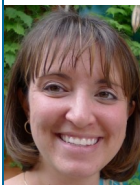




Vital Signs of Northeastern New York

Presidents Message



Dear HFMA Colleagues:

It's hard to believe we are almost half way through our chapter year and nearing the end of 2010! In today's healthcare environment, many organizations are struggling financially and strategically. The landscape is becoming increasingly competitive. The composition of your workforce should be a critical aspect of your strategic planning. The demographics of the workforce are rapidly changing. The baby-boomer generation is nearing retirement and make up a significant portion of the current workforce. Educating and inspiring the newcomers to the workforce is extremely important and I am appealing to you with this message to either get more involved with HFMA or mentor someone else to get involved with HFMA.

As with every organization, HFMA is facing a similar challenge's with succession planning. Not a board meeting passes without our serious consideration for our chapter's future. Recently, our chapter came very near to extinction and our officers and board of directors went on a planning retreat to determine the future of our chapter. It was decided to "forge on" and that the future lies with new volunteers and reaching out to the newcomers to our workforce. Earlier in the year we held an "Introduction to HFMA" session which was well attended. There were a few individuals who took extra initiative and "Stepped Up" wanting to volunteer with our chapter in a more formal role. I want to take this opportunity to recognize these individuals: Paul Gordon, AVP of Corporate Affairs at Seton Health, as our new Secretary and next year President-Elect. Jean Russell, Partner with Epoch Health Solutions and Rabin Kayastha, Financial System Analyst at Saratoga Hospital, as our new program co-chairs.

HOWEVER, we need to keep planning; we need more volunteers to keep our chapter viable year after year!!

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*HFMA's Vision Is "To Be
An Indispensable
Professional Resource
For Healthcare Financial
Managers."*





“Vital Signs of Northeastern New York” is the official newsletter of the Northeastern New York Chapter of the Healthcare Financial Management Association.

EDITORIAL POLICY

Submission of material for publication is strongly encouraged. Articles should be typewritten. The editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. Send all correspondence, or materials for publication, to:

Rabin Kayastha
Saratoga Hospital
125 High Rock Avenue
Saratoga Springs, NY 12866
FAX: 518-584-4108
Email: rkayastha@saratogacare.org

Opinions expressed in articles or features are those of the author and do not necessarily reflect the views of the Healthcare Financial Management Association, Northeastern New York Chapter or the editor.

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HFMA helps finance leaders create and maintain fiscally sound health-care organizations in order to provide excellent patient care.

[Benefits of membership!](#)

Programming is a big part of what we do every year and there is a lot of coordination to bring you educational programs that are relevant and meaningful to our ever changing industry. So I am encouraging you to either get more involved by volunteering or mentoring someone in your organization to get more involved with HFMA. It can be big or small, whether it is starting by attending a session and getting to know one of the officers, helping to plan a session by finding a speaker or helping at the registration table, or someday becoming president of the chapter.

As a newcomer to the field, right out of college several years ago I quickly became involved in HFMA because of their educational offerings and networking opportunities. I found that the people I met, the programs I attended, and my involvement at the board level significantly influenced my continual success and growth in the health care financial field. So, I encourage you to get involved or recognize someone who wants to get involved... because you or they will be the future of your organization and

you can't afford to miss this opportunity to plan for your organizations future success.

If you are interested in learning more about volunteering, please contact myself or any of the officers or board of directors for more information about getting involved in HFMA. We would love to have you on our team!

Sincerely,

Mollie Kennedy
HFMA NENY Chapter
President

EDUCATIONAL EVENTS

Interesting educational topics that you may find useful:

Local Events:

CORPORATE COMPLIANCE PROGRAMS - Industry Best Practices

Date: November 18, 2010

Time: 8:30 - 12:00 PM

Where: Edison Club, Rexford New York

This upcoming educational program will be focused on Corporate Compliance. What





every healthcare professional needs to know about the ever changing rules and regulations. Key elements of the Stark Laws, self-reporting processes, RAC audit defense and more.

Don't miss this exciting opportunity coming to a HFMA session near you!

See our website for more details: www.hfmaneny.org

Webinars:

Integrating Healthcare Delivery and Financial Solutions to Maximize Reimbursement

Date and Time:

Tuesday, November 30, 2010, 2:00 – 3:30 p.m. Central Time

Linda J. Corley, MBA, CPC
Senior Leader—Compliance and Associate Development
Dell Services, Revenue Cycle Solutions

Vanessa Stacks, MHA
Revenue Cycle Director
Baptist Health System

Webinar Summary

Find out about new clinical (patient care) and financial management strategies that will allow providers to reduce unnecessary services and to positively react to healthcare reform, and enhance communications between financial and clinical staff to drive results.

After this Webinar you will be able to understand the requirements for optimum reimbursement under CMS programs, incorporate best practice procedures, and evaluate your organizations performance and ensure all staff members are knowledgeable and have clearly focused measurable outcomes. You will learn to communicate more effectively with clinical staff and improve habits and processes that drive reimbursement.

Tools and Takeaways

After this session, the participant will be able to lead organizational changes required for meeting governmental quality and pay-for-performance initiatives through patient care methodologies that

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allow for optimum reimbursement.

Recommended For

CFOs, PAS, PFS, CNO, and HIM leaders, PFS staff members, patient care managers, and nurse auditors

Pricing

HFMA Members: Free

Non-Members: \$99

**HFMA 2010 Fall Seminar Series:
Chicago**

**Chicago, Illinois
December 6-8, 2010**

In-depth seminars on:

- Managed care contracting, negotiation, and reimbursement in the era of reform
- Industry standard KPIs to create a high-performance revenue cycle
- Research-based models to benchmark, shape, and influence organizational performance
- Best-practice cost accounting systems designed to cope with today's complex reimbursement environment
- Better decision-making with improved financial reporting
- Opportunities for collaboration with physician partners, or employed physicians, including performance and quality measures
- Charge master integrity basics, and advanced charge master strategies to optimize reporting and compliance
- The conversion to ICD-10 and potential pitfalls

**Look for brand-new sessions in the
Session Descriptions!**

Facilitated by professional faculty with real-world healthcare finance experience, HFMA's seminars provide unique take-aways and tools that can be implemented quickly. Seminars are divided into two content areas:

- Financial Management Strategies and Operations
- Revenue Cycle Improvements / Payment Trends / Managed Care / Reimbursement

NEW MEMBERS

Please Welcome!

TRANSFERS:

NEW MEMBERS:

Michele Smith, MBA

Robert LaPolt

Shannon Campoli

David B. Antolowitz,
CPA

Marcy C. Maloy

William Allison

Anthony J. Lombardo

REINSTATED

Fred Matthews

Allan S. Filler





SAVE THE DATE

LEADERSHIP TRAINING CONFERENCE!

Hilton New Orleans Riverside

Two Poydras Street
New Orleans, LA 70140
Reservations: 1-800-HILTONS

SAVE THE DATE: MAY 15-17, 2011



Here's an opportunity for you to meet the people that make up HFMA. At the LTC you'll bring home new skills, strategies and successful practices back to your chapter. If you are interested in leadership opportunities in HFMA, "Step Up" and volunteer!

http://www1.hilton.com/en_US/hi/hotel/MSYNHHH-Hilton-New-Orleans-Riverside-Louisiana/index.do for hotel information.

This year, each of these areas provide sessions that fit into three distinct focus areas. Look for the icons below in the session descriptions: For more information please [click here](#)

Feature Article:

Medicare: Drifting Toward Disaster

By: Michael O. Leavitt

In health care, the core problem is that costs are rising significantly faster than costs in the economy as a whole. Every piece of evidence shows the trend continuing. The problem is beyond the fact that medical cost growth is faster than that of any other part of the economy. Our problem is also demographic. Our population is aging and as we age, the medical expenses grow. Today, 12 percent of the population is 65 or older. By 2030, nearly 20 percent of us will be seniors. The demographic reality is that there are diminishing numbers of workers per senior. This ratio will decline rapidly once the "baby boom" generation reaches Medicare eligibility age starting in 2011.

The real urgency of this problem starts between now and 2019 when the Medicare Hospital Insurance Trust Fund is projected to become insolvent. There is no backup plan in the law to ensure that hospitals continue to be paid when the Trust Fund is depleted. Congress will not be able to sit idly by and allow the Medicare program to become insolvent – they will be forced to take action. They will have the old familiar choices of raising taxes, cutting benefits to seniors, or imposing reduced





payment rates on health care providers. Some of these choices represent the ugliest of political dilemmas, pitting a generation of workers against their parents and grandparents.

Our choices about social investment – in infrastructure, education, national defense – are being reduced as mandatory spending crowds out discretionary spending. In the last two decades, we’ve gone from half of our national spending being discretionary to only 38 percent. In four years, it is projected to be down to less than one-third. We are seeing mandatory health care expenses crowd out other government spending – just as we are going to see health care spending crowd out non-health care spending in American households. Let’s think on a horizon of 20 years.

The massive burden we are feeling is created by a full 16 percent of our Gross Domestic Product rushing through a single sector of the economy. We need changes that can affect this entire sector we call health care. But there is a very close relationship between Medicare and the balance of the U.S. health sector. Medicare is such a powerful payer; the rest of the sector has based their billing and reimbursement mechanisms on Medicare.

I believe the key to health care reform in our nation is Medicare reform. Successfully changing Medicare will trigger the rest of the health care sector to follow. That would be

better news if changing Medicare were not so politically and bureaucratically complicated. I hope I have made clear to you just how alarmed I am and how alarmed we should all be. There is serious danger here. To members of Congress, fixing entitlements like Medicare is lethal. Persuading them to accept the inherent risks will require a system of special political protection. Without it, Congress is unlikely to ever deal directly with Medicare’s problems. It will require what I call a partisan eclipse – a brief moment of time when political planets align to create an opportunity.

Partisan eclipses are often brought on by a crisis or national emergency. There are moments during certain election cycles when both parties feel mutually at risk of being the minority party. What if leaders of both parties in Congress had met privately and acknowledged that while they could not agree on how to fix Medicare, they could agree that the approaching Medicare insolvency had to be dealt with. Both would likely be motivated by an understanding that it was in their party’s long-term interests because solving such a problem would be especially costly in political terms to the party in power at the time the dilemma matures. The equilibrium of uncertainty creates an elegant self-enforcing fairness.

What if Congressional leaders used a moment of political equilibrium of uncertainty to define a process not for themselves, but for a



Congress and President to be elected years in the future? What if that legislative process they agreed on was so scrupulously fair and bipartisan that either party would be willing to proceed even if they were not in the majority? A partisan eclipse will occur in the future and it should be used to provide political protection and a viable path forward at a future date.

The legislation resulting from the partisan eclipse must incorporate another practical principal: separate commitment-making from pain-taking. The bill should establish measurable trigger points for action. The special process could resemble the one Congress has used successfully for military base closure. A special bipartisan committee was established to assemble a proposal. The proposed plan is submitted to the President for review. Within a time certain, the President is required to approve or disapprove the entire plan. Once the President approved a plan, it was submitted to Congress, where they could not amend the proposal, but were forced to vote the proposal up or down within a specific time frame. It worked.

It would be critical that the law enabling this

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special process also include one other provision. If either the Congress or the President fails to act, a series of default provisions must be triggered which solve the problem. Without a default trigger, Congress will not act.

Finally, there is a group of budget-estimating tools referred to as scoring conventions that are used universally across the federal government. In an age when the power of investment and productivity are the keys to success, the federal scoring conventions overvalue the status quo while undervaluing the investments that could transform it. Many have called for those to be modernized. I add my voice to that chorus. So far I have talked about the serious imperative our nation has to change the course of Medicare. I also discussed several parts of a political construct that would allow political action. Now I would like to frame up, at a high level, what a solution should look like from my perspective.

A Medicare System solvent through the 21st Century would have three characteristics. First, value-of-care would replace volume-of-care as Medicare's best-rewarded virtue. Second, Medicare parts A and B would operate like Part D. Third, each generation would carry its share of the load. In Medicare, our most expensive patients are those with multiple chronic diseases. The combination of ailments compounds to magnify each other. The same is true with Medicare. Medicare has three



chronic ailments that are defeating the system. The first, I call Silo Syndrome: each medical action is paid for separately. That provides little opportunity or incentive for coordination among providers and it often results in bad referral decisions, sloppy hand-offs, duplications, fraud, and poor quality of care. The result is inappropriate care and unnecessary cost. Medicare needs to use its power as the nation's biggest payer to change this. It's not only wasteful but it encourages unnecessary care and expensive medical mistakes.

The second category is Quality Indifference: doctors, hospitals and other medical providers are paid at the same rate for low-quality or high quality performance. Physicians who take measures that prevent acute flare-ups of chronic conditions are paid no more than those who don't. Skilled nursing facilities that prevent unnecessary re-hospitalizations are paid the same as those that don't. When patients contract preventable hospital infections, costs skyrocket and in most settings, the hospital profits from it. Not only is our current system quality-indifferent, we reward poor quality.

This leads naturally to the third category of Chronic More: there are no mechanisms or incentives for controlling the volume and intensity of care. Not for the patient or the provider. The entire process rewards volume. Doctor and hospital incomes rise as more units

of service are ordered. If those units are more costly, they generate even more revenue. It is the same for a patient. Our current payment system provides no means for a patient to know the cost and little reason to care. These volume incentives need to be treated with strong doses of information transparency and by building incentives for high quality, efficient care directly into our payment structure. A variety of policies would force these changes, and luckily the infrastructure of quality metrics and strategies for rewarding value are available. It just takes Congressional action. Make Medicare Parts A and B more like Medicare Part D.

In addition to changing the incentives from volume-rewarding, the Medicare Part D Prescription Drug Program provides a good example of how better transparency and competition can drive change. It has not only ensured that seniors get the drugs they need; it has also demonstrated that seniors can use an organized marketplace to drive quality up and cost down.

If the Medicare Part D structure were applied to Medicare Parts A and B, it would revolutionize the entire system.

Imagine a physician practice investing resources to monitor and track patients





with chronic conditions. They might if the program provided beneficiaries with information on the quality-of-care and dollar savings if they used more effective providers. It would drive quality up and cost down.

Medicare can be made more efficient by rewarding value and shifting to a Part-D-like competitive model of delivery. However, what remains the most important obstacle is rebalancing the generational obligation. It is unreasonable to think Medicare can be sustained unless this is changed. If we start now, the change can be made over time and with genuine fairness. We can avoid an intergenerational economic struggle from which both sides suffer. Promises to today's and future beneficiaries to provide coverage of health care must be kept, but not at the expense of future generations.

Medicare is indeed drifting toward disaster, but we know what to do. Every generation of Americans has overcome challenges to secure our nation's role as the world's leader. I believe solving the health care puzzle is this generation's challenge. It will require change. In a global market there are three ways to approach change. You can fight it and fail; you can accept it and survive, or you can lead it and prosper.

We are the United States of America; let us lead.

Considerations for Acquiring or Affiliating with Another Hospital

By Mike Johns, Vice President, Finance Practice, QHR and Tanya K. Hahn, Senior Vice President, Lancaster Pollard

The economic downturn and resulting restricted access to capital have caused many hospitals to consider a partner or other affiliation strategy. Declining volumes and the deteriorating payer mix, a result of high unemployment rates, are further forcing these discussions – as are the seemingly countless opportunities for capital rich hospitals to acquire struggling, undervalued hospitals

Recent healthcare reforms signed into law may have a further impact on hospital affiliation. In fact, a recent Moody's report predicts that "as governmental auditing and oversight of revenue are tightened, hospitals will be pressured to operate more efficiently, forcing spending cuts and mergers among smaller hospitals after 2014." In layman's terms: as reform legislation reduces Medicare reimbursement and disproportionate share funding, and with higher costs, less efficient hospitals could see further Medicare reductions under the law's efficiency provisions.

Affiliating or acquiring may be the right thing to do, but before taking such a step, there are some considerations for both parties. From the



perspective of the facility that needs a partner to survive in the long term, the executive team and board of directors need to carefully consider the type of affiliation needed (i.e. what objectives need to be achieved through the affiliation) and the type of partner needed. From the perspective of the hospital needing a partner, there is a continuum of control that the board wants to consider (i.e. How much control and independence do they want or have the ability to retain?). At one end of the spectrum is an affiliation arrangement that simply calls for cooperation between the hospitals for some mutual benefit and virtually all control is maintained. At the other end of the spectrum is an acquisition of one facility by the other and all control is surrendered to the acquiring facility. In between are management agreements, clinical affiliations, lease transactions, and more formal partnerships with legal and financial commitments by each party. Consideration should also be given to the benefits provided by the other party. For example:

If capital needs are driving the decision, then the strength of the balance sheet of the acquiring facility should be evaluated. Will they be able to provide the capital needed for the coming years?

If expanding the hospital's market is the objective, will the partner provide the complementary service lines, the brand name and reputation that will enhance the ability to increase market share?

Another consideration is whether the acquiring hospital or system has had experience with successfully acquiring other facilities. The merging of two cultures and achieving the synergies planned are not always easy or successful. Those facilities with a successful track record of achieving these objectives are more likely to be successful again. Does the acquiring facility have the management staff depth to assume the assimilation of another hospital into the organization's structure? Does the acquiring facility have the ability to recruit physicians in a different way? If so, they may be able to bring physicians who can facilitate strategic growth initiatives. Achieving synergies through elimination of duplicate services and departments seems rather simple on paper, but are often met with failure due to poor execution or cultural conflicts. Do not underestimate the cultural differences between two organizations that come together.

And what are the capital needs of the acquiring facility? Are they capital starved? If so, they won't have the capital to fund your capital needs either.

Debt Factors

Most debt structures have broad provisions for mergers and acquisitions, and they often require bondholder or lender approval prior to such a transaction. Reviewing the debt



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documentation is a key first step in proceeding with any affiliation/merger discussion. Hospitals must understand what corporate entity is obligated in the outstanding debt of the hospital being brought in, usually known as the Obligated Group. For example, a debt obligation may be supported by both a hospital and its physician practice group – two separate entities. The merger/affiliation, however, may be desired with the hospital only. Understanding the assets or collateral the hospital owns and the debt it can support without the physician practice group is important to knowing how it might be able to refinance or restructure existing debt. In addition, the acquiring hospital/system may have limitations on its ability to restructure its Obligated Group and must understand current refinancing limitations on its own debt before proceeding with the merger/affiliation.

My Debt is Your Debt

A hospital with outstanding letter-of-credit-enhanced debt may see its debt structure improved by affiliating with a partner that

brings a stronger financial position or banking relationship to the table. The LOC may be able to remain in place, saving both hospitals the time and cost of refinancing. Further benefits can be realized if the acquirer has a significant banking relationship with the letter of credit provider, which may prove cost beneficial. HUD/FHA Section 242 mortgage-insured loans are assumable by acquiring hospitals, with approval from FHA, and they remain non-recourse to the affiliation/acquiring hospital. It is important to understand the limitations of transfers among affiliated entities when assuming such a financing structure, but the current limitations on transfers are not overly burdensome and should not be viewed as a deterrent to the affiliation/merger. FHA-insured loans can be assumed by either nonprofit or for-profit hospitals.

USDA direct loans may be assumable depending on the acquirer or affiliation partner. USDA financing is limited to nonprofit hospitals that are rural and that cannot access other means of capital. If an affiliation changes any of these features, then the USDA financing would most likely have to be refinanced. If the partner is a similar-sized rural nonprofit, then assuming the debt may be negotiable.

If a hospital is considering a new debt instrument and is also considering a future affiliation/merger, it should proactively consider future flexibility in creating its financing documents. Potential negative





implications of a merger/affiliation can be minimized or eliminated through active management of debt covenants and prepayment requirements within the financing documentation.

Lastly, as organizations consider a merger/affiliation, they need to evaluate the impacts of such a transaction on the investment portfolios of each as well as any interest rate mitigation contracts such as swaps, caps or collars on the new combined entities. Often these contracts will also include provisions related to mergers/affiliations, which may impact the ultimate decision and/or timing of the transaction. A comprehensive balance sheet analysis needs to occur along with the evaluation of the debt instruments of both parties.

Mike Johns is vice president, Finance Practice, at Quorum Health Resources. For additional information on QHR's consulting solutions, contact vice president Susan Hassell at (866) 371-4669.

Tanya K. Hahn is senior vice president at Lancaster Pollard. She can be reached at (614) 224-8800 or

thahn@lancasterpollard.com.

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Mini LTC, Buffalo NY



Adams Mark Hotel in Buffalo, NY



Reception



Mini LTC, Buffalo NY



Meet & Greet



Buffalo Bills!!!



Rabin getting an autograph from Steve Tasker of the Buffalo Bills GO #89!!



Maybe I could have played pro football. I'm 5' 7"!



Education Session



Bob Masi - at the podium and Rick White (left)

MEMBER PHOTOS - From the Archives!



Larry Melita and Bob Masi



Mollie Kennedy & Rico



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Member Spotlight - Paul Gordon

This interview was conducted for HFMA Northeastern New York by Veronica Ziac, Revenue Cycle Manager at Ellis Medicine. Paul Gordon is an Associate Vice President of Corporate Affairs at Seton Health. He is also the HFMA's Northeast Chapter's Secretary for 2011.

VZ: Tell us about your background and what led to your decision to pursue a career in healthcare management.

PG: I'm from New York City originally – more specifically Staten Island. After graduating from college with an accounting degree I moved to Colorado to get a new and fresh perspective on life. I took a job with Standard and Poor's in Denver and remained with the company for approximately five years. This was my first introduction to the world of finance with all of its complexities. After Denver, my next stop was Boston where I was introduced to Healthcare. I took an Accounting Manager's position with a staff model HMO and that was when I decided that Healthcare was the field that I wanted to remain in. After working there for approx five years I moved to the Capital District and accepted the position of Controller with St. Clare's Hospital in Schenectady. I was with St. Clare's until I moved to my current position with Seton in the middle of 2007.

VZ: Tell us about your current position at Seton Health.

PG: As Associate Vice President – Corporate Affairs, I have three avenues of responsibility. I am responsible for the review and negotiation of all contractual arrangements that Seton Health enters into. Examples of contracts that I work with are; managed care agreements, physician contracts, building and equipment lease agreements, etc. There are many scenarios that need to be taken into account in order to develop the best possible arrangement for your organization. My second avenue of responsibility is the oversight of the Contracting and Revenue Integrity Department. This department is responsible for auditing our insurance reimbursements to ensure that we are being paid according to contracted rates. We have software in place to help administer this and the department has been very successful in recouping dollars that might otherwise have not been collected (Great Staff!!). My third avenue of responsibility is the management of our offsite facilities – which includes landlord-tenant relationships and coordination of administrative activities. I also serve on select committees and work groups that deal with such topics as revenue cycle and facility issues.

VZ: How did you learn about HFMA? What do you see as the benefits of belonging to HFMA?

PG: I first learned about HFMA through my peers at St. Clare's Hospital. The benefits of belonging to an association such as HFMA are



Member Spotlight (Cont..)

VZ: What would you say is one of the top challenges facing healthcare financial managers today?

PG: The recent trend to tie reimbursement to quality initiatives presents new challenges to healthcare providers. Payers want more openness from providers, and want to ensure that their members receive high quality care. However, while payers may try to guide their members to certain providers, a patient's decision regarding which hospital to use is still commonly dictated by their physician. The challenge for hospitals, therefore, is to balance the interests of all three stakeholders – patients, physicians, and our payer partners.

VZ: Tell us a little about your personal life: family, hobbies, interests.

PG: I am married (26 years) and have two sons (a college sophomore and a junior in high school). We love to travel – whether it is for the day, weekend or vacation. I enjoy music, especially live concerts, mountain biking, most sports and dining out. A few of my favorite things to do is to spend a night out or weekend away with my wife or attend a sporting event or concert with my kids or friends. I also enjoy reading and researching the market. Oh – and by the way – I like most Micro Brewed beers!

VZ: Thanks, Paul. On a final note, would you share some of your top picks with us?

PG:

Favorite Travel Destinations = Europe and St. John's

Top Capital District Restaurants = La Serre (French cuisine), Sitar (Indian cuisine)

Favorite Microbrew = Ruddles

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