Executive Summary

NYU Langone Hospital is submitting this Administrative Review Certificate of Need application for the consolidation of its Transplant services to a central location. NYU Langone Hospital is certified to provide the following transplant services:

- Transplant-Bone Marrow
- Transplant -Heart-Adult
- Transplant-Heart-Pediatric
- Transplant-Kidney
- Transplant-Liver

Currently, patients access Transplant services at the following locations:

- NYU Langone Rivergate Transplant Clinic located at 401 East 34th Street, New York, NY 10016. This Article 28 Extension Clinic is licensed to provide Medical Services-Primary Care.
- NYU Langone Rivergate Transplant Extension Clinic located at 317 East 34th Street, 8th floor, New York, NY 10016. This Article 28 Extension Clinic is licensed to provide Medical-Services-Primary Care.
- NYU Langone Hospital's main campus at 550 First Avenue, New York, NY 10016.

The Transplant Institute aims to consolidate transplant services for liver, lung and heart under one umbrella in a central location, the 3rd floor of the Schwartz Health Care Center (HCC) on NYU Langone Hospital's Manhattan campus (550 First Avenue, New York, NY 10016). The Transplant Institute will provide transplant patients and donors with comprehensive education, support, and screening programs. HCC is currently a mixed-use building and the NYU Langone Health Transplant Institute space will be an Article 28 Facility.

The proposed scope of work consists of approximately 12,772 departmental square feet that will be fully renovated to accommodate the new program. The Transplant program will consist of the following components:

- Patient waiting and reception
- (18) exam rooms
- (1) pulmonary function tests room (PFT)
- (3) phlebotomy stations
- (1) vital signs assessment alcoves
- (1) admin/nurse station with (4) positions
- Clean supply, soiled holding, environment services closet, and storage room

- (9) physician offices, (2) physicians shared offices, (1) MD touchdown (2) MA Touchdowns, (2) Staff Touchdown, (2) Admin. rooms, (1) Admin. shared room, (2) Medical Director's Offices, (1) Staff Workroom, (1) Education.
- (1) Research Lab, (1) Lab Storage
- Staff lounge and lockers
- (2) public toilets, (4) patient toilets, (2) staff toilets

Please note that a Health Equity Impact Assessment has been prepared and will be submitted in support of this Administrative Review Certificate of Need application. Also, please note that the Dormitory Authority of the State of New York (DASNY) will review the architectural components of this application.

Schedule 1
All CON Applications

Contents:

- **Acknowledgement and Attestation**
- **General Information**
- **Contacts**
- **Affiliated Facilities/Agencies**

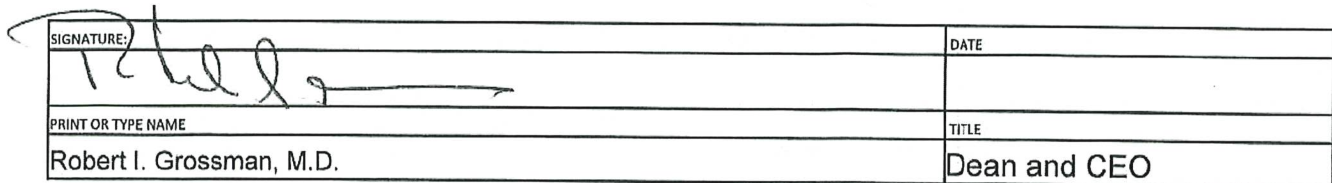
New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: NYU Langone Hospital

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and implementing regulations, as applicable.



SIGNATURE:	DATE
PRINT OR TYPE NAME	TITLE
Robert I. Grossman, M.D.	Dean and CEO

General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project.	YES ☒ NO ☐	
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES ☒ NO ☐	

Contacts

The Primary and Alternate contacts are the only two contacts who will receive email notifications of correspondence in NYSE-CON. ***At least one of these two contacts should be a member of the applicant.*** The other may be the applicant's representative (e.g., consultant, attorney, etc.). What is entered here for the Primary and Alternate contacts should be the same as what is entered onto the General Tab in NYSE-CON.

Primary Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Shari Liss, Director Strategy Planning and Bus. Development	NYU Langone Health	
BUSINESS STREET ADDRESS		
One Park Avenue, Rm. 4-402		
CITY	STATE	ZIP
New York	New York	10016
TELEPHONE	E-MAIL ADDRESS	
212 404-3882	Shari.liss@nyulangone.org	

Alternate Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Christopher Panettieri, Senior manager	NYU Langone Health	
BUSINESS STREET ADDRESS		
One Park Avenue, Rm. 4-483		
CITY	STATE	ZIP
New York	New York	10016
TELEPHONE	E-MAIL ADDRESS	
212 263-3492	Christopher.panettieri@nyulangone.org	

New York State Department of Health
Certificate of Need Application

Schedule 1

The applicant must identify the operator's chief executive officer, or equivalent official.

CHIEF EXECUTIVE

NAME AND TITLE		
Robert I. Grossman, M.D., Dean and CEO		
BUSINESS STREET ADDRESS		
550 First Avenue		
CITY	**STATE**	**ZIP**
New York	New York	
TELEPHONE	**E-MAIL ADDRESS**	
(212) 263-5000	N/A	

The applicant's lead attorney should be identified:

ATTORNEY

NAME	FIRM	BUSINESS STREET ADDRESS
Annette Johnson, Esq.	NYU Langone Health	550 First Avenue
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**
New York, NY 10016	212 263-7921	Annette.johnson@nyumc.org

If a consultant prepared the application, the consultant should be identified:

CONSUTANT

NAME	FIRM	BUSINESS STREET ADDRESS
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**

The applicant's lead accountant should be identified:

ACCOUNTANT

NAME	FIRM	BUSINESS STREET ADDRESS
Michelle Ulrich	NYU Langone Health	One Park Avenue, 6th Floor
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**
New York, New York 10016	212 404-4159	Michelle.ulrich@nyulangone.org

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER

NAME	FIRM	BUSINESS STREET ADDRESS
Louis Meilink, Jr.	Ballinger	833 Chestnut St., Ste. 1400
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**
Philadelphia, PA 19107	215-446-0900	lmeilink@ballinger.com

ARCHITECT and/or ENGINEER

NAME	FIRM	BUSINESS STREET ADDRESS
Chris Prochner	Jaros, Baum & Bolles	80 Pine Street
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**
New York, NY 10005	212-530-9300	prochnerc@jbb.com

Other Facilities Owned or Controlled by the Applicant

Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

Does the applicant legal entity or any related entity (parent, member or subsidiary corporation) operate or control any of the following in New York State?

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE	
Hospital	HOSP	Yes ☒ No ☐
Nursing Home	NH	Yes ☐ No ☐
Diagnostic and Treatment Center	DTC	Yes ☒ No ☐
Midwifery Birth Center	MBC	Yes ☐ No ☐
Licensed Home Care Services Agency	LHCSA	Yes ☐ No ☐
Certified Home Health Agency	CHHA	Yes ☐ No ☐
Hospice	HSP	Yes ☐ No ☐
Adult Home	ADH	Yes ☐ No ☐
Assisted Living Program	ALP	Yes ☐ No ☐
Long Term Home Health Care Program	LTHHCP	Yes ☐ No ☐
Enriched Housing Program	EHP	Yes ☐ No ☐
Health Maintenance Organization	HMO	Yes ☐ No ☐
Other Health Care Entity	OTH	Yes ☐ No ☐

Upload as an attachment to Schedule 1, the list of facilities/agencies referenced above, in the format depicted below:

Facility Type	Facility Name	Operating Certificate or License Number	Facility ID (PFI)

Out-of-State Affiliated Facilities/Agencies

In addition to in-state facilities, please upload, as an attachment to Schedule 1, a list of all health care, adult care, behavioral, or mental health facilities, programs or agencies located outside New York State that are affiliated with the applicant legal entity, as well as with parent, member and subsidiary corporations, in the format depicted below.

Facility Type	Name	Address	State/Country	Services Provided

In conjunction with this list, you will need to provide documentation from the regulatory agency in the state(s) where affiliations are noted, reflecting that the facilities/programs/agencies have operated in substantial compliance with applicable codes, rules and regulations for the past ten (10) years (or for the period of the affiliation, whichever is shorter). More information regarding this requirement can be found in Schedule 2D.

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

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

3.1		
	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:	

<table>
<tr><td rowspan="10"></td><td>Address:</td><td colspan="3"></td></tr>
<tr><td>State and Zip Code:</td><td colspan="3"></td></tr>
<tr><td>E-Mail Address:</td><td colspan="3"></td></tr>
<tr><td>Phone Number:</td><td colspan="3"></td></tr>
<tr><td>Agency Name:</td><td colspan="3"></td></tr>
<tr><td>Contact Name:</td><td colspan="3"></td></tr>
<tr><td>Address:</td><td colspan="3"></td></tr>
<tr><td>State and Zip Code:</td><td colspan="3"></td></tr>
<tr><td>E-Mail Address:</td><td colspan="3"></td></tr>
<tr><td>Phone Number:</td><td colspan="3"></td></tr>
<tr><td rowspan="7">3.2</td><td colspan="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.</td><td>Yes
☐</td><td>No
☒</td></tr>
<tr><td>Agency Name:</td><td></td><td></td><td></td></tr>
<tr><td>Contact Name:</td><td></td><td></td><td></td></tr>
<tr><td>Address:</td><td></td><td></td><td></td></tr>
<tr><td>State and Zip Code:</td><td></td><td></td><td></td></tr>
<tr><td>E-Mail Address:</td><td></td><td></td><td></td></tr>
<tr><td>Phone Number:</td><td></td><td></td><td></td></tr>
<tr><td>3.3</td><td colspan="2">Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.</td><td>Yes
☐</td><td>No
☒</td></tr>
<tr><td>Part IV.</td><td colspan="2">Storm and Flood Mitigation</td><td></td><td></td></tr>
<tr><td rowspan="2"></td><td colspan="2">Definitions of FEMA Flood Zone Designations</td><td></td><td></td></tr>
<tr><td colspan="2">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.</td><td></td><td></td></tr>
<tr><td></td><td colspan="2">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.</td><td>Yes</td><td>No</td></tr>
<tr><td rowspan="5">4.1</td><td colspan="2">Is the proposed site located in a flood plain? If Yes, indicate classification below and provide the Elevation Certificate (FEMA Flood Insurance).</td><td>☐</td><td>☒</td></tr>
<tr><td colspan="2">Moderate to Low Risk Area</td><td>Yes</td><td>No</td></tr>
<tr><td>Zone</td><td>Description</td><td>☒</td><td>☐</td></tr>
<tr><td colspan="2">In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:</td><td></td><td></td></tr>
<tr><td>B and X</td><td>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.</td><td>☐</td><td></td></tr>
</table>

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

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

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

http://www.fema.gov/media-library-data/20130726-1437-20490-3457/f_053_elevationcertificate_jan13.pdf

Schedule 6 - CON Form Regarding Architectural/Engineering Submission

Contents:

- **Schedule 6 – Architectural/Engineering Submission**

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

Schedule applies to all projects with construction, including Articles- 28, 36 & 40, i.e., Hospitals, D&TCs, RHCFs, CHHAs, LTHHCPs and Hospices.

Instructions

- Provide Narrative using format below.
- Provide Architect/Engineering Certification Form
  List of Architectural or Engineering Certification Forms
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Full Review Projects, 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 BFE Certificate 11Feb2020.pdf
- Functional Space Program: A record of the key environment of care considerations and facility functional and operational parameters that drive the space program for a project. Note: The governing body or its delegate develops the functional program, which is intended to inform the designers of record, authority having jurisdiction, and users of the facility. The size and complexity of the project will determine the length and complexity of the functional program.
- Provide Architecture/Engineering Drawings in PDF format for review. Refer to Electronic Review Guidance Document for instructions for providing drawings for CON review.
- Provide Physicist's Report and the supporting information including drawings, details and supporting information.
  - Physicist's Letter of Certification (PDF)
- Required attachments must be submitted as separate documents and labeled accordingly.
- If any of the attachments require to be updated, provide an updated Schedule 6 form with the revised dates indicated on the form, in the date column.
- Do not combine the narrative, A/E Cert Form and FEMA BFE Certificate into one document.
- Refer to the Contingent Approval or Contingency Satisfaction for Submission Table requirements listed below.

Format

- Refer to "NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews" located on the NYSDOH Website. (Drawing files less than 100 MB can be uploaded into one file and bookmarked in PDF format.)

"Architecture/Engineering Narrative"

Narrative shall include but not limited to the following information. Please address all items in the narrative located in the response column. Incomplete responses will not be accepted.

Description	
Original Schedule 6 Date:12/8/2023	Revised Schedule 6 Date: Click or tap to enter a date.
Has this project received Contingent Approval or State Hospital Code Approvals? No	If so, what is the original CON number? Click or tap here to enter text.

New York State Department of Health Certificate of Need Application

Schedule 6

Intent/Purpose:	
Site Location: 3rd floor of the existing Schwartz Health Care Center (HCC) on the main NYU Langone Health campus, 550 First Avenue, New York, NY 10016.	
Brief description of current facility, including Facility Type: The HCC Building is a mixed-use 270,000 SF fifteen story high-rise building with healthcare and business occupancies. The space is an existing business occupancy consisting of doctor's offices of approximately 10,542 departmental gross square feet that will relocate to another floor within this building.	
Brief description of proposed facility: The proposed work consists of approximately 12,772 departmental gross square feet of the 16,192-floor gross square footage 3rd floor of the existing HCC Building that will be fully renovated to accommodate the new business occupancy program, which is less than 50% of the building area	
Location of proposed spaces or spaces. (Occupancy type for each occupied space.) Business Occupancy	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Please describe the required smoke and fire separations between occupancies: This floor will be Business Occupancy with incidental use spaces. This floor is separated from other floors and occupancies with 2-hour fire-rated construction.	
If this is an existing facility, is it currently a licensed Article 28 Facility?	Yes
Is this facility being converted from a Non-Article 28 Facility to an Article 28 Facility.	No
Relationship of spaces conforming with Article 28 space and Non-Article 28 space: Non-Article 28 Spaces are located on separate floors within the facility and are separated by 2 Hour fire-rated construction	
List all Exceptions to the NYSDOH referenced standards. (Also, to be noted on the exceptions portion of the Architecture/Engineering Certification Form. No Exceptions	
List all Requests for equivalencies. (Also, to be noted on the exceptions portion of the Architecture/Engineering Certification Form. No equivalencies are noted.	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. Click or tap here to enter text.	Choose an item. Yes
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, fire protection, plumbing, etc. The floors will be served by two central air handling units located on the 8th floor that have been replaced and upgraded. The existing supply and return ductwork which serves the existing risers will be removed and replaced to accommodate the new air flows. All existing induction units on the floors will be removed.	
Describe scope of work involved in building system upgrades and or replacements, fire protection systems, HVAC systems, Sprinkler, etc. The air conditioning supply air to the 3rd floor will be a medium pressure, variable volume, minimum outdoor air system. Each VAV zone will be provided with a dedicated supply VAV box with reheat coil. Spaces with pressurization requirements will be provided with ducted supply and ducted exhaust to maintain pressurization. Working in tandem with the VAV box, there will be hot water finned tube convectors installed at the perimeter of each elevator lobby/waiting area. All existing induction units on the floors will be removed. The Toilet Rooms will be exhausted directly to the out of doors via dedicated vertical toilet exhaust duct risers and connected to the suction side of the TX fan located in the 8th Floor Mechanical Room.	
Fire Detection, Alarm and Communication System:	

Describe existing system: The building is equipped with an existing individually coded fire alarm system with the main Fire Alarm Control Panel located in the building lobby.	
Fire Detection, Alarm and Communication System: Describe proposed system: New fire alarm devices consisting of audible and visual signals (speaker strobes), area smoke detectors, fan system smoke detectors, elevator smoke detectors, manual pull stations and fire warden stations will be connected to the existing fire alarm system.	
Is the work involved associated with a waiver provided by NYSDOH and or CMS? No If yes, provide waiver number. Click or tap here to enter text.	
Provide a FEMA BFE Certificate from the FEMA website link www.fema.gov if located in a flood zone. (Applies only to Hospitals and Nursing Homes) What type of work will be associated to mitigate damage and provide the ability to maintain operations if located in a Flood Zone? This work has been completed to maintain the existing Article 28 occupancy	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe equipment. No.	
If yes, provide Physicist's Report and the respective drawings and information shall be submitted for review at the Design Development phase of review.	
Compliance with ADA. List any areas of noncompliance. Click or tap here to enter text.	
Any other additional information? Click or tap here to enter text.	
Description	**Response**
Type of Work:	Alteration
Square footages of existing areas of work, existing floor and or existing building.	Existing Floor: 14,685 SF
Square footages of the proposed work area or areas. Provide the total aggregated sum of the work area	Proposed area: 12,772 SF
Does the area of work exceed more than 50% of the area, floor or building?	Less than 50%
Square Footage of Proposed Spaces.	12,772 SF
Sprinklered	Will be sprinklered as part of the work.
Construction Types for the Existing Building and or Proposed Building (NFPA 101 per occupancy, NFPA 220)	Type 1 (332)
Building Height	202'-0"
Number of Stories	15
Is the proposed Article 28 space located in a basement or underground building?	Not Applicable
Is the proposed Article 28 space windowless space, area or building?	No
Is the building a High Rise?	Yes
Does the high-rise building have a generator?	Yes
What is the occupancy of this project per NFPA 101 Life Safety Code Handbook?	Chapter 38 Business/ Chapter 39 Existing Business
List other occupancies types that are adjacent or within this facility: Healthcare, Business, Ambulatory Healthcare, Storage Ensure those spaces are designated on the plans.	
Will the project construction be phased?	No
If yes, how many phases and what is the duration for each phase? Click or tap here to enter text.	
Does the project contain shell space?	No
Describe propose shell space. Identified Article 28 Shell Space and Non-Article 28 Space. Click or tap here to enter text.	
Will spaces be temporarily relocated during the construction of this project.	No
If yes, where will the temporary space be? Click or tap here to enter text.	

Question	Response
Does the temporary space meet the current DOH referenced standards?	Not Applicable
Will spaces be permanently relocated to allow the construction of this project. If yes, where will this space be? Another floor within this building	Yes
Does the proposed temporary space meet the current DOH referenced standards? If no, please describe in detail how the space does not comply.	Not Applicable
Is there a companion CON associated with the temporary space? If so, provide the associated CON number. Click or tap here to enter text.	Not Applicable
Which edition of FGI is being used for this project?	2018 Edition of FGI
Changes in bed capacity? If yes, please describe. Click or tap here to enter text.	Not Applicable
Changes in the number of occupants? If yes, what is new number of occupants? Click or tap here to enter text.	No
Does the facility have an EES system? If yes, what type? Type 1	Yes
Is the existing EES Type 1 and does it meet the current referenced standards?	Yes
Does the project involve Operating Room alterations, renovations or rehabilitation? Click or tap here to enter text.	No
Does the existing EES system have the capacity for the additional electrical loads? Click or tap here to enter text.	Yes
Does the Project involve Bulk Oxygen Systems? If yes, provide brief description. Click or tap here to enter text.	No
Does the existing Bulk Oxygen System have the capacity for additional loads for without bringing in additional supplemental systems? Click or tap here to enter text.	Yes
Does the project involve a pool?	No

New York State Department of Health Certificate of Need Application

Schedule 6

REQUIRED ATTACHMENT TABLE			
CONTINGENT APPROVAL	CONTINGENCY APPROVAL	Title of Attachment	Attachment File Name in PDF format
•	•	Architectural/Engineering Narrative	A/E Narrative.PDF
•	•	Functional Space Program	SpaceProgram.PDF
•	•	Architect/Engineer Certification Form	A/E Cert Form. PDF
•	•	FEMA BFE Certificate	FEMA BFE Certificate.PDF
•	•	Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Code Plans (Floor plans and reflected ceiling plans.)	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans and Details	A400.PDF
Optional	•	Wall Sections and Details	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 Report and the respective drawings and information	X100.PDF

NYU Langone Health

HCC 3rd Floor
Transplant Institute

3rd Floor Program

Space	NSF	Current Plan Qty	Subtotal	Remarks
Public Spaces				
Reception / Check-In / Scanning	70	4	280	4 staff + 4 self-check-in
Waiting + Pantry	25	40	1000	2.2 seats per exam room
Check-Out	50	4	200	4 stations + waiting
Public Toilet	55	2	110	
Storage / Wheel Chairs	20	1	20	
Subtotal		NSF	**1,610**	
	1.50	DGSF	**2,414**	
Clinical Spaces				
Exam Rooms	115	15	1725	
Exam Room (Flex / Infusion)	115	2	230	
Exam Room (LVAD)	115	1	115	
PFT Room	115	1	115	
Height/Weight Alcove	30	1	30	
Crash Cart	30	1	30	
Phlebotomy	50	3	150	
Nourishment	40	1	40	Required for Infusion
Equipment Alcove	30	1	30	
MA Touchdown	115	2	230	6 TD stations per room
Soiled Holding	55	1	55	
Clean Supply	110	1	110	
Patient Toilet	55	4	220	
Tank Storage	10	1	10	
Subtotal		NSF	**3,090**	
	1.50	DGSF	**4,632**	
Faculty + Staff Workspaces				
MD Private Office	105	9	945	
MD Shared Office (2/office)	105	3	315	
MD Touchdown	105	1	105	Sofa + computer station
Admin Private Office	105	1	105	
Admin Shared Office (2/office)	105	1	105	
Manager Office	80	1	80	
Admin Workroom	60	4	240	
Staff Touchdown	115	2	230	3-4 TD stations per room
Director's Suite				
Medical Director	190	1	190	Montgomery
Medical Director	120	1	120	Mehta
Admin / Reception	140	1	140	2 workstations + waiting
Alcove	30	1	30	
Research Lab	220	1	220	
Research Staff Workroom	110	1	110	2-3 workstations
Research Storage	60	1	60	
Subtotal			**2,995**	
	1.50	DGSF	**4,490**	
Shared Spaces				
Education	220	1	220	10-12 at table, 1 facilitation
Consult / Multipurpose	120	0	0	Confirm Consult vs Office
Conference	240	1	240	10 at table
Staff Lounge	230	1	230	
Staff Toilet	50	2	100	
Lockers	20	1	20	(24) Lockers in Corridor
Housekeeping	15	1	15	Existing
Subtotal		NSF	**825**	
	1.50	DGSF	**1,237**	

3rd Floor Total

Total Net Square Feet	**8,520**	
Total Department Gross Square Feet	**12,772**	
Floor Gross Square Feet	**15,965**	**1.25**
Floor Gross Square Feet Available	15,986	
Over (Under)	**(21)**	

ballinger

12/15/2023

Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS
ARCHITECTS & ENGINEERS

(For projects not meeting the prerequisites for Self-Certification submission.)

Date:
CON Number:
Facility Name:
Facility ID Number:
Facility Address:

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, including drawings and specifications for the aforementioned project. During the course of construction, periodic site observation visits will be performed, and the necessary standard of care, noting progress, quality and ensuring conformance of the work with documents provided for all regulatory approvals associated with the aforementioned project.

2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed, in accordance with the functional program for the referenced construction project and in accordance with any project definitions, waivers or revisions approved or required by the New York State Department of Health.

3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations, and the applicable provisions of the State Hospital Code -- 10 NYCRR Part 711 (General Standards for Construction) and Parts (check all that apply):

   a. X 712 (Standards of Construction for General Hospital Facilities)
   b. __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:

   ____

   ____

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: NYU Langone HCC Renovations - Transplant Institute

Location: 550 First Avenue, New York, NY 10016

Description: Relocation of outpatient transplant institute to the third floor of the Schwartz HCC building.

Architectural or Engineering Professional Stamp

Signature of Architect or Engineer

Louis A. Meilink, Jr.
Name of Architect or Engineer (Print)

031163-1
Professional New York State License Number

833 Chestnut St., Suite 1400, Philadelphia, PA 19107
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.

Authorized Signature for Applicant

Date

Robert I. Grossman Dean & CEO
Name (Print) Title

Notary signing required for the applicant

STATE OF NEW YORK)
) SS:
County of New York)

On the 11 day of 3 2024, before me personally appeared Robert Grossman, to me known, who being by me duly sworn, did depose and say that he/she is the Dean & CEO of the NYU Langone Health, 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)

MICHELLE KARELL
NOTARY PUBLIC-STATE OF NEW YORK
No. 01KA6352365
Qualified in Queens County
My Commission Expires 12-27-2024

New York State Department of Health
Certificate of Need Application
Schedule 8A Summarized Project Cost and Construction Dates

This schedule is required for all Full or Administrative review applications except Establishment-Only applications.

1.) Project Cost Summary data:

	Total	Source
Project Description:		
Project Cost	$21,771,730	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$21,771,730	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$996,730	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	N/A	Schedule 10
Cost/Per Square Foot for Renovation Construction	$1,112	Schedule10
Total Operating Cost		Schedule 13C, column B
Amount Financed (as $)		Schedule 9
Percentage Financed as % of Total Cost		Schedule 9
Depreciation Life (in years)		

2) Construction Dates

Anticipated Start Date	5/1/2024	Schedule 8B
Anticipated Completion Date	9/1/2025	

New York State Department of Health
Certificate of Need Application
Schedule 8B - Total Project Cost - For Projects without Subprojects.

This schedule is required for all Full or Administrative review applications except Establishment-Only applications

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	10.00%	Normally 10%
Construction Contingency - Renovation Work	10.00%	Normally 10%
Anticipated Construction Start Date:		as mm/dd/yyyy
Anticipated Midpoint of Construction Date		as mm/dd/yyyy
Anticipated Completion of Construction Date		as mm/dd/yyyy
Year used to compute Current Dollars:		

Subject of attachment	Attachment Number	Filename of attachment - PDF
For new construction and addition, at the schematic stage the design contingency will normally be 10% and the construction contingency will be 5%. If your percentages are otherwise, please explain in an attachment.		
For renovation, the design contingency will normally be 10% and the construction contingency will be 10%. If your percentages are otherwise, please explain in an attachment.		

	A	B	C
Item	**Project Cost in Current Dollars**	**Escalation amount to Mid-point of Construction**	**Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$14,200,000	$0	$14,200,000
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$500,000	$0	$500,000
3.1 Design Contingency	$1,420,000	$0	$1,420,000
3.2 Construction Contingency	$1,420,000	$0	$1,420,000
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$75,000	$0	$75,000
4.3 Architect/Engineering Fees	$1,050,000	$0	$1,050,000
4.4 Construction Manager Fees	$40,000	$0	$40,000
4.5 Other Fees (Consultant, etc.)	$470,000	$0	$470,000
Subtotal (Total 1.1 thru 4.5)	$19,175,000	$0	$19,175,000
5.1 Movable Equipment (from Sched 11)	$996,730	$0	$996,730
5.2 Telecommunications	$1,600,000	$0	$1,600,000
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$21,771,730	$0	$21,771,730
7.1 Financing Costs (Points etc)	$0		$0
7.2 Interim Interest Expense:: $ [ ] At [ ] % for [ ] months	$0		$0
8. Total Project Cost: w/o CON fees Total 6 thru 7.2	$21,771,730	$0	$21,771,730
Application fees: 9.1 Application Fee. Articles 28, 36 and 40. See Web Site.	$2,000		$2,000
9.2 Additional Fee for projects with capital costs. Not applicable to "Establishment Only" projects. See Web Site for applicable fees. (Line 8, multiplied by the appropriate percentage.) Enter Multiplier ie: .25% = .0025 --> 0.003	$65,315	$0	$65,315
10 Total Project Cost with fees	$21,839,045	$0	$21,839,045

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 43). Codes for completing this table are found in the Functional Codes Lookups sheet (see tab below).

Indicate if this project is: New Construction: [ ] **OR** Renovation: [X]

A		B	D	E	F	G	H	I
Location								
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
	1463	3	704	General Baseline (Includes Medical Staff)	12772	$1,111.81	$14,200,000	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**12772**	**1112**	**14200000**	

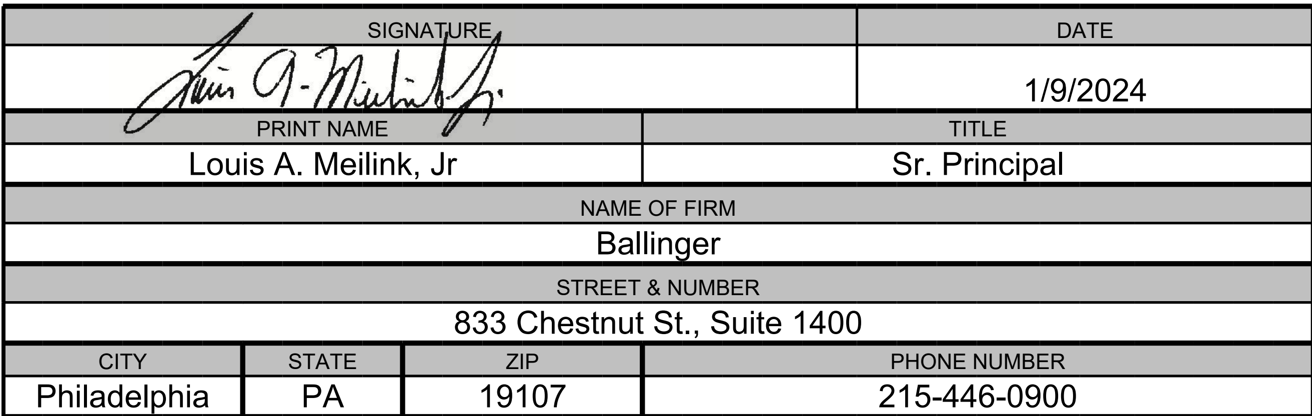
New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

If additional sheets are necessary, go to the toolbar, select "Edit", select "Move or copy sheet", make sure the "create a copy" box is checked, and select this document as the destination for the copy then select "OK". An additional worksheet will be added to this spreadsheet

	YES	NO
1. If New Construction is Involved, is it "freestanding?	☐	☐

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	X	☐	☐

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,



SIGNATURE			DATE
[signature]			1/9/2024
PRINT NAME			TITLE
Louis A. Meilink, Jr			Sr. Principal
NAME OF FIRM			
Ballinger			
STREET & NUMBER			
833 Chestnut St., Suite 1400			
CITY	STATE	ZIP	PHONE NUMBER
Philadelphia	PA	19107	215-446-0900

New York State Department of Health
Certificate of Need Application
Schedule 11 - Moveable Equipment
For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review *

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
		Please see attached.				
Total lease and purchase costs: Subproject 1						
Total lease and purchase costs: Subproject 2						
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						
Total lease and purchase costs: Subproject 5						
Total lease and purchase costs: Subproject 6						
Total lease and purchase costs: Subproject 7						
Total lease and purchase costs: Subproject 8						
Total lease and purchase costs: Whole Project:						0

New York State Department of Health
Certificate of Need Application
Schedule 11 - Moveable Equipment

Table 2 - Equipment being replaced:

List only equipment that is being replaced on a one for one basis. On the first line list the new equipment. On the second line list the equipment that is being replaced.

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Disposition	Estimated Current Value
				Total estimated value of equipment being replaced: Subproject 1	
				Total estimated value of equipment being replaced: Subproject 2	
				Total estimated value of equipment being replaced: Subproject 3	
				Total estimated value of equipment being replaced: Subproject 4	
				Total estimated value of equipment being replaced: Subproject 5	
				Total estimated value of equipment being replaced: Subproject 6	
				Total estimated value of equipment being replaced: Subproject 7	
				Total estimated value of equipment being replaced: Subproject 8	
				Total estimated value of equipment being replaced: Whole Project:	0

Location	Floor	Room Type	Qt	Furniture Item	Qt	Unit Cost	Extended	Totals
530 First Av	3	Private Office	11	Desk with returns	1	$5,500.00	$5,500.00	
				Task chair	1	$850.00	$850.00	
				Overhead	2	$800.00	$1,600.00	
				Lateral File	1	$700.00	$700.00	
				Wardrobe	1	$1,000.00	$1,000.00	
				Guest Chairs (wood)	2	$850.00	$1,700.00	
						Total	$11,350.00	$124,850.00
		Shared Office	4	Desk	2	$4,000.00	$8,000.00	
				Task chair	2	$800.00	$1,600.00	
				Overhead	2	$800.00	$1,600.00	
				Wardrobe	1	$1,200.00	$1,200.00	
				Guest Chairs (wood)	1	$850.00	$850.00	
						Total	$13,250.00	$53,000.00
		Shared Admin/EA	1	Desk	2	$4,000.00	$8,000.00	
				Task chair	2	$800.00	$1,600.00	
				Overhead	2	$800.00	$1,600.00	
				Guest Chairs (wood)	1	$850.00	$850.00	
						Total	$12,050.00	$12,050.00
		Medical Director Office	1	Desk with returns	1	$5,500.00	$5,500.00	
				Task chair	1	$800.00	$800.00	
				Overhead	2	$800.00	$1,600.00	
				Wardrobe	1	$1,200.00	$1,200.00	
				Guest Chairs (wood)	4	$850.00	$3,400.00	
				Lateral File	1	$800.00	$800.00	
				Table	1	$1,000.00	$1,000.00	
						Total	$14,300.00	$14,300.00
	3	Conference Room	1	Conference Table	1	$7,000.00	$7,000.00	
				Credenza	1	$5,500.00	$5,500.00	
				Side Chairs	4	$800.00	$3,200.00	
				Conference Chairs	10	$950.00	$9,500.00	
						Total	$25,200.00	$25,200.00
		Consult Room	1	Conference Table	1	$1,000.00	$1,000.00	
				Conference Chairs	4	$950.00	$3,800.00	
						Total	$4,800.00	$4,800.00
		Education	1	Tables	4	$1,800.00	$5,400.00	
				Chairs	4	$1,000.00	$4,000.00	
				Chairs	12	$650.00	$7,800.00	
				Recycle Station	1	$1,000.00	$1,000.00	
				Charging station	1	$1,000.00	$1,000.00	
						Total	$19,200.00	$19,200.00
		Waiting Area	1	Side table	12	$800.00	$9,600.00	
				Small Table	15	$700.00	$10,500.00	
				Chairs	14	$1,000.00	$14,000.00	
				Tandum seating	44	$900.00	$39,600.00	
				Recycle Station	2	$1,000.00	$2,000.00	
				Charging station	2	$1,000.00	$2,000.00	
						Total	$77,700.00	$77,700.00
		Reception/Check-In	1	Task chair	4	$800.00	$3,200.00	
				Pedestal	4	$550.00	$2,200.00	
						Total	$5,400.00	$5,400.00

		Workstations	1	Workstation	5	$4,000.00	$20,000.00	
		Behind reception		Task chair	5	$800.00	$4,000.00	
						Total	$24,000.00	$24,000.00
		Check in Check out	1	Workstation	4	$3,200.00	$12,800.00	
				Task chair	4	$800.00	$3,200.00	
				Guest Chairs	8	$800.00	$6,400.00	
				Bench	1	$3,500.00	$3,500.00	
						Total	$25,900.00	$25,900.00
		Staff lounge	1	Table	2	$1,100.00	$2,200.00	
				Side chair	15	$550.00	$8,250.00	
				Waste management	1	$1,200.00	$1,200.00	
				Locker	15	$1,200.00	$18,000.00	
						Total	$29,650.00	$29,650.00
		Exam room/PFT	19	Stool	1	$800.00	$800.00	
				Guest sofa	1	$1,000.00	$1,000.00	
						Total	$1,800.00	$34,200.00
	3	MA Touch Down	2	Task chair	6	$800.00	$4,800.00	
				Pedestal	6	$550.00	$3,300.00	
						Total	$8,100.00	$8,100.00
		Staff TD/Work	2	Task chair	3	$800.00	$2,400.00	
				Pedestal	3	$550.00	$1,650.00	
						Total	$4,050.00	$8,100.00
		NP station	1	Task chair	4	$800.00	$3,200.00	
				Pedestal	4	$550.00	$2,200.00	
				Counter	4	$1,800.00	$7,200.00	
						Total	$12,600.00	$12,600.00
		Research	1	Task chair	1	$800.00	$800.00	
				Stool	1	$800.00	$800.00	
						Total	$1,600.00	$1,600.00
		Phelebotomy	1	Stool	3	$800.00	$2,400.00	
				Phelebotomy	3	$1,400.00	$4,200.00	
				Cubicle Curtain	3	$1,200.00	$3,600.00	
						Total	$10,200.00	$10,200.00
						3rd Floor Total		$490,850.00
						10% contingency		$49,085.00
						Grand Total		$539,935.00

NYU Langone Hospitals
HCC Renovations
Room By Room Detail Report

[C] = GPO Contract [C] = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Clean Supply Room Room#: Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
6643-003 MNR0054		1 O/O 2	Pump, Infusion, Controller, Modular Alaris PC Unit (8015)	BD - Becton, Dickinson and Company (8015) BD - Becton, Dickinson and Company (8015)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	2,900.00	0.00	Vendor 2,900.00 [C]
4986-013 SHL0441		1 O/C 1	Shelving, Bins, Wall 30161 Louvered Panel (36 x 61) 08/03/2018: Qty & SIze TBC.	Akro-Mils (30161) Akro-Mils (30161)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	100.00	0.00	List 100.00
5697-002 SHL0713		1 O/O 3	Shelving, Solid, Steel, 60 inch Super Erecta 60x24x63 (4-Tier)	InterMetro Industries Corp ((4x)2460FG/(4x)63P) InterMetro Industries Corp ((4x)2460FG/(4x)63P)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	822.00	0.00	Vendor 822.00 [C]
6260-010 MAY0006		3 O/O 3	Stand, Mayo, Foot-Operated P-1069-SS	Pedigo Products, Inc (P-1069-SS) Pedigo Products, Inc (P-1069-SS)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	912.00	0.00	Vendor 2,736.00 [C]
5257-068 ULT0424		1 O/O 2	Ultrasound, Imaging, Multipurpose, Portable Sonosite PX System w/ Stand 08/08/2018: Probe Types TBC.	FUJIFILM SonoSite, Inc (L25100/L25110) FUJIFILM SonoSite, Inc (L25100/L25110)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	75,000.00	0.00	Estimate 75,000.00 [C]

Room Total : 81,558.00
Room Qty : 1

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Exam Room #17   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302 Stainless Steel	Omnimed, Inc (305302) Omnimed, Inc (305302)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	40.00	0.00	List 40.00
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (2720-12) GOJO Industries (2720-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	38.00	0.00	List 38.00
BSE389X DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount ________________	Kimberly-Clark Professional (09746) Kimberly-Clark Professional (09746)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	71.00	0.00	List 71.00
5868-036 DSP0806		1 O/C 1	Dispenser, Soap, Wall Mount Provon TFX Touch Free (2745-12)	GOJO Industries (2745-12) GOJO Industries (2745-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	63.00	0.00	List 63.00
3723-035 DIS0290		1 O/C 1	Disposal, Sharps, Wall Mount Bio Systems C-04RES-04 w/Locking Bracket	Stericycle (C-04RES-04/WB-04) Stericycle (C-04RES-04/WB-04)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00
3803-044 FLW0040		2 O/O 3	Flowmeter, Oxygen Compact (0-15 lpm, DISS Hand Tight)	Precision Medical (8MFA1003) Precision Medical (8MFA1003)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	36.00	0.00	List 72.00
4092-038 OPH0131		1 O/C 1	Oto/Ophthalmoscope Set, Wall Mount, w/Sphyg Green Series 777 [77910]	Hillrom - Welch Allyn, Inc. (77910) Hillrom - Welch Allyn, Inc. (77910)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,700.00	0.00	Estimate 1,700.00
4109-019 OXM0041		1 O/O 2	Oximeter, Pulse, Hand Held Rad-5 (SpO2 Only) 08/13/2018: Wall Mount Option If Available.	Masimo Corp. (9196) Masimo Corp. (9196)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,200.00	0.00	List 1,200.00 C
4267-004 SCL0052		1 O/O 3	Scale, Clinical, Adult, Digital, Platform 5125 Portable	Hillrom - Scale-Tronix (5125-X-X) Hillrom - Scale-Tronix (5125-X-X)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,590.00	0.00	Vendor 1,590.00 C
4352-025 SDM0039		1 O/O 1	Stadiometer, Wall Mount 845010W Height Gauge (Wall Mounted)	Hillrom - Welch Allyn, Inc. (845010W) Hillrom - Welch Allyn, Inc. (845010W)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	407.00	0.00	Vendor 407.00 C

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Exam Room #17 Room#: Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
5936-012 TBL0626	C340098 6751-014	1 O/O 2	Table, Exam/Treatment, Powered Ritter 225 Barrier Free (Seamless Top)	Midmark Corporation (225-003/002-2009-XXX) Midmark Corporation (225-003/002-2009-XXX)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	9,088.00	0.00	Vendor 9,088.00 C
9007-000		1 O/O 0	UnderCounter Waste Can __________________	____________________ ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00

Room Total : 14,269.00
Room Qty : 1

NYU Langone Hospitals
HCC Renovations
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Exam Room, General   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302 Stainless Steel	Omnimed, Inc (305302) Omnimed, Inc (305302)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	40.00	0.00	List 40.00
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (2720-12) GOJO Industries (2720-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	38.00	0.00	List 38.00
BSE399X DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount _________________	Kimberly-Clark Professional (09746) Kimberly-Clark Professional (09746)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	71.00	0.00	List 71.00
5868-036 DSP0806		1 O/C 1	Dispenser, Soap, Wall Mount Provon TFX Touch Free (2745-12)	GOJO Industries (2745-12) GOJO Industries (2745-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	63.00	0.00	List 63.00
3723-035 DIS0290		1 O/C 1	Disposal, Sharps, Wall Mount Bio Systems C-04RES-04 w/Locking Bracket	Stericycle (C-04RES-04/WB-04) Stericycle (C-04RES-04/WB-04)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00
3803-044 FLW0040		2 O/O 3	Flowmeter, Oxygen Compact (0-15 lpm, DISS Hand Tight)	Precision Medical (8MFA1003) Precision Medical (8MFA1003)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	36.00	0.00	List 72.00
4092-038 OPH0131		1 O/C 1	Oto/Ophthalmoscope Set, Wall Mount, w/Sphyg Green Series 777 [77910]	Hillrom - Welch Allyn, Inc. (77910) Hillrom - Welch Allyn, Inc. (77910)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,700.00	0.00	Estimate 1,700.00
4267-004 SCL0052		1 O/O 3	Scale, Clinical, Adult, Digital, Platform 5125 Portable	Hillrom - Scale-Tronix (5125-X-X) Hillrom - Scale-Tronix (5125-X-X)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,590.00	0.00	Vendor 1,590.00 C
4352-025 SDM0039		1 O/O 1	Stadiometer, Wall Mount 845010W Height Gauge (Wall Mounted)	Hillrom - Welch Allyn, Inc. (845010W) Hillrom - Welch Allyn, Inc. (845010W)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	407.00	0.00	Vendor 407.00 C
5936-012 TBL0626	C340098 6751-014	1 O/O 2	Table, Exam/Treatment, Powered Ritter 225 Barrier Free (Seamless Top)	Midmark Corporation (225-003/002-2009-XXX) Midmark Corporation (225-003/002-2009-	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	9,088.00	0.00	Vendor 9,088.00 C

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Exam Room, General   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
				XXX)					
9007-000		1 O/O 0	UnderCounter Waste Can __________________	____________________ ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00

Room Total : **13,069.00**
Room Qty : **15**
Room Ext Total : **196,035.00**

NYU Langone Hospitals
HCC Renovations
Room By Room Detail Report

[C] = GPO Contract [C] = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Exam Rooms W/recliners Room#: Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302 Stainless Steel	Omnimed, Inc (305302) Omnimed, Inc (305302)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	40.00	0.00	List 40.00
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (2720-12) GOJO Industries (2720-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	38.00	0.00	List 38.00
BSE409X DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount _______________	Kimberly-Clark Professional (09746) Kimberly-Clark Professional (09746)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	71.00	0.00	List 71.00
5868-036 DSP0806		1 O/C 1	Dispenser, Soap, Wall Mount Provon TFX Touch Free (2745-12)	GOJO Industries (2745-12) GOJO Industries (2745-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	63.00	0.00	List 63.00
3723-035 DIS0290		1 O/C 1	Disposal, Sharps, Wall Mount Bio Systems C-04RES-04 w/Locking Bracket	Stericycle (C-04RES-04/WB-04) Stericycle (C-04RES-04/WB-04)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00
3803-044 FLW0040		2 O/O 3	Flowmeter, Oxygen Compact (0-15 lpm, DISS Hand Tight)	Precision Medical (8MFA1003) Precision Medical (8MFA1003)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	36.00	0.00	List 72.00
4092-038 OPH0131		1 O/C 1	Oto/Ophthalmoscope Set, Wall Mount, w/Sphyg Green Series 777 [77910]	Hillrom - Welch Allyn, Inc. (77910) Hillrom - Welch Allyn, Inc. (77910)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,700.00	0.00	Estimate 1,700.00
4109-019 OXM0041		1 O/O 2	Oximeter, Pulse, Hand Held Rad-5 (SpO2 Only) 08/13/2018: Wall Mount Option If Available.	Masimo Corp. (9196) _______________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	750.00	0.00	List 750.00 [C]
4267-004 SCL0052		1 O/O 3	Scale, Clinical, Adult, Digital, Platform 5125 Portable	Hillrom - Scale-Tronix (5125-X-X) Hillrom - Scale-Tronix (5125-X-X)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,590.00	0.00	Vendor 1,590.00 [C]
4352-025 SDM0039		1 O/O 1	Stadiometer, Wall Mount 845010W Height Gauge (Wall Mounted)	Hillrom - Welch Allyn, Inc. (845010W) Hillrom - Welch Allyn, Inc. (845010W)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	407.00	0.00	Vendor 407.00 [C]

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Exam Rooms W/recliners   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
7763-066 STR0603	 6751-014	1 O/O 2	Stretcher, Procedure / Recovery, Chair Contour Recline Standard Procedure Chair	Mid Central Medical (MCM5000) Mid Central Medical (MCM5000)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	10,950.00	0.00	Vendor 10,950.00 C
9007-000		1 O/O 0	UnderCounter Waste Can _________________	____________________ ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00

Room Total :	**15,681.00**
Room Qty :	**2**
Room Ext Total :	**31,362.00**

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: North Alcove, Vitals   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
7347-001 CST0530		1 O/C 1	Cabinet, Storage, Clinical, Defibrillator Premium Surface Mounted	Philips Healthcare - Cardiology (PFE7024D) Philips Healthcare - Cardiology (PFE7024D)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	399.00	0.00	List 399.00 C
5088-009 DFB0075		1 O/O 2	Defibrillator, Automatic, Advisory HeartStart OnSite	Philips Healthcare - Cardiology (M5066A) Philips Healthcare - Cardiology (M5066A)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,504.00	0.00	Vendor 1,504.00 C
4275-121 SCL0606		1 O/O 2	Scale, Clinical, Adult, Wheelchair 6202-XX-X Stow-A-Weigh Wheelchair Scale	Hillrom - Scale-Tronix (6202-XX-X) Hillrom - Scale-Tronix (6202-XX-X)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	3,811.52	0.00	Vendor 3,811.52 C
4352-022 SDM0036		1 O/O 1	Stadiometer, Wall Mount seca 222 Mech telescopic rod/large measuring range	Seca Corporation (222 1714 008) Seca Corporation (222 1714 008)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	222.00	0.00	Vendor 222.00 C

Room Total : 5,936.52

Room Qty : 1

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: PFT Lab   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302 Stainless Steel	Omnimed, Inc (305302) Omnimed, Inc (305302)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	40.00	0.00	List 40.00
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (2720-12) GOJO Industries (2720-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	38.00	0.00	List 38.00
BSE656Y DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount ________________	Kimberly-Clark Professional (09746) Kimberly-Clark Professional (09746)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	71.00	0.00	List 71.00
5868-036 DSP0806		1 O/C 1	Dispenser, Soap, Wall Mount Provon TFX Touch Free (2745-12)	GOJO Industries (2745-12) GOJO Industries (2745-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	63.00	0.00	List 63.00
6998-002 ERG0113		1 O/O 2	Pulmonary Function Testing System, Allowance TBD 08/08/2018: http://www.innovision.dk/Products/Innocor-1.aspx	Vyaire Medical (TBD) Vyaire Medical (TBD)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	70,000.00	0.00	Estimate 70,000.00
9007-000		1 O/O 0	UnderCounter Waste Can ________________	________________ ________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00

Room Total : 70,212.00
Room Qty : 1

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Phlebotomy Lab   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
7026-020 PRC0762		1 O/O 3	Cart, Procedure, Phlebotomy All-In-One Mobile Cabinet ML6938 (37in.H)	MarketLab, Inc (ML6938) MarketLab, Inc (ML6938)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,299.00	0.00	List 1,299.00
6943-000 CEN0000		1 O/O 2	Centrifuge, Allowance _________________ 07/16/2013: Place Holder For Quest Centrifuge To Be Provided By Quest.	____________________ ____________________	Existing (Reuse) Unassigned Unassigned	Draft (Existing) Unassigned Unassigned	0.00	0.00	List 0.00
3600-000 CHA0000		3 O/O 3	Chair, Clinical, Blood Draw _________________ 07/23/2013: Winco 2573 To Be Purchased.	Winco ( ) ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	500.00	0.00	Estimate 1,500.00
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302 Stainless Steel	Omnimed, Inc (305302) Omnimed, Inc (305302)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	40.00	0.00	List 40.00
CHU910F DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount _________________	Kimberly-Clark Professional (09746) Kimberly-Clark Professional (09746)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	71.00	0.00	List 71.00
5868-036 DSP0806		1 O/C 1	Dispenser, Soap, Wall Mount Provon TFX Touch Free (2745-12)	GOJO Industries (2745-12) GOJO Industries (2745-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	63.00	0.00	List 63.00
6457-008 DIS0077		1 O/O 3	Disposal, Sharps, Floor Cart Bio Systems C-08-2004LR/D-08	Stericycle (C-08-2004LR/D-08) Stericycle (C-08-2004LR/D-08)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00
7351-001 DIS0063		1 O/O 3	Disposal, Sharps, Floor Cart, Chemo SharpsCart 8938FP w/Chemosafety 8939 (18 gal)	Medtronic - Covidien Kendall Products (8938FP/8939) Medtronic - Covidien Kendall Products (8938FP/8939)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	410.00	0.00	List 410.00 C
4071-092 MON1048		1 O/O 2	Monitor, Physiologic, Vital Signs, w/Stand EarlyVue VS30 w/ Premium Rollstand	Philips Healthcare - Monitoring Systems (863380/989803176601) Philips Healthcare - Monitoring Systems (863380/989803176601)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	4,360.50	0.00	Vendor 4,360.50 C

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Phlebotomy Lab   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
9589-004 REF1794		3 O/O 2	Refrigerator, Medical Grade, Undercounter Medical-Grade Refrigerator REF4P 04/02/2013: To Be Placed in Nurse Stations For Specimens.	Follett LLC (REF4P) Follett LLC (REF4P)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	4,930.00	0.00	List 14,790.00 C
4920-001 WST0081		1 O/O 3	Waste Can, Step-On FG614300BEIG (Beige, 8 gal.)	Rubbermaid Commercial Products (FG614300BEIG) Rubbermaid Commercial Products (FG614300BEIG)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	119.00	0.00	List 119.00

Room Total : 22,652.50

Room Qty : 1

NYU Langone Hospitals
HCC Renovations
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: Soiled Holding Room   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
3355-011 ANA0706	C308977	1 O/O 2	Analyzer, Lab, Glucose, Point-of-Care StatStrip Wireless Glucose Hospital Mtr w/Dock Stn	Nova Biomedical (54790 / 53400) Nova Biomedical (54790 / 53400)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,849.00	0.00	List 1,849.00 C
4920-087 WST0482		1 O/O 3	Waste Can, Step-On Slim Jim Resin Front Step 13 Gal/Beige	Rubbermaid Commercial Products (1883458) Rubbermaid Commercial Products (1883458)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	245.00	0.00	Vendor 245.00
7003-000 WDS0000		1 O/C 1	Waste Disposal, Allowance __________________ Black bins for toxic waste	____________________ ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00

Room Total : 2,094.00

Room Qty : 1

NYU Langone Hospitals

HCC Renovations

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: 3rd Floor - Transplant Program *

Building: Unassigned

Room: South Alcove, Vitals   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (2720-12) GOJO Industries (2720-12)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	25.00	0.00	List 25.00
3768-094 ECG0662		1 O/O 2	Electrocardiograph (ECG), Interpretive MAC VU360 Resting ECG Workstation w/ Basic Trolley	GE Healthcare - Cardiology (MAC VU360) GE Healthcare - Cardiology (MAC VU360)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	19,000.00	0.00	Vendor 19,000.00 C
4071-092 MON1048		2 O/O 2	Monitor, Physiologic, Vital Signs, w/Stand EarlyVue VS30 w/ Premium Rollstand	Philips Healthcare - Monitoring Systems (863380/989803176601) Philips Healthcare - Monitoring Systems (863380/989803176601)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	4,360.50	0.00	Vendor 8,721.00 C
9589-004 REF1794		1 O/O 2	Refrigerator, Medical Grade, Undercounter Medical-Grade Refrigerator REF4P 04/02/2013: To Be Placed in Nurse Stations For Specimens.	Follett LLC (REF4P) Follett LLC (REF4P)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	4,930.00	0.00	List 4,930.00 C

Room Total : 32,676.00
Room Qty : 1

Department Total : 456,795.02
Grand Total : 456,795.02

Schedule 13
All Article 28 Facilities

Contents:

- **Schedule 13 A - Assurances**
- **Schedule 13 B - Staffing**
- **Schedule 13 C - Annual Operating Costs**
- **Schedule 13 D - Annual Operating Revenue**

New York State Department of Health
Certificate of Need Application

Schedule 13 A. Assurances from Article 28 Applicants

Article 28 applicants seeking combined establishment and construction or construction-only approval must complete this schedule.

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.

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 ensure that the completed work conforms to the approved plans and specifications.

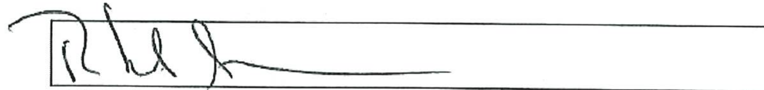
f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.

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.

Date



Signature:

Robert I. Grossman, M.D.

Name (Please Type)

Dean and CEO

Title (Please type)

Schedule 13 B-1. Staffing

See "Schedules Required for Each Type of CON" to determine when this form is required. Use the "Other" categories for providers, such as dentists, that are not mentioned in the staff categories. If a project involves multiple sites, please create a staffing table for each site.

☑ Total Project or ☐ Subproject number

A		B	C	D
		Number of FTEs to the Nearest Tenth		
Staffing Categories		Current Year*	First Year Total Budget	Third Year Total Budget
1. Management & Supervision				
2. Technician & Specialist				
3. Registered Nurses				
4. Licensed Practical Nurses				
5. Aides, Orderlies & Attendants				
6. Physicians				
7. PGY Physicians				
8. Physicians' Assistants				
9. Nurse Practitioners				
10. Nurse Midwife				
11. Social Workers and Psychologist**				
12. Physical Therapists and PT Assistants				
13. Occupational Therapists and OT Assistants				
14. Speech Therapists and Speech Assistants				
15. Other Therapists and Assistants				
16. Infection Control, Environment and Food Service				
17. Clerical & Other Administrative				
18. Other	Pharmacist			
19. Other				
20. Other				
21. Total Number of Employees		76.5	76.5	76.5

**Last complete year prior to submitting application*
***Only for RHCF and D&TC proposals*

Describe how the number and mix of staff were determined:

The number and mix of staff were determined based on the current visit/staff ratios.

N/A

Schedule 13 B-2. Medical/Center Director and Transfer Agreements

All diagnostic and treatment centers and midwifery birth centers should complete this section when requesting a new location. DTCs are required to have a Medical Director who is a physician. MBCs may have a Center Director who is a physician or a licensed midwife.

Medical/Center Director	
Name of Medical/Center Director:	
License number of the Medical/Center Director	

	Not Applicable	**Title of Attachment**	**Filename of attachment**
Attach a copy of the Medical/Center Director's curriculum vitae	☐		

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	
o Distance in miles from the proposed facility to the Hospital affiliate.	
o Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	
o Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.	N/A ☐ Attachment Name:
Name of the **nearest** Hospital to the proposed facility	
o Distance in miles from the proposed facility to the nearest hospital.	
o Distance in minutes of travel time from the proposed facility to the nearest hospital.	

Schedule 13 B-3. AMBULATORY SURGERY CENTERS ONLY - Physician Commitments

Upload a spreadsheet or chart as an attachment to this Schedule of all practitioners, including surgeons, dentists, and podiatrists who have expressed an interest in practicing at the Center. The chart must include the information shown in the template below.

Additionally, upload copies of letters from each practitioner showing the number and types of procedures he/she expects to perform at the Center per year.

Practitioner's Name	License Number	Specialty/(s)	Board Certified or Eligible?	Expected Number of Procedures	Hospitals where Physician has Admitting Privileges	Title and File Name of attachment

The remainder of Schedule 13 has been redacted.

Schedule 16
CON Forms Specific to Hospitals
Article 28

Contents:

- **Schedule 16 A - Hospital Program Information**
- **Schedule 16 B - Hospital Community Need**
- **Schedule 16 C - Impact of CON Application on Hospital Operating Certificate**
- **Schedule 16 D - Hospital Outpatient Departments**
- **Schedule 16 E - Hospital Utilization**
- **Schedule 16 F - Hospital Facility Access**

Schedule 16 A. Hospital Program Information

See "Schedules Required for Each Type of CON" to determine when this form is required.

Instructions: Briefly indicate how the facility intends to comply with state and federal regulations specific to the services requested, such as cardiac surgery, bone marrow transplants. For clinic services, please include the hours of service for each day of operation, name of the hospital providing back-up services (indicating the travel time and distance from the clinic) and how the facility intends to provide quality oversight including credentialing, utilization and quality assurance monitoring.

The NYU Langone Transplant Institute currently exists in several locations on and off the main hospital campus. This project will consolidate those services in a single comprehensive location on the third floor of the Schwartz Health Care Center (HCC) on the main NYU Langone Health Campus and as such, NYU Langone Hospital will provide oversite on its quality of care, including credentialing, utilization and quality assurance monitoring.

Please refer to the Executive Summary and to the Architectural Narrative for additional information.

For Hospital-Based -Ambulatory Surgery Projects:
Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category
N/A

For Hospital-Based -Ambulatory Surgery Projects:
Please provide the following information:

Number and Type of Operating Rooms:

- Current: 0
- To be added: 0
- Total ORs upon Completion of the Project: **0**

Number and Type of Procedure Rooms:

- Current: 0

- To be added: 0
- Total Procedure Rooms upon Completion of the Project: **0**

Schedule 16 B. Community Need

See "Schedules Required for Each Type of CON" to determine when this form is required.

Public Need Summary:
Briefly summarize on this schedule why the project is needed. Use additional paper, as necessary. If the following items have been addressed in the project narrative, please cite the relevant section and pages.

1. Identify the relevant service area **(**e.g., Minor Civil Division(s), Census Tract(s), street boundaries, Zip Code(s), Health Professional Shortage Area (HPSA) etc.)

The relevant service area for this project includes the 5 boroughs of New York City as well as Nassau and Suffolk Counties.

2. Provide a quantitative and qualitative description of the population to be served. Data may include median income, ethnicity, payor mix, etc.

The population to be served resides in the 5 boroughs of New York City as well as Nassau and Suffolk Counties. As of January 1, 2022, The total population for this area is as follows:

	Total Population	% Aged 65+	% Living in Poverty
Nassau	**1,383,726**	**18.9%**	**5.6%**
Suffolk	**1,525,416**	**18.2%**	**6.8%**
NYC	**8,335,897**	**15.5%**	**17.2%**
Total	**11,245,033**	**16.3%**	**14.4%**

The patient population served by NYU Langone Hospitals Transplant program is as follows:

Birth Sex:68% Male and 32% Female

Ethnicity: 33% White Non-Hispanic
25% Black Non-Hispanic
22% Hispanic/Latino
20% Asian, Non-Hispanic

Primary Sourve of Payment

35% Private Insurance

35% Medicaid

25% Medicare and Choice

5% Medicare FFS

3. Document the current and projected demand for the proposed service in the population you plan to serve. If the proposed service is covered by a DOH need methodology, demonstrate how the proposed service is consistent with it.

During 2023, transplant patients made 7,197 visits to the NYU Langone Hospital Transplant Clinics and this is expected to increase to 11,518 by year 3.

4. (a) Describe how this project responds to and reflects the needs of the residents in the community you propose to serve.

Currently, the NYU Langone Hospital Transplant Institute exists in several locations on and off the main hospital campus. This project will consolidate those services into a single comprehensive location on the third floor of the Schwartz Health Care Center (HCC) on the main NYU Langone Health Campus improving patient access to services.

(b) Will the proposed project serve all patients needing care regardless of their ability to pay or the source of payment? If so, please provide such a statement.

The proposed project will serve all patients needing care regardless of their ability to pay or the source of payment.

5. Describe where and how the population to be served currently receives the proposed services.

The population to be served currently receives their care in multiple locations on and off the main hospital campus. This project will consolidate those services in a single comprehensive location on the third floor of the existig Schwartz Health Care Center (HCC) on the main NYU Langone Health Campus located at 550 First Avenue, New York, New York, 10016.

6. Describe how the proposed services will be address specific health problems prevalent in the service area, including any special experience, programs or methods that will be implemented to address these health issues.

The relocated and consolidated Transplant Clinic will provide tranplant patients with care from their initial evaluation visit through their post procedure visit. In addition, pre- and post-living donor patients will also be seen in this space.

ONLY for Hospital Applicants submitting Full Review CONs

Non-Public Hospitals

7. (a) Explain how the proposed project advances local Prevention Agenda priorities identified by the community in the most recently completed Community Health Improvement Plan (CHIP)/Community Service Plan (CSP). *Do not submit the CSP*. Please be specific in which priority(ies) is/are being addressed.

   (b) If the Project does not advance the local Prevention Agenda priorities, briefly summarize how you are advancing local Prevention Agenda priorities.

8. Briefly describe what interventions you are implementing to support local Prevention Agenda goals.

9. Has your organization engaged local community partners in its Prevention Agenda efforts, including the local health department and any local Prevention Agenda coalition?

10. What data from the Prevention Agenda dashboard and/or other metrics are you using to track progress to advance local Prevention Agenda goals?

11. In your most recent Schedule H form submitted to the IRS, did you report any Community Benefit spending in the Community Health Improvement Services category that supports local Prevention Agenda goals? (Y/N question)

N/A

ONLY for Hospital Applicants submitting Full Review CONs

Public Hospitals

12. Briefly summarize how you are advancing local public health priorities identified by your local health department and other community partners.

13. Briefly describe what interventions you are implementing to support local public health priorities.

14. Have you engaged local community partners, including the local health department, in your efforts to address local public health priorities?

15. What data are you using to track progress in addressing local public health priorities?

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

C. Impact of CON Application on Hospital Operating Certificate

Note: If the application involves an extension clinic, indicate which services should be added or removed from the certificate of the extension clinic alone, rather than for the hospital system as a whole. If multiple sites are involved, complete a separate 16C for each site.

TABLE 16C-1 AUTHORIZED BEDS

LOCATION:

(Enter street address of facility)

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30		☐	☐	
BONE MARROW TRANSPLANT	21		☐	☐	
BURNS CARE	09		☐	☐	
CHEMICAL DEPENDENCE-DETOX *	12		☐	☐	
CHEMICAL DEPENDENCE-REHAB *	13		☐	☐	
COMA RECOVERY	26		☐	☐	
CORONARY CARE	03		☐	☐	
INTENSIVE CARE	02		☐	☐	
MATERNITY	05		☐	☐	
MEDICAL/SURGICAL	01		☐	☐	
NEONATAL CONTINUING CARE	27		☐	☐	
NEONATAL INTENSIVE CARE	28		☐	☐	
NEONATAL INTERMEDIATE CARE	29		☐	☐	
PEDIATRIC	04		☐	☐	
PEDIATRIC ICU	10		☐	☐	
PHYSICAL MEDICINE & REHABILITATION	07		☐	☐	
PRISONER				☐	
PSYCHIATRIC**	08		☐	☐	
RESPIRATORY				☐	
SPECIAL USE				☐	
SWING BED PROGRAM				☐	
TRANSITIONAL CARE	33		☐	☐	
TRAUMATIC BRAIN INJURY	11		☐	☐	
TOTAL			☐	☐	

*CHEMICAL DEPENDENCE: Requires additional approval by the Office of Alcohol and Substance Abuse Services (OASAS)
**PSYCHIATRIC: Requires additional approval by the Office of Mental Health (OMH)

Does the applicant have previously submitted Certificate of Need (CON) applications that have not been completed involving addition or decertification of beds?

☐ No ☐ Yes (*Enter CON number(s) to the right)*

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:

(Enter street address of facility)

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
AMBULATORY SURGERY				
MULTI-SPECIALTY	☐	☐	☐	☐
SINGLE SPECIALTY – GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
CARDIAC CATHETERIZATION				
ADULT DIAGNOSTIC	☐	☐	☐	☐
ELECTROPHYSIOLOGY (EP)	☐	☐	☐	☐
PEDIATRIC DIAGNOSTIC	☐	☐	☐	☐
PEDIATRIC INTERVENTION ELECTIVE	☐	☐	☐	☐
PERCUTANEOUS CORONARY INTERVENTION (PCI)	☐	☐	☐	☐
CARDIAC SURGERY ADULT	☐	☐	☐	☐
CARDIAC SURGERY PEDIATRIC	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
CLINIC PART-TIME SERVICES	☐	☐	☐	☐
COMPREHENSIVE PSYCH EMERGENCY PROGRAM	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
EMERGENCY DEPARTMENT	☐	☐	☐	☐
EPILEPSY COMPREHENSIVE SERVICES	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐

[1] A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.
[2] A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.
[4] DIALYSIS SERVICES require additional approval by Medicare
[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators
[6] PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric
[7] Must be certified for Home Hemodialysis Training & Support

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-2 LICENSED SERVICES *(cont.)*	Current	Add	Remove	Proposed
RADIOLOGY-THERAPEUTIC [5]	☐	☐	☐	☐
RENAL DIALYSIS, ACUTE	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b)	_____	_____	_____	_____
TRANSPLANT				
HEART - ADULT	☐	☐	☐	☐
HEART - PEDIATRIC	☐	☐	☐	☐
KIDNEY	☐	☐	☐	☐
LIVER	☐	☐	☐	☐
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

The Sites Tab in NYSE-CON has replaced the beds and services Tables of Schedule 16C. The Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-3 LICENSED SERVICES FOR HOSPITAL EXTENSION CLINICS and OFF-CAMPUS EMERGENCY DEPARTMENTS

LOCATION: (Enter street address of facility)				Check if this is a mobile van/clinic ☐
	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
AMBULATORY SURGERY				
SINGLE SPECIALTY -- GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
MULTI-SPECIALTY	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐
RADIOLOGY-THERAPEUTIC[5]	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b) below][4]	______	______	______	______
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐
FOR OFF-CAMPUS EMERGENCY DEPARTMENTS ONLY[8]				
EMERGENCY DEPARTMENT	☐	☐	☐	☐

[1] A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.
[2] A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.
[4] DIALYSIS SERVICES require additional approval by Medicare
[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators
[6] PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric
[7] Must be certified for Home Hemodialysis Training & Support
[8] OFF-CAMPUS EMERGENCY DEPARTMENTS must meet all relevant Federal Conditions of Participation for a hospital per CMS S&C-08-08

END STAGE RENAL DISEASE (ESRD)

TABLE 16C-3(*a*) CAPACITY	Existing	Add	Remove	Proposed
CHRONIC DIALYSIS				

If application involves dialysis service with existing capacity, complete the following table:

TABLE 16C-3(b) TREATMENTS	Last 12 mos	2 years prior	3 years prior
CHRONIC DIALYSIS			

All Chronic Dialysis applicants must provide the following information in compliance with 10 NYCRR 670.6.

1. Provide a five-year analysis of projected costs and revenues that demonstrates that the proposed dialysis services will be utilized sufficiently to be financially feasible.

2. Provide evidence that the proposed dialysis services will enhance access to dialysis by patients, including members of medically underserved groups which have traditionally experienced difficulties obtaining access to health care, such as; racial and ethnic minorities, women, disabled persons, and residents of remote rural areas.

3. Provide evidence that the hours of operation and admission policy of the facility will promote the availability of dialysis at times preferred by the patients, particularly to enable patients to continue employment.

4. Provide evidence that the facility is willing to and capable of safely serving patients.

5. Provide evidence that the proposed facility will not jeopardize the quality of care or the financial viability of existing dialysis facilities. This evidence should be derived from analysis of factors including, but not necessarily limited to current and projected referral and use patterns of both the proposed facility and existing facilities. A finding that the proposed facility will jeopardize the financial viability of one or more existing facilities will not of itself require a recommendation to of disapproval.

Schedule 16 D. Hospital Outpatient Department - Utilization projections

a	b Current Year *Visits**	**d** First Year *Visits**	**f** Third Year *Visits**
CERTIFIABLE SERVICES			
MEDICAL SERVICES – PRIMARY CARE			
MEDICAL SERICES – OTHER MEDICAL SPECIALTIES			
AMBULATORY SURGERY			
SINGLE SPECIALTY -- GASTROENTEROLOGY			
SINGLE SPECIALTY – OPHTHALMOLOGY			
SINGLE SPECIALTY – ORTHOPEDICS			
SINGLE SPECIALTY – PAIN MANAGEMENT			
SINGLE SPECIALTY -- OTHER			
MULTI-SPECIALTY			
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC			
ELECTROPHYSIOLOGY			
PEDIATRIC DIAGNOSTIC			
PEDIATRIC INTERVENTION ELECTIVE			
PERCUTANEOUS CORONARY INTERVENTION (PCI)			
CERTIFIED MENTAL HEALTH O/P			
CHEMICAL DEPENDENCE - REHAB			
CHEMICAL DEPENDENCE - WITHDRAWAL O/P			
CLINIC PART-TIME SERVICES			
CLINIC SCHOOL-BASED SERVICES			
CLINIC SCHOOL-BASED DENTAL PROGRAM			
COMPREHENSIVE EPILEPSY CENTER			
COMPREHENSIVE PSYCH EMERGENCY PROGRAM			
DENTAL			
EMERGENCY DEPARTMENT			
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT			
HOME HEMODIALYSIS TRAINING & SUPPORT			
INTEGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY			
METHADONE MAINTENANCE O/P			
NURSING HOME HEMODIALYSIS			
RADIOLOGY-THERAPEUTIC			
RENAL DIALYSIS, CHRONIC			
OTHER SERVICES			
Transplant	7,197	9,519	11,518
Total	7,197	9,519	11,518

Note: In the case of an extension clinic, the service estimates in this table should apply to the site in question, not to the hospital or network as a whole.
*The 'Total' reported MUST be the SAME as those on Table 13D-4.

Schedule 16 E. Utilization/discharge and patient days

See “Schedules Required for Each Type of CON” to determine when this form is required

This schedule is for hospital inpatient projects only. This schedule is required if hospital discharges or patient days will be affected by ± 5% or more, or if this utilization is created for the first time by your proposal.

Include only those areas affected by your project. Current year data, as shown in columns 1 and 2, should represent the last complete year before submitting the application. Enter the starting and ending month and year in the column heading.

Forecast the first and third years after project completion. The first year is the first twelve months of operation after project completion. Enter the starting and ending month and year being reported in the column headings.

For hospital establishment applications and major modernizations, submit a summary business plan to address operations of the facility upon project completion. All appropriate assumptions regarding market share, demand, utilization, payment source, revenue and expense levels, and related matters should be included. Also, include your strategic plan response to the escalating managed care environment. Provide a complete answer and indicate the hospital’s current managed care situation, including identification of contracts and services.

NOTE: Prior versions of this table referred to “incremental” changes in discharges and days. The table now requires the full count of discharges and days.

N/A

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date:		1st Year Start date:		3rd Year Start date:	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
AIDS						
BONE MARROW TRANSPLANT						
BURNS CARE						
CHEMICAL DEPENDENCE - DETOX						
CHEMICAL DEPENDENCE - REHAB						
COMA RECOVERY						
CORONARY CARE						
INTENSIVE CARE						
MATERNITY						
MED/SURG						
NEONATAL CONTINUING CARE						
NEONATAL INTENSIVE CARE						
NEONATAL INTERMEDIATE CARE						
PEDIATRIC						
PEDIATRIC ICU						
PHYSICAL MEDICINE & REHABILITATION						
PRISONER						
PSYCHIATRIC						
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM						
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL						

NOTE: Prior versions of this table referred to "incremental" changes in discharges and days. The table now requires the full count of discharges and days.

New York State Department of Health
Certificate of Need Application

Schedule 16F

N/A

Schedule 16 F. Facility Access

See “Schedules Required for Each Type of CON” to determine when this form is required.

Complete Table 1 to indicate the method of payment for inpatients and for inpatients and outpatients who were transferred to other health care facilities for the calendar year immediately preceding this application.
Start date of year for which data applies (m/c/yyyy):

Table 1. Patient Characteristics	Total Number of Inpatients	Number of Patients Transferred		
Payment Source		Inpatient	OPD	ER
Medicare				
Blue Cross				
Medicaid				
Title V				
Workers' Compensation				
Self Pay in Full				
Other (incl. Partial Pay)				
Free				
Commercial Insurance				
Total Patients				

Complete Table 2 to indicate the method of payment for outpatients.

Table 2. Outpatient Characteristics	Emergency Room		Outpatient Clinic		Community MH Center	
Primary Payment Source	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions
Medicare						
Blue Cross						
Medicaid						
Title V						
Workers' Compensation						
Self Pay in Full						
Other (incl. Partial Pay)						
Free						
Commercial Insurance						
Total Patients						

A. Attach a copy of your discharge planning policy and procedures.

B. Is your facility a recipient of federal assistance under Title VI or XVI of the Public Health Service? Act (Hill-Burton)?

Yes ☐ No ☐

If yes, answer the following questions and attach the most recent report on Hill-Burton compliance from the Federal Department of Health and Human Services.

1. Is your facility currently obligated to provide uncompensated service under the Public Health Service Act?

   Yes ☐ No ☐

   If yes, provide details on how your facility has met such requirement for the last three fiscal years - including notification of the requirement in a newspaper of general circulation. Also, list any restricted trusts and endowments that were used to provide free, below-cost or charity care services to persons unable to pay.

2. With respect to all or any portion of the facility which has been constructed, modernized, or converted with Hill-Burton assistance, are the services provided therein available to all persons residing in your facility's service area without discrimination on the basis of race, color, national origin, creed, or any basis unrelated to an individual's need for the service or the availability of the needed service in the facility?

   Yes ☐ No ☐

   If no, provide an explanation.

3. Does the facility have a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility?

   Yes ☐ No ☐

4. Do Medicaid beneficiaries have full access to all of your facility's health services?

   Yes ☐ No ☐

   If no, provide a list of services where access by Medicaid beneficiaries is denied or limited.