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
1401013H	Sister's of Charity Hospital	Hospital

OPERATOR ADDRESS – STREET & NUMBER		PFI	NAME AND TITLE OF CONTACT PERSON		
2157 Main St.		218	Melissa Armstrong, Planning Analyst		
CITY	COUNTY	ZIP	STREET AND NUMBER		
Buffalo	Erie	14214	144 Genesee St		
PROJECT SITE ADDRESS – STREET & NUMBER		PFI	CITY	STATE	ZIP
6199 Transit Rd		218	Buffalo	NY	14203
CITY	COUNTY	ZIP	TELEPHONE NUMBER	FAX NUMBER	
Depew	Erie	14043	716-862-2445	716-862-2448	
TOTAL PROJECT COST: $ Redacted			CONTACT E-MAIL: marmstrong@chsbuffalo.org		

(Rev 09/2019)

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Schedule LRA 7

Proposed Operating Budget

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

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Schedule LRA 7A

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

Total of Inpatient and Outpatient Services	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted	Redacted

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

*Net of Deductions from Revenue

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Schedule LRA 8

Staffing

Staffing Categories	Number of FTEs to the Nearest Tenth		
	Current Year*	First Year of implementation	Third Year of implementation
Health Providers:**			
Physician (Oncologist)	2.13	2.13	3.20
Nurse Practitioners	1.22	1.22	2.22
Advanced Practice Providers	3.00	3.00	3.00
			0
			0
			0
Support Staff*:**			
Practice Admin	1.00	1.00	1.00
Nurse Mgr	.0	0	0
RN	5.00	6.00	8.00
Service Rep	3.12	3.12	4.12
Medical Assistant	0	1.0	2.00
Nurse Navigator	0	0	1.00
Total Number of Employees	15.47	17.47	24.54

* 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:

Transit Rd. Infusion staff expensed to 100-7686. Excludes any staff that provide ancillary services (i.e. Hospital Pharmacy, Lab). Oncologists expensed to 100-7110. No support staff expenses here.

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