

Limited Review Application

State of New York Department of Health
Office of Primary Care and Health Systems Management

LRA Cover Sheet

Project to be Proposed/Applicant Information

This application is for those projects subject to a limited review pursuant to 10 NYCRR 710.1(c)(5)-(7). Please check the appropriate box(es) reflective of the project being proposed by your facility (**NOTE** – Some projects may involve requisite “Construction”. If so, and **total** project costs are below designated thresholds, then **both boxes** must be checked and necessary LRA Schedules submitted). **Please read the LRA Instructions to ensure submission of an appropriate and complete application:**

- ☒ **Minor Construction** – Minor construction project with total project costs of up to \$30,000,000 for general hospitals and up to \$8,000,000 for all other facilities.

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, and 6.

- ☐ **Equipment** – Project related to the acquisition, relocation, installation or modification of certain medical equipment, with total project costs of up to \$30,000,000 for general hospitals and up to \$8,000,000 for all other facilities. (**NOT** necessary for “1-for-1” replacement of existing equipment without construction, pursuant to Chapter 174 of the Laws of 2011 amending Article 28 of the Public Health law to eliminate limited review and CON review for one for one equipment replacement)

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, and 5.

- ☒ **Service Delivery** – Project to decertify a facility's beds/services; add services which involve a total project cost up to \$30,000,000 for general hospitals and up to \$8,000,000 for all other facilities; or convert beds within approved categories. (*If construction associated, also check “Construction” above.*)

Necessary LRA Schedules: Cover Sheet, 2, 6, 7, 8, 10, and 12. **If proposing to decertify beds within a nursing home, provide a description of the proposed alternative use of the space including a detailed sketch (unless the decertification is being accomplished by eliminating beds in multiple-bedded rooms). If proposing to convert beds within approved categories, an LRA Schedule 6 and all supporting documentation are required to confirm appropriate space for the new use.*

- ☐ **Mobile Vans** – Project to certify a new mobile van extension clinic or replace a previously certified mobile extension clinic van.

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, and 6.

- ☐ **Relocation of Extension Clinic** – Project to relocate an extension clinic within the same service area which involve a total project cost up to \$15,000,000 for general hospitals and up to \$6,000,000 for all other facilities. (*If construction associated, also check “Construction” above.*)

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, 6 and 7. Also include a Closure Plan for vacating extension clinic.

- ☐ **Part-Time Clinic** – Project to operate, change services offered, change hours of operation or relocate a part-time clinic site – for applicants already certified for “part-time clinic”. (*If construction associated, also check “Construction” above.*)

Necessary LRA Schedules: Cover Sheet, 2, 8, 10, 11, and 12.

OPERATING CERTIFICATE NO. 7002053H	CERTIFIED OPERATOR NYU Langone Hospitals	TYPE OF FACILITY Hospital
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OPERATOR ADDRESS – STREET & NUMBER 550 First Avenue		PFI 1463	NAME AND TITLE OF CONTACT PERSON Chris Panettieri, Associate Director, Strategy Planning and Bus. Development		
CITY New York	COUNTY NY	ZIP 10016	STREET AND NUMBER One Park Ave, Fourth Floor		
PROJECT SITE ADDRESS – STREET & NUMBER 550 First Avenue		PFI 1463	CITY New York	STATE NY	ZIP 10016
CITY New York	COUNTY NY	ZIP 10016	TELEPHONE NUMBER 212-263-3492	FAX NUMBER	
TOTAL PROJECT COST: \$ 11,536,000			CONTACT E-MAIL: christopher.panettieri@nyulangone.org		

(Rev 09/2025)

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 2

Total Project Cost

ITEM	
1.1 Land Acquisition <i>(attach documentation)</i>	
1.2 Building Acquisition	
2.1 New Construction	
2.2 Renovation and Demolition	
2.3 Site Development	
2.4 Temporary Power	
3.1 Design Contingency	
3.2 Construction Contingency	
4.1 Fixed Equipment (NIC)	
4.2 Planning Consultant Fees	
4.3 Architect/Engineering Fees (incl. computer installation, design, etc.)	
4.4 Construction Manager Fees	
4.5 Capitalized Licensing Fees	
4.6 Health Information Technology Costs	
4.6.1 Computer Installation, Design, etc.	
4.6.2 Consultant, Construction Manager Fees, etc.	
4.6.3 Software Licensing, Support Fees	
4.6.4 Computer Hardware/Software Fees	
4.7 Other Project Fees (Consultant, etc.)	
5.1 Movable Equipment	
6.1 Total Basic Cost of Construction	
7.1 Financing Cost (points, fees, etc.)	
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount \$ @ % for months	
7.3 Application Fee	
8.1 Estimated Total Project Cost (Total 6.1 – 7.3)	\$ 11,536,000.00

If this project involves construction enter the following anticipated construction dates on which your cost estimates are based.

Construction Start Date 9/1/2026

Construction Completion Date 3/31/2027

(Rev. 1/31/2013)

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 3

Proposed Plan for Project Financing

A. LEASE ☐

If any portion of the cost for land, building or Equipment is to be financed through a lease, rental agreement or lease/purchase agreement, complete the chart at the right.

A complete copy of each proposed lease must be submitted.

Attachment # _____

ITEM	COST AS IF PURCHASED
	\$
	\$
	\$
	\$
	\$

B. CASH ☒

If cash is to be used, complete the chart at the right.

Attach a copy of the latest certified financial Statement and interim monthly or quarterly financial reports to cover the balance of time to date.

Attachment # _____

Accumulated Funds	\$ 11,536,000.00
Sale of Existing Assets*	\$
Other – (i.e. gifts, grants, **etc.)	\$
TOTAL CASH	\$ 11,536,000.00

Please see note below in red regarding financing.

*Attach a full and complete description of the assets to be sold.

Attachment # _____

** If grants, attach a description of the source of financial support

Attachment # _____

C. DEBT FINANCING ☐

If the project is to be financed by debt of any type, complete the chart at the right.

Attach a copy of the proposed letter of interest From the intended source of permanent financing.

This letter must include an estimate of the Principal, term, interest rate and pay-out period presently being considered.

Attachment # _____

Principal	\$
Interest Rate	%
Term	Yrs
Pay-out Period	Yrs
Type *	

* Commercial, Dormitory Authority Bonds, Dormitory Authority, TELP Lease, Industrial Development Agency Bonds, Other (identify).

NOTE: It should be noted that the applicant reserves the option to seek financing for this project. The applicant is prepared to discuss this potential financing with the Department, but it wants to ensure the Department is aware that this may occur. In addition, the applicant understands that it must propose such financing prior to the completion of work on this project.

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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1.2	Does this plan involve construction and change land use or density?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1.3	Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1.4	Does this plan involve construction and require work related to the disposition of asbestos?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.5	Will the project involve parking for 1,000 vehicles or more?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.12	Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.13	Will the project significantly affect drainage flow on adjacent sites?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2.14	Will the project affect any threatened or endangered plants or animal species?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.15	Will the project result in a major adverse effect on air quality?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.19	Will the project have any adverse impact on health or safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
	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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	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 <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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).		<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Moderate to Low Risk Area		Yes	No
	Zone	Description	<input type="checkbox"/>	<input type="checkbox"/>
	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.	<input type="checkbox"/>	

C and X	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.	<input type="checkbox"/>	
High Risk Areas		Yes	No
Zone	Description	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	
AE	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30.	<input checked="" type="checkbox"/>	
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).	<input type="checkbox"/>	
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.	<input type="checkbox"/>	
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.	<input type="checkbox"/>	
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.	<input type="checkbox"/>	
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.	<input type="checkbox"/>	
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.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	
Undetermined Risk Area		Yes	No
Zone	Description	<input type="checkbox"/>	<input type="checkbox"/>

	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?		<input checked="" type="checkbox"/>	<input type="checkbox"/>
	If Yes, the Elevation Certificate (FEMA Flood Insurance) shall be submitted with the application.			
	If yes which zone is the site located in?	AE/Shd X/X		
4.3	Does this project reflect the post Hurricane Lee, and or Irene, and Superstorm Sandy mitigation standards?		<input type="checkbox"/>	<input type="checkbox"/>
	If Yes, which floodplain?	100 Year	<input type="checkbox"/>	
		500 Year	<input type="checkbox"/>	

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

[FEMA Elevation_Certificate_and Instructions](#)

Space & Construction Cost Distribution

☐ New

Alteration

[illegible]

Schedule 6

Architectural/Engineering Submission

Contents:

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

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

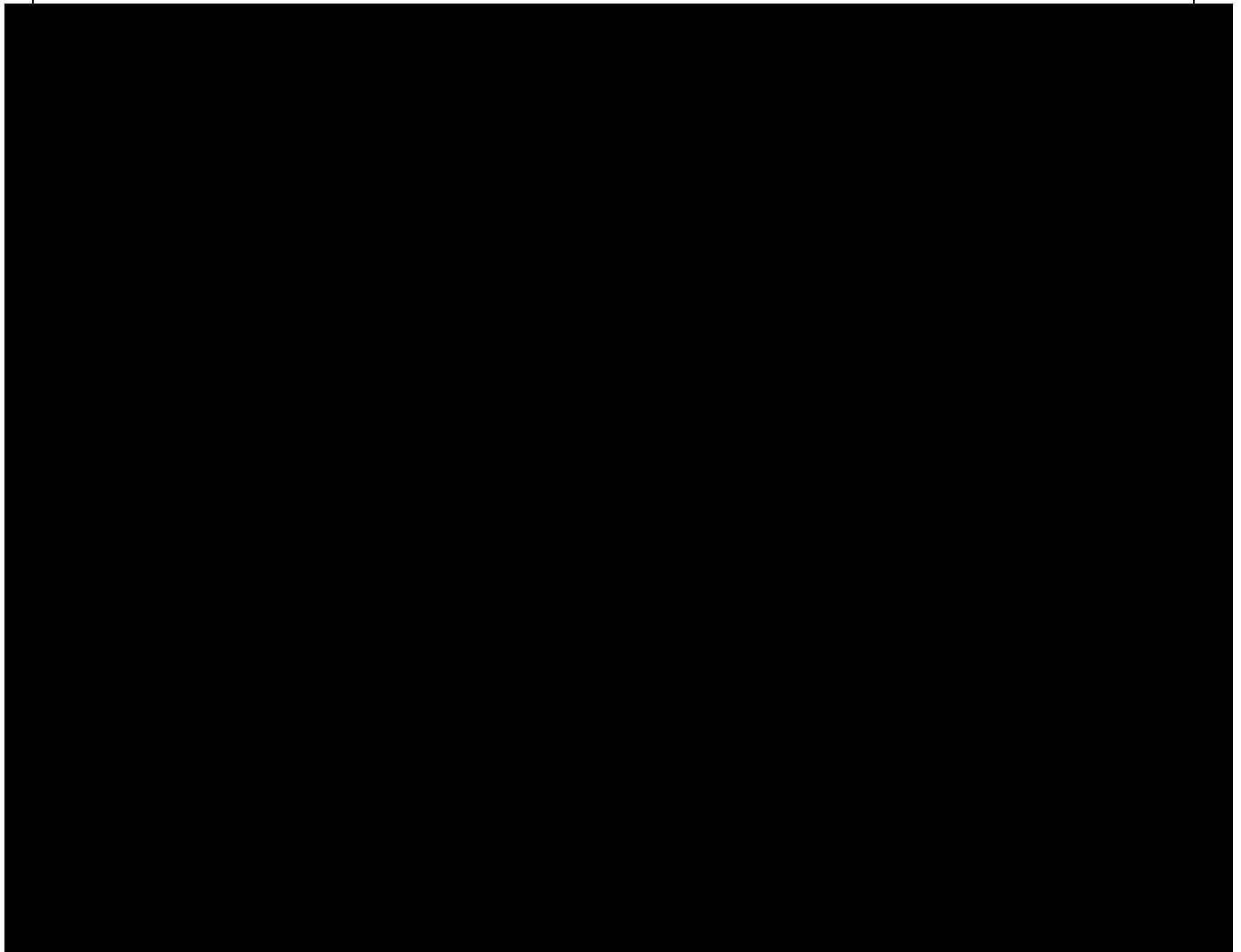
Narrative shall include but not limited to the following information. Please address all items in the narrative including items located in the response column. **Incomplete responses will not be accepted.**

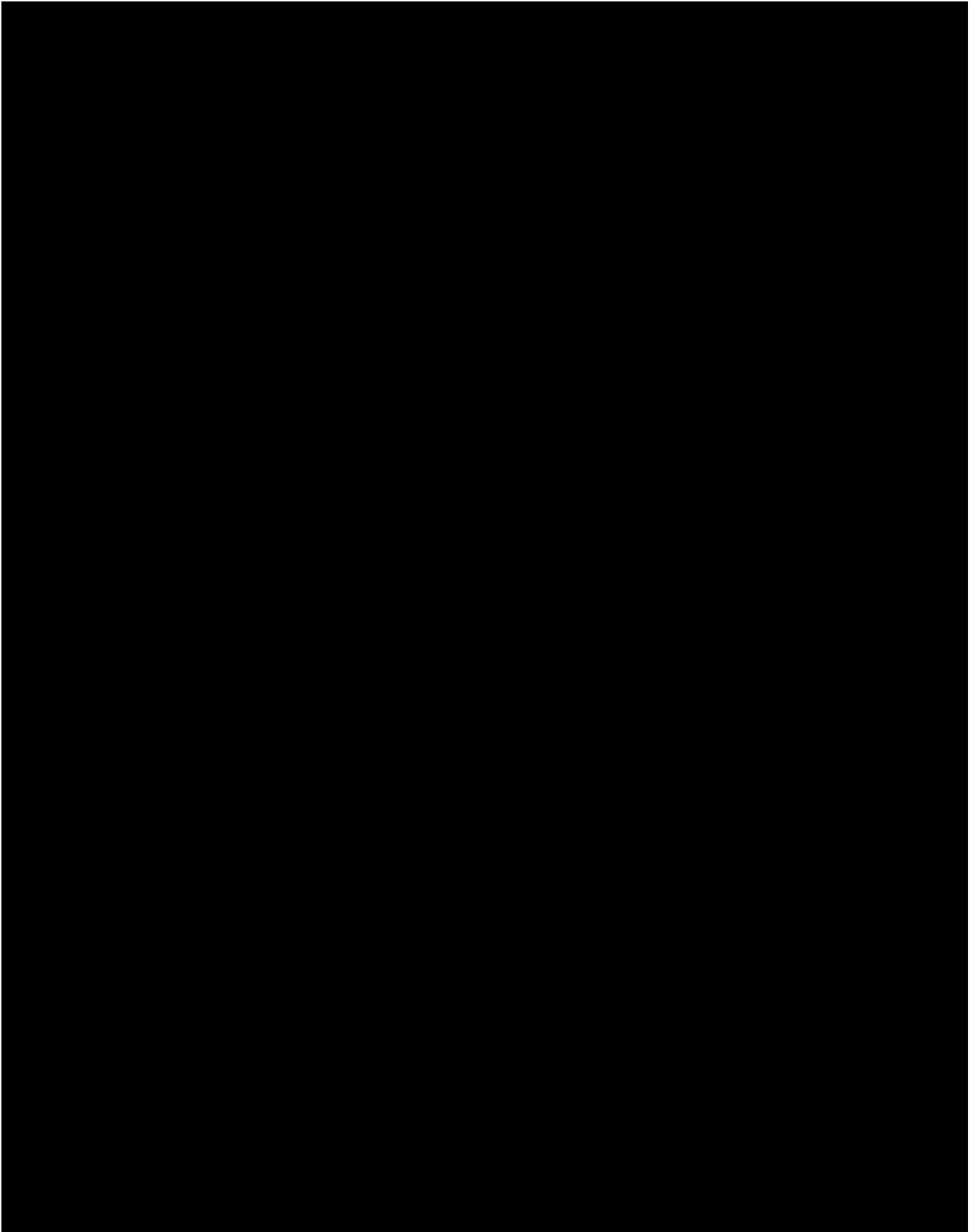
Project Description	
Schedule 6 submission date: 12/31/2025	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? No If so, what is the original CON number? No	
Intent/Purpose: NYU Langone Health (NYULH) intends to pursue a strategic effort to elevate healthcare services and optimize facility use related to its infant and maternal care program. The institution intends to relocate the well-baby nursery locally within one floor of its Family Care Suite to facilitate the addition of six (6)	

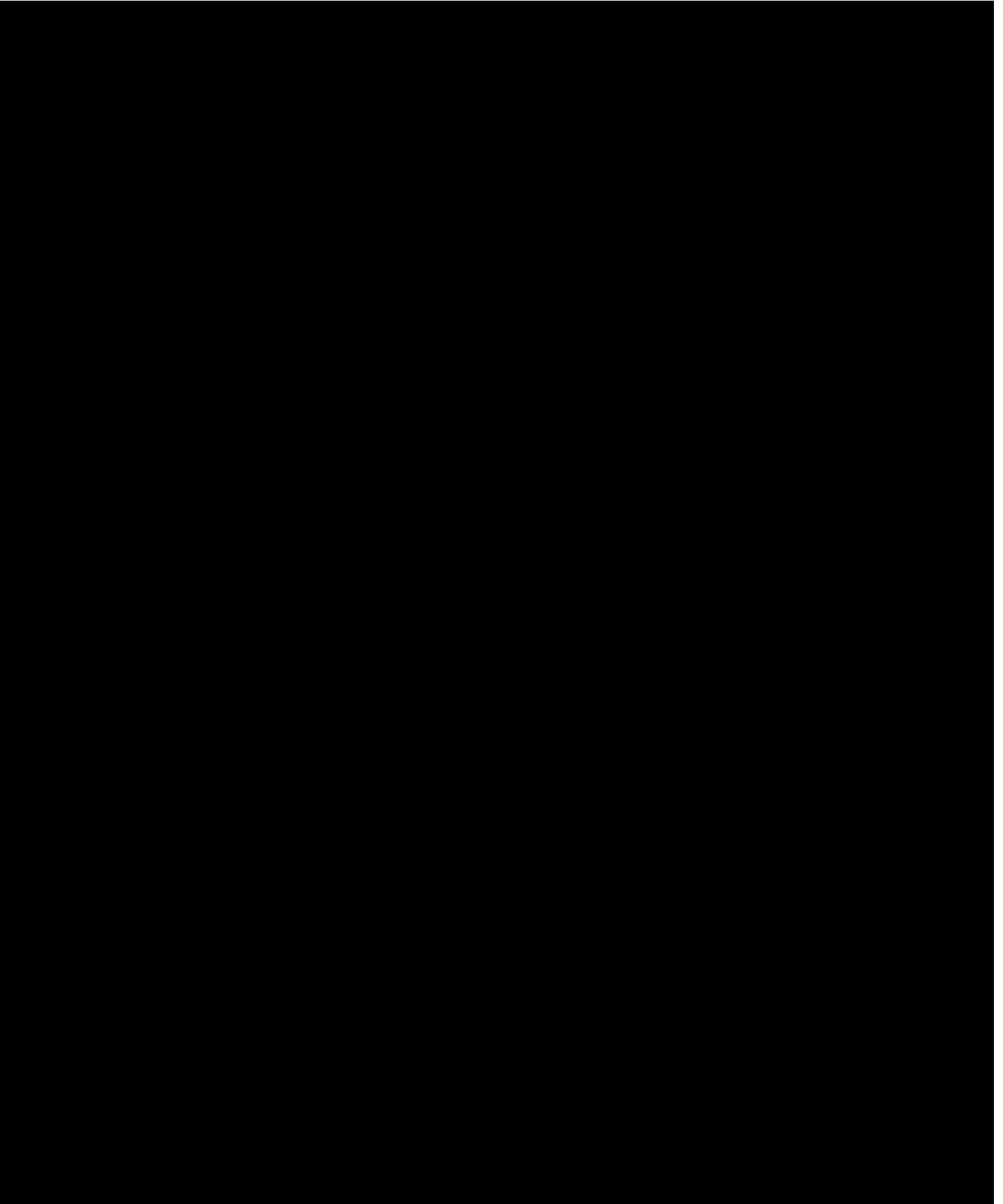
New York State Department of Health Certificate of Need Application

Schedule 6

continuing care licensed positions to care for lower acuity patients as a complement to the hospital's NICU program.	
Site Location: The new Continuing Care and relocated Nursery renovation will be located at NYULH's main campus, situated at 562 1st Avenue, New York, NY 10016, within the Tisch Hospital on the 12 th floor. The existing Tisch hospital is situated between Kimmel Pavilion and Skirball. The overall site is bounded by FDR Drive to the East, 1 st Ave to the West, East 34 th Street to the North, and East 30 th streets to the South.	
Brief description of current facility, including facility type: The project is located within the existing Tisch Hospital.	
Brief description of proposed facility: The proposed facility will remain as existing, with a small portion of the floor renovated to accommodate the new Continuing Care beds and relocate the Nursery beds within the same unit.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. The proposed renovation area is located within existing Health Care Occupancy, Healthcare 'H-2'.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: There is no mixed occupancy.	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	No
Relationship of spaces conforming with Article 28 space and non-Article 28 space: All programmatic requirements for the project are Article 28 compliant. There are no Non-Article 28 spaces.	







**New York State Department of Health
Certificate of Need Application**

Schedule 6


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

Limited Review Application

Schedule LRA 7

State of New York Department of Health
Office of Primary Care and Health Systems Management

Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue			
Grants Funds			
Foundation			
Other			
Fees			
Other Income			
(1) Total Revenues			
Expenses			
Salaries and Wage Expense			
Employee Benefits			
Professional Fees			
Medical & Surgical Supplies			
Non-Medical Equipment			
Purchased Services			
Other Direct Expense			
Utilities Expense			
Interest Expense			
Rent Expense			
Depreciation Expense			
Other Expenses			
(2) Total Expense			
Net Total - (1-2) 			

Limited Review Application

Schedule LRA 7A

State of New York Department of Health
Office of Primary Care and Health Systems Management

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

Patient Days ☐ Patient discharges ☒

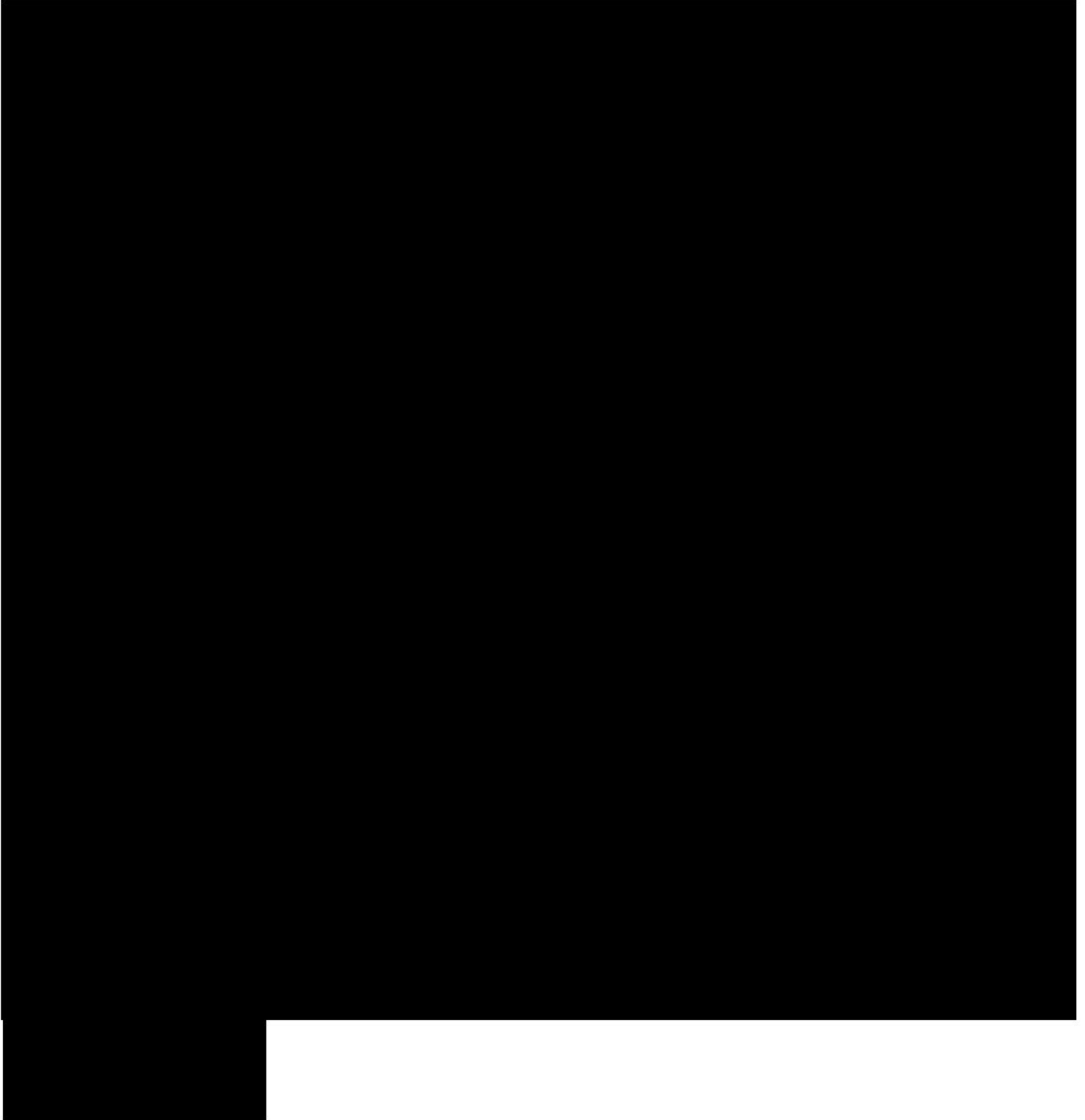
Inpatient Services Source of Revenue		Total Current Year		First Year Incremental			Third Year Incremental			
		Patient Days or dis-	Net Revenue*		Patient Days or dis-	Net Revenue*		Patient Days or dis-	Net Revenue*	
			%	Dollars (\$)		% based on days or	Dollars-\$		% based on days or	Dollars-\$
Commercial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

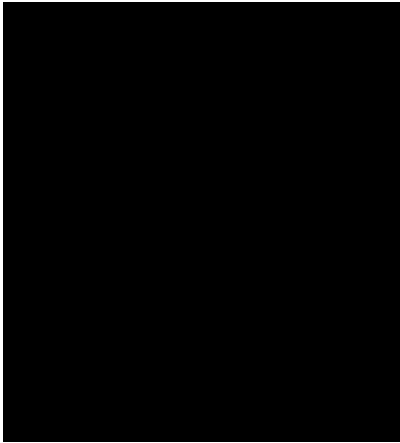
Outpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue*		Visits	Net Revenue*		Visits	Net Revenue*	
			%	Dollars (\$)		%	Dollars (\$)		%	Dollars (\$)
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										
Total of Inpatient and Outpatient Services										

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

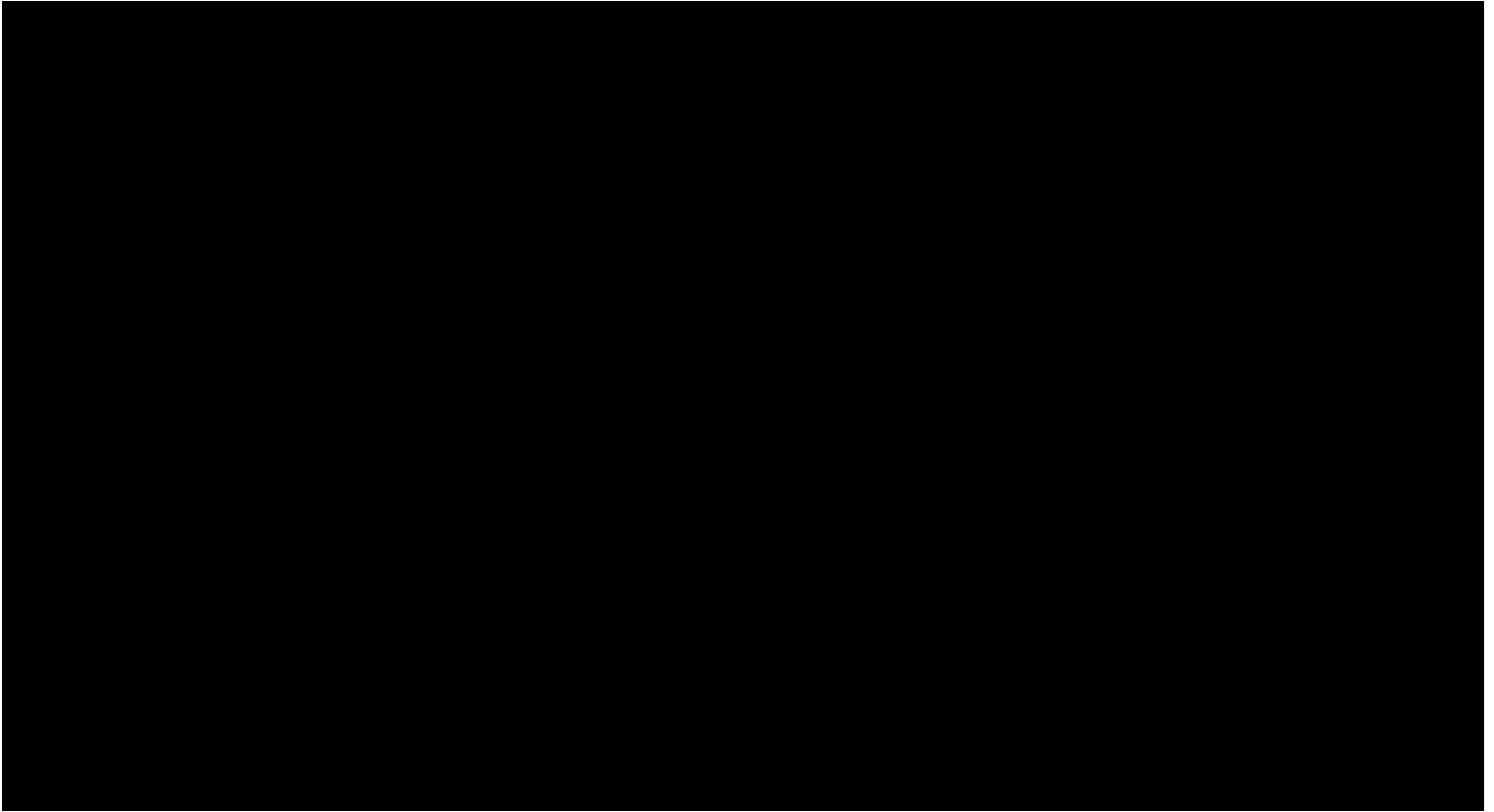
*Net of Deductions from Revenue

Schedule 13c – Annual Operating Costs





Schedule 13d – Annual Operating Revenues



Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 8

Staffing

Staffing Categories	Number of FTEs to the Nearest Tenth		
	Current Year*	First Year of implementation	Third Year of implementation
Health Providers**:			
Registered Nurses			
Occupational Therapist			
Physical Therapist			
Attending Physician			
PGY Physician			
Patient Care Tech			
Support Staff***:			
Management & Supervision			
All Other			
Total Number of Employees			

* Last complete year prior to submitting application

** "Health Providers" includes all providers serving patients at the site. A Health Provider is any staff who can provide a billable service – physician, dentist, dental hygienist, podiatrist, physician assistant, physical therapist, etc.

*** All other staff.

Describe how the number and mix of staff were determined:

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 10

The Sites Tab in NYSE-CON has replaced Schedule LRA 10. Schedule LRA 10 is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval. However, due to programming issues, you may still be required to upload a blank Schedule LRA 10 to submit a Service Delivery LRA application.

Impact of Limited Review Application on Operating Certificate (services specific to the site)

Instructions:

“Current” Column: Mark "x" in the box only if the service *currently* appears on the operating certificate (OpCert), prior to any requested changes

"Add" Column: Mark "x" in the box if this CON application seeks to add.

“Remove” Column: Mark "x" in the box if this CON application seeks to decertify.

“Proposed” Column: Mark "x" in the boxes corresponding to all the services that will ultimately appear on the OpCert if this CON application is approved.

[illegible]

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

☐ No☐ Yes (*Enter CON numbers to the right*)

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 12

Assurances

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

- a) The applicant has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way, sufficient to assure use and possession for the purpose of the construction and operation of the facility.
- b) The applicant will obtain the approval of the Commissioner of Health of all required submissions, which shall conform to the standards of construction and equipment in Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (Title 10).
- c) The applicant will submit to the Commissioner of Health final working drawings and specifications, which shall conform to the standards of construction and equipment of Subchapter C of Title 10, prior to contracting for construction, unless otherwise provided for in Title 10.
- d) The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.
- e) The applicant will provide and maintain competent and adequate architectural and/or engineering inspection at the construction site to insure that the completed work conforms to the approved plans and specifications.
- f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.
- g) The facility will be operated and maintained in accordance with the standards prescribed by law.
- h) The applicant will comply with the provisions of the Public Health Law and the applicable provisions of Title 10 with respect to the operation of all established, existing medical facilities in which the applicant has a controlling interest.
- i) The applicant understands and recognizes that any approval of this application is not to be construed as an approval of, nor does it provide assurance of, reimbursement for any costs identified in the application. Reimbursement for all cost shall be in accordance with and subject to the provisions of Part 86 of Title 10.

Alec Kimmelman, MD, PhD

Name (Please Type)

Dean and CEO

Title (Please Type)

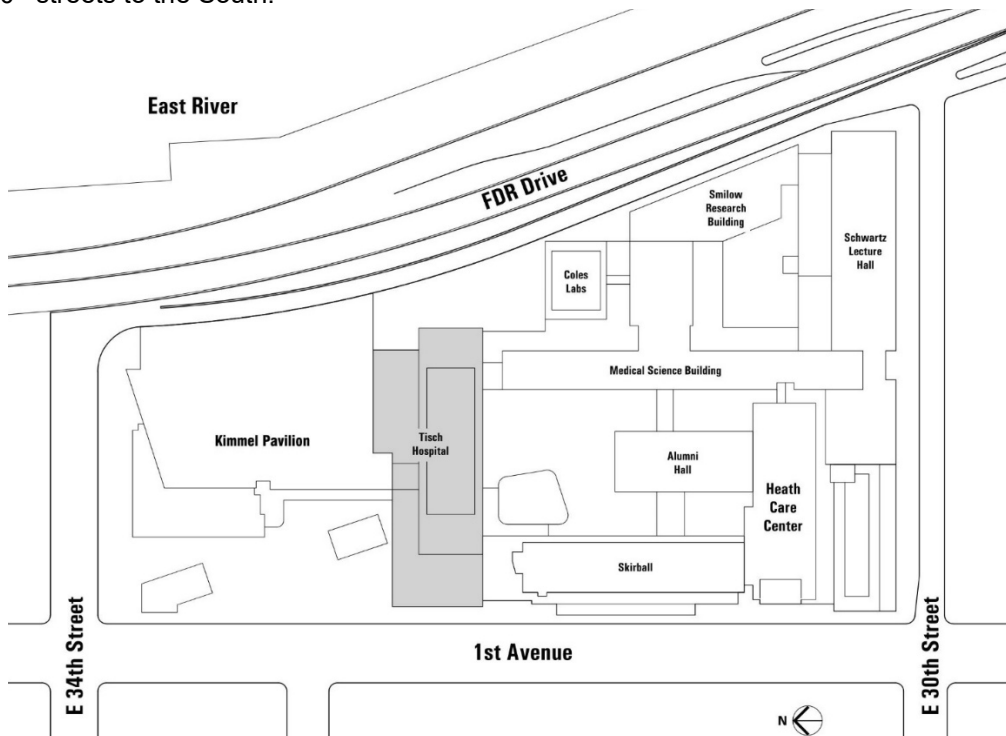
CON Architectural/Engineering Project Narrative

- Intent/Purpose**

NYU Langone Health (NYULH) intends to pursue a strategic effort to elevate healthcare services and optimize facility use related to its infant and maternal care program. The institution intends to relocate the well-baby nursery locally within one floor of its Family Care Suite to facilitate the addition of six (6) continuing care licensed positions to care for lower acuity patients as a complement to the hospital's NICU program.

- Site Location**

The new Continuing Care and Nursery renovation will be located at NYULH's main campus, situated at 562 1st Avenue, New York, NY 10016, within the Tisch Hospital on the 12th floor. The existing Tisch hospital is situated between Kimmel Pavilion and Skirball. The overall site is bounded by FDR Drive to the East, 1st Ave to the West, East 34th Street to the North, and East 30th streets to the South.



- Brief description of current Facility including Facility Type**

The project is located within the existing Tisch Hospital.

- Brief description of proposed facility**

The proposed facility will remain as existing, with a small portion of the floor renovated to accommodate the new Continuing Care beds and relocate the Nursery beds within the same unit.

- Location of proposed spaces or spaces (Occupancy type for each occupied space)**

The proposed renovation area is located within existing Health Care Occupancy, Healthcare 'H-2'.

- **Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Please describe the required smoke and fire separations between occupancies:**

There us no mixed occupancy.

- **If this is an existing facility, is it currently a licensed Article 28 facility?:**

Yes

- **Is the project space being converted from a non-Article 28 space to an Article 28 space?**

No

- **Relationship of spaces conforming with Article 28 space and Non-Article 28 space:**

All programmatic requirements for the project are Article 28 compliant. There are no Non-Article 28 spaces

