Limited Review Application

State of New York Department of Health
Office of Primary Care and Health Systems Management

LRA Cover Sheet

Project to be Proposed/Applicant Information

This application is for those projects subject to a limited review pursuant to 10 NYCRR 710.1(c)(5)-(7). Please check the appropriate box(es) reflective of the project being proposed by your facility (**NOTE** – Some projects may involve requisite "Construction". If so, and ***total*** project costs are below designated thresholds, then **both boxes** must be checked and necessary LRA Schedules submitted). ***Please read the LRA Instructions to ensure submission of an appropriate and complete application:***

☐ **Minor Construction** – Minor construction project with total project costs of up to $30,000,000 for general hospitals and up to $8,000,000 for all other facilities.

Necessary LRA Schedules: ***Cover Sheet, 2, 3, 4, 5, and 6.***

☐ **Equipment** – Project related to the acquisition, relocation, installation or modification of certain medical equipment, with total project costs of up to $30,000,000 for general hospitals and up to $8,000,000 for all other facilities. (**NOT** necessary for "1-for-1" replacement of existing equipment without construction, pursuant to Chapter 174 of the Laws of 2011 amending Article 28 of the Public Health law to eliminate limited review and CON review for one for one equipment replacement)

Necessary LRA Schedules: ***Cover Sheet, 2, 3, 4, and 5.***

☒ **Service Delivery** – Project to decertify a facility's beds/services; add services which involve a total project cost up to $30,000,000 for general hospitals and up to $8,000,000 for all other facilities; or convert beds within approved categories. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: ***Cover Sheet, 2, 6, 7, 8, 10, and 12.*** **If proposing to decertify beds within a nursing home, provide a description of the proposed alternative use of the space including a detailed sketch (unless the decertification is being accomplished by eliminating beds in multiple-bedded rooms). If proposing to convert beds within approved categories, an LRA Schedule 6 and all supporting documentation are required to confirm appropriate space for the new use.*

☐ **Mobile Vans** – Project to certify a new mobile van extension clinic or replace a previously certified mobile extension clinic van.

Necessary LRA Schedules: ***Cover Sheet, 2, 3, 4, 5, and 6.***

☐ **Relocation of Extension Clinic** – Project to relocate an extension clinic within the same service area which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: ***Cover Sheet, 2, 3, 4, 5, 6 and 7. Also include a Closure Plan for vacating extension clinic.***

☐ **Part-Time Clinic** – Project to operate, change services offered, change hours of operation or relocate a part-time clinic site – for applicants already certified for "part-time clinic". (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: ***Cover Sheet, 2, 8, 10, 11, and 12.***

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
2701339N	The Church Home of the Episcopal Protestant Church	SNF

OPERATOR ADDRESS – STREET & NUMBER		PFI	NAME AND TITLE OF CONTACT PERSON		
505 Mount Hope Avenue			Amanda Teugeman, SVP Healthcare		
CITY Rochester	COUNTY NY	ZIP 14620	STREET AND NUMBER 505 Mount Hope Avenue		
PROJECT SITE ADDRESS – STREET & NUMBER 505 Mount Hope Avenue		PFI	CITY Rochester	STATE NY	ZIP 14620
CITY Rochester	COUNTY Monroe	ZIP 14620	TELEPHONE NUMBER 5855468400 ext 3106	FAX NUMBER 585.546.4678	
TOTAL PROJECT COST: $ 15,000.00			CONTACT E-MAIL: ateugeman@episcopalseniorlife.org		

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State of New York Department of Health/Office of Health Systems Management

Schedule LRA 2

Total Project Cost

ITEM	ESTIMATED PROJECT COST
1.1 Land Acquisition (*attach documentation*)	$
1.2 Building Acquisition	$
	1.1-1.2 Subtotal: 0.00
2.1 New Construction	$
2.2 Renovation and Demolition	$
2.3 Site Development	$
2.4 Temporary Power	$
	2.1-2.4 Subtotal: 0.00
3.1 Design Contingency	$
3.2 Construction Contingency	$
	3.1-3.2 Subtotal: 0.00
4.1 Fixed Equipment (NIC)	$
4.2 Planning Consultant Fees	$
4.3 Architect/Engineering Fees (incl. computer installation, design, etc.)	$
4.4 Construction Manager Fees	$
4.5 Capitalized Licensing Fees	$
4.6 Health Information Technology Costs	$
4.6.1 Computer Installation, Design, etc.	$
4.6.2 Consultant, Construction Manager Fees, etc.	$
4.6.3 Software Licensing, Support Fees	$
4.6.4 Computer Hardware/Software Fees	$
4.7 Other Project Fees (Consultant, etc.)	$ 15,000.00
	4.1-4.7 Subtotal: 15,000.00
5.1 Movable Equipment	$
6.1 Total Basic Cost of Construction	**$ 15,000.00**
7.1 Financing Cost (points, fees, etc.)	$
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount $ @ % for months	
7.3 Application Fee	$
8.1 Estimated Total Project Cost (Total 6.1 – 7.3)	**$ 15,000.00**

If this project involves construction enter the following anticipated construction dates on which your cost estimates are based.

Construction Start Date _____

Construction Completion Date _____

Limited Review Application

Schedule LRA 7

State of New York Department of Health
Office of Primary Care and Health Systems Management

Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue	22,741,691	24,036,295	$25,330,582.00
Grants Funds	156,574		
Foundation	26,000	26,000	$26,000.00
Other	408,823	436,000	$450,000.00
Fees			
Other Income			
(1) Total Revenues	$23,333,088	$24,498,295	$25,806,582
Expenses			
Salaries and Wage Expense	12,513,161	13,013,687	$13,806,221.00
Employee Benefits	2,805,117	2,863,011	$3,037,369.00
Professional Fees	215,672	222,142	$235,671.00
Medical & Surgical Supplies	446,500	459,895	$487,903.00
Non-Medical Equipment	835,391	860,453	$912,854.00
Purchased Services	861,992	887,852	$941,922.00
Other Direct Expense	4,498,556	4,911,524	$5,206,215.00
Utilities Expense	376,746	388,048	$411,681.00
Interest Expense	76,086	168,975	$202,029.00
Rent Expense	0	0	$0.00
Depreciation Expense			
Other Expenses			
(2) Total Expense	$22,629,221	$23,775,587	$25,241,865
Net Total - (1-2) →	$703,867	$722,708	$564,717

(Rev. 7/2015)

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Schedule LRA 7A

State of New York Department of Health
Office of Primary Care and Health Systems Management

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 ☒ Patient discharges ☐

Inpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Patient Days or dis-charges	Net Revenue*		Patient Days or dis-charges	Net Revenue*		Patient Days or dis-charges	Net Revenue*	
			%	Dollars ($)		% based on days or discharges	Dollars-$		% based on days or discharges	Dollars-$
Commercial	Fee for Service		1.5	346171		1.5	353011		1.4	360097
	Managed Care	3412	8.6	1961900	3832	9.4	2247762	3832	9.2	2337672
Medicare	Fee for Service	1463	3.7	841225	1643	4.0	963326	1643	4.0	1001859
	Managed Care									
Medicaid	Fee for Service	27615	25.6	5790037	27375	24.5	5886355	27375	23.3	5894659
	Managed Care	365	0.3	76530	365	.3	77745	365	.3	78595
Private Pay		20445	55.0	12498263	20805	55.1	13224818	20805	56.5	14300197
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other			5.3	1201900		5.2	1257100		5.3	1330800
Total		53300	100%	22716026	54020	100%	24010117	54020	100%	25303879

(Rev. 7/2015)

Outpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue*		Visits	Net Revenue*		Visits	Net Revenue*	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	Fee for Service									
	Managed Care	300	34.25	9825	300		10022	300		10223
Medicare	Fee for Service	576	64.75	15840	576		16156	576		16480
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total		876	100%	25665		100%	26178		100%	26703

Total of Inpatient and Outpatient Services				22741691			24036295			25330582

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Schedule LRA 7 payer calcs	Schedule LRA 7 payer calcs
2. In an attachment, provide the basis for charity care.	N/A	N/A

*Net of Deductions from Revenue

ESLC
ECH
Revenue
Room and Payor Mix
Budget Year 2029

Room and Payor Mix :

	# Beds	Occupancy
2N	33	32
3N	33	32
4N	40	40
SH1	22	20
SH2	25	24
	153	148

96.73%

	# of Residents per day	TCU	LTC	% of Total Mix	% of LTC Mix
Private	57	1	56	38.5%	40.9%
Medicare	15	10	5	10.1%	3.6%
Medicaid	76	0	76	51.4%	55.5%
Total	**148**	**11**	**137**	**100%**	**100%**
Occupancy	**96.7%**	**50.0%**	**104.6%**		

priv	681	708	82
seml	620	645	40
		687.344262	

Total

	# of Beds	Mix	Billed Days	Daily Rate	Total Revenue for budget	Average Residents per day	
Private 302101		38.5%	20,805	$ 687.34	14,300,197	57	*Rate based on 4% increase over 2028 budgeted private rate
Medicare 302201		10.1%	5,475	$ 609.96	3,339,531	15	*Rate based on 2.0% increase over 2028 budgetd MCR rate
Medicaid 302301		51.4%	27,740	$ 215.33	5,973,254	76	
	145	100.0%	54,020		23,612,983	148	
						102.1%	

Revenue Assessment & Expense

		Rounded		
760911 Revenue Assessment @ 6.8%	1,378,595	1,378,600		
760913 Pri Rev Assess Offset @ 6.8%	(972,413)	(972,400)	CRAT Rate	22.14
760923 Medicaid Assess Offset @ 6.0%	(358,395)	(358,400)		(614,163.60)
	47,786	47,800		
	24,943,791			

Part B

Inpatient	Proj Units	Monthly Avg rate	Total	Proj Units	Annual Avg rate	Total
Commercial	1712	$ 13.98	$ 23,940.95	20,544	$ 13.98	$ 287,291.40
Medicare	107	$ 56.70	$ 6,067.09	1,284	$ 56.70	$ 72,805.11
Outpatient						
Commercial	25	$ 34.08	$ 851.96	300	$ 34.08	$ 10,223.46
Medicare	48	$ 28.61	$ 1,373.33	576	$ 28.61	$ 16,479.94
			Budget total	876		$ 26,703.40
				Total Revenue		25,330,582

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 8

Staffing

Staffing Categories	Number of FTEs to the Nearest Tenth		
	Current Year*	First Year of implementation	Third Year of implementation
Health Providers:**			
	6.1	6.1	6.1
6.1	2	2	2
2	3	3	3
3	.5	.5	.5
.5	.4	.4	.4
.4	.2	.2	.2
.2			
Nursing 121.10 Therapy 9.73 Food Service 21.37 Housekeeping 14.23 Laundry 4.43 Maintenance 2.85 Recreation 3.60 Security 4.70 Reception 2.65 Social Work 2.60 Admin 1.00 Admissions 2.00 Pastoral 1.00 Medical Records 1.05 **Year of year the numbers are not projected to change.	192.31	192.31	192.31
Total Number of Employees	198.41	198.41	198.41

* Last complete year prior to submitting application

** "Health Providers" includes all providers serving patients at the site. A Health Provider is any staff who can provide a billable service – physician, dentist, dental hygienist, podiatrist, physician assistant, physical therapist, etc.

*** All other staff.

Describe how the number and mix of staff were determined:

Health care providers and support staff are calculated as described above. Our census is not changing with the decertification of the beds; therefore, the FTE count will remain the same.

PLEASE COMPLETE THE FOLLOWING:

1. Are staff paid and on Payroll? ☒ Yes ☐ No

2. Provide copies of contracts for any independent contractor.

3. Please attach the Medical Doctors C.V.

4. Is this facility affiliated with any other facilities?
   (If yes, please describe affiliation and/or agreement.) ☐ Yes ☒ No

(Rev. 7/7/2010)

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 10

The Sites Tab in NYSE-CON has replaced Schedule LRA 10. Schedule LRA 10 is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval. ***However, due to programming issues, you may still be required to upload a blank Schedule LRA 10 to submit a Service Delivery LRA application.***

Impact of Limited Review Application on Operating Certificate (services specific to the site)

Instructions:
"Current" Column: Mark "x" in the box only if the service ***currently*** appears on the operating certificate (OpCert), prior to any requested changes
"Add" Column: Mark "x" in the box if this CON application seeks to add.
"Remove" Column: Mark "x" in the box if this CON application seeks to decertify.
"Proposed" Column: Mark "x" in the boxes corresponding to all the services that will ultimately appear on the OpCert if this CON application is approved.

Category/Authorized Service	Code	Current	Add	Remove	Proposed
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Does the applicant have any previously submitted Certificate of Need (CON) applications that have not been completed involving addition or decertification of beds?

☐ No

☐ Yes (*Enter CON numbers to the right)* ☐ ☐ ☐

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State of New York Department of Health/Office of Health Systems Management

Schedule LRA 12

Assurances

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 (Title 10).

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 insure 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.

5/15/2026
Date

Amanda Teu
Signature

Amanda Teugeman
Name (Please Type)

SVP Healthcare Services
Title (Please Type)

New York State Department of Health

Health Equity Impact Assessment Template

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

SECTION A. SUMMARY

1. Title of project	Transformation Grant Bed Decertification
2. Name of Applicant	Episcopal SeniorLife Communities
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Sachs Policy Group (SPG) – 212-827-0660 • Jaclyn Pierce, MPH (Lead Contact) – jpierce@sachspolicy.com • Anita Appel, LCSW - AnitaAppel@sachspolicy.com • Maxine Legall, MSW, MBA - mlegall@sachspolicy.com Qualifications: • Health equity – 6+ years • Anti-racism – 6+ years • Community engagement – 25+ years • Health care access and delivery – 10+ years
4. Description of the Independent Entity's qualifications	The Health Equity Impact Assessment (HEIA) Team at Sachs Policy Group (SPG) is a diverse and experienced group dedicated to addressing health disparities and promoting equitable access to care. The team comprises experts with extensive backgrounds in health policy, population health, data analysis, community engagement, and anti-racism. They are committed to understanding and improving how social, environmental, and policy factors impact health equity, particularly for historically marginalized communities. The team collaborates with a wide range of health care organizations, government agencies, and communities to provide strategic support with an overarching goal of advancing diversity, equity, and inclusion. Their work encompasses research and evaluation of health programs and initiatives, stakeholder engagement, policy analysis, and development of mitigation and monitoring strategies. In particular, the team has experience analyzing policy proposals that impact medically underserved groups, such as Medicaid programs serving low-income individuals and maternal health initiatives that aim to reduce pre- and post-partum health disparities. They are dedicated to supporting organizations that serve vulnerable

	populations, including safety net hospitals, community health centers, long-term care organizations, behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities. The SPG HEIA team is deeply passionate about improving the health care delivery system, especially for underserved populations. The team is unwavering in its commitment to promoting equity through rigorous research, insightful consulting, and strategic advisory work.
5. Date the Health Equity Impact Assessment (HEIA) started	May 15, 2026
6. Date the HEIA concluded	June 11, 2026

7. Executive summary of project (250 words max)
Episcopal SeniorLife Communities received a Statewide Health Care Facility Transformation Grant from the New York State Department of Health (DOH) in 2023 to complete capital renovations and transition the skilled nursing facility at Episcopal Church Home from a traditional institutional layout to a household model. As a result of this transformation project and other changes to the facility since 2016, the facility has reduced the number of quad and double rooms in favor of more private rooms. This has resulted in a significant reduction in the number of active beds at the facility. Episcopal Church Home, located at 505 Mt. Hope Avenue in Rochester, NY, is currently certified to operate 182 beds. The applicant seeks approval to formally decertify 31 beds to better align its certified capacity with current operational bed utilization and census levels. Upon decertification, the facility's certified capacity would be reduced to 151 beds. Of these beds, 40 are designated for memory care and 22 for short-term rehabilitation, while the remaining beds are dedicated to traditional long-term stays.
8. Executive summary of HEIA findings (500 words max)
Our assessment finds that the proposed decertification of 31 skilled nursing beds at Episcopal Church Home is unlikely to reduce access to care for medically underserved groups because the beds have already been offline for years and current census levels remain below the proposed 151-bed capacity. The project primarily affects older adults, low-income individuals, and Medicaid beneficiaries, who make up a substantial share of the facility's residents. The broader transformation to a household model is expected to improve quality of life, privacy, infection control, accessibility, and person-centered care for current and future residents. While reducing licensed bed capacity could create concerns if community

demand rises, available capacity at nearby nursing homes and the facility's continued ability to accept referrals mitigate this risk.

Stakeholders interviewed as part of this assessment, including residents and family members, were generally supportive of the project. Stakeholders felt that since the beds have been offline for many years, the decertification does not represent a change to current operations or service capacity.

To mitigate any concerns related to community access to skilled nursing home beds, we recommend the Applicant continue to monitor admissions, waitlists, and referral patterns to identify any unintended access issues.

SECTION B: ASSESSMENT

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

STEP 1 – SCOPING

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

   Please see attached spreadsheet titled "heia_data_tables_ESLC.xlsx"

2. **Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:**
   - Low-income people
   - Older adults
   - People who are eligible for or receive public health benefits

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

   We analyzed utilization data from the Applicant, census data for the community/service area, academic literature, DOH nursing home data, the Monroe County Community Needs Assessment, and information obtained from interviews with staff, community-based organizations, referral partners, residents, and family members.

In our geographic analysis and scoping tables, we included the zip code where the facility is located and the zip codes where current residents originated from as listed in Table 1. The facility is located in an urban setting within the city of Rochester. However, the facility draws residents from across Monroe County, and some residents also come from nearby Ontario, Livingston, and Erie counties.

Table 1. Applicant Service Area[1]

Zip Code	County
14620	Monroe
14626	Monroe
14621	Monroe
14624	Monroe
14467	Monroe
14622	Monroe
14616	Monroe
14610	Monroe
14619	Monroe
14526	Monroe
14534	Monroe
14424	Ontario
14432	Ontario
14472	Livingston/Ontario
14203	Erie

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

Nursing homes, also known as skilled nursing facilities (SNFs), are inpatient residential health facilities that provide a range of health and personal care services to individuals on a 24/7 basis. Along with skilled nursing, nursing homes provide short-term rehabilitation and/or long-term residential care for individuals who need help with activities of daily living (ADLs). In addition to long-term residential care, short-term rehabilitation, and hospice care, Episcopal Church Home dedicates approximately 40 beds to a memory care unit for residents with dementia.

We expect the Applicant's proposal to formally decertify 31 skilled nursing beds as part of its larger facility transformation project to primarily impact older adults and

[1] Data provided by Applicant

low-income individuals/those eligible for or receiving public health benefits.

Older Adults

The prevalence of older adults (65 years or older) is approximately 19% in the Applicant's service area, compared to 17% statewide.[2] In Monroe county, the population aged 65 and older has increased from 13% in 2000 to 19% in 2025.[3] Nationally, the older adult population continues to grow and is projected to more than double over the next 40 years.[4,5] Individuals over the age of 85, who most often require help with personal care and activities of daily living, will quadruple between 2000 and 2040.[3] New York currently has the 4th largest population of older adults in the country, and the aging population continues to increase statewide.[6]

While nursing homes do not exclusively serve older adults, residents age 65 and older account for the majority of the national nursing home population at approximately 82% of residents.[7] Demand for long-term services and supports is expected to continue to grow, with the U.S. Department of Health and Human Services estimating that more than half of Americans turning 65 will need such services at some point in their lives.[8] All current residents of Episcopal Church Home are over the age of 65, and over 66% are over the age of 85.[9] Older adults will be impacted by this project given their representation within the facility's resident population, the continued growth of the older population both locally and nationally, and the ongoing need for access to skilled nursing services among seniors.

Low-income people and people who are eligible for or receive public health benefits

In the Applicant's service area, an estimated 8% of families live below the poverty level, compared to 13% in Monroe County, and 10% statewide. Rochester, where the facility is located, has one of the highest poverty rankings among U.S. cities. Approximately 26.7% of Rochester residents live below the federal poverty level, a rate that is more than

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[2] U.S. Census Bureau. (2023). *American Community Survey 5-Year Estimates*. Retrieved May 12, 2026, from https://data.census.gov

[3] University of Rochester Medical Center. (2025). *2025 Monroe County community health needs assessment*. https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/community/documents/2025-monroe-county-community-health-needs-assessment.pdf

[4] U.S. Census Bureau. (2023, May). *2020 Census: The United States' older population grew.* Retrieved from https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

[5] Urban Institute. (n.d.). *The U.S. population is aging.* Retrieved from https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging

[6] New York State Department of Health, Office of Aging and Long Term Care, & New York State Office for the Aging. (2025, June 30). *New York State master plan for aging: Final report*. https://planforaging.ny.gov/system/files/documents/2025/06/mpa-final-report-6.30.25.pdf

[7] National Center for Health Statistics. (2024). *Data brief no. 208: [Overview of Post-acute and Long-term Care Providers and Services Users in the United States, 2020]*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/nhsr/nhsr208.pdf

[8] Assistant Secretary for Planning and Evaluation. (2022). *Long-term services and supports for older Americans: Risks and financing, 2022*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/ltss-older-americans-risks-financing-2022

[9] Data provided by Applicant

three times higher than that of the surrounding suburban communities, where the poverty rate is 7.9%.[3] Similarly, poverty levels vary considerably across the Applicant's service area. While some zip codes have poverty levels below 1%, certain Rochester neighborhoods experience poverty rates exceeding 26%, highlighting substantial socioeconomic disparities in the region. Median household income also varies widely in the Applicant's service area, from approximately $48,000 to over $144,000.

Medicaid is the primary payer for skilled nursing services both nationally and in New York State, where more than 70% of skilled nursing facility resident care is covered by Medicaid. [10,11] At the same time, individuals living in socioeconomically disadvantaged communities often face significant disparities in access to nursing home care. [12] Over half of residents at Episcopal Church Home are Medicaid beneficiaries.[13]

Given the socioeconomic profile of the community and facility, as well as Medicaid's central role in financing skilled nursing services, this project will impact low-income individuals and families, including those eligible for or currently receiving public benefits and require long-term services and supports.

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

The tables below outline the utilization of skilled nursing and short-term rehabilitation services at Episcopal Church Home among medically underserved groups.[14] Because the beds proposed for decertification are already offline and the facility's current census remains below the proposed operating capacity, we do not anticipate any reductions in access to care or changes to the number of medically underserved residents at the facility.

Table 2. Age

Age	Percent of Residents
Under 65 years	0%

[10] Chidambaram, P., & Burns, A. (2024, December 6). *A look at nursing facility characteristics between 2015 and 2024*. KFF. https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics/

[11] New York State Senate. (2021). *Long-term care workforce hearing report 2021.* Retrieved from https://www.nysenate.gov/sites/default/files/article/attachment/long-term_care_workforce_hearing_report_2021.pdf

[12] Yuan, Y., Louis, C., Cabral, H., Schneider, J. C., Ryan, C. M., & Kazis, L. E. (2018). Socioeconomic and geographic disparities in accessing nursing homes with high star ratings. *Journal of the American Medical Directors Association, 19*(9), 784-791.

[13] Data provided by Applicant

[14] Data provided by the Applicant

65 to 74 years	4.1%
75 to 84 years	28.3%
85 years and older	66.9%
Total	*100%*

Table 3. Payor Mix

Payor	Percent of Residents
Medicaid	51%
Medicare	4.8%
Private Pay	42.1%
Total	*100%*

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

Skilled nursing facilities in Monroe County and their distance from Episcopal Church Home are provided in Table 4 below.

Table 4. Nursing Homes in Monroe County[15]

Facility Name	Address	Distance from ECH (driving)
Episcopal Church Home	505 Mt Hope Avenue Rochester, NY 14620	-
St Johns Health Care Corporation	150 Highland Avenue, Rochester, NY 14620	1 mile, 3 minutes
Kirkhaven	254 Alexander Street, Rochester, NY 14607	1.4 miles, 7 minutes
Unity Living Center	89 Genesee St, Rochester, NY 14611	1.6 miles, 8 minutes
Monroe Community Hospital	435 East Henrietta Road, Rochester, NY 14620	2.1 miles, 7 minutes
Lilac Manor Rehabilitation and Nursing Center	3 Upton Park, Rochester, NY 14607	2.1 miles, 9 minutes
The Brightonian, Inc	1919 Elmwood Avenue, Rochester, NY 14620	2.8 miles, 8 minutes

[15]New York State Department of Health. (n.d.). *Nursing home weekly bed census: Last submission*. Health Data NY. Retrieved June 1, 2026, from Health Data NY – Nursing Home Weekly Bed Census: Last Submission; distances calculated via GoogleMaps

The Hurlbut	1177 East Henrietta Rd, Rochester, NY 14623	3.2 miles, 10 minutes
Woodside Manor Nursing Home Inc	2425 Clinton Avenue South, Rochester, NY 14618	3.4 miles, 9 minutes
The Highlands at Brighton	5901 Lac De Ville Blvd, Rochester, NY 14618	3.7 miles, 10 minutes
The Pearl Nursing Center of Rochester	1335 Portland Avenue, Rochester, NY 14621	4.3 miles, 15 minutes
The Brook at High Falls Nursing Home and Rehabilitation Center	2150 St. Paul Street, Rochester, NY 14621	4.6 miles, 15 minutes
St Anns Community	1500 Portland Avenue, Rochester, NY 14621	4.6 miles, 16 minutes
Rochester Center for Rehabilitation and Nursing	525 Beahan Road, Rochester, NY 14624	4.8 miles, 14 minutes
Jewish Home of Rochester	2021 South Winton Road, Rochester, NY 14618	4.9 miles, 13 minutes
Blossom Health Care Center Inc	989 Blossom Road, Rochester, NY 14610	5 miles, 10 minutes
The Friendly Home	3156 East Avenue, Rochester, NY 14618	5.9 miles, 11 minutes
Penfield Place	1700 Penfield Rd, Penfield, NY 14526	8.1 miles, 14 minutes
Park Ridge Nursing Home	1555 Long Pond Road, Rochester, NY 14626	8.8 miles, 17 minutes
Waterview Heights Rehabilitation and Nursing Center	135 Meriden Street, Rochester, NY 14612	9.5 miles, 25 minutes
Hamilton Manor Nursing Home	1172 Long Pond Road, Rochester, NY 14626	9.7 miles, 17 minutes
Aaron Manor Rehabilitation and Nursing Center	100 St. Camillus Way, Fairport, NY 14450	10.2 miles, 20 minutes

Highlands Living Center	500 Hahnemann Trail, Pittsford, NY 14534	11.2 miles, 18 minutes
Fairport Skilled Nursing and Rehab	4646 Nine Mile Point Road, Fairport, NY 14450	11.6 miles, 20 minutes
Latta Road Nursing Home East	2102 Latta Road, Rochester, NY 14612	11.7 miles, 18 minutes
Latta Road Nursing Home West	2100 Latta Road, Rochester, NY 14612	11.7 miles, 18 minutes
Edna Tina Wilson Living Center	700 Island Cottage Road, Rochester, NY 14612	12.4 miles, 19 minutes
Crest Manor Living and Rehabilitation Center	6745 Pittsford-Palmyra Road, Fairport, NY 14450	12.7 miles, 19 minutes
Wedgewood Nursing and Rehabilitation Center	5 Church Street, Spencerport, NY 14559	12.8 miles, 19 minutes
St Anns Community	920 Cherry Ridge Boulevard, Webster, NY 14580	13.6 miles, 20 minutes
Maplewood Nursing Home Inc	100 Daniel Drive, Webster, NY 14580	15.3 miles, 20 minutes
Elderwood of Lakeside at Brockport	170 West Avenue, Brockport, NY 14420	21.2 miles, 29 minutes

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

Table 5. Nursing Home Adult Bed Market Share in Monroe County

Facility Name	Number of Adult Beds	Current Market Share	Projected Market Share
Episcopal Church Home	182 (151 projected)	4%	3%
St Johns Health Care Corporation	455	10%	10%
Kirkhaven	147	3%	3%

Unity Living Center	120	3%	3%
Monroe Community Hospital	566	12%	12%
Lilac Manor Rehabilitation and Nursing Center	200	4%	4%
The Brightonian, Inc	54	1%	1%
The Hurlbut	160	3%	3%
Woodside Manor Nursing Home Inc	44	1%	1%
The Highlands at Brighton	145	3%	3%
The Pearl Nursing Center of Rochester	120	3%	3%
The Brook at High Falls Nursing Home and Rehabilitation Center	28	1%	1%
St Anns Community	376	8%	8%
Rochester Center for Rehabilitation and Nursing	124	3%	3%
Jewish Home of Rochester	328	7%	7%
Blossom Health Care Center Inc	80	2%	2%
The Friendly Home	200	4%	4%
Penfield Place	48	1%	1%
Park Ridge Nursing Home	120	3%	3%

Waterview Heights Rehabilitation and Nursing Center	204	4%	4%
Hamilton Manor Nursing Home	40	1%	1%
Aaron Manor Rehabilitation and Nursing Center	140	3%	3%
Highlands Living Center	122	3%	3%
Fairport Skilled Nursing and Rehab	142	3%	3%
Latta Road Nursing Home East	40	1%	1%
Latta Road Nursing Home West	40	1%	1%
Edna Tina Wilson Living Center	120	3%	3%
Crest Manor Living and Rehabilitation Center	80	2%	2%
Wedgewood Nursing and Rehabilitation Center	29	1%	1%
St Anns Community	72	2%	2%
Maplewood Nursing Home Inc	74	2%	2%
Elderwood of Lakeside at Brockport	120	3%	3%
Total	4,720	*100%**	*100%**

**Discrepancy due to rounding*

8. **Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with**

disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.

N/A

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

   N/A – no staff were dismissed as a result of this project

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

    No

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

    N/A

STEP 2 – POTENTIAL IMPACTS

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

   The reduction from 182 beds to 151 beds at the facility provided the physical space necessary to fully adopt a household model and reduce the number of semi-private rooms for residents. The household model reimagines the traditional nursing home by transforming three key components: the physical environment, the approach to care, and the staffing model.[16] Its purpose is to create a home-like setting that fosters a genuine sense of community for residents. The model emphasizes personal choice,

[16] PHI National. (2018, April 17). *The household model: Creating a "home" in nursing homes*. https://www.phinational.org/household-model-creates-real-home-people-living-nursing-homes/

respect for individual routines and preferences, and opportunities for meaningful engagement, all with the goal of enhancing residents' quality of life and overall well-being. Supporting this approach is a redesigned workforce model that empowers staff to work collaboratively with residents, responding to their individual needs, preferences, and goals. The number of residents per "household" is typically limited to 18-20. The impacts of the facility's transition to this model for each medically underserved group identified in the assessment is detailed below.

Older Adults

Seventy-five percent of older adults would like to age in place in their home.[17] However, this is not always feasible due to functional, financial, caregiver, and/or community barriers. As a result, skilled nursing care becomes necessary for older adults who can no longer remain safely in their home and community, despite the generally negative perceptions of nursing homes among older adults.[18]

The household model addresses some of these negative perceptions and concerns among older adults and their families. It provides a less institutional and more home-like setting, which research has shown can enhance residents' psychosocial well-being.[19] The spread of infectious disease is also a primary concern for older adults and families following the Covid-19 pandemic. The reduction of semi-private rooms at the facility in may help improve infection control, as single-occupancy rooms decrease the risk of acquiring and spreading infections.[20]

Low-income people and people who are eligible for or receive public health benefits

This approach can also advance access and health equity by ensuring that residents, including those who rely on Medicaid or have limited financial resources, have access to a more person-centered model of skilled nursing care. Inadequate state Medicaid reimbursement rates can be a financial barrier to implementing more person-centered nursing home models, including the household model.[21] For that reason, adopting the household model in a facility where approximately half of residents are covered by Medicaid represents an important step toward expanding access to a higher-quality, more home-like care environment for residents, regardless of payer source.

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[17] Lohmeyer, S. (2024, December 10). *Older adults want to age-in-place, but many don't expect they'll be able to*. AARP. https://www.aarp.org/home-living/home-community-preferences-survey-2024/

[18] The John A. Hartford Foundation. (2021, December 7). *Age-friendly insights: Poll reveals how older adults feel about nursing homes*. https://www.johnahartford.org/resources/view/age-friendly-insights-how-do-older-adults-feel-about-nursing-homes

[19] Hermer, L., Bryant, N. S., Pucciarello, M., Mlynarczyk, C., & Zhong, B. (2017). Does comprehensive culture change adoption via the household model enhance nursing home residents' psychosocial well-being? *Innovation in Aging, 1*(2), igx033. https://doi.org/10.1093/geroni/igx033

[20] Brown, K. A., Jones, A., Daneman, N., Chan, A. K., Schwartz, K. L., Garber, G. E., Costa, A. P., & Stall, N. M. (2021). Association between nursing home crowding and COVID-19 infection and mortality in Ontario, Canada. *JAMA Internal Medicine, 181*(2), 229–236. https://doi.org/10.1001/jamainternmed.2020.6466

[21] Meyer, H. (2023, December 29). *Turning nursing homes into true homes: The household model*. Center for Health Care Strategies. https://www.chcs.org/turning-nursing-homes-into-true-homes-the-household-model/

Additionally, low-income older adults may have fewer community-based alternatives to care and may be more likely to receive long-term care in older, more institutional physical environments. By modernizing the care setting and embedding resident choice, privacy, and individualized support into the facility's design and operations, the household model can help reduce disparities in the quality of the long-term care experience.

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

An unintended negative health equity impact of this project is that it reduces the number of available skilled nursing facility beds in the community, which could create access issues for older adults and Medicaid beneficiaries if there is insufficient capacity. However, because the beds being decertified are no longer operational, any related impact has likely already occurred.

In terms of community capacity, there are 11 nursing homes within a 15-minute drive of the facility (see Table 4). According to state census data, all but one of these nursing homes currently have available beds (however, the data may include beds that are offline but have not been formally decertified).

Additionally, the Applicant has not been at the full 182-bed capacity in many years and has room to accept residents within its new proposed capacity of 151 beds. Staff and community-based partners confirmed during the interview process that the facility is able to accept referrals from hospitals and other community partners, particularly for short-term rehabilitation. Traditional long-term care beds may occasionally reach capacity and result in a waitlist. In those instances, the Applicant may admit the patient to a short-term bed until a long-term care bed becomes available.

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

N/A

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

The skilled nursing facility provides a bus for resident outings. If the resident has a medical visit, they typically use MediCab.

For family members and other visitors, the facility is accessible via the region's public transit bus system on the local bus route.[22]

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

The facility remains compliant with all ADA requirements following the renovation. Additionally, stakeholders indicated that the renovations improved accessibility, with larger spaces for wheelchairs and better accommodations in restrooms, showers, hair salons, and common areas for people with mobility impairments.

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

N/A

Meaningful Engagement

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

Monroe County Department of Health

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

No, the Independent Entity reached out to the Monroe County Department of Health for feedback but they did not respond.

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[22] Rochester Genesee Regional Transportation Authority. (2021, April 12). *RTS system map: UR connection points* [Map]. University of Rochester Parking and Transportation Services. https://www.rochester.edu/parking/wp-content/uploads/2022/06/RTS-System-Map-UR-Connection-Points-04.12.21.pdf

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

   Please refer to attached spreadsheet titled "heia_data_tables_ESLC.xlsx"

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

    The populations most impacted by the proposed project are individuals in need of skilled nursing services, inclusive of older adults and low-income individuals. For existing and future residents of the facility, the project includes numerous enhancements to their environment, including private rooms, IT and facility upgrades, and improved ADA accommodations. Stakeholders were broadly supportive of the project, recognizing that the beds have been offline for many years and therefore do not represent a change to current operations or service capacity. One stakeholder expressed concern about the broader decline in nursing home bed capacity in the community, while another indicated that they did not have sufficient information about the project to provide substantive feedback.

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

    As part of our stakeholder engagement, we conducted 13 interviews with staff, community-based organizations, referral partners, family members, and residents. The meaningful engagement process yielded valuable insight into the characteristics and needs of current residents, the community's skilled nursing capacity, and the rationale for and anticipated benefits of the facility renovation.

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

    No, the Independent Entity believes it was able to reach individuals or representatives from all medically underserved groups impacted by the project via the interview process.

STEP 3 – MITIGATION

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

    The Applicant conducted ongoing communication with residents, family members, staff, and referral sources before, during, and after the renovations to the facility. Communication methods included email distributions, town halls, resident councils, and family councils. The Applicant has a 24/7 interpreter line, offers American Sign Language, and is designated as a deaf-friendly community. The Applicant reported that it did not need to translate any communications as residents are all English-speaking. A caregiver confirmed that their family member who is hard of hearing received appropriate communication, including paper reading materials.

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

    No specific changes are suggested for this project.

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

    Since the construction and renovation has already taken place and the beds are not currently in use, no further communication is anticipated to referral sources, staff, residents, or family members. Because the 31 beds have been offline for many years and the official decertification is not expected to have any practical impact on existing residents or referral sources, we recommend that the Applicant refrain from proactively communicating the decertification to avoid confusion or the impression that additional changes are occurring.

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

Consistent with national trends across the health care sector, New York State continues to face significant workforce challenges within residential long-term care settings.[23] These workforce challenges can create systemic barriers to equitable care, particularly for low-income residents and residents who rely on Medicaid, who may have fewer alternative long-term care options and are more dependent on the quality and stability of facility-based staffing. Staff turnover can also be disruptive for residents, particularly older adults with dementia or other challenges.

Research demonstrates that compared to traditional nursing homes, household models lead to reduced staff turnover and improved work environments.[21,24] By supporting staff retention and continuity of care, the model may help ensure that residents with limited resources receive more consistent, individualized, and responsive support.

STEP 4 – MONITORING

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

The facility currently tracks several quality measures, including staff ratios, resident falls, and infection control.

The Applicant has a full-time admissions coordinator who is in daily communication with the hospitals regarding available capacity and potential offers for short-term and long-term stays at the facility.

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

We recommend the Applicant conduct periodic review of admissions, waitlist activity, referral patterns, resident census, and bed availability to assess whether the project has affected access to short-term or long-term skilled nursing care. Where available and appropriate, the Applicant can review this information by key demographic and access-related factors, such as payer source, race and ethnicity, language preference, age, disability status, and ZIP code, to identify any disparities or unintended consequences.

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[23] University at Albany. (2026, June 1). *Report shows continued healthcare workforce shortages across New York State*. https://www.albany.edu/news-center/news/2026-report-shows-continued-healthcare-workforce-shortages-across-new-york-state

[24] Sabatino, C. P. (2023, April 23). *Why nursing homes need a total redesign*. Health Affairs Forefront. https://doi.org/10.1377/forefront.20230329.308199

The Applicant can also create a structured feedback mechanism with hospital referral partners, residents, families, and staff to identify any concerns related to access, care transitions, or capacity following implementation of the project. Findings from this monitoring process can be reviewed by facility leadership on a regular basis, with any identified issues addressed through corrective actions, such as adjustments to admissions practices, enhanced communication with referral sources, or targeted outreach to affected populations.

STEP 5 – DISSEMINATION

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

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

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

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

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

I. Acknowledgement

I, (APPLICANT), attest that I have reviewed the Health Equity Impact Assessment for the (PROJECT TITLE) that has been prepared by the Independent Entity, (NAME OF INDEPENDENT ENTITY).

_____Amanda Teugeman_____

Name

_____SVP Healthcare Services_____

Title

_____ Amanda Teugeman _____

Signature

_____6/16/2026_____

Date

II. Mitigation Plan

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

The Applicant does not anticipate any negative impact to medically underserved groups as a result of this project. The proposed bed decertification involves beds that have not been utilized for resident care for approximately seven to ten years and have therefore not been contributing to the community's current access to services. As a result, the project does not reduce existing service capacity available to residents, including individuals from medically underserved populations.

As outlined in the project narrative, the facility has maintained operations and resident services without utilizing these beds for an extended period of time. Historical occupancy trends and utilization data demonstrate that the beds proposed for decertification are excess licensed capacity and are not necessary to meet current community demand. Therefore, the project is not expected to create barriers to access, increase wait times, or reduce the availability of services for any population served by the facility.

Additionally, the Applicant will continue to monitor occupancy levels, referral patterns, admission requests, and community needs to ensure that access to care remains sufficient for all populations, including medically underserved groups. Should future demand indicate a need for additional capacity, the Applicant will work with the appropriate regulatory agencies to evaluate available options and ensure continued access to care.

The project will not result in the elimination of any programs, services, staffing positions, or resident care resources. The facility's census is not expected to change as a result of the bed decertification, and no reduction in staffing levels is anticipated. Residents currently receiving services will experience no disruption in care, and the facility will continue to provide the same level of access and quality services to all individuals regardless of socioeconomic status, race, ethnicity, disability, insurance status, or other factors associated with health disparities.

Based on the long-term nonuse of the beds, the absence of any reduction in active service capacity, and the facility's ongoing commitment to monitoring community needs and maintaining access to care, the Applicant believes this project will not negatively impact medically underserved populations and therefore does not require additional mitigation measures beyond those described above.

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

Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	Organization (if applicable)	Date(s) of outreach	What required stakeholder group did they represent?	If other, please describe	Is this person/organization a resident of the project's service area?	Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)	Did this person/organization participate in the meaningful engagement?	Is this person/organization supportive of this project?	Did this person/organization provide a statement?	If permission is granted to share a statement or quote (250 word max), please include below:	If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:
Employee A	Episcopal Church Home	5/26/2026	employees		yes	Phone Call	yes	yes	no		The employee provided an overview of current residents, census and referral capacity, and details on the project. They noted that all construction was completed prior to their tenure at the organization. They did not anticipate any impacts on existing residents.
Employee B	Episcopal Church Home	5/27/2026	employees		yes	Zoom Call	yes	yes	no		The employee provided an overview of the project and details on the organization's commitment to diversity, equity, and inclusion, including several initiatives for staff and residents that are underway.
Employee C	Episcopal Church Home	5/27/2026	employees		yes	Phone Call	yes	yes	no		The employee understood the need for the project, but noted that they had mixed feelings as a reduction of beds can be worrisome for the community. They mentioned that access to nursing home beds can be challenging and they felt for seniors in need of affordable housing.
Respondent 1	Accelerated Care Plus	5/29/2026	community-based organizations		yes	Phone Call	yes	yes	no		The respondent was familiar with the organization and spoke very highly of the recent renovations and household model that allows for more single rooms for residents. They also spoke very highly of the facility, noting that Episcopal Church Home is one of the best nursing facilities in the state. They also work with other skilled nursing facilities in the area and did not feel that there are capacity issues in Rochester.
Respondent 2	Celtic Consulting	6/1/2026	other	Advisor	no	Phone Call	yes	yes	no		The respondent was supportive of the project, stating that more private rooms results in a better experience for residents and families. They felt that if the facility is not using the beds they should be de-certified. They did not think there would be any negative community impact.
Respondent 3	Rochester Regional Health	6/2/2026	other	Referral and Hospice Partner	yes	Phone Call	yes	yes	no		The respondent was supportive of the project, commenting on the improvements from the renovations including enhanced ADA accommodations. They did not anticipate any impacts on capacity or access in the area. They thought the facility handled the renovations very well in terms of the impact on residents (e.g., noise, temporary relocations).
Respondent 4	Together in Caring	6/3/2026	community-based organizations		yes	Phone Call	yes	yes	no		The respondent said the renovations to the facility are "wonderful," the staff are attentive, and the organization is a great communicator. They both refer to and receive referrals from Episcopal Church Home, and noted that they have had no issues placing people with the current capacity.
Respondent 5	Episcopal Church Home	6/4/2026	patients or residents and/or their caregivers		yes	Phone Call	yes	yes	no		The resident is very satisfied with the facility in general and with their own private room. They did not have any concerns about the project, including the official decertification of the offline beds. The staff reportedly did a good job communicating the construction project, including areas to avoid and any temporary relocations.
Respondent 6	Episcopal Church Home	6/4/2026	patients or residents and/or their caregivers		yes	Phone Call	yes	yes	no		The resident is happy at the facility, noting that previously they had a double room which did not accommodate their wheelchair. Now they have a single room and it is much easier to maneuver. They did not feel inconvenienced by the construction and renovation. They did not have any concerns about the decertification of the 31 beds.
Employee D	Episcopal Church Home	6/8/2026	employees		yes	Phone Call	yes	yes	no		The employee was supportive of the project, noting that the project aligns the organization's official capacity with the actual use of the beds at the facility. They did not feel there would be any negative health equity impact or capacity issues in the community as a result of the project. They spoke of the improvements to the facility as a result of the renovations, including more private space, better common areas, new bathrooms and kitchens, enhanced space for PT/OT, and more advanced equipment.
Respondent 7	Episcopal Church Home	6/9/2026	patients or residents and/or their caregivers		yes	Phone Call	yes	yes	no		The respondent was supportive of the project and had no concerns. They noted that the beds went offline before their family member entered the facility several years ago, so they did not feel there would be any impact. They attested that the organization provides appropriate accommodations and communication materials to their family member who is hard of hearing.
Respondent 8	Episcopal Church Home	6/10/2026	patients or residents and/or their caregivers		yes	Phone Call	yes	yes	no		The respondent reported that they were able to access a long-term care bed for their family member relatively quickly after a brief stay in the short-term rehab unit. They were very happy with the renovations and the accommodations and communication from the staff. They were supportive of the project as they didn't see any impact on their family member since the reduction of the beds happened in the past.
Respondent 9	Episcopal Church Home	6/10/2026	patients or residents and/or their caregivers		yes	Phone Call	yes	Not sure	no		The respondent did not think the project would impact their family member at all, but didn't know enough about it to make a reasonable comment on whether or not they were supportive. They were able to get their family member into the facility quickly and were happy with the renovations.
Respondent 10	Monroe County Health Department	6/2/26, 6/5/26	public health experts		yes	Email	no				

Label	2CTAS 14620 Estimate	2CTAS 14620 Margin of Error	2CTAS 14620 Percent	2CTAS 14620 Percent Margin of Error	2CTAS 14626 Estimate	2CTAS 14626 Margin of Error	2CTAS 14626 Percent	2CTAS 14626 Percent Margin of Error	2CTAS 14621 Estimate	2CTAS 14621 Margin of Error	2CTAS 14621 Percent	2CTAS 14621 Percent Margin of Error	2CTAS 14624 Estimate	2CTAS 14624 Margin of Error	2CTAS 14624 Percent	2CTAS 14624 Percent Margin of Error	2CTAS 14467 Estimate	2CTAS 14467 Margin of Error	2CTAS 14467 Percent	2CTAS 14467 Percent Margin of Error	2CTAS 14622 Estimate	2CTAS 14622 Margin of Error	2CTAS 14622 Percent	2CTAS 14622 Percent Margin of Error	2CTAS 14616 Estimate	2CTAS 14616 Margin of Error	2CTAS 14616 Percent	2CTAS 14616 Percent Margin of Error	2CTAS 14610 Estimate	2CTAS 14610 Margin of Error	2CTAS 14610 Percent	2CTAS 14610 Percent Margin of Error	2CTAS 14619 Estimate	2CTAS 14619 Margin of Error	2CTAS 14619 Percent	2CTAS 14619 Percent Margin of Error	2CTAS 14526 Estimate	2CTAS 14526 Margin of Error	2CTAS 14526 Percent	2CTAS 14526 Percent Margin of Error	2CTAS 14424 Estimate	2CTAS 14424 Margin of Error	2CTAS 14424 Percent	2CTAS 14424 Percent Margin of Error	2CTAS 14432 Estimate	2CTAS 14432 Margin of Error	2CTAS 14432 Percent	2CTAS 14432 Percent Margin of Error	2CTAS 14472 Estimate	2CTAS 14472 Margin of Error	2CTAS 14472 Percent	2CTAS 14472 Percent Margin of Error	2CTAS 14534 Estimate	2CTAS 14534 Margin of Error	2CTAS 14534 Percent	2CTAS 14534 Percent Margin of Error	2CTAS 14203 Estimate	2CTAS 14203 Margin of Error	2CTAS 14203 Percent	2CTAS 14203 Percent Margin of Error
SEX AND AGE (Census Table DP05)																																																														
Total population	22866	1086	22866	(X)	29210	1447	29210	(X)	33349	1554	33349	(X)	38834	1226	38834	(X)	10468	1015	10468	(X)	12794	910	12794	(X)	26837	1520	26837	(X)	14082	982	14082	(X)	14223	1303	14223	(X)	19348	1293	19348	(X)	28851	389	28851	(X)	5583	658	5583	(X)	9156	485	9156	(X)	33361	1267	33361	(X)	2526	395	2526	(X)
Male	11408	745	49.9	2.3	13837	931	47.4	1.6	15612	999	46.8	1.8	18978	901	48.9	1.6	4917	592	47	3.7	6372	535	49.8	2.7	12941	976	48.2	2.1	6693	556	47.5	2.2	6641	938	46.7	3.8	9071	607	46.9	2.4	14041	483	48.7	1.5	2491	343	44.6	2.9	4641	410	50.7	3.1	15933	759	47.8	1.4	1203	275	47.6	8.3
Female	11458	762	50.1	2.3	15373	773	52.6	1.6	17737	966	53.2	1.8	19856	837	51.1	1.6	5551	683	53	3.7	6422	608	50.2	2.7	13896	893	51.8	2.1	7389	609	52.5	2.2	7582	727	53.3	3.8	10277	965	53.1	2.4	14810	457	51.3	1.5	3092	392	55.4	2.9	4515	326	49.3	3.1	17428	808	52.2	1.4	1323	302	52.4	8.3
Sex ratio (males per 100 females)	99.6	5.1	(X)	(X)	90	5.8	(X)	(X)	88	6.4	(X)	(X)	95.6	6.1	(X)	(X)	88.6	13.2	(X)	(X)	99.2	10.8	(X)	(X)	93.1	7.6	(X)	(X)	90.6	8.0	(X)	(X)	87.6	13.3	(X)	(X)	88.3	8.5	(X)	(X)	94.8	5.6	(X)	(X)	80.6	9.5	(X)	(X)	102.8	12.6	(X)	(X)	91.4	5.1	(X)	(X)	90.9	30.6	(X)	(X)
Under 5 years	535	132	2.3	0.6	1477	309	5.1	1	2441	312	7.3	1	2509	483	6.5	1.2	538	238	5.1	2.1	606	148	4.7	1.2	1448	411	5.4	1.5	629	155	4.5	1	926	332	6.5	2.1	1083	308	5.6	1.6	1102	208	3.8	0.7	294	103	5.3	1.6	629	212	6.9	2.3	1951	345	5.8	1	65	58	2.6	2.3
5 to 9 years	713	220	3.1	0.9	1135	254	3.9	0.8	2365	324	7.1	0.9	2622	417	6.8	1	609	227	5.8	2.1	629	248	4.9	1.8	2019	716	7.5	2.5	514	125	3.7	0.8	827	338	5.8	2.1	1121	317	5.8	1.6	1293	233	4.5	0.8	540	187	9.7	2.9	645	273	7	2.9	2361	443	7.1	1.2	20	24	0.8	1
10 to 14 years	609	221	2.7	1	1399	325	4.8	1	2923	393	8.8	1	1922	333	4.9	0.9	530	221	5.1	2	736	259	5.8	1.8	2117	424	7.9	1.5	559	190	4	1.3	1104	272	7.8	1.6	1526	474	7.9	2.2	1359	205	4.7	0.7	482	151	8.6	2.3	532	208	5.8	2.2	2318	338	6.9	1	80	60	3.2	2.2
15 to 19 years	1066	326	4.7	1.4	1732	293	5.9	0.9	2123	383	6.4	1.2	2366	479	6.1	1.2	321	197	3.1	1.8	533	193	4.2	1.4	1904	569	7.1	2	363	139	2.7	0.9	1085	313	7.6	2.2	1086	330	5.6	1.6	1365	254	6.3	0.9	387	155	6.9	2	540	180	5.9	2.1	1736	285	5.2	0.8	46	53	1.8	2
20 to 24 years	2695	740	11.8	3	1436	291	4.9	1	2291	374	6.9	1.1	1822	384	4.7	1	395	222	3.8	2	579	261	4.5	2.1	1322	344	4.9	1.2	978	257	6.9	1.7	835	303	5.9	2.1	772	374	4	1.8	1859	363	6.4	1.2	196	91	3.5	1.5	317	202	3.5	2.2	981	263	2.9	0.8	305	223	12.1	8.4
25 to 34 years	5216	691	27.3	2.7	3846	525	13.2	1.7	5248	536	15.7	1.5	5125	645	13.2	1.6	1463	423	14	3.4	1480	270	11.6	1.8	3848	563	14.3	2	2432	367	17.2	2.4	2206	465	15.5	2.8	1568	326	8.1	1.7	3164	352	11	1.3	651	270	11.7	4.4	506	143	5.5	1.6	2334	398	7	1.1	909	250	36	8.4
35 to 44 years	2846	401	12.4	1.8	3323	432	11.4	1.5	4015	458	12	1.1	4713	591	12.1	1.5	1392	392	13.1	3.6	1681	283	13.1	2.2	3386	467	12.6	1.5	2060	334	14.6	2.1	1802	414	12.7	2.6	2243	337	11.6	1.5	3561	387	12.3	1.3	658	166	11.8	2.6	1418	264	15.5	2.6	3951	329	11.8	0.9	246	131	9.7	5.1
45 to 54 years	2016	337	8.8	1.5	3527	416	12.1	1.4	3285	361	9.9	1.1	4290	524	11	1.3	1236	423	11.8	3.7	1930	296	15.1	2.1	3127	359	11.7	1.3	1691	276	12	1.8	1469	320	10.3	2.1	2688	585	13.9	2.6	3425	359	11.9	1.2	577	151	10.3	2.3	1541	293	16.8	3	4570	502	13.7	1.3	216	79	8.6	3.2
55 to 59 years	1273	276	5.3	1.2	2180	390	7.5	1.2	1824	305	5.5	0.9	3718	547	8.3	1.4	934	259	8.9	2.4	929	271	7.3	1.9	1816	328	6.8	1.3	886	228	6.3	1.6	1082	286	7.6	1.9	1470	345	7.6	1.8	1799	253	6.2	0.9	244	88	4.4	1.6	794	234	8.7	2.5	2670	392	8	1.1	109	82	4.3	3.2
60 to 64 years	1252	335	5.5	1.4	1912	363	6.5	1.2	1905	272	5.7	0.8	3084	404	7.9	1	686	224	6.6	2.3	840	210	6.6	1.7	1521	301	5.7	1.2	586	159	4.2	1.1	838	168	5.8	1.3	1501	293	7.8	1.5	2354	308	8.2	1.1	429	99	7.7	1.9	721	227	7.9	2.5	2451	403	7.3	1.3	272	158	10.8	6
65 to 74 years	1659	251	7.3	1.1	3877	423	13.3	1.5	2705	363	8.1	1.1	4446	520	11.4	1.3	1075	351	10.1	3.2	1720	215	13.4	1.7	2347	356	8.7	1.3	1466	205	10.4	1.5	1477	319	10.4	2.4	2324	340	12	1.9	4136	267	14.3	0.9	627	134	11.2	2.7	947	180	10.3	2.1	4323	452	13	1.4	170	98	6.7	4
75 to 84 years	1175	282	5.1	1.2	2029	313	6.9	1.1	1524	303	4.6	0.9	1844	312	4.7	0.8	946	227	9	2.2	792	221	6.2	1.7	1166	243	4.3	0.9	1113	234	7.9	1.6	494	133	3.5	0.9	1150	234	5.9	1.3	2057	276	7.1	1	344	93	6.2	1.7	422	133	4.6	1.5	2307	301	6.9	0.9	38	38	1.5	1.6
85 years and over	861	170	3.8	0.7	1337	365	4.6	1.2	700	171	2.1	0.5	875	212	2.3	0.5	337	161	3.2	1.5	339	140	2.6	1.1	816	207	3	0.8	795	331	5.6	2.3	98	62	0.7	0.4	818	242	4.2	1.3	936	277	3.2	0.9	154	65	2.8	1.1	144	77	1.6	0.8	1410	481	4.2	1.4	50	65	2	2.6
Median age (years)	33.8	1.8	(X)	(X)	46	2.3	(X)	(X)	33.3	1.5	(X)	(X)	40.3	1.7	(X)	(X)	44.9	3.3	(X)	(X)	46.3	3.6	(X)	(X)	36.5	1.9	(X)	(X)	42.5	1.9	(X)	(X)	36.5	3.4	(X)	(X)	46.5	2.7	(X)	(X)	45.8	2	(X)	(X)	38.9	5.8	(X)	(X)	44.8	5.5	(X)	(X)	47.6	2.3	(X)	(X)	32	2.6	(X)	(X)
RACE (Census Table DP05)																																																														
Total population	22866	1086	(X)	(X)	29210	1447	(X)	(X)	33349	1554	(X)	(X)	38834	1226	(X)	(X)	10468	1015	(X)	(X)	12794	910	(X)	(X)	26837	1520	(X)	(X)	14082	982	(X)	(X)	14223	1303	(X)	(X)	19348	1293	(X)	(X)	28851	389	(X)	(X)	5583	658	(X)	(X)	9156	485	(X)	(X)	33361	1267	(X)	(X)	2526	395	(X)	(X)
One race	21433	1044	93.7	1.7	27438	1385	93.9	1.5	29409	1468	88.2	2.3	36887	1246	95	1.1	10060	995	95.9	2.2	12147	941	94.9	1.7	24696	1572	92	2.1	13305	962	94.5	1.5	13156	1281	92.5	2.5	18011	1421	93.1	2.4	27441	581	95.1	1.3	4992	652	89.4	7.1	8652	521	94.5	2.1	31344	1193	94	1.8	2341	405	92.7	4.9
Two or more races	1433	413	6.3	1.7	1772	468	6.1	1.5	3940	758	11.8	2.3	1947	436	5	1.1	408	232	4.1	2.2	647	209	5.1	1.7	2141	570	8	2.1	777	214	5.5	1.5	1067	358	7.5	2.5	1337	439	6.9	2.4	1410	368	4.9	1.3	591	415	10.6	7.1	504	196	5.5	2.1	2017	626	6	1.8	185	120	7.3	4.5
One race	21433	1044	93.7	1.7	27438	1385	93.9	1.5	29409	1468	88.2	2.3	36887	1246	95	1.1	10060	995	95.9	2.2	12147	941	94.9	1.7	24696	1572	92	2.1	13305	962	94.5	1.5	13156	1281	92.5	2.5	18011	1421	93.1	2.4	27441	581	95.1	1.3	4992	652	89.4	7.1	8652	521	94.5	2.1	31344	1193	94	1.8	2341	405	92.7	4.9
White	15755	961	68.9	3.4	23680	1404	80.4	2.6	7914	746	23.7	2	31053	1506	80	2.8	8400	952	80.2	5.5	10114	882	79.2	5.1	18956	1501	70.6	4.2	11635	869	82.6	3.6	3051	451	21.5	3.5	17133	1418	88.6	2.7	26524	615	91.9	1.5	4888	657	87.6	7.1	8412	540	91.9	2.7	27512	1248	82.5	2.4	874	187	34.6	7.9
Black or African American	2777	634	12.1	2.6	2668	612	9.3	2.1	14513	1277	43.5	2.8	3647	744	9.4	1.9	651	318	6.2	2.9	830	398	6.5	2.9	3593	977	13.4	3.4	916	396	6.5	2.7	9782	1268	68.8	4.4	225	93	1.2	0.5	383	137	1.3	0.5	37	34	0.7	0.6	111	52	1.2	0.7	773	439	2.3	1.3	1119	309	44.3	10
American Indian and Alaska Native	19	19	0.1	0.1	8	12	0	0.1	198	141	0.6	0.4	29	25	0.1	0.1	5	5	0	0.1	7	10	0.1	0.1	147	103	0.5	0.4	16	26	0.1	0.2	8	9	0.1	0.1	0	21	0	0.2	0	25	0	0.1	17	21	0.3	0.4	0	19	0	0.4	3	2	0	0.1	9	22	0.4	0.9
Asian	2027	414	8.9	1.8	993	351	3.4	1.2	376	194	1.1	0.6	1245	527	3.2	1.4	936	390	8.9	3.6	784	390	6.1	3	791	586	2.7	2.2	388	214	2.8	1.5	197	148	1.4	1	388	182	2	1	127	83	0.4	0.3	22	34	0.4	0.6	100	67	1.1	0.7	758	381	8.3	1.2	184	178	7.3	6.6
Native Hawaiian and Other Pacific Islander	6	13	0.0	0.1	0	25	0.0	0.1	190	180	0.6	0.5	23	37	0.1	0.1	0	21	0.0	0.4	35	47	0.3	0.4	0	25	0.0	0.1	0	21	0.0	0.3	0	21	0.0	0.3	7	13	0.0	0.1	0	25	0.0	0.1	0	19	0.0	0.7	0	19	0.0	0.4	3	3	0	0.1	0	13	0.0	1.6
Some other race	849	431	3.7	1.9	289	152	1	0.5	6218	863	18.6	2.7	890	387	2.3	1	50	57	0.5	0.5	357	199	2.8	1.5	1269	492	4.7	1.8	350	201	2.5	1.4	118	97	0.8	0.7	258	207	1.3	1.1	407	220	1.4	0.8	28	35	0.5	0.6	29	36	0.3	0.4	299	172	0.9	0.5	155	141	6.1	5.2
Two or more races	1433	413	6.3	1.7	1772	468	6.1	1.5	3940	758	11.8	2.3	1947	436	5	1.1	428	232	4.1	2.2	647	209	5.1	1.7	2141	570	8	2.1	777	214	5.5	1.5	1067	358	7.5	2.5	1337	439	6.9	2.4	1410	368	4.9	1.3	591	415	10.6	7.1	504	196	5.5	2.1	2017	626	6	1.8	185	120	7.3	4.9
HISPANIC OR LATINO AND RACE (Census Table DP05)																																																														
Total population	22866	1086	22866	(X)	29210	1447	29210	(X)	33349	1554	33349	(X)	38834	1226	38834	(X)	10468	1015	10468	(X)	12794	910	12794	(X)	26837	1520	26837	(X)	14082	982	14082	(X)	14223	1303	14223	(X)	19348	1293	19348	(X)	28851	389	28851	(X)	5583	658	5583	(X)	9156	485	9156	(X)	33361	1267	33361	(X)	2526	395	2526	(X)
Hispanic or Latino (of any race)	1473	419	6.4	1.8	2306	568	7.9	1.8	13378	969	40.1	2.6	2474	663	6.4	1.7	544	325	5.2	3.1	1268	573	9.9	4.3	3305	669	12.3	2.4	1268	358	9	2.7	988	356	5.1	1.9	1422	311	4.9	1.1	289	181	5.2	3.3	245	124	2.7	1.4	1439	591	4.3	1.7	295	183	11.7	6.8
Not Hispanic or Latino	21393	1116	93.6	1.8	26904	1319	92.1	1.8	19971	1393	59.9	2.6	36360	1387	93.6	1.7	9924	1038	94.8	3.1	11526	920	90.1	4.3	23532	1448	87.7	2.4	13266	969	94.2	1.6	13368	1290	94	2.7	18360	1360	94.9	1.9	27429	496	95.1	1.1	5294	687	94.8	3.3	8911	512	97.3	1.4	31922	1130	95.7	1.7	2231	368	88.3	6.8
HEALTH INSURANCE COVERAGE (Census Table DP03)																																																														
Civilian noninstitutionalized population	21783	1095	21783	(X)	29082	1446	29082	(X)	32734	1552	32734	(X)	38720	1225	38720	(X)	10468	1015	10468	(X)	12794	910	12794	(X)	26832	1520	26832	(X)	13851	981	13851	(X)	14207	1303	14207	(X)	19102	1295	19102	(X)	28268	385	28268	(X)	5444	658	5444	(X)	9143	486	9143	(X)	33136	1268	33136	(X)	2490	397	2490	(X)
With health insurance coverage	21095	1094	96.8	1.1	28526	1483	98.1	0.5	30684	1460	93.7	1.3	37599	1256	97.1	0.9	10301	1008	98.4	0.8	12417	931	97.1	1	26226	1495	97.7	0.9	13464	940	97.2	1	13696	1267	96.4	1.5	18801	1292	98.4	0.9	27538	422	97.4	0.9	5313	643	97.6	1.4	8989	525	98.3	1.6	32901	1286	99.3	0.4	2388	390	95.9	2.8
With private health insurance	16006	1023	73.5	2.8	20743	1248	71.3	2.6	19243	1248	58.8	3.5	29421	1215	76	2.2	7878	953	75.3	4.6	9113	823	71.2	4.6	17507	1366	65.2	4	11052	881	79.8	3.5	9424	909	66.3	4.6	15811	1223	82.8	2.7	21265	727	75.2	2.4	3598	552	66.1	6.9	7827	564	85.6	3.3	28356	1239	85.6	2.4	1151	234	46.2	8.3
With public coverage	7442	764	34.2	3.1	12731	1020	43.8	2.7	21943	1438	67	2.8	14079	1020	36.4	2.5	4364	684	41.7	5.4	5720	742	44.7	4.5	12771	1429	47.6	4.6	4078	598	33.8	3.6	5960	974	42	5	5842	563	30.6	3	11393	799	40.3	2.8	2491	464	45.8	6.8	2066	321	22.6	3.6	9878	879	29.8	2.4	1304	319	52.4	7.8
No health insurance coverage	688	250	3.2	1.1	556	147	1.9	0.5	2050	388	6.3	1.1	1121	361	2.9	0.9	167	88	1.6	0.8	377	126	2.9	1	606	234	2.3	0.9	387	146	2.8	1	511	220	3.6	1.5	301	165	1.6	0.9	740	269	2.6	0.9	131	77	2.4	1.4	154	141	1.7	1.6	235	121	0.7	0.4	102	71	4.1	2.8
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)																																																														
Total Civilian Noninstitutionalized Population	21783	1095	21783	(X)	29082	1446	29082	(X)	32734	1552	32734	(X)	38720	1225	38720	(X)	10468	1015	10468	(X)	12794	910	12794	(X)	26832	1520	26832	(X)	13851	981	13851	(X)	14207	1303	14207	(X)	19102	1295	19102	(X)	28268	385	28268	(X)	5444	658	5444	(X)	9143	486	9143	(X)	33136	1268	33136	(X)	2490	397	2490	(X)
With a disability	3155	447	14.5	1.9	4223	682	14.5	2.2	8152	703	24.9	2	4523	501	11.7	1.2	1359	355	13	3.1	1838	408	14.4	2.9	4519	619	16.8	2.1	1545	324	11.2	2.3	2252	561	15.9	3.3	2033	444	10.6	2	5026	619	17.8	2.1	1073	155	19.7	2.9	742	249	8.1	2.7	3064	506	9.2	1.5	446	142	17.9	5.8

NAME	DP03_0119PE	DP03_0119PM	DP03_0062E	DP03_0062M	DP03_0074PE	DP03_0074PM	DP03_0005PE	DP03_0005PM	DP02_0067PE	DP02_0067PM	DP04_0058PE	DP04_0058PM
ZCTA Name	Percent!!PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL!!All families	Percent Margin of Error!!PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL!!All families	Estimate!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!Median household income (dollars)	Margin of Error!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!Median household income (dollars)	Percent!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!With Food Stamp/SNAP benefits in the past 12 months	Percent Margin of Error!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!With Food Stamp/SNAP benefits in the past 12 months	Percent!!EMPLOYMENT STATUS!!Population 16 years and over!!In labor force!!Civilian labor force!!Unemployed	Percent Margin of Error!!EMPLOYMENT STATUS!!Population 16 years and over!!In labor force!!Civilian labor force!!Unemployed	Percent!!EDUCATIONAL ATTAINMENT!!Population 25 years and over!!High school graduate or higher	Percent Margin of Error!!EDUCATIONAL ATTAINMENT!!Population 25 years and over!!High school graduate or higher	Percent!!VEHICLES AVAILABLE!!Occupied housing units!!No vehicles available	Percent Margin of Error!!VEHICLES AVAILABLE!!Occupied housing units!!No vehicles available
ZCTA5 14620	6.3	2.4	$ 59,525	$ 6,082	14.8	2.5	3.2	0.8	92.4	1.5	18.8	2.5
ZCTA5 14626	5	1.9	$ 78,785	$ 6,824	10.6	2	2.9	1	90.7	2.3	6.5	1.4
ZCTA5 14621	25.8	4.1	$ 36,534	$ 2,335	45.4	3.2	5.3	1.1	76.4	2.3	30.7	3.4
ZCTA5 14624	4.4	1.8	$ 86,046	$ 4,204	8.1	1.7	2.2	0.5	94.3	0.9	3.7	1.1
ZCTA5 14467	3.3	2.8	$ 88,548	$ 6,030	11.8	3.9	0.8	0.7	93.8	2.6	6.6	3.4
ZCTA5 14622	8.9	4.5	$ 73,683	$ 5,749	11.3	3.7	2.6	1.6	91.2	2.8	6.2	2.8
ZCTA5 14616	12.1	3.5	$ 62,564	$ 3,817	18.3	2.8	3.4	1.2	89.7	2.6	11.5	2.3
ZCTA5 14610	5.9	3	$ 83,260	$ 11,537	4.6	1.4	2.2	1.3	97.1	1.1	10.9	3.8
ZCTA5 14619	11.5	4.1	$ 66,345	$ 6,155	18.7	4	3.6	1.5	90.7	2.5	10.4	2.9
ZCTA5 14526	3	1.4	$ 110,566	$ 9,573	3.7	1.7	3.4	1.4	96.7	1.3	7	1.9
ZCTA5 14424	3.3	1.1	$ 79,135	$ 7,017	8.1	1.9	2.1	0.6	94.5	1.2	7.6	1.7
ZCTA5 14432	5.2	3.1	$ 69,750	$ 16,106	10.9	2.9	1.3	1	92.7	2.6	6.6	2.6
ZCTA5 14472	2.3	3	$ 128,456	$ 16,121	5.8	3.9	2.5	2.2	97.6	1.1	4.4	1.8
ZCTA5 14534	0.7	0.7	$ 144,832	$ 8,241	1.6	0.7	1.9	0.5	98.1	0.6	3.7	1.4
ZCTA5 14203	22.5	21	$ 48,529	$ 14,422	36.7	9.1	2.1	1.5	88.8	6.6	35.7	8.5

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

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

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

Table A.

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

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

Section B. All Article 28 Facilities

Table B.

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

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

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

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

- HEIA Contract with Independent Entity
- HEIA Template
- HEIA Data Tables
- Full version of the CON Application with redactions, to be shared publicly

- ***If you checked "no" for all questions in Table B***, this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.

New York State Department of Health

Health Equity Impact Assessment Conflict of Interest Form

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

Section 1 – Definitions

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

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

Stakeholders shall include individuals or organizations currently or anticipated to be served by the facility, employees of the facility including facility boards or committees, public health experts including local health departments, residents of the facility's service area and organizations representing those residents, patients or residents of the facility, community-based organizations, and community leaders.

Section 2 – Independent Entity

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

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

Section 3 – General Information

About the Independent Entity

1. Name of Independent Entity: Sachs Policy Group (SPG)
2. Is the Independent Entity a division/unit/branch/associate/employee of, or in a similar role in relationship to, an organization (Y/N)?
   ☒ If yes, indicate the name of the organization:
   Ankura Consulting Group
3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (Y/N)?
   Yes
4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity or any organization to which the Independent Entity has belonged performed any work for the Applicant in the last 5 years?

   N/A

Section 4 – Attestation

I, David Gross (individual name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of Sachs Policy Group, do hereby attest that the Health Equity Impact Assessment for project Transformation Grant Bed Decertification provided for Episcopal SeniorLife Communities has been conducted in an independent manner and without a conflict of interest as defined in Title 10 NYCRR § 400.26.

I attest that the feedback and personal information collected from stakeholders through the meaningful engagement process is legitimate, having not been altered, misrepresented, or falsified in any manner.

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

Signature of Independent Entity: David Gross

Date: 6/10/26