Limited Review Application

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

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
3227305N	St Lukes Home Residential Health Care Facility, Inc	RHCF

OPERATOR ADDRESS – STREET & NUMBER 1650 Champlin Ave		PFI 6057	NAME AND TITLE OF CONTACT PERSON Amy Bowerman, VP Post-Acute/Rehabilitation Services		
CITY Utica	COUNTY Oneida	ZIP 13502	STREET AND NUMBER		
PROJECT SITE ADDRESS – STREET & NUMBER 1650 Champlin Ave		PFI 6057	CITY Utica	STATE NY	ZIP 13502
CITY	COUNTY	ZIP	TELEPHONE NUMBER 315-624-8603	FAX NUMBER 315-624-8995	
TOTAL PROJECT COST: $ 0.00			CONTACT E-MAIL: abowerma@mvhealthsystem.org		

(Rev 09/2019)

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Schedule

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

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.)	$
	4.1-4.7 Subtotal: 0.00
5.1 Movable Equipment	$
6.1 Total Basic Cost of Construction	**$ 0.00**
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)	**$ 0.00**

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

Construction Start Date _____

Construction Completion Date _____

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Schedule LRA 7

State of New York Department of Health
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Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue			
Grants Funds			
Foundation			
Other			
Fees			
Other Income			
(1) Total Revenues	$	$	$
Expenses			
Salaries and Wage Expense			
Employee Benefits			
Professional Fees			
Medical & Surgical Supplies			
Non-Medical Equipment			
Purchased Services			
Other Direct Expense			
Utilities Expense			
Interest Expense			
Rent Expense			
Depreciation Expense			
Other Expenses			
(2) Total Expense	$	$	$
Net Total - (1-2) ⟶	***$***0	***$***0	***$***0

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Schedule LRA 7A

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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									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total			100%			100%			100%	

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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									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total			100%			100%			100%	

Total of Inpatient and Outpatient Services									

	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

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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:**			
Program Director, RN	1.0	0.0	0.0
RN	1.0	0.0	0.0
CNA	1.0	0.0	0.0
Support Staff*:**			
Administrative Assistant	1.0	0.0	0.0
Total Number of Employees			

* 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:

Current staff for the ADHC Program will be offered positions elsewhere in the Mohawk Valley Health System.

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

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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
Adult Day Health Care		☐	☐	☒	☐
Audiology		☒	☐	☐	☐
Baseline Services-Nursing Home		☒	☐	☐	☐
Dental		☒	☐	☐	☐
Medical Social Services		☒	☐	☐	☐
Nursing		☒	☐	☐	☐
Nutritional		☒	☐	☐	☐
Optometry		☒	☐	☐	☐
Pharmaceutical Service		☒	☐	☐	☐
Physician Services		☒	☐	☐	☐
Psychology		☒	☐	☐	☐
Therapy-Occupational		☒	☐	☐	☐
Therapy-Physical		☒	☐	☐	☐
Therapy-Speech Language Pathology		☒	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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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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.

5/22/24
Date

Amy Bowerman
Signature

Amy Bowerman, RN BSN
Name (Please Type)

VP Post-Acute/Rehabilitation Services
Title (Please Type)