Planned Parenthood®
of Nassau County, Inc.

94-06-152

June 21, 1994

Don McDonald
New York State Department of Health
Empire State Plaza
2230 Corning Tower
Albany, New York 12237

RE: 920078
Planned Parenthood of Nassau County, Inc.
Certify Abortion Services

Dear Mr. McDonald:

I am requesting a copy of our Certificate of Need application. The above referenced CON application was received on March 2, 1992 and approved June 1992. Due to several changes to our staff, we have been unable to locate our original certificate. If any further information is needed, please do not hesitate to contact me @ (516)488-3193 x3024. Thank you.

Sincerely,

Theresa L. Brown
Administrative Assistant

Denied

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

OFFICE OF HEALTH SYSTEMS MANAGEMENT
Raymond Sweeney
Director
Brian Hendricks
Executive Deputy Director

November 30, 1992

Ms. Judith Haasis
Executive Director
Planned Parenthood of Nassau County, Inc
540 Fulton Avenue
Hempstead, New York 11550

RE: 920078
PLANNED PARENTHOOD OF NASSAU COUNTY, INC.
(NASSAU COUNTY)
CERTIFY [redacted] SERVICES

Dear Ms. Haasis:

The submitted material has been reviewed and found acceptable for the purpose of meeting the following contingency:

#1. Submit an architect's letter certifying code conformance.

This contingency is hereby deemed met. All contingencies on this project have been satisfied effective this date. Contact the New Rochelle Area Office of the Office of Health Systems Management to complete project requirements in order to assure reimbursement and/or the issuance of a revised operating certificate.

Please be reminded that your assigned project completion date is October 19, 1994. Please contact Mr. Morris of the Bureau of Project Management at (518) 473-7915 if you have any questions regarding this letter.

Sincerely,

William J. Gormley
Deputy Director
Division of Health Facility Planning

cc: Mr. Lipsen
Dr. Pekmezaris
Mr. Morris
Mr. Johansson
Ms. Michalski

Planned Parenthood®
of Nassau County, Inc.

November 4, 1992

Robert Stackrow, Director
NYS Department of Health
Bureau of Project Management
Corning Tower, ESP
Albany, New York 12237

Dear Mr. Stackrow:

On October 19, we received approval from William Gormley's office regarding our request to certify our [redacted] service, project #920078. The one contingency that needed to be addressed was that of a letter of certification from our architect that the structure of our facility complied with the State Hospital Code.

Per Mr. Gormley's letter, I am forwarding you two copies of the letter of certification from our architect, Angelo Corva and Associates, which designed the facility located at 540 Fulton Avenue, Hempstead.

I will be in touch with your office next week to ensure that you have received the letter and that a final letter of approval indicating that we have met this contingency will be forwarded to us shortly. My conversations with our New Rochelle area office indicate that this final letter must be received by us in order for me to schedule a site survey with them.

Thank you very much for your cooperation.

Sincerely,

Barbara Chang
Associate Executive Director

cc: Mr. Dempsey

540 Fulton Avenue, Hempstead, New York 11550
Administration: Tel. (516) 483-3193 Fax: (516) 483-3592
Patient Services: Tel. (516) 483-3033

ANGELO FRANCIS CORVA
& ASSOCIATES, ARCHITECTS

ANGELO FRANCIS CORVA, R.A., AIA NCARB CERTIFIED

ARCHITECT'S LETTER OF CERTIFICATION FOR PROPOSED CONSTRUCTION

Date November 3, 1992

NYS Department of Health/Office of Health Systems Management
Division of Health Facility Planning
Bureau of Architectural and Engineering Facility Planning
The Governor Nelson A. Rockefeller Empire State Plaza
Corning Tower, Room 1780
Albany, New York 12237

RE: NAME: **PLANNED PARENTHOOD OF NASSAU COUNTY**

LOCATION: [redacted]

DESCRIPTION: **PROJECT NO.** [redacted]

Gentlemen:

This is to certify that under the terms of my contract for the above named facility to provide services to design, prepare working drawings and specifications, and during construction to make periodic visits to the site and to perform such other required services to familiarize myself with the general progress, quality and conformance of the work, I certify that this project was designed and constructed in substantial compliance with the provisions of the construction sections of the State Hospital Code, the NFPA-101 Life Safety Code, local codes and the ANSI A-117.1 - 1986, which were in effect at the time of the design and construction.

I also certify that I have read and understood the conditions of Section 710.1 of 10 NYCRR.

November 3, 1992
(Date)

REGISTERED ARCHITECT
ANGELO F. CORVA
13559
STATE OF NEW YORK

Angelo Francis Corva, Architect
(Name of Architect)

New York State 13559
(Professional NYS License No.)

141 E.A.B. Plaza, Uniondale, NY
11556-0141

DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire

Lorna McBarnette
Executive Deputy Commissioner

GD/nm
bcc: [redacted]

October 19, 1992

Ms. Judith Haasis
Executive Director
Planned Parenthood of Nassau County, Inc.
540 Fulton Avenue
Hempstead, New York 11550

RE: 920078
PLANNED PARENTHOOD OF NASSAU CO. INC.
(NASSAU COUNTY)
CERTIFY [redacted] SERVICES
ESTIMATED CAPITAL COST: $12,000
OPERATING COST IMPACT: $64,000

Dear Ms. Haasis:

The Office of Health Systems Management has reviewed your application in accordance with Section 710.1 of the State Hospital Code. We are pleased to inform you that your project has been approved administratively with the following contingency:

1. Submission of a Letter of Certification by an Architect/Engineer licensed to practice in New York State. Pursuant to Department of Health, Health Facilities Series 88-52 (6-30-88):

   The written Certification in the above requirements to this part shall be prepared and signed by an Architect/Engineer licensed by New York State. Should violations be noted upon review of documents or found at the time of on-site inspections, or surveys, such violations shall be corrected without additional costs allowed for reimbursement beyond costs previously approved per State Hospital Code, Part 710.1(3)(iii)(b). (A sample of an acceptable letter of certification is enclosed).

Two copies of information which is responsive to this contingency should be sent to the Bureau of Project Management within 60 days of the date of this letter. If the requested information is not submitted within the time frame(s) set forth, the project shall be deemed abandoned pursuant to 10 NYCRR 710.10(c)(1).

You must receive notification from the Department that plans, specifications or reports required by the Bureau of Architectural and Engineering Facility Planning are acceptable, and that all contingencies noted above have been satisfied before construction may commence.

Please note that this project has been approved at a capital cost of $12,000. Any change in the capital cost requires the prior approval of the Commissioner before construction or the purchase of equipment.

If any project scope other than that which is described in your application is desired, submission of a new or amended application will be necessary for our review and approval.

When your project is complete, please notify:

Mr. Nathan Lipsen
Area Administrator
New Rochelle Office of Health
Systems Management
145 Huguenot Street, 6th Floor
New Rochelle, New York 10801

so that an on-site visit can take place in order to verify that the project has been completed in accordance with all applicable regulations and conditions. Please be informed that this project must be completed within two (2) years of this approval letter or it shall be deemed abandoned pursuant to 10 NYCRR 710.10.

Upon completion of the on-site survey by the Area Office, a revised operating certificate will be transmitted to your facility.

Please contact Mr. Morris of the Bureau of Project Management at (518) 473-7915 if you have any questions regarding this letter.

Sincerely,

William J. Gormley
Deputy Director
Division of Health Facility Planning

Enclosure
cc: Mr. Lipsen
Dr. Pekmezaris
Mr. Morris
Chairman of the Board

GD/ mm
bcc:

[redacted]

OF NEW YORK
TMENT OF HEALTH

The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

OFFICE OF HEALTH SYSTEMS MANAGEMENT
Raymond Sweeney
Director
Brian Hendricks
Executive Deputy Director

Ms. Judith Haasis
Executive Director
Planned Parenthood of Nassau County, Inc.
540 Fulton Avenue
Hempstead, New York 11550

RE: 920078
PLANNED PARENTHOOD OF NASSAU CO. INC.
(NASSAU COUNTY)
CERTIFY [redacted] SERVICES
ESTIMATED CAPITAL COST: $12,000
OPERATING COST IMPACT: $64,000

Dear Ms. Haasis:

The Office of Health Systems Management has reviewed your application in accordance with Section 710.1 of the State Hospital Code. We are pleased to inform you that your project has been approved administratively with the following contingency:

1. Submission of a Letter of Certification by an Architect/Engineer licensed to practice in New York State. Pursuant to Department of Health, Health Facilities Series 88-52 (6-30-88):

   The written Certification in the above requirements to this part shall be prepared and signed by an Architect/Engineer licensed by New York State. Should violations be noted upon review of documents or found at the time of on-site inspections, or surveys, such violations shall be corrected without additional costs allowed for reimbursement beyond costs previously approved per State Hospital Code, Part 710.1(3)(iii)(b). (A sample of an acceptable letter of certification is enclosed).

Two copies of information which is responsive to this contingency should be sent to the Bureau of Project Management within 60 days of the date of this letter. If the requested information is not submitted within the time frame(s) set forth, the project shall be deemed abandoned pursuant to 10 NYCRR 710.10(c)(1).

NASSAU-SUFFOLK HEALTH SYSTEMS AGENCY, INC.

Serving Long Island

1537 Old Country Road, Plainview, NY 11803 Phone: 516-293-5740 Fax: 516-293-6288

May 18, 1992

475

Mr. William Gormley, Deputy Director
Division of Health Care Planning &
Resource Management
Office of Health Systems Management
New York State Department of Health
Corning Tower - Room 1743
Empire State Plaza
Albany, New York 12237

Re: Project #920078-C
Planned Parenthood of Nassau County, Inc.
(Nassau County)
Certify [redacted] service

Dear Mr. Gormley:

The Nassau-Suffolk Health Systems Agency, Inc. (N-S HSA) has reviewed the application submitted on behalf of Planned Parenthood of Nassau County, Inc. (PPNC) in accordance with Article 28 of the New York State Public Health Law, and in conformance with the Medical Facilities Plan for Long Island.

PPNC is an Article 28 Diagnostic and Treatment Center. It is proposing to add a new service to its operating certificate, involving provision of this service during the [redacted] of pregnancy on site to patients who use its pregnancy diagnosis service and who choose to use the proposed new service.

The N-S HSA has reviewed this application administratively and recommends it for **APPROVAL** to the New York State Department of Health subject to State determination of the financial feasibility of the proposal.

Sincerely,

Renee Pekmezaris

Renee Pekmezaris, Ph.D.
Executive Director

cc: Raymond Sweeney, OHSM
Robert Stackrow, OHSM
Brian Morris, DOH
Dominick Testo, OHSM
Nathan Lipsen, OHSM
Michael Domanski, DOH
Judith Haasis, PPNC

920078

RECEIVED
AUG 12 1992
BUREAU OF
PROJECT MANAGEMENT

Planned Parenthood®
of Nassau County, Inc.

August 11, 1992

George Dempsey
Assistant Director
Bureau of Project Management
NYS Department of Health
Office of Health Systems Management
Corning Tower Building
Room 1717
Albany, New York 12237-0725

Dear George:

As you already know, Planned Parenthood of Nassau County, Inc. (PPNC) submitted a certificate of need application for the addition of [redacted] services in March 1992. We received a project number (920078-C) on March 18 and approval of the service from our HSA on May 18, 1992. Since that time, however, we have not heard from the Department of Health regarding a final decision on the project.

I am writing to express my frustration with this process since according to the guidelines set forth for administrative review applications, we should have had a decision from the Department of Health within 90 days of receipt of the application. We are anxious to get started and cannot really get moving until an official approval is received.

George, I just want you to know that I appreciate everything you have done to expedite the process and I appreciate the delicate nature of this particular request. You have been so helpful on many occasions and I value your advice and support during this particular process. I simply wanted to put in writing an appeal to you (and your colleagues) to once again put our application at the top of your consideration list and give us a response as soon as possible.

Please let me know if I can be helpful. Thanks again and I'll be in touch soon.

Sincerely,

Barbara Chang
Associate Executive Director

cc: Lori Rockett, Esq., Hollyer, Brady, Smith, et. al.

8/12/92
Copy to Bill G.

540 Fulton Avenue, Hempstead, New York 11550
Administration: Tel. (516) 483-3193 Fax: (516) 483-3592
Patient Services: Tel. (516) 483-3033

p mc

NASSAU-SUFFOLK HEALTH SYSTEMS AGENCY, INC.

Serving Long Island

1537 Old Country Road, Plainview, NY 11803 Phone: 516-293-5740 Fax: 516-293-6288

May 18, 1992

Division of Health Facility Planning
RECEIVED
MAY 22 1992

Mr. William Gormley, Deputy Director
Division of Health Care Planning &
Resource Management
Office of Health Systems Management
New York State Department of Health
Corning Tower - Room 1743
Empire State Plaza
Albany, New York 12237

Re: Project #920078-C
Planned Parenthood of Nassau County, Inc.
(Nassau County)
Certify [redacted] service

Dear Mr. Gormley:

The Nassau-Suffolk Health Systems Agency, Inc. (N-S HSA) has reviewed the application submitted on behalf of Planned Parenthood of Nassau County, Inc. (PPNC) in accordance with Article 28 of the New York State Public Health Law, and in conformance with the Medical Facilities Plan for Long Island.

PPNC is an Article 28 Diagnostic and Treatment Center. It is proposing to add a new service to its operating certificate, involving provision of this service during the [redacted] of pregnancy on site to patients who use its pregnancy diagnosis service and who choose to use the proposed new service.

The N-S HSA has reviewed this application administratively and recommends it for **APPROVAL** to the New York State Department of Health subject to State determination of the financial feasibility of the proposal.

Sincerely,

Renee Pekmezaris, Ph.D.
Executive Director

RECEIVED
MAY 26 1992
BUREAU OF
PROJECT MANAGEMENT

cc: Raymond Sweeney, OHSM
Robert Stackrow, OHSM
Brian Morris, DOH
Dominick Testo, OHSM
Nathan Lipsen, OHSM
Michael Domanski, DOH
Judith Haasis, PPNC

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Lorna McBarnette
Executive Deputy Commissioner

March 18, 1992

OFFICE OF HEALTH
SYSTEMS MANAGEMENT
Raymond Sweeney
Director
Brian Hendricks
Executive Deputy Director

Ms. Judith Haasis, Executive Director
Planned Parenthood of Nassau County, Inc.
540 Fulton Avenue
Hempstead, New York 11550

RE: 920078-C
PLANNED PARENTHOOD OF NASSAU COUNTY, INC.
(NASSAU COUNTY)
Certify [redacted] service

Dear Ms. Haasis:

The above referenced CON application was received on March 2, 1992 and will be processed in accordance with 10 NYCRR 710. Please identify all subsequent submissions (correspondence, plans, additional information, etc.) with the project number shown above. All correspondence from the Office of Heath Systems Management (OHSM) will be directed to the contact person identified in your application. Should the contact person change during processing, please provide written notification directly to the Bureau of Project Management at the above address.

Subsequent to this letter, you may receive requests for additional information from OHSM and/or the Health Systems Agency. Please note that you must respond within the time allotted or risk withdrawal of the application from further processing. In addition, you may voluntarily submit any additional information which you believe might facilitate the review of your proposal, unless specific deadlines have otherwise been established. Any such submission must be accompanied by nine (9) copies of the material to be reviewed. If timely the submission of additional information will not result in a disruption of the processing of the application unless such information represents a substantial change in the proposal, thereby, amending the project. The transmission of additional information must be made sufficiently in advance of the application's presentation to the State Hospital Review and Planning Council, since it is the intent of the Office not to defer action on applications that are scheduled for action at Council meetings.

The mandatory review of your project for the criteria of public need, financial feasibility, and character and competence as required by Article 28 of the Public Health Law may determine that the proposal is unapprovable. Therefore, prior to entering into any contractual commitments or commencing construction, the final determination of the Director of the OHSM or the Public Health Council, if establishment is involved, and a favorable finding by the Secretary, DHHS, as to a capital reimbursement under Titles V, XVIII, and XIX of the Social Security Act, must be obtained.

You are urged to develop and maintain a close working relationship with your Area OHSM Office, Mr. Nathan Lipsen, Area Administrator at (914) 632-3701. Should you require assistance regarding this application, please contact the Bureau of Project Management at (518) 473-7915.

Sincerely,

William J. Gormley
Deputy Director
Division of Health Facility Planning

WJG/BWM/dlr
bcc: [redacted]

POTENTIAL NON-SUB

SCHEDULE 2 -- PROJECT NARRATIVE

The submission of this certificate of need for the addition of [redacted] services to the operating certificate of Planned Parenthood of Nassau County, Inc. (PPNC) comes at a time when the need for a licensed, high quality provider of [redacted] services in Nassau County is critical. PPNC is requesting approval to provide [redacted] services onsite to patients who utilize its pregnancy diagnosis service and choose to [redacted] pregnancies. We anticipate that 75% of those patients will be eligible to receive [redacted] at PPNC.

Continuity of Care

PPNC, an Article 28 Diagnostic and Treatment Center, serves approximately 7000 unduplicated patients making over 11,000 visits every year with high quality family planning and related services. Our pregnancy diagnosis service tested and counseled over 1000 patients in 1991. Over 600 of these women chose to [redacted] pregnancies and were referred to an outside [redacted] provider.

One of our greatest concerns regarding this current practice is the often confusing and potentially intimidating process that many of our patients experience in their attempts to find an [redacted] provider which is truly accessible, given their needs. Even though she is given a referral list of [redacted] providers, PPNC cannot ensure the promptness with which she will receive an appointment for the procedure nor can it help her overcome the multitude of barriers that she might encounter including transportation to the provider, language differences, acceptance of Medicaid and/or cost for the procedure, and a one day versus multi-day procedure process. For so many of our patients, PPNC is the primary if not exclusive source of their health care. Feedback in counseling sessions frequently indicate that they would much prefer to stay with PPNC as the provider they know and trust.

The availability of a PPNC [redacted] would ensure that the patient who came to us for her pregnancy diagnosis visit could also receive [redacted] at the same place, if appropriate, thereby eliminating the often difficult next step of having to find another provider. She would be scheduled for [redacted] in a timely manner (usually within one week) and would receive the quality of care that is synonymous with Planned Parenthood and that motivated her to initially select PPNC as her provider.

The addition of [redacted] services would also enhance PPNC's ability to retain these patients and convert a higher percentage

of them into successful contraceptive patients, thereby lessening the chance that a [redacted] would be necessary.

Quality of Care

Another issue of concern regarding our current practice of referring out for [redacted] services is the lack of control PPNC has regarding the quality of care rendered at other facilities.

As a provider who is committed to high quality, comprehensive, affordable care, PPNC visits its non-hospital based [redacted] referrals regularly to ensure that the care being rendered continues to meet our rigorous standards. Unfortunately, the number of providers who meet our criteria have decreased to a mere handful.

If PPNC were approved to add [redacted] services to its operating certificate, it would be the only Article 28 Diagnostic and Treatment Center in Nassau County that rendered this service. From a quality of care standpoint, a licensed [redacted] provider would ensure that the regulatory standards set forth by the Department of Health were maintained and regularly monitored.

In addition, the medical protocols for the [redacted] service and the quality of care rendered will be reviewed and monitored by the medical division of the Planned Parenthood Federation of America. The service will be supervised by a gynecologist with support from PPNC's Affiliate Medical Committee.

Affordable Care

In addition, PPNC would offer the service at a more reasonable cost than a hospital-based service could. A recent fee survey by PPNC staff reported that the average cost for a [redacted] performed in a hospital setting was $325-$400 while the average cost at a private clinic was between $250 and $300.

The cost of services has also affected their availability to the indigent population. Recent cutbacks in Nassau County Medical Center's (NCMC) [redacted] services may leave women in need of a low cost [redacted] with nowhere to go. The medical center has announced its intention of limiting the number of patients who cannot pay for an [redacted] and increasing the charge for a procedure to $400. The future of NCMC's [redacted] service itself is tenuous as evidenced by Nassau County's current budget crisis which resulted in the threatened "suspension" of the service in its entirety.

PPNC is committed to offering the service to as many patients as

possible, including Medicaid recipients. We anticipate that our fee would be set at the low end of the private clinic scale with flexible payment plans as needed by the patient.

Meeting the Needs of a Special Population

Currently, nearly half of PPNC's pregnancy diagnosis patients are teenagers. In 1989, over 2000 teens became pregnant in Nassau County with [redacted]% choosing [redacted] as their option. The provision of [redacted] services would allow PPNC to address the problems of young people who often fail to return to a provider for subsequent contraceptive visits and to:

* ensure that all options regarding a pregnancy are discussed and reviewed in a comprehensive, informed and confidential manner;

* provide counseling to clients and partners both before and after the procedure in order to encourage responsible decision-making and acceptance of a contraceptive method(s) as appropriate;

* create a convenient and familiar setting to assure that follow-up visits are kept;

* provide medical, educational and counseling services -- as well as low cost supplies to promote effective contraceptive use.

PPNC Program Components

PPNC's proposed program will provide [redacted] on an outpatient basis for women whose pregnancy is not greater than [redacted] by gestational age and who elects surgery under a local anesthesia. To ensure that our [redacted] patients are screened appropriately a three visit format would be utilized as follows:

1. Counseling and Diagnosis: The patient would receive a urine pregnancy test and a pelvic exam to confirm the pregnancy. The initial workup would include a counseling session to explore all options regarding the pregnancy and to provide the appropriate referrals related to her individual choice. If the patient is at all ambivalent about her decision, a second counseling visit would be scheduled. Participation of the patient's partner and/or parents would be encouraged. If a pregnancy [redacted] is ultimately desired, women would be offered [redacted] referrals through a private physician, a hospital-based program, as well as through PPNC.

2. Procedure Visit: PPNC's [redacted] service will take place

at its main facility located at 540 Fulton Avenue, Hempstead. During this visit, the patient would undergo a pre-surgical evaluation, other lab tests, a sonogram as necessary to confirm gestational age, the procedure, and post-operative recovery. [redacted] counseling will be utilized to explain the procedure, obtain written informed consent and explain appropriate follow-up care. Twenty-four hour telephone access to medical assistance will be provided.

3. Follow-up visit: This visit, scheduled within 2 weeks of the procedure, would include a medical exam, repeat pregnancy test, lab tests and education and counseling on an appropriate method of contraception.

16. Type of Financing ____ (SKIP FIELD)

17. Date Application was distributed for Program Review ___ ___/___ ___/___ ___
y y m m d d

18. Modify or create another Sub-project (Y/N) ___

19. Indicate with an * which Review Units are involved.

HSP REVIEW STATUS ___	CHA REVIEW STATUS ___
LTC REVIEW STATUS ___	CSL REVIEW STATUS ___
AMB REVIEW STATUS ___	DMH REVIEW STATUS ___
SEQ REVIEW STATUS ___	CCC REVIEW STATUS ___
ADS REVIEW STATUS X	

20. Extra Reviews:

UNIT(s) ___ ___ ___ , ___ ___ ___, ___ ___ ___ (from Table 29)

21. SUBPROJECT:

SUBMITTED CAPITAL COST 0 2 0 0 12
(Enter 0's if there isn't any entry)

CURRENT CAPITAL COST 0 2 0 0 12

SUBMITTED ANNUAL AGGREGATE COST 0 0 0 0 0 0

CURRENT ANNUAL AGGREGATE COST 0 0 0 0 0 0

SUBMITTED ANNUAL OPERATING COST 0 0 0 0 64
(Enter 0's if there isn't any entry)

CURRENT ANNUAL OPERATING COST 0 0 0 0 64

(Rev. 9/88)

PROJECT:

SUBMITTED PROJECT CAPITAL COST 002012

CURRENT PROJECT CAPITAL COST 002012

SUBMITTED PROJECT ANNUAL AGGREGATE COST 0 0 0 0 0 0

CURRENT ANNUAL AGGREGATE PROJECT COST 0 0 0 0 0 0

SUBMITTED PROJECT ANNUAL OPERATING COST 000064

CURRENT ANNUAL PROJECT OPERATING COST 000064

PROCEDURE E02 - PART 1 DISTRIBUTED

Part 1 Application Distributed __ __/__ __/__ __
y y m m d d

REVIEWER [signature] DATE 3/13/92

DATA OPERATOR _____ DATE _____

(Rev. 9/88) (To be filed in project file)

Planned Parenthood®
of Nassau County, Inc.

920078

February 26, 1992

Mr. Strackrow, Director
Project Management Unit
New York State Dept. of Health
Room 1717
Erastus Corning Tower Building
Empire State Plaza
Albany, N.Y. 12237

Dear Mr. Strackrow,

Please find attached the Certificate of Need application for administrative review. An additional eight (8) copies are being mailed to your office under separate cover. A copy of all materials is also being sent to the Nassau-Suffolk H.S.A.

Thank you for your prompt attention.

Sincerely,

Judith Haasis
Executive Director

JH/smh
P.S. The $1,000 filing fee is enclosed.

540 Fulton Avenue, Hempstead, New York 11550
Administration: Tel. (516) 483-3193 Fax: (516) 483-3592
Patient Services: Tel. (516) 483-3033

768

15

New York State Department of Health
Office of Health Systems Management

002066

administrative review

Certificate of Need Application*

General Information
Page 1 of 2

920078

RECEIVED
MAR 0 2 1992
BUREAU OF
PROJECT MANAGEMENT

General Information

I Facility Identification

OPERATING CERTIFICATE NO	FACILITY NAME	PFI NO.
2950205R	Planned Parenthood of Nassau County, Inc.	

FACILITY ADDRESS — STREET & NUMBER			NAME AND TITLE OF CONTACT PERSON		
540 Fulton Avenue			Judith Haasis, Executive Director		
CITY	COUNTY	ZIP	STREET AND NUMBER		
Hempstead	NY	11550	540 Fulton Avenue		
NAME OF OPERATOR			CITY	STATE	ZIP
Planned Parenthood of Nassau County, Inc.			Hempstead	NY	11550
STREET AND NUMBER			TELEPHONE NUMBER		
540 Fulton Avenue			(516) 483-3193		
CITY	STATE	ZIP	NAME OF ADMINISTRATOR		
Hempstead	NY	11550	Judith Haasis		

Address of the site/location of the proposed activity: (attach sketch if appropriate)

540 Fulton Avenue, Hempstead, NY 11550

II Project Outline

FACILITY TYPE	CODE	PROPOSED SOLUTION/ACTION	CODE	FUNCTIONAL AREAS/SERVICES BED TYPES AFFECTED	MFR RANKI
(1)	(2)	(3)	(4)	(5)	(6)
J	F	Certify a new service	401	[redacted] O/P	

III Board Resolution and Authorizing Signature

- Board resolution for Corporate Applicants... ☐ Attached ☒ Not Required
- Authorizing Signature: The undersigned hereby certifies under penalty of perjury I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, except that relating to Schedule 3, Environmental Assessment, Schedule 10, Space & Construction Cost Distribution and Schedule 16, Assurances (which must be individually certified), is accurate, true and complete in all material respects. I further acknowledge that the application will be processed pursuant to the provisions of Article 28 of the Public Health Law and the pertinent regulations adopted pursuant thereto including, but not limited to Part 709 and 710 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.

2/25/92	Judith Haasis	Judith Haasis	Executive Director
DATE	SIGNATURE	PRINT OR TYPE NAME	TITLE

* Do not use the master copy. Photocopy master and then complete copy.

DOH-54 (9/85)

768

New York State Department of Health
Office of Health Systems Management

administrative review

Certificate of Need Application*

IV Total Project Cost

Total Project Cost
$ 12,095
(FROM SCHEDULE 4, LINE 8)

Total Basic Cost of Construction
$ 0
(FROM SCHEDULE 4, LINE 6)

Total Cost of Moveable Equipment
$ 12,095
(FROM SCHEDULE 4, LINE 5.1)

Cost/SF New Construction
$ --
(FROM SCHEDULE 10)

Cost/SF Renovation Construction
$ --
(FROM SCHEDULE 10)

Total Incremental Operating Cost
$ 63,775
(FROM SCHEDULE 6, LINE 12)

Type of Financing
n/a
(FROM SCHEDULE 5, SECTION C)

Percentage Financed 0 %

Interest Rate -- %
(FROM SCHEDULE 5, SECTION C)

Depreciation Life 10 Yrs.

V Construction Dates

From Schedule 4 n/a

Anticipated Start Date ____ / ____ / ____

Anticipated Completion Date ____ / ____ / ____

Midpoint of Proposed Construction Schedule ____ / ____ / ____

VI General Questionnaire

	YES	NO
1. Do all of the components and solutions contained in this project appear in the 1983 Capital Needs Assessment Inventory (CNA) or Services Capital Needs Inventory (SCNI)?	n/a	
If yes, enter year of inventory ____		
If no, explain in attachment # ____ (emergency, minor entity...)		
2a. Have you submitted a Long Range Capital Plan to the Bureau of Architectural and Engineering Review?	n/a	
If yes, date of submission ____		
If no, explain in attachment # ____		
2b. Is this proposal consistent with the Long Range Capital Plan?		
If no, explain in attachment # ____		
3. Have all the solutions contained in this project been ranked in the Regional/ State Medical Facility Plan?	n/a	
If no, explain in attachment # ____		
Please provide a brief description of the consistency or lack of consistency of the proposed project with the State/Medical Facility Plan.		
Attachment # ____ .		
4. Has a site visit been conducted by the Office of Health Systems Management?	X	
If yes, date of last site visit 5/21/91		
5. Has the architectural alternatives review process with the Office of Health Systems Management been completed?	n/a	

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New York State Department of Health
Office of Health Systems Management

administrative review

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Schedule 1

Checklist of Schedules

Schedule No.	Schedule Name	Submitted	Not Required
1	Checklist of Schedules	X	
2	Project Narrative	X	
3	Environmental Assessment		X
4	Total Project Cost	X	
5	Proposed Plan for Project Financing	X	
6	Annual Operating Costs	X	
7	Annual Operating Revenues	X	
8	Inpatient and Outpatient Services Utilization	X	
9	Utilization/Discharge & Patient Days		X
10	Space & Construction Cost Distribution		X
11	Architectural Submission or Letter of Certification		X
12	Moveable Equipment	X	
13A	Certified Services	X	
13B	RHCF Rehabilitation & Non Occupant Services		X
14A	Bed Decertification		X
14B	RHCF Bed Conversions		X
15	Staffing	X	
16	Assurances	X	

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Office of Health Systems Management

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Schedule 2

Project Narrative

HEADING

Facility Type (1)	Code (2)	Proposed Solution/Action (3)	Code (4)	Functional Areas/Services Bed Types Affected (5)	MFP Ranking (6)
J	F	Certify New Service	401	[redacted] O/P	n/a

Narrative

See Attached

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29

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Office of Health Systems Management

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Schedule 3

Environmental Assessment

Part I

	YES	NO
1. If this application involves construction will it: (a) change land use or density? (b) have permanent effect on the environment if temporary land use is involved? (c) require work related to the disposition of asbestos?		n/a

If the answer to above is yes, then Parts II and III must be completed. All applicants must complete the signature block.

Part II

(A) if any question in Part II is answered "Yes", the project may be significant and more information will be necessary.
(B) if all questions in Part II are answered "No", it is likely that this project is not significant.

	YES	NO
1. Does the project meet or exceed any of the thresholds listed below; or if the project involves expansion of the facility by more than 50% of the thresholds listed below, does the proposed expansion plus the existing facility meet or exceed any of the thresholds listed below? Check the appropriate boxes below (a thru e).		
(a) the physical alteration of 10 acres or more?		
(b) use ground or surface water or discharge waste water to ground or surface waters in excess of 2,000,000 gallons per day?		
(c) parking for 1,000 vehicles or more?		
(d) in a city, town or village of 150,000 population or less, will the project entail more than 100,000 square feet of gross floor area?		
(e) 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. In a locality without any zoning regulation to height, will the project contain any structure exceeding 100 feet above original ground area?		
3. Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law, Article 25, Section 303?		
4. Will the project significantly affect drainage flow on adjacent sites?		
5. Will the project affect any threatened or endangered plant or animal species?		
6. Will the project result in a major adverse effect on air quality?		
7. 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?		
8. Will the project result in major traffic problems or have a major effect on existing transportation systems?		
9. Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?		
10. Will the project have any adverse impact on public health or safety?		
11. Will the project affect the existing community by directly causing a growth in permanent population of more than 5 percent over a one-year period or have a major negative effect on the character of the community or neighborhood?		
12. 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.		
13. 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?		
14. Is the project within the Coastal Zone as defined in Executive Law, Article 42?		

Part III

1. List all other state or local agencies involved in approval of the project

_____

_____

_____

2. Has any other agency made an environmental review of this project?

If so, give name.

_____

_____

3. Is there public controversy concerning environmental aspects of this project? If yes attach a brief description of the controversy.

Attachment # _____

Preparer's Signature: _____

Print or type name: _____

Title: _____ Date _____

Representing: _____

DOH-54 (9/85)

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Office of Health Systems Management

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Schedule 4

Total Project Cost

Item	Cost as of Filing Date of Application (1)	Escalation to Midpoint of Construction. Escalation is Projected at ____ % per year (2)	Estimated Project Costs (3)
1.1 Land Acquisition	$ -		$
1.2 Building Acquisition	-		
2.1 New Construction	-	$	
2.2 Renovation & Demolition	-		
2.3 Site Development	-		
2.4 Temporary Power	-		
3.1 Design Contingency	-		
3.2 Construction Contingency	-		
4.1 Fixed Equipment (NIC)			
4.2 Planning Consultant Fees			
4.3 Architect/Engineering Fees	-		
4.4 Construction Manager Fees	-		
4.5 Other Fees (Consultant, etc.)	-		
Subtotal (Total 1.1 thru 4.5)			
5.1 Moveable Equipment	12,095		12,095
6 Total Basic Cost of Construction (total 1.1 thru 5.1)			
7.1 Financing Cost (points, etc.)			
7.2 Interim Interest Expense (Total Interest on Construction Loan: ____ @ ____ % for ____ mos)			
8 Estimated Total Project Cost (total 6 thru 7.2)	12,095		12,095

Construction Start Date N/A Midpoint of Construction Date N/A

Construction Completion Date _____ Estimated Number of Months to Complete Construction _____

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DOH 51 (9/85)

31

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Office of Health Systems Management

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Schedule 5

Proposed Plan for Project Financing

A. Lease ☐

A complete copy of each proposed lease must be submitted.

Attachment # _____

ITEM	NET PRICE AS IF PURCHASED
	$
	$
	$
	$

B. Cash ☒

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

Attachment # _____

Accumulated Funds	$ 12,095
Sale of Existing Assets*	$
Other — (ie, gifts, grants, **etc)	$
TOTAL CASH	$

*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 ☐

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 payout period presently being considered.

Attachment # _____

Principal	$
Interest Rate	%
Term	Yrs
Payout Period	Yrs
Type Financing	

To be considered for review, all applications must include a complete copy of the financing proposal

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Office of Health Systems Management

administrative review

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Schedule 6

Annual Operating Costs

Categories	First Full Year Annual Incremental Cost Impact From 1/93 (MO/YR) to 12/93 (MO/YR)
1. Salaries & Wages	$ 26,490
2. Employee Benefits	
3. Professional Fees	
4. Medical & Surgical Supplies	10,350
5. Non-medical & Non-surgical Supplies	
6. Utilities	
7. Purchased Services	18,750
8. Other Direct Expenses Insurance	6,885
9. Subtotal (total 1 thru 8)	62,475
10. Interest	--
11. Depreciation & Rent	1,300
12. Total Incremental Operating Costs	63,775

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Office of Health Systems Management

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Schedule 7

Annual Operating Revenues

Categories	First Full Year Annual Incremental Revenue Impact From 1/93 (MO/YR) to 12/93 (MO/YR)
1. Daily Hospital Services	$
2. Ambulatory Services	65,000
3. Ancillary Services	
4. Total Gross Patient Care Services Rendered	
5. Deductions from Revenue	
6. Net Patient Care Services Revenue	
7. Other Operating Revenue	
8. Total Operating Revenue (Total 1-7)	65,000
9. Non-Operating Revenue	
10. Total Incremental Project Revenue	65,000

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Office of Health Systems Management

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Schedule 8

Inpatient and Outpatient Services Utilization

Service Classification (1)	Utilization Measure (2)	Current Year 1/1/92 (MO/YR) to 12/31/92 (MO/YR) (3)	First Full Year After Project Implementation 1/1/93 (MO/YR) to 12/31/93 (MO/YR) (4)	Percent Out-Patient (5)
401- [redacted] O/P	Procedures/year	[redacted]	[redacted]	100%

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DOH-51 (9/85)

35 New York State Department of Health
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Schedule 9

Utilization/Discharge and Patient Days

Service Classification	Current Year Mo/Yr _____ To Mo/Yr _____		First Full Year After Project Implementation Mo/Yr _____ To Mo/Yr _____	
	Discharges (1)	Patient Days (2)	Discharges (3)	Patient Days (4)
HOSPITALS				
151 Alcohol Detoxification				
152 Alcohol Rehabilitation				
103 Burns Care Beds				
153 Drug Detoxification				
154 Drug Rehabilitation				
107 Intensive Care				
214 Maternity Beds				
302 Medical Rehabilitation				
701 Medical/Surgical (Beds)				
108 Neonatal Continuing Care				
109 Neonatal Intensive Care				
110 Neonatal Intermediate Care				
218 Pediatric				
111 Pediatric - ICU				
220 Prisoner - Beds				
221 Psychiatric				
226 Respiratory Beds				
361 Self Care				
364 Special Use Beds (Describe)				
Other (Describe)				

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

34

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Office of Health Systems Management

3C

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Certificate of Need Application*

Schedule 10

Space & Construction Cost Distribution

☐ new
☐ alteration

LOCATION							
Bldg. No.	Floor No.	Sect. No.	Code and Functional Category Description	Function Gross SF	Construction Cost per SF	Total Construction Cost	(ALT) Scope of Work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Signature Blocks for preparer of this schedule

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 ☐ Other Metropolitan or Suburban ☐ Rural Area
3. This submission consists of: ☐ New Construction Report Number of pages _____
   ☐ Alteration Construction Report Number of pages _____

APPLICANT OR REPRESENTATIVE **OR** **PROJECT ARCHITECT, ENGINEER OR ESTIMATOR**

SIGNATURE	SIGNATURE OF PREPARER DATE
PRINT OR TYPE NAME	FIRM NAME: PROJECT ARCHITECT, ENGINEER OR ESTIMATOR
TITLE	MAILING ADDRESS
DATE	CITY & STATE
AREA CODE AND TELEPHONE NUMBER	AREA CODE AND TELEPHONE NUMBER

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37

New York State Department of Health
Office of Health Systems Management

administrative review

Certificate of Need Application*

Schedule 10
continuation

Space & Construction Cost Distribution

☐ new
☐ alteration

LOCATION							
Bldg. No.	Floor No.	Sect. No.	Code and Functional Category Description	Functional Gross SF	Construction Cost per SF	Total Construction Cost	(ALT) Scope of Work
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

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Office of Health Systems Management

administrative review

Certificate of Need Application*

Schedule 11

Architectural Submission or Letter of Certification

Enter the appropriate attachment number of your submission.

Copy of Architectural
Submission transmittal letter:

Attachment # _____

OR

Architect's Letter
of Certification

Attachment # _____

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39

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Office of Health Systems Management

administrative review

Certificate of Need Application

Schedule 12

Moveable Equipment

Table I: New Equipment Description

Funct. Area (1)	Machine (2)	Model (3)	Manufacturer (4)	Model Year (5)	Utilization (6)	Lease Amount Purchase Price (7)
401	[redacted]					
401						
401	General Electric Vaginal Probe Sonogram			1992	100	1000/mo

Table II: Equipment Replacement (One-for-One Only)

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

Funct. Area (1)	Machine (2)	Model (3)	Manufacturer (4)	Model Year (5)	Utilization (6)	Lease Amount Purchase Price (7)

Table III: Equipment Replacement (Not One-for-One)

On the first line list the new equipment, and on the second line list the equipment that is being replaced.

Funct. Area (1)	Machine (2)	Model (3)	Manufacturer (4)	Model Year (5)	Utilization (6)	Lease Amount Purchase Price (7)
401 + 471	Pelton & Crane Validator Plus 10 Autoclave			1992	N/A	2795
471	Ritter Sterilizer		Sybron	Not Available		
471 + 401	Midmark 413 power exam table			1992	N/A	5800
471	Hamilton Tiara Exam Table			Not Available		

Description of what is being done with old equipment: Attachment # _____

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Certificate of Need Application*

Schedule 13A

Certified Services Table

Code	Service Name	Effect on Operating Certificate			Site(s) and Method of Provision
		Certify	Decertify	Change	
(1)	(2)		(3)		(4)
401	[redacted] O/P	X			540 Fulton Avenue Onsite- Direct

RHCF PROPOSALS where the addition or deletion of service space is involved, describe in Attachment # _____.

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Office of Health Systems Management

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Certificate of Need Application *

Schedule 13B

RHCF Rehabilitation and Non-Occupant Services

	Audiology		Occupational Therapy		Physical Therapy		Speech Pathology		Non-Occupant Services
1. Estimated number of facility patients and/or residents requiring treatment. (For non-occupants, use total registrants)									
2. Estimated number of evaluations per month.									
3. Number of days a week the service is to be offered.									DAYS & HOURS OF CARE
4. Number of hours a day the service is to be offered.									
5. Estimated number of patients and/or residents to be treated a day.									REGISTRANTS
6. Full Time Equivalents for: Occupational Therapist(s)	FTE'S		FTE'S		FTE'S		FTE'S		FTE'S
Certified OT Asst.(s)									
Occupational Therapy Aide(s)									
Audiologist(s)									
Physical Therapist									
Physical Therapist Asst(s)									
Physical Therapy Aide(s)									
Speech Pathologist(s)									
7. Treatment space (minus office & storage space) SNF Existing / Upon completion	SF	SF	SF	SF	SF	SF	SF	SF	
HRF Existing / Upon completion									
In combined SNF/HRF is the treatment area to be used by both SNF and HRF Residents?	Y	N	Y	N	Y	N	Y	N	Y
NOTE: If the answer to the above question is "no" please explain. Attachment	#		#		#		#		#
8. If audiology proposal, have you made plans for an on-site soundproof room or a two room test suite for audiometric evaluations?	Yes	No							
If yes, provide description. Attachment #	#								
9. Office Space (square feet)									
Shared with another service?	Y	N	Y	N	Y	N	Y	N	Y
If yes, which one?									
Describe location: Attachment	#		#		#		#		#
10. Storage Space (Square Feet)									
Describe location: Attachment:	#		#		#		#		#
11. Toilet(s) available for patient use (Number)									
12. Lavatory in Department?	Y	N	Y	N	Y	N	Y	N	Y
Is it shared with another service?	Y	N	Y	N	Y	N	Y	N	Y
If Yes, which one									

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Office of Health Systems Management

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Certificate of Need Application*

Schedule 14A

Bed Decertification

Bed Code & Title	Existing Certified* Beds (1)	Proposed Bed Reductions (2)	Beds Upon Completion (3)
151 Alcohol Detoxification			
152 Alcohol Rehabilitation			
103 Burns Care Beds			
153 Drug Detoxification			
702 HRF (Health Related Facility) Beds**			
154 Drug Rehabilitation			
107 Intensive Care			
214 Maternity Beds			
302 Medical Rehabilitation			
701 Medical/Surgical (Beds)			
108 Neonatal Continuing Care			
109 Neonatal Intensive Care			
110 Neonatal Intermediate Care			
218 Pediatric			
111 Pediatric - ICU			
220 Prisoner - Beds			
221 Psychiatric			
226 Respiratory Beds			
703 SNF (Skilled Nursing Facility) Beds**			
361 Self Care			
Other (Describe)			

*Number of beds appearing on your operating certificate.

**Provide a description of how the area will be utilized if HRF or SNF beds are being decertified. Use space below, if appropriate, or Attachment # _____.

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

administrative review

Certificate of Need Application*

Schedule 14B

RHCF Bed Conversions

Bed Type	Number of Existing Certified Beds* (1)	Number of Proposed Bed Conversions (2)	Number of Beds Upon Completion (3)
702-HRF			
703-SNF			
TOTAL			

*Number of beds on your operating certificate

Submit one set of single line sketches indicating all rooms affected by proposed change.

Attachment # _____

Narrative:

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Office of Health Systems Management

44

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Certificate of Need Application*

Schedule 15

Staffing

Staffing Categories	Number of FTE's to nearest tenth	
	Current year 1/92 (MO/YR) to 12/92 (MO/YR) (1)	First year of Implementation 1/93 (MO/YR) to 12/93 (MO/YR) (2)
1. Management & Supervision	.35	.35
2. Technician & Specialist	0	.11
3. Registered Nurses	.23	.23
4. Licensed Vocational (Practical) Nurses Aides, Orderlies & Attendees	0	.46
5. Physicians	0	.11
6. Intern, Resident & Fellow Non-Physician Medical Practitioners	0	0
7. Social Workers & Psychologists*	0	0
8. Physical, Occupational & Rehabilitation Therapists*	0	0
9. Environment, Hotel & Food Service	0	0
10. Clerical & Other Administrative	.69	.46
11. Other Employee Classifications (Identify)	.11	.33
12. TOTAL NUMBER OF EMPLOYEES	1.38	2.05

*Use only for RHCF and D&T Center Proposals.

Provide an attachment to describe any health professional teaching programs (in house staff training programs) associated with this project. Attachment # _____.

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Office of Health Systems Management

administrative review

Certificate of Need Application*

Schedule 16

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 all required submissions, which shall conform to the standards of construction and equipment pursuant to 10 NYCRR;

(C) The applicant will obtain the approval of the commissioner of the final working drawings and specifications, which shall conform to the standards of construction and equipment of 10 NYCRR, prior to contracting for construction, unless otherwise provided for in section 710.7 of 10 NYCRR;

(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 or engineering supervision and inspection at the construction site to insure that the completed work conforms with 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 which are not in compliance with 10 NYCRR Section 711.4 through 711.8 of this Title, or other pertinent provisions of 10 NYCRR Chapter 5 Subchapter C, unless a waiver is granted to specific provisions by the commissioner, under 10 NYCRR Section 711.9;

(G) The facility will be operated and maintained in accordance with the standards prescribed by law; and

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

Judith Haasis 2/25/92

SIGNATURE DATE

Judith Haasis

PRINT OR TYPE NAME

Executive Director

TITLE

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Office of Health Systems Management

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Certificate of Need Application*

Attachments

Page # _____

Schedule # _____ ; Attachment # _____ Title _____

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Lorna McBarnette
Executive Deputy Commissioner

OFFICE OF HEALTH SYSTEMS MANAGEMENT
Raymond Sweeney
Director
Brian Hendricks
Executive Deputy Director

June 27, 1991

Jan R. Figueira
Patient Service Administrator
Planned Parenthood of Nassau County
540 Fulton Avenue
Hempstead, New York 11550

RE: Addition of Social Work Services and Nursing services to Operating Certificate

Dear Ms. Figueira:

We have received your request to add Social Work and Nursing services to your operating certificate. The request has been reviewed pursuant to Section 710.1(c)(6)(iii) of the Code which authorizes the Department to certify under certain conditions without the need for filing a certificate of need application.

With the understanding that no additional staff person will be hired and no construction costs will be incurred, your request to certify Social Work and Nursing services is hereby approved. The area office should be contacted to arrange for a review of the manuals and a preopening survey if deemed appropriate before the amended operating certificate is issued.

I trust this information is useful.

Sincerely,

William J. Gormley
Deputy Director
Division of Health Facility Planning

caj

cc: Mr. Parker
Mr. Dowling
Mr. Testo
Ms. Michalski
Nassau/Suffolk HSA
New Rochelle Area Office
Joyce Gallimore

Planned Parenthood®
of Nassau County, Inc.

June 11, 1991

Philip J. Sgarlata,
Special Assistant
Bureau of Health Facilities Planning
Corning Tower-Empire State Plaza--17th Flr.
Albany, NY 12237

Dear Mr. Sgarlata:

Please be advised that Planned Parenthood of Nassau County, Inc. (PPNC) would like to add Social Services and Nursing to our current operating certificate in order to better serve the community of Nassau County. The addition of these services will not have any impact on our current operating budget.

Hugh Blank, the Regional Medical Care Administrator, was in to review the facility and suggested we write you concerning this matter. It is my understanding that you will communicate with the appropriate office in order to expedite this request.

Please let me know if you have any questions. Thank you very much for your help.

Sincerely,

Jan R. Figueira
Patient Service Administrator

JRF:yr

91165HDC0647

540 Fulton Avenue, Hempstead, New York 11550
Administration: Tel. (516) 483-3193 Fax: (516) 483-3592
Patient Services: Tel. (516) 483-3033

Bob Stadrow
BM

Planned Parenthood®
of Nassau County, Inc.

July 19, 1991

William J. Gormley
Deputy Director
Division of Health Facility Planning
NYS Department of Health
Corning Tower - Empire State Plaza
Albany, New York 12237

Division of Health
Facility Planning
JUL 22 1991
RECEIVED

Dear Mr. Gormley,

I am writing to seek clarification regarding the services that are approved by the Department of Health for all sites of Planned Parenthood of Nassau County, Inc. (PPNC) and therefore to be listed on our operating certificates.

At this time, it is my understanding that the following services are approved for all sites:

1. Family Planning
2. Prenatal Services -- This was approved upon the submission of a certificate of need last year (Project # 900460). The approval letter is attached. Subsequent letters regarding this project were solely in reference to our request to add an extension clinic.
3. Part-time clinics -- This was also approved per the same CON that requested the addition of prenatal services.
4. Social Services -- The approval of this service was per your letter of June 27, 1991 (copy attached) contingent upon the review of our social work protocols. The protocols will be forwarded to Hugh Blank.
5. Nursing -- The approval of this service was granted in the same letter as that of social services. Any paperwork requested of Hugh Blank will be promptly forwarded.

As you may already know, a pre-opening survey of our new facility at 540 Fulton Avenue, Hempstead was conducted by OHSM on May 23, 1991. I anticipate that once we have adequately responded to the list of deficiencies, we will receive our operating certificate with the above services listed.

Please let me know if you have a problem with anything that I have said in this letter. Thank you for your consideration.

RECEIVED
JUL 23 1991
BUREAU OF
PROJECT MANAGEMENT

Sincerely

Barbara Chang
Associate Executive Director

cc: Hugh Blank

91203HOC0811D

540 Fulton Avenue, Hempstead, New York 11550
Administration: Tel. (516) 483-3193 Fax: (516) 483-3592
Patient Services: Tel. (516) 483-3033

997

2950205R

PFI NO. 0532

06/27/91

9
1
3
0
2

01/31/92

DIAGNOSTIC & TREATMENT CENTER

PLANNED PARENTHOOD OF NASSAU CO
INC
540 ~~HEMPSTEAD~~ Fulton AVENUE
HEMPSTEAD NY 11550

OPERATOR VOLUNTARY CORPORATION
PLANNED PARENTHOOD OF NASSAU
COUNTY INC

HAS BEEN GRANTED THIS OPERATING CERTIFICATE PURSUANT TO ARTICLE 28
OF THE PUBLIC HEALTH LAW FOR THE SERVICE(S) SPECIFIED:

FAMILY PLANNING
****

NURSING
****

SOCIAL WORK SERVICE
****

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

April 17, 1995

Karen Pearl
Executive Director
Planned Parenthood of Nassau County, Inc.
540 Fulton Avenue
Hempstead, New York 11550

Re: Addition of Primary Care Services to the Operating Certificate

Dear Ms. Pearl:

We have received your request to add primary care services to your operating certificate. The request has been reviewed pursuant to Section 710.1(c)(6)(iii) of the Code which authorizes the Department to certify services under certain conditions without the need for filing a certificate of need application.

With the understanding that three additional staff will be hired at a cost of $250,000 and no construction costs will be incurred, your request to certify primary care services is hereby approved. The area office should be contacted to arrange for a review of the manuals and a preopening survey before the amended operating certificate is issued.

Sincerely,

Edward J. Dowling, Jr.
Associate Director
Division of Health Facility Planning

bcc: [redacted]

RECEIVED
APR 19 1995
BUREAU OF
PROJECT MANAGEMENT

Planned Parenthood®
of Nassau County, Inc.

March 3, 1995

Mr. John Ferrara
Alternative Delivery Systems Program Director
NYS Department of Health
Office of Health Systems Management
145 Huguenot Street, 6th Floor
New Rochelle, NY 10801

Dear Mr. Ferrara:

We would like to request that Primary Care Services be added to our operating certificate in order to implement services, initially in our full-time health center in Hempstead and, when feasible, in our center in Glen Cove.

Primary care service will initially be for women only. Fees for uninsured patients will be based on a sliding scale depending on income.

Our plans are to hire a family practice physician and two nurse practitioners trained in adult medicine. (We have supported their education for primary care during the last year.)

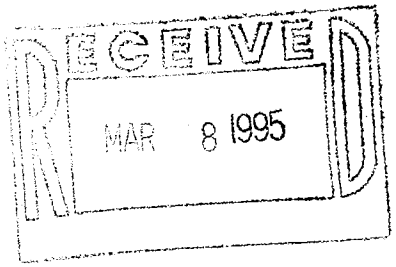
If you have any further questions, please let me know.

Sincerely,

Karen Pearl

Karen Pearl
Executive Director

KP/ib



Administrative Offices: 540 Fulton Avenue, Hempstead, New York 11550 • Tel. (516) 483-3193 • FAX (516) 483-3592

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DIAGNOSTIC & TREATMENT CENTER

01/31/96

PLANNED PARENTHOOD OF NASSAU CO
INC
540 FULTON AVENUE
HEMPSTEAD NY 11550

OPERATOR VOLUNTARY CORPORATION
PLANNED PARENTHOOD OF NASSAU
COUNTY INC

HAS BEEN GRANTED THIS OPERATING CERTIFICATE PURSUANT TO ARTICLE 28
OF THE PUBLIC HEALTH LAW FOR THE SERVICE(S) SPECIFIED:

[redacted]

PART TIME CLINICS	FAMILY PLANNING	NURSING
SOCIAL WORK SERVICE	PRENATAL	PRIMARY MEDICAL CARE
**********	**********	**********

OTHER AUTHORIZED LOCATION(S) 1
[redacted]