



**COMMITTEE OF THE WHOLE – MINUTES  
JUNE 20, 2012  
6:00 P.M.**

**MEMBERS PRESENT**

Harriet D. Cornell, Chairwoman  
Christopher J. Carey  
Toney L. Earl  
Michael M. Grant  
Douglas J. Jobson  
Nancy Low-Hogan  
Aney Paul  
Ilan S. Schoenberger  
Philip Soskin  
Aron B. Wieder

**MEMBER ABSENT**

Edwin J. Day  
Jay Hood, Jr.  
Joseph L. Meyers  
Patrick J. Moroney  
John A. Murphy  
Frank P. Sparaco  
Alden H. Wolfe

**OTHERS PRESENT**

Laurence O. Toole  
Mary Widmer  
Chris Seidel  
Suzanne Barclay  
Nicole Doliner  
Elana Yeger  
Eugene Laks, Esq.  
Dave Bonk, CPA  
Susan Sherwood  
Paul Brennan  
Amy Piperato  
John Piperato  
Richard Maloney  
Michael Rockhill  
Sue Rutledge  
P.T. Thomas

Chairwoman Cornell called the meeting to order at 6:15 p.m.

**A. COMMITTEE OF THE WHOLE**

- 1. Referral No. 9485 – Continue The Review Of The Public Benefit Corporation Evaluation And Privatization Alternatives As Submitted By Toski & Company Dated May 17, 2012.**

**David Bonk, Project Leader**

Yesterday we talked about the nursing home component. One of the difficulties with this is the fact that both, hospital and nursing home, to some extent are intertwined either through sharing of services or physical location. If we were to relocate the nursing home we now have an issue with the hospital being all by itself within the building. The cost to support two separate entities is more than to support one that is combined. If a decision is made to keep one or the other, that is fine. If a decision is made to keep both than you have to look at some issues with respect to configuration. If you were to stay in the existing hospital building there is approximately \$5,000,000 worth of capital improvements. We back off of the CON, Certificate of Need, recommendations for building a hospital, because at the time the moratorium looked like it could be extended for a number of years going forward on either transfer of the hospital or creation of a new building. Since then some of that has changed in the regulatory environment. It looks like that moratorium putting a new facility up or moving the facility will go away effective December 31, 2012. There are obviously some options. You could leave the facility where it is at, you could move it to another hospital or you can build a new building. I think building a new building for a hospital of this nature becomes a little difficult in this environment in New York, as well as nationally with Medicare regulations and where reimbursement will eventually go.

Right now the real draw to LTCH's, Long Term Care Hospital, from a provider standpoint is there is a premium on reimbursement by virtue of the Medicare regulations. It looks like that is going to become more intertwined with the acute care setting so we won't see those premiums probably in the future. But, on top of that, the issue of managed care becomes more of an issue for all of us.

No matter what kind of medical services you are going to get in the future you will be seeing payments being really ratcheted down and negotiated very closely with providers to save costs to the system. If you negotiate and the health care insurance agencies drive the market how does a hospital or nursing home get paid for doing the services it is supposed to perform if their costs are higher? That is kind of the conundrum in health care these days. We are seeing rising premiums to employees. We are seeing ratcheted down payments to providers. Consequently, who is making the money? It has to be the insurance companies. Their profit margins seem to be getting larger and ours keep shrinking.

The other issue is the government, because the government funds so much health care either at the Medicare level or the Medicaid level. With the increases in the aging population we are going to see even more people needing chronic disease management and long-term care services, which is going to put more of a burden on the State and Federal government in terms of payments. The Medicaid redesign team in New York State has been taking a very big push at establishing managed Medicaid programs in New York State and trying to get from the fee-for-service to one that is going to be more of a per capita or budgeted bundled payment over the course of a disease. Those are the pressures happening to providers. This is the world the provider lives in.

Suppliers, doctors and employees and their salaries and wages play an important point in your decision to continue operation, because those costs will continue to accelerate. Buyers, consumer and insurance companies put pressure on the competition in the health care segment through negotiated contracts and basically tell you what you are going to get paid. In health care you are told what you are going to get paid and the issue you have is to provide that services under that payment.

Substitutions play a relevant factor, because there is a trend toward home-based care. As we see over the next couple of years there will be more pressure to keep people in their homes with supportive services, like home care agencies or a residential setting such as a retirement community or adult home type of facility, which is less costly in terms of medical services than in a nursing home or acute care setting.

These are the things that have to be grappled with in the decision model. You have to be able to make sure that if you are going to continue on in operation that you can position yourself in such a way that you can make the best deals with the buyers and suppliers and minimize your costs. That is why on a number of occasions I have said the need for affiliations and associations with larger organizations, Nyack, Helen Hayes or Good Samaritan Hospitals, become paramount, because they feed your system in terms of admissions, as well as the fact that those types of associations can leverage certain benefits on your costs. This is probably the most current thinking now in health care. Michael Porter who is out of Harvard developed this.

There are actually multiple prongs and you actually have a decision whether to stay in business and if you were to stay in business you would go to a PBC or LDC. This is an option versus closure. You could go to a PBC and continue operation as a County sponsored PBC or you could sell the facility or transfer ownership to another provider. If a PBC did not come about, because of legislation issues at the State level your fallback option would really be an LDC where you can temporarily transfer the assets, receive some money to cover some operational costs and then potentially sell or transfer the asset at that point. No matter what happens the problem you have to deal with is getting from point "A" to point "B". Right now I think everybody has seen in the newspapers that there is a lot of pressure in the County with respect to finances. It is important over this period of time, however long it takes to get evaluation and make a decision, to also look at operational and tactical strategies of how you are going to manage the business over that short-term. Even if you are going to continue to operate it in the long term you need to change that cost structure model in order to be competitive in the future.

(See attached report)

With respect to the hospital, one of the things we looked at was where do your patients come from and what kind of patients do you take care of. On the LTCH side you can see a predominate portion of the patients admitted to the LTCH do come from the County of Rockland, 77%, Orange County, 11.5%, Dutchess County, 2.7%, and actually some from the Bronx and Westchester. The percentages are relatively the same from year to year.

The number of discharges pays hospitals. Nursing homes get paid based on the number of days. Medicare makes up about 81.9% of the total population of the utilization of the facility. Medicare makes up 13.1%. We talked about safety net facilities and impoverished care so you can see Medicaid is making up the big piece. As we move down the chart and get into charity care there is none. This develops a problem, because if we are in the business providing safety net care we should see a higher number. A lot of people in New York State, because it is such an entitlement State, qualify for Medicaid quickly and you do get paid for them. Under the hospital system in New York for LTCH's they don't have a designation for a LTCH so they get paid on a per diem basis. We do not see a huge shift from year to year of these percentages. This is not stuff that has dramatically changed over the past five years.

On the outpatient side of the business there is a total of 710 referred ambulatory visits. That is an incredibly low volume of visits. Hospitals generally, in order to create any kind of economy, you have to drive a lot of volume. If you are an established provider why aren't you attracting patients? Why aren't people using your services?

There are significant marketing issues with respect to the hospital. All these things come into making a decision and how strong your market position is and whether you are going to go forward or sell. The biggest piece of this is you would want to drive as much Medicare as possible through, because that is the advantageous rate. That also assumes that you are in the right diagnosis groups. Certain diagnosis groups pay more than others. You want to get into the highest paying groups and that is the whole idea behind the LTCH. The LTCH is supposed to take care of the very difficult patients that have very high reimbursement associated with them, but they also have very high costs associated with them.

Would it make sense to get rid of the nursing home and leave the LTCH? One of the problems with that are the allocated costs. We zoned in yesterday about the \$9,500,000 of allocated costs coming from the County, \$3,600,000 was allocated through the LTCH and the nursing home. We had a slight discussion about whether or not all of those costs would go away if you closed one or the other. I had made a comment that realistically those costs don't go away 100%. What makes up all these costs? We did more research and I broke it out in this report (see attached report).

Chairwoman Cornell

The MIS administration, \$1,100,000 and central services charges in addition to the hospital administration (see attached report). What would central services charges be for \$1,500,000?

David Bonk, Project Leader

Supplies and purchasing.

Mr. Brennan, Director of Purchasing

Those are charges from New City that covers what we are allocated for finance, purchasing, and personnel; those types of services that are down here, but they oversee for the whole County. That is what is charged to us. I think Law Department is in there too.

Chairwoman Cornell

Dave, given the size of the hospital and the fact that presumably from your report the information technology has not been as useful as it could be, what are we getting for the \$1,100,000?

David Bonk, Project Leader

You have a homegrown system that has been here for 20-years. Obviously there has been a lot of research and development internally done to develop this system. The hardware is up to date, but the software and operating system are really out of date systems. They are not open data based so it makes it difficult to transfer data freely. It is hard to get any kind of interoperability with clinical management programs, which is what you are seeing under health information technology. There is pressure from the government to do that.

When we walked the information technology and looked at the billing office and talked to people what was happening was a lot of information was being offloaded off the computer at the mainframe and then being reentered into multiple databases. Any time you need statistics or whatever you may be going to five or six different databases to get information or to manage your department. It is inefficient and there is always the possibility of error the more times that you are replicating information that should really only be in one place. The other issue comes down to billing. We observed and talked with staff, watching the billing preparation of some of the claims we saw the claims come out without some of the key information that is necessary to get paid so you have staff whitening out areas that are incorrect or printed in the improper spot and then filling it out by hand. A lot of insurances don't even want to accept anything like that. When we talked to Mental Health they actually had to get a waiver from the insurance companies to submit their bills, because they were submitting hardcopy bills and the companies would only take electronic. The way they got around it was to fax the bills electronically instead of a claim file that gets processed overnight and paid within fifteen days. You may be waiting 30 to 90 days for payments. Those are the types of inefficiencies in addition to numerous people touching things and a lot of redundancy.

The other part is because you are doing all the research and development in-house you don't have the benefit of 6,000 other providers telling you how to do things better. A big software company is in the business and they have the consumer groups that work with them. You end up getting a lot of ancillary systems coding software from third parties, because you can't develop the program in-house so now you have these stand alone programs that somehow have to be integrated overnight through dump file, because the type of operating system is an open database so you can't integrate it. There is some lag in seeing payments. To get any time of real time information managers are at a real disadvantage. If you walk into your Medical Records Department and see the stacks upon stacks of paper there is the issue of storage cost for that and trying to find things. It is a very well run Records Department in terms of people knowledge and skill, but they are at a disadvantage, because a lot of their time where they could be using their skills on more important things is spent managing this giant volume of paper.

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Chairwoman Cornell

We have a quorum now so I will ask my Clerk to call the roll.

Chairwoman Harriet D. Cornell called for the Legislature to move into the Committee of the Whole at 6:44 p.m.

Legislator Michael M. Grant moved to convene as a Committee of the Whole, which was seconded by Legislator Douglas J. Jobson and passed unanimously.

The Legislature now resolved itself into a Committee of the Whole, Chaired by Harriet D. Cornell.

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Chairwoman Cornell

There is not a lot of change in terms of information that we want. Legislator Low-Hogan would like to ask a question.

Mrs. Low-Hogan

Please explain why certain costs would remain if there were a sale or closure.

Mr. Maloney, Commissioner of Hospitals

We estimate that \$6,580,000 would still be left if Summit Park would be closed in 2012. Of course, that really couldn't go away, because they are central service charges from the County, and this is for both institutions. I don't think there is anybody to cut in the Department of Finance or the County Attorney's office. These cost really reflect the cost of operating a County. Some are allocated to us. I think an enormous amount is allocated to us and hit our bottom-line and make it a negative bottom-line.

Mrs. Low-Hogan

There is something wrong or it is very confusing. The County allocations are \$9,950,000 as of 2010. What will happen to the County allocations if we sell or close?

Mr. Maloney, Commissioner of Hospitals

We did that estimate based on the 2012 budget. We didn't do it for 2010 or 2011.

Mrs. Low-Hogan

What are the County allocations for 2012?

Mr. Maloney, Commissioner of Hospitals

To the hospital and nursing home a little bit over \$8,000,000. We figure about \$6,500,000 would be left if we went out of business. Those costs are personnel with fringe benefits. The only way to get at those costs is to lay people off in departments other than the Department of Hospitals.

Mrs. Low-Hogan

If we sell or close why do we maintain all of those maintenance, grounds, security and other costs?

Mr. Maloney, Commissioner of Hospitals

If we have a snowstorm we still have to plow all of the roads. Whether the hospital was closed or not there are still other services that are provided on the campus. Just because the hospital closed doesn't mean that the Sheriff wouldn't come by and charge us \$210,000 for that service. It doesn't mean that all of the personnel efforts that take place in New City like establishing list and giving examinations would change very much because we closed. They would still have to perform the central functions of government that we partially support regardless of whether we are there or not.

I would point out that if you take a look at the costs for MIS services they are based on FTE's. Most of our FTE's don't use computers. They are nurse aids, nurses, food service helpers and laundry workers that don't use computers. That allocation of over \$1,000,000 is based on FTE's not based on the cost study of what we use. Most of those costs will revert back to the County and have to be picked up somewhere. Even if there is a proper reallocation of these costs going forward it is just reallocating reallocations. It is not going to save you any money and it is still County tax money.

Looking at the slide report (attached) these numbers are based on the 2011 audit. Summit Park is scheduled to lose, in 2011, \$7,600,000. However, \$4,000,000 is retiree health benefits that do not go away if we go out of business. Jail medical services cost \$2,200,000 and the County will still be obligated to do those services whether we are in business or not. County cost allocations of \$8,200,000; yes they could be ratcheted down, but only by about \$2,000,000. What you have is about \$12,000,000 in loss by putting us out of business and \$7,000,000 in loss if you keep us in business. We tried to simplify this so everybody could stay on the same page. There are costs inside our budget that just will not go away. We would be happy to get into detail once the audit comes out about this chart, because it is accurate.

Mrs. Rutledge, Office of the County Executive

This is the first time I am seeing this presentation. I do not believe either the County Executive's office or the Finance Commissioner has reviewed it. This is coming from the hospital office, but it does need to be reviewed by the County Executive's office.

Mr. Maloney, Commissioner of Hospitals

The next chart (attached) indicates fifteen years of audited figures of operation in Summit Park Hospital and Nursing Home. Out of \$830,000,000 spent on Summit Park Hospital and Nursing Home \$20,000,000 was put on the burden of County taxpayers. I would suggest that most of the costs would still be on the backs of the County taxpayers if we were out of business. These are KPMG audited figures. I believe

Mr. Schoenberger

We went to Albany and met with the Ways and Means Committee staff twice. We met with the Senate Finance Committee twice. We met with the Governor's office. We then met with the rating agencies. You know what everybody asked us? What are you doing to cut costs? Well, we have 583 less employees today than we had thirty years ago. We list all the cost cuts and everything else we are doing. Then when we were done you know what they say to us, what are you doing about the nursing home? Do you know what I believe? I believe that there is a State policy that nobody wants to enunciate and they don't want to put it on them that the State is pushing municipalities/counties to close their nursing homes and to divest the business just like the State divested the mental health institutions and pushed people into group homes and home care. They are doing the same thing, but they are being smarter now. Before they made a State mandate and they passed the Padavan Law. The Padavan Law said that you couldn't deny a group home unless you had saturation and I don't know of anyone that has ever been denied in this State, because of saturation. They took away zoning and local control so you couldn't deny group homes. They forced mental health institutions to close. They put people from the institutions into smaller group homes and there was a State Policy, but they don't want to do that with nursing homes. They want to force us to close them so the people from our County complain about us and not complain to them. That is what is going on.

I am looking at an email from Michael Grant to Harriet Cornell with a copy to me, Moody's had given us a negative watch and a negative outlook – they took away our negative watch and kept us on negative outlook. They say under the ratings rationale, "Management has also failed to either sell or make financial improvements to the County owned nursing home, which depends on operating support from the County." "Negative outlook reflects ongoing challenges and plan to close significant... and continues pressure from the County run nursing home." What could make ratings go up and removal of the negative outlook? They list four things and one of the things is "...clear and decisive plans to reduce the liability to the nursing home annual losses." What could make the ratings go down? "...Lack of State support or approval for actions to restore fiscal balance and inability to get approval for the deficit reduction bonds." Everywhere you look, Albany, Moody's, S & P, all they want to know is when you are closing the nursing home. Is this a surprise to you?

Mr. Maloney, Commissioner of Hospitals

No, it is not a surprise to me, because my job before this was to represent public nursing homes in Albany as a Lobbyist. I am very familiar with the plight of County nursing homes. When I took the job in 2002 there were 43 nursing homes operated by counties outside of New York City out of 57 counties and now there are approximately 35.

Mr. Schoenberger

You may be the best nursing home in the world, but the pressure coming down from Albany and the ratings agencies upon counties, and not just ours, is that they believe we shouldn't be in this business and private people should be in the business or there should be more home health care. Mr. Bonk just spoke about the pressures to move to home health care. I don't know how true it is that by having a nursing home we are saving \$7,600,000 or the loss would be \$14,400,000. I don't know if that is true or not, I really don't. I must say that it may all be irrelevant. We are going to have continued pressure put upon this County and the other counties in New York State until we comply with the State policy. Honestly and truly, I would rather have the State man-up. Get up and say that this is our policy and we want all the nursing homes closed and we are going to use the power of the State whether it is with sharing of revenues, the ability to pass bills, get deficit bonds or do whatever else you are going to do; we will help you financially or do anything else for you if you come out and close the nursing homes. They don't want that, because then everyone else will say that my grandmother's out in the street, because of what they are doing up in Albany. They would rather make us do it and then people will say that we put their grandmother out in the street. They put pressure constantly upon us so they can have a political umbrella. I am sitting here tonight and I am saying to myself, "I don't know how we are going to avoid that pressure." It disturbs me.

I certainly believe in the nursing home. I have seen what the nursing home can do and how it can help people that otherwise would not be able to have a place to go. You can't talk to me about health care if someone has a brainstem infarction and everything below their brainstem is gone, including their ability to talk, and all they can do is blink their eyes. They can live like that for years and at our nursing home they would be taken care of. Where are they going to go? Home health care? People that can't eat and have tubes in and out of them, where are they going to go? You know what? This is what the State wants and is forcing the counties to do. I don't know how many average nursing homes are equipped to take care of a person like that. We get the people that nobody else can take care of and we served them. That was always our mission. Where is that mission going to go now?

Chairwoman Cornell

If we weren't under this terrible financial situation at the moment, I see what is happening in the State and the region as an opportunity for us. It could be an opportunity for us in terms of having a nursing home of a smaller size number of beds. At this point in time we are just under such enormous pressure, which is why we keep asking about all of these costs. Where can we save? What can we do? I always thought that the idea of the modern nursing home that we have the Certificate of Need for was exactly right for us, and something that was on one floor and level where people would really enjoy being there. It all seems to be about money and not about what we think the needs are for our residents. With all of the statistics and demographics the older population is burgeoning in Rockland County. We need to be clear with regards to the percentage of certain patients.

Mr. Maloney, Commissioner of Hospitals

You can get a short-term stay on Medicare if you have improvable condition or an infection that needs to be managed. You can get up to 100 days per year in a nursing home for that kind of condition. Once you can't make more progress you have to come off Medicare. Medicaid pays for custodial care. There is very little Medicare in our nursing home. Most of our Medicare is in our hospital, because the hospital pays a premium and we can admit many more complicated cases than a typical nursing home can. Medicare is a primary payer. We average \$925.00 at the hospital and some are around \$255.00 for Medicaid in our nursing home. Obviously the hospital, although it is more intense and requires more FTE's, is where the action is in terms of making money.

The hospital supports the nursing home. We have the most expensive employees in the health care industry, because of the fringe benefit package they have. If I hired a brand new Nurses Aid tomorrow 80% of their salary would be cost for fringe benefit. There isn't any other place in the State and maybe the nation other than a public facility that is saddled with those kinds of costs. It is very hard to make money in a nursing home, even in a for-profit that has no unions, because Medicaid doesn't pay enough to actually take care of people.

Chairwoman Cornell

I think the Toski Report indicated that employee benefits for the LTCH are a much higher percentage than the nursing home, 76% of salaries as compared to 36% for the nursing home. What does that mean in terms of what Richard just said.

David Bonk, Project Leader

I am not sure where that reference is coming from. I would believe that they would be relatively the same unless there was a specific charge item that went through on the cost report. That may be where it is coming from. It could be a large proportion of Workers' Compensation cases or something like that, but I would have to go back and look at that, because I do not want to mislead you.

Mr. Carey

Go back to the chart that showed utilization (attached). I am very surprised by this. Do you have a similar chart for the nursing home as well as for mental health? It has been stated many times that the most important thing about this complex is as the provider of the last resort. That is directly not being represented on this chart. From your professional experience does the same situation happen in those other two tiers?

David Bonk, Project Leader

People qualify very quickly for Medicaid due to the Medicaid regulations. You will see less charity care, if you will, on a nursing home than you would in a hospital. You would see a larger percentage of charity care at a hospital, because they are getting people who are being dumped through the emergency room, which include homeless people, etcetera. You may get them when they come out and need placement in a long-term care setting, but at that point the caseworker will set them up for Medicaid and they will instantly qualify. I know you do not have charity care like that at the nursing home, that I can tell you.

Mr. Carey

So we are not the provider of last resort. There are options in the community to take care of this.

David Bonk, Project Leader

I think what Richard is saying is that there are certain people who are very difficult to manage, because of either a behavior issue, complexity in their medical care or perhaps they are ambulatory than we would typically see in a nursing home, but they have some other problems and a typical nursing home would try to make sure they could find somebody else to fit that slot if they had it open, because the amount of time and complexity of care.

Mr. Carey

Last night your position was that each of those services would eventually see the private sector ramp up, have the skills setting which to handle that, but some of the more complex would take a longer time and may set the pace for the transition. Do you see that apply here as well?

David Bonk, Project Leader

Definitely. I think it is applicable in any County or State. If you don't have a County or public health component those people still have to be cared for. There are Medicaid and Medicare regulations to prevent discrimination against people, because of their ability to pay, level of illness and national origin. The regulation does not allow you to discriminate on a person when they come in to an emergency room. You cannot even ask a person about their finances if they are in an emergency situation until they are stabilized. You can't transfer them if they don't have insurance.

Mr. Carey

If the reason to keep this open were the safety net, would other folks in the County provide that safety net?

David Bonk, Project Leader

I think it is being provided now by other folks. If you take a hard look at the data from Nyack Hospital and Good Samaritan Hospital and surrounding hospitals they are the ones that are going to be the most acute care in nature, they are going to have to take people through the emergency room or through a physician referral. If you look at their income statements you will see a high proportion, because they have to report the amount of charity care they get. They also get reimbursed due to a formula in the State that is outside the rate methodology where they do get some funding for that. If you are a non-for-profit you are going to derive additional funding from people making donations to support the mission and good work.

There are counties that don't have hospitals and/or nursing homes, but yet they still service their residents, because there are proprietary and non-for-profit facilities that are there. In worse case scenarios they migrate across the boarder to the next County for service from a hospital.

Mr. Schoenberger

They migrate across another County that does have a nursing home too.

David Bonk, Project Leader

That is a possibility too and we do see that. I think the majority of people in your nursing home come from Rockland County.

Chairwoman Cornell

Are you talking about the hospital or nursing home right now? I need to keep this clear in my mind, because the chart that is here is about the hospital.

Mr. Carey

I asked if that was representative of the other two sectors.

David Bonk, Project Leader

In the other sector you will see higher percentage of Medicaid, because that is the payer for a long-term care resident in a nursing home. The population of Medicare patients in a nursing home can be increased to a certain extent depending on how aggressive your nursing rehab services are.

Mr. Carey

My question was specific to those under the safety net issue.

Mr. Schoenberger

I would like to follow up on that if I may.

Mr. Carey

The percent allocations; is that as high as you have seen? Have you seen worse?

David Bonk, Project Leader

You are carrying a lot of overhead and that is burying you. If your intention is to move on, even in a PBC, you have to do something with those costs, because they are just going to strangle you. There is no amount of reimbursement you can get for that. If we did a breakeven point on this it is not a matter of getting up to your capacity in order to cover the fixed costs you would have to be three times the size you are without increasing your fixed costs in order to cover them. It is abnormal for this industry, other than County or State run facilities. If you look comparatively you will see this type of higher cost infrastructure. Yours does have a lot of central County costs that we don't normally see. Like on a nursing home of \$12,000,000 we may see \$200,000 worth of County allocations. We don't see \$9,000,000. Again, I think it all comes down to the allocation methodology and there may be an area that needs to be looked at.

I was going through the more detailed pieces of that cost allocation earlier today. There is \$150,000 of legal costs to support the County Attorney's office. Most nursing homes don't have \$150,000 worth of legal costs. They buy an attorney when they need one.

Mr. Carey

Would this chart look the same in five years or ten years? We didn't get into this problem over night.

Mr. Moroney, Commissioner of Hospitals

I would expect that the jail costs would go up. I would expect that the costs for employee retirement benefits will go up and those costs do not go away for twenty to thirty years. So \$4,000,000 might be \$5,000,000 to \$6,000,000 down the road. The allocations are up to you. There must be a fair way of allocating to show our true costs for operation. By reallocating allocations County costs aren't going to go down and the impact on the taxpayer isn't going to be much. In order to get at those allocations you need to lay people off and get the salaries and benefits out of the system. Reallocating them to another department isn't going to save a nickel.

Every time we have an arcane or complicated legal issue involving health law we hire an outside attorney and we pay that cost over and above the County Attorney's cost. The allocation doesn't reflect what we get in terms of services. I am not saying that the people in the County Attorney's office don't work hard, but they are not necessarily providing services to us. That is a cost in our budget that shouldn't be there and should be allocated somewhere else.

With regard to the hospital, we operate a specialty hospital. There are only four of them like this in New York. There are a lot of them in New Jersey and throughout the country. It is known as a Long Term Acute Hospital. We do not operate an emergency room. Every day we visit our referral sources to see what patients are available and we are very interested in Medicare. Medicare is automatic for you when you turn 65 years old. There is no application process. We analyze what Medicare beds that are available and the average length of stay has to be 25 days for Medicare. We make money on Medicare. Medicare Managed Care companies will not do business with us. Even though it is appropriate for them to admit somebody to our service, because our cost is too high and they don't want to pay that cost. They will admit people through lower levels of care inappropriately where they don't receive the services that they need. Although they will keep them in a hospital at a rate, which is lower than what our rate is. Medicare is a wonderful payer to us and that is where our business is. We don't go refuse anybody. Every single referral that we get is a Medicare referral with the exception of some Medicaid. Medicaid pays us pretty well as well, but there are very few other payer sources that are willing to pay in an LTCH. That is not just us, but also across the country.

With regard to the nursing home, if you take a look at the nursing home it is predominately Medicaid, over 80%. You don't make money on Medicaid reimbursement in this State. The hospital is the jewel in the crown.

When I took this job five years ago the CEO of Kindred Corporation in New Jersey, the second LTCH provider in the country, called me and wanted presence in New York. They would have done almost anything to come in and take over Summit Park Hospital for the purposes of making a profit, not for serving the community necessarily, and they didn't want anything to do with the nursing home. They wanted the LTCH, because of the profit and that is what it is all about. We are gifted and we are the only northern most County with an LTCH. The rest of them are in New York City.

Every single operator of a nursing home in New York State that knows about LTCH's would clearly buy our beds if they could be transferred. They would flip over backwards to buy our beds.

Mr. Schoenberger

Please address whether or not we are the place of last resort, as Legislator Carey mentioned. I think that he was trying to derive at whether we are in fact really that or there are other places that provide equal or available to provide equal or substitute service. Am I correct Chris?

Mr. Carey

Yes.

Mr. Schoenberger

I always believed we were a place of last resort. I would like for you to clarify that for me as well. I always believed that there are people who may be in an actual hospital, like Nyack, who no longer are appropriate for Nyack, but may not have Medicare, Medicaid, eligible and may not have private insurance. That is what I think Legislator Carey is really asking about. Why can't those people wind up somewhere else and a private place won't take them?

Mr. Moroney, Commissioner of Hospitals

It is all about money. It is a very complicated system for classifying people under the Medicaid program. What you want are complicate medical cases and complicated rehab cases. If you have somebody with a behavioral issue or Alzheimer's the system pays very poorly. What you do is create a case fix and I really don't want to get into that, because it is so complicated and I am not sure if even four people in the entire country understand it completely. We recently downsized and we are trying to close 8-South. We closed 7-South for lack of demand a couple of years ago. We have taken all the FTE's out of there and we saved money. I would contend that we probably saved less money than we could have gotten in reimbursement. We have twenty-two people that we are trying to discharge. We made a real effort to discharge eight people over the last couple of weeks. We sent out PRI's to other institutions and assisted living as well. They weren't interested. You have to send social work and psychiatric background. Not one of those persons was picked up by another institution and we even had them visit the other institutions. Not one of them was taken, because we are the institution of last resort. I wouldn't say that every nursing home resident that we have is in that category, they can't be. We have to market ourselves and try to maximize our reimbursement, but we are a safety net provider. It would be very hard to discharge these folks.

Mr. Schoenberger

Commissioner of Social Services, may I ask you a question?

Mrs. Sherwood, Commissioner of Social Services

Yes.

Mr. Schoenberger

I am under the impression that there are people, who not yet 65 years old and not eligible for Medicare, they do not have private pay and there are people who by law are ineligible for Medicaid as well.

Mrs. Sherwood, Commissioner of Social Services

Medicaid is the safety net.

Mr. Schoenberger

Illegal aliens get Medicaid?

Mrs. Sherwood, Commissioner of Social Services

No, illegal aliens cannot get Medicaid. They can get emergency care, but that is not going to change with Medicare or anywhere else. The difference now is Medicaid instead of a safety net place being a place the safety net is now the portable money, which is Medicaid. We are so good at processing in the County that we are getting everybody eligible that we can. Many times they are in nursing homes for days and weeks before we get all the paper work to put them through. The safety net is Medicaid. The fact that there is no "charity cases" is because we have them on Medicaid. The County is paying for this care that is about the \$75,000,000 in local share you are paying for Medicaid that is covering our people. So the trick is some places don't want certain people, but there are laws that they have to.

Mr. Carey

That structure would still be in place whether Summit Park was there or not.

Mrs. Sherwood, Commissioner of Social Services

And it will grow.

David Bonk, Project Leader

I had a discussion with the Health Department about two years ago over nursing homes in general in New York State and specifically about a client of mine that was under a closure proceeding. In talking with the Commissioners up there they had said to me that over the next two to five years that it would really be the survival of the fittest in providers across the State. It wasn't intentional that they were targeting public, non-for-profits or bad proprietor's it was just a matter of weaning out the strongest of the providers. From what I am seeing now with my own client base we are getting a lot of feedback from people that are looking to put their places on the market, because it is just too difficult to operate if you are a standalone operation.

There are a number of groups in New York City that are in expansion mode. The philosophy at the proprietary level is to take Medicaid cases, because it is less hassle for them. If I take a self pay case I have to make sure that they pay me every month and chase them down if their assets are tied up in a house, which costs money to do in legal fees. If I can get a person qualified for Medicaid I know that every time I bill in four weeks I will get a check.

When you see a push toward managed care programs it is not going to matter whether you are on Medicaid, Medicare or a commercial insurer, because managed care programs are going to force those rates to come down and down and down. The only way you are going to be able to sustain any operation, whether a County facility or non-for-profit is by controlling costs. If the County facility costs are 40% greater, because of benefits and salary costs then their competitors there is no way for these County facilities to compete not just in Rockland County, but in Erie County, Livingston County and others.

You can keep going the way you are going and your costs are going to continue to escalate, because over the next two to three years from now salaries are going to increase. You may negotiate a freeze for three to five years, but generally salary costs will go up. Benefit costs, which you may not have control of, are going to continue to climb. If retirement investment earnings don't climb faster more money will have to be invested.

There is also the bargaining power of the insurance companies to make the market for what they pay. If you want to participate with the insurance company you will have to accept that dollar amount of payment. Governments set the market price by regulation, but insurance companies do it by competition.

If you have any thought of going forward or trying to rebalance your budget now with the pressure you are getting from the State you have to take a hard look at costs. You have to go back to almost a zero based budgeting. In every one of your departments you have to go out and look at what you spent the money on in that department. You have to look at lower cost alternatives.

Mr. Carey

I would like to see "Costs That Won't Go Away" chart for 2011 trend out five or ten years in reference to the hospital and nursing care center.

Chairwoman Cornell

Have there been governments that have been able successfully to do this? Government is under a lot of constraints that might make it difficult to really go to true zero based budgeting.

David Bonk, Project Leader

There are governments in the past that have done it.

Chairwoman Cornell

In this country?

David Bonk, Project Leader

Yes, in this country. It is a critical review of your budgeting process and expenses as department manager. If my budget is \$200,000 do I need to spend \$200,000 just because somebody said that is my budget or do I manage it to make sure my department operates as a sufficiently as possible and bring it in at \$180,000? This always confused me when I was on the CFO side. I would sit through budget meetings and the manager would explain the services they needed and never would mention any other alternatives that were available to accomplish the same purpose or any improvements to the process that would reduce costs. You have to look at each item in the process if you are department manager.

Chairwoman Cornell

We don't need to go into this, because we all obviously want to see efficiencies. I do know the County Executive indicated we have under spent the budget by \$20,000,000 for x-number of years and our departments have been under enormous pressure and really stepped up to the plate in terms of doing exactly what you are saying by doing more with less. There are just so many mandates that need to take place in government, which is very different from the private sector.

David Bonk, Project Leader

You deliver the mandated service only and go out to the not-for-profits for the rest of the support services. That is certainly a type of option. Look at your expenses and Actuals this year compared to your actual expenditures last year, because that is really an indicator as to where you are going after adjusting for volume.

Eugene Laks, Esq., Hiscock & Barclay, LLP

The present moratorium has been present for the last five years and is actually scheduled to expire at the end of December.

**ACTIONS:**

**Legislator Carey:**

- ✓ **“Costs That Won’t Go Away” chart for 2011 should trend out five or ten years in reference to the hospital and nursing care center.**

Chairwoman Harriet D. Cornell called to adjourn the Committee of the Whole and report back to the full Legislature at 7:42 p.m., which was moved by Legislator Douglas J. Jobson and seconded by Legislator Toney L. Earl and passed.

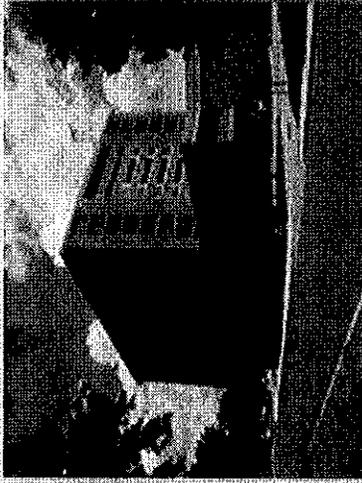
Respectfully Submitted,

Darcy M. Greenberg, Proceedings Clerk



**Summit Park**

HOSPITAL & NURSING CARE CENTER



# THE COUNTY OF ROCKLAND PBC Consulting Services

**David A. Bonk, CPA, CITP, CMA, CGMA, CISA, CRISC, CHFP – Project Leader**  
Director – Healthcare Consulting Services, Toski & Co. PC CPA's

**Donald Pryor, Phd – Center for Government Research (CGR)**

**Eugene Laks, Esq – Hiscock & Barclay, LLP**

**Leonard Franco, AIA – WASA/Studio A**

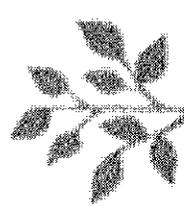
**Gregor MacMillan, Esq – Hiscock & Barclay, LLP**

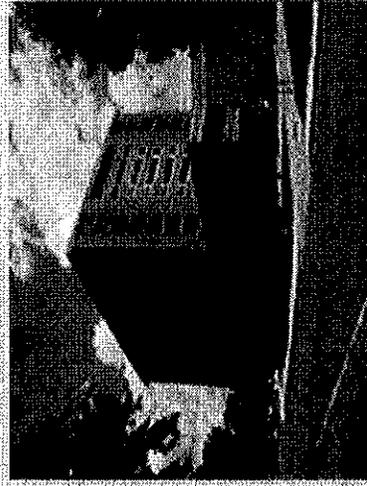
**Toski & Co., P.C.**  
CERTIFIED PUBLIC ACCOUNTANTS  
A DIVISION OF EPP ROTENBERG, LLP

Legislative Meeting

June 20, 2012

# Discussion Topics

 **Summit Park**  
HOSPITAL & NURSING CARE CENTER



 **TOSKI & Co., P.C.**  
CERTIFIED PUBLIC ACCOUNTANTS  
A DIVISION OF EEP ROTENBERG, LLP

**Today:**

✓ LTACH

✓ Wrap-Up

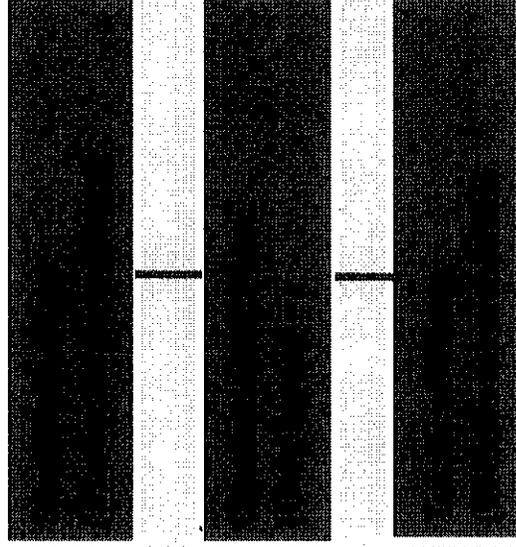
# **AGENDA ITEMS:**

- **Strategic Planning**
- **Mission/Vision**
- **Example**
- **Next Steps**

# The Corporate Planning Hierarchy

Strategic differentiation →

Operational Effectiveness →

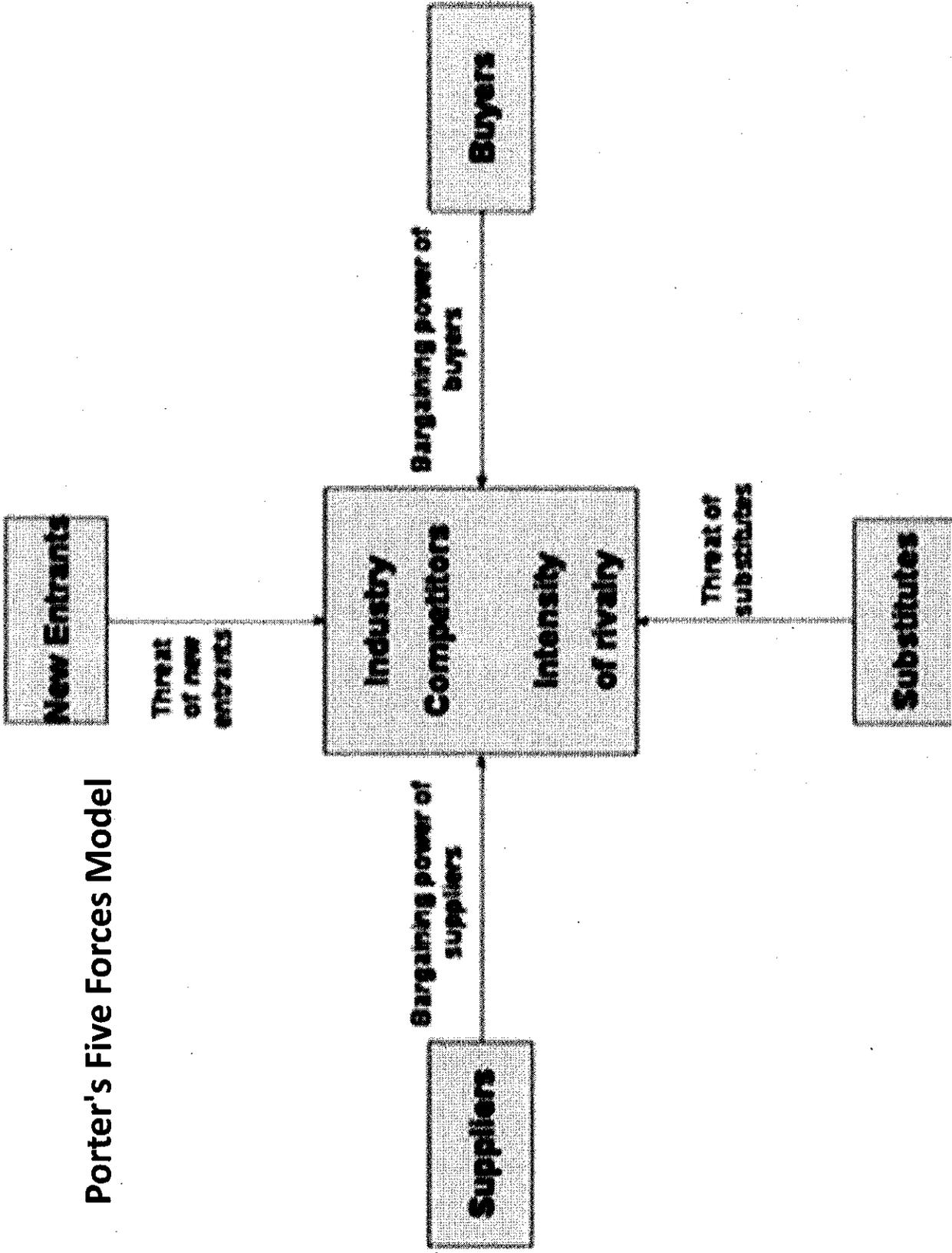


Differ in:

Time,

Scope of activities,  
employees,  
geography,  
money  
involved

# Porter's Five Forces Model



# Strategy:

## 2 Prong Approach

PBC

LDC

Continue

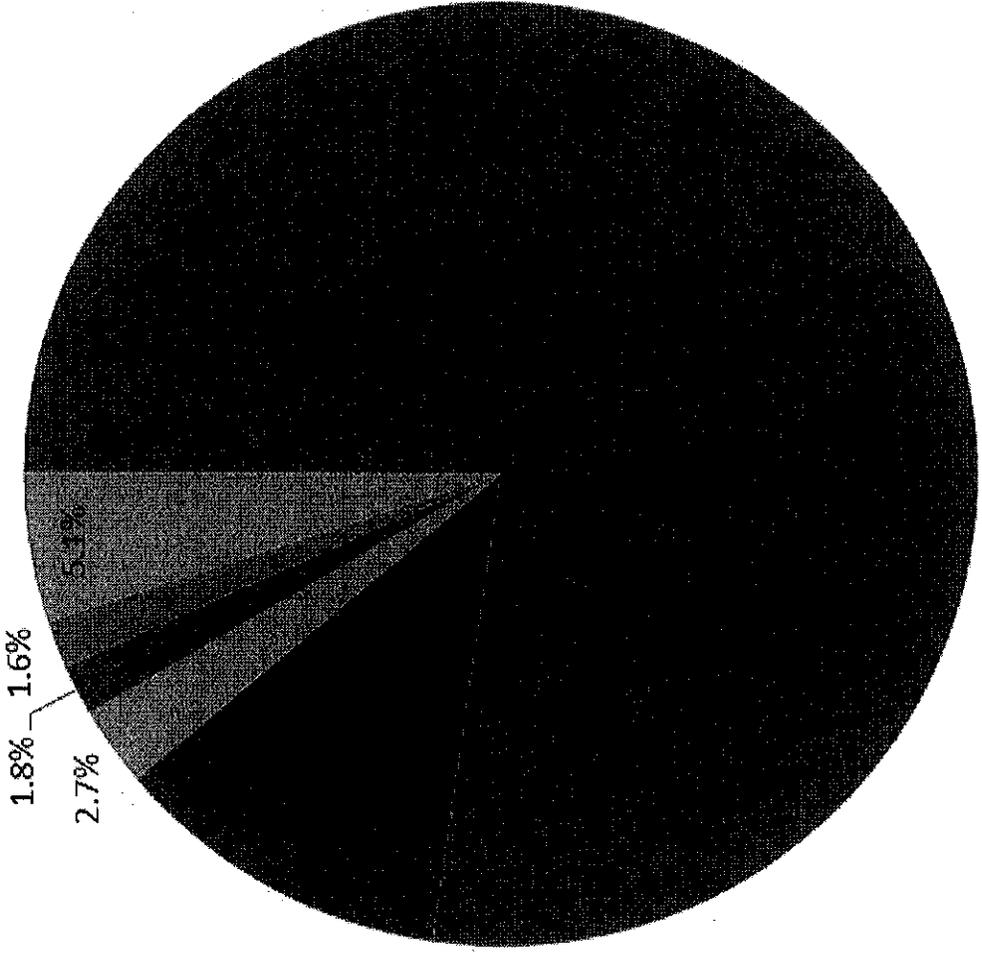
Sale/Transfer

Operational/Tactical Strategy

# Summit Park LTACH Admissions 2010 and 2011

	2011		2010	
	Pts	Pct	Pts	Pct
Rockland	483	77.3%	429	77.9%
Orange	72	11.5%	67	12.2%
Dutchess	17	2.7%	7	1.3%
Bronx	11	1.8%	10	1.8%
Westchester	10	1.6%	5	0.9%
Other	32	5.1%	33	6.0%
<b>Total</b>	<b>625</b>	<b>100.0%</b>	<b>551</b>	<b>100.0%</b>

# 2011 LTACH Admissions

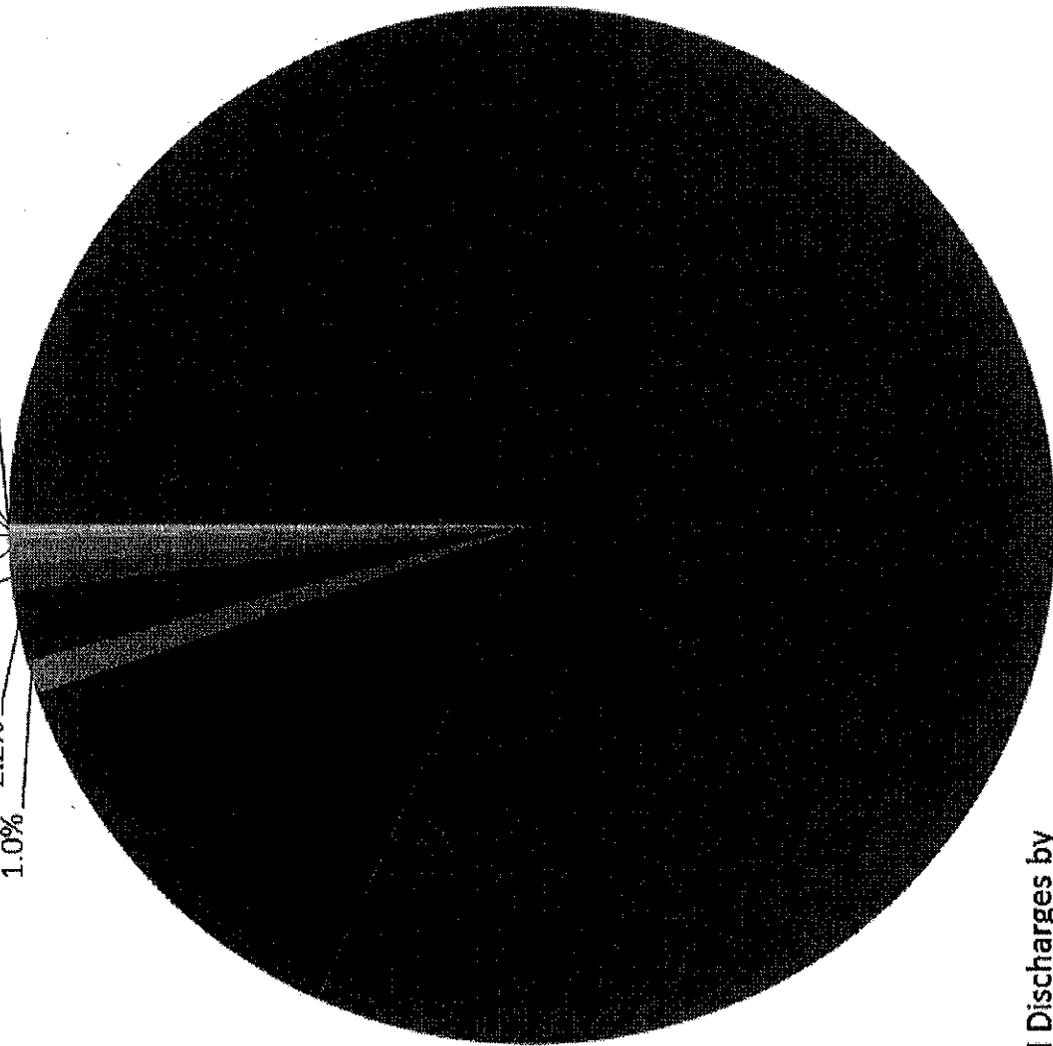


- Rockland
- Orange
- Dutchess
- Bronx
- Westchester
- Other

**Summit Park  
LTACH Utilization by Payor  
2010 and 2011**

Payor	2011					2010				
	Inpatient				Out-patient Visits	Inpatient				Out-patient Visits
	Pt Days	Dischs	Pct	ALOS		Pt Days	Dischs	Pct	ALOS	
Medicare	13,628	406	81.9%	33.6	492	445	78.3%	28.9	784	
Medicaid	3,239	65	13.1%	49.8	125	70	12.3%	44.8	168	
Non Profit Indemnity	28	5	1.0%	5.6		22	3.9%	7.2		
Commercial Indemnity	372	11	2.2%	33.8	86	17	3.0%	26.8	145	
Hmo - Medicare	117	4	0.8%	29.3		9	1.6%	26.1		
HMO/PHSP - Medicaid	79	4	0.8%	19.8		4	0.7%	15.5		
No Fault	-		0.0%			1	0.2%	131.0		
Uninsured/Self-Pay	38	1	0.2%	38.0	7	1	0.2%	44.0	14	
Government	1	1	0.2%	1.0			0.0%			
Charity Care	-						0.0%			
Courtesy	-						0.0%			
<b>Total</b>	<b>17,501</b>	<b>496</b>	<b>100.0%</b>	<b>35.3</b>	<b>710</b>	<b>568</b>	<b>100.0%</b>	<b>30.1</b>	<b>1,111</b>	

1.0% 2.2% 0.8% 0.8% 0.2% 0.2% 0.0% 0.0% 0.0%



- Medicare
- Medicaid
- Non Profit Indemnity
- Commercial Indemnity
- Hmo - Medicare
- HMO/PHSP - Medicaid
- No Fault
- Uninsured/Self-Pay
- Government
- Charity Care
- Courtesy

2011 LTACH Discharges by Payer

# Summit Park

2010

	Hospital & Nursing Home		
	Total	LTACH	NH
Net Patient Service Revenue	52,607,201	20,071,443	32,535,758
<b>Other Operating Revenue:</b>			
County Jail	-	-	-
County of Rockland	3,074,763	3,074,763	-
Other	537,812	537,812	-
<b>Total Operating Revenue</b>	<b>56,219,776</b>	<b>23,684,018</b>	<b>32,535,758</b>
<b>Operating Expenses:</b>			
Salaries and Wages	29,419,878	6,809,155	22,610,723
Employee benefits	13,378,183	5,180,787	8,197,396
Supplies and other	6,643,565	3,193,001	3,450,564
Depreciation	1,990,342	1,062,971	927,371
County Allocations	9,545,320	3,641,865	5,903,455
<b>Total Operating Expense</b>	<b>60,977,288</b>	<b>19,887,779</b>	<b>41,089,509</b>
<b>Other</b>	<b>(4,757,512)</b>	<b>3,796,239</b>	<b>(8,553,751)</b>
OPEB	(12,169,461)	(2,815,591)	(9,352,870)
Interest Expense	(121,134)	(64,693)	(56,441)
County Transfers	-	-	-
<b>Net Deficit</b>	<b>(17,048,107)</b>	<b>914,955</b>	<b>(17,963,062)</b>

# Summit Park

2010

## Hospital & Nursing Home

Total	LTACH	NH
2,677,677	1,021,625	1,656,052
355,604	135,675	219,929
6,512,039	2,484,565	4,027,474
9,545,320	3,641,865	5,903,455

## County Allocations:

Admin & Gen'l  
Insurance  
Dept of Gen'l Svcs

COUNTY OF ROCKLAND  
 DEPARTMENT OF HOSPITALS  
 SUMMARY OF COUNTY ALLOCATIONS

DESCRIPTION	12/31/10 TOTAL
JAIL - 4080	
HOUSEKEEPING (E7250)	22,545
MIS (E7250)	26,968
PURCHASING (E7250)	32,788
REPRODUCTION (E7250)	5,769
TOTAL E7250 CHARGE	<u>88,070</u>

CENTRAL SERVICES CHARGE (E7100)	32,989
GENERAL LIABILITY INS (E7450)	10,511

TOTAL JAIL CHARGES 131,570

HOSPITAL ADMINISTRATION - E301	
GROUNDS (E7250)	84,169
MIS (E7250) (IN E4710 IN 2010)	1,148,393
MAIL ROOM (E7250)	12,650
MAINTENANCE (E7250)	2,313,834
PURCHASING (E7250)	134,598
REPRODUCTION (E7250)	31,191
SECURITY (E7250)	1,775,623
COMMUNICATIONS (E7250)	25,652
UTILITIES (E7250)	1,377,823
UTILITIES SALARIES (E7250)	276,947
TOTAL E7250 CHARGE	<u>7,180,880</u>

DIRECT CHARGES	
POSTAGE (E4111)	13,741
TELEPHONE (E4608)	140,444
TOTAL DIRECT CHARGES	<u>154,185</u>

CENTRAL SERVICES CHARGE (E7100) 1,498,295

GENERAL LIABILITY INS (E7450)	345,093
SHERIFF PATROL CHARGE (E4098)	210,000

TOTAL ADMINISTRATION CHARGES 9,386,453

HOSPITAL TRANSPORTATION - E607 GARAGE (E7250)	27,297
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GRAND TOTAL HOSPITAL CHARGES 9,545,320

COUNTY OF ROCKLAND  
DEPARTMENT OF HOSPITALS  
SUMMARY OF COUNTY ALLOCATIONS

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**COUNTY OF ROCKLAND**  
**DEPARTMENT OF HOSPITALS**  
**SUMMARY OF COUNTY ALLOCATIONS**

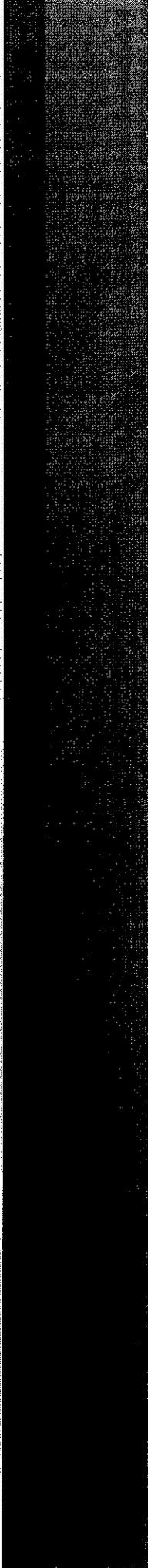
<u>DESCRIPTION</u>	<u>12/31/10</u>
<b><u>HOSPITAL ADMINISTRATION - E301</u></b>	
<u>    </u> GROUND (E7250)	84,169
MIS (E7250) (IN E4710 IN 2010)	1,148,393
MAIL ROOM (E7250)	12,650
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**COUNTY OF ROCKLAND  
DEPARTMENT OF HOSPITALS  
SUMMARY OF COUNTY ALLOCATIONS**

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CENTRAL SERVICES CHARGE (E7100)	<u>1,496,295</u>
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SHERIFF PATROL CHARGE (E4098)	<u>210,000</u>
<b>TOTAL ADMINISTRATION CHARGES</b>	<b><u>9,386,453</u></b>
<u>HOSPITAL TRANSPORTATION - E607</u> GARAGE (E7250)	<u>27,297</u>
<b>GRAND TOTAL HOSPITAL CHARGES</b>	<b><u>9,545,320</u></b>

**Summit Park Hospital  
2011 Financial Information**

**Presented by  
Richard Maloney,  
Rockland County Commissioner of Hospitals**



Costs that  
**WON'T GO AWAY!**  
**(2011 AUDIT)**

\$14,400,000

SUMMIT PARK  
HOSPITAL &  
NURSING CARE  
CENTER  
LOSS  
\$7,600,000.

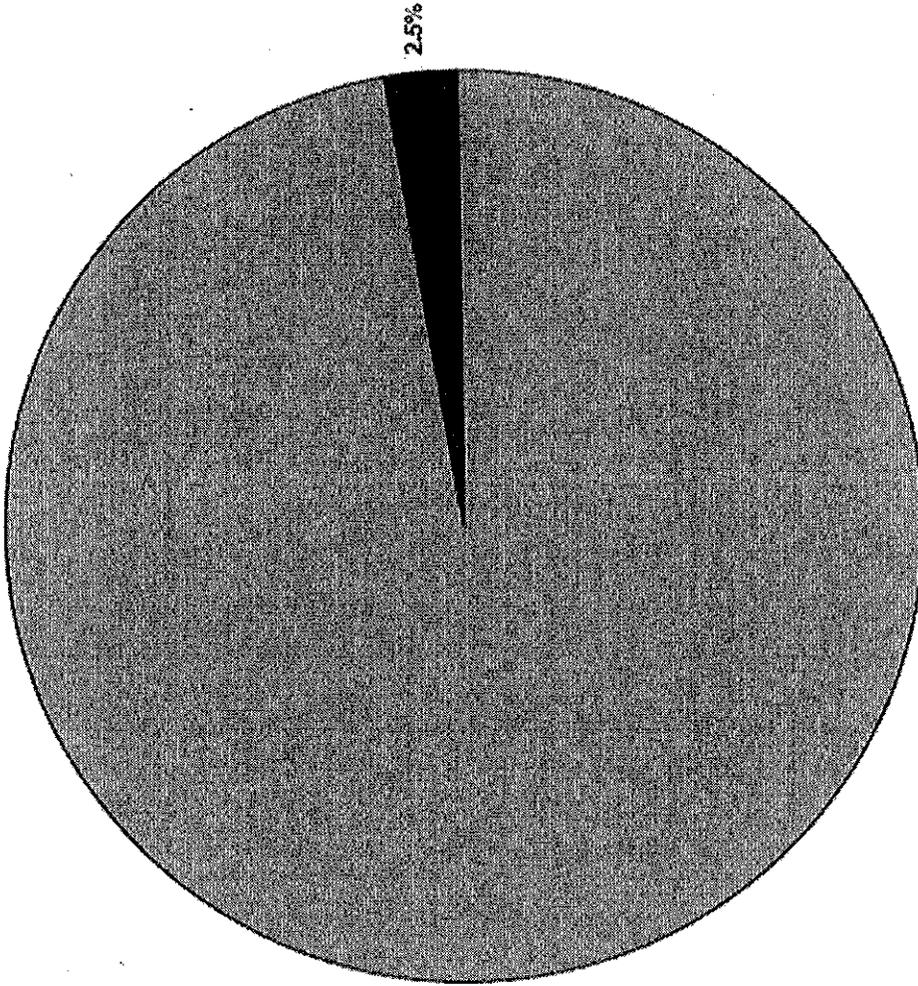
\$7,600,000



COUNTY COST  
ALLOCATIONS  
\$8,200,000.

RETIREE  
HEALTH  
BENEFITS  
\$4,000,000.

DEPARTMENT OF HOSPITALS  
CUMULATIVE LOSSES AS A PERCENTAGE OF CUMULATIVE BUDGETS  
FOR THE YEARS 1997 THROUGH 2011



CUMULATIVE BUDGETS - \$830,777,891

CUMULATIVE LOSSES - \$20,536,137

DEPARTMENT OF HOSPITALS

**LONG-TERM ACUTE CARE AND SKILLED NURSING FACILITY**

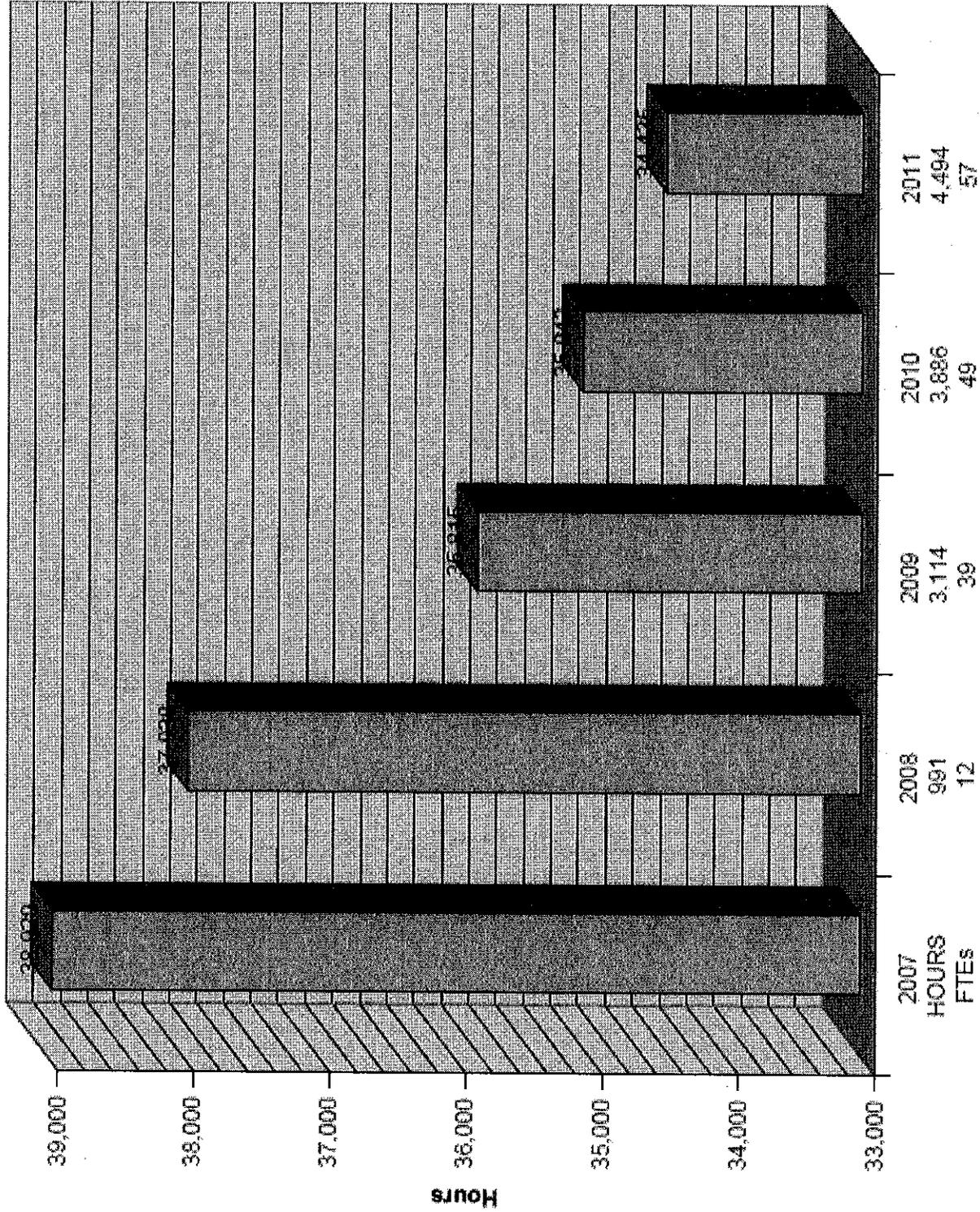
RESULTS OF OPERATIONS AND CHANGES IN FUND BALANCE (NET ASSETS)

FOR THE YEARS 1997 - 2011

(NET OF GASB 45 EFFECT AS REFLECTED IN THE FINANCIAL STATEMENTS)

YEAR	TOTAL BUDGET	INCOME/(LOSS) BEFORE SUBSIDY	COUNTY SUBSIDY	NET INCOME/(LOSS) AFTER SUBSIDY	CUMULATIVE FUND BALANCE
1996					7,149,308
1997	40,451,498	2,489,603	1,170,118	3,659,721	10,809,029
1998	43,323,009	219,690	0	219,690	11,028,719
1999	44,432,459	692,492	500,883	1,193,375	12,222,094
2000	46,551,314	944,357	1,292,002	2,236,359	14,458,453
2001	49,309,809	1,374,961	0	1,374,961	15,833,414
2002	49,922,624	342,996	154,940	497,936	16,331,350
2003	51,316,756	623,391	0	623,391	16,954,741
2004	55,195,431	(309,304)	428,225	118,921	17,073,662
2005	59,270,410	(4,520,817)	1,142,490	(3,378,327)	13,695,335
2006	60,738,630	(2,573,967)	0	(2,573,967)	11,121,368
2007	64,168,008	(1,877,490)	4,270,462	2,392,972	13,514,340
2008	66,264,425	1,027,824	531,612	1,559,436	15,073,776
2009	66,374,369	(3,053,386)	0	(3,053,386)	12,020,390
2010	64,317,050	(8,164,464)	0	(8,164,464)	3,855,926
2011	69,122,279	(7,752,023)	0	(7,752,023)	(3,896,097)
<b>TOTALS</b>	<b>830,777,891</b>	<b>(20,536,137)</b>	<b>9,490,732</b>	<b>(11,045,405)</b>	<b>(3,896,097)</b>

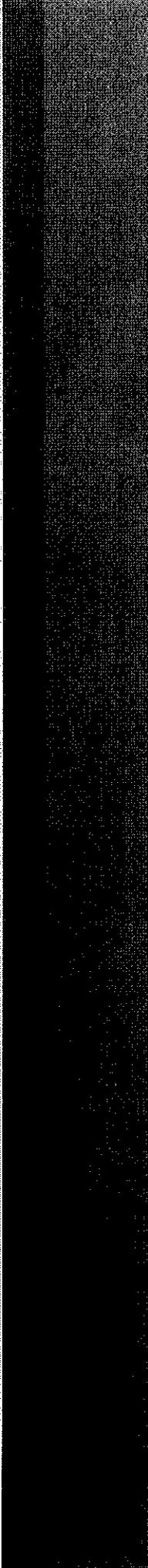
Average Hours Worked Per Pay Period - 2007 thru 2011



Average Hours Worked

Year (With Reductions from 2007)

# Mission



# Mission

The Rockland County Department of Hospitals states its mission as:

*“To be the county leader in medical treatment and long-term care and provide centers of excellence in the areas of geriatrics, rehabilitation and care of residents with Alzheimer’s disease. To provide services for the unique physical, social and emotional needs of each resident and patient within a therapeutic and home-like atmosphere.*”

# **Mission**

*To render care with dignity and respect for the individual regardless of race, beliefs, national origin, sex, age or financial status."*

## **Outpatient Services:**

*"To bridge the gap between symptoms and medical treatment"*

# **Mission**

*To render care with dignity and respect for the individual regardless of race, beliefs, national origin, sex, age or financial status."*

## **Outpatient Services:**

*"To bridge the gap between symptoms and medical treatment"*

# Next Steps

1. Decide on Mission/Vision
1. Develop Plan and Implement
  - PBC
  - LDC
  - Continuation
  - Sale Transfer
3. Operational and Tactical Plans / Budget