Executive Summary

NYU Langone Hospital is submitting this Administrative Review Certificate of Need application for the expansion of its Pediatric Intensive Care Unit (PICU) service to the 7th floor (in addition to its current location on the 9th floor) of the Hassenfeld Children's Hospital, 430 E 34th St, New York, NY 10016. This expansion increases the capacity of the PICU by adding 12 beds for a total of 46 PICU beds. This expansion of the PICU will be accomplished by converting 12 Physical Medicine and Rehabilitation (PM&R) beds which are not in service to 12 PICU beds.

In Calendar Year 2023, the PICU's occupancy rate was consistently above NYULH's 85% target. Additionally, NYULH's inpatient pediatric units, from which pediatric ICU patients are regularly transferred, have shown consistent volume growth. These inpatient pediatric units have recently been over 90% occupied. The proposed expansion is anticipated to increase overall pediatric capacity by 17%.

Programmatically, the expansion will enable NYULH to accommodate increased volume of pediatric heart and liver transplant patients in response to the Transplant Institute's consistent year-over-year growth. Upon implementation of the project, NYULH will also be able to accommodate elective PICU admissions from its outpatient chronic pulmonary care program, which focuses on sleep studies, ventilator adjustments, and antibacterial therapy. The aforementioned occupancy constraints have limited these services.

The project will also enable NYULH to have more beds available for transfers from external hospitals with pediatric patients needing a higher level of care, and will increase NYULH's ability to accommodate high-acuity pediatric critical care services. NYULH has an internal transfer team that is available 24/7 to accept transfers from external hospitals for pediatric patients who need a higher level of care, and partners with other hospitals to provide these transport services to ensure their pediatric patients have expedient access to the life-saving care and services the NYULH PICU can provide. Additionally, as a regional resource, children needing extracorporeal membrane oxygenation (ECMO), chemotherapy, transplant services, and other high-acuity treatments are transferred directly to NYULH's PICU.

During the first and third years of operation, NYULH expects to increase discharges by 481 and 508, respectively, compared to what would be expected with the current number of beds.

The project will replace approximately 11,800 square feet of existing outpatient space with new construction to provide a pediatric inpatient unit. The unit will contain (12) inpatient rooms, including (1) ECMO (Extracorporeal membrane oxygenation) and (1) AII/PE patient room. Additional spaces within the unit will support patients, visitors, staff, and facilitate patient care.

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:

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

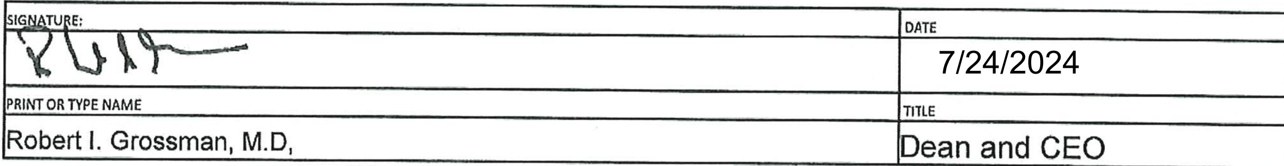
New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

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

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



SIGNATURE:	DATE
	7/24/2024
PRINT OR TYPE NAME	TITLE
Robert I. Grossman, M.D,	Dean and CEO

General Information

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

Contacts

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

Primary Contact

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

Alternate Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Christopher Panettieri, Senior Manager	NYU Langone Health	
BUSINESS STREET ADDRESS		
One Park Avenue, Rm. 483		
CITY	STATE	ZIP
New York	New York	10016
TELEPHONE	E-MAIL ADDRESS	
212 2623492	Christopher.panettieri@nyulangone.org	

New York State Department of Health
Certificate of Need Application

Schedule 1

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

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

The applicant's lead attorney should be identified:

ATTORNEY		
NAME	FIRM	BUSINESS STREET ADDRESS
Annette Johnson, Esq.	NYU Langone Health	550 First Avenue, 15th floor
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
New York, New York 10016	212 263-7921	Annette.johnson@nyulangone.org

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

CONSUTANT		
NAME	FIRM	BUSINESS STREET ADDRESS
N/A		
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

The applicant's lead accountant should be identified:

ACCOUNTANT		
NAME	FIRM	BUSINESS STREET ADDRESS
Michelle Ulrich	NYU Langone Health	One Park Avenue, 5th floor
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
New York, New York 10016	212 404-4159	Michelle.ulrich@nyulangone.org

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER		
NAME	FIRM	BUSINESS STREET ADDRESS
Thomas Jay Wong	Ennead Architects	320 W. 13th Street
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
New York, New York 10014	212 807-7171	TWong@ennead.com

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

New York State Department of Health
Certificate of Need Application

Schedule 1

Other Facilities Owned or Controlled by the Applicant
Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

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

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

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

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

Out-of-State Affiliated Facilities/Agencies

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

Facility Type	Name	Address	State/Country	Services Provided

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

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

Schedule LRA 4/Schedule 7 - Environmental Assessment

Environmental Assessment

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

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

3.1	**Agency Name:**	
	Contact Name:	
	Address:	
	State and Zip Code:	
	E-Mail Address:	
	Phone Number:	
	Agency Name:	
	Contact Name:	
	Address:	
	State and Zip Code:	
	E-Mail Address:	
	Phone Number:	
	Agency Name:	
	Contact Name:	

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

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

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

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

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

Schedule 6
Architectural/Engineering Submission

Contents:

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

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.

<table>
<tr><th colspan="2">Project Description</th></tr>
<tr><td>Schedule 6 submission date:
7/24/2024</td><td>Revised Schedule 6 submission date:
Click to enter a date.</td></tr>
<tr><td colspan="2">Does this project amend or supersede prior CON approvals or a pending application? Yes
If so, what is the original CON number?</td></tr>
<tr><td colspan="2">Intent/Purpose:
Expansion of the pediatric intensive care unit by 12 additional beds.</td></tr>
<tr><td colspan="2">Site Location:
424 East 34th Street, New York, NY 10016</td></tr>
<tr><td colspan="2">Brief description of current facility, including facility type:</td></tr>
</table>

<table>
<tr><td colspan="2">The Hassenfeld Children's Hospital is located within the Kimmel Pavilion in the NYU Langone Health Main Campus.</td></tr>
<tr><td colspan="2">Brief description of proposed facility:
The Hassenfeld Children's Hospital plans to expand its services with a new Pediatric Intensive Care Unit (PICU) adding 12 new intensive care rooms along with required support spaces.</td></tr>
<tr><td colspan="2">Location of proposed project space(s) within the building. Note occupancy type for each occupied space.
7th Floor. Refer to Functional Space Program for list of spaces; the PICU will be classified as an I-2 Institutional occupancy.</td></tr>
<tr><td colspan="2">Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies:
Existing mixed-use space located on the floor consists of A-2, A-3 and B occupancies and will be separated from the new I-2 occupancy PICU by a 2 hr rated smoke barrier.</td></tr>
<tr><td>If this is an existing facility, is it currently a licensed Article 28 facility?</td><td>Yes</td></tr>
<tr><td>Is the project space being converted from a non-Article 28 space to an Article 28 space?</td><td>Yes</td></tr>
<tr><td colspan="2">Relationship of spaces conforming with Article 28 space and non-Article 28 space:
All non-Article 28 spaces will be outside of the new unit. Unit entry will be secured from the public, with authorized staff and family members having controlled access, Refer to CON100 file</td></tr>
<tr><td colspan="2">List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3.
Section 2.3-2.6.10.1 (2) seating capacity inside Family/Visitor Lounge: full capacity is provided between Family Lounge and Reception Waiting.</td></tr>
<tr><td>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.

The project involves the demolition of existing outpatient cardiac center and multipurpose/hospital entertainment program spaces on the 7th floor. These spaces are served by an existing AHU located on the floor below named AHU-KP-6M-2. This system and all associated ductwork will demolished as part of the project and a new HVAC system including ductwork and terminal units will be provided connected to the existing base building inpatient risers.

The spaces noted to be demolished above will also have all existing normal and emergency branch circuits serving the area removed back to their existing panels. Any branch circuits serving areas outside the scope of work will remain. Several branch circuits that pass through the area being renovated will be relocated as required to accommodate the new program. Any fire alarm devices in the area of work will be removed, and all fire alarm devices outside the scope of work on the floor will remain.

The spaces noted to be demolished above will also have all plumbing associated with the existing plumbing fixtures removed back the associated main or riser. Several existing plumbing risers will be offset and relocated to accommodate the new program. All plumbing fixtures outside the area of work will remain online throughout the course of construction.

All existing sprinkler heads within the area of work will be removed, and all associated branch piping will be demolished back the existing sprinkler main.</td><td>Yes</td></tr>
</table>

Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. These spaces are served by an existing AHU located on the floor below named AHU-KP-6M-2. This system and all associated ductwork will be demolished as part of the project. All ductwork, piping, terminal units and diffusers within the existing outpatient heart center space will be demolished. Electrically, these spaces are fed from existing normal and emergency panels located on the floor and on the floor below. The building has emergency distribution on the equipment, critical, and life safety branches that serve the area. Additionally, all fire alarm devices are served via a DGP located on the floor that is connected to the base building fire alarm system. For plumbing these spaces are served from existing domestic water, sanitary and vent mains/risers on both the 7th floor as well as the MER floor below. The existing sprinkler system is fed from an existing sprinkler floor control valve assembly off the combined sprinkler/standpipe riser in Stair A. The existing standpipe for auxiliary fire hose valves is fed from the combined sprinkler/standpipe riser in Stair B.
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. The new PICU space will be served by new ductwork connected to the existing base building inpatient risers. These risers are served by AHUs located on the 6th and 19th floor MERs. A new fire smoke damper shall be provided at the riser penetration and medium pressure ductwork shall be run to the new inpatient space. New medium pressure ductwork, air terminal units with reheat, water piping, low pressure ductwork, and diffusers shall be provided within the space in compliance with ASHRAE 170. A new electrical closet will contain the electrical distribution that will serve the new patient areas. This will consist of normal and emergency power panels for the equipment and critical branches of power. These new panels will be fed via existing bus duct distribution. Additionally, existing life safety power panels will be utilized for any life safety loads, including egress lighting and exit signs. All new patient areas will be provided with receptacles and electrical distribution throughout and as required by the FGI guidelines. The space will be provided with new plumbing fixtures fed from existing domestic water, sanitary and vent mains/risers in accordance with NYC Plumbing Code. Each patient room will also be provided with medical gases fed from existing risers in accordance with NFPA 99 and FGI 2022. Each medical gas line will pass through a zone valve box to serve the (2) two zones on the 7th floor. Each gas line will also be tied to an area alarm panel for each zone. The space will be provided with new wet sprinkler coverage supplied from the existing automatic sprinkler system serving the building.
Describe existing and or new work for fire detection, alarm, and communication systems: New fire alarm devices will be provided throughout the space as required to accommodate the new program layout. Notification and initiating devices will be provided per NYC building code and NFPA 72.
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. Yes, certificate in place.
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. No Imaging equipment.
Does the project comply with ADA? If no, list all areas of noncompliance. Yes, the project will comply with ADA.
Other pertinent information:

N/A	
Project Work Area	**Response**
Type of Work	Renovation
Square footages of existing areas, existing floor and or existing building.	32,500 sf
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	11,870
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 I (443)
Building Height	374.02'
Building Number of Stories	22
Which edition of FGI is being used for this project? **2022 Edition of FGI**	Choose an item.
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?	Yes
If a high-rise, does the building have a generator?	Yes
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 18 New Health Care Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. **Business, Assembly, Mechanical and Storage**	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.	No
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? The existing Congenital Heart Center will be relocated to a new location : **577 First Avenue, New York, NY 10016**	Yes
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. **Existing PICU total is 34, Proposed increase of 12 beds to total 46 beds.**	Increase
Changes in the number of occupants? If yes, what is the new number of occupants? 980	Yes
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Type 1	Yes
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Yes
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Yes
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No

If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	No

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

New York State Department of Health
Certificate of Need Application
Functional Space Program
CON:

PROPOSED 7TH FLOOR ICU 12-BED UNIT							
Visitors and Family Support	**Floor**	**Qty**	**Functional Gross (sf)**	**Clear floor area (sf)**	**Total Functional**	**Total Clear floor area**	
Reception/Concierge	7	1	334	304	334	304	Includes waiting area
Family Lounge	7	1	271	254	271	254	
Play Room							Included in Family Lounge
Visitor Toilet	7	1	45	45	45	45	
SUB-TOTAL					**650**		
Intensive Care Beds	**Floor**	**Qty**	**Functional Gross SF**	**Clear floor area (sf)**	**Total Functional**	**Total Clear floor area**	
IC - Patient Rooms	7	9	varies	varies	2004	1959	
IC - Combo AII/PE Room	7	1	255	250	255	250	Includes 40 sf Anteroom
IC - ECMO Ready/ADA	7	1	305	300	305	300	
IC - ADA	7	1	227	222	227	222	
IC- Patient Toilet Rooms	7	12	varies	varies	446	446	
SUB-TOTAL					**3237**		
Support	**Floor**	**Qty**	**Functional Gross SF**	**Clear floor area (sf)**	**Total Functional**	**Total Clear floor area**	
Clinical Integration Center N	7	1	390		390		includes equipment alcove
Clinical Integration Center S	7	1	161		161		
Medication Room	7	1	170		170		
Clean Supply	7	1	144		144		Includes Formula Storage
Respiratory Supply	7	1	69		69		
Soiled Holding	7	1	72		72		
Equipment Storage	7	1	283		283		min per FGI 20 sf/bed for ICU
Nutrition	7	1	74		74		
Formula Storage							Included in Meds Room
Linen Closets	7	2	varies		45		(1 @ 24 sf, 1 @ 21 sf)
Oxygen Storage Closet	7	2	7		14		1 Empty/1 Full
Environmental Services Closet	7	1	21		21		Provided outside the unit
Equipment Alcoves	7	2	varies		25		1 @ 7 sf, 1 @ 18 sf, (1) addt'l included @ North CIC
SUB-TOTAL					**1,468**		
Team Support and Work Space	**Floor**	**Qty**	**Functional Gross SF**	**Clear floor area (sf)**	**Total Functional**	**Total Clear floor area**	
Staff Lounge	7	1	253		253		
Staff Lockers / Changing Room	7	1	50		50		
On Call	7	2	varies		175		(1 @ 80 sf, 1 @ 95 sf)
Linen Closet	7	1	10		10		
Staff Toilet	7	1	54		54		
Staff Toilet/Shower	7	1	63		63		Part of on-call suite
Offices	7	2	74		148		
Touchdown Space	7	1	214		214		
Multi-purpose Room	7	1	126		126		Will also serve as conference room
SUB-TOTAL					**1,093**		
TOTAL					**6,448**		
TOTAL DGSF Inpatient Unit					**11, 870**		

** clear floor area provided for patient and resident spaces only, moveable equipment and furniture included in clear floor area

Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS

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

Date: July 24, 2024
CON Number:
Facility Name: NYU Langone Health
Facility ID Number: 1463
Facility Address: 550 First Avenue, New York, NY 10016

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.

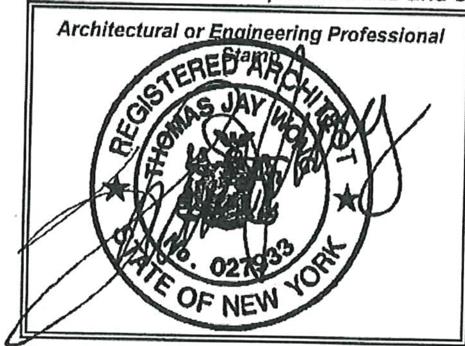
This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative,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

Project Name: Hassenfeld Children's Hospital PICU 7

Location: 424 East 34TH Street, New York, NY 10016

Description: Expansion of the Pediatric Intensive Care Unit to add 12 new patient beds and clinical support spaces.

Architectural or Engineering Professional Stamp



Signature of Architect or Engineer

Thomas Jay Wong
Name of Architect or Engineer (Print)

027933
Professional New York State License Number

1 World Trade Center, 40th Floor, New York, NY 10007
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

7/23/2024
Date

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

Notary signing required for the applicant

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

On the 23 day of 7 2024 before me personally appeared Robert Grossman to me known, who being by me duly sworn, did depose and say that he/she is the Dean & CEO of the NYU Langone Health, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary)

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

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	$28,173,214	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$28,173,214	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$3,331,981	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	$2,378	Schedule10
Total Operating Cost	$35,471,013	Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.00%	Schedule 9
Depreciation Life (in years)	20	

2) Construction Dates

Anticipated Start Date	5/1/2026	Schedule 8B
Anticipated Completion Date	6/15/2027	

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

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

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	10.00%	Normally 10%
Construction Contingency - Renovation Work	10.00%	Normally 10%
Anticipated Construction Start Date:	5/1/2026	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	12/30/2026	as mm/dd/yyyy
Anticipated Completion of Construction Date	6/15/2027	as mm/dd/yyyy
Year used to compute Current Dollars:	2026	

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	$17,411,404	$0	$17,411,404
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$10,000	$0	$10,000
3.1 Design Contingency	$1,741,140	$0	$1,741,140
3.2 Construction Contingency	$1,741,140	$0	$1,741,140
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$55,000	$0	$55,000
4.3 Architect/Engineering Fees	$1,773,381	$0	$1,773,381
4.4 Construction Manager Fees	$409,168	$0	$409,168
4.5 Other Fees (Consultant, etc.)	$200,000	$0	$200,000
Subtotal (Total 1.1 thru 4.5)	$23,341,233	$0	$23,341,233
5.1 Movable Equipment (from Sched 11)	$3,331,981	$0	$3,331,981
5.2 Telecommunications	$1,500,000	$0	$1,500,000
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$28,173,214	$0	$28,173,214
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	$28,173,214	$0	$28,173,214
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	$154,953	$0	$154,953
10 Total Project Cost with fees	$28,330,167	$0	$28,330,167

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

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

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

A	B	D	E	F	G	H	I
Location							
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
Hassenfeld Children's Hospital	Kimmel Pavilion	7	111	Pediatric - ICU	11870	$2,373.48	$28,173,214	12 New Pediatric ICU beds and supporting spaces.
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				

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

A		B	D	E	F	G	H	I
Location				Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
Sub project	Building	Floor	Functional Code					
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**11870**	**2373**	**28173214**	

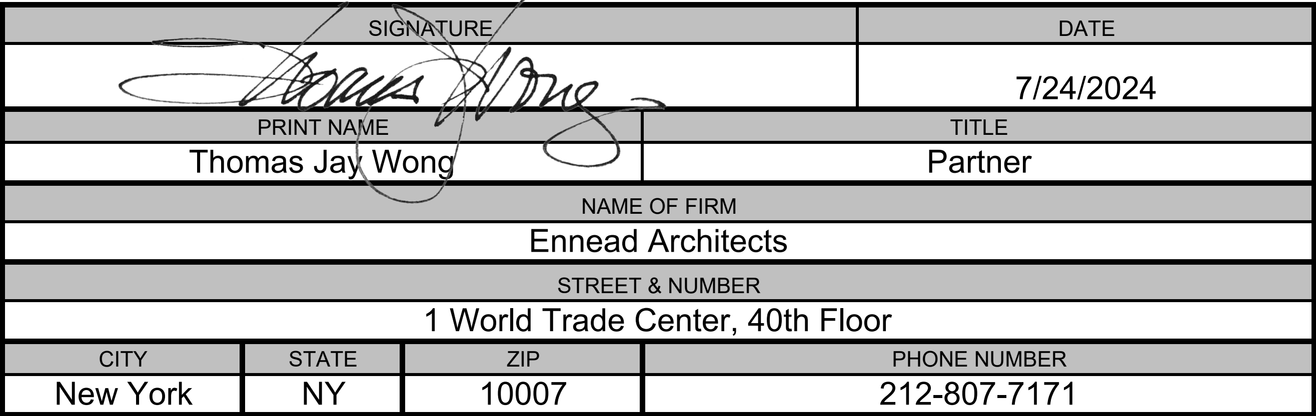
New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

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
[signature]			7/24/2024
PRINT NAME			TITLE
Thomas Jay Wong			Partner
NAME OF FIRM			
Ennead Architects			
STREET & NUMBER			
1 World Trade Center, 40th Floor			
CITY	STATE	ZIP	PHONE NUMBER
New York	NY	10007	212-807-7171

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

For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review *

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
		pls. see attached.				
		Furniture (See Attached Schedule 11 Attachment for detail)				$ 314,604.00
		Equipment (See Schedule 11 Attachment for detail)				$ 3,017,376.00
Total lease and purchase costs: Subproject 1						
Total lease and purchase costs: Subproject 2						
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						
Total lease and purchase costs: Subproject 5						
Total lease and purchase costs: Subproject 6						
Total lease and purchase costs: Subproject 7						
Total lease and purchase costs: Subproject 8						
Total lease and purchase costs: Whole Project:						$ 3,331,980.00

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

Table 2 - Equipment being replaced:

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

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

Building	Floor	Room Type	Qty	Furniture Item	Qty	Unit Cost	Extended	Totals
KP 7	7	Staff Lounge	1	Table	2	$3,200.00	$6,400.00	
				Chairs	8	$800.00	$6,400.00	
							$12,800.00	$12,800.00
	7	Patient Room	12	Stools	1	$950.00	$950.00	
				Guest Chair	1	$650.00	$650.00	
				Sleeper Sofa	1	$6,500.00	$6,500.00	
				Recliner	1	$5,900.00	$5,900.00	
							$14,000.00	$168,000.00
	7	Touchdown Spaces/Nurse Station	1	Task Chair	16	$760.00	$12,160.00	
							$12,160.00	$12,160.00
	7	Family Lounge	1	Table	1	$1,900.00	$1,900.00	
				Chairs	4	$800.00	$3,200.00	
				Ottoman	2	$720.00	$1,440.00	
				Benches	2	$4,200.00	$8,400.00	
				Coffee Table	1	$1,400.00	$1,400.00	
				Rug	1	$850.00	$850.00	
				Side Table	1	$1,100.00	$1,100.00	
							$18,290.00	$18,290.00
	7	Multipurpose Room	1	Conf. Room Table	1	$9,500.00	$9,500.00	
				Chairs	6	$1,300.00	$7,800.00	
							$17,300.00	$17,300.00
	7	Changing Room	1	bench	1		$0.00	
	7	Waiting Room	1	Side Table	4	$950.00	$3,800.00	
				Ottoman	1	$720.00	$720.00	
				Couch	2	$4,200.00	$8,400.00	
							$12,920.00	$12,920.00
	7	Office	2	Desking	1	$4,200.00	$4,200.00	
				Return/file				
				Wardrobe				
				Task Chair	1	$750.00	$750.00	
							$4,950.00	$9,900.00
	7	On-Call Room	2	bunk Bed	1	$3,800.00	$3,800.00	
				Task Chair	1	$750.00	$750.00	
				Desk	1	$850.00	$850.00	
							$5,400.00	$10,800.00

						SUBTOTAL		***$262,170.00***
				D&I/ contingency		*20%*		*$52,434.00*
						total		**$314,604.00**

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Diet/Nourishment   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
5869-000 DSP0000		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	12.00	0.00	List 12.00
6084-000 DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	53.00	0.00	List 53.00
5868-000 DSP0000		1 O/C 1	Dispenser, Soap, Wall Mount __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	68.00	0.00	List 68.00
4817-026 ICE0074		1 O/C 1	Ice Machine, Dispenser, Nugget, Countertop Symphony 25CI400A-S	Follett LLC (25CI400A-S) Follett LLC (25CI400A-S)	Project Unassigned	Draft (New) Unassigned Unassigned	8,790.00	0.00	Vendor 8,790.00
9589-003 REF1382	6050-124	1 O/O 2	Refrigerator, Medical Grade, Undercounter REF4P ADA-Compatible Performance Plus	Follett LLC (REF4P-XX-00-00) Follett LLC (REF4P-XX-00-00)	Project Unassigned	Draft (New) Unassigned Unassigned	4,580.00	0.00	Vendor 4,580.00
9589-028 REF3006		1 O/O 2	Refrigerator, Medical Grade, Undercounter ARS62MLMCBIADA (6 Cu.Ft.)	Summit Appliance (ARS62MLMCBIADA) Summit Appliance (ARS62MLMCBIADA)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	2,498.00	0.00	Vendor 2,498.00
4232-088 REF2229		1 O/O 2	Refrigerator, Pharmaceutical, 1 door ACR1718RH (17 cu.ft.)	Summit Appliance (ACR1718RH) Summit Appliance (ACR1718RH)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	5,608.00	0.00	Vendor 5,608.00
4690-000 WST0000		1 O/O 3	Waste Can, 32-40 Gallon __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	97.00	0.00	List 97.00
7277-001 ICE0157		1 O/C 1	Water Treatment System, Ice Maker, Wall Mount Standard Capacity Filter System 00130229	Follett LLC (00130229) Follett LLC (00130229)	Project Unassigned	Draft (New) Unassigned Unassigned	595.00	0.00	List 595.00

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Diet/Nourishment   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config

Room Total :	**22,301.00**
Room Qty :	**1**

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Medication Room w/Dispenser_001   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302-1 Stainless Steel	Omnimed, Inc (305302-1) Omnimed, Inc (305302-1)	Project Unassigned	Draft (New) Unassigned Unassigned	80.00	0.00	Estimate 80.00
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (2720-12) GOJO Industries (2720-12)	Project Unassigned	Draft (New) Unassigned Unassigned	50.00	0.00	Estimate 50.00
3711-053 MED0281	C318785	2 O/V 2	Dispenser, Medication, Auxiliary Omnicell XT Med Aux 1-Cell Cabinet 02/12/2020: Qty: TBC W/ Pharmacy.	Omnicell, Inc. (MED-AUX-101) Omnicell, Inc. (MED-AUX-101)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	37,500.00	0.00	Estimate 75,000.00
3708-148 MED0270		2 O/V 2	Dispenser, Medication, Host (Main) Omnicell XT One-Cell Cabinet	Omnicell, Inc. (MED-FRM-101) Omnicell, Inc. (MED-FRM-101)	Project Unassigned	Draft (New) Unassigned Unassigned	55,000.00	0.00	Estimate 110,000.00
6451-008 MED0271		3 O/O 3	Dispenser, Medication, Lock Module Omnicell XT FlexLock w/ 50 Ft Cable	Omnicell, Inc. (SRD-0PT-012) Omnicell, Inc. (SRD-0PT-012)	Project Unassigned	Draft (New) Unassigned Unassigned	3,900.00	0.00	Estimate 11,700.00
6084-000 DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	45.00	0.00	List 45.00
5868-000 DSP0000		1 O/C 1	Dispenser, Soap, Wall Mount __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	54.00	0.00	List 54.00
3723-035 DIS0290		1 O/O 1	Disposal, Sharps, Wall Mount Bio Systems C-04RES-04 w/Locking Bracket	Stericycle (C-04RES-04/WB-04) ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	List 0.00
9589-003 REF1382	6050-124	4 O/O 2	Refrigerator, Medical Grade, Undercounter REF4P ADA-Compatible Performance Plus	Follett LLC (REF4P-XX-00-00) Follett LLC (REF4P-XX-00-00)	Project Unassigned	Draft (New) Unassigned Unassigned	4,580.00	0.00	Vendor 18,320.00

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Medication Room w/Dispenser_001   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
4300-040 SHL0711		1 O/O 3	Shelving, Wire, Chrome, 60 inch Super Erecta - Super Adjustable 60x24x74 (5-Tier)	InterMetro Industries Corp ((5x)A2460NC/(4x)74P) InterMetro Industries Corp ((5x)A2460NC/(4x)74P)	Project Unassigned	Draft (New) Unassigned Unassigned	743.00	0.00	Estimate 743.00 C
4687-070 WST0460		1 O/O 3	Waste Can, Bio-Hazardous 1883564 Slim Jim Front Step 8 Gal Red	Rubbermaid Commercial Products (1883564) Rubbermaid Commercial Products (1883564)	Project Unassigned	Draft (New) Unassigned Unassigned	225.00	0.00	List 225.00
4688-004 WST0035		1 O/O 3	Waste Can, Open Top 2543 Fire Resistant Beige 28 qt	Rubbermaid Commercial Products (FG254300BEIG) Rubbermaid Commercial Products (FG254300BEIG)	Project Unassigned	Draft (New) Unassigned Unassigned	51.00	0.00	List 51.00

Room Total : 216,268.00
Room Qty : 1

NYU Langone Hospitals

Tisch Projects

Room By Room Detail Report

C = GPO Contract C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Nursing Station w/Central Monitoring Room#: Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
9570-000 ALL0000		1 O/O 0	Allowance, Miscellaneous __________________	____________________ ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	165,000.00	0.00	Estimate 165,000.00
5510-000 CSM0000		1 O/O 2	Monitor, Central Station, Workstation __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	150,000.00	0.00	Estimate 150,000.00

Room Total :	**315,000.00**
Room Qty :	**2**
Room Ext Total :	**630,000.00**

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Patient Room   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
3418-043 BED0488		1 O/O 2	Bed, Electric, Critical Care ProCuity ZMX w/Zoom Drive & Isolibrium	Stryker Medical ( ) Stryker Medical ( )	Capital Unassigned	Draft (New) Unassigned Unassigned	37,076.00	0.00	Estimate 37,076.00 C
3436-001 BLD0001		1 O/O 3	Blender, Gas, Air/Oxygen Bird High Flow Microblender (w/Hoses,Wall Brkt)	Vyaire Medical (03800A/00060/02899/05213) CareFusion - Bird ( )	Project Unassigned	Draft (New) Unassigned Unassigned	974.00	0.00	List 974.00
3446-008 BRK0066		1 O/C 1	Bracket, Monitor, Wall VHM for Philips MP60/70/MX600/700/800	GCX Corporation (AG-0018-25/WC0002-04) GCX Corporation (AG-0018-25/WC-0002-04)	Project Unassigned	Draft (New) Unassigned Unassigned	675.00	0.00	List 675.00
6194-003 CRB0063		1 O/O 3	Crib, Critical Care Doernbecher 752-KPGP (w/ Scale) Spec TBD	Hard Mfg Company, Inc. (E752-KPGP) Hard Mfg Company, Inc. (PC752-KPGP)	Project Unassigned	Draft (New) Unassigned Unassigned	9,695.00	0.00	List 9,695.00 C
7745-004 DIA0031		1 O/C 1	Dialysis Unit, Supply/Waste Box 8196 Recessed Dialysis Box	Whitehall Manufacturing (8196) Whitehall Manufacturing (8196)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	760.00	0.00	Vendor 760.00
6364-000 GLV0000		4 O/C 1	Dispenser, Glove, Triple Box __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	62.00	0.00	List 248.00
3723-000 DIS0000		1 O/O 1	Disposal, Sharps, Wall Mount __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	62.00	0.00	List 62.00
3805-001 FLW0086		3 O/O 3	Flowmeter, Oxygen, Pediatric/ Neonatal Chrome (0-200cc, DISS Male)	Precision Medical (6MFA1004) Precision Medical (6MFA1004)	Project Unassigned	Draft (New) Unassigned Unassigned	235.00	0.00	Vendor 705.00
5046-000 LTS0000		1 O/V 1	Light, Surgical, Single, Ceiling __________________ Lumina B - Spec TBD	Skytron ( ) Skytron ( )	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	11,560.00	0.00	Vendor 11,560.00 C

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Patient Room   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
6228-035 MTS0037		1 O/O 3	Mattress, Pressure Reduction, Bed AtmosAir with SAT 9000A	Arjo Inc (KA9APREVG3580.S) Arjo Inc (KA9APREVG3580.S)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	900.00	0.00	Estimate 900.00 C
C-417771 C-417771		1 O/O 2	Monitor, Physiologic, Bedside IntelliVue MX850	Philips Healthcare - Monitoring Systems ( ) Philips Healthcare - Monitoring Systems ( )	Project Unassigned	Draft (New) Unassigned Unassigned	45,712.00	0.00	Estimate 45,712.00 C
4092-038 OPH0131		1 O/C 1	Oto/Ophthalmoscope Set, Wall Mount, w/Sphyg Green Series 777 [77910]	Hillrom - Welch Allyn, Inc. (77910) Hillrom - Welch Allyn, Inc. (77910)	Project Unassigned	Draft (New) Unassigned Unassigned	1,173.00	0.00	Vendor 1,173.00
6643-003 MNR0054		1 O/O 2	Pump, Infusion, Controller, Modular Alaris PC Unit (8015)	BD - Becton, Dickinson and Company (8015) BD - Alaris Infusion (Moved To BD - Becton, Dickinson and Company, Do Not Use) (8015)	Project Unassigned	Draft (New) Unassigned Unassigned	2,856.00	0.00	Vendor 2,856.00 C
4177-028 INF0022		2 O/O 2	Pump, Infusion, Single Alaris Pump Module (8100)	BD - Becton, Dickinson and Company (8100) BD - Alaris Infusion (Moved To BD - Becton, Dickinson and Company, Do Not Use) (8100)	Project Unassigned	Draft (New) Unassigned Unassigned	1,595.00	0.00	Vendor 3,190.00 C
4248-159 REG0298		1 O/O 3	Regulator, Suction, Intermittent/Continuous 3814 Platinum Series Neonatal	Boehringer Laboratories, Inc. (3814) Boehringer Laboratories, Inc. (3814)	Project Unassigned	Draft (New) Unassigned Unassigned	778.26	0.00	Vendor 778.26
4360-107 IVS0248		1 O/O 3	Stand, IV, Stainless Steel 176 (8 Rake Hook/Steel Base)	Pryor Products, Inc. (176) BD - Alaris Infusion (Moved To BD - Becton, Dickinson and Company, Do Not Use) (925-0176)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	399.00	0.00	Vendor 399.00
5934-014 TOB0013		1 O/O 3	Table, Overbed, General Tru-Fit Single Top w/o Vanity	Stryker Medical (3150-000-100) Stryker Medical (3150-000-100)	Project Unassigned	Draft (New) Unassigned Unassigned	544.00	0.00	Vendor 544.00

NYU Langone Hospitals

Tisch Projects

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Patient Room   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
4687-002 WST0006		2 O/O 3	Waste Can, Bio-Hazardous 6144 Red (12 gal)	Rubbermaid Commercial Products (6144) Rubbermaid Commercial Products (FG614400RED)	Project Unassigned	Draft (New) Unassigned Unassigned	125.00	0.00	List 250.00
4920-010 WST0089		2 O/O 3	Waste Can, Step-On 6146 Beige (23 gal)	Rubbermaid Commercial Products (6146) Rubbermaid Commercial Products (FG614600BEIG)	Project Unassigned	Draft (New) Unassigned Unassigned	203.00	0.00	List 406.00

Room Total :	**117,963.26**
Room Qty :	**12**
Room Ext Total :	**1,415,559.12**

NYU Langone Hospitals

Tisch Projects

Room By Room Detail Report

= GPO Contract = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Soiled Utility_001 Room#: Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
3355-010 ANA0702		1 O/O 2	Analyzer, Lab, Glucose, Point-of-Care StatStrip Glucose Hospital Meter w/Docking Station	Nova Biomedical (53398/53400) Nova Biomedical (53398/53400)	Project Unassigned	Draft (New) Unassigned Unassigned	1,849.00	0.00	Estimate 1,849.00
6133-015 ANA0650		1 O/O 2	Analyzer, Lab, Urinalysis, Semi-Automated Clinitek Status Connect System	Siemens Healthcare Diagnostics (1797) Siemens Healthcare Diagnostics (1797)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	2,939.12	0.00	Vendor 2,939.12
6338-000 CTK0000		2 O/O 3	Cart / Truck, Soiled Utility __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	820.00	0.00	List 1,640.00
6364-013 GLV0048		1 O/C 1	Dispenser, Glove, Triple Box 305302-1 Stainless Steel	Omnimed, Inc (305302-1) Omnimed, Inc (305302-1)	Project Unassigned	Draft (New) Unassigned Unassigned	80.00	0.00	Estimate 80.00
5869-012 DSP0043		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount Purell TFX Touch Free (2720-12)	GOJO Industries (12/01/2720) ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	50.00	0.00	Estimate 50.00
6084-000 DSP0000		1 O/C 1	Dispenser, Paper Towel, Surface Mount __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	45.00	0.00	List 45.00
5868-000 DSP0000		1 O/C 1	Dispenser, Soap, Wall Mount __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	54.00	0.00	List 54.00
4300-040 SHL0711		1 O/O 3	Shelving, Wire, Chrome, 60 inch Super Erecta - Super Adjustable 60x24x74 (5-Tier)	InterMetro Industries Corp ((5x)A2460NC/(4x)74P) InterMetro Industries Corp ((5x)A2460NC/(4x)74P)	Project Unassigned	Draft (New) Unassigned Unassigned	743.00	0.00	Estimate 743.00
CMF882J SNK0000		1 O/C 1	Sink, Utility, 1-Compartment __________________	____________________ ____________________	Construction Unassigned Unassigned	Draft (New) Unassigned Unassigned	0.00	0.00	Estimate 0.00

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Soiled Utility_001   Room#:   Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
4690-000 WST0000		1 O/O 3	Waste Can, 32-40 Gallon __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	97.00	0.00	List 97.00
7263-000 WST0000		1 O/O 3	Waste Can, Bio-Hazardous, Roll-Out __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	250.00	0.00	List 250.00
4711-002 WLD0024		1 O/O 2	Welder, Sterile Tubing TSCD II Sterile Tubing Welder	Terumo BCT (3ME-SC203A) Terumo BCT (3ME-SC203A)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	15,884.00	0.00	Vendor 15,884.00

Room Total : 23,631.12
Room Qty : 1

NYU Langone Hospitals

Tisch Projects

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

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

Comments: *Currency: Dollar (US)*

Atta ID CAD ID	Alt ID Item ID	Qty F/I AC	Description Model Item Notes	Manufacturer Vendor	Funding Source Cost Center Budget Name	Item Status Custom 1 Custom 2	Unit Cost Opt Subtotal	Item Tax Opt Tax	Price Type Total Config
5039-000 BIN0000		1 O/C 1	Bin, Supply, Wall Mounted __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	33.00	0.00	List 33.00
7461-001 SPC0115		1 O/O 3	Cart, Supply, Linen, 72 inch Super Erecta (24"x72)	InterMetro Industries Corp ((4x)2472NC/(4x)63UP/EP56C/EP36C/5M/ InterMetro Industries Corp ((4x)2472NC/(4x)63UP/EP56C/EP36C/5M/	Project Unassigned	Draft (New) Unassigned Unassigned	2,663.50	0.00	Vendor 2,663.50 C
5835-000 UTC0000		1 O/O 3	Cart, Utility, Stainless __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	289.00	0.00	List 289.00
5869-000 DSP0000		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount __________________	____________________ ____________________	Project Unassigned	Draft (New) Unassigned Unassigned	12.00	0.00	List 12.00

Room Total : 2,997.50

Room Qty : 1

NYU Langone Hospitals

Tisch Projects

Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Storage, Equipment   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
5319-035 CWA0456		1 O/C 1	Cabinet, Warming, Dual, Recessed D-Series DWC242464T-G-4B-R2 (Glass Door)	MAC Medical, Inc. (DWC242464T-G-4B-R2) MAC Medical, Inc. (DWC242464T-G-4B-R2)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	11,562.00	0.00	Vendor 11,562.00 C
6035-015 CYL0322		12 O/O 3	Cart, Cylinder, D&E, Single CYL1	LogiQuip, LLC (CYL1) LogiQuip, LLC (CYL1)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	316.00	0.00	Estimate 3,792.00 C
5863-483 PRC1271		1 O/O 3	Cart, Procedure, General PEL-B-24 Aluminum 5-Drwr Auto-Locking Beige	Armstrong Medical Industries (PEL-B-24) Armstrong Medical Industries (PEL-B-24)	Capital Unassigned	Draft (New) Unassigned Unassigned	2,495.00	0.00	Vendor 2,495.00
5859-021 PRC0134		1 O/O 3	Cart, Procedure, Resuscitation PAR-30 Premier Aluminum Breakaway 5-Dwr (Red/Red)	Armstrong Medical Industries (PAR-30) Armstrong Medical Industries (PAR-30)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,750.00	0.00	List 1,750.00
5860-033 PRC1352		1 O/O 3	Cart, Procedure, Resuscitation, Pediatric AMC-3B-E Aluminum 6-Dwr. Narrow Cart (Beige)	Armstrong Medical Industries (AMC-3B-E) Armstrong Medical Industries (AMC-3B-E)	Capital Unassigned	Draft (New) Unassigned Unassigned	1,880.00	0.00	List 1,880.00
5835-001 UTC0001		1 O/O 3	Cart, Utility, Stainless 311 (3 Shelf, Standard Duty)	Lakeside Manufacturing, Inc. (311) Lakeside Manufacturing, Inc. (311)	Project Unassigned	Draft (New) Unassigned Unassigned	404.00	0.00	Vendor 404.00
6525-007 CPA0046		2 O/O 2	CPAP Unit, Automatic (APAP) Lumis Tx Humidifier Kit w/ Trolley	ResMed Corp (360122) ResMed Corp (360122)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	10,679.00	0.00	Vendor 21,358.00
3678-069 DFB0179		1 O/O 2	Defibrillator, Monitor, w/Pacing R Series ALS w/Pacing/EtCO2/NIBP/Massimo SpO2	Zoll Medical Corporation (3 0320 0052 0133 0012) Zoll Medical Corporation (3 0320 0052 0133 0012)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	24,170.00	0.00	Estimate 24,170.00
5869-000 DSP0000		1 O/C 1	Dispenser, Hand Sanitizer, Wall Mount __________________	__________________ __________________	Project Unassigned	Draft (New) Unassigned Unassigned	12.00	0.00	List 12.00

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract   C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Storage, Equipment   Room#:   Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
6145-028 DOP0065		1 O/O 3	Doppler, Vascular Smartdop 30EX	Koven Technology, Inc. (A-SD 30EX) Koven Technology, Inc. (A-SD 30EX)	Project Unassigned	Draft (New) Unassigned Unassigned	6,995.00	0.00	Vendor 6,995.00
3768-094 ECG0662		2 O/O 2	Electrocardiograph (ECG), Interpretive MAC VU360 Resting ECG Workstation w/ Basic Trolley Procured by VC.	GE Healthcare - Cardiology (MAC VU360) GE Healthcare - Cardiology (MAC VU360)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	19,000.00	0.00	Vendor 38,000.00 C
3874-000 HYP0000		1 O/O 2	Hypo-Hyperthermia Unit, General ____________________ Arctic Sun - Spec TBD	____________________ ____________________	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	55,099.00	0.00	Estimate 55,099.00
6490-004 ISF0035		1 O/O 2	Insufflator, Exsufflator, Mechanical VitalCough System	Baxter - Hillrom, Advanced Respiratory Div. (PVC1CAP) Baxter - Hillrom, Advanced Respiratory Div. (PVC1CAP)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	4,995.00	0.00	Vendor 4,995.00
7233-004 LAR0014		1 O/O 2	Laryngoscope Set, Video GlideScope Cobalt AVL-Adult w/ Mobile Stand (3/4)	Verathon (0003-0378) Verathon (0003-0378)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	34,111.00	0.00	Vendor 34,111.00
3944-042 LFT0025		1 O/O 2	Lift, Patient, Battery Powered Maxi Move (w/Scale, Power DPS)	Arjo Inc (KMCSUN-D) Arjo Inc (KMCSUN-D)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	10,130.76	0.00	List 10,130.76 C
7570-034 LFT0386		1 O/O 2	Lift, Patient, Stand Assist SARA Stedy	Arjo Inc (NTB2000) Arjo Inc (NTB2000)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	2,636.00	0.00	List 2,636.00 C
7933-017 LCR0042		1 O/O 2	Locator, Vein AV500 Vein Viewing System w/ HF580 Mobile Stand	AccuVein (AV500/HF580) AccuVein (AV500/HF580)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	6,250.00	0.00	Vendor 6,250.00 C
8683-001 MON0674	 4075-179	3 O/O 3	Monitor, Physiologic, Vital Signs, Ambulatory IntelliVue MX40 Wearable Monitor 12/14/2015: Price Includes Cabling and Accessories.	Philips Healthcare - Monitoring Systems (865350) Philips Healthcare - Monitoring Systems (865350)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	5,300.00	0.00	Estimate 15,900.00

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Storage, Equipment Room#: Room Sign: Area/Phase: Unassigned

Comments:

Currency: Dollar (US)

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
4122-009 PER0011		1 O/O 2	Percussor, Chest Physiotherapy IPV-2C	Sentec (F00002-C) Sentec (F00002-C)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	9,529.00	0.00	Vendor 9,529.00
4123-002 PER0007		1 O/O 2	Percussor, Chest Therapy Vest The Vest System, Model 205	Baxter - Hillrom, Advanced Respiratory Div. (P205CAP) Baxter - Hillrom, Advanced Respiratory Div. (P205CAP)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	9,500.00	0.00	Vendor 9,500.00
4174-003 PMP0091		1 O/O 2	Pump, Heart / Lung, ECMO CARDIOHELP w/ Sprinter Cart	Getinge Group - MAQUET Cardiovascular (70104.8012/70105.4184) Getinge Group - MAQUET Cardiovascular (70104.8012/70105.4184)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	121,000.00	0.00	Vendor 121,000.00
3374-022 ASP0022		1 O/O 2	Pump, Suction/Aspirator, General, Portable SSCOR DUET w/Retention Bracket	Armstrong Medical Industries (AE-6976) Armstrong Medical Industries (AE-6976)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	1,135.00	0.00	List 1,135.00
4569-022 ULT0013		1 O/V 2	Ultrasound, Imaging, Multipurpose HDI 5000	Philips Healthcare - Imaging Systems (8500-9832-01) Philips Healthcare - Imaging Systems (8500-9832-01)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	152,000.00	0.00	Vendor 152,000.00 C
5672-018 ULT0354		1 O/O 2	Ultrasound, Imaging, Urology BladderScan Prime w/Mobile Cart	Verathon (0270-0870 / 0800-0532) Verathon (0270-0870 / 0800-0532)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	17,540.00	0.00	List 17,540.00
4590-024 VNT0190		2 O/O 2	Ventilator, Adult / Pediatric / Neonatal Servo-U w/Cart	Getinge Group - MAQUET Critical Care (6694800/6693695) Getinge Group - MAQUET Critical Care (6694800/6693695)	Capital Unassigned	Draft (New) Unassigned Unassigned	59,807.00	0.00	Vendor 119,614.00
5362-023 VNT0211		2 O/O 2	Ventilator, BiPAP Trilogy EV300	Philips Healthcare - Respironics (DS2200X11B) Philips Healthcare - Respironics (DS2200X11B)	Project Unassigned Unassigned	Draft (New) Unassigned Unassigned	15,000.00	0.00	Vendor 30,000.00

NYU Langone Hospitals
Tisch Projects
Room By Room Detail Report

C = GPO Contract C = My Org Contract

Department: HCH7 PICU

Building: Unassigned

Room: Storage, Equipment Room#: Room Sign: Area/Phase: Unassigned

Comments: *Currency: Dollar (US)*

Atta ID / CAD ID	Alt ID / Item ID	Qty / F/I / AC	Description / Model / Item Notes	Manufacturer / Vendor	Funding Source / Cost Center / Budget Name	Item Status / Custom 1 / Custom 2	Unit Cost / Opt Subtotal	Item Tax / Opt Tax	Price Type / Total Config
4657-021		1	Warmer, Patient, Hypothermia	3M Health Care (77500)	Project	Draft (New)			
WMR0107		O/O	Bair Hugger 775	3M Health Care (77500)	Unassigned	Unassigned	4,762.40	0.00	Vendor
		2			Unassigned	Unassigned			4,762.40 C

Room Total :	**706,620.16**
Room Qty :	**1**
Department Total :	**3,017,376.90**
Grand Total :	**3,017,376.90**

Schedule 13
All Article 28 Facilities

Contents:

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

Schedule 13 A. Assurances from Article 28 Applicants

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

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

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

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

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

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

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

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

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

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

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

Date: 7/24/2024

Signature:

Robert I. Grossman, M.D.

Name (Please Type)

Dean and CEO

Title (Please type)

New York State Department of Health
Certificate of Need Application

Schedule 13 B-1. Staffing

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

[X] Total Project or [ ] Subproject number

A	B	C	D
	Number of FTEs to the Nearest Tenth		
Staffing Categories	Current Year*	First Year Total Budget	Third Year Total Budget
1. Management & Supervision			
2. Technician & Specialist			
3. Registered Nurses			
4. Licensed Practical Nurses			
5. Aides, Orderlies & Attendants			
6. Physicians			
7. PGY Physicians			
8. Physicians' Assistants			
9. Nurse Practitioners			
10. Nurse Midwife			
11. Social Workers and Psychologist**			
12. Physical Therapists and PT Assistants			
13. Occupational Therapists and OT Assistants			
14. Speech Therapists and Speech Assistants			
15. Other Therapists and Assistants			
16. Infection Control, Environment and Food Service			
17. Clerical & Other Administrative			
18. Other			
19. Other			
20. Other			
21. Total Number of Employees	70	122.0	122.0

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

Describe how the number and mix of staff were determined:

The number and mix of staff were determined by using the current patient/staff ratios and adjusting them to the increased bed numbers and projected patient volume.

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

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

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

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

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

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

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

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

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

Schedule 13 D: Annual Operating Revenues

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

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

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

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

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

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

Required Attachments

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

Schedule 16
CON Forms Specific to Hospitals
Article 28

Contents:

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

Schedule 16 A. Hospital Program Information

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

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

NYU Langone Hospitals is an existing acute care facility certified under Article 28 of the New York State Public Health Laws. Through implementation of this project, NYU Langone Hospitals 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 NYU Langone Hospitals' addition of Pediatric Intensive Care (PICU) beds.

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

List of Proposed Ambulatory Surgery Category
N/A

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

Number and Type of Operating Rooms:

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

Number and Type of Procedure Rooms:

- Current: 0
- To be added: **0**

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

Schedule 16 B. Community Need

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

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

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

The relevant service area for this project includes Brooklyn, New York and Queens Counties.

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

72% of the patients discharged from the PICU reside in the boroughs of Manhattan, Brooklyn and Queens.

2022 Population Aged <20 by County

	Population
Brooklyn	622,216
New York	308,696
Queens	486,360
Total	1,417,272

It is anticipated that 63.4% of PICU discharges will be Medicaid and it is expected to remain the same percentage for years 1 and 3.

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 541 discharges from the Pedicatric ICU. By 9/1/2027, this is expected to increase to 1,022 and to 1,049 by 9/1/2029

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

NYU Langone Hospitals has an internal transfer team that is available 24/7 to accept transfers from external hospitals for pediatric patients who need a higher level of care. We partner with other hospitals to provide transport services to ensure their pediatric patients have expedient access to the life-saving care and services our PICU can provide. Children needing ECMO, chemotherapy, transplant services and other high-acuity treatments are transferred directly to us as a regional resource.

(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 the payment.

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

The population served currently receives their intensive care services in the Pediatric Intensive Care Unit.

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.

NYU Langone Hospitals has, in recent years, gained approvals for pediatric transplant programs (i.e. heart and liver), which have grown consistently since inception. With a consistently increasing volume of high-acuity patients, more PICU beds are needed to accommodate and ensure pediatric patients in the region can access high-quality, complex healthcare services, close to home.

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?

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

C. Impact of CON Application on Hospital Operating Certificate

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

TABLE 16C-1 AUTHORIZED BEDS

LOCATION:

(Enter street address of facility)

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

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

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

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

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

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:

(Enter street address of facility)

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

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

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

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

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

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

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

LOCATION: (Enter street address of facility)	Check if this is a mobile van/clinic ☐

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

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

END STAGE RENAL DISEASE (ESRD)

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

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

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

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

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

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

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

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

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

Schedule 16 D. Hospital Outpatient Department - Utilization projections

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

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

Schedule 16 E. Utilization/discharge and patient days

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

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

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

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

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

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

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date: 9/1/2022		1st Year Start date: 9/1/2027		3rd Year Start date:9/1/2029	
	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	541	3,547	1,022	6,700	1,049	6,877
PHYSICAL MEDICINE & REHABILITATION						
PRISONER						
PSYCHIATRIC						
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM						
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL	541	3,547	1,022	6,700	1,049	6,877

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

Schedule 16 F. Facility Access

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

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

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

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

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

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

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

Yes ☐ No ☐

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

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

   Yes ☐ No ☐

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

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

   Yes ☐ No ☐

   If no, provide an explanation.

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

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

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

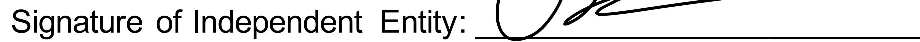
4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years?

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

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

Section B. All Article 28 Facilities

Table B.

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

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

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

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

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

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