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PUBLIC HEALTH AND HEALTH PLANNING COUNCIL
ESTABLISHMENT AND PROJECT REVIEW COMMITTEE MEETING
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TRANSCRIPT

Mr. Robinson: Participants and observers. I have the pleasure to announce that Dr. Larry Eisenstein has accepted our request to serve on this committee. And Larry, we look forward to working with you and thank you for your contributions going forward.

Just some normal reminders. The webcast with regard to webcasting, the meeting is subject to the open meeting law and is being broadcast over the internet. And the webcasts are accessed on the Department of Health's website, nyhealth.gov. The on-demand webcast will be available no later than seven days after the meeting for a minimum of 30 days and then a copy will be retained in the department for four months.

Just a couple of reminders, there is synchronized captioning on the webcast, so it's important that people don't talk over each other so that we get accuracy in that webcast. The first time you speak, please state your name and briefly identify yourself as council member, staff or applicant as the case may be. And that'll assist the broadcasting company in recording the meeting.

We're using different microphones today, but they are hot and therefore, I recommend you avoid rustling papers around them and anticipate that side conversations will be picked up and recorded. There is a record of appearance form. Most of you have already filled that out before you enter the meeting room. If you haven't, we ask that you take a moment and do that now so that we have a record that complies with the Executive Law, the Joint Commission on Public Ethics in accordance with Executive Law Section 106.

So, we are set. I just will say that we may take some applications a bit out of order in order to maintain quorum. We're still waiting for other members to arrive and hopefully, that will get settled.

So here we go. Application 252112C, Roswell Park Cancer Center in Erie County. This is to certify a new hospital extension clinic from multi-specialty ambulatory surgery at 199 Park Club Lane in Williamsville and to perform requisite renovations. The department

is recommending approval with conditions and contingencies. May I have a motion? Mr. Thomas, may I have a second? Mr. Kraut?

Mr. Kraut: Yes.

Mr. Robinson: Ms. Glock?

Mr. Kraut: This is what happens when Howard Berliner [inaudible 00:03:00].

Mr. Robinson: Yeah. I'm looking at Howard for a motion all the time.

Ms. Glock: Is my mic on? Yes.

Mr. Robinson: It's your turn.

Ms. Glock: Good morning. This is Shelly Glock from the department. So, this first project was submitted by Roswell Park Cancer Institute, which is a public benefit corporation. And this application is seeking approval to certify a multi-specialty ambulatory surgery hospital extension clinic in Williamsville, Ari County.

The new extension clinic will provide oncology related outpatient surgery, imaging services, primary care, and other medical specialties. Upon approving, the extension clinic will be known as Roswell Park Amherst Center Annex. According to the applicant, Roswell Park proposes to perform minimally invasive ambulatory surgical procedures within this extension clinic.

Currently, patients in need of care receive services at the main hospital located in downtown Buffalo. However, imaging services at the downtown campus face scheduling constraints, which the applicant hopes to alleviate by expanding certain imaging modalities, primarily MRI. Roswell Park plans to backfill seven surgeon vacancies, which are expected to increase their surgery volumes considerably, supporting the need to expand their service through this new facility.

Another goal of the application is to offer patients a convenient alternative to traveling downtown since many patients are choosing to receive services at non-Article 28 providers located closer to home, according to the applicant. They're projecting 10,364 visits in year one with almost 13,000 in year three, with Medicaid at 11.3%. The project costs will be met with accumulated funds from the current operations. Project costs are \$19,555,587. The department is recommending approval with contingencies and conditions.

Mr. Robinson: Thank you very much. First, are there any questions about the department on behalf of the committee or other members of the council? Can we ask the applicant to come forward and introduce themselves?

Ms. Johnson: Good morning. Candace Johnson, president and CEO of Roswell Park.

Mr. Tier: I'm David Tier, chief of hospital and network operations.

Frank Cicero: And Frank Cicero, consultant to the applicant.

Mr. Robinson: Thank you. The one question that came up as we were reviewing the application was the evidence of charity care, which I am sure you are providing, but it wasn't evident in the documentation. Can you comment on that?

Ms. Johnson: Yes. We haven't done these in a while. Quite honestly, it was a mistake and didn't portray the charity care that we do. Out of the 11% of Medicaid patients that we have, an additional 11% of those people are also eligible for our charity care program.

If you look at 2022, where we had about \$2 million in charity care, we now have almost four million. So those numbers are increasing. I believe this past year we had around 1,300 applications. I think this year, 95% of those were approved. So, we use charity care for companies. We have a really robust charity, but it was not reflected in our numbers, and so we're happy to correct that.

Mr. Robinson: Thank you very much. That was really my key question. Are there any other questions from the committee? Yes.

Ms. Monroe: Hello.

Ms. Johnson: Hi.

Ms. Monroe: I thought I might see you on the train this time.

Ms. Johnson: We drove.

Ms. Monroe: I just have a question about your primary care facet. Is that for people who are current patients of Roswell? Is it people from the community who might come in with no affiliation with Roswell? And if so, why do you think there's a need for primary care for non-Roswell Park patients?

Ms. Johnson: So, our primary care functions in survivorship where we follow patients and we have a very robust program of survivorship. We also have a very large screening program where our primary care physicians help to facilitate it. So, it's really in only those two buckets.

Ms. Monroe: So, there's no outreach into the community for regular general old primary care?

Ms. Johnson: No.

Ms. Monroe: Okay. Thank you.

Mr. Robinson: Are there any other questions? And we'll call the question then. All in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? The motion carries. Thank you very much for coming.

Ms. Johnson: Thank you very much, Peter. Thank you all.

Mr. Kraut: Skip over. I think we're going to skip over because they're still on the train.

Mr. Robinson: We are going to, for the moment, skip over the next application in order for the other members of the-

Ms. Monroe: [Inaudible 00:08:34].

Mr. Robinson: Is this better?

Ms. Monroe: That's perfect.

Mr. Robinson: Okay. Application 252145C. Good Samaritan Hospital Medical Center in Suffolk County. I'll note a conflict and recusal by Dr. Eisenstein who's leaving the room. This is to certify St. Charles Hospital as a division of Good Samaritan Hospital Medical Center. Rename the division Good Samaritan University Hospital St. Charles Campus and rename Good Samaritan Hospital Medical Center to Good Samaritan University Hospital.

Upon completion of the merger, Good Samaritan University Hospital and St. Charles Hospital will operate as one hospital with two campuses. The department is recommending approval with a

condition. May I have a motion? Mr. Thomas, may I have a second? Mr. Kraut? Ms. Glock.

Ms. Glock:

Good Samaritan University Hospital is requesting approval to certify St. Charles Hospital, which is a 253-bed hospital in Port Jefferson as a new division of Good Samaritan University Hospital through a plan of merger. St. Charles Hospital's nine extension clinics will be included as part of this merger. Good Samaritan University Hospital is a member of the Catholic Health System of Long Island.

Catholic Health and a New York not for-profit corporation was initially established as the active parent and the sole corporate member of Article 28, 36 and 40 affiliates, including Good Samaritan University Hospital and St. Charles, as well as Mercy Hospital, St. Francis Hospital and Heart Center, St. Catherine of Sienna and St. Joseph Hospital.

Upon completion of the merger, they will operate as one Good Samaritan University Hospital and St. Charles Hospital will operate as one hospital with two campuses. St. Charles Hospital will be named Good Samaritan University Hospital, St. Charles Campus.

The integration will augment St. Charles' current roster of clinical services with Good Samaritan University Hospital's tertiary offerings. There are no costs associated with this project. There also will be no change in either the authorized services or the number or types of beds at St. Charles as a direct result of approval.

According to the applicant, the purpose of the project is to benefit both patients and staff by one, better care for patients through closer coordination between the campuses, shared medical staff, and easier access to advanced services at Good Samaritan University Hospital, such as their tertiary care offerings.

Secondly, the stronger financial performance across both hospitals is expected, helping Charles Catholic Health reinvest in their care and services, and finally, more opportunities for medical education and training under Good Samaritan University Hospital sponsorship. The application projects Medicaid discharges at 25% and Medicaid at 22% in both year one and year three. The department is recommending approval with a condition.

Mr. Robinson:

Thank you. Questions from members of the committee or council? Hearing none, does anybody from the public wish to speak on this application? Hearing none, all in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? The motion carries.

Mr. Kraut: Let's have Dr. Eisenstein come back into the room and just give Dr. Calcutt a second to catch his breath here and he'll move on the next application.

Dr. Kalkut: What? Which one is it?

Mr. Kraut: We skipped over Rochester.

Dr. Kalkut: So, is it Rochester?

Mr. Kraut: Yeah, it's going to be Rochester General.

Dr. Kalkut: Thank you. Okay, good morning.

Mr. Kraut: Just pull it. They're big. Pull it closer.

Dr. Kalkut: Sure. Good morning. Next application is 252112C Roswell Park Cancer Institute.

Mr. Kraut: No, no. It's the Rochester General.

Dr. Kalkut: My apologies.

Mr. Kraut: That's okay.

Dr. Kalkut: This application, 252116C, Rochester General Hospital in Monroe County. Mr. Robinson has a conflict and is out of the room. This is to certify a new hospital extension for multi-specialty ambulatory surgery, primary care, and other medical specialties at 183 Parrish Street in Rochester and perform requisite innovation. Pardon me. I thought this was in Canandaigua, not Rochester.

Mr. Kraut: It is Canandaigua.

Dr. Kalkut: Focus will be on orthopedic surgery, pain management, and podiatric surgery. Office visits will be primarily orthopedics and neurology. The department represents approval with conditions and contingencies. Can I have a motion? Dr. Tier? Dr. Berliner.

Mr. Kraut: Second Hugh

Dr. Kalkut: Hugh? I can't see it there. Thank you. Shelly?

Ms. Glock:

This application is for a new extension clinic for multi-specialty ambulatory surgery, primary care and other medical specialties, and MRI imaging in Canandaigua, Ontario County. The proposed center will be in a leased medical office building across the street from F.F. Thompson Hospital. University of Rochester Medical Center is the passive parent of F.F. Thompson Hospital.

The primary focus of the 41-room center will be orthopedics and neurology. The center will also have four operating rooms and MRI imaging surgical visits will be primarily orthopedic pain management in podiatric. Did I say that right? Okay. Rochester Regional Health contends that this site will provide centralized service for their existing outpatient surgical patients in the region with neither Clifton Springs Hospital nor Newark Wayne, which are part of Rochester Regional Health, having the capacity to accommodate such consolidation.

93% of the 40,538 projected clinic visits and 95.5% of the 3,863 projected surgical visits at this proposed clinic will be from multiple existing Rochester regional health practices and surgical sites, including three freestanding ambulatory surgery centers and Clifton Springs and Newark Wayne Hospitals.

Rochester Regional Health already has existing practice sites in Canandaigua, including a neurology and two orthopedic sites with an additional small non-Article 28 practice in the center's proposed lease building. Staff for the new extension clinic will be provided by relocating current Rochester Regional Health staff for the clinic and the operating rooms. However, staff needed for the MRI imaging will be incremental.

The department has received a letter of opposition from F.F. Thompson Hospital stating there is no need for this new hospital extension, and there is potential for F.F. Thompson to lose high margin outpatient surgical services and MRI volume. They are also concerned about competition for staff from the new state-of-the-art outpatient orthopedic center, which has weekday hours right across the street.

Historically, the department and the Public Health and Planning Council have approved these types of projects. Orthopedic surgical procedures continue to move out of the hospital setting with many hospital systems building ambulatory surgery extension clinics. New York's public need regulations for ambulatory surgery require demonstration of financial feasibility and sufficient utilization while

considering community access and service to underserved populations.

Department policy has favored approval of such applications, emphasizing increased access and consumer choice over existing market area capacity for proposed services, accepting situations where existing critical access hospitals or sole community hospital essential services would be endangered. The Health Systems Agency, Common Ground Health, has recommended approval of this project. In accordance with the above, the department is recommending approval of this project with contingencies and conditions.

Dr. Kalkut: Thank you. Any questions from the committee?

Ms. Monroe: I have a question for the applicant.

Dr. Kalkut: Sure. Let's just see if there's any others and we'll ask the applicant to come up. All right. Can the applicant come to the table, please? Questions? Please introduce yourself.

Mr. Curley: Yes, sir. Good morning. Tom Curley, chief financial officer at Rochester Regional.

Ms. Esslinger: Good morning. Jennifer Esslinger, chief operating officer for Rochester Regional.

Mr. Cicero: And Frank Cicero, consultant to Rochester Regional.

Dr. Kalkut: Okay. Ms. Monroe?

Ms. Monroe: Well, I don't need to go first.

Dr. Kalkut: Well, it doesn't look like there was other-

Ms. Monroe: Well, first of all, I don't know if anybody's here from F.F. Thompson Hospital, but I want to make sure that I let them know what a great report they wrote, how clear it was, how well it addressed its points. So, I want to give them that kudo even if they're not here.

Dr. Eisenstein: I appreciate that. I'm here. Go ahead.

Dr. Kalkut: Go get the talk.

Ms. Monroe: But my questions for you are, and this is a question about ambulatory surgery centers on mass. You're taking a lot of

procedures and interventions that are being done now somewhere else. And they look to me like relatively high-income producing procedures and interventions.

So, I'm wondering if you could just tell me, can you imagine in this ambulatory surgery center, what procedures, interventions, whatever you want to call them, will you be doing where you'll be losing money on them?

Ms. Esslinger: Thank you for the question. Very thoughtful. In all of our patients-

Ms. Monroe: A little louder, please, into the mic. Thank you.

Mr. Cicero: Lean closer to the mic.

Dr. Kalkut: Just pull the mic as close as you can to you.

Ms. Esslinger: Is that better?

Dr. Kalkut: Yes.

Ms. Monroe: Absolutely.

Ms. Esslinger: Thank you. In all encounters with our patients, whether it's an extension clinic such as this or the hospitals themselves, we take all patients regardless of payer source. And so, depending on the payer, there is very high likelihood. Some of these procedures carry very high implant cost, very high cost of supplies associated with these procedures.

So, whether it's podiatric surgery or an implant of a typical knee, and depending on the payer, there is a chance that a single procedure could lose money.

Ms. Monroe: Because the concern is that you will take, I'll use the technical terms, cream of the crop, and leave the others to this hospital in particular, but other organizations that are left with very few money-making procedures.

Ms. Esslinger: If I may, if you look at the details in our application, all of the patients, 93 and 95% of the patients for this proposed location respectively will be coming from Rochester Regional existing locations. So, this is a consolidation of existing services that are otherwise bifurcated across the region. Our intent here is to consolidate efficiency and optimization.

Ms. Monroe: So, you're saying you're not going to be recruiting new patients who are currently served by other entities?

Ms. Esslinger: That is correct.

Ms. Monroe: Okay. And what about staffing? I know you talked about the physicians and how they would come to this facility, but there are a lot of other ancillary positions necessary, nurses, aides, et cetera. Are you seeing them all transferring from other locations or will you be recruiting staff from the area who might be working in another organization?

Mr. Cicero: Ms. Monroe, in the staff report, it shows that there will be about 73 FTEs at this site. Only 4.5 of those will be new FTEs. The remainder, 68 and a half will be coming from existing Rochester Regional sites, including those in this town already.

I also want to add, just to follow up on your first question, that the payer mix includes 20% Medicaid and 2% charity care based on the existing mix of the cases that are being relocated and visits that are being relocated to this site.

Ms. Monroe: Thank you for that. And I guess I just have a comment for... Oh, Peter's not here. But it would be really nice if we had a follow-up at some point to see, and I don't mean this just to you, but generally where care is being moved from one location to another, we hear about high rates of Medicaid, high rates of uninsured, but we never learned at the council how much of that really happened.

And I'm just putting a request in that we figure out a way with the department to follow up on situations like this to make sure that what was attested to is actually happening. So that's not for you, but for us.

Mr. Kraut: Actually, Anne raises a good point and I'm going to just bring it up a level above the question you answered, and I'll direct this to the department. Since we have established regulations for ambulatory surgery centers, I'm going to go back to the 80s. And you remember in this room in particular, there always have been debates about the impact of the evolution of the healthcare delivery system and its impact on existing providers that don't adapt and are threatened by an AmSurg center opening up proximate to a hospital or sometimes it's a different hospital as in this one where it's a bunch of physicians.

And the arguments that were made very eloquently in the document from Thompson, we've seen before, right? To my knowledge, and I asked the department, has there ever been the expected kind of disaster scenario that applicants or opposition has raised that has ever come true? We have years of data now that no hospital, to my knowledge, has closed because of an ambulatory surgery center. Yes, has it changed? No question about it.

But I'm just wondering, do we have anything that's more concrete like Anne had said? And this is probably anecdotally more than its data driven. And I think that's Anne's point. She'd like to see data.

Mr. Cicero: Mr. Kraut, I think you're right. We have no data that suggests that there's any destabilizing force or anything that would suggest what's being asked. I'll just see if you want to add anything.

Mr. Kraut: I wouldn't think, to my knowledge, because it would have been relevant to any review of an application we would take a look at. Okay.

Dr. Kalkut: Dr. Eisenstein?

Dr. Eisenstein: Good morning, Dr. Larry Eisenstein committee and council member. So, continuing this conversation, first I want to thank the state for clarifying what the state's policy has been in this scenario, because reviewing both sides of this discussion, we needed to hear that. So, thank you for that.

And Jeff, also thank you for clarifying in the discussion. You testified that you expected, these were your words, 93 to 95% of the patients are going to be already your existing patients. The allegations have been made that essentially by doing this, you'll be taking patients away from a competitor.

So where five to 7% is not insignificant, especially when hospitals are running at very small margins. These were your numbers, 93 to 95%. Where do the other five to 7% come from? And I do think we need to at least think about the impact.

Ms. Esslinger: Yes. Great question. Thank you. And I would also just ask if we could put it into context of the totality. Within the application, over 40,000 of the visits are clinical, all in on the campus visits. About 3,500 of those would be procedural visits. So, we want to put those numbers in the right scope and scale to start with.

The others are organic growth. If you look at the demographics in this area, the aging population, the projections for organic growth are actually significantly higher than the growth projections that we applied to our five-year lookout in this application.

Dr. Eisenstein: Great. I was hoping you would say something like that. Thank you.

Ms. Esslinger: Yes.

Dr. Eisenstein: Thank you.

Dr. Kalkut: Any other questions from the committee? Anyone from the public wish... Oh, thank you very much.

Mr. Cicero: I just would like to say, Dr. Kalkut, if we, in keeping with traditional treatment in such cases, would have the opportunity to come back up after the opposition speaks.

Mr. Kraut: Certainly.

Mr. Cicero: Thank you.

Dr. Kalkut: Sir, please come on up.

Mike Stapleton: Good morning, everybody. I'm Mike Stapleton. I'm president and CEO of Thompson Health in Canada, New York. As I start first, I want to thank Shelly and others from the Department of Health who took our opposition letter seriously. Also followed up with several phone calls and I greatly appreciate that. We obviously, as a hospital CEO, when we go through our own CON process, the CON is rooted in community need and benefits.

This project will do nothing to make any changes to community need and benefit. In fact, I have no issue with them consolidating two orthopedic practices, but adding four ORs, a DEXA scan and an MRI directly across the street from my hospital, I do have an issue with, and I don't see that as a consolidation. I didn't see anything in the application or anything in DOH's report where they were going to shut down four ORs to replace them with these or shut down an MRI and replace them with these.

You're all healthcare executives and in healthcare. Nobody is going to spend \$22 million and just move the same revenue with that \$22 million project. You have to go get additional revenue and additional patience to make that work. The other issue is in the

health equality assessment, every single box was checked no. Every single box. No one was checked yes.

The other thing about the workforce that you brought up is that we are the provider of 24/7 OR care in Ontario County. Clifton Springs does not have after-hours OR. They run Monday through Friday, 7:30 to 3:30 vaguely. They do not provide emergency services. They do not provide emergency on-call. We do. We actually are very, very well staffed. We have 2,300 associates. I only have two travelers in our entire organization, but this is a risk to us.

No matter how much we recognize, how much we communicate with our associates and have satisfied associates, an OR nurse who could go across the street, work Monday through Friday with no call, that's an impossible thing to compete with. And that's also with the MRI. That's an impossible thing to compete with because our MRI is open 24/7.

The other thing that I believe severely lacked in this application, at least in the public pieces that I saw, is truly what is the OR utilization OR schedules at Newark and Clifton? Because the vast majority of this volume is moving over from Clifton Hospital. It's their orthopedic volume of an existing private practice that was bought by Rochester Regional, which moved their cases from Thompson into Clifton Springs. That's what's being moved.

So, I would strongly encourage the group to look better at the utilization and also look at the impact this will have on the hospital that provides 24/7 coverage in Ontario County. I greatly appreciate the opportunity and appreciate Department of Health taking our opposition seriously. I am happy to answer any questions.

Dr. Kalkut: Thank you, Mr. Stapleton. Questions from the committee?

Mr. LaRue: Dr. Kalkut. Dr. Dr. Kalkut.

Dr. Kalkut: Oh, sorry. Mr. LaRue, thank you.

Mr. LaRue: I'm sorry. I didn't catch what you said about the checking of the boxes. What were you referring to? The health equity assessment?

Mike Stapleton: The health equity assessment that was in the application of how this is going to meet the needs of the underserved and underprivileged in the community, all of those boxes were checked no. There was going to be no impact.

Mr. Kraut: Wait a minute. It wasn't required as part of this application. Don't make mistakes. They had to check those boxes. If you read the summary of the report, there is no requirement to file the health equity impact assessment for this type of project.

Mr. Kraut: My understanding of that was as supplying-

PART 1 OF 6 ENDS [00:33:04]

Mr. Kraut: ... for this type of project.

Mr. Stapleton: My understanding of that was, as we apply for the CONs, we have to fill that form out.

Mr. Kraut: No.

Mr. Stapleton: I saw that form in the application.

Mr. Kraut: Well, let me defer to the department to explain to the applicant.

Ms. Glock: So, there is a health equity impact assessment checklist, which is part of the application process, and the instructions on the checklist are, if the answers are no, and the questions really are not around public need, the questions are around what impact this project will have on operating certificates, closure of beds or services. So, according to the instructions in the statute, if those answers are no's, then a health equity impact assessment is not indicated for that project.

Mr. Stapleton: Understood.

Dr. Kalkut: Other questions from the committee? Any questions from the public, or comments from the public? Okay-

Mr. Kraut: [inaudible 00:34:05] the applicant a chance to come back?

Dr. Kalkut: Certainly. RRH, do you want to come back and reply to those comments?

Mr. Cicero: Just brief comments in response. We understand there's a recommendation for approval. The first thing we'd like to say is that this is a consolidation of services that are in this area already. We've already spoken to the staff. In this area, the hospital system has been in the market, in Canandaigua for over 10 years, has a 49% musculoskeletal market share, compared to 43% for the other hospital.

And I think Ms. Esslinger will add some other points, but again, thinking about what has been said here from a recommendation numbers standpoint, we know that the HSA that was referenced by the department has recommended approval. I think there are some members of this council who may not know what an HSA is, or maybe you've heard about it in your introduction to joining a council, but this HSA is very strong, and I think it would be said very clearly that when they have objected to projects in the past, they have made it very clear to this council. They have a clear recommendation of approval, and I think that's a big point that's been raised at this council before, about local input from a third-party recommending approval. And I think the only other point I would like to make is, again, these cases today, and visits today are Rochester regional cases. I think Ms. Esslinger will talk about why they may want to invest, and why many facilities, including some by folks probably around this table, are built in at a time when they may not be all new revenue, but replacement of aging facilities. And in this case, there are real reasons why it can't be built elsewhere. Thank you.

Ms. Esslinger:

Thank you. And I really want to appreciate Mr. Stapleton's comments about staffing. Our region truly is challenged on a staffing basis across the board, so we all feel that pain, and I wanted to acknowledge that. Currently, there is a question raised around, can we not do these cases in Clifton Springs or at Newark? This is a consolidation strategy around this type of case, this type of specialty, and I do not have capacity at either Clifton Springs or Newark Hospitals to consolidate all MSK cases that are currently in this region, or in this region, and again, specifically to RRH in this region. And coming into Monroe County ORs, we are having to transfer a significant number of patients out of Clifton and Newark because we are over capacity. We have significant boarding issues in both of those hospitals. So, by moving the elective cases out of the acute care setting, not only can we operate on these patients in a more patient friendly manner and environment, but we also can do so in a more cost-effective manner.

This will also enable us to detect cases out of RGH in Monroe County, that are currently coming out of the eastern region for elective procedures. So, we have a tremendous need. There is a backlog of cases that meet the needs of this specialty and this population, and thus the reason for the additional ORs in the eastern region, which, as Mr. Cicero said, we have had a stronghold in that market for over 10 years now.

I'm sure I have other questions here that I should point out. And as we pointed out earlier, 4.5 FTEs, those will be the addition of the new imaging center in this location that we have applied for in your application. We do have, again, a lot of market data that tells us most patients that are musculoskeletal, coming in from the eastern region for these elective imaging procedures, are on a backlog, they're waiting six to eight weeks for these imaging studies. Most of these patients that are coming in for these imaging studies come from our primary care offices. We can actually see when a patient has to get referred to out of our own system from our primary care offices because our waiting times are so long. So, these are net accretive imaging studies, thus net accretive FTEs to support those imaging services, specifically at this MSK focused location.

The mentioned earlier, we also have two surgery centers in Monroe County that also take overflow out of the eastern region. Our goal in all of this is to really try to consolidate those services, but also to keep patient care close to home. There is, and we heard it in the applicant earlier, there is no need for these patients to have to come into Monroe County, much less for these patients to have to come to the RGH campus to have their surgeries because we cannot get them into our ORs in the eastern region.

Mr. Stapleton: And I'll just add one point. I do believe that hospitals and other healthcare facilities, you do invest where you don't necessarily have new incremental revenue. There are many situations, we've got a couple of these in process today, where sites that have aged beyond their limit, we're building new sites or repairing new sites for significant dollars and not necessarily expecting incremental revenue. So, I do think, and if you move care out of the hospitals, as we talked about earlier, and into new locations, again, most of that is not new revenue, it's just shifting from site to site. So those investments are happening, at least in our shop.

Dr. Kalkut: Thank you. Mr. Stapleton, if you're opposing this, you do not get another opportunity at the front desk. That's the way the committee operates.

Mr. Stapleton: I can't answer their questions [inaudible 00:40:50]? That's the way the committee operates.

Dr. Kalkut: No, sir. No. I actually have a-

Mr. Stapleton: [inaudible 00:41:00].

Dr. Kalkut: I have a question. Sure.

Ms. Monroe: Go ahead, Gary. I'll follow you.

Dr. Kalkut: For the ASCs that you're moving patients out of and consolidating, will they continue to operate? Someone mentioned, I think it was Frank, that their older facilities. Will they continue to do surgery and see patients?

Ms. Esslinger: Yes. Thank you, great question. The two surgery centers specifically include what we refer to as RAS, Rochester Ambulatory Surgery Center and Linden Oak Surgery Center where, some of these procedures will be migrating to the new location in Canandaigua. They will continue to operate. We have a significant number of outpatient cases that are being done in our Monroe County Acute Care Hospital ORs. And again, I am boarding, we are logging jamming, we are doing cases well, we're running six to eight ORs at RGH every night. Many of the elective procedures that are done at RGH need to get out of those ORs so we can keep that care, the acute care going, and not log jam the ORs by bouncing between the acute and the elective cases.

Dr. Kalkut: Thank you. Ms. Monroe?

Ms. Monroe: Yes. Thank you. You're going to be neighbors. Have you had dialogue with Thompson Hospital?

Ms. Esslinger: You mean besides before the meeting today?

Ms. Monroe: Well, I don't mean eight o'clock this morning. I mean, as this was being developed, and you were looking at your options and potential impact, has there been a true discussion with the hospital?

Ms. Esslinger: No. Obviously, this is a strategic initiative for us, so we would not have discussed it beforehand with Thompson directly, of course. However, we do partner with them, and again, we actually have several common organizations that we sit on together in Monroe County for the betterment of the communities that we serve, but this project, we did not meet with them beforehand on.

Ms. Monroe: If we approve this project, do you think that's the time to have more discussions with them? They will be impacted, no matter what you say. You know that, and how they're impacted, we'll have to see. But the idea that there would not be an attempt or effort to work out a neighborly, if you would, arrangement about how this is going to work without hurting that delicate ecosystem in rural areas, I would have expected that you would have had some dialogue with them.

Since you haven't, do you see that as something that if this is approved, you would pursue?

Mr. Stapleton: I think our position continues to be... I appreciate your comments, that this shouldn't be-

Ms. Monroe: I'm sorry, you need to speak a little louder for me.

Mr. Stapleton: Alrighty. I'm sorry. I appreciate your comments about it will. We don't think it will, and we do believe that this is truly... A very, very large piece of what we're describing is shifting existing patients that are Rochester regional patients, staying within the system. So, I think under that guise... I'm happy to talk it through, but I think we would end up in the same situation, where this is-

Ms. Monroe: Perhaps, yes.

Mr. Kraut: I just have a question for this department. Is Thompson a member of the University of Rochester Health System? Is there a big parent with a very good balance sheet behind them?

Ms. Monroe: So, the University of Rochester Medical Center is a passive parent.

Mr. Kraut: Parent. Okay. But they are part of a larger health system.

Ms. Monroe: As a passive parent, they're part.

Mr. Kraut: Okay. And that could change if there's an obligation here. I think Anne, to your point is, although we've never in the last 20 years have a hospital, their concerns come true as a consequence of this, what I think Ms. Monroe was saying, that there's always a possibility that will happen here. And if there is, there's an obligation to see how to mitigate that for the benefit of the community. That's basically-

Ms. Monroe: Thank you.

Mr. Kraut: Okay.

Dr. Kalkut: Okay, any other questions from the committee? Okay, thank you. Before we took a vote, Shelly, Ms. Monroe had asked for data on payer mix from the applicant in three years.

Mr. Kraut: So, we should just put that on our follow-up list, that in three years we'd love to know that they hit the payer mix that they're saying.

And look, that's a more generic question in almost all of our applications-

Dr. Kalkut: Yes.

Mr. Kraut: ... I would argue that even though somewhere we've created a limited life operating certificate, this doesn't lend itself necessarily to doing that as an extension clinic. But it would be nice to have a look back on these things, because we're trying to make a point of access here, and we don't know if we actually accomplish it. And it's not hard to do. Maybe it's a great project for a graduate student to go do, because all of the-

Ms. Monroe: Are you going back to school, Jeff?

Mr. Kraut: I may have a little more time in the future. But yeah, actually one of my graduate students might. Well, it's not my responsibility, but it's something the department, the data is there, it's public, everybody files cost reports, we are able... It shouldn't be able... Maybe there's an AI agent we can develop to do that. Okay, put that on the list of AI agents.

Ms. Monroe: Jeff, I want to clarify what I'm asking.

Mr. Kraut: Yeah, yeah, yeah.

Ms. Monroe: I agree that it's a more generic issue that we want to know, but this is the application in front of us now, and I would like to start that process by putting a condition on that in three years we want to know how it went, and we want to hear from both the hospital and from the applicant.

Mr. Kraut: You need to make it a condition.

Dr. Kalkut: Right. We need-

Mr. Kraut: ... of the approval.

Dr. Kalkut: ... to oblige the applicant to provide that data.

Mr. Kraut: In three years.

Dr. Kalkut: In three years.

Mr. Kraut: I guess that's the...

Dr. Kalkut: So, we need...

Mr. Kraut: Who made the motion? You made the motion, and it was seconded.

Dr. Kalkut: No, you made the motion, so just Dr. Berliner, yes.

Mr. Kraut: Is that correct?

Dr. Berliner: [inaudible 00:47:51].

Mr. Kraut: It was actually Berliner and...

Dr. Kalkut: It was Thomas.

Mr. Kraut: Thomas. Okay. And could you just amend your motion, please, to make that a condition? And we'll write the language.

Dr. Berliner: I accept them. I accept the amendment to the motion.

Mr. Kraut: Okay. And you second.

Dr. Kalkut: Second.

Mr. Kraut: Okay.

Dr. Kalkut: Great. There is some difference here, because if they're bringing such a large percentage, their Medicaid rate was 20% previously.

Mr. Kraut: Right. Look, so we just want to see if they're going to hit it. And look, we didn't even get into it, but Medicaid, their rates are pretty low compared to hospital-based rates.

Dr. Kalkut: Right.

Mr. Kraut: But anyway.

Dr. Kalkut: All right.

Mr. Kraut: Okay.

Dr. Kalkut: Having no other questions, let's-

Mr. Kraut: Vote.

Dr. Kalkut: ... take a vote. All in favor? Aye. Opposed? One. Ms. Monroe, one?

Mr. Kraut: Motion.

Dr. Kalkut: Abstain.

Mr. Kraut: Motion carries.

Dr. Kalkut: Motion carries. Thank you. Can we have Mr. Robinson back in the room please?

Mr. Kraut: Okay. It's okay. It doesn't affect... Okay. It doesn't affect the public. Okay. [inaudible 00:49:58].

Ms. Monroe: Yep. No, that was perfect. That's what Jeff wanted.

Mr. Robinson: Sorry. I missed the excitement. Application 252080C, Manhattan Endoscopy Center, LLC. This is in New York County. The Manhattan Endoscopy Center, LLC, an existing single specialty freestanding ambulatory surgery center is seeking approval to convert from a single specialty, specializing in gastroenterology, to a dual single specialty, with the addition of vascular surgery. The department is recommending approval with condition and contingencies motion. Dr. Berliner, I'm so glad you're here. Second, Mr. Thomas. Ms. Glock.

Ms. Glock: Manhattan Endoscopy Center is an existing single specialty freestanding ambulatory surgery center. They're seeking approval to convert from this single specialty specializing in gastroenterology to a dual single specialty freestanding ASC with the addition of vascular surgery. The ambulatory surgery center will bring on a new vascular surgeon, currently performing these services in their private office-based surgical practice, located within the same building as the center. And they have committed... The surgeon has committed to performing approximately 1,800 procedures in the first year of the project implementation.

There's no construction required as part of this application. Manhattan Endoscopy's existing seven procedure rooms will be adequate and equipped for both gastroenterology and vascular procedures. They're projecting about almost 17,000 procedures by year three, with Medicaid at 7%, charity care at 2%. Total project costs of \$37,193 will be funded with equity from Manhattan Endoscopy's existing operations, and the information and analysis presented in the Health Equity Impact Assessment and the applicant's mitigation plan demonstrated that the proposed project would not result in any significant adverse health equity impacts.

The department is recommending approval with contingencies and conditions.

Mr. Robinson: Thank you. Questions? Applicant... Oh, I'm sorry. Thank you, please, Dr. Lim.

Dr. Lim: It's a question for the applicant.

Mr. Robinson: Can we have the applicant come forward, please? [inaudible 00:53:00]. Dr. Lim, go ahead.

Dr. Lim: Is this working? Yes. Okay. Hi, thank you. Sabina Lim, committee and council member. I just have a question about both your payer, your volumes, and then your P&L, basically. So, I see your... And I hope I'm reading this correctly. You identify that your payer mix will be about 7% Medicaid, with about a little over 1,000 in volume, but I don't see in the operating budget a separate line for Medicaid revenues. And I don't think all others are accounting for that. So, I just want to clarify, you will be accepting Medicaid patients, and I just want to just inquire about that particular omission in the operating budget.

Frank Cicero: First of all, Dr. Lim, I'm Frank Cicero, a consultant to the applicant.

Ms. Sariego: And Anne Sariego, member of Manhattan Endoscopy.

Mr. Cicero: I think, and I would ask the department, I think it may be a typo that shows Medicare fee for service, Medicare, managed care, and then a second Medicare managed care line. I believe, and I can look at our budget, but I believe that's probably just the typo.

Dr. Lim: Oh, I see. Okay.

Mr. Cicero: They absolutely do accept Medicaid today. This project, a part of it, because of the type of procedure, will increase. It's expected to increase their Medicaid percentage.

Dr. Lim: Okay, that's it. I just wanted to confirm that.

Mr. Cicero: Thank you.

Mr. Robinson: Other questions for...

Mr. Kraut: You got to put it on. On top of it. No, just the top. Slide the button down.

Dr. Soffel: This is a new mic for us.

Mr. Kraut: Yes.

Dr. Kalkut: Yeah, it's a new system today.

Dr. Soffel: Good morning, Denise Soffel, a council member. I just had a question about your observation on charity care, where you say that you will be encouraging primary care providers to send uninsured and underinsured patients to your facility for care. I must say that in all my years in the healthcare business I have never seen anybody say that they're actively recruiting uninsured and underinsured patients to their facility, and I'm curious about why that strategy appears in your application.

Ms. Sariego: Thank you for the question. We have developed or redeveloped our outreach program. In New York City, the Community Cares Program, which was a very large outreach program that partnered with the FQHCs in the area has unsettled, and that has resulted in increasing our efforts for outreach to the primary care physicians, which currently are a big source of referrals to the ASC. In addition to that, we have started hosting quarterly community outreach events and meetings with OB-GYNs, et cetera. So, that has been really our mantra and our ability to always, besides Medicaid and other patients, is to really to provide access to the uninsured and underserved.

Mr. Cicero: Ms. Soffel, also, I would just like to say that about six or seven years ago, Mr. Robinson chaired a charity care committee for ambulatory surgery centers, and the Community Cares Program that Ms. Sariego discussed was discussed at that meeting. It has been unsettled. It brought together... And Ms. Sariego, I believe, spoke before that committee with the New York City Department of Health. It really helped to get more people into endoscopy centers and just screenings generally for gastroenterological concerns, and that is what she is talking about, that they're trying to reinvigorate.

Mr. Robinson: Other questions for the applicant? Hearing none. Anyone from the public wishing to speak on this application? Pardon my voice. Hearing none, we'll call the question. All in favor?

Group: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. Thank you.

Ms. Sariego: Thank you.

Mr. Robinson: Application 252091C, Surgical Pain Center of the Adirondacks LLC. This is in Clinton County. Convert an existing single specialty ambulatory surgery center to a multi-specialty ambulatory surgery center with the addition of ear, nose, and throat, and podiatry services. This project also involves the performance of the renovations. I also want to note that the following contingency has been added by the department, the submission of an executed transfer and affiliation agreement acceptable to the department, with a local acute care hospital. With that, the department recommends approval with conditions and contingencies. Motion by Dr. Berliner. Second by doctors... Thank you. Ms. Glock.

Ms. Glock: The Surgical Pain Center of the Adirondacks is an existing ambulatory surgery center located in Plattsburgh, in Clinton County. This application is seeking approval to convert from a single specialty ASC specializing in pain management, to a multi-specialty ambulatory surgery center with the addition of ears, nose, and throat and podiatry services. Dr. Bonevas will remain the sole member and medical director. The total project cost of \$91,484 will be funded with equity, or with accumulated funds. The application is projecting just under 4,800 procedures by year three, with Medicaid at 11.1% and charity care at 0.2%. The department is recommending approval with conditions and contingencies.

Mr. Robinson: Questions for the department? Any questions for the applicant? Applicant questions only? Anybody from the public wishing to speak on this application? Hearing none, call the question, all in favor?

Group: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. We're moving on to diagnostic and treatment centers.

Ms. Monroe: Peter, I might recommend they look at their acronym, which is SPCA, and see if that serves them well.

Mr. Robinson: Good pickup. Good pickup. You heard about it from a very distinguished member of our council, so take it to heart.

Application 251079C, Community Health Center of Richmond, Inc. in Richmond County. For those of you don't know, that's Staten Island. Relocate the main site from the 235 Port Richard Avenue, Staten Island location to a new building, to be constructed at 21 Grove Street, also in Staten Island, and certifying birthing services, outpatient and dental outpatient services as an FQHC and safety

net provider. The department recommends approval with conditions and contingencies. Motioned by Dr. Berliner, second by Dr. Eisenstein. Ms. Glock.

Ms. Glock: Community Health Center of Richmond, an Article 28 diagnostic treatment center and a federally qualified health center, is requesting approval to relocate their main site from 235 Port Richmond Avenue in Staten Island, to a new building, to be constructed at 21 Grove Avenue in Staten Island, Richmond, and also to certify birthing services and dental outpatient to their operating certificate.

This new location is about 0.2 miles from the current site. They will continue to provide medical services of primary care and podiatry at the facility, as well as adding dental and birthing services. The applicant has received a Statewide Healthcare Facility Transformation 2 grant for this project. The new location is in a health professional shortage area for primary care, mental health, and dental, and the new center will offer an expanded, modernized facility to better serve Staten Island residents, particularly those in the North Shore.

Their main site is operating at full capacity and is not able to undergo any physical expansion. The new and expanded modernized main site will have 20 primary care exam rooms, as well as four birthing rooms, four OB-GYN exam rooms, six dental operatories, and a dedicated behavioral health unit for mental health assessment, provided by a social worker. The applicant projects 59,821 procedures in year one, with 78,567 in year three. The projected payer mix is 70% Medicaid and 13.1% charity care.

The medical director is Dr. Rosario Lipka, who's Board for Certified and Family Practice, and the total project cost of \$42,058,329 will be met with land equity, operational equity, grants from the Statewide Healthcare Facility Transformation Program of six million, the American Rescue Plan, State and Municipalities Facilities Program from the New York State Assembly, the City of New York Capital Commitment Program, and EPA Brownfield, and a new markets tax credit program. The department has reviewed this application and is recommending approval with conditions and contingencies.

Mr. Robinson: Any questions or comments? Dr. Berliner. Dr. Berliner.

Dr. Berliner: Yeah, I guess this is for the applicant. For the applicant. Could the applicant come forward, please? Please introduce yourself.

Mr. Cicero: Frank Cicero, a consultant to the applicant. I have to apologize. Henry Thompson, who's the CEO, is on his way, but he could not get out of dropping off his children at school on Staten Island today, and he's not here yet.

Dr. Berliner: Frank, my question is really, when is the new building expected to be completed?

Mr. Cicero: It'll be done late 2028.

Dr. Berliner: Yeah, so the facility will continue to operate in its current location until then.

Mr. Cicero: Yes, it'll be midnight transfer, yes.

Dr. Berliner: Thank you.

Mr. Robinson: Other questions? I think this is a terrific application, and glad that you were able to garner transformation dollar support for it as well. Anybody from the public wishing to speak on this application? Hearing none, call the question. All in favor?

Dr. Berliner: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. Thank you. Anne, I'll give you an opportunity to make a comment on the name in just a moment.

Application 252114B, Gold Coast Surgery Center in Nassau County, established and constructed a single specialty ambulatory surgery center for gastroenterology at 123 Eileen Way in Syosset, converting an existing private office-based surgical practice to Article 28. The department is recommending approval of conditions and contingencies, with an exploration of the operating certificate five years from the date of issuance. Motion by Dr. Berliner, second by Dr. Torres. Ms. Glock.

Ms. Glock: Gold Coast Surgery Center is seeking approval to establish and construct this Article 28, single specialty freestanding ambulatory surgery center, which will specialize in gastroenterology, by converting an existing private office-based surgical practice in Syosset, Nassau County. The two physicians, Dr. Cottam and Dr. Sidiradus, apologies if I mispronounce those, will each have a 50% membership-

PART 2 OF 6 ENDS [01:06:04]

Ms. Glock: ... announce those will each have a 50% membership and are board-certified in gastroenterology. Dr. Kadam will serve as the medical director. The applicant is projecting 4,500 procedures year one, 4,773 year three, with Medicaid at 22% and charity care at 2% by year three. The project costs of \$2,446,624 will be funded with the proposed member's equity. The department is recommending approval with contingencies and conditions, and an expiration of the operating certificate five years from the date of its issuance.

Mr. Robinson: Thank you. Questions from the committee? Dr. Berliner.

Dr. Berliner: My question, I guess in the department, is how does the utilization statistics that they're projecting compare with the current utilization of the physician office?

Ms. Glock: I don't have data on the existing office, but I'm not sure if maybe the applicant can answer the question.

Mr. Robinson: Can we have the applicant, please?

Mr. Cicero: Frank Cicero, consultant to the applicant.

Mr. Kadam: Hi Jaydeep Kadam.

Mr. Cicero: So, the procedures that are going to be performed at the ambulatory surgery center are relocating from private practice. It's the same number, but we do expect that there will be a change in payer mix. There will be more Medicaid that they'll be able to accommodate. They're currently about 10% Medicaid, so they're expecting the same rough volume between the four physicians, and they're expecting to be 22% Medicaid now.

Mr. Robinson: Thank you. Ms. Monroe, do you have a comment?

Ms. Monroe: Well, I just have a question for us. I don't want to offer that amendment on every ASC that comes before us about looking back three years to see what they've done. You weren't in the room when we did that, Peter. If we have to put that condition on every ASC, I guess we can do it, but-

Mr. Robinson: So, this is a limited life application. This one's limited life.

Ms. Monroe: Up to five years.

Mr. Robinson: This is five years.

Ms. Monroe: Okay. Sorry.

Mr. Robinson: So, I'll take it on. I recognize that the geographic area where your center is located is going to be called... It is the Gold Coast, that's the generic name for it. It seems somewhat unbecoming to have that in the title of a healthcare facility. I may be expressing more a personal point of view, and so you don't have to take this as a mandate or anything like that but would like you to rethink what you call it.

Mr. Cicero: We'll take that back before the full council, Mr. Robinson. The reason why Dr. Kadam and Dr. Sideridis went with that is because their private practice has that name, so they're hoping to carry over the goodwill of that, if you will.

Mr. Robinson: Which is understandable. Thank you. Okay. With that gratuitous comment on my part, I'll call the question. All in favor.

Ayes: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. Thank you.

Application 252165E, Progressive Surgery Center, LLC, in Suffolk County. Transferring 100% membership interest from one member LLC and three individual members to two new member LLCs. Here, the department is recommending conditions and contingency, with an expiration of the operating certificate three years from the date of issuance. Motion by Dr. Berliner, second by Mr. Thomas. Ms. Glock.

Ms. Glock: Progressive Surgery Center is an existing Article 28 multi-specialty freestanding ambulatory surgery center. They're located in Farmingdale, Suffolk County. This application is seeking approval for 100% membership change. The current and proposed ownership of Progressive is presented in the staff report. The center is projecting 34, 26 cases year one, 3,582 by year three, with Medicaid at 9%, charity care at 2%. There is no construction or new equipment costs. The total purchase price of \$5,420 will be funded with the members' equity. The department is recommending approval with contingencies and conditions, with the expiration of the operating certificate three years from the date of issuance.

Mr. Robinson: Questions? Can we have the applicant come forward, please? Introductions, please.

Mr. Cicero: Frank Cicero, consultant to the applicant.

Mr. Garber: Dr. Shawn Garber, chairman of Progressive Surgery Center.

Mr. Kraut: Yeah. So, my question is, for the most part, it's an ownership change, you're adding one other doctor, but you're also claiming you're going to increase access to underserved communities, you've committed to a certain amount of Medicaid charity care, and your income loss is going from negative 400 in three years to positive 3.6 million. I just can't reconcile. Is that all on rate? Because a lot of the contracts for underserved communities are going to be Medicaid managed care. How do you reconcile that large increase in revenue and in profit?

Mr. Cicero: Mr. Crow, I will start and then Doctor will finish. So, the existing center, which has been around for quite a long time, has had some ups and downs. It has not been well recently. The increase in bariatric surgery really is what will drive this. A part of that is that they have recently signed a contract with Fidelis, and they're working on other managed Medicaid care plans. So, Dr. Garber has a plan for increasing access that will improve access, particularly for the Medicaid population, that's where they're going. But I would like him to have a chance to say that.

Mr. Garber: Yeah. Since we joined the center, I've helped negotiate better payer contracts as well, so it helped increase revenues since we've been there. The bariatric surgery is a more profitable service line. And from Medicaid, right now, there's very little Medicaid from when we got involved with the center. Since then, as of actually two weeks ago, we finally got Fidelis, after working over a year to get a contract, to do bariatric surgery at the center. So that's going to dramatically increase the Medicaid volume at the center.

Mr. Robinson: Thank you. Dr. Eisenstein, then Dr. Berliner.

Dr. Eisenstein: Good morning, Larry Eisenstein, committee and council member. You're projecting these growth with bariatric procedures in a time when we're reading how weight loss meds are significantly altering the need for bariatric surgery. Can you comment on that?

Mr. Garber: Yeah, it's a very good question. Obviously, GLP-1s definitely has affected our business. Most of the effect happened over the previous bunch of years. We're predicting a 9% decrease in bariatric surgery volume for next year, for 2026. That being said, our volumes are going to go up for two reasons. One is we have a lot more payer contracts now than we had initially. So, for example, one payer, which I won't mention names, took a year and a half, two years, to get a contract with that went into effect about six

months ago, so that's increased volumes. And also, the Fidelis contract that we are going to go into effect will also help increase volumes.

Dr. Eisenstein Thank you.

Mr. Robinson: Doctor.

Dr. Berliner: I was going to ask Dr. Eisenstein's question.

Mr. Robinson: Okay. That sounds good. Other questions for the applicant or the department? Okay. Anybody from the public wishing to speak on this application? Hearing none, call the question, all in favor.

Ayes: Aye.

Mr. Robinson: Opposed? Abstentions? Motion carries. Thank you.

Application 252173E, Saratoga Schenectady Endoscopy Center, LLC, in Saratoga County. Transferring 6.67% ownership interest from 14 current members to one new member. Also note, the contingency on page two was removed. Also, page three now says, "Since 2004, Saratoga Schenectady Endoscopy Center has had transfer and affiliation agreements with Saratoga Hospital and Ellis Hospital. Saratoga Hospital is 13.3 miles, 26 minutes away, and Ellis Hospital is eight miles, 15 minutes away." With those notes, the department is recommending approval with a condition. Motion by Dr. Berliner, second by Mr. Thomas. Ms. Glock.

Ms. Glock: Saratoga Schenectady Endoscopy Center, an existing single specialty ambulatory surgery center specializing in gastroenterology. They're located in Burnt Hills in Saratoga County. This application is seeking approval to transfer 6.667% ownership interest from 14 current members to one new member. So, upon completion, all members will have equal shares of 6.67%. The staff report shows the current and proposed membership. And the purchase price of \$567,142 is going to be funded with the new members' equity. This transaction's limited to a small change in membership, with no changes in services or locations. As Mr. Robinson mentioned, the applicant had an existing transfer and affiliation agreement, therefore, that contingency has been eliminated. And the department is recommending approval with a condition.

Mr. Robinson: Thank you. Questions? Hearing none, applicant questions only? Anybody from the public wishing to speak on this application?

Hearing none, call the question, all in favor. Any opposition? Any abstentions? Motion carries. Thank you.

Continuing on with diagnostic and treatment centers... Oh, starting with applications for diagnostic and treatment centers, application 242277B, Hyp+Care, Hype Care, in New York County, noting an interest by Dr. Calcett, to establish and construct a new diagnostic and treatment center to be constructed at 111 West 24th Street in New York, to provide primary medical care and medical specialty services, to include saline hydration infusion services for patients who exhibit symptoms of connective tissues disorder. The department is recommending approval with conditions and contingencies. Motion by Dr. Berliner, second by Mr. Thomas. Ms. Glock.

Ms. Glock:

So Hyp+Access, Inc., which I will refer to as the center, is an existing not-for-profit organization. And this application is seeking approval to establish and construct an Article 28 diagnostic treatment center on West 24th Street in New York on the fourth floor of a seven-story building. The center will be certified to provide primary medical care and other medical specialties, such as podiatry, gastroenterology, pain management, orthopedics, physical therapy, oncology, endocrinology, cardiology, ophthalmology and urology, as well as behavioral health services and infusion therapy services. The center intends to provide services for patients presenting who exhibit symptoms of connective tissue disorders, such as connective tissue diagnosis, autonomic dysfunction, allergy and immunological dysfunction, chronic pain, fatigue, rheumatic dysfunction, all of which can cause a variety of physical, psychological and economic problems for those affected. The primary service area is the New York City region, Bronx, Kings, New York, Richmond and Queens County.

According to the applicant, there's a significant and growing need for specialized care for individuals with connective tissue variants, as these conditions often go undiagnosed or misdiagnosed, leading to inadequate treatment and worsening health outcomes. As a result, individuals with these conditions often endure years of unnecessary medical expenses, psychological distress and deteriorating health. Given the increasing recognition of these disorders and their complex interactions with other medical conditions, the applicant states there's a pressing need for a dedicated center that provides comprehensive treatment for connective tissue disorders for residents in this New York City region. The applicants have been providing case management and other non-medical services to this population for approximately five

years. Hyp+Care contends that the inability to find and to access care for this population is due to lack of providers with expertise in diagnosis and treatment of connective tissue disorders and overlapping conditions, and that many physicians who comprehensively address connective tissue disorders do not take Medicaid and Medicare, and they're not actively accepting new patients due to the inability to add these patients to their current patient loads.

The proposed medical director will be Dr. Polizzi, who specializes in treating patients with connective tissue disorders and related cardiovascular manifestations. Dr. Polizzi will be full-time at the center and provide direct patient care services. And currently, Dr. Polizzi practices non-invasive cardiology at NYU Langone Medical Center and is a cardiology clinical instructor and a member of the Long COVID Clinic at NYU Langone. The applicant is projecting a little over 18,257 visits in year one and over 39,000 visits in year three, with almost 29% Medicaid and 2% charity care. The projected number of annual infusions treatments is 4,899, and that's based on an average of about 19 infusions per clinical eight-hour day across the seven-infusion base. So, the percentage of infusions is actually a small percentage of these actual visits. The total project costs of \$1,965,820 will be met with landlord equity and equity from Hyp+Access.

The department's had this application, you'll see from the exhibit, for quite some time and has really taken a close look at this, we've met several times with the applicant. And they're really requesting to provide what I'll state as a first-of-its-kind Article 28 diagnostic and treatment medical clinic to provide this primary medical care and medical specialties for patients who exhibit symptoms of the connective tissue disorders. As such, the department has added two conditions to this project. The first one is that hydration and infusion services shall be administered solely when deemed medically necessary by a licensed healthcare provider, and the medication is approved by the US Food and Drug Administration. The second condition that we are recommending is submission of a report to the department one year after the facility's opening, which would include a summary of their first year of operations, the services provided, the payer mix, the clinical outcomes program and key lessons learned. The department is recommending approval of this application with those conditions, as well as others, and contingencies.

Mr. Robinson: Okay. First questions from the committee and the council? Please, go ahead.

Dr. Lim: Okay. Is the applicant here?

Mr. Robinson: Oh, do you want the applicant?

Dr. Lim: Yeah.

Mr. Robinson: I'm sorry. Can the applicant come forward, please?

Introductions, please.

Mr. Cicero: Frank Cicero, consultant to the applicant.

Ms. Wirtanen: Hello. I'm Audre Wirtanen. I'm the founder and director of Hyp+Access, the nonprofit who is the applicant.

Dr. Polizzi: Good morning, Dr. Susan Polizzi.

Dr. Lim: Morning. Thank you. So, I guess I have a two-part question. In the application, there's listed about 12 different specialties, including oncology, behavioral health, physical therapy, et cetera, and I understand you don't necessarily have to separately apply for each service. When you look at the staffing list, it doesn't include social workers, psychologists, physical therapists, et cetera. So, I guess my first question is, can you go into a little bit more detail about, are these specialties, are you going to be focusing within the scope of primary care or are you actually going to be hiring specific physicians or other staff to provide highly specialized care? I guess that's part one.

And part two is, I think... I guess my question is, how are you going to ensure proper scope of practice? And just overall, can you speak a little bit about how you're going to assure safety and quality? What's your Q&A infrastructure or platform that you're going to maintain within the practice to ensure safe and quality outcomes?

Mr. Cicero: So, Dr. Lim, if it's okay with the committee, I'd like to give an introduction to the project because it is the first of its kind, and then Ms. Wirtanen and Dr. Polizzi will speak about those questions in particular and talk about the specifics of the center. So first, as I think I've said to Ms. Glock a couple of times during the course of the review of this, it reminded me of something that's about 17 years ago when we brought the first pain management ambulatory surgery center to front of the department, and the initial response was that can't be done in a surgery center. Now, we see it's common. I know Mr. Crowd has referenced before in these

meetings, when MRI first came into the world, that these things happened.

But I really do want to say, in reference to what Ms. Glock said, that we very much appreciate the chance to be here today and all the effort that the department put into the review of this project, the two meetings that Ms. Glock referenced, extensive calls led by Dr. Fish and others, and we'd like to thank Robyn Dillon from Hospital Services for all the work that she did. It has been a very long process, but I think it is a good process, where people have learned about what this project is and what it will do. It's a different type of service than you have seen before and the department's seen before, but we think it's a good one, and Ms. Wirtanen and Dr. Polizzi will explain it.

The couple of things I would like to say is, number one, it is a not-for-profit, and the board consists primarily of folks who have gone through these difficult circumstances in their lives, and that has led them, first, to try to help other people like them receive services, which are very difficult to receive. Second, as you see, the Medicaid payer mix is 29%. With the skepticism that often comes with folks who have these types of conditions, it is not only difficult to receive care, but it's virtually impossible to receive care if you're not able to pay a lot of money for it. So, the first thing that they want to do is ensure access to this site.

And then, the last thing I'd like to say is there is a focus on infusion therapy, there are questions about it, I'm sure there may be today. We want to make sure... And it's justified. We see these medical spa, or non-medical, really, spa hangover sites that do infusion. That is not what this is. In fact, you'll hear, I think, Ms. Wirtanen say that they're a mortal enemy of what they're proposing to do. But the infusion therapy, first of all, Ms. Glock has correctly pointed out that the percentage of the visits is relatively low to the total visits, but the number of patients, the percentage of patients is roughly 2% to 3% of all patients will ever get that service. As with something like physical therapy, when you are prescribed it, your number of visits is higher than if you're going to a primary care physician once or twice a year, so the number of visits outweighs the number of patients. But it's a treatment of last resort, it will be a treatment of last resort at this center.

So, I just want to set the table there, and I think I think I should let the two folks next to me, who really know what this is, speak more about it.

Ms. Wirtanen: Sure.

Mr. Cicero: [inaudible 01:29:13]

Ms. Wirtanen: Oh, yes, for sure. Thank you so much. On page six, where the list of services are, is actually unfortunately a misrepresentation of our application. We are only providing primary care, non-interventional cardiology, pain management and hydration therapy. So, to clarify, I'm not quite sure where these other specialties came from. So, our scope is much smaller, and the providers that we're hiring are credential physicians in those areas. Our QA process, we actually plan on including staff of all tiers in our QA process, and we are also including patient feedback as well in a way that really comes from my background in non-clinical care management and coordination. So, we really care about making sure that patient voices are heard, because they've been so, so underserved. But I do just want to really say again that our scope is much more limited, following the lead of Dr. Polizzi, who is a non-interventional cardiologist.

Dr. Polizzi: Okay. So, I'm not sure what everyone knows about these things or what they think they know, but connective tissue disease is a very broad term, and so it's difficult when people hear that, they don't know what it is. So, things that people, when we talk about chronic illness, we're talking about a lot of things, autoimmune disease, so people with rheumatoid arthritis, lupus, inflammatory arthritis, people that have chronic fatigue syndrome, which is a real post-viral syndrome, long COVID is another post-viral syndrome. And when most people think of connective tissue disease, we hear a lot of things, hypermobility spectrum disorder, hypermobile Ehlers-Danlos, and the more we're learning about all this is these processes are all very interconnected and we feel that inflammation is driving a lot of it.

So as a cardiologist, I would see these people from an autonomic perspective. People would come to me with palpitations, dizziness, passing out, inability to exercise, shortness of breath, and we'd rule out all the cardiac causes and find that they have nervous system dysfunction. So, the autonomic nervous system, which controls everything in our body, is dysregulated, causing severe issues with symptoms, problems with quality of life because of this inability to hold down jobs, et cetera. Often, these patients are women, which is a problem in and of itself because we are misheard often, and also younger women. So, a lot of patients who have these symptoms, again, bounce around from place to place to place, being poo-pooed, telling them it's all in their mind, et cetera.

So we have been trying to find a way to make sure these people are heard, make sure they're getting care, people that do not have access to traditional insurance because they're unable to work, so they are on Medicare or Medicaid, have the opportunity to see providers that are not just concierge, because a lot of people that do this are concierge-only. I am not, and I am completely overwhelmed because it's a lot of work and we need help. So, our scope would be to help coordinate these patients' care, have primary care to help. I and I have expanded to know a lot of things about a lot of non-cardiac things because they are all interconnected.

And infusions are really what we would call last resort therapy. This is not a medium spa, you don't come in and say, "Hey, I'm hungover. I need fluids." This is you have tried various non-pharmacologic treatments, pharmacologic treatments, and you continue to have unrelenting symptoms or problems with quality of life and inability to do things. The infusions... And we're talking saline Lactated Ringer's. There are no vitamins, there's no pain medication, et cetera. This is purely increasing intravascular volume to help with symptoms. It would only be prescribed by a medical provider, again, as a more last resort form of therapy. So, it is a small portion of our care, but it is something that people who have Medicaid, Medicare have been having a lot of difficulties accessing because of the inability to find an infusion center who would take their insurance, or even in the very few existing infusion centers that are around having space to accommodate people for just saline infusions.

Dr. Lim: Thank you for... Oh, go ahead.

Ms. Wirtanen: Is that okay?

Ms. Wirtanen: [inaudible 01:34:18]

Mr. Robinson: Did you have something else you were-

Mr. Kraut: Did you want to add to the question that was just asked?

Mr. Cicero: [inaudible 01:34:24]

Ms. Wirtanen: Okay. I'll go ahead. You can go ahead.

Mr. Robinson: Okay. Dr. Eisenstein.

Dr. Eisenstein: Yeah. Hi. So, I find this discussion very interesting. Certainly, this is not the place to debate the comments we just heard. Just quickly, in your comment about you don't know why all those specialties, this is your application, I just wanted to say that. But really important, Frank, before I go back to you, I don't want to get into a long debate about infusion therapy and some of the diseases you named. I'm a board-certified infectious disease doctor for a long time, I've dealt with a lot of this too. So, I'm going to focus on my question very simply.

A lot of times, infusion therapy, and I'm not doubting the need, a lot of times, infusion therapy and other therapies that kind of sound like where you're going are not evidence-based or being done holistically, which I'm not opposed to, but if we're approving this CON, my question to you is, do you plan to do this based on evidence and with the current guidance of the appropriate leadership in the fields? In other words, we're talking about, I saw there's a thing on lupus, do you have rheumatologists? Do you have endocrinologists? Do you have the proper people guiding the care? Because you are entering a field, as you know, that is very controversial and a lot has been done over the years not evidence-based, and I've always questioned the first do no harm responsibility of medicine, and I've seen stuff that I don't always think was done with the proper motive to help people the way you're describing. So, my question is, do you plan to follow evidence-based medicine and the standard accepted guidance in doing all of this work?

Ms. Wirtanen: Yes. Thank you for your question. We absolutely do. We provided the department with close to probably 50 pages of citations relating to these diagnoses, and in addition, within those citations, evidence that hydration therapy is effective and safe in these populations. In particular, so these patients are... Connective tissue surrounds every cell type. It connects the cells within the organ systems, and it also connects the organ systems together. And so, these patients actually present with an average of 10 diagnoses and an average of three misdiagnoses. So, if somebody comes in with lupus, they will very likely have a rheumatologist, who's outside of Hyp+Care who's referring to us, and be presenting with autonomic dysfunction symptoms. They would then come to Dr. Polizzi, or somebody who is working with Dr. Polizzi that is a Hyp+Care-credentialed cardiologist, and they would then assess that lupus patient for the comorbidity of some form of dysautonomia. Then we would go through lifestyle changes first. That includes increasing water intake, increasing electrolyte intake and salt intake, compression garments.

Dr. Polizzi [inaudible 01:37:27]

Ms. Wirtanen: Huh? Okay.

Dr. Eisenstein: Okay.

Ms. Wirtanen: I'm told not to explain that.

Mr. Cicero: I just wanted to speak to the issue of medical specialties. We're not sure why those ones are listed in that area, but on page 11, under the financial review, it says, "Medical specialty services include cardiology, pain management, infusion therapy." Those are the ones... I apologize, I have to apologize. I should have brought it to Ms. Glock's attention. We spotted that when we were preparing. I should have brought it to the department's attention.

Dr. Eisenstein: And if I could just follow up, Mr. Robinson, you mentioned those 51 citations, and certainly I asked if you were practicing evidence-based medicine, so that's the appropriate response. But my message to the state, more and more, there's citations that are not evidence-based medicine, they're people who had an agenda and got something published. And so, I just would ask the state, if there's something that we should be flagged that we're not heading down that path, I think that's important for us to know, because that's the evaluation. I know it's getting harder and harder to do. This area for me has always been sensitive because I want to make sure that we are doing no harm to our patients.

Mr. Robinson: Thank you.

Dr. Lim: Peter, if I could just close up.

Mr. Robinson: Go ahead.

Dr. Lim: I just want to follow up on my original question. So, thank you for the clarification. I think I would say that in order to make sure that you distinguish yourself from the Medi-spas and the concierge practices, and I don't mean to parse your words, it's very important and required to have a robust QA-

PART 3 OF 6 ENDS [01:39:04]

Dr. Lim: ... Show words, it's very important and required to have a robust QA program. It's not just a process. And that's for the protection of your patients and for your site as well. So, I'm sure that within the 31 group of people, just make sure you have a robust program to

ensure, and I think the evidence-based part is in part of a larger QA program that'll be critical for this site.

Mr. Kraut: What you're hearing is a general skepticism on this because the hydration therapy, you go down to California, you go into Topanga Canyon, and you get drunk the night before, you go dry out and they give you a bag of saline. So, the other thing that we realize, I think, is science is evolving in this. And what we're concerned about primarily is when you start infusion therapy for people who have had these cluster of symptoms, they're looking for an answer, they'll try anything. And sometimes they become a dependency on these infusion therapy that they're client for life. And we're not sure of the marginal benefit of doing that. So, we have that perspective to protect the public as well. You obviously have the qualifications, you understand science. So, I'm less concerned about that. But also, with the viability of what you're proposing, you're going to have a rate of between 250 and \$275 a visit.

Insurance companies, particularly when there's these cluster of symptoms and it's unspecified, connective type stuff, we see higher denial rates. So, the economic viability, I'm just wondering, your approach, has your experience been with insurance companies where you get reimbursed, you're able to deal with it, or do you anticipate that this is going to be a problem, just [inaudible 01:41:07]?

Ms. Wirtanen: Thank you for that question. We actually started building our model based off of medical coding because we knew that it was so heavily important because we saw denials coming through various practices. But I'll turn it over to Dr. Pelizzi who's been doing this for about 12 years.

Mr. Kraut: Because you recognize, we're afraid of balanced billing patients. You think you're going to get paid or you're not going to get paid and it's going to be on the patient's back.

Ms. Wirtanen: Yes.

Mr. Kraut: Okay.

Ms. Wirtanen: Thank you.

Dr. Polizzi: I've been seeing these patients for several years and I've had no issues with coding, denials, et cetera.

Mr. Kraut: Thank you.

Dr. Polizzi: Yeah, all medically necessary.

Mr. Kraut: Okay. Thank you.

Mr. Robinson: Just a general observation, I was very touched by your point about the fact that the majority of the patients coming to you are women and that in fact there's just a general tendency for women who present symptoms not to be believed in the same way that men are. I actually think that's a legitimate concern, and I'm actually glad that you're aware of that and focusing on it because I think it's an important piece of access and something that we need to do. As my colleague said, I think you're a first of a kind for us. And now speak for me first, but I'd almost like to have you at some point not only report back to the department, but I think the council itself would like to hear back from you with regard to what the real outcomes are of the work that you're doing.

And if you can develop some patient outcome data, that would be really, really, I think, informative for us as we look at other applications like this. So, I think we can, if you're in agreement, somehow put that into the contingencies that the department is putting out there, because I'd like to structure a return visit for you guys at some point in the future so that the general public can be informed about exactly how this is progressing.

Ms. Wirtanen: Thank you. If I may add, we have plans to do that, to be tracking quality of life, levels of disability and other outcomes in all of our patients throughout their treatment. So, we will have that data and are happy to present it.

Mr. Robinson: I'm sure that there will be some clinical biomarkers that you can point out to, but I am sure a lot of this is going to be on patient reported outcomes as well.

Ms. Wirtanen: Yes.

Mr. Robinson: And I think we have to recognize that that's as legitimate a mark as any that we would be looking at.

Mr. Kraut: Well, so we don't open up the floodgates of these type of applications that may not have the same perceived quality. We attach sometimes a condition to an application, just as we did the freestanding emergency departments, that in two years you write a report to the department about your experience addressing some of the issues you heard today. And I would make that a condition of this application just to give us the comfort level. And I think it will be

two years from operation, not from today, till you get rolling. And I forgot who made the motion, just to go back, if we could add a condition that the applicant provide the department with a condition.

Mr. Robinson: I added that amendment to my motion.

Mr. Kraut: Exactly.

Mr. Robinson: And you add that to your second.

Mr. Kraut: And I would say two years hence from operations.

Mr. Robinson: Two years from the start of operations.

Mr. Kraut: Start of operations. Is that okay?

Mr. Robinson: Is that okay?

Ms. Glock: Yes, we can add that as a condition. We can also add to the condition of reporting back to the department. We can add the language that says, and to the FIPIC.

Mr. Kraut: Yes, please.

Ms. Glock: And I just want to also say while I have the mic that apologies for the medical specialties' confusion, while we strive for excellence, we do make a mistake once in a while, so I apologize. And we will correct that for the full exhibit for the full...

Mr. Kraut: Okay. And I would generally suggest to any applicant that when you get the staff report, if you see there's a material problem, call the department before the meeting. That's all.

Mr. Robinson: Dr. Kalkut?

Dr. Kalkut: Yeah, and then Howard.

Mr. Robinson: Oh, Howard.

Dr. Kalkut: Thank you. Yeah. I'd like to start with the arithmetic because I didn't understand, Frank, Shelly and you both said my understanding is for the first year you're projecting 18,000 visits and 4,900 infusions. If it's a small percentage of patients, then the patients get 4,900 infusions, 18 to 20 a day as you project during the week, they would be on infusions for an awfully long time. I don't think that's what you're... You said two to 3% of the patients are getting? Can

you just tell me how you got to that, because if there's 5,000 infusion, 18,000 visits, it's only two, 3%? I don't get it. And I know it's last resort.

Ms. Wirtanen: Yes. So many of Dr. Palizzi's current patients are actually unable to fill their medically necessary scripts in New York, largely because of the low reimbursement rates of hydration therapy. And so, we have a very hard time getting patient scripts filled. So, there are seven infusion bays. We have eight exam rooms. Our ENMs are an average of 45 minutes long. So, there is a longer time period of our visits because patients are much more complex and do require more time than we need to spend a lot of time. And patients tend to need a series of infusions over the course of a period of time. And so, within those infusion days of 6,000 patients with a two-to-three-hour infusion, because patients sometimes need slower rates than someone who goes to a hangover center per se, all of that together contributes to those numbers.

Dr. Polizzi: I think the other thing is remember the total patient visit's going to include physicians, other therapies, infusion therapy, et cetera. And if you're getting infusions, you do it one to two times a week, two to four hours per visit.

Dr. Kalkut: And how long are the infusion episodes?

Dr. Polizzi: Like two to four hours. Right.

Dr. Kalkut: Right. Does that go on for a week?

Dr. Polizzi: Oh, no. It depends on patient response to treatment. It also depends on time of year. We tend to have people more in the warmer months have a lot more problems because of the heat, dilating blood vessels, et cetera, having more problems. So, we would anticipate less people in the winter, more in the summer. Some people that have more acute autonomic gastrointestinal issues might need a course and then get back on track. Not everyone does them all year round. Some people do them part of the time, some people do require them all the time, and some people just need a short course to get back on track and be able to reinitiate other therapies.

Mr. Robinson: Let's keep moving.

Mr. Robinson: Yeah, I have a couple of questions if you can. First, can you explain the organizational structure of your company?

Ms. Wirtanen: Sure. So Hyp+Access is not for-profit. We started out as a non-clinical care management and coordination organization, and we worked with clients locally, nationally, and globally. We were actually tracking clinics and available care all over the world. And it became very clear very quickly that the issue was that there is no care really at any price point. So Hyp+Access is the nonprofit, and Hyp+Care, which is a DBA of Hyp+Access, will be the clinic itself. So, this will become one of our primary programs that we will supplement with our other non-clinical programs.

Mr. Robinson: Thank you. And where do we get all the Medicaid patients from?

Ms. Wirtanen: So, most of our clients are Medicaid patients. Medicaid patients tend to have the highest barriers to care. We're very connected with patient communities that are patient led, like long COVID organizations, Ehlers Danlos organizations, et cetera. And we, through those relationships, know that these are the patients who are almost wholly unserved. And so, we, through these relationships, will be reaching out if and when we have an opening date to make sure that we fill that load, we really care about Medicaid equity. Yeah.

Mr. Robinson: Okay. And finally, if I may?

Mr. Robinson: Okay. We just have to move.

Dr. Berliner: I want to try to say this in a way that's constructive and not as controversial as it might sound, but many of the conditions that you're dealing with are incredibly subjective. And I would be interested in how you would determine success. Is this going to be like a lifelong treatment thing? I just don't know the answer to that kind of question. How will you determine quality of care? When would you decide that someone needs to be referred to from alternative care too, if you go more standard types of therapy? I'd just be interested.

Dr. Polizzi: This is standard therapy. What we do is standard therapy. This is what I do now, yeah. We assess people, we rule out other major medical issues, and then there are documents for autonomic dysfunction from neurological societies, cardiovascular societies on treating things. And infusion is on there. It's way down because again, it is not the thing. And it can be controversial. Some people don't believe it, but there was a gentleman who I think has since retired in Boston who actually did invasive testing that prove these patients, they don't have any retention of oral hydration, their intravascular pressures are extremely low, and you have to volume

load them. And clinically, they feel better. They can think, they can function, they can work and be a productive member of society. So, one of our metrics will be how many people their quality of life is improved. Are they able to return to work? Things like that. But these are all standard treatments.

Dr. Berliner: Okay, just one comment. So, I'm not saying anything about standard treatment, non-standard treatment, but why is what you're doing not just placebo therapy? You're giving people care of some sort. I can't answer whether it works, or it doesn't work, and yet the state Medicaid will be paying for this.

Mr. Kraut: That's correct.

Dr. Berliner: Nothing wrong with people feeling better if it makes them feel better, but what's the public benefit of that type of care?

Mr. Cicero: Dr. Berliner, I think they've seen in their daily lives, and we don't take it as an insult, the question, it's a fair question, I think in the reporting, we'll be able to, if we're approved, to document that in a couple of years. And there's no question, there is skepticism. Again, they deal with it, and we're very, again, thankful to be here today and hopefully to have an opportunity.

Mr. Kraut: Yeah. Could I make a suggestion going forward? You said you had a long conversation with the applicant trying to understand this. When we're confronted with a new approach or something we've not seen before, instead of trying to respond to what are absolutely appropriate questions during a packed EPRC agenda, I'd rather that we bring it to the planning committee to have a little more extensive discussion where we're freer to ask these questions and educate ourselves because they're all valid because we haven't seen this before. So just for the future, if the department is confronted with similar questions, we probably would have the same ones. And I think the planning committee is a more appropriate venue. Not that this is inappropriate, don't get me wrong, it's just that I think in the future we'd benefit from that a freer discussion...

Mr. Kraut: ... That's more focused educational. Okay. And guys, just remember we have a planning committee right after this. Okay. Do you want to ask the question?

Mr. Robinson: Yes, I do. Thank you for your responses and for educating us. And as part of this process, we appreciate it. Is there anyone from the

public that wishes to speak on this application? I'm hearing none, so I'm going to call the question. All in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? One abstention, Dr. Eisenstein?

Mr. La Rue: I'm abstaining as well. I don't feel like I have enough understanding of this to vote affirmatively or not, so I'm going to abstain.

Mr. Robinson: Two abstentions, thank you.

Mr. Kraut: Just let's move on. Okay.

Mr. Robinson: Three abstentions. So, we have three abstentions. I believe the motion still carries.

Ms. Monroe: Who is the third?

Mr. Robinson: Okay. So, I have Dr. Eisenstein, Mr. LaRue, and Dr. Calcutt abstaining. Motion carries with three abstentions. Thank you. Application 252045B, Doctors of New York Healthcare Center in Queens County establish and construct a new diagnostic and treatment center at 19411A Northern Boulevard in Flushing. Department is recommending approval with conditions and contingencies motion by Dr. Berliner, second by Mr. Thomas, Ms. [inaudible 01:57:26].

Ms. Glock: This application is to establish and construct an Article 28 Diagnostic and Treatment Center in an existing building in Flushing in Queens County. The Diagnostic and Treatment Center will be named Doctors of New York Healthcare Center. The center will be certified for primary care and other medical specialties. They will also provide diagnostic radiology and infusion therapy services. The newly established entity whose sole member is Tammy Ku and Dr. Tripsakovsky, apologies, who's a board-certified internist will serve as the medical director. According to the applicant, the center is going to be catering to a large Korean and Chinese population and will have culturally appropriate and sensitive services and staff who will be bilingual when possible. They're projecting 32,402 visits in year one, 61,000 in year three, with 62% Medicaid and charity care at 3%. Total project cost of 3.2 million will be funded with equity, and we are recommending approval with conditions and contingencies.

Mr. Robinson: Thank you. Questions for the department? Applicant questions only? Anyone from the public wishing to speak on this application? Hearing none, all in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. On to long-term care and Mr. Lebwohl. Application 241092E, Foxwoods Home Care LLC. This is to establish a new licensed home care services agency at 705 Renaissance Drive in Williamsville. Department recommends approval with conditions. Motion by Dr. Beliner, second by Mr. Thomas. Mr. Lebwohl?

Mr. Lebwohl: Thank you. This is to establish a new licensed home care services agency pursuant to Article 36 of the PHL to provide home care services to the Canterbury Woods and the Fox Run Continuing Care Retirement Communities. Because the agency will only serve the residents of specific CCRCs, it is exempt from need review. The applicants are satisfied with all applicable reviews, and the department recommends approval subject to standard conditions.

Mr. Robinson: Questions for the department? Applicant questions only? Thank you, anybody from the public who wish to speak on this application? Hearing none, all in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. Thank you. Under change of ownership, application 232059E, Grifinger Rocha LLC doing business at Home at Last Homecare. There is a range of geographic service areas in your material. This is to establish Grifinger Rocha LLC, the new operator of a licensed home care services agency previously operated by Home at Last Home Care Services LLC at 51-27 Queens Boulevard in Suites 2D and 2E in Woodside. Department is recommending approval with a condition. Motion by Dr. Beliner, second by Mr. Thomas. Mr. Lebwohl?

Mr. Lebwohl: All right, so this would establish Grifinger Rocha as the new operator of Elixia that was previously operated by Home at Last Home Care Services. The transaction would involve the transfer of the entire ownership interest from the current owner to new owners. There are no changes to services offered or to counties served. The applicant has attested that the agency serves more than 25 patients, so the application is exempt from public need review. The applicants are satisfied with all applicable reviews, and the department recommends approval subject to standard conditions.

Mr. Robinson: Okay. Questions for the department? I note that on this application and the next degree, there is nobody signed in from the applicant. Did people forget to sign in, or are you not here?

Applicant: I'm here.

Mr. Robinson: Okay.

Applicant: [inaudible 02:02:14].

Mr. Robinson: I don't need you to come up, I just needed to know you were here.

Mr. Kraut: That's all.

Mr. Robinson: You fill out the forms? Thank you very much. Okay, questions? Anybody from the public wishing to speak on this application? All the questions, all in favor? Any opposition? Any abstentions? Motion carries. Moving on, 242282E, the Home Agency Inc. Again, there's a list of geographic service areas in the material to establish the Home Agency, Inc. as the new operator of a licensed home care services agency currently operated as Nannies 4 grannies. I don't know why you don't want to keep that name.

Mr. Kraut: That is a great name. I love that name.

Mr. Robinson: Yeah, just so you know.

Mr. Kraut: All right.

Mr. Robinson: At 34 Sunset Lane in Patchogue, the department is recommending approval with a condition. Motion by Dr. Berliner, second by Mr. Thomas. Mr. Lebwohl.

Mr. Lebwohl: All right, he stole my thunder on Nannies 4 Grannies. The applicant has been providing services under a management agreement since September of 2024. There are no changes to services offered or to counties served. The applicant has attested that the agency serves more than 25 patients, so the application is exempt from public need review. The applicants are satisfied with all applicable reviews, and the department recommends approval subject to standard conditions.

Mr. Robinson: Thank you. Are there Nanny 4 Granny people here? Thank you. Okay.

Mr. Kraut: Want to sell the name? Okay.

Mr. Robinson: Questions for the department? What for the applicant, applicant questions only? Anybody from the public on this application? Hearing none, call the question. All in favor?

Mr. Kraut: Aye.

Mr. Robinson: Opposed? Abstentions, motion carries. Next is 252046E, the Elliot of Catskills LLC. Doing business as the Elliott at Catskill Elixia. Again, a list of service area designations. This is to transfer 100% loan membership interest from a new member LLC to a membership interest to a new LLC with the same members. Department is recommending approval with conditions. Motion by Dr. Berliner, second by Mr. Thomas. Mr. Lebwohl?

Mr. Lebwohl: This is one of two applications in the same category with the same owners. The change in owner operator is due to a HUD 232 refinancing program that requires each agency owned by the operator to have its own separate legal entity as part of the structuring for refinancing. There are no changes to services offered or to counties served. The applicant has attested that the agency serves more than 25 patients. The application is exempt from public need review, and the applicants have satisfied all applicable reviews. The department recommends approval subject to standard conditions.

Mr. Robinson: Are the Elliot people here?

Mr. Kraut: Yeah, they are.

Mr. Robinson: Okay, thank you. Questions for the department? Questions for the applicant? Applicant questions only? Anybody from the public on this application? Hearing none, call the question. All in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. I can't move my fingers fast enough. Application 252047E, The Sentinel of Port Jervis, LLC, doing business as the Sentinel of Port Jervis Elixia. List of service areas in the material. Transfer 100% membership interest to a new member of LLC with the same members. Department recommending approval with conditions. Motion by Dr. Beliner, second by Mr. Thomas. Mr. Lebwohl?

Mr. Lebwohl: Like the last one, this change in owner operator is due to a HUD 232 refinancing program that requires each agency owned by the operator to have its own separate legal entity as part of the

structuring for refinancing. The transfer will be to a new entity with the same owners. There are no changes to services offered or to county served. The applicant has attested that the agency serves more than 25 patients, so the application is exempt from public need review. The applicants are satisfied with all applicable reviews, and the department recommends approval subject to standard conditions.

Mr. Robinson: Applicant is here because [inaudible 02:06:46]. Yes, no? Yes. Yes, okay. Questions for the department? Questions for the applicant? Applicant's questions only? Anybody from the public? Hearing none. Are all the questions in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries, thank you. Onto now, application for residential healthcare facilities. Application 242307E, 378 Slywood LLC doing business as Woodbury Heights Nursing and Rehabilitation Center in Nassau County. This is to establish 378 Slywood LLC as the new operator of Coldspring Hills Center for Nursing and Rehab, a very large 588 bed residential healthcare facility currently operated by Coldspring Acquisition LLC at 378 Syosset Woodbury Road in Woodbury. The department is recommending approval with conditions and contingencies motioned by Dr. Beliner, second by Mr. Thomas. Mr. Lebwahl?

Mr. Lebwahl: So, this is the second-largest facility on Long Island. The facility was formerly known as Cold Springs Hills Center for Nursing and Rehabilitation, and it has been the subject of chapter 11 bankruptcy proceeding since January of 2025. The applicant is 100% owned by Eliezer J. Zellman and was previously approved as the voluntary receiver of the facility effective April 22nd, 2025. The applicant has satisfied all applicable reviews, and the department is recommending approval with conditions and contingencies.

Mr. Robinson: Thank you. Questions? Mr. LaRue?

Mr. La Rue: Thank you. My first questions for the department, and I don't necessarily need an answer now, but it might be helpful for future meetings knowing that Jeff is concerned about timing today. But I'd be interested in knowing how a receiver is chosen for a facility, because that would help with the decision making about the applicant.

Mr. Kraut: Go ahead and answer if you can.

Mr. Lebwohl: A receiver is subject to a character incompetence review. We review to make sure that we're not putting somebody in who has a significantly checkered background. But actually, I'm going to turn to Mike over here.

Mr. Kraut: You have a list of receivers though.

Mr. Heeran: So, the receiver, it's an agreement between the current operator and the department. There's an actual agreement that they come in and they have to still go through a character competence review, financial feasibility, but we do a small review of them to make sure that they're sound enough to operate the facility. And in this case...

Mr. Robinson: I think it's less the criteria, but what's the process for identifying the candidate receivers?

Mr. Kraut: Yeah, don't you have a list of approved receivers?

Mr. Heeran: No.

Mr. Kraut: No, or every time you need a receiver, you go out with a request, or how does that work?

Mr. Heeran: This would be the current operator who reached an agreement with this person to [inaudible 02:10:04].

Mr. Kraut: So, the current operator finds a receiver, and you have to approve them?

Mr. Heeran: Correct. The application [inaudible 02:10:10] of the agreement has to be reached.

Mr. Kraut: Obviously you've never managed-

Mr. La Rue: So, the operator that owned it or still owned it, who's gone bankrupt and had whatever issues they had with the facility, picked the receiver and recommended that individual to the department for approval?

Mr. Heeran: Yes.

Mr. Kraut: If it's a voluntary receiver?

Mr. La Rue: Was this voluntary?

Mr. Heeran: Yes, yes.

Mr. La Rue: All right, my next questions were for the applicant. Thank you.

Mr. Kraut: Okay. Involuntary is a court appointment, right? [inaudible 02:10:56].

Mr. Cicero: I'm Frank Cicero, a consultant to the applicant.

Mr. Zellman: I'm Eliezer J. Zellman, current receiver at Woodbury Heights.

Mr. La Rue: Good morning or good afternoon. Thank you. So, my first question is the proposed new owner and operator and the current receiver, do you have any business relationships with the individual who owned it prior to you? The individual or the group that owned this facility during all of its difficulties with either the health department or the attorney general, do you have any business relationships with them whatsoever?

Mr. Zellman: Absolutely not.

Mr. La Rue: How is it that they recommended you as a receiver?

Mr. Zellman: I am pleased that I have a reputation in the industry for the past approximately 28 plus years. And they knew that I had been involved with some difficult turnarounds.

PART 4 OF 6 ENDS [02:12:04]

Mr. Zellman: ... Been involved with some difficult turnarounds, and they sourced me. That's the most direct response.

Mr. La Rue: Okay. So, is there no connection to the prior owner and there will be no benefit accrued to the prior owner from your ownership of this facility?

Mr. Zellman: Correct.

Mr. La Rue: Okay, great. My next question was about the administrative services agreement. So, I see that you own a number of nursing homes. Are they under any corporate umbrella? Like if you're doing administrative services, do you have a corporate entity that's providing those services?

Mr. Zellman: No. And as a matter of fact, at this facility, I went out of the way to bring in a separate back office, which is named in the application, with zero connection with any of my other current facilities. I want there to be no question that there are no prior relationships.

Mr. La Rue: Okay. Is Infinite Care something that you're responsible for or provides administrative services?

Mr. Zellman: No.

Mr. La Rue: Okay. I noticed in the administrative services agreement that the annual fee is \$330,000. Are you providing any FTEs under the administrative services agreement to the nursing home, like the CFO or anything like that?

Mr. Zellman: Correct, the unrelated back office provides staff to us, we don't have a dedicated FTE that's on our payroll.

Mr. La Rue: I'm just trying to understand, it says that you're going to be providing accounting, receivable billing services, HR, payroll oversight, cash management, cost reports, corporate services, oversight and purchasing. For a 588-bed facility for \$330,000 a year, that seems like a really good deal.

Mr. Cicero: Well, Mr. La Rue, Centralized Business Services LLC is not related to Mr. Zellman in any way. They're providing those services under the \$330,000 agreement.

Mr. La Rue: It's a third-party?

Mr. Cicero: Yes, you have no relationship.

Mr. Zellman: No relationship.

Mr. Cicero: No relationship with that entity, it's third party.

Mr. La Rue: I'll have to find out who they are because I could never do all that for \$330,000. Thank you.

Mr. Zellman: Don't tell them.

Mr. Robinson: Other questions for the applicant?

Mr. Kraut: Just to clarify, I know Scott asked business relationships. Any familial relationships, cousins, nephews, nieces, between the prior ownership group or the business group you hired, just to be clear about it so there's no misunderstanding?

Mr. Zellman: Absolutely not.

Mr. Kraut: Thank you.

Mr. Robinson: Good. Okay. Thank you very much. Anybody from the public wishing to speak on this application? Hearing none. We'll call the question, all in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. Thank you.

Mr. Zellman: Thank you.

Mr. Robinson: Thank you very much. Mr. Perry, it's time for you to step out for a moment. Pardon me? Oh, I think we can do them both. That's fine. Okay, we're going to certificate here, the certificate of dissolution for AHRC Healthcare Inc. AHRC Healthcare Inc. requests Public Health and Health Planning Council approval for its proposed dissolution in accordance with the requirements of not-for-profit corporation law 1002C and 1003, and 10 NYCRR Part 650. Department recommends approval. Motion by Dr. Berliner, second by Mr. Thomas. Any questions for the department about this? Anybody from the public on this? Call the question, all in favor? Any opposition? Any abstentions? Motion carries.

Certificate of amendment for the certificate of incorporation for Northwell Health Foundation. Conflict and recusal by Mr. Crowd, who's left the room. Northwell Health Foundation requests Public Health and Health Planning Council approval for its certificate of amendment of the Certificate of Incorporation of Northwell Health Foundation in order to change its name from Northwell Health Foundation to Northwell Foundation. Department recommends approval. Motion by Dr. Berliner, second by Mr. Thomas. Questions about the department? Anybody from the public? Call the question, all in favor?

Mr. Kraut: Aye.

Mr. Robinson: Any opposition? Any abstentions? Motion carries. Have the accused people returned. Guess what folks or the folks that are left? We've gotten to the end of this agenda. I know there's more work to come, so I will call to adjourn at the committee meeting and turn it over to Mr. Kraut.

Mr. Kraut: So, we have a motion to adjourn the meeting. [inaudible 02:17:36], all in favor? Aye. Okay, we're going to take a 15-minute break and then we're going to convene the planning committee to take up an agenda, and we hope everybody will have an opportunity to stay

and get educated. We'll be back 15 minutes from now, so it's 10 to 1.