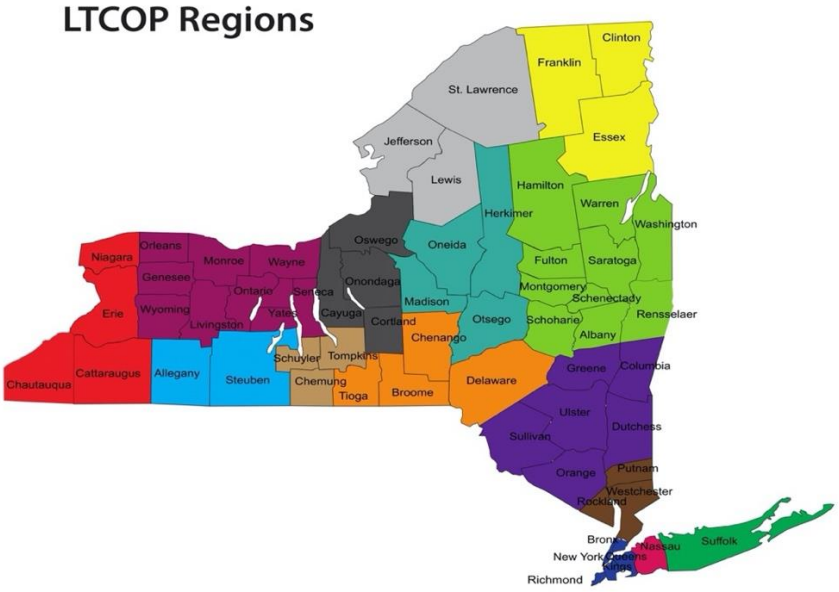
LONG TERM CARE
COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Regional Variations of Nursing Home Quality & Oversight in New York



Richard J. Mollot, JD, Executive Director

Eric Goldwein, MPH, Policy Fellow

Dara Valanejad, JD, Policy Counsel

THE LONG TERM CARE COMMUNITY COALITION

One Penn Plaza, Suite 6252, New York, NY 10119

INFO@LTCCC.ORG

WWW.NURSINGHOME411.ORG

TABLE OF CONTENTS

Note: This report is based on provider information and Payroll-Based Journal (PBJ) data from Nursing Home Compare. We have summarized these data in the complementary data file, NYS Nursing Home Staffing + Ownership Data, which is available in the nursing home information and data section of our website https://nursinghome411.org/nursing-home-data-information/.

Visit our homepage for quarterly staffing data for all US nursing homes, other facility, and state-level data on quality and oversight, and free resources on residents' rights and quality standards.

www.nursinghome411.org

INTRODUCTION

PURPOSE OF REPORT

This report provides a regional review and assessment of nursing home quality in New York based on key indicators such as average staffing levels, antipsychotic drugging rates, and fines for substandard health violations. Previous research and anecdotal reports have indicated differences between the regions, particularly in respect to the efficacy of nursing home oversight (based on the jurisdictions of the various regional offices of the New York State Department of Health (NYDOH)).[1]

In this report, we focus on LTCOP regions for the following reasons:

1. **For LTC Ombudsman Programs**. To provide information to support the work of both the state and regional LTCOPs. For example, information on regional differences in antipsychotic drugging rates and citation rates can be useful in shaping both individual and systems advocacy.
2. **For New York Families**. To provide information that is useful to communities across New York. When nursing home care is needed, families may consider facilities both within and outside their own county. While no system can account for everyone's community, we believe that separating the state by LTCOP regions is useful for residents and their families (particularly since all nursing home residents in a region are served by the same LTCOP office).
3. **For State and Federal Legislators & Policymakers**. Given increasing concerns about the basic safety and dignity of nursing home residents and attacks on minimum regulatory standards, it is essential, from our perspective, that our political representatives are aware of quality, dignity, and other issues facing the families that they represent in Albany and Washington, DC.

BACKGROUND ON THE LONG TERM CARE OMBUDSMAN PROGRAM

The Long Term Care Ombudsman Program (LTCOP) was established by the federal Older Americans Act in 1972 to help address widespread abuse and neglect in nursing homes. The Act requires that each state have an Office of the State Long Term Care Ombudsman.[2] Within each state, there are typically local ombudsman programs which carry out the activities of the LTCOP in their communities.

The LTCOP mission is focused on improving care, quality of life, and dignity for residents by providing residents and families with advocacy support and helping them to "understand and exercise their rights in order to effectively address concerns which impact their health, safety

[1] *See,* for example, *Nursing Home Oversight in New York State: A Regional Assessment* (2006). Available at https://nursinghome411.org/nursing-home-oversight-in-new-york-state-a-regional-assessment/.

[2] The Long-Term Care Ombudsman Program 1972-2016 - Program Milestones. National Consumer Voice. Available at: https://ltcombudsman.org/about/about-ombudsman/program-history .

and quality of life."[3] Though some LTC ombudsmen are paid staff, trained volunteers provide a significant amount of the facility-level monitoring and individual support to nursing home residents as a result of funding restraints.

Ombudsmen do not have regulatory authority (for instance, they cannot penalize a nursing home for abuse or neglect), but they are the only oversight/monitoring entity that has a regular presence in nursing homes (and other residential care settings) and in the lives of residents. The program aims for weekly ombudsman visits to facilities, with sufficient time to observe care and quality of life, engage and educate residents and families, and help resolve care and quality of life issues.

Unfortunately, this goal is often unmet; funding restraints often prevent ombudsman programs from fully covering all nursing homes in their communities. However, this is partially compensated for by the requirement that facilities prominently post contact information for the LTCOP, ensuring that residents and families have access to the services of an ombudsman when necessary.

Information on complaints and investigations handled by ombudsmen on the state and local levels are compiled in a national database, the National Ombudsman Reporting System (NORS).[4] The system provides data on complaint handling, state LTCOP funding, staffing, and more.

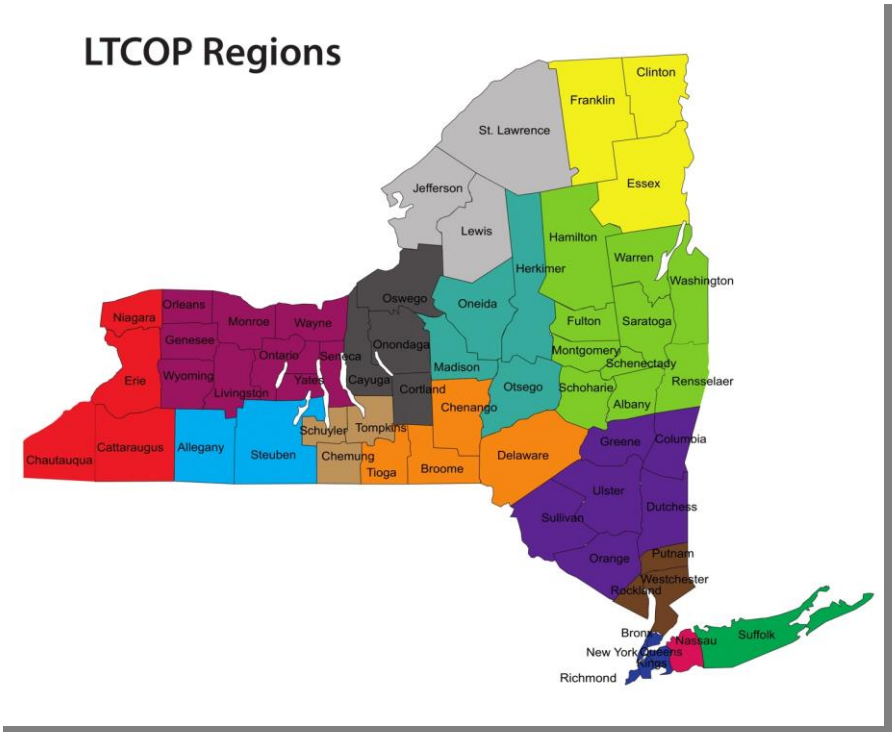
In New York State, the office of the state LTCOP is housed in the state Office for the Aging. The program operates on the local level through 15 regional offices, which are housed in independent, non-profit agencies.

NOTES ON THE DATA

- The data presented in this report provide averages of the nursing homes in each region based upon different criteria. Some of these relate to quality of nursing home care while others (specifically the sections on citations and fines) may be more reflective of variations in the performance of the different regional offices of the NYS Department of Health (DOH) (see Page 8 for the chart of DOH regional offices).
- This report uses Payroll-Based Journal (PBJ) data from CMS from the first quarter of 2019 (see: 2019Q1 Daily Nurse Staffing data set) and from Nursing Home Compare (see: Provider Info).
- Each nursing home's LTCOP region was assigned based on its county listed in the CMS and Nursing Home Compare datasets. For example, a nursing home in Nassau county would be assigned to LTCOP Region 2, according to the official map provided by the New York State website shown on Page 6.

[3] 2017 Annual Report, *Office of the State Long Term Care Ombudsman*. See https://www.ltcombudsman.ny.gov/Whatis/2017%20LTCOP%20Annual%20Report.pdf.
[4] https://agid.acl.gov/DataGlance/NORS/.

MAP: LTCOP REGIONS BY COUNTIES



1 Suffolk
2 Nassau
3 Bronx, New York, Richmond, Queens, Kings
4 Putnam, Westchester, Rockland
5 Greene, Columbia, Ulster, Dutchess, Sullivan, Orange
6 Hamilton, Warren, Washington, Fulton, Saratoga, Montgomery, Schenectady, Schoharie, Albany, Rensselaer
7 Clinton, Franklin, Essex
8 Jefferson, St. Lawrence, Lewis
9 Oneida, Herkimer, Madison, Otsego
10 Cayuga, Oswego, Onondaga, Cortland
11 Tioga, Broome, Chenango, Delaware
12 Schuyler, Chemung, Tompkins
13 Orleans, Genesee, Wyoming, Monroe, Wayne, Livingston, Ontario, Yates, Seneca
14 Allegany, Steuben
15 Chautauqua, Niagara, Erie, Cattaraugus

Please see the next page for a chart of the regions, sponsoring agencies, and counties covered.

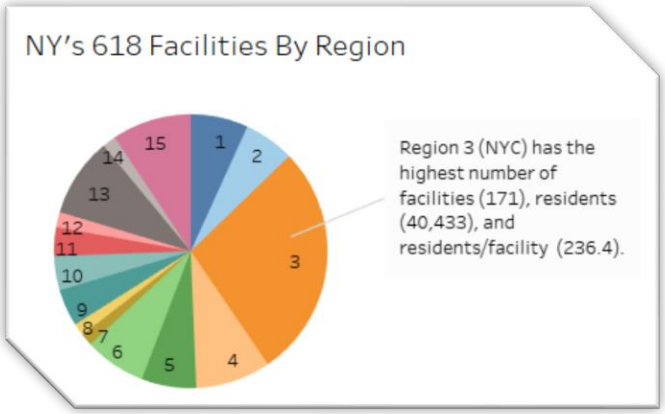
LTCOP REGIONAL OFFICE SPONSORS AND COUNTIES COVERED

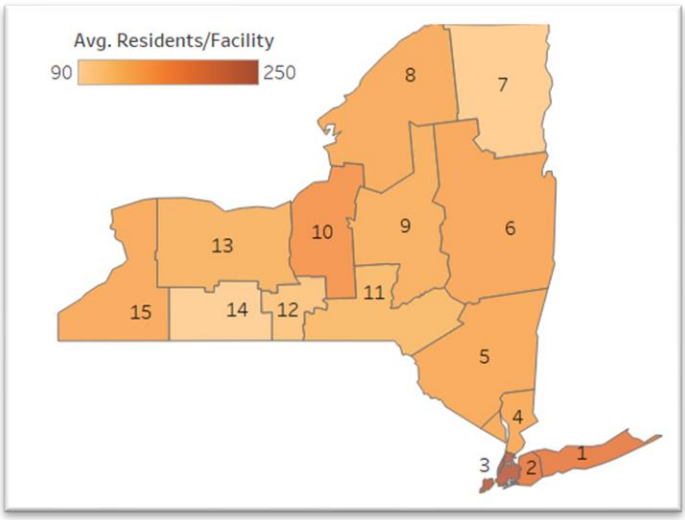
LTCOP REGION	SPONSOR	COUNTIES UNDER REGION
1	Family Service League	Suffolk
2	Family and Children's Association	Nassau
3	Center for Independence of the Disabled	Bronx, New York, Richmond, Queens, Kings
4	Long Term Care Community Coalition	Putnam, Westchester, Rockland
5	Long Term Care Community Coalition	Greene, Columbia, Ulster, Dutchess, Sullivan, Orange
6	Catholic Charities Senior and Caregiver Support Services	Hamilton, Warren, Washington, Fulton, Saratoga, Montgomery, Schenectady, Schoharie, Albany, Rensselaer
7	North Country Center for Independence	Clinton, Franklin, Essex
8	Northern Regional Center for Independent Living, Inc.	Jefferson, St. Lawrence, Lewis
9	Resource Center for Independent Living	Oneida, Herkimer, Madison, Otsego
10	ARISE Child and Family Services, Inc.	Cayuga, Oswego, Onondaga, Cortland
11	Action for Older Persons	Tioga, Broome, Chenango, Delaware
12	Tomkins County Office for the Aging	Schuyler, Chemung, Tompkins
13	Lifespan	Orleans, Genesee, Wyoming, Monroe, Wayne, Livingston, Ontario, Yates, Seneca
14	AIM Independent Living Center, Inc.	Allegany, Steuben
15	People, Inc.	Chautauqua, Niagara, Erie, Cattaraugus

LTCOP REGIONS BY THE NUMBERS

LTCOP Region	Facilities	Total Residents	Residents Per Facility
1	42	7,772	185
2	37	6,941	188
3	171	40,433	236
4	55	7,571	138
5	40	5,491	137
6	45	6,322	140
7	9	875	97
8	9	1,219	135
9	27	3,529	131
10	25	3,942	158
11	21	2,521	120
12	11	1,197	109
13	58	7,402	128
14	10	953	95
15	58	7,927	137
Average	41	6,940	142
Total	618	104,093	2,134

Note: LTCOP regions vary significantly in number of facilities and residents.





NYS DEPARTMENT OF HEALTH REGIONAL OFFICES AND COUNTIES COVERED

NEW YORK DEPARTMENT OF HEALTH REGIONAL OFFICE	COUNTIES UNDER REGION
Capital District Regional Office	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington
Central New York Regional Office	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and Tompkins
Metropolitan Area Regional Office	Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester
Western Regional Office	Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Schuyler, Seneca, Steuben, Wayne, Orleans, Wyoming, and Yates

TOTAL STAFFING HOURS PER RESIDENT PER DAY

BACKGROUND

Staffing levels are perhaps the most important indicators of a nursing home's quality and safety. A landmark federal study in 2001 found that 97% of facilities failed to meet one or more staffing requirements and 52% failed to meet all staffing requirements necessary to prevent avoidable harm to residents.[5] The federal study determined that 91% lacked sufficient staff to provide decent care. Unfortunately, this situation continues today. For instance, a 2014 study by the US DHHS Inspector General found that an astounding one-third of people who turn to a nursing home for Medicare rehab are harmed within an average of about two weeks and that 59% of the time that harm is "clearly or likely preventable."[6]

The 2001 federal study identified 4.1 hours of direct care staff time per resident per day (HPRD) as, essentially, the threshold necessary for a typical nursing home resident to receive sufficient clinical care and avoid unnecessary harm. However, while the study is frequently used as a reference point in discussions of minimum staffing standards, several factors indicate that its findings are insufficient to meet requirements for resident care and dignity, including:

1. The study was not focused on measuring the staffing levels necessary to provide the quality of care specifically required by federal regulations;
2. The study focused on clinical outcomes and did not address staffing needed to ensure that residents receive the care services required (under federal law) to meet their emotional and psycho-social needs (including living with dignity); and
3. The facilities selected for the study were not required to provide "high quality of care."

Other studies have indicated that greater than 4.1 HPRD is needed. A 2000 study in *The Gerontologist* indicated that 4.13 HPRD as the minimum total number of direct nursing care staff and 4.55 HPRD for total administrative and direct and indirect nursing. The study noted that staffing must be adjusted upward for residents with higher nursing care needs.[7] A 2016 study, focused only on nurse aide (CNA) care staffing needs, found that residents need 2.8 to 3.6 HPRD of CNA care, on average, to keep rate of care omissions below 10%.[8] That is approximately 20% higher than the CNA time identified in the 2001 federal study.[9]

---

[5] Abt Associates (Prepared for the Centers for Medicare and Medicaid Services), *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report To Congress: Phase II Final (December 2001). Available at https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf.

[6] *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (Feb. 2014). Available at https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf.

[7] Harrington, C., et. al., "Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States," *The Gerontologist,* Vol. 40, No. 1, 5-16 (2000). [Emphasis in original.]

[8] Schnelle, J., et. al., "Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model," *JAMDA* 17 (2016) 970e977.

[9] The 2001 Abt study identified an upper range of 2.8 CNA HPRD. We subtracted 2.8 from the upper range of the 2016 Schnelle study, 3.6, resulting in .8 which is 22% of 3.6.

STAFFING BENCHMARKS

- **Safety Threshold**. This report uses 4.10 hours per resident day (HPRD) of direct care staff time as the safety threshold.
- **National Average**. The national average for care staff is 3.36 HPRD.
- **New York State Average**. The state care staff average is 3.40 HPRD.

Notes:

Total and RN staffing HPRDs were calculated by dividing a given sample's total staffing hours by its total average residents. Calculations excluded facilities that did not report staffing data.

National and state care staff averages include staff assigned to provide care. They *do not* include the RN and LPN staffing assigned to administrative duties. The NYS average and nationwide average were calculated from the 2019Q1 PBJ (payroll-based journal) staffing data set.

OBSERVATIONS & IMPLICATIONS

- All regions in New York failed to meet the minimum safety threshold of 4.1 staffing HPRD, demonstrating that staffing levels are a state-wide problem.
- Total staffing HPRD ranged from 3.25 to 3.75 HPRD and had a low degree of regional variability compared to other measures reviewed.

LTCOP REGION	TOTAL STAFFING HPRD		LTCOP REGION	TOTAL STAFFING HPRD
1	3.43		10	3.52
2	3.41		11	3.43
3	3.25		12	3.47
4	3.55		13	3.75
5	3.27		14	3.27
6	3.50		15	3.56
7	3.52		NYS AVG	3.40
8	3.55		US AVG	3.36
9	3.40		Safety Threshold	4.10

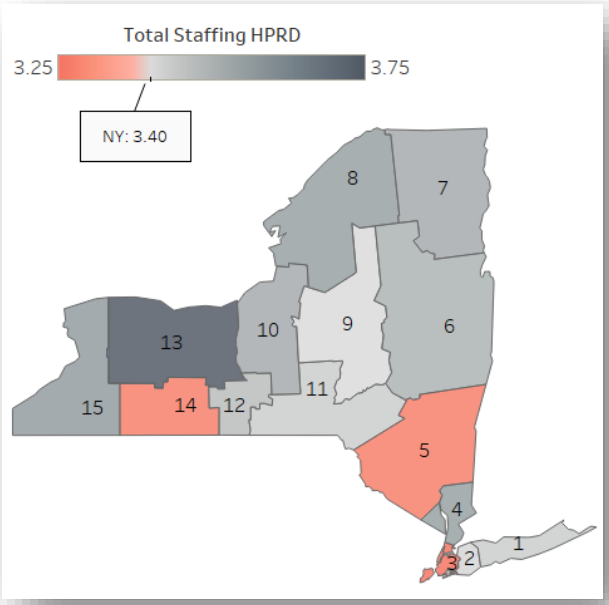
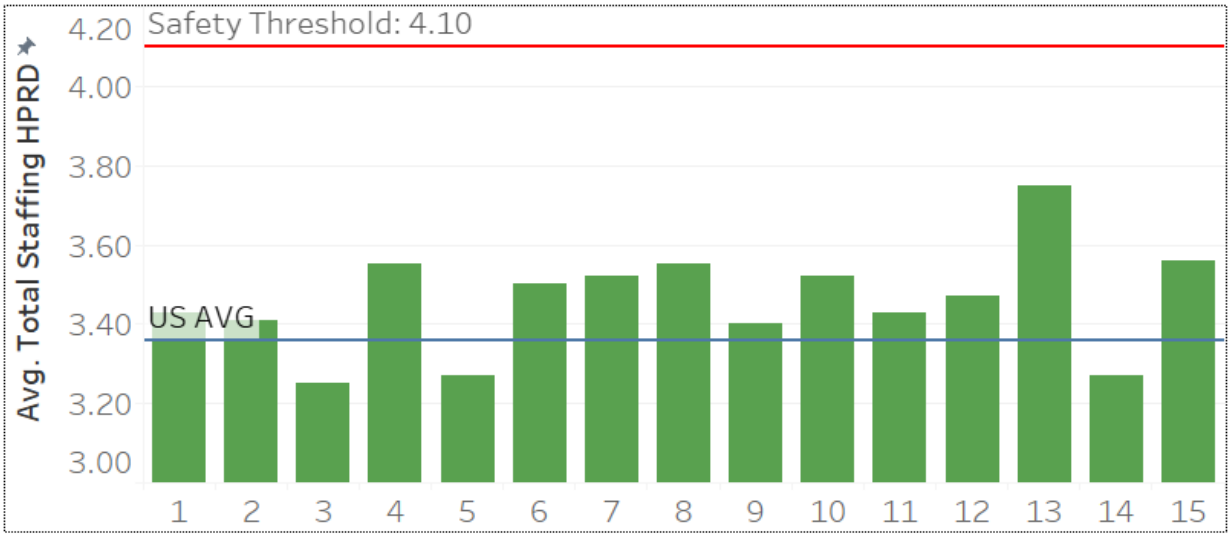


CHART: LTCOP REGION VS. TOTAL STAFFING



RN HOURS PER RESIDENT PER DAY

BACKGROUND

Nursing homes are required to have an RN in their facility working eight consecutive hours a day, every day of the week.[10] Public data on average RN hours per resident per day can help determine facility RN staffing levels.

The 2001 federal report on staffing indicated that a minimum of 0.55 to 0.75 RN HPRD is needed to meet residents' clinical care needs.[11] Because subsequent studies have found that resident acuity has increased over the years, this report utilizes the upper limit, 0.75 HPRD, as the minimum safety threshold.

Notes: For the NYS map displayed below, the numbers represent the corresponding counties as listed in the legend. The NYS average and nationwide average were calculated from the 2019Q1 PBJ data set.

OBSERVATIONS & IMPLICATIONS

- All regional averages fall below the safety threshold of 0.75 HPRD.
- Regions 4 and 7 have the highest RN HPRD. All remaining regions recorded RN HPRDs below 0.50.

[10] CMS Manual System, *Centers for Medicare & Medicaid Services (CMS).* See https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R97SOMA.pdf.

[11] *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report To Congress: Phase II Final, December 2001. See https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf.

LTCOP REGION	RN HPRD		LTCOP Region	RN HPRD
1	0.47		10	0.29
2	0.45		11	0.34
3	0.47		12	0.47
4	0.63		13	0.32
5	0.40		14	0.36
6	0.38		15	0.44
7	0.56		NYS AVG	0.44
8	0.31		US AVG	0.42
9	0.36		Safety Threshold	0.75

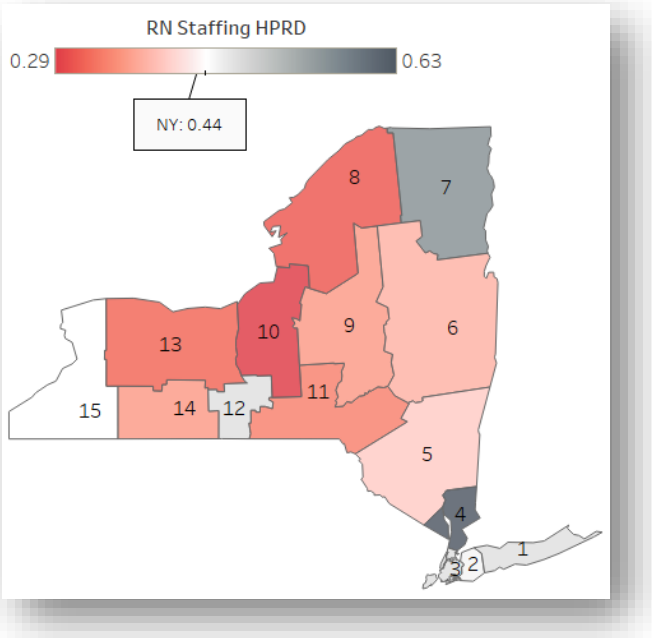
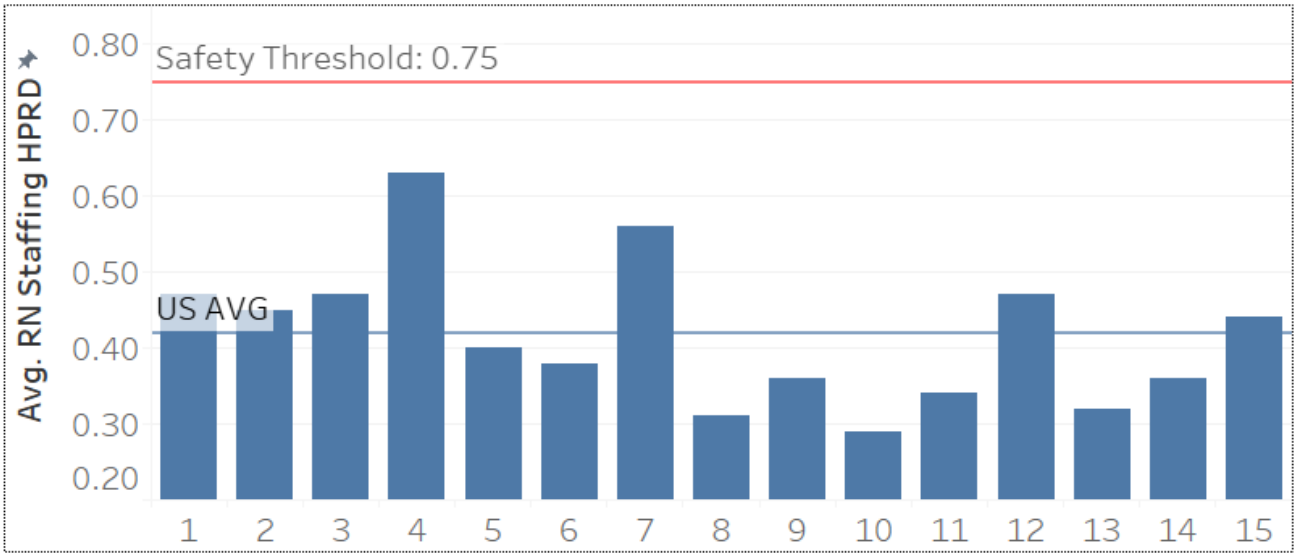


CHART: LTCOP REGION VS. RN STAFFING



PRESSURE ULCER RATE

BACKGROUND

Pressure ulcers are defined as "wounds caused by unrelieved pressure on the skin," and are considered "serious medical conditions and one of the important measures of the quality of clinical care in nursing homes."[12] A high pressure ulcer rate may indicate serious deficiencies in the quality of care delivered to residents in the nursing home.

According to CMS, "[p]ressure ulcers are high-cost adverse events across the spectrum of health care settings, from acute hospitals to home health."[13] Federal expectations for nursing homes state that "[b]ased on the comprehensive Assessment of a resident, the facility must ensure that-- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."[14]

OBSERVATIONS & IMPLICATIONS

- Overall, New York's pressure ulcer rates are well above the national average.
- Regions 3, 2, 4, and 14 had the state's highest pressure ulcer rates, while Regions 1, 6, 8, and 10 are markedly below the state average.

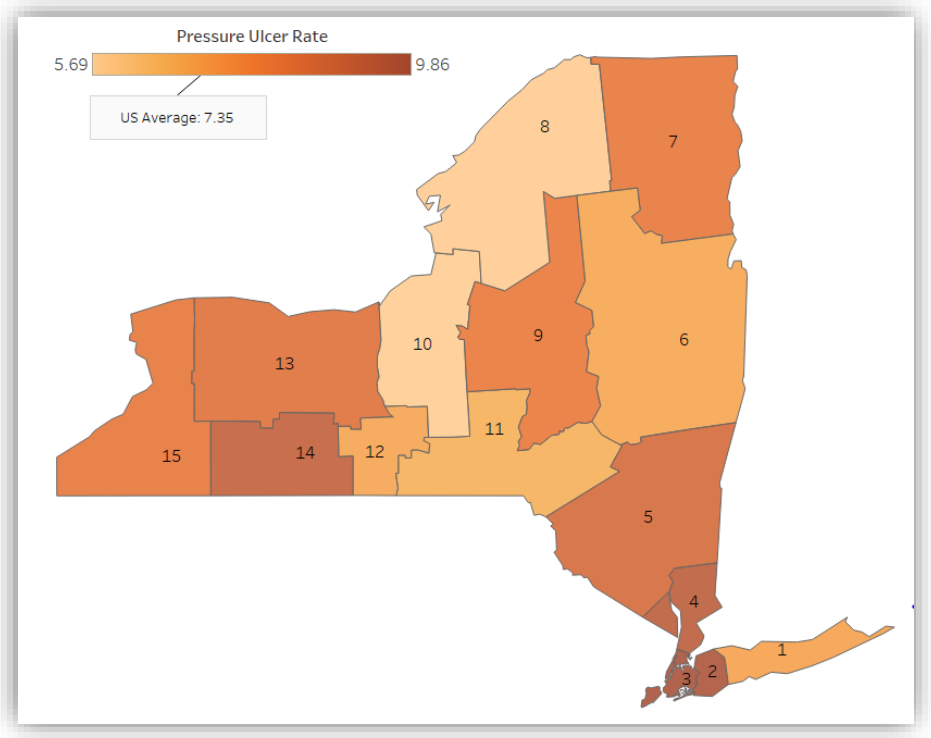
LTCOP REGION	PRESSURE ULCER RATE		LTCOP REGION	PRESSURE ULCER RATE
1	6.96		10	5.69
2	9.74		11	6.61
3	9.86		12	6.86
4	9.35		13	8.35
5	8.67		14	9.19
6	6.85		15	8.12
7	8.09		NYS AVG	8.71
8	5.74		US AVG	7.35
9	8.05			

[12] NCHS Data Brief, No. 14 (February 2009), which incorporates *Pressure Ulcers Among Nursing Home Residents: United States, 2004*. Available at www.cdc.gov/nchs/data/databriefs/db14.pdf.

[13] Skilled Nursing Facility Quality Reporting Program – Specifications for Percent of Residents or Patients with Pressure Ulcers That are New or Worsened, *Centers for Medicare & Medicaid Services*, August 2016. *See* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNF-QRP-Measure-Specifications_October-2016.pdf.

[14] 42 C.F.R. § 483.25. https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/som107ap_pp_guidelines_ltcf.pdf. [Capitalization in original.]

MAP: LTCOP REGION VS. PRESSURE ULCER RATE



ANTIPSYCHOTIC DRUGGING RATE

BACKGROUND

The inappropriate and dangerous use of antipsychotic (AP) drugs is an ongoing and widespread problem in nursing homes across the country. Too many residents, particularly those with dementia, are administered these drugs to sedate them. Particularly in respect to residents with dementia, they have been often used as chemical restraints against nursing home residents. These drugs carry a Food and Drug Administration (FDA) “black box” warning against use on elderly patients with dementia, indicating that the drugs pose serious health risks and may increase risk of death. The use of these drugs as chemical restraints, to sedate residents for the convenience of staff, is an indicator of substandard care.

Despite the FDA’s “black box” warning and longstanding federal requirements that prohibit both unnecessary drugs and the use of chemical restraints, close to 20 percent of U.S. nursing home residents receive inappropriate AP drugs. Thus, the persistence of unnecessary AP drugging is of concern to both individual residents and families as well as policymakers.

Important note: The 20% AP drugging rate discussed above refers to the *actual* drugging rate; the data that CMS provides to the public, from which the below charts are derived, are *risk-adjusted* data. Risk-adjusted in this context means that residents who were administered AP drugs, but have a diagnosis of schizophrenia, Tourette’s Syndrome, or Huntington’s Disease, are excluded from the rates. Sadly, this has provided an incentive to give elderly residents a diagnosis of schizophrenia in order to given them dangerous AP drugs with impunity. As a result,

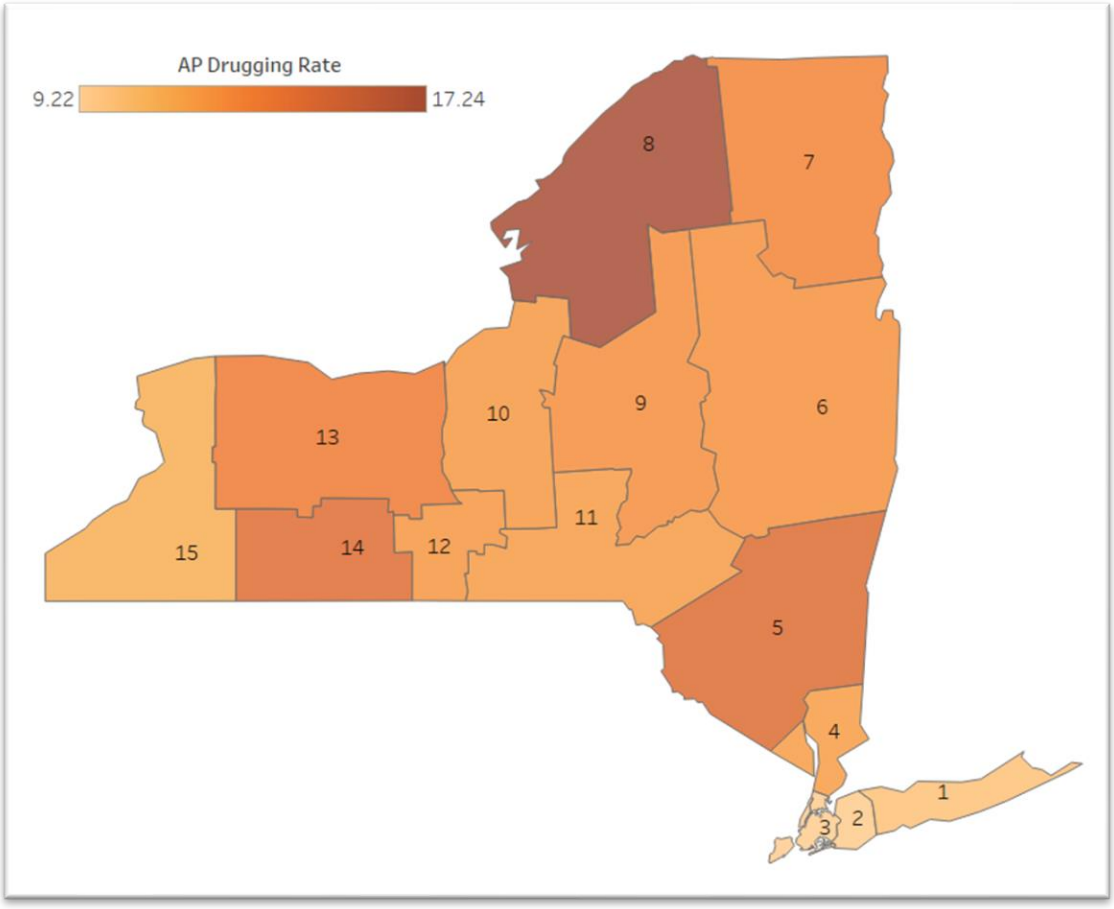
even though the below figures are high (less than two percent of the population will ever have a diagnosis of schizophrenia), they do not capture all of the residents administered these drugs.

OBSERVATIONS & IMPLICATIONS

- Region 8 has the highest average AP drugging rates, followed by Regions 5 and 14.
- Regions 3, 2, and 1 have the lowest AP drugging rates.

LTCOP REGION	AP DRUGGING RATE		LTCOP REGION	AP DRUGGING RATE
1	9.91		10	11.94
2	9.33		11	11.79
3	9.22		12	12.07
4	11.69		13	13.31
5	14.43		14	14.35
6	12.27		15	10.97
7	12.89		NYS AVG	10.82
8	17.2		US AVG	14.56
9	12.38			

MAP: LTCOP REGION VS. AP DRUGGING RATE



HEALTH INSPECTION RATING

BACKGROUND

Health inspections (referred to as surveys) are conducted by state survey agencies annually and in response to complaints to determine whether a facility is complying with federal and state regulations and to ensure residents are receiving good care and are free from abuse and neglect. New York's survey agency is the New York State Department of Health (DOH).

In assessing the quality of the nursing home during the inspection, the state surveyor interviews residents, families, and staff members; observes care, dining and other services; and reviews data and other information on any incidents that may have occurred in the facility. Based on the surveyors' substantiated findings, the nursing home receives a health inspection rating on Nursing Home Compare ranging from one to five stars (one is the lowest, five is the highest).

Important Note: Though the identification of substandard care, abuse, and neglect through the survey system is essential, state surveyors too often fail to identify and properly cite problems. As a result, though low ratings indicate the existence of often serious deficiencies, a high health inspection rating does not necessarily indicate that a facility is safe or providing high quality care.[15] As discussed in the introduction to this report, higher inspection ratings may be a better indication of poor safety assurance by the DOH regional office for the LTCOP region than of the actual quality of nursing homes in the area.

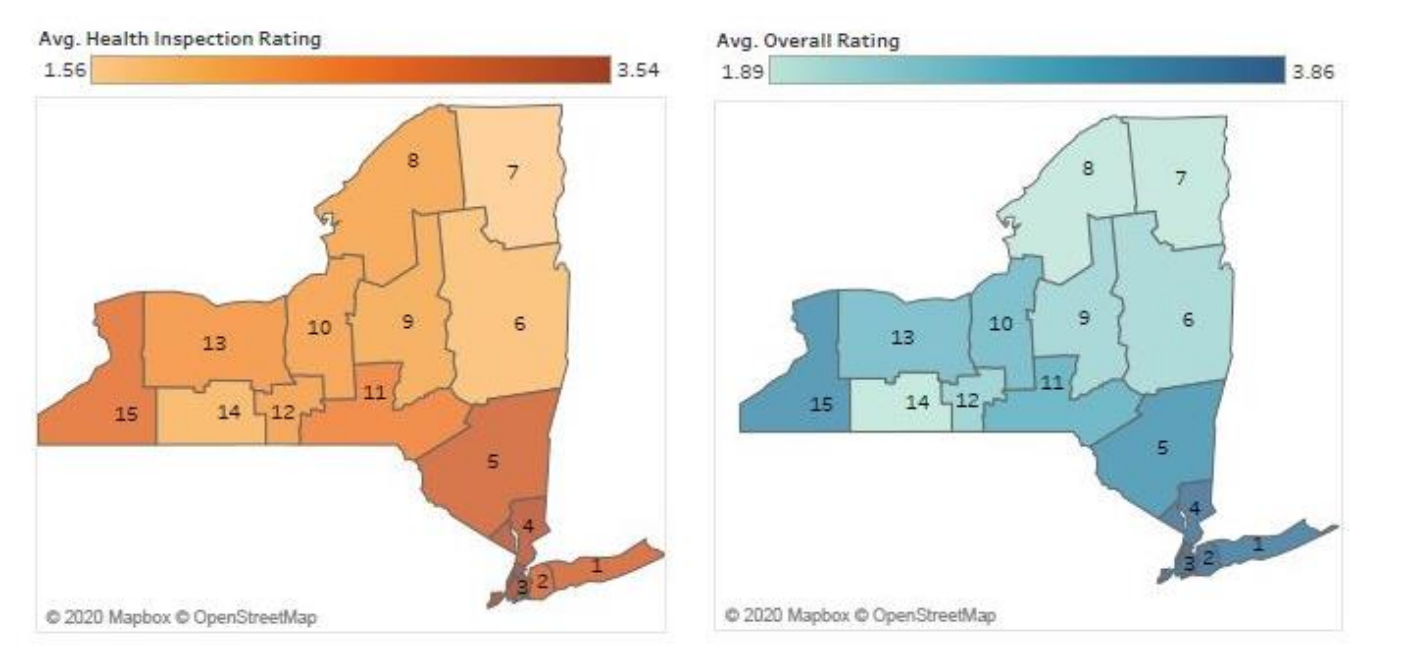
OBSERVATIONS & IMPLICATIONS

- Regions 3 and 4 have the highest average health inspection ratings.
- Region 7 has the lowest average health inspection rating, followed closely by Region 6.
- Regions 3, 2, 4, and 1 had the highest average overall ratings, averaging above 3.5. Regions 7, 8, and 14 had the lowest overall ratings, averaging below 2.0.

LTCOP REGION	AVG HEALTH INSPECTION RATING	AVG OVERALL RATING		LTCOP REGION	AVG HEALTH INSPECTION RATING	OVERALL RATING
1	2.98	3.55		9	2.04	2.19
2	2.95	3.76		10	2.16	2.64
3	3.54	3.86		11	2.50	2.80
4	3.29	3.64		12	2.18	2.27
5	3.00	3.20		13	2.30	2.63
6	1.77	2.16		14	1.90	1.90
7	1.56	1.89		15	2.72	3.26
8	2.11	1.89		NYS AVG	2.76	2.98

[15] For insights into the strengths and weaknesses of the survey system, *see* LTCCC's 2017 report, *The Identification of Resident Harm in Nursing Home Deficiencies: Observations & Insights*. Available at https://nursinghome411.org/identification-of-resident-harm-in-nursing-home-citations/.

MAPS: HEALTH INSPECTION AND OVERALL RATINGS



AVERAGE NUMBER OF FINES

BACKGROUND

Under the federal Nursing Home Reform Law of 1987, the government can issue sanctions against nursing homes that fail to comply with federal Medicare and Medicaid quality of care requirements. Civil money penalties (CMPs, i.e., fines) are a potentially potent sanction which can be used to encourage nursing homes to comply with minimum standards and prevent poor quality of care, abuse, and neglect.

Unfortunately, CMPs are an under-utilized option nationwide and, particularly, in New York State. When nursing homes are not penalized for substandard care, abuse, and neglect, it sends the message that these outcomes are “okay.”

OBSERVATIONS & IMPLICATIONS

New York State as a whole:

- New York State’s average number of fines per facility (0.20) is less than half the national rate (0.47) which is itself extremely low.
- New York State’s average fine amount ($3,971) is less than a quarter of the national average ($16,240).
- These findings indicate that the New York State Department of Health levies far fewer fines and significantly lower fines than other states, on average.

Regions:

- Fines per facility and amount fined per facility ($) were highest in Regions 8, 10, and 9.
- Regions 3, 4, and 11 have significantly lower average fines ($).
- Fines per facility for Regions 3, 4, 5, and 14 were significantly lower than the state average.
- Only Regions 8, 9, and 10 approached the national average in respect to total fines per facility.
- Though Region 8 has the largest average fines, much of this can be attributed to a single nursing home, Massena Rehabilitation & Nursing Center, which had fines totaling $109,189.

LTCOP REGION	FINES PER FACILITY	AMOUNT FINED PER FACILITY		LTCOP REGION	FINES PER FACILITY	AMOUNT FINED PER FACILITY
1	0.24	$3,045.93		10	0.36	$11,093.92
2	0.27	$8,154.35		11	0.14	$1,304.76
3	0.08	$938.85		12	0.18	$8,857.27
4	0.05	$1,019.47		13	0.21	$2,712.97
5	0.10	$4,102.03		14	0.10	$6,060.60
6	0.27	$7,975.78		15	0.16	$3,348.67
7	0.33	$3,961.22		NYS AVG	0.20	$3,971.00
8	0.56	$15,423.00		US AVG	0.47	$16,240.00
9	0.52	$10,971.19				

CHARTS: FINES PER FACILITY & AMOUNT FINED PER FACILITY