Executive Summary

The Family Health Centers at NYU Langone (FHC) and NYU Langone Hospital—Brooklyn (NYULHB) submit this Administrative Review Certificate of Need application to consolidate two existing Brooklyn FHC locations—one at 6317 4th Avenue, which includes family health, women's health, and dental services, and another at 150 55th Street housing a dental practice—into a newly constructed, ADA-accessible five-story facility located at 602 60th Street, Brooklyn. In addition to the relocated clinics, the new facility will support the expansion of existing services offered across the FHC network.

The new FHC location will offer services including family medicine, women's health, dental care, and adult and pediatric rehabilitation services. The new facility will encompass approximately 13,000 square feet on the ground floor dedicated to family health services, 6,000 square feet on the second floor for women's health, 18,000 square feet across the third and fourth floors for adult and pediatric dental practices, and 9,000 square feet on the fifth floor for adult and pediatric rehabilitation services.

This consolidation and expansion intend to establish a comprehensive medical home, allowing patients to access multiple services conveniently at a single location, thereby reducing the need to visit multiple sites. The new facility's increased space will also enhance capacity, enabling FHC to serve a greater number of patients over time. Situated adjacent to FHC's Family Support Center, which provides community services such as nutrition support, early childhood programs, and educational services, the location supports integrated community health efforts. The FHC anticipates improvements in wait times and increased patient capacity resulting from the expanded space.

The total project cost is projected to be $78,373,526 which includes CON fees.

Please note the architectural components of this application will be reviewed by DASNY.

Schedule 1
All CON Applications

Contents:

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

New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

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

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
Larry McReynolds	7/14/25
PRINT OR TYPE NAME	TITLE
Larry K. Mcreynolds	Executive Director

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	
	Christopher Panettieri, Associate Director, Strategy Planning and Business Development	NYU Langone Health	
	BUSINESS STREET ADDRESS		
	One Park Avenue, Fourth Floor		
	CITY	STATE	ZIP
	New York	New York	10016
	TELEPHONE	E-MAIL ADDRESS	
	212-263-3492	Christopher.Panettieri@nyulangone.org	

Alternate Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	Laura Charney, Senior Management Analyst, Strategy Planning and Business Development	NYU Langone Health	
	BUSINESS STREET ADDRESS		
	One Park Avenue		
	CITY	STATE	ZIP
	New York	New York	10016
	TELEPHONE	E-MAIL ADDRESS	
	646-574-9363	Laura.Charney@nyulangone.org	

New York State Department of Health
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Schedule 1

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Larry K. Mcreynolds, Executive Director			
BUSINESS STREET ADDRESS			
5800 Third Avenue, Second Floor			
CITY	STATE	ZIP	
Brooklyn	NY	11220	
TELEPHONE	E-MAIL ADDRESS		
646-929-7870	LarryK.Mcreynolds@nyulangone.org		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM		BUSINESS STREET ADDRESS
Annette Johnson, Esq	NYU Langone Health		550 First Avenue
CITY, STATE, ZIP	TELEPHONE		E-MAIL ADDRESS
New York, NY 10016	212-263-7921		Annette.johnson@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
Astrid P. Gonzalez, Vice President, Finance	NYU Langone Health		150 55th Street
CITY, STATE, ZIP	TELEPHONE		E-MAIL ADDRESS
Brooklyn, NY, 11220	718-630-8973		Astrid.Gonzalez@nyulangone.org

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER			
NAME	FIRM		BUSINESS STREET ADDRESS
Michael Wyetzner	MICHIELLI+WYETZNER ARCHITECTS		143 West 29th St. Suite 4A
CITY, STATE, ZIP	TELEPHONE		E-MAIL ADDRESS
New York, NY, 10001	212-594-5075		mwyetzner@mwarch.net

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

New York State Department of Health
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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.

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*

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.

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

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

Schedule applies to all projects with construction, including Articles 28 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

Instructions

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Projects over $15 Million, or Projects Requiring a Waiver (PDF)
  - Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY. (PDF) (Not to Be Submitted with Self-Certification Projects)
  - Architect's Letter of Certification for Completed Projects (PDF)
  - Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings (PDF)
- Provide FEMA BFE Certificate. Applies only to Hospitals and Nursing Homes.
  - FEMA Elevation Certificate and Instructions.pdf
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - Physicist's Letter of Certification (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews
  - DSG-1.0 Schematic Design & Design Development Submission Requirements
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: Click to enter a date.	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Choose an item. If so, what is the original CON number? N/A	
Intent/Purpose: To create a new facility for the NYU Langone Health Family Health Center.Click here to enter text.	
Site Location: 602 60th Street, Brooklyn, New York 11220	
Brief description of current facility, including facility type:	

Currently, FHC has a facility nearby called Parkridge at 6317 4th Avenue and the former Lutheran Hospital at 150 55th Street, Brooklyn. The Parkridge facility contains family health, women's health, and dental practices which will be moving to the new facility, and the Hospital houses a dental practice which will also be moving to the new facility at 602 60th Street in Brooklyn Click here to enter text.	
Brief description of proposed facility: The new facility at 602 60th Street will inhabit a new building which is currently under construction. the new 5-story building will contain a 13,000 square foot family health practice on the ground floor, a 9,000 square foot women's health practice on the second floor, a 9,000 square foot adult dental practice on the third floor, a 9,000 square foot pediatric dental clinic on the fourth floor and a 9,000 square foot adult and pediatric rehabilitation practice on the fifth floor. Click here to enter text.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. All the new spaces will be ambulatory health facilities which are designated as Business Occupancies in the NYC Building Code. Please see above Click here to enter text.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: There will not be mixed occupancies in this building. All the occupancies will be ambulatory health facilities which are designated as Business Occupancies in the NYC Building Code. Click here to enter text.	
If this is an existing facility, is it currently a licensed Article 28 facility?	Not Applicable
Is the project space being converted from a non-Article 28 space to an Article 28 space?	Not Applicable
Relationship of spaces conforming with Article 28 space and non-Article 28 space: All practices will be Article 28 spaces. Click here to enter text.	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. No Exceptions are being requested at this time.	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. Click here to enter text.	Not Applicable
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. This will be a new facility from the ground up and will contain all new mechanical systems including HVAC, Electrical, Plumbing, Fire Protection and Fire Alarm Click here to enter text.	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. This will be a new facility from the ground up and will contain all new mechanical systems including HVAC, Electrical, Plumbing, Fire Protection and Fire Alarm	
Describe existing and or new work for fire detection, alarm, and communication systems: This will be a new facility from the ground up and will contain all new mechanical systems including HVAC, Electrical, Plumbing, Fire Protection and Fire Alarm	

If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. Not applicable
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. This project does not contain any imaging equipment other than x-ray machines for routine dental exams.
Does the project comply with ADA? If no, list all areas of noncompliance. Yes. this project will comply with ADA.
Other pertinent information: Click here to enter text.

Project Work Area	**Response**
Type of Work	Addition
Square footages of existing areas, existing floor and or existing building.	NA
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	49,000 square feet
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Exceeds 50% of the building
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type I (443)
Building Height	64'-5"
Building Number of Stories	5 stories above grade
Which edition of FGI is being used for this project?	2018 Edition of FGI
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 38 New Business Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Click here to enter text.	No
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	No
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	Not Applicable
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	Not Applicable
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	Not Applicable
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	No
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Not Applicable

Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	No

REQUIRED ATTACHMENT TABLE			
SCHEMATIC DESIGN SUBMISSION for **CONTINGENT APPROVAL**	DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for **CONTINGENCY SATISFACTION**	**Title of Attachment**	**File Name in PDF format**
•		Architectural/Engineering Narrative	A/E Narrative.PDF
•		Functional Space Program	FSP.PDF
•		Architect/Engineer Certification Form	A/E Cert Form. PDF
•		FEMA BFE Certificate	FEMA BFE Cert.PDF
•		Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Plans including level of exit discharge, and NFPA 101-2012 Code Analysis	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details. Illustrate FGI compliance on plans.	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
optional	•	Wall Sections and Partition Types	A500.PDF
optional	•	Interior Elevations, Enlarged Plans and Details	A600.PDF
	•	Fire Protection	FP100.PDF
	•	Mechanical Systems	M100.PDF
	•	Electrical Systems	E100.PDF
	•	Plumbing Systems	P100.PDF
	•	Physicist's Letter of Certification and Report	X100.PDF

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS

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

Date: July 17, 2024
CON Number:
Facility Name:
Facility ID Number:
Facility Address:

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

To The New York State Department of Health:

I hereby certify that:

1. I have been retained by the aforementioned facility, to provide professional architectural/engineering services related to the design and preparation of construction documents, including drawings and specifications for the aforementioned project. During the course of construction, periodic site observation visits will be performed, and the necessary standard of care, noting progress, quality and ensuring conformance of the work with documents provided for all regulatory approvals associated with the aforementioned project.

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

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

   a. __712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. **X 715 (Standards of Construction for Freestanding Ambulatory Care Facilities)**
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:

   _____

   _____

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

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

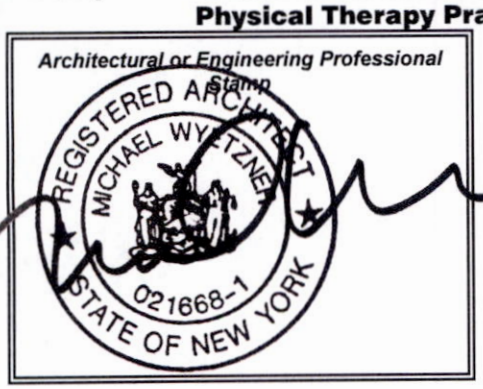
This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative,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

ProjectName: **Family Health Center Consolidation Project**

Location: **602 60th Street, Sunset Park, Brooklyn**

Description: **5 floor fitout of new building including Primary Care, Women's Health, Dental and Physical Therapy Practices.**

Architectural or Engineering Professional Stamp



Signature of Architect or Engineer

Michael Wyetzner
Name of Architect or Engineer (Print)

021668
Professional New York State License Number

143 West 29th Street 4th fl, New York, NY 10001
Business Address

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

Authorized Signature for Applicant

Date

Larry K. McReynolds, Executive Director
Name (Print) Title

Notary signing required for the applicant

STATE OF NEW YORK)
) SS:
County of Kings)

On the 16 day of July 2025 before me personally appeared Larry K. McReynolds to me known, who being by me duly sworn, did depose and say that he/she is the Executive Director of the Family Health Centers at NYU Langone, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary) Maria Escalera

MARIA ESCALERA
NOTARY PUBLIC, State of New York
No. 01ES4747931
Qualified in Kings County
My Commission Expires 9/30/25

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		Schedule 8b, column C, line 8
Total Basic Cost of Construction		Schedule 8B, column C, line 6
Total Cost of Moveable Equipment		Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction		Schedule 10
Cost/Per Square Foot for Renovation Construction		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	10/1/2026	Schedule 8B
Anticipated Completion Date	10/1/2027	

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:	10/1/2026	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	5/1/2027	as mm/dd/yyyy
Anticipated Completion of Construction Date	10/1/2027	as mm/dd/yyyy
Year used to compute Current Dollars:		

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

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

Item	A Project Cost in Current Dollars	B Escalation amount to Mid-point of Construction	C Estimated Project Costs
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition			
1.2 Building Acquisition			
2.1 New Construction			
2.2 Renovation & Demolition			
2.3 Site Development			
2.4 Temporary Utilities			
2.5 Asbestos Abatement or Removal			
3.1 Design Contingency			
3.2 Construction Contingency			
4.1 Fixed Equipment (NIC)			
4.2 Planning Consultant Fees			
4.3 Architect/Engineering Fees			
4.4 Construction Manager Fees			
4.5 Other Fees (Consultant, etc.)			
Subtotal (Total 1.1 thru 4.5)			
5.1 Movable Equipment (from Sched 11)			
5.2 Telecommunications			
6. Total Basic Cost of Construction (total 1.1 thru 5.2)			
7.1 Financing Costs (Points etc)			
7.2 Interim Interest Expense:: $ [ ] At [ ] % for [ ] months			
8. Total Project Cost: w/o CON fees - Total 6 thru 7.2			
Application fees: 9.1 Application Fee. Articles 28, 36 and 40. See Web Site.			
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 --> 0.0025			
10 Total Project Cost with fees			

New York State Department of Health VT DRAFT 4.1.25

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

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	$78,373,526
☐	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)	$78,373,526

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	$78,373,526
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$
TOTAL CASH	$78,373,526

	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 11 - Moveable Equipment
For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review *

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
		Please see attachment.				

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 13-
CON Forms Applicable to all Article 28 Facilities

Contents:

Schedule 13 A. Assurances From Article 28 Applicants

Article 28 applicants seeking combined establishment and construction or construction approval only 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 (Title 10).

c) The applicant will submit to the Commissioner of Health final working drawings and specifications, which shall conform to the standards of construction and equipment of Subchapter C of Title 10, prior to contracting for construction, unless otherwise provided for in Title 10.

d) The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.

e) The applicant will provide and maintain competent and adequate architectural and/or engineering inspection at the construction site to insure that the completed work conforms to the approved plans and specifications.

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

g) The facility will be operated and maintained in accordance with the standards prescribed by law.

h) The applicant will comply with the provisions of the Public Health Law and the applicable provisions of Title 10 with respect to the operation of all established, existing medical facilities in which the applicant has a controlling interest.

i) The applicant understands and recognizes that any approval of this application is not to be construed as an approval of, nor does it provide assurance of, reimbursement for any costs identified in the application. Reimbursement for all cost shall be in accordance with and subject to the provisions of Part 86 of Title 10.

Date

Signature:

Larry K. McReynolds

Name (Please Type)

Executive Director

Title (Please type)

Schedule 13 B. Staffing

Table 13B - 1: 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 ☐ Subproject number

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

*Last complete year prior to submitting application
**Use only for RHCF and D and T Center proposals

Describe how the number and mix of staff were determined:

Used last completed fiscal year for current year totals, and increased amounts in Year 1 & 3 for specific categories based on additonal services provided as well as an increase in projected volume

1.) All diagnostic and treatment centers should complete the following section:

Name of medical director:	
License number of the Medical Director	

	Not Applicable:	Title of Attachment	Filename of attachment
Attach a copy of the medical director's curriculum vitae.	☐		

Acute care facility with which an affiliation agreement is being negotiated:	
In the space below, Indicate the status of those negotiations:	

Distance in miles from the proposed facility to the acute care affiliate.	
Distance in minutes of travel time from the proposed facility to the acute care affiliate.	
Name of the acute care facility, nearest the proposed facility:	
Distance in miles from the proposed facility to the nearest acute care facility:	
Distance in minutes of travel time from the proposed facility to the nearest acute care facility.	

	Not Applicable:	Title of Attachment	Filename of attachment
Attach a copy of a letter of intent or the affiliation agreement, if appropriate.	☐		

Table 13B - 2. Ambulatory surgery centers should complete the following Table:

List all practitioners -- including surgeons, Dentists and Podiatrists, who have expressed an interest in practicing at the Center.
NOTE: Attach copies of letters from each giving the number and type of procedures he or she expects to perform per year.

Practitioner's Name	License No.	Specialty (s)	Board Certified or Eligible	Expected Number of Procedures	List hospitals where Physician has Admitting Privileges:	Title and File Name of attachment
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			

Schedule 13 C. Annual Operating Costs

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

Use this schedule to summarize the first and third full year's incremental 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. Project the first and third full year's total incremental costs in current year dollars. Current year costs added to first year incremental cost impact should equal total first year budget. Current year costs added to third year incremental budget should equal total third year budget. Show cost reductions in parentheses.

☒ Total Project
☐ Subproject Number ☐

Table 13C - 1

	a	b	c
Categories	Current Year	Year 1 Incremental Cost Impact	Year 3 Incremental Cost Impact
Start date of year in question:(m/d/yyyy)	9/1/2023	9/1/2026	9/1/2028
1. Salaries and Wages	[redacted]		
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			
11. Depreciation and Rent			
12. Total Incremental Operating Costs			

Table 13C - 2

	a	b	c
Inpatient Categories	Current Year	Year 1 Incremental Cost Impact	Year 3 Incremental Cost Impact
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			
11. Depreciation and Rent			
12. Total Incremental Inpatient Operating Costs			

Table 13C - 3

	a	b	c
Outpatient Categories	Current Year	Year 1 Incremental Cost Impact	Year 3 Incremental Cost Impact
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			
11. Depreciation and Rent			
12. Total Incremental Outpatient Operating Costs			

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for depreciation and rent expense	[redacted]	
2. In an attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital		

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 please submit. If no incremental budget changes, indicate n/a within incremental year one and year three.

This schedule is to be used for all proposals except (a) establishment applications for RHCFs and D&TCs, and (b) RCHF and D&TC applications which will increase total year current costs by more than 10%.

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 this schedule to summarize the current year's operating revenue, and the first and third year's incremental operating revenue 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 incremental revenue in current year dollars

Current year revenues added to first year incremental revenue impact should equal total first year budget.

Current year revenues added to third year incremental revenue impact should equal total third year budget.

Revenue reductions should be shown in parentheses.

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 incremental revenues (i.e., additional 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' 2a and b should equal the totals given on line 10 of table 1.

Provide as an attachment to this schedule 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. Please complete Schedule 5, Working Capital Schedule, in conjunction with the cash flow analysis.

Table 13D - 1

Categories	a Current Year	b Year 1 Incremental Revenue Impact	c Year 3 Incremental Revenue Impact
Start date of year in question:(m/d/yyyy)	[redacted]		
1. Daily Hospital Services			
2. Ambulatory 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)			
Grant Revenue			
Indigent Care Pool Pass Thru			
Other (Profesional Billing, Capitation,Patient Transportation, etc.)			
Mediciad Rate Appeal (see attachment for calculation)			
8. Total Operating Revenue (Total 1-7)			
9. Non-Operating Revenue			
10. Total Project Revenue			

Table 13D – 3

* Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ Patient discharges ☐

Inpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Patient Days or dis-charges *	Net Revenue* %	Net Revenue* Dollars ($)	Patient Days or dis-charges*	Net Revenue* % based on days or discharges	Net Revenue* Dollars-$	Patient Days or dis-charges*	Net Revenue* % based on days or discharges	Net Revenue* Dollars-$
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										

Table 13D - 4

Outpatient Services** Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue*		Visits	Net Revenue*		Visits	Net Revenue*	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	Fee for Service	[redacted]								
	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										

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	[redacted]	
2. In an attachment, provide the basis for charity care.		

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 Health will maintain compliance with all applicable federal and state regulations pertaining to the delivery of care through the FHCs. Clinic operational hours will remain unchanged 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.)

NYU Langone Hospital—Brooklyn proposes to consolidate several FHC locations, each providing different services, into a single, centralized site to enhance patient care coordination and convenience. The consolidated facility will be located at 602 60th Street, Brooklyn, NY. This location is situated within Kings County and will serve as the primary county 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.

The Family Health Centers at NYU Langone Hospital–Brooklyn primarily serve the Sunset Park community in Brooklyn, New York, one of the most diverse and historically underserved neighborhoods in the city. The patient population is characterized by the following demographics:

Geographically, Sunset Park comprises three neighborhoods: Sunset Park West, Sunset Park Central, and Sunset Park East/Borough Park West. The community has a significant immigrant presence, with approximately 49% of residents born outside the United States and 77% speaking languages other than English. In response to this diversity, the Family Health Centers offer bilingual services in languages such as Spanish, Mandarin, and Cantonese.

According to estimates from the NYC DOHMH, the ethnicity of Sunset Park is approximately 31% Asian, 3% Black, 41% Latinx, and 23% White.

The Centers provide comprehensive care for individuals across all age groups, from infants to seniors. Given that over 80% of patients live in poverty, the facility functions as a vital safety net provider for low-income families. Care is offered regardless of patients' ability to pay or insurance status, with acceptance of most major insurance plans, including Medicaid and Medicare.

A significant portion of the patient population is foreign-born, often facing challenges such as language barriers and difficulties navigating complex healthcare and social service systems.

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 consolidation of multiple FHC clinics into a single location at 602 60th Street in Brooklyn is expected to enhance access to services and ensure more consistent continuity of care for patients. This initiative is particularly beneficial for individuals facing socioeconomic challenges, such as limited transportation options, rigid work schedules, and caregiving commitments.

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

By consolidating services such as adult and pediatric medicine, women's health, dental care, and physical rehabilitation, patients will have access to comprehensive healthcare services within a single location. This approach aims to reduce the need for multiple visits to different sites, thereby minimizing missed appointments and enhancing treatment adherence. Moreover, integrated care within a single facility promotes improved coordination among healthcare providers, leading to more efficient and patient-centered services.

This model supports NYU Langone Health's commitment to health equity and specifically addresses key social determinants of health in underserved communities such as Sunset Park, where a significant portion 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.

Currently, patient care is provided at the existing FHC clinics situated in the following locations: family medicine and dental services are offered at Park Ridge FHC and NYU Langone Hospital–Brooklyn. The obstetrics and gynecology, as well as adult and pediatric rehabilitation services, represent expansions of our existing programs.

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

The FHCs are strategically positioned to address the prevalent health challenges within Sunset Park and surrounding Brooklyn neighborhoods through an integrated, community-based care approach that has received national recognition for its effectiveness.

The proposed consolidation aims to improve service delivery for critical health issues affecting the community, such as chronic disease management, maternal and child

health, disparities in oral health, and the rehabilitation needs of individuals with physical disabilities. Sunset Park experiences elevated rates of asthma, diabetes, obesity, and hypertension, often associated with social determinants of health including poverty, crowded housing, food insecurity, and limited access to preventive care (NYC Health Profile – Sunset Park, 2018).

With over 50 years of experience serving medically underserved populations, the FHCs provide comprehensive primary and specialty care regardless of patients' ability to pay, immigration status, or insurance coverage. As a federally qualified health center (FQHC) network, they employ proven care models, such as:

• Patient-Centered Medical Home (PCMH): Improving care coordination and patient engagement through team-based, culturally competent services.

• School-Based Health Programs: Over 50 clinics offering integrated medical, dental, and behavioral health services to students—allowing early intervention within accessible settings (NYU Langone Family Health Centers).

• Community Medicine Program: Reaching at-risk groups via mobile units, home visits, and collaborations with shelters and supportive housing organizations.

• Multilingual Services and Health Literacy Initiatives: Bilingual staff and patient navigators help overcome language barriers and enhance access to healthcare for Sunset Park's large immigrant population (NYU Langone News, 2023).

By co-locating services within a modern facility, the Family Health Centers can further streamline care for patients managing multiple chronic conditions, reduce fragmentation, and promote adherence to treatment plans—leading to improved health outcomes and a more equitable healthcare environment for Brooklyn's most vulnerable residents.

Non-Public Hospitals

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

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

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

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

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

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

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.

New York State Department of Health

Health Equity Impact Assessment Conflict-of-Interest

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

Section 1 – Definitions

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

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

Section 2 – Independent Entity

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

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

Section 3 – General Information

A. About the Independent Entity

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

     _____

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

Section 4 – Attestation

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

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

Signature of Independent Entity: _____

Date: __/__/____

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

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

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

Table A.

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

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

Section B. All Article 28 Facilities

Table B.

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

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

*Calculate the percentage change from the number of certified/authorized beds and/or certified/authorized services (as indicated on the facility's operating certificate) specific to the category of service or care. For example, if a residential health care facility adds two ventilator-dependent beds and the facility had none previously, this would exceed the 10% threshold. If a hospital removes 5 out of 50 maternity certified/authorized beds, this would meet the 10% threshold.

- ***If you checked "yes" for one or more questions in Table B***, the following HEIA documents are required to be completed and submitted along with the CON application:
    - HEIA Requirement Criteria with Section B completed
    - HEIA Conflict-of-Interest

- HEIA Contract with Independent Entity
- HEIA Template
- HEIA Data Tables
- Full version of the CON Application with redactions, to be shared publicly

- ***If you checked "no" for all questions in Table B***, this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.