Limited Review Application

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

LRA Cover Sheet

Project to be Proposed/Applicant Information

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

☐ **Minor Construction** – Minor construction project with total project costs of up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities, if not relating to clinical space – check "Non-Clinical" box below).

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

☐ **Equipment** – Project related to the acquisition, relocation, installation or modification of certain medical equipment, with total project costs of up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (**NOT** necessary for "1-for-1" replacement of existing equipment without construction, pursuant to Chapter 174 of the Laws of 2011 amending Article 28 of the Public Health law to eliminate limited review and CON review for one for one equipment replacement)
Necessary LRA Schedules: Cover Sheet, 2, 3, 4, and 5.

☒ **Service Delivery** – Project to decertify a facility's beds/services; add services which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities; or convert beds within approved categories. (*If construction associated, also check "Construction" above.*)
Necessary LRA Schedules: Cover Sheet, 2, 6, 7, 8, 10, and 12. **If proposing to decertify beds within a nursing home, provide a description of the proposed alternative use of the space including a detailed sketch (unless the decertification is being accomplished by eliminating beds in multiple-bedded rooms). If proposing to convert beds within approved categories, an LRA Schedule 6 and all supporting documentation are required to confirm appropriate space for the new use.*

☐ **Cardiac Services** – Project by an appropriately certified facility to add electrophysiology (EP) services; or add, upgrade or replace a cardiac catheterization laboratory or equipment. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 7, 8, 10, and 12.

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

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

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

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

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
4501000H	The Saratoga Hospital Inc.	Extension Clinic

OPERATOR ADDRESS – STREET & NUMBER 211 Church Street		PFI 818	NAME AND TITLE OF CONTACT PERSON [redacted] Project Manager		
CITY Saratoga Springs	COUNTY Saratoga	ZIP 12866	STREET AND NUMBER 211 Church St		
PROJECT SITE ADDRESS – STREET & NUMBER 959 Route 9		PFI 818	CITY Saratoga Springs	STATE NY	ZIP 12866
CITY Queensbury	COUNTY Warren	ZIP 12804	TELEPHONE NUMBER [redacted]	FAX NUMBER	
TOTAL PROJECT COST: $ 0			CONTACT E-MAIL: [redacted]@saratogahospital.org		

(Rev 09/2019)

Limited Review Application

Schedule LRA 7

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

Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue	[redacted]	0	$0.00
Grants Funds			
Foundation			
Other		0	$0
Fees			
Other Income			
(1) Total Revenues	[redacted]	$0	$0
Expenses			
Salaries and Wage Expense	[redacted]	0	$0.00
Employee Benefits	[redacted]	0	$0.00
Professional Fees			
Medical & Surgical Supplies	[redacted]	0	$0.00
Non-Medical Equipment			
Purchased Services	[redacted]	0	$0.00
Other Direct Expense	[redacted]	0	$0.00
Utilities Expense			
Interest Expense			
Rent Expense	[redacted]	0	0
Depreciation Expense			
Other Expenses			
(2) Total Expense	[redacted]	$0	$0
Net Total - (1-2) →	[redacted]	***$***0	***$***0

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	179	3.2	[redacted]	0	0	0	0	0	0
	Managed Care	2,147	38.3	[redacted]	0	0	0	0	0	0
Medicare	Fee for Service	332	5.9	[redacted]	0	0	0	0	0	0
	Managed Care	556	9.2	[redacted]	0	0	0	0	0	0
Medicaid	Fee for Service	51	1.1	[redacted]	0	0	0	0	0	0
	Managed Care	1,799	32.6	[redacted]	0	0	0	0	0	0
Private Pay		197	3.6	[redacted]	0	0	0	0	0	0
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		290	6.2	[redacted]	0	0	0	0	0	0
Total		5,551	100%	[redacted]		100%	0	0	100%	0

Total of Inpatient and Outpatient Services				[redacted]			0			0

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	ADK UC Close Supporting File	ADK UC Close Supporting File for Limited CON.xlsx
2. In an attachment, provide the basis for charity care.	NA	NA

*Net of Deductions from Revenue

Limited Review Application

Schedule LRA 7

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

Proposed Operating Budget

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

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	168	7.8	[redacted]	0	7.9	[redacted]	0	7.9	[redacted]
	Managed Care	1,936	31.4	[redacted]	0	31.4	[redacted]	0	31.4	[redacted]
Medicare	Fee for Service	974	19.7	[redacted]	0	19.7	[redacted]	0	19.7	[redacted]
	Managed Care	1,434	27.2	[redacted]	0	27.2	[redacted]	0	27.2	[redacted]
Medicaid	Fee for Service	58	0.5	[redacted]	0	0.5	[redacted]	0	0.5	[redacted]
	Managed Care	574	13.3	[redacted]	0	13.3	[redacted]	0	13.3	[redacted]
Private Pay		24	0.0	[redacted]	0	0.0	[redacted]	0	0.0	[redacted]
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		14	0.1	[redacted]	0	0.1	[redacted]	0	0.1	[redacted]
Total		5,182	100%	[redacted]		100%	[redacted]	0	100%	[redacted]

Total of Inpatient and Outpatient Services									

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Pulmonology Move Supporting Data	Pulmonology Move Limited CON Supporting File.xlsx
2. In an attachment, provide the basis for charity care.	NA	NA

*Net of Deductions from Revenue

This is an Outpatient service. No Inpatients.

Outpatient Services		Total Current Year		
			Net Revenue	
		Visits	%	Dollars
Commercial	Fee for Service	179	3.2%	$ [redacted]
	Managed Care	2,147	38.3%	$ [redacted]
Medicare	Fee for Service	332	5.9%	$ [redacted]
	Managed Care	556	9.2%	$ [redacted]
Medicaid	Fee for Service	51	1.1%	$ [redacted]
	Managed Care	1,799	32.6%	$ [redacted]
Private Pay		197	3.6%	$ [redacted]
OASAS				
OMH				
Charity Care				
Bad Debt				
All Other		290	6.2%	$ [redacted]
Total		5,551	100%	$ [redacted]

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

Note:
Current Year Revenues are actual.
Years 1 & 3 assume 3% increases per year.

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:**			
Registered Nurse	2.11	0.00	0.00
Physician Assistant	1.60	0.00	0.00
Nurse Practitioner	0.48	0.00	0.00
Patient Care Tech	2.21	0.00	0.00
		0.00	0.00
Support Staff*:**			
Patient Access Specialist	2.12	0.00	0.00
Site Manager	1.04		
Total Number of Employees	9.56	0.00	0.00

* 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 Year is actual FTE's. The program is closing. Future year FTE's will be zero.

PLEASE COMPLETE THE FOLLOWING:

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

Affiliated with Saratoga Hospital.

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:**			
Registered Nurse	1.04	1.04	1.04
Medical Assistant	1.10	1.10	1.10
Nurse Practitioner	1.00	1.00	1.00
Support Staff*:**			
Patient Access Specialist	1.64	1.64	1.64
Total Number of Employees	4.78	4.78	4.78

* Last complete year prior to submitting application

** "Health Providers" includes <u>all</u> 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 Year is actual FTE's. Future years FTE's are expected to be at constant levels.

PLEASE COMPLETE THE FOLLOWING:

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

Affiliated with Saratoga Hospital.

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
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
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		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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)* _____ _____ _____

New York State Department of Health
Health Equity Impact Assessment Requirement Criteria

Effective June 22, 2023, a Health Equity Impact Assessment (HEIA) will be required as part of Certificate of Need (CON) applications submitted by facilities (Applicant), pursuant to Public Health Law (PHL) § 2802-b and corresponding regulations at Title 10 New York Codes, Rules and Regulations (NYCRR) § 400.26. This form must be used by the Applicant to determine if a HEIA is required as part of a CON application.

Section A. Diagnostic and Treatment Centers (D&TC) - *This section should only be completed by D&TCs, all other Applicants continue to Section B.*

Table A.

Diagnostic and Treatment Centers for HEIA Requirement	Yes	No
Is the Diagnostic and Treatment Center's patient population less than 50% patients enrolled in Medicaid and/or uninsured (combined)?		
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?		

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

Section B. All Article 28 Facilities

Table B.

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

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

*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 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.

7/3/2024

Date

[redacted]

Signature

[redacted]

Name (Please Type)

[redacted]

Title (Please Type)

New York State Department of Health

Health Equity Impact Assessment Conflict-of-Interest

This Conflict-of-Interest form must be completed in full, signed by the Independent Entity, and submitted with the Health Equity Impact Assessment.

Section 1 – Definitions

Independent Entity means individual or organization with demonstrated expertise and experience in the study of health equity, anti-racism, and community and stakeholder engagement, and with preferred expertise and experience in the study of health care access or delivery of health care services, able to produce an objective written assessment using a standard format of whether, and if so how, the facility's proposed project will impact access to and delivery of health care services, particularly for members of medically underserved groups.

Conflict of Interest shall mean having a financial interest in the approval of an application or assisting in drafting any part of the application on behalf of the facility, other than the health equity assessment.

Section 2 – Independent Entity

What does it mean for the Independent Entity to have a conflict of interest? For the purpose of the Health Equity Impact Assessment, if one or a combination of the following apply to the Independent Entity, the Independent Entity **HAS** a conflict of interest and must **NOT** perform the Health Equity Impact Assessment:

- The Independent Entity helped compile or write any part of the Certificate of Need (CON) application being submitted for this specific project, other than the Health Equity Impact Assessment (for example, individual(s) hired to compile the Certificate of Need application for the facility's project cannot be the same individual(s) conducting the Health Equity Impact Assessment);
- The Independent Entity has a financial interest in the outcome of this specific project's Certificate of Need application (i.e. individual is a member of the facility's Board of Directors or advisory board); or
- The Independent Entity has accepted or will accept a financial gift or incentive from the Applicant above fair market value for the cost of performing the Health Equity Impact Assessment.

Section 3 – General Information

A. About the Independent Entity

1. Name of Independent Entity: Crescendo Consulting Group
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)?
   - ❑ If yes, indicate the name of the organization:

     _____

3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (Y/N)?
   _____
4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years?

Crescendo Consulting Group had no prior working relationship with Saratoga Hospital. Crescendo is currently conducting two HEIAs for the Applicant at the same time. One is this project under the Conflict of Interest form and the second is the relocation of its neurology practice submitted under a separate HEIA and CON Application.

Section 4 – Attestation

I, Katelyn Michaud (individual name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of Crescendo (INDEPENDENT ENTITY), do hereby attest that the Health Equity Impact Assessment for project ADK Urgent Care / Pulmonary (PROJECT NAME) provided for Saratoga Hospital (APPLICANT) has been conducted in an independent manner and without a conflict of interest as defined in Title 10 NYCRR § 400.26.

I further attest that the information provided by the INDEPENDENT ENTITY in the Health Equity Impact Assessment is true and accurate to the best of my knowledge, and fulfills the intent of the Health Equity Impact Assessment requirement.

Signature of Independent Entity: [redacted]

Date: 07/31/2024

Removal of Primary Care Services from 959 US Rt 9, Queensbury (CON 4501000H, facility ID 10351. Move of Queensbury Pulmonary practice currently located at 161 Carey Road, Queensbury (CON 4501000H, facility ID 10395), into the vacated space at 959 US Rt 9 from

Please note that the Urgent Care Practice is closing. The Pulmonary Clinic is not closing, just moving into the space vacated by Adirondack Urgent Care. There will be no interruption of services or changes in staffing for the Pulmonary practice.

- Notification to DOH
  - *Filed CON application to notify the DOH of the practice moving*
- Anticipated Closure date
  - *Closure of Adirondack Urgent Care anticipated for 10/31/2024*
  - *No closure of Pulmonary service. Anticipated date of relocation is 12/8/24*
- Number and types of patients and facility staff affected
  - Pulmonary Clinic
    - *3838 unique patients – no patients will be affected*
    - *7 current staff members, no staff will be affected*
  - Adirondack Urgent Care
    - *11,267 unique patients (August 2022 thru July 2024) – These patients will still be able to seek urgent or emergent care at one of the current local providers, (WellNow Glens Falls, WellNow Queensbury, Hudson Headwaters Health Center in Glens Falls, GFH Emergency room)*
    - *Staff members*
      - *2 Medical Providers – staying within Saratoga Hospital (TSH)*
      - *1 Practice manager/X-ray technician – staying within Albany Med Health System (AMHS), she has accepted a position at Glens Falls Hospital (GFH)*
      - *2 Registered Nurses*
        - *1st has accepted another position within TSH*
        - *2nd is actively working with TSH HR to find another position*
      - *2 Per Diem X-ray technicians has been offered per diem positions within TSH*
      - *2 F/T Patient Access staff*
        - *1st has accepted a position within AMHS, transitioning to GFH*
        - *2nd is working with HR ant TSH to find another position*
      - *1 F/T Phlebotomist – staying with TSH, transferring to another TSH outpatient location*
      - *2 F/T Patient Care Technicians*
        - *1st is retiring*
        - *2nd is transitioning to another position at TSH*

- Contracts/Grants
    - *None*
- Proposed schedule for phases of closing
    - *Close Adirondack Urgent Care on 10/31/2024, move Pulmonary practice into the space on or about 12/8/2024*
- Dates admission will be discontinued
    - *N/A*
- Plan to ensure adequate staffing
    - *No staffing changes*
- Payroll/Health Insurance
    - *No changes in payroll or health insurance*
- Facility Contact person
    - *No change in contact person*
- Identification to nearest alternate facility
    - *There are multiple Urgent Care centers in the area including:*
        - *WellNow Urgent Care (920 US Rt 9, Queensbury, NY)*
        - *Hudson Headwaters Health Center on Broad Street – Urgent Care (100 Broad Street, Glens Falls)*
        - *Wellnow Urgent Care (202 Broad Street, Glens Falls)*
- Notification to patients and staff
    - *Patients will be sent a letter to be notified of the closure of the Urgent Care center and the relocation of the Pulmonary Practice to 959 US Rt 9, Queensbury from current location as soon as relocation is approved.*
    - *Staff have already been notified of relocation*
- Notification to community and elected officials
    - *As part of our Health Equity Impact Assessment the Hospital is letting many community stakeholders know of the Urgent Care closure and the Pulmonary relocation. Stakeholders include but are not limited to:*
        - *Local Urgent Care centers and Hospitals*
        - *County Public Health*
        - *County Office for the Aging*
        - *Local School Districts*
        - *County Youth Bureau*
- Copies of draft notification letters

- Patient Notification Information
    - *Patients of the Pulmonary practice to be relocated to new location at 959 US 9, Queensbury, NY*
    - *Patients communication will include emails and written notification of the relocation as appropriate*
    - *No changes to patients medical records*
    - *No changes to patient access of care*
- Media/Communications plan
    - *External communications will include press release, targeted social media posts, home page content, and coverage in business community communications and print advertising as appropriate*
- Placement of signs at facility regarding closure and include contact #
    - *Internal signage to be displayed internally at the current Pulmonary location to announce the relocation to 959 US 9, Queensbury, NY including, map, dates and directions*
- Provisions for proper maintenance, storage, retrieval of medical records
    - *Medical records For Pulmonary practice will be relocated to new location following Saratoga Hospital guidelines*
    - *Medical records from Urgent Care will be archived following Saratoga Hospital guidelines*
- Proper disposal of medications and supplies
    - *All Pulmonary practice medication and supplies will be relocated to the new location following Saratoga Hospital guidelines*
    - *All medication and supplies from Urgent Care will be evaluated by the appropriate department and re-allocated as directed by that department*
- Disposition of building and contents after closure
    - *Building at 959 US 9 is being leased therefore no disposition of building*
    - *The current pulmonary space will continue to be leased, with satellite practice(s) of existing Hospital practices filling the space.*
- Maintenance of all records as required by federal, state, and local laws and regulations
    - *N/A*

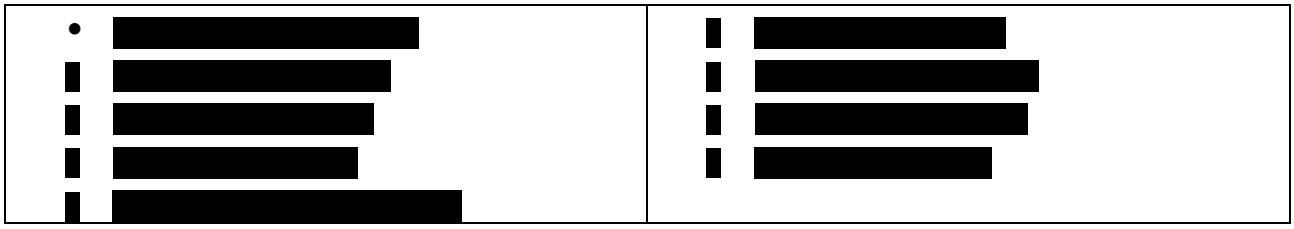
ALBANY MED Health System

SARATOGA HOSPITAL
Medical Group

October 1, 2024

Dear Patient:

It is with great pleasure to share with you that Queensbury Pulmonology at Carey Road is moving to a new location. As of Monday, November 18th, 2024 the practice will be relocated to a new space at **959 US 9, Queensbury, NY**. This includes office visits previously performed at 161 Carey Road by:



You can expect to receive the same care from the same group of caring professionals at their new location.

As of November 18th, all appointments will be scheduled at the practice location listed below.

Queensbury Pulmonology
959 US Route 9, Queensbury, NY
518-886-5880

On the reverse side of this letter is a map to help you arrive at this new facility as easily as possible. We very much appreciate having you as a patient and we are working hard to make sure this transition is as seamless as possible.

If you have any questions about this move and/or your upcoming appointment, please do not hesitate to call the office at 518-886-5880. Thank you!

Sincerely,

Queensbury Pulmonary