# 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 $15,000,000 for general hospitals and up to $6,000,000 for all other facilities, if not relating to clinical space – check "Non-Clinical" box below).

*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 $15,000,000 for general hospitals and up to $6,000,000 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 $15,000,000 for general hospitals and up to $6,000,000 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.*

☐ **Cardiac Services** – Project by an appropriately certified facility to add electrophysiology (EP) services; or add, upgrade or replace a cardiac catheterization laboratory or equipment. (*If construction associated, also check "Construction" above.*)

*Necessary LRA Schedules: Cover Sheet, 2, 7, 8, 10, and 12.*

☐ **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 |
|---|---|---|
| 5903309N | The Wartburg Home of the Evangelical Lutheran Church | SNF |

| OPERATOR ADDRESS – STREET & NUMBER | | PFI | NAME AND TITLE OF CONTACT PERSON | | |
|---|---|---|---|---|---|
| Bradley Avenue | | 1068 | Bridget Zimmermann, VP of Operations | | |
| CITY | COUNTY | ZIP | STREET AND NUMBER | | |
| Mount Vernon | Westchester | 10552 | Bradley Avenue | | |
| PROJECT SITE ADDRESS – STREET & NUMBER | | PFI | CITY | STATE | ZIP |
| Bradley Avenue | | 1068 | Mount Vernon | NY | 10552 |
| CITY | COUNTY | ZIP | TELEPHONE NUMBER | FAX NUMBER | |
| Mount Vernon | Westchester | 10552 | 914-359-9749 | 914-513-5498 | |
| **TOTAL PROJECT COST:** $ 0.00 | | | CONTACT E-MAIL: BZimmermann@wartburg.org | | |

*(Rev 09/2019)*

# Limited Review Application

**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*) | $ 0.00 |
| 1.2 Building Acquisition | $ 0.00 |
| | 1.1-1.2 Subtotal: 0.00 |
| 2.1 New Construction | $ 0.00 |
| 2.2 Renovation and Demolition | $ 0.00 |
| 2.3 Site Development | $ 0.00 |
| 2.4 Temporary Power | $ 0.00 |
| | 2.1-2.4 Subtotal: 0.00 |
| 3.1 Design Contingency | $ 0.00 |
| 3.2 Construction Contingency | $ 0.00 |
| | 3.1-3.2 Subtotal: 0.00 |
| 4.1 Fixed Equipment (NIC) | $ 0.00 |
| 4.2 Planning Consultant Fees | $ 0.00 |
| 4.3 Architect/Engineering Fees (incl. computer installation, design, etc.) | $ 0.00 |
| 4.4 Construction Manager Fees | $ 0.00 |
| 4.5 Capitalized Licensing Fees | $ 0.00 |
| 4.6 Health Information Technology Costs | $ 0.00 |
| 4.6.1 Computer Installation, Design, etc. | $ 0.00 |
| 4.6.2 Consultant, Construction Manager Fees, etc. | $ 0.00 |
| 4.6.3 Software Licensing, Support Fees | $ 0.00 |
| 4.6.4 Computer Hardware/Software Fees | $ 0.00 |
| 4.7 Other Project Fees (Consultant, etc.) | $ 0.00 |
| | 4.1-4.7 Subtotal: 0.00 |
| 5.1 Movable Equipment | $ 0.00 |
| | |
| **6.1 Total Basic Cost of Construction** | **$ 0.00** |
| | |
| 7.1 Financing Cost (points, fees, etc.) | $ 0.00 |
| 7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount $ 0 @ % for months | 0.00 |
| 7.3 Application Fee | $ 500.00 |
| | |
| **8.1 Estimated Total Project Cost (Total 6.1 – 7.3)** | **$ 500.00** |
| | |

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

Construction Start Date _____

Construction Completion Date _____

# Schedule 6
# Architectural/Engineering Submission

**Contents:**

# New York State Department of Health Certificate of Need Application

# Schedule 6

## Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

### Instructions

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

### Architecture/Engineering Narrative

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

| **Project Description** | |
|---|---|
| Schedule 6 submission date:<br>Click to enter a date. | Revised Schedule 6 submission date:<br>Click to enter a date. |
| Does this project amend or supersede prior CON approvals or a pending application? Choose an item.<br>If so, what is the original CON number? Click here to enter text. | |
| Intent/Purpose:<br>Click here to enter text. | |
| Site Location:<br>Click here to enter text. | |
| Brief description of current facility, including facility type: | |

| | |
|---|---|
| Click here to enter text. | |
| Brief description of proposed facility:<br>Click here to enter text. | |
| Location of proposed project space(s) within the building. Note occupancy type for each occupied space.<br>Click here to enter text. | |
| Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies:<br>Click here to enter text. | |
| If this is an existing facility, is it currently a licensed Article 28 facility? | Choose an item. |
| Is the project space being converted from a non-Article 28 space to an Article 28 space? | Choose an item. |
| Relationship of spaces conforming with Article 28 space and non-Article 28 space:<br>Click here to enter text. | |
| List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3.<br>Click here to enter text. | |
| Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below.<br>Click here to enter text. | Choose an item. |
| Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc.<br>Click here to enter text. | |
| Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc.<br>Click here to enter text. | |
| Describe existing and or new work for fire detection, alarm, and communication systems:<br>Click here to enter text. | |
| If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. Click here to enter text. | |
| Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted.<br>Click here to enter text. | |
| Does the project comply with ADA? If no, list all areas of noncompliance.<br>Click here to enter text. | |
| Other pertinent information:<br>Click here to enter text. | |

| **Project Work Area** | **Response** |
|---|---|
| Type of Work | Choose an item. |
| Square footages of existing areas, existing floor and or existing building. | Click here to enter text. |
| Square footages of the proposed work area or areas.<br>Provide the aggregate sum of the work areas. | Click here to enter text. |
| Does the work area exceed more than 50% of the smoke compartment, floor or building? | Choose an item. |
| Sprinkler protection per NFPA 101 Life Safety Code | Choose an item. |
| Construction Type per NFPA 101 Life Safety Code and NFPA 220 | Choose an item. |
| Building Height | Click here to enter text. |
| Building Number of Stories | Click here to enter text. |

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

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

# 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 | [redacted] | [redacted] | [redacted] |
| Grants Funds | | | |
| Foundation | | | |
| Other | [redacted] | [redacted] | [redacted] |
| Fees | | | |
| Other Income | | | |
| (1) Total Revenues | [redacted] | [redacted] | [redacted] |
| **Expenses** | | | |
| Salaries and Wage Expense | [redacted] | [redacted] | [redacted] |
| Employee Benefits | [redacted] | [redacted] | [redacted] |
| Professional Fees | [redacted] | [redacted] | [redacted] |
| Medical & Surgical Supplies | [redacted] | [redacted] | [redacted] |
| Non-Medical Equipment | [redacted] | [redacted] | [redacted] |
| Purchased Services | [redacted] | [redacted] | [redacted] |
| Other Direct Expense | [redacted] | [redacted] | [redacted] |
| Utilities Expense | [redacted] | [redacted] | [redacted] |
| Interest Expense | [redacted] | [redacted] | [redacted] |
| Depreciation and Rent Expense | [redacted] | [redacted] | [redacted] |
| Depreciation Expense | | | |
| Other Expenses | | | |
| (2) Total Expense | [redacted] | [redacted] | [redacted] |
| *Net Total - (1-2)* → | [redacted] | [redacted] | [redacted] |

# Limited Review Application

**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* % | Net Revenue* Dollars ($) | Patient Days or dis-charges | Net Revenue* % based on days or discharges | Net Revenue* Dollars-$ | Patient Days or dis-charges | Net Revenue* % based on days or discharges | Net Revenue* Dollars-$ |
| Commercial | Fee for Service | 348 | [redacted] | [redacted] | 17 | [redacted] | [redacted] | 0 | [redacted] | [redacted] |
| | Managed Care | 0 | [redacted] | [redacted] | 0 | [redacted] | [redacted] | 0 | [redacted] | [redacted] |
| Medicare | Fee for Service | 8,989 | [redacted] | [redacted] | 1,703 | [redacted] | [redacted] | 1,188 | [redacted] | [redacted] |
| | Managed Care | 2,207 | [redacted] | [redacted] | 2,304 | [redacted] | [redacted] | 792 | [redacted] | [redacted] |
| Medicaid | Fee for Service | 7,602 | [redacted] | [redacted] | -4,589 | [redacted] | [redacted] | -1,980 | [redacted] | [redacted] |
| | Managed Care | 0 | [redacted] | [redacted] | 0 | [redacted] | [redacted] | 0 | [redacted] | [redacted] |
| Private Pay | | 652 | [redacted] | [redacted] | -287 | [redacted] | [redacted] | 0 | [redacted] | [redacted] |
| OASAS | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| OMH | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Charity Care | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Bad Debt | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| All Other | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Total | | 19,798 | [redacted] | [redacted] | -852 | [redacted] | | 0 | [redacted] | |

*(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 | 1,760 | [redacted] | [redacted] | -756 | [redacted] | [redacted] | 0 | 0% | 0 |
| | Managed Care | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Medicare | Fee for Service | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| | Managed Care | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Medicaid | Fee for Service | 8,956 | [redacted] | [redacted] | -476 | [redacted] | [redacted] | 0 | 0% | 0 |
| | Managed Care | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Private Pay | | 1,693 | [redacted] | [redacted] | 1,265 | [redacted] | [redacted] | 0 | 0% | 0 |
| OASAS | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| OMH | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Charity Care | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Bad Debt | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| All Other | | 0 | 0% | 0 | 0 | 0% | 0 | 0 | 0% | 0 |
| Total | | 12,409 | [redacted] | [redacted] | | [redacted] | [redacted] | 0 | 100% | 0 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Total of Inpatient and Outpatient Services | | | | [redacted] | | | [redacted] | | | [redacted] |

| | Title of Attachment | Filename of attachment |
|---|---|---|
| 1. In an attachment, provide the basis and supporting calculations for all revenues by payor. | | |
| 2. In an attachment, provide the basis for charity care. | | |

*Net of Deductions from Revenue

# 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**:** | | | |
| Physician | 0.55 | 0.57 | 0.57 |
| Therapists | 6.15 | 5.6 | 5.6 |
| Registered Nurse | 3.99 | 2.6 | 2.6 |
| Licensed Practice Nurse | 10.66 | 7.8 | 7.8 |
| Certified Nursing Assistants | 43.02 | 29.0 | 29.0 |
| Social Services | 4.71 | 1.8 | 1.8 |
| **Support Staff***:** | | | |
| Clerical | 5.21 | 5.2 | 5.2 |
| Maintenance | 21.93 | 17.41 | 17.41 |
| Clinical | 2.01 | 1.9 | 1.9 |
| Management | 9.62 | 7.6 | 7.6 |
| Food Service | 17.97 | 13.2 | 13.2 |
| | | | |
| *Total Number of Employees* | 122.62 | 92.68 | 92.68 |

* 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:**

The number and mix of staff for the 50-bed skilled nursing facility were determined in accordance with New York State Department of Health staffing requirements, CMS guidelines, and best practices for resident care and safety. Full-time equivalents (FTEs) were calculated using a combination of regulatory minimums, historical staffing patterns, and projected resident acuity.

Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs) were allocated to meet or exceed mandated hours per resident per day while ensuring 24/7 coverage. Professional disciplines such as social work, rehabilitation, dietary, and activities were proportioned based on resident care needs, regulatory standards, and interdisciplinary care models. Ancillary and support staff, including environmental services, maintenance, and administrative personnel, were included to maintain a safe, compliant, and therapeutic environment.

**PLEASE COMPLETE THE FOLLOWING:**

1. Are staff paid and on Payroll? ☒ Yes ☐ No
2. Provide copies of contracts for any independent contractor. N/A
3. Please attach the Medical Doctors C.V. Attached.

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

# 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 |
|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
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| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |
| | | ☐ | ☐ | ☐ | ☐ |

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)* ☐ ☐ ☐

# Limited Review Application

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.

10/13/2025
Date

Signature

David J. Gentner
Name (Please Type)

Pres. Board & CEO
Title (Please Type)