REV 2/19/2026

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)?	N/A	
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?	N/A	

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

Section B. All Article 28 Facilities

Table B.

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

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

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

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

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

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

Limited Review Application

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

LRA Cover Sheet

Project to be Proposed/Applicant Information

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

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

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

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

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

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

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

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

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

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

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

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
7003351N	Chapin Home for the Aging	SNF

OPERATOR ADDRESS – STREET & NUMBER		PFI	NAME AND TITLE OF CONTACT PERSON		
165-01 Chapin Parkway		1715	Andrew Blatt – CENSELI LLC, Consultant		
CITY	COUNTY	ZIP	STREET AND NUMBER		
Jamaica	Queens	11462	65 Locust Ave, Suite 200		
PROJECT SITE ADDRESS – STREET & NUMBER		PFI	CITY	STATE	ZIP
165-01 Chapin Parkway		1715	New Canaan	CT	06840
CITY	COUNTY	ZIP	TELEPHONE NUMBER	FAX NUMBER	
Jamaica	Queens	11462	914-215-1648	646-349-5889	
TOTAL PROJECT COST: 500.00			CONTACT E-MAIL: ablatt@censeli.com		

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

Click here to enter text.	
Brief description of proposed facility: Click here to enter text.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. Click here to enter text.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: 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: 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. 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. 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. Click here to enter text.	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. Click here to enter text.	
Describe existing and or new work for fire detection, alarm, and communication systems: 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. Click here to enter text.	
Does the project comply with ADA? If no, list all areas of noncompliance. Click here to enter text.	
Other pertinent information: 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. 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	16,187,424		
Grants Funds	0		
Foundation	0		
Other	0		
Fees	0		
Other Income	234,548		
(1) Total Revenues	$16,421,972	$	$
Expenses			
Salaries and Wage Expense	6,614,112		
Employee Benefits	2,784,739		
Professional Fees	0		
Medical & Surgical Supplies	0		
Non-Medical Equipment	0		
Purchased Services	442,624		
Other Direct Expense	12,285,882		
Utilities Expense	353,486		
Interest Expense	286,493		
Rent Expense	0		
Depreciation Expense	629,200		
Other Expenses	SEE ATTACHED		
(2) Total Expense	$23,228,350	$	$
Net Total - (1-2) →	***$***-6,806,378	***$***	***$***

(Rev. 7/2015)

Schedule LRA 7

Attachment for Reference Purposes
Operating Budget Details

CHAPIN HOME FOR THE AGING

PER THE 2024 RHCF-4 COST REPORT

REVENUES	CURRENT YEAR	REMOVAL OF ADHCP	FIRST YEAR PROJECTED
Service Revenue	$ 16,187,424	$ -	$ 16,187,424
Grtants Funds	$ -	$ -	$ -
Foundation	$ -	$ -	$ -
Other	$ -	$ -	$ -
Fees	$ -	$ -	$ -
Other Income	$ 234,548	$ -	$ 234,548
TOTAL REVENUE	$ 16,421,972	$ -	$ 16,421,972
EXPENSES			
Salaries and Wage Expense	$ 6,614,112	$ -	$ 6,614,112
Employee Benefiits	$ 2,784,739	$ -	$ 2,784,739
Professional Fees	$ -	$ -	$ -
Medical & Surgical Supplies	$ -	$ -	$ -
Non-Medical Equipment	$ -	$ -	$ -
Purchased Services	$ 442,624	$ -	$ 442,624
Other Direct Expenses	$ 12,285,882	$ -	$ 12,285,882
Utilities Expense	$ 353,486	$ -	$ 353,486
Interest Expense	$ 286,493	$ -	$ 286,493
Rent Expense	$ -	$ -	$ -
Depreciation Expense	$ 629,200	$ -	$ 629,200
Other Expenses	$ -	$ -	$ -
Non-Operating Revenue / Expeneses	$ (1,793,464)		$ (1,793,464)
Cash Receipt Assessment	$ 807,384		$ 807,384
Bad Debt Expense	$ 817,894		$ 817,894
TOTAL EXPENSE	$ 23,228,350	$ -	$ 23,228,350
NET TOTAL	$ (6,806,378)	$ -	$ (6,806,378)

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									
	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

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:**			
Management and Supervision	14.8	14.8	14.8
Techs and Non-Physicians	1.03	1.03	1.03
Registered Nurses	6.65	6.65	6.65
Licensed Practical Nurses	7.04	7.04	7.04
Aides / Orderlies	64.46	64.46	64.46
Support Staff*:**			
Clerical and other Administrative Staff	11.34	11.34	11.34
Environmental and Food Services	8.61	8.61	8.61
Total Number of Employees	113.93	113.93	113.93

* 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:

Staffing reductions are based on the 2024 RHCF-1 cost report. As indicated, the adult day health care program has been dormant since 2020, as a result of COVID-19, and Chapin Home for the Aging has not incurred any operational costs and dedicated staffing as a result of this program.

PLEASE COMPLETE THE FOLLOWING:

1. Are staff paid and on Payroll? ☒ Yes ☐ No
2. Provide copies of contracts for any independent contractor.
3. Please attach the Medical Doctors C.V.
4. Is this facility affiliated with any other facilities? (If yes, please describe affiliation and/or agreement.) ☐ Yes ☒ No

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
Adult Day Health Care Program		☒	☐	☒	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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.

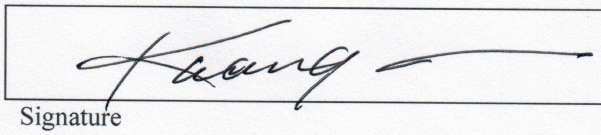
g) The facility will be operated and maintained in accordance with the standards prescribed by law.

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.

9/16/25

Date



Signature

Kwang Lee, LNHA

Name (Please Type)

Administrator

Title (Please Type)