Schedule 1
All CON Applications

Contents:

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—Brooklyn

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
	7-1-24
PRINT OR TYPE NAME	TITLE
Bret J. Rudy, MD	Executive Vice President and Chief of Hospital Operations, NYU Langone Hospital—Brooklyn

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	
Chris Panettieri, Assistant Director, Strategy, Planning & Business Development	NYU Langone Health	
BUSINESS STREET ADDRESS		
One Park Avenue, Fourth Floor		
CITY	CITY	CITY
New York	New York	New York
TELEPHONE	TELEPHONE	
212 263-3492	212 263-3492	

Alternate Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Laura Charney, Sr. Analyst, Strategy, Planning, & Business Development	NYU Langone Health	
BUSINESS STREET ADDRESS		
One Park Avenue, Fourth Floor		
CITY	STATE	ZIP
New York	New York	10015
TELEPHONE	E-MAIL ADDRESS	

	646-574-9363	Laura.charney@nyulangone.org

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Bret J. Rudy, MD, Executive Vice President and Chief of Hospital Operations, NYU Langone Hospital—Brooklyn			
BUSINESS STREET ADDRESS			
150 55th Street Brooklyn, NY 11220			
CITY	STATE	ZIP	
Brooklyn	New York	11220	
TELEPHONE	E-MAIL ADDRESS		
718-630-7000	N/A		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM	BUSINESS STREET ADDRESS	
Annette Johnson, Esq.	N/A	550 First Avenue, 15th floor	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
New York, NY 10016	212-263-7921	annette.johnson@nyulangone.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		One Park Avenue	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
New York, NY 10016		Michelle.Ulrich@nyulangone.org	

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER			
NAME	FIRM	BUSINESS STREET ADDRESS	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

ARCHITECT and/or ENGINEER			
NAME	FIRM	BUSINESS STREET ADDRESS	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

New York State Department of Health Certificate of Need Application

Schedule 1

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.

NYU Langone Hospitals

For the twelve months ended August 31, 2025

NYU Langone Hospitals
Statement Of Operations
For The Twelve Months Ended August 31, 2025
(Amounts In Thousands)

Amounts Reported include NYU Langone Hospitals - Suffolk, merged 3/1/25

	(Unaudited) Fiscal Year To Date Actual
Operating revenue	
Inpatient	[redacted]
Outpatient	
Grants and sponsored programs	
Affiliations	
Contributions	
Endowment distribution and return on short-term investments	
Commercial insurance recoveries	
Other revenue	
Net assets released from restrictions for operating purposes	
Total operating revenue	
Operating expenses	
Salaries and wages	
Temporary agencies	
Employee benefits	
Pharmaceuticals	
Medical supplies	
Professional fees	
Purchased services	
Facility costs	
Other expenses	
FGP physician services	
GME purchased services	
Malpractice	
Depreciation and amortization	
Interest	
Total operating expenses	
Gain from operations before support:	
SoM support	
Gain from operations after support	
Operating Margin	
Other items	
Disaster recovery reimbursement for capital	
Other	
Other component of pension & post retirement costs	
Support to NYUSoM	
Gain on extinguishment of debt	
Return on long-term investment	
Investment return less endowment distribution, net	
Endowment transfer	
Excess of revenue over expenses	[redacted]
Other changes in unrestricted net assets without donor restrictions	
Changes in pension and post retirement obligations	
Grants and contributions for capital asset acquisitions	
Commercial insurance for capital	
Equity transfer	
Transfers	
Net assets released from restrictions for capital purposes	
Net increase in net assets without donor restrictions	**$ 774,182**

NYU Langone Hospitals

Statement of Financial Position

(Amounts In Thousands)

Amounts Reported include NYU Langone Hospitals - Suffolk, merged 3/1/25

	(Unaudited) August 31, 2025	(Unaudited) August 31, 2024
Assets		
Current assets:		
Cash and cash equivalents	[redacted]	
Short-term investments		
Assets limited as to use		
Patient accounts receivable, net		
Due from related organizations		
Contributions receivable - current		
Inventories		
Other current assets		
Total current assets		
Long-term investments		
Assets limited as to use, less current portion		
Contribution receivable, less current portion		
Professional liabilities insurance receivable		
Other assets		
Due from related organizations less current portion		
Right-of-use-assets		
Property, plant and equipment - net		
Total assets	$ 13,091,046	$ 12,504,587
Liabilities and net assets		
Current liabilities:		
Current portion of long-term debt	[redacted]	
Accounts payable and accrued expenses		
Accrued salaries and related liabilities		
Accrued interest payable		
Current portion of accrued postretirement liabilities		
Current portion of professional liabilities		
Current portion of operating lease liabilities		
Deferred revenue		
Due to related organizations		
Other current liabilities		
Total current liabilities		
Long-term debt, less current portion	[redacted]	
Operating lease liabilities, less current portion		
Professional liabilities		
Accrued pension liabilities		
Accrued postretirement liabilities		
Due to related organization, net		
Other liabilities		
Total liabilities		
Net assets:	[redacted]	
Without donor restrictions		
With donor restrictions		
Total net assets		
Total liabilities and net assets	$ 13,091,046	$ 12,504,587

Schedule 5
Working Capital Plan

Contents:

Working Capital Financing Plan

1. Working Capital Financing Plan and Pro Forma Balance Sheet:

This section should be completed in conjunction with Schedule 13. The general guidelines for working capital requirements are two months of first year expenses for changes of ownership and two months of third year expenses for new establishments, construction projects or when the first year budget indicates a net operating loss. Any deviation from these guidelines must be supported by the monthly cash flow analysis. If working capital is required for the project, all sources of working capital must be indicated clearly. Borrowed funds are limited to 50% of total working capital requirements and cannot be a line of credit. Terms of the borrowing cannot be longer than 5 years or less than 1 year. If borrowed funds are a source of working capital, please summarize the terms below, and attach a letter of interest from the intended source of funds, to include an estimate of the principal, term, interest rate and payout period being considered. Also, describe and document the source(s) of working capital equity.

Titles of Attachments Related to Borrowed Funds	Filenames of Attachments
Example: *First borrowed fund source*	Example*: first_bor_fund.pdf*

In the section below, briefly describe and document the source(s) of working capital equity

Any necessary working capital will be provided through operating cash flow. Audited financial statements are included with the CON application.

2. Pro Forma Balance Sheet

This section should be completed for all new establishment and change in ownership applications. On a separate attachment identified below, provide a pro forma (opening day) balance sheet. If the operation and real estate are to be owned by separate entities, provide a pro forma balance sheet for each entity. Fully identify all assumptions used in preparation of the pro forma balance sheet. If the pro forma balance sheet(s) is submitted in conjunction with a change in ownership application, on a line-by-line basis, provide a comparison between the submitted pro forma balance sheet(s), the most recently available facility certified financial statements and the transfer agreement. Fully explain and document all assumptions.

Titles of Attachments Related to Pro Forma Balance Sheets	Filenames of Attachments
Example: *Attachment to operational balance sheet*	Example: *Operational_bal_sheet.pdf*

THE LINE SHOWN ABOVE IS EXACTLY ONE INCH LONG AT FULL SIZE ON ORIGINAL ARCH D SHEET

LEGEND- OVERALL FLOOR PLANS

BUILDING ELEMENTS

- EXISTING PARTITION
- EXISTING DOOR
- EXISTING PROGRAMS TO REMAIN (NO CHANGE)
- NEW BMT PROGRAM (NO CHANGE TO EXISTING SPACE OR CONSTRUCTION REQUIRED)

1 **3RD FLOOR PLAN**
A-130.00 SCALE: 3/16" = 1'-0"

TRUE NORTH PROJECT NORTH

ENVIRONMENTS FOR HEALTH ARCHITECTURE
15 W37th Street, 6th Floor, New York, NY 10018
888.781.8441 : 212.869.1940
BOSTON | DALLAS | NEW YORK | BURLINGTON | PORTLAND
e4harchitecture.com

NYU Langone Health

OWNER
NYU LANGONE HOSPITAL BROOKLYN
150 55TH STREET BROOKLYN
P: 718-630-7300

ARCHITECT
ENVIRONMENTS FOR HEALTH
15W 37TH ST., 6TH FLOOR
P: 212-869-1640

MEP
JRAD
55 WATER STREET, 38TH FLOOR
P: 212-530-5300

STRUCTURE
SEVERUD ASSOCIATES
469 7TH AVE, SUITE 900
P: 212-986-3700

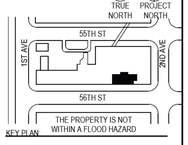
NYULH 3500 BMT BEDS

150 55TH STREET
BROOKLYN, NY 11220

CON
PROJECT: 5025011

Δ	DATE	DESCRIPTION
	05/26/2026	CON Submission

TRUE NORTH PROJECT NORTH



KEY PLAN

REGISTERED ARCHITECT JOHN RODENBECK #037995-1 STATE OF NEW YORK

JOHN RODENBECK #037995-1

ORIG SUBMISSION: XXXX.XX.XX
CURRENT:

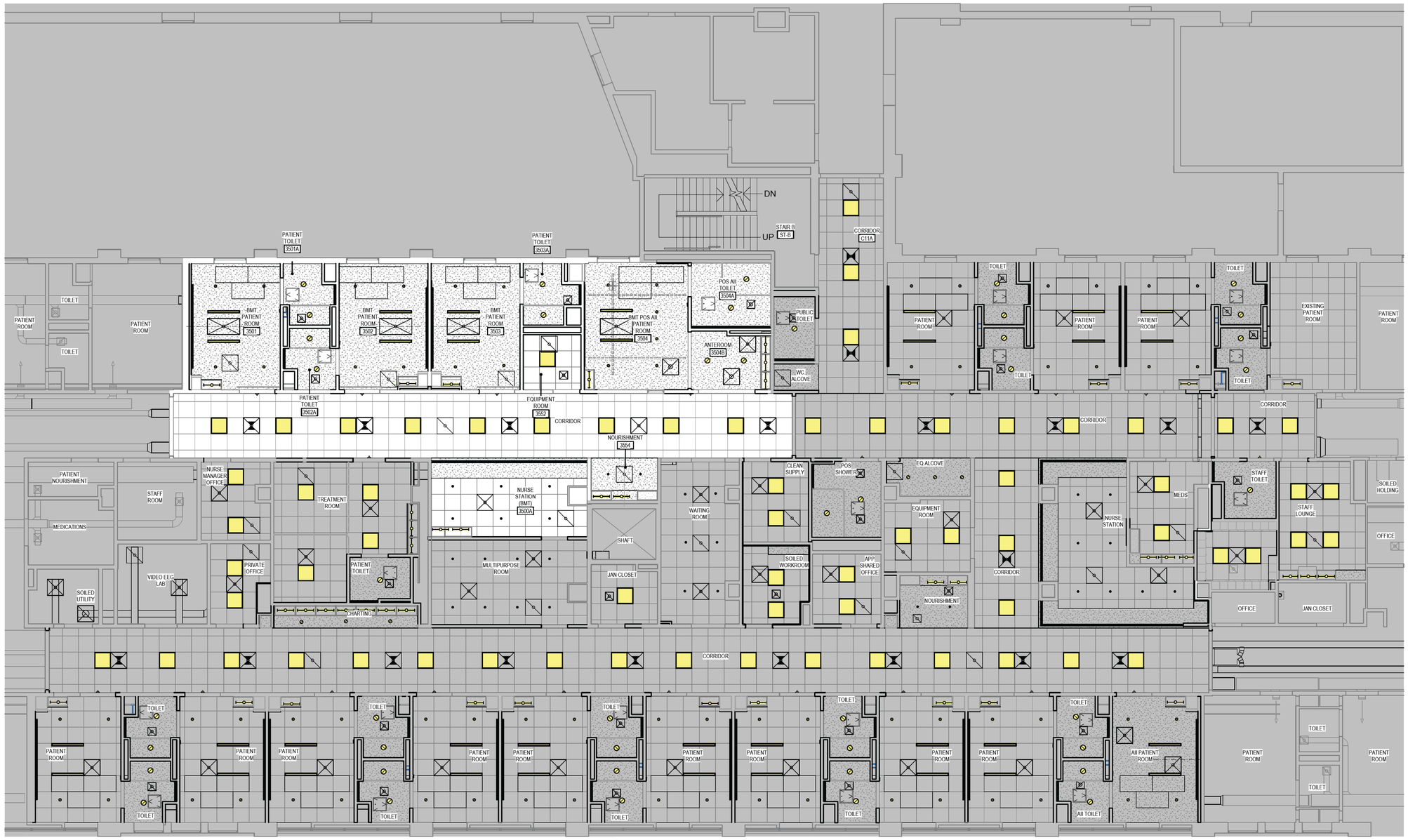
SHEET TITLE AND NUMBER:

A-130.00
3RD FLOOR PLAN

THE LINE SHOWN ABOVE IS EXACTLY ONE INCH LONG AT FULL SIZE ORIGINAL PLOTTING

LEGEND- RCP'S

- EXISTING GYP. CEILING
- EXISTING ACT
- EXISTING RETURN AIR GRILLE
- EXISTING SUPPLY AIR GRILLE
- EXISTING EXHAUST FAN
- EXISTING LIGHT FIXTURE
- EXISTING CEILING ACCESS PANEL



1 **3RD FLOOR - REFLECTED CEILING PLAN**
A-230.00 SCALE: 3/16" = 1'-0"

ENVIRONMENTS FOR HEALTH ARCHITECTURE
e4h
15 W37th Street, 6th Floor, New York, NY 10018
888.781.8441 : 212.889.1940
BOSTON | DALLAS | NEW YORK | BURLINGTON | PORTLAND
e4harchitecture.com

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P: 718-630-7300

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ENVIRONMENTS FOR HEALTH
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P: 212-889-1940

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JRAD
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P: 212-530-5300

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SEVERUD ASSOCIATES
469 7TH AVE, SUITE 900
P: 212-986-3700

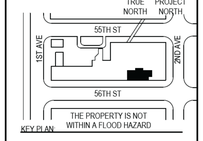
NYULH 3500 BMT BEDS

150 55TH STREET
BROOKLYN, NY 11220

CON
PROJECT: 5025011

Δ	DATE	DESCRIPTION
	05/26/2026	CON Submission

TRUE NORTH
PROJECT NORTH



KEY PLAN

REGISTERED ARCHITECT
JOHN RODENBECK
037995-1
STATE OF NEW YORK

JOHN RODENBECK #037995-1

ORIG SUBMISSION: xxxx.xx.xx
CURRENT:

SHEET TITLE AND NUMBER:

A-230.00

3RD FLOOR - REFLECTED CEILING PLAN

THE LINE SHOWN ABOVE IS EXACTLY ONE INCH LONG, AS MEASURED ON ORIGINAL ANSI B SIZE SHEETS

LEGEND- EQUIPMENT PLANS

FURNISHING ITEM - FOR REFERENCE (NO CHANGE)

EQUIPMENT ITEM - FOR REFERENCE (NO CHANGE)

1 3RD FLOOR EQUIPMENT PLAN
EQ-030.00 SCALE: 3/16" = 1'-0"

ENVIRONMENTS FOR HEALTH ARCHITECTURE
e4h
15 W26th Street, 6th Floor, New York, NY 10018
888.781.8441 : 212.889.1940
BOSTON | DALLAS | NEW YORK | BURLINGTON | PORTLAND
e4harchitecture.com

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150 55TH STREET BROOKLYN
P: 718-630-7300

ARCHITECT
ENVIRONMENTS FOR HEALTH
15W 37TH ST., 6TH FLOOR
P: 212-889-1940

MEP
JRAD
55 WATER STREET, 38TH FLOOR
P: 212-530-5300

STRUCTURE
SEVERUD ASSOCIATES
409 7TH AVE, SUITE 900
P: 212-986-3700

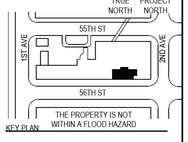
NYULH 3500 BMT BEDS

150 55TH STREET
BROOKLYN, NY 11220

CON
PROJECT: 5025011

Δ	DATE	DESCRIPTION
	05/26/2026	CON Submission

TRUE NORTH
PROJECT NORTH



KEY PLAN

REGISTERED ARCHITECT
JOHN RODENBECK
#037995-1
STATE OF NEW YORK

JOHN RODENBECK #037995-1

ORIG SUBMISSION: xxxx.xx.xx

CURRENT:

SHEET TITLE AND NUMBER:

EQ-030.00

3RD FLOOR EQUIPMENT PLAN

NEW YORK STATE OF OPPORTUNITY. Department of Health

Center for Health Care Facility Planning, Licensure and Finance

Bureau of Architecture and Engineering Review

Architect or Engineer Certification

Date: 5/28/2026

Facility ID: 1304

Facility Name: NYULH - 3500 BMT Beds

Project Name/Description: Recertification of Existing Medical Oncology Patient Rooms for BMT Use

Mark below whether the architectural/engineering submission is intended for review by New York State Department of Health (DOH), by Dormitory Authority of the State of New York (DASNY) on behalf of the department, or for self-certification in lieu of formal plan review. Please also acknowledge if the project is for Article 28 certification of an existing space with no proposed construction.

Choose review option:

- ☐ **Review provided by DOH Architects & Engineers**
- ☐ **Review provided by DASNY Architects & Engineers**
- ☐ **Self-Certification by Applicant's Architects & Engineers**
  Complete and include page 3, Eligibility Checklist.

Mark if applicable:

- ☑ **Existing building inspected with no construction**
  Drawings must illustrate existing conditions are compliant to current reference standards.

The **architect or engineer** for the project to complete the following.

I hereby certify to the New York State Department of Health that:

I have been retained by the facility to provide professional architectural/engineering services and have concluded that the project is designed, or has been inspected, in accordance with project definitions, modifications and/or revisions approved or required by the New York State Department of Health.

I have concluded that the project is compliant with all applicable local, state, and federal codes and regulations. This includes the provisions of the State Hospital Code 10 NYCRR Part 711, applicable provisions of Parts 712-717, and the current Article 28 construction standards:

2012 NFPA 101 Life Safety Code
2012 NFPA 99 Health Care Facilities Code when required
2014 or 2018 Facility Guidelines Institute, Design and Construction Guidelines
2010 ADA Standards for Accessible Design

I understand that non-Article 28 areas, spaces, rooms and facilities being converted to Article 28 space, as well as renovations to existing Article 28 space shall be evaluated and brought into compliance with new construction standards as indicated within applicable requirements the State Hospital Code.

I understand that any component inconsistent with State Hospital Code must be brought to the attention of the Bureau of Architecture and Engineering Review for evaluation and compliance resolution.

Note proposed exceptions to the construction standards with the section number.
Does not apply to self-certifications.

I understand that upon completion of construction, or inspection of an existing building with no proposed construction, that the costs of any subsequent corrections necessary to achieve compliance with applicable requirements may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

This certification is being submitted to facilitate the Certificate of Need review for approval by the department. It is understood that an electronic copy of final Construction Documents, meeting the requirements of DSG-05, must be provided for all construction projects, including limited, administrative, full reviews, self-certified reviews, and reviews completed by DASNY.

Architect or Engineer Professional Stamp

Signature of Architect or Engineer

John Rodenbeck
Name of Architect or Engineer (print)

037995-1
Professional New York State License Number

15 West 37th Street, 6th Floor, New York, NY 10018
Business Address

The **applicant** for the project to complete the following.

The undersigned applicant understands and agrees that, despite this architect/engineer certification, the Department of Health retains the authority to (a) review the project documents and/or inspect the associated work, and (b) revoke its approval of the application for failure to comply with the State Hospital Code. The applicant is obligated to implement changes mandated by the Department to ensure compliance with the codes and regulations, regardless of whether physical plant construction or alterations have been completed and understands that the costs of any subsequent corrections necessary to achieve compliance may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

Authorized Signature for Applicant

BRET J. RUDY
Name (print)

EXECUTIVE VICE PRESIDENT & CHIEF OF HOSPITAL OPS
Title

6/26/26
Date

For projects intending to self-certify, please fill out the following checklist.
If the answer to any of the questions below is *"Yes"*, the project is not eligible for self-certification.

Project Eligibility Checklist for Architectural/Engineering Self-Certification

#	Question	Yes	No
1	Is a waiver or an exception to the standards required?	☐	☑
2	Will the project costs exceed $30,000,000?	☐	☑
3	Is Bulk Oxygen Medical Gas Storage associated with this project? Examples of Bulk Oxygen /Medical Gas Storage projects include but not limited to the following: a. Hyperbaric Chambers b. Bulk Systems include Nitrous Oxide System and Oxygen System defined below: **Bulk Oxygen System**: an assembly of equipment such as oxygen storage containers, pressure regulators, pressure relief devices, vaporizers, manifolds, and interconnecting piping that has a storage capacity of more than 20,000 ft3 of oxygen including unconnected reserves on hand at the site. The bulk oxygen system terminates at the point where oxygen at service pressure first enters the supply line. **Bulk Nitrous Oxide System**: an assembly of equipment as described in the definition of bulk oxygen system that has a storage capacity of more than 3200 lb., approximately 28,000 ft3, of nitrous oxide.	☐	☑
4	Will this project have Locked or Secured Units? Examples of Locked or Secured Units include but not limited to the following: a. Observation Units for behavioral health in ED's. b. Behavioral health located within inpatient settings. c. Nursing Homes or other facilities with Dementia Units that are locked. d. Corrections and Detention Facilities located in Hospitals, Ambulatory Health Care Occupancies and Business Occupancies where healthcare is provided.	☐	☑
5	Will this project involve construction of new procedure rooms or operating rooms, or the renovation of existing procedure rooms or operating rooms, including modifications to associated support systems such as mechanical, electrical, plumbing, medical gas, fire detection or fire protection systems, within a hospital or ambulatory surgery center? *(Projects limited to cosmetic upgrades are eligible for self-certification.)* Examples, include but not limited to the following: a. Endoscopy Procedure Rooms b. Procedure Rooms c. Operating Rooms d. Interventional Imaging located in procedure rooms or operating rooms	☐	☑
6	Will this project involve construction that is required to comply with New Ambulatory Health Care Occupancy requirements as indicated in Chapter 20 of NFPA 101, 2012 edition? Examples, include but not limited to the following: a. Ambulatory Surgery Centers b. Endoscopy Centers and or other Procedure Rooms c. Free Standing Emergency Departments	☐	☑
7	Is this project intended to provide Ventilator Units for patients located in nursing homes?	☐	☑
8	Does this project involve Airborne Infection Isolation (Aii) Rooms or Protective Environment (PE) Rooms?	☑	☐

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

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.	☐	☒
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		

	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.2	Has any other agency made an environmental review of this project? If so, give name, and submit the SEQRA Summary of Findings with the application in the space provided below.		Yes ☐	No ☒
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.3	Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.		Yes ☐	No ☒
Part IV.	**Storm and Flood Mitigation**			
	Definitions of FEMA Flood Zone Designations			
	Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.			
	Please use the FEMA Flood Designations scale below as a guide to answering all Part IV questions regardless of project location, flood and or evacuation zone.		Yes	No
4.1	Is the proposed site located in a flood plain? If Yes, indicate classification below and provide the Elevation Certificate (FEMA Flood Insurance).		☐	☒
	Moderate to Low Risk Area		Yes	No
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:			
	B and X	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.	☐	

	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.

FEMA **Elevation Certificate** and Instructions

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	$0	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$0	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$0	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction		Schedule 10
Cost/Per Square Foot for Renovation Construction	$50	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	4/30/2027	Schedule 8B
Anticipated Completion Date	5/30/2027	

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	0.00%	Normally 10%
Construction Contingency - Renovation Work	0.00%	Normally 10%
Anticipated Construction Start Date:		as 04/30/2027
Anticipated Midpoint of Construction Date		as 05/15/2027
Anticipated Completion of Construction Date		as 05/30/2027
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.		

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

	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	$0	$0	$0
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency		$0	$0
3.2 Construction Contingency		$0	$0
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$0	$0	$0
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$0	$0	$0
Subtotal (Total 1.1 thru 4.5)	$0	$0	$0
5.1 Movable Equipment (from Sched 11)	$0	$0	$0
5.2 Telecommunications		$0	$0
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$0	$0	$0
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	$0	$0	$0
Application fees: 9.1 Application Fee. Articles 28, 36 and 40. See Web Site.	$0		$0
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	$0	$0
10 Total Project Cost with fees	$0	$0	$0

Schedule 9
Project Financing

Contents:

Schedule 9 Proposed Plan for Project Financing:

I. Summary of Proposed Financial plan

Check all that apply and fill in corresponding amounts.

	Type	Amount
☐	A. Lease	$
☐	B. Cash	$
☐	C. Mortgage, Notes, or Bonds	$
☐	D. Land	$
☐	E. Other	$
☒	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$0

If refinancing is used, please complete area below.

☐	Refinancing	$
☐	Total Mortgage/Notes/Bonds (Sum E + Refinancing)	$

II. Details

A. Leases

	N/A	Title of Attachment
1. List each lease with corresponding cost as if purchased each leased item. Breakdown each lease by total project cost and subproject costs, if applicable.	☐	
2. Attach a copy of the proposed lease(s).	☐	
3. Submit an affidavit indicating any business or family relationships between principals of the landlord and tenant.	☐	
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	☐	
5. If applicable, identify separately the total square footage to be occupied by the Article 28 facility and the total square footage of the building.	☐	
6. Attach two letters from independent realtors verifying square footage rate.	☐	
7. For all capital leases as defined by FASB Statement No. 13, "Accounting for Leases", provide the net present value of the monthly, quarterly or annual lease payments.	☐	

B. Cash

Type	Amount
Accumulated Funds	$
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$
TOTAL CASH	$0

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	
2. Attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations. In establishment applications for **Residential Health Care Facilities**, attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date for **the subject facility and all affiliated Residential Health Care Facilities**. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented (or to be implemented in the case of the subject facility) to improve operations.	☐	
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☐	
4. Attach a full and complete description of the assets to be sold, if applicable.	☐	
5. If amounts are listed in "Gifts (fundraising program)": • Provide a breakdown of total amount expected, amount already raised, and any terms and conditions affixed to pledges. • If a professional fundraiser has been engaged, submit fundraiser's contract and fundraising plan. • Provide a history of recent fund drives, including amount pledged and amount collected	☐	

	N/A	Title of Attachment
6. If amounts are listed in "Government Grants": • List the grant programs which are to provide the funds with corresponding amounts. Include the date the application was submitted. • Provide documentation of eligibility for the funds. • Attach the name and telephone number of the contact person at the awarding Agency(ies).	☐	
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	☐	
8. Current Department policy expects a minimum equity contribution of 10% of total project cost (Schedule 8b line 10)) for all Article 28 facilities with the exception of Residential Health Care Facilities that require 25% of total project cost (Schedule 8b, line 10). Public facilities require 0% equity.	☐	
9. Provide an equity analysis for member equity to be provided. Indicate if a member is providing a disproportionate share of equity. If disproportioned equity shares are provided by any member, check this box ☐	☐	

C. Mortgage, Notes, or Bonds

	Total Project	Units
Interest		%
Term		Years
Payout Period		Years
Principal		$

	N/A	Title of Attachment
1. Attach a copy of a letter of interest from the intended source of permanent financing that indicates principal, interest, term, and payout period.	☐	
2. If New York State Dormitory Authority (DASNY) financing, then attach a copy of a letter from a mortgage banker.	☐	
3. Provide details of any DASNY bridge financing to HUD loan.	☐	
4. If the financing of this project becomes part of a larger overall financing, then a new business plan inclusive of a feasibility package for the overall financing will be required for DOH review prior to proceeding with the combined financing.	☐	

D. Land

Provide details for the land including but not limited to; appraised value, historical cost, and purchase price. See sample table below.

	Total Project
Appraised Value	$
Historical Cost	$
Purchase Price	$
Other	

	N/A	Title of Attachment
1. If amounts are listed in "Other", attach documentation and a description as applicable.	☐	
2. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	☐	
3. Submit a copy of the proposed purchase/option agreement.	☐	
4. Provide an affidavit indicating any and all relationships between seller and the proposed operator/owner.	☐	

E. Other

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

	N/A	Title of Attachment
Attach documentation and a description of the method of financing	☐	

F. Refinancing

	N/A	Title of Attachment
1. Provide a breakdown of the terms of the refinancing, including principal, interest rate, and term remaining.	☐	
2. Attach a description of the mortgage to be refinanced. Provide full details of the existing debt and refinancing plan inclusive of original and current amount, term, assumption date, and refinancing fees. The term of the debt to be refunded may not exceed the remaining average useful life of originally financed assets. If existing mortgage debt will not be refinanced, provide documentation of consent from existing lien holders of the proposed financing plan.	☐	

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: ☐

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
N/A	N/A	3		736	Baseline Medical/Surgical	997			
				908	Medical/Social Services	175			
				944	Medical Supplies/Central Services/Storage	30			
				947	Tunnels, Bridges and Other Enclosed Circulation Spaces	620			
				980	Other Functions	300			
					#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:					**2122**	**0**	**0**	

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?		x

	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
			5/18/2026
PRINT NAME			TITLE
JOHN RODENBECK			MANAGING PRINCIPAL
NAME OF FIRM			
E4H Architecture			
STREET & NUMBER			
15 W 37TH ST, 6FL			
CITY	STATE	ZIP	PHONE NUMBER
NEW YORK	NY	10017	212.889.1840

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

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 91).
Codes for completing this table are found in the Functional Code Lookups sheet (see tab below).

Indicate if this project is:	New Construction:		**OR**	Renovation:	

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
				#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 with Subprojects

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
				#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				
				#N/A				
Raw totals for whole project:					**0**	**0**	**0**	

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

Subtotals for Sub Project 1		0		
Subtotals for Sub Project 2		0		
Subtotals for Sub Project 3		0		
Subtotals for Sub Project 4		0		
Subtotals for Sub Project 5		0		
Subtotals for Sub Project 6		0		
Subtotals for Sub Project 7		0		
Subtotals for Sub Project 8		0		
Totals for Whole Project:	**0**	**0**	**0**	

1. If New Construction is Involved, is it "freestanding?	YES	NO
Sub Project 1		
Sub Project 2		
Sub Project 3		
Sub Project 4		
Sub Project 5		
Sub Project 6		
Sub Project 7		
Sub Project 8		
Totals for Whole Project:		

2. Check the box that best describe\s the location of the facilities affected by this	Dense Urban	Other metropolitan or suburban	Rural
Sub Project 1			
Sub Project 2			
Sub Project 3			
Sub Project 4			
Sub Project 5			
Sub Project 6			
Sub Project 7			
Sub Project 8			
Totals for Whole Project:			

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
PRINT NAME			TITLE
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A

For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE
This appendix lists the functional areas and services, beds and equipment, by facility type, which should be used in describing your proposals. In listing these services in the application, do not include any description inside parentheses.

HOSPITAL including Extension Clinics

Use the following listing for hospital proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
701	General Baseline Services (includes Anesthesia, Emergency Procedures, Nursing and Physician Services)
733	Baseline Clinical Laboratory Service
734	Baseline Dietetic
736	Baseline Medical/Surgical
741	Baseline Operating Room
742	Baseline Pharmaceutical Service
744	Baseline Recovery Room
	INPATIENT SERVICES
101	Acute Renal Dialysis
151	Alcohol Detoxification
152	Alcohol Rehabilitation
102	Ambulance
301	Audiology
201	Blood Services
103	Burn Center
104	Burn Program
203	Cardiac Catheterization - Adult
204	Cardiac Catheterization - Pediatric
205	Cardio-Pulmonary Function Analysis
206	Cleft Palate Center
105	Coronary Care
208	Cystoscopy
209	Dental
210	Diagnostic Radiology
153	Drug Detoxification
154	Drug Rehabilitation
106	Emergency Department
107	Intensive Care
213	Kidney Transplantation
214	Maternity
302	Medical Rehabilitation
108	Neonatal Continuing Care
109	Neonatal Intensive Care

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

110	Neonatal Intermediate Care
303	Occupational Therapy
215	Cardiac Surgery - Adult
216	Cardiac Surgery - Pediatric
356	Pathology Laboratory
218	Pediatric
111	Pediatric - ICU
304	Physical Therapy
112	Poison Control Center
221	Psychiatric
222	Psychiatric - Day/Night
230	Radioactive Materials - Diagnostic
231	Radioactive Materials - Therapeutic
224	Radioisotope Implantation
226	Respiratory Care
227	Respiratory Therapy
361	Self Care
362	Social Work Service
305	Speech-Language Pathology
228	Therapeutic Radiology
306	Vocational Rehabilitation

OUTPATIENT SERVICES

491	Alcohol Rehabilitation O/P
402	Ambulatory Surgery
451	Audiology O/P
452	C.O.R.F.
423	Chronic Renal Dialysis O/P
406	Clinical Laboratory Service
407	Dental O/P
492	Drug Abuse Screening O/P
495	Drug Detoxification O/P
493	Drug Rehabilitation O/P
471	Family Planning O/P
472	Health Education O/P
473	Home Dialysis Training O/P
453	Medical Rehabilitation O/P
494	Methadone Maintenance O/P
413	Multiphasic Screening O/P
476	Nutritional O/P
454	Occupational Therapy O/P
414	Optometry O/P
425	Organized Outpatient Department
415	Outpatient Surgery
477	Part-Time Clinic(s)

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P
418	Prenatal O/P
419	Primary Medical Care O/P
420	Psychiatric O/P
421	Psychological O/P
424	Respiratory Therapy O/P
479	Social Work Service O/P
457	Speech-Language Pathology O/P
458	Vocational Rehabilitation O/P

BED TYPE

151	Alcohol Detoxification
152	Alcohol Rehabilitation
103	Burns Care
105	Coronary Care
153	Drug Detoxification
154	Drug Rehabilitation
107	Intensive Care
214	Maternity
302	Medical Rehabilitation
701	Medical/Surgical
221	Psychiatric
108	Neonatal Continuing Care
109	Neonatal Intensive Care
110	Neonatal Intermediate Care
218	Pediatric
111	Pediatric ICU
220	Prisoner
226	Respiratory
361	Self Care
364	Special Use

EQUIPMENT TYPE

423	Chronic Renal Dialysis Stations
501	CT Scanner
502	Cobalt Unit
503	Echo Cardiograph
504	Hyperbaric Chamber
505	Linear Accelerator
506	Megavoltage Unit
508	Ultrasound
601	Nuclear Magnetic Resonance Demonstration

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

RESIDENTIAL HEALTH CARE FACILITY
Use the following listing for Residential Health Care Facilities

Functional Codes	Service Description:
	BASELINE SERVICES
702	General Baseline Services - HRF's (includes Medical Services)
703	General Baseline Services - SNF's (includes Medical Services)
731	Baseline Activities Program
734	Baseline Dietetic
737	Baseline Nursing
742	Baseline Pharmaceutical Service
746	Baseline Social Work Service
	OPTIONAL SERVICES
301	Audology
352	Clinical Laboratory Service
209	Dental
210	Diagnostic Radiology
474	Non-Occupant Services
303	Occupational Therapy
217	Optometry
304	Physical Therapy
357	Physician Services
219	Podiatry
223	Psychological
359	Religious Services and Counseling
227	Respiratory Therapy
305	Speech-Language Pathology
	BED TYPES
703	SRF
	EQUIPMENT TYPES
501	CT Scanner
503	ECHO Cardiograph
508	Ultrasound

DIAGNOSTIC AND TREATMENT CENTER including Extension Clinics
Use the following listing for Diagnostic and Treatment Center proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
704	General Baseline (Includes Medical Staff)

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

	OPTIONAL SERVICES
401	Abortion O/P
491	Alcohol Rehabilitation O/P
402	Ambulatory Surgery
451	Audiology O/P
406	Clinical Laboratory Service
452	C.O.R.F.
423	Chronic Renal Dialysis O/P
407	Dental O/P
408	Diagnostic Radiology O/P
492	Drug Abuse Screening O/P
495	Drug Detoxification O/P
493	Drug Rehabilitation O/P
471	Family Planning O/P
472	Health Education O/P
473	Home Dialysis Training O/P
453	Medical Rehabilitation O/P
494	Methadone Maintenance O/P
413	Multiphasic Screening O/P
475	Nursing O/P
476	Nutritional O/P
454	Occupational Therapy O/P
414	Optometry O/P
477	Part-Time Clinic(s)
416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P
418	Prenatal O/P
419	Primary Medical Care O/P
420	Psychiatric O/P
421	Psychological O/P
479	Social Work Service O/P
457	Speech-Language Pathology O/P
427	Therapeutic Radiology O/P

	EQUIPMENT
423	Chronic Renal Dialysis Stations
502	Cobalt Unit
501	CT Scanner
503	Echo Cardiograph
505	Linear Accelerator
506	Megavoltage Unit
508	Ultrasound

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

MIDWIFERY BIRTH CENTER including Extension Clinics
Use the following listing for Midwifery Birth Center proposals:

Functional Codes	Service Description:
416	Pediatric O/P
418	Prenatal O/P
419	Primary Medical Care O/P

HOME HEALTH AGENCY
Use the following listing for Home Health Agency proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
705	General Baseline (includes Home Health Aide and Medical Supplies, Equipment and Appliances)
738	Baseline Nursing (Contract)
739	Baseline Nursing (Direct)
	OPTIONAL SERVICES
481	Medical Social Services O/P
476	Nutritional O/P
454	Occupational Therapy O/P
455	Physical Therapy O/P
482	Personal Care
483	Physicians Services
424	Respiratory Therapy
457	Speech-Language Pathology O/P

LONG-TERM HOME HEALTH CARE PROGRAM
Use the following listing for Long-Term Home Health Care Program Proposals

Functional Codes	Service Description:
	BASELINE SERVICES
707	General Baseline Services (includes Audiology; Home Health Aide; Homemaker, Housekeeper; Medical Social Work; Medical Supplies; Equipment And Appliances; Nutritional; Occupational Therapy; Personal Care; Physical Therapy; Respiratory Therapy; and Speech-L
738	Baseline Nursing (Contract)
739	Baseline Nursing (Direct)
	OPTIONAL SERVICES
357	Physician Services

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

	PATIENT CAPACITY
707	Designated patient capacity

HOSPICE

Use the following listing for Hospice Proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
706	General Baseline Services (includes Bereavement, Home Health Aide, Homemaker, Housekeeper, Nursing, Medical Supplies, Equipment & Appliances, Nutritional, Pastoral Care, Personal Care, Physician Services and Psychological)
732	Baseline Audiology
733	Baseline Clinical Laboratory Service
735	Baseline Inpatient Services
740	Baseline Occupational Therapy
742	Baseline Pharmaceutical Service
743	Baseline Physical Therapy
745	Baseline Respiratory Therapy
746	Baseline Social Work Service
747	Baseline Speech-Language Pathology
	BEDS
706	Hospice beds

NON-MEDICAL FUNCTIONAL AREAS

Use these codes for all health care facilities to describe non-medical functional areas:

Functional Codes	Service Description:
	NON-MEDICAL SERVICES
901	Administration (Routine)
902	General Administration
903	Admitting
904	Accounting/Financial Service
905	Administrative Personnel
906	Data Processing
907	Fund Appeal/Volunteers
908	Medical/Social Services
909	Energy Proposal
910	Telephone System
920	Public Areas
921	Cafeteria
922	Chapel/Meditation
923	Lobby/Waiting/Public Entrance
924	Coffee/Gift Shop/Flower/Canteen/Snack Bar

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

930	Education/Research
931	Supervising Physicians' Offices (Hospital Physicians involved in
932	Nursing School
933	Medical Laboratory/Auditorium
934	Research (Laboratory areas)
935	Medical Teaching (for residents and interns; Classrooms)
940	Industrial/Service Functions
941	Central Sterile and Supply
942	Laundry/Linen
943	Maintenance/Housekeeping
944	Medical Supplies/Central Services/Storage
945	Parking Structures (free-standing structures)
946	Staff Lockers
947	Tunnels, Bridges and Other Enclosed Circulation Spaces
948	Equipment Maintenance (includes Biomedical Engineering Service)
960	Building System
961	Site Work (Replant grass, signs, etc.)
962	On-site Parking, Excluding Garage Structure (parking lot)
963	Outside Utilities (water, sprinkler, lights, Outside sewer, etc.)
964	Structure, Including Finisher (Paint building, etc.)
965	Heating/Ventilation/Air Conditioning (HVAC)
966	Sanitary System (Inner plumbing and ventilation)
967	Electrical System
968	Vertical & Horizontal Mechanized Movement (elevators, cart system)
980	Other Functions
981	Private Physicians Offices
982	Housing on Call (Interns, residents, physicians)
983	Housing Other (for parents of young patients, visitors, etc.)
984	Medically Related Computer

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

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

Schedule 13c – Annual Operating Costs

In an attachment, provide the basis for determining budgeted expenses, including details for how depreciation and rent/lease expenses were calculated.

NYU Langone Hospital – Brooklyn Response:

Budgeted Expenses

Salaries and Wages

- Salaries and Wages were determined by multiplying the required FTEs by the average annual salary amount (in current year dollars) for each given position. Please see response contained within Schedule 13 B-1 Staffing regarding the number of mix of staff.

Employee Benefits

- Employee Benefits expense were estimated at 41.9% of salary expense, consistent with historical employee benefits expense.

Medical & Surgical Supplies

- Medical & Surgical Supplies were calculated using a cost per patient methodology.

Non-Medical, Non-Surgical Supplies

- Non-Medical, Non-Surgical Supplies were calculated based on historical cost per patient and include general/administrative expense, cleaning supplies, and other expenses.

Purchased Services

- Purchased Services expense represents cost associated with blood product purchases through a third party vendor as well as outsourced laboratory testing.

Other Direct Expenses

- Other Direct Expenses consist of pharmaceutical expense.

Depreciation Expense

This project does not require capital costs and therefore no depreciation expense was included.

Rent/Lease Expense

Not applicable.

Schedule 13d – Annual Operating Revenues

Provide the basis and supporting calculations for all utilization and revenues by payor.

NYU Langone Hospital – Brooklyn Response:

Utilization

Inpatient Services

- This project will enable NYU Langone Hospital – Brooklyn to perform bone marrow transplantation (BMT) services on an inpatient basis.
- Clinical and administrative staff reviewed patients who reside in Brooklyn who received BMT services at the NYU Langone Health – Manhattan Campus to estimate the volume of patients who could be treated locally in Brooklyn. This review resulted in approximately 27 discharges in the first year of the program and 56 discharges in year three.

Revenues

Schedule 13d-1 reflects the net patient services revenue for the projected volume. To determine the net inpatient revenue, the payor mix was applied to the projected volume, as described above. Payor-specific contractual rates were then applied to calculate the net patient service revenue. Revenue was calculated using current year payor rates. Please note that the slight increase in revenue per discharge is related to slight changes in the payor plans within the payor groups as well as volume growth in the type of BMT services performed.

Provide the basis for charity care revenue assumptions used in year 1 and 3 Budgets (Table 13D-2B). If less than 2%, provide a reason why a higher level of charity care cannot be achieved and remedies that will be implemented to increase charity care.

NYU Langone Hospital – Brooklyn Response:

The volume and revenue on Schedule 13D-1 does not include volume or revenue for charity care. Due to the nature of BMT services, patients would require a payor source or financial clearance prior to being eligible for BMT. All services will be provided in accordance with NYU Langone Health's Charity Care and Financial Assistance Policy. In addition, financial counselors are available to assist patients in exploring their options for coverage and treatment. Please note that NYU Langone Hospital – Brooklyn is projecting 30% Medicaid volume in year one and 34% in year three.

Schedule 13
All Article 28 Facilities

Contents:

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 7-1-26

Signature:

Bret J. Rudy, MD
Name (Please Type)

Executive Vice President & Chief of Hospital Operations
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			5.5	5.5
3. Registered Nurses			5.8	5.8
4. Licensed Practical Nurses				
5. Aides, Orderlies & Attendants				
6. Physicians				
7. PGY Physicians				
8. Physicians' Assistants				
9. Nurse Practitioners			5.0	5.0
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			3.0	3.0
18. Other	Pharmacist		1.0	1.0
19. Other				
20. Other				
21. Total Number of Employees			20.3	20.3

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

Describe how the number and mix of staff were determined:

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:	N/A
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	
○ Distance in miles from the proposed facility to the Hospital affiliate.	
○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	
○ 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	
○ Distance in miles from the proposed facility to the nearest hospital.	
○ 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

Schedule 13 C. Annual Operating Costs

See "Schedules Required for Each Type of CON" to determine when this form is required. One schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule that matches the structure of the tables (Attachment Title:) to summarize the first and third full year's total cost for the categories, which are affected by this project. The first full year is defined as the first 12 months of full operation after project completion. Year 1 and 3 should represent projected total budgeted costs expressed in current year dollars. Additionally, you must upload the required attachments indicated below.

Required Attachments

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis for determining budgeted expenses, including details for how depreciation and rent / lease expenses were calculated.	Schedule 13c - Annual Operating Costs	NYULHB Schedule 13c - Annual Operating Costs_BMT Program.doc
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital		

☒ Total Project or ☐ Subproject Number ☐

Table 13C - 1

	a	b	c
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)		9/1/2027	9/1/2029
1. Salaries and Wages		2290288	2290288
1a. FTEs		20	20
2. Employee Benefits		959631	959631
3. Professional Fees			
4. Medical & Surgical Supplies		90672	212298
5. Non-med., non-surg. Supplies		26500	28100
6. Utilities			
7. Purchased Services		170521	542718
8. Other Direct Expenses		6416199	14642452
9. Subtotal (total 1-8)		9953811	18675487
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs		9953811	18675487

Table 13C - 2

	a	b	c
Inpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)			
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs		9953811	18675487

Table 13C - 3

	a	b	c
Outpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)			
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Outpatient Operating Costs			

Any approval of this application is not to be construed as an approval of any of the above indicated current or projected operating costs. Reimbursement of any such costs shall be in accordance with and subject to the provisions of Part 86 of 10 NYCRR. Approval of this application does not assure reimbursement of any of the costs indicated therein by payers under Title XIX of the Federal Social Security Act (Medicaid) or Article 43 of The State Insurance Law or by any other payers.

Schedule 13 D: Annual Operating Revenues

See "Schedules Required for Each Type of CON" to determine when this form is required. If required, one schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule (Attachment Title:) to summarize the current year's operating revenue, and the first and third year's budgeted operating revenue (after project completion) for the categories that are affected by this project.

Table 1. Enter the current year data in column 1. This should represent the total revenue for the last complete year before submitting the application, using audited data. Project the first and third year's total budgeted revenue in current year dollars

Tables 2a and 2b. Enter current year data in the appropriate block. This should represent revenue by payer for the last complete year before submitting the application, using audited data.

Indicate in the appropriate blocks total budgeted revenues (i.e., operating revenues by payer to be received during the first and third years of operation after project completion). As an attachment, provide documentation for the rates assumed for each payer. Where the project will result in a rate change, provide supporting calculations. For managed care, include rates and information from which the rates are derived, including payer, enrollees, and utilization assumptions.

The Total of Inpatient and Outpatient Services at the bottom of Tables 13D-2A and13D-2B should equal the totals given on line 10 of Table 13D-1.

Required Attachments

	N/A	Title of Attachment	Filename of Attachment
1. Provide a cash flow analysis for the first year of operations after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project.	☒		
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	Schedule 13d - Annual Operating Revenues	NYULHB Schedule 13d - Annual Operating Revenues_BMT Program.doc
3. Provide the basis for charity care revenue assumptions used in Year 1 and 3 Budgets ((Table 13D-2B). *If less than 2%, provide a reason why a higher level of charity care cannot be achieved and remedies that will be implemented to increase charity care.*	☐	Schedule 13d - Annual Operating Revenues	NYULHB Schedule 13d - Annual Operating Revenues_BMT Program.doc

Table 13D - 1

	a	b	c
Categories	Current Year	Year 1 Total Revenue Budget	Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)	[redacted]		
1. Inpatient Services			
2. Outpatient Services			
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered			
5. Deductions from Revenue			
6. Net Patient Care Services Revenue			
7. Other Operating Revenue (Identify sources)			
8. Total Operating Revenue (Total 1-7)			
9. Non-Operating Revenue			
10. Total Project Revenue		11158763	23706797

Table 13D – 2A
Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ or Patient Discharges ☒

Inpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
			Net Revenue			Net Revenue			Net Revenue	
		(A) Patient Days or dis-charges	**(B)** Dollars ($)	$ per Patient Day or dis-charge **(B)/(A)**	**(C)** Patient Days or dis-charges	**(D)** Dollars ($)	$ per Patient Day or dis-charge **(D)/(C)**	**(E)** Patient Days or dis-charges	**(F)** Dollars ($)	$ per Patient Days or dis-charges **(F)/(E)**
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total					27	11158763	413288	56	23706797	423336

Table 13D – 2B

Various outpatient services may be reimbursed as visits or procedures. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Visits (V) ☐ or Procedures (P) ☐

Outpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
			Net Revenue			Net Revenue			Net Revenue	
		(A) V/P	**(B)** Dollars ($)	$ per V/P **(B)/(A)**	**(C)** V/P	**(D)** Dollars ($)	$ per V/P **(D)/(C)**	**(E)** V/P	**(F)** Dollars ($)	$ per V/P **(F)/(E)**
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										

Total of Inpatient and Outpatient Services					11158763			23706797	

Schedule 16
CON Forms Specific to Hospitals Article 28

Contents:

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.

NYU Langone Hospital—Brooklyn (NYULHB) will continue to adhere to all relevant federal and state regulations regarding the provision of inpatient medical, surgical, and bone marrow transplant (BMT) services. There will be no changes to the operational hours of the unit as a result of this initiative.

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

List of Proposed Ambulatory Surgery Category

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

Number and Type of Operating Rooms:

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

Number and Type of Procedure Rooms:

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

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.)

NYULHB proposes to convert four medical-surgical beds into BMT beds. Currently, there are no BMT beds available within Kings County, which results in the majority of residents needing to travel to Manhattan for such services. In 2023, approximately 94% of Kings County residents requiring BMT services traveled to facilities in Manhattan (SPARCS, 2023). This initiative aims to enhance access to BMT care by providing services closer to patients' homes. The facility is located within Kings County and will serve as the primary site for this initiative.

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

NYULHB primarily serves the Kings County community in New York City, a culturally diverse neighborhood with a rich history and historically underserved populations. The patient demographic includes the following characteristics:

Geographically, Kings County encompasses six areas: Central Brooklyn, Eastern Brooklyn, Northern Brooklyn, Northwestern Brooklyn, Southern Brooklyn, and Southwest Brooklyn, comprising over 50 neighborhoods. Each neighborhood offers a unique living experience with distinct cultural identities. Overall, approximately 36% of residents were born outside the United States, and 44% speak languages other than English (SPARCS, 2023).

According to estimates from the NYC DOHMH, the ethnic composition of Kings County is approximately 12% Asian, 28% Black, 9% Latinx, and 36% White, with approximately 19% of residents living in poverty (2023).

NYULHB provides comprehensive healthcare services to individuals of all ages, including infants and seniors, regardless of insurance coverage or ability to pay. Many residents of Kings County who receive Bone Marrow Transplant (BMT) services in Manhattan are children or older adults—populations that are particularly vulnerable and would benefit from receiving these services closer to home within their community. This program aims to support patients and families locally, reducing the need for long and potentially costly travel to healthcare facilities in Manhattan.

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.

The expansion of BMT services into Brooklyn aims to improve access to care and promote more consistent continuity of treatment for patients. This initiative is especially advantageous for individuals facing socioeconomic challenges, such as limited transportation options, demanding work schedules, and caregiving responsibilities, as services will now be offered within their local community rather than requiring travel for care (SPARCS, 2023).

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

Currently, BMT services are unavailable within Kings County. Consequently, approximately 31% of patients residing in Brooklyn must seek treatment at facilities in Manhattan or Long Island (SPARCS, 2023). This program aims to reduce travel burdens and improve the quality of life for patients and their families, considering the intensive follow-up care required for BMT treatments.

This model aligns with NYULHB's commitment to health equity and specifically addresses critical social determinants of health in underserved communities such as Kings County, where a substantial proportion of residents live below the poverty line.

(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.

As a leading institution in Kings County dedicated to serving diverse populations—including seniors, uninsured individuals, and those with limited access to healthcare—this proposed project is guided by a commitment to meet the community's needs, regardless of patients' ability to pay.

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

BMT services are currently unavailable within Kings County, requiring residents of Brooklyn to travel to other facilities. In 2021, over 70% of residents receiving care at three primary facilities—NYU Langone Tisch Hospital (27%), Mount Sinai Hospital (25%), and NYP Weill Cornell Medical Center (20%)—were residents of Kings County (SPARCS, 2023). In 2022, 27% of patients received care at Memorial Sloan Kettering Cancer Center, followed by 24% at Mount Sinai Hospital and 19% at NYP Weill Cornell Medical Center (SPARCS, 2023). In 2023, the distribution shifted, with 37% receiving care at Memorial Sloan Kettering, 23% at Mount Sinai, and 19% at NYU Langone Tisch Hospital (SPARCS, 2023). Since these frequently visited sites are all located in Manhattan, patients must travel from Brooklyn. This project aims to address this disparity by providing local access to these essential services for the community.

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.

Between 2021 and 2023, approximately 480 patients residing in Kings County received Bone Marrow Transplant (BMT) services (SPARCS, 2023). Although the number of BMT cases is relatively low, each case typically requires a hospital or outpatient treatment stay of 30 to 60 days (SPARCS, 2023). Additionally, ongoing follow-up and monitoring are critical during the weeks and months following the procedure. This project presents an opportunity to enhance long-term care delivery, improve patient outcomes, and ultimately improve quality of life for BMT candidates, survivors, and their families.

The proposed program aims to expand access to BMT services within Kings County. Improving service delivery for patients requiring BMT can benefit individuals with various cancerous and non-cancerous conditions, especially given that BMT is often the primary treatment for certain blood disorders.

Providing high-acuity patient care within the community aligns with NYU Langone Health's ongoing mission. This initiative is focused on delivering high-quality, comprehensive, and innovative care to historically underserved patient populations.

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.

Aligned with the New York State Prevention Agenda, the Community Service Plan (CSP) emphasizes the prevention of chronic diseases, reduction of disparities in access and quality, and enhancement of screening and early detection efforts. Specifically, the CSP aims to increase cancer screening rates, improve chronic disease management, incorporate community input to identify necessary program enhancements, strengthen provider engagement in cancer screening initiatives serving uninsured populations, and utilize provider assessment and feedback systems to improve screening rates in accordance with national guidelines—particularly targeting high-risk populations.

The proposed project will support the NYS Prevention Agenda by enabling NYULHB to deliver comprehensive cancer care to residents of Kings County across all levels of care, thereby advancing evidence-based management of cancer treatment and prevention.

To ensure alignment with the priorities outlined in the NYS Prevention Agenda and its Community Service Plan (CSP), NYULHB utilizes data sources including the U.S. Census Bureau American Community Survey, HANYS Community Benefit reports, and SPARCS data.

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

N/A

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

Access to Cancer Screening and Treatment: Providing comprehensive BMT services to Kings County will enable patients to receive essential treatment locally. As the program expands to serve an additional borough, the number of individuals screened for various cancers and blood disorders is expected to increase. These services will be accessible to both insured and uninsured patients.

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

NYULHB conducts numerous community-based initiatives focused on cancer prevention and education. These programs will be expanded to serve residents of Brooklyn, allowing them to receive care closer to home while maintaining engagement with healthcare providers. An example of such services includes timely treatment for leukemia, lymphoma, and certain solid tumors.

In addition to the faculty and staff at NYULHB, professionals from the Community & Government Affairs, Marketing, and Continuing Medical Education (CME) departments support the hospital's efforts through various activities, including representing the organization at community events related to cancer and assisting in the development of marketing materials to promote NYU Langone's brand and oncology services.

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

City Health Dashboard: interactive website to track health and health related metrics at the city level

US Census Bureau American Community Survey

SPARCS Data

DOH Community Health Profiles

DOH New York State Health Indicators by Race and Ethnicity

NYC Neighborhood Atlas

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)

Yes, the Community Benefit expenditure in the Community Health Improvement Services category, which aligns with the local Prevention Agenda Goals, was included in the most recent Schedule H form submitted to the IRS.

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?

New York State Department of Health
Certificate of Need Application

Schedule 16C

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

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	d	f
	Current Year *Visits**	First Year *Visits**	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			
Total			

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.

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.

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		
		Inpatient	OPD	ER
Payment Source				
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	
	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions
Primary Payment Source						
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.