Executive Summary

Long Island Community Hospital at NYU Langone is submitting this Administrative Review Certificate of Need application for the relocation of its Infusion Suite from the main hospital at 101 Hospital Road, Patchogue to the second floor of 100 Hospital Road. This project is necessary as it will increase the total infusion chair count from 4 chairs to 13 chairs. The addition in the number of infusion chairs will allow for oncology and endocrinology infusions and expand current neurology infusion offerings beyond multiple sclerosis. This will give new patients with cancer, Alzheimer's disease, organ transplant, immune –related disorders/conditions and other conditions easy access to infusion services instead of having to travel to Manhattan for care. Once implemented, patients and their caregivers will no longer have to navigate through multiple hospital corridors to the Infusion Center. There will also be expanded evening and weekend appointments available.

The new Infusion Center will be located on the same floor as the pharmacy which will allow patients easy access to medications as well as Hepatitis B testing if required prior to their infusion.

The infusion treatment Spaces will include:

- (3) Infusion Bays
- (9) Infusion Cubicles
- (1) Private Infusion Room
- (1) Exam Room
- USP Compliant Pharmacy Department
- Clinical Lab Department
- Required support spaces to help staff provide a high-quality level of care.

The new Infusion Center will be created by combining multiple existing suites in order to create the 5,800 SF required for this program.

The current Infusion Center currently accounts for 2,577 visits annually and it is expected to increase to 7,283 visits by the third year of implementation.

Please note that the Architectural components of this application will be reviewed by the Dormitory Authority of the State of New York (DASNY).

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: Long Island Community Hospital at NYULH

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
	8/7/2024
PRINT OR TYPE NAME	TITLE
Marc Adler, M.D.	SVP, Chief of Operations

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.

	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Primary Contact	Shari 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	

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

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

CHIEF EXECUTIVE	NAME AND TITLE		
	Marc Adler, M.D., SVP, Chief of Hospital Operations, Long Island Community Hospital		
	BUSINESS STREET ADDRESS		
	101 Hospital Road		
	CITY	STATE	ZIP
	Patchogue	New York	11772
	TELEPHONE	E-MAIL ADDRESS	
	631 654-7177	Marc.adler@nyulangone.org	

The applicant's lead attorney should be identified:

ATTORNEY	NAME	FIRM	BUSINESS STREET ADDRESS
	Annette Johnson	NYU Langone Health	550 First Avenue, HCC 15
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
	New York, NY 10016	212 263-2003	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, NY 10016	212 404-4159	Michelle.ulrich@nyulangone.org

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER	NAME	FIRM	BUSINESS STREET ADDRESS
	Robert Clemens	Perkins and Will	1250 Broadway, Suite 200
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
	New York, NY 10001	212 251-7000	Robert.Clemens@Perkinsandwill.com

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 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.

https://www.fema.gov/media-library-data/1582295171786-6506170c5f54026f585e44e2fc94950d/FF086033_ElevCert_FormOnly_RE_11Feb2020.pdf

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: Click to enter a date.	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Choose an item. If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: This project will create a new 5,600 Square Feet Infusion Center at 100 Hospital Road 2nd Floor.	
Site Location: 100 Hospital Road, East Patchogue, NY 11772	
Brief description of current facility, including facility type:	

The current facility is an existing 2 Story Business Occupancy Building. This building currently includes office space, radiology space, and clinical practices. This project seeks to provide a new Infusion Center on Level 02.	
Brief description of proposed facility: Outpatient Infusion Center: This project will be a renovation of 5,600 square feet and will include (3) Infusion Bays, (9) Infusion Cubicles, & (1) Private Infusion Room. The program also includes a lab, pharmacy, and additional required support space. This will be an Article 28 compliant space.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. The project is on the Second Floor and will be business occupancy.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: This project includes multiple tenants/occupancies. The 5,600 sf Infusion Center will be separated from adjacent building corridors & adjacent suites with a 1-hour fire separation.	
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: The new Article 28 suite will be separated from adjacent suites and adjacent building circulation with a 1-hour fire separation.	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. None	
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.	No

Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc.

HVAC:

The new NYULH space on the 2nd floor is currently served by two roof top units (RTU-6 and RTU-11). Each RTU is a constant volume unit with an air-cooled DX cooling coil, natural gas fired heating coil, and MERV 8 filters. RTU-11 serves the existing 2nd floor conference room (Suite 201). The unit has a capacity of approximately 7 1/2-ton with 24 percent minimum outdoor air. RTU-6 serves the 2nd floor northwest area (Suites 203, 205, 213, 215, and 217). The unit has a capacity of approximately 17 1/2 tons, with 24 percent minimum outdoor air.

There is no existing reheat hot water system currently serving the NYULH spaces on the second floor. Perimeter heating is achieved by fin tube radiators installed along the perimeter windows and supported by multiple supply and return hot water risers. Shut-off valves are installed on supply and return branches, control valves installed on supply branches.

The existing 2nd floor toilets located in the building core are exhausted by a toilet exhaust fan located on roof. The NYULH space on the 2nd floor does not have any existing toilet rooms.

ELECTRICAL:

The main electrical service to the building is provided by PSEG Long Island to a main switchboard with (1) 2500-amp service switch and a (1) 1600-amp service main breaker. The utilization voltage is 208Y/120V, 3-phase. Each switch is separately metered by PSEGLI. An additional metered trough is served from ahead of the two main switches and feeds Suite 101, Suite 113, and Suite 201 directly.

The 2500-amp service switch consists of a bolted pressure contact switch, and it serves a series of taps for (3) 800-amp panelboards, PP1, PP2, and PP3. Each of these panels are main-lug-only and do not have main circuit breakers. No other overcurrent protection is installed between the 2500-amp switch and

each of these (3) panelboards in the main electrical room.
The 1600-amp service switch consists of a main breaker, and it serves a switchboard section with circuit breakers. The section is dedicated to an existing medical outpatient tenant with a step-up transformer for an MRI. The section also includes a spare 400-amp breaker.
A 400-amp distribution panel, EP2, is located in the base building electrical room on the 2nd floor. This panel serves various branch circuit panels for tenants on the floor. A 40-amp load center is located within the demised tenant space on the 2nd floor, named S213.
The building does not have an existing emergency generator. Emergency lighting is provided by batteries.

PLUMBING:
An existing conventional (two pipe) interior waste collection system is installed throughout the building. Conventional hard piped sanitary waste stack and vent stack systems are located in shafts throughout the floor. Sanitary waste pipe distribution is located in the ceiling of the floor below and connects to the existing sanitary waste stacks. Vent pipe distribution is located in the ceiling of the area of work and connects to the existing vent stacks located at columns.
Existing domestic hot-water risers and hot water return risers are installed at the various shafts throughout the floor. Existing cold-water is routed throughout the floor and serves existing fixtures. Existing hot-water distribution at the ceiling of the area of work has a hot water return system in conformance with the 2020 Energy Conservation Construction Code of New York State.
Existing storm water risers are installed at the various shafts throughout the floor and main horizontal distribution serving the existing roof drains is at the 2nd floor ceiling.
An existing gas riser is installed at the building serving boilers, and rooftop HVAC units.

FIRE PROTECTION:
The existing building is currently protected throughout by an automatic sprinkler system designed in accordance with NFPA 13. The wet-pipe automatic sprinkler system is currently zoned per floor via zone control assemblies each inclusive of indicating isolation valve, check valve, flow switch and combination test/drain valve.
The municipal potable water distribution network supplies the building fire sprinkler systems via underground piping service entrance(s). One (1) underground 6-in fire service currently supplies the building. An existing 6-in backflow prevention device is currently installed at the fire service entrance to prevent cross-connection between the building sprinkler / standpipe system and the potable water supply.

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

HVAC
A new air handling unit will be provided to serve the Lab and Pharmacy. The spaces served by the unit shall include: HD Buffer Room, ANTE Room, NHD Buffer Room, Workroom, Office, Storage and Lab. The new AHU shall be roof mounted and will have the following features and performance parameters: MERV-8 pre-filter (located upstream of supply air fans); Two plenum type supply fans 5,000 cfm each (N+1 redundancy). Each fan shall have a dedicated back-draft damper to prevent air recirculation when the fans are off; Two unit-mounted Variable Frequency Drives (VFD) shall be provided. Each VFD shall control the speed of both fans simultaneously; Hot Water preheat coil sized for 0 deg. F entering air; Air-Cooled Direct Expansion (DX) cooling coils sized for 95/75 deg. F entering air; Hot-gas reheat coil; MERV-15 final filter (downstream of re-heat coil); Exhaust Fans.
The remainder of the space shall be provided by a new roof mounted air handling unit. The new AHU shall have the following features and performance parameters: Nominal 12-ton roof mounted packaged air handling unit; MERV-13 filter; One plenum type supply fan; One unit-mounted Variable Frequency Drive (VFD) shall be provided; Hott Water preheat coil; Hot-gas reheat coil.
The duct distribution system will consist of medium pressure ductwork from the AHU to each direct digital controlled variable air volume (VAV) box, with low-pressure ductwork from each VAV box to the air outlets. There will be no exposed fiberglass insulation in the supply air and return airstreams. Sound attenuation at each VAV box will be accomplished via “hospital grade” (media free) sound traps. VAV boxes serving areas requiring specific air change rates will be set for constant volume to maintain the required air change rate. These VAV/CVR boxes will be provided with Hot Water Reheat coils to prevent over cooling of the space. VAV boxes serving all other areas will operate with a standard sequence of operation and will not be provided with reheat coils. Return air from all spaces will be fully ducted back to the new RTU. The

Pharmacy spaces will be provided with tracking pair supply and Exhaust VAV boxes. The boxes will modulate in tandem to maintain a minimum space pressure required for each room type. Hot Water Reheat coils will be provided for each supply air VAV box. Room pressure monitors will be provided for each of the Pharmacy rooms (HD Buffer, NHD Buffer and Ante rooms).
A new 300 cfm toilet exhaust system shall be provided to exhaust the toilet rooms. The new system shall consist of a dedicated roof-mounted exhaust fan and a new low-pressure distribution system. The new toilet exhaust fan will be constant air flow and run continuously based on a time schedule.
A new 500 cfm general exhaust system shall be provided to exhaust the soiled utility rooms, EVS closet and Staff Lounge. The new system shall consist of a dedicated roof-mounted exhaust fan and a new low-pressure distribution system. The new general exhaust fan will be constant air flow and run continuously based on a time schedule.
A new 800 cfm lab exhaust system shall be provided to exhaust the Lab. The new system shall consist of two dedicated roof-mounted exhaust fans (N+1 redundancy) and a new low-pressure distribution system. **Each** fan shall be provided with motorized damper to prevent recirculation when the exhaust fan is not in operation. New Lab exhaust fans will be constant air flow and run continuously.
The hot water heating requirements will be provided by a roof mounted air source heat pump.

ELECTRICAL:
A new 600-amp distribution panel will be installed either in the main electrical room or in the 2nd floor electrical room. This will serve normal power branch circuit panels, and the normal service to an automatic transfer switch. The normal source of power shall be a new 600-amp circuit breaker located in the main distribution panel in the main electrical room.
(3) 100-amp branch circuit panels for plug loads and lighting will be located in the 2nd floor demised space and served from the new 400-amp panel. (2) panelboards will serve plug loads, and (1) panelboard will be for lighting loads.
An Essential Electrical System (EES) is not required for the space, and one is not being provided. Power for emergency egress lighting shall be via a central emergency battery system.

PLUMBING:
The following existing plumbing systems will be removed: cold water, hot water, and sanitary/vent system serving the area of renovation. New piping will be extended from existing systems as necessary to support the new program spaces. Sanitary vent shall be extended from existing network to vent new plumbing fixtures. Drainage from new fixtures will drain by gravity and connect to existing sanitary piping located on the floor below. All new fixtures will be in conformance with the 2020 Plumbing Code of New York State and FGI Guidelines.
A new cold water RPZ and sub-meter will be provided at the connection to the existing cold-water distribution. A new hot water RPZ and sub-meter will be provided at the connection to the existing hot water distribution.
The existing hot water return distribution system and new hot water return distribution system will be modified in conformance with the 2020 Energy Conservation Construction Code of New York State.
The existing storm water distribution system will be modified to accommodate new ductwork at the second-floor ceiling that will serve the new rooftop units.
The existing gas distribution system will be modified to accommodate the new rooftop units.

FIRE PROTECTION:
The proposed renovation areas will be protected throughout by an automatic sprinkler system designed in accordance with NFPA 13. Sprinklers will be provided in all areas required by NFPA 13 in accordance with requirements for fully sprinklered buildings. The building sprinkler systems will be automatic wet-pipe type. Sprinklers will be quick / fast response type throughout, unless not permitted by NFPA 13 (extra hazard occupancies) or otherwise not suitable for an application (high temperature spaces). Concealed pendent sprinklers will be provided in spaces with finished ceilings. Upright sprinklers will be provided where ceilings are exposed.

Describe existing and or new work for fire detection, alarm, and communication systems:
An existing protected premises fire alarm system, designed in accordance with NFPA 72, is currently provided on-site. An existing fire command center is currently provided for fire department operations in a location approved by the local fire department.

New initiating devices and notification appliances shall be installed as a part of the project based on the new layout and will be connected to the existing Fire Alarm system of the building.
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. N/A
Does the project contain imaging equipment used for diagnostic or treatment purposes? No. If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. Click here to enter text.
Does the project comply with ADA? If no, list all areas of noncompliance. Yes
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.	24,615 SF
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	5,600 SF
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Less than 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 (111)
Building Height	29'-10"
Building Number of Stories	2
Which edition of FGI is being used for this project?	2018 Edition of FGI
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 38 New Business Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Other Suites are Existing Business	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.	No
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	No
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	Increase
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.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	No

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

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS
ARCHITECTS & ENGINEERS

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

Date:
CON Number:
Facility Name: Long Island Community Hospital
Facility ID Number:
Facility Address: 100 Hospital Road, Patchogue, NY 11772

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

To The New York State Department of Health:

I hereby certify that:

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

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

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

   a. __712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. __715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:
   _____
   _____

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

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

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

Project Name: NYU LANGONE HEALTH PERLMUTTER CANCER CENTER - PATCHOGUE INFUSION

Location: 100 HOSPITAL ROAD 2ND FLOOR, EAST PATCHOGUE, NY 11772

Description: Approximately 5,200 SF renovation of existing medical office suites into a 13-seat infusion center with integrated laboratory and pharmacy.

Architectural or Engineering Professional Stamp

Signature of Architect or Engineer

Robert Clemens AIA NCARB LEED BD+C
Name of Architect or Engineer (Print)

NY 038324
Professional New York State License Number

1250 Broadway Suite 200 NYC NY 10001
Business Address

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

Authorized Signature for Applicant

August 15, 2024 — Date

Marc S. Adler, MD, MBA, SVP & Chief of Hospital Operations — Name (Print) Title

Notary signing required for the applicant

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

On the 15 day of Aug 2024 before me personally appeared Marc S. Adler, to me known, who being by me duly sworn, did depose and say that he/~~she~~ is the SVP & Chief of Hospital Operations of the Long Island Community Hospital, the facility described herein which executed the foregoing instrument; and that he/~~she~~ signed his/~~her~~ name thereto by order of the governing authority of said facility.

(Notary)

~~CAROL ANN OAKLEY~~
Notary Public, State of New York
No. 52-4621203
Qualified in Suffolk County
Commission Expires June 30, 2027

ARCHITECTURAL AND ENGINEERING LETTER OF CERTIFICATION

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	$5,866,305	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$3,750,000	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$959,805	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	$976	Schedule10
Total Operating Cost	$9,352,847	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	12/3/2024	Schedule 8B
Anticipated Completion Date	6/19/2025	

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

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

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	375000.00%	Normally 10%
Construction Contingency - Renovation Work	375000.00%	Normally 10%
Anticipated Construction Start Date:	12/3/2024	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	3/15/2025	as mm/dd/yyyy
Anticipated Completion of Construction Date	6/19/2025	as mm/dd/yyyy
Year used to compute Current Dollars:	2024	

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

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

	A	B	C
Item	**Project Cost in Current Dollars**	**Escalation amount to Mid-point of Construction**	**Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$3,750,000	$0	$3,750,000
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$375,000	$0	$375,000
3.2 Construction Contingency	$375,000	$0	$375,000
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$400,000	$0	$400,000
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$0	$0	$0
Subtotal (Total 1.1 thru 4.5)	$4,900,000	$0	$4,900,000
5.1 Movable Equipment (from Sched 11)	$959,805	$0	$959,805
5.2 Telecommunications	$6,500	$0	$6,500
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$5,866,305	$0	$5,866,305
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	$5,866,305	$0	$5,866,305
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	$32,265	$0	$32,265
10 Total Project Cost with fees	$5,900,570	$0	$5,900,570

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				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
		2	901	Administration (Routine)	167	$976.16	$163,018.72	
		2	903	Admitting	110	$976.16	$107,377.60	
		2	923	Lobby/Waiting/Public Entrance	299	$976.16	$291,871.84	
		2	406	Clinical Laboratory Service	547	$976.16	$533,962.52	
		2	941	Central Sterile and Supply	82	$976.16	$80,045.12	
		2	942	Laundry/Linen	80	$976.16	$78,092.80	
		2	943	Maintenance/Housekeeping	45	$976.16	$43,927.20	
		2	944	Medical Supplies/Central Services/Storage	30	$976.16	$29,284.80	
		2	946	Staff Lockers	169	$976.16	$164,971.04	
		2	967	Electrical System	22	$976.16	$21,475.52	

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

A		B	D	E	F	G	H	I
Location								
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
		2	478	**Pharmaceutical Service O/P**	959	$976.16	$936,138.44	
		2	425	**Organized Outpatient Department**	3090	$976.16	$3,016,334.40	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**5600**	**976**	**5,466,500.00**	

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

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

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

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

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

SIGNATURE	DATE
Carl Damas	8/26/2024

PRINT NAME	TITLE
Carl Damas	Project Architect

NAME OF FIRM
Perkins&Will

STREET & NUMBER
1411 Broadway, 17th Floor, Suite G

CITY	STATE	ZIP	PHONE NUMBER
New York	NY	10018	212-251-7000

p	CAD ID	Item ID	Total Qty	Description	Manufacturer	Mfr #	Model	Unit Cost	Ext. Cost
9007-000			2	Not Selected, Not Selected	DoseEdge/Dispense Prep		Unspecified	$0.00	$0.00
7493-017	DSP0300		1	Dispenser, Disinfectant Wipes, Wall Mount	Medline Industries Inc.	MSC351128H	MSC351128H	$0.00	$0.00
7493-017	DSP0300		12	Dispenser, Disinfectant Wipes, Wall Mount	Medline Industries Inc.	MSC351128H	MSC351128H	$0.00	$0.00
7493-017	DSP0300		1	Dispenser, Disinfectant Wipes, Wall Mount	Medline Industries Inc.	MSC351128H	MSC351128H	$0.00	$0.00
5869-012	DSP0043		1	Dispenser, Hand Sanitizer, Wall Mount	GOJO Industries	12/1/2720	Purell TFX Touch Free (2720-12)	$0.00	$0.00
5869-012	DSP0043		1	Dispenser, Hand Sanitizer, Wall Mount	GOJO Industries	12/1/2720	Purell TFX Touch Free (2720-12)	$0.00	$0.00
5869-012	DSP0043		12	Dispenser, Hand Sanitizer, Wall Mount	GOJO Industries	12/1/2720	Purell TFX Touch Free (2720-12)	$0.00	$0.00
5869-012	DSP0043		1	Dispenser, Hand Sanitizer, Wall Mount	GOJO Industries	2720-12	Purell TFX Touch Free (2720-12)	$0.00	$0.00
5869-077	DSP1102		1	Dispenser, Hand Sanitizer, Wall Mount	GOJO Industries	7724-01	Purell ES8 Touch-Free (7724-01)	$0.00	$0.00
6084-000	DSP0000		1	Dispenser, Paper Towel, Surface Mount	Unspecified		Unspecified	$0.00	$0.00
CML068X	DSP0000		1	Dispenser, Paper Towel, Surface Mount	Kimberly-Clark Professional	9746	Unspecified	$0.00	$0.00
5868-036	DSP0806		1	Dispenser, Soap, Wall Mount	GOJO Industries	2745-12	Provon TFX Touch Free (2745-12)	$0.00	$0.00
5868-036	DSP0806		1	Dispenser, Soap, Wall Mount	GOJO Industries	2745-12	Provon TFX Touch Free (2745-12)	$0.00	$0.00
5868-089	DSP1291		1	Dispenser, Soap, Wall Mount	GOJO Industries	7730-01	PURELL ES8 Touch-Free (White)	$0.00	$0.00
3723-034	DIS0289		1	Disposal, Sharps, Wall Mount	Stericycle	C-02RES-0203 / OC-02-2004	Bio Systems C-02RES-0203 w/ Cabinet	$0.00	$0.00
3723-035	DIS0290		1	Disposal, Sharps, Wall Mount	Stericycle	C-04RES-04/WB-04	Bio Systems C-04RES-04 w/Locking Bracket	$0.00	$0.00
3723-035	DIS0290		12	Disposal, Sharps, Wall Mount	Stericycle	C-04RES-04/WB-04	Bio Systems C-04RES-04 w/Locking Bracket	$0.00	$0.00
3723-035	DIS0290		1	Disposal, Sharps, Wall Mount	Stericycle	C-04RES-04/WB-04	Bio Systems C-04RES-04 w/Locking Bracket	$0.00	$0.00
DT909HG	PTH0000		1	Pas Thru Window	Unspecified		TBD	$0.00	$0.00
6364-013	GLV0048		1	Dispenser, Glove, Triple Box	Omnimed, Inc	305302-1	305302-1 Stainless Steel	$40.00	$40.00
6364-013	GLV0048		1	Dispenser, Glove, Triple Box	Omnimed, Inc	305302-1	305302-1 Stainless Steel	$40.00	$40.00
6364-013	GLV0048		1	Dispenser, Glove, Triple Box	Omnimed, Inc	305302	305302-1 Stainless Steel	$80.00	$80.00
7347-002	CST0531		1	Cabinet, Storage, Clinical, Defibrillator	Philips Healthcare - Cardiology	9.89803E+11	Basic Surface Mounted	$229.00	$229.00
4352-004	SDM0003		1	Stadiometer, Wall Mount	Seca Corporation	222 1714 004	seca 222 Mechanical Telescopic Measuring Rod (cm)	$310.00	$310.00
7277-001	ICE0157		1	Water Treatment System, Ice Maker, Wall Mount	Follett LLC	130229	Standard Capacity Filter System 00130229	$595.00	$595.00
6364-013	GLV0048		12	Dispenser, Glove, Triple Box	Omnimed, Inc	305302	305302-1 Stainless Steel	$80.00	$960.00
8794-011	IDS0003		1	Diagnostic System, Integrated	Baxter - Hillrom, Welch Allyn, Inc.	77798	Green Series 777 [77798]	$1,462.00	$1,462.00
3478-083	CST0962		1	Cabinet, Storage, Clinical, Narcotic	Armstrong Medical Industries	PEL-IC	PEL-IC Auto-Locking w/Prox Reader	$1,595.00	$1,595.00
4817-057	ICE0267		1	Ice Machine, Dispenser, Nugget, Countertop	Follett LLC	12CI425A-S	Symphony Plus 12CI425A-S	$6,525.00	$6,525.00
DT611CN	PTH0000		1	Pass-thru, Window	TBD		TBD	$14,880.00	$14,880.00
8955-009	WTR0318		1	Water Treatment System, Lab, Reagent Grade (Type 1) Floor	EMD Millipore Corporation	ZAFS61080	Milli-Q CLX 7080 Water Purification System	$24,500.00	$24,500.00
6981-001	COF0077		1	Coffee Maker, Allowance	To Be Determined		TBD	$0.00	$0.00
5470-047	POW0108		1	Power Supply, Uninterruptible (UPS)	Powervar, Inc.	52061-01GR	GTS Series ABCEG601-11	$0.00	$0.00
5470-063	POW0130		1	Power Supply, Uninterruptible (UPS)	Powervar, Inc.	ABCDEF3002-22	Security Plus II UPS (3KVA)	$0.00	$0.00
4942-000	REF0000		1	Refrigerator, Domestic with Freezer	TBD		Unspecified	$0.00	$0.00
4103-000	OVN0000		1	Oven, Domestic, Microwave, Countertop	TBD		Unspecified	$249.99	$249.99
CML972W	IVS0000		1	Stand, IV, Multi-Pump	Baxter Healthcare - Sigma Pumps (Moved to Baxter Healthcare, Do Not Use)	N7516	Unspecified	$553.00	$553.00
4266-169	SCL0613		1	Scale, Clinical, Adult, Digital, Floor	Health o Meter	500KLHB	Eye-level Dgitl Scle w/ Live Wrap Around Handlebar	$687.00	$687.00
CML654Y	IVS0000		2	Stand, IV, Multi-Pump	Baxter Healthcare - Sigma Pumps (Moved to Baxter Healthcare, Do Not Use)	N7516	Unspecified	$553.00	$1,106.00
3355-011	ANA0706		1	Analyzer, Lab, Glucose, Point-of-Care	Nova Biomedical	54790 / 53400	StatStrip Wireless Glucose Hospital Mtr w/Dock Stn	$1,200.00	$1,200.00
5088-009	DFB0075		1	Defibrillator, Automatic, Advisory	Philips Healthcare - Cardiology	M5066A	HeartStart OnSite	$1,389.00	$1,389.00
CML010X	HTR0000		1	Heater, Dri-Bath	Dri-Bath Labnet International, Inc	D1301	D1301	$1,500.00	$1,500.00
3374-007	ASP0010		2	Pump, Suction/Aspirator, General, Portable	Armstrong Medical Industries	AE-6975 (2314)	SSCOR DUET (AE-6975)	$1,195.00	$2,390.00
6133-014	ANA0593		2	Analyzer, Lab, Urinalysis, Semi-Automated	Siemens Healthcare Diagnostics	1780	Clinitek Status +	$1,200.00	$2,400.00
6133-015	ANA0650		1	Analyzer, Lab, Urinalysis, Semi-Automated	Siemens Healthcare Diagnostics	1797	Clinitek Status Connect System	$2,685.00	$2,685.00

6643-003	MNR0054		1	Pump, Infusion, Controller, Modular	BD - Becton, Dickinson and Company	8015	Alaris PC Unit (8015)	$2,856.00	$2,856.00
6643-003	MNR0054		1	Pump, Infusion, Controller, Modular	BD - Becton, Dickinson and Company	8015	Alaris PC Unit (8015)	$2,856.00	$2,856.00
4218-012	REF0837		1	Refrigerator, Blood Bank, Undercounter	Helmer Scientific	5101105-1	Horizon HB105 (115V)	$3,472.00	$3,472.00
3319-009	AGT0032		1	Agitator/Rotator, Platelet	Helmer Scientific	PF48-Pro	i.Series Pro PF48-Pro	$3,735.85	$3,735.85
4177-028	INF0022		3	Pump, Infusion, Single	BD - Becton, Dickinson and Company	8100	Alaris Pump Module (8100)	$1,595.00	$4,785.00
4177-028	INF0022		3	Pump, Infusion, Single	BD - Becton, Dickinson and Company	8100	Alaris Pump Module (8100)	$1,595.00	$4,785.00
9589-022	REF2870		1	Refrigerator, Medical Grade, Undercounter	Follett LLC	REF4P-0R-00-00	Performance Plus REF4P-0R-00-00	$5,410.00	$5,410.00
6619-007	MIC0152		1	Microscope, Diagnostic	Nikon Inc Instrument Group	MBA85020 Package	Eclipse 50i Tilting (Hema/Microbio Pkg)	$5,573.00	$5,573.00
3901-004	INL0046		1	Incubator, Lab, Platelet, Countertop	Helmer Scientific	PC900	PC900	$5,626.00	$5,626.00
6643-003	MNR0054		2	Pump, Infusion, Controller, Modular	BD - Becton, Dickinson and Company	8015	Alaris PC Unit (8015)	$2,856.00	$5,712.00
7933-017	LCR0042		1	Locator, Vein	AccuVein	AV500/HF580	AV500 Vein Viewing System w/ HF580 Mobile Stand	$6,250.00	$6,250.00
CML981W	IVS0000		12	Stand, IV, Multi-Pump	Baxter Healthcare - Sigma Pumps (Moved to Baxter Healthcare, Do Not Use)	N7516	Unspecified	$553.00	$6,636.00
5320-047	CWA0331		1	Cabinet, Warming, Single, Freestanding	MAC Medical, Inc.	SWC243074-G-4B	D-Series SWC243074-G-4B (Glass Door)	$7,700.00	$7,700.00
5320-047	CWA0331		1	Cabinet, Warming, Single, Freestanding	MAC Medical, Inc.	SWC243074-G-4B	D-Series SWC243074-G-4B (Glass Door)	$7,700.00	$7,700.00
9587-010	FRZ1212		1	Freezer, Medical Grade, Undercounter	Follett LLC	FZR5P-T-KP-00	FZR5P-T Performance Plus Touchscreen w/Keypad	$8,475.00	$8,475.00
3591-008	CEN0007		2	Centrifuge, Coagulation	Beckman Coulter, Inc.	SSMP	StatSpin MP	$4,300.00	$8,600.00
3817-149	FRZ2316		1	Freezer, Laboratory, 1 door	Helmer Scientific	5223125-1	Horizon Series HLF125-GX (115V)	$8,715.99	$8,715.99
3768-097	ECG0666		1	Electrocardiograph (ECG), Interpretive	GE Healthcare - Cardiology		MAC 5 A4	$9,234.93	$9,234.93
4177-028	INF0022		6	Pump, Infusion, Single	BD - Becton, Dickinson and Company	8100	Alaris Pump Module (8100)	$1,595.00	$9,570.00
5699-025	REF2116		1	Refrigerator, Pharmaceutical, 2 door	Thermo Fisher Scientific	TSX5005PA	TSX Series High-Performance (51.1 cu. ft.)	$10,000.00	$10,000.00
4232-080	REF2105		1	Refrigerator, Pharmaceutical, 1 door	Follett LLC	REF20-PH	REF20-PH	$11,655.00	$11,655.00
4232-080	REF2105		1	Refrigerator, Pharmaceutical, 1 door	Follett LLC	REF20-PH	REF20-PH	$11,655.00	$11,655.00
4903-131	REF2603		1	Refrigerator, Laboratory, 2 door	Thermo Fisher Scientific	TSX4505GA	TSX Series High-Performance TSX4505GA (45.8 cu ft)	$11,980.00	$11,980.00
CML932W	HOD0000		2	Hood, Vertical Laminar Flow	Baker Company	EG4252	EDGEGARDÂ® EG4252	$8,200.00	$16,400.00
4023-013	MIC0241		1	Microscope, Dual Head	Nikon Inc Instrument Group	Eclipse Ni-U	Nikon Eclipse Ni-U Upright Microscope	$18,000.00	$18,000.00
6158-029	STN0059		1	Stainer, Slide, Automatic, Benchtop	Siemens Healthcare Diagnostics	10805311	Hematek 3000	$18,695.00	$18,695.00
4071-092	MON1048		5	Monitor, Physiologic, Vital Signs, w/Stand	Philips Healthcare - Monitoring Systems	863380/989803176601	EarlyVue VS30 w/ Premium Rollstand	$4,360.50	$21,802.50
6643-003	MNR0054		12	Pump, Infusion, Controller, Modular	BD - Becton, Dickinson and Company	8015	Alaris PC Unit (8015)	$2,856.00	$34,272.00
CML921W	HOD0000		2	Hood, Vertical Laminar Flow	Baker Company	SG604	STERILGARDÂ® 604 EÂ³	$17,500.00	$35,000.00
4177-028	INF0022		36	Pump, Infusion, Single	BD - Becton, Dickinson and Company	8100	Alaris Pump Module (8100)	$1,595.00	$57,420.00
3597-003	CEN0307		1	Centrifuge, Ultra High Speed, Table Top	Beckman Coulter, Inc.	393315	Optima MAX-XP	$68,200.00	$68,200.00
3708-150	MED0274		1	Dispenser, Medication, Host (Main)	Omnicell, Inc.	MED-FRM-102	Omnicell XT Two-Cell Cabinet	$111,000.00	$111,000.00
3347-058	ANA0837		1	Analyzer, Lab, Chemistry	Abbott Laboratories Diag Div	ALINITY c	ALINITY c	$150,000.00	$150,000.00
3356-100	ANA0777		1	Analyzer, Lab, Hematology	Sysmex Partec	XN-2000/WG-20	XN-2000 w/ Wagon Kit	$177,918.00	$177,918.00
3426-000	BCH0000		1	Bench, Work, Steel	TBD		Unspecified	$0.00	$0.00
3615-000	CHA0000		1	Chair, Clinical, Recliner	Unspecified		Unspecified	$0.00	$0.00
3615-000	CHA0000		12	Chair, Clinical, Recliner	Unspecified		Unspecified	$0.00	$0.00
DT114CL	CHA0000		1	Chair, Clinical, Recliner	TBD		TBD	$0.00	$0.00
CMQ503K	SHL0000		2	Shelving, Solid, Stainless Steel, 18 x 24 x 72	InterMetro Industries Corp		18 x 24 x 72	$0.00	$0.00
CML923W	SHL0000		2	Shelving, Solid, Stainless Steel, 18 x 30 x 63	InterMetro Industries Corp		18 x 30 x 63	$0.00	$0.00
CML965W	SHL0000		1	Shelving, Wire , Stainless Steel, 18 x 30 x 72	InterMetro Industries Corp		18 x 30 x 72	$0.00	$0.00
CMM597W	SHL0000		2	Shelving, Wire, Chrome, 24 inch	InterMetro Industries Corp		24x54x74	$0.00	$0.00
DT990HH	SHL0000		2	Shelving, Wire, Chrome, 24 inch	InterMetro Industries Corp		24x60x74	$0.00	$0.00
4296-034	SHL0529		1	Shelving, Wire, Chrome, 36 inch	InterMetro Industries Corp	(5x)1836NC/(4x)74P	Super Erecta 36x18x74 (5-Tier)	$0.00	$0.00
4421-000	STL0000		1	Stool, Exam, w/Backrest	TBD		Unspecified	$0.00	$0.00
5491-022	WST0663		1	Waste Can, 03-19 Gallon	Rubbermaid Commercial Products	1883613	1883613 Slim Jim Resin Front Step (18 Gal.)	$0.00	$0.00

5491-022	WST0663		2	Waste Can, 03-19 Gallon	Rubbermaid Commercial Products	1883613	1883613 Slim Jim Resin Front Step (18 Gal.)	$0.00	$0.00
7359-000	WST0000		2	Waste Can, Allowance	TBD		Unspecified	$0.00	$0.00
4687-070	WST0460		1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	1883564	1883564 Slim Jim Front Step 8 Gal Red	$0.00	$0.00
4687-070	WST0460		12	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	1883564	1883564 Slim Jim Front Step 8 Gal Red	$0.00	$0.00
DT901CN	WST0000		2	Waste Can, Bio-Hazardous	Health Care Logistics	TBD	TBD	$0.00	$0.00
4920-087	WST0482		12	Waste Can, Step-On	Rubbermaid Commercial Products	1883458	Slim Jim Resin Front Step 13 Gal/Beige	$0.00	$0.00
4920-087	WST0482		1	Waste Can, Step-On	Rubbermaid Commercial Products	1883458	Slim Jim Resin Front Step 13 Gal/Beige	$0.00	$0.00
4920-087	WST0482		1	Waste Can, Step-On	Rubbermaid Commercial Products	1883458	Slim Jim Resin Front Step 13 Gal/Beige	$0.00	$0.00
6034-044	CYL0336		1	Cart, Cylinder, D&E, Multi	Anthony Welded Products, Inc.	6060-PC	6060-PC (6 cap./Casters)	$199.00	$199.00
5491-022	WST0663		1	Waste Can, 03-19 Gallon	Rubbermaid Commercial Products	1883613	1883613 Slim Jim Resin Front Step (18 Gal.)	$361.66	$361.66
4687-072	WST0501		1	Waste Can, Bio-Hazardous	Rubbermaid Commercial Products	1883568	1883568 Slim Jim Resin Front Step 18 Gal/Red	$361.66	$361.66
7351-001	DIS0063		1	Disposal, Sharps, Floor Cart, Chemo	Cardinal Health - Medical	8938FP/8939	SharpsCart 8938FP w/Chemosafety 8939 (18 gal)	$410.00	$410.00
CML006X	CST0000		1	Cabinet, Storage, Clinical, Flammable Items	Global Industrial Equipment Company	T9F962355	Manual Close Single Door, 12 Gallon	$415.95	$415.95
5491-017	WST0554		1	Waste Can, 03-19 Gallon	Rubbermaid Commercial Products	FGCC16SSSGL	CC16 Metallic Open Top 15G Satin Stainless	$423.00	$423.00
3836-034	HAM0031		2	Hamper, Linen	Blickman Industries	096211800P	2118	$251.04	$502.08
5835-074	UTC0069		1	Cart, Utility, Stainless	InterMetro Industries Corp	MW301	Super Erecta MW301 (3-Shelf, Solid & Wire)	$527.00	$527.00
5835-141	UTC0975		1	Cart, Utility, Stainless	Blickman Industries	2427536000	7536SS	$733.44	$733.44
4360-091	IVS0214		2	Stand, IV, Stainless Steel	Blickman Industries	541370400	1370SS-4 (6-Leg, 4-Hook)	$451.47	$902.94
4360-091	IVS0214		2	Stand, IV, Stainless Steel	Blickman Industries	541370400	1370SS-4 (6-Leg, 4-Hook)	$451.47	$902.94
5835-074	UTC0069		2	Cart, Utility, Stainless	InterMetro Industries Corp	MW301	Super Erecta MW301 (3-Shelf, Solid & Wire)	$527.00	$1,054.00
5092-012	SHL0818		1	Shelving, Wire, Stainless Steel, 36 inch	InterMetro Industries Corp	(4x)1836NS/(4x)74PS	Super Erecta 36x18x74 (4-Tier)	$1,438.00	$1,438.00
CML071X	SCL0000		1	Scale, Clinical, Adult, Digital, Platform	Seca Corporation		Seca 813	$1,445.00	$1,445.00
6292-009	WCR0107		1	Wheelchair, Adult, Bariatric	Invacare Corporation	T4X22RDAP	Tracer IV (22in. seat, 450lb.)	$1,556.25	$1,556.25
CML927W	WST0000		4	Waste Can, Allowance	TBD		TBD	$450.00	$1,800.00
5832-036	SPC1250		1	Cart, Supply, Linen, 48 inch	InterMetro Industries Corp	A2448NC/74UP/2448FG/5MP/5MPB/EP37C/EP57C/VUCMB	Super Erecta w/Cover (24''x48'')	$2,251.10	$2,251.10
4717-010	WCR0187		2	Wheelchair, Adult, Large	Invacare Corporation	TRSX5/WD26/1228	Tracer SX5 (22''W Seat)	$1,267.56	$2,535.12
7351-001	DIS0063		12	Disposal, Sharps, Floor Cart, Chemo	Cardinal Health - Medical	8938FP/8939	SharpsCart 8938FP w/Chemosafety 8939 (18 gal)	$410.00	$4,920.00
								Total =	$959,805.40

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 8/7/2024

Signature:

Marc Adler, M.D.

Name (Please Type)

SVP and Chief of Operations

Title (Please type)

Long Island Community Hospital
100 Hospital Road Infusion
Schedule 13 B-1: Staffing

	13B-1		
Staffing Categories	**Current Year**	**First Year Total Budget**	**Third Year Total Budget**
1. Management & Supervision	-	-	-
2. Technican & Specialist	-	-	-
3. Registered Nurses	-	-	-
4. Licensed Practice Nurses	-	-	-
5. Aides, Orderlies, & Attendants	-	-	-
6. Physicians	-	-	-
7. PGY physicians	-	-	-
8. Physicians' Assistants	-	-	-
9. Nurse Practitioners	-	-	-
10. Nurse Midwife	-	-	-
11. Social Workers & Psychologist	-	-	-
12. Physical Therapists & PT Assistants	-	-	-
13. Occupational Therapists & OT Assistants	-	-	-
14. Speech Therapists & Speech Assistants	-	-	-
15. Other Therapists and Assistants	-	-	-
16. Infection Control, Environmental & Food Service	-	-	-
17. Clerical & Other Administrative	-	-	-
18. Other - Private Practices, Non-Reimb Personnel	-	-	-
19. Other - Health Prof	-	-	-
20. Other Dieticians	-	-	-
Total	**6.0**	**20.0**	**23.0**

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.

Long Island Community Hospital (LICH) at NYU Langone is an existing acute care facility certified under Article 28 of the New York State Public Health Laws. Through implementation of this project, LICH will continue to comply with federal and state regulations pertaining to the patient care environment. Please also refer to the Executive Summary and the Architectural Narrative. Both documents provide details concerning LICH's relocation of Infusion Bays.

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

List of Proposed Ambulatory Surgery Category
N/A

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

Number and Type of Operating Rooms:

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

Number and Type of Procedure Rooms:

- Current: 0
- To be added: 0

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

Schedule 16 B. Community Need

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

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

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

The relevant service area for this project is Suffolk County.

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

The 2022 population of Suffolk County, New York as per the NYSDOH totaled 1,525,465 with the following racial breakdown:

White	**981,757 (64.4%)**
Black	**120,351 (7.9%)**
Asian/Pacific Islander	**70,765 (4.6%)**
Hispanic	**329,910 (21.4%)**

18.2% of the popualtion were aged 65 and over and 4.4% of the population had no health insurance.

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.

Currently, there were 2,577 visits to the Infusion Center with 15.6% being Medicaid. By the first year of implementation of this project, the visit count is expected to increase to 2,877 with 15.6% being Medicaid and by year 3, the visit count is expected to increase to 7,283 with 15.6% Medicaid.

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 permit greater access to infusion services for current patients and patients with other conditions, reduced travel time because of access to local services, greater continuity of care, and less reliance on caregiver support to access services. This new location will be on the same floor as the pharmacy, which allows patients to get their medication and, if they need a Hepatitis B test faster before they receive an infusion.

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

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

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

The population to be served currently receives services in the main hospital located at 101 Hospital Road to a building directly across the street, where it will occupy space on the second floor of 100 Hospital Road. This will increase the total chair count from 4 to 12 chairs and the visit volume from 2,577 visits to 7,283 visits by the third year of implementation.

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.

Additional infusion chairs will allow for oncology and endocrinology infusions and expand current neurology infusion offerings beyond multiple sclerosis (MS). This will give new patients with Cancer, Alzheimer's Diseasee, organ transplant, immune-related disorders/conditions, and other conditions local access to infusion services instead of traveling to Manhattan for services. Once implemented, patients and their caregivers will no longer have to navigate through multiple hospital corridors to the Infusion Center. There will also be expanded evening and weekend appointments available.

ONLY for Hospital Applicants submitting Full Review CONs

Non-Public Hospitals

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

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

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

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

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

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

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	2,577	2,877	7,283
AMBULATORY SURGERY			
SINGLE SPECIALTY -- GASTROENTEROLOGY			
SINGLE SPECIALTY – OPHTHALMOLOGY			
SINGLE SPECIALTY – ORTHOPEDICS			
SINGLE SPECIALTY – PAIN MANAGEMENT			
SINGLE SPECIALTY -- OTHER			
MULTI-SPECIALTY			
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC			
ELECTROPHYSIOLOGY			
PEDIATRIC DIAGNOSTIC			
PEDIATRIC INTERVENTION ELECTIVE			
PERCUTANEOUS CORONARY INTERVENTION (PCI)			
CERTIFIED MENTAL HEALTH O/P			
CHEMICAL DEPENDENCE - REHAB			
CHEMICAL DEPENDENCE - WITHDRAWAL O/P			
CLINIC PART-TIME SERVICES			
CLINIC SCHOOL-BASED SERVICES			
CLINIC SCHOOL-BASED DENTAL PROGRAM			
COMPREHENSIVE EPILEPSY CENTER			
COMPREHENSIVE PSYCH EMERGENCY PROGRAM			
DENTAL			
EMERGENCY DEPARTMENT			
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT			
HOME HEMODIALYSIS TRAINING & SUPPORT			
INTEGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY			
METHADONE MAINTENANCE O/P			
NURSING HOME HEMODIALYSIS			
RADIOLOGY-THERAPEUTIC			
RENAL DIALYSIS, CHRONIC			
OTHER SERVICES			
Total	2,577	2,877	7,283

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

N/A-Outpatient program only

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

N/A-Outpatient program only

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 N/A

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

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

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

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

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

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

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

Yes ☐ No ☐

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

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

   Yes ☐ No ☐

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

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

   Yes ☐ No ☐

   If no, provide an explanation.

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

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

New York State Department of Health

Health Equity Impact Assessment Conflict-of-Interest

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

Section 1 – Definitions

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

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

Section 2 – Independent Entity

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

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

Section 3 – General Information

A. About the Independent Entity

1. Name of Independent Entity: 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 PICU Expansion (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: 7 /22/ 2024

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?		N/A

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

Section B. All Article 28 Facilities

Table B.

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

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

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

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

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

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