THE ERIE COUNTY LEGISLATURE

HEALTH & HUMAN SERVICES COMMITTEE

Lisa M. Chimera
Chair

John J. Gilmour
Vice-Chair

Meeting No. 5 – April 22, 2021 – 2:30 PM

			TAB	R&F	APP
1.	**INTRO. 10-9 (2020)** Session 10	**LORIGO** *"Calling on Administration to Provide Statistics on Active COVID-19 Infections in EC"*			
2.	**COMM. 3E-4 (2021)** Session 3	**LORIGO, GREENE, TODARO & MILLS** *"Letter Requesting In-Person Legislative Sessions & Committee Meetings"*			
3.	**INTRO. 4-3 As Amended (2021)** Session 4	**BASKIN, MEYERS, HARDWICK, JOHNSON, CHIMERA, GILMOUR & VINAL** *"Supporting Our Vulnerable Senior Citizens in Long-Term Care and Nursing Homes and Calling for a State Inquiry into COVID Nursing Home Deaths"*			
4.	**INTRO. 6-4 (2021)** Session 6	**GREENE** *"Calling for the ECDoH to Reduce the Six Foot Distancing Guidelines to Help Get Students Back in School"*			

			TAB	R&F	APP
5.	**COMM. 6M-7 (2021)** Session 6	**WORLD HEALTH ORGANIZATION** *"A How-To-Guide for Physical Distancing"*			
6.	**COMM. 6M-8 (2021)** Session 6	**INFECTIOUS DISEASES SOCIETY OF AMERICA** *"Information Regarding Metrics of Physical Distancing"*			
7.	**INTRO. 8-5 (2021)** Session 8	**GILMOUR** *"Expressing Support for the Re-Examination of Social Distancing Guidelines in Schools by NYS"*			
8.	**COMM. 8E-12 (2021)** Session 8	**COMPTROLLER** *"Letter to Commissioner of Social Services Regarding COMM. 3E-9 (2021)"*			
9.	**COMM. 8E-34 (2021)** Session 8	**COUNTY EXECUTIVE** *"Extension of Home Care Services Contracts"*			
10.	**COMM. 8D-1 (2021)** Session 8	**COMMISSIONER OF HEALTH** *"Updated Nursing Home Outbreak Information - 3/20/2021"*			
11.	**COMM. 8D-3 (2021)** Session 8	**DIRECTOR OF BUDGET & MANAGEMENT** *"Notification of New COVID-19 Related Contracts"*			
12.	**COMM. 8D-5 (2021)** Session 8	**COMMISSIONER OF SOCIAL SERVICES** *"Child Protective Caseloads for 02/2021"*			

			TAB	R&F	APP
13.	COMM. 8D-6 (2021) Session 8	**COMMISSIONER OF HEALTH** *"Updated Nursing Home Outbreak Information - 3/27/2021"*			
14.	COMM. 8D-7 (2021) Session 8	**DIRECTOR OF BUDGET & MANAGEMENT** *"Notification of New COVID-19 Related Contracts"*			
15.	COMM. 8D-9 (2021) Session 8	**DEPARTMENT OF LAW** *"Local Emergency Order Extensions"*			
16.	COMM. 8M-5 (2021) Session 8	**ECCSAB** *"Letter to Governor Urging Prioritization of Incarcerated People for COVID-19 Vaccine Distribution"*			
17.	COMM. 8M-6 (2021) Session 8	**NYS ATTORNEY GENERAL'S OFFICE** *"Report Titled, "Nursing Home Response to COVID-19 Pandemic""*			
18.	COMM. 8M-14 (2021) Session 8	**ECMCC** *"2020 Annual Report of ECMCC"*			

SUSPENSION

A RESOLUTION TO BE SUBMITTED BY
LEGISLATOR LORIGO

Re: Calling on the Administration to Provide Statistics on Active COVID-19 Infection in Erie County

WHEREAS, as of May 6th, COVID-19 related infection statistics, as published on Erie County's COVID-19 heat map, showed 3,939 confirmed cases, 323 deaths, with 20,734 residents being tested; and

WHEREAS, this information is a cumulative tally of infected persons since the middle of March; and

WHEREAS, what this cumulative record does not show is the number of residents who have tested positive for COVID-19 but are no longer active cases nor does it show the number of active cases of residents who need ventilator assistance, though the latter is reported during daily press conferences with the Executive; and

WHEREAS, the CDC provides guidelines for infection control that assume a 7-10 day period of isolation from the date a first positive test for residents not under hospital care; and

WHEREAS, inferring numbers of active cases should be avoided when making policy decisions, especially if better information is available as to spread and severity; and

WHEREAS, it is a finding of this body that clarity is vital to helping residents cope with the lock-down requirements and that the total number of active cases is needed to provide that clarity and to allow the Legislature to create appropriate policy; and

WHEREAS, New York State has set criteria for re-opening regional economies. Failure to accurately depict our active numbers of cases might inhibit our opportunity for a timely re-open as well and should be avoided.

NOW, THEREFORE, BE IT

RESOLVED, that this honorable body hereby requests that the County Executive and his administration provide residents with a tally of active infection in the community and the number of residents currently requiring the use of a ventilator on the county's COVID through Erie County's interactive heat map; and, be it further

SUSPENSION

RESOLVED, that certified copies of this Resolution be sent to the Erie County Executive Mark Poloncarz, the Commissioner of the Department of Health, and any other party deemed necessary and proper.

Fiscal Impact: None for resolution

ERIE COUNTY LEGISLATURE

92 Franklin Street
Buffalo, New York 14202

January 28, 2021

Hon. April N.M. Baskin
Erie County Legislature, Chairwoman
92 Franklin Street, Fourth Floor
Buffalo, New York 14202

RE: In-Person Legislative Sessions & Committee Meetings

Dear Chairwoman Baskin,

We are writing to request that the Erie County Legislature return to in-person meetings in our Chambers in Old County Hall. We believe it is imperative to do so in order to handle the People's Business properly. While we acknowledge the fact that Covid-19 remains a presence in our community, we also acknowledge that our region is heading in the right direction in terms of testing and controlling the spread of the virus. Recently, Governor Andrew Cuomo removed the Micro-Cluster Zone Designations that burdened so many in our community with restrictions. He did this out of recognition that our region is managing the virus sufficiently.

We also recognize the difficulty that every single member of the Legislature has encountered while participating in official meetings. This is not the fault of any individual Legislator, but it is indisputable that someone experiences technical difficulties during each meeting that could easily be avoided if we return to in-person meetings.

The Legislature is meant to be a deliberative body, and the evidence is clear that proper deliberation is done best in person. Our Legislative Chamber is large and can easily accommodate proper social distancing. We would be happy to work with you and your colleagues to develop a plan that allows for proper debate in person. We are confident that together we can figure this out.

Sincerely,

Joseph C. Lorigo
Minority Leader, District 10

Christopher D. Greene
Legislator, District 6

Frank J. Todaro
Legislator, District 8

John J. Mills
Legislator, District 11

A RESOLUTION SUBMITTED BY BASKIN, MEYERS, HARDWICK, JOHNSON, CHIMERA, GILMOUR & VINAL

Supporting Our Vulnerable Senior Citizens in Long-Term Care and Nursing Homes and Calling for a State Inquiry into COVID Nursing Home Deaths

WHEREAS, the care of our most vulnerable persons is one of the government's most important functions, and our senior citizens residing in nursing homes, long term care facilities and skilled nursing facilities are amongst the most-vulnerable persons during the COVID pandemic; and

WHEREAS, our seniors deserve the most compassionate care possible in their golden years, particularly for those who are confined to nursing facilities and who are not ambulatory or who cannot leave those congregate settings; and

WHEREAS, as of February 4, 2021, in 2020 and 2021, Erie County lost 621 people who died in nursing homes whose deaths were confirmed as caused by COVID-19, and lost 211 people who died in nursing homes whose deaths are presumed to be of COVID-19 and lost 9 people who were nursing home residents whose deaths were confirmed as COVID-19 but who died in the hospital, and lost 6 people who died at adult care facilities in Erie County whose deaths were confirmed and we mourn those losses; and

WHEREAS, the New York State Department of Health issued a comprehensive report in July 2020 (revised on February 11, 2021), entitled "Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global Health Crisis," indicated, among other things, that infected staff without symptoms accounted for the bulk of the spread as during the peak in mortality in nursing homes in 2020 it was not known that people without symptoms were contagious; and

WHEREAS, the Office of the New York State Attorney General recently issued a report which was critical of the care provided by nursing home operators across New York during the COVID pandemic, finding allegations of patient neglect and other concerning conduct that may have jeopardized the health and safety of residents and employees such as lack of compliance with infection control protocols; and

WHEREAS, the State Attorney General also found that a large number of people who died in the hospital of COVID had been nursing home residents at the time they contracted COVID-19 and were reported as hospital deaths and were not published as related to a nursing home; and

WHEREAS, a court order that prompted the release of new numbers from the State concerning the COVID deaths in nursing and related long-term care facilities, recently increased the state's long-term care COVID-19 death toll from about 8,500 to around 15,000 when including presumed and confirmed cases, when previously presumed but not confirmed cases

were excluded from the number of deaths released daily by the State and such exclusion was so noted in the daily figures released; and

WHEREAS, some State Legislators are now calling for hearings and inquiries by the State Assembly and State Senate concerning the COVID reporting discrepancy, as well as the care and preventive measures utilized by nursing home operators to protect their residents and staff.

NOW, THEREFORE, BE IT

RESOLVED, that the Erie County Legislature expresses its support for a State inquiry into the measures undertaken by nursing homes, long term care facilities and skilled nursing facilities to address COVID-19, including preventive measures to protect residents and staff; and be it further

RESOLVED, that the Erie County Legislature requests the New York State Department of Health provide this Honorable Body and the residents of Erie County the results of said State inquiry into the measures undertaken by nursing homes long term care facilities and skilled nursing facilities to address COVID-19, including preventive measures to protect residents and staff, as soon as possible to promote transparency, decrease confusion, decrease worry, and allow for informed decision making and informed consent for patients, residents, and their family members; and be it further

RESOLVED, that this Honorable Body declares our support for the health and wellbeing of senior citizens as evidenced in our 2017 passage of Ruthie's Law to help protect seniors; and be it further

RESOLVED, that this honorable body finds the deliberate actions of Governor Andrew Cuomo to conceal and lie about nursing home COVID death statistics to the public and federal authorities, as admitted by Secretary to the Governor Melissa DeRosa, to be deeply concerning and hereby supports an in-depth federal investigation; and be it further

RESOLVED, that said investigation should include a full review of the measures undertaken by Governor Andrew Cuomo and his executive staff relating to their handling of COVID-19 infected persons sent to nursing homes, and the effects of that deadly decision; and be it further

RESOLVED, that certified copies of this resolution to be transmitted to the Governor, State Health Commissioner and the local New York State Legislature delegation.

A RESOLUTION TO BE SUBMITTED BY
LEGISLATOR GREENE

Re: Calling for the Erie County Health Department to Reduce the Six Foot Distancing Guidelines to Help Get Students Back in School

WHEREAS, Erie County's students have been attending school in some virtual learning capacity since March of last year; and

WHEREAS, virtual learning has been very difficult on students, parents, and teachers; and

WHEREAS, many students have struggled with the new form of learning, especially the younger students who have not yet developed the ability to focus on one task for several continuous hours; and

WHEREAS, parents are having to work from home, when possible, while simultaneously caring their children. Those that do not have the ability to work from home have been forced to send their children to virtual learning centers, often at tremendous personal expense; and

WHEREAS, further, our teachers have been forced to work from a distance making it difficult, if not impossible, to teach individual students; especially younger students who do not have the attention span to sit in front of a computer for hours on end; and

WHEREAS, many children have been without peer-level social interaction for the better part of a year. The lack of social interact is proving to be tremendously detrimental to their mental well-being, raising concerns of an increase in adolescent suicide; and

WHEREAS, the current guidelines require all people, including students, to maintain six feet of separation between each other at all times. This distance makes it very difficult and expensive to physically bring students back into the classroom; and

WHEREAS, the County Executive has stated that Erie County is "following the CDC standard, the New York State Department of Health standard" but has not taken a position on changing that standard to meet more recent medical opinions that three feet is sufficient for students in school; and

WHEREAS, with proper precautions, including temperature checks, required hand washing, and masking, some school districts, including here in New York, are finding it possible to decrease the social distancing requirements and allow children to come back to school safely; and

WHEREAS, Onondaga County's health department has made the decision to allow schools to reopen with only three feet of social distancing space, which is the normal spacing

between desks. This change would allow all students to be able to return to class on a full time basis. Erie County's Health department should review the available data and, if possible, revise their current guidance.

NOW, THEREFORE, BE IT

RESOLVED, that this honorable body recognizes the importance of in-person attendance for thousands of students here in Erie County; and, be it further

RESOLVED, that this honorable body places a high priority on the physical and mental health and wellbeing of Erie County's teachers, students, and parents; and, be it further

RESOLVED, that this honorable body hereby urges the Erie County Health Department to review the six foot social distancing rule and the feasibility of decreasing the guidelines to three feet for the purpose of returning students to school; and, be it further

RESOLVED, that certified copies of this resolution be forwarded to the Commissioner of the Erie County Health Department, the Erie County Executive, and any other party deemed necessary and proper.

Fiscal Impact: None

A HOW-TO GUIDE FOR PHYSICAL DISTANCING

Shaking hands and hugging are common greetings but now is the time to try out some of these:

Wave Bow Nod

Keep a distance of at least 1m from others and **#BreakTheChain of #COVID19 transmission.**

World Health Organization
Western Pacific Region

What to do to keep yourself and others safe from COVID-19

- **Maintain at least a 1-metre distance between yourself and others** to reduce your risk of infection when they cough, sneeze or speak. Maintain an even greater distance between yourself and others when indoors. The further away, the better.
- **Make wearing a mask a normal part of being around other people. The appropriate use, storage and cleaning or disposal are essential to make masks as effective as possible.**

Here are the basics of how to wear a mask:

- Clean your hands before you put your mask on, as well as before and after you take it off, and after you touch it at any time.
- Make sure it covers both your nose, mouth and chin.
- When you take off a mask, store it in a clean plastic bag, and every day either wash it if it's a fabric mask, or dispose of a medical mask in a trash bin.
- Don't use masks with valves.

- *For specifics on what type of mask to wear and when, read our Q&A and watch our videos. There is also a Q&A focused on masks and children.*
- *Find out more about the science of how COVID-19 infects people and our bodies react by watching or reading this interview.*
- *For specific advice for decision makers, see WHO's technical guidance.*

Mask use in the context of COVID-19

Interim guidance

1 December 2020

World Health Organization

This document, which is an update of the guidance published on 5 June 2020, includes new scientific evidence relevant to the use of masks for reducing the spread of SARS-CoV-2, the virus that causes COVID-19, and practical considerations. It contains updated evidence and guidance on the following:

- mask management;
- SARS-CoV-2 transmission;
- masking in health facilities in areas with community, cluster and sporadic transmission;
- mask use by the public in areas with community and cluster transmission;
- alternatives to non-medical masks for the public;
- exhalation valves on respirators and non-medical masks;
- mask use during vigorous intensity physical activity;
- essential parameters to be considered when manufacturing non-medical masks (Annex).

Key points

- The World Health Organization (WHO) advises the use of masks as part of a comprehensive package of prevention and control measures to limit the spread of SARS-CoV-2, the virus that causes COVID-19. A mask alone, even when it is used correctly, is insufficient to provide adequate protection or source control. Other infection prevention and control (IPC) measures include hand hygiene, physical distancing of at least 1 metre, avoidance of touching one's face, respiratory etiquette, adequate ventilation in indoor settings, testing, contact tracing, quarantine and isolation. Together these measures are critical to prevent human-to-human transmission of SARS-CoV-2.
- Depending on the type, masks can be used either for protection of healthy persons or to prevent onward transmission (source control).
- WHO continues to advise that anyone suspected or confirmed of having COVID-19 or awaiting viral laboratory test results should wear a medical mask when in the presence of others (this does not apply to those awaiting a test prior to travel).
- For any mask type, appropriate use, storage and cleaning or disposal are essential to ensure that they are as effective as possible and to avoid an increased transmission risk.

Mask use in health care settings

- WHO continues to recommend that health workers (1) providing care to suspected or confirmed COVID-19 patients wear the following types of mask/respirator in addition to other personal protective equipment that are part of standard, droplet and contact precautions:
  - medical mask in the absence of aerosol generating procedures (AGPs)
  - respirator, N95 or FFP2 or FFP3 standards, or equivalent in care settings for COVID-19 patients where AGPs are performed; these may be used by health workers when providing care to COVID-19 patients in other settings if they are widely available and if costs is not an issue.
- In areas of known or suspected community or cluster SARS-CoV-2 transmission WHO advises the following:
  - universal masking for all persons (staff, patients, visitors, service providers and others) within the health facility (including primary, secondary and tertiary care levels; outpatient care; and long-term care facilities)
  - wearing of masks by inpatients when physical distancing of at least 1 metre cannot be maintained or when patients are outside of their care areas.
- In areas of known or suspected sporadic SARS-CoV-2 transmission, health workers working in clinical areas where patients are present should continuously wear a medical mask. This is known as targeted continuous medical masking for health workers in clinical areas;
- Exhalation valves on respirators are discouraged as they bypass the filtration function for exhaled air by the wearer.

Mask use in community settings

- Decision makers should apply a risk-based approach when considering the use of masks for the general public.
- In areas of known or suspected community or cluster SARS-CoV-2 transmission:
  - WHO advises that the general public should wear a non-medical mask in indoor (e.g. shops, shared workplaces, schools - see Table 2 for details) or outdoor settings where physical distancing of at least 1 metre cannot be maintained.
  - If indoors, unless ventilation has been be assessed to be adequate[1], WHO advises that the general public should wear a non-medical mask, regardless of whether physical distancing of at least 1 metre can be maintained.

[1] For adequate ventilation refer to regional or national institutions or heating, refrigerating and air-conditioning societies enacting ventilation requirements. If not available or applicable, a recommended ventilation rate of 10 l/s/person should be met (except healthcare facilities which have specific requirements). For more information consult "Coronavirus (COVID-19) response

  - Individuals/people with higher risk of severe complications from COVID-19 (individuals ≥ 60 years old and those with underlying conditions such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease or immunosuppression) should wear medical masks when physical distancing of at least 1 metre cannot be maintained.
- In any transmission scenarios:
  - Caregivers or those sharing living space with people with suspected or confirmed COVID-19, regardless of symptoms, should wear a medical mask when in the same room.

Mask use in children (2)

- Children aged up to five years should not wear masks for source control.
- For children between six and 11 years of age, a risk-based approach should be applied to the decision to use a mask; factors to be considered in the risk-based approach include intensity of SARS-CoV-2 transmission, child's capacity to comply with the appropriate use of masks and availability of appropriate adult supervision, local social and cultural environment, and specific settings such as households with elderly relatives, or schools.
- Mask use in children and adolescents 12 years or older should follow the same principles as for adults.
- Special considerations are required for immunocompromised children or for paediatric patients with cystic fibrosis or certain other diseases (e.g., cancer), as well as for children of any age with developmental disorders, disabilities or other specific health conditions that might interfere with mask wearing.

Manufacturing of non-medical (fabric) masks (Annex)

- Homemade fabric masks of three-layer structure (based on the fabric used) are advised, with each layer providing a function: 1) an innermost layer of a hydrophilic material 2) an outermost layer made of hydrophobic material 3) a middle hydrophobic layer which has been shown to enhance filtration or retain droplets.
- Factory-made fabric masks should meet the minimum thresholds related to three essential parameters: filtration, breathability and fit.
- Exhalation valves are discouraged because they bypass the filtration function of the fabric mask rendering it unserviceable for source control.

Methodology for developing the guidance

Guidance and recommendations included in this document are based on published WHO guidelines (in particular the WHO Guidelines on infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care) (2) and ongoing evaluations of all available scientific evidence by the WHO ad hoc COVID-19 Infection Prevention and Control Guidance Development Group (COVID-19 IPC GDG) (see acknowledgement section for list of GDG members). During emergencies WHO publishes interim guidance, the development of which follows a transparent and robust process of evaluation of the available evidence on benefits and harms. This evidence is evaluated through expedited systematic reviews and expert consensus-building through weekly GDG consultations, facilitated by a methodologist and, when necessary, followed up by surveys. This process also considers, as much as possible, potential resource implications, values and preferences, feasibility, equity, and ethics. Draft guidance documents are reviewed by an external review panel of experts prior to publication.

Purpose of the guidance

This document provides guidance for decision makers, public health and IPC professionals, health care managers and health workers in health care settings (including long-term care and residential), for the public and for manufactures of non-medical masks (Annex). It will be revised as new evidence emerges.

WHO has also developed comprehensive guidance on IPC strategies for health care settings (3), long-term care facilities (LTCF) (4), and home care (5).

Background

The use of masks is part of a comprehensive package of prevention and control measures that can limit the spread of certain respiratory viral diseases, including COVID-19. Masks can be used for protection of healthy persons (worn to protect oneself when in contact with an infected individual) or for source control (worn by an infected individual to prevent onward transmission) or both.

However, the use of a mask alone, even when correctly used (see below), is insufficient to provide an adequate level of protection for an uninfected individual or prevent onward transmission from an infected individual (source control). Hand hygiene, physical distancing of at least 1 metre, respiratory etiquette, adequate ventilation in indoor settings, testing, contact tracing, quarantine, isolation and other infection prevention and control (IPC) measures are critical to prevent human-to-human transmission of SARS-CoV-2, whether or not masks are used (6).

Mask management

For any type of mask, appropriate use, storage and cleaning, or disposal are essential to ensure that they are as effective as possible and to avoid any increased risk of transmission. Adherence to correct mask management practices varies, reinforcing the need for appropriate messaging (7).

WHO provides the following guidance on the correct use of masks:

- Perform hand hygiene before putting on the mask.
- Inspect the mask for tears or holes, and do not use a damaged mask.
- Place the mask carefully, ensuring it covers the mouth and nose, adjust to the nose bridge and tie it securely to minimize any gaps between the face and the mask. If using ear loops, ensure these do not cross over as this widens the gap between the face and the mask.

resources from ASHRAE and others''
https://www.ashrae.org/technical-resources/resources

- Avoid touching the mask while wearing it. If the mask is accidently touched, perform hand hygiene.
- Remove the mask using the appropriate technique. Do not touch the front of the mask, but rather untie it from behind.
- Replace the mask as soon as it becomes damp with a new clean, dry mask.
- Either discard the mask or place it in a clean plastic resealable bag where it is kept until it can be washed and cleaned. Do not store the mask around the arm or wrist or pull it down to rest around the chin or neck.
- Perform hand hygiene immediately afterward discarding a mask.
- Do not re-use single-use mask.
- Discard single-use masks after each use and properly dispose of them immediately upon removal.
- Do not remove the mask to speak.
- Do not share your mask with others.
- Wash fabric masks in soap or detergent and preferably hot water (at least 60° Centigrade/140° Fahrenheit) at least once a day. If it is not possible to wash the masks in hot water, then wash the mask in soap/detergent and room temperature water, followed by boiling the mask for 1 minute.

Scientific evidence

Transmission of the SARS-CoV-2 virus

Knowledge about transmission of the SARS-CoV-2 virus is evolving continuously as new evidence accumulates. COVID-19 is primarily a respiratory disease, and the clinical spectrum can range from no symptoms to severe acute respiratory illness, sepsis with organ dysfunction and death.

According to available evidence, SARS-CoV-2 mainly spreads between people when an infected person is in close contact with another person. Transmissibility of the virus depends on the amount of viable virus being shed and expelled by a person, the type of contact they have with others, the setting and what IPC measures are in place. The virus can spread from an infected person's mouth or nose in small liquid particles when the person coughs, sneezes, sings, breathes heavily or talks. These liquid particles are different sizes, ranging from larger 'respiratory droplets' to smaller 'aerosols.' Close-range contact (typically within 1 metre) can result in inhalation of, or inoculation with, the virus through the mouth, nose or eyes (8-13).

There is limited evidence of transmission through fomites (objects or materials that may be contaminated with viable virus, such as utensils and furniture or in health care settings a stethoscope or thermometer) in the immediate environment around the infected person (14-17). Nonetheless, fomite transmission is considered a possible mode of transmission for SARS-CoV-2, given consistent finding of environmental contamination in the vicinity of people infected with SARS-CoV-2 and the fact that other coronaviruses and respiratory viruses can be transmitted this way (12).

Aerosol transmission can occur in specific situations in which procedures that generate aerosols are performed. The scientific community has been actively researching whether the SARS-CoV-2 virus might also spread through aerosol transmission in the absence of aerosol generating procedures (AGPs) (18, 19). Some studies that performed air sampling in clinical settings where AGPs were not performed found virus RNA, but others did not. The presence of viral RNA is not the same as replication- and infection-competent (viable) virus that could be transmissible and capable of sufficient inoculum to initiate invasive infection. A limited number of studies have isolated viable SARS-CoV-2 from air samples in the vicinity of COVID-19 patients (20, 21).

Outside of medical facilities, in addition to droplet and fomite transmission, aerosol transmission can occur in specific settings and circumstances, particularly in indoor, crowded and inadequately ventilated spaces, where infected persons spend long periods of time with others. Studies have suggested these can include restaurants, choir practices, fitness classes, nightclubs, offices and places of worship (12).

High quality research is required to address the knowledge gaps related to modes of transmission, infectious dose and settings in which transmission can be amplified. Currently, studies are underway to better understand the conditions in which aerosol transmission or superspreading events may occur.

Current evidence suggests that people infected with SARS-CoV-2 can transmit the virus whether they have symptoms or not. However, data from viral shedding studies suggest that infected individuals have highest viral loads just before or around the time they develop symptoms and during the first 5-7 days of illness (12). Among symptomatic patients, the duration of infectious virus shedding has been estimated at 8 days from the onset of symptoms (22-24) for patients with mild disease, and longer for severely ill patients (12). The period of infectiousness is shorter than the duration of detectable RNA shedding, which can last many weeks (17).

The incubation period for COVID-19, which is the time between exposure to the virus and symptom onset, is on average 5-6 days, but can be as long as 14 days (25, 26).

Pre-symptomatic transmission – from people who are infected and shedding virus but have not yet developed symptoms – can occur. Available data suggest that some people who have been exposed to the virus can test positive for SARS-CoV-2 via polymerase chain reaction (PCR) testing 1-3 days before they develop symptoms (27). People who develop symptoms appear to have high viral loads on or just prior to the day of symptom onset, relative to later on in their infection (28).

Asymptomatic transmission – transmission from people infected with SARS-CoV-2 who never develop symptoms – can occur. One systematic review of 79 studies found that 20% (17–25%) of people remained asymptomatic throughout the course of infection. (28). Another systematic review, which included 13 studies considered to be at low risk of bias, estimated that 17% of cases remain asymptomatic (14%–20%) (30). Viable virus has been isolated from specimens of pre-symptomatic and asymptomatic individuals, suggesting that people who do not have symptoms may be able to transmit the virus to others. (25, 29-37)

Studies suggest that asymptomatically infected individuals are less likely to transmit the virus than those who develop symptoms (29). A systematic review concluded that individuals who are asymptomatic are responsible for transmitting fewer infections than symptomatic and pre-symptomatic cases (38). One meta-analysis estimated that there is a 42% lower relative risk of asymptomatic transmission compared to symptomatic transmission (30).

Guidance on mask use in health care settings

Masks for use in health care settings

Medical masks are defined as surgical or procedure masks that are flat or pleated. They are affixed to the head with straps that go around the ears or head or both. Their performance characteristics are tested according to a set of standardized test methods (ASTM F2100, EN 14683, or equivalent) that aim to balance high filtration, adequate breathability and optionally, fluid penetration resistance (39, 40).

Filtering facepiece respirators (FFR), or respirators, offer a balance of filtration and breathability. However, whereas medical masks filter 3 micrometre droplets, respirators must filter more challenging 0.075 micrometre solid particles. European FFRs, according to standard EN 149, at FFP2 performance there is filtration of at least 94% solid NaCl particles and oil droplets. US N95 FFRs, according to NIOSH 42 CFR Part 84, filter at least 95% NaCl particles. Certified FFRs must also ensure unhindered breathing with maximum resistance during inhalation and exhalation. Another important difference between FFRs and other masks is the way filtration is tested. Medical mask filtration tests are performed on a cross-section of the masks, whereas FFRs are tested for filtration across the entire surface. Therefore, the layers of the filtration material and the FFR shape, which ensure the outer edges of the FFR seal around wearer's face, result in guaranteed filtration as claimed. Medical masks, by contrast, have an open shape and potentially leaking structure. Other FFR performance requirements include being within specified parameters for maximum CO_2 build up, total inward leakage and tensile strength of straps (41, 42).

A. Guidance on the use of medical masks and respirators to provide care to suspected or confirmed COVID-19 cases

Evidence on the use of mask in health care settings

Systematic reviews have reported that the use of N95/P2 respirators compared with the use of medical masks (see mask definitions, above) is not associated with statistically significant differences for the outcomes of health workers acquiring clinical respiratory illness, influenza-like illness (risk ratio 0.83, 95%CI 0.63-1.08) or laboratory-confirmed influenza (risk ratio 1.02, 95%CI 0.73-1.43); harms were poorly reported and limited to discomfort associated with lower compliance (43, 44). In many settings, preserving the supply of N95 respirators for high-risk, aerosol-generating procedures is an important consideration (45).

A systematic review of observational studies on the betacoronaviruses that cause severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS) and COVID-19 found that the use of face protection (including respirators and medical masks) is associated with reduced risk of infection among health workers. These studies suggested that N95 or similar respirators might be associated with greater reduction in risk than medical or 12–16-layer cotton masks. However, these studies had important limitations (recall bias, limited information about the situations when respirators were used and limited ability to measure exposures), and very few studies included in the review evaluated the transmission risk of COVID-19 (46). Most of the studies were conducted in settings in which AGPs were performed or other high-risk settings (e.g., intensive care units or where there was exposure to infected patients and health workers were not wearing adequate PPE).

WHO continues to evaluate the evidence on the effectiveness of the use of different masks and their potential harms, risks and disadvantages, as well as their combination with hand hygiene, physical distancing of at least 1 metre and other IPC measures.

Guidance

WHO's guidance on the type of respiratory protection to be worn by health workers providing care to COVID-19 patients is based on 1) WHO recommendations on IPC for epidemic- and pandemic-prone acute respiratory infections in health care (47); 2) updated systematic reviews of randomized controlled trials on the effectiveness of medical masks compared to that of respirators for reducing the risk of clinical respiratory illness, influenza-like illness (ILI) and laboratory-confirmed influenza or viral infections. WHO guidance in this area is aligned with guidelines of other professional organizations, including the European Society of Intensive Care Medicine and the Society of Critical Care Medicine, and the Infectious Diseases Society of America (48, 49).

The WHO COVID-19 IPC GDG considered all available evidence on the modes of transmission of SARS-CoV-2 and on the effectiveness of medical mask versus respirator use to protect health workers from infection and the potential for harms such as skin conditions or breathing difficulties.

Other considerations included availability of medical masks versus respirators, cost and procurement implications and equity of access by health workers across different settings.

The majority (71%) of the GDG members confirmed their support for previous recommendations issued by WHO on 5 June 2020:

1. In the absence of aerosol generating procedures (AGPs)[2], WHO recommends that health workers providing care to patients with suspected or confirmed COVID-19 should wear a medical mask (in addition to other PPE that are part of droplet and contact precautions).
2. In care settings for COVID-19 patients where AGPs are performed, WHO recommends that health workers should wear a respirator (N95 or FFP2 or FFP3 standard, or equivalent) in addition to other PPE that are part of airborne and contact precautions.

In general, health workers have strong preferences about having the highest perceived protection possible to prevent COVID-19 infection and therefore may place high value on the potential benefits of respirators in settings without AGPs. WHO recommends respirators primarily for settings where AGPs are performed; however, if health workers prefer them and they are sufficiently available and cost is not an issue, they could also be used during care for COVID-19 patients in other settings. For additional guidance on PPE, including PPE

[2] The WHO list of AGPs includes tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual ventilation before intubation, bronchoscopy, sputum induction using nebulized hypertonic saline, and dentistry and autopsy procedures.

beyond mask use by health workers, see WHO IPC guidance during health care when COVID-19 infection is suspected (3) and also WHO guidance on the rational use of PPE (45).

Exhalation valves on respirators are discouraged as they bypass the filtration function for exhaled air.

B. Guidance on the use of mask by health workers, caregivers and others based on transmission scenario

Definitions

Universal masking in health facilities is defined as the requirement for all persons (staff, patients, visitors, service providers and others) to wear a mask at all times except for when eating or drinking.

Targeted continuous medical mask use is defined as the practice of wearing a medical mask by all health workers and caregivers working in clinical areas during all routine activities throughout the entire shift.

Health workers are all people primarily engaged in actions with the primary intent of enhancing health. Examples are: nursing and midwifery professionals, doctors, cleaners, other staff who work in health facilities, social workers, and community health workers.

Evidence on universal masking in health care settings

In areas where there is community transmission or large-scale outbreaks of COVID-19, universal masking has been adopted in many hospitals to reduce the potential of transmission by health workers to patients, to other staff and anyone else entering the facility (50).

Two studies found that implementation of a universal masking policy in hospital systems was associated with decreased risk of healthcare-acquired SARS-CoV-2 infection. However, these studies had serious limitations: both were before-after studies describing a single example of a phenomenon before and after an event of interest, with no concurrent control group, and other infection control measures were not controlled for (51, 52). In addition, observed decreases in health worker infections occurred too quickly to be attributable to the universal masking policy.

Guidance

Although more research on universal masking in heath settings is needed, it is the expert opinion of the majority (79%) of WHO COVID-19 IPC GDG members that universal masking is advisable in geographic settings where there is known or suspected community or cluster transmission of the SARS-CoV-2 virus.

1. In areas of known or suspected community or cluster SARS-CoV-2 transmission, universal masking should be advised in all health facilities (see Table 1).

- All health workers, including community health workers and caregivers, should wear a medical mask at all times, for any activity (care of COVID-19 or non-COVID-19 patients) and in any common area (e.g., cafeteria, staff rooms).
- Other staff, visitors, outpatients and service providers should also wear a mask (medical or non-medical) at all times
- Inpatients are not required to wear a mask (medical or non-medical) unless physical distancing of at least 1 metre cannot be maintained (e.g., when being examined or visited at the bedside) or when outside of their care area (e.g., when being transported).
- Masks should be changed when they become soiled, wet or damaged or if the health worker/caregiver removes the mask (e.g., for eating or drinking or caring for a patient who requires droplet/contact precautions for reasons other than COVID-19).

2. In the context of known or suspected sporadic SARS-CoV-2 virus transmission, WHO provides the following guidance:

- Health workers, including community health workers and caregivers who work in clinical areas, should continuously wear a medical mask during routine activities throughout the entire shift, apart from when eating and drinking and changing their medical masks after caring for a patient who requires droplet/contact precautions for other reasons. In all cases, medical masks must be changed when wet, soiled, or damaged; used medical masks should be properly disposed of at the end of the shift; and new clean ones should be used for the next shift or when medical masks are changed.
- It is particularly important to adopt the continuous use of masks in potentially high transmission risk settings including triage, family physician/general practitioner offices; outpatient departments; emergency rooms; COVID-19 designated units; haematology, oncology and transplant units; and long-term health and residential facilities.
- Staff who do not work in clinical areas (e.g., administrative staff) do not need to wear a medical mask during routine activities if they have no exposure to patients.

Whether using masks for universal masking within health facilities or targeted continuous medical mask use throughout the entire shift, health workers should ensure the following:

- Medical mask use should be combined with other measures including frequent hand hygiene and physical distancing among health workers in shared and crowded places such as cafeterias, break rooms, and dressing rooms.
- The medical mask should be changed when wet, soiled, or damaged.
- The medical mask should not be touched to adjust it or if displaced from the face for any reason. If this happens, the mask should be safely removed and replaced, and hand hygiene performed.
- The medical mask (as well as other personal protective equipment) should be discarded and changed after caring for any patient who requires contact/droplet precautions for other pathogens, followed by hand hygiene.
- Under no circumstances should medical masks be shared between health workers or between others wearing them. Masks should be appropriately disposed of whenever removed and not reused.

- A particulate respirator at least as protective as a United States of America (US) National Institute for Occupational Safety and Health-certified N95, N99, US Food and Drug Administration surgical N95, European Union standard FFP2 or FFP3, or equivalent, should be worn in settings for COVID-19 patients where AGPs are performed (see WHO recommendations below). In these settings, this includes continuous use by health workers throughout the entire shift, when this policy is implemented.

Note: Decision makers may consider the transmission intensity in the catchment area of the health facility or community setting and the feasibility of implementing a universal masking policy compared to a policy based on assessed or presumed exposure risk. Decisions need to take into account procurement, sustainability and costs of the policy. When planning masks for all health workers, long-term availability of adequate medical masks (and when applicable, respirators) for all workers should be ensured, in particular for those providing care for patients with confirmed or suspected COVID-19. Proper use and adequate waste management should be ensured.

The potential harms and risks of mask and respirator use in the health facility setting include:

- contamination of the mask due to its manipulation by contaminated hands (53, 54);
- potential self-contamination that can occur if medical masks are not changed when wet, soiled or damaged; or by frequent touching/adjusting when worn for prolonged periods (55);
- possible development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours (56-58);
- discomfort, facial temperature changes and headaches from mask wearing (44, 59, 60);
- false sense of security leading potentially to reduced adherence to well recognized preventive measures such as physical distancing and hand hygiene; and risk-taking behaviours (61-64);
- difficulty wearing a mask in hot and humid environments
- possible risk of stock depletion due to widespread use in the context of universal masking and targeted continuous mask use and consequent scarcity or unavailability for health workers caring for COVID 19 patients and during health care interactions with non-COVID-19 patients where medical masks or respirators might be required.

Alternatives to medical masks in health care settings

The WHO's disease commodity package (DCP) for COVID-19 recommends medical masks for health workers to be type II or higher (65). Type II medical masks provide a physical barrier to fluids and particulate materials and have bacterial filtration efficiency of ≥98% compared to Type I mask, which has bacterial filtration efficiency of ≥95% and lower fluid resistance (66) In case of stock outs of type II or higher medical masks, health workers should use a type I medical mask as an alternative. Other alternatives such as face shields or fabric masks should be carefully evaluated.

Face shields are designed to provide protection from splashes of biological fluid (particularly respiratory secretions), chemical agents and debris (67, 68) into the eyes. In the context of protection from SARS-CoV-2 transmission through respiratory droplets, face shields are used by health workers as personal protective equipment (PPE) for eye protection in combination with a medical mask or a respirator (69, 70) While a face shield may confer partial protection of the facial area against respiratory droplets, these and smaller droplets may come into contact with mucous membranes or with the eyes from the open gaps between the visor and the face (71,67).

Fabric masks are not regulated as protective masks or part of the PPE directive. They vary in quality and are not subject to mandatory testing or common standards and as such are not considered an appropriate alternative to medical masks for protection of health workers. One study that evaluated the use of cloth masks in a health care facility found that health care workers using 2 ply cotton cloth masks (a type of fabric mask) were at increased risk of influenza-like illness compared with those who wore medical masks (72).

In the context of severe medical mask shortage, face shields alone or in combination with fabric mask may be considered as a last resort (73). Ensure proper design of face shields to cover the sides of the face and below the chin.

As for other PPE items, if production of fabric masks for use in health care settings is proposed locally in situations of shortage or stock out, a local authority should assess the product according to specific minimum performance standards and required technical specifications (see Annex).

Additional considerations for community care settings

Like other health workers, community health workers should apply standard precautions for all patients at all times, with particular emphasis regarding hand and respiratory hygiene, surface and environmental cleaning and disinfection and the appropriate use of PPE. When a patient is suspected or confirmed of having COVID-19, community health workers should always apply contact and droplet precautions. These include the use of a medical mask, gown, gloves and eye protection (74).

IPC measures that are needed will depend on the local COVID-19 transmission dynamics and the type of contact required by the health care activity (see Table 1). The community health workforce should ensure that patients and workforce members apply precautionary measures such as respiratory hygiene and physical distancing of at least 1 metre (3.3 feet). They also may support set-up and maintenance of hand hygiene stations and community education (74). In the context of known or suspected community or cluster transmission, community health workers should wear a medical mask when providing essential routine services (see Table 1).

Table 1. Mask use in health care settings depending on transmission scenario, target population, setting, activity and type*

Transmission scenario	Target population (who)	Setting (where)	Activity (what)	Mask type (which one) *
Known or suspected community or cluster transmission of SARS-CoV-2	Health workers and caregivers	Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)	For any activity in patient-care areas (COVID-19 or non-COVID-19 patients) or in any common areas (e.g., cafeteria, staff rooms)	Medical mask (or respirator if aerosol generating procedures performed)
	Other staff, patients, visitors, service suppliers		For any activity or in any common area	Medical or fabric mask
	Inpatients	In single or multiple-bed rooms	When physical distance of at least 1 metre cannot be maintained	
	Health workers and caregivers	Home visit (for example, for antenatal or postnatal care, or for a chronic condition)	When in direct contact with a patient or when a distance of at least 1 metre cannot be maintained.	Medical mask
		Community	Community outreach programmes/essential routine services	
Known or suspected sporadic transmission of SARS-CoV-2 cases	Health workers and caregivers	Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)	In patient care area- irrespective of whether patients have suspected/confirmed COVID-19	Medical mask
	Other staff, patients, visitors, service suppliers and all others		No routine activities in patient areas	Medical mask not required. Medical mask should be worn if in contact or within 1 metre of patients, or according to local risk assessment
	Health workers and caregivers	Home visit (for example, for antenatal or postnatal care, or for a chronic condition)	When in direct contact or when a distance of at least 1metre cannot be maintained.	Medical mask
		Community	Community outreach programs (e.g., bed net distribution)	
No documented SARS-CoV-2 transmission	Health workers and caregivers	Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)	Providing any patient care	Medical mask use according to standard and transmission-based precautions
		Community	Community outreach programs	
Any transmission scenario	Health workers	Health care facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities), in settings where aerosol generating procedures (AGP) are performed	Performing an AGP on a suspected or confirmed COVID-19 patient or providing care in a setting where AGPs are in place for COVID-19 patients	Respirator (N95 or N99 or FFP2 or FFP3)

**This table refers only to the use of medical masks and respirators. The use of medical masks and respirators may need to be combined with other personal protective equipment and other measures as appropriate, and always with hand hygiene.*

Guidance on mask use in community settings

Evidence on the protective effect of mask use in community settings

At present there is only limited and inconsistent scientific evidence to support the effectiveness of masking of healthy people in the community to prevent infection with respiratory viruses, including SARS-CoV-2 (75). A large randomized community-based trial in which 4862 healthy participants were divided into a group wearing medical/surgical masks and a control group found no difference in infection with SARS-CoV-2 (76). A recent systematic review found nine trials (of which eight were cluster-randomized controlled trials in which clusters of people, versus individuals, were randomized) comparing medical/surgical masks versus no masks to prevent the spread of viral respiratory illness. Two trials were with healthcare workers and seven in the community. The review concluded that wearing a mask may make little or no difference to the prevention of influenza-like illness (ILI) (RR 0.99, 95%CI 0.82 to 1.18) or laboratory confirmed illness (LCI) (RR 0.91, 95%CI 0.66-1.26) (44); the certainty of the evidence was low for ILI, moderate for LCI.

By contrast, a small retrospective cohort study from Beijing found that mask use by entire families before the first family member developed COVID-19 symptoms was 79% effective in reducing transmission (OR 0.21, 0.06-0.79) (77). A case-control study from Thailand found that wearing a medical or non-medical mask all the time during contact with a COVID-19 patient was associated with a 77% lower risk of infection (aOR 0.23; 95% CI 0.09–0.60) (78). Several small observational studies with epidemiological data have reported an association between mask use by an infected person and prevention of onward transmission of SARS-CoV-2 infection in public settings. (8, 79-81).

A number of studies, some peer reviewed (82-86) but most published as pre-prints (87-104), reported a decline in the COVID-19 cases associated with face mask usage by the public, using country- or region-level data. One study reported an association between community mask wearing policy adoption and increased movement (less time at home, increased visits to commercial locations) (105). These studies differed in setting, data sources and statistical methods and have important limitations to consider (106), notably the lack of information about actual exposure risk among individuals, adherence to mask wearing and the enforcement of other preventive measures (107, 108).

Studies of influenza, influenza-like illness and human coronaviruses (not including COVID-19) provide evidence that the use of a medical mask can prevent the spread of infectious droplets from a symptomatic infected person to someone else and potential contamination of the environment by these droplets (75). There is limited evidence that wearing a medical mask may be beneficial for preventing transmission between healthy individuals sharing households with a sick person or among attendees of mass gatherings (44, 109-114).

A meta-analysis of observational studies on infections due to betacoronaviruses, with the intrinsic biases of observational data, showed that the use of either disposable medical masks or reusable 12–16-layer cotton masks was associated with protection of healthy individuals within households and among contacts of cases (46). This could be considered to be indirect evidence for the use of masks (medical or other) by healthy individuals in the wider community; however, these studies suggest that such individuals would need to be in close proximity to an infected person in a household or at a mass gathering where physical distancing cannot be achieved to become infected with the virus. Results from cluster randomized controlled trials on the use of masks among young adults living in university residences in the United States of America indicate that face masks may reduce the rate of influenza-like illness but showed no impact on risk of laboratory-confirmed influenza (115, 116).

Guidance

The WHO COVID-19 IPC GDG considered all available evidence on the use of masks by the general public including effectiveness, level of certainty and other potential benefits and harms, with respect to transmission scenarios, indoor versus outdoor settings, physical distancing and ventilation. Despite the limited evidence of protective efficacy of mask wearing in community settings, in addition to all other recommended preventive measures, the GDG advised mask wearing in the following settings:

1. In areas with known or suspected community or cluster transmission of SARS-CoV-2, WHO advises mask use by the public in the following situations (see Table 2):

   Indoor settings:

- in public indoor settings where ventilation is known to be poor regardless of physical distancing: limited or no opening of windows and doors for natural ventilation; ventilation system is not properly functioning or maintained; or cannot be assessed;
- in public indoor settings that have adequate[3] ventilation if physical distancing of at least 1 metre cannot be maintained;
- in household indoor settings: when there is a visitor who is not a household member and ventilation is known to be poor, with limited opening of windows and doors for natural ventilation, or the ventilation system cannot be assessed or is not properly functioning, regardless of whether physical distancing of at least 1 metre can be maintained;
- in household indoor settings that have adequate ventilation if physical distancing of at least 1 metre cannot be maintained.

[3] For adequate ventilation refer to regional or national institutions or heating, refrigerating and air-conditioning societies enacting ventilation requirements. If not available or applicable, a recommended ventilation rate of 10 l/s/person should be met (except healthcare facilities which have specific requirements). For more information consult "Coronavirus (COVID-19) response resources from ASHRAE and others" https://www.ashrae.org/technical-resources/resources

Table 2. Mask use in community settings depending on transmission scenario, setting, target population, purpose and type*

Transmission scenario	Situations/settings (where)	Target Population (who)	Purpose of mask use (why)	Mask type (which one)
Known or suspected community or cluster transmission of SARS-CoV-2	Indoor settings, where ventilation is known to be poor or cannot be assessed or the ventilation system is not properly maintained, regardless of whether physical distancing of at least 1 meter can be maintained	General population in public* settings such as shops, shared workplaces, schools, churches, restaurants, gyms, etc. or in enclosed settings such as public transportation. For households, in indoor settings, when there is a visitor who is not a member of the household	Potential benefit for source control	Fabric mask
	Indoor settings that have adequate [4] ventilation if physical distancing of at least 1 metre cannot be maintained			
	Outdoor settings where physical distancing cannot be maintained	General population in settings such as crowded open-air markets, lining up outside a building, during demonstrations, etc.		
	Settings where physical distancing cannot be maintained, and the individual is at increased risk of infection and/or negative outcomes	Individuals/people with higher risk of severe complications from COVID-19: • People aged ≥60 years • People with underlying comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease, immunosuppression, obesity, asthma	Protection	Medical mask
Known or suspected sporadic transmission, or no documented SARS-CoV-2 transmission	Risk-based approach	General population	Potential benefit for source control and/or protection	Depends on purpose (see details in the guidance content)
Any transmission scenario	Any setting in the community	Anyone suspected or confirmed of having COVID-19, regardless of whether they have symptoms or not, or anyone awaiting viral test results, when in the presence of others	Source control	Medical mask

**Public indoor setting includes any indoor setting outside of the household*

[4] For adequate ventilation refer to regional or national institutions or heating, refrigerating and air-conditioning societies enacting ventilation requirements. If not available or applicable, a recommended ventilation rate of 10l/s/person should be met (except healthcare facilities which have specific requirements).). For more information consult "Coronavirus (COVID-19) response resources from ASHRAE and others'' https://www.ashrae.org/technical-resources/resources

In outdoor settings:

- where physical distancing of at least 1 metre cannot be maintained;
- individuals/people with higher risk of severe complications from COVID-19 (individuals ≥ 60 years old and those with underlying conditions such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease or immunosuppression) should wear medical masks in any setting where physical distance cannot be maintained.

2. In areas with known or suspected sporadic transmission or no documented transmission, as in all transmission scenarios, WHO continues to advise that decision makers should apply a risk-based approach focusing on the following criteria when considering the use of masks for the public:

- **Purpose of mask use**. Is the intention source control (preventing an infected person from transmitting the virus to others) or protection (preventing a healthy wearer from the infection)?
- **Risk of exposure to SARS-CoV-2**. Based on the epidemiology and intensity of transmission in the population, is there transmission and limited or no capacity to implement other containment measures such as contact tracing, ability to carry out testing and isolate and care for suspected and confirmed cases? Is there risk to individuals working in close contact with the public (e.g., social workers, personal support workers, teachers, cashiers)?
- **Vulnerability of the mask wearer/population**. Is the mask wearer at risk of severe complications from COVID-19? Medical masks should be used by older people (≥ 60 years old), immunocompromised patients and people with comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer and cerebrovascular disease (117).
- **Setting in which the population lives**. Is there high population density (such as in refugee camps, camp-like settings, and among people living in cramped conditions) and settings where individuals are unable to keep a physical distance of at least 1 metre (for example, on public transportation)?
- **Feasibility**. Are masks available at an affordable cost? Do people have access to clean water to wash fabric masks, and can the targeted population tolerate possible adverse effects of wearing a mask?
- **Type of mask**. Does the use of medical masks in the community divert this critical resource from the health workers and others who need them the most? In settings where medical masks are in short supply, **stocks should be prioritized for health workers and at-risk individuals.**

The decision of governments and local jurisdictions whether to recommend or make mandatory the use of masks should be based on the above assessment as well as the local context, culture, availability of masks and resources required.

3. In any transmission scenario:

- Persons with any symptoms suggestive of COVID-19 should wear a medical mask and (5) additionally:
  - self-isolate and seek medical advice as soon as they start to feel unwell with potential symptoms of COVID-19, even if symptoms are mild);
  - follow instructions on how to put on, take off, and dispose of medical masks and perform hand hygiene (118);
  - follow all additional measures, in particular respiratory hygiene, frequent hand hygiene and maintaining physical distance of at least 1 metre from other persons (46). If a medical mask is not available for individuals with suspected or confirmed COVID-19, a fabric mask meeting the specifications in the Annex of this document should be worn by patients as a source control measure, pending access to a medical mask. The use of a non-medical mask can minimize the projection of respiratory droplets from the user (119, 120).
  - Asymptomatic persons who test positive for SARS-CoV-2, should wear a medical mask when with others for a period of 10 days after testing positive.

Potential benefits/harms

The potential advantages of mask use by healthy people in the general public include:

- reduced spread of respiratory droplets containing infectious viral particles, including from infected persons before they develop symptoms (121);
- reduced potential for stigmatization and greater of acceptance of mask wearing, whether to prevent infecting others or by people caring for COVID-19 patients in non-clinical settings (122);
- making people feel they can play a role in contributing to stopping spread of the virus;
- encouraging concurrent transmission prevention behaviours such as hand hygiene and not touching the eyes, nose and mouth (123-125);
- preventing transmission of other respiratory illnesses like tuberculosis and influenza and reducing the burden of those diseases during the pandemic (126).

The potential disadvantages of mask use by healthy people in the general public include:

- headache and/or breathing difficulties, depending on type of mask used (55);
- development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours (58, 59, 127);
- difficulty with communicating clearly, especially for persons who are deaf or have poor hearing or use lip reading (128, 129);
- discomfort (44, 55, 59)
- a false sense of security leading to potentially lower adherence to other critical preventive measures such as physical distancing and hand hygiene (105);
- poor compliance with mask wearing, in particular by young children (111, 130-132);
- waste management issues; improper mask disposal leading to increased litter in public places and environmental hazards (133);
- disadvantages for or difficulty wearing masks, especially for children, developmentally challenged persons, those with mental illness, persons with cognitive impairment, those with asthma or chronic respiratory or breathing problems, those who have had facial trauma or recent oral maxillofacial surgery and those living in hot and humid environments (55, 130).

Considerations for implementation

When implementing mask policies for the public, decision-makers should:

- clearly communicate the purpose of wearing a mask, including when, where, how and what type of mask should be worn; explain what wearing a mask may achieve and what it will not achieve; and communicate clearly that this is one part of a package of measures along with hand hygiene, physical distancing, respiratory etiquette, adequate ventilation in indoor settings and other measures that are all necessary and all reinforce each other;
- inform/train people on when and how to use masks appropriately and safely (see mask management and maintenance sections);
- consider the feasibility of use, supply/access issues (cleaning, storage), waste management, sustainability, social and psychological acceptance (of both wearing and not wearing different types of masks in different contexts);
- continue gathering scientific data and evidence on the effectiveness of mask use (including different types of masks) in non-health care settings;
- evaluate the impact (positive, neutral or negative) of using masks in the general population (including behavioural and social sciences) through good quality research.

Mask use during physical activity

Evidence

There are limited studies on the benefits and harms of wearing medical masks, respirators and non-medical masks while exercising. Several studies have demonstrated statistically significant deleterious effects on various cardiopulmonary physiologic parameters during mild to moderate exercise in healthy subjects and in those with underlying respiratory diseases (134-140). The most significant impacts have been consistently associated with the use of respirators and in persons with underlying obstructive airway pulmonary diseases such as asthma and chronic obstructive pulmonary disease (COPD), especially when the condition is moderate to severe (136). Facial microclimate changes with increased temperature, humidity and perceptions of dyspnoea were also reported in some studies on the use of masks during exercise (134, 141). A recent review found negligeable evidence of negative effects of mask use during exercise but noted concern for individuals with severe cardiopulmonary disease (142).

Guidance

WHO advises that people should not wear masks during vigorous intensity physical activity (143) because masks may reduce the ability to breathe comfortably. The most important preventive measure is to maintain physical distancing of at least 1 meter and ensure good ventilation when exercising.

If the activity takes place indoors, adequate ventilation should be ensured at all times through natural ventilation or a properly functioning or maintained ventilation system (144). Particular attention should be paid to cleaning and disinfection of the environment, especially high-touch surfaces. If all the above measures cannot be ensured, consider temporary closure of public indoor exercise facilities (e.g., gyms).

Face shields for the general public

At present, face shields are considered to provide a level of eye protection only and should not be considered as an equivalent to masks with respect to respiratory droplet protection and/or source control. Current laboratory testing standards only assess face shields for their ability to provide eye protection from chemical splashes (145).

In the context of non-availability or difficulties wearing a non-medical mask (in persons with cognitive, respiratory or hearing impairments, for example), face shields may be considered as an alternative, noting that they are inferior to masks with respect to droplet transmission and prevention. If face shields are to be used, ensure proper design to cover the sides of the face and below the chin.

Medical masks for the care of COVID-19 patients at home

WHO provides guidance on how to care for patients with confirmed and suspected COVID-19 at home when care in a health facility or other residential setting is not possible (5).

- Persons with suspected COVID-19 or mild COVID-19 symptoms should wear a medical mask as much as possible, especially when there is no alternative to being in the same room with other people. The mask should be changed at least once daily. Persons who cannot tolerate a medical mask should rigorously apply respiratory hygiene (i.e., cover mouth and nose with a disposable paper tissue when coughing or sneezing and dispose of it immediately after use or use a bent elbow procedure and then perform hand hygiene).
- Caregivers of or those sharing living space with people with suspected COVID-19 or with mild COVID-19 symptoms should wear a medical mask when in the same room as the affected person.

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Acknowledgments

This document was developed based on advice by the Strategic and Technical Advisory Group for Infectious Hazards (STAG-IH), and in consultation with the following members of:

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WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 1 year after the date of publication.

Annex: Updated guidance on non-medical (fabric) masks

Background

A non-medical mask, also called fabric mask, community mask or face covering, is neither a medical device nor personal protective equipment. Non-medical masks are aimed at the general population, primarily for protecting others from exhaled virus-containing droplets emitted by the mask wearer. They are not regulated by local health authorities or occupational health associations, nor is it required for manufacturers to comply with guidelines established by standards organizations. Non-medical masks may be homemade or manufactured. The essential performance parameters include good breathability, filtration of droplets originating from the wearer, and a snug fit covering the nose and mouth. Exhalation valves on masks are discouraged as they bypass the filtration function of the mask.

Non-medical masks are made from a variety of woven and non-woven fabrics, such as woven cotton, cotton/synthetic blends, polyesters and breathable spunbond polypropylene, for example. They may be made of different combinations of fabrics, layering sequences and available in diverse shapes. Currently, more is known about common household fabrics and combinations to make non-medical masks with target filtration efficiency and breathability (119, 146-150). Few of these fabrics and combinations have been systematically evaluated and there is no single design, choice of material, layering or shape among available non-medical masks that are considered optimal. While studies have focussed on single fabrics and combinations, few have looked at the shape and universal fit to the wearer. The unlimited combination of available fabrics and materials results in variable filtration and breathability.

In the context of the global shortage of medical masks and PPE, encouraging the public to create their own fabric masks may promote individual enterprise and community integration. Moreover, the production of non-medical masks may offer a source of income for those able to manufacture masks within their communities. Fabric masks can also be a form of cultural expression, encouraging public acceptance of protection measures in general. The safe re-use of fabric masks will also reduce costs and waste and contribute to sustainability (151-156).

This Annex is destined intended for two types of readers: homemade mask makers and factory-made masks manufacturers. Decision makers and managers (national/sub-national level) advising on a type of non-medical mask are also the focus of this guidance and should take into consideration the following features of non-medical masks: breathability, filtration efficiency (FE), or filtration, number and combination of fabric layers material used, shape, coating and maintenance.

Evidence on the effectiveness of non-medical (fabric) masks

A number of reviews have been identified on the effectiveness of non-medical masks (151-156). One systematic review (155) identified 12 studies and evaluated study quality. Ten were laboratory studies (157-166), and two reports were from a single randomized trial (72, 167). The majority of studies were conducted before COVID-19 emerged or used laboratory generated particles to assess filtration efficacy. Overall, the reviews concluded that cloth face masks have limited efficacy in combating viral infection transmission.

Homemade non-medical masks

Homemade non-medical masks made of household fabrics (e.g., cotton, cotton blends and polyesters) should ideally have a three-layer structure, with each layer providing a function (see Figure 1) (168). It should include:

1. an innermost layer (that will be in contact with the face) of a hydrophilic material (e.g., cotton or cotton blends of terry cloth towel, quilting cotton and flannel) that is non-irritating against the skin and can contain droplets (148)
2. a middle hydrophobic layer of synthetic breathable non-woven material (spunbond polypropylene, polyester and polyaramid), which may enhance filtration, prevent permeation of droplets or retain droplets (148, 150)
3. an outermost layer made of hydrophobic material (e.g. spunbond polypropylene, polyester or their blends), which may limit external contamination from penetrating through the layers to the wearer's nose and mouth and maintains and prevents water accumulation from blocking the pores of the fabric (148).

Although a minimum of three layers is recommended for non-medical masks for the most common fabric used, single, double or other layer combinations of advanced materials may be used if they meet performance requirements. It is important to note that with more tightly woven materials, breathability may be reduced as the number of layers increases. A quick check may be performed by attempting to breathe, through the mouth, through the multiple layers.

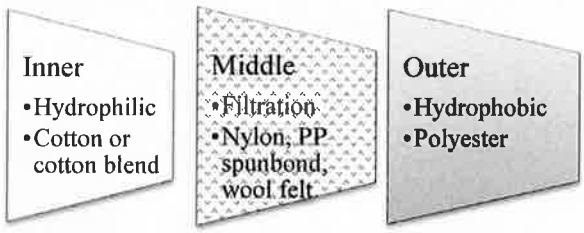

Figure 1. Non-medical mask construction using breathable fabrics such as cotton, cotton blends, polyesters, nylon and polypropylene spunbond that are breathable may impart adequate filtration performance when layered. Single- or double-layer combinations of advanced materials may be used if they meet performance requirements (72).

Assumptions regarding homemade masks are that individual makers only have access to common household fabrics and do not have access to test equipment to confirm target performance (filtration and breathability). Figure 1 illustrates a multi-layer mask construction with examples of fabric options. Very porous materials, such as gauze, even with multiple layers, may provide very low filtration efficiency (147). Higher thread count fabrics offer improved filtration performance (169). Coffee filters, vacuum bags and materials not meant for clothing should be avoided as they may contain injurious content when breathed in. Microporous films such as Gore-Tex are not recommended (170).

Factory-made non-medical masks: general considerations for manufacturers

The non-medical mask, including all components and packaging, must be non-hazardous, non-toxic and child-friendly (no exposed sharp edges, protruding hardware or rough materials). Factory-made non-medical masks must be made using a process that is certified to a quality management system (e.g., ISO 9001). Social accountability standards (e.g., SAI SA8000) for multiple aspects of fair labour practices, health and safety of the work force and adherence to UNICEF's Children's Rights and Business Principles are strongly encouraged.

Standards organizations' performance criteria

Manufacturers producing masks with consistent standardized performance can adhere to published, freely available guidance from several organizations including those from: the French Standardization Association (AFNOR Group), The European Committee for Standardization (CEN), Swiss National COVID-19 Task Force, the American Association of Textile Chemists and Colorists (AATCC), the South Korean Ministry of Food and Drug Safety (MFDS), the Italian Standardization Body (UNI) and the Government of Bangladesh.

Essential parameters

The essential parameters presented in this section are the synthesis of the abovementioned regional and national guidance. They include filtration, breathability and fit. Good performance is achieved when the three essential parameters are optimized at the preferred threshold (Figure 2).

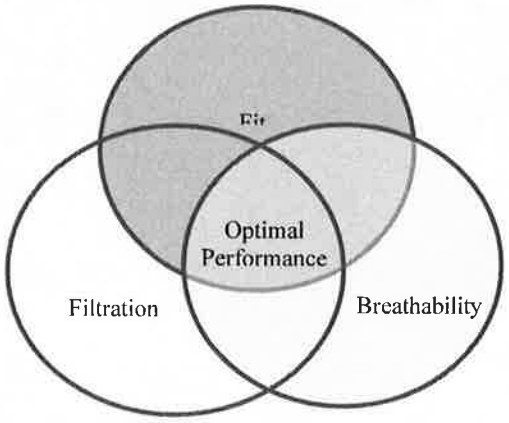

Figure 2. Illustration of the three essential parameters of filtration, breathability and fit.

The summary of the three essential parameters can be found in Table 1 and the additional performance considerations in Table 2. The minimum threshold is the minimum acceptable parameter, while the preferred threshold is the optimum.

Filtration and breathability

Filtration depends on the filtration efficiency (in %), the type of challenge particle (oils, solids, droplets containing bacteria) and the particle size (see Table 1). Depending on the fabrics used, filtration and breathability can complement or work against one another. The selection of material for droplet filtration (barrier) is as important as breathability. Filtration is dependent on the tightness of the weave, fibre or thread diameter. Non-woven materials used for disposable masks are manufactured using processes to create polymer fibres that are thinner than natural fibres such as cotton and that are held together by partial melting.

Breathability is the difference in pressure across the mask and is typically reported in millibars (mbar) or Pascals (Pa) or, normalized to the cm^2 in $mbar/cm^2$ or Pa/cm^2. Acceptable breathability of a medical mask should be below 49 Pa/cm^2. For non-medical masks, an acceptable pressure difference, over the whole mask, should be below 60 Pa/cm^2, with lower values indicating better breathability.

Non-medical fabric masks consisting of two layers of polypropylene spunbond and two layers of cotton have been shown to meet the minimum requirements for droplet filtration and breathability of the CEN CWA 17553 guidance. It is preferable not to select elastic material to make masks as the mask material may be stretched over the face, resulting in increased pore size and lower filtration through multiple usage. Additionally, elastic fabrics are sensitive to washing at high temperatures thus may degrade over time.

Coating the fabric with compounds like wax may increase the barrier and render the mask fluid resistant; however, such coatings may inadvertently completely block the pores and make the mask difficult to breathe through. In addition to decreased breathability unfiltered air may more likely escape the sides of the mask on exhalation. Coating is therefore not recommended.

Valves that let unfiltered air escape the mask are discouraged and are an inappropriate feature for masks used for the purpose of preventing transmission.

Table 1. Essential parameters (minimum and preferred thresholds) for manufactured non-medical mask

Essential Parameters	Minimum threshold	Preferred threshold
1. Filtration*		
1.1. filtration efficiency	70% @ 3 micron	> 70%, without compromising breathability
1.2. Challenge particle	Solid: sodium chloride (NaCl), Talcum powder, Holi powder, dolomite, Polystyrene Latex spheres Liquid: DEHS Di-Ethyl-Hexyl-Sebacat, paraffin oil	Based on availability
1.3. Particle size	Choose either sizes: 3 μm, 1 μm, or smaller	Range of particle sizes
2. Breathability		
2.1. Breathing resistance**	≤60 Pa/cm^2	Adult: ≤ 40 Pa/cm^2 Paediatric: ≤ 20 Pa/cm^2
2.2 Exhalation valves	Not recommended	N/A
3. Fit		
3.1. Coverage	Full coverage of nose and mouth, consistent, snug perimeter fit at the nose bridge, cheeks, chin and lateral sides of the face; adequate surface area to minimize breathing resistance and minimize side leakage	Same as current requirements
3.2 Face seal	Not currently required	Seal as good as FFR (respirator): Fit factor of 100 for N95 Maximum Total Inward Leakage of 25% (FFP1 requirement)
3.2. Sizing	Adult and child	Should cover from the bridge of the nose to below the chin and cheeks on either side of the mouth Sizing for adults and children (3-5, 6-9, 10-12, >12)
3.3Strap strength		> 44.5 N

* Smaller particle may result in lower filtration.
** High resistance can cause bypass of the mask. Unfiltered air will leak out the sides or around the nose if that is the easier path.

Fit: shape and sizing

Fit is the third essential parameter, and takes into consideration coverage, seal, sizing, and strap strength. Fit of masks currently is not defined by any standard except for the anthropometric considerations of facial dimensions (ISO/TS 16976-2) or simplified to height mask (South Korean standard for KF-AD). It is important to ensure that the mask can be held in place comfortably with as little adjustment of the elastic bands or ties as possible.

Mask shapes typically include flat-fold or duckbill and are designed to fit closely over the nose, cheeks and chin of the wearer. Snug fitting designs are suggested as they limit leaks of unfiltered air escaping from the mask (148). Ideally the mask should not have contact with the lips, unless hydrophobic fabrics are used in at least one layer of the mask (148). Leaks where unfiltered air moves in and out of the mask may be attributed to the size and shape of the mask (171).

Additional considerations

Optional parameters to consider in addition to the essential performance parameters include if reusable, biodegradability for disposal masks, antimicrobial performance where applicable and chemical safety (see Table 2).

Non-medical masks intended to be reusable should include instructions for washing and must be washed a minimum of five cycles, implying initial performance is maintained after each wash cycle.

Advanced fabrics may be biodegradable or compostable at the end of service life, according to a recognized standard process (e.g., UNI EN 13432, UNI EN 14995 and UNI / PdR 79).

Manufacturers sometimes claim their NM masks have antimicrobial performance. Antimicrobial performance may be due to coatings or additives to the fabric fibres. Treated fabrics must not come into direct contact with mucous membranes; the innermost fabric should not be treated with antimicrobial additives, only the outermost layer. In addition, antimicrobial fabric standards (e.g., ISO 18184, ISO 20743, AATCC TM100, AATCC 100) are generally slow acting. The inhibition on microbial growth may take full effect after 2- or 24-hour contact time depending on the standard. The standards have generally been used for athletic apparel and substantiate claims of odour control performance. These standards are not appropriate for non-medical cloth masks and may provide a false sense of protection from infectious agents. If claims are maid, manufacturers should specify which standard supports antimicrobial performance, the challenge organism and the contact time.

Volatile additives are discouraged as these may pose a health risk when inhaled repeatedly during wear. Certification according to organizations including OEKO-TEX (Europe) or SEK (Japan), and additives complying with REACH (Europe) or the Environmental Protection Agency (EPA, United States of America) indicate that textile additives are safe and added at safe levels.

Table 2. Additional parameters for manufactured non-medical masks

Additional parameters	Minimum thresholds
If reusable, number of wash cycles	5 cycles
Disposal	Reusable If biodegradable (CFC-BIO), according to UNI EN 13432, UNI EN 14995
Antimicrobial (bacteria, virus, fungus) performance	ISO 18184 (virus) ISO 20743 (bacteria) ISO 13629 (fungus) AATCC TM100 (bacteria)
Chemical safety	Comply with REACH regulation, including inhalation safety

WHO reference number: WHO/2019-nCoV/IPC_Masks/2020.5

Effectiveness of three versus six feet of physical distancing for controlling spread of COVID-19 among primary and secondary students and staff: A retrospective, state-wide cohort study

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Summary: There is no significant difference in K-12 student and staff SARS-CoV-2 case rates in Massachusetts public school districts that implemented ≥3 feet versus ≥6 feet of physical distancing between students, provided other mitigation measures, such as universal masking, are implemented.

Abstract:

Background: National and international guidelines differ about the optimal physical distancing between students for prevention of SARS-CoV-2 transmission; studies directly comparing the impact of ≥3 versus ≥6 feet of physical distancing policies in school settings are lacking. Thus, our objective was to compare incident cases of SARS-CoV-2 in students and staff in Massachusetts public schools among districts with different physical distancing requirements. State guidance mandates masking for all school staff and for students in grades 2 and higher; the majority of districts required universal masking.

Methods: Community incidence rates of SARS-CoV-2, SARS-CoV-2 cases among students in grades K-12 and staff participating in-person learning, and district infection control plans were linked. Incidence rate ratios (IRR) for students and staff members in districts with ≥3 versus ≥6 feet of physical distancing were estimated using log-binomial regression; models adjusted for community incidence are also reported.

Results: Among 251 eligible school districts, 537,336 students and 99,390 staff attended in-person instruction during the 16-week study period, representing 6,400,175 student learning weeks and 1,342,574 staff learning weeks. Student case rates were similar in the 242 districts with ≥3 feet versus ≥6 feet of physical distancing between students (IRR, 0.891, 95% CI, 0.594-1.335); results were similar after adjusting for community incidence (adjusted IRR, 0.904, 95% CI, 0.616-1.325). Cases among school staff in districts with ≥3 feet versus ≥6 feet of physical distancing were also similar (IRR, 1.015, 95% CI, 0.754-1.365).

Conclusions: Lower physical distancing policies can be adopted in school settings with masking mandates without negatively impacting student or staff safety.

Key words: COVID-19, schools, physical distancing, infection control, adaptation

Background:

In March, 2020, as Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) cases were increasing across the United States, schools across the country were closed, and the vast majority stayed closed for the remainder of the school year [1]. This policy decision was based on data adapted from influenza transmission, for which children and schools may be major drivers of pandemics [2]. Since schools were initially closed, new data have emerged suggesting that SARS-CoV-2 transmission in schools is limited, provided mitigation measures are implemented, and that children and schools are not the primary drivers of the pandemic [3–5].

Current guidance from the World Health Organization (WHO) is to maintain 1 meter (3.3 feet) between students while the Centers for Disease Control and Prevention (CDC) recommends students maintain 6 feet of distancing; the American Academy of Pediatrics recommends 3-6 feet [6–8]. However, the evidence for physical distancing to mitigate SARS-CoV-2 transmission in primary and secondary educational settings remains limited. Data from different countries that have implemented different physical distancing guidance in educational settings seem to suggest no major difference between ≥3 feet and ≥6 feet of distancing [9–12], though these studies did not directly compare different distancing requirements. To date, the impact of distancing in school settings has not been directly studied and remains a critical national policy question [13].

Between March and September of 2020, school officials designed plans for how to provide instruction for the 2020-2021 academic year. In June 2020, Massachusetts's Department of Elementary and Secondary Education (DESE) provided initial health and safety guidance for school re-opening to prioritize student return to school buildings in the fall [14]. Schools and districts were required to prepare and submit re-opening plans to the state that addressed district re-opening in three possible learning models (full in-person, hybrid, and remote) and addressed adherence to health and safety requirements including the use of masks/face coverings, physical distancing, grouping students into cohorts to minimize student interaction, utilizing symptom screening of staff and students, hand

hygiene, facilities cleaning, and dedicating isolation space for students displaying possible COVID-19 symptoms. Based on initial DESE guidance, students in grade 2 and above, and all staff were required to wear a mask/face covering in school buildings; districts were permitted to choose to require or recommend universal masking mandates for students in all grades. Schools were encouraged to aim for ≥6 feet of distancing between individuals when possible, with a minimum requirement of ≥3 feet of distancing between students [14].

In this retrospective analysis of data from public schools in the state of Massachusetts that opened with any in-person learning, we sought to measure the effectiveness of different physical distancing policies (≥3 versus ≥6 feet) on incidence of SARS-CoV-2 infections among students and school staff after school re-opening in fall 2020.

Methods

Data sources:

District Infection Control Plans

Publicly available district infection control plans, which were developed independently across the state but with guidance and ultimate approval from DESE, were identified through a variety of sources, including the Boston Globe school tracker [15] and public documents available on town websites. A standardized data extraction template was created using Microsoft Forms (Supplementary materials) and each district plan was individually reviewed and entered into the dataset. Variables of interest included school model type (e.g., fully remote, hybrid, or full in-person) and details of infection control strategies adopted by the district (e.g., physical distancing of ≥3 versus ≥6 feet, details of masking policy, including details about how the masking policy was applied to students in younger grades, ventilation upgrades, cleaning protocols).

Districts that permitted a minimum of ≥3 feet of distancing, even if greater distances were "preferred," were classified as allowing ≥3 feet of distancing between students. Similarly, districts that allowed ≥3 feet of distancing for some grades, even if not for all, were classified as permitting ≥3 feet of distancing. Districts that implemented intermediate

distancing requirements (e.g., minimum of 4 feet, 4.5 feet, 5 feet) were excluded from the primary analysis. Districts that allowed ≥3 feet of physical distancing in their full re-opening plan but opened in a hybrid learning model with requirements of ≥6 feet in the hybrid model, were classified as requiring ≥6 feet of physical distancing. Districts with contradictory recommendations (e.g., statements of permitting 3-6 feet in some sections of the infection control plan but requiring 6 feet in others) were excluded.

Prior to data abstraction, three investigators abstracted and entered the same infection control plans. After an inter-rater reliability score >80% was achieved for all variables (five districts reviewed, one round), data abstraction and entry was continued. To ensure data quality and accuracy of the physical distancing variable, all districts that included a minimum of ≥3 feet of distancing in their infection control plan underwent a double-check. If there was disagreement between the two reviews, then a third reviewer also manually reviewed the district plan and made a final decision regarding classification of the district policy. Additionally, a random sample of 10% of the districts classified as requiring ≥6 feet of physical distancing underwent a second review to ensure accuracy.

Case and Enrollment Data:

We obtained data on positive SARS-CoV-2 case counts from the DESE website, where they are available publicly, for the period of September 24, 2020 through January 27, 2021 [16]. District-level SARS-CoV-2 case counts are reported by school districts to DESE weekly.

Mandatory case reporting to DESE is only required for districts with any in-person learning (full in-person or hybrid districts). Case counts for students include students with a laboratory-confirmed diagnosis of SARS-CoV-2 infection who are enrolled in hybrid or in-person learning models and were in a school building within the seven days prior to the positive test. Similarly, staff case counts only include those who had been in a school building in the seven days prior to the laboratory confirmed positive test. Individual school districts are responsible for reporting these data to DESE.

Student enrollment data was provided electronically to the research team from DESE [17]. This includes total enrollment and counts of students enrolled in each learning model, in-person, hybrid, and remote, by district. DESE pulled this information from the district information system on a biweekly basis. The in-person, hybrid, and remote counts represent what the district is reporting at that time. In-person counts vary by week and are lower in the winter surge period, although detailed data about school closures is not reported.

Because in-person staff counts are not part of the dataset, we estimated these by using the 2018-2019 National Center for Education Statistics Common Core of Data (NCES CCD) statistics [18] for total full-time staff and teachers for all districts with at least 5% of enrolled students in an in-person or hybrid learning model. District demographic data (proportion of children aged 5-17 living in poverty, racial and ethnic enrollment within the school district) were also obtained from NCES CCD.

Community Case Data

Community incidence data was obtained from USAFacts [19], at the county level, dividing each county's totals among the county's zip codes, weighting by zip code population. These zip code-level community rates were matched to the district data using the zip code of the district's location in the NCES CCD dataset to provide a comparison for school rates and the surrounding community rates.

Analysis:

Because the number of students on-campus varies over the study period, we define high on-campus enrollment as districts with an average of 80% or more of their total enrolled students participating in on-campus instruction throughout the time period. Lower on-campus enrollment is defined as districts with an average of less than 80% of enrolled students participating in on-campus instruction.

After the three data sets were combined, we calculated the student and staff incidence rates for each district-week. We calculated the daily student incidence rate per

100,000 students who were attending in-person or hybrid models, and the daily staff incidence rate per 100,000 staff members for districts with at least 5% in-person or hybrid attendance. Weeks with less than 5% of total enrollment as in-person or hybrid attendance were excluded from the analysis.

To assess the impact of distancing policies on incidence of infection rates, we estimated negative binomial regression models. We used separate regression models for student and staff infection incidence outcomes. The key independent variable in these models was an indicator for a policy of 6 feet distance. We also estimated models controlling for community SARS-CoV-2 incidence and controlling for district demographic variables (proportion of children living in poverty, racial and ethnic enrollment within the district). In each model, standard errors were clustered by district and all models included week fixed effects to capture week-specific factors that were constant across districts. All data were analyzed using STATA and Microsoft Excel.

Sensitivity Analyses:

To ensure our findings were robust and not driven by other infection control mitigation measures, we conducted two sensitivity analyses. First, we re-estimated models after excluding districts with surveillance testing programs and re-estimated unadjusted and adjusted incidence rate ratios. We also estimated models among districts that permitted less than 6 feet of physical distancing (e.g., included districts that allowed 4-5 feet of distancing in the analysis).

Results:

Among 279 districts with detailed infection control plans available for review, 266 opened for any type of in-person learning during the period from September 24, 2020 to January 27, 2021 (hybrid and/or full-in person). Nine districts allowed intermediate distancing (e.g., 4-5 feet) and were excluded from the primary analysis. Two districts allowed 3 feet among some grades, but 6 feet among others (one allowing 3 feet for high school, another

allowing 3 feet for younger grade-levels). Two district's plans included contradictory statements regarding their physical distancing policy and were excluded. Districts that remained fully remote until November 1, 2020 were also excluded, leaving 251 districts in our analysis.

Within districts meeting inclusion criteria, 537,336 students and 99,390 staff were in attendance in school buildings, representing 6,400,175 student learning weeks and 1,342,574 staff learning weeks. During the entire study period, 4226 cases were reported in students and 2382 in school staff (daily incidence rate by week, Table 1). Because learning models vary by district over the study period, we instead consider on-campus enrollment by comparing the number of students enrolled in both in-person and hybrid models compared to total district enrollment. The majority of districts that opened for any in-person learning did so with lower on-campus enrollment, which we define as an average of less than 80% of enrolled students on campus during the study period (161/251, 64.14% lower on-campus enrollment; 90/251,35.86% high on-campus enrollment). 98.01% of districts included applied the same infection control policy, including distancing recommendations, across all grade levels. 100% of districts with any type of in-person learning adopted universal masking for both students in grade 2 and above and for school staff. 69.72% of districts required masking for younger grades, although the policy was not mandated by the state, and 26.29% of districts strongly encouraged masking for students in the younger grades. Three districts required masking for students in grade 1 and above and seven districts did not have details in their masking policy to comment on grade requirements. Other commonly implemented interventions included physical distancing between students (48 ≥3 foot requirement, 194, ≥6 foot requirement, 9, 4-5 foot requirement), cohorting of students (214/232, 92.24%), enhanced disinfection protocols (218/227, 96.04%) and variable ventilation interventions (205/227, 90.31%) (Table 2).

Districts that implemented ≥3 feet of distancing between students reported 895 cases among students and 431 cases among staff (Figure 1). Districts with ≥6 feet of physical distancing reported 3223 cases among students and 2382 among staff, (unadjusted

incidence rate ratio (IRR, 0.891, 95% CI, 0.594-1.335). Incident cases among both students and staff were highly correlated with community rates (Figure 2). In multivariable regression models controlling for community incidence, the risk of COVID-19 among students in districts with ≥3 versus ≥6 feet of distancing was similar (adjusted IRR, 0.904, 95% CI, 0.616-1.325) (Table 3). The model for staff controlling for community incidence also showed a similar risk with ≥3 versus ≥6 feet of distancing (adjusted IRR, 1.015, 95% CI, 0.754-1.365). After adjusting for the proportion of children aged 5-17 living in poverty and the racial and ethnic distribution of students within the districts, the effect estimate for the IRR changed by >10% but results remained non-significant (students: adjusted IRR, 0.789, 95% CI, 0.528-1.179). In the adjusted models, the IRR ratio for staff did not change (adjusted IRR, 0.915, CI, 0.669-1.252). Incidence rate ratios for the two distancing policies were similar in the sensitivity analyses, including the sensitivity analysis that included districts that adopted intermediate distancing policies (e.g., 4-5 feet) (Table 3).

Discussion:

In June, 2020 the Massachusetts DESE released guidance for re-opening schools that included universal masking of staff and for most students and recommended ≥3 to 6 feet of distancing between students. Due to the inherent flexibility in the DESE recommendations, application of physical distancing interventions varied throughout the state of Massachusetts. In this retrospective cohort study, we leveraged this variation to evaluate the effectiveness of different physical distancing recommendations on SARS-CoV-2 incidence rates in students and school staff participating in any in-person learning. Using case-report data from DESE and combining it with a manually-validated dataset with detailed district infection control plans, we found that adoption of greater physical distancing between individuals in school buildings was not associated with significantly reduced rates of SARS-CoV-2 among students and staff.

National and international guidance on distancing in schools is varied. The WHO recommends 1 meter (3.3 feet) of distancing in school settings while conversely, CDC

guidance recommends 6 feet of distance "to the greatest extent possible," and the American Academy of Pediatrics recommends 3-6 feet [6–8]. Several countries have published data on case rates among school children with various physical distancing recommendations after school re-opening, although studies directly comparing different policies are limited. In Australia, New South Wales, children were recommended to distance 1.5 meters; a study evaluating SARS-CoV-2 transmission and secondary attack rates in children who attended schools and early childhood care settings while considered infectious found low rates of transmission, with a secondary attack rate of 1.2% [20,21]. In educational settings in England during the summer half term, children were advised to maintain distance "as able;" and universal masking was not required. Reported infections and outbreaks with a limited distancing policy were low, with 113 cases of infection and 55 outbreaks, among a large population (median daily student school attendance of 929,000) [22]. Similarly, in Singapore educational settings, where students adopted 3-6 feet of distancing, case rates were low, with identification of only three potential transmission incidents in three disconnected educational settings [23].

Our study adds to the literature as we were able to directly compare the impact of different physical distancing policies while controlling for other important mitigation measures, notably universal masking among staff and near universal masking among students, including close in younger grades. Our finding of no significant difference in student or staff case rates between schools with ≥3 versus ≥6 feet of distancing with a large sample size suggests that the lower physical distancing recommendation can be adopted in school settings without negatively impacting safety.

While incidence rates in both students and staff were lower than cases in surrounding communities, we found a strong correlation between community rates and positive cases in schools, particularly among school staff. Community transmission contributes to the number of individuals who enter the school building infected with SARS-CoV-2. A variety of factors may drive the relationship between community incidence and cases introduced into schools, including mandated compliance with mitigation measures,

such as masking and symptom screening. The finding of the strong correlation between community incidence and incidence in schools does not, however, imply that there is increased transmission in schools when community disease prevalence is high, nor that community metrics should dictate school opening/closing policies.

These findings have important implications for national policy for SARS-CoV-2 infection control recommendations applied to school settings. The practical implication of a 6 feet of distancing recommendation is that many schools are unable to open for full-in person learning, or at all, due to physical limitations of school infrastructure. This is particularly true in public school districts, which are unable to limit the number of students enrolled, compared to private schools, which have been able to more successfully open with 6 feet of distance between individuals [24]. Three-feet of physical distancing is more easily achieved in most school districts, including public ones, and thus, relaxing distancing requirements would likely have the impact of increasing the number of students who are able to benefit from additional in-person learning. Our data also suggest that intermediate distances (4 or 5 feet) can also be adopted without negatively impacting safety; adoption of intermediate distancing policies might be leveraged as a step-wise approach to return more students to the classroom.

Our study was limited by lack of complete data on potential cases among students and school staff; only cases reported to the state were able to be included in our analysis, thus it is possible that some cases may have been missed. However, it is unlikely that cases were differentially missed in districts with 3 versus 6 feet, mitigating the impact of this limitation on our main study finding. We also did not have detailed contact tracing data available, and so were not able to determine if cases in students were due to transmissions that happened within the school environment or independent introductions from cases acquired in the community. During the study period, active surveillance programs were rare, and thus we were not able to identify asymptomatic cases that may have resulted from in-school transmission, or to measure the effectiveness of this intervention as a tool for controlling SARS-CoV-2 spread in school settings.

Additionally, we were not able to measure the impact of physical distancing stratified by school type (elementary, middle, high) or age group. Thus, it is possible that the intervention may be more effective in one school type or age group, however, the vast majority of the districts included in the study (98%) adopted the same distancing policy, suggesting that findings are broadly applicable. We were not able to fully exclude a small benefit of greater physical distancing requirements among student cases, however, due to our large sample size, we can conclude that more restrictive physical distancing policies would not have substantial impact on preventing cases in students attending in-person schooling. It is possible that districts that officially allowed ≥3 feet of distancing between students ultimately succeeded in attaining more distance between students, and our methods were only able to capture official policy, not real-world implementation of the policy. We also were not able to examine how lower distancing policies may have impacted school closures; it is possible that districts with lower distancing requirements closed more frequently, or required more quarantines, due to how SARS-CoV-2 exposures are defined. Finally, we were not able to fully evaluate the impact of other types of infection control interventions, due to a lack of variation across the state. In particular, we were not able to examine the impact of universal masking due to nearly 100% adoption of this intervention, however, data from other sources and other settings clearly highlights the importance of masking as a mitigation measure and that mask compliance in school settings is high [4,25].

Conclusions:

Increasing physical distancing requirements from 3 to 6 feet in school settings is not associated with a reduction in SARS-CoV-2 cases among students or staff, provided other mitigation measures, such as universal masking, are implemented. These findings may be used to update guidelines about SARS-CoV-2 mitigation measures in school settings.

NOTES

Disclaimer

The views presented here are those of the authors, and do not necessarily represent those of the U.S. Federal Government.

Funding:

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Potential Conflicts:

WBE is the site PI for a grant funded by Gilead pharmaceuticals (funds to institution). WBE reports grants to institution from the NHLBI and VA HSRD. EO and RJ are affiliated with the COVID-19 School Dashboard, which is funded in part by the Chan Zuckerberg Foundation and the Arnold Foundation. E.M.S. reports grant support from Gilead FOCUS Program. All other authors have no conflicts to report.

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Table 1. COVID-19 Daily Incidence Among Students and School Staff Participating in In-Person Instruction in Massachusetts as Reported to the Department of Elementary and Secondary Education

Week End Date	Daily Student Cases per 100,000; ≥6 feet of physical distancing	Daily Student Cases per 100,000; ≥3 feet of physical distancing	Daily Staff Cases per 100,000; ≥6 feet of physical distancing	Daily Staff Cases per 100,000; ≥3 feet of physical distancing
Sep 30, 2020	1.38	2.17	2.09	3.23
Oct 7, 2020	2.90	3.26	6.26	2.42
Oct 14, 2020	2.61	2.95	6.89	4.03
Oct 21, 2020	3.59	4.32	5.19	6.47
Oct 28, 2020	5.86	6.21	9.29	7.91
Nov 4, 2020	4.81	4.67	12.85	13.47
Nov 11, 2020	4.54	7.96	17.13	8.98
Nov 18, 2020	10.36	15.70	25.33	39.86
Nov 25, 2020	7.64	7.40	24.66	22.36
Dec 2, 2020	7.61	11.96	31.52	24.62
Dec 9, 2020	16.45	10.82	53.94	44.31
Dec 16, 2020	17.71	17.18	47.89	53.78
Dec 23, 2020	14.92	16.19	46.32	53.36
Jan 13, 2021	15.65	16.48	48.10	44.59
Jan 20, 2021	17.49	11.46	45.90	42.65
Jan 27, 2021	18.01	17.63	38.14	43.64

Table 2. Distribution of Infection Control Interventions Implemented in Massachusetts Public Schools with Any In-Person Instruction

Infection Control Intervention	Districts	Students (All districts)	Students ≥6 Feet	Students ≥3 Feet	Staff (All districts)	Staff ≥6 Feet	Staff ≥3 Feet
School Model[a]							
High on-campus enrollment	90	188,134	121,949	55,989	27,270	18,699	7,997
Lower on-campus enrollment	161	349,202	270,691	67,167	72,120	58,341	11,866
Elementary, Middle, and High School All in the Same Model	188	450,881	327,416	105,331	82,907	64,118	16,823
Universal Masking[b]							
Among all staff	251	537,336	392,640	123,156	99,390	77,040	19,863
Among all students	251	537,336	392,640	123,156	99,390	77,040	19,863
Physical Distancing							
≥6 Feet	194	392,640	392,640	--	77,040	77,040	--
≥3 Feet	48	123,156	--	123,156	19,863	--	19,863
Other (4-5 feet)	9	21,540	--	--	2,487	--	--
Enhanced Cleaning Protocol[c]	218	445,916	343,834	80,542	78,290	62,521	13,282
Cohorting (Any)	214	483,042	357,384	104,500	88,264	69,486	16,605
Mandatory Symptom Screens Prior to Entering School Buildings	223	492,223	368,688	105,161	91,428	72,832	16,533
Ventilation Interventions[d]	205	430,264	334,404	79,309	76,539	60,891	13,189
Surveillance Testing	5	7,310	6,582	728	2,307	2,181	126
Universal Vaccination Policy[e]	251	537,336	392,640	123,156	99,390	77,040	19,863
District Demographic Variables[f]							
Children ages 5-17 in poverty (%)		10.47	10.24	12.13	--	--	--

White (%)		65.25	65.10	64.09	--	--	--
Black (%)		6.97	7.36	5.76	--	--	--
Asian (%)		7.58	7.91	6.34	--	--	--
Other (%)		4.23	4.32	3.909	--	--	--
Hispanic (%)		15.99	15.33	19.93	--	--	--

[a] High on-campus enrollment is defined as districts with an average of at least 80% of their total enrolled students participating in on-campus instruction throughout the time period. Lower on-campus enrollment is defined as districts with an average of less than 80% of enrolled students participating in on-campus instruction.

[b] During the study period, universal masking among staff and students grades two and higher was a pre-requisite for approval to open schools according to Department of Elementary and Secondary Education. Many districts opted to require (69.7%) or strongly recommend (26.3%) masking among students in younger grade levels.

[c] Cleaning protocols were variably defined but recorded if the district reported any enhanced protocols beyond usual practices.

[d] Ventilation interventions were highly heterogeneous and included requirements to open windows, purchase HEPA filters, plans for HVAC upgrades, and plans to move classrooms to outdoor spaces.

[e] Universal influenza vaccination for all students was mandated in the state of Massachusetts during the Fall of 2020. The requirement was later waived due to low rates of influenza during the 2020-2021 influenza season.

[f] Demographics variables obtained from NCES at the district level

Table 3. Regression Analysis

	IRR[a], Students (unadjusted for community incidence)	IRR, Students (adjusted for community incidence)[b]	IRR Staff (unadjusted for community incidence)	IRR Staff (adjusted for community incidence)
≥6 Feet of Physical Distancing, all Districts (N=3,625)[c,d]	0.891 (0.594 – 1.335)	0.904 (0.616 - 1.325)	0.989 (0.733 – 1.334)	1.015 (0.754-1.365)
≥6 Feet of Physical Distancing, adjusted for district demographics (N=3,612)[e]	0.761 (0.500-1.157)	0.789 (0.528-1.179)	0.902 (0.663-1.226)	0.915 (0.669-1.252)
≥6 Feet of Physical Distancing, excluding districts with surveillance testing (N=3,554)[d]	0.879 (0.587 – 1.315)	0.891 (0.609 - 1.304)	0.971 (0.721 – 1.307)	0.997 (0.743-1.338)
≥6 Feet of Physical Distancing versus < 6 feet of distancing (N=3,763)[f]	0.983 (0.665 – 1.453)	0.976 (0.678 - 1.407)	1.096 (0.818 – 1.467)	1.103 (0.830-1.466)

All regressions adjusted for week. Standard errors adjusted for clustering by school district.

[a] IRR= Incidence rate ratio

[b] adjusted for community incidence by week

[c] N=Number of district-weeks included in the regression

[d] 3 feet of physical distancing referent group

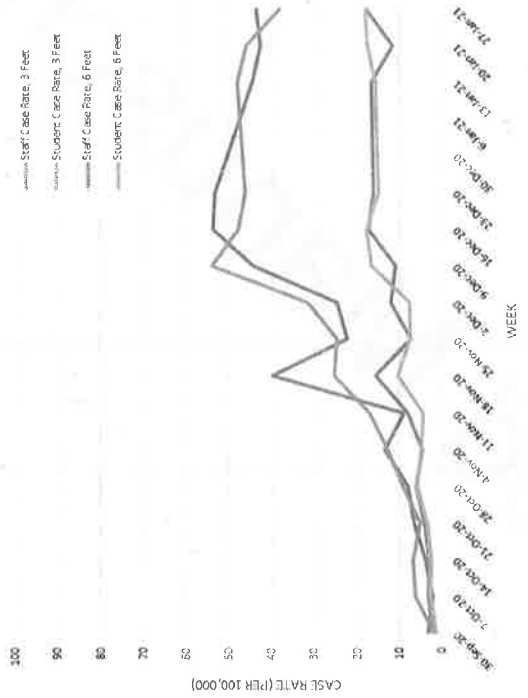
[e] Demographic variables included in the model, of total enrolled students: % Black, % Hispanic, % Asian, % Other (Native American, Native Alaskan, Native Hawaiian, Pacific Islander, Two or more races, Unknown, and Other), and % of children 5-17 in poverty. One district is missing poverty data and was dropped from the regression

[f] <6 feet of physical distancing referent group

Figure 1 Legend. Incidence of COVID-19 Cases Among Students and School Staff, by Physical Distancing, Reported to DESE During the First 16 Weeks of the 2020-21 Academic Year

Figure 2 Legend. Incidence of COVID-19 cases Among Students and School Staff Reported to DESE During the First 16 Weeks of the 2020-21 Academic Year

Figure 1



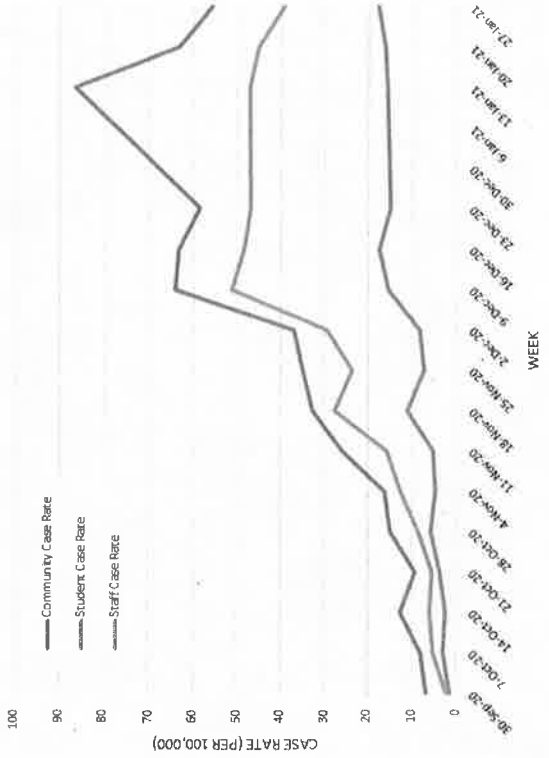


Figure 2

A RESOLUTION SUBMITTED BY
LEGISLATOR GILMOUR

Re: Expressing Support for the Re-Examination of Social Distancing Guidelines in Schools by New York State

WHEREAS, since March 13, 2020 many local school districts within Erie County and New York State have been operating under hybrid or virtual models based on the risks associated with transmission of the COVID-19 virus; and

WHEREAS, President Joseph R. Biden Jr. has set a benchmark goal of safe school re-openings by May 1st and has included $130 billion in the American Rescue Plan to fund cleaning supplies and other improvements that will "reduce the risk of virus transmission and exposure to environmental health hazards"; and

WHEREAS, the American Academy of Pediatrics has advised that "all policy considerations for school COVID-19 plans should start with a goal of having students physically present in school" and notes there may be a choice to make between strict 6 foot social distancing regulations and the obvious downsides of remaining in remote models of education; and

WHEREAS, Dr. Anthony Fauci of the National Institute of Allergy and Infectious Diseases and others have acknowledged that reputable studies have shown that schools may be low risk if other mitigation is continued, such as mask wearing, while lessening social distancing guidelines to three feet; and

WHEREAS, according to a recently published *New York Times* article, the US Centers for Disease Control and Prevention is said to be re-evaluating their guidelines while the World Health Organization recommends only one meter (3.3 feet) of social distancing in a school setting; and

WHEREAS, teachers are working exceptionally hard in trying conditions to educate their students via virtual learning, hybrid learning, and in some cases, in-school; and

WHEREAS, parents, grandparents and guardians are also working hard at home, trying to help their children with school work and learning, often while attempting to do their own work from home during the pandemic; and

WHEREAS, public education is vital to our children, to our economy and to the future of Erie County, and at-home issues, technological difficulties and a lack of high-speed or any Internet service for remote learning may have set our local students back in immeasurable ways.

NOW, THEREFORE, BE IT

RESOLVED, that the Erie County Legislature requests that the New York State Departments of Health and Education re-examine their guidance on social distancing requirements in schools to help facilitate a safe return to school of students; and be it further

RESOLVED, that this Honorable Body supports a safe return to fully in-person learning for all students in Erie County and New York State in accordance with the support and concurrence of medical experts; and be it further

RESOLVED, that certified copies of this resolution be transmitted to the Governor, the New York State Commissioners of Health and Education, to the local delegation of the New York State Assembly and State Senate, the Chairs of the New York State Assembly and Senate Education Committee, the Superintendents of Erie 1 and Erie 2 BOCES, the Erie County Executive and Erie County Commissioner of Health.

Fiscal Impact: None for this resolution.

STEFAN I. MYCHAJLIW
ERIE COUNTY COMPTROLLER

March 19, 2021

Marie Cannon
Erie County Commissioner of Social Services
95 Franklin Street
Buffalo, NY 14202

Dear Commissioner Cannon,

Three weeks have passed since our last correspondence concerning the hiring of Randall Hoak for an almost $100,000 political patronage position with a $22,000 raise. We are still looking for answers concerning the questionable timing and circumstances of hiring Mr. Hoak as your Special Assistant to the Commissioner, a Managerial Confidential position, Step 15. Specifically, his intention to quit this job after a few months of being hired is a direct contradiction to the public reasons you gave to the Erie County Legislature on why there was an urgent need to quickly create this patronage job.

On February 26th, 2021, we notified you that Erie County Board of Elections employee and Town of Hamburg Democratic Chairman Terrence MacKinnon told The Hamburg Sun that Mr. Hoak plans to quit by the end of this year:

"MacKinnon said if Hoak were to win the election he would be a 'full-time Supervisor' and leave his other (Special Assistant to the Commissioner) job."

Source: Terrence MacKinnon, Hamburg Sun, February 26th, 2021

There are four questions you still refuse to answer:

- Why would you hire someone for such an urgent need knowing they planned to quit in ten months?
- Did you know Mr. Hoak had planned on quitting prior to offering him this position?
- As far as the 19 other applicants go, did any of them notify you they would only work for ten months, then quit?
- Why would a manager hire an employee for a critically needed position if that person planned to quit less than one year after being hired?

The most important question asked many months ago also remains unanswered:

- Is it possible anyone in the Poloncarz Administration promised this political position to someone with the "quid pro quo" to run for public office while in this position?

Thank you for providing answers to these important questions, considering the political appointee you just hired plans to quit less than one year on the job. Not answering leads us to believe this hire was transactional in nature.

Sincerely,

Stefan I. Mychajliw, Jr.
Erie County Comptroller

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

April 12, 2021

Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, New York 14202

Re: Extend Home Care Services Contracts

Dear Honorable Members:

The attached resolution requests authorization for the Department of Senior Services to extend contracts with two (2) agencies to provide Home Care service to residents of Erie County. Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home, were selected through an RFP process, and are currently providing service. The Department will utilize available grant funding to pay for services.

Should your Honorable Body require any further information, I encourage you to contact Commissioner David J. Shenk in the Department of Senior Services. Thank you for your consideration on this matter.

Sincerely yours,

Mark C. Poloncarz, Esq.
Erie County Executive

MCP/ds
Enclosure

cc: David J. Shenk, Commissioner, Department of Senior Services

MEMORANDUM

To: Honorable Members of the Erie County Legislature
From: Department of Senior Services
Re: Extend Home Care Services Contracts
Date: April 12, 2021

SUMMARY

Approve the attached resolution to allow the Department of Senior Services to extend contracts, for the period April 1, 2021 through March 31, 2022, with Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home, to provide Home Care Services to eligible clients of the Department. The two agencies were selected through an RFP process and will be paid with existing Department grant funds.

FISCAL IMPLICATIONS

No additional County funds are required. Budgetary appropriations for aggregate home care expenditures (which include PCA1, PCA2, and Consumer Direct home care) are available in the Department's Home Care Services account (#516026) in the following grants, 163EISEP2122 $1,452,099, 163III-E2021 $204,965, 163ADCSI2021 $58,224 and 163UNMETNEED2122 $511,000.

REASONS FOR RECOMMENDATION

Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home are currently providing service to clients, and Department of Senior Services wishes to extend their contracts for the benefit of department clients.

BACKGROUND INFORMATION

The Department of Senior Services receives funding to provide Home Care Services to residents of Erie County and employs a variety of service options to meet the needs of the community. Home care services provide assistance with daily tasks including personal care and housekeeping for frail, elderly clients.

CONSEQUENCES OF NEGATIVE ACTION

The Department of Senior Services would be unable to utilize available grant appropriations to meet the needs of seniors and their caregivers.

STEPS FOLLOWING APPROVAL

Contracts with Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home will be extended and the Department of Senior Services will continue providing services.

A RESOLUTION SUBMITTED BY:
DEPARTMENT OF SENIOR SERVICES

RE: Extend Home Care Services contracts

WHEREAS, the Department of Senior Services continually looks to enhance services to help seniors remain in their homes longer; and

WHEREAS, the Department wishes to reduce long-term care costs by providing services to reduce or delay long-term admissions to facilities; and

WHEREAS, providing Home Care is a cost effective manner to provide service; and

WHEREAS, the Department desires to continue to offer Home Care Services to eligible residents in Erie County; and

WHEREAS, the Department, through an RFP process, selected Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home to provide services to the clients of the Department; and

WHEREAS, the Department now desires to extend contracts with Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home for a one year period of April 1, 2021 to March 31, 2022, which at the sole discretion of the County may be extended beyond the initial term for up to two one-year periods; and

WHEREAS, no additional County funds are required as budgetary appropriations for aggregate home care expenditures are available in the Department's Home Care Services account (#516026) in the 163EISEP2122, 163III-E2021, 163ADCSI2021 and 163UNMETNEED2122 Grants.

NOW, THEREFORE, BE IT

RESOLVED, that the County Executive be and is hereby authorized to extend contracts with Ciambella Home Care Inc, d/b/a First Light Home Care, and JTT Business Solutions, d/b/a Happier at Home to provide Home Care Services for the Department of Senior Services during the April 1, 2021 to March 31, 2022 period, which at the sole discretion of the County may be extended beyond the initial term for up to two, one-year periods; and be it further

RESOLVED, that existing aggregate Home Care Services account (#516026) appropriations in the 163EISEP2122, 163III-E2021, 163ADCSI2021 and 163UNMETNEED2122 grants be utilized to pay for the Home Care Services; and be it further

RESOLVED, and if necessary the County Executive is hereby authorized to execute amendments to the contract to effectuate adjusted funding levels; and be it further

RESOLVED, that certified copies of this resolution be forwarded to the: County Executive's Office, Division of Budget and Management, Comptroller's Office, and the Department of Senior Services.

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

GALE R. BURSTEIN, MD, MPH
COMMISSIONER OF HEALTH

March 22, 2021

Erie County Legislature
92 Franklin Street
Buffalo, NY 14202

Dear Legislators:

As requested by the Erie County Legislature in its resolution on November 5, 2020, the Erie County Department of Health (ECDOH) is providing the names and addresses of nursing homes in Erie County with infection rates of 5% or more.

This information is provided with the following caveats.

The nursing home COVID case data sources may be multiple sources and received at different times. One source is NY HERDS data. Another source is surveillance data case reports. NYSDOH may occasionally inform ECDOH of active nursing home investigations.

Data may include "persistent positives." Nursing homes test residents regularly. Older residents, particularly with compromised immune systems, may have positive COVID tests for an extended period. HERDS data do not specify if COVID+ tests are new cases or persistent positive tests. Repeat positive COVID-19 tests may be included in the data.

Reported case numbers may not include all Erie County residents and may include residents from outside Erie County.

The ECDOH reports may not include information about residents who were transferred to a different facility or discharged home.

continued

For the week ending March 20, 2021, no nursing homes had a percent positive rate of more than 5% based on the data available to our department.

It is our department's intent to provide this information on a weekly basis.

Sincerely,

Gale R. Burstein, MD, MPH, FAAP
Commissioner of Health

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

March 29th, 2021

The Honorable
Erie County Legislature
92 Franklin Street, Fourth Floor
Buffalo, New York 14202

Re: COVID-19 New Contracts

Dear Honorable Legislators:

Per Budget Resolution #101 of the 2021 Adopted Budget, this letter serves as notice to your Honorable Body that Erie County has the following position for the purposes of responding to the COVID-19 public health emergency at no county share:

	Position	JG	Bargaining Unit
•	Pharmacist	15	CSEA

Justification from ECDOH

A pharmacist is a critical position for the ECDOH COVID-19 vaccine distribution programs. All 3 FDA authorized COVID-19 vaccines have unique and complicated storage and administration requirements. In addition, NYSDOH requires a significant amount of technical training, supervision, and administrative work to use these vaccines. A pharmacist is the most qualified to supervise the technical aspects of vaccine storage and administration. The pharmacist also provides provider training, quality review of the existing vaccinators, as well as the communication with the state directly and through NYSIIS. With the expanding ECDOH COVID-19 vaccine program, a reliable employee who is available 40 hours per week and accountable for their work is essential for the success of this program.

Sincerely yours,

Robert W. Keating

Robert W. Keating
Director of Budget and Management

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

March 10, 2021

Erie County Legislature
92 Franklin St. – 4th Floor
Buffalo, NY 14202

Dear Honorable Members:

RE: Comm. 12E-34 Compliance Report

In accordance with Comm. 12E-34, please find an update of Child Protective caseloads for the month of February.

	February	Change Since January
Caseload size at the last day of the Month	1455	-12
Number of CPS workers assigned at least five case last day of month	96	9
Average number of cases per worker	15.16	-2
Cases Closed in Month	1634	14
Intake during Month	711	-57
Overdue Investigations at the last day of month	291	-47
Timely Determinations during month	1232	28

Thank you.

Sincerely,

Marie A. Cannon

Marie A. Cannon, MSW, Commissioner
Erie County Department of Social Services

cc: Erie County Executive Mark Poloncarz

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

GALE R. BURSTEIN, MD, MPH
COMMISSIONER OF HEALTH

March 29, 2021

Erie County Legislature
92 Franklin Street
Buffalo, NY 14202

Dear Legislators:

As requested by the Erie County Legislature in its resolution on November 5, 2020, the Erie County Department of Health (ECDOH) is providing the names and addresses of nursing homes in Erie County with infection rates of 5% or more.

This information is provided with the following caveats.

The nursing home COVID case data sources may be multiple sources and received at different times. One source is NY HERDS data. Another source is surveillance data case reports. NYSDOH may occasionally inform ECDOH of active nursing home investigations.

Data may include "persistent positives." Nursing homes test residents regularly. Older residents, particularly with compromised immune systems, may have positive COVID tests for an extended period. HERDS data do not specify if COVID+ tests are new cases or persistent positive tests. Repeat positive COVID-19 tests may be included in the data.

Reported case numbers may not include all Erie County residents and may include residents from outside Erie County.

The ECDOH reports may not include information about residents who were transferred to a different facility or discharged home.

continued

For the week ending March 27, 2021, no nursing homes had a percent positive rate of more than 5% based on the data available to our department.

It is our department's intent to provide this information on a weekly basis.

Sincerely,

Gale R. Burstein, MD, MPH, FAAP
Commissioner of Health

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

March 23rd, 2021

The Honorable
Erie County Legislature
92 Franklin Street, Fourth Floor
Buffalo, New York 14202

Re: COVID-19 New Contracts

Dear Honorable Legislators:

Per Budget Resolution #101 of the 2021 Adopted Budget, this letter serves as notice to your Honorable Body that Erie County has entered into contracts with the following entities for the purposes of responding to the COVID-19 public health emergency:

Vendor	Cost	Purpose
• Buffalo Homecare Inc.	$60.00/hour	Vaccination of homebound
• Visiting Nurses Association	$60.00/hour	Vaccination of homebound
• Mount Olive Development Corp.	$7,998.53	Outreach to schedule vaccines for target ZIP codes

Sincerely yours,

Robert W. Keating
Director of Budget and Management

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 19, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
1220 Washington Avenue
Suite 101, Building 22
Albany, NY 12226-2551

CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.9[32]) issued on October 13, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 22, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on October 13, 2020, I issued a local emergency order which suspends or modifies any local law, ordinance, regulation, or executive order which, if complied with, would prevent, hinder, or delay the issuance of contracts intended to improve, expand, renovate, acquire, lease or modify Erie County buildings, facilities, technology, property or other type of non-road infrastructure, which safeguard the health and welfare of the public and are reasonably necessary to respond to the COVID-19 pandemic for certain delineated buildings/projects; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, those certain delineated buildings/projects have not yet been completed.

WHEREAS, since October 13, 2020, I have duly extended such local emergency order in increments of five days; and

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on October 13, 2020.**

This local emergency order extension shall take effect at 10:00 am on March 22, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

MARK C. POLONCARZ
COUNTY EXECUTIVE

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 19, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
1220 Washington Avenue
Suite 101, Building 22
Albany, NY 12226-2551

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Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.7[62]) issued on May 15, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 21, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on May 15, 2020, I issued a local emergency order which orders all Erie County employees and agents to wear a mask or cloth face covering while in buildings owned or operated by Erie County; and

WHEREAS, since May 15, 2020, I have duly extended such local emergency order in increments of five days; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, the Center for Disease Control and Prevention (CDC) continues to

recommend wearing cloth face coverings which cover the nose and mouth in order to slow the spread of the novel coronavirus.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on May 15, 2020.**

This local emergency order extension shall take effect at 10:00 am on March 21, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 19, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

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Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.4[69]) issued on April 9, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 20, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 9, 2020, I issued a local emergency order which prohibits facilities from denying entry to patrons who choose to wear cloth face coverings, masks, or gloves and further prohibits employers from preventing employees from wearing cloth face coverings, masks, or gloves and further mandates that employers provide employees access and opportunity to clean their hands frequently; and

WHEREAS, since April 9, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and the need to mitigate the transmission of COVID-19 continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on April 9, 2020.**

This local emergency order extension shall take effect at 3:00pm on March 20, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 19, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
1220 Washington Avenue
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Albany, NY 12226-2551

CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.3[71]) issued on April 1, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 22, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 1, 2020, I issued a local emergency order which directs sick employees to stay home, directs building security to deny entry to sick individuals, and directs Erie County supervisors to send sick employees home; and

WHEREAS, since April 1, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and, in response to the COVID-19 pandemic, the need to maintain a healthy Erie County workforce for the provision of essential governmental services continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Further extend the local emergency order issued under my hand on April 1, 2020.**

This local emergency order extension shall take effect at 3:00pm on March 22, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 25, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
1220 Washington Avenue
Suite 101, Building 22
Albany, NY 12226-2551

CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.9[33]) issued on October 13, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 27, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on October 13, 2020, I issued a local emergency order which suspends or modifies any local law, ordinance, regulation, or executive order which, if complied with, would prevent, hinder, or delay the issuance of contracts intended to improve, expand, renovate, acquire, lease or modify Erie County buildings, facilities, technology, property or other type of non-road infrastructure, which, safeguard the health and welfare of the public and are reasonably necessary to respond to the COVID-19 pandemic for certain delineated buildings/projects; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, those certain delineated buildings/projects have not yet been completed.

WHEREAS, since October 13, 2020, I have duly extended such local emergency order in increments of five days; and

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on October 13, 2020.**

This local emergency order extension shall take effect at 10:00 am on March 27, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 25, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
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Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.7[63]) issued on May 15, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 26, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on May 15, 2020, I issued a local emergency order which orders all Erie County employees and agents to wear a mask or cloth face covering while in buildings owned or operated by Erie County; and

WHEREAS, since May 15, 2020, I have duly extended such local emergency order in increments of five days; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, the Center for Disease Control and Prevention (CDC) continues to

recommend wearing cloth face coverings which cover the nose and mouth in order to slow the spread of the novel coronavirus.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on May 15, 2020.**

This local emergency order extension shall take effect at 10:00 am on March 26, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 25, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
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CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.4[70) issued on April 9, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 25, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 9, 2020, I issued a local emergency order which prohibits facilities from denying entry to patrons who choose to wear cloth face coverings, masks, or gloves and further prohibits employers from preventing employees from wearing cloth face coverings, masks, or gloves and further mandates that employers provide employees access and opportunity to clean their hands frequently; and

WHEREAS, since April 9, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and the need to mitigate the transmission of COVID-19 continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on April 9, 2020.**

This local emergency order extension shall take effect at 3:00pm on March 25, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 25, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

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Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.3[72]) issued on April 1, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 27, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 1, 2020, I issued a local emergency order which directs sick employees to stay home, directs building security to deny entry to sick individuals, and directs Erie County supervisors to send sick employees home; and

WHEREAS, since April 1, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and, in response to the COVID-19 pandemic, the need to maintain a healthy Erie County workforce for the provision of essential governmental services continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Further extend the local emergency order issued under my hand on April 1, 2020.**

This local emergency order extension shall take effect at 3:00pm on March 27, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 30, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
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CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.3[73) issued on April 1, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective April 1, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 1, 2020, I issued a local emergency order which directs sick employees to stay home, directs building security to deny entry to sick individuals, and directs Erie County supervisors to send sick employees home; and

WHEREAS, since April 1, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and, in response to the COVID-19 pandemic, the need to maintain a healthy Erie County workforce for the provision of essential governmental services continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Further extend the local emergency order issued under my hand on April 1, 2020.**

This local emergency order extension shall take effect at 3:00pm on April 1, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 30, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
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One Commerce Plaza
99 Washington Avenue
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CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.4[71]) issued on April 9, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 30, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 9, 2020, I issued a local emergency order which prohibits facilities from denying entry to patrons who choose to wear cloth face coverings, masks, or gloves and further prohibits employers from preventing employees from wearing cloth face coverings, masks, or gloves and further mandates that employers provide employees access and opportunity to clean their hands frequently; and

WHEREAS, since April 9, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and the need to mitigate the transmission of COVID-19 continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on April 9, 2020.**

This local emergency order extension shall take effect at 3:00pm on March 30, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 30, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

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CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.9[34]) issued on October 13, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective April 1, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on October 13, 2020, I issued a local emergency order which suspends or modifies any local law, ordinance, regulation, or executive order which, if complied with, would prevent, hinder, or delay the issuance of contracts intended to improve, expand, renovate, acquire, lease or modify Erie County buildings, facilities, technology, property or other type of non-road infrastructure, which safeguard the health and welfare of the public and are reasonably necessary to respond to the COVID-19 pandemic for certain delineated buildings/projects; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, those certain delineated buildings/projects have not yet been completed.

WHEREAS, since October 13, 2020, I have duly extended such local emergency order in increments of five days; and

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on October 13, 2020.**

This local emergency order extension shall take effect at 10:00 am on April 1, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

March 30, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
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99 Washington Avenue
Albany, NY 12231

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Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.7[64]) issued on May 15, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective March 31, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on May 15, 2020, I issued a local emergency order which orders all Erie County employees and agents to wear a mask or cloth face covering while in buildings owned or operated by Erie County; and

WHEREAS, since May 15, 2020, I have duly extended such local emergency order in increments of five days; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, the Center for Disease Control and Prevention (CDC) continues to

recommend wearing cloth face coverings which cover the nose and mouth in order to slow the spread of the novel coronavirus.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on May 15, 2020.**

This local emergency order extension shall take effect at 10:00 am on March 31, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 1, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
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Suite 101, Building 22
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CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.9[34]) issued on October 13, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective April 1, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on October 13, 2020, I issued a local emergency order which suspends or modifies any local law, ordinance, regulation, or executive order which, if complied with, would prevent, hinder, or delay the issuance of contracts intended to improve, expand, renovate, acquire, lease or modify Erie County buildings, facilities, technology, property or other type of non-road infrastructure, which safeguard the health and welfare of the public and are reasonably necessary to respond to the COVID-19 pandemic for certain delineated buildings/projects; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, those certain delineated buildings/projects have not yet been completed.

WHEREAS, since October 13, 2020, I have duly extended such local emergency order in increments of five days; and

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on October 13, 2020.**

This local emergency order extension shall take effect at 10:00 am on April 6, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 1, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
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One Commerce Plaza
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CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.7[65]) issued on May 15, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective April 5, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on May 15, 2020, I issued a local emergency order which orders all Erie County employees and agents to wear a mask or cloth face covering while in buildings owned or operated by Erie County; and

WHEREAS, since May 15, 2020, I have duly extended such local emergency order in increments of five days; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, the Center for Disease Control and Prevention (CDC) continues to

recommend wearing cloth face coverings which cover the nose and mouth in order to slow the spread of the novel coronavirus.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on May 15, 2020.**

This local emergency order extension shall take effect at 10:00 am on April 5, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE
DEPARTMENT OF LAW

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

April \, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
Office of Emergency Management
1220 Washington Avenue
Suite 101, Building 22
Albany, NY 12226-2551

CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.4[72]) issued on April 9, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective April 4, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 9, 2020, I issued a local emergency order which prohibits facilities from denying entry to patrons who choose to wear cloth face coverings, masks, or gloves and further prohibits employers from preventing employees from wearing cloth face coverings, masks, or gloves and further mandates that employers provide employees access and opportunity to clean their hands frequently; and

WHEREAS, since April 9, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and the need to mitigate the transmission of COVID-19 continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on April 9, 2020.**

This local emergency order extension shall take effect at 3:00pm on April 4, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 1, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
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CERT. MAIL/RETURN RECEIPT
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.3[74]) issued on April 1, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on March 15, 2021 and effective April 6, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 1, 2020, I issued a local emergency order which directs sick employees to stay home, directs building security to deny entry to sick individuals, and directs Erie County supervisors to send sick employees home; and

WHEREAS, since April 1, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and, in response to the COVID-19 pandemic, the need to maintain a healthy Erie County workforce for the provision of essential governmental services continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Further extend the local emergency order issued under my hand on April 1, 2020.**

This local emergency order extension shall take effect at 3:00pm on April 6, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 15th day of March, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 1 2020

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
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99 Washington Avenue
Albany, NY 12231

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NYS HSES
Office of Emergency Management
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Albany, NY 12226-2551

CERT. MAIL/RETURN REC.
Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County State of Emergency Declaration issued on March 15, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County State of Emergency Declaration Extension executed by the Erie County Executive on April 1, 2021 and effective April 9, 2021.

Very truly yours,

MICHAEL A. SIRAGUSA
Erie County Attorney

By/S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF

STATE OF EMERGENCY DECLARATION

WHEREAS, I declared a State of Emergency within the County of Erie, State of New York on March 15, 2020 due to the impact of the Global Pandemic related to the Novel Coronavirus, the resulting disease COVID-19, and the aftereffects thereof; and

WHEREAS, I hereby find that the COVID-19 Pandemic continues to threaten the health, welfare, and safety of the residents of Erie County.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(1) of New York State Executive Law do hereby:

- **Declare that the State of Emergency within the County of Erie, State of New York continues and is extended for a period not to exceed 30 days unless further extended or rescinded.**

- **Direct all departments and agencies of the County of Erie, State of New York, to continue to take whatever steps necessary to protect life and property, public infrastructure, and provide such emergency assistance deemed necessary.**

This State of Emergency Extension shall take effect at 12:00 p.m. on the 9th day of April, 2021.

Signed this 1st day of April, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 8, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
One Commerce Plaza
99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
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Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.9[36]) issued on October 13, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on April 8, 2021 and effective April 11, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on October 13, 2020, I issued a local emergency order which suspends or modifies any local law, ordinance, regulation, or executive order which, if complied with, would prevent, hinder, or delay the issuance of contracts intended to improve, expand, renovate, acquire, lease or modify Erie County buildings, facilities, technology, property or other type of non-road infrastructure, which safeguard the health and welfare of the public and are reasonably necessary to respond to the COVID-19 pandemic for certain delineated buildings/projects; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, those certain delineated buildings/projects have not yet been completed.

WHEREAS, since October 13, 2020, I have duly extended such local emergency order in increments of five days; and

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on October 13, 2020.**

This local emergency order extension shall take effect at 10:00 am on April 11, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 8th day of April, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 8, 2021

VIA FEDERAL EXPRESS
NYS Department of State
Division of Corporations, State Records
& Uniform Commercial Code
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99 Washington Avenue
Albany, NY 12231

VIA FEDERAL EXPRESS
NYS HSES
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Hon. Michael P. Kearns
Erie County Clerk
Old Erie County Hall
92 Franklin Street, 1st Floor
Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.7[66]) issued on May 15, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on April 8, 2021 and effective April 10, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on March 7, 2020, Andrew M. Cuomo, Governor of the State of New York issued Executive Order Number 202, declaring a State Disaster Emergency for the entire State of New York; and

WHEREAS, on May 15, 2020, I issued a local emergency order which orders all Erie County employees and agents to wear a mask or cloth face covering while in buildings owned or operated by Erie County; and

WHEREAS, since May 15, 2020, I have duly extended such local emergency order in increments of five days; and

WHEREAS, the County of Erie and the State of New York remain in a state of emergency; and

WHEREAS, the Center for Disease Control and Prevention (CDC) continues to

recommend wearing cloth face coverings which cover the nose and mouth in order to slow the spread of the novel coronavirus.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on May 15, 2020.**

This local emergency order extension shall take effect at 10:00 am on April 10, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 8th day of April, 2021, at 9:00 AM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
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JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 8, 2021

VIA FEDERAL EXPRESS
NYS Department of State
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Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.4[73]) issued on April 9, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on April 8, 2021 and effective April 9, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 9, 2020, I issued a local emergency order which prohibits facilities from denying entry to patrons who choose to wear cloth face coverings, masks, or gloves and further prohibits employers from preventing employees from wearing cloth face coverings, masks, or gloves and further mandates that employers provide employees access and opportunity to clean their hands frequently; and

WHEREAS, since April 9, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and the need to mitigate the transmission of COVID-19 continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Extend the local emergency order issued under my hand on April 9, 2020.**

This local emergency order extension shall take effect at 3:00pm on April 9, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 8th day of April, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

COUNTY OF ERIE

MARK C. POLONCARZ
COUNTY EXECUTIVE

MICHAEL A. SIRAGUSA
COUNTY ATTORNEY

JEREMY C. TOTH
FIRST ASSISTANT COUNTY ATTORNEY

DEPARTMENT OF LAW

April 8, 2021

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Buffalo, New York, 14202

CERT. MAIL/RETURN REC.
Hon. Robert M. Graber, Clerk
Erie County Legislature
92 Franklin Street, 4th Floor
Buffalo, NY 14202

Re: Extension of Erie County Local Emergency Order (1.3[75]) issued on April 1, 2020

Dear Sirs:

Enclosed for filing in your office please find the Erie County Local Emergency Order Extension executed by the Erie County Executive on April 8, 2021 and effective April 11, 2021.

Very truly yours,
MICHAEL A. SIRAGUSA
Erie County Attorney

By /S/GREGORY P. KAMMER
Gregory P. Kammer
Assistant County Attorney
Direct Dial: (716) 858-2248
E-mail: gregory.kammer@erie.gov

GPK/jls
Enclosure

EXTENSION OF LOCAL EMERGENCY ORDER

WHEREAS, on March 15, 2020, in response to the COVID-19 pandemic, I declared a State of Emergency within the County of Erie; and

WHEREAS, on April 1, 2020, I issued a local emergency order which directs sick employees to stay home, directs building security to deny entry to sick individuals, and directs Erie County supervisors to send sick employees home; and

WHEREAS, since April 1, 2020, I have duly extended such local emergency order in five day increments; and

WHEREAS, the County of Erie remains in a State of Emergency and, in response to the COVID-19 pandemic, the need to maintain a healthy Erie County workforce for the provision of essential governmental services continues.

NOW THEREFORE, I, Mark C. Poloncarz, the Chief Executive of the County of Erie, New York, by virtue of the authority vested in me by Section 24(2) of New York State Executive Law do hereby:

- **Further extend the local emergency order issued under my hand on April 1, 2020.**

This local emergency order extension shall take effect at 3:00pm on April 11, 2021 and shall remain in effect for five days or until removed by order of the Chief Executive. The local emergency order may continue to be renewed in five (5) day increments.

Signed this 8th day of April, 2021, at 2:00 PM, in Erie County, New York.

Mark C. Poloncarz, County Executive
Erie County, New York

Jennifer Hibit, Chief of Staff
Witness

Erie County Corrections
Specialist Advisory Board
Old County Hall
92 Franklin St., 4th Floor
Buffalo, NY 14202
Switchboard: 716/858-7500

March 31, 2021

Governor Andrew M. Cuomo
Governor of New York State
NYS State Capitol Building
Albany, New York 12224

Re: Erie County Corrections Specialist Advisory Board Urges Prioritization of Incarcerated People for COVID-19 Vaccine Distribution.

Dear Governor Cuomo:

Under your COVID-19 vaccine distribution plan, Erie County's corrections staff are now eligible for COVID-19 vaccine, but the Phased Distribution Plan does not include incarcerated populations as part of either the Phase 1a or Phase 1b priority groups. Incarcerated persons should be prioritized for vaccination along with corrections staff because vaccination of staff may not be sufficient to prevent transmission of COVID-19 in our New York's jails and prisons.

Incarcerated persons are at a higher risk for infection and are unable to take the steps necessary to protect themselves. They are also more likely to be overweight or obese and have certain other health conditions that put them at a greater risk of having severe illness if they contract COVID-19. As a result, the infection rate of incarcerated persons is four times that of the general public and they are twice as likely to die from an infection. These facts should put incarcerated persons at the top of the state's priority list along with others in group living facilities, like homeless shelters, nursing homes, and other congregate settings.

The state is responsible for the health and well-being of incarcerated individuals and is required to do what is reasonably necessary to protect them. Nevertheless, the State's decision to deprioritize incarcerated persons illustrates its failure to target the virus where it is most destructive and protect a group that is among the most vulnerable to the virus.

Jails and prisons have been major vectors for outbreaks of COVID-19; preventing the spread inside these facilities is essential to controlling the virus in surrounding communities. If incarcerated persons are not vaccinated along with corrections staff, there is a significant risk that an outbreak in a correctional facility will be transmitted beyond the walls of the facility. Therefore, preventing the virus from spreading inside places of detention is essential to the success of measures taken to control the disease in the general population.

In the alternative, the Erie County Corrections Specialist Advisory Board recommends that the state vaccinate incarcerated persons if they qualify under a higher priority group, for example persons over 50 years old and persons with certain comorbidities and underlying conditions, regardless of age are included in Phase 1a and Phase 1b priority groups. This would allow incarcerated persons to be vaccinated at the same time as everyone else in the priority group who does not reside in a place of detention.

The Board also recommends that state and local governments continue their effort to reduce the number of persons being held in correctional facilities. Demarcation is the most effective way to prevent fatalities and limit the spread of the virus both inside and outside facilities.

The decision to deprioritize the vaccination of incarcerated persons is not only morally unjust, but it also totally disregards the recommendation of health experts to prioritize the vaccination of individuals living in congregate settings. On March 29, 2021, a State Supreme Court judge ruled that the state's decision to exclude incarcerated persons from eligibility for the vaccine was arbitrary and irrational and ruled that New York must immediately offer vaccines to incarcerated persons.

We must ensure that the people who are most vulnerable to COVID-19 are among the first to receive the vaccine. We now urge you to practice responsible governance by acting with the required urgency to expand vaccination to the almost 50,000 persons incarcerated in the State's correctional facilities. Thank you.

Sincerely,

The Erie County Corrections Specialist Advisory Board

cc: Erie County Executive
Erie County Commissioner of Health
Erie County Legislature
Erie County Sherriff
New York State Commission of Correction
NYS Commissioner of Health

New York State Office of the Attorney General Letitia James

Nursing Home Response to COVID-19 Pandemic

Revised January 30, 2021

Contents

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Executive Summary

This report is based on preliminary findings of the Office of Attorney General Letitia James (OAG)[1] from a review of information available through November 16, 2020. The report includes facts from the OAG's preliminary investigations of allegations of COVID-19-related neglect of nursing home residents across New York state and health data maintained as a matter of law by nursing homes and the New York State Department of Health (DOH).

In early March,[2] OAG received and began to investigate allegations of COVID-19-related neglect of residents in nursing homes. On April 23, OAG set up a hotline to receive complaints relating to communications by nursing homes with family members prohibited from in-person visits to nursing homes.[3] OAG received 774 complaints on the hotline through August 3 (an additional 179 complaints were received through November 16). OAG also continued to receive allegations of COVID-19-related neglect of residents through pre-existing reporting systems. During this time, OAG received complaints regarding nursing homes across the state, with a greater volume of complaints regarding nursing homes in geographic areas with higher rates of community-based transmission of COVID-19.

OAG is conducting ongoing investigations into more than 20 nursing homes across the state whose reported conduct during the first wave of the pandemic presented particular concern. Other law enforcement agencies also have ongoing investigations relating to nursing homes. Under normal circumstances, OAG would issue a report with findings and recommendations after its investigations and enforcement activities are completed. However, circumstances are far from normal. DOH data reports over 6,645 resident deaths as of November 16, with the vast majority (over 6,420) of those deaths occurring as of August 3. The COVID-19 health crisis is continuing and projected to worsen in the coming winter months. Infection rates are rising across the state, and across states nationwide, following increased travel and social gatherings over the holiday season. Inconsistent public compliance with face mask wearing, social distancing, and hand washing persists — despite orders and scientific guidance that shows these practices reduce the risk of COVID-19. Under these circumstances, nursing home residents remain especially vulnerable to transmission of COVID-19.

Attorney General James is issuing this report including findings based on data obtained in investigations conducted to date, recommendations that are based on those findings, related findings in pre-pandemic investigations of nursing homes in New York, and other available data and analysis thereof. Attorney General James offers this information to the public in the interest of increasing transparency and awareness and encouraging collective action by our state's residents to protect each other and our state's vulnerable nursing home residents. In addition, this information may be useful to other decision-makers for their consideration as they continue to respond to the ongoing pandemic.

OAG's preliminary findings are:

» A larger number of nursing home residents died from COVID-19 than DOH data reflected.

» Lack of compliance with infection control protocols put residents at increased risk of harm during the COVID-19 pandemic in some facilities.

» Nursing homes that entered the pandemic with low U.S. Centers for Medicaid and Medicare Services (CMS) Staffing ratings[4] had higher COVID-19 fatality rates than facilities with higher CMS Staffing ratings.

» Insufficient personal protective equipment (PPE) for nursing home staff put residents at increased risk of harm during the COVID-19 pandemic in some facilities.

» Insufficient COVID-19 testing for residents and staff in the early stages of the pandemic put residents at increased risk of harm in some facilities.

» The current state reimbursement model for nursing homes gives a financial incentive to owners of for-profit nursing homes to transfer funds to related parties (ultimately increasing their own profit) instead of investing in higher levels of staffing and PPE.

» Lack of nursing home compliance with the executive order requiring communication with family members caused avoidable pain and distress; and,

» Government guidance requiring the admission of COVID-19 patients into nursing homes may have put residents at increased risk of harm in some facilities and may have obscured the data available to assess that risk.

To address the report's findings, a summary of recommendations follows below.

Recommendations:

» Ensure public reporting by each nursing home as to the number of COVID-19 deaths of residents occurring at the facility — and those that occur during or after hospitalization of the residents — in a manner that avoids creating a double-counting of resident deaths at hospitals in reported state COVID-19 death statistics.

» Enforce, without exception, New York state law requiring nursing homes to provide adequate care and treatment of nursing home residents during times of emergency.

» Require nursing homes to comply with labor practices that prevent nursing homes from pressuring employees to work while they have COVID-19 infection or symptoms, while ensuring nursing homes obtain and provide adequate staffing levels to care for residents' needs.

» Require direct care and supervision staffing levels that (1) are expressed in ratios of residents to Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants; (2) require calculation of sufficiency that includes adjustment based on average resident acuity; (3) are above the current level reflected at facilities with low CMS Staffing ratings; and, (4) are sufficient to care for the facility's residents' needs reflected in their care plans.

» Require additional and enforceable transparency in the operation of for-profit nursing homes, including financial transactions and financial relationships between nursing home operators and related parties, and relatives of all individual owners and officers of such entities with contractual or investor relationships with the nursing home. Through a variety of related party transactions and relationships, owners and investors of for-profit nursing homes can exert control over the facility's operations in a manner that extracts significant profit for them, while leaving the facility with insufficient staffing and resources to provide the care that residents deserve.

» Ensure that nursing homes invest sufficiently in effective training so staff can fully comply with infection control protocols. Hold operators accountable for failure to have clinically appropriate policies in place and to effectively train staff to comply with them.

» Support manufacturing of PPE to facilitate sufficient supply of PPE for purchase by nursing homes. Enforce requirements that nursing homes have sufficient inventory of PPE for all staff to be able to follow infection control protocols.

» Ensure that adequate COVID-19 testing is available to nursing home residents and employees and enforce requirements that nursing homes test residents and staff in accordance with DOH and the Centers for Disease Control and Prevention (CDC) evidence-based guidelines.

» Eliminate the recently enacted immunity provisions that can provide financial incentives to for-profit nursing home operators to put residents at risk of harm by refraining from investing public funds to obtain sufficient staffing to meet residents' care needs, to purchase sufficient PPE for staff, and to provide effective training to staff to comply with infection control protocols during pandemics and other public health emergencies.[5]

» Formally enact and continue to enforce regulatory requirements that nursing homes communicate with family members of residents promptly, but not later than within 24 hours of any confirmed or suspected COVID-19 infection and of any confirmed or suspected COVID-19 death.

» Increase staffing at DOH to ensure sufficient skilled resources for oversight, complaint assessment, surveys, inspections, and immediate responses to information requests from state agencies in support of health care and law enforcement efforts.

» Ensure that nursing homes engage in thoughtful planning regarding post-mortem care needs and implement and train staff on policies for dignified care of the remains of deceased residents.

» Urge families to consult the CMS Care Compare online database (medicare.gov/care-compare), ask questions of nursing homes relating to staffing, policies, procedures, and recent and current COVID-19 infections of staff and residents, and to obtain information relevant to their current or future long-term care decisions for their loved ones. Where possible, visit family member residents in person and through "window" visits and videocalls even if resident is unable to communicate, to provide emotional support and to enable observation of the resident's physical appearance and condition. Ensure family members know to report suspected neglect or abuse to DOH and OAG.

Timeline

On January 31, the Secretary of the U.S. Department of Health and Human Services (HHS) declared a public health emergency for the United States to aid the nation's health care community in responding to COVID-19. The emergency declaration gave state, tribal, and local health departments more flexibility to request that HHS authorize them to temporarily reassign personnel to respond to COVID-19.[6] While everyone is at risk of getting COVID-19, older adults and people of any age who have serious underlying medical conditions are at higher risk for more severe illness. In early February, DOH issued specific correspondence to health care facilities in New York directing them to plan for COVID-19. In early March, travel-related cases and community contact transmissions of COVID-19 were documented in New York. On March 7, Governor Andrew Cuomo declared a COVID-19 Disaster Emergency, declaring that a "disaster is impending in New York State, for which the affected local governments are unable to respond adequately."

New York took the brunt of the initial wave of COVID-19 infections from March through May, as reflected in the high number of COVID-19 infections and deaths. As reported in numerous sources, the New York City metropolitan area received the bulk of travelers from Europe prior to federal closure of international airports. From March through August 3, DOH reported a total of 6,423 resident deaths in nursing homes due to COVID-19, including 3,640 confirmed COVID-19 deaths and 2,783 presumed[7] COVID-19 deaths.[8] These reported deaths are based on data reported by New York's 619 nursing homes to DOH through its Health Emergency Response Data System (HERDS). As reported by *The New York Times*, there were 422,296 COVID-19 infections and 32,422 COVID-19 deaths in New York state as of August 4:[9]

Effect on Nursing Home Residents

A. Facility-Reported Deaths

In New York state, the first wave of the COVID-19 pandemic impacted many of the residents and staff of the 304 nursing homes located within the nine downstate counties in the New York City metropolitan area.[10] Within these counties, according to DOH, there were 2,567 confirmed COVID-19 resident deaths and 2,687 presumed COVID-19 resident deaths, for a total of 5,254 resident deaths in nursing homes from March through August 3. Of the total 6,423 reported resident deaths in nursing homes statewide as of August 3, 81 percent occurred in facilities in these nine downstate counties. (Through November 16, reports total 6,645 resident deaths due to COVID-19.)

Western, Northern, and Central New York also experienced COVID-19 infections in nursing homes during this time. According to DOH, from March through August 3, nursing homes upstate reported 1,169 resident deaths, including 1,073 confirmed COVID-19 deaths and 96 presumed COVID-19 deaths. The state's peak of nursing home resident COVID-19 reported deaths occurred on April 8.[11]

1. A Larger Number of Nursing Home Residents Died from COVID-19 Than Public DOH Data Reflected

Preliminary data analysis obtained from OAG inquiries to a portion of nursing homes during the pandemic suggests that many residents died from COVID-19 in hospitals after being transferred from their nursing homes.

OAG asked 62 nursing homes for information about on-site and in-hospital deaths from COVID-19 for the week of March 1 to the date of the facility's response, which varied from the week of April 12 to July 19. This sample of facilities – approximately 10 percent of the number of nursing homes in New York – was not randomly selected. OAG investigation teams requested data regarding resident deaths during the course of its preliminary investigations.[12]

Using the data from these 62 nursing homes, OAG compared: (1) in-facility deaths reported to OAG to in-facility deaths publicized by DOH, and (2) total deaths reported to OAG to total deaths publicized by DOH.[13]

The first comparison raised some questions, as shown on the chart below:

Deaths at Facilities – Comparison of Reports to OAG and DOH

Facility Deaths Reported to OAG	1,266
Facility Deaths Publicized by DOH	1,229
Difference	(37)
Over/Under Percentage	-3.01%

Although the calculated discrepancy of 3.01 percent may seem relatively low under the circumstances, closer analysis revealed that some facilities reported the location of the person at the time of death inconsistently. The discrepancies raise concerns because, when the data is removed for seven facilities that reported differing locations of death yet had a consistent total death count, the difference in reporting of deaths at the remaining 55 facilities jumps as publicized by DOH to **18.66 percent**. The DOH reporting system explicitly requires facilities to correct inaccurate reporting. Either such correction was not made by a number of facilities, or data were not reflected in DOH's published data for other reasons.

Total Deaths Reported to OAG (incl. residents sent to hospitals) vs. Publicized by DOH

Facility Deaths Reported to OAG	1,914
Total Deaths Publicized by DOH	1,229
Difference	(685)
Over/Under Percentage	-55.74%

The examples below illustrate that discrepancies remain even when the data reported to OAG is compared to data published by DOH as of later time periods through August 3:

- A facility reported 11 confirmed COVID-19 deaths at the facility, one suspected COVID-19 death at the facility, and four hospital deaths to DOH as of May 2020, and reported the same data to OAG. However, DOH published only one confirmed COVID-19 death at the facility until July 31, when its publication reflected eleven confirmed in-facility deaths -- a discrepancy of five deaths from what was reported to DOH by the facility. [14]
- A facility reported one confirmed and six presumed COVID-19 deaths at the facility as of August 3 to DOH. However, the facility reported to OAG a total of 31 COVID-19 suspected deaths at the facility as of April 18 – a discrepancy of 25 deaths.
- A facility reported five confirmed and six presumed COVID-19 deaths at the facility as of August 3 to DOH. However, the facility reported to OAG a total of 27 COVID-19 deaths at the facility and 13 hospital deaths – a discrepancy of 29 deaths.

Applying the data that these 62 nursing homes reported to OAG, which includes resident deaths occurring in the facility and in the hospital after transfer, shows a significantly higher number of resident COVID-19 deaths can be identified than is reflected in the deaths publicized by DOH.

OAG is investigating those circumstances where the discrepancies cannot reasonably be accounted for by error or the difference in the question posed.

In conclusion, this preliminary data for the 62 facilities and time periods noted above suggests that COVID-19 resident deaths associated with nursing homes in New York state appear to be undercounted by DOH by approximately 50 percent. [15]

2. High Numbers of Deaths at Nursing Homes During the Pandemic Exceeded Morgue Capacity and High Volumes of Deaths Citywide Exceeded Capacity of County Medical Examiners and Funeral Homes

OAG preliminary investigations indicate that in April, six New York City nursing homes experienced resident death numbers that exceeded the facilities' onsite morgue capacity. In each of those instances, the facility appropriately contacted funeral homes or the medical examiner's office. However, the high numbers of COVID-19 deaths across New York City had filled the capacity of local medical examiners and funeral homes. As a result, there were times when several days passed before remains could be transported out of the facilities.[16] Media reports in New York City during the peak of the first wave of the pandemic contained allegations that bodies of deceased residents were "piling up"[17] [18] inside a number of nursing homes. OAG investigated these allegations.

OAG determined that the allegations were unfounded with respect to two of the six nursing homes. In three for-profit facilities, OAG determined that the remains awaiting transfer were stored in accordance with accepted industry practice, which is to place the bodies in unoccupied patient rooms with the air conditioning on full power and with doors sealed. In an investigation of one not-for-profit facility, OAG determined that deceased residents' bodies awaiting transfer were appropriately stored in rented refrigerated trucks in the parking lot of the facility.

Under the circumstances, the preliminary investigations indicate no violation of law or industry practice in the storage of the remains of deceased residents. These incidents raise the question of whether the facilities engaged in enough planning. Relatedly, some staff conveyed surprise and shock at the discovery of onsite storage of remains other than in the morgue, indicating internal communication and training lapses.

Guidance Issued by Federal and State Governments

Federal and state agencies issued and updated guidance from January to May as evidence and knowledge about COVID-19 developed. During the pandemic, Governor Cuomo issued many executive orders in an effort to flatten the rising curves of COVID-19 infection and death rates, including directing New York to be "On Pause," and requiring the public to wear masks and practice social distancing. In addition, CDC, CMS, and DOH issued guidance relative to COVID-19. As the virus spread through New York and other states and countries, more information was promulgated about COVID-19 infection, illness, and treatment, prompting federal and state health agencies to issue updated guidance. Much of this information contained reminders and updates about best practices for containment and control of respiratory viruses – a disease vector well understood in health care facilities. This guidance also reflected updates on evolving medical knowledge about COVID-19.

A chronology of key guidance and directives issued by CDC, CMS, DOH, and Governor Cuomo that relates to nursing homes appears in the table in Appendix A.

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With these health care directives as background, OAG conducted the investigations described in the following sections.

Methodology: Phase One Investigations, Hotline Reports, and Data Analysis

OAG used three investigative approaches for this report. First, OAG opened a hotline to receive reports of violations of executive orders concerning communications with families, which expanded to receive reports of abuse and neglect. Second, OAG analyzed data from CMS and DOH for correlations between COVID-19 outcomes and CMS facility ratings. Third, OAG followed up on direct or media reports of potential abuse or neglect due to COVID-19. OAG conducted preliminary, or phase one, investigations of many nursing homes, and has continued and expanded investigations with respect to a number of them.

Except where noted, this preliminary report excludes information from enforcement investigations, and, where such information is set out, portions were redacted or paraphrased to protect the investigation or privacy of individuals not accused of wrongdoing. Names of individuals or business entities have been redacted, unless the person was convicted of criminal conduct or named in public filings such as settlement agreements or Assurances of Discontinuance under Executive Law § 63(12).

A. Phase One Investigations of Nursing Homes Conducted by OAG During the First Wave of the Pandemic

Based on allegations of COVID-19 related neglect received as of August 9, OAG conducted phase one investigations into 174 nursing homes statewide. Preliminary findings in this report are based on information obtained in the investigations, and the other data referenced herein. The data obtained during these investigations includes interviews conducted by telephone, documents obtained from nursing homes and third parties, and surveillance conducted. These complaints and investigations included facilities everywhere in the state. Based on the preliminary investigations, OAG is continuing investigations of over 20 facilities in greater depth.

Upon receipt of these allegations, OAG investigative teams followed up with complainants and promptly contacted the nursing home in question to determine whether substandard infection prevention and control practices existed at the reported home that could endanger residents, or if critically low staffing existed to the same effect. In the vast majority of these instances, the subject nursing homes cooperated fully. The primary goal of the initial inquiries was to determine whether, among other things, each facility reported having PPE and proper infection control protocols in place, and whether, based on the staffing and other conditions reported, the residents appeared to be in danger. If OAG concluded that alleged circumstances at a facility presented likely and significant risks of harm to the residents, OAG referred those facilities to DOH for immediate action. DOH responded to such facilities, including with onsite teams. A DOH referral does not mean that OAG closed its own investigation.

B. Attorney General James' COVID-19 Hotline

OAG opened a dedicated internet and telephone hotline on April 23, to address public and inter-agency concerns about a lack of prompt and effective compliance with Executive Orders 202.18 (April 16) and 202.19 (April 17) concerning communications with family members. The executive orders require nursing homes and assisted living facilities to notify "family members or next of kin of residents" within 24 hours when a resident of the facility either tests positive for COVID-19 or suffers a COVID-19-related death.

Earlier DOH guidance that was issued on April 4 similarly encourages a broader range of communication with families, including notifying families of all residents when anyone who has been in the facility has actual or suspected COVID-19, and encouraging frequent communication through direct and internet means on the status of prevention efforts in the facility. The guidance applies to all facilities and provides communications best practices for facilities with and without COVID-19 cases. CDC issued similar guidance on March 13.

Immediately before opening the hotline, OAG received numerous reports that nursing homes across New York were doing a poor job of such communication. The most concerning reports indicated some families were not even informed that their family member was ill prior to hearing of their death. The reports also suggested that some facilities were extremely insensitive in their communications.[19]

As only a violation of the executive orders were immediately sanctionable, which could not be accomplished in the short-run, OAG's main goals were to:

» Identify facilities doing a poor job of compliance with, or violating, the executive orders;

» Communicate with facilities and require them to change practices immediately; and,

» Communicate with DOH, if necessary, to solve these and other problems.

OAG employees responded to each caller, and, with the information from such discussions, often made further contact directly with facility administration. From April 23 through November 16, the hotline received 953 contacts, the vast majority of which were received through August 3 (774 complaints). Of the complaints received through August 3, 653 related to identifiable facilities in the state. In those communications, 276 different facilities were named. Notably, these facilities were located throughout the state and were not over-represented in the areas initially hardest hit by COVID-19 deaths. This wide geographic distribution strongly indicates that even though some of the facilities were not immediately challenged by extremely ill residents, they were nonetheless unprepared to handle relatively basic communication issues. (While a few calls also named hospitals or assisted living facilities, they do not significantly alter the numbers or distribution.)

MFCU Nursing Home COVID-19 Hotline Intake by Region 4/23/2020 – 8/3/2020 [20]

New York Region (with Counties of Facilities Subject of Intakes)	Number of Intakes
Capital Region *Albany, Columbia, Greene, Rensselaer, Schenectady, Warren, and Washington*	68
Central New York *Cayuga, Madison, and Onondaga*	24
Finger Lakes *Livingston, Monroe, Orleans, and Wayne*	35
Long Island *Nassau and Suffolk*	130
Mid-Hudson *Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester*	104
Mohawk Valley *Fulton, Herkimer, Montgomery, Oneida, and Otsego*	16
New York City *Bronx, Kings, New York, Queens, and Richmond*	196
Southern Tier *Broome, Chemung, and Steuben*	24
Western New York *Erie and Niagara*	56
Total	653

OAG staff were able to address the bulk of these hotline contacts through a variety of interventions, including:

» Direct communication to facilities, with verbal or written warnings in some instances;

» Direct communication to facilities, identifying weaknesses and connecting people;

» Referrals to OAG investigation teams for longer-term follow-up;

» Comfort and clarity to family members who were not well informed of their options and avenues for communications.

While the executive orders and DOH guidance used the non-specific term "family," most facilities keep contact information and privacy authorizations for "designated representatives" or "next of kin." Given the wide variety of human relationships, the phrases can indicate different individuals within a given family or other individuals acting pursuant to a resident's designation. Greater precision as to such legal terms in future guidance would help clarify expectations of family members in their communications with facilities.

Preliminary Findings from OAG Investigation and Data Analysis

OAG's investigations conducted during and in the aftermath of the first wave of the pandemic reflect preliminary findings as to factors that increased risks of COVID-19 transmission to nursing home residents.

A. Lack of Compliance with Infection Control Protocols Put Residents at Increased Risk of Harm During the COVID-19 Pandemic in Some Facilities

During phase one investigations, OAG received multiple reports through the COVID-19 hotline and direct communications to OAG that several nursing homes failed to implement proper infection controls to prevent or mitigate the transmission of COVID-19 to vulnerable residents. Among those reports were allegations that, despite medical best practices, existing regulations, and specific COVID-19 guidance from CDC, CMS, and DOH, several nursing homes in all regions of the state failed to plan and take proper infection control measures, including:

» Failing to properly isolate residents who tested positive for COVID-19;

» Failing to adequately screen or test employees for COVID-19;

» Demanding that sick employees continue to work and care for residents or face retaliation or termination;

» Failing to train employees in infection control protocols; and,

» Failing to obtain, fit, and train caregivers with PPE.

1. Pre-Existing Infection Control Requirements for Nursing Homes

Infection prevention and control has long been a fundamental aspect of basic nursing home care. Nursing homes are expected to take all reasonable steps to avoid the transmission of disease. Never was this obligation more important than during the early stages of COVID-19, nor will it be less important as we continue to navigate through this global pandemic. Nursing home infection control regulations, which have been in effect for years, require every nursing home to maintain an infection control program with policies designed to provide a safe, sanitary, and comfortable environment in which residents vulnerable to infection reside (and where their health care providers work).[21] A facility is required to have an infection control program in which the facility: (1) investigates, controls, and takes action to prevent infections in the facility; (2) determines what procedures, such as isolation, should be utilized for an individual resident to prevent continued transmission of a disease; and, (3) maintains a record of incidence and corrective actions related to infections. Nursing homes are required to isolate residents and properly sterilize and store all equipment to prevent the spread of infection. Facilities are required to mandate basic infection control practices including ensuring staff wash their hands after each direct resident contact and properly handle and store linens.[22]

2. Health Oversight Agencies Directed Nursing Homes to Strengthen Pre-Existing Infection Control Policies at the Onset of the COVID-19 Pandemic

On March 11, DOH issued COVID-19 guidance to nursing homes setting forth the facts of the virus as known at the time, DOH's expectations of nursing homes during the pandemic, and applicable infection control procedures that each facility was required to follow to ensure the safety of residents and staff during the COVID-19 outbreak. Citing the nationally reported COVID-19 outbreak at the Life Care Center nursing home in the state of Washington in late February, DOH warned New York nursing homes that the "potential for more serious illness among older adults, coupled with the more closed, communal nature of the nursing home environment, represents a risk of outbreak and a substantial challenge for nursing homes." DOH noted that it was "essential" that all nursing homes "maintain situational awareness about the disease, its signs and symptoms, where cases and outbreaks are occurring, and necessary infection prevention and control procedures by regularly visiting" CDC and DOH websites to review the most up-to-date information. DOH advised nursing homes that they "must review and reinforce their policies and procedures with all staff, residents, and visitors regarding infection prevention and control."[23]

In addition to DOH's continuing COVID-19 guidance and pre-existing New York nursing home regulations mandating strict infection controls, federal health oversight agencies also issued guidance and directives to the nursing home sector to tighten infection control measures to protect nursing home populations. As early as February 6, CMS issued guidance noting that "[b]ecause coronavirus infections can rapidly appear and spread, facilities must take steps to prepare, including reviewing their infection control policies and practices to prevent the spread of infection."[24] On March 13, CMS issued directives to nursing homes nationally to prevent the further spread and transmission of the virus to "America's seniors, who are at highest risk for complications from COVID-19," including:

» Restricting all visitors except for compassionate care, such as end-of-life situations;

» Restricting all volunteers and nonessential personnel;

» Canceling all group activities and communal dining; and,

» Screening residents and personnel for fever and respiratory symptoms.

In conjunction with CMS's directives, CDC issued several notices including a coronavirus "Preparedness Checklist for Nursing Homes and other Long-Term Care Settings," as "one tool in developing a comprehensive COVID-19 response plan."[25] The checklist identified key areas that long-term care facilities should consider in their COVID-19 planning. It also included several key planning recommendations, such as incorporating COVID-19 into written emergency plans[26] and instructions on infection control policies.

3. Examples of Preliminary Findings Regarding Infection Control Practices

Below is a representative factual summary of some of the allegations received by OAG from March 11 to June 30 regarding infection control. Given that this is a preliminary report, the sources of the information and the subject nursing homes will remain confidential to protect the identity of witnesses and the integrity of ongoing investigations.

These factual summaries are not meant to convey legal conclusions. The examples laid out represent facilities that are under investigation that could result in legal action, facilities that are no longer under investigation due to lack of evidence or confirmed wrongdoing, and facilities that OAG is continuing to closely monitor.

Starting in March, OAG received several reports from concerned staff and family members that nursing homes failed to ensure proper infection prevention and control practices. In OAG's COVID-19 rapid-response model, investigative teams followed up on these reports, interviewed key staff at the subject nursing homes, and, if necessary, reviewed records produced by the facilities either voluntarily, pursuant to OAG's authority to demand the production of records under 18 NYCRR § 504.3 or by subpoena pursuant to New York Executive Law § 63(12). OAG determined that several of these reports required additional investigation or referral to DOH.

CMS Star Ratings – Staffing versus Overall

The CMS Staffing rating is a separately published rating for each facility. It is also a component of the rating published as the Overall rating of a facility, along with two other separate ratings. The Staffing rating specifically reflects the number of staffing hours in the nursing department of a facility relative to the number of residents. This ratio is expressed as a star rating, with the lowest rating of 1-Star signifying the lowest number of staff per resident, and the highest rating of 5-Star signifying the highest number of staff per resident.

On March 1, 21 percent of New York's 619 nursing homes had very low Staffing and/or Overall ratings, as shown in this chart:

Category	Number of New York State Nursing Homes
CMS 1-Star Staffing rating *(22 of which has 1-Star Overall ratings)*	75
CMS 2-Star Staffing rating and 1-Star Overall rating	58

a. Failure to Isolate COVID-19 Residents Put Residents and Staff at Increased Risk of Harm

OAG received several credible reports from concerned staff and family members that nursing homes failed to promptly isolate residents who they knew or presumed to have had COVID-19. For example, in early April, a Certified Nursing Assistant (CNA) from a for-profit nursing home in New York City with CMS 2-Star Staffing and 4-Star Overall ratings reported that residents who tested both positive and negative for COVID-19 were simply treated with Tylenol, without isolation, or any other specific respiratory care. A few days later, OAG received a report from a member of the family council of the same nursing home alleging several concerns about how the facility responded to the COVID-19 pandemic. Among the complaints was that the facility was not properly sanitizing rooms of residents after they were transferred from the rooms.

Early in the COVID-19 pandemic, OAG began a preliminary investigation into a for-profit nursing home in New York City due to indications of neglect, including: a high number of resident deaths, poor performance during past DOH inspections, and the lowest possible CMS ratings (1-Star Staffing and 1-Star Overall). OAG received reports of multiple problems at the facility, including failure to isolate residents who tested positive for COVID-19. CDC and DOH conducted an infection control survey and found that the facility, while in need of policy changes, was in compliance with New York and federal infection control guidelines.

In mid-May, OAG received an anonymous call to the hotline in which the caller indicated that COVID-19 positive residents at a for-profit nursing home north of New York City with CMS 3-Star Staffing and 3-Star Overall ratings were intermingled with the general population for a period of time that allegedly ended in mid-May, when the facility started using its first floor as the designated COVID-19 floor. During an interview conducted by OAG investigators shortly thereafter, the administrator stated that the facility had not yet created a "COVID-19 only" unit but that it had placed COVID-19 positive residents in private rooms. He indicated at that time that the facility was planning on using one floor or part of a floor just for those residents.

b. Continued Communal Activities, Including Communal Dining, Put Residents and Staff at Increased Risk of Harm

In late April, weeks after communal activities, including communal dining, were restricted by CMS and DOH, OAG received an allegation from a family member of a resident that a for-profit Long Island nursing home with CMS 2-Star Staffing and 3-Star Overall ratings was still operating communal dining. OAG investigators promptly contacted the facility staff who admitted to OAG investigators that "aspiration precaution"[27] dementia residents were still being brought into the dining room for meals irrespective of COVID-19 status. They stressed that social distancing was observed and that only one resident would be allowed to sit at a table that typically would accommodate six residents. They explained that the decision to continue communal dining was made given the elevated levels of supervision required for residents at risk of aspirating. This purported safety concern directly implicates staffing. Aspiration precautions requires fewer staff if done in a group setting. After the OAG interview, the facility reportedly changed its policy and ensured that all residents would take meals in the rooms under appropriate supervision depending on each resident's care plan.

c. Lax Employee Screening Put All Residents and Staff at Increased Risk of Harm

OAG received reports that nursing homes did not properly screen staff members before allowing them to enter the facility to work with residents. Among those reports, OAG received an allegation that a for-profit nursing home north of New York City with CMS 2-Star Staffing and 4-Star Overall ratings failed to consistently conduct COVID-19 employee screening. It was reported that some staff avoided having their temperatures taken and answering a COVID-19 questionnaire at times when the facility's front entrance screening station had no employee present to conduct the screening, and when staff entered through a back entrance to the facility.

d. DOH Inspections Increased Facility Compliance with Infection Control Protocols

During an inquiry at a for-profit Western New York facility with CMS 1-Star Staffing and 1-Star Overall ratings, a Registered Nurse (RN) reported to OAG that immediately prior to the facility's first DOH inspection in late April, a nurse supervisor had set up bins in front of the units with gowns and N95 masks to make it appear that the facility had an adequate supply of appropriate PPE for staff. The RN alleged that the nurse supervisor came in to work unusually early at 5:30 AM the day of the first inspection and brought out all new PPE and collected all of the used gowns. Although the initial DOH survey conducted that day did not result in negative findings, DOH returned to the facility for follow-up inspections, issued the facility several citations, and ultimately placed the facility in "Immediate Jeopardy." "Immediate Jeopardy" means a deficiency has resulted in the provider's noncompliance, "has caused or is likely to cause serious injury, harm, impairment or death to the residents" and immediate action is necessary to address it.[28]

It was also reported to OAG that at a for-profit nursing home on Long Island with CMS 2-Star Staffing and 5-Star Overall ratings, COVID-19 patients who were transferred to the facility after a hospital stay and were supposed to be placed in a separate COVID-19 unit in the nursing home were, in fact, scattered throughout the facility despite available beds in the COVID-19 unit. According to the report, this situation was resolved only after someone at the facility learned of an impending DOH infection control survey scheduled for the next day, before which those residents were hurriedly transferred to the appropriate designated unit.

CMS and DOH conducted onsite infection control surveys at nursing homes statewide, which helped decrease risks to residents.[29] DOH provided infection control support in an effort to enforce compliance with regulations and guidance designed to protect residents. While these efforts helped, OAG's preliminary investigations indicate that nursing homes' lack of compliance with infection control protocols resulted in increased risks to residents at a number of facilities.

B. Nursing Homes with Low CMS Staffing Ratings Had Higher COVID-19 Fatality Rates

Most of the state's nursing homes are for-profit, privately owned and operated entities. There were 401 for-profit facilities, 189 not-for-profit facilities, and 29 government facilities statewide as of June 1. Not-for-profit facilities operate for the charitable purpose set forth in their charters. Government facilities have a public service mission. For-profit facilities are, by definition, operated with a goal of earning profit. Of the 401 for-profit facilities, more than two-thirds have the lowest possible CMS Staffing rating of 1-Star or 2-Stars. Similarly, of the 100 facilities in New York state with a CMS 1-Star overall rating, 82 are for-profit facilities.

While New York has minimal staffing level requirements for nursing homes, nursing homes require sufficient staffing levels on a daily basis and over the long haul in order to be able to provide the care required by New York law, including by individualized resident care plans. The main direct caregivers in a nursing home are, in order of training, CNAs, Licensed Practical Nurses (LPN), and RNs. These staffers are the bulk of the caregivers in a facility and have primary, daily contact with residents. CNAs provide assistance with activities of daily living, such as ambulation, transfers to/from bed, feeding, hygiene, toileting, bathing, dressing, bed cleaning and adjustments, turning and positioning of immobile patients, and other care and comfort. LPNs primarily focus on medication administration, monitoring vital signs, and providing certain treatments. RNs primarily focus on acute care needs, complex treatments, compliance with medical orders, communication with physicians and specialists, record-keeping, and complex health assessments.

Data presented in Appendix B hereto reflects that financial incentives within the current system result in a business model in too many for-profit nursing homes that: (1) seeks admission of increased numbers of residents to reach census goals; (2) assigns low numbers of staff to cover the care needs of as many residents as feasible; and, (3) transfers facility funds to related parties and investors that the home could otherwise invest in staffing to care for residents – essentially taking profit prior to ensuring care. In this model, hiring additional staff above the numbers set in low staffing models, and/or offering a higher wage in order to obtain more employees in the current labor market, are viewed as optional and unnecessary expenses. OAG's past cases and ongoing investigations reflect that this business model too often also includes extracting and transferring revenue received by for-profit nursing homes to related parties in a manner that enriches entities and individuals who have control over the nursing home, as well as their family members and business associates, at the expense of resident care and safety. These transfers of funds from such for-profit nursing homes occur through a variety of complex contractual relationships and transactions between private parties in order to enhance profit for owners, investors, landlords, and other private parties with relationships to the nursing home owners and operators, even though New York regulations prohibit directly extracting capital from a facility unless certain criteria are met. Notably, almost all revenue for nursing homes is from public funds — Medicare, Medicaid, and other state and federal programs — as well as funds such as retirement-benefit health insurance. Before the pandemic, OAG investigations, prosecutions, and civil actions reflected that this low staffing business model had created conditions of systemic causes of resident neglect and abuse at a number of facilities. *See, e.g.,* Appendix B, B-1, and B-2 below, for an illustration of this business model.

Given the complaints of neglect received during the COVID-19 pandemic[30] and the OAG investigation findings to date, the pandemic has laid bare the risks to vulnerable nursing home residents that are inherent in a low staffing business model.

Pre-existing insufficient staffing levels in many nursing homes put residents at increased risk of harm during the COVID-19 pandemic. As nursing home resident and staff COVID-19 infections rose during the initial wave of the pandemic, staffing absences increased at many nursing homes. As a result, pre-existing low staffing levels decreased further to especially dangerous levels in some homes, even as the need for care increased due to the need to comply with COVID-19 infection control protocols and the loss of assistance from family visitors.

1. Preliminary Investigative Findings Regarding Low Staffing Levels

COVID-19 and Staffing Shortages: OAG's preliminary investigations reflect many examples where for-profit nursing homes' pre-pandemic low staffing model simply snapped under the stress of the pandemic:

» OAG received a complaint from a resident's son about a for-profit nursing home in New York City with CMS 2-Star Staffing and 5-Star Overall ratings. The complaint alleged critically low staffing levels at the facility and the resident's son voiced concern about the care his mother was receiving. His mother was never tested for COVID-19, but later died while exhibiting COVID-19 symptoms. For several weeks, the facility was short of caregivers due to COVID-19 illness and quarantine, and most of its management was either out ill or working remotely. During one period of time between late March and early April, the director of nursing, the assistant director of nursing, and the medical director were all out ill and the administrator was working from home, leaving onsite management of the entire facility in the hands of just two nurse supervisors. Two to three weeks later, residents started dying from COVID-19. During the week of April 5, 33 residents died – 15 percent of all the patients in the facility. In mid-April, the administrator was overwhelmed and stated that the facility's greatest need was staffing.

» A for-profit facility in Western New York with CMS 1-Star Staffing and 1-Star Overall ratings was named in multiple reports from employees for having insufficient staffing, especially on the weekends. One CNA reported that on a day in late March, for at least a few hours, there was only one CNA in the entire building of approximately 120 residents. She also reported that on a day in mid-April, there was one CNA on each hall, one RN to cover the Rehabilitation and Dementia units, and one supervisor performing double duty by dispensing medication from two medicine carts. An RN stated that during a weekend late in May, during the day shift, one nurse called out and another nurse was a "no call no show," leaving one nurse for the entire building. The same RN stated that on a later day in May, she worked an overnight shift for which she was the only nurse for three units. Facility records indicate that only one nurse was on duty during the day shift the following day. Another employee alleged that the staffing levels at the facility were so low that CNAs, rather than nurses licensed to do so, were dispensing medications to residents. According to various staff members, the facility required staff who were not licensed clinicians to take an eight-hour temporary CNA course and to cover shifts working as CNAs.[31]

» A for-profit nursing home in New York City with CMS 2-Star Staffing and 5-Star Overall ratings indicated that in late March and early April, the facility's low staffing levels were decreased further due to staff illness and quarantine from COVID-19. A nursing supervisor alleged in mid-April that she had been working for 21 days straight, 14 hours per day, and described a facility stretched to the absolute limit to care for its residents. The following week, the nurse and the administrator conveyed that staffing levels had improved and that staff who had been out sick and quarantined were returning to work, staff were working extra shifts, and the facility used agency staffing of direct caregivers to supplement care provided by facility employees. The facility reported to OAG that it had 32 COVID-19 deaths during the three-week period with decreased staffing.

Preliminary investigations also indicate that residents at a number of facilities with pre-existing low CMS Staffing ratings faced other, predictable, increased risks. As nursing home resident and staff COVID-19 infections rose during the first wave of the pandemic, staffing absences increased at many nursing homes. Often, as health care workers became infected with COVID-19, they were either asymptomatic and continued working, or became ill and/or were required to self-quarantine under CDC and DOH guidance. When low staffing levels dropped further due to staff COVID-19 illness or quarantine, there were even fewer staff available to care for residents' needs at these facilities. At the same time, when residents had COVID-19, their individual and collective care needs increased due to the need to comply with COVID-19 infection control protocols. This need increased the workload for the remaining staff providing direct care in several respects, even as low staffing numbers dropped further. These decreases in staffing levels occurred at the same time that necessary visitation restrictions removed the supplemental caregiving provided pre-pandemic by many family visitors at low staff facilities.

In addition, preliminary investigations indicate that when there were insufficient staff to care for residents, some nursing homes pressured, knowingly permitted, or incentivized existing employees who were ill or met quarantine criteria to report to work and even work multiple consecutive shifts, in violation of infection control protocols. Thus, poor initial staffing before the pandemic meant even less care for residents during the pandemic: subtraction of any caregivers from an already under-staffed facility results in increased interaction among possibly infectious staff and residents, with less time for the staff to adhere to proper infection control precautions.

In addition to the examples discussed below, during an investigation of an upstate for-profit facility with CMS 2-Star Staffing and 2-Star Overall ratings, a manager said the facility had 14 known staff members who tested positive for COVID-19 and was following all CDC guidelines before allowing COVID-19 positive staff members to return to work, which had made staffing an issue. A CNA alleged that it was common to have only one or two CNAs per unit since the COVID-19 pandemic started. The CNA added that prior to this, there were "some" staffing issues but it "was not this bad." The CNA alleged residents are "lucky" to "get toileted and cleaned up once a shift...there is not enough time in the day to do it more than that." According to a nurse manager, the facility used DOH's database to hire more CNAs, which led to an improvement in staffing.

DOH Staffing Portal Helped: As reflected in the example above, during the COVID-19 pandemic, DOH referred facilities to an online staffing portal to help provide temporary assistance when they were experiencing staffing shortages due to staff illness and quarantine. This resource helped several nursing homes address staffing problems.

Multiple Complaints of Insufficient Staffing: OAG received several other complaints and allegations of insufficient staffing due to COVID-19 in facilities that had pre-pandemic low CMS Staffing ratings:

» The daughter of a resident at a for-profit facility north of New York City with CMS 2-Star Staffing and 5-Star Overall ratings reported that the facility experienced even lower staffing in May. The daughter said that the facility was short-staffed and that employees said the facility "forgot" to call her for about a week to inform her that her father tested positive for COVID-19.

» Complaints regarding a for-profit nursing home in New York City with CMS 1-Star Staffing and 1-Star Overall ratings claimed the facility experienced staffing absences early in the pandemic, but reportedly addressed these shortages by contracting or hiring additional staff.

» An employee complained that a for-profit nursing home on Long Island with CMS 2-Star Staffing and 5-Star Overall ratings had an insufficient number of staff due to staff being out sick. The facility reportedly tried to fill vacant positions by using staffing agencies but said there was a limited pool of personnel from which it could hire. It later reportedly supplemented staffing with agency staffing.

» A staff member at a for-profit nursing home on Long Island with CMS 2-Star Staffing and 3-Star Overall ratings alleged low staffing levels. Facility management acknowledged that low staffing levels had decreased from the pre-pandemic level to an insufficient level due to staff being out sick or being unable to work due to the need to care for the staff's family members. The facility sought to address the vacancies by incentivizing staff to work additional shifts, specifically by paying bonuses and by paying "hazard pay," which is additional pay above the employee's salary to compensate for working in an environment where COVID-19 infection exists and therefore presents increased health risks to the employee.

» A staff member at a for-profit nursing home on Long Island with CMS 4-Star Staffing and 4-Star Overall ratings alleged, and the facility acknowledged, that low staffing levels had decreased from the pre-pandemic level to an insufficient level, due to staff being out sick or being unable to work due to the need to care for the staff's family members. The facility sought to address the vacancies by paying $2 per hour more in hazard pay to incentivize staff to work additional shifts and by utilizing staffing agencies to provide per diem staff.

» Management at a for-profit nursing home in New York City with CMS 1-Star Staffing and 3-Star Overall ratings admitted that the facility experienced a shortage of staff below pre-pandemic levels from the end of March to the beginning of April. At the time of the preliminary investigation, the facility stated that its employees were stepping up and working double and triple shifts, with managers helping as well by distributing medications and filling in to help with some of the tasks that needed to be done to care for the residents.

OAG's phase one investigations also found that under conditions of pre-existing low staffing levels that were exacerbated by COVID-19, many nursing homes placed frontline health care workers under incredibly challenging and exhausting circumstances for extended periods of time, where they pushed themselves to the brink physically and emotionally. While working in an environment in which they knew COVID-19 was present and posed health risks to themselves and their families, many direct care staff worked multiple double shifts, repeatedly and over extended periods of time, doing incredible and compassionate work in attempt to care for the needs of many isolated, vulnerable, and ill residents. OAG heard many reports of direct care workers pushing themselves under extremely challenging circumstances of insufficient staffing — to the point of exhaustion, serious illness, and in some cases, the ultimate sacrifice of their own lives.

Many nursing homes mandated or encouraged health care workers to work multiple double shifts, repeatedly and over extended periods of time, because their pre-pandemic low staffing levels decreased further during the pandemic. Preliminary investigations illustrate that a number of health care workers believed that unless they worked under these strenuous conditions to provide necessary care to the residents, their needs would otherwise have gone unmet, in light of the nursing home's decisions on staffing levels.

When staffing levels decreased in low staffed facilities, the workload of RNs, LPNs, and CNAs increased in volume in four ways: (1) workers had to perform extra steps in caring for residents that were required to comply with COVID-19 infection control protocols; (2) workers' duties to provide more care to residents also increased as residents became ill with COVID-19; (3) workers' assignments also changed as staffing levels dropped and they were required to provide care to an increased number of residents in a single shift; and, (4) workers also often had to work a higher total number of hours per day or week when they were mandated or volunteered to work multiple shifts to cover for call-outs or other staff absences. The stress on direct care providers working under these circumstances for a prolonged period of time predictably took a heavy toll on their health and well-being. It also imposed a practical limit on the number of hours of caregiving these individuals could work over a sustained period of time. While the owners of for-profit nursing homes that operate in a low staffing business model have the power to change this dynamic, OAG's investigations reflect that they lack the motivation to do so. The results are tragic and, at this point, predictable, even as the second wave of COVID-19 continues.

Staffing Shortages Impacted Infection Control Compliance: As previously discussed, preliminary investigations indicate that infection control within nursing homes was a significant problem during the pandemic. At the same time that nursing homes with pre-pandemic low staffing levels were experiencing decreased staffing due to COVID-19, the staff's capacity to provide care to residents decreased because complying with infection control protocols required investing additional time in their duties. Reports also reflect instances where low staffing levels resulted in staff perceptions that the facility pressured them to work in violation of infection control protocols and other guidance that was designed to protect residents.

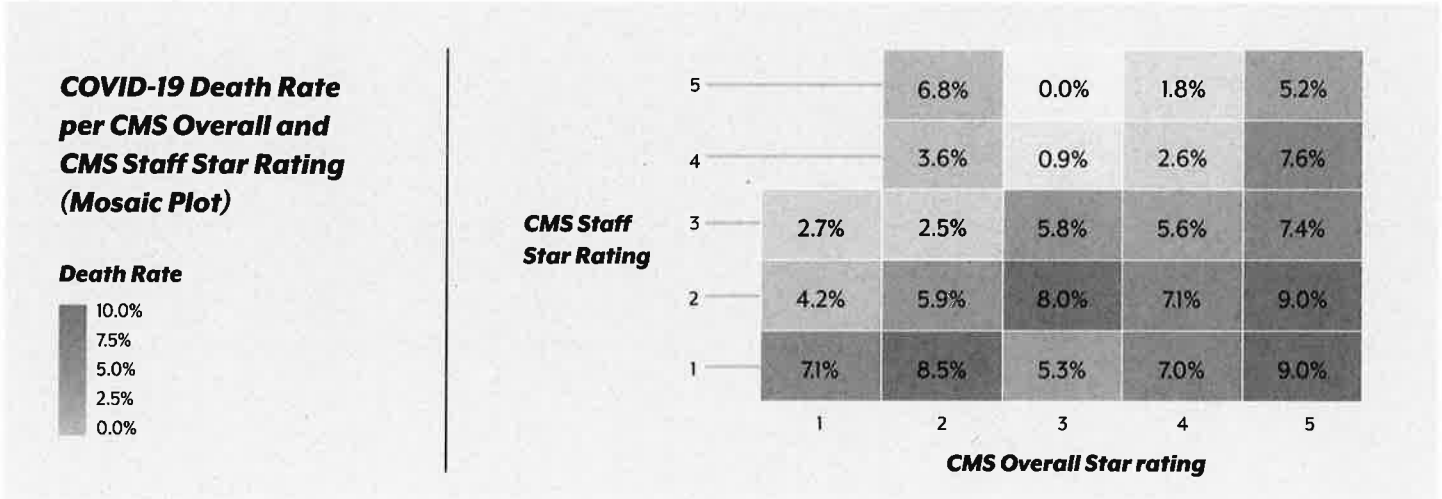
2. CMS Staffing Ratings Correlate More Strongly with COVID-19 Death Rates than CMS Overall Ratings

OAG's preliminary analysis, based on DOH's published[32] statistics of deaths in nursing homes from confirmed COVID-19 cases and presumed COVID-19 cases, shows a strong correlation to the CMS Staffing rating.[33] Nursing home residents died at a higher rate – deaths per average population of residents — in facilities that entered the COVID-19 pandemic with low CMS Staffing ratings. This data reflects that facilities with the highest CMS Staffing ratings had much lower death rates.

OAG's data analysis set forth in this preliminary report relies primarily on two data sources: the data made available through the "CMS Care Compare" website and DOH's daily reports of nursing home COVID-19 deaths. The New York state data, "Nursing Home and ACF COVID Related Deaths Statewide", are a publication by DOH of statistics self-reported by nursing homes and adult care facilities to DOH during the COVID-19 pandemic. As previously noted, OAG found discrepancies between COVID-19-related death data publicized by DOH and information reported to OAG during investigations. For the death data analysis below, OAG used the DOH-published figures, except where noted. The analysis revealed that most nursing home residents live in a CMS 1-Star or 2-Star Staffing rated facility. To avoid skewing the rate of COVID-19 deaths, OAG divided the total COVID-19 death count in each facility by the total resident count in each facility. This calculation results in a direct comparison across all facilities, which produces a COVID-19 death rate uninfluenced by the census of CMS 1-Star and 2-Star Staffing rated facilities.

With the exception of certain combinations of data points, the death rate increases as the CMS Staffing rating decreases, regardless of the CMS Overall rating. Thus, nursing home facilities with CMS 5-Star Overall ratings still saw the highest death rates if they had CMS 1-Star or 2-Star Staffing ratings. Indeed, facilities with 3-Star Overall ratings evinced lower death rates if their base staffing levels were high.

In the chart below, facilities with CMS 5-Star Overall ratings had an observed death rate of nine residents out of every 100 when their CMS Staffing rating was 1-Star or 2-Star. That rate dropped nearly by half, to five out of 100, if the facility had a CMS 5-Star Staffing rating.[34] Relatedly, facilities with low CMS Staffing ratings had higher death rates than similar CMS Overall rated facilities.[35] The chart includes all deaths from March 1 to November 16.



a. The Majority of the COVID-19 Reported Nursing Home Deaths Occurred in CMS 1-Star and 2-Star Staffing Rated Homes

As of November 16, DOH reported 6,645 nursing home COVID-19 resident deaths (confirmed and presumed). Nursing homes with CMS 1-Star or 2-Star Staffing ratings represented an outsized number of deaths, as compared to nursing homes with higher CMS Staffing ratings.

Table A — Distribution of Nursing Home Deaths as of November 16 by CMS Staffing Rating

CMS Staffing Rating as of 6/1	Number of Facilities	Percentage of Total Facilities	Total COVID Deaths 11/16	Percentage of Total	Total Average Census 6/1	Death rate per Resident
1	77	12.44%	975	14.67%	13,671	7.13%
2	266	42.97%	3426	51.56%	49,542	6.92%
3	169	27.30%	1611	24.24%	28,975	5.56%
4	68	10.99%	478	7.19%	9,329	5.12%
5	31	5.01%	97	1.46%	1,965	4.94%
NO RATING	8	1.29%	58	0.87%	600	9.67%

Of the state's 401 for-profit facilities, over two-thirds – a total of 280 – entered the COVID-19 pandemic with CMS 1-Star or 2-Star Staffing ratings.[36] As of November 16, 3,487 COVID-19 resident deaths (over half of all deaths) occurred in these 280 facilities. Also concerning has been the recent trend observed by OAG of for-profit owners buying not-for-profit nursing homes in transactions that result in more for-profit facilities.[37]

b. Staffing Was More Determinative of Death Rates Than "COVID-19 Geography" During the Initial Wave of the Pandemic

As noted by DOH, the harshest impact of the first wave of COVID-19 was in New York City and neighboring counties, which reflect eight of the ten highest populated counties in the state. Those counties also host the greater number of CMS 5-Star Staffing rated facilities as well as the greatest number of CMS 5-Star Overall rated facilities. As DOH noted, even 5-Star Overall rated facilities in those counties had high death rates.[38]

However, OAG found that when controlling for geographic variance among nursing facilities, CMS 5-Star Staffing rated facilities nonetheless suffered a lower death rate compared to facilities with low CMS Staffing ratings.[39] Thus, a resident anywhere in New York was likely to face roughly half the risk of death from COVID-19 if cared for in a CMS 5-Star Staffing rated facility.

Weighted Death Rate Controlled for Geographic Variance, by CMS Staffing Stars

Star Rating	*Overall weighted death rate*	*Staffing weighted death rate*
1	5.56%	6.03%
2	5.59%	6.94%
3	6.89%	7.56%
4	5.83%	6.07%
5	6.60%	2.97%

C. Lack of Sufficient PPE for Nursing Home Staff Put Residents at Increased Risk of Harm During the COVID-19 Pandemic in Some Facilities

New York state and federal laws and guidance require nursing homes to follow infection control protocols, which include obtaining sufficient infection control supplies such as PPE to provide to staff and residents to protect them from the risk of infection from transmissible disease, including COVID-19. Science, common sense, and OAG's preliminary findings following initial COVID-19 investigations indicate that a nursing home's lack of sufficient PPE and failure to comply with CDC and DOH guidance increased the risk that COVID-19 spread to other residents and staff within the facility. Conversely, OAG's preliminary investigations indicate that residents had better health outcomes in nursing homes that had trained staff and plans in place to obtain sufficient PPE.

OAG received multiple reports that during the first wave of the pandemic, several nursing homes across the state had woefully inadequate PPE to prevent the transmission of COVID-19. OAG received allegations that due to PPE shortages, facilities violated basic infection control practices by requiring staff to re-use PPE or to clean used PPE. OAG received a report that in a for-profit facility in Western New York with CMS 2-Star Staffing and 2-Star Overall ratings, there was a lack of PPE for staff use until the first resident with suspected COVID-19 went to the hospital, and that an LPN at the facility was allegedly forced to resign after she questioned inadequate PPE policies and refused to work under conditions where staff and residents would not be safe. In early April, OAG heard from several other employees of that same nursing home who advised OAG that the staff at the facility allegedly were not provided adequate PPE for several weeks at the beginning of the pandemic and were forced to share gowns, which were kept hanging in hallways on hooks. OAG also heard that, in addition to not having adequate PPE, the facility allegedly violated basic infection control protocols by allowing communal dining, contrary to government-issued guidance, until the first resident went to the hospital in late March. Another LPN at this facility reported that she cared for a COVID-19 positive resident with only sanitizer and gloves because that was all that was available at the time and facility management told her and other staff members that they would have to make do with what they had. According to the LPN, there were not enough surgical masks to change between COVID-19 positive and negative residents and staff were instructed to make surgical masks last as many days as possible. She reported that the facility did not have N95 masks or face shields and that staff resorted to using surgical masks or homemade cloth masks, gloves, and "contaminated" shared gowns.

Regarding a for-profit nursing home in Western New York with CMS 1-Star Staffing and 2-Star Overall ratings, OAG received a report from a nurse manager that the owner of the facility directed staff not to wear masks and that it would be "business as usual" because the facility did not have sufficient PPE. This nurse manager allegedly went directly to the New York State Office of Emergency Management (OEM)[40] to attempt to obtain additional PPE for her staff. The same nurse manager reported that inexplicably her decisions were continually undermined by ownership. For example, after the nurse manager allegedly attempted to stop communal dining after CDC guidance restricting communal activities, ownership reversed her decision days later and resumed communal dining. Another RN supervisor at this facility resigned when she began to feel like continuing to work was putting her license at risk due to inadequate PPE at the facility. A CNA from this facility also reported that "masks were optional" even after visitors were barred from the facility and there was no quarantining of residents until weeks into the pandemic.

Though these reports allege that these facilities did not have adequate PPE during the first few months of the pandemic, and investigations are ongoing, OAG has been assured that each of these facilities now has an adequate supply and is appropriately distributing PPE to staff.

In another continuing investigation into a different for-profit Western New York nursing home with CMS 1-Star Staffing and 1-Star Overall ratings, OAG heard from an aide who reported that between mid-March and early April, she asked the nurse supervisor of the facility for her own gown. The nurse supervisor replied to the aide that she cannot pass out PPE "willy nilly" and that gowns were only for those "on the front line," even though the aide was very much on the front line and providing direct care to residents. The aide alleged that she was eventually given a gown but told she had to reuse it every day. She noted to OAG investigators that over time those gowns became visibly soiled, such that she and her fellow caregivers threw them out and resorted to simply wearing a regular sleeping gown over their clothes when tending to residents. Some of the aide's statements were corroborated by a funeral director who reported to OAG that when he entered the facility in mid-April to retrieve a deceased resident, he observed staff wearing PPE that was only in the forms of gowns, regular surgical masks, and gloves. He stated staff did not take his temperature when he entered the facility, nor was he asked to fill out a health questionnaire. He also stated that he observed used gloves strewn on the floor of the facility.

As widely reported in the media and confirmed by OAG in its preliminary investigations, many health care institutions faced challenges to acquire and compile sufficient PPE to meet the demands placed on institutions during the COVID-19 pandemic. PPE was most scarce during the first few months of pandemic, but ultimately became more available due to the efforts of DOH, OEM, and county and local governments. New York state also coordinated with other states and worked to secure additional PPE. During preliminary investigations, OAG learned of several facilities that had dangerously low stockpiles of PPE but received additional supplies from DOH or OEM, including two for-profit facilities in New York City, one with a CMS 2-Star Staffing rating and one with a CMS 1-Star Staffing rating, and two other facilities on Long Island, both CMS 2-Star Staffing rated facilities. DOH and OEM's provision of PPE to nursing homes helped decrease risks of infection and harm to residents in many facilities.

On February 6, DOH issued a guidance to the health care industry reminding facilities to "be ready and equipped" to "manage patients presenting to their facility with the potential of being infected with [COVID-19]." The guidance reminded institutions that shortages of PPE may occur and of the importance to strictly adhere to the latest guidance from CDC. DOH instructed all facilities to compare their existing inventories of PPE against the expected rate of use of these items under a surge situation and to determine the quantities needed to be on hand. Facilities that identified a shortage of PPE were directed to use existing vendors and to activate mutual aid agreements to obtain available support if needed. If the facility was unable to obtain needed PPE from those sources, facilities were instructed to notify their local emergency management agency, DOH or, if necessary, OEM. OAG observed that many facilities that had dangerously low inventories of PPE ultimately received PPE from either DOH, OEM, their local government, or other sources, including donations from the public. On April 2, DOH issued another advisory to the health care industry noting that New York state continued to fulfill requests for PPE, as available, and that health care entities should continue to submit requests for PPE through their local emergency management agency.

OAG observed that many institutions were making good faith efforts to purchase sufficient PPE but were hampered by several external factors, including supply chain issues. OAG's preliminary findings appear to show that many nursing homes, consistent with their obligation to ensure emergency preparedness, made admirable efforts to get needed PPE in time to protect residents and health care workers. At the same time, timing and expenditure levels of effort and funds made by nursing homes to obtain PPE appear to have varied. OAG will continue to investigate whether those facilities that failed to obtain adequate supplies of PPE made good faith, but ultimately unsuccessful, efforts or whether facilities that failed to provide PPE to their staff and their residents did so due to their lack of responsible planning, their refusal to purchase critically needed PPE through available vendors, or similar conduct relating to their operations.

D. Lack of COVID-19 Testing for Residents and Staff in Early Stages of the Pandemic Put Residents at Increased Risk of Harm in Many Facilities

During a pandemic, the federal government plays a key role in the ability of states' access to testing for new viruses. In February, CDC's work to develop the first COVID-19 test failed, resulting in a critical delay of several weeks before CDC developed an effective test. By the time CDC sent the new test kits out to the states, COVID-19 had spread within the United States, including to New York. Afterward, CDC encouraged the Food and Drug Administration (FDA) to allow hospitals and commercial labs to produce tests for sale faster. Additional delays occurred when the FDA took weeks to begin issuing emergency authorizations for other tests.

In March, COVID-19 testing capacity in New York state was limited. New York state agencies took action that helped protect nursing home residents, including working to obtain the ability within the state to conduct increased COVID-19 testing. At the same time, OAG's preliminary investigations indicate that nursing homes had varying degrees of access to COVID-19 testing early in the pandemic, with many lacking access to sufficient testing in March and April. Some facilities reported that once receiving test kits, the turnaround time on test results was lengthy. One facility reported that it transferred patients to the hospital because there was no other means to get testing.

After testing became increasingly available, Governor Cuomo issued an executive order requiring COVID-19 testing by nursing homes of their staff, which helped protect residents from the risk of infection and harm. DOH tested nursing home residents at various facilities, which also helped protect residents.

While testing of staff is now regular and mandatory, and testing availability has improved significantly, the preliminary investigations reflect insufficient availability of COVID-19 testing for residents and staff of nursing homes in the early stages of the pandemic. The lack of testing increased the risk of COVID-19 infection of residents and staff. If residents and staff are not tested for COVID-19, they may be infected yet asymptomatic, and unknowingly transmit the virus to others through informal contact when they otherwise would be isolated or quarantined under CDC guidance. In addition, a lack of readily available testing for residents and staff also can hinder their ability to obtain prompt and specific medical treatment for those who become symptomatic and ill.

DOH guidance issued on March 21 directed downstate nursing homes, which were in areas of high community-based transmission, to treat all residents who exhibited COVID-19 symptoms as if they had been diagnosed with COVID-19 for purposes of infection control protocols. However, if a nursing home lacked access to testing, it is possible that asymptomatic residents who were not tested and who were unable to communicate symptoms they were experiencing might not be readily apparent to staff for a period of time before symptoms were identified. Under those circumstances, those residents are at greater risk of harm from not receiving treatment and/or close monitoring for changes in condition. In addition, the circumstances create an increased risk of transmission to others in the facility.

For example, OAG received a credible allegation from the daughter of an asymptomatic nursing home resident about a for-profit upstate facility with CMS 2-Star Staffing and 1-Star Overall ratings. She alleged that the facility responded that due to the limited number of test kits at the facility, it could only test her father if he exhibited symptoms. He later exhibited symptoms, including a high fever, and was sent to the hospital where he tested positive for COVID-19.

OAG's preliminary investigations also provide anecdotal support that staff infected with COVID-19 in certain instances worked within nursing homes during periods that they were undiagnosed and asymptomatic, thereby increasing the risk of infection and harm to residents. CDC guidance provides that when a health care provider is infected with COVID-19, "Anyone who had prolonged close contact (within 6 feet for at least 15 minutes) with the infected health care provider might have been exposed." CDC guidance also states that "if the provider had COVID-19 symptoms, the provider is considered potentially infectious beginning 2 days before symptoms first appeared." If the provider was asymptomatic and the date of exposure to COVID-19 infection can be identified, the provider should be considered potentially infectious beginning 2 days after the exposure. CDC guidance also states that the infectious period for COVID-19 is generally accepted to be 10 days after onset of the infection.

As one example, in a large not-for-profit nursing home in New York City with CMS 2-Star Staffing and 3-Star Overall ratings, a facility manager indicated that an experienced LPN worked on a unit with over 40 residents until March 14, when he stopped working, was diagnosed with COVID-19, and later died. By March 21, the facility reported 20 percent of its staff were out sick. The facility reported no COVID-19 resident deaths up to that date. From March 22 to March 29, the facility reported seven COVID-19 resident deaths, including two within the facility and five after transfer to the hospital. From March 29 to April 4, the facility reported 26 COVID-19 resident deaths, including 18 within the facility and eight after transfer to the hospital. The facility management stated that in early stages of the pandemic, DOH's Wadsworth lab was the only lab doing COVID-19 testing, and then others started, including the facility's own lab. In April, the facility stated that getting COVID-19 test results took 36 hours.

More nursing homes tested residents in April and May as testing capacity increased in the state, including in the months that followed.

1. Testing Requirements Helped Facilities Identify Residents and Staff Who Were Infected with COVID-19

Governor Cuomo issued Executive Order 202.19 on May 17 for DOH to establish a "statewide coordinated testing prioritization process" for all laboratories in the state, both public and private, for conducting COVID-19 diagnostic testing. Executive Order 202.30, issued May 10, required nursing homes to test full time staff twice a week for COVID-19.[41] These measures, along with the increased testing capacity, helped facilities identify residents and staff who were infected with COVID-19 and decrease the risk of transmission of infection and illness to nursing home residents and staff. Testing staff enables facilities to identify asymptomatic individuals who can then quarantine until they can safely return to work to provide care to residents. Testing residents enables facilities to identify asymptomatic individuals who can then remain isolated from non-infected residents. A lack of testing of health care workers who are at risk of COVID-19 infection increases the risk of transmission to residents when COVID-19 is present in the surrounding community.

OAG's investigations indicate that, absent Executive Order 202.30, many staff would not have been tested by the nursing homes. For example, one for-profit upstate nursing home with CMS 1-Star Staffing and 1-Star Overall ratings referred its staff to their primary physicians[42] to obtain COVID-19 testing in the earlier stages of the pandemic. However, the facility reported that after COVID-19 testing was required, it tested staff weekly. Similarly, a for-profit nursing home in New York City with CMS 1-Star Staffing and 3-Star Overall ratings reported that it had started testing residents in late March. The facility also reported that staff were tested, and that after Executive Order 202.30 providing testing guidelines, they were adhering to them.

This, and other information, indicates that absent an obligation to test staff, many nursing homes would not have tested staff for COVID-19, and many staff could not have obtained testing frequently on their own, unless testing was otherwise easily available and free.

2. DOH Testing Protected Residents

The preliminary investigations reflect that DOH tested many residents and staff at nursing homes later in the pandemic. For example, at a for-profit nursing home in New York City with CMS 2-Star Staffing and 1-Star Overall ratings, the administrator indicated that DOH provided facility testing and more PPE, and tested the entire facility, including residents and staff. Similarly, a for-profit facility in Western New York with CMS 2-Star Staffing and 2-Star Overall ratings that had reported a lack of testing ability, stated that its testing issues had been resolved through apparent facility-wide testing conducted by DOH. Relatively shortly thereafter, the facility reported it was COVID-free.

E. Lack of Nursing Home Compliance with Executive Order Requiring Communications with Family Members Caused Avoidable Pain and Distress

OAG took immediate and direct action with respect to a number of facilities regarding communication with family members. The most formal actions consisted of written warnings and cease & desist notices. Most communication issues were rapidly solved with less formal contact by OAG staffers with the facility and/or families. Three facilities were given such formal warnings, and ten facilities were advised orally that there was credible information that they were failing to comply with executive orders and action would be taken if not promptly resolved. (As noted elsewhere, roughly half of the intakes involved allegations of further or other problems at facilities.)

F. Government Issued Guidance May Have Led to an Increased Risk to Residents in Some Facilities and May Have Obscured the Data Available to Assess the Risk

While government-issued guidance from CDC and DOH based on updated information relating to COVID-19 helped protect many New York residents, nursing home implementation of some guidance may have led to an increase risk of fatalities in some facilities and may have obscured data reported by nursing homes.

1. At Least 4,000 Nursing Home Residents Died After DOH's March 25 Guidance on Admission Practices

On March 25, DOH issued guidance providing that "[n]o resident shall be denied re-admission or admission to the nursing home solely based on a confirmed or suspected diagnosis of COVID-19. Nursing homes are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or re-admission."[43] The guidance was rescinded on May 10 in Executive Order 202.30. From March 25 to May 8, 6,326 hospital patients were admitted to 310 nursing homes. The peak of these admissions was the week of April 14.[44] The peak single day in reported resident COVID-19 deaths was April 8, with 4,000 reported deaths occurring after that date.

Many nursing home industry and other commentators have criticized DOH's March 25 guidance as a directive that nursing homes had to accept COVID-19 patients who were infectious.[45] At the same time, the March 25 guidance was consistent with the CMS guidance on March 4 that said nursing homes should accept residents they would have normally admitted, even if from a hospital with COVID-19, and that patients from hospitals can be transferred to nursing homes if the nursing homes have the ability to adhere to infection prevention and control recommendations. It was also consistent with CDC Published Transmission-Based Precaution (T-BP) guidance, which was referred to in CMS's March 4 guidance, and which stated that if T-BP were still required for a patient being discharged to a nursing home, the patient should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19. *See* Appendix A.

It is worth noting that to the extent New York hospitals had capacity concerns due to the pandemic, the March 25 guidance would have been helpful to communities where those facilities were experiencing longer COVID-19 patient stays due to delays in receiving testing results, and were at or exceeding acute care capacity while they simultaneously were anticipating more new patients in need of acute care.[46] This is because many hospitals in areas of high COVID-19 infection rates in some other states reported that "post-acute facilities were requiring negative COVID-19 tests before accepting patients discharged from hospitals."[47] This practice meant that some patients who no longer required acute care were occupying valuable hospital beds while waiting to be discharged.[48]

DOH has said that nothing in the guidance stated that a facility should accept patients who could not be safely cared for. As to whether the March 25 guidance affected risks to residents, DOH presented data[49] reflecting the spike in health care worker infection and the later spike in deaths as circumstantial support for the position that the guidance did not contribute much to resident risks or deaths. Criticism since then notes that there has been no presentation of additional evidence as to whether the admission of patients from hospitals to nursing homes may have contributed to COVID-19 transmission or COVID-19 related deaths of nursing home residents. DOH states CDC says COVID-19 positive patients cannot likely transmit the virus after nine days of infection, and that patients are most infectious within two days after symptoms appear.[50] CDC guidance also says there is uncertainty on this. DOH says the median hospital stay was nine days.

Data linking the number of nursing home deaths to the admissions policy contained in the March 25 guidance is obscured by that same guidance, which also prohibited nursing homes from requiring COVID-19 testing as a criterion for admission. This phenomenon was compounded by both the March 21 directive that largely paused the testing of downstate residents, and the under-reporting of nursing home deaths generally (as previously discussed). OAG's investigation to date has not revealed an admission from any nursing home operator that they could not care for referred residents. However, using the DOH publicized data, over 4,000 nursing home deaths occurred after the issuance of the March 25 guidance.[51] While additional data and analysis would be required to ascertain the effect of such admissions in individual facilities, these admissions may have contributed to increased risk of nursing home resident infection, and subsequent fatalities (whether due to actual transmission of infection from new residents to incumbent residents, or due to the facilities' poor self-assessment during the admission process that was followed by failure to provide appropriate care to that patient or other residents.)

2. DOH's March 21 Guidance on Testing Practices Obscured the Data

As previously discussed, OAG's preliminary investigations reflect that COVID-19 testing availability for nursing homes downstate was limited in March and April, and fraught with delays. In this context, OAG preliminary investigations reflected that in the nine downstate counties that experienced higher community-based transmission of COVID-19, some facilities stopped testing residents for COVID-19 after the March 21 guidance was issued. For example, the administrator of a for-profit facility in New York City with CMS 1-Star Staffing and 1-Star Overall ratings alleged in April that the facility was not currently testing residents for COVID-19. He alleged that DOH told the facility to stop testing at some point in March. He alleged that prior to that, the facility was conducting testing through a lab. Similarly, the administration of a for-profit facility on Long Island with CMS 3-Star Staffing and 2-Star Overall ratings alleged that the facility originally tested seven residents and had suspended the testing of residents following the DOH "directive" that tests were not required. The facility alleged that it understood that all parties should be considered infected and treated as such. A for-profit facility in New York City with CMS 3-Star Staffing and 2-Star Overall ratings alleged that while it did not have access to COVID-19 testing, it was relying on DOH guidance issued March 21 for not testing.

G. Immunity Provisions May Have Allowed Facilities to Make Financially-Motivated Decisions

Due to several recent changes in law, it is unclear to what extent facilities or individuals can be held accountable if found to have failed appropriately to protect the residents in their care. On March 23, Governor Cuomo issued Executive Order 202.10, which created limited immunity provisions for health care providers relating to COVID-19.

The specific statute, the Emergency Disaster Treatment Protection Act (EDTPA), was enacted on April 6, and provides immunity to health care professionals from potential liability arising from certain decisions, actions and/or omissions related to the care of individuals during the COVID-19 pandemic retroactive to Governor Cuomo's initial emergency declaration on March 7. The legislation created a new Article 30-D of the Public Health Law. The legislature noted that the purpose of the EDTPA was to "promote the public health, safety and welfare of all citizens by broadly protecting the health care facilities and health care professionals in this state from liability that may result from treatment of individuals with COVID-19 under conditions resulting from circumstances associated with the public health emergency."[52]

The original form of the EDTPA,[53] in effect during the time period of this report, provided that:

> *Any health care facility or health care professional shall have immunity from any liability, civil or criminal, for any harm or damages alleged to have been sustained as a result of an act or omission in the course of providing health care services, if: (a) the health care facility or health care professional was providing health care services in accordance with applicable law, or where appropriate pursuant to a COVID-19 emergency rule; (b) the act or omission occurs in the course of providing health care services and the treatment of the individual is impacted by the health care facility's or health care professional's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives; and, (c) the health care facility or health care professional is providing health care services in good faith.*[54]

There is an exception, but it comes with a potential loophole:

> "[Immunity] shall not apply if the harm or damages were caused by an act or omission constituting willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm. . . *provided, however, that acts, omissions or decisions resulting from a resource or staffing shortage* [emphasis added] shall not be considered to be willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm."[55]

The EDTPA is silent as to whether the safe-harbor for "resource or staffing shortage" is to be assessed only based on conditions that arose as a result of the COVID-19 emergency or whether it intended to include such shortages existing prior to the emergency period. As seen in this report, pre-pandemic staffing shortages are associated with deaths from COVID-19. Therefore, the question of the scope of immunity is important in determining remedies.

To the extent that the executive order and/or EDTPA were interpreted by any nursing homes as providing blanket immunity for harm to residents other than intentional harm, even if the harm was related to intentional resource and staffing allocations, Attorney General James disagrees with such an interpretation as illogical, contrary to public policy, and contrary to the law's intent. The intent was to support health care professionals making impossible health care decisions in good faith during this unprecedented crisis. As exemplified in subsections below, the preliminary investigations illustrate instances of facility decisions that relate to or affect resident care that are financially motivated, rather than clinically motivated. OAG investigations will continue as to acts both prior to, and after, the August 3 amendments to Public Health Law Article 30-D.

Admissions Decisions and Staffing Decisions: A facility's decision to admit new residents is also a staffing decision because it requires a facility to assess whether its staffing level is sufficient to provide care to meet the needs of the existing residents and any proposed new residents. When a for-profit nursing home has an empty bed, it has a financial motivation to increase its census by admitting residents in order to obtain the daily rate of reimbursement offered by the resident's payor – Medicaid, Medicare, other federal health insurance, or private insurance.[56]

During the pandemic, many facilities experienced empty beds as residents died from COVID-19 or other causes. Some families took their loved ones to a family member's home. A decrease statewide in elective surgeries at hospitals reportedly stopped a regular flow of patients to nursing homes for rehabilitation. As discussed above, many facilities also experienced staffing reductions due to COVID-19 illness and quarantine, which necessarily decreased the facility's capacity to provide care for its residents, and, as the examples discussed herein reflect, resulted in exacerbated staffing problems.

The preliminary investigations indicate that nursing homes took a variety of approaches to decisions to admit residents during the COVID-19 pandemic, even as they were experiencing staffing shortages due to staff illness from, or otherwise inability to work due to, COVID-19. The approaches suggest admissions decisions were affected to varying degrees by financial motives, and by clinical and administrative evaluations of the facility's ability to provide appropriate care to its residents. OAG received information during its investigations that some facilities decided that the safest course was to stop admitting residents for periods of time while their staffing was low. For example, a not-for-profit nursing home in New York City with CMS 2-Star Staffing and 3-Star Overall ratings that experienced staffing shortages due to COVID-19 infection reported that it stopped admissions on March 21 due to 20 percent of staff calling in sick. In addition, to improve staffing, the facility brought in agency staff home health aides and restructured the staff.

In contrast, a for-profit nursing home in Western New York with CMS 1-Star Staffing and 1-Star Overall ratings indicated it took a different approach to admissions. Managers at that facility alleged that as of the end of April, the facility continued to accept new residents despite ongoing staffing difficulties, having nine out of 126 residents who tested positive for COVID-19, five residents dying from confirmed COVID-19, and five staff testing positive for COVID-19.

A for-profit facility in Western New York with CMS 2-Star Staffing and 2-Star Overall ratings indicated it also accepted new patients in April, but only admitted residents if they had recovered from COVID-19. However, as of April 30, according to a nurse supervisor, the facility was not taking admissions for at least a week due to the "state of the facility." The investigation reflected that the "state of the facility" included unstable conditions as alleged by staff:

» A high rate of COVID-19 positive cases, with 33 out of 59 residents testing positive;

» The facility had tested less than half of the residents;

» The facility did not have enough tests to test the remaining residents, and was trying to get more;

» 14 positive staff members and 12 more pending staff tests;

» Staffing shortages;

» The facility administrator was out sick.

As of mid-May, the nurse supervisor asserted that staffing had improved, with most staff who were out sick or quarantined returning to work. As of the following week, the acting administrator advised that staffing issues were continuing to improve, testing issues had been resolved, and facility had been COVID-19 free for two weeks, and facility expected to be taken "off precautions" from DOH shortly. The facility provided documentation indicating it had passed DOH infection control surveys in early May and mid-May.

Financial Incentives Illustration — Admissions: As illustrated in the example below, the preliminary investigations reflect how the financial incentives within the current system resulted in pressure by some for-profit owners to push staff to admit increased numbers of residents from hospitals in order to reach census goals, regardless of whether the facility had sufficient staff to care for them. Specifically, in one for-profit facility in New York City with CMS 2-Star Staffing and 1-Star Overall ratings, an administrator reported communications with an owner about hospital admissions. The facility interpreted DOH's March 25 guidance not to deny admission of residents from the hospital solely on the basis of a COVID-19 positive diagnosis as "they were to admit COVID-19 residents from the hospital." The facility admitted five hospital patients on March 26, but the owners wanted to admit more. The administrator alleged that there were arguments with the owners over how many residents they could safely care for. According to the administrator, every new admission from the hospital was a patient who was "COVID positive."[57]

Incentive Pay and Bonuses to Staff: Preliminary investigative findings also reflected a range of sizes of financial investment that facilities and/or owners were willing to make for short periods of time during the pandemic to provide monetary incentives to health care workers in order to retain staff, to attract new staff as full-time employees or as temporary agency staff, and to encourage staff to work additional shifts at the facility. Facilities' reported choices in providing financial incentives to increase staffing reflect different perspectives on what level of expenses were determined to be necessary versus optional. Some facilities paid small bonuses to staff for each additional shift they took, with some limiting the bonus to shifts involving work with COVID-19 positive residents. Other facilities paid generous salary increases per hour for hazard pay. Still other facilities paid staff both salary increases and bonuses per extra shift worked. Some offered hazard pay for a few weeks, while others offered it for longer periods of time. Some paid agency staff extra, while others did not.

H. Ongoing Investigative Work

Following the first wave of COVID-19 in New York, OAG has continued to conduct in-depth investigations involving the COVID-19 impact at over 20 facilities, and to monitor and follow up as needed with the facilities that were the subject of initial investigations. During this time, OAG has received new allegations of neglect and abuse connected with COVID-19 conditions, as well as reports of neglect and abuse of nursing home residents seemingly unrelated to COVID-19, and conducted additional investigative work. OAG continues to investigate and to find and follow the facts in order to serve its mission to protect nursing home residents from abuse and neglect, and to protect Medicaid from provider fraud. OAG will continue these investigations, without fear or favor, and make recommendations regarding remedies, when and where appropriate.

COVID-19 is continuing to spread from person to person throughout our communities, bringing more illness and untimely death in our state, as well as in our nation and our world. This preliminary report serves to increase transparency and awareness of preliminary findings from the first wave in New York state, including the conditions and risks that many nursing home residents faced. This information will help to identify challenges we face together and potential solutions, and to encourage collective action by our state's residents to protect each other, and our state's vulnerable nursing home residents. The recent advent of the COVID-19 vaccine is a welcome development that will help save lives as it is distributed, providing additional protection to health care workers, nursing home residents, and, eventually, everyone. At the same time, it is not a panacea. More action is needed to protect nursing home residents, and to provide them with the care and dignity that they deserve while living in the skilled nursing facilities that are their homes.

Regulatory Framework

A. New York State Law on Nursing Home Requirements to Provide Care and Staffing to Meet Resident Needs

New York law explicitly recognizes that for the vast majority of nursing home residents, "the nursing home will be their last home." Accordingly, a license to operate a nursing home carries with it "a special obligation to the residents who depend upon the facility to meet every basic human need."[58] New York law recognizes that "*nursing homes should be viewed as homes as much as medical institutions* [emphasis added]."[59] Each nursing home is required to give each resident "the appropriate treatment and services to maintain or improve his or her abilities" and provide each resident with "the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care subject to the resident's right of self-determination."[60] A nursing home is required to "accept and retain only those residents for whom it can provide adequate care."[61]

New York state's current minimum nursing home staffing standards require one RN for eight consecutive hours every day of the week, plus one RN or one LPN as a "Charge Nurse" 24/7 (or one charge nurse for each unit or "proximate" units for each tour of duty). This is proximate to the federal Medicaid/Medicare minimum standard. A facility must have a full-time employee RN as director of nursing who counts towards the staffing formula.

New York law requires nursing homes to provide "sufficient nursing staff and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being."[62] State law also provides that homes, in conjunction with a physician, describe each resident's needs in a "Comprehensive Care Plan," which identifies health concerns and directs particular courses of treatment, specifying, among other things, medications, assisted movement, skin care, bowel and bladder care, and nutrition needs.[63]

B. New York State Law on Nursing Home Duties to Residents

Nursing home residents in New York have basic protections and legal rights to ensure that they are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the facility.[64] Among those rights are adequate and appropriate medical care, and the right to be fully informed by a physician in a language that the resident can understand, using an interpreter when necessary, of their total health status, including but not limited to, their medical condition including diagnosis, prognosis, and treatment plan. Each resident or their representative has the right to ask questions and have them answered, be fully informed in advance about care and treatment, and of any changes in that care or treatment that may affect the resident's well-being.

Each nursing home has a legal obligation to communicate important information to the resident or the resident's representative. Every resident has the right to name an agent or "health care proxy" to act as their designated representative. The designated representative shall receive any written and oral information required to be provided to the resident and participate in decisions regarding the care, treatment and well-being of the resident if such resident lacks the capacity to make such decisions.[65] Each facility is required (except in a medical emergency) to notify the resident's physician and designated representative within 24 hours when there is an accident involving the resident, which results in injury requiring professional intervention; a significant improvement or decline in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.

C. Federal Law on Nursing Homes

Nursing homes must comply with certain requirements under federal statutes and regulations in order to participate in the Medicare and Medicaid programs.[66] The Nursing Home Reform Act, updated in 2016, contains a broad mandate that nursing homes "must provide [each resident with] the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care."[67] The law also prioritizes individualization of care plans and the primacy of resident autonomy and choice.[68] The regulation states that "[a] facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality."[69] Following this aim, residents have the right to: participate in their treatment; receive all services included in their plan of care; be free from any physical or chemical restraints that are not required to treat medical symptoms and are imposed for purposes of discipline or convenience; express grievances and have them addressed; and, engage in choice (as to activities, schedules, visitors, etc.).[70] Residents also have the right to be free from abuse, neglect, misappropriation of property and exploitation, and the facility must ensure these resident rights are upheld and report any instances where these rights have allegedly been violated to applicable state officials.[71]

Nursing homes are also specifically required to ensure residents "[m]aintain[] acceptable parameters of nutritional status, such as usual body weight" and receive "sufficient fluid intake to maintain [their] proper hydration and health."[72] Nursing homes must also develop personalized plans of care for each resident and conduct periodic assessments of each resident, at which point personal plans are "reviewed and revised."[73] The goals of the resident are also to be included in their personal care plans, and the complete interdisciplinary care team must help prepare the care plan, including the resident's attending physician, registered nurse, nurse aid, and a nutrition staff member.[74]

Nursing homes must also provide necessary services "to ensure that a resident's abilities in activities of daily living do not diminish" unnecessarily.[75] This means the facility must give residents the appropriate treatments and services so that residents can perform daily living activities (*e.g.*, personal hygiene, mobility, dining, communication) on their own. For those residents who are unable to accomplish daily living activities on their own, the facility must provide services to maintain good nutrition, grooming, and hygiene.[76] In addition, nursing homes must ensure an ongoing program of both group and individual activities based on each resident's care plan, that ensures the "well-being of each resident, [and] encourage[s] both independence and interaction in the community."[77]

Every resident must be in the care of a physician who must visit them once every 60 days and more often in the first three months of a resident's stay.[78] Nursing homes must also have "sufficient nursing staff with the appropriate competencies and skills sets...to assure resident safety" and the total "well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population."[79] Each facility must also employ sufficient staff for food and nutrition services, and the staff must possess appropriate competencies "taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population."[80]

Among other things, facilities must also provide or obtain dental services, laboratory services, radiology services, and other diagnostic services to meet residents' needs.[81] Similarly, residents requiring physical therapy, speech-language pathology, occupational therapy and/or rehabilitative services for mental disorders and intellectual disability, must be provided with such services.[82] Facilities must also "operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility."[83] The facilities must comply with all HHS regulations, including those relating to nondiscrimination, confidentiality of health information, fraud, and abuse.[84] Operationally, they must maintain medical records containing residents' assessments, care plans, diagnostic results, and other progress notes.[85] They must also develop a quality assurance and performance improvement (QAPI) program that collects and reviews data, as well as resident and staff complaints, in order to facilitate facility improvement.[86] They are required to have a compliance program to prevent and detect criminal, civil, and administrative violations, and promote quality of care.[87]

1. Federal Law for Nursing Homes Especially Pertinent to the COVID-19 Pandemic

Some federal requirements are very pertinent in the COVID-19 pandemic. Nursing homes must conduct "a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies." The assessment must be updated at least annually and whenever there is a "change that would require a substantial modification to any part of this assessment."[88] Additionally, nursing homes must develop, maintain and update an emergency preparedness plan. This plan must be a "facility-based and community-based risk assessment, utilizing an all-hazards approach."[89] They must complete annual emergency preparedness training based on their plan.[90]

The regulations also require facilities to have an infection prevention and control program "to help prevent the development and transmission of communicable diseases and infections."[91] The program must include "a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services;" and "precautions to be followed to prevent spread of infections."[92] The plan must be reviewed annually and updated as necessary and the facility must hire an infection preventionist who is responsible for the infection control plan.[93] Finally, the regulation outlining infection control was updated on May 8, 2020 to include specific reporting and communication requirements relating to COVID-19.[94]

2.2019 Changes to Federal Nursing Home Regulations

In 2019, CMS made changes to nursing home regulations, including the elimination of the ban on binding arbitration agreements between facilities and residents. In July 2019, CMS rolled back regulations that had prohibited pre-dispute arbitration agreements between facilities and residents. Under the new rules, facilities are able to enter into binding arbitration agreements with residents at any point prior to a dispute, including prior to the resident living in the facility.[95] This change means that many residents will not have the ability to sue their facilities in court. It also shields nursing homes from legal accountability for their actions.

3.CMS's 2019 Proposed Changes to Nursing Home Regulations

In July 2019, CMS proposed sweeping changes to long-term care facility regulations, citing an interest in minimizing facilities' obligations.[96] Attorney General James submitted comments objecting to this proposal, urging CMS to prioritize resident well-being and facility accountability. Some of the regulations, especially a proposal to lessen infection control requirements, likely would have caused more resident morbidity and mortality had they been finalized before the COVID-19 pandemic. Some of the proposed changes that are most pertinent to the COVID-19 pandemic are described below.

Reducing Infection Control Requirements: CMS's proposed regulations would change infection preventionists' required work duration from "at least part time" to "sufficient time ... to meet the objective's [sic] set forth in the facility's [infection prevention and control program]."[97] CMS correctly noted in its proposal that infection is the leading cause of morbidity and mortality in nursing homes, yet still made this proposal to alleviate "excessive administrative burden."[98] The ongoing pandemic and mounting toll of COVID-19 resident deaths nationwide underscore the importance of more stringent infection control protections.

Decreasing Frequency of Facility Assessments: The existing regulations require facilities to conduct an annual facility assessment to determine what resources are needed to care for residents in the ordinary course, and in emergencies. The 2019 proposed rule relaxes the current annual safety assessment requirement and replaces it with the need for the facility to conduct such assessments only biennially.[99] Decreasing the frequency of the assessment would allow safety hazards to go unnoticed, changes in staffing and resident populations to remain unconsidered, and evolving resident health acuity and morbidity to continue unaddressed.

Reducing Requirements of Quality Improvement Programs: CMS's 2019 proposed rules also remove most of the elements required for QAPI programs.[100] The effect of this is to render the proposed regulation too vague to be useful. CMS justifies deleting the QAPI required elements by stating, "the level of specificity and detail in the QAPI requirements... may limit a facility's ability to design their QAPI program to fit their individual needs."[101] However, the required QAPI elements are all broad and leave plenty of room for facility customization of their QAPI plans.

Reducing Public Transparency: Current CMS guidance is that facility compliance survey results should not be included in the Certification and Survey Provider Enhanced Reports (CASPER) system before the conclusion of any informal dispute resolution, which prevents the results from being incorporated in facilities' CMS Quality Measures rating. CMS proposes to incorporate this guidance as a new regulation.[102]

Removing Residents' Rights-Medical Providers: CMS proposed to only provide residents with their primary physician's name and contact information, removing the current requirement that facilities ensure residents remain informed of the names of all primary care professionals involved in their care.[103] The proposed change would make it difficult for patients to learn about and make changes to their broader medical team and services, and in some cases, effectively prevent them from exercising any control over their medical team and services.

Removing Residents' Rights-Grievance Process: The proposed regulations contain a provision that distinguishes between resident "feedback" and resident "grievances" and suggests different treatment for each, at the expense of residents' rights.[104] With facilities' power to determine the definition of a "grievance," they are also empowered to determine which complaints will undergo a full grievance investigation. This proposed change would likely result in a lack of accountability for facilities and a corresponding lack of support for residents.

Decreasing Review of Anti-Psychotic Drug Prescriptions: The proposed regulations remove the requirement that Pro re Nata (PRN or "as needed") prescriptions for anti-psychotic drugs can only be renewed after the physician re-evaluates the patient for the drug's continued appropriateness.[105] This proposal removes vital patient protections. Given the past abuse of these drugs as a means of physical control of residents and their potential danger, a close monitoring of anti-psychotic prescriptions must remain in place. Evidence shows that antipsychotics are associated with increased cerebrovascular morbidity and mortality among patients with dementia. Multiple government agencies and medical associations have taken notice of the overprescribing of antipsychotics to nursing home residents with dementia. Removing review requirements for anti-psychotic drug prescriptions places patients at health risk that might be further exacerbated during a pandemic.

Recommendations

Ensure public reporting by each nursing home as to the number of COVID-19 deaths of residents occurring at the facility — and those that occur during or after hospitalization of the residents — in a manner that avoids creating a double-counting of resident deaths at hospitals in reported state COVID-19 death statistics.

As detailed in the report, discrepancies remain over the number of New York nursing home residents who died of COVID-19. Data obtained by OAG shows that DOH publicized data vastly undercounted these deaths. Ensuring standardized public reporting will alleviate these discrepancies and provide needed transparency.

Enforce, without exception, New York state law requiring nursing homes to provide adequate care and treatment of nursing home residents during times of emergency.

As detailed in the report, too many nursing home residents did not receive the adequate care and treatment to which they are entitled. While the COVID-19 pandemic put undue stress on many of our nation's systems, nursing homes must be prepared for these types of outbreaks.

Require nursing homes to comply with labor practices that prevent nursing homes from pressuring employees to work while they have COVID-19 infection or symptoms, while ensuring nursing homes obtain and provide adequate staffing levels to care for residents' needs.

There were too many instances of employees being pressured to work while contagious to ensure higher staffing levels. This put all residents and employees of the nursing home at risk. Employees should be encouraged to promptly report to DOH and OAG when owners or managers require, encourage, or knowingly permit staff to work when they are have a COVID-19 diagnosis or symptoms.

Require direct care and supervision staffing levels that: (1) are expressed in ratios of residents to RNs, LPNs, and CNAs; (2) require calculation of sufficiency that includes adjustment based on average resident acuity; (3) are above the current level reflected at facilities with low CMS Staffing ratings; and, (4) are sufficient to care for the facility's residents' needs reflected in their care plans.

Before considering any increases in Medicaid reimbursement rates to nursing homes, the state should require specified direct care and supervision staffing levels above the current level reflected at facilities with low CMS Staffing ratings and that are sufficient to care for residents' needs, and enact effective laws and regulations requiring nursing homes to provide complete disclosure of all monies transferred to related parties and the salaries, compensation, and distributions made to their owners, officers, directors and investors, and all loans made to and from any nursing home, and the repayment thereof.

Most states' standards include minimum levels for both total nursing hours and staffing levels in specific categories, without reference to the staffer's experience, familiarity with the residents or consistency of care. For example, the California standard is 3.2 hours per resident per day (HPRD) of total nursing care. Vermont requires 3 HPRD of total nursing care including an average of 2 HPRD of CNA care. Ohio requires average total care of at least 2.75 HPRD, including 0.2 HPRD of RN care and 2 HPRD of nurse aide care. Some states mix these requirements with other ratios (e.g., 1:15 staff to patient ratio) or include other staff hours (e.g., nutritionists, physical therapists). New Jersey recently enacted a minimum staffing law that requires, among other things, one CNA per eight residents (day shift); one direct caregiver per 10 residents (evening); one caregiver per 14 residents (night).

Changes in regulations regarding staffing should also address different categories of caregivers, each of which provide a different kind of care, and that accounts for the caregivers' experience and familiarity with the residents, on a 24/7 basis.

Require additional and enforceable transparency in the operation of for-profit nursing homes, including financial transactions and financial relationships between nursing home operators and related parties, and relatives of all individual owners and officers of such entities with contractual or investor relationships with the nursing home. Through a variety of related party transactions and relationships, owners and investors of for-profit nursing homes can exert control over the facility's operations in a manner that extracts significant profit for them, while leaving the facility with insufficient staffing and resources to provide the care that residents deserve.

Through a variety of related party transactions and relationships — including between owners, investors, corporate parents, landlords, purported management companies, consultants, vendors, service provider, charities and owner's family members,— owners and investors of for-profit nursing homes can exert control over the facility's operations in a manner that extracts significant profit for them, while leaving the facility with insufficient staffing and resources to provide the care that residents deserve.[106]

Before providing any supplemental funding to nursing homes, the state should require transparency, accountability and complete disclosure of the disposition of all funds received by the facilities. As a condition of payment of public funds to the nursing homes, the state should also require operators to execute monthly certifications affirming that staffing is sufficient to meet residents' needs.

Ensure that nursing homes invest sufficiently in effective training so staff can fully comply with infection control protocols. Hold operators accountable for failures to have clinically appropriate policies in place and to effectively train staff to comply with them.

Clearly, some facilities were not prepared to handle outbreaks through early and effective training or staffing. Rising COVID-19 infection rates in multiple areas of the state and a concerning number of nursing homes within those communities underscore the need for effective training in infection control protocols.

Support manufacturing of PPE to facilitate sufficient supply of PPE for purchase by nursing homes. Enforce requirements that nursing homes have sufficient inventory of PPE for all staff to be able to follow infection control protocols.

Many nursing homes severely lacked PPE for workers. In some instances, nursing home owners forewent infection control protocols, telling staff that masks and other PPE were not mandatory because they did not have enough supplies. In other cases, re-use of PPE may have contributed to the spread of infection. Nursing homes should be required to have a sufficient inventory of PPE in case of a future outbreak.

Ensure that adequate COVID-19 testing is available to nursing home residents and employees and require nursing homes to test residents and staff in accordance with CDC and DOH evidence-based guidelines.

Insufficient testing in the early days of the pandemic undoubtedly led to spread of COVID-19 by asymptomatic patients and staff. With regular testing for residents and employees, nursing homes will be much better able to contain future COVID-19 outbreaks.

Eliminate the recently enacted immunity provisions that can provide financial incentives to for-profit nursing home operators to put residents at risk of harm by refraining from investing public funds to obtain sufficient staffing to meet residents' care needs, to purchase sufficient PPE for staff, and to provide effective training to staff to comply with infection control protocols during pandemics and other public health emergencies.

The state's immunity laws were designed to provide necessary protection to frontline health care workers who placed their lives on the line during the pandemic, managers who are faced with impossible choices in caring for patients with COVID-19 in circumstances that are not of their own making, and facilities whose processes led to those decisions in good faith. These circumstances can include shortages of ventilators, respirators, medicine, other equipment, or available beds or services. As written, the immunity laws could be wrongly used to provide any individual or entity from liability, even if those decision were not made in good faith or motivated by financial incentives.

Formally enact and continue to enforce regulatory requirements that nursing homes communicate with family members of residents promptly, but not later than within 24 hours, of any confirmed or suspected COVID-19 infection, and of any COVID-19 confirmed or suspected death.

Too many facilities failed to appropriately communicate with families about COVID-19 infections and deaths. Existing requirements that nursing homes communicate with family members within 24 hours of COVID-19 infections and deaths must be enforced. Nursing homes should utilize technology, including their websites, to communicate efficiently with families in compliance with confidentiality laws regarding the presence of COVID-19 infection within the facility, as well as on updates on scheduling visitation. Additionally, nursing homes must ensure that only trained staff engage in complex and compassionate communications with families.

Increase staffing at DOH to ensure sufficient skilled resources for oversight, complaint assessment, surveys, inspections and immediate responses to information requests from state agencies in support of health care and law enforcement efforts.

DOH faced an unprecedented challenge: an agency staffed to visit each nursing facility once per year, under stable conditions, was called upon to visit nearly every facility in barely two months, under emergency conditions. In addition, the preliminary investigations indicate that facilities often misreported basic information to DOH. The agency's enforcement and referral programs should be strengthened through additional staff.

Ensure that nursing homes engage in thoughtful planning regarding post-mortem care needs and implement and train staff on policies for dignified care of the remains of deceased residents.

Facilities should have clear policies that set forth protocols for the dignified treatment of remains. Staff should be effectively trained on the facility's policies and protocols for dignified treatment of remains while they are onsite, including emergency situations; and, ensure timely communication between management and staff as to the facility's active implementation of these measures, including informing staff of pre-designated alternative morgue locations.

Urge families to CMS Care Compare online database, ask questions of nursing homes relating to staffing, policies, procedures, and recent and current COVID-19 infections of staff and residents, and to obtain information relevant to their current or future long-term care decisions for their loved ones. Where possible, visit family member residents in person and through "window" visits and videocalls even if resident is unable to communicate, to provide emotional support and to enable observation of the resident's physical appearance and condition. Ensure family members know to report suspected neglect or abuse to DOH and OAG.

Before deciding on a nursing home, families should consult CMS ratings, and be armed with the appropriate questions to ask potential facilities. Additionally, nursing homes should facilitate communication with family members, either through window visits, video calls, or phone calls so that family members can provide emotional support to their loved one and observe the conditions in the facility.

Conclusion

This report provides an overview of OAG's preliminary investigative findings into the response by New York's nursing homes to the COVID-19 pandemic, and the heartbreaking reality that over 6,600 New Yorkers have died in nursing homes from complications related to COVID-19. OAG's investigations are ongoing. Attorney General James will continue to follow the facts, diligently and impartially, wherever they lead. In the meantime, given the ongoing COVID-19 pandemic and the risks to the state's estimated 90,000 nursing home residents as reflected by the data herein, systemic changes are warranted now. This report provides an overview of the recommended primary systemic reforms, as well as other measures that we believe will address the public's widely reported concerns about the pandemic's tragic impact on nursing home residents. As detailed in the report, nursing homes have a special obligation to the residents who depend upon the facility to meet every basic human need in what is for many, probably their last home. New York needs to ensure that nursing homes take care of our seniors and our most vulnerable residents with dignity, respect and the sufficient care that the law requires — and that the public primarily funds.

Attorney General Letitia James continues to encourage all residents, family members of residents and all caregivers to contact MFCU at (800) 771-7755 or at ag.ny.gov/nursinghomes if they believe that a patient in a residential health care facility has been neglected, abused, or mistreated.

Acknowledgments & MFCU Mission Statement

New York State's Medicaid Fraud Control Unit (MFCU) is a bureau within the Criminal Justice Division of the Office of the Attorney General of the State of New York. The Division of Criminal Justice is led by Chief Deputy Attorney General for Criminal Justice José Maldonado and overseen by First Deputy Jennifer Levy. MFCU's mission is to protect the public from all forms of fraud against the Medicaid program and to protect the state's vulnerable nursing home residents from exploitation, neglect, and abuse by unscrupulous providers. MFCU investigates and brings criminal prosecutions and civil actions to stop Medicaid provider fraud, to protect vulnerable residents, and to protect Medicaid program integrity.

This report is the collective product of investigative work undertaken since March 2020 by MFCU's 275 attorneys, forensic auditors, police investigators, medical analysts, data scientists, electronic investigation team, legal assistants, and support staff in eight offices across New York.

MFCU receives 75 percent of its funding from the U.S. Department of Health and Human Services under a grant award totaling $60,071,905 for Federal fiscal year (FY) 2019-20, of which $45,053,932 is federally funded. The remaining 25 percent of the approved grant, totaling $15,017,973 for FY 2019-20, is funded by New York state. Through MFCU's recoveries by means of law enforcement actions and civil enforcement actions, it regularly returns more to the state than it receives in state funding.

APPENDIX A (referenced on p. 9)

Table of Key Federal and State Guidance

Date	Federal	New York
1/21/20	CDC confirmed and announced the first case of COVID-19. cdc.gov/media/releases/2020/p0121-novel-coronavirus-travel-case.html	
1/31/20	HHS Secretary declared a public health emergency for the US, giving state, tribal, and local health departments flexibility to request HHS authorization to temporarily reassign personnel to respond to COVID-19. hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html	
2/6/20		DOH issued a letter to nursing homes and hospitals, asking "all facilities to compare their existing inventories of PPE, such as face shields, gowns, gloves, masks, N95 respirators, against the expected rate of use of these items under a surge situation, to determine the quantities needed to be on hand" and then to coordinate with existing vendors and local offices of emergency management to procure additional PPE. coronavirus.health.ny.gov/system/files/documents/2020/03/2020-02-06_ppe_shortage_dal.pdf
2/7/20	CDC's Morbidity and Mortality Weekly Report stated, "CDC is working closely with state and local health partners to develop and disseminate information to the public on general prevention of respiratory illness, including [COVID-19]. This includes everyday preventive actions such as washing your hands, covering your cough, and staying home when you are ill," and referred readers to CDC's website. It noted, "[t]hese measures are being implemented based on the assumption that there will be more U.S. [COVID-19] cases occurring with potential chains of transmission, with the understanding that these measures might not prevent the eventual establishment of ongoing, widespread transmission of the virus in the [U.S.]. It is important for public health agencies, health care providers, and the public to be aware of [COVID-19] so that coordinated, timely, and effective actions can help prevent additional cases or poor health outcomes."[107] cdc.gov/mmwr/volumes/69/wr/mm6905e1.htm	

3/4/20	**CMS published to State Survey Agencies a Guidance for Infection Control and Prevention of COVID-19 in Nursing Homes**, with information on (1) screening and, if necessary, restricting visitors to nursing homes; (2) screening and, if necessary, restricting employees with signs or symptoms of COVID-19 from working in the facility; (3) when to transfer residents to the hospital; and, (4) when a nursing home should accept a resident diagnosed with COVID-19 from the hospital. It stated that "a nursing home can accept a patient with a COVID-19 diagnosis who is still under Transmission-Based Precautions "as long as it can follow CDC guidance for [T-BP]. If a nursing home cannot, it must wait until precautions are discontinued." (See Transmission-Based Precautions Guidance from CDC.) The CMS guidance stated that nursing homes should admit any individuals that they would normally admit, including from hospitals where a case of COVID-19 was present. cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf	
3/4/20	CMS published guidance to State Survey Agency Directors on, among other things, discharging patients with COVID-19 diagnoses to subsequent care facilities. CMS instructed that the decision to discharge a patient transfer should be based on clinical considerations of the patient, and that if T-BP must be continued, the receiving facility must be able to implement all recommended infection prevention and control recommendations. Medicare hospital planning required all medically necessary information, including communicable diseases, be provided to post-acute care providers for COVID-19, prior to discharge. cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2	

3/7/20	CDC issued "Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel (HCP) with Potential Exposure in a Healthcare Setting." The guidance states that "contact tracing, monitoring, and work restrictions. . . includ[ing] allowances for asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program." It stated that asymptomatic staff exposed to COVID-19 were "not restricted from work." fluxguard.com/coronavirus/site/331dd37e-f2af-4323-9424-0e0cc4dee8aa/session/9cf5a974-73a6-4fcf-a397-9d68cf59342d/page/a0400044-4df1-47b2-ae8d-f318b3c27c5c/txtview?actionId=6564a241-1186-4b51-8185-9cc4da76263f&captureId=1583805385934	Governor Cuomo declared a Disaster Emergency due to COVID-19, state that a "disaster is impending in New York State, for which the affected local governments are unable to respond adequately." Executive Order 202 governor.ny.gov/news/no-202-declaring-disaster-emergency-state-new-york

3/11/20		DOH issued guidance to nursing home owners/ operators and administrators regarding "precautions and procedures nursing homes must take to protect and maintain the health and safety of their residents and staff during" the COVID-19 outbreak. The guidance noted that it was essential that all nursing home owner/ operators, administrators, and clinical staff maintain situational awareness about the disease, its signs and symptoms, and necessary infection prevention and control procedures and review the most up-to-date information for health care providers. The guidance still permitted visitation but required screening of visitors and recommended modified hours. It also required employee screening and that staff showing symptoms "not be permitted to remain at work" and "not return to work until completely recovered." It required 14-day voluntary or mandatory quarantine for an asymptomatic staff person who had potential exposure to COVID-19 following the exposure. It required a mandatory 14-day quarantine for symptomatic staff following the date of onset of symptoms. It provided information on conserving PPE, but specifically instructed that facilities' controls should not discourage the use of masks when indicated for patient care. It emphasized the need to reinforce infection control regulations at 10 NYCRR § 415.19 and noted that residents suspected of infection with COVID-19 should be given a surgical or procedure mask (not an N95) and that while awaiting the transfer, the resident must be isolated in a separate room with the door closed. DOH also (1) restricted visitation in nursing homes; (2) provided information on conserving PPE but specifically instructed that facilities' controls should not discourage the use of masks when indicated for patient care; and, (3) set forth practices to prevent the spread of COVID-19. It described the symptoms of COVID-19 and conveyed the obligation and need to often check for updates on CDC, and DOH Health Commerce System websites for situational awareness, symptoms, and infection control. It emphasized the need to reinforce infection control regulations 10 NYCRR § 415.19 and noted that residents suspected of infection with COVID-19 should be given a surgical or procedure mask (not an N95) and that while awaiting the transfer, the resident must be isolated in a separate room with the door closed. coronavirus.health.ny.gov/system/files/ documents/2020/03/nursing_home_guidance.pdf

3/13/20		**DOH issued updated COVID-19 Health Advisory Guidance** to nursing homes and adult care facilities suspending all visitation, except where it was medically necessary or for imminent end-of-life situations.[108] The advisory also required facilities to immediately implement health checks for all HCP before each shift and require that all HCP wear a facemask while within six feet of residents. If there were confirmed cases of COVID-19, the advisory required nursing homes and adult care facilities to (1) notify the local health department and DOH if not already involved; (2) monitor all residents on affected shifts; (3) assure that all residents in affected units remained in their rooms to the extent possible; (4) require residents to wear facemasks when HCP entered their rooms, unless resident could not tolerate facemasks; (5) preclude "floating" staff between units, minimize staff entering rooms, and cohort positive residents with dedicated providers; (6) place residents on affected units on "droplet and contact precautions"; and, (7) required re-testing immediately residents who initially tested negative, if they developed symptoms consistent with COVID-19. If there were suspected cases of COVID-19, residents were to be given a facemask and isolated in a separate room with the door closed. The advisory required that staff should wear full PPE and maintain social distancing of at least six feet from resident except for "brief, necessary interaction." coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf

3/16/20	CDC issued updated guidance on time tables for HCP with confirmed or suspected COVID-19 to return to work, instructing officials to use one of two strategies. Under the "test-based strategy," CDC advised that HCP should be excluded from work until (1) resolution of fever without the use of medication; (2) improvement in respiratory symptoms; and, (3) after at least two negative test results taken at least 24 hours apart. Under the "non-test-based strategy," CDC advised that symptomatic HCP should be excluded from work until (1) "at least 3 days (72 hours) have passed since recovery (defined as resolution of fever without the use of medication), (2) "improvement of respiratory symptoms," and (3) "at least 7 days have passed since symptoms first appeared." It acknowledged that appropriate state and local authorities "might determine that the recommended approaches cannot be followed due to the need to mitigate HCP staffing shortages." phdmc.org/program-documents/healthy-lifestyles/gumc/emergency/covid-19/physicians-healthcare-providers/1449-return-to-work-criteria-for-healthcare-workers/file	DOH issued updated guidance advising that "facilities may allow HCP exposed to or recovering from [COVID-19]" to work if: • Furloughing such staff would result in shortages that adversely impact the operation of the facility; • HCP who had contact with confirmed or suspected cases are asymptomatic; • Symptomatic HCP with confirmed or suspected COVID-19 isolated for at least 7 days after illness onset and were fever-free at least 72 hours with other symptoms improving. • HCP who were asymptomatic after contact with confirmed or suspected cases were directed to self-monitor twice a day (temperature, symptoms), and undergo temperature monitoring and symptom checks at the beginning of each shift and at least every 12 hours. • Staff who recovered from COVID-19 were directed to wear a facemask until 14 days after onset of illness if mild symptoms persisted but were improving. • Staff who were asymptomatic after contact were directed to wear a facemask while working until 14 days after the last high-risk exposure. Staff working under these conditions were to be assigned to patients at lower risk (on COVID-19 units) as opposed to severely immunocompromised or elderly patients. If staff developed symptoms, they were directed to immediately stop work and isolate at home. Testing was prioritized for hospitalized health care workers. All staff with symptoms consistent with COVID-19 were assume they were COVID-19 positive regardless of the availability of test results. nyshfa-nyscal.org/files/2020/03/Advisory-HCP-return-to-work-20200316-final.pdf

3/18/20		Executive Order 202.5 allowed transfer to Article 28 facilities and suspended regulations: • 10 NYCRR § 400.12 to the extent necessary to allow patients affected by the disaster emergency to be transferred to receiving Article 28 facilities; • 10 NYCRR § 415.15 to the extent necessary to permit facilities receiving individuals affected by the disaster emergency to obtain physician approvals for admission as soon as practicable or to forego such approval for returning residents; and, • 10 NYCRR § 415.26 to the extent necessary to permit facilities receiving individuals affected by the disaster emergency to comply with admission procedures as soon as practicable after admission or to forego such approval for returning residents. governor.ny.gov/news/no-2025-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
3/21/20		DOH issued guidance with different testing protocols for facilities within New York City, Long Island, Westchester, and Rockland Counties – which had "sustained community transmission" of COVID-19 – and for facilities located in the rest of the state. It stated that in the nine downstate counties, "testing of residents and [HCPs] with suspect COVID-19 is no longer necessary and should not delay additional infection control actions" for any resident with symptoms of a febrile respiratory illness, and that such residents should be presumed to be COVID-19 positive. Facilities outside of these nine counties "should continue to pursue testing for residents and health care workers with suspect COVID-19 to inform control strategies." coronavirus.health. ny.gov/system/files/documents/2020/03/22-doh_covid19_nh_alf_ilitest_032120.pdf
3/23/20	CDC published Transmission-Based Precautions (T-BP) and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance) stating that "a patient can be discharged from the healthcare facility whenever clinically indicated: If discharged to a long-term care or assisted living facility," and T-BP were still required, the patients "should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with COVID-19." The guidance indicated that preferably, the patient would be placed in a location "designated to care for COVID-19 residents." If T-BP had been discontinued, the patient does not require further restrictions, based upon their history of COVID-19 infection. hsdl.org/?view&did=836726	Executive Order 202.10 included specified immunity for health care providers, including from civil liability for any injury or death alleged to have been sustained directly as a result of an act or omission by such medical professional in the course of providing medical services in support of the state's response to the COVID-19 outbreak, unless it is established that such injury or death was caused by the gross negligence of such medical professional. The executive order relieved health care providers of certain record keeping requirements to the extent necessary for them to perform tasks as necessary to respond to the COVID-19 outbreak and provided them immunity from liability for failure to comply with recordkeeping requirements if they acted reasonably and in good faith. governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency

3/25/20		DOH issued guidance to nursing home administrators, directors of nursing and hospital discharge planners stating, "No resident shall be denied re-admission or admission to the nursing home solely based on a confirmed or suspected diagnosis of COVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or re-admission." It also provided information on how to request PPE from DOH. (On May 26, DOH removed this guidance from its website.) skillednursingnews.com/wp-content/uploads/sites/4/2020/03/DOH_COVID19_NHAdmissionsReadmissions_032520_1585166684475_0.pdf
3/31/20		DOH issued guidance on April 1, dated March 31, entitled "Protocols for Essential Personnel to Return to Work Following COVID-19 Exposure or Infection." coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_essentialpersonnelreturntowork_rev2_033120.pdf
4/3/20	HHS-Office of Inspector General issued "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020," OEI-06-20-00300, noting CDC delay in producing COVID-19 test, and hospital reports of need for PPE, testing, staffing, supplies and equipment, delays waiting for test results and challenges maintaining or expanding their facilities' capacity to treat patients with COVID-19.[109] oig.hhs.gov/oei/reports/oei-06-20-00300.asp	
4/6/20		The Emergency Disaster Treatment Protection Act was enacted to "promote the public health, safety and welfare of all citizens by broadly protecting the health care facilities and health care professionals in this state from liability that may result from treatment of individuals with COVID-19 under conditions resulting from circumstances associated with the public health emergency." PHL § 3080. (See Section VI(G) above for the statute's text.) nysenate.gov/legislation/laws/PBH/A30-D

4/13/20	CDC issued updated guidance entitled "Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19" to express a preference for the test-based strategy for HCP to return to work, if feasible, yet still accepted the non-test based model. According to the guidance, asymptomatic staff who tested positive COVID-19 "should be excluded from work until 10 days after the date of their first positive COVID-19 diagnostic test" if they have remained asymptomatic throughout that time. web.archive.org/web/20200417191400/https:/www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html	
4/16/20		Executive Order 202.18 required nursing homes to notify family members within 24 hours of a resident COVID-19 diagnosis or death. governor.ny.gov/news/no-20218-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
4/17/20		Executive Order 202.19 directed DOH to establish "a single, statewide coordinated testing prioritization process" that required all laboratories in the state, both public and private, to coordinate with the DOH and prioritize COVID-19 testing. governor.ny.gov/news/no-20219-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
4/29/20		DOH issued a letter to nursing home administrators stating that the state would no longer adhere to CDC's "shorter" standard on HCP returning to work as set forth in CDC's interim guidance. DOH required that a nursing home HCP who tested positive for COVID-19 but remains "asymptomatic" not return to work "for 14 days from [the] first positive test date in any situation." It stated, "symptomatic nursing home employees may not return to work until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and respiratory symptoms are improving." It invited "nursing homes facing staffing difficulties" to use DOH's online staffing portal, noting 200 facilities used it as of April 29. coronavirus.health.ny.gov/system/files/documents/2020/05/nh-letterregardingemployees-4.29.20.pdf

5/10/20		Executive Order 202.30 required nursing homes to make arrangements for COVID-19 testing of all personnel twice per week and report any positive test to DOH the next day. It also required the operator and the administrator of each home to provide to DOH a certification of compliance with the Executive Order and "directives of the Commissioner of Health." governor.ny.gov/news/no-20230-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency
6/10/20		Executive Order 202.40 continued the directives of EO 202.30 yet modified them to require nursing homes to make arrangements for COVID-19 testing of all employees, contract staff, medical staff, operators and administrators once per week for all nursing homes and all adult care facilities that are located in regions that have reached Phase Two of New York state's reopening plan.
6/17/20		Public Health Law § 2803(12) requires residential health facilities to submit to DOH an annual "Pandemic Emergency Plan" by 9/15/20. nysenate.gov/legislation/laws/PBH/2803#:~:text=(a)%20The%20commissioner%20shall%20have,including%20health%2Drelated%20service%2C%20system

APPENDIX B

An Illustration of the Too Prevalent "Low Staffing for Profit" Model of Exploitation Through Insufficient Staffing, Lack of Transparency, and Financial Incentives: a Pre-Pandemic OAG Investigation, Findings, and Prosecution

The 2018 investigation described below is relevant to the COVID-19 pandemic because the operating model for staffing that led to systemic abuse and neglect at this facility remains prevalent in too much of the for-profit sector of the nursing home industry in New York. Of the state's 619 total nursing homes, 401, or 61 percent, are for-profit entities. The chronic staffing failures caused neglect throughout the facility even without a severe external strain such as COVID-19.

Most nursing homes operate on a model that essentially seeks 100 percent resident capacity at the facility every day, because billing and insurance payments are per-day, per-patient. Each empty bed is lost potential revenue. Conversely, from too many facilities' perspectives, each additional resident does not require additional staffing if the time and labor of the staff already on-duty can be stretched and shifted to assign coverage for the care needs of the patients. Every facility has some financial incentive to avoid hiring additional staff, because each staffer's pay, and benefits (if any), are an expense. However, if a nursing home stretches that staffing model to assign employees to cover the care needs for too many residents – with insufficient numbers of appropriate employees – the model snaps.

1. OAG Pre-Pandemic Investigation of Focus at Otsego Nursing Home

OAG conducted an investigation of allegations of neglect of residents in Focus Rehabilitation and Nursing Center at Otsego (Focus), a 174-bed nursing home in Cooperstown, New York, after a number of earlier incidents that resulted in arrests of several health care workers for offenses including neglect of residents and falsification of medical records to conceal neglect. In one incident of neglect, a 94-year old resident was left in a recliner in a common living room area of the facility for approximately 41 hours during a holiday weekend without appropriate care, treatment, or service. The investigation included an inquiry into systemic causes of neglect of Focus residents. To obtain the facts that resulted in the investigative findings, OAG conducted extensive forensic accounting investigation and detailed analysis of medical and staffing records relating to the Focus nursing home. This work was required to bring transparency to what happened to millions of Medicaid reimbursement dollars that went through many financial transactions from the facility to related parties. (See Appendix B at B-1, Funding Flow Through chart). It also included significant investigation and analysis of records of staffing levels.

2. *Findings: Chronic Insufficient Staffing Increased Resident Neglect and Harm; Lack of Transparency in Profit-taking*

The findings of this investigation included that the owners and management of Focus cut staffing at the facility in late 2014 in order to increase their personal profit, through a variety of financial transactions with related parties.[110] The cuts in staffing at Focus resulted in:

» Neglect and injury to residents of the facility;

» Increased risk of injury to residents of the facility;

» Very challenging working conditions for the direct care staff whose responsibilities included providing care for the residents in accordance with their plans of care;

» Resignations of direct care staff members in frustration after unsuccessful warnings to owners and management that the insufficient staffing levels created risks for the residents and untenable working conditions;

» Refusals by the operator, 99 percent owner, and manager to increase the facilities' budget and reverse insufficient staffing levels at Focus;

» Use of staff from a "temporary agency staffing" company owned by a party to the defendant manager, in lieu of hiring full time staff; and,

» Failure to maintain staff even at the level deemed "critical" by other licensed managers.

Routine reliance on temporary agency staff in lieu of full-time employees to fill budgeted staffing levels resulted in staffing that met fewer residents' care needs. Agency staff, who are sent to any nearby facility to work any shift on any assignment within the facility, are usually less familiar with each of the resident's care needs, facility protocols, facility resources, medical professional resources, and therefore, less effective in delivering care. Agency staff must often familiarize themselves with each resident's chart and care plan in order to provide appropriate care. Agency staff also often have less familiarity with facility policies, operations, and personnel, which can result in the need for more time to complete work.[111]

3. Prosecution, Convictions, and Civil Remedies

Prosecution: Based on relevant aspects of these findings, in May 2018, OAG filed criminal charges against the entity that held the operator's license for, and controlled, Focus, an individual who was the 99 percent owner of Focus, and an individual who was the owner's business partner in other ventures while acting as a high level manager for Focus, for their conduct between October 14, 2014 to December 31, 2017. The charges included three felony counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the First Degree, in violation of Penal Law § 260.25, a Class E felony: one count as to all residents of the facility from October 14, 2014 to November 29, 2016, and two counts as to two specific residents who each suffered injury. The charges against each defendant also included two misdemeanor counts of Endangering the Welfare of an Incompetent or Physically Disabled Person in the Second Degree in violation of Penal Law § 260.24 ("Misdemeanor Endangering") as: one count as to all residents of the home from May 26, 2016 to November 29, 2016, and one count as to a specific resident from May 28, 2016 to June 1, 2016; and, two misdemeanor counts of Willful Violation of Health Laws, in violation of Public Health Law §§ 12-b(2), 2803-d(7), and 10 NYCRR §§ 81.1, 415.11 and 415.12(c)(2): one count for the neglect of all the residents of the home from May 26, 2016 to November 29, 2016, and one count for the neglect of a specific resident from May 28 to 30, 2016.

Convictions and Assurance of Discontinuance: In September 2018, the corporate operator's 99 percent owner and its manager both pleaded guilty to misdemeanor Endangering, and also entered a civil Assurance of Discontinuance under Executive Law § 63(15) in which they agreed to repay $1 million to the New York State Medicaid program, and to be voluntarily excluded from Medicaid and from operating health care businesses in New York state for 5 years. The corporate operator pleaded guilty to felony Endangering and was dissolved. Absent OAG's investigation, findings, prosecution, and civil remedy of an Assurance of Discontinuance, it is most likely that the owner, manager, and Focus corporate operator would have been operating the Focus nursing home during the COVID-19 pandemic with levels of staffing that were insufficient to meet the pre-pandemic needs of the residents for care and services. Fortunately, this result and its predictable negative outcomes were prevented.

4. Law Enforcement Resource Investment

Conducting the investigation regarding the Focus nursing home noted above, and reflected in part in Appendix B-1, required a significant amount of OAG resources and expertise. Many law enforcement agencies lack the resources to conduct such comprehensive investigations of the financial transactions and records that identify and address what can be a root cause of incidents of neglect – i.e., insufficient staffing.[112] A more efficient way to address the problem of chronic insufficient levels of staffing in for-profit nursing homes is to require effective minimum staffing levels and transparency in financial relationships with all related parties.
(See Recommendations D and E in Section VIII)

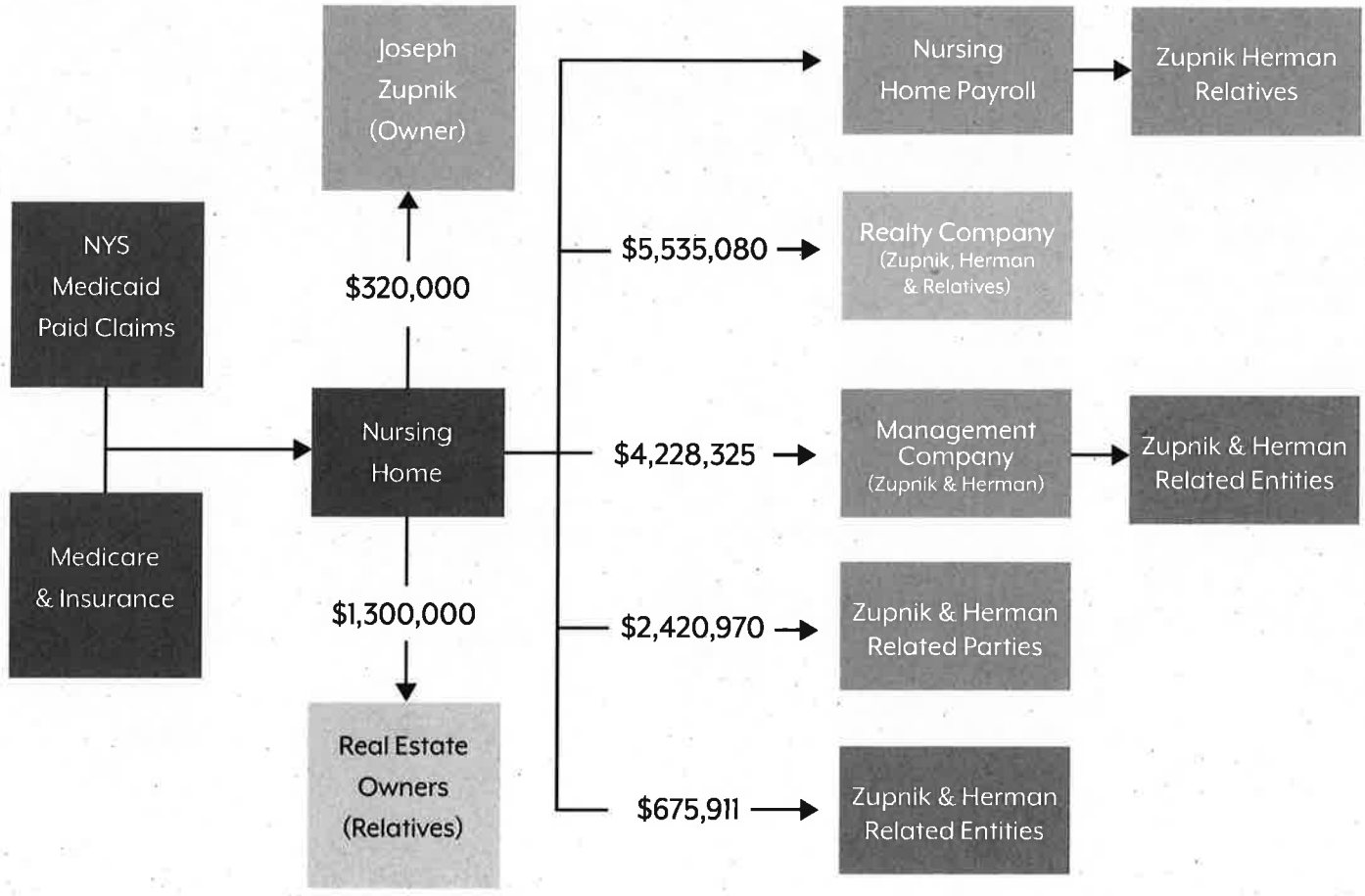
5. Similar Findings Regarding Lack of Transparency in Operation of Some For-Profit Nursing Homes

News organizations and advocacy groups have published findings about the ways in which too many for-profit nursing homes operate – specifically by extracting money from the facility and transferring it to investors, owners and related parties through divided ownership interests, mortgages, leases,[113] contracts and arrangements for services, such as management services, agency staffing, rehabilitation services, laundry and food services. Against the backdrop of lack of transparency regarding the related party financial transactions, members of the for-profit nursing home industry have claimed government reimbursement rates are "too low." As shown in the chart attached hereto as Appendix B-1, self-dealing obscures the true net revenue of such operations. Such transactions create a balance sheet that may suggest the facility is running even or at a loss, when in fact the owners are taking out profits as "fees", salaries for low-activity positions, or revenue to affiliated businesses.[114] The question whether reimbursement rates should be increased to enable for-profit nursing homes to provide care they are obligated to provide cannot be answered without full transparency into the facilities' mortgages, leases, management and "consulting" companies, contracts and arrangements for services.

Appendix B-1

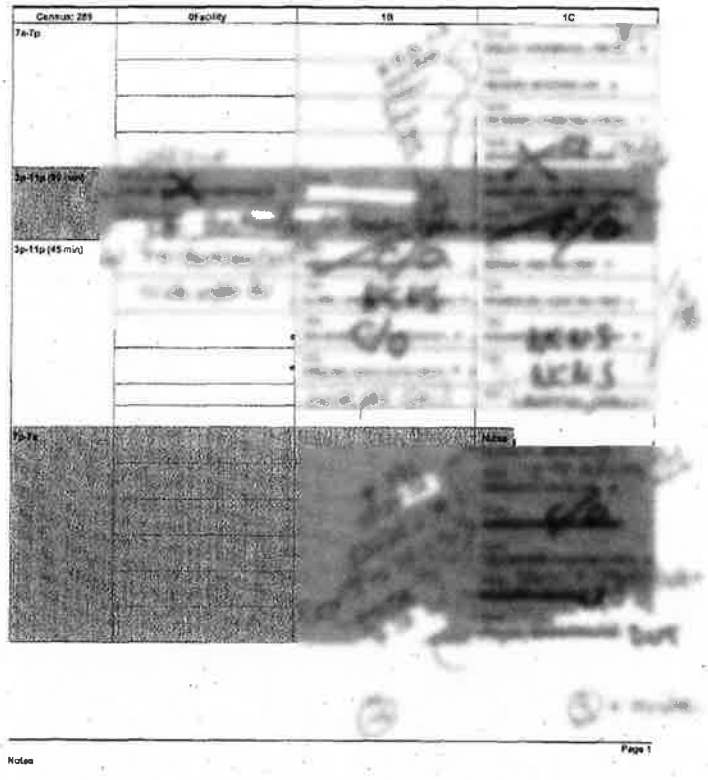
Related Party Transactions at a Nursing Home

October 2014 - December 2017 Funds Directly Paid to Related Parties

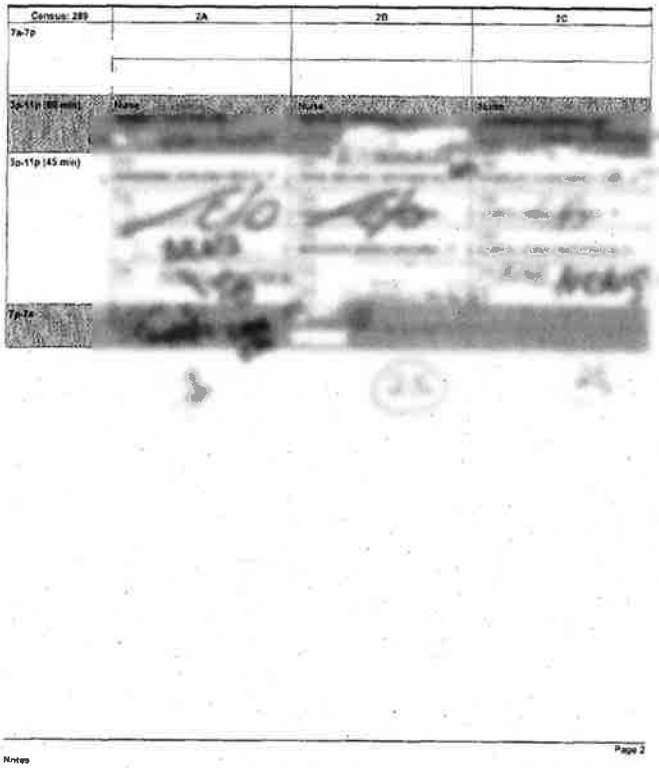


Appendix B-2

The Nursing Care Center [redacted]
Sunday April 12, 2020



The Nursing Care Center [redacted]
Sunday April 12, 2020



DATE: Friday, [redacted]uary 13,2017 — [redacted] Rehabilitation and Nursing Center Daily Nursing Staff Sheet

DAYS		EVENINGS		NIGHTS	
RN SUP/		RN SUPERVISOR:		RN SUPERVISOR:	
UNIT 2		UNIT 2		UNIT 2	
NURSES	C.N.A.	NURSES	C.N.A.	NURSES	C.N.A.
L. Garner 1/8	[illegible]	[illegible]	N. Edmond 1/07	[illegible]	[illegible]
[illegible]	[illegible]	N. Humphries 1/8	D. Justin 1/8	[illegible]	A. Atkins 1/8
N. Humphries 1/8	J. Banks 1/8	M. Gilbert 1/8	E. Lee 1/8	[illegible]	A. Appolinar 1/8
[illegible]	K. Torres 1/8	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	J. Bankston 1/8	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	M. Bryan 1/8	[illegible]	[illegible]
UNIT 3		UNIT 3		UNIT 3	
RN SUPERVISOR:	[redacted]	[illegible]		[illegible]	
NURSES	C.N.A.	NURSES	C.N.A.	NURSES	C.N.A.
D. Kalzenberg 1/8	M. Southard 1/8	D. Kalzenberg 1/8	M. Burrows 1/8	N. Agyeman 1/8	J. Zanelli 1/8
N. Kane 1/8	C. McCants 1/8	[illegible]	A. Sanders 1/8	[illegible]	A. Stewart 1/8
[illegible]	L. Hodges 1/8	K. Kane 1/8	B. Bailey 1/8	[illegible]	[illegible]
[illegible]	T. Hamilton 1/8	[illegible]	C. Gildea 1/8	[illegible]	[illegible]
[illegible]	M. Contreras 1/8	[illegible]	K. Toro 1/8	[illegible]	[illegible]
[illegible]	A. Pardo 1/8	[illegible]	[illegible]	[illegible]	[illegible]

Endnotes

[1]The investigation was conducted by the Medicaid Fraud Unit (MFCU), a federally funded, multi-disciplinary unit within the OAG that serves a dual mission to investigate Medicaid provider fraud and the abuse and neglect of patients in residential health care facilities, and bring civil and/or criminal remedies to address wrongdoing.

[2]All dates are in the year 2020 unless otherwise specified.

[3]This was following an Executive Order issued by Governor Andrew Cuomo relating to communications between nursing homes and family members.

[4]On September 3, CMS launched Care Compare, a redesign of eight existing CMS health care compare tools that were available on Medicare.gov, including Nursing Home Compare, which previously contained CMS's ratings for each nursing home in the four categories of Overall, Staffing, Infection Control and Quality of Care. medicare.gov/care-compare

[5]The legislature enacted, and the governor signed, amendments to Public Health Law §§ 3081-82 effective August 3, limiting the scope of immunity to acts relating to the "diagnosis or treatment of COVID-19" or "the assessment or care of an individual as it relates to COVID-19, when such individual has a confirmed or suspected case of COVID-19," and eliminating a clause concerning care of any other individuals. However, the potential defenses as to resources or staffing shortages were not amended.

[6]hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html

[7]CDC issued guidance for uniform reporting of COVID-19 vital health statistics: deaths of people whose laboratory tests resulted in a COVID-19 positive diagnosis and where COVID-19 played a role in the death should be reported as "confirmed" COVID-19 deaths. The guidance also provides that where a definite COVID-19 diagnosis cannot be made but is suspected or likely given the circumstances, a COVID-19 death may be reported as "presumed." cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf

[8]health.ny.gov/statistics/diseases/covid-19/fatalities_nursing_home_acf.pdf

[9]"New York Coronavirus Map and Case Count," *The New York Times*, nytimes.com/interactive/2020/us/new-york-coronavirus-cases.html

[10]Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester counties.

[11]As of August 3, nursing home deaths due to COVID-19 were reported in 40 counties: Albany, Bronx, Broome, Chenango, Columbia, Dutchess, Erie, Fulton, Greene, Herkimer, Kings, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Richmond, Rockland, Schenectady, Steuben, Suffolk, Sullivan, Tioga, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, and Yates.

[12]The data has not yet been verified against other data sources.

[13]The DOH data used for 58 of the 62 facilities was the data published on the date that matched the end of the timeframe of the data reported by each facility to OAG, or if DOH had not published data on that day, the data published on the following date. For four facilities reporting data to OAG for a timeframe ending prior to May 3, the DOH data published as of that date was used. This is because the data DOH published before May 3 for those facilities reflected no or few deaths, whereas the data DOH published as of May 3 reflected an increase in deaths at those facilities and was expressly stated as including presumed and confirmed COVID19 deaths.

[14]Through July 16, DOH reported one confirmed death at the facility, and as of July 30, DOH reported 11 confirmed deaths at the facility.

[15]At the same time, to the extent that the discrepancy results from the omission in DOH published data of resident deaths that occurred in hospitals, the under-counting of nursing home resident COVID-19 deaths does not reflect under-counting of total NYS COVID-19 deaths.

[16]The New York State Cemetery Board issued emergency crematory regulations adopted by the New York State Cemetery Board on May 1, 2020 that permitted funeral homes to transfer deceased awaiting cremation to crematories with ready capacity. With this change, for which Attorney General James advocated and her designee to the Cemetery Board voted, funeral directors, with the consent of the family of the deceased, have been able avoid significant delays by manually correcting cremation authorization forms rather than needing to create a new form and obtain another physical signature from the person arranging the funeral.

[17]Meaghan. McGoldrick, "Staffers say that bodies at Brooklyn nursing home are 'piling up'," *amny*, April 14, 2020

[18]"Coronavirus Deaths: Officials Told 'Bodies Being Piled Up In Nursing Homes' As Desperate Families Face Silence," CBS New York, April 14, 2020

[19]OAG's hotline reflected instances where residents' families were contacted by, or were only able to contact, nursing home employees unprepared to deliver such news, without the training, knowledge, and expertise to provide the appropriate end of life communications usually performed by experienced licensed nurses and social workers. In others, upon making inquiry as to their loved ones' mortal health risks, families were told that authorized persons were unreachable due to personal religious observances or days off and that their call would have to wait.

[20] The analysis focuses on the data through August 3, because this was the period of the first wave, when infection and death rates were concentrated downstate.

[21] 10 NYCRR § 415.19.

[22] Failure to have robust infection prevention and control policies could constitute resident neglect for failing "to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility." 10 NYCRR § 81.1(c). "Willful" neglect is a misdemeanor punishable by imprisonment not exceeding one year, a $10,000 fine or both. Public Health Law § 12-b(2).

[23] DAL NH 20-04 COVID-19 Guidance for Nursing Homes – Revised, Mar 11, 2020, coronavirus.health.ny.gov/system/files/documents/2020/03/nursing_home_guidance.pdf

[24] Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCOV), Feb 6, 2020. cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/information-healthcare-facilities-concerning-2019-novel-coronavirus-illness-2019-ncov

[25] Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings, Mar 13, 2020, cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

[26] New York nursing homes are required to have a written "disaster and emergency preparedness" plan, updated at least twice a year, with procedures to be followed for the proper care of residents and personnel in the event of "an internal or external emergency resulting from natural or man-made causes." 10 NYCRR § 415.26(f).

[27] Aspiration precautions are taken for residents at high risk of choking during self-feeding, with a staff member staying nearby to watch.

[28] health.ny.gov/facilities/nursing/about_nursing_home_reports.htm#comdefrr

[29] DOH spearheaded 1,300 onsite infection control inspections, including of every nursing home and adult care facility, and initiated its own administrative enforcement actions against a number of nursing homes for violations of infection control protocols, of HERDS data reporting requirements, and of Executive Order 202.18 communication requirements.

[30] OAG continues to receive complaints of neglect of residents that occurred during the pandemic in New York.

[31] Some staff reassignment was permissible under emergency COVID "scope of practice waivers" issued by DOH, such as shifting clerical or food service staffers to work as CNAs. Those emergency waivers were to offset the already-critical staffing crisis, not new employment opportunities.

[32]*Nursing Home and ACF COVID Related Deaths Statewide* (web-published daily by NYS DOH), accessed daily, using data published through 11/16/20. The published data notes, "This data captures COVID-19 confirmed and COVID-19 presumed deaths within nursing homes and adult care facilities. This data does not reflect COVID-19 confirmed or COVID-19 presumed positive deaths that occurred outside of the facility. Retrospective data reporting dates back to March 1, 2020."

[33]This analysis utilized the CMS quarterly metrics from June. Although CMS waived certain reporting requirements in 2020 at various times and held certain data points constant, there is no reason to believe that staffing and outcomes improved during the waiver periods. CMS has stated that it will resume calculating nursing homes Health Inspection and Quality Measure ratings on January 27, 2021.

[34]As noted in DOH Revised Report (7/20/20) and consistent with OAG analysis, this drop is despite the location of most CMS 5-Star Overall rated facilities in the hardest-hit counties.

[35]OAG continues to explore the anomalous rate shown by CMS 5-Star Staffing and 2-Star Overall rated facilities. There are few facilities in this group, and perhaps other poor practices result in little net difference from the COVID-19 death rate for a CMS 1-Star Staffing and 1-Star Overall rating combination. (There are no data points for CMS 1-Star Staffing and 4- or 5-Star Overall rated facilities, as the CMS methodology does not permit those combinations.)

[36]medicare.gov/nursinghomecompare/search.html

[37]skillednursingnews.com/2018/11/new-york-officials-call-greater-scrutiny-non-profit-nursing-home-sales

[38]DOH Revised Report 7/20/20 at pp. 23-24.

[39]OAG also accounted for a sample that ensured that at least one facility at each star level was in the county.

[40]The New York State Office of Emergency Management (OEM) is an office within the division of the NYS Division of Homeland Security and Emergency Services (DHSES).

[41]Executive Order 202.40, issued June 10, 20, continued this testing requirement yet modified it to a once a week testing requirement for nursing homes in areas in the second phase of the State's multi-tiered reopening plan.

[42]This approach of placing to onus on staff to obtain testing is less likely to result in staff being tested because many staff Statewide have low salaries and lack health insurance.

[43]DOH, Advisory: Hospital Discharges and Admissions to Nursing Homes, March 25, 2020

[44]DOH Revised Report at pp. 4-5.

[45]While some commentators have suggested DOH's March 25 guidance was a directive that nursing homes accept COVID-19 patients even if they could not care appropriately for them, such an interpretation would violate statutes and regulations that place obligations on nursing homes to care for residents. For example, New York law requires a nursing home to "accept and retain only those residents for whom it can provide adequate care." See 10 NYCRR § 415.26(i)(1)(ii). Preliminary findings show a number of nursing homes implemented the March 25 guidance with understanding of this fundamental assessment.

[46]U.S. Dep't of Health and Human Services Office of the Inspector General, "Hospital Experiences Responding to the COVID-19 Pandemic: Results of a National Pulse Survey March 23–27, 2020," OEI-06-20-00300 dated April 2020. The HHS-OIG report's key findings included hospitals reporting that "their most significant challenges centered on testing and caring for patients with known or suspected COVID-19 and keeping staff safe." Hospitals also reported challenges maintaining or expanding their facilities' capacity to treat patients with COVID-19, and frequently waiting seven days or longer for COVID-19 test results. Hospitals reported that as "patient stays were extended while awaiting test results, this strained bed availability, [PPE], supplies, and staffing." In addition, "acute care capacity concerns emerged as hospitals anticipated being overwhelmed if they experienced a surge of patients" who may require special beds and rooms to treat and contain infections.

[478]ibid.

[48]ibid.

[49]*See* DOH Revised Report at 25.

[50]*See* DOH Revised Report at 19-20.

[51]*See* DOH published nursing home death data as of August 8. *An earlier version of this report suggested a number of facilities that had potentially not been exposed to COVID-19 prior to the March 25th guidance. That number has been removed, but the overall findings remain unchanged.

[52]PHL § 3080

[53]Though amendments were enacted to Public Health Law §§ 3081-82 effective August 3, limiting the scope of immunity to acts relating to the "diagnosis or treatment of COVID-19" or "the assessment or care of an individual as it relates to COVID-19, when such individual has a confirmed or suspected case of COVID-19," and eliminating a clause concerning care of any other individuals, the potential defenses as to resources or staffing shortages were not amended.

[54]Public Health Law § 3082.

[55]ibid.

[56]Very few nursing home residents are completely "self-pay," without some form of private or public insurance.

[57]Notably, OAG investigations have revealed different structures and power balances between licensed administrators and owners in other for-profit facilities, compared to the above example. NYS Nursing Home regulations do not mention "owners" as part of the admissions process. 10 NYCRR § 415.26(i).

[58]10 NYCRR § 415.1(l)(a)(1).

[59]10 NYCRR § 415.1(l)(a)(5)

[60]10 NYCRR § 415.12

[61]10 NYCRR § 415.26(i)(1)(ii)

[62]10 NYCRR § 415.13

[63]10 NYCRR § 415.11(c)

[64]10 NYCRR § 415.3(a)

[65]10 NYCRR § 415.2(f)

[66]42 C.F.R. § 483.1.

[67]42 C.F.R. § 483.24

[68]42 C.F.R. § 483.25 ("Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices...").

[69]42 C.F.R. § 483.10; *See also* 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[70]42 C.F.R. § 483.10; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[71]42 C.F.R. § 483.12.

[72]42 C.F.R. § 483.25.

[73]42 C.F.R. § 483.20; 42 C.F.R. § 483.21; *See also* 42 C.F.R. § 483.21; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[74]42 C.F.R. § 483.21; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[75]42 C.F.R. § 483.24.

[76]ibid.

[77]ibid.

[78]42 C.F.R. § 483.30; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[79]42 C.F.R. § 483.35; *See also,* 42 U.S.C. § 1395i-3.

[80]42 C.F.R. § 483.60; *See also,* 42 U.S.C. § 1395i-3.

[81]42 C.F.R. § 483.50; 42 C.F.R. § 483.55; *See also* 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[82]42 C.F.R. § 483.40; *See also,* 42 U.S.C. § 1395i-3.

[83]42 C.F.R. § 483.70; *See also,* 42 U.S.C. § 1395i-3.

[84]ibid.

[85]ibid.

[86]42 C.F.R. § 483.75; 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[87]42 C.F.R. § 483.85.

[88]42 C.F.R. § 483.70(e).

[89]42 C.F.R. § 483.73. *See also* 10 NYCRR § 415.26(f).

[90]ibid.

[91]42 C.F.R. § 483.80; *See also* 42 U.S.C. § 1396r; 42 U.S.C. § 1395i-3.

[92]42 C.F.R. § 483.80.

[93]ibid.

[94]Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program, 85 FR 27550-01. The additional requirements include the reporting of COVID-19 information, including deaths, suspected and confirmed infections, PPE supply, ventilator supply; access to testing; and staffing shortages to CDC on at least a weekly basis. The changes also include a requirement for facilities to inform residents and their families each time there has been a confirmed infection of COVID-19, or when three or more residents or staff display newly-onset respiratory symptoms within 72 hours of each other. They must inform residents and their families and representatives of such occurrence by 5pm the next calendar day and must provide cumulative updates at least weekly. 42 C.F.R. § 483.80(g).

[95]42 C.F.R. § 483.70(n).

[96]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34737.

[97]ibid.

[98]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34747, 34746.

[99]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34738, 34745.

[100]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34748, 34745-6.

[101]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34745.

[102]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34749-50. These survey reports are the product of required state surveys of facilities that seek to assess compliance with statutes and regulations that facilities have notice of and are required to follow. Permitting facilities to wait to upload the data onto the CASPER system until a pending dispute resolution process has concluded would deprive residents and consumers of vital information that is accurate and relevant to their healthcare decisions, including which facility to reside in, or entrust a loved one to.

[103]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34740.

[104]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34737, 34740-41.

[105]Medicare and Medicaid Programs, 84 Fed. Reg. 138 at 34738, 34743-4.

[106]*See* Sections VI(A), (B), and (G), and Appendix B, B-1, and B-2.

[107]Patel A, Jernigan DB. Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak — United States, December 31, 2019–February 4, 2020. MMWR Morb Mortal Wkly Rep 2020;69:140–146. DOI: cdc.gov/mmwr/volumes/69/wr/mm6905e1.htm

[108]DOH issued new guidance effective September 17, 2020 that permitted nursing homes that have been without COVID-19 infection for at least 14 days to resume limited visitation under restrictions designed to keep residents safe from infections of COVID-19. This was a revision to the 28-day guidelines previously set by CMS, which also issued guidance regarding the 14-day period following any COVID-19 infection in the facility.

[109]The HHS-OIG report was issued on April 3 by Principal Deputy Inspector General of HHS OIG Christi A. Grimm, who was also serving as Acting Inspector General of HHS-OIG at the time. The President reportedly sought to remove Grimm from the latter position after he expressed displeasure on April 6 at the report's findings. On May 26, Acting Inspector General Grimm testified before Congress, emphasizing "the importance of independent oversight from the nation's watchdogs." pbs.org/newshour/politics/watch-live-hhs-watchdog-testifies-on-trump-administrations-response-to-covid-19

[110]For the purpose of this discussion, "related party" means entities controlled by the owners or controlled by other individuals who have family relationships or joint ownership of other business ventures with the facility owners.

[111]Among guidance issued in March, CDC noted that agency staffers, working in multiple location, are higher risk as disease vectors. "Facilities should identify staff that work at multiple facilities (*e.g.*, agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19." CDC, *Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)*, March 13, 2020.

[112]In order to enable OAG to investigate the financial transactions, related-party relationships and staffing levels in all of the facilities where insufficient staffing may be a root cause of neglect, MFCU's funding would need to be increased by over 300 percent. Such a budget increase is not one of this report's recommendations. It would be far more efficient to address the identified problem by implementing the recommendations of requiring mandatory, sufficient, defined staffing and supervision levels and more transparency in transactions between nursing homes, related parties and investors.

[113]*See, e.g.,* media reports such as projects.newsday.com/long-island/coronavirus-cold-spring-hills-nursing-home

[114]Such practices also have tax implications.

2020 ANNUAL REPORT OF

ERIE COUNTY MEDICAL CENTER CORPORATION

(AS REQUIRED BY N.Y. PUBLIC AUTHORITIES LAW)

Respectfully Submitted by the Corporation
March 31, 2021

TABLE OF CONTENTS

MESSAGE FROM THE LEADERSHIP OF ECMC CORPORATION

On behalf of the over three thousand employees and many hundreds of others who work each day at one of the numerous facilities of Erie County Medical Center Corporation ("ECMC Corporation" or the "Corporation"), it is our pleasure to present this 2020 Annual Report.

As we approached 2020, we had no idea the challenges we would face. We were focused on reimbursement and challenges across the community of being paid for the care we deliver. We also focused on long anticipated transformational capital projects that would literally change the ECMC health campus landscape and prepare us for the future. Notably, the planned opening of the new Russell J. Salvatore Atrium main hospital entrance and the new KeyBank Trauma and Emergency Department. These and other activities towards improving the patient experience and care continued to place ECMC as a leader in our region's healthcare environment.

And then came COVID-19. While we had heard varying reports of what this pandemic might mean to healthcare in the United States, nobody in early 2020 could ever anticipate what impact it would have and continues to have on our industry and our lives.

But despite the dire forecasts and predictions, our ECMC Family rose to the challenge to protect the health and safety of our patients, as well as each other. Since March of 2020, as an institution, ECMC has faced every aspect of the COVID-19 pandemic while maintaining our commitment to care for every patient we receive, no matter their background or their circumstance. We recorded our first COVID-19 inpatient on March 16th and have care for over 900 additional COVID-19 patients to date since that time. Thanks to our very talented and dedicated caregivers, we have successfully discharged over 780 COVID-19 patients (also to date).

Despite the continuing challenges of the pandemic, our frontline heroes remain committed to doing everything they can to care for the benefit of their patients. And fortunately our frontline caregivers started receiving the first of two required COVID-19 vaccinations on December 18th. Since then, 2,888 staff received the first of two scheduled vaccinations (we have been administering both the Pfizer and Moderna vaccines; and the Johnson and Johnson vaccine as of March 5, 2021). In addition, our valiant COVID-19 Vaccine Center team, which was established to oversee the entire vaccination process and is composed of physicians, nurses, LPNs and administrative staff, has also administered first round vaccinations to over 4,000 members of our community, predominantly first responders and healthcare workers from our region.

And while this healthcare crisis pervaded every aspect of our lives, so too did the senseless deaths of George Floyd, Breonna Taylor, Ahmaud Arbery and others in 2020. Our ECMC Family grieved the deaths of these individuals and we came together as a family to publicly express our sympathy, condolences and anger over these preventable killings. Establishing an Office of Diversity and Inclusion three years ago that reports directly to the CEO's office, we continue to be committed to promoting and fulfilling diversity, equity and inclusion throughout ECMC, as well as participating in programs and initiatives to strengthen our neighboring community and ensure that issues such as the social determinants of health are properly addressed and that residents of our community receive the healthcare services they deserve. We are proud to have provided the initial funding of $372,000, which started the African American Health Equity Task Force when it was first formed in 2019 and that strong relationship forged our joint efforts during the pandemic to provide critically needed services to at-risk residents throughout the City of Buffalo and beyond.

In May, ECMC announced 10 community health center and primary care practice organizations were approved to receive $2.3M in Delivery Service Reform Incentive Program (DSRIP) funds to support COVID-19 testing at 27 sites and from three mobile units operating in 17 priority zip codes located in Amherst, Buffalo, Dunkirk, Jamestown, Lockport, Niagara Falls, North Tonawanda, Wheatfield and Williamsville, NY. The organizations selected for funding had existing agreements under the DSRIP Medicaid program in these vulnerable communities. They were able to apply for COVID-19 testing site grant funding for up to $2,500/day for up to 100 days. The ECMC DSRIP-funded community testing sites program was part of a multi-pronged community-based healthcare initiative designed to support Western New York's vulnerable, at-risk residents during the COVID-19 pandemic. NYS Medicaid Waiver funding was used in these vulnerable communities to increase testing and link individuals with primary care.

An additional $1.125M in funding was also provided to the African American Health Equity Task Force, to facilitate the Task Force's work with Buffalo-area churches and other community-based organizations to reach out to vulnerable individuals and educate them on COVID-19-related health issues and identify barriers to care and link individuals with primary care and COVID-19 testing sites. Also, with support of the New York State Department of Health, an additional $7.24 million was released as early distribution of funds to outpatient community partners, including primary care and behavioral health partners, as well as organizations who were engaged in three areas of activity: 1) Expanding healthcare capacity to reach Medicaid and vulnerable populations (e.g. telehealth); 2) Address social determinants of health (e.g., food, food pantries, rent assistance, housing); 3) and provide COVID-19-related care.

But as pervasive as the pandemic was and continues to be, operationally, ECMC continued to provide the high-quality healthcare services our community has come to expect from our institution. And our remarkable caregivers' excellence was acknowledged in many instances during 2020 by national third-party organizations. We achieved ECMC's second Leapfrog A patient safety score in spring 2020, an achievement seldom seen by safety net hospitals across the nation. Our Medical Intensive Care Unit, Trauma Intensive Care Unit and the Roger W. Seibel, MD, Burn Treatment Center were all awarded a silver-level American Association of Critical Care Nurses (AACN) Beacon Award for Excellence, which is a three-year designation highlighting the Unit's achievement of exceptional care through improved outcomes and greater overall patient satisfaction. These are great accomplishments that underscore and affirm our caregivers' national best-in-class services that elevate ECMC's overall reputation, but, more importantly, demonstrate the excellent care they provide every day to our patients.

It was inevitable, however, that the pandemic, and more specifically national and state policies related to fighting its effects, would impact our patient volumes and ECMC's finances. With all surgeries first suspended from March into May (and then again from December 20, 2020 to January 21, 2021), along with the public's increasing fear of the virus, hospitals across our state, including ECMC, suffered significant decreases in operations and finances. As has been reported publicly previously, even with federal Cares Act funds coming into ECMC, the overall cost of the pandemic is estimated to be $85 million in 2020 alone. We experienced sharp reductions in inpatients, Emergency Department visits, total surgeries, and outpatient visits, while the acute length of stay and the average length of stay both increased. It was encouraging that patient volumes began increasing to pre-pandemic levels after all surgeries were again permitted in early June and continuing through the summer and into the fall but, the second wave of the pandemic again caused the cancellation of all surgeries in early December.

We know well that extraordinary circumstances require extraordinary actions and that has never been truer than what has occurred among our amazing ECMC Family since the first days of the pandemic. We have always prided ourselves on our truly unique and very special culture. Our frontline heroes – from physicians, nurses, LPNs, respiratory therapists, psychiatrists, lab techs, and pharmacists to CNAs, physical therapists, CRNAs, patient transport, environmental services, dietary and plant operations – have all stood shoulder to shoulder, fighting for our patients and ensuring that ECMC can meet the challenging healthcare needs of our community.

As we begin ECMC's second century, we are mindful of the role played by the remarkable caregivers within our facilities and our colleagues at Kaleida Health and the University at Buffalo. Together, we are committed to improving the health of our community.

Sincerely,

Thomas J. Quatroche Jr., PhD
President & Chief Executive Officer

Jonathan A. Dandes
Chair, Board of Directors

Michael Cummings, MD
President, Medical Executive Committee

CERTIFICATION

The financial reports submitted in this Annual Report have been approved by the Board of Directors of the Erie County Medical Center Corporation and are hereby certified, as indicated by signatures below, by the Chief Executive Officer and Chief Financial Officer.

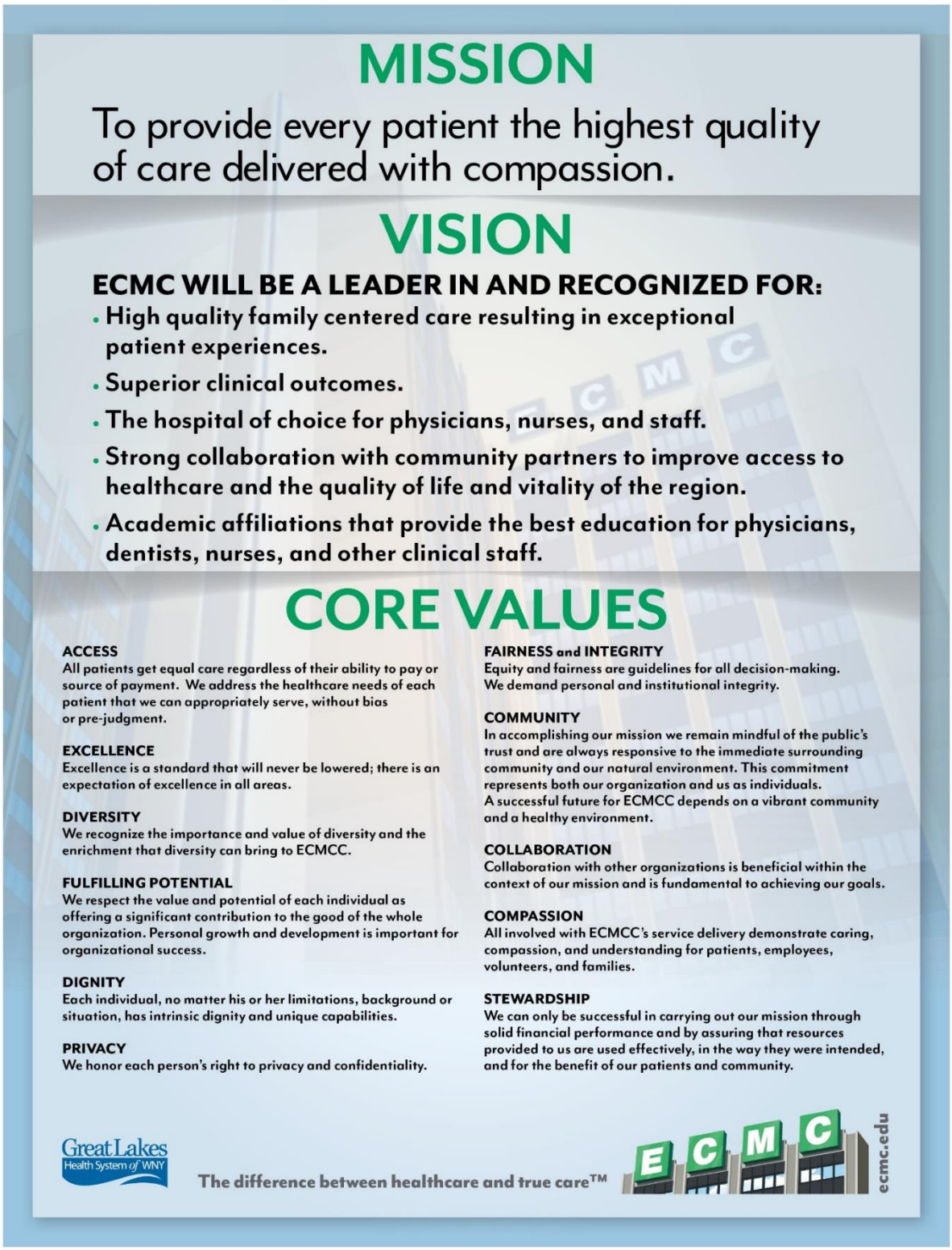
Specifically, the undersigned certify, based on knowledge and information provided to us that the financial reports and the information provided therein (1) are accurate, correct and do not contain any untrue statement of material fact; (2) do not omit any material fact which, if omitted, would cause the financial statements to be misleading in light of the circumstances under which such statements are made; and (3) fairly present, in all material respects, the financial condition and results of operations of the Erie County Medical Center Corporation as of, and for, the year ended December 31, 2020.

Respectfully submitted,

Thomas J. Quatroche, Ph.D.
President and Chief Executive Officer

Jonathan T. Swiatkowski, CPA
Chief Financial Officer

ECMCC MISSION STATEMENT



2020 ACCOMPLISHMENTS

January

- ECMC awarded inaugural IDEA award from Business First as one of eight companies in Western New York who prioritize the importance of diversity and inclusion, champion equitable human resources practices and develop inclusive cultures.

- ECMC designated as a Pathway to Excellence® organization by the American Nurses Credentialing Center. To qualify, organizations must meet six Practice Standards essential to an ideal nursing practice environment. Applicants undergo a review process to fully document the integration of those standards in the organization's practices, policies, and culture. Pathway designation can only be achieved if an organization's nurses validate the data and other evidence submitted, via an independent, confidential survey.

February

- ECMC Internal Medicine Center received a Certificate of Recognition from the National Committee for Quality Assurance for "systematic use of patient-centered, coordinated care management processes."

April

- The Leapfrog Group, a trusted independent, national not-for-profit organization founded more than a decade ago by the nation's leading employers and private health care experts, rated ECMC's overall safety score at 'A'.

June

- Medical Intensive Care Unit (MICU) awarded a silver-level American Association of Critical Care Nurses (AACN) Beacon Award for Excellence, which is a three-year designation highlighting the Unit's achievement of exceptional care through improved outcomes and greater overall patient satisfaction.

July

- Commission on Accreditation of Rehabilitation Facilities (CARF) issued three-year accreditation to ECMC's Acute Inpatient Rehabilitation Programs (through June 30, 2023) stating that this "achievement is an indication of [ECMC's] dedication to improving the quality of the lives of the persons served."

September

- ECMC has earned platinum level national recognition for its efforts to increase organ, eye, and tissue donor registrations across the state through the Workplace Partnership for Life (WPFL) Hospital Organ Donation Campaign. The WPFL is a national initiative that unites the U.S.

Department of Health and Human Services, Health Resources and Services Administration (HRSA), and the organ donation community with workplaces across the nation in spreading the word about the importance of donation. The WPFL Hospital Organ Donation Campaign challenges hospitals and healthcare organizations to "let life bloom" by educating their staff, patients, visitors, and communities about the critical need for organ, eye, and tissue donation, including offering opportunities to register as organ donors. ECMC earned points for conducting awareness and registry activities between October 2019 and April 2020.

October

• Roger W. Seibel, MD, Burn Treatment Center awarded a silver-level American Association of Critical Care Nurses (AACN) Beacon Award for Excellence, which is a three-year designation highlighting the Unit's achievement of exceptional care through improved outcomes and greater overall patient satisfaction.

2020 PERFORMANCE GOALS/OUTCOMES

ECMC Strategic Plan Priorities and Goals

1. **Exceptional Quality and Experience** – Raise the standard of clinical care to improve quality, patient safety, and patient experience in the acute care and ambulatory environments.
2. **Cultural Identity** – Preserve ECMC's strong cultural identity while further instilling a sense of urgency and genuine stewardship to achieve our organizational objectives.
3. **Campus Transformation** – Address our deferred maintenance issues, expand capacity, and integrate the development of Kensington Heights and the surrounding community.
4. **Performance Improvement** – Generate the margin necessary to meet our budgetary goals by lowering ECMC's overall cost position, enhancing revenue cycle performance, and targeted growth.
5. **Population Health Capabilities** – Take greater responsibility for managing the overall health of our patient populations through a shift from fee-for-service to risk-based arrangements.
6. **Community Needs** – Through partnerships and targeted investments, be a leading corporate citizen by addressing socioeconomic challenges that impact our communities.
7. **Great Lakes Health Collaboration** – Further increase interconnectivity between ECMC, Kaleida and our partners through clinical and operational collaborations.
8. **Strengthen Relationship with Academic Partners** – Partner with the University at Buffalo and other local professional training programs to enhance our impact across the tripartite academic mission.

Progress Against Strategic Plan Priorities and Goals

1. **Exceptional Quality and Experience**
   - Despite the impact of the COVID-19 pandemic, great quality achievements were accomplished in 2020, including:
     - Zero CLABSIs in Critical Care and Rehab in 2019
     - Leapfrog A Safety Grade.

    - Terrace View Long-Term Care Facility named to *Newsweek's* Best Nursing Homes list for 2021.
    - Medical Intensive Care, Trauma Intensive Care and Burn Units all achieved American Association of Critical Care Nurses silver-level Beacon Award for Excellence.
- Received the American Heart Association/American Stroke Association's Get With The Guidelines®-Stroke Gold Plus Quality Achievement Award.
- American College of Radiology's Commission on Quality and Safety designated ECMC a Diagnostic Imaging Center of Excellence.
- Consistent strong Hospital Consumer Assessment of Healthcare Providers and Systems scores, including: overall hospital rating, communication with doctors, and cleanliness of hospital environment
- Improved Global Rating of Overall Hospital to 71.3%

2. Cultural Identity

- Focus on Diversity, Equity & Inclusion across the organization
- Human Rights Campaign Healthcare Equality Index Top Performer
- Obtained Nursing Pathway to Excellence designation in January 2020
- Continued investment in nursing education and professional development
- Employee safety efforts focused on nursing education and engagement
- Improvements to HRIS functionality

3. Campus Transformation

- New front lobby opened – February 2020
- New KeyBank Emergency Department and Trauma Center opened – June 2020
- Continuation of building envelope project including reinstallation of ECMC sign and window replacement
- Kensington Heights community planning process completed in February 2020
- Additional ICU and observation capacity added
- Completion of on-site hearing room

4. Performance Improvement

- Accelerating Excellence programs and projects continued despite COVID-19
- Launched COVID-19 testing site and managed patient surge volumes
- Physician recruitment: 90 new physicians added to medical staff
- 2020 volumes were significantly impacted by the COVID-19 pandemic:

	2020	Versus 2019
Inpatient	19,116	-4.4%
Outpatient visits	299,297	-2.43%
Surgeries	11,555	-16.3%
Emergency Visits	65,261	-6.0%
Observation Cases	2,221	-37.5%

5. Population Health Capabilities

- Orthopedic bundled payment program and launch of orthopedic IPA
- ECMC primary care participation in Medicaid VBP arrangements
- Continued investment in Great Lakes Integrated Network
- Launch of ECMC Virtual Care, including on-demand visits
- Deployment of COVID-19 chatbot technology

6. Community Needs

- Partnered with the African American Health Equity Task Force and community partners for COVID outreach and testing efforts
- Continued required wind-down of DSRIP initiatives
- Exceeded MWBE goal for 2020

7. Great Lakes Health Collaboration

- Continued expansion of Wellnow Urgent Care
- Continued growth of Great Lakes Cancer Care
- Collaborative value-analysis efforts

8. Strengthen Relationship with Academic Partners

- Alignment of ECMC Department of Neurosurgery with UBNS
- Participation in UB Medical School Council on Inclusion in Medicine and Science

CAPITAL PROJECTS IN PROCESS IN 2020

Project	Project Duration
Emergency Room Renovation Project	Began December 2015
Comprehensive Psychiatric Emergency Program (CPEP) Renovations	Began January 2017
Main Lobby Renovations	Began August 2017
Water Piping/Valve	Began August 2018
Parking Access Control System	Began September 2018
Mechanical, Electrical, Plumbing and Elevator Improvements	Began November 2018
Building Envelope Replacement and Renovation	Began December 2018
Data Center Renovations	Began August 2019
Pharmacy Renovations	Began September 2019

REAL PROPERTY ACQUISITIONS

The Corporation had no real property acquisitions in 2020.

CODE OF ETHICS

See Appendix D. Article XI; Sections 1-8

INTERNAL CONTROL STRUCTURE AND PROCEDURES

Assessment of Effectiveness of Internal Controls

New York State Public Authority Reporting System (PARIS)

Erie County Medical Center Corporation

At and For the Year Ended December 31, 2020

The evaluation of the system of internal control is an ongoing process conducted throughout the year by myself in the capacity as the Chief Financial Officer of Erie County Medical Center Corporation. In this ongoing process there is engagement and oversight by the Audit Committee of the Board of Directors with support, advice and assistance provided by the Chief Executive Officer, the Chief Operating Officer, the General Counsel and a robust internal audit function.

The conclusions of the ongoing assessment were that no control deficiencies, significant deficiencies or material weaknesses, collectively as defined in generally accepted auditing standards, in internal controls were identified, however, performance improvement opportunities to enhance internal control were identified and implemented.

Based on my ongoing assessment, the work of the internal audit function and the work of the independent audit firm for ECMC there is an effective system of internal control to safeguard assets and to assure that transactions are properly authorized.

Respectfully submitted,

Jonathan T. Swiatkowski, CPA
Chief Financial Officer

PENDING LITIGATION

The corporation is involved in several matters related to medical malpractice, workers' compensation, and business disputes as discussed in Note 14 in the enclosed audited financial statements beginning on page 42. There are no other material matters pending litigation at this time.

CORPORATION AND BOARD STRUCTURE

ECMC's Board of Directors is comprised of 15 voting Directors, drawn from institutions and occupations across Western New York. Of these directors, eight are appointed by the Governor of New York – via the recommendations of the County Executive (3), County Legislature (3), the Temporary President of the NYS Senate and (1) the Speaker of the NYS Assembly (1) – and seven are appointed by the County Executive with the advice and consent of the Erie County legislature.

ECMC CORPORATION BOARD OF DIRECTORS

OFFICERS

Jonathan A. Dandes
Chair

Jennifer C. Persico, Esq.
Vice Chair, Chair Elect

Bishop Michael A. Badger
Secretary

Eugenio Russi
Treasurer

Thomas J. Quatroche Jr., PhD
President & CEO

BOARD MEMBERS

Ronald P. Bennett, Esq.

Scott A. Bylewski, Esq.

Ronald A. Chapin

Darby Fishkin, CPA

Kathleen Grimm, MD

Sharon L. Hanson

Michael H. Hoffert

James L. Lawicki, II

Christopher J. O'Brien, Esq.

William A. Pauly

Jack Quinn

Michael A. Seaman

BOARD OF DIRECTORS REGULAR AND ANNUAL MEETINGS

Tuesday, January 28, 2020 (Annual and Regular Meeting)

Present:	Bishop Michael Badger, Ronald Bennett, Anthony J. Colucci, III, Jonathan Dandes, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert (via phone), James Lawicki, Christopher O'Brien, William Pauly, Jennifer Persico, Thomas J. Quatroche, Jack Quinn (via phone), Eugino Russi, Michael Seaman
Excused:	Scott Bylewski, Ronald A Chapin
Also Present:	Donna Brown, Peter Cutler, Andrew Davis, Richard Embden, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, February 24, 2020

Present:	Ronald Bennett, Scott Bylewski, Ronald A. Chapin, Anthony J. Colucci, III (via phone), Jonathan Dandes, Darby Fishkin, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert (via phone), William Pauly, Jennifer Persico, Thomas J. Quatroche, Jack Quinn (via phone), Eugino Russi, Michael Seaman
Excused:	Bishop Michael Badger, James Lawicki, Christopher O'Brien
Also Present:	Cynthia Bass, Peter Cutler, Andrew Davis, Richard Embden, Victor Filadora, MD, William Flynn, MD, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Charlene Ludlow, Keith Lukasik, Nadine Mund, Brian Murray, MD, James Turner, Karen Ziemianski

Tuesday, March 24, 2020

Present:	Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Ronald A. Chapin, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert, James Lawicki, Christopher O'Brien, William Pauly, Jennifer Persico, Thomas J. Quatroche, Jack Quinn, Eugino Russi, Michael Seaman
Also Present:	Donna Brown, Peter Cutler, Andrew Davis, Richard Embden, William Flynn, MD, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Lindy Nesbitt, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, April 28, 2020

Present:	Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Ronald A. Chapin, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert, James Lawicki, Christopher O'Brien, William Pauly, Jennifer Persico, Thomas J. Quatroche, Jack Quinn, Eugino Russi, Michael Seaman

Also
Present: Donna Brown, Peter Cutler, Andrew Davis, Richard Embden, William Flynn, MD, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, May 26, 2020

Present: Scott Bylewski, Ronald A. Chapin, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert, James Lawicki, Christopher O'Brien, William Pauly, Jennifer Persico, Thomas J. Quatroche, Michael Seaman

Excused: Bishop Michael Badger, Ronald Bennett, Jack Quinn, Eugino Russi
Also
Present: Donna Brown, Peter Cutler, Andrew Davis, Richard Embden, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, June 23, 2020

Present: Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Ronald A. Chapin, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert, James Lawicki, Christopher O'Brien, William Pauly, Jennifer Persico, Thomas J. Quatroche, Eugenio Russi, Michael Seaman

Excused: William Pauly, Jack Quinn
Also
Present: Donna Brown, Peter Cutler, Andrew Davis, Richard Embden, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, July 28, 2020

Present: Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, MD, Sharon Hanson, Michael Hoffert, James Lawicki, Christopher O'Brien, William Pauly, Jennifer Persico, Thomas J. Quatroche, Jack Quinn, Eugenio Russi

Excused: Ronald A. Chapin, Michael Seaman
Also
Present: Donna Brown, Peter Cutler, Andrew Davis, Richard Embden, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, September 22, 2020

Present:	Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Sharon Hanson, Michael Hoffert, James Lawicki, Jennifer Persico, Thomas J. Quatroche, Jack Quinn, Eugenio Russi, Michael Seaman
Excused:	Ronald A. Chapin, Kathleen Grimm, Christopher O'Brien, William Pauly
Also Present:	Donna Brown, Peter Cutler, Andrew Davis, William Flynn, MD, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Jonathan Swiatkowski, James Turner, Karen Ziemianski

Tuesday, October 27, 2020

Present:	Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Ronald Chapin, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, Sharon Hanson, Michael Hoffert, Jennifer Persico, Thomas J. Quatroche, Jack Quinn, Eugenio Russi, Michael Seaman
Excused:	James Lawicki, Christopher O'Brien, William Pauly
Also Present:	Donna Brown, Peter Cutler, Andrew Davis, Victor Filadora, MD, William Flynn, MD, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Michelle Krause, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Paul Shields, DO, Jonathan Swiatkowski, James Turner, Cassandra Williams, MD, Karen Ziemianski

Tuesday, November 24, 2020

Present:	Bishop Michael Badger, Ronald Bennett, Scott Bylewski, Ronald Chapin, Anthony J. Colucci, III, Jonathan Dandes, Darby Fishkin, Kathleen Grimm, Sharon Hanson, Michael Hoffert, James Lawicki, Christopher O'Brien, Jennifer Persico, Thomas J. Quatroche, Jack Quinn, Eugenio Russi, Michael Seaman
Excused:	William Pauly
Also Present:	Donna Brown, Peter Cutler, Andrew Davis, Victor Filadora, MD, William Flynn, MD, Joseph Giglia, Susan Gonzalez, Al Hammonds, Donna Jones, Michelle Krause, Pamela Lee, Charlene Ludlow, Keith Lukasik, Brian Murray, MD, Paul Shields, DO, Jonathan Swiatkowski, James Turner, Cassandra Williams, MD, Karen Ziemianski

COMMITTEES OF THE BOARD

STANDING COMMITTEE	*# OF MEMBERS*	*BOARD MEMBERSHIP*	*STAFF*
EXECUTIVE/ OFFICERS ***Call of Chair***	**5**	**Jonathan Dandes – Chair** Bishop Michael A. Badger Darby Fishkin Sharon L. Hanson Eugenio Russi *A.J. Colucci, III, ex officio*	A.J. Colucci, III Andrew Davis Jonathan Swiatkowski Brian Murray, MD Thomas Quatroche Joseph Giglia Jeffra Wilson (Asst.)
QUALITY IMPROVEMENT/ PATIENT SAFETY ***Meets Monthly***	**5**	**MICHAEL HOFFERT – Chair** Kathleen Grimm James Lawicki Michael Seaman Jack Quinn	Andrew Davis Thomas Quatroche Donna Jones Brian Murray, MD Karen Ziemianski Pam Lee James Turner Lisa Giacomazza (Asst.)
FINANCE ***Meets Monthly***	**4**	**MICHAEL A. SEAMAN – Chair** Scott Bylewski Ronald A. Chapin Darby Fishkin	A.J. Colucci, III Andrew Davis Jonathan Swiatkowski Thomas Quatroche Lynn Sacha (Asst.)
AUDIT & COMPLIANCE ***Call of Chair***	**4**	**DARBY FISHKIN – Chair** Bishop Michael Badger Scott Bylewski James Lawicki *A.J. Colucci, III, ex officio*	Andrew Davis Jonathan Swiatkowski Thomas Quatroche Joseph Giglia Lynn Sacha (Asst.)
EXECUTIVE COMPENSATION ***Call of Chair***	**3**	**JONATHAN DANDES – Chair** Sharon Hanson Christopher O'Brien	A.J. Colucci, III Thomas Quatroche Joseph Giglia

GOVERNANCE ***Call of Chair***	**3**	**<u>SHARON HANSON – Chair</u>** Ronald Chapin Jennifer Persico *Thomas Quatroche, ex officio* *A.J. Colucci, III, ex officio*	Joseph Giglia Lindy Nesbitt Lori Hoffman (Asst.)
HUMAN RESOURCES ***Call of Chair***	**3**	**<u>MICHAEL BADGER – Chair</u>** Michael Hoffert Michael Seaman	Joseph Giglia Cory Wright (Asst.)
INVESTMENT ***Call of Chair***	**3**	**<u>EUGENIO RUSSI - Chair</u>** Sharon L. Hanson Jack Quinn	Jonathan Swiatkowski Thomas Quatroche Lynn Sacha (Asst.)
BUILDINGS & GROUNDS ***Ad-Hoc Committee*** ***Call of Chair***	**3**	**<u>RONALD BENNETT – Chair</u>** Michael Hoffert William Pauly Jennifer Persico	Andrew Davis Thomas Quatroche James Turner Michelle Kroupa (Asst.)
M/WBE ***Call of Chair***	**3**	**<u>BISHOP MICHAEL BADGER – Chair</u>** Ronald A. Chapin Kathleen Grimm, MD	A.J. Colucci, III Thomas Quatroche Diane Artieri Sarina Rohloff Lindy Nesbitt
POST-ACUTE QI ***Call of Chair***	**3**	**<u>RONALD CHAPIN – Chair</u>** Michael Seaman Christopher O'Brien	Andrew Davis Thomas Quatroche Anthony DePinto
CONTRACTS ***Meets Quarterly***	**3**	**<u>JENNIFER PERSICO - Chair</u>** Ronald Bennett Christopher O'Brien	A.J. Colucci, III Lindy Nesbitt Lori Hoffman (Asst.)

CONFIDENTIAL EVALUATION OF BOARD PERFORMANCE

The below is the evaluation tool utilized by ECMC for its annual Evaluation of Board Performance.

Evaluation Tool: Completed on _____

Criteria	Agree	Somewhat Agree	Somewhat Disagree	Disagree
Board members have a shared understanding of the mission and purpose of ECMCC.				
The policies, practices and decisions of the Board are always consistent with this mission.				
Board members comprehend their role and fiduciary responsibilities and hold themselves and each other to these principles.				
The Board has adopted policies, by-laws, and practices for the effective governance, management and operations of ECMCC and reviews these annually.				
The Board sets clear and measurable performance goals for ECMCC that contribute to accomplishing its mission.				
The decisions made by Board members are arrived at through independent judgment and deliberation, free of political influence or self-interest.				
Individual Board members communicate effectively with executive staff so as to be well informed on the status of all important issues.				
Board members are knowledgeable about ECMCC's programs, financial statements, reporting requirements, and other transactions.				
The Board meets to review and approve all documents and reports prior to public release and is confident that the information being presented is accurate and complete.				
The Board knows the statutory obligations of ECMCC and if ECMCC is in compliance with state law.				
Board and committee meetings facilitate open, deliberate and thorough discussion, and the active participation of members.				
Board members have sufficient opportunity to research, discuss, question and prepare before decisions are made and votes taken.				
Individual Board members feel empowered to delay votes, defer agenda items, or table actions if they feel additional information or discussion is required.				
The Board exercises appropriate oversight of the CEO and other executive staff, including setting performance expectations and reviewing performance annually.				
The Board has identified the areas of most risk to ECMCC and works with management to implement risk mitigation strategies before problems occur.				
Board members demonstrate leadership and vision and work respectfully with each other.				

ECMC CORPORATION EXECUTIVE ADMINISTRATION

Thomas J. Quatroche Jr., PhD
President and Chief Executive Officer

Andrew L. Davis, MBA
Chief Operating Officer

Brian M. Murray, MD
Chief Medical Officer

Jonathan Swiatkowski, CPA
Chief Financial Officer

Karen Ziemianski, MS, RN
Senior Vice President of Nursing

James Turner, RN, BSN
Senior Vice President, Surgical and Outpatient Services

Pamela Lee, MBA, MS, RN
Senior Vice President of Operations

Joseph T. Giglia, II, Esq.
General Counsel and Chief Human Resources Officer

Anthony J. Colucci, III, Esq.
Executive Vice President

Donna M. Brown
Associate Hospital Administrator

Peter K. Cutler
Vice President of Communications and External Affairs

Charlene Ludlow, MHA, RN, CIC
Vice President and Chief Quality & Safety Officer

Keith Lukasik
Chief Strategy Officer

Donna Jones, MHA, MSN, RN, FACHE, CPHQ
Chief Quality Officer

Susan M. Gonzalez
Executive Director, ECMC Foundation

ECMC CORPORATION MEDICAL-DENTAL STAFF OFFICERS

Michael Cummings, MD
President

William J. Flynn Jr., MD, FACS
Immediate Past President

Jennifer Pugh, MD, MBA, FACEP
President-Elect

Michael A. Manka, Jr., MD
Treasurer

Andrea Manyon, MD
Secretary

PRIMARY CORPORATION

Erie County Medical Center Corporation

ECMC Corporation was established as a New York State Public Benefit Corporation and since 2004 has included an advanced academic medical center with 573 inpatient beds, on- and off-campus health centers, more than 30 outpatient specialty care services and Terrace View, a 390-bed long-term care facility. ECMC is Western New York's only Level 1 Adult Trauma Center, as well as a regional center for burn care, behavioral health services, transplantation, medical oncology and head & neck cancer care, rehabilitation and a major teaching facility for the University at Buffalo. Most ECMC physicians, dentists and pharmacists are dedicated faculty members of the university and/or members of a private practice plan. More Western New York residents are choosing ECMC for exceptional patient care and patient experiences – the difference between healthcare and true care™.

ECMC Corporation Employees: 3,881

SUBSIDIARY INFORMATION

PPC Strategic Services, LLC

ECMC Corporation is the sole owner of this enterprise, which was established to enable the Corporation to enter into various other business relationships, and to provide management services to them, as needed. The accounts of PPC Strategic Services LLC are consolidated into the accounts of the Corporation as of, and for the years ended, December 31, 2020 and 2019, respectively.

The assets of PPC Strategic Services LLC were unwound during 2019.

PPC Strategic Services LLC (formerly named ECMCC Strategic Services, LLC) owns Greater Buffalo Niagara SC Venture, LLC, a presently inactive entity. The ownership interest is accounted for utilizing the equity method of accounting.

The sole member of this entity is Erie County Medical Center Corporation.

Employees: 7

Grider Community Gardens, LLC

This entity is wholly owned and controlled by the Corporation. The Corporation's net investment as of December 31, 2020 and 2019 is approximately $474 thousand and $462 thousand, respectively, and is reflected in other non-current assets of the parent company's financial statements.

The sole member of this entity is Erie County Medical Center Corporation.

Employees: None

Grider Support Services, LLC

This entity was formed to act as a Management Services Organization ("MSO") for oncology and physician services for ECMC Hospital. The entity acts as a pass-through entity, and has no substantial assets or liabilities, or significant operating results. Its activity is consolidated into ECMC Corporation operations.

The sole member of this entity is Erie County Medical Center Corporation.

Employees: 5

1827 Fillmore LLC

This entity was formed in order to purchase real estate adjacent to the current health campus for the purpose of future development. Its activities to date consist of remediating and improving land adjacent to the ECMC campus and is consolidated into ECMC Corporation.

Net position as of December 31, 2020 and 2019 is $799 and $815 thousand, respectively.

The sole member of this entity is Erie County Medical Center Corporation.

Employees: None

APPENDIX A
Financial Reports

Erie County Medical Center Corporation

(A Component Unit of the County of Erie)

Financial Report
December 31, 2020

Contents

RSM

RSM US LLP

Independent Auditor's Report

To the Board of Directors
Erie County Medical Center Corporation

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities and aggregate discretely presented component units of Erie County Medical Center Corporation (the "Corporation"), a component unit of the County of Erie, as of and for the years ended December 31, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the Corporation's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement. The financial statements of ECMC Foundation, Inc., the Grider Initiative, Inc., and Research for Health in Erie County, Inc. were not audited in accordance with *Government Auditing Standards*.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Corporation's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of Erie County Medical Center Corporation as of December 31, 2020 and 2019, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 3-12 as well as the required supplementary information data on pages 53-55 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audits of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated March 23, 2021 on our consideration of the Corporation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Corporation's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Corporation's internal control over financial reporting and compliance.

RSM US LLP

March 23, 2021

Management's Discussion and Analysis

Erie County Medical Center Corporation (the Corporation or ECMCC) is a state public benefit corporation dedicated to provide every patient the highest quality of care delivered with compassion. The Corporation fully embraces and is proud to serve as the safety net provider for the greater western region of New York State, supporting persons in need who lack the ability to pay.

To assist the reader in understanding the operations of the Corporation, this annual report has been organized into three parts that should be read together:

- Management's discussion and analysis
- Financial statements and notes to the financial statements and
- Supplemental schedules

The purpose of the discussion and analysis is to provide the reader with objective data to evaluate the Corporation for the year ended December 31, 2020. This narrative and the financial statements and footnotes are the responsibility of the Corporation's management.

The financial statements (the statements of net position, the statements of revenues, expenses and changes in net position and the statements of cash flows) present financial information in a form similar to that used by other government hospitals and have been prepared in accordance with accounting principles generally accepted in the United States of America.

The accompanying financial statements of the Corporation include financial data of the Corporation's discretely presented component units (i) ECMC Foundation, Inc. (ii) The Grider Initiative, Inc. and (iii) Research For Health in Erie County, Inc.; however, Management's Discussion and Analysis focuses on the Corporation.

Introduction

During 2020, the Corporation continued our second century journey of providing high quality, compassionate care to the tens of thousands of Western New Yorkers who depend on ECMCC, serving as the region's community hospital, helping patients from the most influential to the most vulnerable. The Corporation continued to invest in its workforce by increasing clinical care at the bedside, increasing support services for staff, and paying hazard pay during the height of the pandemic. The Corporation completed work on multiple construction projects including the new KeyBank Trauma and Emergency Department (which is the only Adult Level 1 Trauma Center in Western New York), the renovated Russell J. Salvatore Atrium, and capital improvements to the Comprehensive Psychiatric Emergency Program (CPEP). The Corporation also continued updating the building façade, windows, roofing and other exterior elements. The exciting future of the ECMCC health campus and strong continuing collaboration with community partners is producing quantifiably strong, efficient outcomes that will benefit the entire community and, of course, ECMCC patients.

Operations Analysis

The Corporation completed calendar year 2020 providing another year of significant levels of combined inpatient and outpatient services to Western New York residents and, given its unique services, to many others beyond this region despite the unfavorable impacts resulting from the COVID-19 pandemic. Volumes of patient encounters (not expressed in thousands) are as follows:

	2015	2016	2017	2018	2019	2020	% Change 2015 - 2020
Inpatients	18,378	18,839	19,260	20,555	19,996	19,110	4.0%
Surgeries	14,364	14,552	14,818	15,315	15,606	12,481	-13.1%
Emergency	67,296	69,290	68,862	70,110	69,391	65,261	-3.0%
Outpatients	305,737	316,691	314,927	321,661	322,625	328,625	7.5%
Dialysis	24,617	27,291	24,772	25,063	27,549	27,973	13.6%

The global outbreak of COVID-19, a new strain of coronavirus that can result in severe respiratory disease, was declared a pandemic by the World Health Organization on March 11, 2020 and was declared a national emergency on March 13, 2020. The outbreak of the disease has affected travel, commerce, economies and financial markets globally, nationally, in New York State, and in Erie County. In response to the public health crisis, the New York State Governor and the New York State Commissioner of Health took certain actions to limit the spread of the virus and its impact on the State's communities and health care services, including the declaration of a state of emergency and the closure of all non-essential businesses in March 2020.

ECMCC voluntarily suspended non-essential or elective surgeries on March 20, 2020, while New York State, on March 23, 2020, issued orders to temporarily suspend healthcare providers and hospitals from performing non-essential or elective surgeries and procedures, which also impacted primary care and clinic appointments. The temporary suspension of these procedures and visits was enacted in order to create capacity within healthcare facilities to care for a potential increase in COVID-19 patients. On March 23, 2020, New York State mandated that hospitals in New York plan to increase capacity by 50%. The temporary suspension of non-essential and elective procedures was lifted for the Corporation on May 20, 2020.

On December 4, 2020, the State of New York again issued orders to temporarily suspend non-essential or elective surgeries and procedures in Erie County. The temporary suspension was intended to create capacity within healthcare facilities in Erie County to care for a potential increase in COVID-19 patients. This temporary suspension was lifted for the Corporation on January 25, 2021.

In response to the impact on the healthcare environment from the COVID-19, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was enacted by Congress and was signed into law on March 27, 2020. The CARES Act included, among other things, support for healthcare providers and patients in the form of grants, payments for uninsured patients, and changes to Medicare and Medicaid payments. The Corporation to date has received $62.8 million of Provider Relief Fund distributions provided under the CARES Act. Amounts provided under the CARES Act grant funds are recognized as non-operating revenues in the Statements of Revenue, Expenses and Changes in Net Position as eligibility requirements are met. Reporting and eligibility requirements under the CARES Act have continued to change and as such, the amounts recorded under the CARES Act for Provider Relief Funds may change in future periods. The Corporation also received $39.1 million and $10 million in loans under the Medicare Accelerated and Advance Payment Program and the Paycheck Protection Program, respectively.

Operations Analysis (Continued)

Suspended operations due to the COVID-19 pandemic resulted in decreases in revenues and patient care volumes significantly below budget projections. Additionally, in order to adequately prepare to respond to the pandemic and the increased number of regulations governing the provision of care and safety guidelines, the Corporation incurred significant additional expenses above budgeted projections on personnel costs, the purchase of personal protective equipment, lab equipment, ventilators and other clinical equipment, and other purchased services. Due to the temporary financial market downturn in March 2020, the Corporation experienced additional pension expense in 2020. The federal government provided relief funding did not offset the unfavorable financial impact of COVID-19 in 2020. Despite these challenges, the Corporation remained committed to continuing its mission to "provide every patient the highest quality of care delivered with compassion."

The continued volume and visit trends reflect the trust that the Western New York community has placed in ECMCC. Notable achievements in 2020 include:

- NYS Department of Health grant in the amount of $10 million to support the new KeyBank Level 1 Adult Trauma Center and Emergency Department at ECMCC.
- Beacon Award for Excellence in quality recognizing the Trauma ICU, Medical ICU and Burn Unit.
- ECMCC was designated a nursing Pathways to Excellence organization by the American Nurses Credentialing Center.
- NYS Division of Minority and Women's Business Development MWBE Program Performance Report graded ECMCC's participation as an 'A' for Fiscal Year 2019-20, achieving 30.4% participation.
- ECMCC recognized by Buffalo Business First with its' IDEA award for Inclusion, Diversity, Equity and Awareness.
- ECMCC received the Top Performer award in LGBTQ Healthcare Equality from the Human Rights Campaign Foundation.
- The Leapfrog Group, an independent, national not-for-profit organization rated ECMCC's overall patient safety score at 'A' in the Spring of 2020.
- ECMCC Family Health Center received a Certificate of Recognition from the National Committee for Quality Assurance for "systematic use of patient-centered, coordinated care management processes."
- ECMCC designated as a Blue Distinction Center for Bariatric Surgery by BlueCross/BlueShield of Western New York.
- Terrace View Long-Term Care Facility was named to *Newsweek's* 2021 Best Nursing Homes List for performance on key measures on health inspections, quality measures and staffing.
- Recruitment of 90 new physicians to the Medical Staff across 17 disciplines.

Fundraising also was challenged by the COVID-19 pandemic in 2020. The ECMC Foundation, Inc., nevertheless, increased employee participation in annual fundraising by 34% and overall participation reached 41% in 2020 while also receiving significant support from the community, including the completion of a successful $15 million capital campaign for its new KeyBank Trauma and Emergency Department.

(Dollars in Thousands)

Operations Analysis (Continued)

Financial Metric Analysis

The Corporation's total net position decreased in 2020 due to unfavorable results from operations as a result of the COVID-19 pandemic and its impacts, as further discussed below.

Comparative financial ratios for the Corporation to the 2019 (most recent publicly available audited data, pre-pandemic) average of NYS Public Benefit Corporation (PBC) hospitals are presented in the following table. The financial statements used for the calculation of the following ratios, where appropriate, have been reclassified to conform to the presentation used in the development of the benchmarks, consistent with GAAP for entities not subject to GASB standards.

	ECMCC			PBC Average
	2020	2019	2018	2019
Operating margin	-17.60%	0.04%	0.6%	-5.4%
Operating cash flow margin	-10.8%	4.8%	6.0%	0.0%
Debt service coverage	-1.3	2.2	2.0	1.1
Days cash on hand	151.7	119.0	112.1	62.9
Days in accounts receivable	56.8	58.2	61.5	40.2
Average age of plant	14.0	14.7	14.1	20.3

Prior to 2020, the operational performance ratios reflected favorable results of operations and generally favorable performance compared to NYS Public Benefit Corporations, while liquidity ratios have performed comparatively well throughout 2020. Federal provider relief funds reimbursing for additional operating expenses and lost operating revenues have been recognized as non-operating revenue, and are excluded from the operating ratio calculations. Days cash on hand increased as a result of Medicare Advance Payments and the collection of a 2021 disproportionate share revenue (DSH) payment in 2020. Days in accounts receivable decreased by 1.4 days (2.4%) due to additional collections and additional valuation reserves. Average age of plant decreased by 0.7 years as a result of new construction.

Summary Financial Statements with Analysis

Management is providing the following summary financial statements and variance analysis for certain financial statement lines where it believes the readers understanding of the financial statements is enhanced.

(Dollars in Thousands)

Statements of Net Position

Net position is categorized as follows:

Net investment in capital assets: Consists of capital assets, net of accumulated depreciation and reduced by outstanding debt and deferred inflows and outflows of resources that are attributable to the acquisition, construction or improvement of those assets.

Restricted: Result when constraints placed on the use of the net position are either externally imposed by creditors, grantors, contributors, or imposed by law through constitutional provisions or enabling legislation.

Unrestricted: Represents the resources derived primarily from services rendered to patients and other operating revenues and not meeting the previously listed criteria. These resources are used for transactions related to the general healthcare and academic operations of the Corporation, and may be used at the discretion of the Board of Directors to meet current expenses for any purpose.

Condensed Statements of Net Position are as follows:

			2020-2019	
	2020	2019	$ Change	% Change
Assets				
Current assets, excluding assets whose use is limited	$ 296,792	$ 189,310	$ 107,482	56.8
Assets whose use is limited	194,391	277,229	(82,838)	(29.9)
Capital assets, net	334,157	319,358	14,799	4.6
Other assets	25,679	27,074	(1,395)	(5.2)
Total assets	851,019	812,971	38,048	4.7
Deferred outflows of resources	239,216	116,898	122,318	104.6
Total assets and deferred outflows	$ 1,090,235	$ 929,869	$ 160,366	17.2
Liabilities				
Current liabilities	$ 319,701	$ 276,812	$ 42,889	15.5
Noncurrent liabilities	882,754	703,699	179,055	25.4
Total liabilities	1,202,455	980,511	221,944	22.6
Deferred inflows of resources	101,575	98,402	3,173	3.2
Net Position				
Net investment in capital assets	106,297	112,081	(5,784)	(5.2)
Restricted	91,986	142,045	(50,059)	(35.2)
Unrestricted	(412,078)	(403,170)	(8,908)	2.2
Total net position	(213,795)	(149,044)	(64,751)	43.4
Total liabilities, deferred inflows and net position	$ 1,090,235	$ 929,869	$ 160,366	17.2

Statements of Net Position (Continued)

Overall, total assets and deferred outflows of resources increased $160,366 from 2019 to 2020.

The following variances in total assets are noteworthy:

Total current assets, excluding the current portion of assets whose use is limited, increased by $107,482 due to the following:

- Cash, cash equivalents and investments increased by $112,805 due to the receipt of current and future years DSH payments and receipt of Medicare Advance Payments.
- Patient accounts receivable, net, decreased by $7,856 as a result of current year decrease in net patient service revenue.
- Other receivables, decreased by $1,292 which is due to a $1,042 decrease in Medicaid DSH and UPL program receivables, $4,384 decrease in the CREPS Program grant receivable, $551 decrease in receivables from joint ventures and a $249 decrease in health insurance rebates. In addition, there was an increase of $4,641 in due from third party payors and a $293 increase in other receivables.

- Assets whose use is limited, including current portion, decreased by a net of $82,838, which is due to a decrease of $50,122 of DSRIP grant funds due to grant expenditures, a $28,425 decrease from the use of proceeds from the 2017 financing for various construction and renovation projects and a $4,916 reduction in required collateral held for workers compensation claims offset by a $625 increase in increased reserve account funding for actuarial liabilities and other limited use assets.
- Capital assets, net, increased by $14,799 due to investments in new capital assets being greater than depreciation expense. Significant investments in capital assets are summarized in a following section.

Overall, total liabilities and deferred inflows increased $225,117 and net position decreased $64,751 from 2019.

The following variances in total liabilities are noteworthy:

Total current liabilities increased by $42,889 due to the following:

- Accounts payable and accrued salaries and benefits decreased by $38,986, $60,920 of which is due to a decrease in liabilities related to the DSRIP grant program. In addition, $10,926 of social security taxes were deferred under the CARES Act program resulting in an increase partially offsetting the aforementioned DSRIP decline. The remainder is due to timing of payments to vendors and employees.
- Accrued other liabilities decreased by $6,813 largely as a result of payments of amounts due to Erie County.
- Unearned revenue increased by $69,094, $12,565 due to receipt of DSRIP grant funds exceeding DSRIP grant expenses during the year and receipt of a payment for 2021 DSH funds during 2020 in the amount of $56,529.
- Receipt of Medicare Advance payments resulted in $15,275 recognized as a current liability and $23,826 as a long-term liability based upon payment terms in the CARES Act.

- An increase in the net pension liability was recognized during 2020 in the amount of $167,957 due to changes in actuarial assumptions and investment performance of the New York State and Local Retirement System (NYSLRS) further described in Note 10.
- The long-term portion of self-insured obligations increased by $5,588 due to changes in actuarial estimates for self-insured retentions for malpractice and workers' compensation claims greater than payments made on those claims. The current portion of these self-insured obligations decreased by $442.

(Dollars in Thousands)

Statements of Net Position (Continued)

- The liability for OPEB decreased by $14,962 primarily as a result of the favorable impact of experience changes in claim costs offset by a decrease in the discount rate as disclosed in Note 11.
- Net position decreased by $64,751 due to unfavorable financial performance partially offset by CARES Act provider relief funds and capital grants and contributions.

Statements of Revenues, Expenses, and Changes in Net Position

Condensed Statements of Revenues, Expenses and Changes in Net Position are as follows:

			2020-2019	
	2020	2019	$ Change	% Change
Net patient service revenue	$ 505,591	$ 543,370	$ (37,779)	(7.0)
Disproportionate share revenue (DSH)	79,510	89,802	(10,292)	(11.5)
DSRIP grants	32,246	80,880	(48,634)	(60.1)
Other operating revenue	20,662	36,799	(16,137)	(43.9)
Total operating revenues	638,009	750,851	(112,842)	(15.0)
Operating expenses:				
Payroll and employee benefits	386,561	360,730	(25,831)	(7.2)
Professional fees	96,360	92,777	(3,583)	(3.9)
Purchased services	68,854	69,434	580	0.8
Supplies	97,872	97,065	(807)	(0.8)
Other operating expenses	32,268	25,155	(7,113)	(28.3)
DSRIP grant expenses	24,840	64,319	39,479	61.4
Depreciation and amortization	32,283	28,659	(3,624)	(12.6)
Total operating expenses	739,038	738,139	(899)	(0.1)
Operating (loss) income before pension amortization component	(101,029)	12,712	(113,741)	(894.8)
Pension expense, amortization component	36,875	5,263	31,612	100.0
Operating (loss) income	(137,904)	7,449	(145,353)	(1,951.3)
Non-operating expenses:				
Investment gain	6,854	5,895	959	(16.3)
CARES Act Provider Relief Funds	62,807	-	62,807	100.0
Interest expense	(11,037)	(7,135)	(3,902)	54.7
(Loss) income before capital grants and contributions	(79,280)	6,209	(85,489)	1,376.9
Capital grants	9,269	-	9,269	100.0
Capital contributions	5,260	6,739	(1,479)	(21.9)
Total change in net position	(64,751)	12,948	(77,699)	(600.1)
Net position – beginning of year	(149,044)	(161,992)	12,948	8.0
Net position - end of year	$ (213,795)	$ (149,044)	$ (64,751)	(43.4)

Statements of Revenues, Expenses, and Changes in Net Position (Continued)

Overall, operating revenues decreased by $112,842 or 15.0% in 2020 with decreases attributable to the following:

- Net patient service revenue decreased $37,779, or 7.0%, in 2020. Volumes decreased across multiple lines of business due to the impact of New York State imposed restrictions resulting from the coronavirus pandemic as further described in the section entitled "Operations Analysis".
- DSH decreased by $10,292, or 11.5%, in 2020 as a result of a decrease in the nursing home upper payment limit of $3,845 and a $6,447 decrease in federal DSH due to changes in calculations of prior year estimates.
- DSRIP grant revenue decreased by $48,634 or 60.1% primarily due to a decrease of $22,382 in high performance fund program receipts, a decrease in program awards, and timing of payments made under the program. Total DSRIP revenue earned by the corporation related to the program decreased $9,155 of which $10,520 relates to the decrease in high performance fund program awards offset by increases in other grant related program awards mainly due to the coronavirus response activities.
- Other operating revenue decreased by $16,137, or 43.9%, in 2020, principally as the result of the expiration of the CREPs grant revenue program on March 31, 2020 resulting in a decrease of $16,882 in CREPs grant revenue offset by an increase of $745 in other operations revenue.

Operating expenses including the pension expense increased $32,511 or 4.4%, in 2020. Expense changes are attributable to the following:

- Payroll and employee benefit expenses have increased by $25,831 or 7.2% as the net result of increases in staffing costs related to premium pay for employees related to treating patient during the coronavirus pandemic, increased staffing levels to implement regulations related to the coronavirus pandemic and related costs and increases for workers compensation and health insurance costs offset by decreases in actuarial determined expense for retiree health insurance as previously noted. Salaries and employee benefit expense increased by 16.4% of net patient service revenue, from 67.4% in 2019 to 76.5% of net patient service revenue in 2020.
- Pension expense increased by $39,917 or 117.6% as a result of unfavorable differences between projected and actual investment earnings on pension plan investments largely due to the plan valuation date of of March 31, 2020 and the impact of the coronavirus on the financial markets at that time and differences between expected and actual experience.
- Purchased services expense decreased by $580 or 0.8% as a result of minimal changes related to operations as the focus was on responding to the coronavirus in 2020.
- Supply expenses as a percentage of net patient service revenue increased from 17.9% in 2019 to 19.4% in 2020 mostly attributed to purchases of personal protective equipment for employees despite significant decreases in patient volumes and patient service revenue.
- DSRIP grant expenses decreased by $39,479 or 61.4% as a result of the participation high performance fund program awards, timing of award payments and the wind down of the program which ended March 31, 2020.

Statements of Revenues, Expenses, and Changes in Net Position (Continued)

Capital Assets, Net

At December 31, 2020, the Corporation had capital assets, net of accumulated depreciation, of $334,157 compared to $319,358 at December 31, 2019, representing an increase of $14,799 or 4.6%.

During 2020, the Corporation invested $47,667 in various capital projects. Noteworthy investments include: additional investments in the development of a new Level 1 Adult Trauma Center and Emergency Department, including its enabling projects ($12,399) and the main lobby project ($3,111). Construction of these projects began in 2017 and were completed in 2020. In addition, the Corporation continued investment into various mechanical, electrical, plumbing and building envelope improvements ($16,980), and continued implementing a new ambulatory electronic medical records system ($5,124) along with various other facility infrastructure projects. Other additions to capital assets included other medical and non-medical equipment, software and furniture and fixtures.

Forward Looking Factors

Management has prepared the following forward looking factors to assist the reader in understanding the financial, economic and market factors impacting the Corporation.

Collective Bargaining Agreements

The Corporation operates under three collective bargaining agreements that cover substantially all employees. Corporation employees of the Civil Service Employee Association (CSEA) are covered by a contract negotiated in concert with Erie County, New York, which contains a sub-bargaining unit representing only Corporation employees. The agreement began in 2018 and runs through December 31, 2022. Registered Nurses (RNs) are covered under an agreement with the New York State Nurses Association (NYSNA). This agreement expired on December 31, 2018 and a new agreement was negotiated during 2019, which is in effect through December 31, 2022. The Corporation's agreement with the American Federation of State, County and Municipal Employees (AFSCME), a contract negotiated in concert with the County of Erie, New York, and ratified with AFSCME employees in 2017 runs through December 31, 2022.

Transactions with the County of Erie

The Corporation is a component unit of the County of Erie, New York. The County has ongoing contractual and legal obligations to the Corporation and the Corporation has ongoing contractual and legal obligations to the County.

Delivery System Reform Incentive Payment (DSRIP)

On April 14, 2014, Gov. Andrew M. Cuomo announced that New York finalized terms and conditions of an agreement with the U.S. government that will allow New York State to reinvest $8 billion in federal savings generated by Medicaid Redesign Team reforms. This program is known as the Delivery System Reform Incentive Payment (DSRIP) Program.

The Corporation was selected as one of the lead entities and has worked with others to form a Performing Provider System (PPS) to achieve the goals established in the waiver. As a result, the Corporation and the PPS have been awarded a five (5) year grant which began April 1, 2015. Certain revenues and expenses associated with this effort, and the related receivables and payables, have been recognized in the financial statements. This grant period ended on March 31, 2020 and has not been extended beyond this date.

Care Restructuring Enhancement Pilot (CREPS) Program Grant

The Corporation was awarded a grant under the CREPS Program administered by the New York State Department of Health. The total award amount is approximately $97,260 over the period April 1, 2016 to March 31, 2020 in state fiscal year annual distribution amounts of $43,930, $30,010, $13,320, and $10,000, respectively. The Corporation is responsible for achieving certain goals of the CREPS Program in each year in order to qualify for the funding. The Corporation believes it has achieved all of the goals for years 1 through 4 of the program and has recognized related revenue in the amount of $5,618 and $22,500, in the 2020 and 2019 financial statements, respectively. This grant period ended on March 31, 2020 and has not been extended beyond this date.

Medicare and Medicaid Reimbursement

The future state of both reimbursement levels and reimbursement methods related to the Medicare and Medicaid programs remains uncertain. Budget proposals related to both of these programs for the upcoming year and beyond may significantly alter reimbursements or methodologies, thus changing the environment in which we conduct business as the Corporation relies heavily on these programs for reimbursement for services. The impact of these state and federal budget proposals are unknown at this time but could materially impact the Corporation.

Contacting the Corporation's Financial Management

This financial report is designed to provide our community and creditors with a general overview of Erie County Medical Center Corporation's finances and to demonstrate the Corporation's accountability for the resources it receives. If you have any questions about this report or need additional financial information, contact the Chief Financial Officer, Erie County Medical Center Corporation, 462 Grider Street, Buffalo, New York 14215.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Statements of Net Position
December 31, 2020 and 2019
(Dollars in Thousands)

	2020	2019
Assets and Deferred Outflows		
Current assets:		
Cash and cash equivalents	**$ 120,308**	$ 13,771
Investments	**16,393**	10,125
Assets whose use is limited	**117,163**	195,804
Patient accounts receivable, net	**78,716**	86,572
Other receivables	**63,393**	64,685
Supplies, prepaids and other	**17,982**	14,157
Total current assets	**413,955**	385,114
Assets whose use is limited	**77,228**	81,425
Capital assets, net	**334,157**	319,358
Other assets, net	**25,679**	27,074
	437,064	427,857
Total assets	**851,019**	812,971
Deferred outflows of resources:		
Pension	**167,313**	55,673
Other post employment benefits	**56,939**	44,691
Other	**14,964**	16,534
Total deferred outflows of resources	**239,216**	116,898
Total assets and deferred outflows of resources	**$ 1,090,235**	$ 929,869
Liabilities, Deferred Inflows and Net Position		
Current liabilities:		
Current portion of long-term debt	**$ 11,955**	$ 11,090
Current portion of Medicare Advance Payment Program	**15,275**	-
Accounts payable	**49,508**	102,856
Accrued salaries, wages and employee benefits	**38,410**	24,048
Net pension liability	**34,754**	30,167
Other post employment benefits	**12,076**	12,903
Accrued other liabilities	**28,903**	35,716
Unearned revenue	**127,708**	58,614
Estimated third-party payor settlements	**1,112**	1,418
Total current liabilities	**319,701**	276,812
Long-term debt, net	**237,089**	236,779
Medicare Advance Payment Program, net of current portion	**23,826**	-
Net pension liability, net of current portion	**190,443**	27,073
Self-insured obligations	**41,652**	36,064
Other post employment benefits, net of current portion	**385,845**	399,980
Other	**3,899**	3,803
Total liabilities	**1,202,455**	980,511
Deferred inflows of resources:		
Pension	**14,403**	28,011
Other post employment benefits	**87,172**	70,391
Total deferred inflows of resources	**101,575**	98,402
Net Position:		
Net investment in capital assets	**106,297**	112,081
Restricted:		
Nonexpendable	**-**	-
Expendable	**91,986**	142,045
Unrestricted	**(412,078)**	(403,170)
Total net position	**(213,795)**	(149,044)
Total liabilities, deferred inflows and net position	**$ 1,090,235**	$ 929,869

See notes to the financial statements.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Statements of Revenues, Expenses and Changes in Net Position
Years Ended December 31, 2020 and 2019
(Dollars in Thousands)

	2020	2019
Operating revenues:		
Net patient service revenue, net of provision for bad debts of $33,605 and $19,591 for 2020 and 2019, respectively	**$ 505,591**	$ 543,370
Disproportionate share revenue (DSH)	**79,510**	89,802
DSRIP grants	**32,246**	80,880
Other operating revenue	**20,662**	36,799
Total operating revenues	**638,009**	750,851
Operating expenses:		
Payroll and employee benefits	**386,561**	360,730
Professional fees	**96,360**	92,777
Purchased services	**68,854**	69,434
Supplies	**97,872**	97,065
Other operating expenses	**32,268**	25,155
DSRIP grant expenses	**24,840**	64,319
Depreciation and amortization	**32,283**	28,659
Total operating expenses	**739,038**	738,139
Operating (loss) income before pension expense amortization component	**(101,029)**	12,712
Pension expense, amortization component	**36,875**	5,263
Operating (loss) income	**(137,904)**	7,449
Non-operating revenues (expenses):		
Investment gain	**6,854**	5,895
CARES Act Provider Relief Funds	**62,807**	-
Interest expense	**(11,037)**	(7,135)
Total non-operating expenses	**58,624**	(1,240)
(Loss) income before capital grants and capital contributions	**(79,280)**	6,209
Capital grants	**9,269**	-
Capital contributions	**5,260**	6,739
Total change in net position	**(64,751)**	12,948
Net position – beginning of year	**(149,044)**	(161,992)
Net position – end of year	**$ (213,795)**	$ (149,044)

See notes to the financial statements.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Statements of Cash Flows
Years Ended December 31, 2020 and 2019
(Dollars in Thousands)

	2020	2019
Cash flows from operating activities:		
Receipts from patients and third party payors	**$ 514,433**	$ 533,230
Receipts from Medicare Advance Payment Program	**39,101**	-
Payments to employees for salaries and benefits	**(368,809)**	(356,538)
Payments to vendors for supplies and other	**(370,053)**	(308,875)
Other receipts	**201,512**	210,968
Net cash provided by operating activities	**16,184**	78,785
Cash flows from capital and related financing activities:		
Purchases of capital assets	**(60,545)**	(83,681)
Borrowings on long-term debt	**2,555**	1,805
Payments on long term debt	**(11,380)**	(11,261)
Proceeds from the Paycheck Protection Program	**10,000**	-
Interest paid on long term debt	**(11,037)**	(7,135)
Grants for capital purposes	**9,269**	-
Net cash used in capital and related financing activities	**(61,138)**	(100,272)
Cash flows from noncapital financing activities:		
CARES Act Provider Relief Funds	**62,807**	-
Cash flows from investing activities:		
Sales (purchases) of assets whose use is limited, net	**82,838**	(19,127)
Investment gain	**6,854**	5,895
(Purchases) sales of investments, net	**(6,268)**	22,675
Capital contributions	**5,260**	6,739
Net cash provided by investing activities	**88,684**	16,182
Net change in cash and cash equivalents	**106,537**	(5,305)
Cash and cash equivalents:		
Beginning	**13,771**	19,076
Ending	**$ 120,308**	$ 13,771

Noncash capital and related financing activities:
Included in accounts payable at December 31, 2020 and 2019 was $6,128 and $19,591, respectively, of invoices related to capital asset acquisitions.

(Continued)

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Statements of Cash Flows (Continued)
Years Ended December 31, 2020 and 2019
(Dollars in Thousands)

	2020	2019
Reconciliation of operating (loss) income to net cash provided by operating activities:		
Operating (loss) income	**$ (137,904)**	$ 7,449
Adjustments to reconcile operating (loss) income to net cash provided by operating activities:		
Depreciation and amortization	**32,283**	28,659
Provision for bad debts	**33,605**	19,591
Changes in assets, deferred outflows, liabilities and deferred inflows:		
Patient accounts receivable	**(25,749)**	(16,876)
Medicare Advance Payment Program	**39,101**	-
Other receivables	**1,292**	2,637
Supplies, prepaids and other	**(2,430)**	(2,612)
Deferred outflows of resources	**(122,318)**	(9,818)
Accounts payable	**(39,885)**	43,354
Accrued liabilities	**7,645**	1,620
Unearned revenue	**69,094**	3,487
Estimated third-party payor settlements	**(306)**	(5,674)
Self-insured obligations	**5,588**	(6,589)
Net pension liability	**167,957**	32,563
OPEB	**(14,962)**	22,829
Deferred inflows of resources	**3,173**	(41,835)
Net cash provided by operating activities	**$ 16,184**	$ 78,785

See notes to the financial statements.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Statements of Net Position - Discretely Presented Component Units
December 31, 2020 and 2019
(Dollars in Thousands)

	2020				2019			
	ECMC Foundation, Inc.	**The Grider Initiative, Inc.**	**Research for Health in Erie County, Inc.**	**Total**	ECMC Foundation, Inc.	The Grider Initiative, Inc.	Research for Health in Erie County, Inc.	Total
Assets								
Current assets:								
Cash and cash equivalents	**$ 1,789**	**$ 272**	**$ 14**	**$ 2,075**	$ 1,522	$ 273	$ 4	$ 1,799
Investments	**-**	**-**	**1,073**	**1,073**	-	-	1,020	1,020
Other receivables	**2,403**	**-**	**-**	**2,403**	2,966	-	-	2,966
Supplies, prepaids and other	**15**	**-**	**-**	**15**	65	-	-	65
Total current assets	**4,207**	**272**	**1,087**	**5,566**	4,553	273	1,024	5,850
Other receivables	**2,364**	**-**	**-**	**2,364**	2,489	-	-	2,489
Endowment and other investments	**3,815**	**9,943**	**-**	**13,758**	6,080	10,407	-	16,487
Equipment and vehicles, net	**6**	**-**	**-**	**6**	50	-	-	50
	6,185	**9,943**	**-**	**16,128**	8,619	10,407	-	19,026
Total assets	**$ 10,392**	**$ 10,215**	**$ 1,087**	**$ 21,694**	$ 13,172	$ 10,680	$ 1,024	$ 24,876
Liabilities and Net Position								
Current liabilities:								
Accounts payable	**$ 584**	**$ -**	**$ -**	**$ 584**	$ 392	$ -	$ -	$ 392
Funds held in custody for others	**636**	**-**	**-**	**636**	640	-	-	640
Total current liabilities	**1,220**	**-**	**-**	**1,220**	1,032	-	-	1,032
Related party	**6,219**	**-**	**-**	**6,219**	5,431	550	-	5,981
Total liabilities	**7,439**	**-**	**-**	**7,439**	6,463	550	-	7,013
Net Position								
Restricted:								
Nonexpendable	**50**	**10,000**	**-**	**10,050**	50	10,000	-	10,050
Expendable	**511**	**215**	**-**	**726**	4,400	130	-	4,530
Unrestricted	**2,392**	**-**	**1,087**	**3,479**	2,259	-	1,024	3,283
Total net position	**2,953**	**10,215**	**1,087**	**14,255**	6,709	10,130	1,024	17,863
Total liabilities and net position	**$ 10,392**	**$ 10,215**	**$ 1,087**	**$ 21,694**	$ 13,172	$ 10,680	$ 1,024	$ 24,876

See notes to the financial statements.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Statements of Revenues, Expenses and Changes in Net Position - Discretely Presented Component Units
Years Ended December 31, 2020 and 2019
(Dollars in Thousands)

	2020				2019			
	ECMC Foundation, Inc.	**The Grider Initiative, Inc.**	**Research for Health in Erie County, Inc.**	**Total**	ECMC Foundation, Inc.	The Grider Initiative, Inc.	Research for Health in Erie County, Inc.	Total
Operating revenues:								
Grants, contributions and special events	**$ 5,000**	**$ -**	**$ -**	**$ 5,000**	$ 6,661	$ -	$ -	$ 6,661
Total operating revenues	**5,000**	**-**	**-**	**5,000**	6,661	-	-	6,661
Operating expenses:								
Program services and grants	**7,968**	**-**	**18**	**7,986**	8,569	-	21	8,590
Fundraising	**564**	**-**	**-**	**564**	1,502	-	-	1,502
Other operating expenses	**224**	**1**	**2**	**227**	196	1,079	1	1,276
Total operating expenses	**8,756**	**1**	**20**	**8,777**	10,267	1,079	22	11,368
Operating income (loss)	**(3,756)**	**(1)**	**(20)**	**(3,777)**	(3,606)	(1,079)	(22)	(4,707)
Non-operating revenue:								
Investment income (loss)	**-**	**86**	**83**	**169**	(187)	268	44	125
Change in net position	**(3,756)**	**85**	**63**	**(3,608)**	(3,793)	(811)	22	(4,582)
Net position – beginning of year	**6,709**	**10,130**	**1,024**	**17,863**	10,502	10,941	1,002	22,445
Net position – end of year	**$ 2,953**	**$ 10,215**	**$ 1,087**	**$ 14,255**	$ 6,709	$ 10,130	$ 1,024	$ 17,863

See notes to the financial statements.

Note 1. Organization

The Corporation: Erie County Medical Center Corporation (referred to as the "Corporation" or "ECMCC") is a public benefit corporation created by the Erie County Medical Center Corporation Act, Chapter 143 of the Laws of New York State, 2003 (Title 6 of Article 10-C of the Public Authorities Law) (the "Act") as amended in 2016. The Corporation was created under the Act to secure a form of governance which permits the Corporation to have the legal, financial, and managerial flexibility to operate its health care facilities for the benefit of the residents of New York State (the "State"), the County of Erie (the "County"), and Western New York, including persons in need who lack the ability to pay.

The Corporation's "Health Care Facilities" consist of the Medical Center, a 573 bed acute tertiary care facility providing inpatient, emergency, outpatient, primary care and specialty clinic services (Medical Center), a 390-bed residential health care facility (Terrace View) both located on Grider Street in the City of Buffalo and three chemical dependency and alcohol rehabilitation clinics located throughout the County. The Corporation serves as the region's only Level 1 Adult Trauma Center, burn center, comprehensive traumatic brain injury and spinal cord injury rehabilitative center, Comprehensive Psychiatric Emergency Program provider for acute psychiatric emergencies, Regional Center of Excellence for Transplantation and Kidney Care, and is the primary provider of HIV inpatient and outpatient specialty care.

The Corporation has the power under the Act to acquire, operate, and manage its facilities and to issue bonds and notes to finance the costs of providing such facilities. The Act specifically provides that the Corporation's existence shall continue until terminated by law; provided, however, that no such termination shall take effect so long as the Corporation shall have bonds or other obligations outstanding unless adequate provision has been made for the payment or satisfaction thereof. The Corporation's primary purpose is the operation of the Medical Center and Terrace View, and its powers, duties, and functions are as set forth in the Act, as amended, and other applicable laws.

The Corporation qualifies as a governmental entity and, accordingly, is exempt from federal income tax pursuant to Section 115 of the Internal Revenue Code of 1986.

In accordance with Governmental Accounting Standards Board (GASB) Statement No. 14, *The Financial Reporting Entity*, as amended, the Corporation's financial statements are included, as a discretely presented component unit, in the County's Comprehensive Annual Financial Report (CAFR). A copy of the CAFR can be obtained from the Erie County Comptroller's Office, 95 Franklin Street, Room 1100, Buffalo, New York, 14202. The Corporation is subject to New York civil service law.

Governance: The Corporation is governed by its Board of Directors (the "Board") consisting of fifteen (15) voting directors, eight (8) of whom are appointed by the Governor of the State of New York and seven (7) of whom are appointed by the Erie County Executive with the advice and consent of the Erie County Legislature. There are four non-voting representatives, as well. The directors and non-voting members serve staggered terms and continue to hold office until their successors are appointed. Directors have experience in the fields of health care services, quality and patient safety, human resources, strategic growth, law, and financial management and reflect a broad representation of the community served by the Corporation. Regular meetings of the Board are scheduled eleven (11) times per year. Board leaders are appointed by the Board.

Note 1. Organization (Continued)

Great Lakes Heath System: The Corporation is a member of Great Lakes Health System of Western New York (Great Lakes). Great Lakes is a not-for-profit, community-based corporation comprised of unified partners whose objective is to provide the highest quality of healthcare to the residents of Western New York. Great Lakes is comprised of the Corporation, Kaleida Health, The Center for Hospice and Palliative Care and the State University of New York at Buffalo (the "University").

Great Lakes Health Integrated Network: The Corporation, together with Kaleida Health has formed Great Lakes Health Integrated Network (GLIN) with each maintaining a 50% ownership interest. As of December 31, 2020 and 2019 capital contributions due to GLIN totaled $1,738 and $1,250, respectively. Contributions are used to pay for care coordination services, information systems infrastructure, a physician incentive program, and routine operating expenses.

Medical School Collaboration: The Corporation serves as a primary teaching hospital for the Jacobs School of Medicine and Biomedical Sciences of the State University of New York at Buffalo (the "Medical School"). An agreement governs the relationship between the Corporation and the Medical School. The Corporation serves as an integral part of the education and research mission of the Medical School by providing the clinical settings for the Medical School's public mission to educate and train physicians, nurses and other healthcare professionals, conduct clinical research programs and deliver healthcare services to patients. There are currently 183 full-time equivalent medical residents assigned to the Corporation in various Academic College of Graduate Medical Education accredited residency programs.

Component Units: Accounting principles generally accepted in the United States of America (U.S. GAAP) require the inclusion within the Corporation's financial statements of certain organizations as component units. The component units discussed below are included because the nature and significance of their relationship to the Corporation are such that exclusion would cause the reporting entity's financial statements to be misleading or incomplete under criteria set forth by the Governmental Accounting Standards Board (GASB).

The component unit information in the accompanying basic financial statements includes the financial data of the Corporation's three discretely presented component units. These component units are discussed in more detail below:

ECMC Foundation, Inc.: The ECMC Foundation, Inc. (the "Foundation"), formerly the ECMC Lifeline Foundation, Inc., is a not-for-profit organization exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). The Foundation was formed for the purpose of supporting Corporation programs. The financial statements of the Foundation have been prepared on an accrual basis. The annual financial report can be obtained by writing to: Executive Director, ECMC Foundation, Inc., 462 Grider Street, Buffalo, NY 14215.

The Grider Initiative, Inc.: The Grider Initiative, Inc. (the "Physician Endowment") is a not-for-profit organization exempt from federal income taxes under Section 501(c)(3) of the IRC. The Physician Endowment was funded in 2010, for the purpose of recruiting physicians who shall practice on the Grider Street campus of the Corporation. The entity was funded with an initial transfer of $10,000 from the Corporation. Earnings from the investment of the initial transfer may be used only for physician recruitment and retention and necessary expenses of the entity. The financial statements of The Grider Initiative, Inc. have been prepared on an accrual basis. The annual financial report can be obtained by writing to: Chair, The Grider Initiative, Inc. 462 Grider Street, Buffalo, NY 14215.

Note 1. Organization (Continued)

Research for Health in Erie County, Inc.: Research for Health in Erie County, Inc. (RHEC) is a not-for-profit organization dedicated to support research activities relating to the causes, nature, and treatment of diseases, disorders, and defects of particular importance to the public health in areas served by the Corporation. RHEC is exempt from income tax as a not-for-profit corporation under Section 501(c)(3) of the IRC and is incorporated under the laws of the State of New York. The entity has not received external funding in recent years and its revenue comes primarily from investment income. The annual financial report can be obtained by writing to: Grant Administration, Research for Health in Erie County, Inc., 462 Grider Street, Buffalo, NY 14215.

In addition, the financial statements of the Corporation include the operations of the following component units, which are blended with the accounts of the Corporation:

PPC Strategic Services LLC (PPC): The Corporation is the sole owner of this enterprise, which was established to enable the Corporation to enter into various other business relationships. The entity was formed as a management support organization (MSO) to provide various support services to the Corporation and Preferred Physician Care, P.C. These services include providing employees, management and administrative services, and facilities management.

Grider Support Services, LLC: The Corporation is the sole owner of this enterprise, which was formed to act as an MSO for oncology and physician services.

Grider Community Gardens, LLC: This entity is wholly-owned and controlled by the Corporation and was formed for the purpose of purchasing and holding properties in proximity to the Corporation's Grider Street Campus.

1827 Fillmore, LLC: This entity is controlled by the Corporation and was formed for the purchase and development of property immediately adjacent to the Corporation's Grider Street campus.

Note 2. Summary of Significant Accounting Policies

Basis of accounting: The Corporation uses the accrual basis of accounting. Revenue is recognized in the period it is earned and expenses are recognized in the period incurred. Under this basis of accounting, all assets, deferred outflows of resources, liabilities and deferred inflows of resources associated with the operation of the Corporation are included in the statements of net position.

For financial accounting and reporting purposes, the Corporation follows all pronouncements of the GASB. All references to relevant authoritative literature issued by the GASB with which the Corporation must comply are hereinafter referred to generally as "U.S. GAAP." The discretely presented component units, as previously described, report under Financial Accounting Standards Board (FASB) standards. As such, certain revenue recognition criteria and presentation features are different from GASB revenue recognition criteria and presentation features.

Use of estimates: The preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts in the financial statements and accompanying notes. The reserve for uncollectible accounts, contractual allowances, amounts payable to third-party payors, workers compensation reserves, malpractice reserves, pension obligations, other post-employment benefits, self-insured obligations, as well as Disproportionate Share (DSH) revenue and certain other accounts, require the significant use of estimates. Actual results could differ from those estimates.

Note 2. Summary of Significant Accounting Policies (Continued)

Included in net patient service revenue are adjustments to prior year estimated third-party payor settlements, and their related estimated receivables and payables that were originally recorded in the period the related services were rendered, as well as adjustments to the net realization rate for collections on patient accounts receivable. These adjustments are made in the normal course of operations and amounts reported are consistent with the approach in prior years. The adjustments to prior year estimates and other third-party reimbursement or recoveries that relate to prior years also impact Disproportionate Share revenues as discussed in Note 5. The combined effect of changes related to prior years' estimates resulted in a decrease of $3,009 and $6,457 in total operating revenues for the years ended December 31, 2020 and 2019, respectively.

Cash and cash equivalents: The Corporation's cash and cash equivalents include cash on hand and cash in checking and money market accounts as well as investments with a maturity of three months or less when purchased. Cash and cash equivalents designated for long-term purposes or received with donor-imposed restrictions limiting their use to long-term purposes are not considered cash and cash equivalents for purposes of the statements of cash flows. Monies deposited in Federal Deposit Insurance Corporation (FDIC) insured commercial banks are collateralized with specifically designated securities held by a pledging financial institution, as required by State regulations.

Patient accounts receivable: Patient accounts receivable are reported net of both an estimated allowance for contractual adjustments and an estimated allowance for uncollectible accounts. The contractual adjustments represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid and other third party payor programs. Current operations are charged with an estimated provision for bad debts estimated based on the age of the account, prior experience and any other circumstances which affect collectability. The Corporation's policy does not require collateral or other security for patient accounts receivable and the Corporation routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies. The allowance for estimated doubtful accounts at December 31, 2020 and 2019 was approximately $56,831 and $43,700, respectively.

Investments and assets whose use is limited: The Corporation generally records its investments at fair value. Such assets are comprised of cash and cash equivalents, including money market funds, fixed income securities, commercial paper and equity funds. Assets classified as investments are unrestricted. Assets classified as limited as to use are restricted under Board designation or terms of agreements with third parties and include debt service funds, funds for self-insured workers compensation costs and medical malpractice costs, collateral for insured workers compensation programs, patient and resident monies, funding for future retiree health costs, and funds limited as to use for the acquisition of property, plant and equipment.

Investment securities are exposed to various risks, such as interest rate, market and credit risk. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the fair value of investment securities, it is at least possible that changes in risks in the near term could materially affect the net position of ECMCC.

(Dollars in Thousands)

Note 2. Summary of Significant Accounting Policies (Continued)

Other receivables: The composition of other receivables, as of December 31, is as follows:

	2020	2019
Medicaid Disproportionate Share (DSH) and Upper Payment Limit (UPL) (Note 5)	$ 41,797	$ 42,839
Due from affiliated organizations and joint ventures	1,733	2,284
Due from third party payors	15,896	11,255
Care Restructuring Enhancement Pilot (CREPS) Program Grant (Note 13)	-	4,384
Health insurance rebates	1,008	1,257
Other	2,959	2,666
	$ 63,393	$ 64,685

Capital assets: Capital assets are stated at cost. Depreciation is computed under the straight-line method over the estimated useful life of the asset. Estimated useful lives of assets have been established as follows:

Land and land improvements	5 – 25 years
Buildings and improvements	10 – 40 years
Fixed equipment	10 – 20 years
Movable equipment	3 – 20 years

When assets are retired, or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts, and any resulting gain or loss is reflected for the period. Amortization of capital leases is computed using the straight-line method over the lease term or the estimated useful life of the asset, whichever is shorter. Maintenance and repairs are charged to expense as incurred with significant renewals and betterments being capitalized. Effective January 1, 2020, the Corporation adopted GASB Statement No. 89, *Accounting for Interest Cost Incurred before the End of a Construction Period*. Adoption of GASB Statement No. 89 resulted in $1,694 of interest that otherwise could have been capitalized and was charged to interest expense during the period. Prior to January 1, 2020, during periods of construction, the Corporation capitalized interest incurred with borrowings for construction. Capitalized interest was $11,309 for the year ended December 31, 2019.

Capital assets that are donated (without restriction) are recorded at their fair market values as a direct increase to the component of net investment in capital assets.

Deferred outflows of resources: Deferred outflows of resources represent a consumption of net position that applies to a future period(s) and therefore will not be recognized as an outflow of resources (expense) until that time. Deferred outflows of resources consist primarily of unrecognized items not yet charged to pension expense and retiree health expense related to the net pension liability and post-employment benefit obligations, and items related to the 2017 financing transaction as described below.

The 2017 financing transaction included the payment of points, in the amount of $17,040 to Erie County associated with the differential in interest rate on the 2017 financing using the credit rating of Erie County and the rate that the Corporation was projected to pay independent of a relationship with Erie County. The points are being amortized on the interest method over the term of the 2017 financing. The unamortized amount of points at December 31, 2020 and 2019 is $12,260 and $13,557, respectively. The 2017 financing transaction also included the advance refunding of the 2011 financing, the proceeds of which were used to finance the construction of the Terrace View Nursing Home on the Corporation's campus. The deposit required to the advance refunding escrow was greater than the balance outstanding on the 2011 financing in the amount of $2,038 and is being amortized on the interest method over the life of the advance refunding component of the transaction. The unamortized portion of this advance refunding at December 31, 2020 and 2019 is $1,240 and $1,464, respectively.

Note 2. Summary of Significant Accounting Policies (Continued)

Deferred inflows of resources: Deferred inflows of resources represent an acquisition of net position that applies to a future period(s) and therefore will not be recognized as an inflow of resources (revenue) until that time. Deferred inflows of resources consist primarily of the unamortized portion of certain items related to the Corporation's pension and other post-employment benefits.

Other assets: Amounts due from the County, as noted in Note 15 as well as ownership interests in various business enterprises are included in other assets.

Collaborative Care Ventures, LLC (Collaborative Care) was formed in 2014 by ECMCC and Kaleida Health System (KHS). Collaborative Care was created as a vehicle for ECMCC and KHS to participate in various investments in the future consistent with their missions. At December 31, 2020 and 2019, the Corporation's share of the net assets of Collaborative Care amounted to $918 and $694, respectively.

Great Lakes Integrated Network (GLIN) was formed in 2018 by ECMCC and Kaleida Health System. GLIN was formed to support, manage and negotiate value based contracts and/or risk based contracts with third party payors for the purpose of managing population health and anticipated payment reform. GLIN is a development stage enterprise with the Corporation's share of contributed capital supporting organizational development. The Corporation's share of GLIN's profit or loss is recognized as a non-operating expense. At December 31, 2020 and 2019, the Corporation's share of the net assets of GLIN amounted to $589 and $(774), respectively.

Unearned revenue: Unearned revenue represents funds received by the Corporation for the DSRIP and CREPS Program for expenses not yet incurred.

Compensated absences: The Corporation has accrued liabilities for certain compensated absences earned by its employees, to include vacation, sick, and compensatory time. The Corporation's employees are permitted to accumulate unused vacation and sick leave time up to certain maximum limits. The Corporation accrues the estimated obligation related to vacation pay based on pay rates currently in effect. Sick leave credits, if accumulated above certain prescribed levels, may be the basis of a supplemental payment to employees upon retirement. The Corporation accrues an estimated liability for these estimated terminal payments. These amounts have been included in the statements of net position at December 31, 2020 and 2019, within the caption accrued salaries, wages and employee benefits in the amount of $14,757 and $13,580, respectively.

Net position: Net position is classified into three categories according to external donor restrictions or availability of assets for satisfaction of the Corporation's obligations. The Corporation's net position is described as follows:

Net investment in capital assets: This represents the Corporation's total investment in capital assets, net of accumulated depreciation and reduced by outstanding debt and deferred inflows and outflows of resources that are attributable to the acquisition, construction or improvement of those assets. To the extent debt has been incurred but not yet expended for capital assets, such amounts are not included as a component of net investment in capital assets.

Restricted: The restricted expendable component of net position consists of constraints placed on net position through external constraints imposed by creditors (such as through debt covenants), grantors, contributors, or laws or regulations of other governments or constraints imposed by law through constitutional provisions or enabling legislation. The restricted nonexpendable component of net position is permanently unavailable for use. The earnings on the nonexpendable net position are classified as restricted expendable.

Note 2. Summary of Significant Accounting Policies (Continued)

Unrestricted: This component of net position consists of net position that does not meet the definition of other components of net position described above. These resources are used for transactions relating to the general health care operations of the Corporation, and may be used at the discretion of the Board of Directors to meet current expenses for any purpose.

Net patient service revenue: Net patient service revenue is reported as services are rendered at estimated net realizable amounts, including estimated retroactive revenue adjustments under reimbursement agreements with third party payors. Estimated settlements under third party reimbursement agreements are accrued in the period the related services are rendered and adjusted in future periods as final settlements are determined. An estimated provision for bad debts is included in net patient service revenue.

Charity care: The Corporation provides care to patients who meet certain criteria under its charity care policy, without charge or at amounts less than established rates. Because the Corporation does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue in the accompanying statements of revenues, expenses, and changes in net position. The estimated costs of caring for charity care patients were $3,363 and $4,420 for the years ended December 31, 2020 and 2019, respectively. Additionally, the Corporation provided approximately $1,664 and $2,977 in discounts to self-pay patients for the years ended December 31, 2020 and 2019, respectively.

Contributions: The Foundation reports gifts of cash or promises to give as restricted contributions when they are received with donor stipulations that limit the use of the donated assets. When the intent of the donor is that the assets are to remain in perpetuity and the Foundation does not have the right to invade the original principal, the assets are reported as with donor restrictions. When a donor restriction expires, restricted - expendable net positions are released to unrestricted net position. The Foundation conducted a capital campaign to raise funds to support the construction of a new Level 1 Adult Trauma Center, Emergency Department and other capital needs in support of the mission of the Corporation. Receivables for pledges associated with this campaign are recorded net of a reserve for uncollectible pledges and are discounted to present value using a 0.36% discount rate, over the expected collection period of the pledges.

Classification of revenues: The Corporation has classified its revenues as either operating or non-operating revenues according to the following criteria:

Operating revenues: Operating revenues include activities that have the characteristics of exchange transactions, such as payments for providing services and payments for goods and services received, for health care services provided to patients, net of contractual adjustments and provisions for bad debts.

Non-operating revenues: Non-operating revenues include activities that have the characteristics of nonexchange transactions, such as gifts and contributions, CARES Act Provider Relief Funds, income from investments and contributions.

Income taxes: The Corporation is a Public Benefit Corporation of the State of New York and is exempt from federal income taxes under Section 115 of the Internal Revenue Code. Accordingly, no provision for income taxes has been made in the accompanying financial statements.

Note 2. Summary of Significant Accounting Policies (Continued)

Contributed services: RHEC receives contributions from the Corporation consisting primarily of donated space, equipment, and personnel support. During 2020 and 2019, the value of contributed services meeting the requirements for recognition in the financial statements was not material and has not been recorded.

Certain immaterial amounts related to contributed rents have been reflected in the Foundation's financial statements as contribution revenue. The Foundation generally pays for services requiring specific expertise. However, many individuals volunteer their time and perform a variety of tasks that assist the Foundation in meeting its goals and objectives. Such services are not recognized in the Foundation financial statements.

No amounts have been reflected in the Physician Endowment financial statements for contributed services, as the value of contributed services meeting the requirements for recognition in the financial statements was not material.

Recent and pending accounting pronouncements: Effective May 2020, the Corporation adopted GASB Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance.* The primary objective of this Statement was to provide temporary relief to governments and other stakeholders in light of the COVID-19 pandemic by postponing the effective dates of certain provisions in GASB Statements and Implementation Guides that first became effective or were scheduled to become effective for periods beginning after June 15, 2018, and later.

In June 2017, GASB issued Statement No. 87, *Leases*. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases. Under this Statement, a lessee is required to recognize a lease liability and a right to use asset as a single model for lease accounting based on the principle that leases are financing instruments. The requirements of this Statement for fiscal years beginning after June 15, 2021.

In May 2019, GASB issued Statement No. 91, *Conduit Debt Obligations*. The primary objectives of this Statement are to provide a single method of reporting conduit debt obligations by issuers and eliminate diversity in practice associated with (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures. This Statement achieves those objectives by clarifying the existing definition of a conduit debt obligation; establishing that a conduit debt obligation is not a liability of the issuer; establishing standards for accounting and financial reporting of additional commitments and voluntary commitments extended by issuers and arrangements associated with conduit debt obligations; and improving required note disclosures.

Note 2. Summary of Significant Accounting Policies (Continued)

This Statement also addresses arrangements—often characterized as leases—that are associated with conduit debt obligations. In those arrangements, capital assets are constructed or acquired with the proceeds of a conduit debt obligation and used by third-party obligors in the course of their activities. Payments from third-party obligors are intended to cover and coincide with debt service payments. During those arrangements, issuers retain the titles to the capital assets. Those titles may or may not pass to the obligors at the end of the arrangements.

This Statement requires issuers to disclose general information about their conduit debt obligations, organized by type of commitment, including the aggregate outstanding principal amount of the issuers' conduit debt obligations and a description of each type of commitment. Issuers that recognize liabilities related to supporting the debt service of conduit debt obligations also should disclose information about the amount recognized and how the liabilities changed during the reporting period. The requirements of this Statement are effective for reporting periods beginning after December 15, 2021. The Corporation has not yet determined the impact this statement will have on the financial statements.

In January 2020, GASB issued Statement No. 92, *Omnibus 2020.* The objectives of this Statement are to enhance comparability in accounting and financial reporting and to improve the consistency of authoritative literature by addressing practice issues that have been identified during implementation and application of certain GASB Statements. The requirements of this Statement are effective for reporting periods beginning after June 15, 2021. The Corporation has not yet determined the impact this statement will have on the financial statements.

In May 2020, GASB issued Statement No. 96, *Subscription-Based Information Technology Arrangements.* This Statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users. This Statement (1) defines a SBITA; (2) establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; (3) provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and (4) requires note disclosures regarding a SBITA. To the extent relevant, the standards for SBITAs are based on the standards established in Statement No. 87, *Leases*. A SBITA is defined as a contract that conveys control of the right to use another party's information technology software alone or in combination with tangible capital assets as specified in the contract for a period of time in an exchange or exchange-like transaction. The requirements of this Statement are effective for fiscal years beginning after June 15, 2022. The Corporation has not yet determined the impact this statement will have on the financial statements.

Note 2. Summary of Significant Accounting Policies (Continued)

In June 2020, GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans*. The primary objectives of this Statement are to (1) increase consistency and comparability related to the reporting of fiduciary component units in circumstances in which a potential component unit does not have a governing board and the primary government performs the duties that a governing board typically would perform; (2) mitigate costs associated with the reporting of certain defined contribution pension plans, defined contribution other postemployment benefit (OPEB) plans, and employee benefit plans other than pension plans or OPEB plans (other employee benefit plans) as fiduciary component units in fiduciary fund financial statements; and (3) enhance the relevance, consistency, and comparability of the accounting and financial reporting for Internal Revenue Code (IRC) Section 457 deferred compensation plans (Section 457 plans) that meet the definition of a pension plan and for benefits provided through those plans. This Statement requires that for purposes of determining whether a primary government is financially accountable for a potential component unit, except for a potential component unit that is a defined contribution pension plan, a defined contribution OPEB plan, or an other employee benefit plan (for example, certain Section 457 plans), the absence of a governing board should be treated the same as the appointment of a voting majority of a governing board if the primary government performs the duties that a governing board typically would perform. The requirements of this Statement that are related to the accounting and financial reporting for Section 457 plans are effective for fiscal years beginning after June 15, 2021. The Corporation has not yet determined the impact this statement will have on the financial statements.

Reclassifications: Certain prior-year amounts have been reclassified to conform to the current-year presentation. Such reclassifications had no effect on previously reported operating income or changes in net position.

Subsequent events: The Corporation has evaluated subsequent events for potential recognition and/or disclosure through March 23, 2021, the date the financial statements were issued.

Note 3. Coronavirus Pandemic (COVID-19)

In response to the impact on the Healthcare environment from the COVID-19, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was enacted by Congress and was signed into law on March 27, 2020. The CARES Act included a variety of economic assistance provisions for businesses and individuals. It includes provisions to support healthcare providers and patients in the form of grants, payments for uninsured patients, and changes to Medicare and Medicaid payments, among other types of relief. COVID-19 has had a significant impact on the results of the Corporation's operations. The Corporation under New York State regulations suspended non-emergent and non-critical surgeries, procedures and appointments beginning in mid-March through May in 2020 and again beginning in early December 2020 through January 2021 due to COVID-19. This resulted in a substantial decrease to hospital revenue and an increase in expenses due to the purchase of Personal Protective Equipment (PPE), lab equipment and testing supplies, increase in personnel costs and other preparedness measures taken related to COVID-19.

Note 3. Coronavirus Pandemic (COVID-19) (Continued)

Under certain provisions in the CARES Act, the Corporation recognized benefits totaling $62,807 in its statement of revenues, expenses and changes in net position. The $62,807 benefit is entirely comprised of distributions from the Provider Relief Fund established under the CARES Act and is recognized as non-operating revenue. The Corporation also deferred payment of $10,926 for the employer portion of the Social Security payroll taxes as allowed by the CARES Act which has been recorded in the statement of net position as a current liability within the accrued salaries, wages and employee benefits caption at December 31, 2020. Under the CARES Act, fifty percent of the deferred payroll taxes must be paid by December 31, 2021 with the remainder by December 31, 2022.

Under the CARES Act, the Centers for Medicare & Medicaid Services (CMS) expanded the Medicare Accelerated and Advance Payment Program to provide necessary funds to Medicare providers to assist with the disruption in claims submission and claims processing. During 2020, the Corporation received advance payments under this program totaling $39,101. Amounts provided under the Medicare Accelerated and Advance Payment Program will begin to be recouped against future Medicare claims beginning in 2021 through 2022. The Corporation will reduce the liability over time as Medicare claims for services are provided during the recoupment period.

Under certain provisions of the CARES Act, the Corporation applied for and received a Paycheck Protection Program (PPP) loan in the amount of $10,000. This loan accrues interest and has been recorded in the statement of net position as a long-term debt at December 31, 2020 (see Note 9). The Corporation has applied for forgiveness as of the date of this report.

Note 4. Net Patient Service Revenue and Patient Accounts Receivable

The Corporation has agreements with third-party payors that provide for payment to the Corporation at amounts different from its established rates. A summary of the payment arrangements for hospital services with major third-party payors is as follows:

Medicare: Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge and per patient day depending on the service. Acute care rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Certain inpatient and outpatient services, as well as defined organ acquisition, capital and medical education costs related to Medicare beneficiaries are paid based on regulatory proscribed formulae. The Corporation is reimbursed for such items at a tentative rate with final settlement determined after submission of annual cost reports by the Corporation and audits thereof by the Medicare fiscal intermediary. The Corporation's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Corporation. Most outpatient reimbursements are based on an Ambulatory Payment Classification weighting by acuity system, although some outpatient cost reimbursement still exists.

Medicaid: Inpatient services rendered to Medicaid program beneficiaries are reimbursed at prospectively determined rates in accordance with Part 86 of the New York Codes, Rules and Regulations and New York State Law which are promulgated by the New York State Department of Health (DOH). Outpatient services are similarly paid at either prospective rates or fee schedule amounts.

(Dollars in Thousands)

Note 4. Net Patient Service Revenue and Patient Accounts Receivable (Continued)

Under the New York Health Care Reform Act, the Corporation also enters into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Corporation under these agreements includes prospectively determined rates, discounts from charges, and prospectively determined per diem rates. Medicaid, Workers' Compensation and No-fault continue to have reimbursement rates determined based on New York's Prospective Reimbursement Methodology.

Terrace View provides services to residents under agreements with third-party payors (Medicaid, Medicare and HMO's) under provisions of their respective cost reimbursement formulas or contractually negotiated rates. If amounts received are less than established billing rates, the difference is accounted for as a reduction of revenue. Final determination of the reimbursement rates are subject to review by appropriate third-party payors. Provisions are made in the financial statements for anticipated adjustments that may result from such reviews. The difference between the estimated amounts accrued and final settlements are reported in operations in the year of settlement.

Net patient service revenue, as reported on the statements of revenues, expenses and changes in net position is comprised of the following for the years ended December 31:

	2020	2019
Gross charges	$ 1,215,298	$ 1,191,460
Less:		
Discounts and allowances	676,102	628,499
Provision for bad debts	33,605	19,591
	$ 505,591	$ 543,370

Net patient service revenue by payor for the years ended December 31, is as follows:

	2020		2019	
		%		%
Medicare*	$ 185,501	36.7%	$ 186,281	34.3%
Medicaid*	150,629	29.8%	160,960	29.6%
Commercial and other third party payors	145,210	28.7%	165,434	30.4%
No-fault	20,052	4.0%	24,777	4.6%
Self-pay	4,199	0.8%	5,918	1.1%
	$ 505,591	100.0%	$ 543,370	100.0%

*Medicare and Medicaid include Managed Care plans.

Laws and regulations governing Medicare, Medicaid, and other third-party payor programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates could change by a material amount in future periods. The Corporation believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare and Medicaid programs.

(Dollars in Thousands)

Note 4. Net Patient Service Revenue and Patient Accounts Receivable (Continued)

Patient accounts receivable consist of the following at December 31:

	2020	2019
Gross accounts receivable	$ 212,187	$ 205,428
Less:		
Discounts and allowances	76,640	75,156
Allowance for bad debts	56,831	43,700
	$ 78,716	$ 86,572

Concentration of credit risk: The Corporation grants credit without collateral to its patients, most of whom are insured under third-party payor arrangements. The mix of net receivables from patients and third-party payors at December 31, is as follows:

	2020	2019
Medicare*	30.6%	26.8%
Medicaid*	27.6%	24.9%
Commercial and other third party payors	29.8%	32.6%
No-fault	9.5%	12.2%
Self-pay	2.5%	3.5%
Total	100.0%	100.0%

*Medicare and Medicaid include Managed Care plans.

Note 5. Disproportionate Share Revenue

The Medicaid DSH program is designed to provide funds to certain hospitals to help offset the cost of uncompensated care provided to the uninsured. Each state has a specified Federal DSH allotment. In addition, New York State law authorizes the DOH to make supplemental DSH medical assistance payments to public hospitals located in Erie County, Nassau County, and Westchester County. For long term care facilities, DSH revenue is recognized in accordance with Upper Payment Limit (UPL) regulations promulgated by CMS.

In 2020 and 2019, DSH funding recorded by the Corporation totaled $79,510 and $89,802, respectively. The DSH funding process is complex and includes both tentative and final settlements for various state fiscal years which are subject to the availability of state and federal funding among other factors. As a result, DSH revenue is estimated and final settlements may vary significantly from the initial estimates.

For hospital services, DSH revenue of $67,461 and $74,407 was recognized in 2020 and 2019, respectively. In addition, during 2020 and 2019 the Corporation recognized $12,049 and $15,395, respectively, of UPL revenue for Terrace View. UPL revenue has been recognized based off New York State fiscal year 2020-2021 as determined by the New York State Department of Health (DOH), using cost report year 2018 data.

In addition, the Centers for Medicare and Medicaid Services (CMS) has indicated that cost reports dating back to the 2018 reporting year and the methodology employed to calculate DSH revenue are subject to audit. At this time, the impact of the CMS audit activity on the Corporation’s DSH revenue is not certain. Management has taken what it believes to be reasonable and appropriate steps to assure compliance with the CMS methodology.

(Dollars in Thousands)

Note 6. Cash and Cash Equivalents, Investments, and Assets Whose use is Limited

Cash and cash equivalents and investments: The Corporation's investments are made in accordance with State regulations and its own investment policy. The investment policy is regularly reviewed by an investment committee of the Board which evaluates the performance of investment managers and monitors compliance with the investment policy.

The Corporation's investments are generally reported at fair value, as discussed in Note 2. The carrying amounts of cash and cash equivalents, investments and assets whose use is limited are included in the Corporation's statements of net position as follows:

	2020	2019
Cash and cash equivalents	$ 120,308	$ 13,771
Investments	16,393	10,125
Assets whose use is limited – current	117,163	195,804
Assets whose use is limited – non-current	77,228	81,425
	$ 331,092	$ 301,125
Current portion of assets whose use is limited:		
Patient and residents trust cash	$ 576	$ 347
Restricted for debt service [(a)]	2,304	2,291
Restricted for capital projects [(d)]	12,425	40,850
Designated for self-insurance obligations [(b)]	8,924	8,544
Designated for retiree health obligations [(b)]	12,077	12,903
Designated for DSRIP program [(b)]	79,969	130,091
NYS voluntary defined contribution plan escrow	201	237
Medical and dental staff funds	687	541
Total current portion of assets whose use is limited	$ 117,163	$ 195,804
Noncurrent portion of assets whose use is limited:		
Restricted for debt service [(a)]	$ 9,710	$ 9,664
Designated for long-term investment [(b)]	18,595	18,595
Designated for retiree health obligations [(b)]	12,754	11,928
Designated for self-insurance obligations [(b)]	29,308	29,462
Restricted – insured workers compensation collateral [(c)]	6,861	11,776
Total noncurrent portion of assets whose use is limited	$ 77,228	$ 81,425

[(a)] Funds restricted by operation of indenture agreement
[(b)] Funds internally designated by operation of Board authority
[(c)] Funds restricted – insured workers compensation collateral agreement
[(d)] Unspent proceeds from borrowings, which are to be used for construction projects

Note 6. Cash and Cash Equivalents, Investments, and Assets Whose use is Limited (Continued)

The Corporation's cash and cash equivalents as well as investments are exposed to various risks, including credit, custodial credit, interest rate, and market risks, as discussed in more detail below:

Deposits

All monies are deposited with banks or trust companies designated by the Corporation's investment committee of the Board of Directors. Funds not needed for immediate expenditure may be deposited in interest or non-interest bearing accounts or invested in various marketable securities and bonds.

Custodial credit risk: Custodial credit risk is the risk that, in the event of bank failure, the Corporation's deposits might not be recovered. FDIC insurance through December 31, 2020 for funds held in interest bearing accounts is $250 per depositor per category of legal ownership. New York law requires that deposits in excess of FDIC insured amounts are collateralized. The Corporation's bank deposits at December 31, 2020 and 2019, totaled $139,567 and $71,815, of which $827 and $863 of the deposits were insured at December 31, 2020 and 2019, respectively. Amounts over FDIC insured limits were fully collateralized with securities held by the pledging financial institution.

Investments

The Corporation's investment policy authorizes the Corporation to invest in accordance with New York State Finance Law Section 8(14), Section 201 and Public Authorities Law Article 9 Section 2800 to 2985, as well as the relevant provisions of the ECMCC Act. Compliance with the policy is monitored by the Corporation's investment committee and reported on regularly throughout the year by the Corporation's investment advisor.

Credit risk: Credit risk is the risk that the issuer or other counterparty to an investment will not fulfill its obligation, causing the Corporation to experience a loss of principal. The Corporation's investment policy limits investments in equity and fixed income securities with ratings only in the highest category. ECMCC's investments in government bonds carry the explicit guarantee of the U.S. government. The corporate bonds, short-term fixed income and government bonds are all rated AA+ or better by the Standards & Poor's rating agency.

Interest rate risk: Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. The Corporation's cash equivalent securities are limited to maturities of no greater than eighteen months; short-term fixed income securities are limited to maturities of no greater than five years; and long-term fixed income securities are limited to maturities to no more than ten years. Substantially all of the Corporation's investments and assets whose use is limited have stated maturities of less than one year.

Custodial credit risk: For an investment, custodial credit risk is the risk that, in the event of the failure of the counterparty, the Corporation will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. The Corporation's investment policy does not address custodial credit risk.

(Dollars in Thousands)

Note 6. Cash and Cash Equivalents, Investments, and Assets Whose use is Limited (Continued)

Concentration of credit risk: Concentration of credit risk is the risk of loss attributable to the magnitude of investments in any single issuer. The Corporation's investment policy indicates the combined holdings of securities from one issuer shall not constitute more than 5.0% of the fund except for issues guaranteed directly or indirectly by the U.S. Government. The Corporation had no holdings in Federal National Mortgage Association (Fannie Mae) or Federal Home Loan Mortgage Corporation (Freddie Mac) issues at December 31, 2020 and 2019.

Fair value of financial instruments: Fair value is defined in the accounting standards as the amount that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Management utilizes valuation techniques that maximize the use of observable inputs (Levels 1 and 2) and minimize the use of unobservable inputs (Level 3) within the fair value hierarchy established by GASB. Assets and liabilities carried at fair value are required to be classified and disclosed in one of the following three categories:

Level 1: Valuations based on quoted prices in active markets for identical assets that the Corporation has the ability to access.

Level 2: Valuations based on quoted prices in active markets for similar assets, quoted prices in markets that are not active or for which all significant inputs are observable, directly or indirectly.

Level 3: Valuations based on inputs that are unobservable and significant to the overall fair value measurement. These are generally company generated inputs and are not market-based inputs. The Corporation has no Level 3 assets.

	2020			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 120,308	$ -	$ -	$ 120,308
Investments and assets whose use is limited:				
Cash and cash equivalents	138,780	-	-	138,780
Marketable equity securities:				
Small/Mid-cap equities	5,141	-	-	5,141
Growth equities	1,795	-	-	1,795
Core equities	10,411	-	-	10,411
International equities	10,202	-	-	10,202
US fixed income	40,839	-	-	40,839
International fixed income	-	3,616	-	3,616
Total investments and assets whose use is limited	207,168	3,616	-	210,784
Total	$ 327,476	$ 3,616	$ -	$ 331,092

(Dollars in Thousands)

Note 6. Cash and Cash Equivalents, Investments, and Assets Whose use is Limited (Continued)

	2019			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 13,771	$ -	$ -	$ 13,771
Investments and assets whose use is limited:				
Cash and cash equivalents	229,201	-	-	229,201
Marketable equity securities:				
Small/Mid-cap equities	3,716	-	-	3,716
Growth equities	1,513	-	-	1,513
Core equities	8,700	-	-	8,700
International equities	8,990	-	-	8,990
US fixed income	29,900	-	-	29,900
International fixed income	-	5,334	-	5,334
Total investments and assets whose use is limited	282,020	5,334	-	287,354
Total	$ 295,791	$ 5,334	$ -	$ 301,125

Note 7. Capital Assets, Net

Capital asset activity for the years ended December 31, is as follows:

	2020			
	Beginning Balance	Additions	Disposals/ Transfers	Ending Balance
Capital assets – being depreciated				
Land and land improvements	$ 28,731	$ 11,724	$ -	$ 40,455
Buildings and improvements	435,501	92,858	-	528,359
Fixed/major moveable equipment	182,780	16,444	(652)	198,572
Total capital assets – being depreciated	647,012	121,026	(652)	767,386
Less accumulated depreciation	(419,718)	(32,234)	19	(451,933)
Total capital assets – being depreciated, net	227,294	88,792	(633)	315,453
Capital assets – not being depreciated				
Construction in progress	92,064	41,532	(114,892)	18,704
Total capital assets, net	$ 319,358	$ 130,324	$ (115,525)	$ 334,157

(Dollars in Thousands)

Note 7. Capital Assets, Net (Continued)

	2019			
	Beginning Balance	Additions	Disposals/ Transfers	Ending Balance
Capital assets – being depreciated				
Land and land improvements	$ 23,646	$ 5,085	$ -	$ 28,731
Buildings and improvements	424,954	10,547	-	435,501
Fixed/major moveable equipment	177,380	7,678	(2,278)	182,780
Total capital assets – being depreciated	625,980	23,310	(2,278)	647,012
Less accumulated depreciation	(393,287)	(28,610)	2,179	(419,718)
Total capital assets – being depreciated, net	232,693	(5,300)	(99)	227,294
Capital assets – not being depreciated				
Construction in progress	32,849	68,891	(9,676)	92,064
Total capital assets, net	$ 265,542	$ 63,591	$ (9,775)	$ 319,358

Construction in progress at December 31, 2019 included costs associated with the planning, design, and construction of the Level 1 Adult Trauma Center and emergency department expansion project, as well as construction and planning costs for various other facility projects. $100,000 of the projects are funded through loans from Erie County (see Note 9) and $10,000 through a grant from New York State (see Note 14). In May 2020, the Level 1 Adult Trauma Center and emergency department expansion was completed and opened. Construction in progress at December 31, 2020 includes costs associated with the new ambulatory electronic medical records system, and various mechanical, electrical, plumbing and building envelope improvements.

Depreciation expense amounted to $32,234 and $28,610 for the years ended December 31, 2020 and 2019, respectively.

Note 8. Accrued Other Liabilities

The composition of accrued other liabilities as of December 31, is as follows:

	2020	2019
Due to Erie County	$ 4,713	$ 15,329
Due to joint venture	1,738	1,250
Medical malpractice claims	1,893	1,903
Other	13,533	10,592
Workers compensation claims	7,026	6,642
Total	$ 28,903	$ 35,716

(Dollars in Thousands)

Note 8. Accrued Other Liabilities (Continued)

GASB Statement No. 83, *Certain Asset Retirement Obligations,* establishes criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources for asset retirement obligations (ARO's). An ARO is a legally enforceable liability associated with the retirement of a tangible capital asset. In accordance with this Statement, the Corporation completes an analysis of assets meeting the criteria of an ARO for specific types of medical equipment such as medical imaging equipment (e.g., MRIs, CT scanners, and PET scanners), X-Rays, and ultrasounds as well as computers containing information protected by HIPAA laws, and certain types of laboratory equipment. In addition, the Corporation evaluates the requirements for disposal of underground fuel and lab acid tanks. The Corporation determined, based on industry standards for disposition of similar assets, the total asset retirement obligation totaled $2,008 and $2,185 at December 31, 2020 and 2019, respectively, and is reflected in accrued other liabilities in the statements of net position. The assets have a remaining useful life ranging from 0 to 30 years. This obligation is discounted using a rate of 4.0% and an inflation factor of 3.0% at December 31, 2020 and 2019.

Note 9. Indebtedness

Long-term debt consisted of the following at December 31:

	2020				
	Beginning Balance	Additions	Payments	Ending Balance	Due Within One Year
Erie County - Guaranteed Senior Revenue Bonds, Series 2004	$ 72,365	$ -	$ (3,545)	$ 68,820	$ 3,740
Erie County – 2017 loan payable	97,430	-	(1,914)	95,516	2,649
Erie County – 2017 loan payable	65,075	-	(3,843)	61,232	3,946
Erie County – 2017 capitalized interest assumption obligation	8,110	-	(159)	7,951	220
PPP Loan	-	10,000	-	10,000	553
Capital lease obligations	4,889	2,555	(1,919)	5,525	847
Total debt	$ 247,869	$ 12,555	$ (11,380)	$ 249,044	$ 11,955

	2019				
	Beginning Balance	Additions	Payments	Ending Balance	Due Within One Year
Erie County - Guaranteed Senior Revenue Bonds, Series 2004	$ 75,725	$ -	$ (3,360)	$ 72,365	$ 3,545
Erie County – 2017 loan payable	98,799	-	(1,369)	97,430	1,914
Erie County – 2017 loan payable	68,804	-	(3,729)	65,075	3,842
Erie County – 2017 capitalized interest assumption obligation	8,224	-	(114)	8,110	159
Capital lease obligations	5,773	1,805	(2,689)	4,889	1,630
Total debt	$ 257,325	$ 1,805	$ (11,261)	$ 247,869	$ 11,090

(Dollars in Thousands)

Note 9. Indebtedness (Continued)

Future annual principal payments applicable to long term debt for the years subsequent to December 31, 2020 are as follows:

2021	$	11,955
2022		14,550
2023		15,017
2024		15,497
2025		14,274
2026 - 2030		69,252
2031 - 2035		68,558
2036 - 2040		39,941
Total	$	249,044

The Series 2004 Bonds are secured by a pledge of the gross receipts of the Corporation and amounts on deposit in certain debt service reserve funds. Interest rates on the bonds range from 5.5% to 5.7%, with principal payments ranging from $3,740 to $7,220 due annually on November 1 with interest payments due semi-annually on May 1 and November 1.

Pursuant to a Guaranty Agreement, the County has unconditionally guaranteed to the Corporation, the punctual payment of the principal, interest, and redemption premium, if any, on the Series 2004 Bonds, as the same shall become due and payable, and has pledged the faith and credit of the County for the performance of such guaranty. A municipal bond insurance policy has been purchased by the Corporation to guarantee all debt service payments in case of default by the Corporation and the County.

In 2017, the Corporation entered into a loan agreement and a capitalized interest liability assumption agreement with the County of Erie, with the assistance of the Erie County Fiscal Stability Authority. The proceeds of the loan were used to finance the construction of a new Level 1 Adult Trauma Center and Emergency Department, fund various other capital projects on the Corporation's campus as well as refinance a 2011 loan. The loan has an interest rate of 3.377% with monthly principal and interest payments ranging from $38 to $930 during the term of the loan. In addition to the loan, the Corporation assumed the liability related to funds borrowed to pay capitalized interest during construction on the various projects noted above. The capitalized interest liability assumption has an interest rate of 3.377% with monthly principal and interest payments ranging from $3 to $77 during the term of the loan. The new money portion of the loan and the capitalized interest assumption agreement is fully amortized and matures in 2039. The refinancing component of the loan has an interest rate of 2.649% with monthly principal and interest payments ranging from $300 to $460 during the term of the loan and is fully amortized and maturing in 2034.

During 2015, the Corporation entered into a capital lease agreement in the amount of $10,000, the proceeds of which were used to purchase various equipment. The agreement required principal and interest payments (cost of capital is estimated at 2.3%) of $194 and was paid in full June 2020.

During 2018, the Corporation entered into a capital lease agreement in the amount of $2,044, the proceeds of which were used to purchase various equipment. The agreement requires principal and interest payments (cost of capital is estimated at 5.5%) of $29 and matures September 2025.

Note 9. Indebtedness (Continued)

During 2018, the Corporation entered into a second capital lease agreement in the amount of $409, the proceeds of which were used to purchase various suite improvements. The agreement requires principal and interest payments (cost of capital is estimated at 3.8%) of $4 and matures October 2028.

During 2019, the Corporation entered into a capital lease agreement in the amount of $1,805, the proceeds of which were used to finance various cafeteria improvements. The agreement requires principal and interest payments (cost of capital ranges from 0 – 9.0%) of $17 and matures March 2029.

During 2020, the Corporation entered into a capital lease agreement in the amount of $2,555, the proceeds of which were used to purchase various equipment. The agreement requires principal and interest payments (cost of capital is estimated at 5.5%) of $34 and matures July 2026.

During June 2020, the Corporation received a Paycheck Protection Program (PPP) loan in the amount of $10,000. The loan accrues interest at 1.0%. If forgiveness is not received, beginning in October 2021 monthly principal and interest payments of $228 are required until maturity in May 2025. The Corporation has applied for forgiveness as of the date of this report and is expecting to receive forgiveness.

Note 10. Pension Plan

Retirement plan: The Corporation participates in the New York State and Local Retirement System ("NYSLRS" or the "System"), which is a cost-sharing, multiple-employer public employees' retirement system. There are more than 487,000 pensioners and beneficiaries in the System with nearly 1.1 million participants.

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the NYSLRS and additions to/deductions from NYSLRS' fiduciary net position have been determined on the same basis as they are reported by NYSLRS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. The net pension liability is measured as the portion of the present value of projected benefit payments to be provided through the pension plan to current active and inactive employees that is attributed to those employees' past periods of service (total pension liability), less the amount of the pension plan's fiduciary net position. The net pension liability should be measured as of a date (measurement date) no earlier than the end of the employer's prior fiscal year, consistently applied from period to period.

Obligations of employers and employees to contribute and benefits to employees are governed by the New York State Retirement and Social Security Law (RSSL). As set forth in the RSSL, the Comptroller of the State of New York (the "Comptroller") serves as sole trustee and administrative head of the System. The Comptroller shall adopt and may amend rules and regulations for the administration and transaction of the business of the System and for custody and control of its funds. The System issues a publicly available financial report that includes financial statements and required supplementary information. That report may be obtained by writing to the New York State and Local Retirement System, 110 State Street, Albany, NY 12244.

NYSLRS provides three main types of retirement benefits: service retirements, ordinary disability retirements (non job-related disabilities), and accident disability retirements (job-related disabilities) to members who are in different "Tiers." The members' Tier is determined by the date of membership. Subject to certain conditions, members generally become fully vested as to benefits upon the completion of 5 or 10 years of service depending on their Tier. Employees may be required to contribute a percentage of their salary to the pension plan based on their Tier, determined by their date of membership in the plan. Annual pension benefits can be calculated as a percentage of final average salary times number of years of service and changes with the number of years of membership within the plan.

(Dollars in Thousands)

Note 10. Pension Plan (Continued)

At December 31, 2020 and 2019, the Corporation reported a liability of $225,197 and $57,240, respectively, for its proportionate share of the NYSLRS net pension liability. The total pension liability used to calculate the net pension liability is determined by an actuarial valuation as of April 1st each year and rolled forward to March 31st. The Corporation's proportion for the net pension liability for each fiscal year was based on the Corporation's indexed present value of future compensation to NYSLRS of all participating employers for 2020 and 2019, which was 0.8504% and 0.8079%, respectively.

(a) Actuarial Assumptions

The total pension liability for the March 31, 2020 measurement date was determined using an actuarial valuation as of April 1, 2019, with update procedures used to roll-forward the total pension liability to March 31, 2020. The actuarial valuations used the following actuarial assumptions:

Inflation	2.5%
Salary increases	4.2%, including inflation
Investment rate of return	6.8%, net of pension plan investment expense
Cost of living adjustments	1.3%
Mortality improvement	Society of Actuaries Scale MP-2018

The total pension liability for the March 31, 2019 measurement date was determined using an actuarial valuation as of April 1, 2018, with update procedures used to roll-forward the total pension liability to March 31, 2019. The actuarial valuations used the following actuarial assumptions:

Inflation	2.5%
Salary increases	4.2%, including inflation
Investment rate of return	7.0%, net of pension plan investment expense
Cost of living adjustments	1.3%
Mortality improvement	Society of Actuaries Scale MP-2014

(Dollars in Thousands)

Note 10. Pension Plan (Continued)

(b) Expected Rate of Return on Investments

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected return, net of investment expenses and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized in the following tables at December 31:

	2020	
Asset class	Target Asset Allocation	Long-Term Expected Real Rate of Return
Domestic equity	36.0%	4.1%
International equity	14.0%	6.2%
Private equity	10.0%	6.8%
Real estate	10.0%	5.0%
Absolute return strategies	2.0%	3.3%
Bonds and mortgages	17.0%	0.8%
Inflation-indexed bonds	4.0%	0.5%
Opportunistic portfolio	3.0%	4.7%
Real assets	3.0%	6.0%
Cash	1.0%	0.0%
	100.0%	

	2019	
Asset class	Target Asset Allocation	Long-Term Expected Real Rate of Return
Domestic equity	36.0%	4.6%
International equity	14.0%	6.4%
Private equity	10.0%	7.5%
Real estate	10.0%	5.6%
Absolute return strategies	2.0%	3.8%
Bonds and mortgages	17.0%	1.3%
Inflation-indexed bonds	4.0%	1.3%
Opportunistic portfolio	3.0%	5.7%
Real assets	3.0%	5.3%
Cash	1.0%	-0.3%
	100.0%	

(Dollars in Thousands)

Note 10. Pension Plan (Continued)

(c) Discount Rate

The discount rate used to measure the total pension liability as of December 31, 2020 and 2019 was 6.8% and 7.0%, respectively. The projection of cash flows used to determine the discount rate assumes that contributions from plan members will be made at the current contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the NYSLRS fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on NYSLRS investments was applied to all periods of projected benefit payments to determine the total pension liability.

The following presents the Corporation's proportionate share of the net pension liability calculated using the discount rate of 6.8% and 7.0% at December 31, 2020 and 2019, respectively, as well as what the Corporation's proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current rate:

	2020		
	1% Decrease (5.8%)	Discount Rate (6.8%)	1% Increase (7.8%)
Corporation's proportionate share of the net pension liability	$ 413,299	$ 225,197	$ 51,953

	2019		
	1% Decrease (6.0%)	Discount Rate (7.0%)	1% Increase (8.0%)
Corporation's proportionate share of the net pension liability	$ 250,264	$ 57,240	$ (104,913)

(Dollars in Thousands)

Note 10. Pension Plan (Continued)

(d) Deferred Outflows and Inflows of Resources

At December 31, 2020 and 2019, the Corporation reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2020	2019
Deferred outflows of resources:		
Differences between expected and actual actuarial experience	$ 13,254	$ 11,272
Difference between projected and actual investment earnings on pension plan investments	115,447	-
Changes in assumptions	4,534	14,388
Corporation contributions subsequent to the measurement date	30,167	27,343
Other	3,911	2,670
Total	$ 167,313	$ 55,673
Deferred inflows of resources:		
Differences between expected and actual actuarial experience	$ -	$ 3,842
Change in assumptions	3,915	-
Difference between projected and actual investment earnings on pension plan investments	-	14,691
Changes in proportion and differences between Corporation contributions and proportionate share of contributions	10,488	9,478
Total	$ 14,403	$ 28,011

The change in employer proportionate share is the difference between the employer proportionate share of net pension liability in the prior year compared to the current year. Changes in these amounts are amortized over a five-year closed period, reflecting the average remaining service life of plan members.

The net deferred outflows and inflows of resources of resources related to pensions will be recognized in pension expense as follows:

Year ended December 31:	Amount
2021	$ 19,001
2022	30,383
2023	40,456
2024	32,903
	$ 122,743

(e) Annual Pension Expense

The Corporation's annual pension expense for calendar year ending 2020 and 2019, which includes contributions toward the actuarially determined accrued liability and the amortization of deferred outflows and inflows of resources, was approximately $72,875 and $33,553, respectively.

(Dollars in Thousands)

Note 11. Other Post-Employment Benefits (OPEB)

Plan description: The Corporation provides OPEB that include basic medical and hospitalization plan coverage to eligible retirees. Eligible retirees may only be covered under the indemnified plan of the Corporation. To qualify, a retiree must meet various eligibility requirements as agreed to in collective bargaining agreements. The Corporation pays varying amounts based on specific union agreements.

Funding the plan: Currently, there is no New York State statute that expressly authorizes local governments to create a trust for OPEB purposes. Additionally, New York State's General Municipal Law does not allow for a reserve fund to accumulate funds for OPEB obligations. The Corporation's Board of Directors and management believe it is prudent to reserve funds for the Plan and have therefore internally designated $24,831 in 2020 and 2019, for purposes of funding future post-employment benefits. These internally designated funds are included within assets whose use is limited in the statements of net position. In addition to the funding for future post-employment benefits, the Corporation continues to finance current benefits on a pay-as-you-go basis.

Annual OPEB cost and net OPEB obligation: The Corporation's total OPEB liability measured at December 31, 2020 and 2019 of $397,921 and $412,883 was determined by an actuarial valuation as of January 1, 2020 and 2019, respectively. The measurement date of the obligation is December 31, 2020 and 2019.

(a) Actuarial Assumptions

The total OPEB liability in the December 31, 2020 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.3%
Salary increases	3.3% per annum
Pre-Medicare Plans	7.0% for 2020, 3.8% ultimate trend rate in 2075
Medicare Plans	4.5% for 2020, 3.8% ultimate trend rate in 2075
Prescription Plan	7.0% for 2020, 3.8% ultimate trend rate in 2075
Mortality	Society of Actuaries Scale MP-2020

(Dollars in Thousands)

Note 11. Other Post-Employment Benefits (OPEB) (Continued)

The total OPEB liability in the December 31, 2019 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.3%
Salary increases	3.3% per annum
Pre-Medicare Plans	6.8% for 2019, 3.8% ultimate trend rate in 2075
Medicare Plans	4.5% for 2019, 3.8% ultimate trend rate in 2075
Prescription Plan	7.0% for 2019, 3.8% ultimate trend rate in 2075
Mortality	Society of Actuaries Scale MP-2019

(b) Changes in the OPEB Liability

	2020	2019
Changes in the OPEB obligation		
Projected OPEB obligation at the beginning of year	$ 412,883	$ 389,730
Service cost	5,143	4,034
Interest cost	9,849	14,724
Difference between expected and actual experience	(49,027)	(38,435)
Change in assumptions	33,117	57,042
Actual benefit payments	(14,044)	(14,212)
Projected OPEB obligation at the end of year	$ 397,921	$ 412,883

(c) Discount Rate

The discount rate used to measure the total OPEB liability as of December 31, 2020 was 2.1%, based on the Bond Buyer 20-year Bond GO index rate.

The following presents the Corporation's total OPEB liability calculated using the discount rate of 2.1% as well as what the Corporation's total OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (1.1%) or 1 percentage point higher (3.1%) than the current rate.

	2020		
	1% Decrease (1.1%)	Discount Rate (2.1%)	1% Increase (3.1%)
The Corporation's total OPEB liability	$ 468,812	$ 397,921	$ 341,422

(Dollars in Thousands)

Note 11. Other Post-Employment Benefits (OPEB) (Continued)

The discount rate used to measure the total OPEB liability as of December 31, 2019 was 2.7%, based on the Bond Buyer 20-year Bond GO index rate.

The following presents the Corporation's total OPEB liability calculated using the discount rate of 2.7% as well as what the Corporation's total OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (1.7%) or 1 percentage point higher (3.7%) than the current rate.

	2019		
	1% Decrease (1.7%)	Discount Rate (2.7%)	1% Increase (3.7%)
The Corporation's total OPEB liability	$ 485,311	$ 412,883	$ 355,225

The following presents the Corporation's total OPEB liability calculated using healthcare cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current healthcare cost trend rates.

	2020		
	1% Decrease	Healthcare Cost Trend Rates	1% Increase
The Corporation's total OPEB liability	$ 339,507	$ 397,921	$ 471,752

	2019		
	1% Decrease	Healthcare Cost Trend Rates	1% Increase
The Corporation's total OPEB liability	$ 353,653	$ 412,883	$ 487,571

(Dollars in Thousands)

Note 11. Other Post-Employment Benefits (OPEB) (Continued)

(d) Deferred Outflows and Inflows of Resources

The following are components of deferred outflows and inflows at December 31, 2020 and 2019:

	2020	
	Deferred Outflows	Deferred Inflows
Differences between expected and actual actuarial experience	$ 481	$ 58,647
Changes in assumptions	56,458	28,525
Total	$ 56,939	$ 87,172

	2019	
	Deferred Outflows	Deferred Inflows
Differences between expected and actual actuarial experience	$ 687	$ 29,673
Changes in assumptions	44,004	40,718
Total	$ 44,691	$ 70,391

The net deferred outflows and inflows of resources at December 31, 2020 will be recognized as follows:

	Amount
2021	$ (11,017)
2022	(10,202)
2023	(7,150)
2024	(1,864)
	$ (30,233)

(e) Annual OPEB Expense

The Corporation's annual OPEB expenses for the years ended December 31, 2020 and 2019 was $3,614 and $11,046, respectively.

Note 12. Delivery System Reform Incentive Payment (DSRIP) Program

In April 2014, the federal government approved a New York State Medicaid waiver request to reinvest $8 billion in federal savings to support implementation of transformative reforms to the State's healthcare system. Delivery system reforms will primarily be implemented through $7.4 billion of DSRIP Incentive payments for community-level collaborations to achieve programmatic objectives with a goal of reducing avoidable hospital use by 25% over five years. Additionally, $500 million was awarded through an Interim Access Assurance Fund (IAAF) to ensure the financial viability of critical safety net providers during the period prior to DSRIP implementation.

In June 2015, the New York State Department of Health (NYSDOH) announced DSRIP valuation awards, which represent the total potential amount that each Performing Provider System (PPS) is eligible to earn in performance payments over the five years of the DSRIP program. The Corporation-led PPS received a valuation award of $243,020.

As the DSRIP program requires, the Corporation serves as fiduciary or lead entity for a coalition of Medicaid provider and social services organizations referred to as a Performing Provider System (PPS). The PPS is referred to as Millennium Collaborative Care (MCC). Since April 2014, the Corporation has dedicated significant effort to enterprise-level and PPS-level preparation for participation in the DSRIP program, and in execution of NYSDOH required organizational and project planning essential to implementing and managing DSRIP program efforts. Notable activities include the establishment of PPS governance structures and the operationalization of MCC which is dedicated to DSRIP implementation and management.

During 2020 and 2019, net DSRIP payments received by the Corporation totaled $44,532 and $83,978, respectively. In addition, $32,246 and $80,880 was recorded as grant revenue for the years ended December 31, 2020 and 2019 based on meeting the eligibility requirements and $24,840 and $64,319 of related grant program expenses were incurred during 2020 and 2019, respectively.

Note 13. Care Restructuring Enhancement Pilot (CREPS) Program Grant

During 2016, the federal government approved a New York State (NYS) Medicaid waiver request establishing the CREPS Program. The Corporation was awarded a grant under the CREPS Program administered by the New York State Department of Health. The total award amount is approximately $97,260 over the period April 1, 2016 to March 31, 2020 in state fiscal year annual distribution amounts of $43,930, $30,010, $13,320, and $10,000, respectively. The Corporation is responsible for achieving certain goals of the CREPS Program in each year in order to qualify for the funding. The Corporation has achieved all of the goals for years 1 through 4 and has recognized related revenue in the amount of $5,618 and $22,500 for 2020 and 2019, respectively, in the other operating revenue caption on the statements of revenues, expenses and changes in net position.

Note 14. New York State Capital Grant

During 2020, New York State Department of Health awarded the Corporation a $10,000 grant to assist in funding the construction of the new Level 1 Adult Trauma Center and Emergency Department under the Statewide Health Care Facility Transformation Program 2.3. The Corporation has earned $9,269 of that grant during the year ended December 31, 2020. The grant program goes through 2024, however the remainder of the grant is expected to be received during the year ended December 31, 2021.

Note 15. Transactions With the County of Erie

On December 30, 2009, the Corporation and the County entered into a "Settlement Agreement". The Settlement Agreement resulted in the Corporation and the County entering into a number of transactions to resolve litigation and prepare for implementing the Corporation's master facility plan.

In October 2012, the Corporation and the County signed an amendment to the 2009 Settlement Agreement (the "Amendment"). The terms of the Amendment provide for the County to be reimbursed from the Corporation for certain workers compensation claims incurred by Corporation employees that were paid by the County. The Amendment also provides for the County to reimburse the Corporation, over time, for post-retirement health expenses that the Corporation incurred for Corporation employees with service time at the County.

In 2017, the Corporation entered into a loan agreement and a capitalized interest liability assumption agreement with the County of Erie. A component of the loan agreement included the payment of points by the Corporation to the County of Erie in the amount of $17,040 as further described in Note 2 and Note 9.

Other transactions: Amounts that are included in operating revenues and expenses in the statements of revenues, expenses, and changes in net position, which represent related-party transactions that occurred between the Corporation and the County during the years ended December 31, 2020 and 2019 are as follows:

The Corporation earned revenue totaling $3,453 and $3,250 for the years ended December 31, 2020 and 2019, respectively, from the County. Revenue earned relates to services provided to School 84, mental health services and various other charges related to County departments located within the Corporation's physical plant.

The net amount due from the County of approximately $12,171 and $5,523 at December 31, 2020 and 2019, respectively, is non-interest bearing and reflect the Corporation's net amount owed from the County as a result of various transactions and services between parties. This balance is reported as a component of other assets in the statements of net position.

Note 16. Self-Insured Obligations

The Corporation is self-insured for all medical malpractice claims for occurrences on or after January 1, 2004. Additionally, the Corporation began purchasing excess stop loss insurance on a claims made basis for medical malpractice effective November 2008. The current policy provides $35,000 of coverage in excess of $4,000 of individual claims or $12,000 in aggregate claims effective November 18, 2013. Previously the policy provided $35,000 of coverage in excess of $3,000 of individual claims or $10,000 in aggregate claims.

(Dollars in Thousands)

Note 16. Self-Insured Obligations (Continued)

Effective April 1, 2016, the Corporation became self-insured for workers compensation claims through a combination of self-insurance and a high-deductible plan for certain periods as follows: The Corporation maintains a stop-loss insurance policy for the claims in excess of $750. Effective January 1, 2012, the Corporation insured a portion of its workers' compensation exposure through a claims made high-deductible plan. The Corporation remains responsible for the first $750 of an individual claim payment after December 31, 2011. The Corporation is required to pledge certain assets under this arrangement. As of December 31, 2020 and 2019, $6,861 and $11,776, respectively, has been designated to service workers compensation claims and included as part of assets whose use is limited. The Corporation remains self-insured for workers' compensation claims prior to January 1, 2012. The County has assumed a portion of liabilities for all occurrences originating prior to 2004.

Losses from asserted and unasserted medical malpractice and workers compensation claims are accrued based on actuarial estimates that incorporate the Corporation's past experience, the nature of each claim or incident, relevant trend factors, and estimated recoveries, if any, on unsettled claims.

The Corporation has accrued $22,085 and $19,212 at December 31, 2020 and 2019, respectively, for medical malpractice related exposures. Such amounts have been discounted at 2.0% for 2020 and 2019 and the accrued liabilities are included within the accrued other liabilities and self-insured obligations caption of the accompanying statement of net position. Charges to expense for medical malpractice costs are included within the other operating expenses caption of the accompanying statements of revenues, expenses and changes in net position.

The Corporation has accrued $28,539 and $25,397 at December 31, 2020 and 2019, respectively, for workers compensation related exposures. Such amounts have been discounted at 1.75% for 2020 and 2019, and the liabilities are included within the accrued other liabilities and self-insured obligations captions of the accompanying statement of net position. Charges to expense for workers compensation costs approximated $11,550 and $8,654 in 2020 and 2019, respectively, and are included within the payroll, employee benefits and contract labor caption of the accompanying statements of revenues, expenses and changes in net position.

Eligible retirees are provided basic medical and hospitalization coverage by the Corporation as more fully described in Note 11.

The composition of self-insured obligations as of December 31, is as follows:

	2020				
	Beginning Balance	Actuarial estimate of claims incurred	Claims Paid	Ending Balance	Due Within One Year
Medical malpractice	$ 19,212	$ 6,054	$ (3,181)	$ 22,085	$ 1,893
Workers compensation	25,397	10,745	(7,603)	28,539	7,026
	$ 44,609	$ 16,799	$ (10,784)	$ 50,624	$ 8,919

	2019				
	Beginning Balance	Actuarial estimate of claims incurred	Claims Paid	Ending Balance	Due Within One Year
Medical malpractice	$ 23,743	$ (391)	$ (4,140)	$ 19,212	$ 1,903
Workers compensation	25,610	8,132	(8,345)	25,397	6,642
	$ 49,353	$ 7,741	$ (12,485)	$ 44,609	$ 8,545

Note 16. Self-Insured Obligations (Continued)

Medical malpractice and workers compensation amounts due within one year are management's estimates based on historical claims.

Note 17. Commitments and Contingencies

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to future government review and interpretation as well as regulatory actions unknown or unasserted at the time. Government activity, in recent years, has increased with respect to investigations and allegations concerning possible violations by health care providers of fraud and abuse statutes and regulations, which could result in the imposition of significant fines and penalties as well as significant repayments for patient services previously billed. While no regulatory allegations have been made against the Corporation, compliance with such laws and regulations can be subject to future government review and interpretations as well as regulatory actions unknown or unasserted at this time. Management and its counsel are not aware of any such actions that will have a material adverse effect on the Corporation's financial statements.

Loss contingency liabilities are recorded in accordance with U.S. GAAP, which requires recognition of a loss when it is deemed probable that an asset has been impaired or a liability has been incurred, and the amount of the loss can be reasonably estimated. As of December 31, 2020 and 2019, the Corporation has recorded no loss contingencies except as disclosed in Note 16.

The COVID-19 pandemic has negatively affected national, state, and local economies and global financial markets. The outbreak and related actions taken by federal and state governments may materially impact the Corporation's financial position and its results of operations. While the impacts of COVID-19 may materially affect financial results for 2021 and potentially beyond, the Corporation's management believes that the Corporation has sufficient liquidity to meet its operating and financial needs in fiscal year 2021. However, given the difficulty in predicting the duration and severity of the COVID-19 pandemic and its effects on the Corporation, the economy and financial markets, the ultimate impact is unknown. The Corporation's management continues to monitor the course of the pandemic and is prepared to take additional measures to protect the health of the community and promote the continuity of the Corporation's mission.

The Corporation has recognized revenue related to the CARES Act provider relief funding based on information contained in laws and regulations, as well as interpretations issued by the Department of Health and Human Services (HHS), governing the funding that was publically available at December 31, 2020. Subsequent to December 31, 2020, HHS issued new reporting and eligibility requirements for the CARES Act provider relief funding. The new requirements expanded the relief fund eligibility and updated reporting requirements. CARES Act provider relief funds are also subject to future audit adjustments based on compliance audits and potential changes to statutes. Due to the ongoing changes in the compliance requirements, amounts recorded under the CARES Act provider relief fund by the Corporation may change in future periods.

There are other government funding and relief sources, in addition to other components of the CARES Act not mentioned, that the Corporation continues to assess for eligibility. The possible impact of these funding and relief sources are not reflected in the financial performance through December 31, 2020.

(Dollars in Thousands)

Note 17. Commitments and Contingencies (Continued)

The Corporation leases various equipment and facilities under operating leases expiring at various dates through December 2030. Certain leases include optional extensions that are not included in the amounts below. Total rental expense for all operating leases was approximately $5,256 and $3,300 in 2020 and 2019, respectively. During 2017, the Corporation entered into a $10,000 revolving operating lease facility to support various equipment in information technology infrastructure. As of December 31, 2020 and 2019, $10,000 of this lease facility has been disbursed.

The following is a schedule by year of future minimum lease payments under operating leases as of December 31, 2020 that have initial or remaining lease terms in excess of one year:

2021	$	6,715
2022		6,380
2023		6,006
2024		4,219
2025		3,304
2026-2030		8,102
	$	34,726

The Corporation formed 1827 Fillmore, LLC (1827) for the purpose of acquiring and developing land immediately adjacent to its Grider Street campus. A condition of the acquisition was that 1827 demolish a building on the site with known asbestos abatement requirements. This condition was met in 2018. The Corporation has started a community planning process to determine the future use(s) of the site. The site requires the environmental remediation expenditures, however the amount of such expenditures is dependent on the ultimate use of the site and requirements from regulators. Through December 31, 2020, approximately $4,600 has been spent on remediating and improving the land.

Required Supplementary Information

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Required Supplementary Information
Schedule of Corporation's Contributions
NYSLRS Pension Plan
December 31, 2020
(Dollars in Thousands)

	2020	2019	2018	2017	2016	2015	2014	2013
Contractually required contribution	$ 27,343	$ 26,447	$ 25,803	$ 25,235	$ 26,722	$ 29,771	$ 29,835	$ 27,164
Contributions in relation to the contractually required contribution	27,343	26,447	25,803	25,235	26,722	29,771	29,835	27,164
Contribution deficiency	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ECMCC covered-employee payroll	$ 246,772	$ 235,284	$ 216,044	$ 183,540	$ 166,691	$ 175,409	$ 163,395	$ 151,906
Contributions as a percentage of covered-employee payroll	11.1%	11.2%	11.9%	13.7%	16.0%	17.0%	18.3%	17.9%

Note: During December 2020, the Corporation prepaid its 2021 contribution to the plan in the amount of $30,167 to take advantage of a prepayment discount in the amount of $249.

Note: GASB requires ten years of information to be presented in this table. However, until a full 10-year trend is compiled, the Corporation wil present information for those year for which information is available.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Required Supplementary Information
Schedule of Corporation's Proportionate Share of Net Pension Liability
NYSLRS Pension Plan
December 31, 2020
(Dollars in Thousands)

	2020	2019	2018	2017	2016	2015
ECMCC proportion of the net pension liability	0.8504%	0.8079%	0.7646%	0.7614%	0.7228%	0.7137%
ECMCC proportionate share of the net pension liability	$ 225,197	$ 57,240	$ 24,677	$ 71,544	$ 116,006	$ 24,112
ECMCC covered-employee payroll	246,772	235,284	216,044	183,540	166,691	175,409
ECMCC proportionate share of the net pension liability as a percentage of it's covered-employee payroll	91.3%	24.3%	11.4%	39.0%	69.6%	13.7%
Plan fiduciary net position as a percentage of the total pension liability	86.4%	96.3%	98.2%	94.7%	90.7%	97.9%

Note: GASB requires ten years of information to be presented in this table. However, until a full 10-year trend is compiled, the Corporation wil present information for those year for which information is available.

Erie County Medical Center Corporation
(A Component Unit of the County of Erie)

Required Supplementary Information
Schedule of Corporation's Changes in Total OPEB Liability and Related Ratios
December 31, 2020 and 2019
(Dollars in Thousands)

	2020	2019
Total OPEB liability		
Service cost	$ 5,143	$ 4,034
Interest cost	9,849	14,724
Differences between expected and actual experience	(49,027)	(38,435)
Changes of assumptions	33,117	57,042
Benefit payments	(14,044)	(14,212)
Net change in total OPEB liability	(14,962)	23,153
Total OPEB liability - beginning	412,883	389,730
Total OPEB liability - ending	$ 397,921	$ 412,883
Covered employee payroll	$ 87,699	$ 95,417
Total OPEB liability as a percentage of covered employee payroll	453.73%	432.71%
Discount rate	2.10%	2.70%

RSM US LLP

Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Independent Auditor's Report

To the Board of Directors
Erie County Medical Center Corporation

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, the financial statements of the business-type activities and the discretely presented component units of Erie County Medical Center Corporation (the "Corporation"), as of and for the year ended December 31, 2020, and the related notes to the financial statements, which collectively comprise the Corporation's basic financial statements, and have issued our report thereon dated March 23, 2021. The financial statements of ECMC Foundation, Inc., the Grider Initiative, Inc. and Research for Health in Erie County, Inc. were not audited in accordance with *Government Auditing Standards,* and accordingly, this report does not include reporting on internal controls over financial reporting or instances of reportable noncompliance associated with ECMC Foundation, Inc., the Grider Initiative, Inc. and Research for Health in Erie County, Inc.

Internal Control Over Financial Reporting
In planning and performing our audit of the financial statements, we considered the Corporation's internal control over financial reporting (internal control) as a basis for designing the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, we do not express an opinion on the effectiveness of the Corporation's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements, will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters
As part of obtaining reasonable assurance about whether the Corporation's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report
The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

RSM US LLP

March 23, 2021

APPENDIX A
Four-Year Financial Plan

The difference between healthcare and true care™ ecmc.edu

Erie County Medical Center Corporation Operating and Capital Budgets

For the year ending 2021

Table of Contents

The difference between healthcare and true care™ ECMC ecmc.edu

Management Discussion and Analysis

September 30, 2020

The 2021 Budget maintains a path along the ECMCC Strategic Plan while addressing short and long-term recovery efforts resulting from the COVID-19 Pandemic. ECMCC's long-term goals will continue to be measured through the achievement of the ECMCC mission: improving clinical quality, service excellence, and the continued provision of health services to the communities ECMCC serves with compassion, all of which will require a slow and steady recovery from the financial impacts seen during 2020 and 2021.

Management Discussion and Analysis

Given the additional preparedness costs and the time needed to recover, the 2021 goal is to improve operating results without sacrificing quality. The proposed 2021 operating budget reflects an operating loss of $29 million, with the expectation of eliminating the loss by 2022. The proposed budget has been developed without compromising the following goals:

Budget Goals

- ✓ Maintain the highest quality of care provided
- ✓ Maintain critical services provided to the community
- ✓ Use a stepped approach to recovery with a reduction in net loss from 2020 in the wake of the Pandemic
- ✓ Maintain clinical preparedness for the Pandemic
- ✓ Stabilize cash flow
- ✓ Comply with applicable bond covenants
- ✓ Prepare the budget to accomplish the goals without significant job actions

Management Discussion and Analysis

Budgetary assumptions are a key component of the process that was followed in developing the Budget. The following summarizes management's perspective in the development of these assumptions

Activity Levels

The Budget has been prepared consistent with prior stable periods, with consideration given to the impacts of the Pandemic during 2020 and 2021. Further consideration was given to the changes internally related to recent trends in volume and activity, the opening of the newly constructed emergency department, changes in outpatient activity as a result of the Pandemic, changes in evidence based medicine supporting clinical practice utilization rates, changing regulations and payer payment policies, and other factors. Management believes that the levels of activity contained within the Budget are achievable.

Management Discussion and Analysis

Revenue and Reimbursement

Projected reimbursement from government payers is based on current regulations and, where Management has evaluated as probable, proposed regulations. Reimbursement from commercial payers is based on current contracts, or at rates that Management has evaluated as probable for contracts currently being negotiated. Increases in net revenue associated with revenue cycle improvement initiatives have also been incorporated at levels that Management believes are attainable. Other Operating Revenue has been budgeted based on historical experience while taking into account the impact of the discontinuation of the Delivery System Reform Incentive Payment program (DSRIP) and the Care Restructuring Enhancement Pilots program payments (CREPS). Disproportionate Share and UPL payments have been budgeted based on the most current information available to Management.

Management Discussion and Analysis

Operating Expenses

Projected operating expenses are budgeted based on the volume of anticipated activity, along with adjustments for salary rate increases consistent with collective bargaining agreements, estimated benefit cost increases, supply and other expense inflation rates as well as impacts of critical performance improvement initiatives. In addition, anticipated expenses relating to Pandemic preparedness efforts within supplies, staffing and other expenses have been included. Management believes that the expenses contained in the Budget are reasonable and attainable.

Non-Operating Revenue

Non-Operating Revenues have been budgeted consistent with the recent historical trends related to investment income.

Management Discussion and Analysis

Cash Flows

Cash Flows have been budgeted based on the results of operations, the continuation of ongoing investments in routine and non-routine capital assets, required principal payments on long-term debt and funding of employee benefit plans.

Range of Outcomes and Contingency Plans

Management has considered the sensitivity of each material assumption within the Budget. Management believes that the Budget is reasonably positioned within the range of potential outcomes and recognizes its responsibility for achieving these results. Given the uncertainty of certain material assumptions related to the Pandemic, future governmental reimbursement and benefit costs, Management acknowledges that it may have to adjust operationally during 2021.

Regulatory Budget Reporting Requirements

- All requirements have been met
  - NYCRR, Part 203, Chapter V, Title 2
  - This package communicates each of the 18 requirements
- New York State Office Of The State Comptroller
- Authority Budget Office
- PARIS submission and certification

Budget Process

- Executive Leadership Team (ELT) adopt budget schedule and goals
- Using both 2019 and 2020 (pre-COVID) year-to-date performance, the 2020 budget and known or anticipated budget variances, a baseline budget and financial projections were prepared
- ELT members meet with department managers to develop goals for operational performance
- ELT budget recommendation reviewed and approved by Finance Committee of ECMCC Board
- Budget recommendation reviewed and approved by ECMCC Board

Key Financial Ratios

	2018	2019	Projected 2020	Budget 2021
Operating Margin %	0.60%	0.04%	-14.55%	-4.28%
NYS PBC Average %	-4.5%	-1.9%		
Operating EBITDA %	6.0%	4.8%	-7.5%	2.5%
NYS PBC Average %	0.9%	4.0%		
FTE's	3,299	3,558	3,575	3,462
FTE's per Adjusted Occupied bed	3.92	3.65	3.84	3.24
Days Cash On Hand	112.1	119.0	96.8	70.4
NYS PBC Average	57.5	54.2		
Debt Service Coverage	1.7	2.2	0.9	1.1
NYS PBC Average	1.0	2.5		
Salaries, Wages & Benefits % of Revenue	62.5%	67.4%	75.5%	65.4%
Supply Expense % of Revenue	18.2%	17.9%	18.5%	17.0%
Benefit % of Salaries and Wages	38.0%	40.7%	41.3%	41.3%
Days In Accounts Receivable, net	61.5	58.2	58.1	58.1

Statements of Revenues and Expenses

(Thousands)

	2019 Audited		2020 Projected		2021 Budget		Increase (Decrease)	
	$	%	$	%	$	%	$	%
Net Patient Revenue	543,370	72.4%	512,024	100.0%	580,642	100.0%	68,618	13.4%
Disproportionate Share / IGT and UPL Payments	89,802	12.0%	86,172	16.8%	91,172	15.7%	5,000	5.8%
Other Operating Revenues	117,679	15.7%	39,760	7.8%	16,340	2.8%	(23,420)	-58.9%
Total Operating Revenues	750,851	100.0%	637,956	124.6%	688,154	118.5%	50,198	7.9%
Operating Expenses								
Salaries and Wages	259,844	34.6%	273,540	53.4%	269,012	46.3%	(4,528)	-1.7%
Employee Benefits	106,149	14.1%	112,940	22.1%	110,982	19.1%	(1,958)	-1.7%
Physician & Resident Fees	92,777	12.4%	96,503	18.8%	95,594	16.5%	(909)	-0.9%
Purchased Services	69,434	9.2%	68,410	13.4%	66,154	11.4%	(2,256)	-3.3%
Supplies	97,065	12.9%	94,794	18.5%	98,949	17.0%	4,155	4.4%
Other Expenses	89,474	11.9%	39,282	7.7%	30,145	5.2%	(9,137)	-23.3%
Depreciation	28,659	3.8%	34,261	6.7%	35,936	6.2%	1,675	4.9%
Interest	7,135	1.0%	11,058	2.2%	10,811	1.9%	(247)	-2.2%
Total Operating Expenses	750,537	100.0%	730,788	142.7%	717,583	123.6%	(13,205)	-1.8%
Operating Income	314	0.0%	(92,832)	-14.6%	(29,429)	-4.3%	63,403	-68.3%
CARES Act Funding Relief	-	0.0%	52,157	8.2%	-	0.0%	(52,157)	-100.0%
Income/(Loss) from Operations with CARES Act Relief	314	0.0%	(40,675)	-6.4%	(29,429)	-4.3%	11,246	-27.6%
Non Operating Revenues	12,634	1.7%	3,998	0.6%	4,000	0.6%	2	0.1%
Excess of Revenues Over Expenses	12,948	1.7%	(36,677)	-5.7%	(25,429)	-3.7%	11,248	-30.7%

Statements of Net Position

(Thousands)

	2019 Audited		2020 Projected		2021 Budget		Increase (Decrease)	
	$	%	$	%	$	%	$	%
Assets								
Current Assets								
Cash and Investments	23,896	2.6%	99,533	11.2%	49,359	6.0%	(50,174)	-50.4%
Patient Accounts Receivable, Net	86,572	9.3%	81,566	9.2%	92,509	11.3%	10,943	13.4%
Other Current Assets	274,646	29.5%	162,971	18.4%	141,481	17.2%	(21,490)	-13.2%
Total Current Assets	385,114	41.4%	344,070	38.8%	283,349	34.5%	(60,721)	-17.6%
Assets Whose Use Is Limited	81,425	8.8%	76,555	8.6%	74,799	9.1%	(1,756)	2.7%
Property and Equipment, Net	319,358	34.3%	320,250	36.1%	315,564	38.4%	(4,685)	-1.5%
Other Assets	143,971	15.5%	145,602	16.4%	147,003	17.9%	1,401	1.0%
Total Assets	929,868	100.0%	886,477	100.0%	820,715	100.0%	(65,761)	-7.4%
Liabilities and Net Assets								
Current Liabilities								
Current Portion of Long Term Debt	11,090	1.2%	11,046	1.2%	11,442	1.4%	396	3.6%
Accounts Payable, Third-Party & Accrued	235,555	25.3%	208,623	23.5%	176,065	21.5%	(32,558)	-15.6%
Total Current Liabilities	246,645	26.5%	219,669	24.8%	187,507	22.8%	(32,162)	-14.6%
Long Term Debt	236,779	25.5%	244,577	27.6%	227,913	27.8%	(16,664)	-6.8%
Deferred Inflows	98,402	10.6%	103,402	11.7%	108,402	13.2%	5,000	4.8%
Other Post Employment Benefits	399,980	43.0%	405,980	45.8%	408,980	49.8%	3,000	0.7%
Self Insurance Liabilities	97,107	10.4%	98,569	11.1%	99,062	12.1%	493	0.5%
Total Liabilities	1,078,913	116.0%	1,072,197	121.0%	1,031,864	125.7%	(40,333)	-3.8%
Net Position	(149,044)	-16.0%	(185,720)	-21.0%	(211,149)	-25.7%	(25,429)	13.7%
Total Liabilities and Net Assets	929,869	100.0%	886,477	100.0%	820,715	100.0%	(65,762)	-7.4%

Statements of Cash Flow

(Thousands)

	Audited 2019	Projected 2020	Budget 2021	Increase (Decrease)	%
Cash Flows From Operating Activities					
Excess of Revenues Over Expenses	12,948	(36,676)	(25,429)	11,247	-31%
Depreciation & Amortization	28,659	34,261	35,936	1,675	5%
(Increase) Decrease in Patient Accounts Receivable, Net	2,715	5,006	(10,943)	(15,949)	-319%
(Increase) Decrease in Current and Other Assets	(9,793)	110,045	20,089	(89,956)	-82%
Increase (Decrease) in Accounts Payable, Third-Party & Accrued	75,350	(26,932)	(32,558)	(5,626)	21%
Increase (Decrease) in Deferred In-Flows	(19,006)	5,000	5,000	-	0%
Increase (Decrease) in Self Insurance Liabilities	(6,589)	7,462	3,493	(3,969)	-53%
Net Cash Provided By (Used In) Operating Activities	84,284	98,166	(4,412)	(102,578)	-104%
Cash Flows From Investing Activities					
(Increase) Decrease in Assets Whose Use is Limited	13,673	4,870	1,756	(3,114)	-64%
Cash Flows From Financing Activities					
Additions to Property and Equipment	(83,681)	(35,153)	(31,250)	3,903	-11%
Changes in Long Term Debt	(9,456)	(7,754)	(16,268)	(8,514)	110%
Net Cash (Used In) Financing Activities	(93,137)	(42,907)	(47,518)	(4,611)	11%
Net Increase (Decrease) in Cash and Investments	4,820	75,637	(50,174)	(125,811)	-166%
Cash and Investments, Beginning	19,076	23,896	99,533	75,637	317%
Cash and Investments, Ending	23,896	99,533	49,359	(50,174)	-50%

Operating Performance Reconciliation

(Thousands)

	Increase / (Decrease)
2020 Budgeted Income from Operations	1,000
Operating Revenues	
Net Patient Service Revenue	(8,694)
Disproportionate Share, IGT and UPL	14,775
Other Operating Revenue	(34,768)
Total Operating Revenues	(28,687)
Operating Expenses	
Salaries and Benefits	(5,003)
Physician Fees and Professional Servi	6,872
Supplies	9,481
Other Expenses	(10,202)
Depreciation and Amortization	1,088
Interest	(494)
Total Operating Expenses	1,742
2021 Budgeted Loss from Operations	(29,429)

Principal Budget Assumptions

- Volume
- Patient Revenue and Reimbursement
- IGT / UPL Payments
- Other Revenues
- Staffing Costs / Vacancy Management
- Other Expenses
- Cash Flows

Volume Summary

	2019 Actual	2020 Projection	2021 Budget	Increase (Decrease) 21 - 20	%
Discharges					
Acute	13,354	12,709	13,411	702	5.5%
Other	6,642	6,169	6,590	421	6.8%
Total	19,996	18,878	20,001	1,123	5.9%
Average Length of Stay					
Acute	6.5	6.9	6.5	(0.4)	-5.8%
Other	10.2	10.4	10.2	(0.2)	-2.0%
Total	7.8	8.0	7.7	(0.3)	-3.8%
Observation Cases	3,550	2,569	2,774	205	8.0%
Outpatient Visits	305,022	288,761	303,356	14,595	5.1%
Clinics	130,097	136,258	133,609	(2,649)	-1.9%
Behavioral Health	39,719	40,701	40,516	(185)	-0.5%
Chemical Dependency	39,689	33,539	35,201	1,662	5.0%
Dialysis	27,549	27,686	31,359	3,673	13.3%
Other	67,968	50,577	62,671	12,094	23.9%
Surgical Cases					
Inpatient	6,254	5,529	6,163	634	11.5%
Outpatient	7,556	6,586	7,512	926	14.1%
Total	13,810	12,115	13,675	1,560	12.9%
Case Mix Index - Acute	1.95	1.90	1.92	0	1.1%
Emergency Visits	57,262	53,997	58,345	4,348	8.1%
CPEP Visits	12,130	11,628	12,250	622	5.3%
Terrace View ADC	379.0	377.3	378.0	0.7	0.2%

Revenue

- Payer rate increase net of 2% (before cuts)
- Acute – IP Discharges return to 2019 levels
  - Opening of 12z1 MICU and realignment of CTU
  - Expansion of 8z3 from 10 to 20 beds
  - 8 bed dedicated observation unit (old ED) with expansion to 16
- Outpatient volume slight declines from 2019 levels
- IGT – Consistent with current year assumptions
- Revenue cycle process improvements within clinical documentation, professional billing, denials and bad debt expense

IGT and UPL Revenue (Accrual Basis Revenue)

	Budget 2020	Projected 2020	Budget 2021
DSH	61,616	71,391	76,391
UPL	14,781	14,781	14,781
Total	76,397	86,172	91,172

Expenses

- Salaries
  - Decrease in FTE's to 3,462 (3,574 - YTD August) through vacancy management
  - Contracted union wage and step adjustments total an average of 3.0%
  - Non-Union wage adjustments total 2.0%
- Benefits
  - Increased health insurance, workers compensation and unemployment related costs
  - Pension expense and post-retiree health expense included at current run rate

Expenses (cont'd)

- Physician & Residents
  - Increases in anticipated contractual obligations to meet additional volume and contractual rate increases
  - Improved economics of GPPC physician practices and total cost
- Contractual Fees/Purchased Services
  - Reduction in consulting, purchased service contracts and certain sponsorships
- Supplies
  - COVID Supply cost increases – PPE, lab testing, pharmacy inflation, 90 day supply inventory
  - Inflationary increases offset by targeted savings initiatives
- Depreciation and Interest
  - Increased overall depreciation and interest costs – project completion and debt service on bonds

Cash Flow Assumptions

- Net decrease in cash of $50.1 Million
  - Net loss & Medicare Advance payback
  - 96.8 days cash reduced to 70.4 days cash
- Days in accounts receivable remaining consistent at 58.1 days
- Consistent other net working capital accounts
- Routine capital budget spend of $5.0 Million in addition to project spending of $20 Million

Performance Improvement Opportunities

- Accelerating Excellence operational improvements
- Insurance plan payer relationship & improved governance
- Continued growth strategies including continuum of care management
- Length of stay management
- Vacancy management
- Continued infrastructure planning and investment in population health strategies

Emerging Issues and Risk Areas

- Federal and NYS legislative and funding uncertainty
- COVID-19 impact uncertainty
- Inpatient volume sensitivity / insurance plan uncertainty
- Operating performance improvements
- Pension expense and contribution changes
- Management of supply chain improvements
- GASB 87 – accounting for leases
- GASB 91 – conduit debt obligations
- GASB 94 – Public-private partnerships

2021 Capital Budget Summary

- $20 Million construction projects
  - $10 Million from bond funds
  - $10 Million from internal funds
- $5.0 Million routine capital spend

5 Year Financial Projections

- Phase into a breakeven operating margin
- Reimbursement rate increases consistent with 2021 budget
- IGT/UPL at current projections
- Salary expense consistent with current collective bargaining agreements
- Benefits % of salary expense increase due to actuarial estimates
- Supply and other expense inflation consistent with current trend
- Achievement of operational improvement goals and/or reduced COVID related costs

Statements of Revenues and Expenses – Projected

(Thousands)

	Audited 2019	Projected 2020	Budget 2021	2022	2023	Projected 2024	2025	2026
Operating Revenues								
Net Patient Service Revenue	543,370	512,024	580,642	591,673	602,756	613,937	625,216	636,595
Disproportionate Share, IGT and UPL Revenue	89,802	86,172	91,172	91,172	91,172	91,172	91,172	91,172
Other Operating Revenue	117,679	39,760	16,340	16,503	16,668	16,835	17,003	17,174
Total Operating Revenues	750,851	637,956	688,154	699,349	710,597	721,944	733,391	744,941
Operating Expenses								
Salaries and Benefits	365,993	386,480	379,994	391,164	401,661	412,439	423,506	434,870
Physician Fees and Professional Services	162,211	164,912	161,748	164,799	167,917	171,103	174,358	177,684
Supplies	97,065	94,794	98,949	100,787	102,647	104,533	106,446	108,386
Other Expenses	89,474	39,282	30,145	31,363	32,630	33,948	35,320	36,747
Depreciation and Amortization	28,659	34,261	35,936	33,060	31,263	31,858	33,592	35,720
Interest	7,135	11,058	10,811	10,164	9,535	8,883	8,516	7,900
Total Operating Expenses	750,537	730,787	717,583	731,337	745,653	762,764	781,738	801,306
	314	(92,831)	(29,429)	(31,989)	(35,056)	(40,820)	(48,347)	(56,365)
Performance Improvement Initiatives	-	-	-	32,289	35,406	41,220	48,797	56,865
Income/(Loss) from Operations	314	(92,831)	(29,429)	300	350	400	450	500
CARES Act Funding Relief	-	52,157	-	-	-	-	-	-
Income/(Loss) from Operations with CARES Act Relief	314	(40,674)	(29,429)	300	350	400	450	500
Non Operating Revenues & Capital Contributions	12,634	3,998	4,000	1,862	1,853	1,812	1,816	1,816
Excess of Revenues Over Expenses	12,948	(36,676)	(25,429)	2,162	2,203	2,212	2,266	2,316

Statements of Financial Position – Projected

(Thousands)

	Audited 2019	Projected 2020	Budget 2021	2022	2023	Projected 2024	2025	2026
ASSETS								
Current Assets								
Cash & Investments	23,896	99,533	49,359	50,872	50,422	50,625	50,856	51,439
Patient Accounts Receivable	86,572	81,566	92,509	92,632	90,970	89,667	91,320	92,973
Other Current Assets	274,646	162,971	141,481	131,167	133,456	135,495	96,787	100,998
Total Current Assets	385,114	344,070	283,350	274,671	274,848	275,788	238,963	245,410
Assets Whose Use Is Limited	81,425	76,555	74,799	72,646	70,399	70,411	70,207	70,087
Property and Equipment	319,358	320,250	315,564	305,504	299,241	292,384	283,791	273,072
Other Assets	143,971	145,602	147,003	150,452	154,073	158,169	162,340	166,890
Total Assets	929,869	886,477	820,715	803,273	798,561	796,751	755,301	755,458
LIABILITIES AND NET ASSETS								
Current Liabilities								
Current Portion of Long Term Debt	11,090	11,046	11,442	11,860	12,290	12,735	13,197	13,675
Accounts Payable, Third-Party & Accrued	235,555	208,623	176,065	164,743	165,832	167,757	129,766	131,797
Total Current Liabilities	246,645	219,669	187,507	176,603	178,122	180,492	142,963	145,472
Long Term Debt	236,779	244,577	227,913	210,718	193,786	178,894	164,205	151,032
Deferred Inflows	98,402	103,402	108,402	113,402	118,402	123,402	128,402	133,402
Other Post Employment Benefits	399,980	405,980	408,980	411,980	414,980	417,980	420,980	423,980
Self Insurance Reserves	97,107	98,569	99,062	99,557	100,055	100,555	101,058	101,563
Total Liabilities	1,078,913	1,072,197	1,031,864	1,012,260	1,005,345	1,001,323	957,608	955,449
Net Position	(149,044)	(185,720)	(211,149)	(208,987)	(206,784)	(204,572)	(202,306)	(199,990)
Total Liabilities and Net Assets	929,869	886,477	820,715	803,273	798,561	796,751	755,301	755,458

Statements of Cash Flow - Projected

(Thousands)

	Audited 2019	Projected 2020	Budget 2021	2022	2023	Projected 2024	2025	2026
Cash Flows From Operating Activities								
Excess of Revenues Over Expenses	12,948	(36,676)	(25,429)	2,162	2,203	2,212	2,266	2,316
Depreciation & Amortization	28,659	34,261	35,936	33,060	31,263	31,858	33,592	35,720
(Increase) Decrease in Patient Accounts Receivable, Net	2,715	5,006	(10,943)	(123)	1,662	1,303	(1,653)	(1,653)
(Increase) Decrease in Current and Other Assets	(9,793)	110,045	20,089	6,865	(5,910)	(6,135)	34,537	(8,760)
Increase (Decrease) in Accounts Payable, Third-Pary & Accrued	75,350	(26,932)	(32,558)	(11,323)	1,089	1,924	(37,991)	2,031
Increase (Decrease) in Deferred In Flows	(19,006)	5,000	5,000	5,000	5,000	5,000	5,000	5,000
Increase (Decrease) in Self Insurance Liabilities	(6,589)	7,462	3,493	3,495	3,498	3,500	3,503	3,505
Net Cash Provided By (Used In) Operating Activities	84,284	98,166	(4,412)	39,137	38,805	39,662	39,254	38,158
Cash Flows From Investing Activities	13,673	4,870	1,756	2,153	2,247	(12)	204	120
Cash Flows From Financing Activities								
Additions to Property and Equipment	(83,681)	(35,153)	(31,250)	(23,000)	(25,000)	(25,000)	(25,000)	(25,000)
Changes in Long Term Debt	(9,456)	7,754	(16,268)	(16,777)	(16,502)	(14,447)	(14,227)	(12,695)
Net Cash (Used In) Financing Activities	(93,137)	(27,399)	(47,518)	(39,777)	(41,502)	(39,447)	(39,227)	(37,695)
Net Increase (Decrease) in Cash and Investments	4,820	75,637	(50,174)	1,513	(450)	203	231	583
Cash and Investments, Beginning	19,076	23,896	99,533	49,359	50,872	50,422	50,625	50,856
Cash and Investments, Ending	23,896	99,533	49,359	50,872	50,422	50,625	50,856	51,439

Outstanding Bonds and Notes

Erie County Guaranteed Senior Revenue Bonds, Series 2004

No bonds were issued, called, or re-financed during 2020.

$3,545,000 of bonds matured or were redeemed in 2020.

$68,820,000 of 2004 bonds remain outstanding at December 31, 2020.

Erie County Loan Payable-2017 (Refinance)

During 2017, the Corporation refinanced its 2011 Loan with a $74,366,859 loan from the County of Erie.

$3,842,300 in principal payments were made in 2020.

$61,232,797 of debt is outstanding at December 31, 2020.

Erie County Loan Payable-2017 (New Money)

During 2017, the Corporation entered into a $99,492,034 loan with the County of Erie.

$1,913,771 in principal payments were made in 2020.

$95,516,516 of debt is outstanding at December 31, 2020.

Erie County Capitalized Interest Assumption Obligation-2017

During 2017, the Corporation entered into an $8,281,141 capitalized interest assumption obligation with the County of Erie.

$159,291 in principal payments were made in 2020.

$7,950,242 of debt is outstanding at December 31, 2020.

Key Government Finance Master Tax Exempt Lease/Purchase Agreement

During 2015, the Corporation entered into a $10,000,000 capital lease obligation

$1,155,247 in principal payments were made in 2020.

$0 of debt is outstanding at December 31, 2020.

Metz Culinary Management Food Service Improvements Loan

During 2019, the Corporation entered into a $1,805,430 loan with Metz Culinary Management

$180,540 in principal payments were made in 2020.

$1,489,486 of debt is outstanding at December 31, 2020.

Paycheck Protection Program Loan

During 2020, the Corporation entered into a Paycheck Protection Program Loan in the amount of $10,000,000

$0 in principal payments were made in 2020.

$10,000,000 of debt is outstanding at December 31, 2020.

APPENDIX B
COMPENSATION SCHEDULE

Name	Job Title	2020 Gross Earnings	Annual Salary
Abafita, Aziza	General Duty Nurse	103,259	87,899
Abbott, Patricia	General Duty Nurse	103,001	85,336
Addison, Jessica	General Duty Nurse	130,475	87,899
Aiad, Jean	Dentist ECMC RPT	104,267	104,267
Alexander, David	General Duty Nurse	105,001	73,597
Anders, Mark	Medical Specialist	171,221	171,221
Anderson, Jennifer	General Duty Nurse	115,268	87,899
Annas, Jennifer	General Duty Nurse	115,015	80,432
Aquilina, Marina	General Duty Nurse	102,610	75,791
Aquilina, Therese	Unit Manager Ambulatory Care	117,331	112,773
Arcadi, Kristine Anne	Unit Manager Medical Surgical	119,021	112,773
Arnold, William	Nursing Informatics Mgr.	123,289	121,861
Artieri, Diane	Vice President of Materials Management	154,177	156,062
Asare, Martin	General Duty Nurse	120,259	70,321
Austin, Cheryl	Director of Imaging Services	120,569	120,598
Baetzhold-Fabiniak, Karen	Physician Assistant	122,973	133,297
Bailey, Steven	Nursing Team Leader LTC	122,885	99,638
Baker, Shawn	General Duty Nurse	112,458	85,336
Ballard, Katrina	Charge Nurse	100,192	87,129
Barr, Tamara	General Duty Nurse	101,120	75,791
Basher, William	Nursing Team Leader Dialysis Services	102,153	96,730
Bass, Cynthia	Director of Diversity and Inclusion	93,928	108,212

Bass, Edmond	Nursing Informatics Mgr.	110,160	111,519
Bastian, Michele	General Duty Nurse	102,695	87,899
Batson, John	Charge Nurse	101,704	87,129
Bauer, Christine	Charge Nurse	116,279	82,116
Beauchamp, Sandra	Nurse Case Manager	26,496	109,487
Becker, Melissa	Unit Manager Operating Room	119,361	103,199
Becker, Paula	Pharmacist ECMC	128,511	128,097
Beckman-Pilcher, Karen	Clinical Nurse Specialist Emergency Svcs	146,890	133,428
Bell, Shentelle	Director of Nursing Services Ambulatory	114,953	115,000
Berkmans, Pier	General Duty Nurse	100,157	70,321
Bernier, Deborah	Operations Manager LTC	106,690	102,789
Bethea, Marquita	Director of Admissions LTC	117,374	111,925
Bieber, Jolene	General Duty Nurse	103,179	78,098
Bielicki, Kim	Registered Nurse Trauma Registrar	104,262	102,600
Biersbach, Bret	Anesthesiologist	306,471	437,500
Bigelow, Katy	General Duty Nurse	100,297	85,336
Biondolillo, Rhonda	Nursing Team Leader	112,261	102,600
Bish, Brian	Anesthetist	69,473	205,000
Blair, Lindsey	Nursing Team Leader	106,899	102,600
Blecha, Kortney	Charge Nurse	134,651	95,220
Boersch, Martin	General Duty Nurse	106,320	71,972
Boice, Allison	Nurse Case Manager	108,324	106,303
Borton, Angela	Pharmacist ECMC	122,969	119,687

Boustany, Christopher	Anesthesiologist	349,654	325,000
Bowen, Taylor	Charge Nurse	110,649	77,954
Boyer, Maria	Charge Nurse	110,701	87,129
Boyer, Nikita	General Duty Nurse	103,211	78,098
Bozich, Danielle	Director of Recruitment and Training	106,762	108,212
Brandon, Brianna	General Duty Nurse	102,678	71,972
Bratcher, Kerri	Charge Nurse	101,452	82,116
Brennan, Melinda	Unit Manager Medical Surgical	100,926	100,192
Brennan, Stephanie	Pharmacist ECMC	120,771	119,687
Brindisi, Joseph	Nurse Practitioner ECMC	110,240	111,748
Brinker, Debra	Charge Nurse	109,958	95,220
Brinkworth, Jennifer	Charge Nurse	123,048	95,220
Broeneman, Kourtney	Nurse Case Manager	111,177	109,497
Brooks, Latoya	Unit Manager Medical Surgical	111,607	112,773
Brown, Dana	Anesthetist	229,252	205,000
Brown, Donna	Associate Hospital Administrator	126,023	126,090
Brown, Jillian	VP of Behavioral Health Services	150,273	150,000
Brown, Lisa	CONSULTANT IV PD	100,291	100,291
Brundin Jr, Douglas	Anesthetist	209,826	205,000
Bruno, Karen	Senior Magnetic Resonance Image Tech	118,422	78,152
Buchanan, Amber	Clinical Laboratory Technologist	101,503	67,843
Buckley, Peter	Nursing Team Leader LTC	103,472	85,933
Budu, James	General Duty Nurse	100,769	71,972

Bufalino, Rosalia	General Duty Nurse	105,746	87,899
Bulinski, Alexis	Charge Nurse	106,127	82,116
Buono, Deanne	General Duty Nurse	104,153	87,899
Burgio, Susan	Clinical Laboratory Quality Coordinator	129,417	98,238
Burke, Mark	Attending Physician	667,195	655,636
Burnett, Julie	Charge Nurse	113,177	92,431
Burridge, Suzanne	Pharmacist ECMC	129,710	128,097
Burt, Mary	Nursing Team Leader	136,347	102,600
Buttaccio, Rebecca	Physician Assistant	100,230	104,424
Bystrak, Cathy	Nursing Team Leader LTC	145,743	102,600
Canallatos, Paul	Dentist ECMC	177,449	180,353
Cantie, Shawn	Anesthesiologist	557,318	465,000
Capozzi, Nicole	General Duty Nurse	101,830	87,899
Carl, Karen	Nursing Team Leader	114,444	102,600
Carlo, Joseph	Hospital Public Safety Officer	104,038	65,225
Carnevale, Marinela	General Duty Nurse	109,085	82,857
Carpenter, Cheryl	Director of Medical Dental Staff Svcs	111,426	112,199
Carroll, Jennifer	Behavioral Health Clinical Manager	109,046	109,408
Caruana, Joseph	Attending Physician PT	111,635	111,635
Cavaretta, Mark	Attending Physician	277,503	347,782
Cavo, Paul	Clinical Systems Analyst	109,063	89,538
Cheng, Yi Shun	Attending Physician	28,269	245,000
Cherkis, Jennifer	Transplant Coordinator	34,016	109,487

Chilbert, Kevin	Pharmacist ECMC	120,945	119,687
Chizuk, Steven	Director of Budget ECMCC	142,724	142,800
Ciancone, Gabriella	Infection Prevention Practitioner	105,686	102,600
Cieri, Margaret	Nursing Care Coordinator	148,194	121,861
Cirillo, Joseph	Director of Public Relations Communic.	115,332	119,569
Ciurczak, Tiffany	Charge Nurse	122,326	95,220
Clark, Cynthia	Nurse Case Manager	125,602	112,773
Clark, Sarah	Nurse Navigator Plast & Rec Surgery	101,276	103,199
Cloud, Samuel	Attending Physician	341,404	355,350
Colebeck, Amanda	Dentist ECMC	254,471	257,500
Collichio, Alexander	Director of Labor & Employee Relations	128,626	136,579
Collins, Chiqkena	General Duty Nurse	104,352	82,857
Colomaio, Rosemarie	Nurse Case Manager	121,288	112,773
Colucci, Anthony	Consultant IV	562,154	562,154
Comstock, Scott	Charge Nurse	112,934	95,220
Coniglio, Julia	Anesthetist	205,733	205,000
Cozzemera, John	Nursing Team Leader	101,161	96,730
Cretacci, Nicole	Unit Manager Medical Surgical	116,715	112,773
Crowe, Ruth	Nursing Team Leader LTC	126,177	102,600
Cumbo, John	Director of Technical Services	178,425	162,639
Current, Susan	Physical Therapist	134,471	81,892
Currin, Shawntres	Unit Manager Medical Surgical	98,942	103,199
Cutler, Peter	VP of Communications & External Affairs	215,260	215,374

Czajka, Valerie	Nursing Supervisor LTC	14,062	112,773
Czora, Andrea	Assistant Director Nursing LTC	39,009	100,000
Dalton, Wendy	Nursing Team Leader LTC	108,268	91,175
Daoust, Jeffrey	Physician Assistant	116,109	120,819
Davis, Andrew	Chief Operating Officer ECMC	577,525	577,830
Davis, Cassandra	VP of Ambulatory Svs & Population Health	176,857	173,349
Davis, Howard	Anesthesiologist	283,713	468,096
Davis, Karen	General Duty Nurse	109,351	82,857
Davis, Shelly	Nurse Case Manager	113,233	112,773
DeFilippo, Jenna	General Duty Nurse	101,778	82,857
Deguire, Janelle	General Duty Nurse	106,488	80,432
DeLaPlante, Suzanne	Clinical Perfusionist	110,349	96,851
DelGuidice, Natalie	Clinical Pharmacy Specialist	133,336	133,430
DelPrince, Becky	VP of Systems and Integrated Care	170,561	177,468
DelVecchio, Regina	Staff Counsel ECMC	177,373	177,468
Denisco, Dawn	Anesthetist	217,118	205,000
Denny, Patricia	Director of Dialysis Operations	56,604	108,212
DePinto, Anthony	Administrator LTC	86,097	158,445
DePlato, Anthony	Anesthesiologist	524,196	531,802
Derenda, Nicole	Director of Nursing Education Med/Surg	121,956	126,073
DeSantis-Evans, Leigh	Charge Nurse	101,618	92,431
Diaw, Vanessa	Charge Nurse	104,405	89,752
Diina, David	Nurse Practitioner Transplant	226,729	129,557

Dipirro, Michele	Nursing Team Leader LTC	132,419	102,600
Dishunts, Olga	Nursing In-service Instructor ECMC	115,268	96,730
Dobson, Judy	VP Medical Surgical Nursing Services	191,355	172,203
Doherty, Danielle	Anesthetist	98,018	190,000
Dolansky, Evan	Pharmacist ECMC	132,542	128,097
Donovan, Kevin	Charge Nurse	104,036	89,752
Draper, Cristina	General Duty Nurse	101,493	87,899
Drozdowski, Michael	Director of Capital Projects	136,301	141,831
Drysdale, Michelle	Nursing Supervisor LTC RPT	110,911	110,911
Duell, Susan	Minimum Data Set Director	107,084	100,192
Duffin, Joy	Transplant Coordinator	169,846	109,497
Duffy, Brian	Anesthesiologist	413,626	383,800
Durant, Jason	Systems Administrator	120,080	96,851
Dvinova, Larisa	Charge Nurse	134,929	95,220
Dycha, Brandon	General Duty Nurse	106,270	75,791
Dycha, David	General Duty Nurse	121,687	70,321
Dytschkowskyj, Sheila	Nursing Team Leader LTC	127,246	93,910
Eckert, Patricia	Senior Ultra sonographer	133,661	84,644
Egan, Carol	Charge Nurse	107,064	95,220
Eiss, Megan	Director of Biomedical Services	112,896	113,730
Eleey, Lynnette	Charge Nurse	121,784	95,220
Embden, Richard	Management Systems Consultant	271,624	250,000
Englert, Amanda	Nurse Practitioner Rehab Services	149,151	118,554

Erhardt, Robert	Chief Hospital Public Safety Officer	174,951	106,032
Ervolina, Daryl	Senior Pharmacist ECMC	143,463	142,657
Everett, Charles	Anesthesiologist	235,105	468,096
Exposito Vazquez, Manuel	Certified Nursing Assistant RPT	106,415	106,415
Fallis, Susan	VP of Behavioral Health Services	47,724	154,500
Fanning, Rozalyn	Charge Nurse	112,104	87,129
Farkas, Tina	General Duty Nurse	112,218	75,791
Feidt, Leslie	Chief Information Officer ECMC	196,261	220,900
Fenner, Nicholas	Pharmacist ECMC	125,133	119,687
Ferguson, Richard	Director of Neurology RPT	403,462	403,462
Fetzer, Melanie	General Duty Nurse	129,073	82,857
Flaherty, Amy	Staff Counsel - Risk Management	129,234	134,476
Flett, Deborah	Nursing Team Leader LTC	114,235	102,600
Flynn, William	Director of Surgery	173,302	169,703
Forgensi, Stacey	Anesthetist	212,896	205,000
Foster, Amanda	Director of Respiratory Therapy Services	102,795	105,668
Foster, Antoinette	General Duty Nurse	100,404	70,321
Fowler, Julia	Charge Nurse	109,738	89,752
Fox, Heather	Nurse Case Mgr AIDS Services	114,626	112,773
Fretthold, Christine	Ultra-Sonographer	103,269	72,053
Frey, Jordan	Attending Physician	230,101	470,000
Frustino, Jennifer	Dentist ECMC	212,568	215,893
Fryling, Kathleen	Transplant Coordinator	148,833	112,773

Furlani, Lisa	Anesthetist	208,455	205,000
Furnari, Graziella	Clinical Pharmacy Specialist	130,344	130,360
Gallagher, Heather	Director of Comp, Benefits, & HRIS	112,228	107,099
Gallineau, Anne-Marie	Nursing Care Coordinator	142,019	121,861
Gary, Stephen	Consultant IV	410,119	410,119
Gatti, Donna	Director of CPEP	112,467	117,031
Gerretsen, Carly	Director of Outpatient Opers & Oncology	146,397	152,337
Gian, Kathleen	General Duty Nurse	149,805	87,899
Gibbens, Robert	General Duty Nurse	174,965	73,597
Giglia, Joseph	General Counsel	453,991	459,000
Giordano, Donald	Clinical Resource Nurse Emergency Services	117,275	95,220
Gompah, Santosha	Unit Manager Medical Surgical	112,597	109,497
Gonzalez, Susan	Executive Director ECMC Lifeline Foundation	190,894	183,855
Gorczynski II, Thomas	Information Technology Systems Architect	131,962	129,540
Gozdalski, Nicole	Charge Nurse	115,765	95,220
Grabski, Meghan	General Duty Nurse	117,160	75,791
Gray, Linda	Assistant Vice President BH Nursing	33,734	133,900
Greco, Timothy	General Duty Nurse RPT	113,669	113,669
Green, Karen	Nursing Supervisor LTC	64,051	109,487
Gregorio, Tara	Unit Manager Medical Surgical	106,194	106,303
Grenier, Shannon	General Duty Nurse	105,766	80,432
Griffin, Susan	Physical Therapist	128,014	81,892
Grolemund, Stephanie	Anesthetist	222,738	205,000

Grzebinski, Jane	Pharmacist ECMC	139,286	130,903
Grzybowski, Helen	In-service Education Coordinator	123,693	112,773
Guinnane, Sean	Charge Nurse	101,866	82,116
Habonimana, Colette	Charge Nurse	115,668	95,220
Haines, Tracey	General Duty Nurse	106,230	80,432
Halladay, Nicholas	Charge Nurse	113,118	87,129
Halloran, Ashley	Director of Pharmacy	158,798	165,239
Hamilton, Catherine	Director of Patient Financial Services	54,138	117,300
Handley, Sarah	Pharmacist ECMC	120,332	119,687
Hanna, Jennifer	Charge Nurse	104,211	87,129
Harrington, Crystal	Charge Nurse	109,792	92,431
Harris, Rachel	Nurse Practitioner Plastic Recon Surgery	118,367	109,210
Hartman, Nancy	Registered Nurse Trauma Registrar	101,718	102,600
Hartman, Sandra	Nursing Care Coordinator	148,629	121,861
Haseley, Nicole	Transplant Coordinator	150,459	106,303
Hauss, Lisa Marie	Nurse Case Manager	116,527	112,773
Havers, Amy	Charge Nurse	101,588	87,129
Hayes, Dale	Anesthetist	181,312	205,000
Hayes, Ellyn	General Duty Nurse RPT	100,712	100,712
Hayes, Renee	General Duty Nurse	147,598	80,432
Heigl, Deborah	Nurse Case Manager	111,548	112,773
Heimbueger, Robert	General Duty Nurse	101,934	71,972
Hepburn, Jeremy	Nursing Care Coordinator	141,191	121,861

Hidalgo, Francisco	Code Compliance Manager	113,947	108,324
Hill, Tara	Charge Nurse	175,409	95,220
Hinderliter, Vanessa	Director of Finance ECMC	138,880	142,800
Hines, Holly	Nurse Case Manager	114,146	112,773
Hodgson, Matthew	Nurse Practitioner Plastic Recon Surgery	125,226	125,767
Hoerner, Audrey	Senior Nurse Practitioner - Burn Unit	153,079	149,384
Holcomb, Megan	Unit Manager Medical Surgical	109,062	106,303
Holcomb, Steven	Charge Nurse	100,014	84,596
Honkomp, Cheryl	General Duty Nurse	107,423	87,899
Horne, Shawndre	Senior Clinical Laboratory Technologist	100,943	83,358
Hovak, Melissa	Nurse Practitioner Transplant	166,450	133,428
Hudson, Jeremiah	Charge Nurse	111,189	82,116
Hughes, Christopher	Attending Physician	598,362	561,000
Hughes, Robert	Nurse Case Manager	116,019	112,773
Hunley, Kizzie	Nursing Care Coordinator	131,335	114,880
Hunt, Benjamin	Nursing Team Leader	103,514	96,730
Hunter, Thameena	Nursing Care Coordinator RPT	117,379	117,379
Hyjek, Maria	Nursing Care Coordinator RPT	112,790	112,790
Iancu, Adriana	Charge Nurse	106,069	87,129
Iheke, Patience	General Duty Nurse	122,219	78,098
Ireland, Shari	Charge Nurse	102,008	92,431
Isler, Bonnie	Charge Nurse	100,316	95,220
Jack, Jennifer	Charge Nurse	107,777	89,752

Jager, Jonathan	Pharmacist ECMC	130,343	119,687
Jamison, Shannon	Charge Nurse	102,184	92,431
Janetzke, David	General Duty Nurse	127,731	78,098
Jax, James	Senior Nuclear Medicine Technologist	122,499	80,515
Jensen, Erik	Anesthesiologist	519,697	477,458
Johnson, Marie	Vice President of Rehab Services	148,995	155,039
Johnson, Maureen	General Duty Nurse	124,834	85,336
Jones, Donna	Quality Officer	210,009	210,120
Jones, Veronica	General Duty Nurse	101,055	85,336
Jonmaire, Kenneth	Senior Director Outpatient Operations	124,356	120,819
Jubert, John	Special Procedures Tech Angiographer	114,618	70,880
Juncewicz, Edmund	Anesthesiologist	444,093	403,400
Kabayiza, Thamar	General Duty Nurse	102,568	87,899
Kaid, Rafiq	Charge Nurse	100,990	84,596
Kalinka, Lisa	Nurse Practitioner Transplant	192,958	122,117
Kane, Justin	General Duty Nurse	110,997	87,899
Kapral, Elizabeth	Dentist ECMC	191,697	185,657
Kariman, Douglas	General Duty Nurse	106,256	80,432
Karl, Stephanie	Nurse Case Manager	100,638	103,199
Katilus, Alan	General Duty Nurse	101,869	82,857
Kaun, Andrew	Senior Hospital Public Safety Officer	117,037	78,551
Kaur, Kanwarbir	Nurse Case Manager	100,230	97,273
Kaurich, Justine	Vice President of Operations	188,601	188,700

Kayler, Liise	Attending Physician RPT	164,025	164,025
Keenan-Uschold, Lisa	Chief Clinical Psychologist	122,298	122,502
Kelsch, Kathleen	Comp Tomography (CT) Tech	102,110	72,946
Kemp, Amanda	Charge Nurse	115,744	82,116
Ketter-Franklin, Krystal	Charge Nurse	109,812	92,431
Kiblin, Patricia	Unit Manager Medical Surgical	116,628	112,773
Kiel, Alyssa	Pharmacist ECMC	58,633	119,687
Killion, Valerie	Assistant Director Nursing Sub Acute	105,788	100,312
Kimori, Everesto	General Duty Nurse	117,477	82,857
Kinkade, Phillip	General Duty Nurse	108,058	87,899
Kinney, Elizabeth	Charge Nurse	104,685	95,220
Kirsch, Heidi	Assistant VP of Critical Care & Emergency	119,164	137,700
Kline, Timothy	Unit Manager Critical Care	114,155	112,773
Knihinicki, Crystal	General Duty Nurse	101,007	80,432
Knox, Nicole	Director of Transplantation	111,233	111,459
Koch, Elizabeth	Anesthesiologist	270,766	425,000
Kocz, Remek	Anesthesiologist	433,692	397,000
Kolbert, Cynthia	Charge Nurse	115,866	95,220
Konikoff, Karen	VP Critical Care & Emergency Services	178,463	168,270
Kordasiewicz, Lynn	Nurse Practitioner Wound Care	137,729	133,428
Korff, Kathryn	Dentist ECMC	225,617	184,410
Koszuta, Ceilia	Nurse Case Manager	114,377	112,773
Kraus, Michelle	Administrator LTC	31,096	165,000

Krawczyk, Heather	Charge Nurse	101,922	84,596
Kuechle, Claire	Staff Counsel ECMC	156,494	162,843
Kurek, Alecia	Unit Manager Medical Surgical	108,914	109,497
Kuzma-Trigilio, Jacqueline	Occupational Therapist	120,646	81,892
Kwiatkowski, Andrew	Director of Project Management HIT	156,264	147,083
Labelle, Marc	VP Surgical Services	162,232	162,317
LaMacchia, Brandy	Nurse Case Manager	107,896	103,199
Lariviere, Michele	General Duty Nurse	105,970	87,899
Lauer, Sandra	Director of Continuum Care	119,995	124,030
Laurich, Theresa	Charge Nurse	5,930	106,298
Lauter, Lori	Assistant Head Nurse	105,270	95,220
Lavarnway, Nicole	Nursing Supervisor LTC	127,987	112,773
Lawley, Melinda	Unit Manager Critical Care	123,156	112,773
Leas, Adam	Emergency Department Patient Flow TL	123,467	96,730
Leas, Christie	Unit Manager Critical Care	101,869	100,192
Lee, Pamela	Senior VP of Operations ECMC	294,013	294,168
Leitten, Deborah	General Duty Nurse	104,501	87,899
Lenhard, Eric	Pharmacist ECMC	125,955	122,502
Lewis, Jennifer	Charge Nurse	102,486	79,751
Leyh, Virginia	Transplant Coordinator	139,706	112,773
Lilic, Dijana	General Duty Nurse	109,740	85,336
Lorden, Bernard	Network Analyst	109,893	91,603
Loree, Thom	Attending Physician	867,310	852,327

Lowitzer, Heidi	General Duty Nurse	101,548	78,098
Lucas, Paul	General Duty Nurse	101,186	87,899
Ludlow, Charlene	VP of Safety & Security	315,013	315,180
Lukasik, Keith	Chief Strategy Officer	257,459	262,650
MacTurk, Nancy	General Duty Nurse	105,063	87,899
Madoo, Kevin	Director of Plant Operations	115,506	115,567
Madore, Donat	General Duty Nurse	101,019	85,336
Maggio, Sarah	Director of Nursing Education Behavioral	122,279	113,622
Makson, Theresa	Manager - Care Management	96,505	113,622
Malek, Theresa	General Duty Nurse	100,390	80,432
Maloney, Jennifer	Charge Nurse	101,164	95,220
Malovich, Jeanne	In-service Education Coordinator	121,813	112,773
Maltby, Michelle	General Duty Nurse	114,377	82,857
Manning, Jeremy	Charge Nurse	120,901	87,129
Marasco, Marjorie	Nurse Case Manager	97,507	103,199
Marczak, Juliet	Nurse Practitioner ECMC	127,038	125,767
Marella, Melissa	Ultra-Sonographer	121,983	78,728
Markiewicz, Anthony	VP Clinical Business Intelligence and In	177,996	174,487
Marso, Lisa	Anesthetist	204,937	205,000
Martin, Janet	VP of Finance ECMC	196,046	204,000
Martina, Kristin	Charge Nurse	101,120	84,596
Massaker, Andrea	General Duty Nurse	104,631	85,336
Masters, Raymond	Anesthetist	195,459	190,000

Mattina, Adrianne	General Duty Nurse	104,780	87,899
Matyjasik, Robin	General Duty Nurse	102,051	78,098
Mazur, Christopher	Senior Pharmacist ECMC	155,091	133,430
McAndrews, Lisa	Charge Nurse	111,436	95,220
McCarthy, Kevin	Senior Clinical Laboratory Technologist	101,463	83,358
McCloud, Arletha	Charge Nurse	108,788	95,220
Mcdougall, Sarah	Pharmacist ECMC	120,822	119,687
McDuffie, Ann	Nursing Team Leader Orthopedics	105,512	102,600
McGuigan, Jessica	Unit Manager Medical Surgical	113,650	112,773
McKeever, Ashley	Anesthetist	197,117	190,000
McLean, Terrence	Dentist ECMC	420,436	420,700
McRae, Elizabeth	Charge Nurse	121,753	95,220
Menter, Danielle	Charge Nurse	120,083	89,752
Metzler, Ashley	Charge Nurse	110,705	95,220
Meyers, Shannon	Anesthetist	218,277	205,000
Meyers, Tracy	Charge Nurse	107,332	95,220
Miano, Joanne	Nurse Case Manager	113,282	112,773
Milbrand, Alison	Pharmacist ECMC	120,141	119,687
Miller, Kelly	General Duty Nurse	106,444	80,432
Minhas, Parveen	Nurse Practitioner Transplant	205,979	125,767
Mitchell, Alexandria	Charge Nurse	102,445	92,431
Mitchell, Shawn	General Duty Nurse	150,564	87,899
Mogavero, Joseph	Healthcare Business System Manager	114,403	114,477

Montague, Victoria	Unit Manager Transplant	104,994	100,192
Mooney, Michelle	Nurse Case Manager	110,455	109,497
Moore-Haley, Maureen	General Duty Nurse	101,596	87,899
Morrissey, Colin	Anesthetist	194,692	190,000
Moses, Beth	Trauma Injury Prevention & Education Coo	105,879	102,600
Mothena, Casey	General Duty Nurse	119,574	70,321
Mullen, Meghan	Nursing Team Leader	103,795	99,638
Mund, Nadine	Director of Corporate Compliance	143,588	156,042
Murawski, Phyllis	VP Transplantation & Renal Care	183,805	191,262
Murphy, Holly	Pharmacist ECMC	119,648	119,687
Murray, Brian	Medical Director ECMC	519,772	520,048
Muscarella, Mary	General Duty Nurse RPT	101,727	101,727
Musielak, Pia	Director of Outpatient Opers Surg Care	139,660	128,232
Myers, Starr	Charge Nurse Ambulatory Care	105,352	109,487
Nagai, Michael	Attending Physician	493,926	465,000
Napierala, Randal	Pharmacist ECMC	120,056	119,687
Nasca, Maureen	Chief of Service Dentistry	430,119	430,456
Nawojski, Kari	General Duty Nurse	143,579	82,857
Nazzarett, Jody	Nursing Team Leader	103,977	102,600
Ndow, Awa	General Duty Nurse	105,900	78,098
Neff, Melissa	Unit Manager Cardiac Cath Lab	184,233	112,773
Nelson, Deirdre	Senior Clinical Laboratory Technologist	102,804	88,460
Nesbitt, David	Staff Counsel (DSRIP)	147,033	162,843

Newell, William	Charge Nurse	102,808	82,116
Nice, Kimberly	Anesthetist RPT	149,862	149,862
Nicosia, Cheryl	Clinical Nurse Specialist Critical Care	135,237	133,428
Norcia, Deborah	Pharmacist ECMC RPT	101,234	101,234
Nowak, Lisa	Nursing Team Leader LTC	110,771	91,175
Nowotarski, Donna	Clinical Laboratory Technologist	112,345	82,645
Nuttle, Thomas	Vice President Managed Care	76,509	150,000
Nye, Maria	Charge Nurse	108,116	92,431
Occhino, Erin	Clinical Pharmacy Specialist	130,790	130,360
Oddo, Donna	Nursing Care Coordinator Emergency Dept	161,790	121,861
Ordon, Cheryl	Nurse Case Manager	115,722	112,773
Osinski, Krystal	General Duty Nurse	105,890	73,597
Ott, Michael	Clinical Coord Pharmacy Services	136,412	133,430
Ozanne, Lindsey	Director of Employee Health and Safety	82,325	114,736
Pagano, Christina	Physician Assistant	110,530	110,589
Paladino, Matthew	Anesthesiologist	488,308	450,000
Palermo, Loretta	Emergency Department Patient Flow TL	138,645	102,600
Panesar, Mandip	Chief Medical Information Officer	425,404	430,534
Paolini, Karen	Nurse Practitioner Transplant	201,413	133,428
Park-Brooks, Jessica	General Duty Nurse	104,655	85,336
Parker, Adam	Pharmacist ECMC	120,773	119,687
Parker, Michael	Psychiatric Social Worker	110,356	68,218
Parks, Mary	Charge Nurse	112,376	89,752

Parmenter, Tonya	Charge Nurse	115,817	92,431
Patterson, Sandra	General Duty Nurse	105,618	87,899
Pawenski, Edward	Director of Oncology Dentistry and Prost	52,124	126,000
Peals, Letrice	Charge Nurse	113,638	92,431
Pecoraro, Cindy	Nursing Team Leader	104,053	102,600
Pellicane, Stephen	General Duty Nurse	119,935	85,336
Perkins, Melissa	Unit Manager Medical Surgical	114,279	109,497
Perno, Amy	Physician Assistant	99,984	104,040
Perrino, Adam	Assistant Director of Capital Projects	116,181	106,833
Pesta, Joslyn	Pharmacist ECMC	121,218	119,687
Petry, Christina	Nursing Team Leader Ostomy WC	102,767	102,600
Phillips, Kristen	Anesthetist	94,025	190,000
Picciano, Cathleen	Lead Clinical Documentation Specialist	102,089	102,600
Picciano, Thomas	Manager - Care Management	116,251	120,000
Pierce, Erin	General Duty Nurse	103,719	87,899
Pilat, Cynthia	Charge Nurse	131,569	95,220
Pinti, Maria	Infection Prevention Practitioner	103,333	99,638
Piscatelli, Nicole	Dentist ECMC PT	120,481	120,481
Pittman, Courtney	Director of Patient Access Services	86,308	112,199
Pitz, Anita	Charge Nurse	108,726	92,431
Pollock, Michael	Info Technology Operations Manager	120,760	114,477
Poodry, Abby	Charge Nurse	102,257	92,431
Popat, Saurin	Attending Physician PT	432,068	432,068

Powers, Paul	Information Systems Analyst	105,980	89,538
Pressley III, Charles	Staff Counsel ECMC	95,691	124,000
Price, Donna	Nurse Case Manager	34,888	109,487
Prybylski, Monica	Nurse Practitioner Orthopedic Services	133,026	133,428
Pulka, Ashley	Pharmacist ECMC	113,759	119,687
Quatroche Jr., Thomas	Chief Executive Officer ECMC	983,781	984,300
Quinby, Barrett	Senior Hospital Public Safety Officer	113,276	71,240
Radovic, Vladan	Attending Physician	392,921	355,136
Rassman, Jeffrey	Physician Assistant	113,716	118,329
Ratinskaya, Olga	General Duty Nurse	140,881	78,098
Rayer, Ethan	Clinical Laboratory Technologist	110,263	67,843
Redtchik, Galina	General Duty Nurse	103,996	87,899
Reed, Karen	Anesthesiologist	518,158	477,458
Reeners, Eric	Manager of Financial Reporting	100,001	100,312
Reeves, Sandra	Charge Nurse	108,554	92,431
Reigle, Corey	Charge Nurse	115,731	95,220
Reiter, Braden	Attending Physician	240,587	233,398
Requena, Steven	Nursing Supervisor LTC RPT	102,992	102,992
Resetarits, Christopher	Anesthetist RPT	138,047	138,047
Rhinehart, Mary	Director of Nursing Education-CC	120,252	123,831
Riley, Pamela	Unit Manager Medical Surgical	90,337	109,487
Riley, Peggy-Sue	Charge Nurse	101,917	92,431
Rizzo, Ann	General Duty Nurse	100,934	87,899

Rizzo, Heather	Anesthetist RPT	152,263	152,263
Rizzo, John	Charge Nurse	101,995	87,129
Robb, Noel	Charge Nurse	108,612	92,431
Robertson, Heather	Charge Nurse	102,716	89,752
Robinson, Constance	Nursing Supervisor LTC	135,463	112,773
Robinson, Migdalys	Licensed Practical Nurse	136,538	50,001
Roeder, Anastasia	Director of Development & Marketing ECMC	105,162	105,217
Rogan, Ilona	Echocardiography Technician EKG	105,284	80,382
Rogers, Angeline	Nurse Case Manager	113,901	112,773
Rogers, Nancy	Clinical Nurse Specialist Behavioral Health	126,277	125,767
Rohl, Kathleen	Assistant Head Nurse	102,371	95,220
Rohrbacher, Bernhard	Medical Specialist RPT	108,887	108,887
Rojek, Janet	Senior Pharmacist ECMC	146,026	142,657
Roman, Julie	Clinical Documentation Specialist	101,315	89,752
Roof, Donald	Director of Materials Management	102,984	105,061
Root, Sarah	Nursing Team Leader LTC	113,230	99,638
Roskopf, Laura	Consultant IV	55,391	166,860
Rossi, Lucia	Director of Outpatient Operations PC	115,317	107,099
Rossitto, Rachael	Dentist ECMC	303,495	305,963
Rubin, Kari	Nurse Case Manager	115,241	112,773
Rudyk, Jenine	Nursing Team Leader	101,684	96,730
Ruh, Christine	Clinical Pharmacy Specialist	131,966	130,360
Rust, Shawna	Charge Nurse	110,889	95,220

Rutty, Amy	General Duty Nurse	100,722	87,899
Salh, Manpreet	Minimum Data Set Specialist	132,992	93,910
Sammarco-Delmont, Renee	Unit Manager Medical Surgical	117,788	109,497
Sanders, Tamika	Infection & Wound Care Preventionist LTC	128,915	106,303
Sands, Robert	Anesthesiologist	519,697	477,458
Schubbe, Jayson	Healthcare Data Warehouse Architect	106,384	110,700
Schultz, Rachael	Anesthetist	94,311	190,000
Schunke, Katrina	Pharmacist ECMC	132,792	130,903
Schurr, Karen	Clinical Asst to VP Surg & Card. Svcs	115,354	116,280
Schwab, Linda	Trauma Program Manager	136,181	133,428
Schwanekamp, Karen	Anesthetist	212,650	205,000
Scrocco, Mary Carol	Nurse Practitioner Cardiovascular Lab	153,311	133,428
Seay, Michelle	Clinical Patient Care Liaison	120,009	121,861
Semrau, Jeffrey	Pharmacist ECMC	125,274	119,687
Senchoway, Laura	Anesthetist	100,478	190,000
Serafin, Laura	Clinical Resource Nurse Emergency Services	110,724	95,220
Shanahan, Robert	Network Analyst	115,314	91,603
Shea, Mary Molly	Patient Safety Clinical Investigation Co	123,494	112,773
Sheppard, Judith	Nursing Supervisor LTC	152,174	112,773
Short, Amy	Charge Nurse	105,588	92,431
Simon, Alexander	Clinical Application Systems Manager	112,858	107,099
Sitgreaves, Theressa	General Duty Nurse	104,934	80,432
Skomra, Richard	Chief Anesthetist	260,498	260,915

Skrzypczyk, Nancy	Charge Nurse	108,905	95,220
Smith, Andrew	Assistant Nurse Case Manager	102,836	95,220
Smith, Michael	Physician Assistant	57,291	110,000
Smith, Samantha	Clinical Laboratory Technologist	101,610	67,843
Smith, Taneca	Assistant Nurse Case Manager	103,569	84,596
Smolen, Ashley	General Duty Nurse	101,368	82,857
Snodgrass, Darress	Anesthetist	206,362	205,000
Sojda, Hollie	Echocardiography Technician EKG	108,358	82,218
Sole, Jennifer	Charge Nurse	107,786	95,220
Sorce, Lynn	Charge Nurse	100,678	95,220
Sperry, Howard	Clinical Director Medicine	311,583	300,750
Srodawa, Christopher	Administrative Director of Laboratory Se	126,129	127,500
Stadler, Nicholas	General Duty Nurse	105,475	75,791
Stanford, Benjamin	Unit Manager Medical Surgical	108,233	106,303
Staniorski, Paula	Charge Nurse	103,810	95,220
Steffen, Tracy	Charge Nurse	106,186	95,220
Stegemann, Philip	Chief of Orthopedic Surgery	117,148	117,148
Steinhart, Lorne	Special Asst to CEO	69,602	126,888
Stercula, Edna	Anesthetist	21,007	205,000
Stevenson, Gigi	General Duty Nurse	111,757	87,899
Steward, Kevin	Nursing Care Coordinator	135,483	121,861
Stobnicki, Cortney	Anesthetist	196,399	205,000
Stokes, Laura	Point of Care Clinical Laboratory Coord	102,831	102,209

Stroud, Kerry	Nursing Care Coordinator	137,173	121,861
Sturtz, Janice	General Duty Nurse	102,923	82,857
Suckow, Kyle	Senior Hospital Public Safety Officer	106,763	78,551
Sullivan, Michele	General Duty Nurse	105,767	87,899
Summerton, Thomas	Special Procedures Tech Angiographer	105,500	70,880
Surowiec, Stephanie	General Duty Nurse	106,719	78,098
Sutton, Danielle	Charge Nurse	107,425	92,431
Swain, Anthony	Charge Nurse	109,617	95,220
Swain, Maureen	Charge Nurse	113,053	95,220
Sweeney, Kathleen	Nurse Case Manager	103,191	112,773
Sweetland, Jennifer	Nursing In-service Instructor ECMC	105,255	102,600
Sweitzer, Sarah	Charge Nurse	107,773	82,116
Swiatkowski, Jonathan	Chief Financial Officer ECMC	490,385	509,999
Syed, Masroor	Anesthesiologist	509,663	468,096
Tabi-Mensah, Harold	Charge Nurse	132,738	87,129
Tadak, Monica	Director of Revenue Capture and Integrity	124,072	127,071
Tadt, Stephanie	Nurse Case Manager	111,631	109,497
Tague, Dana	Nurse Practitioner Rehab Services	183,649	133,428
Tait, Christopher	Nurse Case Manager	116,441	112,773
Tarbell, Ross	Senior Pharmacist ECMC	159,247	139,583
Tedesco, Kelly	General Duty Nurse	106,402	78,098
Teresi, Salvatore	General Duty Nurse	136,199	85,336
Thanki, Pamela	Senior Financial Analyst	100,375	100,429

Thomas, Katheleen	General Duty Nurse	125,879	87,899
Thompson, Denise	Nursing Care Coordinator	129,624	114,880
Thorpe, Lisa	Director of Rehabilitation Services	130,824	119,569
Toal, Emily	General Duty Nurse	105,706	82,857
Tomljanovich, Darcy	General Duty Nurse	132,188	80,432
Tomljanovich, Paul	Attending Physician PT	209,402	209,402
Tornambe, Lynne	Pharmacist ECMC	129,130	125,295
Torres, Carmen	Nurse Practitioner ECMC	137,388	129,557
Toy, Amy	General Duty Nurse	103,010	87,899
Turner, Charlaina	Assistant Head Nurse	171,002	95,220
Turner, Jacqueline	General Duty Nurse	106,290	87,899
Turner, James	Senior VP of Surgical and Ambulatory	303,129	315,180
Twichell, Jerome	Senior Director Outpatient Operations	120,756	120,819
Urban, Paul	Assistant Info Tech Sys Architect	117,238	117,300
Vacanti, Angela	Infection Prevention Practioner	141,089	102,600
Vacanti, Charles	Nursing Team Leader	105,085	102,600
Vacanti, Jason	General Duty Nurse	124,435	80,432
Vaccaro, Jessica	General Duty Nurse	122,079	78,098
Vail, Robert	Healthcare Information Security Officer	160,407	141,881
Vazquez, Alexandra	Charge Nurse	111,148	87,129
Vazquez, Dionna	Utilization Review Nurse	115,150	80,432
Velicu, Simona	Attending Physician	265,595	307,661
Villacorta, Maria	Charge Nurse	120,906	95,220

Vogel, Jerald	General Duty Nurse	106,119	87,899
Walleshauser, Caitlin	Ultra-Sonographer	104,908	73,726
Walter, Robert	Chief Clinical Laboratory Technologist	117,993	102,209
Walters, Amy	General Duty Nurse	101,184	87,899
Walters, Kimberly	General Duty Nurse	132,902	87,899
Wang, Shirley	Pharmacist ECMC	23,155	119,687
Warmus, Renelle	Nurse Case Manager	106,674	106,303
Warne, Matthew	General Duty Nurse	113,588	82,857
Waterstram, Richard	Unit Manager Behavioral Health	101,922	103,199
Weber, Joseph	Network Analyst	114,685	91,603
Weiss, Katherine	Pharmacist ECMC	138,279	130,903
Welka, Andrew	Anesthesiologist	427,538	400,000
Weslow, Beth	Unit Manager Post Anesthesia Care	120,465	103,199
West, Ashley	Nurse Case Manager	109,589	109,497
Wheaton, Tina	General Duty Nurse RPT	109,413	109,413
Wickett, Rachel	General Duty Nurse	119,244	78,098
Wik, Michelle	General Duty Nurse	100,214	78,098
Wilcox, Ann	General Duty Nurse	100,519	87,899
Wilde, Michelle	General Duty Nurse	101,603	85,336
Williams, Sonia	Assistant Director Ambulatory Services	112,588	106,032
Williams, Stephanie	Charge Nurse	103,182	87,129
Williamson, Latecia	Licensed Practical Nurse	107,922	51,060
Wilson, Nicolette	VP Revenue Cycle	162,386	168,299

Wilson, Tiffany	Charge Nurse	106,877	87,129
Wittmann, Paula	Charge Nurse	120,908	95,220
Wohaibi, Eyad	Attending Physician	413,629	380,000
Wolf, Joann	Assistant Vice President Surgical Nursing	129,991	135,264
Woods, Kara	Physician Assistant	119,709	120,819
Yak, Joseph	Senior Clinical Laboratory Technologist	109,732	81,725
York-Renaud, Jamie	Assistant Head Nurse	107,880	95,220
Yotter, Emily	General Duty Nurse	111,296	80,432
Zajac, Jamie	Emergency Department Patient Flow TL	121,507	102,600
Zak, Katherine	General Duty Nurse	101,261	87,899
Zakrzewski, Thomas	Nursing Supervisor LTC	130,881	112,773
Zanghi, Marie	Charge Nurse	102,577	95,220
Zdon, Glen	Unit Manager Hemodialysis	104,724	103,199
Ziemianski, Karen	Senior VP of Nursing	353,651	367,711
Zimmer, Michelle	Charge Nurse	112,235	92,431
Zolnowski, Kimberly	General Duty Nurse	113,163	80,432
Zynda, Elizabeth	Nurse Practitioner Transplant	184,812	125,767

APPENDIX C
2020 CORPORATION EXPENDITURES IN EXCESS OF $100,000

Vendor Name	Payments	Reporting Year	Contract Period		Purpose
1 ACCORD SERVICES INC	$195,473	2020	2/15/2012	Evergreen	Other Professional Services
3M HEALTH INFORMATION SYSTEMS, INC	$585,121	2020	10/1/2018	Evergreen	Technology - Software
ABBOTT LABORATORIES DIAGNOSTIC DIV	$547,870	2020	Various	Evergreen	Commodities/Supplies
ABBOTT LABORATORIES, INC.	$180,081	2020	Various	Evergreen	Commodities/Supplies
ACADEMIC MEDICAL SERVICES, INC.	$7,160,089	2020	3/8/2018	3/7/2022	Other Professional Services
ACELL, INC.	$285,101	2020	02/21/2020	Evergreen	Commodities/Supplies
ADVANCED CRITICAL DEVICES	$138,470	2020	01/22/2020	Evergreen	Commodities/Supplies
AIRGAS USA, LLC	$153,878	2020	9/10/2012	Evergreen	Commodities/Supplies
ALIGN HEALTHCARE SOLUTIONS	$146,123	2020	6/10/2019	2/14/2020	Consulting Services
ALLERGAN USA INC	$166,269	2020	01/31/2020	Evergreen	Commodities/Supplies
ALLOSOURCE	$113,455	2020	01/22/2020	Evergreen	Commodities/Supplies
ALLPRO PARKING LLC	$363,071	2020	12/8/2017	12/19/2020	Other Professional Services
ALLSCRIPTS LLC	$951,000	2020	Various	Evergreen	Technology - Software
AMICO LIGHTS CORPORATION	$149,164	2020	06/25/2020	Evergreen	Design and Construction/Maintenance
ANGIO DYNAMICS INC	$108,330	2020	01/08/2020	Evergreen	Commodities/Supplies
ANS ADVANCED NETWORK	$217,600	2020	11/18/2019	11/17/2022	Telecommunication Equipment or Services
APOGEE MEDICAL MANAGEMENT	$7,812,829	2020	9/1/2015	3/31/2020	Other Professional Services
AQUA SCIENCES INC	$210,732	2020	5/1/2018	4/40/21	Other Professional Services
ARC BUILDING PARTNERS, LLC	$4,011,007	2020	2/18/2019	Evergreen	Design and Construction/Maintenance
ARTHREX INC	$1,267,617	2020	10/1/2018	9/30/2021	Commodities/Supplies
AUDIO-VIDEO CORPORATION	$260,616	2020	05/15/2020	Evergreen	Design and Construction/Maintenance
AXOGEN INC	$274,897	2020	7/1/2004	6/30/2020	Commodities/Supplies
B.E. SMITH LLC	$469,162	2020	4/9/2018	4/9/2021	Staffing Services
BAXTER	$148,862	2020	Various	Evergreen	Commodities/Supplies
BAXTER HEALTHCARE CORP	$355,861	2020	5/14/2018	4/4/2021	Commodities/Supplies
BAXTER HEALTHCARE CORP	$193,401	2020	Various	Evergreen	Technology - Software
BAXTER HEALTHCARE CORP	$107,426	2020	Various	Evergreen	Commodities/Supplies
BAXTER HEALTHCARE CORPORATION	$110,170	2020	Various	Evergreen	Commodities/Supplies
BAYER HEALTHCARE LLC	$281,886	2020	4/1/2016	3/31/2020	Commodities/Supplies
BCH, INC.	$160,800	2020	01/03/2020	Evergreen	Other Professional Services
BEAUTIFUL BRAINS, LLC	$138,700	2020	08/31/2020	Evergreen	Commodities/Supplies
BHS FOODSERVICE SOLUTIONS	$180,502	2020	05/15/2020	Evergreen	Commodities/Supplies
BIOCARE SD	$335,641	2020	01/03/2020	Evergreen	Commodities/Supplies
BIOFIRE DIAGNOSTICS LLC	$381,268	2020	06/12/2020	Evergreen	Commodities/Supplies
BIOQUELL INC.	$118,314	2020	09/24/2020	Evergreen	Commodities/Supplies
BOSTON SCIENTIFIC CORPORATION	$203,316	2020	4/28/2016	4/27/2020	Commodities/Supplies

BOSTON SCIENTIFIC/MICROVASIVE DIV	$156,276	2020	Various	Evergreen	Commodities/Supplies
BRITE COMPUTERS	$381,960	2020	Various	Evergreen	Technology - Software
BUFFALO INTERNIST AND ASSOCIATES	$4,659,198	2020	6/13/2017	6/30/2024	Other Professional Services
BUFFALO PAPER AND TWINE CO	$886,973	2020	01/03/2020	Evergreen	Commodities/Supplies
BUFFALO TRANSPORTATION INC.	$420,435	2020	01/03/2020	Evergreen	Other Professional Services
C R BARD BARD PHERIPHERAL VASCULAR	$272,749	2020	01/03/2020	Evergreen	Commodities/Supplies
C R BARD INC BARD ACCESS SYSTEMS	$291,608	2020	01/03/2020	Evergreen	Commodities/Supplies
CANNON DESIGN ARCHITECTURE AND ENGINEERING, P.C.	$286,035	2020	6/18/2019	Project Comp	Design and Construction/Maintenance
CANON MEDICAL SYSTEMS USA, INC.	$205,059	2020	11/1/2018	10/31/2021	Technology - Consulting/Development or Support
CARA MEDICAL	$195,000	2020	09/28/2020	Evergreen	Commodities/Supplies
CARAHSOFT TECHNOLOGY CORPORATION	$230,226	2020	1/12/2018	1/11/2021	Technology - Software
CARDINAL HEALTH	$10,132,208	2020	1/19/2013	10/31/2022	Commodities/Supplies
CARDINAL HEALTH 411 INC / BANK OF AMERICA LOCKBOX	$1,524,789	2020	1/19/2013	10/31/2022	Commodities/Supplies
CARDINAL HEALTH MED PRODUCTS & SERVICES	$3,614,222	2020	5/1/2013	10/31/2022	Commodities/Supplies
CAREFUSION 2200, INC.	$189,070	2020	7/1/2016	6/30/2021	Commodities/Supplies
CARESTREAM HEALTH	$369,124	2020	11/12/2020	12/25/2022	Technology - Consulting/Development or Support
CDW GOVERNMENT INC	$1,678,957	2020	01/03/2020	Evergreen	Commodities/Supplies
CERAPEDICS, INC.	$105,039	2020	01/29/2020	Evergreen	Commodities/Supplies
CERNER CORPORATION	$1,630,910	2020	4/6/2015	3/30/2026	Technology - Software
CHANGE HEALTHCARE	$895,294	2020	11/15/2017	11/14/2020	Financial Services
CLARK PATTERSON LEE	$790,758	2020	9/22/2017	Project Comp	Design and Construction/Maintenance
CLEAN CARE LINEN	$1,534,971	2020	5/2/2019	5/1/2024	Other Professional Services
COMPUTERSEARCH CORPORATION	$138,753	2020	9/24/2018	9/23/2021	Technology - Hardware
CONMED LINVATEC	$111,925	2020	01/15/2020	Evergreen	Commodities/Supplies
CONVIRGENT TECHNOLOGIES LLC	$130,987	2020	04/29/2020	Evergreen	Technology - Software
COOK INC	$185,014	2020	01/08/2020	Evergreen	Commodities/Supplies
CORE BTS INC	$3,124,651	2020	Various	Evergreen	Technology - Software
COVIDIEN	$757,001	2020	4/1/2015	3/31/2020	Commodities/Supplies
CREEKRIDGE CAPITAL-LB	$865,303	2020	4/1/2011	4/30/2016	Financial Services
CROTHALL HEALTHCARE	$1,811,585	2020	3/1/2019	2/28/2022	Other Professional Services
CROWN CASTLE FIBER, LLC.	$290,616	2020	01/03/2020	Evergreen	Other
CRS NUCLEAR SERVICES LLC	$241,193	2020	4/1/2011	4/30/2016	Commodities/Supplies
DCB ELEVATOR CO INC	$241,912	2020	1/1/2014	12/31/2018	Design and Construction/Maintenance
DELL MARKETING LP / DELL USA LP	$1,648,534	2020	02/21/2020	Evergreen	Technology - Software
DENTSPLY IMPLANTS DEPT IMP	$153,668	2020	01/08/2020	Evergreen	Commodities/Supplies

DEPUY SYNTHES JOINT RECONSTRUCTION	$1,751,776	2020	03/04/2020	Evergreen	Commodities/Supplies
DOPKINS & CO LLP	$401,815	2020	9/1/2019	6/30/2022	Consulting Services
DRAEGER MEDICAL	$157,301	2020	1/12/2018	Evergreen	Commodities/Supplies
DRFIRST.COM INC.	$267,255	2020	9/1/2011	9/15/2022	Technology - Software
EPOCH HEALTH SOLUTIONS, LLC	$124,469	2020	6/1/2018	5/31/2021	Other Professional Services
EXPERIAN HEALTH, INC.	$218,140	2020	11/30/2020	11/30/2030	Technology - Software
FFF ENTERPRISES	$535,029	2020	01/03/2020	Evergreen	Commodities/Supplies
FINANCIAL SERVICES OF BUFFALO	$149,485	2020	04/29/2020	Evergreen	Commodities/Supplies
FISHER HEALTHCARE	$340,767	2020	01/03/2020	Evergreen	Commodities/Supplies
FLEXLUME	$176,379	2020	03/04/2020	Evergreen	Design and Construction/Maintenance
FOAM DEPOT INC	$1,055,260	2020	04/09/2020	Evergreen	Commodities/Supplies
FORWARD ADVANTAGE	$160,391	2020	6/21/2018	6/20/2019	Technology - Software
FOXY DELIVERY SERVICE INC	$101,296	2020	01/03/2020	Evergreen	Other Professional Services
FREED MAXICK CPAs PC	$410,184	2020	5/15/2015	5/14/2020	Consulting Services
FRESENIUS USA MARKETING, INC.	$596,734	2020	5/1/2017	7/31/2028	Commodities/Supplies
GE HEALTHCARE OEC	$116,547	2020	Various	Evergreen	Technology - Consulting/Development or Support
GE MEDICAL SYSTEMS INFORMATION TECHNOLOGIES, INC.	$442,480	2020	Various	Evergreen	Commodities/Supplies
GENERAL PHYSICIAN SUB II, PLLC	$163,726	2020	10/1/2016	Evergreen	Staffing Services
GENERAL PHYSICIAN, P.C.	$17,230,692	2020	1/1/2018	Evergreen	Staffing Services
GILBANE BUILDING COMPANY	$18,349,595	2020	5/1/2018	Project Comp	Design and Construction/Maintenance
GLAXOSMITHKLINE FINANCIAL INC	$133,182	2020	5/1/2018	Project Comp	Commodities/Supplies
GLOBUS MEDICAL INC	$2,532,201	2020	4/30/2015	4/29/2020	Commodities/Supplies
GORDON COMPANIES	$651,531	2020	04/03/2020	Evergreen	Commodities/Supplies
GOVERNMENT MARKETING & PROCUREMENT, LLC	$293,802	2020	12/31/2019	Project Comp	Technology - Consulting/Development or Support
GRAYLINE NIAGARA FALLS/BUFFALO	$446,307	2020	12/4/2017	12/3/2020	Other Professional Services
GREAT LAKES BUILDING SYSTEMS INC.	$317,304	2020	01/03/2020	Evergreen	Design and Construction/Maintenance
GREAT LAKES MEDICAL IMAGING, LLC	$8,736,937	2020	9/1/2015	8/31/2021	Other Professional Services
GREATER NEW YORK HOSPITAL	$140,295	2020	9/1/2015	8/31/2021	Consulting Services
GREYCASTLE SECURITY, LLC	$158,859	2020	11/1/2017	Evergreen	Consulting Services
GRIDER SUPPORT SERVICES, LLC	$639,452	2020	3/1/2012	Evergreen	other
HAMILTON MEDICAL, INC.	$549,525	2020	08/20/2020	Evergreen	Commodities/Supplies
HEALOGICS WOUND CARE	$315,774	2020	1/18/2019	1/18/2022	Consulting Services
HEALTH SYSTEM SERVICE	$219,872	2020	6/1/2016	5/31/2020	Commodities/Supplies
HILL-ROM	$2,015,164	2020	6/30/2013	3/28/2018	Commodities/Supplies
HOSPITAL SYSTEMS, INC.	$148,929	2020	01/17/2020	Evergreen	Design and Construction/Maintenance
HP, INC.	$698,939	2020	04/17/2020	Evergreen	Commodities/Supplies
ICP MEDICAL, LLC	$101,330	2020	05/29/2020	Evergreen	Commodities/Supplies

IMMCO DIAGNOSTICS INC	$1,802,300	2020	5/5/2005	Evergreen	Other Professional Services
INSPIRE MEDICAL SYSTEMS, INC.	$166,775	2020	4/2/2018	4/1/2020	Commodities/Supplies
INTEGRA LIFESCIENCES CORP	$1,014,408	2020	10/7/2019	10/6/2020	Commodities/Supplies
INTELLIGENT MEDICAL OBJECTS, INC.	$223,722	2020	8/13/2013	7/31/2020	Technology - Software
INTELLIPRINT SOLUTIONS, INC.	$100,530	2020	01/03/2020	Evergreen	Financial Services
IPC HOSPITALIST SERVICES OF NEW YORK, PC	$125,000	2020	7/1/2013	6/30/2020	Other Professional Services
ISECURE, LLC	$193,929	2020	8/10/2018	8/9/2021	Technology - Software
J&J DETAILS & MAINTENANCE LLC	$580,776	2020	05/21/2020	Evergreen	Other Professional Services
JEAN JUREK ASSOCIATES INC	$205,616	2020	9/21/2015	9/30/2020	Other Professional Services
JOHN W DANFORTH CO	$457,961	2020	9/25/2018	2/17/2020	Design and Construction/Maintenance
JOHNSON & JOHNSON HLTH CARE SYS INC	$206,512	2020	11/21/2017	11/20/2019	Commodities/Supplies
JOHNSON CONTROLS FIRE PROTECTION LP	$634,780	2020	4/8/2013	4/7/2018	Design and Construction/Maintenance
JOURNEY'S END REFUGEE SERVICES	$156,405	2020	01/03/2020	Evergreen	Other Professional Services
KARL STORZ ENDOSCOPY-AMERICA INC	$160,914	2020	7/30/2020	7/29/2023	Design and Construction/Maintenance
KCI USA, INC.	$502,999	2020	01/03/2020	Evergreen	Commodities/Supplies
KELLER TECHNOLOGY CORPORATION	$190,825	2020	02/19/2020	Evergreen	Other
KEYSTONE PERFUSION SERVICES, PC	$119,500	2020	1/1/2020	12/31/2020	Other Professional Services
KIDENEY ARCHITECTS PC	$1,626,417	2020	2/6/2017	Project Comp	Design and Construction/Maintenance
KRONOS	$284,595	2020	03/13/2020	Evergreen	Technology - Software
KRUEGER INTERNATIONAL INC	$118,798	2020	01/17/2020	Evergreen	Design and Construction/Maintenance
KSL DIAGNOSTICS, INC	$171,678	2020	01/31/2020	Evergreen	Commodities/Supplies
LAB CORP OF AMERICA	$820,095	2020	01/08/2020	Evergreen	Other Professional Services
LANGUAGE LINE LLC	$100,874	2020	9/21/2009	9/20/2020	Other Professional Services
LAWLEY AGENCY, LLC	$3,705,692	2020	5/31/2016	6/1/2020	Other Professional Services
LEVEL(3) COMMUNICATIONS LLC	$154,600	2020	4/1/2020	4/1/2023	Telecommunication Equipment or Services
LIFENET HEALTH	$230,880	2020	01/08/2020	Evergreen	Commodities/Supplies
LIMA, USA, INC	$519,115	2020	7/25/2019	7/24/2020	Commodities/Supplies
LIRO ENGINEERS, INC.	$624,193	2020	8/13/2018	9/1/2021	Design and Construction/Maintenance
LOGIQUIP LLC	$140,876	2020	02/21/2020	Evergreen	Commodities/Supplies
MAGAVERN, MAGAVERN & GRIMM LLP	$426,481	2020	3/18/2016	Evergreen	Legal Services

McKESSON DRUG CO	$21,854,024	2020	3/30/2019	3/1/2024	Commodities/Supplies
MEDICAL INFO TECH INC	$988,193	2020	7/14/2011	7/13/2020	Technology - Software
MEDLINE INDUSTRIES INC	$203,471	2020	12/16/2020	12/15/2025	Commodities/Supplies
MED-METRIX, LLC	$1,870,612	2020	8/1/2018	7/31/2023	Financial Services
MEDTRONIC ADVANCED ENERGY	$123,529	2020	Various	Evergreen	Commodities/Supplies
MEDTRONIC MIDAS REX	$307,067	2020	8/1/2020	8/20/2023	Commodities/Supplies
MEDTRONIC SD USA INC	$588,989	2020	Various	Evergreen	Commodities/Supplies
MEDTRONIC USA INC	$294,265	2020	Various	Evergreen	Commodities/Supplies
MERGE HEALTHCARE	$493,604	2020	6/29/2017	Evergreen	Technology - Software
MERIDIAN IT INC.	$366,815	2020	1/1/2017	5/7/2020	Technology - Software
METRO COMMUNICATIONS	$263,419	2020	01/03/2020	Evergreen	Telecommunication Equipment or Services
METZ CULINARY MANAGEMENT	$9,985,542	2020	4/6/2019	3/31/2026	Other Professional Services
MICROSOFT CORPORATION	$107,981	2020	1/26/2019	1/25/2021	Technology - Software
MICROTEK MEDICAL	$112,581	2020	01/03/2020	Evergreen	Commodities/Supplies
MINDRAY NORTH AMERICA	$120,669	2020	04/29/2020	Evergreen	Commodities/Supplies
MIZUHO OSI	$117,013	2020	01/15/2020	Evergreen	Commodities/Supplies
MORRISON MANAGEMENT SPECIALISTS	$4,279,080	2020	3/1/2013	2/29/2020	Other Professional Services
NALCO CO	$106,121	2020	4/27/2018	4/26/2023	Commodities/Supplies
NATIONAL GRID	$865,546	2020	01/14/2020	Evergreen	Other
NUANCE COMMUNICATIONS INC	$222,348	2020	11/8/2019	11/7/2020	Technology - Software
NXSTAGE	$328,747	2020	12/11/2017	12/10/2020	Commodities/Supplies
OFFICE DEPOT	$259,378	2020	01/03/2020	Evergreen	Commodities/Supplies
OLYMPUS AMERICA INC	$151,911	2020	01/03/2020	Evergreen	Commodities/Supplies
OPTICOOL TECHNOLOGIES, LLC	$146,419	2020	3/17/2020	3/17/2021	Technology - Hardware
OPTUM360 LLC	$251,839	2020	01/03/2020	Evergreen	Technology - Software
ORLICK, ARTHUR	$376,859	2020	1/1/2018	12/31/2020	Other Professional Services
ORTHO CLINICAL DIAGNOSTICS, INC	$137,880	2020	01/14/2020	Evergreen	Commodities/Supplies
ORTHOFIX, INC.	$273,253	2020	02/07/2020	Evergreen	Commodities/Supplies
PARAGON 28, INC.	$106,380	2020	5/23/2018	5/31/2021	Commodities/Supplies
PARTS SOURCE	$107,885	2020	01/03/2020	Evergreen	Commodities/Supplies
PATTERSON DENTAL INC	$265,838	2020	01/08/2020	Evergreen	Commodities/Supplies
PATTERSON, PAUL	$437,200	2020	4/1/2011	10/31/2016	Staffing Services
PCMG, INC	$1,883,170	2020	02/21/2020	Evergreen	Technology - Software
PHARMERICA	$1,022,777	2020	3/1/2011	Evergreen	Commodities/Supplies
PHILIPS MEDICAL SYSTEMS	$3,057,015	2020	Various	Evergreen	Commodities/Supplies
PHILIPS MEDICAL SYSTEMS NA CO	$3,492,820	2020	Various	Evergreen	Commodities/Supplies
PRE-EMPLOY.COM INC	$135,266	2020	12/1/2017	Evergreen	Other Professional Services
PREMIERE GLOBAL SERVICES	$131,428	2020	01/03/2020	Evergreen	Telecommunication Equipment or Services
PRESS GANEY ASSOCIATES INC	$212,078	2020	7/1/2014	6/30/2020	Other Professional Services
PRIORITY HEALTHCARE DIST DBA CURASCRIPT SD	$158,555	2020	02/21/2020	Evergreen	Commodities/Supplies
RICOTTA & VISCO	$488,892	2020	8/7/2017	Evergreen	Legal Services
ROACH, BROWN	$338,579	2020	8/8/2017	Evergreen	Legal Services
ROCHE DIAGNOSTICS CORPORATION	$3,112,266	2020	Various	Evergreen	Commodities/Supplies
RONCO SPECIALIZED SYSTEMS INC	$105,387	2020	01/29/2020	Evergreen	Design and Construction/Maintenance

RSM MCGLADREY INC	$190,150	2020	03/18/2020	Evergreen	Financial Services
RUPP BAASE PFALZGRAF	$269,002	2020	1/8/2016	Evergreen	Legal Services
SAMIE, MOHAMMAD REZA	$180,784	2020	6/1/2016	5/31/2020	Staffing Services
SAUDER EDUCATION	$136,763	2020	06/19/2020	Evergreen	Design and Construction/Maintenance
SAVIN ENGINEERS, P.C.	$487,893	2020	11/29/2018	5/28/2021	Design and Construction/Maintenance
SCHAEFER PLUMBING SUPPLY INC.	$102,835	2020	01/03/2020	Evergreen	Commodities/Supplies
SICOLI CONSTRUCTION SERVICES, INC.	$528,485	2020	2/26/2018	Project Comp	Design and Construction/Maintenance
SIEMENS INDUSTRY INC	$323,916	2020	Various	Evergreen	Commodities/Supplies
SIEMENS MEDICAL SOLUTIONS USA	$662,027	2020	Various	Evergreen	Technology - Consulting/Development or Support
SIRTEX MEDICAL, INC.	$270,969	2020	01/22/2020	Evergreen	Commodities/Supplies
SMITH & NEPHEW ENDOSCOPY	$451,183	2020	3/1/2020	2/28/2023	Commodities/Supplies
SMITH & NEPHEW ORTHOPAEDICS	$1,609,796	2020	3/1/2020	2/28/2023	Commodities/Supplies
SONEX HEALTH	$357,603	2020	3/26/2016	3/25/2019	Commodities/Supplies
STANSBERRY AND KNIGHT	$460,234	2020	3/28/2018	12/31/2020	Staffing Services
STERICYCLE INC	$616,872	2020	2/1/2017	1/31/2022	Other Professional Services
STERIS CORPORATION	$297,215	2020	1/1/2019	12/31/2021	Commodities/Supplies
STERIS CORPORATION	$128,326	2020	1/1/2019	12/31/2021	Commodities/Supplies
STRYKER COMMUNICATIONS	$137,501	2020	Various	Evergreen	Commodities/Supplies
STRYKER CRAINOMAXILLOFACIAL	$400,683	2020	5/10/2019	5/9/2020	Commodities/Supplies
STRYKER ENDOSCOPY	$324,928	2020	Various	Evergreen	Commodities/Supplies
STRYKER ORTHOPAEDICS	$1,821,702	2020	2/24/2020	2/24/2022	Commodities/Supplies
STRYKER SALES CORP	$601,406	2020	2/24/2020	2/24/2022	Commodities/Supplies
STRYKER SALES CORP	$496,930	2020	Various	Evergreen	Commodities/Supplies
STRYKER SPINE	$131,257	2020	Various	Evergreen	Commodities/Supplies
SUICIDE PREVENTION & CRISIS SERVICES, INC.	$725,979	2020	10/1/2018	9/30/2023	Other Professional Services
SUMMIT HEALTH CARE	$216,635	2020	01/03/2020	Evergreen	Other Professional Services
SUPPLEMENTAL HEALTH CARE	$410,368	2020	12/8/2016	12/7/2021	Other Professional Services
SUTURE EXPRESS	$644,313	2020	1/4/2019	Evergreen	Commodities/Supplies
SYNTHES	$4,742,245	2020	3/30/2020	3/29/2022	Commodities/Supplies
SYNTHES MAXILLOFACIAL	$195,948	2020	4/8/2013	4/7/2018	Commodities/Supplies
SYSMEX AMERICA INC	$209,415	2020	3/30/2017	3/29/2024	Commodities/Supplies
TELETRACKING	$114,251	2020	3/1/2016	8/31/2020	Technology - Software
TERUMO MEDICAL CORP	$164,611	2020	9/24/2019	9/30/2020	Commodities/Supplies
THE ADVISORY BOARD COMPANY	$171,960	2020	3/31/2012	3/30/2022	Technology - Software
THE CHARTIS GROUP, LLC	$2,971,542	2020	5/10/2019	5/9/2024	Consulting Services
THE MARTIN GROUP LLC	$1,512,639	2020	6/9/2014	6/8/2020	Telecommunication Equipment or Services
THE PIKE COMPANY	$15,624,336	2020	7/1/2017	Project Comp	Design and Construction/Maintenance
THE RESEARCH FOUNDATION	$7,065,633	2020	Various	Evergreen	Other Professional Services
THE SSI GROUP LLC	$101,242	2020	01/03/2020	Evergreen	Technology - Software
THREE STICKS MARKETING, LLC	$333,000	2020	10/22/2020	Evergreen	Commodities/Supplies

TORNIER INC	$486,425	2020	9/1/2019	12/31/2021	Commodities/Supplies
TRI-DELTA RESOURCES CORP	$252,960	2020	9/1/2014	3/17/2021	Technology - Software
UB FAMILY MEDICINE INC.	$2,373,926	2020	6/1/2017	5/31/2020	Other Professional Services
UBMD PSYCHIATRY	$11,700,417	2020	8/1/2016	9/30/2019	Other Professional Services
UNITED NETWORK FOR ORGAN SHARING	$124,084	2020	3/31/2017	Evergreen	Other Professional Services
UNITED UNIFORM CO INC	$107,455	2020	12/22/2015	Evergreen	Commodities/Supplies
UNIV. ORTHOPAEDIC SERVICES	$1,984,810	2020	6/1/2017	5/31/2020	Staffing Services
UNIVERISTY AT BUFFALO ORAL AND MAXILLOFACIAL	$339,151	2020	10/1/2016	9/30/2019	Other Professional Services
UNIVERSITY AT BUFFALO NEUROSURGERY, INC.	$1,478,379	2020	11/7/2018	11/6/2019	Other Professional Services
UNIVERSITY AT BUFFALO PATHOLOGISTS	$706,990	2020	12/1/2010	2/28/2019	Other Professional Services
UNIVERSITY EMERGENCY MEDICAL SERVICES, INC.	$3,630,492	2020	8/1/2017	3/31/2021	Other Professional Services
UNIVERSITY GYNECOLOGISTS	$456,704	2020	10/1/2016	9/30/2019	Staffing Services
UNIVERSITY NEUROLOGY, INC.	$119,096	2020	6/14/2016	6/13/2021	Other Professional Services
UNIVERSITY OPHTHALMOLOGY SERVICE, INC.	$301,779	2020	4/1/2013	9/30/2016	Staffing Services
UNVERSITY AT BUFFALO SURGEONS, INC.	$6,778,490	2020	1/1/2018	12/31/2020	Staffing Services
UP TO DATE	$208,882	2020	9/1/2017	8/31/2021	Technology - Software
UPSTATE MEDICAL PHYSICS DIAGNOSTIC RADIOLOGY, MH	$100,425	2020	11/1/2016	10/31/2018	Other Professional Services
UPSTATE NEW YORK TRANSPLANT	$7,744,783	2020	8/2/2016	Evergreen	Commodities/Supplies
US POSTAL SERVICE	$275,000	2020	01/03/2020	Evergreen	Commodities/Supplies
VERATHON INC	$205,942	2020	01/15/2020	Evergreen	Commodities/Supplies
VERIZON	$196,745	2020	01/31/2020	Evergreen	Telecommunication Equipment or Services
VIVIAN L. LINDFIELD MD PC	$108,329	2020	2/15/2012	2/14/2021	Other Professional Services
W L GORE & ASSOC INC	$665,938	2020	9/3/2020	7/31/2022	Commodities/Supplies
WILLIAM BELLES PC	$552,511	2020	4/1/2011	5/31/2018	Staffing Services
WNY UROLOGY ASSOCIATES LLC	$665,792	2020	10/1/2018	9/30/2025	Staffing Services
XEROX CORPORATION	$129,504	2020	3/12/2012	3/11/2017	Other
ZIMMER BIOMET INC	$3,350,007	2020	10/5/2016	1/31/2022	Commodities/Supplies
ZIMMER US INC	$3,474,489	2020	2/11/2015	1/31/2022	Commodities/Supplies
ZOLL MEDICAL CORPORATION	$480,903	2020	11/23/2016	1/31/2022	Design and Construction/Maintenance

APPENDIX D

Enabling Legislation
See N.Y. Public Authorities Law §3625-3646

ECMC Corporation By-Laws
See Below

BY-LAWS OF

ERIE COUNTY MEDICAL CENTER

CORPORATION

As Amended Through November 27, 2018

TABLE OF CONTENTS

BY-LAWS

OF

ERIE COUNTY MEDICAL CENTER CORPORATION

PREAMBLE

The State of New York has enacted legislation, codified at Article 10-C of the Public Authorities Law of the State of New York (the "Act"), creating the Erie County Medical Center Corporation ("ECMCC" or the "Corporation"). These by-laws are intended to supplement the requirements of the Act.

ARTICLE I
OFFICES

ECMCC may maintain offices at such places within or without Erie County, New York as the Board of Directors may, from time to time, determine.

ARTICLE II
PURPOSE OF BY-LAWS

Pursuant to the broad powers granted by the Act, the Board of Directors of ECMCC (the "Board") has adopted these By-Laws, to govern and manage its proceedings and affairs and for the advice and guidance of its members, and nothing contained in these By-Laws shall be deemed, nor are they intended in any manner or degree, to limit or restrict the power and right of the Board under existing law, to manage, control, operate and administer ECMCC and its personnel, patients and medical staff.

ARTICLE III
CORPORATE PURPOSE

To continue as a general, municipal hospital and provide health care services and health facilities for the benefit of the residents of the State of New York and the County of Erie, including persons in need of health care services without the ability to pay, as required by law.

ARTICLE IV
ERIE COUNTY MEDICAL CENTER CORPORATION BOARD OF DIRECTORS

Section 1. General Powers.
In addition to the powers and authorities expressly conferred by these By-laws, the Board may exercise all such general and special powers of the Corporation and do all such lawful acts and things as enumerated by the Act.

Section 2. Hiring Powers.
The Board shall hire, determine the compensation and benefits, and annually review the performance of the Chief Executive Officer ("CEO") and President of the Corporation. After

November 1, 2018, appointments made to fill the roles of the Chief Operating Officer ("COO"), Chief Financial Officer ("CFO"), Chief Medical Officer ("CMO"), Administrator of Terrace View, Associate Administrator for Health Systems Development, Internal Auditor and General Counsel of the Corporation shall be made by the CEO of the Corporation, who shall thereafter also be responsible for determining the compensation and benefits of the persons occupying these positions and for the annual review of the incumbents. The Board shall have the authority to discharge the CEO with or without cause; provided that the removal shall not prejudice the contract rights, if any, of such executive. The CEO shall have the authority to discharge the COO, CFO, CMO, Administrator of Terrace View, Associate Administrator for Health Systems Development, Internal Auditor and General Counsel with or without cause, provided that the removal shall not prejudice the contract rights, if any, of such executive.

Section 3. Voting Directors.
The Corporation shall be governed by fifteen voting Directors. The membership, term of office, selection of the voting Directors and the powers and duties of the Board shall be in accordance with the Act and these By-laws.

Section 4. Nonvoting Representatives.
The Corporation shall have four nonvoting Representatives. The term of office, selection and powers and duties of the nonvoting Representatives shall be in accordance with the Act and these By-laws. For the purpose of these By-Laws, the term "member" or "Board member" shall refer to both voting Directors and non- voting Representatives.

Section 5. Resignation.
Any Director or Representative may resign at any time by giving written notice to the Chairperson of the Board. Such resignation shall take effect at the time specified therein and unless otherwise specified therein the acceptance of such resignation shall not be necessary to make it effective.

Section 6. Removal.
Members of the Board may be removed from office by the Board for inefficiency, neglect of duty, or misconduct of any kind, including but not limited to violation of the law, after the Board has given such member a copy of the charges against him or her and an opportunity to be heard in person or by counsel in his or her defense, upon not less than ten days' notice.

Section 7. Vacancies.
Vacancies occurring other than by expiration of term shall be filled for the unexpired terms in the manner provided for original appointment in accordance with the Act.

Section 8. Monthly Meetings.
The Board shall hold regular monthly meetings at the ECMCC offices or other convenient locations as designated by the Board at such time as the Board may designate. In the event that a previously scheduled regular monthly meeting may not be required for a particular month, the Board may cancel that meeting.

Section 9. Annual & Special Meetings.
A meeting of the Board shall be held annually at which time officers of the Corporation shall be elected. A special meeting may be called by the Chairperson or Vice Chairperson acting in the Chairperson's absence, or by any three (3) members of the Board at any time upon proper notice

under the Public Officers Law. The only action that can be taken at a special meeting is the consideration of the subject or subjects designated in the notice for the special meeting.

Section 10. Open Meetings Law.
All meetings of the Board shall comply with the requirements of Article 7 of the Public Officers Law. In a regular, annual or special meeting, the Board may request an Executive Session pursuant to Article 7 of the Public Officers Law or applicable sections of the Act.

Section 11. Quorum.
The powers of the Corporation shall be vested in and shall be exercised by the Board at a duly called and held meeting, where a quorum of eight Directors is present. No action shall be taken by the Corporation except pursuant to the favorable vote of at least eight Directors present at the meeting at which such action is taken.

Section 12. Telephone Meetings.
The members of the Board or any committee thereof may participate in a meeting of such Board or committee by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time. Participation by such means shall constitute presence in person at a meeting.

Section 13. Action by Written Consent.
To the extent permitted by law, any action required or permitted to be taken by the Board or any committee thereof may be taken without a meeting if all members of the Board or the committee consent in writing to the adoption of a resolution authorizing the action. The resolution and the written consents thereto by the members of the Board or committee shall be filed with the minutes of the proceedings of the Board or committee.

Section 14. Minutes of Meetings.
The Board shall keep a written record of all business conducted, including resolutions, findings, conclusions and recommendations that shall be filed with the minutes of the proceedings of the Board or committee.

Section 15. Compensation.
Neither the voting Directors nor the nonvoting Representatives shall receive compensation for their services, but shall be reimbursed for all their actual and necessary expenses incurred in connection with their duties under the Act and these By-laws.

Section 16. Defense and Indemnification.
The Corporation shall defend and indemnify the Directors of the Corporation and its officers for any and all lawful actions executed in the performance of their duties, to the full extent to which indemnification is permitted under the laws of the State of New York.

Section 17. Extension of Credit.
Pursuant to New York Public Authorities Law Section 2824(5), the Corporation shall not, directly or indirectly, including through any subsidiary, extend or maintain credit, arrange for the extension of credit, or renew any extension of credit, in the form of a personal loan to or for any Director, officer, or employee (or equivalent thereof) of the Agency.

ARTICLE V
OFFICERS

Section 1. General.
The officers of the Corporation shall be elected by the Board and shall be comprised of a Chairperson of the Board, a Vice Chairperson of the Board, a CEO, a Secretary, and a Treasurer. The Board may also appoint an Assistant Secretary and such other officers as the Board shall from time to time provide. All such officers shall exercise the duties as described in the Act, applicable law, by these By-Laws, and/or by Board resolution.

Section 2. Election, Term of Office.
The officers of the Corporation shall be elected by the Board at its annual meeting. Each officer elected shall hold office until his successor has been duly chosen and has qualified or until his or her earlier resignation or removal.

Section 3. Resignation.
Any officer may resign at any time by giving written notice thereof to the Board, provided that the resignation shall not prejudice the contract rights, if any, of the Corporation. Any such resignation shall take effect at the time specified therein and unless otherwise specified therein the acceptance of such resignation shall not be necessary to make it effective.

Section 4. Removal.
The Directors shall have the authority to discharge any officer with or without cause; provided that the removal without cause shall not prejudice the contract rights, if any, of the officer.

Section 5. Vacancies.
In the event of a vacancy occurring in the office of the Chairperson or Vice Chairperson, any member designated by the Board shall serve as Acting Chairperson for that meeting. In the event of a vacancy occurring in any other office, any member designated by the Board shall serve as an Acting officer for that meeting.

Section 6. Chairperson of the Board.
The Directors shall, by majority vote, select one of the fifteen Directors as the Chairperson of the Board. The Chairperson shall preside over all meetings of the Board, shall chair the Executive Committee of the Board, and shall have such other duties as the Directors may provide. Other than the Governance Committee, the Chairperson shall serve ex officio on all Board committees with full voting rights. The Chairperson shall serve for a two year term of office. No member of the Board shall be permitted to serve more than two consecutive two year terms as Chairperson of the Board.

Section 7. Vice-Chairperson(s) of the Board.
The Directors shall, by majority vote, select one or more of the fifteen Directors as the Vice-Chairperson of the Board. The Vice-Chairperson shall preside over all meetings where the Chairperson of the Board is absent, and shall have such other duties as the Directors may provide. The Vice-Chairperson shall serve for a two year term of office. At least one Vice-Chairperson shall be designated by a majority vote of the Board as "Vice-Chair, Chair-Elect" in the second year of that Vice- Chairperson's term of office. At the conclusion of the term of the Vice-Chair, Chair-Elect, the Board shall retain authority to appoint the Vice-Chair, Chair-Elect or any other member of the Board of Directors as Chairperson of the Board of Directors.

Section 8. Chief Executive Officer.

The Board shall hire, set the compensation of, execute direct oversight of, and annually review the performance of the CEO. The CEO shall carry out the policies of the Board, provide services to the Board; and shall be subject to the By-Laws, rules and regulations of the Board. He or she shall have all the general powers and duties of a Superintendent of a public general municipal hospital as set forth and enumerated in the General Municipal Law of the State of New York, Section 129, sub. 1 through 9 as amended and of a chief executive officer as set forth in Title 10, subpart 405.3 of the New York Codes, Rules and Regulations and the Act. The CEO shall provide leadership, direction, and administration in all aspects of the Corporation's activities and other corporate entities to ensure compliance with established objectives and the realization of quality, economical health care services, and other related lines of business. The CEO shall ensure the Corporation's compliance with all applicable laws and regulations. The CEO shall submit monthly and special reports to the Board and its committees regarding strategic, operational and financial performance, along with the current status of ECMCC services and facilities. The CEO shall be expected to provide feedback to the Board regarding those employees which report directly to the CEO. The CEO shall ensure that subordinate officers provide meaningful reports to the Board regarding the previous month's activities. The CEO shall coordinate with the Board, Medical Staff, and other Corporation personnel to respond to the community's needs for quality healthcare services and monitor the adequacy of the Corporation's medical activities.

Section 9. President.

The Board shall hire, set the compensation and annually review the performance of the President. The duties of the President shall be distinct from the duties of other officers of the Corporation and shall be enumerated in a job description reviewed by the Executive Committee of the Board.

Section 10. Secretary & Assistant Secretary.

The Board shall, by majority vote, select either Directors or Representatives to serve as the Secretary and Assistant Secretary, if applicable. The Secretary shall send notices for all meetings of the Board. The Secretary shall act as custodian for all records and reports, and shall be responsible for keeping and reporting of adequate records of all meetings of the Board. The Secretary may delegate these duties to another officer to act on his/her behalf. The Secretary will approve and sign the minutes of all meetings of the Board which shall be kept in an official record book. In the absence of the Secretary at any meeting, the Assistant Secretary, if applicable, or any member designated by the Chairperson shall act as the Secretary for that meeting.

Section 11. Treasurer.

The Board shall, by majority vote, select either a Director or a Representative to serve as the Treasurer. The Treasurer shall monitor the financial affairs of ECMCC as managed by the officers of the Corporation and. The Treasurer will also have the power to establish bank accounts in the name of the Corporation. He or she shall do and perform all other duties incident to the office of Treasurer as may be prescribed by the Board from time to time.

Section 12. Immediate Past Chair.

The Immediate Past Chair of the Board shall remain available to the Board and the Chair for purposes of transitional continuity and may be appointed to serve as a member of any Standing or Special Committee of the Board, assuming his or her term of office as a Director has not expired.

ARTICLE VI
COMMITTEES

General Rules

Section 1. General.
The Standing Committees of the Board shall be: the Executive Committee, the Quality Improvement Committee, the Finance Committee, the Audit and Compliance Committee, the Building and Grounds Committee, the Human Resources Committee, the Executive Compensation Committee, the Ethics Committee, the Terrace View Quality Improvement Committee, the Governance Committee, the Investment Committee and the Contracts Committee. At the discretion of the Chairperson, and upon the advice of the Board, additional special committees may be appointed to address specific issues.

Section 2. Appointment of Committees.
The Chairperson of the Board shall appoint all members of standing and special committees. Appointments will be made at the first regular meeting following the annual election of officers, or at such other time deemed necessary by the Chairperson. The Chairperson of the Board shall appoint a Chairperson for each committee. Committee Chairpersons shall serve one year terms of office. The Chairperson may appoint individuals other than Board members to committees either standing or special, except the Executive Committee.

Section 3. Resignation.
A committee member may resign at any time by giving written notice to the Chairperson of the Board. Such resignation shall take effect at the time specified therein and unless otherwise specified therein the acceptance of such resignation shall not be necessary to make it effective.

Section 4. Removal.
Committee members may be removed from committee membership by the Board for inefficiency, neglect of duty, or misconduct of any kind, including but not limited to, violation of the law, after the board has given such member a copy of the charges against him or her and an opportunity to be heard in person or by counsel in his or her defense, upon not less than ten days' notice.

Section 5. Vacancies.
Vacancies occurring otherwise than by expiration of term of office shall be filled for the unexpired terms by appointment from the Chairperson of the Board.

Section 6. Quorum.
At a committee meeting, a quorum shall be one-half the number of members of the committee.

Section 7. Voting.
Only the members of the Board serving on a Standing or Special Committee, or an appointed non-member of the Board serving on a Standing or Special Committee, and the Chairperson of the Board serving ex officio, shall have a vote.

Section 8. Minutes.
Each committee meeting shall have an agenda, time convened and adjourned recorded, and shall submit minutes of its meeting to the Secretary of the Board in advance of the regular monthly meeting.

Standing Committees

Section 9. The Executive Committee.
The Executive Committee shall consist of four (4) Board members. The Corporation's General Counsel and Chief Executive Officer shall serve ex officio as members of the Executive Committee. Other members of the Board may be added when advisable. The Chairperson shall preside at all meetings of the Committee. The Executive Committee shall meet at least quarterly, or upon the call of the Chairperson.

Section 10. The Quality Improvement Committee.
The Quality Improvement Committee shall consist of three (3) members. The Chairperson of the Committee may, in his or her discretion, request the presence of other persons, as the issues before the Committee may dictate. The Committee shall meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Inform the Board of patient safety, performance improvement and quality assurance issues of relevance to ECMCC.
b. Establishment, maintenance and operation of a coordinated quality assurance program integrating the review of activities of all hospital services in order to enhance the quality of patient care and to identify and prevent professional malpractice. The specific responsibilities of the Committee are further set forth in the quality assurance plan of the hospital.
c. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 11. The Finance Committee.
The Finance Committee shall consist of five (5) financially literate members of the Board. The Chairperson of the Committee may, in his or her discretion, request the presence of other persons, as the issues before the Committee may dictate. The Finance Committee shall meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Review relevant budgets of the Corporation and maintain ongoing oversight of the financial situation of the Corporation.
b. Oversee, evaluate, and where appropriate, make recommendations with respect to financial operations of the Corporation.
c. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 12. The Audit & Compliance Committee.
The Audit & Compliance Committee shall consist of at least four (4) members. At least three (3) of the Committee's members shall be independent, as that term is defined by state law. The Corporation's General Counsel shall serve ex officio as a member of the Audit & Compliance Committee. The Chairperson of the Committee may, in his or her discretion, request the presence of other persons, as the issues before the committee may dictate. The Audit & Compliance Committee shall meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Oversight of any independent auditors engaged by ECMCC.
b. Oversight of all ECMCC internal audit processes.
c. Other duties and responsibilities as may be assigned from time to time by the Board.
d. Collaboration with the Quality Improvement Committee in the establishment and maintenance of a coordinated quality assurance program.

e. Collaboration with the Compliance Officer on the establishment, maintenance and operation of a comprehensive compliance program, which shall comply with the Office of the Inspector General Compliance Program Guidance for Hospitals. Specifically, the Committee shall:
    1. Analyze the legal requirements and specific risk areas of the health care industry,
    2. Assess existing policies that address legal requirements and risk areas for possible incorporation into the ECMCC compliance program,
    3. Work with ECMCC departments to develop standards of conduct and policies and procedures to promote compliance with the ECMCC compliance program,
    4. Recommend and monitor the development of internal systems and controls to carry out ECMCC's standards, policies and procedures as part of its daily operations,
    5. Determine appropriate strategy to promote compliance with the ECMCC compliance program and detection of possible violations, including fraud reporting mechanisms, and
    6. Develop a system to solicit, evaluate and respond to complaints and problems.

Section 13. Buildings and Grounds Committee.

The Buildings and Grounds Committee shall consist of three (3) members. The Corporation's General Counsel shall serve ex officio as a member of the Buildings and Grounds Committee. The Chairperson of the Committee may, at his or her discretion, request the presence of other persons, as the issues before the Committee may dictate. The Buildings and Grounds Committee shall meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Evaluation and provision of recommendations with respect to proposed and ongoing construction and renovation projects and budgets.
b. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 14. The Human Resources Committee.

The Human Resources Committee shall consist of three (3) members. The Chairperson of the Committee may, in his or her discretion, request the presence of other persons, as the issues before the Committee may dictate. The Committee will meet at least quarterly or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Establishment of a formal channel of communication among the Board, ECMCC management and the Labor Unions.
b. Responsibility for assuring that appropriate guidelines are in place and monitored to ensure and maintain open communication.
c. Discussion of issues that arise in the operation of the hospital as they affect all parties.
d. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 15. The Executive Compensation/Evaluation Committee.

The Executive Compensation/Evaluation Committee shall consist of no more than four (4) members of the Board. No person whose compensation is determined by the Executive Compensation/Evaluation Committee may serve as a member of the Committee. The Chairperson of the Committee may, in his or her discretion, request the presence of other persons, as the issues before the committee may dictate. The Executive Compensation/Evaluation Committee shall

meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Evaluation, at least annually, of the CEO and President of the Corporation.
b. Determination of the compensation, including benefits, of the above listed Corporation executives.
c. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 16. The Ethics Committee.

The Ethics Committee shall consist of at least one (1) member. The Committee Chairperson may, at their discretion, request the presence of other persons, as the issues before the committee may dictate. The Ethics Committee shall meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Promotion of ethics, integrity, and compliance with laws, policies, and procedures.
b. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 17. The Terrace View Quality Improvement Committee.

The Terrace View Quality Improvement Committee shall consist of at least one (1) member. The Committee shall meet at least quarterly, or upon the call of the Chairperson. The Committee shall be responsible for the following:

a. Establishment and maintenance of a coordinated quality assurance program as specifically applicable to Terrace View.
b. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 18. The Governance Committee.

The Governance Committee shall consist of at least four (4) independent members, as that term is defined in New York Public Authorities Law §2825. The Chief Executive Officer and the General Counsel for the Corporation shall serve ex officio as members of the Committee, and the Chairperson of the Board may attend Committee meetings, but will not be a member of the Committee and will not vote. The Committee Chairperson may, at his or her discretion, request the presence of other persons as issues before the Committee may dictate. The Governance Committee shall meet at least semi- annually, or upon the call of the Committee Chairperson. The Committee shall be responsible for the following:

a. Provision of information to the Board regarding current best governance practices.
b. Review of corporate governance trends.
c. Recommend updates to the Corporation's governance principles.
d. Provision of advice to the Governor and to the Erie County Executive in their appointment of potential Board members regarding the skills and experience required of Board members.
e. Annually review and, as necessary, make recommendations to the Board regarding updating of the Corporation's Bylaws.
f. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 19. The Investment Committee.

The Investment Committee shall consist of at least three (3) members. The Chair of the Finance Committee and the Chief Executive Officer shall serve ex officio as members of the Investment Committee and the Chief Financial Officer shall serve as staff to the Committee. The Committee Chairperson may, at his or her discretion, request the presence of other persons as issues before the Committee may dictate. The Investment Committee shall meet at least semi-annually, or upon the call of the Committee Chairperson. The Committee shall be responsible for the following:

a. Recommendations regarding the designation of the Corporation's investment officer.
b. Recommendations regarding investment policies and procedures consistent with applicable law and the needs of the Corporation.
c. Implementation of appropriate internal controls for investments.
d. Recommendations regarding the selection of the Corporation's investment advisors and investment managers.
e. Review of independent audits of the investment program.
f. Review of quarterly reports from the Corporation's investment advisors and investment managers.
g. Reports to the Board on a quarterly basis.
h. Monitoring the Corporation's system of internal controls and the performance of the Corporation's investment advisors and investment managers.
i. Other duties and responsibilities as may be assigned from time to time by the Board.

Section 20. The Contracts Committee.

The Contracts Committee shall consist of at least three (3) members. The Contracts Committee shall review and make recommendations to the Board with respect to the approval of all contracts required to be approved by the Board pursuant to Corporation policy and applicable law, including Section 2879(3)(b)(ii) of the Public Authorities Law. The Contracts Committee shall meet at least quarterly or upon the call of the Committee Chairperson. The Committee shall be responsible for the following:

a. Review of contracts of the Corporation requiring Board approval and making recommendations to the Board regarding contracts of the Corporation.
b. Annual review of contracts requiring such review pursuant to Corporation policy and/or applicable law.
c. Reports to the Board on a monthly basis regarding the foregoing subsections.
d. Other duties and responsibilities as may be assigned from time to time by the Board.

ARTICLE VII
MEDICAL/DENTAL STAFF

Section 1. Organization.

The Board shall cause to be created a medical staff organization to be known as the ECMC Medical Dental Staff ("Medical Staff") whose membership shall be comprised of certain categories of health care practitioners, as determined by the Board. Members of the Medical Staff may only practice within the scope of privileges granted by the Board.

Section 2. Medical Staff Governance Documents.

The Medical Staff shall develop, adopt and at least once every three years review the following Medical Staff Governance Documents: By-Laws; Rules & Regulations; Credentials Procedures Manual; and Collegial Intervention, Peer Review, Fair Hearing & Appellate Review Procedures. These Governance Documents shall establish controls that are designed to ensure the achievement and maintenance of the highest quality medical care and high standards of professional and ethical practice. The Board shall approve all such Medical Staff Governance Documents.

Section 3. Appointment of Medical Staff.

Appointments and reappointments to the Medical Staff shall be made by the Board. The Board shall be responsible for granting and defining the scope of the clinical privileges to be exercised by each member of the Medical Staff, including but not limited to providing approval of modifications, suspensions and termination of such privileges and Medical Staff membership in accordance with the Medical Staff Governance Documents and written ECMCC policies. In acting on matters of Medical Staff membership and scope of privileges, the Board shall consider the recommendations of the Medical Staff's Medical Executive Committee. The procedures for Medical Staff appointment are more specifically outlined in the Medical Staff's Credentials Procedure Manual.

Section 4. Authority for Medical Staff Conduct.

Ultimate responsibility for the conduct of the Medical Staff remains with the Board. The Board shall enforce compliance with all medical staff Governance Documents by all members of the Medical Staff. No assignment, referral or delegation of authority by the Board to the Medical Director, COO, CEO, the Medical Staff or any other person shall preclude the Board from exercising the authority required to meet its responsibility for the conduct of the Corporation. The Board retains the right to rescind any such delegation.

Section 5. Duties of the Medical Staff.

The Board shall delegate to the Medical Staff the authority to monitor, evaluate and document professional performance of Medical Staff members in accordance with its Governance Documents. The Board shall hold the Medical Staff accountable, through the chiefs of service of the departments and the Medical Director, for making recommendations based on well-defined and written criteria related to the goals and standards of the Corporation concerning Medical Staff appointments, reappointments and clinical privileges.

Section 6. Quality of Patient Care.

The Medical Staff is accountable to the Board for the quality of care provided to patients.

Section 7. Rights at Meetings.

Members of the Medical Staff shall be entitled to be heard at all public meetings and committee meetings of the Board.

ARTICLE VIII
STANDARDS OF PATIENT CARE

The Board shall require that the following patient care practices are implemented, shall monitor ECMCC's compliance with these patient care practices, and shall take corrective action as necessary to attain compliance:

a. Every patient of ECMCC, whether an in-patient, emergency patient, or out-patient, shall be provided care that meets generally accepted standards of professional practice.
b. Every patient is under the care of a health care practitioner who is a member of the medical staff.
c. Patients are admitted to ECMCC only on the recommendation of a member of the medical staff permitted by the State law and Medical Staff Governance Documents to admit patients to the hospital.
d. A physician, a registered physician's assistant or a nurse practitioner, under the general supervision of a physician, is on duty at all times in the hospital.
e. A physician shall be responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization.
f. In the event that human research is conducted within ECMCC, written policies and procedures shall be adopted and implemented pursuant to the provisions of Public Health Law Article 24-A for the protection of human subjects.
g. ECMCC shall have available at all times personnel sufficient to meet patient care needs.

ARTICLE IX
THE SCHOOL OF MEDICINE
STATE UNIVERSITY OF NEW YORK AT BUFFALO

The Board strongly supports the relationship between ECMCC and the School of Medicine and Biomedical Sciences of the State University of New York at Buffalo through an affiliation agreement. The Board shall take all appropriate action to retain and enhance the benefits arising from said relationship provided that the Board shall hold uppermost the discharge of its legal and fiduciary duties to ECMCC.

ARTICLE X
SUBSIDIARY CORPORATIONS AND ENTITIES

Except as expressly limited by law, the Corporation may exercise and perform all or part of its purposes, powers, duties, functions or activities through one or more subsidiary corporations or companies owned or controlled wholly or in part by the Corporation, which shall be formed pursuant to the Business Corporation Law, the Limited Liability Company Law, or the Not-For-Profit Corporation Law. Any such subsidiary may be authorized to act as a general or limited partner in a partnership or as a member of a limited liability company and to enter into an arrangement calling for an initial and subsequent payment by such subsidiary in consideration of an interest in revenues or other contractual rights. The Board has the exclusive authority to create subsidiaries or other entities related to the Corporation.

ARTICLE XI
CODE OF ETHICS AND CONFLICTS OF INTEREST

Section 1. Responsibility of Members of the Board and Employees.
This Code of Ethics shall apply to all officers and employees of the Corporation. These policies shall serve as a guide for official conduct and are intended to enhance the ethical and professional performance of the Corporation's directors and employees and to preserve public confidence in the Corporation's mission. It is accordingly the responsibility of each member of the Board and each employee to perform in accordance with the following:

a. Each member of the Board and all employees of the Corporation shall perform their duties with transparency, without favor and refrain from engaging in outside matters of financial or personal interest, including other employment, that could impair independence of judgment, or prevent the proper exercise of one's official duties.

b. Each member of the Board and all employees shall not directly or indirectly, make, advise, or assist any person to make any financial investment based upon information available through the director's or employee's official position that could create any conflict between their public duties and interests and their private interests.

c. Each member of the Board and all employees shall not accept or receive any gift or gratuities where the circumstances would permit the inference that: (a) the gift is intended to influence the individual in the performance of official business or (b) the gift constitutes a tip, reward, or sign of appreciation for any official act by the individual. This prohibition extends to any form of financial payments, services, loans, travel reimbursement, entertainment, hospitality, thing or promise from any entity doing business with or before the Corporation.

d. Each member of the Board and all employees shall not use or attempt to use their official position with the Corporation to secure unwarranted privileges for themselves, members of their family or others, including employment with the Corporation or contracts for materials or services with the Corporation.

e. Each member of the Board and all employees must conduct themselves at all times in a manner that avoids any appearance that they can be improperly or unduly influenced, that they could be affected by the position of or relationship with any other party, or that they are acting in violation of their public trust.

f. Each member of the Board and all employees may not engage in any official transaction with an outside entity in which they have a direct or indirect financial interest that may reasonably conflict with the proper discharge of their official duties.

g. Each member of the Board and all employees shall manage all matters within the scope of the Corporation's mission independent of any other affiliations or employment. Directors, including ex officio board members, and employees employed by more than one government entity shall strive to fulfill their professional responsibility to the Corporation without bias and shall support the Corporation's mission to the fullest.

h. Each member of the Board and all employees shall not use Corporation property, including equipment, telephones, vehicles, computers, or other resources, or disclose information acquired in the course of their official duties in a manner inconsistent with State or local law or policy and the Corporation's mission and goals.

i. Each member of the Board and all employees are prohibited from appearing or practicing before the Corporation for two (2) years following employment with the Corporation consistent with the provisions of Public Officers Law.

Section 2. Implementation of Code of Ethics.
This Code of Ethics shall be provided to all members of the Board and all employees upon commencement of employment or appointment and shall be reviewed annually by the Governance Committee.

Section 3. Compliance.
The members of the Board agree to comply with all applicable local and state regulations and laws regarding conflicts of interest.

Section 4. Conflict of Interest Policy.
The Board shall develop, implement, and update as needed a written policy governing conflicts of interest by members of the Board. The policy shall be reviewed annually by the Governance Committee and included and incorporated into these By-Laws as Appendix A.

Section 5. Disclosure of Personal Interest and Abstention.
It is the responsibility of every Board member to disclose to the Chairperson of the Board any personal or business interest in any matter that comes before the Board for consideration. Each member of the Board shall abstain from voting on any matter in which he or she has a personal or business interest.

Section 6. Self-Dealing.
The Corporation shall not engage in any transaction with a person, firm, or other business entity in which one or more of the Board members has a financial interest in such person, firm or other business entity, unless such interest is disclosed in good faith to the Board, and the Board authorizes such transaction by a vote sufficient for such purpose, without counting the vote of the interested Board member.

Section 7. Influence of Decision Makers.
No member of the Board shall use his or her position to influence the judgment or any decision of any Corporation employee concerning the procurement of goods or services on behalf of the Corporation.

Section 8. No Forfeit of Office or Employment.
Except as provided by law, no officer, member, or employee of the state or of any public corporation shall forfeit his or her office or employment by reason of his or her acceptance of appointment as a director, nonvoting representative, officer, or employee of the Corporation, nor shall such service as such a director, nonvoting representative, officer or employee be deemed incompatible or in conflict with such office or employment; and provided further, however, that no public officer elected to his or her office pursuant to the laws of the state or any municipality thereof may serve as a member of the governing body of the Corporation during his or her term of office.

ARTICLE XII
AMENDMENTS

These By-Laws of the Board may be amended by the affirmative vote of a quorum of members at the annual meeting, special or regular meetings of the Board, provided that a full presentation of such proposed amendment(s) shall have been presented to the Board at least thirty (30) days prior to the meeting, unless waived by majority of the whole number of the members of the Board.