Executive Summary

NYU Langone Hospitals is submitting this Full Review Construction Certificate of Need application for the creation of an Ambulatory Surgery Center for orthopedic services in Westchester County at 4 Westchester Park Drive, West Harrison NY 10604. The addition of a freestanding ambulatory surgery center in Westchester County will enable patients who reside in or closer to Westchester to access orthopedic services closer to home. Currently, NYULH patients residing in Westchester and as well as some patients outside the service area must travel to Manhattan for orthopedic services, which creates time and cost burdens for patients. Traveling to and within Manhattan is burdensome for all patients and there are some medically underserved groups who face the greatest burdens from traveling to Manhattan. Once the project is complete, patients will still receive care from their same providers closer to home.

The current facility is a multi-tenant Business Occupancy building with 5 floors. The new program will be a New Ambulatory Healthcare Occupancy and will be shared on the same floor with another tenant which is a Business Occupancy Daycare. The area where the proposed New Ambulatory Surgery Center is currently unoccupied and demolished. The site has parking surrounding the entire building with an abundance of accessible parking spaces.

The project will include an NYULH dedicated waiting room with ADA toilet, pre- and post-procedure/recovery area which will include 12 universal bays, a multi-purpose room that can be used as exam/consult room, 4 operating rooms with a combined sterile/supply core, on-site Sterile Processing, and all the required clinical patient and support spaces.

The construction of the project will be completed in one phase.

Please note that the Dormitory Authority of the State of New York (DASNY) will conduct the architectural review of this project.

Schedule 1
All CON Applications

Contents:

New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

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

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

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

General Information

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

Contacts

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

Primary Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	Shari M. Liss, Director, Strategy, Planning and Business Development	NYU Langone Health	
	BUSINESS STREET ADDRESS		
	One Park Avenue, Rm. 4-402		
	CITY	STATE	ZIP
	New York	New York	10016
	TELEPHONE	E-MAIL ADDRESS	
	212 404-3883	Shari.liss@nyulangone.org	

Alternate Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	Christopher Panettieri, Senior Manager	NYU Langone Health	
	BUSINESS STREET ADDRESS		
	One Park Avenue, Rm. 4-402		
	CITY	STATE	ZIP
	New York	New York	10016
	TELEPHONE	E-MAIL ADDRESS	
	212 263-3492	Christopher.Panettieri@nyulangone.org	

New York State Department of Health
Certificate of Need Application

Schedule 1

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Robert I. Grossman, M.D., Dean and CEO, NYU Langone Health			
BUSINESS STREET ADDRESS			
550 First Avenue, 15th floor			
CITY	STATE	ZIP	
New York	New York	10016	
TELEPHONE	E-MAIL ADDRESS		
212 263-5000	N/A		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM	BUSINESS STREET ADDRESS	
Annette Johnson, Esq.	NYU Langone Health	550 First Avenue, 15th Floor	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
New York, New York 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	
N/A			
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

The applicant's lead accountant should be identified:

ACCOUNTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
Michelle Ulrich	NYU Langone Health	One Park Avenue, 5th Floor	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
New York	212 404-4159	Michelle.Ulrich@nyulangone.org	

Please list all Architects and Engineer contacts:

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

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

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 the monthly Cash Flow. 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

To the extent that working capital is required, it will be funded from operations. Please see Attachment 1- NYU Langone Hospitals Consolidated Financial Statement.

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 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: NEXT MEETING IS NOVEMBER OR JANUARY FOR REVIEW REVIEW TIMELINES 9/30/2024	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? No If so, what is the original CON number?	
Intent/Purpose: The purpose of this project is to provide Ambulatory Surgery services to NYULH patients that live in the Westchester/White Plains/Town of Harrison. These patients typically travel to NYULH in Manhattan to receive Ambulatory Surgical care. Having a location closer to home makes it easier for them to access the	

medical services they need. Many of the patients being treated in this area are elderly and by providing this care closer to their home, it will allow them to spend less time, money and other burdens to receive care. Ultimately making their quality of life and care better. This project also will allow for more of the population living in the surrounding area, who are not currently patients of NYULH, to have access to quality outpatient surgical services and allow NYULH's outreach to expand.

The proposed project is to turn a portion of the Ground level at 4 Westchester Park Drive into an Ambulatory Surgery Center. The space is currently vacant and demolished.

The program will provide an NYULH dedicated waiting room with ADA toilet, 12 universal pre and post-procedure/recovery bays, 4 Operating rooms, on-site Sterile Processing, and all the required clinical, staff and patient support spaces.

The expected construction completion in 2026.

Site Location:
The project is located at 4 Westchester Park Drive, White Plains NY, 10604

Brief description of current facility, including facility type:
The current facility is a multi-tenant Business Occupancy building with 5 floors. The Ground Level, where the NYULH Orthopedic Ambulatory Surgery Center will be located shared with one other tenant which is a Business Occupancy Daycare. The area where the New Ambulatory Surgery Center will be located is currently unoccupied and demolished.

The site has parking surrounding the entire building with an abundance of accessible parking spaces directly at the front entry of the building. The front entry also has a curb cut/drop off area with a fire lane that will allow for the arrival of an ambulance in the event of an emergency.

Brief description of proposed facility:
The new program is for an Ambulatory Surgery Center on the Ground Level on the proposed building.

The current space is vacant and demolished. The project will include an NYULH dedicated waiting room with ADA toilet, pre and post- procedure/recovery are will include 12 universal bays, a multipurpose room that can be used as an exam/consult room, 4 operating rooms with a combined sterile/supply core, on-site Sterile Processing, and all the required clinical, patient and staff support spaces.

Patients & Staff will arrive through the main entry to the site into a parking area surrounding the building, where they can park or be dropped off at the main entry on the Ground Level. Once within the main lobby on the building, NYULH patients will have access to a separate NYULH dedicated waiting and reception area. Staff arrival will be through the same main Ground Level lobby or through an entry on Level 1Once within the building there are various secure access points for staff to gain access into the clinical spaces. Deliveries will be directed to a receiving/breakdown room on the west side of the building.

The project will be completed in one phase. Since the current space is vacant and demolished there is minimal demolition scope to accommodate the proposed plan. The project will require modifications and supplementation of existing HVAC with additional systems to meet code required ventilation requirements. Electrical (NP and EP), Plumbing and Fire Protection systems are sufficient for the new project.

All finishes will reflect NYULH Guidelines.

Location of proposed project space(s) within the building. Note occupancy type for each occupied space.
Ground Level:
NYULH ASC – New Ambulatory Healthcare
Other Tenant – Business Occupancy

Level 01:
Business Occupancy

Level 02:
Business Occupancy

Level 03:
Business Occupancy

Level 04:
Business Occupancy

Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies:
~~Not Appli~~New ambulatory healthcare is divided into 2 smoke compartments, which are 1hr smoke barrier and public corridor including the parameter of other tenant is 1hr fire rated.~~cable~~

If this is an existing facility, is it currently a licensed Article 28 facility?	No
Is the project space being converted from a non-Article 28 space to an Article 28 space?	Yes

Relationship of spaces conforming with Article 28 space and non-Article 28 space:
New construction of article 28 space

List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3.
Click here to enter text.

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.

HVAC System

The building is equipped with central air handling unit on mechanical penthouse on roof level, provides heating, cooling and ventilation air requirement for all floors via central sheet metal supply duct risers and return air shaft. Each floor is equipped with terminal units and sheet metal air distribution ductwork and supply air diffusers. The central air handling unit is equipped with split type of DX coil and hot water coil. The air cooled condenser is located outdoor roof level. The heating system consists of gas fired hot water boiler plant on mechanical penthouse, provide heating requirement for the building via hot water distribution loop, including fin tube radiation devices along the building perimeter spaces.

Electrical System

The building is supplied with a 277/480V, 3-phase electric services from utility company which is terminated to 277/480V switchboards located in the main electrical room on the 1st floor level. One of the services, only serve the existing rooftop unit. Distribution panels are installed throughout the building which are fed from the switchboard. These distribution panels feed several lighting and appliance panels throughout. There are tenants in the building that taps the same service on which they have been provided with their own utility meter separate from the building electric meter. The building has an existing fire alarm system and fire alarm devices are installed throughout the building.

The proposed space has normal power which are composed of several panels in the space. There are two (2) existing automatic transfer switches (ATSs) installed by the previous tenant. These ATSs are fed from the building main switchboard and emergency feeds are coming from the existing outdoor generator. Each ATS feed a panel for the previous tenant.

Plumbing System
The building is supplied by (1) 4" domestic water service, which enters the building within the proposed space. Domestic water distributes on the Ground Floor, including within the proposed space, and connects to several base building and tenant water risers. There is an existing water-to-water heat exchanger located in the Boiler Room which generates domestic hot water for the core restrooms only, outside the proposed space.

The building has (1) 6" sanitary sewer, which exits the building within the proposed space. There are several sanitary and vent stacks available for connection within our space. Several storm leaders connected to the building roof drains are located at the wet columns within our space.

The building is supplied by (1) 2" high pressure gas service, which enters the west side of the building from the parking lot. Upon entering the building, the gas service increases to 4" and distributes within our space to various equipment within the building.

Fire Protection System
The building is supplied by (1) 6" fire service, which enters the southeast corner of the building within the proposed space. Upon entering the building, it tees to the fire department connection located at the building exterior wall adjacent to our space, which serves as the secondary water supply for the building. The 6" main distributes to the combined sprinkler and standpipe risers, located in each Stair. Each riser is equipped with a 2½" fire hose valve for fire department connection. The sprinkler system is equipped with a 2½" control valve with a water flow and tamper switch. There is no fire pump within the building.

Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc.

HVAC System
The existing HVAC system within the project area will be removed at is entirety and new, separate, stand-alone HVAC system will be provided to support the proposed function of the space. New air handling units will be provided, located outdoor on grade level, provides heating, cooling, ventilation, humidification, dehumidification and filtration requirement for OR suites. The OR units will be equipped with cooling coil, heating coil, prefilter, return fans, supply fans, humidifier, final filters. Air distribution system consists of sheet metal ductwork, terminal units, return terminal units, low return and HEPA filters on laminar flow supply diffuser. Dedicated outside air unit will be provided and located on roof level, will provide ventilation air requirement for the project area via dedicated sheet metal duct riser. The new air handling units will be provided to support patient prep / recovery area, will be located outdoor on grade level, provides heating, cooling, ventilation air requirement for the space. The sheet metal air distribution system shall be provided from outdoor air handling units to space with terminal units. The new roof top equipment shall be provided to support central sterile department, the unit will be capable of delivering 100% outside air to the area via sheet metal duct risers. The unit will be equipped with Dx cooling coil, gas fire heating coil, prefilter, supply fan, humidifier and final filter.
The heat rejection and injection requirement will be provided by new air-cooled heat pump type chiller / heater. The unit will be located on roof level, shall provide heating and cooling requirement for the project, via dedicated chilled water and hot water distribution system.
Exhaust fan shall be provided for toilet, EVS rooms, med gas manifold room and decontamination area. Inline type of exhaust fans will be utilized and will be located at the discharge louvers on ground level.

Electrical System

The existing electrical system infrastructure (normal and emergency power) within the project will be removed at its entirety. A new electrical infrastructure will be installed. The existing outdoor emergency generator will be evaluated to determine if it can be used for this project. A new generator will be installed if the existing generator is no longer reliable or undersize for this project. New distribution panels, automatic

transfer switches (ATSs) and lighting/appliance panels will be installed. A minimum of three (3) automatic transfer switches (life safety, critical and equipment branch) will be installed to comply with Type 1 EES.

A new nurse call system will be installed. New devices will be installed where required to comply with FGI.

Plumbing System
The proposed space will be supplied from the building's 4" domestic water service. Hot water will be generated by duplex domestic water heaters, either gas-fired or electric depending upon service availability. New domestic cold water, hot water, and hot water recirculation piping will distribute within the proposed space, connected to plumbing fixtures and equipment.

New sanitary piping will be provided below the slab (underground), connected to the building sanitary system. Existing sanitary piping connected to fixtures on the floor above will be relocated as needed to coordinate with new work in the ceiling of the proposed space. New vent piping will be provided, connected to the building vent system.

New gas piping will be provided, connected to new mechanical and plumbing equipment dedicated to our space. This equipment will likely be located at the building roof. Gas service upgrades will be provided if required by the gas utility company.

New medical gas systems will be provided for the operating rooms and prep/recovery beds. The following systems are anticipated: oxygen, medical air, medical vacuum. Other positive-pressure medical gas and support gas systems may be provided, including but not limited to the following: nitrous oxide, carbon dioxide, nitrogen/instrument air. Source equipment will be provided as follows: medical air compressor, medical vacuum pump, liquid oxygen manifold, high pressure manifolds for nitrous oxide, carbon dioxide, nitrogen, instrument air compressor. Medical air compressors and vacuum pumps will be located on the building roof. Manifolds will be located in a dedicated manifold room located within the proposed space, directly accessible from outside. All medical gas systems will comply with NFPA 99 requirements.

Fire Protection System
The proposed space will be fully sprinklered, connected to the existing 2½" floor control valve assembly located at the stair. New sprinkler mains, branch piping, and sprinkler heads will be provided within the proposed. Space. Auxiliary fire hose valve connections are not anticipated but will be provided if the new architectural program inhibits existing hose coverage on the floor.

Describe existing and or new work for fire detection, alarm, and communication systems:
New fire alarm devices (smoke detectors, duct smoke detectors, audio/visual devices, pull station, control modules and etc.) will be installed throughout the project. These new devices will be connected to the existing fire alarm system in the building. Modification to existing fire alarm system may be required to accommodate the new devices.

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. Yes, the project will include mobile C-arms to be used during surgery.

Does the project comply with ADA? If no, list all areas of noncompliance. Yes, Complies
Click here to enter text.

Other pertinent information:
Click here to enter text.

Project Work Area	**Response**
Type of Work	Renovation
Square footages of existing areas, existing floor and or existing building. Total Ground floor Area: 21,000 SF	15,071 SF

Other tenant space: 2,336 SF Shared Space: 3,593 SF NYULH ASC Space:15,071 SF	
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	15,071 SF
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Exceeds 50% of the floor
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type II (222)
~~Building Height~~	55.5'
Building Number of Stories	5 Stories
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?	Grade Level
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 20 New Ambulatory Health Care 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. **Ground Level:** NYULH ASC – Ambulatory Healthcare Other Tenant – Business Occupancy **Level 01:** Business Occupancy **Level 02:** Business Occupancy **Level 03:** Business Occupancy **Level 04:** Business Occupancy	Yes
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	~~Not Applicable~~~~No~~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.	~~Not Applicable~~~~No~~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.	~~Not Applicable~~~~No~~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~~~~No~~No
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

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Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	Yes
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.	Not Applicable
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	Not Applicable
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?	Not Applicable

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

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

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	$38,435,000	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$38,435,000	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$7,770,000	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	N/A	Schedule 10
Cost/Per Square Foot for Renovation Construction	$683	Schedule10
Total Operating Cost	$20,319,230	Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.00%	Schedule 9
Depreciation Life (in years)	20	

2) Construction Dates

Anticipated Start Date	5/1/2025	Schedule 8B
Anticipated Completion Date	3/1/2026	

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

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

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	10.00%	Normally 10%
Construction Contingency - Renovation Work	10.00%	Normally 10%
Anticipated Construction Start Date:	5/1/2025	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	10/1/2025	as mm/dd/yyyy
Anticipated Completion of Construction Date	3/1/2026	as mm/dd/yyyy
Year used to compute Current Dollars:		

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

	A	B	C
Item	Project Cost in Current Dollars	Escalation amount to Mid-point of Construction	Estimated Project Costs
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$18,000,000	$0	$18,000,000
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$15,000	$0	$15,000
3.1 Design Contingency	$1,800,000	$0	$1,800,000
3.2 Construction Contingency	$1,800,000	$0	$1,800,000
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$1,350,000	$0	$1,350,000
4.4 Construction Manager Fees	$5,400,000	$0	$5,400,000
4.5 Other Fees (Consultant, etc.)	$500,000	$0	$500,000
Subtotal (Total 1.1 thru 4.5)	$28,865,000	$0	$28,865,000
5.1 Movable Equipment (from Sched 11)	$7,770,000	$0	$7,770,000
5.2 Telecommunications	$1,800,000	$0	$1,800,000

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

6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$38,435,000	$0	$38,435,000
7.1 Financing Costs (Points etc)	$0		$0
7.2 Interim Interest Expense:: $ [ ] At [ ] % for [ ] months	$0		$0
8. Total Project Cost: w/o CON fees - Total 6 thru 7.2	$38,435,000	$0	$38,435,000
Application fees: 9.1 Application Fee. Articles 28, 36 and 40. See Web Site.	$2,000		$2,000
9.2 Additional Fee for projects with capital costs. Not applicable to "Establishment Only" projects. See Web Site for applicable fees. (Line 8, multiplied by the appropriate percentage.) Enter Multiplier ie: .25% = .0025 --> 0.0055	$211,393	$0	$211,393
10 Total Project Cost with fees	$38,648,393	$0	$38,648,393

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	$38648393
☐	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)	$38648393

If refinancing is used, please complete area below.

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

II. Details

A. Leases

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

B. Cash

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

	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.	☒	Attachment 1
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☐	
4. Attach a full and complete description of the assets to be sold, if applicable.	☐	
5. If amounts are listed in "Gifts (fundraising program)": • Provide a breakdown of total amount expected, amount already raised, and any terms and conditions affixed to pledges. • If a professional fundraiser has been engaged, submit fundraiser's contract and fundraising plan. • Provide a history of recent fund drives, including amount pledged and amount collected	☐	

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

C. Mortgage, Notes, or Bonds

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

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

D. Land

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

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

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

E. Other

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

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

F. Refinancing

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

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

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

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

A		B	D	E	F	G	H	I
Location								
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
		G	903	Admitting	143	$159,213		
		G	923	Lobby/Waiting/Public Entrance	1073	$1,194,652		
		G	402	Ambulatory Surgery	7709	$8,583,013		
		G	946	Staff Lockers	902	$1,004,076		
		G	941	Central Sterile and Supply	1747	$1,945,067		
		G	967	Electrical System	242	$269,437		
		G	906	Data Processing	205	$228,242		
		G	965	Heating/Ventilation/Air Conditioning (HVAC)	926	$1,030,986		
		G	960	Building System	227	$252,736		
		G	944	Medical Supplies/Central Services/Storage	368	$410,023		

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

		G	942	Laundry/Linen	176	$195,954		
		G	943	Maintenance/Housekeeping	415	$462,051		
		G	980	Other Functions	1041	$1,158,968		
		G	901	Administration (Routine)	823	$916,308		

A		B	D	E	F	G	H	I
Location								
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
		ROOF	980	Other Functions	170	$189,274		
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				

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

				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**16,167**	**18,000,000**	**-**	

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

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

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

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

SIGNATURE			DATE
Jennifer Calin			10/1/2024
PRINT NAME			TITLE
Jennifer Calin			SPM
NAME OF FIRM			
NYULH			
STREET & NUMBER			
One Park Ave, 5th floor,NY,NY 10016			
CITY	STATE	ZIP	PHONE NUMBER
New York	NY	10016	646-799-2901

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

Table I: New Equipment Description

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

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

Table 2 - Equipment being replaced:

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

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

Schedule 13
All Article 28 Facilities

Contents:

Schedule 13 A. Assurances from Article 28 Applicants

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

The undersigned, as a duly authorized representative of the applicant, hereby gives the following assurances:

a) The applicant has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way sufficient to assure use and possession for the purpose of the construction and operation of the facility.

b) The applicant will obtain the approval of the Commissioner of Health of all required submissions, which shall conform to the standards of construction and equipment in Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.

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

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

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

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

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

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

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

Date 9/4/25

Signature:

Robert I. Grossman, M.D.
Name (Please Type)

Dean and CEO
Title (Please type)

Schedule 13 B-1. Staffing

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

☐ Total Project or ☐ Subproject number

A		B	C	D
		Number of FTEs to the Nearest Tenth		
Staffing Categories		Current Year*	First Year Total Budget	Third Year Total Budget
1. Management & Supervision				
2. Technician & Specialist				
3. Registered Nurses				
4. Licensed Practical Nurses				
5. Aides, Orderlies & Attendants				
6. Physicians				
7. PGY Physicians				
8. Physicians' Assistants				
9. Nurse Practitioners				
10. Nurse Midwife				
11. Social Workers and Psychologist**				
12. Physical Therapists and PT Assistants				
13. Occupational Therapists and OT Assistants				
14. Speech Therapists and Speech Assistants				
15. Other Therapists and Assistants				
16. Infection Control, Environment and Food Service				
17. Clerical & Other Administrative				
18. Other	Supply Chain and CSPD			
19. Other	Anesthesiologist & CRNA			
20. Other				
21. Total Number of Employees			47.0	65.0

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

Describe how the number and mix of staff were determined:

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

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

.

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

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

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

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

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

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

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

Schedule 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.

The NYULH-Westchester Ambulatory Surgery Center located at 4 Westchester Park Drive, West Harrison, NY 10604 will function as a department of NYU Langone Hospital and as such, the Hospital will provide oversight on its quality of care, including credentialing, utilization and quality assurance monitoring.

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

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

List of Proposed Ambulatory Surgery Category
Orthopedic Surgery

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

Number and Type of Operating Rooms:

- Current: 0
- To be added: 4
- Total ORs upon Completion of the Project: **4**

Number and Type of Procedure Rooms:

- Current: 0
- To be added: 0

- 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.)

The relevant service area for this project is Westchester County in New York State.

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

The population to be served includes the residents of Westchester County, New York.The population of Westchester County (2024) totaled 989,776 with 52% female and 48% male. The average age of the population was 41.7 years with the following age distribution:

Age Groups	2024 Population	2024 % of Total
00-17	203,423	20.55%
18-44	328,505	33.19%
45-64	268,231	27.10%
65-UP	189,617	19.16%
Total	989,776	100.00 %

The average household income was $176,396 with 24% of households with incomes less than $50,000. 48% of the population were non-white.

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

During 2022, residents of Westchester County acounted for 536 visits to NYU Langone Hospitals for ambulatory surgical procedures. This is projected to increase to 1,650 visits in year 1 and 3,300 visits by the third year of operation.

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

This project will enable residents of Westchester County to obtain needed orthopedic ambulatory surgical procedures closer to home instead of having to travel to Manhattan for their care.

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

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

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

The population currently served receives their orthopedic ambulatory surgical procedures at the NYU Langone Hospital Ambulatory Surgery Centers on the Manhattan campus.

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 proposed project will provide residents of Westchester County with easier access to the high quality ambulatory orthopedic surgical procedures they are used to receiving at the NYU Langone Hospitals. Instead of having to travel to Manhattan for their care, they will be able to access this high quality ambulatory surgical care closer to their homes.

ONLY for Hospital Applicants submitting Full Review CONs

Non-Public Hospitals

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

The proposed project does not explicitly advance the local Prevention Agenda priorities that were identified in the most recently completed Community Health Improvement/Community Service Plan, but it does improve access for our patients that require ambulatory surgical procedures.

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

We are advancing the local Prevention Agenda priorities by providing residents of Westchester County with easy access to high quality ambulatory orthopedic surgical procedures closer to their homes. They will no longer have to travel to Manhattan for their care.

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

One of the Prevention Agenda goals for Westchester County is to promote healthy activity. By providing residents of Westchester County with easy access to orthopedic ambulatory surgeries, we are enhancing their capacity for engaging in healthy activities. They will be able to once again engage in physical activities that they have previously been unable to partake in.

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

NYU Langone Health reached out to Dr. Sherlita Amler, Commissioner of Health for the Westchester County Department of Health. Dr. Amler indicated that an ambulatory surgery center would be welcomed medical care in Westchester County and particularly in White Plains, as its central location will broaden access for county residents to have surgical procedures closer to home.

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

Dr. Amler highlighted that Westchester County's large population of older adults would benefit from this facility. She noted that there are several retirement communities in Westchester and residents of those communities, as well as older individuals throughout the county in general, would now be able to receive these services without having to go into Manhattan, which she saw as a real benefit

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

Yes, Community Benefit spending in the Community Health Improvement Services Category that supports the local Prevention Agenda Goals was reported in the most recent Schedule H form submitted to the IRS.

ONLY for Hospital Applicants submitting Full Review CONs

Public Hospitals

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

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

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

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

New York State Department of Health
Certificate of Need Application

Schedule 16C

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

C. Impact of CON Application on Hospital Operating Certificate

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

TABLE 16C-1 AUTHORIZED BEDS

LOCATION:

(Enter street address of facility)

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

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

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

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

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

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:

(Enter street address of facility)

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

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

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

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

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

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

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

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

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

END STAGE RENAL DISEASE (ESRD)

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

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

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

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

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

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

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

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

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

Schedule 16 D. Hospital Outpatient Department - Utilization projections

a	b	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	0	1,650	3,300
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	0	1,650	3,300

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 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)?		N/A
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?		

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

Section B. All Article 28 Facilities

Table B.

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

less than or equal to $6,000,000 for all other facilities are eligible for a Limited Review.		
Establishment of an operator (new or change in ownership)	**Yes**	**No**
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		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.

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: Deb Zahn Consulting, LLC
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? 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)?
   Y
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?

   Deb Zahn Consulting, LLC has worked or is working with the Applicant on previous HEIAs. The Independent Entity has not worked with the Applicant in the last 5 years.

Section 4 – Attestation

I, Deborah Zahn (individual name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of Deb Zahn Consulting (INDEPENDENT ENTITY), do hereby attest that the Health Equity Impact Assessment for project Westchester ASC (PROJECT NAME) provided for NYU Langone Health (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: 9 /25/ 2024