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COMMISSION ON HEALTH CARE FACILITIES  
IN THE 21st CENTURY

Hyatt Regency  
125 East Main Street  
Rochester, New York 14604  
April 5, 2006  
1:30 p.m.

STEPHEN BERGER, Chairman  
ROBERT R. HINCKLEY, Vice Chairman  
DAVID SANDMAN, Executive Director

Alliance Shorthand Reporters, Inc.  
Suite 1500 - The Penthouse  
Alliance Building  
183 Main Street East  
Rochester, New York 14604

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2                   CHAIRMAN BERGER: Ladies and gentlemen,  
3 I'd like to welcome you all to the 7th meeting of  
4 the Commission on Health Care Facilities in the  
5 21st Century. It's very appropriate we have this  
6 meeting in Rochester. This city has a long history  
7 of concern, planning, development and improvements  
8 in the health care industry dating back, you know,  
9 probably before Marion Folsom. And certainly  
10 there's a long history that this city and this  
11 institution can be proud of, and we're delighted to  
12 be here today.

13                   One of our members has invited us to  
14 have all our meetings here now and we will take it  
15 under consideration.

16                   I would like to now turn the meeting  
17 over to our executive director, David. Why don't  
18 you start.

19                   DR. SANDMAN: Thank you, Mr. Chairman.  
20 As it has been just three weeks since our last  
21 meeting, I'm pleased to make this brief report on  
22 our progress. Since our last meeting, there have  
23 been nine new appointments made to the Regional  
24 Advisory Committees of the Commission.

25                   The Governor has appointed three

1  
2 additional members: The Reverend Calvin Butts from  
3 Long Island, William Florence from the Hudson  
4 Valley, and Terrence Kane from the Central Region.

5 The Senate has also appointed four  
6 members, all of whom are to the Long Island  
7 Regional Advisory Committee, including Jack  
8 Howlett, Jeffrey Kraut, Joseph Carillo and Ron  
9 Gaudreault.

10 In addition, the Assembly has appointed  
11 two members to the Hudson Valley RAC, Linda  
12 Landesman and Charles Bell.

13 And we are pleased, of course, to welcome  
14 all our new members. We have conducted  
15 orientations for all of them and integrated them  
16 into the process as quickly as possible, and all of  
17 them immediately began attending meetings within  
18 their region as well as the hearings.

19 The Commission has nearly concluded  
20 conducting a very extensive series of almost 20  
21 public hearings across the state, and that phase of  
22 our work is just about to be completed. Just since  
23 our Commission meeting last month we have continued  
24 to conduct public hearings in locations as diverse  
25 as Jamestown, Rochester, the Bronx, Manhattan,

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Riverhead, Long Island, and just yesterday in Watertown here in the Central Region.

We do have one additional hearing scheduled for next week on Long Island, and that hearing will complete that phase of the Commission's work.

In total, we have literally heard from hundreds of witnesses, we have collected thousands and thousands of pages of testimony across the state, which both we and the RACs continue to review to identify common themes. Much of the Commission's work does continue to be focused on the Regional Advisory Committees, all of which are very deeply engaged in their work. All of them are holding discussions with providers and with other stakeholders within their region.

Many of them, in fact all of them are holding day-long sessions in which they talk with many different parties. And quite a few of them are also engaged in site visits to the facilities within their regions, both hospitals as well as nursing homes.

The staff continues to work closely with the RACs. We are providing them with different

1  
2 types of analysis as well as support to model  
3 different scenarios and to understand the impact of  
4 potential restructuring initiatives. Beginning  
5 here today, the Regional Advisory Committees will  
6 begin sharing with us the results of their fact  
7 finding efforts thus far and providing information  
8 to the Commission to assist in the Commission's  
9 deliberations.

10 As always, the Commission continues to  
11 engage in a very active communications program. We  
12 hold numerous meetings and presentations for  
13 various constituencies across the state, so we have  
14 been on the road a great deal between those  
15 hearings and the other outreach efforts.

16 So Mr. Chairman, in summary, we do  
17 continue to remain on our scheduled working plan  
18 and making good progress with our work.

19 CHAIRMAN BERGER: There are two things  
20 I want to say, and I want to say them in public.  
21 I want to thank the members of the Regional  
22 Advisory Committees for the work that they have  
23 been putting in around the state, will continue to  
24 put in over the months ahead. They've been  
25 diligent, they've been working hard, and we are

1  
2 very anxious to hear the information that we will  
3 be receiving from them.

4 I also want to thank the staff which has  
5 been moving around the state as well as working in  
6 the office trying to support the Regional Advisory  
7 Committees, support the members of the Commission.  
8 And we are, as a member of this Commission, I'm  
9 very grateful, David, to you and your staff for all  
10 of you guys, all you have been able to produce.

11 The next two meetings will be on -- are  
12 they posted on the Website? Tell me whether I'm  
13 wrong.

14 MR. USTIN: Correct.

15 CHAIRMAN BERGER: Good. It's posted on  
16 the Website. The next meeting is May 11 in New  
17 York City. And the one after that will also be in  
18 New York on June 8th. They are scheduled to start  
19 10 a.m. in the morning. They will be much longer  
20 meetings. As the second part of this meeting, the  
21 Commission will be gathering reports from the  
22 different Regional Advisory Committees, and we will  
23 be doing that both in May and in June, getting the  
24 preliminary reports from each of these groups. The  
25 meetings will begin at 10 o'clock in the morning,

1  
2 and a good portion of it will be in Executive  
3 Session, so we will be gathering information about  
4 their judgments and their information about  
5 particular institutions.

6 But these will be longer meetings; I'm  
7 just alerting everybody to that fact. So travel  
8 plans, all the rest, just going to get much more  
9 complicated as we go into much longer meetings.

10 MR. LEE: Steve, just a question. What  
11 length of time do you think our meetings are going  
12 to last?

13 CHAIRMAN BERGER: You know, I'll know  
14 better after today, Pat, because today we're going  
15 to have our first report from a Regional Advisory  
16 Committee, and we'll find out how long their report  
17 is and how long our questions are. We can answer  
18 that question at the end of today a lot better than  
19 we can right now. Right now it's purely  
20 theoretical.

21 MR. LEE: Okay.

22 CHAIRMAN BERGER: Okay? Anything else?  
23 All right. David, do you now want to take us  
24 through a little bit of information that some of us  
25 are going to be looking at in terms of the

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Central Region?

DR. SANDMAN: Thank you again, Mr. Chairman. We are very pleased to be here in Rochester and in the Central Region, a very appropriate setting for today's discussion. So I'd like to set the stage for our continued discussions by presenting this overview of the Central Region.

I would like to describe some of the characteristics of the region to you, talk about its demographic profile as well as its supply of hospitals and nursing homes and its other non-institutional long-term care resources. Here on the map before you, you can see what we actually mean when we say "the Central Region" as the regions are defined, by the way, in the Commission's enabling statute, so this is the Central Region.

And I do want to note that it does include Monroe County, where we are today. Sometimes in defining exercises Monroe can be grouped in the Western Region of the state, but for the Commission's purposes it is part of the Central Region.

When you look at that map, obviously the

1  
2 most glaring thing that you are going to see is  
3 that the region is incredibly vast. And it is, in  
4 fact, the largest of our six regions in terms of  
5 geography. It encompasses a total of 23 counties,  
6 which span almost 20,000 square miles; is in fact  
7 41 percent of the entire state, has nearly three  
8 million residents which comprise about 16 percent  
9 of the state's population.

10           Given the vastness of the region, it is  
11 really more accurately and appropriately thought of  
12 in terms of sub-regions or specific markets, and  
13 there are at least five of those sub-regions that  
14 I would recommend we focus on.

15           There is the central part of the Central  
16 Region, that's not too much alliteration, which is  
17 made up of Cayuga, Cortland, Onondaga and Oswego  
18 Counties.

19           There's the Finger Lakes area; the  
20 Mohawk Valley made up of Herkimer, Madison and  
21 Oneida Counties; the North Country, which is  
22 Jefferson, Lewis and St. Lawrence Counties; and the  
23 Southern Tier which includes six counties, which  
24 often can be and are further broken down in terms  
25 of how the Southern Tier is regarded, it's usually

1  
2 thought of in terms of both it's western and  
3 eastern parts, so there are really at least five or  
4 six sub-regions you might want to think about in  
5 terms of where we are.

6           This next picture is another way of  
7 looking at the diversity which does define the  
8 Central Region. You can see that it does include  
9 the Finger Lakes area where we are now, it includes  
10 the Mohawk River Valley, and up in the Northern  
11 Country which extends all along the Canadian  
12 border, we have the Adirondack Mountains and the  
13 Southern Tier, which borders Pennsylvania and is in  
14 the Appalachian Mountain range.

15           So those kind of geographic aspects and  
16 diversity become even more important during the  
17 winter and the snow season. We are here in the  
18 snow belt of New York State, where it becomes  
19 particularly important to consider climate and  
20 travel patterns during those times of year.

21           In addition to the geographic diversity,  
22 the region includes both metropolitan areas as well  
23 as rural areas. The two largest counties, as you  
24 can see, are Monroe and Onondaga, which have  
25 population densities well above the New York State

1  
2 average of 400 people per square mile. But at the  
3 same time much of the region, as you can see I  
4 guess on the right-hand side, is composed of quite  
5 rural counties that are very sparsely populated.

6 This slide shows the actual population  
7 counts for each county that makes up the Central  
8 Region. Leading the list again is Monroe, home to  
9 Rochester, which has almost three quarters of a  
10 million residents. Next is Onondaga County, home  
11 to Syracuse, with close to half a million  
12 residents. And followed by Oneida, which is home  
13 both to Utica and Rome, and then Broome County,  
14 which is home to Binghamton, each of which have  
15 about 200,000 residents.

16 But by contrast, you can also see that  
17 there are a lot of counties with quite small  
18 populations such as Seneca, Lewis, Yates and  
19 Schuyler Counties, which have populations down to  
20 only around 20,000 people. So we have counties at  
21 20,000 and counties of almost three quarters of a  
22 million, so a hugely different place all within the  
23 Central Region.

24 In recent years the Central Region has  
25 not grown. During the 1990s the population of

1  
2 New York State as a whole grew by about 5 percent.  
3 But here in the Central Region the population  
4 essentially remained flat, the blue line toward the  
5 bottom is the Central Region compared to the red  
6 representing the state. And in fact, the region  
7 began to experience a slight decline in the later  
8 years of that decade.

9           That downward trend that began to emerge  
10 as the decade came to a close is projected to  
11 continue and to accelerate, looking into the  
12 future. Between now and the year 2030 it is  
13 expected that the Central Region's population would  
14 decline by about 5 percentage points.

15           Getting beyond the total population and  
16 looking at the age distribution of the Central  
17 Region, you can see that it actually looks pretty  
18 much like the state as a whole; about 13 percent of  
19 the population of the Central Region was age 65 or  
20 older in the year 2000, a proportion very much in  
21 line with the state.

22           And similarly the proportion of the  
23 elderly population is going to grow gradually over  
24 the next 25 years, and will do so at a rate very  
25 similar to that of the state as a whole. Again,

1  
2 this state is depicted in the red line and the  
3 region in the blue, and you can see the slopes of  
4 the curves are quite similar with actually Central  
5 just slightly below.

6 But again, given the vastness of the  
7 region, you really have to drill deeper, you can't  
8 think of the region as a completely homogeneous  
9 place. I put this up by way of illustration. You  
10 can see the proportion of the elderly does vary  
11 from county to county and will continue to do so  
12 into the future. Broome County is one example  
13 which is at the higher end of the scale, it's up  
14 around 16 percent now, will grow to about 20  
15 percent, and a place like Tompkins County is down  
16 toward the lower end of the scale at 9 and moving  
17 to about 12.5.

18 Some good news about the Central Region:  
19 It does appear to have a slightly lower  
20 unemployment rate compared to the statewide  
21 average. You can see 5.5 percent versus 5.8,  
22 although its average wage is substantially lower  
23 than the statewide. Perhaps associated with a  
24 somewhat better employment rate is the positive  
25 news the region also has a significantly lower

1  
2 proportion of uninsured residents than the  
3 statewide average; about 10 percent of Central  
4 Region residents lack health insurance versus a  
5 statewide average of 14 percent. And obviously,  
6 health insurance coverage is among the major  
7 determinants of access to care.

8 Just to recap what I've said thus far,  
9 the Central Region is obviously very large and very  
10 diverse. It requires a sub-regional approach.  
11 It's not homogeneous. And the analysis which we  
12 are doing, which the Regional Advisory Committee is  
13 doing, is at a much more gradual level with  
14 particular sensitivity to urban and rural  
15 differences in the region.

16 Given the geography of the land, it's  
17 especially important to consider seasonal and  
18 climate issues, and in particular transportation  
19 availability when evaluating access to care. And  
20 transportation, of course, in this region and  
21 particularly in other rural areas, is a major issue  
22 for the Commission to take into account.

23 The population of the region is expected  
24 to decline. It will age at a rate quite similar to  
25 the rest of the state, and more of its residents do

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have health insurance than the statewide norms.

Moving on to the supply of hospitals in the region, there are 48 acute care hospitals, which collectively have 8,438 licensed beds, and the hospitals report staffing 7,600 of those licensed beds.

Among the hospitals, five of them are designated as critical access hospitals. And if you are not really into the lingo of all of this, critical access is a federal designation for small and limited service hospitals that have 50 or fewer beds. A CAH, as they are sometimes referred to, is required to have a length of stay less than 96 hours, so they tend to treat uncomplicated cases like simple pneumonia on an inpatient basis, and they transfer more complicated cases to full service hospitals once the patients are stabilized. They do also serve as a source of emergency and routine outpatient services, and the CAHs are entitled to enhanced reimbursement rates.

Similarly, seven of them are designated as sole community providers. A hospital can obtain such a designation if it is the only one in an area which is generally defined as being at least 35

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2 miles from the nearest provider. These rural  
3 providers also qualify for higher reimbursement  
4 rates. Sole community provider hospitals tend to  
5 have fewer than 50 beds.

6 The hospitals in the Central Region  
7 collectively have almost 50,000 full-time  
8 employees, and in some parts of the region the  
9 hospital can be and is the largest local employer,  
10 or at least a very important economic anchor within  
11 its county or its community.

12 This slide shows the actual distribution  
13 of those 48 hospitals by the county and the region.  
14 No surprise here; they do tend to cluster in the  
15 more populous counties such as Monroe and Onondaga,  
16 which have seven and four hospitals respectively.

17 I would point out that there are quite a  
18 few counties in the region that have only one  
19 hospital, and many of them are like that. And I  
20 will also note St. Lawrence County. It's a bit of  
21 an anomaly, it does have five hospitals in total  
22 which would appear to be a fairly robust number,  
23 you know, compared to other counties. But all of  
24 those five are designated as either critical access  
25 or sole community provider, which reflects the size

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and the very rural nature of that county.

Looking at the occupancy rates, the Central Region averages are lower than the statewide averages. This is true whether looking at it on either a certified or staffed bed basis.

It has an average occupancy of 58 percent of its licensed beds versus a statewide rate of 65 percent. And it has an average occupancy of 69 percent of available beds versus a statewide average of 77 percent. So using either measure, the region's average occupancy is about 7 points below the statewide norms.

Despite those lower average occupancies, the fiscal condition of the Central Region hospitals is somewhat better than the statewide average. These results are actually from an analysis conducted by HANYS that breaks the Central Region into two sub-regions; you can see the Rochester area and the county which define it, and the balance of the counties. This analysis examined the operating margins of the hospitals in those two sub regions. And you can see that while the statewide average operating margin was negative in 2004, the hospitals in the Central Region had a

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positive margin of about 2 percent.

And lastly, just a bit of history, the region has had five hospitals close over the past decade. Most recent was Myers Community Hospital in 2003, in Wayne County. And then Genesee and St. Mary's, both in Monroe County, closed in 2001 and 1999 respectively.

Turning quickly to the long-term care situation of the Central Region, there are 156 licensed nursing homes here with about 22,000 licensed beds. And among current nursing home residents, about 4,000 of them are classified as low acuity residents, meaning that they score as either a PA or PB on RUGS. This, like the hospital slide I showed you, reveals the actual distribution of the nursing homes by county.

Once again, as you would expect, the distribution generally reflects the population distribution, ranging from a high of 34 homes here in Monroe County to counties again which have only one or two nursing homes within them. So the patterns are actually pretty similar, as you might expect. Facilities cluster where the people cluster. Nursing homes then tend to cluster where

1  
2 the hospitals are, there's ecosystems of  
3 facilities.

4 Nursing home occupancy is reasonably  
5 high in the Central Region. It averages almost 95  
6 percent and tops the statewide average rate of  
7 about 93. And again a short history, there have  
8 been two nursing home closures to note within the  
9 region, both which occurred in 2003, one in Monroe  
10 and one in St. Lawrence County.

11 In addition to the nursing home  
12 resources, this summarizes the non-institutional  
13 long-term care resources in the region. There are  
14 over 1,000 adult day health care slots. There are  
15 3,800 long-term home health care slots, three  
16 managed long-term care resources, and over 7,000  
17 supportive housing units. But despite those  
18 resources, you can see that the existing supply of  
19 non-institutional services is incomplete. On a  
20 per capita basis among the elderly, there are  
21 only two counties in the region that have a supply  
22 that exceeds the statewide average; statewide of  
23 course being reflected by that red line across my  
24 chart.

25 Some counties, the bottom three we put

1  
2 for illustrative purposes, are very well below the  
3 statewide average, like Tioga, Lewis and Chenango.  
4 And this generally reflects a pattern that you can  
5 see across the state when you compare urban and  
6 rural areas; it's not just true in the Central  
7 Region. There are gaps and there are challenges to  
8 developing alternative placements to nursing homes,  
9 and you can see in this region there is a relative  
10 paucity of those non-institutional resources  
11 available to nursing homes.

12 So at this point I'd like to wrap up.  
13 I would be happy to answer any questions you may  
14 have, or more likely, I would like to defer to our  
15 members who come from the Central Region who can  
16 offer us any additional insights or understanding.

17 Thank you very much.

18 CHAIRMAN BERGER: Thank you, David.

19 Is there anything that anybody wants to  
20 ask of David on his presentation, on the public  
21 side of the meeting? Yes.

22 MS. PROUD: We talked several meetings  
23 ago about the projects that are in the pipeline,  
24 both hospital projects and nursing home projects.

25 Can you give us some sense of what is in

1  
2 the pipeline in terms of those requests from  
3 Central Region facilities?

4 DR. SANDMAN: Absolutely, but not off the  
5 top of my head. We do have -- you are saying any  
6 pending CONs for the Central Region?

7 MS. PROUD: Right. We've talked about  
8 the number of acute care facilities and nursing  
9 homes that we have. Can you provide us going  
10 forward with what is --

11 DR. SANDMAN: We have a master list of  
12 all pending CONs, and we can break that out by  
13 county. So we will provide that to you when we get  
14 back to the office, if that's okay.

15 MS. PROUD: Okay.

16 DR. SIMONE: Could you put that last  
17 slide back up?

18 CHAIRMAN BERGER: Of course.

19 That's very important, Kristin. We will  
20 do it for every region and have it for later on  
21 after we're talking and looking at the future.

22 DR. SIMONE: This is an information  
23 question. Like Tioga, 10, what does 10 mean? Is  
24 it 10 slots per 100,000, so is that 10 places for  
25 people?

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DR. SANDMAN: If you summed those alternative types of slots -- since they're not beds per se, you know, we call them slots as opposed to a nursing home bed -- so if you summed all of those and then did it on a per capita basis, per thousand people of the elderly population, per thousand aged 65 and plus in each county, it shows you how many slots are available on that ratio.

DR. SIMONE: Now low is bad; is that right? I mean, you want more availability if it's below the average.

DR. SANDMAN: Low would be -- the supply per capita is certainly low relative to at least the statewide average. And you would generally say, especially in those low counties, that the supply is less than the demand for those kind of services.

DR. SIMONE: So some people would be left lacking, would that be?

DR. SANDMAN: The non-institutional alternatives, which is something like nursing home care, is relatively limited, particularly in the rural counties.

DR. SIMONE: Right. Thanks.

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CHAIRMAN BERGER: Joe?

BISHOP SULLIVAN: A couple questions.  
The slots are not paid for if they're vacant?

DR. SANDMAN: I believe that's correct.

Allison, is that right?

MS. SILVERS: Right.

BISHOP SULLIVAN: Do you know the  
available beds, the staffing for the available  
beds, the FTEs, the ratios, and to what extent the  
health employment is a percentage of the overall  
employment in the Central Region?

DR. SANDMAN: Again, we can definitely  
get it. We know that back at the office, what are  
the health care employees in each county as a  
percentage of total employment by county. And we  
also have what is the contribution to employment by  
each individual facility.

We're noting all of these questions.  
We will get them out.

CHAIRMAN BERGER: We will get them out to  
people. And we'll start doing it, if I think  
they're good requests, we'll do them systematically  
for each of the regions as we're talking about  
them.

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2 MR. BRIDEAU: The thing that has to  
3 strike us about this particular region is its size  
4 and its diversity. And I think as we look at this,  
5 the sub-regions I think, David, as you laid them  
6 out, are very important because that tends to be  
7 how care flows, and I think we need to pay  
8 attention to that.

9 The issues that the hospitals and nursing  
10 homes face in the urban areas versus the rural  
11 areas again are very, very different. And even  
12 among the rural areas, the differences between the  
13 North Country and the Southern Tier, there are some  
14 very significant differences in health care seeking  
15 patterns and providers' roles in those as well. So  
16 this is going to be a challenging region to tackle.

17 DR. SANDMAN: Your points, of course, are  
18 enormously well taken. And although the details  
19 differ, it's pretty well true in virtually every  
20 region. I guess New York City, for example, across  
21 New York City, five boroughs, are all very  
22 different from each other, you know. Brooklyn is  
23 not Brooklyn, Manhattan is not Manhattan; we would  
24 have to take it down to a budget micro-neighborhood  
25 level and the real care-seeking patterns.

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Your point is correct, and it's correct almost everywhere we go in the state.

MR. BRIDEAU: Up here we just think of New York City as being homogeneous.

CHAIRMAN BERGER: And I'm told that there are people from New York City who think the same thing of everywhere north of the border. Neither are correct.

MR. DUNCAN: In looking at the Central planning area that we have, when you look at the geography in a county like Chenango County, some of the ones on the outside, it strikes me that the in-migration and out-migration of service providers on geographic boundaries are really something that we have to factor in, and we haven't discussed that in this paper, this information. I wonder if that's something we can look at. Or just be sensitive to.

CHAIRMAN BERGER: We will.

DR. SANDMAN: Another very good point. And the RACs are very well aware of county lines, you know, in part officially reflecting what the actual care seeking patterns are. So the RACs are well aware of not just crossing county lines, but in some cases there are kind of even cross-

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2 regional issues where, okay, this county belongs to  
3 the Central Region but it borders the Hudson  
4 Valley. And, you know, the RACs have sometimes  
5 even talked to each other about some of those  
6 cross-regional issues.

7 CHAIRMAN BERGER: And we will find  
8 that -- to go back, Leo, for a second about the New  
9 York City homogeneous and all the rest, we will  
10 find that, for example, as we deal with material in  
11 New York City and the Long Island region and the  
12 Hudson Valley region, we're going to find it's true  
13 probably pretty much almost everywhere in the state  
14 we have to deal with that.

15 CHAIRMAN BERGER: Are there any other  
16 questions here?

17 (There was no response.)

18 DR. SANDMAN: It's not a "speak now."  
19 On reflection, if the members have additional  
20 requests for data or ways to look for this,  
21 obviously let us know. We will be happy to  
22 generate that back when we are at the office.

23 CHAIRMAN BERGER: We may have many more  
24 when we come out of the Executive Session as well.

25 Do you have a motion?

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MR. HINCKLEY: I would like to make a motion to have a more specific discussion of the medical and financial details of the facilities in the Central Region.

CHAIRMAN BERGER: Is there a second?

MR. HOWLETT: Second.

CHAIRMAN BERGER: Any objection?

(There was no response.)

CHAIRMAN BERGER: Thank you very much. This meeting is adjourned. We are now going to move into Executive Session.

Thank you.

(Time: 2:00 p.m.)

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C E R T I F I C A T I O N

STATE OF NEW YORK:  
COUNTY OF MONROE:

I, MARIA A. WOLCZYK, CSR, being a Shorthand Reporter and Notary Public in and for Monroe County, New York, do hereby certify that I reported in machine shorthand the proceedings in the above-styled cause; and that the foregoing pages were typed by computer-assisted transcription under my personal supervision and constitute a true record of this proceeding.

WITNESS my hand in the City of Rochester, County of Monroe, State of New York.

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MARIA A. WOLCZYK, CSR  
Notary Public in and  
for Monroe County, New York