Schedule 1
All CON Applications

Contents:

New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

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

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
Elizabeth Weir	3.4.24
PRINT OR TYPE NAME	TITLE
Elizabeth Weir	Site Administrator

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 x☐ NO ☐	IDMH Board of Directors 2024
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 x☐ NO ☐	IDMH Org Chart 2024

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	
Elizabeth Weir		Ira Davenport Memorial Hospital/Arnot Health	
BUSINESS STREET ADDRESS			
7571 State Route 54			
CITY		STATE	ZIP
Bath		New York	14810
TELEPHONE		E-MAIL ADDRESS	
607-776-8670		Elizabeth.weir@arnothealth.org	

Alternate Contact			
NAME AND TITLE OF CONTACT PERSON		CONTACT PERSON'S COMPANY	
Ronette Wiley		Arnot Health	
BUSINESS STREET ADDRESS			
601 Roe Ave			
CITY		STATE	ZIP
Elmira		New York	14905
TELEPHONE		E-MAIL ADDRESS	
607.737.4100		Ronette.wiley@arnothealth.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			
Jonathan Lawrence Chief Executive Officer			
BUSINESS STREET ADDRESS			
601 Roe Avenue			
CITY	STATE	ZIP	
Elmira	NY	14905	
TELEPHONE	E-MAIL ADDRESS		
607.737.4100	Jonathan.lawrence@arnothealth.org		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM	BUSINESS STREET ADDRESS	
John Alexander	Sayles and Evans	1 West Church Street	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Elmira, NY 14905	607.734.2271	John R Alexander" <jalexander@saylesevans.com>	

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

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

The applicant's lead accountant should be identified:

ACCOUNTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
John Mallia	NA CFO	601 Roe Ave	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Elmira, NY 14905	607.737.4100	John.mallia@arnothealth.org	

Please list all Architects and Engineer contacts:

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

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

Other Facilities Owned or Controlled by the Applicant

Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

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

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE	
Hospital	HOSP	Yes x☐ 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.

ArnotHealth
Ira Davenport Memorial Hospital

Jonathan Lawrence CEO

Ronette Wiley, RN, BSN, MHA

Arnot Health Senior Vice President & COO

James Mark, NHA

Nursing Home Administrator

Taylor Health Center

Elizabeth Weir, MSN, RN, CENP

IDMH Site Administrator

Vice President of Nursing

- Nursing Department
  - Nurse Managers (Acute Care)
  - Nursing Supervision- IDMH
- Stroke Program
- Corporate Compliance

Jessica Perry, MSN, AGPC-NP

Director of Quality & Patient Safety

- Quality /Performance Improvement
- Infection Prevention
- Provider Credentialing
- Utilization Management
- Patient Experience
- Regulatory Affairs
- Risk Management

Valerie Brundage MSN, RN

Director of Nursing – Taylor Health Center

- Admissions
- Nursing Units- A/B/C
- Nursing Supervision-THC

Amanda Cervoni

Activities Director – Taylor Health Center

Stacey McMail-Jerzak,

System Director of Social Work

- Social Services – THC
- Social Services - IDMH

Rosalyn Dudash

Vice President of Support Services

Alan Wendlandt

Facilities Manager

Corbye Rathbun

Environmental Services/ FAN Manager

Name	Position	O	Conviced of a criminal offense related to Medicaid, Medicare, Title XX, Title, XXI or state health care program	Address	City	State	Zip
Werner Brammer, MD	Chair of the Board	5	No	8783 Greyton H. Taylor Memorial Dr	Hammondsport	NY	14840-9683
Bernard Burns (Secretary)	Secretary	6	No	3430 Loon Lake Rd	Cohocton	NY	14826-9725
Joseph F. Meade, III (Treasurer)	Treasurer	9	No	9601 Gateway Lane	Hammondsport	NY	14840-8574
Belinda Hoad	Vice Chair	5	No	61185 State Rt 415	Avoca	NY	14809
Jonathan Lawrence	President & CEO	3	No	4 Eagle View Drive	Elmira	NY	14903-9325
Jo Miller	Director		No	9806 Munson Hill Road	Bradford	NY	14815
Kathryn Muller	Director	9	No	19 Shannon Street	Bath	NY	14810-1225
Jeffrey Streeter	Director		No	133 Drive A	Elmira	NY	14905-1739
Jack Wheeler	Director	3	No	7000 Golf View	Bath	NY	14810-8339

Facility Id. 873
Certificate No. 5022000H

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

Certified Beds - Total	**35**
Medical / Surgical	35

OPERATING CERTIFICATE

Effective Date: 12/19/2019
Expiration Date: NONE

Hospital

Ira Davenport Memorial Hospital
7571 State Route 54
Bath, New York 14810

Operator: Ira Davenport Memorial Hospital Inc
Co-Operator: Arnot Ogden Medical Center
Operator Class: Voluntary Not for Profit Corporation

Has been granted this Operating Certificate pursuant to Article 28 of the Public Health Law for the service(s) specified.

Ambulatory Surgery - Multi Specialty	Clinic Part Time Services	Clinical Laboratory Service	Coronary Care	Dental O/P
Emergency Department	Maternity	Medical Services - Other Medical Specialties	Medical Services - Primary Care	Medical Social Services
Medical/Surgical	Nuclear Medicine - Diagnostic	Primary Stroke Center	Radiology - Diagnostic	Swing Bed Program

20191220

Deputy Commissioner, Office of Primary Care and Health Systems Management

This certificate must be conspicuously displayed on the premises.

Howard Zucker M.D.
Commissioner

Schedule 5
Working Capital Plan

Contents:

Working Capital Financing Plan

1. Working Capital Financing Plan and Pro Forma Balance Sheet:

This section should be completed in conjunction with Schedule 13. The general guidelines for working capital requirements are two months of first year expenses for changes of ownership and two months of third year expenses for new establishments, construction projects or when the first year budget indicates a net operating loss. Any deviation from these guidelines must be supported by the monthly cash flow analysis. If working capital is required for the project, all sources of working capital must be indicated clearly. Borrowed funds are limited to 50% of total working capital requirements and cannot be a line of credit. Terms of the borrowing cannot be longer than 5 years or less than 1 year. If borrowed funds are a source of working capital, please summarize the terms below, and attach a letter of interest from the intended source of funds, to include an estimate of the principal, term, interest rate and payout period being considered. Also, describe and document the source(s) of working capital equity.

Titles of Attachments Related to Borrowed Funds	Filenames of Attachments
Example: *First borrowed fund source*	Example: *first_bor_fund.pdf*
NA	NA

In the section below, briefly describe and document the source(s) of working capital equity

There are no capital expenses tied to this Administrative Review CON application.

2. Pro Forma Balance Sheet

This section should be completed for all new establishment and change in ownership applications. On a separate attachment identified below, provide a pro forma (opening day) balance sheet. If the operation and real estate are to be owned by separate entities, provide a pro forma balance sheet for each entity. Fully identify all assumptions used in preparation of the pro forma balance sheet. If the pro forma balance sheet(s) is submitted in conjunction with a change in ownership application, on a line-by-line basis, provide a comparison between the submitted pro forma balance sheet(s), the most recently available facility certified financial statements and the transfer agreement. Fully explain and document all assumptions.

Titles of Attachments Related to Pro Forma Balance Sheets	**Filenames of Attachments**
Example: *Attachment to operational balance sheet*	Example: *Operational_bal_sheet.pdf*
NA	NA

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: 3/1/2024	Revised Schedule 6 submission date: 3/1/2024
Does this project amend or supersede prior CON approvals or a pending application? Not Applicable If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: The intent is to decertify inpatient and swing beds to apply for Rural Emergency Hospital designation through Centers for Medicare and Medicaid Services.	
Site Location: Ira Davenport Memorial Hospital 7571 State Route 54 Bath, NY 14810	

Brief description of current facility, including facility type: Acute care hospital	
Brief description of proposed facility: Not applicable	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. No project and no physical changes to existing facility	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: NA	
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: NA	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. NA	
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. NO	Choose an item.
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. No proposed space or physical change to facility	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. NA	
Describe existing and or new work for fire detection, alarm, and communication systems: Existing fire panel with automatic call to fire department.	
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. NA	
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. Click here to enter text.	
Does the project comply with ADA? If no, list all areas of noncompliance. No project, but facility is ADA compliant	
Other pertinent information: This is a request to decertify inpatient and swing beds. No project or physical change to facility or other services.	

Project Work Area	**Response**
Type of Work	Choose an item.
Square footages of existing areas, existing floor and or existing building.	Click here to enter text.
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	NA
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Choose an item.
Sprinkler protection per NFPA 101 Life Safety Code	Partially Sprinklered
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Choose an item.
Building Height	Click here to enter text.

Building Number of Stories	2
Which edition of FGI is being used for this project?	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?	Not Applicable
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Choose an item.
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Click here to enter text.	Not Applicable
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	Not Applicable
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	Not Applicable
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	Not Applicable
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	Not Applicable
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Decertify 35 inpatient and 15 swing beds	Decrease
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	Not Applicable
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	Not Applicable
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Not Applicable
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	Not Applicable
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	Not Applicable
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	Not Applicable

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

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

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

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

	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	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 ☐
3.2	**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.

FEMA **Elevation Certificate** and Instructions

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	$0	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$0	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$0	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction		Schedule 10
Cost/Per Square Foot for Renovation Construction		Schedule10
Total Operating Cost		Schedule 13C, column B
Amount Financed (as $)		Schedule 9
Percentage Financed as % of Total Cost		Schedule 9
Depreciation Life (in years)		

2) Construction Dates

Anticipated Start Date		Schedule 8B
Anticipated Completion Date		

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

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

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

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

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

	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	$0	$0	$0
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$0	$0	$0
3.2 Construction Contingency	$0	$0	$0
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$0	$0	$0
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$0	$0	$0
Subtotal (Total 1.1 thru 4.5)	$0	$0	$0
5.1 Movable Equipment (from Sched 11)	$0	$0	$0
5.2 Telecommunications	$0	$0	$0
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$0	$0	$0
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	$0	$0	$0
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	$0	$0
10 Total Project Cost with fees	$2,000	$0	$2,000

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

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

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Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	0.00%	Normally 10%
Construction Contingency - Renovation Work	0.00%	Normally 10%
Anticipated Construction Start Date:		as mm/dd/yyyy
Anticipated Midpoint of Construction Date		as mm/dd/yyyy
Anticipated Completion of Construction Date		as mm/dd/yyyy
Year used to compute Current Dollars:		

Subject of attachment	Attachment Number	Filename of attachment - PDF
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New York State Department of Health
Certificate of Need Application
Schedule 8B - Total Project Cost - For Projects without Subprojects.

	A	B	C
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3.1 Design Contingency	$0	$0	$0
3.2 Construction Contingency	$0	$0	$0
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4.2 Planning Consultant Fees	$0	$0	$0
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7.2 Interim Interest Expense:: $ [ ] At [ ] % for [ ] months	$0		$0
8. Total Project Cost: w/o CON fees - Total 6 thru 7.2	$0	$0	$0
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	$0	$0
10 Total Project Cost with fees	$2,000	$0	$2,000