NASSAU HEALTH CARE CORPORATION

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BOARD OF DIRECTORS/EXECUTIVE COMMITTEE MEETING

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Nassau University Medical Center

2201 Hempstead Turnpike

East Meadow, New York

December 30, 2015

5:32 p.m.

REPORTED BY:

Angela Arena

A P P E A R A N C E S:

BOARD OF DIRECTORS/EXECUTIVE COMMITTEE MEMBERS PRESENT:

Michael B. Mirotznik, Esq. - Chairman of the Board
Victor F. Politi, MD - President/CEO
Warren D. Zysman, LCSW - Board Member
Linda Reed - Board Member
Beatriz Fuschetto - Assistant to the Board
Asif M. Rehman, MD - Board Member
Jemma Marie-Hanson, RN - Board Member
Russell Caprioli, DPM, FACFAS
Frank J. Saracino, EdD
Michael Ferrandino, VP Security and Chief Compliance Officer
Robert Heatley, EVP Ambulatory Services and Business Development
Paul Mustacchia, MD - Chair of Medicine Department
Karen McGlynn, RN - Deputy Chief Nursing Officer
Judy Eisele-Laplante, RN, MPA - Ambulatory Care and Community Medicine Director
Robert Tepper, ESQ. - Associate General Counsel
Nyapati Rao, MD - Chair of Psychiatry
Harold McDonald - Chief Administrative Officer
John Maher - Chief Financial Officer
Kathy Skarka, CNO
Ann Marie Studdert, Director of Intergovernmental Affairs
Timothy Sullivan
Andrea Rivera
Megan Ryan - Chief Compliance Officer, NQP
Teresa Silversmith - Director of

BOARD OF DIRECTORS/EXECUTIVE COMMITTEE MEMBERS PRESENT: (Continued)

Patient Accounts
Tony Campanaro - Director of Finance
Karen G. Leslie, Esq. - Office of Sponsored Research and Programs
Maureen Hutcheon
Jerry Laricchiuta, President of CSEA
Nina Gavan, VP of CSEA
Ron Gurrieri, EVP of CSEA
Christine Apicella, CFO LIFQHC
Tom Alfano, Esq. - Associate Counsel

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MR. MIROTZNIK: I call to order the Nassau Healthcare Corporation Executive Committee. We have a full Board meeting this evening of Wednesday, December 30th. I call to order the meeting. First order of business, approval of the minutes. I will read my preamble.

The first order of business is to approve the minutes from Thursday, December 17th, 2015, regular meeting. I have a resolution that reads: Whereas minutes were kept at the regular meeting of the Board of Directors, held on December 17th, 2015, and whereas those minutes were reviewed on or before this dually-convened December 30th, 2015, regular meeting of the Board of Directors, now be it resolved that this December 30th, 2015, regular meeting of the Board of Directors, that the minutes of December 17th, 2015, are approved.

Do I have a motion? I have a

second. All in favor, unanimous. Thank you.

Briefly, I would like to welcome Dr. Saracino back as I know that you have been in lovely Florida and taking care of yourself, so it's good to see you, Doc, as always, and thank everybody else for coming this evening. I know Jemma and Dr. Venditto worked very hard yesterday morning into the afternoon, so thank you all.

Christine Apicella, I would like to welcome you back from the FQHC. I know we had just a brief discussion on how things are going with NMA and your possible acquisition of NMA. Do you want to talk to us briefly about this or would you rather talk next year?

MS. APICELLA: I would rather defer when David Nemiroff returns.

MR. MIROTZNIK: Fine. I know you have your budget to present.

MS. APICELLA: Correct.

MR. MIROTZNIK: Thank you. With

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that being said, Dr. Politi, the report of the President.

DR. POLITI: Thank you, Mr. Chairman. I will be brief. We have some bad news I wanted to bring across the Board, a passing of one of our radiation oncologists unexpectedly yesterday. Dr. Carlton, whose been here for approximately 28 years or so, died in his sleep. So our flag is half-mast outside for him and we all feel a great loss in that department.

MR. MIROTZNIK: I had the pleasure of only meeting her once, Dianna Coleman, Board member of the FQHC, former Chairlady. So I know she passed last week as well. It just came out in the memorial.

On a positive note, through some hard work we received a $40 million grant called the 1115 Waiver, which basically will be distributed over five years front-loaded to receive approximately $14 million now and

another $10 million in March. So we are looking to receive $24 million just from this one grant coming up and we have quite a few others in the pipeline hopefully to come across with some good numbers for us as well, so that is really positive.

MR. DELUCA: Does that grant have certain parameters that go with how it has to be spent?

DR. POLITI: There are certain parameters on that grant that require us to institute some value-based payment programs, but we feel about 90 percent of that grant is available for general budget. So it really is great and if you need more, John Maher can also speak to that.

But we believe the majority of that can go to the bank, so that's good. And keeping with the budget, we have hired additional coders. We are filling up our coders ranks. As soon as we can get THEM on board,

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Ms. Silversmith is here, and interviewing continuously and hiring coders for our inpatient and outpatient.

We brought on quite a few temporary coders from various companies that specialize in various different areas, whether it's inpatient, Part A or Part B billing, to increase our revenue and we are planning on instituting a pay step increase in the coming few weeks in January to help retain some of the elder and more-experienced coders that we have down there.

So I think that working on this front end and that revenue cycle will really give us a real good kick. I don't see Vince DiSanti here, but he is constantly coming in with some really good numbers with the unbilled and uncoded charts dropping precipitously. Our edits are almost down to zero and they are doing an amazing job

collecting cash on the front end.

MR. ZYSMAN: Is all the backlog or coding that we have been talking about over the last few months in these meetings, has that all been caught up to date?

DR. POLITI: They are getting close. There is still a large backlog of coding that needs to be caught up on. Teresa is here. She can speak to that if you want.

MR. DELUCA: Teresa, what is your last name?

MS. SILVERSMITH: Silversmith.

MR. DELUCA: And I asked you that once before, I apologize. What is your job here?

MS. SILVERSMITH: Director of Medical Records.

MR. DELUCA: Who do you report to?

MS. SILVERSMITH: John Maher.

MR. DELUCA: Okay, go ahead.

MS. SILVERSMITH: So the

inpatient records are down to 226 uncoded, down from 800 or 900. There are some on hold for validation and there are also some on hold for yearly and various missing documents, so that has improved significantly.

MR. DELUCA: What does validation mean?

MS. SILVERSMITH: We put cases on a certain hold because they are scrutinized. The insurance companies, the OIG, targets certain records like ventilators, sepsis, renal failure. These are all diagnoses they will scrutinize and they deny these records very readily, so we have another layer of review.

MR. DELUCA: How long do we have until those expire where we can't collect money on those?

MS. SILVERSMITH: Different insurance companies have different timelines. Medicare is a year, I believe, and Medicaid is 90 days.

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MR. DELUCA: I know something is 90 days.

MS. SILVERSMITH: And the commercials, it depends on the contracts.

DR. CAPRIOLI: Medicare is not 90 days.

MS. SILVERSMITH: Medicare is a year initially. At first you have a year initially, if it is a re-bill. Then you don't you have, I believe, it is 60-to-90 days.

MR. MAHER: It is a year on the first bill.

DR. CAPRIOLI: How many of these are collectible? What percentage of those 2,300 are?

MS. SILVERSMITH: All. They are all. We are not even a month behind anymore, less than 10 days.

MR. ZYSMAN: We had learned about the emergency room.

MS. SILVERSMITH: Right.

MR. ZYSMAN: When you say they

are all caught up from 800 to 200, does that mean for the whole Institution, does that include the emergency room or something else?

MS. SILVERSMITH: Just inpatient records. The ED is different.

MR. ZYSMAN: The coders, obviously, I think, originated in this discussion, at least at the Board level, had to do specifically with the emergency room.

MS. SILVERSMITH: It is improving. It is not perfect improvement. Rozan has given us three of her coders, which has helped.

MR. DELUCA: Who is Rozan?

MS. SILVERSMITH: Rozan is the manager of I don't know what her department is.

MR. MAHER: She works for Vince DiSanti.

MR. DELUCA: Doesn't Vince work for you?

MR. MAHER: Yes, he does. He

reports to me.

MR. DELUCA: I am a little confused then. I'm sorry I cut you off. Go ahead.

MR. ZYSMAN: So the issue with the emergency room, there was a contract that had a name that had to be changed. Is that contract done?

MS. SILVERSMITH: No, it is being worked on.

MR. ZYSMAN: Rob or Tommy? Is Tommy here?

MR. ALFANO: I am right here. I will follow up as I --

MR. ZYSMAN: I think Beth had told us she would have it done by the end of the year. Is she going to have it done tomorrow?

MR. ALFANO: I will find out.

DR. POLITI: This is McKesson? This is the McKesson contract.

MR. DELUCA: So legal is holding it up, is that right? This is not a smiling thing. We need to move this

forward. This cannot go any longer. This is money. The hospital is behind in money. This cannot go on any longer.

I don't care who is responsible. We got to know why it isn't done. I got to know who. Does the Board disagree with me? We are not trying to blame anybody here. We want the hospital -- we want it to go forward. If legal is holding you up, then tell us that. John, what is holding this up?

MR. MAHER: The contract is with legal.

MR. ALFANO: I will get a status for you.

MR. DELUCA: When do you think it will be done?

MR. ALFANO: I'm going to check with the author of the contract who is out of town right now, but I am texting her as we speak.

MR. MIROTZNIK: So you may have

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an answer within 10 minutes, Tom?

MR. ZYSMAN: Can we go off the record?

(A discussion was held off the record.)

MR. ZYSMAN: Back on the record. It is my recollection that when this had come up at the last meeting and had been discussed multiple times that this contract was originally issued to a company that then changed it's name and that the only thing that needed to be done on the revision of this contract was changing the name.

Beth Faughnan, who I don't belief is here tonight, commented at the last meeting it would be done at the end of the year. It's now the end of the year and it's not done. Millions of dollars -- is it millions of dollars in the ER? How much is it?

MS. SILVERSMITH: It is under a million now.

MR. MIROTZNIK: Plenty of money.

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MR. DELUCA: For the ER is under a million?

MS. SILVERSMITH: Yes, it has gotten a lot better.

MR. ZYSMAN: Well, how much would you guesstimate?

MS. SILVERSMITH: If I had to guess, I would say maybe 800.

MR. ZYSMAN: $800,000 or thereabout is what Teresa is indicating, around $800,000 is being held up based on changing the name on the contract. The original name that was presented to us was approved and as soon as we were notified of the name change, the Board approved it and the attorney handling it said she was going to have it done by the end of the year. Why isn't it done?

MR. ALFANO: May I? Tomorrow Mr. Tepper and I will address this ourselves. We will get it done and I can report to whomever the Board designates orally and by e-mail

tomorrow.

MR. ZYSMAN: Thank you, Tom.

DR. POLITI: May I make a comment also? Just to let you know, a couple of weeks ago, maybe two months ago, it was 4,000 open charts. It is now down to approximately 1,600 open cases, so that even though we are saying it is $800,000, 1,700 charts we have made great strides in, chopping that back in half over the last few weeks.

MS. SILVERSMITH: It was well over a million.

MR. ZYSMAN: There was a point in time recently where I think there was an e-mail or something that you sent out, Doc, where you said you had gotten permission to hire temporary coders. This is going back over the month, maybe two or three months ago.

DR. POLITI: She did. We hired about six or eight coders.

MS. SILVERSMITH: We did.

MR. ZYSMAN: Are they working in

every department?

MS. SILVERSMITH: They weren't specifically assigned to the ED. They were assigned to different areas, but there are some that are working on the ED now.

MR. ZYSMAN: Is there any -- how many departments have these temporary coders working in them?

MS. SILVERSMITH: Vince has a bunch. I have one, but Vince has most of them.

MR. ZYSMAN: Do you need more than one to catch up on the backlog? If you had more than one would they be done?

MS. SILVERSMITH: The issue with my department is I need someone experienced, to find someone experienced.

MR. DELUCA: If we pay the right amount, I think you would be able to get someone.

MS. SILVERSMITH: Yes and HR and

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Vince are working on that.

MS. ROARTY: Can I give you an update where we are?

MR. MIROTZNIK: May I recognize Dr. Saracino has a comment?

DR. SARACINO: We have an existing backlog and we also have an ongoing.

MR. MIROTZNIK: Doc, hang on one second. Would you please give your name and appearance to this young lady and continue with what you were saying?

DR. SARACINO: Frank Saracino, no relation to Mr. Mirotznik. Back to what I was looking at, we seem to have two items here, a backlog that exists and we have ongoing needs to code. I don't know if we cleared up the backlog, but we still have the ongoing needs of coding that exist. What's happened to the backlog that I think would give us a good hand on whether we are making progress with the coding?

MS. SILVERSMITH: There was such

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a significant decrease in backlog.

DR. SARACINO: We are still working on the backlog?

MS. SILVERSMITH: For the inpatient cases we were at 900 and now we are down to 226.

DR. SARACINO: That is for the backlog, or what has come since we hired the coders?

MS. SILVERSMITH: Sorry, I'm not following you. We had 800-900 uncoded inpatient records.

DR. SARACINO: They hired some temporary coders to address that?

MS. SILVERSMITH: They are venders.

DR. SARACINO: We cleared up the backlog?

MS. SILVERSMITH: Right, for the inpatient for the ED, which is outpatient.

DR. SARACINO: We are just dealing now with the new coding needs that arrived after we hired the

temporary?

MS. SILVERSMITH: We are dealing with both.

MR. MIROTZNIK: Teresa and Mr. DeLuca, I want to make a comment. This is a big problem and we were talking, my recollection, John, $38 million. Mr. DiSanti told us at our last meeting that was AR.

MR. MAHER: Correct. That would be about right.

MR. MIROTZNIK: So about $38 million. And how much of that $38 million do you and Mr. Sullivan, within a reasonable degree of your financial certainty, think we are going to collect?

MR. MAHER: On that amount of money?

MR. MIROTZNIK: Yes.

MR. MAHER: That number is down to it's net realizable value, so I would expect to complete an accurate 100 percent of this number.

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MR. MIROTZNIK: Of $38 million?

MR. MAHER: Correct.

MR. MIROTZNIK: Okay.

DR. CAPRIOLI: How has ICD-10 affected your job as far as the coding?

MS. SILVERSMITH: It has slowed productivity by 50 percent.

DR. CAPRIOLI: And the new coders are well-versed in ICD-10?

MS. SILVERSMITH: They are versed in ICD-10. It's so new that we're still analyzing it.

DR. CAPRIOLI: We are not hiring anyone who is not, I would assume, well-versed in ICD-10 because that would be required training.

MS. SILVERSMITH: They couldn't work if they didn't know ICD-10. They would be of no use to us.

MR. MIROTZNIK: How much is aged-out dollars? Give me an idea.

MR. MAHER: I would say probably 50 percent of that is below 120 days.

MR. MIROTZNIK: 50 percent of the

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$38 million?

MR. MAHER: Right.

MR. MIROTZNIK: And the other 50 percent?

MR. MAHER: It goes out, we collect numbers and we are going to have this at the next Finance Committee meeting or sooner. We collect on the inpatient side. 18 months of the year is over, just because of the lags that are created by Workers Comp and No-Fault.

You get Medicaid applications where people are giving you wrong information and you go back and correct it. That $38 million is down to what I am referring to as the net realizable value and most of our cash comes in between 90 and 120 days.

MR. MIROTZNIK: Mr. DiSanti told us there are a huge amount of accounts receivable that are completely going to be lost, and I recall Mr. DeLuca making a very strong point that we have to

ensure that billing gets done properly and timely, et cetera, so this won't confuse us each and every meeting and the only reason the charts are down to where they are, and we thank you for your work and moving it along, is because someone realized that the Board is very angry about what is going on and I think Mr. DeLuca can speak for himself.

MR. DELUCA: Well, Mr. Zysman made it clearer than I did, but I think $19 million probably we are going to lose forever and ever. Didn't you say half of 38 just now?

MR. MAHER: That is an ageing category.

MR. DELUCA: What is the difference?

MR. MAHER: There is a lot of differences.

MR. DELUCA: It aged out for a reason.

MR. MAHER: They are aged out for

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a reason, could be people gave us wrong information, so we re-bill and submit it to go out to Workers Comp and No-Fault takes a much longer period of time to adjudicate than normal Medicare and Medicaid plans.

We can prove a significant amount of money comes in 12 months, 18 months, after the discharges. So it is not that the money is lost. What we do is we estimate what is in the receivable and gross level, what is collectible over a period of time, and that is the number you see in the balance sheet.

So all of those various categories are reserved against and yes, at some point in time, an account that's two years old, it's zero, we're estimating zero recovery on those.

But as you get closer to, let's say, 18 months, those accounts are still very much collectible and for a variety of reasons they age out. Sometimes they're missing

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documentation, sometimes there is a challenge by an insurance company and the utilization management department is filing appeals. All of these things take time and that's why it ages out. Should the number be lower? Yes. That number is not a bad number. It's not a great number, but it's not a bad number.

DR. CAPRIOLI: Can I ask a question?

DR. VENDITTO: I think the question you're asking is what percentage of the backlog for the 4,000 outpatient charts and the 800 inpatient charts as a backlog was chiseled down to 200 and 1,700?

What percentage of them were tossed aside saying there is no hope here, we will never get a collection on it? How much of that backlog was whittled away.

MR. MAHER: On the inpatient side --

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DR. VENDITTO: It was 100 percent viable?

MR. MAHER: Yes. I would have to go back and take a look, but what I would tell you is anything that is over six months old on the outpatient side, we reserve at zero. It's gone. Most of these cases, as much as there is a backlog, we try to get it out generally well within the 90 days for the Medicaid side and certainly for the year on the Medicare side. It is just that it is a backlog that occurred because of processing issues that occurred earlier in the year.

DR. VENDITTO: That percentage is essentially the question. How much?

MR. MAHER: Of the $39 million that's in that AR that Mr. DiSanti was referring to, none of it. This amounts beyond that, but that $39 million is 100 percent collectible in our opinion and that is looked at several times during the course of the year.

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DR. VENDITTO: Because the AR doesn't reflect what we didn't bill?

MR. MAHER: That is correct.

DR. CAPRIOLI: What percentage of these are related to doctor errors, incomplete charts, or incomplete coding by the physicians themselves?

MS. SILVERSMITH: Right now we stand at 100 for inpatient queries for documentation.

DR. CAPRIOLI: How do you motivate the doctors to code properly and finish their charts?

MS. SILVERSMITH: We constantly are in communications with them. We e-mail them, we call them, we --

DR. CAPRIOLI: Do they have any incentive? Is there any way to motivate the doctors to do it, in other words?

MS. SILVERSMITH: We have tried food --

DR. CAPRIOLI: In private practice you won't get your paycheck

unless you finish the charts on your desk. But you know something, that gets it done. I don't know if you can do that in this situation here.

MR. DELUCA: We did that in this hospital. We did just that. The medical director held the checks and they didn't get their checks. We did it here.

DR. CAPRIOLI: It works. They will get paid, but I know doctors who have 30 charts on their desk and they pick up their paycheck and they get paid, but the hospital doesn't get paid.

DR. POLITI: You can't hold the checks. It's illegal.

MR. DELUCA: Then they get disciplined.

DR. CAPRIOLI: I think you probably have the same problem. How do you incentivize them to do it? What is their motivation to do it?

MR. MIROTZNIK: Dr. Scarmato, why

don't you address that?

DR. SCARMATO: In general, we don't have big problems with the employed physicians. Occasionally some of them build some up. Usually a call from me they will get down there in a day or two and it gets cleared up.

MR. MIROTZNIK: When is the last time you received an e-mail or a call from Teresa?

DR. SCARMATO: I get them all the time.

MS. SILVERSMITH: For other doctors, not for you, though.

DR. SCARMATO: Not for me personally, but to intervene and get other people to sign their charts. The problem is we have voluntary physicians, or contracted physicians, who don't receive a paycheck and come here once a blue moon.

So it's sometimes a problem if it's a contracted group or an outside physician who comes here once a month,

or once every two months. It's not even necessarily they will try to get to it, but they forget it.

MR. MIROTZNIK: Can you cut their privileges?

DR. SCARMATO: That is also a thing you can do, but then we don't have coverage from those physicians.

MR. ZYSMAN: By contracted physicians, are we talking about individual or they're contracted through a group?

DR. SCARMATO: I would say certain groups that we have contracts with.

MR. ZYSMAN: In that case, maybe the notification should be going to whoever is in charge of the group.

MS. SILVERSMITH: We do that.

DR. SCARMATO: It does.

MR. ZYSMAN: What happens when they don't respond?

MS. SILVERSMITH: We go to him.

DR. CAPRIOLI: As any recourse,

that is the plan. How do you incentivize them to do it? I am sure you have people who are big offenders and --

MR. ZYSMAN: Mr. Tepper, we have a contract with a group to provide physicians here and they are not doing the work necessary to bill for their services. What remedies do we have with that group because we are paying them to provide a service that we never get reimbursed on because they never finish the job?

MR. TEPPER: Most, if not all, the physician contracts have chart completion standards written in. It would largely be a breach in terms of the contract and these are licensed medical professionals, so to whatever degree the license requires them to complete charts in a timely manner, we have the normal physician discipline things.

MR. MIROTZNIK: Hold on, you

answered it perfectly. However, when is the last time legal sent out a breach letter, a notice letter, to a group?

MR. TEPPER: We wouldn't do that unless the owner of the contract wanted to do that. We wouldn't be involved in that.

MR. MIROTZNIK: Hold on, let's do this slower. There are some of us that don't understand it.

MR. DELUCA: So the owner of the contract could be a nurse, right?

MR. TEPPER: Will not likely a nurse.

MR. MIROTZNIK: Who would the owner of the contract be for the plastic surgery group?

MR. TEPPER: It would probably be an administrator --

MR. MIROTZNIK: Give me an idea.

MR. TEPPER: McDonald and Scarmato.

MR. MIROTZNIK: Maureen, one of

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your groups, the Neurosurgical Group, the anesthesia group, obviously it is one of these groups that are not completing their charts. Have we ever sent them a formal letter?

MS. HUTCHEON: We have not sent them a formal breach letter. What we do is we contact within that group the administration of that group, or the medical director of that group, and constantly have them come in.

MR. MIROTZNIK: Everyone around here, you have all heard the dialogue for the last 40 minutes over this. You see how dysfunctional it is. Everybody is shaking their head, all of the professionals in the room. It is dysfunctional at best.

It is an embarrassment so Maureen, you are a professional and we always enjoy your presentation here and Dr. Scarmato, someone had to pick up the phone and straighten this out so Harold, you know --

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MS. REED: We need to start sending out the letter.

MR. MIROTZNIK: Rob answers a question very articulately and says this is what the contract says. The the owner of the contract never knew there is a problem until now, so they have never contacted them to complain for years.

MR. MCDONALD: The chairs are responsible for the physicians in their department. They know which physicians are documenting and completing their charts timely and those that don't.

MR. MIROTZNIK: I am sorry to cut you off. I am going to suggest next week Dr. Politi call a meeting in this room with all our chairs. CC them all in an e-mail and tell them what is going on. This is not acceptable.

DR. VENDITTO: Normally under these circumstances when there are charts to be dictated and coded and held up, clinical privileges are

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suspended. They lose their privileges and it goes out to all the stations. You can't admit and you can't book cases and you can't book the OR.

DR. CAPRIOLI: That is standard.

DR. VENDITTO: You are suspended until you go down to medical records and do what you need to do. Do we have that policy in place?

DR. POLITI: What happens here, I think they explained that, Teresa notifies the chairman, the chairman notifies the physicians. If we don't have a good response, it goes to the chief medical officer and it actually gets to me.

I actually speak to the group's president. I actually have them in my office. I sit down with them and tell them, Dr. Politi, there are 17 outstanding charts. I need these charts done by Friday or we are going to suspend his privileges.

I have done that on several

occasions and attendings have come in and done those charts with that threat. Sometimes I get put into a situation where the fellow is a specialist in opthalmopathy that only works on left eye retina problems and we need that doctor, and I have a case for that doctor, and I can't suspend that doctor.

So in rare cases I can't suspend them because I need that service, but the overwhelming cases, whenever that does progress to that and I get involved, those things get done. So I get a list. I call the owner of those things in and it gets done.

DR. CAPRIOLI: Dr. Politi, can I interject? I am the chief of my department and today I got a list of my attendings and my staff whose charts are delinquent and I think it wouldn't be necessarily your responsibility to do it for the whole hospital, but head of this department.

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So head of, let's say, orthopedics gets a notice saying 20 charts in arrears. We are going to suspend his physicians and I noticed even with my staff this is just an endemic problem everywhere, but if the doctors are notified, the first thing they say is nobody told me. So there is no warning system. You don't have to say breach of contract, but this is your first warning. Now with e-mail it is very easy.

I got three of them today. I e-mailed those attendings and said your charts are in arrears and you are going to be suspended on Monday. Even if someone is suspended, the OR can cover it, but another way you can motivate them is a warning or suspension and we don't have to treat them like children, but if you don't do something, no one likes to do their charts. They're just going to keep accumulating until no one's paying attention, I don't care.

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I get paid. I don't care.

DR. POLITI: That is what the chairmen do and I think all the chairmen in the room are very active in this regard and they do speak to their physicians. In most cases it works. They get them and they get them done.

DR. CAPRIOLI: If each department chief knows this is a potential crisis that needs to be averted, they are going to be watching us from now on, that they will know to stay on the ball and I think everybody needs to wake up, that we are watching the charts. We are losing money and we are going to be on your back.

DR. POLITI: Next week we are going to have a meeting of all the chairmen in this room. I will take attendance and hold them accountable and ask for a list of any outstanding charts.

MS. SILVERSMITH: It went out today at 5 o'clock.

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DR. POLITI: We will certainly take the advice of the Board.

DR. CAPRIOLI: I know, Teresa, you know the people who are the constant offenders, so maybe off the record you give that list to Dr. Politi so he can address them. These are the bad guys and I think you can get it rectified quickly.

MS. REED: Dr. Scarmato, I think going forward what we might need to do is also, as some of the docs come up for renewal and they come to MPACT, if they have files they have not been taking care of, they will not be renewed at MPACT. So we will discuss that, but maybe Dr. Politi, when you talk to the chairmen you want to let them know that we will not be approving --

DR. POLITI: Sure.

MS. REED: -- those docs that have outstanding --

DR. POLITI: We have our Chairman

of Medicine, so Paul, in your case, when you have your physicians, how do you handle that?

DR. MUSTACCHIA: I regularly reach out to any physician that has outstanding charts. Today at 5:00 p.m. like many of you I received a list of those docs. I will reach out to them, could be two or three charts.

It's not terribly common in my department, I must say, and I think on average the employed faculty does a very good job of completing their records and they are receptive, I think, to you, Teresa, and to Dr. Politi, and to the group.

Nevertheless. There are charts outstanding. I will contact them. They are taking care of the charts.

MS. SILVERSMITH: Dr. Mustacchia has the largest group in the hospital and his group is not one of the biggest offenders.

MR. ZYSMAN: So he does a good

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job?

MS. SILVERSMITH: He does a great job.

DR. POLITI: Great job.

MR. MIROTZNIK: So where is it coming from? Is it leadership or is it just --

MS. SILVERSMITH: Surgery, certainly plastics, who is contracted.

MR. MIROTZNIK: And we approved a contract for what, John, $7 million? How much was -- I hate to hold you to these numbers, within a million or so?

MR. MAHER: On a multi-year basis I would have to go back and look. It's not a small contract.

MR. MIROTZNIK: That is unacceptable.

MR. ZYSMAN: John, if they were to run a report and they could see which department is a contractor, based on the way the contracts are written, is that vender liable for those moneys?

MR. TEPPER: It is a little bit

of a stretch. I would have to look at the contract. Each one is it's own contract.

MR. MIROTZNIK: Could you answer it the same way you answered the last question?

MR. TEPPER: On or about?

DR. POLITI: Just to build on that, prospectively, in contracts that we do have, can we not build into those contracts a clause that says if your charts fall outside the standard of deviation that we can deduct a certain amount of money from you?

MR. TEPPER: You can try to do those things in the contract. We have clear guidelines and we don't say here is what you are supposed to do and if you decide not to do what you're supposed to do, here is how we're going to handle it.

You can put damages in there, but it doesn't lend itself to that type of remedy. I think it lends itself to the

more direct type, by the people that are supervising them, and then we do have a physician discipline process. Using the contract as a remedy in these situations is probably not the preferred option.

MR. MIROTZNIK: We are going to close it down. No one has ever said here yet -- is there anyone in the room, Dr. Scarmato, that is going to tell the Board listen, I have heard everything. I am going to straighten out this problem? Nobody. Nobody. It goes around and around.

MR. DELUCA: That's right.

MR. MIROTZNIK: Doc, this is --

DR. SCARMATO: The physicians in the room can say this is a problem that has gone on for years and will continue to go on in various degrees. We had a big issue with an IT problem, which I think raised our numbers. That has been completely solved now.

MS. SILVERSMITH: Yes.

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DR. SCARMATO: I think going forward we should have less of an issue than we had for about a year, really, with an IT issue.

MR. MIROTZNIK: If finance perchance misses the payment on the LIPS contract, you can be sure that somebody is going to get on the phone immediately and say where is our quarterly payment, right John?

MR. MAHER: Absolutely.

MR. MIROTZNIK: But yet when the shoe is on the other foot, it is all acceptable. It has to be straightened out.

DR. REHMAN: In times now it is electronic medical records. You can do dictation. You can do signing from your office, from your home. What are we talking about? There was a time when they used to do manual writing. You used to dictate and then type and correct it and it will come into the record and then sign, but now we go to

electronic medical records.

DR. SCARMATO: So for example, the ED, which is completely electronic, has no unsigned charts, I don't believe.

DR. VENDITTO: But they have the biggest backlog.

DR. CAPRIOLI: They are not unsigned, but are they coded properly?

MR. DELUCA: Fair question for you. The majority of the charts that are not complete, I would venture to guess they are from our own employees.

MS. SILVERSMITH: Actually, the majority is from the contracted staff.

MR. DELUCA: What I am hearing here in this room is I am hearing every excuse and every reason. Probably meanwhile this is the money that this hospital needs as a Safety Net hospital and the reason that these charts are not getting done, and the reason you are having a problem getting these things to be able to submit them

completely is because there is no consequences.

That's the reason, there are no consequences and I haven't heard anyone in this room say I am going to be the person that is going to be in charge to make sure that this happens, or I am going to report back to Dr. Politi in writing, or this Board in writing. I haven't heard anyone say that. I don't understand that.

So this is going to go on and on and on. John, as a Chief Financial Officer, don't you think that you should be telling Dr. Politi in writing that you have a problem, that you couldn't collect these, that these charts are not done? Don't you think you should have been doing that?

MR. MAHER: Those notices go out.

MR. DELUCA: What notices?

MR. MAHER: To the doctors.

MR. DELUCA: I am not asking about the notice. I'm talking about a

memo or an e-mail to Dr. Politi saying that's the reason it's not happening. We have this roadblock, this roadblock and don't you think that should be happening?

MR. MAHER: We can do that.

DR. POLITI: I will make sure when we have the meeting next week I will ask all the chairmen what the specific issues are.

MR. DELUCA: It shouldn't be you. This is too big an institution for you to have to do it. You have executives here. They should be doing this. I don't mean to sound so hostile. I am trying for us to collect the money so we can be a successful hospital.

This is money that is on the table. We are trying to attract these patients in this place and we aren't even collecting money that is owed to us. Doesn't anyone really see that as being really critical.

DR. CAPRIOLI: May I add one more

thing?

MR. DELUCA: Please do.

DR. CAPRIOLI: Everyone knows ICD-10 is a major problem for everyone with regard to coding, so we have all been on our game, but if the government decides that -- right now we are coding ICD-9 and 10 and learning how to use it. If they decide this is going into effect, these numbers can grow exponentially and suddenly we are not collecting.

They did tell us put some money aside because we may not be paying you if you are not coding right. So we have been warned and it seems like we should really be on our game because if they enforce the next October 1st deadline, these numbers can grow. If the private groups, or the contracted groups, are not on the ball, someone has to get them straight-ended because it's only going to get worse, you know?

Teresa, everybody with ICD-10

should be scared. We used to know how to code. Now we don't know how to code. We have 55,000 more codes. There is a coding emergency nationwide.

MS. SILVERSMITH: The challenge is we need more coders because the productivity is cut. They are doing well in terms of using the new system. Coders train for more than a year, so I think the issue is more that we need more of them.

For instance, our comp should be 11 full-time coders with ICD-10 coming in. We have 3.5 in-house. We have a lot of venders, but those venders are not full-time, so that is --

MR. MIROTZNIK: To be fair, Teresa, you brought this up only recently and we jumped on it right, Maureen?

MS. ROARTY: Yes.

MR. MIROTZNIK: There was no obstacle from this Board, and for that matter, from Dr. Politi as well. There

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has been no obstacle to do the hiring, correct?

MS. ROARTY: No, that is correct, but I can share with you that we have hired eight coders in the past four months. That is significant. They are not all on the inpatient side, but that is the overall number.

MR. MIROTZNIK: You are saying, Teresa, you are short three?

MS. SILVERSMITH: I need more-qualified people and the issue with this is I can't take a brand new coder because you can't take a brand new coder in front of an inpatient record with a complicated neurosurgery. We will lose money.

MR. DELUCA: Teresa, did you document this need in writing to your boss?

MS. SILVERSMITH: What specifically, that we needed more coders?

MR. DELUCA: That you need x

number of coders of a certain caliber.

MS. SILVERSMITH: It is a known fact. I have sent my e-mails out to everybody.

MR. MIROTZNIK: Listen to what Mr. DeLuca is saying and you better start doing it only because --

MR. DELUCA: You know where I'm going here.

MR. MIROTZNIK: You hear it, right?

MS. SILVERSMITH: Yes.

MR. MIROTZNIK: You take your job seriously and you have come to the Board and you asked, you begged us for coders; is that fair, begged?

MS. REED: Yes.

MR. DELUCA: Yes.

MR. MIROTZNIK: We did it and if you are not getting it you better back it up so you come here with a slew of e-mails to whomever and say this is why.

MR. DELUCA: And these are the

dates I asked.

MS. SILVERSMITH: It is a process for the type of coders I need. You can't hire overnight.

MR. DELUCA: We are not talking about the details now. The fact that you need x number of coders, you need it in writing to your superior. This Board is doing the wrong thing here by micromanaging.

We are not supposed to be micromanaging. We are micromanaging what needs to happen. One person needs to be held responsible for this, and if they can't do it they come back to the Board with Dr. Politi.

MR. MIROTZNIK: 100 percent. Mr. Maher?

MR. DELUCA: This is what's wrong here. There are no consequences. Everybody turns their finger to another department. It's ridiculous.

MR. MAHER: So to your point, Mr. DeLuca, we were looking for coders

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at this time last year because we knew what was going to happen with ICD-10. We knew it and we began to search this time last year. We were looking for people working at home, additional companies, and all through this year we were looking for additional coding companies. We went through a process, RFP, that's we've been doing.

Regrettably, this time last year, or a month later, three of our seasoned coders just up and left. So we were kind of caught in a storm of ICD-10 coming. We were sending our coders out to be trained.

MR. DELUCA: They up and left because they got better jobs for more money.

MR. MAHER: So we are working internally to determine how we could keep our coders within the system and we are hearing today we still cannot contract seasoned coders because of the salary structures and we are working

with HR to correct that.

MS. ROARTY: May I share some additional information?

MR. DELUCA: Please.

MS. ROARTY: As I said, we hired eight coders over the past several months. We also did an analysis of where we are in market. The market data that is out there says that we are in the tenth percentile for the region, but the average salary is $40,000.

We are finding when we are recruiting they are making much more than that, perhaps because some of them are able to work from home.

MR. ZYSMAN: Why can't they work from home? That is an industry standard. Have you looked into that John, if they can work from home?

MR. MAHER: That can't happen.

MR. MIROTZNIK: One at a time, only for the stenographer.

MR. MAHER: We looked into this a while ago and said no we can't do it

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whether it was civil service issues or corporate policy at the time. We were unable to get people who worked at home.

Keep in mind, contract coders are typically working from home, just individuals. There was a prohibition on that and I am not sure what those rules are, but we don't allow people to work from home who are on our payroll, but that's what the industry is right now.

MR. DELUCA: So get a waiver. There is always ways around it.

DR. REHMAN: How can't you work from home if everything is on the computer?

MR. MAHER: It is --

DR. REHMAN: If everything is on the computer, they can work from home.

MR. MAHER: Everything is available and that's how the coding companies --

MR. MIROTZNIK: There are so many

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bright people in this room and for instance, I don't like to throw any lawyers under the bus, or the legal profession because I'm part of it, but we are hearing about simple name changes.

We put our hands up immediately and voted for the name change and shame on whoever didn't follow up to say where is McKesson? No one has ever said anything until tonight and McKesson would be helpful, right?

MS. SILVERSMITH: Yes.

MR. MAHER: For the emergency room, yes, absolutely.

MR. MIROTZNIK: It just belies credibility and I think we have killed this enough.

MS. MARIE-HANSON: Please move the agenda. I think we need to move the agenda. I think this has to be dealt with at another level.

MR. MIROTZNIK: Maureen, last word on this?

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MS. HUTCHEON: In regards to the contract physician group with plastics that is under the surgery department, this is very timely because I just RFP'd this service. That contract is up on June 30th, 2016.

I'm proposing to work with legal to enter some language in that contract that has consequences in terms of them not completing the documentation in the charts. So I can only control my contract groups as the contract comes up. We can address that.

MR. ZYSMAN: Maureen, what you just did is what I think we expect everybody in this room to do. Thank you for your leadership.

MS. HUTCHEON: Thank you.

MR. DELUCA: I want to ask the CEO a question. Who, Dr. Politi, in this room can this Board hold responsible if this does not get done?

DR. POLITI: Ultimately I think I am responsible, Mr. DeLuca. I will

work together with my team to put this together. I think John Maher and Victor Scarmato as Chief Medical Officer are the two key players in this.

MR. DELUCA: Are you going to include consequences if things don't get done here?

DR. POLITI: Within the scope of our ability to include consequences, such as --

MR. DELUCA: You have the ability to use that consequence. Believe me.

DR. POLITI: There are certain things we can do to physicians for not doing their charts, and certain things we, as a system, need to fix, whether it's an IT issue.

MR. DELUCA: Well, the physicians is one piece of it. You have the coders as a piece of it, and nobody is taking their arms and putting their arm around us. That's why I'm troubled.

DR. POLITI: The coder issue we

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are resolving. We are bringing people on board as fast as we can. Teresa is constantly interviewing people. We are constantly interviewing coders and trying to get as many as we can in here to do that, but there are a lot of moving pieces.

MR. ZYSMAN: I want to tie it all together. It came up before. Teresa did a very good presentation. It seems like she is very, very involved and very dedicated.

From all the reports and all the physicians in the room said it, Dr. Scarmato who is the Chief Medical Officer, Dr. Mustacchia, who is the Chair of Medicine, it sounds like her people are giving these updates, doing it electronically, all these things that Dr. Caprioli talked about. It sounds like those are the types of things that need to be happening and she is doing them.

The issue is cooperation and

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getting it done, whether it is with the venders or with specific physicians. You guys have to get together as a group. You have key people, Harold McDonald, who is the Chief Administrative Officer --

MR. DELUCA: Financial.

MR. MCDONALD: Chief Administrative Officer.

MR. ZYSMAN: -- who is involved with operations. It's an operations issue as well. We need to take a look at this, but your chairmen have to take responsibility for their department, each of their departments.

If their people are not closing out their charts and they have been notified, finance is only going to be able to give the information that this isn't done. Someone has to do it. They are not in the position to close out the charts or validate it. If they were, I have no doubt, based on what Teresa is saying, she would have done

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it.

So Dr. Scarmato, you are responsible for all the chairs of these departments, correct?

DR. SCARMATO: Sure.

MR. MIROTZNIK: Sure or yes?

DR. SCARMATO: I am not sure what you mean by responsible.

MR. ZYSMAN: Don't all the chairmen of each department report to you as Chief Medical Officer?

DR. SCARMATO: They do report to me as Chief Medical Officer.

MR. ZYSMAN: Aren't you responsible for their evaluation?

DR. SCARMATO: Yes.

MR. ZYSMAN: So you have to come up with another policy and coordination.

MR. DELUCA: I have to have Dr. Politi hear this. This is really important.

MR. ZYSMAN: You are the Chief Medical Officer. Dr. Politi, you need

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to have Dr. Scarmato come up with a policy of how this is going to get done so that's going to work well for him and his chairmen and his chairmen's staff so that it can get done quickly.

They need to get finance and operations involved as well, but this is something that the physical work on this that isn't getting done has to do with the department. Those departments are the ones that are managing these contracts with these outside venders.

Mr. Tepper very eloquently before laid it out. He has never gotten a phone call from any of the people who hold those contracts that there is a problem. If you are chair of a department, you better know that we are not getting paid for the services that you, your staff, is providing, and doing a great job providing, and your staff is going to want to know that their employer is getting reimbursed for services they are providing.

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Everyone should work as a team to resolve this and move this forward, but it starts with you holding your chairs accountable and your chairs holding their people accountable. If you are not getting information from finance, if you're not getting cooperation from operations, then I want to look at these other folks, but if the issue is your folks aren't closing out the charts, Doc, I'm going to look at you.

DR. SCARMATO: I can tell you I do come up with the people on a monthly basis.

MR. ZYSMAN: And Dr. Politi, I want you to look at him, too, and I want this resolved.

DR. SCARMATO: I follow up with people on a monthly basis and the chair on the other ones, but some of the chairs are some of our worst offenders.

MR. DELUCA: Why don't you get rid of one of them then? Why don't you fire one if they are your worst

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offender?

DR. SCARMATO: He is the chair of the contracted service.

MR. DELUCA: There is a way to do it.

MR. ZYSMAN: Don't we have 60-day out on every contract?

DR. SCARMATO: Then we don't have coverage on that.

MR. DELUCA: We will get coverage.

DR. SCARMATO: That is not so easy.

MR. MIROTZNIK: We're going around.

DR. SCARMATO: I will do whatever you want to do. I will start suspending privileges. It has been brought up.

MR. MIROTZNIK: Vic -- you want us to give you the guidance. I want you to tell us what you think you should do.

MR. DELUCA: Exactly.

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MR. MIROTZNIK: I'm a lawyer. You want me to tell you what to do with your surgeries?

DR. SCARMATO: There has been a ton of problems with the electronic signings of the records. It has to be signed in two places, so people would sign it in one place and it would remain as an undone record, even though it was done.

MR. ZYSMAN: Dr. Politi, can you make sure that Dr. Scarmato gets all the support he needs to make sure this is done? Are you taking responsibility for this getting done?

DR. POLITI: I will work as hard as I can together with the team to make sure this gets done.

MR. ZYSMAN: Are you going to fix it?

DR. POLITI: I will do the best I can, whether or not we can fix this 100 percent, if it is a fixable problem, we will fix it.

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MR. DELUCA: I will request to have things in writing because we don't want to sit here again and see this go on. I want documentation. I would like to see documentation as to who is not doing their job here because we don't want to take action with the wrong people. That would be horribly unfair. It would be reckless. It would be horrible.

MR. MIROTZNIK: And reprehensible and not how this Board acts. Dr. Saracino, last word on this.

DR. SARACINO: Listening to what is going on, I am coming to certain conclusions. One is that the problem we have is more governance than anything else. We seem to have protocols in place as to how things are operational and yet, if you look at the general protocols of identifying a problem, selecting a solution, going through affecting the solution, and the end of the protocols, comes down to

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remediation. If remediation is not there, the final protocol has to be accountability.

We have stopped with accountability and if you want to look at the book learning on administration, we are just not following the rules of -- the acceptable rules of administrating this organization.

There has to be an element of accountability at the end of all the protocols and we don't seem to have that. We are blaming this party, blaming that party. If we had the accountability level to our protocols we wouldn't have to be blaming people. All we would have to do is show what is happening.

I hate to use the word blame, but the shortfall of our problem would be evident and the accountability would be addressable, but we have no accountability at the end of the protocols and this is a job of the

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Board.

MR. MIROTZNIK: Protocol? We have the protocol. That's in place.

DR. SCARMATO: The protocols end before the accountability, Mr. Mirotznik. We have to identify what we need in a way of accountability. We have had suggestions of firing or doing this or that, but the Board has to come to a conclusion to add to the protocol the last elements of accountability and I don't see that here, or hear it here.

MR. MIROTZNIK: You are going to hear it from me. The end of this is Dr. Scarmato, you are in an interim position, correct?

DR. SCARMATO: Correct.

MR. MIROTZNIK: If the interim part of it is not acceptable, or you are unable to make certain, difficult decisions, we need to know about it because it seems to me and when I made a suggestion of Dr. Politi sitting

around this room, it was more tongue and cheek.

He can't micromanage the hospital and nor can we. We just can't do it. You have identified issues. You said you just came out after an hour discussion and you said that the offenders are contract offenders. You know who they are, correct?

DR. SCARMATO: I know the worst offenders because I e-mail them every month.

MR. MIROTZNIK: You have to do something about it, and if you don't do something about it, then we are going to have to do something about you not doing it.

DR. SCARMATO: I will make sure you will have -- something will be done and I will show you whatever progress there is.

MS. REED: Thank you.

DR. SCARMATO: And I'll discuss the consequences with Dr. Politi. We

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have discussed over the course of the 18 months that I have been here, because this has been an issue, about different consequences and we haven't moved to suspension --

MR. MIROTZNIK: No one has been sent a bad letter.

DR. SCARMATO: Maybe Dr. Saracino can work on the detention.

MR. MIROTZNIK: You know what I mean. It's enough of this. You should document that whatever you are thinking and what you just articulated, you put it into that e-mail so that when we come back in January, we'll know where we are at with this.

DR. POLITI: As I said, at the beginning of my presentation, this was going to be a short presentation. Thank you, Mr. Chairman.

MR. MIROTZNIK: John, moving to something really easy and fun and interesting.

MR. MAHER: 2016 proposed

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operating budget.

DR. VENDITTO: Before we do that, one bit of business. Can we get a motion to approve the minutes of the November 15th, 2015, Finance Committee Meeting? Second? All in favor? Thank you.

MR. MIROTZNIK: I didn't see that on the agenda.

DR. VENDITTO: It's not on the agenda.

MR. MIROTZNIK: Fair enough. John, the 2016 budget.

MR. MAHER: You have before you the proposed budget as a booklet and I would, in the interest of time, direct your attention to page 10 of 27. That page, on the far right-hand side lays out the 2016 budget and it is projected to be basically a break-even budget from operations, revenue and expenses.

I would ask you to focus on one number, which is the net patient service revenue of $393,537,000, the

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top number of the right-hand side. That number pretty much consists mostly of the hospital's revenue and expenses.

So now I would like you to go back to page 6 of 27. Somebody gave me an old book, I'm sorry. It's page 5 of 27, my apologies. The hospital's total revenue that we are looking at, that patient service revenue, after bad debt and charity care is $312,471,000. Starting at the top, what you see is the first section, which is the inpatient section, which shows that total patient service revenue from adults and peds, newborn, detox, residential rehab, psych and rehab is $249,673,000. The outpatient side below that is $85,220,195. We are on page 5 of 27.

MR. MIROTZNIK: 6 of 27?

MR. MAHER: The outpatient revenue is $85,220,195. The next section where you look at broadly how the hospital gets paid, the information

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above is coming from mostly the third-party payers, Medicare, Medicaid, the managed care companies, No-Fault, Workers Compensation, et cetera.

This next section of $29 million consists of the bad debt and charity care for which the hospital receives money. You have heard this referred to in the past as a DSH IGT payment, interim adjustments, the supplemental pools, and then we also pay into pools. So the net of those pool transactions nets the hospital $29,166,004.

The next section, which you may or may not have seen in the past, is Healthfirst. This is the capitation that we receive from the Healthfirst members that are enrolled with us and we receive basically a per-member per-month distribution from Healthfirst. On an annual basis that comes out to almost $3 million. It's $2,991,441.

So that gives us a total revenue

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before bad debt and charity care of $366,640,665. From that number we subtract bad debt and charity care and those are the last numbers that you see at the bottom. You will notice that the inpatient amount is $14.6 million in bad debt and charity care, and that is $249 million.

The bad debt and charity care on the outpatient side is almost 50 percent of the outpatient number. Is everybody following me?

MR. MIROTZNIK: Page 6 of 27 at the bottom. John, can I interrupt? Didn't we talk about outpatient and inpatient charting earlier?

MR. MAHER: We did.

MR. MIROTZNIK: The likelihood was you would receive more reimbursement on outpatient than inpatient charts or is it the opposite?

MR. MAHER: The opposite. Just to put it in perspective, inpatient charts with a case mix neutral value of

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one, is probably worth somewhere around $10,000 a discharge. On the outpatient charge, the average per-visit, so taking clinics and the emergency room, might be $125 a visit. So there is significant difference between those two numbers.

MR. ZYSMAN: Is there a way to bring them down?

MR. MAHER: That 312, that's correct. It is allowanced for bad debt and charity care.

MR. ZYSMAN: What percent of our AR does that cover?

MR. MAHER: Let me just add one more thing to that. The numbers you see above have already been netted down for contractual adjustments, so what you have left over is what we are referring to as bad debt. In this case, it's a total of $54 million spread on roughly $366 million of --

MR. ZYSMAN: So you are saying you bill out at a higher number?

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MR. MAHER: 366 in this case.

MR. ZYSMAN: That would be the gross. What you have done is you netted this?

MR. MAHER: Correct.

MR. ZYSMAN: That is an actual number of what would have been received?

MR. MAHER: Yes.

MR. ZYSMAN: Otherwise what did you net off of, the contracted rate?

MR. MAHER: Yes. So for those -- each month and we will be discussing --

MR. ZYSMAN: How do you net on charity care?

MR. MAHER: You don't net on charity care. It's called charity care.

MR. ZYSMAN: What is the difference between the value of the charity care visit in the ER versus the non-charity care?

MR. MAHER: $150 on average. This is what it would come out to. The

emergency room might be a little higher.

MR. ZYSMAN: I am just asking, on a charity care case, how do you value it?

MR. MAHER: We would take the charges and depending on if the patient went to a sliding scale, we would take the difference between gross charges and what we think that patient should pay us. So if the bill came out to $3,000 and we think they are only going to pay us $200, we would allowance that down, that amount of money, to $2,800.

MR. ZYSMAN: You are doing that based on what you typically receive, like a blend rate?

MR. MAHER: Yes. So again, the top numbers have contractual adjustments already netting them down.

MR. ZYSMAN: So the other question I asked before, this covers the AR that you have reserved for. What percent of AR is not reserved for?

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What is that value?

MR. MAHER: It is reserved across all.

MR. ZYSMAN: So, 100 percent of accounts receivable for 15 is reserved for?

MR. MAHER: Yes. That's what I'm saying. That goes back to somebody's question before, how much do I expect to collect? I am saying 100 percent of that number.

MR. MIROTZNIK: I want the record to reflect we spent approximately four hours in this room, most of the members that are here were here yesterday morning going over this budget, so we worked through it.

Is there anything else, John, that you want to inform those that were not present yesterday?

MR. MAHER: Of substance, no, except to say that going forward all of these rates that you see in front of you on this one page, 6 of 27, is

supported by a changed model that we are using.

So we are looking for every payer, and you don't have this in your packet, but for every payer that's there, there is a base rate and an add-on rate that accounts for denials, accounts for sequestration, for anything that would be reducing the value of this receivable.

That has already been netted against this and going forward at the Finance Committee meeting we will be discussing that and showing you where the variances are not only for volume, but for rate, to do with rate. So you will have a complete picture of what is going on.

MR. ZYSMAN: Off the record.

(A discussion was held off the record.)

MR. ZYSMAN: Back on the record. Does this contract fully comport with the PEO Service Agreement that

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Dr. Politi entered into on December 17th, 2015, as the Nassau Foundation?

MR. MAHER: Yes, it does.

MR. ZYSMAN: Thank you.

MS. MARIE-HANSON: Related to the expense assumptions on page seven, the overtime and other, can you expound on what the other is?

MR. MAHER: Sure. It's mostly overtime that we're looking to curtail. So what we're talking about on page 7 of 27 is some of the expense assumptions and there is a difference between last year's salary and fringe benefits and this year's and we are taking down those expenses by roughly $10 million.

So the question that Gemma has asked is what's in other? It's mostly due to the overtime savings and what I am going to call our special-type savings where we have the option not to go into, not so much employees, but

people that we bring in on a part-time basis, and so those expenses would be reduced as needed. So instead of hiring someone, we will move someone around.

MS. MARIE-HANSON: But my concern is we don't have FTE there. We don't have the human there that we may need. We are trying to cut overtime as understood, but as an IT, there are holes in the program. We actually need people to do the work.

So how does that affect the work on the ground level and the ability of our people to work well and effectively if we are cutting back on having FTEs and are we at the total FTEs that we need to have a functioning hospital? Because there are some holes here.

MR. MAHER: There are holes in the staff, there is no question about it, but because there are some here, doesn't mean we are not going to fill that with a needed position. We are

talking about if there is a vacancy up here, you may not have to fill that vacancy because there is no demand for it.

What we do, and Mr. McDonald can address this, we look at the visit statistics and the counts for those departments to determine whether or not there is really a body needed there. Just because someone leaves, it doesn't necessarily mean you have to backfill that position, whether it's a sick time, vacation time, or a vacancy. You may not have to fill it.

Just because the vacancy is there or the position is there, doesn't mean you automatically backfill when it's created. That is pretty much what happens.

MR. MCDONALD: In 2014 we did a pretty significant analysis of staff around the hospital and we had a significant reduction in the workforce in 2014, but it brought down the

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staffing levels that were in the range of what is typical for Safety Net hospitals operating at.

During 2015 we spent a six-to-nine month period of taking a deeper dive on many of the different service lines. We took a look at the clinics, the number of work RPUs that were being produced by each of the physicians, to try to figure out do we have the right number of physicians covering the clinic? Do we have the right number of clinics? Do we have three clinics with not enough volume, should we merge those and just have two clinics? Do we have three that are backed up?

We took a look at the skill mix, so do we need an RN or an NA? We took a look at the average daily census on all of the inpatient units and took a look at the numbers of hours of the patient day and also patients for the RN staff. We found there were a number

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of opportunities to reduce.

So it's a mix of nursing, a mix of skill mix, a mix of physicians. It's a pretty significant mix, taking a look at the inpatient side of the operations and the outpatient side of the operations and tying it back to the work RPUs, but also looking at assignment.

So if there is a physician that is here employed 40 hours a week, whereas that individual, if they are in the clinic for two days, on the floor for another, and they have other responsibilities.

So we are coming at it from a number of different directions to identify what is the actual need. We went through that process with most of the departments here and most of what you see in the reduction in staffing is based on the analysis that we put together.

MS. MARIE-HANSON: My concern is

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you can go through all your analysis, but at the end of the day we have to take care of patients. I asked the question because I have had someone that came to the hospital, used our clinics, and one in particular, there was a delay in identifying a problem with the test. It took several months before that person was gotten back to.

So I would ask that the process be looked at because I want to be able to go out into the community and say I want my people to come to this hospital. I want this hospital used because we are an excellent hospital, but it's problematic when you send people here and you get a call back saying I was notified two months, three months or whatever months later there was a problem with my test and now I have to go back to get evaluated.

So I understand there are a lot of factors. I actually was one of the people that was not happy with the

skill mix in outpatient at all and I made that known at that time when we were having those discussions. But moving forward, we really have to make sure we are doing the job we need to do, and that is taking care of our community, taking care of the people that come into this hospital and utilize our services.

I am concerned that we are falling through the cracks here, so I would like that to be looked at further and I would like that to be looked at also as we move forward in cutting back our FTE's in certain areas because I don't know what the process is, but I am sure, and I have been down in clinic, and to be honest with you, you are short in the clinic. You are very short a line.

MR. MCDONALD: That was a pretty exhaustive analysis we did. We went clinic to clinic and took a look at the staff we use and benchmarked it against

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industry norms and we found that number one, we were lacking middle management.

So each of those clinics we didn't have someone on the floor everyday running the shop. So there was no CEO of certain clinics. So we are implementing that change now. We found we did not have enough of the front end staff to make sure that the schedule -- and this is in every clinic --

MS. MARIE-HANSON: I am not talking about your process. I am sure you were very, very good with your process and I am sure you expedited it the way you needed to. That's not the issue. The issue is that the process now is taking care of patients and if we have a hole in the program and things are not being expedited correctly, or making sure that a client gets taken care of if they have an abnormal whatever, then that's the problem.

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I remember a long time ago when I first started on this Board we had a long discussion about taking care of patients. That's my concern. We can do all the calculations and put all the nice stuff in a booklet and make it look real good, but if we are losing at the ground level taking care of patients and making sure they get the care they need, we are not doing what we need to do. I am not blaming anybody, but I am saying we need to look at that as we move forward.

MR. ZYSMAN: I think what Ms. Hanson is saying, correct me if I'm wrong, Ms. Hanson, is that analysis is good, but it's only as good as the outcome of taking care of patients. If the outcome is still patients are not getting everything they need, then the analysis, even if there was a tremendous amount of time and effort put into it, what does it amount to?

When you're talking about the

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staffing, I am bringing up something just as an example. You're the person who did the analysis, right?

MR. MCDONALD: I did it with each of the departments.

MR. ZYSMAN: You were the person who oversees and coordinates all of that?

MR. MCDONALD: Yes.

MR. ZYSMAN: Our hospitalist group, they are academic hospitalists?

MR. MCDONALD: Yes.

MR. ZYSMAN: How many patients does the average academic hospitalist see a day?

MR. MCDONALD: We are short and depending on the average census, we are overloading our hospitalists. So we have been -- Dr. Mustacchia can --

MR. ZYSMAN: What is the standard for the society of hospitalists for an academic hospital?

MR. MCDONALD: Roughly 20 patients per physician.

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MR. ZYSMAN: For an academic hospitalist?

MR. MCDONALD: For an academic hospitalist in a Safety Net setting, about 20. We are over that, aren't we?

MR. ZYSMAN: Harold, if you don't know, say I don't know. That's not correct.

MR. MCDONALD: There are benchmarks and industry standards.

MR. ZYSMAN: What you said is not the correct answer. You should look it up if you don't know. What I'm trying to say is how long have we had a problem with not having enough hospitalists at the hospital? How long has it been?

MR. MCDONALD: Since the summer.

DR. MUSTACCHIA: We have had a problem with not enough hospitalists for at least 12 months, if not greater.

MR. ZYSMAN: Are they accounted for in the budget? We need how many more hospitalists, Harold, in your

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assessment?

MR. MCDONALD: In my assessment, two more hospitalists.

DR. MUSTACCHIA: That would be an accurate assessment from my perspective. We need two more.

MR. ZYSMAN: Is that accounted for in the budget?

MR. MCDONALD: Yes. The question is is it going to be one medicine hospitalist or one family practice hospitalist?

MR. ZYSMAN: That is for you guys to figure out. That's the answer to the question, but in terms of what I think Ms. Hanson said, it had to amount to outcomes. We have asked for outcomes.

MS. REED: This is what I would like: All of the clinics, I would like to know how many receptionists are down there for each clinic and if you can e-mail me that, and any other front end staff in the clinic, if you can e-mail

me that for each clinic.

DR. SCARMATO: Absolutely.

MS. REED: As Gemma had said, I also very recently had a problem that I had to step in because it was three months and the person couldn't get another appointment because nobody was calling them back.

So I would like for each clinic receptionists and any other front end personnel, a tally of that.

DR. SCARMATO: We can give you that and the current state and the future state, so clinic-by-clinic.

MS. REED: That is wonderful, thank you. I appreciate that, thank you.

MS. MARIE-HANSON: I would also ask Dr. Politi to look into -- I don't know what the process is when you get an abnormal reading, maybe you can share with us or tell us what that process is to get back to that person because having several months' delay is

truly unacceptable.

MS. REED: Who does get back to them in that department?

DR. POLITI: I would ask Dr. Mustacchia what is the process for an abnormal blood test? I'm not familiar with that.

DR. MUSTACCHIA: Physicians regularly check the tests that they order and depending on the significance of that test, if it's something that is quite -- there is some clinical judgment. You would expect that someone would be contacted if not that business day, the next.

MR. MIROTZNIK: Paul, is that a general statement or general to your department, for the record?

DR. MUSTACCHIA: That is to my department that I can speak to.

DR. POLITI: Which is the largest department. So is there any checks and balances on that? Obviously Ms. Hanson had an issue and it wasn't done.

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DR. MUSTACCHIA: We all have supervisors so the checks and balances would include an escalation to that individual supervisor to the standard if that standard is not met. So there would certainly be a raw view of the case and there would be education offered if you need to offer them education, some sort of disciplinary approach. You would advance it in that matter.

MR. MIROTZNIK: May I make a suggestion regarding practice and procedures? This is something we can talk about off the record for various and sundry reasons. Let me move this forward, John. We are ready to take a vote on the budget.

DR. VENDITTO: Can I please? John, I want to, for the record, and it is hard to predict short of having a crystal ball, but if you go to the top of page 3 of 27 in the executive summary, last year we presented a

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balanced budget of 2015 and to quote several negative factors arose in 2015 with negative impact. It comes up to about $52.4 million that vanished that we were expecting.

You don't have a crystal ball, I know, but can you make some sort of prediction of what might happen in 2016 and how we are prepared to deal with these changes in revenue?

MR. MAHER: Yes. So by way of contrast, money coming in to offset that shortfall would be IGT. We will go through these numbers slowly. Offsetting that would be in 2016 is going to be an increase in IGT of $11 million. State aid is also going up $11 million for various programs. State and federal aid is going to be going up.

DR. VENDITTO: John, in the 2016 budget on page 6 of 27, the BDCC pools, New York State statewide assessment, looks like it is going to be $2,204,000

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less?

MR. MAHER: What page are you on?

DR. VENDITTO: Six of 27 in the BDCC pools. I said New York State revenue is going to go up and the budget for 2016, does it go down? New York State statewide assessment pool. I am trying to make sure $52.4 million disappeared.

MR. MAHER: There are two different numbers. What happens with these pools, we receive money from the pools, but it also requires us to pay out money. So we are showing you the transaction grossed up because the total is 29. That's not a decrease in the sense of '16 compared to '15. It's the amount of money we have to pay into the pool in order to get more money out. So it is an assessment that comes in that we have to pay. That's all it is.

DR. VENDITTO: Let me simplify it then. The $29,166,000 that is the

total for the BDCC pools, how confident are we that money will be present throughout 2016 since they pulled the rug out from under us significantly in 2015?

MR. MAHER: To the extent we are relying on their latest information, which is the only thing I can use, I am confident that this number should be correct. We have enough experience to know where the issue is.

DR. VENDITTO: This is no reason right now to expect we are not going to see that money?

MR. MAHER: No, there isn't.

MR. MIROTZNIK: John, before we take a vote, all members please pay attention. John and your team, you prepared the 2016 budget. Are you satisfied with the document prepared in connection with our operating budget?

MR. MAHER: Yes, I am.

MR. MIROTZNIK: Are there any additions or deletions that you would

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like to discuss with us before we take a vote?

MR. MAHER: No.

MR. MIROTZNIK: Mr. Sullivan?

MR. SULLIVAN: No, sir.

MR. MIROTZNIK: Dr. Politi, you have had an opportunity to review this with your team?

DR. POLITI: Yes, I have.

MR. MIROTZNIK: Any additions or deletions?

DR. POLITI: No.

MR. MIROTZNIK: Any comment or concern?

DR. POLITI: Nothing.

MR. MIROTZNIK: You both recommend approval of the operating budget, fiscal year ending December 31st, 2016?

MR. MAHER: I am.

MR. SULLIVAN: Yes.

DR. POLITI: Yes.

MR. MIROTZNIK: Members of the Board, I take a vote to approve the

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operating budget as distributed in front of you for the fiscal year ending December 31st, 2016. Do I have a first? Mr. Zysman. Second? Ms. Reed. All in favor? Unanimous.

Thank you for preparing it, and on behalf of the members of my Board and myself, I invite everyone for a quick dinner. Let's eat and we will finish the balance of the agenda with a little food in our bellies. I make a motion to adjourn for dinner. Unanimous.

(A recess was taken.)

MR. MIROTZNIK: I make a motion to go back into Board meeting? Unanimous, thank you. We have Christine Apicella, with the Long Island FQHC budget.

MS. APICELLA: Hello, everybody.

MR. MIROTZNIK: Let the record reflect Christina joined us yesterday for some four hours and we worked through your budget and I want to say

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your presentation was wonderful and et cetera, et cetera.

MS. APICELLA: Thank you, everyone, for having me tonight. I do have booklets. I don't know if this was passed out to you, so I will pass that along.

MS. FUSCHETTO: It was passed out. It is in your packets.

MS. APICELLA: Overall for the Long Island FQHC, over the last four years from '12 through '14 the LIFQHC has been growing substantially at probably around a 15 percent rate. For 2015 our budgeted visits were estimated to come in at 98,000 and annualized it looks like we are going to come in at about 106,000 visits.

On the revenue side for 2016, our total projected revenue is $36,842,000. The total patient revenue is $25,380,000 and nonpatient revenue is $11,482,000. On the expense side we are showing projected about $36,104,000

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and our expenses of operating revenue and expenditures is $738,000.

I want to note the LIFQHC has two major programs. One is WIC, who has joined us this year in 2015. WIC is Women, Infants and Children. The other major program the LIFQHC is beginning on 1/4 is Health Home. So those two programs alone are around $4 million.

In general, I presented to the Finance Committee. Does anyone have any questions for the LIFQHC?

MR. MIROTZNIK: I know most of us worked through it yesterday so we are familiar with it. In that case I make a motion to approve the LIFQHC 2016 budget contingent upon the LIFQHC's agreement to comport and comply with the PEO Service Agreement that was approved and signed by the NHCC CEO Dr. Victor Politi on December 17th, 2015. Additionally, the LIFQHC agrees that in accordance with the passing of their 2016 budget, the LF is obligated

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to advise the NHCC Board when seeking to establish competing services and must obtain NHCC Board/NHCC Executive Committee approval before acting on such proposals. That is my motion.

MR. ZYSMAN: Comment on the motion?

MR. MIROTZNIK: Any issues, concerns with my motion?

MS. APICELLA: No.

MR. MIROTZNIK: Acceptable to your Committee and your Board?

MS. APICELLA: Accepted.

MR. MIROTZNIK: All in favor of the motion? I have a first, Mr. Zysman. Ms. Hanson? All in favor? Unanimous. Christine, best of luck --

MR. ZYSMAN: In what we were looking at yesterday, you had brought up the Article 31 application in DSRIP, integration of behavior health. Primary care is a vital part in one of the projects being worked on here.

Dr. Rao is here who chairs

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behavioral health here at NHCC. They have an Article 31 clinic here and I think it is important that a dialogue begin immediately to work on having extension clinics for our Article 31 co-located at FQHC, consistent with FQHC's desire to do that.

That Dr. Rao and his department and FQHC create a presentation on how to do this and present it to our Board for approval prior to moving forward.

MR. MIROTZNIK: Acceptable?

MS. APICELLA: Acceptable.

MR. MIROTZNIK: Christine, do you mind sticking around to our NMK presentation in case some questions come up?

MS. APICELLA: No problem.

DR. POLITI: Just an update for the Board. This morning there was a test at A Holly Patterson of their generator system. The generator was disconnected and a portable generator was hooked up. When they turned on

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that generator, there was a power surge causing a giant short and smoke condition, requiring that A Wing to be evacuated.

So we had the fire department, EMS and the police department evacuate the A Holly Patterson. The staff did an amazing job evacuating 40 patients out of that A Wing into another wing. There were no injuries. The fire department showed up.

Apparently it was an electrical issue. They evacuated the area and took the smoke out. I just got the report from Kevin Mannle that everything is back to normal. They moved everyone back into their rooms. All the ventilators have been checked. All the alarms have been checked, but because there was some issues with some of the fire department systems, we are going to have to have a fire watch, someone that will be on walking patrol to make sure that nothing happens until

they get the alarm up.

So I want to make sure the Board members are aware because the media was there, News Channel 12, and it may be on the press and I didn't want anyone surprised.

MR. MIROTZNIK: Thank you. We appreciate that report. I am glad everybody was okay.

MR. HEATLEY: I think I would second that the staff did a fabulous job. It was actually the ventilator patients that needed to be moved, which is much more complex. We have to move several things with them, not only the ventilator machine, but the suction machine and the staff did a really remarkable job and had most of the unit evacuated by the time the fire department got there. So the fire department was actually very complimentary as well.

MR. MIROTZNIK: Thank you for that update.

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MR. MCDONALD: It is nice, sometimes, to have a partnership with the hospital when you are a nursing home. Within a half an hour or so we had a crew from the hospital over there, electricians, other facilities people, like the man power just poured in quickly so we could get all of the repairs that needed to be made in place very timely.

DR. VENDITTO: There was no interruption in mechanical ventilation of any of the patients?

MR. MCDONALD: No. They have battery packs.

DR. VENDITTO: We seldom test those batteries.

MR. MCDONALD: They work.

MS. REED: Please thank the staff from the Board.

MR. MIROTZNIK: Mr. Zysman, moving right along.

MR. ZYSMAN: DSRIP Committee is asking for an approval of the minutes

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from the December 16th, 2016 meeting. Can I get a motion? Second? Favor? Unanimous.

MR. MIROTZNIK: Mr. Tepper?

MR. TEPPER: Yes?

MR. MIROTZNIK: That's how you answer?

MR. TEPPER: What am I up on?

MS. REED: Ad hoc Committee appointments.

MR. MIROTZNIK: That was pulled.

MS. FUSCHETTO: I gave you an updated agenda. That was pulled.

MR. MIROTZNIK: Dr. Scarmato?

DR. SCARMATO: Update on NMA --

MR. ZYSMAN: No, update on -- off the record.

(A discussion was held off the record.)

MR. MIROTZNIK: Maureen, the PAS Contract extension?

MS. HUTCHEON: First, I would like to thank you also for the food, which was a wonderful meal, and last

minute consideration of this request.

That contract was approved by the Board on 12/17 for two years for $280,000. However, after careful consideration and it expires on 12/31, it was for physiological assessment services. They are an interoperative monitoring company.

After consideration of looking at it in terms of a two-year, we have to do a whole new contract for it at this time. Since it expires tomorrow, we really need the extension for six months so that we can go further and do due diligence with this contract.

So it was really a time factor and that is why I'm coming last minute and asking for it. This LD200 was submitted on November 23rd by my predecessor and I brought it to the Board in December. I think it is really aggressive at this time to get a contract out there so I was going to ask for a six-month extension.

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MR. MIROTZNIK: I believe she apprized us of this potential issue.

MS. HUTCHEON: Yes.

MR. ZYSMAN: What is the value of the contract?

MS. HUTCHEON: $70,000. I'm asking for six months.

MR. ZYSMAN: Effective what date?

MS. HUTCHEON: January 1st, 2016.

MR. MIROTZNIK: For the record, can you tell us what PAS stands for?

MS. HUTCHEON: Physiological Assessment Services.

MR. ZYSMAN: $70,000?

DR. POLITI: A needed service.

MR. MIROTZNIK: You are recommending we approve it?

DR. POLITI: Absolutely.

MR. MIROTZNIK: I make a motion to extend the PAS contract for six months, up to $70,000? Dr. Venditto, second. All in favor? Unanimous. Thank you, Ms. Hutcheon.

MS. HUTCHEON: Thank you, very

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much.

MR. MIROTZNIK: Dr. Scarmato, NMA?

DR. SCARMATO: First, I wanted to mention that Dr. Politi had mentioned earlier our radiation oncologist just passed away overnight the day before yesterday. He had actually just two weeks ago put in for an immediate retirement because his health, I guess, had been failing.

We met immediately with the North Shore LIJ Health system to see if they could offer a coverage and we are going to work towards a long-term solution with them to cover radiology/oncology in the short-term.

They helped me identify a person who is known to them, who had worked for them, who is in a private practice up in Westchester, who we are bringing on as a specialty doctor a couple of days a week to keep the program going until we can work out a more formal

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deal with a North Shore LIJ Health system.

We are hoping not to have any real break in service with patients who are in the middle of their treatments right now --

MR. MIROTZNIK: We don't?

DR. SCARMATO: We do have nine patients who are in the midst of their treatments now that didn't finish. Because we knew Dr. Carlton was going to be retiring, we had three others ready and five others waiting, so we have eight other patients waiting to get started, but we will be able to take care of these patients hopefully next week.

The doctor already put in his stuff for privileges. We are going to try to get emergency privileges in the next day or two.

MR. MIROTZNIK: It only requires Dr. Politi's signature, correct?

DR. SCARMATO: We still have to

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do some due diligence. We have an application in. We are going to have emergency clearance and get him in early next week.

MR. MIROTZNIK: We don't want there to be any disruption to the patients.

DR. SCARMATO: We will get him in early next week.

MR. MIROTZNIK: There won't be?

DR. SCARMATO: There will not be.

MS. REED: I understand the urgency right now, but down the road, why are we contracting with North Shore? Why aren't we going out and trying to hire our own doctor?

DR. SCARMATO: We could, but the advantage to doing it with a one-doctor program is our program is not big enough right now the way it is. The other part of the problem is we had no backup for him, so when he is sick, out, or on vacation, there isn't anyone.

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When you go with North Shore LIJ, they can provide you with that backup continuity so God forbid you have a problem like this you are not left like we are left like this. It's hard. We have considered it and it's not that easy a specialty to get people to come in and take over. It's not like the ER where you are getting acute patients.

These are cancer patients whose treatments are long and confusing, so that is the reason why, but we are going to maintain having service and work with them and obviously if the deal is not a good deal, we will not go with North Shore LIJ. This is what I have been doing the last couple of days now.

MS. REED: Do you see that department growing in the future?

DR. SCARMATO: That's the hope. Dr. Carlton has been sick the last few years and I think because of his physical limitations the service really

never did take off the way it could be. It would get off the ground and come back down. I just think he wasn't able to physically handle a larger volume of patients.

MS. REED: So hopefully in the future we will have built up to the degree that we can then hire the full-time person as a backup.

DR. SCARMATO: That is also my hope and as long as we have the right part-time person here we will see how it works out. It is also good because on a special basis to come in, if he works out and is a good fit, we can consider that as well as moving him to full-time.

I think that from the whole standpoint of a service having more than one person this is perfect. When you have one single point of failure, it is very easy to -- this guy is a young guy whose fit. He was out hiking when I got in touch with him, but God

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forbid a tree branch falls on him. So anything can happen to any one of us at any time.

MS. REED: Thank you.

MR. MIROTZNIK: Any other words of encouragement before we move on? Let's hear about some good things.

DR. SCARMATO: We had progress with negotiations with the FQHC and I actually had been talking with David Nemiroff and we were looking to have papers ready to be signed at this point now. Then this morning our outside counsel got a call from their counsel. They will not be able to sign papers for a few weeks and they don't want to take the transfer on January 4th.

So we are moving ahead with moving all the records to the hospital. The staff has already been notified their last day is going to be tomorrow and we are going to be out as of tomorrow. I have calculated the total closing costs. These are the max they

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will be.

MR. MIROTZNIK: Hold on. Christine is here so the negotiations with her people and your team of lawyers has reached an area where they are not able to move it forward until mid-January?

DR. SCARMATO: Right. They are not able to move until mid-January. We are not able to continue until mid-January, so we are going to close and move the records here. If something else happens and they end up taking over what is left of the practice at that point, that is a possibility, but that is something we are moving with the Board's pushing to close.

I won't wait two or three more weeks and there is some other problem. They were waiting for a CON to move the space and some other issues with the lease and rent and stuff. I am not going to get into the details of what

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is happening. We are closing the practice as you wish.

DR. VENDITTO: Have you given patients 30 days' notice?

DR. SCARMATO: We have given patients notice. The letters are going out tomorrow.

DR. VENDITTO: You have to give them 30 days' notice.

DR. SCARMATO: I have to give them reasonable notice or continue their care. We are giving them notice the operation will no longer be there. If they have any problems, or need the records, or want care they should continue at the hospital.

DR. VENDITTO: If they call the practice number now for NMA --

DR. SCARMATO: We are working today to get that number transferred somewhere here at the hospital so someone here will be able to take those calls and follow up with the patients.

MR. ZYSMAN: Rob, legal has

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confirmed that everything that has been done with the closure has been done properly?

MR. MIROTZNIK: The winding down?

MR. TEPPER: Yes.

MR. ZYSMAN: You are comfortable with everything, Rob?

MR. TEPPER: In order to move forward, the key is to get the medical records custodial agreement in place so those reports are available to the patient. The notice goes out and make sure the patients do get their care for a reasonable period of time and get their records without any delay if that is approved and that process is the way it has been planned. I see no problem.

MR. ZYSMAN: This is what Dr. Scarmato is explaining. So you are comfortable?

MR. TEPPER: Yes.

DR. VENDITTO: It has to be 30 days after they receive written notice. I just closed my practice. That's what

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my lawyer had me do.

DR. SCARMATO: I believe our outside counsel said it has to be reasonable notice for follow up.

MS. REED: What is reasonable?

MR. MIROTZNIK: Listen --

DR. VENDITTO: Thirty days.

MR. MIROTZNIK: We have a representation from legal on the record. Any members of the Board have any issue regarding what the representation is from legal?

MS. REED: No, but I do have a concern. You are saying they are going to get notice. They can come over to the hospital and the phone is going to be transferred over to the hospital. Are you dedicating one person who is going to be there everyday from either 8:00 to 4:00 or 9:00 to 5:00 to take those phone calls and make those appointments for these patients?

DR. SCARMATO: I will guarantee someone on a daily basis will get the

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messages for people and get back to them.

MS. REED: In what timeframe? This concerns me. These are people that need care.

DR. VENDITTO: You can't abandon them.

MS. REED: This concerns me.

DR SCARMATO: Within 24 hours. We are not abandoning.

MS. REED: I want to make sure there is a staff member who is going to be taking those phone calls and turnaround is not going to be more than 24 hours so these people get the care that they deserve to get.

DR. VENDITTO: Who is going to be providing their care?

DR. SCARMATO: They will be referred to our clinics here.

DR. VENDITTO: So the NMA doctors are no longer going to see those patients, but if NQP takes over NMA, those NMA doctors are going to continue

to see the patients?

MS. APICELLA: We are in the process.

DR. SCARMATO: That's what we had hoped to do.

DR. VENDITTO: Why wouldn't you in the interim have the NMA docs see them here?

DR. SCARMATO: They are not employees here. I'm not sure that -- that is a whole different ball game. You might want to go to executive session to discuss details like this.

MR. MIROTZNIK: Christine, is there a better process? Let me ask you this: Your Board has made a decision that they want to take over the NMA Assets and the patients, et cetera?

MS. APICELLA: Yes.

MR. MIROTZNIK: Isn't there a better way to facilitate it? I would bet you $100 that this phone number will be a machine and these people aren't going to get called back on a

timely basis.

MR. DELUCA: He is going to call them back.

MR. MIROTZNIK: It's not going to happen.

DR. SCARMATO: Why would you say that?

MR. MIROTZNIK: Do we have a number set up?

DR. SCARMATO: It is going to be the same number we have now.

DR. VENDITTO: What is the date and time for an appointment in the clinic now?

DR. SCARMATO: Which clinic?

DR. VENDITTO: The outpatient clinic is all NMA patients --

DR. SCARMATO: In pediatrics they have open walk-ins for patient care for sick calls.

MS. REED: Judy, can you answer that question?

MS. EISELE-LAPLANTE: Judy Eisele-Laplante, I am part of

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ambulatory administration. We have open access for adult primary care and pediatrics primary care, so should a patient need to be seen that day, they will be seen.

DR. VENDITTO: The NMA patients have been given written notice to that effect?

DR. SCARMATO: The notice is going out.

MR. MIROTZNIK: So that means it didn't go out?

DR. VENDITTO: But you're closing it tomorrow?

DR. SCARMATO: Yes.

MR. MIROTZNIK: Judy, have you had any discussion with anybody two minutes before you just introduced yourself about the process?

MS. EISELE-LAPLANTE: No.

MR. MIROTZNIK: Thank you. That answers it. Chris, what do we do?

MS. APICELLA: The LIFQHC is in the process of speaking with the

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providers. I know we have hired some of the support staff that are already going to go out to, I believe, two of our health centers.

Right now I know we were told that as of the fourth, we do not have any papers signed, custodial agreement, the business agreement. So David Nemiroff has asked our attorney -- the last e-mail I saw was if we can delay the closing for two weeks only because we do not have anything in place.

We are working on trying to hire the providers and I spoke with Stacy Jackson-Harley who is our COO and she was going to contact Joanne and cancel the patients as of this point because we don't have access to the records and that's where we are right now.

MR. MIROTZNIK: This is a terrible disservice to the community and we have talked about this, Dr. Scarmato, for months. Only if Mr. Cohen was here his recollection

would be superb.

DR. SCARMATO: It was one month ago, approximately. You wanted NMA closed down by the end of the year, if I recall correctly.

MR. MIROTZNIK: And certainly notices to have gone out.

DR. SCARMATO: If the plan was to send them to the FQHC, I couldn't send the notice there without them signing an agreement. They have not done that. That was always my plan, to keep the patients in the family, so to speak, and to move them there. That was always the plan. At this point, what else can we do?

DR. VENDITTO: I just went to the website and the information I was given, you have to, at a minimum, give them 30 days' notice, 60 to 90 days is recommended. You have to include an authorization form to transfer the medical records to patients' new provider. You have to give them a form

to fill out and sign.

You're closing a practice. This is what you are legally required to do, otherwise you have abandoned the patients. You have to place a dated copy of the notification in each patients' medical record, proof that you sent them the letter. You are telling me this is going to go out tomorrow?

DR. SCARMATO: Absolutely.

DR. VENDITTO: But it hasn't been done yet. You don't have a letter.

DR. SCARMATO: We do.

DR. VENDITTO: You have this notification letter?

DR. SCARMATO: Yes.

DR. VENDITTO: You have given them a medical records transfer form?

DR. SCARMATO: We have the letters that were prepared by the --

MR. MIROTZNIK: Wait a minute. You were asked a very simple question. It is either yes or no.

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DR. SCARMATO: Yes.

MR. MIROTZNIK: Your letter is out?

DR. SCARMATO: I don't know they are actually out. I know they were being printed today.

MR. MIROTZNIK: It is New Year's Eve tomorrow. It's not happening. The whole thing is a debacle. We have to protect the community.

I have a suggestion. I think we have to fund it for another 30 days. Chris, do you think within the best of your crystal ball, and the knowledge you have, that 30 days will make this transaction happen so there aren't people going without healthcare and there is no health crisis?

MS. APICELLA: The CON in process will take four-to-six weeks. In order to submit a CON we need a signed lease. If we can get the signed lease by the beginning of next week, I believe the landlord will be back from vacation, so

we can work through that.

Once we get a signed lease we can also -- and this also includes the Oceanside office, PNG and NMK.

MR. ZYSMAN: In your best estimation, Christine, it's going to take a few months?

MS. APICELLA: Yes.

MR. ZYSMAN: If we give an extension, Dr. Politi can you oversee this and make sure that notifications and all the things that Dr. Venditto labeled and that Mr. Tepper and the legal staff all make sure that every I is dotted and every T is crossed, to make sure patient care is handled appropriately and the medical records are handled properly?

DR. VENDITTO: I am confused about the proposed transition of care from NMA to LIFQHC because what you just said before was that in this interim period while the charts are transferred here and the patients are

welcomed to come to our patient clinics, they will not be seen by the providers they were seeing at NMA.

So we are breaking that continuity of care. So besides that, you have to give them an option to see another doctor. Are you planning to have, once this transition at FQHC goes through, the NMA providers at FQHC or the existing FQHC practice going to simply absorb the patient volume without the NMA providers?

MS. APICELLA: Our plan was to hire the NMA providers once we have the space because we have no space right now --

DR. VENDITTO: For the healthcare providers?

MS. APICELLA: We were going to use the healthcare providers for an additional space, to take in those patients.

DR. VENDITTO: Christine, in the interim period, the patient volume of

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NMA is admittedly not that great. Can you absorb the patient volume in your existing clinic in the interim period?

MS. APICELLA: In SOC we could.

MR. MIROTZNIK: Now this is all our problem so we have to -- now the Board has to figure out -- let me ask you, Doc. What do you have in front of you, knowing this is problematic on a number of points, specifically continuity for healthcare to the community, what were you going to suggest to us to do? What was your plan?

DR. SCARMATO: My plan was to close it as you wished.

MR. MIROTZNIK: So it is our fault?

DR. SCARMATO: I am not saying it's your fault.

MR. MIROTZNIK: As we wish. So what is the plan then for continuity?

DR. SCARMATO: My original plan was that for three months to work out

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with the FQHC. You wanted it done in one month. I wasn't able to get done.

MR. MIROTZNIK: Nothing got done.

DR. SCARMATO: No, not nothing got done. A lot got done.

MR. MIROTZNIK: You called lawyers?

DR. SCARMATO: We did. We had a lawyer and we had an outside counsel who might be able to speak to some of the issues you brought up.

MS. REED: Who is the outside counsel?

DR. SCARMATO: It's Garfunkel Wild.

MR. MIROTZNIK: What do you suggest just from the professional point of view, because I don't treat patients? What should we do? What is the suggestion to this group?

DR. SCARMATO: If it was two weeks ago, I would have said yes, continue the funding, we should work on this for a while. At this point, we

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have given notice to all of our staff. Some of it --

MR MIROTZNIK: The notice that was given, I heard, was deplorable. I understand no one from this facility even went there to speak to these doctors, and some of them have been practicing, Christine, one of them I know is practicing, what, 50 years pediatrics?

MS. APICELLA: I believe so.

MR. MIROTZNIK: Very upset, but that's your style, but go ahead.

DR. SCARMATO: That's not entirely true.

MR. MIROTZNIK: You never went to the facility.

DR. SCARMATO: No, I have not.

MR. MIROTZNIK: Go ahead.

DR. SCARMATO: I can't say I never did. I was there last week.

MR. MIROTZNIK: Did you tell them what was going on?

DR. SCARMATO: They know exactly

what's going on. Joann Campbell is there every day. She has been the main person over there. I have spent a lot of time. I am in contact. I have e-mailed with some of the doctors there. I have been there and spoken to some of them on the phone.

I have not been there physically every day because I have other issues, radiation therapy, my own department, the rest of the hospital.

DR. VENDITTO: Do we have contract obligations to the physicians?

DR. SCARMATO: We do. We have to give some of them six months' notice, so we will have about a months' notice. We will owe them still five months' worth of time. One of them had severance, which wasn't that much money, about $15,000. There is tail coverage requirements.

MR. MIROTZNIK: You talk about tail coverage requirements. Some doctors were asked today or yesterday

to sign some acknowledgment with PRI insurance that they have no more coverage. One guy in particular, practicing physician for 50-plus years, is scared out of his whits. He said he can't sign anything. He said, God forbid, there's a claim against me, that nobody was giving them tail insurance.

When you came here last month and asked for money, some of the numbers you asked for, you went over the fact they needed tail insurance. Why did they tell these doctors -- the man is ready to have a heart attack that he can't have insurance and he has to sign?

DR. SCARMATO: I don't want to get into the details of the negotiations with the individual doctors. I really don't think this is the place for it.

MR. MIROTZNIK: Is there a tail policy?

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DR. SCARMATO: The coverage hasn't stopped yet and a lot of it depends on what happens with these conditions and where they end up going.

MR. MIROTZNIK: They are supposed to sign something that they had no coverage.

DR. VENDITTO: I wouldn't discontinue the malpractice coverage.

MR. ZYSMAN: Let me propose --

DR. VENDITTO: I think when you discontinue the --

DR. SCARMATO: It is claims made --

DR. VENDITTO: The practice still exists until the custodial agreement is signed and the responsibility for the charts is managed by another entity. Until that time those doctors are still responsible, so you want to close their malpractice. If a claim is made while they were covered --

DR. SCARMATO: I was planning on moving it to the hospital.

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DR. VENDITTO: I am saying you have to watch out because even though you think -- it makes sense logically that you closed the practice. It isn't closed until a custodial agreement is signed and control of the charts becomes someone else's.

DR. SCARMATO: That is absolutely true.

DR. VENDITTO: They are still medically and legally responsible for those patients.

MR. MIROTZNIK: What about the patients? What happens if they get sick over the weekend?

DR. SCARMATO: What would happen any way? We would be closed. They would be told to go to the emergency room.

DR. VENDITTO: You can't do that.

DR. CAPRIOLI: Dr. Venditto is correct. So the letter that goes out to these patients says that within 30 days your care will be terminated.

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At this time if you have an emergency or problem we will still be able to help you for that 30-day period. After that 30-day period we recommend you seek your own physician or go to the following clinics as an outpatient.

So it would be a marketing thing so we don't lose this population here in light of all the clinics you can go to. A lot of people will stay. If you do stay, an incentive is we have your files. If you care to leave, you have to sign this form. So it also incentivizes the people to stay in the system, but if you don't do that, it's abandonment.

DR. SCARMATO: Letters --

MR. MIROTZNIK: Letters are both in English and Spanish, I take it?

DR. SCARMATO: That I am not even 100 percent sure.

MR. MIROTZNIK: Whose planning the winding down? It's not even worked out properly.

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DR. SCARMATO: Outside counsel has worked on all the stuff, has approved everything and has gone over all the stuff.

MR. MIROTZNIK: He approved the letters?

DR. SCARMATO: He wrote the letters.

MR. MIROTZNIK: What about the people that don't read or write English? It's like me getting a letter in Chinese. I don't know how to read it.

DR. SCARMATO: Do you go to a Chinese doctor?

MR. MIROTZNIK: Do I go to a Chinese doctor?

DR. SCARMATO: If you like I will write the letter in Chinese as well --

MR. MIROTZNIK: Point of order, please.

DR. POLITI: Dr. Politi, are you comfortable with the way this is being closed down?

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DR. POLITI: I am not.

MR. ZYSMAN: Will you take responsibility to make sure this is being done properly because I don't have confidence this is being done properly? There is lots of concern coming up and we need you to step up to the plate and make sure this runs properly.

DR. POLITI: I will work together with Mr. Scarmato and legal and Mr. McDonald to make sure this gets taken care of.

MR. ZYSMAN: You will take responsibility to this Board you will do it properly? You are a physician and know all about this stuff.

DR. POLITI: It is kind of little notice with one day left to put this together.

MR. ZYSMAN: I am going to propose we continue funding so you have the funding to do it. The FQHC scenario doesn't really seem like a

logical one at this time for one reason. It sounds like there are a lot of moving targets. They have to get the CON. They have to secure a lease. There are a lot of things that are not in the control of NMA and FQHC, to get this done.

It would be two-to-three months, six months, a year. This Board, I don't think, is prepared to continue funding this ongoing as we have for many years with significant losses.

However, I do think we need to give enough funding to protect the patients who are our primary concern here and it sounds like we need your expertise as well as our CEO and a physician to make sure it's done properly and patients are properly cared for.

There has to be a certain notice that goes out and needs to be something that is reasonable with compliance with the law. There should be efforts to

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communicate with these patients, how to get them here, whatever those things are, I am fully confident you will know how to do it.

You are a very experienced doctor and hospital administrator. I just want to know that you take full responsibility to this Board to make sure this is done properly.

DR. POLITI: My suggestion to go forward with this is to fund it for one month, or whatever the legal amount of time is to send out this notice. If it's 30 days, we need 30 days to send out this notice, as Mr. Mirotznik said, both in English and Spanish.

We also need to make sure we have someone in care of those charts and that we have someone here who is going to be specifically dedicated to that phone number to make sure these patients do not fall through the cracks. That's my suggestion, Mr. Zysman, as the Chairman.

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I will gradually take the lead on this and make sure that we, in the next 30 days, are able to fulfill whatever the legal requirements are. I will call Garfunkel Wild with Mr. Tepper's assistance to find out what we legally have to do, but I think the number one priority in this case, and I think everyone in the room agrees, are those patients.

We are not going to let anything happen to those patients or in any way allow those patients not to receive the care that they deserve. That, Mr. Zysman, you have my word on. I will not abandon these patients.

MR. ZYSMAN: Thank you, Doctor. Dr. Scarmato, how much does it cost to keep this going for a month?

DR. SCARMATO: I don't know. I have to undue a lot of things that have started in motion.

MR. ZYSMAN: What's your payroll cost?

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DR. SCARMATO: I don't know. We have some payroll.

MR. ZYSMAN: I'm asking you what the payroll cost was for this last month.

DR. SCARMATO: It's strange because I paid out vacation stuff and other stuff that I otherwise wouldn't have had to pay off.

MR. MIROTZNIK: Hold on. When we were here a month ago you never said to us there is a CON issue. How did --

DR. SCARMATO: I didn't know about it.

MR. MIROTZNIK: Who would know about it?

DR. SCARMATO: The FQHC. It came up in the negotiations with them.

MR. MIROTZNIK: How do you not know? You're a principal in the corporation.

DR. VENDITTO: The only reason there is a CON issue is because you need to occupy the space upstairs as an

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FQC, but if they come into our space downstairs there is no issue.

So can we temporarily move them in, and if you need more space we get the CON and then they move back downstairs? But in the interim --

MS. APICELLA: If the patients go to SOC and the providers are hired by us, they can be seen in SOC. The issue is space. All of our exam rooms are occupied at SOC. So if the patients are going to NMA, we can't physically take them downstairs.

DR. VENDITTO: We are talking a small volume of patients here. What are the number of charts?

DR. SCARMATO: We did about 6,500 visits last year.

DR. VENDITTO: How many active charts?

DR. SCARMATO: I don't know.

DR. VENDITTO: You don't know how many active charts in the practice?

DR. SCARMATO: We did 6,500

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visits. I don't know how many patients that is.

DR. VENDITTO: How many letters do you have? How many stamps did you buy?

DR. SCARMATO: We haven't bought all the stamps yet, but I think it is about 3,000.

DR. VENDITTO: So you only see each patient twice?

DR. SCARMATO: Something like that.

DR. VENDITTO: So all the hours and whatnot probably could absorb that in an interim period until you get the CON and you can work on a better scale?

DR. SCARMATO: I wanted to get the --

DR. VENDITTO: You can hire the docs, that doesn't take long. There is a continuity of care. The patient goes downstairs instead of upstairs. This could happen, I think, in a smoother transition. You don't even need a

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custodial agreement because the same providers are coming over to the same entity and being hired.

MR. ZYSMAN: Christine, will FQHC do that without the process that you have?

MS. APICELLA: They could, but I would have to defer to operations.

MR. ZYSMAN: At is that point in the negotiations, they haven't decided to do that?

MS. APICELLA: No, because we are still waiting for --

DR. VENDITTO: That is not a formal plan.

MR. ZYSMAN: Off the record.

(A discussion was held off the record.)

MR. ZYSMAN: I'm being told that the Board, you're working within our timeframes, so if you are going to legally represent that everything is proper even after all the stuff, then go ahead and do it on the record or

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don't do it all.

If you don't represent this Board and this Board's interest and you are not going to give us advice and you're going to dump things on us that we have been unbelievably lenient with, agreeable, we have extended millions of dollars toward this program at the advice and guidance of the leadership here, it's really not a fair position to put us in.

MR. TEPPER: I am more than comfortable speaking on the record. What I'm not comfortable doing is giving you privileged advice on the record because you owe a duty to yourselves and everybody else not to do those types of things on the record.

What I will say in response to that is I believe the meeting took place early in the week of Thanksgiving, and the directive was to have notices out by the end of the week, and there was limited funding

given and that was not practical.

I had some off the record conversation about that and I talked about it off the record and it has been brought up in meetings since that time that we have been doing everything we can to make this closing happen in 30 days. That was very clear and that's what Dr. Scarmato is doing.

I am fully aware of the legal framework for this transaction. We are using an excellent partner at Garfunkel Wild and the doctors are correct, more time would be much preferred. This is something that would be better off done an in extended period of time in an orderly fashion. We're working the best we can. Dr. Scarmato and the NMA team are.

I don't want to negotiate this deal that is not a deal at this time on the record in a public board meeting. There has been ongoing discussions with lawyers from both sides. It's not a

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complex deal. It's a business deal that both sides have to agree to.

MR. ZYSMAN: I want to put forward a motion. The motion is for Dr. Politi to take full lead and responsibility on this with the assistance of whomever he deems necessary, legal, medical, and otherwise, to ensure that this program is closed safely and properly and comports with all laws and standards of care in this area.

We call upon Dr. Politi as the CEO of this hospital and a physician with significant experience and I ask that we fund NMA for 45 days, the calculation I hope someone here can give me because I did not get a coherent answer before.

DR. VENDITTO: Just do two months.

MR. ZYSMAN: Sixty days and that FQHC, it seems like there has been an impasse and you haven't been able to

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reach a deal. So let's be clear. However it's going to be done with the standard of care and the lawyers, the patients should come to the clinics here at the hospital.

DR. VENDITTO: After 60 days?

MR. ZYSMAN: You have 60 days to figure it out, but the plan shouldn't be that FQHC has 1,000 moving targets that are out of their control and out of our control. The plan should be to close it within 60 days as long as that closure comports with laws, standards of care and we want you to take full responsibility for making sure this gets done, because this wasn't something that was just discussed in November. This has been something that was discussed for months, maybe even years.

DR. VENDITTO: September was the three month --

MR. MIROTZNIK: Off the record.

(A discussion was held off the

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record.)

MR. MIROTZNIK: I make a motion to adjourn to executive session? All in favor? Unanimous. Sorry, everyone.

(A discussion was held off the record.)

MR. MIROTZNIK: Back on the record. Make a motion to adjourn executive session of the Board? Unanimous. Not everyone stayed. We have a motion. We spent an enormous amount of time on item number eight with NMA. We heard from Dr. Scarmato and Dr. Politi and we have a motion on behalf of the Board.

It will be articulated as follows: I propose a resolution to fund NMA for their winding down under the direction and control of Dr. Victor Politi, our CEO, and the winding down process to comport with all laws and regulations, and continuous standard of care for all patients of NMA for up to 60 days, not

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to exceed $250,000 with the assistance of our Chief Medical Officer, but under the direction and control as aforementioned by Dr. Victor Politi. All in favor of the motion? Second, Mr. Zysman. Unanimous. Thank you.

John, that's funded now so please. Dr. Mustacchia, last words on this. I know you undertook an executive session. Dr. Politi's request for tomorrow is for you to sojourn over to NMA and to speak with the doctors, the ones that are there, the ones that are not there you are going to call and let them know what the bottom line is about their work, about what they can expect, about what Dr. Politi will offer them, where they can hang their hats, so to speak.

Make sure everything is running properly there and report back to Dr. Politi; is that fair?

DR. MUSTACCHIA: Yes, I shall tomorrow.

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MR. ZYSMAN: One more comment. Before we ask for information from you, Rob, related to an opinion, just going forward, the privilege is on us. We are privileged by your representation of us. If we ask you to put your representation of us on the record, I expect you to do that going forward.

If there is some reason you are concerned about it, please state that to us, but if we still feel it needs to be on the record, we would expect you to put that on the record.

MR. TEPPER: If that's the Board's wishes and you feel strongly about that, I would honor those wishes. I would ask at least have the discussion off the record first so you hear the advice and make that decision. As has happened many times here, it is very difficult for me to, in a public session, to convey what you need to hear.

MR. ZYSMAN: As we always have,

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we will continue to always give you that option, but if it's something that needs to be on the record, we put it on the record.

MR. TEPPER: I don't have a problem with that.

MR. MIROTZNIK: Thank you, Mr. Tepper. I think we had a consensus. We are going to call off the lawyers. Dr. Politi, we are calling off the lawyers on this program?

DR. POLITI: Can you please speak to them first and see what they have accomplished? Give me some time to discuss with them where they are and what they are at with Mr. Alfano's guidance.

MR. ALFANO: This is very reasonable, I think.

MR. MIROTZNIK: To be under your guidance or be patient?

MR. ALFANO: To meet with and discuss this with our outside counsel

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who have done a lot of work on this already.

MR. ZYSMAN: Can we cap it?

DR. POLITI: Mr. Alfano, can we cap it?

MR. ALFANO: It's not in our general arrangement with them.

MR. TEPPER: It's part of a larger contract.

MR. ZYSMAN: We were told that the bill of this is a significant bill in relation to the transaction. We don't want this to be where you tell us it has gone sufficiently above. If you guys need it for discussion, fine, but if it's going to be extensive, greater than $5,000, you let us know.

DR. CAPRIOLI: Why is Dr. Venditto's information more accurate than that of the attorneys? That's what I would like to know, and they are getting paid.

DR. VENDITTO: I closed my practice in September.

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MR. MIROTZNIK: Motion to adjourn? I wish everybody happy holidays and healthy holidays. God bless.

(TIME NOTED: 8:20 p.m.)

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MOTIONS

CERTIFICATION

I, ANGELA ARENA, a Notary Public in and for the State of New York, do hereby certify:

THAT the foregoing is a true and accurate transcript of my stenographic notes.

IN WITNESS WHEREOF, I have hereunto set my hand this 30th day of December, 2015.

ANGELA ARENA