

Schedule 4 – Financial Information

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Instructions

Answer each question on Schedule 4A. If the facility is to be constructed, but will be leased by the operator, information regarding the construction and financing by the landlord is required as part of the operator's application.

Instructions: All applicants must answer each question.

Article 7 requires that financing be secured as a condition of Part I approval. The following documentation must be provided depending on the way the facility will be "established":

1. Will the facility be leased? Yes No

If "Yes," enclose a copy of lease(s) with your legal submission.

Please note Schedule 3 – Legal Information for additional instructions as to specific language required in the lease.

2. Does the application involve purchase of an existing certified adult care facility? Yes No

If "Yes":

a. State the total purchase price \$_____;

b. State the amount of the down payment and describe its source below \$_____;

c. Provide a copy of financing commitment document indicating total mortgage amount, interest rate and payback period, holder of mortgage, and terms and conditions; and

d. Briefly describe and enclose any necessary documentation to show any other purchase and/or financing arrangements not covered in a, b, and c of this part.

3. Does the application involve new construction or rehabilitation of an existing structure? Yes No

If "Yes", enclose a copy of the following:

a. Construction financing commitment document (e.g. letter) indicating total mortgage amount, interest rate, and terms and conditions;

b. Permanent mortgage commitment document (e.g. letter) indicating total mortgage amount, interest rate and payback period, holder of mortgage, and terms and conditions;

c. Necessary documentation to show any other purchase and/or financing arrangements not covered in a and b of this part; and

d. Estimate of total project cost. \$_____

4. For applicants who are applying as a business corporation or who wish to establish a not-for-profit adult care facility, do your two most recent Form 990s or your annual financial report for the last fiscal year show revenues in excess of expenses? Yes No

If No: attach copies.

NOTE: If the applicant is (i) a newly formed corporation without assets or (ii) a sole proprietor, complete the Personal Financial Statement (Schedule 2B) for each controlling person. See controlling person definition [18 NYCRR 485.6(11)(i)(v)]. If applicable, also include a copy of the parent corporation's annual financial report for the last fiscal year.

5. For all ACF and ALR applications, complete the Projected Operating Budget at 90% Occupancy (See Schedule 4C). A start-up budget based on the increasing quarterly rate occupancy schedule outlined in #6 below is also required (See Schedule 4B) for the following applications: (1) new facilities; (2) substantial capacity increases (10 or more ACF/ALR/EALR/SNALR beds); or (3) applications for existing facilities that are both: (a) under 90% occupancy; and (b) not currently financially profitable. The start-up budget must project revenue and expenses for each quarter until the facility reaches either 90% occupancy or sustained financial profitability.

For all ALP applications, complete the Projected 12-month Operating Budget (See Schedule 4D).

NOTE: Under certain circumstances, a sworn attestation may be submitted in lieu of the proposed budgets for change of operator applications or substantial capacity increases (10 or more ACF/ALR/EALR/SNALR beds). Attestation forms for such applications can be found at Schedule 4E and 4F.

Instructions: Complete for increase in capacity or for new facilities. In lieu of Schedule 4B, applicants may submit the attestation in Schedule 4E or 4F.

ACF and/or ALR Projected 2-year Start-up Operating Budget

Include Revenue and Expenses Until Facility Reaches Either 90% Occupancy or Sustained Financial Profitability

Anticipated Revenue	Quarter1	Q 2	Q 3	Q 4	Total for Year 1	Q 5	Q 6	Q 7	Q 8	Total for Year 2
1. Estimated Revenue at 100% Occupancy	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2. Occupancy Percentage	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
3. Estimated Monthly Income (Line1 x Line 2)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Anticipated Expenses										
4. Salaries and Wages	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
5. Payroll Deductions	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
6. Fringe Benefits	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
7. Dietary Consultant	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
8. Raw Food Cost	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
9. Food Supplies	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
10. Rental of Facility	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
11. Rental of Equipment	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
12. Real Estate Taxes	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
13. Water and Sewer	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
14. Heat, Light & Power	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
15. Repairs & Maintenance	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
16. Housekeeping Supplies, Laundry & Linen	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
17. Social & Recreation	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
18. Insurance	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
19. Interest Expense	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
20. Telephone	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
21. Legal & Accounting	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
22. Advertising	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
23. Other Administrative and General Expenses	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
24. Other Expenses	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
25. Service Contracts	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
26. Total Anticipated Operating Expenses	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
27. Net Operating Surplus/profit (Deficit/loss)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
28. Depreciation & Amortization	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Adult Care Facility Common Application

To be completed for ALL ACF and/or ALR Applications.

Instructions: Complete the budget assuming occupancy of 90% of certified capacity. In lieu of submitting Schedule 4E, applicants may submit the attestation in Schedule 4F.

ACF and/or ALR Projected Operating Budget at 90% Occupancy for 12-month Period Ending: _____

Anticipated Revenue	Dollar Amount	Department Use Only	Attachment Name
Room, Board and Routine Care	_____	_____	_____
Other Resident Revenue (Attach Schedule)	_____	_____	_____
Other Revenue (Attach Schedule)	_____	_____	_____
Total Anticipated Revenue	_____	_____	_____
Anticipated expenses			
Salaries and Wages	_____	_____	_____
Payroll Taxes	_____	_____	_____
Other Fringe Benefits	_____	_____	_____
Dietary Consultant	_____	_____	_____
Raw Food Costs	_____	_____	_____
Food Supplies	_____	_____	_____
Rental of Facility	_____	_____	_____
Rental of Equipment	_____	_____	_____
Real Estate Taxes	_____	_____	_____
Water and Sewer	_____	_____	_____
Heat, Light, Power	_____	_____	_____
Repairs and Maintenance	_____	_____	_____
Housekeeping Supplies, Laundry & Linen	_____	_____	_____
Social and Recreation	_____	_____	_____
Insurance	_____	_____	_____
Interest Expense (Attach Schedule)	_____	_____	_____
Telephone	_____	_____	_____
Legal and Accounting	_____	_____	_____
Advertising	_____	_____	_____
Other Administrative and General Expenses (Attach Schedule)	_____	_____	_____
Other Expenses (Attach Schedule)	_____	_____	_____
Purchase of Service Contracts (Attach Schedule)	_____	_____	_____
Total Anticipated Operating Expenses	_____	_____	_____
Depreciation and Amortization	_____	_____	_____
Anticipated Resident Care Days	_____	_____	_____

Adult Care Facility Common Application

ALP - Projected Twelve Month Operating Budget

To be completed for ALL ALP Applications.

Projected operating budget for twelve months ending: _____

Anticipated Revenue	Total	ALP	Adult Care Facility*	Home Health Care*
Room, Board and Routine Care	_____	_____	_____	_____
Home Care	_____	_____	_____	_____
Other Resident Revenue (attach schedule)	_____	_____	_____	_____
Other Revenue (attach schedule)	_____	_____	_____	_____
Total Anticipated Revenue	_____	_____	_____	_____
Anticipated Expense	_____	_____	_____	_____
Salaries and Wages	_____	_____	_____	_____
Director/Administrator (1)	_____	_____	_____	_____
Supervisor/Case Management (2)	_____	_____	_____	_____
Total Service Personnel (3)	_____	_____	_____	_____
Clerical Staff	_____	_____	_____	_____
Other	_____	_____	_____	_____
Payroll Taxes	_____	_____	_____	_____
Other Fringe Benefits	_____	_____	_____	_____
Purchase of Service Contracts (attach schedule)	_____	_____	_____	_____
Dietary Consultant	_____	_____	_____	_____
Raw Food Costs	_____	_____	_____	_____
Food Supplies	_____	_____	_____	_____
Medical and Nursing Supplies (including non-depreciable equipment)	_____	_____	_____	_____
Rental of Facility	_____	_____	_____	_____
Real Estate Taxes	_____	_____	_____	_____
Water and Sewer	_____	_____	_____	_____
Heat, Light and Power	_____	_____	_____	_____
Repairs and Maintenance	_____	_____	_____	_____
Housekeeping Supplies, Laundry & Linen	_____	_____	_____	_____
Social and Recreation	_____	_____	_____	_____
Transportation	_____	_____	_____	_____
Insurance	_____	_____	_____	_____
Interest expense (attach schedule)	_____	_____	_____	_____
Telephone	_____	_____	_____	_____
Legal and Accounting	_____	_____	_____	_____
Advertising	_____	_____	_____	_____
Other Administrative and general (attach schedule)	_____	_____	_____	_____
Total Anticipated Expenses	_____	_____	_____	_____
Net Operating Surplus/Profit (deficit/loss)	_____	_____	_____	_____
Depreciation and Amortization	_____	_____	_____	_____
Anticipated Resident Care Days	_____	_____	_____	_____

* "Adult Care Facility" refers to other ACF residents not occupying ALP beds

Substantial Bed Increase Application

Instructions:

1. This Attestation may be submitted in lieu of Schedule 4C (Annual Operating Budget Projections) and Schedule 4B (Start-Up Operating Budget Projections) for the following:
 - (a) ACF bed increase applications of 10 beds or more; or
 - (b) ALR/EALR/SNALR bed increase applications of 10 beds or more, except where a new certification (EALR or SNALR) is being added for the first time. If EALR or SNALR is being added for the first time, a Schedule 4C (Annual Operating Budget Projections) should be submitted.
2. All other application information regarding the proposed bed increase must be submitted for Department review (e.g., programmatic information to the Regional Office).
3. If the bed increase application involves construction that is being financed, then the applicant must also submit construction financing documents to the Department for review (as well as any other materials that may be required, such as an Architectural Certification).
4. **This Attestation may only be utilized if the facility has filed its Annual Financial Report for the most recent year with the Department.**

On behalf of _____, the licensed operator of the adult care facility known as _____ ("the facility"), I make this attestation to provide assurance to the Department that:

- (1) the increase in operating revenues that will result from the bed increase application to add _____ (insert # and type) beds to the licensed capacity of the facility will be more than sufficient to cover the related increase in expenses that will result from the anticipated bed increase;
- (2) as reflected in the Annual Financial Report filed with the Department, the operating revenue at the facility has been sufficient to meet all operating expenses and resident needs;
- (3) the operator has the financial resources and financing to meet all operating expenses and residents needs in the event operating revenue is not sufficient to do so.

 AUTHORIZED OFFICER/REPRESENTATIVE DATE

 TYPE OR PRINT NAME TITLE

 NOTARY (NOTARY MUST AFFIX STAMP OR SEAL) DATE

Change of Operator Application

Instructions:

- 1. This Attestation may be submitted in lieu of Schedule 4C (Annual Operating Budget Projections) and Schedule 4B (Start-Up Operating Budget Projections) for Change of Operator applications where the operating budget will not change in any material way as a result of the proposed license transfer.
- 2. All other application information must be submitted for Department review.
- 3. This Attestation may only be utilized if the facility has filed its Annual Financial Report for the most recent year with the Department.

On behalf of _____, the proposed operator of the adult care facility known as _____ ("the facility"), I make this attestation to provide assurance to the Department that:

(1) the operating revenues and expenses in the operating budget now in place at the facility (check one):

will not be changed in any material way as a result of the proposed change of operator application to approve _____ as the new operator of the facility; or

will not be changed in any material way as a result of the proposed change of operator application to approve _____ as the new operator of the facility with the exception of the facility rent which will increase but is not anticipated to create a deficit;

(2) as reflected in the Annual Financial Report filed with the Department, the operating revenue at the facility has been sufficient to meet all operating expenses and resident needs;

(3) the proposed operator has the financial resources and financing to meet all operating expenses and residents needs in the event operating revenue is not sufficient to do so.

AUTHORIZED OFFICER/REPRESENTATIVE

DATE

TYPE OR PRINT NAME

TITLE

NOTARY (NOTARY MUST AFFIX STAMP OR SEAL)

DATE