

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. 2750306N | CERTIFIED OPERATOR The Meadows at Westfall, Inc | TYPE OF FACILITY SNF |
|---------------------------------------|--|-------------------------|

| | | | | | |
|---|------------------|--------------|--|----------------------------|--------------|
| OPERATOR ADDRESS – STREET & NUMBER 601 Elmwood Avenue | | PFI 5538 | NAME AND TITLE OF CONTACT PERSON Walter Winiarczyk, Administrator | | |
| CITY Rochester | COUNTY Monroe | ZIP 14642 | STREET AND NUMBER 5901 Lac De Ville Blvd | | |
| PROJECT SITE ADDRESS – STREET & NUMBER 5901 Lac De Ville Blvd | | PFI 5538 | CITY Rochester | STATE NY | ZIP 14618 |
| CITY Rochester | COUNTY Monroe | ZIP 14618 | TELEPHONE NUMBER 585-442-7960 | FAX NUMBER 585-442-6984 | |
| TOTAL PROJECT COST: \$ ██████████ | | | CONTACT E-MAIL: walter_winiarczyk@urmc.rochester.edu | | |

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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 <i>(attach documentation)</i> | \$ | |
| 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: | |
| 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 | \$ | |
| 4.7 Other Project Fees (Consultant, etc.) | \$ | |
| | 4.1-4.7 Subtotal: | |
| 5.1 Movable Equipment | \$ | |
| 6.1 Total Basic Cost of Construction | \$ | |
| 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) | \$ | |

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

Schedule LRA 3

Proposed Plan for Project Financing

A. LEASE

If any portion of the cost for land, building or Equipment is to be 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.

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 # HAB Financials

| | | |
|--------------------------------------|----|------------|
| Accumulated Funds | \$ | ██████████ |
| Sale of Existing Assets* | \$ | |
| Other – (i.e. gifts, grants, **etc.) | \$ | |
| TOTAL CASH | \$ | ██████████ |

*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 be financed by debt of any type, complete the chart at the right.

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 # _____

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

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

Schedule LRA 4/Schedule 7 CON Forms Regarding Environmental issues

Contents:

Schedule LRA 4/Schedule 7 - Environmental Assessment

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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.2 | Does this plan involve construction and change land use or density? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.3 | Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.4 | Does this plan involve construction and require work related to the disposition of asbestos? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.5 | Will the project involve parking for 1,000 vehicles or more? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.12 | Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.13 | Will the project significantly affect drainage flow on adjacent sites? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| | | | |
|------------------|--|--------------------------|-------------------------------------|
| 2.14 | Will the project affect any threatened or endangered plants or animal species? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.15 | Will the project result in a major adverse effect on air quality? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.17 | Will the project result in major traffic problems or have a major effect on existing transportation systems? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.18 | Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.19 | Will the project have any adverse impact on health or safety? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.23 | Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | 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 |
| | | | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | 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 |
| | | | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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). | | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | Moderate to Low Risk Area | | | Yes | No |
| | Zone | Description | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | 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. | | | <input type="checkbox"/> |

| | | | |
|--|---|--------------------------|--------------------------|
| C and X | Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level. | <input type="checkbox"/> | |
| High Risk Areas | | Yes | No |
| Zone | Description | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | |
| AE | The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30. | <input type="checkbox"/> | |
| 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). | <input type="checkbox"/> | |
| 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. | <input type="checkbox"/> | |
| 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. | <input type="checkbox"/> | |
| 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. | <input type="checkbox"/> | |
| 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. | <input type="checkbox"/> | |
| High Risk Coastal Area | | Yes | No |
| Zone | Description | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | |
| Undetermined Risk Area | | Yes | No |
| Zone | Description | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|-----|--|---|--------------------------|-------------------------------------|
| | 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? | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | 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? | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| | If Yes, which floodplain? | 100 Year | <input type="checkbox"/> | |
| | | 500 Year | <input type="checkbox"/> | |

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

[FEMA Elevation_Certificate_and Instructions](#)

Limited Review Application

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

| |
|-----------------------|
| Schedule LRA 5 |
|-----------------------|

Space & Construction Cost Distribution

- New
 Alteration

| LOCATION | | | Code and Functional Category Description (4) | Functional Gross SF (5) | Construction Cost per SF (6) | Total Construction Cost (7) | (ALT) Scope of Work (8) |
|---------------------------|------------------|------------------|---|----------------------------|---------------------------------|--------------------------------|----------------------------|
| Bldg. No. (1) | Floor No. (2) | Sect. No. (3) | | | | | |
| | 1 | | Bedside Dialysis | ● | ● | ● | |
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| | | | | | | | |
| Total Construction | | | | ● | ● | ● | |

1. If new construction is involved, is it "freestanding"? Yes No
2. (Check where applicable) The facilities to be affected by this project are located in a:
 Dense Urban Area Other Metropolitan or Suburban Area 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 complete copy if this schedule is required.

Schedule 6 Architectural/Engineering Submission

Contents:

- Schedule 6 – Architectural/Engineering Submission

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: 5/12/2025 | Revised Schedule 6 submission date: Click to enter a date. |
| Does this project amend or supersede prior CON approvals or a pending application? Not Applicable If so, what is the original CON number? Click here to enter text. | |
| Intent/Purpose: The intent of the project is to add bedside only dialysis to two resident rooms at Highlands at Brighton Nursing Home (HAB) in order to discharge vented patients on dialysis at Highland Hospital to HAB. | |
| Site Location: | |

**New York State Department of Health
Certificate of Need Application**

Schedule 6

| | |
|---|-----------------------|
| 5901 Lac De Ville Blvd, Rochester, NY 14618 | |
| Brief description of current facility, including facility type: The existing facility is an I-2 Institutional occupancy, skilled nursing facility. The building is 2 stories high with a basement. | |
| Brief description of proposed facility: No change from existing | |
| Location of proposed project space(s) within the building. Note occupancy type for each occupied space. Project spaces include two existing resident rooms plus two additional existing rooms that will be used for support space all on the first floor. The spaces are I-2 Institutional occupancy | |
| Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: N/A; entire facility is I-2 Institutional | |
| 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 are Article 28 | |
| List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. FGI 2018 | |
| 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. Existing heating, ventilating and air conditioning systems will be modified to serve the rooms within the project space. Electrical receptacles and equipment connections will be modified within project area. Existing plumbing systems will be extended for the dialysis. | Yes |
| Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. The building HVAC system includes natural gas fired hot water boilers serving radiant floors and terminal units, and packaged rooftop units with DX cooling and natural gas heat. | |
| Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. The HVAC system modifications will include new variable air volume terminal units with hot water reheat coils, new exhaust air system and electric radiant ceiling panels. Electric power for equipment. | |
| Describe existing and or new work for fire detection, alarm, and communication systems: A fire alarm notification appliance added in the dialysis storage room. | |
| 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. N/A | |
| Does the project comply with ADA? If no, list all areas of noncompliance. Construction required to accommodate the installation of the new dialysis equipment will be designed for accessibility in accordance with the 2020 Building Code of New York State and ICC A117.1-09 | |
| Other pertinent information: N/A | |

New York State Department of Health Certificate of Need Application

Schedule 6

| Project Work Area | Response |
|---|---|
| Type of Work | Alteration |
| Square footages of existing areas, existing floor and or existing building. | Existing first floor = [REDACTED] |
| Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas. | [REDACTED] |
| Does the work area exceed more than 50% of the smoke compartment, floor or building? | Less than 50% of the smoke compartment |
| Sprinkler protection per NFPA 101 Life Safety Code | Sprinklered throughout |
| Construction Type per NFPA 101 Life Safety Code and NFPA 220 | Type II (111) |
| Building Height | 24'-6" |
| Building Number of Stories | 2 stories |
| Which edition of FGI is being used for this project? | 2018 Edition of FGI |
| Is the proposed work area located in a basement or underground building? | Grade Level |
| 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? | Not Applicable |
| What is the Occupancy Classification per NFPA 101 Life Safety Code? | Chapter 18 New Health Care Occupancy |
| 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? The hair salon will be permanently relocated to accommodate dialysis repair and storage. | Yes |
| Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text. | No Change |
| 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? Type 2 | Yes |
| 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 |

**New York State Department of Health
Certificate of Need Application**

Schedule 6

| | |
|----------------------------------|-----------|
| Does the project involve a pool? | No |
|----------------------------------|-----------|

| 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 |



CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS (For projects not meeting the prerequisites for Self-Certification submission.)

Date: 5/12/2025
CON Number:
Facility Name: The Highlands at Brighton
Facility ID Number: PFI #5538; Operating Certificate #2750306N
Facility Address: 5901 Lac De Ville Blvd, Rochester, NY 14618; Monroe County

NYS Department of Health/Office of Health Systems Management
Center for Health Care Facility Planning, Licensure, and Finance
Bureau of Architectural and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

To The New York State Department of Health:

I hereby certify that:

- 1. I have been retained by the aforementioned facility, to provide professional architectural/engineering services related to the design and preparation of construction documents...
2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed...
3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations...
a. 712 (Standards of Construction for General Hospital Facilities)
b. X 713 (Standards of Construction for Nursing Home Facilities)
c. 714 (Standards of Construction for Adult Day Health Care Program Facilities)
d. 715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
e. 716 (Standards of Construction for Rehabilitation Facilities)
f. 717 (Standards of Construction for New Hospice Facilities and Units)

PLEASE NOTE ANY EXCEPTIONS HERE:
FGI 2018 Guidelines

- 4. I understand that as the design of this project progresses, if a component of this project is inconsistent with the State Hospital Code (10 NYCRR Parts 711, 712, 713, 714, 715, 716, or 717), I shall bring this to the attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department of Health prior to or upon submitting final drawings for compliance resolution.

5. I understand that upon completion of construction, the costs of any subsequent corrections necessary to achieve compliance with applicable requirements of 10 NYCRR Parts 711, 712, 713, 714, 715, 716 and 717, when the prior work was not completed properly as certified herein, may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative, full review, self-certification and reviews performed and completed by DASNY.

Project Name: The Highlands at Brighton - Bedside Dialysis

Location: 5901 Lac De Ville Blvd, Rochester, NY 14618; Monroe County; First Floor

Description: Addition of bedside only dialysis to two existing resident rooms as well as renovation to two existing rooms for dialysis support



James Woodcock

Signature of Architect or Engineer

James Woodcock

Name of Architect or Engineer (Print)

030712

Professional New York State License Number

85 Allen St., Suite 210, Rochester, NY 14608

Business Address

The undersigned applicant understands and agrees that, notwithstanding this architectural/engineering certification the Department of Health shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the Division to comply with the above-mentioned codes and regulations, whether or not physical plant construction or alterations have been completed.

Walter Winiarczyk

Authorized Signature for Applicant

Walter Winiarczyk Administrator

Name (Print)

Title

5/20/25

Date

Notary signing required for the applicant

STATE OF NEW YORK)

County of Monroe)

) SS:

On the 20 day of May 2025, before me personally appeared Walter Winiarczyk to me known, who being by me duly sworn, did depose and say that he/she is the Administrator of the The Highlands at Brighton, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary)

Julie Hutchison (Gattelaro)

Reg# 01HU6419010

Exp. 06/28/2025



ARCHITECTURAL AND ENGINEERING LETTER OF CERTIFICATION

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 | ██████████ | ██████████ | ██████████ |
| 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) → | ██████████ | ██████████ | ██████████ |

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 | | ████ | ████ | ████████ | ████ | ████ | ██████████ | ████ | ████ | ████████ |

| 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. | n/a | n/a |

*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**: | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Support Staff***: | | | |
| Clerical & Other Administrative | ██ | ██ | ██ |
| Technician & Specialist | ██ | ██ | ██ |
| Registered Nurses | ██ | ██ | ██ |
| Licensed Practical Nurses | ██ | ██ | ██ |
| Aides, Orderlies & Attendants | ██ | ██ | ██ |
| Infection Control, Environment and Food Service | ██ | ██ | ██ |
| 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 from cost report.

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

Schedule LRA 10

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

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 |
|--|------|--------------------------|-------------------------------------|--------------------------|--------------------------|
| Nursing Home Hemodialysis-Bedside Only | | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

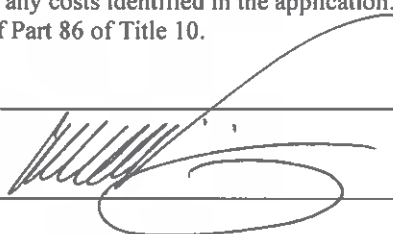
Assurances

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.

5/20/25

Date



Signature

Walter Winiarczyk

Name (Please Type)

Administrator

Title (Please Type)