15. So I would say sometime in '16 we will have 18 19 data across multiple payers including commercial insurance. 20 21 22 FOSTER GESTEN: So, pertains to activities of not our office 23 but the Office of Health Systems Management. I'm told that the 24 SODs for Yorkville are up on our website. I don't know if

1 that's what you were referring to or you were referring to some 2 other sort of report. Statement of deficiencies. 3 4 PETER ROBINSON: OK. So, -- I'm sorry, Dr. Brown. 5 6 I'm sort of curious, you mentioned LAWRENCE BROWN: 7 curious about evidence-based approaches that you are focusing 8 upon, and I'm sort of curious if you can share with us briefly 9 how does the Department really assess whether they actually are 10 in practice? I mean, we hear that term quite often. Really 11 wonder how do you assess that's indeed what happened? 12 Well, the plan is to assess it by 13 PAT ROOHAN: measurements of compliance using the data that we're collecting. 14 15 We don't have another loop on survey on this yet, do we? 16 17 LAWRENCE BROWN: So are you using outcome measures? Are 18 you using process measures? 19 20 21 FOSTER GESTEN: You're referring to sepsis is your question? 22 So, I think this is one of the few examples, actually, where we 23 have actually sort of a structural and a process and an outcome 24 component as part of the evaluations. So the structural 25 component as Pat mentioned is the evaluation of the protocols.

- 1 As you say, so that's nice, but how do you know that they're
- 2 actually being used in practice? That part is part of the
- 3 measurement in the data that we're collecting is to evaluate the
- 4 degree to which hospitals are adhering to their own protocols
- 5 and specifically the aspects of protocols that have the
- 6 strongest evidence and that have sort of a time limited
- 7 component to it; three hour bundles, six hour bundles, that's in
- 8 the literature around surviving sepsis and other data. And then
- 9 the third component in terms of outcomes obviously is to look at
- 10 how patients do. So, in this case, unlike some others, we
- 11 actually kind of have a complete set, and part of what we're
- 12 want to put together over the next year or two is how those
- 13 components actually relate to one another, how the protocols,
- 14 the specifics of the protocol relate to adherence and also
- 15 ultimately relate to patient outcome.
- 17 PETER ROBINSON: So, Dr. Gesten, why don't we let you
- 18 continue with your report on the ad-hoc committee on office-
- 19 based surgery.

- 21 FOSTER GESTEN: Happy to. So, I want to thank my colleagues
- 22 who have been working on this issue with me. Nancy and Pat, but
- 23 also the long standing interest that the Committee has on
- 24 office-based surgery and the office-based surgery program,

- 1 including but not limited to support and suggestions relative to
- 2 legislative changes which I'll talk about a little bit later.
- 3 So, I'm going to provide a brief update on program
- 4 activities related to our review of adverse events. We did
- 5 create an ad-hoc office-based surgery advisory committee. We
- 6 established this in late August of this year. That committee is
- 7 chaired by Dr. Bernie Russoff who may be familiar to many of
- 8 you. He's certainly worked extensively both with the Department
- 9 and nationally on quality and safety issues and has been the
- 10 chair of two previous committees on quality assurance and
- 11 office-based surgery that were appointed by the Department to
- 12 look into specific issues of safety and adverse events at the
- 13 request of the public health council. Our ad-hoc committee
- 14 members include Dr. Clair Bradley from iPro, Dr. David Fox who's
- 15 a vasco-surgeon, Dr. Renee Garrick who's a nephrologist, Dr.
- 16 Gary Kalkut who's a member of PHHPC and I have the ID
- 17 specialist, I hope we have that right. Yes. Dr. Rebecca
- 18 Twersky is an anesthesiologist, Jim Tift is a
- 19 gastroenterologist, and (Pierre Robson) who is a clinical nurse
- 20 specialist in interventional radiology. This, the major
- 21 objectives of the Committee are to assist the patient safety
- 22 center and the Department in reviewing adverse event data with a
- 23 focus on office-based surgery related deaths to identify
- 24 potential systemic and preventable issues that we can tackle as
- 25 a program and as a state. We're also looking for the group to

- 1 make recommendations to the program to enhance our data
- 2 collection and improve patient safety for those individuals who
- 3 are having office-based surgery procedures. The committee, to
- 4 date, is met by conference call. Initial call was on September
- 5 30 and we had a face to face meeting on November 13, and we have
- 6 meetings scheduled into 2015. We envision that the work of the
- 7 group in terms of concluding its recommendations and report may
- 8 be somewhere between a six to 10 month timeframe.
- 9 We have also done additional analysis of the office-based
- 10 surgery adverse event data that was received by the Department
- 11 over the past four years from 2010 to 2013 with a focus on
- 12 deaths. Particularly those involving vascular and GI
- 13 procedures, patients who have undergone those procedures, and
- 14 those were presented in deeper analysis to the Committee in the
- 15 two meetings that we had. As may have been stated previously
- 16 and some of you may know, the majority of the office-based
- 17 surgery deaths involve end stage renal disease patients,
- 18 apparently the subject of today, who are on dialysis and
- 19 receiving various kinds of surgical interventions to correct
- 20 shunt abnormalities or deal with shunt dysfunction. So a lot of
- 21 our focus is on looking at those cases and trying to better
- 22 understand those.
- Our plans for next steps include review, and external
- 24 review of the 2014 deaths and those going forward with external
- 25 experts, combination of anesthesiology and appropriate

- 1 procedural lists to look at interrelated reliability between our
- 2 internal review and having independent external expert review to
- 3 better understand what it is that we're looking at and help us
- 4 come to appropriate conclusions about related or un-relatedness
- 5 to procedure. We're also looking to match the adverse event
- 6 data to vital statistics death data to give us potentially more
- 7 information, particularly on those individuals who may die
- 8 outside of an institutional setting some number of days from a
- 9 procedure. See if we can better understand whether there may
- 10 have been any connection between the procedure and that event.
- 11 We are engaging the office-based surgery accrediting bodies.
- 12 There are three of them in New York state in discussions
- 13 regarding the collection of adverse event data, their
- 14 collection, what they collect, and other data from practices
- 15 that may be useful to us. The requirements that they have for
- 16 accreditation, particularly in some high interest areas
- 17 including documentation, peri-procedural monitoring, staffing,
- 18 and other areas that the Committee is starting to generate some
- 19 particular questions around. And as well as the potential to
- 20 calculate denominator or procedures which we suffer from not
- 21 having. We have a numerator of reported adverse events, but we
- 22 don't have the denominator of the actual procedures to be able
- 23 to look at the actual rate of adverse events which is critical
- 24 to understand overall safety or to be able to compare for

- 1 example, the overall safety of procedures in one setting versus
- 2 another.
- 3 We've engaged, planned to engage the targeted medical
- 4 specialty societies and experts, particularly in vascular and GI
- 5 to review, help us review and help the subcommittee, the ad-hoc
- 6 committee review our findings and interpretations and look for
- 7 other potential sources of data and recommendations that may be
- 8 useful to us. We are in terms of data, not being able to maybe
- 9 answer both this and broader questions that were raised earlier
- 10 around dialysis centers, we're interested in exploring the
- 11 usefulness of the U.S. renal data system database which is a
- 12 comprehensive dataset that may enable us to answer some
- 13 questions about morbidity and mortality of end stage renal
- 14 patients undergoing vascular access related procedures across
- 15 all settings. It may also enable us to look at New York
- 16 specific, which I think was part of your recommendation or
- 17 suggestion. We're also looking at the, and exploring the
- 18 usefulness of other datasets that might help us fill in some
- 19 gaps or look for potential underreporting. Those include
- 20 looking at the Medicaid data sets, SPARCS. Again, with the
- 21 focus on potentially identifying underreporting of adverse
- 22 events or to gain additional information regarding adverse
- 23 events, encourage subsequent procedures in regulated outpatient
- 24 settings.

- 1 Couple of other things we're continuing to pursue
- 2 electronic submission as process for reporting adverse events to
- 3 try to decrease the barriers or the burden of making adverse
- 4 events reports to the Department, and also, as I mentioned up
- 5 front we'll be pursuing the amendments to OBS legislation that
- 6 were supported by PHHPC last year, submitted last year. We'll
- 7 resubmit those again, because we think those are also important
- 8 recommendations that help us enhance our ability to both
- 9 understand what's going on and also improve the safety. So,
- 10 thank you. That concludes my update. I'd welcome comments,
- 11 questions from the Committee but also would welcome any
- 12 additions that Dr. Kalkut since he was part of those
- 13 conversations might want to make.

15 PETER ROBINSON: Thank you Dr. Gesten. Mr. Levin.

- 17 ART LEVIN: Couple things. I know it isn't your bucket
- 18 of water to carry, but back to your call for a moment. Is there
- 19 actually a State Department of Health statement of deficiency on
- 20 Yorkville? I mean, trying to find it on the website is like an
- 21 adventure. And I'm curious. I mean, the CMS statement of the
- 22 deficiency got widespread notice and publicity you could read it
- 23 everywhere. As far as I know I haven't seen a peep about
- 24 anything the State has done. It's just odd to me, and I know,
- 25 again, it isn't your office, but to the Department in general it

- 1 seems to me it's sort of embarrassing to have a CMS SOD out
- 2 there for two weeks and nothing from the State Department of
- 3 Health and what went on in Yorkville. So that's just a comment.
- 4 Again, I know -

- 6 PETER ROBINSON: Is there somebody from the Department
- 7 that can comment on that?

8

- 9 LISA ULLMAN: I don't think so, but we'll take it back and
- 10 if there is further information we'll provide it.

- 12 ART LEVIN: I mean, it would be nice to know whether the
- 13 Department concurs or has additional concerns about what
- 14 happened at Yorkville, and what the lessons learned are. I
- 15 mean, if we want to make things better, that was a licensed
- 16 ambulatory surgery right? Facility. That wasn't office-based
- 17 surgery. So, we need to know. What went wrong and what can we
- 18 do to make sure it doesn't happen again.
- 19 Foster, on the denominator issue, legally is there a way to
- 20 require offices, physician offices to report into something like
- 21 SPARCS where we could create an denominator? If I remember
- 22 having been part of this process for a long time, view was that
- 23 the Department had no authority over offices. They had
- 24 authority over physicians, and so everything was done through
- 25 230 and 6510 of ED law. But I mean, under what authority would

- 1 the Department be able to require physician offices to report
- 2 into a database like SPARCS and why aren't we moving ahead with
- 3 that? Because we really need to have that denominator.

- 5 FOSTER GESTEN: So, Art, the view is that there isn't
- 6 current authority to request this information from office-based
- 7 practices. That there's current legislation that circumscribes
- 8 what information we collect, but the recommendations on new
- 9 legislation would allow us to collect information like that. I
- 10 don't know that it would be like SPARCS, but it would be, for
- 11 example, information that would allow us to collect denominator
- 12 data on a number of procedures. Or also, as I mentioned,
- 13 exploring getting that information from accreditations agencies,
- 14 but I think that our desire, our preference would be to collect
- 15 it directly from practices as well.

16

- 17 PETER ROBINSON: And obviously as Mr. Levin was stating,
- 18 this is actually a licensed ambulatory surgery center, so in
- 19 this case, there are probably more reporting obligations and
- 20 hence some additional data that might be available already.

21

- 22 ART LEVIN: Am-surge licensed facilities report to
- 23 SPARCS. There's a separate database.

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         FOSTER GESTEN: Yes, I assumed you were talking about
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    office-based in your question, Art, not -
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         PETER ROBINSON: Is there a request here Mr. Levin?
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6
                        Well, I think it'd be interesting to know
         ART LEVIN:
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    why the proposal for sort of upgrading office-based surgery
8
    regulations sort of didn't happen. And how helpful we can be
9
    since we passed on those proposals. How helpful this council
10
    can be in making sure that they happen this year. I mean, there
11
    are upgrades. They're not everything that one might want, but
12
    they're certainly upgrades.
13
14
         PETER ROBINSON:
                             So I guess there are two questions that
15
    we're kind of handing back to the Department for follow-up. One
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    is that and the other is the earlier question that was raised
17
    about the Yorkville ambulatory surgery center, and the status of
    the State Health Department's stance with regard to it. Dr.
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19
    Kalkut and then Dr. Bhat.
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21
                        All right. Thank you. It was a good
         GARY KALKUT:
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    discussion at the November 13 meeting and there was data
23
    presented that we hadn't seen in the previous presentation to
24
    the Council that was helpful. I think to me there were two
25
    outstanding issues and Foster mentioned both of them. One is
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- 1 the issue of rates, which until it's settled there's a lot of
- 2 circular reasoning and circular discussion about what's the
- 3 actual meaning of these numbers, and I think if it is in the
- 4 legislation that be resubmitted. I think that's an absolute
- 5 foundation to try to assess what's happening in the office-based
- 6 surgery. And the second is in classifying the cases that are
- 7 looked at, the Department is dependent wholly on the
- 8 documentation that is provided to them, and that documentation
- 9 is not always comprehensive, certainly, and is episodically it
- 10 seems like, not helpful. So in classifying whether they're
- 11 related, unrelated or cannot determine, it really depends on
- 12 what we get from the office-based surgery center and some
- 13 standards for that could be helpful in saying really one of the
- 14 base questions is, is it related and are there issues in a
- 15 specific center. So I think that's another area of sort of
- 16 basic focus for the group.
- 17
- 18 PETER ROBINSON: So it does seem as though the Council
- 19 is sort of requesting some greater level of accountability and
- 20 reporting here, and some of that probably does require
- 21 legislation and so therefore probably asking that the Department
- 22 be an advocate inside state government for the passage or the
- 23 submission of such legislature.
- Dr. Bhat.
- 25

- 1 DR. BHAT: There was a reference that was made for U.S. RDS,
- 2 it's absolutely right. I think over the last one decade the
- 3 number of admissions to the hospital for
- 4 surgery has gone done by about 50 percent. That means most of
- 5 them have migrated into am-surg and office-based. The issue
- 6 about whether you could ask USRDS, USRDS has a lot of data but
- 7 only thing is the one they are publishing may not have it but
- 8 you have to go back and request them to tease it out and tell
- 9 you how many of these procedures that were done in office-based
- 10 hospital, then you might be able to find out about the
- 11 denominator issue that you have. I think last time we had
- 12 extensive discussion, we knew there were a lot of deaths in
- 13 vascular surgery that died in office-based surgical centers.
- 14 But we did not know how many procedures that were done. And the
- 15 last issue that I have is, there's a mention that was made about
- 16 JACO and QUAD-A. I don't think they're coming back, the office-
- 17 based, to ask them how many procedures were done or adverse
- 18 events. Once the accreditation is done I doubt very much they
- 19 would go back and take a look. Experience to say that they come
- 20 back every four years. That means in the interim period nobody
- 21 is looking at what's going on in the office-based surgery.
- 23 PETER ROBINSON: Thank you Dr. Bhat. Any other questions
- 24 for Dr. Gesten? Thank you for your report. Appreciate that.

1 Ms. Rautenberg for the activities of the Committee on Public

2 Health.

- 4 ELLEN RAUTENBERG: OK. Here's the report from the public
- 5 health committee. You will remember the Prevention Agenda is
- 6 now two years old and the local planning activities are at the
- 7 end of their first year. When we looked back on our first cycle
- 8 five years ago, what we saw is that everything was great in the
- 9 planning cycle, but then seemed to lose a lot of traction in the
- 10 implementation cycle. So we are now highly focused on the
- 11 implementation of the local plans between local health
- 12 departments, hospitals, and their community partners.
- 13 A couple of things I want to highlight; in terms of health
- 14 disparities, 10 members of the ad-hoc committee met in September
- 15 to discuss how to support stronger action of local health
- 16 departments and hospitals towards advancing health equity and
- 17 specifically to identify ways to support local communities in
- 18 addressing health disparities as requested by New York State as
- 19 part of the public health agenda. There was a good discussion
- 20 on that day and a lot of it came down to tracking the disparity
- 21 related activities of each organization on the committee to find
- 22 some success stories that we could talk about around the state
- 23 and identify lessons learned from partnerships that are focusing
- 24 on health disparities.

- 1 There's a health equity report that's coming out from the
- 2 Office of Minority Health. They're working around a legislative
- 3 mandate to produce this report and the Committee has offered to
- 4 help them communicate the findings of this report throughout the
- 5 state. We're also making sure that the local partnerships are
- 6 aware of and have access to data on health disparities.
- 7 The second thing I want to highlight is a meeting that was
- 8 held for those localities that are working on promoting mental
- 9 health and the prevention of substance abuse. This was the
- 10 second most-likely chosen priority within the Prevention Agenda-
- 11 the first being chronic disease. The New York State Health
- 12 Department, along with the New York State Office of Mental
- 13 Health, the Office of Alcohol and Substance Abuse, and the New
- 14 York State Association of County Health Officials, the
- 15 Conference of Local Mental Health Agencies, and the New York
- 16 Academy of Medicine hosted a one-day meeting to provide training
- 17 and technical assistance to communities that selected this
- 18 particular Prevention Agenda item as one of their top two. There
- 19 were-and I think this is a great success-29 counties were in
- 20 attendance at this meeting, and counties came with their
- 21 government counterparts, as well as their hospital partners, and
- 22 sometimes even the community partners. They were -- there was a
- 23 lot of conversation about evidence-based interventions in areas
- 24 around suicide prevention, prescription drug prevention, tobacco
- 25 cessation for those with mental illness, and ESBERT. The meeting

- 1 was an opportunity for communities to share what they were doing
- 2 and learn from each other.
- 3 New York State will be requesting a one-year update from
- 4 the local health departments on hospitals via a survey tool, as
- 5 well as the Schedule H from hospitals to see how investments in
- 6 community benefit may be linked to the Prevention Agenda
- 7 efforts. The survey asks local health departments and hospitals
- 8 to answer brief questions about the progress made since they
- 9 submitted the 2013 plan and on the two Prevention Agenda
- 10 priorities or focus areas and the intervention selected for
- 11 implementation. We plan to host an ad hoc committee meeting in
- 12 early February to provide a summary of what we learned from the
- 13 survey. I'll take questions.
- 14
- 15 PETER ROBINSON: Thank you, Ms. Rautenberg. Any
- 16 questions? Hearing none, we're going to move to the Committee on
- 17 Health Planning and ask for Dr. Rugge's report.
- 18
- 19 JOHN RUGGE: Health Planning has two items to report. One
- 20 is informational and that is we've had two sessions on
- 21 development criteria for the approval of off-campus EDs, where
- 22 there has been no ED previously. There is a mechanism in place
- 23 for recognition of off-campus EDs when a hospital closes but the
- 24 ED continues. At our first meeting, the committee could do no
- 25 better than come up with a Potter-Stuart solution-we'll know it

- 1 when we see it, but we can't imagine developing criteria. In
- 2 response, Chris Delker and the Health Department came back with
- 3 an array for potential criteria for identifying communities
- 4 that, indeed, would be well-served by an ED not currently in
- 5 place. Through committee discussion, the determination was to
- 6 focus on essentially the interaction of two criteria: one is
- 7 distance from the nearest available existing emergency
- 8 department and the second being the size of the population.
- 9 Recognizing that at a certain distance, but with very low
- 10 population, reliance would have to be made upon rescue squads
- 11 and more high-tech mobile services, but where there is
- 12 sufficient population density and growing communities, there may
- 13 well be a need in this era for emergency services-full-scope
- 14 emergency services—in the absence of in-patient beds. With that,
- 15 based on that conversation, the Department is now working on a
- 16 proposal, which may well be ripe for presentation to the full
- 17 Council. If there are any questions on that? I can pause and
- 18 barring any questions, move on. Yes. Dr. Martin.
- 20 GLENN MARTIN: Just a clarification. When you said
- 21 distance, I thought we... that included distance and also travel
- 22 time.

- 24 JOHN RUGGE: Yes, I should say distance and time. Yes.
- 25 Moving on. In addition, the Committee took up the proposed

- 1 designation of Nicholas Noyes Memorial Hospital as a stroke
- 2 center and I believe Anna Colello has some detail for
- 3 consideration by the full Council at this time. Anna.

- 5 ANNA COLELLO: Thank you, Dr. Rugge. At the time of the
- 6 committee meeting, we discussed several of the contingencies
- 7 that the application from Noyes Hospital had to meet prior to
- 8 becoming designated; those contingencies have been met, except
- 9 for approval of a transfer agreement for surgery when needed has
- 10 to be within two hours of when deemed necessary. I am still
- 11 awaiting that. The full Council can recommend that we go forward
- 12 and have that contingency remain and be subject to our seeing it
- 13 when we go on site prior to full designation.

14

- 15 JOHN RUGGE: With that report, I would, on behalf of the
- 16 Committee, move approval with that contingency for Nicholas
- 17 Noyes Hospital. Not sure who wants to take the lead here.

18

19 CHRIS BOOTH: Mr. Robinson's absence.

20

21 JOHN RUGGE: We have a whole lot of seconds.

22

- 23 CHRIS BOOTH: Is there any further discussion? All those
- 24 in favor, say aye.

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1
    Aye.
2
3
         Any opposed? Any abstentions? Motion passes.
4
         Thank you.
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         CHRIS BOOTH: That concludes your report?
7
8
         JOHN RUGGE:
                        That concludes my report.
9
10
                        Thank you, Dr. Rugge. Dr. Gutierrez, with a
         CHRIS BOOTH:
11
    report on the Committee on Codes, Regulations, and Legislation.
12
13
         ANGEL GUTIERREZ: We're past the meridian, so good
    afternoon. Today we'll report on the proceedings of this
14
    morning's Code Committee meeting. The Committee reviewed three
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16
    regulations at the meeting-two for adoption and one for
17
    information. For adoption is a Certificate of Need Requirements.
18
    These proposed regulations are for an amendment section of
19
    Article 28 that now allows the submission of a written notice,
20
    as opposed to a CON application, for construction projects
21
    regardless of cost that involved only non-clinical
22
    infrastructure, facility repairs and maintenance, or the one-
23
    for-one replacement of equipment (medical or non-medical). Where
24
    applicable, architect and engineering certifications, and a plan
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for patient safety during construction would still have to be

1 submitted. The Committee voted to recommend for adoption to the 2 full Council, and I so move. 3 4 So, I have a motion. Do I have a PETER ROBINSON: 5 second? Dr. Berliner. Any questions? I'll call the question. All 6 in favor? 7 8 [Aye]. 9 10 Any opposed? Abstentions? The motion carried. 11 12 ANGEL GUTIERREZ: For adoption also is the integrated 13 services licensure. IT'S an option to consider proposed 14 regulations pertaining to the integration of primary care and 15 behavioral health care outpatient services. Lisa Ullman, who was 16 present for question and further information from the Department 17 Advisory Committee, that the regulations have been jointly developed by the Department of Health, the Office of Mental 18 19 Health, and the Office of Alcoholism and Substance Abuse 20 Services. For the Department, this proposal will create a new 21 part 404 of Title 10 of the NYCRR. OMH and OASAS will each issue 22 identical regulations. The regulations will apply to stand-alone 23 Article 28 diagnostic and treatment centers and extension 24 clinics, general hospital outpatient programs, mental hygiene 25 law Article 31 clinic treatment programs, [and] mental hygiene

- 1 law Article 32 substance-use disorder programs. Regulations will
- 2 allow these outpatient providers, who are already licensed or
- 3 certified by more than one state licensing agent or in the
- 4 process of pursuing licensure or certification to add services
- 5 at one of their other sites through an expedited process.
- 6 Without the regulations, they would have to get licensed by the
- 7 second agency in order to provide the additional services at the
- 8 additional site. Providers adding behavioral services would have
- 9 to engage in appropriate treatment planning and provide certain
- 10 minimum services. Providers adding primary care services would
- 11 have to meet hygiene and safety standards, pertaining to things
- 12 like the storage of supplies, the handling of soiled linens,
- 13 space requirements for treatment rooms and waiting areas, and
- 14 the availability of hand-washing stations. Finally, providers
- 15 would be subject to inspection only by the one agency that
- 16 originally licensed this site at issue. The agencies will
- 17 consult with each other as they conduct such oversight. With
- 18 concerns expressed about the readiness of this proposal and
- 19 assurances from the DOH that the concerns will be addressed, the
- 20 Committee voted seven to one to recommend adoption to the full
- 21 Council, and I so move.
- 23 PETER ROBINSON: Thank you. I have a second by Mr.
- 24 Fassler. Questions? Call the question, all in favor... Oh, sorry,
- 25 there is a question. Dr. Brown. I apologize.

2	LAWRENCE BROWN: Thank you. In fairness to the fact that
3	Dr. Martin and I had an opportunity to speak to the Behavioral
4	Health Services Advisor Council, the question I am going to pose
5	is the one that I posed to them—that we didn't get really an
6	answer and it maybe something that the Department of Health
7	could consider down the line-because it was not clear why OASAS
8	certifies its providers to provide care and Department of Health
9	licenses its providers to provide care. So it would be useful to
10	understand is that a distinction because it gives the impression
11	of something different and that something different is the
12	thing, the reason why we are having to integrate so they won't
13	have that sense that something is so different that someone has
14	to be treated a different way that was substandard. Only this
15	allowed me to bring this up to the share with the Department, so
16	that maybe they can bring back to us some sense from their
17	collaborations with OASAS about the value of that, continuing in
18	that way.
19	
20	LISA ULLMAN: We can certainly, you know, bring back-I'll
21	be here again, so I can certainly bring back further information

on that. I mean, the practical effect of the regulations as we 22 talked about is that there are those formal approval processes. 23 They are licensing in nature whether you call them licensure or 24 25 certification. The point is that those formal approval processes

- 1 for both agencies and we were just trying to expedite that
- 2 formal process so that you wouldn't have to undergo it for both
- 3 of them. But we can certainly...

- 5 LAWRENCE BROWN: I apologize. I have no objection with
- 6 the process, it's just the nomenclature that we're using and the
- 7 provision of care in the State of New York. For services that
- 8 are provided for physical health we say we license a provider;
- 9 services provided for behavioral health, particularly addiction
- 10 services, we say we certify a provider. So, that, just from the
- 11 standpoint of a citizen of the State of New York, to have such a
- 12 distinction to continue, if we can find out why it was the case
- 13 in the first place, and then decide, having discussion about why
- 14 it should continue.

15

- 16 LISA ULLMAN: Sure, the terminology in these regulations
- 17 is simply reflective of what's used elsewhere. You know, the
- 18 practical effect, I think, is the same, but we can certainly,
- 19 you know, come back with more information next time.

20

- 21 PETER ROBINSON: So, we have a motion and second on the
- 22 floor, so I am now going to call the question. Oh. Dr.
- 23 Gutierrez.

1 ANGEL GUTIERREZ: I am still concerned about the language 2 in the proposal and I understand that Dr. Rugge pressed the 3 Department for a time of definition or change of the wording on 4 that regulation. Their response was this needs immediate 5 attention. We heard opinions strongly expressed that there is 6 objections by the community out there on the moving of this 7 regulation forward. It would take two months to recycle this. 8 This is so pressing that we have to move it forward or can we 9 just-or is there any other mechanism that we can hold the feet 10 of the Health Department to the fire so they come back? One way 11 or the other, they are going to have to come back. 12 13 PETER ROBINSON: Can we get a response to Dr. Gutierrez? 14 15 LISA ULLMAN: Yeah, I do feel the pressure of answering 16 the questions in a very expedited fashion. If we do not move 17 forward with the regulation at this time, you know, we will not have moved forward with the integration of services, which, I 18 19 think everyone agrees is a really important thing that we need 20 to achieve. What you have, you know, suggested the addition of 21 those prenatal services, which we had not included, if we were 22 to layer that on later, that's, you know, something that we 23 could do. If we did not move forward at this time, we just 24 aren't going to be able to put into play, you know, the important idea of trying to, you know, get services to people 25

- 1 who just aren't able to get them now in those settings. So,
- 2 again, I definitely appreciate, you know, your interest in
- 3 getting an expedient answer and I want to provide one for you.
- 4 And we can do that, you know, on the next occasion on which, you
- 5 know, the Committee, and then the Council convenes. But, again,
- 6 I would just urge that if we could move forward at this time, it
- 7 would just allow us to move forward with the process and allow
- 8 the providers to start putting together their requests to move
- 9 forward with the integration of services.

- JOHN RUGGE: I would just like to express my full
- 12 confidence that you will be back with this in two months and I
- 13 think going half a mile and the next half mile in another two
- 14 months would be prudent.

15

16 ANGEL GUTIERREZ: I can live with that.

17

- 18 PETER ROBINSON: Please, could you repeat what you just
- 19 said?

20

- 21 JOHN RUGGE: Yeah. Only that I am sure that the
- 22 Department will bring back further information regarding the
- 23 potential inclusion of prenatal services in the integration and
- 24 to take this step forward today seems wise.

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ANGEL GUTIERREZ: And also addressing the restriction on
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2
    the use of perfectly usable...
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4
         JOHN RUGGE: Yes, absolutely, architectural...
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6
         ANGEL GUTIERREZ: If that, if we, if I can hear a
7
    guarantee that those two particular issues will be recycled, I
8
    am prepared to vote today.
9
10
         LISA ULLMAN: Yeah, I absolutely confirm that we will come
11
    back to the next meeting and provide you, you know, with further
12
    explanation. If it does turn out that, you know, we do recommend
13
    making the changes, we'll certainly process any needed
14
    regulatory changes at that time quickly. But, you know, you
15
    certainly will come back with the information.
16
17
                             So, I think what we're saying here is
         PETER ROBINSON:
    that this would be an agenda item on the next Codes Committee
18
19
    meeting, with those two topics specifically being addressed. I
20
    think that's the ....
21
         ANGEL GUTIERREZ: I would appreciate that. Yes.
22
23
24
        PETER ROBINSON: Ok. With that... Yes.
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1 [unidentified]: Can we also get some kind of assurance 2 that the discussion will be not only among the agencies, but the 3 provider community, because what I heard expressed was that 4 there was some concerns lingering in the provider community, 5 which may go beyond what we talked about in the Codes Committee? 6 7 LISA ULLMAN: Yeah, we, as I sort of mentioned, we you 8 know, certainly evaluated those, you know, requests that had 9 come forward from commenters and, you know, we made some 10 changes, but, you know, certainly, you know, there were items 11 that we felt we could not address or some that we felt we could 12 address by quidance going forward because some of it had to do 13 with, you know, questions about the meaning of overlapping 14 regulations and we think we can clarity that through guidance. 15 We will, as we move forward in finalizing the regulations, if, 16 you know, the council does, you know, agree to let us move 17 forward, we will be assessing those comments on a more formal basis, and those will, you know, be published. So certainly 18 19 there will be, you know, an opportunity to understand those 20 comments in more detail. And with this initiative, you know, 21 again, we don't anticipate this is the end of the road. You 22 know, we'll certainly come back and have dialogue on the 23 questions, you know, that were raised here, but we expect that 24 as this initiative moves forward, this is going to be something 25 that we're engaging the provider community in on a regular

basis, and, you know, we look forward to continuing to refine it 1 2 the best that we can to, you know, continue letting this go 3 forward and help more and more people. 4 5 PETER ROBINSON: Dr. Martin. 6 7 GLENN MARTIN: It's actually a process question, which I 8 should know the answer to, but don't. So, the public, the 9 comments on regs that go to the State and are responded to, are 10 those comments and the responses available online somewhere that 11 I just can't find or how does that work? Because I know that 12 there's a fair amount of work put into that, and it's not 13 distributed to us with the regulations, so is that readily 14 available, or are we going to ask for that separately? 15 16 LISA ULLMAN: Well, when we publish the notice of adoption 17 we would also include an assessment of the comments that were 18 received, so that would be available in the State Registry. Is 19 there, I mean, I'll just turn to the full Council. Is that 20 right? 21 22 JOHN DERING: Yes, that's correct. Under the State 23 Administrative Procedure Act, with the promulgation, there's a 24 document called "assessment of public comments," where the

public comments are listed and there needs to be an explanation 1 2 in terms of the consideration given to them. 3 4 GLENN MARTIN: So, the regulation that we're voting on 5 today, if I had done my homework, I could have found all of that 6 before I walked in today? 7 8 JOHN DERING: No. It's not on the Department website now 9 in terms of the actual submission. That's a statutory 10 requirement. And it's a summary of the comments, so it's not-11 they aren't, the letters themselves don't get submitted. But I think if you have an interest in seeing those letters, what I 12 13 would suggest is we could confer with Colleen's office and Dan 14 Sheppard and see what arrangements can be made. 15 16 GLENN MARTIN: Yeah, I have, I'm probably going to hate myself for saying that's a good idea when I see how voluminous 17 18 that is, but, no, there's just the concept that it's a bit-and, 19 again, I say I didn't review what probably was available, but 20 there is a feeling of voting a little bit in a vacuum of just 21 not knowing exactly what was there and I just for process it 22 would be better if that was made available to us, at least as a

23

possibility going forward.

1 PETER ROBINSON: So I am getting a strong sense that 2 while we are voting on this particular item today, we expect 3 there to be some additional discussion and significant-and 4 potentially another vote following that next meeting as you bring forward those refinements that we've been discussing. Is 5 6 that enough? I'm seeing a nod. 7 8 LISA ULLMAN: Absolutely. 9 10 PETER ROBINSON: OK, with that on the table, I will now 11 call the question. All in favor? 12 13 Aye. 14 15 Any opposed? The motion carries. Thank you. 16 17 ANGEL GUTIERREZ: For information was the item of nursing home transfers and discharge rights. We were advised on this by 18 Mr. HARAN from the Department, who is still available for 19 20 questions. The proposed amendment to section 415.3 of Title 10 21 NYCRR are required to clarify the requirements for transfer and 22 discharge of residents from nursing homes, as mandated by 23 federal law. The amendments: more-clearly define what 24 constitutes a transfer or discharge; specify the elements that

must be included in a notice of transfer or discharge to the

- 1 residents; and the deadlines for service of notice; and clarify
- 2 the rights of a residents at a hearing, should one be requested.
- 3 These amendments do not change existing requirements, they
- 4 simply ensure that the Department's regulations clearly reflect
- 5 the existing federal requirements. This proposal has gone
- 6 through the 45-day comment period, but has not been before the
- 7 Codes Committee for discussion or information before today.
- 8 Before it, because this was before the committee for
- 9 information, there was not vote. Mr. Chairman, this concludes my
- 10 report.

- 12 PETER ROBINSON: Thank you. Any questions of Dr.
- 13 Gutierrez? Thank you for the work of your committee. I'm up next
- 14 to provide a very brief report on the Ad Hoc Advisory Committee
- 15 on Free-Standing Ambulatory Surgery Centers and Charity Care. I
- 16 want to thank Mr. Decker for his work in staffing the committee
- 17 and the members of the Council who have been participating in
- 18 this. I am actually not going to read the report, but I ask that
- 19 it be put into the record for the minutes, but I would say that
- 20 we made significant progress in working through the various
- 21 criteria that we think are going to be applied here and at the
- 22 next meeting we are going to see draft criteria, which we will
- 23 invite public comment on at the next round of committee
- 24 meetings, which is in January, right? So, that, along with the
- 25 written report, concludes my report-mercifully-I think we've

- 1 been reported out here. So, what we're going to do now is take a
- 2 20-minute lunch break and when we reconvene, we will go through
- 3 the establishment and project review committee activities that
- 4 Mr. Booth will lead us through. So 20 minutes and we will be
- 5 back.
- 6 [BREAK]
- 7 PETER ROBINSON: So ladies and gentlemen, I'd like to
- 8 reconvene. Those of you who are enjoying lunch should continue
- 9 to do so. Do I have a quorum in the room?

11 [counting]

12

- 13 We have a quorum in the room. That's terrific. Welcome back and
- 14 we are now moving to Project Review and Establishment actions
- 15 and I am going to turn this over to Mr. Booth for his report.
- 16 Mr. Booth.

- 18 CHRIS BOOTH: Thank you. The committee met on November
- 19 13th and again this morning. We have a number of applications.
- 20 We're going to do a lot of batching, but not for the first
- 21 couple. The first application is 142157C, United Memorial
- 22 Medical Center, North Street Campus. A conflict declared by Mr.
- 23 Robinson and Ms. Hines, both of whom are leaving the room.
- 24 Interest declared by Mr. Booth. Construct a new 8,498-square-
- 25 foot building addition to the hospital's main site to include

Page 97

- 1 radiation therapy and medical oncology services. Both the
- 2 Department and the Committee recommended approval with
- 3 conditions and contingencies and I so move.

4

5 Second.

6

- 7 I have a second. Motion has been made and seconded. Is there any
- 8 questions or comments? Hearing none, I'll call the question. All
- 9 those in favor say aye.

10

11 [Aye.]

12

- 13 Any opposed? Any abstentions? The motion passes.
- 14 Application 142079C, CareFirst Southern Tier Hospice and
- Palliative Care. Southern Tier Hospice, Steuben County, interest 15
- 16 Mr. Booth. Renovate previously purchased school building into
- 17 administrative offices. Both the Department and the Committee
- 18 recommends approval with conditions and contingencies and I so
- 19 move.

20

21 We have a motion.

22

- 23 Back into the rhythm. I have a motion PETER ROBINSON:
- 24 and a second. Any comments? Mr. Fassler.

1 MICHAEL FASSLER: Just a question to the Department. With 2 the code changes made this morning, would that eliminate the 3 need for this to come before us again? If a similar application 4 comes before us. 5 6 CHARLIE ABEL: Actually, no, it's a different article and 7 we need to do some work over there on the Hospice regs. 8 9 PETER ROBINSON: Thank you. I'll call the question. All 10 in favor? 11 12 [Aye.] 13 Any opposed? Abstentions? Hearing none, the motion carries. 14 15 Application 142140E, NYP Community Programs. CHRIS BOOTH: 16 Establish NYP Community Programs as the active parent and co-17 operator of Hudson Valley Hospital Center, which will then do 18 business as New York Presbyterian Hudson Valley Hospital. Dr. 19 Boutin-Foster has declared a conflict and has left the room. 20 Both the Department and the Committee recommend approval with 21 condition and contingencies and I so move. 22 23 Second.

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1
                             Second by Dr. Berliner. Questions? I'll
         PETER ROBINSON:
2
    call the question. All in favor?
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4
    [Aye.]
5
6
    Any opposed? Abstentions? Motion carries.
7
8
         CHRIS BOOTH: So I am going to batch a number of
9
    applications now that had no conflicts and no interests and no
10
    issues at the Committee. Application 132340B, Richmond ASC, LLC,
11
    d/b/a Richmond Pain Management. Establish and construct a new
12
    single-specialty ambulatory surgery center providing pain
13
    management services to be located at 1360 Highland Boulevard,
14
    State Island. Both the Department and the Committee recommend
15
    conditional and contingent approval with an expiration of the
16
    operating certificate five years from the date of issuance was
17
    recommended. Application 142077E, Island Digestive Health
    Center. Establish Good Samaritan Hospital Medical Center as a
18
19
    51% member of the Center. Both the Department and the Committee
20
    recommended approval with a condition and contingencies.
21
    Application 142056E, Hope Center Operations, LLC, d/b/a Hope
22
    Center for HIV and Nursing Care. Establish Hope Center
23
    Operations, LLC, as the new operator of the facility located at
24
    1401 University Avenue, Bronx, that is currently operated by
25
    Help/PSI. Both the Department and the committee recommended
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- 1 approval with a condition and contingencies. Application
- 2 142090E, L&A Operations, LLC, d/b/a Adira at Riverside
- 3 Rehabilitation. Establish L&A Operations, LLC, as the new
- 4 operator of the facility located at 120 Odell Avenue, Yonkers,
- 5 currently the Michael Malotz Skilled Nursing Pavilion. Both the
- 6 Department and the Committee recommended approval with
- 7 contingencies. Application 142060E, Dominican Sisters Family
- 8 Health Services. Establish Dominican Sisters Family Health
- 9 Services as the new operator of an existing certified home-
- 10 health agency and long-term home health care program through a
- 11 merger with Visiting Nurse Association of Long Island. Both the
- 12 Department and the Committee recommended approval with
- 13 conditions and contingencies. Application 142068E, Royal Care
- 14 Certified Home Health Care, LLC. Establish Royal Care Certified
- 15 Home Health Care, LLC, as the new operator of Franklin Medical
- 16 Center's Home Health Agency located at 444 Merrick Road,
- 17 Lynbrook. Both the Department and the Committee recommended
- 18 approval with a condition and contingencies. And finally,
- 19 application 142100E, A and T Certified Home Care, LLC; 100%
- 20 change in membership of A and T Certified Home Care, LLC, to
- 21 marital trust of Tony BABBINGTON. Both the Department and the
- 22 Committee recommended approval with a condition and
- 23 contingencies and I move the batch. Motion and a second. Dr.
- 24 Gutierrez. Oh.

```
1
    [inaudible]
2
3
         PETER ROBINSON: Yes. Any questions for Mr. Booth? Call
4
    the question. All in favor?
5
6
    [Aye.]
7
8
    Any opposed? Any abstentions? Motion carries.
9
10
         CHRIS BOOTH: We have three certificates that we will
11
    batch. The first one is a name change for Fletcher-Allen's
12
    partners. Dr. Rugge had declared an interest in that and both
13
    the Department and the Committee recommended approval. There is
14
    a certificate of amendment of the application of authority for
15
    the Debutante Cotillion and Christmas Ball, Inc. for
16
    fundraising. Again, both the Department and the Committee
17
    recommended approval. And finally there is the restated
18
    certificate of incorporation of the Health Center Foundation at
19
    Syracuse, Inc., which is for fundraising and approval was
20
    recommended by the Department and the Committee and I move that
21
    batch.
22
23
    Second.
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1
         PETER ROBINSON: Motion and a second by Dr. Gutierrez.
2
    Any questions? All in favor?
3
4
    [Aye.]
5
6
    Opposed? Abstentions? Carried.
7
8
         CHRIS BOOTH: I have a very large number of home health
9
    agency licensures that I am going to move as a batch and I will
10
    read the number for each of those applications: 2162L, 2172L,
11
    2191L, 2161L, 2236L, 2187L, 2174L, 2252L, 2207L, 2060L, 2257L,
12
    2164L, 2230L, 2232L, 2189L, 2087L, 2182L, 2201L, 2208L, 2159L,
13
    1728L, 2183L, 2197L, 2055L, 2391L, 2127L, and 2256L. In each
14
    case, the Department and the Committee recommend approval with a
    contingency and I so move.
15
16
17
    Second.
18
19
         PETER ROBINSON: Motion and a second; Dr. Bhat, this
20
    time. Questions? Ms. Hines.
21
22
         VICKY HINES: Not about any of these specific
23
    applications, but just for an update, I don't remember if it was
24
    last cycle or the cycle before we had talked about having some
    separate review of the total number of licensed agencies that
25
```

we've approved over the last couple of years and what impact 1 2 that has on the State's ability to do surveillance and the 3 impact it's had on the structure of the home care agencies. 4 5 PETER ROBINSON: Right, and I think we discussed this 6 with Mr. Abel prior to the meeting and he is going to be 7 bringing a report to the Council at the next cycle, so thank you 8 for reminding us and bringing that up. I'll call the question, 9 all in favor? 10 11 [Aye.] 12 13 Opposed? Abstentions? Motion carries. 14 15 CHRIS BOOTH: The next category will be a number of 16 applications where there were interests declared but no issues 17 at the Committee and I'll also do these as a batch. 152108E, Long Island Jewish Medical Center. Interest declared by Dr. Bhat 18 19 and Dr. Martin. Establish Forest Hills Hospital and Franklin 20 Hospital as divisions of the Long Island Jewish Medical Center, 21 and establish LIJ as the operator of the ORZAK Center for 22 Extended Care and Rehabilitation. Both the Department and the 23 Committee recommended approval with a condition and 24 contingencies. Application 142105E, Mount Saint Mary's Hospital

and Health Center. Interest declared by Mr. Booth. Establish the

- 1 Catholic Health System as the active parent/co-operator of Mount
- 2 Saint Mary's Hospital and Health Center. Both the Department and
- 3 the Committee recommended approval with a condition and
- 4 contingencies. Application 142039E, North County [sic]
- 5 Orthopedic Ambulatory Surgi Center. Interest declared by Mr.
- 6 Booth. Change in ownership interests for three existing members,
- 7 three new members, and four withdrawing members. Both the
- 8 Department and the Committee recommended approval with a
- 9 condition and contingencies. Application 142073E, Buffalo
- 10 Surgery Center. Interest declared by Mr. Booth. Transfer of
- 11 49.96 percent membership interest to nine new members and one
- 12 current member. Both the Department and the Committee
- 13 recommended approval with a condition and contingencies.
- 14 Application 141210B, Peninsula Continuum Services, LLC, d/b/a
- 15 Cassena Care Dialysis Center at Peninsula. Interest declared by
- 16 Dr. Bhat. Establish and construct a new 20-station end-stage
- 17 renal dialysis center to be located at 5015 Beech Channel Drive,
- 18 Far Rockaway, at Cardiff Bay Center for Rehabilitation and
- 19 Nursing. Both the Department and the Committee recommend
- 20 approval with conditions and contingencies. Application 141280E,
- 21 Liverpool LD, LLC, d/b/a FMS Liverpool Dialysis Center. Interest
- 22 declared by Mr. Booth. Establish Liverpool LD, LLC, as the new
- 23 operator of the renal dialysis clinic located at 1304 Buckley
- 24 Road, Syracuse, that is currently operated by Liverpool Dialysis

1 Center, LLC. Both the Department and the Committee recommend 2 approval with condition and contingencies and I so move. 3 4 Second. 5 PETER ROBINSON: Dr. Brown, you get credit for that 6 7 second. 8 9 Thanks for breaking up that rhythm. That's good. That's very 10 good. Any questions for Mr. Booth? Hearing none, we'll call the 11 question. All in favor? 12 13 [Aye.] 14 15 PETER ROBINSON: Opposed? Abstentions? Motion carries. 16 Mr. Booth. 17 18 CHRIS BOOTH: Application 132128B, DOJ Operations 19 Associates, LLC, d/b/a Tri-Borough Center for Rehabilitation and 20 Specialty Health Care. A conflict has been declared by Dr. Bhat, 21 who is outside the room. Establish DOJ Operations Associates, 22 LLC, as the permanent operator of the Daughters of Jacob Nursing 23 Home. Both the Department and the Committee recommend approval 24 with a condition and contingencies and I so move.

```
1
    Second.
2
3
         PETER ROBINSON: Motion and a second by Dr. Brown.
4
5
    Fassler.
6
7
         PETER ROBINSON: Oh, it was Mr. Fassler. Thank you for
8
    that correction. Questions? Call the question. All in favor?
9
10
    [Aye.]
11
12
    Opposed? Abstentions? Motion carries.
13
         CHRIS BOOTH: Application 141213E, Comprehensive at
14
15
    Williamsville, LLC, d/b/a Comprehensive Rehabilitation and
16
    Nursing Center at Williamsville. Interest declared by Mr. Booth.
17
    Establish Comprehensive at Williamsville, LLC, as the new
18
    operator of the residential health care facility located at 147
19
    REESE Street, Williamsville that is currently operated as St.
20
    Francis Home of Williamsville. Both the Department and the
21
    Committee recommend approval with a condition and contingencies
22
    and I so move.
23
24
    Second.
```

1 Second. 2 3 Second. 4 5 PETER ROBINSON: Dr. Gutierrez, thank you. Who... You 6 didn't say anything? I keep missing these seconds. Dr. Berliner, 7 you take the ... 8 9 CHRIS BOOTH: Our regular chair doesn't make these 10 mistakes. 11 12 Second. 13 14 PETER ROBINSON: Oh... Let's give Dr. Foster for this second. I think we should. We're having fun here today. Any 15 16 questions? Hearing none, I'll call the question. All in favor? 17 Any opposed? Abstentions? Motion carries. 18 19 CHRIS BOOTH: We have several more home health agency 20 licensures, these with interests. I will also do these as a 21 batch: 2226L, Beech Development Corporation, interest declared 22 by Mr. Booth and Ms. Hines; 2241L, New York Congregational 23 Licensed Home Care Services Agency, interest declared by Mr. 24 Fassler; 2316L-I don't know if anybody can help me with that

word, but whatever that word is-[Rehekah] Rehab Licensed Home

- 1 Care Services Agency, interest Mr. Fassler; 2449L, The Gardens
- 2 by Morningstar, interest by Mr. Booth; 2211 UCSL, interest
- 3 declared by Mr. Booth; and 2331, Shire Senior Living, interest
- 4 by Ms. Hines. I move it as a batch for approval.

6 Second.

7

8 Second.

9

- 10 PETER ROBINSON: Dr. Bhat. He got you. Questions? Call
- 11 the question. All in favor?

12

13 [Aye.]

14

15 Opposed? Abstentions? Motion carries.

- 17 CHRIS BOOTH: Application 141290B, SOW West Side, LLC,
- 18 d/b/a Surgi Care of West Side. A conflict declared by Dr. Kalkut
- 19 and Dr. Martin, both of whom are leaving the room. Establish and
- 20 construct a new free-standing multi-specialty ambulatory surgery
- 21 center to be located at 438 West 51st Street, New York. Both the
- 22 Department and the Committee recommend conditional and
- 23 contingent approval with an expiration of the operating
- 24 certificate five years from the date of issue was recommended,
- 25 with two members opposing at the committee level. I so move.

- 2 PETER ROBINSON: Second by Dr. Gutierrez. Questions?
- 3 We'll call the question then. All in favor?

4

5 [Aye.]

6

- 7 Any opposed? Any abstentions? Motion carries. Please have Dr.
- 8 Kalkut and Dr. Martin return.

9

- 10 CHRIS BOOTH: Application 142061E, East Side Endoscopy.
- 11 Request for limited-life extension for project 082085. Both the
- 12 Department and the Committee recommended conditional and
- 13 contingent approval with a one-year extension to be to the
- 14 operating certificate from the date of the Public Health and
- 15 Health Planning Council recommendation letter of approval, and I
- 16 so move.

17

18 Second.

19

- 20 PETER ROBINSON: Thank you, Ms. Fine. Glad to see you
- 21 joining the fray. Questions? I'll call the question. All in
- 22 favor?

23

24 [Aye.]

1 Opposed? Abstentions? Motion carries. 2 3 CHRIS BOOTH: The final application is 142058E, Massena 4 Center, LLC, d/b/a Massena Dialysis Center. Interest declared by Mr. Booth. Establish Massena Center, LLC, d/b/a Massena Dialysis 5 6 Center as the new operator of an eight-station dialysis center 7 located at 290 Main Street, Massena, currently operated as an 8 extension clinic of Massena Memorial Hospital. I would note for 9 the record that the following contingency has been added: 10 Submission of an executed amendment to the operating certificate 11 of Massena Center, LLC, acceptable to the Department. Both the 12 Department and the Committee recommended approval with 13 conditions and contingencies and I so move. 14 15 Second. 16 Motion and a second, by Dr. Gutierrez. 17 PETER ROBINSON: 18 Questions? I'll call the question. All in favor? 19 20 [Aye.] 21 22 Opposed? Abstentions? Motion carries. Thank you.

23

24 CHRIS BOOTH: That concludes my report.

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1	PETER ROBINSON: Excellent report, Mr. Booth. So to just
2	remind you that the public session of the Public Health and
3	Health Planning Council is now adjourned. Do we have a-we're
4	good. So we don't actually go into executive session. Just as a
5	reminder, the next Committee Day is January 29th and the full
6	Council will convene on February 12th. Both of those meetings
7	are in New York City. So we thank you very much and the meeting
8	is adjourned.
9	
10	
11	
12	
13	

## Ad Hoc Advisory Committee on Freestanding ASCs and Charity Care

## **Summary of November 13, 2014 Discussion**

Discussion first focused on previously reported SPARCS data, clarifying that the low percentage of charity care reported by both freestanding and hospital-based ASCs (less than one percent) was accounted for by the fact that most providers report such care under the SPARCS Self-Pay category. This category also includes bad debt, which many providers may "forgive" and consider as charity care.

It was agreed that in evaluating ASC applications for proposed levels of charity care, applicants should describe such care in terms of the number of expected <u>cases</u> rather than number of procedures or associated costs.

Members also agree that bad debt should be considered charity care in the evaluation of ASC applications.

Members reached consensus on several recommendations developed through discussions at the committee's first meeting:

- 1. ASCs should be required to enter into contracts with Medicaid managed care plans. To ensure a sufficient number of Medicaid cases, ASCs should have contracts with at least two plans.
- 2. ASCs should be required to enter into referral arrangements with FQHCs or other providers of services to the uninsured. Based on comments by a currently operating ASC and other speakers, these arrangements should include special efforts by the ASC in the form of service coordinators or patient navigators to ensure that referred patients are actually able to connect to the ASC and be scheduled for services in a timely manner.
- 3. ASC applications should be evaluated according to the totality of the proposed level of services to the underserved, whether Medicaid, charity care or a combination of the two. It was agreed that this evaluation should be done through an integrated standard that would still identify a target for Medicaid and charity care but allow consideration of a blended number that would take into account the particular service mix and circumstances of the proposed ASC.
- 4. Members rejected the recommendation that ASCs be allowed to substitute payments to FQHCs for direct services to Medicaid and charity care clients.

## Next Steps

Staff will draft possible criteria for the evaluation of charity care efforts by specialized ASCs\_that may be serving a clientele more likely to be insured or covered by Medicare.

Staff will draft guidelines for flexibility in the evaluation of an ASC applicant's proposed total effort to serve Medicaid and charity care clients while still maintaining the notion of reasonable targeted percentages for each.

## **SUMMARY OF EXPRESS TERMS**

The Department is amending 10 NYCRR Subpart 7-2 Children's Camps as an emergency rulemaking to conform the Department's regulations to requirements added or modified as a result of Chapter 501 of the Laws of 2012 which created the Justice Center for the Protection of Persons with Special Needs (Justice Center). Specifically, the revisions:

- amend section 7-2.5(o) to modify the definition of "adequate supervision," to incorporate the additional requirements being imposed on camps otherwise subject to the requirements of section 7-2.25
- amend section 7-2.24 to address the provision of variances and waivers as they apply to the requirements set forth in section 7-2.25
- amend section 7-2.25 to add definitions for "camp staff," "Department," "Justice Center," and "Reportable Incident"

With regard to camps with 20 percent or more developmentally disabled children, which are subject to the provisions of 10 NYCRR section 7-2.25, add requirements as follows:

- amend section 7-2.25 to add new requirements addressing the reporting of reportable incidents to the Justice Center, to require screening of camp staff, camp staff training regarding reporting, and provision of a code of conduct to camp staff
- amend section 7-2.25 to add new requirements providing for the disclosure of information to the Justice Center and/or the Department and, under certain circumstances, to make certain records available for public inspection and copying

- amend section 7-2.25 to add new requirements related to the investigation of reportable incidents involving campers with developmental disabilities
- amend section 7-2.25 to add new requirements regarding the establishment and operation of an incident review committee, and to allow an exemption from that requirement under appropriate circumstances
- amend section 7-2.25 to provide that a permit may be denied, revoked, or suspended if the camp fails to comply with the regulations, policies or other requirements of the Justice Center

Pursuant to the authority vested in the Public Health and Health Planning Council by Section 225 of the Public Health Law, subject to the approval by the Commissioner of Health, Subpart 7-2 of the State Sanitary Code, as contained in Chapter 1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended as follows, to be effective upon filing with the Secretary of State.

#### **SUBPART 7-2**

#### Children's Camps

(Statutory Authority: Public Health Law §§ 201, 225, 1390, 1394, 1395, 1399-a; L. 2012, ch. 501)

Subdivision (o) of section 7-2.5 is amended to read as follows:

- (o) The camp operator shall provide adequate supervision. *Adequate supervision* shall mean:
  - (1) supervision such that a camper is protected from any unreasonable risk to his or her health or safety, including physical or sexual abuse or any public health hazard; [and]
  - (2) as a minimum, there shall exist visual or verbal communications capabilities between camper and counselor during activities and a method of accounting for the camper's whereabouts at all times[.]; and

(3) at camps required to comply with section 7-2.25 of this Subpart, protection from any unreasonable risk of experiencing an occurrence which would constitute a reportable incident as defined in section 7-2.25(h)(4) of this Subpart.

Section 7-2.24 is amended to read as follows:

Variance; waiver.

- (a) *Variance* <u>i</u>[I]n order to allow time to comply with certain provisions of this Subpart, an operator may submit a written request to the permit-issuing official for a variance from a specific provision(s) when the health and safety of the children attending the camp and the public will not be prejudiced by the variance, and where there are practical difficulties or unnecessary hardships in immediate compliance with the provision. An operator must meet all terms of an approved variance(s) including the effective date, the time period for which the variance is granted, the requirements being varied and any special conditions the permit-issuing official specifies. The permit-issuing official shall consult with the State Department of Health and shall obtain approval from the State Department of Health for the proposed decision, prior to granting or denying a variance request for requirements in section 7-2.25 of this Subpart.
- (b) *Waiver* <u>i</u>[I]n order to accept alternative arrangements that do not meet certain provisions of this Subpart but do protect the safety and health of the campers and the public, an operator may submit a written request to the permit-issuing official for a

waiver from a specific provision of this Subpart. Such request shall indicate justification that circumstances exist that are beyond the control of the operator, compliance with the provision would present unnecessary hardship and that the public and camper health and safety will not be endangered by granting such a waiver. The permit-issuing official shall consult with a representative of the State Department of Health prior to granting or denying a waiver request. An operator must meet all terms of an approved waiver(s), including the condition that it will remain in effect indefinitely unless revoked by the permit-issuing official or the facility changes operators. The permit-issuing official shall consult with the State Department of Health, and shall obtain the approval of the State Department of Health for the proposed decision, prior to granting or denying a waiver request related to the requirements in section 7-2.25 of this Subpart.

New subdivisions (h)-(m) of section 7-2.25 are added to read as follows:

- (h) Definitions. The following definitions apply to Section 7-2.25 of this Subpart.
  - (1) Camp Staff shall mean a director, operator, employee or volunteer of a children's camp; or a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to a children's camp pursuant to contract or other arrangement that permits such person to have regular and substantial contact with individuals who are cared for by the children's camp.
  - (2) *Department* shall mean the New York State Department of Health.

- (3) *Justice Center* shall mean the Justice Center for the Protection of People with Special Needs, as established pursuant to Section 551 of the Executive Law.
- (4) Reportable Incident shall include those actions incorporated within the definitions of "physical abuse," "sexual abuse," "psychological abuse," "deliberate inappropriate use of restraints," "use of aversive conditioning," "obstruction of reports of reportable incidents," "unlawful use or administration of a controlled substance," "neglect," and "significant incident" all as defined in Section 488 of the Social Services Law.

## (i) Reporting.

(1) In addition to the reporting requirements of section 7-2.8(d), a camp operator subject to section 7-2.25 of this Subpart and all camp staff falling within the definition of "mandated reporter" under section 488 of the Social Services Law shall immediately report any reportable incident as defined in section 7-2.25(h)(4) of this Subpart and Section 488 of the Social Services Law, where such incident involves a camper with a developmental disability, to the permit-issuing official and to the Justice Center's Vulnerable Persons' Central Register. Such report shall be provided in a form and manner as required by the Justice Center.

- (j) Employee Screening, Training, and Code of Conduct
  - (1) Prior to hiring anyone who will or may have direct contact with campers, or approving credentials for any camp staff, the operator shall follow the procedures established by the Justice Center in regulations or policy, to verify that such person is not on the Justice Center's staff exclusion list established pursuant to section 495 of the Social Services Law. If such person is not on the Justice Center's staff exclusion list, the operator shall also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment as required by section 424-a of the Social Services Law. Such screening is in addition to the requirement that the operator similarly verify that a prospective camp staff is not on the sexual abuse registry, as required by section 7-2.5(l) of this Subpart.
  - (2) A camp operator must ensure that camp staff, and others falling within the definition of mandated reporter under Section 488 of the Social Services Law who will or may have direct contact with campers having a developmental disability, receive training regarding mandated reporting and their obligations as mandated reporters. A camp operator shall ensure that the telephone number for the Justice Center's hotline for the reporting of reportable incidents is conspicuously displayed in areas accessible to mandated reporters and campers.
  - (3) The camp operator shall ensure that all camp staff and others falling within the definition of "custodian" under Section 488 of the Social Services Law are

provided with a copy of the code of conduct established by the Justice Center pursuant to Section 554 of the Executive Law. Such code of conduct shall be provided at the time of initial employment, and at least annually thereafter during the term of employment. Receipt of the code of conduct must be acknowledged, and the recipient must further acknowledge that he or she has read and understands such code of conduct.

#### (k) Disclosure of information

- (1) Except to the extent otherwise prohibited by law, the camp operator shall be obliged to share information relevant to the investigation of any incident subject to the reporting requirements of this Subpart with the permit-issuing official, the State Department of Health, and the Justice Center. The permit-issuing official, the department and the Justice Center shall, when required by law, or when so directed by the department or the Justice Center and except as otherwise prohibited by law, be permitted to share information obtained in their respective investigations of incidents subject to the reporting requirements of section 7-2.25 (i) of this Subpart.
- (2) Except as otherwise prohibited by law, the operator of a camp not otherwise subject to Article Six of the Public Officers Law shall make records available for public inspection and copying to the extent required by subdivision six of Section 490 of the Social Services Law and regulations of the Justice Center.

- (l) Incident Management.
  - (1) The camp operator shall cooperate fully with the investigation of reportable incidents involving campers with developmental disabilities and shall provide all necessary information and access to conduct the investigation. The camp operator shall promptly obtain an appropriate medical examination of a physically injured camper with a developmental disability. The camp operator shall provide information, whether obtained pursuant to the investigation or otherwise, to the Justice Center and permit-issuing official upon request, in the form and manner requested. Such information must be provided in a timely manner so as to support completion of the investigation subject to the time limits set forth in this subdivision.
  - (2) Unless delegated by the Justice Center to a delegate investigatory agency as defined in subdivision seven of Section 488 of the Social Services Law, incidents of abuse or neglect, as defined in subdivision eleven of Section 488 of the Social Services Law, shall be investigated by the Justice Center. With regard to all other reportable incidents, as defined in Section 488 of the Social Services Law, the permit-issuing official shall initiate a prompt investigation of an allegation of a reportable incident, which shall commence no later than five business days after notification of such an incident, unless the Justice Center agrees that it will undertake such investigation. Additional time for completion of the investigation

may be allowed, subject to the approval of the department, upon a showing of good cause for such extension. At a minimum, the investigation of any reportable incident shall comply with the following:

- (i) Investigations shall include a review of medical records and reports, witness interviews and statements, expert assessments, and the collection of physical evidence, observations and information from care providers and any other information that is relevant to the incident. Interviews should be conducted by qualified, objective individuals in a private area which does not allow those not participating in the interview to overhear. Interviews must be conducted of each party or witness individually, not in the presence of other parties or witnesses or under circumstances in which other parties or witnesses may perceive any aspect of the interview. The person alleging the incident, or who is the subject of the incident, must be offered the opportunity to give his/her version of the event. At least one of the persons conducting the interview must have an understanding of, and be able to accommodate, the unique needs or capabilities of the person being interviewed The procedures required by this Subparagraph (i) may be altered if, and only to the extent necessary to, comply with an applicable collective bargaining agreement.
- (ii) All evidence must be adequately protected and preserved.

- (iii) Any information, including but not limited to documents and other materials, obtained during or resulting from any investigation shall be kept confidential, except as otherwise permissible under law or regulation, including but not limited to Article 11 of the Social Services Law.
- (iv) Upon completion of the investigation, a written report shall be prepared which shall include all relevant findings and information obtained in the investigation and details of steps taken to investigate the incident. The results of the investigation shall be promptly reported to the department, if the investigation was not performed by the department, and to the Justice Center.
- (v) If any remedial action is necessary, the permit-issuing official shall establish a plan in writing with the camp operator. The plan shall indicate the camp operator's agreement to the remediation and identify a follow-up date and person responsible for monitoring the remedial action. The plan shall be provided, and any measures taken in response to such plan shall be reported, to the department and to the Justice Center.
- (vi) The investigation and written report shall be completed and provided to the department and the Justice Center within 45 days of when the incident was first reported to the Justice Center. For purposes of this

section, "complete" shall mean that all necessary information has been obtained to determine whether and how the incident occurred, and to complete the findings referenced in paragraph (l)(2)(iv) of this subdivision.

- (3) (i) The camp shall maintain a facility incident review committee, composed of members of the governing body of the children's camp and other persons identified by the camp operator, including some members of the following: camp administrative staff, direct support staff, licensed health care practitioners, service recipients, the permit-issuing official or designee and representatives of family, consumer and other advocacy organizations, but not the camp director. The camp operator shall convene a facility incident review panel to review the timeliness, thoroughness and appropriateness of the camp's responses to reportable incidents; recommend additional opportunities for improvement to the camp operator, if appropriate; review incident trends and patterns concerning reportable incidents; and make recommendations to the camp operator to assist in reducing reportable incidents. The facility incident review panel shall meet at least annually, and also within two weeks of the completion of a written report and remedial plan for a reportable incident.
- (ii) Pursuant to paragraph (f) of subdivision one of section 490 of the Social Services

  Law and regulations of the Justice Center, a camp operator may seek an

exemption from the requirement to establish and maintain an incident review committee. In order to obtain an exemption, the camp operator must file an application with the permit-issuing official, at least sixty days prior to the start of the camp operating season, or at any time in the case of exemptions sought within the first three months following the effective date of this provision. The application must provide sufficient documentation and information to demonstrate that that compliance would present undue hardship and that granting an exemption would not create an undue risk of harm to campers' health and safety. The permit-issuing official shall consult with the State Department of Health (department), and shall not grant or deny an application for an exemption unless it first obtains department approval for the proposed decision. An operator must meet all terms of an approved exemption(s), including the condition that it will remain in effect for one year unless revoked by the permit-issuing official, subject to department approval, or the facility changes operators. Any application for renewal shall be made within 60 days prior to the start of the camp's operating season. The procedure set forth in this Subparagraph (ii) shall be used instead of the general procedures set forth in section 7-2.24 of this Subpart.

(m) In addition to the requirements specified by subdivisions (d) and (g) of section 7-2.4 of this Subpart, a permit may be denied, revoked, or suspended if the children's camp fails to comply with regulations, policies, or other requirements of the Justice Center. In

considering whether to issue a permit to a children's camp, the permit-issuing official shall consider the children's camp's past and current compliance with the regulations, policies, or other requirements of the Justice Center.

#### **Regulatory Impact Statement**

## **Statutory Authority:**

The Public Health and Health Planning Council is authorized by Section 225(4) of the Public Health Law (PHL) to establish, amend and repeal sanitary regulations to be known as the State Sanitary Code (SSC), subject to the approval of the Commissioner of Health. Article 13-B of the PHL sets forth sanitary and safety requirements for children's camps. PHL Sections 225 and 201(1)(m) authorize SSC regulation of the sanitary aspects of businesses and activities affecting public health including children's camps.

## **Legislative Objectives:**

In enacting to Chapter 501 of the Laws of 2012, the legislature established the New York State Justice Center for the Protection of People with Special Needs (Justice Center) to strengthen and standardize the safety net for vulnerable people that receive care from New York's Human Services Agencies and Programs. The legislation includes children's camps for children with developmental disabilities within its scope and requires the Department of Health to promulgate regulations approved by the Justice Center pertaining to incident management. The proposed amendments further the legislative objective of protecting the health and safety of vulnerable children attending camps in New York State (NYS).

#### **Needs and Benefits:**

The legislation amended Article 11 of Social Services law as it pertains to children's camps as follows. It:

- included overnight, summer day and traveling summer day camps for children with developmental disabilities as facilities required to comply with the Justice Center requirements.
- defined the types of incident required to be reported by children's camps for children with developmental disabilities to the Justice Center Vulnerable Persons' Central Registry.
- mandated that the regulations pertaining to children's camps for children with developmental disabilities are amended to include incident management procedures and requirements consistent with Justice Center guidelines and standards.
- required that children's camps for children with developmental disabilities
   establish an incident review committee, recognizing that the Department could
   provide for a waiver of that requirement under certain circumstances
- required that children's camps for children with developmental disabilities consult the Justice Center's staff exclusion list (SEL) to ensure that prospective employees are not on that list and to, where the prospective employee is not on

that list, to also consult the Office of Children and Family Services State Central Registry of Child Abuse and Maltreatment (SCR) to determine whether prospective employees are on that list.

required that children's camps for children with developmental disabilities
 publicly disclose certain information regarding incidents of abuse and neglect if
 required by the Justice Center to do so.

The children's camp regulations, Subpart 7-2 of the SSC are being amended in accordance with the aforementioned legislation.

# Compliance Costs: Cost to Regulated Parties:

The amendments impose additional requirements on children's camp operators for reporting and cooperating with Department of Health investigations at children's camps for children with developmental disabilities (hereafter "camps"). The cost to affected parties is difficult to estimate due to variation in salaries for camp staff and the amount of time needed to investigate each reported incident. Reporting an incident is expected to take less than half an hour; assisting with the investigation will range from several hours to two staff days. Using a high estimate of staff salary of \$30.00 an hour, total staff cost would range from \$120 to \$1600 for each investigation. Expenses are nonetheless expected to be minimal statewide as between 40 and 50 children's camps for children with developmental disabilities operate each year, with combined reports of zero to two

incidents a year statewide. Accordingly, any individual camp will be very unlikely to experience costs related to reporting or investigation.

Each camp will incur expenses for contacting the Justice Center to verify that potential employees, volunteers or others falling within the definition of "custodian" under section 488 of the Social Services Law (collectively "employees") are not on the Staff Exclusion List (SEL). The effect of adding this consultation should be minimal. An entry level staff person earning the minimum wage of \$7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the Justice Center, within a few hours.

Similarly, each camp will incur expenses for contacting the Office of Children and Family Services (OCFS) to determine whether potential employees are on the State Central Registry of Child Abuse and Maltreatment (SCR) when consultation with the Justice Center shows that the prospective employee is not on the SEL. The effect of adding this consultation should also be minimal, particularly since it will not always be necessary. An entry level staff person earning the minimum wage of \$7.25/hour should be able to compile the necessary information for 100 employees, and complete the consultation with the OCFS, within a few hours. Assuming that each employee is subject to both screens, aggregate staff time required should not be more than six to eight hours. Additionally, OCFS imposes a \$25.00 screening fee for new or prospective employees.

Camps will be required to disclose information pertaining to reportable incidents to the Justice Center and to the permit issuing official investigating the incident. Costs

associated with this include staff time for locating information and expenses for copying materials. Using a high estimate of staff salary of \$30.00 an hour, and assuming that staff may take up to two hours to locate and copy the records, typical cost should be under \$100.

Camps must also assure that camp staff, and certain others, who fall within the definition of mandated reporters under section 488 of the Social Services Law receive training related to mandated reporting to the Justice Center, and the obligations of those staff who are required to report incidents to the Justice Center. The costs associated with such training should be minimal as it is expected that the training material will be provided to the camps and will take about one hour to review during routine staff training. Camps must also ensure that the telephone number for the Justice Center reporting hotline is conspicuously posted for campers and staff. Cost associated with such posting is limited, related to making and posting a copy of such notice in appropriate locations.

The camp operator must also provide each camp staff member, and others who may have contact with campers, with a copy of a code of conduct established by the Justice Center pursuant to Section 554 of the Executive Law. The code must be provided at the time of initial employment, and at least annually thereafter during the term of employment. Receipt of the code of conduct must be acknowledged, and the recipient must further acknowledge that he or she has read and understands it. The cost of providing the code, and obtaining and filing the required employee acknowledgment,

should be minimal, as it would be limited to copying and distributing the code, and to obtaining and filing the acknowledgments. Staff should need less than 30 minutes to review the code.

Camps will also be required to establish and maintain a facility incident review committee to review and guide the camp's responses to reportable incidents. The cost to maintain a facility incident review committee is difficult to estimate due to the variations in salaries for camp staff and the amount of time needed for the committee to do its business. A facility incident review committee must meet at least annually, and also within two weeks after a reportable incident occurs. Assuming the camp will have several staff members participate on the committee, an average salary of \$50.00 an hour and a three hour meeting, the cost is estimated to be \$450.00 dollars per meeting. However, the regulations also provide the opportunity for a camp to seek an exemption, which may be granted subject to Department approval based on the duration of the camp season and other factors. Accordingly, not all camps can be expected to bear this obligation and its associated costs.

Camps are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

Finally, the regulations add noncompliance with Justice Center-related requirements as a ground for denying, revoking, or suspending a camp operator's permit.

#### **Cost to State and Local Government:**

State agencies and local governments that operate children's camps for children with developmental disabilities will have the same costs described in the section entitled "Cost to Regulated Parties." Currently, it is estimated that five summer day camps that meet the criteria are operated by municipalities. The regulation imposes additional requirements on local health departments for receiving incident reports and investigations of reportable incidents, and providing a copy of the resulting report to the Department and the Justice Center. The total cost for these services is difficult to estimate because of the variation in the number of incidents and amount of time to investigate an incident. However, assuming the typically used estimate of \$50 an hour for health department staff conducting these tasks, an investigation generally lasting between one and four staff days, and assuming an eight hour day, the cost to investigate an incident will range \$400.00 to \$1600. Zero to two reportable incidents occur statewide each year, so a local health department is unlikely to bear such an expense. The cost of submitting the report is minimal, limited to copying and mailing a copy to the Department and the Justice Center.

#### **Cost to the Department of Health:**

There will be routine costs associated with printing and distributing the amended Code. The estimated cost to print revised code books for each regulated children's camp in NYS is approximately \$1600. There will be additional cost for printing and distributing training materials. The expenses will be minimal as most information will be

distributed electronically. Local health departments will likely include paper copies of training materials in routine correspondence to camps that is sent each year.

#### **Local Government Mandates:**

Children's camps for children with developmental disabilities operated by local governments must comply with the same requirements imposed on camps operated by other entities, as described in the "Cost to Regulated Parties" section of this Regulatory Impact Statement. Local governments serving as permit issuing officials will face minimal additional reporting and investigation requirements, as described in the "Cost to State and Local Government" section of this Regulatory Impact Statement. The proposed amendments do not otherwise impose a new program or responsibilities on local governments. City and county health departments continue to be responsible for enforcing the amended regulations as part of their existing program responsibilities.

## Paperwork:

The paperwork associated with the amendment includes the completion and submission of an incident report form to the local health department and Justice Center. Camps for children with developmental disabilities will also be required to provide the records and information necessary for LHD investigation of reportable incidents, and to retain documentation of the results of their consultation with the Justice Center regarding whether any given prospective employee was found to be on the SEL or the SCR.

# **Duplication:**

This regulation does not duplicate any existing federal, state, or local regulation.

The regulation is consistent with regulations promulgated by the Justice Center.

## **Alternatives Considered:**

The amendments to the camp code are mandated by law. No alternatives were considered.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

#### Federal Standards:

Currently, no federal law governs the operation of children's camps.

## **Compliance Schedule:**

The proposed amendments are to be effective upon filing with the Secretary of State.

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## **Regulatory Flexibility Analysis**

#### for Small Business and Local Government

## **Types and Estimated Number of Small Businesses and Local Governments:**

There are between 40 and 50 regulated children's camps for children with development disabilities (38% are expected to be overnight camps and 62% are expected to be summer day camps) operating in New York State, which will be affected by the proposed rule. About 30% of summer day camps are operated by municipalities (towns, villages, and cities). Typical regulated children's camps representing small business include those owned/operated by corporations, hotels, motels and bungalow colonies, non-profit organizations (Girl/Boy Scouts of America, Cooperative Extension, YMCA, etc.) and others. None of the proposed amendments will apply solely to camps operated by small businesses or local governments.

## **Compliance Requirements:**

## Reporting and Recordkeeping:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties," "Local Government Mandates," and "Paperwork" sections of the Regulatory Impact Statement. The obligations imposed on local government as the permit issuing official is described in "Cost to State and Local Government" and "Local Government Mandates" portions of the Regulatory Impact Statement.

#### Other Affirmative Acts:

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" "Local Government Mandates," and "Paperwork" sections of the Regulatory Impact Statement.

#### **Professional Services:**

Camps with 20 percent or more developmentally disabled children are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

## **Compliance Costs:**

#### **Cost to Regulated Parties:**

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

#### **Cost to State and Local Government:**

The obligations imposed on small business and local government as camp operators are no different from those imposed on camps generally, as described in the

"Cost to Regulated Parties" section of the Regulatory Impact Statement. The obligations imposed on local government as the permit issuing official is described in "Cost to State and Local Government" and "Local Government Mandates" portions of the Regulatory Impact Statement.

# **Economic and Technological Feasibility:**

There are no changes requiring the use of technology.

The proposal is believed to be economically feasible for impacted parties. The amendments impose additional reporting and investigation requirements that will use existing staff that already have similar job responsibilities. There are no requirements that that involve capital improvements.

## **Minimizing Adverse Economic Impact:**

The amendments to the camp code are mandated by law. No alternatives were considered. The economic impact is already minimized.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

# **Small Business Participation and Local Government Participation:**

No small business or local government participation was used for this rule development. The amendments to the camp code are mandated by law. Ample opportunity for comment will be provided as part of the process of promulgating the regulations, and training will be provided to affected entities with regard to the new requirements.

# **Rural Area Flexibility Analysis**

## **Types and Estimated Number of Rural Areas:**

There are between 40 and 50 regulated children's camps for children with development disabilities (38% are expected to be overnight camps and 62% are expected to be summer day camps) operating in New York State, which will be affected by the proposed rule. Currently, there are seven day camps and ten overnight camps operating in the 44 counties that have population less than 200,000. There are an additional four day camps and three overnight camps in the nine counties identified to have townships with a population density of 150 persons or less per square mile.

# Reporting and Recordkeeping and Other Compliance Requirements:

## Reporting and Recordkeeping:

The obligations imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

#### **Other Compliance Requirements:**

The obligations imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

## **Professional Services:**

Camps with 20 percent or more developmentally disabled children are now explicitly required to obtain an appropriate medical examination of a camper physically injured from a reportable incident. A medical examination has always been expected for such injuries.

# **Compliance Costs:**

## **Cost to Regulated Parties:**

The costs imposed on camps in rural areas are no different from those imposed on camps generally, as described in "Cost to Regulated Parties" and "Paperwork" sections of the Regulatory Impact Statement.

# **Economic and Technological Feasibility:**

There are no changes requiring the use of technology.

The proposal is believed to be economically feasible for impacted parties. The amendments impose additional reporting and investigation requirements that will use existing staff that already have similar job responsibilities. There are no requirements that that involve capital improvements.

## **Minimizing Adverse Economic Impact on Rural Area:**

The amendments to the camp code are mandated by law. No alternatives were considered. The economic impact is already minimized, and no impacts are expected to be unique to rural areas.

Consideration was given to including a cure period to afford camp operators an opportunity to correct violations associated with this rule; however, this option was rejected because it is believed that lessening the department's ability to enforce the regulations could place this already vulnerable population at greater risk to their health and safety.

## **Rural Area Participation:**

No rural area participation was used for this rule development. The amendments to the camp code are mandated by law. Ample opportunity for comment will be provided as part of the process of promulgating the routine regulations, and training will be provided to affected entities with regard to the new requirements.

## **Job Impact Statement**

No Job Impact Statement is required pursuant to Section 201-a (2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment that it will have no impact on jobs and employment opportunities, because it does not result in an increase or decrease in current staffing level requirements. Tasks associated with reporting new incidents types and assisting with the investigation of new reportable incidents are expected to be completed by existing camp staff, and should not be appreciably different than that already required under current requirements.

#### **Emergency Justification**

Chapter 501 of the Laws of 2012 established the Justice Center for the Protection of People with Special Needs ("Justice Center"), in order to coordinate and improve the State's ability to protect those persons having various physical, developmental, or mental disabilities and who are receiving services from various facilities or provider agencies. The Department must promulgate regulations as a "state oversight agency." These regulations will assure proper coordination with the efforts of the Justice Center.

Among the facilities covered by Chapter 501 are children's camps having enrollments with 20 percent or more developmentally disabled campers. These camps are regulated by the Department and, in some cases, by local health departments, pursuant to Article 13-B of the Public Health Law and 10 NYCRR Subpart 7-2. Given the effective date of Chapter 501 and its relation to the start of the camp season, these implementing regulations must be promulgated on an emergency basis in order to assure the necessary protections for vulnerable persons at such camps. Absent emergency promulgation, such persons would be denied initial coordinated protections until the 2015 camp season. Promulgating these regulations on an emergency basis will provide such protection, while still providing a full opportunity for comment and input as part of a formal rulemaking process which will also occur

pursuant to the State Administrative Procedures Act. The Department is authorized to promulgate these rules pursuant to sections 201 and 225 of the Public Health Law.

Promulgating the regulations on an emergency basis will ensure that campers with special needs promptly receive the coordinated protections to be provided to similar individuals cared for in other settings. Such protections include reduced risk of being cared for by staff with a history of inappropriate actions such as physical, psychological or sexual abuse towards persons with special needs. Perpetrators of such abuse often seek legitimate access to children so it is critical to camper safety that individuals who that have committed such acts are kept out of camps. The regulation provides an additional mechanism for camp operators to do so. The regulations also reduce the risk of incidents involving physical, psychological or sexual abuse towards persons with special needs by ensuring that such occurrences are fully and completely investigated, by ensuring that camp staff are more fully trained and aware of abuse and reporting obligations, allowing staff and volunteers to better identify inappropriate staff behavior and provide a mechanism for reporting injustice to this vulnerable population. Early detection and response are critical components for mitigating injury to an individual and will prevent a perpetrator from hurting additional children. Finally, prompt enactment of the proposed regulations will ensure that occurrences are fully investigated and evaluated by the camp, and that measures are taken to reduce the risk of re-occurrence in the future. Absent emergency adoption, these benefits and protections will not be available to campers

with special needs until the formal rulemaking process is complete, with the attendant loss of additional protections against abuse and neglect, including physical, psychological, and sexual abuse.

# **Summary of Express Terms**

The amendments to section 415.3 of Title 10 (Health) NYCRR are required to clarify the requirements for transfer and discharge of residents from nursing homes as mandated by federal law. The amendments more clearly define what constitutes a transfer or discharge, specify the elements that must be included in a notice of transfer or discharge to the resident and the deadlines for service of notice, and clarify the rights of a resident at a hearing should one be requested. These amendments do not change existing requirements; they simply ensure that the Department's regulations clearly reflect the existing federal requirements.

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by sections 2801, 2801-a and 2803(2) of the Public Health Law, Section 415.3(h) of Part 415 of Subchapter A (Medical Facilities-Minimum Standards) of Chapter V, Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York are hereby amended to be effective upon publication of a Notice of Adoption in the State Register, to read as follows:

- (h) *Transfer and discharge rights*. Transfer and discharge shall include movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge shall not refer to movement of a resident to a bed within the same certified facility, and does not include transfer or discharge made in compliance with a request by the resident, the resident's legal representative or health care agent, as evidenced by a signed and dated written statement, or those that occur due to incarceration of the resident.
- (1) With regard to the transfer or discharge of residents, the facility shall:
- i) permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless such transfer or discharge is made in recognition of the resident's rights to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the rights of other residents in the facility:

- a) The resident may be transferred only when the interdisciplinary care team, in consultation with the resident or the resident's designated representative, determines that:
- 1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met after reasonable attempts at accommodation in the facility;
- 2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- 3) the [health or] safety of individuals in the facility [would otherwise be] <u>is</u> endangered[, the risk to others is more than theoretical and all reasonable alternatives to transfer or discharge have been explored and have failed to safely address the problem]; or
- 4) The health of individuals in the facility is endangered;
- b) transfer and discharge shall also be permissible when the resident has failed, after reasonable and appropriate notice, to pay for (or have paid under Medicare, Medicaid or third-party insurance) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid. Such transfer or discharge shall be permissible only if a charge is not in dispute, no appeal of a denial of benefits is pending, or funds for payment are actually available and the resident refuses to cooperate with the facility in obtaining the

funds;

- c) transfer or discharge shall also be permissible when the facility discontinues operation and has received approval of its plan of closure in accordance with subdivision (i) of section 401.3 of this Title;
- ii) ensure complete documentation in the resident's clinical record when the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (i) of this paragraph. The documentation shall be made by:
- a) the resident's physician and, as appropriate, interdisciplinary care team[, as appropriate], when discharge or transfer is necessary under subclause (1) or (2) of clause
  (a) of subparagraph (i) of this paragraph; and
- b) a physician when transfer or discharge is necessary due to the endangerment of the health of other individuals in the facility under subclause (3) of clause (a) of subparagraph (i) of this paragraph;
- iii) before it transfers or discharges a resident:
- a) Notify the resident, designated representative, if any, and, if known, family member of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner the [y] resident and/or family member understand;

b) record the reasons in the resident's clinical record; and
c) include in the notice the items described in paragraph (v) of this paragraph;
iv) provide the notice of transfer or discharge required under subparagraph (iii) of this paragraph at least 30 days before the resident is transferred or discharged, except that
notice shall be given as soon as practicable before transfer or discharge, but no later than the date on which a determination was made to transfer or discharge the resident, under the following circumstances:
(a) the safety of individuals in the facility would be endangered;
(b) the health of individuals in the facility would be endangered;
(c) the resident's health improves sufficiently to allow a more immediate transfer or discharge;
(d) an immediate transfer or discharge is required by the resident's urgent medical needs  [or]
(e) [the transfer or discharge is being made in compliance with a request by the resident; the transfer or discharge is the result of a change in the level of medical care prescribed

by the resident's physician; or
(f) the resident has not resided in facility for 30 days.
v) include in the written notice specified in subparagraph (iii) of this paragraph the following:
(a) The reason for transfer or discharge;
(b) The specific regulations that support, or the change in Federal or State law that requires, the action;
(c) The effective date of transfer or discharge;
(d) The location to which the resident will be transferred or discharged;
([a]e) [for transfers or discharges] a statement that the resident has the right to appeal the action to the State Department of Health, which includes: [in accordance with paragraphs (2) and (3) of this subdivision. The statement shall include a current phone number for the department which can be used to initiate an appeal];
(1) an explanation of the individual's right to request an evidentiary hearing appealing the decision;

- (2) the method by which an appeal may be obtained;
- (3) in cases of an action based on a change in law, an explanation of the circumstances under which an appeal will be granted;
- (4) an explanation that the resident may remain in the facility (except in cases of imminent danger) pending the appeal decision if the request for an appeal is made within 15 days of the date the resident received the notice of transfer/discharge;
- (5) in cases of residents discharged/transferred due to imminent danger, a statement that the resident may return to the first available bed if he or she prevails at the hearing on appeal; and
- (6) a statement that the resident may represent him or herself or use legal counsel, a relative, a friend, or other spokesman;
- ([b]f) the name, address and telephone number of the State long term care ombudsman;
- ([c]g) for nursing facility residents [who are mentally ill or who have] with developmental disabilities, the mailing address and telephone number of the [Commission on Quality of Care for the Mentally Disabled which is responsible for the

protection and advocacy of such individuals] agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; [and]

- (h) for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals

  Act;
- [(d) a statement that, if the resident appeals the transfer or discharge to the Department of Health within 15 days of being notified of such transfer or discharge, the resident may remain in the facility pending an appeal determination. This clause shall not apply to transfers or discharges based on clauses (iv) (a), (b), (d), or (e) of this paragraph; and]
- (vi) provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility [including an opportunity to participate in deciding where to go], in the form of a discharge plan which addresses the medical needs of the resident and how these will be met after discharge, and provide a discharge summary pursuant to section 415.11, subdivision (d) of this Title; and
- (vii) permit the resident, their legal representative or health care agent the opportunity to participate in deciding where the resident will reside after discharge from the facility.

- (2) The department shall grant an opportunity for a hearing to any resident who requests it because he or she believes the facility has erroneously determined that he or she must be transferred or discharged [Appeals of transfer and discharge decisions to the Department of Health as permitted by clause (a) of subparagraph (v) of paragraph (1) of this subdivision shall be] in accordance with the following:
- (i) The resident has the right to:
- (a) [a pre-transfer on-site appeal determination under the auspices of the Department of Health, provided that the resident has appealed the transfer or discharge within 15 days of the notice, except in cases involving imminent danger to others in the facility; and]

  request a hearing to appeal the transfer or discharge notice at any time within 60 days

  from the date the notice of transfer or discharge is received by the resident;
- (b) remain in the facility pending an appeal determination <u>if the appeal request is made</u> within 15 days of the date of receipt of the transfer or discharge notice; [or]
- (c) a post-transfer/discharge appeal determination [within 30 days of transfer] if the resident did not request an appeal determination [prior to transfer] within 15 days of the date of receipt of the transfer or discharge notice;
- (d) return to the facility to the first available <u>semi-private</u> bed if the resident wins the appeal, <u>prior to admitting any other person to the facility</u>; and

(e) represent him or herself, or use legal counsel, a relative, a friend or other spokesman.
[examine his/her medical records.]
(ii) [The presiding officer shall have the power to obtain medical and psychosocial
consultations.] The resident or the resident's representative as described in (2)(i)(e) of this
paragraph must be given the opportunity to:
(a) examine at a reasonable time before the date of the hearing, at the facility, and during
the hearing, at the place of the hearing:
1) the contents of the resident's file including his/her medical records; and
2) all documents and records to be used by the facility at the hearing on appeal;
(b) bring witnesses;
(c) establish all pertinent facts and circumstances;
(d) present an argument without undue interference; and
(e) question or refute any testimony or evidence, including the opportunity to confront
and cross-examine adverse witnesses.

- (iii) [The nursing home shall have the burden of proof that the transfer is/was necessary and the discharge plan appropriate.] All hearings must be conducted in accordance with Article 3 of the State Administrative Procedure Act, and in accordance with the following:
- (a) the presiding officer shall have the power to obtain medical assessments and psychosocial consultations, and the authority to issue subpoenas;
- (b) the nursing home shall have the burden of proof that the discharge or transfer is/was necessary and the discharge plan appropriate;
- (c) an administrative hearing must be scheduled within 90 days from the date of the request for a hearing on appeal; and
- (d) the parties must be notified in writing of the decision and provided information on the right to seek review of the decision, if review is available.
- [(iv) in cases involving imminent danger to others in the facility, an involuntary transfer may be arranged before a hearing. However, the facility shall be required to hold the resident's bed until after the hearing decision. If the transfer is found to be appropriate, the facility may charge a private pay resident for the time the bed was held. If the transfer is found to be inappropriate, the facility shall readmit the resident to his or her bed on a

priority basis the first available bed,]

- [(v) the department shall conduct a review and render a decision on the appeal as required in clause (a) of subparagraph (i) of this paragraph within 15 days of the request.]
- [(3) If an appeal decision rendered after discharge finds the discharge or transfer to be inappropriate, the facility shall readmit the resident prior to admitting any other person.]
- ([4]3) The facility shall establish and implement a bed-hold policy and a readmission policy that reflect at least the following:
- (i) at the time of admission and again at the time of transfer for any reason, the facility shall verbally inform and provide written information to the resident and the designated representative that specifies:
- (a) the duration of the bed-hold policy during which the resident is permitted to return and resume residence in the facility; and
- (b) the facility's policies regarding bed-hold periods, which must be consistent with subparagraph (iii) of this paragraph, permitting a resident to return;
- (ii) At the time <u>of transfer of a resident for hospitalization or</u> for therapeutic leave, a nursing home shall provide written notice to the resident and the designated

representative, which specifies the duration of the bed-hold policy described in subparagraph (i) of this paragraph.

- (iii) a nursing home shall establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:
- (a) requires the services provided by the facility; and
- (b) is eligible for Medicaid nursing home services.
- (iv) a nursing home shall establish and follow a written policy under which a resident who has resided in the nursing home for 30 days or more and who has been hospitalized or who has been transferred or discharged on therapeutic leave without being given a bed-hold is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:
- (a) requires the services provided by the facility; and
- (b) is eligible for Medicaid nursing home services.
- ([5]4) With regard to the assurance of equal access to quality care, the facility shall

establish and maintain identical policies and practices regarding transfer, discharge and the provision of all required services for all individuals regardless of source of payment.

#### **Regulatory Impact Statement**

#### **Statutory Authority:**

The statutory authority for this rule is Public Health Law, Sections 2801, 2801-a and 2803(2), which require the Public Health and Health Planning Council to promulgate regulations, subject to the Commissioner's approval, governing the standards and procedures followed by nursing homes. Those standards and procedures must, at a minimum, meet federal standards.

#### **Legislative Objectives:**

To clarify, in accordance with a Stipulation of Settlement in *Gautam, et. al. v.*Novello, et. al., SDNY 03 Civ. 2473(THK), the requirements that must be met by nursing homes in connection with the transfer or discharge of residents. The state's regulations governing transfer and discharge must meet, at a minimum, federal standards.

#### **Needs and Benefits:**

Since July 2005, transfer and discharge of nursing home residents has been in accordance with an interim policy that clarifies state requirements in a way that ensures compliance with federal requirements. Amending 10 NYCRR 415.3 in accordance with the interim policy will permanently clarify the requirements that must be met by nursing homes prior to transferring and discharging patients and will ensure that all required policies and procedures are clearly included in the Department's regulations.

#### **Costs:**

Costs to Regulated Parties for the Implementation of and Continuing Compliance with the Rule:

Nursing homes are already required to comply with federal regulations prior to transferring and discharging residents. These regulations do not expand upon already existing requirements.

Costs to the Agency, the State and Local Governments for the Implementation and Continuation of the Rule:

The amendments to 10 NYCRR 415.3 will not increase any costs currently borne by the Department or state and local governments. The amendments clarify existing requirements that all facilities are required to follow.

The information, including the source(s) of such information and the methodology upon which the cost analysis is based:

Cost analysis is based on the substance of the regulations and the interim policy clarifying those regulations. There has been no change in the requirements that must be met by all affected entities.

#### **Local Government Mandates:**

Local governments that operate nursing homes are already complying with the requirements clarified by these amendments.

## Paperwork:

The paperwork required by these amendments has not changed.

## **Duplication:**

These amendments do not duplicate existing regulations or requirements.

#### **Alternatives:**

None. The amendments simply clarify state requirements by ensuring the Department's regulations clearly incorporate existing federal mandates.

#### **Federal Standards:**

Federal requirements, upon which these amendments are based, are located at 42 CFR Parts 431 and 483. These amendments do not expand upon these requirements.

## **Compliance Schedule:**

Affected entities are already required to comply with the proposed amendments.

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#### Regulatory Flexibility Analysis for Small Businesses and Local Governments

#### **Effect of Rule:**

Local governments will not be affected by this rule except to the extent that they operate a nursing home. There are 34 counties that operate nursing homes. The Department does not have information regarding the number of small business nursing homes in NYS readily available. As the amendments do not add to or change existing requirements, and are mandated by federal law, small businesses and local governments will not be affected.

#### **Compliance Requirements:**

There are no new reporting and record keeping requirements. The regulations simply clarify state requirements by ensuring the Department's regulations clearly incorporate existing federal mandates.

#### **Professional Services:**

No additional professional staff is expected to be needed as a result of the regulations.

#### **Compliance Costs:**

There are no new or additional costs associated with these proposed rules.

#### **Economic and Technological Feasibility:**

These regulations simply clarify existing requirements. They do not require any new technology and should not affect the routine cost of doing business.

#### **Minimizing Adverse Impact:**

The Department has no flexibility with respect to these regulations as all requirements are mandated by federal law. Nonetheless, the rule will have no adverse economic impact on small businesses or local governments since it simply clarifies state requirements by ensuring the Department's regulations clearly incorporate existing federal mandates.

#### **Small Business and Local Government Participation:**

The Department will meet the requirements of SAPA § 202-b(6) in part by publishing a notice of proposed rulemaking in the State Register with a comment period. Input was not requested with respect to these amendments since they reflect federal mandates. The proposed rules are not expected to have a deleterious effect on small businesses and local governments, since these requirements are already in effect. Accordingly, opposition is not expected.

#### **Rural Area Flexibility Analysis**

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

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The proposed amendment will apply statewide, including the 43 rural counties with less than 200,000 inhabitants, and the 10 urban counties with a population density of 150 per square mile or less.

#### Reporting, Recordkeeping and Other Compliance Requirements and Professional Services:

There are no new or additional requirements as a result of this rule. The regulations simply clarify state requirements by ensuring the Department's regulations clearly incorporate existing federal mandates.

#### Costs:

There are no capital costs associated with these rules. There are no additional operational costs as providers are currently required to have policies and procedures in place to implement existing transfer and discharge requirements. Any administrative costs associated with transfer or discharge are mandated by federal law.

#### **Minimizing Adverse Impact:**

The Department has no flexibility with respect to these regulations as all requirements are mandated by federal law. Nonetheless, the rule will have no adverse economic impact on

rural area providers since it simply clarifies state requirements by ensuring the Department's regulations clearly incorporate existing federal mandates.

## **Rural Area Participation:**

The Department will meet the requirements of SAPA Section 202-bb(7), in part, by publishing a notice of proposed rulemaking in the State Register with a comment period. The Department did not solicit input regarding these amendments since they reflect federal mandates. The proposed rules are not expected to have a deleterious effect on rural areas, since these requirements are already in effect. Accordingly, opposition is not expected.

# **Job Impact Statement**

A Job Impact Statement is not required because it is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs and employment opportunities.



# Public Health and Health Planning Council

# Project # 142181-C Orange Regional Medical Center

Program: Hospital County: Orange

Purpose: Construction Acknowledged: October 31, 2014

# **Executive Summary**

#### **Description**

Orange Regional Medical Center (ORMC or Orange Regional), a not-for-profit 383-bed acute care hospital, requests approval to construct a new medical office building and a cancer center on its main campus located at 707 East Main Street, Middletown. Upon completion ORMC will relocate many of the outpatient services currently being provided in its Orange Regional Medical Pavilion, located about one mile away at 75 Crystal Run Road, Middletown. Orange Regional will also relocate services currently being provided at its outpatient Patient Services Center located at 70 Hatfield Lane, Goshen. The hospital is not proposing to develop any new clinical services as a result of this project. Rather, this project seeks only to relocate existing services from remote locations onto ORMC's main campus.

The medical office building will consist of five floors, of which floors 3 through 5 will be entirely non-Article 28 space. Floors 3 through 5 will house the Greater Hudson Valley Health System Medical Group (GHVMG). GHVMG is a New York Professional Service Corporation engaged in the private practice of medicine.

Orange Regional's decision to pursue this project is based on a number of factors that include: improving the quality of its outpatient care services, the opportunity to develop a dedicated cancer center, creating a flagship location for the ORMC Medical Group, progression towards integrated delivery system development, achieving significant cost reductions, achieving various operational efficiencies to benefit both staff and patients, and giving ORMC the ability to directly impact at least three of the ten

Delivery System Reform Incentive Payment (DSRIP) projects being pursued by its Performing Provider System (PPS). The applicant has indicated that Montefiore Medical Center is the lead applicant for ORMC's PPS for the DSRIP program.

#### **DOH Recommendation**

**Contingent Approval** 

#### **Need Summary**

This project would relocate many services from the two extension clinics to the site of the proposed expansion of Orange Regional Medical Center. The proposed expanded Cancer Center would relocate the Radiology and LINAC services from the two clinics to a centralized, modern cancer treatment facility in Orange County. Because such a move would keep the services in Orange County, there is little risk of a decline in utilization rates or a disruption in services.

#### **Program Summary**

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

#### **Financial Summary**

Total Project Cost is \$99,872,535.**Total Reimbursable** Cost is \$77,155,692 due to Non-Article 28 and shell space on floors 3 through 5.

Project costs of \$99,872,535 will be met as follows: Equity via operations of \$16,828,342, Fundraising of \$2,000,000, Outstanding 2008 Bond Proceeds from construction of ORMC's new replacement hospital of \$5,084,193, DASNY bond financing of \$68,460,000 at an interest rate of 5.078% for a thirty year term, and an equipment lease of \$7,500,000 at an interest rate of 3.80% for a five year term.

Enterprise Budget:

 Revenues
 \$382,745,550

 Expenses
 380,643,538

 Excess Revenues over Expenses
 \$2,102,012

Incremental Budget:

 Revenues
 \$4,371,421

 Expenses
 4,474,332

 Excess Revenues over Expenses
 (\$102,911)

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

# **Office of Primary Care and Health Systems Management** Approval contingent upon:

- Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
- 2. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest, acceptable by the Department of Health. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
- 3. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-02 SHC Hospitals (as required) and DSG-03 Outpatient Facilities (as required) [AER]

#### **Approval conditional upon:**

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]
- 6. The applicant shall start construction on or before April 1, 2015 and complete construction by October 1, 2016 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 71 0.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.1 O(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]
- 7. The submission of Final Construction Documents, as described in BAER Drawing Submission Guidelines DSG-05, prior to the applicant's request for, and Department's granting approval for the start of construction [AER]
- 8. Reimbursable project costs shall be limited to \$77,155,692 due to the undeveloped 5th floor and Non-Article 28 Private Physician floors 3 & 4 of the MOB. These areas represent a total of \$22,716,843 in project costs. Reimbursement of these costs will be withheld until these areas are approved for article 28 services by the department (via approval of future CON submission or modification of this CON project).
- 9. Submission of an executed equipment lease, acceptable to the Department of Health. [BFA]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Project Description**

Orange Regional Medical Center is a 383-bed acute care hospital located at 707 East Main Street, Middletown, 10940, in Orange County. It is requesting approval to renovate and expand the Cancer Center on its main campus, and to construct a 5-story medical office building there. The first two floors of the medical office building would be Article 28 certified and would contain relocated services from two extension clinics run by the Center. Floors three and four of the proposed medical office building will contain physician offices, examination rooms and procedure rooms. The fifth floor would be vacant.

A summary of the services the two extension clinics currently provide is as follows:

#### Orange Regional Radiation Oncology Extension Clinic

Linear Accelerator
Magnetic Resonance Imaging
Medical Services – Primary Care
Radiology – Diagnostic O/P
Radiology – Therapeutic O/P

<u>Horton Medical Pavilion</u> Ambulatory Surgery – Multi Specialty CT Scanner

Linear Accelerator Medical Services – Primary Care

Radiology – Diagnostic O/P Radiology – Therapeutic O/P

On completion of this project, the current location of the Orange Regional Oncology Extension Clinic would be left vacant, all services having been moved to the main site of Orange Regional Medical Center. Horton Medical Pavilion would continue to provide a Sleep Center and Wound Care services.

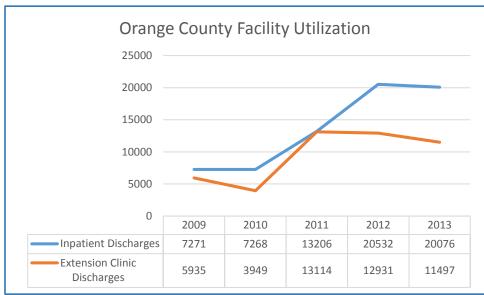
**Table 1: Orange Regional Medical Center Bed Chart** 

Bed Category	Certified Beds	Requested Action	Certified Capacity Upon Completion
Coronary Care	6	0	6
Intensive Care	34	0	34
Maternity	23	0	23
Medical / Surgical	244	0	244
Neonatal Intensive Care	10	0	10
Pediatric	12	0	12
Physical Medicine and Rehabilitation	24	0	24
Psychiatric	30	0	30
Total	383	0	383

Source: HFIS

#### **Analysis**

Utilization numbers for Orange Regional Medical Center and the two extension clinics involved in this project are shown below. With no change to services being proposed, these utilization numbers should not be affected by this project.



Source: SPARCS

Prevention Quality Indicators for Orange and Sullivan Counties are listed below. The PQIs for the primary service area of Orange Regional Medical Center and its extension clinics are well above the state average. This indicates a continuing need for primary care and ambulatory surgery. The medical office building with its primary care clinic would help to reduce these indicators.

**Table 2: PQI Indicators for Orange and Sullivan Counties** 

Year	200	09	20	10	20	11	20	12
	Observed		Observed		Observed		Observed	
	Rate Per	%						
PQI	100,000	Expected	100,000	Expected	100,000	Expected	100,000	Expected
Overall								
Composite	3,286	245.6%	2,975	242.9%	3,054	248.3%	2,567	224.2%
Acute								
Composite	1,410	274.6%	1,201	258.1%	905	193.9%	1,303	304.9%
Chronic								
Composite	1,876	227.5%	1,774	233.6%	2,148	281.5%	1,263	176.1%
All Circulatory								
Composite	851	237.8%	907	280.4%	1,135	364.3%	718	248.5%
All Diabetes								
Composite	333	191.1%	347	202.1%	243	135.1%	160	93.3%
All Respiratory								
Composite	692	236.5%	520	196.6%	770	283.5%	386	149.9%

Source: health.data.ny.gov

#### Conclusion

This proposal is expected to improve the patient experience and access to vital health services in Orange and Sullivan Counties. The applicant believes that the project will increase the ability of the Center to respond to a patients' needs by shortening supply chains and improving communication. By moving a primary care clinic onto the same campus as the Emergency Department, the triaging process can be improved and ED visits reduced. The high PQIs for the primary service area indicate that need still exists for additional primary care. The proposed medical office building, with an additional procedure room, will start to address this need. No change to services is being proposed. This project will increase the efficiency and accessibility of existing resources in Orange and Sullivan Counties.

#### Recommendation

From a need perspective, approval is recommended.

# **Program Analysis**

#### **Program Description**

Orange Regional Medical Center (ORMC) requests approval to construct a new medical office building (MOB) and a dedicated cancer center on its main campus located at 707 East Main Street in the Town of Wallkill (Orange County). ORMC is not proposing to develop any new clinical services as a result of this project, rather, this project seeks only to relocate existing services from remote locations onto the main campus. Once construction is complete many of the outpatient services currently being provided at the Orange Regional Medical Pavilion (located in Middletown) and services currently being provided the Patient Services Center (located in Goshen) will be relocated to the new medical office building. Additionally, the proposed cancer center, which will combine new construction with renovated space, will give ORMC the opportunity to consolidate all of its existing outpatient cancer services into a single site.

ORMC is one of two hospitals in the Greater Hudson Valley Health System (GHVHS), the other being Catskill Regional Medical Center. GHVHS serves as the active parent to both.

This project will consolidate most of ORMC's services onto a single campus for added convenience and create technologic and operational efficiencies that will, in turn, result in a more seamless health care environment.

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

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, approval is recommended.

# **Financial Analysis**

#### **Total Project Cost and Financing**

Total project cost, which is for new construction and the acquisition of moveable equipment, is estimated at \$99,872,535, further broken down as follows:

New Construction	\$51,975,224
Renovation and Demolition	2,699,028
Site Development	8,071,476
Temporary Utilities	55,000
Design Contingency	6,280,073
Construction Contingency	3,274,988
Architect/Engineering Fees	3,592,000
Construction Manager Fees	1,808,895
Other Fees (Consultant)	1,558,482
Moveable Equipment	12,773,012
Telecommunications	1,212,062
Financing Costs	960,000
Interim Interest Expense	5,188,271
CON Fee	2,000
Additional Processing Fee	<u>422,024</u>
Total Project Cost	\$99,872,535
Total Reimbursable Cost	\$77,155,692

Project costs are based on an April 1, 2015 construction start date and an eighteen month construction period. The Bureau of Architectural and Engineering Review has determined that this project includes Non-Article 28 space costs totaling \$22,716,843. As a result, the total approved project cost for reimbursement purposes shall be limited to \$77,155,692.

Total project costs are divided into three subprojects as follows:

<u>Project</u>	<u>Description</u>	Total Project Cost
Subproject 1	Medical Office Building	\$78,308,918
Less: Non-Article 28	Private Physician Practice	(\$22,716,843)
Sub Project 1 Total:	Article 28 Allowable	\$55,592,075
Sub Project 2:	Cancer Center - New Construction	\$16,659,044
Sub Project 3:	Cancer Center - Renovation	\$4,480,548
CON Fees:	Application Fees	\$424,024
Total Reimbursable		\$77,155,691

The applicant's financing plan appears as follows:

Equity	\$16,828,342
Fundraising	2,000,000
Outstanding 2008 Bond Proceeds	5,084,193
DASNY Bond Loan (5.078% interest, thirty year term)	68,460,000
Equipment Lease (3.80% interest rate, five year term)	<u>7,500,000</u>
Total	\$99,872,535

Staff has contacted the Dormitory Authority of the State of New York (DASNY) and verified that the funds from the Outstanding 2008 Bond Proceeds are available for use on this project. DASNY also indicated that they have been in contact with ORMC regarding the proposed bond financing and advised the applicant that they will consider issuing bonds in conjunction with the proposed plan of finance for the entire project as described in this CON. J.P. Morgan has provided a letter of interest in serving as underwriter for the Bond Issue.

#### **Operating Budget**

The applicant has submitted an incremental operating budget, in 2014 dollars, during the first and third years, summarized below:

Revenues	<u>Year One</u> \$3,491,568	<u>Year Three</u> \$4,371,421
Expenses: Operating Capital Total Expenses	\$0 <u>5,761,145</u> \$5,761,145	\$0 <u>4,474,332</u> \$4,474,332
Excess of Revenues over Expenses	(\$2,269,577)	(\$102,911)
Utilization: (Visits)	3,109	3,235

Utilization assumptions are based on modest increases based on growth in the area. Utilization is projected to increase by 2% from historical. Expense assumptions are based on incremental interest and depreciation expense and the reduction in lease rental payments as it vacates the old locations and/or sunsets existing leases on the old locations. The applicant has indicated that certain expenses are constant despite expected modest volume increases because they feel the volume increases can be absorbed with the current staffing levels and associated operating expenses. The applicant anticipates becoming more efficient in the new building space based on LEAN studies forcing the planning process and improved patient flow and co-location of related services and operational functions, thereby allowing it to treat more patients with the same number of staff.

Incremental utilization broken down by payor source during the first and third years (3,109 and 3,235 visits respectively) as follows:

	<u>Year One</u>	<u>Year Three</u>
Medicaid Managed Care	6,27%	6.27%
Medicaid Fee For Service	2.09%	2.10%
Medicare Managed Care	4.50%	4.51%
Medicare Fee For Service	37.09%	37.06%
Commercial Managed Care	.35%	.34%
Commercial Fee For Service	46.35%	46.34%
Private Pay	2.19%	2.19%
Other	<u>1.16%</u>	<u>1.19%</u>
Total	100.00%	100.00%

#### **Capability and Feasibility**

Total project cost of \$99,872,535 will be met as follows: Equity via operations of \$16,828,342; Fundraising of \$2,000,000; outstanding 2008 bond proceeds from construction of ORMC's new replacement hospital of \$5,084,193; Equipment Lease of \$7,500,000 at an interest rate of 3.80% for a five year term; and DASNY bond financing of \$68,460,000 at an interest rate of 5.078% for a thirty year term. If there are fundraising shortfalls, the hospital has indicated that they will provide equity to offset the shortfalls. BFA Attachment B is the 2012 and 2013 certified financial statements of Orange Regional Medical Center, which indicates the availability of sufficient funds for the equity contribution and the fundraising portion if fundraising proceeds are not met.

The submitted incremental budget indicates an operating loss of \$2,269,577 and \$102,911 during the first and third years, respectively. The first and third year losses will be offset via operations. The budget for the whole facility for the third year after project completion is projecting excess revenues over expenses of \$1,862,648. Revenues are based on current reimbursement rates.

As shown on BFA Attachment B the hospital had an average positive working capital position and an average positive net asset position from 2012 through 2013. Also, the hospital incurred average operations losses of \$7,882,000 from 2012 through 2013. The applicant has indicated that the reasons for the losses are the result of the following:

- In August 2011, ORMC closed its two existing community hospitals and consolidated its operations into its new hospital, which led to increased expenses due to debt service on the new building.
- Rising unemployment rates in the area led to a loss of medical coverage for patients and subsequently, a delay in seeking medical care, which reduced patient volume and revenue.
- Medicare imposed Sequestration implemented in 2013 reduced Medicare rates by 2% which negatively impacted revenue.
- Inpatient discharges decreased as a result of patients who had historically been considered inpatients being re-classified as outpatient observation. Reimbursement for observation status patients is significantly less than for inpatient status, up to 60% less in some cases, contributing to operating losses.

The applicant implemented the following steps to improve operations: implemented a reduction in work force to bring down the FTEs to address the operating losses, worked to improve inpatient and outpatient volumes which increased by 7.5% and 2% respectively in the first half of 2014, and improved ORMC's debt service coverage ratio which improved to 1.95 from 1.36 the prior year.

BFA Attachment A is the June 30, 2014 internal financial statement of Orange Regional Medical Center. As shown, the hospital had a positive working capital position and a positive net asset position through June 30, 2014. Also, the hospital achieved an operating income of \$1,965,559 through June 30, 2014.

#### Recommendation

From a financial perspective, contingent approval is recommended.

#### **Attachments**

BFA Attachment A - Financial Summary- Orange Regional Medical Center's June 30, 2014 internal financial statements

BFA Attachment B - Financial Summary- 2012 and 2013 certified financial statements of Orange Regional Medical Center



# Public Health and Health Planning Council

# Project # 142134-C Mohawk Valley Eye Surgery Center

**Program:** Diagnostic & Treatment Center

Purpose: Construction

County: Montgomery
Acknowledged: October 6, 2014

# **Executive Summary**

#### **Description**

Amsterdam REC, LLC d/b/a Mohawk Valley Eye Surgery Center, an existing single-specialty ambulatory surgery center (ASC) located at 108 Holland Circle Drive in Amsterdam, Montgomery County, is requesting approval to become a multispecialty ASC by adding interventional pain management services. Mohawk Valley Eye Surgery Center was established under CON 112179 and licensed as of June 11, 2013 for a five-year limited life.

As a contingency of approval, the center will submit a request for a new d/b/a such that the assumed name conveys the multi-specialty nature of the services.

#### **DOH Recommendation**

Contingent Approval, maintaining the current expiration date of the operating certificate of June 11, 2018.

#### **Need Summary**

Amsterdam REC, LLC d/b/a Mohawk Valley Eye Surgery Center, a single-specialty ophthalmology ASC proposes certification as a multi-specialty ASC by adding interventional pain management services in Amsterdam, Montgomery County. Amsterdam REC, LLC has determined the Center is not fully utilized, and

it has the capacity to handle additional cases. The number of projected visits in pain management services is 1,000 in year 1, with 28 percent Medicaid and two (2) percent charity care. These projections are based on the current practices of participating physicians.

#### **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**

Project costs are \$42,220 and will be met with accumulated funds from Dr. Kwiat, sole member.

Budget: Revenues: \$712,874

Expenses: <u>196,150</u> Gain: \$ 516,724

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

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

#### Office of Primary Care and Health Systems Management

Approval, maintaining the current expiration date of the operating certificate of June 11, 2018, contingent upon:

- 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. A copy of the check must be uploaded into the Contingencies Tab within NYSECON upon mailing of the check. [PMU]
- Submission of a signed agreement with an outside independent entity satisfactory to the Department to provide annual reports to the DOH beginning in the second year of operation. Said reports should include:
  - a. Data showing actual utilization including procedures;
  - b. Data showing breakdown of visits by payor source;
  - c. Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - d. Data showing number of emergency transfers to a hospital;
  - e. Data showing percentage of charity care provided, and
  - f. Number of nosocomial infections recorded during the year in question. [RNR]
- 3. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
- 4. Submission by the governing body of the ambulatory surgery center of an Organizational Mission Statement which identifies, at a minimum, the populations and communities to be served by the center, including underserved populations (such as racial and ethnic minorities, women and handicapped persons) and the center's commitment to meet the health care needs of the community, including the provision of services to those in need regardless of ability to pay. The statement shall also include commitment to the development of policies and procedures to assure that charity care is available to those who cannot afford to pay. [RNR]
- 5. Submission of an acceptable dba recognizing that the facility provides more than just eye surgery services. [HSP]

#### Approval conditional upon:

1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Background**

Amsterdam REC, LLC d/b/a Mohawk Valley Eye Surgery Center (MVESC) requests approval to certify the single-specialty ophthalmology ambulatory surgery center (ASC) as a multi-specialty ASC, by adding interventional pain management services. It is located at 108 Holland Circle Drive, Amsterdam, 12010, Montgomery County. It opened with one operating room on June 11, 2013 with a five year limited life under CON 112179. The proposed pain management services are currently being performed in an office setting. With the approval of this project, these services will be provided in a regulated Article 28 facility. The operating certificate expiration date will remain as June 11, 2018.

#### **Analysis**

The service area includes Montgomery, Fulton, Herkimer, and Otsego Counties.

Mohawk Valley Eye Surgery Center is the only ambulatory surgery center in Montgomery County. Moreover, Fulton, Herkimer, and Otsego Counties have no freestanding ASCs.

Based on CON 112179, MVESC had the following projections for Year 1 and Year 3:

CON 112179: Projections	Year 1	Year 3
# of Procedures	826	877

CON 112179: Projections Payor Source	% Procedures
Medicare FFS	39.0%
Medicaid FFS	10.0%
Medicaid MC	12.0%
Commercial MC	35.0%
Private Pay	2.0%
Charity	2.0%
Total	100.0%

Based on utilization data submitted by the applicant, MVESC had 1,254 procedures from January to September 2014; Medicaid was 20.8 percent and charity was 2.8 percent.

Upon approval of this multi-specialty ASC, the number of projected visits in pain management services is 1,000 in year 1 and 1,060 visits in year 3 with 28 percent Medicaid and two (2) percent charity care. Projected utilization for Year 1 and Year 3 is as follows:

CON 142134: Projections	Year 1		Year 3	
Visits by Payor Source	Visits	Percentage	Visits	Percentage
Medicare (FFS+MC)	350	35.0%	371	35.0%
Medicaid (FFS+MC)	280	28.0%	297	28.0%
Commercial (FFS+MC)	200	20.0%	212	20.0%
Private Pay				
Charity	20	2.0%	21	2.0%
All Other (Workers' Comp).	150	15.0%	159	15.0%
Total	1,000	100.0%	1,060	100.0%

MVESC is located in a Health Professional Shortage Area for Primary Care Services-Medicaid Eligible-Montgomery County. (Source: HRSA).

The applicant is committed to serving patients needing care regardless of their ability to pay or the source of payment.

#### Conclusion

The proposed pain management services are currently being performed in an office setting. With the approval of this project, these services will be provided in a regulated Article 28 facility.

#### Recommendation

From a need perspective, contingent approval is recommended.

# **Program Analysis**

#### **Project Proposal**

Amsterdam REC, LLC, d/b/a Mohawk Valley Eye Surgery Center, an existing single-specialty ophthalmology ambulatory surgery center located at 108 Holland Circle Drive, in Amsterdam (Montgomery County), requests approval to add pain management services and become a multi-specialty ambulatory surgery center. The conversion to multi-specialty will not involve any renovation or alteration of the facility. It is anticipated that staffing will increase by 1.5 FTEs in the first year after completion and remain at that level through the third year.

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

The medical staff will continue to ensure that 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/or expertise. The facility's admissions policy will include anti-discrimination regarding age, race, creed, color, national origin, marital status, sex, sexual orientation, religion, disability, or source of payment. All procedures will be performed in accordance with all applicable federal and state codes, rules and regulations, including standards for credentialing, anesthesiology services, nursing, patient admission and discharge, a medical records system, emergency care, quality assurance and data requirements.

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, contingent approval is recommended.

# **Financial Analysis**

#### **Total Project Cost and Financing**

Total cost for movable equipment is projected to be \$42,220, broken down as follows:

Movable Equipment	40,000
CON Application Fee	2,000
CON Processing Fee	<u>220</u>
Total Project Cost	<u>\$42,220</u>

#### **Operating Budget**

The applicant has submitted an operating budget for the first and third years, in 2014 dollars, which is summarized below:

	Year One	Year Three
Total Revenues	\$672,420	\$712,874
Expenses:		
Operating	\$177,500	\$188,150
Capital	<u>8,000</u>	<u>8,000</u>
Total Expenses	\$185,500	\$196,150
Net Income(Loss)	<u>\$503,537</u>	<u>\$516,724</u>
Visits	1,000	1,060
Cost Per Visit	\$185.50	\$185.05
Utilization by payor source for the first	t year is as follows:	
Medicare Fee-For-Service	35.0%	
Medicaid Managed Care	28.0%	
Commercial Fee-For-Service	20.0%	
Other	15.0%	
Charity Care	<u>2.0%</u>	
Total	100.0%	

Expense and utilization assumptions are based on the historical private practice of Dr. Paul Soccio, the physician who will join the medical staff of the Center after final approval by the Public Health and Health Planning Council.

#### **Capability and Feasibility**

Project costs are \$42,220 and will be met with accumulated funds from Dr. Kwiat, sole member of the ASC. Dr. Kwiat has submitted a personal bank statement showing he has sufficient funds for the total project cost.

The submitted budget projects a net profit of \$503,537 and \$516,724 during the first and third years, respectively. Medicare and Medicaid reflect prevailing reimbursement methodologies. All other revenues assume current reimbursement methodologies. The budget appears reasonable.

BFA Attachments A and B, financial summaries of Mohawk Valley Eye Surgery Center, show negative working capital, net equity as of December 31, 2013 and October 27, 2014 and a net loss from operations of \$113,482 as December 31, 2013. As of October 27, 2014, Mohawk Valley Eye Surgery Center is showing a net profit of \$260,983. The negative working capital, net equity and the net loss in 2013 and negative working capital and net equity as of October 27, 2014 were due to startup costs. Mohawk Valley Eye Surgery Center opened in September of 2013 and 2014 is the first full year of operations.

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

#### Recommendation

From a financial perspective, approval is recommended.

# **Supplemental Information**

Below are presented summaries of responses by hospitals to letters from the Department asking for information on the impact of the ambulatory surgery center's proposed expansion of services in their service areas. There follows a summary of the applicant's response to DOH's request for information on the proposed facility's expanded volume of surgical cases, the sources of those cases, and on how additional staff will be recruited and retained by the ambulatory surgery center (ASC).

Facility: St. Mary's Hospital at Amsterdam -- No Response

427 Guy Park Avenue

Amsterdam, New York 12010

Facility: Nathan Littauer Hospital -- No Response

99 East State Street

Gloversville, New York 12078

#### **Supplemental Information from Applicant**

**Need and Sources of Cases:** The applicant states that all of the facility's pain management cases will be drawn from the office-based cases of Dr. Soccio, the pain management physician who will join the facility.

**Staff Recruitment and Retention:** The facility expects to add one 0.5 FTE registered nurse and 1.0 FTE licensed practical nurse to handle its interventional pain management cases. These positions will be filled by Dr. Soccio's current employees. Additional staffing requirements, if any, will be met through recruitment from accredited schools and training programs and through advertisements in local newspapers and professional publications. To retain staff, the facility currently offers competitive salaries and benefits and maintains good human resource and communications systems. In addition, the facility provides a positive work environment and flexible working hours.

**Office-Based Cases:** Fully 100 percent of the projected pain management procedure volume to be added to the ASC's caseload is currently performed in an office setting.

#### **DOH Comment**

In the absence of comments from hospitals in the ASC's service area, the Department finds no basis on which to consider reversal or modification of the recommendation for approval based on public need, financial feasibility and operator character and

#### **Attachments**

BFA Attachment A BFA Attachment B Financial Summary of Mohawk Valley Eye Surgery Center, 2013 draft Financial Summary of Mohawk Valley Eye Surgery Center, as of October 27, 2014 draft



# Public Health and Health Planning Council

# Project # 142081-C Huntington Hospital

Program: Hospital County: Suffolk

Purpose: Construction Acknowledged: August 27, 2014

# **Executive Summary**

#### **Description**

Huntington Hospital (HH), a 408-bed not-for-profit acute care facility located at 270 Park Avenue, Huntington in Suffolk County, requests approval to construct a replacement Emergency Department.

HH is a member of the North Shore-Long Island Jewish Health System, Inc. (NS-LIJ), a comprehensive integrated delivery system. Also, the Hospital is a member of the NS-LIJ Obligated Group, formed to provide its members an enhanced credit position and expanded access to capital markets.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

Huntington Hospital (HH) proposes to construct a replacement emergency department (ED) to address its currently undersized ED (29 bays) by installing an additional 18 ED treatment bays, for a total of 47. During the construction of the replacement ED, the current ED will remain open and functioning without disruption of care. Huntington anticipates 56,747 visits by the 3<sup>rd</sup> year of operation. The addition of these stations will help reduce patient wait time and allow for future growth.

#### **Program Summary**

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

#### **Financial Summary**

Project costs of \$45,150,953 will be met with \$4,515,095 in accumulated funds and Tax Exempt DASNY Bonds of \$40,635,858 @ 6.5% over 30 years.

Incremental Budget: Revenues: \$16,357,600

Expenses: \$17,722,600 Gain(Loss): \$(1,365,000)

A letter from the CFO of the NSLIJ Health System has been submitted stating that NSLIJ is able and willing to absorb the operational incremental budgeted losses. Subject to the noted condition, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

#### **Office of Health Systems Management**

#### **Approval contingent upon:**

- 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-02. [AER]
- 3. Submission of written acknowledgment that the design contingency and the construction contingency will not be spent without written approval from the Construction Cost Control Unit. [CCC]

#### Approval conditional upon:

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. This project is approved to be initially funded with North Shore-Long Island Jewish Hospital (NS-LIJ) obligated group equity with the prospect that the project will be 90% financed as part of a future NS-LIJ obligated group tax exempt bond financing through the Dormitory Authority. The bond issue is expected to include a 6.5% interest rate and a 30 year term. Financing is conditioned upon the Department having the opportunity to review the final financing proposal in advance to ensure that it meets approval standards. [BFA]
- 3. The applicant shall start construction on or before March 1, 2015 and complete construction by January 31, 2016 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 710.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.10(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Project Description**

Huntington Hospital (HH), a 408-bed community hospital located at 270 Park Avenue in Huntington (Suffolk County), is seeking approval for the construction, expansion, and replacement of their emergency department (ED). The purpose of this project is to improve operational efficiency and patient flow. Huntington Hospital is a member of North Shore LIJ Health Care Inc. Additionally, North Shore LIJ Health Care Inc. is the co-operator of HH.

Huntington Hospital is a Level II area trauma center. Its existing Emergency Department is over 30 years old and has become spatially, functionally, technologically and operationally obsolete. Current patient volume is roughly 50,000 visits/year and growing.

#### **Background/Analysis**

Huntington Hospital has the following inpatient certified beds:

Table 1 Huntington Hospital: Certified Beds.	
Source: HFIS, June 2013.	
Bed Type	Certified Capacity
Coronary Care	14
Intensive Care	12
Maternity	30
Medical-Surgical	301
Neonatal Intermediate Care	10
Pediatric	20
Psychiatric	21
Total	408

The hospital has the following New York State designation(s):

- Stroke Center
- Level 2 Perinatal Center
- Area Trauma Center

The primary service area for the emergency department is Northwest Suffolk County. The hospital serves approximately 301,000 residents. PQI rates for this area are 6.1% higher than the expected rate.

The new ED will create a new fast track to decrease wait times and reduce overcrowding. The existing ED will remain open until construction is finished and state approval is granted. Upon opening the replacement ED, the existing ED will close.

The existing ED is 31 years old, severely undersized, and no longer able to efficiently handle the increasing annual patient volume. Huntington Hospital (HH) proposes to construct a replacement emergency department (ED) to address the currently undersized ED (29 bays) by installing an additional 18 ED treatment bays for a total of 47. During the construction of the replacement ED, the current ED will remain open and functioning without disruption of care. Huntington anticipates 56,747 visits by the 3<sup>rd</sup> year of operation. The addition of these stations will help reduce patient wait time and allow for future growth.

#### **Current ED Data Utilization (Total ED Visits)**

2012	2013
51,211	49,204

Current ED volume shows that the hospital is treating approximately 50,000 ED patients yearly in an outdated and undersized ED space. The renovation and expansion will greatly enhance throughput and quality of patient care.

#### **Projected Total Visits (Total ED Visits)**

Year 1	Year 3
54,543	56,747

Projected visits are anticipated to be 54,543 in the first year and increase to 56,747 by the 3<sup>rd</sup> year. The anticipated visits to the new space will equate to approximately 1,207 visits per ED bay.

#### Conclusion

The replacement and expansion of the ED will reduce wait time, improve quality of ED care, and allow for growth of ED service.

#### Recommendation

From a need perspective, approval is recommended.

# **Program Analysis**

#### **Project Proposal**

Huntington Hospital (HH) is requesting approval for the construction of a replacement emergency department (ED) at 270 Park Avenue in Huntington (Suffolk County). The purpose of this project is to improve operational efficiency and patient flow by replacing the ED. Huntington Hospital is a member of North Shore LIJ Health Care Inc. Additionally, North Shore LIJ Health Care Inc. is the co-operator of HH.

Huntington Hospital, a 408-bed community hospital, is a level II area trauma center. Its existing Emergency Department is over 30 years old and has become spatially, functionally, technologically and operationally obsolete. Current patient volume is roughly 50,000 visits/year and growing. Combined with an inflexible, land-locked location in the hospital, there are no good options for expansion in its current location. A replacement ED, created from decanted non-clinical areas, will provide an appropriate number of treatment spaces and accompanying support space.

The replacement ED is designed to achieve faster throughput by implementing a dual-track ED, where patients are quickly assessed by a registered nurse at the reception desk, processed through an intake/triage area by dedicated staff, then directed to one of two treatment areas based on their acuity. Further efficiencies will be achieved by integrating value-added waiting into the patient experience.

Additionally, the replacement ED will include its own imaging service, with a dedicated CT Scan room, and radiography facilities (currently patients have to leave the ED to have a CT or MRI performed), as well as a new, larger, state-of-the-art trauma and resuscitation rooms.

Upon completion of this project, the total emergency department capacity will increase from 29 patient positions to 47 positions. The existing ED will remain open until construction is finished and state approval to occupy is granted. Upon opening the replacement ED, the existing ED will be decanted.

It is anticipated that the project will result in an additional 78.3 FTEs in the first year of operation and remain at that level through the third year.

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

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, approval is recommended.

# **Financial Analysis**

#### **Total Project Cost and Financing**

Total project cost for new construction, renovations and movable equipment, is estimated at \$45,150,953, broken down as follows:

New Construction	\$ 12,019,605
Renovation & Demolition	13,990,889
Asbestos Abatement or Removal	150,000
Design Contingency	2,601,049
Construction Contingency	2,601,049
Planning Consultant Fees	456,681
Architect/Engineering Fees	2,080,840
Construction manager Fees	200,000
Consultant Fees	825,600
Movable Equipment	5,120,000
Telecommunications	2,700,000
Financing Costs	2,156,279
Application Fees	2,000
Additional Processing Fees	<u>246,961</u>
Total Project Cost	\$45,150,953

The applicant's financing plan is as follows:

Cash	\$ 4,515,095
Tax Exempt Bonds, Dormitory Authority of the	
State of New York, 6.5%, 30 years	\$40,635,858
Total	\$45,150,953

#### **Operating Budget**

The applicant has submitted incremental operating budgets, in 2014 dollars, for the first and third years, which are summarized below:

Inpatient Revenue Operating Expense	First Year \$8,614,300 \$4,520,640	<u>Third Year</u> \$13,377,400 <u>\$5,731,200</u>
Excess Revenue(Loss)	\$4,093,660	\$7,646,200
Outpatient Revenue Expense:	<u>First Year</u> \$2,080,400	<u>Third Year</u> \$2,980,200
Operating Interest Depreciation Total Expense	\$6,384,400 2,366,000 <u>2,596,400</u> \$11,346,800	\$6,640,600 2,754,400 <u>2,596,400</u> \$11,991,400
Excess Revenue(Loss)	\$(9,266,400)	\$(9,011,200)
Net Excess Revenue(Loss)	\$(5,172,740)	\$(1,365,000)
Inpatient Discharges Visits	948 3,893	1,467 4,611

Utilization by payor source, for the first and third years, is projected as follows:

<u>Inpatient</u>	Years One and Three
Commercial Managed Care	23.6%
Medicare-Fee-For-Service	56.9%
Medicare Managed Care	7.1%
Medicaid Managed Care	9.0%
Private Pay	3.4%

<u>Outpatient</u>	Years One and Three
Commercial Managed Care	40.1%
Medicare-Fee-For-Service	16.5%
Medicare Managed Care	2.5%
Medicaid Managed Care	23.6%
Private Pay	17.3%

Expenses and utilization assumptions are based on the historical operations of HH, as well as market trends.

#### **Capability and Feasibility**

HH will finance \$40,635,858 through the Dormitory Authority at stated terms with the remaining \$4,515,095 as equity from the hospital. A letter of interest from Citigroup has been submitted by HH. BFA Attachment B and C are the financial summaries of HH, which is part of the NSLIJ Health System, Inc., and indicate the availability of sufficient resources for this project.

The submitted incremental budget projects net losses for the first and third years of \$5,172,740 and \$1,365,000, respectively. A letter from the CFO of the NSLIJ Health System has been submitted stating that NSLIJ is able and willing to absorb the operational incremental budgeted losses. Revenues are based on prevailing payment methodologies and current payment rates. The budget appears reasonable.

As shown on BFA Attachment B, as of December 31, 2013, and BFA Attachment C, as of June 30, 2014, HH has maintained positive working capital, positive net asset position and a net operating profit of \$2,623,000 and \$203,000, respectively.

Based on the preceding, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

#### Recommendation

From a financial perspective, approval is recommended.

### **Attachments**

BFA Attachment A	Organizational Chart of the NS-LIJ Health System, Inc.
BFA Attachment B	Financial Summary for 2013, NS-LIJ Health System, Inc. and Huntington Hospital
BFA Attachment C	Financial Summary as of June 30, 2014, NS-LIJ Health System, Inc. and Huntington Hospital



# Public Health and Health Planning Council

# Project # 142168-C Westchester Medical Center

Program: Hospital County: Westchester
Purpose: Construction Acknowledged: October 23, 2014

# **Executive Summary**

#### **Description**

Westchester County Health Care Corporation (WCHCC), a public benefit corporation which operates Westchester Medical Center (WMC), a 652-bed public acute care hospital located at 100 Woods Road in Valhalla, seeks approval for the construction of a new Ambulatory Care Pavilion (ACP) on the main campus of the Medical Center. The project will also include a new addition adjacent to the main building that will be used for future inpatient rooms but will be fitted out as shell space at this time. The construction of the inpatient rooms will be the subject of a separate CON application. The new seven story addition will include Article 28 and non-Article 28 functional space. WMC is a Regional Trauma Center and also operates a separate division in Dutchess County known as MidHudson Regional Hospital, a 243-bed acute care facility.

The healthcare marketplace is requiring that all providers become more integrated, patient-centered and cost-effective. This applicant intends the project to support the ongoing healthcare transformation efforts put forth by both the State and Federal governments, including the Medicaid Redesign Team of New York State and the federal Patient Protection and Affordable Care Act. This project will help support the realignment of healthcare services in the region by supporting WMC in its efforts as the lead agency for a Performing Provider System (PPS), the Hudson Valley Coalition for Care Transformation, under the Delivery System Reform Incentive Payment (DSRIP) program of the New York State Department of Health. The DSRIP program promotes community level collaborations and focuses on system reform, with a specific goal of achieving a 25% reduction in avoidable hospital use over a period of five (5) years. Through this project, WMC seeks to invest in its capabilities and facilities in order to be successful in achieving this goal and to adapt to the changing marketplace.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

The addition of this new ambulatory care pavilion will allow Westchester Medical Center (WMC) to focus their outpatient care into one pavilion. The expansion and consolidation of services will create a more efficient environment, streamlining patient care. The result of this will be convenient and timely care. WMC will be able to continue to provide quality care more efficiently.

The new facility will add two net new MRI machines, a new X-ray machine, a new CT-scanner, ultrasound, a procedure room, an operating room, an intervention room, and a new cardiac catheterization lab.

#### **Program Summary**

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

#### **Financial Summary**

Total Project Cost is \$205,899,357. However, as a result of identified non-Article 28 space and shell space, the Total Reimbursable Cost is limited to \$119,198,762.

Project costs of \$205,899,357 will be met with \$20,651,444 in accumulated funds, \$36,012,913 in capital leases, and \$149,235,000 in tax exempt and taxable Westchester County Health Corporation Bonds at 6.0% interest over 30 years.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### Incremental Budget:

Revenues: \$27,442,465 Expenses: \$27,402,742 Gain (Loss): \$39,723

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

# **Office of Primary Care and Health Systems Management** Approval contingent upon:

- 1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
- 2. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest, acceptable by the Department. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
- 3. Submission of an executed equipment lease acceptable to the Department of Health. [BFA]
- 4. The submission of State Hospital Code (SHC) Drawings for review and approval, as described in BAEFP Drawing Submission Guidelines DSG-02 SHC Hospitals (as required) and DSG-03 Outpatient Facilities (as required). The drawings must address the following:
  - a. The occupant load of each smoke/fire compartment and the occupant load of each type of exit being claimed, that proves compliance with NFPA 7.2.4.1.2. Presently the plan shows a ratio of 7 horizontal exits to 3 exit stairs. The label system described does not indicate actual occupant loads.
  - An explanation why the three stairs are not required to be 48 inches wide to meet NFPA
     7.5.4.4 and 7.2.12.2.3 accessibility requirements. Areas of refuge must be demonstrated if
     they are being claimed.
  - c. Demonstrate a compliant egress from elevator lobby AB-121 to a compliant exit discharge.
  - d. FGI Guidelines 3.7-7.2.2.1: a six foot wide ambulance transfer exit, or path to the attached hospital, from the surgical suites and the PACU units (each floor containing these uses) shall be clearly marked on the drawings. [AER]

#### Approval conditional upon:

- 1. The project must be completed within five years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]
- 6. The applicant shall start construction on or before March 15, 2015 and complete construction by January 15, 2017 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 710.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.10(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Project Description**

Westchester Medical Center (WMC) is an existing 652-bed hospital located at 100 Woods Rd, Valhalla New York 10595. The facility is seeking approval to construct a new Ambulatory Care Pavilion on its main campus and an addition to the main building. The new Ambulatory pavilion will include two net new MRI machines, a new X-ray machine, a new CT-scanner, ultrasound, a procedure room, an operating room, an intervention room, and a new cardiac catheterization lab.

#### **Background**

Westchester Medical Center has the following certified beds and services:

Table 1: Westchester Medical Center.	
Source: HFIS, 2014	
Bed Category	Certified Capacity
AIDS	21
Bone Marrow Transplant	4
Burns Care	10
Coronary Care	8
Intensive Care	58
Maternity	15
Medical / Surgical	267
Neonatal Intensive Care	35
Neonatal Intermediate Care	14
Pediatric	69
Pediatric ICU	18
Physical Medicine and Rehabilitation	18
Prisoner	14
Psychiatric	101
Total	652

Table 2: Westshoster Medical Contar: Cartified Son	vices	
Table 2: Westchester Medical Center: Certified Services. Source: HFIS, 2014		
AIDS	Magnetic Resonance Imaging	
AIDS Center	Maternity	
Ambulatory Surgery - Multi Specialty	Medical Services - Primary Care	
Audiology O/P	Medical Social Services	
Burn Center	Medical/Surgical	
Burns Care	Neonatal Intensive Care	
CT Scanner	Neonatal Intermediate Care	
Cardiac Catheterization - Adult Diagnostic	Nuclear Medicine - Diagnostic	
Cardiac Catheterization - Electrophysiology (EP)	Nuclear Medicine - Therapeutic	
Cardiac Catheterization - Pediatric Diagnostic	Pediatric	
Cardiac Catheterization - Percutaneous Coronary Intervention (PCI)	Pediatric Intensive Care	
Cardiac Surgery - Adult	Pharmaceutical Service	
Cardiac Surgery - Pediatric	Physical Medical Rehabilitation	
Certified Mental Health Services O/P	Physical Medicine and Rehabilitation O/P	
Chemical Dependence - Rehabilitation O/P	Psychiatric	
Chemical Dependence - Withdrawal O/P	Radiology - Diagnostic	
Clinic Part Time Services	Radiology-Therapeutic	
Clinical Laboratory Service	Renal Dialysis - Acute	
Coronary Care	Respiratory Care	
Dental O/P	Therapy - Occupational O/P	

Emergency Department	Therapy - Physical O/P
Family Planning O/P	Therapy - Speech Language Pathology
Intensive Care	Transplant - Bone Marrow
Linear Accelerator	Transplant - Heart - Adult
Lithotripsy	Transplant - Kidney
	Transplant - Liver

#### State designations:

- AIDS Center:
- Regional Perinatal Center;
- Regional Trauma Center;
- Burn Center: and
- Stroke Center

#### **Analysis**

The new pavilion will house eight operating rooms and the Westchester Medical Center will decertify seven of its 25 operating rooms in its main building, resulting in the addition of one net new OR, for a total of 26 operating rooms. The case mix index at Westchester Medical Center is above two, which is higher than the average for most hospital centers. This indicates the hospital sees more difficult/specialized surgical procedures, leading to a slightly lower rate of surgical procedures per operating room than normally expected. Some examples of surgery include organ transplant, open heart surgery, trauma, bariatric, neurology and orthopedics, oncologic surgery, and specialty pediatric.

As seen in the table below, Westchester Medical Center completed 19,157 total surgeries in 2013. Based on the total surgeries and the total operating rooms, it is expected the hospital will see 737 surgeries per OR. Given the high acuity of patients and the specialty surgeries needed, this is an acceptable utilization level.

Year	All Surgeries
2011	18,301
2012	18,926
2013	19,157

The new Ambulatory Care Pavilion will also include two new MRI units, a new digital X-Ray, a new CT Scanner, three new Ultrasounds, a new procedure room, a new vascular/interventional radiology room, and a cardiac catheterization lab.

Services	2014
Surgical Procedures	9,001
MRI Scans	8,310
X Ray	43,800
CT Scans	25,201
Ultrasound Procedures	12,733

The proposal includes the addition of one net new Cardiac Catheterization Laboratory. Two labs will be certified in the new pavilion and one will be decertified on the main campus for a total of seven labs. Due to the way the labs are utilized by Westchester Medical Center - one space/lab is an EP lab and another is a Cath/EP lab - the facility considers that it is only running 4.5 labs.

	2013	2014
Emergency PCI	142	144
Adult PCI	456	420

Westchester Medical Center has seen an increase in more advanced procedures such as electrophysiology studies, device implementation, and peripheral procedures, leading to an increase in lab time needed. An additional factor affecting longer lab times is an increase in heart catheterizations and biopsies, leading to the use of one to two rooms every Monday and Wednesday for these procedures alone. Pediatric procedures, which take significantly longer than a standard procedure, also contribute to longer lab times, limiting the number of procedures that each lab can perform. Westchester Medical Center is the only provider of pediatric cardiac services in the Hudson Valley Region. These several factors help justify the addition of the new PCI lab, even though the number of procedures is on an overall decline.

• Section 405.29 (2)(iv): Minimum workload standards. There shall be sufficient utilization of a center to ensure both quality and economy of services, as determined by the Commissioner. For hospitals that are part of an Article 28 network and multi-site facilities with more than one approved PCI Capable Cardiac Catheterization Laboratory Center, and for PCI Capable Cardiac Catheterization Laboratory Centers operating under a co-operator agreement pursuant to section 709.14(d)(1)(ii)(c)(3)(viii), minimum volume standards are site specific and may not be combined for purposes of achieving minimum workload standards. Any hospital seeking to maintain approval shall present evidence that the annual minimum workload standards have been achieved by the second full year following initiation of the service and maintained thereafter. Each PCI Capable Cardiac Catheterization Laboratory Center must maintain a minimum volume of 150 percutaneous coronary intervention cases per year including at least 36 emergency percutaneous coronary intervention cases per year.

HUDSON VALLEY HSA							
			Diag	Diag		Cardiac	Total
		Cath	Cath	Caths	PCI	Surgery	Diag
Facility	PFI	Labs	W/O PCI	W/PCI	Volume	Vol.	Caths
Good Samaritan HospSuffern	779	2	893	561	637	126	1,454
Orange Regional M.C.	699	3	1,272	509	517	0	1,781
St. Francis HospPoughkeepsie	180	1	10	0	0	0	10
St. Lukes Cornwall-Newburgh	694	2	455	257	267	0	712
The Kingston Hospital	990	1	362	0	0	0	362
Vassar Brothers M.C.	181	3	862	572	648	332	1,434
Westchester M.C.	1,139	4	1,164	420	456	493	1,584
White Plains Hosp. Center	1,045	1	551	308	347	0	859
Total:		17	5,569	2,627	2,872	951	8,196

#### Conclusion

This new pavilion will permit consolidation of equipment and services and will help streamline patient care. The dedicated outpatient care unit will help address the future direction of health care, where care is focused more on patient-centered treatment in an outpatient setting.

#### Recommendation

From a need perspective, approval is recommended.

# **Program Analysis**

#### **Project Proposal**

Westchester Medical Center (WMC), an existing 895-bed hospital with two campuses, seeks approval for the construction of a new Ambulatory Care Pavilion (ACP) on the main (652 bed) campus of the Medical Center located at 100 Woods Road in Valhalla (Westchester County). The new, seven story building addition is to be constructed adjacent to the main building of the Medical Center and will include shell space to be used for future inpatient rooms (the fit-out of that shelled space will be the subject of a separate CON).

The Medical Center is experiencing growing volumes and currently lacks an appropriate dedicated outpatient venue on its campus. The proposed Ambulatory Care Pavilion will provide for a dedicated outpatient setting and will enable state-of-the-art ambulatory care services to be provided in a new, patient-friendly and operationally efficient building. It is the hope of WMC that the integrated outpatient services provided at the proposed Ambulatory Care Pavilion will lead to improved health outcomes, particularly those related to cardiac services and cancer.

It is anticipated that staffing will increase by 29.0 FTEs by the first year and by 50.0 FTE by the end of the third year in operation.

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

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, approval is recommended.

### **Financial Analysis**

#### **Total Project Cost**

Total project cost for new construction and equipment is estimated at \$205,899,357, broken down as follows:

New Construction	\$117,757,601
Site Development	4,865,267
Design Contingency	11,678,365
Construction Contingency	5,839,182
Fixed Equipment	2,168,951
Architect/Engineering Fees	7,496,800
Construction Manager Fees	309,500
Other Fees (Consultant)	3,822,176
Movable Equipment	31,730,064
Telecommunications	4,282,849
Financing Costs	2,238,525
Interim Interest Expense	13,056,081
Con Application Fee	2,000
Additional CON Processing Fee	<u>651,996</u>
Total Project Cost	\$205,899,357
Total Reimbursable Cost	\$119,198,762

Total costs are based on a twenty two month construction period with a start date of May 1, 2015, and a completion date of March 1, 2017. Total project costs are divided into three sub projects as follows:

Project	<u>Description</u>	Total Project Cost
Sub Project One	Ambulatory Care Pavilion	\$119,198,762
Sub Project Two	Shell-Inpatient Bed Tower	\$11,857,760
Sub Project Three	Physician Private Offices	\$74,842,835
Total		\$205,899,357

The Bureau of Architectural and Engineering Review has determined that this project includes non-Article 28 space costs for physician medical offices of \$74,842,835, and shell space for an inpatient bed tower of \$11,857,760 which will be submitted under a future CON. The to-be-built inpatient bed tower in the near future will be utilized to accommodate single patient rooms and will not result in a net increase of new beds. As a result, the total approved project cost for reimbursement purposes shall be limited to \$119,198,762.

The applicant's financing plan is as follows:

Accumulated Funds-WCHCC	\$20,651,444
Capital Leases:	
Movable Equipment	31,730,064
Telecommunications	4,282,849
Mortgage (30 years at 6% tax exempt and taxable bonds)	<u>149,235,000</u>
Total	\$205,899,357

WMC will utilize only tax-exempt bonds for Article 28 space. The taxable bonds will be used only for non-Article 28 space. WMC's current bond rating is an A3 rating with Moody's and a BBB rating with Standard & Poor's.

### **Operating Budget**

The applicant has submitted an incremental operating budget, in 2015 dollars, for the first and third years, summarized below:

Inpatient Revenue	<u>First Year</u> \$9,936,985	<u>Third Year</u> \$10,749,281
Expense: Operating Interest	3,770,541 7,445,922	6,296,869 6,739,586
Depreciation	<u>7,544,429</u>	<u>9,305,531</u>
Total Expense	<u>\$18,760,892</u>	<u>\$22,341,986</u>
Inpatient Excess Revenue(Loss)	\$(8,823,907)	\$(11,592,705)
Outpatient Revenue Expense: Operating Interest Depreciation	First Year \$13,312,821 \$857,431 1,693,223 3,857,335	Third Year \$16,693,184 \$1,431,924 1,532,599 2,096,233
Total Expense	\$6,407,989	\$5,060,756
Outpatient Excess Revenue(Loss)	\$6,904,832	\$11,632,428
Total Net Excess Revenue(Loss)	\$(1,919,075)	\$39,723
Inpatient Discharges Visits	1,500 4,500	1,875 6,000

Inpatient utilization by payor source for the first and third years is as follows:

Medicaid Fee-For-Service Medicaid Managed Care	6.5% 23.3%
Medicare Fee-For Service	19.8%
Medicare Managed Care	3.7%
Commercial Fee for Service	11.3%
Commercial Manage Care	32.1%
Private	1.3%
Charity Care	2.0%

Outpatient utilization by payor source for the first and third years is as follows:

Medicaid Fee-For-Service	6.4%
Medicaid Managed Care	23.3%
Medicare Fee-For Service	19.8%
Medicare Managed Care	3.7%
Commercial Fee for Service	11.3%
Commercial Manage Care	32.1%
Private	1.4%
Charity Care	2.0%

Expenses and utilization are based upon WMC's current experience in providing ambulatory care services, as well as the growth in diagnostic imaging, non-invasive cardiology, surgical, interventional radiology and cardiac catheterization programs at WMC. WMC serves a large number of individuals applying for emergency Medicaid coverage who are covered under Medicaid Fee-For-Service, and not Medicaid Managed Care, which leads to higher than expected utilization for Medicaid Fee-For-Service.

#### **Capability and Feasibility**

Total project costs will be met with WMC accumulated funds of \$20,651,444, capital equipment leases of \$36,012,913 and \$149,235,000 from tax exempt and taxable bonds issued through WCHCC. A letter of interest has been submitted by WMC for both the capital equipment leasing from Insight Financial Services and the mortgage from Wells Fargo Securities. BFA Attachments A and B are Westchester County Health Care Corporation's 2013 and WMC's current 2014 certified financial summaries, respectively, which indicates sufficient resources to fund this project.

The submitted incremental budget indicates a loss of revenues over expenses of \$1,919,075 and a net gain of \$39,723 during the first and third years, respectively. WMC will absorb the first year incremental losses through operations. Revenues reflect current outpatient reimbursement methodologies for ambulatory care services. The budget appears reasonable.

As shown on BFA Attachments A and B, the WCHCC and the hospital maintained positive working capital and experienced negative net asset positions, and incurred an excess of revenues over expenses of \$26,134,421 and \$718,000 for 2013 and September 30, 2014, respectively. WMC has historically experienced negative net assets in the past and has decreased negative net assets by approximately \$138,104,000 as of September 30, 2014 from \$200,000,000 in 2005 with positive results.

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

#### Recommendation

From a financial perspective, contingent approval is recommended.

#### **Attachments**

BFA Attachment A Financial Summary of Westchester County Health Care Corporation,2013

BFA Attachment B Financial Summary of Westchester Medical Center, 2013 - September 30, 2014 unaudited



# Public Health and Health Planning Council

# Project # 142083-C Southside Hospital

Program: Hospital County: Suffolk

Purpose: Construction Acknowledged: August 26, 2014

# **Executive Summary**

#### **Description**

Southside Hospital (SH), a 341-bed not-for-profit acute care facility located at 301 East Main St., Bay Shore in Suffolk County, requests approval to renovate and expand their Emergency Department.

SH is a member of the North Shore-Long Island Jewish Health System, Inc. (NSLIJ). Also, the Hospital is a member of the NSLIJ Obligated Group, formed to provide its members an enhanced credit position and expanded access to capital markets.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

Southside Hospital (SSH) propose to construct a replacement emergency department (ED) to address the currently undersized ED by adding an additional 14 ED treatment bays, for a total of 49, and expanding the square footage. Southside anticipates 82,783 visits by the 3<sup>rd</sup> year of operation, which equates to 1,689 visits per ED bay. The additional stations and space will help reduce patient wait time and improve throughput.

#### **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**

Project costs of \$38,088,576 are initially provided to be met with \$3,808,858 in accumulated funds and Tax Exempt DASNY Bonds of \$34,279,718 @6.5% over 30 years. The applicant intends to apply for grant funding under the DSRIP Capital Restructuring Financing Program (CRFP). In the event that CRFP funding is granted as a source of capital to finance any portion of this project, then the amount of CRFP funding will be used as an alternative source for that portion of the project budget. In the event that CRFP funds are not available, then the original project financing sources will remain in place.

Incremental Budget: Revenues: \$6,573,000

Expenses: \$10,094,300 Gain(Loss): (\$ 3,521,300)

NSLIJ Health System has provided documentation stating that NSLIJ is able and willing to absorb the operational incremental budgeted losses as management focuses on various initiatives to improve efficiencies and revenues at SH.

Subject to the noted condition, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

#### **Office of Health Systems Management**

#### **Approval contingent upon:**

- 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 BAEFP Drawing Submission Guidelines DSG-02. [AER]

#### **Approval conditional upon:**

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. This project is approved to be initially funded with North Shore-Long Island Jewish Hospital (NS-LIJ) obligated group equity, with the prospect that the project will be 90% financed as part of a future NS-LIJ obligated group tax exempt bond financing through the Dormitory Authority. The bond issue is expected to include a 6.5% interest rate and a 30 year term. The applicant intends to apply for DSRIP Capital Restructuring Financing Program (CRFP) grant funding for this project. In the event that CRFP funding is granted as a source of capital to finance any portion of this project, then the amount of CRFP funding will be used as an alternative source for that portion of the project budget. In the event that CRFP funds are not available, then the original project financing sources will remain in place. Financing is conditioned upon the Department having the opportunity to review the final financing proposal in advance to ensure that it meets approval standards. [BFA]
- 3. The submission of 100% Final Construction Documents for record, as described in BAER Drawing Submission Guidelines DSG-05, prior to the applicant's request for, and Department's granting approval for the start of construction. [AER]
- 4. The applicant shall start construction on or before March 1, 2015 and complete construction by March 30, 2016 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 710.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.10(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. The approved project does not qualify for, and the facility will not request Medicaid rated rebasing. [AER]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Background**

Southside Hospital (SSH), a 341 bed voluntary not for profit hospital located at 301 East Main Street, Bay Shore, Suffolk County, is requesting approval for the renovation of its existing Emergency Department (ED) and its expansion from 35 to 49 bays. Southside Hospital is a member of North Shore LIJ Health Care Inc. Additionally, North Shore LIJ Health Care Inc. is the co-operator of SSH.

Southside Hospital's existing ED was built in the late 1970s and has become spatially, functionally, technologically and operationally obsolete. The undersized space has resulted in operational inefficiency, inadequate storage and support space, long wait times and patient dissatisfaction. To meet current and projected patient volume, the ED is in need of comprehensive renovation and expansion.

#### **Analysis**

Southside Hospital has the following inpatient certified beds:

Table 1 Southside Hospital: Certified Beds. Source: HFIS, June 2013.	
Bed Type	Certified Capacity
Coma Recovery	5
Coronary Care	14
Intensive Care	16
Maternity	29
Medical-Surgical	194
Neonatal Intermediate Care	6
Neonatal Continuing Care	5
Pediatric	16
Physical Medicine and Rehabilitation	24
Psychiatric	20
Traumatic Brain Injury	16
Total	341

The hospital has the following New York State designation(s):

- Stroke Center
- Level 2 Perinatal Center
- Area Trauma Center
- The primary service area for the emergency department is a large portion of Suffolk County extending beyond the Southside, serving approximately 601,272 residents.
- In addition, the ED will be expanding from 35 ED bays to a total of 49 and adding its own CT and Radiology room.
- The existing ED is over 30 years old, severely undersized, and finding it increasingly difficult to efficiently handle the expanding patient volume.
- The majority of patients in the service area receive emergency department services at a hospital. Southside is currently an area trauma center and will be a certified regional trauma center. Currently, Southside services approximately 70,000 emergency department visits with a space built for far fewer. The proposed expansion will help reduce extended wait times and improve quality of care.

#### Current ED Data Utilization (Total ED Visits)

2012	2013
69,300	67,849

Current ED volume shows SSH has been treating approximately 70,000 ED patients yearly in an outdated and undersized ED space. The renovation and expansion will greatly enhance throughput and patient care quality. Southside Hospital (SSH) propose to construct a replacement emergency department (ED) to address the currently undersized ED by adding an additional 14 ED treatment bays, for a total of 49, and expanding the square footage. Southside anticipates 82,783 visits by the 3<sup>rd</sup> year of operation, which equates to 1,689 visits per ED bay. The additional stations and space will help reduce patient wait time and throughput.

#### Projected Total Visits (Total ED Visits)

		/
Current	Year 1	Year 3
69,446	81,093	82,783

#### Conclusion

The expansion of this high volume ED will allow residents to continued access to ED services but in an enhanced, more efficient environment.

#### Recommendation

From a need perspective, approval is recommended.

# **Program Analysis**

#### **Program Description**

Southside Hospital (SSH) is requesting approval for the renovation and expansion of their existing Emergency Department (ED) at 301 East Main Street, in Bay Shore (Suffolk County). Southside Hospital is a member of North Shore LIJ Health Care Inc. Additionally, North Shore LIJ Health Care Inc. is the cooperator of SSH.

Southside Hospital's existing ED was built in the late 1970s and has become spatially, functionally, technologically and operationally obsolete. The undersized space has resulted in operational inefficiency, inadequate storage and support space, long wait times and patient dissatisfaction. To meet current and projected patient volume, the ED is in need of comprehensive renovation and expansion.

This will be achieved through renovation of the First Floor of the Brackett Building (an existing building adjacent to the existing ED to the west), construction of a one-story infill addition to the hospital which will connect the Brackett Building to the existing ED, and through renovation of the existing ED.

The upgrade and renovation will include the implementation of a dual-track ED where patient volume is split between acute treatment space and the Super Track ED to achieve faster throughput. Additionally, the new ED will also include its own CT and radiography rooms and sub-waiting areas to support improved patient flow throughout the department. New staff, patient and clinical support spaces throughout the ED will be created to appropriately support the expanded clinical footprint.

Upon completion of this project, the total ED capacity will increase from 35 to 49 patient treatment positions. SSH expects that the existing ED will remain open until construction is completed in the first phase of the expansion project. Once the expansion space is occupied, the existing Emergency Department will be renovated in phases, culminating in the completion of the fully modernized and expanded Emergency Department.

It is anticipated the project will result in an additional 37.5 FTEs in the first year of operation and remain at that level through the third year.

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

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, approval is recommended.

# **Financial Analysis**

#### **Total Project Cost and Financing**

Total project cost for new construction, renovations and movable equipment, is estimated at \$38,088,576, broken down as follows:

New Construction	¢ 9 170 000
	\$ 8,170,000
Renovation & Demolition	13,330,000
Construction Contingency	2,580,000
Planning Consultant Fees	430,000
Architect/Engineering Fees	1,720,000
Construction manager Fees	1,075,000
Consultant Fees	645,000
Movable Equipment	4,642,245
Telecommunications	3,467,000
Financing Costs	1,819,001
Application Fees	2,000
Additional Processing Fees	<u>208,330</u>
Total Project Cost	\$38,088,576

The applicant's financing plan appears as follows:

Cash	\$ 3,808,858
Tax Exempt Bonds, Dormitory Authority of the	
State of New York, 6.5%, 30 years	<u>\$34,279,718</u>
Total *	\$38.088.576

<sup>\*</sup> The applicant intends to apply for CRFP grant funding for this project. In the event that DSRIP CRFP funding is granted as a source of capital to finance any portion of this project, then that amount of funding will be used as an alternative source of funds for that portion of the project budget.

#### **Operating Budget**

The applicant has submitted incremental operating budgets, in 2014 dollars, for the first and third years, which are summarized below:

Inpatient Revenue Operating Expense Excess Revenue(Loss)	First Year \$4,142,500 <u>\$783,800</u> \$3,358,700	Third Year \$1,074,600 \$202,700 \$871,900
Outpatient Revenue Expense: Operating Interest Depreciation Total Expense	First Year \$4,801,700 \$5,091,400 2,385,000 2,346,100 \$9,822,500	Third Year \$5,498,400 \$5,221,900 2,323,600 2,346,100 \$9,891,600
Excess Revenue(Loss)	(\$5,020,800)	(\$4,393,200)
Net Excess Revenue(Loss)	(\$1,662,100)	(\$3,521,300)
Utilization(Discharges) Visits	451 11,647	117 13,337

Utilization by payor source, for the first and third years, is projected as follows:

<u>Inpatient</u>	Years One and Three	
Commercial Managed Care	19.5%	
Medicare-Fee-For-Service	37.7%	
Medicare Managed Care	12.2%	
Medicaid Managed Care	23.1%	
Private Pay	7.5%	
<u>Outpatient</u>	Years One and Three	
Outpatient Commercial Managed Care	Years One and Three 26.7%	
Commercial Managed Care	26.7%	
Commercial Managed Care Medicare-Fee-For-Service	26.7% 11.5%	

Expense and utilization assumptions are based on the historical operations of SH, as well as market trends.

#### **Capability and Feasibility**

The applicant intends to apply for DSRIP CRFP grant funding. Should any grant monies be awarded as a source of capital funding for this project, then the original funding will be reduced in direct proportion. In the event that CRFP funds are not available, then the original project financing sources will remain in place as follows.

SH will finance \$34,279,718 through the Dormitory Authority at stated terms with the remaining \$3,808,858 as equity from the hospital. A letter of interest from Citigroup has been submitted by SH. BFA Attachment B is the financial summary of SH, which is part of the NSLIJ Health System, Inc., documenting resources to provide the equity necessary for this project. BFA Attachments B and C, NSLIJ Health System, Inc. cash and cash equivalents indicates the availability of sufficient resources for this project.

The submitted incremental budget projects net losses for the first and third years of \$1,662,100 and \$3,521,300, respectively. A letter from the CFO of the NSLIJ Health System has been submitted stating that NSLIJ is able and willing to absorb the operational incremental budgeted losses. NSLIJ has stated that they recognize the third year losses are expected to increase due to continued declines in inpatient admissions and expects current trends to continue during the budgeted years with outpatient treat and release and observation volume increasing and inpatient admissions decreasing. Management continues to focus on various initiatives such as revenue cycle improvement, supply chain savings and productivity and efficiency initiatives to counteract programmatic losses. Revenues are based on prevailing payment methodologies and current payment rates. The budget appears reasonable.

As shown on BFA Attachments B and C, for the year ending December 31, 2013, and the six-months ended June 30, 2014, SH has experienced negative working capital, negative net asset position, and maintained net operating income of \$5,221,000 and a net operating loss of \$1,741,000, respectively. SH's negative working capital is due to the inclusion of the full value of certain paid time off and third party liabilities that may be resolved and paid in more than a one year period. Management is continually working to improve net assets by managing operating expenses and investing in the facility's programs to enhance capacity. The June 30, 2014, net loss is due to lower than expected volume and employee overtime issues which are being corrected through the following strategic planning initiatives:

- Strategic program growth and physician recruitment to improve volume,
- Managing overtime utilization and flexing staff levels in conjunction with volume.

Based on the preceding, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

#### Recommendation

From a financial perspective, approval is recommended.

#### **Attachments**

BFA Attachment A Organizational Chart of the NS-LIJ Health System, Inc. BFA Attachment B Financial Summary for 2013, NS-LIJ Health System, Inc. and

Southside Hospital

BFA Attachment C Financial Summary as of June 30, 2014, NS-LIJ Health System,

Inc. and Southside Hospital



# Public Health and Health Planning Council

# **Project # 142185-C**

# New York Presbyterian Hospital - New York Weill Cornell Center

Program: Hospital County: New York

Purpose: Construction Acknowledged: November 4, 2014

# **Executive Summary**

#### **Description**

New York Presbyterian Hospital (NYP Hospital) is part of a 2,478-bed not-for-profit hospital system consisting of the following campuses: Columbia University Medical Center (977 beds); Weill Cornell Medical Center (850 beds); Westchester Division (270 beds); Allen Hospital (201 beds); and Lower Manhattan Hospital (180 beds). NYP Hospital requests approval to certify an existing radiation oncology private practice as a new hospital extension clinic. The site, formerly known as the Farber Center, is located at 100 Church Street, New York, New York, with the facility's entrance located at 21 West Broadway. The Center was acquired through an asset purchase agreement between Leonard A. Farber, M.D., PLLC and NYP Hospital. NYP Hospital proposes to certify the Farber Center as an extension clinic specializing in outpatient therapeutic radiation oncology services.

The Center will include one (1) linear accelerator, one (1) High Dose Rate (HDR) remote afterloader, one (1) CT simulator, exam/consultation space for initial outpatient consults, and associated support spaces. Certifying this existing radiation oncology practice will enable NYP Hospital to accomplish the following:

- Expand their existing capacity with state-ofthe-art radiation oncology technology:
- Create a more patient-centered and accessible setting for radiation therapy;
- Provide high-quality care by internationally recognized skilled professional staff; and
- Provide continuity of care for patients already treated at the Center through increased access to NYP Hospital services.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

New York Presbyterian proposes to certify a private practice as an extension clinic specializing in outpatient radiation oncology services. The center will include one (1) linear accelerator, one (1) High Dose Rate (HDR) remote afterloader, and one (1) CT simulator. Certifying this project will expand the existing capacity of certified linear accelerators for radiation oncology services and provide continuity of care for patients in the New York City area.

#### **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**

Project costs of \$5,121,630 will be met via cash equity of \$5,121,630.

Budget:

Revenues \$6,051,668 Expenses \$5,380,669 Net Income/(Loss) \$670,999 The applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

# Office of Primary Care and Health Systems Management Approval contingent upon:

- 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 applicant is required to submit design developement drawings, complying with requirements of 10NCYRR Part 710.4, for review and approval by DASNY. [DAS]

#### **Approval conditional upon:**

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]
- 6. All devices producing ionizing radiation must be licensed by the New York State Department of Health -- Bureau of Environmental Radiation Protection. [HSP]
- 7. The applicant is required to submit final construction documents, complying with requirements of 10NCYRR Part 710.7, to NYS DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) priior to start of construction. [DAS]

**Council Action Date** 

February 12, 2015

### **Need Analysis**

#### **Project Description**

The New York Presbyterian Hospital is seeking approval to certify an existing radiation oncology private practice, known as The Faber Center, as an extension clinic. The extension clinic, to be called NY-Presbyterian Radiation Oncology Outpatient Center, will be located at 21 West Broadway, New York, 10007 in New York County. This project will also include the certification of one linear accelerator.

#### **Background and Analysis**

New York Presbyterian Hospital provides services to New York City, although the primary service area will consist of lower Manhattan including the zip codes of 10002-10007, 10009, 10011-10014, 10019, 10038 and 10280.

Cancer patients in lower Manhattan have limited access to radiation therapy treatments in their community. This limited access tends to increase the waiting time patients experience for treatments. Traveling to daily treatment appointments to other locations in Manhattan and New York City either by car or public transportation can result in patients spending more than an hour in travel time to and from treatments. The proposed extension clinic will be located within Manhattan's busiest business district, which will help address the needs of patients who are able to work while undergoing radiation treatments. Many patients who work in lower Manhattan would benefit from having access to the NY Presbyterian Hospital expertise in radiation therapy close to where they work.

The need methodology set forth in 10 NYCRR Section 709.16 calculates the need for therapeutic radiology devices by health planning region. The five-county New York City health planning region has a total of 29 facilities - 22 hospitals and 7 hospital extension clinics - providing linear accelerator services as follows:

Current Resources	# Facilities With Linac. Services		# Linac. Machines			
Five County New York City Region	Hospitals	Hospital Clinics	Total	in Hospitals	in Hospital Clinics	Total
Bronx	5	1	6	23	2	25
Kings	6	1	7	11	1	12
New York	7	5	12	14	8	22
Queens	3	0	3	10	0	10
Richmond	1	0	1	5	0	5
Total New York City Region	22	7	29	63	11	74

The table below shows a need for 12 MEV devices (linear accelerators) in the five-county New York City health planning region:

Linac Need in New York City	Total
# of Cancer Cases/Year	37,840
60% will be Candidates for Radiation Therapy	22,704
50% of (2) will be Curative Patients	11,352
50% of (2) will be Palliative Patients	11,352
Course of Treatment for Curative Patients is 35 Treatments	397,322
Course of Treatment for Palliative patients is 15 Treatments	170,281
The Total Number of Treatments [(5)+(6)]	567,603
Need for MEV Machines	
(Each MEV Machine has Capacity for 6,500 Treatments)	87
Existing/Approved Resources (Upon Approval of 142185)	75
Remaining Need for MEV Machines	12

The table below shows the need methodology calculation for MEV devices (linear accelerators) in the New York County area.

Linac Need in New York County	Total
# of Cancer Cases/Year	8,180
60% will be Candidates for Radiation Therapy	4,908
50% of (2) will be Curative Patients	2,454
50% of (2) will be Palliative Patients	2,454
Course of Treatment for Curative Patients is 35 Treatments	85,894
Course of Treatment for Palliative patients is 15 Treatments	36,812
The Total Number of Treatments [(5)+(6)]	122,706
Need for MEV Machines	
(Each MEV Machine has Capacity for 6,500 Treatments)	19
Existing/Approved Resources (Upon Approval of 142185)	23
Remaining Need for MEV Machines	-4

The table below shows a need for 1 MEV devices (linear accelerators) in the primary service area of lower Manhattan.

Linac Need in Primary Service Area <sup>1</sup>	Total
# of Cancer Cases	2,523
60% will be Candidates for Radiation Therapy	1,514
50% of (2) will be Curative Patients	757
50% of (2) will be Palliative Patients	757
Course of Treatment for Curative Patients is 35 Treatments	26,495
Course of Treatment for Palliative patients is 15 Treatments	11,355
The Total Number of Treatments [(5)+(6)]	37,850
Need for MEV Machines	
(Each MEV Machine has Capacity for 6,500 Treatments)	6
Existing/Approved Resources (Upon Approval of 142185)	5
Remaining Need for MEV Machines	1

<sup>&</sup>lt;sup>1</sup> Primary Service Area includes following zip codes: 10002-10007, 10009, 10011-10014, 10019, 10038 and 10280

#### **Conclusion**

Certification of this project will help create a more patient-centered and accessible setting for radiation therapy, provide high quality care, and continuity of care for cancer patients in the lower Manhattan area and the greater New York City region.

#### Recommendation

From a need perspective, approval is recommended.

# **Program Analysis**

#### **Project Proposal**

New York Presbyterian Hospital (NYP Hospital) requests approval to certify an existing radiation oncology private practice (formerly known as The Farber Center) as an extension clinic that will become known as the New York-Presbyterian Radiation Oncology Outpatient Center.

The Center will include one (1) linear accelerator, one (1) High Dose Rate (HDR) remote afterloader, one (1) CT simulator, exam/consultation space and associated support spaces. Certifying this existing radiation oncology center will enable NYP Hospital to expand the existing capacity, create a more patient centered and accessible setting for radiation therapy, and provide continuity and high quality care by skilled professional staff for patients already treated at the Center through increased access to NYP Hospital services.

Site	Approved Services
New York-Presbyterian Radiation	Radiology – Therapeutic
Oncology Outpatient Center	
21 West Broadway	
New York, NY 10007	

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

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, approval is recommended.

# **Financial Analysis**

#### **Asset Purchase Agreement**

The applicant has submitted an executed asset purchase agreement, which is summarized as follows:

Date:	October 15, 2014
Seller:	Leonard A. Farber, M.D., PLLC, d/b/a The Farber Center for Radiation Oncology
Purchaser:	The New York and Presbyterian Hospital
Acquired Assets:	Cash; accounts receivable; all rights, title and interest in and to the assets and properties of every kind, character and description (other than property and rights specifically excluded in the agreement), owned or leased by seller and used in the operation and management of the practice, or otherwise for the benefit of the practice, whether tangible, intangible, real, personal or mixed, movable or fixed, and wherever located. Only the excluded assets listed below will not be transferred via this agreement.

Excluded Assets:	Income tax receivables; deferred tax assets; employee advances; prepaid
	professional liability insurance; contracts and leases that are not designated
	contracts; the purchase price and all rights of the seller under this agreement; any
	patient records in which the patients have objected to a transfer of the records;
	any claims, rights or interest of any seller in or to any refund, rebate, abatement
	or other recovery for taxes; all Medicare and Medicaid Provider agreements of the
	seller, and all other governmental licenses and permits not capable of being sold
	to the buyer; any claims or causes of action of the seller against its officers; all
	artwork located at the leased real property, to the extent that the artwork is not
	property of the seller as of the closing date; the proceeds of an insurance claim
	held by seller in a debtor-in-possession bank account at JP Morgan Chase bank.
Assumed	Designated contracts with a Cure Cost Cap in the amount of \$2,512,341
Liabilities:	·
Excluded	N/A
Liabilities:	
Purchase Price:	\$5,076,626
Payment:	Due at closing, apportioned as follows:
	• \$400,000 for forgiveness of indebtedness,
	• \$2,512,341 cure cost,
	• \$1,477,500 settlement payment to Community National Bank,
	• \$550,000 settlement payment to Ocean Pacific Interiors, Inc. and Pristine
	Maintenance, Inc.
	• \$136,785 payment for unsecured claims.

#### **Lease Rental Agreement**

The applicant has submitted an executed lease rental agreement for the site they will occupy, which is summarized below:

Premises:	100 Church Street, New York, New York (entrance at 21 West Broadway)
Lessor:	100 Church Fee Owner, LLC
Lessee:	The New York and Presbyterian Hospital
Term:	16 years 1 month with 1 10-year extension period
Space:	22,626 sq. ft.
Rental:	First 3 months \$299,283.21 or (\$99,761.07 monthly),
	Year 1 at \$1,233,046.80 annually or (\$102,753.90 monthly).
	Annual rent increases of 3% each year based on the previous year's rent.
Provisions:	The lessee shall be responsible for maintenance, utilities and real estate taxes.

The applicant has indicated that the lease arrangement will be an arm's length lease arrangement. The applicant has submitted 2 letters from realtors attesting to the reasonableness of the per square foot rental.

#### **Total Project Cost and Financing**

Total project costs, which include fees associated with the Asset Purchase Agreement, are estimated at \$5,121,630 broken down as follows:

Other Fees*	\$5,091,626
Application Fees	\$2,000
Additional Processing Fees	\$28,004
Total Project Cost	\$5,121,630

#### \*Other Fees are broken down as follows:

Asset Purchase Agreement:

Forgiveness of indebtedness	\$400,000
Cure cost	\$2,512,341
Settlement payment	\$1,477,500
Settlement payment	\$550,000
Payment of unsecured claims	\$136,785
DASNY Drawing Review:	<b>\$15,000</b>
Total	\$5,091,626

The applicant's financing will come from cash equity in the amount of \$5,121,630.

#### **Operating Budget**

The applicant has submitted an operating budget, in 2015 dollars, for years 1 and 3 of operations, summarized below:

Operating Revenue	<u>Year 1</u> \$5,504,927	<u>Year 3</u> \$6,051,668
Expenses: Operating Capital Total Expenses	\$3,608,667 1,497,132 \$5,105,799	\$3,883,537 <u>1,497,132</u> \$5,380,669
Net Income/(Loss)	\$399,128	\$670,999
Utilization: Treatments Cost per treatment	5,000 \$1,021.16	5,202 \$1,034.35

Utilization broken down by payor source during year 1 and 3 is as follows:

	<u>Ye</u>	ar 1	Year 3	
	<u>Treatments</u>	% Utilization	<u>Treatments</u>	% Utilization
Medicaid Fee-For-Service	1,725	34.50%	1,794	34.49%
Medicare Fee For Service	1,410	28.20%	1,467	28.20%
Commercial Managed Care	1,553	31.06%	1,616	31.06%
Private Pay	<u>312</u>	<u>6.24%</u>	<u>325</u>	<u>6.25%</u>
Total	5,000	100.0%	5,202	100.0%

Expense and utilization assumptions are based on the historical experience of the hospital.

#### **Capability and Feasibility**

Total project costs of \$5,121,630 will be met through cash equity from the overall operations of NYP Hospital.

Working capital requirements are estimated at \$896,778, which is equivalent to two months of Year 3 expenses. The full amount of the working capital requirement will be provided as equity from the overall operations of NYP Hospital.

BFA Attachment A is NYP Hospital's 2012 through 2013 certified financial statements and their internal financial summary for the period 1/1/14 through 8/31/14. The hospital generated both positive working capital and net asset positions, and had an average net income of \$352,524,000 for the period 2012 through 2013. The hospital generated both positive working capital and net asset positions, and had a net income of \$239,609,000 for the period 1/1/2014-8/30/14. BFA Attachment A shows that NYP Hospital has sufficient funds available to cover both the working capital and equity requirements for this project.

The submitted budget indicates a net income of \$399,128 and \$670,999 during Year 1 and Year 3, respectively. Revenues are based on the current reimbursement methodologies for therapeutic radiology services. The submitted budget appears reasonable.

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

#### Recommendation

From a financial perspective, approval is recommended.

#### **Attachments**

BFA Attachment A

1/1/14 through 8/31/14 internal financial summary and 2012 through 2013 certified financial statements of NYP Hospital



# Public Health and Health Planning Council

# Project # 142228-C Strong Memorial Hospital

Program: Hospital County: Monroe

Purpose: Construction Acknowledged: December 2, 2014

# **Executive Summary**

#### **Description**

Strong Memorial Hospital (SMH), an 830-bed not-forprofit hospital located at 601 Elmwood Avenue, Rochester, New York (Monroe County), requests approval to renovate the existing Neonatal Intensive Care Unit (NICU) and add eight Level IV neonatal intensive care beds to its operating certificate. Upon completion of the project, 10 newly renovated neonatal intensive care single family rooms will be added to the 44 recently constructed single family rooms previously approved under CON 072135-C, and the hospital's total licensed beds will increase to 838 beds. It is noted that SMH is a designated Regional Perinatal Center and serves the nine counties of the Finger Lakes Region. The facility is currently licensed for 60 neonatal beds as follows: 26 Level IV neonatal intensive care beds, 20 Level III neonatal intermediate care beds, and 14 Level II neonatal continuing care beds.

Statewide Planning and Research Cooperative System (SPARCS) data indicates that SMH's 26-bed Level IV NICU has been operating above capacity. From 2011 through September 30, 2014, average occupancy grew from 119% to 130% of capacity. The applicant indicated that NICU overflow is currently managed by boarding higher acuity patients in the Pediatric Intensive Care Unit (PICU) and lower acuity patients in the normal newborn nursery staffed and managed by NICU physicians and nurses. The eight new Level IV beds will help the unit meet increasing demand in a more efficient manner.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

The proposed project includes the renovation and expansion of the existing NICU and the addition of eight (8) net new Level IV neonatal intensive care beds. The

Strong Memorial Hospital NICU is the designated Regional Perinatal Center for the Finger Lakes Region and thereby is the only hospital that provides Level IV neonatal intensive care for a nine county area. The average length of stay for high-risk neonates at the facility is long with an average of 22.9 days for the 2009-2013 period, and is explained by an increase in the survival rate for infants born preterm. Current occupancy of the 26 bed Level IV NICU is 130%, and has increased by 9% since 2011. During periods of NICU overcapacity, high acuity neonatal patients are boarded in the Pediatric Intensive Care Unit, and low acuity neonatal patients are boarded in the normal newborn nursery. The dispersion of NICU patients and staff over three different units of the hospital contributes to operational inefficiency. The addition of eight new Level IV NICU beds for a total of 34 beds will help the facility more efficiently meet the increasing demand for high-risk neonatal subspecialty care in the region.

#### **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 costs of \$2,261,373 will be provided from Strong Memorial Hospital's accumulated funds.

Incremental Budget: Revenues \$461,154

Expenses <u>410,310</u> Gain/Loss \$50,844

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

#### Recommendations

#### **Health Systems Agency**

The Finger Lakes Health Systems Agency recommends approval.

#### Office of Primary Care and Health Systems Management

#### Approval contingent upon:

- 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 BAEFP Drawing Submission Guidelines DSG-02 SHC Hospitals (as required). The drawings must address the following:
  - a. Stair widths must be properly dimensioned to demonstrate compliance with accessible egress where required. Actual drawing shall scale the same as listed dimensions.
  - b. None of the submitted drawings provide a north arrow for orientation. A full drawing capable of showing the referenced elevators on the "east" side shall be provided.
  - c. The Functional Program spaces indicated "south" of corridor 33450 i.e. Nurse/Supervisor, Social worker, and staff lounge, shall be labeled and room numbers shown.
  - d. On-call rooms 33469 and 33467 shall be shown on drawing. [AER]

#### Approval conditional upon:

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The applicant shall start construction on or before September 1, 2015 and complete construction by August 30, 2016 upon the filing of Final Construction Documents in accordance with 10 NYCRR section 710.7. In accordance with 10 NYCRR Part 710.2(b)(5), if construction is not started on or before the start date, this shall constitute abandonment of the approval. In accordance with Part 710.10(a), this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]
- 3. The approved project does not qualify for, and the facility will not request Medicaid rated rebasing. [AER]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Background**

Strong Memorial Hospital, an 830-bed, voluntary, not-for-profit hospital located at 601 Elmwood Ave., Rochester, NY 14642 in Monroe County, requests approval to renovate existing space and add eight (8) Neonatal Intensive Care Unit (NICU) beds for a total of 34 NICU beds. The purpose of this project is to improve operational efficiency during census overflows.

Strong Memorial Hospital is a Regional Perinatal Center. The applicant attributes swings in census overflow to the increase in the number of preterm patients and their increased survival rates associated with longer NICU lengths of stay and out of region admissions needing subspecialty care.

As the designated Level IV Regional Perinatal Center, the Strong Memorial Hospital NICU provides services to the nine counties of the Finger Lakes Region: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates. In 2012 and 2013, over 92% of Strong Memorial Hospital's High Risk births originated in the aforementioned counties.

Strong Memorial Hospital has the following New York State designations:

- AIDS Center
- Burn Center
- Regional Perinatal Center
- Regional Trauma Center
- SAFE Center of Excellence
- Stroke Center

The combined number of Neonatal Continuing, Intensive and Intermediate Care beds is currently 60. There are 24 Neonatal Intensive Care beds which have been operating over census for the past three years. Census increase is due to an increase in the number of preterm patients as a result of assisted fertility, increasing maternal age and multiple births. NICU overflow is managed by boarding higher acuity patients in the Pediatric Intensive Care Unit and lower acuity patients in the newborn nursery under the care of NICU physicians and nurses. The addition of eight (8) beds would bring the total number of neonatal intensive care beds to 34.

Strong Memorial Hospital: Certified Beds				
·	Certified	Requested	Certified Capacity	
Bed Category	Capacity	Action	Upon Completion	
Burns Care	7		7	
Coronary Care	8		8	
Intensive Care	67		67	
Maternity	45		45	
Medical/Surgical	458		458	
Neonatal Continuing Care	14		14	
Neonatal Intensive Care	26	8	34	
Neonatal Intermediate Care	20		20	
Pediatric	60		60	
Pediatric ICU	12		12	
Physical Medicine & Rehabilitation	20		20	
Psychiatric	93		93	
Total	830	8	838	

Source: HFIS, December 2014

Through July 1, 2014, the applicant reports 801 NICU discharges with a total of 20,265 patient days. They anticipate reaching capacity of 813 discharges and 20,565 patient days by the end of the first year following project completion.

The number of high risk births at Strong Memorial Hospital increased from 539 in both 2011 and 2012 to 620 in 2013 while the number of normal births decreased from 2,300 in 2011 to 2,154 in 2013. The chart below presents data on utilization at Strong Memorial Hospital by service type. Over the last five years, the number of high-risk neonate discharges increased with a range of 817 in 2010 to 1,020 in 2013, an increase of 25%. The average length of stay for high-risk neonates is high with an average of 22.9 days for the period under review. A long average length of stay for high-risk neonates is explained by an increase in the survival rate for infants born preterm.

Strong Memorial Hospital: Inpatient Utilization by Service Category					
Service	2009	2010	2011	2012	2013
Discharges					
High-Risk Neonates	898	817	882	899	1020
Healthy Newborns	2405	2449	2430	2257	2242
Obstetric	3538	3529	3585	3376	3397
Pediatric	3770	3765	3776	3800	3700
Average Length of Stay					
High-Risk Neonates	21.6	22.7	24.3	24.5	21.5
Healthy Newborns	2.5	2.5	2.5	2.6	2.5
Obstetric	3.2	3.3	3.2	3.3	3.2
Pediatric	4.5	4.4	4.5	4.4	4.7

Source: SPARCS 2008-2013.

The chart below presents utilization data for Strong Memorial Hospital's 26 bed Level IV Neonatal Intensive Care Unit. From 2011 – 2014, NICU Level IV occupancy increased from 119% to 130%, a 9% jump, as of 9/30/14. During this period, the average NICU Level IV occupancy was 124%.

Strong Memorial Hospital: Newborn Level IV – Intensive Care Utilization of 26 Certified Beds			
Year	Patient Days	<u>Occupancy</u>	
2011	11,332	119%	
2012	11,416	120%	
2013	11,953	126%	
2014*	9,325	130%	

Source: SPARCS 2011-2014

#### Conclusion

The renovation and expansion of the NICU to add eight neonatal intensive care beds to the facility will help meet the increasing demand for subspecialty neonatal care in the region. As a designated Regional Perinatal Center, expansion of Strong Memorial Hospital's Level IV NICU will more efficiently allow the facility to provide critical care to neonates and their families throughout the Finger Lakes Region and beyond.

#### Recommendation

From a need perspective, approval is recommended.

<sup>\*</sup>Reporting dates 1/1/14 through 9/30/14

### **Program Analysis**

#### **Program Description**

Strong Memorial Hospital (SMH), an existing not-for-profit hospital, requests approval to renovate existing space within the hospital to certify an additional eight (8) Neonatal Intensive Care beds.

For the past three years, the NICU has operated over census. Most recently, in calendar year 2014 (through 11/19/14), the NICU operated over census for 161 days, or 50% of the year. The overflow has been managed by dispersing patients over three units—the NICU, the Pediatric ICU and the newborn nursery staffed with NICU physicians and nurses; but SMH believes that this is not an optimal, efficient or appropriate long-term solution.

The higher census and the need for additional beds has come from an increase in the number of preterm infants due to assisted fertility, increasing maternal age and multiple births, as well as SMH's designation as a Regional Perinatal Center that serves patients from out of the region for subspecialty needs.

First year staffing will increase by an additional 3.5 FTEs and remain at that level through the third year of operation.

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

This facility has no outstanding Article 28 surveillance or enforcement actions and, based on the most recent surveillance information, is deemed to be currently operating in substantial compliance with all applicable State and Federal codes, rules and regulations. This determination was made based on a review of the files of the Department of Health, including all pertinent records and reports regarding the facility's enforcement history and the results of routine Article 28 surveys as well as investigations of reported incidents and complaints.

#### Recommendation

From a programmatic perspective, approval is recommended.

# **Financial Analysis**

#### **Total Project Cost and Financing**

Total project costs for the renovation and acquisition of moveable equipment is estimated at \$2,261,373, which is broken down as follows:

Renovation & Demolition	\$1,234,115
Design Contingency	123,412
Construction Contingency	123,412
Architect/Engineering Fees	77,000
Construction Manager Fees	34,320
Other Fees (consultant, etc.)	20,041
Movable Equipment	379,061
Telecommunications	255,653
CON Application Fees	2,000
Additional Processing Fee	<u>12,359</u>
Total Project Cost	\$2,261,373

Total project costs are based on a September 1, 2015 start date with a 12-month construction period.

Strong Memorial Hospital will fund the \$2,261,373 total project cost from accumulated funds.

#### **Operating Budget**

The applicant has submitted their first and third year incremental operating budget for the total NICU complement of beds (intensive, intermediate, and continuing care), in 2014/2015 dollars, as summarized below:

	Current Year	Year 1 Incremental*	Year 3 Incremental*	Year 3 Cumulative*
Revenues	\$38,181,812	\$461,154	\$461,154	\$38,642,966
Expenses:	•			
Operating	\$23,863,985	\$260,085	\$271,209	\$24,135,194
Capital	<u>\$797,412</u>	<u>\$139,101</u>	<u>\$139,101</u>	<u>\$936,513</u>
Total Expenses	\$24,661,397	\$399,186	\$410,310	\$25,071,707
Net Income or (Loss)	\$13,520,415	\$61,968	\$50,844	\$13,571,259
Utilization:				
Discharges	801	12	12	813
Patient Days	20,265	300	300	20,565
Occupancy%	92.53%			82.86%
Cost per Discharge				
Operating	\$29,792.74			\$29,686.59
Capital	\$995.52			\$1,151.92
Total Cost Per Discharge	\$30,788.26			\$30,838.51
Total Cost I of Discharge	ψου, 100.20			ψου,000.01

<sup>\*</sup> Over current 2014/2015 base year.

Utilization by payor source for the first and third years is anticipated as follows:

Medicaid Fee-For-Service	21.0%
Medicaid Manage Care	32.9%
Commercial Fee-For-Service	37.6%
Commercial Manage Care	7.0%
All Other	<u>1.5%</u>
Total	100.0%

Expenses are based upon SMH's current experience in operating the neonatal care beds.

Utilization assumptions are based on SMH's historical pattern for inpatient NICU neonatal care services. The applicant has indicated that over the years pre-term birth rates have increased as a result of assisted fertility, increasing maternal age, and an increase in the number of multiple births. There has also been an increased in the survival rates of infants born pre-term, which has impacted NICU utilization. As a designated Regional Perinatal Center for the Finger Lakes Region, SMH is the only hospital providing Level IV neonatal intensive care for a nine county area. They also admit out of region high-risk births that require neonatal subspecialty care available at SMH. As a result, the applicant has experienced an occupancy rate greater than 92% for the full NICU complement of beds, with the Level IV unit averaging 124% occupancy from 2011 through September 30, 2014.

#### **Capability and Feasibility**

SMH will satisfy the \$2,261,373 total project cost from accumulated funds. BFA Attachment A is SMH's 2012-2013 certified financial summary, which indicates the availability of sufficient resources.

Working capital requirements are estimated at \$68,385 based upon two months of third year incremental cost and will be provided from operation. Review of BFA Attachment A indicates working capital requirements can be met through operations.

The incremental budgets project net incremental income for the first and third years of \$61,968 and \$50,844, respectively. Revenues are based on prevailing reimbursement methodologies while commercial payers are based on experience. The overall budget appears reasonable.

As shown on BFA Attachment A, for 2012 through 2013 SMH has maintained an average working capital position of \$365,309,559, average net asset position of \$497,492,664, and generated an average income from operation of \$109,704,876. BFA Attachment B is SMH's November 30, 2014 internal financial summary showing income from operations after clinical transfers of \$97,519,000 and net assets totaling \$626,094,220.

The applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

#### Recommendation

From a financial perspective, approval is recommended.

#### **Attachments**

BFA Attachment A	Financial Summary for 2012 and 2013, Strong Memorial Hospital
BFA Attachment B	Internal Financial Summary for November 30,2014, Strong Memorial Hospital
FLHSA Attachment	Project Review and Recommendation



# Public Health and Health Planning Council

# **Project # 132305-C**

# **Jewish Home of Rochester**

**Program:** Residential Health Care Facility

Purpose: Construction

County: Monroe

Acknowledged: December 12, 2013

# **Executive Summary**

#### **Description**

Jewish Home of Rochester, a 362-bed skilled nursing facility located in Rochester, Monroe County, is requesting approval for a renovation and construction project. The certified bed capacity of Jewish Home is proposed to decrease to 328 beds at the conclusion of the project. The applicant also has an Adult Day Health Care Program (ADHCP) with 84 registrants, which will remain unchanged.

The proposed project includes construction of a total of 168 new resident rooms in Green House homes in the following configuration:

- Four new three-story Green House homes with each floor comprised of a household with twelve private bedrooms; and
- Two single-story Green House homes with twelve private bedrooms.

These rooms will replace the semi-private beds currently being operated at the Jewish Home site.

Jewish Home of Rochester is an affiliate of Jewish Senior Life, which is the nursing homes co-operator via CON #132135. Jewish Senior Life operates a full continuum of senior residential living options on its campus including independent living, assisted living and skilled nursing, in addition to a range of community based programs to meet the needs of seniors in the community at large.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

There will be a reduction of bed capacity from 362 to 328 as a result of this application.

#### **Program Summary**

The modernization of Jewish Home of Rochester will result in a greatly improved residential environment. The addition of Green House model of care will offer residents a choice of living arrangements, and the short term rehabilitation units will be modern and spacious.

#### **Financial Summary**

Total project costs of \$89,926,882 will be met as follows: Fundraising of \$27,784,577 and a loan of \$62,142,305 at an interest rate of 7.5% for a 30 year term.

Total project cost is \$89,926,882. However, based on current allowable bed caps, plus applicable fees, the total reimbursable cost is \$77,677,882.

Budget:

Revenues \$44,573,000 Expenses 44,277,400 Excess of Revenues over Expenses \$295,600

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

#### **Recommendations**

#### **Health Systems Agency**

The HSA recommends approval for this project.

#### Office of Health Systems Management

#### Approval contingent upon:

- 1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
- 2. The submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
- 3. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - Identify community resources that serve the low-income and frail elderly population who may
    eventually use the nursing facility, and inform them about the facility's Medicaid Access policy;
  - Submit an annual report for two years to the DOH which demonstrates substantial progress with the implement of the plan. The plan should include but not be limited to:
    - Information on activities relating to a-c above;
    - Documentation pertaining to the number of referrals and the number of Medicaid admissions:
    - Other factors as determined by the applicant to be pertinent.
  - The DOH reserves the right to require continued reporting beyond the two year period. [RNR]
- 4. Submission and programmatic review and approval of the final floor plans for the construction of the Green Houses and the renovation of the existing Jewish Home building. Plans should demonstrate an equivalent residential environment, including activity space and resident amenities, between each renovated floor of the existing building, as well as the Green House units. [LTC]
- 5. Submission and programmatic review and approval of the final room layouts for all types of resident rooms, including the renovated Jewish Home building and the Green Houses. The plans should be labelled and depict the dimensions and total square footage of each resident room type. [LTC]
- 6. Submission of an expanded and updated phasing plan for the construction which explains how the existing residents will be selected for transfer into the new Green Houses, and how residents will be selected for transfer into the renovated short term rehabilitation nursing units. [LTC]
- 7. Submission of a commitment for a permanent mortgage for a maximum term of 30 years for the project to be provided from a recognized lending institution at a prevailing rate of interest that is determined to be acceptable by The Department of Health. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
- 8. Submission of documentation of contributions to be used as the source of financing, acceptable to the Department. [BFA]

- 9. Submission of design development drawings, complying with requirements of 10NCYRR Part 710.4, for review and approval by DASNY. [DAS]
- 10. Submission of State Environmental Quality Review (SEQR) findings. [SEQ]

#### **Approval conditional upon:**

- 1. The project must be completed within five years from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. Submission and approval of the patient safety and transfer plan by the Western Regional Office-Rochester. [LTC]
- 3. The applicant is required to submit final construction documents, complying with requirements of 10NCYRR Part 710.7, to NYS DOH Bureau of Architecture and Engineering Facility Planning (BAEFP) prior to start of construction. [DAS]
- 4. The anticipated construction start date is 5/15/2015 and the anticipated construction completion date is 8/25/2017. It is the applicant's responsibility to request revised construction dates, if necessary. [AER]

**Council Action Date** February 12, 2015

### **Need Analysis**

#### **Background**

Jewish Home of Rochester seeks approval for renovation and construction to modernize the facility and to decertify 34 residential health care facility (RHCF) beds. Jewish Home of Rochester is an existing 362-bed Article 28 residential health care facility located at 2021 Winton Road South, Rochester, 14618, in Monroe County. Current plans for these decertified beds will be a conversion to Assisted Living Program (ALP) beds.

#### **Analysis**

As indicated in Table 1, there is currently a surplus of 1,150 beds in Monroe County below. The overall occupancy for Monroe County is 98.1% for 2012, as indicated in Table 2.

Table 1: RHCF Need – Monroe County

2016 Projected Need	4,167
Current Beds	5,370
Beds Under Construction	-53
Total Resources	5,317
Unmet Need	-1,150

Jewish Home of Rochester's utilization in 2010-2012 was 95.6%, 93.2%, and 94.4% respectively. Current utilization for this facility is 92.8%, which falls below the Department's 97% optimum, however, the reduction of 34 beds will put this facility at 97.5%, which exceeds the Department's optimum.

Table 2: Jewish Home of Rochester/Monroe County Occupancy

Facility/County/Region	% Occupancy 2010	% Occupancy 2011	% Occupancy 2012
Jewish Home of Rochester	95.6%	93.2%	94.4%
Monroe County	92.5%	90.3%	98.1%

#### Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, or of the Health Systems Agency area Medicaid admissions percentage, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department.

An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patient's admissions is at least 75% of the planning area percentage or the Health Systems Agency percentage, whichever is applicable.

Jewish Home of Rochester's Medicaid admissions of 5.0% in 2011 and 6.6% in 2012 did not meet the Monroe County 75% rate of 13.3% occurring in 2011 and 2012. Jewish Home of Rochester will be required to follow the contingent approval requirements as noted below.

#### **Conclusion**

Approval of this application will result in a reduction of excess RHCF bed capacity in the planning area and in a higher, more efficient level of occupancy for an improved and modernized facility.

#### Recommendation

From a need perspective, contingent approval is recommended.

# **Program Analysis**

#### **Facility Information**

	Existing	Proposed
Facility Name	Jewish Home of Rochester	Same
Address	2021 Winton Road South	Same
	Rochester, NY 14618	
RHCF Capacity	362	328
ADHCP Capacity	84	Same
Type Of Operator	Voluntary	Same
Class Of Operator	Corporation	Same
Operator	Jewish Home of Rochester	Same

#### **Program Review**

Jewish Home (Jewish Home) of Rochester is an existing 362 bed nursing home which includes an adult day health care program with a program capacity of 84. Jewish Home is located on a 75 acre campus, which also includes separate independent living and assisted living apartment buildings. The project concept is to create a true multi-level campus providing a variety of residential alternatives. A separate application will request the addition of 34 assisted living program beds on the fifth floor of the existing Jewish Home building. The project will in turn completely renovate and modernize the Jewish Home building to create 100% single-bedded rooms. 110 of the newly renovated rooms will be programmed as short term rehabilitation units, and 50 rooms will remain as traditional long stay neighborhoods.

In concert with the reduction of beds in the existing building, the subject application proposes the construction of six separate Green Houses totaling 168 beds. The project will include two traditional one story Green Houses of 12 beds each, and four three-story Green Houses, each totaling 36 beds. This will be the first nursing home project to employ multi-level trademarked Green Houses in New York State. In keeping with the Green House model, the residences will be 100% single occupancy rooms surrounding the central living and dining area. The Green Houses will employ multi-purpose workers, or "shabazim", to care for the residents of the Green House.

The construction of the six Green Houses and renovation of the existing building will result in the decertification of 34 beds, which will be converted into ALP beds.

The applicant has submitted a phasing plan for the construction, which requires some fine tuning. Construction is scheduled to commence in December, 2015 on the four multi-story Green House units, with the traditional Green Houses to be underway by February, 2016. Upon completion of the initial two Green House units in November, 2016, residents of the first wing of Floors 3-6 in the existing Jewish Home building will be relocated into the two 36 bed Green House buildings. When the next two multi-story Green Houses are completed in December, 2016, residents of the second wing of floors 3-6 will occupy the new units. Renovations for the first wing of the existing Jewish Home building will commence in November, 2016 and complete in March, 2017. Renovations for the next three wings will follow, beginning in December, 2016, with the final fourth wing slated for completion in January, 2018. The completion of renovations for the first two wings of floors 3-6 will enable the decanting of the first two wings of the second floor in April, 2017. The renovation of the remaining two wings of the second floor is slated for July, 2017, with construction to complete in October, 2017. The final phase of the project will undertake the modest renovations to the first floor public areas, in May, 2017, and the renovation of the fourth wing of floors 3-6 in September, 2017. The project's estimated completion date is February, 2018. The applicant does not expect that the project will have any impact upon the overall census, or revenue during the construction period.

#### **Physical Environment**

The initial phase of the project will involve the construction of the Green Houses. The two single story houses will contain 12 single occupancy resident rooms, each with a bathroom containing European-type shower. The design includes the common elements of the Green House model, including hearth room, open dining area with meals prepared on premises, and spa room with whirlpool tub and salon services. The houses also feature a porch providing outdoor space which opens into the dining area. The design omits the garage usually included in traditional Green Houses, which may limit available storage space in the houses.

The three story Green Houses veer from the traditional model by locating houses on separate floors, with a spa room only located on the third floor. In order to comply with the Code, which requires the availability of assistive bathing on every floor, the applicant has agreed to create a separate stretcher shower on each floor. Egress from each floor is made via a single elevator adjacent to the entrance, or by a stairway located on the opposite end of the house. The elevator also doubles as the service elevator for transport of supplies and materials to the upper level houses.

Following the completion and occupancy of the Green Houses, Jewish Home will embark upon a comprehensive modernization of the existing nursing home building. The renovations will be focused upon transforming the nursing units to resident centered living space, with all bedrooms converted to single occupancy configuration. The second and third floor nursing units will be programmed as short term rehabilitation, and consist of 44 beds arrayed into sub-units of 10, 10, 11 and 13 beds respectively. The linear sub-units surround a core area which contains a 30 chair dining room with open kitchen, and a 14 chair private dining room and lounge area adjacent to the main dining room. A concierge desk is situated adjacent to the dining room, and its function will require subsequent development by the applicant. The opposite end of the core finds a den/library, with a socialization and gathering area connecting the den and the therapy room. A spa room with whirlpool tub and stretcher shower is situated on the northeast sub-unit, connected by corridor to the central core. The nursing suite is located on the northeast side, and includes a staff lounge and locker room. An additional bathing suite with stretcher shower is located on the other side of the nurse station. The floor includes a large rehabilitation area serving the residents of the floor. A bariatric sized resident room will be situated on the southeast sub-unit.

The sixth floor will be programmed as a conventional nursing unit serving mainly private pay residents, estimated as 50% private pay and 50% Medicaid. The design will offer a significant contrast to the other three floors, with the nursing unit consisting of only 28 beds divided into 7 bed sub-units. The resident rooms, or "SNF suites", will be roughly twice the size of the other bedrooms in the building, and include a living room separated from the sleeping area by the generously sized bathroom with shower. The living area includes a couch facing a large flat screen television, a lounge chair with end tables, and a kitchenette with an adjacent dining room table and chairs,. The design seems more suggestive of hotel-style occupancy than skilled nursing residency. The applicant has noted that the living room and kitchenette will be used for family and friends visitation. The floor layout also differs from floors 2 and 3, with the additional central shower area omitted, consistent with the sizing for a nursing unit with 36% fewer beds. The nursing suite will expand into this area and the concierge satellite station will be eliminated. The use for this area has not been identified. The rehabilitation area on the sixth floor is also sized in relation to the reduced bed complement, with a square footage roughly half that of the therapy rooms on the lower floors. The additional space becomes a living and socialization area, complete with fireplace. A bariatric sized SNF suite is also included on the north wing.

The fourth floor will be a hybrid nursing unit, containing 22 short term rehabilitation and 22 conventional beds. The design of the floor will be similar to the second and third floors, but the rehab gym will be of reduced size, similar to the sixth floor, with the area used for additional activity space. The programmatic relationships on this floor will require additional consideration prior to the submission of final plans. The current fifth floor will be emptied, to be re-used as an assisted living program bed unit.

#### **Compliance**

Jewish of Home of Rochester is currently in substantial compliance with all applicable codes, rules and regulations.

#### Conclusion

The modernization of Jewish Home of Rochester will result in a greatly improved residential environment. The addition of Green House model of care will offer residents a choice of living arrangements, and the short term rehabilitation units will be modern and spacious. The applicant should compare the design of the renovated sixth floor rooms to the needs of the wheelchair bound, long stay resident. Similarly the design of the renovated fourth floor should meet the needs of both the short term rehabilitation and long-stay residents. Sensitivity should be maintained to ensure that all living spaces, including the renovated nursing units in the existing building and the new Green House units, demonstrate an equivalent residential environment.

#### Recommendation

From a programmatic perspective, contingent approval is recommended.

# **Financial Analysis**

#### **Total Project Cost and Financing**

Total project cost for the new construction, renovations and acquisition of moveable equipment is estimated at \$89,926,882, broken down as follows:

New Construction	\$30,724,504
Renovation and Demolition	20,737,511
Site Development	5,577,364
Design Contingency	5,703,938
Construction Contingency	3,898,845
Planning Consultant Fees	536,702
Architect/Engineering Fees	5,094,739
Construction Manager Fees	1,415,205
Other Fees (Consultant Fees)	1,376,383
Moveable Equipment	5,967,809
Financing Costs	2,491,825
Interim Interest Expense	5,908,175
CON Fee	2,000
Additional Processing Fee	<u>491,882</u>
Total Project Cost	\$89,926,882
Total Reimbursable Cost	\$77,677,882

Project costs are based on a May 15, 2015 construction start date and a twenty-seven month construction period. The Bureau of Architectural and Engineering Facility Planning has determined that project cost exceeds the allowable construction caps per bed. As a result, the reimbursable project cost is \$77,677,882.

The applicant's financing plan is as follows:

Fundraising	\$27,784,577
Loan (7.5% interest rate for a 30 year term)	62,142,305
Total	\$89,926,882

Due to the applicant decertifying beds, the equity requirement will be reduced to 20% of reimbursable project cost.

#### **Operating Budget**

The applicant has submitted a budget for the whole facility, in 2014 dollars, for the third year after project completion. The budget is summarized below:

RHCF (328 beds)	Per Diem	<u>Total</u>
Revenues:		
Medicaid Managed Care	\$223.33	\$12,055,559
Medicare Fee-For-Service	410.62	4,773,846
Commercial Fee-For-Service	390.26	11,851,329
Commercial Managed Care	418.94	7,898,240
Ancillary Income		1,940,000
*Other Operating Income		2,229,000
Total Revenues		\$40,747,974
Expenses:		
Operating	\$286.62	\$32,783,197
Capital	80.49	9,197,998
Total Expenses	\$367.11	\$41,981,195
Excess of Revenues over Expenses		(\$1,233,221)
Utilization: (patient days) Occupancy		114,273 95.45%

<sup>\*</sup>Other operating income consists of \$450,000 in miscellaneous income such as A/P discounts, interest income, and \$1,779,000 in grant income (Jewish Home Foundation and Jewish Community Federation).

Utilization, broken down by payor source during the third year is as follows:

Medicaid Managed Care47.01%Medicare Fee-For-Service10.12%Commercial Fee-For-Service26.44%Commercial Managed Care16.43%

#### ADHCP and Other Programs\*

 Revenues\*
 \$3,825,026

 Expenses
 2,296,205

 Excess of Revenues over Expenses
 \$1,528,821

 Visits
 27,375

Utilization, broken down by payor source for the third year for the ADHCP is as follows:

Medicaid Managed Care 94.66% Private 94.66%

The total revenues and expenses for the facility during the third year is as follows:

 Revenues
 \$44,573,000

 Expenses
 44,277,400

 Excess of Revenues over Expenses
 \$295,600

<sup>\*</sup> Other Programs revenue consists of \$925,000 for physician house calls, home services, and outpatient rehabilitation. ADHCP revenue is \$2,900,026.

Expense assumptions for the Green House were based on the staffing models and expense assumptions provided by the Green House organization. Expenses for the Tower, which includes the 110 Transitional Care beds, as well as 50 Long Term beds were based on current costs trended forward, with some adjustment for additional clinical staffing given the anticipated increase in acuity. Utilization assumptions for the Green House are based on the applicant's current occupancy rates and reflect a slight increase due to the fact that the number of long term care beds in the facility will be reduced with the reduction of 34 beds, as well as the conversion of 42 beds to transitional care. Utilization for the short term rehabilitation beds is based on current occupancy trends at the nursing home as well as market estimates for the future use of post-acute beds. Expense and utilization assumptions are based on historical experience.

#### **Capability and Feasibility**

Total project cost of \$89,926,882 will be met as follows: Fundraising of \$27,784,577 and a loan of \$62,142,305 at an interest rate of 7.5% for a 30 year term. As of this date, the applicant has indicated that they have received pledges of \$14,000,000. As a contingency of approval, the applicant must submit documentation of contributions to be used as the source of equity. If adequate funds are not received from fundraising, then the remaining funds will be provided via the Jewish Senior Life Foundation, Inc. BFA Attachment B are the 2012 and 2013 certified financial statements of Jewish Senior Life Foundation, Inc., which indicates the availability of sufficient funds to offset any shortfalls of fundraising efforts.

The submitted budget indicates an excess of revenues over expenses of \$295,600 during the third year after project completion. It is anticipated that with the decrease in the number of LTC beds (decertifying 34) and the use of an additional 42 beds for transitional care, the payor mix in the overall facility will change. The applicant is anticipating with the new Green House model the Jewish Home will be able to attract more private pay residents than currently, which will favorably impact the percentage of private pay. As a result, Medicaid utilization is projected to decrease. The submitted budget appears reasonable.

A transition of nursing home (NH) residents to Medicaid managed care is currently being implemented statewide. Effective February 1, 2015, all eligible beneficiaries in NYC age 21 and over, in need of long term placement in a nursing facility, will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP). On April 1, 2015, the counties of Nassau, Suffolk, and Westchester will be phased in, and the rest of the State is scheduled to transition beginning July 1, 2015, for both dual and non-dual eligible populations. Under the managed care construct, Managed Care Organizations (MCOs) will negotiate payment rates directly with the NH providers. In order to mitigate the financial impact to NH providers during the transition to managed care, a department policy, as described in the "Transition of Nursing Home Benefit and Population into Managed Care Policy Paper," provided further guidance requiring MCOs to pay the benchmark Medicaid FFS rate, or a negotiated rate acceptable to both plans and NHs, for 3 years after a county has been deemed mandatory (phased in) for NH population enrollment. As a result, the benchmark FFS rate remains a reliable basis for assessing NH Medicaid revenues through to January 31, 2018 (NYC), March 31, 2018 (Nassau, Suffolk and Westchester), and June 30, 2018 (upstate), respectively.

BFA Attachment A is the financial summary of Jewish Home of Rochester from 2011 through 2013. As shown, the facility had an average positive working capital position and an average positive net asset position from 2011 through 2013. Also, the facility incurred average operating losses of \$1,345,253 from 2011 through 2013. The applicant indicated that the reason for the historical operating losses were the result of the following:

- The Transitional Care Unit had a change in the nursing management, which resulted in overstaffing;
- The physical and occupational therapy departments were not as efficient as they should have been resulting in higher expenses;
- There was a significant turn over in administrative areas, such as finance, human resources and other support departments, resulting in overtime and higher training costs;
- Several residents of the nursing home contracted the Noro Virus in early 2012 and admissions had to be limited, which reduced the census and negatively impacted revenues from the ADHCP.

To improve operations, the applicant implemented a cost containment project in 2012 that significantly reduced operating expenses. All aspects of expenditures were reviewed including payroll costs, supplies, expenses and contract costs. Cost efficiencies were continued in 2013 with the elimination of the dining services contract.

As shown on Attachment B, Jewish Senior Life Foundation, Inc. had an average positive working capital position and an average positive net asset position from 2012 through 2013. Also, the entity achieved an average excess of revenues over expenses of \$3,769,685 from 2012 through 2013.

BFA Attachment C is the October 31, 2014 internal financial statements of Jewish Home of Rochester. As shown, the entity had a positive working capital position and a positive net asset position for the period through October 31, 2014. Also, the entity achieved an income from operations of \$690,715 through October 31, 2014. Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner and contingent approval is recommended.

#### Recommendation

From a financial perspective, contingent approval is recommended.

#### **Attachments**

BFA Attachment A Financial Summary - Jewish Home of Rochester

BFA Attachment B Financial Summary - Jewish Senior Life Foundation, Inc.

BFA Attachment C October 31, 2014 internal financial statements, Jewish Home of Rochester

BNHLC Attachment A Quality Measures and Inspection Report



# Public Health and Health Planning Council

# Project # 141253-E South Brooklyn Endoscopy Center

Program: Diagnostic and Treatment Center County: Kings

Purpose: Establishment Acknowledged: June 13, 2014

# **Executive Summary**

#### **Description**

Digestive Disease Diagnostic and Treatment Center, LLC d/b/a South Brooklyn Endoscopy Center (the Center), a New York limited liability company, is an existing Article 28 freestanding ambulatory surgical center (FASC) located at 214 Avenue P, Brooklyn (Kings County). The Center is certified as a single-specialty FASC specializing in the field of gastroenterology and is also certified to provide Lithotripsy O/P procedures.

On November 14, 2008, the applicant received contingent Public Health and Health Planning Council (PHHPC) approval under CON #081088 for the establishment and construction of a FASC with a limited life of five (5) years from the date of issuance of an operating certificate. The applicant received its operating certificate effective December 29, 2009; hence, the Center's current limited life certification expired December 29, 2014. The applicant is requesting approval to extend its limited life for three (3) years, and also requests a partial change in the ownership of the facility. The ownership change consists of the removal of two current members, Dr. Oleg Gutnik and Mr. Jordan Fowler, and the transfer of 40% ownership interest in the Center to four new members: Dr.Rabin Rahmani, Dr. Ian Wall, Dr. Nison Badalov, and Dr. Pierre Hindy.

Membership in the Center is currently composed of 2 corporate entities, Frontier Healthcare Associates, LLC and Beth Israel Ambulatory Care Services Corp, and 10 individual members. Upon approval of this application, there will be a total of 14 members including two corporate entities. The proposed issuance of new membership interest exceeds 25% ownership change within five years, and therefore requires PHHPC approval.

Ownership of the operation before and after the requested change is as follows:

Current Owners		Proposed Owners	
Members:	%	Members:	%
Frontier	7.73	Frontier	4.13
Healthcare		Healthcare	
Beth Israel	11.46	Beth Israel	6.12
Ambulatory Care		Ambulatory Care	
Srvs Corp		Srvs Corp	
Mark Chu, M.D.	5.33	Mark Chu, M.D.	1.75
Danny Chu, M.D.	5.33	Danny Chu, M.D	1.75
Lorenzo	5.33	Lorenzo	1.75
Ottaviano, M.D.		Ottaviano, M.D.	
Zhanna Gutnik,	11.33	Zhanna Gutnik,	4.50
M.D.		M.D.	
Jay Weissbluth,	17.32	Jay Weissbluth,	10.00
M.D.		M.D.	
Alex Shapsis,	11.99	Alex Shapsis,	10.00
M.D.		M.D.	
Igor Grosman,	11.99	Igor Grosman,	10.00
M.D.		M.D.	
Paul Cohen, M.D.	11.99	Paul Cohen, M.D.	10.00
Oleg Gutnik, M.D.	.10	Dr. Rabin	10.00
		Rahmani	
Jordan Fowler	.10	Dr. Ian Wall	10.00
		Dr. Nison L.	10.00
		Badalov	
		Dr. Pierre Hindy	10.00
Total	100.00	Total	100.00

#### **DOH Recommendation**

Contingent Approval for a three year extension of the operating certificate from the date of the Public Health and Health Planning Council recommendation letter.

#### **Need Summary**

Based on CON 081088, SBEC was approved with contingencies for a three year limited life with Medicaid at five percent and charity care at two percent. The Center has satisfied its contingency that required filing annual reports with DOH. Upon approval of this project, the applicant projects to have a total of 9,935 procedures in year 1 with Medicaid at 35.5 percent and charity care at two percent. Based on the efforts taken by the applicant to improve its charity care, their application budget includes a projected charity care allowance of two percent, which they are confident that they can achieve in Year 1. There will be no changes in services.

#### **Program Summary**

Based on the information reviewed, staff found nothing that would reflect adversely upon the applicants'

character and competence or standing in the community.

#### **Financial Summary**

There are no project costs associated with this proposal. The purchase price of \$1,192,884 will be met with \$298,221 in personal equity from each of the four proposed new members.

		<u>Year One</u>	Year Three
Budget:	Revenues	\$8,304,631	\$8,597,199
	Expenses	\$6,186,839	\$6,487,409
	Gain/(Loss)	\$2.117.792	\$2.109.790

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

#### Office of Primary Care and Health Systems Management

Approval for a three year extension of the operating certificate from the date of the Public Health and Health Planning Council recommendation letter, contingent upon:

- Submission of an executed loan commitment from Dr. Hindy acceptable to the Department of Health. [BFA]
- 2. Submission of an executed loan commitment from Dr. Wall 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 the DOH beginning in the second year of operation. Said reports should include:
  - a. Data showing actual utilization including procedures;
  - b. Data showing breakdown of visits by payor source;
  - c. Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - d. Data showing number of emergency transfers to a hospital;
  - e. Data showing percentage of charity care provided, and
  - f. Number of nosocomial infections recorded during the year in question.
  - g. Corrective measures implemented for submitting data to SPARCS. [RNR]
- 4. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
- 5. Submission by the governing body of the ambulatory surgery center of a detailed plan that will be implemented to improve charity care to two (2) percent. [RNR]
- 6. Submission of a photocopy of an executed amendment to the applicant's Articles of Organization, acceptable to the department. [CSL]

#### Approval conditional upon:

- 1. The project must be completed within one year from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The applicant must submit proof from the Department of State of the filing of a certificate of amendment of its Articles of Organization that has found to be acceptable to the Department of Health. [DLA]

**Council Action Date** February 12, 2015

# **Need Analysis**

#### **Project Description**

Digestive Diseases Diagnostic and Treatment Center, LLC d/b/a South Brooklyn Endoscopy Center (SBEC), an existing single specialty (gastroenterology) Article 28 diagnostic and treatment center, requests approval to extend its limited life for three (3) additional years following a limited life of five-years from December 29, 2009 to December 29, 2014 (CON 081088). In addition, SBEC also requests approval to transfer 40 percent membership interest to four (4) new physician members and to remove two (2) existing members. The facility is located at 214 Avenue P, Brooklyn, 11204, Kings County.

#### **Analysis**

The table below provides information on the number of projected procedures and actual utilization for 2013. It shows that the applicant provided well above the projected number of procedures of 4,509. The actual utilization for Medicaid was 34.2 percent, close to the projected utilization at 35.3 percent. The applicant provided only 0.1 percent charity care, and thus did not meet its projection of two (2) percent (CON 081088).

South Brooklyn: Procedures	Projected 2013	Projected 2013	2013 Actual	2013 Actual
Medicare Total	938	20.8%	1,041	20.3%
Medicaid Total	1,592	35.3%	1,757	34.2%
Commercial	1,960	43.5%	2,334	45.5%
Private/Other	17	0.4%	0	0.0%
Charity	2	0.0%	3	0.1%
Total	4,509	100.0%	5,135	100.0%

Upon approval of this application, SBEC projects to have a total of 9,935 procedures in year 1 and 10,286 procedures in year 3 with Medicaid at 35.5 percent and charity care at 2.0 percent. The proposed addition of four (4) new physicians supports the projected increases for Years 1 and 3.

141253: South			
Brooklyn	Projections	Projections	Projections
Procedures	Year 1	Year 3	Years 1 and 3
Medicare	2,074	2,150	20.9%
Medicaid	3,522	3,650	35.5%
Commercial	4,124	4,262	41.4%
Private/Other	16	18	0.2%
Charity	199	206	2.0%
Total	9,935	10,286	100.0%

Annual Reports for 2010 to 2013 submitted by the applicant indicate that the applicant has not met its original commitment of two (2) percent charity care. During these years, charity care was less than one (1) percent. The applicants acknowledge the fact that their charity care utilization has been lower than the original projection. They relied on member referrals for charity care cases; it was difficult for them to obtain and refer a satisfactory number of cases to meet the projected rate. To ameliorate this, they have partnered with Charles B. Wang Community Health Center to obtain charity care case referrals. Additionally, SBEC is also in the process of implementing a formal, written Charitable Care Program to provide charity care to its communities. Based on these efforts, the applicants expect their charity care rate to grow to at least two (2) percent in Year 1.

The numbers for total visits shown on Annual Reports submitted by the applicant are comparable to those on the Statewide Planning and Research Cooperative System (SPARCS); however, there are discrepancies between the numbers for Medicaid and Medicare among the two sources. The applicant believes that this is due to the difference in the breakout of cases on Applicants' Annual Reports and on SPARCS. Specifically, on the SPARCS report, it appears that in certain years the Medicaid and Medicare figures represent just Fee-for-Service (FFS) visits, and that the Managed Care visits (for Medicaid and Medicare) were erroneously ascribed to the Commercial Insurance category by the applicants.

The applicants are committed to serving patients in need of care regardless of their ability to pay or the source of payment.

# **Program Analysis**

#### **Project Proposal**

Digestive Diseases Diagnostic and Treatment Center, LLC d/b/a South Brooklyn Endoscopy Center, an existing single specialty (gastroenterology) Article 28 diagnostic and treatment center in Kings County, requests permission to extend the Center's limited life for three (3) years following a five (5) year limited life (under CON 081088). There will be no changes in services however, due to the addition of four (4) new physician members to the center, staffing is expected to increase from 6.0 FTEs to 15.0 FTEs in the first year and then to 16.0 FTEs by the third year.

Additionally, South Brooklyn Endoscopy Center seeks approval to transfer 40% membership interest in the center to four (4) new physician members who will each purchase a 10% interest in the Center. In addition, two (2) existing members of the Center will withdraw from the Center as individual members. There is no construction or other capital cost associated with this proposal.

The following table details the proposed change in ownership:

	Current	Membership
Manufact Manua	Membership	Interest Proposed
Member Name	Interest	
Oleg Gutnik, MD	0.10%	
Jordan Fowler	0.10%	
Frontier Healthcare Assoc., LLC	7.73%	4.13%
Oleg Gutnik, MD (50%)		
Jordan Fowler (50%)		
Beth Israel Ambulatory Care Services, Corp	11.46%	6.12%
*Adam Henick – board member		
*Donald Scanlon – board member		
*Jeremy Boal, MD – board member		
Mark Chu, DO	5.33%	1.75%
Danny Chu, MD	5.33%	1.75%
Lorenzo Ottaviano, MD	5.33%	1.75%
Zhanna Gunik, MD	11.33%	4.50%
Jay Weissbluth, MD (Manager)	17.32%	10.0%
Alex Shapsis, MD	11.99%	10.0%
Igor Grosman, MD	11.99%	10.0%
Paul Cohen, MD	11.99%	10.0%
*Rabin Rahmani, MD		10.0%
*lan Wall, DO		10.0%
*Nison Badalov, MD		10.0%
*Pierre Hindy, MD		10.0%
*Members subject to review		

#### **Character and Competence**

The four new proposed individual members, Rabin Rahmani, MD; Ian Wall, DO; Nison Badalov, MD; and Pierre Hindy, MD, are all practicing general surgeons, who are board-eligible in gastrointestinal endoscopy

The withdrawing members are: Oleg Gutnik, MD and Jordan Fowler (who will continue as members of Frontier Healthcare Associates, LLC, which is an existing member of the Center).

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

#### Recommendation

From a programmatic perspective, approval is recommended.

# **Financial Analysis**

#### **Membership Purchase Agreement**

The applicant has submitted an executed membership purchase agreement for the change of 40% membership interest of Digestive Disease D&TC, the terms of which are summarized below:

Purpose:	Sale of 40% membership interest in Digestive Disease Diagnostic and Treatment Center, LLC d/b/a South Brooklyn Endoscopy Center
Date:	May 8, 2014
Sellers:	Frontier Healthcare Associates, LLC (3.60%), Beth Israel Ambulatory Care Services Corp (5.34%), Mark Chu, M.D. (3.58%), Danny Chu, M.D. (3.58%), Lorenzo Ottaviano, M.D. (3.58%), Zhanna Gutnik, M.D. (6.83%), Jay Weissbluth, M.D. (7.32%), Alex Shapsis, M.D. (1.99%), Igor Grosman, M.D. (1.99%), Paul Cohen, M.D. (1.99%), Oleg Gutnik, M.D. (0.10%), and Jordan Fowler (0.10%)
Purchasers:	Dr. Rabin Rahmani (10.00%), Dr.Ian Wall (10.00%), Dr. Nison L Badalov (10.00%) and Dr. Pierre Hindy (10.00%)
Purchase Price:	\$1,192,884 (\$29,882.10 per percent)
Payment:	\$12,000 dollars (\$3,000 per purchaser) good faith deposit at execution of agreement held in escrow, with the remaining \$1,180,884 due at closing (\$295,221 per purchaser)

#### **Operating Budgets**

Following is a summary of the submitted operating budget, presented in 2015 dollars, for the first and third year subsequent to change in ownership:

	Per Proc.	Year 1	Per Proc.	Year 3
Revenues:				
Medicaid Fee For Service	\$853.97	\$84,543	\$853.97	\$84,543
Medicaid Managed Care	\$853.97	\$2,923,126	\$853.97	\$3,032,434
Medicare Fee For Service	\$853.96	\$1,622,517	\$853.96	\$1,687,417
Medicare Managed Care	\$853.97	\$148,590	\$853.97	\$148,590
Commercial Fee For Service	\$853.97	\$3,521,756	\$853.97	\$3,639,604
Private Pay/Other	\$256.19	\$4,099	\$256.17	\$4,611
Total		\$8,304,631		\$8,597,199
Expenses:				
Operating		\$5,615,311		\$5,867,084
Capital		\$571,528		\$620,325
Total		\$6,186,839		\$6,487,409
Net Income/(Loss)		\$2,117,792		\$2,109,790

Utilization by payor source for the Current Year and Years 1 and 3 subsequent to the change in owner/operator is summarized below:

	2013	2013	Projected	Projected
	Projected	Actual	Year 1	Year 3
Payor Source:	<u>Utilization</u>	<u>Utilization</u>	<u>Utilization</u>	<u>Utilization</u>
Medicare Fee For Service	851	867	1,900	1,976
Medicare Managed Care	87	174	174	174
Medicaid Fee For Service	110	99	99	99
Medicaid Managed Care	1,482	1,658	3,423	3,551
Commercial	1,960	2,334	4,124	4,262
Private Pay/Other	17	0	16	18
Charity Care	<u>2</u>	<u>3</u>	<u>199</u>	<u>203</u>
Total	4,509	5,135	9,935	10,286
	2013	2013	Projected	Projected
Payor Source:	Projected %	Actual %	<u>Year 1 %</u>	Year 3 %
Medicare Fee or Service	18.87%	16.88%	19.12%	19.21%
Medicare Managed Care	1.93%	3.39%	1.75%	1.69%
Medicaid Fee For Service	2.44%	1.93%	1.00%	.96%
Medicaid Managed Care	32.87%	32.29%	34.45%	34.52%
Commercial	43.47%	45.45%	41.52%	41.44%
Private Pay/Other	.38%	0%	.16%	.18%
Charity Care	<u>.04%</u>	<u>.06%</u>	2.00%	2.00%
Total	100.00%	100.00%	100.00%	100.00%

The anticipated increase in utilization from the current year (2013) to the projected Years 1 and 3 is due to the addition of 4 new doctors to the practice.

The Department has reviewed the facility's certified 2010 through 2013 cost report submissions and determined that the facility has not met the 2% charity care commitment as provided in their establishment CON. The applicant indicated that the Center experienced 34.22% Medicaid utilization in 2013, exceeding their original Year 1 and Year 3 commitment of 5% Medicaid utilization, but acknowledges the charity care shortfall. The Center primarily relied upon member referrals for charity care cases, and the applicant indicates that while the members worked diligently to refer charity care patients to the Center, the need for additional charity care referral sources has become evident. To increase charity care volume, the facility implemented a formal Charity Care Program in 2014 to ensure that they serve the needs of the local community. After vetting alternatives, the Center entered into a partnership with Charles B. Wang Community Health Center, an organization dedicated to serving low income communities, to help refer charity care patients to the Center. The partnership began in September 2014 and they have already seen several additional referrals as a result. The Center is hopeful that this proactive relationship will allow them to increase charity care cases to at least the 2% level going forward. In addition to charity care cases, the Center will continue its emphasis on serving lower income populations.

After reviewing the corrective action information provided by the applicant, the Department recommends a three (3) year limited life extension to allow the facility additional time to achieve their 2% charity care commitment.

#### **Capability and Feasibility**

The purchase price of \$1,192,884 will be met with \$298,221 in personal equity from each proposed new member. BFA Attachment A, the net worth of two of the four proposed members, indicates that they do not have sufficient resources available to meet the required equity. The two members, Dr. Pierre Hindy and Dr. Ian Wall, have provided letters of interest from Chase bank for personal loans in the amount of \$250,000 each, at 5% interest for a 5 year term. When these loans are secured, there will be sufficient resources to fund this transaction.

The submitted budget indicates an excess of revenues over expenses of \$2,117,792 during Year 1 and \$2,109,790 during Year 3 of operations. The budget is reasonable.

BFA Attachment B is the 2012 and 2013 certified financial summary for Digestive Disease D&TC, which indicates that the facility experienced both positive average working capital and members' equity positions. The facility also generated an average net income of \$1,909,382 for the years 2012 and 2013.

BFA Attachment C is the internal financial summary for Digestive Disease D&TC for the period 1/1/2014-10/31/2014, which indicates that the facility experienced a positive working capital position and a negative members' equity position. The facility also generated a net income of \$2,419,125 for the period ended 10/31/2014. The negative members' equity position is due to a loan the Center took out in early 2014 to retire pre-existing debt and repurchase shares from existing members. The loan was for \$2.587 million, with approximately \$225,000 used to retire the debt and approximately \$2,362,000 used to repurchase shares from existing members of the Center. The repurchased shares equated to 24.9% in ownership interest. The loan has already been paid down to \$2.523 million by 10/31/2014. If the loan had not been taken out, the Center would have had a positive members' equity position for the period as shown below:

	Original 2014 Internal Balance Sheet	Revised 2014 Internal Balance
	(with loan included)	Sheet (without loan included)
Total Assets	\$1,361,816	\$1,361,816
Total Current Liabilities	\$138,488	\$138,488
Total Long Term Liabilities	\$2,253,027	\$0
Total Liabilities	\$2,391,515	\$138,488
Members' Equity	(\$1,029,699)	\$1,223,328

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### Recommendation

From a financial perspective, contingent approval is recommended.

### **Attachments**

BFA Attachment A Net Worth Statement of New Members

BFA Attachment B 2012-2013 Financial Summary, Digestive Disease Diagnostic and Treatment

Center, LLC d/b/a South Brooklyn Endoscopy Center

BFA Attachment C 1/1/2014-10/31/2014 Internal Financial Summary, Digestive Disease Diagnostic

and Treatment Center, LLC d/b/a South Brooklyn Endoscopy Center

#### RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 12th day of February, 2015 having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to transfer 40% of membership interest to four (4) new members and the withdrawal of two (2) existing members; certify an additional three (3) year limited life extension for CON 081088, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER: FACILITY/APPLICANT:

141253 E South Brooklyn Endoscopy Center

#### APPROVAL CONTINGENT UPON:

# Approval for a three year extension of the operating certificate from the date of the Public Health and Health Planning Council recommendation letter, contingent upon:

- 1. Submission of an executed loan commitment from Dr. Hindy acceptable to the Department of Health. [BFA]
- 2. Submission of an executed loan commitment from Dr. Wall 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 the DOH beginning in the second year of operation. Said reports should include:
  - a. Data showing actual utilization including procedures;
  - b. Data showing breakdown of visits by payor source;
  - c. Data showing number of patients who need follow-up care in a hospital within seven days after ambulatory surgery;
  - d. Data showing number of emergency transfers to a hospital;
  - e. Data showing percentage of charity care provided, and
  - f. Number of nosocomial infections recorded during the year in question.
  - g. Corrective measures implemented for submitting data to SPARCS. [RNR]
- 4. Submission of a statement, acceptable to the Department, that the applicant will consider creating or entering into an integrated system of care that will reduce the fragmentation of the delivery system, provide coordinated care for patients, and reduce inappropriate utilization of services. The applicant will agree to submit a report to the Department beginning in the second year of operation and each year thereafter detailing these efforts and the results. [RNR]
- 5. Submission by the governing body of the ambulatory surgery center of a detailed plan that will be implemented to improve charity care to two (2) percent. [RNR]
- 6. Submission of a photocopy of an executed amendment to the applicant's Articles of Organization, acceptable to the department. [CSL]

#### APPROVAL CONDITIONAL UPON:

- 1. The project must be completed within one year from the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The applicant must submit proof from the Department of State of the filing of a certificate of amendment of its Articles of Organization that has found to be acceptable to the Department of Health. [DLA]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.



# Public Health and Health Planning Council

# Project # 142152-E Odyssey Community Services, Inc.

**Program:** Diagnostic & Treatment Center

Purpose: Establishment

County: New York

Acknowledged: October 15, 2014

# **Executive Summary**

#### **Description**

Odyssey Community Services, Inc. a to-be-formed New York State not-for-profit corporation, seeks approval to be established as the operator of an Article 28 diagnostic and treatment center (D&TC) facility, which is currently operated as an extension clinic of Odyssey House of New York, Inc. (Odyssey House). The D&TC is located at 219 East 121st Street, New York, 10035 (New York County). Odyssey House seeks to establish the extension clinic site as a separate Article 28 D&TC entity so it can obtain designation as a Federally Qualified Health Center (FQHC) Look-Alike clinic. Odyssey House will submit a closure plan to the Department for its extension clinic upon Public Health and Health Planning Council approval of this application. There is no construction proposed for this project.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

Proposed services are Medical Services-Primary Care, Medical Services-Other, and Dental O/P. The proposed project will continue providing medical services to patients referred from Odyssey House, in addition to serving the communities of the service area. The number of projected visits is 14,476 in year 1, with Medicaid at 87.14 percent, and charity care at 11.85 percent.

#### **Program Summary**

The Department's recommendation for approval has been made after consideration of the statutory factors found in the New York State Correction Law (Sections 752 and 753).

#### **Financial Summary**

There are no project costs associated with this application. There is no asset purchase agreement associated with this application.

Establishment as a separate Article 28 D&TC is required before the facility can apply for FQHC designation. Therefore, the facility submitted their budget based on current D&TC reimbursement rates as follows:

Current Rates: (Year 1)	Revenues Expenses Gain	\$1,519,980 <u>1,512,227</u> \$7,753
Current Rates: (Year 3)	Revenues Expenses Gain	\$1,612,547 

The FQHC sensitized budget for year 1 and year 3 based on projected FQHC payment rates is as follows:

FQHC Budget: (Year 1)	Revenues Expenses Gain	\$2,570,018 <u>2,518,057</u> \$51,961
FQHC Budget: (Year 3)	Revenues Expenses Gain	\$2,726,436 2,638,638 \$87,798

DOH staff has reviewed the DTC budgets under both rate structures and has determined that the applicant can meet costs and maintain at least a break even operating margin under both scenarios. Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and contingent approval is recommended.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

# **Office of Primary Care and Health Systems Management** Approval contingent upon:

- 1. Submission of an executed building lease, acceptable to the Department of Health. [BFA]
- 2. Submission of an executed working capital loan commitment, acceptable to the Department of Health. [BFA]
- 3. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
- 4. Submission of a photocopy of the applicant's executed Bylaws, acceptable to the Department. [CSL]
- 5. Submission of a photocopy of an executed Certificate of Incorporation of Odyssey Community Services Inc., acceptable to the Department. [CSL]

#### **Approval conditional upon:**

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]

**Council Action Date** February 12, 2015

## **Need Analysis**

#### **Project Description**

Odyssey Community Services, Inc., a to-be-formed NYS not-for-profit corporation, seeks approval to establish Odyssey Community Services, Inc as the operator of a diagnostic and treatment facility located at 219 East 121st Street, 10035, New York County. This facility, on 121st Street, is currently being operated as an Article 28 diagnostic and treatment center (D&TC) extension clinic of Odyssey House of NY, Inc. (OHNY).

#### **Background**

Odyssey House of New York, Inc. is a Voluntary Not-for-Profit Corporation; it has a main facility, and three extension clinics, all in New York County. Additionally, OHNY also has an extension clinic in Bronx County. All these facilities are located as follows:

- a) Main Facility: Odyssey House of New York, Inc.: 666 Broadway Tenth Floor, NY, 10012 (NY County)
- b) Extension Clinic: OH East 121st Street: 219 East 121 Street, NY, 10035 (NY County)
- c) Extension Clinic: OH East 6th Street Clinic: 309-11 East 6th Street, NY, 10003 (NY County)
- d) Extension Clinic: OH Mabon Clinic: Mabon Bldg. #13 (600 East 125th St.), Ward's Island, 10035 (NY County)
- e) Extension Clinic-Bronx: 953 Southern Blvd.-Suite 301, Bronx, 10459 (Bronx County)

The five facilities provide a range of medical services as described below:

	Odyssey	Odyssey	Odyssey	Odyssey	Odyssey
Licensed Services Available	House of	House East	House East	House	House
Currently	New York	121st St.	6th St.	Mabon Clinic	Bronx
Dental O/P	Yes	Yes	Yes	Yes	No
Medical Services- Primary Care	Yes	Yes	Yes	Yes	No
Cert. Mental Health Services O/P	Yes	No	Yes	Yes	No
Chemical Dependence-Rehab O/P	Yes	No	Yes	Yes	Yes
Clinic P/T Services	Yes	No	No	No	No

Source: HFIS

The table below provides information on time and distance from the proposed project on 121st Street in New York to the OHNY main facility and also to each extension clinic including the one in Bronx.

Driving Time and Distance from the CON 142152 Project Site	Minutes	
(219 East 121 St to Other Facilities)	By Car/By Public Transit	Miles
To: OHNY, Inc. Main Facility, 666 Broadway NY, 10012	22 min. / 34 min.	7.7 mi.
To: Extension Clinic at 309-11 East 6th Street, NY, 10003	21 min. / 38 min.	7.2 mi.
To: Extension Clinic at 600 East 125th St., Ward's Island, 10035	7 min. / 15 min.	1.9 mi.
To: Extension Clinic at 953 Southern Blvd., Bronx, 10459	12 min. / 21 min.	3.9 mi.

#### **Analysis**

The primary service area is East Harlem including zip codes 10029 and 10035. The proposed site and the surrounding extension clinics operated by Odyssey House will continue providing medical services to patients referred from Odyssey House, a social services agency, in addition to serving the communities of the primary service area.

Proposed services are as follows:

Certify:
Medical Services-Primary Care
Medical Services-Other
Dental O/P

The number of projected visits is 14,476 in Year 1 and 15,343 in Year 3. Sixty-six percent of the total visits will be primary care service visits and the remaining 34 percent will be dental care service visits. These projections are based on the current experience of OHNY, Inc.

The proposed location is in a Health Professional Shortage Area (HPSA) and also in a Medically Underserved Area/Population (MUA/P) as follows:

HPSA for Primary Care Services: Medicaid Eligible-East Harlem HPSA for Dental Care Services: Medicaid Eligible-East Harlem MUA/P: Medicaid Eligible- East Harlem Service Area

The applicant is committed to serving all persons in need of care regardless of their ability to pay or the source of payment.

The applicant reports that the existing extension clinic of the OHNY, Inc. will remain open until this CON application 142152 is approved and that the proposed D&TC is established as the new Article 28 extension clinic of Odyssey Community Services, Inc.

#### Conclusion

The location of the proposed new center is currently operated as an extension clinic of Odyssey House of New York, and is an existing Article 28 provider. This change of sponsorship will enable the applicant to continue to meet the needs of a vulnerable population with complex health care needs, as well as provide an existing resource for residents of the primary service area

#### Recommendation

From a need perspective, contingent approval is recommended.

### **Program Analysis**

#### **Program Description**

Odyssey Community Services, Inc., a to-be-formed, New York State not-for-profit corporation, seeks approval to establish an existing diagnostic and treatment center (D&TC) extension clinic operated by Odyssey House of New York, Inc. as a separate Article 28 entity so it may more easily seek designation as a Federally Qualified Health Center (FQHC).

Odyssey House is a comprehensive social services agency that provides housing services and substance abuse and mental health treatment. Odyssey House's existing Article 28 D&TC, located at 219 East 121st Street in New York (New York County), provides comprehensive primary medical care services to clients of the larger social services agency. Under the new proposed operator, the clinic will be able to continue to provide medical services to patients referred from Odyssey House. Services will also be available to residents of the primary service area.

Proposed Operator	Odyssey Community Services, Inc	
Site Address	219 East 121st Street, New York, NY (NY County)	
Specialties	Medical Services - Primary Care	
	Medical Services – Other Medical Specialties	
	Dental O/P	
Hours of Operation	Monday & Tuesday from 9:45 am - 5:30 pm	
	Wednesday through Friday 9:45 am - 9:00 pm	
Staffing (1st Year / 3rd Year)	14.24 FTEs / 15.09 FTEs	
Medical Director(s)	David L. Foster, MD	
Emergency, In-Patient and Backup	Is expected to be provided by	
Support Services Agreement and	Metropolitan Hospital Center	
Distance	1.7 miles and 7 minutes	
On-call service	After-hours On-Call Service available 24/7/365	

#### **Character and Competence**

The members of the Odyssey Community Services, Inc. are:

#### Name

Sunita Manjrekar Monica Thomas Maria White Cynthia Smith Alexandra Arizaga Jeffrey Savoy Dwain Carryl Malcolm Stone Cecelia Scott-Croff

Ms. Manirekar holds dual Master's degrees in Education and Sociology. She is the Deputy Commissioner of Employment, Vocational and Community Services for the Nassau County Department of Social Services. Ms. Thomas holds a Master's of Social Work degree and is currently pursuing a Master's in Public Administration. She is a Licensed Social Worker (LSW) and a Certified Alcohol and Substance Abuse Counselor employed by Volunteers of America, a non-profit social services organization. In that capacity, she oversees all single adult homeless shelters for the organization, to include \$19M budget, 9 programs and 240 employees. Ms. White holds a business certificate and was employed as the Assistant Manager of a retail establishment until her retirement in June 2008. She is a patient of the center. Ms. Smith worked as a housekeeper for a national hotel chain until her retirement in February 2010. She is also a patient of the center. Ms. Arizaga, who holds a Bachelors of Business Administration, has been employed by the Odyssey House for over 20 years and currently serves as its Assistant Controller. Mr. Savoy holds a Master of Social Work degree and is a Licensed Clinical Social Worker (LCSW). He has been employed by the Odyssey House since July 2001, currently serving as its Administrator. Mr. Carryl holds an MBA from the Yale School of Management and works as a Sr. Vice President/Portfolio Manager for the U.S. Trust. Mr. Stone earned a Master's Degree in Marriage and Family Therapy and works as a Career Advisor for a non-profit organization. Ms. Scott-Croft, who holds dual Masters of Science in Education degrees (Early Childhood and Administration & Supervision) and numerous NY State teaching certifications, is the Executive Director of the Early Childhood Center for the City University of New York.

In addition to members of the Board, information was also submitted and reviewed for the Center's Medical Director, David Foster, MD. Dr. Foster has operated a private practice for the past 14 years and, since June 2010, he has served as Odyssey House's Medical Director.

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.

Ms. Smith disclosed that she was convicted of a Class C Felony in 1975 and twelve (12) Class E Felonies between 1977 and 2004. On April 5, 2004, she was convicted of possession of a controlled substance that resulted in referral for Substance Use Disorder treatment, which she completed in July 2005.

Ms. White disclosed that she was convicted of a Class A Felony (Possession of controlled substance) in August 1990 and served 10 years in the federal prison system.

In evaluating this application, the Department needed to consider the statutory factors found in the New York State Correction Law Sections 752 and 753.

Section 752 prohibits unfair discrimination against persons previously convicted of one or more criminal offenses. Specifically, "No application for any license or employment...shall be denied or acted upon adversely by reason of the individual's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless: (1) there is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or (2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public."

Section 753 sets forth factors that are required to be considered in making a determination to deny licensure based on the conviction. Specifically, "(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses; (b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person; (c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities; (d) The time which has elapsed since the occurrence of the criminal offense or offenses; (e) The age of the person at the time of occurrence of the criminal offense or offenses or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct; (h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

#### Recommendation

From a programmatic perspective, contingent approval is recommended.

# **Financial Analysis**

#### **Lease Rental Agreement**

The applicant has submitted a draft lease rental agreement for the site they will occupy, which is summarized below:

Premises: 2,200 square feet located at 219 East 121st St., NY, NY 10035

Lessor: Odyssey House, Inc.

Lessee: Odyssey Community Services, Inc.

Term: 10 years

Rental: \$77,000 annually (\$35.00 per sq. ft.)

Rental of existing equipment is included in the base rent.

Provisions: Utilities and maintenance services are included in the base rent.

The applicant has provided two letters indicating the rent reasonableness. The applicant has submitted an affidavit that indicates that the lease agreement will be a non-arms-length lease agreement.

#### **Operating Budget**

The applicant has submitted an operating budget, in 2015 dollars, for the first and third years based on current DTC reimbursement rates, which is summarized below:

Revenues	<u>Year One</u> \$1,519,980	<u>Year Three</u> \$1,612,547
Expenses: Operating Capital Total Expenses	\$1,431,246 <u>80,981</u> \$1,512,227	\$1,515,593 <u>78,367</u> \$1,593,960
Excess of Revenues over Expenses	\$7,753	\$18,587
Utilization: (Visits) Cost Per Visit	14,476 \$104.46	15,343 \$103.89

Expense and utilization assumptions are based on the actual experience of Odyssey House of New York, Inc., which is the current operator of the extension clinic site. It is noted that the Odyssey House provides chemical dependency rehabilitation services and presently close to 100% of their patients are Medicaid eligible.

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

	<u>Year One</u>	<u>Year Three</u>
Medicaid Managed Care	99.00%	99.00%
Commercial Fee For Service	1.00%	1.00%
Total	100.00%	100.00%

#### **Sensitized Budget**

The applicant has provided a sensitized budget for the first and third years of operation, in 2015 dollars, based on FQHC reimbursement rates, as summarized below:

Year One	Year Three
\$2,570,018	\$2,726,436
\$2,437,076	\$2,560,271
<u>80,981</u>	<u>78,367</u>
\$2,518,057	\$2,638,638
\$51,961	\$87,798
14,476	15,343
\$173.95	\$171.98
	\$2,570,018 \$2,437,076 80,981 \$2,518,057 \$51,961 14,476

Utilization by payor source for the first and third years is as follows for the sensitized FQHC budgets:

	Year One	Year Three
Commercial Fee For Service	1.01%	1.00%
Medicaid Managed Care	87.07%	87.07%
Charity Care	11.92%	11.93%

Budget differences resulting from the use of sensitized FQHC rate assumptions are due to the following:

- The HRSA Section 330 Grant revenues have been included for FQHC status.
- Outreach and case management administrative staff expenses have been included for FQHC status.

#### **Capability and Feasibility**

There are no total project costs and no asset purchase agreement associated with this application.

Working capital requirements are estimated at \$265,660, which is equivalent to two months of third year expenses. The applicant will finance \$132,830 via a bank loan from Odyssey Foundation of New York, Inc. at an interest rate of 3% for a three year term. The remaining \$132,830 will be provided in the form of equity to be provided by Odyssey Foundation of New York, Inc. BFA Attachment A is the June 30, 2013 certified financial statements and the June 30, 2014 internal financial statements of Odyssey Foundation of New York, Inc., which indicates the availability of sufficient funds for the equity contribution to meet the working capital requirement. BFA Attachment B is the pro forma balance sheet of Odyssey Community Services, Inc. as of the first day of operation, which indicates a positive net asset position of \$132,830.

The submitted budget using current DTC reimbursement rates indicates an excess of revenues over expenses of \$7,753 and \$18,587 during the first and third years, respectively. Revenues are based on current reimbursement rates of the current facility, which are based on the Ambulatory Patient Group (APG) payment rate methodology.

The submitted sensitized FQHC status based budgets indicates an excess of revenues over expenses of \$51,961 and \$87,798 in Year 1 and Year 3. FQHC revenues are based on the current cost based reimbursement methodology applicable for FQHC designated facilities. The sensitized budget appears reasonable.

As shown on BFA Attachment A, Odyssey Foundation of New York, Inc. had an average positive working capital position and an average positive net asset position from July 1, 2012 through June 30, 2014. Also, the Foundation achieved an average increase in unrestricted net asset of \$44,068 from July 1, 2012 through June 30, 2014.

Subject to the noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### Recommendation

From a financial perspective, contingent approval is recommended.

#### **Attachments**

BFA Attachment A BFA Attachment B Financial Summary- Odyssey Foundation of New York, Inc.

Pro Forma Balance Sheet

#### RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 12th day of February, 2015 having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish Odyssey Community Services, Inc. as the operator of a diagnostic and treatment facility located at 219 East 121st Street, which is currently operated as an extension clinic of Odyssey House, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER: FACILITY/APPLICANT:

142152 E Odyssey Community Services, Inc.

#### APPROVAL CONTINGENT UPON:

- 1. Submission of an executed building lease, acceptable to the Department of Health. [BFA]
- 2. Submission of an executed working capital loan commitment, acceptable to the Department of Health. [BFA]
- 3. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
- 4. Submission of a photocopy of the applicant's executed Bylaws, acceptable to the Department. [CSL]
- 5. Submission of a photocopy of an executed Certificate of Incorporation of Odyssey Community Services Inc., acceptable to the Department. [CSL]

#### APPROVAL CONDITIONAL UPON:

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.



# Public Health and Health Planning Council

# Project # 142195-B Delhi Rehabilitation & Nursing Center

Program: Residential Health Care Facility County: Delaware

Purpose: Establishment and Construction Acknowledged: November 10, 2014

# **Executive Summary**

#### **Description**

DRNC Operating, LLC d/b/a Delhi Rehabilitation & Nursing Center, a New York State limited liability company, seeks approval to be established as the operator of a to-be-constructed 176-bed residential health care facility (RHCF) at the former site of the Countryside Care Center, a 160-bed RHCF which closed in October 2012. The new facility will be located on a 58.73 acre parcel at 41861 State Route 10, Delhi (Delaware County).

On May 2, 2014, Personal Healthcare, LLC entered into an Agreement of Sale with Leatherstocking Realty for the acquisition of the property at 41861 State Route 10, Delhi. The members of Personal Healthcare, LLC will assign its acquisition of the land to DRNC Realty, LLC for \$10 and other valuable consideration received in hand. DRNC Operating, LLC, as tenant, will enter into a proposed construction and lease agreement with DRNC Realty, LLC, as landlord, for site control of the facility. DRNC Realty, LLC will construct the 176-bed RHCF in accordance with plans approved by the tenant and will lease the facility to the tenant.

DRNC Realty, LLC will fund the cost of the property purchase, the demolition of existing buildings and the construction of a new, 176-bed RHCF at a total cost of \$30,846,346. The proposed financing plan is as follows: a loan from M&T Bank in the amount of \$23,134,760, with the remaining \$7,711,586 to be paid from the individual members' personal equity.

There is a non-arm's length arrangement between the entity purchasing the real property, Personal Healthcare, LLC, the entity performing the construction and building on the real property, DRNC Realty, LLC, and the proposed operating entity, DRNC Operating,

LLC. There is common ownership among the above mentioned entities as follows:

	Personal	DRNC	DRNC
	Healthcare,	Realty,	Operating,
	LLC	LLC	LLC
	%	%	%
Members:	Ownership	Ownership	Ownership
Ephraim	50.0%	48.0%	48.0%
Zagelbaum			
Alexander	25.0%	23.0%	23.0%
Barth			
Yehudah	25.0%	23.0%	23.0%
J. Walden			
Pincus		2.0%	2.0%
Zagelbaum			
Yechiel		2.0%	2.0%
Zagelbaum			
Yoel		2.0%	2.0%
Zagelbaum			

All of the members of DRNC Operating, LLC have ownership interest in Highland Rehabilitation and Nursing Center, a 98-bed RHCF located in Middletown, which was given final approval under CON #121103 effective February 1, 2013.

Members Ephraim Zagelbaum, Alexander Barth, Pincus Zagelbaum, Yachiel Zagelbaum, and Yoel Zagelbaum have ownership interest in the following 3 RHCFs:

- Tarrytown Hall Care Center, a 120-bed RHCF located in Tarrytown;
- Alpine Rehabilitation and Nursing Center, an 80bed RHCF located in Little Falls; and

 Norwich Rehabilitation and Nursing Center, an 80-bed RHCF located in Norwich.

Members Ephraim Zagelbaum, Alexander Barth, Yehuda Walden, Yachiel Zagelbaum, and Yoel Zagelbaum also have ownership interest in Utica Rehabilitation & Nursing Center, a 120-bed RHCF located in Utica, which was given final approval under CON #132357 effective November 6, 2014.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

Countryside Care Center's utilization was 95.4% in 2009, 93.7% in 2010, and 82.6% in 2011. The county's overall utilization for 2012 and 2013 was 96.7% and 98.5%, respectively. This proposed application will provide a much needed resource in the community.

#### **Program Summary**

No negative information has been received concerning the character and competence of the proposed applicants identified as new members. The proposed design will create a modern resident-centered facility that will help meet the need for long term care beds in the area.

#### **Financial Summary**

The total project cost of \$30,846,346 will be met with members' equity of \$7,711,586 and a bank loan of \$23,134,760 at 5.5% with a 10 year term and 25 year amortization. Each member of DRNC Operating, LLC has submitted an affidavit stating that they will personally contribute resources to fund the balloon payment should acceptable financing not be available at the time the loan comes due after the 10 year term.

Budget: Revenues: \$16,166,695

Expenses: <u>14,547,030</u> Gain: \$ 1,619,665

Subject to noted contingencies, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## **Recommendations**

## **Health Systems Agency**

There will be no HSA recommendation for this project.

# **Office of Primary Care and Health Systems Management** Approval contingent upon:

- Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
- 2. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
- 3. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily be limited to, ways in which the facility will:
  - Reach out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b. Communicate with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility; 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]
- 4. Submission of a commitment, signed by the applicant, to submit annual reports to the DOH, for at least two years, demonstrating substantial progress with the implementation of the plan. These reports should include, but not be limited to:
  - a. Describing how the applicant reached out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b. Indicating that the applicant communicated with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c. Identifying the community resources that serve the low-income and frail elderly population that have used, or may eventually use, the nursing facility, and confirming they were informed about the facility's Medicaid Access policy.
  - Documentation pertaining to the number of referrals and the number of Medicaid admissions;
     and
  - e. Other factors as determined by the applicant to be pertinent. [RNR]

The DOH reserves the right to require continued reporting beyond the two year period.

- 5. Submission and programmatic review and approval of the final floor plans. [LTC]
- 6. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest, acceptable to the Department of Health. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
- 7. Submission of an executed building lease acceptable to the Department of Health. [BFA]
- 8. Submission of an executed working capital loan commitment acceptable to the Department of Health. [BFA]

- 9. Submission of an executed assignment of agreement of sale acceptable to the Department of Health. [BFA]
- 10. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-05, prior to the applicant's request for, and Department's granting approval for the start of construction. [AER]
- 11. Submission of an amended Articles of Organization of DNRC Operating, LLC, acceptable to the Department. [CSL]
- 12. Submission of an amended Operating Agreement of DNRC Operating, LLC, acceptable to the Department. [CSL]
- 13. Submission of an amended Agreement of Lease between DNRC Realty, LLC and DNRC Operating, LLC, acceptable to the Department. [CSL]

## **Approval conditional upon:**

- 1. The project must be completed within five years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The applicant shall complete construction by February 1, 2017. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

**Council Action Date** February 12, 2015

## **Need Analysis**

## **Project Description**

DRNC Operating, LLC dba Delhi Rehabilitation & Nursing Center seeks approval to become the established operator of a new 176-bed residential health care facility (RHCF) at the site of the former Countryside Care Center, located at 41861 State Route 10, Delhi, 13753, in Delaware County, which closed in 2012.

## **Analysis**

There is currently a need for 309 beds in Delaware County as indicated in Table 1 below. The overall occupancy for Delaware County is 96.7% for 2012 and 98.5% for 2013, as indicated in Table 2.

Table 1: RHCF Need - Delaware County

2016 Projected Need	511
Current Beds	202
Beds Under Construction	0
Total Resources	202
Unmet Need	309

**Table 2: Countryside Care Center/Delaware County** 

Facility/County	% Occupancy 2009	% Occupancy 2010	% Occupancy 2011	% Occupancy 2012	% Occupancy 2013
Countryside Care Ctr	95.4%	93.7%	82.6%	(Closed)	(Closed)
Delaware County	94.0%	92.7%	88.9%	96.7%	98.5%

Countryside Care Center's utilization was 95.4% in 2009, 93.7% in 2010, and 82.6% in 2011. As of December 22, 2014, county occupancy was 94.6%, with 11 vacant beds. Although the county's utilization currently falls below 97%, there is a documented need for additional beds in this county. There are only two RHCFs remaining in Delaware County and none in the neighboring county of Schoharie. Residents of Schoharie County are utilizing the resources within Delaware County. Patients requiring nursing home care end up going to facilities outside of Delaware County, and many times out of state, thereby causing an undue burden for both patient and family. The addition of a replacement facility will not only serve the elderly, but will contribute to the overall well-being of all residents within both Delaware and Schoharie Counties.

Proposed changes to the county if this application is approved:

Facility Name	Current Beds	Proposed Beds	<b>Upon Completion</b>
Countryside Care Center	0	0	0
Delhi Rehabilitation Center	0	+176	176
Mountainside Residential Care Center	82	0	82
Robinson Terrace	120	0	120
Total Beds	202	+176	378
Unmet Need	309	(176)	133

This application will result in new beds and services.

Since the closure of Countryside Care Center, two nursing homes remain in the county, with a combined total of 11 beds currently available. With such limited beds available for new patients, wait lists have been established and, according to one hospital provider, patients needing nursing home care are put in facilities that may be far from home (over 180 miles away), as well as placed out of state. This places an extreme hardship on the patient's families, especially in the winter months when the roads can become too dangerous to traverse.

Letters and a memorandum of support were filed with this application noting a strong desire for additional nursing home beds within this county. Delaware Valley Hospital, the Critical Access Hospital in the county, said that of all the hospital discharges needing nursing home care, 80% would have chosen Countryside Care Center as their first choice had it remained open. This proposed project will be able to keep county residents closer to their communities and families.

The closure of Countryside Care Center had a negative impact on the county as the facility was one of its largest employers. The facility also provided placement for nursing students from SUNY Delhi's School of Nursing Program. The proposed new facility is prepared to discuss the reinstatement of this program.

#### Access

Regulations indicate that the Medicaid patient admissions standard shall be 75% of the annual percentage of all Medicaid admissions for the long term care planning area in which the applicant facility is located. Such planning area percentage shall not include residential health care facilities that have an average length of stay 30 days or fewer. If there are four or fewer residential health care facilities in the planning area, the applicable standard for a planning area shall be 75% of the planning area percentage of Medicaid admissions, or of the Health Systems Agency area Medicaid admissions percentage, whichever is less. In calculating such percentages, the Department will use the most current data which have been received and analyzed by the Department.

An applicant will be required to make appropriate adjustments in its admission policies and practices so that the proportion of its own annual Medicaid patient's admissions is at least 75% of the planning area percentage or the Health Systems Agency percentage, whichever is applicable.

Prior to its closure, Countryside Care Center's Medicaid admissions for 2010 and 2011 45.6% and 59.6%, respectively. This facility exceeded Delaware County 75% rates in 2010 and 2011 of 31.1% and 29.6%, respectively.

## Conclusion

Approval of this application will result in the provision of a much-needed resource for the residents in Delaware County and contiguous counties.

## Recommendation

From a need perspective, contingent approval is recommended.

## **Program Analysis**

## **Facility Information**

	Existing	Proposed
Facility Name	N/A	Delhi Rehabilitation and Nursing
		Center
Address	(site of former Countryside	41861 State Highway 10
	Care Center)	Delhi, NY 13753
RHCF Capacity	N/A	176
ADHC Program Capacity	N/A	None
Type of Operator	N/A	Limited Liability Company
Class of Operator	N/A	Proprietary
Operator	N/A	DRNC Operating, LLC d/b/a Delhi
		Rehabilitation & Nursing Center
		Members:
		Ephraim Zagelbaum 48.0%
		Alexander Barth 23.0%
		Yahudah Walden 23.0%
		Yechiel Zagelbaum 2.0%
		Yoel Zagelbaum 2.0%
		Pinchus Zagelbaum 2.0%

## **Character and Competence - Background**

## Facilities Reviewed

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Tarrytown Hall Care Center	04/2008 to present
Alpine Rehabilitation and Nursing Center	07/2009 to present
Norwich Rehabilitation and Nursing Center	01/2011 to present
Highland Rehabilitation and Nursing Center	02/2013 to present

## Massachusetts Nursing Homes

Cambridge Rehabilitation and Nursing Center 09/2010 to present Medford Rehabilitation and Nursing Center 04/2012 to present Rehabilitation and Nursing Center at Everett 01/2013 to present

## Individual Background Review

**Ephraim Zagelbaum** is a licensed New York State Nursing Home Administrator with license in good standing. Mr. Zagelbaum currently is the President/Chief Executive Officer at Personal Healthcare Management LLC which is located in Tarrytown, NY. He was previously employed as Administrator at Windsor Park Nursing from 2004 to 2012. Mr. Zagelbaum discloses the following health facility ownership interests:

Alpine Rehabilitation and Nursing Center	07/2009 to present
Cambridge Rehabilitation and Nursing Center (MA)	09/2010 to present
Norwich Rehabilitation and Nursing Center	01/2011 to present
Tarrytown Hall Care Center	04/2008 to present
Medford Rehabilitation and Nursing Center (MA)	04/2012 to present
Rehabilitation and Nursing Center at Everett (MA)	01/2013 to present
Highland Rehabilitation and Nursing Center	02/2013 to present

<u>Alexander Barth</u> is a licensed New York State Nursing Home Administrator with license in good standing. Mr. Barth also holds a current EMT license. Mr. Barth is a Managing Partner at Personal Healthcare Management LLC since January 2013. Previous to this he was employed as Administrator at Tarrytown Hall Care Center from 2007 to 2012. Mr. Barth discloses the following health facility ownership interests:

Alpine Rehabilitation and Nursing Center 07/2009 to present Cambridge Rehabilitation and Nursing Center (MA) 09/2010 to present Norwich Rehabilitation and Nursing Center 01/2011 to present

Tarrytown Hall Care Center 01/2010 to present Medford

Rehabilitation & Nursing Center (MA) 04/2012 to present

Rehab & Nursing Center at Everett (MA)

O1/2013 to present
Highland Rehabilitation & Nursing Center

02/2013 to present

<u>Yehudah Walden</u> is a managing member at Personal Healthcare since 2010. Mr. Walden discloses the following health facility ownership interests:

Cambridge Rehabilitation and Nursing Center (MA)	09/2010 to present
Medford Rehabilitation & Nursing Center (MA)	04/2012 to present
Rehab & Nursing Center at Everett (MA)	01/2013 to present
Highland Rehabilitation & Nursing Center	02/2013 to present

<u>Yechiel Zagelbaum</u> has been a pediatrician in private practice in Brooklyn, NY since 2002. Dr. Zagelbaum is a New York State Physician with license in good standing; and current certification in general pediatrics. Mr. Zagelbaum discloses the following health facility ownership interests:

Alpine Rehabilitation and Nursing Center	07/2009 to present
Cambridge Rehabilitation and Nursing Center (MA)	09/2010 to present
Norwich Rehabilitation and Nursing Center	01/2011 to present
Tarrytown Hall Care Center	04/2008 to present
Medford Rehabilitation & Nursing Center (MA)	04/2012 to present
Rehab & Nursing Center at Everett (MA)	01/2013 to present
Highland Rehabilitation & Nursing Center	02/2013 to present

<u>Yoel Zagelbaum</u> is an attorney in good standing who serves as the President of Riverside Abstract, LLC, a title insurance company, located in Brooklyn, NY. Mr. Zagelbaum is a U.S. patent attorney in good standing. Mr. Zagelbaum discloses the following health facility ownership interests:

Alpine Rehabilitation and Nursing Center	07/2009 to present
Cambridge Rehabilitation and Nursing Center (MA)	09/2010 to present
Norwich Rehabilitation and Nursing Center	01/2011 to present
Tarrytown Hall Care Center	04/2008 to present
Medford Rehabilitation & Nursing Center (MA)	04/2012 to present
Rehab & Nursing Center at Everett (MA)	01/2013 to present
Highland Rehabilitation & Nursing Center	02/2013 to present

<u>Pincus Zagelbaum</u> is currently employed as Chief Financial Officer at Personal Healthcare Management LLC since 2012. Previously Mr. Zagelbaum served as the Vice-President/CEO of St. Mary's Healthcare System for Children, a specialty nursing home located in Bayside, Queens. Mr. Zagelbaum discloses the following health facility ownership interests:

Alpine Rehabilitation and Nursing Center	7/29/2009 to present
Cambridge Rehabilitation and Nursing Center (MA)	9/23/2010 to present
Norwich Rehabilitation and Nursing Center	1/1/2011 to present
Tarrytown Hall Care Center	4/1/2008 to present
Medford Rehabilitation & Nursing Center (MA)	04/2012 to present
Highland Rehabilitation & Nursing Center	02/2013 to present

## **Character and Competence - Analysis**

No negative information has been received concerning the character and competence of the above applicants.

A review of operations for Alpine Rehabilitation and Nursing Center, Norwich Rehabilitation and Nursing Center, Tarrytown Hall Care Center and Highland Rehab & Nursing Center results in a conclusion of substantially consistent high level of care since there were no enforcements. A review of the affidavits submitted by the applicant for Cambridge Rehabilitation and Nursing Center (MA), Rehab & Nursing Center at Everett (MA), and Medford Rehabilitation & Nursing Center (MA) for the periods identified above results in a conclusion of substantially consistent high level of care since there were no enforcements disclosed.

## **Project Review**

## **Program Review**

DRNC Operating, LLC d/b/a Delhi Rehabilitation and Nursing Center (Delhi), a proposed limited liability company, requests approval to establish and construct a 176-bed nursing home. The new facility will be located on the site of Countryside Care Center, a 160-bed nursing home that closed in October, 2010. The proposal will involve the demolition of the 1972 building applicant and the recycling of the existing 1963 building to be converted to a 56 bed short-term rehabilitation unit. A new 120 bed wing will be constructed and attached to the remaining building, with a new entryway joining the two buildings.

## Physical Environment

The proposed Delhi nursing facility will be located on a large site totaling 66.2 acres, directly off Route 10. The remaining 1963 building totals 46,389 square feet, and the new addition will encompass 79,992 square feet. The new building will more than double the residential space contained in the to-bedemolished 1972 addition. The 1963 building consists of a one story structure with two linear nursing units in the general shape of a "4", surrounding a central courtyard. Service and activity space is located on the north side of the courtyard. The new addition will be located on the west end of the existing building, and will consist of a two story structure with two nursing units framing a pentagonal shaped interior courtyard. A new entrance with drop-off and covered patio will be constructed in a connector between the new and old buildings. The central connector will also include a new enlarged therapy suite serving the entire nursing home.

The new building will be constructed with two mirror image floors divided into three neighborhoods of 14, 20 and 28 beds respectively. Each floor will feature 30 single- bedded and 15 double- bedded rooms, for a total of 60 beds. The doubles will be designed as enhanced doubles with a partition separating the beds on opposite walls. Two dining rooms with country kitchens will be located adjacent to the interior courtyard, opening onto the entrance area on the first level. Each neighborhood will offer ample activity space, or parlors, generally situated in the center of the neighborhood allowing light to stream through windows located on the outside wall. Additional parlors are located next to the dining room, and on the opposite side of the courtyard in the corridor connecting the two residential clusters. Each neighborhood will include a central bathing area, two of which will include tub and shower.

In order to avoid an unfavorable comparison with the contemporary building, the single story 1963 building will be renovated to serve residents requiring short term rehabilitation. All of the existing resident rooms will be converted to single occupancy bedrooms, with each room fully ADA compliant. The unit will be re-designed to form 21 and 25 bed neighborhoods. The unit will be comprised of 14 enhanced doubles, 32 single bedrooms sharing a common toilet room, 6 conventional singles, 1 single with tub, and 3 singles with shower. Most of the rooms will face the existing or new entrance areas, with some new rooms created with view of the interior courtyard. The lounge area at the south finger will remain and new parlors/activity areas will be created in the corner of the eastern finger and adjacent to the interior courtyard.

The nursing unit will retain the existing dining room, appropriately sized for the number of residents, with a new area created for family dining. The private dining room will also open into the existing entry parlor, which will provide exclusive access into the short term rehabilitation unit. A multi-use auditorium lies opposite the dining room, providing large activity space for the entire nursing home.

Industrial and service functions are located on the north side of the 1963 building, including the boilers, laundry and kitchen. This space will undergo minor renovation, re-allocating space to create efficiencies. The staff dining room and medical office and records room will be relocated within this area. A new personal care area will be created adjacent to the central therapy suite, sized to serve the entire nursing home.

#### **Conclusion**

No negative information has been received concerning the character and competence of the proposed operators. The design reflects a sensitivity to residents' needs, and successfully integrates an outdated nursing home building with a contemporary residential structure, culminating in a unified residential health care facility.

#### Recommendation

From a programmatic perspective, contingent approval is recommended.

## **Financial Analysis**

## **Agreement of Sale**

Personal Healthcare, LLC entered into an Agreement of Sale with Leatherstocking Realty on May 2, 2014, for the acquisition of the property as shown below. A MAI appraisal was submitted by the applicant substantiating the purchase price.

Date:	May 2, 2014
Seller:	Leatherstocking Realty, of 321 N. Bellinger Street, Herkimer NY 13350
Buyer:	Personal Healthcare LLC, of 20 Wood Court, Tarrytown NY 10591
Purchased:	Parcel of real property and improvements constructed thereon known
	as 41861 State Highway 10, Delhi, NY
Purchase Price:	\$2,780,000
Payment of	\$25,000 paid by Buyer prior to the execution of this agreement.
Purchase Price:	\$2,755,000 put in escrow account until legal closing.

## **Assignment of Agreement of Sale**

Personal Healthcare, LLC entered into an Assignment of Agreement of Sale with DRNC Realty, LLC on September 26, 2014, for assignment of the property as follows:

Date:	September 16, 2014
Assignor:	Personal Healthcare, LLC
Assignee:	DRNC Realty, LLC
Assignment:	The Agreement of Sale for property known as 41861 State Highway
	10, Delhi, New York 13753
Price:	For \$10 dollars and other valuable consideration received in hand

## **Lease Agreement**

DRNC Realty, LLC will construct the 176-bed RHCF in accordance with plans approved by the tenant and will lease the facility to the tenant, DRNC Operating, LLC. The lease arrangement is a non-arm's length agreement. The applicant has submitted an affidavit attesting to the relationship between the landlord and the operating entity. Facility occupancy is subject to a lease agreement, the terms of which are summarized as follows:

Premises:	A 176-bed RHCF located at 41861 State Highway 10, Delhi, NY
Landlord:	DRNC Realty, LLC
Tenant:	DRNC Operating, LLC
Terms:	10 years commencing on the execution of the lease with an additional 20 year
	renewal, year to year.
Rental:	Annual rent is \$1,774,812 equal to the debt service on the initial permanent
	financing, insurance and real estate taxes.
Provisions:	Triple Net Lease. Tenant is responsible for taxes, general liability insurance,
	utilities and maintenance.

## **Total Project Cost and Financing**

Total project cost for land acquisition, new construction and movable equipment is estimated at \$30,846,346, broken down as follows:

Land acquisition	\$2,780,000
New Construction	15,406,348
Renovation and Demolition	4,168,293
Site Development	968,159
Asbestos Abatement or Removal	46,800
Design Contingency	1,090,080
Construction Contingency	1,090,080
Architect/Engineering Fees	1,138,644
Other Fees	192,400
Movable Equipment	1,751,256
Financing Costs	347,021
Interim Interest	1,696,549
CON Application Fee	2,000
CON Additional Processing Fees	<u>168,716</u>
Total Project Cost	\$30,846,346

DRNC Realty, LLC will fund the total cost of \$30,846,346 for the land purchase, demolition of existing buildings, and construction of a new 176-bed RHCF. The financing plan for the project is as follows:

Members' Equity \$ 7,711,586 Mortgage (5.5%, 10 year term, with a 25 year amortization) 23,134,760

Total project cost is based on a start date of December 1, 2015, with a 14 month construction period. The Bureau of Architectural and Engineering Facility Planning has determined that the reimbursable cost per bed of \$174,293 (excluding CON fees) is acceptable.

## **Operating Budget**

The applicant has provided an operating budget, in 2015 dollars, for the first and third years subsequent to project completion, summarized as follows:

	Year One	Year Three
Revenues:		
Medicaid	\$8,578,849	\$8,742,881
Medicare	3,890,535	3,972,441
Private/Other	3,380,892	3,451,373
Total Revenues	\$15,850,276	\$16,166,695
Expenses:		
Operating	\$12,352,177	\$12,483,914
Interest	60,613	38,125
Depreciation and Rent	<u>2,024,991</u>	2,024,991
Total Expenses	\$14,437,781	\$14,547,030
Net Income	\$1,412,495	\$1,619,665
Total Patient Days	61,028	62,313
Occupancy %	95.0%	97.0%

Review of the budget reveals the following:

- Medicare and private pay revenues reflect historical payment rates of the members affiliated RHCFs.
- The facility's Medicaid rate is based on Medicaid Regional Pricing methodology per Part 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.
- Overall utilization is based on 2009 from the former Countryside Care Center RHCF.
- Overall Occupancy is projected at 95.0% and 97.0% for the first and third years, respectively.
- Utilization by payer source for years one and three, based on historical experience, is expected as follows:

 Medicaid
 70.0%

 Medicare
 15.0%

 Private
 10.0%

 All Other
 5.0%

• Breakeven utilization is projected at 86.5% and 87.3% for year one and year three, respectively.

## **Capability and Feasibility**

The total project cost of \$30,846,836 will be met with members' equity of \$7,711,586 and a bank loan of \$23,134,760 at terms stated previously. A letter of interest has been provided for mortgage financing from M&T Bank. BFA Attachment B is a summary of the net worth of the members of DRNC Operating, LLC, which indicates the availability of sufficient funds for project cost. It is noted that the members of DRNC Operating, LLC have different equity contributions than their ownership percentages as follows:

		⁄o ⊑quity
<u>Members</u>	% Ownership	<b>Contribution</b>
Ephraim Zagelbaum	48.0%	20.0%
Alexander Barth	23.0%	5.0%
Yehudah J. Walden	23.0%	5.0%
Pincus Zagelbaum	2.0%	0.0%
Yechiel Zagelbaum	2.0%	50.0%
Yoel Zagelbaum	2.0%	20.0%

Each member of DRNC Operating, LLC has submitted an affidavit stating that they will personally contribute resources to fund the balloon payment should acceptable financing not be available at the time the loan comes due after the 10 year term.

Working capital requirements are estimated at \$2,424,505 based on two months of the third year budgeted expenses and will be met with a bank loan of \$1,212,252 at 5% over 5 years with the remaining \$1,212,253 from members' equity. A letter of interest has been submitted from M&T Bank for the working capital. Affidavits from Yoel Zaglebaum and Yechiel Zaglebaum have been submitted to the Department of Health which state that they are willing to contribute resources disproportionate to their ownership percentages for working capital requirements. BFA Attachment B is a summary of the net worth of the members of DRNC Operating, LLC, which indicates the availability of sufficient funds for working capital. BFA Attachment C, the pro-forma balance sheet of DRNC Operating, LLC d/b/a Delhi Rehabilitation & Nursing Care as the first day of operation, indicates positive members' equity of \$1,212,253.

The submitted budget indicates a net profit of \$1,412,495 and \$1,619,665 for Years 1 and 3, respectively. Annual rental expense is sufficient to cover the landlord's financing requirements. The budget appears reasonable.

A transition of nursing home (NH) residents to Medicaid managed care is currently being implemented statewide. Effective February 1, 2015, all eligible beneficiaries in NYC age 21 and over, in need of long term placement in a nursing facility, will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP). On April 1, 2015, the counties of Nassau, Suffolk, and Westchester will be phased in, and the rest of the State is scheduled to transition beginning July 1, 2015, for both dual and non-dual eligible populations. Under the managed care construct, Managed Care Organizations (MCOs) will negotiate payment rates directly with the NH providers. In order to mitigate the financial impact to NH providers during the transition to managed care, a department policy, as described in the "Transition of Nursing Home Benefit and Population into Managed Care Policy Paper," provided further guidance requiring MCOs to pay the benchmark Medicaid FFS rate, or a negotiated rate acceptable to both plans and NHs, for 3 years after a county has been deemed mandatory (phased in) for NH population enrollment. As a result, the benchmark FFS rate remains a reliable basis for assessing NH Medicaid revenues through to January 31, 2018 (NYC), March 31, 2018 (Nassau, Suffolk and Westchester), and June 30, 2018 (upstate), respectively.

BFA Attachment D is a 2011 through 2013 financial summary of the operations for the members affiliated RHCFs, which shows the following:

- Alpine Rehabilitation & Nursing Center had an average negative working capital position and an
  average positive net asset position from 2011 through 2013. The reason for the negative working
  capital position is due to Medicaid rate adjustment liabilities. Also, the entity achieved an average
  operating net income of \$86,002 for the period.
- Norwich Rehabilitation & Nursing Center had an average negative working capital position and an
  average negative net asset position from 2011 through 2013. Also, the entity achieved an average
  net operating loss of \$32,300 for the period. The facility was newly acquired effective January 1,
  2011, and the current owners are attempting to turn the operation around from the previous owners.
- Tarrytown Hall Care Center had an average negative working capital position and an average positive net asset position from 2011 through 2013. Also, the entity achieved an average net operating loss of \$70,092 for the period. The negative working capital was largely due to the facility categorizing a \$2.8 million Medicaid base year rate adjustment in 2011 as an expense rather than as revenue.
- Highland Rehabilitation & Nursing Center, which was acquired on February 1, 2013, ended the year 2013 with a negative working capital position, a negative net asset position, and a net operating loss \$89,978. The facility was still in transition from the previous owners.

BFA Attachment E is a 2011 through 10/1/2014 financial summary of the combined operations of each nursing facility and its related realty company for the members affiliated RHCFs, which shows the following:

- Alpine Rehabilitation & Nursing Center and Tarrytown Hall Center had an average negative working
  capital position and an average positive net asset position from 2011 through 2013. Also, the entities
  achieved an average operating net income of \$532,380 and 1,718,496 respectively for the period.
- Norwich Rehabilitation & Nursing Center had an average negative working capital position and an average negative net asset position from 2011 through 2013. Also, the entity achieved an average net operating income of \$462,241 for the period.
- Highland Rehabilitation & Nursing Center, which was acquired on February 1, 2013, ended the year 2013 with a negative working capital position, a positive net asset position, and a net operating income of \$967,521.

A review of the 2014 internal financial statements presented as of 10/31/2014 for the combined operations indicates that all of the nursing homes demonstrated a positive net asset and working capital position. In addition, the aggregate net operating income of the combined operations of each nursing facility and its related realty company, for the periods 2011, 2012, and 2013, and year to date 10/31/2014, showed positive operating net income of \$1,533,342, \$2,507,236, \$5,066,193, and \$4,698,302 respectively.

Based on the preceding, and subject to the noted contingencies, it appears the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### Recommendation

From a financial perspective, contingent approval is recommended.

## **Attachments**

BFA Attachment A	Organizational Chart
BFA Attachment B	Net Worth Statement of the Members of DRNC Operating, LLC
BFA Attachment C	Pro Forma for Delhi Rehabilitation & Nursing Care
BFA Attachment D	Financial Summary-Affiliated Residential Health Care Facilities
BFA Attachment E	Financial Summary-Combined Affiliated Facilities' Operating and related Realty
BNHLC Attachment A	Quality Measures and Inspection Reports

## RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 12th day of February, 2015 having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish DRNC Operating, LLC as the operator of a to-be constructed, 176 bed residential health care facility to be located at 41861 Route 10, Delhi on the site of the former Countyside Care Center, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER</u>: <u>FACILITY/APPLICANT</u>:

142195 B Delhi Rehabilitation & Nursing Center

## APPROVAL CONTINGENT UPON:

- 1. Submission of a check for the amount enumerated in the approval letter, payable to the New York State Department of Health. Public Health Law Section 2802.7 states that all construction applications requiring review by the Public Health and Health Planning Council shall pay an additional fee of fifty-five hundredths of one percent of the total capital value of the project, exclusive of CON fees. [PMU]
- 2. Submission of a commitment signed by the applicant which indicates that, within two years from the date of the council approval, the percentage of all admissions who are Medicaid and Medicare/Medicaid eligible at the time of admission will be at least 75 percent of the planning area average of all Medicaid and Medicare/Medicaid admissions, subject to possible adjustment based on factors such as the number of Medicaid patient days, the facility's case mix, the length of time before private paying patients became Medicaid eligible, and the financial impact on the facility due to an increase in Medicaid admissions. [RNR]
- 3. Submission of a plan to continue to enhance access to Medicaid residents. At a minimum, the plan should include, but not necessarily 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
  - 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]
- 4. Submission of a commitment, signed by the applicant, to submit annual reports to the DOH, for at least two years, demonstrating substantial progress with the implementation of the plan. These reports should include, but not be limited to:
  - a. Describing how the applicant reached out to hospital discharge planners to make them aware of the facility's Medicaid Access Program;
  - b. Indicating that the applicant communicated with local hospital discharge planners on a regular basis regarding bed availability at the nursing facility;
  - c. Identifying the community resources that serve the low-income and frail elderly population that have used, or may eventually use, the nursing facility, and confirming they were informed about the facility's Medicaid Access policy.
  - d. Documentation pertaining to the number of referrals and the number of Medicaid admissions; and
  - e. Other factors as determined by the applicant to be pertinent. [RNR] The DOH reserves the right to require continued reporting beyond the two year period.
- 5. Submission and programmatic review and approval of the final floor plans. [LTC]
- 6. Submission of a commitment for a permanent mortgage for the project to be provided from a recognized lending institution at a prevailing rate of interest, acceptable to the Department of Health. This is to be provided within 120 days of approval of state hospital code drawings and before the start of construction. Included with the submitted permanent mortgage commitment must be a sources and uses statement and a debt amortization schedule, for both new and refinanced debt. [BFA]
- 7. Submission of an executed building lease acceptable to the Department of Health. [BFA]

- 8. Submission of an executed working capital loan commitment acceptable to the Department of Health. [BFA]
- 9. Submission of an executed assignment of agreement of sale acceptable to the Department of Health. [BFA]
- 10. The submission of Final Construction Documents, as described in BAEFP Drawing Submission Guidelines DSG-05, prior to the applicant's request for, and Department's granting approval for the start of construction. [AER]
- 11. Submission of an amended Articles of Organization of DNRC Operating, LLC, acceptable to the Department. [CSL]
- 12. Submission of an amended Operating Agreement of DNRC Operating, LLC, acceptable to the Department. [CSL]
- 13. Submission of an amended Agreement of Lease between DNRC Realty, LLC and DNRC Operating, LLC, acceptable to the Department. [CSL]

## APPROVAL CONDITIONAL UPON:

- 1. The project must be completed within five years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The applicant shall complete construction by February 1, 2017. In accordance with 10 NYCRR Part 710.2(b)(5) and 710.10(a), if construction is not completed on or before that date, this may constitute abandonment of the approval and this approval shall be deemed cancelled, withdrawn and annulled without further action by the Commissioner. [AER]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.



# Public Health and Health Planning Council

## Project # 142193-E Kindred Healthcare

Program: Certified Home Health Agency

Purpose: Establishment

County: Saratoga

Acknowledged: November 5, 2014

## **Executive Summary**

## **Description**

Kindred Healthcare, Inc. (Kindred) and Kindred Healthcare Operating, Inc. (Kindred Operating) are seeking approval to become the new controlling persons of QC-Medi New York, Inc., a wholly-owned subsidiary of Gentiva Health Services, Inc. (Gentiva). QC-Medi New York, Inc. presently operates five Gentiva Certified Home Health Agencies (CHHA) which are as follows:

<u>Address</u>	Counties Served
200 Elwood Davis Rd., Liverpool	Cayuga, Onondaga, Oswego
865 Merrick Ave.,3rd floor, Westbury	Nassau
888Veterans Memorial Hwy,	Suffolk
Hauppauge	
11849 East Corning Rd., Corning	Chemung, Steuben
100 Saratoga Village Blvd., Ballston	Montgomery,
Spa	Saratoga

Kindred and Gentiva are nationwide providers of health care services whose stock are publically traded on the New York Stock Exchange and the NASDAQ, respectively.

Kindred is also seeking approval, under separate application, as controlling persons of Quality Care-USA, Inc., Gentiva's other wholly-owned New York subsidiary, which presently operates four Gentiva Licensed Home Care Service Agencies (LHCSA).

On October 9, 2014, Kindred entered into and executed an Agreement and Plan of Merger with Gentiva whereby Kindred Operating will acquire 100% of the shares of Gentiva common stock by the merger into Gentiva, the surviving entity of Kindred Healthcare Development 2, Inc., and a wholly-owned subsidiary of Kindred Operating. Under the terms of the agreement, Gentiva shareholders will receive

\$14.50 per share in cash and \$5.00 of Kindred common stock, which equates to 0.257 shares of Kindred common stock. The total purchase price in cash, stock and assumption of debt will be approximately \$1.8 billion. The portion of the aggregate purchase price allocated to the Gentiva assets in New York is \$38,086,770.

Gentiva, incorporated in Delaware and qualified to do business in New York, is the sole stockholder of Gentiva Health Services Holding Corp., the sole stockholder of QC-Medi New York, Inc. and Quality Care-USA, Inc., both of which are New York corporations. Therefore, the affiliation will create a "change in controlling person" for each of the Article 36 Entities due to their new relationships with Kindred and Kindred Operating. BFA Attachment A is the organizational chart for Kindred and Kindred Operating.

## **DOH Recommendation**

**Contingent Approval** 

## **Need Summary**

This project is a change of ownership and is not expected to have an impact on services provided by the facility or the utilization of those services.

## **Program Summary**

Five (5) Article 36 Certified Home Health Agencies (CHHAs) in New York State are currently operated by QC-Medi New York, Inc. d/b/a Gentiva Health Services, a proprietary business corporation. In addition, four (4) Article 36 Licensed Home Care Services Agencies (LCHSAs) in New York State are currently operated by Quality Care - USA, Inc. d/b/a

Gentiva Health Services, a proprietary business corporation. The parent corporation and 100% stockholder of both QC-Medi New York. Inc. d/b/a Gentiva Health Services and Quality Care - USA, Inc. d/b/a Gentiva Health Services, is Gentiva Health Services Holding Corporation, a proprietary business corporation. The parent corporation and 100% stockholder of Gentiva Health Services Holding Corporation is Gentiva Health Services, Inc., a publicly-traded proprietary business corporation. This proposal seeks approval for Kindred Healthcare Operating, Inc., a proprietary business corporation, to become the new parent corporation and new 100% sole stockholder of Gentiva Health Services. Inc. Since the parent corporation and 100% sole stockholder of Kindred Healthcare Operating, Inc. is Kindred Healthcare. Inc., a publicly-traded proprietary business corporation, this proposal also seeks approval for Kindred Healthcare, Inc., to become the new grandparent corporation and ultimate controlling entity and stockholder of Gentiva Health Services, Inc. This CHHA CON application # 142193-E applies only to the five (5) QC-Medi New York, Inc. d/b/a Gentiva Health Services CHHAs, which are located in Ballston Spa, Liverpool (with branch offices in Auburn and Oswego), Corning, Westbury, and Hauppauge (with a sub-unit in Riverhead). A separate LHCSA application has been submitted for the four (4) Quality Care - USA, Inc. d/b/a Gentiva Health Services LHCSAs, which is also being presented on this agenda as LHCSA application # 2556-L.

The direct corporate operator of the five (5) CHHAs will remain QC-Medi New York, Inc. d/b/a Gentiva Health

Services. The direct corporate operator of the four (4) LHCSAs will remain Quality Care - USA, Inc. d/b/a Gentiva Health Services. The parent corporation of both will remain Gentiva Health Services Holding Corporation, and the grandparent corporation of both will remain Gentiva Health Services, Inc., as previously approved by both the State Hospital Review and Planning Council and the Public Health Council. However, the new incoming great-grandparent corporation and controlling entity will now be Kindred Healthcare Operating, Inc., and the new incoming great-great-grandparent corporation and ultimate controlling entity will now be Kindred Healthcare, Inc. Programmatic Attachment A is the before and after organizational chart.

## **Financial Summary**

There are no project costs associated with this application. The portion of the \$1.8 billion purchase price allocated to the Gentiva assets in New York, comprised of the CHHAs and LHCSA, is \$38,086,770 of which \$37,917,489 is attributable to the CHHAs.

Budget: Revenues: \$39,300,747

Expenses: <u>30,931,126</u> Gain: \$8,369,621

It appears that the applicant has demonstrated the capability to proceed in a financially feasible manner.

## **Recommendations**

## **Health Systems Agency**

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management Approval contingent upon:

- 1. Submission of the executed Amended and Restated Certificate of Incorporation of Gentiva Health Services, Inc., acceptable to the Department. [CSL]
- 2. Submission of the executed Certificate of Merger of Kindred Healthcare Development 2, Inc. with and into Gentiva Health Services, Inc., acceptable to the Department. [CSL]

## Approval conditional upon:

1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

**Council Action Date** February 12, 2015

## **Need Analysis**

## **Background**

Kindred Healthcare, Inc. a nationwide healthcare services company, is seeking to establish Kindred Healthcare, Inc. and Kindred Healthcare Operating, Inc., its subsidiary, as controlling persons of QC—Medi New York Inc., a New York corporation which operates five Certified Home Health Agencies in the state.

The five CHHAs owned and operated by Gentiva Health Services in New York State are listed in the following table:

FacID	Name	Address	City	Zip	County
3852	Gentiva Health Services	888 Veterans Memorial Hwy	Hauppauge	11788	Suffolk
4718	Gentiva Health Services	865 Merrick Avenue, 3rd Fl	Westbury	11590	Nassau
3972	Gentiva Health Services	200 Elwood Davis Road	Liverpool	13088	Onondaga
5554	Gentiva Health Services	100 Saratoga Village Blvd	Ballston Spa	12020	Saratoga
4945	Gentiva Health Services	11849 East Corning Road	Corning	14830	Steuben

## **Conclusion**

This project will have no effect on the need for or utilization of services in the counties affected. Certified Home Health Agencies play an important role in reducing long-term care residents and reducing hospitalizations. This change in ownership should allow these facilities to continue to operate and gain access to more resources to support their work.

#### Recommendation

Because this transaction involves no change in services, the Bureau of Public Need Review has no recommendation regarding this proposal.

## **Program Analysis**

## **Program Description**

Five (5) Article 36 Certified Home Health Agencies (CHHAs) in New York State are currently operated by QC-Medi New York, Inc. d/b/a Gentiva Health Services, a proprietary business corporation. In addition, four (4) Article 36 Licensed Home Care Services Agencies (LCHSAs) in New York State are currently operated by Quality Care - USA, Inc. d/b/a Gentiva Health Services, a proprietary business corporation. The parent corporation and 100% stockholder of both QC-Medi New York, Inc. d/b/a Gentiva Health Services and Quality Care - USA, Inc. d/b/a Gentiva Health Services, is Gentiva Health Services Holding Corporation, a proprietary business corporation. The parent corporation and 100% stockholder of Gentiva Health Services Holding Corporation is Gentiva Health Services, Inc., a publicly-traded proprietary business corporation. This proposal seeks approval for Kindred Healthcare Operating, Inc., a proprietary business corporation, to become the new parent corporation and new 100% sole stockholder of Gentiva Health Services, Inc. Since the parent corporation and 100% sole stockholder of Kindred Healthcare Operating, Inc. is Kindred Healthcare, Inc., a publicly-traded proprietary business corporation, this proposal also seeks approval for Kindred Healthcare, Inc., to become the new grandparent corporation and ultimate controlling entity and stockholder of Gentiva Health Services, Inc. This CHHA CON application # 142193-E applies only to the five (5) QC-Medi New York, Inc. d/b/a Gentiva Health Services CHHAs, which are located in Ballston Spa, Liverpool (with branch offices in Auburn and Oswego), Corning, Westbury, and Hauppauge (with a sub-unit in Riverhead). A separate LHCSA application has been submitted for the four (4) Quality Care - USA, Inc. d/b/a Gentiva Health Services LHCSAs, which is also being presented on this agenda as LHCSA application # 2556-L.

The direct corporate operator of the five (5) CHHAs will remain QC-Medi New York, Inc. d/b/a Gentiva Health Services. The direct corporate operator of the four (4) LHCSAs will remain Quality Care - USA, Inc. d/b/a Gentiva Health Services. The parent corporation of both will remain Gentiva Health Services Holding Corporation, and the grandparent corporation of both will remain Gentiva Health Services, Inc., as previously approved by both the State Hospital Review and Planning Council and the Public Health Council. However, the new incoming great-grandparent corporation and controlling entity will now be Kindred Healthcare Operating, Inc., and the new incoming great-grandparent corporation and ultimate controlling entity will now be Kindred Healthcare, Inc. Programmatic Attachment A is the before and after organizational chart.

Kindred Healthcare Operating, Inc., a proprietary business corporation, is a wholly owned subsidiary of Kindred Healthcare, Inc. Kindred Healthcare, Inc. owns 100% of the stock of Kindred Healthcare Operating, Inc. Kindred Healthcare, Inc., a publicly-traded proprietary business corporation, is authorized to issue 176,000,000 shares of capital stock, consisting of 175,000,000 shares of common stock and 1,000,000 shares of preferred stock, both with par value of \$0.25 per share. The applicant confirms in writing that no stockholder (either natural person or business entity) owns 10% or more of the stock of Kindred Healthcare, Inc.

Kindred Healthcare, Inc., operates over 360 health care facilities and providers in 38 states. The complete list of affiliated health care facilities and providers, by provider type and by state, has been included in the application and a copy is attached (see Programmatic Attachment B – Kindred Providers / Facilities). All facilities and providers listed are therefore affiliated with each board member, and each officer, named below. Since there are no stockholders owning 10% or more of the publicly traded stock of Kindred Healthcare, Inc., there are no principal stockholders to disclose below.

The governing body of Kindred Healthcare, Inc., consists of the following members of the Board of Directors:

Phyllis Yale, Chairperson Advisory Partner, Bain and Company, Inc. (Management Consulting) Additional Affiliations: National Surgical Healthcare, Inc. (see Programmatic Attachment C - Ms. Yale Affiliations for list of ambulatory surgical center providers); Blue Cross and Blue Shield of Massachusetts (Health Benefits Provider)	Thomas Cooper, MD (AL, AZ, FL, IN, LA, MN, MO, NY, OK, OR, TX, VA, WA, WI), Vice-Chairperson Retired Founder and Vice Chairman, Vericare Management, Inc. (RHCF Management Contractor)
Joel Ackerman Chief Executive Officer, Champions Oncology, Inc. (Oncology Drug Development and Services)	Jonathan Blum Senior Vice President / Chief Public Affairs Officer / Chief Global Nutrition Officer, Yum! Brands, Inc. (Restaurants)
Paul Diaz Chief Executive Officer, Kindred Healthcare, Inc. Additional Affiliations: DaVita Healthcare Partners, Inc. (ESRD providers located both in NYS and out of state - see Programmatic Attachment D – Mr. Diaz Affiliations for list of NYS ESRD Centers operated by Liberty RC, Inc., and Knickerbocker Dialysis, Inc. both of which DaVita Healthcare Partners, Inc., is the 100% sole stockholder)	Heyward Donigan President / Chief Executive Officer, ValueOptions, Inc. (Health Care Benefits Administrator)

Richard Goodman, PhD Retired Executive Vice President – Global Operations / Chief Financial Officer, PepsiCo, Inc.	Christopher Hjelm Senior Vice President / Chief Information Officer, The Kroger Company (Retail Grocery, Department, Convenience, Jewelry, and Pharmacy Stores)
Frederick Kleisner, Gaming Licensure granted in IN, LA, MO, NJ, OH, Ontario, Canada, and Ak-Chin Tribe AZ; pending in AZ, CA, NY, PA, Cherokee Tribe NC, National Indian Gaming Commission DC, and Rincon Tribe CA. Retired Chief Executive Officer, Morgan's Hotel Group (Luxury Hotels)	John Short, PhD Retired Executive Board Chairman, Vericare Management, Inc. (RHCF Management Contractor) Additional Affiliations: Seton Family of Health Care Facilities / Providers in Texas (see Programmatic Attachment E – Mr. Short Affiliations for list of Seton providers); Wellpoint, Inc. (Health Care Benefits Company)

Additional officers of Kindred Healthcare, Inc., who are not members of the Board of Directors listed above, are as follows:

William Altman, Esq. (DC) Executive Vice President – Strategy, Policy, and Integrated Care, Kindred Healthcare, Inc.	Michael Beal, LNHA (ME and NH) President - Nursing Center Division, Kindred Healthcare, Inc.
Benjamin Breier President / Chief Operating Officer, Kindred Healthcare, Inc.	Stephen Farber Executive Vice President / Chief Financial Officer, Kindred Healthcare, Inc.
Stephen Cunanan Chief People Officer, Kindred Healthcare, Inc.	Patricia Henry, Speech Language Pathologist (TX) Executive Vice President / President of RehabCare Division, Kindred Healthcare, Inc.
Joseph Landenwich, Esq. (KY), CPA (KY), Corporate Secretary Co-General Counsel, Kindred Healthcare, Inc.	Steven Monaghan President – Hospital Division, Kindred Healthcare, Inc.
Mary Suzanne Riedman, Esq. (CA) General Counsel / Chief Diversity Officer, Kindred Healthcare, Inc.	Jon Rousseau President – Care Management Division, Kindred Healthcare, Inc.

The governing bodies of Kindred Healthcare Operating, Inc., and of Gentiva Health Services, Inc., are identical, and consist of the following members of the Board of Directors:

Douglas Cornutte, CPA (KY) Senior Vice President – Corporate Development, Kindred Healthcare, Inc.	Stephen Cunanan Chief People Officer, Kindred Healthcare, Inc. (Disclosed above)
Joseph Landenwich, Esq. (KY), CPA (KY), Corporate Secretary Co-General Counsel, Kindred Healthcare, Inc. (Disclosed above)	

Additional officers of both Kindred Healthcare Operating, Inc., and of Gentiva Health Services, Inc., who are not members of the Board of Directors listed above, are also identical as follows:

William Altman, Esq. (DC) Executive Vice President – Strategy, Policy, and Integrated Care, Kindred Healthcare, Inc. (Disclosed above)	Benjamin Breier President / Chief Operating Officer, Kindred Healthcare, Inc. (Disclosed above)
Mary Suzanne Riedman, Esq. (CA) General Counsel / Chief Diversity Officer, Kindred Healthcare, Inc. (Disclosed above)	Jon Rousseau President – Care Management Division, Kindred Healthcare, Inc. (Disclosed above)

A search of all of the above named board members, employers, and affiliations revealed no matches on either the NYS Medicaid Disqualified Provider List or the federal Office of the Inspector General's Provider Exclusion List.

The Bar Associations of the State of Kentucky, State of California, and the District of Columbia all report that the attorneys listed above are all licensed in good standing with no disciplinary actions taken. In addition, the NYS Education Department's Office of the Professions, NYSDOH Office of Professional Medical Conduct, NYSDOH Physician Profile, Ohio Casino Control Commission, Maine Nursing Home Administrator Licensing Board, New Hampshire Nursing Home Administrator Licensing Board, Wisconsin Department of Safety and Professional Services, Washington State Department of Health, Kentucky Board of Accountancy, Texas Department of State Health Services, Arizona Medical Board, Indiana Medical Licensing Board, Louisiana Board of Medical Examiners, Minnesota Board of Medical Practice, Missouri Division of Professional Registration, Oklahoma Board of Medical Licensure, Oregon Medical Board, Alabama State Medical Board, and Texas Medical Board all indicate there are no issues with the licensure of the health professionals and other licensed professionals associated with this application.

The Virginia Department of Health Professions Board of Medicine reports that in 2002, Thomas Cooper, MD, failed to respond to a state requirement to file certain information with the Department of Health Professions within the mandated time frame. Dr. Cooper did not update his physician profile as required until January 7, 2005. As such, the Virginia Department of Health Professions Board of Medicine imposed a \$1000 monetary penalty upon Dr. Cooper in February 2005. In addition, the Florida Department of Health Board of Medicine reports that Dr. Cooper violated Florida Statute section 458.331(1)(b), in that his medical license to practice in another jurisdiction (Virginia) was disciplined as described above, and Florida Statute section 458.331(1)(kk), in that he failed to report in writing within 30 days to the Florida Department of Health Board of Medicine that the above described disciplinary action was imposed by the Virginia Department of Health Professions Board of Medicine. As such, the Florida Department of Health Board of Medicine imposed a \$5000 monetary penalty for the statute violations, plus \$1000 for the Board's administrative costs, upon Dr. Cooper in October 2006.

The applicant has provided the attached list of legal actions taken against Kindred Healthcare, Inc., its predecessor Vencor, Inc., and its affiliate RehabCare Group, Inc., which is now the RehabCare Division of Kindred Healthcare, Inc. (see Programmatic Attachment F – Kindred Legal Actions).

The NYSDOH Division of Hospital Certification and Surveillance reviewed the compliance history of all End Stage Renal Dialysis (ESRD) centers located in New York State that are operated by Liberty RC, Inc., and Knickerbocker Dialysis, Inc., both of which DaVita Healthcare Partners, Inc., is the 100% sole stockholder (see Programmatic Attachment D – Mr. Diaz Affiliations). For the time period 2007 through 2014, these ESRD centers affiliated with DaVita Healthcare Partners, Inc. have all remained in substantial compliance with no history of enforcement action taken.

The NYSDOH Division of Home and Community Based Services reviewed the compliance history of all the affiliated Gentiva Health Services certified home health agencies (CHHAs) and licensed home care service agencies (LHCSAs) located in New York State, for the time period 2007 to 2014.

An enforcement action was taken in 2008 against QC-Medi New York, Inc. d/b/a Gentiva Health Services, a CHHA located in Liverpool, based on December 2006, February 2007, and March 2007 complaint surveys, citing two violations in Policies and Procedures of Service Delivery, two violations in Patient Assessment and Plan of Care, and two violations in Governing Authority. This action was resolved with a \$12,000 civil penalty.

Another enforcement action was taken in 2010 against QC-Medi New York, Inc. d/b/a Gentiva Health Services, a CHHA located in Liverpool, based on an April 2009 survey, citing one violation in Policies and Procedures of Service Delivery, three violations in Patient Assessment and Plan of Care, and two violations in Governing Authority. This action was resolved with a \$13,500 civil penalty.

It has been determined that the certified home health agencies and licensed home care service agencies have exercised sufficient supervisory responsibility to protect the health, safety, and welfare of patients and to prevent the recurrence of code violations. When code violations did occur, it was determined that the operators investigated the circumstances surrounding the violation, and took steps appropriate to the gravity of the violation that a reasonably prudent operator would take to promptly correct and prevent the recurrence of the violation.

To date, the following states have responded to requests for out-of-state compliance status and enforcement history for each of the affiliated out-of-state health care providers listed on the attachments: Alabama, Arkansas, Arizona, Connecticut, Colorado, Florida, Georgia, Kansas, Kentucky, Idaho, Illinois, Indiana, Louisiana, Maine, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming. Out-of state enforcement actions that were reported by the states are as follows:

Florida reported that Kindred Hospital South Florida – Fort Lauderdale was fined \$350 based on a May 2010 application late fee; Kindred Hospital South Florida – Coral Gables was fined \$250 based on a May 2008 application late fee; Kindred Hospital - The Palm Beaches was fined \$500 based on a July 2010 application late fee, and \$4000 based on a October 2011 survey; Kindred Hospital Bay Area – St. Petersburg was fined \$1000 based on a November 2010 survey; Kindred Hospital Bay Area – Tampa was fined \$1000 based on a September 2008 survey, \$1000 based on a December 2010 survey, \$1000 based on a January 2011 survey, \$1000 based on a July 2011 survey, \$1000 based on a March 2012 survey, \$6000 based on a June 2012 survey, and \$2000 based on an August 2012 survey; and Kindred Hospital – Central Tampa was fined \$1000 based on a June 2010 survey, \$1000 based on a November 2010 survey, \$1000 based on a January 2011 survey, and \$1000 based on a July 2011 survey.

Georgia reported that Kindred Transitional Care, a nursing home in Fayetteville, was assessed a federal Civil Monetary Penalty (CMP) of \$11,570 based on a September 2012 survey, a federal Civil Monetary Penalty (CMP) of \$24,245 based on a January 2012 survey, and a federal Civil Monetary Penalty (CMP) of \$975 based on a September 2008 survey.

Indiana reported enforcements for the following facilities: Kindred Transitional Care and Rehabilitation – Wildwood had a federal Civil Monetary Penalty (CMP) imposed of \$250 per day from 05/22/2012 – 06/19/2012; Kindred Transitional Care and Rehabilitation – Southwood was fined \$2000 in June 2014; Kindred Transitional Care and Rehabilitation – Sellersburg was fined \$6000 in August 2012; Kindred Transitional Care and Rehabilitation – Rolling Hills was fined \$3000 in October 2014, and had a federal Civil Monetary Penalty (CMP) imposed of \$600 per day from 08/22/2014 – 09/20/2014; Kindred Transitional Care and Rehabilitation – Kokomo had federal Civil Monetary Penalties (CMPs) imposed of

\$3600 per day and \$100 per day from 02/02/2012 – 02/28/2012; Kindred Transitional Care and Rehabilitation – Greenwood had a federal Civil Monetary Penalty (CMP) imposed of \$100 per day from 11/01/2012 – 12/07/2012; Kindred Transitional Care and Rehabilitation – Greenfield was fined \$1500 in December 2011; Kindred Transitional Care and Rehabilitation – Columbus was fined \$3000 in June 2012, had a federal Civil Monetary Penalty (CMP) imposed of \$100 per day from 07/26/2012 – 07/26/2012, and had federal Civil Monetary Penalties (CMPs) imposed of \$5950 per day and \$350 per day from 07/10/2014 – 07/14/2014; Kindred Transitional Care and Rehabilitation – Allison Pointe was fined \$3000 in August 2009, and had federal Civil Monetary Penalties (CMPs) imposed of \$100 per day and \$150 per day from 08/16/2012 – 09/21/2012; and Kindred Nursing and Rehabilitation – Valley View Nursing Home had a federal Civil Monetary Penalty (CMP) imposed of \$100 per day from 09/27/2012 – 10/26/2012.

Nevada reported that Kindred Hospital Las Vegas (Sahara Campus) was fined \$400 based on a June 2010 survey; Kindred Hospital Las Vegas (Flamingo Campus) was fined \$300 based on a December 2012 survey; and Torrey Pines Post-Acute and Rehabilitation Hospital was fined \$1500 based on a January 2014 survey, and \$400 based on a June 2012 survey.

North Carolina reported that Kindred Transitional Care and Rehabilitation – Rose Manor, a nursing home in Durham, was assessed a federal Civil Monetary Penalty (CMP) of \$1950 based on an August 2012 survey, and a federal Civil Monetary Penalty (CMP) of \$29,120 based on a January 2007 survey citing Immediate Jeopardy; and Kindred Transitional Care and Rehabilitation – Elizabeth City, a nursing home in Elizabeth City, was assessed a federal Civil Monetary Penalty (CMP) of \$1885 based on a May, 2008 survey.

Texas reported that Kindred Hospital San Antonio was fined \$22,750 based on a February 2008 survey; Kindred Hospital Town and Country was fined \$6550 based on a January 2013 survey; Kindred Hospital Dallas Central was fined \$9000 based on a May 2011 survey, and \$4400 based on a February 2012 survey; and Kindred Rehabilitation Hospital Northeast Houston was fined \$7150 based on a December 2013 survey.

Utah reported that Kindred Nursing and Rehabilitation, a nursing home in St. George, had an enforcement action resolved in September, 2012. The state did not report the survey date or if any monetary fine was imposed.

Wyoming reported that Kindred Transitional Care and Rehabilitation, a nursing home in Cheyenne, had a federal Denial of Payment for New Admissions (DoPNA) imposed for a two week period based on a June, 2008 survey, which was resolved in 2008. The state did not report if any monetary fine was imposed.

A review of all personal qualifying information indicates there is nothing in the background of the board members and officers of both Kindred Healthcare, Inc., and Kindred Healthcare Operating, Inc., to adversely affect their positions on the boards or as officers. The applicant has the appropriate character and competence under Article 36 of the Public Health Law.

## Recommendation

From a programmatic perspective, approval is recommended.

## **Financial Analysis**

## **Operating Budget**

The applicant has submitted operating budgets for the first and third years, in 2015 dollars, which is summarized below:

	Year One	Year Three
Revenues:		
Medicaid Managed Care	\$1,258,786	\$ 1,322,512
Medicare Managed Care	31,751,500	33,228,739
Commercial Managed Care	1,382,871	1,452,879
Commercial Fee-for-Service	3,093,065	3,249,651
Private Pay	<u>44,702</u>	<u>46,965</u>
Total Operating Revenues	\$37,530,924	\$39,300,747
Total Expenses	29,156,444	30,931,126
Net Gain(Loss)	\$8,374,480	\$8,369,621
Visits	215,568	228,033

Utilization by payor source in the first and third years is as follows:

<u>Payor</u>	Year One and Year Three
Commercial Managed Care	3.6%
Commercial Fee-for-Service	11.4 %
Medicare Managed Care	79.6%
Medicaid Managed Care	3.3%
Private Pay	0.1%
Charity Care	2.0%

Expense and utilization assumptions are based on the existing CHHA Program's historical experience. Revenues are reflective of current payment rates as well as the Medicaid Episodic Payment system. The operating costs include all expenditures incurred and to be incurred for management of the 8 QC-Medi New York, Inc. CHHA locations. Kindred Healthcare, Inc. does not anticipate that either legal or consulting services will be required in the ongoing operation of QC-Medi New York, Inc. Should any such services be necessary, they will be furnished by Kindred, with no allocation to QC-Medi New York of the cost of those services. Outside counsel may be retained in the event additional legal services are needed in the development stage of any new or purchased CHHA in New York. Any such engagement would be by Kindred and legal fees incurred would be a Kindred development expense and not a QC-Medi New York, Inc. operating expense.

## **Capability and Feasibility**

There are no project costs associated with this application. The purchase price allocated to the New York entities is \$38,086,770 of which \$37,917,489 is attributable to the CHHAs which is comprised of \$2,085,462 cash, \$8,076,425 stocks and \$27,755,602 assumption of debt. There is no change in program or utilization, but a change in governance.

Working capital requirements for all five CHHAs will be provided from current operations. Any additional working capital will be provided from Kindred Healthcare Inc. BFA Attachment B is the financial summary of Kindred Healthcare Inc. showing sufficient funds.

On October 9, 2014, Kindred issued a press release stating that with the merger of the two companies it would create a Pro Forma with annual revenues of \$7.1 billion and operating income of \$1 billion, and will create earnings and operating cash flows, exclusive of transaction and integration costs. Kindred expects the acquisition to be approximately \$0.40 to \$0.60 accretive to pro forma earnings, and pro forma operating cash flows of \$350 million to \$400 million (before capital expenditures, dividends and changes in working capital), both on a run rate basis, once Gentiva is fully integrated and expected synergies are fully realized in the second full year following the closing. On this same basis, following the combined company's expected annual maintenance capital expenditures of \$120 million to \$130 million, Kindred expects pro forma cash flows (before growth capital expenditures, dividends and changes in working capital) of \$230 million to \$270 million.

The submitted budget projects a net profit of \$8,374,480 and \$8,369,621 during the first and third years, respectively. Medicare and Medicaid reflect prevailing reimbursement methodologies. All other revenues assume current reimbursement methodologies. The budget appears reasonable.

BFA Attachment B is the 2013 certified statements of Kindred Healthcare, Inc. The entity has maintained positive working capital and net assets positions and has experienced a \$36,136,000 net loss from operations. The net operating loss is due to corporate expenses and do not reflect Kindred's ability to maintain operating divisions on a profitable basis going forward.

BFA Attachment C is the 2013 certified statements of Gentiva Health Services, Inc. The entity has maintained positive working capital and net assets positions and has experienced a \$598,507,000 net loss from operations. However, as of June 30, 2014, Gentiva Health Services, Inc. is showing a \$10,497,000 net gain from operations. The 2013 loss was due to one-time asset impairments of more than \$610,000,000 due to corporate expenses rather than direct operating expenses.

Based on the preceding, it appears that the applicant has demonstrated the capability to proceed in a financially feasible manner, and approval is recommended.

## Recommendation

From a financial perspective, approval is recommended.

## **Attachments**

Programmatic Attachment A Before and After Gentiva Organizational Charts

Programmatic Attachment B Kindred Providers / Facilities

Programmatic Attachment C
Programmatic Attachment D
Programmatic Attachment E
Programmatic Attachment E
Programmatic Attachment E
Programmatic Attachment E
Mr. Diaz Affiliations
Mr. Short Affiliations
Kindred Legal Actions

BFA Attachment A Organizational Chart for Kindred and Kindred Operating
BFA Attachment B Financial Summary of Kindred Healthcare, Inc. - 2013

BFA Attachment C Financial Summary of Gentiva Health Services, Inc. - 2013 and unaudited

June 30, 2014

## RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3606 of the Public Health Law, on this 12th day of February, 2015, having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council, and after due deliberation, hereby approves the following application to establish Kindred Healthcare, Inc. and Kindred Healthcare Operating, Inc. as new controlling persons of QC-Medi New York, Inc., the operator of five (5) certified home health agencies, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER</u> <u>APPLICANT/FACILITY</u>

142193 E Kindred Healthcare

## **APPROVAL CONTINGENT UPON:**

- 1. Submission of the executed Amended and Restated Certificate of Incorporation of Gentiva Health Services, Inc., acceptable to the Department. [CSL]
- 2. Submission of the executed Certificate of Merger of Kindred Healthcare Development 2, Inc. with and into Gentiva Health Services, Inc., acceptable to the Department. [CSL]

## **APPROVAL CONDITIONED UPON:**

1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.

Name of Agency: 1<sup>st</sup> Class Care Services, Inc.

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2276-L

## **Description of Project:**

1<sup>st</sup> Class Care Services, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned solely by Monique Merivil.

The Board of Directors of 1st Class Care Services, Inc. comprises the following individual:

Monique Merivil, President/CEO Registered/Licensed Occupational Therapist The Curtis Estabrook School, New York City Department of Education

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 2016 Ralph Avenue, Brooklyn, New York 11234:

Bronx Kings New York Queens Richmond Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Speech-Language Pathology

Medical Social Services Nutrition Homemaker

Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

## Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 2, 2014

Name of Agency: All Heart Homecare Agency, Inc.

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2178-L

## **Description of Project:**

All Heart Homecare Agency, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock, which are owned as follows:

Steven Gershkowitz – 140 Shares Albert Finkelshteyn – 60 Shares

The Board of Directors of All Heart Homecare Agency, Inc. comprises the following individuals:

Steven Gershkowitz, HHA, President Administrator, A Life Saver Home Care Services, Inc.

Albert Finkelshteyn, Vice President

VP of Business Development, A Life Saver Home Care Services, Inc.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

A search of the individual named above on the New York State Home Care Registry revealed that the individual is certified as an HHA and has no convictions or findings.

The applicant proposes to serve the residents of the following counties from an office located at 1425 Kings Highway, 2<sup>nd</sup> Floor, Brooklyn, New York 11229:

New YorkKingsQueensRichmondBronxWestchester

The applicant proposes to provide the following health care services:

NursingHome Health AidePersonal CarePhysical TherapyOccupational TherapyRespiratory TherapySpeech-Language PathologyAudiologyMedical Social Services

Nutrition Homemaker Housekeeper

Medical Equipment, Supplies

and Appliances

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

## Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval November 17, 2014

Name of Agency: Angels of Mercy Counseling Center, Inc.

Address: West Babylon

County: Suffolk

Structure: Not-For-Profit Corporation

Application Number: 2292-L

## Description of Project:

Angels of Mercy Counseling Center, Inc., a not-for-profit corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The Board of Directors of Angels of Mercy Counseling Center, Inc. is comprised of the following individuals:

Michele Butler, HHA – Director Steven Butler – Director Stock Clerk, Amityville USFD

Tanisha Wilson – Program Coordinator Telemarketing & Sales, Pro-Quality

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

A search of the individual named above on the New York State Home Care Registry revealed that the individual is certified as a HHA, and has no convictions or findings.

The applicant proposes to serve the residents of the following counties from an office located at 505 Lakeway Drive, West Babylon, New York:

Nassau Suffolk Queens Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care Physical Therapy Nutrition Homemaker

Housekeeper Occupational Therapy Respiratory Therapy
Speech-Language Pathology Audiology Medical Social Services

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

## Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval January 14, 2015

Name of Agency: A Plus Homecare Agency, Inc.

Address: Woodside County: Queens

Structure: For-Profit Corporation

Application Number: 2272-L

## **Description of Project:**

A Plus Homecare Agency, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned solely by Fei Guo.

The Board of Directors of A Plus Homecare Agency, Inc. is comprised of the following individual:

Fei Guo - President

Marketing Director, Asian Senior Adult Day Care Center

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 49-03 69th Street, Woodside, New York 11377:

Queens Bronx New York Kings Richmond Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Respiratory Therapy Occupational Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

## Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 9, 2014

Name of Agency: Bright Home Care, Inc.

Address: New York County: New York

Structure: Proprietary Corporation

Application Number: 2037L

## **Description of Project:**

Bright Home Care, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

Bright Home Care, Inc. has authorized and issued 200 shares of stock to Yong Jun Kim, MD as the sole shareholder.

The Board of Directors is comprised of the following individuals:

Yong Jun Kim, MD, CEO/Chairman Medical Director/Physician, Yong Jun Kim, MD, PC Medical Director/Physician, Penn Prime Care	Yong Suk Kim, Vice Chairman Business Development, GENY
Kyung Uk Kung, Secretary Assistant Manager: International Healthcare Manager, Yong Jun Kim, MD, P.C.	Emily Shim, Treasurer Manager/Biller, Seoul Pain Clinic
Kyoungmee Kim, RN, FNP, Administrative FNP, Penn Prime Clinic ER/ASU, Flushing Hospital Medical Center	Vasati Sankar-Deonarine, RN, Director of Patient Services RN, Prime Staffing RN, Promed Advanced Medical Staffing Company

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department and the Office of Professional Medical Conduct indicates no issues with the licenses of the medical professionals associated with this application.

The applicant confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and concluded that proceeding with the proposal is appropriate

The applicant proposes to serve the residents of the following counties from an office located at 33-37 Farrington Street, Suite #3, Flushing, New York 11354.

New York Kings Queens
Bronx Richmond Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Medical Social Services

Speech-Language Pathology Nutrition Homemaker

Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### <u>Contingency</u>

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval

Date:

Name of Agency: Central Westchester Home Health Services, LLC

Address: Port Chester County: Westchester

Structure: Limited Liability Company

Application Number: 2266-L

## Description of Project:

Central Westchester Home Health Services, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The proposed membership of Central Westchester Home Health Services comprises the following individuals:

Yemisi Akintola-Okunoye, RN – 50% Chief Executive Manager Registered Nurse, Montefiore Medical Center

Segun Okunoye – 50% Assistant Manager Management Analyst, Westchester County Department of Health

A search of the individuals named above reveal no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of Professions of the State Education Department indicates no issues with the licenses of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following county from an office located at 15 Nella Lane, Port Chester, New York 10573:

Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

## Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval January 6, 2015

Name of Agency: Chinatown Home Health Care, Inc.

Address: New York County: New York

Structure: For-Profit Corporation

Application Number: 2268-L

## Description of Project:

Chinatown Home Health Care, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned as follows: Jie Li owns 100 shares and Yue Lam owns 100 shares.

The Board of Directors of Chinatown Home Health Care, Inc. is comprised of the following individuals:

Jie Li, Chief Executive Officer Yue Lam, Vice President

Administration-Wellcare Health Plan Administrator-Chinatown Senior Service, Inc.

Coordinator-Home Family Care

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 90 Ludlow Street, 2<sup>nd</sup> Floor, New York, New York 10002:

New York Bronx Kings Queens Richmond Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Respiratory Therapy Occupational Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval January 9, 2015

## Ciambella Home Care, Inc. d/b/a FirstLight Home Care of East Buffalo

Deferred at the Department's Request

Name of Agency: Comprehensive Elder Care, LLC

Address: Flushing County: Queens

Structure: Limited Liability Company

Application Number: 2218-L

#### **Description of Project:**

Comprehensive Elder Care, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The sole member of Comprehensive Elder Care, LLC is:

Brian Rosenman, MBA – 100% Real Estate Broker Asset Manager, Woodman Enterprise, LLC

#### Affiliations:

Operator, Sutton Gardens Senior Living (2010 – Present) Receiver, Kelly's Home for Adults (2011 – Present) Receiver, Birchwood Rest Home (2014 – Present)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Bureau of Professional Credentialing has indicated that Brian Rosenman, holds a Real Estate Broker license in good standing and disciplinary action has never been taken against this individual or his license.

The applicant proposes to serve the residents of the following counties from an office located at 147-02 34th Avenue, Flushing, New York 11354:

Bronx Kings Queens Richmond New York Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Medical Social Services

Nutrition Homemaker Housekeeper

A 7 year review of the operations of the following adult care facilities was performed as part of this review. The Adult Care Facility Policy and Surveillance unit has indicated the following:

Sutton Gardens Senior Living was fined two thousand dollars (\$2,000.00) pursuant to a stipulation and order dated November 21, 2012 for surveillance findings of June 9, 2011 and August 25, 2011. Deficiencies were found under 18 NYCRR 487.8(e)(1) Food Service.

Kelly's Home for Adults was fined thirty thousand dollars (\$30,000.00) pursuant to a stipulation and order dated February 6, 2014 for surveillance findings of September 8, 2011, September 20, 2012, January 27, 2013 and October 10, 2013. Deficiencies were found under 18 NYCRR 487.4(a) Admission Standards, 487.6(a)(1) Resident Funds and Valuables, 487.7(g)(1)(i) Resident Services, 487.7(h)(1) Resident Services, 487.11(f)(19) Smoke/Fire Protection,

487.11(i)(11-12) Environmental Standards, 487.11(j)(1-3) Environmental Standards, 487.11(k)(4) Environmental Standards, 487.11(k)(5) Environmental Standards, 487.11(f)(19) Smoke/Fire Protection and for 487.11(j)(1-3) Housekeeping.

Kelly's Home for Adults was fined one thousand five hundred dollars (\$1,500.00) pursuant to stipulation and order dated October 22, 2014 for surveillance findings of October 10, 2013 and March 4, 2014. Deficiencies were found under 18 NYCRR 487.11(f)(10) Environmental Standards, 487.11(i)(11-12) Environmental Standards and 487.11(k)(5) Environmental Standards.

The information provided by the Division of Assisted Living has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 9, 2014

Name of Agency: Elite Home and Community Care Service, Inc.

Address: New City County: Rockland

Structure: For-Profit Corporation

Application Number: 2285-L

#### **Description of Project:**

Elite Home and Community Care Service, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned solely by Gharyea Wegee.

The Board of Directors of Elite Home and Community Care Service, Inc. is comprised of the following individuals:

Gharyea Wegee, RN – President/Secretary Administrator/Supervisor – Elite Home Care Services, Inc. Registered Nurse – Montefiore Medical Center Long Term Home Health Agency

Steve Karpeh, LPN – Vice-President/Treasurer Licensed Practical Nurse – Pine Valley Rehab and Nursing Center

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the licenses of the healthcare professionals associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 6 Zabela Drive, New City, New York 10956:

Rockland Putnam Westchester Orange Bronx

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Respiratory Therapy Occupational Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval January 7, 2015

Name of Agency: Ellison Home Care Companion Agency, Inc.

Address: Brentwood County: Suffolk

Structure: For-Profit Corporation

Application Number: 2254-L

#### **Description of Project:**

Ellison Home Care Companion Agency, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned as follows: Shirley Ellison owns 60 shares. Cedric Ellison owns 40 shares. The remaining 100 shares are unissued.

The Board of Directors of Ellison Home Care Companion Agency, Inc. comprises the following individuals:

Shirley Ellison, President

Executive Director, Ellison Home Care Companion Agency, Inc.

Cedric Ellison, Secretary/Treasurer Director, MTA Transit

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 147 West Orange Street, Brentwood, New York 11717:

Nassau Westchester Rockland Queens Suffolk

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 18, 2014

Name of Agency: Grupp II, Inc. Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2247-L

#### **Description of Project:**

Grupp II, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned solely by Aleksandr Vaysblat.

The Board of Directors of Grupp II, Inc. comprises the following individuals:

Aleksandr Vaysblat, President President, Grupp II, Inc. Director of Operations, Light 101, Inc.

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 1954 78th Street, Brooklyn, New York 11214:

Bronx New York Kings Richmond Queens Westchester

The applicant proposes to provide the following health care services:

NursingHome Health AidePersonal CarePhysical TherapyOccupational TherapyRespiratory TherapySpeech-Language PathologyAudiologyMedical Social Services

Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval November 3, 2014

Name of Agency: Guiding Angels Home Care, LLC

Address: Jamaica County: Queens

Structure: Limited Liability Company

Application Number: 2152-L

#### **Description of Project:**

Guiding Angels Home Care, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The sole member of Guiding Angels Home Care, LLC is:

Yolanda Vitulli, RN, 100% President, Guiding Angels Home Care, LLC Founder/CEO, Tender Care Human Services, Inc.

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 92-21 165<sup>th</sup> Street, Jamaica, New York 11433:

Bronx New York Queens Kings Richmond Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Speech-Language Pathology

Medical Social Services Nutrition Homemaker

Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval October 31, 2014

Name of Agency: Home at Last Home Care Services, LLC

Address: Brooklyn County: Kings

Structure: Limited Liability Company

Application Number: 2138-L

#### Description of Project:

Home at Last Home Care Services, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The sole member of Home at Last Home Care Services, LLC is as follows:

Cynthia V. Simpson, 100% HHA, Blue Bird Home Care HHA, All City Care

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 418 Bleecker Street, #3L, Brooklyn, New York 11237:

Kings Queens New York

Bronx Richmond

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Medical Social Services

Speech Language Pathology Homemaker Housekeeper

Nutrition

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingeny

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: November 4, 2014

Name of Agency: Human First Community Health Care, LLC

Address: Lynbrook County: Nassau

Structure: Limited Liability Company

Application Number: 2175-L

#### **Description of Project:**

Human First Community Health Care, LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The sole member of Human First Community Health Care, LLC is Human First, Inc., a not-for-profit corporation.

The Board of Directors of Human First, Inc. comprises the following individuals:

Sharon Jones, RN, President Sr. Physician Referral Service Nurse, NYU Langone Medical Center

Fadia Zahrieh, Treasurer Homemaker/Care Provider for an Autistic Child

Audrey Jackman-Wesson, Secretary
Permit Manager, NYC Department of Transportation

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 128 Atlantic Avenue. Lynbrook. New York 11563:

Nassau Suffolk Queens

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Speech-Language Pathology

Medical Social Services Nutrition Homemaker

Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: October 31, 2014

Name of Agency: La'Dorch Homecare, Inc.

Address: Staten Island County: Richmond

Structure: For-Profit Corporation

Application Number: 2215-L

#### **Description of Project:**

La'Dorch Homecare, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned solely by Ruslan Braginskiy.

The members of the Board of Directors of La'Dorch Homecare, Inc. comprises the following individual:

Ruslan Braginskiy, HHA, President Financial Associate, Blackrock, Inc. (2004 – 2012) Administrator, Sincere Care Agency (2007 – 2010)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The New York State Home Care Registry indicates no issues with the certification of the Home Health Aide associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 87 Alan Loop, Staten Island, New York 10304:

Bronx Kings Queens
Richmond New York Westchester

The applicant proposes to provide the following health care services:

NursingHome Health AidePersonal CarePhysical TherapyOccupational TherapyRespiratory TherapySpeech-Language PathologyAudiologyMedical Social Services

Nutrition Homemaker Housekeeper

Medical Equipment, Supplies

and Appliances

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval November 25, 2014

Name of Agency: Marabi Homecare Agency, Inc.

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2261-L

#### **Description of Project:**

Marabi Homecare Agency, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned solely by Marina Rabinovich.

The Board of Directors of Marabi Homecare Agency, Inc. comprises the following individual:

Marina Rabinovich – President Attorney/President, Law Offices of Marina Rabinovich

#### Affiliations:

MR Homecare Agency of NY, Inc. (2012 – Present)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 2698 East 66<sup>th</sup> Street, Brooklyn, New York 11234:

New YorkKingsQueensRichmondBronxNassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Respiratory Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Medical Supplies, Equipment

and Appliances

The information provided by the Division of Home and Community Based Services has indicated that MR Homecare Agency of NY, Inc. has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

A Certificate of Good Standing has been received for the attorney associated with this application.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: November 28, 2014

Name of Agency: Masih Home Care Incorporated

Address: South Richmond Hill

County: Queens

Structure: For-Profit Corporation

Application Number: 2274-L

#### Description of Project:

Masih Home Care Incorporation, a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned solely by Mana Masih.

The Board of Directors of Masih Home Care Incorporated is comprised of the following individuals:

Mana Masih, RN – President Yasmin Masih - Treasurer

RN, Good Shepherd Hospice Unemployed

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 94-36 114<sup>th</sup> Street, South Richmond Hill, New York 11419:

Queens Kings Richmond New York Bronx Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care Physical Therapy Occupational Therapy Nutrition

Speech-Language Pathology Housekeeper Medical Social Services

Homemaker

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: November 12, 2014

Name of Agency: MY Care Health Services, Inc.

Address: Fresh Meadows

County: Queens

Structure: For-Profit Corporation

Application Number: 2202-L

#### **Description of Project:**

MY Care Health Services, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock, which are owned solely by Vandana Behl-Malhotra.

The members of the Board of Directors of MY Care Health Services, Inc. comprises the following individual:

Vandana Behl-Malhotra, RN

Hospice Nurse, Hospice Care Network

Patient Service Coordinator, Cold Spring Hills Center for Nursing and Rehabilitation

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 192-20C 67<sup>th</sup> Avenue, Apt. 1A, Fresh Meadows, New York 11365:

QueensBronxKingsNew YorkRichmondNassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Physical Therapy Occupational Therapy Speech-Language Pathology

Medical Social Services Nutrition Homemaker

Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval October 31, 2014

Name of Agency: New Hope Services, Inc.

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2244-L

#### **Description of Project:**

New Hope Services, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned solely by Natalya Epshteyn.

The Board of Directors of New Hope Services, Inc. comprises the following individual:

Natalya Epshteyn, HHA President, New Hope Services, Inc.

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The New York State Home Care Registry indicates no issues with the certification of the healthcare professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 175 Ardsley Loop, Apt. 4A, Brooklyn, New York 11239:

Bronx New York Kings

Richmond Queens Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care
Physical Therapy Occupational Therapy Respiratory Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval November 5, 2014

Name of Agency: NMC Homecare Agency of NY, Inc.

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2259-L

#### **Description of Project:**

NMC Homecare Agency of NY, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned solely by Natalya Chornaya.

The Board of Directors of NMC Homecare Agency of NY, Inc. comprises the following individual:

Natalya Chornaya, RN, President RN, Mount Sinai Beth Israel

#### Affiliations:

NC Homecare Agency of NY, Inc. (2011 – Present) Unihelp Homecare, Inc. (2008 – 2009)

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 155 Oceana Drive, Apartment 2C, Brooklyn, New York 11235:

New York Kings Queens
Richmond Bronx Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care
Physical Therapy Occupational Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Medical Supplies, Equipment and Appliances

The information provided by the Division of Home and Community Based Services has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval November 19, 2014

Name of Agency: Augusta Osinowo

d/b/a Nightingale Care Services

Address: Brooklyn County: Kings

Structure: Sole Proprietor

Application Number: 2176-L

#### **Description of Project:**

Augusta Osinowo, d/b/a Nightingale Care Services, a sole proprietorship, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The sole proprietor of Augusta Osinowo d/b/a Nightingale Care Services is the following individual:

Augusta Osinowo, RN, Sole Owner/Operator RN Field Supervisor, Best Care, Inc.

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department indicates no issues with the licensure of the health professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 17 Paerdegat 7<sup>th</sup> Street, Brooklyn, New York 11236:

Bronx New York Kings Queens Richmond Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care
Physical Therapy Occupational Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 1, 2014

Name of Agency: Passion for Seniors of NY, Inc.

Address: Kew Gardens

County: Queens

Structure: For-Profit Corporation

Application Number: 2157-L

#### **Description of Project:**

Passion for Seniors of NY, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares of stock which are owned as follows: Bipin Nirola owns 100 Shares and Reema Nirola owns 100 Shares.

The Board of Directors of Passion for Seniors of NY, Inc. comprises the following individuals:

Bipin Nirola, President

Owner/President, Passion for Seniors, LLC d/b/a Seniors Helping Seniors (2007 - Present)

Reema Nirola, CNA, Vice President

Nursing Assistant

Owner/Vice President, Passion for Seniors, LLC d/b/a Seniors Helping Seniors (2007 - Present)

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to serve the residents of the following counties from an office located at 119-40 Metropolitan Avenue, CU2, Suite 107, Kew Gardens, New York 11415:

Bronx Kings New York Queens Richmond Nassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care
Physical Therapy Occupational Therapy
Speech-Language Pathology Audiology Medical Social Services

Nutrition Medical Equipment and

Supplies

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval January 7, 2015

Name of Agency: Premium Home Services LLC

Address: Rockaway Park

County: Queens

Structure: Limited Liability Company

Application Number: 2299-L

#### Description of Project:

Premium Home Services LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The proposed membership of Premium Home Services LLC comprises the following individuals:

Manana Zaft, HHA – 50% Case Manager/Coordinator – Scharome Cares President – M&T Consulting NY, Inc.

Tamari Chikvaidze – 50% Marketing Manager/Coordinator-Signature Care Vice-President – M&T Consulting NY, Inc.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

A search of the New York State Home Care Registry revealed that the Home Health Aid (HHA) is certified as a HHA with no convictions or findings.

The applicant proposes to serve the residents of the following counties from an office located at 103-00 Shore Front Parkway #7H, Rockaway Park, New York: 11694:

QueensBronxRichmondKingsNew YorkNassau

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval January 9, 2015

Name of Agency: Scope Healthcare Services, Inc.

Address: Melville County: Suffolk

Structure: For-Profit Corporation

Application Number: 2279-L

#### **Description of Project:**

Scope Healthcare Services, Inc., a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The applicant has authorized 200 shares, which are owned as follows: Deren Karakaplan owns 160 shares. The remaining 40 shares are unissued.

The Board of Directors of Scope Healthcare Services, Inc. comprises the following individuals:

Deren Karakaplan, President/Chairman Executive Director, Guiding Pathways, Inc.

Rachel R. Silverberg, RN, Vice President/Secretary
Certified Legal Nurse Consultant
Director of Resident Services, The Bristal at East Northport (2011 – 2012)

Ajaz U. Siddiqui, Treasurer Senior Accountant/Accounting Officer, Bank Hapoalim (2000 – 2013)

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 68 South Service Road, Suite 100, Melville, New York 11747:

Suffolk Nassau Queens

The applicant proposes to provide the following health care services:

Nursing Personal Care

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 4, 2014

Name of Agency: Global Private Home Care LLC

Address: Kew Gardens

County: Queens

Structure: Limited Liability Company

Application Number: 2163-L

#### **Description of Project:**

Global Private Home Care LLC, a limited liability company, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

The members of Global Private Home Care LLC are as follows:

Terence Kerrigan – 50% Owner/Trainer, Terry Kerrigan Performance, LLC

Tiffany C. Italiano, RN, BSN – 50% Private Duty Nurse, Private Duty, LLC

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The State of New York Office of the Professions of the State Education Department indicates no issues with the license of the health care professional associated with this application.

The State of New Jersey Department of Law and Public Safety, Division of Consumer Affairs indicates no issues with the license of the health care professional associated with this application.

The applicant proposes to serve the residents of the following counties from an office located at 119-40 Metropolitan Avenue, Suite 111, Kew Gardens, New York 11415:

Bronx Kings New York Queens Richmond Nassau

The applicant proposes to provide the following health care services:

NursingHome Health AidePersonal CarePhysical TherapyOccupational TherapyRespiratory TherapySpeech-Language PathologyAudiologyMedical Social Services

Nutrition Medical Supplies, Equipment and Appliances

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval February 3, 2015

Name of Agency: Alice Hyde Medical Center

Address: Malone
County: Franklin
Structure: Not-For-Profit

Application Number: 2461L

#### Description of Project:

Alice Hyde Medical Center, a not-for-profit corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

This application amends and supersedes application number 1755L which was approved by the Public Health and Health Planning Council at July 2009 meeting. This LHCSA will be associated with Alice Hyde Medical Center Assisted Living Program.

The Board of Directors of Alice Hyde Medical Center is comprised of the following individuals:

Daniel E. Clark – Chair

President/Owner, King-Clark Co., Inc. Co-Owner, Broker, North Country Realty

Co-Owner, Adirondack Quarry Co-Owner, Rainbow Quarries, Inc.

Dean F. Johnston, CPA – Treasurer Craig E. LaVigne – Secretary

Chief Operating Officer, Citizen Advocates, Inc. Owner/Operator, Craig, Inc. (tax preparation)

Brian J. Monette - Vice Chair

Rev. William J. Bond - Member

Sharon O. Noreault - Member

**United Methodist Church** 

Vice President, Adirondack Energy Products, Inc.

Pastor, Upper New York Conference, Centenary

Anjni Bhagat, M.D. – Member

Private Practice, Main Street Medical Group

Affiliations:

Member, Alice Hyde Nursing Home

Wayne R. Duso – Member Jerry E. Griffin – Member

Management Consultant, Elbow Street Consulting, Superintendent, Malone Central School District

Inc.

Bryan J. Hughes, Esq. – Member Benson J. Kelly, M.D. – Member

Senior Partner, Bryan J. Hughes, P.C/ Physician, St. Regis Mohawk Health Services

Paul F. Koehler, Registered Pharmacist – Member

Registered Pharmacist, Kinney Drugs, Inc. Retired

The Office of the Professions of the State Education Department, the New York State Physician Profile and the Office of Professional Medical Conduct, where appropriate, indicate no issues with the licensure of the health professionals associated with this application.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant has confirmed that the proposed financial/referral structure has been assessed in light of anti-kickback and self-referral laws, with the consultation of legal counsel, and it is concluded that proceeding with the proposal is appropriate.

The applicant proposes to serve the residents of the Franklin County from an office located at 133 Park Street, Malone, New York 12953.

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care Occupational Therapy
Audiology Physical Therapy Respiratory Therapy Speech Language Pathology
Housekeeper Homemaker Nutrition Medical Social Services

A 7 year review of the operations of the following facilities was performed as part of this review (unless otherwise noted):

- Alice Hyde Medical Center
- Alice Hyde Nursing Home

The information provided by the Division of Hospitals and Diagnostic & Treatment Centers has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The Information provided by the Bureau of Quality Assurance for Nursing Homes has indicated that the residential health care facilities reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 31, 2014

Name of Agency: Hyde Park Assisted Living Facility, Inc.

d/b/a Hyde Park Licensed Home Care Agency

Address: Hyde Park County: Dutchess

Structure: Business Corporation

Application Number 2295-L

Hyde Park Assisted Living Facility, Inc., d/b/a Hyde Park Licensed Home Care Agency, a business corporation, requests approval to obtain licensure as a home care services agency under Article 36 of the Public Health Law.

James K. Rogers is the sole shareholder of Hyde Park Assisted Living Facility, Inc. Hyde Park Licensed Home Care Agency will be affiliated with an Assisted Living Program known as Hyde Park Assisted Living Program.

The applicant authorized 200 shares of stock of which 100 shares will be issued to James K. Rogers, RN. 100 shares of stock will remain unissued.

The Board of Directors of Hyde Park Assisted Living Facility, Inc. comprises of the following individual:

James K. Rogers, RN – President Assistant Administrator/New Haven Manor

Affiliation:

Crystal House Manor/Adult Home 2004 - present

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Office of the Professions of the State Education Department and the Office of Professional Medical Conduct, where appropriate, indicates no issues with the license of the medical professional associated with this application.

A 7 year review of the operations of the following facility was performed as part of this review (unless otherwise noted):

• Crystal House Manor (Adult Home)

Crystal House Manor was fined \$5,000.00 for deficiencies cited pursuant to a stipulation and order dated August 22, 2011 for surveillance findings found on February 10, 2009, May 29, 2009, December 23, 2009 and on March 22, 2010. Deficiencies were found under 18 NYCRR 487.4(f) - Admission Standards and 18 NYCRR 487.8(c) - Food Service.

The applicant proposes to serve the residents of Dutchess County from an office located at 394 Violet Avenue, Hyde Park, New York 12538.

The applicant proposes to provide the following health care services:

Nursing Personal Care Aide Housekeeper

The information provided by the Division of Assisted Living has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### **Contingency**:

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: January 12, 2015

Name of Agency: Acare HHC, Inc. d/b/a Four Seasons Home Care

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2319-L

#### Description of Project:

Acare HHC, Inc. d/b/a Four Seasons Home Care, a business corporation, requests approval for a change in ownership of a licensed home care services agency under Article 36 of the Public Health Law.

Acare HHC, Inc. was previously approved as a home care services agency by the Public Health Council at its May 2, 2008 meeting and subsequently licensed as 1635L001.

Acare Acquisition, LLC acquired a nine and nine-tenths percent (9.9%) interest in Acare HHC, Inc. effective as of April 1, 2013. The purpose of this proposal is for Acare Acquisition, LLC to acquire the remaining ninety and one-tenth percent (90.1%) interest in Acare HHC, Inc.

Acare Acquisition, LLC proposes to become the sole stockholder of Acare HHC, Inc. d/b/a Four Seasons Home Care and will own all 200 shares of authorized stock.

The Board of Directors of Acare HHC, Inc. d/b/a Four Seasons Home Care is comprised of the following individuals:

Rachel Friedman – Vice President/Director Unemployed

Caroline L. Rich, NHA – Secretary/Treasurer/Director Chief Operating Officer, Four Seasons Nursing and Rehabilitation Center

#### Affiliations:

• Renaissance Home Health Care

Barry Friedman – President/Director

Chief Executive Officer, Parkshore Health Care LLC d/b/a Four Seasons Nursing & Rehabilitation Center Chief Executive Officer, Four Seasons Dialysis LLC d/b/a Gateway Dialysis Center Chief Executive Officer, Parkshore Home Health Care, LLC d/b/a Renaissance Home Health Care

#### Affiliations:

- Parkshore Health Care LLC d/b/a Four Seasons Nursing & Rehabilitation Center
- Four Seasons Dialysis LLC d/b/a Gateway Dialysis Center
- Parkshore Home Health Care, LLC d/b/a Renaissance Home Health Care

The sole member of Acare Acquisition, LLC is:

Barry Friedman – Member (Previously Disclosed)

Caroline Rich, NHA License # 04996 holds a NHA license in good standing and the Board of Examiners of Nursing Home Administrators has never taken disciplinary action against this individual or her license.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

A seven year review was conducted for the following healthcare facilities:

- Four Seasons Dialysis LLC d/b/a Gateway Dialysis Center
- Parkshore Health Care LLC d/b/a Four Seasons Nursing and Rehabilitation Center
- Parkshore Home Health Care, LLC d/b/a Renaissance Home Health Care

The information provided by the Division of Home and Community Based Services has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The information provided by the Division of Hospitals and Diagnostic & Treatment Centers has indicated that the applicant has provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The Information provided by the Bureau of Quality Assurance for Nursing Homes has indicated that the residential health care facilities reviewed have provided sufficient supervision to prevent harm to the health, safety and welfare of residents and to prevent recurrent code violations.

The applicant proposes to continue to serve the residents of the following counties from an office located at 1222 East 96th Street, Brooklyn, New York 11236:

Bronx Kings Nassau New York

Queens Richmond

The applicant proposes to continue to provide the following health care services:

Nursing Home Health Aide Medical Social Services Personal Care

Occupational Therapy Physical Therapy Speech-Language Pathology

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 23, 2014

# Anchor Home Care LLC Deferred at the Department's Request

Name of Agency: Crown of Life Care NY, LLC

Address: Brooklyn County: Kings

Structure: Limited Liability Company

Application Number: 2389-L

#### Description of Project:

Crown of Life Care NY, LLC, a limited liability company, requests approval for a change in ownership of a licensed home care services agency under Article 36 of the Public Health Law.

Crown of Life Care, Inc. was previously approved as a home care services agency by the Public Health Council at its May 16, 2003 meeting and subsequently licensed 1180L001. At that time it was owned as follows: Gussie Halyard – 70 Shares, Edward Blocker – 15 Shares and Bunny Lower – 15 Shares.

The proposed members of Crown of Life Care NY, LLC comprise the following individuals:

Toby Kahan, Owner – 95% Caroline Nonan, RN, Owner – 5%

Homemaker VP of Clinical Operations, Gemini Quality Care, Inc.

The Office of the Professions of the State Education Department indicate no issues with the licensure of the health professional associated with this application.

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The applicant proposes to continue to serve the residents of the following counties from an office located at 5308 13<sup>th</sup> Avenue, Suite 236, Brooklyn, New York 11219.

Bronx Kings Nassau New York

Queens Richmond

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care Medical Social Services
Occupational Therapy Respiratory Therapy Audiology Speech-Language Pathology

Physical Therapy Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval October 31, 2014

Name of Agency: Elite HHC, LLC

Address: Brooklyn County: Kings

Structure: Limited Liability Company

Application Number: 2342-L

#### **Description of Project:**

Elite HHC LLC, a limited liability company, requests approval for a change in ownership of a licensed home care services agency under Article 36 of the Public Health Law.

Elite Home Services, LLC was previously approved as a home care services agency by the Public Health and Health Planning Council at its August 4, 2011 meeting and subsequently licensed 1806L001. At that time it was owned as follows: Diane Schottenstein – sole member.

The sole member of Elite HHC, LLC is:

Gershon Strasser , NHA – Managing Member/President Director of Operations, Dry Harbor HRF, Inc.

A search of the individual named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Bureau of Professional Credentialing has indicated that Gershon Strasser NHA license #05524 holds a NHA license in good standing and the Board of Examiners of Nursing Home Administrators has never taken disciplinary action against this individual or his license.

The applicant proposes to serve the residents of the following counties from an office located at 2050 57<sup>th</sup> Street, Brooklyn, New York 11204:

Bronx Kings New York Queens

Richmond Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care Medical Social Services
Occupational Therapy Respiratory Therapy Audiology Speech-Language Pathology

Physical Therapy Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 17, 2014

Name of Agency: Prestige LHCSA Management, Inc.

Address: Brooklyn County: Kings

Structure: For-Profit Corporation

Application Number: 2401-L

#### Description of Project:

Prestige LHCSA Management, Inc., a business corporation, requests approval for a change in ownership of a licensed home care services agency under Article 36 of the Public Health Law.

AZA Home Health Care, LLC d/b/a Hand in Hand Together Homecare was previously approved as a home care services agency by the Public Health and Health Planning Council at its August 4, 2011 meeting and subsequently licensed 1722L001. At that time it was owned as follows: Amy Monroe – 100% Membership. Through a Purchase Agreement, Amy Monroe will sell the company and will no longer be affiliated with the LHCSA.

The applicant has authorized 200 shares of stock which are owned as follows:

David Modnyy – 100 Shares Diana Nabitovsky – 100 Shares

The proposed Board of Directors of Prestige LHCSA Management, Inc. comprises the following individuals:

David Modnyy – Chairman/Treasurer

Administrator, Hand in Hand Together Home Care

Diana Nabitovsky – Vice Chairman/Secretary

Assistant Administrator and Human Resources

Director, Hand in Hand Together Home Care

A search of the individuals named above revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

AZA Home Health Care, LLC has entered into a management agreement with Prestige LHCSA Management, Inc. which was approved by the Department of Health on November 17, 2014.

The applicant proposes to continue to serve the residents of the following counties from an office located at 672 Britton Avenue, Staten Island, New York 10304.

Bronx Kings New York Queens

Richmond Westchester

The applicant proposes to provide the following health care services:

Nursing Home Health Aide Personal Care Medical Social Services
Occupational Therapy Respiratory Therapy Audiology Speech-Language Pathology

Physical Therapy Nutrition Homemaker Housekeeper

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

Recommendation: Contingent Approval Date: December 3, 2014

Name of Agency: Quality Care – USA, Inc.

d/b/a Gentiva Health Services

Address: Merrick County: Nassau

Structure: For-Profit Corporation

Application Number: 2556-L

#### Description of Project:

Quality Care – USA, Inc. d/b/a Gentiva Health Services, a business corporation with a corporate office in Merrick, NY, requests approval for a change in ownership of four (4) licensed home care services agencies under Article 36 of the Public Health Law.

Quality Care – USA, Inc. d/b/a Gentiva Health Services was previously approved as a home care services agency by the Public Health Council at its March 18, 1994 meeting and subsequently licensed as 9511L040, 9511L001, 9511L022 and 9511L027.

A separate CHHA CON application has been submitted as 142193-E for the five (5) QC-Medi New York, Inc., d/b/a Gentiva Health Services CHHAs, which are located in Ballston Spa, Liverpool (with branch offices in Auburn and Oswego), Corning, Westbury, and Hauppauge (with a sub-unit in Riverhead).

The direct corporate operator of the four (4) LHCSAs will remain Quality Care - USA, Inc., d/b/a Gentiva Health Services, the parent corporation will remain Gentiva Health Services Holding Corporation, the grandparent corporation will remain Gentiva Health Services, Inc., as was previously approved by both the Public Health Council. However, the new incoming great-grandparent corporation and controlling entity will now be Kindred Healthcare Operating, Inc., and the new incoming great-great-grandparent corporation and ultimate controlling entity will now be Kindred Healthcare, Inc. (See Programmatic Attachment A – Before and After Organizational Charts)

Kindred Healthcare Operating, Inc., a proprietary business corporation, is a wholly owned subsidiary of Kindred Healthcare, Inc. Kindred Healthcare, Inc. owns 100% of the stock of Kindred Healthcare Operating, Inc. Kindred Healthcare, Inc., a publicly-traded proprietary business corporation, is authorized to issue 176,000,000 shares of capital stock, consisting of 175,000,000 shares of common stock and 1,000,000 shares of preferred stock, both with par value of \$0.25 per share. The applicant confirms in writing that no stockholder (either natural person or business entity) owns 10% or more of the stock of Kindred Healthcare, Inc.

Kindred Healthcare, Inc., operates over 360 health care facilities and providers in 38 states. The complete list of affiliated health care facilities and providers, by provider type and by state, has been included in the application and a copy is attached (see Programmatic Attachment B – Kindred Providers / Facilities). All facilities and providers listed are therefore affiliated with each board member, and each officer, named below. Since there are no stockholders owning 10% or more of the publicly traded stock of Kindred Healthcare, Inc., there are no principal stockholders to disclose below.

The Board of Directors of Kindred Healthcare, Inc. comprises the following individuals:

Phyllis Yale, Chairperson Advisory Partner, Bain and Company, Inc. (Management Consulting) Additional Affiliations: National Surgical Healthcare, Inc. (see Programmatic Attachment C - Ms. Yale Affiliations for list of ambulatory surgical center providers); Blue Cross and Blue Shield of Massachusetts (Health Benefits Provider)	Thomas Cooper, MD (AL, AZ, FL, IN, LA, MN, MO, NY, OK, OR, TX, VA, WA, WI), Vice-Chairperson Retired Founder and Vice Chairman, Vericare Management, Inc. (RHCF Management Contractor)
Joel Ackerman Chief Executive Officer, Champions Oncology, Inc. (Oncology Drug Development and Services)	Jonathan Blum Senior Vice President / Chief Public Affairs Officer / Chief Global Nutrition Officer, Yum! Brands, Inc. (Restaurants)
Paul Diaz Chief Executive Officer, Kindred Healthcare, Inc. Additional Affiliations: DaVita Healthcare Partners, Inc. (ESRD providers located both in NYS and out of state - see Programmatic Attachment D – Mr. Diaz Affiliations for list of NYS ESRD Centers operated by Liberty RC, Inc., and Knickerbocker Dialysis, Inc. both of which DaVita Healthcare Partners, Inc., is the 100% sole stockholder)	Heyward Donigan President / Chief Executive Officer, ValueOptions, Inc. (Health Care Benefits Administrator)
Richard Goodman, PhD Retired Executive Vice President – Global Operations / Chief Financial Officer, PepsiCo, Inc.	Christopher Hjelm Senior Vice President / Chief Information Officer, The Kroger Company (Retail Grocery, Department, Convenience, Jewelry, and Pharmacy Stores)
Frederick Kleisner, Gaming Licensure granted in IN, LA, MO, NJ, OH, Ontario, Canada, and Ak-Chin Tribe AZ; pending in AZ, CA, NY, PA, Cherokee Tribe NC, National Indian Gaming Commission DC, and Rincon Tribe CA. Retired Chief Executive Officer, Morgan's Hotel Group (Luxury Hotels)	John Short, PhD Retired Executive Board Chairman, Vericare Management, Inc. (RHCF Management Contractor) Additional Affiliations: Seton Family of Health Care Facilities / Providers in Texas (see Programmatic Attachment E – Mr. Short Affiliations for list of Seton providers); Wellpoint, Inc. (Health Care Benefits Company)

Additional officers of Kindred Healthcare, Inc., who are not members of the Board of Directors listed above, are as follows:

William Altman, Esq. (DC)	Michael Beal, LNHA (ME and NH)
Executive Vice President – Strategy, Policy, and	President - Nursing Center Division, Kindred
Integrated Care, Kindred Healthcare, Inc.	Healthcare, Inc.

Benjamin Breier President / Chief Operating Officer, Kindred Healthcare, Inc.	Stephen Farber Executive Vice President / Chief Financial Officer, Kindred Healthcare, Inc.
Stephen Cunanan Chief People Officer, Kindred Healthcare, Inc.	Patricia Henry, Speech Language Pathologist (TX) Executive Vice President / President of RehabCare Division, Kindred Healthcare, Inc.
Joseph Landenwich, Esq. (KY), CPA (KY), Corporate Secretary Co-General Counsel, Kindred Healthcare, Inc.	Steven Monaghan President – Hospital Division, Kindred Healthcare, Inc.
Mary Suzanne Riedman, Esq. (CA) General Counsel / Chief Diversity Officer, Kindred Healthcare, Inc.	Jon Rousseau President – Care Management Division, Kindred Healthcare, Inc.

The governing bodies of Kindred Healthcare Operating, Inc., and of Gentiva Health Services, Inc., are identical, and consist of the following members of the Board of Directors:

Douglas Cornutte, CPA (KY) Senior Vice President – Corporate Development, Kindred Healthcare, Inc.	Stephen Cunanan Chief People Officer, Kindred Healthcare, Inc. (Disclosed above)
Joseph Landenwich, Esq. (KY), CPA (KY), Corporate Secretary Co-General Counsel, Kindred Healthcare, Inc. (Disclosed above)	

Additional officers of both Kindred Healthcare Operating, Inc., and of Gentiva Health Services, Inc., who are not members of the Board of Directors listed above, are also identical as follows:

William Altman, Esq. (DC) Executive Vice President – Strategy, Policy, and Integrated Care, Kindred Healthcare, Inc. (Disclosed above)	Benjamin Breier President / Chief Operating Officer, Kindred Healthcare, Inc. (Disclosed above)
Mary Suzanne Riedman, Esq. (CA) General Counsel / Chief Diversity Officer, Kindred Healthcare, Inc. (Disclosed above)	Jon Rousseau President – Care Management Division, Kindred Healthcare, Inc. (Disclosed above)

The applicant proposes to serve the residents of the following counties from offices located at:

425 Grant Avenue, Suite 2, Auburn, New York 13021:

Cayuga Onondaga		
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### Malta Commons Business Park, 100 Saratoga Village Boulevard, Suite 5, Ballston Spa, New York 12020

Albany	Montgomery	Warren	Essex
Rensselaer	Washington	Fulton	Saratoga
Hamilton	Schenectady	Herkimer	Schoharie

#### 200 Elwood Davis Road, Liverpool, New York 13088

Cayuga	Onondaga	Cortland	Oswego
Jefferson	Seneca	Lewis	Madison

#### 19 4th Avenue, Oswego, New York 13126

Cayuga	Jefferson	Lewis	Onondaga
Oswego			

The applicant proposes to provide the following health care services from the indicated office locations:

#### Auburn, New York

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Speech-Language Pathology
Medical Social Services	Nutrition	Homemaker

#### Ballston Spa, New York

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Speech-Language Pathology
Medical Social Services	Nutrition	Medical Supplies and Equipment

#### Liverpool, New York

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Speech-Language Pathology
Medical Social Services	Medical Supplies and Equipment	

#### Oswego, New York

Nursing	Home Health Aide	Personal Care
Physical Therapy	Occupational Therapy	Speech-Language Pathology
Medical Social Services	Nutrition	Medical Supplies and Equipment

A search of all of the above named board members, employers, and affiliations revealed no matches on either the Medicaid Disqualified Provider List or the OIG Exclusion List.

The Bar Associations of the State of Kentucky, State of California, and the District of Columbia all report that the attorneys listed above are all licensed in good standing with no disciplinary actions taken. In addition, the NYS Education Department's Office of the Professions, NYSDOH Office of Professional Medical Conduct, NYSDOH Physician Profile, Ohio Casino Control Commission, Maine Nursing Home Administrator Licensing Board, New Hampshire Nursing Home Administrator Licensing Board, Wisconsin Department of Safety and Professional Services, Washington State Department of Health, Kentucky Board of Accountancy, Texas Department of

State Health Services, Arizona Medical Board, Indiana Medical Licensing Board, Louisiana Board of Medical Examiners, Minnesota Board of Medical Practice, Missouri Division of Professional Registration, Oklahoma Board of Medical Licensure, Oregon Medical Board, Alabama State Medical Board, and Texas Medical Board all indicate there are no issues with the licensure of the health professionals and other licensed professionals associated with this application. Virginia Department of Health Professions Board of Medicine reports that in 2002, Thomas Cooper, MD, failed to respond to a state requirement to file certain information with the Department of Health Professions within the mandated time frame. Dr. Cooper did not update his physician profile as required until January 7, 2005. As such, the Virginia Department of Health Professions Board of Medicine imposed a \$1000 monetary penalty upon Dr. Cooper in February 2005. In addition, the Florida Department of Health Board of Medicine reports that Dr. Cooper violated Florida Statute section 458.331(1)(b), in that his medical license to practice in another jurisdiction (Virginia) was disciplined as described above, and Florida Statute section 458.331(1)(kk), in that he failed to report in writing within 30 days to the Florida Department of Health Board of Medicine that the above described disciplinary action was imposed by the Virginia Department of Health Professions Board of Medicine. As such, the Florida Department of Health Board of Medicine imposed a \$5000 monetary penalty for the statute violations, plus \$1000 for the Board's administrative costs, upon Dr. Cooper in October 2006.

The applicant has provided the attached list of legal actions taken against Kindred Healthcare, Inc., its predecessor Vencor, Inc., and its affiliate RehabCare Group, Inc., which is now the RehabCare Division of Kindred Healthcare, Inc. (See Programmatic Attachment F – Kindred Legal Actions)

The NYSDOH Division of Hospital Certification and Surveillance reviewed the compliance history of all End Stage Renal Dialysis (ESRD) centers located in New York State that are operated by Liberty RC, Inc., and Knickerbocker Dialysis, Inc., both of which DaVita Healthcare Partners, Inc., is the 100% sole stockholder (see Programmatic Attachment D – Mr. Diaz Affiliations). For the time period 2007 through 2014, these ESRD centers affiliated with DaVita Healthcare Partners, Inc., have all remained in substantial compliance with no history of enforcement action taken.

The NYSDOH Division of Home and Community Based Services reviewed the compliance history of all the affiliated Gentiva Health Services certified home health agencies (CHHAs) and licensed home care service agencies (LHCSAs) located in New York State, for the time period 2007 to 2014.

An enforcement action was taken in 2008 against QC-Medi New York, Inc., d/b/a Gentiva Health Services, a CHHA located in Liverpool, based on December 2006, February 2007, and March 2007 complaint surveys, citing two violations in Policies and Procedures of Service Delivery, two violations in Patient Assessment and Plan of Care, and two violations in Governing Authority. This action was resolved with a \$12,000 civil penalty.

Another enforcement action was taken in 2010 against QC-Medi New York, Inc., d/b/a Gentiva Health Services, a CHHA located in Liverpool, based on an April 2009 survey, citing one violation in Policies and Procedures of Service Delivery, three violations in Patient Assessment and Plan of Care, and two violations in Governing Authority. This action was resolved with a \$13,500 civil penalty.

It has been determined that the certified home health agencies and licensed home care service agencies have exercised sufficient supervisory responsibility to protect the health, safety, and welfare of patients and to prevent the recurrence of code violations. When code violations did occur, it was determined that the operators investigated the circumstances surrounding the violation, and took steps appropriate to the gravity of the violation that a reasonably prudent operator would take to promptly correct and prevent the recurrence of the violation.

To date, the following states have responded to requests for out-of-state compliance status and enforcement history for each of the affiliated out-of-state health care providers listed on the attachments: Alabama, Arkansas, Arizona, Connecticut, Colorado, Florida, Georgia, Kansas, Kentucky, Idaho, Illinois, Indiana, Louisiana, Maine, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, and Wyoming. Out-of state enforcement actions that were reported by the states are as follows:

Florida reported that Kindred Hospital South Florida – Fort Lauderdale was fined \$350 based on a May 2010 application late fee; Kindred Hospital South Florida – Coral Gables was fined \$250 based on a May 2008 application late fee; Kindred Hospital - The Palm Beaches was fined \$500 based on a July 2010 application late fee, and \$4000 based on a October 2011 survey; Kindred Hospital Bay Area – St. Petersburg was fined \$1000 based on a November 2010 survey; Kindred Hospital Bay Area – Tampa was fined \$1000 based on a September 2008 survey, \$1000 based on a December 2010 survey, \$1000 based on a January 2011 survey, \$1000 based on a July 2011 survey, \$1000 based on a March 2012 survey, \$6000 based on a June 2012 survey, and \$2000 based on an August 2012 survey; and Kindred Hospital – Central Tampa was fined \$1000 based on a June 2010 survey, \$1000 based on a January 2011 survey, and \$1000 based on a July 2011 survey.

Georgia reported that Kindred Transitional Care, a nursing home in Fayetteville, was assessed a federal Civil Monetary Penalty (CMP) of \$11,570 based on a September 2012 survey, a federal Civil Monetary Penalty (CMP) of \$24,245 based on a January 2012 survey, and a federal Civil Monetary Penalty (CMP) of \$975 based on a September 2008 survey.

Indiana reported enforcements for the following facilities: Kindred Transitional Care and Rehabilitation – Wildwood had a federal Civil Monetary Penalty (CMP) imposed of \$250 per day from 05/22/2012 - 06/19/2012; Kindred Transitional Care and Rehabilitation - Southwood was fined \$2000 in June 2014; Kindred Transitional Care and Rehabilitation - Sellersburg was fined \$6000 in August 2012; Kindred Transitional Care and Rehabilitation - Rolling Hills was fined \$3000 in October 2014, and had a federal Civil Monetary Penalty (CMP) imposed of \$600 per day from 08/22/2014 - 09/20/2014; Kindred Transitional Care and Rehabilitation - Kokomo had federal Civil Monetary Penalties (CMPs) imposed of \$3600 per day and \$100 per day from 02/02/2012 - 02/28/2012; Kindred Transitional Care and Rehabilitation - Greenwood had a federal Civil Monetary Penalty (CMP) imposed of \$100 per day from 11/01/2012 - 12/07/2012; Kindred Transitional Care and Rehabilitation - Greenfield was fined \$1500 in December 2011; Kindred Transitional Care and Rehabilitation - Columbus was fined \$3000 in June 2012, had a federal Civil Monetary Penalty (CMP) imposed of \$100 per day from 07/26/2012 - 07/26/2012, and had federal Civil Monetary Penalties (CMPs) imposed of \$5950 per day and \$350 per day from 07/10/2014 - 07/14/2014; Kindred Transitional Care and Rehabilitation - Allison Pointe was fined \$3000 in August 2009, and had federal Civil Monetary Penalties (CMPs) imposed of \$100 per day and \$150 per day from 08/16/2012 - 09/21/2012; and Kindred Nursing and Rehabilitation Valley View Nursing Home had a federal Civil Monetary Penalty (CMP) imposed of \$100 per day from 09/27/2012 - 10/26/2012.

Nevada reported that Kindred Hospital Las Vegas (Sahara Campus) was fined \$400 based on a June 2010 survey; Kindred Hospital Las Vegas (Flamingo Campus) was fined \$300 based on a December 2012 survey; and Torrey Pines Post-Acute and Rehabilitation Hospital was fined \$1500 based on a January 2014 survey, and \$400 based on a June 2012 survey.

North Carolina reported that Kindred Transitional Care and Rehabilitation – Rose Manor, a nursing home in Durham, was assessed a federal Civil Monetary Penalty (CMP) of \$1950 based on an August 2012 survey, and a federal Civil Monetary Penalty (CMP) of \$29,120 based on a January 2007 survey citing Immediate Jeopardy; and Kindred Transitional Care and Rehabilitation – Elizabeth City, a nursing home in Elizabeth City, was assessed a federal Civil Monetary Penalty (CMP) of \$1885 based on a May, 2008 survey.

Texas reported that Kindred Hospital San Antonio was fined \$22,750 based on a February 2008 survey; Kindred Hospital Town and Country was fined \$6550 based on a January 2013 survey; Kindred Hospital Dallas Central was fined \$9000 based on a May 2011 survey, and \$4400 based on a February 2012 survey; and Kindred Rehabilitation Hospital Northeast Houston was fined \$7150 based on a December 2013 survey.

Utah reported that Kindred Nursing and Rehabilitation, a nursing home in St. George, had an enforcement action resolved in September, 2012. The state did not report the survey date or if any monetary fine was imposed.

Wyoming reported that Kindred Transitional Care and Rehabilitation, a nursing home in Cheyenne, had a federal Denial of Payment for New Admissions (DoPNA) imposed for a two week period based on a June, 2008 survey, which was resolved in 2008. The state did not report if any monetary fine was imposed.

Review of the Personal Qualifying Information indicates that the applicant has the required character and competence to operate a licensed home care services agency.

#### **ATTACHMENTS**

Programmatic Attachment A Before and After Gentiva Organizational Charts

Programmatic Attachment B Kindred Providers / Facilities

Programmatic Attachment C
Programmatic Attachment D
Programmatic Attachment E
Programmatic Attachment E
Programmatic Attachment F

Ms. Yale Affiliations
Mr. Diaz Affiliations
Mr. Short Affiliations
Kindred Legal Actions

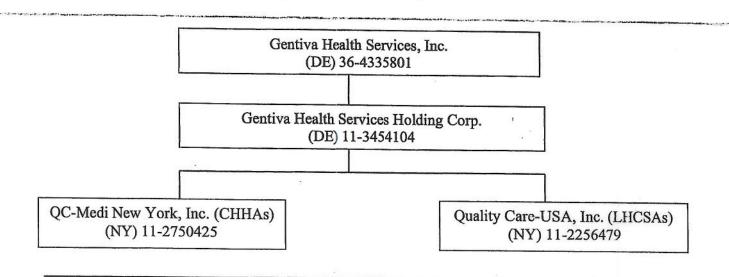
#### Contingency

Submission of any and all information requested by the Division of Legal Affairs, in a form and manner acceptable to the Department.

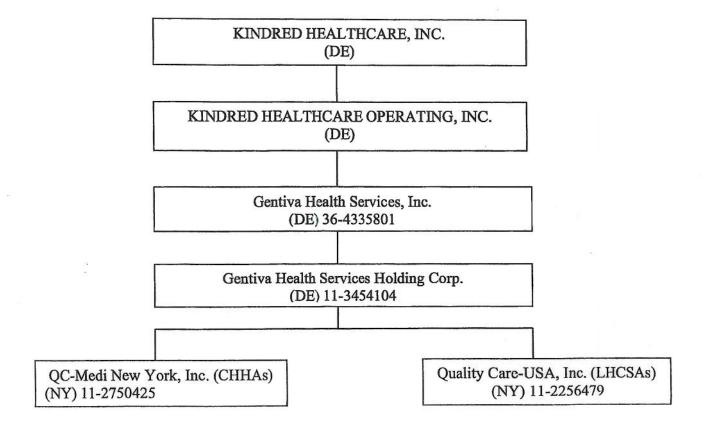
Recommendation: Contingent Approval Date: January 14, 2015

CON Project #142193-E and LHCSA Application #2556-L Programmatic Attachment A – Page 1 of 1 Before and After Gentiva Organizational Charts

=Provider Entity



#### KINDRED HEALTHCARE, INC. KINDRED HEALTHCARE OPERATING, INC. ORGANIZATIONAL SCHEMATIC AFTER STOCK TRANSFER



CON Project #142193-E and LHCSA Application #2556-L Programmatic Attachment B - Page 1 of 8 Kindred Providers/Facilities

Kindred Healthcare: Long-Term Care Hospitals

State	Facility Name	State	Facility Name
A7	Kindred Hospital Arizona - Northwest Dhospio		Control Line of Children (M. Control Control Control
1 1	Mildred Hospital Alizona - Nottilwest Prioenix	_	Kindred Hospital - Chicago (Northlake Campus)
AZ	Kindred Hospital - Arizona - Phoenix	-	Kindred Hospital - Chicago (North Campus)
ΑZ	Kindred Hospital - Tucson	1	Kindred Hospital - Sycamore
۲ ک	Kindred Hospital Baldwin Park	<u> </u>	Kindred - Chicago - Central Hospital
& C	Kindred Hospital Riverside	1	Kindred Hospital Peoria
S	Kindred Hospital South Bay	II.	Kindred - Chicago - Lakeshore
S	Kindred Hospital South Bay - Tri-City Campus	Z	Kindred Hospital - Indianapolis
S	Kindred Hospital Rancho	Z	Kindred Hospital - Indianapolis South
CA	Kindred Hospital - Brea	Z	Kindred Hospital Northwest Indiana
S S	Kindred Hospital - Ontario	Z	Kindred Hospital Northern Indiana
CA CA	Kindred Hospital - San Francisco Bay Area	Κ	Kindred Hospital - Louisville
S	Kindred Hospital - La Mirada	Κ	Kindred Hospital - Louisville at Jewish Hospital
CA	Kindred Hospital - San Gabriel Valley	4	Kindred Hospital - New Orleans
S	Kindred Hospital - Santa Ana	MA	Kindred Hospital - Boston
CA	Kindred Hospital - Westminster	MA	Kindred Hospital - Boston North Shore
CA	Kindred Hospital - San Diego	MA	Kindred Hospital Northeast - Natick
S	Kindred Hospital - Los Angeles	MA	Kindred Hospital Northeast - Stoughton
8	Kindred Hospital - Denver	MI	Kindred Hospital Detroit
8	Kindred Hospital Aurora	MO	Kindred Hospital - Kansas City
FL	Kindred Hospital Ocala	MO	Kindred Hospital - St. Louis
FL	Kindred Hospital The Palm Beaches	MO	Kindred Hospital - St. Louis - St. Anthony's
FL	Kindred Hospital - South Florida - Coral Gables	MO	Kindred Hospital Northland
긥	Kindred Hospital - Bay Area St. Petersburg	MO	Kindred Hospital - St. Louis at Mercy
FL	Kindred Hospital - Bay Area - Tampa	S	Kindred Hospital New Jersey - Morris County
日	Kindred Hospital - South Florida Ft. Lauderdale	S	Kindred Hospital New Jersey - Rahway
교	Kindred Hospital - North Florida	- CN	Kindred Hospital New Jersey - Wayne
교	Kindred Hospital - Central Tampa	NN	Kindred Hospital - Albuquerque
FL	Kindred Hospital Melbourne	N N	Kindred Hospital - Las Vegas (Sahara Campus)
교	Kindred Hospital - South Florida - Hollywood	N N	Kindred Hospital Las Vegas - Flamingo Campus
GA	Kindred Hospital - Atlanta	N	Kindred Hospital – Las Vegas at St. Rose Dominican Hospitals – Rose de Lima Campus
GA	Kindred Hospital Rome	NC	Kindred Hospital - Greensboro

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Kindred Healthcare: Long-Term Care Hospitals

State	e Facility Name	State	Facility Name
Ę	Kindred Hosnital - Darton	À	(A 114 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
5	Niluieu nospital - Dayton	<u> </u>	Kindred Hospital (Houston NVV)
ᆼ	Kindred Hospital - Cleveland	X	Kindred Hospital (Bay Area)
ᆼ	Kindred Hospital - Cleveland - Gateway	¥	Kindred Hospital - Mansfield
P	Kindred Hospital Central Ohio	¥	Kindred Hospital - Fort Worth
ᆼ	Kindred Hospital Lima	Ϋ́	Kindred Hospital Houston Medical Center
ð	Kindred Hospital - Oklahoma City - South	X	Kindred Hospital - White Rock
š	Kindred Hospital - Oklahoma City	¥	Kindred Hospital Town & Country
PA	Kindred Hospital Philadelphia - Havertown	¥	Kindred Hospital Sugar Land
PA	Kindred Hospital - Philadelphia	¥	Kindred Hospital Dallas Central
PA	Kindred Hospital - Pittsburgh	¥	Kindred Hospital El Paso
PA	Kindred Hospital at Heritage Valley	¥	Kindred Hospital Spring
PA	Kindred Hospital South Philadelphia	¥	Kindred Hospital Tomball
Z	Kindred Hospital - Chattanooga	¥	Kindred Hospital The Heights
Z	Kindred Hospital - Nashville	¥	Kindred Hospital Baytown
ĭ	Kindred Hospital - Dallas	¥	Kindred Hospital Clear Lake
¥	Kindred Hospital - San Antonio	WA	Kindred Hospital Seattle - Northgate
ĭ	Kindred Hospital - Tarrant County (Arlington Campus)	WA	Kindred Hospital Seattle - First Hill
¥	Kindred Hospital - Tarrant County (Fort Worth Southwest		
	(charles)		

	Kindred Healthcare: Rehabilitation Hospitals		Hospita
State	Facility Name	State	
MO	St. Luke's Rehabilitation Hospital	8	Kindred Hospita
TX	Kindred Rehabilitation Hospital Northeast Houston	₹	Kindred Hospita
XT	Kindred Rehabilitation Hospital Arlington	NC	Kindred Hospita
XT	Kindred Rehabilitation Hospital Clear Lake	ž	Kindred Hospita
ΥT	Central Texas Rehabilitation Hospital	공	Kindred Hospita

	Hospital Based Subacute Units
State	Facility Name
CA	Kindred Hospital - Brea
KY	Kindred Hospital - Louisville
NC	Kindred Hospital - Greensboro
N/	Kindred Hospital Las Vegas - Flamingo Campus
НО	Kindred Hospital - Cleveland
XT	Kindred Hospital - Dallas
WA	Kindred Seattle - Northgate
WA	Kindred Seattle - First Hill
	Control of the contro

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Kindred Healthcare: Nursing Centers

State	Facility Name	State	Facility Name
			donny vanie
AZ	Kindred Nursing and Rehabilitation-Hacienda	Q	Kindred Transitional Care and Rehabilitation-Lewiston
CA	Kindred Transitional Care and Rehabilitation-Village Square	Ω	Kindred Nursing and Rehabilitation - Nampa
CA	Kindred Transitional Care and Rehabilitation-Tunnell Center	Q	Kindred Nursing and Rehabilitation - Weiser
CA	Kindred Nursing and Rehabilitation-Nineteenth Avenue	₽	Kindred Nursing and Rehabilitation - Aspen Park
CA	Kindred Transitional Care and Rehabilitation-Canyonwood	Q	Kindred Nursing and Rehabilitation - Mountain Valley
CA	Kindred Nursing and Healthcare - Livermore	Z	Kindred Transitional Care and Rehabilitation-Bridgewater
CA	Kindred Transitional Care and Rehabilitation-Lawton	Z	Kindred Transitional Care and Rehabilitation-SouthPointe
CA	Kindred Transitional Care and Rehabilitation - Valley Gardens	<u>Z</u>	Kindred Transitional Care and Rehabilitation-Eagle Creek
CA	Kindred Nursing and Transitional Care - Santa Cruz	Z	Kindred Transitional Care and Rehabilitation-Allison Pointe
CA	Kindred Transitional Care and Rehabilitation - Walnut Creek	Z	Kindred Transitional Care and Rehabilitation-Dyer
CA	Kindred Nursing and Healthcare-Bayberry	Z	Kindred Transitional Care and Rehabilitation-Greenwood
S	Kindred Nursing and Transitional Care-South Marin	N	Kindred Transitional Care and Rehabilitation-Greenfield
C <sub>A</sub>	Kindred Nursing and Rehabilitation - Medical Hill	Z	Kindred Transitional Care and Rehabilitation-Sellersburg
ĕ.	Kindred Nursing and Transitional Care - Pacific Coast	Z	Kindred Transitional Care and Rehabilitation-Indian Creek
	Kindred Transitional Care and Rehabilitation-Smith Ranch	Z	Kindred Nursing and Rehabilitation-Valley View
	Kindred Nursing and Rehabilitation - Ygnacio Valley	Z	Kindred Transitional Care and Rehabilitation-Dyer
CA	Kindred Transitional Care and Rehabilitation-Siena	<u>z</u>	Kindred Transitional Care and Rehabilitation-Greenwood
č	Kindred Nursing and Rehabilitation-Golden Gate	Z	Kindred Transitional Care and Rehabilitation-Greenfield
	Kindred Nursing and Healthcare - Victorian	Z	Kindred Transitional Care and Rehabilitation-Sellersburg
	Kindred Transitional Care and Rehabilitation-Foothill	N.	Kindred Transitional Care and Rehabilitation-Indian Creek
	Kindred Nursing and Rehabilitation - Aurora	Z.	Kindred Nursing and Rehabilitation-Valley View
	Kindred Nursing and Rehabilitation-Crossings West	Z.	Kindred Transitional Care and Rehabilitation-Kokomo
CT	Kindred Transitional Care and Rehabilitation-Windsor	Z	Kindred Transitional Care and Rehabilitation-Wildwood
СТ	Kindred Nursing and Rehabilitation-Crossings East	N	Kindred Transitional Care and Rehabilitation-Southwood
ст	Kindred Transitional Care and Rehabilitation-Parkway Pavilion	N.	Kindred Transitional Care and Rehabilitation-Columbus
4	Kindred Transitional Care and Rehabilitation-Lafayette	N N	Kindred Transitional Care and Rehabilitation-Wedgewood
۵	Kindred Nursing and Rehabilitation - Caldwell	N N	Kindred Transitional Care and Rehabilitation-Harrison
<b>□</b>	Kindred Nursing and Rehabilitation - Canyon West	Z Z	Kindred Transitional Care and Rehabilitation-Rolling Hills

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Kindred Healthcare: Nursing Centers

aple ashford ashford allitation-Harrington litation-Eagle Pond arkorlights articler Lake Investion-Park Place arkview	State	Facility Name	State	Facility Name
Kindred Nursing and Rehabilitation-Maple  Kindred Nursing and Rehabilitation-Bashford  Kindred Transitional Care and Rehabilitation-Westborough  Kindred Transitional Care and Rehabilitation-Eagle Pond  Kindred Transitional Care and Rehabilitation-Eagle Pond  Kindred Transitional Care and Rehabilitation-Guntry Estates  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Horestview  Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Barkview  K	¥	Heritage Manor Healthcare Center	동	Kindred Transitional Care and Rehabilitation-The Greens
Kindred Nursing and Rehabilitation-Bashford  Kindred Transitional Care and Rehabilitation-Harrington  Kindred Nursing and Rehabilitation-Hallmark  Kindred Transitional Care and Rehabilitation-Brain Hights  Kindred Transitional Care and Rehabilitation-Country Estates  Kindred Transitional Care and Rehabilitation-Avery  Kindred Transitional Care and Rehabilitation-Hallmader  Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Coreenbriar  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Rose Manor	≿	Kindred Nursing and Rehabilitation-Maple	동	Kindred Nursing and Rehabilitation-Community
Kindred Transitional Care and Rehabilitation-Harrington  Kindred Nursing and Rehabilitation-Hallmark  Kindred Transitional Care and Rehabilitation-Gountry Estates  Kindred Transitional Care and Rehabilitation-Avery  Kindred Transitional Care and Rehabilitation-Halphader  Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Center  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Newark	₹	Kindred Nursing and Rehabilitation-Bashford	Н	Kindred Transitional Care and Rehabilitation-Stratford
Kindred Nursing and Rehabilitation-Hallmark Kindred Transitional Care and Rehabilitation-Seade Pond Kindred Transitional Care and Rehabilitation-Country Estates Kindred Transitional Care and Rehabilitation-Country Estates Kindred Transitional Care and Rehabilitation-Highgate TX Kindred Transitional Care and Rehabilitation-Highgate Kindred Transitional Care and Rehabilitation-Highgate Kindred Transitional Care and Rehabilitation-Forestview Kindred Nursing and Rehabilitation-Braintree Kindred Transitional Care and Rehabilitation-Forestview Kindred Nursing and Rehabilitation-Laurel Lake Clark House Nursing and Rehabilitation Center Seacoast Nursing and Rehabilitation Park Place Kindred Transitional Care and Rehabilitation-Bark Place Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Rose Manor	MA	Kindred Transitional Care and Rehabilitation-Harrington	Н	Kindred Transitional Care and Rehabilitation-LakeMed
Kindred Nursing and Rehabilitation-Timberlyn Heights  Kindred Transitional Care and Rehabilitation-Bagle Pond  Kindred Transitional Care and Rehabilitation-County Estates  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Nursing and Rehabilitation-Braintree  Kindred Nursing and Rehabilitation-Laurel Lake  Kindred Nursing and Rehabilitation-Laurel Lake  Kindred Nursing and Rehabilitation Center  Clark House Nursing and Rehabilitation Center  Seacoast Nursing and Rehabilitation - Parkview  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Rivankark  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Nursing and Rehabilitation-Hallmark	N.	Kindred Nursing and Rehabilitation - Loudon
Kindred Transitional Care and Rehabilitation-Westborough Kindred Transitional Care and Rehabilitation-Eagle Pond Kindred Transitional Care and Rehabilitation-Country Estates Kindred Transitional Care and Rehabilitation-Highgate Kindred Transitional Care and Rehabilitation-Avery Kindred Transitional Care and Rehabilitation-Avery Kindred Nursing and Rehabilitation-Harborlights Kindred Nursing and Rehabilitation-Braintree Kindred Transitional Care and Rehabilitation-Highlander Kindred Transitional Care and Rehabilitation-Laurel Lake Kindred Transitional Care and Rehabilitation-Laurel Lake Kindred Transitional Care and Rehabilitation-Park Place Kindred Transitional Care and Rehabilitation-Park Place Kindred Transitional Care and Rehabilitation-Park Place Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Brak Manor Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Highlander	MA	Kindred Nursing and Rehabilitation-Timberlyn Heights	N	Kindred Transitional Care and Rehabilitation-Maryville
Kindred Transitional Care and Rehabilitation-Eagle Pond Kindred Transitional Care and Rehabilitation-Ocuntry Estates Kindred Transitional Care and Rehabilitation-Highgate Kindred Transitional Care and Rehabilitation-Avery Kindred Transitional Care and Rehabilitation-Avery Kindred Nursing and Rehabilitation-Braintree Kindred Nursing and Rehabilitation-Braintree Kindred Transitional Care and Rehabilitation-Forestview Kindred Transitional Care and Rehabilitation-Forestview Kindred Transitional Care and Rehabilitation-Highlander Kindred Transitional Care and Rehabilitation-Bark Place Kindred Transitional Care and Rehabilitation-Park Place Kindred Transitional Care and Rehabilitation-Park Place Kindred Transitional Care and Rehabilitation-Bark Place Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Rose Manor Kindred Transitional Care and Rehabilitation-Rose Manor Kindred Transitional Care and Rehabilitation-Elizabeth City Kindred Transitional Care and Rehabilitation-Rose Manor	MA	Kindred Transitional Care and Rehabilitation-Westborough	N F	Kindred Nursing and Rehabilitation - Fairpark
Kindred Transitional Care and Rehabilitation-Great Barrington  Kindred Transitional Care and Rehabilitation-Avery  Kindred Transitional Care and Rehabilitation-Avery  Kindred Nursing and Rehabilitation-Braintree  Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Rose Manor	MA	Kindred Transitional Care and Rehabilitation-Eagle Pond	N.	Kindred Nursing and Rehabilitation - Smith County
Kindred Transitional Care and Rehabilitation-Country Estates  Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Harborlights  Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Center  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Higher City  Kindred Transitional Care and Rehabilitation-Newark  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Nursing and Rehabilitation-Great Barrington	N.	Kindred Nursing and Rehabilitation - Northhaven
Kindred Transitional Care and Rehabilitation-Highgate  Kindred Transitional Care and Rehabilitation-Avery  Kindred Nursing and Rehabilitation-Harborlights  Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Transitional Care and Rehabilitation-Country Estates	Ϋ́	Kindred Transitional Care and Rehabilitation-Ridgmar
Kindred Transitional Care and Rehabilitation-Avery  Kindred Nursing and Rehabilitation-Harborlights  Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Laurel Lake  Kindred Nursing and Rehabilitation Center  Clark House Nursing and Rehabilitation Center  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Transitional Care and Rehabilitation-Highgate	¥	Kindred Transitional Care and Rehabilitation-Mansfield Plaza
Kindred Nursing and Rehabilitation-Harborlights  Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation Center  Kindred Nursing and Rehabilitation Center  Seacoast Nursing and Rehabilitation Center  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Newark  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Transitional Care and Rehabilitation-Avery		Kindred Transitional Care and Rehabilitation-Grapevine
Kindred Nursing and Rehabilitation-Harborlights  Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Transitional Care and Rehabilitation-Laurel Lake  Kindred Nursing and Rehabilitation Center  Seacoast Nursing and Rehabilitation Center  Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Nursing and Rehabilitation-Tower Hill		Kindred Nursing and Rehabilitation - Wasatch Care
Kindred Nursing and Rehabilitation-Braintree  Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation-Highlander  Kindred Nursing and Rehabilitation Center  Seacoast Nursing and Rehabilitation Center  Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Bizabeth City  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Nursing and Rehabilitation-Harborlights		Kindred Nursing and Rehabilitation - St. George
Kindred Transitional Care and Rehabilitation-Forestview  Kindred Transitional Care and Rehabilitation Highlander  Kindred Nursing and Rehabilitation Center  Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Newark  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Nursing and Rehabilitation-Braintree		Kindred Transitional Care and Rehabilitation-Birchwood Terrace
Kindred Transitional Care and Rehabilitation-Highlander  Kindred Nursing and Rehabilitation Laurel Lake  Ledgewood Rehabilitation and Skilled Nursing Center  Seacoast Nursing and Rehabilitation Center  Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Newark  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Transitional Care and Rehabilitation-Forestview		Starr Farm Nursing Center
Kindred Nursing and Rehabilitation-Laurel Lake  Ledgewood Rehabilitation and Skilled Nursing Center  Seacoast Nursing and Rehabilitation Center  Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Newark  Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Transitional Care and Rehabilitation-Highlander		Kindred Transitional Care and Rehabilitation-Nansemond Pointe
Ledgewood Rehabilitation and Skilled Nursing Center Seacoast Nursing and Rehabilitation Center Clark House Nursing Center at Fox Hill Village Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Henderson Kindred Transitional Care and Rehabilitation-Elizabeth City Kindred Transitional Care and Rehabilitation-Newark Kindred Transitional Care and Rehabilitation-Newark	MA	Kindred Nursing and Rehabilitation-Laurel Lake		Kindred Nursing and Rehabilitation-River Pointe
Seacoast Nursing and Rehabilitation Center  Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Bark Place  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Newark  Kindred Transitional Care and Rehabilitation-Newark	MA			Kindred Transitional Care and Rehabilitation-Bay Pointe
Clark House Nursing Center at Fox Hill Village  Kindred Transitional Care and Rehabilitation-Park Place  Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Newark	MA	Seacoast Nursing and Rehabilitation Center		Kindred Nursing and Rehabilitation-Arden
Kindred Transitional Care and Rehabilitation-Park Place  Kindred Nursing and Rehabilitation - Parkview  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Transitional Care and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Newark	MA	Clark House Nursing Center at Fox Hill Village		Kindred Transitional Care and Rehabilitation-Lakewood
Kindred Nursing and Rehabilitation - Parkview Kindred Transitional Care and Rehabilitation-Greenbriar Kindred Transitional Care and Rehabilitation-Rose Manor Kindred Nursing and Rehabilitation-Henderson Kindred Transitional Care and Rehabilitation-Elizabeth City Kindred Transitional Care and Rehabilitation-Newark	MT	Kindred Transitional Care and Rehabilitation-Park Place		Kindred Transitional Care and Rehabilitation-Vancouver
Kindred Transitional Care and Rehabilitation-Greenbriar  Kindred Transitional Care and Rehabilitation-Rose Manor  Kindred Nursing and Rehabilitation-Henderson  Kindred Transitional Care and Rehabilitation-Elizabeth City  Kindred Transitional Care and Rehabilitation-Newark	MT	Kindred Nursing and Rehabilitation - Parkview		(indred Transitional Care and Rehabilitation - Cheyenne
Kindred Transitional Care and Rehabilitation-Rose Manor Kindred Nursing and Rehabilitation-Henderson Kindred Transitional Care and Rehabilitation-Elizabeth City Kindred Transitional Care and Rehabilitation-Newark	¥	Kindred Transitional Care and Rehabilitation-Greenbriar		1
Kindred Nursing and Rehabilitation-Henderson Kindred Transitional Care and Rehabilitation-Elizabeth City Kindred Transitional Care and Rehabilitation-Newark	NC	Kindred Transitional Care and Rehabilitation-Rose Manor		Kindred Nursing and Rehabilitation - Wind River
Kindred Transitional Care and Rehabil	NC	Kindred Nursing and Rehabilitation-Henderson		
Kindred Transitional Care and Rehabil	NC	Kindred Transitional Care and Rehabilitation-Elizabeth City		
	동	Kindred Transitional Care and Rehabilitation-Newark		

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	Assisted Living Facilities: Independently Licensed		Hospice
State	Facility Name	State	Facility Nan
ME	Kindred Assisted Living-Village Crossings	AZ	Granite Mountain Hospice
ME	Kindred Assisted Living-The Monarch Center of Saco	AZ	Granite Mountain Home Care & Hos
ME	Kindred Assisted Living-Senior Day Program (Part of The Monarch Center of Saco)	AZ	Kindred at Home-Hospice-Glendale
MA	Kindred Assisted Living-Avery Crossings	8	Professional Healthcare at Home
MA	Kindred Assisted Living - Laurel Lake	CA	Professional Healthcare at Home
MA	Foxhill Village Rehab Center	8	Kindred at Home-Hospice-Denver
ЮН	Kindred Assisted Living-Fountains	Z	Kindred at Home-Hospice-Indianapo
공	Kindred Assisted Living-Stratford Commons	Z	Bridgepoint Supportive Care
<b>≶</b>	Hillcrest Retirement Center	MA	Kindred at Home-Boston

State	Facility Name
AZ	Granite Mountain Hospice
AZ	Granite Mountain Home Care & Hospice Anthem
AZ	Kindred at Home-Hospice-Glendale
CA	Professional Healthcare at Home
CA	Professional Healthcare at Home
00	Kindred at Home-Hospice-Denver
Z	Kindred at Home-Hospice-Indianapolis
Z	Bridgepoint Supportive Care
MA	Kindred at Home-Boston
MA	Peoplefirst HomeCare & Hospice
N	Virgin Valley Hospice
ЮН	Acclaim Hospice and Palliative Care
X	IntegraCare Hospice of Abilene, LLC
X	IntegraCare of West Texas Hospice, LLC
ΤX	IntegraCare of Athens Hospice, LLC
XT	IntegraCare Hospice
ΧT	IntegraCare Hospice of Decatur
ΧT	Kindred at Home-Hospice-South Houston
X	Kindred at Home-Hospice-West Houston
ΧT	IntegraCare Home Health and Hospice
TU	BridgePoint Palliative Care
T)	Kindred at Home - Hospice - Murray
TO	BridgePoint Palliative Care
TO	Southern Utah Hospice

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Home Care Agencies

State	Facility Name	State	Facility Namo
V 7	Oranita Manustain Union		
¥!	Granite Mountain Home Care	4	Synergy Home Care-Southeastern Region, Inc.
*	Kindred at Home-Home Health-Glendale	MA	Kindred at Home-Marlborough
S	Professional Healthcare at Home	N	Kindred at Home-Home Health-Las Vegas
S	Kindred at Home (San Diego)	Ю	Kindred at Home-Home Health-Akron
ర	Kindred at Home (Garden Grove)	Ю	Kindred at Home-Home Health-Columbus
ర	Professional Healthcare at Home	Ю	Kindred at Home-Home Health-Findlay
& S	Kindred at Home-Torrance	ЮН	Western Reserve Senior Care
S	Community Home Health	¥	IntegraCare of Abilene, LLC
8	Kindred at Home-Home Health-Denver	¥	IntegraCare of Albany, LLC
8	PeopleFirst Homecare (Ft. Collins)	¥	IntegraCare of West Texas Home Health, LLC
딘	Senior Home Care (Boynton Beach)	¥	IntegraCare of Athens Home Health, LLC
FL	Senior Home Care (Miami Lakes)	ኦ	IntegraCare of South Central Texas
교	Senior Home Care (Port Saint Lucie)	Ϋ́	IntegraCare Home Health Services
긥	Senior Home Care (Sunrise)	Χ̈́	IntegraCare Home Health of Big Spring
긥	Senior Home Care, Inc. (Clearwater)	ΧL	IntegraCare of Olney
님	Senior Home Care, Inc. (Fort Myers)	ኦ	IntegraCare of Texas, LLC
FL	Senior Home Care, Inc. (Ocala)	<u>አ</u>	IntegraCare of Cleburne
긥	Senior Home Care, Inc. (Jacksonville)	XT	IntegraCare Home Health of Colorado City
FL	Senior Home Care, Inc. (Maitland)	አፐ	IntegraCare of El Paso
긥	Bodymax Physical Therapy	Ϋ́	IntegraCare of Granbury, LLC
긥	Senior Home Care, Inc. (Pensacola)	ΧT	Kindred at Home-Home Health-South Houston
딥	Senior Home Care, Inc. (Spring Hill)	ΧT	Kindred at Home-Home Health-West Houston
FL	Senior Home Care, Inc. (Tampa)	ΧL	IntegraCare of Littlefield, LLC
	Kindred at Home - Chicago Home Health	Χ̈́L	IntegraCare of North West Texas
Z	Kindred at Home-Home Health-Indianapolis	χŁ	IntegraCare Home Health and Hospice
_5	Synergy Home Care-Acadiana Region, Inc.	ኦ	IntegraCare of North East Texas
	Synergy Home Care-Capitol Region, Inc.	۲	IntegraCare Home Health-Permian Basin
4	Synergy Home Care-Central Region, Inc.	χŁ	IntegraCare of the Panhandle
4	Synergy Home Care-Northeastern Region, Inc.	Ĭ.	IntegraCare of North Texas
4	Synergy Home Care-Northshore Region, Inc.		IntegraCare of South West Texas
4	Synergy Home Care-Northwestern Region, Inc.	<u></u>	IntegraCare of Seymour

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Home Care Agencies

State	Facility Name	State	Facility Name
¥	IntegraCare of North Central Texas	15	Kindred at Home - Home Health - Murray
ΧŁ	IntegraCare of Waco-Home Health	5	Southern Utah Home Care
X	IntegraCare of Wichita Falls, LLC	٧A	All Heart Home Health and Hospice

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Rehab Care Agencies

AR AR	racinity Maille	State	Facility Name
	RehabCare Agency AL	MN	RehabCare Agency MN / TCK Coon Rapids (#5514) **PEDS
	Arkansas Agency	₽	Autumn View Gardens Ellisville
	RehabCare Agency S CA (Laguana Hills)	MO	Crab Apple Village Senior Estates
CA	RehabCare Agency N CA (Pleasant Hill)	MO	Little Sisters of the Poor
CO	Atria Inn at Lakewood	MO	Mother of Good Counsel
000	Balfour Retirement	MO	RehabCare Agency MO
8	RehabCare, LLC - Colorado	S	Brooks Howell Home
00	Springbrooke	S	RehabCare Agency NC
FL	RehabCare Agency FL	N N	Emeritus at Spring Valley (Kindred Nevada LLC dba Torrey Pines Care Center)
FL	RehabCare/Barrington Terrace	N	Emeritus at Sun Mountain (Kindred Nevada LLC dba Torrey Pines Care Center)
- F	RehabCare Agency IL	N	Emeritus of Las Vegas (Kindred Nevada LLC dba Torrey Pines Care Center)
<u> </u>	Cedarhurst at Shiloh	동	RehabCare Agency OH
Z	Atria Eastlake Terrace	ş	RehabCare Agency OK
<u>∢</u>	Atria Tangelwood Trace	PA	RehabCare Agency at Davidsville Care Center
<u>R</u>	First Steps KINDRED (special Medicaid program in IN)	သွ	RehabCare Agency SC
<u>Z</u>	Kindred Rehab Service, Inc., d/b/a Bedford Outpatient Therapy Specialists	N.	RehabCare Agency TN
<u>R</u>	RehabCare Agency IN	¥	Isle at Watermere
KS	RehabCare Agency KS	¥	RehabCare Agency TX
± Y	The Therapy Group, Inc.	× ×	Peoplefirst Virginia, LLC, d/b/a Peoplefirst Rehabilitation Services (Envoy of Staunton)*
MD	Mercy Ridge Retirement Community (formerly Villa Assumpta/Maria Hith)	٧A	Peoplefirst Virginia, LLC, d/b/a Peoplefirst Rehabilitation Services (Envoy of Winchester)*
MI	Atria Shorehaven	M	RehabCare Agency WI
MI	RehabCare Agency MI		

	National Surgical Healthcare, Inc Locations
State	Name
Arizona	Arizona Spine and Joint Hospital
Arizona	Canyon Ambulatory Surgery Center
California	Aspen Surgery Center
California	Brentwood Surgery Center
California	Sequoia Surgical Pavilion
California	Skyway Surgery Center
California	Sutter Surgical Hospital - North Valley
Connecticut	Fairfield Surgery Center
Idaho	Northwest Specialty Hospital
Illinois	NSH Corporate Offices
Louisiana	Lafayette Surgical Specialty Hospital
North Carolina	North Carolina Specialty Hospital
North Carolina	Triangle Orthopaedics Surgery Center
Michigan	Lakes Surgery Center
Michigan	Michigan Surgical Hospital
Texas	El Paso Specialty Hospital
Texas	South Texas Spine & Surgical Hospital
Texas	South Texas Surgical Hospital
Texas	The Physicians Centre Hospital
Utah	Cache Valley Specialty Hospital
Wisconsin	OakLeaf Surgical Hospital
Wyoming	Mountain View Regional Hospitals

CON Project #142193-E and LHCSA Application #2556-L Programmatic Attachment D - Page 1 of 2 Mr. Diaz Affiliations

### DaVita Healthcare Partners, Inc. New York State Affiliates

Operator: Liberty RC, Inc.

Туре
Diagnostic and Treatment
Center
Diagnostic and Treatment
Center Extension Clinic
Diagnostic and Treatment
Center Extension Clinic
Diagnostic and Treatment
Center Extension Clinic
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Center Extension Clinic
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Diagnostic and Treatment
Center Extension Clinic

Name	City
Cleve Hill Dialysis Center	Buffalo
Bedford Park Dialysis Center	Bronx
Celia Dill Dialysis Center	Carmel
Dyker Heights Dialysis Center	Brooklyn
Eastchester Road Dialysis Center	Bronx
Hudson Vally Dialysis Center	Tarrytown
Lowville Dialysis Center	Lowville
Niagara Falls Kidney Care Center	Niagara Falls
Port Chester Dialysis & Renal Center	Port Chester
Renal Care of Buffalo	West Seneca
South Brooklyn Nephrology Center	Brooklyn
Southtowns Dialysis Center	Hamburg
White Plains Dialysis Center	White Plains
Yonkers East Dialysis Center	Yonkers

CON Project #142193-E and LHCSA Application #2556-L Programmatic Attachment D - Page 2 of 2 Mr. Diaz Affiliations

### DaVita Healthcare Partners, Inc. New York State Affiliates

Operator: Knickerbocker Dialysis, Inc.

	ysis, nic.	
Туре	Name	City
Diagnostic and Treatment Center	Bronx Dialysis Center	Bronx
Diagnostic and Treatment Center Extension Clinic	Boston Post Road Dialysis Center	Bronx
Diagnostic and Treatment Center Extension Clinic	Catskill Dialysis Center	Monticello
Diagnostic and Treatment Center Extension Clinic	Central New York Dialysis Center	Syracuse
Diagnostic and Treatment Center Extension Clinic	Garden City Dialysis Center	Garden City
Diagnostic and Treatment Center Extension Clinic	Jamestown Dialysis Center	Jamestown
Diagnostic and Treatment Center Extension Clinic	Long Island Renal Care	Amityville
Diagnostic and Treatment Center and Extension Clinic	Lynbrook Dialysis Center	Lynbrook
Diagnostic and Treatment Center Extension Clinic	Northtowns Dialysis Center	Tonawanda
Diagnostic and Treatment Center Extension Clinic	Orange Dialysis Center	Middletown
Diagnostic and Treatment Center Extension Clinic	Orachard Park Dialysis Center	Orchard Park
Diagnostic and Treatment Center Extension Clinic	Peeksill Cortland Dialysis Center	Cortlandt Manor
Diagnostic and Treatment Center Extension Clinic	Port Washington Dialysis Center	Port Washington
Diagnostic and Treatment Center Extension Clinic	Queens Dialysis Center	Jamaica
Diagnostic and Treatment Center Extension Clinic	Queens Village Dialysis Center	Queens Village
Diagnostic and Treatment Center Extension Clinic	Richmond Kidney Center	Staten Island
Diagnostic and Treatment Center Extension Clinic	Riverdale Dialysis Center	Bronx
Diagnostic and Treatment Center Extension Clinic	Sheepshead Bay Renal Care Center	Brooklyn
Diagnostic and Treatment Center Extension Clinic	Soundview Dialysis Center	Bronx
Diagnostic and Treatment Center Extension Clinic	South Bronx Dialysis Center	Bronx
Diagnostic and Treatment Center Extension Clinic	Staten Island Dialysis Center	Staten Island
Diagnostic and Treatment Center Extension Clinic	Suburban Dialysis Center	Williamsville
Diagnostic and Treatment Center Extension Clinic	Waters Place Dialysis Center	Bronx
Diagnostic and Treatment Center Extension Clinic	Yonkers Dialysis Center	Yonkers

	Seton Family Facilities - Texas
	Seton Edgar B Davis Hospital
	Seton Highland Lakes Home Health - Texas Department of Aging and Disability Services
	Seton Highland Lakes Hospice - Texas Department of Aging and Disability Services
	Seton Highland Lakes Hospital
	Seton Lampasas Healthcare Center
	Seton Lockhart Family Health Center
	Seton Marble Falls Healthcare Center
	Seton Medical Center Hays
	Seton Medical Center Williamson
_	Seton Northwest Hospial
	Seton Riverbend Home Health - Texas Department of Aging and Disability Services
	Seton Shoal Creek Hospital
	Seton Smithville Regional Hospital
	Seton Southwest Hospital
	SHL Care-A-Van
	SHL Professional Support Services
	Towers Nursing Home - Texas Department of Aging and Disability Services
	Dell Children's Medical Center
	Emergency Medical Center
	SEBD Care-A-Van
	SEBD Professional Support Services
	Seton Bertram Healthcare Center
	Seton Burnet Healthcare Center
	Seton Community Health Centers
50%	University Medical Center at Brackenridge

CON Project #142193-E and LHCSA Application #2556-L Programmatic Attachment F – Page 1 of 3 Kindred Legal Actions

#### Schedule 2A Responses

ITEM 6.11(a)

Vencor, Inc. filed voluntary petitions for protection under the Bankruptcy Code on September 13, 1999, primarily as a result of decreased Medicare and Medicaid reimbursement rates introduced by the Balanced Budget Act of 1997, which led to the company being unable to meet its then existing financial obligations, including rent payable to its principal landlord, Ventas, Inc. ("Ventas"), and debt service obligations under existing indebtedness. On March 1, 2001, the Bankruptcy Court approved the Vencor, Inc. Plan of Reorganization. From September 13, 1999 until the company emerged from bankruptcy on April 20, 2001, the company operated as a debtor-in-possession subject to the jurisdiction of the Bankruptcy Court.

Pursuant to the Plan of Reorganization, the company issued creditors (in exchange for their claims) secured notes, common stock and two series of warrants, entered into a new credit agreement as well as new master lease agreements with Ventas, and cancelled all existing senior debt and equity. The company also appointed a new board of directors including representatives of principal security holders, adopted fresh-start accounting pursuant to applicable accounting rules and changed its name to Kindred Healthcare, Inc.

#### ITEM 6.11(c)

- 1. OIG Investigation into SNF RUGs Coding. In October and November of 2009 the Department of Health and Human Services Office of the Inspector General ("OIG") served various administrative subpoenas for documents on nine Kindred skilled nursing facilities located in seven different states, the corporate office and Kindred Rehab Services, Inc. The subpoenas sought numerous documents related to the billing of rehab therapy services to Medicare Part A and Part B from January 1, 2004 to the present. The OIG confirmed to us that this is an active industry-wide investigation involving skilled nursing providers in addition to Kindred, and that there is no whistleblower or "qui tam" lawsuit pending against Kindred. The federal government has not made any demand for money on the Company.
- 2. Boston DOJ Investigation into RehabCare. In September 2012 the Company received a subpoena from the United States Attorney's Office in Boston, Massachusetts ("USAO") which sought extensive information about RehabCare's business customers and employees and various records concerning RehabCare's provision of rehab therapy services to long term care facilities including skilled nursing facilities in Massachusetts from January 1, 2007 to December 31, 2011. The Company has continued to receive document requests including subpoenas seeking various records of RehabCare concerning its rehab therapy services and billings to skilled nursing facilities nationwide, and we have produced these records to the USAO. The Company's attorneys met with USAO and other Government employees in Boston on July 22, 2014, and August 26, 2014, to discuss the Government's federal False Claims Act ("FCA") allegations against RehabCare and our defense response. The USAO has not made any demand for money upon the Company.

CON Project #142193-E and LHCSA Application #2556-L Programmatic Attachment F – Page 2 of 3 Kindred Legal Actions

- Whistleblower Lawsuit regarding a RehabCare Missouri Transaction in 2005-2006 Settled. Investigation began with a subpoena dated August 29, 2008, from the St. Paul Field Office, U.S. Department of Health and Human Services, Office of Inspector General (the "Subpoena"), being served upon RehabCare Group, Inc. A whistleblower lawsuit pending "under seal" in federal court in Minnesota apparently initiated the investigation. [Kindred Healthcare, Inc. purchased RehabCare Group Inc. and its subsidiaries on June 1, 2011.] The Government intervened in the lawsuit styled United States ex rel. Health Dimensions Rehabilitation, Inc. v. RehabCare Group Inc., et al., Case No. 4:12-CV-00848AGF, by filing a new complaint and demand for jury trial in the U.S. District Court for the District of Minnesota against the defendants including RehabCare Group on December 5, 2011. The Government alleged violations of the federal Anti-Kickback Statute, the federal False Claims Act and other common law causes of action. This action was transferred to the U.S. District Court for the Eastern District of Missouri in St. Louis in May 2012. A final Settlement Agreement was executed by all parties effective January 17, 2014. RehabCare Group paid \$25 million to the United States and \$150,000 to the whistleblower's attorneys as fees and the unrelated co-defendants paid an additional \$5 million to the United States to settle the lawsuit. The court dismissed the lawsuit with prejudice on January 31, 2014.
- A. Bettencourt/Harrison (formerly Walsh) v. Kindred Healthcare, Inc., et al. On November 30, 2010, in state court in San Francisco County, California, a discharged resident of our Golden Gate nursing facility filed a purported class action lawsuit against the Company's nursing centers in California for alleged failures to meet the statutory 3.2 hour nursing home per patient day ("NHPPD") minimum during the alleged class period, which runs from November 23, 2006 through April 15, 2013. In June 2013 the parties agreed to a settlement in principle in which the Company agreed to fund up to \$8.25 million to pay eligible class members who file timely claims pursuant to a formula. Defendants also agreed to pay up to \$200,000 for settlement administration costs, using a third-party administrator; to pay a total of \$35,000 as service payments to the seven named plaintiffs representing the class; to pay the costs of a third-party monitor to monitor the Company's compliance with a two-year forward injunction up to \$100,000; and to pay the plaintiffs class counsels' attorneys fees and expenses in the amount of \$2.6 million as approved by the court. The court has approved the settlement. This matter is insured by the Company's wholly-owned subsidiary, Cornerstone Insurance Company.
- 5. Bethany Lutheran Home, Inc. v. RehabCare Group East, et al. On September 10, 2012, the plaintiff nursing home ("Bethany"), which formerly contracted for rehab therapy services with RehabCare, filed an indemnification action against RehabCare in the U.S. District Court for the Southern District of Iowa. The complaint seeks to recover \$675,000 paid by Bethany to the U.S. Government in settlement of alleged False Claims Act violations based on RehabCare's having provided excessive therapy services to Bethany's residents for the 2005 through 2008 time period. The claims include breach of contract, regligence and fraudulent misrepresentation; and plaintiff seeks money damages and injunctive relief. Plaintiff further seeks future indemnification for false claims allegedly submitted to Medicare from 2009 to 2011. The court has denied RehabCare's motion to dismiss the complaint for failure to state a claim. Discovery is ongoing.

United States of America, et al., v. Amgen, Omnicare, PharMerica and Kindred Healthcare. On February 4, 2014, the Company was served with a Summons and Complaint in the above-styled action which has been pending under seal as Case #311CV1464JFA in the U.S. District Court for the District of South Carolina since June 2011. The lawsuit is brought by a whistleblower under the federal False Claims Act alleging violations of the federal and state Anti-Kickback Statutes. The defendants allegedly received illegal rebates and other kickbacks from Amgen for switching patients who were prescribed certain drugs from other manufacturers to Amgen's products instead. The complaint seeks damages, statutory fines and penalties, the whistleblower's attorneys' fees and an injunction prohibiting such conduct in the future. Apparently the United States and twenty-five state Attorneys General and the District of Columbia and the City of Chicago have informed the court that they are intervening in the lawsuit as against Omnicare. It also appears from the recently unsealed court docket sheet that the United States is entering into a settlement with Omnicare and is declining to intervene into the action against PharMerica and Kindred Healthcare. These actions by the Government leave the whistleblower to pursue his claims against PharMerica and Kindred Healthcare on his own. The Company has made a claim for indemnification against PharMerica as provided for in the Master Transaction Agreement related to Kindred's spinoff of its former subsidiary, Kindred Pharmacy Services, Inc., to PharMerica on July 1, 2007, which PharMerica has accepted.

#### ITEM 6.11(d)

Effective April 20, 2001, Kindred Healthcare, Inc. entered into a Corporate Integrity Agreement with the Office of Inspector General of the U.S. Department of Health and Human Services (the "OIG") to promote compliance with the requirements of Medicare, Medicaid and all other federal healthcare programs. Under the Corporate Integrity Agreement, the company implemented a comprehensive internal quality improvement program and a system of internal financial controls in its hospitals, nursing centers, pharmacies, rehabilitation operations, and regional and corporate offices. The Corporate Integrity Agreement expired in April 2006.

The Corporate Integrity Agreement required the Company to, among other things:

- engage the Long Term Care Institute to monitor and evaluate the company's quality improvement program and report its findings to the OIG;
- adopt and implement written standards on federal healthcare program requirements with respect to financial and quality of care issues;
- conduct training each year for all employees to promote compliance with federal healthcare requirements;
- put in place a comprehensive internal quality improvement program;
- enhance its system of internal financial controls to promote compliance with federal healthcare program requirements on billing and related financial issues, including a variety of internal audit and compliance reviews;
- notify the OIG of allegations that the company committed a crime, engaged in fraudulent activity, or discovered a potential violation of the federal fraud and abuse laws or other criminal or civil laws related to any federal healthcare program, and
- submit an implementation report to the OIG in August 2001 and an annual report each
  year thereafter.

#### **RESOLUTION**

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 3605 of the Public Health Law, on this 12th day of February, 2015, having considered any advice offered by the staff of the New York State Department of Health and the Establishment and Project Review Committee of the Council, and after due deliberation, hereby approves the following applications for licensure, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER:</u> 2276 L	FACILITY:  1st Class Care Services, Inc.  (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)
2178 L	All Heart Homecare Agency, Inc. (New York, Richmond, Kings, Bronx, Queens, and Westchester Counties)
2292 L	Angels of Mercy Counseling Center, Inc. (Nassau Suffolk Queens and Westchester Counties)

2272 L	A Plus Homecare Agency, Inc. (Queens, Bronx, New York, Kings, Richmond, and Nassau Counties)
2037 L	Bright Home Care, Inc. (New York, Bronx, Kings, Richmond, Queens and Westchester Counties)
2266 L	Central Westchester Home Health Services, LLC (Westchester County)
2268 L	Chinatown Home Health Care, Inc. (New York, Bronx, Kings, Queens, Richmond and Nassau Counties)
2218 L	Comprehensive Elder Care, LLC (Bronx, Richmond, Kings, New York, Queens, and Nassau Counties)
2285 L	Elite Home and Community Care Service, Inc. (Rockland, Putnam, Westchester, Orange and Bronx Counties)
2254 L	Ellison Home Care Companion Agency, Inc. (Nassau, Westchester, Rockland, Queens, and Suffolk Counties)
2247 L	Grupp KK, Inc. (Bronx, Richmond, New York, Queens, Kings, Westchester Counties)
2152 L	Guiding Angels Home Care, LLC (Bronx, Kings, New York, Richmond, Queens and Nassau Counties)
2138 L	Home at Last Home Care Services, LLC (Kings, Bronx, Queens, Richmond, and New York Counties)

2175 L	Human First Community Health Care, LLC (Nassau, Suffolk and Queens Counties)
2215 L	La'Dorch Homecare, Inc. (Bronx, Richmond, Kings, New York, Queens, and Westchester Counties)
2261 L	Marabi Homecare Agency, Inc. (New York, Richmond, Kings, Bronx, Queens, and Nassau Counties)
2274 L	Masih Home Care Incorporated (Queens, Kings, Richmond, New York, Bronx, and Nassau Counties)
2202 L	MY Care Health Services, Inc. (Queens, New York, Bronx, Richmond, Kings, and Nassau Counties)
2244 L	New Hope Services, Inc. (Bronx, Richmond, New York, Queens, Kings and Westchester Counties)
2259 L	NMC Homecare Agency of NY, Inc. (New York, Richmond, Kings, Bronx, Queens, and Westchester Counties)
2176 L	Augusta Osinowo d/b/a Nightingale Care Services (Bronx, Queens, New York, Richmond, Kings, and Nassau Counties)
2157 L	Passion for Seniors of NY, Inc. (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)
2299 L	Premium Home Services, LLC (Queens, Kings, Bronx, New York, Richmond, and Nassau Counties)
2279 L	Scope Healthcare Services, Inc. (Suffolk, Nassau and Queens Counties)

2163 L	Global Private Home Care LLC (Bronx, Queens, Kings, Richmond, New York and Nassau Counties)
2461 L	Alice Hyde Medical Center (Franklin County)
2295 L	Hyde Park Assisted Living Facility, Inc. d/b/a Hyde Park Licensed Home Care Agency (Dutchess County)
2319 L	Acare HHC, Inc. d/b/a Four Seasons Home Care (Bronx, Queens, Kings, Richmond, Nassau and New York Counties)
2389 L	Crown of Life Care NY, LLC (Bronx, Queens, Kings, Richmond, Nassau and New York Counties)
2342 L	Elite HHC, LLC (Bronx, Richmond, Kings, Westchester, New York and Queens Counties)
2401 L	Prestige LHCSA Management, Inc. (Bronx, Richmond, Kings, Westchester, New York and Queens Counties)
2556 L	Quality Care – USA, Inc. d/b/a Gentiva Health Services (See exhibit for counties served)



# Public Health and Health Planning Council

# Project # 142218-E NYU Lutheran Medical Center

Program: Hospital County: Kings

Purpose: Establishment Acknowledged: December 5, 2014

#### **Executive Summary**

#### **Description**

NYU Langone Health System, Inc. (NYUHS), an existing not-for-profit corporation which is controlled by New York University (NYU), a not-for-profit corporation in New York County, requests approval to become the active parent and co-operator of Lutheran Medical Center, a 450-bed not-for-profit hospital located at 150 55th Street, Brooklyn (Kings County). NYUHS would replace Lutheran Medical Center Health System, Inc. as the sole corporate member of Lutheran Medical Center. Approval is also sought to change the name of the Lutheran Medical Center to NYU Lutheran Medical Center.

The purpose of the transaction is to establish a more integrated system with the objectives of improving quality, increasing access and lowering the costs of health care in the communities served by Lutheran Medical Center. There will be no change in authorized services or the number or type of beds as a result of approval of this project. Also, there are no projected changes in the utilization, revenues or expenses of Lutheran Medical Center as a direct result of this project. The hospital will maintain a separate not-for-profit corporation licensed under Article 28 of the Public Health Law, maintaining its separate operating certificate following completion of the project.

As active parent and co-operator, NYUHS will have the following rights, powers and authorities with respect to Lutheran Medical Center:

- Electing the Corporation's Board of Trustees;
- Removing the Corporation's Board of Trustees;
- Filling any vacancies in the Corporation's Board of Trustees;
- Amending or repealing these By-laws or adopting new By-laws;

- Approving the Corporation's merger or consolidation with another entity;
- Approving the sale, lease, exchange or other disposition of all, or substantially all, the assets of the Corporation;
- Reviewing the vision, mission and strategic and financial plans to the Corporation;
- Reviewing the Corporation's annual operating and capital budgets, provided that final approval of the budgets shall remain with the Corporation;
- Approving any transaction having a value of \$25,000,000 or more; and
- Approving the creation, acquisition and/or dissolution of an entity in which the Corporation is proposed to be, or is, the contracting member.

Presented as BFA Attachment A are the organizational charts of Lutheran Medical Center and NYU Langone Health System, Inc. pre-closing and post-closing.

#### **DOH Recommendation**

**Contingent Approval** 

#### **Need Summary**

This project will not change utilization, services, or beds. This transaction will help with the financial stability of the facility, improve access to clinical expertise, and establish a commitment to high quality care. NYUHS plans to expand the IT infrastructure and connectivity at Lutheran to further improve patient care.

#### **Program Summary**

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

**Financial Summary** 

There are no project cost or budgets associated with this application.

The applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

## **Office of Primary Care and Health Systems Management** Approval contingent upon:

- Submission of evidence of approval by the Office of Mental Health, acceptable to the Department. [PMU]
- 2. Submission of the executed Certificate of Incorporation of NYULMC System, Inc., acceptable to the Department. [CSL]
- 3. Submission of an executed amendment to the Certificate of Incorporation of NYULMC System, Inc., acceptable to the Department, that changes the corporation's name to NYU Langone Health System, Inc. [CSL]
- 4. Submission of an executed amendment to the Certificate of Incorporation of Lutheran Medical Center, acceptable to the Department. [CSL]
- 5. Submission of the finalized Amended and Restated Constitution and Bylaws of NYU Lutheran Medical Center, acceptable to the Department. [CSL]
- 6. Submission of the Certificate of Incorporation of NYU Hospitals Center, and any amendments thereto, acceptable to the Department. [CSL]
- 7. Submission of the bylaws of NYU Hospitals Center, and any amendments thereto, acceptable to the Department. [CSL]

#### Approval conditional upon:

1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

**Council Action Date** February 12, 2015

#### **Need Analysis**

#### **Background**

A newly formed entity, NYU Langone Health System, Inc., controlled by New York University, seeks approval to be established as the active parent and co-operator of Lutheran Medical Center (LMC), a 450-bed voluntary not-for-profit facility located at 150 55th street Brooklyn, NY 11220. The applicant plans to change the facility name to NYU Lutheran Medical Center upon project approval.

Lutheran Hospital Certified Beds	
Category	<u>Beds</u>
AIDS	11
Chemical Dependence - Detoxification	8
Coronary Care	8
Intensive Care	24
Maternity	28
Medical / Surgical	282
Neonatal Continuing Care	6
Neonatal Intermediate Care	4
Pediatric	14
Physical Medicine and Rehabilitation	30
Psychiatric	35
Total	450

#### **Conclusion**

This project will allow the health system to operate in a more cost effective manner, provide a more streamlined patient health system, and offer better access to care.

#### Recommendation

From a need perspective, approval is recommended.

#### **Program Analysis**

#### **Program Description**

A newly formed entity, NYU Langone Health System, Inc. (NYUHS), for which New York University (NYU), a not-for-profit corporation, is the passive parent, seeks approval to be established as the active parent and co-operator of the Lutheran Medical Center (LMC), an existing 450-bed not-for-profit hospital located in Kings County. Approval is also sought to change the name of LMC to NYU Lutheran Medical Center. Additionally, shortly after NYUHS is approved as the active parent and co-operator of LMC, NYU Medical Center will seek approval to become the co-operator of LMC's Cardiac Catheterization Lab. The applicant does not anticipate any change in staffing, authorized services or number and/or type of bed complement.

NYU Langone Medical Center, located in Manhattan, is composed of the NYU School of Medicine which, since 1841, has trained thousands of physicians and scientists and three (3) hospitals: Tisch Hospital, its flagship acute care facility; the Rusk Institute of Rehabilitation Medicine, a university-affiliated facility devoted entirely to rehabilitation medicine; and the NYU Hospital for Joint Diseases, a facility dedicated to orthopedics and rheumatology.

Lutheran Medical Center is the principal provider of healthcare for the residents of southwest Brooklyn. Its emergency department is designated as a Level I Trauma Center as well as a Regional Stroke Center and it has one of the largest Federally Qualified Health Center networks in the nation, to include school-based health centers and social support services, a Level 3 Patient-Centered Medical home, and affordable housing and support services to older adults.

The applicant views an NYUHS-Lutheran affiliation as an opportunity to respond to the changing health care environment in Brooklyn through financial stability, leadership, expertise in population health and IT infrastructure which will support the delivery of comprehensive, highly coordinated care to Brooklyn patients and support local providers.

#### **Character and Competence**

The proposed Board of Directors of NYUHS is comprised of:

Robert I. Grossman, MD

Robert Berne, PhD

Kenneth G. Langone

CEO/Director

Director

Director

Dr. Grossman serves as both Dean of the New York University School of Medicine and Chief Executive Officer of NYU Langone Medical Center. Mr. Berne is the Executive Vice President for Health at New York University and Mr. Langone is the CEO of Inversed Associates, an investment banking firm.

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.

Between 2006 and 2008, the Department issued the following four (4) Stipulations and Orders to NYU Hospital Center:

- 11/16/06 \$16,000 fine based on an investigation of two occurrences of wrong-sided surgery (one involving a hernia and the other involved removal of a catheter).
- 2/7/07 \$6,000 fine based on a complaint investigation regarding the care rendered to a patient who had jaw surgery involving fixation. Following periods of extensive bleeding, the patient arrested. Intubation was hindered by the fixation and the patient died.
- 5/29/07 \$6,000 fine based on an incident involving the care rendered to an infant who presented to the ED bleeding from a tracheotomy site. There were significant delays in diagnosing a bowel that had herniated into the chest cavity and delays in recognizing the infant's deteriorating condition and notifying senior staff which led to the patient's death.
- 5/28/08 \$6,000 fine based on an incident relating to a patient who was admitted for treatment of a long-standing, poorly controlled seizure disorder. Hospital policy required continuous monitoring of such a patient but said monitoring did not occur due to a known problem with equipment at the nursing station.

#### Recommendation

From a programmatic perspective, approval is recommended.

#### **Financial Analysis**

#### **Capability and Feasibility**

There are no issues of capability or feasibility, as there is no project cost or budgets associated with this application.

BFA Attachment B is the 2012 and 2013 consolidated certified financial statements of NYU Hospitals Center. As shown, the hospital had an average positive working capital position and an average positive net asset position from 2012 through 2013. Also, the hospital achieved an average operating income of \$141,606,500 from 2012 and 2013.

BFA Attachment C is the August 31, 2014 internal financial statements of NYU Hospitals Center. As shown, the hospital had a positive working capital position and a positive net asset position through August 31, 2014. Also, the facility achieved an operating income of \$214,791,000 through August 31, 2014.

BFA Attachment D is the 2012 and 2013 certified financial statements of Lutheran HealthCare. As shown, the entity had an average positive working capital position and an average positive net asset position from 2012 through 2013. Also, the entity incurred average operating losses of \$16,341,500 from 2012 through 2013. The applicant has indicated that the reasons for the losses are the result of the following:

- The losses were primarily generated by Lutheran Healthcare's physician corporation, which had been supported by the positive margins generated at Lutheran Medical and Lutheran Family Health Centers
- The operations of Health Plus were sold on May 1, 2012, and then changed its name to OHP.
   OHP's function as of May 1, 2012, was to pay off liabilities, resolve all claims, collections and
   receivables (basically to run-out the company). In 2012 the company incurred significant additional
   cost as a result of the sale for staff retention bonus, severance and terminating cost that resulted in
   the loss from operations.
- The loss in 2013 was due to a run-out of administrative cost and settlements of above recorded liabilities.

The applicant implemented the following steps to improve operations:

- Over the last few years, the hospital invested in the retention and recruitment of physician and
  physician practices. Revenues will increase as the practices grow and they are able to negotiate
  better rates and realize additional admissions. Management is currently reviewing many of the
  physician practice sites to reduce costs through consolidation and efficiency.
- Under the proposed arrangement, the physician corporation of Lutheran Healthcare will become part
  of NYU School of Medicine's Faculty Group Practice. This will eliminate the losses from Lutheran
  Healthcare, and the management of these physicians within the larger Faculty Group Practice will
  provide improved revenue collections and more efficient overhead.

BFA Attachment E is the September 30, 2014 internal financial statements of Lutheran HealthCare. As shown, the entity had a positive working capital position and a positive net asset position through September 30, 2014. Also, the entity incurred operating losses of \$19,123,000 through September 30, 2014. The losses through September 30, 2014 were due to the run-out of administrative cost settlements above recorded liabilities of OHP. The hospital is at the tail-end of the run-out and they anticipate a resolution by May 1, 2015.

The applicant has demonstrated the capability to proceed in a financially feasible manner and approval is recommended.

#### Recommendation

From a financial perspective, approval is recommended.

#### **Attachments**

BFA Attachment A Organizational Chart

BFA Attachment B Financial Summary - 2012 and 2013 certified financial statements of NYU

**Hospitals Center** 

BFA Attachment C August 31, 2014 internal financial statements of NYU Hospitals Center

BFA Attachment D Financial Summary - 2012 and 2013 certified financial statements of Lutheran

HealthCare

BFA Attachment E September 30, 2014 internal financial statements of Lutheran HealthCare

#### RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 12th day of February, 2015 having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish NYU Langone Health System, Inc. as the active parent and co-operator of Lutheran Medical Center to be renamed NYU Lutheran Medical Center, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER: FACILITY/APPLICANT:

142218 E NYU Lutheran Medical Center

#### APPROVAL CONTINGENT UPON:

- 1. Submission of evidence of approval by the Office of Mental Health, acceptable to the Department. [PMU]
- 2. Submission of the executed Certificate of Incorporation of NYULMC System, Inc., acceptable to the Department. [CSL]
- 3. Submission of an executed amendment to the Certificate of Incorporation of NYULMC System, Inc., acceptable to the Department, that changes the corporation's name to NYU Langone Health System, Inc. [CSL]
- 4. Submission of an executed amendment to the Certificate of Incorporation of Lutheran Medical Center, acceptable to the Department. [CSL]
- 5. Submission of the finalized Amended and Restated Constitution and Bylaws of NYU Lutheran Medical Center, acceptable to the Department. [CSL]
- 6. Submission of the Certificate of Incorporation of NYU Hospitals Center, and any amendments thereto, acceptable to the Department. [CSL]
- 7. Submission of the bylaws of NYU Hospitals Center, and any amendments thereto, acceptable to the Department. [CSL]

#### APPROVAL CONDITIONAL UPON:

1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.



# Public Health and Health Planning Council

# Project # 142115-E Pure Life Renal of Buffalo, Inc

Program: Diagnostic & Treatment Center County:

Purpose: Establishment Acknowledged: September 23, 2014

#### **Executive Summary**

#### **Description**

Pure Life Renal of Buffalo, Inc. (Pure Life), a to-be formed corporation, requests approval to become the operator of Comprehensive Dialysis Center of Western New York, Inc. (Comprehensive Dialysis), an existing Article 28 diagnostic and treatment center (D&TC) located at 6010 Main Street, Williamsville (Erie County), that provides in-center and home-based renal dialysis services. Pure Life will be a subsidiary of Pure Life Renal, Inc., a Delaware C Corporation that provides dialysis services to end stage and acute renal failure patients. Pure Life Renal, Inc. will own 100% of the stock of Pure Life Renal of Buffalo, Inc. and will provide all financing for the purchase of the program and provide working capital needs. The ownership of Pure Life Renal, Inc. is shown as BFA Attachment D.

Pure Life Renal, Inc. entered into a lease agreement with Buffalo Medical Group Building, Inc. (lessor), to lease the premises located at 6010 Main Street, Williamsville, for the purpose of operating the outpatient renal dialysis clinic. There will be no disruption in services in the implementation of this arrangement.

#### **DOH Recommendation**

Contingent Approval

#### **Need Summary**

Erie County currently has a population of 919,866 with 1,132 residents needing dialysis treatment. Currently there are 256 total stations approved to be operational

Erie County which can treat 1,152 patients according to the Department of Health's methodology. This project would not bring about a change in the dialysis capacity of Erie County.

Erie

#### **Program Summary**

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

#### **Financial Summary**

The purchase price of the business is \$12,000,000 based on Pure Life's assessment of the anticipated return on equity of the purchase. Payment of the purchase price will be met as follows: \$12,000,000 from the operations of Pure Life Renal, Inc.

There are no project costs associated with this CON.

#### Budget:

Revenues \$7,739,189 Expenses \$6,665,481 Net Income/(Loss) \$1,073,708

Subject to the noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

## Office of Primary Care and Health Systems Management Approval contingent upon:

- 1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
- 2. Submission of an executed Medical Director Agreement, acceptable to the Department. [HSP]
- 3. Submission of an executed Assignment and Assumption Agreement associated with the asset purchase agreement, acceptable to the Department of Health. [BFA]
- 4. Submission of an executed Assignment and Assumption Agreement associated with the lease rental agreement, acceptable to the Department of Health. [BFA]
- 5. Submission of documentation showing the receipt of the additional funds from the sale of the Series A stock, acceptable to the Department of Health. [BFA]
- 6. Submission of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project. [CSL]
- 7. Submission of Bylaws with the following amendments: (1) removal of proxy language or amended to provide that the proxy may vote only as specifically instructed by the shareholder with regard to each vote, unless the shareholders proxy is another shareholder approved by the Public Health and Health Planning Council to vote the shares that are covered by the proxy. [CSL]
- 8. Submission of an executed Certificate of Incorporation which must comply with 10 NYCRR Section 620.1. [CSL]
- 9. Submission of original stockholder affidavits from each stockholder including the specific information set forth in 10 NYCRR Section 620.1(b). [CSL]
- 10. Submission of a stock certificate including specific language set forth in 10 NYCRR 620.1(a)(4). [CSL]
- 11. Submission of the Certificate of Incorporation and Bylaws of Pure Life Renal, Inc. [CSL]
- 12. Submission of an executed and dated Application for Authority authorizing Pure Life Renal, Inc., a Delaware corporation, to conduct business in the State of New York. [CSL]
- 13. Submission of a photocopy of the executed Assignment and Assumption Agreement with the following amendments: (1) all blanks must be filled in, (2) the document must be executed. [CSL]

#### **Approval conditional upon:**

- The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from other adjacent entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]

**Council Action Date** February 12, 2015

#### **Need Analysis**

#### **Project Description**

Pure Life Renal of Buffalo, Inc., is seeking approval to transfer ownership of Comprehensive Dialysis Center of Western New York, Inc., a 25 station renal dialysis diagnosis and treatment center located at 6010 Main Street, Williamsville 14221. This project would have no impact on the number of renal dialysis stations in the county.

#### **Analysis**

The primary service area for this facility is Erie County, which had a population estimate of 919,866 in 2013. The percentage of the population aged 65 and over was 16.3%. The nonwhite population percentage was 23.1%. These are the two population groups that are most in need of end stage renal dialysis service. Comparisons between Erie County and New York State are listed below.

	Erie County	State Average
Ages 65 and Over:	16.3%	14.1%
Nonwhite:	23.1%	42.8%
Source: U.S. Census 2013		

#### Capacity

The Department's methodology to estimate capacity for chronic dialysis stations is specified in Part 709.4 of Title 10 and is as follows:

- One free standing station represents 702 treatments per year. This is based on the expectation that the center will operate 2.5 patient shifts per day at 6 days per week, which can accommodate 15 patients per week (2.5 x 6 x 15 x 52 weeks). This projected 702 treatments per year is based on a potential 780 treatments x 52 weeks x 90% utilization rate = 702. The estimated average number of dialysis procedures each patient receives per year is 156.
- One hospital based station is calculated at 499 treatments per year per station. This is the result of 2.0 shifts per day x 6 days per week x 52 weeks x 80% utilization rate. One hospital based station can treat 3 patients per year.
- Per Department policy, hospital-based stations can treat fewer patients per year. Statewide, the
  majority of stations are free standing, as are the majority of applications for new stations. As
  such, when calculation the need for additional stations, the Department bases the projected need
  on establishing additional free standing stations.
- There are currently 256 free standing chronic dialysis stations operating in Erie County and 0 in pipeline for a total of 256. This project will not result in any changes to the capacity in the county. The total will remain 256 chronic dialysis stations. These stations will be able to treat 1,152 patients.

#### **Erie County Projected Need**

	2012	2013	201	7
	Patients Treated	Residents Treated	Projected Patients Treated*	Projected Residents Treated*
	1175	1132	1363	1274
Free Standing Stations Needed	262	252	303	284
Existing Stations	256	256	256	256
Pipeline Stations	0	0	0	0
Total Stations with Pipeline	256	256	256	256
w/Approval of This CON and Pipeline	256	256	256	256
Unmet Need With Approval	6	-4	47	28

<sup>\*</sup>Patient data is from 2012 and is projected out 5 years, assuming a 3% annual rate of increase. Resident data is from 2013 and is projected out 4 years, assuming a 3% annual rate of increase.

The data in the first row, "Free Standing Stations Needed," comes from the DOH methodology of each station being able to treat 4.5 patients, and each hospital station being able to treat 3 patients annually. The data in the next row, "Existing Stations," comes from the Department's Health Facilities Information System (HFIS). "Unmet Need" comes from subtracting needed stations from existing stations. "Total Patients Treated" is from IPRO data from 2012.

#### Conclusion

The facility accommodates a population in need of access to dialysis stations in the service area. The 256 stations in Erie County currently serve a population of 919,866 residents and the county is near capacity for dialysis stations. This indicates that these resources are well-utilized. The proposed ownership change would have no impact on the number of renal dialysis stations, and the facility would continue to provide this critical service.

#### Recommendation

From a need perspective, approval is recommended.

#### **Program Analysis**

#### **Project Proposal**

Pure Life Renal of Buffalo, Inc., a to-be-formed corporation, requests approval for the transfer of ownership of Comprehensive Dialysis Center of Western New York, Inc. The existing 25-station center is located at 6010 Main Street in Williamsville (Erie County). If approved, the name of the facility will be changed to Pure Life Renal of Buffalo, Inc. and this will represent the first dialysis center owned/operated by Pure Life Renal, Inc. There are no significant programmatic changes anticipated as a result of this proposal.

Proposed Operator	Pure Life Renal of Buffalo, Inc.	
Site Address	6010 Main Street	
	Williamsville, NY (Erie County)	
Approved Services	Chronic Renal Dialysis (25 stations)	
	Home Hemodialysis Training & Support	
	Home Peritoneal Dialysis Training & Support	
Shifts/Hours/Schedule	3 shifts per day, 6 days per week	
	Monday/Wednesday/Friday 5:30am - 9:30 pm	
	Tuesday/Thursday/Saturday 5:30 am - 8:30 pm	
Staffing (1st Year / 3rd Year)	33.09 FTEs / 34.59 FTEs	
Medical Director(s)	Inkee Min, MD	
Emergency, In-Patient and Backup Support	t Expected to be provided by	
Services Agreement and Distance	Millard Fillmore Suburban Hospital	
_	2.2 miles / 5 minutes	

#### **Character and Competence**

Pure Life Renal, Inc. holds 100% shares of Pure Life Renal of Buffalo, Inc.

Name
Pure Life Renal of Buffalo, Inc.
Pure Life Renal, Inc. (100%)

The proposed board members of Pure Life Renal of Buffalo, Inc. are:

<u>Name</u>	Position Held
Orestes Lugo (CEO of Pure Life Renal, Inc.)	President
Jeff Fernandez (CFO of Pure Life Renal, Inc.)	Treasurer
Stefano Sola (Stockholder of Pure Life Renal, Inc.)	Secretary

Messrs. Lugo and Fernandez each have considerable employment experience in health care entities providing renal dialysis services. Mr. Sola has extensive experience in international finance.

The proposed Medical Director, Dr. Min, has been a practicing physician for over 30 years and is board-certified in Internal Medicine and Nephrology.

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

Between 2002 and 2009, when Mr. Lugo was in the position of Chief Financial Officer (CFO) and Mr. Fernandez was in the position of Controller, Renal Care Partners, Inc. was the parent entity of 24 dialysis centers operating in eight (8) states. In March 2007, the Centers for Medicare and Medicaid Services (CMS) determined that a center operating in Hialeah, Florida was not in substantial compliance with four (4) Medicare conditions for coverage and subsequently terminated the Hialeah center's Medicare participation. (None of the compliance issues noted related to Messrs. Lugo and Fernandez' duties and responsibilities.) In 2009, Renal Care reorganized its own management and appointed Mr. Lugo as the Chief Executive Officer and Mr. Fernandez as CFO. The dialysis facilities have sustained substantial compliance.

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

#### Recommendation

From a programmatic perspective, contingent approval is recommended.

#### **Financial Analysis**

#### **Financial Analysis**

#### **Asset Purchase Agreement**

The applicant has submitted an executed asset purchase agreement, which is summarized as follows:

Date:	September 15, 2014
Seller:	Comprehensive Dialysis Center of Western New York, Inc.
Purchaser:	Pure Life Renal, Inc.
Acquired Assets:	Seller's right, title and interest in all of the following assets owned and used by the seller in the business: All inventories and other materials; All supplies, equipment, vehicles, machinery, furniture, fixtures, leasehold improvements and other tangible personal property; All proprietary knowledge, trade secrets, patient, physician and referral lists, technical information, quality control data, processes, methods or rights; The business as a going concern and its franchises, insurance policies, telephone numbers, customer and vendor lists, assigned contracts, personal property leases, advertising material and data, obligations owing to CDC, all physical and electronic data relating to the business; All other tangible and intangible property, other than the excluded assets.
Excluded Assets:	All cash owned by the Seller, including any bank accounts owned by the Seller as of the closing; All accounts and other receivables payable and reimbursable to the Seller relating to the period prior to the closing date.
Assumed Liabilities:	N/A
Excluded Liabilities:	N/A
Purchase Price:	\$12,000,000
Payment:	\$1,200,000 non-refundable deposit upon execution of this agreement, \$1,260,000 refundable deposit upon execution of the agreement, \$9,540,000 payable at closing.

The applicant has submitted an affidavit, which is acceptable to the Department, in which the applicant agrees, notwithstanding, any agreement, arrangement or understanding between the applicant and transferor to the contrary, to be liable and for any Medicaid overpayments, made to the facility and/or surcharges, assessments, or fees due from the Seller 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 Seller of its liability and responsibility. Currently, the facility has no outstanding audit liabilities and assessments.

#### **Lease Rental Agreement**

The applicant has submitted an executed lease rental agreement for the proposed site, the terms are summarized below:

Date:	September 4, 2014
Lessor:	Buffalo Medical Group Building, Inc.
Lessee:	Pure Life Renal, Inc.
Premises:	14,428 sq. ft. located at 6010 Main Street, Williamsville, NY
Term:	5 years with 2 additional 5 year renewal terms
Payment:	\$259,704 for year 1 (\$18.00 per sq. ft.), with a \$0.25 per sq. ft. increase annually over
	the prior lease year.
Provisions:	The lessee shall be responsible for maintenance, utilities and real estate taxes.

The applicant has stated that the proposed lease is an arm's length agreement. The applicant has submitted two letters from realtors attesting to the reasonableness of the per square foot rental.

#### **Assignment and Assumption Agreements**

The applicant has submitted draft Assignment and Assumption Agreements for both the assignment of the asset purchase agreement and the lease associated with this project, as shown below:

Assignor:	Pure Life Renal, Inc.
Assignee:	Pure Life Renal of Buffalo, Inc.
Assets Transferred:	All of the acquired assets listed in the asset purchase agreement
Excluded Assets:	All of the excluded assets listed in the asset purchase agreement
Liabilities:	N/A
Lease Assigned:	Lease associated with premises located at 6010 Main Street, Williamsville, NY
Lease Terms/Payments and Provisions:	No change

#### **Operating Budget**

The applicant has submitted the Current Year, Year 1 and Year 3 operating budgets for the facility, in 2015 dollars, as shown below:

	Current Year	Year 1	Year 3
Revenues:			
Medicaid Fee For Service	\$145,856	\$148,773	\$154,784
Medicaid Managed Care	729,281	743,867	773,919
Medicare Fee For Service	2,771,268	2,826,694	2,940,892
Medicare Managed Care	3,062,981	3,124,240	3,250,460
Commercial	<u>583,425</u>	<u>595,093</u>	<u>619,135</u>
Total Revenues	\$7,292,811	\$7,438,667	\$7,739,189
Expenses: Operating Capital Total Expenses	\$4,725,470 <u>238,296</u> \$4,963,766	\$4,851,333 <u>1,675,961</u> \$6,527,294	\$5,033,963 1,631,518 \$6,665,481
Net Income	\$2,329,045	\$911,373	\$1,073,708
Utilization (Treatments) Cost Per Treatment	25,117 \$197.63	25,366 \$257.32	25,873 \$257.62

The significant increase in capital expenses from the current year to years 1 and 3 is due to the following:

- An increase in annual rental expense by approximately \$100,000 due to an increase in the base rent.
- An increase of approximately \$1.3 Million per year for the amortization of intangible assets (trade name, non-compete agreements and patient relationships) recorded in purchase accounting resulting from the acquisition of the clinic.

Utilization by payor source for the Current Year, Year 1 and Year 3, subsequent to the change in ownership, is summarized below:

	<u>Curre</u>	nt Year	<u>Ye</u>	<u>ear 1</u>	<u>Υ</u> ε	<u>ear 3</u>
Payor:	<u>Visits</u>	<u>%</u>	<u>Visits</u>	<u>%</u>	<u>Visits</u>	<u>%</u>
Medicaid Fee For Service	351	1.40%	355	1.40%	362	1.40%
Medicaid Managed Care	1,626	6.47%	1,642	6.47%	1,675	6.47%
Medicare Fee For Service	14,708	58.56%	14,855	58.56%	15,153	58.57%
Medicare Managed Care	6,636	26.42%	6,702	26.42%	6,837	26.43%
Commercial	1,646	6.55%	1,662	6.55%	1,696	6.56%
Charity Care	<u>150</u>	<u>.60%</u>	<u>150</u>	<u>.59%</u>	<u>150</u>	<u>.58%</u>
Total	25,117	100.00%	25,366	100.00%	25,873	100.00%

Expense and utilization assumptions are based on the historical experience of the current operator, with the assumption of an annual 2% increase in revenues and an annual 1% increase in visits (treatments). These assumptions appear reasonable.

#### **Capability and Feasibility**

The total purchase price for the operation of the facility is \$12,000,000. Pure Life will meet the purchase price as follows: \$12,000,000 from the operations of Pure Life Renal, Inc., the facility's sole shareholder. There are no project costs associated with this CON.

Working capital requirements are estimated at \$1,087,882, based upon two months of Year 1 expenses. The applicant will provide the full amount of the working capital requirement from the operations of Pure Life Renal, Inc., the applicant's sole shareholder. BFA Attachment B is the internal financial statement for Pure Life Renal, Inc. for the period February 10, 2014 through October 31, 2014, which indicates insufficient liquid resources to meet both the equity and working capital requirements for this project. The applicant has explained that they are in the process of raising funds through the sale of Series A Stock in the business and have an agreement in place to receive \$10,500,000 in additional funds by the first quarter of 2015. When this additional money is received, the facility will have sufficient liquid resources to meet both the equity and working capital requirements, therefore making it financially feasible.

BFA Attachment C is the Pro Forma Balance sheet for Pure Life, which shows that the operations will start with \$13,200,000 in equity. It is noted that assets include \$3,433,000 in goodwill and \$8,302,000 in net intangible assets, which are not available liquid resources, nor are they recognized for Medicaid reimbursement purposes. Thus, the net asset position would be a positive member's equity position of \$1,465,000.

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

#### Recommendation

From a financial perspective, contingent approval is recommended.

#### **Attachments**

BFA Attachment A Pure Life Table of Organization

BFA Attachment B Internal Financial Statements for Pure Life, Inc.

BFA Attachment C Pro-Forma Balance Sheet of Pure Life Renal of Buffalo, Inc.

BFA Attachment D Pure Life Renal, Inc. ownership list

#### RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 12th day of February, 2015 having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish Pure Life Renal of Buffalo, Inc. as the new operator of the facility located at 6010 Main Street, Williamsville which is currently operated by Comprehensive Dialysis Center of New York, Inc., and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

<u>NUMBER</u>: <u>FACILITY/APPLICANT</u>:

142115 E Pure Life Renal of Buffalo, Inc.

#### APPROVAL CONTINGENT UPON:

- 1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital. [HSP]
- 2. Submission of an executed Medical Director Agreement, acceptable to the Department. [HSP]
- 3. Submission of an executed Assignment and Assumption Agreement associated with the asset purchase agreement, acceptable to the Department of Health. [BFA]
- 4. Submission of an executed Assignment and Assumption Agreement associated with the lease rental agreement, acceptable to the Department of Health. [BFA]
- 5. Submission of documentation showing the receipt of the additional funds from the sale of the Series A stock, acceptable to the Department of Health. [BFA]
- 6. Submission of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project. [CSL]
- 7. Submission of Bylaws with the following amendments: (1) removal of proxy language or amended to provide that the proxy may vote only as specifically instructed by the shareholder with regard to each vote, unless the shareholders proxy is another shareholder approved by the Public Health and Health Planning Council to vote the shares that are covered by the proxy. [CSL]
- 8. Submission of an executed Certificate of Incorporation which must comply with 10 NYCRR Section 620.1. [CSL]
- 9. Submission of original stockholder affidavits from each stockholder including the specific information set forth in 10 NYCRR Section 620.1(b). [CSL]
- 10. Submission of a stock certificate including specific language set forth in 10 NYCRR 620.1(a)(4). [CSL]
- 11. Submission of the Certificate of Incorporation and Bylaws of Pure Life Renal, Inc. [CSL]
- 12. Submission of an executed and dated Application for Authority authorizing Pure Life Renal, Inc., a Delaware corporation, to conduct business in the State of New York. [CSL]
- 13. Submission of a photocopy of the executed Assignment and Assumption Agreement with the following amendments: (1) all blanks must be filled in, (2) the document must be executed. [CSL]

#### APPROVAL CONDITIONAL UPON:

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from other adjacent entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.



# Public Health and Health Planning Council

# Project # 132178-E Big Apple Dialysis Management, LLC

Program: Diagnostic and Treatment Center County: Kings

Purpose: Establishment Acknowledged: October 4, 2013

# **Executive Summary**

#### **Description**

Big Apple Dialysis Management, LLC d/b/a Big Apple, a for-profit corporation located at 23-14 College Point Blvd, College Point, NY, requests approval to become the established operator of four dialysis center programs currently operated by the New York City Health and Hospitals Corporation (NYCHHC). Big Apple will acquire the dialysis centers through an asset purchase agreement and will operate the Kings County Hospital site as the main clinic location. The remaining three sites will be operated as extension clinic sites.

The four locations and the number of End-Stage Renal Disease (ESRD) stations per site are as follows:

- Kings Co. Hospital site at 451 Clarkson Avenue, Dialysis Unit Room C6210, Brooklyn – 26 stations;
- Lincoln Hospital site at 234 East 149<sup>th</sup> Street, Hemodialysis Unit Bronx – 8 stations;
- Metropolitan Hospital site at 1901 First Avenue, Dialysis Unit, New York – 12 stations;
- Harlem Hospital site at 506 Lenox Avenue-Room 18-107 Dialysis Unit, New York – 11 stations.

All of the dialysis centers/ESRD stations noted above are located within their respective hospitals and no change or modifications will occur to the approved number of stations or program locations upon the approval of the change in ownership.

Big Apple will enter into four separate license agreements with NYCHHC for the right to occupy the space and continue to provide ESRD services at each respective site. There will be no change in the physical environment of the facilities and no disruption in services to existing patients. The ESRD clinics are outpatient only clinics and will not be accepting any

patients for dialysis services that are inpatients of the hospital within which the dialysis clinic is located. Such inpatients will receive their dialysis treatments in the given hospital's acute dialysis center. Big Apple has stated that once the project receives contingent approval they will start to hire and retain all of the necessary dialysis staff members. This hiring process will prevent a lapse in services once the change in ownership is fully approved.

The members of Big Apple and their ownership percentages are as follows: Dr. Jodumutt G. Bhat (50%) and Dr. Nirmal Matoo (50%). Both members are New York State licensed Nephrologists.

The members of Big Apple Dialysis also own the following seven dialysis centers in New York State: Central Brooklyn Dialysis Center, LLC; East End Dialysis Management, LLC; New Hyde Park Dialysis Center, LLC; Newtown Dialysis Center, Inc.; New York Renal Associates, Inc.; Ridgewood Dialysis Center, Inc.; and West Nassau Dialysis Center, Inc. Shown as BFA Attachment D are the 2012 and 2013 certified and 1/1/2014 – 7/31/2014 internal financial statements for the above listed facilities.

#### **DOH Recommendation**

**Contingent Approval** 

#### **Need Summary**

All three counties serve a total population of 5,593,198 with a total of 1674 stations, including approval of not-yet-operational stations. There continues to be need in all three counties. These stations are necessary to provide continued service to patients in the service areas.

#### **Program Summary**

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

#### **Financial Summary**

NYCHHC is selling the four ESRD dialysis programs listed above to Big Apple for a purchase price of \$1,137,380.88. The purchase price is based on the estimated current fair market value of the equipment located within the centers. Payment of the purchase price will be met as follows: \$113,738.88 in equity from the proposed members, and a loan of \$1,023,642 with a 5-year term at 3.16% interest rate. The interest rate

is based on the 30 day Libor rate plus 3.00%. The current 30 day Libor rate per the Wall Street Journal published December 4, 2014, is 0.16%.

There are no project costs associated with this CON.

Budget:	Year 1	Year 3
Revenues:	\$15,100,828	\$16,897,520
Expenses:	\$12,021,686	\$13,334,998
Net income/(loss):	\$3,079,142	\$3,562,522

Subject to the noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner.

#### **Recommendations**

#### **Health Systems Agency**

There will be no HSA recommendation for this project.

# **Office of Primary Care and Health Systems Management** Approval contingent upon:

- 1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital for each of the four (4) sites. [HSP]
- 2. Submission of a proposed Medical Director Agreement, acceptable to the Department. (The document entitled "Medical Director Agreement" submitted with the application delegates more authority to the contractor, Physicians Affiliate Group of New York, than is provided for in regulation. Specifically, it is an employment contract for the provision of multiple, unnamed, Medical Directors at four separate sites. As drafted, it constitutes an unacceptable management contract because the established operator is not retaining direct independent authority to appoint and discharge the Medical Directors as required by regulation.) [HSP]
- 3. Submission of an executed loan commitment, acceptable to the Department of Health. [BFA]
- 4. Submission of an executed working capital loan commitment, acceptable to the Department of Health. [BFA]
- 5. Submission of site specific executed license agreements, acceptable to the Department of Health, for site control of the following dialysis center clinic programs: Kings County Hospital Center site, Lincoln Hospital Center site, Metropolitan Hospital Center site, and Harlem Hospital site. [BFA]
- 6. Submission of site specific executed administrative service agreements, acceptable to the Department of Health, for the following dialysis center clinic programs: Kings County Hospital Center site, Lincoln Hospital Center site, Metropolitan Hospital Center site, and Harlem Hospital site. [BFA]
- 7. The submission of existing conditions schematic floor plans and architect's letter of certification for existing buildings, for review and approval. [AER]
- 8. Submission of a completed Schedule 3. [CSL]
- Submission of an executed Certificate of Assumed Name, acceptable to the Department and clarification regarding whether each location requires a Certificate of Assumed Name – if they are all operating under different names. [CSL]
- 10. Submission of an executed Certificate of Amendment of the Articles of Organization, acceptable to the Department. [CSL]
- 11. Submission of an executed Operating Agreement (and Joinder), acceptable to the Department. [CSL]
- 12. Submission of an executed Administrative Services Agreement for all four (Harlem, Kings, Lincoln and Metropolitan) locations, acceptable to the Department. [CSL]
- 13. Submission of an executed license agreement for all four (Harlem, Kings, Lincoln and Metropolitan) sites, acceptable to the Department. [CSL]
- 14. Submission of an executed Purchase and Sale Agreement. [CSL]

#### Approval conditional upon:

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]
- 6. To provide Transfusion Services, licensure by the New York State Department of Health- Wadsworth Center is required. [HSP]

**Council Action Date** February 12, 2015

## **Need Analysis**

#### **Background**

Big Apple is seeking approval to be established as the new operator of four existing dialysis centers. These centers are as follows:

- Kings County Hospital Center, a 26-station chronic dialysis facility located at 451 Clarkson Avenue in Brooklyn, 11203;
- Lincoln Medical and Mental Health, an 8-station chronic dialysis facility located at 234 East 149<sup>th</sup> Street in the Bronx. 10451:
- Metropolitan Hospital Center, a 12-station chronic dialysis facility located at 1901 First Avenue in Manhattan, 10029;
- Harlem Hospital, an 11-station chronic dialysis unit located at 506 Lenox Ave Room 18-107 in Manhattan, 10037.

There is need in Kings, Bronx, and New York Counties for additional chronic dialysis stations. Retention of these existing facilities is necessary for community residents and patients. There will be no changes in the number of stations or the services offered at the facilities under the proposed new operator.

#### **Analysis**

The service area for Big Apple and the facilities they are purchasing is Kings, Bronx, and New York Counties.

Kings Population - 2,56	<u>85,635</u>		
Ages 65 and Over:	11.7%	State Average:	14.1%
Nonwhite:	64.2%	State Average:	42.4%
Bronx Population - 1,40	<u> 08,473</u>		
Ages 65 and Over:	10.9%	State Average:	14.1%
Nonwhite:	89.2%	State Average:	42.4%
New York County Popu	ulation - 1,619,090		
Ages 65 and Over:	13.9%	State Average:	14.1%
Nonwhite:	52.4%	State Average:	42.4%

Source: U.S. Census 2012

The non-white and elderly groups are target groups with the highest need for dialysis services.

#### Capacity

The Department's methodology to estimate capacity for chronic dialysis stations is specified in Part 709.4 of Title 10 and is as follows:

- One free standing station represents 702 treatments per year. This is based on the expectation that the center will operate 2.5 patient shifts per day at 6 days per week, which can accommodate 15 patients per week (2.5 x 6 x 15 x 52 weeks). This projected 702 treatments per year is based on a potential 780 treatments x 52 weeks x 90% utilization rate = 702. The estimated average number of dialysis procedures each patient receives per year is 156.
- One hospital based station is calculated at 499 treatments per year per station. This is the result of 2.0 shifts per day x 6 days per week x 52 weeks x 80% utilization rate. One hospital based station can treat 3 patients per year.
- Per Department policy, hospital-based stations can treat fewer patients per year. Statewide, the
  majority of stations are free standing, as are the majority of applications for new stations. As
  such, when calculating the need for additional stations, the Department bases the projected need
  on establishing additional free standing stations.

#### **Existing Stations**

Kings – 585 current stations and 132 in pipeline Bronx- 389 current stations and 93 in pipeline New York- 380 current stations and 95 in pipeline

Based upon DOH methodology, Kings County could treat 3227 patients with the operational stations and pipeline stations combined. Bronx County could treat 2169 patients with the operational stations and pipeline stations combined. New York County could treat 2138 patients with the operational stations and pipeline stations combined.

#### **Projected Need**

	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated
Kings County	3954	4507	4584	5073
Free Standing Stations Needed	879	1002	1019	1128
Existing Stations	585	585	585	585
Total Stations (Including Pipeline)	717	717	717	717
Net new stations from this project	0	0	0	0
Unmet Need With Approval	162	285	302	411

	2	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated	
Bronx County	2616	2739	3033	3083	
Free Standing Stations Needed	582	609	674	686	
Existing Stations	389	389	389	389	
Total Stations (Including Pipeline)	482	482	482	482	
Net new stations from this project	0	0	0	0	
Unmet Need With Approval	100	127	192	204	

	2011		2016	
	Total Patients Treated	Total Residents Treated	***Projected Total Patients Treated	***Projected Residents Treated
New York County	1917	2756	2223	3102
Free Standing Stations Needed	426	613	494	690
Existing Stations	380	380	380	380
Total Stations (Including Pipeline)	475	475	475	475
Net new stations from this project	0	0	0	0
Unmet Need With Approval	-49	138	19	215

<sup>\*\*</sup>FS - Free Standing

The data in the first row, "Free Standing Stations Needed," comes from the DOH methodology of each station being able to treat 4.5 patients, and each hospital station being able to treat 3 patients annually. The data in the next row, "Existing Stations," comes from the Department's Health Facilities Information System (HFIS). "Unmet Need" comes from subtracting needed stations from existing stations. "Total Patients Treated" is from IPRO data from 2011.

<sup>\*\*\*</sup>Based upon an estimate of a three percent annual increase

#### Conclusion

All three counties serve a total population of 5,593,198 with a total 1674 stations, including pipeline stations. There continues to be need in all three counties. These stations are necessary to provide continued service to patients in the service areas, thus approval is recommended.

#### Recommendation

From a need perspective, approval is recommended.

# **Program Analysis**

#### **Project Proposal**

Establish Big Apple Dialysis Management, LLC as the new operator of four (4) dialysis programs/centers that are currently being operated by the New York City Health & Hospitals Corporation. The center in Kings Hospital will be designated as the main site, and three (3) remaining centers, located in Lincoln Hospital, Metropolitan Hospital and Harlem Hospital, will be designated as extension sites. The applicant does not anticipate any physical changes or changes to the number of stations.

Proposed Operator	Big Apple Dialysis Management, LLC
Doing Business As	Big Apple Dialysis at Kings County Hospital
Site #1 Address	451 Clarkson Avenue, Brooklyn
Approved Services	Chronic Renal Dialysis (26 Stations)
Shifts/Hours/Schedule	Open 6 days per week, nearly 3 shifts per day.
Staffing (1st Year/3rd Year)	28.0 FTEs and will remain at that level by the third year of operation.
Medical Director(s)	Gary Briefel, MD
Emergency, In-Patient and	Expected to be provided onsite by Kings County Hospital.
Backup Support Services	
Agreement and Distance	

Proposed Operator	Big Apple Dialysis Management, LLC
Doing Business As	Big Apple Dialysis at Lincoln Hospital
Site #2 Address	234 East 149 <sup>th</sup> Street, Bronx
Approved Services	Chronic Renal Dialysis (8 Stations)
Shifts/Hours/Schedule	Open 6 days per week, nearly 3 shifts per day.
Staffing (1 <sup>st</sup> Year/3 <sup>rd</sup> Year)	14.1 FTEs and will remain at that level by the third year of
	operation.
Medical Director(s)	Isaiarasi Gnanasekaran, MD
Emergency, In-Patient and Backup	Expected to be provided onsite by Lincoln Hospital.
Support Services Agreement and	
Distance	

Proposed Operator	Big Apple Dialysis Management, LLC
Doing Business As	Big Apple Dialysis at Metropolitan Hospital
Site #3 Address	1901 First Avenue, Manhattan
Approved Services	Chronic Renal Dialysis (12 Stations)
Shifts/Hours/Schedule	Open 6 days per week, nearly 3 shifts per day.
Staffing (1 <sup>st</sup> Year/3 <sup>rd</sup> Year)	13.0 FTEs and will remain at that level by the third year of
	operation.
Medical Director(s)	Ashok P. Chaudhuri, MD
Emergency, In-Patient and Backup	Expected to be provided onsite by Metropolitan Hospital
Support Services Agreement and	
Distance	

Proposed Operator	Big Apple Dialysis Management, LLC
Doing Business As	Big Apple Dialysis at Harlem Hospital
Site #4 Address	506 Lenox Avenue, Manhattan
Approved Services	Chronic Renal Dialysis (11 Stations)
Shifts/Hours/Schedule	Open 6 days per week, nearly 3 shifts per day.
Staffing (1 <sup>st</sup> Year/3 <sup>rd</sup> Year)	15.7 FTEs and will remain at that level by the third year of
	operation.
Medical Director(s)	LeRoy Herbert, MD
Emergency, In-Patient and Backup	Expected to be provided onsite by Harlem Hospital
Support Services Agreement and	
Distance	

#### **Character and Competence**

The members of the LLC are:

<u>Name</u>	<u>Percent</u>	
Jodumutt G. Bhat, MD	50.0%	
Nirmal Mattoo, MD	50.0%	

Drs. Bhat and Mattoo are both local physicians, board-certified in Internal Medicine. Dr. Mattoo holds a subspecialty in Nephrology. As shareholders in Atlantic Dialysis Management Services, they each have over 20 years of experience operating multiple free-standing dialysis centers in New York State.

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.

#### **Summary of Dialysis Facility Compare Statistics**

A table has been prepared (*HSP Attachment A*) which lists the 10 quality performance measures (based on treatment and patient outcomes) for the four HHC and twelve (12) applicant dialysis facilities using publicly available information from the Centers for Medicare and Medicaid Services (CMS) website, "Medicare.gov Dialysis Facility Compare" <a href="http://www.medicare.gov/dialysisfacilitycompare/search.html">http://www.medicare.gov/dialysisfacilitycompare/search.html</a>.

A Summary Statistic (the percent of scores at, or better than, the New York State average) for the acquiring entity (Bhat and Mattoo) and the relinquishing entity (HHC) is presented below. The Summary Statistic is intended to be a rough indicator of performance. (Higher is better.)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Operator		Statistics per Site	Statistics Possible (1) x (2)		(3)-(4)	Not Reported	Statistics worse than NYS Average	(6)+(7)	Summary Statistic at or above NYS Average 100-((8)/(5))
HHC	4	10	40	5	35	3	10	13	63%
Bhat 8									
Mattoo	12	10	120	12	108	1	34	35	68%

Data taken from http://www.medicare.gov/DialysisFacilityCompare/search.html as it appeared on 12/4/14.

Additionally, the applicant commissioned a (third party) quality assessment study to compare publicly available Centers for Medicare and Medicaid Services (CMS) dialysis facility quality measures at both the HHC dialysis operations and those of the applicant members. The report was prepared by Nephrologists Drs. Hart and Perumal of Cook County Health & Hospitals System (Chicago, IL) and is included for review as *HSP Attachment B*.

#### Recommendation

From a programmatic perspective, contingent approval is recommended.

## **Financial Analysis**

#### **Asset Purchase Agreement**

The applicant has submitted a draft asset purchase agreement, which is summarized as follows:

Seller:	New York City Health and Hospitals Corporation
Purchaser:	Big Apple Dialysis Management, LLC
Acquired Assets:	The facilities' physical assets including: reverse osmosis system, dialysis machines, telephone, fax and computers; all furniture; all inventory and supplies located at the facilities; all rights and interest in and to claims made or to be made by seller against the party from whom seller purchased the assets, and its principals and any recoveries or proceeds.
Excluded Assets:	Cash and cash equivalents immediately preceding the closing date; all accounts receivable relating to services rendered prior to the closing date; all retroactive rate increases and/or lump sum or other payments, which may be paid on or after the closing date for services rendered prior to the closing date; all payments or cash equivalent credits paid or accruing for periods prior to the closing date; Seller's Medicare and Medicaid provider numbers and agreements; all income tax refunds and deposits for periods prior to the closing dates; all original documents and records of the Seller; goodwill and other intangible assets used in the operations of the facilities; any real property or real property improvements used in the operations of the facilities. The Seller retains the ownership of real property and improvements and licenses to Buyer their use under the License Agreement.
Assumed and	None
Excluded Liabilities:	
Purchase Price:	\$1,137,380.88 allocated as follows:
	• Kings County Hospital Ctr. – \$655,104.84
	Lincoln Hospital Center – \$35,800
	Metropolitan Center – \$353,676.04
	Harlem Hospital Center – \$92,000
Payment:	Members' equity – \$113,738.88
	Loan – \$1,023,642 (5 year term, 3.16% interest)

The applicant has submitted an affidavit, which is acceptable to the Department of Health, in which the applicant agrees, notwithstanding any agreement, arrangement or understanding between the applicant and transferor to the contrary, to be liable and responsible for any Medicaid overpayments made to the facility and/or surcharges, assessments or fees due from the transferor pursuant to Article 28 of the Public Health Law with respect to the period of time prior to the applicant acquiring its interest, without releasing the transferor of its liability and responsibility. Currently, the facilities have no outstanding Medicaid audit liabilities.

#### **Administrative Services Agreements**

The applicant submitted a draft administrative service agreement for each discrete site. The agreements are identical in terms, except for the compensation amount for the respective sites, as summarized below:

Provider:	Atlantic Dialysis Management Services, LLC (ADMS)		
Facility:	Big Apple Dialysis at Kings County Hospital (main site)		
	Big Apple Dialysis at Lincoln Hospital (extension site)		
	Big Apple Dialysis at Metropolitan Hospital (extension site)		
	Big Apple Dialysis at Harlem. Hospital (extension site)		
Services	Billing and collection services excluding physician professional services; accounting and		
Provided:	financial services including developing and presenting annual budgets; quality and		
	utilization controls; installation of ADMS proprietary and confidential dialysis clinical		
	information system software program (Dialysis System) to support clinical and billing		
	operations; discount pricing of all supplies, inventory and drugs necessary for operation.		
	The dialysis centers shall be responsible for and pay directly to the laboratory any lab		
	services ordered for the patients treated at the dialysis centers.		
Term:	3 Years with unlimited 1 year renewal terms.		
Payments:	Total Annual Compensation (Bi-Weekly Payments) as follows:		
- Kings:	Yr. 1 \$300,000 (\$11,538.46), Yr. 2 \$350,000 (\$13,461.54), Yr. 3 \$400,000 (\$15,384.62)		
- Lincoln:	Yr. 1 \$200,000 (\$7,692.31), Yr. 2 \$250,000 (\$9,615.38), Yr. 3 \$300,000 (\$11,538.46)		
- Metro:	Yr. 1 \$200,000 (\$7,692.31), Yr. 2 \$250,000 (\$9,615.38), Yr. 3 \$300,000 (\$11,538.46)		
- Harlem:	Yr. 1 \$300,000 (\$11,538.46), Yr. 2 \$350,000 (\$13,461.54), Yr. 3 \$400,000 (\$15,384.62)		

Both ADMS and the Big Apple are owned by the same individuals with the same ownership percentages: Dr. Jodumutt G. Bhat (50%) and Dr. Nirmal Matoo (50%).

#### **License Agreement**

The applicant has submitted draft license agreements for the proposed sites as summarized below:

Premises:	Kings site: 6 <sup>th</sup> floor "C" building
	Lincoln site: interim location 9 <sup>th</sup> floor, permanent location 7 <sup>th</sup> floor
	Metropolitan site: 14 <sup>th</sup> floor Main hospital building
	Harlem site: 4 <sup>th</sup> floor new patient pavilion
Licensor:	New York City Health and Hospitals Corporation
Licensee:	Big Apple Dialysis Management, LLC
Fees:	Kings: \$484,380 annually (\$54.00/sq. ft.)
	Lincoln: interim \$239,920 annually (\$40/sq. ft.), permanent \$296,800 annually (\$40/sq. ft.)
	Metropolitan \$250,750 annually (\$50/sq. ft.)
	Harlem \$463,000 annually (\$50/sq. ft.)
	On 5 <sup>th</sup> anniversary of start date fees for all sites will increase 10% above original fees.
Term:	5-year term with one four (4) year extension
Provisions:	Licensor will provide utilities and maintenance services

The applicant has stated that the proposed license agreements are arm's length arrangements.

#### **Operating Budget**

The applicant has submitted year 1 and year 3 operating budgets, in 2014 dollars, for each discrete site. Presented below are the consolidated year 1 and year 3 budgets:

	Year 1	Year 3
Total Revenues	\$15,090,828	\$16,897,520
Expenses:		
Operating	\$10,138,306	\$11,451,618
Capital	1,883,380	\$1,883,380
Total Expenses	\$12,021,686	\$13,334,998
Net Income/(Loss)	\$3,069,142	\$3,562,522
Utilization: (treatments) Cost per treatment	54,187 \$221.86	60,767 \$219.44

Expenses include the cost of pharmaceuticals.

Consolidated utilization by payor source for years 1 and 3 subsequent to the change in operator is summarized below:

	Year 1	Year 3
Medicaid Fee-For-Service	10.69%	11.38%
Medicare Fee-For-Service	78.62%	77.63%
Commercial Fee-For-Service	10.69%	10.99%
Total	100.00%	100.00%

Expense and utilization assumptions are based on the historical experience of the applicant's other dialysis facilities.

#### **Capability and Feasibility**

The purchase price for the four sites is \$1,137,380.88, allocated as follows: Kings \$655,104.84; Lincoln \$35,800; Metropolitan \$353,676.04; and Harlem \$92,000. Big Apple will meet the \$1,137,380.88 purchase price as follows: \$113,738.88 in equity from the proposed members, with the remaining \$1,023,642 coming from a loan at the above stated terms. There are no project costs associated with this CON.

Working capital requirements are estimated at \$2,222,500 based upon two months of Year 3 expenses. The proposed members will provide \$1,111,250 of the working capital from personal resources. The remaining \$1,111,250 will be provided through a proposed one year working capital line of credit at a 3.25 % interest rate. The interest rate is based on the current prime rate, which is 3.25% as of December 4, 2014, as published in the Wall Street Journal. BFA Attachment A is the personal net worth statements of the members which indicate sufficient liquid resources to meet both the equity and working capital requirements.

BFA Attachment C is the pro forma balance sheet for Big Apple which shows consolidated operations starting with \$1,224,987 in members' equity. The site specific operations will start with the following members' equity: Kings \$396,103, Lincoln \$232,228, Metropolitan \$219,765 and Harlem \$263,152.

Year 1 shows a combined net income of \$3,069,142 for the four sites with site specific net income as follows: Kings \$ 866,728; Lincoln \$ 694,968; Metropolitan \$316,415; and Harlem \$1,191,031. Year 3 shows a combined net income of \$3,562,522 for the four sites with site specific net income as follows: Kings \$1,398,674; Lincoln \$728,573; Metropolitan \$215,846; and Harlem \$1,219,429.

Revenues reflect current reimbursement methodologies for Medicaid and Medicare. Commercial revenues are based on Big Apple's experience in operating other dialysis centers throughout New York State. The budget is reasonable.

BFA Attachment D is the 2012 and 2013 certified and 1/1/2014 – 7/31/2014 internal financial statements of the following facilities also owned by the members:

- Central Brooklyn Dialysis Center, LLC: The D&TC generated both positive average working capital
  and net asset positions, and had an average net income of \$1,806,203 for the period 2012 through
  2013. The D&TC generated both positive working capital and net asset positions and had a net
  income of \$941,184 for the period 1/1/2014 7/31/2014.
- East End Dialysis Management, LLC. The D&TC generated both positive average working capital and net asset positions, and had an average net income of \$394,131 for the period 2012 through 2013. The D&TC generated both positive working capital and net asset positions, and had a net income of \$357,796 for the period 1/1/2014 7/31/2014.
- New Hyde Park Dialysis Center, LLC. The D&TC generated both positive average working capital
  and net asset positions, and had an average net income of \$1,215,858 for the period 2012-2013.
  The D&TC generated both positive working capital and net asset positions, and had a net income of
  \$727,660 for the period 1/1/2014 7/31/2014.
- Newtown Dialysis Center, Inc. The D&TC generated both positive average working capital and net asset positions, and had an average net income of \$749,654 for the period 2012-2013. The D&TC generated both positive working capital and net asset positions, and had a net income of \$850,811 for the period 1/1/2014 – 7/31/2014.
- New York Renal Associates, Inc. . The D&TC generated both positive average working capital and net asset positions, and had an average net income of \$1,053,183 for the period 2012-2013. The D&TC generated both positive working capital and net asset positions, and had a net income of \$903,392 for the period 1/1/2014 – 7/31/2014.
- Ridgewood Dialysis Center, Inc. The D&TC generated both positive average working capital and net asset positions, and had an average net income of \$1,709,752 for the period 2012 through 2013.
   The D&TC generated both positive working capital and net asset positions, and had a net income of \$1,450,743 for the period 1/1/2014 7/31/2014.
- West Nassau Dialysis Center, Inc. The D&TC generated both average positive working capital and positive net asset positions and had an average net income of \$1,075,947 for the period 2012-2013. The D&TC generated both positive working capital and net asset positions, and had a net income of \$548,988 for the period 1/1/2014 7/31/2014.

Subject to the noted contingencies, the applicant has demonstrated the capability to proceed in a financially feasible manner and contingent approval is recommended.

#### Recommendation

From a financial perspective, contingent approval is recommended.

# **Attachments**

HSP Attachment A	CON 132178 Big Apple Dialysis Management, LLC - "Dialysis Facility Compare"		
HSP Attachment B	CON 132178 Big Apple Dialysis Management, LLC – Quality Assessment Study		
	(commissioned and submitted by applicant)		
BFA Attachment A	Big Apple Dialysis Management, LLC Member's net worth statements		
BFA Attachment B	Big Apple site specific Year 1 budgets and utilization		
BFA Attachment C	Pro forma balance sheet for Big Apple Management, LLC and the 4 sites		
BFA Attachment D	The 2012 and 2013 certified and 1/1/2014 – 7/31/2014 internal financial		
	statements of the following facilities:		
	Central Brooklyn Dialysis Center, LLC		
	East End Dialysis Management, LLC		
	New Hyde Park Dialysis Center, LLC		
	Newtown Dialysis Center, Inc.		
	New York Renal Associates, Inc.		
	Ridgewood Dialysis Center, Inc.		
	West Nassau Dialysis Center, Inc.		

#### RESOLUTION

RESOLVED, that the Public Health and Health Planning Council, pursuant to the provisions of Section 2801-a of the Public Health Law, on this 12th day of February, 2015 having considered any advice offered by the Regional Health Systems Agency, the staff of the New York State Department of Health, and the Establishment and Project Review Committee of this Council and after due deliberation, hereby proposes to approve the following application to establish Big apple Dialysis Management, LLC as the operator of a chronic renal dialysis diagnostic and treatment center and three extension clinics currently operated by the New York City Health and Hospitals Corporation, and with the contingencies, if any, as set forth below and providing that each applicant fulfills the contingencies and conditions, if any, specified with reference to the application, and be it further

RESOLVED, that upon fulfillment by the applicant of the conditions and contingencies specified for the application in a manner satisfactory to the Public Health and Health Planning Council and the New York State Department of Health, the Secretary of the Council is hereby authorized to issue the approval of the Council of the application, and be it further

RESOLVED, that any approval of this application is not to be construed as in any manner releasing or relieving any transferor (of any interest in the facility that is the subject of the application) of responsibility and liability for any Medicaid (Medicaid Assistance Program -- Title XIX of the Social Security Act) or other State fund overpayments made to the facility covering the period during which any such transferor was an operator of the facility, regardless of whether the applicant or any other entity or individual is also responsible and liable for such overpayments, and the State of New York shall continue to hold any such transferor responsible and liable for any such overpayments, and be it further

RESOLVED, that upon the failure, neglect or refusal of the applicant to submit documentation or information in order to satisfy a contingency specified with reference to the application, within the stated time frame, the application will be deemed abandoned or withdrawn by the applicant without the need for further action by the Council, and be it further

RESOLVED, that upon submission of documentation or information to satisfy a contingency specified with reference to the application, within the stated time frame, which documentation or information is not deemed sufficient by Department of Health staff, to satisfy the contingency, the application shall be returned to the Council for whatever action the Council deems appropriate.

NUMBER: FACILITY/APPLICANT:

132178 E Big Apple Dialysis Management, LLC

#### APPROVAL CONTINGENT UPON:

- 1. Submission of an executed transfer and affiliation agreement, acceptable to the Department, with a local acute care hospital for each of the four (4) sites. [HSP]
- 2. Submission of a proposed Medical Director Agreement, acceptable to the Department. (The document entitled "Medical Director Agreement" submitted with the application delegates more authority to the contractor, Physicians Affiliate Group of New York, than is provided for in regulation. Specifically, it is an employment contract for the provision of multiple, unnamed, Medical Directors at four separate sites. As drafted, it constitutes an unacceptable management contract because the established operator is not retaining direct independent authority to appoint and discharge the Medical Directors as required by regulation.) [HSP]
- 3. Submission of an executed loan commitment, acceptable to the Department of Health. [BFA]
- 4. Submission of an executed working capital loan commitment, acceptable to the Department of Health. [BFA]
- 5. Submission of site specific executed license agreements, acceptable to the Department of Health, for site control of the following dialysis center clinic programs: Kings County Hospital Center site, Lincoln Hospital Center site, Metropolitan Hospital Center site, and Harlem Hospital site. [BFA]
- 6. Submission of site specific executed administrative service agreements, acceptable to the Department of Health, for the following dialysis center clinic programs: Kings County Hospital Center site, Lincoln Hospital Center site, Metropolitan Hospital Center site, and Harlem Hospital site. [BFA]
- 7. The submission of existing conditions schematic floor plans and architect's letter of certification for existing buildings, for review and approval. [AER]
- 8. Submission of a completed Schedule 3. [CSL]
- 9. Submission of an executed Certificate of Assumed Name, acceptable to the Department and clarification regarding whether each location requires a Certificate of Assumed Name if they are all operating under different names. [CSL]
- 10. Submission of an executed Certificate of Amendment of the Articles of Organization, acceptable to the Department. [CSL]
- 11. Submission of an executed Operating Agreement (and Joinder), acceptable to the Department. [CSL]
- 12. Submission of an executed Administrative Services Agreement for all four (Harlem, Kings, Lincoln and Metropolitan) locations, acceptable to the Department. [CSL]
- 13. Submission of an executed license agreement for all four (Harlem, Kings, Lincoln and Metropolitan) sites, acceptable to the Department. [CSL]
- 14. Submission of an executed Purchase and Sale Agreement. [CSL]

#### APPROVAL CONDITIONAL UPON:

- 1. The project must be completed within three years from the date of the Public Health and Health Planning Council recommendation letter. Failure to complete the project within the prescribed time shall constitute an abandonment of the application by the applicant and an expiration of the approval. [PMU]
- 2. The staff of the facility must be separate and distinct from staff of other entities. [HSP]
- 3. The signage must clearly denote the facility is separate and distinct from other adjacent entities. [HSP]
- 4. The entrance to the facility must not disrupt any other entity's clinical program space. [HSP]
- 5. The clinical space must be used exclusively for the approved purpose. [HSP]
- 6. To provide Transfusion Services, licensure by the New York State Department of Health-Wadsworth Center is required. [HSP]

Documentation submitted to satisfy the above-referenced contingencies shall be submitted within sixty (60) days. Enter a **complete** response to each **individual** contingency via the New York State Electronic Certificate of Need (NYSE-CON) system by the due date(s) reflected in the *Contingencies Tab in NYSE-CON*.