

## **Executive Summary**

Northern Metropolitan Residential Health Care Facility Inc (Northern Metropolitan) is an existing 120-bed residential health care facility, with a 46-slot off-site Medical Model Adult Day Health Care Program, located at 225 Maple Avenue Monsey, New York 10952. Northern Metropolitan is seeking Department of Health approval to construct a new facility to replace the existing leased 120-bed facility. There will be no change in the certified bed capacity of the facility. The proposed replacement facility will be located at 11 College Road, Monsey, New York, 11091.

# Schedule 1

## All CON Applications

### Contents:

- **Acknowledgement and Attestation**
- **General Information**
- **Contacts**
- **Affiliated Facilities/Agencies**

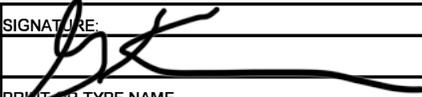
# New York State Department of Health Certificate of Need Application

Schedule 1

## Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: Northern Metropolitan Residential Health Care Facility Inc

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and implementing regulations, as applicable.

SIGNATURE: 	DATE
PRINT OR TYPE NAME	TITLE
Gedalia Klein	Executive Director
	May 27, 2025

## General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Attachment 1 – Board resolution
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

## Contacts

The Primary and Alternate contacts are the only two contacts who will receive email notifications of correspondence in NYSE-CON. **At least one of these two contacts should be a member of the applicant.** The other may be the applicant's representative (e.g., consultant, attorney, etc.). What is entered here for the Primary and Alternate contacts should be the same as what is entered onto the General Tab in NYSE-CON.

Primary Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	Leanne R. Kontogiannis, Attorney	Hinman Straub P.C.	
	BUSINESS STREET ADDRESS		
	121 State Street		
	CITY	STATE	ZIP
	Albany	New York	12207
	TELEPHONE	E-MAIL ADDRESS	
	(518) 436-0751	lkontogiannis@hinmanstraub.com	

Alternate Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	Caron O'Brien Crummey - Consultant	Hinman Straub P.C.	
	BUSINESS STREET ADDRESS		
	121 State Street		
	CITY	STATE	ZIP
	Albany	New York	12207
	TELEPHONE	E-MAIL ADDRESS	
	(518) 436-0751	ccrummey@hinmanstraub.com	

# New York State Department of Health Certificate of Need Application

# Schedule 1

The applicant must identify the operator's chief executive officer, or equivalent official.

<b>CHIEF EXECUTIVE</b>	NAME AND TITLE		
	Gedalia Klein - Executive Director		
	BUSINESS STREET ADDRESS		
	225 Maple Avenue		
	CITY	STATE	ZIP
	Monsey	Rockland	10952
	TELEPHONE	E-MAIL ADDRESS	
(845) 629-1204	GKlein@northernmet.com		

The applicant's lead attorney should be identified:

<b>ATTORNEY</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	Leanne R. Kontogiannis, Attorney		Hinman Straub P.C.	121 State Street
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS
	Albany, New York, 12207		(518) 436-0751	lkontogiannis@hinmanstraub.com

If a consultant prepared the application, the consultant should be identified:

<b>CONSULTANT</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	NONE			
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS

The applicant's lead accountant should be identified:

<b>ACCOUNTANT</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	NONE			
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS

Please list all Architects and Engineer contacts:

<b>ARCHITECT and/or ENGINEER</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	William Dahn		Dahn & Krieger Architects Planners PC	216 Route 17 North - Suite 203
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS
	Rochelle Park New Jersey 07662		(201)-489-8575	www.dahn-krieger.com

<b>ARCHITECT and/or ENGINEER</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS

**New York State Department of Health  
Certificate of Need Application**

**Schedule 1**

**Other Facilities Owned or Controlled by the Applicant**  
*Establishment (with or without Construction) Applications only*

**NYS Affiliated Facilities/Agencies**

Does the applicant legal entity or any related entity (parent, member or subsidiary corporation) operate or control any of the following in New York State?

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE		
Hospital	HOSP	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Nursing Home	NH	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Diagnostic and Treatment Center	DTC	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Midwifery Birth Center	MBC	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Licensed Home Care Services Agency	LHCSA	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Certified Home Health Agency	CHHA	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Hospice	HSP	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Adult Home	ADH	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Assisted Living Program	ALP	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Long Term Home Health Care Program	LTHHCP	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Enriched Housing Program	EHP	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Health Maintenance Organization	HMO	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Other Health Care Entity	OTH	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Upload as an attachment to Schedule 1, the list of facilities/agencies referenced above, in the format depicted below: - N/A

Facility Type	Facility Name	Operating Certificate or License Number	Facility ID (PFI)
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**Out-of-State Affiliated Facilities/Agencies**

In addition to in-state facilities, please upload, as an attachment to Schedule 1, a list of all health care, adult care, behavioral, or mental health facilities, programs or agencies located outside New York State that are affiliated with the applicant legal entity, as well as with parent, member and subsidiary corporations, in the format depicted below. – N/A

Facility Type	Name	Address	State/Country	Services Provided
---------------	------	---------	---------------	-------------------

In conjunction with this list, you will need to provide documentation from the regulatory agency in the state(s) where affiliations are noted, reflecting that the facilities/programs/agencies have operated in substantial compliance with applicable codes, rules and regulations for the past ten (10) years (or for the period of the affiliation, whichever is shorter). More information regarding this requirement can be found in Schedule 2D.

# **Schedule 5 Working Capital Plan**

## **Contents:**

- **Schedule 5 - Working Capital Plan**

**Working Capital Financing Plan**

**1. Working Capital Financing Plan and Pro Forma Balance Sheet:**

This section should be completed in conjunction with the monthly Cash Flow. The general guidelines for working capital requirements are two months of first year expenses for changes of ownership and two months' of third year expenses for new establishments, construction projects or when the first year budget indicates a net operating loss. Any deviation from these guidelines must be supported by the monthly cash flow analysis. If working capital is required for the project, all sources of working capital must be indicated clearly. Borrowed funds are limited to 50% of total working capital requirements and cannot be a line of credit. Terms of the borrowing cannot be longer than 5 years or less than 1 year. If borrowed funds are a source of working capital, please summarize the terms below, and attach a letter of interest from the intended source of funds, to include an estimate of the principal, term, interest rate and payout period being considered. Also, describe and document the source(s) of working capital equity.

<b>Titles of Attachments Related to Borrowed Funds</b>	<b>Filenames of Attachments</b>
<i>Example: First borrowed fund source</i>	<i>Example: first_bor_fund.pdf</i>
Attachment 4 – Monthly Cash Flow Analysis	Attachment 4 – Monthly Cash Flow Analysis.pdf
Attachment 5 – Equity Analysis	Attachment 5 – Equity Analysis.pdf
Attachment 8 – Financial Statements	Attachment 8 – Financial Statements.pdf
Attachment 13 - Organizational Chart	Attachment 13 - Organizational Chart.pdf
Attachment 14 - Certificates of Incorporation and Amended and Restated Certificates of Incorporation	Attachment 14 - Certificates of Incorporation and Amended and Restated Certificates of Incorporation.pdf

In the section below, briefly describe and document the source(s) of working capital equity

Northern Metropolitan Residential Health Care Facility, Inc. shall contribute the required working capital, equivalent to two months of third year expenses, through the facility's equity.

**2. Pro Forma Balance Sheet**

This section should be completed for all new establishment and change in ownership applications. On a separate attachment identified below, provide a pro forma (opening day) balance sheet. If the operation and real estate are to be owned by separate entities, provide a pro forma balance sheet for each entity. Fully identify all assumptions used in preparation of the pro forma balance sheet. If the pro forma balance sheet(s) is submitted in conjunction with a change in ownership application, on a line-by-line basis, provide a comparison between the submitted pro forma balance sheet(s), the most recently available facility certified financial statements and the transfer agreement. Fully explain and document all assumptions.

<b>Titles of Attachments Related to Pro Forma Balance Sheets</b>	<b>Filenames of Attachments</b>
Example: <i>Attachment to operational balance sheet</i>	Example: <i>Operational_bal_sheet.pdf</i>
N/A	N/A

# Schedule 6 Architectural/Engineering Submission

## Contents:

- Schedule 6 – Architectural/Engineering Submission

**Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction**

Schedule applies to all projects with construction, including Articles 28 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

**Instructions**

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - [Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Projects over \\$15 Million, or Projects Requiring a Waiver](#) (PDF)
  - [Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY](#). (PDF) (Not to Be Submitted with Self-Certification Projects)
  - [Architect's Letter of Certification for Completed Projects](#) (PDF)
  - [Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings](#) (PDF)
- Provide FEMA BFE Certificate. Applies only to Hospitals and Nursing Homes.
  - [FEMA Elevation Certificate and Instructions.pdf](#)
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - [Physicist's Letter of Certification](#) (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - [NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews](#)
  - [DSG-1.0 Schematic Design & Design Development Submission Requirements](#)
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

**Architecture/Engineering Narrative**

Narrative shall include but not limited to the following information. Please address all items in the narrative including items located in the response column. **Incomplete responses will not be accepted.**

Project Description	
Schedule 6 submission date: <b>2/15/2025</b>	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Choose an item. If so, what is the original CON number? No	
Intent/Purpose: <b>New 120-bed facility to replace existing leased 120-bed facility.</b>	
Site Location: <b>11 College Road Monsey, New York</b>	
Brief description of current facility, including facility type:	

**New York State Department of Health  
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**Schedule 6**

<b>Existing lease facility is circa 1970 120 bed long term care facility.</b>	
Brief description of proposed facility: <b>A new 120-bed, four story facility with 3 – 40 bed nursing units. Each nursing unit shall be broken down into 3 neighborhood clusters.</b>	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. <b>All new construction. Replacement of an existing facility.</b>	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: <b>Single occupancy.</b>	
If this is an existing facility, is it currently a licensed Article 28 facility?	<b>Not Applicable</b>
Is the project space being converted from a non-Article 28 space to an Article 28 space?	<b>No</b>
Relationship of spaces conforming with Article 28 space and non-Article 28 space: <b>Entire new building complying with Article 28 requirements.</b>	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. <b>None</b>	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. <b>No, the project is new construction.</b>	<b>No</b>
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. <b>The building is new construction. All HVAC, Electrical, and Plumbing systems shall be new.</b>	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. <b>No upgrades – new construction.</b>	
Describe existing and or new work for fire detection, alarm, and communication systems: <b>New Construction.</b>	
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from <a href="http://www.fema.gov">www.fema.gov</a> , and describe the work to mitigate damage and maintain operations during a flood event. <b>FEMA BFE certificate enclosed.</b>	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist’s letter of certification and report are submitted. <b>No imaging equipment planned</b>	
Does the project comply with ADA? If no, list all areas of noncompliance. <b>Yes, compliant with ADA</b>	
Other pertinent information: <b>The proposed building is a replacement facility for an existing Northern Metropolitan at 225 Maple Avenue Monsey, NY</b>	
<b>Project Work Area</b>	<b>Response</b>
Type of Work	<b>New Construction</b>
Square footages of existing areas, existing floor and or existing building.	<b>New Construction</b>
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	126,563
Does the work area exceed more than 50% of the smoke compartment, floor or building?	<b>New Construction</b>
Sprinkler protection per NFPA 101 Life Safety Code	<b>Sprinklered throughout</b>
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type 1 (332)

# New York State Department of Health Certificate of Need Application

## Schedule 6

Building Height	<b>50'</b>
Building Number of Stories	<b>4 Stories</b>
Which edition of FGI is being used for this project?	<b>2018 Edition of FGI</b>
Is the proposed work area located in a basement or underground building?	<b>Not Applicable</b>
Is the proposed work area within a windowless space or building?	<b>No</b>
Is the building a high-rise?	<b>No</b>
If a high-rise, does the building have a generator?	<b>Not Applicable</b>
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 18 New Health Care Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. <a href="#">Click here to enter text.</a>	<b>No</b>
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? <a href="#">Click here to enter text.</a>	<b>No</b>
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. <a href="#">Click here to enter text.</a>	<b>No</b>
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? <a href="#">Click here to enter text.</a>	<b>No</b>
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. <a href="#">Click here to enter text.</a>	<b>Not Applicable</b>
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. <a href="#">Click here to enter text.</a>	No
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? <a href="#">Click here to enter text.</a>	<b>No</b>
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. <a href="#">Click here to enter text.</a>	<b>No Change</b>
Changes in the number of occupants? If yes, what is the new number of occupants? <a href="#">Click here to enter text.</a>	<b>No</b>
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? <a href="#">Click here to enter text.</a>	Yes
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? <a href="#">Click here to enter text.</a>	Not Applicable
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. <a href="#">Click here to enter text.</a>	<b>No</b>
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. <a href="#">Click here to enter text.</a>	<b>No</b>
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	<b>Not Applicable</b>
Does the project involve a pool?	<b>No</b>

REQUIRED ATTACHMENT TABLE			
SCHEMATIC DESIGN SUBMISSION for CONTINGENT APPROVAL	DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for CONTINGENCY SATISFACTION	Title of Attachment	File Name in PDF format
•		Architectural/Engineering Narrative	A/E Narrative.PDF
•		Functional Space Program	FSP.PDF
•		Architect/Engineer Certification Form	A/E Cert Form. PDF
•		FEMA BFE Certificate	FEMA BFE Cert.PDF
•		Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Plans including level of exit discharge, and NFPA 101-2012 Code Analysis	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details. Illustrate FGI compliance on plans.	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
optional	•	Wall Sections and Partition Types	A500.PDF
optional	•	Interior Elevations, Enlarged Plans and Details	A600.PDF
	•	Fire Protection	FP100.PDF
	•	Mechanical Systems	M100.PDF
	•	Electrical Systems	E100.PDF
	•	Plumbing Systems	P100.PDF
	•	Physicist's Letter of Certification and Report	X100.PDF



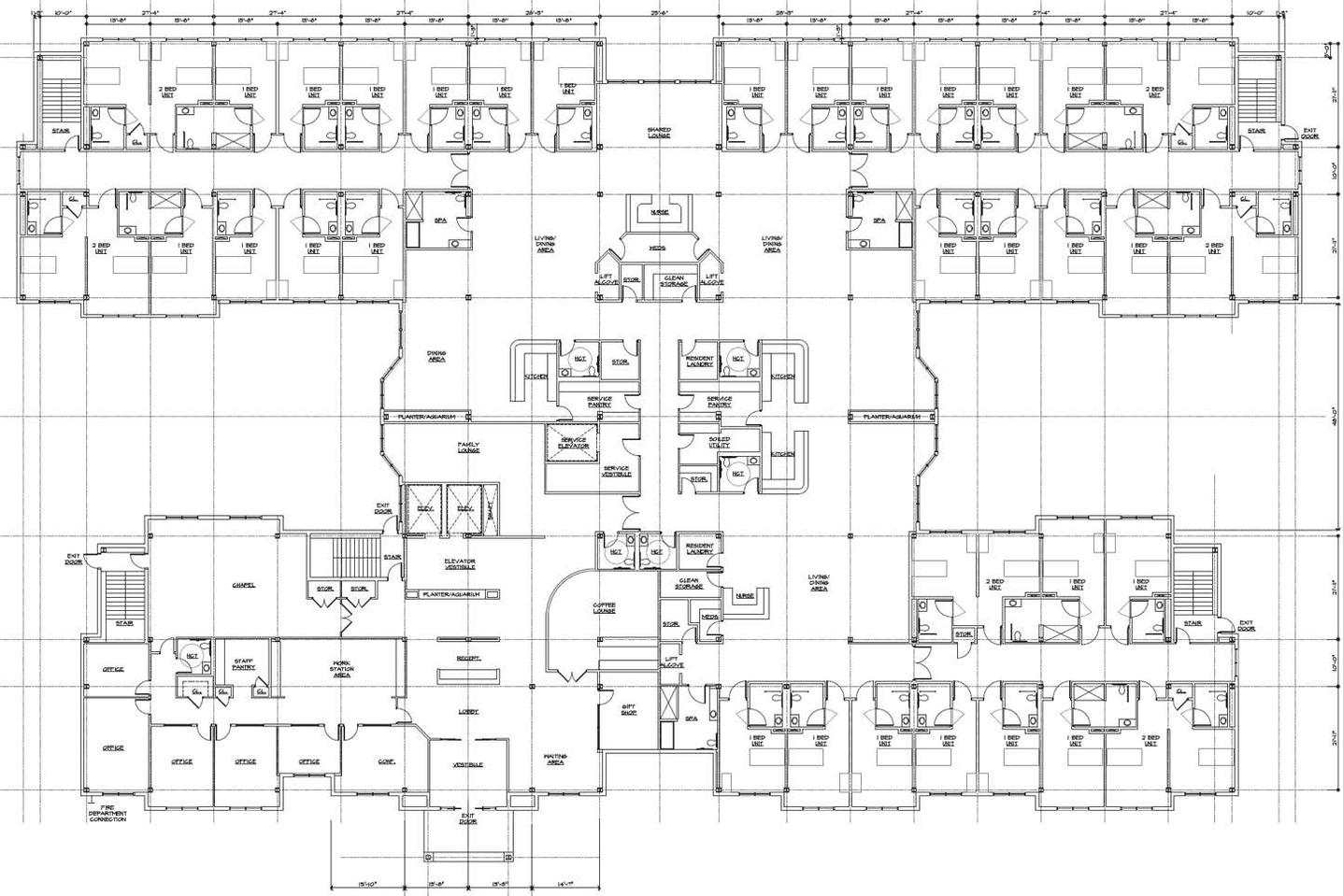
*William Dale*

© Dale & Krieger Architects Planners PC

**Fountainview  
 Additions**  
 2000 Fountainview Drive  
 Township of Ramapo, New York

**Dahn & Krieger  
 Architects Planners PC**  
 216 Route 17 North - Suite 203  
 P.O. Box 201  
 Ramapo, NJ 07643  
 Tel: 201-489-8572 Fax: 201-489-5814  
 www.dahn-krieger.com

Revised: 2022-09-01 REVISION PER OWNER  
 2022-08-08 REVISION PER OWNER  
 2022-05-04 REVISION PER BOARD  
 REVISION PER OWNER



ENTRY LEVEL  
 1 CONCEPT PLAN  
 SCALE: 1/8"=1'-0"

CONCEPTUAL FLOOR PLAN

SK No. 2300 Drawing No. 20220201-01  
 Scale: AS NOTED  
 Date: 10/1/22  
 Drawn: [Signature]  
 Checked: [Signature]

SK.2





■  
**Dahn & Krieger**  
Architects Planners PC

April 23, 2025

NYS Department of Health/Office of Health Systems Management  
Center for Health Care Facility Planning, Licensure, and Finance  
Bureau of Architectural and Engineering Review  
ESP, Corning Tower, 18<sup>th</sup> Floor  
Albany, New York 12237

RE: Northern Metropolitan Residential Health Care Facility Inc.  
11 College Road  
Monsey, NY  
D&K Project#: 22006

To The New York State Department of Health:

I am the Architect for a proposed new 120-bed Skilled Nursing Facility at the above-noted location. This facility shall be a replacement for the following facility:

Northern Metropolitan Residential Health Care Facility Inc.  
225 Maple Ave  
Monsey, NY 10952

PFI: 0797  
Operating Certificate: 4353301N

This existing facility will close upon completion of the new facility referenced above.

I am writing this letter to certify that:

1. I have been retained by the aforementioned facility to provide professional architectural/engineering services related to the design and preparation of construction documents, including drawings and specifications for the aforementioned project. During the course of construction, periodic site observation visits will be performed, with the necessary standard of care, noting progress, quality and ensuring conformance of the work with documents provided for all regulatory approvals associated with the aforementioned project.
2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed in accordance with the functional program for the referenced construction project and in accordance with any project definitions, waivers, or revisions approved or required by the New York State Department of Health.

3. The above-referenced construction project shall be designed and constructed in compliance with all applicable local codes, statutes, regulations, including the applicable provisions of the State Hospital Code – 10 NYCRR Part 711 (General Standards for Construction) and Part 713 (Standards of Construction for Nursing Home Facilities).
4. I understand that as the design of this project progresses, if a component of this project is inconsistent with the State Hospital Code (10 NYCRR Part 713), I shall bring this to the attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department prior to or upon submitting final drawings for compliance resolution.
5. I understand that upon completion of construction, the costs of any subsequent corrections necessary to achieve compliance with applicable requirements of 10 NYCRR Part 713, when the prior work was not completed properly as certified herein, may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative, full review, self-certification and reviews performed and completed by DASNY.

**Project Name:** Northern Metropolitan  
**Location:** Monsey, New York  
**Description:** New 120-Bed Nursing Home Facility

Architectural Professional Stamp



019334  
 Signature of Architect

William Dahn

Name of Architect (Print)

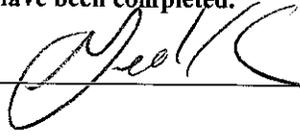
019334

Professional New York State License Number

216 Route 17 North, Suite 203, Rochelle Park, NJ 07662

Business Address

The undersigned applicant understands and agrees that, notwithstanding this architectural/engineering certification the Department of Health shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the Division to comply with the above-mentioned codes and regulations, whether or not physical plant construction or alterations have been completed.



Authorized Signature for Applicant

5.1.25

Date

GEDALIA KLEIN

Name (Print)

Executive Director

Title

Notary signing required for the applicant

STATE OF NEW YORK )

)

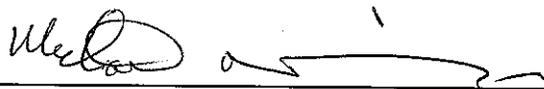
) SS:

County of ROCKLAND )

)

On the 1<sup>ST</sup> day of MAY 2025 before me personally appeared GEDALIA KLEIN, to me known, who being by me duly sworn, did depose and say that he/she is the EXECUTIVE DIRECTOR of the NORTHERN METROPOLITAN RESIDENTIAL HEALTH CARE FACILITY, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary)



MICHAEL NOWICKI  
Notary Public, State of New York  
Reg. # 4755024  
Residing in Rockland County  
Commission Expires 5-31-27

# **Schedule LRA 4/Schedule 7 CON Forms Regarding Environmental issues**

## **Contents:**

**Schedule LRA 4/Schedule 7 - Environmental Assessment**

<b>Environmental Assessment</b>			
<b>Part I.</b>	The following questions help determine whether the project is "significant" from an environmental standpoint.	<b>Yes</b>	<b>No</b>
1.1	If this application involves establishment, will it involve more than a change of name or ownership only, or a transfer of stock or partnership or membership interests only, or the conversion of existing beds to the same or lesser number of a different level of care beds?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.2	Does this plan involve construction and change land use or density?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1.3	Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1.4	Does this plan involve construction and require work related to the disposition of asbestos?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Part II.</b>	If any question in Part I is answered "yes" the project may be significant, and Part II must be completed. If all questions in Part II are answered "no" it is likely that the project is not significant	<b>Yes</b>	<b>No</b>
2.1	Does the project involve physical alteration of ten acres or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.2	If an expansion of an existing facility, is the area physically altered by the facility expanding by more than 50% and is the total existing and proposed altered area ten acres or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.3	Will the project involve use of ground or surface water or discharge of wastewater to ground or surface water in excess of 2,000,000 gallons per day?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.4	If an expansion of an existing facility, will use of ground or surface water or discharge of wastewater by the facility increase by more than 50% and exceed 2,000,000 gallons per day?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.5	Will the project involve parking for 1,000 vehicles or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.6	If an expansion of an existing facility, will the project involve a 50% or greater increase in parking spaces and will total parking exceed 1000 vehicles?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.7	In a city, town, or village of 150,000 population or fewer, will the project entail more than 100,000 square feet of gross floor area?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.8	If an expansion of an existing facility in a city, town, or village of 150,000 population or fewer, will the project expand existing floor space by more than 50% so that gross floor area exceeds 100,000 square feet?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.9	In a city, town or village of more than 150,000 population, will the project entail more than 240,000 square feet of gross floor area?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.10	If an expansion of an existing facility in a city, town, or village of more than 150,000 population, will the project expand existing floor space by more than 50% so that gross floor area exceeds 240,000 square feet?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.11	In a locality without any zoning regulation about height, will the project contain any structure exceeding 100 feet above the original ground area?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.12	Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.13	Will the project significantly affect drainage flow on adjacent sites?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2.14	Will the project affect any threatened or endangered plants or animal species?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.15	Will the project result in a major adverse effect on air quality?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.19	Will the project have any adverse impact on health or safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>Part III.</b>		<b>Yes</b>	<b>No</b>	
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.		<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<b>Agency Name:</b>		Town of Ramapo	
	Contact Name:		Yisroel Eisenbach - Planning Board Chairman	
	Address:		237 Route 59	
	State and Zip Code:		Suffern, NY 10901	
	E-Mail Address:		townoframapobpz@ramapo-ny.gov	
	Phone Number:		845-357-5100	
	<b>Agency Name:</b>			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	<b>Agency Name:</b>			
	Contact Name:			

	Address:				
	State and Zip Code:				
	E-Mail Address:				
	Phone Number:				
	<b>Agency Name:</b>				
	Contact Name:				
	Address:				
	State and Zip Code:				
	E-Mail Address:				
Phone Number:					
3.2	Has any other agency made an environmental review of this project? If so, give name, and submit the SEQRA Summary of Findings with the application in the space provided below.			Yes	No
				<input checked="" type="checkbox"/>	<input type="checkbox"/>
	<b>Agency Name:</b>		Town of Ramapo		
	Contact Name:		Yisroel Eisenbach - Planning Board Chairman		
	Address:		237 Route 59		
	State and Zip Code:		Suffern, NY 10901		
	E-Mail Address:		townoframapobpz@ramapo-ny.gov		
Phone Number:		845-357-5100			
3.3	Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.			Yes	No
				<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>Part IV. Storm and Flood Mitigation</b>					
Definitions of FEMA Flood Zone Designations					
Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.					
Please use the FEMA Flood Designations scale below as a guide to answering all Part IV questions regardless of project location, flood and or evacuation zone.				Yes	No
4.1	Is the proposed site located in a flood plain? If Yes, indicate classification below and provide the Elevation Certificate (FEMA Flood Insurance).			<input type="checkbox"/>	<input checked="" type="checkbox"/>
	<b>Moderate to Low Risk Area</b>			Yes	No
	<b>Zone</b>	<b>Description</b>		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:				
	<b>B and X</b>	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.			<input type="checkbox"/>

<b>C and X</b>	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.	<input type="checkbox"/>	
<b>High Risk Areas</b>		<b>Yes</b>	<b>No</b>
<b>Zone</b>	<b>Description</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
<b>A</b>	Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones.	<input type="checkbox"/>	
<b>AE</b>	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30.	<input type="checkbox"/>	
<b>A1-30</b>	These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format).	<input type="checkbox"/>	
<b>AH</b>	Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	<input type="checkbox"/>	
<b>AO</b>	River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones.	<input type="checkbox"/>	
<b>AR</b>	Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations.	<input type="checkbox"/>	
<b>A99</b>	Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones.	<input type="checkbox"/>	
<b>High Risk Coastal Area</b>		<b>Yes</b>	<b>No</b>
<b>Zone</b>	<b>Description</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
<b>Zone V</b>	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>VE, V1 - 30</b>	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	<input type="checkbox"/>	
<b>Undetermined Risk Area</b>		<b>Yes</b>	<b>No</b>
<b>Zone</b>	<b>Description</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

	<b>D</b>	Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk.		
4.2	Are you in a designated evacuation zone?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	If Yes, the Elevation Certificate (FEMA Flood Insurance) shall be submitted with the application.			
	If yes which zone is the site located in?			
4.3	Does this project reflect the post Hurricane Lee, and or Irene, and Superstorm Sandy mitigation standards?		<input type="checkbox"/>	<input checked="" type="checkbox"/>
	If Yes, which floodplain?	100 Year	<input type="checkbox"/>	
		500 Year	<input type="checkbox"/>	

The Elevation Certificate provides a way for a community to document compliance with the community's floodplain management ordinance.

[FEMA Elevation Certificate and Instructions](#)

# **Schedule 8 – CON Form Regarding Space & Construction Cost Distribution**

## **Contents:**

- **Schedule 8A - Summarized Project Cost and Construction Dates**
- **Schedule 8B - Total Project Cost - For Projects without Subprojects**

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 8A - Summarized Project Cost and Construction Dates**

This schedule is required for all Establishment Applications and Full or Administrative Review Construction Applications

**1.) Project Cost Summary Data:**

	<b>TOTAL</b>	<b>SOURCE</b>
<b>Project Description:</b>		
Project Cost	\$79,734,514	Schedule 8B, Column C, Line 8
Total Basic Cost of Construction	\$79,734,514	Schedule 8B, Column C, Line 6
Total Cost of Moveable Equipment	\$1,511,554	Schedule 8B, Column C, Line 5.1
Cost Per Square Foot for New Construction	\$425	Schedule 10
Cost Per Square Foot for Renovation Construction	\$0	Schedule 10
Total Operating Cost	\$19,569,948	Schedule 13C, 17C, 19D
Amount Financed (as \$)	\$75,000,000	Schedule 9
Percentage Financed (as % of Total Cost)	93.60%	Schedule 9
Depreciation Life (in years)		

**2.) Construction Dates:**

Anticipated Start Date	03/1/2026	Schedule 8B
Anticipated Completion Date	12/1/2027	

**New York State Department of Health**  
**Certificate of Need Application**  
**Schedule 8B - Total Project Cost - For Projects without Subprojects**

<b>Constants:</b>	<b>Value</b>	<b>Comments</b>
Design Contingency - New Construction	10.00%	Normally 10%
Construction Contingency - New Construction	5.00%	Normally 5%
Design Contingency - Renovation Work	0.00%	Normally 10%
Construction Contingency - Renovation Work	0.00%	Normally 10%
Anticipated Construction Start Date	03/1/2026	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	01/1/2027	as mm/dd/yyyy
Anticipated Completion of Construction Date	12/1/2027	as mm/dd/yyyy
Year used to compute Current Dollars		

<b>Subject of Attachment</b>	<b>Attachment Number</b>	<b>Filename of Attachment</b>
For new construction and addition, at the schematic stage the design contingency will normally be 10% and the construction contingency will be 5%. If your percentages are otherwise, please explain in an attachment.	N/A	
For renovation, the design contingency will normally be 10% and the construction contingency will be 10%. If your percentages are otherwise, please explain in an attachment.	N/A	

**New York State Department of Health  
Certificate of Need Application  
Schedule 8B - Total Project Cost - For Projects without Subprojects**

	A	B	C
Item	Project Cost in Current Dollars	Mid-Point	Estimated Project Costs
Source:	Schedule 10 Col. 7	Computed by Applicant	(A+B)
1.1 - Land Acquisition	\$650,000	X	\$650,000
1.2 - Building Acquisition	\$0		\$0
2.1 - New Construction	\$53,789,275	\$3,764,900	\$57,554,175
2.2 - Renovation & Demolition	\$0	\$0	\$0
2.3 - Site Development	\$840,488	\$58,834	\$899,322
2.4 - Temporary Utilities	\$45,000	\$3,150	\$48,150
2.5 - Asbestos Abatement or Removal	\$0	\$0	\$0
3.1 - Design Contingency	\$5,378,928	\$376,490	\$5,755,418
3.2 - Construction Contingency	\$2,689,464	\$188,262	\$2,877,726
4.1 - Fixed Equipment (NIC)	\$0	\$0	\$0
4.2 - Planning Consultant Fees	\$200,000	\$14,000	\$214,000
4.3 - Architect/Engineer Fees	\$2,689,464	\$188,262	\$2,877,726
4.4 - Construction Manager Fees	\$6,454,113	\$451,830	\$6,905,943
4.5 - Other fees (Consultant, etc.)	\$150,000	\$10,500	\$160,500
<b>Subtotal (Total 1.1 thru 4.5)</b>	<b>\$72,886,732</b>	<b>\$5,056,228</b>	<b>\$77,942,960</b>
5.1 - Moveable Equipment (from Schedule 11)	\$1,405,746	\$105,808	\$1,511,554
5.2 - Telecommunications	\$260,400	\$19,600	\$280,000
<b>6. Total Basic Cost of Construction (Total 1.1 thru 5.2)</b>	<b>\$74,552,878</b>	<b>\$5,181,636</b>	<b>\$79,734,514</b>
7.1 - Financing Costs (Points, etc.)	\$0	X	\$0
7.2 - Interim Interest Expense <input type="text"/> at <input type="text"/> for <input type="text"/> months	\$0		\$0
<b>8. Total Project Cost: w/o CON fees (Total 6 thru 7.2)</b>	<b>\$74,552,878</b>	<b>\$5,181,636</b>	<b>\$79,734,514</b>
Application Fees:		X	
9.1 Application Fee. Articles 28, 36, and 40. See Web Site Link below.	\$2,000		\$2,000
<a href="#">9.2 Additional Fee for projects with capital costs. Not applicable to "Establishment Only" projects. See Web Site for applicable fees. (line 8, multiplied by the appropriate percentage)</a>			
Enter Multiplier ie: .25% = .0025 -->	<input type="text" value="0.0055"/>		
	\$410,041	\$0	\$410,041
<b>10. Total Project Cost with Fees</b>	<b>\$74,964,919</b>	<b>\$5,181,636</b>	<b>\$80,146,555</b>

# Schedule 9 Project Financing

## Contents:

- **Schedule 9 - Proposed Plan for Project Financing**

**Schedule 9 Proposed Plan for Project Financing:**

**I. Summary of Proposed Financial plan**

Check all that apply and fill in corresponding amounts.

	Type	Amount
<input type="checkbox"/>	A. Lease	
<input checked="" type="checkbox"/>	B. Cash	\$5,146,555
<input checked="" type="checkbox"/>	C. Mortgage, Notes, or Bonds	\$75,000,000
<input type="checkbox"/>	D. Land	
<input type="checkbox"/>	E. Other	
<input checked="" type="checkbox"/>	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	\$80,146,555

If refinancing is used, please complete area below.

<input type="checkbox"/>	Refinancing	
<input type="checkbox"/>	Total Mortgage/Notes/Bonds (Sum E + Refinancing)	

**II. Details**

**A. Leases**

	N/A	Title of Attachment
1. List each lease with corresponding cost as if purchased each leased item. Breakdown each lease by total project cost and subproject costs, if applicable.	<input checked="" type="checkbox"/>	
2. Attach a copy of the proposed lease(s).	<input checked="" type="checkbox"/>	
3. Submit an affidavit indicating any business or family relationships between principals of the landlord and tenant.	<input checked="" type="checkbox"/>	
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	<input checked="" type="checkbox"/>	
5. If applicable, identify separately the total square footage to be occupied by the Article 28 facility and the total square footage of the building.	<input checked="" type="checkbox"/>	
6. Attach two letters from independent realtors verifying square footage rate.	<input checked="" type="checkbox"/>	
7. For all capital leases as defined by FASB Statement No. 13, "Accounting for Leases", provide the net present value of the monthly, quarterly or annual lease payments.	<input checked="" type="checkbox"/>	

**New York State Department of Health  
Certificate of Need Application**

**Schedule 9**

**B. Cash**

Type	Amount
Accumulated Funds	\$5,146,555
Sale of Existing Assets	
Gifts (fundraising program)	
Government Grants	
Other	
<b>TOTAL CASH</b>	<b>\$5,146,555</b>

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	<input type="checkbox"/>	See table above
2. Attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations.  In establishment applications for <b>Residential Health Care Facilities</b> , attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date for <b>the subject facility and all affiliated Residential Health Care Facilities</b> . If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented (or to be implemented in the case of the subject facility) to improve operations.	<input type="checkbox"/>	Attachment 8 – Financial Statements
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	<input type="checkbox"/>	Attachment 8 – Financial Statements
4. Attach a full and complete description of the assets to be sold, if applicable.	<input checked="" type="checkbox"/>	
5. If amounts are listed in "Gifts (fundraising program)": <ul style="list-style-type: none"> <li>• Provide a breakdown of total amount expected, amount already raised, and any terms and conditions affixed to pledges.</li> <li>• If a professional fundraiser has been engaged, submit fundraiser's contract and fundraising plan.</li> <li>• Provide a history of recent fund drives, including amount pledged and amount collected</li> </ul>	<input checked="" type="checkbox"/>	

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**Schedule 9**

	<b>N/A</b>	<b>Title of Attachment</b>
6. If amounts are listed in "Government Grants": <ul style="list-style-type: none"> <li>List the grant programs which are to provide the funds with corresponding amounts. Include the date the application was submitted.</li> <li>Provide documentation of eligibility for the funds.</li> <li>Attach the name and telephone number of the contact person at the awarding Agency(ies).</li> </ul>	<input checked="" type="checkbox"/>	
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	<input checked="" type="checkbox"/>	
8. Current Department policy expects a minimum equity contribution of 10% of total project cost (Schedule 8b line 10) ) for all Article 28 facilities with the exception of Residential Health Care Facilities that require 25% of total project cost (Schedule 8b, line 10). Public facilities require 0% equity.	<input type="checkbox"/>	Attachment 5 – Equity Analysis
9. Provide an equity analysis for member equity to be provided. Indicate if a member is providing a disproportionate share of equity. If disproportioned equity shares are provided by any member, check this box <input type="checkbox"/>	<input checked="" type="checkbox"/>	

**C. Mortgage, Notes, or Bonds**

	<b>Total Project</b>	<b>Units</b>
Interest	0.0%	%
Term	10	Years
Payout Period	35	Years
Principal	\$75,000,000	\$

	<b>N/A</b>	<b>Title of Attachment</b>
1. Attach a copy of a letter of interest from the intended source of permanent financing that indicates principal, interest, term, and payout period.	<input type="checkbox"/>	Attachment 2 – Bond Financing Letter of Interest, Attachment 13 - Organizational Chart, and Attachment 14 - Certificates of Incorporation and Amended and Restated Certificates of Incorporation
2. If New York State Dormitory Authority (DASNY) financing, then attach a copy of a letter from a mortgage banker.	<input checked="" type="checkbox"/>	
3. Provide details of any DASNY bridge financing to HUD loan.	<input checked="" type="checkbox"/>	
4. If the financing of this project becomes part of a larger overall financing, then a new business plan inclusive of a feasibility package for the overall financing will be required for DOH review prior to proceeding with the combined financing.	<input checked="" type="checkbox"/>	

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**Schedule 9**

**D. Land**

Provide details for the land including but not limited to; appraised value, historical cost, and purchase price. See sample table below.

	Total Project
Appraised Value	\$
Historical Cost	\$
Purchase Price	\$
Other	

	N/A	Title of Attachment
1. If amounts are listed in "Other", attach documentation and a description as applicable.	<input checked="" type="checkbox"/>	
2. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	<input checked="" type="checkbox"/>	
3. Submit a copy of the proposed purchase/option agreement.	<input checked="" type="checkbox"/>	
4. Provide an affidavit indicating any and all relationships between seller and the proposed operator/owner.	<input checked="" type="checkbox"/>	

**E. Other**

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

	N/A	Title of Attachment
Attach documentation and a description of the method of financing	<input checked="" type="checkbox"/>	

**F. Refinancing**

	N/A	Title of Attachment
1. Provide a breakdown of the terms of the refinancing, including principal, interest rate, and term remaining.	<input checked="" type="checkbox"/>	
2. Attach a description of the mortgage to be refinanced. Provide full details of the existing debt and refinancing plan inclusive of original and current amount, term, assumption date, and refinancing fees. The term of the debt to be refunded may not exceed the remaining average useful life of originally financed assets. If existing mortgage debt will not be refinanced, provide documentation of consent from existing lien holders of the proposed financing plan.	<input checked="" type="checkbox"/>	

# **Schedule 10 – CON Form Regarding Space & Construction Cost Distribution**

## **Contents:**

- **Schedule 10 - Space & Construction Cost Distribution**

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 43). Codes for completing this table are found in the Functional Codes Lookups sheet (see tab below).

Indicate if this project is: New Construction:  **OR** Renovation:

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		B	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	834	\$425.00	\$354,450	
		B	968	Vertical & Horizontal Mechanized Movement (elevators, cart system)	511	\$425.00	\$217,175	
		B	920	Public Areas	5806	\$425.00	\$2,467,550	
		B	943	Maintenance/Housekeeping	1441	\$425.00	\$612,425	
		B	910	Telephone System	180	\$425.00	\$76,500	
		B	734	Baseline Dietetic	739	\$425.00	\$314,075	
		B	946	Staff Lockers	1332	\$425.00	\$566,100	
		B	921	Cafeteria	986	\$425.00	\$419,050	
		B	734	Baseline Dietetic	4157	\$425.00	\$1,766,725	
		B	940	Industrial/Service Functions	718	\$425.00	\$305,150	
		B	942	Laundry/Linen	1527	\$425.00	\$648,975	
		B	944	Medical Supplies/Central Services/Storage	1520	\$425.00	\$646,000	

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		B	980	Other Functions	1321	\$425.00	\$561,425	
		B	960	Building System	1157	\$425.00	\$491,725	
		B	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	4818	\$425.00	\$2,047,650	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
<b>Totals for Whole Project:</b>					<b>27047</b>	<b>425</b>	<b>11494975</b>	

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

If additional sheets are necessary, go to the toolbar, select "Edit", select "Move or copy sheet", make sure the "create a copy" box is checked, and select this document as the destination for the copy then select "OK". An additional worksheet will be added to this spreadsheet

1. If New Construction is Involved, is it "freestanding?"	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
-----------------------------------------------------------	--------------------------------------------	--------------------------------

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE		DATE	
		5/12/25	
PRINT NAME		TITLE	
GEDALIA KELIN		EXECUTIVE DIRECTOR	
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

**New York State Department of Health  
Certificate of Need Application  
Schedule 10 - Space & Construction Cost Distribution**

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 43). Codes for completing this table are found in the Functional Codes Lookups sheet (see tab below).

Indicate if this project is: New Construction:  **OR** Renovation:

Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		1	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	834	\$425.00	\$354,450	
		1	968	Vertical & Horizontal Mechanized Movement (elevators, cart system)	424	\$425.00	\$180,200	
		1	703	General Baseline Services - SNF's (includes Medical)	14302	\$425.00	\$6,078,350	
		1	944	Medical Supplies/Central Services/Storage	676	\$425.00	\$287,300	
		1	920	Public Areas	3778	\$425.00	\$1,605,650	
		1	737	Baseline Nursing	409	\$425.00	\$173,825	
		1	742	Baseline Pharmaceutical Service	114	\$425.00	\$48,450	
		1	980	Other Functions	242	\$425.00	\$102,850	
		1	941	Central Sterile and Supply	328	\$425.00	\$139,400	
		1	943	Maintenance/Housekeeping	208	\$425.00	\$88,400	
		1	734	Baseline Dietetic	1187	\$425.00	\$504,475	
		1	703	General Baseline Services - SNF's (includes Medical)	289	\$425.00	\$122,825	

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		1	942	Laundry/Linen	149	\$425.00	\$63,325	
		1	923	Lobby/Waiting/Public Entrance	2105	\$425.00	\$894,625	
		1	924	Coffee/Gift Shop/Flower/Canteen/Snack Bar	830	\$425.00	\$352,750	
		1	902	General Administration	306	\$425.00	\$130,050	
		1	903	Admitting	363	\$425.00	\$154,275	
		1	922	Chapel/Meditation	1426	\$425.00	\$606,050	
		1	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	5202	\$425.00	\$2,210,850	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
<b>Totals for Whole Project:</b>					<b>33172</b>	<b>425</b>	<b>14098100</b>	

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

If additional sheets are necessary, go to the toolbar, select "Edit", select "Move or copy sheet", make sure the "create a copy" box is checked, and select this document as the destination for the copy then select "OK". An additional worksheet will be added to this spreadsheet

1. If New Construction is Involved, is it "freestanding?"	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
-----------------------------------------------------------	--------------------------------------------	--------------------------------

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

<i>JK</i> SIGNATURE		DATE	
		5/12/25	
PRINT NAME		TITLE	
GEDALIA KLEIN		EXECUTIVE DIRECTOR	
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

**New York State Department of Health  
Certificate of Need Application  
Schedule 10 - Space & Construction Cost Distribution**

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Indicate if this project is: New Construction:  **OR** Renovation:

Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		2	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	834	\$425.00	\$354,450	
		2	968	Vertical & Horizontal Mechanized Movement (elevators, cart system)	424	\$425.00	\$180,200	
		2	703	General Baseline Services - SNF's (includes Medical)	14302	\$425.00	\$6,078,350	
		2	944	Medical Supplies/Central Services/Storage	712	\$425.00	\$302,600	
		2	920	Public Areas	3819	\$425.00	\$1,623,075	
		2	737	Baseline Nursing	409	\$425.00	\$173,825	
		2	742	Baseline Pharmaceutical Service	114	\$425.00	\$48,450	
		2	980	Other Functions	383	\$425.00	\$162,775	
		2	941	Central Sterile and Supply	328	\$425.00	\$139,400	
		2	943	Maintenance/Housekeeping	208	\$425.00	\$88,400	
		2	734	Baseline Dietetic	1133	\$425.00	\$481,525	
		2	703	General Baseline Services - SNF's (includes Medical)	289	\$425.00	\$122,825	

**New York State Department of Health  
Certificate of Need Application  
Schedule 10 - Space & Construction Cost Distribution**

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		2	942	Laundry/Linen	149	\$425.00	\$63,325	
		2	703	General Baseline Services - SNF's (includes Medical	844	\$425.00	\$358,700	
		2	908	Medical/Social Services	188	\$425.00	\$79,900	
		2	905	Administrative Personnel	2968	\$425.00	\$1,261,400	
		2	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	6068	\$425.00	\$2,578,900	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
<b>Totals for Whole Project:</b>					<b>33172</b>	<b>425</b>	<b>14098100</b>	

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

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1. If New Construction is Involved, is it "freestanding?"	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
-----------------------------------------------------------	--------------------------------------------	--------------------------------

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE		DATE	
		5/12/25	
PRINT NAME		TITLE	
GEDALIA KLEIN		EXECUTIVE DIRECTOR	
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

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Indicate if this project is: New Construction:  **OR** Renovation:

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		3	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	834	\$425.00	\$354,450	
		3	968	Vertical & Horizontal Mechanized Movement (elevators, cart system)	424	\$425.00	\$180,200	
		3	703	General Baseline Services - SNF's (includes Medical	14302	\$425.00	\$6,078,350	
		3	944	Medical Supplies/Central Services/Storage	712	\$425.00	\$302,600	
		3	920	Public Areas	3819	\$425.00	\$1,623,075	
		3	737	Baseline Nursing	409	\$425.00	\$173,825	
		3	742	Baseline Pharmaceutical Service	114	\$425.00	\$48,450	
		3	980	Other Functions	383	\$425.00	\$162,775	
		3	941	Central Sterile and Supply	328	\$425.00	\$139,400	
		3	943	Maintenance/Housekeeping	208	\$425.00	\$88,400	
		3	734	Baseline Dietetic	1133	\$425.00	\$481,525	
		3	703	General Baseline Services - SNF's (includes Medical	289	\$425.00	\$122,825	

**New York State Department of Health  
Certificate of Need Application  
Schedule 10 - Space & Construction Cost Distribution**

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. <i>Current</i> (un-escalated)	(F x G) Construction Cost TOTAL <i>Current</i> sch.8B col.A (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		3	942	Laundry/Linen	149	\$425.00	\$63,325	
		3	303	Occupational Therapy	709	\$425.00	\$301,325	
		3	304	Physical Therapy	3179	\$425.00	\$1,351,075	
		3	908	Medical/Social Services	142	\$425.00	\$60,350	
		3	947	Tunnels, Bridges and Other Enclosed Circulation Spaces	6038	\$425.00	\$2,566,150	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
<b>Totals for Whole Project:</b>					<b>33172</b>	<b>425</b>	<b>14098100</b>	

**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

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1. If New Construction is Involved, is it "freestanding?"	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
-----------------------------------------------------------	--------------------------------------------	--------------------------------

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE		DATE	
		5/12/25	
PRINT NAME		TITLE	
GEDALIA KLEIN		EXECUTIVE DIRECTOR	
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

# **Schedule 11 – CON Form Regarding Moveable Equipment**

## **Contents:**

- **Schedule 11 – Moveable Equipment**

**New York State Department of Health**

**Certificate of Need Application**

**Schedule 11 - Moveable Equipment**

For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review \*

**Table I: New Equipment Description**

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufacturer where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
1	943	003 ENGINEERING/ MAINTENANCE OFFICE 6' X 7' DESK W/ RETURNS	2			1,800.00
1	943	003 ENGINEERING/ MAINTENANCE OFFICE 3' X 8' REF. DESK	2			2,040.00
1	734	003 ENGINEERING/ MAINTENANCE OFFICE 18" X 96" SHELVES	5			8,730.00
1	734	003 ENGINEERING/ MAINTENANCE OFFICE DESK CHAIRS	2			1,080.00
1	734	003 ENGINEERING/ MAINTENANCE OFFICE FILE CABINETS	3			2,106.00
1	921	004 STAFF LOUNGE 4 TABLES	7			6,930.00
1	921	004 STAFF LOUNGE CHAIRS	28			15,960.00
1	921	004 STAFF LOUNGE REFRIGERATOR	2			3,000.00
1	734	005 FOOD SERVICE OFFICE 6' X 7' DESK W/ RETURNS	3			2,300.00
1	734	005 FOOD SERVICE OFFICE DESK CHAIRS	3			1,620.00
1	734	005 FOOD SERVICE OFFICE FILE CABINETS	3			2,106.00
1	734	009 SOILED HOLDING 2'x4' METAL SHELVING	3			2,394.00
1	734	009 SOILED HOLDING CARTS	4			1,224.00
1	946	013 FAMILY ROOM LOUNGE CHAIR	1			780.00
1	980	017 RESIDENT STORAGE 36' X 48" X 80" STORAGE CUBICLES	60			18,000.00

1	980	018 MAINTENANCE OFFICE 6' X 7' DESK W/ RETURNS	2			1,800.00
1	980	018 MAINTENANCE OFFICE 4' X 8' REF. DESK	1			1,020.00
1	980	018 MAINTENANCE OFFICE 2' X 4' METAL SHELVING	6			4,788.00
1	980	018 MAINTENANCE OFFICE DESK CHAIRS	2			1,080.00
1	980	018 MAINTENANCE OFFICE FILE CABINETS	4			2,808.00
1	980	031 KITCHEN STORAGE 24"x4' METAL SHELVES	5			3,990.00
1	980	031 KITCHEN STORAGE 24"x8' METAL SHELVES	13			22,698.00
1	980	032 STORAGE 24"x8' METAL SHELVES	8			13,968.00
1	980	032 STORAGE 24"x6' METAL SHELVES	3			2,970.00
1	980	033 ENVOIR. SERV. SUPPLY/ STORAGE 24"x4' METAL SHELVES	1			798.00
1	980	033 ENVOIR. SERV. SUPPLY/ STORAGE 18"x8' METAL SHELVES	4			6,984.00
1	920	042 MULTI-PURPOSE ROOM 6' ROUND TABLES	20			25,440.00
1	920	042 MULTI-PURPOSE ROOM CHAIRS	80			45,600.00
Total lease and purchase costs: Subproject 1						
Total lease and purchase costs: Subproject 2						
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						
Total lease and purchase costs: Subproject 5						
Total lease and purchase costs: Subproject 6						
Total lease and purchase costs: Subproject 7						
Total lease and purchase costs: Subproject 8						
Total lease and purchase costs: Whole Project:						204,014.00

**New York State Department of Health**

**Certificate of Need Application**

**Schedule 11 - Moveable Equipment**

For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review \*

**Table I: New Equipment Description**

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufacturer where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
1	980	115 STORAGE 24" X 4' METAL SHELVING	4			3,192.00
1	980	115 STORAGE 24" X 5' METAL SHELVING	3			2,898.00
1	980	117 NURSE STATION DESK CHAIR	7			3,780.00
1	923	118 LOUNGE LOUNGE CHAIR	6			4,680.00
1	923	118 LOUNGE 3 SEATER LOUNGE CHAIR	2			3,840.00
1	923	118 LOUNGE SIDE TABLE	8			3,360.00
1	923	118 LOUNGE CENTER TABLE	2			1,200.00
1	980	120 STORAGE 24" X 4' METAL SHELVING	4			3,192.00
1	980	120 STORAGE 24" X 5' METAL SHELVING	3			2,898.00
1	980	135 STORAGE 24" X 4' METAL SHELVING	3			2,394.00
1	980	135 STORAGE 24" X 5' METAL SHELVING	1			966.00
1	980	138 MEDICINE ROOM 18" X 4' METAL SHELVING	2			1,380.00
1	980	138 MEDICINE ROOM COLD STORAGE/ REFRIGERATOR	2			1,800.00
1	980	139 CLEAN STORAGE 24" X 5' METAL SHELVING	2			1,932.00
1	980	139 CLEAN STORAGE 24" X 8' METAL SHELVING	2			3,492.00

1	980	142 STORAGE 24" X 4' METAL SHELVING	3			2,394.00
1	980	142 STORAGE 24" X 5' METAL SHELVING	1			966.00
1	923	143 LIVING/ DINING ROOM LOUNGE CHAIR	2			1,560.00
1	923	143 LIVING/ DINING ROOM 3 SEATER LOUNGE CHAIR	1			1,920.00
1	923	143 LIVING/ DINING ROOM COFFEE CHAIR	4			1,920.00
1	923	143 LIVING/ DINING ROOM COFFEE TABLE	2			960.00
1	923	143 LIVING/ DINING ROOM CENTER TABLE	1			600.00
1	923	143 LIVING/ DINING ROOM 4' TABLE	3			2,970.00
1	923	143 LIVING/ DINING ROOM CHAIRS	12			6,840.00
1	734	144 PANTRY BAR CHAIR	5			2,400.00
1	734	148 SERVICE VESTIBULE CARTS	4			1,600.00
1	734	147 PREP. KITCHEN REFRIGERATOR	1			900.00
1	942	150 RESIDENT LAUNDRY WASHER/DRYER	2			6,000.00
1	734	152 PREP. KITCHEN REFRIGERATOR	1			900.00
1	734	152 PREP. KITCHEN 24" X 4' METAL SHELVING	2			1,596.00
1	943	153 SOILED UTILITY CARTS	2			612.00
1	943	155 PANTRY BAR CHAIR	12			5,760.00
1	923	156 LIVING/ DINING ROOM LOUNGE CHAIR	4			3,120.00
1	923	156 LIVING/ DINING ROOM 3 SEATER LOUNGE CHAIR	2			3,840.00
1	923	156 LIVING/ DINING ROOM COFFEE CHAIR	4			1,920.00
1	923	156 LIVING/ DINING ROOM COFFEE TABLE	2			960.00

1	923	156 LIVING/ DINING ROOM CENTER TABLE	2			1,200.00
1	923	156 LIVING/ DINING ROOM 4' TABLE	5			4,950.00
1	923	156 LIVING/ DINING ROOM CHAIRS	20			11,400.00
1	942	158 RESIDENT LAUNDRY WASHER/DRYER	2			6,000.00
1	980	159 CLEAN STORAGE 24" X 5' METAL SHELVING	4			3,864.00
1	980	160 NURSE STATION DESK CHAIR	2			1,080.00
1	980	161 STORAGE 18" X 4' METAL SHELVING	6			4,140.00
1	923	162 LOUNGE LOUNGE CHAIR	6			4,680.00
1	923	162 LOUNGE 3 SEATER LOUNGE CHAIR	2			3,840.00
1	923	162 LOUNGE CENTER TABLE	2			1,200.00
1	924	179 COFFEE SHOP COFFEE CHAIR	4			1,920.00
1	924	179 COFFEE SHOP COFFEE TABLE	2			960.00
1	924	179 COFFEE SHOP HIGH TABLE	4			1,920.00
1	924	179 COFFEE SHOP BAR CHAIR	20			9,600.00
1	923	181 WAITING LOUNGE LOUNGE CHAIR	4			3,120.00
1	923	181 WAITING LOUNGE 3 SEATER LOUNGE CHAIR	2			3,840.00
1	923	181 WAITING LOUNGE CENTER TABLE	4			2,400.00
1	923	181 WAITING LOUNGE SECTIONAL LOUNGE CHAIR	1			1,500.00
1	902	184 SECURITY OFFICE DESK CHAIRS	3			1,620.00
1	902	184 SECURITY OFFICE FILE CABINETS	4			2,808.00
1	902	185 MULTI-PURPOSE/ CONFERENCE 39" X 96' CONFERENCE TABLE	1			2,000.00

1	902	185 MULTI-PURPOSE/ CONFERENCE CHAIRS	6			3,240.00
1	902	185 MULTI-PURPOSE/ CONFERENCE 2' X 6' CREDENZA	1			650.00
1	903	186 OFFICE 6' X 7' DESK W/ RETURNS	3			3,000.00
1	903	186 OFFICE DESK CHAIR	1			540.00
1	903	186 OFFICE SIDE CHAIR	1			450.00
1	903	186 OFFICE 2' X 5' CREDENZA	1			500.00
1	903	186 OFFICE FILE CABINETS	2			1,404.00
1	902	187 RECEPTION DESK CHAIR	3			1,620.00
1	922	191 CHAPEL STACKING CHAIR	77			43,890.00
1	920	192 FAMILY LOUNGE LOUNGE CHAIR	4			3,120.00
1	920	192 FAMILY LOUNGE 4 SEATER LOUNGE CHAIR	1			4,000.00
1	920	192 FAMILY LOUNGE CENTER TABLE	1			600.00
1	703	RESIDENT ROOM BED	40			87,600.00
1	703	RESIDENT ROOM OVERHEAD TABLE	40			19,200.00
1	703	RESIDENT ROOM VISITOR CHAIR	40			18,000.00
1	703	RESIDENT ROOM SIDE CHAIR	40			19,200.00
1	703	RESIDENT ROOM CHEST WARDROBE	40			55,200.00
1	703	RESIDENT ROOM NIGHT STAND	40			21,120.00
1	703	RESIDENT ROOM TV	40			24,000.00
Total lease and purchase costs: Subproject 1						
Total lease and purchase costs: Subproject 2						
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						

Total lease and purchase costs: Subproject 5	
Total lease and purchase costs: Subproject 6	
Total lease and purchase costs: Subproject 7	
Total lease and purchase costs: Subproject 8	
Total lease and purchase costs: Whole Project:	472,118.00

**New York State Department of Health**

**Certificate of Need Application**

**Schedule 11 - Moveable Equipment**

For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review \*

**Table I: New Equipment Description**

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufacturer where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
1	944	215 STORAGE 24" X 4' METAL SHELVING	4			3,192.00
1	944	215 STORAGE 24" X 5' METAL SHELVING	3			2,898.00
1	737	217 NURSE STATION DESK CHAIR	7			3,780.00
1	920	218 LOUNGE LOUNGE CHAIR	6			4,680.00
1	920	218 LOUNGE 3 SEATER LOUNGE CHAIR	2			3,840.00
1	920	218 LOUNGE SIDE TABLE	8			3,360.00
1	920	218 LOUNGE CENTER TABLE	2			1,200.00
1	944	220 STORAGE 24" X 4' METAL SHELVING	4			3,192.00
1	944	220 STORAGE 24" X 5' METAL SHELVING	3			2,898.00
1	944	235 STORAGE 24" X 4' METAL SHELVING	3			2,394.00
1	944	235 STORAGE 24" X 4' METAL SHELVING	1			966.00
1	742	238 MEDICINE ROOM 18" X 4' METAL SHELVING	2			1,380.00
1	742	238 MEDICINE ROOM COLD STORAGE/ REFRIGERATOR	2			1,800.00
1	941	239 CLEAN STORAGE 24" X 5' METAL SHELVING	2			1,932.00
1	941	239 CLEAN STORAGE 24" X 8' METAL SHELVING	2			3,492.00

1	944	242 STORAGE 24" X 4' METAL SHELVING	4			3,192.00
1	944	242 STORAGE 24" X 5' METAL SHELVING	3			2,898.00
1	923	243 LIVING/ DINING ROOM LOUNGE CHAIR	2			1,560.00
1	923	243 LIVING/ DINING ROOM 3 SEATER LOUNGE CHAIR	1			1,920.00
1	923	243 LIVING/ DINING ROOM COFFEE CHAIR	4			1,920.00
1	923	243 LIVING/ DINING ROOM COFFEE TABLE	2			960.00
1	923	243 LIVING/ DINING ROOM CENTER TABLE	1			600.00
1	923	243 LIVING/ DINING ROOM 4' TABLE	3			2,970.00
1	923	243 LIVING/ DINING ROOM CHAIRS	12			6,840.00
1	734	244 PANTRY BAR CHAIR	5			2,400.00
1	734	248 SERVICE VESTIBULE CARTS	4			1,600.00
1	734	247 PREP. KITCHEN REFRIGERATOR	1			900.00
1	942	250 RESIDENT LAUNDRY WASHER/DRYER	2			6,000.00
1	734	252 PREP. KITCHEN REFRIGERATOR	1			900.00
1	734	252 PREP. KITCHEN 24" X 4' METAL SHELVING	2			1,596.00
1	943	253 SOILED UTILITY CARTS	2			1,404.00
1	734	255 PANTRY BAR CHAIR	12			5,760.00
1	923	256 LIVING/ DINING ROOM LOUNGE CHAIR	4			3,120.00
1	923	256 LIVING/ DINING ROOM 3 SEATER LOUNGE CHAIR	2			3,840.00
1	923	256 LIVING/ DINING ROOM COFFEE CHAIR	4			1,920.00
1	923	256 LIVING/ DINING ROOM COFFEE TABLE	2			960.00

1	923	256 LIVING/ DINING ROOM CENTER TABLE	2			1,200.00
1	923	256 LIVING/ DINING ROOM 4' TABLE	5			4,950.00
1	923	256 LIVING/ DINING ROOM CHAIRS	20			11,400.00
1	942	258 RESIDENT LAUNDRY WASHER/DRYER	2			6,000.00
1	980	259 CLEAN STORAGE 24" X 5' METAL SHELVING	4			3,864.00
1	980	260 NURSE STATION DESK CHAIR	2			1,080.00
1	980	261 STORAGE 18" X 4' METAL SHELVING	6			4,140.00
1	923	262 LOUNGE LOUNGE CHAIR	6			4,680.00
1	923	262 LOUNGE 3 SEATER LOUNGE CHAIR	2			3,840.00
1	923	262 LOUNGE CENTER TABLE	2			1,200.00
1	944	242 STORAGE 24" X 5' METAL SHELVING	1			966.00
1	944	242 STORAGE 24" X 6' METAL SHELVING	1			990.00
1	908	282 STAFF OFFICE 6' X 7' DESK W/ RETURNS	3			2,700.00
1	908	282 STAFF OFFICE DESK CHAIR	3			1,620.00
1	908	282 STAFF OFFICE FILE CABINET	2			1,404.00
1	703	286 BEAUTY PARLOR HYDRAULIC STYLING/ DRYING CHAIR	4			4,000.00
1	703	286 BEAUTY PARLOR SHAMPOOING CHAIR	2			4,000.00
1	703	286 BEAUTY PARLOR 2 SEATER LOUNGE CHAIR	1			1,200.00
1	703	286 BEAUTY PARLOR 6' X 7' DESK W/ RETURNS	1			900.00
1	703	286 BEAUTY PARLOR DESK CHAIR	1			540.00
1	947	291 CORRIDOR 6' X 7' DESK W/ RETURNS	1			650.00

1	947	291 CORRIDOR DESK CHAIR	1		540.00
1	947	291 CORRIDOR 2' X 6' CREDENZA	1		650.00
1	944	293 FILE ROOM FILE CABINETS	6		4,212.00
1	921	295 STAFF PANTRY 4' TABLE	1		990.00
1	921	295 STAFF PANTRY CHAIRS	4		2,280.00
1	921	295 STAFF PANTRY REFRIGERATOR	1		600.00
1	905	297 OFFICE EXECUTIVE DESK W/ RETURNS	1		3,100.00
1	905	297 OFFICE DESK CHAIR	1		540.00
1	905	297 OFFICE 2' X 6' CREDENZA	1		650.00
1	905	297 OFFICE 24" X 4' OFFICE SHELF	2		1,596.00
1	905	297 OFFICE SIDE CHAIR	1		450.00
1	905	298 OFFICE DESK W/ RETURNS	1		900.00
1	905	298 OFFICE DESK CHAIR	1		540.00
1	905	298 OFFICE 2' X 6' CREDENZA	1		650.00
1	905	298 OFFICE 24" X 4' OFFICE SHELF	2		1,596.00
1	905	298 OFFICE SIDE CHAIR	1		450.00
1	905	299 OFFICE DESK W/ RETURNS	1		900.00
1	905	299 OFFICE DESK CHAIR	1		540.00
1	905	299 OFFICE 2' X 6' CREDENZA	1		650.00
1	905	299 OFFICE 24" X 4' OFFICE SHELF	2		1,596.00
1	905	299 OFFICE SIDE CHAIR	1		450.00

1	905	2100 OFFICE EXECUTIVE DESK W/ RETURNS	1			2,100.00
1	905	2100 OFFICE DESK CHAIR	1			540.00
1	905	2100 OFFICE 2' X 6' CREDENZA	1			650.00
1	905	2100 OFFICE 24" X 4' OFFICE SHELF	2			1,596.00
1	905	2100 OFFICE SIDE CHAIR	1			450.00
1	905	2101 OFFICE 2' X 6' CREDENZA	1			650.00
1	905	2101 OFFICE 24" X 4' OFFICE SHELF	1			798.00
1	905	2102 OFFICE EXECUTIVE DESK W/ RETURNS	1			2,100.00
1	905	2102 OFFICE DESK CHAIR	1			540.00
1	905	2102 OFFICE 2' X 6' CREDENZA	1			650.00
1	905	2102 OFFICE 24" X 4' OFFICE SHELF	2			1,596.00
1	905	2102 OFFICE SIDE CHAIR	1			450.00
1	905	2103 OFFICE DESK W/ RETURNS	2			1,800.00
1	905	2103 OFFICE DESK CHAIR	2			1,080.00
1	905	2103 OFFICE 24" X 4' OFFICE SHELF	4			3,192.00
1	905	2104 CONFERENCE TABLE	1			1,600.00
1	905	2014 CONFERENCE CHAIRS	10			5,400.00
1	703	RESIDENT ROOM BED	40			87,600.00
1	703	RESIDENT ROOM OVERHEAD TABLE	40			19,200.00
1	703	RESIDENT ROOM VISITOR CHAIR	40			18,000.00
1	703	RESIDENT ROOM SIDE CHAIR	40			19,200.00

1	703	RESIDENT ROOM CHEST WARDROBE	40			55,200.00
1	703	RESIDENT ROOM NIGHT STAND	40			21,120.00
1	703	RESIDENT ROOM TV	40			24,000.00
Total lease and purchase costs: Subproject 1						
Total lease and purchase costs: Subproject 2						
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						
Total lease and purchase costs: Subproject 5						
Total lease and purchase costs: Subproject 6						
Total lease and purchase costs: Subproject 7						
Total lease and purchase costs: Subproject 8						
Total lease and purchase costs: Whole Project:						448,980.00

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**Schedule 11 - Moveable Equipment**

For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review \*

**Table I: New Equipment Description**

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufacturer where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
1	944	315 STORAGE 24" X 4' METAL SHELVING	4	P		3,192.00
1	944	315 STORAGE 24" X 5' METAL SHELVING	3	P		2,898.00
1	737	317 NURSE STATION DESK CHAIR	7	P		3,780.00
1	920	318 LOUNGE LOUNGE CHAIR	6	P		4,680.00
1	920	318 LOUNGE 3 SEATER LOUNGE CHAIR	2	P		3,840.00
1	920	318 LOUNGE SIDE TABLE	8	P		3,360.00
1	920	318 LOUNGE CENTER TABLE	2	P		1,200.00
1	944	320 STORAGE 24" X 4' METAL SHELVING	4	P		3,192.00
1	944	320 STORAGE 24" X 5' METAL SHELVING	3	P		2,898.00
1	944	335 STORAGE 24" X 4' METAL SHELVING	3	P		2,394.00
1	944	335 STORAGE 24" X 4' METAL SHELVING	1	P		966.00
1	742	338 MEDICINE ROOM 18" X 4' METAL SHELVING	2	P		1,380.00
1	742	338 MEDICINE ROOM COLD STORAGE/REFRIGERATOR	2	P		1,800.00
1	941	339 CLEAN STORAGE 24" X 5' METAL SHELVING	2	P		1,932.00
1	941	339 CLEAN STORAGE 24" X 8' METAL SHELVING	2	P		3,492.00

1	944	342 STORAGE 24" X 4' METAL SHELVING	4	P		3,192.00
1	944	342 STORAGE 24" X 5' METAL SHELVING	3	P		2,898.00
1	923	343 LIVING/ DINING ROOM LOUNGE CHAIR	2	P		1,560.00
1	923	343 LIVING/ DINING ROOM 3 SEATER LOUNGE CHAIR	1	P		1,920.00
1	923	343 LIVING/ DINING ROOM COFFEE CHAIR	4	P		1,920.00
1	923	343 LIVING/ DINING ROOM COFFEE TABLE	2	P		960.00
1	923	343 LIVING/ DINING ROOM CENTER TABLE	1	P		600.00
1	923	343 LIVING/ DINING ROOM 4' TABLE	3	P		2,970.00
1	923	343 LIVING/ DINING ROOM CHAIRS	12	P		6,840.00
1	734	348 SERVICE VESTIBULE CARTS	4	P		1,600.00
1	734	344 PANTRY BAR CHAIR	5	P		2,400.00
1	734	347 PREP. KITCHEN REFRIGERATOR	1	P		900.00
1	942	350 RESIDENT LAUNDRY WASHER/DRYER	2	P		6,000.00
1	734	352 PREP. KITCHEN REFRIGERATOR	1	P		900.00
1	734	352 PREP. KITCHEN 24" X 4' METAL SHELVING	2	P		1,596.00
1	943	353 SOILED UTILITY CARTS	2	P		612.00
1	943	355 PANTRY BAR CHAIR	12	P		5,760.00
1	923	356 LIVING/ DINING ROOM LOUNGE CHAIR	4	P		3,120.00
1	923	356 LIVING/ DINING ROOM 3 SEATER LOUNGE CHAIR	2	P		3,840.00
1	923	356 LIVING/ DINING ROOM COFFEE CHAIR	4	P		1,920.00
1	923	356 LIVING/ DINING ROOM COFFEE TABLE	2	P		960.00

1	923	356 LIVING/ DINING ROOM CENTER TABLE	2	P		1,200.00
1	923	356 LIVING/ DINING ROOM 4' TABLE	5	P		4,950.00
1	923	356 LIVING/ DINING ROOM CHAIRS	20	P		11,400.00
1	942	358 RESIDENT LAUNDRY WASHER/DRYER	2	P		6,000.00
1	980	359 CLEAN STORAGE 24" X 5' METAL SHELVING	4	P		3,864.00
1	980	360 NURSE STATION DESK CHAIR	2	P		1,080.00
1	980	361 STORAGE 18" X 4' METAL SHELVING	6	P		4,140.00
1	923	362 LOUNGE LOUNGE CHAIR	6	P		4,680.00
1	923	362 LOUNGE 3 SEATER LOUNGE CHAIR	2	P		3,840.00
1	923	362 LOUNGE CENTER TABLE	2	P		1,200.00
1	905	381 OFFICE 6' X 7' DESK W/ RETURNS	1	P		900.00
1	905	381 OFFICE DESK CHAIR	1	P		540.00
1	905	381 OFFICE 2' X 6' CREDENZA	1	P		650.00
1	905	381 OFFICE 24" X 4' OFFICE SHELF	2	P		1,596.00
1	905	381 OFFICE SIDE CHAIR	1	P		450.00
1	905	385 WORK AREA DESK CHAIR	4	P		2,160.00
1	703	RESIDENT ROOM BED	40	P		87,600.00
1	703	RESIDENT ROOM OVERHEAD TABLE	40	P		19,200.00
1	703	RESIDENT ROOM VISITOR CHAIR	40	P		18,000.00
1	703	RESIDENT ROOM SIDE CHAIR	40	P		19,200.00
1	703	RESIDENT ROOM CHEST WARDROBE	40	P		55,200.00

1	703	RESIDENT ROOM NIGHT STAND	40	P		21,120.00
1	703	RESIDENT ROOM TV	40	P		24,000.00
Total lease and purchase costs: Subproject 1						
Total lease and purchase costs: Subproject 2						
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						
Total lease and purchase costs: Subproject 5						
Total lease and purchase costs: Subproject 6						
Total lease and purchase costs: Subproject 7						
Total lease and purchase costs: Subproject 8						
Total lease and purchase costs: Whole Project:						386,442.00

# **Schedule 13- All Article 28 Facilities**

## **Contents:**

- **Schedule 13 A - Assurances**
- **Schedule 13 B - Staffing**
- **Schedule 13 C - Annual Operating Costs**
- **Schedule 13 D - Annual Operating Revenue**

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**Schedule 13A**

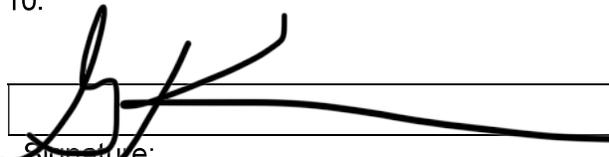
**Schedule 13 A. Assurances from Article 28 Applicants**

Article 28 applicants seeking combined establishment and construction or construction-only approval must complete this schedule.

The undersigned, as a duly authorized representative of the applicant, hereby gives the following assurances:

- a) The applicant has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way sufficient to assure use and possession for the purpose of the construction and operation of the facility.
- b) The applicant will obtain the approval of the Commissioner of Health of all required submissions, which shall conform to the standards of construction and equipment in Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.
- c) The applicant will submit to the Commissioner of Health final working drawings and specifications, which shall conform to the standards of construction and equipment of Subchapter C of Title 10, prior to contracting for construction, unless otherwise provided for in Title 10.
- d) The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.
- e) The applicant will provide and maintain competent and adequate architectural and/or engineering inspection at the construction site to ensure that the completed work conforms to the approved plans and specifications.
- f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.
- g) The facility will be operated and maintained in accordance with the standards prescribed by law.
- h) The applicant will comply with the provisions of the Public Health Law and the applicable provisions of Title 10 with respect to the operation of all established, existing medical facilities in which the applicant has a controlling interest.
- i) The applicant understands and recognizes that any approval of this application is not to be construed as an approval of, nor does it provide assurance of, reimbursement for any costs identified in the application. Reimbursement for all cost shall be in accordance with and subject to the provisions of Part 86 of Title 10.

Date May 27, 2025



Signature:

Gedalia Klein

Name (Please Type)

Executive Director

Title (Please Type)

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**Schedule 13B**

**Schedule 13 B-1. Staffing**

See “Schedules Required for Each Type of CON” to determine when this form is required. Use the “Other” categories for providers, such as dentists, that are not mentioned in the staff categories. If a project involves multiple sites, please create a staffing table for each site.

Total Project    Subproject number

A		B	C	D
		Number of FTEs to the Nearest Tenth		
Staffing Categories		Current Year*	First Year Total Budget	Third Year Total Budget
1.	Management & Supervision	9.57	9.57	9.57
2.	Technician & Specialist	4.43	4.43	4.43
3.	Registered Nurses	14.92	14.92	14.92
4.	Licensed Practical Nurses	16.78	16.78	16.78
5.	Aides, Orderlies & Attendants	51.50	51.50	51.50
6.	Physicians			
7.	PGY Physicians			
8.	Physicians' Assistants			
9.	Nurse Practitioners			
10.	Nurse Midwife			
11.	Social Workers and Psychologist**	4.37	4.37	4.37
12.	Physical Therapists and PT Assistants			
13.	Occupational Therapists and OT Assistants			
14.	Speech Therapists and Speech Assistants			
15.	Other Therapists and Assistants			
16.	Infection Control, Environment and Food Service	31.36	31.36	31.36
17.	Clerical & Other Administrative	2.58	2.58	2.58
18.	Other Activities	4.54	4.54	4.54
19.	Other			
20.	Other			
21.	Total Number of Employees	140.05	140.05	140.05

\*Last complete year prior to submitting application

\*\*Only for RHCF and D&TC proposals

**Describe how the number and mix of staff were determined:**

The first year and third year staffing projection is based upon the operator’s staffing plan as implemented upon the approval of this application. The staffing may be adjusted further based upon resident need.

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**Schedule 13B**

**Schedule 13 B-2. Medical/Center Director and Transfer Agreements**

*All diagnostic and treatment centers and midwifery birth centers should complete this section when requesting a new location. DTCs are required to have a Medical Director who is a physician. MBCs may have a Center Director who is a physician or a licensed midwife.*

Medical/Center Director	
Name of Medical/Center Director:	
License number of the Medical/Center Director	

	Not Applicable	Title of Attachment	Filename of attachment
Attach a copy of the Medical/Center Director's curriculum vitae	<input checked="" type="checkbox"/>		

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	
<ul style="list-style-type: none"> <li>○ Distance in miles from the proposed facility to the Hospital affiliate.</li> </ul>	
<ul style="list-style-type: none"> <li>○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.</li> </ul>	
<ul style="list-style-type: none"> <li>○ Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.</li> </ul>	N/A <input checked="" type="checkbox"/> Attachment Name:
Name of the <b>nearest</b> Hospital to the proposed facility	
<ul style="list-style-type: none"> <li>○ Distance in miles from the proposed facility to the nearest hospital.</li> </ul>	
<ul style="list-style-type: none"> <li>○ Distance in minutes of travel time from the proposed facility to the nearest hospital.</li> </ul>	

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**Schedule 13B**

**Schedule 13B-3. AMBULATORY SURGERY CENTERS ONLY - Physician Commitments**

Upload a spreadsheet or chart as an attachment to this Schedule of all practitioners, including surgeons, dentists, and podiatrists who have expressed an interest in practicing at the Center. The chart must include the information shown in the template below.

**Additionally**, upload copies of letters from each practitioner showing the number and types of procedures he/she expects to perform at the Center per year.

Practitioner's Name	License Number	Specialty/(s)	Board Certified or Eligible?	Expected Number of Procedures	Hospitals where Physician has Admitting Privileges	Title and File Name of attachment
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**Schedule 13C**

**Schedule 13C. Annual Operating Costs**

See “Schedules Required for Each Type of CON” to determine when this form is required. One schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule that matches the structure of the tables (Attachment Title: ) to summarize the first and third full year’s total cost for the categories, which are affected by this project. The first full year is defined as the first 12 months of full operation after project completion. Year 1 and 3 should represent projected total budgeted costs expressed in current year dollars. Additionally, you must upload the required attachments indicated below.

**Required Attachments**

	<b>Title of Attachment</b>	<b>Filename of Attachment</b>
1. In an attachment, provide the basis for determining budgeted expenses, including details for how depreciation and rent / lease expenses were calculated.	Attachment 11 - Schedule of Depreciation	Attachment 11 - Schedule of Depreciation.pdf
2. In a separate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital		

Total Project or  Subproject Number

**Table 13C - 1**

	<b>a</b>	<b>b</b>	<b>c</b>
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	01/01/2023	01/01/2028	01/01/2030
1. Salaries and Wages	\$8,002,968	\$8,203,041	\$8,449,132
1a. FTEs	140.05	140.05	140.05
2. Employee Benefits	\$2,796,955	\$2,987,143	\$3,181,945
3. Professional Fees	\$664,963	\$674,295	\$693,443
4. Medical & Surgical Supplies	\$531,032	\$541,653	\$552,486
5. Non-med., non-surg. Supplies	\$1,004,825	\$1,024,921	\$1,045,419
6. Utilities	\$568,230	\$585,277	\$596,983
7. Purchased Services	\$3,819,291	\$3,876,579	\$3,915,347
8. Other Direct Expenses	\$1,342,898	\$1,114,073	\$1,136,354
9. Subtotal (total 1-8)	<b>\$18,731,162</b>	<b>\$19,006,982</b>	<b>\$19,571,109</b>
10. Interest (details required below)	\$0	\$0	\$0
11. Depreciation (details required below)	\$676,099	\$200,710	\$166,623
12. Rent / Lease (details required below)	\$752,256	\$362,256	\$362,256
13. Total Operating Costs	<b>\$20,159,517</b>	<b>\$19,569,948</b>	<b>\$20,099,988</b>

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**Schedule 13C**

**Table 13C - 2**

	a	b	c
<b>Inpatient</b> Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	Current Year	Year 1	Year 3
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs			

**Table 13C - 3**

	a	b	c
<b>Outpatient</b> Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)			
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Outpatient Operating Costs			

*Any approval of this application is not to be construed as an approval of any of the above indicated current or projected operating costs. Reimbursement of any such costs shall be in accordance with and subject to the provisions of Part 86 of 10 NYCRR. Approval of this application does not assure reimbursement of any of the costs indicated therein by payers under Title XIX of the Federal Social Security Act (Medicaid) or Article 43 of The State Insurance Law or by any other payers.*

**Schedule 13 D: Annual Operating Revenues**

See “Schedules Required for Each Type of CON” to determine when this form is required. If required, one schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule (Attachment Title: ) to summarize the current year’s operating revenue, and the first and third year’s budgeted operating revenue (after project completion) for the categories that are affected by this project.

Table 1. Enter the current year data in column 1. This should represent the total revenue for the last complete year before submitting the application, using audited data. Project the first and third year’s total budgeted revenue in current year dollars

Tables 2a and 2b. Enter current year data in the appropriate block. This should represent revenue by payer for the last complete year before submitting the application, using audited data.

Indicate in the appropriate blocks total budgeted revenues (i.e., operating revenues by payer to be received during the first and third years of operation after project completion). As an attachment, provide documentation for the rates assumed for each payer. Where the project will result in a rate change, provide supporting calculations. For managed care, include rates and information from which the rates are derived, including payer, enrollees, and utilization assumptions.

**The Total of Inpatient and Outpatient Services at the bottom of Tables 13D-2A and 13D-2B should equal the totals given on line 10 of Table 13D-1.**

**Required Attachments**

	N/A	Title of Attachment	Filename of Attachment
1. Provide a cash flow analysis for the first year of operations after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project.	<input type="checkbox"/>	Attachment 4 – Monthly Cash Flow Analysis	Attachment 4 – Monthly Cash Flow Analysis.pdf
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	<input type="checkbox"/>	Attachment 10 – Analysis of Net Patient Revenue	Attachment 10 – Analysis of Net Patient Revenue.pdf
3. Provide the basis for charity care revenue assumptions used in Year 1 and 3 Budgets ((Table 13D-2B). <i>If less than 2%, provide a reason why a higher level of charity care cannot be achieved and remedies that will be implemented to increase charity care.</i>	<input checked="" type="checkbox"/>		

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**Schedule 13D**

**Table 13D - 1**

	a	b	c
Categories	Current Year	Year 1 Total Revenue Budget	Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)	01/01/2023	01/01/2028	01/01/2030
1. Inpatient Services	\$18,104,512	\$17,870,725	\$18,052,938
2. Outpatient Services			
3. Ancillary Services	\$1,575,958	\$1,627,839	\$2,116,189
4. Total Gross Patient Care Services Rendered	\$19,680,470	\$19,498,564	\$20,169,127
5. Deductions from Revenue	(\$143,808)		
6. Net Patient Care Services Revenue	\$19,536,662	\$19,498,564	\$20,169,127
7. Other Operating Revenue (Identify sources)			
Investment Income	\$249,011	\$250,000	\$250,000
Other Income	\$1,295,877	\$693,000	\$693,000
8. Total Operating Revenue (Total 1-7)	\$21,081,550	\$20,441,564	\$21,112,127
9. Non-Operating Revenue			
<b>10. Total Project Revenue</b>	<b>\$21,081,550</b>	<b>\$20,441,564</b>	<b>\$21,112,127</b>

**New York State Department of Health  
Certificate of Need Application**

**Schedule 13D**

**Table 13D – 2A**

Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days  or Patient Discharges

Inpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
		(A) Patient Days or dis- charges	Net Revenue		(C) Patient Days or dis- charges	Net Revenue		(E) Patient Days or dis- charges	Net Revenue	
			(B) Dollars (\$)	\$ per Patient Day or dis- charge <b>(B)/(A)</b>		(D) Dollars (\$)	\$ per Patient Day or dis- charge <b>(D)/(C)</b>		(F) Dollars (\$)	\$ per Patient Days or dis- charges <b>(F)/(E)</b>
Commercial	Fee for Service	243	\$108,977	\$448.47	248	\$111,221	\$448.47	251	\$112,566	\$448.47
	Managed Care									
Medicare	Fee for Service	6,924	\$6,758,599	\$976.11	7,087	\$6,917,692	\$976.11	7,159	\$6,987,971	\$976.11
	Managed Care	1,061	\$504,210	\$475.22	1,086	\$516,089	\$475.22	1,097	\$521,316	\$475.22
Medicaid	Fee for Service	27,276	\$8,714,357	\$319.49	27,922	\$8,213,256	\$294.15	28,207	\$8,297,089	\$294.15
	Managed Care	5,860	\$1,745,547	\$297.87	6,001	\$1,832,885	\$305.43	6,062	\$1,851,517	\$305.43
Private Pay		565	\$272,822	\$482.87	579	\$279,582	\$482.87	585	\$282,479	\$482.87
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total		41,929	\$18,104,512	\$431.79	42,923	\$17,870,725	\$416.34	43,361	\$18,052,938	\$416.34

**New York State Department of Health  
Certificate of Need Application**

**Schedule 13D**

**Table 13D – 2B**

Various outpatient services may be reimbursed as visits or procedures. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Visits (V)  or Procedures (P)

Outpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
		(A) V/P	Net Revenue		(C) V/P	Net Revenue		(E) V/P	Net Revenue	
			(B) Dollars (\$)	\$ per V/P (B)/(A)		(D) Dollars (\$)	\$ per V/P (D)/(C)		(F) Dollars (\$)	\$ per V/P (F)/(E)
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service	6,669	\$1,059,143	\$159	7,641	\$1,026,721	\$134	9,934	\$1,334,832	\$134
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		3,770	\$516,815	\$137	4,319	\$601,118	\$139	5,614	\$781,357	\$139
Total		10,439	\$1,575,958	\$150.97	11,960	\$1,627,839	\$136.11	15,548	\$2,116,189	\$136.11
Total of Inpatient and Outpatient Services		52,368	\$19,680,470	\$375.81	54,883	\$19,498,564	\$355.28	58,909	\$20,169,127	\$342.38

# **Schedule 18 CON Forms Specific to Residential Health Care Facilities Article 28**

## **Contents:**

- **Schedule 18 Part A - Residential Health Care Facility Program Project Narrative**
- **Schedule 18 Part B - Residential Health Care Facility Program Information**
- **Schedule 18 Part C - Impact of CON Application on Residential Health Care Facilities' Operating Certificate (Only for use with Modifications)**
- **Schedule 18 Part D - RHCF Space & Construction Distribution**
- **Schedule 18 Part E - RHCF Statement of Functional Expenses (Excel Spreadsheet)**
- **Schedule 18 Part F - RHCF Analysis of Net Patient Revenue**

## A. Residential Health Care Facility Program Project Narrative

This section is required for **all** residential health care facility (RHCF) applications. If left incomplete, the application will not be accepted.

- Please provide a Project Narrative. The Project Narrative must be a detailed explanation of the proposal and give the reviewer a clear understanding of the proposal. The Project Narrative must include the following information:
  - Utilization information for the last three years, along with explanations for any decreases over those years. Please note: Utilization numbers should be for RHCF beds only, not specialty beds (i.e. AIDS, vent, pediatrics, TBI, etc.), unless the proposal is for the addition or decertification of specialty RHCF beds or the facility provides only these specific bed types.
  - If utilization is below 97%, reasons for low utilization should be provided, along with details of how the applicant intends to increase utilization over the first three years, including any new or existing programs or services to the facility that would benefit area residents.
  - If the proposal requires decertification of beds, please include a patient displacement form.
  - If the proposal is to add beds and there is no RHCF bed surplus in the county and the county utilization is below 97%, there is a rebuttable presumption there is no need for additional beds in that county. Please explain, in as much detail as possible, how the proposal will benefit the community to be served. (See 10 NYCRR 709.3 (3)(g) for more details.)
- Please cite sources from any data provided in the Project Narrative.

## B. Residential Health Care Facility Program Information

### COMMUNITY

- How does your program or service proposal fit into the existing array of services available in the health and social services area? How did you determine this?

Northern Metropolitan is one of nine residential health care facilities in Rockland County and operates a 120 bed facility, equivalent to 9.1% of all licensed beds in Rockland County. According to the Facility's NYS Department of Health Nursing Home Profile, Northern Metropolitan's current occupancy rate is 98%. Historically, the Facility has consistently maintained an average occupancy rate of 95% or higher.

The lease term for the Facility's current location will expire in 10 years. The operator determined that an extension or renewal of the lease term was unlikely, and was compelled to find a location to construct a brand new building (replacing a building over fifty years old) in order to ensure that Northern Metropolitan could continue to care for its residents and be an available resource for the community. This CON application seeks Department of Health approval to construct a new building for existing nursing home operations, within one and one-half miles of its existing location, allowing the Facility to enhance the quality of life through a modern, resident-centered design. There will be no change to the certified bed capacity or CMS 4-star quality services being provided in the Facility's current location.

- Provide an accurate depiction of currently available services and a service gap analysis or marketing study.

In addition to Northern Metropolitan, there are eight other residential health care facilities in Rockland County:

The Willows at Ramapo (203 beds, 15.4 % of market share, 1.9 miles from Northern Metropolitan)

Pine Valley Center (160 beds, 12.2% of market share, 3.2 miles from Northern Metropolitan)

Friedwald Center (168 beds, 12.8% of market share, 4 miles from Northern Metropolitan)

Northern Manor Geriatric Center (231beds (203 RHCF and 28 Ventilator Dependent), 15.4% of market share, 4.2 miles from Northern Metropolitan)

Nyack Ridge (160 beds, 12.2% of market share, 7.9 miles from Northern Metropolitan)

Tolstoy Foundation (96 beds, 7.3% of market share, 8.4 miles from Northern Metropolitan)

Northern Riverview Health Center (180 beds, 13.7% of market share, 8.6 miles from Northern Metropolitan)

Helen Hayes Hospital (25 beds, 1.9% of market share, 8.8 miles from Northern Metropolitan)

Metropolitan

- What transportation considerations in your community/service area/catchment area affect consumers or consumers' friends and family access to your program/service? How do you propose to address these? How will you know if you are successful?

The same modes of transportation, car and taxi, used by family members and friends to visits residents in the current location, will be used in the new location, which is within one and one-half miles from the current location. More parking will be available at the new location.

- What linkages have you developed with other community service providers that will complement, support and/or supplement the needs, e.g. housing, social, environmental or medical supports of your proposed client base? How will you maintain current information of this nature for consumers? How will you educate program staff on new program initiatives?

The staff at Northern Metropolitan has cultivated a number of linkages to various recreational, social, medical, religious and emergency services providers throughout Suffern and neighboring towns. Northern Metropolitan's Medical Director and Administrator maintain professional relationships with nearby acute care facilities, rehabilitation centers and other residential health care facilities, specialty hospitals, mental health facilities, diagnostic and treatment centers, certified home health agencies and certified laboratories. Staff will use these well established linkages to develop new relationships and broaden existing relationships with local discharge planners at area hospitals, agencies and other health care facilities. Additionally, staff at Northern Metropolitan work closely with families and other community based organizations to provide comprehensive care and information regarding available resources.

The Medical Director supervises the in-service training program and develops educational programs, such as those concerning new program initiatives and those regarding general policies and procedures, as needed. All staff participate, as appropriate, in the in-service training programs.

- What local planning processes have been required for your proposal?

The project received approval from the Town of Ramapo.

- What specific population will you serve? How does it match the demographic need in your service area and the desires of consumers?

The service area, Rockland County, has a highly diverse population with the highest per capita Jewish population, 31.4%, in the United States and a Hispanic/Latino population of 20%. The elderly population in the county has grown rapidly with the 70-74 age group increasing over 25% since the 2010 Census. Approximately one-third of Northern Metropolitan's residents are Jewish. Male and female residents are evenly split. Over

80% of the Facility's residents are Medicaid recipients.

- How does your program/service fit into the community's long-range plan? Please document the local source for this information. How will you evaluate the continued effectiveness of your program?

Since Rockland County has unmet need for skilled nursing facility beds, the project, by maintaining capacity in a diverse and relatively high poverty area, positively addresses equitable access.

Northern Metropolitan routinely analyzes its services and service delivery methods as part of its Quality Assurance Program to evaluate its ability to meet consumer needs.

- Document the current and projected demand for the proposed service. If the proposed service is covered by an existing DOH need methodology, demonstrate how the proposed service is consistent with the relevant need methodology.

The current and projected demand for the Facility is substantiated by its current occupancy rate of 98% and historically strong utilization of 95% or higher. According to the most currently available NYS Department of Health estimates of RHCF need by county, Rockland County was estimated to need 1,635 beds with a current capacity of 1,315 beds and an unmet need of 320 beds. Given the rapid growth of the 70-74 age group within the county, increasing over 25% since the 2010 Census, the unmet need is likely greater.

## **CONSUMER**

How did you determine this service meets consumer needs in the proposed service area/catchment area? How will you incorporate consumers in planning, implementation and ongoing operation of this program/service?

Consumers were engaged by MP Care Solutions in conjunction with the Health Equity Impact Assessment. Community stakeholders were very supportive of the relocation, particularly because the current building is over 50 years old and having a new building was seen as beneficial to the residents.

Construction of a new building located within one and one-half miles of the current location will not negatively impact existing residents as there will be no change in the delivery of CMS 4-star quality care, and promotes enhanced quality of life for all groups through better living space and modernized design.

The elderly population in Rockland County has grown rapidly, with the 70-74 age group increasing over 25% since the 2010 Census. The current certified bed capacity in Rockland county is 1,315 beds with Northern Metropolitan comprising 9.1% of that capacity. The most recent NYS Department of Health estimate of residential health care

facility (RHCF) bed need by county reflected that Rockland County had an estimated need of 1,635 beds resulting in a current unmet need of 320 beds. Given the increase in the aging population in Rockland County, the unmet need is likely greater.

Occupancy at Northern Metropolitan is currently 98% according to the Facility's NYS DOH Nursing Home Profile. Historically, the Facility has consistently maintained an average occupancy rate of 95% or higher.

Of note, local hospitals often discharge clinically complex patients with comorbidities to Northern Metropolitan due to their exceptional clinical capabilities.

Northern Metropolitan routinely analyzes its services and service delivery methods as part of its Quality Assurance Program to evaluate its ability to meet consumer needs.

Will you include active consumer involvement in advisory committees or boards?

The Quality Assurance Committee, which meets quarterly, considers the needs of patients as part of the Quality Assurance and Improvement Program. Patients are encouraged to share comments and suggestions with the Facility for consideration of the Quality Assurance Committee. Additionally, Northern Metropolitan's Resident Council meets monthly and is another venue for voicing concerns.

- Given the consumer alternatives currently available in your community service area, why would consumers want your proposed program or service?

Northern Metropolitan delivers the highest quality of care, offering both short and long term rehabilitation. Staff at Northern Metropolitan strives to provide dignified care to its residents to allow them to achieve the highest quality of life possible. Northern Metropolitan offers a high nursing staff to patient ratio. The desire for the services provided by Northern Metropolitan is validated by its historically strong utilization and current occupancy rate of 98%. The ability to receive high quality care (reflected in the facility's 4-star CMS quality rating) in a brand new building will make Northern Metropolitan a top choice for individuals requiring nursing home placement.

- Education: how will consumers know about your service? What specific information and referral information will be available to assist consumers in making informed decisions on the services they need?

Northern Metropolitan continues to receive community inquiries and referrals for its services and maintains strong relationships within the community and with discharge planners at area hospitals and health care facilities. Educational information is tailored to meet the social and media needs of the population that Northern Metropolitan services. Northern Metropolitan's user friendly website provides information to consumers detailing the services available.

## **PROGRAM/SYSTEM**

- Provide a statement of facility philosophy (whether new or existing).

Northern Metropolitan is committed to ensuring the highest quality of life by maintaining each resident's dignity and independence. Everyone gets stronger at Northern Metropolitan. The residents aspire to get physically and emotionally stronger, to live a vibrant life worth celebrating every day. Northern Metropolitan caregivers strive to strengthen their skills and increase the positive impact on each resident. Care provided to residents is driven by the facility's core values: teamwork, compassion and inclusivity.

- Describe in detail the projected resident profile characteristics of the population to be served using the language of the regulations and/or nationally accepted criteria; include any specialty populations. The project must demonstrate an awareness that as many as 70% of residents admitted to residential health care facilities are cognitively impaired and design a therapeutic environment which compensates for these impairments as well as for functional disabilities. Should a facility choose to designate a distinct unit for a subset of residents with dementia, specific descriptors which distinguish this group from the majority of other residents with dementia, admission and discharge criteria for the unit and delivery of services must be addressed.

Northern Metropolitan's resident population is comprised of the following races: White (70.6%), Black (13.4%), Other or no race indicated (11.8%) and Hispanic or Latino (4.2%).

Approximately one-third of Northern Metropolitan's residents are Jewish. The average age of residents is 74.3%, with 84% age 65 years or older. Nearly all of the residents come from Monsey and Suffern. Over 85% of the Facility's residents are Medicaid recipients, A majority of residents are diagnosed with conditions associated with aging: ambulation difficulties, hypertension, heart disease, cancer, Alzheimer's and dementia. Northern Metropolitan also provides comprehensive therapeutic services such as physical therapy, speech therapy, occupational therapy and recreational therapy and caters to a vast age and ability range in its rehabilitation units.

- Describe resident needs based on the proposed resident population.

Northern Metropolitan anticipates that the proposed resident population that will occupy the 120 RHCf beds in the newly constructed building will be the same population currently occupying the existing building.

Approximately one-third of Northern Metropolitan's residents are Jewish. The average age of residents is 74.3%, with 84% age 65 years or older. Nearly all of the residents come from Monsey and Suffern. Over 85% of the Facility's residents are Medicaid recipients, A majority of residents are diagnosed with conditions associated with aging:

ambulation difficulties, hypertension, heart disease, cancer, Alzheimer's and dementia.

- Provide a complete plan for programs and services to meet the needs of the residents. This plan must address all services required by regulation (e.g., specialized rehabilitation, dietary, nursing services and for each service).
  - Goals and objectives of program/service
  - Function and activities involved
  - Unique characteristics of each
  - Relationships between services
  - Location in the facility and rationale for placement
  - Resources needed, e.g., staffing

Northern Metropolitan is committed to providing residents with the highest level of care necessary for promoting each resident's self-worth and overall well-being. To achieve this goal, Northern Metropolitan has developed a service integration model that provides opportunities for all residents to embrace a superior quality of life and to attain the highest level of physical, mental and social well-being in accordance with a comprehensive treatment plan developed by an interdisciplinary team. The coordinated medical, nursing, rehabilitative and ancillary service programs at Northern Metropolitan focus on ensuring a home-like atmosphere for residents, preserving individual rights and self-determination, and operating in accordance with accepted professional standards.

An interdisciplinary team develops an individualized care plan for each resident based on his or her individual needs, interests, abilities, goals and personal preferences. and in recognition of the resident's mental and physical capabilities. The treatment plan includes services and activities designed to elevate the resident's sense of independence, promote social interaction, and stimulate and support the desire to use physical and mental capabilities to the fullest extent. Individual and group activities are planned in conjunction with the Activity Director to enhance the resident's enjoyment without disrupting existing daily routines.

The following services are provided to residents:

**\*Medical Services:** Northern Metropolitan strives to provide residents with dignified medical care responsive to their needs. The Facility's Medical Director is an experienced physician with a background in providing long term care and supervises all aspects relating to the provision of medical services, including quality of care. The Medical Director is responsible for: (1) obtaining medical history and physical examination of each resident for admission; (2) arranging for medical consultation services; (3) developing, in conjunction with the interdisciplinary team, a medical plan for each resident; (4) reviewing and updating treatment plans and medical records; (5) ensuring proper documentation of services including orders for medication, diet, physical limitation or rehabilitation; (6)

reviewing with the Administrator incidents and accidents that occur in the facility and (7) facilitating compliance with all applicable laws and regulations and residents' bill of rights.

**\*Nursing Services:** Nursing services ensure the continuity of care provided to each resident. A full-time registered nurse supervises all nursing services provided to residents. Licensed nursing personnel are on staff twenty-four hours a day, seven days a week. Prior to a resident's admission, the Facility's professional nursing staff reviews physician recommendations and the resident's social history in order to assess individual medical needs. A registered professional nurse performs a nursing evaluation of each resident using the MDS. The findings of all nursing evaluations, the nursing care plan and the nursing follow-up are documented, dated, signed and maintained in the residents' records. Nursing services include: (1) development of a comprehensive individualized care plan in conjunction with the interdisciplinary care team; (2) administration and supervision of treatment; (3) application of rehabilitative and restorative nursing techniques; (4) monitoring of vital signs and overall physiology; (5) teaching self-help skills to residents; (6) review and maintenance of residents' health records; (7) assessments on a periodic and continuing basis of each resident's need for nursing care; and (8) supervision of certified nurse assistants and ongoing nursing staff supervision.

**\*Secured Dementia Unit:** Safe, secure and well-cared for: that's Northern Metropolitan's promise to residents in its Secured Dementia Unit as well as to their families. The goal of this unit is to allow residents to feel purpose, a sense of satisfaction and enjoyment every day. The Dementia Unit program is run by a team that includes social work, recreation, dietary, nursing, medical, psychology, therapy and housekeeping. The Residents' daily activities may include brain fitness exercises and memory games, specialty food programs, music, reminiscence groups, and more. The mission of the program is to improve the quality of life of each and every resident.

**\*Social Work Services:** The Facility's social worker helps both residents and family members respond to interpersonal, emotional and behavioral difficulties and ensures that all psycho/social needs are assessed, evaluated, documented and meeting the resident's needs. The social worker: (1) advocates for residents, specifically in terms of resident's rights; (2) promotes self-advocacy for residents; (3) works with other disciplines to enhance understanding of the aging process, sensory loss and personal and emotional problems that residents may experience; (4) acts as a liaison between the consulting psychiatrist and the resident; (5) connects residents and family members to community agencies to help fulfill needs; (6) participates in care planning and contributes to written care summaries; and (7) handles transfer and discharge planning.

**\*Rehabilitation Services:** Northern Metropolitan's RehabStrong™ approach to recovery involves a results focused, tech driven, individualized rehabilitation ecosystem focused on getting residents stronger. An extensive array of rehabilitation services is available to residents based upon diagnosis, need and physician's orders. These services include:

(1) Physical Therapy: Physical therapists examine each resident and develop a plan using treatment techniques to promote the ability to move, reduce pain, restore

function, prevent increased disability and encourage adaptation to permanent disability.

(2) Occupational Therapy: Occupational therapists work with residents who suffer from mentally, physically, developmentally, and/or emotionally disabling conditions by utilizing treatments that develop, recover or maintain residents' activities of daily living. The program includes adaptive skills designed to achieve maximum physical and mental functioning and enhance self-esteem and feelings of self worth.

(3) Speech Therapy: Speech pathologists provide a wide range of services including speech, language, and swallowing as well as empowering residents to regain full oral and oratory faculties whether recovering from a stroke or in need support for a lifelong impairment.

(4) Cardiac Therapy: Specialists provide individualized plans of care focusing on exercise, behavioral modification and education to enable individuals with heart disease to best improve their condition.

(5) Stroke Therapy: Stroke recovery therapy provides for formal rehabilitation that aims to restore independence by improving physical, mental and emotional functions.

(6) Respiratory Therapy & Management: Professional respiratory therapists manage overall respiratory health as well as mitigating potential complications (e.g., pneumonia, collapsed lung) arising from viral infections or other ailments.

(7) Amputee Therapy and Training: Skilled professionals provide a full range of specialized programs for amputees, including grief counseling, recovery from surgical complications and skin problems related to artificial limbs.

(8) IV Antibiotic Therapy: IV therapy specializes in techniques for delivering fluids and medications directly into the veins to facilitate residents' independence and minimize interference in their normal activities.

(9) Post Surgery Orthopedic Therapy: Post-surgery orthopedic care concentrates on restoring health and stability to the musculoskeletal system, including the muscles, ligaments, tendons and connective tissues that enable the body to perform its regular physical activities.

**\*Vision Care:** Staff conducts simple vision tests, glaucoma examinations and other tests designed to detect changes in vision. If appropriate, referrals are made for further evaluations, laser surgeries and other procedures. Opticians and Optometrists visit each unit bi-monthly.

**\*Hearing Care:** Hearing technologists conduct tests to evaluate the hearing capacity of residents with diminished hearing and assist residents in securing hearing aids as needed. If necessary, referrals are made to appropriate specialists. Monthly visits by audiologists are coordinated.

**\*Recreational Therapy Services:** The primary purpose of recreational therapy is to restore, remediate or rehabilitate residents in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The interdisciplinary care team in conjunction with the Activity Director plans a program of diverse, meaningful activities within the Facility for each resident to satisfy individual

needs and interests. Examples of activities offered include: (1) arts & crafts; (2) clubs and special interest groups; (3) small and large group discussions; (4) individual sessions; (5) musical programs; (6) table games; (7) social games; (8) outings; (9) parties; (10) educational programs; (11) religious services; (12) exercise (chair, dance); and (13) pet therapy. Activities will occur daily in the recreation room of each neighborhood.

**\*Nutritional Services:** A certified dietician works with residents and, when appropriate, family members, to develop meal plans and dietary counseling tailored to the individual likes and dislikes and cultural or ethnic background of the resident. Residents are encouraged to participate in community dining whenever physically possible. A team of nurses, food services staff and caregivers work together to review allergies and/or intolerances and help eliminate or minimize exposure to certain foods and accommodate specialized or modified diets.

**\*Pharmaceutical Services:** A pharmacist reviews each resident's prescribed medications and ensures that each resident's drug regimen is reviewed upon admission and at least twice annually. The pharmacist provides appropriate guidance and recommendations to the interdisciplinary care team when developing treatment plans.

**\*Dental Services:** The Nursing Services Director arranges for yearly dental screening of residents and other dental services if required. Dental visits are arranged on a weekly basis.

**\*Tracheostomy Care:** Physicians and nurses provide daily care of the tracheostomy site to prevent infection and skin breakdown under the tracheostomy tube and ties.

**\*Wound Care & Wound Vac:** Northern Metropolitan utilizes the latest wound care technologies including the V.A.C. treatment, the latest advancement in wound closure therapy, to minimize hospitalization, increase comfort and promote healing response.

**\*Comfort Care/Palliative Care:** Provide comfort and maintain the highest possible quality of life for terminally-ill individuals through symptom and pain management.

**\*Noninvasive Vent Care:** Provides respiratory support using a mask to deliver oxygen to the lungs using positive pressure without the need for endotracheal intubation.

**\*Post Surgical Fleurx Management:** Care of indwelling pleural catheter to ensure effective draining and prevent complications including regular dressing changes, proper drainage techniques and monitoring for signs of infection or other issues.

**\*Life Vest Management:** Ensuring that the vest is worn at all times except for short periods during showers or baths, daily battery changes, and monitoring the alert system.

**\*Diabetes Management:** Focuses on regular blood glucose monitoring, medication administration, dietary guidance and addressing potential complications.

**\*Post Surgical Orthopedic Care:** Entails a multi-faceted approach to ensure successful recovery from surgery including pain management, wound care, physical therapy and adherence to specific instructions from the surgeon.

**\*Additional Resident Services:** In addition to the care services described above, Northern Metropolitan also provides beautician and barber services, discharge planning and the services of a resident ambassador to help new residents become acclimated to

the Facility

- How will you evaluate program/service effectiveness? What consumer satisfaction measures will you employ?

Evaluation of program/service effectiveness is an ongoing process at Northern Metropolitan. The Administrator maintains an open door policy and strives to maintain open lines of communication with residents as well as their families and friends. Northern Metropolitan holds scheduled Quality Assurance Committee meetings and Resident Council meetings and maintains a "suggestion box" for input from residents. In addition, resident care undergoes regular review as part of the Facility's Quality Improvement Program.

- How do you propose to address cultural, rural vs. urban and/or ADA considerations in the design and operation of your program/service?

Northern Metropolitan is currently in compliance with Federal and State ADA laws and regulations and takes pride in its culturally diverse resident population and staff, providing a variety of religious services, cultural cuisines and activities. Sensitivity to cultural differences, including rural and urban differences, is a highly regarded principle of the administration.

## ENVIRONMENT

Provide a floor plan for an overall design that facilitates use of the facility by residents and caregivers. Explain how the proposed floor plan layout will promote planned programs. In addition, include in the floor plans the area where it attaches to the original building. If the project includes renovation of existing areas, provide a floor plan that shows the areas before and after renovation.

Floor plans are attached to Schedule 6 of the CON application. The new building will contain 120 beds (same capacity as existing Facility) which will be configured in 40 bed units located on floors one through three. Each floor will contain 28 private rooms and 6 semi-private rooms.

The facility design is based upon a neighborhood concept in which each floor is organized into three neighborhoods with centralized dining/activity spaces with the goal of creating a de-institutionalized, home-like setting for residents. The spacious common areas are designed to encourage social interaction and engagement in activities. The neighborhood configuration will eliminate institutional barriers between staff and residents. Staff and clinical support space will be disbursed throughout each neighborhood so as to remain unobtrusive and allow for enhanced staff and resident interaction. The decentralized floor plan will allow for more personal care and improve

staff efficiency. The design promotes independence and dignity for residents. Features include: (i) an abundance of natural light throughout the facility; (ii) spacious common areas for social interaction and activities; (iii) ample outdoor spaces for recreation and relaxation; and (iv) enhanced safety features integrated into a modern design to promote resident well-being.

The new building will include Kosher kitchen facilities to meet dietary laws, dedicated spaces for prayer and observance, design considerations for Sabbath observance and accommodation for family involvement in care (a dedicated suite for use by residents' families for overnight stays during Sabbath observance).

A synagogue, gift shop and coffee shop will be located on the first floor of the facility.

The second floor will include the secure dementia unit, a beauty parlor, an administrative suite including open office area, conference room, offices, copy and file areas and staff pantry.

The OT/PT suite will be located on third floor and will include open therapy areas, a gym (containing an ADL focus area) and staff work area and offices.

Utility, mechanical, staff locker rooms and bathrooms, central kitchen, dietary office, central laundry, storage, multi-purpose activity/assembly/classroom/seminar space will be located on the basement level of the building.

- Provide an enlarged floor plan for each type of resident bedroom. Each bedroom shall be designed to permit:
  - Wheelchair access and a minimum 5'0" diameter turnaround adjacent to at least one side of the bed(s).
  - Access to furniture and equipment intended for resident use by residents confined to a wheelchair.
  - Specialized furniture and equipment as may be needed.
  - Privacy spaces.

- An area for socialization for residents, family, friends and staff.
- An outside view.
- Personalization of the resident's room: rooms show individualization with personal belongings such as pictures, chairs, and favorite objects.

Please refer to Attachment 15 for enlarged floor plans for each type of resident bedroom.

- Describe how the proposed facility design provides wayfinding and orientation through the use of:
  - Signs: visible, eye level, "eye catchy," appropriate location, use of cues.
  - Hallways: visually distinct, color, wall treatment, art work appropriate to age and interests, interactive or tactile wall hangings.
  - Individualized resident cues to orient residents to their own rooms.

The Facility will contain wayfinding signs and orientation boards on each floor to help aid and orient residents. ADA compliant signage will be used. Fonts will be easy to read and the characters will contrast with non-glare backgrounds. Each resident room will be labeled with its own room number. In addition, each of the resident floors will have an open plan design that will eliminate many environmental barriers which will facilitate directing and assisting residents.

- Describe how the proposed facility design provides areas for privacy and socialization of residents to include the following items:
  - At intervals along corridors/wandering path(s), the provision of small rest areas to encourage social interaction on a one-to-one or in small groups and enable limited ambulators to progress short distances toward a goal.

The Facility will utilize a neighborhood concept, organizing each resident floor into three neighborhoods with a common dining and recreation area. The open concept design of the resident floors will maximize ambulation and socialization of residents. A dedicated storage area on each floor will allow corridors to be clear of obstructions. Corridors will feature handrails and will be designed to ensure that corridor traffic will not be restricted by furniture or other ancillary items. Lounges will be located on each floor to allow for rest and social interaction. The location of the recreation/dining areas and chairs as well as lounges within each neighborhood will enable limited ambulators to travel short distances. The placement of staff and clinical support spaces will allow their functions to be unobtrusive.

- Dining rooms that provide opportunities for residents to eat in small groups with a

minimum of distraction.

Each neighborhood will have its own dining/recreation zone. The dining rooms will allow residents to eat their meals at a table with one, two or three other residents or in larger groups when two or more tables are joined together.

- Chair placement to encourage conversation in resident rooms as well as in public areas.

Resident rooms will contain bedside chairs to encourage conversation at times when more privacy is desired or mobility is diminished. Chairs in the public area will vary according to the room but will contrast with the vinyl floor tile so that the edges of the chairs are clearly differentiated. Chairs will be clustered in a configuration that encourages interaction of residents and guests.

- Rooms designed to residential scale.

The Facility will feature rooms designed to residential scale which will provide more privacy for residents and accommodate equipment without limiting resident movement. Resident room area and dimensions will permit residents to move about the room in a wheelchair or to use assistive devices and adaptive equipment. Room dimensions will ensure that residents can gain access to the bathroom, bed, nightstand, chair, closet and any other area where personal belongings may be stored.

- Traffic kept to a minimum.

Facility employees will be trained to keep corridors clear and uncluttered to facilitate navigation of these areas for residents. The open concept design of the resident floors will reduce clutter and maximize the amount of open space available to encourage mobility and ambulation. Seating areas will be dispersed throughout resident floors and each floor will have dedicated storage for wheelchairs and stretchers. Chairs and lounge areas will be strategically placed to allow limited ambulators to travel short distances toward a goal but to also keep corridors free from obstruction.

- "Watching space": people like watching life going on around the elevator/nursing station area; windows or sunrooms, porches or verandas overlooking the main entrance, busy streets, etc.

Areas throughout the Facility will allow residents to "watch life" going on around the Facility. Residents will be able to congregate in the dining/recreation areas and lounge areas. These spaces will allow residents to socialize and observe the daily life of the Facility. The coffee shop located on the first floor will also provide watching space for residents.

- Describe how the interior design and finishes will be chosen to reduce resident confusion and to contribute to the homelike environment of the facility.

The interior design will use finishes and materials that are durable, classic, warm, and

light. The design will evoke a comfortable, home-like feel. The floor layout will reduce resident confusion and eliminate as many barriers to access as possible. Walls will be covered with a flat paint, wallpaper and wainscoting. Bathroom walls will be covered with ceramic tile that contrasts with the flooring. Flooring will be made of glare resistant vinyl and non-slip, non-glare ceramic tile in the bathrooms. The Facility will also have orientation boards on each floor and room numbers to minimize resident confusion.

- Strictly limit use of fluorescent lights. Sufficient lighting for general activities without unnecessary glare and adequate individual lighting for visually impaired to read, do handwork, etc.

The new Facility will have an abundance of natural light. Fluorescent lights will be limited to areas used for activities and within resident rooms and shared spaces. General illumination will be provided through the use of recessed type light fixtures. Accent lighting will be provided in public areas and resident amenity areas. Resident rooms will have task lighting over each bed to minimize glare, to aid in reading and handiwork, and to help with visual adaptation to dark spaces.

- Visual contrast between objects and background, between walls and floor.

Details and finishes will create differentiations between objects, such as furniture, and backgrounds and between walls and floors. Walls will be painted a different color than the floors and will feature wainscoting or other textured coverings to create a greater distinction between the wall and flooring. All finishes will minimize glare. Chairs and furniture will have varying colors and distinguishing textures in order to mark edges clearly. Lighting will further minimize glares and help to differentiate between vertical and horizontal planes and between objects and backgrounds. Excessive differences in lighting levels will be avoided in order to help residents visually adapt to the transition from daytime to nighttime.

- Floor colors/patterns that minimize the illusion of steps or varying levels.

In all areas except the bathrooms, floors will be covered with slip-resistant, non-glare vinyl flooring. Bathroom floors will be covered with slip-resistant, non-glare ceramic tiling. All floor finishes will be conducive to safe ambulation and minimize the appearance of varying steps or levels.

- Carpeting: although it lowers noise levels and creates a residential feeling, it may increase the problems of mobility for wheelchair bound residents.

Vinyl flooring will be the predominant flooring throughout the Facility. Carpeting will be used as residential accents in limited resident spaces and in certain public spaces to provide a homelike atmosphere. All carpeted areas will be maintained as part of the Facility's overall housekeeping and maintenance plan to ensure that the carpeted areas do not decrease mobility for residents.

- Aural concerns addressed, i.e., carpeting, wall coverings, curtains, etc., for noise abatement; TV and radio noise controlled or confined.

Carpeting and wall coverings will be installed as residential accents in limited resident spaces and certain public spaces. In addition, acoustic tile suspended ceilings throughout the Facility will help reduce noise. The dining/recreation areas on each floor will allow for shared space to watch TV, listen to the radio or participate in activities. Residents may also watch TV, read, etc., in the privacy of their room or lounge areas. Resident rights will always be prioritized. The Facility will take all steps necessary to ensure that every resident has both a mixture of socialization and quiet time on a daily basis.

- Describe how physical outlets for residents will be provided and accessed. Address the following items in this plan:
  - Meaningful wandering circuits.
  - Access to outdoors:
    - Direct to an enclosed or limited access courtyard.
    - Visual access or other monitoring method of area by staff.
    - Chairs and benches.
    - Sunny and shady.
    - Visual objects of interest.

Physical outlets will be accessible for all residents and will be maintained in accordance with all necessary regulations and requirements. Meaningful wandering circuits and access to the outdoors will be provided.

- Space to place an angry/agitated resident without disturbing others, “quiet area.”

The Facility's "quiet area" policy for placing angry/agitated residents will vary by situation. Staff will assess each resident's level of agitation to determine whether they are a danger to themselves or others, and appropriate interventions will be utilized to diffuse the resident's agitation. Agitated residents in need of privacy will be placed within their individual room so they will not disturb other residents within the Facility.

- Identification of space for “unstructured” activities during, evenings, nights and weekends as well as on days.

The Facility will have both a dining/recreation space and living area/lounge area on each floor which will allow space for "unstructured" activities during the day and evening as well as on nights and weekends. Activities will be provided daily within the dining/recreation areas, except when meals are being served. Residents will have the option to participate in the daily activities or socialize in the dining/recreation areas without participating in a particular activity. Residents may also participate in unstructured activities within the lounge areas or recreation rooms with friends and family members.

**WORKFORCE**

- What is the current availability of professional/paraprofessional workers to staff your proposal? Who are the competing employers? What will you do to successfully compete? Include training, recruitment and transportation strategies. How do you coordinate with Department of Labor or any other local workforce initiatives?

Maintaining staff continuity is a fundamental component to providing quality of care at Northern Metropolitan. As such, Northern Metropolitan will retain its current employees at its new location. If hiring is needed, Northern Metropolitan will familiarize all new employees on its DOH approved policies and procedures and integrate new staff into its in-service training and continuing development program.

- What measures will you adopt to promote retention of specific categories of your workforce?

Northern Metropolitan has consistently complied with the Department of Health's minimum staffing requirements and has delivered CMS 4-star quality of care due to its ability to retain all categories of staffing. Northern Metropolitan fully expects to retain its entire workforce when it transitions to the new location located within one and one-half miles of its existing location. Northern Metropolitan values its employees, promoting a culture of respect, collaboration and integrity with opportunities for advancement, inspiring employees to strive to provide the best possible quality of care to residents. Northern Metropolitan is invested in its employees who likewise are invested in the residents.

- What will the impact be of opening/expanding your program on the workforce of other health care providers in the community? How will you minimize any adverse impact?

The relocation of the facility is not expected to have any adverse impact on the workforce of other health care providers within the community. Northern Metropolitan will retain its existing workforce at the new facility.

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Services Tables of Schedule 18C. The Authorized Beds and Services Tables in Schedule 18C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

**C. Impact of CON Application on Residential Health Care Facility Operating Certificate**

**TABLE 18C-1 AUTHORIZED BEDS**

Category	Code	Current	Add	Remove	Propose
AIDS	30		<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIORAL INTERVENTION	32		<input type="checkbox"/>	<input type="checkbox"/>	
BEHAVIORAL INTERVENTION STEPDOWN	35		<input type="checkbox"/>	<input type="checkbox"/>	
COMA RECOVERY	26		<input type="checkbox"/>	<input type="checkbox"/>	
PEDIATRIC	04		<input type="checkbox"/>	<input type="checkbox"/>	
PEDIATRIC VENTILATOR DEPENDENT	36		<input type="checkbox"/>	<input type="checkbox"/>	
RHCF	16		<input type="checkbox"/>	<input type="checkbox"/>	
TRAUMATIC BRAIN INJURY	11		<input type="checkbox"/>	<input type="checkbox"/>	
VENTILATOR DEPENDENT	31		<input type="checkbox"/>	<input type="checkbox"/>	

**TABLE 18C-2 AUTHORIZED SERVICES <sup>1</sup>**

Category	Code	Current	Add	Remove	Propose
ADULT DAY HEALTH CARE	58		<input type="checkbox"/>	<input type="checkbox"/>	
ADULT DAY HEALTH CARE - AIDS	172		<input type="checkbox"/>	<input type="checkbox"/>	
CLINICAL LABORATORY SERVICES	18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEALTH FAIRS O/P	197	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NURSING HOME HEMODIALYSIS		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NURSING HOME HEMODIALYSIS – BEDSIDE ONLY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHOLOGY	85	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RADIOLOGY - DIAGNOSTIC	109	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY CARE	91	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRE 1	178	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRE 2	179	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THERAPY–PHYSICAL O/P	147	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THERAPY–OCCUPATIONAL O/P	146	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THERAPY–SPEECH LANGUAGE PATH O/P	155	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFUSION SERVICES- LIMITED	233	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRANSFUSION SERVICES- LIMITED O/P	189	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup> Services listed below are baseline services included in the establishment of an RHCF and not requested separately:

- |                                      |                             |                                 |
|--------------------------------------|-----------------------------|---------------------------------|
| Audiology                            | Dental                      | Health Education                |
| Medical Social Services              | Medical Suppl Equip & Appl  | Optometry                       |
| Nursing                              | Nutritional                 | Pharmaceutical Services         |
| Physician Services                   | Physical Therapy (resident) | Occupational Therapy (resident) |
| Speech Language Pathology (resident) |                             |                                 |

**D. RHCf Space & Construction Distribution -**

For Construction Projects Requiring Full or Administrative  
 On the following table, record the total Gross Square Footage of the facility before and after completion of this project and the gross square footage dedicated to each of four functions, inpatient care, staff and patient areas, administrative and public areas, and service and maintenance areas. The functions are labeled as A through B in the table.

a	b	c	d	e	f	g
Building Gross Square Feet	Existing Space			Total Space Upon completion		
	Existing Beds before project:	Total G.S.F.	Total G.S.F. Per Bed	Beds on completion	Total G.S.F.	Total G.S.F. Per Bed
A. Inpatient						
B. Staff/Patient						
C. Admin/Public						
D. Serv/Maint.						
<b>TOTALS</b>						

The following table (next page) summarizes the uses associated with each functional area.

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**Schedule 18D**

<b>A. INPATIENT</b>	<b>B. STAFF/PATIENT</b>	<b>C. ADMINISTRATION AND PUBLIC AREAS</b>	<b>D. SERVICE/MAINTENANCE AREAS</b>	
<p>1. Nursing Unit</p> <p>Patient</p> <ul style="list-style-type: none"> <li>MultiBed Rm. (Multi: Single)</li> <li>Toilet</li> <li>Closet</li> <li>Bath/Shower</li> <li>Nurses Station</li> <li>Drug Prep</li> </ul> <p>Lounge</p> <ul style="list-style-type: none"> <li>Toilet</li> <li>Exam &amp; Treatment Rm. '(without nursing units)</li> <li>Clean Work/Holding Rm.</li> <li>Soiled Work/Holding Rm.</li> <li>Clean Linen Storage</li> </ul> <p>Nourishment Station</p> <ul style="list-style-type: none"> <li>Equipment Storage Rm.</li> <li>Parking for Stretchers and Wheelchairs</li> </ul> <p>2. Patient Dining and Recreation Area</p> <ul style="list-style-type: none"> <li>Recreation Area</li> <li>Dietary Preparation Area</li> <li>Dining Day Room (SNF)</li> <li>Dining Room (HRF)</li> <li>Lounges</li> <li>Chapel/Meditation</li> <li>Storage Space</li> <li>Toilets</li> </ul>	<p>1. Physical Therapy Facilities</p> <p>Treatment Areas</p> <ul style="list-style-type: none"> <li>Thermotherapy</li> <li>Diathermy</li> <li>Ultrasonics</li> <li>Hydrotherapy</li> <li>Exercise Area</li> <li>Patient Dressing Areas</li> </ul> <p>Showers</p> <ul style="list-style-type: none"> <li>Lockers</li> <li>Toilet Rooms</li> <li>Office Space</li> <li>Storage</li> <li>Wheelchair and Stretcher Storage</li> </ul> <p>2. Occupational Therapy Facilities</p> <ul style="list-style-type: none"> <li>Activities Area</li> <li>Storage</li> <li>Toilet Rooms</li> </ul> <p>3. Personal Care Unit</p> <p>4. Dental</p> <p>5. Pharmacy</p> <p>6. Speech/Audiology</p> <p>7. Medical Services</p> <p>8. Podiatry</p> <p>9. Laboratory</p>	<p>1. Entry</p> <p>2. Lobby</p> <ul style="list-style-type: none"> <li>Reception</li> <li>Coffee Shop</li> <li>Gift Shop</li> <li>Waiting</li> <li>Storage for Wheelchairs</li> <li>Toilets</li> </ul> <p>3. Interview</p> <ul style="list-style-type: none"> <li>Social Services</li> <li>Credit</li> <li>Admissions</li> </ul> <p>4. General or Individual Offices</p> <ul style="list-style-type: none"> <li>Business Transactions</li> <li>Medical Records</li> <li>Financial Records</li> <li>Administrative Staff</li> <li>Professional Staff</li> </ul> <p>5. Multipurpose Room (Not Patient Use Areas)</p> <ul style="list-style-type: none"> <li>Conferences</li> <li>Meeting and Rooms</li> <li>Health Education</li> </ul> <p>6. Storage</p> <ul style="list-style-type: none"> <li>Office Equipment</li> <li>Supplies</li> </ul> <p>7. Counseling</p> <ul style="list-style-type: none"> <li>Social Services</li> </ul> <p>3. Central Stores</p>	<p>1. Dietary (Kitchen Area) Control Station/Receiving</p> <ul style="list-style-type: none"> <li>Storage</li> <li>Refrigerated</li> <li>Dry Food Preparation</li> <li>Patient Meal Service</li> <li>Dishwashing</li> <li>Pot washing</li> <li>Sanitizing Facilities</li> <li>Storage Cans</li> <li>Carts</li> <li>Mobile Tray</li> <li>Waste Storage Facilities</li> <li>Office (Dietitian or Dietary Manager)</li> <li>Staff Toilets</li> <li>Janitors Closet</li> </ul> <p>2. Linen Services (Onsite Processing)</p> <ul style="list-style-type: none"> <li>Laundry Processing Room</li> <li>Soiled Linen Receiving</li> <li>Holding</li> <li>Sorting</li> <li>Storage for Laundry</li> <li>Supplies</li> <li>Clean Linen Inspection</li> <li>Mending</li> <li>Clean Linen Storage</li> <li>Issue</li> <li>Holding</li> <li>Janitors Chest</li> <li>Storage, Housekeeping</li> </ul>	<p>Equipment and Supplies</p> <p>Sanitizing Facilities and Storage for Carts</p> <p>3. Central stores</p> <p>4. Employees Facilities</p> <ul style="list-style-type: none"> <li>Locker Rooms</li> <li>Lounges</li> <li>Toilets</li> <li>Showers</li> </ul> <p>5. Janitors Closets and Housekeeping</p> <ul style="list-style-type: none"> <li>Storage Housekeeping</li> <li>Equipment and Supplies</li> </ul> <p>6. Engineering Service and Equipment Areas</p> <ul style="list-style-type: none"> <li>Equipment Room</li> <li>Boiler Room</li> <li>Mechanical Equipment Room(s)</li> <li>Electrical Equipment Room</li> <li>Engineers Quarters</li> <li>Office</li> <li>Maintenance Shop(s)</li> <li>Storage Room for Maintenance Supplies</li> <li>Yard Equipment Storage</li> <li>Yard Maintenance Equipment</li> <li>Yard Maintenance Supplies</li> </ul> <p>7. Waste Disposal Storage</p> <ul style="list-style-type: none"> <li>Storage and Disposal</li> <li>Incinerator</li> </ul>

**Schedule 18 Part E is an Excel spreadsheet available from the DOH website.**

**F. RHCF Analysis of Net Patient Revenue:**

This section must be completed for

- all RHCF establishment applications
- all establishment and construction RHCF applications which will increase current year total costs by more than 10%.

If neither condition applies, Schedule 13d – Annual Operating Revenue will be sufficient, and the detailed monthly cash flow analysis will not be required.

This schedule consists of two parts:

I. Analysis of Net Patient Revenue. Provide a breakdown of utilization by payor source indicated; provide supporting calculations for the rates assumed for each payor. A separate schedule should be provided for each discrete program. The breakdown must be provided for the current year, as well as the first and third year of the project.

II. Cash Flow Analysis. Provide as an attachment to this schedule a cash flow analysis for the first full year of operation after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project. Please complete Schedule 5, Working Capital Schedule, in conjunction with the cash flow analysis.

	Attachment Title	Attachment Filename
Cash Flow Analysis Attachment	Attachment 4 - Monthly Cash Flow Analysis	Attachment 4 - Monthly Cash Flow Analysis.pdf

**New York State Department of Health  
Certificate of Need Application  
Analysis of Net Patient Revenue**

**Schedule 18F**

A	B	C	D	E
	Skilled Nursing Facility	Long Term Home Health Care Program	Adult Day Health Care Program	All Other Program Revenue Centers
<b>I. Analysis of Net Patient Revenue</b>				
Current Year:				
Medicaid Revenue:	\$10,459,904		\$1,059,143	
Medicare Revenue				
A. Part A--All Income	\$6,432,030			
B. Part B--Income	\$830,779			
Commercial Insurance	\$108,977			
Private Pay	\$272,822			
Other Revenue ( )			\$516,815	
Other Patient Revenue				
Total Revenue	\$18,104,512		\$1,575,958	
Bad Debt				
First Year:				
Medicaid Revenue:	\$10,046,141		\$1,026,721	
Medicare Revenue				
A. Part A--All Income	\$7,433,781			
B. Part B--Income				
Commercial Insurance	\$111,221			
Private Pay	\$279,582			
Other Revenue ( )			\$601,118	
Other Patient Revenue				
Total Revenue	\$17,870,725		\$1,627,839	
Bad Debt				
Third Year:				
Medicaid Revenue:	\$10,148,606		\$1,334,832	
Medicare Revenue				
A. Part A--All Income	\$7,509,287			
B. Part B--Income				
Commercial Insurance	\$112,566			
Private Pay	\$282,479			
Other Revenue ( )			\$781,357	
Other Patient Revenue				
Total Revenue	\$18,052,938		\$2,116,189	
Bad Debt				

SCHEDULE 18E - Functional Expenses

Current Year - Statement of Non-Revenue Support Services Functional Expenses

	a	b	c	d	e	f	g	h	i	j	k
Non-Revenue Support Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Total
Depreciation. Leases & Rentals							1,003,861				1,003,861
Depreciation. Major Movable Equip.							62,238				62,238
Interest on Capital Debt											-
Fiscal Services	56,224		5,308	46,949	16,559	1,311,281	81,544		25,823		1,543,688
Administrative Services	123,547		10,126	118,588		165,195			1,317,400		1,734,856
Plant Operation and Maintenance	273,607		112,667		18,802	80,485	14,939		567,905		1,068,405
Utilities											
Property Taxes											
Property Insurance											
Grounds						15,537					15,537
Security				1,028		1,875					2,903
Laundry and Linen					57,755	165,609					223,364
Housekeeping	499,331		201,248		44,608	100,142					845,329
Patient Food Service	879,444		354,629	121,154	829,787	87,278					2,272,292
Cafeteria											-
Nursing Administration	710,697		88,851								799,548
Activities Program	234,424		92,720		36,591	201,963	3,500				569,198
Nonphysician Education											-
Medical Education											-
Medical Director's Office		36,000									36,000
Housing											-
Medical Records				14,618	73						14,691
Utilization Review											-
Social Service	252,880		30,869	100,279	650	14,421					399,099
Transportation				198,385							198,385
<b>Subtotal</b>	<b>3,030,154</b>	<b>36,000</b>	<b>896,418</b>	<b>601,001</b>	<b>1,004,825</b>	<b>2,143,786</b>	<b>1,166,082</b>		<b>1,911,128</b>	<b>-</b>	<b>10,789,394</b>

SCHEDULE 18E - Functional Expenses

Year 1 - Statement of Non-Revenue Support Services Functional Expenses

	a	b	c	d	e	f	g	h	i	j	k
Non-Revenue Support Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Total
Depreciation. Leases & Rentals							\$0				-
Depreciation. Major Movable Equip.							\$200,710				200,710
Interest on Capital Debt									-		-
Fiscal Services	57,630	-	5,440	47,653	16,890	1,330,950	81,544		26,339	-	1,566,446
Administrative Services	126,636	-	10,384	120,367	-	167,673	-		1,093,748	-	1,518,808
Plant Operation and Maintenance <sup>1</sup>	280,447	-	119,695	-	19,178	81,692	14,939		579,263	-	1,095,214
Utilities											
Property Taxes											
Property Insurance											
Grounds	-	-	-	-	-	15,770	-		-	-	15,770
Security	-	-	-	1,043	-	1,903	-		-	-	2,946
Laundry and Linen	-	-	-	-	58,910	168,093	-		-	-	227,003
Housekeeping	511,814	-	213,938	-	45,500	101,644	-		-	-	872,896
Patient Food Service	901,430	-	376,978	122,971	846,383	88,587	-		-	-	2,336,349
Cafeteria	-	-	-	-	-	-	-		-	-	-
Nursing Administration	728,464	-	101,985	-	-	-	-		-	-	830,449
Activities Program	240,285	-	98,637	-	37,323	204,992	3,500		-	-	584,737
Nonphysician Education	-	-	-	-	-	-	-		-	-	-
Medical Education	-	-	-	-	-	-	-		-	-	-
Medical Director's Office	-	36,000	-	-	-	-	-		-	-	36,000
Housing	-	-	-	-	-	-	-		-	-	-
Medical Records	-	-	-	14,837	74	-	-		-	-	14,911
Utilization Review	-	-	-	-	-	-	-		-	-	-
Social Service	259,202	-	35,537	101,783	663	14,637	-		-	-	411,822
Transportation	-	-	-	201,361	-	-	-		-	-	201,361
<b>Subtotal</b>	<b>3,105,908</b>	<b>36,000</b>	<b>962,594</b>	<b>610,015</b>	<b>1,024,921</b>	<b>2,175,941</b>	<b>300,693</b>		<b>1,699,350</b>	<b>-</b>	<b>9,915,422</b>

SCHEDULE 18E - Functional Expenses

Year 3 - Statement of Non-Revenue Support Services Functional Expenses

	a	b	c	d	e	f	g	h	i	j	k
Non-Revenue Support Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Total
Depreciation. Leases & Rentals							\$0				-
Depreciation. Major Movable Equip.							\$166,623				166,623
Interest on Capital Debt									-		-
Fiscal Services	59,359	-	6,791	49,083	17,228	1,344,260	81,544		26,866	-	1,585,131
Administrative Services	130,435	-	13,304	123,978	-	169,350	-		1,115,623	-	1,552,690
Plant Operation and Maintenance <sup>1</sup>	288,860	-	129,063	-	19,562	82,509	14,939		590,848	-	1,125,781
Utilities											
Property Taxes											
Property Insurance											
Grounds	-	-	-	-	-	15,928	-		-	-	15,928
Security	-	-	-	1,074	-	1,922	-		-	-	2,996
Laundry and Linen	-	-	-	-	60,088	169,774	-		-	-	229,862
Housekeeping	527,168	-	230,900	-	46,410	102,660	-		-	-	907,138
Patient Food Service	928,473	-	406,857	126,660	863,311	89,473	-		-	-	2,414,774
Cafeteria	-	-	-	-	-	-	-		-	-	-
Nursing Administration	750,318	-	120,051	-	-	-	-		-	-	870,369
Activities Program	247,494	-	106,546	-	38,069	207,042	3,500		-	-	602,651
Nonphysician Education	-	-	-	-	-	-	-		-	-	-
Medical Education	-	-	-	-	-	-	-		-	-	-
Medical Director's Office	-	36,000	-	-	-	-	-		-	-	36,000
Housing	-	-	-	-	-	-	-		-	-	-
Medical Records	-	-	-	15,282	75	-	-		-	-	15,357
Utilization Review	-	-	-	-	-	-	-		-	-	-
Social Service	266,978	-	41,942	104,836	676	14,783	-		-	-	429,215
Transportation	-	-	-	207,402	-	-	-		-	-	207,402
<b>Subtotal</b>	<b>3,199,085</b>	<b>36,000</b>	<b>1,055,454</b>	<b>628,315</b>	<b>1,045,419</b>	<b>2,197,701</b>	<b>266,606</b>		<b>1,733,337</b>	<b>-</b>	<b>10,161,917</b>

SCHEDULE 18E - Functional Expenses

Current Year - Statement of Ancillary Services Functional Expenses

	a	b	c	d	e	f	g	h	i	j	k
	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Totals
<b>ANCILLARY SERVICES:</b>											
Clinical Laboratory Services				12,350							12,350
Electrocardiology											-
Electroencephalography											-
Radiology					25,234						25,234
Inhalation Therapy											-
Podiatry											-
Dental						13,274					13,274
Psychiatric											-
Physical Therapy					248	533,204					533,452
Occupational Therapy						549,901					549,901
Speech/Hearing Therapy						79,856					79,856
Pharmacy				15,512	369,420						384,932
Central Service Supply	44,417		5,375		136,130	91,345	85,335				362,602
Medical Staff Services		100									100
<b>Subtotal</b>	<b>44,417</b>	<b>100</b>	<b>5,375</b>	<b>27,862</b>	<b>531,032</b>	<b>1,267,580</b>	<b>85,335</b>		<b>-</b>	<b>-</b>	<b>1,961,701</b>

SCHEDULE 18E - Functional Expenses

Year 1 - Statement of Ancillary Services Functional Expenses

	a	b	c	d	e	f	g	h	i	j	k
Non-Revenue Support Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Totals
<b>ANCILLARY SERVICES:</b>											
Clinical Laboratory Services	-	-	-	12,535	-	-	-	-	-	-	12,535
Electrocardiology	-	-	-	-	-	-	-	-	-	-	-
Electroencephalography	-	-	-	-	-	-	-	-	-	-	-
Radiology	-	-	-	-	25,739	-	-	-	-	-	25,739
Inhalation Therapy	-	-	-	-	-	-	-	-	-	-	-
Podiatry	-	-	-	-	-	-	-	-	-	-	-
Dental	-	-	-	-	-	13,473	-	-	-	-	13,473
Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Physical Therapy	-	-	-	-	253	541,202	-	-	-	-	541,455
Occupational Therapy	-	-	-	-	-	558,150	-	-	-	-	558,150
Speech/Hearing Therapy	-	-	-	-	-	81,054	-	-	-	-	81,054
Pharmacy	-	-	-	15,745	376,808	-	-	-	-	-	392,553
Central Service Supply	45,527	-	6,192	-	138,853	92,715	85,335	-	-	-	368,622
Medical Staff Services	-	-	-	-	-	-	-	-	-	-	-
<b>Subtotal</b>	<b>45,527</b>	<b>-</b>	<b>6,192</b>	<b>28,280</b>	<b>541,653</b>	<b>1,286,594</b>	<b>85,335</b>		<b>-</b>	<b>-</b>	<b>1,993,581</b>

SCHEDULE 18E - Functional Expenses

Year 3 - Statement of Ancillary Services Functional Expenses

	a	b	c	d	e	f	g	h	i	j	k
Non-Revenue Support Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Totals
<b>ANCILLARY SERVICES:</b>											
Clinical Laboratory Services	-	-	-	12,911	-	-	-	-	-	-	12,911
Electrocardiology	-	-	-	-	-	-	-	-	-	-	-
Electroencephalography	-	-	-	-	-	-	-	-	-	-	-
Radiology	-	-	-	-	26,254	-	-	-	-	-	26,254
Inhalation Therapy	-	-	-	-	-	-	-	-	-	-	-
Podiatry	-	-	-	-	-	-	-	-	-	-	-
Dental	-	-	-	-	-	13,608	-	-	-	-	13,608
Psychiatric	-	-	-	-	-	-	-	-	-	-	-
Physical Therapy	-	-	-	-	258	546,614	-	-	-	-	546,872
Occupational Therapy	-	-	-	-	-	563,732	-	-	-	-	563,732
Speech/Hearing Therapy	-	-	-	-	-	81,865	-	-	-	-	81,865
Pharmacy	-	-	-	16,217	384,344	-	-	-	-	-	400,561
Central Service Supply	46,893	-	7,102	-	141,630	93,642	85,335	-	-	-	374,602
Medical Staff Services	-	-	-	-	-	-	-	-	-	-	-
Subtotal	46,893	-	7,102	29,128	552,486	1,299,461	85,335	-	-	-	2,020,405

SCHEDULE 18E - Functional Expenses

Current Year - Summary of Expenses:

	a	b	c	d	e	f	g	h	i	j	k
Revenue Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Totals
Residential Health Care Facility	4,573,259		1,849,367			407,925					6,830,551
Adult Care Facility											-
Intermed. Care Facility-Mental Retard											-
Independent Living											-
Other Program (Specify)											-
Outpatient Clinics											-
Adult Day Health Care	355,138		45,795				176,938				577,871
Home Health Care											-
Homemaker Services											-
Meals on Wheels											-
Research											-
Physicians' Offices & Other Rentals											-
Gift Shop											-
Public Restaurant											-
Fund Raising											-
Barber and Beauty Shop											-
Sold Services											-
Other - Long Term Ventilator											-
Subtotal	4,928,397	-	1,895,162	-	-	407,925	176,938		-	-	7,408,422
GRAND TOTAL	8,002,968	36,100	2,796,955	628,863	1,535,857	3,819,291	1,428,355		1,911,128	-	20,159,517

SCHEDULE 18E - Functional Expenses

Year 1 - Summary of Expenses:

	a	b	c	d	e	f	g	h	i	j	k
Revenue Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Totals
Residential Health Care Facility	4,687,590	-	1,965,975	-	-	414,044	-	-	-	-	7,067,609
Adult Care Facility	-	-	-	-	-	-	-	-	-	-	-
Intermed. Care Facility-Mental Retard	-	-	-	-	-	-	-	-	-	-	-
Independent Living	-	-	-	-	-	-	-	-	-	-	-
Other Program (Specify)	-	-	-	-	-	-	-	-	-	-	-
Outpatient Clinics	-	-	-	-	-	-	-	-	-	-	-
Adult Day Health Care	364,016	-	52,382	-	-	-	176,938	-	-	-	593,336
Home Health Care	-	-	-	-	-	-	-	-	-	-	-
Homemaker Services	-	-	-	-	-	-	-	-	-	-	-
Meals on Wheels	-	-	-	-	-	-	-	-	-	-	-
Research	-	-	-	-	-	-	-	-	-	-	-
Physicians' Offices & Other Rentals	-	-	-	-	-	-	-	-	-	-	-
Gift Shop	-	-	-	-	-	-	-	-	-	-	-
Public Restaurant	-	-	-	-	-	-	-	-	-	-	-
Fund Raising	-	-	-	-	-	-	-	-	-	-	-
Barber and Beauty Shop	-	-	-	-	-	-	-	-	-	-	-
Sold Services	-	-	-	-	-	-	-	-	-	-	-
Other - Long Term Ventilator	-	-	-	-	-	-	-	-	-	-	-
Subtotal	5,051,606	-	2,018,357	-	-	414,044	176,938	-	-	-	7,660,945
<b>GRAND TOTAL</b>	<b>8,203,041</b>	<b>36,000</b>	<b>2,987,143</b>	<b>638,295</b>	<b>1,566,574</b>	<b>3,876,579</b>	<b>562,966</b>		<b>1,699,350</b>	<b>-</b>	<b>19,569,948</b>

SCHEDULE 18E - Functional Expenses

Year 3 - Summary of Expenses:

	a	b	c	d	e	f	g	h	i	j	k
Revenue Services	Salaries & Wages	Physician Remuneration	Employee Benefits	Fees	Supplies & Materials	Purchased & Contracted Services	Deprec. Leases & Rentals	Utilities, Property Taxes & Insurance	Other Expense	Assessments	Totals
Residential Health Care Facility	4,828,218	-	2,059,727	-	-	418,185	-	-	-	-	7,306,130
Adult Care Facility	-	-	-	-	-	-	-	-	-	-	-
Intermed. Care Facility-Mental Retard	-	-	-	-	-	-	-	-	-	-	-
Independent Living	-	-	-	-	-	-	-	-	-	-	-
Other Program (Specify)	-	-	-	-	-	-	-	-	-	-	-
Outpatient Clinics	-	-	-	-	-	-	-	-	-	-	-
Adult Day Health Care	374,936	-	59,662	-	-	-	176,938	-	-	-	611,536
Home Health Care	-	-	-	-	-	-	-	-	-	-	-
Homemaker Services	-	-	-	-	-	-	-	-	-	-	-
Meals on Wheels	-	-	-	-	-	-	-	-	-	-	-
Research	-	-	-	-	-	-	-	-	-	-	-
Physicians' Offices & Other Rentals	-	-	-	-	-	-	-	-	-	-	-
Gift Shop	-	-	-	-	-	-	-	-	-	-	-
Public Restaurant	-	-	-	-	-	-	-	-	-	-	-
Fund Raising	-	-	-	-	-	-	-	-	-	-	-
Barber and Beauty Shop	-	-	-	-	-	-	-	-	-	-	-
Sold Services	-	-	-	-	-	-	-	-	-	-	-
Other - Long Term Ventilator	-	-	-	-	-	-	-	-	-	-	-
Subtotal	5,203,154	-	2,119,389	-	-	418,185	176,938	-	-	-	7,917,666
<b>GRAND TOTAL</b>	<b>8,449,132</b>	<b>36,000</b>	<b>3,181,945</b>	<b>657,443</b>	<b>1,597,905</b>	<b>3,915,347</b>	<b>528,879</b>		<b>1,733,337</b>	<b>-</b>	<b>20,099,988</b>

## New York State Department of Health

### Health Equity Impact Assessment Conflict-of-Interest

*This Conflict-of-Interest form must be completed in full, signed by the Independent Entity, and submitted with the Health Equity Impact Assessment.*

#### **Section 1 – Definitions**

**Independent Entity** means individual or organization with demonstrated expertise and experience in the study of health equity, anti-racism, and community and stakeholder engagement, and with preferred expertise and experience in the study of health care access or delivery of health care services, able to produce an objective written assessment using a standard format of whether, and if so how, the facility's proposed project will impact access to and delivery of health care services, particularly for members of medically underserved groups.

**Conflict of Interest** shall mean having a financial interest in the approval of an application or assisting in drafting any part of the application on behalf of the facility, other than the health equity assessment.

#### **Section 2 – Independent Entity**

What does it mean for the Independent Entity to have a conflict of interest? For the purpose of the Health Equity Impact Assessment, if one or a combination of the following apply to the Independent Entity, the Independent Entity **HAS** a conflict of interest and must **NOT** perform the Health Equity Impact Assessment:

- The Independent Entity helped compile or write any part of the Certificate of Need (CON) application being submitted for this specific project, other than the Health Equity Impact Assessment (for example, individual(s) hired to compile the Certificate of Need application for the facility's project cannot be the same individual(s) conducting the Health Equity Impact Assessment);
- The Independent Entity has a financial interest in the outcome of this specific project's Certificate of Need application (i.e. individual is a member of the facility's Board of Directors or advisory board); or
- The Independent Entity has accepted or will accept a financial gift or incentive from the Applicant above fair market value for the cost of performing the Health Equity Impact Assessment.

#### **Section 3 – General Information**

##### **A. About the Independent Entity**

1. Name of Independent Entity: MP CareSolutions
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)?

If yes, indicate the name of the organization:  
Monroe Plan for Medical Care

3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (Y/N)?  
Yes
4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years?

The Independent Entity has not previously worked with the Applicant.

**Section 4 – Attestation**

I, Howard R. Brill (individual name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of MP CareSolutions (INDEPENDENT ENTITY), do hereby attest that the Health Equity Impact Assessment for project Relocation and New Building (PROJECT NAME) provided for Northern Metropolitan (APPLICANT) has been conducted in an independent manner and without a conflict of interest as defined in Title 10 NYCRR § 400.26.

I further attest that the information provided by the INDEPENDENT ENTITY in the Health Equity Impact Assessment is true and accurate to the best of my knowledge, and fulfills the intent of the Health Equity Impact Assessment requirement.

Signature of Independent Entity: 

Date: 4/23/2025



February 18, 2025

Gedalia Klein  
Executive Director  
Northern Metropolitan Foundation for Health  
Care 2000 Fountain View Dr.  
Monsey, NY 10952

Re: Health Equity Impact Assessments Letter of Agreement

To whom it may concern,

This Letter of Agreement ("LOA") dated the 18th day of February 2025 between Northern Metropolitan Foundation for Health Care ("NMFHC"), located at 2000 Fountain View Dr., Monsey, NY 10952 and MP CareSolutions, LLC ("MPCS") located at 1120 Pittsford-Victor Road, Pittsford, NY 14534, is intended to memorialize NMFHC's intent to engage MPCS and its affiliates to provide designated Health Equity Impact Assessment Services ("Services") for NMFHC Certificate of Need (CON) to move its Northern Metropolitan Residential and Rehabilitation Facility from 225 Maple Ave, Monsey, NY 10952 to 11 College Ave., Monsey, NY 10952.

The following outlines the terms and conditions of this LOA:

**1. Term, Payment, and Termination**

This LOA shall begin on the date the LOA has been signed by the parties and shall end upon completion of the project unless earlier terminated by either party.

Payment shall be at a rate not to exceed \$200.00 (two hundred dollars and 00/100) per hour for services rendered as defined herein. Service project is estimated at 55 hours with duration of approximately 6 weeks following the project kickoff meeting with NMFHC stakeholder staff.

MPCS shall provide NMFHC with an invoice at the conclusion of this assessment in an agreed upon format for Services performed and payment shall be made by NMFHC to MPCS within thirty (30) days of receipt. If this LOA is terminated prior to delivery of the assessment, NMFHC shall be invoiced for the time spent up to the date of termination.

Termination without Cause: Either party may terminate this LOA at any time. The intent to terminate this LOA must be sent, in writing, to the other party, as outlined in the Notices section below.

## **2. Responsibilities of MPCS**

To independently complete the HEIA assessment (“Project”) in an acceptable manner to meet the requirements for inclusion in the Certification of Need (“CON”) application in a format required by the New York State Department of Health (“NYSDOH”).

Project documents to be completed shall include the following:

1. A quantitative analysis of the service area's demographics and the utilization of the project's services including utilizing multiple data sources, geographic information systems, and statistical analysis.
2. Extensive and meaningful engagements with the affected communities and other stakeholders, employing multiple techniques such as interviews, community forums, focus groups, and surveys. These will occur in the context of local community culture and the history of systemic barriers, building on relationships with active social organizations.
3. Development of proposed modifications and adaptations to the project that creatively address the communities' concerns, insights, and strengths, informed by a knowledge of local health system capabilities, opportunities, and funding sources, leveraging the knowledge and experience of the facility's staff.

MPCS shall also adhere to the standard format of the Health Equity Impact Assessment template issued by the NYSDOH reflecting the following recommended “stepwise” structure:

- Scoping
- Potential Impact
- Mitigation
- Monitoring
- Dissemination

## **3. Responsibilities of NMFHC**

NMFHC shall be responsible for providing MPCS all documentation and requests reasonably required by MPCS to complete the Project within the parameters of NYSDOH requirements. NMFHC and its affiliated staff shall also work cooperatively with MPCS to develop HEIA processes related to completion of the assessment tools.

## **4. Miscellaneous**

In the performance of its obligations hereunder, MP CareSolutions, LLC shall be and shall act at all times as an independent contractor to NMFHC and its affiliates.

- A. This is a non-exclusive agreement and neither party is restricted from entering into agreements comparable to this LOA with any other third parties.
- B. Hold Harmless/Indemnification: Each party covenants to hold the other party harmless against; and to indemnify the other party for, all losses, damages, expenses, liabilities and any other costs, including attorney fees, arising out of or incurred in connection with such party's breach or default in performance of this LOA or arising out of the negligence or other unlawful malfeasance or non-feasance by such party or its servants, agents, employees or agencies in relation to this LOA. Each party further covenants to the other that, in the event any claim or demand is asserted against it which may result in indemnification liability to the other, it will give prompt written notice thereof to the other party and will cooperate in the investigation of any such claim and/or the defense of any action arising there from.
- C. Jurisdiction/Choice of Law: This LOA shall be governed by the laws of the State of New York.
- D. Confidentiality: Each party agrees that all information concerning the other which may be made available to respective personnel during the course of this LOA shall be deemed to be confidential, and such personnel shall not be permitted or required to disclose any such information to any third party without the express written consent of the other party.
- E. Health Insurance Portability and Accountability Act ("HIPAA"): Both parties agree to be bound by all current terms and conditions of HIPAA.
- F. This LOA constitutes the entire agreement of the parties hereto, and all previous communications between the parties, whether written or oral, with respect to the subject matter of this contract, are hereby superseded. No amendment, change or modification of this agreement shall be effective unless in writing and signed by the parties hereto.

***REST OF PAGE LEFT BLANK INTENTIONALLY***

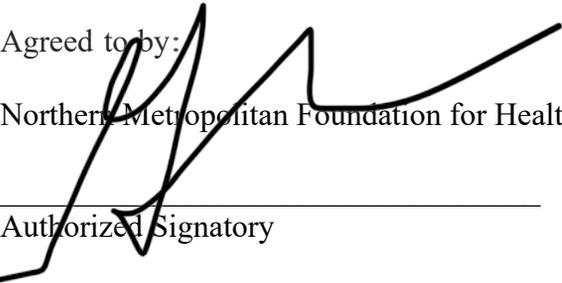
If the foregoing is acceptable, please sign where indicated below and return the other to Monroe Plan at:

Monroe Plan for Medical Care, Inc.  
MP CareSolutions, LLC  
1120 Pittsford-Victor Road  
Pittsford, New York 14534  
Attn: Kim Hess, EVP & COO  
E-Mail: [khess@monroeplan.com](mailto:khess@monroeplan.com)

Sincerely yours,

*Kim Hess*  
\_\_\_\_\_  
Kim Hess  
EVP & COO  
MP CareSolutions, LLC

2/18/2025  
\_\_\_\_\_  
Date

Agreed to by:  
  
Northern Metropolitan Foundation for Health Care  
\_\_\_\_\_  
Authorized Signatory

\_\_\_\_\_  
Date



**New York State Department of Health  
Health Equity Impact Assessment Requirement Criteria**

Effective June 22, 2023, a Health Equity Impact Assessment (HEIA) will be required as part of Certificate of Need (CON) applications submitted by facilities (Applicant), pursuant to Public Health Law (PHL) § 2802-b and corresponding regulations at Title 10 New York Codes, Rules and Regulations (NYCRR) § 400.26. This form must be used by the Applicant to determine if a HEIA is required as part of a CON application.

**Section A. Diagnostic and Treatment Centers (D&TC) - This section should only be completed by D&TCs, all other Applicants continue to Section B.**

**Table A.**

<b>Diagnostic and Treatment Centers for HEIA Requirement</b>	<b>Yes</b>	<b>No</b>
Is the Diagnostic and Treatment Center’s patient population less than 50% patients enrolled in Medicaid and/or uninsured (combined)?		
Does the Diagnostic and Treatment Center’s CON application include a change in controlling person, principal stockholder, or principal member of the facility?		

- ***If you checked “no” for both questions in Table A***, you do not have to complete Section B – this CON application is considered exempt from the HEIA requirement. This form with the completed Section A is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section A, along with the CON application to acknowledge that a HEIA is not required.
- ***If you checked “yes” for either question in Table A***, proceed to Section B.

**Section B. All Article 28 Facilities**

**Table B.**

<b>Construction or equipment</b>	<b>Yes</b>	<b>No</b>
Is the project minor construction or the purchase of equipment, subject to Limited Review, <u>AND</u> will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours? <i>Per the Limited Review Application Instructions: Pursuant to 10 NYCRR 710.1(c)(5), minor construction projects with a total project cost of less than or equal \$15,000,000 for general hospitals and</i>		<b>X</b>

<i>less than or equal to \$6,000,000 for all other facilities are eligible for a Limited Review.</i>		
<b>Establishment of an operator (new or change in ownership)</b>	<b>Yes</b>	<b>No</b>
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, <u>AND</u> will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		X
<b>Mergers, consolidations, and creation of, or changes in ownership of, an active parent entity</b>	<b>Yes</b>	<b>No</b>
Is the project a transfer of ownership in the facility that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		X
<b>Acquisitions</b>	<b>Yes</b>	<b>No</b>
Is the project to purchase a facility that provides a new or similar range of services or care, that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		X
<b>All Other Changes to the Operating Certificate</b>	<b>Yes</b>	<b>No</b>
Is the project a request to amend the operating certificate that will result in one or more of the following:  a. Elimination of services or care; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours, and/or; d. Change in location of services or care?	X	

\*Calculate the percentage change from the number of certified/authorized beds and/or certified/authorized services (as indicated on the facility's operating certificate) specific to the category of service or care. For example, if a residential health care facility adds two ventilator-dependent beds and the facility had none previously, this would exceed the 10% threshold. If a hospital removes 5 out of 50 maternity certified/authorized beds, this would meet the 10% threshold.

- **If you checked “yes” for one or more questions in Table B**, the following HEIA documents are required to be completed and submitted along with the CON application:
  - HEIA Requirement Criteria with Section B completed
  - HEIA Conflict-of-Interest

- HEIA Contract with Independent Entity
  - HEIA Template
  - HEIA Data Tables
  - Full version of the CON Application with redactions, to be shared publicly
- ***If you checked “no” for all questions in Table B***, this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.

## New York State Department of Health

### Health Equity Impact Assessment Template

Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

#### **SECTION A. SUMMARY**

1. Title of project	Northern Metropolitan Relocation and New Building
2. Name of Applicant	Northern Metropolitan
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	MP Care Solutions <b>Kim Hess</b> , COO <a href="mailto:khess@monroeplan.com">khess@monroeplan.com</a> <b>Howard Brill</b> , SVP Population Health Management and Quality <a href="mailto:hbrill@monroeplan.com">hbrill@monroeplan.com</a> <b>Andrea Indiano</b> , Project Manager <a href="mailto:aindiano@monroeplan.com">aindiano@monroeplan.com</a> <b>Todd Glanton</b> , SVP Technology and Analytics, IT <a href="mailto:tglanton@monroeplan.com">tglanton@monroeplan.com</a> <b>Sylvia Yang</b> , Health Systems Analyst <a href="mailto:syang@monroeplan.com">syang@monroeplan.com</a>
4. Description of the Independent Entity's qualifications	The Monroe Plan was founded in 1970 to provide innovative means to providing healthcare for the underserved in Upstate New York. We have over fifty years of experience partnering with providers, managed care organizations and community-based organizations to reduce disparities, bringing a deep understanding of all facets of healthcare and its constituencies. We are a data-driven organization experience delivering actionable data and designing data-informed and financially-sustainable programs. We have long-term relationships with stakeholders and community organizations and a large team providing direct face-to-face care and outreach to vulnerable persons throughout the Upstate Region.
5. Date the Health Equity Impact Assessment (HEIA) started	2/25/2025
6. Date the HEIA concluded	4/21/2025

7. Executive summary of project (250 words max)
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The project is a relocation and construction of a new building for a skilled nursing facility. The skilled nursing facility is located at 225 Maple Ave, Monsey, and the relocation will be to 11 College Rd., Monsey, which is 1.5 miles from the current location. The new building will have the same bed capacity as the current building and facility is expected to maintain the same services and staffing. The existing building is over fifty years old. The project is expected to be completed in three to five years.

#### 8. Executive summary of HEIA findings (500 words max)

The project is a relocation of an over fifty-year-old skilled nursing facility in Monsey, NY, to a new building 1.5 miles away, also in Monsey, on a campus shared with an independent living and assisted living residential facilities. The new location has a minimal impact on transportation accessibility. The new building will have the same bed capacity and is expected to support the same services as the old building. However, as a new building, it can provide improved quality of life and amenities through a state-of-the-art design.

The service area – Rockland County -- has a highly diverse population. Notably, the county has the highest per capita Jewish population, 31.4%, in the United States, and a Hispanic/Latino population of 20%. The elderly population in the county has grown rapidly, with the 70-74 age group increasing over 25% since the 2010 Census. There is an increasing proportion of persons who speak languages other than English. Major needs identified in county health needs assessments include affordable housing, the availability of mental health providers, and access to affordable, nutritious food. Barriers to health included knowledge of existing resources, health literacy, and limited public transportation. The needs assessments also pointed to concerns about persons without health insurance, and problems with some providers not accepting Medicaid insurance. The overall poverty rate in the service area is 11.9%. The zip code of the facility, 10952, has the highest poverty rate in the service area at 28.4%. The adjacent 10977 zip code, which is directly to the east of 10952, has a poverty rate of 24.3%. The facility is located in a highly populated, diverse area of Rockland County.

The community stakeholders were supportive of the relocation, particularly because the current facility is a very old structure, and having a new building was seen as beneficial to the residents. Both the current and proposed locations were seen as accessible. Also discussed by stakeholders was the importance of financial accessibility and affordability. They hoped that the facility would remain affordable. Stakeholders noted that mental health service availability is problematic in the service area. Stakeholders drew attention to the facility providing a locked unit, which provides a higher level of care for persons with psychiatric problems or dementia, which they viewed as very needed and having limited availability in the service area. There were many suggestions and recommendations regarding the transition to a new facility for residents and how the quality of life in the new building could be enhanced. It was emphasized that having a careful communication plan for residents and family about the move was critical. There was considerable positive excitement, particularly among residents, about how the new building could provide improved space and related programming.

The facility and its proposed future location is in an area of Rockland County that has the highest poverty rates and is highly diverse racially and ethnically. The location is considered accessible, with the project having a minor positive impact on transportation accessibility. The facility provides a higher level of care for persons needing greater psychiatric services. Since Rockland County has unmet needs for skilled nursing facility beds, the project, by maintaining capacity in a diverse and relatively high poverty area, positively addresses equitable access. Through a new building, replacing a building over fifty years old, it potentially improves the quality of life for its residents.

## **SECTION B: ASSESSMENT**

**For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.**

### **STEP 1 – SCOPING**

1. Demographics of service area: Complete the “Scoping Table Sheets 1 and 2” in the document “HEIA Data Tables”. Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.

The project is a relocation and construction of a new building for a skilled nursing facility. The new building will have the same bed capacity as the current building. The existing building is over fifty years old. The skilled nursing facility is located at 225 Maple Ave, Monsey, and the relocation will be to 11 College Rd., Monsey, which is 1.5 miles from the current location. The project is expected to be completed in three to five years.

The facility is located in Rockland County. The service area for this assessment was Rockland County. There are 26 zip codes in this service area, located in the Mid-Hudson Region. Both the current and project locations are in the 10952 zip code. Scoping Sheets 1 and 2 were completed using the U.S. Census Bureau 2023 5-year estimates for ZCTAs. Racial and ethnic distributions by ZCTA are displayed in Figure 1.

Rockland County ranks 11th in New York State poverty for all age groups in 2020, and 2<sup>nd</sup> for those under age 18 (NYS Office of the State Comptroller 2023). The 10927 and 10977 zip codes are HRSA-designated Medically Underserved Areas.

The Community Health Assessment and Community Health Improvement Plan for Rockland County noted that it has a highly diverse population, with large Jewish, Hispanic, and Asian populations. The elderly population in the county has grown rapidly, with the 70-74 age group increasing over 25% since the 2010

Census. There is an increasing proportion of persons who speak languages other than English. Major needs identified for the county include affordable housing, the availability of mental health providers, and access to affordable nutritious food. Barriers to health included knowledge of existing resources, health literacy, and limited public transportation. The Community Health Assessment include concerns about persons without health insurance, and problems with some providers not accepting Medicaid insurance.

The population of the service area is 338,936 persons. The county has the highest per capita Jewish population in the United States, with 31.4% of the residents. 20.0% of the population identifies as Hispanic or Latino. The overall poverty rate in the service area is 11.9%. The zip code of the facility, 10952, has the highest poverty rate in the service area at 28.4%. The adjacent 10977 zip code, which is directly to the east of 10952, has a poverty rate of 24.3%, and the 10927 zip code's poverty rate is 13.2%. 10.8% of the households in the service area lack their own vehicles, with the proportion in 10927 at 25.7% and 10952 at 20.6%.

The New York State Prevention Agenda shows that the difference in premature deaths (before age 65) for Hispanics compared to non-Hispanic Whites is 26.3% (2022) for Rockland County compared to 18.2% for the Mid-Hudson region and 19.4% for New York State. The premature death disparity for Black non-Hispanics versus White non-Hispanics is at 16.2%, which is better than the Prevention Agenda 2024 objective of 17.3%. Potentially preventable hospitalization rates and related disparity metrics are better for Rockland County than the Prevention Agenda objectives. Rockland County's hospitalizations due to falls were 144.2 per 10,000 (2020) for persons aged 65+ years, which is also better than the Prevention Agenda objective for 173.7 per 10,000.

Sources:

ACS 2023 "Five-Year Estimates."

Hudson Valley Public Health Collaborative. 2022. *Mid-Hudson Region Community Health Assessment 2022-2024*. Hudson Valley Public Health Collaborative.

McKay, Kevin. 2019. *Rockland County Community Health Improvement Plan*. Rockland County Department of Health.

New York State Department of Health. 2025. "Prevention Agenda Tracking Dashboard." Retrieved February 12, 2025 ([https://apps.health.ny.gov/public/tabvis/PHIG\\_Public/pa/reports/#county](https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/reports/#county)).

2. Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:

- X Low-income people
- X Racial and ethnic minorities
- Immigrants
- Women
- Lesbian, gay, bisexual, transgender, or other-than-cisgender people
- X People with disabilities
- X Older adults
- Persons living with a prevalent infectious disease or condition
- Persons living in rural areas
- X People who are eligible for or receive public health benefits
- X People who do not have third-party health coverage or have inadequate third-party health coverage
- Other people who are unable to obtain health care
- Not listed (specify):

3. For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?

Low-income people

Low-income people were included because of the overall poverty rate in Rockland County and the high poverty rate in the zip code in which the facility is located.

Racial and ethnic minorities

The service area is diverse, with the largest per capita percentage, 31.4%, of Jewish people among U.S. counties and has a large Hispanic/Latino population, comprising 20% of the population. Blacks are 11.0% of the service area's population.

Persons with disabilities

The facility provides a locked unit, which provides availability for persons needing a facility that supports a higher level of psychiatric and dementia care.

Older Adults

As a skilled nursing facility, the project primarily involves adults over the age of 65 years.

People who are eligible for or receive public health benefits

For the service area, 46.6% of the population receives public health benefits. The utilization data for the facility indicates that the large majority of residents are on public benefits.

People who do not have third-party health coverage or have inadequate third-party health coverage.

The ACS 2023 data indicates that 4.5% of the service area's population lacks third-party health coverage. The New York State Prevention Agenda indicates that Rockland County, 93.6% of persons age 18 to 64 had health insurance (2022), which is below the Prevention Agenda objective of 97.0%.

Sources:

ACS 2023 "Five-Year Estimates."

Community Stakeholders.

Hudson Valley Public Health Collaborative. 2022. *Mid-Hudson Region Community Health Assessment 2022-2024*. Hudson Valley Public Health Collaborative.

4. How does the project impact the unique health needs or quality of life of each medically underserved group (identified above)?

Because the project is a relatively short relocation to a new building of the same capacity, it is not expected to have a major impact on any of the identified groups, other than maintaining the availability of skilled nursing facility capacity. A new building potentially allows for an improved quality of life for all groups through better living space and providing amenities through modern SNF design. The new location is collocated with independent living and assisted living facilities, potentially providing more opportunities for social activities.

Group	Impact on Unique Needs or Quality of Life
Low-income people	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>
Racial and ethnic minorities	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>
People with disabilities	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li>   <li><input type="checkbox"/> The facility provides a locked unit for persons needing a higher level of psychiatric and dementia care.</li> </ul>

Older Adults	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>
People who are eligible for or receive public health benefits	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>
People who do not have third-party health coverage or have inadequate third-party health coverage.	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>

5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

SPARCS data does not provide utilization information for skilled nursing facilities. The Applicant provided a resident census that describes utilization for several of the identified groups. There were 119 persons listed in the resident census.

#### Low-income people

As noted above, the service area has a poverty rate of 11.9%. The zip code that the facility is located in has the highest poverty rate in the area, at 28.4%, and the neighboring zip code is at 24.3%. The resident census does not directly provide income information, but it provides information about insurance providers. Using Medicaid insurance as a proxy for income, 81.5% of residents receive Medicaid benefits.

#### Racial and ethnic minorities

In the service area, 64.2% of the population is White, 11.0% are Black, 10.0% are listed as Other Race, 8.4% are multi-race, 5.9% are Asian, and 0.4% are Native American. 20.0% of the population is Hispanic or Latino.

The resident census indicates that 70.6% are White, 13.4% are Black, 11.8% were listed as "Other Race" or had no race indicated, and 4.2% were Hispanic or Latino. Because the census does not distinguish between race and ethnicity, the percentage of Hispanic or Latino residents may be underreported.

About 1/3 of the Northern Metropolitan's residents with a reported religious affiliation were Jewish, similar to the service area's proportion.

#### People with Disabilities

The ACS 2023 data shows 8.9% of the population has a disability. Nursing home residence indicates that a person requires 24-hour nursing care and supervision outside of a hospital. The Applicant also provides specialized services for persons with psychiatric disorders and dementia.

#### Older Adults

In the service area, 15.6% of the population is age 65 years or older. The average age of Northern Metropolitan's residents is 74.3 years. 84% are age 65 years or older.

#### People who are eligible for or receive public health benefits

The ACS 2023 data shows that 46.6% of the population has public insurance coverage.

The resident census provided by the Applicant has some missing or inconsistent information on insurance coverage. Based on whether residents have Medicare or Medicaid identifiers, 83.2% of the patients are on public coverage.

People who do not have third-party health coverage or have inadequate third-party health coverage.

ACS 2023 shows 4.5% of the population lacking insurance coverage. No facility residents are without insurance coverage based on whether persons have Medicare or Medicaid identifiers or if some other insurance coverage is listed.

Sources:

American Community Survey 2023. “Five-year estimates.”

Northern Metropolitan 2025. “Resident List Report.”

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

The skilled nursing facilities in Rockland County, is shown in Table 1. The table identifies the facilities, their market share and the distance to the proposed new location. These locations are also mapped in Figure 2.

*Table 1 Alternative Facilities in the Service Area, Distance and Capacity*

Facility	Bed Capacity (RHCF)	Market Share (%)	Distance (miles)
Northern Metropolitan	120	9.1%	0
The Willows at Ramapo	203	15.4%	1.9
Pine Valley Center	160	12.2%	3.2
Friedwald Center	168	12.8%	4.0
Northern Manor Geriatric Center	203	15.4%	4.2
Nyack Ridge	160	12.2%	7.9
Tolstoy Foundation	96	7.3%	8.4
Northern Riverview Health Center	180	13.7%	8.6
Helen Hayes Hospital	25	1.9%	8.8
<b>Total</b>	<b>1315</b>	<b>100.0%</b>	

Source: New York State Department of Health 2025. “Health Facility Certification Information.” Retrieved and Last Updated April 17, 2025.

7. What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?

As seen in Table 1, the current certified bed capacity in Rockland County is 1,315 beds, with Northern Metropolitan comprising 9.1% of that capacity. The

most recent estimate of residential health care facility (RHCF) bed need by county dates from 2016 (NYS DOH 2016). In 2016, Rockland County was estimated to need 1,635 beds, with a current capacity of 1,315 beds and an unmet need of 320 beds. Since the population has been aging, the unmet need is likely greater.

Source:

New York State Department of Health. 2016. "Estimates of RHCF Bed Need by County." Retrieved April 17, 2025 ([https://www.health.ny.gov/facilities/nursing/rhcf\\_bed\\_need\\_by\\_county.htm](https://www.health.ny.gov/facilities/nursing/rhcf_bed_need_by_county.htm)).

8. Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.

Not applicable. To our knowledge, the General Hospital Indigent Care Pool does not apply to skilled nursing facilities not associated with a hospital operator.

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

The project will not modify staffing for the facility. The short relocation is not anticipated to affect staff.

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.

The Applicant reports no civil rights complaints regarding employees or consumers to Federal or State agencies in the past ten years.

11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.

The Applicant has not relocated the facility in the last five years.

## **STEP 2 – POTENTIAL IMPACTS**

1. For each medically underserved group identified in Step 1 Question 2, describe how the project will:
  - a. Improve access to services and health care
  - b. Improve health equity
  - c. Reduce health disparities

The project is not expected to impact access, health equity, or reduce disparities for any of the identified underserved groups because it is a short, 1.5-mile relocation, without a change in capacity or services. Maintaining the capacity of residential healthcare beds in the service area is a positive health equity benefit for underserved groups in a county with unmet needs. The current and proposed locations are in the highest poverty zip code of the service area and is a racially and ethnically diverse area. The project also maintains services for patients needing a higher level of psychiatric and dementia care, with a capacity of 40 beds. Since the project involves replacing an over fifty-year-old structure with a new state-of-the-art building, it is expected to provide quality of life improvements for all the groups.

Group	Improve Access to health services and care	Improve Health Equity	Reduce Health Disparities
Low income people	<ul style="list-style-type: none"> <li><input type="checkbox"/> The relocation has minimal impact on access.</li> <li><input type="checkbox"/> The current and proposed locations are in a zip code with the highest poverty rate in the service area.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Not expected affect disparities.</li> </ul>
Racial and ethnic minorities	<ul style="list-style-type: none"> <li><input type="checkbox"/> The relocation has minimal impact on access.</li> <li><input type="checkbox"/> The area surrounding the locations is racially and ethnically diverse.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Not expected to affect disparities</li> </ul>
People with disabilities	<ul style="list-style-type: none"> <li><input type="checkbox"/> The relocation has minimal impact on access.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Maintains availability of skilled nursing facility capacity.</li> <li><input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities.</li> <li><input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.</li> <li><input type="checkbox"/> The facility provides a locked unit for persons needing a higher level of psychiatric and dementia care. The unit has a capacity of 40 beds.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Not expected to affect disparities</li> </ul>

Older Adults	<input type="checkbox"/> The relocation has minimal impact on access.	<input type="checkbox"/> Maintains availability of skilled nursing facility capacity. <input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities. <input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.	<input type="checkbox"/> Not expected to affect disparities
People who are eligible for or receive public health benefits	<input type="checkbox"/> The relocation has minimal impact on access.	<input type="checkbox"/> Maintains availability of skilled nursing facility capacity. <input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities. <input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.	<input type="checkbox"/> Not expected to affect disparities
People who do not have third-party health coverage or have inadequate third-party health coverage.	<input type="checkbox"/> The relocation has minimal impact on access.	<input type="checkbox"/> Maintains availability of skilled nursing facility capacity. <input type="checkbox"/> Potentially improved quality of life through modern residential design of living space and amenities. <input type="checkbox"/> Collocation with independent living and assisted living facilities provides more opportunities for social activities.	<input type="checkbox"/> Not expected to affect disparities

2. For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.

There are no identified unintended negative impacts for the underserved groups.

A potential positive unintended impact is providing an adjacent skilled nursing facility for independent and assisted living residents in the new location's campus, requiring rehabilitation services.

3. How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.

The project is not expected to impact indigent care. For 2024, there was \$195,000 of bad debt.

4. Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.

Because the facility is residential, public or private transportation access is not applicable to the project's impact.

The new location is expected to have less traffic congestion, according to local community stakeholders. Neither the current or the proposed locations are near bus stops.

5. Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

The new building is designed to be in full compliance with ADA requirements and standards and applicable State Building Codes and Regulations for accessibility.

6. Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law § 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?

Not applicable. The facility provides residential health care services, and the project does not affect maternal health care services or comprehensive reproductive health care.

### Meaningful Engagement

7. List the local health department(s) located within the service area that will be impacted by the project.

Rockland County Department of Health

8. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?

Yes.

9. Meaningful engagement of stakeholders: Complete the “Meaningful Engagement” table in the document titled “HEIA Data Table”. Refer to the Instructions for more guidance.

See attached Meaningful Engagement Worksheet.

The meaningful engagement included meetings with internal staff, staff of the independent living center at the new location, the SNF Ombudsman for Rockland County, Bikur Cholim, the Resident Council at Northern Metropolitan, and the Rockland Department of Health. An onsite survey of residents (direct consumers) at Northern Metropolitan was also conducted.

The community stakeholders were supportive of the relocation, particularly because the current facility is a very old structure, and having a new building was seen as beneficial to the residents. Both the current and proposed locations were seen as accessible. Some of the stakeholders mentioned the current location as having worse traffic congestion than the proposed location, while others said the reverse. The stakeholders with the most familiarity with the local conditions thought it would be an improvement, although they emphasized the closeness of the locations.

While a stakeholder wondered whether the nearby facilities in the new location would have concerns, a staff member from those facilities saw it as positive. They saw advantages in having an adjacent skilled nursing facility for assisted and independent living residents needing rehabilitation services. Staff at Northern Metropolitan thought it would create increased socialization opportunities.

Regarding general needs in the community, stakeholders pointed to the need for more mental health service availability and low immunization rates, particularly for young children. Mental health service availability is relevant to the project because Northern Metropolitan has a locked unit for persons needing a higher level of psychiatric and dementia care. This capacity was mentioned as very needed in the community.

There were general comments about staffing shortages and problems with workforce development.

Also discussed by stakeholders was the importance of financial accessibility and affordability. They hoped that the facility would remain affordable.

There were many suggestions and recommendations regarding the transition to a new facility for residents and how the quality of life in the new building could be enhanced. It was emphasized that having a careful communication plan for residents and family about the move was critical. Residents should be familiarized with the new location, understand how their possessions will be moved, and have them when they arrive at the new location.

The meeting with the Resident's Council was particularly focused on the quality of life and amenities in the new building. However, maintenance issues in the current building were also mentioned. Some of the recommendations included outdoor space, shared activity rooms, gardens, and the ability for gardening, aquariums, animal visits, and space for family events. Other recommendations included having an exercise space open to residents without needing physical therapy or rehabilitation.

### Direct Consumer Engagement: Onsite Survey

An Onsite Direct consumer survey was conducted with Northern Metropolitan's residents during the week of 4/7/2025. A social worker at the facility brought the survey to the residents and assisted them. The survey is shown in Appendix 3. The survey provided a description of the project, a project support question, open-ended questions about how the changes might affect the respondent and what was most important to them, an area to write a statement about the project, and demographic items. Project support was assessed by a five-point Likert scale, ranging from Strongly Disagree to Strongly Agree for a support statement. A score of five indicated strong agreement with a project's support statement, and a score of one indicated strong disagreement. The written statement question sometimes resulted in the response of "No" or "No statement." Based on the response to the Likert scale, these appear to mean "I have no statement to make," rather than a negative response to the project.

There were twenty responses to the survey. The average project support response was 4.8, indicating strong agreement. Sixteen of the responses were "Strongly Agree," and four responses were "Agree."

Most of the open-ended comments about the project concerned having a nicer building.

84.2% of the respondents were White, 10.5% were Black, and 5% or one respondent indicated Other. There was one non-response. 20% of the respondents marked a Hispanic or Latino identity.

The average age of the respondents was 70.1 years. 52.6% were male and 47% were female.

The open-ended responses included recommendations or, in some cases, aspects of the current facility that the residents would like to have continued. These included family visitation and patient interaction opportunities, garden space, and interactions with companion animals. There were also recommendations for space for religious activities. One comment regarded improving food quality and making sure food is brought up while still warm.

10. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

The most distinctive aspect of the facility is its locked unit for persons needing a higher level of psychiatric or dementia care. It was mentioned that “not many” of the other nursing homes in Rockland County have that service. The feedback concerning this capacity was that it should be maintained or expanded when the facility relocates. The Applicant has indicated they are planning to maintain that service. The other area of higher concern expressed in the meaningful engagements was the affordability of the facility for lower-income persons.

11. How has the Independent Entity’s engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

Overall, the perspective from the meaningful engagements was a positive attitude towards the facility and its move to a newer building. The discussions were much more focused on the potential benefits of a new building compared to the old structure the facility is currently in, and there was minimal concern about the change in location. The main concern regarding burdens was that the transition plan for residents be well-developed and well-communicated to residents, family, and loved ones.

12. Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.

Not applicable.

### **STEP 3 – MITIGATION**

1. If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:
- a. People of limited English-speaking ability
  - b. People with speech, hearing or visual impairments
  - c. If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?

The Assessor recommends the following guidelines to improve communication with persons of limited English-speaking ability:

- Use the U.S. Census Bureau American Community Survey to assess the most commonly spoken non-English language in the service area and/or, use in the Applicant’s resident census to identify with persons with limited English-speaking ability and their spoken language.

- Provide written communications for 80% of the persons with limited English-speaking ability based on language use assessment.
- In written communications, include contact information for bilingual staff or contracted language lines.
- Include translated material in the public website and social media.
- In the facility, provide posters or other visual aids that provide information about interpreting services in multiple languages.
- Staff training on language access resources.

We also recommend the following approaches for persons with speech, hearing, or visual impairments when appropriate.

- The following specialized services may be appropriate for the facility:
  - TRS (711) service, which includes TTY and other support for relaying communication between people who have hearing or speech disabilities and use assistive technology with persons using standard telephones.
  - VRS, a video relay service, which provides relaying between people who use sign language and a person using standard video communication (smartphone) or phone communication.
- General considerations
  - Visual impairment: Provide qualified readers at the facility, information in large print, Braille, or audio recordings, as appropriate.
  - Hearing impairment: Provide qualified sign-language interpreters or written materials.
  - Speech disabilities: For general situations, have pencil and paper available, and in some circumstances, a qualified speech-to-speech transliterator.

2. What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?

**Low-income People, Racial and ethnic minorities, People who are eligible for or receive public benefits, People who do not have third-party insurance coverage or have inadequate third-party coverage:**

*Affordability and Financial Assistance*

The main recommendation from community stakeholders regarding these groups is affordability. This was framed as maintaining affordability after relocating.

Based on learnings from other projects, we also recommend that the Applicant periodically review its financial coordination and financial assistance programs with community stakeholders for ease of use and effectiveness.

Source:

Community Stakeholders

**People with Disabilities:**

*Maintain or Expand Capacity for a Higher Level of Care for persons with Psychiatric or Dementia Needs*

Community stakeholders stated that an important element of its current services was the Applicant's capacity for caring for persons with psychiatric and dementia needs. They noted that it would be beneficial to maintain or expand this capability in the new location. The Applicant indicated that they are planning on maintaining the service.

Source:

Community Stakeholders

**Older Adults:**

*Environmental Improvements*

Stakeholders viewed the new building as an opportunity to create environmental improvements to improve the quality of life. These included outdoor spaces such as gardens, sidewalks, and picnic-like areas for residents and their families. Other internal improvements were shared activity spaces, event areas for families, areas for religious activities, non-medical access to exercise space, and aquariums.

*Programmatic Enhancements*

Similarly to the environmental improvements, there were recommendations for many different kinds of programmatic enhancements. These included socialization activities, movement programs, and opportunities to interact with companion animals.

*Communication of Transition*

The ombudsman emphasized the development of a communication plan for residents and their families. They also noted that residents should have a clear understanding of what is happening with their possessions and that their possessions should be available to them immediately after relocating. The ombudsman requested that the communication plan be made available to them prior to the relocation.

Source:

Community Stakeholders

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?

As noted in Item 2, a communication plan made available to residents, family members, and the ombudsman should be used to engage and consult with stakeholders.

The Residents' Council that the Assessor remotely attended was active and engaged, and willing to discuss their ideas and thoughts about the future building.

4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

The facility and its proposed future location is in an area of Rockland County that has the highest poverty rates and is highly diverse racially and ethnically. The location is considered accessible, with the project having a minor positive impact on transportation accessibility. The facility provides a higher level of care for persons needing greater psychiatric services. Since Rockland County has unmet needs for skilled nursing facility beds, the project, by maintaining capacity in a diverse and relatively high poverty area, positively addresses equitable access. Through a new building, replacing a building over fifty years old, it potentially improves the quality of life for its residents.

#### **STEP 4 – MONITORING**

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?

The Applicant currently collects residents' racial and ethnic identification, religious affiliation, demographics, and insurance coverage. As with all New York State nursing homes, it participates in the New York State Nursing Home Quality Initiative. The Nursing Home Quality Initiative uses an extensive set of measures supported by CMS to evaluate multiple domains of nursing home quality.

2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

The quality data can be used to evaluate the project's overall impact after the relocation. In addition, the quality data can be subset by race, ethnicity, and gender to evaluate disparities among residents.

Based on the residents' race and ethnicity data reviewed for this assessment, there are opportunities to improve the standardization of the data and the methodology used for collection. For example, while this assessment's onsite survey found its sample of residents had a 20% identification as Hispanic or Latino, the resident census found only 4%. This is likely due to the ordering of the race and ethnicity questions and is a common problem.

We also recommend that the primary language spoken by the resident be routinely collected, if it is not already occurring.

## **STEP 5 – DISSEMINATION**

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

**OPTIONAL:** Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

**Disclaimer:**

This document was produced from raw data purchased from or provided by the New York State Department of Health (NYSDOH). However, the calculations, metrics, conclusions derived, and views expressed herein are those of the author(s) and do not reflect the conclusions or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.

Appendix 1: Figures

Primary Service Area: Race and Ethnicity by Zip Code

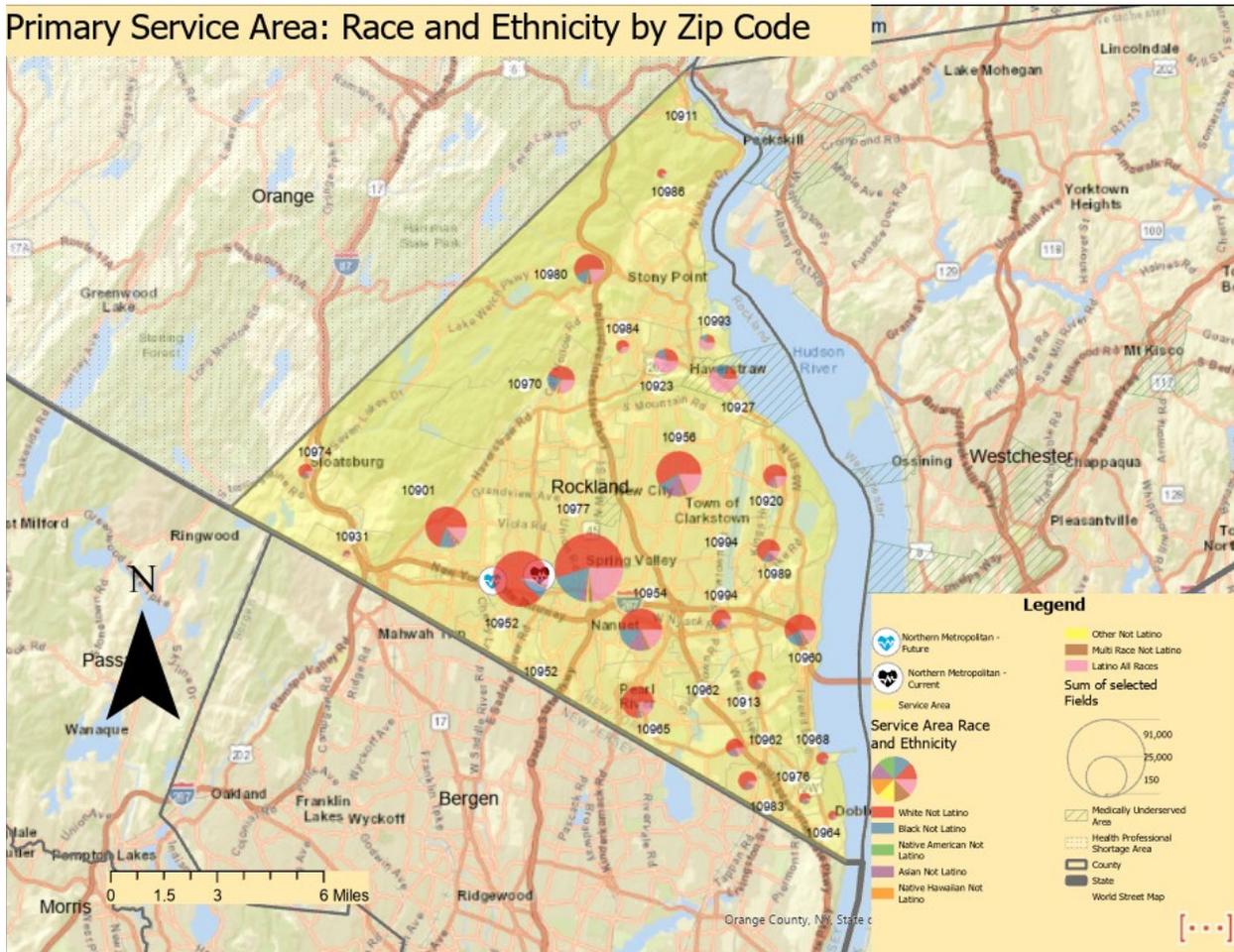


Figure 1 Primary Service Area: Race and Ethnicity by Zip Code

# Alternative Locations

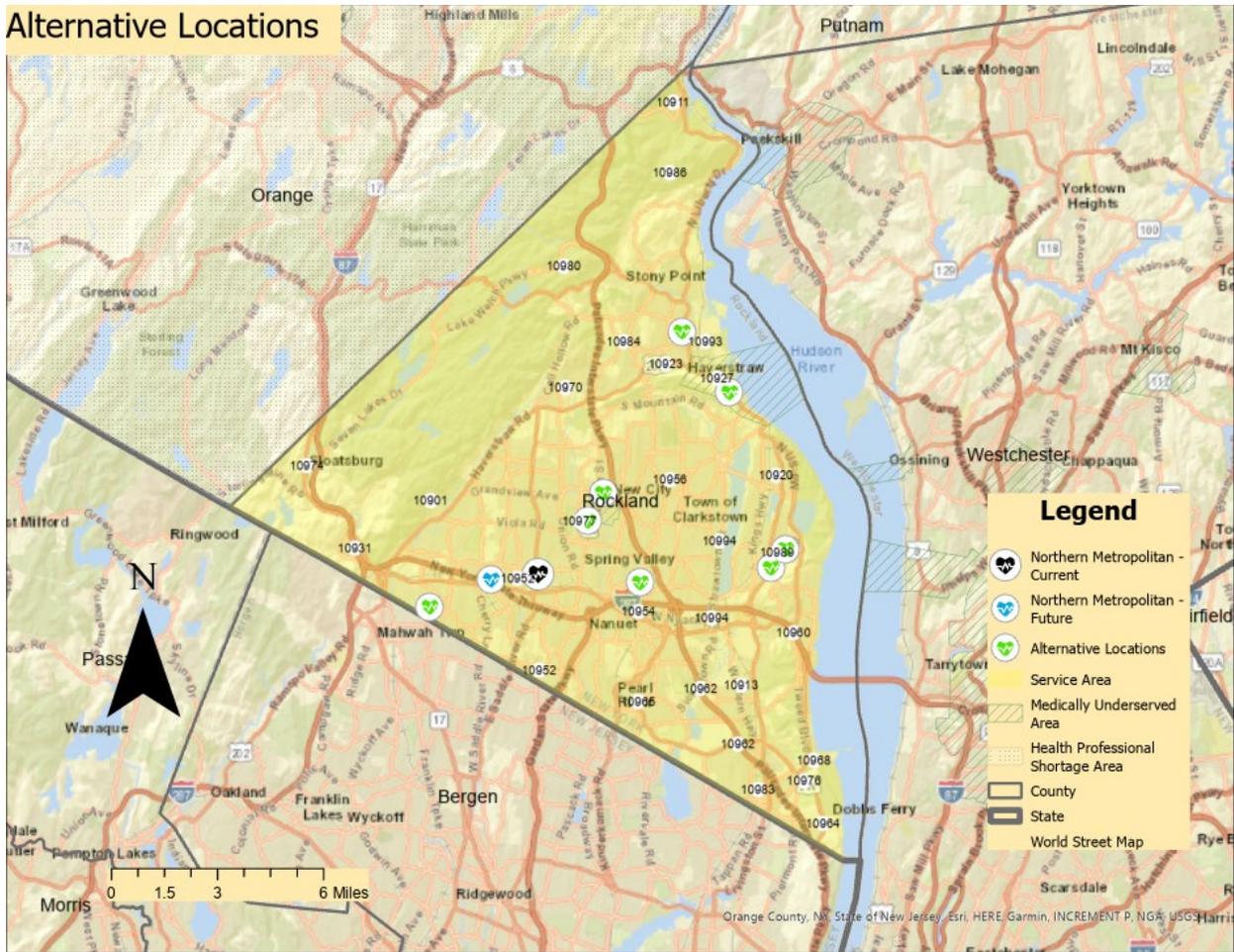


Figure 2 Alternative Locations

## Appendix 2

### Discussion Guide for Community Meaningful Engagement for HEIA Northern Metropolitan

#### Introduction:

- Welcome & Introductions
- Purpose of the Discussion: To gather Community insights on healthcare needs and the impact of planned changes. New York State wants to engage communities in health equity and involve them in the planning processes for healthcare services. The focus is on underserved groups and vulnerable people in the community.
- The Monroe Plan is an independent assessor

#### Background:

- Brief Overview of the planned changes:
  - MP CareSolutions is assessing the relocation of Northern Metropolitan, a skilled nursing facility, from 225 Maple Avenue, Monsey to 11 College Rd. In addition to the relocation, which is about 1.5 miles, the facility will be in a new building. The existing building is over fifty years old. The new location will be on a campus with assisted living and independent living facilities.
  - We like to understand the change in the context of community needs, particularly for underserved and vulnerable persons.
  - Stress the importance of community input in shaping healthcare services and considering ways that services can be improved.

#### Understanding Healthcare Needs:

Question 1: To set the context of the planned change, we want to hear your perspective on what are the greatest healthcare needs in this community for underserved communities?

- Encourage participants to share personal experiences and observations.
- Discuss common healthcare challenges in the community.

#### Impact Assessment

Question 2: What impacts should be considered with the move?

- Explore direct and indirect consequences on individuals within the community.
- Discuss impacts on access, quality, and affordability of healthcare services.

Question 3: Do you see any negative impacts to the community with these changes?

- Solicit ideas for mitigating negative effects.
- Discussion of potential strategies for improving the situation.

Question 4: Support Question: Do you support the move?

#### Improving Services:

Question 5: How might these services be enhanced to benefit underserved communities or vulnerable persons?

- To identify programs, interventions, or other services that may enhance the services.

#### Wrap-Up

- Summarize key insights and recommendations from the discussion.
- Thank participants.
- Explain next steps with the HEIA process including submission of a written statement.

#### Closing Remarks

- Provide contact information for follow-up questions and/or additional input.
- Note that they can submit a statement for inclusion in the Assessment.

### Consumer Questions for Health Equity Impact Assessment Northern Metropolitan Questionnaire

MP CareSolutions is assessing the possible future relocation in three or more years of Northern Metropolitan from 225 Maple Ave, Monsey, to 11 College Rd, Monsey. The new state-of-the-art building will have space for the same number of residents, and there will be no service changes. We want to understand how the relocation may affect persons who are residents at Northern Metropolitan or family, loved ones, or friends of residents. We are also interested in your thoughts on how Northern Metropolitan could be further enhanced.

1. Please indicate your agreement: I support the relocation of the Northern Metropolitan. *(Check one)*

Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. How might these changes affect you?

3. What is most important to you as a resident or loved one of a resident?

4. Would you like to make a statement about the relocation?

5. Can we include your statement in a publicly available assessment of the relocation of Northern Metropolitan?

No  
 Yes

(Please turn over for questions on the back .)

6. Are you Hispanic, Latino/a/x, or Spanish Origin? (Check one)

- No
- Yes

7. What is your race? (One or more categories may be selected)

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Other

8. Age in years? (Enter number)

\_\_\_\_\_

9. Gender? (check one)

- Female
- Male
- Transgender female
- Transgender male
- A gender identity not listed:

- \_\_\_\_\_
- Not sure
  - Prefer not to answer

Thank you for your time today answering these questions. If you would like to submit additional comments or statements, you may do so by sending an email to [mpheia@monroeplan.com](mailto:mpheia@monroeplan.com)

MP CareSolutions is a part of the Monroe Plan, which was founded in 1970 to provide innovative healthcare for the underserved in Upstate New York.

----- SECTION BELOW TO BE COMPLETED BY THE APPLICANT -----

**SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN**

*Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.*

**I. Acknowledgement**

I, GEDALIA KLEIN, attest that I have reviewed the Health Equity Impact Assessment for the Relocation and New Building that has been prepared by the Independent Entity, MP CareSolutions.

GEDALIA KLEIN

Name  
EXECUTIVE DIRECTOR

Title  


Signature  
4.25.25

Date

**II. Mitigation Plan**

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

**Northern Metropolitan Relocation and New Building: Mitigation Plan**

**Introduction**

This plan outlines how Northern Metropolitan will mitigate potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment (HEIA) for our relocation project from 225 Maple Ave to 11 College Rd, Monsey.

**Maintaining Affordability and Financial Accessibility**

- Commit to maintaining our current payor mix, with approximately 80% of residents receiving Medicaid benefits
- Conduct semi-annual reviews of financial coordination processes to ensure accessibility
- Develop clear materials about financial assistance programs for residents and families
- Establish an annual review with community stakeholders to evaluate financial accessibility programs

### **Preserving Specialized Care for Psychiatric and Dementia Needs**

- Maintain our locked unit with the same capacity in the new facility
- Incorporate evidence-based environmental design features that support residents with psychiatric and dementia needs
- Invest in staff training for best practices in dementia and psychiatric care

### **Comprehensive Relocation Communication Plan**

- Develop a communication plan that includes:
  - Written notices in multiple languages based on residents' primary languages
  - Materials appropriate for those with visual or cognitive impairments
  - Regular meetings and updates with residents and families beginning 6 months before relocation
  - Virtual and in-person tours of the new facility
- Share this plan with the Ombudsman before implementation
- Establish a dedicated contact person for relocation questions
- Create individualized plans for relocating each resident's possessions

### **Enhancing Language Access and Communication**

- Conduct assessment of residents' language needs based on Census data and our resident census
- Provide written communications in languages spoken by at least 80% of residents with limited English proficiency

- Implement language line services, TRS (711) service, VRS, and materials in accessible formats
- Train all staff on language access resources and assistive technologies
- Display information about interpreting services in multiple languages throughout the facility

### **Quality of Life Enhancements in New Facility Design**

- Incorporate resident-requested features into the new facility:
  - Accessible outdoor spaces
  - Dedicated spaces for family visits and events
  - Areas for religious activities
  - Non-medical exercise space
  - Shared activity spaces

### **Enhanced Programming and Services**

- Develop increased socialization activities with the adjacent independent and assisted living facilities
- Implement movement programs accessible to residents of all ability levels
- Create culturally and religiously appropriate programming for our diverse resident population
- Form a resident activities committee for ongoing input on programming

### **Transportation Accessibility**

- Evaluate transportation options for family members and visitors
- Explore partnerships with local transportation services to assist visitors without personal vehicles
- Provide clear transportation directions on our website and in facility communications

### **Ongoing Monitoring and Assessment**

- Standardize collection of resident demographic data, including race, ethnicity, and primary language
- Analyze quality data by demographic factors to identify and address potential disparities

- Conduct annual resident and family satisfaction surveys that include questions about accessibility
- Participate actively in the New York State Nursing Home Quality Initiative

### **Implementation Timeline**

- Immediate (0-9 months): Begin communication plan development and share with Ombudsman
- Short-term (9-18 months): Implement language access improvements and conduct resident focus groups
- Medium-term (1-3 years): Complete facility design with resident input and develop transportation partnerships
- Long-term (3-5 years): Complete relocation with individualized transition plans and conduct post-relocation assessment

Northern Metropolitan is committed to ensuring our relocation maintains and enhances access to care for all medically underserved groups. We will continuously monitor these impacts and adjust as needed to provide high-quality, accessible care to all residents, regardless of income, race, ethnicity, or ability.

*Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.*

# Attachment 1 - Board Resolution

**NORTHERN METROPOLITAN RESIDENTIAL HEALTH CARE FACILITY, INC.  
RESOLUTION**

The undersigned, being the Chair of the Board of Directors (the "Board") of Northern Metropolitan Residential Health Care Facility, Inc. (the "Corporation"), has obtained consent from all Board members to the following resolutions without a meeting:

RESOLVED, that the Board of the Corporation hereby approves construction of a new 120-bed residential health care facility, to be located at 11 College Road, Monsey, New York, to replace the existing 120-bed residential health care facility located at 225 Maple Ave., Monsey, New York; and be it further

RESOLVED, that the Board of Directors are hereby authorized and directed to prepare, execute and file all required documents with the appropriate government bodies and regulatory agencies as necessary to complete the transaction.

IN WITNESS WHEREOF, the undersigned has executed this consent on the 28th day of May 2025.



\_\_\_\_\_  
Jacob Tauber, Chair

# Attachment 2 - Bond Financing Letter of Interest

REDACTED

# Attachment 3 - Documentation of Site Control

# TOWN OF RAMAPO

BILL NO: 028512

TAX TYPE: Town  
 BILL DATE: 01/01/2025

FISCAL YR: 1/1/2025-12/31/2025  
 WARRANT DATE: 12/27/2024

PROPERTY DESCRIPTION	PROPERTY LOCATION	ASST ROLL YR	TAX AMOUNT DUE
TAX MAP #: 56.09-1-4.2	11 COLLEGE RD	2025	\$11,669.11
ACRES: 8.1 ac	<b>OWNER INFORMATION</b>		
CLASS: 311	FOUNTAINVIEW AT COLLEGE		
BANK:	ROAD, INC		
FULL MARKET VALUE: 1,288,659	C/O KLEIN GEDALIA		
ASSESSED VALUE: 100,000	2000 FOUNTAINVIEW DR		
UNIFORM PCT VALUE: 8.51%	MONSEY NY 10952		
IF PAYMENT IS MADE AFTER 01/31/2025 <b>YOU MUST PAY TAX AND PENALTY</b>			
INSTALLMENT SCHEDULE (5% Fee)			
<b>SCHEDULE</b>		<b>PAYMENTS</b>	
1st Due By 1/31/2025		3063.18	
2nd Due By 4/15/2025		3063.13	
3rd Due By 7/15/2025		3063.13	
4th Due By 10/15/2025		3063.13	
<b>2nd, 3rd, 4th pay to County Finance Dept</b>			

Levy Description	Total Tax Levy	% Change From Prior Year	Assessed Total Value	Assessed Taxable Value	Tax Rate	Tax Amount
UNINCORP TOWN	744,571	0	100,000	100,000	1.269521	\$126.95
TO OUT/HIGHWAY	5,827,498	0.7	100,000	100,000	9.936103	\$993.61
GENERAL TOWN	25,407,805	11.8	100,000	100,000	14.835279	\$1,483.53
TOWN POLICE	47,016,332	0.9	100,000	100,000	33.627407	\$3,362.74
**COUNTY	125,500,000	-2	100,000	100,000	27.794614	\$2,779.46
AMBULANCE DIST #1	\$2,600,000	-39.4%		100,000.00	1.435802	\$143.58
FIRE HYDRANTS	\$3,235,000	-0.9%		100,000.00	2.388737	\$238.87
GREEN WASTE	\$34,165,741	-5.1%		1.00	43.590002	\$43.59
RAMAPO GARBAGE	\$6,988,789	15.9%		100,000.00	11.216636	\$1,121.66
ROCKLAND GREEN	\$34,165,741	-5.1%		100,000.00	3.41056	\$341.06
SEWER RR TO	\$50,777,063	9.8%		100,000.00	4.637755	\$463.78
TALLMAN FD	\$2,108,400	3.5%		100,000.00	5.702798	\$570.28

Exemptions	Assessed Value Exempt	Full Value Exempt	<b>\$11,669.11</b>	<b>TOTAL AMOUNT DUE</b>
	0	0	<b>1/31/2025</b>	<b>DUE DATE</b>

To Avoid penalties, make sure your payment is delivered to the Tax Office by 01/31/2025.

PLEASE RETURN THIS PAGE AND INCLUDE TELEPHONE NUMBER W/ PAYMENT

FOUNTAINVIEW AT COLLEGE  
 ROAD, INC  
 C/O KLEIN GEDALIA  
 2000 FOUNTAINVIEW DR  
 MONSEY NY 10952

Parcel ID: 56.09-1-4.2  
 Bill Date: 01/01/2025  
 Fiscal Year: 1/1/2025-12/31/2025  
 Bill No.: 028512



Total Tax Due: \$11,669.11

028512200001166911601312025839268962

BILL NO: 028512

Please Make Checks Payable To : RECEIVER OF TAXES Tax Department  
237 ROUTE 59  
SUFFERN, NY 10901

Donna G. Silberman, County Clerk  
1 South Main St., Ste. 100  
New City, NY 10956  
(845) 638-5070

**Rockland County Clerk Recording Cover Sheet**

**Received From :**  
INFINITY LAND SERVICES LLC  
2361 NOSTRAND AVENUE  
SUITE 802  
BROOKLYN, NY 11210

**Return To :**  
INFINITY LAND SERVICES LLC  
2361 NOSTRAND AVENUE  
SUITE 802  
BROOKLYN, NY 11210

**Method Returned : SASE**

**First GRANTOR**

RAMAPO TOWN OF

**First GRANTEE**

FOUNTAINVIEW AT COLLEGE ROAD INC

**Index Type :** Land Records

**Instr Number :** 2021-00055424

**Book :** Page :

**Type of Instrument :** Deed

**Type of Transaction :** Deed Other

**Recording Fee:** \$336.00

**Recording Pages :** 9

The Property affected by this instrument is situated in Ramapo, in the County of Rockland, New York

**Real Estate Transfer Tax**

**RETT # :** 3993

**Deed Amount :** \$650,000.00

**RETT Amount :** \$0.00

**Total Fees :** \$336.00

**Transfer Tax Prepaid to New York State:** \$2,890.00

State of New York

County of Rockland

I hereby certify that the within and foregoing was recorded in the Clerk's office for Rockland County, New York

On (Recorded Date) : 12/31/2021

At (Recorded Time) : 11:05:00 AM



Doc ID - 055183771009

*Donna G. Silberman*  
Donna G. Silberman  
County Clerk



This sheet constitutes the Clerks endorsement required by Section 319 of Real Property Law of the State of New York

Entered By: NYROCKLANDUSER21 Printed On : 12/31/2021 At : 11:05:47AM

CONSULT YOUR LAWYER BEFORE SIGNING THIS INSTRUMENT—THIS INSTRUMENT SHOULD BE USED BY LAWYERS ONLY.

THIS INDENTURE, made the 16th day of December, in the year 2021

BETWEEN the Town of Ramapo, a Municipal Corporation with an address of 237 route 59, Suffern, NY 10901

party of the first part, and

© FOUNTAINVIEW AT COLLEGE ROAD, INC., with an address at 2000 Fountain View Dr, Monsey, NY 10952  
19 College Road, Monsey, NY 10952

party of the second part,

S 56.09  
b 1  
L 4.2

WITNESSETH, that the party of the first part, in consideration of

Ten Dollars (\$10.00) and other valuable consideration dollars paid by the party of the second part, does hereby grant and release unto the party of the second part, the heirs or successors and assigns of the party of the second part forever,

ALL that certain plot, piece or parcel of land, with the buildings and improvements thereon erected, situate, lying and being in the Town of Ramapo, County of Rockland, and State of New York and more particularly bounded and described in Schedule "A" attached. SAID premises being known as 11 College Road, Monsey, New York, 10952.

BEING AND INTENDED TO BE the same premises conveyed to the Town of Ramapo by Deed recorded in the Rockland County Clerk's Office as Document Number 2008-38073

TOGETHER with all right, title and interest, if any, of the party of the first part in and to any streets and roads abutting the above described premises to the center lines thereof; TOGETHER with the appurtenances and all the estate and rights of the party of the first part in and to said premises; TO HAVE AND TO HOLD the premises herein granted unto the party of the second part, the heirs or successors and assigns of the party of the second part forever.

AND the party of the first part covenants that the party of the first part has not done or suffered anything whereby the said premises have been encumbered in any way whatever, except as aforesaid.

AND the party of the first part, in compliance with Section 13 of the Lien Law, covenants that the party of the first part will receive the consideration for this conveyance and will hold the right to receive such consideration as a trust fund to be applied first for the purpose of paying the cost of the improvement and will apply the same first to the payment of the cost of the improvement before using any part of the total of the same for any other purpose. The word "party" shall be construed as if it read "parties" whenever the sense of this indenture so requires.

IN WITNESS WHEREOF, the party of the first part has duly executed this deed the day and year first above written.

IN PRESENCE OF:

\_\_\_\_\_

  
Michael B. Specht  
Town of Ramapo Supervisor

UNOFFICIAL



INFINITY  
TITLE INSURANCE COMPANY

as agent for Old Republic National Title Insurance Company

Title No: IL11595

### Schedule A (Legal Description)

Parcel A

ALL that certain plot, parcel and piece of land, situate, lying and being in the Hamlet of Tallman, Town of Ramapo, County of Rockland and State of New York, and being more particularly described as follows:

COMMENCING from a capped pin found at the southeast corner of Lot 1 of Tallman Terrace as recorded on Map No. 6587 of the Rockland County records of plats;

THENCE along the south line of said Tallman Terrace, S 67° 32' 30" W 363.95 feet to an iron pin set that the northeast corner of a parcel of land conveyed to American Tower Management, Inc. as recorded in instrument No. 2000-43448 of the Rockland County records of deeds and at the northwest corner of a parcel of land now or formerly owned by the Metropolitan Foundation for Health Care, said being the point of beginning of the parcel of land herein described;

THENCE along the west line of said Metropolitan Foundation for Health Care parcel of land, S 29° 40' 30" E 439.32 feet to an iron pin set;

THENCE continuing along the west line of said Metropolitan Foundation for Health Care parcel of land, S 06° 37' 37" W 193.47 feet to an iron pin set;

THENCE S 66° 30' 00" W 110.51 feet to an iron pin set;

THENCE S 29° 04' 50" E 171.59 feet to a concrete monument found on the north right of way line of the New York State Thruway, a variable width limited access public right of way;

THENCE along the north right of way line of said New York State Thruway N 73° 24' 11" W 931.99 feet to an iron pin set at the southeast corner of Lot 10 of said Tallman Terrace;

THENCE along the east line of said Lot No. 10 N 17° 21' 30" W 184.05 feet to an iron pin set;

THENCE along the south line of said Tallman Terrace N 65° 43' 30" E 623.00 feet to an iron pin set;

THENCE N 70° 29' 24" E 210.57 feet to the point of beginning and containing 10.1036 acres (440,112 square feet) of land.

EXCEPTING THE FOLLOWING DESCRIBED PARCEL OF LAND:

1052



as agent for Old Republic National Title Insurance Company

Title No: IL11595

ALL that certain plot, parcel and piece of land, situate, lying and being in the Hamlet of Tallman, Town of Ramapo, County of Rockland and State of New York, and being more particularly described as follows:

COMMENCING from a capped pin found at the southeast corner of Lot 1 of Tallman Terrace as recorded on Map No. 6567 of the Rockland County records of plats;

THENCE along the south line of said Tallman Terrace S 67° 32' 30" W 353.25 feet to an iron pin set at the northeast corner of a parcel of land conveyed to American Tower Management, Inc. as recorded in Instrument No. 2088-43448 of the Rockland County records of deeds;

THENCE along the east line of said American Tower Management parcel of land S 29° 40' 30" E 339.20 feet to a point;

THENCE along a line perpendicular to the east line of said American Tower Management parcel of land, S 60° 19' 30" W 117.23 feet to an iron pin set at the point of beginning of the parcel of land herein described;

THENCE S 40° 12' 33" W 257.52 feet to an iron pin set;

THENCE N 73° 24' 11" W 267.99 feet to an iron pin set;

THENCE N 40° 12' 33" E 418.84 feet to an iron pin set;

THENCE N 70° 29' 24" E 34.14 feet to an iron pin set;

THENCE S 29° 40' 30" E 243.17 feet to the point or place of beginning and

UNOFFICIAL

W.S.



INFINITY

as agent for Old Republic National Title Insurance Company

Title No: IL11595

Parcel B

ALL that certain plot, piece or parcel of land situate, lying and being in the Town of Ramapo, County of Rockland, State of New York, more definitely described as follows:

**BEGINNING** at a point on the northerly line of the lands of the New York State Thruway, said point also being 931.99 feet southeasterly on a course of South 73 degrees 24 minutes 11 seconds East from the dividing line between lands belonging now or formerly to Maria J. Wehrheim and Seventh Masonic District Associates, Inc. and from said point of beginning; running thence

1. North 29 degrees 04 minutes 00 seconds West 171.59 feet along the southeasterly line of lands now or formerly of American Telephone and Telegraph Company to a point; thence
2. North 66 degrees 30 minutes 00 seconds East 110.31 feet along the southeasterly line of lands now or formerly of American Telephone and Telegraph Company to a point; thence
3. South 5 degrees 17 minutes 37 seconds West 194.87 feet by a new line through lands now or formerly of Maria J. Wehrheim to the point or place of **BEGINNING**.

UNOFFICIAL

Insur



as agent for Old Republic National Title Insurance Company

Title No: IL11595

ACCESS AND UTILITY EASEMENT LEGAL DESCRIPTION (AS SURVEYED)

ALL that certain plot, parcel and piece of land, situate, lying and being in the Hamlet of Tallman, Town of Ramapo, County of Rockland and State of New York, and being more particularly described as follows:

COMMENCING from a capped pin found at the southeast corner of Lot 1 of Tallman Terrace as recorded on Map No. 8587 of the Rockland County records of plats;

THENCE along the south line of said Tallman Terrace, S 87° 32' 30" W 383.25 feet to an iron pin set that the northeast corner of a parcel of land conveyed to American Tower Management, Inc. as recorded in Instrument No. 2000-33448 of the Rockland County records of deeds, said point being the point of beginning of the parcel of land herein described;

THENCE along the east line of said American Tower Management parcel of land S 29° 40' 30" E 30.48 feet to a point;

THENCE S 70° 29' 24" W 24.16 feet to a point;

THENCE S 01° 33' 58" E 198.47 feet to a point;

THENCE N 29° 40' 30" W 105.25 feet to a point;

THENCE N 02° 27' 50" E 126.25 feet to a point on the south line of said Tallman Terrace;

THENCE along the south line of said Tallman Terrace N 70° 29' 24" E 52.00 feet to the point of beginning and containing 0.1991 acres (8,875 square feet) of land.

Being a part of the land conveyed to American Tower Management, Inc. as recorded in Instrument No. 2000-33448 of the Rockland County records of deeds.

ACCESS EASEMENT LEGAL DESCRIPTION (AS SURVEYED)

ALL that certain plot, parcel and piece of land, situate, lying and being in the Hamlet of Tallman, Town of Ramapo, County of Rockland and State of New

(15)



INFINITY

as agent for Old Republic National Title Insurance Company

Title No: IL11595

York, and being more particularly described as follows:

BEGINNING at point in the South right-of-way line of Olympia Lane, said point being 40.07 feet measured westerly along said south right-of-way line from the northeast corner of Lot 1 of Tallman Terrace as recorded on Map No. 65B7 of the Rockland County records of plats;

THENCE along the south line of said Olympia Lane S 79° 05' 30" E 40.07 feet to a point;

THENCE S 30° 38' 50" E 115.74 feet to a point;

THENCE S 67° 32' 30" W 363.25 feet to a point;

THENCE S 70° 28' 24" W 52.00 feet to a point;

THENCE N 22° 27' 30" W 27.33 feet to a point;

THENCE N 67° 32' 30" E 380.56 feet to a point;

THENCE N 30° 36' 50" W 108.85 feet to the point of place of BEGINNING

FOR INFORMATIONAL PURPOSES ONLY: 11 College Road, Monsey, NY 10952 a/k/a Section 56.09 Block 1 Lot 4.2 on the ROCKLAND County Tax Map.

For conveyancing only:

TOGETHER with all the right, title and interest of the party of the first part, of, in and to the land lying in the street in front of and adjoining said premises.

UNOFFICIAL

msn

INSTRUCTIONS(RP-5217-PDF-INS) www.orps.state.ny.us

FOR COUNTY USE ONLY

C1. SWIS Code 392689

C2. Date Deed Recorded 12/31/21

C3. Book 2021 C4. Page 55424

New York State Department of Taxation and Finance  
Office of Real Property Tax Services  
RP-5217-PDF  
Real Property Transfer Report (8/10)

**PROPERTY INFORMATION**

1. Property Location 11 College Road  
\*STREET NAME \*STREET NAME  
Ramapo \*CITY OR TOWN 10952 \*ZIP CODE  
\*VILLAGE

2. Buyer Name Fountainview at College  
\*LAST NAME/COMPANY \*FIRST NAME  
\*LAST NAME/COMPANY \*FIRST NAME

3. Tax Billing Address  
Indicate where future Tax Bills are to be sent if other than buyer address (bottom of form)  
\*STREET NUMBER AND NAME \*CITY OR TOWN \*STATE \*ZIP CODE

4. Indicate the number of Assessment Roll parcels transferred on the deed 1 # of Parcels OR  Part of a Parcel (Only if Part of a Parcel) Check as they apply:  
4A. Planning Board with Subdivision Authority Existing   
4B. Subdivision Approval was Required for Transfer   
4C. Parcel Approval for Subdivision with New Lots

5. Deed Property Size \*FRONT FEET X \*DEPTH OR \*ACRES 8.10  
Town of Ramapo

6. Seller Name \*LAST NAME/COMPANY \*FIRST NAME  
\*LAST NAME/COMPANY \*FIRST NAME

\*7. Select the description which most accurately describes the use of the property at the time of sale:  
C. Residential Vacant Land   
Check the boxes below as they apply:  
8. Ownership Type is Condominium   
9. New Construction on a Vacant Land   
10. Property located within Agricultural District   
10a. Buyer received a purchase notice indicating that the property is in an Agricultural District

**SALE INFORMATION**

11. Sale Contract Date 09/02/2021

\*12. Date of Sale/Transfer 12/16/2021

\*13. Full Sale Price 650,000.00  
(Full Sale Price is the total amount paid for the property including personal property. This payment may be in the form of cash, other property or services, or the assumption of mortgages or other obligations.) Please round to the nearest whole dollar amount.

14. Indicate the value of personal property included in the sale 0.00

Check one or more of these conditions as applicable to transfer:  
 A. Sale between Relatives or Former Relatives  
 B. Sale between Related Companies or Partners in Business  
 C. One of the Buyers is also a Seller  
 D. Buyer or Seller is Government Agency or Lending Institution  
 E. Deed Type not Warranty or Bargain and Sale (Specify Below)  
 F. Sale of Fractional or Less than Fee Interest (Specify Below)  
 G. Significant Change in Property Between Taxable Status and Sale Date  
 H. Sale of Business is Included in Sale Price  
 I. Other Unusual Factors Affecting Sale Price (Specify Below)  
 J. None  
 Comment(s) on Condition:

**ASSESSMENT INFORMATION - Data should mirror the latest Full Assessment Roll and Tax Bill**

15. Year of Assessment Roll from which interest began (YY) 21 \*17. Total Assessed Value 100,000

\*18. Property Class 31 \*19. School District Name Suffern CSD

\*20. Tax Map Identifier(s) (if more than four, attach sheet with additional identifier(s))  
56.09-1-1-2

**CERTIFICATION**

I certify that all of the information entered on this form are true and correct (to the best of my knowledge and belief) and I understand that the making of any willful false statement of material fact herein subject me to the provisions of the penal law relative to the making and filing of false instruments.

SELLER SIGNATURE [Signature] DATE 12/15/2021

BUYER SIGNATURE [Signature] DATE 12/16/21

BUYER CONTACT INFORMATION  
(Enter information for the buyer. Note: If Buyer is LLC, entity, association, corporation, and stock company, name of entity/firm is not an individual agent or fiduciary. Use a name and contact information of an individual responsible party who can answer questions regarding the transfer must be entered. Type as print clearly.)  
 LAST NAME KLEIN FIRST NAME GEORALIA  
 \*NYSID CODE 845 \*PHONE NUMBER (xx) xxx-xxxx 426-6757  
 \*ZIP CODE 2000 Fountainview, DC

# Attachment 4 - Monthly Cash Flow Analysis

Working Capital Needed - 2 Months of Year 3 Expenses	\$3,349,998
<b>Total:</b>	<b>\$3,349,998</b>

**Monthly Cash Flow Analysis - Year 1**

<b>Month</b>	<b>January</b>	<b>February</b>	<b>March</b>	<b>April</b>	<b>May</b>	<b>June</b>	<b>July</b>	<b>August</b>	<b>September</b>	<b>October</b>	<b>November</b>	<b>December</b>
Starting Cash	\$3,349,998	\$3,422,633	\$3,495,268	\$3,567,903	\$3,640,538	\$3,713,173	\$3,785,808	\$3,858,443	\$3,931,078	\$4,003,713	\$4,076,348	\$4,148,983
Monthly Revenue	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464	\$1,703,464
Monthly Expenses	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829	\$1,630,829
Remaining Cash	\$3,422,633	\$3,495,268	\$3,567,903	\$3,640,538	\$3,713,173	\$3,785,808	\$3,858,443	\$3,931,078	\$4,003,713	\$4,076,348	\$4,148,983	\$4,221,618

# Attachment 5 - Equity Analysis

REDACTED

# Attachment 6 - Proposed Financing Narrative

**Northern Metropolitan Residential Health Care Facility Inc**  
**Proposed Financing Narrative**

Northern Metropolitan Residential Health Care Facility Inc (Northern Metropolitan) is an existing 120-bed residential health care facility, with a 46-slot off-site Medical Model Adult Day Health Care Program, located at 225 Maple Avenue Monsey, New York 10952. Northern Metropolitan is seeking Department of Health approval to construct a new facility to replace the existing leased 120-bed facility. There will be no change in the certified bed capacity of the facility. The proposed replacement facility will be located at 11 College Road, Monsey, New York, 11091. Please refer to Attachment 3 for documentation of site control.

The total project cost related to construction of the replacement facility is \$80,146,555, \$75,000,000 of which will be funded through municipal bond financing procured by Northern Metropolitan Foundation for Healthcare, the sole corporate member of Northern Metropolitan, with the remaining balance of \$5,146,555 funded by Northern Metropolitan's existing equity. Please see Attachment 5 for the equity analysis, and Attachment 8 for recent financial statements.

# Attachment 8 - Financial Statements

REDACTED

# Attachment 9 - Medicaid Rate Sheets

New York State Department of Health  
 Bureau of Long Term Care Reimbursement  
 01/01/2025 Statewide Pricing Rate Computation Sheet

Opcert: 435330110

Name: Northern Metropolitan Residential Health Care Facility Inc

WEF Region: WESTCHESTER

Peer Group: -300 Beds NF Beds: 120

Nursing Home Statewide Price Summary Sheet

	Medicaid Rate	Medicaid Rate for Part B Eligible Patients	Medicaid Rate for Part D Eligible Patients	Medicaid Rate for Part B&D Eligible Patients
Nursing Home Price Calculation				
1 Facility Specific Non Comp Price (Schedule 1)	9.92	9.92	9.92	9.92
2 Statewide Direct Price	115.29	113.68	115.29	113.68
3 WEF Adjustment (Schedule 2)	0.9932	0.9932	0.9932	0.9932
4 Facility Case Mix Adjustment (Schedule 4)	1.4766	1.4766	1.4766	1.4766
5 WEF and Case Mix Adjusted Price	169.08	166.72	169.08	166.72
6 Statewide Indirect Price	57.18	57.18	57.18	57.18
7 WEF Adjustment (Schedule 2)	1.0026	1.0026	1.0026	1.0026
8 WEF Adjusted Indirect Price	57.33	57.33	57.33	57.33
9 Total Operating Component	236.33	233.97	236.33	233.97
10 DEM, BMI, TBI Per Diem Add Ons (Schedule 3)	4.40	4.40	4.40	4.40
11 Transition Adjustment				
12 Quality Adjustment (Schedule 5)				
13 Misc. Per Diem Adjustments	25.93	25.67	25.93	25.67
14 Adj Per PHL Section 2808(25)(C)	-0.55	-0.55	-0.55	-0.55
15 Adjustment to Cap Case Mix 5.0%				
16 Total Price	266.11	263.49	266.11	263.49
17 Capital Per Diem	28.04	28.04	28.04	28.04
18 Total Price + Capital Per Diem	294.15	291.53	294.15	291.53

New York State Department of Health  
Bureau of Long Term Care Reimbursement  
01/01/2025 Statewide Pricing Rate Computation Sheet

Opcert: 435330110

Name: Northern Metropolitan Residential Health Care Facility Inc

WEF Region: WESTCHESTER

Peer Group: -300 Beds NF Beds: 120

Non-Comparable Component Calculation  
Schedule 1

Non Comparable Component  
-----

Total Allowable Costs	390927
Total Patient Days	39420
-----	
Non Comparable Per Diem	9.92

Wage Equalization Factor Adjustment  
Schedule 2

Direct Wef Calculation  
-----

Regional Wef Adjustment	1.0671
50% of Regional Wef	0.533550
Facility Specific Wef Adjustment	0.9192
50% of Facility Specific Wef	0.459600
Final Blended Wef	0.9932

Indirect Wef Calculation  
-----

Regional Wef Adjustment	1.0356
50% of Regional Wef	0.517800
Facility Specific Wef Adjustment	0.9695
50% of Facility Specific Wef	0.484750
Final Blended Wef	1.0026

New York State Department of Health  
 Bureau of Long Term Care Reimbursement  
 01/01/2025 Statewide Pricing Rate Computation Sheet

Opcert: 435330110

Name: Northern Metropolitan Residential Health Care Facility Inc

WEF Region: WESTCHESTER

Peer Group: -300 Beds NF Beds: 120

Dementia, TBI, and BMI Addon Calculations  
 Schedule 3

Dementia Add On

-----

Total Dementia Patient Count	15
Rate Add On	8.00
Days in Year	365
Add On Total	43800
Medicaid Days	31147

-----

Per Diem Amount	1.41
-----------------	------

Traumatic Brain Injury Add On

-----

No Reported Data

Bariatric Add On

-----

Total BMI Patient Count	15
Rate Add On	17.00
Days in Year	365
Add On Total	93075
Medicaid Days	31147

-----

Per Diem Amount	2.99
-----------------	------

Current Medicaid Only Case Mix Calculation  
 Schedule 4

Current MDS Case Mix Total	335.80
Current MDS Case Mix Patients	250

-----

Facility Specific Case Mix	1.34
----------------------------	------

50% Peer Group/50% Statewide Case Mix	0.907504
---------------------------------------	----------

Facility Case Mix Adjustment	1.4766
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New York State Department of Health  
Bureau of Long Term Care Reimbursement  
01/01/2025 Statewide Pricing Rate Computation Sheet

Opcert: 435330110

Name: Northern Metropolitan Residential Health Care Facility Inc

WEF Region: WESTCHESTER

Peer Group: -300 Beds NF Beds: 120

Quality Adjustment

Schedule 5

Adjustment to Fund Quality Pool	0.00
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Quality Pool Award	0.00
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Total Quality Adjustment	0.00
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Jul 10 2023 11:52AM New York State Department of Health  
Office of Health Insurance Programs  
Division of Health Care Financing  
Bureau of Long Term Care Reimbursement  
01/01/2023 Current Facility MDS Summary All Payer

Opcert: 435330110

Name: Northern Metropolitan Residential Health Care Facility Inc

RUG III Category	Case Mix Index	Patient Count	Case Mix Total		RUG III Category	Case Mix Index	Patient Count	Case Mix Total
RUX	2.38	19.00	45.22	-	SSB	1.06	3.00	3.18
RUL	1.98	9.00	17.82	-	SSA	1.03	18.00	18.54
RVX	1.82			-	CC2	1.12	17.00	19.04
RVL	1.61			-	CC1	0.98	2.00	1.96
RHX	1.62			-	CB2	0.91	21.00	19.11
RHL	1.51			-	CB1	0.86	2.00	1.72
RMX	1.96	53.00	103.88	-	CA2	0.84	33.00	27.72
RML	1.74	21.00	36.54	-	CA1	0.77	9.00	6.93
RLX	1.34			-	IB2	0.80		
RUC	1.82	8.00	14.56	-	IB1	0.78	8.00	6.24
RUB	1.53	15.00	22.95	-	IA2	0.65		
RUA	1.37	14.00	19.18	-	IA1	0.61	7.00	4.27
RVC	1.53	2.00	3.06	-	BB2	0.70		
RVB	1.39	1.00	1.39	-	BB1	0.66		
RVA	1.15			-	BA2	0.55		
RHC	1.40	30.00	42.00	-	BA1	0.47		
RHB	1.27	4.00	5.08	-	PE2	0.80		
RHA	1.12			-	PE1	0.79	6.00	4.74
RMC	1.27	20.00	25.40	-	PD2	0.73		
RMB	1.22	20.00	24.40	-	PD1	0.72	8.00	5.76
RMA	1.17	27.00	31.59	-	PC2	0.67		
RLB	1.15			-	PC1	0.66		
RLA	0.91			-	PB2	0.57		
SE3	1.70	32.00	54.40	-	PB1	0.58	3.00	1.74
SE2	1.37	63.00	86.31	-	PA2	0.48		
SE1	1.15	2.00	2.30	-	PA1	0.46	10.00	4.60
SSC	1.12	8.00	8.96	-	BC1	0.46		

Case Mix Total 670.59

Total Patient Count 495.00

Case Mix Index 1.3547

Jul 10 2023 11:52AM New York State Department of Health  
Office of Health Insurance Programs  
Division of Health Care Financing  
Bureau of Long Term Care Reimbursement  
01/01/2023 Current Facility MDS Summary Medicaid Only

Opcert: 435330110

Name: Northern Metropolitan Residential Health Care Facility Inc

RUG III Category	Case Mix Index	Patient Count	Case Mix Total		RUG III Category	Case Mix Index	Patient Count	Case Mix Total
RUX	2.38	19.00	45.22	-	SSB	1.06		
RUL	1.98	9.00	17.82	-	SSA	1.03	4.00	4.12
RVX	1.82			-	CC2	1.12	10.00	11.20
RVL	1.61			-	CC1	0.98	1.00	0.98
RHX	1.62			-	CB2	0.91	12.00	10.92
RHL	1.51			-	CB1	0.86		
RMX	1.96	14.00	27.44	-	CA2	0.84	16.00	13.44
RML	1.74	4.00	6.96	-	CA1	0.77	6.00	4.62
RLX	1.34			-	IB2	0.80		
RUC	1.82	8.00	14.56	-	IB1	0.78	5.00	3.90
RUB	1.53	15.00	22.95	-	IA2	0.65		
RUA	1.37	14.00	19.18	-	IA1	0.61	6.00	3.66
RVC	1.53	1.00	1.53	-	BB2	0.70		
RVB	1.39	1.00	1.39	-	BB1	0.66		
RVA	1.15			-	BA2	0.55		
RHC	1.40	16.00	22.40	-	BA1	0.47		
RHB	1.27	2.00	2.54	-	PE2	0.80		
RHA	1.12			-	PE1	0.79	4.00	3.16
RMC	1.27	11.00	13.97	-	PD2	0.73		
RMB	1.22	9.00	10.98	-	PD1	0.72	5.00	3.60
RMA	1.17	13.00	15.21	-	PC2	0.67		
RLB	1.15			-	PC1	0.66		
RLA	0.91			-	PB2	0.57		
SE3	1.70	14.00	23.80	-	PB1	0.58	3.00	1.74
SE2	1.37	15.00	20.55	-	PA2	0.48		
SE1	1.15			-	PA1	0.46	10.00	4.60
SSC	1.12	3.00	3.36	-	BC1	0.46		
Case Mix Total			335.80					
Total Patient Count			250.00					
Case Mix Index			1.3432					

OFFICE OF HEALTH INSURANCE PROGRAMS  
 Base Costs and Prices Worksheet  
 COST REPORT BASE - Facility Reported - Dec 21 2010 8:21AM

2007 Nursing Home Cost Base

435330110: Northern Metropolitan Residential Health Care Facility Inc  
 DCN: 81720958V1

NF Freestanding Facility Non-Comparable Cost Per Diem Computation - By Cost Center  
 -----

Cost Center	Amount Reported	Adjustments	Amount Allowed	Trend Factor	Amount Allowed Trended	Trace-back %	Final Amount Allowed
31	35,366	0	35,366	1.0000	35,366	1.0000	35,366
34	35,460	0	35,460	1.0000	35,460	1.0000	35,460
37	26,760	0	26,760	1.0000	26,760	1.0000	26,760
41	42,712	42,600	112	1.0000	112	1.0000	112
106	0	-265,793	265,793	1.0000	265,793	0.8892	236,343
242	0	-56,886	56,886	1.0000	56,886	1.0000	56,886
Total Allowed Costs							390,927
Patient Days							39,420
Non-Comparable Per Diem prior to Ipafs							9.92

Cost Center Descriptions  
 -----

- 31 Laboratory Services
- 34 Radiology
- 37 Dental
- 41 Speech/Hearing Therapy
- 106 Constructed Cost Center
- 242 Constructed Cost Center

NEW YORK STATE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH SYSTEMS MANAGEMENT  
BUREAU OF LONG TERM CARE REIMBURSEMENT  
2025 SCHEDULE VI - PROPERTY

435330110: Northern Metropolitan Residential Health Care Facility Inc  
DCN: 42640850 ROCKLAND COUNTY  
Property Category: Proprietary Arms Length  
Rate Set: 2025 Nursing Home Consolidated Capital Jan.

	COST ACCT	FAC REPORTED	REL CO REPORTED	ADJ FAC COST	ADJ REL CO COST	ARMS LENGTH CEILING	ALLOW CAPITAL	TRACE- BACK PERCENT	REIMBUR CAPITAL
LINE #									
BLDG/FIXED EQUIPMENT:									
1	DEPRECIATION	0	0	613861	0	0	613861	0.9275	569356
2	INTEREST	0	0	0	0	0	0	1.0000	0
3	RENT	390000	0	390000	0	219000	219000	0.9275	203123
4	INSURANCE	26602	0	26602	0	0	26602	0.9064	24112
5	RETURN ON EQUITY	0	0	0	0	0	0	1.0000	0
6	RETURN OF EQUITY	0	0	0	0	0	0	0.9275	0
7	OTHER	0	0	0	0	0	0	0.0000	0
LAND/LEASEHELD IMPR:									
8	AMORTIZATION	613861	0	0	0	0	0	0.9275	0
9	INTEREST	0	0	0	0	0	0	1.0000	0
10	RENT	0	0	0	0	0	0	0.9275	0
11	OTHER	0	0	369277	0	0	369277	0.9391	346788
MOVEABLE EQUIPMENT:									
12	DEPRECIATION	62238	0	62238	0	0	62238	1.0000	62238
13	INTEREST	0	0	0	0	0	0	1.0000	0
14	RENT A	0	0	0	0	0	0	1.0000	0
15	RENT B	81544	0	81544	0	0	81544	0.9064	73911
16	RENT C	14939	0	14939	0	0	14939	0.9391	14029
17	RENT D	3500	0	3500	0	0	3500	0.8007	2802
18	RENT E	85335	0	85335	0	0	85335	1.0000	85335
19	RENT F	0	0	0	0	0	0	0.0000	0
20	RENT G	0	0	0	0	0	0	0.0000	0
21	RENT H	0	0	0	0	0	0	0.0000	0
22	RENT I	0	0	0	0	0	0	0.0000	0
23	RENT J	0	0	0	0	0	0	0.0000	0
24	RENT K	0	0	0	0	0	0	0.0000	0
25	RENT L	0	0	0	0	0	0	0.0000	0
26	RENT M	0	0	0	0	0	0	0.0000	0
27	RENT N	0	0	0	0	0	0	0.0000	0
28	RENT O	0	0	0	0	0	0	0.0000	0
29	RENT P	0	0	0	0	0	0	0.0000	0
30	RENT Q	0	0	0	0	0	0	0.0000	0
31	RENT R	0	0	0	0	0	0	0.0000	0
32	RENT S	0	0	0	0	0	0	0.0000	0
33	RENT T	0	0	0	0	0	0	0.0000	0
34	RENT U	0	0	0	0	0	0	0.0000	0
35	RENT V	0	0	0	0	0	0	0.0000	0
50	INSURANCE	0	0	0	0	0	0	0.0000	0
51	RETURN ON EQUITY	0	0	0	0	0	0	1.0000	0
52	OTHER	0	0	0	0	0	0	0.0000	0
53	MORTGAGE AMORT	0	0	0	0	0	0	0.9275	0
54	MORTGAGE INS	0	0	0	0	0	0	0.9275	0
55	REP/CONT RES	0	0	0	0	0	0	0.9275	0
56	HEALTH AGENC FEE	0	0	0	0	0	0	0.9064	0
57	MORTG EXP AMORT	0	0	0	0	0	0	0.0000	0
NON-TRENDED ITEMS:									
58	ORGN/START-UP	0	0	0	0	0	0	0.0000	0
59	SALES TAX	0	0	0	0	0	0	0.0000	0
60	OTHER	0	0	0	0	0	0	0.0000	0
61	WCI EXPENSE	0	0	0	0	0	0	0.0000	0
INCOME OFFSET:									
62	OTHER INTEREST	249011	0	0	0	0	0	1.0000	0
63	WCI	0	0	0	0	0	0	0.0000	0
64	OTHER	0	0	0	0	0	0	0.0000	0
TOTAL									1381694
TOTAL (95%)									1312609
TOTAL (ADDITIONAL 10% REDUCTION)									1181348
PATIENT DAYS									42127
PER DIEM									28.04

NEW YORK STATE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH SYSTEMS MANAGEMENT  
BUREAU OF LONG TERM CARE REIMBURSEMENT  
2025 SCHEDULE VI - PROPERTY

435330110: Northern Metropolitan Residential Health Care Facility Inc  
DCN: 42640850 ROCKLAND COUNTY  
Property Category: Proprietary Arms Length  
Rate Set: 2025 Nursing Home Consolidated Capital Jan.

C) AVERAGE EQUITY

	Facility	Rel Co 1	Rel Co 2	Rel Co 3	Total
-----					
REPORTED AVG EQUITY	9801426	0	0	0	9801426
DUE TO PAR/AFFIL (+)	0	0	0	0	0
DUE FROM PAR/AFFIL(-)	0	0	0	0	0
CERT OF DEP/INTRST(-)	0	0	0	0	0
CONSTR IN PROG (-)	0	0	0	0	0
GOODWILL (-)	29342	0	0	0	29342
OTHER (+ OR -)	0	0	0	0	0
					-----
Adjusted Average Equity					9772084
Net Investment					0
Remaining Equity					9772084

Remaining	*	Rate of Return	=	Equity
Equity				Returned
-----				
9772084		0.0000		0

NEW YORK STATE DEPARTMENT OF HEALTH  
OFFICE OF HEALTH SYSTEMS MANAGEMENT  
BUREAU OF LONG TERM CARE REIMBURSEMENT  
2025 SCHEDULE VI - PROPERTY - ADHC 1

435330110: Northern Metropolitan Residential Health Care Facility Inc  
DCN: 42640850 ROCKLAND COUNTY  
Property Category: Proprietary Arms Length  
Rate Set: 2025 Nursing Home Consolidated Capital Jan.

	COST ACCT	FAC REPORTED	REL CO REPORTED	ADJ FAC COST	ADJ REL CO COST	ARMS LENGTH CEILING	ALLOW CAPITAL	TRACE- BACK PERCENT	REIMBUR CAPITAL
LINE #									
BLDG/FIXED EQUIPMENT:									
1	DEPRECIATION	0	0	613861	0	0	613861	0.0684	41988
2	INTEREST	0	0	0	0	0	0	0.0000	0
3	RENT	390000	0	390000	0	219000	219000	0.0684	14980
4	INSURANCE	26602	0	26602	0	0	26602	0.0894	2378
5	RETURN ON EQUITY	0	0	0	0	0	0	0.0000	0
6	RETURN OF EQUITY	0	0	0	0	0	0	0.0684	0
7	OTHER	0	0	0	0	0	0	0.0000	0
LAND/LEASEHELD IMPR:									
8	AMORTIZATION	613861	0	0	0	0	0	0.0684	0
9	INTEREST	0	0	0	0	0	0	0.0000	0
10	RENT	0	0	0	0	0	0	0.0684	0
11	OTHER	0	0	369277	0	0	369277	0.0574	21196
MOVEABLE EQUIPMENT:									
12	DEPRECIATION	62238	0	62238	0	0	62238	0.0000	0
13	INTEREST	0	0	0	0	0	0	0.0000	0
14	RENT A	0	0	0	0	0	0	0.0000	0
15	RENT B	81544	0	81544	0	0	81544	0.0894	7290
16	RENT C	14939	0	14939	0	0	14939	0.0574	857
17	RENT D	3500	0	3500	0	0	3500	0.1993	698
18	RENT E	85335	0	85335	0	0	85335	0.0000	0
19	RENT F	0	0	0	0	0	0	0.0000	0
20	RENT G	0	0	0	0	0	0	0.0000	0
21	RENT H	0	0	0	0	0	0	0.0000	0
22	RENT I	0	0	0	0	0	0	0.0000	0
23	RENT J	0	0	0	0	0	0	0.0000	0
24	RENT K	0	0	0	0	0	0	0.0000	0
25	RENT L	0	0	0	0	0	0	0.0000	0
26	RENT M	0	0	0	0	0	0	0.0000	0
27	RENT N	0	0	0	0	0	0	0.0000	0
28	RENT O	0	0	0	0	0	0	0.0000	0
29	RENT P	0	0	0	0	0	0	0.0000	0
30	RENT Q	0	0	0	0	0	0	0.0000	0
31	RENT R	0	0	0	0	0	0	0.0000	0
32	RENT S	0	0	0	0	0	0	0.0000	0
33	RENT T	0	0	0	0	0	0	0.0000	0
34	RENT U	0	0	0	0	0	0	0.0000	0
35	RENT V	0	0	0	0	0	0	0.0000	0
50	INSURANCE	0	0	0	0	0	0	0.0000	0
51	RETURN ON EQUITY	0	0	0	0	0	0	0.0000	0
52	OTHER	0	0	0	0	0	0	0.0000	0
53	MORTGAGE AMORT	0	0	0	0	0	0	0.0684	0
54	MORTGAGE INS	0	0	0	0	0	0	0.0684	0
55	REP/CONT RES	0	0	0	0	0	0	0.0684	0
56	HEALTH AGENC FEE	0	0	0	0	0	0	0.0894	0
57	MORTG EXP AMORT	0	0	0	0	0	0	0.0000	0
NON-TRENDED ITEMS:									
58	ORGN/START-UP	0	0	0	0	0	0	0.0000	0
59	SALES TAX	0	0	0	0	0	0	0.0000	0
60	OTHER	0	0	0	0	0	0	0.0000	0
61	WCI EXPENSE	0	0	0	0	0	0	0.0000	0
INCOME OFFSET:									
62	OTHER INTEREST	249011	0	0	0	0	0	0.0000	0
63	WCI	0	0	0	0	0	0	0.0000	0
64	OTHER	0	0	0	0	0	0	0.0000	0
									-----
TOTAL									89387
TOTAL (95%)									84917
TOTAL (ADDITIONAL 10% REDUCTION)									76425

# Attachment 10 - Analysis of Net Patient Revenue

**Analysis of Net Patient Revenue**

**Current Year - RHCf**

Utilization % 95.7%

# of Beds 120

	Medicaid	Medicaid MC	Medicare	Medicare MC	Commercial	Private	Total
Patient Days	27,276	5,860	6,924	1,061	243	565	41,929
Average Daily Rates	\$319.49	\$297.87	\$976.11	\$475.22	\$448.47	\$482.87	
Revenue Received	\$8,714,357	\$1,745,547	\$6,758,599	\$504,210	\$108,977	\$272,822	\$18,104,512

**Year 1 - RHCf**

Projected Utilization % 98.0%

# of Beds 120

	Medicaid	Medicaid MC	Medicare	Medicare MC	Commercial	Private	Total
Patient Days	27,922	6,001	7,087	1,086	248	579	42,923
Rate	\$294.15	\$305.43	\$976.11	\$475.22	\$448.47	\$482.87	
Revenue	\$8,213,256	\$1,832,885	\$6,917,692	\$516,089	\$111,221	\$279,582	\$17,870,725
Incremental Change from Current Year	(\$501,101)	\$87,338	\$159,093	\$11,879	\$2,244	\$6,760	(\$233,787)

**Year 3 - RHCf**

Projected Utilization % 99.0%

# of Beds 120

	Medicaid	Medicaid MC	Medicare	Medicare MC	Commercial	Private	Total
Patient Days	28,207	6,062	7,159	1,097	251	585	43,361
Rate	\$294.15	\$305.43	\$976.11	\$475.22	\$448.47	\$482.87	
Revenue	\$8,297,089	\$1,851,517	\$6,987,971	\$521,316	\$112,566	\$282,479	\$18,052,938
Incremental Change from Current Year	(\$417,268)	\$105,970	\$229,372	\$17,106	\$3,589	\$9,657	(\$51,574)

**Analysis of Net Patient Revenue**

**Current Year - ADHCP**

Utilization %	44.0%
---------------	-------

# of Slots	46
------------	----

	Medicaid	Other	Total
Registrant Visits	6,669	3,770	10,439
Rate Billed	\$158.82	\$137.09	
Revenue Received	\$1,059,143	\$516,815	\$1,575,958

**Year 1 - ADHCP**

Projected Utilization %	50.0%
-------------------------	-------

# of Slots	46
------------	----

	Medicaid	Other	Total
Registrant Visits	7,641	4,319	11,960
Rate	\$134.37	\$139.18	
Revenue	\$1,026,721	\$601,118	\$1,627,839
Incremental Change from Current Year	(\$32,422)	\$84,303	\$51,881

**Year 3 - ADHCP**

Projected Utilization %	65.0%
-------------------------	-------

# of Slots	46
------------	----

	Medicaid	Other	Total
Registrant Visits	9,934	5,614	15,548
Rate	\$134.37	\$139.18	
Revenue	\$1,334,832	\$781,357	\$2,116,189
Incremental Change from Current Year	\$275,689	\$264,542	\$540,231

# Attachment 11 - Schedule of Depreciation

**Current Year Depreciation**

<b>Moveable Equipment - Other than Motor Vehicles</b>							
Year of Acquisition	Historical Cost	Salvage Value	Cost to be Depreciated	Accumulated Depreciation	Disposal of Assets	Rate (%)	Current Year Depreciation
Additions All Other Years	\$2,925,279		\$2,925,279	\$2,925,279		0.00%	
Preceding Year 5	2018	\$76,140	\$76,140	\$68,526		10.00%	\$7,614
Preceding Year 4	2019	\$50,701	\$50,701	\$35,490		20.00%	\$10,140
Preceding Year 3	2020	\$64,526	\$64,526	\$32,263		20.00%	\$12,905
Preceding Year 2	2021	\$68,023	\$68,023	\$24,165		23.68%	\$16,111
Preceding Year 1	2022	\$62,124	\$62,124	\$6,212		20.00%	\$12,425
Report Year Additions (sum of below):	\$30,433	\$0	\$30,433	\$0		10.00%	\$3,043
Over \$1,000,000			\$0			0.00%	
\$1,000,000 and Under	\$30,433		\$30,433	\$0		10.00%	\$3,043
<b>Moveable Equipment - Other than Motor Vehicles - TOTAL</b>							<b>\$62,238</b>

Current Year Total Depreciation **\$62,238**

**Year One Depreciation**

<b>Moveable Equipment - Other than Motor Vehicles</b>							
Year of Acquisition	Historical Cost	Salvage Value	Cost to be Depreciated	Accumulated Depreciation	Disposal of Assets	Rate (%)	Year One Depreciation
Additions All Other Years	\$3,001,419	\$0	\$3,001,419	\$3,001,419		0.00%	\$0
Preceding Year 5	2019	\$50,701	\$50,701	\$45,630		10.00%	\$5,071
Preceding Year 4	2020	\$64,526	\$64,526	\$45,168		20.00%	\$12,905
Preceding Year 3	2021	\$68,023	\$68,023	\$40,276		23.68%	\$16,111
Preceding Year 2	2022	\$62,124	\$62,124	\$18,637		20.00%	\$12,425
Preceding Year 1	2023	\$30,433	\$30,433	\$3,043		10.00%	\$3,043
Preceding Years	\$1,511,554	\$0	\$1,511,554	\$0		10.00%	\$151,155
<b>Moveable Equipment - Other than Motor Vehicles - TOTAL</b>							<b>\$200,710</b>

Year 1 Total Depreciation **\$200,710**

**Year Two Depreciation**

<b>Moveable Equipment - Other than Motor Vehicles</b>							
Year of Acquisition	Historical Cost	Salvage Value	Cost to be Depreciated	Accumulated Depreciation	Disposal of Assets	Rate (%)	Year Two Depreciation
Additions All Other Years	\$3,052,120	\$0	\$3,052,120	\$3,052,120		0.00%	\$0
Preceding Year 5	2020	\$64,526	\$64,526	\$58,073		10.00%	\$6,453
Preceding Year 4	2021	\$68,023	\$68,023	\$56,387		17.11%	\$11,636
Preceding Year 3	2022	\$62,124	\$62,124	\$31,062		20.00%	\$12,425
Preceding Year 2	2023	\$30,433	\$30,433	\$6,086		10.00%	\$3,043
Preceding Year 1	\$1,511,554	\$0	\$1,511,554	\$151,155		10.00%	\$151,155
<b>Moveable Equipment - Other than Motor Vehicles - TOTAL</b>							<b>\$184,712</b>

Year 2 Total Depreciation **\$184,712**

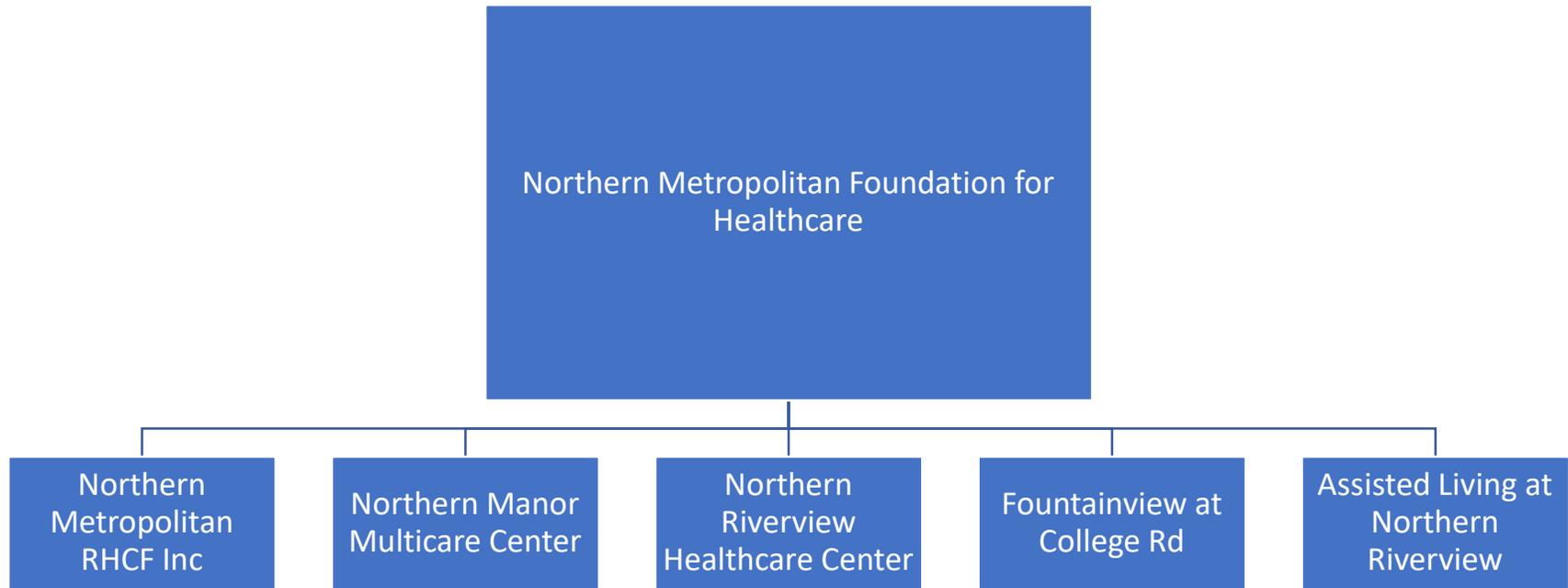
**Year Three Depreciation**

<b>Moveable Equipment - Other than Motor Vehicles</b>							
Year of Acquisition	Historical Cost	Salvage Value	Cost to be Depreciated	Accumulated Depreciation	Disposal of Assets	Rate (%)	Year Three Depreciation
Additions All Other Years	\$3,116,646	\$0	\$3,116,646	\$3,116,646		0.00%	\$0
Preceding Year 5	2021	\$68,023	\$68,023	\$68,023		0.00%	\$0
Preceding Year 4	2022	\$62,124	\$62,124	\$43,487		20.00%	\$12,425
Preceding Year 3	2023	\$30,433	\$30,433	\$9,129		10.00%	\$3,043
Preceding Year 2	\$1,511,554	\$0	\$1,511,554	\$302,310		10.00%	\$151,155
<b>Moveable Equipment - Other than Motor Vehicles - TOTAL</b>							<b>\$166,623</b>

Year 3 Total Depreciation **\$166,623**

# Attachment 13 – Organizational Chart

*Attachment 13 – Organizational Chart*



**Corporate Structure:** The Northern Metropolitan Foundation for Healthcare serves as the sole corporate member for all five affiliated entities, providing unified governance and strategic oversight.

# Northern Metropolitan Foundation for Healthcare and Affiliates

*Corporate Membership Structure*

## Northern Metropolitan Foundation for Healthcare

Sole Corporate Member

### **Northern Metropolitan RHC Inc**

*Healthcare Facility*

### **Northern Manor Multicare Center**

*Healthcare Facility*

### **Northern Riverview Healthcare Center**

*Healthcare Facility*

### **Fountainview at College Rd**

*Senior Care Facility*

### **Assisted Living at Northern Riverview**

*Senior Care Facility*

**Corporate Structure:** The Northern Metropolitan Foundation for Healthcare serves as the sole corporate member for all five affiliated entities, providing unified governance and strategic oversight.

Attachment 14 - Certificates of  
Incorporation and Amended and Restated  
Certificates of Incorporation

State of New York }  
Department of State }<sup>ss:</sup>

*I hereby certify that the annexed copy has been compared with the original document in the custody of the Secretary of State and that the same is a true copy of said original.*

Witness my hand and seal of the Department of State on FEB 23 1998



A handwritten signature in cursive script, appearing to read "J. L. ...", followed by a long horizontal line.

*Special Deputy Secretary of State*

CERTIFICATE OF INCORPORATION  
OF  
NORTHERN METROPOLITAN FOUNDATION FOR  
HEALTH CARE, INC.  
Under Section 402 of the Not-For-Profit  
Corporation Law

668823

IT IS HEREBY CERTIFIED THAT:

FIRST: The name of the corporation is NORTHERN METROPOLITAN FOUNDATION FOR HEALTH CARE, INC. (the "Corporation").

SECOND: The Corporation is a corporation as defined in subparagraph (a) (5) of Section 102 of the Not-For-Profit Corporation Law of the State of New York and shall be a Type B corporation under Section 201 of the said Law.

THIRD: The purposes for which the Corporation is formed are exclusively charitable, educational and scientific in nature within the meaning of Section 501 (c) (3) of the Internal Revenue Code of 1954, as the same may be amended from time to time, to

wit:

A. To receive and administer funds and to take and hold by bequest, devise, gift, grant, purchase, lease or otherwise, either absolutely or jointly or in any other manner or form with any other person, persons, or corporations, any property, real, personal, tangible, or intangible or any undivided interest therein, without limitation as to amount or value; to formulate, manage and control directly or indirectly other entities, firms, corporations and the like as may be deemed necessary or desirable to carry out the purposes of the Corporation; to sell, convey, or otherwise dispose of any property and to invest, reinvest or deal with the principal or the income thereof in such manner as in the judgment of the Corporation will best promote the purposes of the Corporation without limitation, except such limitations, if any, as may be contained in the instrument under which such property is received, this Certificate of Incorporation, the bylaws of the Corporation or any laws applicable thereto.

B. Without limiting the generality of the foregoing, the principal purposes of the Corporation shall include:

- (i) To solicit and receive grants, contracts and funds from federal, state and local government agencies, foundations or any

other sources, to further the corporate purposes.

(ii) To foster and promote health care education, research and advances in the health field and the growth and availability of quality health care services through direct grants, gifts, loans or otherwise to such person or persons, corporations or other organizations or entities determined by the Corporation to be engaged in activities or projects whose goals and purposes are consistent with those of this Corporation.

(iii) To coordinate and support activities of not-for-profit organizations engaged in health care activities for the betterment of the general health of the communities served by them.

(iv) To promote and advance relationships between health care institutions, health care providers and the communities they serve.

FOURTH (a): In furtherance of the foregoing purposes, the Corporation shall have all of the general powers enumerated in Section 202 of the Not-for-Profit Corporation Law together with the power to solicit grants and contributions for any corporate purpose and the power to maintain a fund or funds of real or personal property for any corporate purposes. The Corporation shall have the right to exercise such other powers as now are, or hereafter may be, conferred by law upon a corporation organized for the purposes hereinabove set forth or necessary or incidental to the powers so conferred, or conducive to the furtherance thereof, subject to the limitation and condition that, notwithstanding any other provision of this Article FOURTH, the Corporation shall not have the power to carry on any activity not permitted to be carried on by a corporation exempt from Federal income taxation under Section 501(c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

(b): In the event of dissolution, all of the remaining assets and property of the Corporation shall after necessary expenses thereof be distributed to such organizations as shall qualify under Section 501(c) (3) of the Internal Revenue Code 1954, as amended, subject to an order of a Justice of the Supreme Court of the State of New York.

(c): The Corporation shall distribute its income (if any) for each taxable year at such time and in such manner as not to subject it to tax under Section 4942 of the Internal Revenue Code of 1954; as amended, and the Corporation shall not (i) engage in any act of self-dealing as defined in Section 4941 (d) of the Code; (ii) retain any excess business holdings as defined in Section 4943 (c) of the Code; (iii) make any investments in such manner as to subject the corporation to tax under Section 4944 of the Code; or (iv) make any taxable expenditures as defined in Section 4945 (d) of the Code.

FIFTH: The Corporation shall be empowered to solicit funds from the public.

SIXTH: The Corporation is not formed for pecuniary profit or for financial gain and no part of its assets, income or profit shall be distributed to or inure to the benefit of any private individual. Reasonable compensation, however, may be paid for services rendered to or for the Corporation in furtherance of one or more of its purposes.

SEVENTH: Nothing herein shall authorize the Corporation, directly or indirectly, to engage in or include among its purposes any of the activities mentioned in Section 404 (b) through (u) of the Not-for-Profit Corporation Law and nothing

herein contained shall authorize the corporation to establish, operate, construct, lease or maintain a hospital as defined in Article 28 of the Public Health Law, or to provide hospital services or health related services, a drug maintenance program, a certified home health agency or a health maintenance organization, or to provide a comprehensive health services plan as defined in and covered by applicable sections of the Public Health Law.

EIGHTH: No substantial part of the activities of the Corporation shall be devoted to carrying on propaganda, or otherwise attempting to influence legislation, (except to the extent authorized by Internal Revenue Code 501(h) as amended, or the corresponding provision of any future United States Internal Revenue law, during any fiscal year or years in which the Corporation has chosen to utilize the benefits authorized by that statutory provision) and the Corporation shall not participate in or intervene (including the publishing or distributing of statements) in any political campaign on behalf of any candidate for public office.

NINTH: The Secretary of State is hereby designated as agent of the corporation upon whom process against it may be served. The Post Office address to which the Secretary shall mail a copy of any process against the corporation served his is:

Oscar Abraham  
225 Maple Avenue  
Monsey, New York 10952

TENTH: The Corporation shall have not less than three (3) directors no more than twenty-one (21) directors.

ELEVENTH: The Directors, until the first annual election at their address shall be:

Oscar Abraham, 225 Maple Avenue,  
Monsey, New York 10952

Joseph Grunwald, 225 Maple Avenue  
Monsey, New York 10952

Morris Klein, 225 Maple Avenue,  
Monsey, New York 10951

TWELFTH: The office of the Corporation is to be located in the County of Rockland, State of New York.

IN WITNESS WHEREOF, the undersigned incorporators, being  
at least 18 years of age, affirm that the statements made herein  
are true under the penalties of perjury:

DATED: March 3, 1986

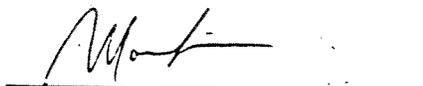
Oscar Abraham  
225 Maple Avenue  
Monsey, New York 10952

  
SIGNATURE

Joseph Grunwald  
225 Maple Avenue  
Monsey, New York 10952

  
SIGNATURE

Morris Klein  
225 Maple Avenue  
Monsey, New York 10952

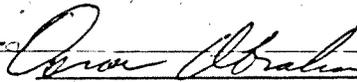
  
SIGNATURE

STATE OF NEW YORK )  
COUNTY OF NEW YORK )

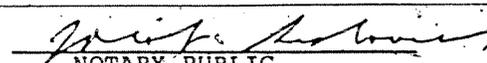
SS.:

OSCAR ABRAHAM, being duly sworn, states under penalty of perjury:

1. I am one of the subscribers to the foregoing Certificate of Incorporation; that all of the subscribers to said Certificate of Incorporation are of full age, citizens of the United States and residents of the State of New York. No previous application has been made to any Court or Justice or Judge thereof for an order approving said Certificate of Incorporation.

  
OSCAR ABRAHAM

Sworn to before me  
this 16 day of March, 1986

  
NOTARY PUBLIC

JACOB SICHOWICH  
NOTARY PUBLIC, STATE OF NEW YORK  
No. 24-1524313  
Qualified in Kings County  
Term Expires March 30, 1986

Attorney General

The undersigned has no objection to the granting of judicial approval hereon and waives statutory notice. *March 21, 1986*

Dated: 1986  
Attorney General,  
State of New York

THE UNDERSIGNED HAS NO OBJECTION  
TO THE GRANTING OF JUDICIAL  
APPROVAL HEREON AND WAIVES  
STATUTORY NOTICE.

By: \_\_\_\_\_  
Assistant Attorney General

ROBERT ABRAMS, ATTORNEY GEN.  
STATE OF NEW YORK

*by Howard Holt*

HOWARD HOLT  
Associate Attorney

Supreme Court

I, the undersigned Justice of the Supreme Court of the State of New York, of the Ninth Judicial District, in which the office of the Corporation is to be located, approve the foregoing Certificate of Incorporation of Northern Metropolitan Foundation for Health Care, Inc. and consent to its filing.

Dated: *APRIL 3, 1986*  
*NEW CITY, N.Y.*

*Robert R. Meehan*  
Acting Justice of the Supreme Court  
of the State of New York,  
Ninth Judicial District  
*HON. ROBERT R. MEEHAN*

STATE OF NEW YORK  
DEPARTMENT OF STATE

FILED JUN 11 1986

AMT. OF CHECK \$ 67.50  
FILING FEE \$ 50  
TAX \$ \_\_\_\_\_  
COUNTY FEE \$ \_\_\_\_\_  
COPY \$ 2.50  
CERT \$ \_\_\_\_\_  
REFUND \$ \_\_\_\_\_  
SPEC HANDLE \$ 12

BY: [Signature]  
FIVEB

CERTIFICATE OF INCORPORATION

OF

NORTHERN METROPOLITAN FOUNDATION FOR HEALTH CARE, INC.

Under Section 402 of the Not-for-Profit Corporation Law

0368825

12

FIVEB

743139

FILED BY: JACOB F. SUSLOVICH, ESQ.  
233 BROADWAY • SUITE 842  
NEW YORK, NEW YORK 10279  
(212) 732-9206

SMS/9  
6/2

NO. 11 9 11 11 11 11

FILED

2004 Amendment

FILING RECEIPT

=====

ENTITY NAME: NORTHERN METROPOLITAN FOUNDATION FOR HEALTH CARE, INC.

DOCUMENT TYPE: AMENDMENT (DOMESTIC NFP)  
PURPOSES PROCESS PROVISIONS

COUNTY: ROCK

SERVICE COMPANY: LIBERTY CORPORATE SERVICES, INC.

SERVICE CODE: AL

=====

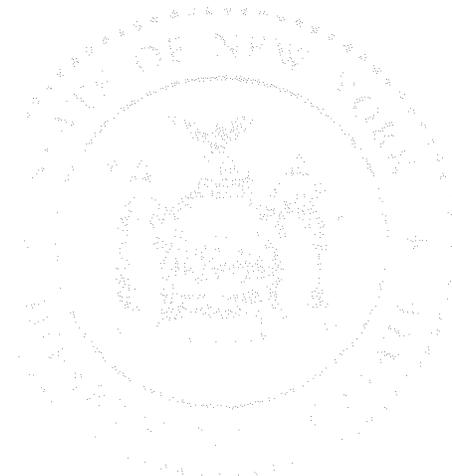
FILED:10/19/2004 DURATION:\*\*\*\*\* CASH#:041019000729 FILM #:041019000699

ADDRESS FOR PROCESS

-----  
THE CORPORATION  
C/O NORTHERN SERVICES GROUP  
MONSEY, NY 10952

INC., 12 COLLEGE ROAD

REGISTERED AGENT



=====

FILER	FEE	65.00	PAYMENTS	65.00
-----	----		-----	
	FILING	30.00	CASH	0.00
	TAX	0.00	CHECK	0.00
NIXON PEABODY LLP	CERT	0.00	CHARGE	0.00
437 MADISON AVENUE	COPIES	10.00	DRAWDOWN	65.00
	HANDLING	25.00	BILLED	0.00
NE WYORK, NY 10022			REFUND	0.00
			-----	

F041019000 699

**CERTIFICATE OF AMENDMENT  
OF THE  
CERTIFICATE OF INCORPORATION  
OF  
NORTHERN METROPOLITAN FOUNDATION FOR HEALTH CARE, INC.**

Under Section 803 of the Not-for-Profit Corporation Law

The undersigned, being the President and Secretary of Northern Metropolitan Foundation for Health Care, Inc. (the "Corporation"), respectively, in order to amend the Corporation's Certificate of Incorporation, certify that:

FIRST: The name of the Corporation is Northern Metropolitan Foundation for Health Care, Inc. The Corporation was formed under the name Northern Metropolitan Foundation for Health Care, Inc.

SECOND: The Certificate of Incorporation of the Corporation was filed by the Department of State of the State of New York on June 11, 1986, under Section 402 of the Not-for-Profit Corporation Law ("N-PCL").

THIRD: The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 of the N-PCL. The Corporation is a Type B corporation under Section 201 of the N-PCL, and after the amendment of its Certificate effect herein, the Corporation shall be a Type B corporation under Section 201 of the N-PCL.

FOURTH: The Certificate of Incorporation is hereby amended to effect the following:

(a) To amend Paragraph "THIRD," relating to purposes, presently reading in its entirety as follows:

"THIRD: The purposes for which the Corporation is formed are exclusively charitable, educational and scientific in nature within the meaning of Section 501(c)(3) of the Internal Revenue Code of 1954, as the same may be amended from time to time, to wit:

A. To receive and administer funds and to take and hold by bequest, devise, gift, grant, purchase, lease or otherwise, either absolutely or jointly or in any other manner or form with any other person, persons, or corporations, any property, real, personal, tangible, or intangible or any undivided interest therein, without limitation as to amount or value; to formulate, manage and control directly or indirectly other entities, firms, corporations and the like as may be deemed necessary or desirable to carry out the purposes of the Corporation; to sell, convey, or otherwise dispose of any property and to invest, reinvest or deal with the principal or the income thereof in such manner as in the judgment of the Corporation will best promote the purposes of the Corporation

1

- 2 -

without limitation, except such limitations, if any, as may be contained in the instrument under which such property is received, this Certificate of Incorporation, the bylaws of the Corporation or any laws applicable thereto.

B. Without limiting the generality of the foregoing, the principal purposes of the Corporation shall include:

- (i) To solicit and receive grants, contracts and funds from federal, state and local government agencies, foundations or any other sources, to further the corporate purposes.
- (ii) To foster and promote health care education, research and advances in the health field and the growth and availability of quality health care services through direct grants, gifts, loans or otherwise to such person or persons, corporations or other organizations or entities determined by the Corporation to be engaged in activities or projects whose goals and purposes are consistent with those of this Corporation.
- (iii) To coordinate and support activities of not-for-profit organizations engaged in health care activities for the betterment of the general health of the communities served by them.
- (iv) To promote and advance relationships between health care institutions, health care providers and the communities they serve."

(b) Paragraph THIRD is amended to read in its entirety as follows:

"THIRD: The Corporation is formed and shall be operated exclusively for the sole charitable purpose of benefiting, promoting and supporting, by gift or otherwise, the qualifying religious, charitable and educational activities conducted by or in connection with Chevira Liady Nusach Hoary ("Chevira Liady"), a religious organization, for so long as it qualifies as an exempt organization under Internal Revenue Code Sections 501(c)(3) and 509(a)(1) or (2), or corresponding section of any future federal tax code, regardless of the geographic location in which those activities are conducted.

More specifically, the Corporation is formed to receive and administer funds and to take and hold by bequest, devise, gift, grant, purchase, lease or otherwise, either absolutely or jointly or in any other manner or form with any other person, persons, or corporations, any property, real, personal, tangible, or intangible or any undivided interested therein, without limitation as to amount or

- 3 -

value; to formulate, manage and control directly or indirectly other entities, firms, corporations and the like as may be deemed necessary or desirable to carry out the purposes of the Corporation; to sell, convey, or otherwise dispose of any property and to invest, reinvest or deal with the principal or the income thereof in such manner as in the judgment of the Corporation will best promote the purposes of the Corporation without limitation, except such limitations, if any, as may be contained in the instrument under which such property is received, this Certificate of Incorporation, the bylaws of the Corporation or any laws applicable thereto.

Without limiting the generality of the foregoing, the principal purposes of the Corporation shall include:

- (i) To solicit and receive grants, contracts and funds from federal, state and local government agencies, foundations or any other sources, to further the corporate purposes.
  - (ii) To foster and promote the advancement and expansion of charitable education, elderly housing and health care through direct grants, gifts, loans or otherwise to such person or persons, corporations or other organizations or entities determined by the Corporation to be engaged in activities or projects whose goals and purposes are consistent with those of this Corporation.
  - (iii) To coordinate and support the charitable activities of the its Member, both within and without Rockland County, the State of New York and the United States.
  - (iv) To promote and advance relationships between its sole Member, health care institutions, health care providers and the communities they serve."
- (c) To insert a new paragraph FOURTH, with respect to the purpose provisions of paragraph THIRD above, to read in its entirety as follows and to renumber subsequent paragraphs:

"FOURTH: The Directors and officers of the Corporation shall carry out these purposes in accord with the teachings and laws of the Jewish religion to encourage broader and deeper religious observance of Orthodox Judaism. Further, the Directors and officers shall communicate regularly with the leadership of Chevira Liady and shall take other measures that may be appropriate to be fully apprised of the current and proposed activities of Chevira Liady. By so doing, it is expected that they will be best able to fulfill the Corporation's purposes in accord with the traditions of Mishne Holochos and the teachings of the Congregation Chevira Liady as communicated to them from time to time by its sole Member."

(d) To amend Paragraph NINTH relating to the address to which process may be served against the Corporation to:

"NINTH: The Secretary of State is hereby designated as agent of the Corporation upon whom process against it may be served. The Post Office address to which the Secretary shall mail a copy of any such process against the Corporation served is:

Northern Metropolitan Foundation for Health Care, Inc.  
c/o Northern Services Group, Inc.  
12 College Road  
Monsey, New York 10952"

(e) To omit Paragraph TENTH in its entirety relating to the number and election of directors pursuant to New York Not-for-Profit Corporation Law Section 805(c).

(f) To omit Paragraph ELEVENTH in its entirety setting forth the initial directors and officers of the Corporation pursuant to New York Not-for-Profit Corporation Law Section 805(c).

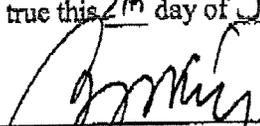
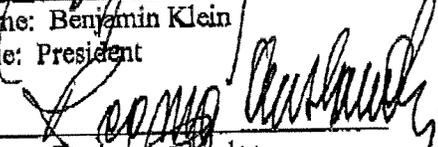
(g) To renumber subsequent paragraphs accordingly.

FIFTH: This Certificate of Amendment to the Certificate of Incorporation was authorized by unanimous written consent of the Board of Directors.

SIXTH: The Secretary of State is hereby designated as agent of the Corporation upon whom process against it may be served. The Post Office address to which the Secretary shall mail a copy of any such process against the Corporation served is:

Northern Metropolitan Foundation for Health Care, Inc.  
c/o Northern Services Group, Inc.  
12 College Road  
Monsey, New York 10952

IN WITNESS WHEREOF, we have made and subscribed this certificate and hereby affirm under the penalties of perjury that its contents are true this 27<sup>th</sup> day of July, 2004.

  
Name: Benjamin Klein  
Title: President  
  
Name: Regina Kuslander  
Title: Secretary

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The undersigned, a Justice of the Supreme Court of the State of New York for the 9th Judicial District, in which the office of the Corporation is to be located, hereby approves the foregoing Certificate of Amendment of the Certificate of Incorporation of Northern Metropolitan Foundation for Health Care, Inc.

Dated: October 6, 2004

*George M. Bergeman*  
Justice, Supreme Court

Hon GEORGE M. BERGEMAN, J.S.C.

THE ATTORNEY GENERAL HAS NO OBJECTION TO THE GRANTING OF JUDICIAL APPROVAL HEREON, ACKNOWLEDGES RECEIPT OF STATUTORY NOTICE AND DEMANDS SERVICE OF THE FILED CERTIFICATE. SAID NO OBJECTION IS CONDITIONED ON SUBMISSION OF THE MATTER TO THE COURT WITHIN 30 DAYS HEREAFTER.

*Andrew C. McCarty* 9.17.04  
ASSISTANT ATTORNEY GENERAL DATE

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CERTIFICATE OF AMENDMENT  
OF THE  
CERTIFICATE OF INCORPORATION  
OF  
NORTHERN METROPOLITAN FOUNDATION FOR HEALTH CARE, INC.

Under Section 803 of the Not-for-Profit Corporation Law

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STATE OF NEW YORK  
DEPARTMENT OF STATE

FILED OCT 19 2004

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Filed by:

Nixon Peabody LLP  
437 Madison Avenue  
New York, New York 10022  
Customer Reference# 2499

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2011 Amendment

***STATE OF NEW YORK***

***DEPARTMENT OF STATE***

I hereby certify that the annexed copy has been compared with the original document in the custody of the Secretary of State and that the same is a true copy of said original.



WITNESS my hand and official seal of the Department of State, at the City of Albany, on December 21, 2011.

A handwritten signature in black ink, appearing to read "Daniel E. Shapiro".

Daniel E. Shapiro  
First Deputy Secretary of State

111220000305

**CERTIFICATE OF AMENDMENT  
OF  
CERTIFICATE OF INCORPORATION  
OF  
NORTHERN METROPOLITAN FOUNDATION FOR HEALTH CARE, INC.**

Under Section 803 of the Not-For-Profit Corporation Law

The undersigned, being a Director of Northern Metropolitan Foundation for Health Care, Inc. (the "Corporation"), in order to amend the corporation's Certificate of Incorporation, certifies that:

**FIRST:** The name of the Corporation is Northern Metropolitan Foundation for Health Care, Inc.

**SECOND:** The Certificate of Incorporation of the Corporation was filed by the Department of State of the State of New York on June 11, 1986 under the New York Not-for-Profit Corporation Law ("N-PCL"). The name under which the Corporation was formed was Northern Metropolitan Foundation for Health Care, Inc.

**THIRD:** The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 of the Not-for-Profit Corporation Law. The Corporation is a Type B corporation under Section 201 of the Not-for-Profit Corporation Law, and after the amendment of its Certificate effected herein, the Corporation shall be a Type C corporation under Section 201.

**FOURTH:** The Corporation, organized and existing under the Not-for-Profit Corporation Law of the State of New York, hereby certifies as follows:

(a) Paragraph THIRD of the Certificate of Incorporation relating to the purposes of the Corporation is hereby amended to read as follows:

"The Corporation is formed and shall be operated exclusively for the sole charitable purpose of benefiting and supporting Northern Metropolitan, Inc., Northern Manor Multicare Center, Inc., Northern Riverview Health Care, Inc., Assisted Living at Northern Riverview, Inc., Fountainview at College Road, Inc., and other corporations of which the Corporation is the sole corporate member under Article 6 of the New York Not-for-Profit Corporation Law ("N-PCL") (provided, in each case, that such organization is qualified under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code") and is not a private foundation under Code Section 509(a)(1) or (a)(2)) (the "Supported Organizations"). More specifically the Company is formed to:

A. To receive and administer funds and to take and hold by bequest, devise, gift, grant, purchase, lease or otherwise, either absolutely or jointly or in any other manner or form with any other person, persons, or corporations, any property, real, personal, tangible, or intangible, or any undivided interest therein, without limitation as to amount or value, to formulate; manage and control directly or indirectly other entities, firms, corporations and the like as may be deemed necessary or desirable to carry out the purposes of the Corporation; to sell, convey, or otherwise dispose of any property and to

invest, reinvest or deal with the principal or the income thereof in such manner as in the judgment of the Corporation will best promote the purposes of the Corporation without limitation, except such limitations, if any, as may be contained in the instrument under which such property is received, this Certificate of Incorporation, the bylaws of the Corporation or any laws applicable thereto.

B. Without limiting the generality of the foregoing, the principal purposes of the Corporation shall include:

- (i) To solicit and receive grants, contracts and funds from federal, state and local government agencies, foundations or any other sources, to further the corporate purposes.
- (ii) To foster and promote health care education, research and advances in the health field and the growth and availability of quality health care services through direct grants, gifts, loans or otherwise to such person or persons, corporations or other organizations or entities determined by the Corporation to be engaged in activities or projects whose goals and purposes are consistent with those of this Corporation.
- (iii) To coordinate and support activities of not for profit organizations engaged in health care activities for the betterment of the general health of the communities served by them.

To promote and advance relationship between health care institutions, health care providers and the communities they serve.

C. To provide advice and assistance concerning long and short-range planning for, and monitor and provide advice and assistance to help coordinate the activities of the Supported Organizations in eliminating duplicative functions; provide management consulting assistance to the Supported Organizations to further improve and advance service delivery to the elderly resident population of Rockland County and cooperate with the Supporting Organizations in carrying out their charitable purposes; and doing and engaging in all activities that will further and are consistent with the foregoing purposes. In furtherance of its corporate purposes, the Corporation shall have all general powers enumerated in Section 202 of the N-PCL.

D. The lawful public or quasi-public objective which each business purpose will achieve is improving the quality and availability of health care services for the betterment of the general health of the community."

(b) Paragraph NINTH of the Certificate of Incorporation relating to the service of process of the Corporation is hereby amended to read as follows:

"The Secretary of State of the State of New York is hereby designated as the agent of the Corporation upon whom process in any action or proceeding against the Corporation may be served. The post office address to which the Secretary of State shall mail a copy of any such process so served is:

Northern Metropolitan Foundation for Health Care, Inc.

~~ADDRESS~~ 2000 FOUNTAINVIEW DR.  
MONSEY, NY 10952

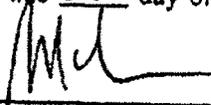
FIFTH: This amendment of the Certificate of Incorporation was authorized by a majority of the entire Board of Directors and by written consent of the members of the Corporation in lieu of a meeting.

SIXTH: The Secretary of State of the State of New York is hereby designated as the agent of the Corporation upon whom process in any action or proceeding against the Corporation may be served. The post office address to which the Secretary of State shall mail a copy of any such process so served is:

Northern Metropolitan Foundation for Health Care, Inc.

~~ADDRESS~~  
2000 FOUNTAINVIEW DRIVE  
MONSEY, NY 10952

IN WITNESS WHEREOF, we have made and subscribed this certificate and hereby affirm under the penalties of perjury that its contents are true this 22 day of SEPT, 2011.

  
Name: ~~EXECUTIVE DIRECTOR~~  
MORRIS KLEIN  
Title: EXECUTIVE DIRECTOR

The undersigned, a Justice of the Supreme Court of the State of New York for the 9th Judicial District, in which the office of the Corporation is located, hereby approves the foregoing Certificate of Amendment of the Certificate of Incorporation of Northern Metropolitan Foundation for Health Care, Inc.

Dated: <sup>13</sup>December 7, 2011  
White Plains, New York

  
Justice, Supreme Court  
OFAZIO R. BELLANTONI  
SUPREME COURT JUSTICE

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CERTIFICATE OF AMENDMENT  
OF  
CERTIFICATE OF INCORPORATION  
OF

METROPOLITAN FOUNDATION FOR HEALTH CARE, INC.

Under Section 803 of the New York Not-for-Profit Corporation Law

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STATE OF NEW YORK  
DEPARTMENT OF STATE  
FILED

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BY: J

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THE ATTORNEY GENERAL HEREBY APPEARS HEREIN,  
HAS NO OBJECTION TO THE GRANTING OF  
JUDICIAL APPROVAL HEREON, ACKNOWLEDGES  
RECEIPT OF STATUTORY NOTICE AND DEMANDS  
SERVICE OF ALL PAPERS SUBMITTED HEREIN  
INCLUDING ALL ORDERS, JUDGMENTS AND  
ENDORSEMENTS OF THE COURT. SAID NO OBJECTION  
IS CONDITIONED ON SUBMISSION OF THE MATTER  
TO THE COURT WITHIN 30 DAYS HEREAFTER.

Deborah A. Green  
ASSISTANT ATTORNEY GENERAL

11/17/11  
DATE

Filed by:

Nixon Peabody LLP  
1300 Clinton Square  
Rochester, New York 14604

Customer Ref. # 39418

FILING RECEIPT

ENTITY NAME: NORTHERN METROPOLITAN, INC.

DOCUMENT TYPE: AMENDMENT (DOMESTIC NFP)  
PROCESS PROVISIONS

COUNTY: NEWY

SERVICE COMPANY: LIBERTY CORPORATE SERVICES, INC.

SERVICE CODE: AL

FILED:08/09/2004 DURATION:\*\*\*\*\* CASH#:040809000612 FILM #:040809000583

ADDRESS FOR PROCESS

NORTHERN METROPOLITAN, INC., C/O NORTHERN SERVICES GROUP,  
INC. 12 COLLEGE ROAD  
MONSEY, NY 10952

REGISTERED AGENT



FILER	FEES		PAYMENTS	
-----	-----	65.00	-----	65.00
NIXON PEABODY LLP	FILING	30.00	CASH	0.00
437 MADISON AVENUE	TAX	0.00	CHECK	0.00
NEW YORK, NY 10022	CERT	0.00	CHARGE	0.00
	COPIES	10.00	DRAWDOWN	65.00
	HANDLING	25.00	BILLED	0.00
			REFUND	0.00
			-----	

State of New York }  
Department of State } ss:

*I hereby certify that the annexed copy has been compared with the original document filed by the Department of State and that the same is a true copy of said original.*

*Witness my hand and seal of the Department of State on*

**August 25, 2004**



A handwritten signature in black ink, appearing to read "John A. ...", is written over the printed name of the Secretary of State.

*Secretary of State*

F040809000583

**RESTATED  
CERTIFICATE OF INCORPORATION  
OF  
NORTHERN METROPOLITAN, INC.**

Under Section 805 of the Not-for-Profit Corporation Law

The undersigned, being the President and Secretary of Northern Metropolitan, Inc. ("the Corporation"), respectively, in order to amend and restate the Corporation's Certificate of Incorporation, certify that:

**FIRST:** The name of the Corporation is Northern Metropolitan, Inc. The Corporation was formed under the name Northern Metropolitan Residential Health Care Facility, Inc.

**SECOND:** The Certificate of Incorporation of the Corporation was filed by the Department of State of the State of New York on April 30, 1981 under Section 402 of the Not-for-Profit Corporation Law.

**THIRD:** The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 of the Not-for-Profit Corporation Law. The Corporation is a Type B corporation under Section 201 of the Not-for-Profit Corporation Law, and after the restatement of its Certificate effected herein, the Corporation shall be a Type B corporation under Section 201.

**FOURTH:** The Certificate of Incorporation is hereby amended to effect the following:

(a) To insert a new Paragraph FOURTH to read in its entirety and to renumber subsequent paragraphs:

"FOURTH: The Members, Directors and officers of the Corporation shall carry out these purposes in accord with the teachings and laws of the Jewish religion to encourage broader and deeper religious observance of Orthodox Judaism. Further, the Members, Directors and officers shall fulfill these purposes in accord with the traditions of Mishne Holochos and teachings of the Congregation Chevira Liady Nusach Hoary as presented from time to time to the Members, Directors and officers."

(b) To omit Paragraph SEVENTH in its entirety setting forth the initial directors and officers of the Corporation pursuant to New York Not-for-Profit Corporation Law Section 805(c).

(c) To amend Paragraph EIGHTH relating to the address to which process may be served against the Corporation to:

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- 2 -

"The Secretary of State is hereby designated as agent of the Corporation upon whom process against it may be served. The Post Office address to which the Secretary shall mail a copy of any such process against the Corporation served is:

Northern Metropolitan, Inc.  
c/o Northern Services Group, Inc.  
12 College Road  
Monsey, New York 10952"

(d) To renumber subsequent paragraphs accordingly.

FIFTH: The Corporation's Certificate of Incorporation is restated as amended herein to read as follows:

FIRST: The name of the corporation is Northern Metropolitan, Inc.

SECOND: That the Corporation is a corporation as defined in subparagraph (a)(5) of Section 102.

THIRD: The purposes for which the Corporation is formed are:

- a) To establish, and maintain a residential skilled nursing facility for sick, aged, infirm, disabled or any other classes of people requiring the services of such a facility, pursuant to establishment certification and/or licensure by the appropriate regulatory agencies having jurisdiction over premises operated for such purposes.
- b) To do any other act or thing incidental to or connected with the foregoing purposes or in advancement thereof, but not for the pecuniary profit or financial gain of its members, directors, or officers except as permitted under Article 5 of the Not-for-Profit Corporation Law.

FOURTH: The Members, Directors and officers of the Corporation shall carry out these purposes in accord with the teachings and laws of the Jewish religion to encourage broader and deeper religious observance of Orthodox Judaism. Further, the Members, Directors and officers shall fulfill these purposes in accord with the traditions of Mishne Holochos and teachings of the Congregation Chevira Liady Nusach Hoary as presented from time to time to the Members, Directors and officers.

FIFTH: The type of corporation it shall be under Section 201 of the Not-for-Profit Corporation Law is Type B.

SIXTH: The office of the Corporation is to be located in the City of New York, County of New York, State of New York.

SEVENTH: The territory in which the operations of the corporation will principally be conducted is Rockland County, New York.

EIGHTH: The Secretary of State is hereby designated as agent of the Corporation upon whom process against it may be served. The Post Office address to which the Secretary shall mail a copy of any such process against the Corporation served is:

Northern Metropolitan, Inc.  
c/o Northern Services Group, Inc.  
12 College Road  
Monsey, New York 10952"

NINTH: That prior to delivery to the Department of State for filing all approvals or consents required by the Not-for-Profit Corporation Law or any other statute will be endorsed upon or annexed to this Certificate of Incorporation.

TENTH: No part of the net earning of the corporation shall insure to the benefit of or be distributed to its members, trustees, officers or any other private persons except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article THIRD thereof.

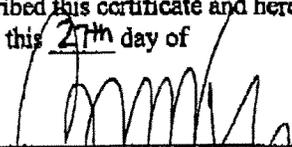
ELEVENTH: No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in (including the publishing or distribution of statements) any political campaign on behalf of any candidate for public office. Notwithstanding any other provision of these Articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 401(c)(3) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law) or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code of 1954 (or the corresponding provision of any future United States Internal Revenue Law).

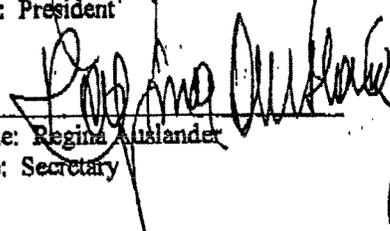
TWELFTH: In the event of liquidation, dissolution, or winding up of the Corporation, whether voluntary or involuntary or by operation of law, all of the remaining assets and property of the Corporation shall after necessary expenses thereof be distributed to Northern Metropolitan Foundation for Health Care, Inc. and/or its tax-exempt affiliates, provided that they shall then qualify under Section 501(c)(3) of the Internal Revenue Code of 1986 (as now in effect or may hereafter be amended) (the "Code"). If none of them shall so qualify, then the distribution shall be made to one or more organizations which are then qualified under Section 501(c)(3) of the Code to be used in such manner as in the judgment of a Justice of the Supreme Court of the State of New York will best accomplish the general purposes of which this Corporation was formed.

SIXTH: This Restated Certificate of Incorporation was authorized by unanimous written consent of the Board of Directors and by written consent of the sole member of the Corporation, Northern Services Group, Inc.

- 4 -

IN WITNESS WHEREOF, we have made and subscribed this certificate and hereby affirm under the penalties of perjury that its contents are true this 27<sup>th</sup> day of JULY, 2004.

  
Name: Benjamin Klein  
Title: President

  
Name: Regina Auslander  
Title: Secretary

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RESTATED  
CERTIFICATE OF INCORPORATION  
OF  
NORTHERN METROPOLITAN, INC.

Under Section 805 of the New York Not-for-Profit Corporation Law

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STATE OF NEW YORK  
DEPARTMENT OF STATE

FILED AUG 09 2004

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BY:           

*New York*

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DRAWDOWN - #AL

Filed by:

Nixon Peabody LLP  
437 Madison Avenue  
New York, New York 10022

Customer Reference# 1688

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