Schedule 16 A. Hospital Program Information

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

Instructions: Briefly indicate how the facility intends to comply with state and federal regulations specific to the services requested, such as cardiac surgery, bone marrow transplants. For clinic services, please include the hours of service for each day of operation, name of the hospital providing back-up services (indicating the travel time and distance from the clinic) and how the facility intends to provide quality oversight including credentialing, utilization and quality assurance monitoring.

The proposed project will be designed and operated in compliance with Federal and State regulations.

All administrative aspects of the services included as part of this project will continue to be directed by an individual who is qualified for such duties by education and experience. The Quality Assurance (QA) Program for these services will be administered by the Chief Quality Officer, and it will be consistent with, and an integral part of, Mohawk Valley Health System's (MVHS's) existing QA Program.

To ensure that care and services are appropriate to an individual's needs, MVHS will continue to use a comprehensive utilization review and monitoring program for services included as part of this project. The appropriate utilization of services will continue to be monitored through the QA Program, under the supervision of the Medical Director.

MVHS will utilize the same credentialing process for the services included as part of this project that is currently in place at its constituent hospitals. Only those physicians who are qualified by virtue of their training and experience will be considered for staff privileges, and only those who demonstrate a high level of competence will be appointed to the staff of MVHS. A similar process will be followed for nursing, technical and support staff members who seek employment at MVHS.

In accordance with current policy at MVHS, the ability to pay will not be a factor in the process of accepting patients. Every effort will be made to ensure that appropriate payment is made, but in no circumstance will a patient be refused treatment based on ability to pay. MVHS currently has a sliding fee scale for its patients. All services will continue to be offered to those in need of care who satisfy admission requirements, regardless of age, sex, sexual orientation, race, creed, religion, disability, source of payment or any other personal characteristic.

PLEASE REFER TO THE SCHEDULE 1 ATTACHMENT FOR THE PROJECT NARRATIVE.

New York State Department of Health
Certificate of Need Application

Schedule 16B

For Hospital-Based-Ambulatory Surgery Projects:

Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category
Ambulatory Surgery – Multi-Specialty

For Hospital-Based -Ambulatory Surgery Projects: **See Table Below**
Please provide the following information:

Number and Type of Operating Rooms:

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

Number and Type of Procedure Rooms:

- Current:
- To be added:
- Total Procedure Rooms upon Completion of the Project:

St. Elizabeth Medical Center (Hospital Campus)	**Existing**	**Proposed**
Number of Operating Rooms	Total OR rooms = 10 Total CTOR rooms = 2 Hybrid room = 1 Cath Lab = 2 EP Lab = 1 Electrophysiology Tilt Room = 1 (used for tilt studies)	0
Number of Procedure Rooms	0	0

St. Luke's Division (Hospital Campus)	**Existing**	**Proposed**
Number of Operating Rooms	8	0
Number of Procedure Rooms	3 IR 4 Endo 1 Adv. Endo Room	0

St. Elizabeth Campus (Future Extension Clinic)	**Existing**	**Proposed**
Number of Operating Rooms	N/A	0
Number of Procedure Rooms	N/A	0

New Hospital Campus	**Existing**	**Proposed**
Number of Operating Rooms	N/A	14
Number of Procedure Rooms	N/A	4 IR rooms 2 EP, 2 Caths 1 Advanced GI 4 Endo rooms 1 Endo/TEE/TILT room

Schedule 16 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.)

The primary service area (PSA) for this project is comprised of Oneida County. This county contains the two (2) main hospitals (St. Elizabeth's and St. Luke's), as well as many of their extension clinics. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

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

Oneida County is located in Central New York and had a population of 231,190 in 2016. The two (2) largest cities in Oneida County are Utica (with a 2015 population of 61,628 (most recent data available)) and Rome (with a 2015 population of about 32,916 (most recent data available)). MVHS's patients generally come from 45 towns and villages covering 1,257 square miles surrounding the facilities. Approximately two-thirds (67%) of the County's population resides in urban/suburban areas, while the remaining one-third (33%) resides in rural areas. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

3. Document the current and projected demand for the proposed service in the population you plan to serve. If the proposed service is covered by a DOH need methodology, demonstrate how the proposed service is consistent with it.

The services included as part of this project are not covered by a DOH need methodology. Through New York Public Health Law Section 2825-b, New York State created the "Oneida County Health Care Transformation Program" that set aside up to $300 million in capital grant funding for the sole purpose of consolidating multiple licensed healthcare facilities into an integrated system of care, within the largest population center in Oneida County (i.e., Utica). Through a response to a Request for Applications (RFA #1505060325) from the New York State Department of Health (NYSDOH) and Dormitory Authority of the State of New York (DASNY), MVHS was awarded $300 million in grant funding for the project proposed in this C.O.N. Application, which will result in the transformation of healthcare services in the region through the consolidation of services from MVHS's two (2) hospital campuses to a new hospital site in Utica, New York. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

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

The new hospital campus will consolidate two (2) existing acute care hospitals into one (1) integrated location, will provide greater access to residents of the City of Utica, Oneida County and the region, and it will improve operational efficiency, patient satisfaction and safety for both patients and caregivers. In particular, this project will create a structured delivery system, end the current service fragmentation, increase service integration and coordinate the work of the hospitals and other community-based organizations. Furthermore, the implementation of this project will reduce gaps/inefficiencies in care coordination, aligns with payment reform and rebalances healthcare delivery through the reduction in the number of hospital beds as care is shifted from an inpatient care model to an outpatient care model focused on population health. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

(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 project is consistent with the Community Service Implementation Plan of Mohawk Valley Health System (MVHS). First, MVHS is dedicated to ensuring access to high-quality healthcare to the region's residents; this project will promote access to services to all patients in need of such services by making a number of its services more efficient and generally consolidated at a single site. Second, this project will help to improve public health outcomes for residents of the region through proper access to needed services. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

(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.

This project will serve all patients needing care, regardless of their ability to pay or source of payment. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

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

The individuals are currently being served at either the Faxton St. Luke's Healthcare St. Luke's Division (St. Luke's) or St. Elizabeth Medical Center (St. Elizabeth). This project consolidates and integrates a number of services into a single location in order to better serve the patient base. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

6. Describe how the proposed services will be address specific health problems prevalent in the service area, including any special experience, programs or methods that will be implemented to address these health issues.

Both campuses of MVHS are major care centers for residents of the region. This project seeks approval for the construction of a new hospital campus in Utica, New York, consistent with New York Public Health Law Section 2825-b. In terms of specific health issues, residents of Oneida County also experience poor health outcomes for a number of conditions, including cardiovascular disease, diseases of the heart, coronary heart disease, acute myocardial infarction (heart attack), congestive heart failure,

cerebrovascular disease (stroke), hypertension, chronic kidney disease, diabetes, chronic lower respiratory disease, asthma and cancer. Please refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

ONLY For Applicants Seeking Permanent Life ***Not Applicable***

Diagnostic and Treatment Centers seeking approval for indefinite 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.

New York State Department of Health
Certificate of Need Application

Schedule 16C

Impact of CON Application on Hospital Operating Certificate

Name of Active Parent:(if applicable): **N/A**
Name of Facility: **Mohawk Valley Health System Integrated Hospital Campus**
Address of Facility: **Address To Be Determined (See Note Below)**
Utica (Oneida County), New York 13502

NOTE: THIS OPERATING CERTIFICATE REFLECTS THE BEDS AND SERVICES OF THE NEW HOSPITAL CAMPUS. PLEASE REFER TO THE PROJECT NARRATIVE (UNDER THE SCHDULE 1 ATTACHMENT) AND ITS APPENDICES FOR ADDITIONAL INFORMATION.

Note: If the application involves an extension clinic, indicate which services should be added or removed from the certificate of the extension clinic alone, rather than for the hospital system as a whole. If multiple sites are involved, complete a separate 16C for each site.

TABLE 16C-1 AUTHORIZED BEDS

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30				
BONE MARROW TRANSPLANT	21				
BURNS CARE	09				
CHEMICAL DEPENDENCE-DETOX *	12				
CHEMICAL DEPENDENCE-REHAB *	13				
COMA RECOVERY	26				
CORONARY CARE	03		8		8
INTENSIVE CARE	02		42		42
MATERNITY	05		22		22
MEDICAL/SURGICAL	01		240		240
NEONATAL CONTINUING CARE	27				
NEONATAL INTENSIVE CARE	28				
NEONATAL INTERMEDIATE CARE	29		8		8
PEDIATRIC	04		16		16
PEDIATRIC ICU	10				
PHYSICAL MEDICINE & REHABILITATION	07				
PRISONER					
PSYCHIATRIC**	08		44		44
RESPIRATORY					
SPECIAL USE					
SWING BED PROGRAM					
TRANSITIONAL CARE	33				
TRAUMATIC BRAIN INJURY	11				
	TOTAL		380		380

*CHEMICAL DEPENDENCE: Requires additional approval by the Office of Alcohol and Substance Abuse Services (OASAS)
**PSYCHIATRIC: Requires additional approval by the Office of Mental Health (OMH)

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

☒ No

☐ Yes (*Enter CON numbers to the right*) _____ _____ _____

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:
Address To Be Determined
Utica (Oneida County), New York 13502
(Enter street address of facility)

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☒	☐	☒
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☒	☐	☒
AMBULATORY SURGERY				
MULTI-SPECIALTY	☐	☒	☐	☒
SINGLE SPECIALTY – GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
CARDIAC CATHETERIZATION				
ADULT DIAGNOSTIC	☐	☒	☐	☒
ELECTROPHYSIOLOGY (EP)	☐	☒	☐	☒
PEDIATRIC DIAGNOSTIC	☐	☐	☐	☐
PEDIATRIC INTERVENTION ELECTIVE	☐	☐	☐	☐
PERCUTANEOUS CORONARY INTERVENTION (PCI)	☐	☒	☐	☒
CARDIAC SURGERY ADULT	☐	☒	☐	☒
CARDIAC SURGERY PEDIATRIC	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
CLINIC PART-TIME SERVICES	☐	☒	☐	☒
COMPREHENSIVE PSYCH EMERGENCY PROGRAM	☐	☐	☐	☐
DENTAL	☐	☒	☐	☒
EMERGENCY DEPARTMENT	☐	☒	☐	☒
EPILEPSY COMPREHENSIVE SERVICES	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☒	☐	☒
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
RADIOLOGY-THERAPEUTIC [5]	☐	☐	☐	☐
RENAL DIALYSIS, ACUTE	☐	☒	☐	☒
RENAL DIALYSIS,CHRONIC [Complete the ESRD section 16C-3(a)&(b) below][4]	___	___	___	___

[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] DIALYSIS SERVICES 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

TABLE 16C-2 LICENSED SERVICES *(cont.)*	Current	Add	Remove	Proposed
TRANSPLANT				
HEART - ADULT	☐	☐	☐	☐
HEART - PEDIATRIC	☐	☐	☐	☐
KIDNEY	☐	☐	☐	☐
LIVER	☐	☐	☐	☐
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐

New York State Department of Health
Certificate of Need Application

Schedule 16C

Impact of CON Application on Hospital Operating Certificate

Name of Active Parent:(if applicable): **N/A**
Name of Facility: **St. Luke's Campus [PFI #0599]**
Address of Facility: **1656 Champlin Avenue**
Utica (Oneida County), New York 13502

NOTE: THIS OPERATING CERTIFICATE REFLECTS THE BEDS AND SERVICES OF THE ST. LUKE'S CAMPUS. PLEASE REFER TO THE PROJECT NARRATIVE (UNDER THE SCHDULE 1 ATTACHMENT) AND ITS APPENDICES FOR ADDITIONAL INFORMATION.

Note: If the application involves an extension clinic, indicate which services should be added or removed from the certificate of the extension clinic alone, rather than for the hospital system as a whole. If multiple sites are involved, complete a separate 16C for each site.

TABLE 16C-1 AUTHORIZED BEDS

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30				
BONE MARROW TRANSPLANT	21				
BURNS CARE	09				
CHEMICAL DEPENDENCE-DETOX *	12				
CHEMICAL DEPENDENCE-REHAB *	13				
COMA RECOVERY	26				
CORONARY CARE	03				
INTENSIVE CARE	02				
MATERNITY	05				
MEDICAL/SURGICAL	01				
NEONATAL CONTINUING CARE	27				
NEONATAL INTENSIVE CARE	28				
NEONATAL INTERMEDIATE CARE	29				
PEDIATRIC	04				
PEDIATRIC ICU	10				
PHYSICAL MEDICINE & REHABILITATION	07		24		24
PRISONER					
PSYCHIATRIC**	08				
RESPIRATORY					
SPECIAL USE					
SWING BED PROGRAM					
TRANSITIONAL CARE	33				
TRAUMATIC BRAIN INJURY	11				
	TOTAL		24		24

*CHEMICAL DEPENDENCE: Requires additional approval by the Office of Alcohol and Substance Abuse Services (OASAS)
**PSYCHIATRIC: Requires additional approval by the Office of Mental Health (OMH)

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

☒ No

☐ Yes (*Enter CON numbers to the right*) _____ _____ _____

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:
1656 Champlin Avenue
Utica (Oneida County), New York 13502
(Enter street address of facility)

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☒	☐	☒
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☒	☐	☒
AMBULATORY SURGERY				
MULTI-SPECIALTY	☐	☐	☐	☐
SINGLE SPECIALTY – GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
CARDIAC CATHETERIZATION				
ADULT DIAGNOSTIC	☐	☐	☐	☐
ELECTROPHYSIOLOGY (EP)	☐	☐	☐	☐
PEDIATRIC DIAGNOSTIC	☐	☐	☐	☐
PEDIATRIC INTERVENTION ELECTIVE	☐	☐	☐	☐
PERCUTANEOUS CORONARY INTERVENTION (PCI)	☐	☐	☐	☐
CARDIAC SURGERY ADULT	☐	☐	☐	☐
CARDIAC SURGERY PEDIATRIC	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
CLINIC PART-TIME SERVICES	☐	☐	☐	☐
COMPREHENSIVE PSYCH EMERGENCY PROGRAM	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
EMERGENCY DEPARTMENT	☐	☐	☐	☐
EPILEPSY COMPREHENSIVE SERVICES	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
RADIOLOGY-THERAPEUTIC [5]	☐	☐	☐	☐
RENAL DIALYSIS, ACUTE	☐	☐	☐	☐
RENAL DIALYSIS,CHRONIC [Complete the ESRD section 16C-3(a)&(b) below][4]	___	___	___	___

[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] DIALYSIS SERVICES 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

TABLE 16C-2 LICENSED SERVICES *(cont.)*	Current	Add	Remove	Proposed
TRANSPLANT				
HEART - ADULT	☐	☐	☐	☐
HEART - PEDIATRIC	☐	☐	☐	☐
KIDNEY	☐	☐	☐	☐
LIVER	☐	☐	☐	☐
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐

TABLE 16C-3 LICENSED SERVICES FOR HOSPITAL EXTENSION CLINICS and OFF-CAMPUS EMERGENCY DEPARTMENTS

LOCATION: **St. Elizabeth Campus (Extension Clinic)** **[PFI #0598]** **2209 Genesee Street** **Utica (Oneida County), New York 13501** *(Enter street address of facility)*	**SEE NOTE BELOW**

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☒	☐	☒
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☒	☐	☒
AMBULATORY SURGERY				
SINGLE SPECIALTY -- GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
MULTI-SPECIALTY	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
RADIOLOGY-THERAPEUTIC[5]	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b) below][4]	___	___	___	___
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐
FOR OFF-CAMPUS EMERGENCY DEPARTMENTS ONLY[7]				
EMERGENCY DEPARTMENT	☐	☐	☐	☐

[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] DIALYSIS SERVICES 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 OFF-CAMPUS EMERGENCY DEPARTMENTS must meet all relevant Federal Conditions of Participation for a hospital per CMS S&C-08-08

Note: This site represents the services to be provided on the former inpatient campus of St. Elizabeth Medical Center. The former St. Elizabeth site will be converted into an outpatient extension clinic (to be known as "St. Elizabeth Campus"). As an extension clinic, it will maintain its current PFI number.

END STAGE RENAL DISEASE (ESRD)

N/A – Replacement Hospital Project

TABLE 16C-3*(a)* CAPACITY	Existing	Add	Remove	Proposed
CHRONIC DIALYSIS				

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

TABLE 16C-3(b) TREATMENTS	Last 12 mos	2 years prior	3 years prior
CHRONIC DIALYSIS			

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

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.

N/A

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.

N/A

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.

N/A

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

N/A

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.

N/A

Mobile Clinic Site Approval Request: ***N/A***

One form must be submitted for each proposed mobile clinic site. Please feel free to photocopy this form as necessary. You may use attach additional sheets as necessary

Facility Name		
Proposed Site Address		
CITY	COUNTY	ZIP
Type of Facility at Site		
Name and Title of Representative at site:		
Type of Service		

Is mobile clinic in a self-contained vehicle or is equipment moved into the temporary site?

Schedule of operation

Justification for service at this site

List of current sites where these services will no longer be offered

a	b	d	f
	Current Year *Visits**	First Year *visits**	Third Year *visits**
CERTIFIABLE SERVICES			
MEDICAL SERVICES - PRIMARY CARE	233,195	241,986	241,986
MEDICAL SERVICES - OTHER MEDICAL SPECIALTIES	68,811	71,405	71,405
AMBULATORY SURGERY			
SINGLE SPECIALTY - GASTROENTEROLOGY			
SINGLE SPECIALTY - OPHTHALMOLOGY			
SINGLE SPECIALTY - ORTHOPEDICS			
SINGLE SPECIALTY - PAIN MANAGEMENT			
SINGLE SPECIALTY - OTHER			
MULTI-SPECIALTY	19,336	20,065	20,065
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC	1,540	1,598	1,598
ELECTROPHYSIOLOGY	1,003	1,041	1,041
PEDIATRIC DIAGNOSTIC	0	0	0
PEDIATRIC INTERVENTIONAL ELECTIVE	0	0	0
PERCUTANEOUS CORONARY INTERVENTION (PCI)	413	429	429
CERTIFIED MENTAL HEALTH O/P			
CHEMICAL DEPENDENCE - REHAB			
CHEMICAL DEPENDENCE - WITHDRAWAL O/P			
CLINIC PART-TIME SERVICES			
CLINIC SCHOOL-BASED SERVICES			
CLINIC SCHOOL-BASED DENTAL PROGRAM			
COMPREHENSIVE EPILEPSY CENTER			
COMPREHENSIVE PSYCH EMERGENCY PROGRAM			
DENTAL	12,473	12,943	12,943
EMERGENCY DEPARTMENT	62,067	64,407	64,407
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT	7,895	8,193	8,193
HOME HEMODIALYSIS TRAINING & SUPPORT	2,013	2,089	2,089
INTEGRATED SERVICES - MENTAL HEALTH			
INTEGRATED SERVICES - SUBSTANCE USE DISORDER			
LITHOTRIPSY	109	113	113
METHADONE MAINTENANCE O/P			
RADIOLOGY-THERAPEUTIC	9,779	10,148	10,148
RENAL DIALYSIS, CHRONIC	53,188	55,193	55,193
OTHER SERVICES	215,809	223,945	223,945
Total	**687,631**	**713,555**	**713,555**

Note: In the case of an extension clinic, the service estimates in this table should apply to the site in question, not to the hospital or network as a whole.

* The 'Total' reported MUST be the SAME as those on Table 13D-4.

Note: Represents the combined facilities upon the implementation of the new hospital campus.

Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date: 1/1/16		1st Year Start date: 1/1/22		3rd Year Start date: 1/1/24	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
AIDS						
BONE MARROW TRANSPLANT						
BURNS CARE						
CHEMICAL DEPENDENCE - DETOX						
CHEMICAL DEPENDENCE - REHAB						
COMA RECOVERY						
CORONARY CARE	226	2,504	217	2,404	217	2,404
INTENSIVE CARE	678	9,387	650	8,999	650	8,999
MATERNITY	1,977	5,097	1,897	4,891	1,897	4,891
MED/SURG	17,587	78,147	16,873	74,974	16,873	74,974
NEONATAL CONTINUING CARE						
NEONATAL INTENSIVE CARE						
NEONATAL INTERMEDIATE CARE	161	1,793	154	1,715	154	1,715
PEDIATRIC	529	1,182	508	1,135	508	1,135
PEDIATRIC ICU						
PHYSICAL MEDICINE & REHABILITATION	343	4,870	329	4,671	329	4,671
PRISONER						
PSYCHIATRIC	2,306	13,241	2,212	12,701	2,212	12,701
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM						
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL	**23,807**	**116,221**	**22,840**	**111,490**	**22,840**	**111,490**

Prior versions of this table referred to "incremental" changes in discharges and days.
Note that the table now requires the full count of discharges and days.

Note: Represents the combined facilities upon the implementation of the new hospital campus.

Schedule 16 F. Facility Access N/A

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

Complete Table 1 to indicate the method of payment for inpatients and for inpatients and outpatients who were transferred to other health care facilities for the calendar year immediately preceding this application.
Start date of year for which data applies (m/c/yyyy):

Table 1. Patient Characteristics Payment Source	Total Number of Inpatients	Number of Patients Transferred		
		Inpatient	OPD	ER
Medicare				
Blue Cross				
Medicaid				
Title V				
Workers' Compensation				
Self Pay in Full				
Other (incl. Partial Pay)				
Free				
Commercial Insurance				
Total Patients				

Complete Table 2 to indicate the method of payment for outpatients.

Table 2. Outpatient Characteristics Primary Payment Source	Emergency Room		Outpatient Clinic		Community MH Center	
	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions
Medicare						
Blue Cross						
Medicaid						
Title V						
Workers' Compensation						
Self Pay in Full						
Other (incl. Partial Pay)						
Free						
Commercial Insurance						
Total Patients						

A. Attach a copy of your discharge planning policy and procedures.

B. Is your facility a recipient of federal assistance under Title VI or XVI of the Public Health Service? Act (Hill-Burton)?

Yes ☐ No ☐

If yes, answer the following questions and attach the most recent report on Hill-Burton compliance from the Federal Department of Health and Human Services.

N/A

1. Is your facility currently obligated to provide uncompensated service under the Public Health Service Act?
Yes ☐ No ☐

If yes, provide details on how your facility has met such requirement for the last three fiscal years - including notification of the requirement in a newspaper of general circulation. Also, list any restricted trusts and endowments that were used to provide free, below-cost or charity care services to persons unable to pay.

2. With respect to all or any portion of the facility which has been constructed, modernized, or converted with Hill-Burton assistance, are the services provided therein available to all persons residing in your facility's service area without discrimination on the basis of race, color, national origin, creed, or any basis unrelated to an individual's need for the service or the availability of the needed service in the facility?

Yes☐ No☐

If no, provide an explanation.

3. Does the facility have a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility?

Yes ☐ No ☐

4. Do Medicaid beneficiaries have full access to all of your facility's health services?

Yes ☐ No ☐

If no, provide a list of services where access by Medicaid beneficiaries is denied or limited.