

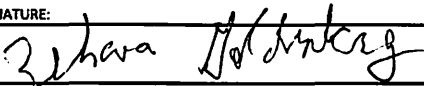
# New York State Department of Health Certificate of Need Application

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: **Care365 LLC**

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 5-11-2023
PRINT OR TYPE NAME Zehava Goldenberg	TITLE Manager/Member

## 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 type="checkbox"/> NO <input checked="" type="checkbox"/>	Sch_1_Attachment
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		
	Shloime Reichman		Free & Rye LLC		
	BUSINESS STREET ADDRESS				
	1052 55 <sup>th</sup> Street				
	CITY		STATE	ZIP	
	Brooklyn		NY	11219	
	TELEPHONE		E-MAIL ADDRESS		
929-430-5040 ext. 701		shloime@freerye.com			

Alternate Contact	NAME AND TITLE OF CONTACT PERSON		CONTACT PERSON'S COMPANY		
	Zehava Goldenberg		Care365, LLC		
	BUSINESS STREET ADDRESS				
	1 Main Street				
	CITY		STATE	ZIP	
	Monsey		NY	10952	
	TELEPHONE		E-MAIL ADDRESS		
845-371-7200		goldsbv@gmail.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		
	Zehava Goldenberg, CEO		
	BUSINESS STREET ADDRESS		
	1 Main Street		
	CITY	STATE	ZIP
	Monsey	NY	10952
	TELEPHONE		E-MAIL ADDRESS
845-371-7200		goldsbv@gmail.com	

The applicant's lead attorney should be identified:

<b>ATTORNEY</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	James E. Dering		Garfunkel Wild	111 Great Neck Road, Suite 600
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS
	Great Neck, NY 11021		518-242-7582	jdering@garfunkelwild.com

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

<b>CONSULTANT</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	Shloime Reichman		Free & Rye LLC	1052 55 <sup>th</sup> Street
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS
	Brooklyn, NY 11219		929-430-5040 ext. 701	shloime@freerye.com

The applicant's lead accountant should be identified:

<b>ACCOUNTANT</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	Joseph Gliksman		J. Gliksman CPA PC	5417 18th Ave
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS
	Brooklyn, NY 11204		718-234-8181	yg@bgcpa.com

Please list all Architects and Engineer contacts:

<b>ARCHITECT and/or ENGINEER</b>	NAME		FIRM	BUSINESS STREET ADDRESS
	Rob Bernstein		BILD Architecture	501 Chestnut Ridge Rd, Suite 301
	CITY, STATE, ZIP		TELEPHONE	E-MAIL ADDRESS
	Chestnut Ridge, NY 10977		212-381-0670	rob@bildny.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 type="checkbox"/> No <input checked="" type="checkbox"/>
Diagnostic and Treatment Center	DTC	Yes <input checked="" type="checkbox"/> No <input 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:

Facility Type	Facility Name	Operating Certificate or License Number	Facility ID (PFI)
Diagnostic and Treatment Center	Care365, LLC	4353205R	15293

### 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.

Facility Type	Name	Address	State/Country	Services Provided
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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.

## **Care365 LLC**

### Schedule 01 Attachments

- Attachment A – Member Resolution
- Attachment B – Project Narrative

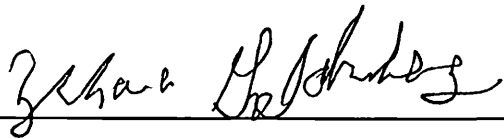
**CARE365, LLC**

**MEMBER RESOLUTION**

RESOLVED, that Care365, LLC's (the "Center") management is hereby authorized to submit a Certificate of Need Application to establish an Article 28 diagnostic and treatment center extension to be located at 112 Route 202, Pomona, NY 10970.

Management is authorized to undertake all tasks necessary in working toward this approval.

Approval certified by:



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Zehava Goldenberg, Sole Member

5-11-2023

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Date

## CARE365 II

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### PROJECT NARRATIVE

#### PROPOSAL

Care365 LLC, (the “Center”) is submitting this application for administrative review – full construction, with the purpose of establishing an extension of its current Article 28 clinic (PFI #15293). The current clinic is located at 1 Main Street, Monsey, (Rockland County) NY, 10952. The proposed extension (“Care365 II” or “Extension Clinic”) will be located at 1633 Route 202, Pomona (Rockland County) NY, 10970 (approximately seven miles north from the existing facility), and will provide primary medical care and specialty medical services (to be certified for “Medical Services – Primary Care” and “Medical Services – Other Medical Specialties”) for the residents of Pomona, NY and surrounding areas.

#### BACKGROUND

Zehava Goldenberg, the sole member of Care365, LLC, has spent the first 25 years of her career working as a Medicaid Coordinator in a nursing home, assisting patients and their families to ensure admission and proper coverage for medical care. In 2019, she submitted an application for establishment of an Article 28 Clinic at 1 Main Street, Monsey, Rockland County NY 10952, which was approved by the PHHPC.



Figure 1 Care365 Reception area at its flagship D&TC at 1 Main Street, Monsey (Rockland County)

According to the Rockland County Community Health Improvement Plan 2019 - 2021<sup>1</sup>, Rockland is the smallest county by area and the third most dense in the state, outside of New York City. The most recent population estimates from 2018 indicates that Rockland County grew by 4.3% between 2010 and 2017. The statewide growth rate over the same period was 2.2%. Between 2010 and 2017, all five Rockland County towns increased in number, with the majority of growth in the Town of Ramapo at 6.2%.

Within Monsey (a hamlet in the Town of Ramapo) there is a large population of Hasidic Orthodox Jews, which has recently been extending northward into neighboring Wesley Hills and Pomona. Pomona has seen a 16.95% growth rate since 2020<sup>2</sup>.

With the local population growing and spreading out, the applicant realized the need to expand Care365 to serve additional neighboring areas. A suitable location for an extension clinic was found at 1633 Route 202, Pomona NY 10970. The proposed Extension Clinic will serve the population in Pomona as well as surrounding areas including Northern Monsey and New Square among others.

The medical director of the extension will be Dr. Seth Kurtz, who also serves as director of the flagship center. Please refer to Dr. Kurtz's CV (Schedule 13 Attachment) for additional information on his experience and expertise.

The proposed Center is a newly renovated 5,333 square foot space within a strip mall with direct access to the street (Route 202). The proposed Center will have nine exam rooms, one treatment room, and an x-ray room. It has been designed in accordance with the FGI guidelines. Construction to make the site of the D&TC Article-28 compliant has been performed by Zehava Goldenberg, prior to DOH approval of this project and at its own risk.

The Center already has a Transfer and Affiliation Agreement with Montefiore Nyack Hospital under which Care365 refers patients to the hospital for services including general medical/surgical hospitalizations; tertiary level of care; obstetrical services; cardiac diagnostic testing; emergency room services; laboratory services; and more. This Affiliation Agreement will cover the Extension as well.

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<sup>1</sup> [https://www.montefiorenyack.org/sites/default/files/health\\_works/Community-assessments/Rockland%20County\\_LHD\\_Hospital\\_CHIP\\_2019\\_2021.pdf](https://www.montefiorenyack.org/sites/default/files/health_works/Community-assessments/Rockland%20County_LHD_Hospital_CHIP_2019_2021.pdf)

<sup>2</sup> <https://worldpopulationreview.com/us-cities/pomona-ny-population>

## POPULATION CHARACTERISTICS

Pomona is a village partly in the town of Ramapo and partly in the town of Haverstraw in Rockland County, New York, United States. Its zip code is 10970 which is this project's Primary Service Area (PSA).

Ramapo, a town in Rockland County, consists of several villages and hamlets including Monsey, Airmont, Suffern, Pomona, Viola, New Square, New Hempstead, and others.

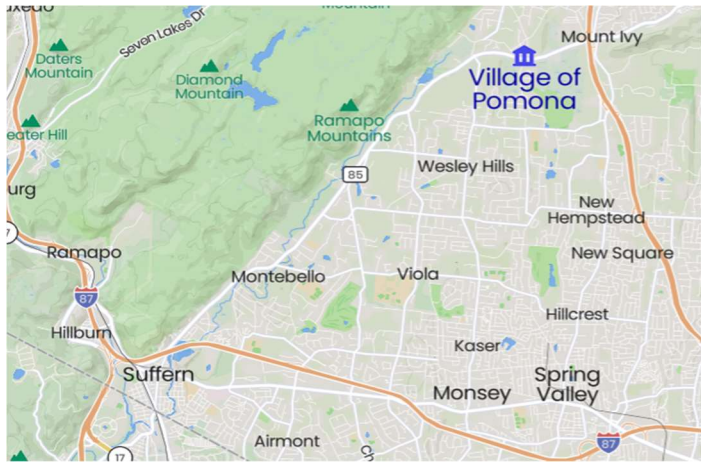


Figure 2 The Village of Pomona and surrounding villages in Ramapo

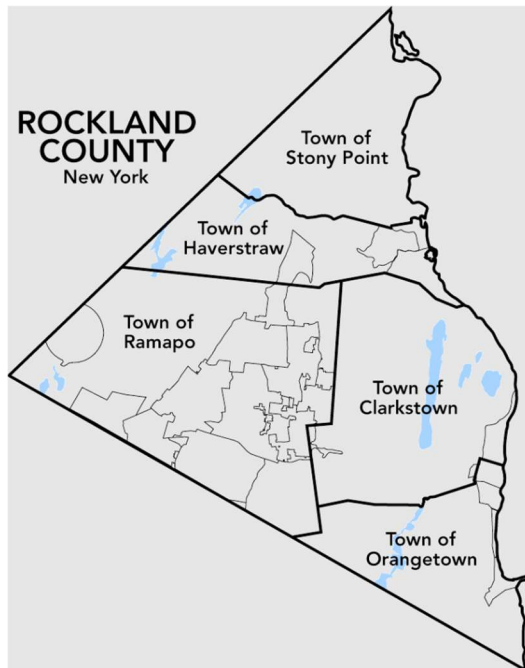


Figure 3 The Five Towns of Rockland County

The PSA has a population of 11,449. The largest racial/ethnic groups are White (53.3%) followed by Hispanic or Latino (26.3%) and then by Black or African American (20.2%). A relatively large portion of the population is children with 26.9% of residents being under the age of 18 compared to 20.7% in New York State. The amount of people with public health insurance coverage in this PSA is slightly higher than the average in New York State (41.3% vs 39.9%), and 7.6% of the population has a disability.<sup>3</sup>

The town of Ramapo occupies a large swath of Rockland County. To get a picture of the health situation in the PSA, we will take a look at some health indicator statistics in Rockland County.

<sup>3</sup> United States Census Bureau



Poverty and health are closely linked, with those in poverty often shown to have an increased risk of chronic and mental health conditions, mortality, and lower life expectancies.<sup>4</sup> 14.2% of Rockland County residents lived in poverty in 2017 compared to 4.8% in nearby Putnam County and 9.4% in neighboring Westchester County.<sup>5</sup>

The obtaining of a high school diploma is tied with higher lifetime earnings, as well as better health outcomes. Those who have dropped out of school before graduating have an increased risk of premature death, are more likely to report at least one chronic health condition, and are more likely to be in poverty, when compared to those who have graduated.<sup>6</sup> 84% of Rockland residents graduated from high school compared to 90% in nearby Putnam County.<sup>7</sup>

Low literacy and language skills are associated with poorer outcomes in educational attainment, employment, and health. While limited English proficiency and low literacy are not the same as health literacy, they can still be barriers to accessing health care. Both make it difficult for patients to understand health information and are associated with lower utilization of health services.<sup>8</sup> Rockland County had the highest percentage (among 7 mid-Hudson counties) of children aged 5-17 years who spoke English less than very well (18.9%).<sup>9</sup>

Housing quality can contribute to a host of exposures associated with negative health outcomes, such as lead, mold, and carbon monoxide. Poor quality housing may also lack air conditioning or cost more to heat. This can make temperature regulation challenging, further exacerbating poor health outcomes.<sup>10</sup> Rockland County had the highest percentage of households (27%) with housing problems, compared to all other mid-Hudson counties.<sup>11</sup>

The rate of adolescent births (ages 15 - 19) in Rockland County (2012 - 2014) was 12.3 per 1,000 females.<sup>12</sup> The rate of newly diagnosed HIV cases (2017 - 2019) was 7.9 per 100,000 while the state objective for the 2024 Prevention Agenda is for the rate to be no higher than 5.2.<sup>13</sup>

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<sup>4</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/poverty>

<sup>5</sup> Mid-Hudson Region Community Health Assessment 2019 - 2021

<sup>6</sup> Office of Disease Prevention and Health Promotion, June 2019

<sup>7</sup> Mid-Hudson Region Community Health Assessment 2019 - 2021

<sup>8</sup> Office of Disease Prevention and Health Promotion, June 2019

<sup>9</sup> Mid-Hudson Region Community Health Assessment 2019 - 2021

<sup>10</sup> Office of Disease Prevention and Health Promotion, July 2019

<sup>11</sup> Mid-Hudson Region Community Health Assessment 2019 - 2021

<sup>12</sup> <https://www.nyskwic.org/>

<sup>13</sup> <https://webbi1.health.ny.gov/>

The percentage of premature deaths (under age 65) in Rockland County was 19.4% (out of all deaths) in 2019. The rate of preventable hospitalizations in 2019 was 96.9 per 10,000 people.<sup>14</sup>

The top 3 causes of death in Rockland County are Cancer, Heart Disease, and Chronic Lower Respiratory Disease. At the county level, data from 2014-2016 shows Rockland County had the highest heart attack mortality rate of the seven Mid-Hudson counties (41.4 per 100,000 population). This rate was higher than the Mid-Hudson Region, as a whole, and New York State (24.8 and 27.5 per 100,000 population, respectively).<sup>15</sup>

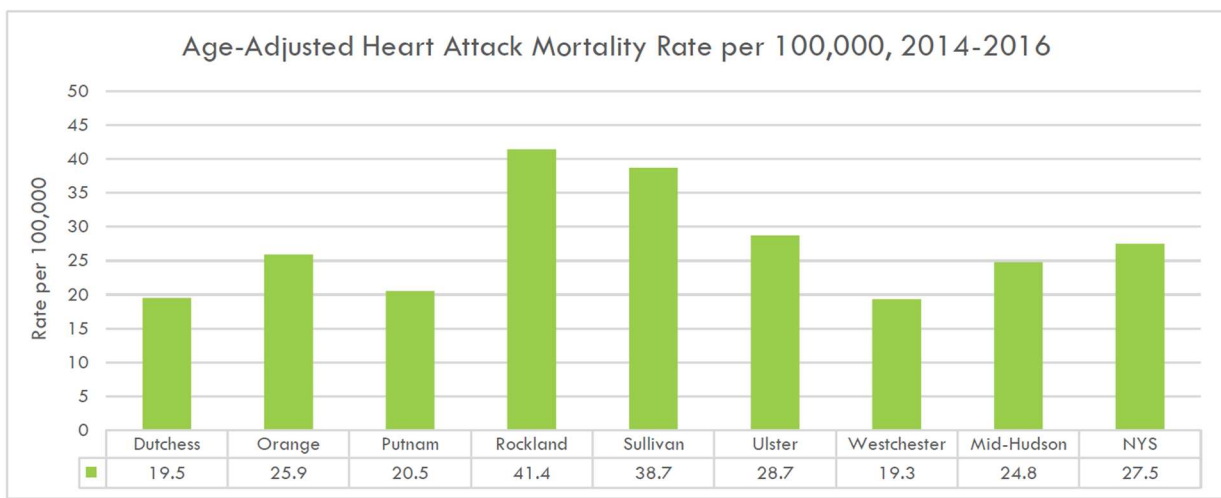


Figure 4 Heart Attack Mortality Rate in Mid-Hudson Counties

PUBLIC NEED

In light of the health and demographic statistics outlined above, it is clear that there is a need for enhanced healthcare services in the PSA. Furthermore, as we will illustrate in this section, the recent population growth in the PSA necessitates a reinforcement of healthcare services. In recent

<sup>14</sup> Ibid.

<sup>15</sup> Mid-Hudson Region Community Health Assessment 2019 - 2021

years, the county of Rockland and the town of Ramapo in particular have experienced drastic population growth.

In 2011, Ramapo had a population of 127,975. In 2021 the population was 150,344.<sup>16</sup> In an article describing the population increase in Rockland, the Rockland County Business Journal reported that “The county’s most significant growth in both adult and youth population came from Ramapo, which saw a 17.6 percent increase over the past decade, bringing its population to 148,929 (April 2020) – the largest in the county. While its adult population increased 10.5 percent, its youth population rocketed by 30.6 percent.”<sup>17</sup>

The Orthodox Jewish population, which comprises more than half of Rockland’s population, shows dramatic signs of growth. Yeshiva enrollment in Rockland County grew more than 63% in the past decade, underscoring rapid Orthodox Jewish population growth in counties north of New York City where these families have increasingly settled in recent years.<sup>18</sup>

With the exponential population growth and rise in housing prices over the last decade in the Monsey area, the Orthodox community started spreading out to Northern areas of Ramapo, including Airmont, Wesley Hills, and Pomona.

New Square, a village in Ramapo which is a ten-minute drive away from the address of the proposed Center, with a population of 8,589<sup>19</sup>, has a designated Health Professional Shortage Area (HPSA ID 13699936B6) as well as a Medically Underserved Area (MUA/P ID 0236). There is an

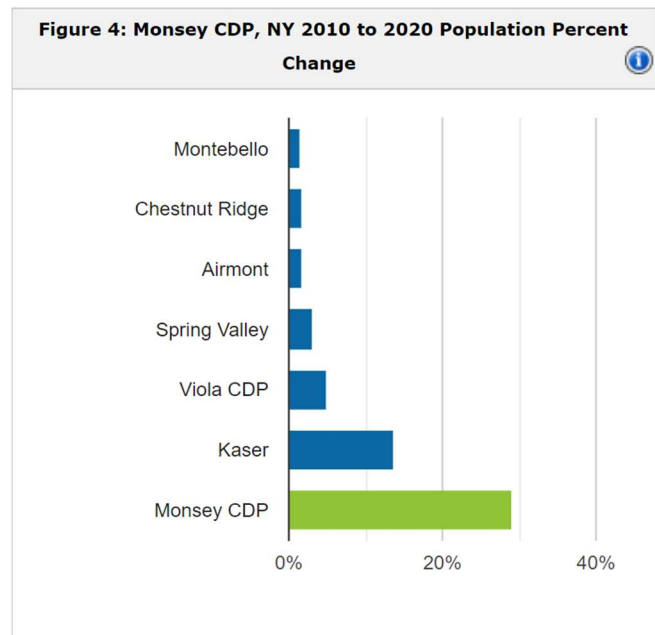


Figure 5 Monsey Shows Close to 30% Population Change in a Decade (<https://www.towncharts.com/>)

<sup>16</sup> <https://www.newyork-demographics.com/ramapo-demographics>

<sup>17</sup> <https://rcbizjournal.com/>

<sup>18</sup> <https://forward.com/news/484700/yeshiva-enrollment-points-to-huge-hasidic-growth-outside-new-york-city/>

<sup>19</sup> United States Census Bureau

additional primary care HPSA in Rockland County (HPSA ID 13699936NP) as well as another MUA (MUA/P ID 07534), pointing to a general shortage of primary healthcare services in the PSA's region.

In 2019, the Rockland County Department of Health, along with HealtheConnections, conducted two focus groups at the Haverstraw Collaborative and the Spring Valley Collaborative to discuss survey results from providers that serve various populations.<sup>20</sup> The survey showed that the top three issues that affect health in Rockland County were:

- Access to affordable, decent, and safe housing
- Access to mental health providers
- Access to affordable, nutritious food

The survey also showed that the top three barriers to people achieving better health in Rockland County were: a. knowledge of existing resources; b. health literacy; and c. Drug and/or alcohol use.

Some of the other major findings included:

- Lack of affordable housing in Rockland was brought up as a major issue. People are paying a large share, often 50-75%, of their income on housing, and this leads to high levels of stress (71.2%).
- Lack of cultural competency is a barrier that deters people from seeking help (15.2%).
- There is an overall lack of services available after 5:00 PM.

In conclusion, one of the five specific recommendations of the provider focus group was that “Services should be open during hours outside of 9:00 AM- 5:00 PM, Monday through Friday, to increase access.”

Receiving regular primary care services is key to chronic disease management, preventative care, and early detection. In a 2018 Mid-Hudson Region Community Health Survey, 17% of Rockland County respondents said they did not visit a primary care physician for a routine physical or checkup within the last 12 months (compared to 16% in neighboring Putnam and 13% in Westchester). To the question, “For which reason did you visit the emergency room for a health-related emergency rather

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<sup>20</sup> Mid-Hudson Region Community Health Assessment 2019 - 2021

than a doctor's office?" 23% of respondents answered that "they do not have a regular doctor/primary care doctor."<sup>21</sup>

17% of people surveyed haven't seen a primary care provider for a routine physical or checkup within the last 12 months, when asked why, 24% responded that they did not have health insurance, and 11% responded that they did not have enough money to see a doctor.<sup>22</sup>

During the 2019 Community Health Priority Selection Forum, it was determined by an open vote that Rockland partners will be focusing on the "Preventing Chronic Diseases and Promoting Well-being" and "Preventing Mental and Substance Use Disorders" Prevention Agenda priority areas.<sup>23</sup>

Within the zip code of the proposed center, there are only 2 other Article 28 D&TC's.<sup>24</sup>

The establishment of Care365 in Pomona will be a key player in "Preventing Chronic Diseases and Promoting Well-being" in the PSA. A welcome addition to the healthcare landscape in Ramapo, the Center will bring quality primary care as well as specialty services, thus playing a role in reducing chronic diseases and promoting well-being among the local population.

## PROGRAM

By providing primary care services, Care365 will increase access to health providers, a factor that is essential in reducing potentially preventable hospitalizations (PPH), preventing chronic diseases, and enhancing the general health and quality of life of residents.

The Center will provide all-encompassing primary and pediatric care as well as other specialty medical services including cardio-care, on-site laboratory testing, x-ray examinations, and sonograms.

The operator has prepared a thorough strategic plan which includes projected visits for Years 1 - 3, marketing and outreach strategies, and priorities and goals for health intervention areas.

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<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid.

<sup>24</sup> <https://health.data.ny.gov/>

Care365 will provide the following services.

1. Primary Medical Care - diagnosis and treatment of illnesses in adults and children:

- Common infections such as strep, ear infection, pneumonia, UTI, viruses etc.
  - Untreated strep infections can lead to the bacteria spreading to other parts of the body, causing complications such as: rheumatic fever and post-streptococcal glomerulonephritis (a kidney disease)
  - In rare cases, ear infections can lead to complications such as meningitis and hearing loss. Thus, it is vital to get proper treatment in a timely manner.
  - Pneumonia can lead to complications such as: acute respiratory distress syndrome, lung abscesses, respiratory failure and sepsis. Timely and targeted intervention is essential to prevent complications.
  - The main danger associated with untreated UTIs is that the infection may spread from the bladder to one or both kidneys. Early detection and treatment are crucial to minimizing long-term complications.
- Chronic illnesses such as diabetes, hypertension, asthma, heart disease etc.
  - In 2014, the rate of emergency department visits due to asthma was 33.1 per 10,000 in Rockland County.
  - Between 2014 and 2016, Rockland County had a heart attack mortality rate of 41.4 per 100,000 - the highest rate among 7 mid-Hudson counties.
  - In 2016, 9.1% of Rockland County residents were reported to have physician-diagnosed pre-diabetes and 6.9% had diabetes.
- Injuries such as sprains, fractures, lacerations, and burns
  - The rate of unintentional injury hospitalization for children ages birth to 19 years in Rockland County per 10,000 was 156.<sup>25</sup> With easier access to local treatment for minor injuries in the community, including x-ray services, hospitalization rates will consequently decline.
- Dehydration, anemia, and other blood deficiencies
  - Risk factors for dehydration include: excessive heat exposure, older age, athletic activity, chronic or temporary illness.

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<sup>25</sup> <https://www.nyskwic.org/>

- Untreated dehydration can lead to life-threatening complications, such as: heat exhaustion, heatstroke, seizures due to electrolyte loss, low blood volume, kidney failure, coma.
- In infants and preschool children, iron-deficiency anemia may result in developmental delays and behavioral disturbances. As many as nine percent of children aged 12-36 months in the United States have iron deficiency. For children older than 36 months, risks for iron deficiency include low family income, migrant or refugee status, and medical conditions that affect iron status.
- In older adults, it's quite common for there to be several coexisting causes of anemia. As severe anemia can be life-threatening, it is vital for older adults to have their iron levels constantly monitored and managed.

2. Specialty Medical Services:

Cardio-care (evaluation and management), x-ray imaging, laboratory moderate complexity testing; and sonograms.

Under the medical leadership of Dr. Seth Kurtz MD, Care365 is committed to providing quality healthcare and maximal accessibility, both in the sense of making its services familiar and available to all community members and in the technical sense of ensuring physical accessibility in every detail of the facility's layout, in accordance with the Americans with Disabilities Act 1990. Dr. Seth Kurtz, the current director of the flagship Care365 Center, has been practicing medicine for over fifteen years and has held multiple leadership roles over the years.

The facility aims to become recognized by NCQA as a Patient-Centered Medical Home (PCMH), a model that is committed to continuous quality improvement and a patient-centered approach putting patients at the forefront of care and increasing staff satisfaction – while reducing health care costs.

Beyond providing services to treat health problems, a big focus of the Center will be disseminating preventive education. This will entail meeting with community leaders, religious and civic organizations to implement educational programming to promote a healthy lifestyle – including reducing tobacco use, increasing physical activity and promoting better nutrition. For many in the proposed service area this will involve dispelling myths concerning vaccinations in general and measles vaccines in particular. Monsey was the epicenter of the measles outbreak in 2018, and there is a sizable

population segment there that opposes vaccination. Strategic and creative intervention is required to allay concerns and increase vaccination rates in the area.

The proposed operator is sensitive to the cultural and religious needs of the community. In order to best serve the population, many of whom are fluent in a language other than English, signs, brochures and other materials will be in English, Spanish and Yiddish as well as any other language that reflects the needs of the population. The operator will ensure there is always staff available that speak one of these languages.

Further, for many women in the ultra-Orthodox community (which comprises a large segment of Care365 clientele), religious practices often provide barriers to care. These women hesitate to see male doctors for gynecological care and mammograms. The Center will endeavor to have female staff available to ensure women in the community receive routine screenings such as pap smears and mammograms and adequate prenatal care.

The proposed Center will be utilizing an electronic Medical Records (EMR) system which will be integrated with the Statewide Health Information Network (SHIN-NY) as per 10NYCRR Part 300. A compliance program will be an integral part of the proposed Center to ensure full compliance with all federal, state, and Medicaid regulations, including the ongoing in-service/training for all employees of the Center.

## SUMMARY

Care365 is submitting this Certificate of Need application for the establishment of an extension Article 28 diagnostic and treatment center to be located at 1633 Route 202, Pomona NY 10970. We are confident that if approved, the Care365 D&TC in Pomona, NY will decrease local hospitalization rates, reduce chronic diseases and enhance the overall health and quality of life of the residents of Pomona NY, and the surrounding areas.



# 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>
Example: <i>First borrowed fund source</i>	Example: <i>first_bor_fund.pdf</i>
Not Applicable	

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

Working capital (two months of third year expenses - \$405,353) will be funded by the member of Care365 LLC. Please refer to the Schedule 2b (Attachment to Schedule 9) of the member. A monthly cash flow analysis is also included under Schedule 5 Attachment.

**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>
<i>Example: Attachment to operational balance sheet</i>	<i>Example: Operational_bal_sheet.pdf</i>
Pro-Forma Balance Sheet	Pro-Forma Balance Sheet – Attachment 5-1

## **Care365 LLC**

### Schedule 05 Attachments

- Attachment A – Pro Forma Balance Sheet
- Attachment B – Year 1 Monthly Cash Flow Analysis

CARE365 II  
Year 1 Monthly Cash Flow Analysis

Month	1	2	3	4	5	6	7	8	9	10	11	12
<b>Starting Cash</b>	\$ 405,353	\$ 347,088	\$ 300,644	\$ 267,335	\$ 248,621	\$ 246,122	\$ 261,641	\$ 297,180	\$ 354,962	\$ 437,461	\$ 547,420	\$ 687,893
<b>Revenue</b>	\$ 106,392	\$ 118,214	\$ 131,349	\$ 145,943	\$ 162,159	\$ 180,177	\$ 200,196	\$ 222,440	\$ 247,156	\$ 274,617	\$ 305,130	\$ 339,034
<b>Expenses</b>	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658	\$ 164,658
<b>Remaining Cash</b>	\$ 347,088	\$ 300,644	\$ 267,335	\$ 248,621	\$ 246,122	\$ 261,641	\$ 297,180	\$ 354,962	\$ 437,461	\$ 547,420	\$ 687,893	\$ 862,270

CARE365 II  
Pro Forma Balance Sheet

ASSETS

Cash	\$	<del>405,352.08</del>
Leasehold Improvements	\$	-
Momveable/Fixed Equipment	\$	-
Total Assets	\$	<del>405,352.08</del>

LIABILITIES & MEMBERS EQUITY

Long Term Debt	\$	-
Short Term Debt	\$	-
Total Liabilities	\$	-
Members Equity	\$	<del>405,352.08</del>
Total Liabilities and Members Equity	\$	<del>405,352.08</del>



501 Chestnut Ridge Road, Suite 301 NY 10977 | ph: 212.381.0670 | e: [info@bildny.com](mailto:info@bildny.com) | w: [www.bildny.com](http://www.bildny.com)

# **CARE 365 SBV**

**1633 Route 202  
Pomona, NY 10970  
Rockland County**

## **Narrative**

### General:

Care 365 is an existing facility that is located in a newly renovated building at 1633 Route 202 in Pomona, New York. The entire space has been renovated into a diagnostic and treatment center providing primary and specialty medical. A phlebotomy room is provided for blood draws and a laboratory is provided to perform moderate complexity testing and specimen storage.

### Existing plans:

The existing facility includes a waiting room, reception area, medical directors' office, phlebotomy room, lab, nurses station, doctors office, 9 exam rooms, 1 treatment room, 1 ultrasound room, x-ray imaging room with a waiting area and changing room, soiled holding, clean work room, janitors closet, storage closets, staff break room, conference room, 1 public toilet, 1 staff toilet and 3 patient toilets.

### Building Code:

The existing facility is newly constructed and complies with applicable sections of the 2020 Building Code of New York State, 2010 ADA Standards for Accessible Design, applicable sections of the 2018 edition of the Guidelines for Design and Construction of Outpatient Facilities, 2012 NFPA 101 and 220 with respect to building and construction codes, fire codes and accessibility. The drawings are also in compliance with the 10NYCRR and the DSG-01.



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9/21/2022

Care 365 SBV  
1633 Route 202  
Pomona, NY 10970

### Functional Space Program:

Lobby / Waiting Area	644 sf
Exam Rooms (patient services)	1,202 sf
Facility	838 sf
Support Spaces	742 sf
Toilets and Utility	283 sf
<hr/> Net Area	<hr/> 3,709 sf
Hallways, Walls, Elevator	1,624 sf
<hr/> Gross Area	<hr/> 5,333 sf





KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., MPH.
Commissioner

KRISTIN M. PROUD
Executive Deputy Commissioner

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS
ARCHITECTS & ENGINEERS

(For projects not meeting the prerequisites for Self-Certification submission.)

Date: 3/28/2023
CON Number: TBD
Facility Name: Care 365"K
Facility ID Number: TBD
Facility Address: 1633 Route 202, Pomona, N.Y. 10970

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, 18th Floor
Albany, New York 12237

To The New York State Department of Health:

I hereby 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...
2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed...
3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations...
a. \_\_712 (Standards of Construction for General Hospital Facilities)
b. \_\_713 (Standards of Construction for Nursing Home Facilities)
c. \_\_714 (Standards of Construction for Adult Day Health Care Program Facilities)
d. ✓715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
e. \_\_716 (Standards of Construction for Rehabilitation Facilities)
f. \_\_717 (Standards of Construction for New Hospice Facilities and Units)

PLEASE NOTE ANY EXCEPTIONS HERE:

\_\_\_\_\_

- 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 Parts 711, 712, 713, 714, 715, 716, or 717), I shall bring this to the attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department of Health 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 Parts 711, 712, 713, 714, 715, 716 and 717, 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: Care 365  
 Location: 1633 Route 202, Pomona, N.Y. 10970  
 Description: Primary, urgent and diagnostic care medical facility



[Signature]  
 Signature of Architect or Engineer  
 Robert Bernstein  
 Name of Architect or Engineer (Print)  
 023796-1  
 Professional New York State License Number  
 501 Chestnut Ridge Road, Chestnut Ridge, N.Y. 10977  
 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.

[Signature]  
 Authorized Signature for Applicant  
5/11/2023 Date  
Zehava Goldenberg Name (Print)  
Managing Member Title

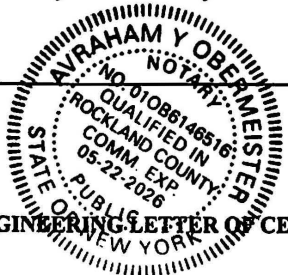
Notary signing required for the applicant

STATE OF NEW YORK  
 County of Rockland

)  
 ) SS:  
 )

On the 11 day of May 2023 before me personally appeared Zehava Goldenberg, to me known, who being by me duly sworn, did depose and say that he/she is the Managing Member of the Care 365 LLC, 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) [Signature]



ARCHITECTURAL AND ENGINEERING LETTER OF CERTIFICATION

# CARE 365

## 1633 ROUTE 202

### TOWN OF RAMAPO

### ROCKLAND COUNTY, NY

**APPLICABLE CODES:**

- 2020 NYS BUILDING CODE
- 2020 NYS EXISTING BUILDING CODE
- 2020 NYS FIRE CODE
- 2013 NFPA 10 ELECTRICAL CODE
- 2020 NYS PLUMBING CODE
- 2020 NYS MECHANICAL CODE
- 2020 NYS FUEL GAS CODE
- 2020 NYS ENERGY CONSERVATION CODE OF NYS
- 2020 NYS PROPERTY MAINTENANCE CODE
- 2010 ADA STANDARDS
- 2018 FGI GUIDELINES

**SHEET INDEX**

T-1.00	TITLE PAGE
G-1.00	GENERAL NOTES
A-1.00	EXISTING FLOOR PLAN
A-2.00	EGRESS PLANS
A-3.00	REFLECTED CEILING PLAN
A-4.00	EXTERIOR ELEVATION
A-4.10	INTERIOR ELEVATIONS
A-5.00	WALL TYPES/ DOOR & WINDOW SCHEDULES
A-6.00	ADA DETAILS



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 CARE 365  
 1633 ROUTE 202  
 POMONA, NY 10970

DRAWING TITLE:  
 TITLE SHEET

PROJECT #:  
 21004

DRAWN BY: T.Z. REVIEWED BY: R.B.

PRINT DATE:  
 09/23/22

T-1.00

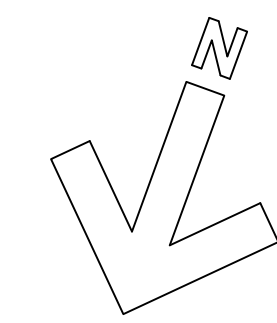


WALL TYPE LEGEND	
TYPE	DESCRIPTION
A	(2) HOUR RATED DEMISING PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION FOR SOUND ABSORPTION • (2) LAYERS 5/8" GYP. BOARD ON EACH SIDE
B	NON-RATED PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION (1) LAYERS 5/8" GYP. BOARD ON THE INTERIOR
C	NON-RATED PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION FOR SOUND ABSORPTION • (1) LAYERS 5/8" GYP. BOARD ON EACH SIDE
D	NON-RATED PLUMBING PARTITION • 6 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION FOR SOUND ABSORPTION • (1) LAYERS 5/8" GYP. BOARD ON THE DRY SIDE • (1) LAYERS 5/8" CEMENT BOARD ON THE WET SIDE
E	NON-RATED PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W • (1) LAYERS 5/8" GYP. BOARD ON EACH SIDE



1 EXISTING FLOOR PLAN  
1/4"=1'-0"

LEGEND	
	AREA OF ARTICLE 28
	AREA OUT OF THE ARTICLE



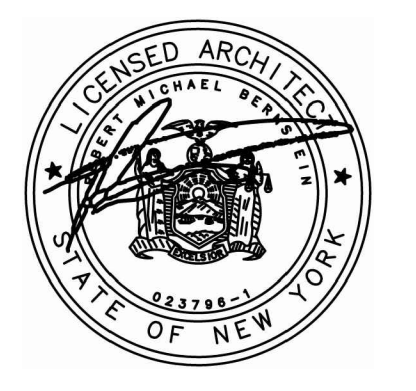
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POMONA, NY 10970

DRAWING TITLE:  
EXISTING FLOOR PLAN

PROJECT #:  
21004

DRAWN BY: T.Z. REVIEWED BY: R.B.

PRINT DATE:  
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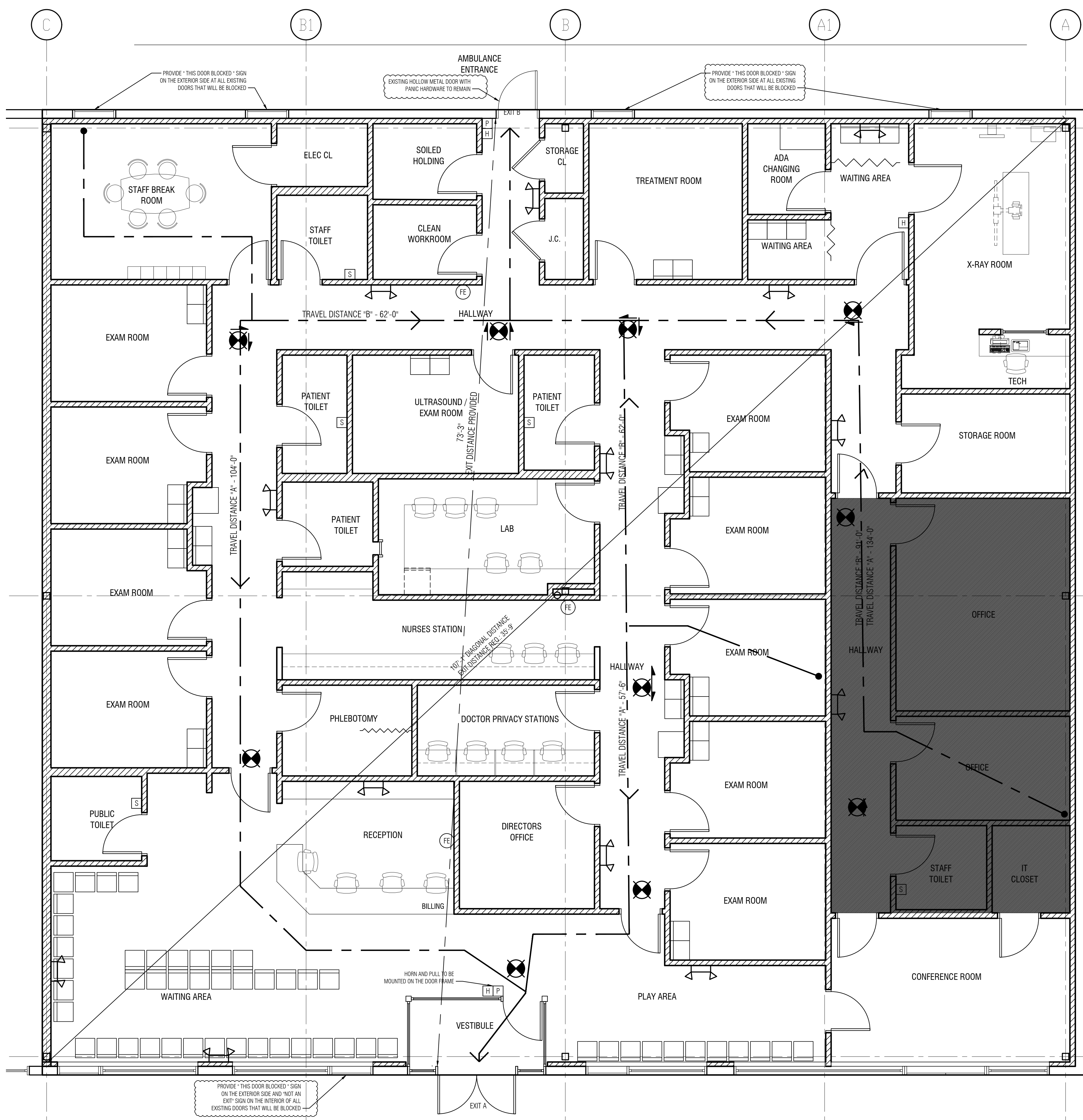
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FIRE / EGRESS SYMBOL LEGEND	
TYPE	DESCRIPTION
	LIGHTED EMERGENCY EXIT SIGN & INTEGRATED LIGHTING WITH BATTERY BACKUP. EMERGENCY EXIT SIGNS SHALL HAVE DIRECTIONAL ARROWS POINTING TO THE DIRECTION OF EGRESS.
	EMERGENCY LIGHTING WITH BATTERY BACKUP.
	STROBE
	PULL STATION
	HORN STROBE
	FIRE EXTINGUISHER

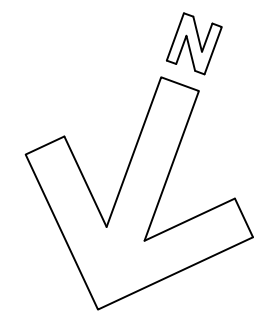
2014 NYCBC OCCUPANCY LOAD:	
BUILDING CODE OCCUPANCY GROUP	B - BUSINESS
FLOOR AREA	5,868
# OCCUPANTS (100 SF/GROSS)	39
EXIT DOOR (2/OCCUPANT)	MIN 36"
MIN. WIDTH OF EXIT DOORS	36"
# EXITS REQUIRED (TABLE 1015.1)	2
# EXITS PROVIDED	2
ACTUAL EXIT WIDTH PROVIDED	72"
MAX. TRAVEL DISTANCE (TABLE 1016.1)	300'
ACTUAL MAX. TRAVEL DIST.	134'-0"
MIN. CORRIDOR WIDTH	44"

OCCUPANCY LOAD - NFPA 101 & 220:	
OCCUPANCY	B - BUSINESS
EXISTING BUILDING CONSTRUCTION TYPE	III (211)
OCCUPANCY LOAD FACTOR	100 SF/PERSON
TOTAL # OCCUPANTS	39
EXITS REQUIRED	2
EXITS PROVIDED	2
MIN. WIDTH FOR DOORS (0.2)	36"
ACTUAL DOOR WIDTH PROVIDED	72"
MAXIMUM TRAVEL DISTANCE	250'
MAXIMUM COMMON PATH OF TRAVEL	100'

LEGEND	
	AREA OF ARTICLE 28
	AREA OUT OF THE ARTICLE



1 FIRE ALARM & EGRESS PLAN  
1/4"=1'-0"



4

3

2

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DRAWING TITLE:  
FIRE ALARM & EGRESS PLAN

PROJECT #:  
21004

DRAWN BY: T.Z. REVIEWED BY: R.B.

PRINT DATE:  
09/23/22

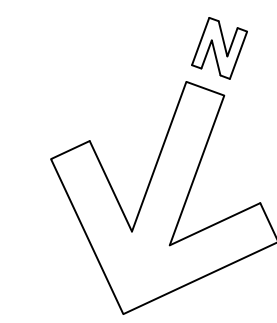
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WALL TYPE LEGEND	
TYPE	DESCRIPTION
A	(2) HOUR RATED DEMISING PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION FOR SOUND ABSORPTION • (2) LAYERS 5/8" GYP. BOARD ON EACH SIDE
B	NON-RATED PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION (1) LAYERS 5/8" GYP. BOARD ON THE INTERIOR
C	NON-RATED PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION FOR SOUND ABSORPTION • (1) LAYERS 5/8" GYP. BOARD ON EACH SIDE
D	NON-RATED PLUMBING PARTITION • 6 METAL STUDS @ 24" O.C. W/ UNFACED BATT INSULATION FOR SOUND ABSORPTION • (1) LAYERS 5/8" GYP. BOARD ON THE DRY SIDE • (1) LAYERS 5/8" CEMENT BOARD ON THE WET SIDE
E	NON-RATED PARTITION • 3 5/8 METAL STUDS @ 24" O.C. W • (1) LAYERS 5/8" GYP. BOARD ON EACH SIDE



1 EXISTING FLOOR PLAN  
1/4"=1'-0"

LEGEND	
	AREA OF ARTICLE 28
	AREA OUT OF THE ARTICLE



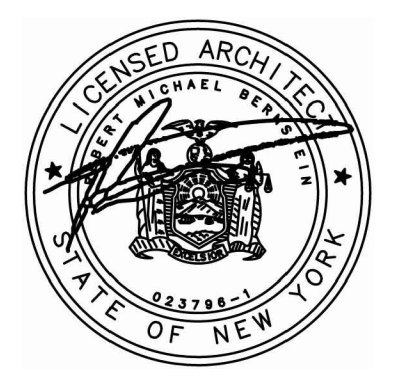
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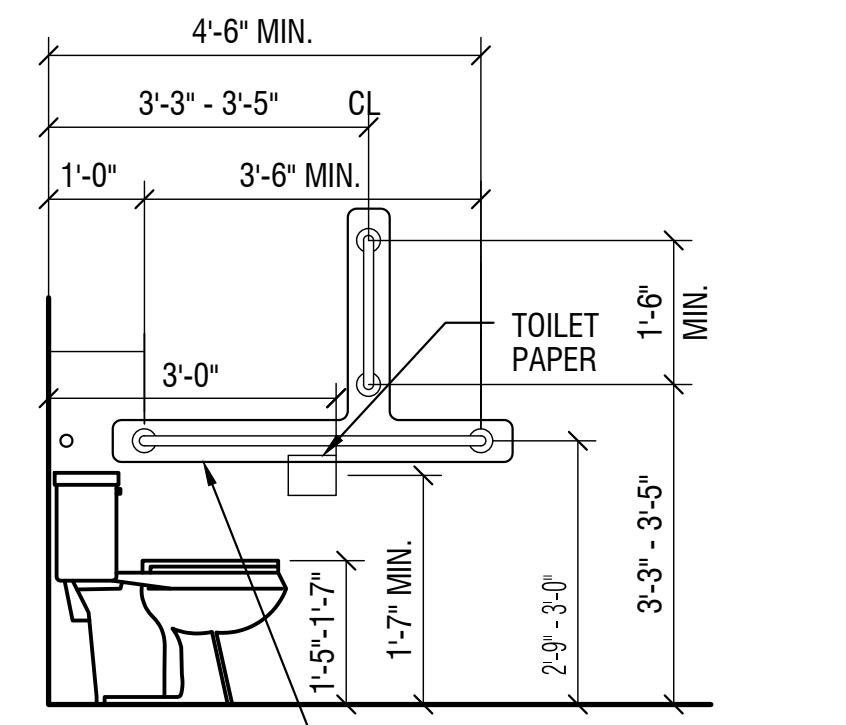
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EXISTING FLOOR PLAN

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09/23/22

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PROVIDE 3/4" THICK PLYWOOD BLOCKING BEHIND WALL FOR ANCHORAGE OF GRAB BAR.  
FIG 604.5.1  
SIDE WALL GRAB BAR FOR WATER CLOSET

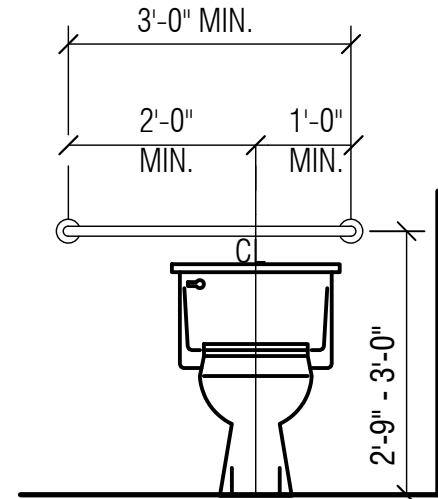


FIG 604.5.2  
REAR WALL GRAB BAR FOR WATER CLOSET

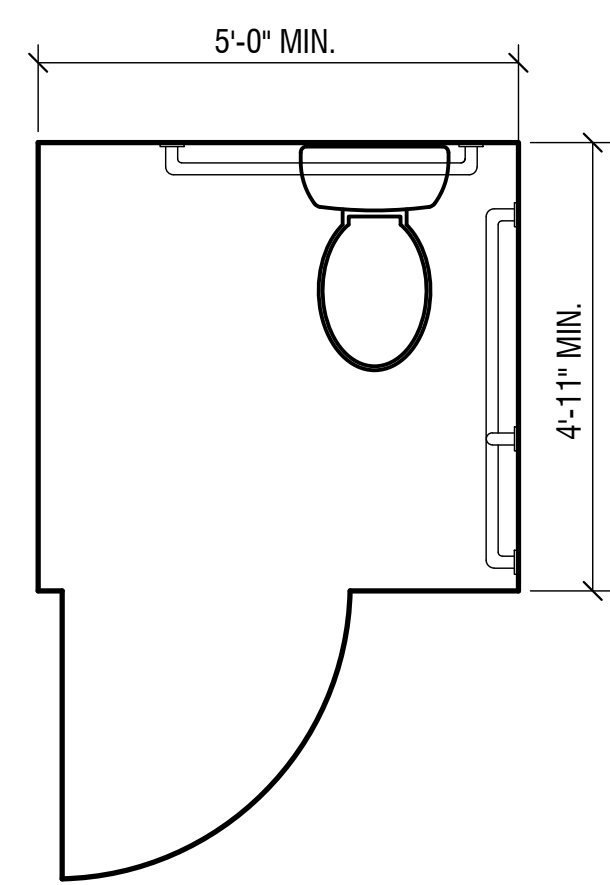
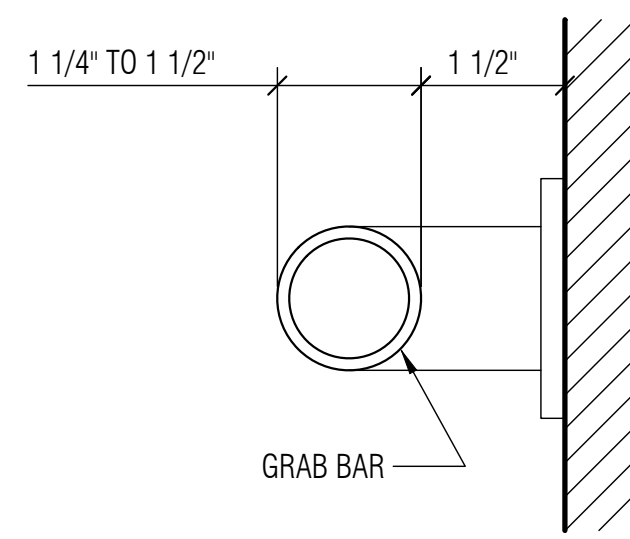


FIG 604.9.2  
WHEELCHAIR ACCESSIBLE TOILET COMPARTMENT

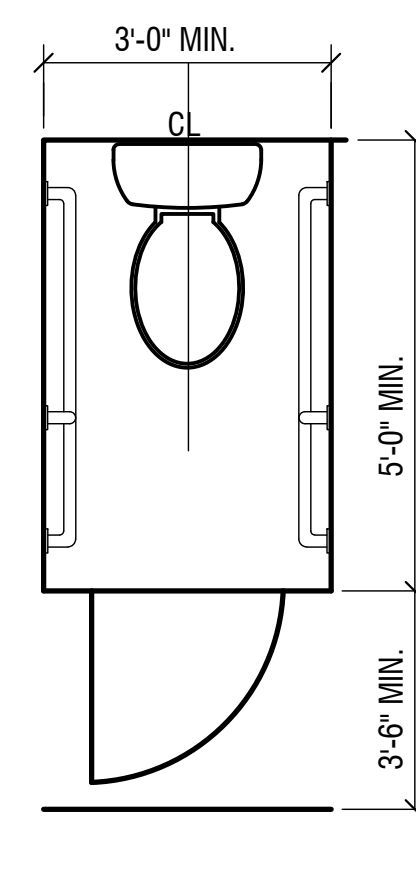


FIG 604.10  
AMBULATORY ACCESSIBLE COMPARTMENT

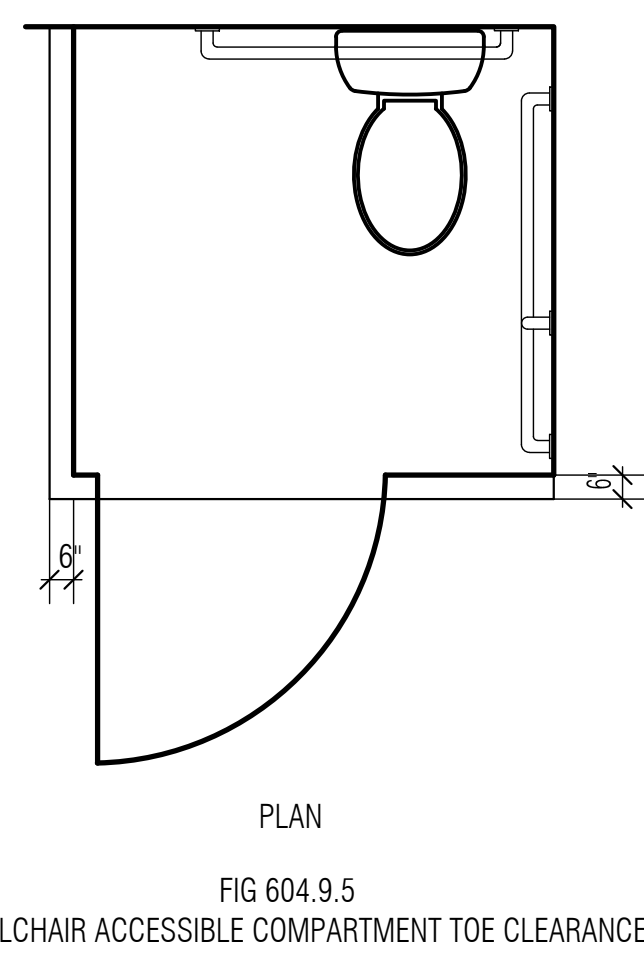
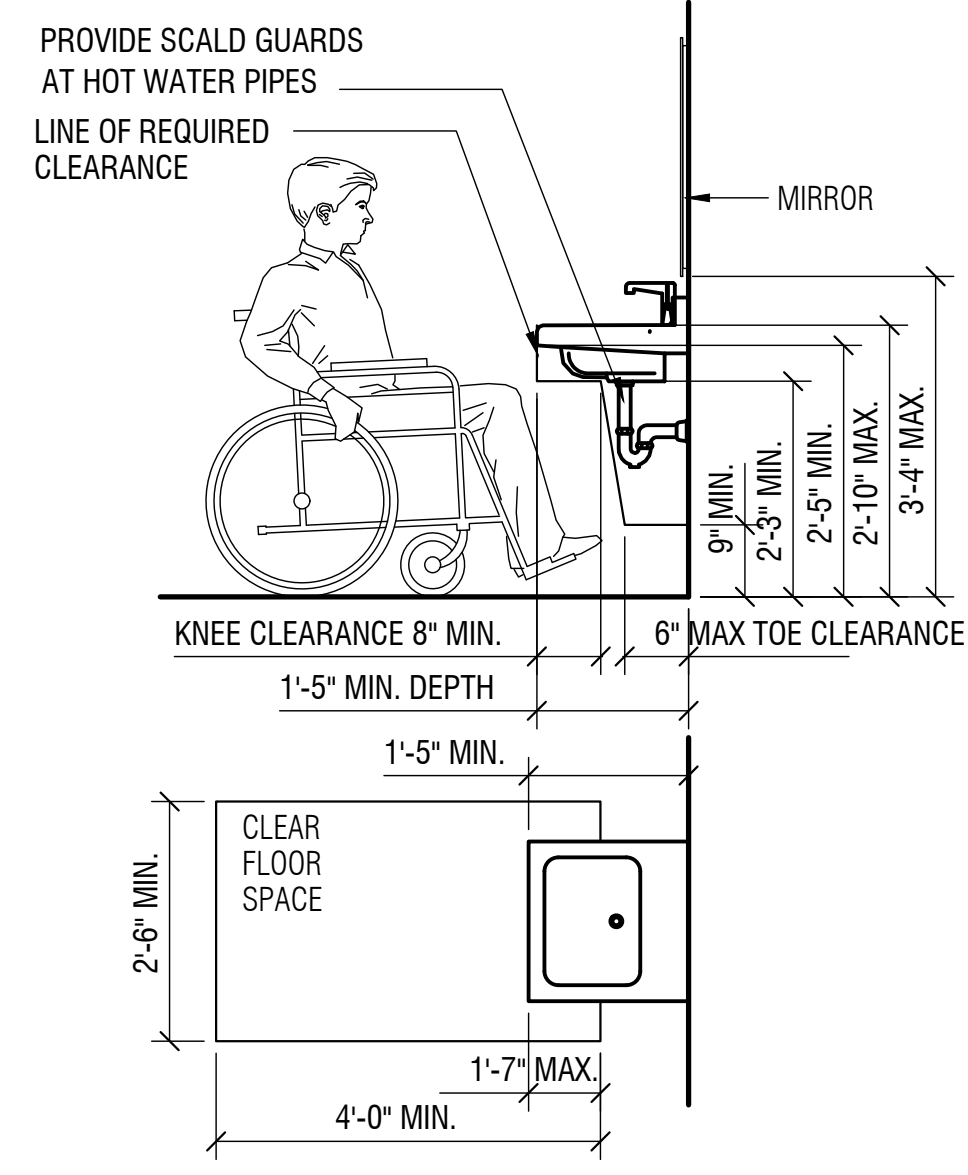
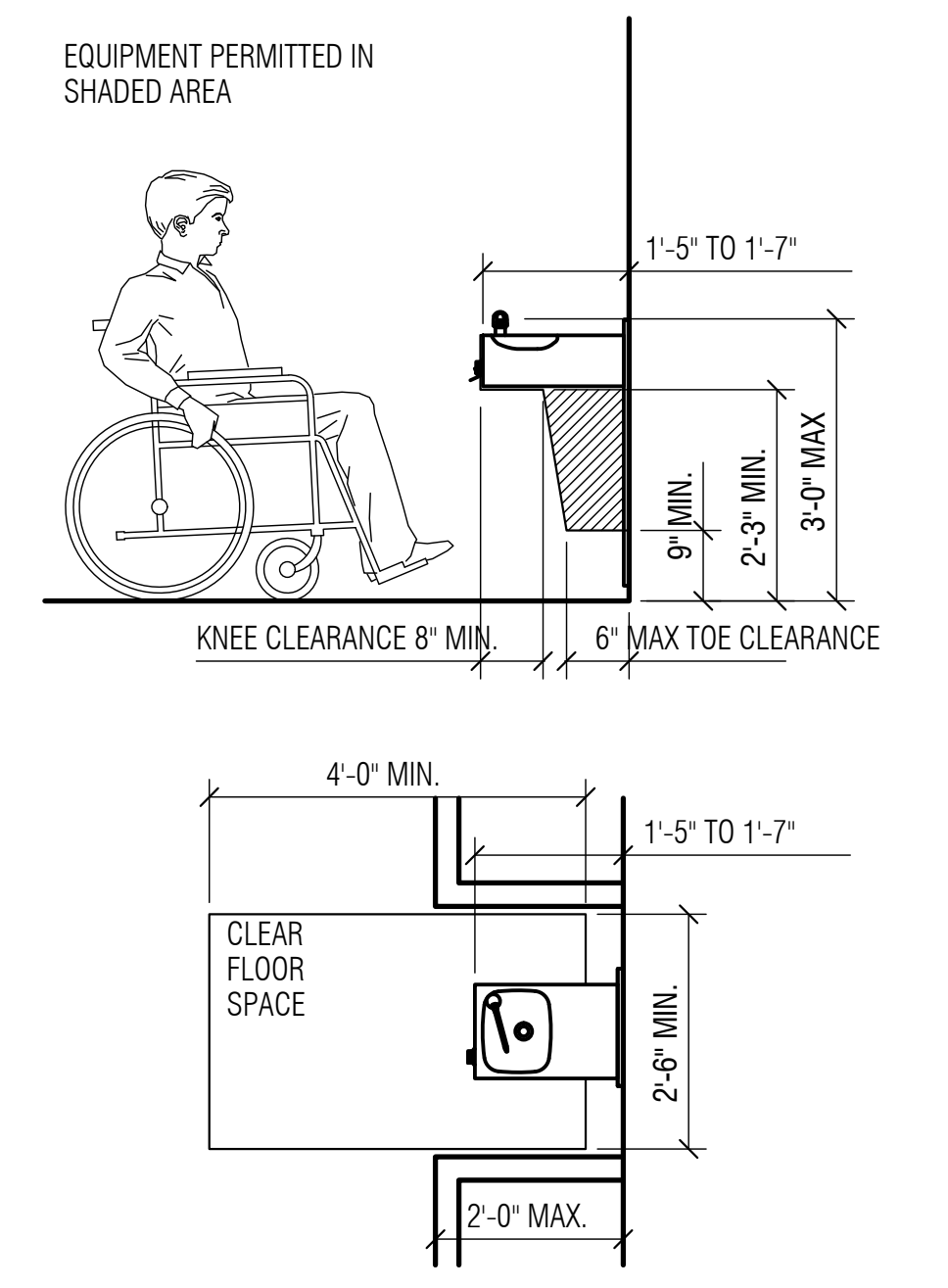


FIG 604.9.5  
WHEELCHAIR ACCESSIBLE COMPARTMENT TOE CLEARANCE



**SINK OR VANITY** **3**

SCALE: 1/4"=1'-0"

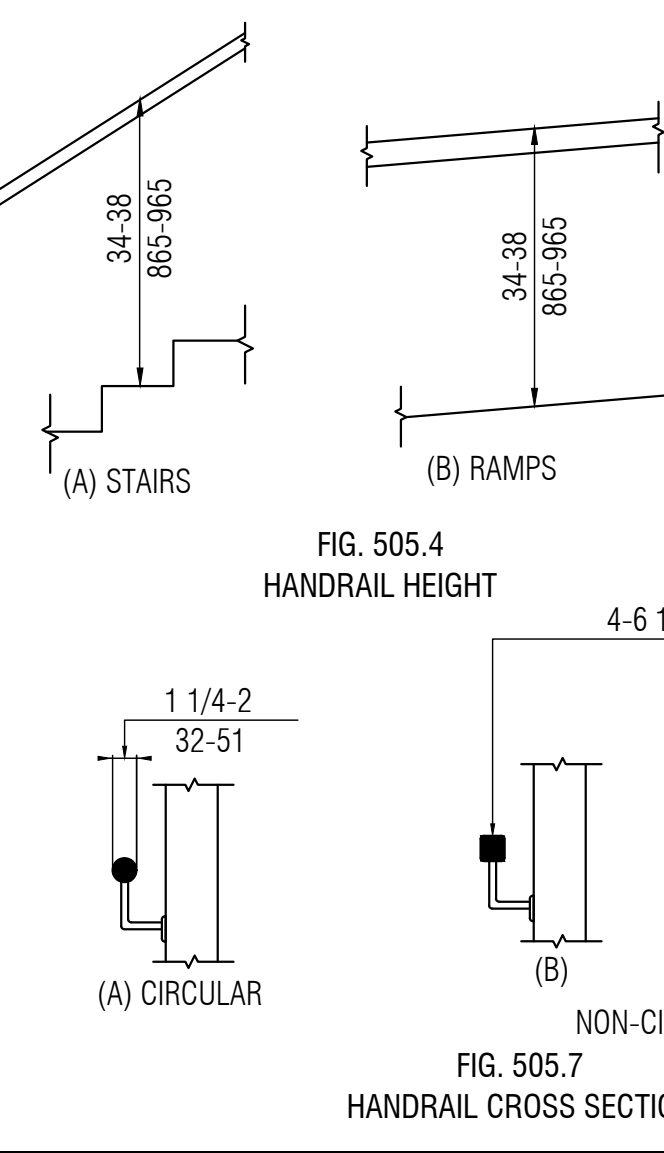


**DRINKING FOUNTAIN** **4**

SCALE: 1/2"=1'-0"

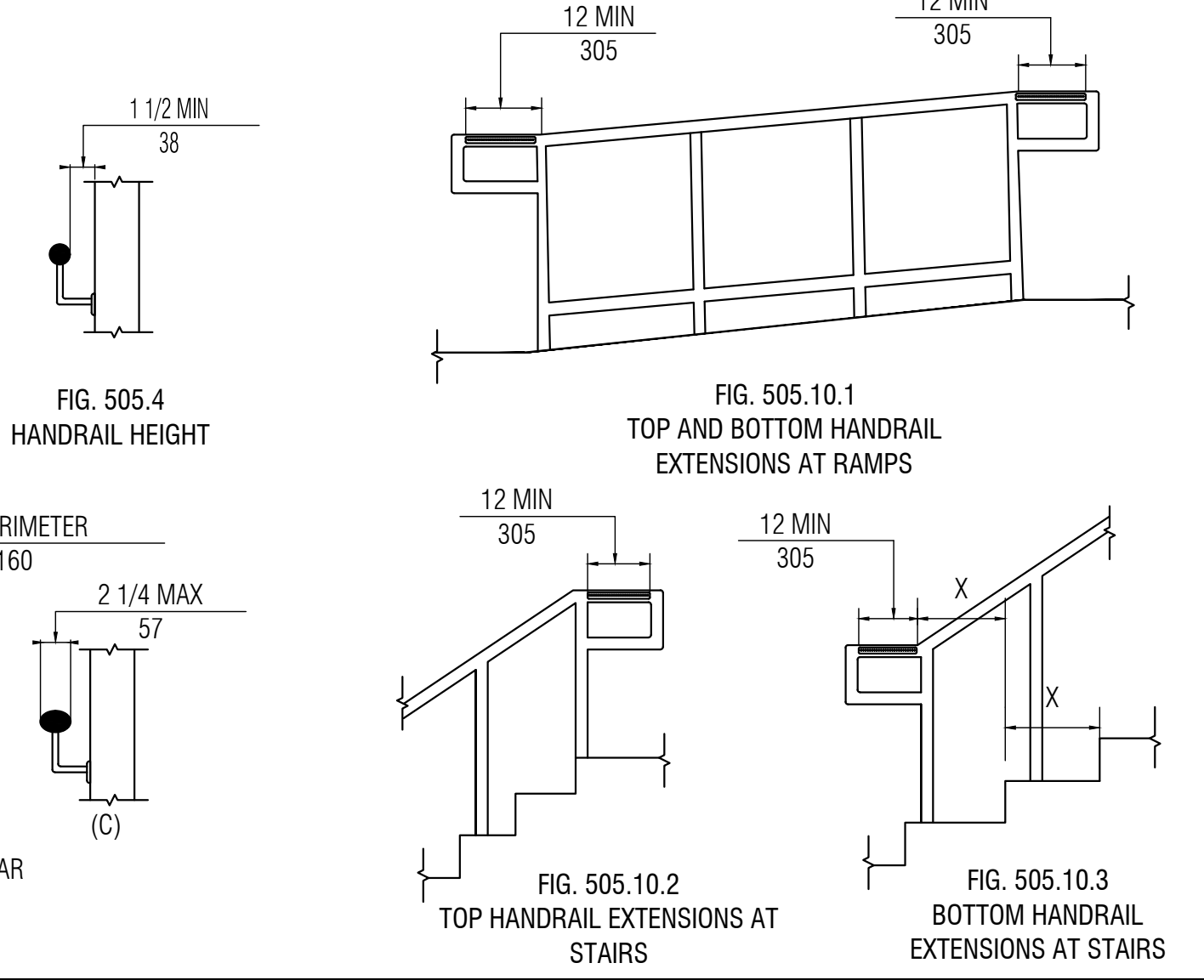
**SINGLE USER TOILET** **1**

SCALE: 1/2"=1'-0"



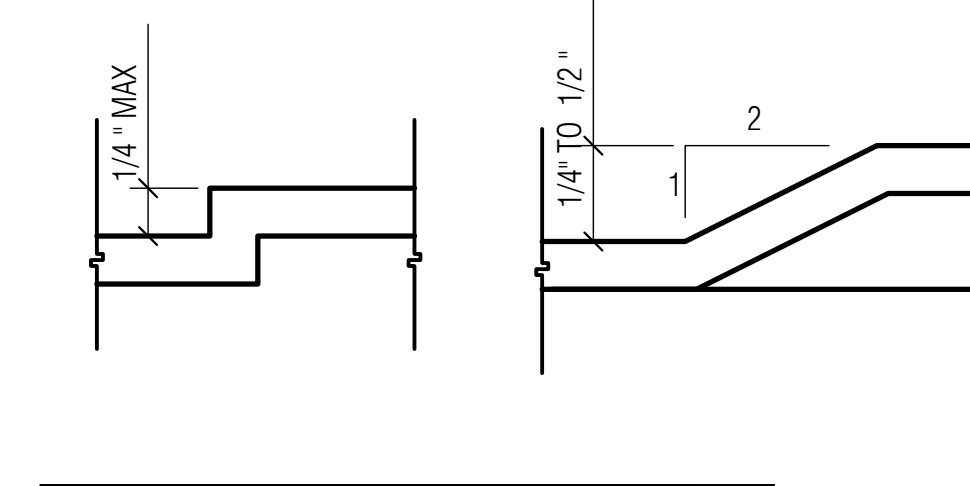
**HANDRAIL DETAILS** **2**

NOT TO SCALE



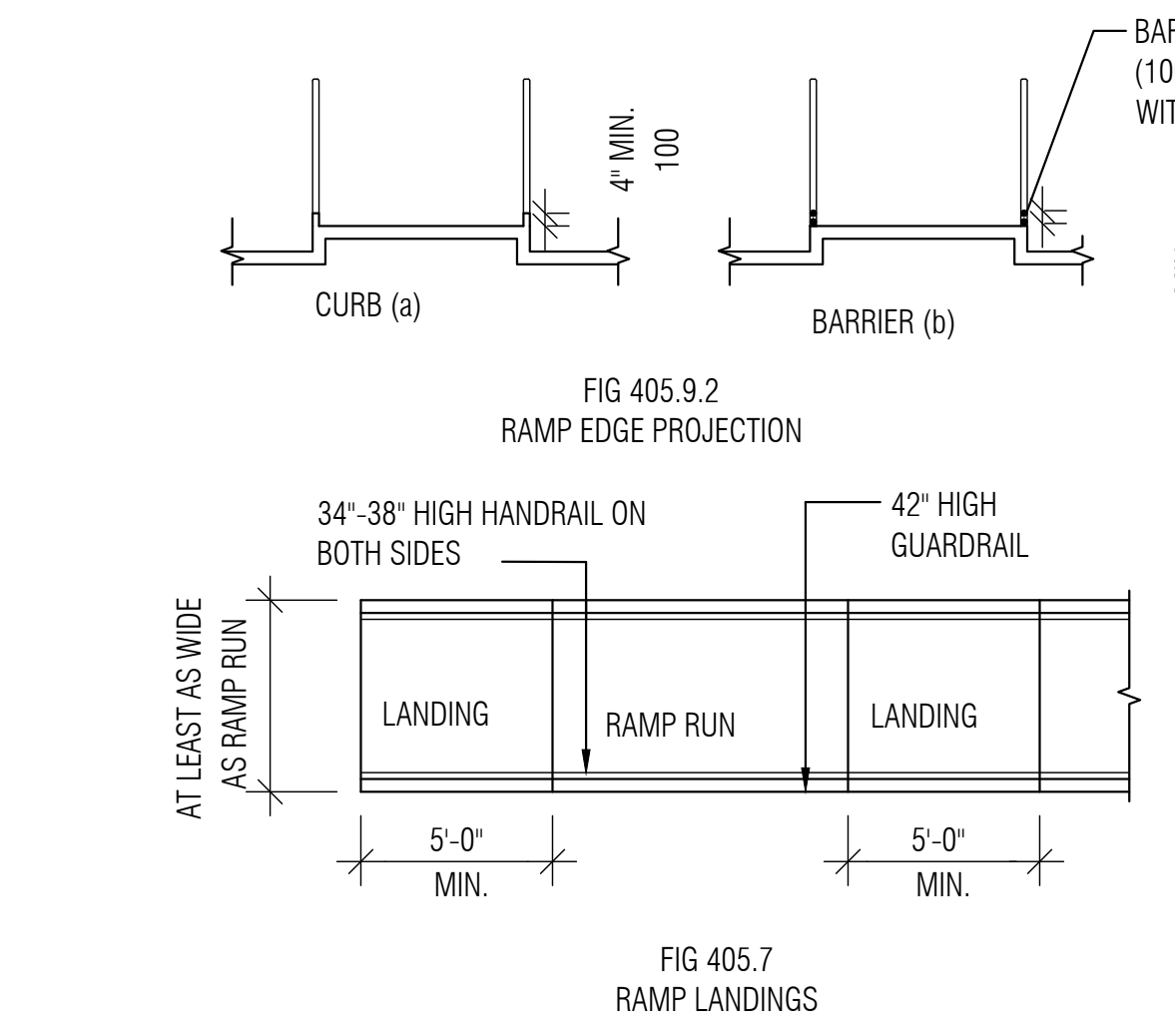
**THRESHHOLDS** **5**

SCALE: FULL



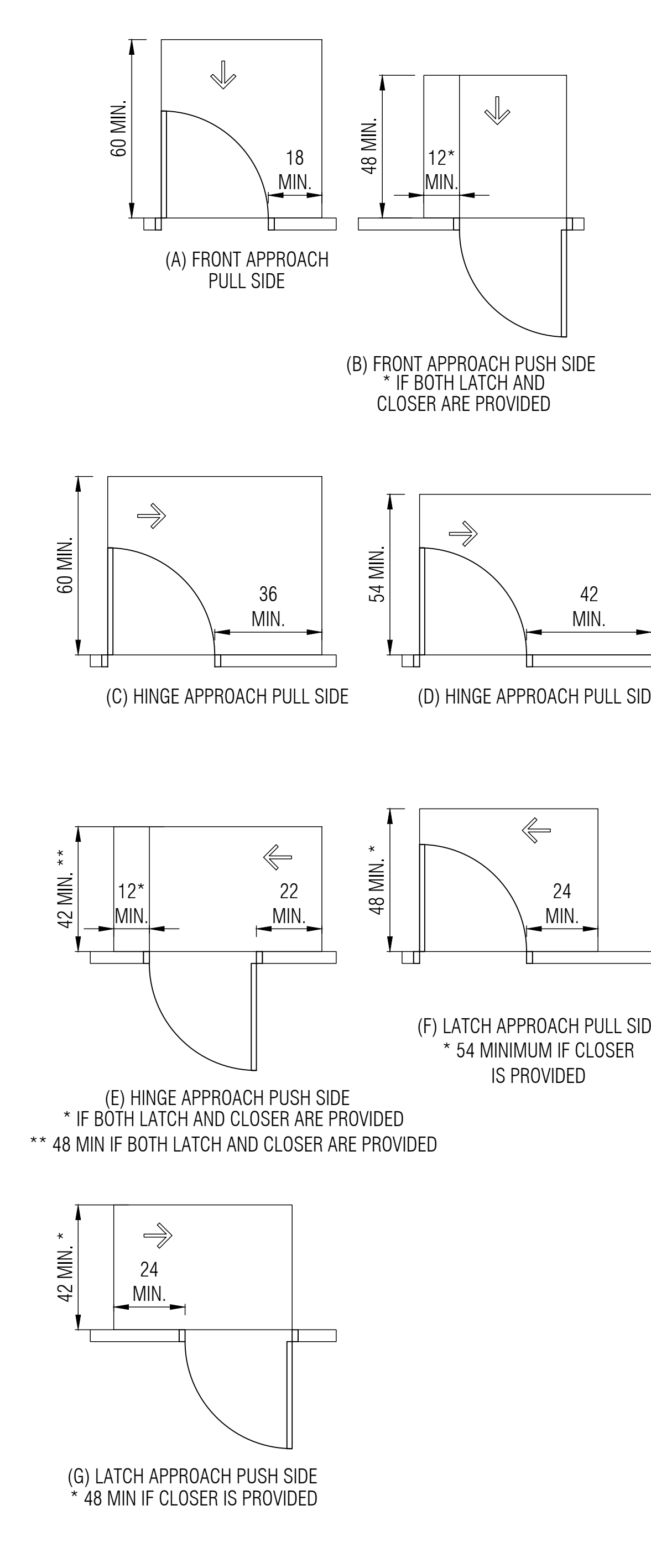
**CLEARANCES** **6**

SCALE: 1/4"=1'-0"



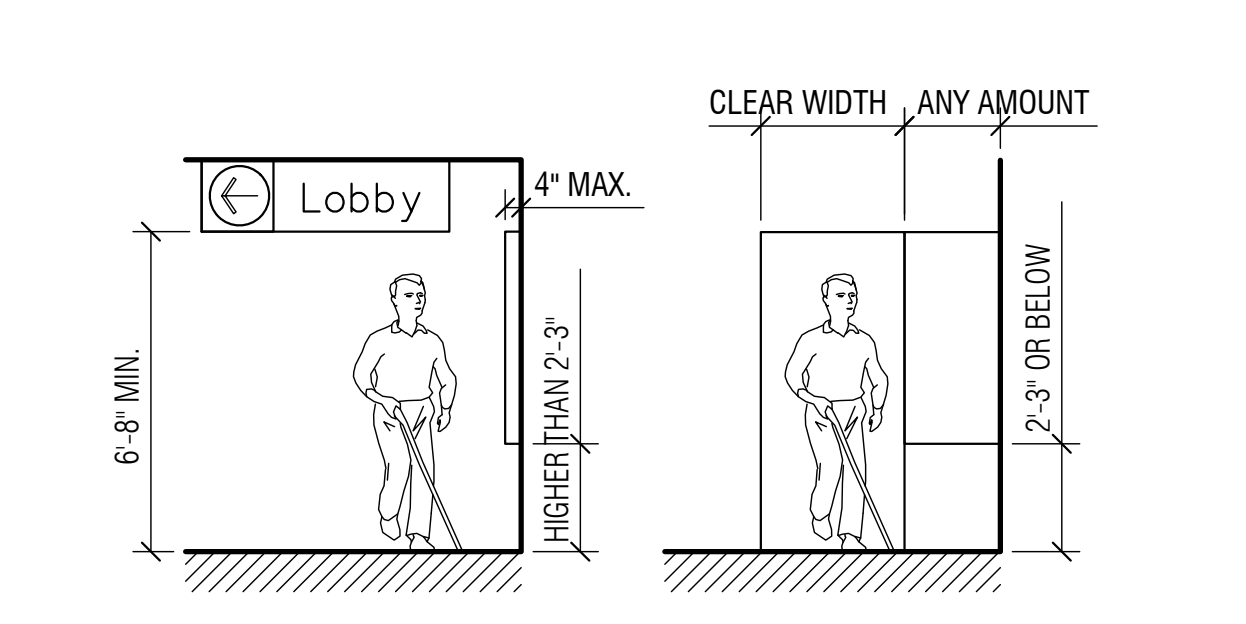
**RAMP DETAILS** **7**

SCALE: 1/4"=1'-0"



**PROTRUDING OBJECTS** **8**

SCALE: 1/4"=1'-0"



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CARE 365  
1663 ROUTE 202  
POMONA, NY 10970

DRAWING TITLE:  
ACCESSIBILITY DETAILS

PROJECT #: 21004  
DRAWN BY: T.Z. REVIEWED BY: R.B.  
PRINT DATE: 09/23/22

**A-6.00**

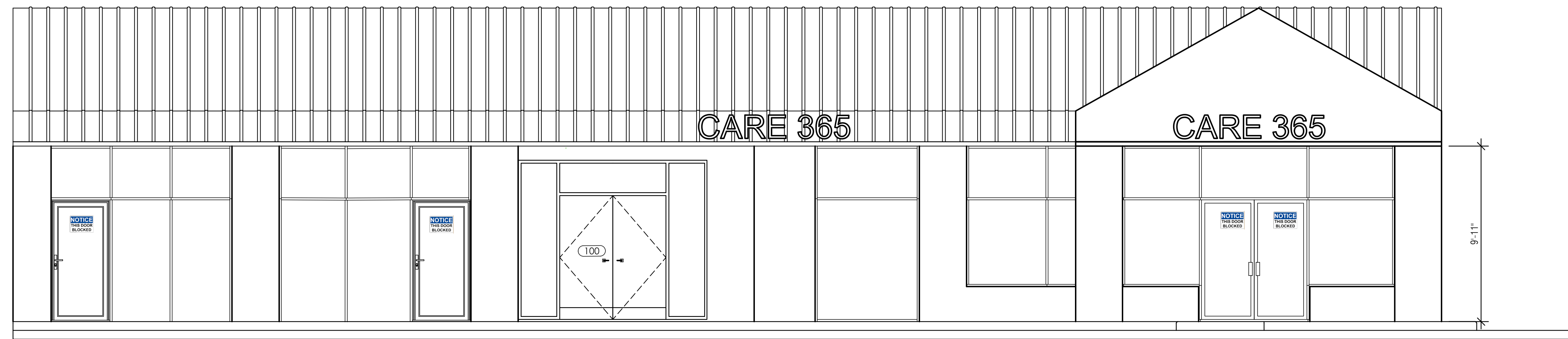


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ISSUED FOR DOH/CON APPROVAL: 9/23/22



**EXTERIOR ELEVATION** **1**  
SCALE: 1/4"=1'-0"

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1663 ROUTE 202  
POMONA, NY 10970

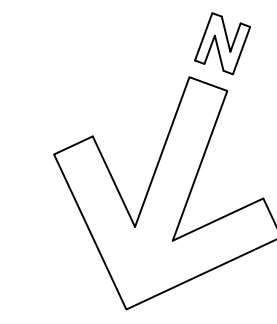
DRAWING TITLE:  
EXTERIOR ELEVATION

PROJECT #:  
21004

DRAWN BY: T.Z. REVIEWED BY: R.B.

PRINT DATE:  
09/23/22

A-4.00



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**BILD**  
 ARCHITECTURE

ADDRESS: 501 CHESTNUT RIDGE ROAD  
 CHESTNUT RIDGE, NY 10977  
 TEL: 212.381.0670  
 EMAIL: INFO@BILDNY.COM  
 WEBSITE: WWW.BILDNY.COM

ISSUED: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ISSUED FOR DOH/CON APPROVAL: 9/23/22



LIGHTING LEGEND	
TYPE	DESCRIPTION
L1	24"x24" RAB FLAT FIXTURE
L2	24"x24" T GRID SQUARE
L3	4"x4" LED SQUARE HIGH HAT
L4	WALL WASHER
L5	CURVED CHANNEL LIGHT
L6	2" LED CHANNEL
L7	SUSPENDED LINEAR LIGHTS
L8	LED COVE LIGHTING

**LEGEND**

	AREA OF ARTICLE 28
	AREA OUT OF THE ARTICLE

1 REFLECTED CEILING PLAN  
 1/4"=1'-0"

SEAL & SIGNATURE



PROJECT ADDRESS:  
 CARE 365  
 1663 ROUTE 202  
 POMONA, NY 10970

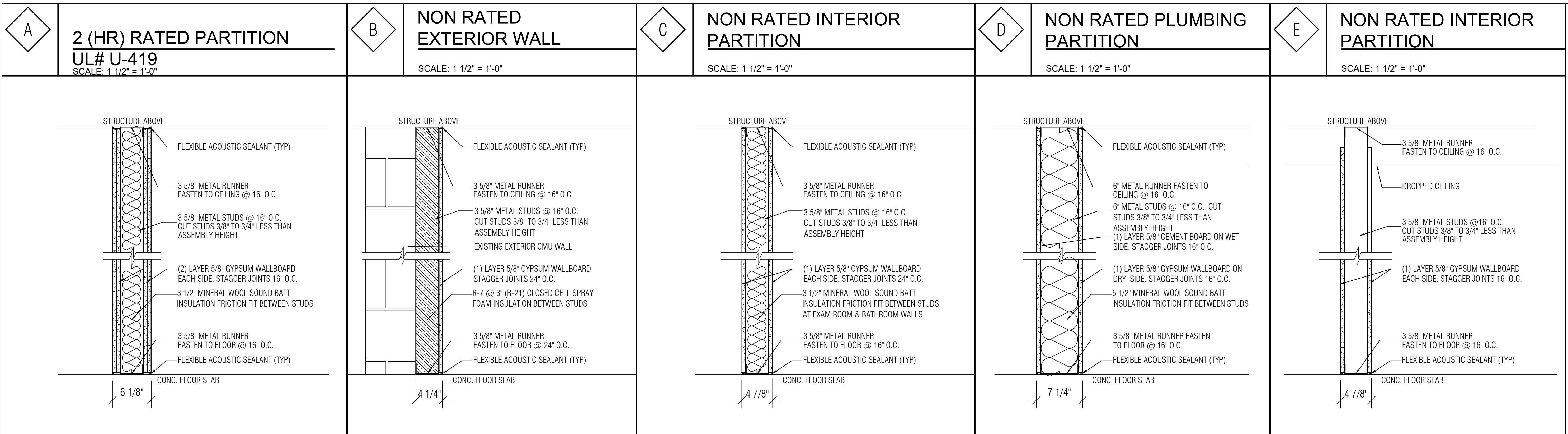
DRAWING TITLE:  
 REFLECTED CEILING PLAN

PROJECT #:  
 21004

DRAWN BY: T.Z. REVIEWED BY: R.B.

PRINT DATE:  
 09/23/22

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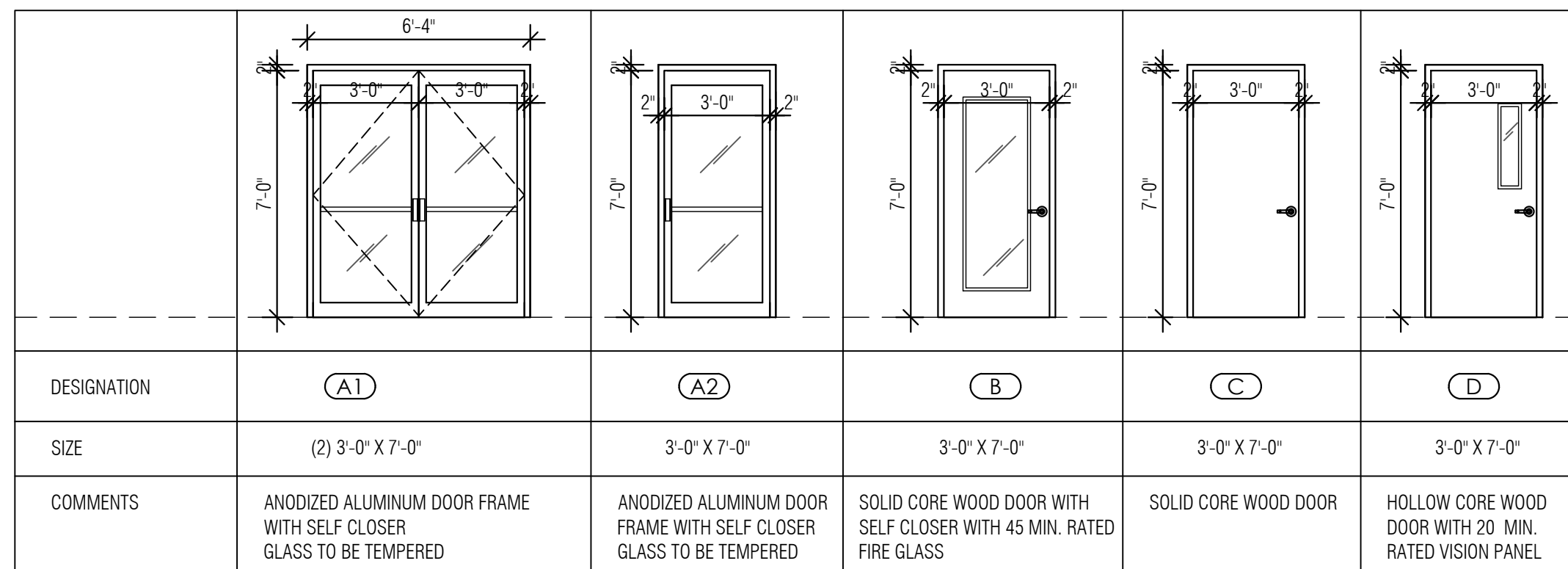


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CHESTNUT RIDGE, NY 10977  
TEL: 212.381.0670  
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ISSUED: \_\_\_\_\_ DATE: \_\_\_\_\_  
ISSUED FOR DOH/CON APPROVAL: 9/23/22

### WALL TYPES 1

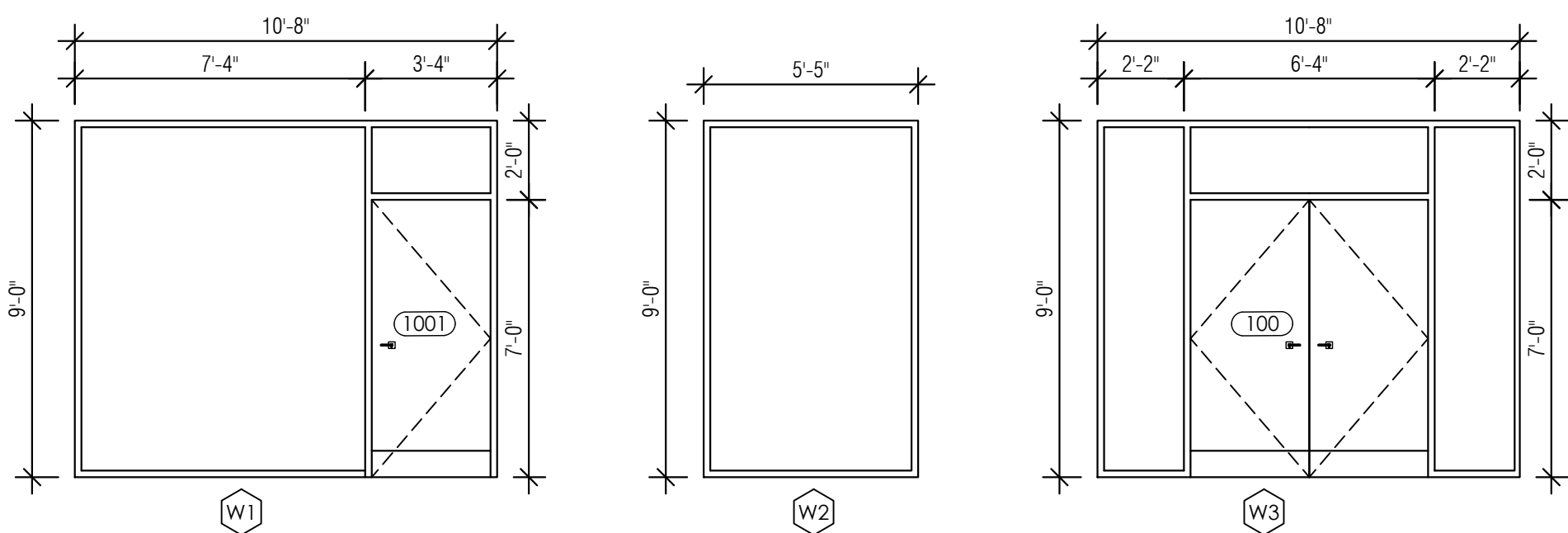
SCALE: 1 1/2" = 1'-0"



ALL HARDWARE TO ADA COMPLIANT LEVER STYLE

### DOOR TYPES 2

SCALE: 1/4" = 1'-0"



WINDOW MANUFACTURER SPECS TO BE PROVIDED TO THE BUILDING DEPARTMENT PRIOR TO INSTALLATION. SPECS SHALL INCLUDE ALL ENERGY PERFORMANCE DATA. ALL GLASS SHALL BE TEMPERED.

### WINDOW SCHEDULE 4

SCALE: 1/4" = 1'-0"

DOOR NUMBER	ROOM NAME	DOOR TYPE	SIZE					FRAME		COMMENTS	
			WIDTH	HEIGHT	THICKNESS	MATERIAL	FINISH	FIRE RATING	MATERIAL		FINISH
100	VESTIBULE	A1	(2)36"	84"		ALUM	ANODIZED		ALUM	ANODIZED	PROVIDE SELF CLOSER
101	VESTIBULE	A2	36"	84"		ALUM	ANODIZED		ALUM	ANODIZED	PROVIDE SELF CLOSER
102	WAITING AREA	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER
103	WAITING AREA	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER
104	PUBLIC TOILET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER & KICK PLATE
105	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
106	PHLEBOTOMY ROOM	C	36"	96"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	OPTIONAL SELF CLOSER
107	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
109	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
110	PATIENT TOILET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER, KICK PLATE & EMERGENCY RESCUE HARDWARE
111	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
112	PATIENT TOILET	C	36"	84"	1 3/4"	SCWD	PAINTED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER, KICK PLATE & EMERGENCY RESCUE HARDWARE
113	STAFF BREAK ROOM	C	36"	84"	1 3/4"	SCWD	PAINTED	20 MIN.	STEEL	PAINTED	
114	ULTRASOUND ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
115	ELECTRIC CLOSET	C	36"	84"	1 3/4"	HWD	STAINED	20 MIN.	STEEL	PAINTED	
116	PATIENT TOILET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER, KICK PLATE & EMERGENCY RESCUE HARDWARE
117	STAFF TOILET	C	30"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER & KICK PLATE
118	LAB	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER
119	CLEAN WORK ROOM	C	36"	84"	1 3/4"	HWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER
120	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
121	SOILED HOLDING	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER
122	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
123	JANITORS CLOSET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
124	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
125	STORAGE CLOSET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
126	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
127	TREATMENT ROOM	C	44"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
128	EXAM ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
129	WAITING AREA	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
130	DOCTORS PRIVACY ROOM	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	OPTIONAL SELF CLOSER
131	ADA CHANGING ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
132	DIRECTORS OFFICE	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
133	WAITING AREA	D	44"	84"	1 3/4"	HWD	STAINED	20 MIN.	STEEL	PAINTED	
135	X-RAY ROOM	C	44"	84"	1 3/4"	HWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE LEAD LINED DOOR
136	LARGE STORAGE ROOM	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
137	OFFICE	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
138	HALLWAY	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
139	OFFICE	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
140	STAFF TOILET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE SELF CLOSER & KICK PLATE
141	IT CLOSET	C	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	PROVIDE LOUVER & OPTIONAL SELF CLOSER
142	CONFERENCE ROOM	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
143	CONFERENCE ROOM	B	36"	84"	1 3/4"	SCWD	STAINED	20 MIN.	STEEL	PAINTED	
144	EXISTING DOOR		36"	84"	1 3/4"	HM	PAINTED		HM	PAINTED	EXISTING PANIC HARDWARE TO REMAIN

### DOOR SCHEDULE 3

SCALE: 1/4" = 1'-0"

SEAL & SIGNATURE



PROJECT ADDRESS:

CARE 365  
1663 ROUTE 202  
POMONA, NY 10970

DRAWING TITLE:

WALL TYPES/ DOOR & WINDOW SCHEDULES

PROJECT #:

21004

DRAWN BY:

T.Z.

REVIEWED BY:

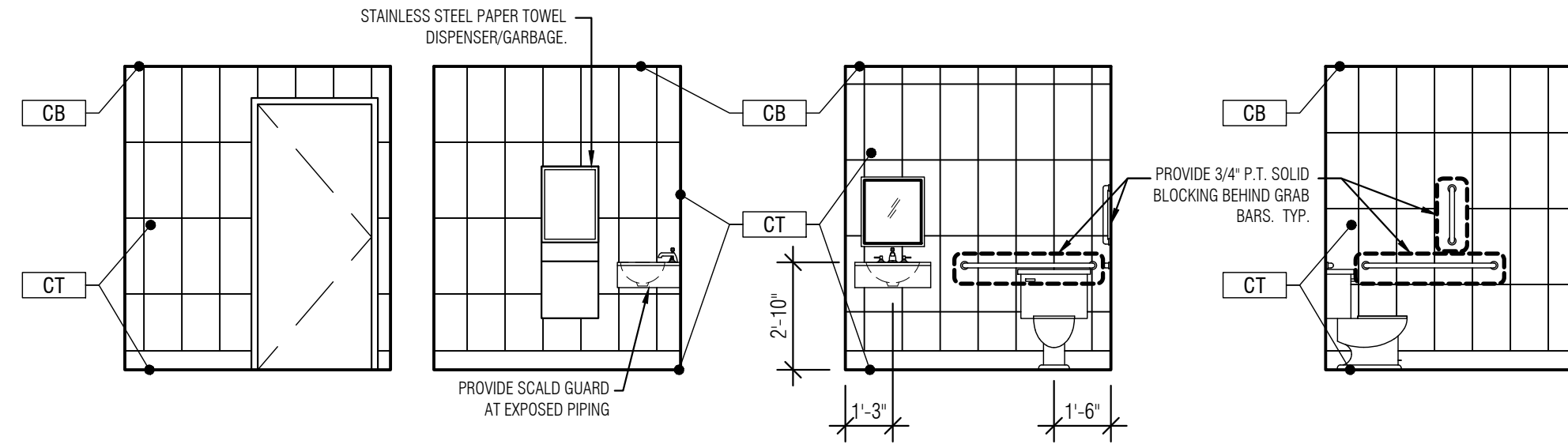
R.B.

PRINT DATE:

09/23/22

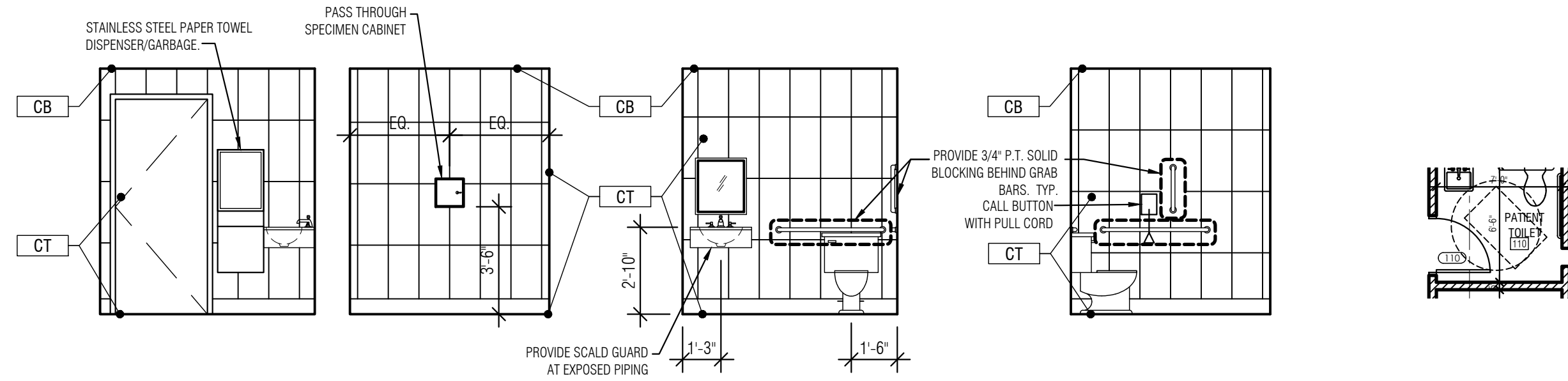
A-5.00

LEGEND:  
 CT - CERAMIC TILE  
 VT - VINYL TILE  
 GB - GYP BOARD  
 CB - CEMENT BOARD



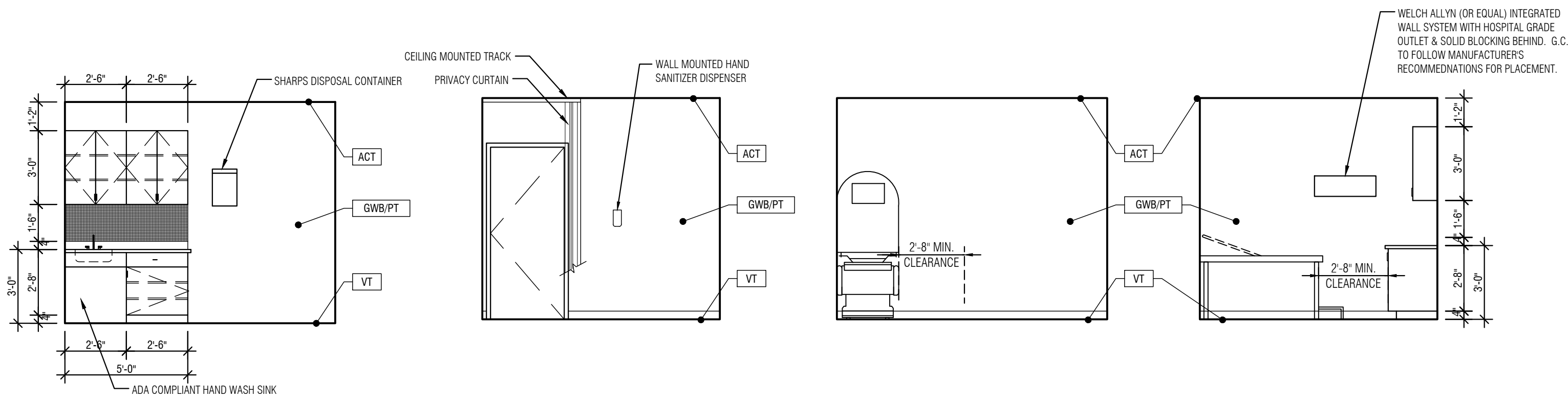
## PUBLIC TOILET ELEVATIONS 1

SCALE: 1/4" = 1'-0"



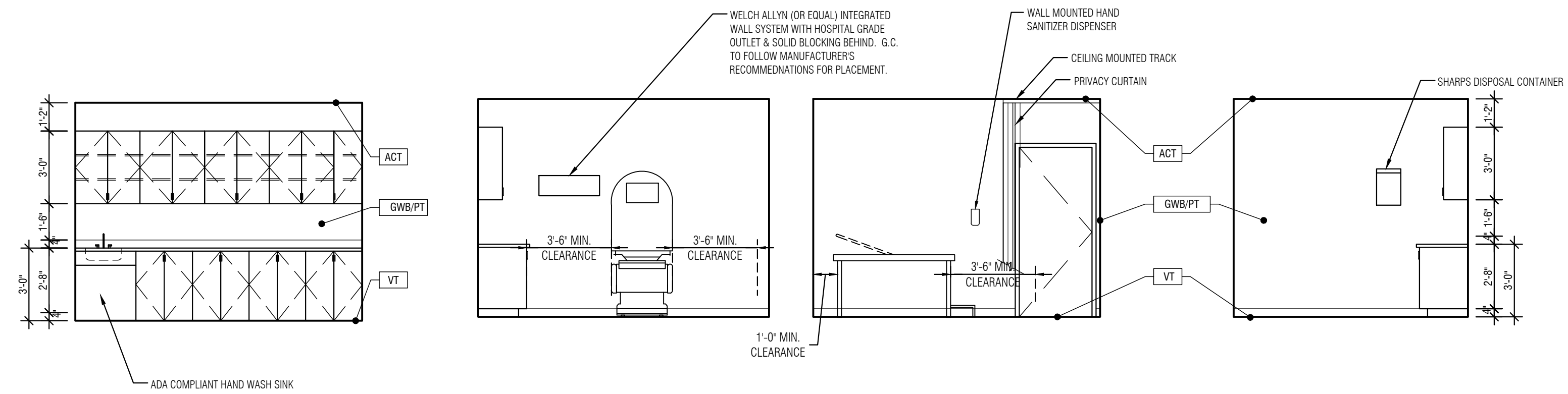
## PATIENT TOILET ELEVATIONS 2

SCALE: 1/4" = 1'-0"



## TYPICAL EXAM ROOM ELEVATIONS 3

SCALE: 1/4" = 1'-0"



## TREATMENT ROOM ELEVATIONS 4

SCALE: 1/4" = 1'-0"

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**BILD**  
 ARCHITECTURE

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 TEL: 212.381.0670  
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 WEBSITE: WWW.BILDNY.COM

ISSUED DATE:  
 ISSUED FOR DOH/CON APPROVAL 9/23/22

SEAL & SIGNATURE



PROJECT ADDRESS:

CARE 365  
 1663 ROUTE 202  
 POMONA, NY 10970

DRAWING TITLE:

INTERIOR ELEVATIONS

PROJECT #:  
 21004

DRAWN BY: T.Z. REVIEWED BY: R.B.

PRINT DATE:

09/23/22

A-4.10



**Department  
of Health**

**KATHY HOCHUL**  
Governor

**JAMES V. McDONALD, M.D., M.P.H.**  
Acting Commissioner

**MEGAN E. BALDWIN**  
Acting Executive Deputy Commissioner

---

**PHYSICIST LETTER OF CERTIFICATION  
FOR  
DIAGNOSTIC RADIOGRAPHY, COMPUTED TOMOGRAPHY (CT) FACILITIES,  
INTERVENTIONAL IMAGING, RADIATION THERAPY FACILITIES, PROTON THERAPY,  
NUCLEAR MEDICINE AND/OR MAGNETIC IMAGING FACILITIES**

**Date:** 05/03/2023  
**CON Number:** TBD  
**Facility Name:** Care365 II  
**Facility ID Number:** TBD  
**Facility Address:** 1633 Route 202, Ponomo, NY 10970

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  
To The New York State Department of Health:

I hereby certify that for:

- A. Diagnostic Radiography, Computed Tomography (CT) Facilities, Interventional Imaging and Radiation Therapy Facilities;**
1. I have been retained by the aforementioned facility, to provide medical physicists services, in conjunction with the construction documents prepared by a NYS Licensed Architect/Engineer.
  2. I have exercised due diligence and, to the best of my knowledge, information and belief, the radiation protection designed and specified for the above-referenced project is in substantial compliance with the requirements of the relevant technical standards listed in 10 NYCRR 711.2 including but not limited to Section 2.2-3.4 (Imaging) and (2) Section 2.2-3.5 (Interventional Imaging, of the 2014 Guidelines for Design and Construction of Hospital and Health Care Facilities and that the radiation exposure to the public and staff is designed to be as low as is reasonably achievable (ALARA), based on the work load provided to me by the facility for the proposed equipment and sound radiation protection principles.
  3. Further, I agree to ensure that a current report detailing the extent of the radiation protection by the facility and the design of the protection systems will be made available to the Regional Office staff of the NYS Department of Health during the final inspection of the facility. I have informed the applicant that such report must be maintained on site as a permanent record.
- B. Magnetic Resonance Imaging (MRI) Facilities, Interventional and Intraoperative MRI (I-MRI) Facilities;**
1. I further certify that I have exercised due diligence and, to the best of my knowledge, information and belief the MRI magnetic shielding and radio frequency shielding as designed and specified are in substantial compliance with the requirements of the relevant technical standards listed in 10 NYCRR

711.2, including but not limited to Section 2.2-3.4 (Imaging) and (2) Section 2.2-3.5 (Interventional Imaging, of the 2014 Guidelines for Design and Construction of Hospital and Health Care Facilities.

2. I have reviewed the manufacturer's certifications accompanying all relevant equipment to ensure that such certifications satisfy all the requirements for patient, operator, and public safety.
3. I agree to submit an Architectural floor plan identifying the proposed MRI location, delineating all areas of the room and including the 5 Gauss line in three-dimensional planes, demonstrating that the electromagnetic and radio frequency environment is appropriate for the locations indicated are being submitted simultaneously with this Letter of Certification.

C. Description (Circle applicable facility type):

Diagnostic Radiography, Computed Tomography (CT) Facilities, Interventional Imaging, Radiation Therapy Facilities, Proton Therapy, Nuclear Medicine, Magnetic Resonance Imaging (MRI) Facilities

NYS Licensed  
Radiological Physicist  
16-01

Thomas J. LaRocca  
Signature of Medical Physicist

Thomas J. LaRocca, MS, DABR  
Name of Medical Physicist (Print)

BioMed Associates, 4 Main St. Flemington, NJ  
Business Address

908-788-9440; Cellphone: 845-849-8336  
Business Telephone

The undersigned applicant understands and agrees that, notwithstanding this Medical Physicist 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.

5/3/23  
Date

Zehava Goldenberg  
Authorized Signature for Applicant  
Zehava Goldenberg Managing member  
Name (Print) Title

Notary signing required for the applicant

STATE OF NEW YORK

County of Rockland

)  
) SS:  
)

On the 3rd day of May 2023 before me personally appeared Zehava Goldenberg, to me known, who being by me duly sworn, did depose and say that he/she is the Managing Member of the Care 365 36U LLC, 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) Moshe C Goldblatt

Moshe C Goldblatt  
Notary Public, State of New York  
No. 01606346353  
Qualified in Rockland County  
Commission Expires Aug. 08, 2024

PHYSICIST LETTER OF CERTIFICATION

August 23, 2021

Stanley Cohen, LRT  
Director of Radiology  
QHC Upstate Medical, PC  
Care365  
1 Main Street  
Monsey, NY 10952

Dear Stan:

This report specifies the radiation protection requirements of the proposed x-ray room at 1633 Route 202, Pomona, NY. It is based upon the architectural drawing A1 by Walsh Imaging dated 8/17/21.

The calculations applied in this report were made in accordance with the recommendations of the National Council on Radiation Protection (NCRP) Report Number 147, and in accord with regulations of the State of New York.

Specifications for each barrier are enclosed. Shielding specifications are the minimum required thickness. Lead sheets of greater thickness may be substituted. Also enclosed are recommendations concerning structural details and notes. Any changes to the drawing, including the location of equipment, position of wall barriers, or change in occupancy or use of adjacent areas, etc, will necessitate recalculation of the shielding specifications.

After installation is complete, please contact me to confirm shielding integrity by performing a radiation protection survey of the facility.

If you require further information, please do not hesitate to contact me.

Thank you for choosing the radiological physics services of Bio-Med Associates.

Sincerely:

*BIO-MED ASSOCIATES, INC.*



Thomas J. LaRocca, M.S., D.A.B.R.  
Radiological Physicist

Enclosure

**ATTACHMENT A**

**Date:** 8/23/2021

**FACILITY INFO**

<b>Facility:</b>	<u>QHC Upstate Medical, PC, Care36</u>	<b>Phone:</b>	<u>(845) 371-7200, ext. 214</u>
<b>Address:</b>	<u>1633 Route 202</u>	<b>State:</b>	<u>NY</u>
<b>City:</b>	<u>Pomona</u>	<b>Zip:</b>	<u>10970</u>

**EQUIPMENT GENERAL**

**Manufacturer:** Shimadzu  
**Model:** Radspeed OTC

**BARRIER SHIELDING SUMMARY - See diagram Page 3**

X-Ray Room	Barrier Type	Shielding Material	Existing Shielding (inches)	Additional Shielding (inches)	Comments
A - Control Room	Secondary	Lead	Two 5/8" Gypsum	1/16" Pb	Window = 1.5 mm lead
B - Storage Room	Secondary	Lead	Two 5/8" Gypsum	1/64" Pb	
C - Corridor	Secondary	Lead	Two 5/8" Gypsum	1/32" Pb	
D - Waiting Room	Secondary	Lead	Two 5/8" Gypsum	1/32" Pb	Wall & Door
E - Outside	Primary	Lead	Cinder Block	1/64" Pb	
F - Outside	Secondary	Lead	Cinder Block	1/64" Pb	
Ceiling - Roof	No Occupancy				
Floor - Earth	No Occupancy				

**ASSUMPTIONS**

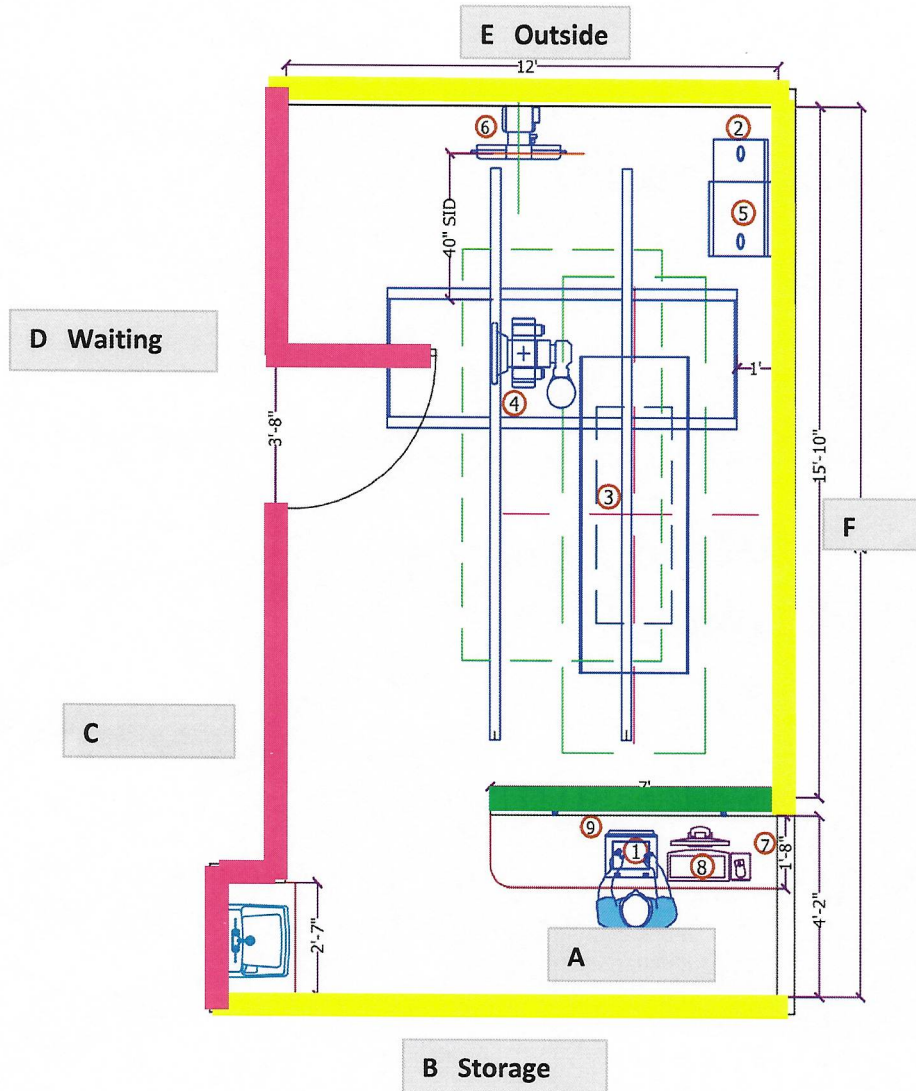
It is based upon the architectural drawing A1 by Walsh Imaging dated 8/17/21.  
 Concrete Cinder Block on outside walls.  
 Above - Roof - No Occupancy  
 Below - Earth/slab - No Occupancy  
 Workload - X-Ray: 200 patients/week.



# ATTACHMENT B

QHC Upstate Medical, PC, Care365  
 1633 Route 202, Pomona, NY 10970

August 23, 2021



## KEY

	1/64" of Lead
	1/32 of Lead
	3/64" of Lead
	1/16" of Lead

## Structural Details of Protective Barriers

1. Lead barriers shall be mounted in such a manner that they will not sag or cold-flow because of their own weight. They shall be protected against mechanical damage. It is recommended that lead of 1/32 inch or less thickness be bonded to panels of some rigid supporting material.
2. Surfaces of lead sheets at joints in the barrier should be in contact with a lap of at least 1/2 inch or twice the thickness of the sheets, whichever is greater.
3. Welded or burned lead seams are permissible, provided the lead equivalent of the seams is not less than the minimum requirement of the barrier.
4. Joints between different kinds of protective materials shall be so designed that the overall protection of the barrier is not impaired.
5. Joints at the floor and ceiling shall be so designed that the overall protection is not impaired.
6. Windows, window frames, doors and door frames shall have the same lead equivalent as that required of the adjacent wall. Where thick concrete walls are tapered into openings, as is frequently done with observation windows, it may be necessary to add lead protective flanges around the window frame to compensate for the reduced thickness of concrete. A door baffle or threshold may be required for installations operating above 125 kVp, if the discontinuity can be struck by the useful beam. Special attention should be given to providing overlap of the shielding of the door frame and the shielding of the door.
7. Holes in protective barriers shall be covered so that overall attenuation is not impaired.
8. Louvers and holes in barriers for pipes, conduits, service boxes and air ducts may require baffles to insure that the overall protection afforded by the barrier is not impaired. It is advisable to locate such holes outside of the range of direction of the useful beam.

Notes:

1. The minimum height recommended by the NCRP is 7 feet 0 inches from the floor to the ceiling for all lead lined wall partitions. When the ceiling has a shielding requirement, the wall specification should extend from the floor to the ceiling.
2. The door frame should be carefully installed with overlapping pieces of lead so that no gaps are created.
3. Cassette Holder - The cassette holder should be mounted as specified by manufacturer.
4. The pass box should be installed as recommended in manufacturer's specifications. Care should be taken on installation of pass box such that gaps are not created when installed. Lead pieces bent to right angles should be fitted around all sides of the pass box.
5. The control booth should be lead lined to 1/16 inch of lead, and the window should have lead glass equivalent to 1/16 inch of lead.
6. All connections in the wall, (i.e. electrical outlets, plumbing, etc.), should have lead in the back of the cutouts in the wall overlapping the lead lined wall so that holes are not created. All corners should be sealed such that gaps are not created in the corner of the room.
7. The type and manufacturer of lead lining used in the X-ray Room should be specified by the general contractor or architect.
8. When a shielded door does not exist, the edge of the observation window should be at least 18 inches from the edge of the control partition.
9. Shielding specifications are the minimum required thickness; lead sheets of greater thickness may be substituted. Lead sheets less than 1/32 inch are usually more expensive than thicker sheets.

**Barrier:** E - Outside  
**Barrier Type:** Rad Room (chest bucky)

$K_p^1$  (mGy/Pt) Table 4.5)= 2.3

Design Goal P (mGy/wk): 0.02  
 Occupancy T: 0.05  
 Distance d (m): 1.8  
 Use Factor U (Table 4.4): 1  
 Patients per week N: 200

**Cinder Blocks**  
 2.5" concrete  
 63.5 mm

Barrier Construction (e.g. lead) =	Lead	Concrete
$\alpha$ (mm-1)	2.26E+00	3.55E-02
$\beta$ (mm-1)	1.31E+01	1.18E-01
$\gamma$	5.60E-01	6.01E-01
<b>Total Barrier thickness (mm):</b>	<b>1.238</b>	<b>101.159</b>
<b>Inherent Shielding (mm):</b>	0.85	72
<b>Required Shielding (mm):</b>	0.39	29.16
<b>Cinder Block Shielding (mm):</b>	0.74	63.5
<b>Required Shielding (in):</b>	None	None
<b>Will recommend 1/64" Lead</b>	<b>1/64" Pb</b>	

Barrier: A - Control Rooms  
 Barrier Type: Rad Room (all barriers)  
 Leakage/Scatter Cat. Leakage & Side Scatter

$$K^1_{sec} \text{ (Table 4.7)} = 3.40E-02$$

Design Goal P (mGy/wk):	<u>0.1</u>	Barrier Construction (e.g. lead) =	Lead
Occupancy T:	<u>1</u>	$\alpha(\text{mm-1})$	2.30E+00
Distance d (m):	<u>2.0</u>	$\beta(\text{mm-1})$	1.74E+01
Patients per week N:	<u>200</u>	$\gamma$	6.19E-01
		Required Barrier thickness (mm):	0.312
		Inherent Shielding (mm):	
		Required Shielding (mm):	0.31
		Required Shielding (in):	1/16" Pb

Barrier: B - Storage Room  
 Barrier Type: Rad Room (all barriers)  
 Leakage/Scatter Cat. Leakage & Side Scatter

$$K^1_{sec} \text{ (Table 4.7)} = 3.40E-02$$

Design Goal P (mGy/wk):	<u>0.02</u>	Barrier Construction (e.g. lead) =	Lead
Occupancy T:	<u>0.05</u>	$\alpha(\text{mm-1})$	2.30E+00
Distance d (m):	<u>4.0</u>	$\beta(\text{mm-1})$	1.74E+01
Patients per week N:	<u>200</u>	$\gamma$	6.19E-01
		Required Barrier thickness (mm):	0.003
		Inherent Shielding (mm):	
		Required Shielding (mm):	0.00
		Required Shielding (in):	1/64" Pb

Barrier: C - Corridor  
 Barrier Type: Rad Room (all barriers)  
 Leakage/Scatter Cat. Leakage & Side Scatter

$$K^1_{sec} \text{ (Table 4.7)} = 3.40E-02$$

Design Goal P (mGy/wk):	<u>0.02</u>	Barrier Construction (e.g. lead) =	Lead
Occupancy T:	<u>0.2</u>	$\alpha(\text{mm-1})$	2.30E+00
Distance d (m):	<u>3.0</u>	$\beta(\text{mm-1})$	1.74E+01
Patients per week N:	<u>200</u>	$\gamma$	6.19E-01
		Required Barrier thickness (mm):	0.180
		Inherent Shielding (mm):	
		Required Shielding (mm):	0.18
		Required Shielding (in):	1/32" Pb

Barrier: D - Waiting Area Wall & Door  
 Barrier Type: Rad Room (all barriers)  
 Leakage/Scatter Cat. Leakage & Side Scatter

$$K^1_{sec} \text{ (Table 4.7)} = 3.40E-02$$

Design Goal P (mGy/wk):	<u>0.02</u>	Barrier Construction (e.g. lead) =	Lead
Occupancy T:	<u>0.2</u>	$\alpha(\text{mm-1})$	2.30E+00
Distance d (m):	<u>2.0</u>	$\beta(\text{mm-1})$	1.74E+01
Patients per week N:	<u>200</u>	$\gamma$	6.19E-01
		Required Barrier thickness (mm):	0.312
		Inherent Shielding (mm):	
		Required Shielding (mm):	0.31
		Required Shielding (in):	1/32" Pb

Barrier: F - Outside  
 Barrier Type: Rad Room (all barriers)  
 Leakage/Scatter Cat. Leakage & Side Scatter

$$K^1_{sec} \text{ (Table 4.7)} = 3.40E-02$$

Design Goal P (mGy/wk):	<u>0.02</u>	Barrier Construction (e.g. lead) =	Concrete
Occupancy T:	<u>0.025</u>	$\alpha(\text{mm-1})$	3.61E-02
Distance d (m):	<u>1.3</u>	$\beta(\text{mm-1})$	1.43E-01
Patients per week N:	<u>200</u>	$\gamma$	5.60E-01
		Required Barrier thickness (mm):	12.825
		Inherent Shielding (mm):	63.5
		Required Shielding (mm):	-50.67
		Required Shielding (in):	NONE
		Will recommend 1/64" Lead	1/64" Pb

Definitions:

Primary Barrier - Barrier sufficient to attenuate the useful beam to the required degree.

Secondary Barrier - Barrier sufficient to attenuate the stray (leakage and scattered) radiation to the required degree. The secondary barrier may not intercept the useful beam.

Controlled Area - A defined area in which the exposure of persons to radiation is under the supervision of a Radiation Protection Supervisor. (This implies that a controlled area is one that requires control of access, occupancy, and working conditions for radiation protection purposes).

Non-controlled Area - Any space not meeting the definition of controlled area.

Use Factor [Beam Direction Factor (U)] - Fraction of the workload during which the radiation under consideration is directed at a particular barrier.

Occupancy Factor (T) - The factor by which the workload should be multiplied to correct for the degree of occupancy of the area in question while the source is "ON".

Workload (W) - The degree of use of an x-ray or gamma ray source. For x-ray equipment operating below 4 MV, the workload is usually expressed in milliamperere minutes per week. For gamma-beam therapy sources, and for x-ray equipment operating at 4 MV or above, the workload is usually stated in terms of the weekly exposure of the useful beam at one meter from the source and is expressed in roentgens per week at one meter.

Maximum Permissible Dose Equivalent (MPD) - For radiation protection purposes, maximum dose equivalents that persons shall be allowed to receive in a stated period of time. For radiation protection purposes of this report, the dose equivalent in rems may be considered numerically equal to the absorbed dose in rads and the exposure in roentgens.

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

## **Contents:**

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

## Environmental Assessment

<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 type="checkbox"/>	<input checked="" type="checkbox"/>
1.2	Does this plan involve construction and change land use or density?	<input type="checkbox"/>	<input checked="" 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 Building Department		
	Contact Name:	Ian Smith		
	Address:	237 Route 59		
	State and Zip Code:	Suffern, NY 10901		
	E-Mail Address:	smithi@ramapo-ny.gov		
	Phone Number:	(845)-357-5100 ext. 326		
	<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 type="checkbox"/>	<input checked="" type="checkbox"/>
	<b>Agency Name:</b>			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
Phone Number:				
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.</b>	<b>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>		
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.

[https://www.fema.gov/media-library-data/1582295171786-6506170c5f54026f585e44e2fc94950d/FF086033\\_ElevCert\\_FormOnly\\_RE\\_11Feb2020.pdf](https://www.fema.gov/media-library-data/1582295171786-6506170c5f54026f585e44e2fc94950d/FF086033_ElevCert_FormOnly_RE_11Feb2020.pdf)

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

This schedule is required for all Full or Administrative review applications except Establishment-Only applications.

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

	<b>Total</b>	<b>Source</b>
<b>Project Description:</b>		
<b>Project Cost</b>	\$40,000	Schedule 8b, column C, line 8
<b>Total Basic Cost of Construction</b>	\$40,000	Schedule 8B, column C, line 6
<b>Total Cost of Moveable Equipment</b>	\$0	Schedule 8B, column C, line 5.1
<b>Cost/Per Square Foot for New Construction</b>	n/a	Schedule 10
<b>Cost/Per Square Foot for Renovation Construction</b>	\$0	Schedule 10
<b>Total Operating Cost</b>	<del>\$2,446,504</del>	Schedule 13C, column B
<b>Amount Financed (as \$)</b>	\$0	Schedule 9
<b>Percentage Financed as % of Total Cost</b>	0.00%	Schedule 9
<b>Depreciation Life (in years)</b>	0	
<b>Depreciation Life (in years)</b>	0	

**2) Construction Dates**

<b>Anticipated Start Date</b>	N/A	Schedule 8B
<b>Anticipated Completion Date</b>	N/A	

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

This schedule is required for all Full or Administrative review applications except Establishment-Only applications.

0	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	0.00%	Normally 10%
Construction Contingency - Renovation Work	0.00%	Normally 10%
Anticipated Construction Start Date:	N/A	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	N/A	as mm/dd/yyyy
Anticipated Completion of Construction Date	N/A	as mm/dd/yyyy
Year used to compute Current Dollars:	2023	2023

Subject of attachment	Attachment Number	Filename of attachment - PDF
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.		
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.		

**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	Escalation amount to Mid-point of Construction	Estimated Project Costs
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	\$0		\$0
1.2 Building Acquisition	\$0		\$0
2.1 New Construction	\$0	\$0	\$0
2.2 Renovation & Demolition	\$0	\$0	\$0
2.3 Site Development	\$0	\$0	\$0
2.4 Temporary Utilities	\$0	\$0	\$0
2.5 Asbestos Abatement or Removal	\$0	\$0	\$0
3.1 Design Contingency	\$0	\$0	\$0
3.2 Construction Contingency	\$0	\$0	\$0
4.1 Fixed Equipment (NIC)	\$0	\$0	\$0
4.2 Planning Consultant Fees	\$0	\$0	\$0
4.3 Architect/Engineering Fees	\$0	\$0	\$0
4.4 Construction Manager Fees	\$0	\$0	\$0
4.5 Other Fees (Consultant, etc.)	\$40,000	\$0	\$40,000
Subtotal (Total 1.1 thru 4.5)	\$40,000	\$0	\$40,000
5.1 Movable Equipment (from Sched 11)	\$0	\$0	\$0
5.2 Telecommunications	\$0	\$0	\$0
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	\$40,000	\$0	\$40,000
7.1 Financing Costs (Points etc)	\$0		\$0
7.2 Interim Interest Expense: \$ <input type="text"/> At <input type="text"/> % for <input type="text"/> months	\$0		\$0
8. Total Project Cost: w/o CON fees Total 6 thru 7.2	\$40,000	\$0	\$40,000
Application fees:			
9.1 Application Fee. Articles 28, 36 and 40. See Web Site.	\$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"/> 0.003	\$120	\$0	\$120
10 Total Project Cost with fees	\$42,120	\$0	\$42,120

# 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	\$42,120
<input type="checkbox"/>	C. Mortgage, Notes, or Bonds	\$
<input type="checkbox"/>	D. Land	\$
<input type="checkbox"/>	E. Other	\$
<input type="checkbox"/>	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	\$42,120

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 type="checkbox"/>	Schedule 9 Attachment
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 type="checkbox"/>	Schedule 9 Attachment
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 type="checkbox"/>	Schedule 9 Attachment
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	\$42,120
Sale of Existing Assets	\$
Gifts (fundraising program)	\$
Government Grants	\$
Other	\$
<b>TOTAL CASH</b>	<b>\$42,120</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 checked="" type="checkbox"/>	
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	<input type="checkbox"/>	Schedule 9 Attachment
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"/>	

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

**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"/>	10% equity met
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**

***Not Applicable***

	<b>Total Project</b>	<b>Units</b>
Interest		%
Term		Years
Payout Period		Years
Principal		\$

	<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 checked="" type="checkbox"/>	
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"/>	

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

**Schedule 9**

**D. Land**

**Not Applicable**

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 type="checkbox"/>	
2. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	<input type="checkbox"/>	
3. Submit a copy of the proposed purchase/option agreement.	<input type="checkbox"/>	
4. Provide an affidavit indicating any and all relationships between seller and the proposed operator/owner.	<input type="checkbox"/>	

**E. Other**

**Not Applicable**

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 type="checkbox"/>	

**F. Refinancing**

**Not Applicable**

	N/A	Title of Attachment
1. Provide a breakdown of the terms of the refinancing, including principal, interest rate, and term remaining.	<input 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 type="checkbox"/>	

## Care365 LLC

### Schedule 09 Attachments

- Attachment A – Property Lease
- Attachment B – Lease Assignment
- Attachment C – Rent Reasonableness Letters
- Attachment D – Member’s Schedule 2B



1609 Route 202  
Pomona, NY 10970  
Office: 845-35Q-4663

March 26, 2023

Care365 North, LLC  
1633 Route 202  
Pomona, NY 10970

To Whom It May Concern:

After a careful analysis of current office and retail store rentals in the Pomona area, near Route 202, in my professional opinion, the rent of about \$32-\$33 per square foot is standard in the area for office space, and about \$4-\$5 more for retail space. My office is in the area at 1609 Route 202, Pomona so I am knowledgeable of the market rental prices.

The fair and reasonable rent for the space at 1633 Route 202, Pomona NY 10970 would be in the same range.

I am a licensed real estate agent and am knowledgeable of the rental prices in the Rockland County area.

Please feel free to contact me if you require additional information.

Sincerely,

Rikki Drillman

Real Estate Assoc. Broker  
Q Home Sales  
C.845.558.1283



☎ 845.875.4400  
☎ 845.512.3029  
@ office@metrexrealty.com

March 27, 2023

Care 365 North, LLC  
1633 Route 202  
Pomona, NY 10970

To whom it may concern:

This will confirm that an annual rent of \$32.00 per sqft for space at 1633 Route 202, Pomona, NY 10970 is fair and reasonable for space of this type in this neighborhood, based upon my experience.

I am a licensed real estate agent in Rockland County and am knowledgeable of the rental prices in the proposed area.

Please feel free to contact me if you require additional information.

Sincerely,

*Meyer Tauber*

**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
A	B	D	E					
				#N/A	No Construction proposed for this project			
				#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>0</b>	<b>0</b>	<b>0</b>	



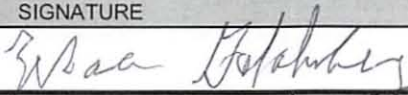
**New York State Department of Health  
 Certificate of Need Application  
 Schedule 10 - Space & Construction Cost Distribution**

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 type="checkbox"/>	NO <input type="checkbox"/>	N/A
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	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	
		5-11-2023	
PRINT NAME		TITLE	
Zehava Goldenberg		Managing Member	
NAME OF FIRM			
Care365, LLC			
STREET & NUMBER			
1 Main Street			
CITY	STATE	ZIP	PHONE NUMBER
Monsey	NY	10952	(845) 371-7200

**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
		Not Applicable (equipment already purchased)				
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:						\$ -

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

**Schedule 13A**

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

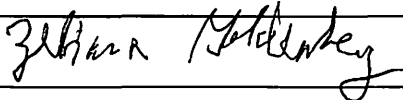
Article 28 applicants seeking combined establishment and construction or construction-only approval must complete this schedule.

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

5-11-2023



Signature:

**Zehava Goldenberg**

Name (Please Type)

**Managing Member**

Title (Please type)

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

**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 or  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		1.0	1.0
2. Technician & Specialist		0.7	0.9
3. Registered Nurses		2.0	2.5
4. Licensed Practical Nurses			
5. Aides, Orderlies & Attendants		4.0	6.0
6. Physicians		0.8	1.0
7. PGY Physicians			
8. Physicians' Assistants		3.0	3.2
9. Nurse Practitioners			
10. Nurse Midwife			
11. Social Workers and Psychologist**			
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			
17. Clerical & Other Administrative		3.0	4.5
18. Other			
19. Other			
20. Other			
21. Total Number of Employees		14.5	19.1

\*Last complete year prior to submitting application

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

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

Staffing is based on expected utilization and the experience of the Center's existing operation at its other site.

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

**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.*

<b>Medical/Center Director</b>	
Name of Medical/Center Director:	Seth Kurtz, MD
License number of the Medical/Center Director	232596

	<b>Not Applicable</b>	<b>Title of Attachment</b>	<b>Filename of attachment</b>
Attach a copy of the Medical/Center Director's curriculum vitae	<input type="checkbox"/>	Medical Director CV	Sch_13_Att

<b>Transfer &amp; Affiliation Agreement</b>	
Hospital(s) with which an affiliation agreement is being negotiated	Nyack Hospital
<ul style="list-style-type: none"> <li>○ Distance in miles from the proposed facility to the Hospital affiliate.</li> </ul>	11.2 miles
<ul style="list-style-type: none"> <li>○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.</li> </ul>	15 minutes
<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 type="checkbox"/> Attachment Name: <b>Sch_13_Att</b>
Name of the <b>nearest</b> Hospital to the proposed facility	Good Samaritan Hospital
<ul style="list-style-type: none"> <li>○ Distance in miles from the proposed facility to the nearest hospital.</li> </ul>	8.3 miles
<ul style="list-style-type: none"> <li>○ Distance in minutes of travel time from the proposed facility to the nearest hospital.</li> </ul>	14 minutes

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

**Schedule 13B**

**Schedule 13 B-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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**New York State Department of Health  
Certificate of Need Application**

**Schedule 13C**

**Schedule 13 C. 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 C	Sch_13_Att
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital	N/A	N/A

Total Project      or       Subproject Number

**Table 13C - 1**

	a	b	c
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)		03/01/2024	03/01/2027
1. Salaries and Wages		\$1,227,000	\$1,569,000
1a. FTEs		14.50	19.10
2. Employee Benefits		\$220,860	\$282,420
3. Professional Fees		\$55,000	\$60,500
4. Medical & Surgical Supplies		\$102,000	\$127,500
5. Non-med., non-surg. Supplies		\$12,750	\$15,937
6. Utilities		\$17,700	\$19,470
7. Purchased Services		\$113,600	\$124,960
8. Other Direct Expenses		\$33,000	\$34,300
9. Subtotal (total 1-8)		\$1,781,910	\$2,234,087
10. Interest (details required below)		\$0	\$0
11. Depreciation (details required below)		\$0	\$0
12. Rent / Lease (details required below)		\$193,980	\$198,030
13. Total Operating Costs		\$1,975,890	\$2,432,117

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

**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)			
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)		03/01/2024	03/01/2027
1. Salaries and Wages		\$1,227,000	\$1,569,000
1a. FTEs		14.50	19.10
2. Employee Benefits		\$220,860	\$282,420
3. Professional Fees		\$55,000	\$60,500
4. Medical & Surgical Supplies		\$102,000	\$127,500
5. Non-med., non-surg. Supplies		\$12,750	\$15,937
6. Utilities		\$17,700	\$19,470
7. Purchased Services		\$113,600	\$124,960
8. Other Direct Expenses		\$33,000	\$34,300
9. Subtotal (total 1-8)		\$1,781,910	\$2,234,087
10. Interest (details required below)		\$0	\$0
11. Depreciation (details required below)		\$0	\$0
12. Rent / Lease (details required below)		\$193,980	\$198,030
13. Total Outpatient Operating Costs		\$1,975,890	\$2,432,117

*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.*



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

**Schedule 13D**

**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"/>	Uploaded as attachment under Schedule 5	
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	<input type="checkbox"/>	Attachment D	Sch_13_Att
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 type="checkbox"/>	Attachment D	Sch_13_Att

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

**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)		03/01/2024	03/01/2027
1. Inpatient Services		\$0.00	\$0.00
2. Outpatient Services		\$2,432,807	\$2,919,368
3. Ancillary Services		\$0.00	\$0.00
4. Total Gross Patient Care Services Rendered		\$2,432,807	\$2,919,368
5. Deductions from Revenue		\$0.00	\$0.00
6. Net Patient Care Services Revenue		\$2,432,807	\$2,919,368
7. Other Operating Revenue (Identify sources)	N/A	\$0.00	\$0.00
8. Total Operating Revenue (Total 1-7)		\$2,432,807	\$2,919,368
9. Non-Operating Revenue		\$0.00	\$0.00
10. Total Project Revenue		\$2,432,807	\$2,919,368

**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)/(A)		(D) Dollars (\$)	\$ per Patient Day or dis- charge (D)/(C)		(F) Dollars (\$)	\$ per Patient Days or dis- charges (F)/(E)
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										

**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			1,530	\$209,809	\$137.13	1,836	\$251,771	\$137.13	
	Managed Care			3,400	\$466,242	\$137.13	4,080	\$559,490	\$137.13	
Medicare	Fee for Service			850	\$83,733	\$98.51	1,020	\$100,480	\$106.30	
	Managed Care			1,700	\$167,467	\$98.51	2,040	\$200,960	\$106.30	
Medicaid	Fee for Service			170	\$29,021	\$170.71	204	\$34,825	\$170.71	
	Managed Care			8,500	\$1,451,035	\$170.71	10,200	\$1,741,242	\$170.71	
Private Pay				170	\$25,500	\$150.00	816	\$30,600	\$150.00	
OASAS										
OMH										
Charity Care				680	\$0.00	\$0.00	204	\$0.00	\$0.00	
Bad Debt										
All Other										
Total				17,000	\$2,432,807		20,400	\$2,919,368		

Total of Inpatient and Outpatient Services					\$2,432,807			\$2,919,368	
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## Care365 LLC

### Schedule 13 Attachments

- Attachment A – Medical Director's Curriculum Vitae
- Attachment B – Hospital Transfer Agreement
- Attachment C – Operating Expenses
- Attachment D – Utilization and Revenues by Payor

**TRANSFER AND AFFILIATION AGREEMENT  
BETWEEN**

**CARE 365, LLC  
AND  
MONTEFIORE NYACK HOSPITAL**

AGREEMENT, entered into this 18<sup>th</sup> day of August 18, 2020, between **Montefiore Nyack Hospital** a duly licensed hospital under the laws of the State of New York, located at 160 N. Midland Ave Nyack, NY (“Hospital”) and **Care365, LLC** a diagnostic and treatment center licensed under Article 28 of the Public Health Law of the State of New York, located at 1 Main St. Monsey, NY 10958 (“Article 28 Facility”).

WHEREAS, the parties hereto wish to further their interests in providing high quality patient care and wish to achieve optimum use of their respective institutions; and

WHEREAS, the Hospital has the capability of providing strong backup support to the Article 28 Facility, including but not limited to medical, diagnostic, emergency and other services; and

WHEREAS, the Hospital can furnish such backup support by providing, as needed, medical, medically related and other support services to enhance the effectiveness of operation of the Article 28 Facility; and

WHEREAS, the Article 28 Facility is required to maintain this Transfer and Affiliation Agreement in accordance with 10 NYCRR § 400.9; and

WHEREAS, the parties wish to provide for an orderly transfer of patients who have received endoscopic procedures from one institution (“Transferring Institution”) to the other institution (“Receiving Institution”) in accordance with the medical needs of their patients, and subject to all applicable laws, rules and regulations;

NOW, THEREFORE, the parties hereto agree as follows:

Section 1. REFERRAL AND TRANSFER OF PATIENTS.

(a) Subject to bed availability, admissions policies and the terms and conditions of this Agreement, both parties may refer and each party agrees to accept for transfer, those patients for whom treatment and care is medically appropriate. When consistent with the foregoing, the Receiving Institution shall give priority consideration to patients of the Transferring Institution with respect to a proposed transfer.

(b) There shall be a timely transfer of patients whenever it is deemed medically appropriate and is mutually agreed upon by the physicians responsible for the patient’s medical care in the Transferring Institution and by the physician at the Receiving Institution who will become responsible for the patient’s care, unless the patient signs out or is signed out against medical advice.

(c) If the patient's personal, alternate or staff physician approves an emergency admission or transfer, the requirement that any referral or transfer of a patient between the parties be mutually agreed upon by appropriate physicians at the respective institutions, as set forth above, may be waived; provided that the circumstances and reasons for such waiver are recorded in the medical record and the Hospital's Emergency Room is notified in advance by telephone and accepts such emergency transfer.

(d) No patient shall be transferred unless the appropriate administrative representative at the Transferring Institution has contacted his or her counterpart at the Receiving Institution and has determined that the Receiving Institution has the facilities available to provide the care and treatment which the patient requires.

(e) Except as provided in Section 2 of this Agreement, in the event, after transfer, the patient's medical condition is such as to warrant the patient's return to the original Transferring Institution, there shall be no automatic re-admission, but rather, the patient's re-admission shall be in accordance with the customary admitting policies of such original Transferring Institution; provided that such original Transferring Institution shall treat such request for re-admission as a priority admission. Nothing herein shall be construed as prohibiting or restricting the use of bed reservations at the Article 28 Facility for eligible patients.

Section 2. CONSENT. Except in the case of an emergency, no patient shall be transferred unless the Transferring Institution shall first have obtained the written consent of the patient (or the patient's legal representative in the event the patient is unable to consent) and shall have provided the Receiving Institution with a copy of such consent with such other patient medical and related information as required under Section 3 of this Agreement. Such information shall be provided to the Receiving Institution prior to the time the patient is transferred. In the event the patient is transferred to the Receiving Institution and the patient, or the patient's legal representative, refuses to consent to the treatment prescribed by the patient's attending physician, or if the patient refuses to consent to care by a physician assigned by the Hospital as provided in Section 7(c) of this Agreement, such patient shall immediately be returned to the Article 28 Facility which shall accept the patient.

Section 3. PROVISION OF MEDICAL AND RELATED INFORMATION. Immediately after the Receiving Institution has agreed to accept the referral and/or transfer of a patient, and prior to the actual transfer, the Transferring Institution shall, subject to all applicable law (including, with limitation, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), forward to the Receiving Institution copies of all medical and other information, including medical, social, nursing and other care plans, as may be relevant to enable the Receiving Institution to provide proper care. Such information may include, but would not necessarily be limited to: current medical findings, diagnosis, rehabilitation potential, brief summary of course of treatment, nutrition and dietary information, consent forms and the patient's ambulation status. The Transferring Institution shall also provide the Receiving Institution with all available information concerning the financial/third party payor status of the patient or those who may be responsible for the patient's financial obligations for care provided to the patient, provided that all necessary consents have been obtained pursuant to HIPAA and any other applicable law.

Section 4. OWNERSHIP OF MEDICAL RECORDS. The medical records for referred or transferred patients which are maintained by each institution shall remain the property of that institution.

Section 5. TRANSPORTATION OF PATIENT. In the event that it becomes necessary to physically transport a patient to the Receiving Institution, it shall be the exclusive responsibility of the Transferring Institution to provide or arrange for the transportation of the patient to the Receiving Institution. The method of physically transporting the patient shall be safe and shall be medically approved by the responsible physician at the Transferring Institution. The Receiving Institution shall have no responsibility for such patient until he/she is admitted to the Receiving Institution as provided herein.

Section 6. PATIENT'S PERSONAL PROPERTY. In the event that it becomes necessary to transfer a patient, simultaneously with such transfer, the Transferring Institution shall arrange for the transfer of the patient's personal effects and valuables to the Receiving Institution. Personal effects, especially monies and valuables, shall be transported safely and shall be stored in a safe place which is reasonably accessible to the patient or person or agency legally authorized to act on behalf of the patient. Information regarding the patient's personal effects shall be maintained in the office of the Administrator or Director of the Receiving Institution and shall be made available to the patient or person or agency legally authorized to act on behalf of the patient. The Receiving Institution shall not be responsible for such personal valuables until such time that the Receiving Institution receives actual possession and signs a receipt for such valuables. The Receiving Institution shall not be responsible for any items retained by the patient, or for any items retained by the Transferring Institution. The parties to this Agreement may develop further policies or procedures to effectuate this paragraph.

Section 7. CONSULTATIONS, CARE AND TREATMENT

(a) The appropriate physicians of each institution shall be reasonably available to the physicians of the other institution for consultation with respect to the care and treatment of any patient who was referred and/or transferred pursuant to this Agreement.

(b) Notwithstanding any provision of this Agreement to the contrary, this Agreement grants no right to a physician in the Transferring Institution to participate in or control the care and treatment of a patient who was referred and/or transferred pursuant to this Agreement unless such physician has medical staff privileges at such Receiving Institution. Any physician who is permitted to participate in the care and treatment of a patient referred and/or transferred pursuant to this Agreement, must comply with the Medical Staff Bylaws, Rules and Regulations of the Receiving Institution.

(c) In the event a patient is transferred from the Article 28 Facility to the Hospital and the physician responsible for the patient's care at the Article 28 Facility is not a member of the Medical Staff of the Hospital or is not otherwise permitted to practice at the Hospital or if the Hospital is informed that the physician responsible for the patient's care at the Article 28 Facility will not continue to manage the patient at the Hospital, the Hospital shall assign a physician to care for the patient at the Hospital consistent with the Hospital's established policies and procedures.



Section 8. INSURANCE. Each party shall maintain and keep in full force and effect through the term of this Agreement general and professional liability insurance policies in amounts generally maintained for like facilities in the same geographical area. To the extent available, the policies shall require at least thirty (30) days' prior written notice to the other party in the case of cancellation, non-renewal or a material change of such insurance. Either party may provide such insurance through a self-insurance program adopted by its governing body. Each party shall provide or cause to be provided to the other party written evidence of such insurance.

Section 9. AUTONOMY OF EACH INSTITUTION. The parties to this Agreement shall remain in exclusive control of their respective policies, management, assets and affairs. All services rendered hereunder and all admissions to or acceptance for treatment by either institution shall be subject to the bylaws, rules and regulations of such institution and its medical staff. Neither institution shall, by virtue of this Agreement, assume any liability or obligation of the other institution. Each institution shall be responsible for billing and collecting charges for the services it has rendered.

Section 10. SHARING OF DIAGNOSTIC AND OTHER SERVICES. The parties to this Agreement shall share diagnostic and other services where the New York States Department of Health finds that such sharing is in the interest of efficiency, economy and quality of care.

Section 11. NON-EXCLUSIVITY. Nothing in this Agreement shall prohibit either institution from affiliating or contracting with any other hospital, Article 28 Facility or other entity for any purpose whatsoever.

Section 12. NON-DISCRIMINATION. There shall be no discrimination against any patient because of race, color, handicap, national origin, creed, sex, sexual orientation, blindness, or source of payment, except that fiscal capability to pay may be considered. In compliance with New York State and Federal Laws which prohibit discrimination based on race, creed, color, national origin, sex, handicap or sponsor, the provisions of this Agreement shall apply to all patients on a non-discriminatory basis.

Section 13. USE OF NAME. Neither institution to this Agreement shall use the name of the other institution in any promotional or advertising material without first obtaining written approval from the institution whose name is to be used.

Section 14. TERMINATION.

(a) Except as provided in paragraph (b) of this Section, this Agreement shall remain in force indefinitely unless terminated, with or without cause, by either party upon not less than sixty (60) days written notice to the other party, or by the mutual consent of the parties at any time. The parties may, by amendment to this Agreement, specify other provisions regarding termination as to any service to be provided hereunder.

(b) In the event that either party shall have its accreditation, operating certificate, or licensure suspended, limited or revoked, it shall immediately notify the other party of that fact in writing and this agreement shall terminate immediately upon such event.

Section 15. STATUTORY REQUIREMENTS.

(a) Compliance with New York State Health Regulations. The following language is required in this Agreement pursuant to 10 NYCRR § 400.4: (i) Each of the parties shall comply with those provisions of Chapter V of Title 10 of The New York Codes, Rules and Regulations which are binding on that party under the law of the State of New York (ii) “Notwithstanding any other provision in this contract, the facility remains responsible for ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations.” For purposes of this Agreement, the term “facility” shall mean the Hospital or the Article 28 Facility, as the case may be.

(b) Federal Requirements Relating to Access to Records. To the extent applicable in accordance with Section 1861(v)(1)(I)(i) of the Social Security act as amended and the regulations promulgated thereunder, 42 CFR Part 420, until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, the Secretary of the Department of Health and Human Services or the Comptroller General (or their duly authorized representatives) may request and each Facility shall provide review of this Agreement, and any agreement between such Facility and a related organization with respect to services provided to such Facility exceeding ten thousand dollars (\$10,000) over any twelve (12) month period.

Section 16. APPLICABLE LAW. This Agreement shall be construed in accordance with the laws of the State of New York.

Section 17. COUNTERPARTS. This Agreement shall be executed in counterparts, each of which shall be considered an original for all purposes.

Section 18. ENTIRE AGREEMENT; MODIFICATION. This Agreement contains the entire understanding between the parties and no alteration or modification hereof shall be effective except in a subsequent written instrument executed by both parties.

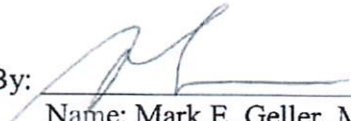
IN WITNESS WHEREOF, the parties have hereunto set their hands and seals as of the day and date first above written.

**HOSPITAL:**

**MONTEFIORE NYACK HOSPITAL**

**ARTICLE 28 FACILITY:**

**Care365, LLC**

By:   
Name: Mark E. Geller, MD  
Title: President and CEO

Date: August 18, 2020

By:   
Name: Zehava Goldenberg  
Title: Managing Member

Date: 8/18/2020

CARE365 II  
Operating Expenses

	Year One			Year Three		
	# of Employees	FTE	Cost	# of Employees	FTE	Cost
Management & Supervision	1	1.00	\$ 175,000.00	1	1.00	\$ 192,500.00
Technician & Specialist	1	0.70	\$ 42,000.00	1	0.90	\$ 58,500.00
Registered Nurses	2	2.00	\$ 160,000.00	3	2.50	\$ 200,000.00
Licensed Practical Nurses			\$ -			\$ -
Aides, Orderlies & Attendants	4	4.00	\$ 180,000.00	6	6.00	\$ 252,000.00
Physicians	1	0.80	\$ 160,000.00	1	1.00	\$ 225,000.00
PGY Physicians			\$ -			
Physicians' Assistants	3	3.00	\$ 375,000.00	4	3.20	\$ 416,000.00
Nurse Practitioners			\$ -			
Nurse Midwife			\$ -			
Social Workers and Psychologist**			\$ -			
Physical Therapists and PT Assistants			\$ -			
Occupational Therapists and OT Assistants			\$ -			
Speech Therapists and Speech Assistants			\$ -			
Other Therapists and Assistants			\$ -			
Infection Control, Environment and Food Service			\$ -			
Clerical & Other Administrative	3	3.00	\$ 135,000.00	5	4.50	\$ 225,000.00
Other Therapists and Assistants			\$ -			
<b>Total Salaries and Wages</b>	<b>15</b>	<b>14.50</b>	<b>\$ 1,227,000.00</b>	<b>21</b>	<b>19.10</b>	<b>\$1,569,000.00</b>
<b>Employee Benefits (18%)</b>			<b>\$ 220,860.00</b>			<b>\$ 282,420.00</b>
Malpractice Insurance			\$ 27,000.00			\$ 29,700.00
Accounting			\$ 13,000.00			\$ 14,300.00
Legal			\$ 15,000.00			\$ 16,500.00
<b>Total Professional Fees</b>			<b>\$ 55,000.00</b>			<b>\$ 60,500.00</b>

CARE365 II  
Operating Expenses

Medical & Surgical Supplies	\$ 102,000.00	\$ 127,500.00
<b>Medical &amp; Surgical Supplies</b>	<b>\$ 102,000.00</b>	<b>\$ 127,500.00</b>
Non-medical Supplies	\$ 12,750.00	\$ 15,937.50
<b>Non-medical Supplies</b>	<b>\$ 12,750.00</b>	<b>\$ 15,937.50</b>
Internet and Phone	\$ 7,000.00	\$ 7,700.00
Electric	\$ 6,300.00	\$ 6,930.00
Gas	\$ 3,000.00	\$ 3,300.00
Water	\$ 1,400.00	\$ 1,540.00
<b>Utilities</b>	<b>\$ 17,700.00</b>	<b>\$ 19,470.00</b>
Insurance	\$ 20,000.00	\$ 22,000.00
Cleaning	\$ 60,000.00	\$ 66,000.00
IT	\$ 33,600.00	\$ 36,960.00
<b>Purchased Services</b>	<b>\$ 113,600.00</b>	<b>\$ 124,960.00</b>
Outreach and Advertising	\$ 20,000.00	\$ 20,000.00
Repairs and Maintenance	\$ 5,000.00	\$ 5,500.00
Miscellaneous	\$ 8,000.00	\$ 8,800.00
<b>Other Direct Expenses</b>	<b>\$ 33,000.00</b>	<b>\$ 34,300.00</b>
<b>SUBTOTAL</b>	<b>\$ 1,781,910.00</b>	<b>\$2,234,087.50</b>
Interest	\$ -	\$ -

CARE365 II  
Operating Expenses

Depreciation Leasehold Improvements	\$ -	\$ -
Depreciation Equipment	\$ -	\$ -
Base Rent	\$ 133,980.00	\$ 138,029.76
Additional Rent (CAM)	\$ 60,000.00	\$ 60,000.00
<b>SUBTOTAL</b>	<b>\$ 193,980.00</b>	<b>\$ 198,029.76</b>
<b>TOTAL OPERATING COSTS</b>	<b>\$ 1,975,890.00</b>	<b>\$2,432,117.26</b>

Two Months of Year 3: \$ 405,352.88

**CARE365 - II**  
**Utilization and Revenues by Payor\***

	<u>Year One</u>				<u>Year Three</u>		
	Rate	Visits	Percentage	Dollars	Visits	Percentage	Dollars
Commercial FFS	\$ 137.13	1530	9%	\$ 209,808.90	1836	9%	\$ 251,770.68
Commercial MC	\$ 137.13	3400	20%	\$ 466,242.00	4080	20%	\$ 559,490.40
Medicare FFS	\$ 98.51	850	5%	\$ 83,733.50	1020	5%	\$ 100,480.20
Medicare MC	\$ 98.51	1700	10%	\$ 167,467.00	2040	10%	\$ 200,960.40
Medicaid FFS	\$ 170.71	170	1%	\$ 29,020.70	204	1%	\$ 34,824.84
Medicaid MC	\$ 170.71	8500	50%	\$ 1,451,035.00	10200	50%	\$ 1,741,242.00
Charity	\$ -	680	4%	\$ -	816	4%	\$ -
Private Pay	\$ 150.00	170	1%	\$ 25,500.00	204	1%	\$ 30,600.00
		17000		<b>\$2,432,807.10</b>	20400		<b>\$2,919,368.52</b>

**Supporting Calculations for All Reimbursement :** Medicaid FFS visit fees are based on the published Medicaid rate of \$170.71 <sup>(1)</sup>. Generally, Medicaid Managed Care Plans (MMCPs) follow NYS Medicaid FFS billing guidance and methodologies for Article 28 facility based payments <sup>(2)</sup>. The Medicare rates used (FFS and Commercial) is based on the published regional rate (New York Area 04) for CPT 99213 <sup>(3)</sup>. Commercial Payors (FFS and Managed Care), pay on average 129% of Medicare's FFS rates <sup>(4)</sup>. Private pay rates are based on the accepted fee within the region.

**Supporting Calculations for Utilization:** The Clinic is estimated to have in Year 1, 1.7 FTE primary care providers and 0.7 specialty provider. The projection for Year 1 is 8,800 primary care visits, which average per FTE 1.7 visits per hour and 2,200 specialty visits which average per FTE 1.5 visits per hour. The projected number of visits is based on the capacity of the physical space, the amount of service hours available (i.e., higher volume on Sundays when other practices are closed), and the needs of the community based on the Needs Assessment (uploaded as an Attachment to Schedule 1). We used a conservative approach to this assumption and based on the statistic that an average patient visits their primary care provider 2.67 times per year <sup>(5)</sup>, which translates into approximately 3,296 distinct patients in Year 1.

(1) [https://www.health.ny.gov/health\\_care/medicaid/rates/apg/rates/dtc/dtc\\_base\\_rates\\_inv.htm](https://www.health.ny.gov/health_care/medicaid/rates/apg/rates/dtc/dtc_base_rates_inv.htm)

(2) <https://www.fideliscare.org/Portals/0/Providers/ProviderManuals/2022-Fidelis-Care-Provider-Manual-Medicaid-English.pdf> p. 26.6;  
[https://assets.healthfirst.org/pdf\\_9432a72611d0176a1f6a5503a1d88d94?v=1212061318](https://assets.healthfirst.org/pdf_9432a72611d0176a1f6a5503a1d88d94?v=1212061318) p. 233

(3) <https://www.ngsmedicare.com/fee-schedule-lookup?lob=96664&state=97133&rgion=93623>

(4) <https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf> p. 6

(5) <https://www.cdc.gov/nchs/fastats/physician-visits.htm>

**\*2023 Dollars**

# **Schedule 17 CON Forms Specific to Diagnostic and Treatment Centers Article 28**

## **Contents:**

- **Schedule 17 A - D&TC Program Information**
- **Schedule 17 B - D&TC Community Need**
- **Schedule 17 C - Impact of CON Application on D&TC Operating Certificate**



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

**Schedule 17A**

**Schedule 17 A - Diagnostic and Treatment Center Program Information.**

See "Schedules Required for Each Type of CON" to determine when this form is required.

**Instructions:** In the space below, briefly indicate how the facility intends to comply with state and federal regulations. If the application involves conversion of an existing practice, state who owns the practice and how the conversion will be done. If there are other entities utilizing the same space or resources, please state exactly how the space and resources will be allocated. Also, provide a description of the other entities.

Care365 LLC is submitting this application for administrative review, with the purpose of establishing an extension to its current Article 28 clinic ("Care365 II"). The current clinic is located at 1 Main Street, Monsey, (Rockland County) NY, 10952. The proposed extension will be located at 1633 Route 202, Pomona (Rockland County) NY, 10970, and will provide primary medical care and specialty medical services (to be certified for "Medical Services – Primary Care" and "Medical Services – Other Medical Specialties") for the residents of Pomona, NY and surrounding areas.

The day-to-day operations of the Center will be supervised by a physician Medical Director. Policies and procedures, pursuant to all applicable laws and regulations will be developed and tailored to this specific Center.

The member will designate a compliance officer with the responsibility to implement an effective compliance program, pursuant to Part 521 of 18NYCRR.

No other entities will be utilizing the space or resources of the Care365 extension clinic.

For D&TC -Ambulatory Surgery Projects:

**Not Applicable**

Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category

For D&TC -Ambulatory Surgery Projects:

**Not Applicable**

Please provide the following information:

Number and Type of Operating Rooms:

- Current:
- To be added:
- Total ORs upon Completion of the Project:

Number and Type of Procedure Rooms:

- Current:
- To be added:
- Total Procedure Rooms upon Completion of the Project:

**Schedule 17 B - Community Need**

See “Schedules Required for Each Type of CON” to determine when this form is required.

**Public Need Summary:**

Briefly summarize on this schedule, why the project is needed. Use additional paper, as necessary. If the following items have been addressed in the project narrative, please cite the relevant section and pages.

1. Identify the relevant service area (e.g., Minor Civil Division(s), Census Tract(s), street boundaries, Zip Code(s), Health Professional Shortage Area (HPSA) etc.)

The Primary Service Area (PSA) is Zip Code 10970, the secondary service area (SSA) includes the surrounding areas that comprise the town of Ramapo, NY. The SSA covers several zip codes in Rockland County: 10901, 10952, 10977, 10970, 10965, and 10974.

2. Provide a quantitative and qualitative description of the population to be served. (Qualitative data may include median income, ethnicity, payor mix, etc.)

The PSA has a population of 11,449. The largest racial/ethnic groups are White (53.3%) followed by Hispanic or Latino (26.3%) and then by Black or African American (20.2%). A relatively large portion of the population is children with 26.9% of residents being under the age of 18 compared to 20.7% in New York State. The amount of people with public health insurance coverage in this PSA is slightly higher than the average in New York State (41.3% vs 39.9%), and 7.6% of the population has a disability.

Please refer to the Project Narrative under Schedule 1 Attachment for more information.

3. Document the current and projected demand for the proposed services. If the proposed services are covered by a DOH need methodology, demonstrate how the proposed service is consistent with it.

To assess the need for the proposed services, we examined the health stats at the county level. In a 2018 Mid-Hudson Region Community Health Survey, 17% of Rockland County respondents said they did not visit a primary care physician for a routine physical or checkup within the last 12 months (compared to 16% in neighboring Putnam and 13% in Westchester). To the question, “For which reason did you visit the emergency room for a health-related emergency rather than a doctor’s office?” 23% of respondents answered that “they do not have a regular doctor/ primary care doctor.”

17% of people surveyed haven’t seen a primary care provider for a routine physical or checkup within the last 12 months, when asked why, 24% responded that they did not have health insurance, and 11% responded that they did not have enough money to see a doctor.

During the 2019 Community Health Priority Selection Forum, it was determined by an open vote that Rockland partners will be focusing on the “Preventing Chronic Diseases and Promoting Well-being” and “Preventing Mental and Substance Use Disorders” Prevention Agenda priority areas.

In 2019, the Rockland County Department of Health, along with HealthConnections, conducted two focus groups at the Haverstraw Collaborative and the Spring Valley Collaborative to discuss survey results from providers that serve various populations. In conclusion, one of the five specific recommendations of the provider focus group was that “Services should be open during hours outside of 9:00 AM- 5:00 PM, Monday through Friday, to increase access.”

The proposed Extension Clinic addresses both, “Preventing Chronic Diseases and Promoting Well-being” and “providing services outside of 9:00 AM- 5:00 PM, Monday through Friday.”

4. (a) Describe how this project responds to and reflects the needs of the residents in the community you propose to serve.

Within the zip code of the proposed center, there are only 2 other Article 28 D&TCs. There are 2 designated HPSAs and 2 MUAs within Rockland County. As noted above, the lack of available primary care was evident in

# New York State Department of Health Certificate of Need Application

## Schedule 17B

local survey responses in which 23% of respondents said that the reason they visited the emergency room rather than a doctor's office was that "they do not have a regular/primary care doctor."

By providing accessible and convenient primary healthcare services outside of conventional 9-5 weekday hours, Care365 II will be a key player in "Preventing Chronic Diseases and Promoting Well-being" in the PSA.

(b) Describe how this project is consistent with your facility's Community Service Implementation Plan (voluntary not-for-profit hospitals) or strategic plan (other providers).

The proposed project is a direct response to the health issues faced by the individuals living in the PSA. As detailed in the Project Narrative under Schedule 1 Attachment, the Rockland County population has a heart attack mortality rate that is significantly higher than the State's rate. Additional health stats as elaborated in the Narrative point to a need for increased prevention of chronic disease.

Receiving regular primary care services is key to chronic disease management, preventative care, and early detection. The proposed Center will focus on a patient-centered approach and accessibly, ensuring patients receive preventative care in an easy and accessible way.

(c) Will the proposed project serve all patients needing care, regardless of their ability to pay or the source of payment? If so, please provide such a statement.

The applicant is committed to providing services to all patients needing care, regardless of their ability to pay or the source of payment.

5. Describe where and how the population to be served currently receives the proposed services.

As noted above, there are only two approved article 28 D&TCs in the zip code of the proposed Center. Currently there are limited hours available to visit a healthcare provider and there are no x-ray services in the PSA.

**ONLY For Applicants Seeking Permanent Life**

**Not Applicable**

**Diagnostic and Treatment Centers seeking approval for a Permanent Life MUST provide the following information:**

**Instructions:** In the space below, please provide detailed information on the **most recent CON application** that was approved for the limited life.

- i. CON number:
- ii. Date of approval:
- iii. Number of years of limited life approved for:
- iv. OpCert number and dates:
- v. Please provide a table with information on projections by payor for year 1 and year 3 **as reported on the approved CON**. (Please identify the projections in terms of **visits or procedures**).

- vi. Please provide a table with information on actual utilization by payor for each year since the implementation of the approved CON.

**Note:** Please use the same category of payors for actual utilization as those used for projections in item 'v' above. Also, use the same category (i.e., **visits or procedures**) for actual utilization as those used for projections in item 'v' above.

- vii. Did you achieve those projections reported in item 'v' above?  
If not, please give reasons for not meeting those projections.  
How do you plan to improve this shortfall?

**Quality and Accreditation:**

- 1. Please cite relevant accreditations, certifications or awards attained by the applicant which build confidence in services of high quality. Examples include certification as a Federally Qualified Neighborhood Health Center.

Under the medical leadership of Dr. Seth Kurtz MD, Care365 is committed to providing quality healthcare and maximal accessibility, both in the sense of making its services familiar and available to all community members and in the technical sense of ensuring physical accessibility in every detail of the facility's layout, in accordance with the Americans with Disabilities Act 1990. Dr. Seth Kurtz, the current director of the flagship Care365 Center, has been practicing medicine for over fifteen years and has held multiple leadership roles over the years.

The facility aims to become recognized by NCQA as a Patient-Centered Medical Home (PCMH), a model that is committed to continuous quality improvement and a patient-centered approach putting patients at the forefront of care and increasing staff satisfaction – while reducing health care costs.

- 2. Describe relevant programs or resources the applicant will bring to the new facility. Include existing programs that have proven track records at the applicant's other sites, if applicable, as well as programs the applicant plans for the future. Such programs include:
  - a. Programs specially tailored to the health needs of the population of the service area.
  - b. Grant funded programs.
  - c. Scholarships or fellowships.

The proposed project will offer x-ray services which is currently not available in the PSA. The proposed center will be open on Sundays, which is also not currently available in the PSA. The applicant has a rich history of patient advocacy and brings an understanding of the cultural, language and religious issues that often are a barrier to obtaining services.

- 3. Describe the applicant's experience or track record serving similar populations:

The applicant and the Medical Director both reside within the County and are also part of the large Orthodox Jewish Community, which currently comprises more than half of Rockland's population.

**Primary and Specialty Care Services Review Criteria:  
Expansion of Services**

When a CON application proposes conversion of a group or solo medical practice to Article 28 status, the applicant must provide a written analysis of the effect of the proposal on the following factors:

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1. The full time equivalent (FTE) number of primary care physicians and specialists, by specialty, engaged in the practice after the conversion compared with the number before conversion.

2. The (FTE) number of non-physician providers of primary care and specialty care, by specialty, such as Physician Assistants, Certified Nurse Practitioners, Physical Therapists, and Dental Assistants after the conversion compared with the number before conversion.

3. The number of primary care and specialty visits, by specialty, after the conversion compared with the number before conversion.

4. The array of services to underserved clients after the conversion compared with the number before conversion.

### Target Population and Service Area:

All applications involving primary care services must provide a written analysis that clearly demonstrates that the proposal meets at least one of the following criteria. For criteria that do not apply, enter "not applicable":

1. The proposed clinic is in an underserved area as indicated by location in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA).

While the proposed clinic itself is not in an HPSA or MUA, there are 2 designated HPSAs and 2 MUAs within a 9-mile range of the proposed clinic.

2. The population to be served exhibits poor health status, as measured by factors such as high levels of inpatient discharges for ambulatory care sensitive conditions (ACSC), incidences of diseases and conditions in excess of standards in Healthy People 2010 or other pertinent indicators.

As elaborated in the Project Narrative (under Schedule 1 Attachment), the health status of the PSA was determined by analyzing health indicators at the county level (since there is a lack of data at the town/village level and 44.3% of the entire county population reside in the Town of Ramapo). According to the Mid-Hudson Region Community Health Assessment 2019 - 2021, Rockland County had the highest heart attack mortality rate of the seven Mid-Hudson counties (41.4 per 100,000 population). The rate of newly diagnosed HIV cases in Rockland (2017 - 2019) was 7.9 per 100,000 while the state objective for the 2024 Prevention Agenda is for the rate to be no higher than 5.2.

According to a CHIRS report, other diseases that had a relatively high incidence rate in Rockland County included pneumonia, pertussis and shigella. The ovarian cancer incidence rate was also higher in Rockland County than the statewide rate.

# New York State Department of Health Certificate of Need Application

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3. The primary care services of the proposed clinic will be targeted to a group or population with special needs or conditions that make it difficult for them to obtain adequate primary care in clinics or physician practices serving the general population. Examples of such needs and conditions are:
- Developmental disabilities.
  - HIV.
  - Alcohol Substance Abuse.
  - Health needs relating to aging.
  - Mental Health needs.
  - Homelessness
  - Linguistic or cultural barriers in obtaining access to primary care.

14.2% of Rockland County residents lived in poverty in 2017 compared to 4.8% in nearby Putnam County and 9.4% in neighboring Westchester County. 5.1% of Rockland County's population under age 65 have a disability. Rockland County had the highest percentage (among 7 mid-Hudson counties) of children aged 5-17 years who spoke English less than very well (18.9%). The rate of newly diagnosed HIV cases in Rockland (2017 - 2019) was 7.9 per 100,000 while the state objective for the 2024 Prevention Agenda is for the rate to be no higher than 5.2. 35.5% of elementary, middle, and high school students were reported as overweight or obese (85th percentile or higher).

### Capacity of Existing Primary Care Providers

The project narrative should describe existing primary care services in the proposed service area. The narrative should include the number and location of existing D&TCs, extension clinics and part-time clinics and a summary of primary care services available through private practices. The narrative should indicate whether travel time and transportation are factors in access to primary care. Examples of travel related issues include topography, seasonal weather conditions, and availability of public transportation. Applicants are not expected to describe the volume of services delivered by existing providers, since they will rarely have access to such data, but the project narrative should indicate that the applicant is reasonably familiar with the overall availability of primary care in the targeted area.

In instances where the target area is likely to already have significant primary care resources, the CON proposal will be reviewed for the following need related factors:

- The ratio of primary care physicians to population in the proposed service area. HPSA uses a ratio of 1.0 FTE physicians to 3000 persons; Medicaid Managed Care uses a ratio of 1 to 1500.
- The number of primary care physicians in the proposed service area who are "active" in serving the Medicaid population. This is often measured as physicians who are reimbursed \$5000 or more per year by Medicaid.
- The annual number of primary care visits per person by Medicaid eligible persons in the proposed service area. An average lower than 2.0 visits per person is often considered a problem.
- The percentage of the Medicaid population that is enrolled in Managed care will be taken into account where appropriate.
- The current volume of primary care visits to existing D&TC and Extension clinics.

Not all of the above criteria need be evaluated for all applications. The number will vary depending on the type and location of services proposed and on how thoroughly the application addresses need in the project narrative and the related schedules.

There are currently only two approved Article 28 D&TC facilities within the zip code of the proposed clinic (10970). There are 6 practicing physicians in internal medicine and pediatrics within zip code 10970. With the population in zip code 10970 numbering at 11,449, this equates to a primary physician-to-population ratio of 1:1,908 which falls short of both the WHO standard of 1:1,000 and the Medicaid Managed Care ratio of 1:1,500.

### Need Review for Specialty Clinics:

***Not Applicable***

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

**Schedule 17B**

Applications not involving primary care services must also provide a written analysis that clearly demonstrates that the need exists for the proposed services

- 4. Is the proposed clinic in an underserved area as indicated by location in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA)?

Empty rectangular box for response to question 4.

- 5. Describe in very specific terms the patients who require the specialty services, including the number of patients and their specific health problems, and how the proposed facility will meet their needs better than existing providers.

Empty rectangular box for response to question 5.

- 6. In the case of Dental clinics, is the application supported by the local Health Department? Is the proposal supported by the Department of Health's Bureau of Dental Services? Is the applicant participating in current dental health initiatives? Has the applicant consulted with resources such as the New York State Oral Health Technical Assistance Center?

Empty rectangular box for response to question 6.

# Impact of Proposed CON on Diagnostic & Treatment Center Operating Certificate

**The Sites Tab in NYSE-CON has replaced the Authorized Services Table of Schedule 17C. The Authorized Services Table in Schedule 17C is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.**

**TABLE 17C-1 AUTHORIZED CERTIFIED SERVICES**

**Instructions:**  
For applications requesting changes to more than one location, complete a separate Table 17-C-1 for each location

<b>LOCATION:</b>  <i>(Enter street address of facility)</i>	<input type="checkbox"/> <b>MOBILE CLINIC DESIGNATION (217)</b> Check box only if extension clinic is mobile <i>(A mobile clinic must be an extension clinic with a fixed main site)</i>
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	Existing	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE <sup>6</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ABORTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADULT DAY HEALTH - AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AMBULATORY SURGERY				
MULTI-SPECIALTY <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE SPECIALTY – GASTROENTEROLOGY <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE SPECIALTY – OPHTHALMOLOGY <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE SPECIALTY – ORTHOPEDICS <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE SPECIALTY -- PAIN MANAGEMENT <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SINGLE SPECIALTY -- OTHER (SPECIFY) <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BIRTHING SERVICE O/P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CERTIFIED MENTAL HEALTH O/P <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHEMICAL DEPENDENCE - REHAB <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHEMICAL DEPENDENCE - WITHDRAWAL O/P <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLINIC PART TIME SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT SCANNER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL O/P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOME HEMODIALYSIS TRAINING AND SUPPORT <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOME PERITONEAL DIALYSIS TRAINING AND SUPPORT <sup>4</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGRATED SERVICES – MENTAL HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LITHOTRIPSY O/P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MAGNETIC RESONANCE IMAGING (MRI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
METHADONE MAINTENANCE O/P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NURSING HOME HEMODIALYSIS <sup>7</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RADIOLOGY – THERAPEUTIC O/P <sup>5</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 17C-1(a)&(b) below] <sup>4</sup>	_____	_____	_____	_____
TRAUMATIC BRAIN INJURY PROGRAM O/P	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup> A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.  
<sup>2</sup> A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.  
<sup>4</sup> Require additional approval by Medicare  
<sup>5</sup> RADIOLOGY – THERAPEUTIC includes Linear Accelerators.  
<sup>6</sup> PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric  
<sup>7</sup> Must be certified for Home Hemodialysis Training & Support



**END STAGE RENAL DISEASE (ESRD)**

<b>TABLE 17C-1(a) CAPACITY</b>	Existing	Add	Remove	Proposed
CHRONIC DIALYSIS				

If application involves dialysis service with existing capacity, complete the following table:

<b>TABLE 17C-1(b) PROCEDURES</b>	Last 12 mos	2 years prior	3 years prior
CHRONIC DIALYSIS			

All Chronic Dialysis applicants must provide information requested on the following page in compliance with 10 NYCRR 670.6.

**END STAGE RENAL DISEASE**

1. Provide a five-year analysis of projected costs and revenues that demonstrates that the proposed dialysis services will be utilized sufficiently to be financially feasible.

2. Provide evidence that the proposed dialysis services will enhance access to dialysis by patients, including members of medically underserved groups which have traditionally experienced difficulties obtaining access to health care, such as; racial and ethnic minorities, women, disabled persons, and residents of remote rural areas.

3. Provide evidence that the hours of operation and admission policy of the facility will promote the availability of dialysis at times preferred by the patients, particularly to enable patients to continue employment.

4. Provide evidence that the facility is willing to and capable of safely serving patients.

5. Provide evidence that the proposed facility will not jeopardize the quality of care or the financial viability of existing dialysis facilities. This evidence should be derived from analysis of factors including, but not necessarily limited to current and projected referral and use patterns of both the proposed facility and existing facilities. A finding that the proposed facility will jeopardize the financial viability of one or more existing facilities will not of itself require a recommendation to of disapproval.

**Table 17C-2 - Projected Utilization of Services:**

The number of projected "visits" should be listed in this table for each existing or proposed certified service. Visits should be estimated for the current, first and third year of the project. This table should contain visit estimates for services at this site alone, not for the applicant's other sites.

	Current Year Visits*	First Year Visits*	Third Year Visits*
<b>CERTIFIABLE SERVICES</b>			
MEDICAL SERVICES – PRIMARY CARE		11,560	13,872
MEDICAL SERVICES – SPECIALTIES		5,440	6,528
ABORTION			
ADULT DAY HEALTH - AIDS			
AMBULATORY SURGERY – GASTROENTEROLOGY			
AMBULATORY SURGERY – OPHTHALMOLOGY			
AMBULATORY SURGERY – ORTHOPEDICS			
AMBULATORY SURGERY -- PAIN MANAGEMENT			
AMBULATORY SURGERY -- OTHER SPECIALTY			
AMBULATORY SURGERY -- MULTI-SPECIALTY			
BIRTHING SERVICE O/P			
CLINIC PART TIME SERVICES			
CLINIC SCHOOL BASED SERVICES			
CLINIC SCHOOL BASED DENTAL PROGRAM			
CT SCANNER			
DENTAL O/P			
HOME HEMODIALYSIS TRAINING AND SUPPORT			
HOME PERITONEAL DIALYSIS TRAINING AND SUPPORT			
INTERGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY O/P			
MAGNETIC RESONANCE IMAGING (MRI)			
METHADONE MAINTENANCE			
NURSING HOME HEMODIALYSIS			
RADIOLOGY – THERAPEUTIC			
RENAL DIALYSIS, CHRONIC			
TRAUMATIC BRAIN INJURY PROGRAM O/P			
UPGRADED DTC SERVICES			
<b>OTHER SERVICES</b>			
<b>Total</b>		17,000	20,400

\* The 'Total' reported MUST be the SAME as those on Table 13D-4