New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: Central New York Eye Center, LTD.

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

SIGNATURE	DATE
	04/07/2025
PRINT OR TYPE NAME	TITLE
Satish Modi, M.D	CEO

General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project	YES ☒ NO ☐	Attachment 1
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart	YES ☐ NO ☒	

Contacts

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

Primary Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
ANN M GORMLEY	EMPIRE HEALTH ADVISORS	
BUSINESS STREET ADDRESS		
60 RAILROAD PLACE, SUITE 101		
CITY	STATE	ZIP
SARATOGA SPRINGS	NY	12866
TELEPHONE	E-MAIL ADDRESS	
518-583-4900	Gorm707@aol.com	

Alternate Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
PATRICIA HASBROUCK	EMPIRE HEALTH ADVISORS	
BUSINESS STREET ADDRESS		
60 RAILROAD PLACE, SUITE 101		
CITY	STATE	ZIP
SARATOGA SPRINGS	NY	12866
TELEPHONE	E-MAIL ADDRESS	
518 583-4900	phasbrouck@empirehealth.com	

New York State Department of Health
Certificate of Need Application

Schedule 1

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

CHIEF EXECUTIVE

NAME AND TITLE		
SATISH MODI, M.D., CEO		
BUSINESS STREET ADDRESS		
22 Green Street		
CITY	STATE	ZIP
Poughkeepsie	NY	12601
TELEPHONE	E-MAIL ADDRESS	
845-629-6280	smodieyes@aol.com	

The applicant's lead attorney should be identified:

ATTORNEY

NAME	FIRM	BUSINESS STREET ADDRESS
RICHARD WRIGHT	RICHARD WRIGHT PLLC	276 Fifth Avenue, Suite 703-3040
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
New York, NY 10036	973-818-1092	richard@wrightlawyer.net

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

CONSULTANT

NAME	FIRM	BUSINESS STREET ADDRESS
Ann Gormley	Empire Health Advisors	60 Railroad Place, Suite 101
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
Saratoga Springs, NY 12866	518-583-4900	Gorm707@aol.com

The applicant's lead accountant should be identified:

ACCOUNTANT

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

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER

NAME	FIRM	BUSINESS STREET ADDRESS
Raymond P VanVooorhis	Liscum,McCormack & VanVoorhis	181 Church Street
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
Poughkeepsie, NY 12601	845-452-2268	rvanvoorhis@LMVarchitects.com

ARCHITECT and/or ENGINEER

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

New York State Department of Health
Certificate of Need Application

Schedule 1

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

NYS Affiliated Facilities/Agencies

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

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

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

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

Out-of-State Affiliated Facilities/Agencies

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

Facility Type	Name	Address	State/Country	Services Provided

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

ATTACHMENT 1-NYS FACILITIES/AGENCIES

FACILITY TYPE	FACILITY NAME	OPERATING CERTIFICATE	FACILITY ID (PFI)
D&TC (ASC)	Central New York Eye Center, LTD	1302209R	4067

ATTACHMENT 1 BOARD RESOLUTION

BE IT RESOLVED, this 17th day of April, 2025 that the Central New York Eye Center, LTD. Approves the submission of a Certificate of Need application to the New York State Department of Health to move its operation from 22 Green Street, Poughkeepsie, NY 12601 to 23 Davis Avenue, Poughkeepsie, NY, 12603.

Satish Modi, M.D., CEO/President

Working Capital Financing Plan

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

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

Titles of Attachments Related to Borrowed Funds	Filenames of Attachments
Example: *First borrowed fund source*	Example: *first_bor_fund.pdf*
Not applicable	

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

2. Pro Forma Balance Sheet

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

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

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: **4/11/2025**	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? No If so, what is the original CON number? **We are not amending a previous CON**	
Intent/Purpose: **Expand and upgrade the existing Article 28 facility by moving to a larger and newly created space to facilitate better patient care delivery**	
Site Location: **23 Davis Avenue, Poughkeepsie, NY 12601**	

Brief description of current facility, including facility type: One story building that will house primarily the ASC in 11,588 square feet of space and one other medical tenant that will utilize separate and distinct space of 2,715 sf.	
Brief description of proposed facility: **The project is a relocated ASC moving to a building/space of a former ASC, with four (4) OR's and eleven (11) Pre-Post patient stations**	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. **See attached Functional Space Program**	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: **The existing building is formerly a "B"-med. office and healthcare ASC is being divided by a new 3hr.fire wall into a "B" Occupancy-medical office and a new ASC- Ambulatory Healthcare.** Click here to enter text.	
If this is an existing facility, is it currently a licensed Article 28 facility?	**No**
Is the project space being converted from a non-Article 28 space to an Article 28 space?	**No**
Relationship of spaces conforming with Article 28 space and non-Article 28 space: **NA**	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. **None**	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. **Entire new HVAC, Electrical plumbing, water and fire protection systems is proposed.**	**Yes**
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. **The existing building systems have been completely removed.**	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. **Replacement of HVAC and Electrical services/systems and new sprinkler systems**	
Describe existing and or new work for fire detection, alarm, and communication systems: **Existing systems are removed. The proposed fire detection, alarm and communication are totally new and code compliant.**	
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. **NA**	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. **Designed for future "C" Arm, physicist information is attached.** **The project does not contain Imaging Equipment. OR #1 is being designed (Lead lined) for future imaging equipment. See Physicist letter of certification and report.**	
Does the project comply with ADA? If no, list all areas of noncompliance. **Yes**	
Other pertinent information: **NA**	

Project Work Area	**Response**
Type of Work	**Renovation**

New York State Department of Health
Certificate of Need Application

Schedule 6

Square footages of existing areas, existing floor and or existing building.	**Total existing building:14,303 sf.**
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	**New ASC- ambulatory healthcare scope of work area:11,588 sf.**
Does the work area exceed more than 50% of the smoke compartment, floor or building?	**Exceeds 50% of the building**
Sprinkler protection per NFPA 101 Life Safety Code	**Will be sprinklered as part of the work.**
Construction Type per NFPA 101 Life Safety Code and NFPA 220	**Type V (000)**
Building Height	**20'-3"**
Building Number of Stories	**1**
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. Adjacent to space is an---use separated by a fire wall	**Yes Adjacent "B" Business med. office**
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.	Choose an item. **no**
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	No
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	**Not applicable**
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	**No**
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	**Yes**
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	**Yes**
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	**Yes**
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Construct 4 new OR's	**Yes**
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?	**No**
Does the project involve a pool?	**No**

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS

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

Date: 4-7-25
CON Number:
Facility Name: Central New York Eye Center LTD
Facility ID Number: 4067
Facility Address:(Current) 22 Green Street, Poughkeepsie, NY 12601

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

To The New York State Department of Health:

I hereby certify that:

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

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

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

   a. __712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. X_715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:

   _____

   _____

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

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

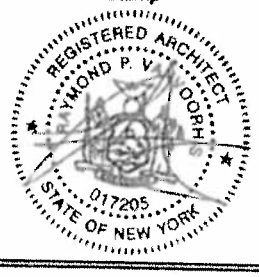
This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative,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

Project Name: Central New York Eye Center LTD

Location: 23 Davis Avenue, Poughkeepsie, NY 12603

Description: Relocation of an existing D&TC to this completely renovated space

Architectural or Engineering Professional Stamp



Signature of Architect or Engineer

Raymond VanVoorhis
Name of Architect or Engineer (Print)

17205
Professional New York State License Number

181 Church Street, Poughkeepsie, NY 12601
Business Address

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

Authorized Signature for Applicant

04/07/2025
Date

SATISH MEDI MD / OWNER
Name (Print) Title

Notary signing required for the applicant

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

On the 7th day of April 2025 before me personally appeared Satish Modi, to me known, who being by me duly sworn, did depose and say that he/she is the applicant of the Central New York Eye Center LTD, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary) Lois A. Carver

LOIS A. CARVER
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01CA4808214
Qualified in Dutchess County
Commission Expires June 30, 2026

Liscum
McCormack
VanVoorhis
ARCHITECTURE
PLANNING
INTERIORS
181 Church Street
Poughkeepsie, NY 12601
845-452-2268
www.LMVarchitects.com

Date: 4-25-25

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

Name: Central New York Eye Center LTD
Location: 23 Davis Avenue, Poughkeepsie, NY 12603
Description: Relocation of an existing D&TC to this completely renovated space

To The New York State Department of Health:

This letter will serve as the Functional Space Program of the above-mentioned project. We, as Architects on this project, have been retained to provide professional services to design the ASC Ambulatory Healthcare of approximately 9,800 plus an equipment platform level of 1,788 feet , totaling 11,588 sf of total space.

The proposed program areas of the renovated areas and their associated square footage (sf) are listed below.

The proposed program items include:

NO.	NAME	SF
200	VESTIBULE	180
200.1	ADA TOILET	57
201.1	ADA TOILET	50
201	WAITING	880
239	RECEPTION	95
202	PRE/POST	1,475
202.1	STORAGE	25
202.2	TOILET	57
203/203.1	NURSES STA./NOURISHMENT	263
203.1	ASC.MANG.	69
205	TOILET	53
206	YAG LASER	57

NO.	NAME	SF
207	FEMTO LASER	156
209	SOILED UTIL.	54
213	OR#1	358
212	OR#2	321
211	OR#3	322
213	OR#4	324
208	SEMI-RESTRICTED CORR. W/2 SCRUB SKS & WORK STA.	678
214	DECONTAMINATION	152
215	STERILZER ASSEMB.	188
216	STERILE SUPPLIES	251
219	SPRINKLER ROOM	163
220	MATERIALS MANAGER	78
220	GAS ROOM	50
222.1	TRASH CLOSET	34
222.2	BIO.HAZARD CLOSET	18
222.3	DIRTY LINEN CLOSET	18
223	ELECTRIC	129
224	MEN'S LOCKER	72
225	WOMENS LOCKER	133
226	STORAGE	272
227	RESTROOM/SHOWER	42
228	RESTROOM	44
217.1	LOCK. MED. RECORDS FILES	28
230	STORAGE	21
232	JANITOR	46
233	LOUNGE / BREAKROOM	191
234	TOILET	44
235	BUS. MNG.	60
236	ADMIN	69
237	WORK/COPY	217
238	IT	30

We hope this illustrates the proposed program requirements. Should you have any questions please do not hesitate to call us.

Sincerely
Raymond VanVoorhis

Liscum McCormack VanVoorhis

cc: File #24093
Ann Gormley- Empire Health Advisors

PHYSICIST LETTER OF CERTIFICATION FOR DIAGNOSTIC RADIOGRAPHY, COMPUTED TOMOGRAPHY (CT) FACILITIES, INTERVENTIONAL IMAGING, RADIATION THERAPY FACILITIES, PROTON THERAPY, NUCLEAR MEDICINE AND/OR MAGNETIC IMAGING FACILITIES

Date: 4-2-25
CON Number:
Facility Name: Central New York Eye Center LTD
Facility ID Number: 4067
Facility Address: (Current) 22 Green Street, Poughkeepsie, NY 12601

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

To The New York State Department of Health:

I hereby certify that for:

A. Diagnostic Radiography, Computed Tomography (CT) Facilities, Interventional Imaging and Radiation Therapy Facilities;

1. I have been retained by the aforementioned facility, to provide medical physicists services, in conjunction with the construction documents prepared by a NYS Licensed Architect/Engineer.

2. I have exercised due diligence and, to the best of my knowledge, information and belief, the radiation protection designed and specified for the above-referenced project is in substantial compliance with the requirements of the relevant technical standards listed in 10 NYCRR 711.2 including but not limited to Section 2.2-3.4 (Imaging) and (2) Section 2.2-3.5 (Interventional Imaging, of the 2014 Guidelines for Design and Construction of Hospital and Health Care Facilities and that the radiation exposure to the public and staff is designed to be as low as is reasonably achievable (ALARA), based on the work load provided to me by the facility for the proposed equipment and sound radiation protection principles.

3. Further, I agree to ensure that a current report detailing the extent of the radiation protection by the facility and the design of the protection systems will be made available to the Regional Office staff of the NYS Department of Health during the final inspection of the facility. I have informed the applicant that such report must be maintained on site as a permanent record.

B. Magnetic Resonance Imaging (MRI) Facilities, Interventional and Intraoperative MRI (I-MRI) Facilities;

1. I further certify that I have exercised due diligence and, to the best of my knowledge, information and belief the MRI magnetic shielding and radio frequency shielding as designed and specified are in substantial compliance with the requirements of the relevant technical standards listed in 10 NYCRR

711.2. including but not limited to Section 2.2-3.4 (Imaging) and (2) Section 2.2-3.5 (Interventional Imaging, of the 2014 Guidelines for Design and Construction of Hospital and Health Care Facilities.

2. I have reviewed the manufacturer's certifications accompanying all relevant equipment to ensure that such certifications satisfy all the requirements for patient, operator, and public safety.

3. I agree to submit an Architectural floor plan identifying the proposed MRI location, delineating all areas of the room and including the 5 Gauss line in three-dimensional planes, demonstrating that the electromagnetic and radio frequency environment is appropriate for the locations indicated are being submitted simultaneously with this Letter of Certification.

C. Description (Circle applicable facility type):

Diagnostic Radiography, Computed Tomography (CT) Facilities. Interventional Imaging, Radiation Therapy Facilities, Proton Therapy, Nuclear Medicine, Magnetic Resonance Imaging (MRI) Facilities

NYS Registered
Diagnostic Radiological Physicist
License No. 16-01
Certificate No. 1471122
Exp: 7/31/26

Signature of Medical Physicist

Thomas J. LaRocca, MS, DABR
Name of Medical Physicist (Print)

BioMed Associates, Inc., 4 Main St., Flemington, NJ 08822
Business Address

845-849-8336
Business Telephone

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

Authorized Signature for Applicant

04/07/2025
Date

SATISH MODI
Name (Print)

MD/OWNER
Title

Notary signing required for the applicant

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

On the 7th day of April 2025, before me personally appeared Satish Modi, to me known, who being by me duly sworn, did depose and say that he/she is the applicant of the Central New York Eye Center LTD, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary)

LOIS A. CARVER
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01CA4808214
Qualified in Dutchess County
Commission Expires June 30, 2026

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

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☒
2.15	Will the project result in a major adverse effect on air quality?	☐	☒
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	☒
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	☒
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	☒
2.19	Will the project have any adverse impact on health or safety?	☐	☒
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	☒
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	☒
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	☒
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☒
Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☒	☐
	Agency Name:	Town of Poughkeepsie Building Department	
	Contact Name:	Bruce Flower-Buildinding Inspector	
	Address:	1 Overrocker Road, Poughkeepsie	
	State and Zip Code:	NY 12603	
	E-Mail Address:	BFlower@TownofPoughkeepsie-NY.gov	
	Phone Number:	845-485-3655	
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		

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

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

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

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

FEMA **Elevation Certificate** and Instructions

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

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

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Unit Cost	Total Cost
	Reception	WAITING ROOM CHAIRS - with arms	10	Purchase	N/A	$ 379	$ 3,790
	Reception	WAITING ROOM CHAIRS - without arms	15	Purchase	N/A	$ 349	$ 5,235
	Reception	WAITING ROOM CHAIRS XL (WIPEABLE)	5	Purchase	N/A	$ 649	$ 3,245
	Reception	END TABLES	6	Purchase	N/A	$ 100	$ 600
	Reception	RECEPTIONIST OFFICE CHAIRS	2	Purchase	N/A	$ 100	$ 200
	Reception	COMPUTER	1	Purchase	N/A	$ 800	$ 800
	Reception	MONITOR	1	Purchase	N/A	$ 100	$ 100
	Pre-Op	RECLINER CHAIRS	3	Purchase	N/A	$ 703	$ 2,109
	Pre-Op	MONITORS	3	Purchase	N/A	$ 3,500	$ 10,500
	Pre-Op	New T5 Stretcher	3	Purchase	N/A	######	$ 36,000
	Post Op	RECLINER CHAIRS	3	Purchase	N/A	$ 703	$ 2,109
	Post Op	MONITORS	3	Purchase	N/A	$ 3,500	$ 10,500
	OR	GE CARESCAPE B450 MONITOR WITH GAS MODULE	1	Purchase	N/A	$ 4,250	$ 4,250
	OR	MOBILE STAND FOR CARESCAPE MONITOR	2	Purchase	N/A	$ 100	$ 200
	OR	GE CARESCAPE B450 MONITOR	1	Purchase	N/A	$ 1,850	$ 1,850
	OR	DRAGER FABIUS TIRO ANESTHESIA MACHINE W/ SERO VAPOR 2000	1	Purchase	N/A	######	$ 12,995
	OR	MH CART *will need MH posters posted	1	Purchase	N/A	$ 6,700	$ 6,700
	OR	EQUIPMENT CART HARLOFF MEDSTOR	1	Purchase	N/A	$ 5,000	$ 5,000
	OR	ANESTHESIA CART	1	Purchase	N/A	$ 500	$ 500
	OR	MAYO STAND	1	Purchase	N/A	$ 125	$ 125
	OR	KICK BUCKET	1	Purchase	N/A	$ 200	$ 200
	Misc	AMSCO AUTOMATED PASS THROUGH WINDOW 28" W/ INSTALL	1	Purchase	N/A	######	$ 16,000
	Misc	SCRUB SINK TRIPLE STATION W/ INSTALL	1	Purchase	N/A	######	$ 24,000

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Unit Cost	Total Cost
	Misc	CRASH CART (CORRIDOR)	1	Purchase	N/A	$ 1,000	$ 1,000
	Misc	NARCOTIC CABINET/SYSTEM (Nurse station)	1	Purchase	N/A	$ 250	$ 250
	Misc	EQUIPMENT CARTS (LOCATION TBD) CLOSED	4	Purchase	N/A	$ 100	$ 400
	Misc	TV/MONITOR 32" OR 42"	3	Purchase	N/A	$ 300	$ 900
	Nurses Station	OFFICE CHAIRS	4	Purchase	N/A	$ 100	$ 400
	Nurses Station	COMPUTER	2	Purchase	N/A	$ 800	$ 1,600
	Nurses Station	MONITOR	2	Purchase	N/A	$ 100	$ 200
	Nurses Station	PRINTER/FAX/COPIER	1	Purchase	N/A	$ 500	$ 500
	Nurses Station	BLANKET WARMER STERIS AMSCO SINGLE COMPARTMENT	1	Purchase	N/A	$ 8,500	$ 8,500
	Nurses Station	MED FRIDGE (UNDER COUNTER)	1	Purchase	N/A	$ 200	$ 200
	Nurses Station	ICE MACHINE (COUNTERTOP)VEVOR70 LB/24 H COMMERCIAL	1	Purchase	N/A	$ 200	$ 200
	Offices	DESKS	3	Purchase	N/A	$ 350	$ 1,050
	Offices	OFFICE CHAIRS	3	Purchase	N/A	$ 100	$ 300
	Offices	FILE CABINETS	2	Purchase	N/A	$ 150	$ 300
	Offices	GUEST CHAIRS	6	Purchase	N/A	$ 100	$ 600
	Offices	BOOKCASE	1	Purchase	N/A	$ 200	$ 200
	Lounge	TABLE	1	Purchase	N/A	$ 500	$ 500
	Lounge	CUBICLES (20 SPACE)	1	Purchase	N/A	$ 200	$ 200
	Lounge	REFRIGERATOR	1	Purchase	N/A	$ 1,000	$ 1,000
	Storage	CARTS/RACKS	10	Purchase	N/A	$ 100	$ 1,000
	Storage	IOL STORAGE	2	Purchase	N/A	$ 4,300	$ 8,600
	Storage	MEDICAL RECORD FILE CABINETS	2	Purchase	N/A	$ 1,200	$ 2,400
	Locker Room	CUBICLES OR SHOE RACKS (20 SPACE)	2	Purchase	N/A	$ 200	$ 400

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Unit Cost	Total Cost
	Locker Room	BENCHES	2	Purchase	N/A	$ 150	$ 300
	Sterile Clean	RACKS	4	Purchase	N/A	$ 100	$ 400
	Sterile Clean	STAINLESS STEEL TABLE/CART VEVOR (TRANSPORT CONTAM.INST)	6	Purchase	N/A	$ 133	$ 800
Total lease and purchase costs: Whole Project							**$ 179,208**

Schedule 13 A. Assurances from Article 28 Applicants

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

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

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

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

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

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

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

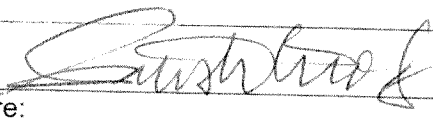
f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.

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

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

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

Date 04/07/2025



Signature:

Satish Modi, M.D.

Name (Please Type)

Owner

Title (Please type)

New York State Department of Health
Certificate Of Need Application

Schedule 13B

Schedule 13 B. Staffing
Table 13B - 1:

For Establishment and/or Construction Requiring Full/Administrative Review
_X_ Total Project
_____ Subproject number

A	B	C	D
	Number of FTEs to the Nearest Tenth		
Staffing Categories	Current Year (1)	First Year Total Budget (2)	Third Year Total Budget (3)
1. Management & Supervision	4.8	4.8	4.8
2. Technician & Specialist	3.7	4.5	5.5
3. Registered Nurses	3.6	4.0	4.5
4. Licensed Practical Nurses	0.8	1.0	1.5
5. Aides, Orderlies & Attendants			
6. Physicians			
7. PGY Physicians			
8. Physicians' Assistants			
9. Nurse Practitioners			
10. Nurse Midwife			
11. Social Workers and Psychologist**			
12. Physical Therapists and PT Assistants			
13. Occupational Therapists and OT Assistants			
14. Speech Therapists and Speech Assistants			
15. Other Therapists and Assistants			
16. Infection Control, Environment and Food Service	0.2	0.0	0.0
17. Clerical & Other Administrative	2.6	2.1	3.5
18. Other Employee Classifications (please specify)			
19. TOTAL NUMBER OF EMPLOYEES	15.7	16.4	19.8

* Last complete year prior to submitting application
** Use only for RHCF and D & T Center proposals

Describe how the number and mix of staff were determined:

Based on existing staffing and plans for moderate procedure volume in first year after relocation. Additional volume will drive increase in staff by year 3.

Schedule 17 A - Diagnostic and Treatment Center Program Information.

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

Instructions: In the space below, briefly indicate how the facility intends to comply with state and federal regulations. If the application involves conversion of an existing practice, state who owns the practice and how the conversion will be done. If there are other entities utilizing the same space or resources, please state exactly how the space and resources will be allocated. Also, provide a description of the other entities.

Central New York Eye Center LTD intends to continue complying with State and Federal regulations. The Center is an approved Medicare and Medicaid provider and is accredited by the Accreditation Association of Ambulatory Health Care (AAAHC) and thus familiar with federal requirements. It is an approved single-specialty ambulatory surgery center by the New York State Deparment of Health since 2004 and is familiar with State requirements. Its policies and procedures reflect both federal and State requirements. The CEO, Medical Director and Adminstrator are responsible for assuring that the Center is in compliance with Federal and State regulations.

For D&TC -Ambulatory Surgery Projects:
Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category
0

For D&TC -Ambulatory Surgery Projects:
Please provide the following information:

Number and Type of Operating Rooms:

- Current: 2
- To be added: 2
- Total ORs upon Completion of the Project: 4

Number and Type of Procedure Rooms:

- Current: 0
- To be added: 0

- Total Procedure Rooms upon Completion of the Project: 0

Schedule 17 B - Community Need

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

Public Need Summary:

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

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

Fifty-one percent of the patients of Central New York Eye Center come from 10 Zip Codes, with 48 percent of those paitents residing in Zip Codes in Dutchess County including 19 percent in the City of Poughkeepsie.

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

The current payor mix for Central New York Eye Center is presensted below.

PAYOR		PERCENT
Medicare	1,433	49.4
Medicare Advantage	1,016	35.0
Commericial	350	12.1
Medicaid	5	0.1
TOTAL	2,902	100.0

These data indicate that the majority of patients served by Central New York Eye Center are enrolled in Medicare (49.4 percent) or Medicare Advantage Plans (35.0 percent).

3. Document the current and projected demand for the proposed services. If the proposed services are covered by a DOH need methodology, demonstrate how the proposed service is consistent with it.

In 2024 in its current lcation at 22 Green Street in Poughkeepsie which has two operating rooms a total of 2,902 procedures were performed. The proposed location to 23 Davis Avenue in Poughkeepsie (3.1 miles) will initially provide one additional operating room with a fourth available in the furture depending upon demand. The number of procedures in future years are projected to be _____

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

In view of the fact that the proposed new location at 23 Davis Avenue in Poughkeepsie is only 3.1 miles from the current facility at 22 Green Street, it is anticipated that the service are will remain the same. However, the propsed new facility will be a modern facilty with increased capacity of one or two operating rooms to meet the needs of an increasingly aging population enrolled in Medicare.

(b) Describe how this project is consistent with your facility's Community Service Implementation Plan (voluntary not-for-profit hospitals) or strategic plan (other providers).

This proposed project is consistent with the strategic plan of Central New York Eye Center which is to expand and modernize the availability of ophthalmological services to an increasing aging population in its service area.

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

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

The population to be served by the proposed new facilty currently is served at the existing Central New York Eye Center located at 22 Green Street in Poughkeepsie.

ONLY For Applicants Seeking Permanent Life

Diagnostic and Treatment Centers seeking approval for a Permanent Life MUST provide the following information:

Instructions: In the space below, please provide detailed information on the **most recent CON application** that was approved for the limited life.

i. CON number:

ii. Date of approval:

iii. Number of years of limited life approved for:

iv. OpCert number and dates:

v. Please provide a table with information on projections by payor for year 1 and year 3 **as reported on the approved CON**. (Please identify the projections in terms of **visits or procedures**).

vi. Please provide a table with information on actual utilization by payor for each year since the implementation of the approved CON.

Note: Please use the same category of payors for actual utilization as those used for projections in item 'v' above. Also, use the same category (i.e., **visits or procedures**) for actual utilization as those used for projections in item 'v' above.

vii. Did you achieve those projections reported in item 'v' above?

If not, please give reasons for not meeting those projections.
How do you plan to improve this shortfall?

Quality and Accreditation:

1. Please cite relevant accreditations, certifications or awards attained by the applicant which build confidence in services of high quality. Examples include certification as a Federally Qualified Neighborhood Health Center.

2. Describe relevant programs or resources the applicant will bring to the new facility. Include existing programs that have proven track records at the applicant's other sites, if applicable, as well as programs the applicant plans for the future. Such programs include:
   a. Programs specially tailored to the health needs of the population of the service area.
   b. Grant funded programs.
   c. Scholarships or fellowships.

3. Describe the applicant's experience or track record serving similar populations:

Primary and Specialty Care Services Review Criteria: Expansion of Services

When a CON application proposes conversion of a group or solo medical practice to Article 28 status, the applicant must provide a written analysis of the effect of the proposal on the following factors:

1. The full time equivalent (FTE) number of primary care physicians and specialists, by specialty, engaged in the practice after the conversion compared with the number before conversion.

2. The (FTE) number of non-physician providers of primary care and specialty care, by specialty, such as Physician Assistants, Certified Nurse Practitioners, Physical Therapists, and Dental Assistants after the conversion compared with the number before conversion.

3. The number of primary care and specialty visits, by specialty, after the conversion compared with the number before conversion.

4. The array of services to underserved clients after the conversion compared with the number before conversion.

Target Population and Service Area:

All applications involving primary care services must provide a written analysis that clearly demonstrates that the proposal meets at least one of the following criteria. For criteria that do not apply, enter "not applicable":

1. The proposed clinic is in an underserved area as indicated by location in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA).

2. The population to be served exhibits poor health status, as measured by factors such as high levels of inpatient discharges for ambulatory care sensitive conditions (ACSC), incidences of diseases and conditions in excess of standards in Healthy People 2010 or other pertinent indicators.

3. The primary care services of the proposed clinic will be targeted to a group or population with special needs or conditions that make it difficult for them to obtain adequate primary care in clinics or physician practices serving the general population. Examples of such needs and conditions are:
   - Developmental disabilities.
   - HIV.
   - Alcohol Substance Abuse.
   - Health needs relating to aging.
   - Mental Health needs.
   - Homelessness
   - Linguistic or cultural barriers in obtaining access to primary care.

Capacity of Existing Primary Care Providers

The project narrative should describe existing primary care services in the proposed service area. The narrative should include the number and location of existing D&TCs, extension clinics and part-time clinics and a summary of primary care services available through private practices. The narrative should indicate whether travel time and transportation are factors in access to primary care. Examples of travel related issues include topography, seasonal weather conditions, and availability of public transportation. Applicants are not expected to describe the volume of services delivered by existing providers, since they will rarely have access to such data, but the project narrative should indicate that the applicant is reasonably familiar with the overall availability of primary care in the targeted area.

In instances where the target area is likely to already have significant primary care resources, the CON proposal will be reviewed for the following need related factors:

- The ratio of primary care physicians to population in the proposed service area. HPSA uses a ratio of 1.0 FTE physicians to 3000 persons; Medicaid Managed Care uses a ratio of 1 to 1500.
- The number of primary care physicians in the proposed service area who are "active" in serving the Medicaid population. This is often measured as physicians who are reimbursed $5000 or more per year by Medicaid.
- The annual number of primary care visits per person by Medicaid eligible persons in the proposed service area. An average lower than 2.0 visits per person is often considered a problem.
- The percentage of the Medicaid population that is enrolled in Managed care will be taken into account where appropriate.
- The current volume of primary care visits to existing D&TC and Extension clinics.

Not all of the above criteria need be evaluated for all applications. The number will vary depending on the type and location of services proposed and on how thoroughly the application addresses need in the project narrative and the related schedules.

Need Review for Specialty Clinics:

Applications not involving primary care services must also provide a written analysis that clearly demonstrates that the need exists for the proposed services

4. Is the proposed clinic in an underserved area as indicated by location in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA)?

5. Describe in very specific terms the patients who require the specialty services, including the number of patients and their specific health problems, and how the proposed facility will meet their needs better than existing providers.

6. In the case of Dental clinics, is the application supported by the local Health Department? Is the proposal supported by the Department of Health's Bureau of Dental Services? Is the applicant participating in current dental health initiatives? Has the applicant consulted with resources such as the New York State Oral Health Technical Assistance Center?

Impact of Proposed CON on Diagnostic & Treatment Center Operating Certificate

The Sites Tab in NYSE-CON has replaced the Authorized Services Table of Schedule 17C. The Authorized Services Table in Schedule 17C is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 17C-1 AUTHORIZED CERTIFIED SERVICES

Instructions:
For applications requesting changes to more than one location, complete a separate Table 17-C-1 for each location

LOCATION: *(Enter street address of facility)*	☐ **MOBILE CLINIC DESIGNATION (217)** Check box only if extension clinic is mobile *(A mobile clinic must be an extension clinic with a fixed main site)*

	Existing	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE[6]	☐	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
ABORTION	☐	☐	☐	☐
ADULT DAY HEALTH - AIDS	☐	☐	☐	☐
AMBULATORY SURGERY				
MULTI-SPECIALTY[4]	☐	☐	☐	☐
SINGLE SPECIALTY – GASTROENTEROLOGY[4]	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY[4]	☒	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS[4]	☐	☐	☐	☐
SINGLE SPECIALTY -- PAIN MANAGEMENT[4]	☐	☐	☐	☐
SINGLE SPECIALTY -- OTHER (SPECIFY)[4]	☐	☐	☐	☐
BIRTHING SERVICE O/P	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☒
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
CLINIC PART TIME SERVICES	☐	☐	☐	☐
CT SCANNER	☐	☐	☐	☐
DENTAL O/P	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING AND SUPPORT[4]	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING AND SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY O/P	☐	☐	☐	☐
MAGNETIC RESONANCE IMAGING (MRI)	☐	☐	☐	☐
METHADONE MAINTENANCE O/P	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐
RADIOLOGY – THERAPEUTIC O/P[5]	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 17C-1(a)&(b) below][4]	____	____	____	____
TRAUMATIC BRAIN INJURY PROGRAM O/P	☐	☐	☐	☐

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

END STAGE RENAL DISEASE (ESRD)

TABLE 17C-1*(a)* CAPACITY	Existing	Add	Remove	Proposed
CHRONIC DIALYSIS				

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

TABLE 17C-1(b) PROCEDURES	Last 12 mos	2 years prior	3 years prior
CHRONIC DIALYSIS			

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

END STAGE RENAL DISEASE

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

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

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

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

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

New York State Department of Health
Certificate Of Need Application

Schedule 17C

Table 17C-2 - Projected Utilization of Services:

The number of projected "visits" should be listed in this table for each existing or proposed certified service. Visits should be estimated for the current, first and third year of the project.

	CERTIFIABLE SERVICES	Current Year Visits	1st Year Total Budget Visits	3rd Year Total Budget Visits
	Ambulatory Surgery - Ophthalmology	2,857	3,420	4,098
Total Visits		**2,857**	**3,420**	**4,098**