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
4501000H	The Saratoga Hospital Inc	11

OPERATOR ADDRESS – STREET & NUMBER		PFI	NAME AND TITLE OF CONTACT PERSON		
211 Church Street		818	[redacted] - Project Manager		
CITY	COUNTY	ZIP	STREET AND NUMBER		
Saratoga Hospital	Saratoga	12866	211 Church Street		
PROJECT SITE ADDRESS – STREET & NUMBER		PFI	CITY	STATE	ZIP
6 Care Lane		818	Saratoga Hospital	NY	12866
CITY	COUNTY	ZIP	TELEPHONE NUMBER	FAX NUMBER	
Saratoga Springs	Saratoga	12866	[redacted]		
TOTAL PROJECT COST: $ 51000			CONTACT E-MAIL: [redacted]@saratogahospital.org		

(Rev 09/2019)

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Schedule LRA 3

Proposed Plan for Project Financing

A. LEASE ☐

If any portion of the cost for land, building or equipment is to financed through a lease, rental agreement or lease/purchase agreement, complete the chart at the right.

A complete copy of each proposed lease must be submitted.

Attachment # _____

ITEM	COST AS IF PURCHASED
	$
	$
	$
	$
	$

B. CASH ☑

If cash is to be used, complete the chart at the right.

Accumulated Funds	$	51,000.00
Sale of Existing Assets*	$	
Other - (i.e. gifts, grants, **etc.)	$	
TOTAL CASH	$	51,000.00

Attach a copy of the latest certified financial statement and interim monthly or quarterly financial reports to cover the balance of time to date.

Attachment # _____

*Attach a full and complete description of the assets to be sold

Attachment # _____

**If grants, attach a description of the source of financial support

Attachment # _____

C. DEBT FINANCING ☐

If the project is to financed by debt or any type, complete the chart at the right.

Principal	$
Interest Rate	%
Term	Yrs
Pay-out Period	Yrs
Type*	

Attach a copy of the proposed letter of interest from the intended source of permanent financing. **This letter must include an estimate of the principal, term, interest rate, and pay-out period presently being considered**.

Attachment # _____

*Commercial, Dormitory Authority Bonds, Dormitory Authority, TELP Lease, Industrial Development Agency Bonds, Other (identify).

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Schedule LRA 2

Total Project Cost

	ITEM		Estimated Project Costs	
1.1	Land Acquisition (*attach documentation*)	$		-
1.2	Building Acquisition	$		-
			1.1-1.2 Subtotal:	-
2.1	New Construction	$		-
2.2	Renovation and Demolition	$		-
2.3	Site Development	$		-
2.4	Temporary Power	$		-
			2.1-2.4 Subtotal:	-
3.1	Design Contingency	$		-
3.2	Construction Contingency	$		-
			3.1-3.2 Subtotal:	-
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	$		15,000
4.7	Other Project Fees (Consultant, etc.)	$		
			4.1-4.7 Subtotal	15,000
5.1	Movable Equipment	$		35,000
			5.1 Subtotal	35,000
6.1	**Total Basic Cost of Construction**	$		**50,000**
7.1	Financing Costs (points, fees etc.)	$		
7.2	Interim Interest Expense-Total interest on Construction Loan Amount $ _____ @ _____ % for _____ months	$		
7.3	Application Fee	$		1,000
8.1	**Estimated Total Project Cost (Total 6.1 - 7.3)**	$		**51,000**

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

Construction Start Date: n/a - no construction planned

Construction Completion Date: _____

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Schedule LRA 5

Space & Construction Cost Distribution

☐ **New**

☐ **Alteration**

Location		Sect No.	Code and Functional Category Description	Functional Gross SF	Construction Cost per SF	Total Construction Cost	(ALT) Scope of Work
Bldg No.	Floor No.						
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	1		Medical Services - Other Medical Specialties	2388	n/a	$0	
			Total Construction	**2,388**	**0**	**0**	

1. If new construction is involved, is it "freestanding"? Yes ☐ No ☐

2. (Check where applicable) The facilities to be affectedby this project are located in a:

☐ Dense Urban ☑ Other Metropolitan or Suburban ☐ Rural Area

3. This submission consists of:

☐ New Construction Report Number of pages _____

☐ Alteration Construction Report Number of Pages _____

Do not use the master copy. Photocopy master and then compklete copy if this schedule is required.

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			
Medical & Surgical Supplies	[redacted]	[redacted]	[redacted]
Non-Medical Equipment			
Purchased Services	[redacted]	[redacted]	[redacted]
Other Direct Expense	[redacted]	[redacted]	[redacted]
Utilities Expense			
Interest Expense			
Rent Expense	[redacted]	[redacted]	[redacted]
Depreciation Expense			
Other Expenses			
(2) Total Expense	[redacted]	[redacted]	[redacted]
Net Total - (1-2) →	[redacted]	[redacted]	[redacted]

(Rev. 7/2015)

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*		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%	

(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	8	0.2	[redacted]	0	0.2	[redacted]	0	0.2	[redacted]
	Managed Care	2,307	41.3	[redacted]	0	41.3	[redacted]	0	41.3	[redacted]
Medicare	Fee for Service	1,462	17.4	[redacted]	0	17.4	8,017	0	17.4	[redacted]
	Managed Care	1,919	25.3	[redacted]	0	25.3	[redacted]	0	25.3	[redacted]
Medicaid	Fee for Service	53	0.3	[redacted]	0	0.3	[redacted]	0	0.3	[redacted]
	Managed Care	983	15.0	[redacted]	0	15.0	[redacted]	0	15.0	[redacted]
Private Pay		246	0.3	[redacted]	0	0.3	[redacted]	0	0.3	[redacted]
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		18	0.2	[redacted]	0	0.2	[redacted]	0	0.2	[redacted]
Total		6,996	100%	[redacted]		100%	[redacted]	0	100%	[redacted]

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.	Neurology Supporting Data	Neurology Move Limited CON Supporting File.xlsx
2. In an attachment, provide the basis for charity care.	NA	NA

*Net of Deductions from Revenue

	2023	Year 1	Year 3
Patient Service Revenue	$ [redacted]	$ [redacted]	[redacted]
Other	$ [redacted]	$ [redacted]	[redacted]
Total	$ [redacted]	[redacted]	[redacted]

Note:

2023 Revenues are actual.

Years 1 & 3 assume 3% increases.

Expenses		2023		Year 1		Year 3
Salaries and Wage	$	[redacted]		[redacted]		[redacted]
Employee Benefits	$	[redacted]		[redacted]		[redacted]
Professional Fees	$	-	$	-	$	-
Medical & Surgical Supplies	$	[redacted]		[redacted]		[redacted]
Non-Medical Equipment	$	-	$	-	$	-
Purchased Services	$	[redacted]		[redacted]		[redacted]
Other Direct Expense	$	[redacted]		[redacted]		[redacted]
Utilities Expense	$	-	$	-	$	-
Interest Expense	$	-	$	-	$	-
Rent Expense	$	[redacted]		[redacted]		[redacted]
Depreciation Expense	$	-	$	-	$	-
Other Expenses	$	-	$	-	$	-
Total Expenses	$	[redacted]		[redacted]		[redacted]
Net Total	$	[redacted]		[redacted]		[redacted]

Note:
2023 Expenses are actual.
Years 1 & 3 assume 3% increases for all line items.

This is an Outpatient practice. No Inpatients.

Outpatient Services		Total Current Year			First Year Incremental			Third Year Incremental		
			Net Revenue			Net Revenue			Net Revenue	
		Visits	%	Dollars	Visits	%	Dollars	Visits	%	Dollars
Commercial	Fee for Service	8	0.2%	$ [redacted]	-	0.2%	$ [redacted]	-	0.2%	$ [redacted]
	Managed Care	2,307	41.3%	$ [redacted]	-	41.3%	$ [redacted]	-	41.3%	$ [redacted]
Medicare	Fee for Service	1,462	17.4%	$ [redacted]	-	17.4%	$ [redacted]	-	17.4%	$ [redacted]
	Managed Care	1,919	25.3%	$ [redacted]	-	25.3%	$ [redacted]	-	25.3%	$ [redacted]
Medicaid	Fee for Service	53	0.3%	$ [redacted]	-	0.3%	$ [redacted]	-	0.3%	$ [redacted]
	Managed Care	983	15.0%	$ [redacted]	-	15.0%	$ [redacted]	-	15.0%	$ [redacted]
Private Pay		246	0.3%	$ [redacted]	-	0.3%	$ [redacted]	-	0.3%	$ [redacted]
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		18	0.2%	$ [redacted]	-	0.2%	$ [redacted]	-	0.2%	$ [redacted]
Total		6,996	100%	$ [redacted]	-	100%	$ [redacted]	-	100%	$ [redacted]

Note:

Total Current Year Visits and Net Revenue are actual 2023

No visit increases are assumed for future years.

Net Revenue is assumed to increase 3% per year due to rate increases.

Health Providers

RN PRIMARY CARE	1.00
MEDICAL ASSISTANT 80	2.00
PHYSICIAN ASSISTANT	1.00
PHYSICIAN	2.00
	6.00

Support Staff

PT ACCESS SPECIALIST 80 HR	1.00

Total	7.00

Note:

FTE's are not expected to change, due to the assumed flat volume from current year.

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

Environmental Assessment			
Part I.	The following questions help determine whether the project is "significant" from an environmental standpoint.	**Yes**	**No**
1.1	If this application involves establishment, will it involve more than a change of name or ownership only, or a transfer of stock or partnership or membership interests only, or the conversion of existing beds to the same or lesser number of a different level of care beds?	☐	☒
1.2	Does this plan involve construction and change land use or density?	☐	☒
1.3	Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved?	☐	☒
1.4	Does this plan involve construction and require work related to the disposition of asbestos?	☐	☒
Part II.	If any question in Part I is answered “yes” the project may be significant, and Part II must be completed. If all questions in Part II are answered “no” it is likely that the project is not significant	**Yes**	**No**
2.1	Does the project involve physical alteration of ten acres or more?	☐	☒
2.2	If an expansion of an existing facility, is the area physically altered by the facility expanding by more than 50% and is the total existing and proposed altered area ten acres or more?	☐	☒
2.3	Will the project involve use of ground or surface water or discharge of wastewater to ground or surface water in excess of 2,000,000 gallons per day?	☐	☒
2.4	If an expansion of an existing facility, will use of ground or surface water or discharge of wastewater by the facility increase by more than 50% and exceed 2,000,000 gallons per day?	☐	☒
2.5	Will the project involve parking for 1,000 vehicles or more?	☐	☒
2.6	If an expansion of an existing facility, will the project involve a 50% or greater increase in parking spaces and will total parking exceed 1000 vehicles?	☐	☒
2.7	In a city, town, or village of 150,000 population or fewer, will the project entail more than 100,000 square feet of gross floor area?	☐	☒
2.8	If an expansion of an existing facility in a city, town, or village of 150,000 population or fewer, will the project expand existing floor space by more than 50% so that gross floor area exceeds 100,000 square feet?	☐	☒
2.9	In a city, town or village of more than 150,000 population, will the project entail more than 240,000 square feet of gross floor area?	☐	☒
2.10	If an expansion of an existing facility in a city, town, or village of more than 150,000 population, will the project expand existing floor space by more than 50% so that gross floor area exceeds 240,000 square feet?	☐	☒
2.11	In a locality without any zoning regulation about height, will the project contain any structure exceeding 100 feet above the original ground area?	☐	☒
2.12	Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303?	☐	☒
2.13	Will the project significantly affect drainage flow on adjacent sites?	☐	☒

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☒
2.15	Will the project result in a major adverse effect on air quality?	☐	☒
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	☒
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	☒
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	☒
2.19	Will the project have any adverse impact on health or safety?	☐	☒
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	☒
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	☒
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	☒
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☒
Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☐	☒
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		

	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.2	Has any other agency made an environmental review of this project? If so, give name, and submit the SEQRA Summary of Findings with the application in the space provided below.		**Yes** ☐	**No** ☒
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.3	Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.		**Yes** ☐	**No** ☒
Part IV.	**Storm and Flood Mitigation**			
	Definitions of FEMA Flood Zone Designations			
	Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.			
	Please use the FEMA Flood Designations scale below as a guide to answering all Part IV questions regardless of project location, flood and or evacuation zone.		**Yes**	**No**
4.1	Is the proposed site located in a flood plain? If Yes, indicate classification below and provide the Elevation Certificate (FEMA Flood Insurance).		☐	☒
	Moderate to Low Risk Area		**Yes**	**No**
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:			
	B and X	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.	☐	

	C and X	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.	☐	
	High Risk Areas		**Yes**	**No**
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
	A	Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones.	☐	
	AE	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30.	☐	
	A1-30	These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format).	☐	
	AH	Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	☐	
	AO	River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones.	☐	
	AR	Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations.	☐	
	A99	Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones.	☐	
	High Risk Coastal Area		**Yes**	**No**
	Zone	**Description**		
	In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
	Zone V	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones.	☐	☒
	VE, V1 - 30	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	☐	
	Undetermined Risk Area		**Yes**	**No**
	Zone	**Description**	☐	☒

	D	Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk.		
4.2	Are you in a designated evacuation zone?		☐	☒
	If Yes, the Elevation Certificate (FEMA Flood Insurance) shall be submitted with the application.			
	If yes which zone is the site located in?			
4.3	Does this project reflect the post Hurricane Lee, and or Irene, and Superstorm Sandy mitigation standards?		☐	☒
	If Yes, which floodplain?	100 Year	☐	
		500 Year	☐	

The Elevation Certificate provides a way for a community to document compliance with the community's floodplain management ordinance.

FEMA **Elevation Certificate** and Instructions

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.

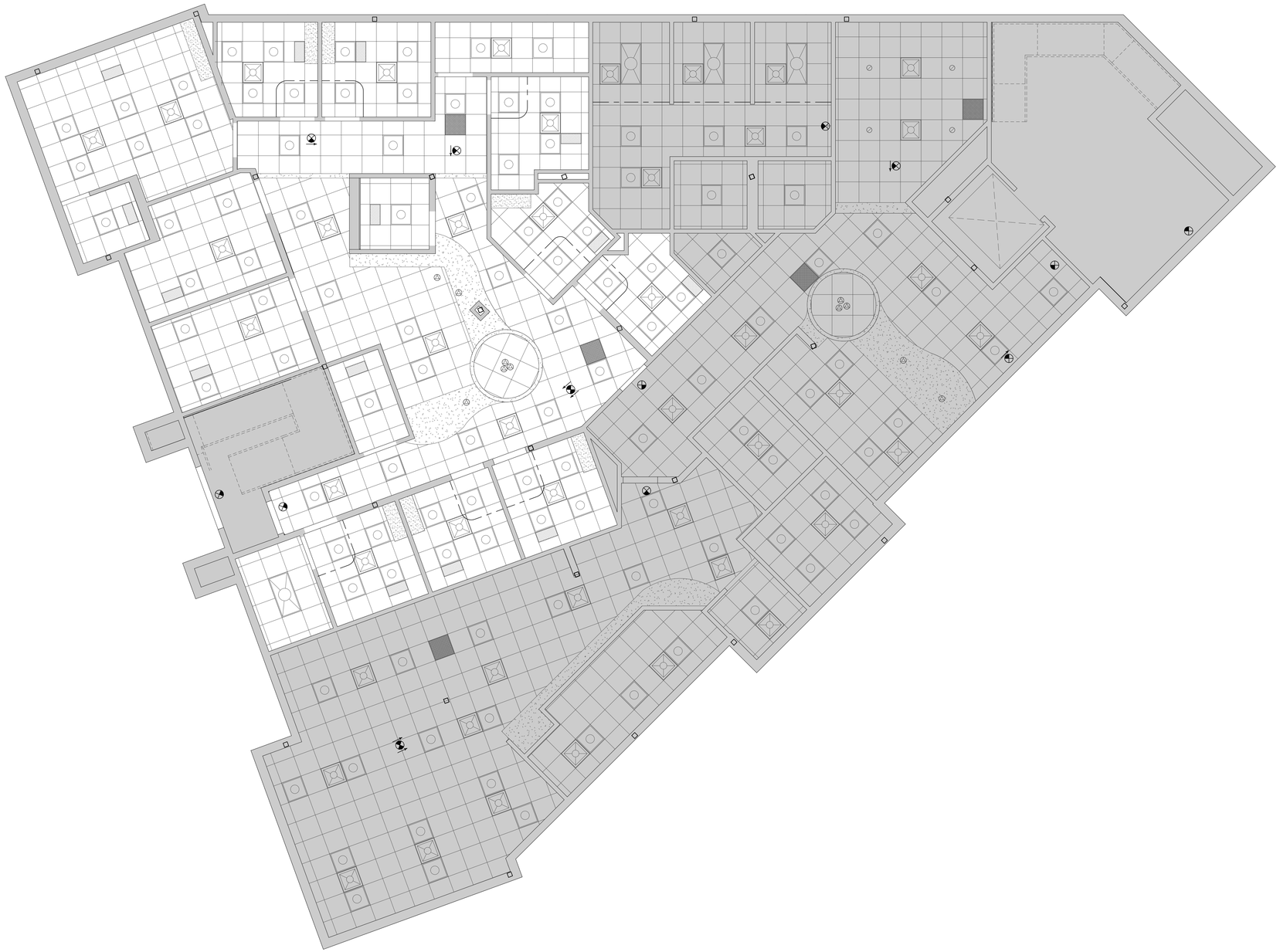
Project Description	
Schedule 6 submission date: 5/9/2024	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Yes If so, what is the original CON number? #131327	
Intent/Purpose: Bring new medical specialty into an existing, approved, article 28 compliant primary care space	
Site Location: 510 Geyser Road, Ballston Spa, NY 12020	

Brief description of current facility, including facility type: Current facility is a two-story building, Article 28 compliant throughout. The second floor is occupied by Primary Care. First floor is occupied by the Saratoga Hospital Medical Group. Services provided include Regional Therapy, and Blood Draw. The first floor also contains a vacant space which was the previous home for the second floor Primary Care.	
Brief description of proposed facility: Proposed facility will maintain all of the existing practices and will add the service of Neurology into the vacant space on the first floor. No room modifications are required for the new practice.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. The vacant shell space is located in the southwest corner of the first floor.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: Single occupancy, single tenant.	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	Not Applicable
Relationship of spaces conforming with Article 28 space and non-Article 28 space: All spaces within the building are Article 28 compliant	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. N/A	
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.	No
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. Electrical – Building is served with a 208V/3PH 800A electrical service to a meter stack. The first floor is fed from a 300A/3P meter and enclosed circuit breaker. The house panel is fed from a 200A/3P meter and enclosed circuit breaker. HVAC – Existing first floor is conditioned from a gas fired roof top unit with VVT distribution boxes through the first floor space. Plumbing/Fire Protection – The building is fed with a 6" combined domestic and sprinkler pipe service into the basement. The first floor is fed with a 2" cold water line and 1" hot water line. The electric water heater that feeds the 1st floor is in the basement. The entire first floor and main lobby have sprinkler coverage per NFPA 13.	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. Project does not involve modification of the MEP/FP systems. All systems are compliant with NYSBC, NFPA, and Article 28 standards and are intended to remain.	
Describe existing and or new work for fire detection, alarm, and communication systems: Fire Alarm – The entire building is protected with an addressable fire alarm system (Honeywell 7100 Series).	

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. N/A
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. No
Does the project comply with ADA? If no, list all areas of noncompliance. Yes
Other pertinent information:

Project Work Area	Response
Type of Work	NO WORK IS EXPECTED/PROPOSED
Square footages of existing areas, existing floor and or existing building.	5,600 s.f.
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	2,385 s.f.
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Less than 50% of the floor
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type V (000)
Building Height	31'
Building Number of Stories	2 + partial basement
Which edition of FGI is being used for this project?	PROJECT PREVIOUSLY APPROVED UNDER 2010
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	No
What is the Occupancy Classification per NFPA 101 Life Safety Code?	
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.	No
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	No
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.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
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.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	No
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	No
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	Not Applicable
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	No
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	No
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Not Applicable

Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	No



LEGEND:

- SUSPENDED CEILING SYSTEM
- GWB CEILING/SOFFIT/BULKHEAD
- 2'x4' LIGHT FIXTURE
- 2'x2' LIGHT FIXTURE
- RECESSED LIGHT FIXTURE
- SUPPLY GRILLE
- EXHAUST / RETURN GRILLE
- PRIVACY CURTAIN TRACK
- EXIT SIGN

1 / A3.1 EXISITNG REFLECTED CEILING PLAN

3/16" = 1'-0"

THIS DRAWING DENOTES THE EXISTING CONDITIONS FOR THE FIRST FLOOR AS A WHOLE. NEW WORK IS NEITHER PROPOSED NOR EXPECTED.

EXISTING REFLECTED CEILING PLAN

CIVIL ENGINEER:

STRUCTURAL ENGINEER:

MEP ENGINEER:

INTERIOR DESIGN: L. Rae Designs

CLIENT: SARATOGA HOSPITAL — people you trust. care you deserve.

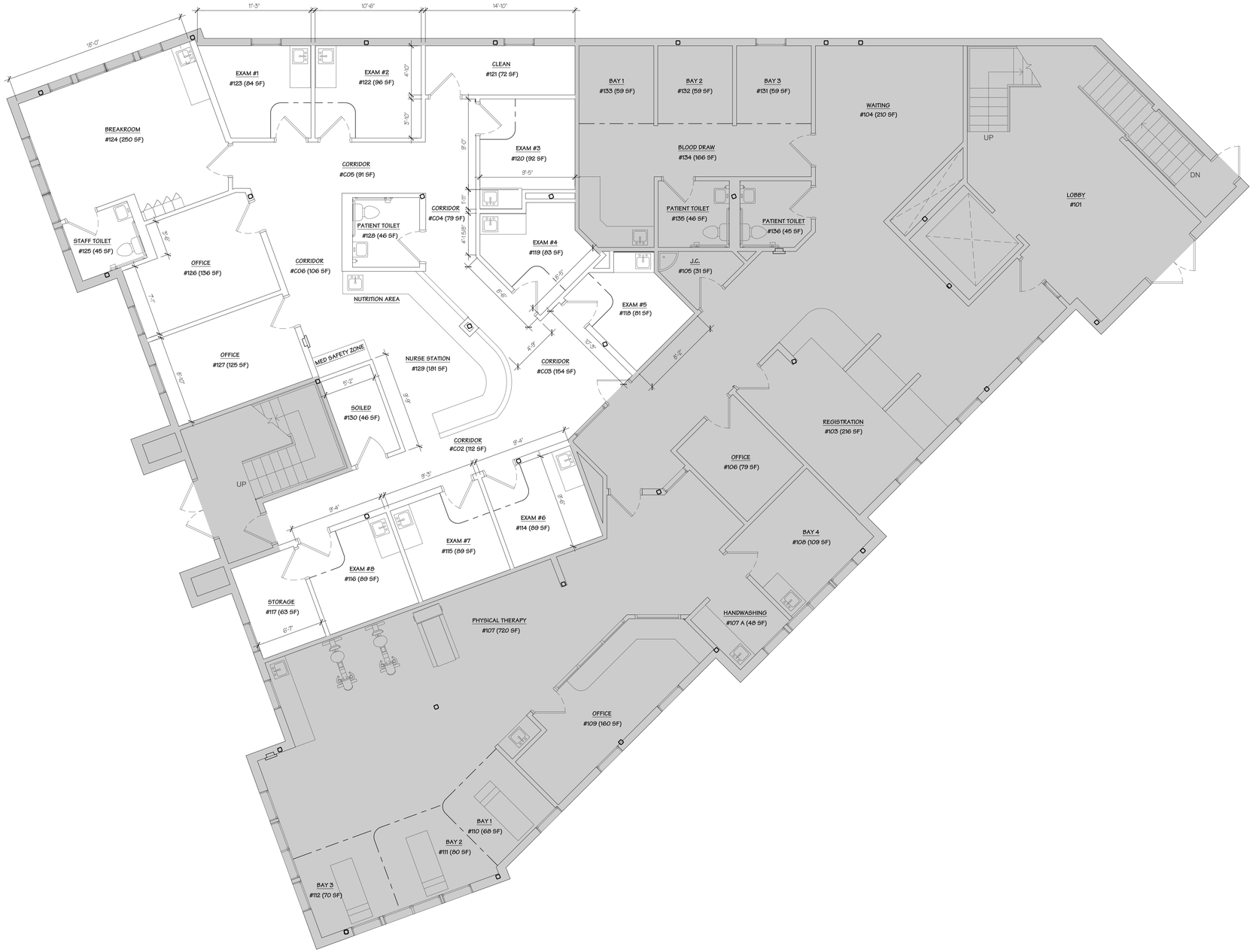
SEAL: REGISTERED ARCHITECT · JONATHAN R. PIRNEAU · 031233 · STATE OF NEW YORK

THE ARCHITECTURAL COLLABORATIVE
518.450.7026 • 33 CHURCH ST, SARATOGA SPRINGS • JON@THEARCHCOLLABORATIVE.COM

#:	DESCRIPTION:	DATE:

PROJECT NAME: MILTON P.C. - NEUROLOGY

DATE:	5.9.24	SHEET #:	A3.1
DRAWN BY:	JP		
CON #/PHASE:	#XX/XX		
PROJECT #:	24011	SCALE:	3/16" = 1'-0"



1 A2.1 EXISITNG FLOOR PLAN

3/16" = 1'-0"

THIS DRAWING DENOTES THE EXISTING CONDITIONS FOR THE FIRST FLOOR AS A WHOLE. NEW WORK IS NEITHER PROPOSED NOR EXPECTED.

EXISTING FLOOR PLAN

CIVIL ENGINEER:

STRUCTURAL ENGINEER:

MEP ENGINEER:

INTERIOR DESIGN:
L. Rae Designs

CLIENT:
SARATOGA HOSPITAL
people you trust. care you deserve.

SEAL:
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031233
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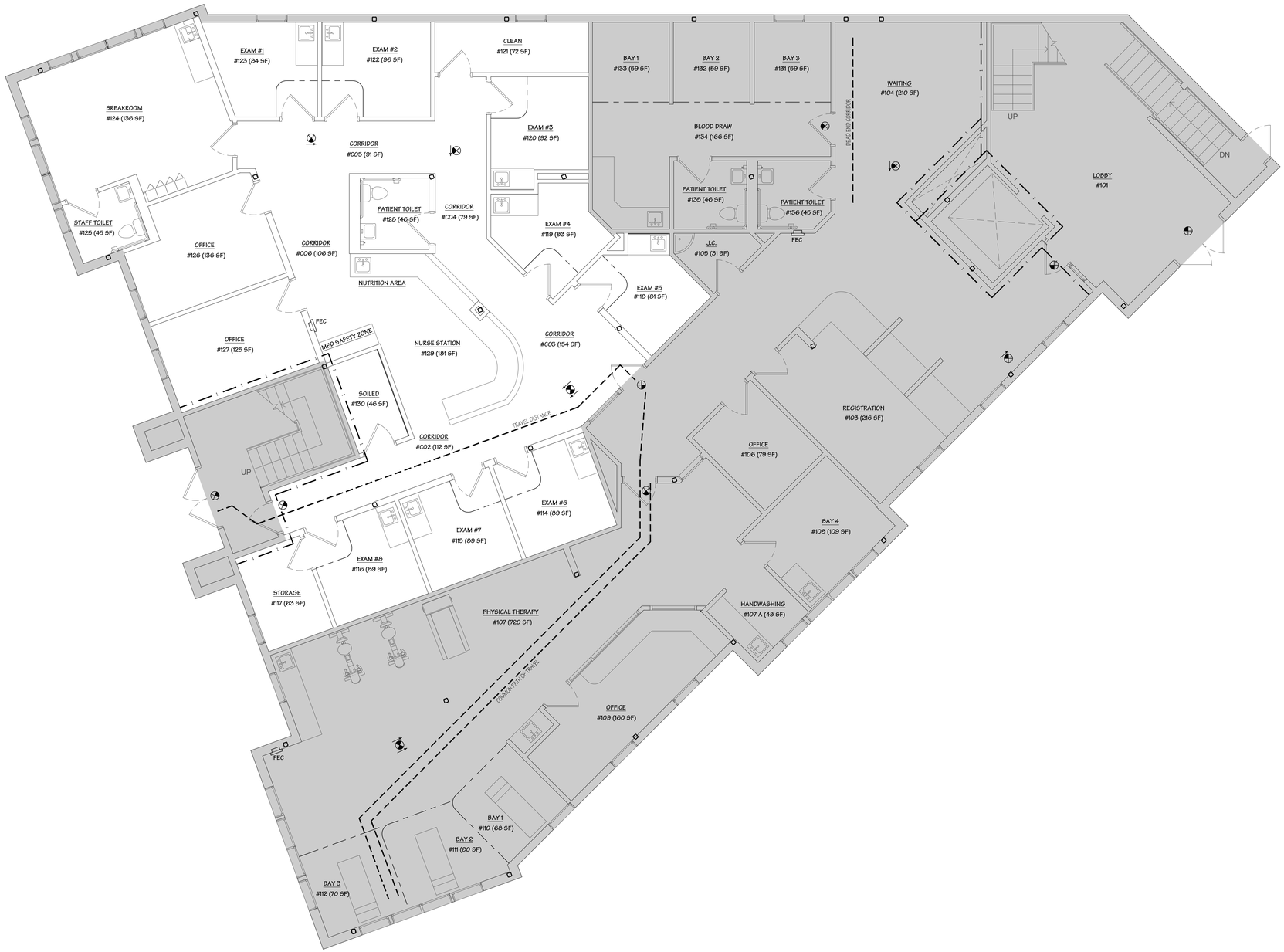
#:	DESCRIPTION:	DATE:

PROJECT NAME:
MILTON P.C. - NEUROLOGY

DATE:	5.9.24	SHEET #:	A2.1
DRAWN BY:	JP		
CON #/PHASE:	#XX/XX		
PROJECT #:	24011	SCALE:	3/16" = 1'-0"



1 AO.1 EXISITNG LIFE SAFETY PLAN

3/16" = 1'-0"

- EXISTING FACILITY FIRST FLOOR WAS CONSTRUCTED IN 2010
- EXISTING FACILITY FIRST FLOOR (IN TOTAL) WAS APPROVED FOR ARTICLE 28 COMPLIANCE IN 2010
- NO CHANGES ARE BEING PROPOSED FOR THE NEUROLOGY CLINIC, SIMPLY A CHANGE IN SARATOGA HOSPITAL'S PHYSICIAN GROUP
- PROJECT WAS DESIGNED IN ACCORDANCE WITH THE 2010 FGI GUIDELINES
- PROJECT IS LOCATED AT 510 GEYSER RD, BALLSTON SPA, NY
- BUILDING IS FULLY SPRINKLED
- BUILDING HAS A TOTAL OF (2) FLOORS + PARTIAL BASEMENT
- FLOOR TO FLOOR HEIGHT = 13'-6"
- NEUROLOGY CLINIC SQUARE FOOTAGE IS = 2,365 S.F.
- MINIMUM CORRIDOR EGRESS CAPACITY = 300 PERSONS PER 2012 NFPA 101 SECTION 7.3.3.1

	NFPA 101 - 2000 EDITION	NYSBC 2010
CONSTRUCTION TYPE	NFPA 220 - TABLE 3 TYPE V (0,0,0)	TABLE 601 TYPE V B
OCCUPANCY	BUSINESS CHAPTER 38	BUSINESS B
# OF EXITS	38.2.4.2 REQ'D - 2 ACTUAL - 2	1015 REQ'D - 2 ACTUAL - 2
MAX. DEAD END CORRIDOR	38.2.5.2 REQ'D - 50' MAX ACTUAL - 16'-0"	1017.3 REQ'D - 50' MAX ACTUAL - 16'-0"
MAX. TRAVEL DISTANCE	38.2.6 REQ'D - 300' MAX ACTUAL - 105'-0"	1016.1 REQ'D - 300' MAX ACTUAL - 105'-0"
MAX. COMMON PATH OF TRAVEL	38.2.5.3 REQ'D - 100' MAX. ACTUAL - 52' - 0"	TABLE 1014.3 REQ'D - 100' MAX. ACTUAL - 52' - 0"
RATING - CORRIDOR	38.3.6 REQ'D - 0 HR MIN. ACTUAL - 0 HR	1017.1 REQ'D - 0 HR MIN. ACTUAL - 0 HR
MINIMUM WIDTH - CORRIDOR	38.2.3.2 REQ'D - 44" ACTUAL - 50"	1017.2 REQ'D - 36" ACTUAL - 50"
RATING - STAIRS	7.2.2.5 / 7.1.3.2 REQ'D - 1 HR ACTUAL - 1 HR (ETR)	1020.1 REQ'D - 1 HR ACTUAL - 1 HR (ETR)

LEGEND:

- DENOTES VARIOUS CODE REQUIRED CLEARANCES
- DENOTES PATH OF TRAVEL
- EXIT SIGN
- FEC — DENOTES FIRE EXTINGUISHER CABINET
- WA — DENOTES WALL ACTUATOR
- PC — DENOTES PROX CARD READER
- SLP — DENOTES SMOKE LIMITING PARTITION
- SBI — DENOTES 1 HOUR SMOKE BARRIER
- 1 — DENOTES 1 HOUR PARTITION
- 2 — DENOTES 2 HOUR PARTITION OR 2 HOUR BUILDING SEPARATION
- 3 — DENOTES 3 HOUR PARTITION OR 3 HOUR BUILDING SEPARATION
- DENOTES PATH OF TRAVEL

EXISTING LIFE SAFETY PLAN

CIVIL ENGINEER:

STRUCTURAL ENGINEER:

MEP ENGINEER:

INTERIOR DESIGN:
L. Rae Designs

CLIENT:
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#:	DESCRIPTION:	DATE:

PROJECT NAME:
MILTON P.C. - NEUROLOGY

DATE:	5.9.24	SHEET #:	A0.1
DRAWN BY:	JP		
CON #/PHASE:	#XX/XX		
PROJECT #:	24011	SCALE:	3/16" = 1'-0"

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 d	

*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.