

# 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 \$15,000,000 for general hospitals and up to \$6,000,000 for all other facilities, if not relating to clinical space – check “Non-Clinical” box below).

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 \$15,000,000 for general hospitals and up to \$6,000,000 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 \$15,000,000 for general hospitals and up to \$6,000,000 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.*

- Cardiac Services** – Project by an appropriately certified facility to add electrophysiology (EP) services; or add, upgrade or replace a cardiac catheterization laboratory or equipment. (*If construction associated, also check “Construction” above.*)

Necessary LRA Schedules: Cover Sheet, 2, 7, 8, 10, and 12.

- 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. 702176R	CERTIFIED OPERATOR New York Dialysis Services, Inc.	TYPE OF FACILITY D&TC
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OPERATOR ADDRESS – STREET & NUMBER 510-526 Avenue of the America		PFI 3414	NAME AND TITLE OF CONTACT PERSON Philip J. Murphy		
CITY New York	COUNTY New York	ZIP 10011	STREET AND NUMBER 121 State Street		
PROJECT SITE ADDRESS – STREET & NUMBER 517 Delaware Avenue		PFI	CITY Albany	STATE NY	ZIP 12207
CITY Albany	COUNTY Albany	ZIP 12209	TELEPHONE NUMBER 518-689-7218	FAX NUMBER 518-436-4751	
TOTAL PROJECT COST: <span style="background-color: black; color: black;">XXXXXXXXXX</span>			CONTACT E-MAIL: pmurphy@hinmanstraub.com		

# Limited Review Application

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

**Schedule LRA 2**

## Total Project Cost

ITEM	ESTIMATED PROJECT COST	
1.1 Land Acquisition <i>(attach documentation)</i>	\$	
1.2 Building Acquisition	\$	
	1.1-1.2 Subtotal:	0.00
2.1 New Construction	\$	
2.2 Renovation and Demolition	\$	
2.3 Site Development	\$	
2.4 Temporary Power	\$	
	2.1-2.4 Subtotal:	
3.1 Design Contingency	\$	
3.2 Construction Contingency	\$	
	3.1-3.2 Subtotal:	
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.)	\$	
	4.1-4.7 Subtotal:	
5.1 Movable Equipment	\$	
<b>6.1 Total Basic Cost of Construction</b>	<b>\$</b>	
7.1 Financing Cost (points, fees, etc.)	\$	
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount \$                                    @                                    % for                                    months		
7.3 Application Fee	\$	
<b>8.1 Estimated Total Project Cost (Total 6.1 – 7.3)</b>	<b>\$</b>	

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

Construction Start Date                     

Construction Completion Date

# Limited Review Application

**Schedule LRA 3**

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

## 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 # 3.1

Accumulated Funds	\$	
Sale of Existing Assets*	\$	
Other – (i.e. gifts, grants, **etc.)	\$	
<b>TOTAL CASH</b>	<b>\$</b>	

\*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		
Pay-out Period		
Type *		

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



NYDS

**Income Statement**

NYDS  
(WO)  
(WO)

7002176R

**FMCH Financial Statement**

Revenue:

- Health care services
- Health care products

\$

**Operating (income) expense:**

- Costs of revenue: health care services
- Costs of revenue: health care products
- Selling, general and administrative expenses
- Research and development expenses
- (Income) loss from equity method investees
- Remeasurement gain from InterWell Health LLC

**Operating income**

**Other (income) expense:**

- Interest income
- Interest expense

**Income before income taxes**

- Income tax expense

**Net income**

**Net income attributable to noncontrolling interests**

**Net income attributable to Fresenius Medical Care Holdings, Inc**

\$

# **Schedule LRA 4/Schedule 7 CON Forms Regarding Environmental issues**

## **Contents:**

**Schedule LRA 4/Schedule 7 - Environmental Assessment**

<b>Environmental Assessment</b>			
<b>Part I.</b>	The following questions help determine whether the project is "significant" from an environmental standpoint.	<b>Yes</b>	<b>No</b>
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?		
<b>Part II.</b>	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	<b>Yes</b>	<b>No</b>
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.		
<b>Part III.</b>		<b>Yes</b>	<b>No</b>
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.		
	<b>Agency Name:</b>		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	<b>Agency Name:</b>		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	<b>Agency Name:</b>		
Contact Name:			

	Address:				
	State and Zip Code:				
	E-Mail Address:				
	Phone Number:				
	<b>Agency Name:</b>				
	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
	<b>Agency Name:</b>				
	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.				
<b>Part IV.</b>	<b>Storm and Flood Mitigation</b>				
	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).				
	<b>Moderate to Low Risk Area</b>			Yes	No
	<b>Zone</b>	<b>Description</b>			
		In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:			
	<b>B and X</b>	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.			

<b>C and X</b>	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.	<input type="checkbox"/>	
<b>High Risk Areas</b>		<b>Yes</b>	<b>No</b>
<b>Zone</b>	<b>Description</b>	<input type="checkbox"/>	<input type="checkbox"/>
In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
<b>A</b>	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"/>	
<b>AE</b>	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30.	<input type="checkbox"/>	
<b>A1-30</b>	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"/>	
<b>AH</b>	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"/>	
<b>AO</b>	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"/>	
<b>AR</b>	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"/>	
<b>A99</b>	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"/>	
<b>High Risk Coastal Area</b>		<b>Yes</b>	<b>No</b>
<b>Zone</b>	<b>Description</b>		
In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
<b>Zone V</b>	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"/>
<b>VE, V1 - 30</b>	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"/>	
<b>Undetermined Risk Area</b>		<b>Yes</b>	<b>No</b>
<b>Zone</b>	<b>Description</b>	<input type="checkbox"/>	<input type="checkbox"/>

	<b>D</b>	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

# Limited Review Application

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

**Schedule LRA 5**

## Space & Construction Cost Distribution

- New  
 Alteration

LOCATION			Code and Functional Category Description (4)	Functional Gross SF (5)	Construction Cost per SF (6)	Total Construction Cost (7)	(ALT) Scope of Work (8)
Bldg. No. (1)	Floor No. (2)	Sect. No. (3)					
1	1	-	[REDACTED]				
			<b>Total Construction</b>	[REDACTED]			

1. If new construction is involved, is it "freestanding"?    Yes             No
2. (Check where applicable) The facilities to be affected by this project are located in a:  
 Dense Urban Area             Other Metropolitan or Suburban Area             Rural Area
3. This submission consists of:     New Construction Report            Number of pages \_\_\_\_\_  
 Alteration Construction Report            Number of pages \_\_\_\_\_

**Do not use the master copy. Photocopy master and then complete copy if this schedule is required.**

# **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.

<b>Project Description</b>	
Schedule 6 submission date: 5/31/2023	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Choose an item. If so, what is the original CON number? No	
Intent/Purpose: [REDACTED]	
Site Location: 517 Delaware Avenue, Albany NY 12209	
Brief description of current facility, including facility type:	

# New York State Department of Health Certificate of Need Application

## Schedule 6

Vacant space in an existing retail building	
Brief description of proposed facility: [REDACTED]	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. Type B Business	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: Tenant demising walls, 1 hour rated	
If this is an existing facility, is it currently a licensed Article 28 facility?	[REDACTED]
Is the project space being converted from a non-Article 28 space to an Article 28 space?	[REDACTED]
Relationship of spaces conforming with Article 28 space and non-Article 28 space: N/A	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. N/A	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care, other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. Click here to enter text.	[REDACTED]
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. [REDACTED]	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. [REDACTED]	
Describe existing and or new work for fire detection, alarm, and communication systems: New fire detection, alarm and communication systems will be installed.	
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from <a href="http://www.fema.gov">www.fema.gov</a> , and describe the work to mitigate damage and maintain operations during a flood event. N/A	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. N/A	
Does the project comply with ADA? If no, list all areas of noncompliance. Yes	
Other pertinent information: N/A	
<b>Project Work Area</b>	<b>Response</b>
Type of Work	[REDACTED]
Square footages of existing areas, existing floor and or existing building.	
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	
Does the work area exceed more than 50% of the smoke compartment, floor or building?	
Sprinkler protection per NFPA 101 Life Safety Code	
Construction Type per NFPA 101 Life Safety Code and NFPA 220	
Building Height	

# New York State Department of Health Certificate of Need Application

## Schedule 6

Building Number of Stories	1 Story
Which edition of FGI is being used for this project?	2018 Edition of FGI
Is the proposed work area located in a basement or underground building?	Grade Level
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 20 New Ambulatory Health Care Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Click here to enter text.	No
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	No
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	Not Applicable
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	Not Applicable
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.	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

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

**Schedule 6**

<b>REQUIRED ATTACHMENT TABLE</b>			
<b>SCHEMATIC DESIGN SUBMISSION for CONTINGENT APPROVAL</b>	<b>DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for CONTINGENCY SATISFACTION</b>	<b>Title of Attachment</b>	<b>File Name in PDF format</b>
•		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, A101.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
	•	Wall Sections and Partition Types	A500.PDF
	•	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

# **R M** architects, llc

133 kenilworth road  
merion station, pa 19066

610 643 4964 t

Facility:  
FKC Albany Regional Dialysis Center  
517 Delaware Avenue  
Albany, NY 12209  
Albany County

May 30, 2023, REV July 12, 2023

## **ARCHITECTURAL NARRATIVE**

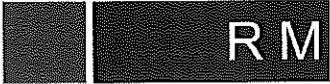
New rooftop HVAC units will be provided for the new clinic. An emergency generator for the dialysis clinic will be provided outside the building.

Adequate electric, gas, water and sewer services shall be provided to accommodate the new clinic.

The occupancy use is B Business. The existing building is of Type II (000) construction, with masonry exterior walls and steel structural system. The building is fully sprinklered.

All new work shall be completed in accordance with the Building codes of NYS 2020, NFPA 101-2012 Edition, New York Department of Health, Title 10, Section 715.2, FGI 2018 Edition and 2009 NYS accessibility code.

- End of Narrative -



**RM** architects, Ilc

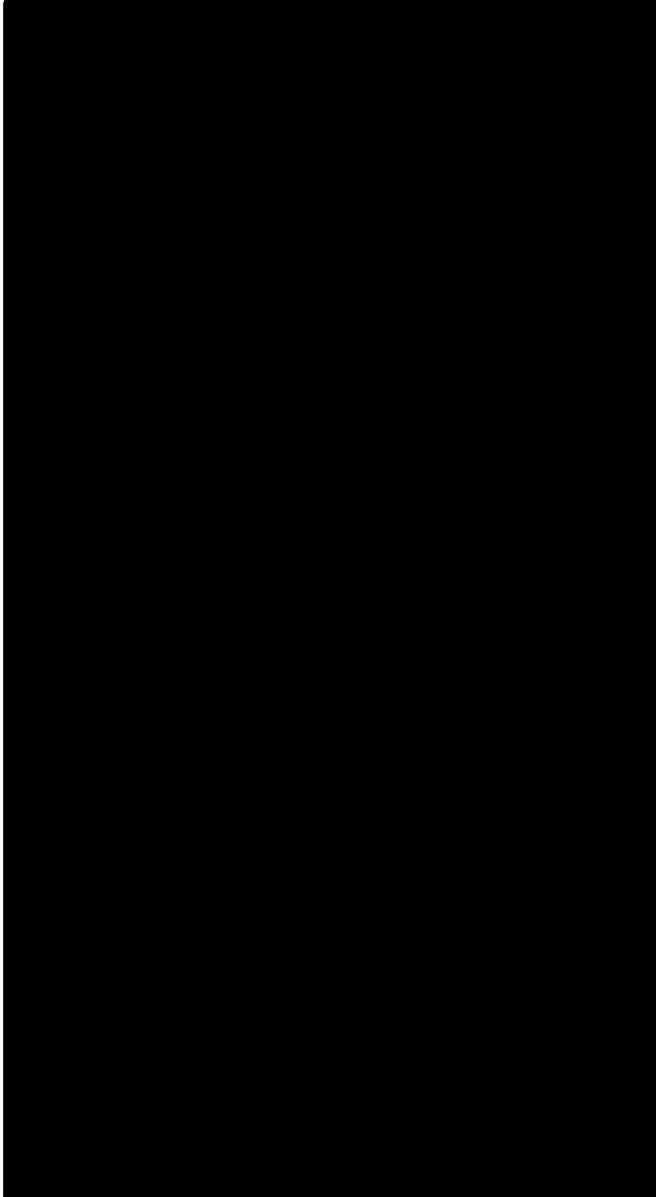
133 kenilworth road  
merion station, pa 19066

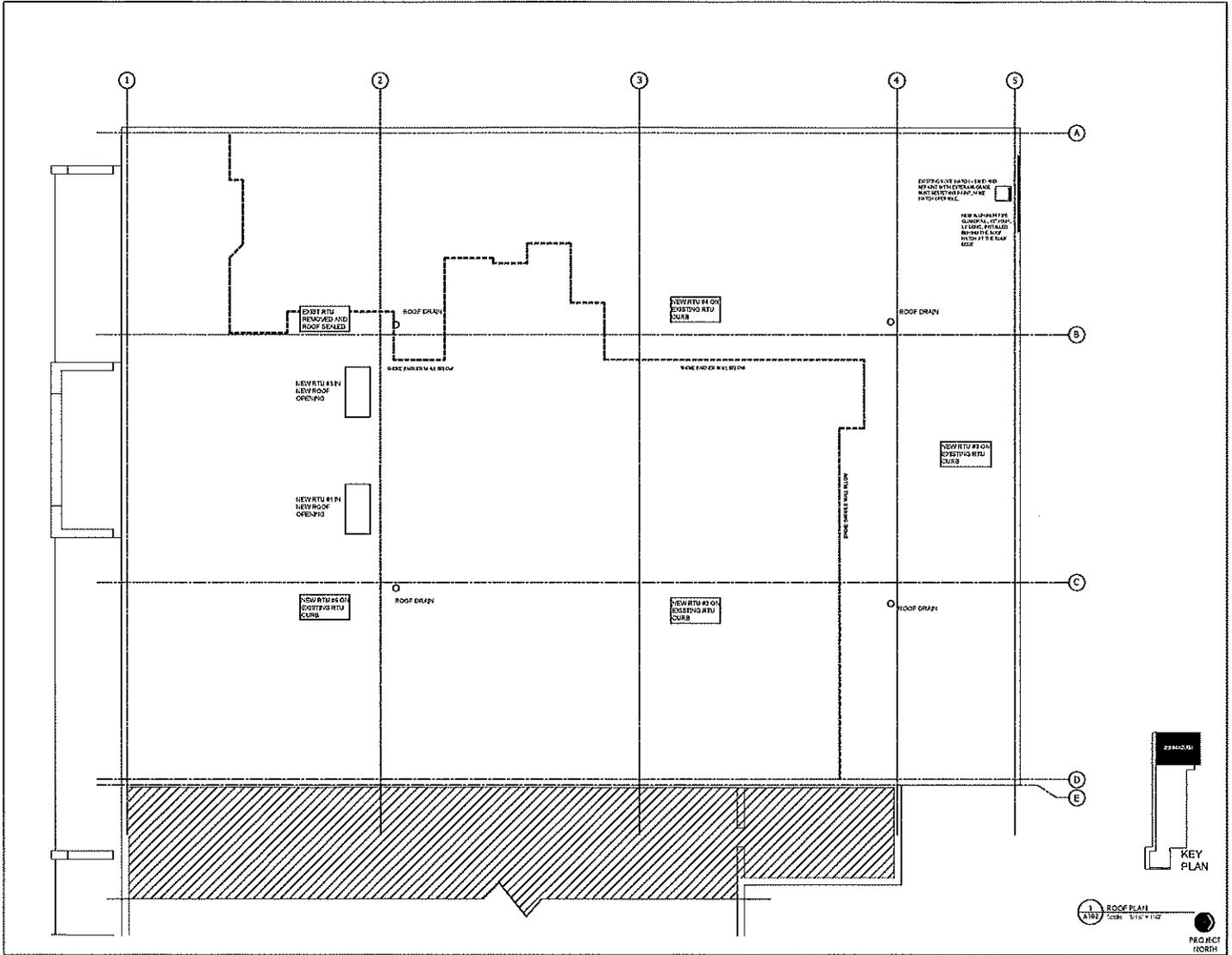
610 643 4964 t

FKC Albany Regional Dialysis Center  
517 Delaware Avenue  
Albany, NY 12209

May 30, 2023

**PROJECT FUNCTIONAL PROGRAM**





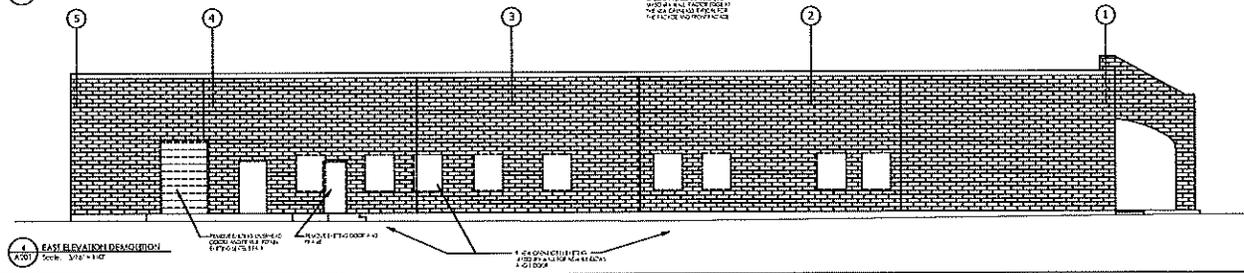
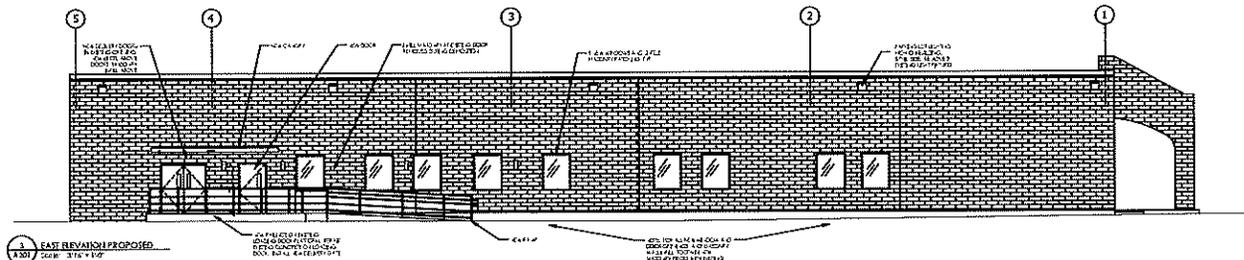
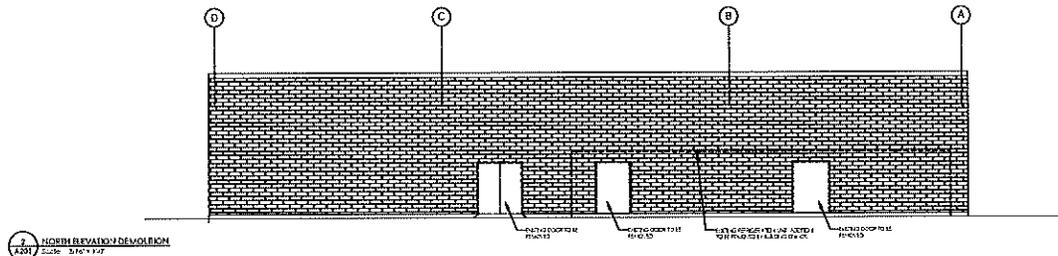
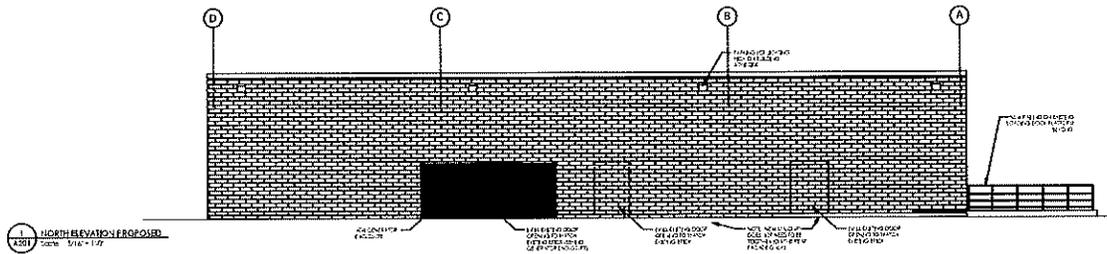
PROJECT: **PCF ALBANY REGIONAL DIALYSIS CENTER**  
 #02483-1-RL-N-RO-203  
 517 DELAWARE AVENUE  
 ALBANY NY 12209

**FREEMAN'S KIDNEY CARE**

DATE	DESCRIPTION	BY	CHKD BY

ROOF PLAN  
 SCALE: 1/16" = 1'-0"  
 PRO RCT NORTH

**A102**



ARCHITECT  
RJA ARCHITECTS, LLC  
137 Cambridge Road  
Albany, NY 12204  
518-486-4001

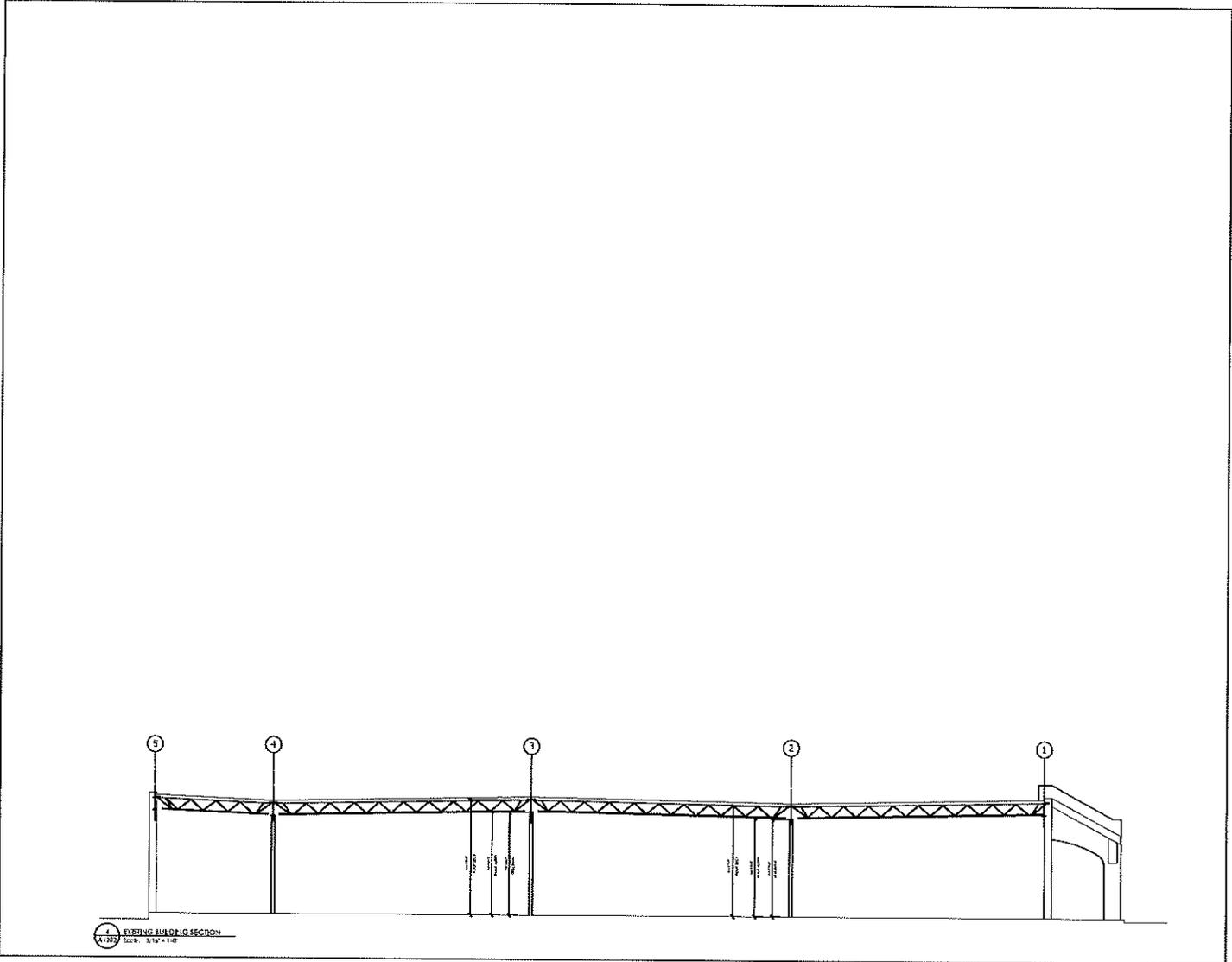
Proposed Dialysis Clinic for:  
FHC ALBANY REGIONAL DIALYSIS CENTER  
#002480-11-PLAN-RC-2023  
517 DEANWASE AVENUE  
ALBANY, NY 12209



Drawn by:	00000000
Checked by:	00000000
Date:	00/00/00
Project:	00000000
DATE	DESCRIPTION

ELEVATIONS

Sheet #  
A201



1 EXISTING BUILDING SECTION  
Scale: 3/16" = 1'-0"

ARCHITECT  
**RM ARCHITECTS, LLC**  
 100 Greenwich Street  
 10th Floor  
 ALBANY, NY 12202

Prepared For: **Prostate Cancer Clinic, Inc.**  
**FAC. ALBANY REGIONAL DIALYSIS CENTER**  
 #002483-11-R-L-N-90-2023  
 517 DELAWARE AVENUE  
 ALBANY, NY 12209



Drawn By:	WJW/0309
Checked By:	WJW/0309
Date Drawn:	05-15-24
Project No.:	00000000
DESCRIPTION	
DATE	BY
05/15/24	WJW

SECTIONS  
 A202

**CODE ANALYSIS**

**PROJECT NAME**

FRESENIUS KIDNEY CARE, NEW YORK REGION

**PROJECT DESCRIPTION**

THE PROJECT CONSISTS OF THE TIE OUT OF A 41 STATION HEALTHCARE REPAIR/ALTER ROOMS + HOME THERAPY FROM LOGICAL OUTPATIENT QUARTERS CLINIC. THE BUILDING IS FULLY SPRINKLERED.

**APPLICABLE CODES FOR ALBANY NY**

- 2018 INTERNATIONAL BUILDING CODE WITH AMENDMENTS, 2020 ALBANY CODE OF NEW YORK STATE
- 2020 INTERNATIONAL CODE OF NEW YORK STATE
- 2018 INTERNATIONAL ENERGY CONSERVATION CODE AMENDED, 2020 ENERGY CODE OF NEW YORK STATE
- IFC 2014 AMENDED, 2020 PLUMBING CODE OF NEW YORK STATE
- NFPA 72, 2018 EDITION, 2017 ELECTRICAL CODE OF NEW YORK STATE
- NFPA 72, 2018 EDITION, 2017 ELECTRICAL CODE OF NEW YORK STATE
- IFC 2014 AMENDED, 2020 FIRE CODE OF NEW YORK STATE
- NFPA 11, 2013 EDITION, 2014 FIRE SUPPRESSION CODE OF NEW YORK STATE
- NFPA 112, 2010 EDITION, 2014 FLAMMABLE LIQUID AND SOLID POLYMER CODE 2014
- ASCE, 2009 WINDLOADS AND EFFECTS, NEW YORK STATE ACCESSIBILITY CODE 2011
- NFPA 101, 2015 EDITION
- IBC 2014 AMENDED FOR DESIGN AND CONSTRUCTION OF HEALTHCARE FACILITIES, 2018 EDITION

**EXISTING BUILDING ISSUES**

- EXISTING BUILDING TYPE: 200 - 210 TOWNHOUSE, 14,500 S.F.
- EXISTING BUILDING HEIGHT: 2 STORIES

**EXISTING ENERGY CODE, INSULATION AND OCCUPANCY**

- BUSINESS AREAS (10,740 SQ FT) = 100 SF GROSS PER OCCUPANT = 107 OCCUPANTS
- ASSEMBLY AREAS (20,740 SQ FT) = 15 SF NET PER OCCUPANT = 80 OCCUPANTS
- STORAGE AREAS (11,110 SQ FT) = 300 SF NET PER OCCUPANT = 15 OCCUPANTS

TOTAL: 14,565 SF, 117 OCCUPANTS FOR PURPOSES OF EXISTING

**EXITS PROVIDED**

EXITS PROVIDED: 2

**PLUMBING FIXTURES**

FOR PURPOSES OF DETERMINING BUILDING FIXTURES, 11,500 TO 146 PERSONS  
ACTUAL OCCUPANCY AT ANY ONE TIME WILL BE MAXIMUM UP TO 42 TREATMENT PATIENTS, 4 HOME THERAPY PATIENTS, & 100 STAFF OR VISITING PHYSICIANS

**WATER FIXTURES**

160 GALLONS PER 25 OCCUPANTS FOR RESTROOM OCCUPANTS, 160 GALLONS PER 50 OCCUPANTS FOR PLUMBING OCCUPANTS ONLY

**WATER FIXTURES**

140 OCCUPANTS = 50 OCCUPANTS = 80 OCCUPANTS  
50 OCCUPANTS = 2 RESTROOM OCCUPANTS = 2 RESTROOMS + 4 W.C.

**WATER FIXTURES**

140 OCCUPANTS = 50 OCCUPANTS = 80 OCCUPANTS  
50 OCCUPANTS = 2 RESTROOMS + 4 W.C. + 1 LAV + 1 SINK

**WATER FIXTURES**

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50 OCCUPANTS = 2 RESTROOMS + 4 W.C. + 1 LAV + 1 SINK

**TYPE OF CONSTRUCTION**

II-B

**PERMITTED PARTY REQUIREMENTS FOR BUILDING ELEMENTS**

- STRUCTURAL FRAMEWORK: 24 HOURS
- LEVEL OF WORK: 12 HOURS
- ROOFING: 24 HOURS
- FLOOR CONSTRUCTION: 24 HOURS
- WALLS: 24 HOURS
- MECHANICAL: 24 HOURS
- ELECTRICAL: 24 HOURS
- PLUMBING: 24 HOURS
- PAINTING: 24 HOURS
- GLASS: 24 HOURS
- MECHANICAL: 24 HOURS
- ELECTRICAL: 24 HOURS
- PLUMBING: 24 HOURS
- PAINTING: 24 HOURS
- GLASS: 24 HOURS

**PERMITTED PARTY REQUIREMENTS FOR ELECTRICAL MECHANICAL**

- 24 HOUR: 24 HOURS

**OCCUPANCY SEPARATIONS PER IBC TABLE 504.4**

1 HOUR SEPARATION REQUIRED BETWEEN AMBULATORY AND OTHER OCCUPANCIES

IBC 2018 AND IBC 2015 OCCUPANCY CLASSIFICATION	CODE ANALYSIS - ALTERATIONS TO EXISTING BUILDING		PROPOSED SPACE CHANGES & ALTER.
	EXISTING BUILDING	EXISTING SPACE	
IBC 2018 BUILDING GROUP CLASSIFICATION	B	B	B
IBC 2018 OCCUPANCY CLASSIFICATION	BUSINESS	BUSINESS	BUSINESS AMBULATORY
SEPARATED REVENUE PER PERSON (R/S)	YES	YES	YES - 1 HR PER IBC FOR AMBULATORY
CONSTRUCTION TYPE PER IBC 2018	IB	IB	IB
NUMBER OF STORIES ABOVE GROUND	1	1ST FLOOR	1ST FLOOR
HEIGHT (FEET)	10	10	10
PROTECTIVE SYSTEM (R/S)	NO	NO	NO
FIRE ALARM SYSTEM (R/S)	YES	YES	YES
FULLY SPRINKLERED & AUTOMATIC (R/S)	YES	YES	YES
FLOOR AREA OF REVENUE PER PERSON SPACE (R/S)	1454 SF	1458 SF	1458 SF

**EXIT OCCUPANCY**

LEVEL EXIT OCCUPANCIES: 82 PERSONS PER PERSON  
STAIR EXIT OCCUPANCIES: 82 PERSONS PER PERSON

**EXIT ACCESS REQUIREMENTS**

MINIMUM WIDTH: 44 INCHES  
MINIMUM CLEARANCE: 66 INCHES  
MINIMUM CLEARANCE: 66 INCHES

**ALARM, SMOKE, & SILENT**

THE BUILDING IS FULLY SPRINKLERED

**REQUIREMENTS**

EXITS ARE TO BE PROVIDED FOR ALL AREAS WITH A FLOOR AREA OF 1000 SQ FT OR MORE WITH AT LEAST A 20' CLEARANCE TO BE PROVIDED

ARCHITECT  
R.C. ALBANY REGIONAL DIALYSIS CENTERS  
100 Delaware Road  
New Albany, NY 12054  
607.486.1111

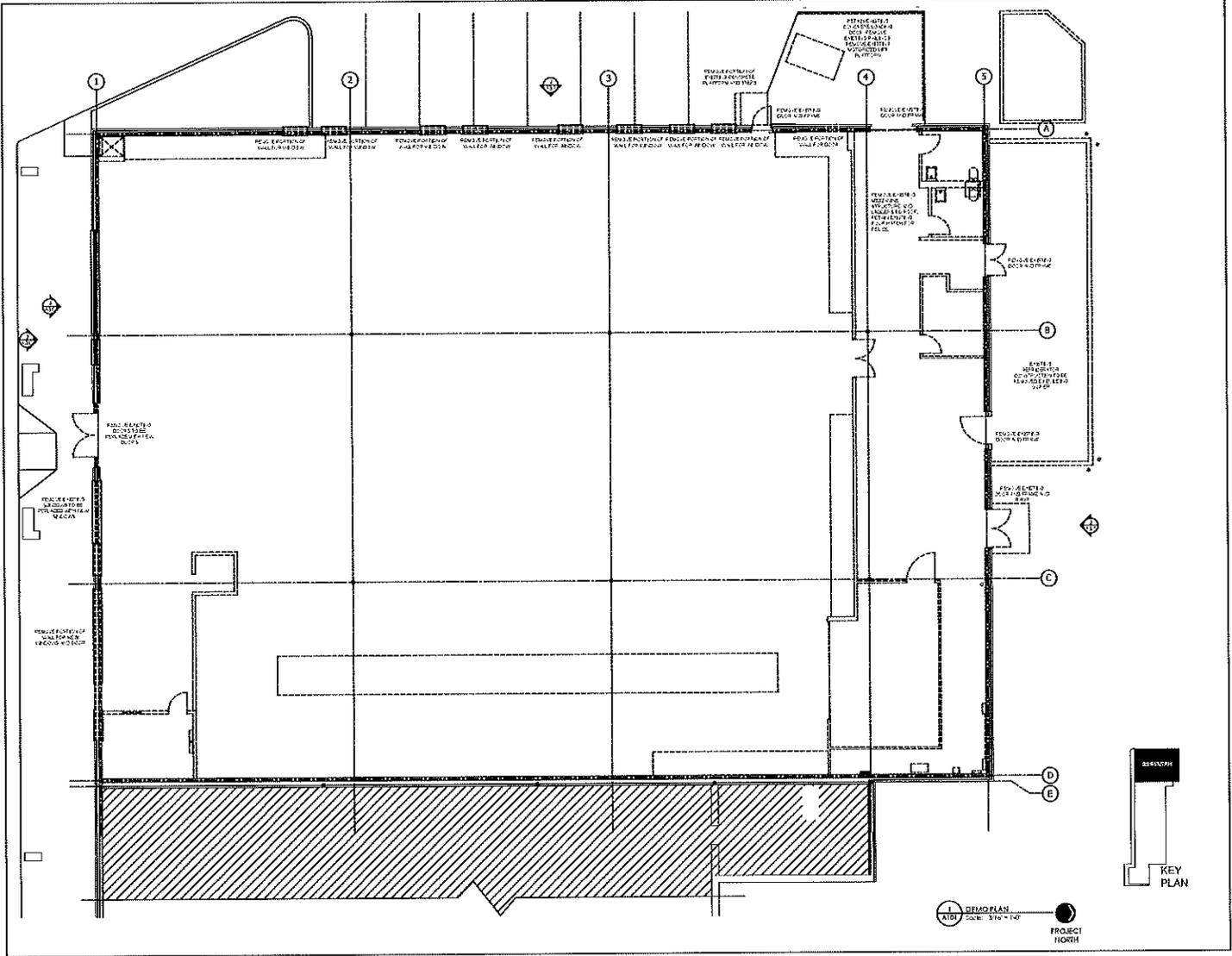
Prepared: 01/11/2023  
Checked by: 01/11/2023  
Date: 01/11/2023  
Project #: 20230001

PRESENIUS KIDNEY CARE

DATE	BY	DESCRIPTION
01/11/2023	01/11/2023	01/11/2023

ADDITIONAL CODE AND BUILDING INFORMATION

T 1.1



ARCHITECT  
**RM ARCHITECTS, LLC**  
 137 Delaware Road  
 Albany, NY 12207  
 518.486.8871

Proposed Dialysis Clinic for:  
**FKC ALBANY REGIONAL DIALYSIS CENTER**  
 #00248-11-PLAN-40-2023  
 517 DELAWARE AVENUE  
 ALBANY, NY 12207

**FRESHENUS**  
**KIDNEY CARE**

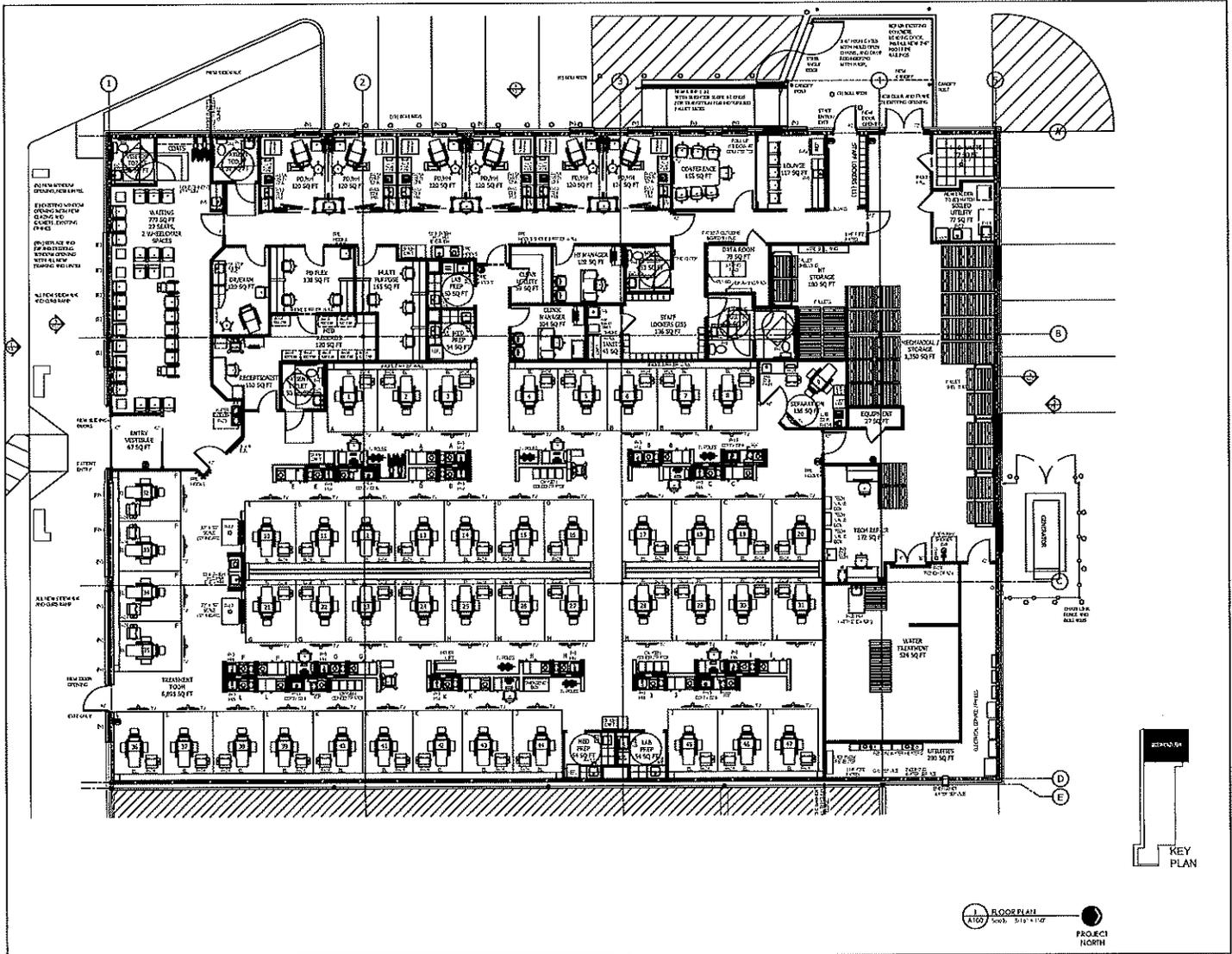
DATE	DESCRIPTION

Dwg No: 40030303  
 Sheet No: 40030303

PROJECT  
 KEY PLAN

DEMO PLAN  
 Scale: 1/8" = 1'-0"  
 PROJECT NORTH

**A101**



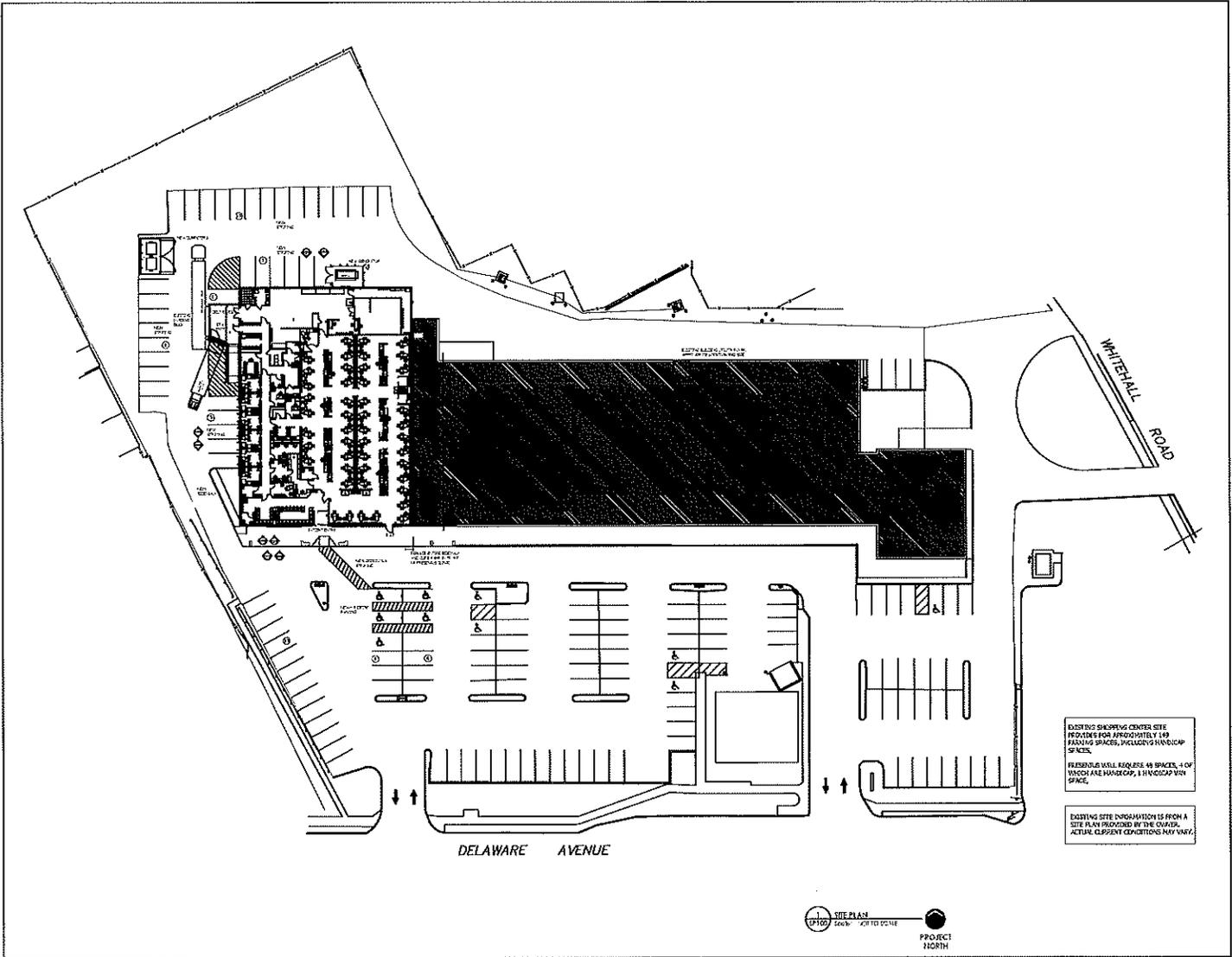
ARCHITECT  
**RB ARCHITECTS, LLC**  
 100 W. 10th Street  
 Albany, NY 12242-1000  
 518.486.4611

Proposed Dialysis Clinic for:  
**FRC ALBANY REGIONAL DIALYSIS CENTER**  
 #002683-11-ELN-840-2023  
 517 DELAWARE AVENUE  
 ALBANY, NY 12207

**FRESENIUS**  
**KIDNEY CARE**

DATE	DESCRIPTION	BY	CHKD
01/11/23	ISSUED FOR PERMIT	ALB	ALB
01/11/23	ISSUED FOR PERMIT	ALB	ALB
01/11/23	ISSUED FOR PERMIT	ALB	ALB
01/11/23	ISSUED FOR PERMIT	ALB	ALB

FLOOR PLAN  
 #11-044  
**A100**



PROJECT: FRC ALBANY REGIONAL DIALYSIS CENTER

ARCHITECTS: 2M ARCHITECTS LLC  
100 Delaware Road  
Albany, NY 12209  
518-486-8411

PROPOSED CLINIC FOR:

FRC ALBANY REGIONAL DIALYSIS CENTER  
#002683-11-81-N-8-C-2023  
517 DELAWARE AVENUE  
ALBANY, NY 12209

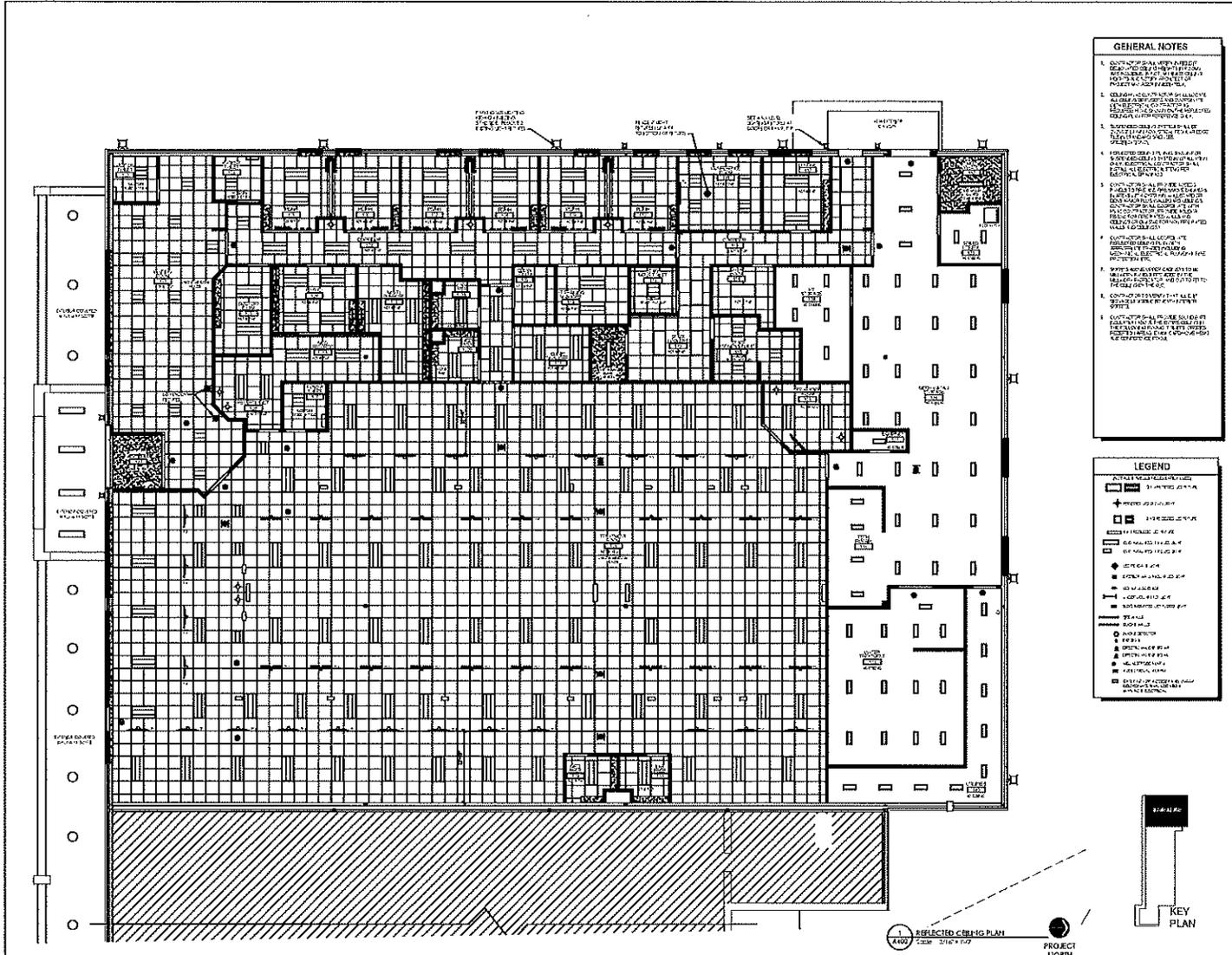
**FRESenius**  
KIDNEY CARE

DATE:	1/10/2024
BY:	J. M. [Name]
FOR:	FRC ALBANY REGIONAL DIALYSIS CENTER
NO.:	SP100

SITE PLAN

SP100





**GENERAL NOTES**

1. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
2. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
3. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
4. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
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6. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
7. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
8. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
9. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.
10. CONTRACTOR SHALL VERIFY ALL DIMENSIONS AND LOCATIONS OF ALL EXISTING AND PROPOSED WALLS, DOORS, WINDOWS, AND CEILING JOISTS.

**LEGEND**

- EXISTING WALL
- PROPOSED WALL
- EXISTING DOOR
- PROPOSED DOOR
- EXISTING WINDOW
- PROPOSED WINDOW
- EXISTING CEILING JOIST
- PROPOSED CEILING JOIST
- EXISTING FLOOR JOIST
- PROPOSED FLOOR JOIST
- EXISTING ROOF JOIST
- PROPOSED ROOF JOIST
- EXISTING STRUCTURAL COLUMN
- PROPOSED STRUCTURAL COLUMN
- EXISTING STRUCTURAL BEAM
- PROPOSED STRUCTURAL BEAM
- EXISTING STRUCTURAL WALL
- PROPOSED STRUCTURAL WALL
- EXISTING STRUCTURAL SLAB
- PROPOSED STRUCTURAL SLAB

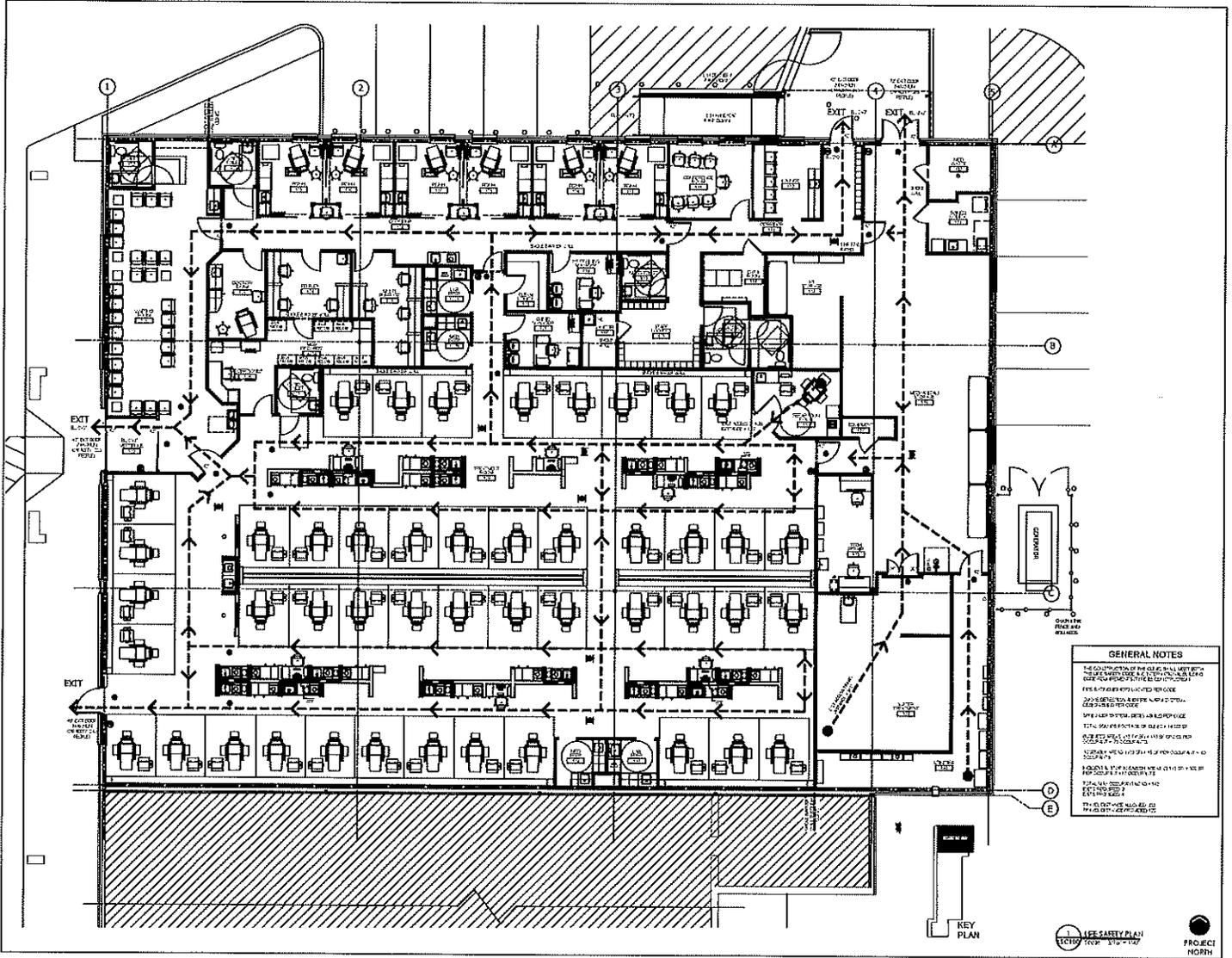
Architect: **REARDOFF, LLC**  
 133 South Street  
 Albany, NY 12209  
 518.435.4600

Proposed Dialysis Clinic for:  
**RKC ALBANY REGIONAL DIALYSIS CENTER**  
 #02483-11-RL-N-RC-2023  
 517 DELAWARE AVENUE  
 ALBANY NY 12209

**FREEMANUS KIDNEY CARE**

DATE	BY	DESCRIPTION

REFLECTED CEILING PLAN  
 A400



**GENERAL NOTES**

1. THE CONTRACTOR SHALL BE RESPONSIBLE FOR OBTAINING ALL NECESSARY PERMITS AND APPROVALS FROM THE LOCAL AND STATE AUTHORITIES.
2. THE CONTRACTOR SHALL BE RESPONSIBLE FOR OBTAINING ALL NECESSARY PERMITS AND APPROVALS FROM THE LOCAL AND STATE AUTHORITIES.
3. THE CONTRACTOR SHALL BE RESPONSIBLE FOR OBTAINING ALL NECESSARY PERMITS AND APPROVALS FROM THE LOCAL AND STATE AUTHORITIES.
4. THE CONTRACTOR SHALL BE RESPONSIBLE FOR OBTAINING ALL NECESSARY PERMITS AND APPROVALS FROM THE LOCAL AND STATE AUTHORITIES.
5. THE CONTRACTOR SHALL BE RESPONSIBLE FOR OBTAINING ALL NECESSARY PERMITS AND APPROVALS FROM THE LOCAL AND STATE AUTHORITIES.

ARCHITECT  
**DM ARCHITECTS, LLC**  
 133 University Road  
 Albany, NY 12242-5001  
 518.435.1111

Proposed Dialysis Clinic for:  
**ALBANY REGIONAL DIALYSIS CENTER**  
 #002483-11-RL-N-80-2023  
 517 DELAWARE AVENUE  
 ALBANY, NY 12208

**FRESHVUE KIDNEY CARE**

DATE	NOVEMBER 2023
BY	DM ARCHITECTS, LLC
PROJECT	ALBANY REGIONAL DIALYSIS CENTER
REVISION	NOVEMBER 2023
DATE	NOVEMBER 2023
BY	DM ARCHITECTS, LLC
PROJECT	ALBANY REGIONAL DIALYSIS CENTER
REVISION	NOVEMBER 2023

**LIFE SAFETY PLAN**

PROJECT NORTH

**LSC100**



**Department  
of Health**

**KATHY HOCHUL**  
Governor

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

**MEGAN E. BALDWIN**  
Acting Executive Deputy Commissioner

---

**SELF-CERTIFICATION FORM  
FOR  
ARCHITECTS AND ENGINEERS**

Date: May 30, 2023, REV August 16, 2023  
CON Number:  
Facility Name: FKC Albany Regional  
Facility ID Number:  
Facility Address: 517 Delaware Avenue, Albany NY 12209

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, 18<sup>th</sup> Floor  
Albany, New York 12237  
To The New York State Department of Health:

I hereby certify that:

1. I have been retained by the above-named facility, to provide services related to the design and preparation of construction documents and specifications for the aforementioned construction project, and, as applicable, to make periodic visits to the site during construction, and perform such other required services to familiarize myself with the general progress, quality and conformance of the work.
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 programmatic requirements for the aforementioned and in accordance with any project definitions, modifications and 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)
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 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 address the pre-opening survey findings of deficiencies by the NYSDOH Regional Office, 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.

6. I have reviewed and acknowledged the Supplemental Self-Certification Eligibility Checklist Page 4 of this document and evaluated and determined this project does meet the prerequisite requirements for Self-Certification. I understand and agree, if the project is deemed by NYSDOH not meeting the criteria allowable for self-certification, I will be required to be resubmit the project documents for an AER review.

This self-certification is being submitted to facilitate the Architectural CON process and is in lieu of a plan review. 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, prior to construction.

Project Name: FKC Albany Regional

Location: 517 Delaware Avenue, Albany NY 12209

Description: New dialysis clinic in an existing building

Signature of NYS Licensed Architect/Engineer

*[Handwritten Signature]*

Name of Architect/Engineer (Print)

David Knapp, AIA

Professional New York State License Number

045413-01

Business Street Address, City, State, Zip Code

RM Architects, LLC

133 Kenilworth Road

Merion Station PA 19066



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.

*[Handwritten Signature]*

Authorized Signature for Applicant

Date 11/17/2023

*[Handwritten Signature]*  
Name (Print) Title

Notary signing required for the applicant

STATE OF NEW YORK )

County of Onondaga ) SS:

On the 17th day of November, 2023 before me personally appeared Susan Jessen, to me known, who being by me duly sworn, did depose and say that he/she is the Regional VP of the Fresenius, 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.

Heather Slavik  
Notary Public, State of New York  
Qualified in Onondaga County #01SL6332100  
My Commission Expires October 28, 2024

(Notary) *[Handwritten Signature]*

**Project Eligibility Checklist for Architectural/Engineering Self-Certification**

		YES	NO
Does the project include any of the following?		If Yes, project is not eligible for Self-Certification and is required to be submitted for an AER review.	
1.	Is a waiver or exceptions required?		
2.	Will the project costs exceed \$15,000,000.00 (fifteen million dollars.)?		
3.	Is Bulk Oxygen /Medical Gas Storage associated with this project? Examples of Bulk Oxygen /Medical Gas Storage projects include but not limited to the following:		
	a. Hyperbaric Chambers		
	b. Bulk Systems include Nitrous Oxide System and Oxygen System: Definitions as defined below:		
	Bulk Nitrous Oxide System. An assembly of equipment as described in the definition of bulk oxygen system that has a storage capacity of more than 3200 lb (1452 kg) [approximately 28,000 ft <sup>3</sup> (793 m <sup>3</sup> ) (NTP)] of nitrous oxide. (PIP)ground		
	Bulk Oxygen System* An assembly of equipment such as oxygen storage containers, pressure regulators, pressure relief devices, vaporizers, manifolds, and interconnecting piping that has a storage capacity of more than 20,000 ft <sup>3</sup> (566 m <sup>3</sup> ) of oxygen (NTP) including unconnected reserves on hand at the site. The bulk oxygen system terminates at the point where oxygen at service pressure first enters the supply line. (PIP)		
4.	Will this project have Locked or Secured Units? Examples of Locked or Secured Units include but not limited to the following;		
	a. Observation Units for behavioral health in ED's.		
	b. Behavioral health located within inpatient settings.		
	c. Nursing Homes or other facilities with Dementia Units that are locked.		
	d. Corrections and Detention Facilities located in Hospitals, Ambulatory Health Care Occupancies and Business Occupancies where healthcare is provided.		
5.	Will this project involve construction of new procedure rooms, new operating rooms, renovations and or alterations to existing procedure rooms and or operating rooms, including modifications made to existing support systems, including, but not limited to heating, cooling, plumbing, electrical systems, medical gas systems, fire detection and fire protection systems, located in hospitals and existing ambulatory surgery centers? Examples, include but not limited to the following.		
	a. Endoscopy Procedure Rooms		
	b. Procedure Rooms		
	c. Operating Rooms		
	d. Interventional Imaging		
	i. Located in procedure rooms		
	ii. Located in operating rooms		
6.	Is this a project requiring construction that is required to comply with New Ambulatory Health Care Occupancies as indicated in Chapter 20 of NFPA 101, 2012 edition requirements? Examples, include but not limited to the following:		
	a. New Ambulatory Surgery Center		
	b. Endoscopy Centers and or Other Procedure Rooms		
	c. Free Standing Emergency Departments providing Definitive Care.		
7.	Is this project intended to provide Ventilator units for patients located in nursing homes?		
8.	Does this project involve Airborne infection isolation (AII) room?		
9.	Does this project involve Protective environment (PE) room?		

# 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)
<b>Revenues</b>			
Service Revenue			
Grants Funds			
Foundation			
Other			
Fees			
Other Income			
<b>(1) Total Revenues</b>			
<b>Expenses</b>			
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			
<b>(2) Total Expense</b>			
<b>Net Total - (1-2)</b> →			

# 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- charges	Net Revenue*		Patient Days or dis- charges	Net Revenue*		Patient Days or dis- charges	Net Revenue*	
			%	Dollars (\$)		% based on days or discharges	Dollars-\$		% based on days or discharges	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			100%			100%			100%	

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.	Support for Revenue	LRA 7.1
2. In an attachment, provide the basis for charity care.		

\*Net of Deductions from Revenue



# 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
<b>Health Providers**:</b>			
Technician & Specialist			
RN			
Aides			
Social Workers and Psychologists			
Home Training			
Dietitians			
<b>Support Staff***:</b>			
Management & Supervision			
Clerical & Other Administrative			
Inservice Coordination			
<b>Total Number of Employees</b>			



\* 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:**

Current operations.

**PLEASE COMPLETE THE FOLLOWING:**

1. Are staff paid and on Payroll?  Yes  No
2. Provide copies of contracts for any independent contractor.
3. Please attach the Medical Doctors C.V.

4. Is this facility affiliated with any other facilities?  
(If yes, please describe affiliation and/or agreement.)

Yes  No

*(Rev. 7/7/2010)*

# Limited Review Application

Schedule LRA 10

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

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.

Category/Authorized Service	Code	Current	Add	Remove	Proposed
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

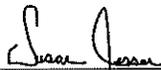
## Assurances

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.

7/20/2023

Date



Signature

Susan Jessen

Name (Please Type)

Regional Vice President

Title (Please Type)

Rahim Dhanani, MBBS.

Cell: +1 518 698 5425.  
Email: [rahim.dhanani@me.com](mailto:rahim.dhanani@me.com)  
1 Westview Court, Clifton Park, NY 12065

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## Clinical Appointments

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### **Nephrology Consultant**

Institution:

Duration of Employment:

Institution:

Duration of Employment:

Primary hospitals:

Secondary hospitals:

Clinical responsibilities:

Provide inpatient and outpatient consultative and procedural services as a Nephrology sub-specialist.

Inpatient consultative services encompass acute and critically ill patients and all patients admitted with end stage renal disease. Procedural services include providing dialytic therapies e.g. continuous renal replacement therapy, peritoneal dialysis, and hemodialysis.

Outpatient consultative services encompass managing acute and chronic renal diseases, dialysis patients and renal transplant patients. Living donor evaluation for Albany Medical Center renal transplant program.

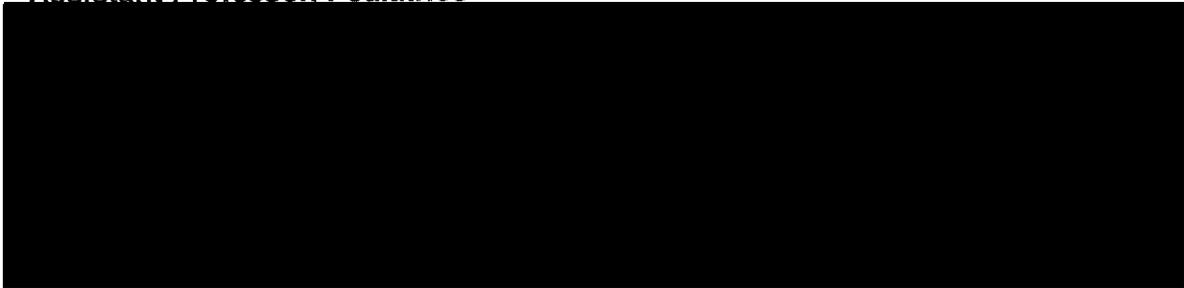
Manage panel of dialysis patients in multiple outpatient dialysis units. Includes home peritoneal dialysis, home hemodialysis, and in-center hemodialysis panel of patients. Establishing a rapid start peritoneal dialysis program at Samaritan Hospital.

### **Medicine Hospitalist**

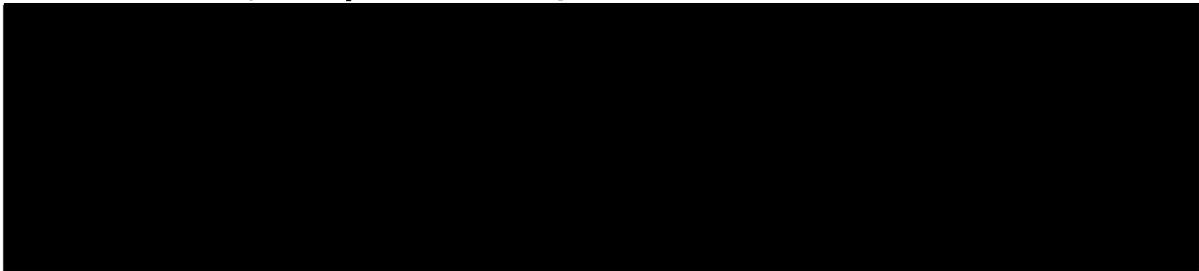
### **Surgical Hospitalist**



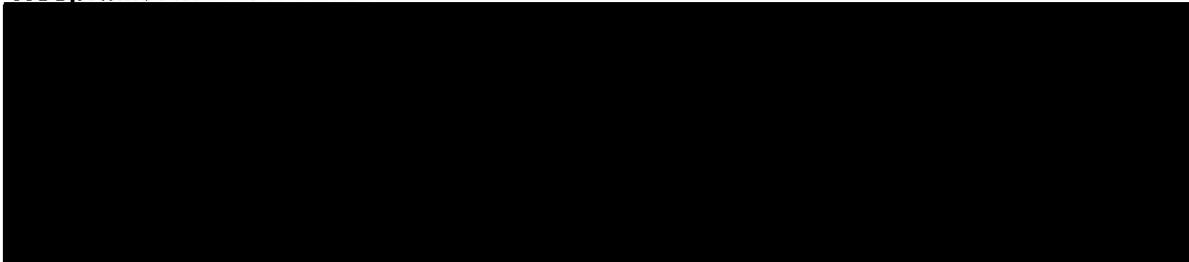
**Assistant Professor, Pediatrics**



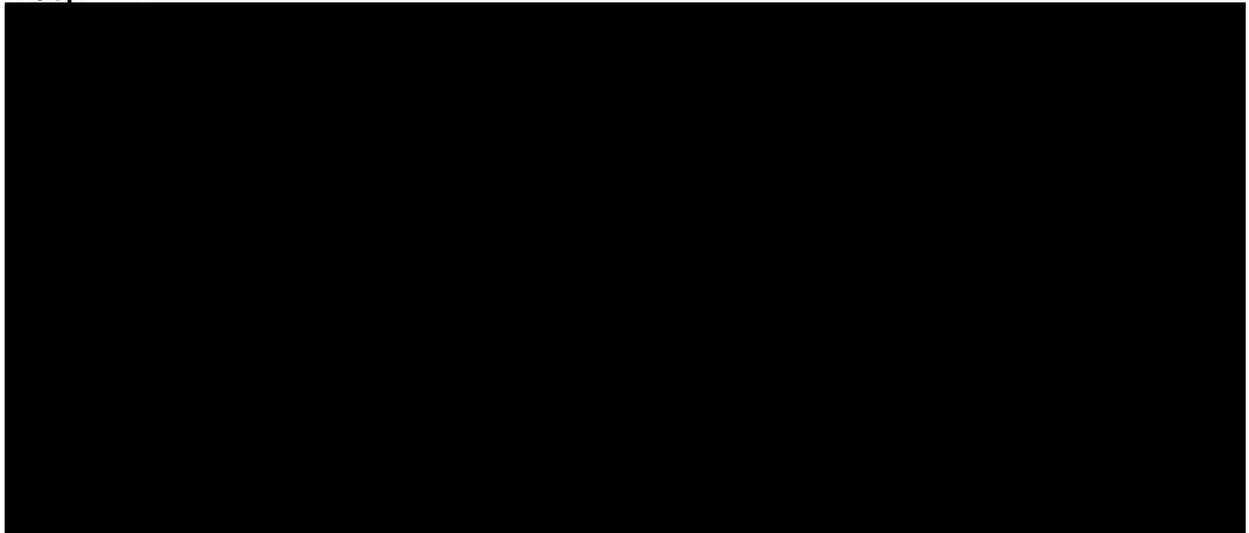
**Medical Director, Family Medical Group**

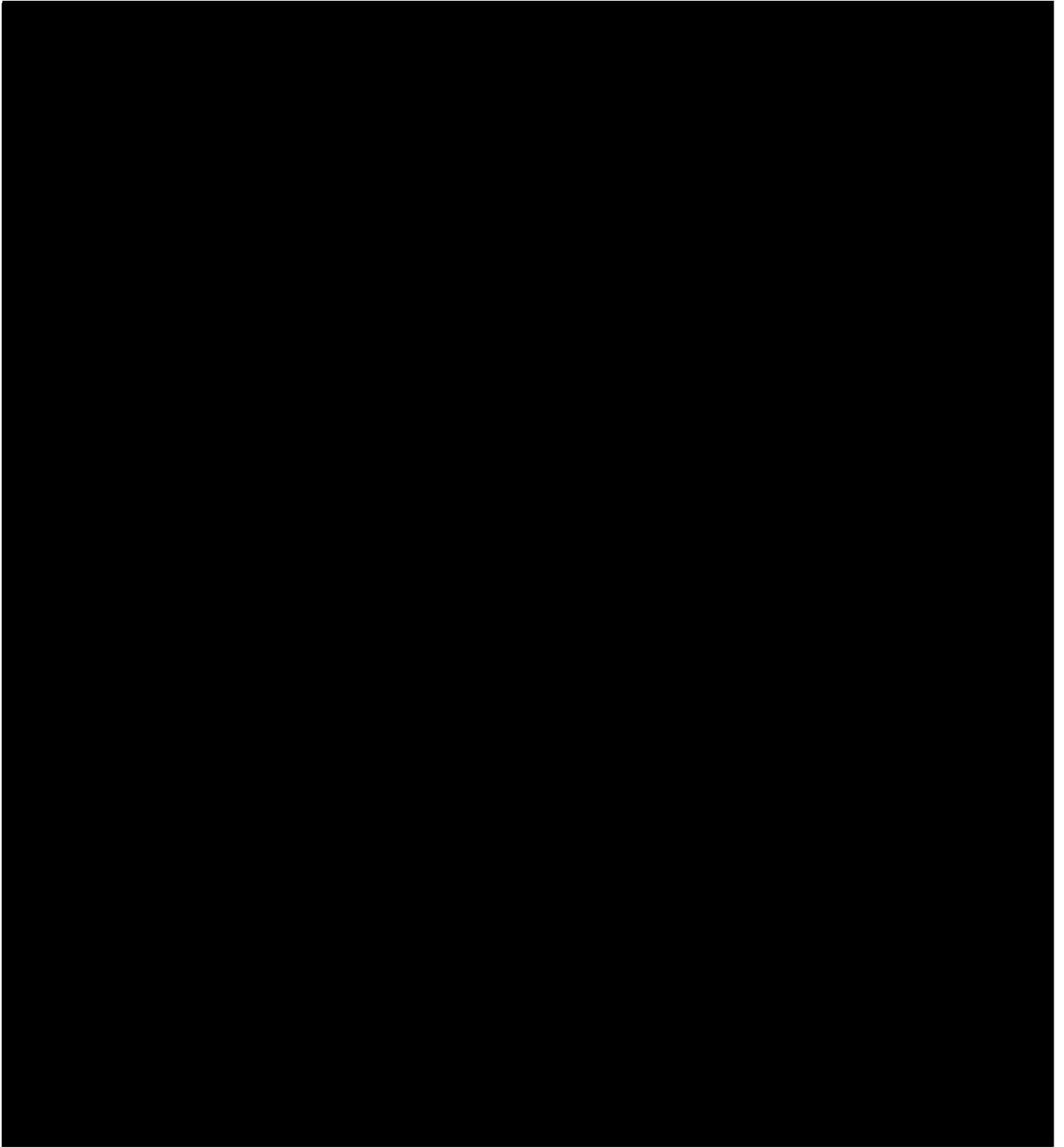


**Hospitalist in Internal Medicine**



**Hospitalist in Internal Medicine and Pediatrics**

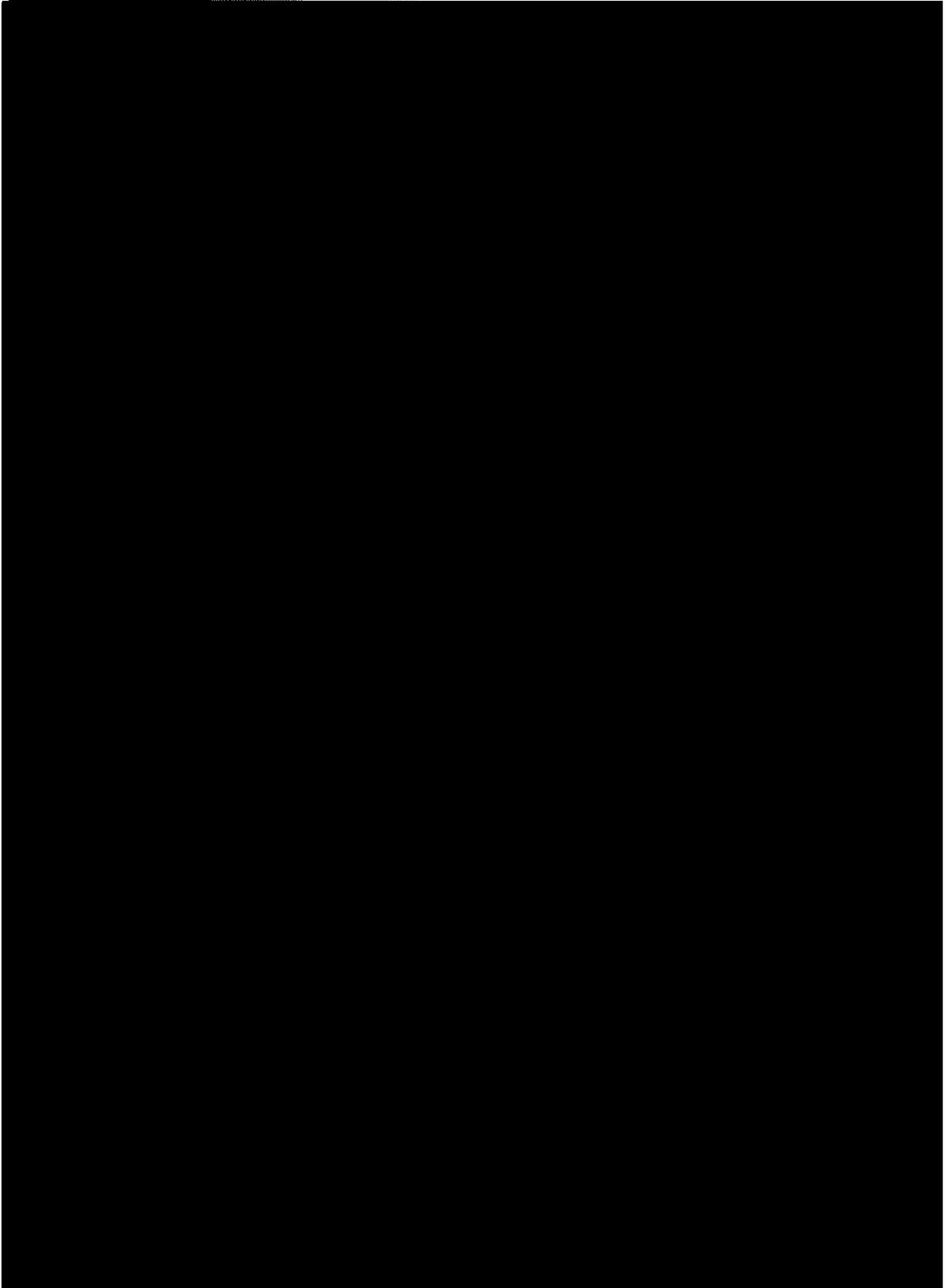


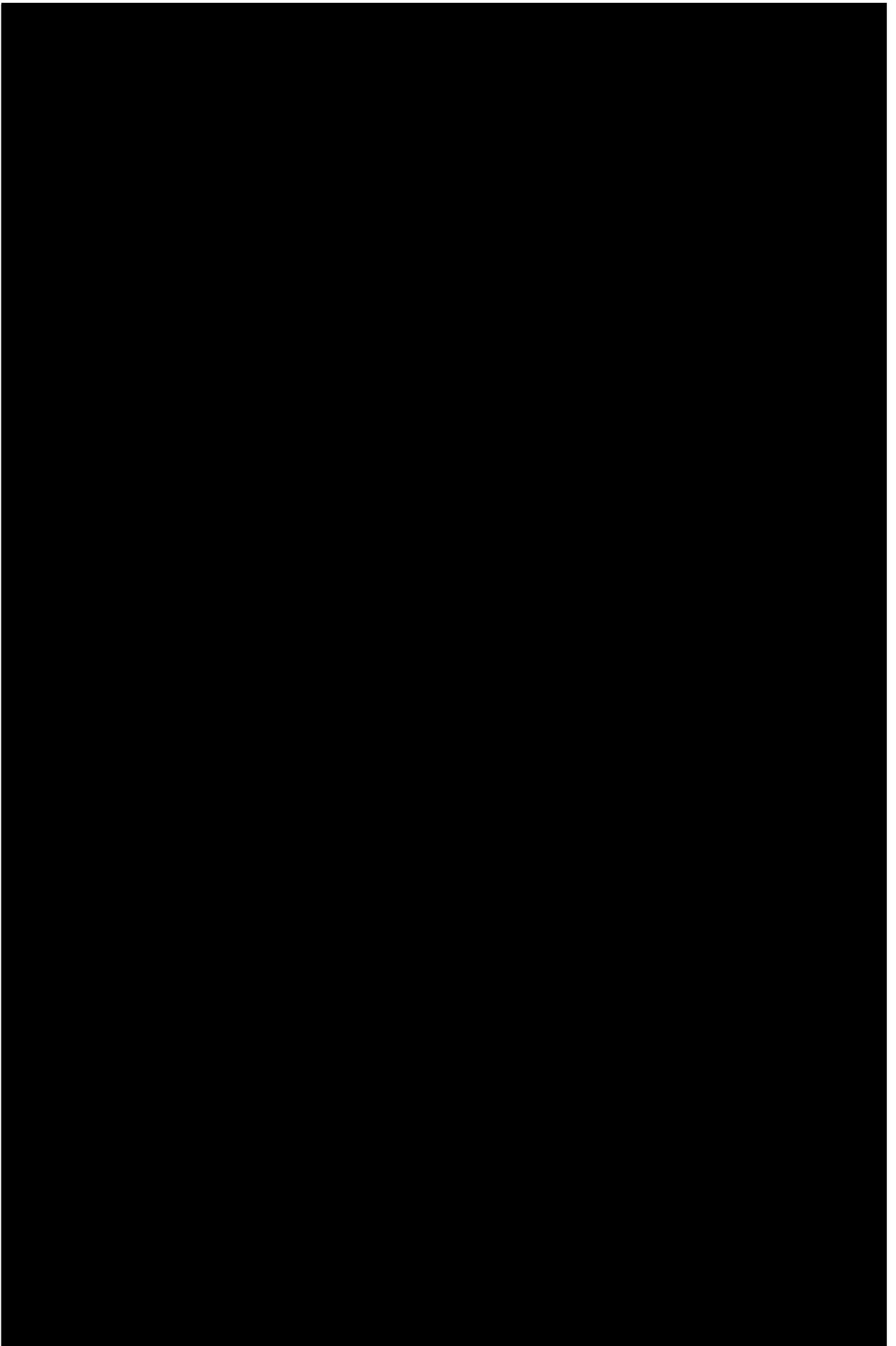


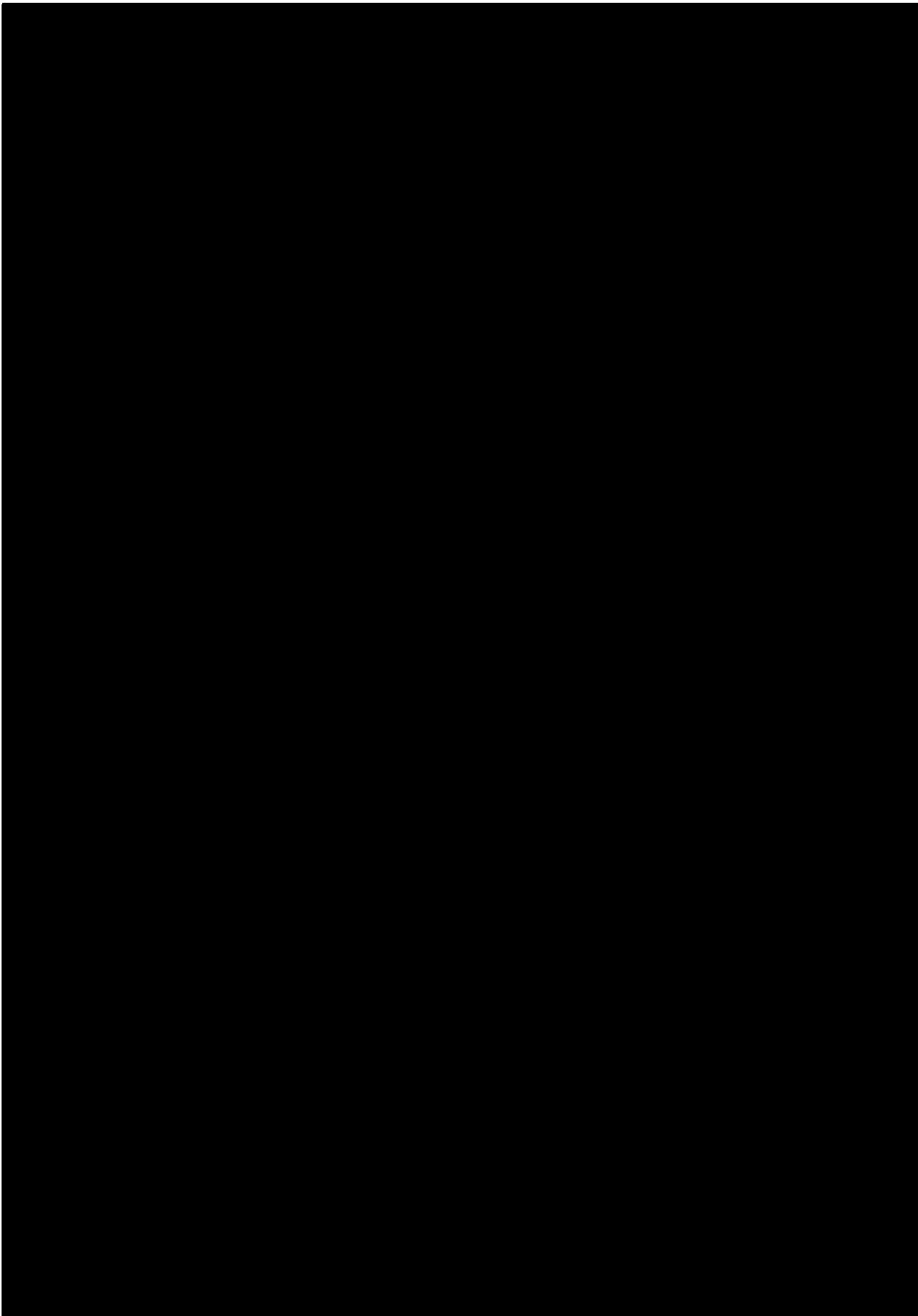
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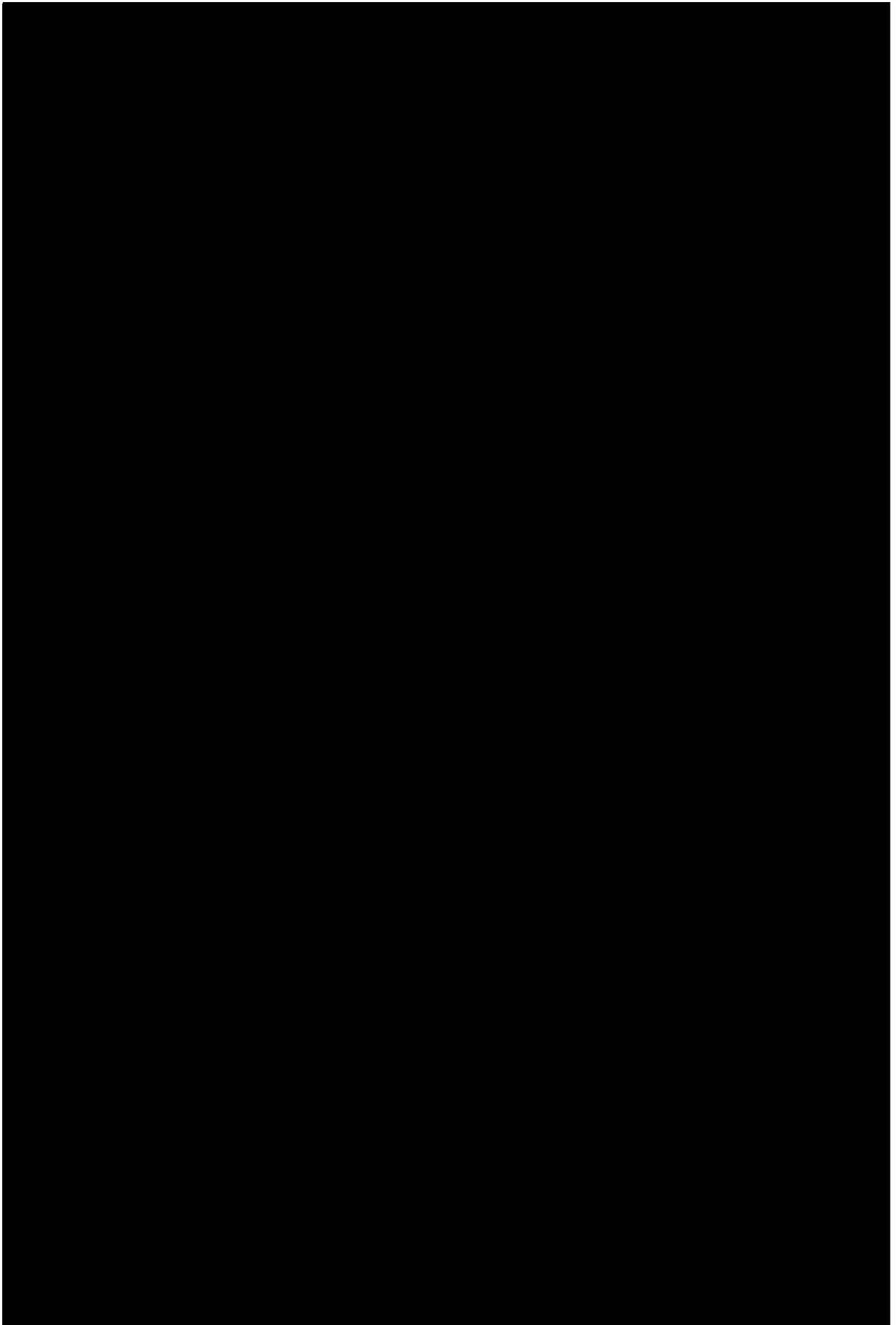
## Administrative Appointments

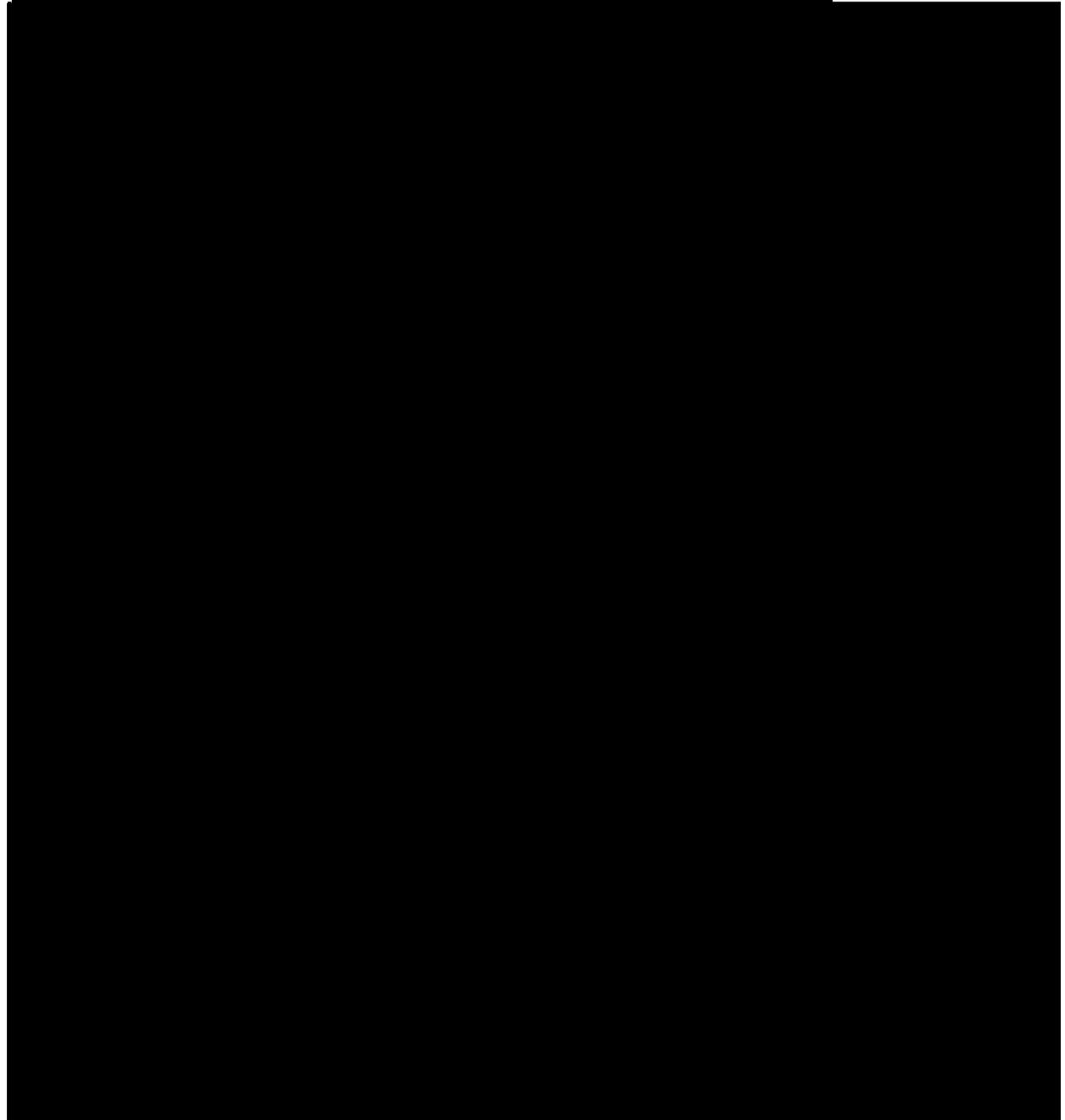
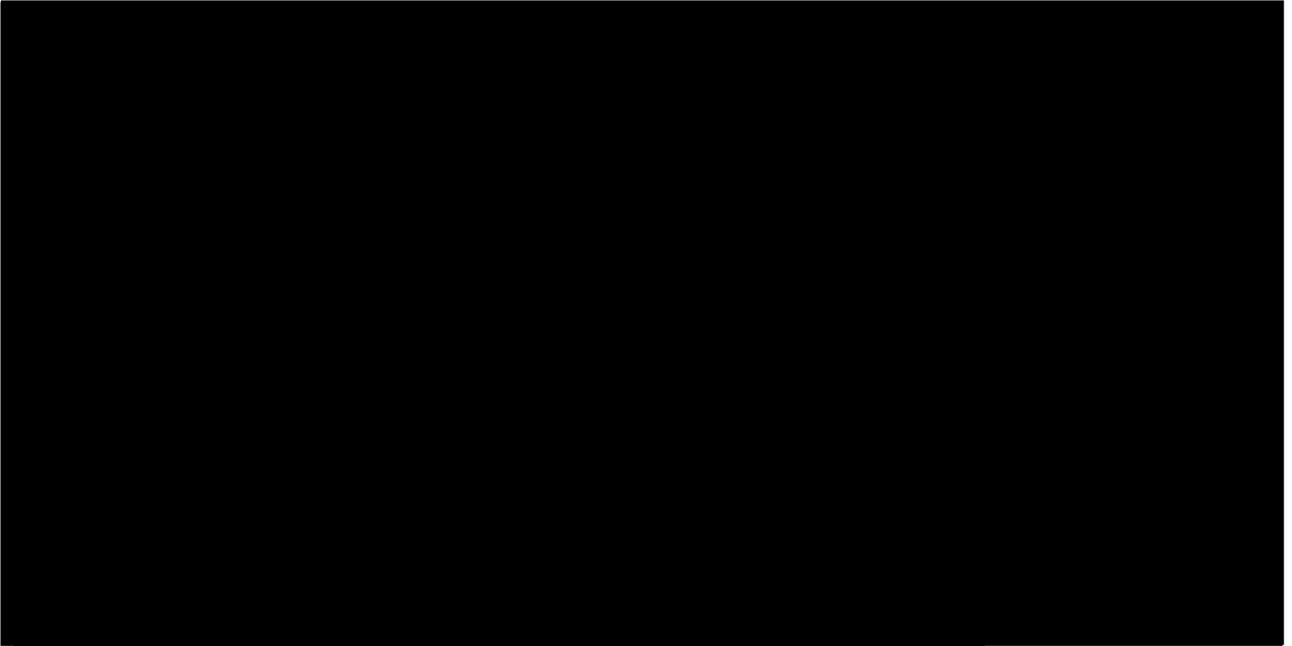
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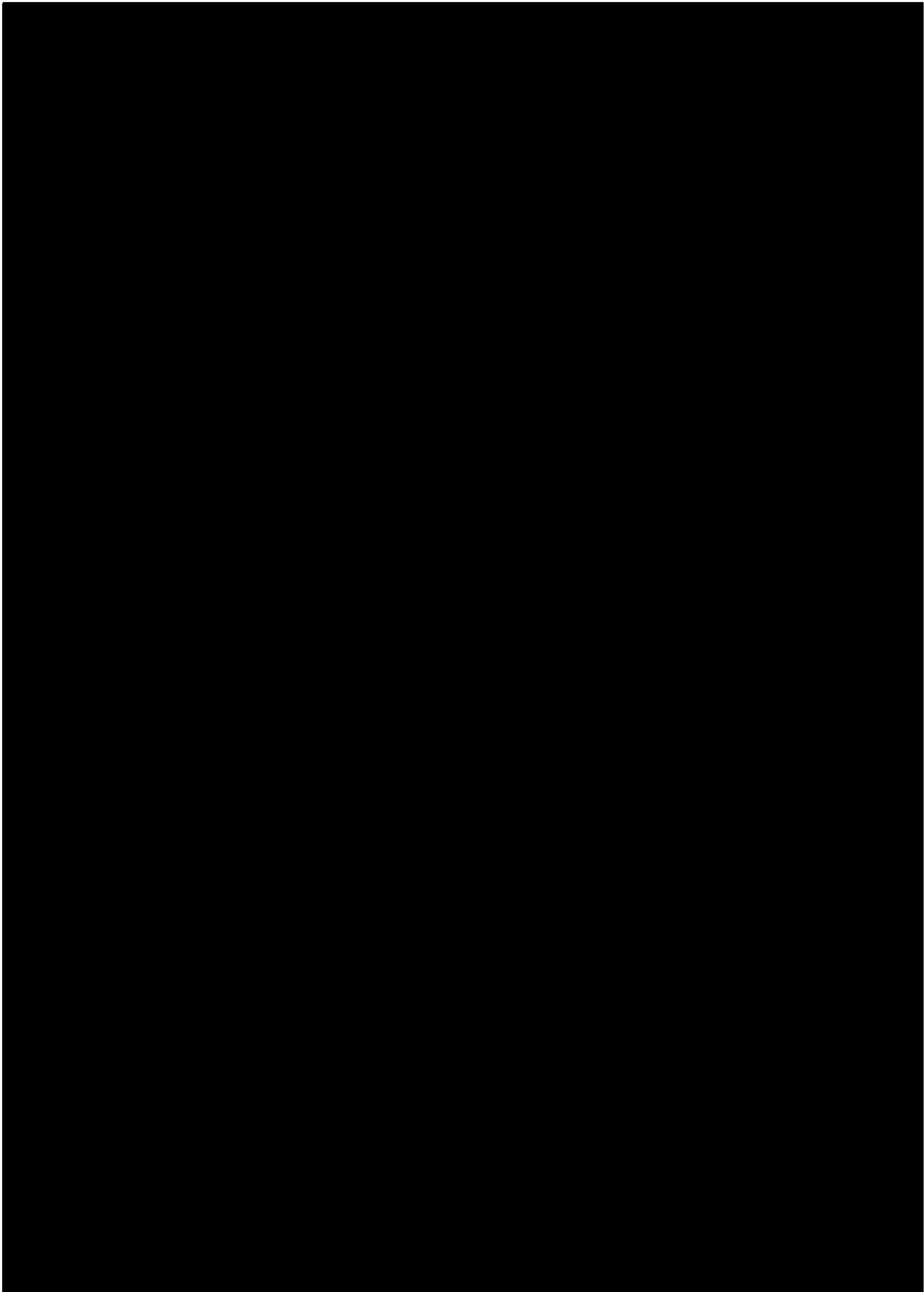


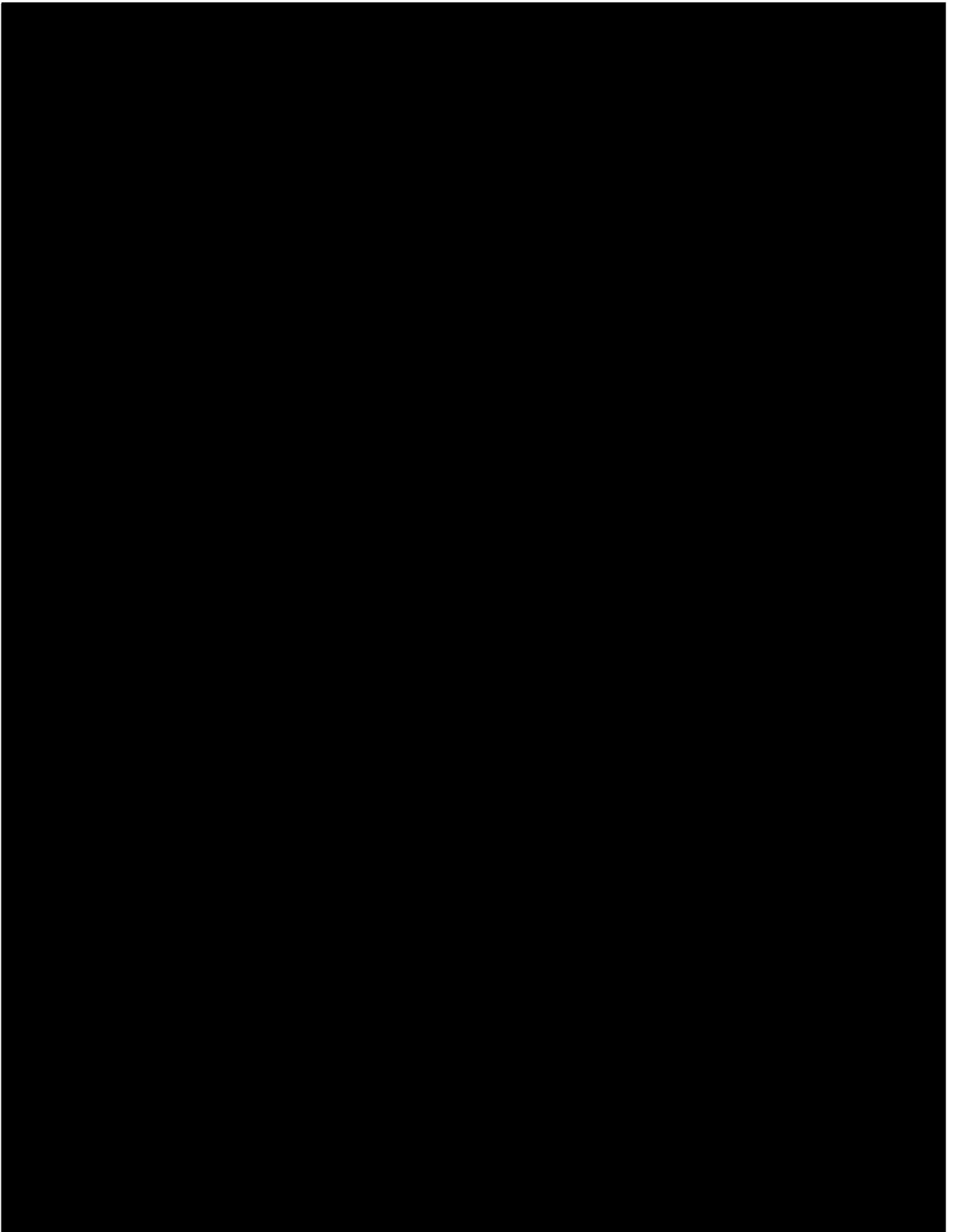


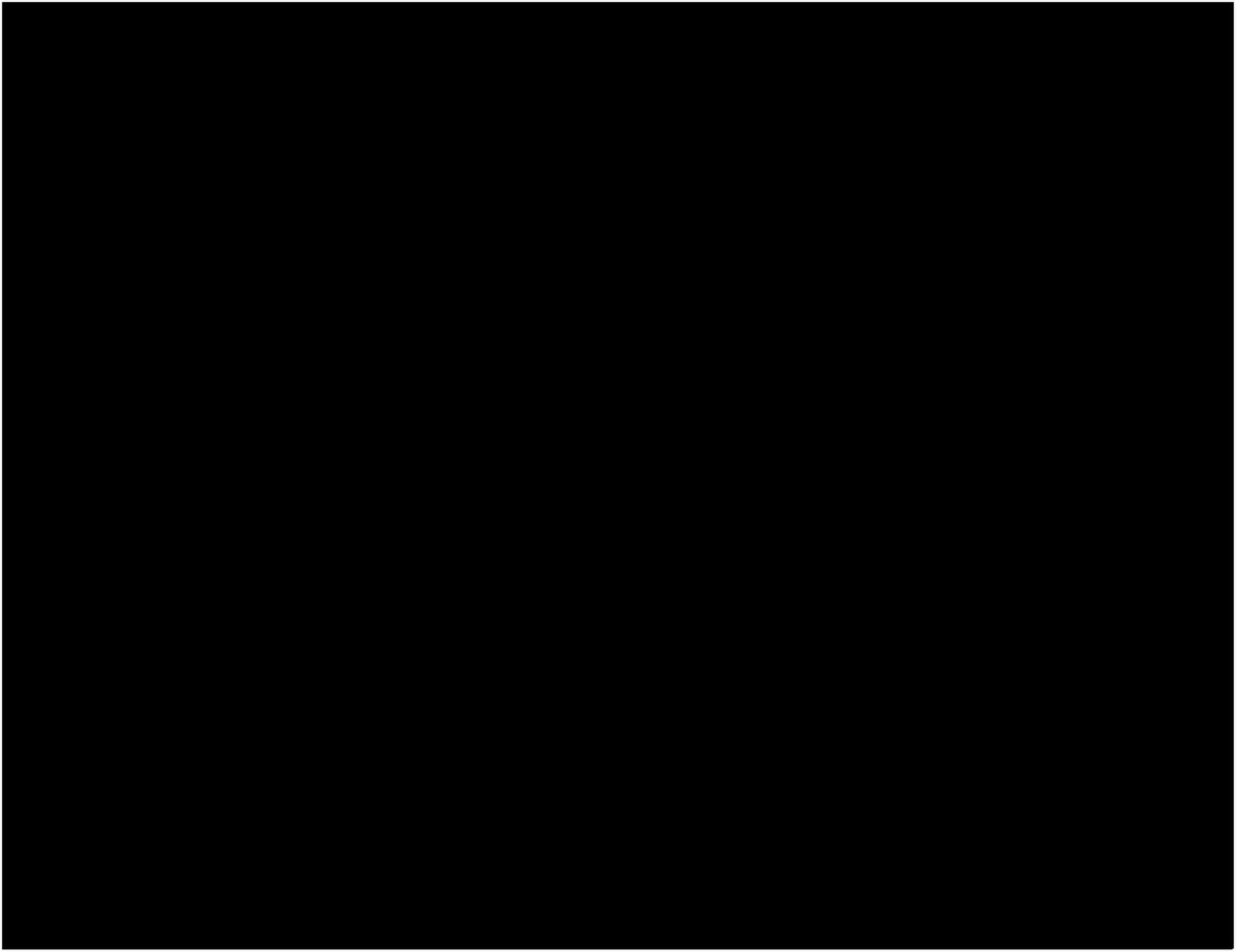




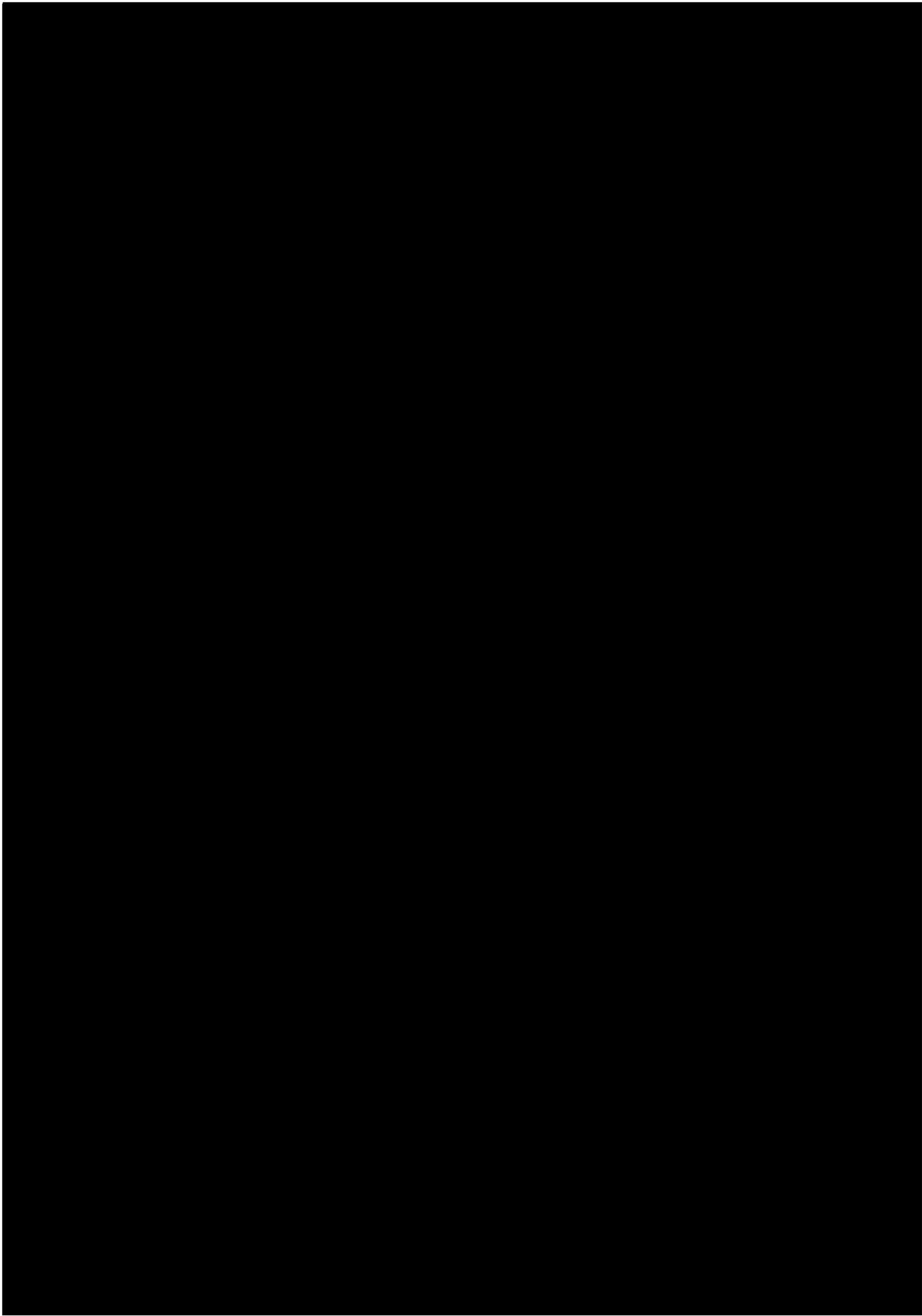


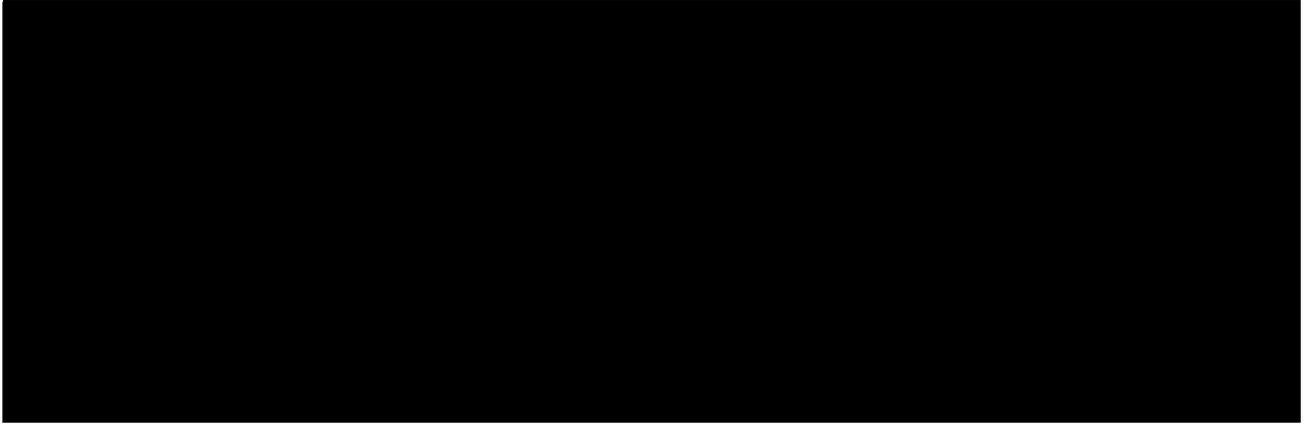


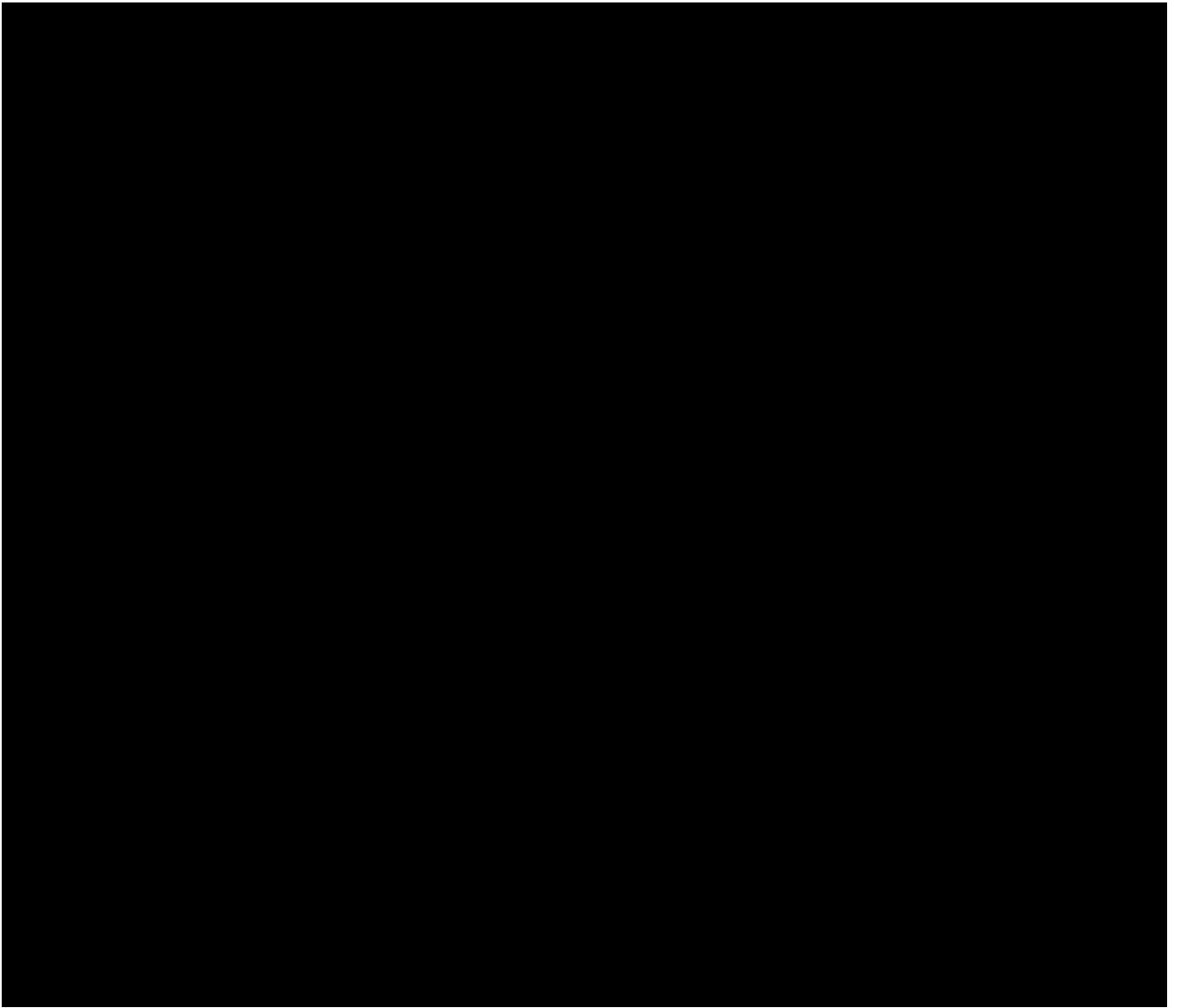
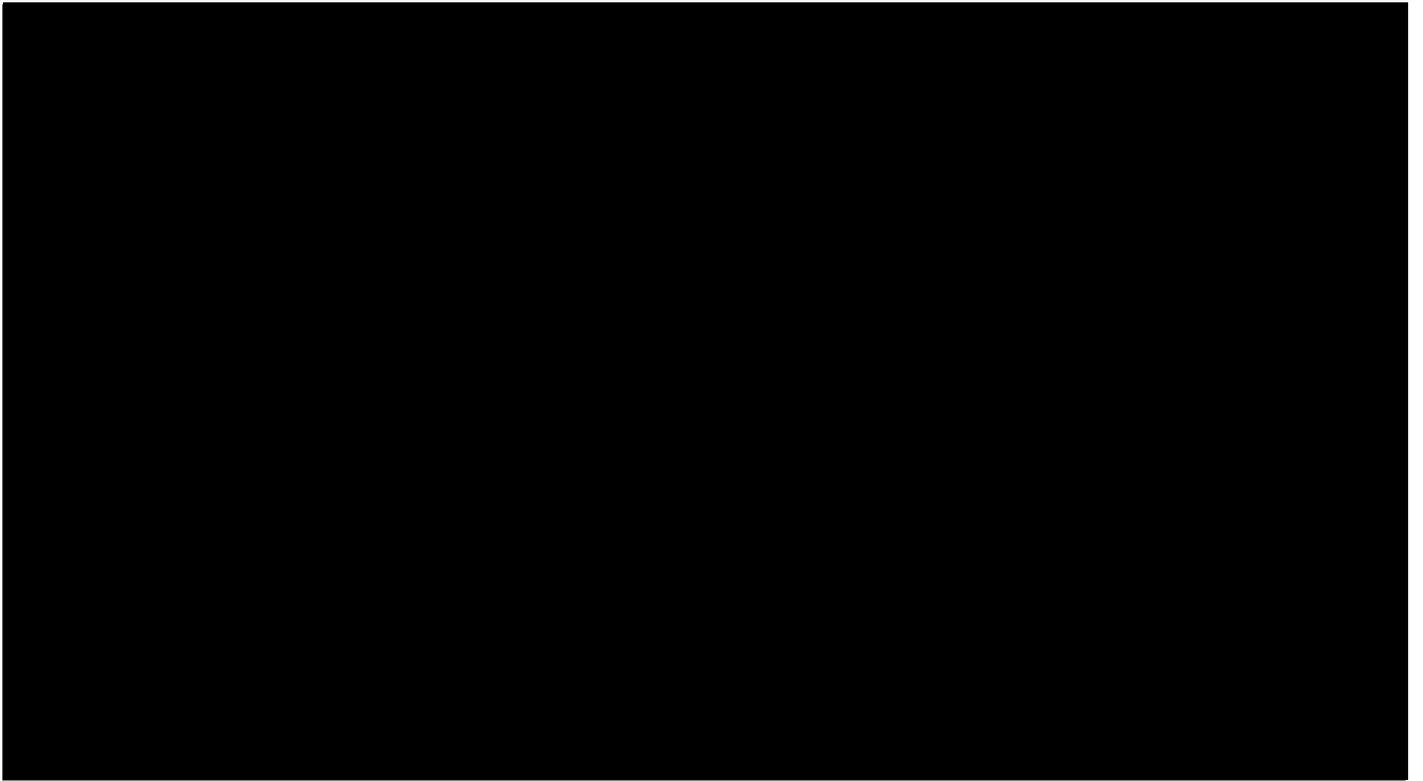


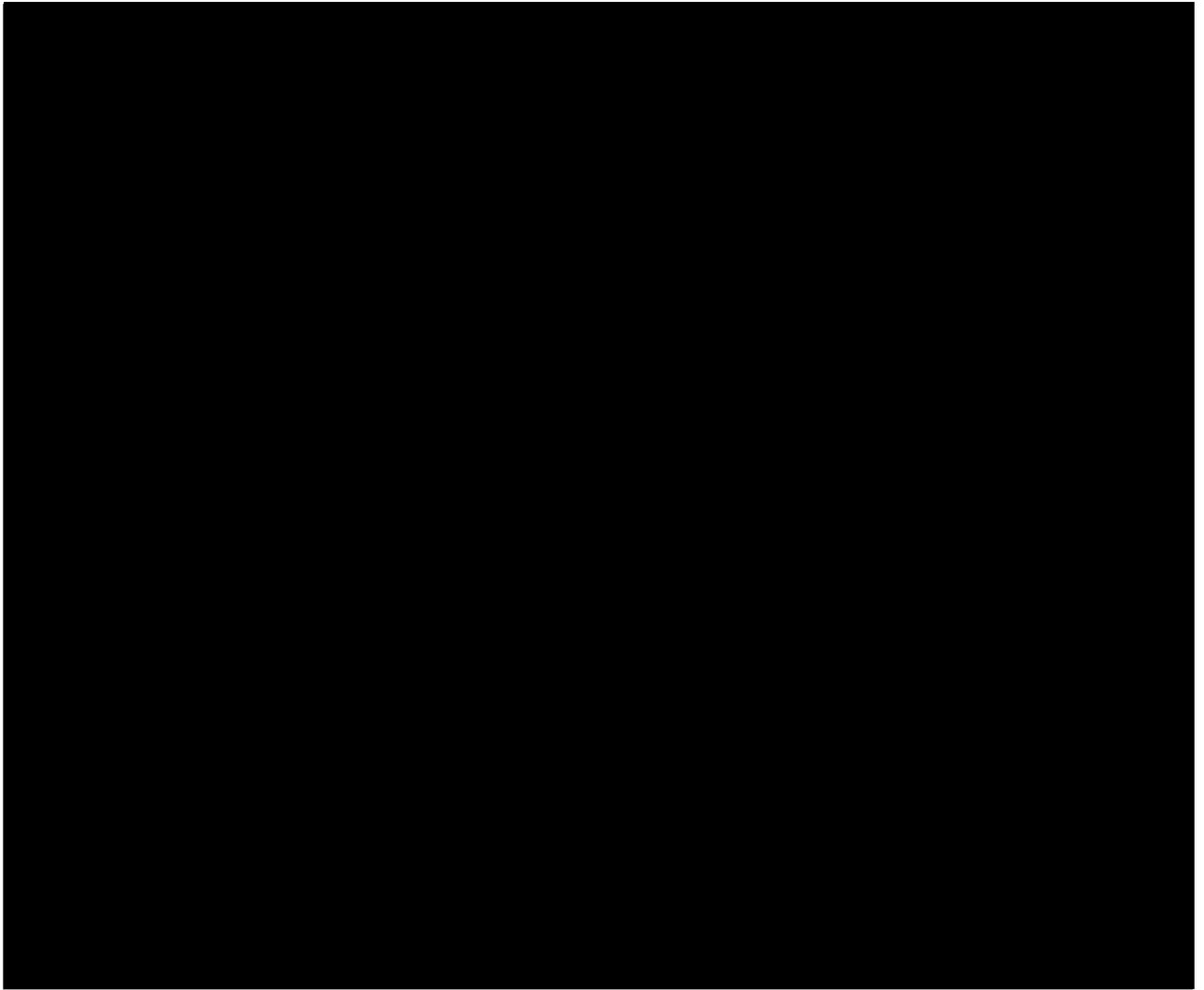














**FRESENIUS  
KIDNEY CARE**

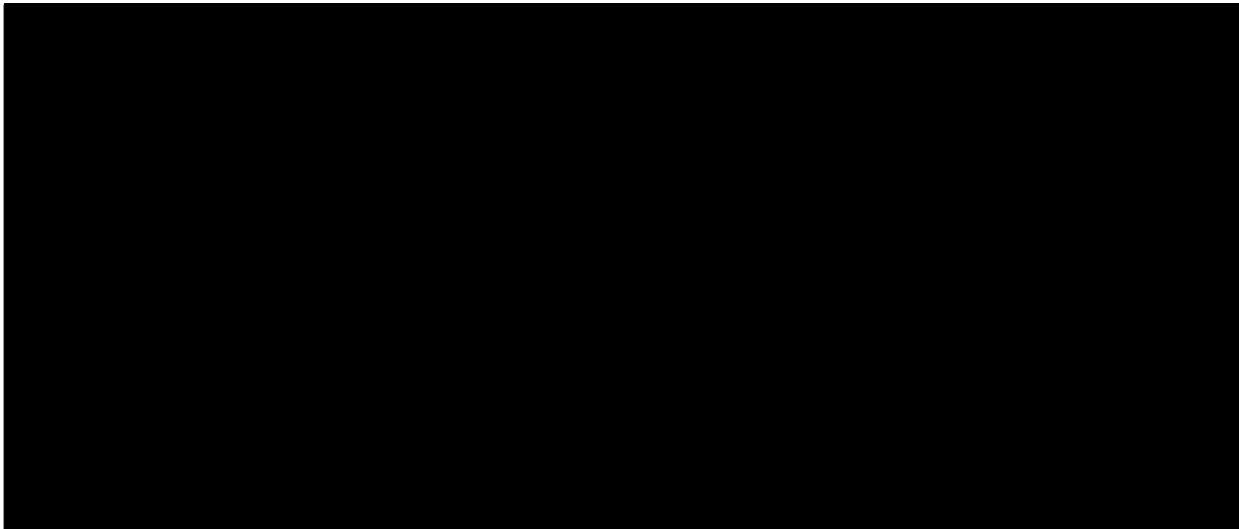
December 23, 2022

New York State Department of Health  
Capital District Region  
875 Central Ave.  
Albany NY 12206-5300

Via FedEx

Re: Closure Plan for FMS-Albany Dialysis Center  
Operating Certificate #7002176R  
Facility Id 4854

Dear Sir/Madam:



The Operator is committed to carrying out a safe and patient-focused relocation of the Facility that will be appropriately coordinated and communicated with nephrologists, caregivers, patients, and staff.

The attached documents represent the closure plan of the Operator to discontinue operations at the Facility and to relocate the Facility to a new location within the current patient service area.

Sincerely,

Susan Jessen

Director of Operations

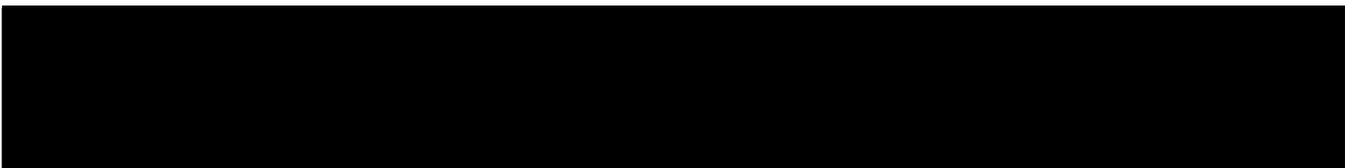
[Susan.Jessen@fmc-na.com](mailto:Susan.Jessen@fmc-na.com)

(315) 200-6747

**PLAN OF CLOSURE  
FMS-ALBANY DIALYSIS CENTER  
64 ALBANY-SHAKER ROAD  
ALBANY, NEW YORK 12204**

I. Recitals.

A. FMS-Albany Dialysis Center located at 64 Albany-Shaker Road, Albany, NY 12204 (the "Facility") is a renal dialysis diagnostic and treatment center operated by New York Dialysis Services, Inc. (the "Operator").



C. By submission of this Plan of Closure (the "Plan") on December 23, 2022, the Operator has given written notice to the Commissioner of Health of the State of New York (the "Commissioner") of its intention to discontinue its operation of the Facility on or before March 23, 2023. Upon receipt of approval by the Commissioner of the Plan, patients of the Facility shall be able to receive in-center hemodialysis, peritoneal dialysis and home hemodialysis at the Operator's FMS-Albany Regional Kidney Center located at 2 Clara Barton Drive, Albany, NY 12208.

D. The Plan includes a plan for the maintenance, storage and safekeeping of patients' medical records in accordance with Section 401.3(i) of the Department's regulations and will provide such other notifications and take such other actions as may be required by applicable provisions of federal and State law and regulation.

E. In furtherance of the foregoing, the Operator hereby submits the Plan for the closure of the Facility and relocation of the Facility to another location within the current patient service area to the Department for approval.

II. Closure of FMS-Albany Dialysis Center

It is the intention of the Operator to discontinue operations at the Facility on or before [REDACTED] subject to the approval of the Commissioner. It is the intention of the Operator to relocate the Facility to a new location within the current patient service area of the Facility and to submit an application to the Department for approval of such relocation within the next 90 days. All communication related to closure issues should be directed to: Susan Jessen, Director of Operations at [REDACTED]

III. Notice to Patients and Physicians.

The Operator will furnish to each patient of the Facility and his or her physician, by letter in the forms annexed hereto as Attachments A and B, respectively, on or before the date of receipt of notification from the Department approving the Plan.

#### IV. Transfer of Patients.

A. It is the Operator's intention to continue to make dialysis services available to current patients of the Facility in accordance with this Plan until all patients have selected and been transferred for treatment to an appropriate successor provider. In furtherance of the provisions of the Plan, the Operator will not admit or readmit any patient to the Facility on or after [REDACTED]

B. Representatives of the Operator have met (or will meet promptly) with patients of the Facility to advise them that dialysis services will no longer be available at the Facility after the date of closure. The patients of the Facility will be notified of the immediate and continuing availability of services at the [REDACTED]

[REDACTED] Patients will promptly be notified, in person and by letter, that dialysis services are also available at several other locations in their geographic area and will be furnished with a list of local dialysis facilities, including the addresses and telephone contact numbers of those facilities.

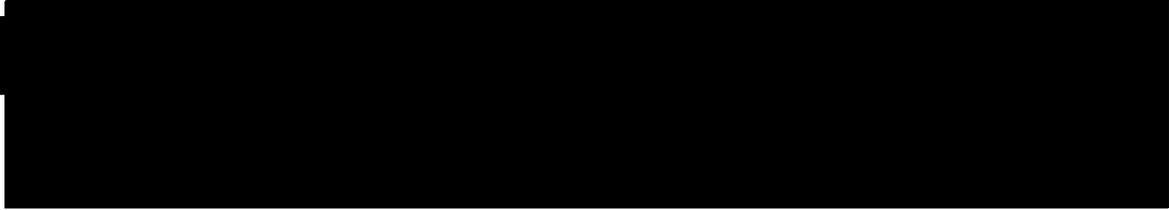
C. The Operator will provide all assistance requested or required by any patient in the selection of a successor dialysis services provider and in the transfer of the patient's care and medical record information to such successor provider. That assistance may include:

1. Answering any questions that the patient has concerning the selection of a new dialysis services provider.
2. Providing for the patient such information relating to each potential successor provider as is made available to the Facility.
3. Contacting one or more dialysis services providers as requested by the patient.
4. Obtaining the patient's written authorization to transfer his or her patient records to the successor dialysis services provider selected by the patient.
5. Facilitating the transfer of patient information maintained by the Facility to a successor dialysis services provider in accordance with and pursuant to written authorization received by the Facility from the patient: and
6. Notifying all third-party payors of the closure of the Facility.

#### V. Notice to Employees.

The employees of the Facility will be notified by the Operator of the closure of Facility.

VI. Maintenance, Storage and Safekeeping of Medical Records.

A. 

- B. As Custodian, the Custodian will arrange for (1) safe and secure storage of all patient records and (2) access to such patient records upon authorized written request to the Custodian. The Custodian shall be responsible for storing and maintaining patient records for such period as may be required by applicable federal and State law, rule, and regulation, and for producing such records at the request or direction of a former patient of the Facility or in compliance with the request or directive of authorized regulatory or legal authority. Any request to the Custodian for the release of records from a former patient must be accompanied by a written release by such patient of the Custodian from all liability that may arise because of complying with such request, which shall be in a form acceptable to the Custodian. Upon receipt of an appropriate request and release, the Custodian will produce any requested patient record in its possession but shall be given a reasonable period to produce such record and shall be required to produce such records only during regular business hours.
- C. The Custodian may destroy any patient record that has been delivered into its custody that has been retained longer than the maximum holding period required by applicable law, rule, and regulation, without notification to any person or entity, unless prior to the destruction of such record the Custodian receives written instructions from the patient to deliver to such person all records in its possession pertaining to him or her that would otherwise be destroyed pursuant to this paragraph.
- D. For purposes of this Section VI, the term “patient record” shall include all patient historical data, assessments, physician orders (when available), nursing notes and any other information that may have been routinely maintained by the Facility in the normal course of its business.
- E. In the event that the Custodian is no longer willing or able to serve as Custodian, the Custodian shall designate a successor Custodian willing and able to serve as such. The rights, duties and responsibilities of such successor Custodian shall be identical with those of the Custodian appointed hereunder.
- F. It shall be the primary responsibility of the Custodian and any successor Custodian properly and appropriately maintain, protect, and preserve the confidentiality of all patient records in his, her or its custody.

VII. Discontinuation of Operation and Surrender of New York State License.

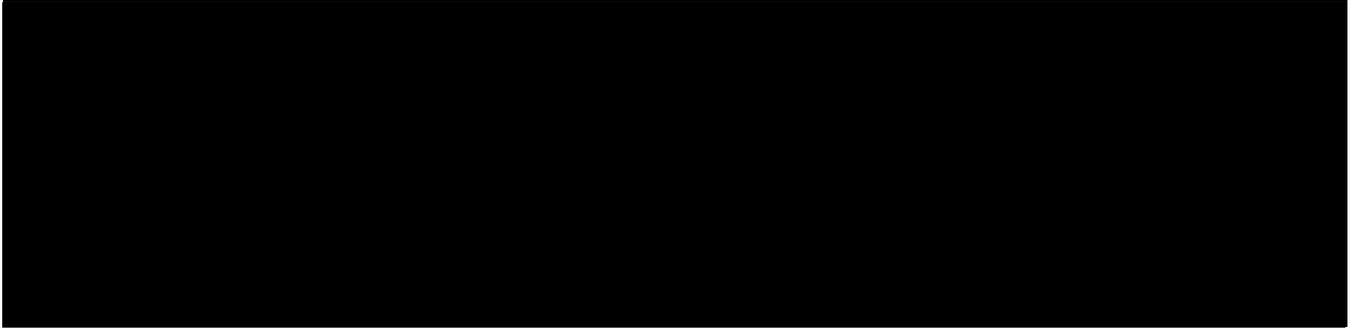
A. The Facility shall always maintain compliance with applicable law, rule, and regulation until such time as the remaining components of this Plan have been completed.

Five (5) days after discontinuation of operation of the Facility pursuant to this Plan, the Operator will surrender the operating certificate for Facility to the Department.

**ATTACHMENT A**

**Notice to Patients**

Dear \_\_\_\_\_



We will make every effort to assist you and your family in addressing any concerns you may have regarding the selection of a new dialysis services provider.

The social worker will contact one or more dialysis providers per your request and provide information relating to each dialysis provider you choose.

Attached you will find a list of dialysis providers in the area.

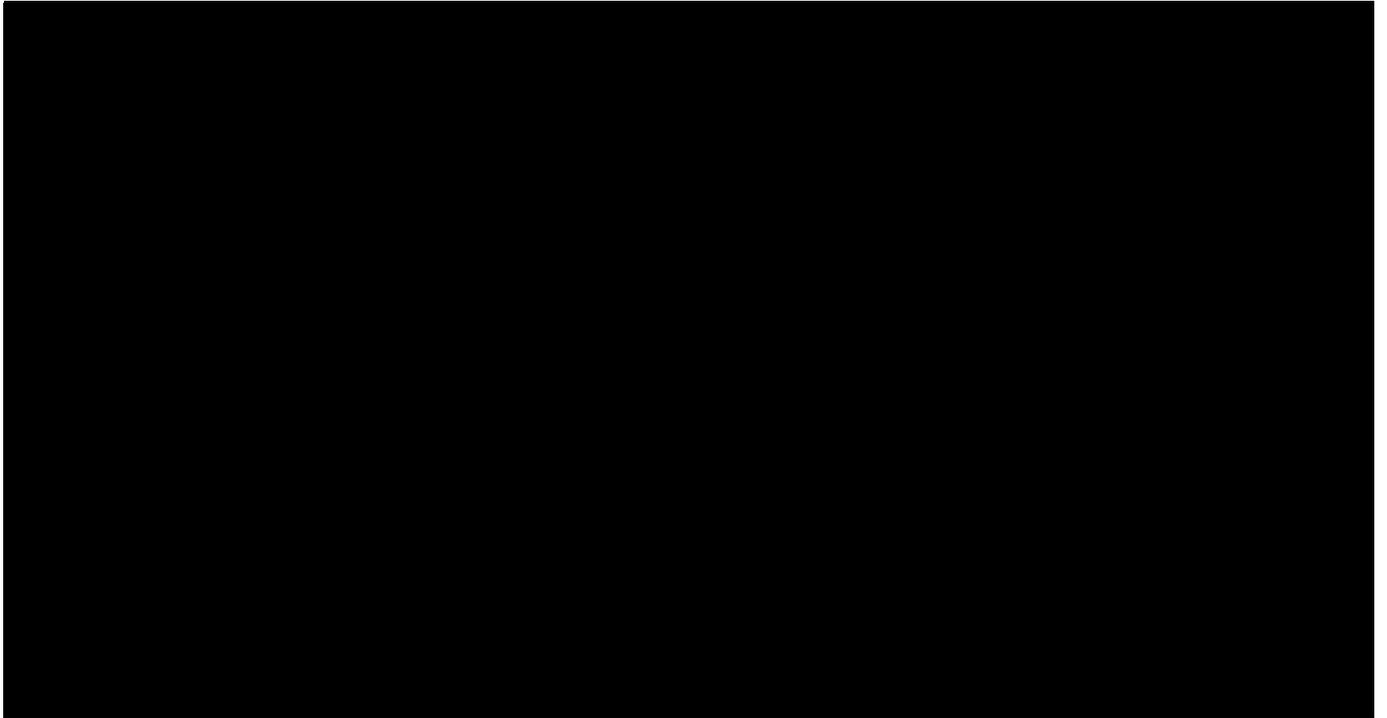
Sincerely,

Administrator

**ATTACHMENT B**

**Notice to Physicians**

Dear Dr. \_\_\_\_\_



Sincerely,

Administrator

4872-5788-8325, v. 2

**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.**

<b>Diagnostic and Treatment Centers for HEIA Requirement</b>	<b>Yes</b>	<b>No</b>
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.**

<b>Construction or equipment</b>	<b>Yes</b>	<b>No</b>
Is the project minor construction or the purchase of equipment, subject to Limited Review, <u>AND</u> will result in one or more of the following: <ul style="list-style-type: none"> <li>a. Elimination of services or care, and/or;</li> <li>b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or;</li> <li>c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours?</li> </ul> <p><i>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</i></p>		

<i>less than or equal to \$6,000,000 for all other facilities are eligible for a Limited Review.</i>		
<b>Establishment of an operator (new or change in ownership)</b>	<b>Yes</b>	<b>No</b>
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, <u>AND</u> 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?		
<b>Mergers, consolidations, and creation of, or changes in ownership of, an active parent entity</b>	<b>Yes</b>	<b>No</b>
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?		
<b>Acquisitions</b>	<b>Yes</b>	<b>No</b>
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?		
<b>All Other Changes to the Operating Certificate</b>	<b>Yes</b>	<b>No</b>
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?		

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

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

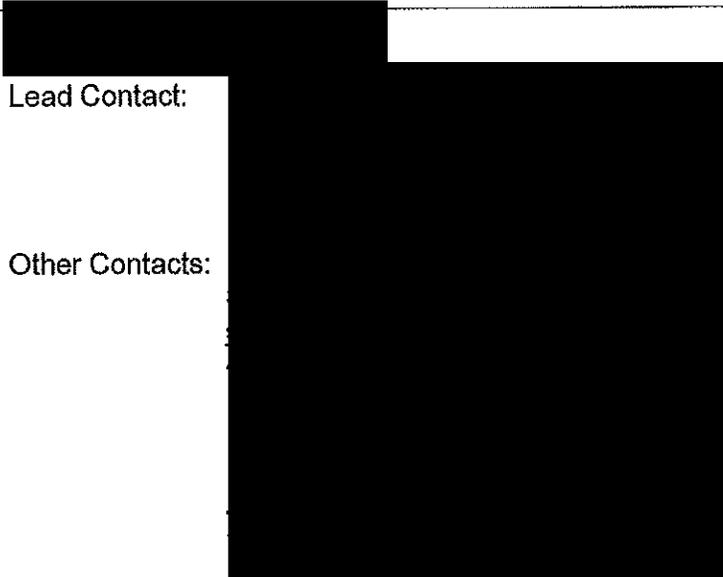
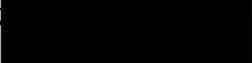
- HEIA Contract with Independent Entity
  - HEIA Template
  - HEIA Data Tables
  - Full version of the CON Application with redactions, to be shared publicly
- ***If you checked “no” for all questions in Table B***, this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.

**New York State Department of Health**

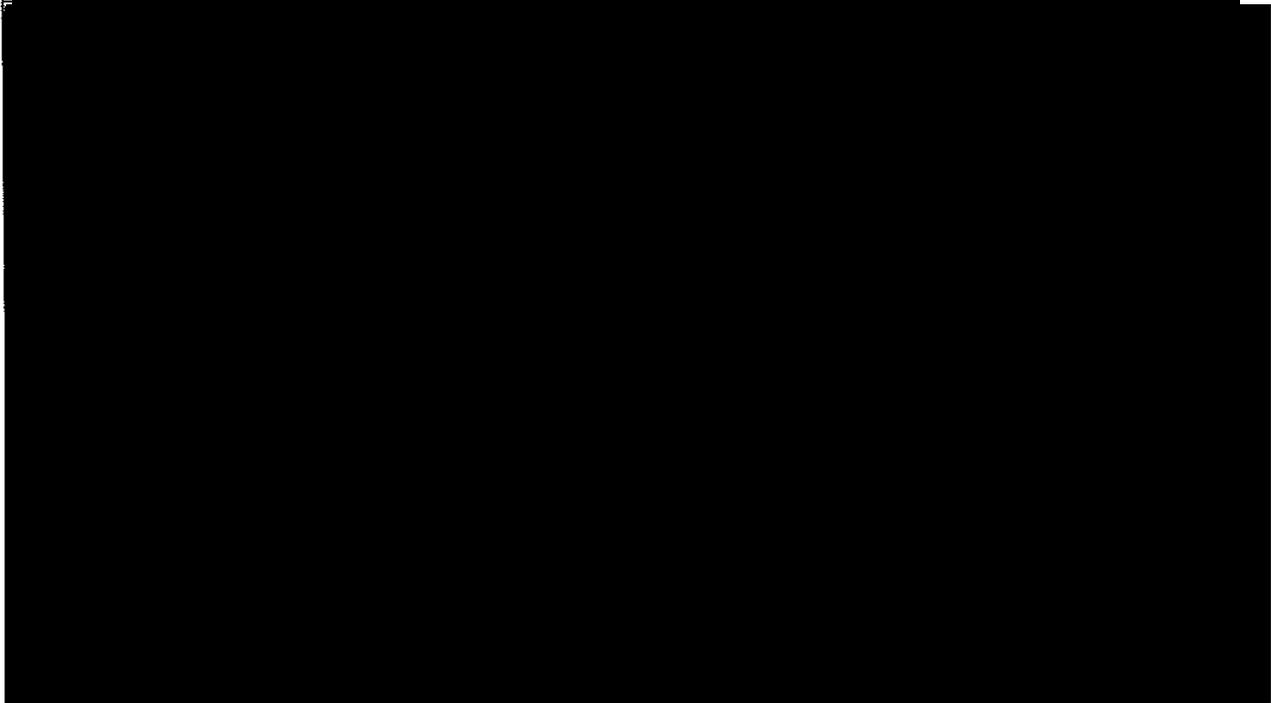
**Health Equity Impact Assessment Template**

Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

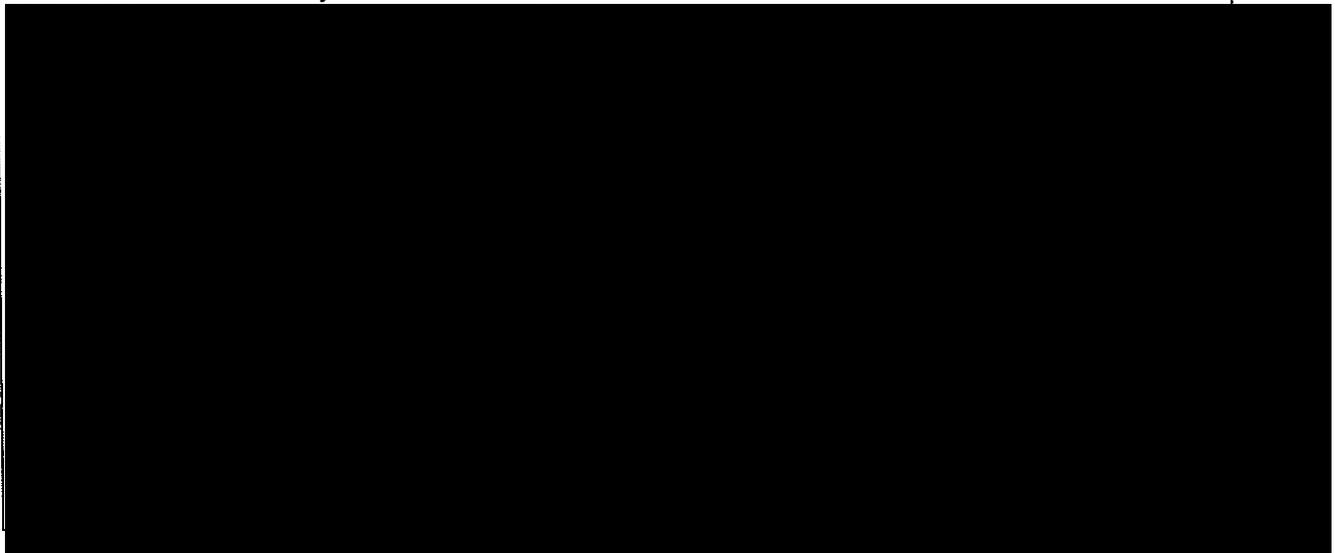
**SECTION A. SUMMARY**

1. Title of project	FKC - Albany Regional
2. Name of Applicant	New York Dialysis Services, Inc.
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	 Lead Contact:  Other Contacts:
4. Description of the Independent Entity's qualifications	See Attachment A
5. Date the Health Equity Impact Assessment (HEIA) started	
6. Date the HEIA concluded	

7. Executive summary of project (250 words max)



8. Executive summary of HEIA findings (500 words max)



## **SECTION B: ASSESSMENT**

**For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.**

### **STEP 1 – SCOPING**

1. Demographics of service area: Complete the “Scoping Table Sheets 1 and 2” in the document “HEIA Data Tables.”

Appendix B presents a map of the market area with locations of the licensed dialysis centers and a list of dialysis centers in the market area.

The following table summarizes the population data from Scoping Table 1.

<b>SEX AND AGE</b>	
Total population	
Male	
Female	
<b>RACE</b>	
Total population	
One race	
Two or more races	
One race	
White	
Black or African American	
American Indian and Alaska Native	
Asian	
Native Hawaiian and Other Pacific Islander	
Some other race	
<b>HISPANIC OR LATINO AND RACE</b>	
Hispanic or Latino (of any race)	
Not Hispanic or Latino	
<b>HEALTH INSURANCE COVERAGE</b>	
Civilian noninstitutionalized population	
With health insurance coverage	
With private health insurance	
With public coverage	
No health insurance coverage	
<b>DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION</b>	
Total Civilian Noninstitutionalized Population	
With a disability	

2. Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:

Low-income people

Racial and ethnic minorities

Women

Lesbian, gay, bisexual, transgender, or other-than-cisgender people

People with disabilities

Older adults

Persons living with a prevalent infectious disease or condition

People who are eligible for or receive public health benefits

People who do not have third-party health coverage or have inadequate third-party health coverage

Other-Native American

3. For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?

The following data sources were used to determine the groups that would be impacted:

- US Census Data
- USRDS Annual Data Report 2022, National Institute of Diabetes and Digestive and Kidney Diseases
- Kidney Diseases Statistics for the United States, National Institute of Diabetes and Digestive and Kidney Diseases
- Albany County Health Indicators 2018-2020
- Prevalence of Chronic Kidney Disease Among Medicare Beneficiaries Ages Greater than or Equal To 65 Years, 2019: CMS
- End Stage Renal Disease Network of NY Annual Report, 2021
- Albany County Health Improvement Plan 2022-2024
- 2022 Capital Region Health Needs Assessment
- NY State Health Equity Report County Edition January 2016

We were not able to identify specific data concerning ESRD for the following medically underserved groups: immigrant, LGBT or other than cisgender people, people with disabilities, persons living with a prevalent infectious disease or condition.

Stakeholder feedback information was difficult to obtain. We emailed survey

forms, mailed survey forms and placed multiple telephone calls to potential stakeholders.

4. How does the project impact the unique health needs or quality of life of each medically underserved group (identified above)?

For each medically underserved group the project will provide care and support to people who are dependent upon ESRD treatment. ESRD treatment is required to sustain life for patients with ESRD.

5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

According to the USRDS 2020 Annual Report, Black people are nearly four times more likely to develop ESRD than White People. Hispanic people and Native American people are more than twice as likely to develop ESRs. Black people make up approximately 13% of the US population but account for 30% of the people with ESRD.

Black people are more likely to have ESRD caused by hypertension than White or Hispanic people. Hispanic people are more likely to have ESRD caused by diabetes than White or Black people.

Among patients with ESRD who were initially waitlisted for kidney transplant in 2015, women were more likely to receive a transplant by five years (57.4%) than men (54.8%). White people were more likely to receive a transplant by five years (63.2%) than Black, Hispanic and Asian people (approximately 50%) and Native American and Native Hawaiian/Pacific Islander (approximately 40%.)

The following table presents the incidence rate/ million population by race:

Race/Ethnicity	Incidence Rate/Million Population
Black	949
Native American	596
Hispanic	511
Asian	349
White	249

The following table documents the ESRD incident rate by age group reported by USRDS:

Age	Incidence Rate/Million Population
0-17	12
18-44	18
45-64	598
65-74	1,225
75 and older	1,447

The following table presents the treatment modality by primary cause of ESRD:

Percent Treatment Modality by Primary Cause of ESRD				
Primary Cause of ESRD	In-Center Hemodialysis	Home Hemodialysis	Peritoneal Dialysis	Transplant
Diabetes	72.72	1.40	8.59	17.29
Hypertension	68.06	1.49	8.87	21.59
Glomerulonephritis	35.45	1.73	8.02	54.80
Cystic Kidney	27.60	1.47	7.83	63.10
Other Urologic	43.39	1.53	5.99	49.08
Other/Unknown	48.04	1.44	6.00	44.51

USRDS reports the following percentage use of modality by race:

Race/Ethnicity	In-Center Hemodialysis	Home Hemodialysis	Peritoneal Dialysis	Transplant
White	51.89	1.84	9.37	36.90
Black	70.16	1.56	6.51	21.76
Hispanic	65.32	0.88	7.49	26.32
Asian	55.84	0.83	11.66	31.68
Native American	71.66	1.01	7.58	19.75
NH/PI	71.87	1.16	8.28	18.69
Other	58.28	1.52	8.71	31.48
Unknown	15.37	0.53	1.07	83.03

USRDS Annual Data Report 2022 reported the following concerning race and access to care:

"In the 2021 ADR, we did not observe disparities in rates of outpatient nephrology visits or receipt of medications to treat CKD or its complications, including angiotensin converting enzyme inhibitors or angiotensin receptor blockers, oral potassium or phosphorus binders, or sodium-glucose cotransporter-2 inhibitors, by race/ethnicity. Rates of nephrology encounters also differed little by level of neighborhood deprivation. These results suggest that Medicare coverage, including Part D and the Low Income Subsidy, appeared to provide comparable access to care for CKD across race/ethnicity groups and across levels of neighborhood deprivation. We hypothesized that barriers to access to care prior to Medicare eligibility likely contribute to the higher rates and earlier onset of diabetes and hypertension among Black and Hispanic individuals as well as to the higher risk of subsequent CKD and ESRD. To address this question, this year's ADR includes data on younger Medicaid beneficiaries aged 18 to 64 years, in which we examined access to medications and nephrology care in these younger patients. We again found little disparity by race/ethnicity or by neighborhood in receipt of medications or nephrology encounters. However, rates of nephrology encounters among younger Medicare beneficiaries were less than half those among older Medicare beneficiaries. Thus, the younger, more heavily Black, Hispanic, and lower socioeconomic status (SES) Medicaid population appeared to have considerably less access to nephrology care. Medicaid coverage may provide less access to nephrology care than Medicare coverage, or insurance coverage may be insufficient to overcome barriers to accessing care experienced by younger patients with low SES, such as transportation or concerns about loss of work income. Furthermore, limitations in access to Medicaid (e.g., across U.S. states) likely introduce further disparities that cannot be examined using medical claims, as uninsured patients almost certainly have more limited access to care. Further examination of these issues using more detailed data sources will be critical to developing and implementing strategies to address healthcare disparities."

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

The following facilities and the number of patient stations are listed by the NY State Department of Health to provide similar services in the service area:

Facility Name	Stations
DCI - Mount Hope	18
DCI-Rubin Dialysis Centers	19
Dialysis Clinic Inc	18
FKC - Latham Dialysis Center	12
FMS - Westmere Dialysis Center	17
Fresenius Kidney Care - Troy	12
Latham Dialysis	17

7. What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?

Based on number of stations the historic market share is presented below. We do not anticipate any change in market share.

Facility Name	Stations	Market Share
DCI - Mount Hope	18	10.5%
DCI-Rubin Dialysis Centers	19	11.1%
Dialysis Clinic Inc	18	10.5%
FKC - Latham Dialysis Center	12	7.0%
FMS - Westmere Dialysis Center	17	9.9%
FMS-Albany Dialysis Center	24	14.0%
FMS-Albany Regional Kidney Center	34	19.9%
Fresenius Kidney Care - Troy	12	7.0%
Latham Dialysis	17	9.9%

8. Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance.

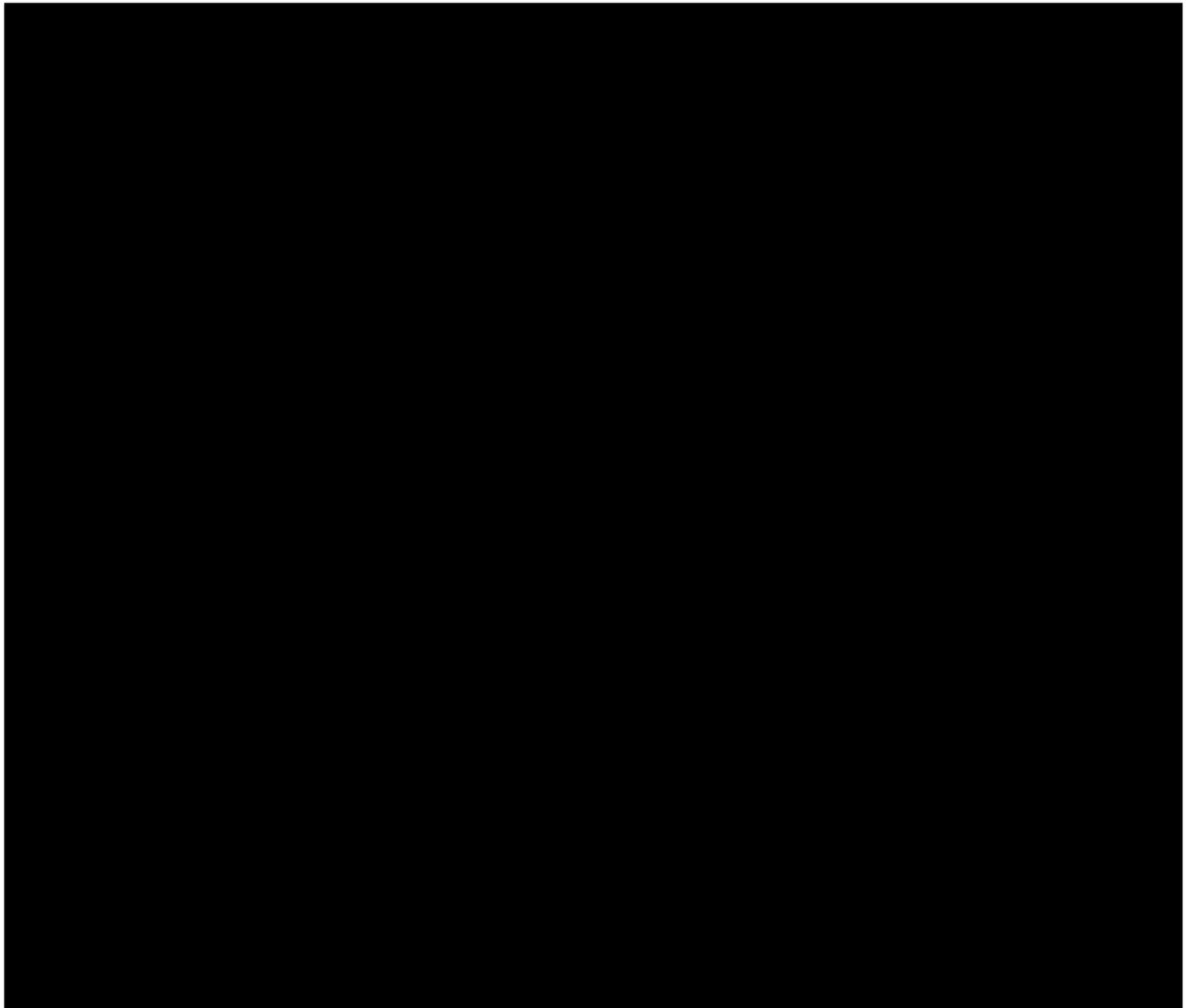
Will these obligations be affected by implementation of the project? If yes, please describe.

4.4% of the services are for indigent care patients. The dialysis center's patient population is reported to be 58% male and 42% female; 45% White, 49% Black or African American, 5% Asian and 0.8% Native American. We do not anticipate the payor mix, gender or racial profile will change.

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

No physician or professional staffing issues are anticipated related to the project or that might result from implementation of the project. Current staff will relocate to the project.

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.



11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.



The projects provided ESRD care to members of the medically underserved groups.

The Albany Relocation Project will continue to serve patients who have ESRD and require dialysis services. The relocation will improve workflow and staffing efficiencies to provide high quality care. The relocation will include new equipment and a new water delivery system. The outcome of the improved workflow, staffing efficiencies, and equipment of the relocation will service the needs of existing patients and expand/add additional shift capacity for future capacity needs.

## **STEP 2 – POTENTIAL IMPACTS**

1. For each medically underserved group identified in Step 1 Question 2, describe how the project will:
  - a. Improve access to services and health care
  - b. Improve health equity
  - c. Reduce health disparities

The project will serve patients who require dialysis care for ESRD. It will serve patients from each identified medically underserved group who have ESRD and require dialysis.

The project will improve health equity because the Applicant currently uses operating protocols for dialysis services that serve each patient's clinical needs and coordinates care that incorporates the patient's psychosocial needs. The project will support additional therapy shifts as needed.

For each identified underserved group the project will improve access to health services due to increasing the number of dialysis stations and peritoneal dialysis/home therapy rooms in one location making providing more options for treatment times and the dialysis center's location providing access to private and public transportation routes.

As discussed previously younger Medicare dialysis patients are reported to have fewer nephrology encounters than older Medicare dialysis patients. No data was reported concerning the effect of comorbidities related to age. The ADR reported

"Medicaid coverage may provide less access to nephrology care than Medicare coverage, or insurance coverage may be insufficient to overcome barriers to accessing care experienced by younger patients with low SES, such as transportation or concerns about loss of work income. Furthermore, limitations in access to Medicaid (e.g., across U.S. states) likely introduce further disparities." We anticipate that any patient in each of the identified medically underserved groups will have better access to nephrology care, other clinical services and referrals to other social and support services when they become patients at the proposed project which will decrease disparities.

2. For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.

Dialysis services are a critical care element for all patients with ESRD who have not received a treatment. We anticipate patients from each medically underserved from each underserved group will have improved access to nephrology care, referrals to other clinical care and social services, and assistance with qualifying for Medicare once they become Fresenius patients. We anticipate that patients will benefit from the ongoing monitoring of their physical status and clinical laboratory results.

3. How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.

Payor mix data supplied by the Applicant included 4.4% indigent care. We do not expect this to change.

4. Describe the access by public or private transportation, including Applicant- sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.

The project site is close to an exit on I87 and is located on Route 9W. There are bus stops within one block walking distance of the proposed project site that serve five different local bus routes.

5. Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

The design will meet current ADA and regulatory standards to reduce

architectural barriers for people with mobility impairments.

### Meaningful Engagement

6. List the local health department(s) located within the service area that will be impacted by the project.

The project is located in the area covered by Albany Health Department. Patients live in areas covered by Rensselaer Health Department.

7. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?

We did not receive a response to inquiries to the Health Department.

8. Meaningful engagement of stakeholders: Complete the "Meaningful Engagement" table in the document titled "HEIA Data Table". Refer to the Instructions for more guidance.
9. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

Women, racial and ethnic minorities, older adults and low income stakeholders are most affected by the project.

**Acacia Network - Capital District LATINOS (CDL) - Cultural Empowerment & Community Engagement Center** Micky Jimenez stated that her organization is supportive of this project primarily because of the location. She stated that the neighborhood for the site of the new dialysis center is close to her organization and is an underserved area. She stated that the most positive impact to the Latino community and low income community will be the center's accessibility. She stated that access to most other centers is by car. Most of her clients do not have cars and rely on the bus system. The new dialysis center will be in an area where the Latinos live. She stated that there has been an increase of Latinos to the area, particularly as a result of the recent migrant influx. Her organization supports those that are low income/Medicaid, uninsured and/or below the poverty line. She stated that historically, Latinos have been underserved in terms of access to care and health education. Her organization has sponsored kidney disease workshops with "kidney coaches" to education the population. She stated that a dialysis center in this neighborhood would be very beneficial.

10. How has the Independent Entity's engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

We did not identify any groups who would be burdened by the project.

11. Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.

See attached list of organizations representing stakeholders contacted.

### STEP 3 – MITIGATION

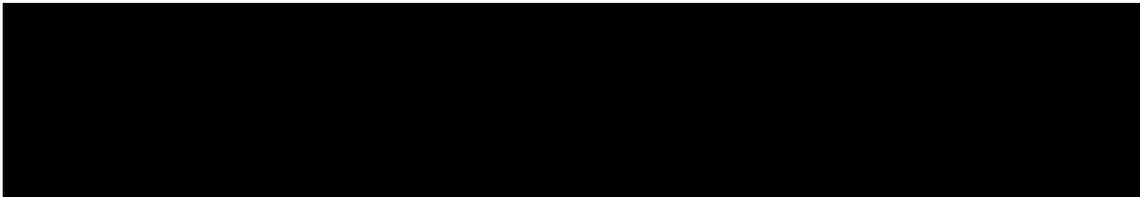
1. If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:
- People of limited English-speaking ability
  - People with speech, hearing or visual impairments
  - If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?

Fresenius will follow company guidelines, policy, and procedures. See attached Language and Communication Barriers Policy & United-Language Group guidelines. See Appendix C.

2. What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?

Fresenius currently serves the needs of each medically underserved group. We suggest staff be trained on health equity and culturally sensitive approaches to improve communication and service coordination with community stakeholders.

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?



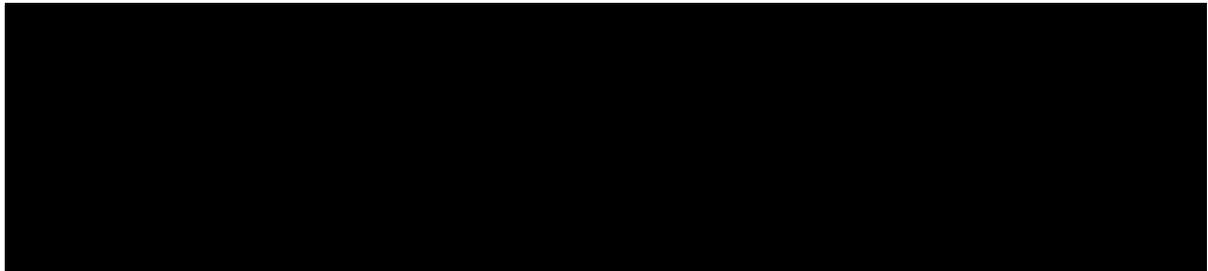
4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

The project will serve a diverse population that reflects the demographics,

racial and clinical profiles of ESRD patients discussed earlier. The project does not need to be modified.

#### **STEP 4 – MONITORING**

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?



2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

Operations, compliance and regulatory team functions could include HEIA goals, action plans, monitoring functions and revisions as needed.

## **STEP 5 – DISSEMINATION**

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

**OPTIONAL:** Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

----- SECTION BELOW TO BE COMPLETED BY THE APPLICANT -----

**SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN**

*Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.*

**I. Acknowledgement**

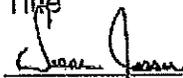
I, (APPLICANT), attest that I have reviewed the Health Equity Impact Assessment for the (PROJECT TITLE) that has been prepared by the Independent Entity, (NAME OF INDEPENDENT ENTITY).

Susan Jessen \_\_\_\_\_

Name

Regional Vice President \_\_\_\_\_

Title

 \_\_\_\_\_

Signature

12/27/2023 \_\_\_\_\_

Date

**II. Mitigation Plan**

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

*Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.*

## New York State Department of Health

### Instructions for Health Equity Impact Assessment Template

#### Contents:

- I. Background
- II. Definitions
- III. Instructions

## I. BACKGROUND

### What is a Health Equity Impact Assessment (HEIA)?

#### Purpose

The requirement for a Health Equity Impact Assessment was established by New York State legislation so that an independent assessment on potential health equity impacts of projects proposed by Article 28 health care facilities across New York State can be completed and considered as part of the project's Certificate of Need application.

#### Structure

The standard format of the Health Equity Impact Assessment ("Template") issued by the New York State Department of Health ("Department") reflects a "stepwise" structure that the Independent Entity follows:

1. Scoping
2. Potential Impact
3. Mitigation
4. Monitoring
5. Dissemination

## II. DEFINITIONS

### Applicant

The organization, entity, facility, or facility system that is submitting the Certificate of Need application for the project.

### Medically underserved group

Medically underserved groups, as defined in the Health Equity Impact Assessment legislation and statute, consist of:

- Low-income people;

- Racial and ethnic minorities;
- Immigrants;
- Women;
- Lesbian, gay, bisexual, transgender, or other-than-cisgender people;
- People with disabilities;
- Older adults;
- Persons living with a prevalent infectious disease or condition;
- Persons living in rural areas;
- People who are eligible for or receive public health benefits;
- People who do not have third-party health coverage or have inadequate third-party health coverage; and
- Other people who are unable to obtain health care.

Tribal Nations are included in “Other people who are unable to obtain health care”

### Health Equity

The New York State Legislature has defined health equity to mean “measurable differences in health status, access to care, and quality of care as determined by race, ethnicity, sexual orientation, a preferred language other than English, gender expression, disability status, aging population, immigration status, and socioeconomic status.”

### Independent Entity

The organization, entity, business, or individual(s) contracted by the Applicant to conduct the Health Equity Impact Assessment for the Applicant’s project.

### Service Area

Geographical region where the Applicant’s facility is located as well geographical regions where populations that use the facility are located. The Service Area should match the service area in the Certificate of Need application correlating with this Assessment.

### Stakeholders

Individuals or organizations currently or anticipated to be served by the Applicant’s facility, employees of the facility including facility boards or committees, public health experts including local health departments, residents of the facility’s service area and organizations representing those residents, patients or residents of the facility and their representatives, community-based organizations, and community leaders.

### Meaningful engagement

Providing advance notice to stakeholders and an opportunity for stakeholders to provide feedback concerning the facility’s proposed project, including phone calls, community forums, surveys, and written statements. Meaningful engagement must be reasonable

and culturally competent based on the type of stakeholder being engaged (for example, people with disabilities should be offered a range of audiovisual modalities to complete an electronic online survey).

## **INSTRUCTIONS**

### **SECTION A. SUMMARY**

#### **1. Title of project**

List the full title of the project as listed on the Applicant's Certificate of Need application.

#### **2. Name of Applicant**

List the full name (business/DBA name) of the organization/entity/facility/system that is submitting the Certificate of Need application for the project.

#### **3. Name of Independent Entity, including lead contact and full names of individuals conducting the HEIA**

List the full name (i.e. business or DBA name, first and last name of individual) of the Independent Entity. List the lead contact (email address and phone number) for the Independent Entity (could be the President/CEO, or the principal/lead investigator) as well as the full names of individuals conducting the HEIA.

#### **4. Description of the Qualifications of Independent Entity**

Describe and list the qualifications of the Independent Entity staff conducting the assessment. Explain expertise and experience in the following mandatory areas, including years of experience for each: health equity, anti-racism, and stakeholder and community engagement. If applicable, describe the expertise and experience the Independent Entity staff have in: health care access and delivery of health care services, and any other relevant areas of expertise or background.

#### **5. Date the Health Equity Impact Assessment started**

List date (MM/DD/YYYY) that the Independent Entity was contracted (i.e. effective date of contract, agreement, memorandum of understanding, etc.) by the Applicant to conduct the Health Equity Impact Assessment for the proposed project.

#### **6. Date the Health Equity Impact Assessment concluded**

List date (MM/DD/YYYY) that the Independent Entity provided the final Health Equity Impact Assessment to the Applicant for review.

#### **7. Executive summary of project (250 words max)**

In 250 words or less, provide an executive level summary of the project being proposed by the Applicant. What is the purpose and “end goal” of the project?

**8. Executive summary of HEIA findings (500 words max)**

In 500 words or less, provide an executive level summary of the findings from the Health Equity Impact Assessment. Based on the Independent Entity’s conclusion of the data and information from meaningful engagement of the community, what is the health equity impact of the project being proposed? Would the project make health outcomes, quality of life, and/or quality of care better, the same, or worse for medically underserved groups?

The above-stated definitions of health equity is offered as a starting point for how the Independent Entity should prepare to answer this question.

**SECTION B: ASSESSMENT**

**For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.**

**STEP 1 – SCOPING**

**1. Demographics of service area**

Complete the “Scoping Table” in the document “HEIA Data Tables” as part of the HEIA submission. The service area definition should be consistent with the Applicant’s definition of how they answer service area in other parts of the Certificate of Need application. If the project will result in a change to the service area, include demographics for both the current service area and the new service area. The purpose of the Scoping Table is to provide demographic information about the service area for the project, including:

- Zip codes/Zip code tabulation area (ZCTAs) associated with the current service area
- Zip codes/ZCTAs associated with the new service area, if applicable
- Population size of zip codes/ZCTAs in the service area(s)
- Age distribution of zip codes/ZCTAs in the service area(s)
- Racial and ethnic makeup of zip codes/ZCTAs in the service area(s)
- Disability status of people in zip codes/ZCTAs in the service areas(s)
- Median household income in zip codes/ZCTAs the service area(s)
- Percent of families in poverty in zip codes/ZCTAs in the service area(s)
- Percent unemployed in zip codes/ZCTAs in the service area(s)
- Percent of households with food assistance in zip codes/ZCTAs in the service area(s)

- Percent of adults (25+) with high school or above in zip codes/ZCTAs in the service area(s)
- Percent insurance coverage in zip codes/ZCTAs in the service area(s)
- Percent of housing units with no vehicle in zip codes/ZCTAs in the service area(s)

For up-to-date data, the Department suggests the most recent year of the U.S. Census American Community Survey 5-year Estimates. General information from the U.S. Census on how to acquire data for a specific neighborhood or service area is available [here](#). (This general method can be used to compile scoping sheet 1.) Information on how to acquire specific variable data from U.S. census zip files is available [here](#) and [here](#). (This general method can be used to compile scoping sheet 2.)

## **2. Medically underserved groups in the service area**

Identify which specific medically underserved group(s) in the service area will be impacted by the proposed project. The Independent Entity can list a specific population or stakeholder that is not covered by the statute's list of medically underserved groups (defined above) by selecting "Not listed" and typing in the group or stakeholder.

## **3. Sources of information for identification of medically underserved groups**

For each medically underserved group (identified in Step 1, Question 2), briefly describe the specific source of information used to determine which group(s) are impacted (for example, U.S. census data, hospital discharge data, insurance claim data, U.S. Health Resource and Services Administration shortage designation, stakeholder interviews, secondary sources, medical literature, or grey literature, etc.) Describe what kinds of information or data were difficult to access or compile for the completion of the Health Equity Impact Assessment.

## **4. Unique health needs or quality of life of medically underserved groups**

Describe how the project specifically impacts the unique health needs or quality of life of individuals in each medically underserved group (identified in Step 1, Question 2).

## **5. Current and expected utilization by medically underserved groups**

Describe to what extent are the medically underserved groups (identified in Step 1, Question 2) currently use the service(s) or care impacted by or as a result of the project? Describe to what extent are the medically underserved groups (identified in Step 1, Question 2) expected to use the service(s) or care impacted by or as a result of the project?

## **6. Availability of similar services or care**

Provide a brief summary of the availability of similar services or care at nearby facilities. The purpose of this question is to 1) understand where else individuals can seek and utilize such services if/when there is a disruption of services or care during/after the project, and/or 2) to identify projects in an area with an existing health care shortage/need. If the project will result in a disruption of services or care, provide any plans the Applicant has for assisting patients or residents when services/care are down.

A Health Data NY map including locations of Article 28, Article 36, and Article 40 health care facilities and programs from the Health Facilities Information System (HFIS), can be found [here](#). A U.S. Health Resources and Services Administration tool for identifying shortage designation areas can be found [here](#).

## **7. Historical and projected market shares**

If applicable, provide information about the historical market shares of providers offering similar services or care in the Applicant's service area. If the market shares are anticipated to change with the project, explain those changes in market shares. For new facilities, provide the projected market shares. If not applicable to the project, write N/A and provide justification.

## **8. Performance of obligations**

If applicable, summarize the current performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. If the Applicant has not met any one of these obligations that apply, please describe. If none of these obligations and federal regulations do not pertain to the project nor facility, write N/A and explain.

Also describe how these obligations will be affected by the project. Will these obligations be affected by implementation of the project? If yes, please describe.

Regarding community services, suggestions of what can be described are community benefit (i.e. grants or resources offered to partners that are to benefit the general public) or partnerships with community-based organizations (i.e. working with neighboring providers to meet social service needs of patients or residents).

If applicable to the facility, please describe the number of Medicaid or uninsured discharges/people served/residents in this facility compared to the total number of Medicaid or uninsured discharges/people served/residents in the region. Describe how this compares to the total number of licensed medical-surgical

beds/people served/residents for this facility compared to the total number of licensed medical-surgical beds/people served/residents in the region.

#### **9. Project's impact on staffing**

If applicable, provide a description of any, and to what extent, staffing issues may result from the project. This can include, but are not limited to, a decreased number of full and part time doctors, nurses, medical assistants, and other technicians needed to perform the services or care. Whereas other Schedules may ask the Applicant to provide a breakdown of staffing, the purpose of this question in the Health Equity Impact Assessment is for a perspective on anticipated staffing impacts that could result from the project. If not applicable to the project, write N/A and provide justification.

#### **10. Civil rights access complaints**

If there are civil rights access complaints filed in the last ten years against the Applicant with the New York State Division of Human Rights, the U.S. Department of Health and Human Services Office of Civil Rights, or any other federal, state, or local agency within the last ten years, provide a brief summary of the complaints and status of each complaint. Indicate "No" if there are no civil rights access complaints filed against the Applicant.

#### **11. Similar projects/work in the last five years**

If applicable, indicate whether the Applicant has undertaken similar projects/work in the last five years. The intent of this question is to better understand whether a singular project is related to a broader strategic effort by the facility (i.e. strategic plan, series of renovations that will apply to a number of facilities over a period of time, etc). If yes, describe the outcomes of the project/work and how medically underserved group(s) were impacted as a result of the project/work. If applicable, explain why the Applicant proposes another investment in a similar project after recent investments in the past.

Describe whether the Applicant has proposed or completed similar projects/work in the last five years. If so, describe the outcomes of similar project/work and how medically underserved group(s) were impacted as a result of the project/work?

### **STEP 2 – POTENTIAL IMPACTS**

#### **1. Intended impacts on health care access, health equity, and health disparities**

Provide an assessment of whether, and if so how, the project will: 1) improve access to services and health care, 2) improve health equity, and 3) reduce health disparities for each medically underserved group identified in Step 1 Question 2. This question is to understand the intended impacts of the project on

medically underserved groups as a whole, so the Independent Entity is welcome to describe any other intended impacts that do not necessarily fall under the three criteria above.

If applicable to the project, describe specific health outcome, and/or quality of life, and/or safety measures which may be impacted, such as those described in New York State's Health Improvement Plan, the Prevention Agenda. If appropriate, include outcome measures available at the sub-county level (such as zip code, census tract, minor civil division, etc). Sub-county level data sources are available from the Prevention Agenda dashboard, Health Data NY, the New York State County/Zip Perinatal Data Profile, and the NYS Cancer Registry and Cancer Statistics, as well as other New York State, local and national sources.

## **2. Unintended impacts**

For each medically underserved group identified in Step 1 Question 2, provide a description of the unintended positive and/or negative impacts the project may have on health equity and medically underserved groups. Explain how the project could positively or negatively affect medically underserved groups in getting high quality, timely, comprehensive, and accessible service or cares. If applicable, how would the currently proposed project either compound or mitigate any negative impacts from other projects carried over the last five years?

## **3. Indigent care**

If applicable, provide a description of the changes that may happen to the Applicant's amount of indigent care if the project is implemented, compared to the amount of indigent care provided currently. Indigent care is defined as both free and below cost care. If possible, quantify the percent change anticipated compared to the current level, such as in the percent change in the number of uninsured and low-income people served. If not applicable to the project, write N/A and provide justification.

## **4. Access by transportation**

If applicable, provide a description of the main types (public, private) and sources (car, bus, shuttle) of transportation for individuals that currently or are projected to utilize the service(s) or care impacted by or as a result of the project. Discuss how those main types and sources of transportation may need to change if the project is implemented. If not applicable to the project, write N/A and provide justification.

## **5. Architectural barriers for people with mobility impairments**

If applicable, provide a description of the architectural barriers that currently exist in the facility and negatively impact individuals with mobility impairments.

Describe the extent to which the project reduces or mitigates existing architectural barriers for patients or residents with mobility impairments. If the project newly creates or exacerbates existing architectural barriers for people with mobility impairments, describe how construction changes to the facility will help eliminate or mitigate the architectural barriers. If not applicable to the project, write N/A and provide justification.

### Meaningful Engagement

Local health department(s) that are part of the geographical and/or population service area are not required to contribute, collaborate, or comment in the Health Equity Impact Assessment. However, the Independent Entity is strongly advised to reach out to the local health department(s) to request expertise on a facility's project or service area.

The Independent Entity is required to seek, consider, and document the totality of voices, input, and perspectives of stakeholders including but not limited to public health experts, organizations representing facility staff, community-based organizations, community leaders, and residents in the project's service area.

#### **6. List of local health department(s)**

List the name(s) of the local health department(s) that are located within the service area that will be impacted by the project. This includes local health departments that are either within the geographical service area (i.e. the facility is within their county) or population service area (i.e. residents from a neighboring county travel across county lines to access a particular facility or health-related service offered by the Applicant).

#### **7. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?**

Provide a summary of the outreach to and, if applicable, input from the local health department(s) related to the project.

If the local health department(s) provided information, indicate the point(s) of contact and key findings.

If the local health department(s) did not respond, please indicate lack of response.

If the local health department(s) declined to provide information or participate, indicate the reason provided or any context given, as applicable. It is not required for a local health department to provide input and/or participate in the Health Equity Impact Assessment. Reasons a local health department may not participate could be staff capacity or bandwidth at the time.

#### **8. Meaningful engagement of stakeholders**

Review and complete the “Meaningful Engagement” table in the document titled “HEIA Data Table” as part of the submission. The purpose of this table is to provide detail of stakeholders engaged in the Health Equity Impact Assessment. The Independent Entity should offer to all stakeholders the opportunity to provide a statement (250 word max). If a stakeholder wishes to offer a statement in their own words, the Independent Entity must include as submitted. Otherwise, the Independent Entity can summarize the high-level topline findings of stakeholders’ input and include direct quotes wherever helpful.

#### Column 1: Name/Organization

➤ Provide the point of contact for the stakeholder organization. Include the email address of the person contacted for comment on the HEIA.

#### Column 2: What stakeholder group did they represent?

➤ List the stakeholder group that the contact person represents. Stakeholder groups that must be included: public health experts, organizations representing employees of the Applicant, community leaders, residents of the project’s service area.

#### Column 3: Is this person/group a resident of the project’s service area?

➤ Provide a yes or no answer from the drop-down menu for this column.

#### Column 4: Method of engagement

➤ List the methods of engagement for the person or organization. Methods can include but are not limited to: phone calls, in-person and/or virtual community forums, electronic, written, or telephonic surveys, written or online statements). The Independent Entity is advised to conduct timely engagement that is appropriate for the size and scope of project, region, stakeholders, and other factors and as needed. The Independent Entity is expected to give reasonable advance notice for outreach using any of the methods above.

#### Column 5: Date(s) of outreach

➤ Include the date of first outreach and any follow-ups that were sent to the person or organization for comments.

Consumers, particularly those considered as medically underserved, are a vital part of the meaningful engagement component and should be included in community outreach and engagement.

### **9. Most affected community members**

Based on your findings and expertise, which stakeholder(s) should be considered the most affected by the project? Has any group(s) representing these

stakeholders expressed concern with the project or offered relevant input? If stakeholders have different perspectives, include a brief description.

#### **10. Results of engaging community members**

Describe how the Independent Entity's engagement of community members has informed the development of the Health Equity Impact Assessment. What are the findings in terms of who will benefit from the project? What are the findings in terms of who will be most burdened from the project?

#### **11. Relevant community members that did not participate**

If there are any relevant stakeholders, especially those considered medically underserved, that did not participate in the meaningful engagement portion of the Health Equity Impact Assessment, list with any relevant information including the Applicant's historical efforts to engage these stakeholders.

### **STEP 3 – MITIGATION**

#### **1. Effective communication of services or care (language access)**

Based on the findings, describe the ways in which the Applicant can most effectively communicate the facility's services or care to the community. If applicable, provide a summary of the Applicant's intended plans to address language access with the proposed project. If applicable, be specific to the populations of interest: a) people of limited English-speaking ability and b) people with speech, hearing, or visual impairments.

Generally, how does the Applicant intend to convey what is going to happen at the facility to patients or residents? How will the communication be tailored (or the outreach be unique) to individuals with Limited English Proficiency (LEP) and/or individuals with speech, hearing, or visual impairments? The Independent Entity should consider the Applicant's "usual" means of communication, and identify gaps or opportunities to improve general communication to impacted stakeholders.

c) If the Independent Entity determines that the Applicant does not plan to nor is able to effectively communicate these services to both populations, what does the Independent Entity advise? From the perspective of the Independent Entity, what opportunities does the Applicant have to more effectively and competently communicate the availability of services or care?

#### **2. Suggested project changes to better meet medically underserved group needs**

Based on the findings of the HEIA, describe suggested changes to the project so the project can better meet the needs of each medically underserved group identified in Step 1, Question 2. If applicable, how can the project be improved, enhanced, or targeted? Provide a description of modifications, customizations, and adaptations that can be undertaken by the Applicant to better deliver services or care for medically underserved groups identified. Consider the various stakeholders impacted and points brought up by them.

### **3. Engaging community members on project changes**

If applicable, provide a summary of community engagement techniques the Applicant can utilize to better engage stakeholders about the project and forthcoming changes to the project. Make recommendations specific to the community or stakeholder of interest. Provide information about best practices for community engagement and successes from the meaningful engagement portion of the HEIA.

### **4. Addressing systemic barriers to equitable access**

Describe how specific components of the project address systemic barriers to services or care. Provide a rationale of why those components address systemic barriers. If the project increases barriers, describe what parts of the project do so and provide an example of how the project can be adapted to decrease systemic barriers instead.

## **STEP 4 – MONITORING**

The intent of this section is to incorporate the Independent Entity's recommendations on how the Applicant can monitor the health equity impacts of a project even after the project is completed. Under the Health Equity Impact Assessment requirement, the Independent Entity is not required to remain contracted with the Applicant for services related to monitoring, but rather to offer perspective on ways the Applicant can establish monitoring "best practices" on their own.

### **1. Existing mechanisms and measures to monitor impacts**

If applicable, describe how the Applicant is currently equipped to keep track of health equity impacts even after the project is completed. The Independent Entity can identify existing mechanisms and measures (i.e. policies, procedures, internal controls, systems, or accountability measures) that the Applicant already has in place and can be leveraged to monitor the potential impacts even after the project is completed. Describe specific indicators and/or objectives.

Existing mechanisms and measures can include but are not limited to:

- Ongoing involvement of a committee or advisory group charged with health equity projects
- Ongoing involvement of a chief equity officer or equity staff and their advisement on a facility project
- Requiring health equity training for staff responsible for the project
- Contracting a third-party vendor (i.e. consultant) to provide services related to monitoring and/or related impact assessments
- Health equity quality measures built into electronic record systems
- Health equity related consumer satisfaction surveys

## **2. Potential mechanisms and measures Applicant can put in place to monitor impacts**

List potential evidence-based measures and mechanisms (i.e. policies, procedures, internal controls, systems, or accountability measures) that can be put in place by the Applicant with respect to the proposed project and can address the findings of the Health Equity Impact Assessment. From the Independent Entity's viewpoint, provide any suggestions for mechanisms and measures that fit the proposed project well. Describe suggested indicators and/or objectives for potential mechanisms and measures.

Though monitoring by the Applicant nor the Independent Entity is not necessarily required, the purpose of this question is to encourage thinking on ways for the Applicant to build in potential measures or actions for monitoring.

Step 4 Question 1 is to identify existing mechanisms already in place, while Step 4 Question 2 is to identify potential evidence-based mechanisms or practices that could be put in place.

## **STEP 5 – DISSEMINATION**

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

## **OPTIONAL: ADDITIONAL COMMENTS FROM THE INDEPENDENT ENTITY**

In 250 words or less, provide any additional points of information the Independent Entity feels is relevant to the proposed project. Add any relevant information that was not asked about in the Template but was found through the development of the Health Equity Impact Assessment.

## **SECTION C: ACKNOWLEDGEMENT AND MITIGATION PLAN**

The purpose of Section C is to provide attestation that the Applicant received and reviewed the Health Equity Impact Assessment from the Independent Entity. Additionally, the Applicant must provide a narrative for how it has, or will, mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment.

This narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made by either the Commissioner of Health or the Public Health and Health Planning Council, as applicable.

## 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.

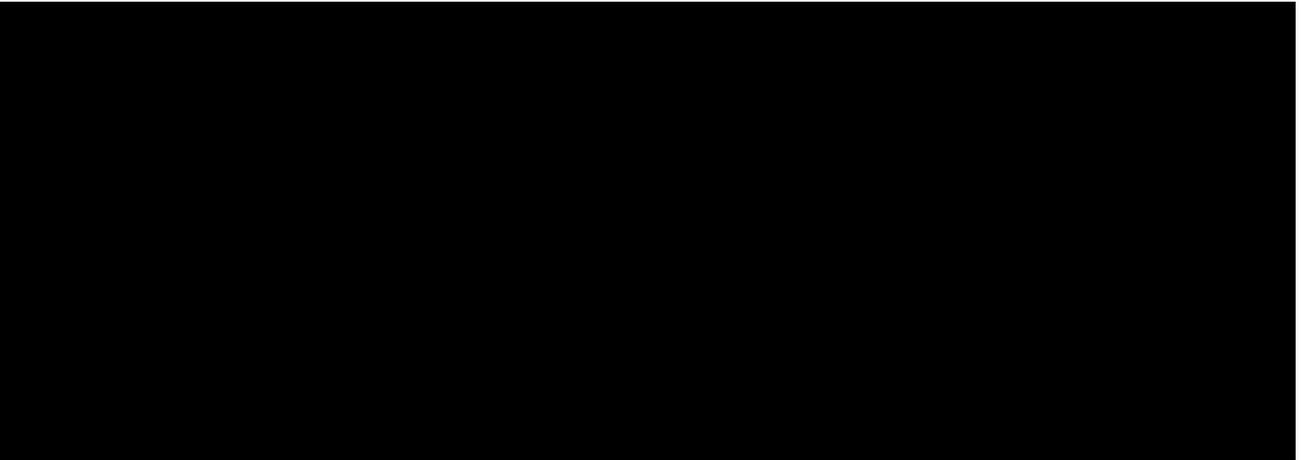
#### **Section 3 – General Information**

##### **A. About the Independent Entity**

1. Name of Independent Entity: The Vinca Group L.L.C.
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? NO  
 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)?  
Yes
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? No

**Section 4 – Attestation**



Date:12/18/2023

## 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.*

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- 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.

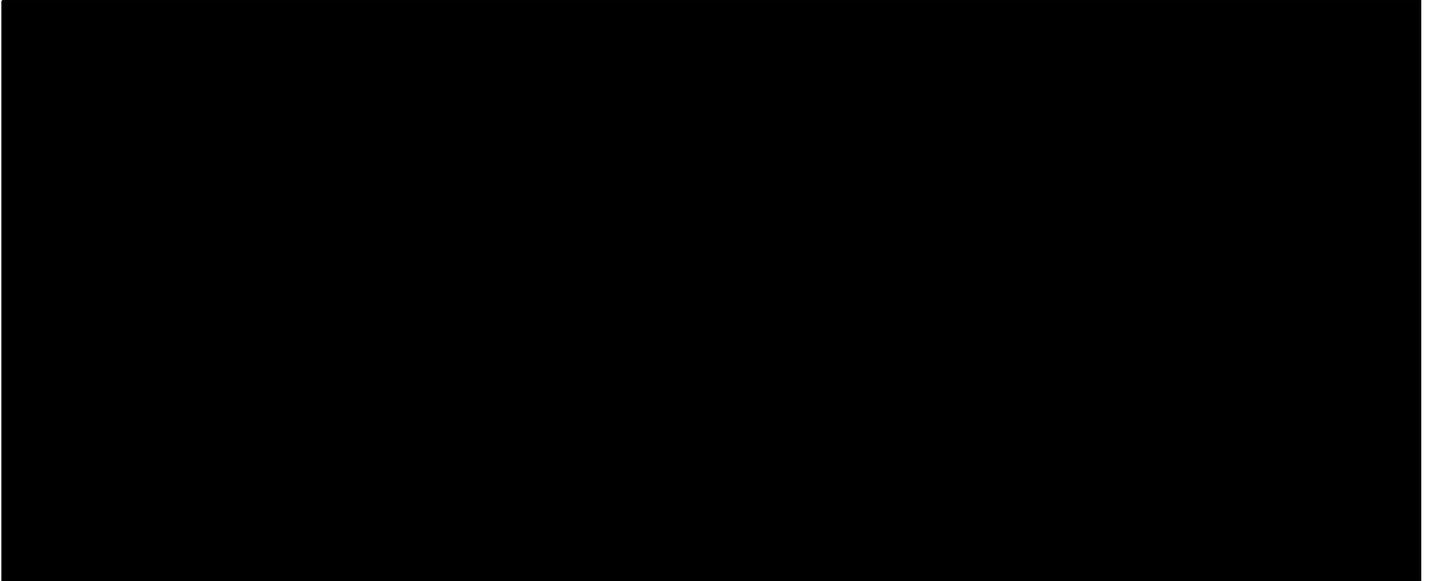
#### **Section 3 – General Information**

##### **A. About the Independent Entity**

1. Name of Independent Entity: [REDACTED]
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? No  
 If yes, indicate the name of the organization:  
\_\_\_\_\_

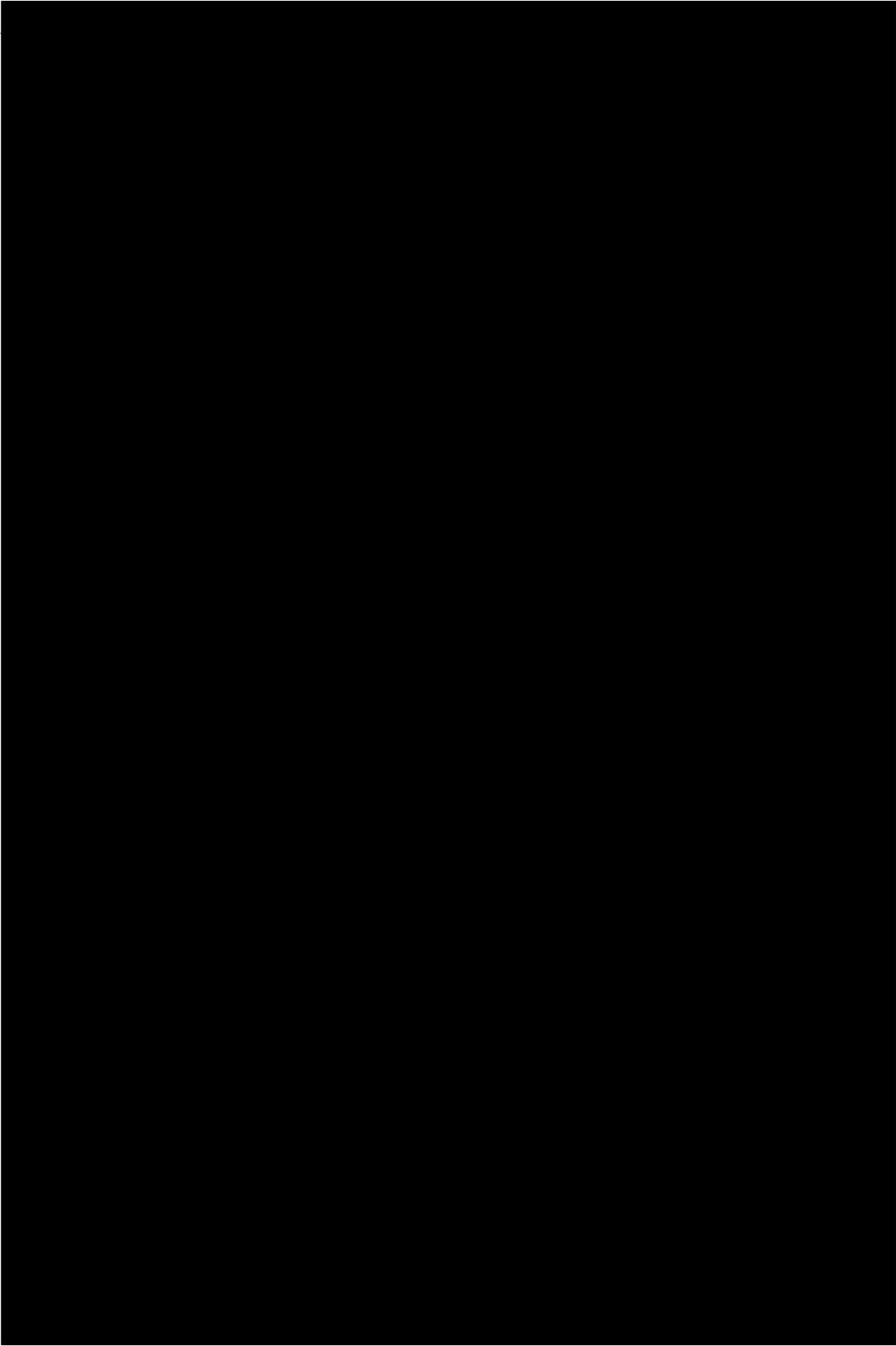
3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (Y/N)? Yes
4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years? No

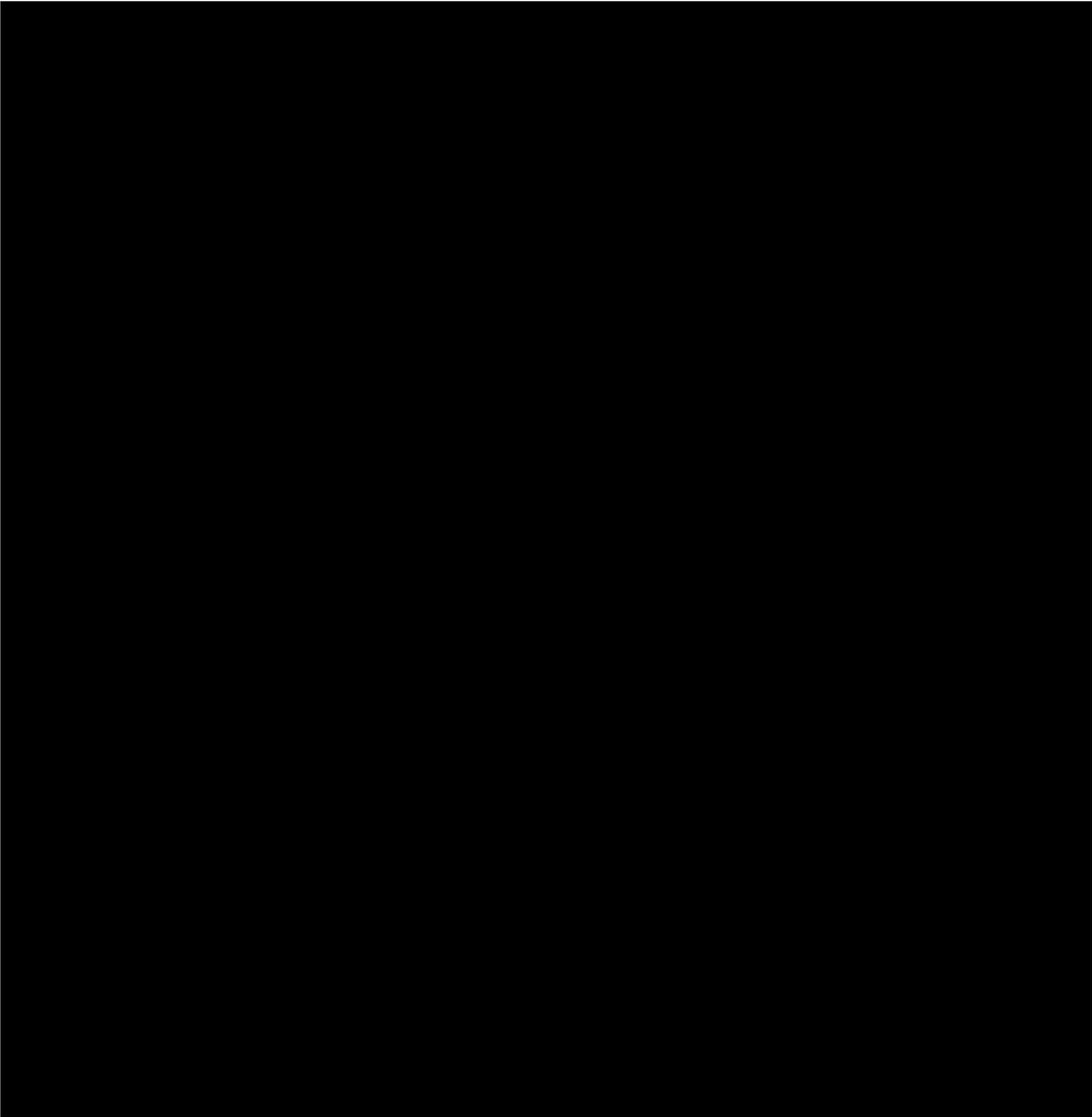
**Section 4 – Attestation**



Name/Organization - if organization, please include contact(s)

Date(s) of outreach





What required stakeholder group did they represent?

If other, please describe

Is this person/group a resident of the project's service area?

community leaders

Yes

public health experts

Yes

community leaders

Yes

public health experts

Yes

community leaders

yes

community leaders

yes

community leaders

Yes

Method of engagement  
(i.e. phone calls,  
community forums,  
surveys, etc.)

Is this group supportive of  
this project?

Did this group provide a  
statement?

Phone Call Response

Yes

Yes

Phone Call Response

Neutral

Yes

Email Response

Yes

Yes

Called, emailed, mailed

No

Called, emailed, mailed

No

Called, Emailed, mailed

No

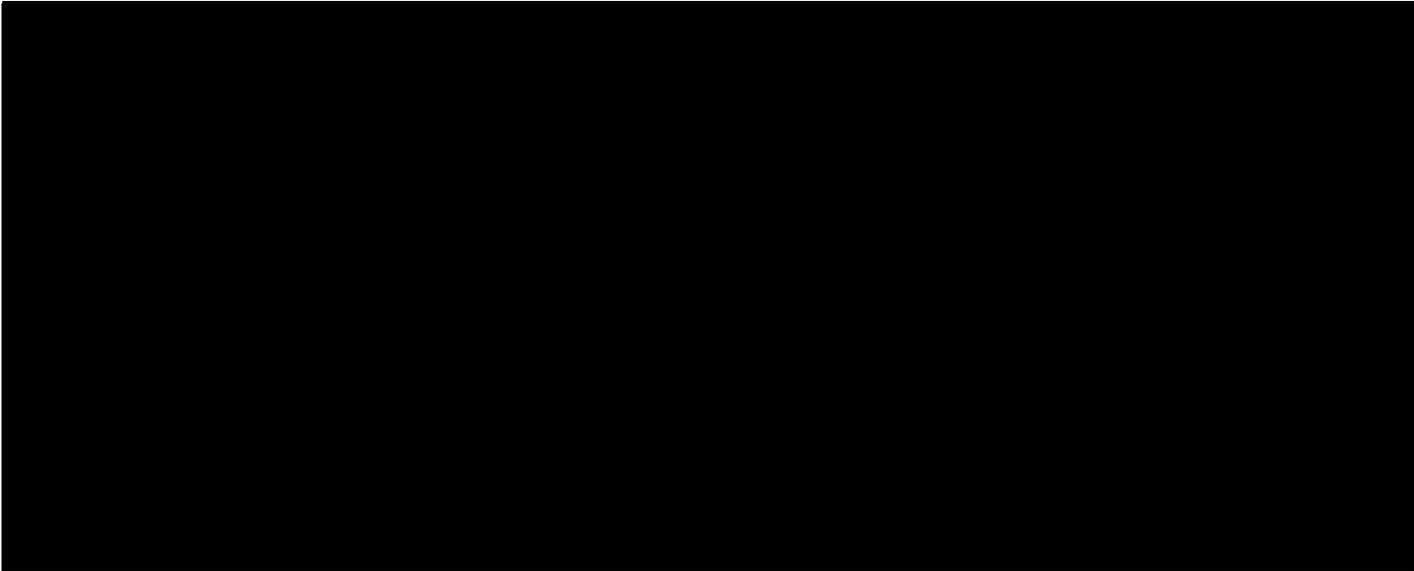
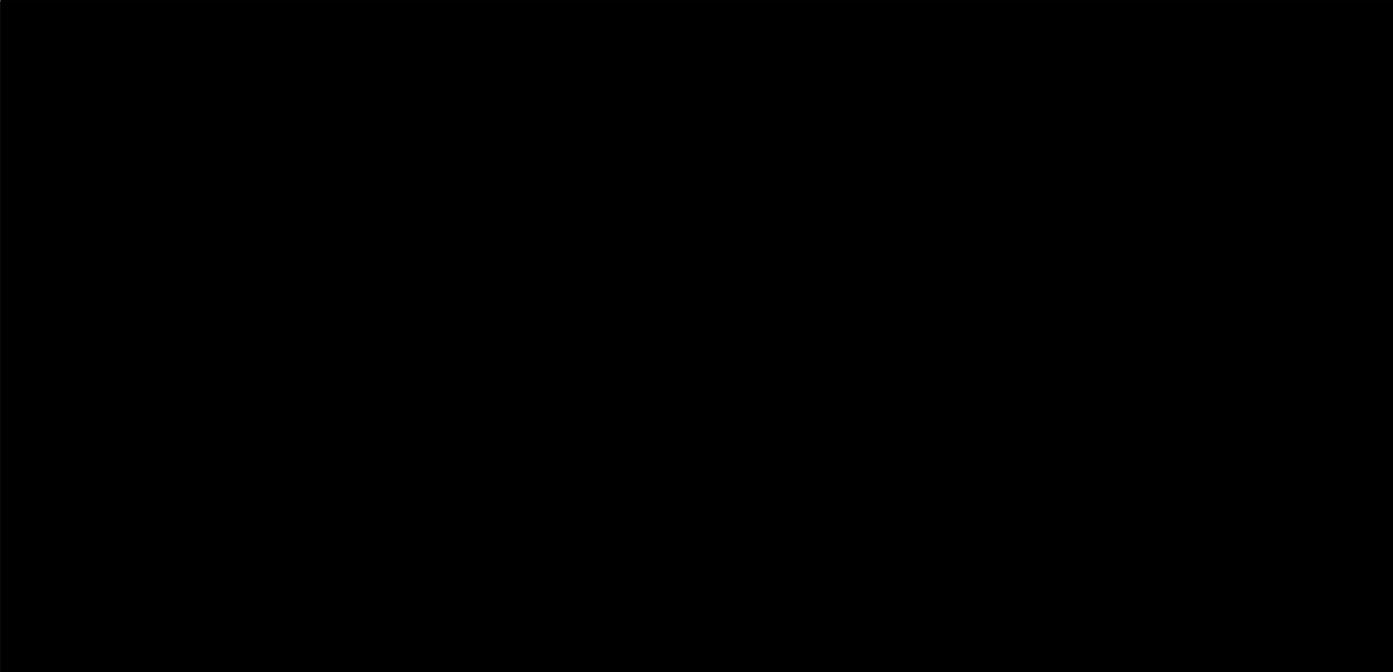
Yes

Called, emailed, mailed

Yes

Yes

If a statement was provided (250 word max), please include below:



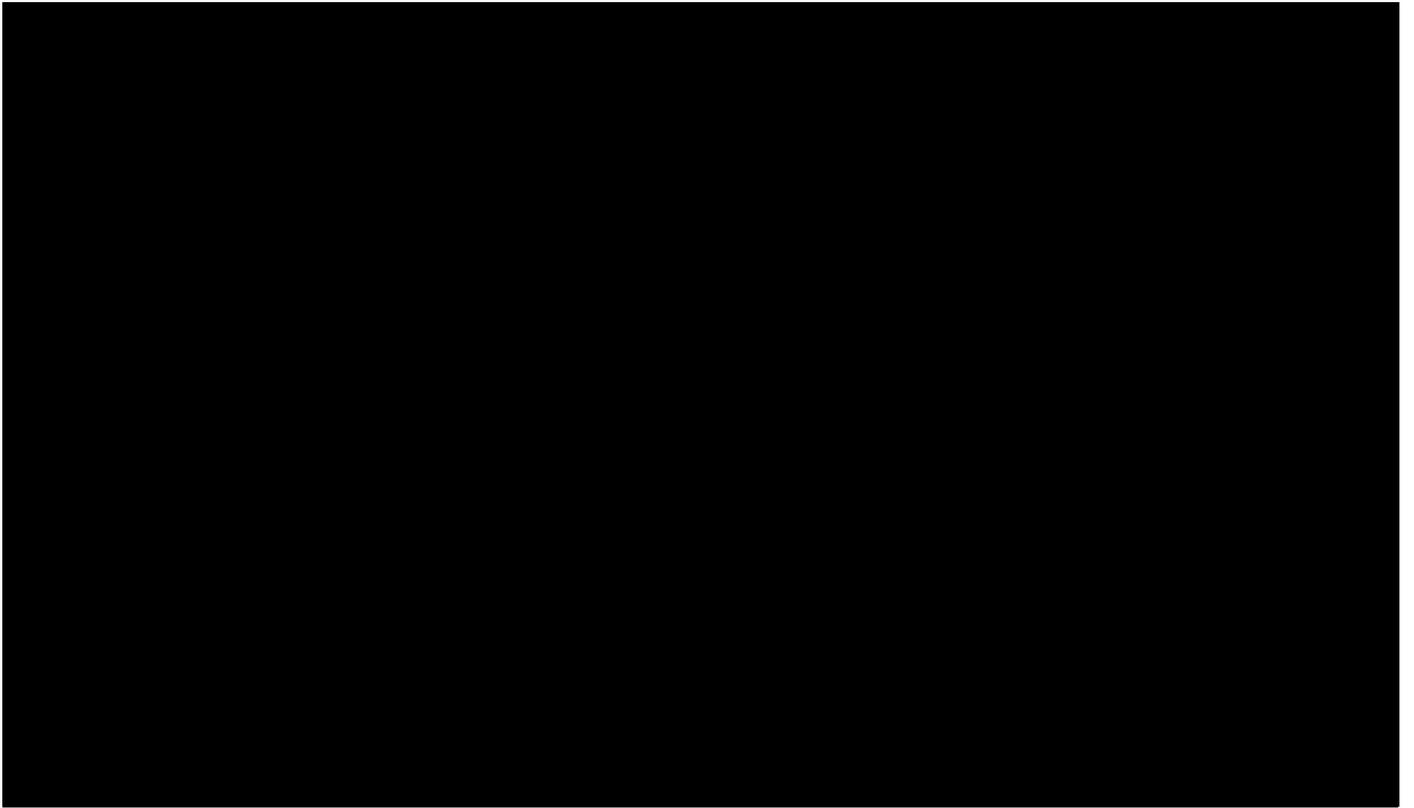


Table: ACSDP5Y2021.DP05

ZCTA5 12047					
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	
<b>SEX AND AGE</b>					
Total population	23,236	±696	23,236	(X)	
Male	10,401	±566	44.8%	±2.3	
Female	12,835	±725	55.2%	±2.3	
Sex ratio (males per 100 females)	81.0	±7.7	(X)	(X)	
Under 5 years	1,252	±270	5.4%	±1.1	
5 to 9 years	1,814	±336	7.8%	±1.4	
10 to 14 years	1,280	±235	5.5%	±1.0	
15 to 19 years	1,228	±285	5.3%	±1.2	
20 to 24 years	1,638	±437	7.0%	±1.9	
25 to 34 years	3,311	±392	14.2%	±1.7	
35 to 44 years	2,767	±447	11.9%	±1.8	
45 to 54 years	2,338	±365	10.1%	±1.6	
55 to 59 years	1,597	±406	6.9%	±1.8	
60 to 64 years	1,776	±390	7.6%	±1.7	
65 to 74 years	2,163	±327	9.3%	±1.4	
75 to 84 years	1,283	±356	5.5%	±1.5	
85 years and over	789	±253	3.4%	±1.1	
Median age (years)	39.9	±1.7	(X)	(X)	
<b>RACE</b>					
Total population	23,236	±696	23,236	(X)	
One race	21,651	±749	93.2%	±2.5	
Two or more races	1,585	±584	6.8%	±2.5	
One race	21,651	±749	93.2%	±2.5	
White	18,804	±942	80.9%	±4.0	
Black or African American	1,467	±545	6.3%	±2.3	
American Indian and Alaska Native	72	±60	0.3%	±0.3	

Table: ACSDP5Y2021.DP05

ZCTA5 12110				ZCTA5 12144			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
19,825	±1,170	19.825	(X)	21,623	±983		
10,027	±756	50.6%	±2.1	10,585	±701		
9,798	±675	49.4%	±2.1	11,038	±692		
102.3	±8.6	(X)	(X)	95.9	±8.8		
781	±182	3.9%	±0.9	927	±197		
901	±239	4.5%	±1.2	971	±250		
1,089	±272	5.5%	±1.3	1,380	±312		
1,767	±402	8.9%	±1.9	936	±249		
1,649	±401	8.3%	±1.9	1,011	±267		
1,980	±402	10.0%	±1.9	3,819	±458		
2,617	±468	13.2%	±2.3	2,845	±483		
2,815	±385	14.2%	±1.6	2,459	±365		
1,170	±231	5.9%	±1.2	1,319	±285		
1,308	±218	6.6%	±1.1	2,064	±491		
2,185	±358	11.0%	±1.9	2,358	±309		
988	±192	5.0%	±1.0	1,128	±253		
575	±195	2.9%	±0.9	406	±161		
41.4	±1.9	(X)	(X)	41.0	±1.4		
19,825	±1,170	19.825	(X)	21,623	±983		
18,721	±1,199	94.4%	±2.3	20,394	±997		
1,104	±454	5.6%	±2.3	1,229	±303		
18,721	±1,199	94.4%	±2.3	20,394	±997		
15,846	±1,013	79.9%	±3.2	18,261	±1,035		
928	±305	4.7%	±1.5	938	±321		
0	±20	0.0%	±0.2	37	±47		

Table: ACSDP5Y2021.DP05

		ZCTA5 12180			
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
21,623	(X)	53,729	±1,263	53,729	(X)
49.0%	±2.3	26,290	±868	48.9%	±1.2
51.0%	±2.3	27,439	±924	51.1%	±1.2
(X)	(X)	95.8	±4.5	(X)	(X)
4.3%	±0.9	2,702	±334	5.0%	±0.6
4.5%	±1.1	2,461	±261	4.6%	±0.5
6.4%	±1.4	2,438	±439	4.5%	±0.8
4.3%	±1.1	5,242	±467	9.8%	±0.8
4.7%	±1.1	5,553	±496	10.3%	±0.9
17.7%	±2.2	8,904	±568	16.6%	±1.0
13.2%	±2.0	6,577	±508	12.2%	±0.9
11.4%	±1.6	5,692	±536	10.6%	±1.0
6.1%	±1.3	3,494	±436	6.5%	±0.8
9.5%	±2.2	3,212	±435	6.0%	±0.8
10.9%	±1.5	4,489	±412	8.4%	±0.7
5.2%	±1.2	1,832	±204	3.4%	±0.4
1.9%	±0.7	1,133	±204	2.1%	±0.4
(X)	(X)	34.5	±0.8	(X)	(X)
21,623	(X)	53,729	±1,263	53,729	(X)
94.3%	±1.4	50,190	±1,206	93.4%	±0.9
5.7%	±1.4	3,539	±518	6.6%	±0.9
94.3%	±1.4	50,190	±1,206	93.4%	±0.9
84.5%	±2.6	38,675	±1,212	72.0%	±1.4
4.3%	±1.5	7,373	±633	13.7%	±1.2
0.2%	±0.2	64	±53	0.1%	±0.1

Table: ACSDP5Y2021.DP05

ZCTA5 12183				ZCTA5 12189			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
2,957	±16	2,957	(X)	18,277	±928		
1,419	±183	48.0%	±6.2	8,469	±551		
1,538	±184	52.0%	±6.2	9,808	±759		
92.3	±23.3	(X)	(X)	86.3	±8.9		
216	±207	7.3%	±7.0	1,195	±336		
98	±71	3.3%	±2.4	765	±174		
151	±100	5.1%	±3.4	1,172	±273		
202	±94	6.8%	±3.2	767	±260		
395	±159	13.4%	±5.4	1,246	±355		
395	±164	13.4%	±5.6	3,074	±506		
170	±88	5.7%	±3.0	2,458	±455		
499	±179	16.9%	±6.0	1,904	±351		
175	±85	5.9%	±2.9	1,228	±260		
180	±113	6.1%	±3.8	1,437	±273		
311	±108	10.5%	±3.7	1,853	±320		
105	±59	3.6%	±2.0	698	±188		
60	±50	2.0%	±1.7	480	±171		
37.1	±14.4	(X)	(X)	37.6	±1.9		
2,957	±16	2,957	(X)	18,277	±928		
2,664	±252	90.1%	±8.5	16,998	±867		
293	±251	9.9%	±8.5	1,279	±378		
2,664	±252	90.1%	±8.5	16,998	±867		
2,245	±422	75.9%	±14.3	13,140	±797		
208	±163	7.0%	±5.5	1,480	±487		
0	±13	0.0%	±1.3	21	±34		

Table: ACSDP5Y2021.DP05

		ZCTA5 12202				
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
18,277	(X)	8,716	±1,022	8.716	(X)	
46.3%	±2.5	4,457	±699	51.1%	±5.2	
53.7%	±2.5	4,259	±659	48.9%	±5.2	
(X)	(X)	104.6	±21.6	(X)	(X)	
6.5%	±1.8	590	±224	6.8%	±2.3	
4.2%	±1.0	445	±209	5.1%	±2.3	
6.4%	±1.4	580	±223	6.7%	±2.2	
4.2%	±1.4	525	±225	6.0%	±2.3	
6.8%	±1.9	316	±164	3.6%	±1.9	
16.8%	±2.8	1,612	±387	18.5%	±4.3	
13.4%	±2.4	1,709	±347	19.6%	±3.7	
10.4%	±1.8	831	±285	9.5%	±3.1	
6.7%	±1.4	427	±199	4.9%	±2.2	
7.9%	±1.5	584	±210	6.7%	±2.2	
10.1%	±1.7	706	±207	8.1%	±2.2	
3.8%	±1.0	344	±161	3.9%	±1.8	
2.6%	±1.0	47	±56	0.5%	±0.6	
(X)	(X)	35.9	±1.6	(X)	(X)	
18,277	(X)	8,716	±1,022	8.716	(X)	
93.0%	±2.0	7,611	±1,008	87.3%	±4.9	
7.0%	±2.0	1,105	±446	12.7%	±4.9	
93.0%	±2.0	7,611	±1,008	87.3%	±4.9	
71.9%	±3.2	2,526	±539	29.0%	±6.0	
8.1%	±2.6	4,305	±850	49.4%	±7.0	
0.1%	±0.2	42	±55	0.5%	±0.6	

Table: ACSDPYSY2021.DP05

ZCTA5 12203				ZCTA5 12204			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
30,470	±1,521	30,470	(X)	8,216	±513		
14,782	±940	48.5%	±1.9	4,263	±426		
15,688	±960	51.5%	±1.9	3,953	±436		
94.2	±7.0	(X)	(X)	107.8	±18.1		
1,144	±247	3.8%	±0.7	899	±258		
1,165	±319	3.8%	±1.0	599	±248		
803	±230	2.6%	±0.7	389	±158		
1,906	±322	6.3%	±1.1	421	±240		
5,028	±733	16.5%	±2.3	490	±236		
5,087	±660	16.7%	±1.9	1,802	±407		
2,807	±406	9.2%	±1.3	1,022	±230		
3,206	±478	10.5%	±1.4	698	±211		
1,968	±536	6.5%	±1.6	457	±158		
2,021	±380	6.6%	±1.2	538	±177		
3,111	±575	10.2%	±1.9	520	±174		
1,269	±239	4.2%	±0.8	281	±126		
955	±211	3.1%	±0.7	100	±83		
35.4	±2.8	(X)	(X)	31.8	±2.5		
30,470	±1,521	30,470	(X)	8,216	±513		
28,842	±1,525	94.7%	±1.8	7,496	±502		
1,628	±559	5.3%	±1.8	720	±293		
28,842	±1,525	94.7%	±1.8	7,496	±502		
22,684	±1,245	74.4%	±3.1	3,483	±522		
2,837	±509	9.3%	±1.6	2,775	±639		
6	±7	0.0%	±0.1	0	±18		

Table: ACSDP5Y2021.DP05

		ZCTA5 12205				
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
8,216	(X)	26,255	±1,014	26,255	(X)	
51.9%	±4.2	13,181	±726	50.2%	±2.3	
48.1%	±4.2	13,074	±862	49.8%	±2.3	
(X)	(X)	100.8	±9.4	(X)	(X)	
10.9%	±2.9	1,234	±269	4.7%	±1.0	
7.3%	±3.0	1,259	±377	4.8%	±1.3	
4.7%	±2.0	1,453	±325	5.5%	±1.2	
5.1%	±2.8	1,809	±361	6.9%	±1.4	
6.0%	±2.9	1,529	±425	5.8%	±1.6	
21.9%	±4.4	3,105	±427	11.8%	±1.6	
12.4%	±2.8	3,201	±384	12.2%	±1.4	
8.5%	±2.6	3,570	±500	13.6%	±1.8	
5.6%	±2.0	1,814	±360	6.9%	±1.4	
6.5%	±2.3	1,932	±416	7.4%	±1.6	
6.3%	±2.2	3,113	±372	11.9%	±1.4	
3.4%	±1.6	1,511	±287	5.8%	±1.2	
1.2%	±1.0	725	±263	2.8%	±1.0	
(X)	(X)	43.2	±2.5	(X)	(X)	
8,216	(X)	26,255	±1,014	26,255	(X)	
91.2%	±3.4	25,149	±993	95.8%	±1.4	
8.8%	±3.4	1,106	±370	4.2%	±1.4	
91.2%	±3.4	25,149	±993	95.8%	±1.4	
42.4%	±6.8	21,727	±981	82.8%	±2.4	
33.8%	±7.2	1,333	±410	5.1%	±1.5	
0.0%	±0.5	30	±26	0.1%	±0.1	

Table: ACSDP5Y2021.DP05

ZCTA5 12206				ZCTA5 12207			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
15,693	±1,256	15,693	(X)	2,157	±426		
7,043	±815	44.9%	±3.8	1,180	±324		
8,650	±928	55.1%	±3.8	977	±295		
81.4	±12.6	(X)	(X)	120.8	±53.1		
606	±234	3.9%	±1.4	173	±156		
1,008	±329	6.4%	±2.0	128	±128		
1,555	±310	9.9%	±1.8	4	±12		
1,221	±286	7.8%	±1.7	0	±13		
1,991	±534	12.7%	±3.0	235	±138		
2,239	±386	14.3%	±2.1	580	±208		
2,074	±332	13.2%	±2.0	180	±75		
1,861	±315	11.9%	±1.9	144	±104		
667	±239	4.3%	±1.4	124	±78		
760	±207	4.8%	±1.3	235	±75		
1,101	±249	7.0%	±1.6	255	±112		
375	±134	2.4%	±0.9	79	±47		
235	±161	1.5%	±1.0	20	±23		
30.3	±2.5	(X)	(X)	33.7	±6.2		
15,693	±1,256	15,693	(X)	2,157	±426		
13,688	±1,214	87.2%	±3.3	2,094	±415		
2,005	±542	12.8%	±3.3	63	±66		
13,688	±1,214	87.2%	±3.3	2,094	±415		
4,477	±851	28.5%	±5.2	998	±188		
7,262	±1,016	46.3%	±4.8	995	±392		
79	±72	0.5%	±0.5	0	±13		

Table: ACSDP5Y2021.DP05

ZCTA5 12208						
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Percent Margin of Error
2,157	(X)	22,143	±1,286	22,143	(X)	(X)
54.7%	±10.5	10,077	±635	45.5%	±2.1	±2.1
45.3%	±10.5	12,066	±934	54.5%	±2.1	±2.1
(X)	(X)	83.5	±7.0	(X)	(X)	(X)
8.0%	±6.6	868	±182	3.9%	±0.8	±0.8
5.9%	±5.5	873	±263	3.9%	±1.2	±1.2
0.2%	±0.5	795	±213	3.6%	±0.9	±0.9
0.0%	±1.7	1,299	±300	5.9%	±1.2	±1.2
10.9%	±5.7	3,854	±611	17.4%	±2.4	±2.4
26.9%	±8.0	3,714	±538	16.8%	±2.1	±2.1
8.3%	±3.4	2,683	±296	12.1%	±1.4	±1.4
6.7%	±4.7	2,019	±380	9.1%	±1.6	±1.6
5.7%	±3.8	1,307	±265	5.9%	±1.2	±1.2
10.9%	±3.9	884	±250	4.0%	±1.1	±1.1
11.8%	±5.4	2,255	±354	10.2%	±1.6	±1.6
3.7%	±2.2	942	±217	4.3%	±1.0	±1.0
0.9%	±1.1	650	±256	2.9%	±1.1	±1.1
(X)	(X)	33.2	±2.3	(X)	(X)	(X)
2,157	(X)	22,143	±1,286	22,143	(X)	(X)
97.1%	±3.0	20,748	±1,177	93.7%	±2.0	±2.0
2.9%	±3.0	1,395	±471	6.3%	±2.0	±2.0
97.1%	±3.0	20,748	±1,177	93.7%	±2.0	±2.0
46.3%	±10.4	15,200	±1,058	68.6%	±3.3	±3.3
46.1%	±11.5	3,156	±631	14.3%	±2.7	±2.7
0.0%	±1.7	13	±17	0.1%	±0.1	±0.1

Table: ACSDP5Y2021.DP05

ZCTA5 12209				ZCTA5 12210			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
10,055	±1,182	10,055	(X)	10,807	±1,144		
4,653	±732	46.3%	±3.7	5,724	±621		
5,402	±649	53.7%	±3.7	5,083	±715		
86.1	±13.0	(X)	(X)	112.6	±14.9		
885	±302	8.8%	±2.5	319	±208		
753	±274	7.5%	±2.4	445	±166		
336	±161	3.3%	±1.5	532	±228		
355	±116	3.5%	±1.2	651	±317		
1,239	±642	12.3%	±5.8	1,160	±354		
1,407	±406	14.0%	±4.0	2,632	±522		
1,348	±513	13.4%	±4.6	1,210	±293		
1,126	±278	11.2%	±3.0	1,729	±687		
840	±236	8.4%	±2.5	365	±132		
624	±215	6.2%	±2.1	514	±212		
742	±337	7.4%	±3.3	772	±197		
233	±92	2.3%	±1.0	378	±139		
167	±90	1.7%	±0.9	100	±56		
35.1	±1.5	(X)	(X)	32.6	±3.4		
10,055	±1,182	10,055	(X)	10,807	±1,144		
9,670	±1,098	96.2%	±2.3	10,224	±1,189		
385	±246	3.8%	±2.3	583	±263		
9,670	±1,098	96.2%	±2.3	10,224	±1,189		
5,914	±973	58.8%	±7.4	5,046	±936		
1,913	±610	19.0%	±6.4	4,791	±880		
0	±20	0.0%	±0.4	0	±20		

Table: ACSDP5Y2021.DP05

		ZCTA5 12211				
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
10,807	(X)	14,094	±1,176	14,094	(X)	
53.0%	±3.3	6,805	±645	48.3%	±1.9	
47.0%	±3.3	7,289	±649	51.7%	±1.9	
(X)	(X)	93.4	±7.2	(X)	(X)	
3.0%	±1.9	839	±338	6.0%	±2.1	
4.1%	±1.6	576	±175	4.1%	±1.1	
4.9%	±1.9	845	±187	6.0%	±1.4	
6.0%	±2.7	1,643	±249	11.7%	±1.8	
10.7%	±3.0	1,888	±322	13.4%	±2.3	
24.4%	±4.7	967	±374	6.9%	±2.4	
11.2%	±2.9	1,457	±467	10.3%	±3.0	
16.0%	±5.7	1,416	±260	10.0%	±1.8	
3.4%	±1.3	1,077	±202	7.6%	±1.5	
4.8%	±1.9	724	±176	5.1%	±1.3	
7.1%	±1.8	1,627	±335	11.5%	±2.3	
3.5%	±1.2	605	±205	4.3%	±1.4	
0.9%	±0.5	430	±192	3.1%	±1.4	
(X)	(X)	36.7	±2.6	(X)	(X)	
10,807	(X)	14,094	±1,176	14,094	(X)	
94.6%	±2.5	13,453	±1,159	95.5%	±2.0	
5.4%	±2.5	641	±286	4.5%	±2.0	
94.6%	±2.5	13,453	±1,159	95.5%	±2.0	
46.7%	±6.9	11,388	±1,067	80.8%	±4.4	
44.3%	±6.4	493	±198	3.5%	±1.4	
0.0%	±0.3	6	±10	0.0%	±0.1	

Table: ACSDP5Y2021.DP05

ZCTA5 12222				ZCTA5 12226			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
6,767	±658	6,767	(X)	0			
3,040	±420	44.9%	±3.4	0			
3,727	±378	55.1%	±3.4	0			
81.6	±11.3	(X)	(X)	-			**
0	±18	0.0%	±0.6	0			±13
0	±18	0.0%	±0.6	0			±13
0	±18	0.0%	±0.6	0			±13
3,823	±459	56.5%	±4.4	0			±13
2,905	±428	42.9%	±4.4	0			±13
13	±15	0.2%	±0.2	0			±13
11	±21	0.2%	±0.3	0			±13
0	±18	0.0%	±0.6	0			±13
0	±18	0.0%	±0.6	0			±13
2	±4	0.0%	±0.1	0			±13
2	±2	0.0%	±0.1	0			±13
5	±4	0.1%	±0.1	0			±13
6	±5	0.1%	±0.1	0			±13
19.8	±0.2	(X)	(X)	-			**
6,767	±658	6,767	(X)	0			±13
6,369	±608	94.1%	±1.5	0			±13
398	±116	5.9%	±1.5	0			±13
6,369	±608	94.1%	±1.5	0			±13
4,099	±463	60.6%	±3.4	0			±13
1,529	±249	22.6%	±3.0	0			±13
0	±18	0.0%	±0.6	0			±13

Table: ACSDP5Y2021.DP05

Percent	Percent Margin of Error
0	(X)
-	**
-	**
(X)	(X)
-	**
-	**
-	**
-	**
-	**
-	**
-	**
-	**
-	**
-	**
-	**
-	**
-	**
(X)	(X)
0	(X)
-	**
-	**
-	**
-	**
-	**
-	**

Table: ACSDP5Y2021.DP05

Asian	1,248	±530	5.4%	±2.2
Native Hawaiian and Other Pacific Islander	23	±39	0.1%	±0.2
Some other race	37	±36	0.2%	±0.2
Two or more races	1,585	±584	6.8%	±2.5
<b>HISPANIC OR LATINO AND RACE</b>				
Total population	23,236	±696	23,236	(X)
Hispanic or Latino (of any race)	1,293	±462	5.6%	±1.9
Not Hispanic or Latino	21,943	±715	94.4%	±1.9
<b>HEALTH INSURANCE COVERAGE</b>				
Civilian noninstitutionalized population	22,363	±775	22,363	(X)
With health insurance coverage	21,674	±795	96.9%	±1.2
With private health insurance	15,643	±942	70.0%	±3.4
With public coverage	9,596	±906	42.9%	±3.9
No health insurance coverage	689	±263	3.1%	±1.2
<b>DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION</b>				
Total Civilian Noninstitutionalized Population	22,363	±775	22,363	(X)
With a disability	3,304	±487	14.8%	±2.2

Table: ACSDP5Y2021.DP05

1,908	±483	9.6%	±2.2	1,030	±300
0	±20	0.0%	±0.2	0	±24
39	±32	0.2%	±0.2	128	±84
1,104	±454	5.6%	±2.3	1,229	±303
19,825	±1,170	19.825	(X)	21,623	±983
600	±284	3.0%	±1.5	1,026	±327
19,225	±1,222	97.0%	±1.5	20,597	±969
19,135	±1,147	19.135	(X)	21,521	±984
18,581	±1,199	97.1%	±1.6	20,660	±982
15,950	±1,101	83.4%	±3.0	16,846	±1,182
6,130	±751	32.0%	±3.6	7,391	±667
554	±298	2.9%	±1.6	861	±265
19,135	±1,147	19.135	(X)	21,521	±984
1,767	±334	9.2%	±1.6	3,343	±486

Table: ACSDP5Y2021.DP05

4.8%	±1.4	2,703	±364	5.0%	±0.7
0.0%	±0.2	0	±30	0.0%	±0.1
0.6%	±0.4	1,375	±360	2.6%	±0.7
5.7%	±1.4	3,539	±518	6.6%	±0.9
21,623	(X)	53,729	±1,263	53.729	(X)
4.7%	±1.5	4,072	±493	7.6%	±0.9
95.3%	±1.5	49,657	±1,232	92.4%	±0.9
21,521	(X)	52,713	±1,264	52.713	(X)
96.0%	±1.2	50,984	±1,240	96.7%	±0.6
78.3%	±3.4	36,892	±1,316	70.0%	±1.9
34.3%	±3.4	20,966	±1,227	39.8%	±2.1
4.0%	±1.2	1,729	±308	3.3%	±0.6
21,521	(X)	52,713	±1,264	52.713	(X)
15.5%	±2.4	8,334	±633	15.8%	±1.2

Table: ACSDP5Y2021.DP05

0	±13	0.0%	±1.3	1,755	±496
0	±13	0.0%	±1.3	0	±20
211	±267	7.1%	±9.0	602	±238
293	±251	9.9%	±8.5	1,279	±378
2,957	±16	2.957	(X)	18,277	±928
314	±277	10.6%	±9.4	1,418	±390
2,643	±278	89.4%	±9.4	16,859	±936
2,957	±16	2,957	(X)	18,239	±934
2,816	±105	95.2%	±3.5	17,735	±958
1,712	±397	57.9%	±13.4	12,789	±930
1,561	±370	52.8%	±12.5	7,491	±611
141	±103	4.8%	±3.5	504	±204
2,957	±16	2,957	(X)	18,239	±934
550	±207	18.6%	±7.0	2,771	±409

Table: ACSDP5Y2021.DP05

9.6%	±2.6	520	±305	6.0%	±3.3
0.0%	±0.2	0	±18	0.0%	±0.4
3.3%	±1.3	218	±164	2.5%	±1.9
7.0%	±2.0	1,105	±446	12.7%	±4.9
18,277	(X)	8,716	±1,022	8,716	(X)
7.8%	±2.1	1,398	±448	16.0%	±4.9
92.2%	±2.1	7,318	±981	84.0%	±4.9
18,239	(X)	8,716	±1,022	8,716	(X)
97.2%	±1.1	8,055	±1,007	92.4%	±3.1
70.1%	±3.2	3,875	±700	44.5%	±6.3
41.1%	±3.3	5,068	±828	58.1%	±5.4
2.8%	±1.1	661	±268	7.6%	±3.1
18,239	(X)	8,716	±1,022	8,716	(X)
15.2%	±2.3	1,621	±316	18.6%	±3.3

Table: ACSDP5Y2021.DP05

2,490	±547	8.2%	±1.7	879	±358
32	±54	0.1%	±0.2	108	±93
793	±447	2.6%	±1.4	251	±198
1,628	±559	5.3%	±1.8	720	±293
30,470	±1,521	30,470	(X)	8,216	±513
1,515	±449	5.0%	±1.4	488	±255
28,955	±1,409	95.0%	±1.4	7,728	±543
29,905	±1,532	29,905	(X)	8,206	±518
29,065	±1,525	97.2%	±1.0	7,928	±492
25,219	±1,479	84.3%	±1.9	6,255	±654
8,339	±761	27.9%	±2.4	2,822	±627
840	±290	2.8%	±1.0	278	±100
29,905	±1,532	29,905	(X)	8,206	±518
3,413	±558	11.4%	±1.8	882	±233

Table: ACSDP5Y2021.DP05

10.7%	±4.3	1,885	±501	7.2%	±1.9
1.3%	±1.1	30	±48	0.1%	±0.2
3.1%	±2.4	144	±101	0.5%	±0.4
8.8%	±3.4	1,106	±370	4.2%	±1.4
8,216	(X)	26,255	±1,014	26,255	(X)
5.9%	±3.1	1,665	±553	6.3%	±2.1
94.1%	±3.1	24,590	±1,123	93.7%	±2.1
8,206	(X)	26,251	±1,013	26,251	(X)
96.6%	±1.2	25,702	±1,031	97.9%	±0.8
76.2%	±6.4	21,284	±1,030	81.1%	±3.4
34.4%	±7.3	9,292	±975	35.4%	±3.3
3.4%	±1.2	549	±212	2.1%	±0.8
8,206	(X)	26,251	±1,013	26,251	(X)
10.7%	±3.0	2,834	±381	10.8%	±1.5

Table: ACSDP5Y2021.DP05

1,546	±494	9.9%	±3.0	20	±21
0	±20	0.0%	±0.2	0	±13
324	±194	2.1%	±1.2	81	±79
2,005	±542	12.8%	±3.3	63	±66
15,693	±1,256	15.693	(X)	2,157	±426
2,123	±568	13.5%	±3.5	135	±103
13,570	±1,214	86.5%	±3.5	2,022	±432
15,624	±1,253	15.624	(X)	2,157	±426
14,661	±1,156	93.8%	±2.1	1,911	±403
6,792	±1,011	43.5%	±5.3	989	±240
9,657	±930	61.8%	±4.5	1,069	±293
963	±362	6.2%	±2.1	246	±113
15,624	±1,253	15.624	(X)	2,157	±426
3,232	±465	20.7%	±3.3	365	±83

Table: ACSDP5Y2021.DP05

0.9%	±1.0	1,917	±504	8.7%	±2.3
0.0%	±1.7	0	±24	0.0%	±0.2
3.8%	±3.7	462	±245	2.1%	±1.1
2.9%	±3.0	1,395	±471	6.3%	±2.0
2,157	(X)	22,143	±1,286	22,143	(X)
6.3%	±4.9	1,358	±396	6.1%	±1.6
93.7%	±4.9	20,785	±1,148	93.9%	±1.6
2,157	(X)	21,726	±1,251	21,726	(X)
88.6%	±5.0	21,037	±1,256	96.8%	±1.1
45.9%	±8.5	16,909	±1,136	77.8%	±2.8
49.6%	±7.6	7,192	±822	33.1%	±3.3
11.4%	±5.0	689	±234	3.2%	±1.1
2,157	(X)	21,726	±1,251	21,726	(X)
16.9%	±4.9	1,955	±341	9.0%	±1.6

Table: ACSDP5Y2021.DP05

898	±592	8.9%	±5.7	331	±195
0	±20	0.0%	±0.4	0	±20
945	±689	9.4%	±6.5	56	±53
385	±246	3.8%	±2.3	583	±263
10,055	±1,182	10,055	(X)	10,807	±1,144
1,856	±867	18.5%	±7.4	659	±299
8,199	±900	81.5%	±7.4	10,148	±1,156
9,996	±1,182	9,996	(X)	10,625	±1,157
9,538	±1,075	95.4%	±2.4	10,076	±1,135
6,224	±926	62.3%	±7.1	6,391	±1,026
4,613	±784	46.1%	±6.5	4,889	±751
458	±265	4.6%	±2.4	549	±218
9,996	±1,182	9,996	(X)	10,625	±1,157
1,401	±452	14.0%	±4.8	1,239	±305

Table: ACSDP5Y2021.DP05

3.1%	±1.8	1,440	±597	10.2%	±4.1
0.0%	±0.3	8	±15	0.1%	±0.1
0.5%	±0.5	118	±65	0.8%	±0.5
5.4%	±2.5	641	±286	4.5%	±2.0
10,807	(X)	14,094	±1,176	14,094	(X)
6.1%	±2.8	668	±229	4.7%	±1.7
93.9%	±2.8	13,426	±1,204	95.3%	±1.7
10,625	(X)	13,821	±1,154	13,821	(X)
94.8%	±2.0	13,629	±1,124	98.6%	±0.8
60.2%	±6.3	12,346	±1,136	89.3%	±2.7
46.0%	±6.0	3,538	±671	25.6%	±4.8
5.2%	±2.0	192	±118	1.4%	±0.8
10,625	(X)	13,821	±1,154	13,821	(X)
11.7%	±2.7	1,069	±240	7.7%	±1.8

Table: ACSDPSY2021.DP05

362	±124		5.3%	±1.7	0	±13
10	±19		0.1%	±0.3	0	±13
369	±89		5.5%	±1.4	0	±13
398	±116		5.9%	±1.5	0	±13
6,767	±658		6,767	(X)	0	±13
1,246	±197		18.4%	±2.5	0	±13
5,521	±582		81.6%	±2.5	0	±13
6,752	±659		6,752	(X)	0	±13
6,503	±627		96.3%	±1.5	0	±13
5,860	±589		86.8%	±2.3	0	±13
757	±159		11.2%	±2.2	0	±13
249	±107		3.7%	±1.5	0	±13
6,752	±659		6,752	(X)	0	±13
338	±108		5.0%	±1.6	0	±13

Table: ACSDP5Y2021.DP05

-	**
-	**
-	**
-	**
-	
0	(X)
-	**
-	**
-	
-	
0	(X)
-	**
-	**
-	**
-	**
-	
0	(X)
-	**

Table: ACSDP5Y2021.DP03

ZCTA5 12047					
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	
<b>PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL</b>					
All families	(X)	(X)	9.7%	±3.4	
<b>INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)</b>					
Median household income (dollars)	65,147	±6,177	(X)	(X)	
With Food Stamp/SNAP benefits in the past 12 months	1,433	±281	14.5%	±2.8	
<b>EMPLOYMENT STATUS</b>					
Population 16 years and over Civilian labor force					
Unemployed	747	±261	4.0%	±1.4	
<b>EDUCATIONAL ATTAINMENT</b>					
Population 25 years and over	16,024	±630	16,024	(X)	
High school graduate or higher	14,676	±662	91.6%	±1.9	
<b>VEHICLES AVAILABLE</b>					
Occupied housing units	9,863	±488	9,863	(X)	
No vehicles available	1,135	±281	11.5%	±2.7	

Table: ACSDP5Y2021.DP03

ZCTA5 12110				ZCTA5 12144			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
(X)	(X)	2.5%	±1.6	(X)	(X)		
93,533	±5,621	(X)	(X)	85,993	±4,679		
243	±109	3.1%	±1.4	909	±175		
447	±167	2.7%	±1.0	384	±151		
13,638	±828	13,638	(X)	16,398	±691		
12,850	±794	94.2%	±1.6	15,349	±732		
7,749	±477	7,749	(X)	9,380	±415		
464	±170	6.0%	±2.2	790	±207		

Table: ACSDP5Y2021.DP03

		ZCTA5 12180				
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
4.5%	±2.3	(X)	(X)	12.8%	±2.5	
(X)	(X)	61,595	±2,963	(X)	(X)	
9.7%	±1.9	3,262	±353	14.9%	±1.6	
2.1%	±0.8	2,173	±303	4.8%	±0.7	
16,398	(X)	35,333	±937	35,333	(X)	
93.6%	±1.7	31,832	±958	90.1%	±1.2	
9,380	(X)	21,958	±678	21,958	(X)	
8.4%	±2.2	3,331	±349	15.2%	±1.5	

Table: ACSDP5Y2021.DP03

ZCTA5 12183				ZCTA5 12189			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
(X)	(X)	12.8%	±9.0	(X)	(X)		
57,750	±21,887	(X)	(X)	53,443	±4,470		
278	±110	21.7%	±9.2	1,159	±234		
152	±78	6.3%	±3.3	330	±165		
1,895	±306	1,895	(X)	13,132	±679		
1,651	±314	87.1%	±7.5	11,869	±674		
1,282	±216	1,282	(X)	8,694	±411		
197	±90	15.4%	±6.4	1,065	±251		

Table: ACSDP5Y2021.DP03

ZCTA5 12202						
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
9.9%	±3.0	(X)	(X)	24.4%	±9.3	
(X)	(X)	45,659	±9,526	(X)	(X)	
13.3%	±2.9	1,365	±254	32.5%	±6.6	
2.2%	±1.1	418	±223	6.0%	±3.0	
13,132	(X)	6,260	±691	6,260	(X)	
90.4%	±2.2	5,275	±672	84.3%	±4.7	
8,694	(X)	4,203	±411	4,203	(X)	
12.2%	±2.8	1,427	±296	34.0%	±6.2	

Table: ACSDP5Y2021.DP03

ZCTA5 12203				ZCTA5 12204			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
(X)	(X)	3.9%	±1.8	(X)	(X)		
71,001	±4,654	(X)	(X)	62,391	±5,704		
967	±259	7.0%	±1.8	529	±195		
591	±216	2.2%	±0.8	474	±255		
20,424	±1,218	20,424	(X)	5,418	±415		
19,402	±1,192	95.0%	±1.3	4,967	±405		
13,755	±791	13,755	(X)	3,819	±323		
1,802	±380	13.1%	±2.5	488	±198		

Table: ACSDP5Y2021.DP03

Percent		ZCTA5 12205				
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
13.7%	±7.3	(X)	(X)	3.4%	±2.1	
(X)	(X)	83,103	±5,165	(X)	(X)	
13.9%	±4.8	781	±216	6.9%	±2.0	
7.6%	±3.9	400	±171	1.8%	±0.8	
5,418	(X)	18,971	±856	18,971	(X)	
91.7%	±2.4	17,530	±848	92.4%	±1.5	
3,819	(X)	11,324	±603	11,324	(X)	
12.8%	±5.0	1,198	±301	10.6%	±2.4	

Table: ACSDP5Y2021.DP03

ZCTA5 12206				ZCTA5 12207			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
(X)	(X)	34.6%	±7.0	(X)	(X)		
32,994	±7,590	(X)	(X)	22,670	±8,115		
2,527	±355	39.2%	±4.9	534	±141		
1,190	±331	9.8%	±2.7	72	±59		
9,312	±795	9.312	(X)	1,617	±307		
7,509	±717	80.6%	±3.3	1,366	±308		
6,443	±519	6.443	(X)	1,225	±198		
2,762	±375	42.9%	±5.1	536	±143		

Table: ACSDP5Y2021.DP03

		ZCTA5 12208				
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
41.5%	±34.7	(X)	(X)	2.7%	±1.7	
(X)	(X)	66,624	±6,237	(X)	(X)	
43.6%	±8.5	794	±213	8.0%	±2.1	
3.9%	±3.1	656	±240	3.4%	±1.2	
1,617	(X)	14,454	±794	14,454	(X)	
84.5%	±5.7	13,514	±764	93.5%	±1.3	
1,225	(X)	9,876	±508	9,876	(X)	
43.8%	±10.6	1,324	±228	13.4%	±2.4	

Table: ACSDPY2021.DP03

ZCTA5 12209				ZCTA5 12210			
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
(X)	(X)	5.1%	±5.4	(X)	(X)		
68,185	±8,120	(X)	(X)	47,177	±8,671		
772	±240	18.2%	±5.8	1,033	±367		
157	±110	2.0%	±1.3	455	±209		
6,487	±679	6.487	(X)	7,700	±833		
5,631	±667	86.8%	±5.1	7,127	±847		
4,247	±378	4.247	(X)	5,475	±503		
543	±233	12.8%	±5.8	1,846	±359		

Table: ACSDPSY2021.DP03

ZCTA5 12211						
Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	
12.3%	±6.5	(X)	(X)	2.8%	±2.4	
(X)	(X)	121,209	±17,423	(X)	(X)	
18.9%	±6.2	39	±40	0.9%	±0.9	
4.8%	±2.1	143	±67	1.2%	±0.6	
7,700	(X)	8,303	±789	8,303	(X)	
92.6%	±2.7	8,141	±773	98.0%	±0.8	
5,475	(X)	4,431	±385	4,431	(X)	
33.7%	±6.3	254	±175	5.7%	±3.8	

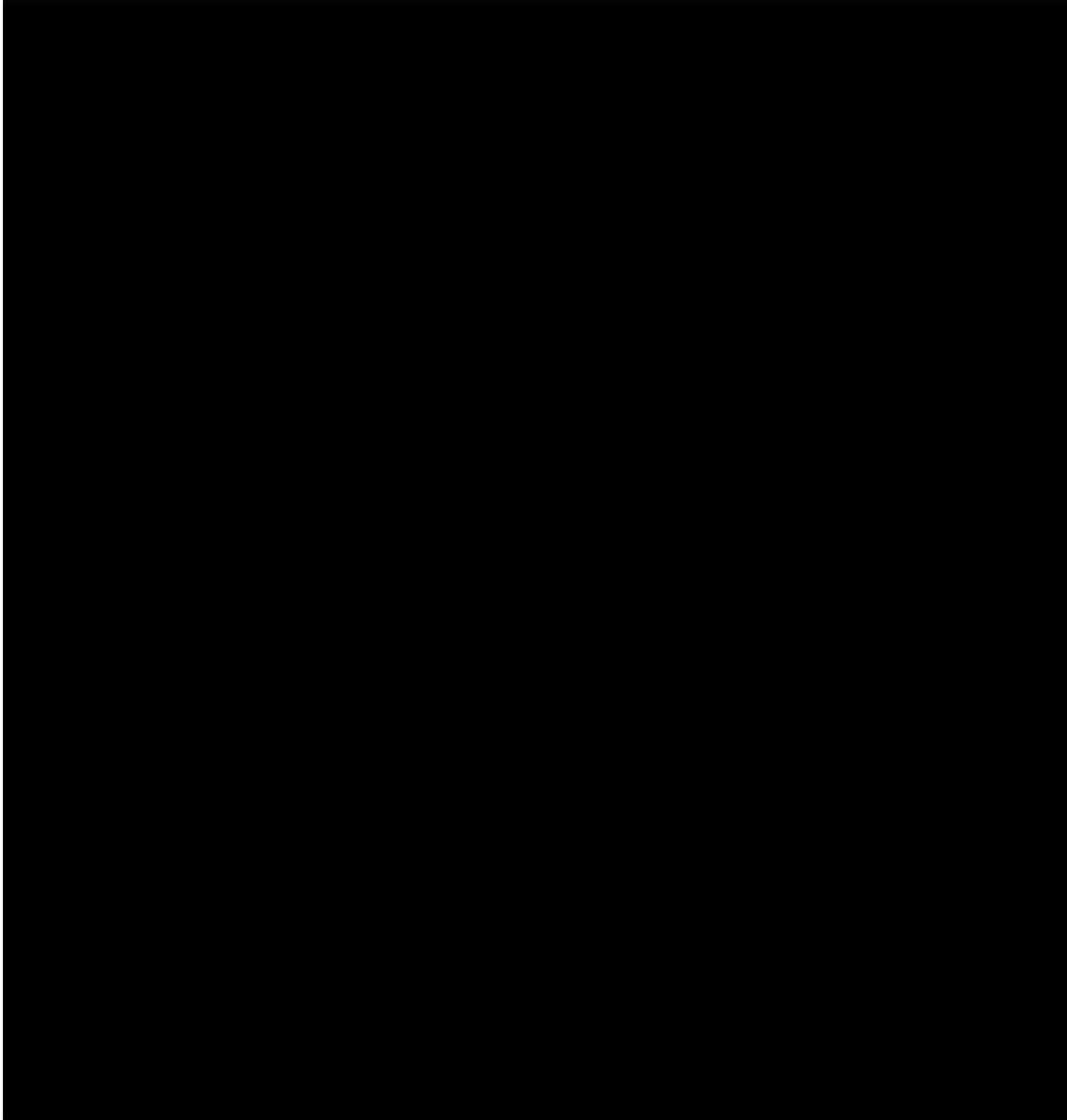
Table: ACSDP5Y2021.DP03

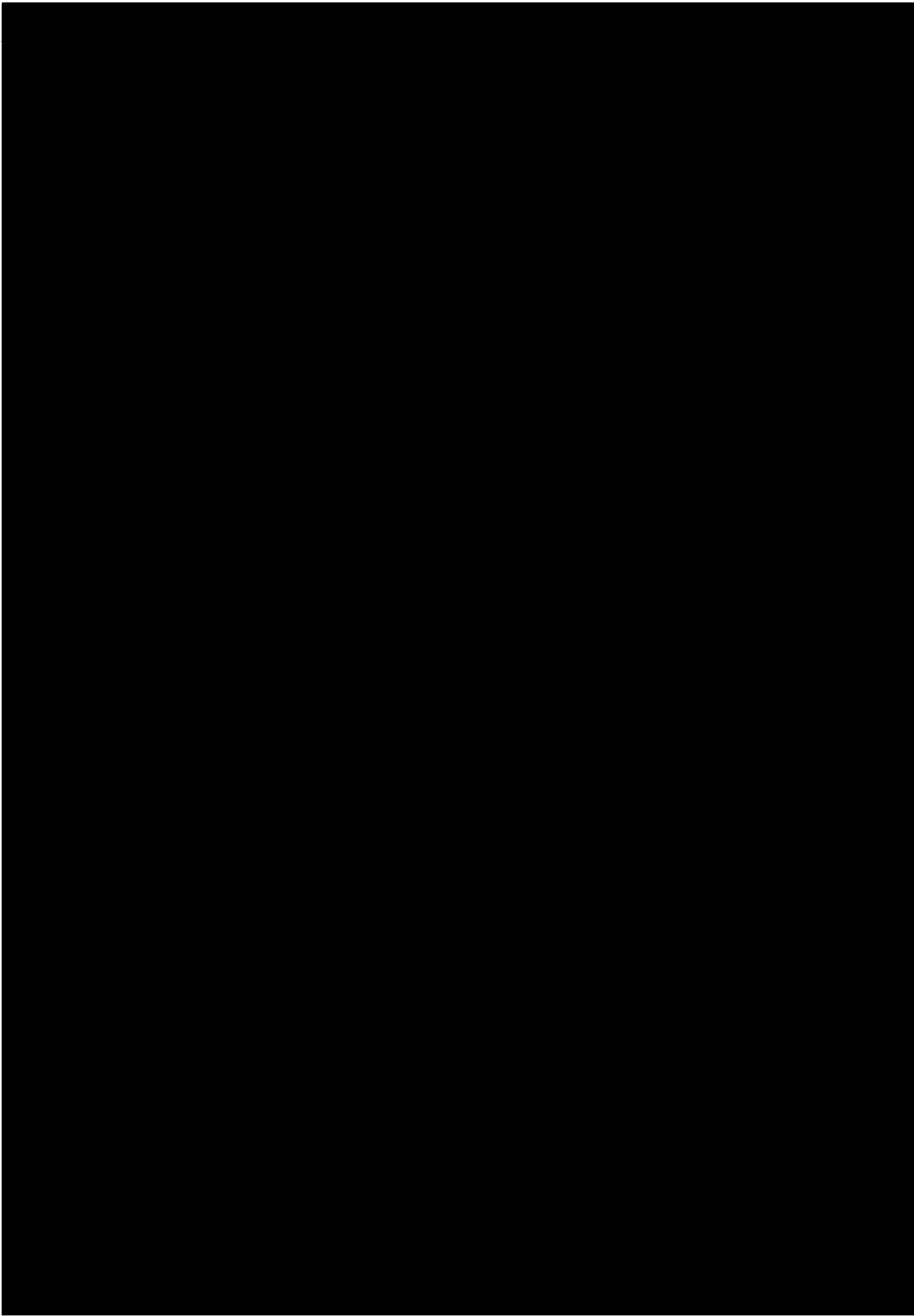
ZCTA5 12222			ZCTA5 12226		
Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error
(X)	(X)	-	**	(X)	(X)
-	**	(X)	(X)	-	**
0	±18	-	**	0	±13
442	±113	6.5%	±1.6	0	±13
39	±26	39	(X)	0	±13
39	±26	100.0%	±51.0	0	±13
0	±18	0	(X)	0	±13
0	±18	-	**	0	±13

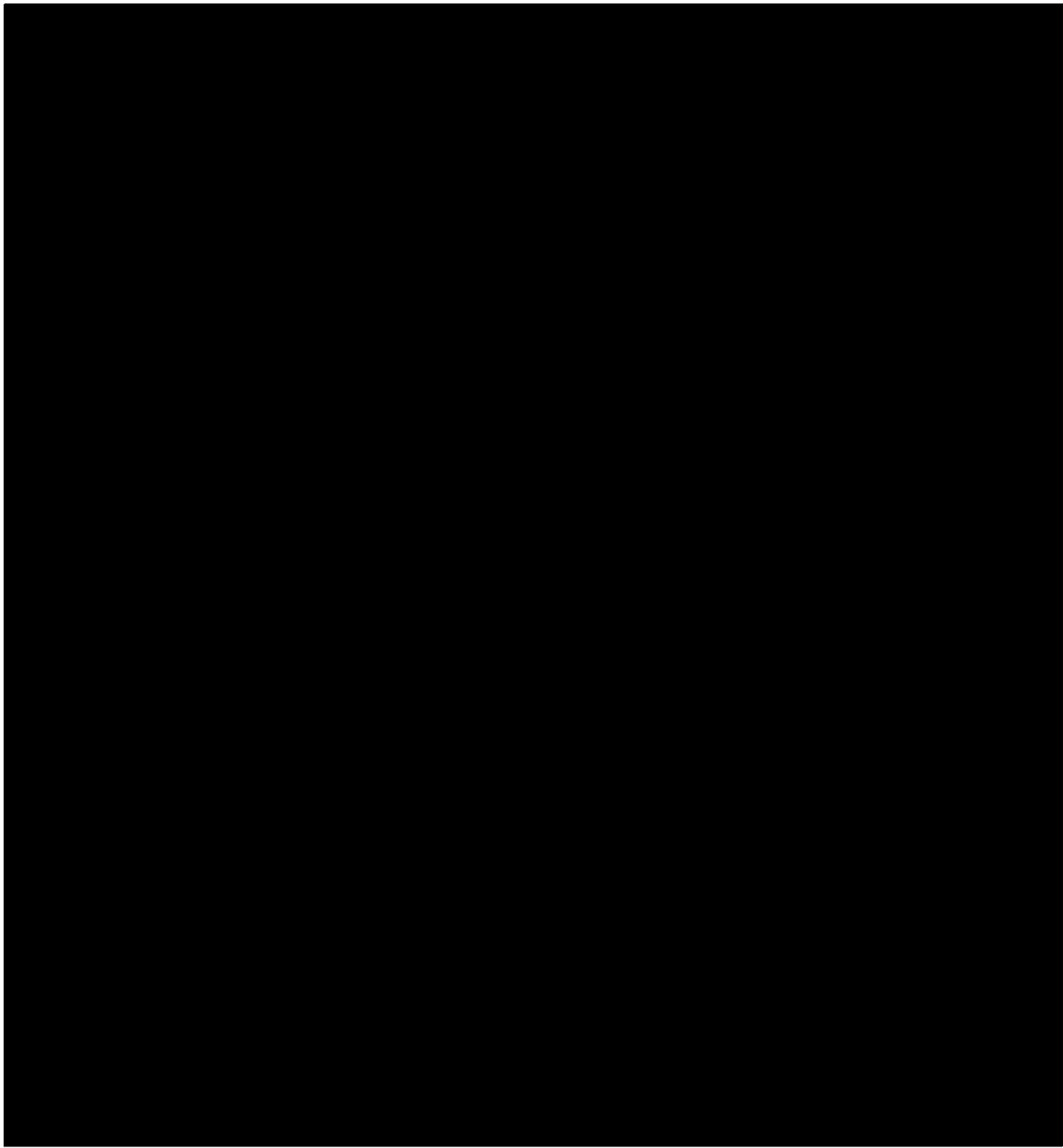
Table: ACSDPSY2021.DP03

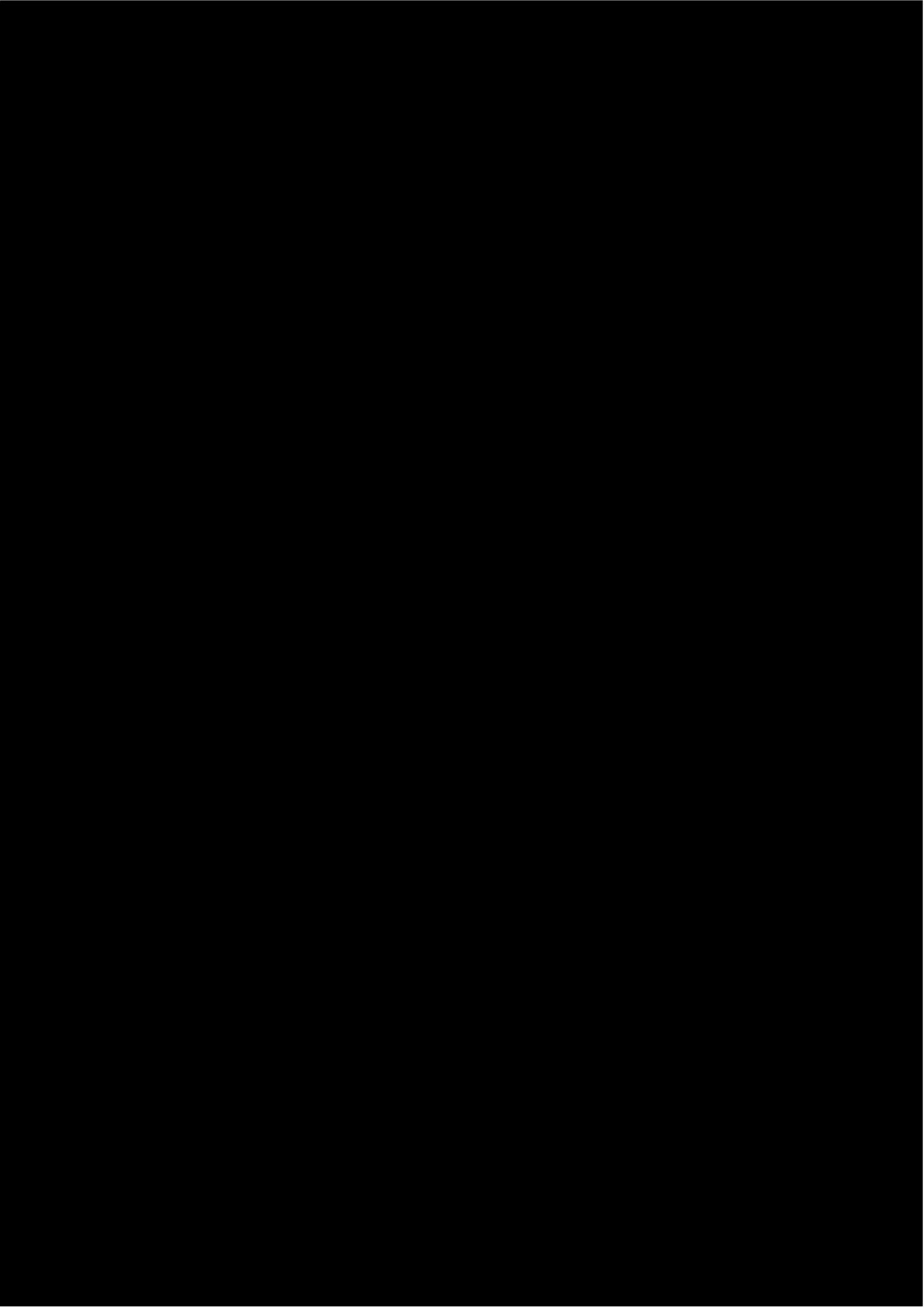
Percent	Percent Margin of Error
-	**
(X)	(X)
-	**
-	**
0	(X)
-	**
0	(X)
-	**

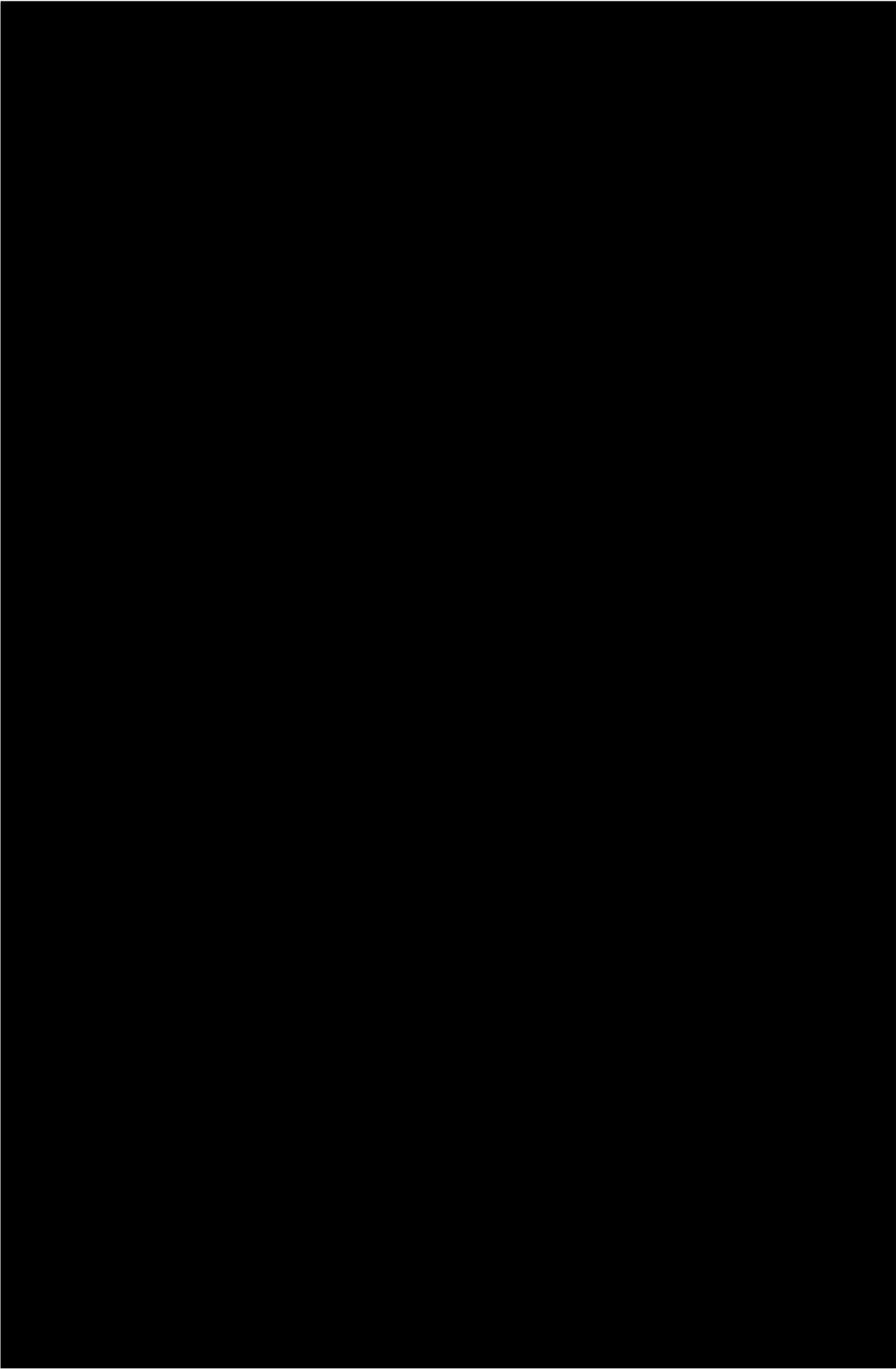
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Owings Mills, Maryland 21117  
410 998 9310 fax 410 998 9320  
[www.thevincagroup.com](http://www.thevincagroup.com)

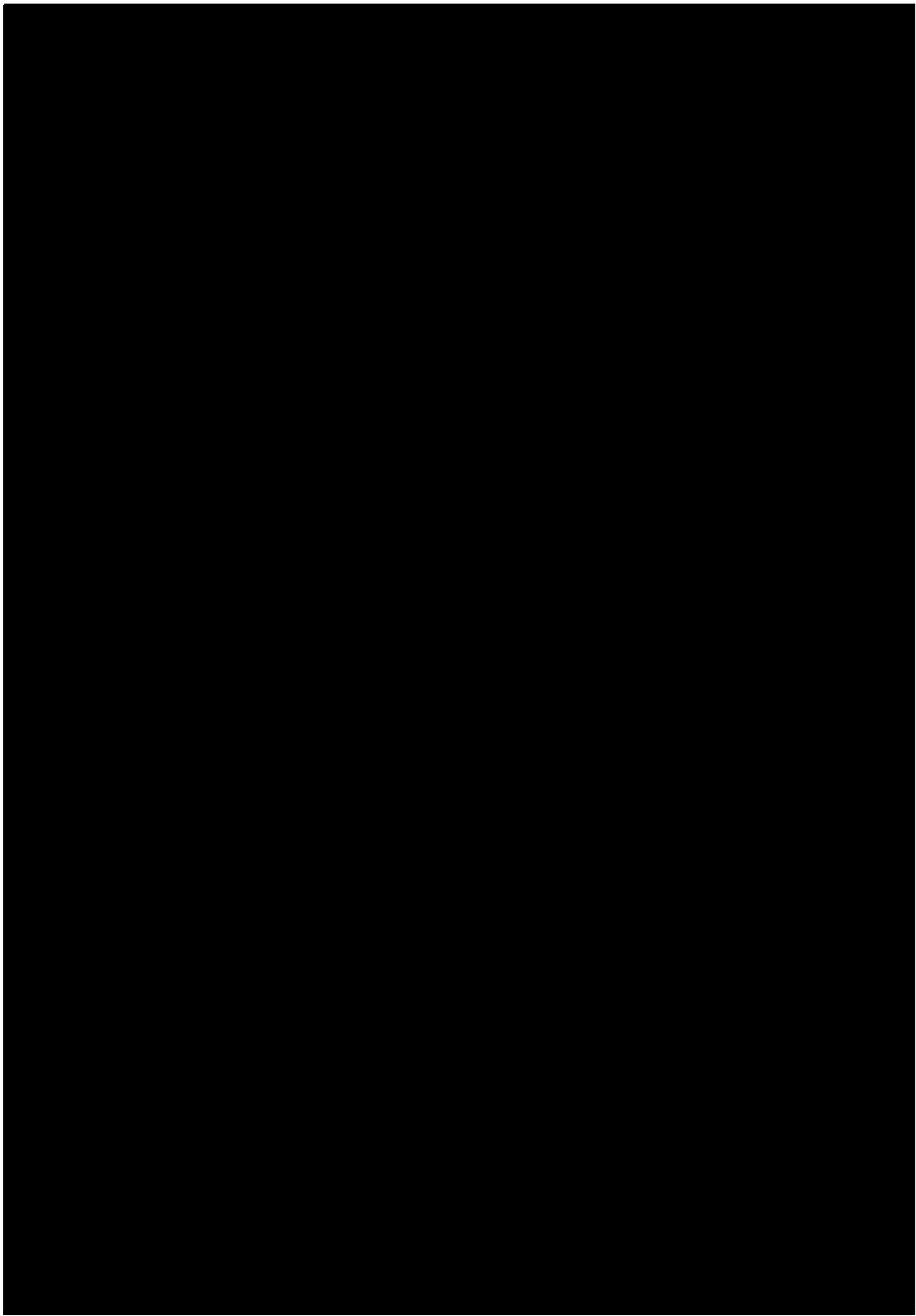














# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
9/15/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> Hamilton Insurance Agency 4100 Monument Corner Drive Suite 500 Fairfax VA 22030		<b>CONTACT NAME:</b> <b>PHONE (A/C, No, Ext):</b> <b>E-MAIL ADDRESS:</b>
License#: 600568 VINCGRO-02		<b>INSURER A:</b> <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>
<b>INSURED</b> The Vir 10461 Owings		

**COVERAGES**                      **CERTIFICATE NUMBER:** 1869227565                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:				6/30/2023	6/30/2024	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Employee Benefits
A	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY				6/30/2023	6/30/2024	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000				6/30/2023	6/30/2024	EACH OCCURRENCE AGGREGATE
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below				6/30/2023	6/30/2024	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT
C	Professional Liability Retro Date 7/1/1994				8/25/2023	8/25/2025	Aggregate Deductible per Claim

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
Coverage is provided in accordance with your written contract/agreement and subject to all terms, conditions and exclusions of the policy.

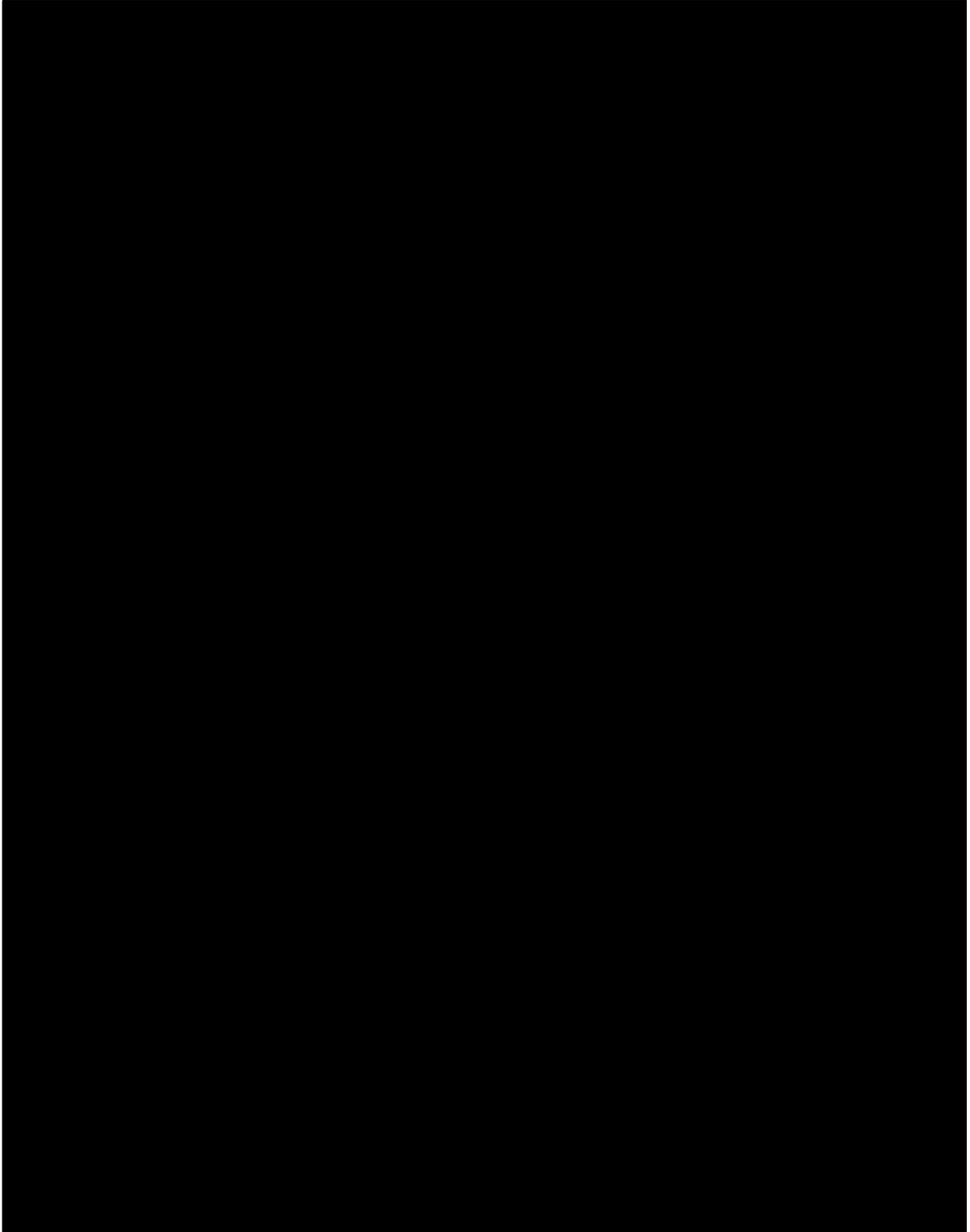
<b>CERTIFICATE HOLDER</b>  For Informational Purposes Only	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE 



**DIALYSIS CENTERS  
ALBANY REGIONAL RELOCATION  
ALBANY, NY  
MARKET AREA**

Facility Name	Address	City	St	Zip	County	Stations	Market Share
DCI - Mount Hope	270 Mount Hope Drive	Albany	New York	12202	Albany	18	10.5%
DCI-Rubin Dialysis Centers	1850 Peoples Ave	Troy	New York	12180	Rensselaer	19	11.1%
Dialysis Clinic Inc	176 Washington Avenue Extension	Albany	New York	12203	Albany	18	10.5%
FKC - Latham Dialysis Center	30 Century Hill Drive	Latham	New York	12110	Albany	12	7.0%
FMS - Westmere Dialysis Center	178 Washington Avenue Extension	Albany	New York	12203	Albany	17	9.9%
FMS-Albany Dialysis Center	64 Albany-Shaker Rd	Albany	New York	12204	Albany	24	14.0%
FMS-Albany Regional Kidney Center	2 Clara Barton Drive	Albany	New York	12208	Albany	34	19.9%
Fresenius Kidney Care - Troy	16 North Greenbush Road	Troy	New York	12180	Rensselaer	12	7.0%
Latham Dialysis	356 Troy Schenectady Road	Latham	New York	12110	Albany	17	9.9%

**APPENDIX A**



- Development of post acute services for young traumatic brain injury patients
- Market study to evaluate the need for low income housing for people ages 55 and older and persons with disabilities in a primarily African American neighborhood.

[REDACTED] clients benefit from decades of work experience in nationally known companies that provide consulting services and operate acute care, post-acute and senior housing services. We bring a team of seasoned professionals who have worked together for many years and are experienced as planners and operators for a variety of private and publicly traded companies.

