New York State Department of Health
Certificate of Need Application
General Information - All Applicants

Schedule 1

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Main Site*	0599	00384309	Hospital	Mohawk Valley Health System/ Faxton-St. Luke's Healthcare St. Luke's Division
	STREET & NUMBER			
	1656 Champlin Avenue			
	CITY		COUNTY	ZIP
	Utica		Oneida	13502

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Project Site #1*	To Be Determined	To Be Determined	Hospital	Mohawk Valley Health System Campus
	STREET & NUMBER			
	To Be Determined**			
	CITY		COUNTY	ZIP
	Utica		Oneida	13502

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Project Site #2*	0598	00279901	Hospital – Extension Clinic	Mohawk Valley Health System/St. Elizabeth Campus
	STREET & NUMBER			
	2209 Genesee Street, Utica (Oneida County), New York 13501			
	CITY		COUNTY	ZIP
	Utica		Oneida	13501

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Project Site #3*	0599	00384309	Hospital	Mohawk Valley Health System/ St. Luke's Campus
	STREET & NUMBER			
	1656 Champlin Avenue			
	CITY		COUNTY	ZIP
	Utica		Oneida	13502

	OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
Operator Information*	3202002H/ 3202003H	Hospitals	St. Elizabeth Medical Center / Faxton-St. Luke's Healthcare St. Luke's Division Mohawk Valley Health System
	STREET & NUMBER		
	2209 Genesee Street / 1656 Champlin Avenue		
	CITY	COUNTY	ZIP
	Utica	Oneida	13501/13502

*** Please refer to the Project Narrative under the Schedule 1 Attachment for a description of this project.**
**** The new, consolidated hospital campus will be located on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13502: State Street, Broadway, Oriskany Street West, and Columbia Street. An address has not yet been assigned to the site.**

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☒ NO ☐	Please refer to the Schedule 1 Attachment

New York State Department of Health Certificate of Need Application

Schedule 1

Is the applicant part of an "established article 28* network" as defined in section 401.1(j) of 10 nycrr? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart, if available.	YES ☒ NO ☐	Please refer to the Schedule 1 Attachment

Type of Application: Establishment ☐ Construction ☒ Administrative ☐ Limited ☐

Total Project Cost: ***(CRFP-Funded Project)(Article 28 only)***	$480,000,000
Amount of Application Fee (see Schedule 8)	$2,000/$2,627,548

Acknowledgement And Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: St. Luke's Healthcare St. Luke's Division / St. Elizabeth Medical Center / Mohawk Valley Health System

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and/or article 7 of the social services law, and implementing regulations, as the case may be.

SIGNATURE:	DATE
	11/6/17
PRINT OR TYPE NAME	TITLE
Scott Perra	President and CEO, Mohawk Valley Health System

New York State Department of Health
Certificate of Need Application
Contacts:

Schedule 1

Applicant should identify the operator's chief executive officer, or equivalent official, to whom all official correspondence from DOH about this application should be addressed

CHIEF EXECUTIVE			
NAME AND TITLE OF CHIEF EXECUTIVE			
Mr. Scott Perra, F.A.C.H.E., President and CEO, Mohawk Valley Health System			
STREET & NUMBER			
1656 Champlin Avenue			
CITY	STATE	ZIP	
Utica	New York	13502	
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS	
(315) 624-6001	(315) 624-6956	sperra@mvhealthsystem.org	

Applicant may designate a second person to whom copies of all official correspondence from DOH about this application should be addressed. (This could be the applicant's attorney, or a consultant)

CONTACT INFORMATION		
CONTACT PERSON'S COMPANY	NAME AND TITLE OF CONTACT PERSON	
Mohawk Valley Health System	Ms. Sharon Palmer, AVP Facilities Services	
STREET & NUMBER		
1656 Champlin Avenue		
CITY	STATE	ZIP
Utica	New York	13502
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
(315) 624-6298	(315) 624-6230	spalmer@mvhealthsystem.org

The applicant's lead attorney should be identified:

ATTORNEY		
NAME		
Traci Boris, Esq.		
STREET & NUMBER		
1656 Champlin Avenue		
CITY	STATE	ZIP
Utica	New York	13502
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
(315) 624-5050	(315) 624-5051	tboris@mvhealthsystem.org

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

CONSULTANT		
NAME		
Frank M. Cicero, Cicero Consulting Associates		
STREET & NUMBER		
701 Westchester Avenue, Suite 210W		
CITY	STATE	ZIP
White Plains	New York	10604
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
(914) 682-8657	(914) 682-8895	conadmin@ciceroassociates.com

New York State Department of Health
Certificate of Need Application

Schedule 1

The applicant's lead accountant should be identified:

ACCOUNTANT	NAME		
	Mr. Louis Aiello		
	STREET & NUMBER		
	1656 Champlin Avenue		
	CITY	STATE	ZIP
	Utica	New York	13502
	TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
	(315) 624-6143	(315) 624-6956	LAIELLO1@mvhealthsystem.org

Please list all Architects and Engineer contacts.

ARCHITECT and/or ENGINEER	NAME	FIRM	STREET & NUMBER
	Mitzi D'Amico	NBBJ	250 S. High Street; Suite 300
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
	Columbus, OH 43215	(614) 232-3033	mdamico@nbbj.com

ARCHITECT and/or ENGINEER	NAME	FIRM	STREET & NUMBER
	N/A		
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

ARCHITECT and/or ENGINEER	NAME	FIRM	STREET & NUMBER
	N/A		
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

ARCHITECT and/or ENGINEER	NAME	FIRM	STREET & NUMBER
	N/A		
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

New York State Department of Health
Certificate of Need Application

Schedule 1

Checklist of Schedules Included in This Application

Schedule Number	Schedule Name	Required	Included
1	Forms Required for all CON Applications	☒	☒
2 (A-D)	Personal Qualifying and Disclosure Information-All Establishment Applications	☐	☐
3 (A-B)	CON Forms Related to Legal Issues	☐	☐
4 (A-B)	Legal Information for Ownership Transfers	☐	☐
5	CON Form Regarding Working Capital Plan	☒	☒
6	CON Form Regarding Architectural Submission	☒	☒
7	CON Forms Regarding Environmental Issues	☒	☒
8 (A-B)	Project & Subproject Cost Summary	☒	☒
9	CON Forms Regarding Project Financing	☒	☒
10	Space & Construction Cost Distribution	☒	☒
11	Moveable Equipment	☒	☒
12 (A-G)	CON Forms Specific to Adult Care Facilities	☐	☐
13 (A-D)	CON Forms Applicable to all Article 28 Facilities	☒	☒
14 (A-D)	Additional Legal Information-Article 28	☐	☐
15	Additional Legal Information-Article 28-Ownership Transfers	☐	☐
16 (A-F)	CON Forms Specific to Hospitals-Article 28	☒	☒
17 (A-E)	CON Forms Specific to Diagnostic & Treatment Centers-Article 28	☐	☐
18 (A-E)	CON Forms Specific to Residential Health Care Facilities-Article 28	☐	☐
19 (A-B)	CON Forms Specific to Adult Day Health Care Programs	☐	☐
20 (A-C)	CON Forms Specific to Programs of OMH, OASAS, and OMRDD (If Applicable)	☒	☒
21 (A-G)	CON Forms Specific to CHHA and LTHHCP Programs-Article 36	☐	☐
22 (A-F)	CON Forms Specific to Hospices-Article 40	☐	☐
23	CON Forms Specific to all Projects Incorporating Health IT	☐	☐

New York State Department of Health
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Schedule 1

Other Facilities Owned or Controlled by the Applicant

(Establishment Applications only)

N/A

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

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE CODE	
Hospital	HOS	Yes ☐ No ☐
Nursing Home	NH	Yes ☐ No ☐
Diagnostic and Treatment Center	DTC	Yes ☐ No ☐
Licensed Home Care Services Agency	LHH	Yes ☐ No ☐
Certified Home Health Agency	CHH	Yes ☐ No ☐
Hospice	HSP	Yes ☐ No ☐
Adult Home	ADH	Yes ☐ No ☐
Assisted Living Program	ALP	Yes ☐ No ☐
Long Term Home Health Care Program	LTC	Yes ☐ No ☐
Enriched Housing Program	EHP	Yes ☐ No ☐
Health Maintenance Organization	HMO	Yes ☐ No ☐
Other	OTH	Yes ☐ No ☐

For each facility or agency referenced above, enter the name, the PFI and facility type in the chart below.

	FACILITY NAME:	PFI	FACILITY TYPE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Attach additional sheet if necessary.

In addition to the information provided on the above chart, provide a complete list of all health care, adult care, behavioral, or mental health facilities, programs or agencies located outside New York State that are affiliated with the applicant corporation, as well as with parent, member and subsidiary corporations. For each health care entity identified, provide the full name, address, and type of services provided. In conjunction with this list, provide documentation from the regulatory agency in the state(s) where affiliations are noted, reflecting that the facilities/programs/agencies have operated in substantial compliance with applicable codes, rules and regulations for the past ten years (or for the period of the affiliation, whichever is shorter). To assist you in securing this information, a recommended form and a sample letter of inquiry are provided in Schedule 2 D.

Please list the facilities outside of New York State that are owned or controlled by the applicant:

N/A

	FACILITY NAME AND ADDRESS:	Services provided:	STATE/ COUNTRY	FACILITY TYPE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

SCHEDULE 1 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

BOARD RESOLUTION

AND

PROJECT NARRATIVE

RESOLUTION
OF THE
BOARD OF DIRECTORS
OF
MOHAWK VALLEY HEALTH SYSTEM
ST. ELIZABETH MEDICAL CENTER
FAXTON-ST. LUKE'S HEALTHCARE
(the "Corporations")

Adopted at a Meeting Held September 28, 2017

WHEREAS, $300 million has been earmarked in the New York State budget to help create an integrated healthcare delivery system in Oneida County; and

WHEREAS, the legislation provides a once in a lifetime opportunity for the Mohawk Valley Health System (MVHS) to build a new hospital in Utica, NY and transform healthcare for our community consistent with the vision of Triple Aim; and

WHEREAS a new 670,000 SF, 392 inpatient bed, state of the art hospital that would replace St. Elizabeth Medical Center (SEMC) built in 1917 and the St. Luke's Campus of Faxton-St. Luke's Healthcare (FSLH) built in 1957; and

WHEREAS, a new hospital would reduce the number of beds in our community and consolidate patient services to one campus in a Delivery System Reform Incentive Payment Program (DSRIP) oriented program; and

WHEREAS, the Hospital desires to construct a new health care facility in Oneida County in the City of Utica;

NOW, THEREFORE, upon motion duly made, seconded and unanimously carried, it is

RESOLVED, that the officers of the Hospital are hereby authorized and directed to file a Certificate of Need Application with the New York State Department of Health requesting its approval for the construction and operation of a new health care facility in Oneida County in the City of Utica; and

IT IS FURTHER RESOLVED, that the officers of the Hospital are hereby authorized and directed to take whatever actions shall be necessary and execute any and all documents as shall be required to effectuate the intent of the foregoing resolutions; and

IT IS FURTHER RESOLVED, that the Hospital hereby adopts and incorporates by reference any form of specific resolution to carry into effect the purpose and intent of the foregoing resolutions, or covering authority included in matters authorized in the foregoing resolutions, including forms of resolutions in connection therewith that may be required by any state, institution, person or agency and the Hospital be, and hereby is, directed to insert a copy thereof in the minute book of the Hospital following this written action and to certify the same as having been duly adopted thereby.

These resolutions shall take effect immediately.

Dated: September 28, 2017

Gregory P. Evans, Secretary

MOHAWK VALLEY HEALTH SYSTEM

PROJECT NARRATIVE

Proposal

Mohawk Valley Health System (MVHS) is submitting this Full Review Certificate of Need (C.O.N.) Application that seeks approval for the construction of a new hospital campus. Mohawk Valley Health System (MVHS) is the active parent and co-operator of St. Elizabeth Medical Center (SEMC) and Faxton St. Luke's Healthcare St. Luke's Division (St. Luke's). St. Luke's is currently located at 1656 Champlin Avenue, Utica (Oneida County), New York 13502. St. Elizabeth Medical Center is currently located at 2209 Genesee Street, Utica (Oneida County), New York 13501. Cardiac PCI and cardiac surgery services currently offered through the Mohawk Valley Heart Institute are also provided on the campus of St. Elizabeth at 2209 Genesee Street, Utica (Oneida County), New York 13501. This C.O.N. Application will be funded, in part, through the **Health Care Facility Transformation Program: Oneida County** grant awarded to MVHS specifically for this purpose. This project is one (1) of at least two (2) Applications being submitted to the New York State Department of Health (NYSDOH) for the transformation of services within the Oneida County region, as described in detail below.

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 (i.e., the creation of a new hospital campus), which will result in the transformation of healthcare services in the region.

Current Situation

MVHS is currently the active parent and co-operator of St. Luke's and St. Elizabeth. In addition, cardiac PCI and cardiac surgery services currently offered through the Mohawk Valley Heart Institute are provided on the campus of St. Elizabeth at 2209 Genesee Street, Utica (Oneida County), New York 13501. The location and NYSDOH identifying information for these facilities are as follows:

- Faxton St. Luke's Healthcare St. Luke's Division – Operating Certificate #3202003H; PFI #0599 – 1656 Champlin Avenue, Utica (Oneida County), New York 13502.
- St. Elizabeth Medical Center – Operating Certificate #3202002H; PFI #0598 – 2209 Genesee Street, Utica (Oneida County), New York 13501.
- Mohawk Valley Heart Institute (MVHI) – Operating Certificate #3202004H; PFI #7528 – 2209 Genesee Street, Utica (Oneida County), New York 13501.

Future Situation

This C.O.N. Application is the first in a series of (at least two (2)) Applications that Mohawk Valley Health System and its two (2) related facilities (St. Elizabeth and St. Luke's) will be submitting that will lead to the merger of St. Elizabeth and St. Luke's, and the relocation and consolidation of the majority of services comprising St. Elizabeth and St. Luke's to the new hospital campus in Utica, New York. A description of the expected Application submissions is as follows:

- Application #1 – Full Review C.O.N. Application (Subject of this Application) – Construction of a new hospital campus. The new, consolidated hospital campus will be located on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street.[1] Please refer to **Appendix I** for a map of the proposed campus. An address has not yet been assigned to the site.

[1] The proposed property is comprised of several land parcels, some of which have structures on them that will need to be demolished. Mohawk Valley Health System is in the process of working with the property owners to attempt to purchase the parcels of land for the proposed new hospital campus. Should an owner of the parcel of land elect not to negotiate with MVHS, the Hospital may need to proceed through the eminent domain process to secure the parcel.

Through this C.O.N. Application, all inpatient and most outpatient services from the current St. Elizabeth campus will be relocated to the new hospital campus, which will be known as the "Mohawk Valley Health System Campus". A separate "merger" C.O.N. Application will be submitted, as described in the next bullet point.[2]

The following programs and services will remain on the St. Elizabeth site, with no construction or relocation necessary:

- Article 28 Services – The St. Elizabeth site will be converted into an outpatient extension clinic to be known as "St. Elizabeth Campus". MVHS prefers that this site maintain its current PFI Number. In particular, sleep center services (Mohawk Valley Sleep Disorders Center), cardiac and thoracic surgery-related services (all of which are medical-only services; no surgical services will be provided at this site), primary care and laboratory patient service center (PSC) services will continue to be provided at this site.

  The Mohawk Valley Sleep Disorders Center and some primary care services are currently located within the campus located at 2209 Genesee Street, Utica (Oneida County), New York 13501. The cardiac and thoracic surgery offices, other primary care services and the laboratory PCS are located within the Marian Medical Building at 2209 Genesee Street, Utica (Oneida County), New York 13501. This site will become an extension clinic, with no construction needed.[3] MVHS prefers that a new operating certificate be created for the

[2] Upon implementation of the merger project, which will result in MVHS preferably having a single new operating certificate number and PFI number through which the two (2) hospital sites will operate as divisions, MVHS will relocate all inpatient and outpatient services from the St. Elizabeth and the St. Luke's sites to the new hospital campus (with the exception of 24 PM&R beds at the St. Luke's Campus and some other outpatient services as described within this C.O.N. application).

[3] For purposes of this C.O.N. Application, we are assuming that, although these services will be located in different buildings, they will remain in their current locations and MVHS prefers that they share the same Operating Certificate and PFI number. MVHS is willing to discuss this issue with the State Health Department, should the Department prefer to certify the sleep center and outpatient cardiac/thoracic services, primary care practice and laboratory PSC as separate extension clinics.

extension clinic while maintaining its current PFI number and being certified for the services of "Medical Services – Primary Care" and "Medical Services – Other Medical Specialties".

- Non-Article 28 Services (St. Elizabeth College of Nursing) – This program is not an Article 28 service, but it will remain on the current site of St. Elizabeth.

➢ Application #2 – Full Review C.O.N. Application – This project will represent the "merger" C.O.N. Application through which St. Elizabeth and St. Luke's will be merged to become a single hospital entity, preferably with a single operating certificate number and new PFI number. St. Luke's will become a division of MVHS. In addition, through that C.O.N. Application, the majority of services from the St. Luke's and St. Elizabeth sites will be relocated to the new hospital campus The "merger" project is expected to be implemented while the new hospital campus is being constructed.

The following programs and services will remain on the St. Luke's campus, with no construction or relocation necessary after the merger:

- Article 28 Services – The St. Luke's site, which will be a hospital "division", will retain the following services, with no construction needed: 24 certified, inpatient PM&R beds, laboratory PSC service, outpatient primary care and obstetrics services, and outpatient surgeon offices for medical visits/services.

  This site will be known as the "St. Luke's Campus". As part of this C.O.N. Application, the majority of the inpatient and outpatient services will relocate to the new hospital campus, leaving behind the 24 PM&R beds and other outpatient services at 1656 Champlin Avenue, Utica (Oneida County). The laboratory PSC, primary care, obstetrics, and outpatient surgeon offices will continue to be located within a Physician Office Building on the St. Luke's

Campus.[4] This campus will be certified for 24 inpatient PM&R beds and the certified services of "Medical Services – Primary Care" and "Medical Services – Other Medical Specialties".

- Article 28 Services – The Operating Certificates of all extension clinics of MVHS (St. Elizabeth and St. Luke's) will be consolidated under the single operating certificate of the operator. In addition, some of the extension clinic sites with different operating certificates have the same addresses. These sites will need to be consolidated to a single operating certificate for each extension clinic.

- Article 28 Services – To maintain service continuity, PCI and Cardiac Surgery services currently offered through Mohawk Valley Heart Institute will be provided on the new hospital campus. MVHS will work with the NYSDOH to determine how to handle the services offered though the Mohawk Valley Heart Institute, and if this entity can be eliminated.

- Other Article 28 and Article 36 Services
  - St. Luke's Home – A 202-bed residential health care facility (RHCF) with an Adult Day Health Care Program (ADHCP) affiliated with MVHS.
  - Mohawk Valley Home Care – A licensed home care services agency (LHCSA) affiliated with MVHS.
  - Visiting Nursing Association of Utica and Oneida County – A certified home health agency (CHHA) and a long-term home health care program (LTHHCP) affiliated with MVHS.

[4] For purposes of this C.O.N. Application, we are assuming that, although the inpatient PM&R beds and the outpatient services will be located in different buildings, they will remain in their same locations and will continue to share the same Operating Certificate and PFI number. MVHS is willing to discuss this issue with the State Health Department, should the Department prefer to certify the outpatient services as a separate extension clinic from the PM&R bed hospital division.

Impact of Overall Transformation on Operating Certificates

The overall transformation project (i.e. not just the implementation of this "new hospital campus" project, but also the merger project) will have an impact upon the operating certificates of the facilities, as follows:

Certified Inpatient Beds

Please refer to **Appendix II** for an inpatient bed complement analysis that shows the number of certified inpatient beds operated at St. Elizabeth and St. Luke's before and after the implementation of the overall, proposed project, as well as a comparison of St. Elizabeth/St. Luke's (combined) and the new hospital campus. The overall project will result in the decertification of 174 certified inpatient beds from the healthcare system. It should be noted that almost all 373 beds on the new hospital campus will be located in single-bedded rooms (four (4) rooms on each medical/surgical floor and four (4) rooms on the behavioral health unit will be constructed as semi-private for use only during high census), which is the standard of inpatient care in the 21st century.

St. Elizabeth is currently certified for 201 inpatient beds (please refer to **Appendix II** for the breakdown of beds by certified bed category). Upon the implementation of the overall project, all inpatient beds at St. Elizabeth will be relocated to the new, consolidated hospital campus. As explained above, the St. Elizabeth campus will retain some outpatient programs and services, and it will become an outpatient extension clinic.

St. Luke's is currently certified for 370 inpatient beds (please refer to **Appendix II** for the breakdown of beds by certified bed category). Upon the implementation of the overall project, all but 24 inpatient PM&R beds will be relocated to the new, consolidated hospital campus. These 24 inpatient PM&R beds will remain in place on the St. Luke's campus, with no construction required. As explained above, the St. Luke's campus will retain other programs and services on its campus.

The St. Luke's campus will retain 24 PM&R beds and the new hospital campus will ultimately have 373 beds, so some inpatient beds of St. Elizabeth and St. Luke's will need to be decertified upon implementation of both the new hospital campus and the merger projects.

Please also refer to **Appendix II** for Transition Plans for St. Luke's and St. Elizabeth.

Certified Services on Hospital Campuses (Existing and New)

Please refer to **Appendix III** for an analysis of certified services and an analysis of programs/services for the various campuses involved in the overall project.

Extension Clinic(s)

St. Elizabeth currently operates eight (8) extension clinics and St. Luke's currently operates 21 extension clinics. Together, these 29 extension clinics will continue to be operated by these entities. In addition, St. Luke's has three (3) approved-but-not-operational extension clinics (approved under Project Nos. 142261, 171306 and 171478). Please refer to **Appendix IV** for a list of these extension clinic sites that are impacted by the overall project. As noted above, some of these extension clinics will be consolidated through the "merger" C.O.N. Application that will be submitted while the new hospital campus project is under construction. In addition, the current St. Elizabeth campus will be converted to an extension clinic.

NYSDOH Designations

St. Elizabeth is currently designated by the NYSDOH as a Level III Adult Trauma Center. St. Luke's is currently designated by the NYSDOH as both a Level II Perinatal Center and a Stroke Center. MVHS plans to continue to maintain these three (3) NYSDOH designations – Level III Adult Trauma Center, Level II Perinatal Center and a Stroke Center – at the new hospital campus.

Disposition of Former St. Elizabeth and St. Luke's Buildings

MVHS plans to engage with a third-party firm for the development of a repurposing plan for the campus spaces that will no longer be utilized by MVHS for healthcare services. It is possible that the properties may be sold or used for other functions, but the future disposition is still to be determined.

Non-Article 28 Spaces on New Hospital Campus

The new hospital campus will contain several spaces/buildings that will be non-Article 28 but are being shown on the drawings for this C.O.N. Application. These programs include the following:

- Masonic Medical Research Lab (MMRL) – The MMRL is a biomedical research institute founded in 1958. MMRL will lease certain space on the new hospital campus, within the new hospital building structure, from MVHS. The capital cost of the construction for the MMRL is included as a separate sub-project on C.O.N. Schedule 8B.

- On-Campus Parking Garage – MVHS will work with the City of Utica (the "City") and the County of Oneida (the "County") to develop an on-campus parking garage that will serve the parking needs of MVHS and the downtown Utica general public. Through a Memorandum of Agreement (MOA), MVHS, the City and the County have agreed to collaborate in the development of a new, on-campus parking garage on the new hospital campus, as well as the refurbishment of another existing parking garage (the "Kennedy Garage") in close proximity to the new hospital campus. At this time, it is expected that MVHS will operate and maintain the on-campus parking garage. Please refer to the **Schedule 9 Attachment** for the MOA. The capital costs of the parking garage are not being included in this C.O.N. Application because they will be jointly paid for by Oneida County and the City of Utica.

In addition, MVHS expects to modify this C.O.N. Application in the future to include a Medical Office Building (MOB) on the new MVHS campus that will likely contain Article 28 services. As of

the time of submission of this C.O.N. Application, MVHS had not yet decided what services would be placed within the MOB, so it is not being included in this initial C.O.N. submission.

Project Background

MVHS is the active parent and co-operator of both St. Luke's and St. Elizabeth. St. Luke's is a 370-bed, not-for-profit hospital located at 1656 Champlin Avenue, Utica (Oneida County), New York 13502. St. Elizabeth's is a 201-bed, not-for-profit hospital located at 2209 Genesee Street, Utica (Oneida County), New York 13501. The two (2) facilities are currently located 1.8 miles and six (6) minutes' travel time from one another.

The new hospital campus and merger will enable MVHS to 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, the overall 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 the overall 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.

The proposed location of the project on 25 acres of land adjacent to the central business district of Utica will centralize healthcare services for Oneida County in the most populated area of the County, which is a requirement of the $300 million grant provided by the NYSDOH under New York Public Health Law Section 2825-b. The additional benefits include the utilization and support of existing parking, retail, restaurants, hotels, small businesses and community events. The new hospital, which

will be approximately 672,000 square feet in size, will also become a catalyst for ongoing and future development of the region.

In addition to improving the efficiency of staff workflow, the proposed consolidation of the two (2) existing acute care facilities will result in a decrease in the total number of inpatient beds from a combined 571 inpatient beds at two (2) campuses to a more efficient model with 174 fewer beds, representing a reduction of about 30%. This is achievable through having 95%private patient rooms, improved throughput metrics, reduced length of stay and a general reduction of utilization in the region, which reflects the national, State and local trends of a reduction in inpatient admissions and an increase in outpatient visits.

The new, consolidated hospital was designed with the following goals in mind:

- 95% of all inpatient rooms will be private to ensure patient privacy, eliminate transfers, promote healing and provide space for families. Private patient rooms also provide greater protection to patients who are highly susceptible to infections and help prevent infections from spreading.
- Patient rooms will be equipped with accommodations for family members and visitors, including seating, Wi-Fi access and a television.
- Patients will have personal control over their room temperature, lighting and window blinds.
- Room design will enable standardization of care and improved efficiency and safety.
- Hospital-wide communication systems will allow for a quieter, more calming environment.
- Critical supplies will be located adjacent to patient rooms to minimize time and travel distances when caring for patients.
- Department locations will be strategically located for maximum efficiency in patient transport and privacy.
- Ample and convenient parking will be constructed to serve various populations, such as patients, visitors, employees, medical staff, vendors and emergency vehicles.

Because of the relocation and decertification of inpatient psychiatric beds through the overall project (please refer to **Appendix II**), the New York State Office of Mental Health (NYSOMH) will also be involved in the review of the overall project. On August 7, 2017, MVHS and its representatives met with representatives of the New York State Office of Mental Health (Mr. Keith McCarthy, Mr. Mark Simone and Ms. Sue Knapik) to discuss the proposed plans for MVHS's new hospital campus. On October 6, 2017, MVHS and its representatives met with Mr. Udo Ammon of the New York State Department of Health and Mr. Keith McCarthy of the NYSOMH to again discuss its proposed plans.

Please refer to the **Schedule 6 Attachment** for architectural documentation for this project.

Background and Evaluation of Public Need

The affiliation of MVHS with St. Elizabeth's and St. Luke's, which occurred in 2014 (under Project No. 132204), began a process of assessing the current operations of both hospitals and developing a plan to reduce/eliminate the duplication of clinical and building services. A number of services were consolidated to one (1) hospital location, which resulted in a reduction of operational costs, as well as improved patient experiences and staffing efficiencies. However, other programs and services such as inpatient care, emergency services, diagnostic imaging and surgery remained at both campuses because they are needed to help operate a full-service acute care facility. A significant number of support services, including dietary, pharmacy, laboratory, administration, materials management, housekeeping, security, and engineering and maintenance staff – all needed to operate two (2) aging facilities – are currently duplicated at the two (2) sites, less than two (2) miles apart.

Multiple facility options were analyzed, including: (1) maintaining both hospital sites; (2) consolidating one facility into the other facility based upon available land, feasibility with phasing and logistics; and (3) consolidating both facilities to a brand new campus. Based upon its analysis, MVHS decided that the option of consolidating both facilities to a new campus would be the most effective option. First, it would give MVHS the opportunity to improve patient access to serve the

County's largest population center, which includes the 4th largest refugee program in the United States. Second, consolidating all services to a single site would improve operational efficiency and maximize resources (including physicians and employees). Third, a new, consolidated site will enable MVHS to reduce infrastructure and energy cost/consumption for decades to come. The existing St. Elizabeth and St. Luke's facilities were constructed in 1917 and 1957. A single campus would reduce the overall building square footage from 928,000 square feet to approximately 672,000 square feet (a 28% decrease).

By consolidating the two (2) facilities to a new campus, MVHS can have nearly all private inpatient rooms, and it will be able to more appropriately segregate the outpatient and inpatient programs of care to meet the needs of population health management. Outpatient services adjacent to a new, integrated healthcare campus will provide a one-(1)-stop care environment for patients who need more specialized care, and a model of care delivery that is seamless and highly accessible.

Inpatient Utilization Statistics

Summary tables of the occupancy rates for St. Elizabeth's and St. Luke's (separately) between 2012 and YTD 2017 are as follows:

Table A. Occupancy Rate by Certified Bed Category at St. Elizabeth's, 2012-YTD 2017

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care	87.1%	86.5%	88.9	86.8%	85.4%	83.9%
Medical/Surgical	84.4%	74.4%	76.4%	74.1%	72.9%	75.1%
Pediatric	11.1%	8.0%	12.7%	9.7%	7.5%	3.9%
Psychiatric	80.5%	74.5%	81.2%	85.8%	73.1%	72.8%
TOTAL	**81.3%**	**73.0%**	**75.7%**	**74.2%**	**71.6%**	**72.9%**

*Data includes information through September 30, 2017.
Source: Internal data from MVHS

Table B. Occupancy Rate by Certified Bed Category at St. Luke's, 2012-YTD 2017

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care/ Coronary Care**	76.4%	75.0%	83.9%	82.9%	79.6%	82.6%
Maternity	61.7%	59.6%	56.5%	56.0%	53.6%	52.4%
Medical/Surgical	58.6%	52.0%	49.0%	48.0%	42.6%	42.2%

Neonatal Continuing/ Intermediate Care***	47.8%	39.4%	33.2%	36.3%	40.8%	36.0%
Pediatric	33.5%	30.5%	29.7%	28.1%	23.1%	24.7%
Physical Medicine & Rehabilitation	61.0%	60.6%	57.4%	56.0%	52.7%	47.4%
Psychiatric	58.8%	60.8%	72.7%	78.1%	70.1%	66.7%
TOTAL	**59.1%**	**54.3%**	**53.3%**	**52.9%**	**48.2%**	**47.4%**

* Data includes information through September 30, 2017.
** Includes 22 certified Intensive Care beds and eight (8) certified Coronary Care beds. MVHS tracks this combined data in this manner.
*** Includes four (4) certified Neonatal Continuing Care beds and eight (8) certified Neonatal Intermediate Care beds. MVHS tracks this combined data in this manner.
Source: Internal data from MVHS

Through the overall project, MVHS will decertify 174 inpatient beds, including three (3) maternity beds, 155 medical-surgical beds, four (4) neonatal continuing care beds, six (6) pediatric beds and six (6) psychiatric beds. Please refer to **Appendix II** for more detailed inpatient utilization statistics by certified bed category for both St. Elizabeth's and St. Luke's.

When the inpatient utilization of both St. Elizabeth's and St. Luke's is combined, the facilities have an overall occupancy rate of 56.4%. Please refer to these statistics in the following table:

Table C. Overall Occupancy Rate by Certified Bed Category at St. Luke's and St. Elizabeth's (Combined) Using 2016 Utilization Data – Current Bed Complement vs. Proposed Bed Complement

	Occupancy Rate	
	Current Bed Complement	**Proposed Bed Complement**
Intensive Care/Coronary Care	87.8%	87.8%
Maternity	53.6%	60.5%
Medical/Surgical	53.5%	89.2%
Neonatal Continuing/ Intermediate Care	40.8%	61.2%
Pediatric	17.4%	23.9%
Physical Medicine & Rehabilitation	52.7%	52.7%
Psychiatric	71.5%	81.3%
TOTAL	**56.4%**	**81.1%**

Upon the implementation of the overall project, which removes 174 inpatient beds from the overall healthcare system, the two (2) facilities of MVHS would have a combined, overall occupancy rate of 81.1% when using 2016 utilization statistics, which is more in line with norms for hospital occupancy in the 21st century and the needs of the hospital.

Through the overall project, MVHS will decertify six (6) inpatient psychiatric beds (i.e., from 50 to 44 beds). Not only is this decertification supported by the historical occupancy rates for inpatient psychiatric beds noted in Table C above, it is also supported by the following statistics:

- Although the number of patient days for inpatient psychiatric patients at the two (2) combined MVHS facilities increased from 2012 to its peak in 2015, it has decreased considerably since 2015. Based upon 2017 data through September 30, 2017, the occupancy rate of the 50 inpatient psychiatric beds was 69.6% (down from the peak occupancy rate of 81.8% in 2015), meaning that about 15 beds remained unused, on average, during this time in 2017.

- A large and growing percentage of inpatient psychiatric cases are originating from outside of Oneida and Herkimer Counties, which means that residents are likely bypassing other inpatient psychiatric units that are closer to home for many residents. These statistics are as follows:

Table D. Number and Percentage of MVHS Inpatient Psychiatric Discharges from Oneida/Herkimer Counties vs. All Other Counties, 2012-YTD 2017

	2012	2013	2014	2015	2016	YTD 2017*
Oneida/Herkimer Counties	1,812	1,707	1,728	1,803	1,766	1,172
All Other Counties	397	450	548	611	540	521
TOTAL	**2,209**	**2,157**	**2,276**	**2,414**	**2,306**	**1,693**
Oneida/Herkimer Counties	82.0%	79.1%	75.9%	74.7%	76.6%	69.2%
All Other Counties	18.0%	20.9%	24.1%	25.3%	23.4%	30.8%
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: Mohawk Valley Health System

In 2012, only 18.0% of the inpatient psychiatric cases at MVHS were from patients residing outside of Oneida and Herkimer Counties. By 2017 (using data through September 30, 2017), 30.8% of the inpatient psychiatric cases at MVHS were from patients residing outside of Oneida and Herkimer Counties. Based upon a review of inpatient psychiatric bed projects within the "Central New York" and the "Northeast" areas of New York State on NYSE-CON (which includes Oneida and Herkimer Counties, as well as the surrounding region), since 2012, the only

inpatient psychiatric project that was implemented was the addition of one (1) psychiatric bed at Rome Memorial Hospital (Oneida County), which went from 11 beds to 12 beds through Project No. 132140. The fact that no psychiatric beds were decertified means that many of the patients who travel from outside of Oneida or Herkimer Counties to receive inpatient psychiatric care at MVHS can likely be served on inpatient psychiatric units located closer to their homes. Nevertheless, it is clear that they are attracted to MVHS facilities for various reasons (one of which is likely the high quality of care provided at its facilities).

- MVHS expects to continue to experience a decrease in its inpatient psychiatric utilization, largely due to the transition of care from the inpatient realm to the outpatient realm, and from the expanded use of front-line outpatient behavioral health services. To this end, MVHS and its two (2) hospital facilities operate numerous extension clinics throughout Utica and the surrounding region that provide outpatient behavioral health services. Furthermore, as indicated below in the section entitled "Alignment with DSRIP", MVHS is continuing to work with its partners through the DSRIP program to integrate behavioral health services into the primary care setting.

Traditionally Underserved Demographic Characteristics

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. Oneida County is located in Central New York and had a population of 231,190 in 2016.[5] 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.

[5] U.S. Census Bureau. American Factfinder. https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed on October 18, 2017.

With nearly 18.0% of the population 65 years and older, Oneida County had a median age of 41.1 in 2016.[6] Furthermore, in 2016, the race/ethnicity of Oneida County was broken down as follows: Hispanic (5.5%); non-Hispanic White (82.2%), non-Hispanic African-American (5.2%), non-Hispanic Asian (4.2%); non-Hispanic other minorities (2.9%).[7] Furthermore, 17.1% of the population is living at or below the Federal Poverty Level (FPL), demonstrating the high poverty that exists in the region. In the City of Utica, 32.2% of the population is living at or below the FPL.[8]

Oneida County is the home to one of the largest refugee resettlement agencies in the country, Mohawk Valley Resource Center for Refugees (MVRCR). Since the 1980s, MVRCR has resettled more than 15,000 individuals in Utica, with ethnicities and nationalities including Vietnamese, Russian, Bosnian, Somali (Bantu), Burmese and Nepali. Importantly, foreign-born residents constituted 18.9% of the Utica population in 2015. Furthermore, about 27.7% of Utica residents aged five (5) and older spoke a language other than English in 2015.[9]

The new hospital campus in downtown Utica will improve access for all area residents, including this large refugee population. MVHS currently spends more than $800,000 annually to provide language assistance associated with its healthcare services. In particular, the Hospital employs four (4) program specialists/interpreters and 22 per-diem interpreters, and it works with outside agencies to cover 30 different languages and dialects. Lastly, within the rural areas of Oneida County, there are also growing numbers of Amish and Mennonite residents.

PQI Statistics and Poor Health Outcomes

Relative to the PQI measures of the New York State Department of Health, geographic areas that need improved access to care in Oneida County include Utica, Rome and Waterville. These areas have total PQI rates that are up to 170% greater than expected.[10] Please refer to **Appendix V** for

[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.map

documentation of these statistics.

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 **Appendix VI** for documentation of these statistics.

Alignment with DSRIP

MVHS is actively involved in the New York State Delivery System Reform Incentive Payment (DSRIP) program, and this proposed project aligns with the goals and system transformation work being done through the program. The overall project supports the development of an integrated delivery system that reduces excess capacity, eliminates the duplication of services and focuses on patient-centered care while improving patient outcomes and reducing costs. The operational efficiencies gained through the new hospital, in concert with DSRIP project implementation, will enhance care coordination and allow resources to be repurposed to better support outpatient models of care and to implement a population health approach for Oneida County.

St. Luke's is a corporate member of the Central New York Care Collaborative (CNYCC) Performing Provider System (PPS), and both St. Luke's and St. Elizabeth's serve as safety net partners within the PPS. The primary goal of DSRIP is to fundamentally transform the healthcare delivery system and reduce avoidable hospital use by 25%. Avoidable hospital use encompasses not only avoidable hospital readmissions, but also inpatient admissions that could have been avoided if the patient had received proper preventive care. MVHS's DSRIP project work is aimed at reducing Potentially Preventable Emergency Room Visits (PPVs), Potentially Preventable Readmissions (PPRs) and improving Prevention Quality Indicators for adults and pediatrics (PQIs and PDIs, respectively). In addition, MVHS is implementing evidence-based strategies for disease management in high

risk/affected populations aiming to improve the management of cardiovascular disease and its associated risk factors. This project addresses blood pressure control, cholesterol management, tobacco cessation, and prevention efforts for stroke and cardiovascular disease.

MVHS is working toward achieving these objectives through the implementation of 11 DSRIP projects designed to support system transformation, clinical improvement and population health. The proposed new hospital project provides the physical infrastructure that removes many of the barriers and challenges currently impeding improvements to these measures. The overall project aligns with DSRIP objectives because it allows for enhanced access to high quality primary care, reduced care gaps and inefficiencies and alignment with payment reform focused on outcomes and population health management. Specific DSRIP performance measures aligned with the project are as follows:

- Increasing the number of practices with NCQA Level 3 Patient-Centered Medical Home (PCMH) recognition: Implementation of DSRIP Project 2.a.i. – Create an Integrated Delivery System that supports the County patients receiving the right care, at the right time and in the right setting. This involves enhancements to primary care, communication and access to health information. MVHS is working with CNYCC to implement a population health management system as a tool for improving communication, efficiency and closing gaps in care for County residents.

- Reducing ED visits for ambulatory sensitive conditions: Implementation of DSRIP Project 2.b.iii – Emergency Department Care Triage for At-Risk Populations provides for a patient navigation program in the proposed Emergency Department to coach patients regarding appropriate ED utilization, address social needs and connect with primary care.

- Reducing hospital admissions for super-utilizers: Implementation of DSRIP Project 2.b.iv – Care Transitions Intervention Model to Reduce 30 Day Readmissions. A key element of this project involves enhancements to care planning and coordination among the healthcare team for those patients most at risk for readmission.

- Integration of behavioral health into the primary care setting: Implementation of DSRIP Project 3.a.i – Integration of Primary Care and Behavioral Health Services enhances a behavioral health network and improves access to behavioral health services for the County.

- Increasing referrals to Health Home: Implementation of DSRIP Project 2.a.ii – DSRIP Care Management will enhance care coordination and management, supporting appropriate utilization of healthcare services.

Background of Mohawk Valley Health System

Mohawk Valley Health System (MVHS) is an integrated delivery system of Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center. MVHS is the active parent and co-operator of St. Luke's and St. Elizabeth's. St. Elizabeth Medical Center is a Catholic hospital, co-sponsored by the Sisters of St. Francis of the Neumann Communities. The Sisters of Francis reserve power related to the mission of St. Elizabeth only. St. Luke's is a secular hospital, and the new proposed hospital (that will result from the implementation of this C.O.N. Application) will also be a secular hospital.

MVHS is also the active parent and co-operator of Mohawk Valley Home Care, LLC, Senior Network Health, LLC, St. Luke's Home Residential Healthcare Facility, Inc., and the Visiting Nurse Association of Utica and Oneida County, Inc. These entities will not be affected by this hospital campus consolidation project.

In 1957, SLMHC opened at its current location in New Hartford. Furthermore, in 1992, the Board of Directors of both Faxton and SLMHC affiliated, forming the Mohawk Valley Network. Between 1998 and 2000, a single management team formed and Faxton St. Luke's Healthcare formed. In 2000, Faxton Hospital (Faxton) and St. Luke's-Memorial Hospital Center (SLMHC) merged to form Faxton-St. Luke's Healthcare. In 2002, all inpatient services consolidated at the St. Luke's campus, and all outpatient services were consolidated to the Faxton campus. The St. Elizabeth's and St. Luke's affiliation began in December 2011, and in March 2014, the Public Health and Health Planning Council approved the active parent and co-operator status for MVHS.

Program Management

MVHS embraces a program of service to reach an underserved population, and an operating philosophy that embodies the principle that comprehensive, coordinated, high-quality care is the right of every person, regardless of age, sex, sexual orientation, race, creed, religion, disability, source of

payment or any other personal characteristic. Services provided through the overall project will be sensitive to the needs of the population and responsive to the desires of the Hospital's patients.

The general operations of the consolidated hospital will adhere to the standards required under 10 NYCRR. MVHS's standards of patient care emphasize accuracy and timeliness of diagnosis, and referral to appropriate medical practitioners. All existing policies and procedures in place at the two (2) hospitals will be incorporated into the operation of the consolidated hospital, which will be operated under the same high standards of care currently in practice at the hospitals.

All administrative aspects of the consolidated hospitals will be directed by an individual who is qualified for such duties by education and experience. The Quality Assurance (QA) Program associated with the consolidated hospitals will be administered by the Chief Quality Officer, Eric Yoss, M.D., F.C.C.P., and the appropriate Medical Director for the services, with the overall oversight from the Chief Medical Officer of MVHS, Michael F. Trevisani, M.D., M.B.A., C.P.E., F.A.S.C.R.S., F.A.C.H.E. Please refer to **Appendix VII** for the curriculum vitae of Dr. Trevisani. The QA Program and operational protocols will be followed for the consolidated hospitals. The QA Program ensures that patients receive the highest level of quality. There are continuing education activities to provide staff with the opportunity to learn the newest technology, techniques and protocols in the provision of services at the Hospital.

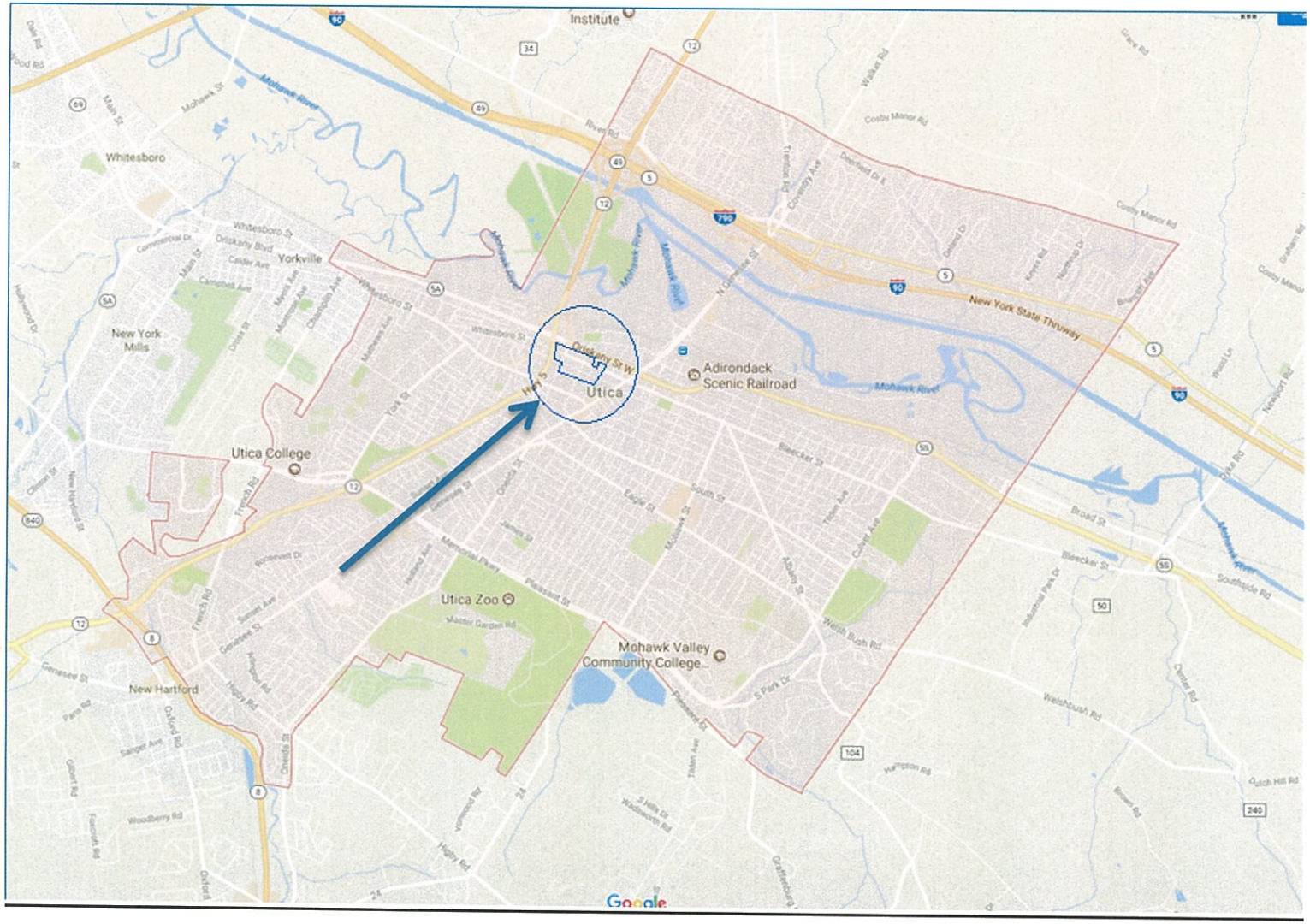
APPENDIX I

MOHAWK VALLEY HEALTH SYSTEM

MAP OF SITE AND PROPOSED HOSPITAL CAMPUS

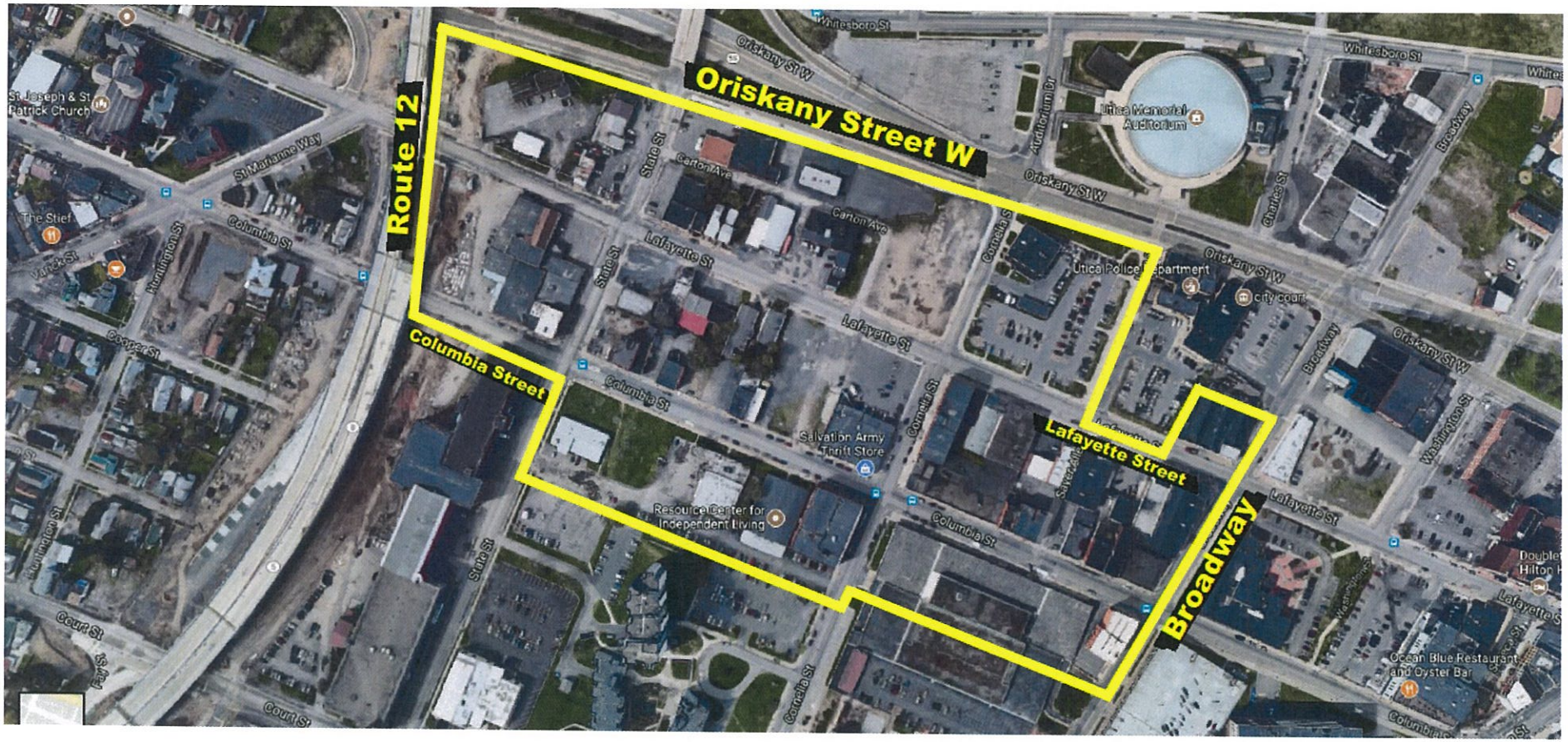
Mohawk Valley Health System

Map of the City of Utica and the Proposed Land Area for New Hospital Campus



Mohawk Valley Health System

Proposed Land Area for New Hospital Campus



APPENDIX II

MOHAWK VALLEY HEALTH SYSTEM

INPATIENT BED COMPLEMENT ANALYSIS

AND

INPATIENT UTILIZATION STATISTICS – ST. ELIZABETH AND ST. LUKE'S

AND

OVERALL TRANSITION PLAN – ST. LUKE'S

AND

OVERALL TRANSITION PLAN – ST. ELIZABETH

MOHAWK VALLEY HEALTH SYSTEM

INPATIENT BED COMPLEMENT ANALYSIS

The following tables show the current and proposed number of certified inpatient beds at the current St. Elizabeth Medical Center (St. Elizabeth), the current Faxton-St. Lukes Healthcare St. Lukes Division (St. Luke's) and the new hospital campus. The post-implementation period represents the time after the new hospital campus and merger projects are complete.

Table A. Inpatient Bed Complement at Current St. Elizabeth Campus, Pre- and Post-Implementation

	St. Elizabeth (Before)	Change	St. Elizabeth* (After)
Intensive Care	20	-20	0
Medical/Surgical	149	-149	0
Pediatric	8	-8	0
Psychiatric	24	-24	0
TOTAL	**201**	**-201**	**0**

Table B. Inpatient Bed Complement at Current St. Luke's Campus, Pre- and Post-Implementation

	St. Luke's (Before)	Change	St. Luke's (After)
Coronary Care	8	-8	0
Intensive Care	22	-22	0
Maternity	26	-26	0
Medical/Surgical	238	-238	0
Neonatal Continuing Care	4	-4	0
Neonatal Intermediate Care	8	-8	0
Pediatric	14	-14	0
Physical Medicine and Rehabilitation	24	0	24**
Psychiatric	26	-26	0
TOTAL	**370**	**-346**	**24****

Table C. Inpatient Bed Complement at St. Elizabeth/St. Luke's (Combined) and New Site

	Combined (Before)	Change	St. Luke's (After)	New Site (After)
Coronary Care	8	0	0	8
Intensive Care	42	0	0	42
Maternity	26	-3	0	23***
Medical/Surgical	387	-155	0	232
Neonatal Continuing Care	4	-4	0	0
Neonatal Intermediate Care	8	0	0	8
Pediatric	22	-6	0	16
Physical Medicine and Rehabilitation	24	0	24	0
Psychiatric	50	-6	0	44
TOTAL	**571**	**-174**	**24**	**373**

* The current St. Elizabeth campus will become an outpatient extension clinic of the new hospital campus, which will be called the "St. Elizabeth Campus".

** All 24 physical medicine and rehabilitation beds will remain on the St. Luke's campus in the same location (i.e., within the same building that houses St. Luke's Home, the 202-bed residential health care facility operated by MVHS), and with no construction necessary.

*** Represents the 21 post-partum and two (2) ante-partum maternity rooms. Excludes labor and delivery rooms.

Note: Mohawk Valley Heart Institute currently has separate operating certificate and PFI numbers (Operating Certificate #3202004H; PFI #7528). MVHS will work with the NYSDOH to determine how to handle the services offered though the Mohawk Valley Heart Institute, and if this entity can be eliminated.

St. Elizabeth Medical Center

Inpatient Utilization Statistics

Certified Beds

	Number
Intensive Care	20
Medical/Surgical	149
Pediatric	8
Psychiatric	24
TOTAL	**201**

	2012	2013	2014	2015	2016	YTD 2017*
Days in Year	366	365	365	365	366	273

Patient Days

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care	6,376	6,312	6,488	6,339	6,249	4,582
Medical/Surgical	46,047	40,474	41,547	40,293	39,753	30,554
Pediatric	324	234	371	282	220	85
Psychiatric	7,070	6,523	7,114	7,512	6,417	4,773
TOTAL	**59,817**	**53,543**	**55,520**	**54,426**	**52,639**	**39,994**

Discharges

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care	601	545	547	484	559	401
Medical/Surgical	9,770	8,865	8,535	8,720	8,640	6,470
Pediatric	138	99	153	129	83	29
Psychiatric	1,134	1,018	1,041	1,079	1,041	742
TOTAL	**11,643**	**10,527**	**10,276**	**10,412**	**10,323**	**7,642**

ALOS

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care	10.6	11.6	11.9	13.1	11.2	11.4
Medical/Surgical	4.7	4.6	4.9	4.6	4.6	4.7
Pediatric	2.3	2.4	2.4	2.2	2.7	2.9
Psychiatric	6.2	6.4	6.8	7.0	6.2	6.4
TOTAL	**5.1**	**5.1**	**5.4**	**5.2**	**5.1**	**5.2**

Occupancy Rate

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care	87.1%	86.5%	88.9%	86.8%	85.4%	83.9%
Medical/Surgical	84.4%	74.4%	76.4%	74.1%	72.9%	75.1%
Pediatric	11.1%	8.0%	12.7%	9.7%	7.5%	3.9%
Psychiatric	80.5%	74.5%	81.2%	85.8%	73.1%	72.8%
TOTAL	**81.3%**	**73.0%**	**75.7%**	**74.2%**	**71.6%**	**72.9%**

* Data includes information through September 30, 2017.

Faxton-St. Luke's Hospital

Inpatient Utilization Statistics

Certified Beds

	Number
Intensive Care/Coronary Care	30
Maternity	26
Medical/Surgical	238
Neonatal Continuing/ Intermediate Care	12
Pediatric	14
Physical Medicine & Rehabilitation	24
Psychiatric	26
TOTAL	**370**

	2012	2013	2014	2015	2016	YTD 2017*
Days in Year	366	365	365	365	366	273

Patient Days

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care/Coronary Care	8,389	8,213	9,183	9,078	8,737	6,766
Maternity	5,869	5,656	5,361	5,318	5,097	3,718
Medical/Surgical	51,027	45,156	42,530	41,697	37,103	27,389
Neonatal Continuing/ Intermediate Care	2,100	1,725	1,453	1,588	1,793	1,179
Pediatric	1,716	1,557	1,517	1,435	1,182	944
Physical Medicine & Rehabilitation	5,360	5,305	5,025	4,907	4,625	3,104
Psychiatric	5,595	5,772	6,898	7,416	6,668	4,734
TOTAL	**80,056**	**73,384**	**71,967**	**71,439**	**65,205**	**47,834**

Discharges

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care/Coronary Care	573	614	661	656	683	538
Maternity	2,255	2,186	2,082	2,073	1,977	1,495
Medical/Surgical	10,688	9,585	9,038	9,112	8,252	6,341
Neonatal Continuing/ Intermediate Care	236	177	179	148	161	118
Pediatric	674	662	617	561	529	383
Physical Medicine & Rehabilitation	413	388	352	313	343	256
Psychiatric	1,075	1,139	1,235	1,335	1,265	951
TOTAL	**15,914**	**14,751**	**14,164**	**14,198**	**13,210**	**10,082**

ALOS

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care/Coronary Care	14.6	13.4	13.9	13.8	12.8	12.6
Maternity	2.6	2.6	2.6	2.6	2.6	2.5
Medical/Surgical	4.8	4.7	4.7	4.6	4.5	4.3
Neonatal Continuing/ Intermediate Care	8.9	9.7	8.1	10.7	11.1	10.0
Pediatric	2.5	2.4	2.5	2.6	2.2	2.5
Physical Medicine & Rehabilitation	13.0	13.7	14.3	15.7	13.5	12.1
Psychiatric	5.2	5.1	5.6	5.6	5.3	5.0
TOTAL	**5.0**	**5.0**	**5.1**	**5.0**	**4.9**	**4.7**

Occupancy Rate

	2012	2013	2014	2015	2016	YTD 2017*
Intensive Care/Coronary Care	76.4%	75.0%	83.9%	82.9%	79.6%	82.6%
Maternity	61.7%	59.6%	56.5%	56.0%	53.6%	52.4%
Medical/Surgical	58.6%	52.0%	49.0%	48.0%	42.6%	42.2%
Neonatal Continuing/ Intermediate Care	47.8%	39.4%	33.2%	36.3%	40.8%	36.0%
Pediatric	33.5%	30.5%	29.7%	28.1%	23.1%	24.7%
Physical Medicine & Rehabilitation	61.0%	60.6%	57.4%	56.0%	52.7%	47.4%
Psychiatric	58.8%	60.8%	72.7%	78.1%	70.1%	66.7%
TOTAL	**59.1%**	**54.3%**	**53.3%**	**52.9%**	**48.2%**	**47.4%**

* Data includes information through September 30, 2017.

** Includes 22 certified Intensive Care beds and eight (8) certified Coronary Care beds. MVHS tracks this combined data in this manner.

*** Includes four (4) certified Neonatal Continuing Care beds and eight (8) certified Neonatal Intermediate Care beds. MVHS tracks this combined data in this manner.

TRANSITION PLAN

FAXTON-ST. LUKE'S HEALTHCARE ST. LUKE'S DIVISION

Purpose

To ensure the smooth transition of inpatient and outpatient services of Faxton-St. Luke's Healthcare St. Luke's Division (St. Luke's) from their current location at 1656 Champlin Avenue, Utica (Oneida County), New York 13502 to a new hospital campus on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street. Faxton-St. Luke's Hospital (FSLH) / Mohawk Valley Health System (MVHS), the New York State Department of Health (NYSDOH) and the New York State Office of Mental Health (NYSOMH) will work collaboratively during the transition process.

Anticipated Date of Transition

The date of transition to the new hospital campus is anticipated to be on or about June 1, 2022 and is dependent on Mohawk Valley Health System receiving all necessary approvals from NYSDOH and NYSOMH for it to construct a new hospital campus in Utica, New York. Furthermore, this date is based upon the timing of the actual construction of the new hospital campus.

Proposed Schedule for Phasing of Transition

Based on the construction timing for the project, FSLH/MVHS will work to identify patients who can appropriately be discharged to community care from the inpatient unit on the existing FSLH campus, to lessen the number of patients who need to be transferred to the new hospital campus on the actual date of transition.

Notification

Once the C.O.N. Application to construct the new hospital campus is approved by the NYSDOH and the NYSOMH, and the construction of the new facility is nearing its end, FSLH/MVHS will begin to provide notice to all constituent populations, including staff, providers, patients and elected officials, that the transition of the services to the new hospital campus will be occurring with an anticipated date on or about June 1, 2022. Signage will also be placed in prominent locations at FSLH, notifying people of the pending transition and providing them with a contact number.

Maintenance, Storage and Retrieval of Records, including Medical Records

There will be no change to the maintenance of records, including medical records, of patients. All records will continue to be maintained by Mohawk Valley Health System in compliance with State and Federal statutes. Patients will be advised on how to obtain copies of their medical record from the Health Information Management Department at FSLH/MVHS.

Proposed Disposal of Medications, Biologicals, Chemicals and Medical Supplies

Unused medical supplies will be brought to the new hospital campus.

Disposition of Equipment

A number of pieces of equipment from the existing FSLH campus will be used, as appropriate, at the new hospital campus. Equipment that is beyond its useful life will be disposed of according to policy.

Link to Alternative Programs

FSLH is part of the larger behavioral health service delivery system in and around Oneida County, which includes other inpatient providers and outpatient, community-based organizations that provide healthcare services to the residents of the service area. Hospital staff, which is knowledgeable of these programs/providers and how to access them, will refer to and provide linkages to such programs/providers as:

General Hospitals

- New Hospital Campus of MVHS
- Cobleskill Regional Hospital
- Community Memorial Hospital
- Crouse Hospital
- Crouse Hospital – Commonwealth Division
- Faxton-St. Luke's Healthcare St. Luke's Division (remaining 24-bed PM&R)
- Little Falls Hospital
- Mary Imogene Bassett Hospital
- Nathan Littauer Hospital
- Oneida Healthcare
- Rome Memorial Hospital
- St. Joseph's Hospital Health Center
- St. Mary's Healthcare
- University Hospital SUNY Health Science Center
- Upstate University Hospital at Community General

Inpatient Psychiatric Units and Outpatient Psychiatric Programs

- New Hospital Campus of MVHS
- Mohawk Valley Psychiatric Center
- Rome Memorial Hospital
- Cath Char RC Dio/Syr, NY, Inc-Oneida/Madison
- Center for Family Life and Recovery, Inc.
- Central New York Psychiatric Center
- Central New York Services, Inc.
- House of the Good Shepherd
- Human Technologies Corporation
- NYS ARC Oneida-Lewis County Chapter
- Oneida County Department of Mental Health
- Rescue Mission of Utica, Inc.
- Resource Center for Independent Living
- The Neighborhood Center, Inc.
- Upstate Cerebral Palsy, Inc.

As it has done successfully in the past, FSLH/MVHS will continue to work with these entities in order to ensure that patients receive needed healthcare services. This includes making sure that alternative programs have agreed to accept the referral, that the patient has appropriate transportation, and that follow-up occurs to confirm recipient linkage to the programs.

TRANSITION PLAN

ST. ELIZABETH MEDICAL CENTER

Purpose

To ensure the smooth transition of inpatient and outpatient services of St. Elizabeth Medical Center (SEMC) from their current location at 2209 Genesee Street, Utica (Oneida County), New York 13501 to a new hospital campus on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street. St. Elizabeth Medical Center / Mohawk Valley Health System (MVHS), the New York State Department of Health (NYSDOH) and the New York State Office of Mental Health (NYSOMH) will work collaboratively during the transition process.

Anticipated Date of Transition

The date of transition to the new hospital campus is anticipated to be on or about June 1, 2022 and is dependent on Mohawk Valley Health System receiving all necessary approvals from NYSDOH and NYSOMH for it to construct a new hospital campus in Utica, New York. Furthermore, this date is based upon the timing of the actual construction of the new hospital campus.

Proposed Schedule for Phasing of Transition

Based on the construction timing for the project, SEMC/MVHS will work to identify patients who can appropriately be discharged to community care from the inpatient unit on the existing SEMC campus, to lessen the number of patients who need to be transferred to the new hospital campus on the actual date of transition.

Notification

Once the C.O.N. Application to construct the new hospital campus is approved by the NYSDOH and the NYSOMH, and the construction of the new facility is nearing its end, SEMC/MVHS will begin to provide notice to all constituent populations, including staff, providers, patients and elected officials, that the transition of the services to the new hospital campus will be occurring with an anticipated date on or about June 1, 2022. Signage will also be placed in prominent locations at SEMC, notifying people of the pending transition and providing them with a contact number.

Maintenance, Storage and Retrieval of Records, including Medical Records

There will be no change to the maintenance of records, including medical records, of patients. All records will continue to be maintained by Mohawk Valley Health System in compliance with State and Federal statutes. Patients will be advised on how to obtain copies of their medical record from the Health Information Management Department at SEMC/MVHS.

Proposed Disposal of Medications, Biologicals, Chemicals and Medical Supplies

Unused medical supplies will be brought to the new hospital campus.

Disposition of Equipment

A number of pieces of equipment from the existing SEMC campus will be used, as appropriate, at the new hospital campus. Equipment that is beyond its useful life will be disposed of according to policy.

Link to Alternative Programs

SEMC is part of the larger behavioral health service delivery system in and around Oneida County, which includes other inpatient providers and outpatient, community-based organizations that provide healthcare services to the residents of the service area. Hospital staff, which is knowledgeable of these programs/providers and how to access them, will refer to and provide linkages to such programs/providers as:

General Hospitals

- New Hospital Campus of MVHS
- Cobleskill Regional Hospital
- Community Memorial Hospital
- Crouse Hospital
- Crouse Hospital – Commonwealth Division
- Faxton-St. Luke's Healthcare St. Luke's Division (remaining 24-bed PM&R)
- Little Falls Hospital
- Mary Imogene Bassett Hospital
- Nathan Littauer Hospital
- Oneida Healthcare
- Rome Memorial Hospital
- St. Joseph's Hospital Health Center
- St. Mary's Healthcare
- University Hospital SUNY Health Science Center
- Upstate University Hospital at Community General

Inpatient Psychiatric Units and Outpatient Psychiatric Programs

- New Hospital Campus of MVHS
- Mohawk Valley Psychiatric Center
- Rome Memorial Hospital
- Cath Char RC Dio/Syr, NY, Inc-Oneida/Madison
- Center for Family Life and Recovery, Inc.
- Central New York Psychiatric Center
- Central New York Services, Inc.
- House of the Good Shepherd
- Human Technologies Corporation
- NYS ARC Oneida-Lewis County Chapter
- Oneida County Department of Mental Health
- Rescue Mission of Utica, Inc.
- Resource Center for Independent Living
- The Neighborhood Center, Inc.
- Upstate Cerebral Palsy, Inc.

As it has done successfully in the past, SEMC/MVHS will continue to work with these entities in order to ensure that patients receive needed healthcare services. This includes making sure that alternative programs have agreed to accept the referral, that the patient has appropriate transportation, and that follow-up occurs to confirm recipient linkage to the programs.

APPENDIX III

MOHAWK VALLEY HEALTH SYSTEM

ANALYSIS OF CERTIFIED SERVICES

AND

ANALYSIS OF PROGRAMS/SERVICES

MOHAWK VALLEY HEALTH SYSTEM

ANALYSIS OF CERTIFIED SERVICES (HOSPITAL CAMPUSES)

The tables below include the list of certified services at St. Elizabeth Medical Center, Faxton-St. Luke's Healthcare St. Luke's Division, Mohawk Valley Heart Institute and the New Hospital Campus, separately, before and after the implementation of the overall project. The "proposed" period represents the time after the new hospital campus and merger projects are complete.

Table A. Certified Services at St. Elizabeth Medical Center

	Current (Hospital Campus) 2209 Genesee Street Utica, NY 13501	**Proposed* (Extension Clinic)** 2209 Genesee Street Utica, NY 13501
Ambulatory Surgery – Multi-Specialty	X	
Cardiac Catheterization – Adult Diagnostic	X	
Cardiac Catheterization – EP	X	
Cardiac Catheterization – PCI	X	
Cardiac Surgery – Adult	X	
Clinic Part-Time Services	X	
Dental O/P		
Emergency Department	X	
Lithotripsy		
Medical Services – Other Medical Specialties		X
Medical Services – Primary Care	X	X
Renal Dialysis – Acute	X	

* Once the new hospital campus is complete and services from the St. Elizabeth campus move to the new site, the former St. Elizabeth campus will become an outpatient extension clinic. Please refer to the section of the Project Narrative entitled "Impact on Operating Certificate" for documentation of services to be provided at this extension clinic site.

Table B. Certified Services at Faxton-St. Luke's Healthcare St. Luke's Division

	Current (Hospital Campus) 1656 Champlin Ave. Utica NY 13502	**Proposed* (Hospital Campus)** 1656 Champlin Ave. Utica NY 13502
Ambulatory Surgery – Multi-Specialty	X	
Cardiac Catheterization – Adult Diagnostic		
Cardiac Catheterization – EP		
Cardiac Catheterization – PCI		
Cardiac Surgery – Adult		
Clinic Part-Time Services	X	
Dental O/P	X	
Emergency Department	X	
Lithotripsy	X	
Medical Services – Other Medical Specialties		X
Medical Services – Primary Care	X	X
Renal Dialysis – Acute	X	

* Once the new hospital campus is complete and services from the St. Luke's campus move to the new site, the St. Luke's campus will retain 24 PM&R beds, along with some outpatient services. Please refer to the section of the Project Narrative entitled "Impact on Operating Certificate" for documentation of services to be provided at this site.

Table C. Certified Services at Mohawk Valley Heart Institute

	Current (Hospital Campus) 2209 Genesee Street Utica, NY 13501	**Proposed* (Hospital Campus)**
Ambulatory Surgery – Multi-Specialty		
Cardiac Catheterization – Adult Diagnostic	X	All Services
Cardiac Catheterization – EP		Will Move To
Cardiac Catheterization – PCI	X	New Hospital
Cardiac Surgery – Adult	X	Campus
Clinic Part-Time Services		
Dental O/P		
Emergency Department		
Lithotripsy		
Medical Services – Other Medical Specialties		
Medical Services – Primary Care		
Renal Dialysis – Acute		

* Once the new hospital campus is complete and services from the Mohawk Valley Heart Institute move to the new site, the address of the Mohawk Valley Heart Institute will change to the address of the new hospital campus.

Table D. Certified Services at the New Hospital Campus

	Current	**Proposed (Hospital Campus)** Address Is To Be Determined
Ambulatory Surgery – Multi-Specialty		X
Cardiac Catheterization – Adult Diagnostic		X
Cardiac Catheterization – EP	Does	X
Cardiac Catheterization – PCI	Not	X
Cardiac Surgery – Adult	Exist	X
Clinic Part-Time Services		X
Dental O/P		X
Emergency Department		X
Lithotripsy		X
Medical Services – Other Medical Specialties		X
Medical Services – Primary Care		X
Renal Dialysis – Acute		X

MOHAWK VALLEY HEALTH SYSTEM

ANALYLSIS OF SERVICES

	CURRENT LOCATION			PROPOSED LOCATION			
	ST. LUKE'S	ST. ELIZ.	EXT. CLINICS	NEW HOSP	ST. LUKE'S	FORMER ST. ELIZ.	EXT. CLINICS
INPATIENT BEDS							
GENERAL MED SURG	X	X		X			
ORTHOPEDICS		X		X			
SPECIAL CARE	X	X		X			
PROGRESSIVE CARE UNIT	X	X		X			
INTENSIVE CARE UNIT	X	X		X			
CORONARY CARE	X	X		X			
CARDIOVASCULAR ICU		X		X			
PEDIATRIC	X	X		X			
PSYCHIATRIC	X	X		X			
MATERNITY	X			X			
NEONATAL CONTINUING CARE	X			X			
NEONATAL INTERMEDIATE CARE	X			X			
PHYSICAL MEDICINE AND REHABILITATION	X				X		
SURGICAL SERVICES							
OPERATING ROOM CASES	X	X	X	X			X
ENDOSCOPY VISITS	X	X	X	X			X
LITHROTRIPSY	X		X	X			X
AMBULATORY SURGERY	X	X	X	X			X
BARIATRIC SURGERY	X			X			
EMERGENCY SERVICES							
EMERGENCY ROOM	X	X		X			
URGENT CARE			X				X

	CURRENT LOCATION			PROPOSED LOCATION			
	ST. LUKE'S	ST. ELIZ.	EXT. CLINICS	NEW HOSP	ST. LUKE'S	FORMER ST. ELIZ.	EXT. CLINICS
IMAGING SERVICES							
DIAGNOSTIC RADIOLOGY PROCEDURES	X	X	X	X			X
ULTRASOUND PROCEDURES	X	X	X	X			X
INTERVENTIONAL PROCEDURES	X			X			
MAMMOGRAPHY PROCEDURES			X	X			X
CAT SCAN PROCEDURES	X	X	X	X			X
PERIPHERAL ANGIOGRAPHY	X	X		X			
NUCLEAR MEDICINE DIAGNOSITIC	X	X		X			
PET SCAN PROCEDURES			X				X
REHAB PROCEDURES							
PHYSICAL THERAPY	X	X	X	X			X
OCCUPATIONAL THERAPY PCU	X	X	X	X			X
SPEECH THERAPY PCU		X	X	X			X
AUDIOLOGY			X				X
NEUROPSYCHOLOGY			X				X
SPORTS MEDICINE			X				X
CARDIAC SERVICES							
CARDIOTHORACIC OR		X		X			
TAVR		X		X			
CATHETERIZATIONS	X	X		X			
ANGIOPLASTIES	X	X		X			
NON-INVASIVE CARDIOLOGY	X	X		X			
ELECTROPHYSIOLOGY PROCEDURES		X		X			
EKG STUDIES	X	X	X	X			X
CARDIAC REHAB			X				X
CARDIIAC TESTING	X	X		X			
DIALYSIS SERVICES							
INPATIENT DIALYSIS	X	X		X			
OUTPATIENT DIALYSIS			X				X
PERITONEAL			X				X

	CURRENT LOCATION			PROPOSED LOCATION			
	ST. LUKE'S	ST. ELIZ.	EXT. CLINICS	NEW HOSP	ST. LUKE'S	FORMER ST. ELIZ.	EXT. CLINICS
HOME HEMO			X				X
RADIATION SERVICES							
RADIATION TREATMENTS			X				X
INFUSION TREATMENTS			X	X			X
RESPIRATORY SERVICES							
RESPIRATORY PROCEDURES	X	X	X	X			X
NEURO/STROKE SERVICES							
EEG PROCEDURES	X	X		X			
PHARMACY SERVICES							
DOSES DISPENSED	X	X	X	X			X
LAB SERVICES							
BLOOD	X	X		X			
HOSPITAL LAB SERVICES	X	X		X			
CLINICAL LAB SERVICES			X		X	X	X
CLINIC SERVICES							
OB/GYN CLINIC			X		X		X
PEDIATRIC CLINIC			X				X
SR. ROSE VINCENT FAMILY MED CTR			X				X
MOHAWK PRACTICE			X				X
SOUTH UTICA			X				X
EAST UTICA			X				X
TOWN OF WEBB			X				X
ADIRONDACK NEUROSURGERY			X				X
LITTLE FALLS			X				X
NEW HARTFORD			X				X
CTOR OFFICE			X				X
BARNEVELD			X				X

	CURRENT LOCATION			PROPOSED LOCATION			
	ST. LUKE'S	ST. ELIZ.	EXT. CLINICS	NEW HOSP	ST. LUKE'S	FORMER ST. ELIZ.	EXT. CLINICS
BOONVILLE			X				X
MOHAWK VALLEY			X				X
NEW HARTFORD			X				X
NORTH UTICA- TRENTON RD			X				X
NORTH UTICA- RIVERSIDE DR			X				X
WASHINGTON MILLS			X				X
WATERVILLE			X				X
WHITESBORO			X				X
CLINTON			X				X
SAUQUOIT			X				X
WATERVILLE			X				X
OB CENTER			X				X
DENTAL CENTER			X				X
PRIMARY CARE	X	X	X	X	X	X	X
MVHS SURGEON VISITS							
GENERAL SURGEON	X				X		
GASTROINTESTINAL SURGEON	X				X		
VASCULAR SURGEON	X		X		X		X
BREASTCARE SURGEON	X				X		
ORTHOPEDIC SURGEON			X				X
MVHS SURGEON FAXTON			X				X
CARDIOTHORACIC SURGEON		X				X	
INTENSIVISTS	X				X		
PULMONARY	X		X		X		X
NEURO ENDOVASCULAR	X				X		
OTHER SERVICES							
SLEEP CENTER STUDIES		X				X	
EYE LASER CLINIC			X	X			X
OSTOMY THERAPY		X		X			
PODIATRY	X			X			
WOUND MANAGEMENT	X		X	X			X

	CURRENT LOCATION			PROPOSED LOCATION			
	ST. LUKE'S	ST. ELIZ.	EXT. CLINICS	NEW HOSP	ST. LUKE'S	FORMER ST. ELIZ.	EXT. CLINICS
NON-CLINICAL SERVICES							
NUTRITIONAL COUNSELING - PARTICIPANTS	X	X	X	X			X
MEDICAL SOCIAL SERVICES	X	X		X			
PALLIATIVE CARE - CONSULTS			X				X
CANCER PROGRAM - PATIENTS			X				X
BREAST PROGRAM VISITS			X				X
DIABETES PROGRAM - PROCEDURES			X				X

APPENDIX IV

MOHAWK VALLEY HEALTH SYSTEM

DISPOSITION OF EXTENSION CLINIC SITES

MOHAWK VALLEY HEALTH SYSTEM

DISPOSITION OF EXTENSION CLINIC SITES

EXISTING EXTENSION CLINICS

	Certified Service(s) (per NYSDOH Website)	Certified Service(s) (per Operating Certificates)	Operating Certificate Number (Current)	PFI Number (Current)	Notes
Community Medicine-East Utica 1256 Culver Ave Utica, NY 13501	Clinical Laboratory Service O/P Medical Services - Primary Care Pediatric O/P	Clinical Laboratory Service O/P Pediatric O/P Primary Medical Care O/P Psychology O/P	3202002H	6226	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Little Falls Family Practice 500 East Main Street Little Falls, NY 13365	Medical Services - Primary Care	Primary Medical Care O/P	3202002H	8572	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
St. Elizabeth Medical Arts 4401 Middle Settlement Road New Hartford, NY 13413	CT Scanner Medical Services - Other Medical Specialties Medical Services - Primary Care Podiatry O/P Therapy - Occupational O/P Therapy - Physical O/P	CT Scanner Podiatry O/P Primary Medical Care O/P Radiology - Diagnostic O/P Therapy - Occupational O/P Therapy - Physical O/P	3202002H	9147	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Sister Rose Vincent Family Medicine Center 120 Hobart Street Utica, NY 13501	Clinical Laboratory Service O/P Medical Services - Other Medical Specialties Medical Services - Primary Care Therapy - Occupational O/P Therapy - Physical O/P	Clinical Laboratory Service O/P Psychology O/P Radiology - Diagnostic O/P Therapy - Occupational O/P Therapy - Physical O/P Well Child Care	3202002H	5950	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
St. Elizabeth Med Grp-New Hartford 86 Genesee St New Hartford, NY 13413	Clinical Laboratory Service O/P Medical Services - Other Medical Specialties Medical Services - Primary Care	Clinical Laboratory Service O/P Primary Medical Care O/P Psychology O/P Radiology - Diagnostic O/P	3202002H	7888	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
St. Elizabeth Medical Group - Town of Webb Health Center 114 South Shore Road Old Forge, NY 13420	Clinical Laboratory Service O/P Medical Services - Other Medical Specialties Medical Services - Primary Care	Clinical Laboratory Service O/P Primary Medical Care O/P Radiology - Diagnostic O/P	3202002H	9489	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Women & Children's Fam Health Center 2212 Genesee St Utica, NY 13502	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P Prenatal O/P	Medical Social Services Nursing Nutritional O/P Pediatric O/P Prenatal O/P Primary Medical Care O/P Radiology - Diagnostic O/P	3202002H	5517	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Hampden Place 6 Hampden Place Utica, NY 13501	Medical Services - Primary Care	Primary Medical Care O/P	3202002H	6732	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.

Barneveld Office 7980 Route 12 Barneveld, NY 13304	Clinical Laboratory Service O/P Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P Well Child Care O/P	Clinical Laboratory Service O/P Pediatric O/P Primary Medical Care O/P Psychology O/P Radiology - Diagnostic O/P Well Child Care O/P	3202003H	6389	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Boonville Medical Office NY State 12 Boonville, NY 13309	Medical Services - Other Medical Specialties Medical Services - Primary Care	Primary Medical Care O/P Psychology O/P Radiology - Diagnostic O/P	3202003H	3800	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Clinton Medical Center 101 College Street Clinton, NY 13323	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P Prenatal O/P	Medical Services - Other Medical Specialties Medical Services - Primary Care	3202003H	7694	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
FSLH - Hamilton Dialysis Unit 10 Eaton Street Hamilton, NY 13346	Renal Dialysis - Chronic O/P	Renal Dialysis - Chronic O/P	3202003H	9289	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
FSLH-Masonic Dialysis Unit 2150 Bleeker Street Utica, NY 13501	Renal Dialysis - Chronic O/P	Renal Dialysis - Chronic O/P	3202003H	8512	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
F-SLH Regional Cancer Center Rome 91 Perimeter Road Rome, NY 13441	Linear Accelerator Radiology-Therapeutic O/P	Linear Accelerator Radiology-Therapeutic O/P	3202003H	6146	To be consolidated into a single extension clinic site using PFI #7671. Certified services will also be consolidated. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
SLMHC - Rome Dialysis Unit 91 Perimeter Road Rome, NY 13441	Renal Dialysis - Chronic O/P	Renal Dialysis - Chronic O/P	3202003H	7671	To be consolidated into a single extension clinic site using PFI #7671. Certified services will also be consolidated. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
FSLH - St. Luke's Home Renal Dialysis 1650 Champlin Avenue Utica, NY 13502	Renal Dialysis - Chronic O/P	Renal Dialysis - Chronic O/P	3202003H	9527	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
FSLH-Herkimer Dialysis Unit 201 East State Street Herkimer, NY 13350	Renal Dialysis - Chronic O/P	Renal Dialysis - Chronic O/P	3202003H	7523	To be consolidated into a single extension clinic site using PFI #7523. Certified services will also be consolidated. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Mohawk Valley Medical Office 201 East State St Herkimer, NY 13350	Linear Accelerator Medical Services - Primary Care Radiology-Therapeutic O/P	Linear Accelerator Primary Medical Care O/P Psychology O/P Radiology-Therapeutic O/P	3202003H	7858	To be consolidated into a single extension clinic site using PFI #7523. Certified services will also be consolidated. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.

Faxton Medical Campus 1676 Sunset Avenue Utica, NY 13502	Ambulatory Surgery - Multi Specialty Audiology O/P Clinical Laboratory Service O/P CT Scanner Dental O/P Family Planning O/P Home Hemodialysis Training and Support Home Peritoneal Dialysis Training and Support Linear Accelerator Medical Services - Other Medical Specialties Medical Services - Primary Care Nuclear Medicine - Diagnostic O/P Nuclear Medicine - Therapeutic O/P Radiology-Therapeutic O/P Renal Dialysis - Chronic O/P Therapy - Occupational O/P Therapy - Physical O/P Therapy - Respiratory O/P Therapy - Speech Language Pathology O/P Therapy - Vocational Rehabilitation O/P	Ambulatory Surgery - Multi Specialty Audiology O/P Clinical Laboratory Service O/P CT Scanner Dental O/P Family Planning O/P Health Fairs Home Hemodialysis Training and Support Home Peritoneal Dialysis Training and Support Linear Accelerator Medical Social Services O/P Nuclear Medicine - Diagnostic O/P Nuclear Medicine - Therapeutic O/P Outpatient Surgery PET Scanner Primary Medical Care O/P Pharmaceutical Service Radiology-Diagnostic O/P Radiology-Therapeutic O/P Renal Dialysis - Chronic O/P Therapy - Occupational O/P Therapy - Physical O/P Therapy - Respiratory O/P Therapy - Speech Language Pathology O/P Therapy - Vocational Rehabilitation O/P	3202003H	0597	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Faxton-St. Luke's - Imaging Services 106 Business Park Drive Utica, NY 13502	Medical Services - Other Medical Specialties	Radiology-Diagnostic O/P	3202003H	9409	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
MVHS Orthopedic Group 1903 Sunset Avenue Utica, NY 13502	Medical Services - Other Medical Specialties Medical Services - Primary Care	Medical Services - Other Medical Specialties Medical Services - Primary Care	3202003H	9835	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
New Hartford ACP Medical Office 8411 Seneca Turnpike New Hartford, NY 13413	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P	Pediatric O/P Primary Medical Care O/P Psychology O/P Radiology-Diagnostic O/P	3202003H	6392	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
North Utica Medical Office 35 Riverside Drive Utica, NY 13502	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P	Pediatric O/P Primary Medical Care O/P Psychology O/P Radiology-Diagnostic O/P	3202003H	7601	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
North Utica Medical Office 417 Trenton Road Utica, NY 13502	Medical Services - Other Medical Specialties Medical Services - Primary Care Prenatal O/P	Medical Services - Other Medical Specialties Medical Services - Primary Care	3202003H	7672	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Sauquoit Medical Office 2888 Oneida Street Sauquoit, NY 13456	Medical Services - Other Medical Specialties Medical Services - Primary Care	Medical Services - Other Medical Specialties Medical Services - Primary Care	3202003H	7073	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Washington Mills Office 3946 Oneida Street New Hartford, NY 13413	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P	Pediatric O/P Primary Medical Care O/P Psychology O/P Radiology-Diagnostic O/P	3202003H	6391	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Waterville Medical Office 117 West Main St Waterville, NY 13480	Medical Services - Other Medical Specialties Medical Services - Primary Care	Medical Services - Other Medical Specialties Medical Services - Primary Care	3202003H	7887	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Waterville Office 358 Madison Street Waterville, NY 13480	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P	Pediatric O/P Primary Medical Care O/P Psychology O/P Radiology-Diagnostic O/P	3202003H	6394	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.
Whitesboro Office 37 Main Street Whitesboro, NY 13492	Medical Services - Other Medical Specialties Medical Services - Primary Care Pediatric O/P	Pediatric O/P Primary Medical Care O/P Psychology O/P Radiology-Diagnostic O/P	3202003H	6390	No change to certified services and PFI number. As part of the "merger" C.O.N. Application, MVHS will work with the NYSDOH to determine what operating certificate number to utilize.

APPROVED BUT NOT OPERATIONAL EXTENSION CLINICS

		Certified Service(s) - Proposed	Operating Certificate Number (Proposed)	PFI Number	Notes
131 Main Street Oneida, NY 13421		Chronic Renal Dialysis O/P Home Dialysis Training	3202002H	To Be Determined	Project No. 142261 NYSE-CON Status: Under Construction Actual Construction Start: 05/03/17
131 Main Street Oneida, NY 13421		Medical Services - Primary Care	3202002H	To Be Determined	Project No. 171306 NYSE-CON Status: Awaiting Construction Start Notification from Applicant
1617 North James Street Rome, NY 13440		Medical Services - Primary Care	3202002H	To Be Determined	Project No. 171478 NYSE-CON Status: Under Construction Actual Construction Start: 10/15/17

Note: MVHS will work with the Department separately to determine if this should represent a single extension clinic site.

NEW EXTENSION CLINIC TO BE CERTIFIED THROUGH THIS PROJECT

		Certified Service(s) - Proposed	Operating Certificate Number - Proposed	PFI Number	Notes
[New Extension Clinic] St. Elizabeth Campus 2211/2215 Genesee Street Utica, NY 13501		Medical Services - Primary Care Medical Services - Other Medical Specialties	3202002H	To Be Determined	These services will remain in their current location, with no construction, on the former SEMC campus*: **Sleep Center (Mohawk Valley Sleep Disorders Center)** **Primary Care Services** 2215 Genesee Street Utica, NY 13501 **Cardiac and Thoracic Surgery Offices** **Primary Care Services** **Laboratory Patient Service Center (PSC)** Marian Medical Building 2211 Genesee Street Utica, NY 13501

The St. Elizabeth site will be converted into an outpatient extension clinic to be known as "St. Elizabeth Campus". MVHS prefers that this site maintain its existing PFI number. In particular, sleep center services (Mohawk Valley Sleep Disorders Center), cardiac and thoracic surgery-related services (all of which are outpatient, medical-only services; no surgical services will be provided at this site), primary care and laboratory patient service center (PSC) services will continue to be provided at this site.

The Mohawk Valley Sleep Disorders Center and some primary care services are currently located on the campus located at 2209 Genesee Street, Utica (Oneida County), New York 13501. The cardiac and thoracic surgery offices, other primary care services and the clinical laboratory are located on the campus within the Marian Medical Building at 2209 Genesee Street, Utica (Oneida County), New York 13501. This site will become an extension clinic, with no construction needed. MVHS prefers that a new operating certificate be created for the extension clinic, which will be certified for the services of "Medical Services – Primary Care" and "Medical Services – Other Medical Specialties".

For purposes of this C.O.N. Application, we are assuming that, although these services will be located in different buildings, they will remain in their current locations and MVHS prefers that they share the same Operating Certificate and PFI number. MVHS is willing to discuss this issue with the State Health Department, should the Department prefer to certify the sleep center and outpatient cardiac/thoracic services, primary care practice and laboratory PSC as separate extension clinics.

APPENDIX V

MOHAWK VALLEY HEALTH SYSTEM

PQI STATISTICS

MOHAWK VALLEY HEALTH SYSTEM

PREVENTION QUALITY INDICATOR (PQI) STATISTICS

Prevention Quality Indicator (PQI) Statistics for Utica, Rome and Waterville

Prevention Quality Indicator Conditions	PQI No.	Statewide Rate/100,000	Admissions as % of Expected (Overall Population)*		
			Utica	Rome	Waterville
Circulatory					
Angina	13	32	29%	35%	103%
Congestive Heart Failure	8	352	107%	92%	60%
Hypertension	7	72	77%	34%	0%
All Circulatory		**456**	**98%**	**79%**	**54%**
Diabetes					
Short-term Complication	1	54	161%	71%	0%
Long-term Complication	3	124	85%	72%	26%
Lower Extremity Amputation	16	24	68%	80%	0%
Uncontrolled Diabetes	14	34	81%	41%	0%
All Diabetes		**224**	**100%**	**68%**	**30%**
Acute					
Bacterial Pneumonia	11	273	127%	90%	160%
Dehydration	10	86	179%	121%	142%
Urinary Tract Infection	12	167	68%	46%	164%
All Acute		**526**	**117%**	**81%**	**158%**
Respiratory					
Asthma	15	176	115%	79%	19%
COPD	5	181	133%	125%	123%
All Respiratory		**357**	**125%**	**104%**	**82%**
All Conditions		**1,563**	**111%**	**84%**	**82%**

***Utica is comprised of ZIP Codes 13501 and 13502. Rome is comprised of ZIP Code 13440. Waterville is comprised of ZIP Code 13480.**

APPENDIX VI

MOHAWK VALLEY HEALTH SYSTEM

POOR HEALTH OUTCOMES

MOHAWK VALLEY HEALTH SYSTEM

POOR HEALTH OUTCOMES

County Health Assessment Indicators

Per the County Health Assessment Indicators (CHAI) from the NYSDOH, residents of Oneida County experience poor health outcomes that support the need for continued service provision through the Mohawk Valley Health System. Following are supporting statistics:

Cardiovascular Disease

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to cardiovascular disease for residents of Oneida County was 370.9 deaths/100,000, as compared to 268.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to cardiovascular disease for residents of Oneida County was 245.6 deaths/100,000, as compared to 221.9/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), premature mortality rate due to cardiovascular disease for residents of Oneida County was 117.8 deaths/100,000, as compared to 99.1/100,000 for residents of New York State overall. Premature death is defined as the death of an individual aged 35-64.

- ✓ The three-(3)-year average (2012-2014), pre-transport mortality rate due to cardiovascular disease for residents of Oneida County was 223.3 deaths/100,000, as compared to 147.1/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to cardiovascular disease for residents of Oneida County was 189.9 admissions/10,000, as compared to 156.5/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to cardiovascular disease for residents of Oneida County was 143.3 admissions/10,000, as compared to 135.8/10,000 for residents of New York State overall.

Diseases of the Heart

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to diseases of the heart for residents of Oneida County was 294.9 deaths/100,000, as compared to 218.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to diseases of the heart for residents of Oneida County was 195.4 deaths/100,000, as compared to 180.1/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), premature mortality rate due to diseases of the heart for residents of Oneida County was 96.4 deaths/100,000, as compared to 80.7/100,000 for residents of New York State overall. Premature death is defined as the death of an individual aged 35-64.

- ✓ The three-(3)-year average (2012-2014), pre-transport mortality rate due to diseases of the heart for residents of Oneida County was 178.9 deaths/100,000, as compared to 126.5/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to diseases of the heart for residents of Oneida County was 122.1 admissions/10,000, as compared to 103.4/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to diseases of the heart for residents of Oneida County was 91.5 admissions/10,000, as compared to 89.4/10,000 for residents of New York State overall.

Coronary Heart Disease

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to coronary heart disease for residents of Oneida County was 204.7 deaths/100,000, as compared to 170.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), premature mortality rate due to coronary heart disease for residents of Oneida County was 66.1 deaths/100,000, as compared to 65.3/100,000 for residents of New York State overall. Premature death is defined as the death of an individual aged 35-64.

- ✓ The three-(3)-year average (2012-2014), pre-transport mortality rate due to coronary heart disease for residents of Oneida County was 131.0 deaths/100,000, as compared to 103.0/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to coronary heart disease for residents of Oneida County was 39.8 admissions/10,000, as compared to 36.5/10,000 for residents of New York State overall.

Heart Attack (Acute Myocardial Infarction)

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to heart attack for residents of Oneida County was 76.0 deaths/100,000, as compared to 36.1/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to heart attack for residents of Oneida County was 50.7 deaths/100,000, as compared to 29.9/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to heart attack for residents of Oneida County was 18.5 admissions/10,000, as compared to 16.8/10,000 for residents of New York State overall.

Congestive Heart Failure

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to congestive heart failure for residents of Oneida County was 16.9 deaths/100,000, as compared to 15.1/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), pre-transport mortality rate due to congestive heart failure for residents of Oneida County was 10.6 deaths/100,000, as compared to 8.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to congestive heart failure for residents of Oneida County was 36.3 admissions/10,000, as compared to 28.3/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to congestive heart failure for residents of Oneida County was 25.7 admissions/10,000, as compared to 24.2/10,000 for residents of New York State overall.

Cerebrovascular Disease (Stroke)

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to stroke for residents of Oneida County was 50.1 deaths/100,000, as compared to 30.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to stroke for residents of Oneida County was 33.0 deaths/100,000, as compared to 25.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), premature mortality rate due to stroke for residents of Oneida County was 13.4 deaths/100,000, as compared to 10.5/100,000 for residents of New York State overall. Premature death is defined as the death of an individual aged 35-64.

- ✓ The three-(3)-year average (2012-2014), pre-transport mortality rate due to stroke for residents of Oneida County was 26.6 deaths/100,000, as compared to 11.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to stroke for residents of Oneida County was 38.6 admissions/10,000, as compared to 26.4/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to stroke for residents of Oneida County was 28.8 admissions/10,000, as compared to 22.8/10,000 for residents of New York State overall.

Hypertension

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to hypertension for adult (18+) residents (for any diagnosis) of Oneida County was 618.2 admissions/10,000, as compared to 541.5/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), Emergency Department visit rate due to hypertension for adult (18+) residents (based on any diagnosis) of Oneida County was 1,082.1 visits/10,000, as compared to 930.8/10,000 for residents of New York State overall.

- ✓ A total of 31.0% of adult residents of Oneida County were told they have high blood pressure, as compared to 27.3% of all residents of New York State.

Chronic Kidney Disease

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to chronic kidney disease for residents of Oneida County was 168.3 admissions/10,000, as compared to 116.8/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to chronic kidney disease for residents of Oneida County was 125.1 admissions/10,000, as compared to 101.0/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude Emergency Department visit rate due to chronic kidney disease for residents of Oneida County was 163.3 visits/10,000, as compared to 120.4/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted Emergency Department visit rate due to chronic kidney disease for residents of Oneida County was 121.7 visits/10,000, as compared to 104.4/10,000 for residents of New York State overall.

Diabetes

- ✓ A total of 9.1% of adult residents of Oneida County were diagnosed with diabetes by a physician, as compared to 8.9% for New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to diabetes for residents of Oneida County was 29.6 deaths/100,000, as compared to 20.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to diabetes for residents of Oneida County was 21.5 deaths/100,000, as compared to 17.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to diabetes (as a primary diagnosis) for residents of Oneida County was 20.2 admissions/10,000, as compared to 18.6/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to diabetes (as a primary diagnosis) for residents of Oneida County was 18.5 admissions/10,000, as compared to 17.1/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to diabetes (as any diagnosis) for residents of Oneida County was 278.6 admissions/10,000, as compared to 237.6/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to diabetes (as any diagnosis) for residents of Oneida County was 219.8 admissions/10,000, as compared to 207.9/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), hospitalization rate due to short-term complication from diabetes for residents of Oneida County aged six (6) to 17 was 5.4 admissions/10,000, as compared to 3.0/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), hospitalization rate due to short-term complication from diabetes for residents of Oneida County aged 18+ was 7.5 admissions/10,000, as compared to 6.5/10,000 for residents of New York State overall.

Health Risks and Behaviors

- ✓ A total of 69.1% of adult residents of Oneida County are overweight or obese (with a BMI of 25 or higher). This was higher than the 60.5% of residents who are overweight or obese in New York State overall.

- ✓ A total of 36.6% of adult residents of Oneida County are obese (with a BMI of 30 or higher), as compared to 24.6% of all New York State adult residents.

Chronic Lower Respiratory Disease

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to chronic lower respiratory disease for residents of Oneida County was 57.0 deaths/100,000, as compared to 35.0/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to chronic lower respiratory disease for residents of Oneida County was 39.7 deaths/100,000, as compared to 29.8/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude hospitalization rate due to chronic lower respiratory disease for residents of Oneida County was 43.7 admissions/10,000, as compared to 34.8/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted hospitalization rate due to chronic lower respiratory disease for residents of Oneida County was 35.3 admissions/10,000, as compared to 32.3/10,000 for residents of New York State overall.

Asthma

- ✓ A total of 12.1% of adult residents of Oneida County were diagnosed with asthma by a physician, as compared to 10.1% for New York State overall.

- ✓ The three-(3)-year average (2012-2014), hospitalization rate due to asthma for residents of Oneida County aged 25 to 44 was 8.3 admissions/10,000, as compared to 8.10/10,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to asthma for residents of Oneida County was 1.7 deaths/100,000, as compared to 1.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to asthma for residents of Oneida County was 1.5 deaths/100,000, as compared to 1.3/100,000 for residents of New York State overall.

Cancer

- ✓ The three-(3)-year average (2012-2014), crude incidence rate of all cancers for residents of Oneida County was 651.3 cases/100,000, as compared to 550.9/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted incidence rate of all cancers for residents of Oneida County was 513.4 cases/100,000, as compared to 489.2/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to all cancers for residents of Oneida County was 229.3 deaths/100,000, as compared to 180.7/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to all cancers for residents of Oneida County was 172.3 deaths/100,000, as compared to 158.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude incidence rate of lip, oral cavity and pharynx cancer for residents of Oneida County was 15.1 cases/100,000, as compared to 12.1/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted incidence rate of lip, oral cavity and pharynx cancer for residents of Oneida County was 11.6 cases/100,000, as compared to 10.5/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to lip, oral cavity and pharynx cancer for residents of Oneida County was 3.0 deaths/100,000, as compared to 2.5/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude incidence rate of colon and rectum cancer for residents of Oneida County was 49.0 cases/100,000, as compared to 46.7/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to colon and rectum cancer for residents of Oneida County was 19.1 deaths/100,000, as compared to 16.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude incidence rate of lung and bronchus cancer for residents of Oneida County was 105.8 cases/100,000, as compared to 69.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted incidence rate of lung and bronchus cancer for residents of Oneida County was 80.8 cases/100,000, as compared to 61.6/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to lung and bronchus cancer for residents of Oneida County was 69.9 deaths/100,000, as compared to 46.4/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to lung and bronchus cancer for residents of Oneida County was 53.2 deaths/100,000, as compared to 41.0/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to female breast cancer for residents of Oneida County was 29.2 deaths/100,000, as compared to 26.3/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to cervix uteri cancer for residents of Oneida County was 3.4 deaths/100,000, as compared to 2.7/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to cervix uteri cancer for residents of Oneida County was 2.8 deaths/100,000, as compared to 2.3/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude incidence rate of ovarian cancer for residents of Oneida County was 19.6 cases/100,000, as compared to 14.9/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted incidence rate of ovarian cancer for residents of Oneida County was 14.6 cases/100,000, as compared to 12.5/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude incidence rate of prostate cancer for residents of Oneida County was 188.9 cases/100,000, as compared to 156.7/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted incidence rate of prostate cancer for residents of Oneida County was 154.0 cases/100,000, as compared to 145.3/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude, late-stage incidence rate of prostate cancer for residents of Oneida County was 25.4 cases/100,000, as compared to 23.3/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to prostate cancer for residents of Oneida County was 19.7 deaths/100,000, as compared to 18.3/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), crude mortality rate due to melanoma cancer for residents of Oneida County was 3.4 deaths/100,000, as compared to 2.5/100,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), age-adjusted mortality rate due to melanoma cancer for residents of Oneida County was 2.7 deaths/100,000, as compared to 2.2/100,000 for residents of New York State overall.

Tobacco Use

- ✓ Approximately 23.7% of adult residents of Oneida County smoke, as compared to 15.9% of adult residents of New York State overall.

Maternal and Infant Health

- ✓ The three-(3)-year average (2012-2014), infant (less than one (1) year) mortality rate for residents of Oneida County was 7.5 deaths/1,000 live births, as compared to 4.8/1,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), neonatal (less than 28 days) mortality rate for residents of Oneida County was 4.9 deaths/1,000 live births, as compared to 3.3/1,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), post-neonatal (one (1) month to one (1) year) mortality rate for residents of Oneida County was 2.6 deaths/1,000 live births, as compared to 1.5/1,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), perinatal (20 weeks gestation to less than 28 days of life) mortality rate for residents of Oneida County was 10.9 deaths/1,000 live births, as compared to 9.6/1,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), perinatal (28 weeks gestation to less than seven (7) days of life) mortality rate for residents of Oneida County was 8.0 deaths/1,000 live births, as compared to 5.3/1,000 for residents of New York State overall.

- ✓ The three-(3)-year average (2012-2014), maternal mortality rate for residents of Oneida County was 38.7 deaths/100,000 live births, as compared to 18.7/100,000 for residents of New York State overall.

- ✓ Approximately 1.6% of all births to Oneida County residents were for infants of a very low birthweight (defined as less than 1.5 kg), as compared to 1.4% of all births to all New York State residents.

- ✓ Approximately 1.3% of all singleton births to Oneida County residents were for infants of a very low birthweight (defined as less than 1.5 kg), as compared to 1.0% of all births to all New York State residents.

- ✓ Approximately 8.1% of all births to Oneida County residents were for infants of a low birthweight (defined as less than 2.5 kg), as compared to 7.9% of all births to all New York State residents.

- ✓ Approximately 6.2% of all singleton births to Oneida County residents were for infants of a low birthweight (defined as less than 2.5 kg), as compared to 6.0% of all births to all New York State residents.

- ✓ Approximately 2.4% of all premature births to Oneida County residents were for infants who were born at less than 32 weeks gestation, as compared to 1.7% of all premature births to New York State residents overall.

- ✓ Approximately 10.2% of all premature births to Oneida County residents were for infants who were born between 32 and 37 weeks gestation, as compared to 9.1% of all premature births to New York State residents overall.

- ✓ Approximately 12.6% of all premature births to Oneida County residents were for infants who were born at less than 37 weeks gestation, as compared to 10.8% of all premature births to New York State residents overall.

- ✓ Approximately 0.8% of all births to Oneida County residents were for infants with a five-(5)-minute APGAR score of less than six (6), as compared to 0.6% of all births to New York State residents overall.

APPENDIX VII

MOHAWK VALLEY HEALTH SYSTEM

CURRICULUM VITAE – CHIEF MEDICAL OFFICER

Michael F. Trevisani, MD, MBA, CPE, FASCRS, FACHE

[redacted]

SUMMARY

Healthcare Leader with experience in complex integrated hospital and outpatient settings. Background includes roles in academic training centers, integrated healthcare systems, community hospitals, rural hospitals and private practice. Demonstrated experience and success in physician recruiting, establishing and growing new service lines and leading a multi-specialty group practice. Combines a strong sense of business and operational improvement with the goals of patient-centered care. A skilled leader of quality management, peer review, utilization review, case management, and revenue cycle management employing team-based approaches and principles toward realizing process and outcomes goals.

PROFESSIONAL EXPERIENCE

MOHAWK VALLEY HEALTH SYSTEM, Utica, NY **2014 – Present**

A recent affiliation (March 6, 2013) between Faxton-St. Luke's Healthcare (FLSH) and St. Elizabeth Medical Center (SEMC) created the Mohawk Valley Health System (MVHS). This is a 573-bed acute care system (450 staffed beds) plus 202 long-term care beds with revenue of $600M per year. Includes an employed multi-specialty group, an Imaging Center, Mohawk Valley Home Care, Senior Network Health, the Visiting Nurse Association of Oneida County, the Advanced Wound Care Center, a Family Medicine Residency Program, a Dental Residency Program and a College of Nursing. The system has 600 credentialed providers, total annual revenue of $536,680,000, 4,740 employees, 25,000 inpatient admissions, 18,500 operating room cases, 76,000 Emergency room visits, 40,000 urgent care visits, and 232,000 primary care visits.

Vice President and Chief Medical Officer – Faxton St. Luke's Healthcare and Medical Group (Jan 2014 – May 2015); then Senior Vice President/Chief Medical Officer (April 2015 – Present) of the MVHS

Member of the Senior Executive team reporting to the CEO of MVHS. Responsible for the employed medical group, the Dental Residency Program, the Laborist Program, the Hospitalist Program, the Designated Institutional Official for the GME program in Family Medicine, Medical Staff Office, Library, Physician Support Services (recruiting), all contract physicians (Anesthesia, Radiology, Psychiatry, Intensivists, and Advanced Endoscopy, Cardiothoracic Surgery).

- Developed the 2015 – 2017 MVHS Strategic Plan: Physician Engagement
- Transitioned the Adirondack Community Physician Medical Group (FSLH) and St. Elizabeth Medical Group to the MVHS Medical Group (133 Providers)
- Led the MVHS Medical Group – developed a Strategic Plan and budget
- Recruited 21 physicians in 2014; 25 in 2015
- Established a Hospitalist program at a partner hospital in Oneida, NY
- Achieved Meaningful Use goals for CPOE 2014
- Coordinated and managed program and finances for the 13th,14th,15th, and 16th Annual Campaign for Quality symposia – quality conferences for providers, staff and community for 500 attendees
- Oversee, manage and negotiate contractual agreements with physicians and Medical Directors
- Created the OPPE process
- Developed focus reviews for mortality, length-of-stay and readmissions
- Saved $250,000/year in reorganizing culture protocol in ICU
- Saved $600,000/year in developing the CPOE order set process
- Reduced the Medical Staff office staffing by 33%
- Established Core Privileging

- Creating the new MVHS bylaws
- Improved OR efficiency: 23% on-time starts to 52% in one year
- Established the first Medical Education Program in partnership with SUNY Upstate Medical Center in Syracuse, NY – the first step in establishing a clinical campus for medical students

UHS CHENANGO MEMORIAL HOSPITAL, Norwich, NY **2007 – 2013**

A 138-bed healthcare facility with 58 licensed acute care beds and an 80-bed Residential Healthcare Facility in the United Health Services Hospitals system. Includes an employed multi-specialty group practice with outpatient offices in Upstate, NY: Norwich, Sherburne, Oxford, Sidney; and an ambulatory imaging center. Service lines include Family Medicine, Internal Medicine, Hospitalist Medicine, Geriatrics, Pediatrics, General Surgery, Orthopedic Surgery, ENT, Dentistry, Ob/Gyn, GI, Anesthesiology, Radiology and Emergency Medicine. The second largest employer in Chenango County with an operating budget of $80,000,000.

Vice President of Medical Affairs/Chief Medical Officer

Member of the Senior Executive team reporting directly to the President/CEO. Responsible for identifying, developing and executing the strategic goals toward Clinical Excellence, Service Excellence, Financial Strength and Market Share; established, monitored and managed Quality and Patient Safety initiatives. Budgetary responsibilities include forecasting patient and service volumes, developing operational expenditure forecasts, determining staffing requirements, and allocating capital expenditures. Simultaneously carrying out VPMA/CMO duties at UHS Delaware Valley Hospital.

- Quality and Patient Safety
  - Developed the process to consistently achieve 95-100% on Core measures
  - Developed the Pre-Procedure Risk Assessment process and tool
  - Created the currently-utilized Generalized Standard Admission Orders sets
  - Decreased radiology turn around times: 96-hour turnaround times from 20% to less than 5%; 24-hour turn around times from 20% to 64%
  - Improved operating room turn around times from 45 minutes to 25 minutes
  - On time Operating Room starts from 30% to 70%
- Interim Emergency Medical Services Medical Director 2011-2012
  - Increased in-system referrals from 50% to 95%
- Hospitalist Medical Director from inception in 2007-2012
- Chairman of the Risk Management Committee
  - Identified opportunities to improve patient satisfaction
- Created, developed and directed the 2009 Pandemic Flu Hospital Response Plan
  - Directed allocation of vaccines and set up community vaccination plan
- Direct Utilization Management
  - Improved forms management
  - Reduced LOS from 5+ days to 3.86 days
  - Coordinated efforts with area nursing homes to improve service delivery and improve resident satisfaction
  - Integrated system-wide Denial Management and Care Management Program
  - Working with Hospice to create a Palliative Care Program
  - Developed the Tdap Cocooning Program
- Lead the Chenango Medical Group – an employed physician group
  - Created the Ongoing Professional Practice Evaluation (OPPE) tool
  - Created the Physician compensation model
  - Identified practice efficiency opportunities by implementing open access scheduling
  - Established and improved quality monitors in diabetic management, chronic anticoagulant therapy and screening recommendation efficiency
- Manage the Medical Staff Office
  - Converted from laundry list privileging to core privileging
  - Directed the credentialing process

- Created a single medical staff application process for the four United Health Services Hospitals
- Review, modify and update medical staff and administrative policies and procedures

- Physician Recruitment
  - Successfully recruited to Family Medicine, General Surgery, ENT, Ob-Gyn, ER, GI, Pediatrics, Orthopedics and Hospitalist services
- Growth initiatives included creation of new service lines
  - Lymphedema care, Breast Care, Wound Care, GI, Hospitalist Program at CMH; integrated CMH Hospitalist program with the United Health Services Program
- Established a two-physician ENT practice
- Developed Professional Service Agreements
  - ENT, GI, Pediatrics, Hospitalist, Oncology
- Health Information Technology
  - Provided operational support for EMR rollout to the outpatient practices
  - Established CPOE in the Emergency Services Department
  - Establishing an EHR and CPOE in the inpatient setting

UHS DELAWARE VALLEY HOSPITAL, Walton, NY **2009 – 2013**
A 25-bed Critical Access Hospital with an outpatient Primary Care group. Service lines include Family Medicine, Behavioral Medicine, Emergency Services, Cardiology and General Surgery. Responsibilities include oversight of the service lines and quality management.

Vice President of Medical Affairs/Chief Medical Officer
Held the simultaneous role at UHS Chenango Memorial Hospital

- Established Cardiology and General Surgery as part of recruiting and integration of the multi-specialty groups.
- Created action plans to achieve Core Measures results

ASSOCIATED COLON and RECTAL SURGEONS, PA, Winter Park, Florida **1990 – 2006**
President/Sole Proprietor
Community private practice specializing in colon and rectal surgery.

SIGNIFICANT LEADERSHIP ROLES

Clinical Assistant Professor in the Department of Surgery - SUNY Health Sciences Center, Syracuse, NY – Rural Medical Education Program
Florida Society of Colon and Rectal Surgeons
President: 2006-07
Secretary: 2005 Re-established the State Society.
IHI Patient Safety Executive Development Program, Cambridge, MA, 2012
TeamSTEPPS Master Trainer, Syracuse, NY – 2012

Corporate Physicians' Committee - Adventist Health System, Orlando, Florida 2005-2008
Team leader in developing Computerized Physician Order Entry (CPOE) order sets as related to assigned disciplines in endoscopy, general surgery, peri-operative care, urology, and surgical infection prophylaxis.

Chairman, Department of Colon and Rectal Surgery, Florida Hospital 2005-2006
Directed the Colon and Rectal Surgery services at 7 campuses.

Vice Chief of Staff – 2006; Secretary 2004-2005; Chairman, Department of Colon an Rectal Surgery 1996-1997; Chairman Surgical Services 2004-2006, Winter Park Memorial Hospital, Winter Park, Florida (as a non-profit community hospital, then as a division of Florida Hospital, An Adventist Hospital).

Attending Surgeon in the Fellowship Training Program, Orlando Regional Healthcare System, Orlando, Florida 1992-2006.

EDUCATION

MBA University of South Florida, College of Business Administration, Tampa, Florida 2002-2003
MD State University of New York, Health Sciences Center, Syracuse, New York, 1980-1984
BA Hamilton College– Cum Laude, Major: Chemistry; Clinton, New York 1976-1980

IHI Patient Safety Executive Development Program, Cambridge, MA 2012
Excellence in Entrepreneurship Certificate Course-University of Central Florida College of Business Administration 2004
The Business of Medicine Program, College of Business Administration, Tampa, Florida, Distance Learning Program 2001

POST-DOCTORAL TRAINING

Residency: 1984-1989, General Surgery, Robert Packer Hospital, Guthrie Clinic, Sayre, Pennsylvania
Fellowship: 1989-1990, Colon and Rectal Surgery, UMDNJ-Robert Wood Johnson Affiliated Hospitals, Plainfield, New Jersey

LICENSURE

Florida: #50918 – Active Issued June 1987
New York #169812 Active Issued April 1987

BOARD STATUS

Certified American Board of Colon and Rectal Surgeons: January '92, Recertified '98, Recertified 2011 #1135
Certified American Board of Surgery: November 1990 Certificate #35678

SELECTED AWARDS and HONORS

Florida Hospital Value Award for Balance 2006 - Chosen among 2400 physician staff
Outstanding Surgical Resident 1989, Guthrie Clinic, Sayre, PA
2nd Prize – Stanley D. Conklin Resident's Research Paper Award 1987
"The effect of vitamin A and zinc on wound healing in steroid-treated mice."
2nd Prize – Laboratory Research – American College of Surgeons Central Pennsylvania Chapter 1987 "The effect of vitamin A and Zinc on wound healing in steroid-treated mice".
3rd Prize - Stanley D. Conklin Resident's Research Paper Award 1986
"Calcifications of the adrenal gland in a 46- year old woman: Ganglioneuroma".

SELECTED PUBLICATIONS

- Relationship Selling and Sales Management: Johnson, Mark W., Marshall, Greg W.; Expert Advice Column, pg. 142. McGraw-Hill 2004
- Ricci MA, **Trevisani MF**, Beck WC: Acute Appendicitis: A five year Review. American Surgeon, May 1991
- **Trevisani MF**, Ricci MA, Tolland JT, Beck WC: The Effect of Vitamin A and Zinc on Wound Healing in Steroid-Treated Mice. Curr Surg 44 (5) 390-393 1987

- **Trevisani MF**, Ricci MA, Michaels, RM, Meyer KK: Multiple Mesenteric Artery Aneurysms Complicating Subacute Bacterial Endocarditis. Arch Surg 122 (7) 823-24, 1987
- Gillott A, **Trevisani MF**: Venous Access Devices: Applications and Complications. Guthrie Journal 55: 173-175, 1986
- **Trevisani MF**, Ricci MA, Vesoulis Z, Deshmukh N: Calcifications of the adrenal gland in a 46-year old woman: Ganglioneuroma. Guthrie Journal 55: 127-133, 1986

SELECTED PRESENTATIONS

- "Patient Safety in the OR" - Healthcare Roundtable for Patient Safety Officers, Dallas, TX, November 11, 2007
- 2nd International Symposium on Tissue Repair: Biological and Clinical Aspects- Accredited by Brown University, Tarpon Springs, Florida. May 13-17, 1987
- "The Effect of Vitamin A and Zinc on Wound Healing in Steroid-Treated Mice" Society of University Surgeons: 29th Annual University Surgical Resident's Conference, Columbus, Ohio, February 11, 1987

PROFESSIONAL SOCIETIES

- FASCRS American Society of Colon and Rectal Surgery-Fellow
- FACHE American College of Healthcare Executives – Fellow 2013
- Piedmont Society of Colon and Rectal Surgeons
- Florida Society of Colon and Rectal Surgeons, Past President
- Iroquois CMO Group
- American College of Physician Executives – CPE Boarded 2007

SELECTED COMMUNITY ACTIVITIES

- Board of Directors, Saints Peter and Paul Early Learning Center – 1998-1999
- Lector Ministry at Sts. Peter and Paul Catholic Church – 1992 - 2001
- Capital Campaign Member for new church project - 2000
- Gus Macker Basketball Tournament – Coordinated and Provided Volunteer First Aid Services – 2007, 2008, 2009, 2010, 2011
- Operation Christmas Child – 2007, 2008
- Emergency Medical Services County Advisory Board – Chenango County, NY - 2007-present
- Leadership Chenango Program – Session on Healthcare Lecturer – January 2008
- Celebrity Waiter – Chenango County Hospice – 2008
- Train the Trainer – DOH/AAFP Colon Cancer Awareness Initiative – 2008
- Board of Directors – Oneida County American Heart Association 2015

[redacted]

HOBBIES

Working Capital Financing Plan

1. Working Capital Financing Plan and Pro Forma Balance Sheet:
This section should be completed in conjunction with the monthly Cash Flow. The general guidelines for working capital requirements are two months of first year expenses for changes of ownership and two months' of third year expenses for new establishments, construction projects or when the first year budget indicates a net operating loss. Any deviation from these guidelines must be supported by the monthly cash flow analysis. If working capital is required for the project, all sources of working capital must be indicated clearly. Borrowed funds are limited to 50% of total working capital requirements. If borrowed funds are a source of working capital, please summarize the terms below, and attach a letter of interest from the intended source of funds, to include an estimate of the principal, term, interest rate and payout period being considered. Also, describe and document the source(s) of working capital equity.

List Titles of Attachments related to Borrowed Funds	List Filenames of Attachments
Example: *First borrowed fund source*	Example: *first_bor_fund.pdf*
N/A	

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

Working capital needs for this project will be funded using existing cash equity from ongoing operations. Please refer to the **Schedule 5 Attachment** for the Cash Flow Analysis, and to the **Schedule 9 Attachment** for the Financial Narrative, a recent 2017 Internal Financial Statement for MVHS, the 2016 Audited Financial Statement for St. Luke's, the 2016 Audited Financial Statement of St. Elizabeth, the Oneida County Transformation Grant Award Letter, the Memorandum of Agreement (Parking) and the Financing Letter of Interest.

2. Pro Forma Balance Sheet N/A

This section should be completed for all new establishment and change in ownership applications. On a separate attachment identified below, provide a pro forma (opening day) balance sheet. If the operation and real estate are to be owned by separate entities,

provide a pro forma balance sheet for each entity. Fully identify all assumptions used in preparation of the pro forma balance sheet. If the pro forma balance sheet(s) is submitted in conjunction with a change in ownership application, on a line-by-line basis, provide a comparison between the submitted pro forma balance sheet(s), the most recently available facility certified financial statements and the transfer agreement. Fully explain and document all assumptions.

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

SCHEDULE 5 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

MONTHLY CASH FLOW STATEMENT

FSLH & SEMC **10/30/2017**
Strategic Planning Forecast
Cash Flows Statement

	PROJECTED						
	2015	2016	2017	2018	2019	2020	2021
Cash flows from operating activities:							
Change in net assets	($7,176,583)	$4,637,756	$10,832,423	$80,372,426	$172,167,019	$81,494,437	$17,459,304
Adjustments to reconcile change in net assets to net cash provided by operating activities:							
Depreciation and amortization	$26,762,289	$24,866,316	$24,943,755	$22,203,450	$20,023,906	$18,552,391	$17,299,797
Changes in operating assets and liabilities:							
Receivables	$1,792,428	$8,885,204	($4,803,828)	($1,114,640)	($1,446,976)	($1,484,194)	($1,632,396)
Other receivables	($1,468,087)	$1,578,488	($2,498,079)	($15,699,059)	($21,700,050)	$39,498,950	($102,061)
Inventories	($466,040)	($532,696)	($119,966)	($121,166)	($122,377)	($123,601)	($124,837)
Prepaid expenses	$348,995	($197,244)	($45,330)	($45,783)	($46,241)	($46,703)	($47,170)
Amounts due to Third Party Payers	$4,580,391	$317,244	$0	$0	$0	$0	$0
Investment in affiliates	$97,433	$707,573	$0	$0	$0	$0	$0
Other Assets	$313,679	$3,499,567	$0	$0	$0	$0	$0
Accounts payable	($263,673)	($1,984,904)	$979,776	$690,691	$827,658	$851,791	$904,835
Accrued payroll, payroll taxes and benefits	$1,348,740	$1,289,578	$388,130	$395,893	$403,810	$411,887	$420,124
Insurance & other current liabilities	$4,571,892	($5,369,231)	$61,036	$62,257	$63,502	$64,772	$66,067
Other liabilities	($2,038,923)	$113,836	$629,934	$642,533	$655,383	$668,491	$681,861
Pension liability	($330,674)	($695,881)	$0	$0	$0	$0	$0
Estimated self-insurance liabilities	$3,637,586	$1,179,908	$331,817	$338,453	$345,222	$352,127	$359,169
Net cash provided by (used in) operating activities	$31,709,453	$38,295,514	$30,699,668	$87,725,055	$171,170,855	$140,240,347	$35,284,692
Cash flow from investing activities:							
Purchase of property, plant and equipment - net	($13,350,758)	($19,009,272)	($18,735,237)	($86,364,713)	($171,313,242)	($176,552,855)	($102,206,786)
Purchase of investments, net	$4,307,731	($3,577,696)	($4,622,092)	($4,853,197)	($5,095,856)	($5,350,649)	($5,618,182)
Change in restricted funds	($130,518)	$371,196	($36,672)	($37,038)	($37,409)	($37,783)	($38,161)
Expenditure (funding) of assets whose use is limited	$245,710					($85,150,000)	
Net cash provided by (used in) investing activities	($8,927,835)	($22,215,772)	($23,394,001)	($91,254,948)	($176,446,507)	($267,091,287)	($107,863,129)
Cash flows from financing activities:							
Net Proceeds from short-term borrowings	($14,377,000)	($5,623,000)	$2,400,000	$15,600,000	$21,600,000	($39,600,000)	$0
Net Proceeds from long-term debt	($3,850,211)	($1,927,317)	($6,914,837)	($4,507,277)	($4,120,321)	$147,308,325	$79,535,733
Net Proceeds from capital lease obligations	($4,355,181)	($968,869)	($4,357,767)	($2,783,441)	($1,356,742)	($1,015,985)	($593,629)
Net cash provided by (used in) financing activities	($22,582,392)	($8,519,186)	($8,872,604)	$8,309,282	$16,122,937	$106,692,340	$78,942,104
Increase (decrease) in cash and cash equivalents	$199,226	$7,560,556	($1,566,937)	$4,779,389	$10,847,285	($20,158,600)	$6,363,668
Cash and cash equivalents at beginning of year	$6,145,023	$6,344,249	$13,904,805	$12,337,868	$17,117,257	$27,964,542	$7,805,943
Cash and cash equivalents at end of year	**$6,344,249**	**$13,904,805**	**$12,337,868**	**$17,117,257**	**$27,964,542**	**$7,805,943**	**$14,169,611**

FSLH & SEMC
Strategic Planning Forecast
Cash Flows Statement

	2022	2023	2024
Cash flows from operating activities:			
Change in net assets	($35,525,035)	$14,249,973	$11,184,130
Adjustments to reconcile change in net assets to net cash provided by operating activities:			
Depreciation and amortization	$26,996,056	$27,725,185	$28,792,564
Changes in operating assets and liabilities:			
Receivables	($1,340,758)	($1,367,773)	($1,395,334)
Other receivables	($103,082)	($104,112)	($105,153)
Inventories	($126,085)	($127,346)	($128,620)
Prepaid expenses	($47,642)	($48,119)	($48,600)
Amounts due to Third Party Payers	$0	$0	$0
Investment in affiliates	$0	$0	$0
Other Assets	$0	$0	$0
Accounts payable	$517,957	$785,975	$806,231
Accrued payroll, payroll taxes and benefits	$428,527	$437,097	$445,839
Insurance & other current liabilities	$67,389	$68,737	$70,111
Other liabilities	$695,498	$709,408	$723,596
Pension liability	$0	$0	$0
Estimated self-insurance liabilities	$366,353	$373,679	$381,153
Net cash provided by (used in) operating activities	($8,070,822)	$42,702,703	$40,725,917
Cash flow from investing activities:			
Purchase of property, plant and equipment - net	$44,055,957	($6,949,639)	($8,954,675)
Purchase of investments, net	($5,899,091)	($6,194,045)	($6,503,747)
Change in restricted funds	($38,542)	($38,928)	($39,317)
Expenditure (funding) of assets whose use is limited			
Net cash provided by (used in) investing activities	$38,118,324	($13,182,612)	($15,497,739)
Cash flows from financing activities:			
Net Proceeds from short-term borrowings	$0	$0	$0
Net Proceeds from long-term debt	($5,735,604)	($5,822,228)	($6,198,575)
Net Proceeds from capital lease obligations	($215,772)	($94,162)	($58,508)
Net cash provided by (used in) financing activities	($5,951,376)	($5,916,390)	($6,257,083)
Increase (decrease) in cash and cash equivalents	$24,096,126	$23,603,701	$18,971,095
Cash and cash equivalents at beginning of year	$14,169,611	$38,265,737	$61,869,438
Cash and cash equivalents at end of year	**$38,265,737**	**$61,869,438**	**$80,840,533**

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission

This Schedule applies to projects with construction, including Articles- 28, 36 & 40, i.e., Hospitals, D&TCs, RHCFs, CHHAs, LTHHCPs and Hospices.

	Example: - *attachment in PDF format*	*Architecture Attachment*	*Architecture Attach A PDF*
A.	Architectural narrative that delineates the project scope of the work to meet the determined program needs, including functional space requirements. The following are suggestions to include in your narrative, should they pertain to your project: • Intent/Purpose • Describe existing physical plant conditions in area of work • Identify spaces that are considered multi-function space • Changes in capacity: beds / occupants • Exceptions to the referenced standards, potential life safety compliance and/or functionality issues • Innovative approaches and or alternate means of compliance • Article 28 space adjacent to non-Article 28 space	Please refer to the Schedule 6 Attachment	N/A
B.	Schematic Design drawings that complement the architectural narrative. Submit electronic (via NYSE-CON) and hardcopy drawings using appropriate design guidelines submission requirements.	Please refer to the Schedule 6 Attachment	N/A
C.	Please select, complete, and submit the appropriate Certification Letter from the following link: Architect's or Engineer's Letter of Certification	Please refer to the Schedule 6 Attachment	N/A
D.	Projects involving the following facility types: Diagnostic Radiology, Computed Tomography (CT) Facilities, Interventional Imaging, Radiation Therapy Facilities, Proton Therapy, Nuclear Medicine and/or Magnetic Imaging Facilities — **Yes** ☒ **No** ☐ If yes, provide Physicist's Report and respective drawings must be attached for Design Development.	Please refer to the Schedule 6 Attachment (Per the architect's discussion with Mr. Ammon, MRI Cert Letter is not being provided)	N/A
E.	Flood zone location? **Yes** ☐ **No** ☒ If yes, please provide a FEMA BFE Certificate from the FEMA website link www.fema.gov.	N/A	N/A

Instructions: Attachments should be saved as PDF documents. The PDF document should be assigned a unique name, so it will not be confused with any other attachment. The title of the attachment, and name of the attached PDF file should be entered in the table below.

SCHEDULE 6 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

ARCHITECTURAL DOCUMENTATION*

1. Architectural Narrative
2. Structural Narrative
3. MEP Narrative
4. Life Safety Code Checklist
5. Occupancy Load Calculations
6. Behavioral Health Product Standards (for NYSOMH)
7. Architect/Applicant Letter of Certification
8. Physicist Letter of Certification
9. PDF of Service Yard Plan
10. PDF of Schematic Drawing

ARCHITECTURAL NARRATIVE MVHS INTEGRATED HEALTH CAMPUS

Background

Faxton St. Luke's Healthcare (FLSH) and St. Elizabeth Medical Center (SEMC) affiliated in 2014 to become the Mohawk Valley Health System (MVHS). MVHS's mission is to provide excellence in healthcare for its communities. Substantial effort has been focused on consolidating existing resources, eliminating redundancies, expanding the depth and breadth of services, improving access and elevating the quality of healthcare services in the region. MVHS has been successful in its efforts thus far, but has been constrained by the age and physical limitations of the existing facilities.

SEMC opened in 1917 and the St. Luke's Campus opened in 1957. Since they were built in a time when healthcare was much different than it is today, these facilities were not designed to accommodate the programs, equipment and overall patient-care delivery and safety that are part of MVHS service today.

MVHS incurs considerable expenses in order to remain code compliant and significant duplication of services for two hospital settings. Current services are provided in a space that is not optimal for patient flow, staff efficiency or patient/family experiences. The two existing campuses, especially SEMC, are also constrained by size and location and cannot easily accommodate much needed parking areas.

In order to deliver higher quality, more effective care with better community outcomes and at a lower cost, a single new hospital which combines services from both campuses will be built and transform healthcare for the community consistent with the vision of Triple Aim. The new MVHS integrated health campus and state-of-art hospital will replace SEMC and FSLH, will reduce the number of beds in the community and consolidate patient services to one campus.

The decision to consolidate the two inpatient campuses to a single facility represents the logical progression of efforts to achieve the MVHS mission and was spurred by several key factors:

- The desire and need to build a facility with the newest technology, services and advancements in patient safety and quality so that our community can receive the most up to date healthcare services that rivals those found in large cities.
- The growing demand for healthcare due to the rapidly increasing and aging population in this region.
- The increasing need to improve accessibility and availability by attracting specialists and providing services that otherwise would not be available to our community.
- The opportunity to gain greater operational efficiencies through the elimination of duplicative and redundant functions will help to reduce the rate of increase in healthcare spending and to achieve improved financial stability

DESCRIPTION BY FLOOR LEVEL AND SERVICE PROGRAM

LEVEL 1

General Description

Level 1 represents the primary public and service components for the building. A pubic circulation concourse towards the north and a separate service, "back-of-house" corridor to the south effectively create an on-stage/off-stage environment and setting.

Public entries and drop-offs are positioned along the Lafayette Street corridor. A gracious Main Entry allows for patient drop-off and easy access to the MVHS parking garage. This concourse connects all public facing programs and services including the chapel, outpatient imaging, visitor elevators, the gift shop, dining and conference center spaces.

The primary service corridor runs along Columbia Street. To the west are both emergency department walk-in entries and the ambulance entry. To the east is the service yard with access to docks, a service center and the Central Utility Plant. A controlled staff entry along the south is planned.

920 Public Areas (Public Entry, Lobby, Waiting)

The single, main entrance and lobby is accessed from the drop-off. A canopy extends past the driver side door on arrival cars to protect visitors from the elements. Visitors arriving via the parking garage are directed towards the main entry via a covered walkway. A large vestibule provides wheelchair storage and secure entry to the hospital.

The two-story lobby welcomes visitors, patients and the community with simple and clear wayfinding along the main concourse. To ensure a secure environment, the security department staffs the information desk. This entry is designed to accommodate metal detectors should that be required. Otherwise, visitors check-in at the security monitoring desk and are given a visitor badge.

Along the public concourse is an array of seating options directly adjacent to and along the Lafayette corridor. The outdoor area here is intended to serve as an amenity space with walkways, gardens and other design elements helping to create a healing environment. The concourse seating area should be light-filled and restful.

Additionally, the concourse is connected to the Emergency Department waiting area so that family members in the ED can access other public functions and so that patients arriving at the wrong entry can access needed services.

The main visitor elevators are directly off the lobby. These are convenient to visitors accessing inpatient floors or to outpatients traveling to procedures.

920 Public Areas (Gift Shop)

Central to the lobby area is the MVHS gift shop where staff, visitors and patients have access to sundries such as newspapers, magazines, books, snack and other gift items. The gift shop is run by volunteer services.

Patron access is directly off the main lobby. Volunteer staff can visualize the gift shop area, staff the check-out and access the storage room from a single point. There is back-of-house access to the storage room for

ease of servicing the gift shop.

920 Public Areas (Public Dining, Vending)

A welcoming dining and servery area is conveniently located off the main lobby. This setting will serve healthy food choices and provide a variety of menu choices for visitors and staff. The new seating area will offer different seating options and is positioned to allow views to the outdoors. A separate physician dining area is also considered to enhance the physician experience at MVHS. Vending areas will be accessible 24/7.

901 Administration (Security)

Security is positioned to allow easy access for officers throughout the building. The main security monitoring room is off the concourse and positioned such that staff can also man the main check-in/info desk. While security officers are stationed in other high priority areas, including the ED and Birthing Center, this location allows for a central point of control. The monitoring area here will also function as the fire command center for the hospital.

901 Administration (Volunteers)

The Volunteer office serves as home base for Volunteer director and coordinators. While some lockers and workstations are available in this location, most volunteers report directly to their assigned positions. The first floor location allows Volunteer coordinators to more easily recruit and review potential volunteer applicants.

903 Admitting (Patient Access)

Nearly all admitting and outpatient registration processes are completed prior to patient arrival, or at the bedside in the case of the ED and Inpatient direct admits. Outpatients only access the imaging/noninvasive department on this level and the intervention/procedure suite on the second level.
Kiosks will be available in the main lobby area as well as on the second level for self-service check-in. The reception desk at Imaging is staffed by registration personnel and serves as a reception point for admitting/patient access.

This department offers additional financial counseling for interface with patients needed additional service. Three private patient interview spaces (2 certified admitting counselors (CAC) offices and 1 flex office) are directly off the imaging waiting area. The reception point at the imaging area serves as reception for this location as well.

The director, manager and administrative staff comprise the remaining areas of the department.
Direct admissions from physician offices or other locations will be identified by the Patient Flow Command Center and arrivals will be coordinated such that they are directed immediately to the awaiting patient room. If patients arrive for admission without the prior notification, they will be escorted to the emergency department where proper clinical monitoring may occur.

922 Chapel/ Meditation

A non-denominational chapel provides spiritual comfort for those of all faiths. The main chapel area will be designed to convert easily for services and needs based on requirements. This includes supporting Catholic services, Protestant, Jewish and Muslim services. Movable seating and storage for faith implements are provided in the space.
A shared office is provided for visiting clergy members and is easily accessible for the public.

106 Emergency Department

Emergency Department unit room overview:

- 2 Triage
- 4 Quick/Turn
- 2 Trauma
- 6 Behavioral Health
- 10 Observation
- 44 ED Treatment rooms

The Emergency Department is located on the first level with access at grade from the west side of the building (State St) and is designed to support clear wayfinding and provide separate entry flows for walk-in patients and those arriving by EMS/Ambulance.

The ambulatory/walk-in entrance on the west side of the building is directly adjacent to the parking garage which also has a covered connector to the ED entrance to provide protection from outdoor elements. At this entry, there has been adequate space provided for wheelchair storage that is easily accessible for patients and staff.

The ambulance drive up and entrance is restricted and is located south of the walk-in entrance on the west side of the building. Patients arriving by ambulance will be taken immediately to a treatment station within the ED. A Helipad is directly adjacent to the EMS/Ambulance entrance with clear paved connection to the ambulance entrance to deliver patients to the ED or to take them directly up a dedicated back elevator to the OR or ICU.

Patients arriving via the walk-in entrance will pass through a metal detector manned by security and then be greeted for treatment at the main triage/quick look desk. This patient-first philosophy provides a welcoming destination staffed by nurses who can make immediate decisions about a patient's disposition. The organization and layout of this area is based on improving patient flow to ensure patient safety and to support a strategy that incorporates immediate bedding, split flow for lower acuity patients and rapid assessment for others to provide appropriate patient treatment.

There is waiting space provided for families and patients adjacent to the main desk so that the area is in direct line of sight of nursing and security to ensure safety of patients, and it is designed to provide a calm environment with access to daylight and amenities via a connection to the main concourse of the hospital. There is also consultation space provided in this area when needed.

Directly behind 2 triage rooms are 4 quick turn exam rooms for further triage and treatment of lower acuity patients. This area has a designated provider, nurse and tech assigned to this space and staff have ready access to all equipment and supplies needed for blood draws, EKGs and medications. All exam rooms in quick turn are private and equipped the same as all ED exam rooms along with a patient toilet/shower in this zone. This area has direct access to all imaging modalities that are adjacent to the ED.

The main Emergency Department is comprised of 6 pods that are organized across the floorplate in groupings of 2 to support flexibility in acuity, staffing ratios for nursing and physicians, and provide ability to flex up and down during fluctuations in volume. A degree of standardization has been carried out across the pod configuration so that each pod contains the same supply/equipment resources, workstation space, medication rooms and patient support located within the center of the pod. This concept assists with minimizing staff travel, improved communication between providers, and enhances timely care to patients. Isolation rooms (All, Airborne Infection Isolation) with dedicated toilets have been provided within 2 of the main ED pods. Lab services within the hospital will be accessible via pneumatic tube with point of care

testing as appropriate within the department. Pharmacy services will also be accessible via pneumatic tube with the plan for the hospital or supporting retail pharmacy to dispense discharge medications with patient instructions and education.

In order to service the many types of needs of the ED patient population and reduce admissions, one of the pods is designated to care for Observation patients and is dedicated for those that have been seen in the ED but need to be monitored for a period of time before they can be discharged. All of the observation beds meet the standards in size and are the same square footage as the ED exam rooms which include space for family, med gases, entertainment monitors, and wardrobe for storage. There are dedicated patient toilets within the pod to support this area. In this pod there is also one isolation room (AII) that has its own dedicated toilet. The central support area is the same as the main ED pods with space for the clinical staff, clean supplies, soiled utility, medication, and a nourishment station.

To address Trauma/Resuscitation patient needs and the Behavioral Health patient population, one pod with a direct back of house connection to EMS and closest access to imaging and critical care services was identified to be the best location for both patient types. This created a division of a pod with one side consisting of 2 trauma rooms with equipment and support and a separate 6 bed behavioral health unit on the other side. Each area has its own designated support; trauma with equipment/supplies, imaging and medication Pyxis with direct access to a dedicated large elevator to transport patients to the operating room or critical care.

The Behavioral side of the pod is a closed area with secure doors(controlled access), a dedicated team space, all support services, behavioral health toilet/shower room and a location for security and monitoring equipment to assist with safety of patients and staff.

A Decontamination treatment room is located near the ambulance entry. It provides one way flow for patient from the exterior into the treatment area, as well as, one way flow for staff into the treatment area via an anteroom. This space is designed to accommodate 2 patients at a time with 2 shower heads. Locker spaces are divided into men and women's rooms. Each locker room will provide space for potential use of scrub vending machines, toilet and shower areas and storage for coats and outer footwear. This locker space will be shared between the ED and Imaging staff. In addition, there is a staff lounge that will be shared for breaks and lunches. Administrative offices that support the ED and Imaging are also in this zone to provide close proximity to key program elements and provide flex workstation space for those who are not within the hospital.

210 Diagnostic Imaging

The Diagnostic Imaging & Non-invasive diagnostics suite consists of the following:

- 2 General Radiology
- 2 Fluoroscopy
- 3 CT
- 1 MRI
- 3 Ultrasound
- 2 Echo/Stress
- 2 SPECT
- 1 Mammography

Diagnostic Imaging will provide state-of-the-art imaging services to inpatients and outpatients at MVHS. The imaging department has been strategically located on the 1st floor so that it can be directly adjacent to

the Emergency department for quick access and near the main hospital entry and inpatient elevators for patients coming to the hospital for out-patient testing or for quick access to back of house in-patient elevators reducing travel distances for patients and staff.

The entry point for imaging is off of the main hospital lobby concourse and will have a key entry point with appropriate signage for point of check in. It is planned that all patients will be pre-registered prior to appointment and will stop at a main check-in point to notify of arrival. A dedicated waiting space has been provided for patients and family along with consultation rooms for private conversations or review of results.

Inpatients coming to the diagnostic imaging department connect vertically from all floors and will use the dedicated elevators adjacent to imaging for transport. This quick connection will reduce transport time for all patients.

The imaging department opens directly into the Emergency department with 1 CT and 1 Gen Rad room dedicated to servicing the ED. Staff within imaging will effectively coordinate flow of patients between rooms to ensure maximum utilization. Both the General Radiology/CT pod and Cardiology testing pod have a dedicated core with workstations for team, support, and medications. This core area will enhance communication for all team members. Each CT contains a control room, with 1 large for 2 rooms and the other CT independent.

All Gen Rad, Fluoroscopy and CT rooms have patient toilets. Toilet rooms will be used for patient changing and will contain lockers and gowns to support privacy.
The MRI diagnostic suite contains an MRI, Control room, wait/holding area, MRI equipment room, patient toilet and MRI work room. All necessary facility radiation safety measures incorporating the four MRI safety zones will be implemented.

2 SPECT nuclear medicine tomographic imaging rooms are located together contiguous to a hot lab and radioactive waste storage. Segregated patient and staff flows ensure that there is no exposure to radiation. Radiology offices for physicians have been provided within the department for digital reading capabilities. Full access to electronic interface will be required to facilitate consultations with other physicians on or off campus.

Alcoves are provided to support portable imaging devices. Most portable equipment is being distributed throughout departments to improve accessibility to key imaging tests, reduce travel time and provide quicker turnaround time on results.

930 Education & Research

A robust education center offers a variety of learning environments for community, staff and patients. The large auditorium seats up to 150 and is convertible to smaller conference/classrooms for use in a variety of settings. Storage for chairs and tables in adjacent rooms allows these conference rooms to be arranged as the demand requires.
In addition to the main auditorium, several other conference rooms and training rooms are outfitted with the latest A/V technology. The IT computer training room and Patient Simulation room are for staff use only. While conference rooms throughout the facility are intended to be shared resources and are managed by the education staff, the Level 1 conference rooms are typically dedicated to broader learning needs. The location adjacent to the kitchen allows for easy catering.

734 Baseline Dietetic (Kitchen, Servery, Nutrition Offices)

The main kitchen, server and nutrition offices support both public cafeteria and inpatient meal service. The kitchen area has back-of-house access to loading docks, both clean and dirty, as well as simple access to a service elevator dedicated primarily to food and pharmacy transport.
A room-service type model is anticipated for patient meals.

733 Baseline Clinical Laboratory Services

The Clinical Laboratory at MVHS efficiently performs and coordinates all inpatient and on-site and off-site outpatient clinical specimen tests ordered by physicians and providers. The Clinical Lab examines materials derived from the human body for the purpose of providing information on diagnosis, prognosis, prevention, or treatment of disease. The Clinical Lab also manages procurement, storage, testing and dispensing of blood products for MVHS. The department procures specimens (phlebotomists or RN collected specimens), processes specimens, performs STAT and routine test, and communicates results to a physician's/providers accurately, in a timely manner.

Services Provided:

- Outpatient Blood Draw: The lab will not have a phlebotomy area within the lab, but there will be a phlebotomy area in an adjacent medical office building
- Phlebotomy Services / Specimen Acquisition: Provides Phlebotomy Services to the Hospital and other outpatient clinic sites. Phlebotomists also work in the Lab, but mainly obtain blood and urine specimens at the bedside. Other specimens are acquired by on-site RN's or physicians. A number of specimens will be acquired from off-site and on-site physician offices or clinics. Specimens collected at medical office buildings off campus will be picked up by MVHS courier service and processed at this lab.
- Accessioning and Processing: Accessions and processes specimens obtained from Blood Draw, RN's and physicians. All specimens will be processed at this lab as it will be the designated Reference Lab for testing including other microbiology, special chemistry, molecular/serology and other specimens scheduled for more esoteric testing.
- Pathology: performs surgical specimen processing, frozen sections, and transcription and reporting of pathological findings
- Frozen Section: Specimens from the Surgery Suite will be processed/accessed and evaluated in the Histology area

Testing:

- Provides STAT testing for inpatients and outpatients (Chemistry, Hematology, Coagulation, and Microbiology) and routine testing for inpatients and outpatients (Chemistry, Hematology, Coagulation)
- Assume to provide Anatomical Pathology
- Could provide back-up to other MVHS locations and clinics if their instruments go down

Results Reporting: Analyzes results and sends to physicians. Re-tests or adds tests as required. Stores specimens for a prescribed period of time after testing

Blood Banking: Receives blood product from outside providers. Tests patient specimens. Cross Matches specimens and blood product. Prepares and stores blood products. Dispenses blood product as needed for the hospital or the clinics

PoCT Coordination: Coordinates, calibrates, and services point-of-care testing equipment.

Blood Gas analysis will be provided by Respiratory Therapy outside of the purview of the Lab

Key Interdepartmental/ Support Relationships

- Close relationship with Blood Draw which must, in turn, be accessible to outpatients in the MOB. Phlebotomists cross cover Blood Draw, Clinical Lab and point-of-care draws to level workload
- Requires back of the house access from blood product and specimen couriers. This has been created with a direct connection from the dock to the drop off location area. Dedicated parking for courier to be provided.
- Location of Lab requires access to Loading Dock for delivery of supplies and packages, therefore the Lab is directly adjacent to the loading dock on the west side of the building
- While some blood can be tubed to the patient destination, bulk blood will need to be picked-up and delivered to Surgery, ED, and other critical areas via the back of houses service elevators directly adjacent to the lab
- All phlebotomists will have their blood draw carts stored on inpatient units and will decentralize from the lab. Carts will not be stored in the lab, and will be restocked on the unit. Proximity to the back of house elevators is currently planned to enhance delivery of specimens to the clinical lab if they cannot be tubed.
- Phlebotomy supplies will be available on the units to limit need for phlebotomists to go to the Lab
- Pneumatic tubes will transport specimens and blood from the floors to the lab

Changes in Practice

- Addition of additional equipment to the hospital lab driving a broader test menu, more STAT's, and Blood Banking.
- Drive for greater efficiency (Lean), as well as the need for faster turnaround times and broader test menus have made Total Lab Automation systems a viable alternative to individual instruments for smaller laboratories. Continue to add automation and will continue evaluate opportunities
- Test volume is growing due to aging population, expanding market share, additional mandated tests, new technology, broadened test menu, taking on additional outpatient testing and community standards. Some additional tests will be accommodated by available instruments sized for growth.
- Some rapid molecular tests (HIV, TB, MRSA) will continue to be done in house.
- Lean planning to enhance staffing compliment, enable cost savings for supplies, increase turnaround time and foster greater reliability is now an integral part of design.
- Tubing of blood product reduces the need for a satellite Blood Bank in the OR. A blood bank refrigerator will be available to and monitored by OR staff. Potential for one in the ED for trauma.
- Emerging pathogens (H5N1, SARS, MRSA, etc.) require greater attention to staff and public safety.
- Intradepartmental
- P-tube system to provide access to all patient care areas.

Staff Areas

- Lab staff will have a dedicated locker and lounge for storage of coats, personal effects and area for respite.

Access and Circulation

- Entry/window for hospital staff and couriers delivering /picking up blood products, delivering/sending out provided at 3 locations: Blood Bank, Histology and Main Lab.

ANATOMICALPATHOLOGY

Operational Objectives: Departmental and Integrative

- The core function of Pathology services is diagnostic pathology. The Pathology Laboratory at MVHS will provide Frozen Section and Grossing, and STAT Cytology services for on-site patients. The Pathology Department examines human tissues and body fluids for the purpose of providing information on diagnosis, prognosis, and treatment planning.

Services:

- Specimen Acquisition: Pathologists may advise other physicians on the acquisition of specimens or obtain cytology specimens directly from patients as in Fine Needle Aspiration (FNA).
- Accessioning: Staff will accessions specimens into the Pathology LIS in the Pathology Laboratory, or, in future, at point-of-care.
- Frozen Section: Un-fixed STAT specimens, acquired intra-operatively, will be prepared, stained and taken directly to the lab for analysis
- Grossing: Grossing stations for pathologists and pathology assistants will be provided in conjunction with Frozen Section to level workload between frozen cases.
- Histology: Blocks prepared at MVHS will be sent to the on-site Pathology Department for processing and interpretation.
- Cytology: STAT body fluids will be rapidly processed in Frozen / Grossing Lab. Routine specimens will be sent to the on-site Pathology Department for processing and interpretation.
- Autopsy: Autopsies will be performed at MVHS. A morgue has been provided adjacent to the lab with an area for autopsies and family viewing.

Key Interdepartmental/ Support Relationships

- Pathologists require access to the Surgical Suite and to clinics where specimens are collected.
- Pathologists need to be accessible to other physicians for consults using multi-headed microscopes therefore offices will incorporate required space to support a multi-headed scope within pathology
- Frozen/Grossing has direct access to the Loading Dock for delivery of supplies and packages

Key Design Features Clinical Lab/ Pathology

- Planned the processing and testing areas of the lab as a large open, rectangular space to maximize future flexibility and reconfiguration of workflow, benches and equipment. The open lab concept permits team members to see each other, enhances supervision and night shift can also see each other, entrances, and pneumatic tubes more easily to increase efficiency and security.
- Offices and other fixed elements are located on the perimeter.
- Direct access to Blood Bank for product delivery provided with a separate entry door off main back of house corridor.
- Frozen/Grossing currently planned as a large open space to permit flexible workflow and also provide an environment for pathologists to dictate cases

General

- Including provisions to temporarily hold bio hazardous waste.
- Incorporated limited access features to provide security to staff.

Patient and Staff Safety

- Biosafety cabinets to control pathogens.
- Chemical fume hood to control odors.
- Hand washing sinks distributed in all areas for staff.

- Adaptable casework systems to adjust work surface height for staff ergonomics.

Environmental Quality and Utilities

- Appropriate air exchanges – 100% exhaust, single pass air for Labs. Design a minimum of 6 air exchanges per hour but air changes may be governed by heat load from equipment.
- ~10 meg ohm RO/DI water is required to support the chemistry instruments and some reagent prep.
- Power will run in wire mold mounted to casework frames or on walls, or in overhead service carriers.
- Cat 6 data will run in the casework cores or in wire mold or overhead service carriers with adapters.
- Cup sinks will be provided in the casework cores 18" AFF for drainage.
- Given the on-grade location, a grid of drains (~11' x 5.5' starting in the perimeter walls) will be provided under the slab to permit equipment and casework changes over time.
- Central uninterruptable power supply (UPS) system will be located where possible to avoid providing UPS at each instrument. UPS is required for all equipment requiring calibration after emergency shutdown (most analyzers, computers).
- Providing emergency power for all equipment including computers and refrigerators.
- Providing FDA compliant monitoring of all Blood Bank refrigerators and freezers.
- Provision for future wireless tele-data access for instruments, computers, and PDAs.
- Key Card access at all entrances.
- Include cable trays in the ceiling.
- Emergency Eyewash and Shower Station with trap primer floor drain and removable cover will be provided
- Lab waste system capable of withstanding chemicals planned for use in lab (while chemicals should not be poured down the drains, an accident could occur). CPVC is not acceptable.
- Lab sinks will have a combination foot control/wrist blade faucet while hand wash sinks could have electric eye faucet as well as an emergency eyewash/face-wash unit.

943 Maintenance & Housekeeping (Loading Docks)

A dedicated clean and soiled loading dock for the MVHS hospital is located directly off of Columbia on the east side of the building at ground level and provides 4 truck loading clean receiving bays, and 3 bays for soiled (trash/recyclables/medical waste/linen) and 3-4 locations for short term parking for small truck or courier deliveries/pick up. Two of the bays will be equipped with a dock leveler and one bay will have a dock lift. This space supports the receipt and staging of all incoming clean equipment, supplies, mail, linen and food with a dedicated separation for waste stream management to the soiled bays. The new receiving docks have direct and immediate access to service elevators that are within the receiving area that can go directly to the interventional platform, CSP and Pharmacy on the 2nd floor and a direct dedicated restricted service connection to an additional back of house elevator bank that services the upper inpatient floors. A receiving check-in office, dedicated portable gas storage tank room, secure holding room, clean linen and temporary cart staging is directly connected to the unloading areas and provides space for primary supply distribution and staging areas/ transferring JIT totes for the supply chain department.

943 Maintenance & Housekeeping (Gas Storage Rooms)

The gas storage room located adjacent to the dock will provide temporary storage for oxidizing and non-oxidizing gases. The gas storage rooms are limited to the maximum allowable gas quantities by code. Full and empty cylinders will be clearly marked and a gas manifold will be provided adjacent to the dock area and be part of the facilities department responsibility.

943 Maintenance & Housekeeping (Central Storage)

The main warehouse storage space is to be located in a separate facility. A central storage room is located adjacent to the loading docks and service elevators which allows for ease of distribution or pick up from user departments. Some bulk non JIT items, including IV fluids disaster preparedness stock, and routine high use items in low unit of measure format will be stored within the MVHS material management storeroom. Most supplies will be shipped in reusable totes from various vendors ready for end-users distribution. All 'STAT" supply storage will be maintained in the storeroom. Bulk supplies, such as IV fluids will be de-cased within the storeroom and delivered to Pharmacy for preparation and distribution.

Materials Management will handle the re-stocking of most supplies in all areas of the hospital including SPD (for redistribution in the case cart system), with Surgery and to other clinical departments. Security will assist materials management with monitoring receipt of supplies and pedestrian traffic in and around the loading dock area.

943 Maintenance & Housekeeping (Linen)

A linen service area for receiving of clean linen is located on the dock with immediate access to service elevators to provide dedicated storage, cart make up, dispatch and distribution of clean linen throughout the hospital. The linen room will accommodate a secure area for additional carts to serve as emergency linen backup supply.

943 Maintenance & Housekeeping (Trash & Linen Chute Rooms)

The waste stream management, including the collection, transport and disposal of general trash, recyclables, and RMW (regulated medical waste) is maintained using manual cart transport and vertical linen and trash gravity chutes along dedicated soiled distribution routes, which terminate on the Ground floor level in separate dedicated collection rooms. EVS staff will transport trash and linen collection carts to the soiled side of the dock for pick up.

943 Maintenance & Housekeeping (Facilities & EVS Admin)

Facilities and EVS leadership and supervisors are located adjacent to the Materials Management area, shops and connected by a corridor to the main dock. This general location of offices and shared conference room provides direct connection and supervision to those departments, creates opportunities of collaboration and communication between staff and leaders and provides an area to have department meetings, team discussions or education. Senior Facilities leadership and the Safety Director are located on the 2nd floor.

943 Maintenance & Housekeeping (Shops)

Shop space has been dedicated contiguous to the CEP to provide space for work benches, as well as storage for multiple items that support the daily operations of the hospital. HVAC, Plumbing, Paint, Electrical, Carpentry, Metal General shops have dedicated spaces to support the work of each specialty. In addition, the shop area is located off a corridor that connects directly to the CEP providing quick access if needed. Staff in this area will share a common locker room and lounge with the dock and materials management team directly adjacent to their area

LEVEL 2

General Description

Level 2 is the main procedure and interventional center for the MVHS hospital. A consolidated interventional platform for outpatients, same day procedure patients, inpatients and trauma patients provides the flexibility and shared services necessary to enhance patient care delivery. Administrative functions as well as clinical support areas, including pharmacy and sterile processing, occupy the remainder of the floor.

This level also supports a front of house and back of house organization. The main visitor elevators offer views to the entry and Lafayette corridor – aiding in wayfinding. Visitors, family and patients access is controlled to the main second floor lobby and waiting areas.

Surgical and interventional areas are controlled access and allow for private, back-of-house transport for patients, services and staff.

A future physician office building located on Columbia could potentially have controlled staff-only access to this level at the east end of the building.

920 Public Areas (Toilets, Waiting)

Outpatients arriving for outpatient surgery, cath, intervention or endoscopic procedures come to the second level with family to be checked in and wait for the procedure. The main visitor elevators bring patients directly to a second floor lobby overlooking the main entry. The intervention center reception desk is immediately off the elevators.

Amenities for family waiting in the lounge include a variety of seating choices, adjacent public restrooms and access to refreshments. Patient tracking technology will be utilized to keep family informed of patient progress throughout his or her procedure. This would allow family to remain on this level or use the first floor amenities as desired.

Consult rooms are immediately adjacent to the family lounge area. Concierge staff will notify family when physicians are ready to speak with them and will direct family to the appropriate consult room. Physicians/surgeons arrive from the opposite direction.

When appropriate, family will be able to stay with patients during pre and post op care via direct access to these areas.

744 Baseline Recovery Room (PreOp, Post Op, PACU)

Directly off the waiting area is a large Periop unit, consisting of PreOp, PACU and Phase 2 recovery functions. This suite is designed as a highly flexible suite to allow for flexing of function based on schedule demands. It is universally designed so that each holding bay or room is able to accommodate both pre-op and post-op patients' requirements.

This suite support the operating rooms, Cath labs, EP labs, interventional rooms, Hybrid OR and endoscopy rooms. It consists of the following areas:

- 24 PACU bays (including 1 isolation with attached toilet, 5 enclosed rooms)
- 60 Periop Rooms (2 are isolation with attached toilets)
- 2 Procedure/Block rooms
- Supporting care giver work, med, clean, soiled, nutrition and other support functions

The Periop suite is consists of several clusters of 8 to 10 Periop patient rooms surrounding support functions. These areas are intended to flex as needed, but will be zoned such that patients are generally positioned nearer to the procedure rooms to which they are scheduled. For instance, the two clusters south of the main elevator bank are adjacent to the endoscopy suite and near Cath lab rooms. This area will primarily serve those procedure rooms

The Periop areas are connected via controlled access corridors where staff and materials are free to move, but public access is limited and controlled. These controlled corridors also lead to the entry of the semi-restricted corridors of the interventional suite as well as patient, staff and service elevators. The control desk areas are central to the entire suite in order to manage traffic and flow around these areas.

741 Baseline Operating Room (OR, Cath/EP,IR, Endo)

The interventional platform creates a dedicated suite to all procedure-based services. This includes the following:

- 8 General ORs
- 4 Specialty ORs (Cardiac, Ortho, Neuro)
- 3 Cath Labs
- 2 EP Labs
- 2 IR rooms
- 1 Hybrid OR
- 6 Endoscopy rooms, including 1 Advanced Endo room and 1 Flex Fluoro room

The suite is comprised of 4 cores with procedure rooms surrounding a clean core, these are organized as follows:

- Eight (8) ORs (general ORs)
- Six ORs (2 general, 2 Ortho, 2 cardiac) plus soft space for 2 future ORs
- Four intervention rooms (3 IR, 1 Hybrid/IR)
- Four cardiac intervention rooms (2 EP, 2 Cath)
- An Endoscopy suite (1 Advanced Endo, 1 Flex Endo/Fluoro (labeled TEE/TILT/ENDO), 4 Endo with 1 capable for Bronchoscopy)

The presence of the clean core or supply core for the procedure rooms means that each will have two points of entry - one off the semi-restricted corridor for patients, staff and the other off the restricted clean core. This is true regardless of the specialty assignment of the procedure room (cardiovascular, neurology, etc...). Universally, the procedure rooms will all be designed to basic operating room standards, yet technologically rich. This includes providing the capability of obtaining OR air exchange rates; specifying cleanable surfaces; and integrating lights, monitors, and booms. The procedure rooms will also include nurse documentation stations with lighting controls, audio-visual componentry for monitoring and education, emergency power, and supply cabinets. Rooms that have significant imaging equipment presence also integrate a control room.

The intervention suite will follow the trend of keep both surgical and interventional rooms behind the "redline" for flexibility and to help mitigate infection risks. However, the endoscopy rooms and potentially a set of cath lab rooms will follow similar protocols but will not be within the semi-restricted corridors. This arrangement is designed flexibility to change in the future should it be necessary.

Infection risks will also be mitigated with a strong sterile processing departments solely responsible for the sterilization of instruments, scope and other material. A closed case cart system will be employed to bring

clean and dirty instruments to and from the operating rooms.
Staff support areas, including offices, lounges, and locker rooms are provided at the east most edge of the suite. The staff lockers and lounge are shared by all interventional staff and physicians as well as sterile processing department staff.

901 Administration (Quality)
The northeast area of the second floor is comprised of several administrative functions. Quality management and analytics are distributed to two locations in the hospital. The administrative suite on Level 2 across from family waiting supports twelve quality management professionals in open office workstations. These staff members support many department throughout the hospital. They access each area and have a particularly strong relationship with physicians, therefore, the location adjacent to physician services proves useful.

901 Administration (Physician Services, GME)
Physician Services and the General Medical Education department are co-located on the second floor of the hospital adjacent to administration and the Interventional platform. This location provides a dedicated space for a Resident lounge, active lounge, medical library, lockers, kitchenette and hoteling workstations for residents in the MVHS program. The GME space supporting internship, residency, sub-specialty and fellowship programs has an office for the Director, Coordinator, 3 Credentialing staff, and space for credentialing records. The space provides a quiet calm atmosphere with access to light and amenities to support the program. This location provides a hub that is close to easy access to elevators for the patient tower or to access conference space for meetings and group education.

901 Administration (Administration, Nursing Administration)
The senior executive Administration suite and Nursing administration are located in adjacent areas. The Administration suite supports the CEO, 7 senior VP offices and associated administrative professionals. This suite is accessible by visitors if directed to the area. A dedicated consultation room is provided to meet with family, patients or visitors as needed.

A large boardroom supports the hospital's mission of community involvement. Adjacent catering, restrooms and direct access to the Administrative suite allow for its use serving a number of functions. Nursing Administration is a primarily distributed service. This suite allows the three AVPs to share an office suite with dedicated staff support and the central locations supports easy access for physicians, nurses, staff and senior administration.

901 Administration (Employee Health)
The MVHS employee health program will primarily be located off-site and will have a robust telehealth presence. However, a small suite is on-site for easy staff access when needed. This location may primarily support quick checks and serve as a triage station for other staff needs.

943 Maintenance & Housekeeping (Facilities Administration)
The AVP for facilities, facilities admin, safety officers and training rooms are dispersed on this level. Other facilities staff are located on the first floor and/or near the annex building.

948 Equipment & Maintenance (Clinical Engineering)
A robust clinical engineering program supports all clinical services. The main clinical engineering work room include work benches for 8 engineers and is located adjacent to the bed repair shop. This second floor location helps to serve the intervention platform effectively and gives the staff here central access to

elevators for easy access throughout the building.

948 Equipment & Maintenance (Patient Transport)

Patient transport staff will be deployed throughout the hospital and will be outfitted with communication tools to aid rapid deployment as needed. The dispatch staff are located with the Patient Flow Command Center on the 3rd floor. This patient transport area is a quick touchdown area for staff and holds additional stretchers and wheelchairs for use if the decentralized transport is not available.

742 Baseline Pharmaceutical Services

The pharmacy department is located on the second floor and is adjacent to the interventional platform and central sterile processing departments. This location puts this important support service in the place of highest use and close to vertical circulation to support the bed tower. The development of the pharmacy plan focused on bringing the most efficient methods of dispensing and service to support inpatient needs. Determining the method of medication distribution on the inpatient units was critical to determining the physical layout of the pharmacy as well as the use of automated technology and medication management throughout the hospital. The pharmacy will utilize the carrousel system for comprehensive medication inventory management. This allows for fewer pharmacists needed in the pharmacy due to the efficiency for cart fill, which supports the organizations goal to have pharmacists out on the units. The pharmacy space contains dedicated area for techs and pharmacists, IV Prep w/ hood, Anteroom and pass thru, Narcotic Vault, Bulk receiving, Pneumatic Tubes and Carrousels with a packaging area.

In addition, there is a service window for clinical staff that may need to pick up medication directly from the Pharmacy which is located on the West end of the department, closest to the elevators. This model assumes physician order entry which will be utilized for medication ordering.

Key Services Provided

- Bulk purchasing of stock medications for pharmacy dispensing
- Dispensing medications to all clinical areas
- Admixture to IV solutions for distribution to clinical areas and for inpatient administration
- Clinical pharmacy program: pharmacists deployed to inpatient units/departments to consult with physicians/providers; provide patient education and counseling
- Employee prescription dispensing – potential retail location in Medical Office Building

Changes in Practice

- Potential for additional partnering with retail pharmacy for discharge medications
- Workload changes and new efficiencies due to having a pneumatic tube system that goes to all departments and can carry other medications not currently able to be dispensed via tube.
- Multiple Pyxis locations that will require pharmacy support

Pharmacy staff have a dedicated lounge and locker room and 2 staff toilets adjacent to the department. Pharmacy offices are connected to the main pharmacy within a suite and also accessible through the pharmacy. Spaces for clinical pharmacists, director, operations manager, purchasing, IT and admin are located in this area to support the department.

941 Central Sterile & Supply (Sterile Processing Department)

Central Sterile (now the Sterile Processing Department (SPD)) will employ the latest equipment technology and lean processes, including a 3-zone design, employing automated pass-thru steam sterilizers and automated instrument washer-decontaminators. Low temperature sterilization will exclude high-risk

ethylene oxide in favor of the efficiency and safety of gas plasma technology. The initial configuration will include four (4 ea.) instrument washer decontaminators, one automated cart and utensils washers and one manual cart washer, four (4 ea.) large capacity floor-loading, pass-thru steam sterilizers, plus one (1 ea.) smaller sterilizers to support rapid turnaround. The department will be staffed 24 hours daily, 7 days each week. The Sterile Processing department is located on the 2nd floor of the hospital and is adjacent to the interventional platform for ease of access and quick turnaround on instrumentation.

Operational Objectives: Departmental and Integrative

- SPD will adhere to the highest standards of care through practice, uniform training and staff certification and the use of advanced technology for reprocessing an sterilization
- SPD is designed to be the single point of responsibility for routine decontamination, sterilization and infection control for MVHS
- The department design, reprocessing equipment and work flows will be consistent with contemporary infection control protocols and will support the department's role as the focal point of the interventional supply chain
- Together with Materials Management, SPD will coordinate the supply and instrument requirements for the Interventional Suite, primarily via a case cart system.

Services

- Decontamination of critical medical devices, including surgical instruments, floor and procedural trays
- Decontamination and sterilization of all scopes which will not be processed at the point-of-care. This reflects provisions in the upcoming 2018 FGI to help optimize the quality of processing.
- Sterilization of all critical medical devices including surgical instrument sets, powered tools and individual instruments used in any surgical/interventional setting
- Storage and distribution of surgical supplies that are maintained within SPD for the case cart system, as well as most consumables supplies, implants and other materials used in any surgical/interventional setting
- Assembly of case carts, specialty carts, room carts and procedure carts/set-ups.
- Monitoring and quality assurance testing of all sterilization equipment used throughout the campus including any point of use decontamination or sterilization units used in patient care settings
- Reprocessing of all flexible scopes used throughout the hospital system

<u>Physical Layout</u>

Decontamination

- Equipment will include high-level washer disinfectors; ultrasonic cleaner/dryer and an automated cart washer
- An automated cart washer shall have a utensil cart/rack option to handle hard goods such as ridged instrument containers and miscellaneous utensils that do not require high level decontamination
- Equipment washroom will be provided to accommodate the washing of large equipment and will provide a back-up option for washing carts, stretchers and other wheeled goods
- A clinical sink and the appropriate number of 2, and 3 basin clean-up sinks will be provided. A pass-through window from decontam will be provided to allow delicate instruments to be processed and then wrapped and sterilized in the Prep and Pack area
- A vendor drop off area for loaner tools and sets will be provided. Vendors will also use this area to pick up the loaned items.
- Decontam will be accessed from the adjoining service corridor via vestibule/interchange. This transition area will include a hand wash sink PPE storage anyone entering or leaving the decontam area.

Scope Processing

- SPD will be processing all scopes from Endoscopy
- A dedicated area for the arrival of dirty scopes is located adjacent to endoscopy. Dirty scopes will arrive in totes to the decontam side of scope processing
- Scopes will be cleaned in scope processing and returned to endoscopy to be stored in cabinets within the department.

Prep and Pack

- The equipment clean up room and automated cart washer will exit into the clean side of SPD. The cleaned but still empty case carts will be staged awaiting assembly.
- The completed/filled case carts will be positioned in cart staging
- Instrument racks will exit the washer decontaminators on to accumulation conveyors. Staff will use transfer carts to move the racks from the conveyors to the prep & pack workstations. The racks will be moved to the assembly area for re-assembly and wrapping. As the racks are emptied, they will be returned to Decontam via a return conveyor.
- Once the instruments and instrument sets are wrapped, the heat stable items will be loaded on to special carts and moved to the steam sterilizers.
- Heat and moisture sensitive items will be processed using gas plasma technology such as
- STERRADTM or another replacement technology for ethylene oxide (EtO) sterilization.
- The hot, sterile instruments will cool upon removal from the steam sterilizer. The sterilized goods will be stored on carts to await picking (case carts) or dispatch (floor trays, etc.)
- Pick sheets or preference cards from the surgical information system (SIS) will be printed at a workstation. Technicians will assemble the case carts for distribution to the surgical/interventional suite and other defined users

Sterile and Clean Stores

- SPD will have the capability to store most (80%+) of the surgical instruments, instrument sets and the routine supplies used by the Interventional Suite. The rest of the interventional instrumentation and supplies will be stored in the clean cores, and within the individual operating and/or procedure rooms.
- SPD technicians will pick the required items using the preference cards generated by the surgical information system (SIS). Supplies and instrument sets will be placed into the case cart, and then staged according to their scheduled use and destination.
- Case carts will be transported via a dedicated back of house corridor in the restricted zone of the platform and delivered to the Interventional Suite
- General floor trays and patient utensils will be held for pick-up and delivery by Materials Management distribution staff
- Supply replenishment within SPD will be provided by Materials Management. Items will be de-cased prior to delivery to SPD or to the Interventional Suite
- De-casing can occur at the loading dock or at the vendor facility if a tote/JIT system is employed

<u>Planning Guidelines</u>

Technology Implications

- Use of a computerized information system with instrument management, productivity monitoring and locator/tracking capabilities
- Potential use of robotics to facilitate the routine delivery and return of surgical case carts
- Use of automated loading/unloading capabilities for the instrument washers

- Access to the SIS information system for comprehensive management of case carts and physician preference requirements.
- Other equipment and/or information technology to streamline departmental operations and support to all end users

Intradepartmental

- Decontamination room shall include workstations for unloading case carts and separating instruments; clean up sinks will allow for initial and supplemental cleaning; decontamination will be achieved using automated pass through washers that exit into the prep and pack area
- Staff working in decontamination will enter and depart through an anteroom where they will don protective over garments
- A staging area will be required for holding soiled case carts. Space will also be needed for rinsing, soaking and cleaning of special instrumentation prior to loading onto an ultrasonic cleaner.
- Cleaning solutions will be located in a room, with close proximity to the washers.
- Dedicated environmental service closets are located in the decontamination area and for the clean area of SPD.
- The storage will accommodate case cart staging along with high-density storage systems with access from both ends and adequate aisle space

Staff Areas

- Dedicated male and female lockers, breakroom and toilets are directly across the corridor from SPD and will be shared with the interventional platform.

Access and Circulation

- Physical layout reflects the appropriate flow of staff and instrumentation from contaminated to clean areas as outlined; appropriate storage of sterile goods within department is essential

Ancillary Services – Support from / for

- Material Management is a key supplier to SPD.
- Materials Management will replenish supplies to the Interventional Suite (non-case cart items) and to all other patient care areas including the inpatient-nursing units.

Key Design Features

- Equipment will require specialized power, enclosure systems and water, steam and drain lines. Deionized water systems should be anticipated in the decontamination room
- HVAC system will be designed to meet ANSI/AMMI ST-79, state health department and MVHS infection control standards.
- Ductwork handling exhaust air from the instrument washers, cart washer and sterilizers must be constructed of stainless steel or other non-corroding, non-rusting material.
- Emergency power will be required to keep certain equipment operational at all times
- Floor and wall surfaces must be waterproof and finished with non-organic materials.
- Local steam generators will be required if house steam boilers are not part of the building central plant.

Patient and Staff Safety

- Appropriate personal protective equipment (PPE) storage will be planned for the decontamination area
- Emergency eyewash stations and separate hand washing sinks to be provided in the decontamination area
- Floor surfaces will be slip resistant

Environmental Quality

- Equipment and activities within SPD create unique environmental and mechanical requirements; the entire area must be located, planned and designed to mitigate potential damage to adjacent areas from water leakage or water vapor accumulation
- Soiled areas of SPD must be maintained under negative air pressure; all clean areas within the department must be maintained under positive air pressure (see ANSI/AMMI ST-79)
- There should be sufficient air exchanges, humidity and temperature controls (see ANSI/AMMI ST-79) to mitigate the heat dissipation of the SPD equipment. This is for staff comfort as well as to protect the sterility of instrument packs

LEVELS 3 TO 9

General Description

The design of the typical inpatient care unit is consistent throughout the remaining seven levels. The organization and layout of the floors are based on delivering superior patient-centered care with integrated, multi-disciplinary care teams, maximizing patient safety, reducing error, accommodating families and proving the opportunity for an enhanced patient, family and staff experience.
Each level generally consists of two (2) inpatient units along with shared and other support functions occupying the center hub. The programs throughout the bed tower include:

- Level 3 Critical Care, Administrative, Respiratory Care, Tenant, Housing On Call, Case Management, Risk Management, Infection prevention
- Level 4 Birthing Center (LDR, Postpartum) ,Neonatal Intermediate Care
- Level 5 Intermediate Care, Inpatient Dialysis
- Level 6 Medical/Surgical Care, Pediatric support, Therapy Gym, PT/OT/Speech offices
- Level 7 Medical/Surgical Inpatient Care, Therapy Gym, Quality Analytics
- Level 8 Medical Surgical Inpatient Care, IT Help desk staff
- Level 9 Behavioral Health

Open Core Inpatient Unit Bed Model (Basis for Design of Inpatient Units)

The basis of design for all inpatient care units is the open core model. This arrangement and configuration was strongly supported by and advocated for by nursing, physician and support staff involved in the design process, which included both testing of various floorplan designs and visiting numerous unit examples. The premise of this plan is to increase visibility and connections between nursing, physicians, patients and other staff. It also strives to bring care closer to the patients and allow the care team to work in a more decentralized manner while still benefiting from team connections.

The overall unit organization consists of patient rooms surrounding a 16 foot wide patient care corridor. One side (8') of the corridor is clear for patient movement. The other 8' zone of the center includes alternating caregiver stations and supply/equipment alcoves along with clear 8' access to patient rooms.

The caregiver stations support every four patient rooms – two pairs across from each other. It includes two seated workstations, two standing workstations and counter area for team use. There is line of sight between each caregiver station as well as throughout the unit. Acoustical controls will be included along corridors and surrounding the care team stations. Patients and families benefit from knowing that the care team is nearby.

The supply/equipment alcoves are standardized along the corridor and will be the same unit to unit so that staff may work anywhere and understand the floorplan layout. While these details have not yet been determined, it is anticipated that alcoves will be dedicated to functions such as, linen, carts, equipment, standard high-use supplies and other functions.

Central to each unit is an additional support zone. This area houses the central medication room, nutrition, clean and soiled rooms. Additional equipment rooms are located towards the center area of the patient floor. It is important to note that no doors are across from patient rooms which also aids in reducing noise levels on the units. To reduce steps by nursing and enable pharmacy efficiency, three med rooms are planned per typical med/surg unit – giving nursing a med room for every 10 rooms.

The entry to each unit includes the 'team center'. This is an open desk for the unit clerk and charge nurse

and serves as a reception point on the unit. In the middle of each unit is an enclosed collaboration room support conversations between care team members and providing additional workspace for physicians and other staff.

Visitors arrive on the floor via the main elevators and are oriented visually towards the family waiting area. They would then go towards the west or south to reach a particular patient's room. At the end of each wing will be a family respite area, encompassing a few seats to allow for a brief getaway from the patient room. Otherwise, family are welcome in patient rooms and are invited to stay overnight. Specific rules regarding numbers of visitors and timing will be determined by hospital and unit leadership.
Staff support is located centrally and shared by both units. A large conference room, staff lounge, lockers and offices create the support core.

Each med/surg or intermediate care unit consists of 30 patient rooms, 1 of which is an isolation room. Two rooms per unit also are capable of flexing up to semi private rooms in the event of emergency surge capacity needs. Thus, the actual capacity of the typical unit is 32 beds.

Typical Patient Room
Details of the typical patient room will be design further in the next phases. There are several principles upon which the room layout is based. This includes:

- Standardization of all rooms for easy of use
- Large patient door openings to support patient movement
- Zones for caregivers, patient and family
- Simple direct access from bed to toilet room

Each room is anticipated to support mobile documentation stations dedicated to the patient room. While this could be a "workstation on wheels", the capability to support future technology, including tablet technology is expected.

Each patient room has its own dedicated toilet, automatic bedpan washer, sink and shower. ICU rooms do not include a shower, but otherwise are similar to typical acute care rooms.

Each patient room has a small cabinet for Personal Protection Equipment (PPE). The intention is that this will be accessible from both inside and outside of the patient room. To be developed in future design phases.

107 Critical Care (Intensive Care) (note that "Critical Care" terminology to be used to be consistent with FGI)

West Unit:	22	Total Critical Care Beds
	1	Critical Care AII (Airborne Infection Isolation) room
	2	Critical Care ADA rooms
	19	Critical Care typical rooms
East Unit:	20	Total Critical Care Beds
	1	Critical Care (Airborne Infection Isolation) room
	2	Critical Care ADA rooms
	17	Critical Care typical rooms
	42	**TOTAL Critical Care BEDS**

The Critical Care Units follow the typical acute inpatient floor design with modifications to meet requirements for Critical Care level of care.

All the rooms on the Critical Care floor meet the clinical requirements of Critical Care level care, including SF, clear floor area, clearances around bed, headwall dimension, and observation into patient rooms, with some additional space for family presence. The toilet rooms contain toilet, automatic bedpan washer, and sink. 10% of the rooms are fully ADA accessible. Two separate shower rooms are located on each unit for patients who may require a shower.

Care Team Stations

- Decentralized care team stations are positioned around every four patient rooms, approximately. These stations provide seated documentation for 2 staff and standing documentation for another 2 staff. In addition, a central desk is positioned on each unit to support unit clerk, charge nurse and other team members. An enclosed documentation workroom offers ancillary team members, physicians and nursing staff to collaborate within the unit.

Supply/Equipment

- Clean supply rooms, medication rooms, equipment rooms and alcoves and soiled utility rooms are positioned both centrally and distributed along the patient care unit. Equipment storage SF requirement of 20SF per patient room has been met with a central equipment storage per unit and four equipment/supply alcoves per unit with additional equipment alcoves for stretchers/wheelchairs near the patient transport elevators.

Family Spaces

- FGI requirements for critical care include a ratio of 1.5 visitor seats per patient room. This has been accommodated through family lounge space on each unit, and floor lounge space at the main visitor elevators. Additionally, because all rooms are single bedded rooms, family presence is welcomed within the room and a family member may sleep overnight. Per FGI, seating for 2 visitors will be provided in each patient room. There are a number of other family support spaces throughout the hospital.

901 Administrative (Infection Prevention, Case Management, Risk Management)
Infection Prevention staff offices and Case Management administrative offices are located within the 3rd floor center core area. These functions serve the entire hospital. While case managers and social work staff are located on each inpatient unit, supervisors/leadership and support staff are located in this administrative suite.

Infection prevention staff use and open workstation environment and use this office suite as their touchdown space. Infection prevention staff travel to other department areas when meeting with clinical team members.

901 Administrative (Patient Flow Command Center)
The Patient Flow Command Center is a multi-disciplinary suite intended to bring all components of patient flow and movement together. This suite includes bed control, transfer center, dispatch and EVS dispatch into a single center. A large bank of monitors create a visual, real-time patient flow information for all team members.

228 Respiratory Care
The Respiratory Care department specializes in treating respiratory illnesses including chronic lung problems such as asthma, bronchitis, emphysema, and COPD, as well as acute breathing problems associated with serious or life-threatening conditions such as traumatic injury, heart attack, or stroke. MVHS Respiratory therapists are experts in managing life support devices, airway management, mechanical ventilation, and other aspects of critical care medicine.

The respiratory care department includes touchdown space for RT staff who are assigned to various care areas, administrative offices and spaces for cleaning and repairing equipment such as ventilators, C-pap and Bipap machines. Critical Care nursing unit, ED, and PACU all have on unit storage of clean ventilators. Minimal storage is located in this area.

Tenant Masonic Lab
The Masonic Lab is a tenant space to be developed. This location is intended to house research lab space associated with heart tissue procurement. There is a relationship with the cardiac operating rooms on the level directly below this area.

982 Housing On-Call
Six (6) single occupant on-call rooms with attached toilet/showers are positioned centrally on this floor. These are shared use on-call rooms by physicians, residents or others requiring sleeping quarters. Additional on-call rooms are located on the Birthing Center floor (Level 4).

LEVEL 4

General Description
Maternity services, at MVHS called the "Birthing Center", occupies the entire fourth floor.

West Unit:

1	Butterfly PP room (for fetal demise parents)
20	Typical Postpartum single patient rooms with toilet/shower
21	**Total Postpartum patient rooms**

Center Unit:

1	NICU AII (Airborne Infection Isolation) room
7	NICU typical rooms
8	**NICU beds**

East Unit:

2 Antepartum patient rooms

31TOTAL INPATIENT BIRTHING CENTER beds (includes NICU)

East Unit	8 LDR rooms (1 AII Room, Airborne Infection Isolation)
3	Triage/ early labor exam rooms
2	C-Section Operating Rooms
3	Recovery bays

Please note that the LDR beds are not considered inpatient beds on the operating certificate. The total number of inpatient beds on this unit is 23 (comprised of 20 post-partum +1 butterfly room +2 ante partum)."

The Birthing Center is located on the 4th floor of the main bed tower which can be directly accessed from the main entry via elevator or through the Emergency Department via a dedicated back of house elevator. Patients arriving in the ED in active labor will be assessed at ED triage and escorted via cart or wheelchair to the Birthing Center. The overall strategy and approach is to create a unit that supports birthing, postpartum care, and Specialty Care nursery needs within a unified environment that is safe, calming, and supportive of new mothers. Maximizing patient and infant safety spanning the entire continuum of care is paramount and patient, staff and visitor flows are optimized to support this approach.

214 Maternity (Birthing Center – LDR)
Patients arrive via patient dedicated elevators and are greeted on the unit at a single intake point and triaged and evaluated in an exam room pod. Registration will occur at bedside for this patient population. This area is supported by 3 exam rooms, 1 patient toilet and clinical team station. After evaluation, the patient can be moved directly to one of the 2 antepartum rooms adjacent to the triage/exam area or to an LDR room. The LDR rooms are positioned in the back of the unit, closest to team collaborative workstations and decentralized nursing hubs to ensure line of site and patient safety. Dedicated soiled, clean, medication rooms and a pneumatic tube are located in the center to provide ease of access and reduce travel for staff and provide timely care.

LDR rooms (8) are designed to provide care to a delivering mother from arrival to delivery. This room also provides space for the baby after delivery for assessment and evaluation. The rooms are designed to

support all clinical situations for mother and baby and will be equipped with the following items: Birthing bed and ceiling mounted light, warmer, wall mounted gases for mother and baby, cabinets for storage at headwall for fetal monitoring and emergency equipment, clinical documentation workstation and cabinetry with sink upon arrival to support hand hygiene practices, linen storage, and PPE. While provisions are included for baby after delivery, a separate Infant Resuscitation room is also provided to support the unit.

Antepartum rooms (2) adjacent to triage will provide initial care or post-delivery care to mothers that will be delivering in the C-Section room. These rooms are also equipped to provide an environment for initial patient exam, ultrasound or other evaluation. The room will be equipped with the following: Maternity bed, over bed table and bedside chair, bassinette or warmer, wall mounted gases, clinical documentation workstation and cabinetry and sink upon arrival to support required hand hygiene practices, linen storage, supplies and PPE.

214 Maternity (Birthing Center – C-Section Suite)

The C-Section suite consists of 2 C-Section ORs and 3 PACU bays. This area is behind the triage exam space with connection from both triage and LDR via semi-restricted corridor. Surgery/delivery staff entering this space will need to enter via the central core thru a dedicated locker room with staff toilet/shower, change into appropriate attire and exit into the suite on the restricted side. All staff entering from the patient floor side will don appropriate PPE located before doors to surgery suite and will require badge access only. The recovery area has 3 PACU bays with a nurse station supporting both flow of patients coming in and out of suite and monitoring of PACU patients. The PACU bays are adjacent to the ORs and are easily accessed via the restricted corridor. The bays have a standard configuration with 3 walls and a curtain for privacy.

Hand washing sinks will be provided at the bays. Bays will contain post procedure patient cart, supplies and emergency equipment at the headwall. Each bay will have required med gases and clinical workstation for documentation and medication administration.

The OR suite is also supported by a dedicated soiled room, clean/equipment/gas room, Anesthesia work/supply and environmental service room. A locker area supports the unit and C-Section suite. All instrumentation, trays and case carts will be processed by SPD on the second floor with some frequently used processed trays to be stored within the OR suite clean supply room.

214 Maternity (Birthing Center – Post Partum)

The postpartum unit is located in the west wing of the bed tower on the same floor as Labor and Delivery. A separate waiting and family arrival zone is directly off the main visitor elevator bank with controlled access to the unit. The postpartum unit is designed to reflect the typical inpatient room type and size (accommodating FGI post-partum requirements) and provides a toilet/shower room and place for family and visitors. All rooms support a couplet care approach for mother/baby bonding and care. There is one isolation room on the unit to support any airborne infection control situations. A small well baby nursery, contiguous to the Special care nursery is located at the beginning of the unit if the mother is away at a procedure or needs a break to rest. The nursing staff are at decentralized hubs throughout the unit with decentralized supplies and medications distributed across the floorplate.

In a central hub on the floor, there is dedicated soiled, clean supply, and a medication room and pneumatic tube to decrease travel distance for these activities. This design is reflective of all inpatient floors and is standardized throughout the inpatient tower to ensure ease of access, reduce errors and improve timeliness of patient care. The unit also has a team space for huddles or quick conferences with multidisciplinary providers located at the front of the unit. One post-partum room is a dedicated "Butterfly Room" for those mothers and families that have experienced a loss. This room will be located at the end of

the unit and reflect a slightly different design and experience to help mothers and families cope during a difficult time.

To support physician and resident needs, there are 2 sleep rooms for OB/GYN physicians and Anesthesia services located at the end of the unit for quick access when needed.

214 Maternity (Birthing Center – Staff Offices, Support)

Additional support services and staff offices are located within the main hub (bar) of the building. Nurse Manager offices are located near their respective units with offices for case management, social work, clinical educators and laborists collocated. A staff lounge, locker and conference room space is also within the hub and can be accessed from the back of house stair/elevator area. This space will be shared by all units on this floor.

110 Neonatal Intermediate Care

Centrally located between the LDR/C-Section unit and the postpartum unit is an 8 bed special care nursery with space for 4 well baby bassinettes. This level II nursery supports and provides basic care to infants that are moderately ill with problems that are expected to resolve rapidly or who are recovering from a serious illness that was treated in a level III nursery. If the level of complexity of an infant should change, the infant would be transported via ambulance or helicopter to another facility. The unit has immediate and direct access to a dedicated large elevator that leads directly to the ambulance entrance and helipad location.

All private Special Care Nursery rooms are provided with doors to provide privacy for families and an environment conducive for neonates. All rooms will have required headwall gases, workstations for documentation, sinks to support appropriate handwashing and space for family to stay overnight if needed.

There is a clinical team station in the center providing line of site to all bays to ensure visibility of patients Alcoves are located within the unit for different bed types required in addition for space to store crash carts and emergency equipment. A dedicated space for the neonatologist is provided adjacent to the unit for documentation and a sleep space if needed. Additional accommodations for long term stay will be provided outside the hospital.

The unit will be controlled by badge access and an infant abduction system will be employed throughout the Birthing Center platform for infant safety. Within the unit, the area is supported by a clean & equipment supply, soiled utility and medication room. Staff will utilize the centrally located staff lounge

LEVEL 5		
West Unit:	**32**	**Total 24 Intermediate Care Beds and 8 Coronary Care beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical private rooms
East Unit:	**32**	**Total Intermediate Care Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use.)
	27	Typical Acute inpatient private rooms
	64	**TOTAL Acute Care Inpatient Beds**
Center:	**8**	**Inpatient Dialysis Bays**

This represents a typical acute care inpatient floor comprised of two (2) separate units each with 30 inpatient rooms. These units will operate as 30 private bed room in all typical situations. Two (2) rooms on each unit are capable of flexing up to a semi-private room in times of emergency need. Thus, the actual bed capacity on the floor is 64 beds.

736 Baseline Medical Surgical (Intermediate Care Unit) – West Unit

All the rooms on the floor meet the clinical requirements of intermediate level care, including SF, clear floor area, clearance around bed, headwall dimension, and observation into patient rooms, with additional space for family presence. The toilet rooms contain toilet, automatic bedpan washer, shower and sink. All patient toilet rooms accommodate ADA requirements. Each All **(Airborne Infection Isolation) room** (one per unit) includes a dialysis box.

Care Team Stations

- Decentralized care team stations are positioned around every four patient rooms. These stations provide seated documentation for two staff and standing documentation for another two staff. In addition, a team station desk is positioned at the entry of each unit to support unit clerk, charge nurse and transient care team. A centrally located, enclosed collaboration room (labeled documentation) offers ancillary team members, physicians and nursing staff to collaborate within the unit. This room will have glass or other transparent walls at the front edge to maintain overall visualization of the unit.

Supply/Equipment

- Clean supply rooms, medication rooms, equipment rooms and alcoves and soiled workrooms are positioned both centrally and distributed along the patient care unit. Equipment storage SF requirement of 10 SF per patient room has been met or exceeded, with a central equipment storage per unit and six equipment/supply alcoves per unit with additional equipment alcoves for stretchers/wheelchairs near the patient transport elevators.

Family Spaces

- All rooms are single bedded rooms and family presence is welcomed within the room and a family member may sleep overnight. A family lounge is located at the entry to the floor by the visitor elevator. A small respite space is also provided at the end of each unit. There are a number of other family support spaces throughout the hospital.

101 Acute Renal Dialysis

The inpatient dialysis unit supports all acute care units with dialysis needs. The dialysis team travel to the Critical Care units and isolation rooms for patient dialysis. All other acute care inpatients are transported to this setting for dialysis. Eight patient bays surround a team care station. These bays accommodate appropriate clearances and work space for staff.

Dialysis staff clean and store portable units in this suite. Additional spaces include, office (manager), water treatment room, clean supply, equipment storage, cart alcoves, a patient toilet and staff toilet.

General Description

West Unit:	**32**	**Total Acute Med/Surg Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical Acute inpatient private rooms
East Unit:	**32**	**Total Acute Med/Surg Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical Acute inpatient private rooms
	64	**TOTAL Acute Care Inpatient Beds**
Center:	**1**	**Therapy Gym**
	3	**Pediatrics Support rooms** (multipurpose play, exam and staff work)

This represents a typical acute care inpatient floor comprised of two (2) separate units each with 30 inpatient rooms. These units will operate as 30 private rooms in all typical situations. Two (2) rooms on each unit are capable of flexing up to a semi-private room in times of emergency need. Thus, the actual bed capacity on the floor is 64 beds.

736 Baseline Medical Surgical (Medical Surgical Unit) - East and West Unit
This unit follows the typical acute care unit design. This med/surg unit is designated as the location for pediatric inpatients when needed.

218 Pediatrics
The East wing med/surg inpatient unit houses any pediatric inpatients requiring general medical/surgical care. Currently, pediatrics has a 1 or 2 day average daily census. An exam room, multi-purpose play room and a child life staff workroom are near the unit entrance.

302 Medical Rehabilitation
Levels 6 and Level 7 have a small inpatient Therapy Gym. The Therapy Gyms support all inpatients needing therapy, which is not accommodated within the patient room or unit. One of these floors will be the primary orthopedics floor and another will be for neuroscience/stroke patients.

The gym includes mat, stairs, parallel bars, suspended gait and an ADL toilet room and floor space for additional treatment. A ceiling lift provides safe patient handling for patients as needed.

Administrative functions for physical therapy, occupational therapy and speech therapy are located on Level 6. Therapists are decentralized to their assigned units, but frequently return to this home-base for collaboration or meetings with managers.

General Description

West Unit:	**32**	**Total Acute Med/Surg Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical Acute inpatient private rooms
East Unit:	**32**	**Total Acute Med/Surg Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical Acute inpatient private rooms
	64	**TOTAL Acute Care Inpatient Beds**
Center:	1	Therapy Gym
	1	Quality Management/Analytics offices

This represents a typical acute care inpatient floor comprised of two (2) separate units each with 30 inpatient rooms. These units will operate as 30 private rooms in all typical situations. Two (2) rooms on each unit are capable of flexing up to a semi-private room in times of emergency need. Thus, the actual bed capacity on the floor is 64 beds.

736 Baseline Medical Surgical (Medical Surgical Unit – West Unit)
This unit follows the typical acute care unit design. No additional features have been added

736 Baseline Medical Surgical (Medical Surgical Unit – East Unit)
This unit follows the typical acute care unit design. No additional features have been added

302 Medical Rehabilitation
Levels 6 and Level 7 have a small inpatient Therapy Gym. The Therapy Gyms support all inpatients needing therapy, which is not accommodated within the patient room or unit. One of these floors will be the primary orthopedics floor and another will be for neuroscience/stroke patients.

The gym includes mat, stairs, parallel bars, suspended gait and an ADL toilet room and floor space for additional treatment. A ceiling lift provides safe patient handling for patients as needed.

901 Administration (Quality)
This suite is the main administrative suite for quality analytics and management programs. It includes offices for director, AVP and a workroom for quality improvement physicians. Workstations for administrative assistants support staff in this location.

General Description

West Unit:	**32**	**Total Acute Med/Surg Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical Acute inpatient private rooms
East Unit:	**32**	**Total Acute Med/Surg Beds**
	1	All private room (Airborne Infection Isolation)
	2	Semi-private rooms (typically used as private room. Sized for 2 patients for emergency use)
	27	Typical Acute inpatient private rooms
	64	**TOTAL Acute Care Inpatient Beds**
Center:	1	IT Help Desk and IT professionals
	1	tbd/ unassigned office area

This represents a typical acute care inpatient floor comprised of two (2) separate units each with 30 inpatient rooms. These units will operate as 30 private bed room in all typical situations. Two (2) rooms on each unit are capable of flexing up to a semi-private room in times of emergency need. Thus, the actual bed capacity on the floor is 64 beds.

736 Baseline Medical Surgical (Medical Surgical Unit – West Unit)
This unit follows the typical acute care unit design. No additional features have been added

736 Baseline Medical Surgical (Medical Surgical Unit – East Unit)
This unit follows the typical acute care unit design. No additional features have been added

901 Administration (IT Systems)
The administrative suite on Level 8 houses IT help desk staff and other IT professionals needed for support of the hospital functions. The suite includes mainly open office workstations for approximately 16 staff, a director office and a small area for IT storage and set-up. This area is intended for small scale work and is supplemented by other off-site IT locations.

General Description

West Unit:	**22**	**Behavioral Health Beds**
	18	Private room
	2	Semi-Private rooms
East Unit:	**22**	**Behavioral Health Beds**
	18	Private rooms
	2	Semi-Private rooms
	44	**TOTAL Behavioral Health Beds**

The inpatient mental health unit at MVHS is located on the 9th floor of the inpatient bed tower and has direct connection to the Emergency Department via a dedicated back of house elevator that is in close proximity to the behavioral health pod in the ED. This allows convenient access for patient, families and staff and facilitates safe transport of this patient population. The goal of this locked inpatient unit is to promote a safe recovery oriented environment. Some key concepts of this unit involve open bright spaces, non-institutional home-like environment and configuration, neighborhood or pod like design to promote social engagement and interaction with staff.

201 Psychiatric (Behavioral Health Beds)

There are two behavioral health units with 20 patient bedrooms in each bed wing. Each room has a bathroom that is planned to provide patient safety while maintaining a normal environment that respects privacy and dignity. The overall unit design supports a neighborhood configuration with an activity room, group room, dining area, nourishment, comfort/quiet space, laundry, and access to secure outdoor space directly off the unit. The space is free of blind corners and the nursing station is located at the beginning of the unit and can view the entire unit and arrival and exit points.

Arrival to each unit consists of two interlocking doors at the entrance (sally port) and is required to prevent patient elopement and ensure items are not brought on to the unit that could cause harm to the patient or others. Behavioral health staff and security will man these entrances based on time of day. Lockers will be provided within a waiting space external to the unit for visitors to utilize when visiting the unit. A small waiting area for family is directly off the main elevator and a consult room is available for private conversations in this zone.

A small suite of 2 seclusion rooms are provided directly off the back of house elevator and corridor to provide safety for patients requiring this level of behavioral control. Space is provided for staff and security to monitor patients directly and document safety requirements. In addition to seclusion, 3 patient rooms are directly adjacent from each unit within the core for initial triage from the Emergency department and utilization for placement decision within the neighborhood. This provides the opportunity to assess patient prior to being within the milieu.

Staff Lockers, lounge and conference room are located in the connector hub towards the north side of the building to provide opportunity to get off the unit and decompress. The area provides daylight and views. Additional offices are also located in the hub area for nurse managers, social work, and counselors. Shared equipment and other storage provided within the core for secure storage

201 Psychiatric (Outdoor Courtyard)

Each behavioral health unit (neighborhood) has direct controlled access to an outside secured courtyard. The space will provide areas for activities, group work, and other events while also providing the opportunity to calm and decompress. This area can only be accessed via card reader and staff will be accompanying and supervising the patients in this area. Patients will not be permitted to utilize this space without staff. The goal is to provide a garden like space for patients to relax and enjoy outdoor space. Walls and screening will be designed to provide safety for all patients.

BULDING EXTERIOR – ARCHITECTURE and CLADDING

The MVHS Integrated Health Campus consists of a 2 story podium and a 7 story bed tower. All elevations of the building, both the podium and the tower, incorporate a mix of curtain wall glazing and a primarily brick cladding system referencing the history of the architecture in Utica and the adjacent context.

The various solar orientations of the project necessitate a solution that allows for a maximum standardization in natural daylight and views while simultaneously negotiating solar heat gains on various facades. This is accomplished with a glazing system with high-performance coatings, along with a mechanical system, that mitigates heat gain. Other elevations that contain back-of-house support spaces do not require expansive views. Accordingly, these walls have been designed with considerably less glazing, further reducing solar loads.

Vehicular and pedestrian entries are marked by canopy systems that provide adequate coverage for public drop off, ED walk-in and loading. Vestibule geometries are designed to mitigate the prevailing seasonal winds on the site. Ambulance traffic is provided with a sally port adjoined to the podium.

Behavioral Health, located on level 9, has 2 outdoor areas that are surrounded by vertical enclosure that is designed to be non-climbable and at a height to provide proper security for the patient population.
The building roofs are understood as a multi-acre façade that will have a major impact on the energy performance of the project. All project roofs have high insulation values and employ cool roof technologies in order to minimize heat island effect. Rooftop mechanical equipment, on the roof of level 2 and roof of level 8 and 9, is screened with an opaque vertical cladding system, open to above, screening direct views from the patients and staff as well as the community.

The 3 story Central Utility Plant, serving the building, is adjoined to the podium and clad in a material to integrate it with the overall project, brick and the appropriate amount of louvers providing air intake and exhaust for the equipment.

MOHAWK VALLEY HEALTH SYSTEM

HOSPITAL PROJECT

Preliminary Structural Engineering Design Narrative

Version 1

KORDA

I. CODES, REGULATIONS AND DESIGN STANDARDS

A. All design will satisfy the applicable portions of the following codes, regulations and standards:

1. IBC, International Building Code
2. ACI 117, Specifications for Tolerances for Concrete Construction and Materials
3. ACI 302.1R, Guide for Concrete Floor and Slab Construction
4. ACI 318, Building Code Requirements for Structural Concrete
5. ACI 347R, Recommended Practice for Concrete Formwork
6. ACI Detailing Manual, SP66 (04)
7. ASCE 7-10, Minimum Design Loads for Buildings and Other Structures
8. CRSI "Placing Reinforcing Bars
9. Design Manual No. 31 for Composite Decks, Form Decks and Roof Decks, by the Steel Deck Institute
10. Diaphragm Design Manual, Third Edition (DDM03), by the Steel Deck Institute
11. Factory Mutual (FM)
12. Specification for the Design of Steel Buildings, by the American Institute of Steel Construction (AISC)
13. Specification for Structural Joints using ASTM A325 or A490 bolts
14. Specification for Structural Steel Buildings
15. Structural Welding Code – Steel AWS D1.1/D1.1M, Paragraph 6.6.5 specifically excluded.
16. Underwriters Laboratories, Inc. (UL)
17. WRI "Manual of Standard Practice" July 2001, 6th Edition
18. Steel Design Guide 11, Floor Vibrations due to Human Activity

II. STRUCTURAL SYSTEMS

A. Design Criteria

Floor Loading:

Stairs, First floor corridors	Live Load	100 psf
Corridors above first floor	Live Load	80 psf
Operating Rooms	Live Load	60 psf
Patient Rooms	Live Load	40 psf
Offices	Live Load	50 psf
Mechanical Rooms	Live Load	150 psf
Note: Live load reduction per IBC.		
Superimposed dead load		15 psf
Risk Category		IV

Roof Loading:	Mechanical Units	Self Weight
	Snow	50 psf plus the effects of drifting snow
	Importance Factor	1.2
Wind Loading:	Basic Wind Speed	120 MPH
	Importance Factor	1
	Exposure Category	B
Seismic Loading:	0.2 Second Spectral Response Acceleration (S_S)	0.174g
	1 Second Spectral Response Acceleration (S_1)	0.069g
	0.2 Second Spectral Response Acceleration (S_{DS})	**T.B.D.**
	1 Second Spectral Response Acceleration (S_{D1})	**T.B.D.**
	Site Class	**T.B.D.**
	Seismic Design Category	**T.B.D.**
	Importance Factor	1.5

B. Foundations

1. **A subsurface investigation report is underway. Based on experience with the general area, deep foundations will be used. Most likely drilled shafts will support the columns and the concrete shear cores.**

2. Grade beams will span between the drilled shafts to support the perimeter walls and provide protection against frost.

C. Slab-on-Grade

1. All slab areas founded on grade will be of slab-on-grade construction. Its composition will be 5" of concrete on gravel sub-base over a polyethylene vapor barrier. The vapor barrier may be placed either below or on top of the gravel base. If there is heavy medical equipment in the basement, such as MRI's and CT's, then thicker and reinforced slab-on-grade will create a path for the transport of the equipment. The slab-on-grade within the rooms housing this equipment may need to be depressed.

2. The slab-on-grade will be reinforced with synthetic fibers for control of cracks due to shrinkage and flexural stresses. It will have control joints or construction joints, spaced at a maximum of 12' to 15' apart, for the control of shrinkage cracks. If some of the finish materials require control joints to control cracks due to shrinkage, the joints in the

flooring material must correspond to the joints in the concrete slab to minimize cracking through the finish material. This would include flooring materials like terrazzo or similar applied cementitious flooring. Slab areas with stained concrete, terrazzo, or similar finishes will be reinforced with re-bars.

3. The strength of concrete used in the floor slabs on grade will be specified as 3,500 psi at 28 days, and 2,100 psi at 3 days of age.

4. All interior slabs on grade will be finished to meet flatness and levelness requirements that are typical for hospitals.

E. Elevated Floor Structures

1. The floor framing system will consist of 16-18 inches deep composite steel beams spaced at about 10'-0" on center and supported by 24-inch deep composite steel girders. The slab construction will be 3,500 psi normal weight concrete fill on a 3-inch galvanized composite metal deck reinforced with 6x6-W2.9xW2.9 welded wire fabric. The overall slab thickness will be 7-1/2 inches and the overall structural depth 32".

2. The steel beams and girders will be cambered in order to reduce the weight of the members.

3. The floor will meet a 2-hour fire resistance rating but the steel beams and girders must be protected with fire resistive material such as spray-on fireproofing.

4. The steel framing will be designed to meet 0.5% of gravity acceleration due to walking excitation as recommended by Design Guide 11 endorsed by AISC.

F. Roof Structure

1. The roof framing will consist of steel beams and 3-inch deep galvanized metal deck with a total structural depth of 27 inches. The structural steel and metal deck must be protected with fire resistive material.

2. The roof framing will be designed to support a significant load of mechanical equipment. All mechanical equipment will be supported on a separate frame constructed above the roof level and supported directly from the building columns which will extend above the roof. There will be no concrete fill on the roof deck.

G. Lateral Force Resisting System

1. The building will be designed to withstand the wind pressure and seismic forces according to IBC.

2. Concrete shear walls will be used as lateral force resisting systems. They will be placed around stairwells and elevator shafts. The wall thickness will vary from 12 to 14 inches. The concrete strength will be in the 4-5 ksi range at 28 days.

3. The seismic design category for the building will be determined once the soils engineer determines the Site Class. If the resulting Seismic Design Category is C, then lateral restrains for life essential mechanical and electrical systems will be required.

H. Expansion Joints

1. The building is approximately 630'-0" long and 240'-0" wide. This length would normally require one expansion joint.

2. Given the locations of the concrete shear cores, we propose to use two temporary expansion joints, one at line 5 and the second at line 15. These two joints will separate the building into three sections and will allow the building to expand and contract towards the cores during construction.

3. Once the building is enclosed, the steel and slab along the temporary joints will be tied to form continuous framing and the temporary joints will be eliminated.

Smith Seckman Reid, Inc.

Mohawk Valley Health System – New Hospital

SSR Project No. 17420570

November 1, 2017

MEP DESIGN NARRATIVE

Project Description:

Project location: Utica, NY.

The project will be classified as Institutional I-2 per 2012 NFPA 101.

The building consists of approximately 670,000 square feet of new construction. The highest occupied floor will be at the ninth level. There is no basement or occupied floor below grade.

The building will be classified as a High Rise building as defined in IBC Chapter 2 and will be designed to comply with the requirements of IBC 403.

Codes and Standards:

The project will be designed under the following codes, standards and guidelines:

- NY State Building Code (adoption of the International Building Code, 2015, with amendments)
- NY State Energy Conservation Code (adoption of the International Energy Conservation Code, 2015)
- FGI/ASHRAE 170 Ventilation for Healthcare Facilities, 2014
- ASHRAE 62.1 Ventilation for Acceptable Indoor Air Quality
- ASHRAE 55 Environmental Conditions for Human Occupancy
- ASHRAE 90.1 Standard for Energy Conservation, 2013 (printing 2014)
- NFPA 10 Portable Fire Extinguishers
- NFPA 13 Installation of Sprinkler Systems
- NFPA 14 Installation of Standpipe and Hose Systems
- NFPA 30 Flammable and Combustible Liquids
- NFPA 45 Laboratories Using Chemicals
- NFPA 70 National Electric Code
- NFPA 90A Air Conditioning and Ventilation Systems
- NFPA 96 Ventilation Control and Fire Protection of Commercial Cooking Operations
- NFPA 99 Health Care Facilities Code, 2012

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- NFPA 101 Life Safety Code, 2012
- NFPA 110 Emergency and Standby Power Systems
- ANSI 9.5 Laboratory Ventilation
- OSHA 29 CFR 1910 Occupational Exposure to Hazardous Chemicals in Labs
- NIH Design Requirements Manual
- AAMI (Central Sterile environmental conditions)
- USP 797 Pharmaceutical Compounding
- USP 800 Pharmaceutical Compounding of Hazardous Drugs

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MECHANICAL SYSTEMS

Design Criteria

Outdoor design conditions:

Building envelope heat gain	ASHRAE 0.4% DB/MCWB
Building envelope heat loss	ASHRAE 99.6% DB

Indoor design conditions and air change rates:

Space Type	Heating	Cooling
Hospital spaces	ASHRAE Table 7-1 as listed in NY DOH Center for Healthcare Planning, Bureau of Architecture and Engineering Review	
Non Hospital spaces	Per IECC	

Space Type	Filtration
Spaces used for in-patient care and treatment	MERV-8 prefilters upstream of fans and cooling coils at central air handling units MERV-14 final filters downstream of fans and cooling coils at central air handling units
Non patient care areas	MERV-8 prefilters upstream of fans and cooling coils at central air handling units MERV-13 final filters downstream of fans and cooling coils at central air handling units

System Description - Airside

Central station air handling units will be provided on the roof. The air handling units will be double wall construction with no thru-metal thermal conduction and consist of the following sections:

- Return plenum
- Return fan array- provide design cfm with 1 fan down; 2 VFDs (N+1) to serve fan array
- Return damper
- 4" MERV-8 prefilter
- Access section
- Enthalpy plate/plate heat exchanger connected to exhaust air stream for heat recovery to comply with IECC requirements
- Access section
- Hot water preheat coil
- Access section

- Steam humidifier
- Chilled water cooling coil
- Ultraviolet light section
- Supply fan array- provide design cfm with 1 fan down; 2 VFDs (N+1) to serve fan array
- 12" cartridge MERV -14 final filters
- Discharge plenum

Return air from spaces shall be ducted back to the air handling unit.

Air from spaces such as toilets, etc. shall be ducted to the roof and exhausted via roof mounted exhaust fans.

Provide separate exhaust fan systems for following equipment (lab hoods in same space may be manifolded together; kitchen hoods will have separate exhaust systems):

- Lab fume hoods
- Lab Bio Safety Cabinets (separate from fume hoods)
- Pharmacy Compounding hoods
- Kitchen hoods
- Dishwasher hood
- Isolation room exhaust (multiple isolation rooms may be manifolded together)
- General exhaust

Supply, return and exhaust ductwork passing through 1 and 2 hour rated walls shall have type C curtain dynamic rated fire dampers. Ductwork passing through smoke barriers shall have airfoil blade fire/smoke dampers with end switches. Duct mounted smoke detectors shall be located within 5 ft. of smoke dampers. BAS shall monitor and report fire/smoke damper position by monitoring end switches on dampers.

System – Terminal Devices

The air handling units will supply conditioned air via medium pressure ductwork to double wall, pressure independent constant and variable volume terminal boxes with hot water reheat coils. Tempered air from the boxes shall be supplied via low pressure ductwork to ceiling diffusers. Terminal units shall reheat supply air from 55 F to 90 F using 130 F hot water supply.
Pressure independent air valves, equal to Phoenix, Tek-Air or Accuvalve, will be utilized in following areas:

- Operating rooms- supply and return, for night setback; provide hot water reheat coils on supply valves.
- Laboratory- supply and exhaust, for pressure control; provide hot water reheat coils on supply valves.
- Isolation rooms – supply and exhaust, for pressure control; provide hot water reheat coils on supply valves.

Air inlets and outlets in spaces shall be as follows

- Ceiling diffusers unless noted otherwise: Titus TMS louvered face, 4 way blow
- Ceiling diffusers (Waiting areas, public corridors): slot diffusers, Titus MLF

- Ceiling diffusers (OR, Isolation rooms, labs with fume hoods): laminar flow Titus TLF
- Ceiling return registers: 1/2'" eggcrate aluminum grid Titus 50 F
- Sidewall supply and return registers: Titus 350

Hot water radiant panels will be used along the perimeter wall of patient rooms.
Hot water fin tube heating, pedestal mount, with extruded aluminum grilles and custom color architectural enclosures, shall be utilized in the following spaces:

- Lobbies with curtain wall glazing
- Vestibules

System – Heat/Cool Source

New centrifugal water cooled chillers will be located in the CEP.

- Centrifugal chillers: 3 chillers at 750 tons each
- Cooler capacity: 52 F entering chilled water, 42 F leaving chilled water
- Compressor efficiency: maximum .52 kw/ton full load
- Condenser capacity: 85 F entering condenser water, 95 F leaving condenser water
- Motor / drive: hermetic motor, unit mounted VFDs
- Arrangement/operation: parallel, variable primary flow
- Chillers are sized so that, if largest chiller is down, remaining chillers can provide 80 % of peak cooling demand.
- Chilled water pumps shall be arranged and sized one per chiller using VFDs.
- Cooling towers: induced draft, cross or counterflow, arranged in parallel.
- Cooling towers shall have remote sump inside the CEP
- Cooling tower quantity and size: 3 towers, each at 2250 gpm from 95 F to 85 F, 76 F ent wb
- Condenser water pumps shall be arranged and sized one per tower.
- 16" chilled water mains will be extended from the CEP to the hospital.
- Double wall plate/frame exchanger to preheat domestic hot water from condenser water
- Closed circuit cooler: 1 cooler at 400 tons to provide chilled water in winter conditions

New heat recovery chiller shall be located in the CEP.

- Quantity and size: 1 chillers at 300 tons.
- Arrangement/operation: sidecar, upstream of centrifugal chillers
- Cooler capacity: 52 F entering chilled water, 42 F leaving chilled water
- Condenser capacity: reject heat to 130 F heating hot water system
- Chilled water and condenser pumps sized for the heat recovery chiller shall use VFDs.

New steam boilers will be provided in the boiler room for domestic hot water, sterilizer and humidifier steam.

- Operating pressure: 150 psig design pressure, 80 psig operating setpoint.
- Type: equal to Fulton VMP
- Fuel: natural gas and #2 fuel oil
- Quantity and size: 4 boilers at 5000 lb/hr each.
- Boilers shall be sized to provide redundancy so that, if the largest boiler is down, the remaining boilers can provide 100% of the peak demand.

- Dearator: .005 cc/L, 5 psig operating pressure, sized for the total capacity of all connected boilers; equal to Fulton FD-400H

New hot water heating condensing boilers will be provided in the boiler room.

- Supply water temp: 130 F
- Fuel: natural gas and #2 fuel oil
- Arrangement/operation: variable primary flow (boilers shall not require separate primary circulating pumps)
- Quantity and size: 8 boilers at 6 mmBtu/hr input each
- Boilers shall be sized to provide redundancy so that, if the largest boiler is down, the remaining boilers can provide 100 % of the peak space heating demand.
- New heating hot water pumps each sized at 50% of peak load (2 and 1 standby, VFD control) will be installed in the central energy plant.
- 12" hot water mains will be extended from the CEP to the hospital

Systems- Fuel Systems

One fuel oil tank, 50,000 gallons, will be installed to store No. 2 fuel oil.

- Location: underground
- Type: double wall, fiberglass, U.L. listed.
- Connecting supply and return piping: double wall, U.L listed for fuel oil piping
- Size: to provide 60 hours of operation of the generator at a demand of 100% of full load demand and 48 hours of operation of the boilers at a demand of 70% of full load demand.
- Circulating pumps: rotary gear, one and one standby, located in the boiler room to draw fuel from the main storage tank, circulate fuel to the generator day tanks and boilers and return unused fuel to the main storage tank.
- A fuel oil filtration system will be provided to periodically clean the fuel when there is no demand for fuel supply.
- Packaged controls for operation of fuel oil circulating pumps, tank level monitoring and leak detection of tank and underground piping; provide safeties and alarms with communication capability to the Building Automation System. Control and interface between generator controls and pump controls shall be hard-wired.

Controls

All valve and damper actuators and thermostats shall be DDC.

A new Building Automation System will be installed to monitor and have central control capability for all mechanical equipment, including replicating information from equipment VFDs. The BAS shall web-based communication capability. The BAS shall also monitor room pressure monitors, domestic hot water supply temp as well as misc equipment alarms (lab and pharmacy refrigerator temperatures, etc.).

Commissioning

The owner will direct the services of an independent Commissioning Agent. The CxA will develop and establish a commissioning plan for all of the systems listed herein.

Special Project Requirements

Isolation rooms will have Phoenix air valves on the exhaust air system.

Room pressure monitors equal to Setra will be provided for each Isolation room, each OR, Central sterile clean/dirty area boundaries, laboratory area boundaries and shall communicate to the BAS. Isolation room exhaust fan systems shall be plume type with effective stack height of 25 ft. with redundant fan equal to Strobic Air.

The laboratory area will have Phoenix tracking air valves on supply and exhaust to maintain negative pressure in the lab area. Lab hoods shall use sash monitors to control exhaust air valves. The laboratory exhaust system shall be plume type with effective stack height of 25 ft. with redundant fan equal to Strobic Air.

Stair pressurization fans shall be provided on the roof near each patient tower stairwell. Elevator shafts shall have smoke dampered roof hoods. A fireman's control panel shall be provided in accordance with operational capability per state and local fire marshal requirements.

Materials of Construction

- Medium pressure ductwork: galvanized steel sheet metal, SMACNA pressure class 6"
- Low pressure supply ductwork: galvanized steel sheet metal, SMACNA pressure class 1"
- All ductwork longitudinal and transverse seams and joints shall be sealed using water based brush-on mastic UL 181 compliant (pressure sensitive tape not acceptable).
- Ductwork insulation (all materials to have max flame spread/smoke developed rating of 25/50):
    - Concealed supply: 2", ¾ lb density fiberglass batt, alum foil facing
    - Exposed supply in mechanical rooms: 2", 1-1/2 lb density rigid fiberglass, alum foil facing
    - Insulate return duct in top floor same as supply.
    - Exposed insulation (supply, return, exhaust) on roof: 2" rigid fiberglass with weather proof wrap. Use 1" on exhaust to hold the weatherproof covering.
- Return ductwork: galvanized steel sheet metal, SMACNA pressure class 2".
- Exhaust ductwork: galvanized steel sheet metal, SMACNA pressure class 2"
- Fume hood and BioSafety Cabinet ductwork: match same material as hood or cabinet connection.
- Kitchen hood grease duct: welded black steel installed per NFPA 96
- Dishwasher exhaust duct: welded aluminum or stainless steel
- Sterilizer exhaust duct: welded aluminum or stainless steel to riser
- HVAC water piping: black steel, schedule 40, threaded or welded joints or Type L copper with soldered joints
- HVAC steam and condensate piping: black steel, seamless, threaded or welded joints; use schedule 40 for steam and 80 piping for condensate
- Refrigerant piping: ACR copper, flared fittings
- Piping insulation (all materials to have max flame spread/smoke developed rating 25/50 and thickness in accordance with IECC):
    - Chilled water: rigid fiberglass

  - Heating hot water: rigid fiberglass
  - Refrigerant piping: closed cell preformed, Armaflex
  - Steam and condensate: rigid fiberglass
- Valves: HVAC circulating water:
  - Isolation valves: 2" and below- full port, 600 psi, bronze ball valves; 2-1/2" and above- lug type 200 psi, class 125, iron body butterfly valves. All isolation valves shall be bi-directional and rated for dead end service.
  - Check valves at pumps: iron body, bronze seat, class 125 non-slam check valves.
  - Check valves at coils: iron body, bronze swing check valves, class 125
  - Balancing valves at terminal devices with water coils: Autoflow pressure independent valves preset for terminal water flow.
  - Balancing valves at air handling units and fan coils: B & G circuit setter.
- Valves: Steam and Condensate:
  - Isolation valves: 2" and below- class 150 bronze gate valves; 2-1/2" and above- class 125 iron body gate valves.
  - Check valves: 2" and below- class 150 bronze swing check valve; 2-1/2' and above- class 125 iron body swing check valve.

ELECTRICAL SYSTEMS

Utility Service

Underground utility service will be provided by National Grid from the Terminal Substation. Two independent 13.2kV utility feeders will be terminated in a hospital-owned 15kV metal-clad primary switchgear assembly located in the hospital central plant. The normal power primary switchgear assembly will use ANSI class construction and contain draw-out style vacuum breakers, and be arranged in a main-tie-main configuration, with a closed-transition auto transfer scheme between utility sources. It is 500 mVA rated and will feed 480Y277V secondary unit substations in the Hospital.

Two means of egress per National Electrical Code (NEC) requirements will be provided from the normal power service switchgear room.

Normal Power Distribution

The secondary unit substations will be radially fed from the 15KV normal service switchgear and constructed as double-ended with main-tie-main secondary's utilizing auto transfer to provide full redundancy. Each will consist of primary vacuum breakers close-coupled to a cast coil transformers connected to a secondary buses with electrically-operated low-voltage, draw-out, power circuit breakers, all constructed to ANSI requirements. Transformer protection will be provided via a transformer differential protective relay which will minimize the arc flash incident energy level on the transformer secondary bus. All unit substations will be 13.2kV-480Y277V switchgear and will be metal-enclosed, rear-connected, with secondary main buses braced for 100,000 AIC fault duties. Available interrupting capacities will range from 65,000A to 100,000A. Power for the hospital will originate from four (4) unit substations and power for the central plant will originate from one (1) unit substation. Each unit substation transformer will be dual rated, utilizing forced air cooling to achieve a power capacity rating that is 133% of the base power rating. The secondary main and feeder distribution breakers in the substation switchgear will also be provided with ground fault protection to provide the two levels required by the National Electrical Code (NEC).

The secondary main overcurrent protective devices will be electrically-operated low voltage power circuit breakers, draw-out type, 100%-rated with adjustable trip units with long time, short time and ground fault (LSG) characteristics. Each main breaker will display, as a minimum, voltage, current, real, reactive and apparent power, frequency, and power factor as well as perform diagnostic functions in an integrated digital display.

The distribution sections in the switchgear will serve the distribution switchboards, power panelboards, and the normal feed to all automatic transfer switches. The overcurrent protective devices in the distribution sections of the switchgear will be electrically-operated, 100% rated low-voltage, draw-out power circuit breakers. Trip units on the breakers will have long time, instantaneous and ground fault (LIG) tripping characteristics. The distribution circuit breakers will have the same interrupting capacity as the secondary main breakers.

Distribution panelboards (1200A-rated and below) or switchboards (1200A-2000A rated) will serve the remainder of the building loads, including mechanical equipment, branch circuit panelboards, and elevators. This equipment will utilize molded case circuit breakers equipped with solid state, electronic trip units. All panelboards and switchboards will be provided with 25% spare capacity, for both available ampacity and circuit breaker spaces.

Two means of egress per NEC requirements will be provided from all electrical switchgear rooms, including those of the Essential Electrical System (EES), which fall under NEC Article 110-26 requirements.

Grounding System

The facility electrical system will utilize a solid grounded system. Main switchgear grounds will be bonded to the incoming main water line, the existing tri-pod ground rod system, any building steel components as well as the existing two 500 kcmil bare copper conductors in the footing under one wall of the Main Electrical Room. 500 kcmil bare copper conductors will be routed from the main switchboard ground bus to each Electrical and Telecommunications equipment room and extended vertically up through the building. The bare conductors will terminate at two 4" x ¼" x 24" long copper ground bars with two 500 kcmil lugs. Additional holes will be provided in the ground bars to terminate eight (8) #2 lugs. The eight lugs will be available to ground transformer secondaries and telephone backboard grounding conductors.

Surge Protection

A surge arrester will be installed at the 15kV main service switchgear. A minimum of three (3) levels of surge protection equipment will be provided in the power distribution system downstream of the unit substations. Surge protective devices will be installed at unit substation secondary mains (load side) and at all downstream locations such as switchboards, distribution panelboards, branch circuit panelboards, including the Essential Electrical System (EES). They will be installed at the fire pump controller, all automatic transfer switches, and panelboards on secondary, separately derived systems.

Motor Control

No motor control centers are projected for the Hospital. Equipment requiring starters will be provided with individual combination starters. Variable Frequency Drives (VFD) will be provided for fan and pump motors noted indicated. VFD's will serve as disconnecting means if within sight of the motors. Harmonic mitigation measures will be required due to the significant number of VFD-controlled motors.

Uninterruptible Power System (UPS)

UPS power will be provided by a central 750 kVA, 480Y/277V static system. Power will be distributed to each telecommunications equipment room, the central hospital lab, and the central pharmacy via a dedicated distribution system. The UPS system will be connected to both normal power and the Essential Electrical System (EES) via automatic transfer switches. This system will provide adequate "ride-through" time to allow the generator system to pick up these loads.

Essential Electrical System (EES) Power Distribution

Emergency power will be provided by two (2) paralleled 1750kW diesel generators at 13.2kV. Paralleling switchgear construction will match the normal power 15kV switchgear construction with respect to style and type. The paralleling switchgear will feed the secondary unit substations dedicated to essential systems in the hospital and central plant. These substations will match the normal power secondary unit substations with respect to style and type.

The Essential Electrical System (EES) will be sized to supply generator power for the hospital and central plant automatic transfer switches supplying loads from the Life Safety, Critical, and Equipment Branches. It will also provide limited generator power for the chilled water system, enabling some areas of the hospital to maintain cooling. Automatic transfer switches will be three or four pole, closed transition, bypass isolation type.

Loads served from the Life Safety branch will include:

- Egress lighting
- Exit signs
- Fire Alarm Systems
- Medical Gas Alarm Systems
- Communications systems used for issuing instructions during emergency situations
- Elevator cab lighting, control, communications, and signal systems
- Generator set locations, accessories, and auxiliaries
- Automatic doors used for building egress

Loads served from the Critical branch will include:

- Critical Care spaces utilizing anesthetizing gases, task illumination, selected receptacles and fixed equipment
- Isolated power systems
- Patient care spaces, task illumination and selected receptacles in Infant Nurseries, Medication Prep areas, Pharmacy Dispensing areas, Acute Nursing areas, Psychiatric bed areas, and Nurse Stations
- Nurse Call System
- Code Blue System
- Blood, Bone and Tissue Banks
- Telecommunications equipment rooms
- Specimen and lab refrigeration equipment
- Task lighting, selected receptacles, and power circuits for general care patient beds, Angio labs, Cath labs, CCU, hemodialysis areas, Emergency room treatment areas, human physiology labs, ICU, and postoperative recovery rooms
- Patient Information Network data servers
- Security Systems

Loads served from the Equipment branch will include:

- Medical air compressors (but will have power restored in 10 seconds or less)
- Medical vacuum pumps (but will have power restored in 10 seconds or less)
- Selected elevators
- Kitchen hoods, including the hood fire suppression system

- Stair pressurization fans
- Smoke control fans and smoke control system auxiliaries
- Sump pumps, sewage ejector pumps, and sanitary pumps
- Domestic water booster pumps
- Hospital boiler system, including controls and fuel oil pumps
- Exhaust fans removing toxic, explosive or flammable fumes
- Air handling equipment
- Water treatment equipment
- Building Automation Control System
- Pneumatic tube system
- Fire suppression jockey pump
- Electrically-driven fire pump (but will have power restored in 10 seconds or less)
- Selected Kitchen refrigeration
- General purpose receptacles for Electrical Rooms, Elevator Equipment Rooms and Telecommunications equipment rooms
- Sterilizers
- Automatically operated doors

Isolated Power System (IPS)

Isolated power panelboards will be provided in Operating Rooms, Cath Labs, and Trauma Rooms, and any other locations which are deemed "wet location" and interruption of power due to ground fault cannot be tolerated. The isolated power panelboards will be rated at 7.5kVA and include an isolation transformer and line isolation monitor. Each isolation panelboard will include provisions for twelve circuits. A separate 3-phase isolated power panel shall feed laser outlets in the operating rooms.

Vertical Power Distribution

Separate vertical conduit and wire risers will be provided in the tower for normal, Life Safety, Critical, and Equipment branch systems. These risers will be located in stacked electrical rooms in order to minimize horizontal offsets. "Emergency" feeders as defined by the NEC will be protected either by installation in fully sprinklered spaces or by the use of 2-hour rated installations.

Power Monitoring

All medium voltage switchgear, unit substation main breakers and automatic transfer switches will be provided with multi-function meters with Modbus RTU (RS-485) and Ethernet connectivity. These meters will be networked and include waveform capture as well as harmonics measurement capability. All draw-out breaker trip units will be monitored for status and alarm conditions, and will include basic metering of volts, amperes, frequency, and power functions.
All unit substation transformers will be provided with temperature monitor and fan controls with Modbus RTU and/or Ethernet connectivity.

Power Distribution System Coordination

Protective device selective coordination for all systems, including normal power, will meet the 0.1 msec threshold. This exceeds the requirement as listed in the NEC, Article 517.31, paragraph G.

Lighting System

An LED type lighting system will be provided for both interior and exterior lighting. The Illuminating Engineering Society's Illuminance Selection Procedure will be used for establishing target maintained illumination levels throughout all areas. Specific influences of glare, task complexity, surface reflectance characteristics, veiling brightness and user age are addressed with this procedure.

Local codes will take precedence when they dictate the use of alternative procedures or require minimum lighting levels for specific areas. Lighting power density requirements indicated in the energy code will be observed.

Lighting and Receptacle Controls

Control of lighting and selected receptacles will comply with IECC 2015 (as amended) and/or ASHRAE 90.1, 2013 edition (as amended).

Lightning Protection System

The building shall be provided with a lightning protection system, which shall conform to the requirements of Underwriter's Laboratories for a Master Label. The lightning protection system will include roof-mounted air terminals, down conductors and grounds. All metal items on roofs, such as exhaust fans, pipes, gutters, downspouts, and ladders will be connected to the lightning protection system. Conductors, terminals and fittings at the roof line will be aluminum. Components below the roof line will be copper. Down conductors will be installed in PVC conduit.

Fire Alarm System

The building will be provided with automatic, multiplexed, addressable, microprocessor based fire alarm system. The main fire alarm control will be located in the Fire Command Center. Supplementary power supply and terminal cabinets will be required in different areas and floors of the building.

Manual pull stations will be provided at egress stair entries, building exits and nurse stations. Automatic, ceiling mounted smoke detectors will be located 30 feet on center in all corridors, in all patient bedrooms, at all elevator lobbies, at the top of stairways and hoistways, in Electrical Rooms, Telecommunications Rooms, Mechanical Rooms, Storage Rooms and Elevator Equipment Rooms. Duct-mounted smoke detectors will be provided in the supply and return ducts of every air handling unit. The fire protection systems (wet pipe, dry pipe, and pre-action) will be supervised via flow and tamper switches.

Occupant notification of an alarm will be achieved with ADA-compliant audio/visual appliances in the corridors, lobbies and general/common use areas, and visual only appliances in Restrooms. Interlocks will be provided for smoke dampers, air handling unit controllers, and smoke evacuation control as well as all smoke door hold open devices, with elevator control panels (for elevator recall), with air handling unit controllers (for shutdown) and with smoke removal systems. The fire alarm system will be capable of being connected, through a telephone line, to a remote monitoring station utilizing a built-in modem.

The fire alarm system will comply with applicable high-rise codes. A fireman's control panel shall be provided in accordance with operational capability per local fire marshal requirements.

Medical Gas Wiring System

Power wiring will be provided to medical gas alarm panels, bulk gas supplies, and manifolds. Signal wiring will be provided between alarm panels, manifolds, bulk gas supplies, sensors, pressure and vacuum switches.

Commissioning

The owner will direct the services of an independent Commissioning Agent (CxA). The CxA will develop and establish a commissioning plan for all of the systems listed herein.

PLUMBING, FIRE PROTECTION, MEDICAL GAS SYSTEMS

Design Criteria

System Descriptions

Domestic Water

The domestic water system will be supplied by a new domestic water service as shown on civil drawings. Two separate water utility mains will serve the facility. The incoming service lines will connect to reduced pressure backflow preventers located in the CEP. Separate backflow preventer assemblies shall be provided for the following building services:

- Main building domestic water supply: 2 assemblies
- Central Energy Plant boiler/cooling tower make up water supply: 2 assemblies
- Central Sterile domestic water supply: 4 assemblies
- Laboratory domestic water supply: 2 assemblies
- Landscape irrigation water supply: 1 assembly
- Medical equipment chiller backup domestic water: 2 assemblies
- Each janitor closet mop sink: 2 DCV assemblies each sink or EVS faucet

A new domestic water booster pump will be provided to serve the upper levels as follows:

- Type: multiple centrifugal pumps, arranged in parallel, with factory control system
- Quantity: 3 pumps, each at 135 gpm, 165 ft. head, 10 hp with variable frequency drives and sized to provide 100% demand with one pump down.

A copper-silver ionization system will be provided on the building's domestic water service.

Domestic Hot Water

New domestic hot water heaters will be provided for domestic hot water service to the building. Two separate systems will serve lower levels and upper levels as follows:

Main building (lower levels):

- Type: steam fired, semi-instantaneous, equal to Aerco SWDW 45
- Quantity: 2 (N + 1)
- Incoming water supply temp: 45 F
- System delivery supply temp: 140 F
- Outlet mixing valves: Armstrong (2)-DRV50 dual pre-piped digital temp control (N+1) set at 120 F supply temp

Main building (upper levels):

- Type: steam fired, semi-instantaneous, equal to Aerco SWDW 45
- Quantity: 2 (N + 1)
- Incoming water supply temp: 45 F
- System delivery supply temp: 140 F
- Outlet mixing valves: Armstrong (2)-DRV50 dual pre-piped digital temp control (N+1) set at 120 F supply temp

Heaters will be sized so that, if one heater is out of service, remaining heater can supply 100% of demand.

Each domestic hot water heating system will have a recirculation system:

- Flow balancing valves sized to maintain a maximum of 5 degree drop
- Recirculation pumps with variable frequency drives

In addition, there will be the following separate domestic hot water systems:

- Laboratory area:
  - Type: electric
  - Incoming water supply temp: 40 F
  - System delivery supply temp: 120 F
- Dishwashing:
  - A booster heater will be provided by the dishwashing equipment vendor

The main building domestic hot water heating system will connect to the mechanical chiller condenser water system to preheat domestic hot water using chiller condenser water via a double wall water/water plate frame heat exchanger.

Filtered/Reverse Osmosis Water System

A pure water system will supply water to the Central Sterile and lab areas with reduced pressure backflow preventers at each system.

Fire Suppression Systems

Fire suppression systems will be supplied by a new fire water service as shown on civil drawings. The service line will be provided with a free standing post indicator valve located on site. Service line will be routed to connect to a reduced pressure backflow preventer located in a mechanical room inside the building with free standing fire department Siamese connection (FDC) will be located on site. A remote fire department connection will be provided. All valves will be electronically supervised by fire alarm system.

The facility will utilize 6" standpipes and 3" standpipe drains in all egress stairwells.

Fire department valves shall be located at intermediate landing of all egress stairs and provided within 200 ft. of any location, including adjacent to both sides of horizontal exits in compliance with NFPA 14.

The facility will be fully sprinklered throughout in compliance with NFPA 13 and insuring agent requirements. All sprinkler heads will be fully concealed, quick response type. Sprinkler heads are to be located in center of ceiling tiles. Extended coverage heads will not be allowed. All major components will be UL/FM rated. The system will be hydraulically calculated.

A dry pipe system will be used for coverage for the following areas:

- Loading dock
- Unheated soffits between interior spaces and outside
- Emergency generator room

A double interlocked pre-action system will be utilized for the following spaces:

- Backup for IT (telecom) rooms primary FM-200 systems
- MRI/medical equipment rooms

A new fire pump and associated emergency storage supply tank will be provided as follows:

- Type: electric centrifugal pump with jockey pump and U.L. factory control system
- Pump shall provide 1000 gpm, 560 ft. head, 250 hp
- 30,000 gallon above ground storage tank with heater, solenoid fill valves, ladder, ultrasonic level controls, monitored by BAS. Tank will comply with NFPA 22.
- (2) 4" dry pipe valves will be provided in the loading dock and ED ambulance areas

Recessed wall mounted fire extinguisher cabinets (ABC type) will be located throughout the facility in accordance with NFPA 10. In addition, surface wall mounted fire extinguishers will be located in the following rooms:

Space type	Extinguisher type
Electrical equipment rooms	CO2
Fire pump room	CO2
Information technology rooms	CO2
Kitchen	Type K wet agent for grease fires
Mechanical equipment rooms	ABC
Operating rooms	CO2

Fixtures

Plumbing fixtures will be hospital grade. Electronic sensor controls will be provided on water closet flush valves and lavatory faucets in public restrooms.
Freeze proof wall hydrants will be installed every 100' around perimeter of building and two free standing type hydrants on roof.

Compressed Air System (Non-Medical)

Compressed air will be supplied by a new medical grade air compressor system as follows:

- Type: scroll
- Quantity: multiple compressors, to provide 100% demand with one compressor down; provide with factory packaged controls.

Non-Medical Vacuum Pump

Vacuum for non-medical use will be supplied by a new vacuum system as follows:

- Type: claw compressors with silencers and mufflers
- Quantity: minimum of two pumps

Medical Gas Systems

Oxygen will be supplied by a new oxygen park provided by others. Oxygen supply will be routed underground from the oxygen park to the building. Oxygen Park will be located in accordance with NFPA 55. Emergency oxygen connection will be provided.

Medical air will be supplied by a new medical air compressor system as follows:

- Type: scroll compressors
- Quantity: multiple compressors manifolded together, sized to provide 100% demand with one compressor down; provide with factory packaged controls.
- System will be located in a conditioned space

Medical vacuum will be supplied by a new medical vacuum system as follows:

- Type: claw type pumps with VFDs
- Quantity: multiple pumps manifolded together, sized to provide 100% demand with one pump down; provide with factory packaged controls.
- System will be located in a conditioned space

Nitrous oxide will be supplied by a new cylinder storage area with supply/distribution 14 x 14 primary/reserve high pressure cylinder manifold located in a conditioned space.

Nitrogen will be supplied by a new cylinder storage area with supply/distribution 14 x 14 primary/reserve high pressure cylinder manifold located in a conditioned space. Nitrogen control panels for pressure regulation will be located near the point of use.

CO2 will be supplied by a new cylinder storage area with supply/distribution 14 x 14 primary/reserve high pressure cylinder manifold located in a conditioned space.

Each medical gas system shall be installed in accordance with NFPA 99 and will have the following components:

- Outlets per FGI space requirements
- Area zone locking service valves
- Zone pressure area alarm panels
- Two master alarm panels
- Communication of alarms to the Building Automation System

Natural Gas System

Natural gas will be supplied by a new service as shown on civil drawings. The gas line will enter the mechanical room at 5 psig. Natural gas pressure will be reduced to 2 psig for distribution to the boilers and kitchen requirements.

Softeners

New domestic water softener will be provided as follows

- Location: Central plant
- Service: boiler makeup water

Storm Water System

The primary storm water system will be roof drains that will be collected together and routed down through the building to below slab to underground storm water mains, which will exit the building and connect to the site storm water system. Drip pans will be provided beneath all drainage piping above areas listed in FGI guidelines.

The secondary storm water system will be overflow drains that will be collected and routed down through the building, separately from the primary roof drain system, and will terminate to daylight at the ground floor. Overflow drains and the daylight termination will be heat traced. Drip pans will be provided beneath all drainage piping above areas listed in FGI guidelines.

Foundation drains will be routed along the underground structure to connect to the site storm water system. All sub-surface drainage systems will be designed by Geotechnical Engineer.

Waste and Vent System

Waste piping will be routed through the building to below slab to underground waste mains, which will exit the building and connect to the site sanitary sewer system. Vent piping will be routed to the roof and terminated as required to maintain code clearances from outdoor intakes to the building. Drip pans will be provided beneath all drainage piping above areas listed in FGI guidelines.

Sewage ejection pumps/lift stations and/or sump pumps will be provided to route waste to the site sanitary sewer system connection points from the following points:

- Elevator pits (pump to include oil filter/collection if the elevator is hydraulic type)

The emergency department will have a decontamination tank from the decontamination shower drain(s) with high water alarm monitored by the BAS.

The laboratory area will have acid waste and vent piping with an acid neutralization basin located on site.

The kitchen will have two grease interceptor traps located on site.

Metering and Building Control interface

The following services will be metered with interface to the Building Automation System:

- Building main incoming water use– gal/day
- Boiler water use – gal/day
- Central sterile water use – gal/day
- Cooling tower water use – gal/day
- Domestic hot water use –gal/day
- Domestic hot water delivery temperature – degrees F
- Food service water use – gal/day
- Food service hot water delivery temperature – degrees F
- Irrigation system water use – gal/day
- Laboratory water use – gal/day
- Natural gas use – ccf/day (coordinate metering with gas company)

All usages shall be totaled and trended per day, per month and for one, three and five year periods.

The Building Automation System shall receive and report the following alarms:

- Domestic hot water temp above/below setpoint
- Food service hot water temp above/below setpoint
- Medical gas pressure alarms
- Sewage lift station high level alarms
- Holding tank high level alarms

Commissioning

The owner will direct the services of an independent Commissioning Agent. The CxA will develop and establish a commissioning plan for all of the systems listed herein.

Materials of Construction

- Domestic water and hot water: type L copper, soldered joints
- Filtered/Reverse Osmosis water: schedule 80 CPVC meeting ASTM E-84 and UL 723 for flame and smoke spread/generation
- Fire suppression: black steel, schedule 40 for piping through 2 ½" and schedule 10 for 3" and up, threaded or grooved joints
- Compressed air: type L copper, soldered joints
- Insulation: rigid fiberglass; ASJ covering indoors, aluminum covering exposed to weather; provide on cold water, ½" thickness, hot water, thickness sized per energy code, and on horizontal runs of storm water piping, 1" thickness.
- Medical gases: type K copper, seamless, brazed joints per NFPA 99. Route underground piping inside protective outer pipe of standard weight cast iron.
- Natural gas: black steel, threaded or welded joints
- Storm water:
  - Below grade: cast iron, standard weight, gasket, bell/spigot or PVC
  - Above ground: cast iron, standard weight, no-hub heavy duty 4-band ASTM 1540C couplings
- Waste and vent:
  - Below grade: cast iron, standard weight, gasket, bell/spigot or PVC
  - Above ground: cast iron, standard weight, no-hub heavy duty 4-band ASTM 1540C couplings
- Valves:
  - Isolation valves: full port, 600 psi, bronze ball valves. All isolation valves shall be bi-directional and rated for dead end service.
  - Check valves: bronze body, bronze seat, swing check valves.

TELECOMMUNICATIONS SYSTEMS

Telecommunications Entrance Facilities

Telecommunications Entrance Facilities shall consist of redundant and physical diverse data communications entrances into the new hospital. Each path (Primary and Redundant) shall consist of (3) 4" metallic conduits (total of 6) originating from the new hospital's property line into two different Ground Level TER/EF/TR (Telecommunications Equipment Room/Entrance Facility/Telecommunications Room). Connection to the health system's network shall be through data service from the Mohawk Valley Health System (MVHS) selected service provider as part of the master MVHS network expansion and disaster recovery plan. The physical separation of the two conduit paths shall be as great as practical, but no less than 20ft as per BICSI Standards. Appropriate lightning protection shall be installed for copper services entering the Facility.

Telecommunications Room/Telecommunications Equipment Rooms (TR/TERs)

Each TRs/TER shall be located to meet the NFPA 99 2012 code which states that a TR/TER can only serve 20,000 sq. ft. of usable space and where the longest distance to any Work Area Outlet (WAO) is less than 275'. TRs shall be stacked vertically to decrease the length of riser conduit and riser cables. A minimum of two walls of the TR shall be expandable meaning two walls that are not adjacent to non-movable building structure. Each TR shall be 12' x 14' in size. The TER shall be 15' x 20'. As a rule, horizontal WAO connections shall start and finish (TR to WAO) on the same floor (no cross-floor connections). Columns in the middle of the room or curved walls are not acceptable in any of the TRs/TER.

Each TR/TER shall contain both building and emergency power as well as separate UPS unit/s (provided by MVHS IT) to manage any transition (loss of service) to emergency power. The number, type and location of emergency power outlets shall be confirmed with MVHS IT before installation. Two convenient building power quadruplex outlets, 20A, 110V shall be installed on each wall at a height of 6" AFF.

HVAC design for the TRs/TER shall be designed to maintain continuous and dedicated environmental control (24 hours per day, 365 days per year). Remote monitoring by MVHS Facilities of the room cooling will be provided. Cooling size requirements shall be designed by the project's mechanical engineer (SSR) with help from SSR and MVHS IT to determine each room's BTU requirements. The room's HVAC shall maintain positive pressure with a minimum of one air change per hour. These rooms shall maintain a temperature and humidity level at 18 °C to 24 °C (64 °F to 75 °F). The humidity range shall be 30% to 55% relative humidity.

TRs shall have a monitored door with card reader access and an IP addressable camera system located within the room with temperature and humidity trending capabilities. All walls within the rooms including above the door shall be covered with four by eight foot ¾ AC grade plywood, mounted vertically from six inches above the finished floor, painted with fire retardant paint. The plywood shall be installed with grade C surface facing the wall. No infrastructure of element shall be mounted directly to any wall without plywood. Each room shall be equipped with a grounding bar connected to the building ground system (provided and installed by the project's Electrical Contractor). All low voltage equipment housed in the TR shall be grounded back to the room's ground bar. Automatic, quick response sprinkler heads with head guard protection shall be

provided to ensure 100% A/S coverage per local authority having jurisdiction. The rooms do not require a drop ceiling and the floor shall be sealed concrete. Lighting shall be mounted at a minimum of 9' AFF and shall be centered above the workspace not the racks. Doors shall be 36" wide and 84" tall. Each TR/TER shall be equipped with a 1-port data outlet for a wall mounted telephone.

TRs/TER shall be equipped with 18" wide ladder rack installed around the perimeter of the room and over the floor mounted racks. Ladder rack shall be installed at a height of 8' and a minimum of 7' 4" to the bottom. Floor mounted racks shall be 7' h x 19" w installed with front mounted 10" w vertical cable management on each side of the rack. There shall be a minimum of 36" in front and behind the row of racks.

Primary and Horizontal Cable Pathways

A cable tray system shall be installed above ceiling as the primary horizontal pathway for all low voltage cables. Cable tray size shall be 24" w x 6" h. Cross corridor sleeves, TR/TER entrance sleeves and vertical conduit sleeves shall be a re-penetrable sleeve (Hilti Speed Sleeve or equivalent). (2) 2" entrance sleeves shall be required for any patient care rooms (patient rooms, ED Exam, Prep/Recovery, PACU, etc.) and (1) 2" for all other locations. Conduit sleeves shall be used for cables passing over a hard ceiling area. Conduit pathway is required for any cable when passing through or being installed in an open ceiling area.

The following wall outlet conduit and back box sizes shall be required:
Data Outlet: 1.00", 4" X 4" X 2.125" with a single gang plaster ring
CATV Outlet: 1.00", single gang box with 1.875" minimum depth
Wall Telephone Outlet: 1.00", 4" X 4" X 2.125" with a single gang plaster ring
Nurse Call Devices: 1.00", determined as needed
Security Devices: 1.00", determined as needed

All conduits shall be installed with pull string.

Structured Cabling System

The new facility shall have backbone cables from the two entrance facility rooms to each TR in the facility to provide main and redundant connections respectively. Each pathway shall be installed to achieve the most physically diverse path as possible. TRs/TERs shall be connected using 4" conduits for riser installation. Each 4" conduit shall be installed with one (3) 4" cell Maxcell innerduct or approved equal. There shall be a minimum of (4) 4" conduits connecting TRs/TER. All conduits/innerducts shall be installed with pull strings.

Fiber riser shall be a combination of multi-mode optical fiber (850nm laser-optimized 50/125 um OM3 bend insensitive) and single mode optical fiber. Fiber riser shall be terminated in rack mounted fiber patch panels (LC or MTP/MPO type connectors). Fiber riser cables shall be placed in flex duct in the ladder rack between the backbone pathway and the rack mounted fiber panel. Copper riser shall consist of Category 3 multi-pair cable originating in the TER and extending into each new TR room. Copper riser shall be terminated on 110 blocks equipped with 5-pair connector blocks. Copper riser pairs shall be determined by SSR and MVHS IT.

Voice, data and networked video requirements will be supported using Category 6 non-plenum Unshielded Twisted Pair (UTP) cables extending from each TER/TR to each Work Area Outlet (WAO). Each typical WAO will contain at least two (2) CAT 6 cables (more if equipment needs require) terminated in a 4-port faceplate with 2 blanks. Each cable shall be considered Universal (not dedicated to a specific technology). Certain exceptions to the Outlet Standard include single CAT 6 non-plenum cables located for but not limited to employee timekeeping systems, wall mounted telephone sets, and medicine distribution cabinets.

In the TRs, all horizontal station cables will be terminated rack mounted 110 style patch panels with rear cable management bar.

PBX/VoIP

This is the system over which all voice communications will travel and be routed. The system will include wired and wireless Voice over IP (VoIP) and a limited PBX presence to service those functions that are not appropriate for the proposed IT network.

Wireless Local Area Network (WLAN) / Wireless Voice / Distributed Antenna System

A building wireless system will accommodate real-time point of care/activity information retrieval (802.11) as well as radio frequency identification (staff locating, patient tracking, asset management). WLAN access point coverage shall be designed to carry wireless traffic for voice and data systems including but not limited to internal wireless device communication, wireless patient charting, RTLS, Security, Nurse Call, Patient Monitoring, Alarm/Alert Notification and Management, and Patient Registration capabilities. The locations of the wireless antennas devices shall be dependent upon several factors including structural makeup of the new facility, desired coverage areas, signal strength of accessing device, and frequencies required. Wireless access points shall be connected to the hospital's network via horizontal data cabling and will be powered via Power over Ethernet technology. Each wireless access point location shall be installed with (2) Category 6A cables terminated on a surface mount box with 20' of cable slack for future adjustments. All horizontal cables installed for wireless access points shall terminate on a separate, dedicated Category 6A patch panel.

Wireless data access shall be accessible in all elevator cars and stairwells for continuity of service. There shall be two (2) Ethernet wires (Cat 6) included in the elevator travel cable served from the TR to the elevator control rooms. Travel cable to be provided and installed by the Elevator Contractor. Access points shall be mounted on the top of each elevator car. The data cable shall be designed to be installed utilizing the same travel cable as the Elevator Emergency Phone.

A separate Distributed Antenna System shall be installed to enhance cellular signal, repeat UHF and 700/800mhz. Separate radio repeaters shall be installed for two-way radio systems.

Audio Visual Systems

Systems providing audio visual services and teleconferencing services external and internal. The new hospital will contain several conference, training and educations rooms, patient entertainment spaces (clinical and non-clinical), and employee lounges that may be used for presentations.

Typical Conference Room Audio Visual Design: (2) large flat panel wall mounted monitors with audio visual connections, data and quad power outlet mounted behind each. Ceiling speakers and microphones, floor connections with data and audio visual connections. Floor connection box requires a 1" conduit direct from the floor outlet to the wall mounted monitor back box and (2) 1.25" conduits stubbed up above ceiling installed with pull strings. Wall mounted touchscreen control unit and wireless audio visual connection device. The project shall utilize electronic scheduling screens for Conference Rooms.

Cable Antenna Television (CATV)

Systems providing patient information and entertainment information in patient rooms, waiting areas, treatment areas, etc. Cable television shall feed the new facility via external connections from the MVHS preferred service provider. Cable television service shall be distributed to each TR over RG-11 coaxial cable. Homerun RG-6 coaxial cable and Category 6 cable will provide connectivity from the TR to each individual television set. At the television set, coax cables shall be terminated with an "F" connector housed in a faceplate that shall contain data and nurse call connections for televisions in patient rooms. In the TR, these cables shall be terminated on taps and/or splitters which will provide connectivity to amplifiers and/or direct connection to the CATV system equipment. In addition, via the Category 6 cable, live feeds from in-house seminars, Chapel Services, telemedicine, and pre-recorded feeds to such services as patient and staff education and training and movie stations shall be available to each television set. Television sets shall be hospital-grade where required. The recommended minimum television display size for patient rooms is 42".

Public Address

One to one, one to group, one to all paging and two-way voice communications. System performs in alarm and non-alarm conditions. Overhead paging shall be provided through a series of paging amplifiers and overhead speakers, some of which may be controlled through individual volume controls. This system shall provide a means of public broadcast for life-safety announcements or any other desired public announcements. The system will provide "zoned" and "all call" paging as required. Amplifiers shall be distributed throughout the TRs. The new hospital shall plan for 2' x 2' "drop-in" paging speakers.

Real Time Locating System (RTLS)

The new hospital shall be equipped with a Real Time Locating System. The system's backbone shall be carried over the hospital's wireless network with Power over Ethernet (PoE) devices providing room level accuracy. Each patient care area shall require a PoE device to track staff and integrate with the Electronic Medical Record. Wireless temperature monitoring shall be required for medication, lab and pharmacy refrigerators. MVHS currently utilizes the Stanley Aeroscout system.

Nurse Call System

A new nurse call/code blue system will be required. The new system will be comprised of nurse master stations, patient stations, staff stations, emergency call stations, dome lights and tracking sensors. Individual systems will be required for each floor and will be networked together to facilitate centralized management functions. The new system will provide a means of two-way communication between patients and clinical staff. The new system shall interface with the Voice over IP (VoIP) telephony system and shall offer such integration of nurse calls, lab results and physiological monitoring to the wireless handset. The code blue feature shall provide the capability of alerting the staff of life threatening code conditions that need immediate response. The system shall be capable of interfacing with hard-wired or wireless telephone service and overhead paging system. The system shall interface with other HL-7 compliant systems, i.e. ADT and electronic medical record systems, providing patient information in a fashion that enhances efficient delivery of patient care and improves patient satisfaction. With the exception of staff toilets, all restrooms shall contain Emergency Pull Cord elements.

The Nurse Call devices for the new Facility shall be planned per NFPA 99, FGI Guidelines for design and construction of healthcare facilities requirements, and user's requests. 37-pin bed connector shall be required in all patient rooms with beds. The bed connector is not required for room utilizing stretchers only.

Wireless Clock System

System consisting of clocks, transmitters, and receivers using global positioning system (GPS) wireless technology to synchronize time without the need to re-set clocks for time changes or power outages. System shall include additional roof transceiver and transceivers in IT rooms where required by system manufacturer to expand existing system signal coverage.

Analog Clocks shall be battery powered models located in staff areas and above elevators only. Digital Clocks and Digital timers in procedure rooms shall be wired or wireless communication AC powered (hardwired) models. The current MVHS wireless clock system is Primex.

Access Control and CCTV System

Systems allowing authenticated access to restricted areas, and general public access control. Various devices and methodologies exist to allow authenticated, monitored physical access. Card readers/keypads are utilized for internal and external access control. Currently MVHS utilizes proximity card technology. CCTV cameras and network video servers are used for security surveillance. Both of these systems are "networkable" and allow system access as needed to provide real time monitoring and archival and retrieval of stored data. IP cameras are used and 30 days of storage are required. System components shall be installed as specified by the owner. Parking lot gates for physician parking, site emergency phones and site cameras shall be required. The project shall also include a Pediatric Abduction System interfaced with building security (door and elevator control). Hugs is the current MVHS Pediatric Abduction System. MVHS utilizes Special Care System as a staff duress system that notifies security through radios. The panic devices are wireless. The EZ Lobby system is currently used for visitor management. Visitors are issued a sticker badge at Front Entrance, ED and Maternity has a visitor badge

station.

All door hardware is installed by a door hardware provider, the Access Control Contractor will install a coil of wire in ceiling above locking mechanism long enough for the hardware installer to wire to their lock.

Typical MVHS Areas of Control:

Pharmacy, Medication Supply Rooms, ICU, Surgery, Peds, LDR, Lab, Behavioral Health, Maternity Elevators, Staff Lounge, Dr. Lounge, Retail Pharmacy, Emergency Department, Imaging.

Radio Systems

The project shall require multiple radio systems. A two-way radio system with repeaters will be installed for use by Security, Facilities, Incident Command, Surgery (a local, departmental system). The Emergency Department will be equipped with an EMS radio system to communicate with the incoming ambulance service. MVHS utilizes pagers for EVS and Bed Tracking communication. Long-range signal shall be required for radio systems.

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
•	•		**Life Safety Floor Plans**		
•	•		Renovation Projects the Life Safety Floor Plan shall include the following elements as a minimum.	NA	
•	•		Mixed occupancies within the existing building.	NA	
•	•		The project floor location.	NA	
•	•		**Height and Area Limits**	Y	
•	•		Total number of Stories and Building Height.		9 occupied and partial penthouse - first floor to roof slab of occupied floor is125'-0", first floor to roof slab of penthouse 142'-0". CEP is 3 stories - First floor to roof is 60'-0"
•	•	Table 18.1.6.1	Maximum Height Allowed	Y	Unlimited
•	•		Allowable Area	Y	None stated in NFPA
•	•	Table 18.1.6.1	Maximum Number of Stories	Y	Unlimited
•	•		Sprinklered or Unsprinklered	Y	Sprinklered per 9.7
•	•	**Occupancy**			
•	•		Occupancy Classification Hospital	Y	I-2
			Occupancy Classification -- Central Energy Plant	Y	Special Purpose Industrial
•	•		The project floor location.	NA	
•	•		**Construction Type**		
•	•	18.1.1.1.4	General - Hospital shall include, general hospitals, psychiatric hospitals and specialty hospitals	NA	
		18.1.1.1.5	The healthcare facilities regulated by this section shall be those that provide sleeping accommodations for their occupants	NA	
		18.1.1.1.6	Buildings or sections of buildings where the occupants are capable of exercising judgment and appropriate physical action for self preservation under emergency conditions shall be permitted to comply with other chapters of this code	NA	
		18.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations.			
•	•	**18.1.1.4.1 Additions.**		NA	
•	•	18.1.1.4.1.1		NA	
		18.1.1.4.3 Rehabilitation.			
•	•	18.1.1.4.3.1		NA	
		18.1.1.4.3.2		NA	
•	•	18.1.1.4.3.3*		NA	
		18.1.1.4.3.4*		NA	
		18.1.1.4.4 Construction, Repair, and Improvement Operations. See 4.6.10.			
•	•	**18.1.2 Classification of Occupancy.**			
		18.1.3 Multiple Occupancies.			
		18.1.3.1		NA	
•	•	18.1.3.2		NA	
•	•	18.1.3.3*		NA	
		18.1.3.4 Contiguous Non-Health Care Occupancies.			
•	•	18.1.3.4.1*		NA	
		18.1.3.4.2		NA	
•	•	18.1.3.5		NA	

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements		Complies	Comments
Schematic	Design Development					
•	•	18.1.3.6			NA	
•	•	18.1.3.7			NA	
•	•	18.1.3.9			NA	
•	•	18.1.3.10			NA	
•	•	Table 18.3.2.1	Boiler and fuel-fired heater rooms	1 hour		
			Central/bulk laundries (more than 100 sq. ft.)	Not applicable		
			Laboratories using flammable or combustible materials in quantities that are less than would be considered severe	corridor doors with closers		
			Laboratories that use hazardous materials that would cause classification as a severe hazard in accordance with NFPA 99	Not applicable		
			Paint shops (not classified as an "H" occupancy)	Not applicable		
			Physical plant maintenance shops	Not applicable		
			Soiled-linen room	1 hour		
			Waste/trash collection	1 hour		
			Storage rooms between 50-100sf	Door closer		
			Storage rooms greater than 100sf	1 hour		
			Trash collection rooms - volume greater than 64 Gal	1 hour		
		18.1.3.11	Non-healthcare related high hazard occupancies		NA	
		18.1.6 Minimum Construction Requirements.				
•	•	18.1.6.1	Healthcare is limited to the construction types specified in Table 18.1.6.1		Y	NFPA I-3.3.2, IBC -1B
•	•	18.1.6.2	Class A roof, separated from occupied portions by a noncombustible floor assembly with a rating of not less than 2 hours, not less than 2 1/2" concrete or gypsum fill		Y	
•	•	18.1.6.3	Class A roof, roof ceiling constructed of fire retardant wood meeting NFPA 220, must have rating required for type of construction		NA	
•	•	18.1.6.7	Floors below grade		NA	
•	•	18.1.7	Occupant load shall be determined on the basis if the occupant load factors of Table 7.3.1.2		Y	See attached occupant load calculation
		Occupants Load Factors				
•	•	Table 7.3.1.2	Office	100sf/person	Y	
			Conference and seminar rooms – classrooms	15nsf/20nsf per person		
			Inpatient treatment areas	240sf/person		
			Sleeping Departments	120sf/person		
			Ambulatory Health Care	100 sf/person		
			Storage and mechanical spaces	300sf/person		
			Locker rooms	50sf/person IBC 1004.1.2		
			Kitchen	100sf/person		
•	•	18.2 Means of Egress Requirements.				
•	•	18.2.1 General.	Every aisle, passageway, corridor, exit discharge, exit location shall comply with 18.2.2-18.2.11 (Locking requirements, hold opens, High Rise rqmts, horizontal sliding doors)		Y	
•	•	7.1.3.1 Exit Access Corridors.	A rating is not required for exit access corridors in I-2		Y	
•	•	7.1.3.2 Exits.				
•	•	7.1.3.2.1	The enclosure should be 1 hour for exits that connect 3 or fewer floors, 2 hours for 4 and more floors. The following can penetrate the enclosure – door assembly from normally occupied spaces and corridors and egress doors: conduits, sprinkler pipe, HVAC piping, stair pressurization ductwork serving the stair.		Y	
•	•	7.1.3.2.2	An exit enclosure shall extend to the exit discharge		Y	
•	•	7.1.3.2.3*	An exit enclosure can not be used for any other function that could compromise its function		Y	

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
		7.1.5 Headroom.			
	•	7.1.5.1	Minimum Ceiling is 7'-6" with projections from the ceiling not less than 6'-8"	Y	
	•	7.1.5.2	The minimum ceiling height shall be maintained for not less than 2/3 of room with remaining ceiling not being less than 6'-8"	Y	
	•	7.1.5.3	Headroom on stairs shall not be less than 6'-8"	Y	
		7.1.7 Changes in Level in Means of Egress.			
	•	7.1.7.1	When the level of means of egress changes exceeds 21 inches the change must be made by an approved means of egress	Y	
•	•	7.1.7.2*	Changes of less than 21 inches can be made by a ramp or compliant stair (see 7.2.5 and 7.2.2)	Y	
	•	7.1.7.2.1	If a ramp is used - the ramp needs to be noticeable		
	•	7.1.7.2.2	If a stair is used the tread shall not exceed 13"		
	•	7.1.7.2.3	See 40.2.5.2 for industrial equipment areas		
	•	7.1.7.2.4	The location and presence of each step must be noticeable.		
	•	7.1.8* Guards.	Provide guards complying with7.2.24 where the open side exceeds more than 30 above the floor - not less than 42"		
		18.2.2.2 Doors			
•	•	18.2.2.2.1	Doors must comply with 7.2.1	Y	
		7.2.1 Door Openings.			
•	•	7.2.1.1.2	Door openings serving as a means of egress shall be noticeable	Y	
		7.2.1.2.3 Minimum Door Leaf Width.			
	•	7.2.1.2.3.2	Door openings shall not be less than 32", except if a pair is provide, one needs to be 32",rooms less than 70sf and not accessible the door can be 24" wide, doors to areas not req'd to be accessible can be 28", automatic pairs of doors can have leafs less than 32". If a single means of egress door from a stair is the only means of egress is req'd to be 56" the door can be reduced to 2/3 the req'd stair width.	Y	
		7.2.1.3 Floor Level			
	•	7.2.1.3.1	the elevation of the floor on each side of an opening shall not very by more than 1/2"	Y	
	•	7.2.1.3.3	Thresholds shall not exceed 1/2"	Y	
	•	7.2.1.3.4	Thresholds greater than 1/4" must be beveled to a slope not greater than 1 to 2	Y	
	•	7.2.1.3.5		NA	
•	•	7.2.1.3.6		NA	
		7.2.1.4 Swing and Force to Open.			
•	•	7.2.1.4.1* Swinging-Type Door Assembly Rqmt.	Doors must be swing type. Where allowed horizontal sliding or vertical rolling security grilles shall be permitted - must be secured when building is occupied, , sign indicating the door will be open when occupied, if more than 2 means of egress are required not more than half can be horizontal sliding or vertical grilles. Sliding doors where allowed by Chapters 11-43	Y	
•	•	7.2.1.4.2 Door Leaf Swing Direction.	Must swing in the direction of egress if there are 50 occupants or more. Doors in Horizontal exits do not need to swing in the means of egress (confirm)	Y	
		7.2.1.4.3 Door Leaf Encroachment.			
•	•	7.2.1.4.3.1*	During its swing the door can not encroach into the corridor more than 1/2 of the corridors width and not protrude more than 7" when fully open (hardware is not included in the 7"	Y	
		7.2.1.5.5 Key-Operated Locks.			
	•	7.2.1.5.5.1	Exterior doors shall be allowed to have a lock on the egress side , there is a sign and a key available.		
	•	7.2.1.5.6 Electrically Controlled Egress Door Assemblies	*1) The hardware for occupant release is affixed to the door leaf, 2) the hardware has an obvious method of operation in the direction of egress, 3)the hardware is capable of being operated with one hand. 4) the operation of the hardware interrupts the power in the electric lock in the direction of egress, 5) Loss of power releases the hardware in the direction of egress.*		
	•	7.2.1.5.8*	In stairs greater than 4 floors. Reenty from stair shall be provided, or there is an automatic release tied to the fire alarm to unlock the door for reentry, or 7.2.5.8.1		
	•	7.2.1.5.8.1	Not less than 2 floors where reentry is allowed, no more than 4 floors where reentry is not allowed, reentry doors to be signed, reentry required at top floor or next to top, provide sign for location of reentry.		
	•	7.2.1.5.8.2		NA	

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements		Complies	Comments
Schematic	Design Development					
	•	7.2.1.5.9	A door to a roof from a stair shall either be locked or allow reentry			
		7.2.1.6.1 Delayed-Egress Locking Systems.				
	•	7.2.1.6.1.1	Delayed egress allowed on low or ordinary hazards spaces in buildings protected by sprinkler. Door shall unlock in the means of egress on activation by sprinkler, heat detector, 2 smoke detectors. Door shall release in the direction of egress. The release shall be 15 to 30 seconds upon application of 15 lbs of force. Release shall activate an alarm. The egress side of the door shall have emergency lighting			
	•	**7.2.1.6.2* Access-Controlled Egress Door Assemblies**				
	•		A sensor shall release door from egress side, leaves shall automatically unlock upon loss of power, doors must have a manual release on egress side within 60in of the door between 40" and 48" AFF, shall indicate Push to Exit, Lock shall remain unlocked for 30 seconds on release.			
	•	**7.2.1.6.3 Elevator Lobby Exit Access Door Assemblies Locking.**				
	•		An elevator lobby can be locked if the door complies with UL 294, building is protected by a sprinkler system, sprinkler water flow initiates the fire alarm, the lobby is protected by a smoke detection system, initiation of the fire alarm releases the door locks, loss of power unlocks the doors, 2 way communication between the lobby and command center is continuous, . delayed egress is not allowed,			
		7.2.1.9* Powered Door Leaf Operation.				
	•	*7.2.1.9.1.4*	a manual sliding door in an exit discharge with less than 50 occupants does not need to swing in the direction of egress			
	•	*7.2.1.9.1.5**	Although a single power-operated door leaf located within a two-leaf opening might alone not provide more than 30 in. (760 mm) of clear width in the emergency breakout mode, where both leaves are broken out to become side hinged, the required egress width is permitted to be provided by the width of the entire opening.			
	•	*7.2.1.9.1.6*	In a bi-parting multi-leaf opening a single leaf can be 30" – not 32"			
	•	*7.2.1.9.1.7*	Horizontal sliding doors are acceptable if they met 7.2.1.14 (won-door)			
	•	*7.2.1.14*	1. readily operable from both sides, 2. force to operate the operating device is less than 15lbs., 3. force to operate door leaf is 30lbs, 4...., Door matches required rating			
	•	18.2.2.2.9	Areas of refuge used as part of a required accessible means of egress shall comply with 7.2.12			
	•	18.2.2.2.10	Horizontal sliding doors are acceptable if they met 7.2.1.14 (won-door)			
		18.2.2.2.10.1	Manual sliding doors are allowed if they do not rebound to a partially opened position when forcible closed.			
	•	18.2.2.2.10.2	Sliding doors are allowed for fewer than 10, no high hazard contents, readable operated from both sides, force to open 30#, to close 15#, is rated and self closing were req'd, latched where req'd			
		18.2.2.3	Stairs. Stairs complying with 7.2.2 shall be permitted.			
•	•	7.2.2.1.1	Stair used as a component in a means of egress must conform to 7.1 and 7.2.2.		Y	
•	•	7.2.2.1.2	The requirements of 7.2.2.1.1 shall not apply to aisle stairs		Y	
		7.2.2.2 Dimensional Criteria.				
	•	**7.2.2.2.1 Standard Stairs.**				
	•	**Table 7.2.2.2.1.1(a)** **7.2.2.2.1.2.**	**Dimensional Criteria New Stairs**			
			Risers	7 inches max, 4 inch min		
			Treads	11 inches		
			Width	For floors with occupancy of less than 50, clear width of all obstructions 36" except projections not more than 4 1/2" at or below the handrail height		
			Landings Width 7.2.1.3 and 7.2.1.4.3.1	7.2.1.3 - floor shall be level, max 1/2" threshold. 7.2.1.4.3.1 During its swing in a means of egress shall not leave less than one half of a landing obstructed and shall not project more than 7" into the req'd means of egress when fully opened		
			Vertical Rise	Maximum height between landings 12'		
			Headroom	6'-8"		
			Handrails (Note: Shall also coordinate with TAS requirements (4.26.2)	34-38 inches above the leading edge of the tread		
			Minimum	circular not less than 1 1/4" and not more than 2"		

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Code Reference Category

Phase		Code Section	Component/Requirements		Complies	Comments
Schematic	Design Development					
			Maximum	shapes , other than round with a perimeter of not less than 4" and not more than 61/4" with largest cross section2 1/4", with grasping edge radius not less than 1/8"		
			Height	Maximum height between landings 12'		
			Clear Space to Wall	2 1/2" min		
			Intermediate Handrails 7.2.2.4.1.2 (1)	For new stairs, handrails shall be provided within 30 in. of all portions of the required egress width.		
		Guardrails	Guardrails	See 7.1.8, see 7.2.2.4 – 7.2.2.4.5.2 Guards shall be 42 inches high- provide intermediate rails or ornamental infill such that a 4" sphere can not pass through the rails. The triangle opening at the riser, tread and bottom element of the guard shall be no larger that a 6" sphere.		
		Dimensional Criteria Existing Stairs				
			Maximum Height of Risers		NA	
			Minimum tread depth		NA	
			Minimum headroom		NA	
		7.2.2.2.1(a) Table	Maximum Height Between Landings	Maximum height between landings 12'	NA	
•	•	7.2.2.2.1.2.	Minimum New Stair Width.	With an occupant load of less than 50 - minimum width is 36 in., with projections below the handrail of more than 4 1/2"	NA	
		7.2.2.3 Stair Details.				
•	•	7.2.2.3.1.2	Shall be not combustible construction		Y	
		7.2.2.3.2 Landings.				
•	•	7.2.2.3.2.1	Stairs shall have a landing at door openings		Y	
•	•	7.2.2.3.2.2	Stairs and intermediate landings shall continue with no decrease in width along the direction of egress travel.		Y	
•	•	7.2.2.3.2.3	Every landing shall have a dimension, measured in the direction of travel, that is not less than the width of the stair.		Y	
•	•	7.2.2.3.2.4	Landings shall not be required to exceed 48 in.(1220 mm) in the direction of travel, provided that the stair has a straight run		Y	
•	•	7.2.2.3.2.5			NA	
		7.2.2.3.3 Tread and Landing Surfaces.				
	•	7.2.2.3.3.1	Stair treads and landings shall be solid, without perforations, except for non-combustible stairs in Assembly, Industrial and storage occupancies			
	•	7.2.2.3.3.2*	Stair treads and landings shall be free of projections or lips that could trip stair users			
	•	7.2.2.3.3.3	If not vertical, risers on other than existing stairs shall be permitted to slope under the tread at an angle not to exceed 30 degrees from vertical, provided that the projection of the nosing does not exceed 1 1/2 in			
		7.2.2.4 Guards and Handrails.				
		7.2.2.4.1 Handrails				
	•	7.7.2.2.4.1.1	Stairs and ramps shall have handrails on both sides unless otherwise permitted by 7.2.2.4.1.5 or 7.2.2.4.1.6 Handrails not req'd at a single step or ramp of a curb that separates a sidewalk from a vehicle way. Existing stairs in dwelling units and within guest rooms may have a rail on one side			
	•	7.2.2.4.1.2	Provide within 30" of all portions of an egress width			
	•	7.2.2.4.1.3			NA	
	•	7.2.2.4.2 Continuity.	Req'd guards and handrails shall continue the full length of each flight of stairs. At turns of new stairs - inside handrails shall be continuous between flights at the landings			
		7.2.2.4.4* Handrail Details.				
	•	7.2.2.4.4.1	not less than 34" and not more than 38"			
	•	7.2.2.4.4.2	existing stairs		NA	
	•	7.2.2.4.4.3	The height of the handrail that forms the guard rail shall be permitted of exceed 38" but not exceed 42"			
	•	7.2.2.4.4.5	provide 2 1/4" clear from handrail to the wall			

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
	•	7.2.2.4.4.6	circular not less than 1 1/4" and not more than 2"		
	•	7.2.2.4.4.8	Handrail brackets or balusters attached to the bottom surface of the handrail shall not be considered to be obstructions to grasp ability, provided that They do not project horizontally beyond the sides of the handrail within 1 1/2 in. (38 mm) of the bottom of the handrail and provided that, for each additional 1/2 in. (13 mm) of handrail perimeter dimension greater than 4 in. (100 mm), the vertical clearance dimension of 1 1/2 in. (38 mm) is reduced by 1/8 in. (3.2 mm). They have edges with a radius of not less than 0.01 in.		
	•	7.2.2.4.4.9	New handrail ends shall be returned to the wall or floor or shall terminate at newel posts		
	•	7.1.8* Guards.	Guards shall be provided at the open sides pf means of egress exceeding 30" AFF		
•	•	7.2.2.4.5.2	Guards shall not be less than 42"	Y	
	•	7.2.2.4.5.3*	Intermediate rails required such that a 4" sphere is not able to pass thru any opening. The triangular opening formed by the riser tread and bottom of ther gaurdrail shall not pass a 6" sphere		
		7.2.2.5 Enclosure and Protection of Stairs.			
•	•	7.2.2.5.1.1	All inside stairs serving as a means of egress shall be enclosed per 7.1.3.2	Y	
•	•	18.2.2.4 Smokeproof Enclosures.			
•	•	7.2.3 Smokeproof Enclosures.	Smokeproof enclosures complying with 7.2.3 shall be permitted.	Y	
•	•	7.2.3.1 General.	General. Where Smokeproof enclosures are required in other sections of this Code, they shall comply with 7.2.3, unless they are approved existing Smokeproof enclosures.	Y	
•	•	7.2.3.2 Performance Design.		Y	
		7.2.3.3 Enclosure.			
•	•	7.2.3.3.1	Smokeproof enclosures must comply to 7.2.3	Y	
•	•	7.2.3.3.2	Where a vestibule is used it must be within a 2 hour enclosure	NA	
•	•	7.2.3.3.3	A Smokeproof enclosure comprised of an enclosed stair and serving floors below the level of exit discharge shall not be required to comply with 7.2.3.3.1 where the portion of the stairway below is separated from the stairway enclosure at the level of exit discharge by barriers with a 1-hour fire resistance rating.	NA	
•	•	7.2.3.4	Vestibule. Where a vestibule is provided, the door opening into the vestibule shall be protected with an approved fire door assembly having a minimum 1 1/2-hour fire protection rating, and the fire door assembly from the vestibule to the Smokeproof enclosure shall have a minimum 20-minute fire protection rating. Door leaves shall be designed to minimize air leakage and shall be self-closing or shall be automatic-closing by actuation of a smoke detector within 10 ft (3050 mm) of the vestibule door opening. New door assemblies shall be installed in accordance with NFPA 105.	NA	
		7.2.3.5 Discharge.			
•	•	7.2.3.5.1	Every Smokeproof enclosure shall discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway.	Y	
•	•	7.2.3.5.2	The Smokeproof enclosure shall be permitted to discharge through interior building areas, provided that all of the criteria in 7.2.3.5.2 .1 to .3 are met 7.2.3.1 General. Where Smokeproof enclosures are required in other sections of this Code, they shall comply with 7.2.3, unless they are approved existing Smokeproof enclosures.	Y	
•	•	7.2.3.6 Access.	For Smokeproof enclosures other than those consisting of a pressurized enclosure access to the Smokeproof enclosure shall be by way of a vestibule or by way of an exterior balcony	NA	
	•	7.2.3.7 Natural Ventilation.	18.2.2.4 Smokeproof Enclosures. Smokeproof enclosures complying with 7.2.3 shall be permitted. See code	NA	
•	•	7.2.3.8 Mechanical Ventilation	Must comply with 7.2.3.8.1-.4	Y	
•	•	7.2.3.8.1	Vestibules shall have a dimension of not less than 44 in..in width and not less than 6 ft in the direction of travel. .2) The vestibule shall be provided with not less than one air change per minute, and the exhaust shall be 150 percent of the supply. 3) The vestibule ceiling shall be not less than 20 in. (510 mm) higher than the door opening into the vestibule. 4) The stair shall be provided with a dampered relief opening at the top and supplied mechanically	Y	
		7.2.3.9 Enclosure Pressurization.			
•	•	7.2.3.9.2	Equipment and ductwork for pressurization shall the located in accordance with one of the following specifications (see.1 to .3)	Y	

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
		7.2.3.10 Activation of Mechanical Ventilation and Pressurized Enclosure Systems.			
	•	7.2.3.10.1	the activation of the systems shall be initiated by a smoke detector installed in an approved location within 10 ft (3050 mm) of each entrance to the smoke-proof enclosure.		
		18.2.2.5 Horizontal Exits. Horizontal exits complying with 7.2.4 and the modifications of 18.2.2.5.1 through 18.2.2.5.7 shall be permitted.			
•	•	**7.2.4 Horizontal Exits.**	Horizontal exits shall be permitted to be substituted or other exits where the total egress capacity and the total number of the other exits (stairs, ramps, door openings leading outside the building) is not less than half that required for the entire area of the building	Y	
		7.2.4.2 Fire Compartments.			
•	•	7.2.4.2.1	Every fire compartment for which credit is permitted in connection with a horizontal exit(s) also shall have at least one additional exit, but not less than 50 percent of the required number and capacity of exits, that is not a horizontal exit,	Y	
•	•	7.2.4.2.2	Every horizontal exit for which credit is permitted shall be arranged so that there are continuously available paths of travel leading from each side of the exit to stairways or other means of egress leading to outside the building	Y	
•	•	7.2.4.2.4	The floor area on either side of a horizontal exit shall be sufficient to hold the occupants of both floor areas and shall provide at least 3 ft 2 (0.28 m 2) clear floor area per person, unless otherwise permitted for the following: (1) Health care occupancies as provided in Chapters 18 and 19	Y	
		7.2.4.3 Fire Barriers			
•	•	7.2.4.3.1	Fire barriers separating buildings or areas between which there are horizontal exits shall have a minimum 2-hour fire resistance rating	Y	
•	•	7.2.4.3.3	Where a fire barrier provides a horizontal exit in any story of a building, such fire barrier shall not be required on other stories	Y	
•	•	7.2.4.3.4	Where fire barriers serving horizontal exits, other than existing horizontal exits, terminate at outside walls, and the outside walls are at an angle of less than 180 degrees for a distance of 10 ft (3050 mm) on each side of the horizontal exit, the outside walls shall have a minimum 1-hour fire resistance rating, with opening protectives having a minimum 3/4-hour fire protection rating, for a distance of 10 ft (3050 mm) on each side of the horizontal exit.	Y	
	•	7.2.4.3.5	Fire barriers forming horizontal exits shall not be penetrated by ducts, unless protected by damper or the building is protected throughout by an approved, supervised automatic sprinkler system		
	•	7.2.4.3.8	swinging fire door assemblies shall be permitted in horizontal exits, 1. The door leaves shall swing in the direction of egress		
•	•	7.2.4.3.8.2		NA	
•	•	**7.2.4.4 Bridges Serving Horizontal Exits Between Buildings.**		NA	
•	•	7.2.4.4.8		NA	
•	•	18.2.2.5.1	Accumulation space shall be provided	Y	
•	•	18.2.2.5.1.1	Not less than 30 net ft 2 (2.8 net m 2) per patient in a hospital, shall be provided within the aggregated area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other similar areas on each side of the horizontal exit.	Y	
•	•	18.2.2.5.1.2	On stories not housing bedridden or litter borne patients, not less than 6 net ft 2 (0.56 net m2) per occupant shall be provided on each side of the horizontal exit	Y	
•	•	18.2.2.5.2	The total egress capacity of the other exits (stairs, ramps, doors leading outside the building) shall not be reduced below one-third of that required for the entire area of the building	Y	
•	•	18.2.2.5.3	A single door shall be permitted in a horizontal exit if all of the following conditions apply (1) The exit serves one direction only. (2) Such door is a swinging door or a horizontal-sliding door complying with 7.2.1.14	Y	
•	•	18.2.2.5.4	A horizontal exit involving a corridor 8 ft (2440 mm) or more in width and serving as a means of egress from both sides of the doorway shall have the opening protected by a pair of swinging doors arranged to swing in opposite directions from each other, with each door having a clear width of not less than 41 1/2 in. (1055 mm), or by a horizontal-sliding door that complies with 7.2.1.14 and provides a clear width of not less than 6 ft 11 in. (2110 mm) .	Y	
•	•	18.2.2.5.5	A horizontal exit involving a corridor 6 ft (1830 mm) or more in width and serving as a means of egress from both sides of the doorway shall have the opening protected by a pair of swinging doors, arranged to swing in opposite directions from each other, with each door having a clear width of not less than 32 in. (810 mm), or by a horizontal-sliding door that complies with 7.2.1.14 and provides a clear width of not less than 64 in. (1625 mm).	Y	

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Code Reference Category

Phase		Code Section	Component/Requirements		Complies	Comments
Schematic	Design Development					
	•	18.2.2.5.6	An approved vision panel shall be required in each horizontal exit door.			
•	•	18.2.2.5.7	Center mullions shall be prohibited in horizontal exit door openings.		Y	
	•	18.2.2.6 Ramps				
	•	18.2.2.6.1	Ramps complying with 7.2.5 shall be permitted.			
	•	7.2.5 Ramps.				
	•	7.2.5.1 General.				
	•	7.2.5.2 Dimensional Criteria.				
•	•	Table 7.2.5.2(a) New Ramps	Width	minimum 44 inches	Y	
			Maximum slope in direction of travel.	1 in 12		
			Maximum rise for a single ramp run.	30 inches		
			Maximum Cross Slope	1 in 48		
			Handrails	Along both sides for rise greater than 6 inches		
•	•	Table 7.2.5.2(b) Existing Ramps	Minimum Width		NA	
			Maximum slope		NA	
			Maximum height between landings		NA	
		7.2.5.3 Ramp Details.				
•	•	7.2.5.3.1 Construction.	Permanently fixed construction, type I or II construction, non-combustible or limited combustible material or fire treated wood. Fire treated wood, max rise 30", less than 3,000sf and 50% of room area, ramp and landing solid w/o perforations		NA	
•	•	7.2.5.3.2 Landings.	Top and at door openings. Landings – width of ramp, not less than 60". If not a req'd means of egress – not req'd to be greater than 48". Landings and ramp to not decrease in width.		NA	
	•	7.2.5.3.3 Drop-Offs	Drop off's shall have curbs, rails or walls – minimum curb 4"			
		7.2.5.4 Guards and Handrails.				
•	•	7.2.5.4.1	comply with 7.2.2.4 except as provided in 7.2.5.4.4– assembly		Y	
•	•	7.2.5.4.2	provide for a rise greater than 6" on both sides of the ramp		Y	
	•	7.2.5.4.3	height of handrail from walking surface to top of rail		Y	
	•	7.2.5.4.4	not applicable to assembly		NA	
	•	7.2.5.5 Enclosure and Protection of Ramps.	protect as stairs where required to be protected		NA	
	•	7.2.5.6 Special Provisions for Outside Ramps.				
	•	7.2.5.6.1* Visual Protection.	Ramps higher than 36' outdoors shall have opaque visual obstruction not less that 48"		NA	
	•	7.2.5.6.2* Water Accumulation.	Outdoor ramps shall minimize water accumulation			
	•	A.7.2.5.6.2	separate where required, fire windows acceptable in sprinkled bldgs.			
•	•	18.2.2.7 Exit Passageways.	Exit passageways complying with 7.2.6 shall be permitted.		Y	
•	•	7.2.6* Exit Passageway	An exit passageway serves as a horizontal means of exit travel that is protected from fire in a manner similar to an enclosed interior exit stair. Where it is desired to offset exit stairs in a multistory building, an exit passageway can be used to preserve the continuity of the protected exit by connecting the bottom of one stair to the top of the stair that continues to the street floor. Probably the most important use of an exit passageway is to satisfy the requirement that at least 50 percent of the exit stairs discharge directly outside from multistory buildings (see 7.7.2). Thus, if it is impractical to locate the stair on an exterior wall, an exit passageway can be connected to the bottom of the stair to convey the occupants safely to an outside exit door. In buildings of extremely large area, such as shopping malls and some factories, the exit passageway can be used to advantage where the travel distance to reach an exit would otherwise be excessive.		Y	
		7.2.6.1* General.	Comply with 7.1 and 7.2.6		Y	
•	•	7.2.6.2 Enclosure.	2 hour, fire windows allowed in sprinkled buildings		Y	

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Code Reference Category

Phase		Code Section	Component/Requirements		Complies	Comments
Schematic	Design Development					
•	•	7.2.6.3 Stair Discharge.	Same enclosure as stair		Y	
		7.2.6.4 Width.				
	•	7.2.6.4.2	Sized to accommodate aggregate capacity of discharging through it.		Y	
•	•	18.2.2.10 Areas of Refuge.	Areas of refuge used as part of a required accessible means of egress shall comply with 7.2.12.		NA	
•	•	7.5.4.1.3 Areas of Refuge.	Accessible means of egress shall not be required in health care occupancies protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.		NA	
•	•	7.2.12.2 Accessibility.	Where required as part of a req'd accessible means of egress per 7.5.4 - not req'd in fully sprinkled healthcare occupancy		NA	
	•	7.2.12.2.1	—		NA	
•	•	7.2.12.2.2	—		NA	
	•	7.2.12.2.3*	—		NA	
	•	7.2.12.2.4*	—		NA	
•	•	7.2.12.2.4.1	—		NA	
•	•	7.2.12.2.4.2	—		NA	
	•	7.2.12.3 Area of Refuge Details.				
	•	7.2.12.3.1*	—		NA	
	•	7.2.12.3.2*	—		NA	
	•	7.2.12.3.3	—		NA	
	•	7.2.12.3.4*	—		NA	
	•	7.2.12.3.5	—		NA	
	•	7.2.12.3.5.1	—		NA	
	•	7.2.12.3.5.2	—		NA	
•	•	18.2.3 Capacity of Means of Egress.				
•	•	18.2.3.1	The capacity of means of egress shall be in accordance with Section 7.3.		Y	
•	•	7.3.1.1.2	Loss of one means of egress does not reduce capacity to less 50%		Y	
•	•	7.3.1.5 Capacity from a Point of Convergence.	Where means of egress from a story above and below converge - the means of egress shall be the sum of the capacity of the 2 means of egress		NA	
	•	7.3.1.6 Egress Capacity from Balconies and Mezzanines.	Where any required egress capacity from a balcony or mezzanine passes through the room below, that required capacity shall be added to the required egress capacity of the room below		NA	
•	•	7.3.2 Measurement of Means of Egress.				
•	•	7.3.2.2	The width of means of egress shall be measured in the clear at the narrowest point of the egress component. Projects of not more than 4 1/2" shall be permitted at a ht of 38" and below		Y	
•	•	7.3.2.3	Projection is allowed in corridors in Healthcare		Y	
•	•	(Table 7.3.3.1)	Capacity Factors			
			Stairways:	0.4 inches per person	Y	
			Level Components & Ramps	0.2 per person	Y	
•	•	7.3.4 Minimum Width.				
		7.3.4.1	not less than 36 where a minimum is not specified		Y	

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Code Reference Category

Phase: Schematic	Phase: Design Development	Code Section	Component/Requirements	Complies	Comments
	•	7.3.4.1.1*	The width of exit access formed by furniture and movable partitions that serves not more 6 people and not exceeding 50' – width not less than 18" below 38" and not less than 28" above 38". Width not less than 36" for new exit access		
•	•	7.3.4.1.2	The number of means of egress from any balcony, mezzanine, story, or portion thereof shall be not less than two, except under one of the following conditions: (1) A single means of egress shall be permitted where permitted in Chapters 11 through 43. (2) A single means of egress shall be permitted for a mezzanine or balcony where the common path of travel limitations of Chapters 11 through 43 are met.	NA	
	•	7.3.4.1.3	7.3.4.1 does not apply to doors per 7.2.1.2, aisles in assembly, industrial equipment access		
	•	7.3.4.2	Where a single exit access leads to an exit, its capacity in terms of width shall not be less than the required capacity of the exit to which it leads.		
•	•	7.3.4.3	Where more than one exit access leads to an exit, each shall have a width adequate for the number of persons it accommodates.	Y	
•	•	**18.2.4 Number of Means of Egress.**			
•	•	18.2.4.1	The number of means of egress shall be in accordance with Section 7.4.		
		7.4* Number of Means of Egress.		Y	
•	•	7.4.1.1	Minimum is 2	Y	
•	•	7.4.1.2		NA	
•	•	7.4.1.3	Accessible means of egress that do not utilize elevators shall be permitted to serve as any or all of the req'd minimum number of means of egress	Y	
•	•	7.4.1.4	The occupant load for each story shall be utilized in computing the number of means of egress at each story, provide the number of means of egress is not reduced	Y	
		7.4.1.6 Elevator Landing and Lobby Exit Access.			
•	•	7.4.1.6.1	Each elevator landing/lobby shall have access to at least one exit	Y	
•	•	7.4.1.6.2	The elevator lobby exit access shall not require the use of a key , special knowledge or effort.	Y	
•	•	7.4.1.6.3	Doors separating the elevator lobby from the exit access shall be permitted to be electronically locked -7.2.1.6.3	Y	
•	•	**7.4.2 Spaces About Electrical Equipment.**			
•	•	7.4.2.1 600 Volts, Nominal, or Less.	The minimum number of means of egress for working space about electrical equipment, other than existing electrical equipment, shall be in accordance with *NFPA70, National Electrical Code*, Section 110.26(C).	Y	
	•	Table 110-26(a)Working Spaces	Nominal Voltage to Ground / Minimum Clear Distance in Feet: Condition 1 / Condition 2 / Condition 3		
	•		0-150: 3' / 3' / 3'		
	•		151-600: 3' / 3'-6" / 4'		
	•		Condition 1: exposed live parts on one side working space, no live or grounded parts on the other side of the working space		
	•		Condition 2: exposed live parts on one side working space, and grounded parts on the other side of the working space. Tile brick or CMU shall be considered grounded		
	•		Condition 3: exposed live parts on north sides of the working space		
•	•	**7.4.2.2 Over 600 Volts, Nominal.**		Y	
•	•	110.33 (A)	at least 1 entrance to enclosed installations accessible to unqualified persons shall be metal enclosed equipment – the entry shall be a minimum 24"x6.5"	Y	
•	•	18.2.4.2	not less than 2 exits be provided for each story	Y	
•	•	18.2.4.3	Not less than 2 separate exits be accessible from every part of every story	Y	
•	•	18.2.4.4*	Not less than 2 exits shall be accessible from each smoke compartment, egress shall be permitted thru a adjacent compartment, provided the 2 req'd egress paths are arranged so that both do not pass thru the same adjacent compartment	Y	
•	•	**18.2.5 Arrangement of Means of Egress.**			
•	•	18.2.5.1 General.	Arrangement of means of egress shall comply with Section 7.5.	Y	

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Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
•	•	18.2.5.2	Dead-End Corridors. Dead-end corridors shall not exceed 30 ft, IBC indicates 20ft	Y	
•	•	18.2.5.3	Common Path of Travel. Common path of travel shall not exceed 100 ft	Y	
•	•	18.2.5.4	Intervening Rooms or Spaces. Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies.	Y	
•	•	18.2.5.5.1 Two Means of Egress	Sleeping rooms of more than 1000 ft 2 shall have not less than two exit access doors remotely located from each other.	Y	
•	•	18.2.5.5.2	Non-sleeping rooms of more than 2500 ft 2 shall have not less than two exit access doors remotely located from each other.	Y	
•	•	18.2.5.6.1	Every habitable room shall have an exit access door leading directly to an exit access corridor, unless otherwise provided in 18.2.5.6.2, 18.2.5.6.3, and 18.2.5.6.4.	Y	
•	•	18.2.5.6.2	Exit access from a patient sleeping room with not more than eight patient beds shall be permitted to pass through one intervening room to reach an exit access corridor, provided that the intervening room is equipped with an approved automatic smoke detection system in accordance with Section 9.6.	Y	
•	•	18.2.5.6.3	Rooms having an exit door opening directly to the outside from the room at the finished ground level shall not be required to have an exit access door leading directly to an exit access corridor.	Y	
•	•	18.2.5.6.4	Rooms within suites complying with 18.2.5.7 shall not be required to have an exit access door leading directly to an exit access corridor	Y	
		7.5 Arrangement of Means of Egress.			
•		7.5.1.1	exits shall be readily accessible at all times	Y	
		7.5.1.1.1*	Where exits are not immediately accessible from an open floor area, continuous passageways, aisles, or corridors leading directly to every exit shall be maintained and shall be arranged to provide access for each occupant to not less than two exits by separate ways of travel, unless otherwise provided in 7.5.1.1.3 and 7.5.1.1.4.	Y	
•		7.5.1.1.2	Corridors that are not required to be fire resistance rated shall be permitted to discharge into open floor plan areas.	Y	
•	•	7.5.1.1.3	the reqmts of 7.5.1.1..1 and 7.5.1.1.2 shall not apply where a single exit is permitted per chtrs 11-43	Y	
•	•	7.5.1.1.4	where a common path of travel is permitted by 11-43, the path shall not exceed the limit specified	Y	
•	•	7.5.1.2	Corridors shall provide exit access w/o passing thru and intervening from other than corridors, lobbies and other space permitted to be open to the coorridor - 7.1.5.2.1 - 7.5.1.2.2	Y	
•	•	7.5.1.2.1		NA	
•	•	7.5.1.2.2	Corridors that are not required to be fire resistance rated shall be permitted to discharge into open floor plan.	Y	
		7.5.1.3	Remoteness shall be provided in accordance with 7.5.1.3.1 through 7.5.1.3.7.	Y	
•	•	7.5.1.3.1	where more than one exit, exit access or exit discharge is req'd from a bldg. or portion of a bldg., the remoteness shall be arranged to minimize that more than one has the potential or be blocked in an emergency conditions	Y	
•	•	7.5.1.3.2*	Where two exits, exit accesses, or exit discharges are required, they shall be located at a distance from one another not less than one-half the length of the maximum overall diagonal dimension of the building or area to be served, measured in a straight line between the nearest edge of the exits, exit accesses, or exit discharges, unless other-wise provided in 7.5.1.3.3 through 7.5.1.3.5.	Y	
•	•	7.5.1.3.3	In buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.	Y	
•	•	7.5.1.3.4*		NA	
•	•	7.5.1.3.5		NA	
•	•	7.5.1.3.6		NA	
•	•	7.5.1.3.7	The balance of exits shall be located so that if one becomes blocked the others are available	Y	
•	•	7.5.1.4	Interlocking or scissor stairs shall comply with .1and .2	NA	
•	•	7.5.1.4.1	new interlocking stair shall be considered one exit	NA	
•	•	7.5.1.4.2*		NA	
•	•	7.5.1.5*	Exit access shall be arranged so there is no dead ends in corridors unless permitted by and limited to the lengths specified in Chapters 11-43	Y	

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Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
		7.5.1.6	Exit access from rooms or spaces shall be permitted through adjoining or intervening rooms or areas that are accessory to the areas served. Foyers, lobbies, reception rooms constructed as req'd for corridors shall be construed as intervening rooms. Intervening rooms shall not include hazardous spaces.	Y	
•	•	18.2.5.2 Dead-End Corridors.	Dead end corridors shall not exceed 30'	Y	
•	•	18.2.5.3 Common Path of Travel.	Common path of travel shall not exceed 100'	Y	
•	•	18.2.5.4* Intervening Rooms or Spaces.	every corridor shall provide access to not less than 2 approved exits (7.4-7.5) w/o passing through any intervening rooms or spaces other than corridors and lobbies	Y	
•	•	18.2.5.5 Two Means of Egress.			
•	•	18.2.5.5.1	Sleeping rooms of more than 1000sf shall have not less than 2 exit access doors, remotely located from each other.	Y	
•	•	18.2.5.5.2	Non-sleeping rooms of more than 2,500sf shall have not less than 2 remotely located exit access doors.	Y	
		18.2.5.6 Corridor Access.			
•	•	18.2.5.6.1*	Every habitable room shall have an exit access door leading directly to an exit access corridor except unless provided by 18.2.3.4.2-.4	Y	
•	•	18.2.5.6.2	Exit access from patient sleeping room with not less than 8 patient beds shall be permitted to pass through one intervening room to reach a exit access corridor	Y	
•	•	18.2.5.6.3	Rooms with doors to the outside on floor one shall not be req'd to have a door to an exit access corridor	Y	
•	•	18.2.5.6.4	Rooms within suites complying with 18.2.5.7 shall not be req'd to have an exit access door leading directly to and exit access corridor	Y	
		18.2.5.7 Suites.			
	•	18.2.5.7.1.1 Suite Permission.	Suites complying with 18.2.5.7 shall be permitted to be used to meet the corridor access reqmt of 18.2.5.6		
•	•	18.2.5.7.1.2* Suite Separation.	Suites shall be separated from the remainder of the bldg. and from other suites with walls and doors meeting the rqmts of 18.3.6.2 to 6.5	Y	
•	•	18.2.5.7.1.3 Suite Hazardous Contents Areas.	Intervening rooms shall no be hazardous area. Hazardous area within a suite shall be separated from the remainder of the suite per 18.3.2.1 unless provided by 18.2.5.7.1.3c	Y	
		18.2.5.7.2 Sleeping Suites.			
•	•	18.2.5.7.2.1 Sleeping Suite Arrangement.		NA	
•	•	A.18.2.5.7.2.1(A)	Occupants of habitable rooms within sleeping suites shall have an exit access to a corridor (18.3.6) or to a horizontal exit, directly from the suite.	NA	
•	•	18.2.5.7.2.2 Sleeping Suite Number of Means of Egress.	a. Sleeping rooms of more than 1000sf shall have not less than 2 remotely located exits. B.One means of egress shall be directly to s corridor complying with 18.3.6. c. floor suites requiring 2 means of egress, one means of egress from the suite shall be permitted to be into another suite.	NA	
•	•	18.2.5.7.2.3 Sleeping Suite Maximum Size.	b. sleeping suites shall not exceed 7500sf unless allowed by c. Sleeping suites greater than 7500sf and not exceeding 10,000sf shall be permitted if there is direct visual supervision and has total coverage by smoke detection system	NA	
•	•	18.2.5.7.2.4 Sleeping Suite Travel Distance.	A. travel distance between any point in a sleeping suite an exit access door from the suite shall not exceed 100', B. travel distance between any point in a sleeping room and an exit shall not exceed 200'.	NA	
•	•	18.2.5.7.3 Patient Care Non-Sleeping Suites.			
•	•	18.2.5.7.3.1 Patient Care Non-Sleeping Suite Arrangement.	Occupants of habitable rooms within non-habitable suites shall have exit access to a corridor or horizontal exit, directly from the suite.	NA	
•	•	18.2.5.7.3.2 Patient Care Non-Sleeping Suite Number of Means of Egress.	non-sleeping suites of more than 2500sf shall not have less than 2 exits access doors remotely located from each other	NA	

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Schematic	Design Development				
•	•	18.2.5.7.3.3 Patient Care Non-Sleeping Suite Maximum Size.	Non-sleeping suites shall not exceed 10,000sf	NA	
•	•	18.2.5.7.3.4 Patient Care Non-Sleeping Suite Travel Distance.	travel distance within a non-sleeping suite to an exit access door from the suite shall not exceed100'. Travel distance between any point in a non-sleeping suite and an exit shall not exceed 200'	NA	
•	•	18.2.5.7.4 Non-Patient-Care Suites. - travel distance shall be in accordance with the primary occupancy			
		18.2.6 Travel Distance to Exits.			
		18.2.6.1	travel distance shall be measured in accordance with 7.6	Y	
		7.6* Measurement of Travel Distance to Exits.			
•	•	7.6.1*	Measure along the centerline of the natural path of travel, starting from the most remote point subject to occupancy. Curve around corners or obstructions with a 12 inch clearance, terminate at the center of a doorway or the point at which the exit begins,	Y	
•	•	7.6.2	Where an exterior stair is allowed, the dimension is to be the leading edge of the noseing of the stair landing.	Y	
•	•	7.6.3*	Where open stairs or ramps are permitted as a path of path of travel to a req'd exit the distance shall include the travel on the stair or ramp from the end of the stair or ramp to an outside door	Y	
•	•	7.6.4	Exterior exit:	Y	
•	•	7.6.5	where measurements includes stairs the measurements shall be taken in the plane of the tread nosing.	Y	
•	•	18.2.6.2	travel distance shall comply with 18.2.6.2.1 to .4	Y	
•	•	18.2.6.2.1	The travel distance between any point in a room and the exit shall not exceed 200ft	Y	
•	•	18.2.6.2.3	The travel distance from any healthcare sleeping room and an exit access door in that room should not exceed 50ft	Y	
•	•	18.2.6.2.4	The travel distance within suites shall be in accordance with 18.2.5.7	Y	
•	•	18.2.7 Discharge from Exits	Discharge from exits shall be arranged in accordance with Section 7.7	Y	
		7.7 Discharge from Exits.			
•	•	7.7.1. Exit termination.	Exits shall terminate directly at a public way or exterior exit discharge	Y	
•	•	7.7.1.1	Yards, courts, open spaces or other portions of the exit discharge shall be of the required width and assemble to provide all occupants with a safe access to a public way.	Y	
•	•	7.7.2 Exit Discharge Through Interior Building Areas	1. not more than 50% of the required number of exits and not more than 50% of req'd egress capacity shall discharge through areas on any level of discharge except at permitted a.) NA – correctional. B.) NA existing	Y	
		7.7.3 Arrangement and Marking of Exit Discharge.			
•	•	7.7.3.1	Where more than one exit discharge is req'd exit discharge shall be arranged to meet remoteness criteria	Y	
•	•	7.5.1.3	remoteness must be provided in accordance with 7.5.1.3.1 to 7.5.1.3.7	Y	
•	•	7.5.1.3.1	Where more than one exit, exit access, or exit discharge is required from a building or portion thereof, such exits, exit accesses, or exit discharges shall be remotely located from each other and be arranged to minimize the possibility that more than one has the potential to be blocked by any one fire or other emergency condition.	Y	
•	•	7.5.1.3.2*	Where two exits, exit accesses, or exit discharges are required, they shall be located at a distance from one another not less than one-half the length of the maximum overall diagonal dimension of the building or area to be served, measured in a straight line between the nearest edge of the exits, exit accesses, or exit discharges, unless other-wise provided in 7.5.1.3.3 through 7.5.1.3.5.	Y	
•	•	7.5.1.3.3	In buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, the minimum separation distance between two exits, exit accesses, or exit discharges, measured in accordance with 7.5.1.3.2, shall be not less than one-third the length of the maximum overall diagonal dimension of the building or area to be served.	Y	
•	•	7.5.1.3.4*	In other than high-rise buildings, where exit enclosures are provided as the required exits specified in 7.5.1.3.2 or 7.5.1.3.3 and are interconnected by not less than a 1-hour fire resistance–rated corridor, exit separation shall be measured along the shortest line of travel within the corridor	NA	

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Schematic	Design Development				
•	•	7.5.1.3.5	In existing buildings, where more than one exit, exit access, or exit discharge is required, such exits, exit accesses, or exit discharges shall be exempt from the diagonal measurement separation distance criteria of 7.5.1.3.2 and 7.5.1.3.3, provided that such exits, exit accesses, or exit discharges are remotely located in accordance with 7.5.1.3.1	NA	
•	•	7.5.1.3.6	In other than existing buildings, where more than two exits, exit accesses, or exit discharges are required, at least two of the required exits, exit accesses, or exit discharges shall be arranged to comply with the minimum separation distance requirement.	Y	
•	•	7.5.1.3.7	The balance of the exits, exit accesses, or exit discharges specified in 7.5.1.3.6 shall be located so that, if one becomes blocked, the others are available.	NA	
•	•	7.7.3.4*	Stairs and ramps that continue more than one-half story beyond the level of discharge shall be provided with an approved means to prevent or dissuade occupants from traveling past the level of discharge during emergency building evacuation.	NA	
		18.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.			
		7.8 Illumination of Means of Egress.			
	•	7.8.1.1*	Illumination provided outside the building should be either a public way or a distance away from the building that is considered safe, whichever is closest to the building being evacuated		
	•	7.8.1.2.2	Unless prohibited automatic, motion sensor type lighting switches shall be permitted within the means of egress provided that such controllers comply with all the following; 1. The switch controllers are listed, 2. The switch controllers are equipped for fail safe operation and evaluation, 3.the illumination timers are set for a minimum of 15 minutes duration, 4.The motion sensor is activated by any occupant movement in the areas served by the lighting units, 5. the switch controller is activated by activation of the building fire alarm system, if permitted for the stair shaft and vestibule emergency lighting power supply		
		18.2.9 Emergency Lighting.			
		18.2.9.1	Emergency lighting shall be provided in accordance with Section 7.9		
	•	7.9.1.1*	Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 43 (2) Underground and limited access structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this code (4) Doors equipped with delayed-egress locks, (5) Stair shafts and vestibules of Smokeproof enclosures, for which the following also apply: (a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the (b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting.		
	•	7.9.1.2	For the purposes of 7.9.1.1, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of 7.9.1.1, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.		
•	•	18.2.9.2	Buildings equipped with or in patients require the use of, life support shall have emergency lighting equipment supplied by the life safety branch of the electrical system as described in NFPA 99	Y	
		18.2.10 Marking of Means of Egress.			
		18.2.10.1	Means of egress shall have signs in accordance with 7.10 unless otherwise permitted by 18.2.10.3 or 18.2.10.4	Y	
		7.10.1.2 Exits.			
•	•	7.10.1.2.1*	Exits, other than main exterior exit doors that obviously and clearly are identified as exits shall be marked by an approved sign that is readily visible from any direction of exit access.	Y	
•	•	7.10.1.2.2*	Horizontal components of egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of egress path is not obvious.	Y	
	•	7.10.1.3 Exit Door Tactile Signage.			
		7.10.1.5 Exit Access			
	•	7.10.1.5.1	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.		
	•	7.10.1.5.2*	New sign placement shall be such that no point in an exit access corridor is in excess of the rated viewing distance or 100ft whichever is less, from the nearest signs.		
	•	7.10.1.6* Floor Proximity Exit Signs.			
•	•	18.2.10.3	Where the path of egress travel is obvious, signs shall not be required at the gates in outside secured areas.	Y	
		18.2.10.4	Access to exits within rooms or sleeping suites shall not be required to be marked where staff is responsible for relocating or evacuating occupants.		
		18.2.10.5	Illuminating of required exit and directional signs in buildings with, or in which patients use, life support systems shall be provided as follows: Illumination shall be supplied by life safety. 1. Illumination shall be supplied by the life safety branch of the electrical systems as described by NFPA 99, 2. Self-luminous exit signs complying with 7.10.4 shall be permitted.		
		18.3 Protection			
	•	18.3.1 Protection of Vertical Openings.	Any vertical opening shall be enclosed or protected in accordance with Section 8.6 unless otherwise modified by 18.3.1.1 through 18.3.1.8 1.2 Unprotected vertical openings in accordance with 8.6.9.1 shall be permitted.. 1.2. Subparagraph 8.6.7.1.b, shall not apply to patient sleeping and treatment rooms, 1.4 Psych units (see code), 1.5 Unprotected openings in accordance with 8.6.6 shall not be permitted, 1.6 Reserved, 1.7. A door in stair enclosures shall be self-closing and shall normally kept in the closed position, unless other wise permitted by 18.3.1.8, 1.8 doors in stair enclosures shall be permitted to be held open under the conditions specified by 18.2.2.2.7 and 18.2.2.2.8		
		8.6 Vertical Openings.			

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Code Reference Category

Phase		Code Section	Component/Requirements			Complies	Comments
Schematic	Design Development						
•	•	**8.6.1 Floor Smoke Barriers.**	Every floor that separates stories in a building shall meet the following criteria, 1. It shall be constructed as a smoke barrier in accordance with section 8.5, 2. it shall be permitted to have openings as described by 8.6.6, 8.6.7, 8.6.9, or chapter 11-43			Y	
•	•	**8.6.2* Continuity.**	Openings through floors shall be enclosed with fire barrier walls, shall be continuous from floor to floor, or floor to roof, and shall be protected as appropriate for the resistance rating of the barrier.			Y	
•	•	**8.6.4 Shafts.**	Shafts that do not extend to the bottom or the top of building or structure shall comply with 8.6.4.1 4.2, 4.3			Y	
•	•	**8.6.4.1**	Shaft shall be enclosed at the lowest or highest level of the shaft, respectively, with construction in accordance w 8.6.5			Y	
•	•	**8.6.4.2**	Shafts shall be permitted to terminate in a room or space having a use related to the purpose of the shaft, provided			Y	
•	•	**8.6.4.3**	Shafts that do not extend to the bottom or top of the building or structure shall be permitted to be protected by approved fire dampers installed in accordance with there listing at the lowest or highest floor level as applicable, within the shaft enclosure			Y	
		8.6.5* Required Fire Resistance Rating. The minimum fire resistance rating for the enclosure of floor openings shall be as follows *(see 7.1.3.2.1 for enclosure of exits):*					
•	•	**8.6.5(1)**	Enclosures (connecting 4 or more stories)	Enclosures connecting 4 or more stories in new construction - 2 hour fire barrier.		Y	
		8.6.5(2)	Enclosures (connecting 3 or fewer stories)	1hour		Y	
		8.6.5(3)	Existing enclosures in existing buildings	NA			
		7.1.3.2.1(2)	Exit Stair enclosures (connecting 4 or more stories)	The separation specified in 7.1.3.2.1(1), other than an existing separation, shall be supported by construction having not less than 1 hour fire resistance rating		Y	
		7.1.3.2.1(1)	Exit Stair enclosures (connecting 3 or fewer stories)	The separation shall have a minimum 1-hour fire resistance rating where the exit connects three or fewer stories		Y	
		7.2.6.2	Exit passageways	Exit passageways used as exit components shall conform to the general requirements of 7.1 and to the special requirements of 7.2.6		Y	
		7.2.6.2	Horizontal exit wall	An exit passageway shall be separated from other parts of the building as specified in 7.1.3.2 and the following alternatives shall be permitted: 1) fire windows in accordance with 8.3.3 shall be permitted to be installed in the separation in a bldg. protected throughout by and approved, supervised automatic sprinkler system in accordance with 9.7. 2) existing (NA)		Y	
•	•	**Table 8.3.4.2**	**Minimum Fire Protection Ratings for Opening Protectives in Fire Resistance-Rated Assemblies & Fire Rated Glazing Markings**				
			Component	**Walls & Partitions**	**Fire Doors Assemblies**		
			Elevator Hoistway	2 hrs.	1 1/2 hours	Y	
				1.5 hrs.	1 hour	Y	
				1/2 hr.	1/3 hour	Y	
			Elevator Lobby	1 hr.	1 hr.	Y	
			Vertical shafts, including stairways, exits, and refuse chutes	2 hrs.	1 1/2 hours	Y	
			Replacement panels in existing vertical shafts	1/2 hr.	1/3 hr.	NA	
			Fire Barriers	3 hr.	3 hr.	NA	
				2 hr.	1 1/2 hr.	Y	
				1	3/4 hrs.	Y	
				1/2 hr.	1/2 hr.	Y	
			Horizontal exits	2	1 1/2 hr.	Y	

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Schematic	Design Development						
			Horizontal exits served by bridges Between buildings	2	3/4 hrs.	NA	
			Exit access corridors	1 hr.	1/3 hrs.	Y	
				1/2 hrs.	1/3 hrs.	Y	
			Smoke Barriers	1	1/3 hrs.	Y	
			Smoke Partitions	1/2 hr.	1/3 hrs.	Y	
	•	8.6.6 Communicating Space. An unenclosed floor opening forming a communicating space between floors shall be permitted provided that the following are met: 1)the communicating space does not connect more than 3 continuous stories. 2) the lowest or next to lowest level within the communicating space is at street level. 3) The entire floor area of the communication space is open and unobstructed, such that fire in any part of the space will be readily obvious to the occupants of the space prior or the time it becomes an occupant hazard. 4). the communicating space is separated from the remainder of the building by fire barriers not less than 1-hr fire resistance, unless the following are met a) in buildings protected throughout by an approved automatic sprinkler system (9.7) a smoke barrier (8.5) shall be permitted to serve as the separation by 8.6.6.(4)				Y	
	•	**8.6.7* Atriums.**	Unless prohibited by 11-43 an atrium shall be permitted provided that the following conditions are met: 1) the atrium is separated from the adjacent spaces by fire barriers with not less than a 1 - hour fire resistance, with opening protectives for corridor walls unless one off the following is met: a) existing NA, Any number of levels shall be permitted to open directly to the atrium without enclosure based on the results of the engineering analysis req'd in 8.6.7(5). c). glass walls and inoperable windows shall be permitted in lieu of the fire barrier where all the following are met:				
			i. Automatic sprinklers are spaced along both sides of the glass wall and the inoperable windows at an interval of 6ft. Ii. The sprinklers are located at a distance form the glass wall not to exceed 12 in. and arranged so the entire surface of the glass is wetted upon activation of the sprinklers. iii. the glass wall is tempered, wired or laminated glass held in place by a gasket system that allows the glass framing system to deflect without breaking the glass before the sprinklers are activated. iv. Sprinklers are not required on the atrium side of a glass wall where there is no walk-way or other floor surface on the atrium side above the main floor level. v. doors in the glass are of glass or other material that resists the passage of smoke. vi. Doors in the glass wall are self closing on detection of smoke. vii. the glass is continuous vertically, without horizontal mullions, window treatments or other obstruction that would interfere with wetting the glass surface.			Y	
•	•	**8.6.8 Two-Story Openings with Partial Enclosure,** A vertical opening serving as other than an exit enclosure, connecting only two adjacent stories and piercing only one floor, shall be permitted to open to one or two stories. .			Y	
		8.6.9 Convenience Openings.					
•	•	**8.6.9.1**	Unenclosed vertical openings not concealed within the building construction shall be permitted (see 1-6)			NA	
•	•	**8.6.9.2**	Unenclosed vertical openings created by a convenience stair shall be permitted (see 1-3)			NA	
•	•	**8.6.9.3**	Convenience stairs shall be permitted to be unenclosed in large open areas such as atriums and shopping malls.			NA	
•	•	**8.6.9.4**	Elevator cars should be enclosed as follows: 1. Where there are three or fewer elevator cars in the building, they shall be allowed to be located in the same hoistway enclosure. 2. where four elevator cars in the building, they shall be divided in such a manner that not less than two separate hoistway enclosures area provided. 3. where there are more than four elevators cars and dumbwaiters in the building, the number of elevator cars located within a single hoistway enclosure shall not exceed four.			Y	
•	•	**8.6.9.6**	Escalators - see code.			NA	
		8.6.9.7	Escalators - see code			NA	
		8.6.10 Mezzanines.				NA	
		8.6.10.2 Area Limitations.					
•	•	**8.6.10.2.1**	The aggregate area of mezzanines located within a room, other than those located in special purpose industrial occupancies shall not exceed one-third the open area of the room in which the mezzanine is located. Enclosed space shall not be included in a determination of the size of the room in which the mezzanine is located			NA	
•	•	**8.6.10.3 Openness.**	The openness shall comply with 8.6.10.3.1 and .2			NA	
•	•	**8.6.10.3.1**	All portions of a mezzanine, other than walls not more than 42" high, columns, and posts, shall be open to and unobstructed from the room in which the mezzanine is located, unless the occupant load of the aggregate area of the enclosed space does not exceed 10.			NA	
•	•	**8.6.10.3.2**	A mezzanine having two or more means of egress shall not be required to open into the room in which it is located if not less than one of the means of egress provides direct access from the enclosed area to an exit at the mezzanine level.			NA	
•	•	**18.3.1.2**	Unprotected vertical openings in accordance with 8.6.9.1 shall be permitted.			Y	
•	•	**18.3.1.3**	8.6.7. 1b, shall not apply to patient sleeping areas and treatment rooms.				
•	•	**18.3.1.4**	Multilevel patient sleeping areas in psych facilities (see code)			NA	
•	•	**18.3.1.5**	Unprotected openings in accordance with 8.6.6 shall not be permitted.			NA	
•	•	**18.3.1.7**	A door in a stair enclosure shall be self closing and shall normally be kept closed unless otherwise permitted by 18.3.1.8			Y	

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Schematic	Design Development					
•	•	18.3.1.8	Doors in stair enclosures shall be permitted to be held open under the conditions specified by 18.2.2.2.7 and 18.2.2.2.8 (.7) maybe open only by automatic release device that complies with 7.2.1.8.2. the automatic sprinkler and fire alarm system shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. (.8) where doors in stair enclosures are held open by automatic release device as permitted by 18.2.2.2.7, initiated of a door closing action on any level shall cause all doors at all levels in the stair enclosure to close.		Y	
		18.3.2 Protection from Hazards.				
•	•	**18.3.2.1* Hazardous Areas.**			Y	
•	•	Table 18.3.2.1 Hazardous Area Protection	**Hazardous Area Description**	**Protection/Separation†**	Y	
			Boiler and fuel-fired heater rooms	1 hr.	Y	
			Central/bulk laundries larger than 100 ft2 (9.3 m2)	1 hr.	Y	
			Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	1 hr. See 18.3.6.3.11	Y	
			Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, *Standard for Health Care Facilities*	1 hr.	Y	
			Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard	1 hr.	Y	
			Physical plant maintenance shops	1 hr.	Y	
			Rooms with soiled linen in volume exceeding 64 gal (242 L)	1 hr.	Y	
			Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) and storing combustible material	1 hr./See 18.3.6.3.11	Y	
			Storage rooms larger than 100 ft2 (9.3 m2) and storing combustible material	1 hr.	Y	
			Rooms with collected trash in volume exceeding 64 gal (242 L)	1 hr.	Y	
		8.7 Special Hazard Protection				
•	•	8.7.1.1*	Protection from any area having a degree of hazard greater than that normal to general occupancy of the building structure shall be provided by one of the following. 1) enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with 8.3. (2.)protecting the area with automatic extinguishing systems in accordance with 9.7. (3.) applying both 8.7.1.1 (1) and (2) where the hazard is severe or where otherwise specified by chapters 11-43.		Y	
•	•	8.7.1.2	In new construction where protection is provided with automatic extinguishing systems without fire resistive separation the space protected shall be enclosed with smoke partitions in accordance with 8.4 unless otherwise permitted by one of the following conditions: (1) mercantile, (2) industrial, (3) detentions		Y	
•	•	8.7.3.2*	No storage or handling of flammable liquids or gases shall be permitted in any location where such storage would jeoperdize egress from the structure, unless permitted by 8.7.3.1.		Y	
	•	**8.7.4 Laboratories.**				
	•	8.7.4.2	Laboratories in healthcare occupancies and medical dental offices shall comply with NFPA 99			
	•	NFPA 99: Laboratories in health care occupancies	NFPA 99 States - Laboratories using chemicals shall comply with NFPA 45 Standard on Fire Protection for Laboratories Using Chemicals, unless otherwise modified by other provisionos of the code			
	•	**8.7.5* Hyperbaric Facilities. Must comply with NFPA 99 chapter 20**			NA	
	•	18.3.2.2* Laboratories.	Laboratories employing quantities of flammable, combustible or hazardous, or hazardsous materials that are considered as a severe hazard shall be protected in accordance with NFPA 99			
	•	**18.3.2.3 Anesthetizing Locations:** Anesthetizing locations shall be protected by NFPA 99				
	•	**18.3.2.4 Medical Gas.** Medical gas storage and administration shall be protected in accordance with NFPA 99				
		18.3.2.5 Cooking Facilities:				
	•	18.3.2.5.1	Cooking facilities shall be protected in accordance with 9.2.3 unless otherwise permitted in 18.3.2.5.2, 3, and 4			
	•	18.3.2.5.2*	Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be proetced in accordance with 9.2.3 and presense of equipment shall not require the area to be protected as a hazardous area.			

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Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
	•	18.3.2.5.3*	Within a smoke compartment, where residential cooking equipment is used to prepare meals for 30 or fewer people, one cooking facility shall be permitted to be open to the corridor, provided that all of the following are met (1) the portion of the healthcare facility served by the cooking is limited to 30 beds, and is separated from other portions of the facility by smoke barrier constructed in accordance with 18.3.7.3, 18.3.7.6 and 18.7.3.8. (2) the cooktop or range is equiped a range hood of a width at least equal to the width of thte cooking surface or other grease collecting and cleaning capability. (3) The hood system has a minimum airflow of 500cfm,except as otherwise provided in 18.3.2.6(6). (6) One dispenser complying with 18.3.2.6(2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 18.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30. Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based handrub solution shall not exceed 95 percent alcohol content by volume.		
	•	18.3.2.5.4*	The hood systems that are not ducted to the exterior additionally have charcoal filters to rmeove smoke and odors.		
	•	18.3.2.5.5*	The cooktop or range is either a) proetcted by a fire suppression system in UL 300, b) a manual release of the extinguishing system is provided in accordance with NFPA 96, c) an interlock is provided to turn off all sources of fuel and electric power to the cooktop or range when the supression system is activated.		
	•	18.3.2.6* Alcohol-Based Hand-Rub Dispensers.	(1)Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft. (2) The maximum individual dispenser fluid capacity shall be as follows: (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms. (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. and shall be limited to Level 1 aerosols. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (5)Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal or 1135 oz , shall be in use outside of a storage cabinet in a single smoke compartment,		
		18.3.2.7 Heliports.	Roof top Helipads shall comply with NFPA 418	NA	
		18.3.3 Interior Finish.			
	•	18.3.3.1 General.	Interior floor finish shall comply with Section 10.2.		
	•	18.3.3.2* Interior Wall and Ceiling Finish			
	•	18.3.3.2.1	Walls and ceilings shall be permitted to be Class A or Class B interior finishes in individual rooms having a capacity not exceeding 4 persons		
	•	18.3.3.2.2	Corridors wall finish not exceeding 48" in height that is restricted to the lower half of the wall shall be permitted to be Class A or B		
		18.3.3.3 Interior Floor Finish.			
	•	18.3.3.3.1	Interior floor finish shall comply with Section 10.2.		
	•	18.3.3.3.2	Interior floor finish in exit enclosures and exit access corridors and spaces not separated from them by walls complying with 18.3.6 shall be Class I or Class II.		
	•	18.3.3.3.3	Interior floor finish shall comply with 10.2.7.1 or 10.2.7.2, as applicable.		
		Interior wall finish			
	•		Permitted throughout, if Class A or B and compliant with 10.2.		
	•	Table A.10.2.2	Maximum smoke developed		
		Table A.10.2.2	Maximum flame spread (for vertical exits; access corridors; other exits, rooms, and enclosed spaces; and textile wall coverings)		
			Textiles (wall and ceiling finish)		
	•	18.3.4 Detection, Alarm, and Communications Systems.			
	•	18.3.4.1 General.	Healthcare occupancies shall be provided with a fire alarm system in accordance with Section 9.6		
		9.6.2 Signal Initiation.			
	•	9.6.2.1	Initiation shall be by manual means in accordance with 9.6.2 and means of any required sprinkler system waterflow alarms, detection devices, or detection systems, unless otherwise permitted by 18.3.4.2.2.		
	•	9.6.2.2	Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses control stations or other continously attended staff location, provided manual fire alarm box are visible and continously accessible, travel distances required by 9.6.2.5 are not exceeded		
	•	9.6.2.3	For new alarm system installations, the manual fire alarm box shall be located within 60 in. of exit doorways.		
	•	9.6.2.4	Manual fire alarm boxes shall be mounted on both sides of grouped openings over 40 ft (12.2 m) in width, and within 60 in. (1525 mm) of each side of the opening.		
	•	9.6.2.5*	Additional manual fire alarm boxes shall be located so that, on any given floor in any part of the building, no horizontal distance on that floor exceeding 200 ft shall need to be traversed to reach a manual fire alarm box.		
	•	9.6.2.6*	For fire alarm systems using automatic fire detection or waterflow detection devices to initiate the fire alarm system in accordance with Chapters 11 through 43, not less than one manual fire alarm box shall be provided to initiate a fire alarm signal. The manual fire alarm box shall be located where required by the authority having jurisdiction.		

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Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
		9.6.2.10 Smoke Alarms.			
	•	9.6.2.10.1.1	Where required by another section of this Code, single-station and multiple-station smoke alarms shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code, unless otherwise provided in 9.6.2.10.1.2, 9.6.2.10.1.3, or 9.6.2.10.1.4.		
	•	9.6.2.10.1.2*	The installation of smoke alarms in sleeping rooms shall be required where required by Chapters 11 through 43.		
	•	9.6.2.10.1.3*	The interconnection of smoke alarms shall apply only to new construction as provided in 9.6.2.10.3		
	•	9.6.2.10.1.4	System smoke detectors in accordance with NFPA 72, National Fire Alarm and Signaling Code, and ar-ranged to function in the same manner as single-station or multiple-station smoke alarms shall be permitted in lieu of smoke alarms.		
	•	9.6.2.10.2	Smoke alarms, other than existing battery- operated smoke alarms as permitted by other sections of this Code, shall be powered in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code.		
		9.6.3.4	Where permitted by Chapters 11 through 43, a positivealarm sequence shall be permitted, provided that it is in accordance with NFPA 72, National Fire Alarm and Signaling Code.		
	•	9.6.3.5	Unless otherwise provided in 9.6.3.5.1 through 9.6.3.5.8, notification signals for occupants to evacuate shall be audible, and visible signals in accordance with NFPA 72, National Fire Alarm and Signaling Code, and ICC/ANSI A117.1, American National Standard for Accessible and Usable		
	•	9.6.3.5.3	Exisiting Systems	NA	
		9.6.5 Fire Safety Functions.			
	•	9.6.5.1	Fire safety functions shall be installed in accordance with the requirements of NFPA 72, National Fire Alarm and Signaling Code		
	•	9.6.5.2	Where required by another section of this Code, the following functions shall be actuated (1) Release of hold-open devices for doors or other opening protectives (2) Stairwell or elevator shaft pressurization (3) Smoke management or smoke control systems (4) Unlocking of doors (5) Elevator recall and shutdown (6) HVAC shutdown		
	•	18.3.4.2* Initiation.	It is not the intent of this Code to require single-station smoke detectors that might be required by local codes to be connected to or to initiate the building fire alarm system.		
	•	18.3.4.2.1	Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems, unless otherwise permitted by 18.3.4.2.2.		
	•	18.3.4.2.2	Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses control stations or other continuously attended staff location, provided that both of the following criteria are met: (1) Such manual fire alarm boxes are visible and continuously accessible. (2) Travel distances required by 9.6.2.5 are not exceeded.		
	•	18.3.4.3 Notification.	Positive alarm sequence in accordance with 9.6.3.4 shall be permitted.		
	•	18.3.4.3.1 Occupant Notification	Occupant notification shall be accomplished automatically in accordance with 9.6.3, unless otherwise modified by the following: (1) Paragraph 9.6.3.2.3 shall not be permitted to be used. (2)* In lieu of audible alarm signals, visible alarm- indicating appliances shall be permitted to be used in critical care areas.		
		18.3.4.3.2 Emergency Forces Notification.			
		18.3.4.3.2.1			
		18.3.4.3.3 Annunciation and Annunciation Zoning.			
	•	18.3.4.3.3.1	Annunciation and annunciation zoning shall be provided in accordance with 9.6.7, unless otherwise permitted by 18.3.4.3.3.2 or 18.3.4.3.3.3.		
	•	18.3.4.3.3.2	The alarm zone shall be permitted to coincide with the permitted area for smoke compartments.		
	•	18.3.4.3.3.3	The provision of 9.6.7.4.3, which permits sprinkler system waterflow to be annunciated as a single building zone, shall be prohibited.		
	•	18.3.4.4 Fire Safety Functions.	Operation of any activating device in the required fire alarm system shall be arranged to accomplish automatically any control functions to be performed by that device.		
	•	**18.3.4.5 Detection.**			
	•	18.3.4.5.1 General.	Detection systems, where required, shall be in accordance with Section 9.6		
	•	18.3.4.5.2 Detection in Spaces Open to Corridors.	See 18.3.6.1. Corridor Separation. Corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5 (see also 18.2.5.4), unless other-wise permitted by one of the following: (1) Spaces shall be permitted to be unlimited in area and open to the corridor, provided that all of the following criteria are met (a)* The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses™ station or similar space. (d) The space does not obstruct access to required exits. (2) Waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met: (a) The aggregate waiting area in each smoke compartment does not exceed 600 ft 2 2). (b) Each area is protected by an electrically supervised automatic smoke etection system in accordance with 18.3.4, or each area is arranged and located to allow direct supervision by the facility staff from a nursing station or similar space. (c) The area does not obstruct access to required exits. (3)* This requirement shall not apply to spaces for nurses stations. (4) Gift shops not exceeding 500 ft 2 (46.4 m 2) shall be permitted to be open to the corridor or lobby.(5)Not applicable (6) Cooking facilities in accordance with 18.3.2.5.3 shall be permitted to be open to the corridor		

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Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
	•	18.3.4.5.3* Nursing Homes.	—	NA	
		18.3.5 Extinguishment Requirements.			
•	•	18.3.5.1*	In areas where the replenishment of water supplies is not immediately available from on-site sources, al-lemate provisions for the water-fill rate requirements of NFPA 13, Standard for the Installation of Sprinkler Systems, rooms, a fire and its life-threatening byproducts can be reduced, thereby allowing the defend-in-place concept to continue. The difficulty in maintaining the proper integrity of life safety elements has been considered, and it has been judged that the probability of a sprinkler system operating as designed is equal to or greater than other life safety features.	Y	
		9.7 Automatic Sprinklers and other Extinguishing Equipment			
	•	9.7.1.1*	Each automatic sprinkler system required by an-other section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems		
	•	9.7.1.2	Sprinkler piping serving not more than six sprin-klers for any isolated hazardous area shall be permitted to be connected directly to a domestic water supply system having a capacity sufficient to provide 0.15 gpm/ft 2 (6.1 mm/min) throughout the entire enclosed area. An indicating shutoff valve, supervised in accordance with 9.7.2 or NFPA 13, Standard for the Installation of Sprinkler Systems, shall be installed in an accessible, visible location between the sprinklers and the connection to the domestic water supply.		
	•	9.7.1.3*	In areas protected by automatic sprinklers, automatic heat-detection devices required by other sections of this Code shall not be required.		
	•	9.7.1.4	Automatic sprinkler systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code that apply to required systems		
		9.7.3 Other Automatic Extinguishing Equipment.			
		9.7.3.1	In any occupancy where the character of the fuel for fire is such that extinguishment or control of fire is accomplished by a type of automatic extinguishing system in lieu of an automatic sprinkler system, such system shall be installed in accordance with the appropriate standard, as determined in accordance with Table 9.7.3.		
		9.7.3.2	If the extinguishing system is installed in lieu of a required, supervised automatic sprinkler system, the activation of the extinguishing system shall activate the building fire alarm system, where provided. The actuation of an extinguishing system that is not installed in lieu of a required, supervised automatic sprinkler system shall be indicated at the building fire alarm system, where provided.		
	•	18.3.5.5	In Type I and Type II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection without causing a building to be classified as nonsprinklered		
	•	18.3.5.6*	Listed quick-response or listed residential sprinklers shall be used throughout smoke compartments containing patient sleeping rooms.		
	•	18.3.5.10*	Sprinklers shall not be required in clothes closets of patient sleeping rooms in hospitals where the area of the closet does not exceed 6 ft 2 (0.55 m 2), provided that the distance from the sprinkler in the patient sleeping room to the back wall of the closet does not exceed the maximum distance permitted by NFPA 13, Standard for the Installation of Sprinkler Systems.		
•	•	18.3.5.11*	Sprinklers in areas where cubicle curtains are installed shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	Y	
•	•	18.3.5.12	Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1	Y	
	•	**9.7.4 Manual Extinguishing Equipment.**			
	•	9.7.4.1*	Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguish		
•	•	9.7.4.2	Where required by the provisions of another section of this Code, standpipe and hose systems shall be provided in accordance with NFPA 14, Standard for the Installation of Standpipe and Hose Systems. Where standpipe and hose systems are installed in combination with automatic sprinkler systems, installation shall be in accordance with the appropriate provisions established by NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 14, Standard for the Installation of Standpipe and Hose Systems.	Y	
•	•	18.3.6 Corridors.		Y	
•	•	18.3.6.1 Corridor Separation.	Corridors shall be separated from all other areas by partitions complying with 18.3.6.2 through 18.3.6.5. (1) Spaces shall be permitted to be unlimited in area and open to the corridor, provided that all of the following criteria are met. a)* The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses™ station or similar space. (d) The space does not obstruct access to required exits. (2) Waiting areas shall be permitted to be open to the corridor, provided that all of the following criteria are met:(a) The aggregate waiting area in each smoke compartment does not exceed 600 ft 2. (b) Each area is protected by an electrically supervised automatic smoke detection system in accordance with 18.3.4, or each area is arranged and located to allow direct supervision by the facility staff from a nursing station or similar space. (c) The area does not obstruct access to required exits. (3)* This requirement shall not apply to spaces for nurses stations. (4) Gift shops not exceeding 500 ft 2 shall be permitted to be open to the corridor or lobby.(5) Cooking facilities in accordance with 18.3.2.5.3 shall be permitted to be open to the corridor.	Y	
•	•	18.3.6.2* Construction of Corridor Walls	It is the intent of the Code that there be no required fire resistance or area limitations for vision panels in corridor walls and doors.	Y	
	•	18.3.6.2.1	Corridor walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke.		

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Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
	•	18.3.6.2.2	No fire resistance rating shall be required for corridor walls.		
	•	18.3.6.2.3*	Corridor walls shall form a barrier to limit the transfer of smoke.		
•		18.3.6.3* Corridor Doors.		Y	
	•	18.3.6.3.1*	Doors protecting corridor openings shall be constructed to resist the passage of smoke, and the following also shall apply: (1) Compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, shall not be required. (2) A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. (3) Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible material shall not be required to be constructed		
	•	18.3.6.3.5	Doors shall be self-latching and provided with positive latching hardware		
		18.3.6.3.6	Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to meet the latching requirements of 18.3.6.3.5.		
	•	18.3.6.3.7	Powered doors that comply with the require-ments of 7.2.1.9 shall not be required to meet the latching requirements of 18.3.6.3.5, provided that both of the following criteria are met: (1) The door is equipped with a means for keeping the door closed that is acceptable to the authority having jurisdiction. (2) The device used is capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of a swinging door and applied in any direction to a sliding or folding door, whether or not power is applied.		
	•	18.3.6.3.8	Corridor doors utilizing an inactive leaf shall have automatic flush bolts on the inactive leaf to provide positive latching.		
		18.3.6.3.9 Roller Latches.		NA	
	•	18.3.6.3.9.1	Roller latches shall be prohibited, except as permitted by 18.3.6.3.9.2	NA	
	•	18.3.6.3.9.2	Roller latches shall be permitted for acute psychiatric settings where patient special clinical needs require specialized protective measures for their safety, providedthat the roller latches are capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door	NA	
	•	18.3.6.3.10*	Doors shall not be held open by devices other than those that release when the door is pushed or pulled	NA	
	•	18.3.6.3.11	Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas	NA	
	•	18.3.6.3.12*	Nonrated, factory- or field-applied protective plates, unlimited in height, shall be permitted	NA	
	•	18.3.6.3.13	Dutch doors shall be permitted where they conform to 18.3.6.3 and meet all of the following criteria: (1) Both the upper leaf and lower leaf are equipped with a latching device. (2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel. (3) Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	NA	
		18.3.6.4 Transfer Grilles.		NA	
	•	18.3.6.4.1	Transfer grilles, regardless of whether they are protected by fusible link Œoperated dampers, shall not be used in corridor walls or doors, unless otherwise permitted by 18.3.6.4.2.	NA	
	•	18.3.6.4.2	Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall be permitted to have ventilating louvers or to be undercut.	NA	
		18.3.6.5 Openings.			
	•	18.3.6.5.1*	In other than smoke compartments containing patient bedrooms, miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 80 in.2 . (2) The openings are installed at or below half the distance from the floor to the room ceiling.	Y	
		18.3.7* Subdivision of Building Spaces.			
•	•	18.3.7.1	Buildings containing health care facilities shall be subdivided by smoke barriers (see 18.2.4.3), unless otherwise permitted by 18.3.7.2, as follows: (1) To divide every story used by inpatients for sleeping or treatment into not less than two smoke compartments (2) To divide every story having an occupant load of 50 or more persons, regardless of use, into not less than two smoke compartments (3) To limit the size of each smoke compartment required by 18.3.7.1(1) and (2) to an area not exceeding 22,500 ft 2 , unless the area is an atrium separated in accordance with 8.6.7, in which case no limitation in size is required (4) To limit the travel distance from any point to reach a door in the required smoke barrier to a distance	Y	
•	•	18.3.7.2	The smoke barrier subdivision requirement of 18.3.7.1 shall not apply to any of the following: (1) Stories that do not contain a health care occupancy located directly above the health care occupancy (2) Areas that do not contain a health care occupancy and that are separated from the health care occupancy by a fire barrier complying with 7.2.4.3 (3) Stories that do not contain a health care occupancy and that are more than one story below the health care occupancy (4) Stories located directly below a health care occupancy where such stories house mechanical equipment only and are separated from the story above by 2-hour fire resistance rated construction (5) Open-air parking structures protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7	Y	
	•	18.3.7.3	Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)* Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems.	Y	
	•	18.3.7.5	Accumulation space shall be provided in accordance with 18.3.7.5.1 and 18.3.7.5.2.	Y	
•	•	18.3.7.5.1	Not less than 30 net ft 2 per patient in a hospital or nursing home, or not less than 15 net ft2 per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier.	Y	
•	•	18.3.7.5.2	On stories not housing bedridden or litterborne patients, not less than 6 net ft 2 (0.56 net m2) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments.	Y	

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Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
	•	18.3.7.6*	Doors in smoke barriers shall be substantial doors, such as 1 3/ 4 in. thick, solid-bonded wood-core doors, or shall be of construction that resists fire for a minimum of 20 minutes, and shall meet the following requirements: (1) Nonrated factory- or field-applied protective plates, unlimited in height, shall be permitted. (2) Cross-corridor openings in smoke barriers shall be protected by a pair of swinging doors or a horizontal sliding door complying with 7.2.1.14, unless otherwise permitted by 18.3.7.7. (3) The swinging doors addressed by 18.3.7.6 (2) shall be arranged so that each door swings in a direction opposite from the other. (4) The minimum clear width for swinging doors shall be as follows: (a) Hospitals and nursing homes 41 1/ 2 in. (b) Psychiatric hospitals and limited care facilities 32 in. (5) The minimum clear width opening for horizontal sliding doors shall be as follows: (a) Hospitals and nursing homes 6 ft 11 in. (b) Psychiatric hospitals and limited care facilities 64 in. (6) The clearance under the bottom of smoke barrier doors shall not exceed 3/4 in.	Y	
•	•	18.3.7.7	Cross-corridor openings in smoke barriers that are not in required means of egress from a health care space shall be permitted to be protected by a single-leaf door.	Y	
	•	18.3.7.8*	Smoke barriers might include walls having door openings other than cross-corridor doors. There is no restriction in the Code regarding which doors or how many doors form part of a smoke barrier. For example, doors from the corridor to individual rooms are permitted to form part of a smoke barrier. Split astragals (i.e., astragals installed on both door leaves) are also considered astragals	Y	
	•	18.3.7.9*	Vision panels consisting of fire-rated glazing in approved frames shall be provided in each cross-corridor swinging door and at each cross-corridor horizontal-sliding door in a smoke barrier.	Y	
	•	18.3.7.10	Vision panels in doors in smoke barriers, if provided, shall be of fire-rated glazing in approved frames	Y	
	•	**18.4 Special Provisions.**			
	•	18.4.1 Limited Access Buildings.	Limited access buildings or limited access portions of buildings shall not be used for patient sleeping rooms and shall comply with Section 11.7.	NA	
		Limited Access or Underground Buildings. See Section 11.7.			
•	•	11.7.3.1.1 One-Story Structures.	One-story structures shall have finished ground level doors or emergency access openings in accordance with 11.7.3.2 on two sides of the building, spaced not more than 125 ft (38 m) apart on the exterior walls.	NA	
•	•	11.7.3.1.2 Multiple-Story Structures	Multiple-story structures shall comply with the following: (1) The story at the finished ground level shall comply with 11.7.3.1.1. (2) Other stories shall be provided with emergency access openings in accordance with 11.7.3.2 on two sides of the building, spaced not more than 30 ft apart.	NA	
•	•	11.7.3.2*	Emergency access openings shall consist of a window, panel, or similar opening that complies with all of the following: (1) The opening shall have dimensions of not less than 22 in. (560 mm) in width and 24 in. (610 mm) in height and shall be unobstructed to allow for ventilation and rescue operations from the exterior. (2) The bottom of the opening shall be not more than 44 in. (1120 mm) above the floor. (3) The opening shall be readily identifiable from both the exterior and interior. (4) The opening shall be readily openable from both the exterior and interior.	NA	
•	•	11.7.3.3	A structure or portion of a structure shall not be considered an underground structure if the story is provided, on not less than two sides, with not less than 20 ft 2 of emergency access opening located entirely above the adjoining finished ground level in each 50 lineal ft of exterior enclosing wall area.	NA	
	•	11.7.3.4	Underground and limited access structures, and all areas and floor levels traversed in traveling to the exit discharge, shall be protected by an approved, supervised automatic sprinkler system in accordance with Section9.7, unless such structures meet one of the following criteria:(1) They have an occupant load of 50 or fewer persons in new underground or limited access portions of the structure. (2) They have an occupant load of 100 or fewer persons in existing underground or limited access portions of the structure. The structure is a one-story underground or limited access structure that is permitted to have a single exit per Chapters 12 through 43, with a common path of travel not greater than 50 ft	NA	
	•	11.7.3.5	Underground or limited access portions of structures and all areas traversed in traveling to the exit discharge, other than in one- and two-family dwellings, shall be provided with emergency lighting in accordance with Section 7.9.	NA	
•	•	**18.4.2 High-Rise Buildings.** High-rise buildings shall comply with Section 11.8.			
•	•	**11.8.2 Means of Egress Requirements.**			
	•	**11.8.2.2 Elevator Lobby Exit Access Door Locking.** In other than newly constructed high-rise buildings, locks in accordance with 7.2.1.6.3 shall be permitted.			
		11.8.3 Extinguishing Requirements.			
	•	11.8.3.1*	High-rise buildings shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. A sprinkler control valve and a waterflow device shall be provided for each floor.		
	•	11.8.3.2	High-rise buildings shall be protected throughout by a Class I standpipe system in accordance with Section 9.7.		
		11.8.4 Detection, Alarm, and Communications Systems.			
	•	11.8.4.1*	A fire alarm system using an approved emergency voice/alarm communication system shall be installed in ac-cordance with Section 9.6.		
	•	11.8.4.2	Two-way telephone service shall be in accordance with 11.8.4.2.1 and 11.8.4.2.2.		
	•	11.8.4.2.1	Two-way telephone communication service shall be provided for fire department use. This system shall be in accordance with NFPA 72, National Fire Alarm and Signaling Code. The communications system shall operate between the emergency command center and every elevator car, every elevator lobby, and each floor level of exit stairs.		
	•	11.8.4.2.2	The requirement of 11.8.4.2.1 shall not apply where the fire department radio system is approved as an equivalent system		

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements		Complies	Comments
Schematic	Design Development					
		11.8.5 Emergency Lighting and Standby Power.				
	•	11.8.5.1	Emergency lighting in accordance with Section 7.9 shall be provided.			
	•	11.8.5.2	Requirements for standby power shall be as specified in 11.8.5.2.1 through 11.8.5.2.4.			
	•	11.8.5.2.1	Type 60, Class 1, Level 1, standby power in accordance with Article 701 of NFPA 70, National Electrical Code, and NFPA 110, Standard for Emergency and Standby Power Systems, shall be provided.			
	•	11.8.5.2.2	The standby power system shall have a capacity and rating sufficient to supply all equipment required to be connected by 11.8.5.2.4.			
	•	11.8.5.2.3	Selective load pickup and load shedding shall be permitted in accordance with NFPA 70, National Electrical Code.			
	•	11.8.5.2.4	The standby power system shall be connected to the following: (1) Electric fire pump (2) Jockey pump, except as otherwise provided in 40.4.2 for special-purpose industrial occupancies (3) Air compressor serving dry-pipe and pre-action systems,except as Otherwise provided in 40.4.2 for special-purpose industrial occupancies (4) Emergency command center equipment and lighting (5) Not less than one elevator serving all floors, with standby power transferable to any elevator (6) Mechanical equipment for smokeproof enclosures (7) Mechanical equipment required to conform with the requirements of Section 9.3			
	•	**18.4.3 Nonsprinklered Existing Smoke Compartment Rehabilitation.**			NA	
		18.4.3.1* General.			NA	
•	•	**18.4.3.2 Minimum Construction Requirements (Nonsprinklered Smoke Compartment Rehabilitation).**			NA	
•	•	**18.4.3.3 Capacity of Means of Egress (Nonsprinklered Smoke Compartment Rehabilitation).**			NA	
		18.4.3.4 Travel Distance (Nonsprinklered Smoke Compartment Rehabilitation).				
•	•	18.4.3.4.1			NA	
•	•	18.4.3.4.2			NA	
		18.4.3.5 Hazardous Area Protection (Nonsprinklered Smoke Compartment Rehabilitation).			NA	
•	•	Table 18.4.3.5 Hazardous Area Protection (Nonsprinklered Buildings)	**Hazardous Area Description**	**Protection†/Separation**	NA	
			Boiler and fuel-fired heater rooms		NA	
			Central/bulk laundries larger than 100 ft2 (9.3 m2)		NA	
			Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard		NA	
			Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, *Standard for Health Care Facilities*		NA	
			Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard		NA	
			Physical plant maintenance shops		NA	
			Soiled linen rooms		NA	
			Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) and storing combustible material		NA	
			Storage rooms larger than 100 ft2 (9.3 m2) and storing combustible material		NA	
			Trash collection rooms		NA	
		18.4.3.6 Interior Finish (Nonsprinklered Smoke Compartment Rehabilitation).				
		18.4.3.6.1 General.	General. Interior finish within the modification area shall be in accordance with Section 10.2.		NA	
	•	18.4.3.6.2 Interior Wall and Ceiling Finish	Interior Wall and Ceiling Finish. Newly installed interior wall and ceiling finish materials complying with Section 10.2 shall be permitted throughout nonsprinklered smoke compartments if the materials are Class A, except as otherwise permitted in 18.4.3.6.2.1 or 18.4.3.6.2.2.		NA	
	•	18.4.3.6.2.1	Walls and ceilings shall be permitted to have Class A or Class B interior finish in individual rooms having a capacity not exceeding four persons		NA	
	•	18.4.3.6.2.2	Corridor wall finish not exceeding 48 in. in height and restricted to the lower half of the wall shall be permitted to be Class A or Class B		NA	
		18.4.3.6.3 Interior Floor Finish.				
	•	18.4.3.6.3.1	Newly installed interior floor finish shall comply with Section 10.2.		Y	
	•	18.4.3.6.3.2	The requirements for newly installed interior floor finish in exit enclosures and corridors not separated from them by walls complying with 19.3.5.7 shall be as follows: (1) Unrestricted in smoke compartments protected through-out by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7 (2) Not less than Class I in smoke compartments not protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7		Y	

REQUIRED LIFE SAFETY CODE REQUIREMENTS FOR HOSPITALS & NURSING HOMES

Code Reference Category

Phase		Code Section	Component/Requirements	Complies	Comments
Schematic	Design Development				
		18.4.3.7	Corridors (Nonsprinklered Smoke Compartment Rehabilitation).	NA	
		18.4.3.7.1 Construction of Corridor Walls.			
•	•	18.4.3.7.1.1	Where the smoke compartment being modified is not protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, corridor walls shall comply with all of the following, as modified by 18.4.3.7.1.2: (1) They shall have a minimum 1 2-hour fire resistance rating. (2) They shall be continuous from the floor to the underside of the floor or roof deck above. (3) They shall resist the passage of smoke.	Y	
•	•	18.4.3.7.1.2	The requirements of 18.4.3.7.1.1 shall be permitted to be modified for conditions permitted by 19.3.6.1(3) and (4) and 19.3.6.1(6) through (8).	Y	
		18.4.3.7.2 Corridor Doors.			
	•	18.4.3.7.2.1	18.4.3.7.2.1 Where the smoke compartment being modified is not protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, all of the following shall apply: (1) Doors protecting corridor openings shall be constructed	Y	
	•	18.4.3.7.2.2	Door-closing devices shall be required on doors in corridor wall openings serving smoke barriers or enclosures of exits, hazardous contents areas, or vertical openings.	Y	
•	•	18.4.3.8	Subdivision of Building Space (Nonsprinklered Smoke Compartment Rehabilitation).	NA	
	•	**18.5 Building Services.**			
	•	18.5.1 Utilities.			
	•	18.5.1.1	Utilities shall comply with the provisions of Section 9.1.		
	•	18.5.1.2	Power for alarms, emergency communications systems, and illumination of generator set locations shall be in accordance with the essential electrical system requirements of NFPA 99, Health Care Facilities Code.		
	•	18.5.1.3	Any health care occupancy, as indicated in 18.1.1.1.4, that normally uses life-support devices shall have electrical systems designed and installed in accordance with NFPA 99, Health Care Facilities Code, unless the facility uses life-support equipment for emergency purposes only.		
		18.5.2 Heating, Ventilating, and Air-Conditioning.			
	•	18.5.2.1	Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturers specifications, unless otherwise modified by 18.5.2.2		
	•	18.5.2.2	Any heating device, other than a central heating plant, shall be designed and installed so that combustibleances, and the following requirements shall also apply: (1) If fuel-fired, such heating devices shall comply with the following: (a) They shall be chimney connected or vent connected. (b) They shall take air for combustion directly from outside. (c) They shall be designed and installed to provide for complete separation of the combustion system from the atmosphere of the occupied area. (2) Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperatures or ignition failure.		
	•	18.5.2.3	The requirements of 18.5.2.2 shall not apply where otherwise permitted by the following: (1) Approved, suspended unit heaters shall be permitted in locations other than means of egress and patient sleeping areas, provided that both of the following criteria are met: (a) Such heaters are located high enough to be out of the reach of persons using the area. (b) Such heaters are equipped with the safety features required by 18.5.2.2.		
		18.5.4 Rubbish Chutes, Incinerators, and Laundry Chutes.			
	•	18.5.4.1	Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2.		
	•	18.5.4.2	The fire resistance rating of chute charging rooms shall not be required to exceed 1 hour.		
	•	18.5.4.3	Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with Section 9.7. (See Section 9.5.)		
	•	18.5.4.4	Any rubbish chute shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with Section 8.7.		

Mohawk Occupancy Load Calculations

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Certificate of Need Submittal

November 1, 2017

Floor	Use Group/Department	Area SF	Occupancy Load Factor SF	Occupant Load	Provided Exit Capacity	Number of Stairs	Number of exit doors	Number of Horizontal exits
1	Assembly - Auditorium/Conf ctr	5,019	15	335				
1	Assembly - chapel	802	15	53				
1	Assembly - Conf/Lounge	1,400	15	93				
1	Assembly - Dietary conf	283	15	19				
1	Assembly - Dining and Servery	4,094	15	273				
1	Assembly - ED Imaging Lounge	948	15	63				
1	Assembly - ED waiting	802	15	53				
1	assembly - Imaging Lounge/Multipurpose	1,680	15	112				
1	Assembly - Lab Conf	289	15	19				
1	Kitchen - Kitchen	10,155	100	102				
1	Locker - Lab	614	50	12				
1	Lockers - Facilities Lockers	1,113	50	22				
1	Lockers - Imaging	792	50	16				
1	Lockers-Dietary	800	50	16				
1	Office -- CAC	313	100	3				
1	Office - Dietary	2,632	100	26				
1	Office - ED	4,978	100	50				
1	Office - Imaging	1,833	100	18				
1	office - Lab	10,551	100	106				
1	Office - Lab/Morgue	1,215	100	12				
1	Office - Security	459	100	5				
1	Office - Warehouse	311	100	3				
1	Office -Security/toilets	2,126	100	21				
1	Retail -Gift Shop	716	15	48				
1	Storage - Chute Collection	307	300	1				
1	Storage - Dock	1,420	300	5				
1	Storage - gift shop	262	300	1				
1	Storage - Lab	904	300	3				
1	Storage -Chairs	636	300	2				
1	Storage EVS/Stat Stor.	2,441	300	8				
1	Storage -- Linen -- Annex	2,516	300	8				
1	Office - Maintenance Shops	3,573	100	36				
1	Inpatient Treatment - Imaging/ED	91,889	240	383				
1	Total	157,873		1,928	3,333	4	8	7
2	Assembly - Admin Conf Room	244	15	16				
2	Assembly - Boardroom	1,528	15	102				
2	Assembly - Pharmacy	179	15	198				
2	Assembly - Surg Lounge	677	15	45				
2	Assembly -Conf Training Endo/Surg	341	15	23				
2	Assembly - Family Lounge	3,428	15	229				
2	Assembly -Surgery Recept and Entry	4,253	15	284				
2	Lockers - Surg/cardio	2,127	50	43				
2	Lockers -Pharmacy	173	50	3				
2	Office - Endo, Surg, Educ	1,238	100	12				
2	Office -- General	1,727	100	17				
2	Office - Off. Hotel and kitchenette	542	100	5				
2	Office -- Pharmacy	1,939	100	19				
2	Office --Clinical eng and Transportation	3,197	100	32				
2	Office- Quality Prof, Admin, GME	10,093	100	101				
2	Storage -- Disaster Water Storage	522	300	2				
2	Storage -Central Sterile	9,414	300	31				
2	Storage -Pharmacy	1,558	300	5				
2	Storage -Temp. Beds	532	300	2				
2	Treatment -- Surgery/Cardio/Endo	105,094	240	438				
2	Total	43,712		1,169	1,643	5	4	4
3	Assembly - Conf	333	15	22				
3	Assembly - East Staff Lounge	345	15	23				
3	Assembly - Floor lobby	719	15	48				
3	Assembly -East Family Lounge	719	15	48				
3	Assembly -West Family Lounge	328	15	22				
3	Assembly-- West Staff Lounge	452	15	30				
3	Inpatient Treatment - Resp Therapy	1,968	120	16				

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Floor	Use Group/Department	Area SF	Occupancy Load Factor SF	Occupant Load	Provided Exit Capacity	Number of Stairs	Number of exit doors	Number of Horizontal exits
3	Lockers - ICU	909	50	18				
3	Office -- Nursing Support	3,308	100	33				
3	Office Command Center	1,466	100	15				
3	Office IC/CM - Case Mgmt.	1,325	100	13				
3	Office -Masonic Lab	1,560	100	16				
3	Inpatient Sleeping - Critical Care	45,434	120	379				
3	Total	58,366		683	909	3	--	2
4	Assembly - Family Lounge	293	15	20				
4	Assembly - Floor lounge	444	15	30				
4	Assembly - Labor lounge	293	15	20				
4	Assembly - Multipurpose Nursery	288	15	19				
4	Inpatient Sleeping - LDR	11,493	120	96				
4	Inpatient Sleeping - NICU Intermed	5,827	120	49				
4	Inpatient Treatment - Delivery	4,445	240	19				
4	Lockers	295	50	6				
4	Lockers	309	50	6				
4	Storage - Switchgear rooms	6,000	300	20				
4	Storage - Equip	215	300	1				
4	Inpatient Sleeping - Post Partum/ Antepartum/Nursery	28,964	120	241				
4	Total	58,366		525	909	3	--	2
5	Assembly - family lounge	765	15	51				
5	Assembly - conf	464	15	31				
5	Assembly - Lounge	503	15	34				
5	Inpatient Treatment - Dialysis	3,631	240	15				
5	Locker - lockers	548	50	11				
5	Office -Clinical	240	100	2				
5	Office - Staff wrkstn	273	100	3				
5	Office - wkstns	258	100	3				
5	Storage - Eq. Storage	250	300	1				
5	Storage - Eq. Storage	154	300	1				
5	Inpatient Sleeping	41,586	120	347				
5	Total	48,672		382	909	3	--	2
6	Assembly - Family Lounge	777	15	52				
6	Assembly - Conf Rm	488	15	33				
6	Assembly - Staff Lounge	484	15	32				
6	Inpatient Treatment - PT/OT	1,792	120	15				
6	Locker - Lockers	542	50	11				
6	Storage - equip Stor.	322	300	1				
6	Storage - equip Stor.	305	300	1				
6	Inpatient Sleeping	43,962	120	366				
6	Total	48,672		511	909	3	--	2
7	Assembly - Conf	485	15	32				
7	Assembly - Family Lounge	836	15	56				
7	Assembly - Staff Lounge	495	15	33				
7	Inpatient treatment - PT	969	240	4				
7	Lockers - Staff Lockers	548	50	11				
7	Office - QA/QC	1,170	100	12				
7	Office - Staff Wrkstns	296	100	3				
7	Office - Wkstns	242	100	2				
7	Storage - equip Stor.	326	300	1				
7	Storage - equip Stor.	318	300	1				
7	Inpatient Sleeping	42,986	120	358				
7	Total	48,671		514	909	3	--	2
8	Assembly - Conf	485	15	32				
8	Assembly - Family Lounge	412	15	27				
8	Assembly - Staff Lounge	463	15	31				
8	Locker -Lockers	548	50	11				
8	Office - Clin	233	100	2				
8	Office - Qual. Control	1,170	100	12				
8	Office -- Staff Wrkstn	282	100	3				
8	Office -- Staff Wrkstn	253	100	3				

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Mohawk Occupancy Load Calculations

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Floor	Use Group/Department	Area SF	Occupancy Load Factor SF	Occupant Load	Provided Exit Capacity	Number of Stairs	Number of exit doors	Number of Horizontal exits
8	Storage - Equip Stor.	313	300	1				
8	Storage - Equip Stor.	312	300	1				
8	Storage - Equipment	297	300	1				
8	Treatment -- PT/OT	1,170	120	10				
8	Inpatient sleeping	42,733	120	356				
8	**Total**	48,671		490	909	3	--	2
9	Assembly - Dining, Group, Activity	1,235	15	82				
9	Assembly - Dining, Group, Activity	1,354	15	90				
9	Assembly - Staff & Family Lounge and Conf	819	15	55				
9	Office -- Offices	1,017	100	10				
9	Outdoor Courtyard - East	1,254	15	84				
9	Outdoor Courtyard - West	1,254	15	84				
9	Inpatient Sleeping	34,081	120	284	372	3	--	1
9	**Total**	41,014	295	689	372	3	--	1
Roof	Mech/Elec - Elevator Penthouse/machine room and Electric Rooms	6,575	300	22	165	1		
Roof	**Total**	6,575		22	165	1	--	--
GEP								
1	Normal Electric, Boilers Domestic Water, Lobby, fire pump, , med gas equip	11,656	300	39	612		2	
2	Emergency Electric, Boilers, Domestic hot water	11,656	300	39	612		2	
3	Generators	5,828	300	19	612		2	

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Behavioral Health Products and Systems

The following is the initial selection of materials, products and systems chosen for the Behavioral Health Nursing Unit on the 9th floor of the patient tower and the BH portion of the Emergency Department. The selections will continue to be refined during the Design Development Phase and we will review those changes with NYS Office of Mental Health. Initial selections are highlighted.

Seclusion Room Standards

- Securetech
  - Multi-Point Deadbolt Mortise Lock
    - Select lock function from options:
      - USL-K3-IHB2 (slam)
        - Latches upon closure
        - Key only projects/retracts bolts and latch
        - Exterior side of door has freely rotating lever/pull
        - Interior cylinder optional
      - UML-K3-IHB2:
        - Does not latch upon closure
        - Key only projects/retracts bolts
        - Exterior side of door has freely rotating lever/pull
        - Interior cylinder optional
- Marathon Engineering Corporation
  - Gold Medal Safety Padding – Resinous coating is scuff-resistant and long lasting. Padding material is uniform and smooth with no cracks or open seams

Anti-Barricade Strategies

- Norva Plastics, Inc. Patient toilet/shower rooms
  - Toilet Partitions, Sentinel Event Reduction (SER) Door with Sloped Top
    - Use only in suite or gang bathrooms. Never use in bathrooms shared between two bedrooms. Expanded PVC door can be painted with Lexan paint to match desired color scheme. To be used with roller latch hardware.
- Rixson
  - 340 Center Hunt Top Pivot
    - Center hung, non-handed walking beam type hinge. Fully concealed when door is closed
  - 117-3/4 Center Hung Pivot Set
    - Fully concealed, parallel arm, non-handed. Can be coordinated with a concealed overhead closer.
- Accurate Lock & Hardware
  - Keyed Emergency Stop ADL-CEK, ADL-OEK
    - Double lip strikes with keyed emergency stop. Designed to restrict and protect against unauthorized out swinging door. Key locks emergency stop into projected position.

Behavioral Health Products and Systems

Division 07 Sealants

- Security Sealants, Tamper Resistant
- Master Builders Solutions
    - MasterSeal CR 195 – one component, moisture curing, aliphatic, non-sag, polyurethane sealant.
- Sika Corporation
    - Sikaflex 11FC – one component, gun grade moisture cure polyurethane based elastomeric sealant

Division 08 Openings

- Door Hardware, Door Top Sensors
    - Stanley Security Solutions/Grainger Industrial Supply
        - SEDA (Stanley emergency Door Alarms) / Lisa (Ligature-Resistant Door Alarm)
            - A pressure activated switch, mounted on the face of a door, provides notification when a foreign object passes over the door and a downward pressure is applied. Notification is sent to a console indicating where a response is required.
- Door Hardware, Continuous Hinges
    - Architectural Builders Hardware MFG. Inc
        - A500HT
            - Stainless steel pin and barrel, full mortise, full concealed edge mount with hospital tips.
    - MARKAR Architectural Products
        - FM300-HT
            - Edge mount stainless steel
- Door Hardware, Locks & Handles
    - Accurate Lock & Hardware
        - Crescent handle (CH) & 9100 Mortise Lockset
    - Sargent
        - BHW Trim (Mortise)
            - The BHW style door trim is not a traditional lever design and can be safely used in a high risk environment.
- Door Hardware, Lever Handles
    - Best Access systems/Grainger Industrial Supply
        - Ligature Resistant Lever Set SPSL Series - LISL/LISE (Mortise)
            - The ligature resistant lever handle "freewheels" in both directions on both sides of the door whether the door is locked or unlocked. Proprietary finish resists looping by earbuds.
    - TownSteel Architectural Hardware Manufacturing
        - Ligature Resistant Lever Set TRXL Series (Cylindrical)

- Whether locked or unlocked, this lever set "free wheels" up and down on both the keyed and non-keyed sides of the door. This "freewheeling" action is standard on double cylinder functions.

- Door Hardware, Stops
  - Kingsway Group
    - KG182 Wall Mounted Door Stop
      - Solid stainless steel surround with high pressure rubber dome. Security screws pass through the rubber part to ensure it can't be removed.
    - KG183 Large Rubber Wall Mounted Door Stop
      - Solid high pressure domed rubber stop
- Door Hardware, Closers
  - Rixson
    - 51 Series Offset Floor Closer
      - Fully concealed, single acting, handed. For use with top pivot hinge. Note: fully concealed closers have no readily visible or accessible components. Note: floor closers require special preparation.
    - 700 Series Overhead Concealed Closer
      - Double-acting, non-handed closer concealed in door frame head. For use with bottom pivot hinge. Note: fully concealed closers have no readily visible or accessible components.
  - Sargent
    - 268/269 Series Overhead Concealed Closer
      - Fully concealed closer body in frame head. Fully concealed track in door. Track arm is only visible when door is open.
- Glazing, Exterior Windows, Polycarbonate Glazing
  - Sabic Innovative Plastics
  - Sheffield Plastics Inc.
- Glazing, Exterior Windows, Laminated Safety Glazing
  - Oldcastle Building Envelope
    - For use as outermost surface of exterior windows.
- Glazing, Interior Windows, Non-Rated
  - Sabic Innovative Plastics
    - Lexan SL-4855 Polycarbonate Glazing
      - 3/8" or ½" thick with Marguard II-UV coating. Specify MR15 with a 15 year warranty. Install in hollow metal frames with a 1" continuous edge bite.
  - Oldcastle Building Envelope
    - ArmorProtect Plyus 161000 Laminated Security Glazing
      - 3/8" thick. 3M film is scratchable and may be removed from the laminated glass panel and new film installed by trained maintenance staff. Curing time for the film installation is two weeks minimum. Maintenance staff should be advised to keep spare stock that is fully cured to eliminate down time. Install in

hollow metal frames with a 1" continuous edge bite if dry glazed or ½" continuous edge bite if silicone glazed.

- Sheffield Plastics Inc.
  - Makrolon 15 Polycarbonate Glazing
    - ½" thick. Use with NYS-OMH 15 year warranty. Install in hollow metal frames with a 1" continuous edge bite.
- 3M
  - Ultra S600 Film
    - 3M film is scratchable. When damaged, it may be removed from the glass panel and new film installed by trained maintenance staff. Curing time for the film installation is two weeks minimum. Exact curing time should be verified with the manufacturer. Maintenance staff should be advised to keep spare stock that is fully cured to eliminate down time.
- DuPont
  - Spallshield CPET Film
    - Hard coated PET film helps stop the showering of small glass particles (called "spall") that can occur when conventional glass fails.

- Glazing, Interior Windows, Fire Rated
  - Technical Glass Products
    - FireLite PLUS
      - 5/16" thick laminated, polished, fire rated, and impact safety rated glazing. Listed for use in doors, sidelites, and transoms with fire rating requirements ranging from 20 minutes to 3 hours.
  - SaftiFirst
    - SuperLite Fire Rated Glazing
      - ¼" monolithic safety and positive pressure fire rated glazing. For use in wood, hollow metal, aluminum or an equally fire rated framing systems.
- Glazing, Observation Mirrors
  - Plaskolite, Inc.
    - See-thru Mirror
      - Two way observation polycarbonate mirror, 0.236" thick minimum. Product is semi-transparent.
- Access Doors
  - Cendrex
    - PF Series Fire Rated Access doors

Division 09 Finishes

- Ceiling Assemblies, General
  - OMH Ceiling Assembly 1: 1 layer ½" or 5/8" drywall with metal framing/suspension system.

Behavioral Health Products and Systems

- OMH Ceiling Assembly 2: 1 layer 5/8" very high impact (VH1) abuse resistant drywall with metal framing/suspension system.
- OMH Ceiling Assembly 3: ¾" suspended acoustic tile on intermediate duty suspension system.

- Wall Base
  - Custom Wood Base
    - Custom Designed Wood Base
      - Solid ¾" hardwood with eased or bullnose top and corners. Provide tamper resistant sealant at joint between floor and base, base and wall surface.
  - Johnsonite
    - Millwork Contoured Wall Base
      - Thermoplastic solid rubber base. Various profiles range in height from 2 1/2" to 6" high, ¼" to 3/8" thick
    - SCC-XX-A Cove Cap Moulding
      - Vinyl cove cap moulding accessory for 1/8" cove base material.
  - Flexco
    - Health Design Wall Base
      - Thermoplastic rubber base tapers from 1/8" thick to adjacent floor thickness. All seams are heat welded.

Division 10 Specialties

- Shower & Privacy Curtains
  - InPro Corporation
    - Clickeze Ultra Cubicle Track
      - Extruded aluminum track provides heavy duty strength. For use with Clickeze accessories.
    - Clickeze Whisper Cubicle track
      - Extruded PVC track allows for noise reduction during curtain movement. For use with Clickeze accessories.
    - Clickeze Pop Out Carrier
      - Hook on carrier releases, allowing the curtain to fall, and disengages at approximately 10 lbs of pressure. For use with both Clickeze Ultra and Whisper Curtain Tracks.
  - Construction Specialties
    - Breakaway Carrier #975P
      - Hook on carrier is designed to pop out of the axle when approximately 22 lbs of pressure is applied to the hook, and can be reused.
  - Architex
    - Rx Privacy Curtain
      - Made with 100% Avora polyester, style #5/2019717-1000
  - Arc/Com
    - Options Curtain

- Customizable textiles to increase durability and fire resistance. Stain repellent.
- Standard Textile
  - Perfect Panel Curtains
    - Note: ganging of multiple snaps along the curtain track can create a ligature point.

- Closet Rods, clothes & Towel Hooks
  - Kingsway Group
    - KG180 Coat Hook
      - Stainless steel surround. Rubber hook releases under downward applies load.
  - Norva Plastics, Inc
    - Polyethylene hook
  - American Specialties, Inc.
    - 123 Square Clothes Hook
  - Oddball Industries
    - SP-6 Clothes/Towel Hook
    - SP-6! Clothes/Towel Hook with adjustable tension release
- Handrails & Grab Bars, General
- Handrails
  - Construction Specialties, Inc.
    - HRB-20CMHLN Acrovyn 4000 Handrail
      - Handrail/bumper guard with psychiatric continuous bracket enclosure, to address safety issues for patients eliminating the gap between the wall and handrail. Meets safety codes with ADA and ANSI compliance.
  - Pawling Corp.
    - BR-400CS Series handrail
      - 6-1/4" high vinyl handrail. Suicide resistant design to minimize leverage and looping with radius corners. Aluminum tube with laser cut 1/8" aluminum closure plates. Continuous secure bracket.
- Toilet Accessories, Grab Bars
  - Kingsway Group
    - Grab Rail KG250/KG251
      - Horizontal and vertical mounting. Painted extruded aluminum, 600 mm long. Provide sealant at the full perimeter to prevent end to end looping.
  - Northwest Specialty Hardware
    - NW Security Bar
  - Cascade Specialty Hardware
    - Safebar Grab Bar
  - Willoughby Industries, Inc.
    - AntiSuicide Grab Bar Modified with End Caps ASGB-X-ODD-MOD

- Specialty self-draining end caps are available from manufacturers and should be specified. Provide sealant at the full perimeter to prevent end to end looping.
- Whitehall Manufacturing
  - 1109-1 24" Ligature Resistant Grab Bar
- American Specialties, Inc.
  - 0165 Grab Bar with Drain Holes

- Toilet Accessories, Soap Dispensers
  - GoJo Industries
    - LTX Behavioral Health Dispensing System
      - Stainless steel soap dispensing unit specifically designed for behavioral health environments with delayed time output, inhibited access interior, and sloped and rounded exterior.
  - Kingsway Group
    - KG06 Liquid soap
      - Stainless steel surface mounted liquid soap dispenser. Soap automatically dispenses from this battery operated unit.
- Toilet Accessories, Paper Towel Holders & Dispensers
  - American Specialties, Inc.
    - 0412 Recessed Shelf
      - 22 gauge type 304 stainless steel with a No. 4 satin finish install with tamper resistant fasteners. Provide tamper resistant sealant at flange perimeter.
  - Whitehall Manufacturing
    - Best-Care WH1820FA Recessed Shelf
      - 16 gauge type 304 stainless steel with a satin in finish or powder coated white finish. Install with tamper resistant fasters. Provide tamper resistant sealant at flange perimeter.
- Toilet Accessories, Toilet Tissue Holders & Dispensers
  - American Specialties, Inc.
    - 110-13 Recessed Toilet Paper Roll Holder (front mounted)
      - 14 gauge type 304 stainless steel with satin finish
  - Bradley corporation
    - SA12 Recessed Toilet Tissue Roll Holder (front mounted)
      - 16 gauge type 304 stainless steel with a satin finish
  - Whitehall Manufacturing
    - 1840-FA Recessed Toilet Paper Roll Holder (front mounted)
- Toilet Accessories, Mirrors
  - Sabic Innovative Plastics
  - Royal Adhesives & Sealants
    - Frameless Polycarbonate Wall to Wall Mirror
  - Behavioral Safety Products
    - Ligature Resistant Stainless Steel Framed Mirror FM 160
      - Polished stainless steel mirror with #8 finish 18x24 hardwood frame

Behavioral Health Products and Systems

- American Specialties, Inc.
  - 0600 Angle Frame Mirror
- Window Treatments
  - InPro Corp.
    - Clickeze Ultra Cubicle Track
      - Extruded aluminum track provides heavy duty strength. For use with Clickeze accessories.
    - Clickeze Whisper Cubicle Track
      - Extruded PVC track allows for noise reduction during curtain movement. For use with Clickeze accessories.
  - Construction Specialties
    - Breakaway Carrier #975P
      - Hook on carrier is designed to pop out of the axle when approximately 22 lbs. of pressure is applied to the hook, and can be reused.
  - Imperial Fastener Company
    - IFC-69 Break-a-way Track & IFC-79 Break-A-Way Track
      - The IFC-69 ceiling mounted and IFC-79 wall mounted tracks are used with "safety tabs" that attach to box pleated window draperies or shower curtains.
  - WebbShade
    - WebbLok Shades
      - The IFC-69 ceiling mounted and IFC-79 wall mounted tracks are used with "safety tabs" that attach to box pleated window draperies or shower curtains.
  - Securing Hospitals
    - 845-S86 SafeSupport SR Window Shades
      - The 845-S86 wall mounted tracks are used with "safety tabs" that attach to box pleated window draperies or shower curtains.
- Artwork Frames
  - Behavioral Safety Products
    - Ligature Resistant Art Frame #AF550
- Cabinet Hardware
  - Accurate Lock & Hardware
    - CP-CAB Crescent Cabinet Pull
  - Doug Mockett & Co.
    - DP74C Radiused Finger Grip Pull
- Signage
  - 2/90 Sign Systems
    - Custom Patient Safe signage
      - Thermoplastic frame, fully adhered to thermoplastic back panel. Clear polycarbonate insert lens. Mechanically fasten to blocking with tamper resistant screws.
  - King Architecture Products
    - KMS Series Signage

Behavioral Health Products and Systems

- Tamper resistant locking: top, bottom, panel profiles and copy covers are held in place by manufacturer's standard concealed locking pin. Specify two locking pins per sign.

- Fire Extinguisher Cabinets
  - Larsen's Manufacturing Co.,
    - Architectural Series 2712 Fire Extinguisher Cabinet
      - Stainless steel tub with a continuous hinge. Specify fully recessed cabinet with flat trim, or semi-recessed cabinet with rolled edge trim & door w/o handle. Specify mortise lock with keyed cylinder.
      - DECS 2409-R4 Fire Extinguisher
  - Activar Construction Products Group
    - JL Industries Cosmopolitan Series Fire Extinguisher Cabinet

Division 21 Fire Suppression

- Sprinklers
  - Tyco Fire Protection Products
    - Raven Institutional Sprinklers
      - Pendant and horizontal sidewall heads. Standard, quick response & extended coverage. Stainless steel escutcheons available for installation in wet or damp areas.
    - Viking Group
      - VK410 Pendant & VK412 Sidewall Institutional Flush Sprinklers

Division 22 Plumbing

- Lavatory Assemblies
  - NYS-OMH Standard Lavatory Assembly
    - Custom solid surface lavatory with integral sink bowl & pipe enclosure.
      - Niche mounted solid surface vanity counter with integral solid surface sink bowl and deck mounted behavioral safety products ligature resistant sensor faucet #SF370. Removable integral solid surface pipe enclosure below mounted with tamper resistant fasteners.
  - Whitehall Manufacturing
    - WH3775 Solid Surface Wall-Hung Lavatory
      - Shown with fully accessible powder-coated stainless steel pipe enclosure, deck-mounted dual temp push button conical faucet. Available without overflow hole.
- Lavatory Basins
  - American Standard
    - Rondolyn Countertop Sink
      - High gloss stain resistant vitreous china sink. Specify without overflow.
    - Mezzo Countertop Sink

- Self-rimming fine fire clay semi-countertop sink. Specify without overflow.

- Lavatory Pipe Enclosures
  - IPS Corp
    - Truebro Lav Shield Model @2018
      - Cautions: pipe enclosure will conceal exposed plumbing piping, but is used with wall mounted lavatory that poses looping opportunity. Careful scribing to underside of lavatory is required for a proper fit and sealant joint.
- Lavatory Faucets
  - Behavioral Safety Products
    - Ligature Resistant Sensor Faucet #SF370
      - Deck mounted faucet is a single temperature faucet without controls. It may be specified as hard-wired or with a 4 year battery.
    - Ligature Resistant Metering Faucet #SF380
      - Deck mounted faucet is a dual temperature faucet with push button controls.
- Lavatory Grid Strainers
  - Oddball Industries
    - SP-11-GDK Grid Drain Kit
      - Effective drainage is achieved with the included air vent. Air introduction valve may not meet all local codes.
    - Typical Grid Strainer & Drain
      - Note: typical grid strainers are rejected because ligature can be created by threading a ligature item through the perforations and be hung over the lavatory or vanity edge.
- Toilets
  - Behavioral Safety Products
    - Ligature Resistant Toilet #TN690
      - Floor mounted, back spud, 1.6 gpm siphon jet with integral seat.
    - Intersan
      - CWC150-AST Toilet
      - CWC156-AST Toilet
        - Solid surface back to wall toilet with non-moving integral seat
  - Whitehall Manufacturing
    - WH2142 Toilet
      - Floor mounted, powder coated stainless steel toilet with ligature resistant ABS toilet seat.
- Toilet Flushometers
  - NYS-OMH Standard Concealed Flush Valve Assembly
    - Concealed flush valve assembly with remote infrared sensor.
- Shower Heads
  - Chicago Faucets

Behavioral Health Products and Systems

        - 621-CP Institutional Shower Head
    - Oddball Industries
        - SP-7 Shower Head
        - SP-7TF Tub Filler
    - Moen
        - M-Dura 8292
    - Speakman Company
        - S-2460-AF Shower Head
    - Behavioral Safety Products
        - SH330 Shower Head
- Shower Controls & Activators
    - Armstrong International
        - Brainwave Water Temp Control
            - Stainless steel face plate is to be specified for all NYS-OMH facilities. Provide tamper resistant sealant at perimeter of plate touchless on/off flow control. Touchless temp adjustment. Cautions: control buttons are plastic and have the potential to be damaged. Product can be specified with a plastic cover by facilities other than NYS-OMH but should be used with caution due to the increased potential to be damaged.
    - Behavioral Safety Products
        - Ligature Resistant Shower Valve, Handle & Escutcheon Plate #SV230
    - Interesan
        - 50140 Ligature Resistant Shower Diverter

Division 23 HVAC

- Diffusers & Grilles
    - Behavioral Safety Products
        - Ligature Resistant Exhaust/Supply Grille #EG450
            - Designed to replace existing grilles that are not ligature resistant. 11 gauge aluminum with 1/8" round holes.
    - Carnes company
        - Model RSPA51 Suicide Deterrent Security R&G
    - Titus
        - SG-SD Maximum Security Suicide Deterrent Grille
            - Face and sleeve are 3/16" hot rolled steel. Hole pattern is 3/16" round holes on staggered 9/32" centers. 2x2x3/16" steel angles are provided as standard in four loose pieces for field welding. Mounting sleeve is for installation in CMU walls only. Specify with 1" flange. Caution: perforated diffusers grilles and radiator covers pose a particular risk as they can be easily looped by a think shoelace or similar object.

Behavioral Health Products and Systems

Division 26 Electrical

- Receptacles & GFCI/AFCI Circuit Breakers
  - Leviton
    - 8200-SG Series Tamper Resistant Receptacles
- Wall Plates
  - Hubbell
    - Nylon Wall Plates
  - Legrand
    - Unbreakable Nylon Wall Plates
  - Leviton
    - Unbreakable Nylon Wall Plates
- Light Fixtures, Lenses
  - Behavioral Safety Products
    - Impact Resistant Prismatic Polycarbonate Light Lenses #PL640
      - Lenses are to be installed in an existing fixture frame. If the existing frame will not adequately secure the lens, it is recommended to install the tamper resistant fasteners through the frame and lens.
- Light Fixtures, Interior, General, Recessed
  - Cooper lighting
    - Fail Safe FRM LED Linear
    - Fail Safe ENV LED 2x2
  - Kenall Manufacturing
    - MedMaster Behavioral Health MMAC 14, MMAC22 & MMAC24
    - Mighty Mac RAC, RCB, RCC, RCD Series
- Light Fixtures, Interior, Task Lighting
  - Cooper Lighting
    - FFLD6A 6" Vandal Resistant LED Downlight – Flush Lens
  - Kenall Manufacturing
    - Millenium HADL Series Downlight LED
    - Stratalume UC Series, UCSL
- Light Fixtures, Interior, Night Lighting
  - Cooper Lighting
    - Fail-safe MCL, MLN & MSN Night Lights
  - Kenall Manufacturing
    - MedMaster SoftStep Contour Steplight, MCSL
- Light Fixtures, Exit Signage
  - Kenall manufacturing
    - Millennium Metrex METSR Series Exit Light (Recessed)
  - Philips Chloride
    - 60 Series Max All Purpose Exit

Behavioral Health Products and Systems

Division 28 Electronic Safety & Security

- Fire Alarm Components, Notification Devices
  - Tyco SimplexGrinnell
    - TruAlert Addressable Notification Appliances, Series 49AV
      - Wall and ceiling mounted. Multi-electronic horn & strobe combinations.
    - 2099 Series Manual Fire Alarm Station
      - Single action with institutional cover, key operated only
  - Edwards Signaling
    - EGC-SVM Series Notification Appliances
      - Caution: the curved return against the ceiling presents a potential ligature opportunity

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS

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

Date: November 1, 2017
CON Number: To be determined
Facility Name: Mohawk Valley Health System
Facility ID Number: PFI #0598
Facility Address: Bounded by Oriskany and Columbia Streets, and Broadway and State Streets, Utica, NY 13501

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

To The New York State Department of Health:

I hereby certify that:

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

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

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

   a. _X_ 712 (Standards of Construction for General Hospital Facilities)
   b. ___ 713 (Standards of Construction for Nursing Home Facilities)
   c. ___ 714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. ___ 715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. ___ 716 (Standards of Construction for Rehabilitation Facilities)
   f. ___ 717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:

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

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

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

Project Name: Mohawk Valley Health System

Location: Bounded by Oriskany and Columbia Streets, and Broadway and State Streets, Utica, NY 13501

Description: Replacement Hospital

Architectural or Engineering Professional Stamp

REGISTERED ARCHITECT
STEVEN MICHAEL KOPF
031484
STATE OF NEW YORK

Steven M Kopf
Signature of Architect or Engineer

STEVEN M. KOPF
Name of Architect or Engineer (Print)

031484
Professional New York State License Number

250 S. HIGH ST · COLUMBUS OH 43215
Business Address

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

Sharon Palmer
Authorized Signature for Applicant

10-25-17
Date

Sharon Palmer, AVP, Facilities Services
Name (Print) Title

Notary signing required for the applicant

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

On the 25th day of October 2017, before me personally appeared Sharon Palmer, to me known, who being by me duly sworn, did depose and say that he/she resides at [redacted], that he/she is the AVP Fac. Services of the Mohawk Valley Health System, the corporation described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the board of directors of said corporation.

(Notary) Margaret A. Kebish

MARGARET A. KEBLISH
Notary Public, State of New York
No. 01KE6029261
Qualified in Oneida County
Commission Expires 08/09/2021

ARCHITECTURAL AND ENGINEERING LETTER OF CERTIFICATION

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

PHYSICIST LETTER OF CERTIFICATION

Date: 6/4/17

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

Re: CON Project #: TBD
Facility Name: MVHS (Mohawk Valley Health System)
Facility Location: Bounded by Oriskany and Columbia Streets and Broadway and State Streets, Utica, NY 13501.
Project Description: New Hospital Campus

To the New York State Department of Health:

I certify that, as an employee or contractor of the above-named facility, it is my duty to design and prepare plans, sketches, and specifications relating to radiation protection for the facility. I further certify that I have exercised due diligence and, to the best of my knowledge, information and belief, the radiation protection designed and specified for the above-referenced project is in substantial compliance with the requirements of the relevant technical standards listed in10NYCRR711.2, and that the radiation exposure to the public and staff is designed to be as low as is reasonably achievable (ALARA), based on the workload provided to me by the facility for the proposed equipment and sound radiation protection principles.

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

I attest that I have been authorized by the above named facility to make this certification.

Jason R Sherman
Signature of Physicist

Jason Sherman
Name of Physicist(Print)

6/4/17
Date

MS, DABR
Degree(s)Certification

Upstate Medical Physics, Diagnostic Radiology, Medical Nuclear and Medical Health, P.C.
1290 Blossom Drive Victor, NY 14564
Business Address

The undersigned applicant understands and agrees that, notwithstanding this certification, the Department of Health shall have continuing authority to: (a) review all plans, sketches, and specifications related to radiation protection for the facility to ensure compliance with the above-mentioned technical standards ;and (b) withdraw its approval of the application for failure to comply with such standards. I understand that I have a continuing obligation to make any changes required by the Department to comply with existing and future codes and regulations.

Sharon Palmer
Authorized Signature for Applicant

6-7-17
Date

Sharon Palmer, Assistant Vice President, Facilities Services
Name (Print) Title

Notary signing required for the applicant

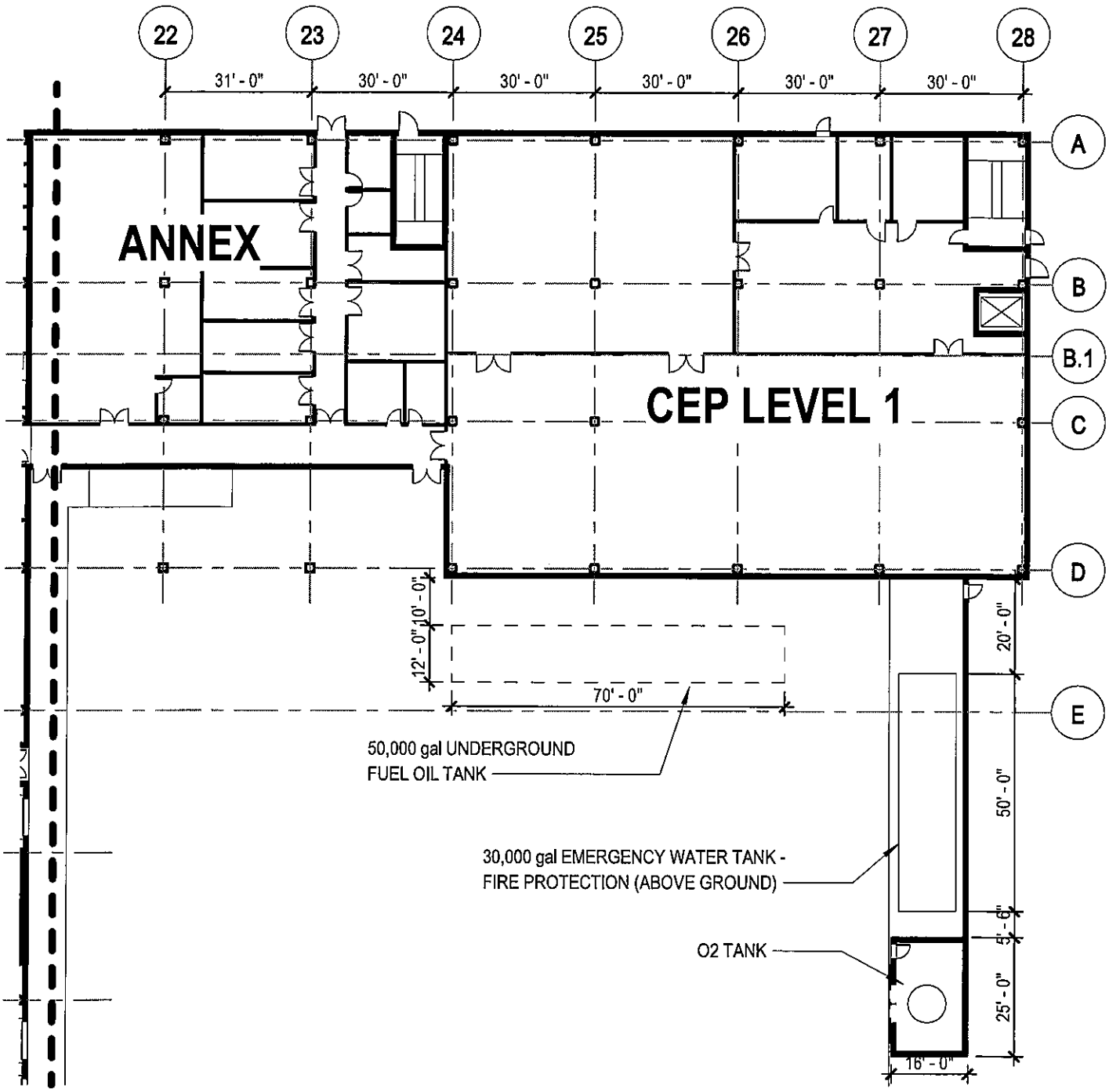
STATEOFNEWYORK)
) SS:
County of Oneida)

On the 7th day of June , 2017, before me personally appeared Sharon Palmer , to me known, who being by me duly sworn, did depose and say that he/she resides at, [redacted] that he/she is the AVP, Facilities Services, of the Mohawk Valley Health System, the corporation described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the board of directors of said corporation.

MARGARET A. KEBLISH
Notary Public, State of New York
No. 01KE6029261
Qualified in Oneida County
Commission Expires 08/09/2017

Notary Margaret A. Keblish

cc: Regional Office-OHSM



	MOHAWK VALLEY HEALTH SYSTEM	SERVICE YARD PLAN	
		Project number 101946.00	A1
		Date NOVEMBER 1, 2017	
		Drawn by GLS	
		Checked by Checker	Scale 1" = 30'-0"

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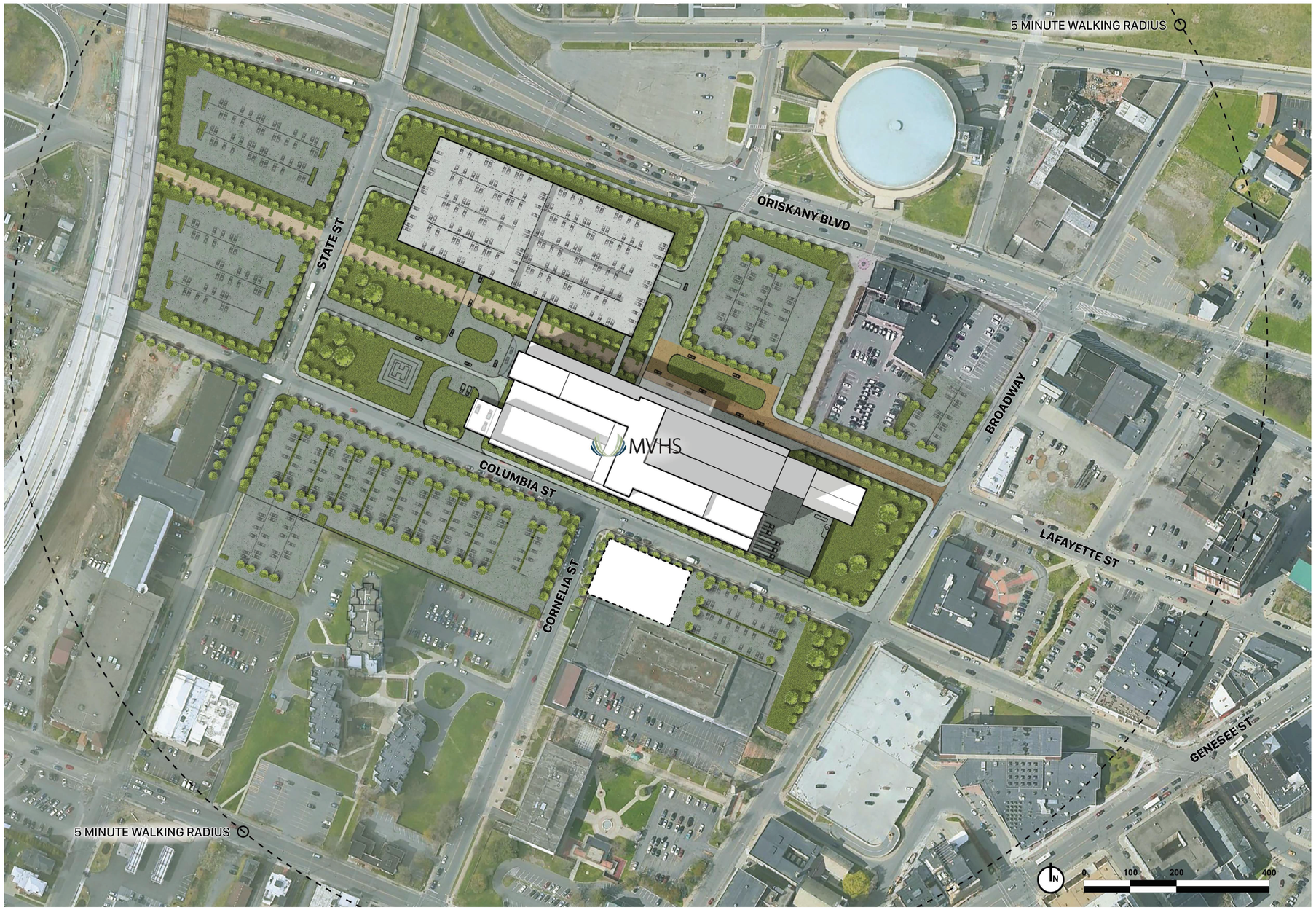
CON - SD SUBMITTAL

NOVEMBER 1, 2017



LIST OF SHEETS

GC000	COVER SHEET
AS101	ARCHITECTURAL SITE PLAN
AS102	STACKING DIAGRAM
GI101	F1 LIFE SAFETY PLAN
GI102	F2 LIFE SAFETY PLAN
GI103	F3, F4 LIFE SAFETY PLANS
GI105	F5, F6 LIFE SAFETY PLANS
GI107	F7, F8 LIFE SAFETY PLANS
GI109	F9, ROOF LIFE SAFETY PLAN
GI201	F1, CEP F1-F3 FUNCTIONAL AREA PLAN
GI202	F2 FUNCTIONAL AREA PLAN
GI203	F3, F4 FUNCTIONAL AREA PLAN
GI205	F5, F6 FUNCTIONAL AREA PLAN
GI207	F7, F8 FUNCTIONAL AREA PLAN
GI209	F9, F10 ROOF FUNCTIONAL AREA PLAN
AE101	F1 OVERALL FLOOR PLAN
AE101-A	F1 FLOOR PLAN - AREA A
AE101-B	F1 FLOOR PLAN - AREA B
AE101-C	F1 FLOOR PLAN - AREA C
AE101-D	F1 FLOOR PLAN - AREA D
AE102	F2 OVERALL FLOOR PLAN
AE102-A	F2 FLOOR PLAN - AREA A
AE102-B	F2 FLOOR PLAN - AREA B
AE102-C	F2 FLOOR PLAN - AREA C
AE103	F3, F4 OVERALL FLOOR PLANS
AE103-AC	F3 FLOOR PLAN - AREA A & C
AE103-B	F3 FLOOR PLAN - AREA B
AE104-AC	F4 FLOOR PLAN - AREA A & C
AE104-B	F4 FLOOR PLAN - AREA B
AE105	F5, F6 OVERALL FLOOR PLANS
AE105-AC	F5 FLOOR PLAN - AREAS A & C
AE105-B	F5 FLOOR PLAN - AREA B
AE106-AC	F6 FLOOR PLAN - AREA A & C
AE106-B	F6 FLOOR PLAN - AREA B
AE107	F7, F8 OVERALL FLOOR PLANS
AE107-AC	F7 FLOOR PLAN - AREA A & C
AE107-B	F7 FLOOR PLAN - AREA B
AE108-AC	F8 FLOOR PLAN - AREA A & C
AE108-B	F8 FLOOR PLAN - AREA B
AE109	F9 OVERALL FLOOR PLAN, ROOF PLAN
AE109-AC	F9 FLOOR PLAN - AREA A & C
AE109-B	F9 FLOOR PLAN - AREA B
AE110	R1 ROOF PLAN
AE110-AC	R1 ROOF PLAN - AREA A & C
AE110-B	R1 ROOF PLAN - AREA B

MVHS

MOHAWK VALLEY HEALTH SYSTEM

UTICA, NY

101946.00

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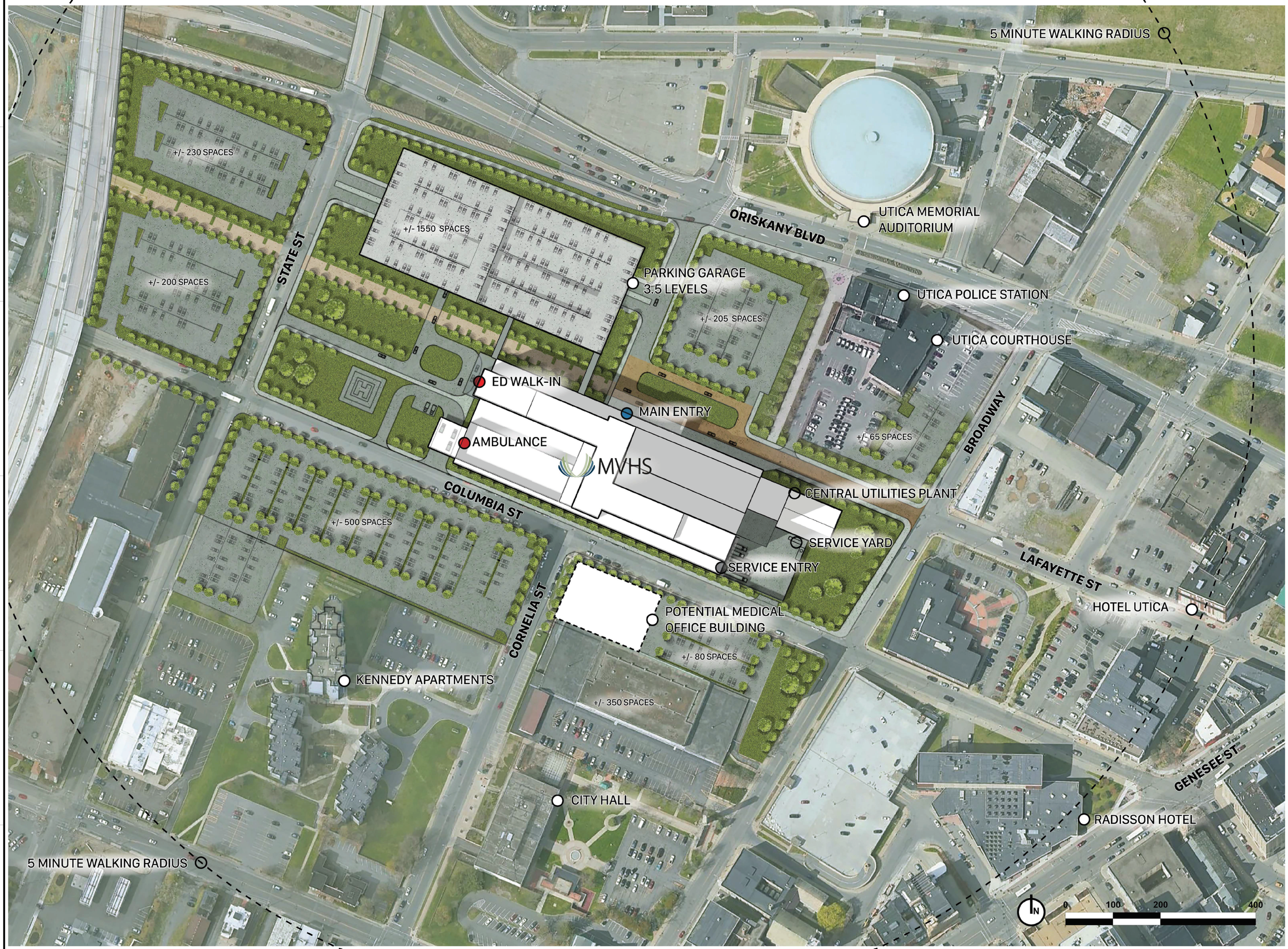
nbbj
140 BROADWAY, 29TH FLOOR
NEW YORK, NY 10005
PHONE 212 924 9000
www.nbbj.com



nbbj

CONSTRUCTION MANAGER:

CIVIL ENGINEER:

LANDSCAPE ARCHITECT:

STRUCTURAL ENGINEER:

MEP:

REGISTERED ARCHITECT
STEVEN MICHAEL
031494
STATE OF NEW YORK

MOHAWK VALLEY
HEALTH SYSTEM

CON - SD
SUBMITTAL

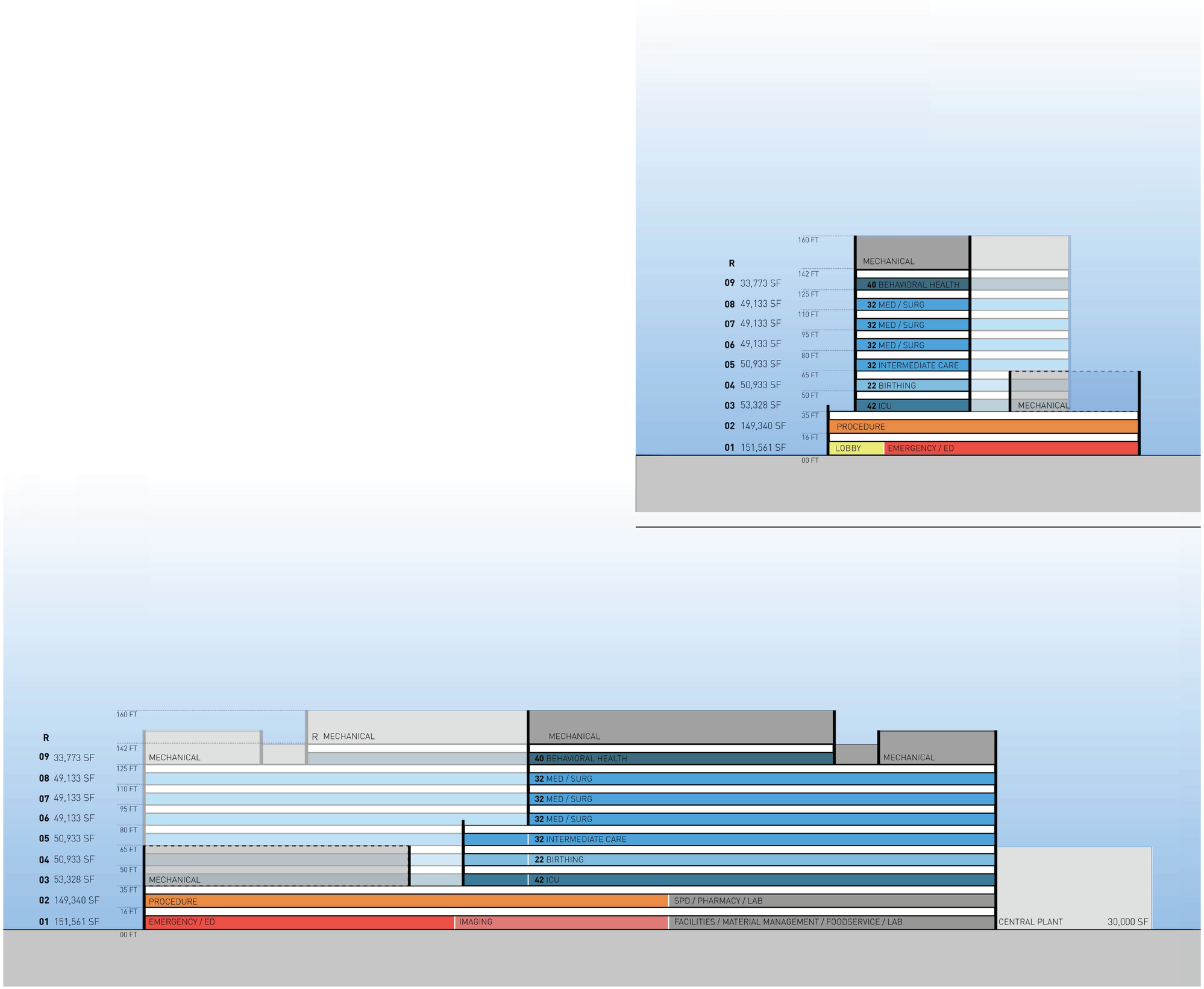
NOVEMBER 1, 2017

Designer
101946.00

ARCHITECTURAL
SITE PLAN

AS101

11/29/2017 10:23:12 AM



W S S S C ON OO G NOR H

nbbj

Y S 9 9 0

CONSTRUCTION MANAGER:

CIVIL ENGINEER:

LANDSCAPE ARCHITECT:

STRUCTURAL ENGINEER:

MEP:

REGISTERED ARCHITECT STEVEN MICHAEL WILLIAMS 031494 STATE OF NEW YORK

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

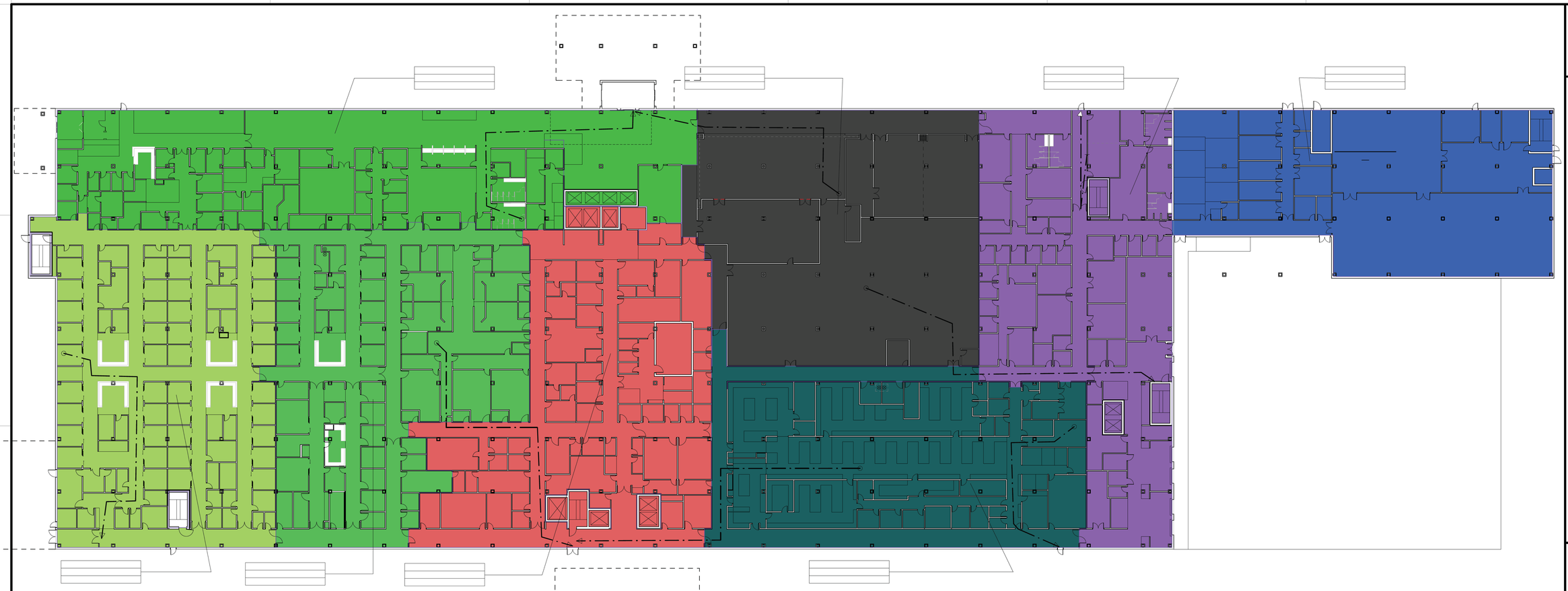
Designer

101946.00

STACKING DIAGRAM

AS102

10/23/2017 10:23:12 AM



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FE SA E Y EGE D

nbbj

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B S

REGISTERED ARCHITECT
STATE OF NEW YORK

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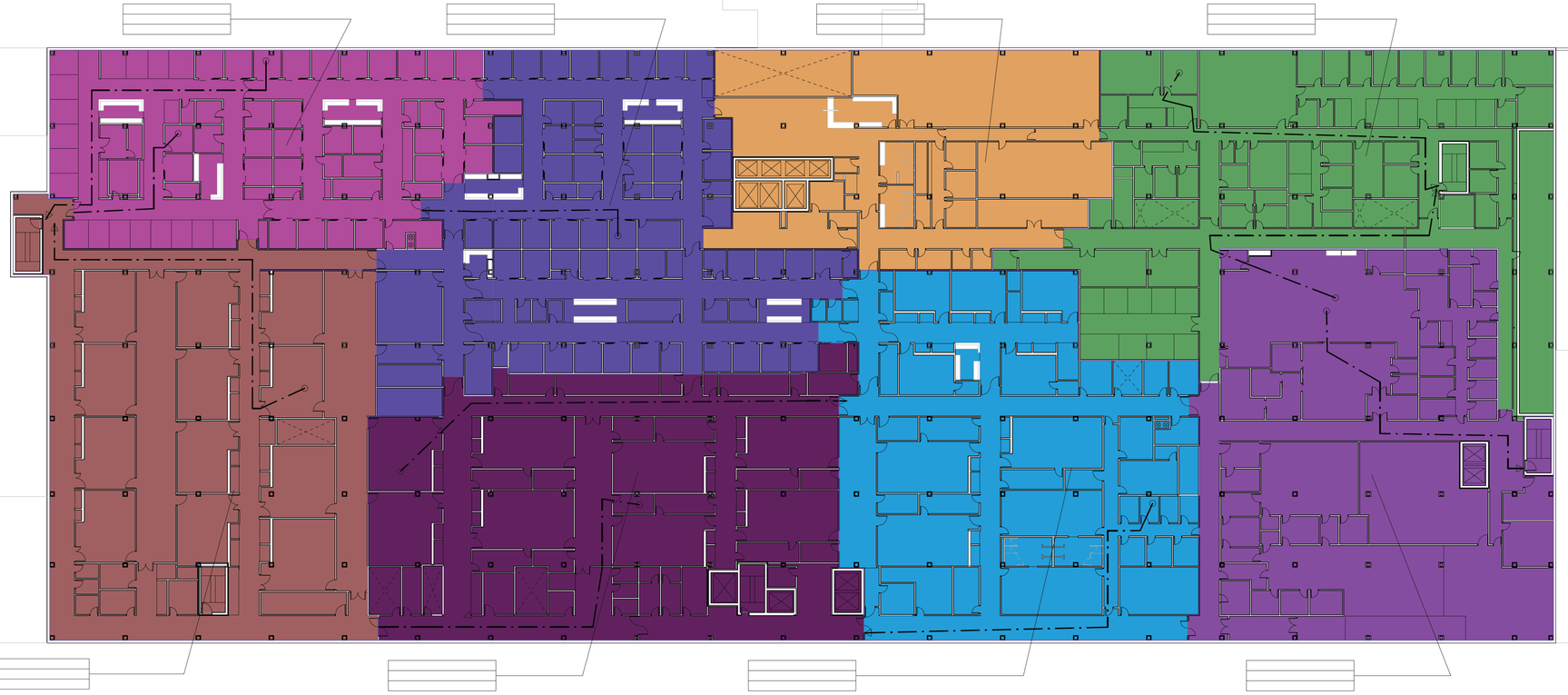

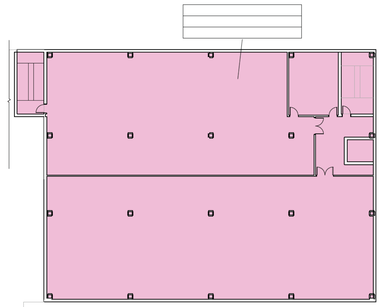

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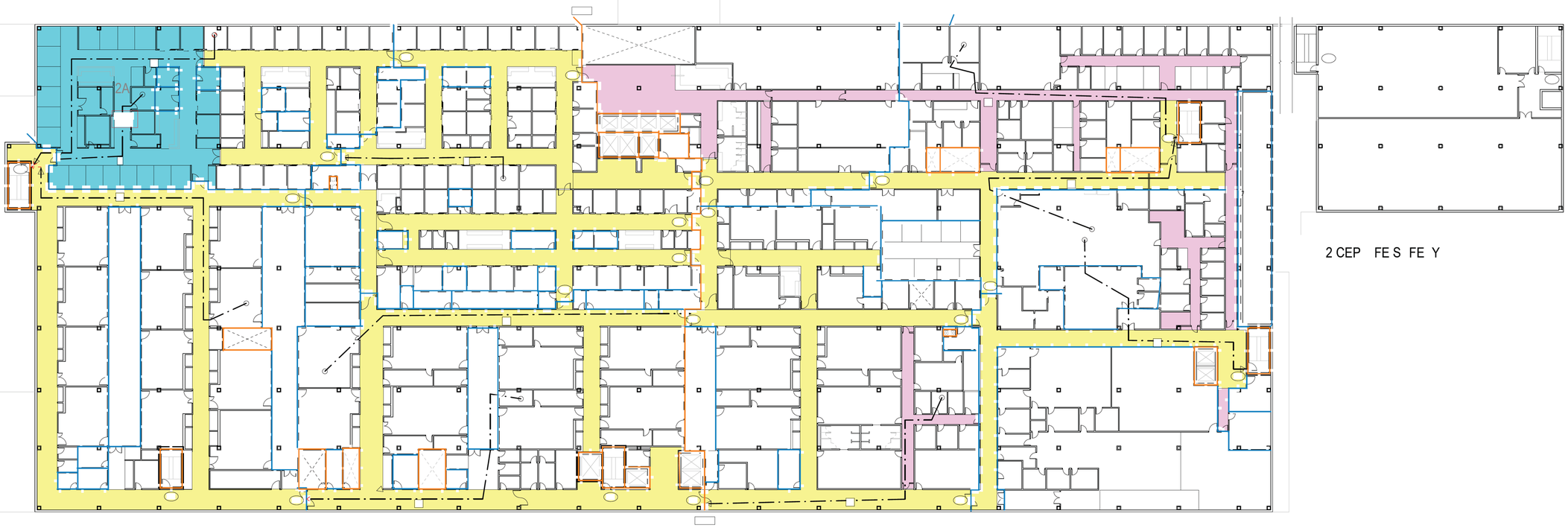

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GI102

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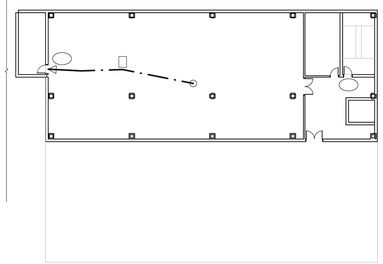

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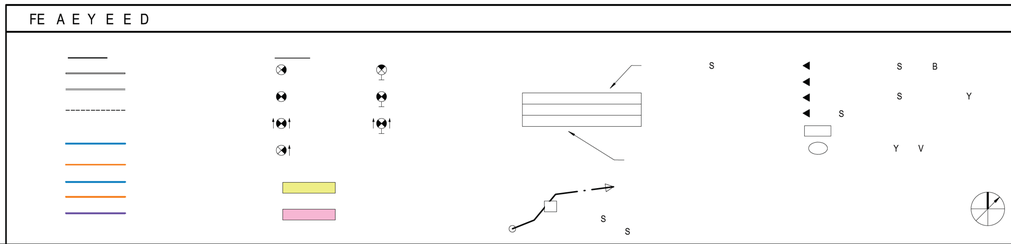

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REGISTERED ARCHITECT
STEVEN MICHAEL WILLIAMS
031494
STATE OF NEW YORK

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SA ETY LA S

GI103

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6 L E SA ETY LAN

F5 L FE S FE Y PL N

FE SA E Y EGE D

nbbj

0S S 0
B S

REGISTERED ARCHITECT
STEVEN MICHAEL WILLIAMS
031494
STATE OF NEW YORK

MOH WK VA LEY
EA TH S ST M

ON - D
S BM T AL
V BR 27

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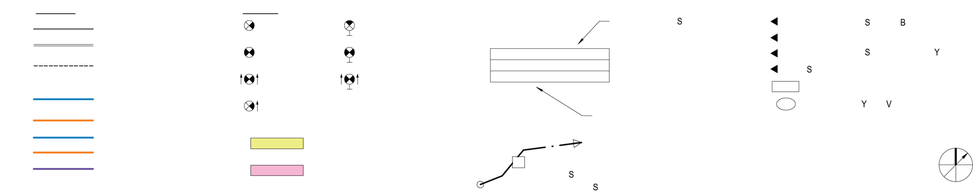

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REGISTERED ARCHITECT
STATE OF NEW YORK

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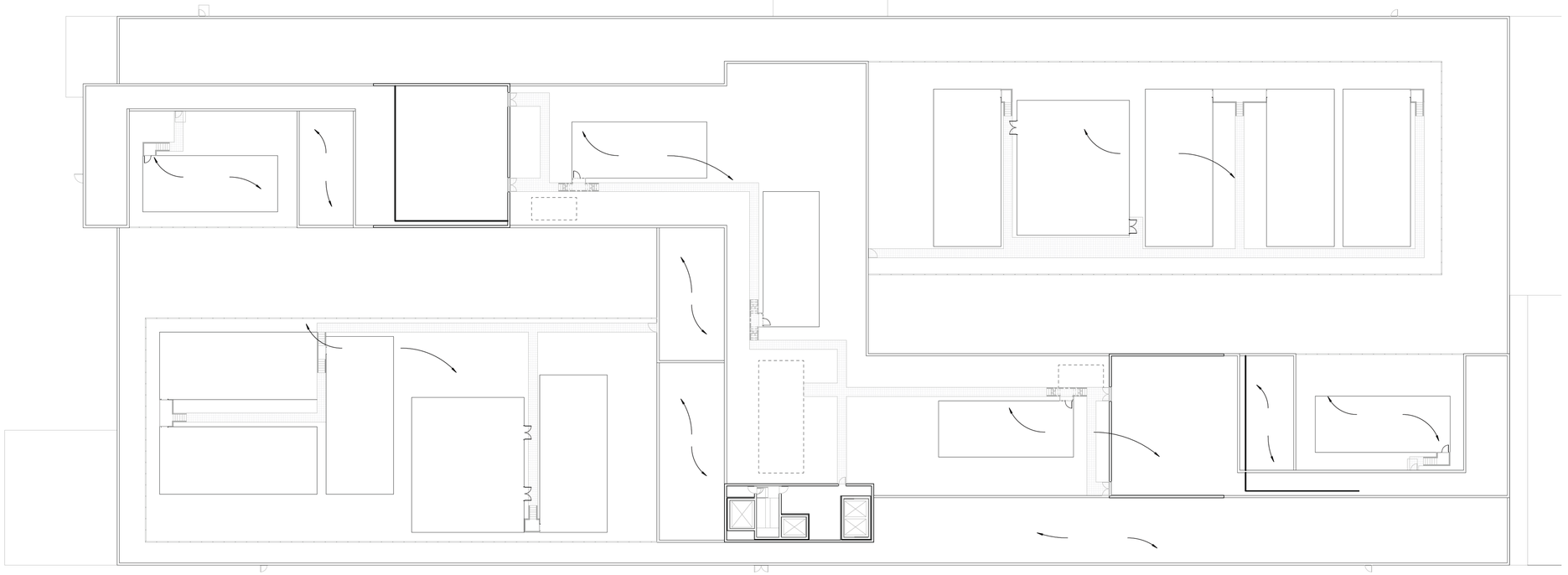

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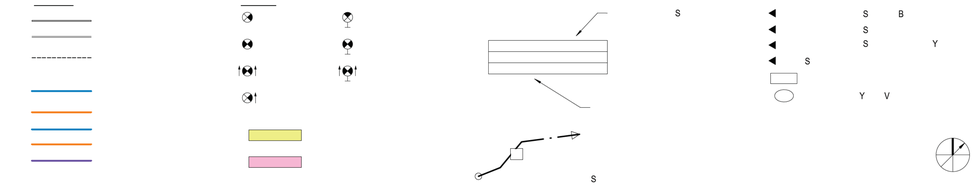

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REGISTERED ARCHITECT
JENNIFER MICHAEL WILLIAMSON
031494
STATE OF NEW YORK

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SA ETY LAN

GI109

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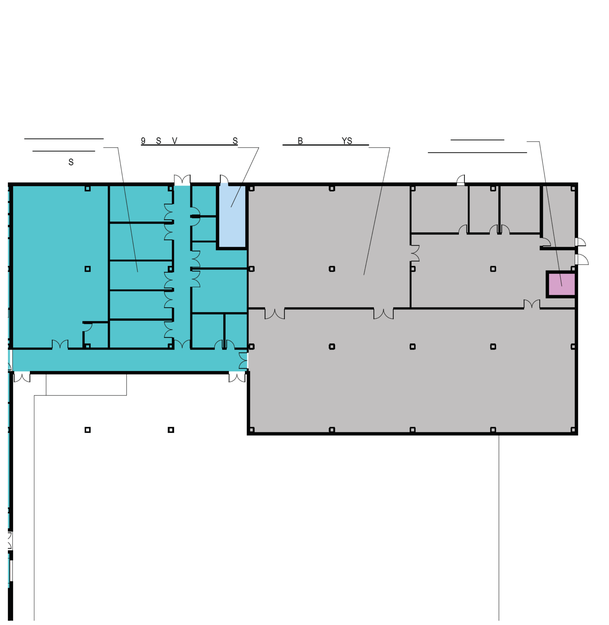

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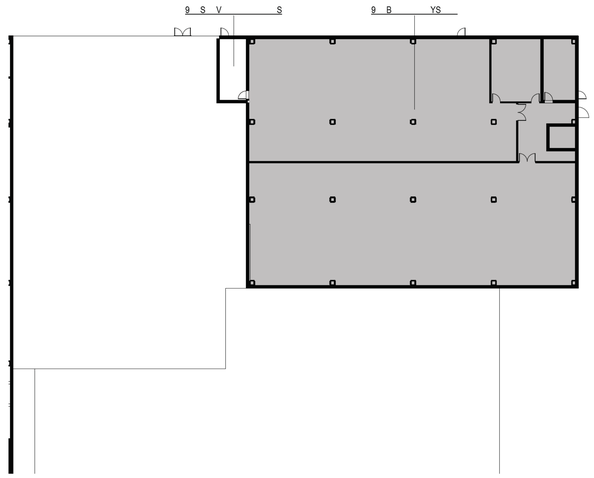
NNE / C P



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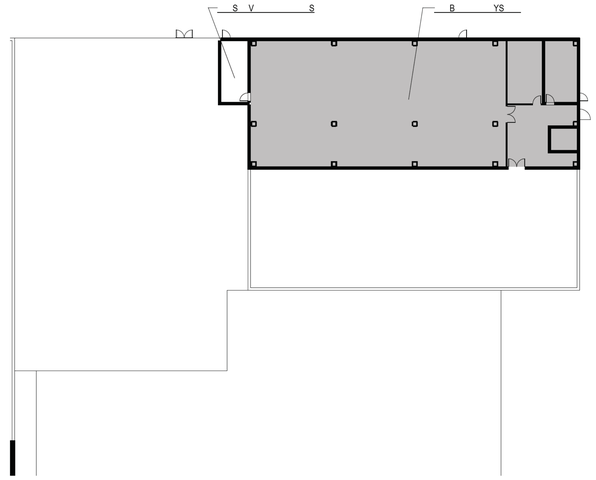

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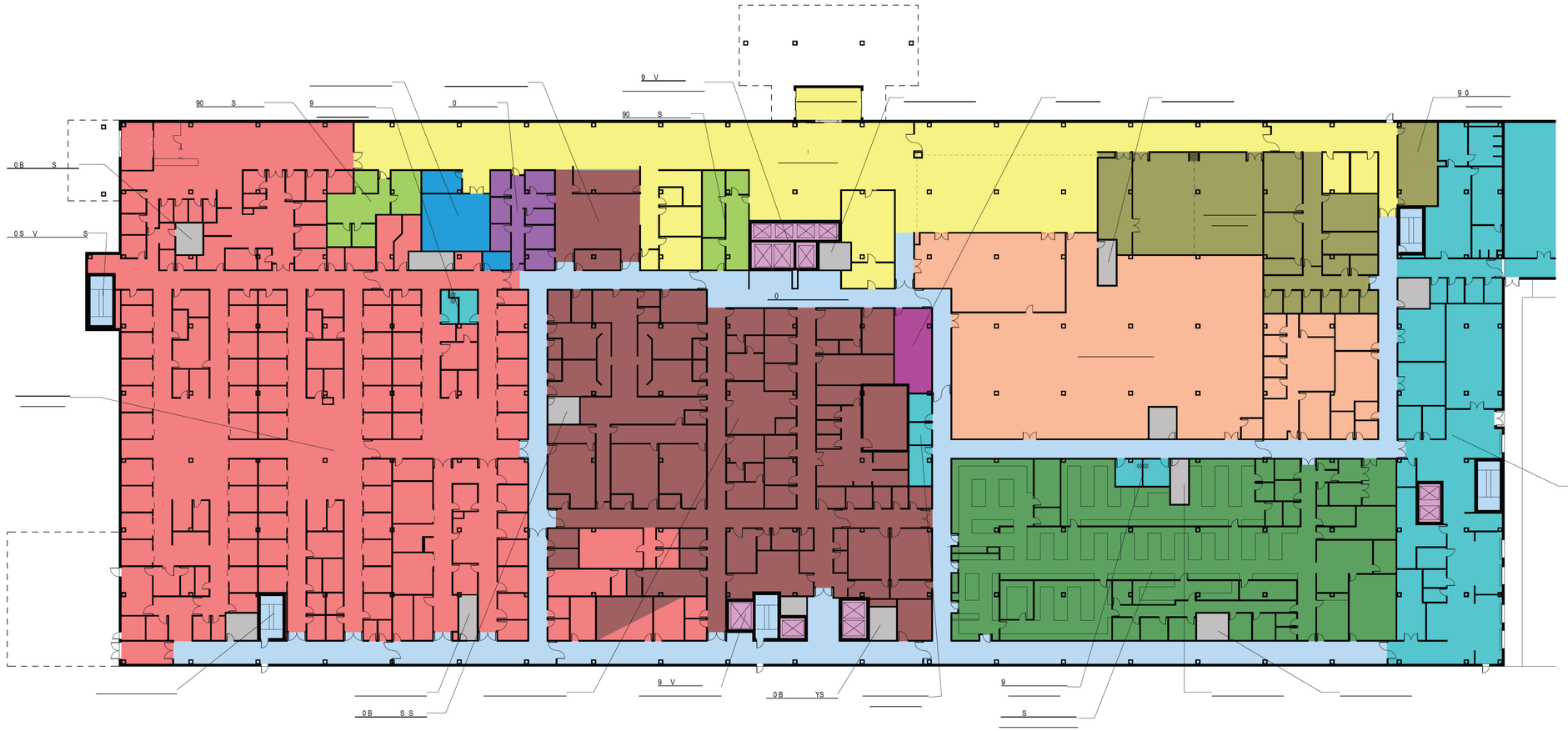

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nbbj

MOH WK VA LEY
EA TH S ST M

ON - D
S BM T AL

V BR 27

F1 CEP 1 F3
FU CT ON L
AREA PL N

G 201

2 FU CT ON L AR A PL N

nbbj

0 S S 0
B S

REGISTERED ARCHITECT
STATE OF NEW YORK

MOH WK VA LEY
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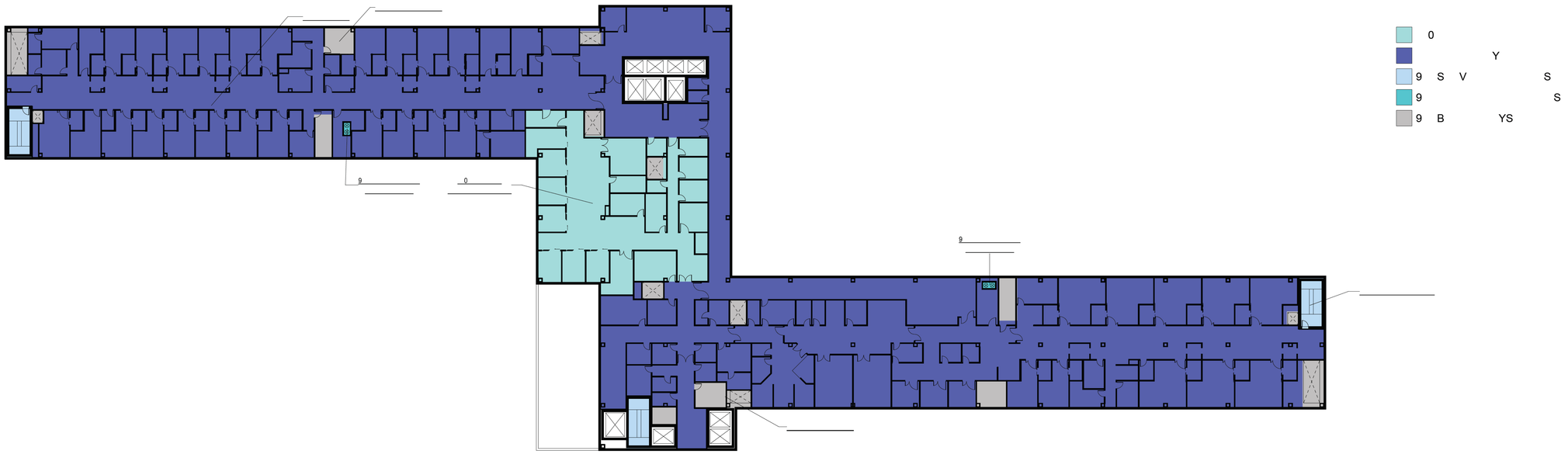
0 6 0

F2 UNC I NAL
AR A PL N

G 202



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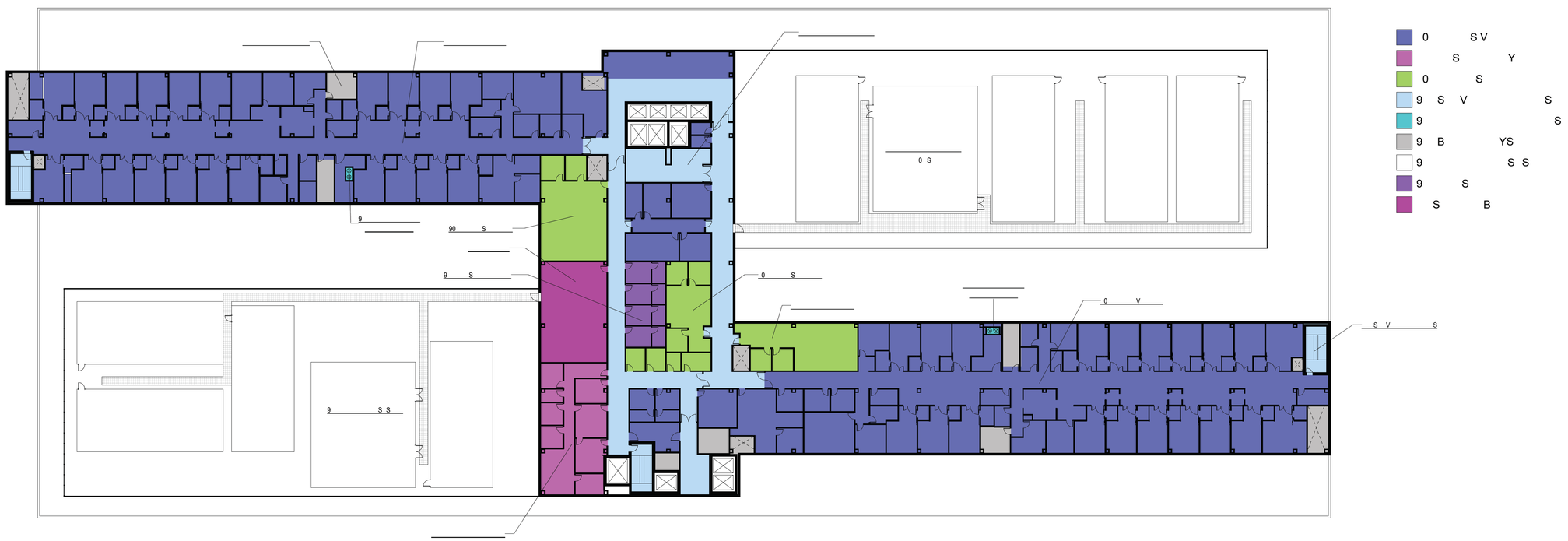

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nbbj

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B S

REGISTERED ARCHITECT
STATE OF NEW YORK

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ON - D
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F3 F4
FU CT ON L
AREA PL N

G 203

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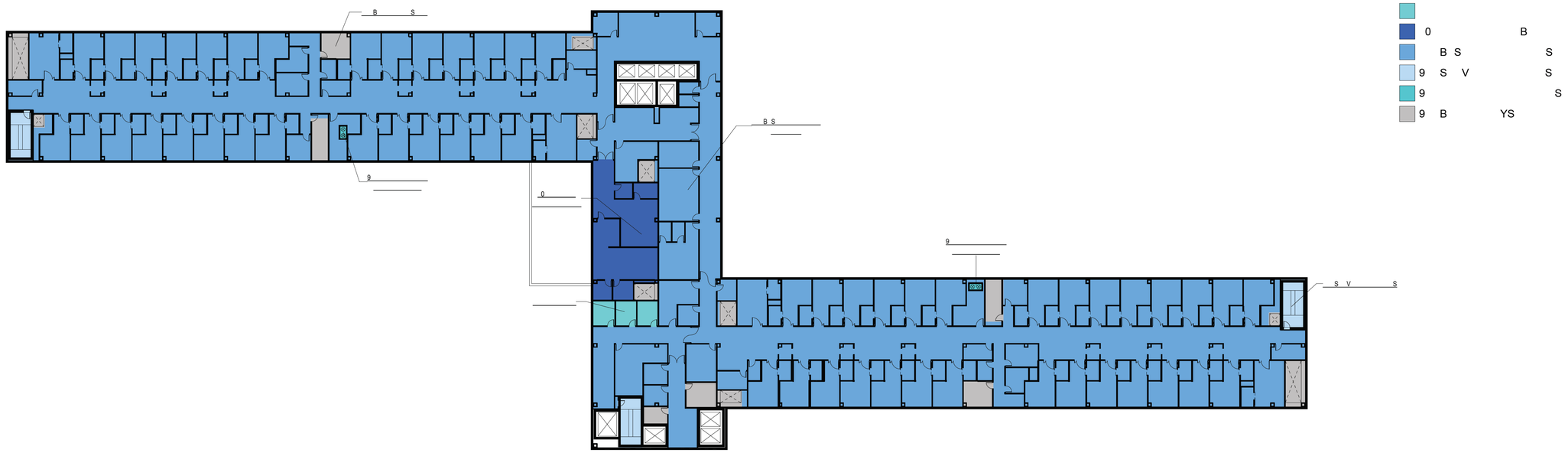

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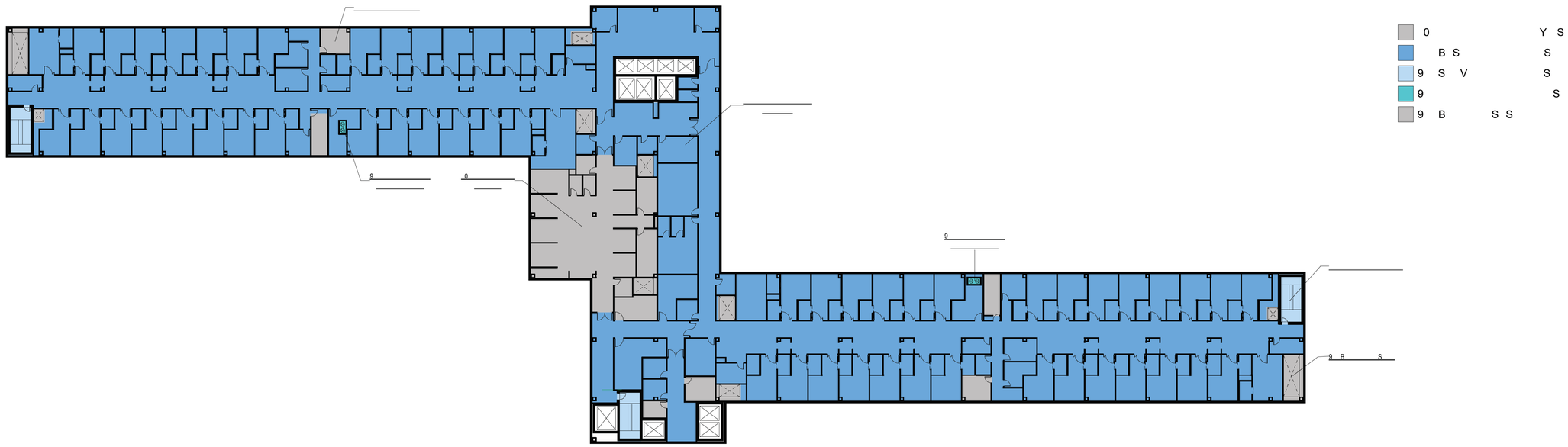

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ON - D
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" 0" e n r
0 6 0

F5 F6
FU CT ON L
AREA PL N

G 205

0 3 7 0 8 M

8 FU CT ON L AR A PL N

7 FU CT ON L AR A PL N

nbbj

0S S 0
B S

MOH WK VA LEY
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AREA PL N

G 207

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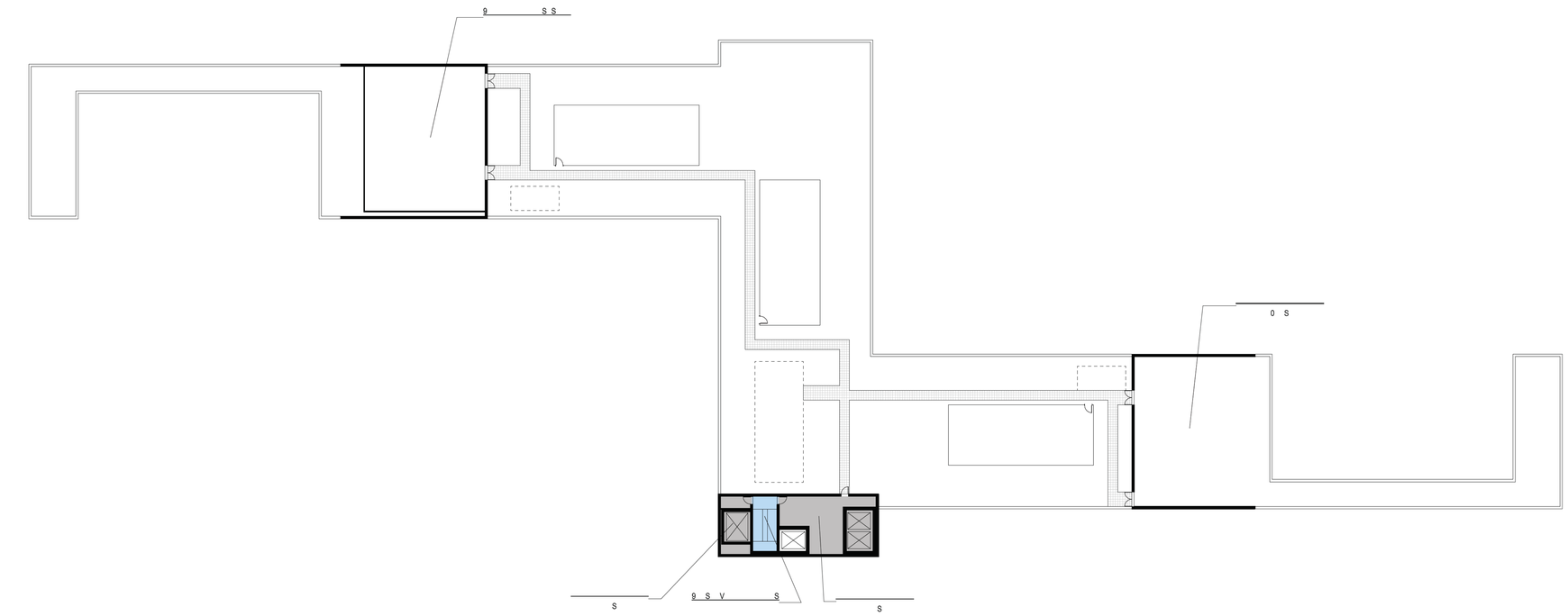

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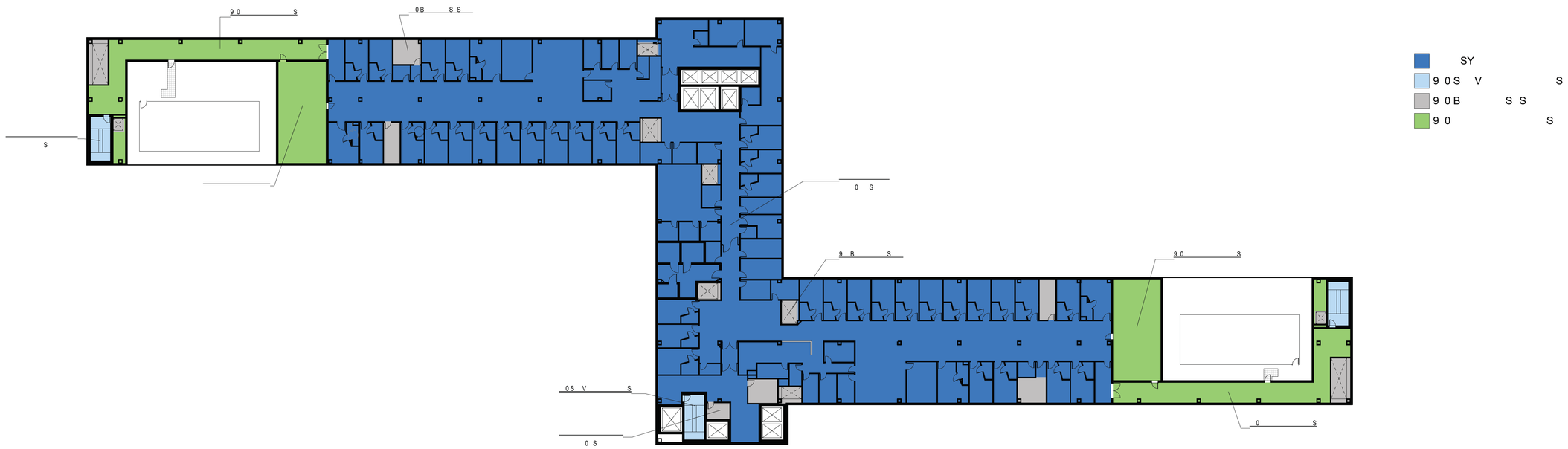

F FUN T ONAL REA LAN

nbbj

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F9 F 0 ROOF
FU CT ON L
AREA PL N

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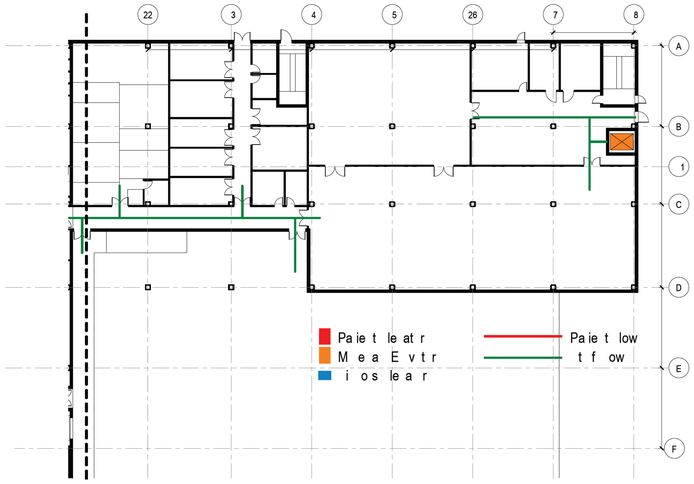

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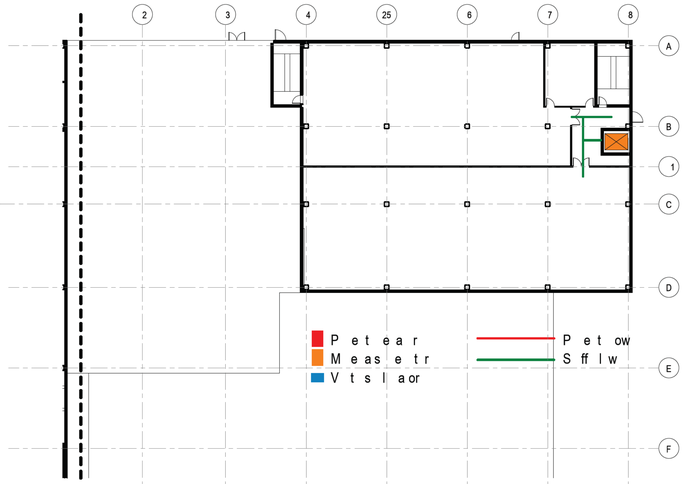

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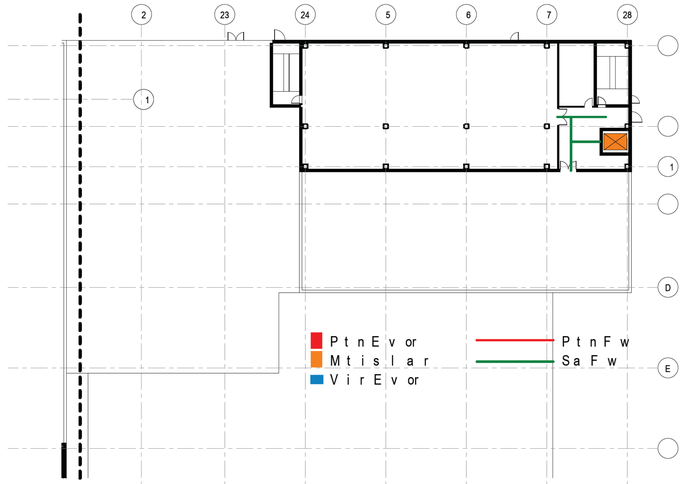

F3 NNEX & EP

OPT ON B - F1 F OOR LAN

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F1 O ER LL
F OOR P AN

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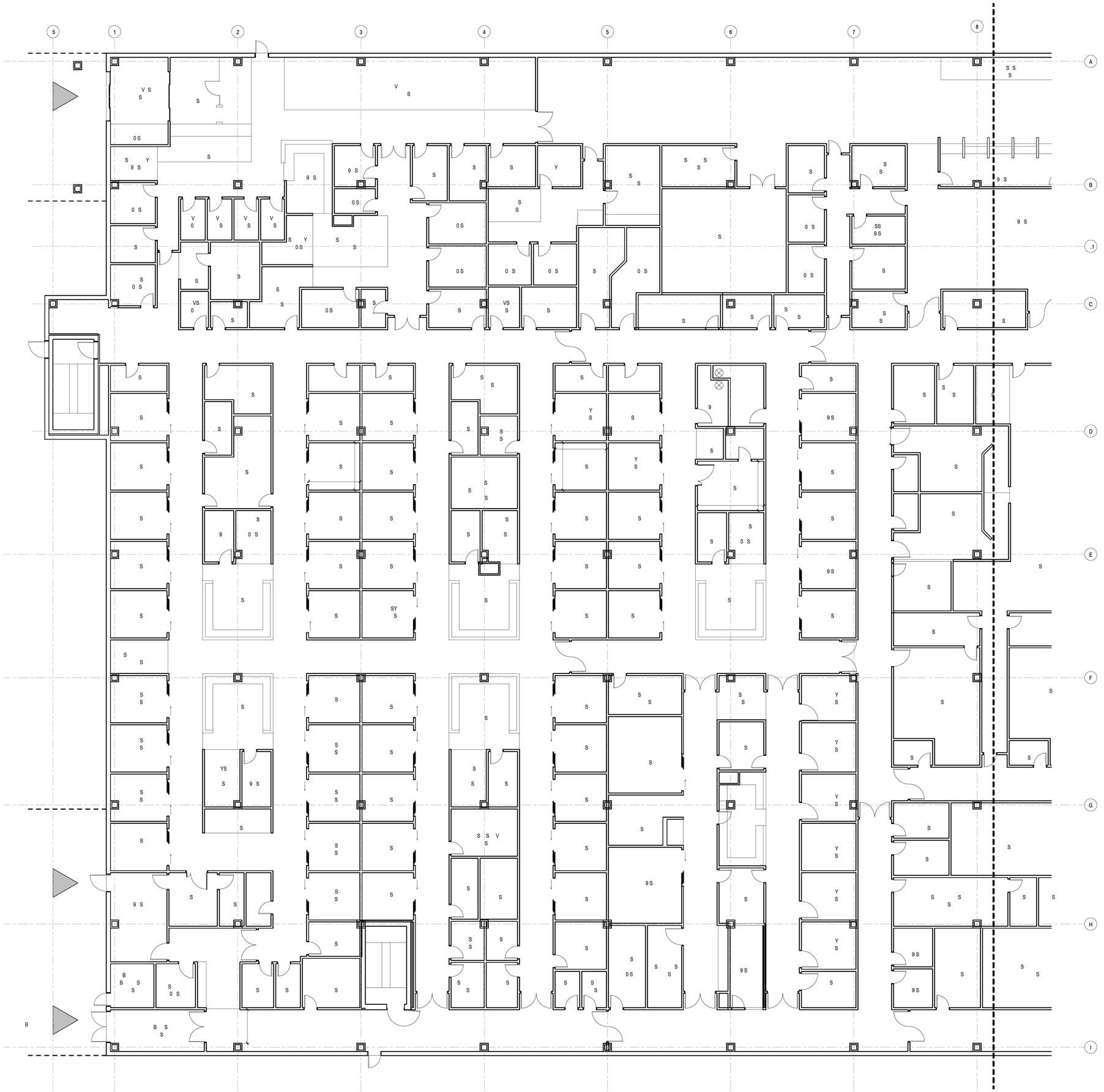

nbbj

REGISTERED ARCHITECT
STATE OF NEW YORK

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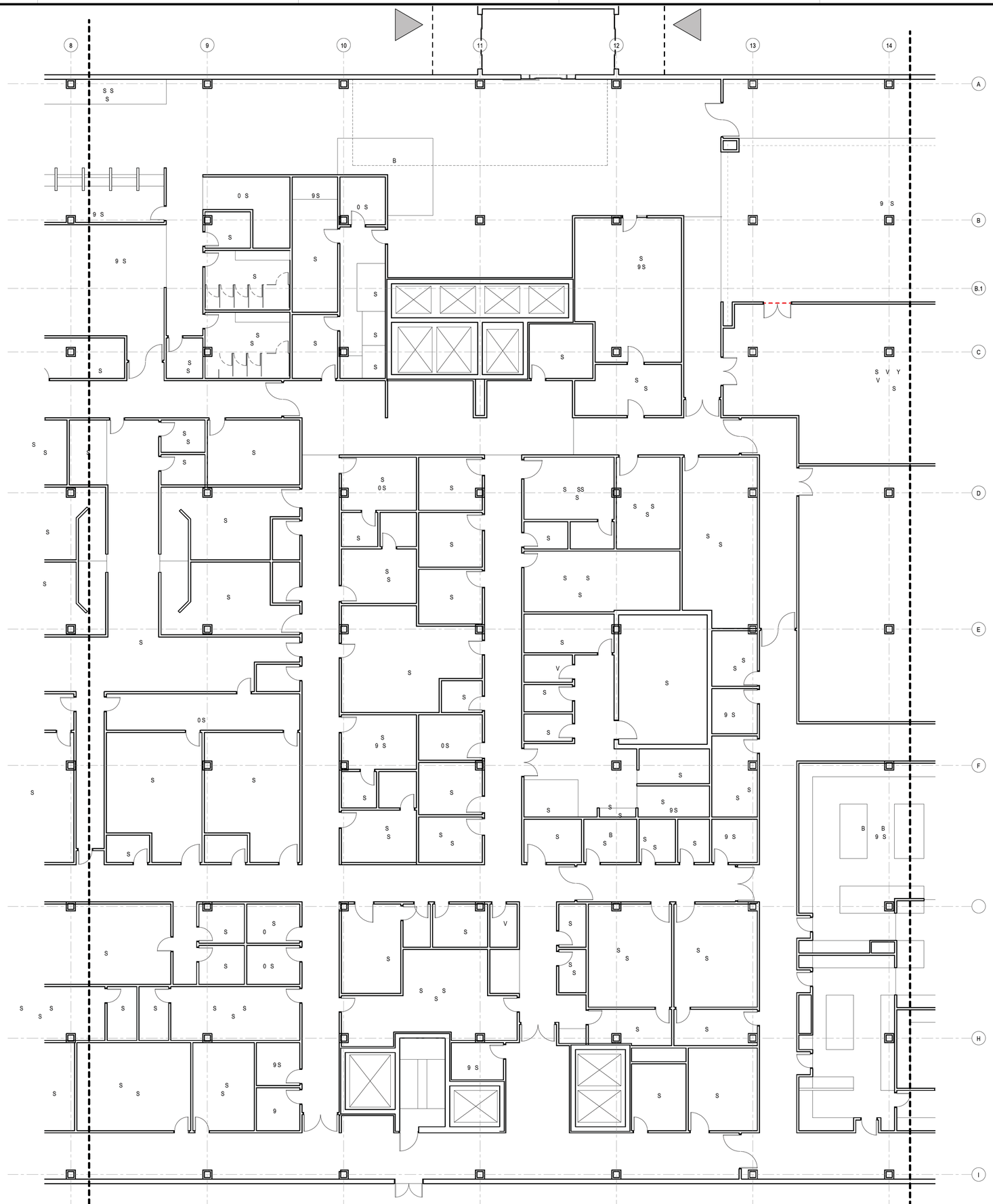

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REGISTERED ARCHITECT
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AR A B

AE 01-B

Y

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nbbj

REGISTERED ARCHITECT
STATE OF NEW YORK

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V BR 27

F1 LOOR LAN -
AR A C

AE 01-C

nbbj

REGISTERED ARCHITECT
STATE OF NEW YORK

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V BR 27

F1 LOOR LAN -
AR A D

AE 01-D

2 F OOR P AN

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nbbj

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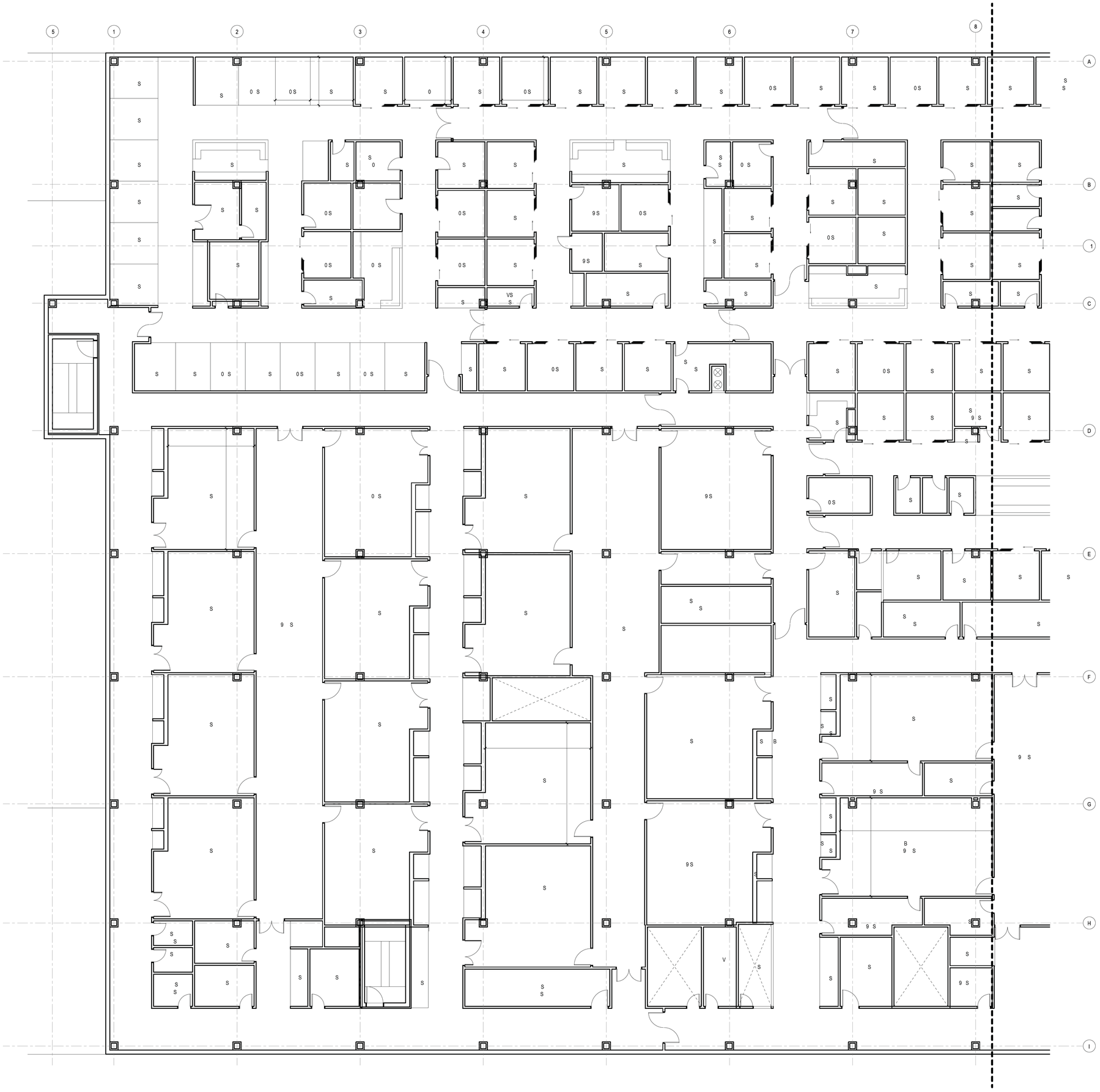

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REGISTERED ARCHITECT
STATE OF NEW YORK

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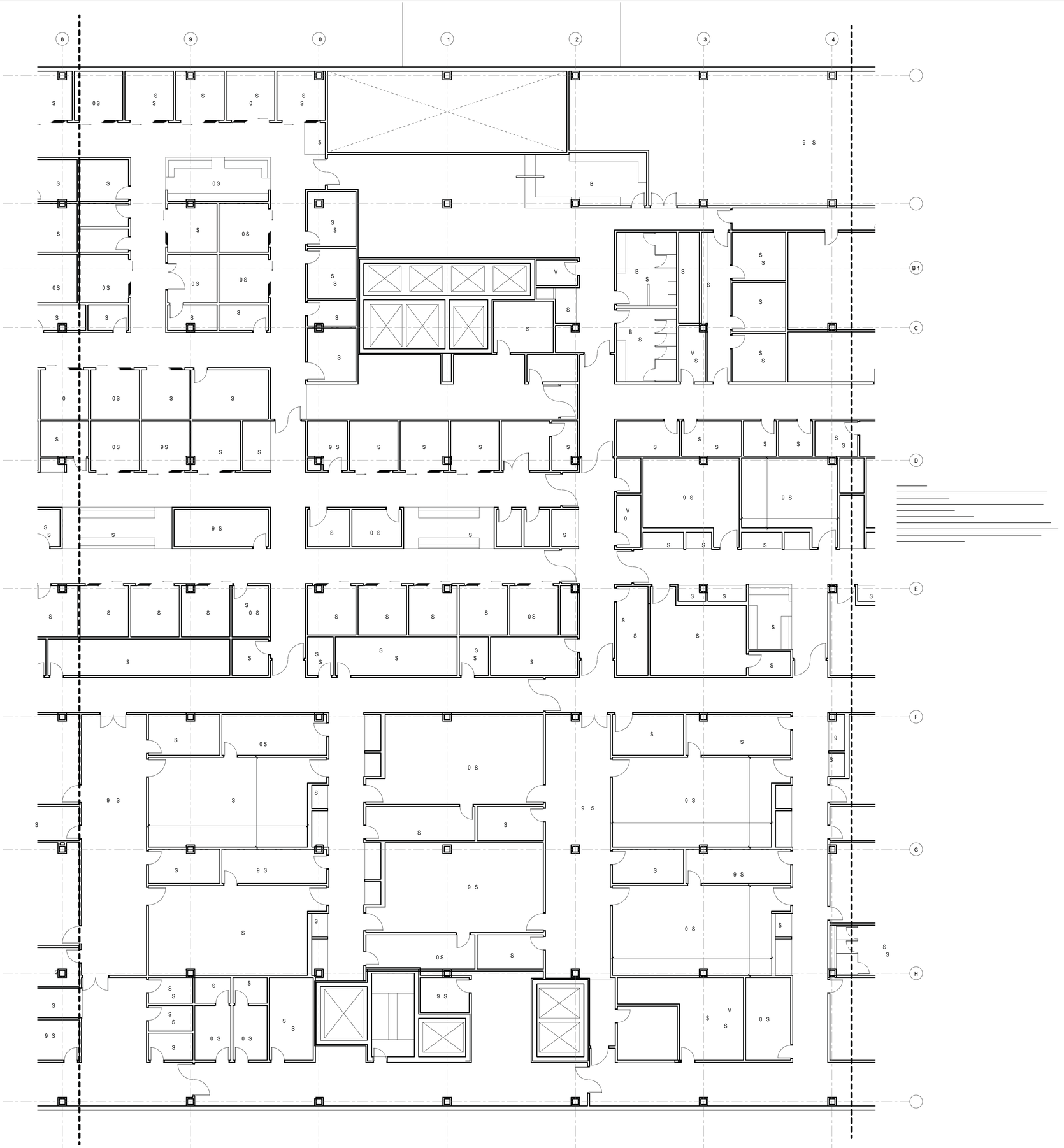

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REGISTERED ARCHITECT
STATE OF NEW YORK

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F2 LOOR LAN -
AR A B

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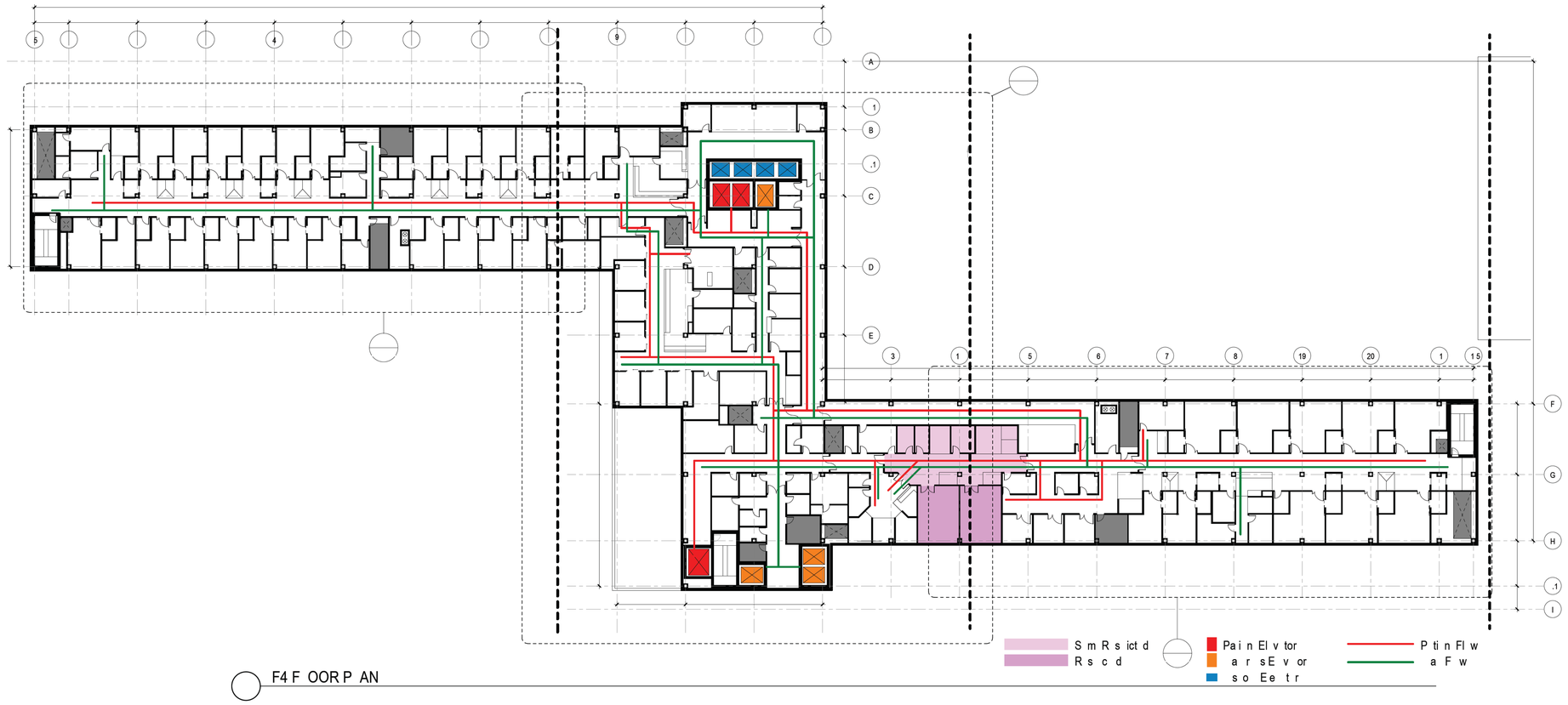

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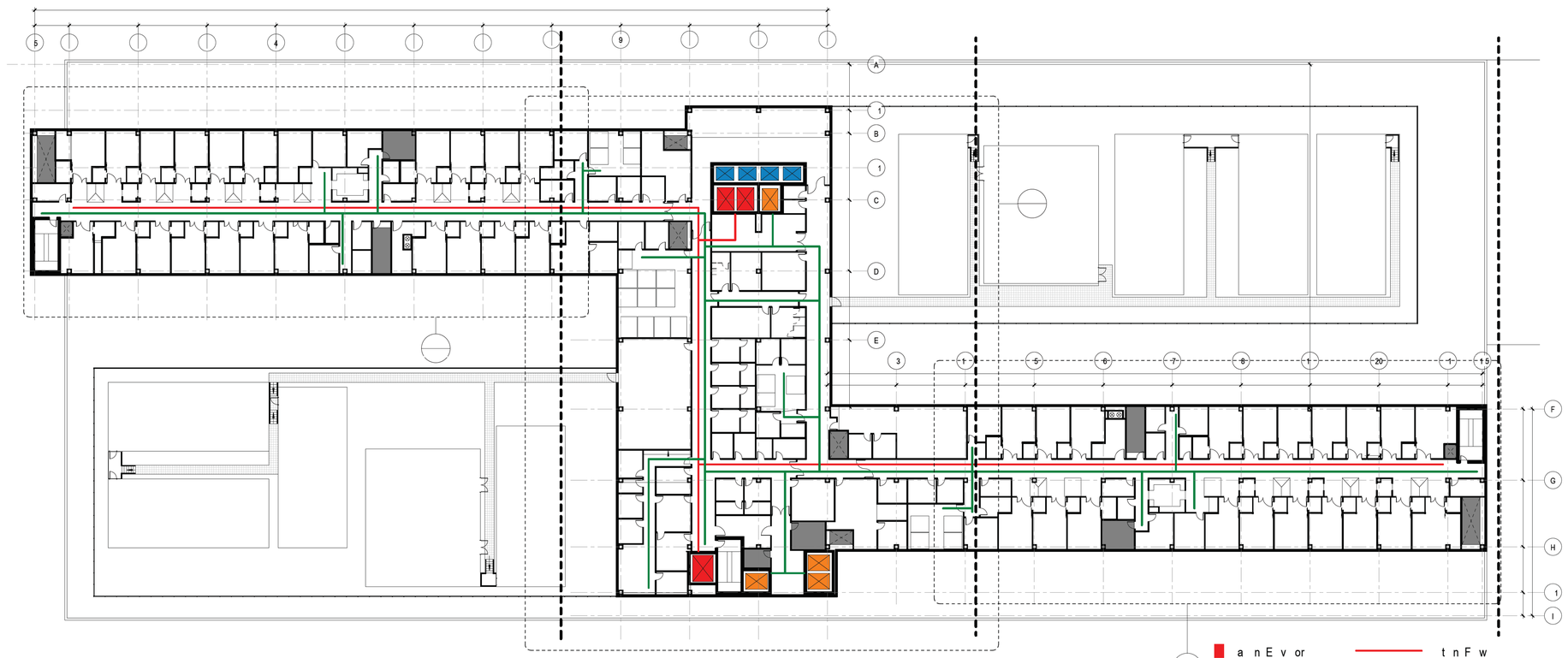

F3 F OOR P AN

nbbj

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F OOR P ANS

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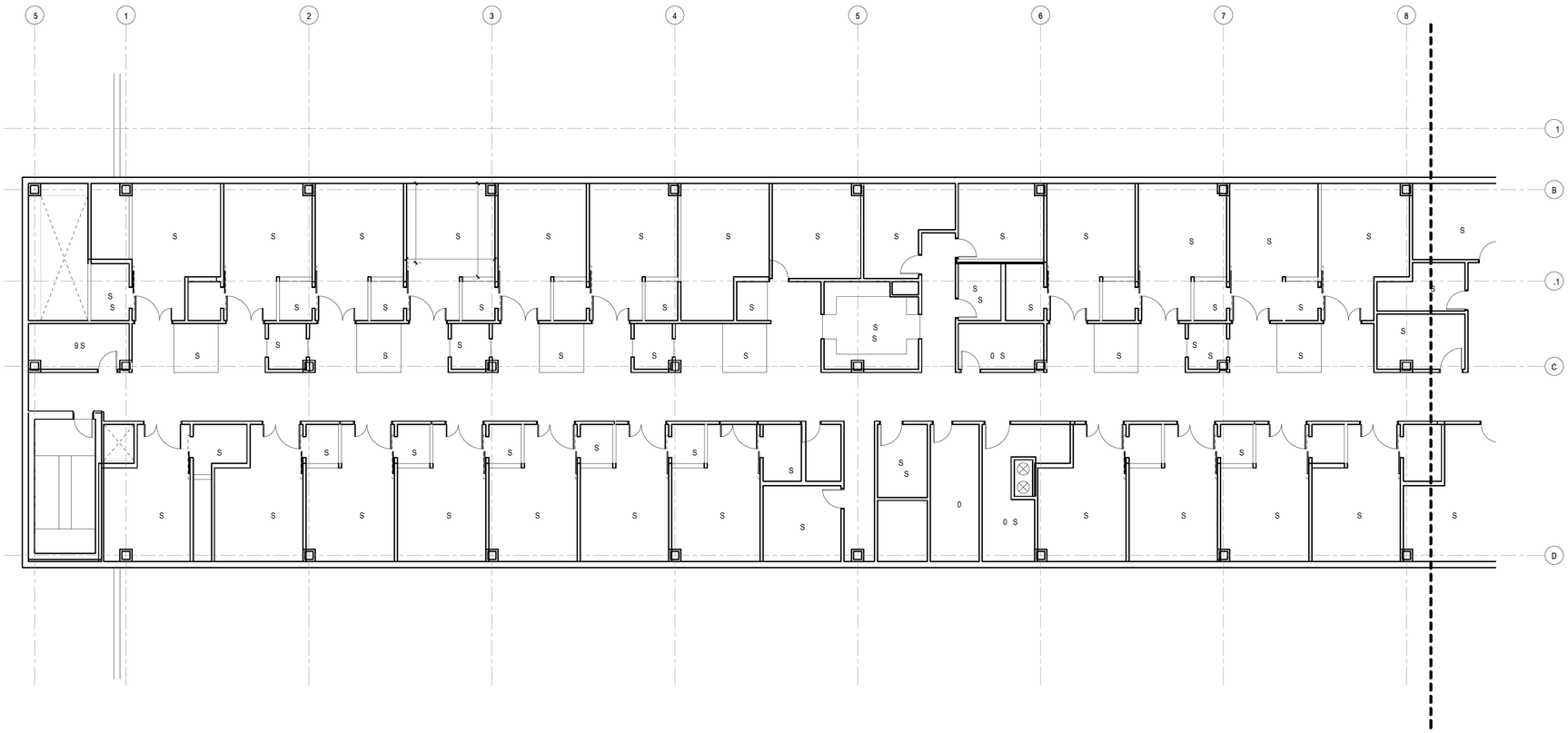

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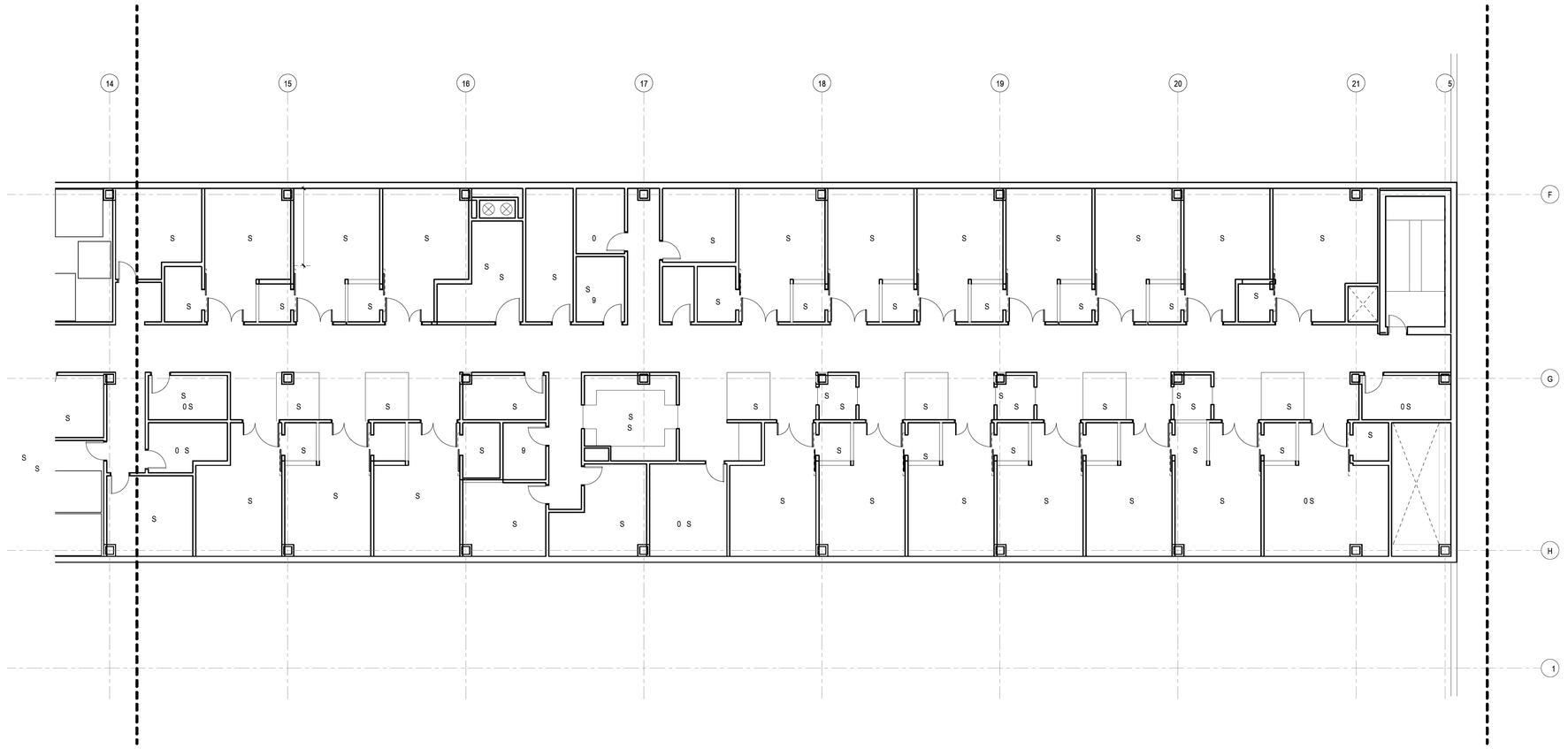

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V BR 27

F3 LOOR LAN -
AR A A & C

AE 03- C

0 3 7 4 PM

F3 - REA B

nbbj

0S S 0
B S

REGISTERED ARCHITECT
STATE OF NEW YORK

MOH WK VA LEY
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AE 03-B

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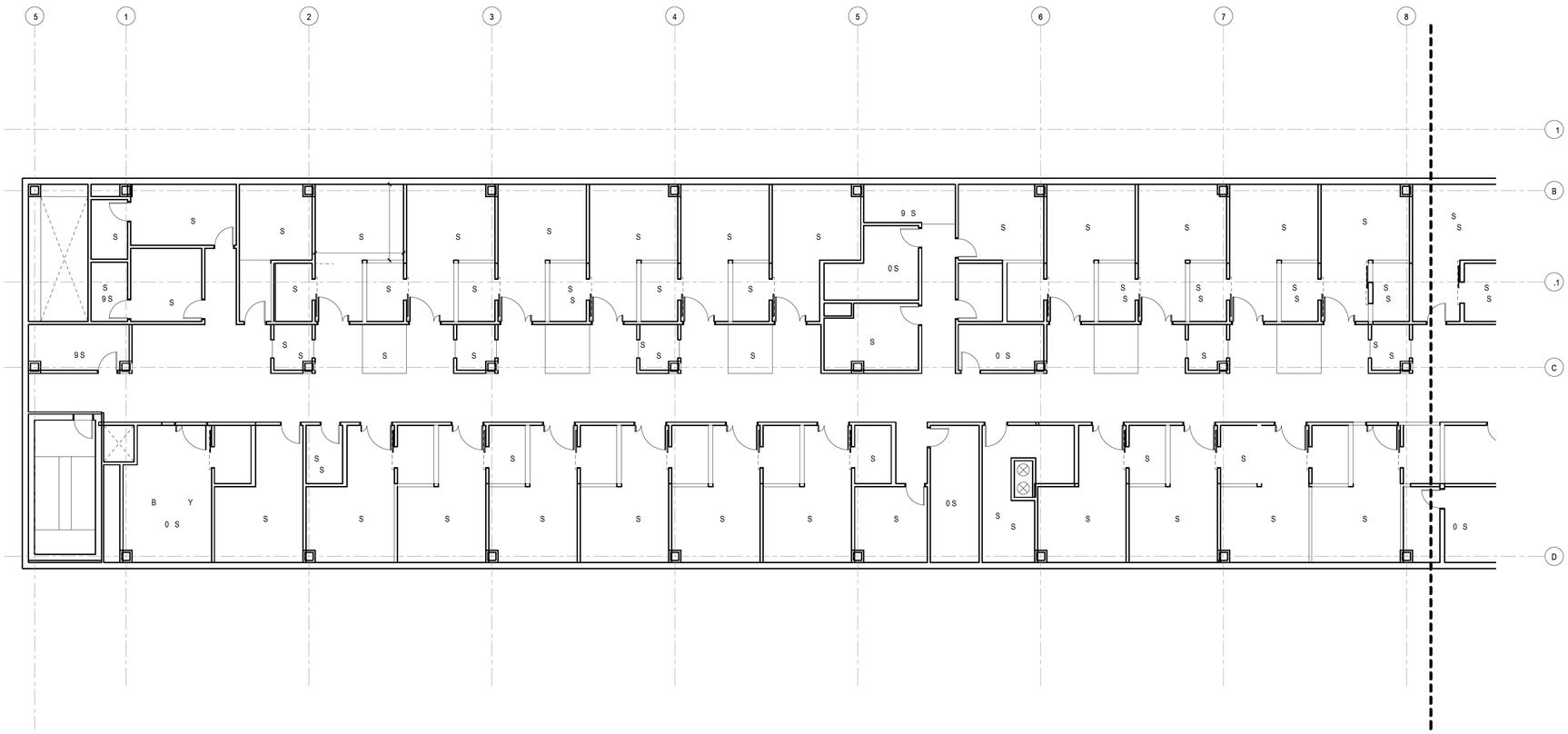

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2 4 - A EA C

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B S

REGISTERED ARCHITECT
STATE OF NEW YORK

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AE 04- C

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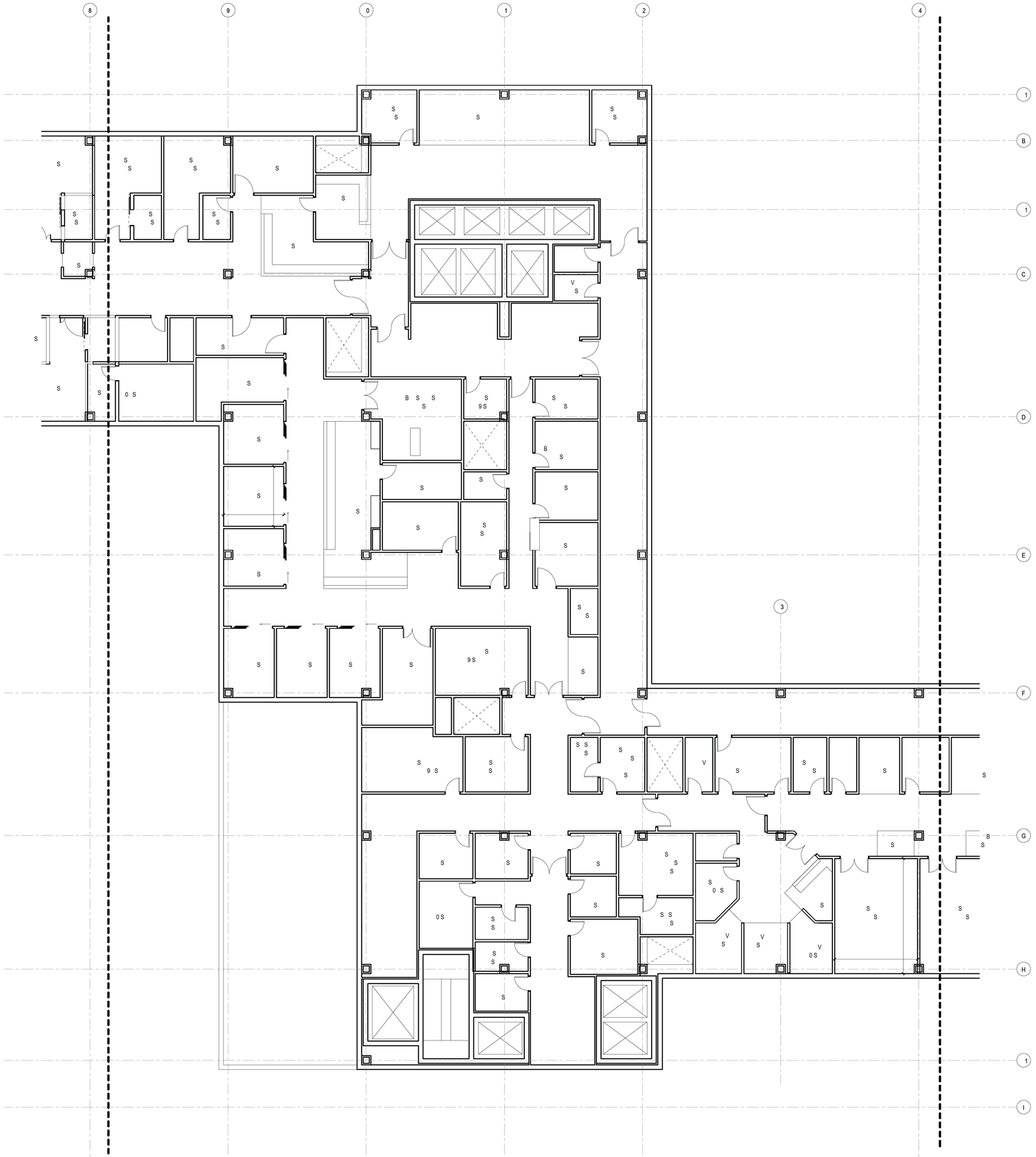

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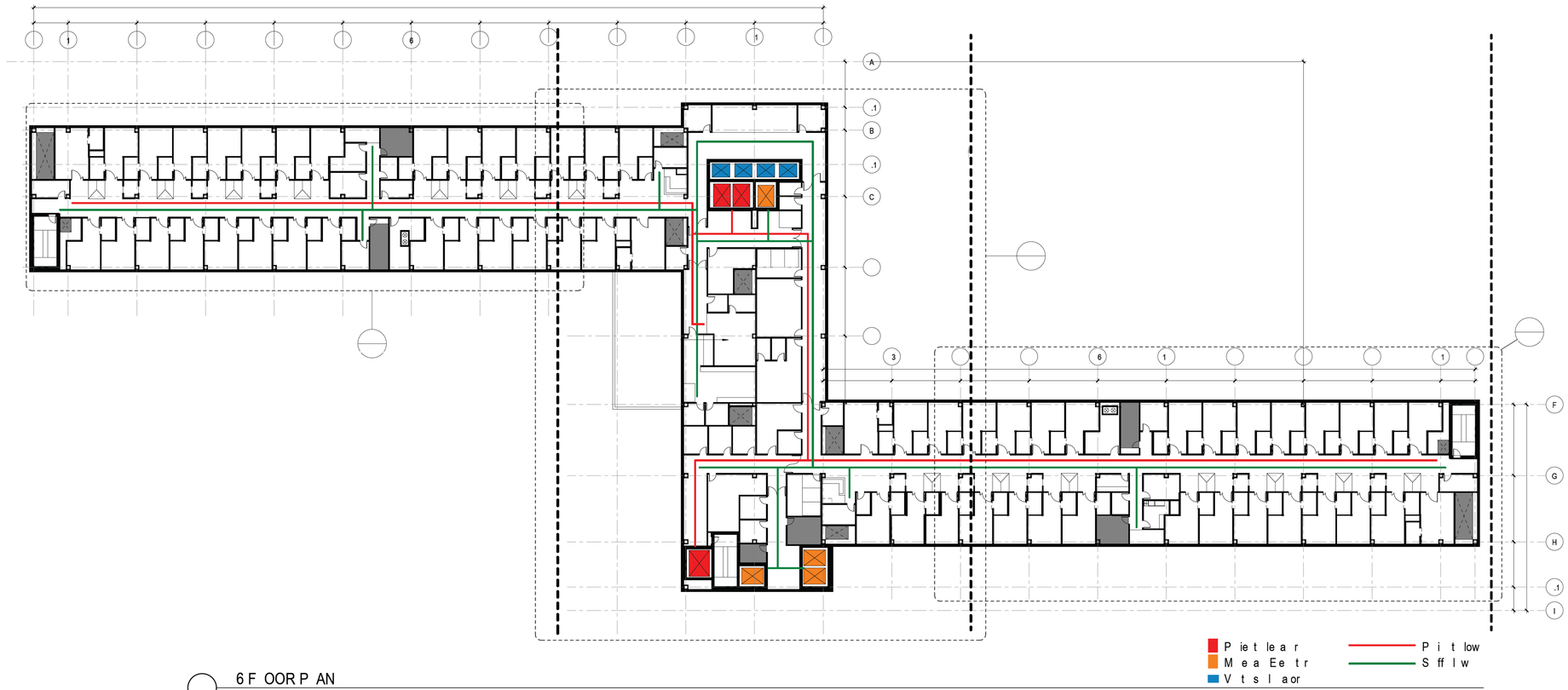

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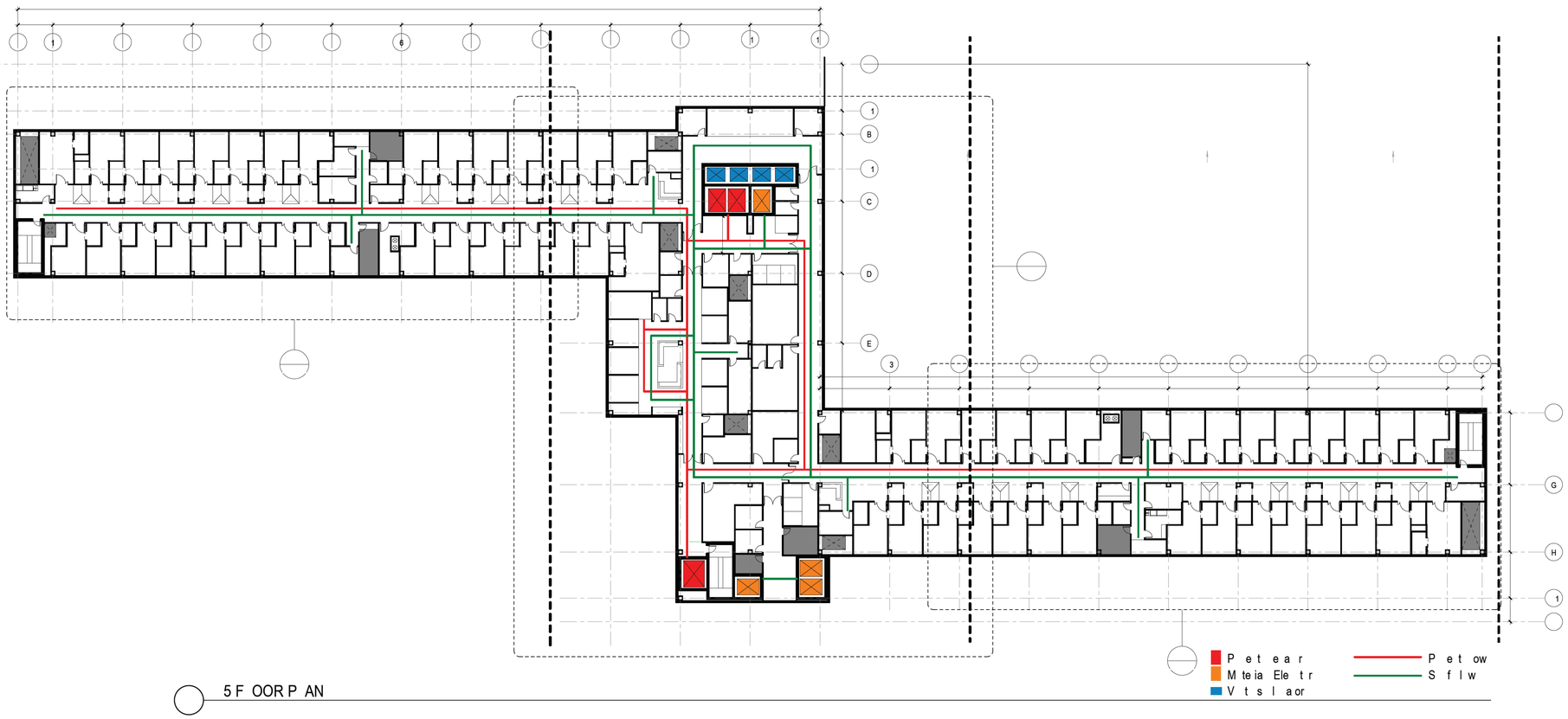

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REGISTERED ARCHITECT
STATE OF NEW YORK

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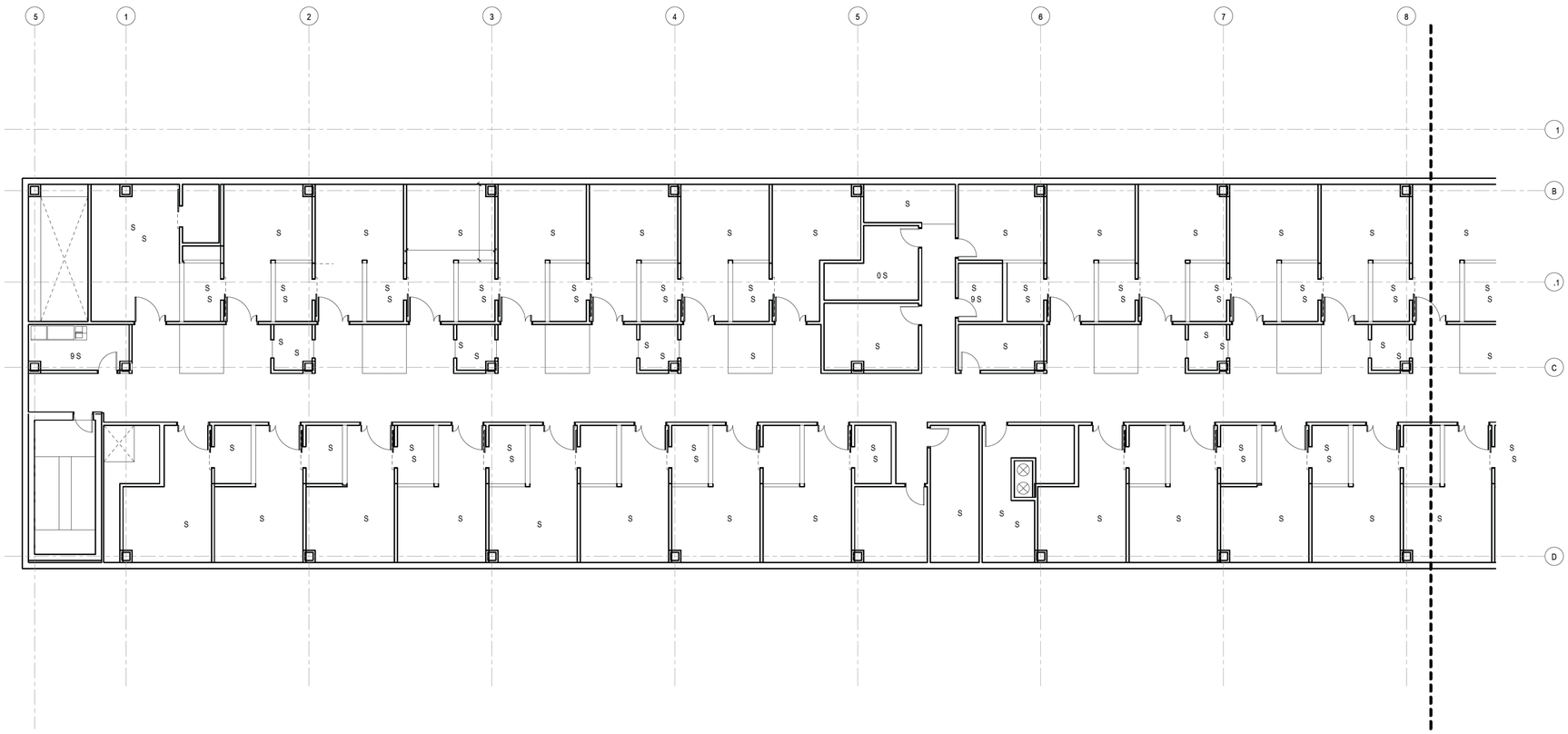

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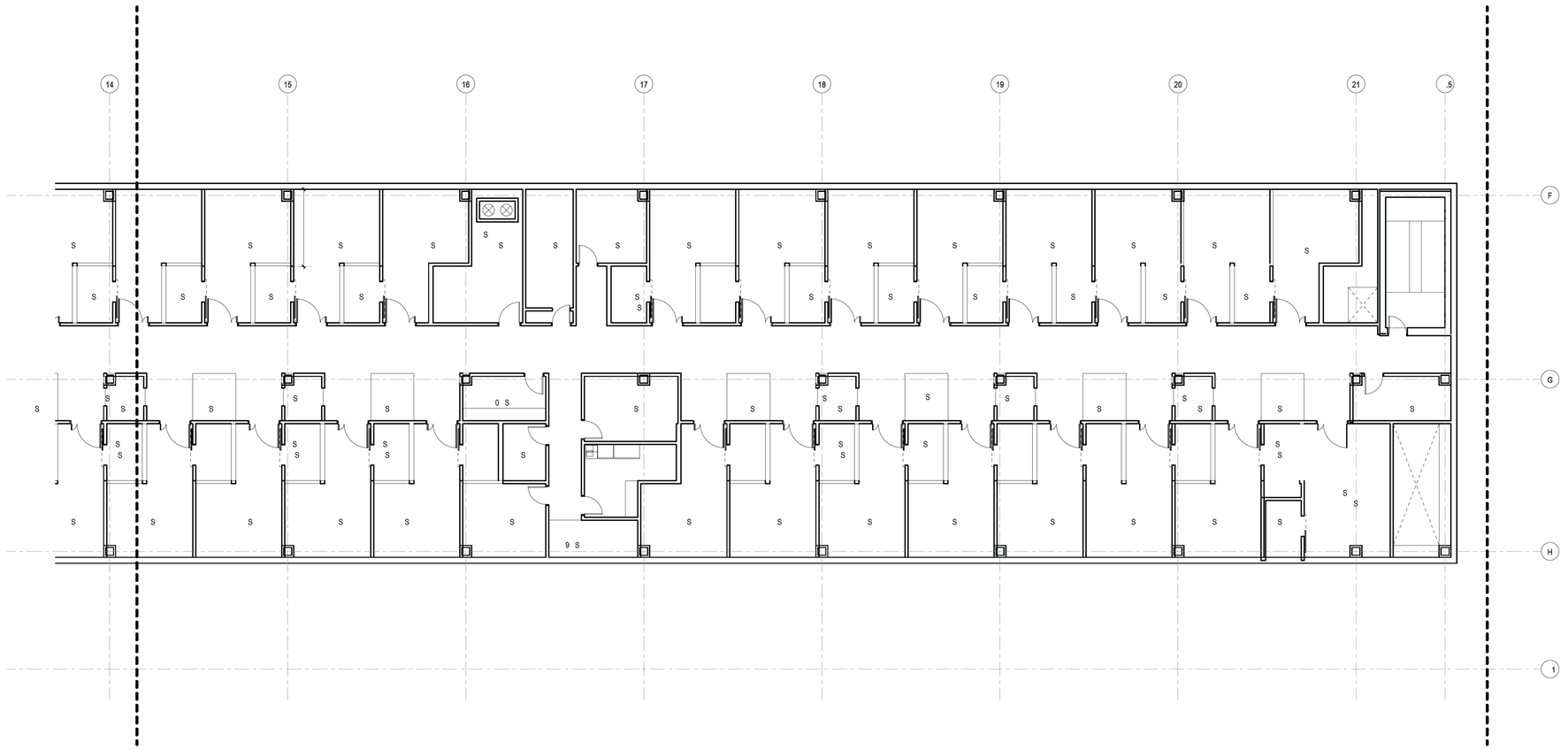

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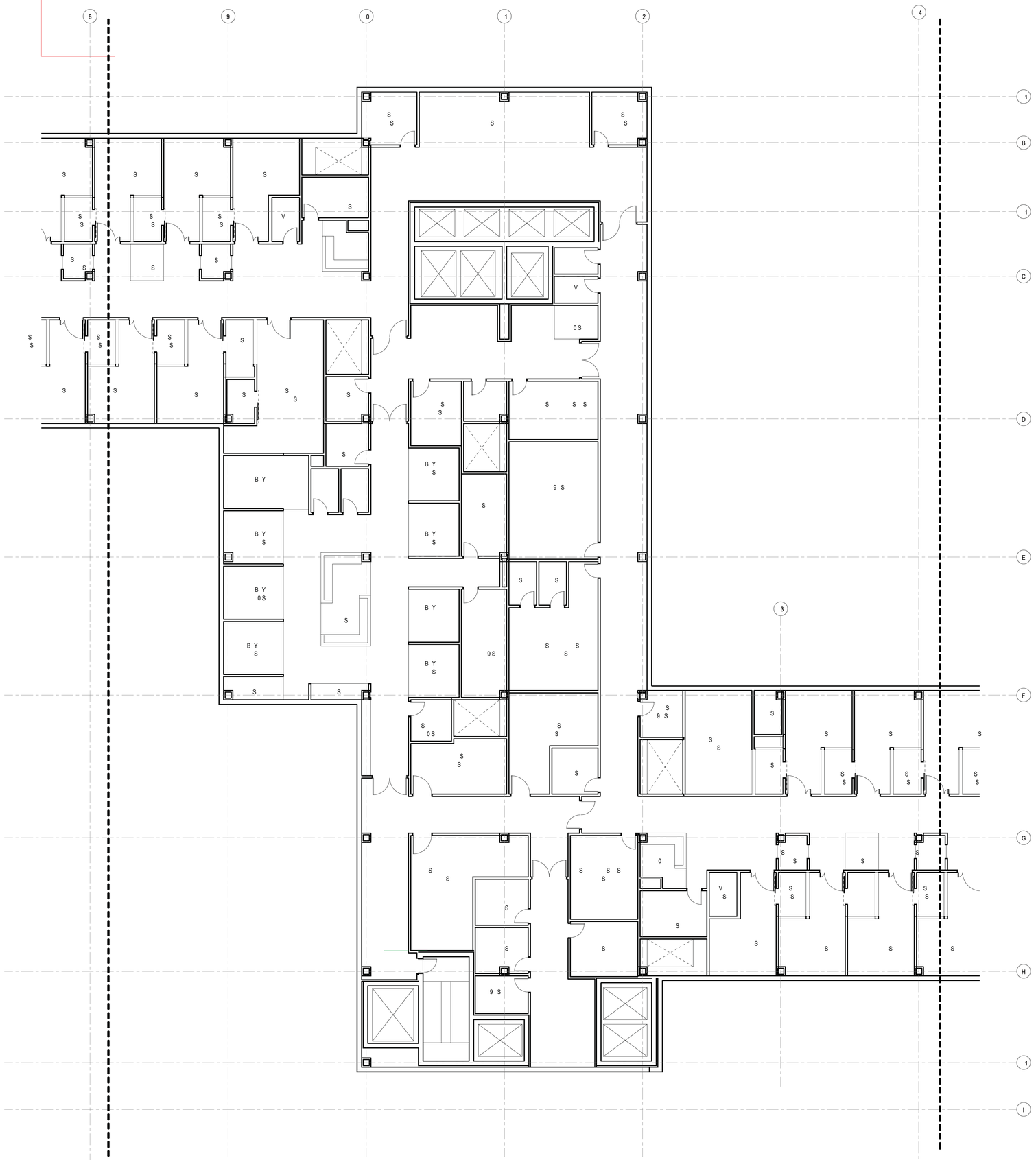

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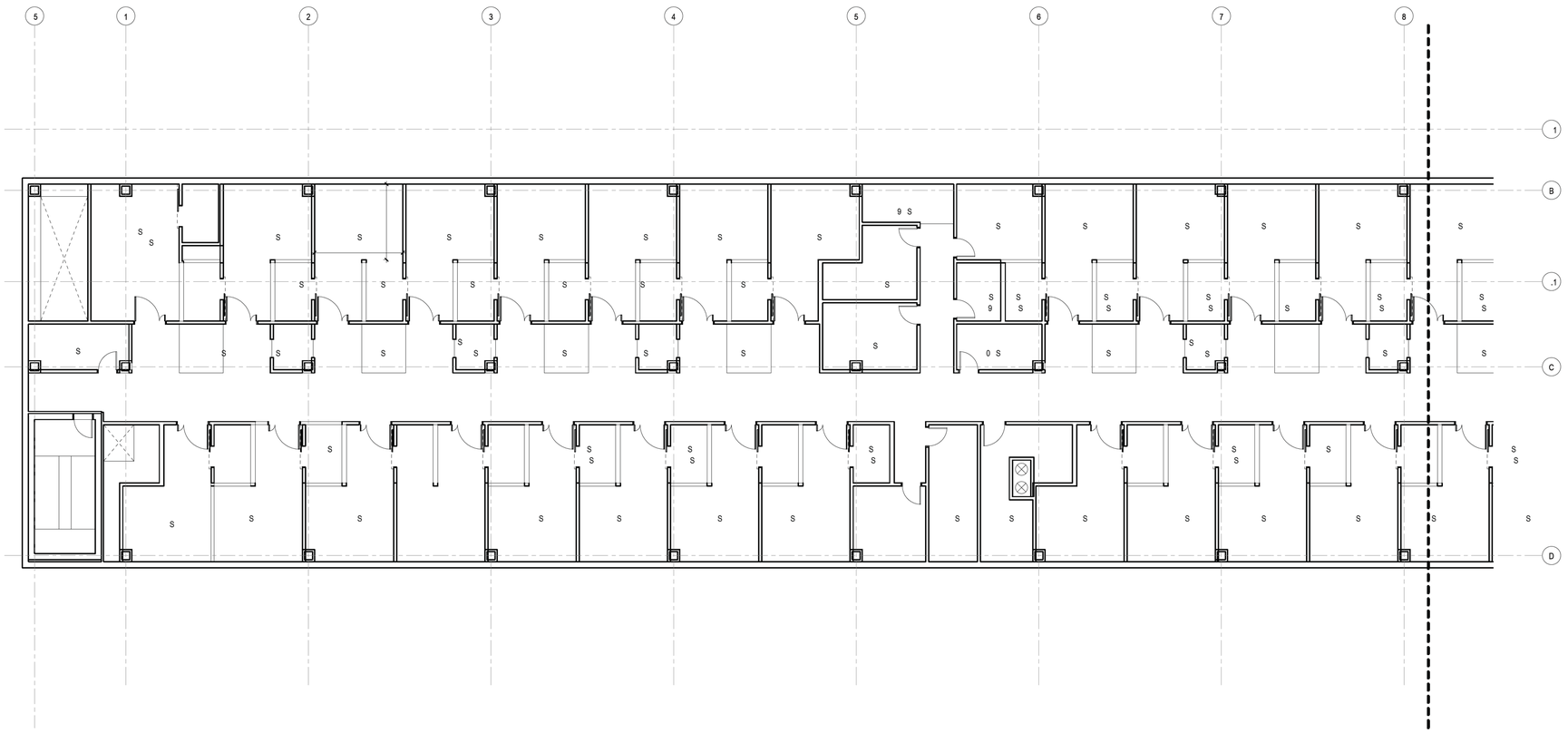

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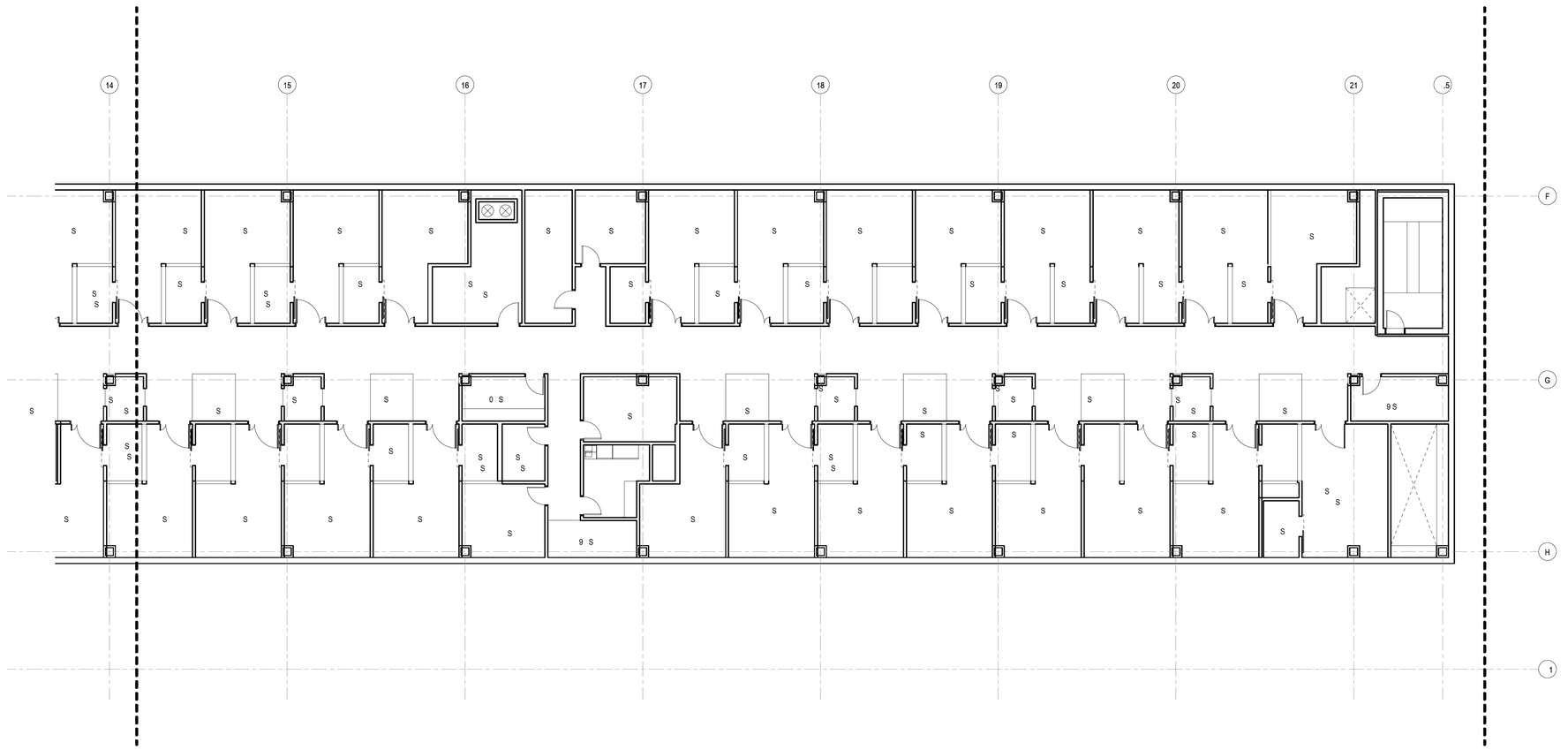

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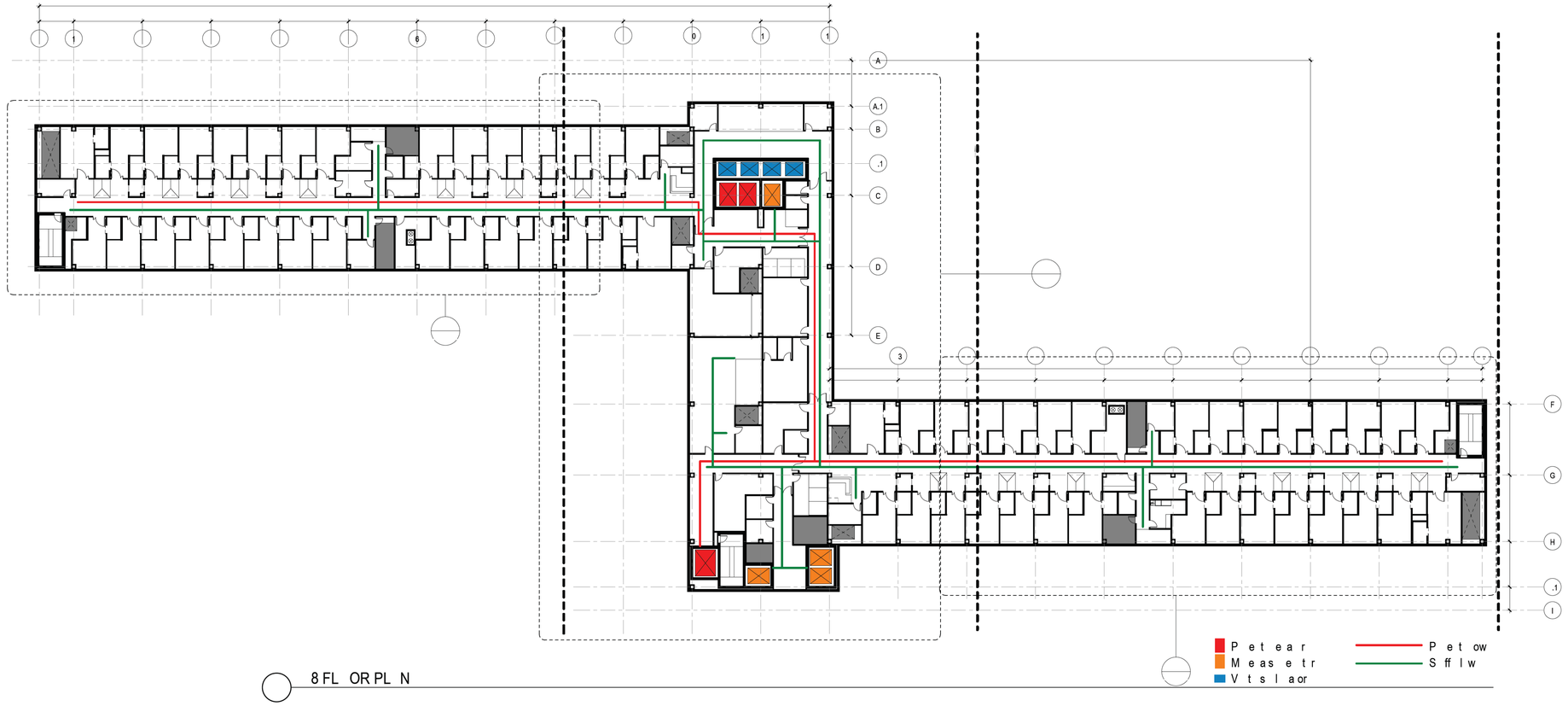

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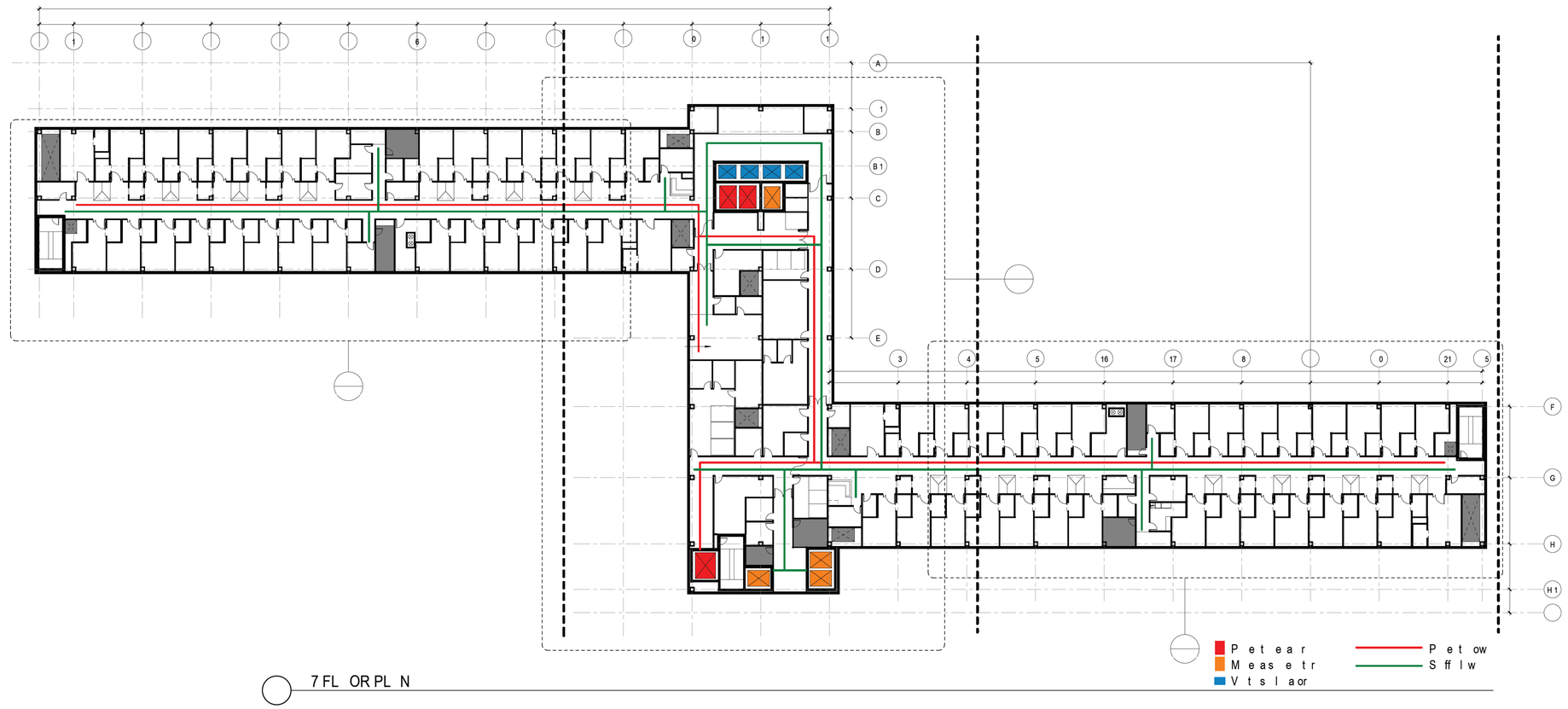

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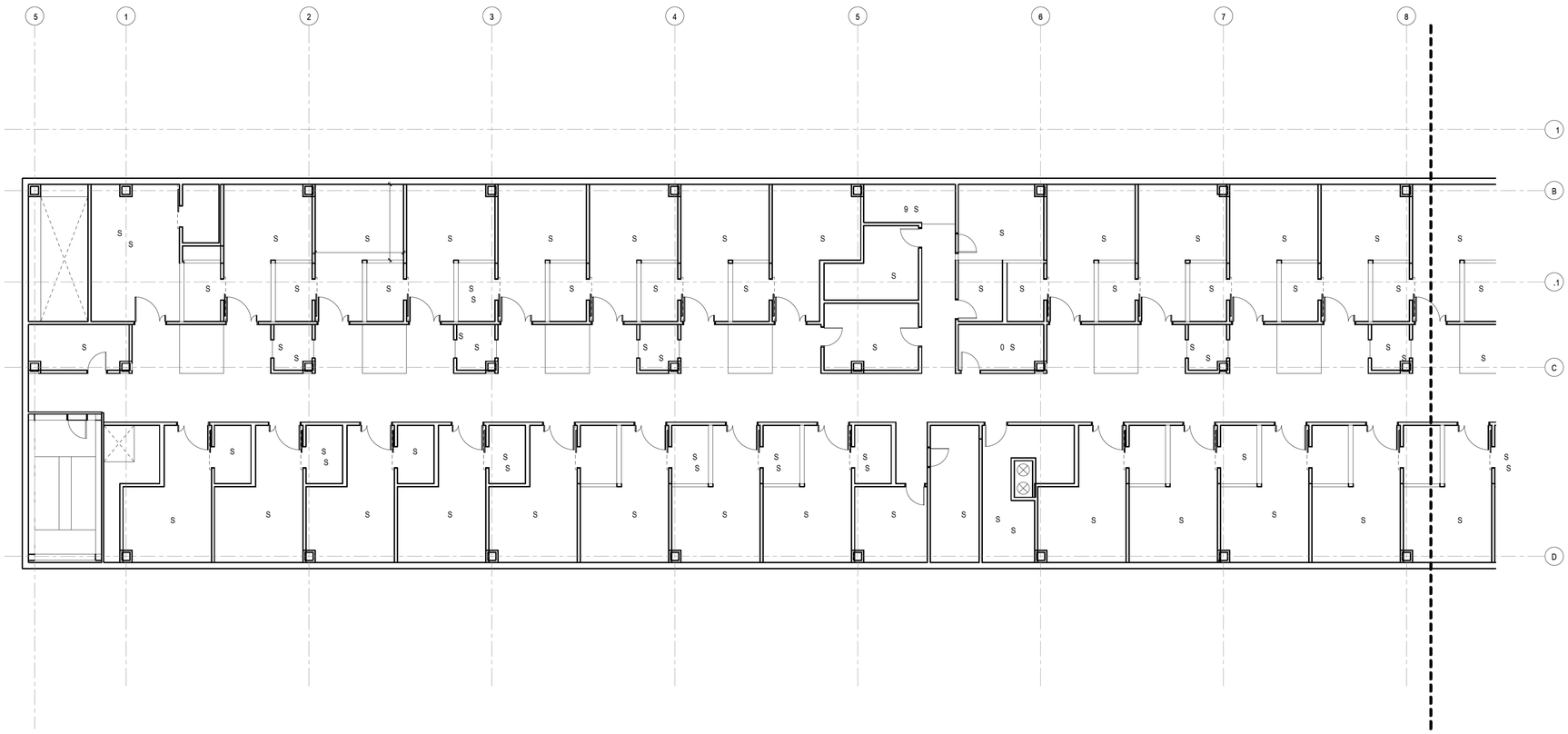

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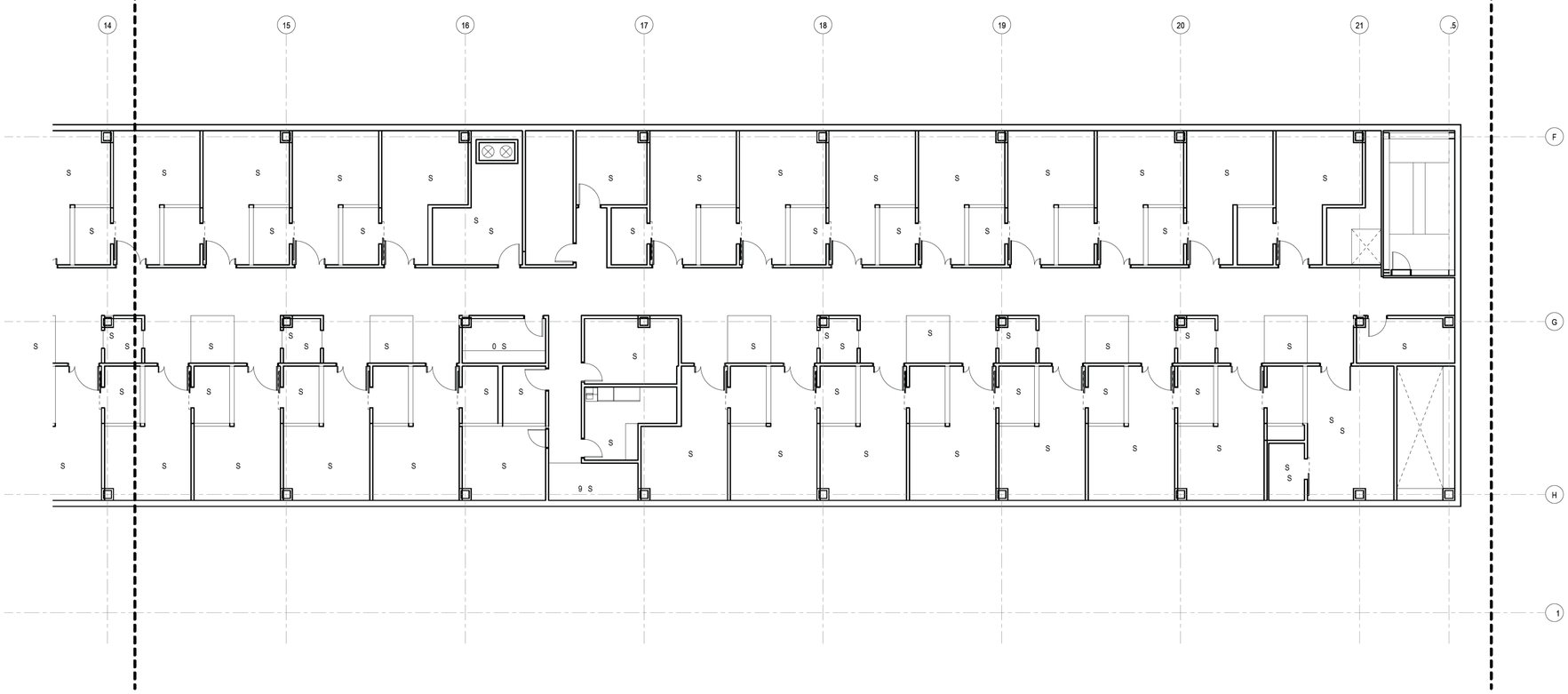

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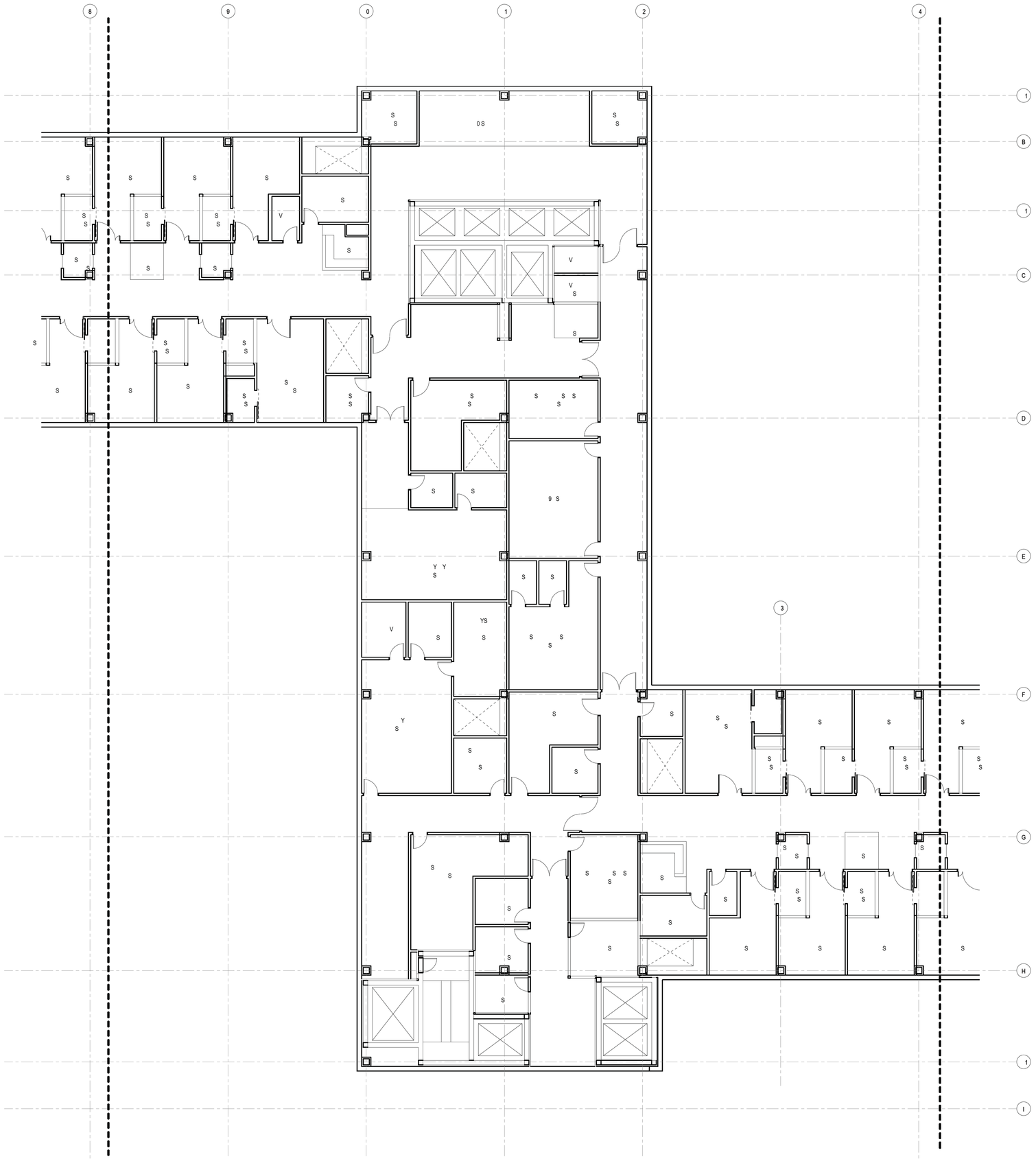

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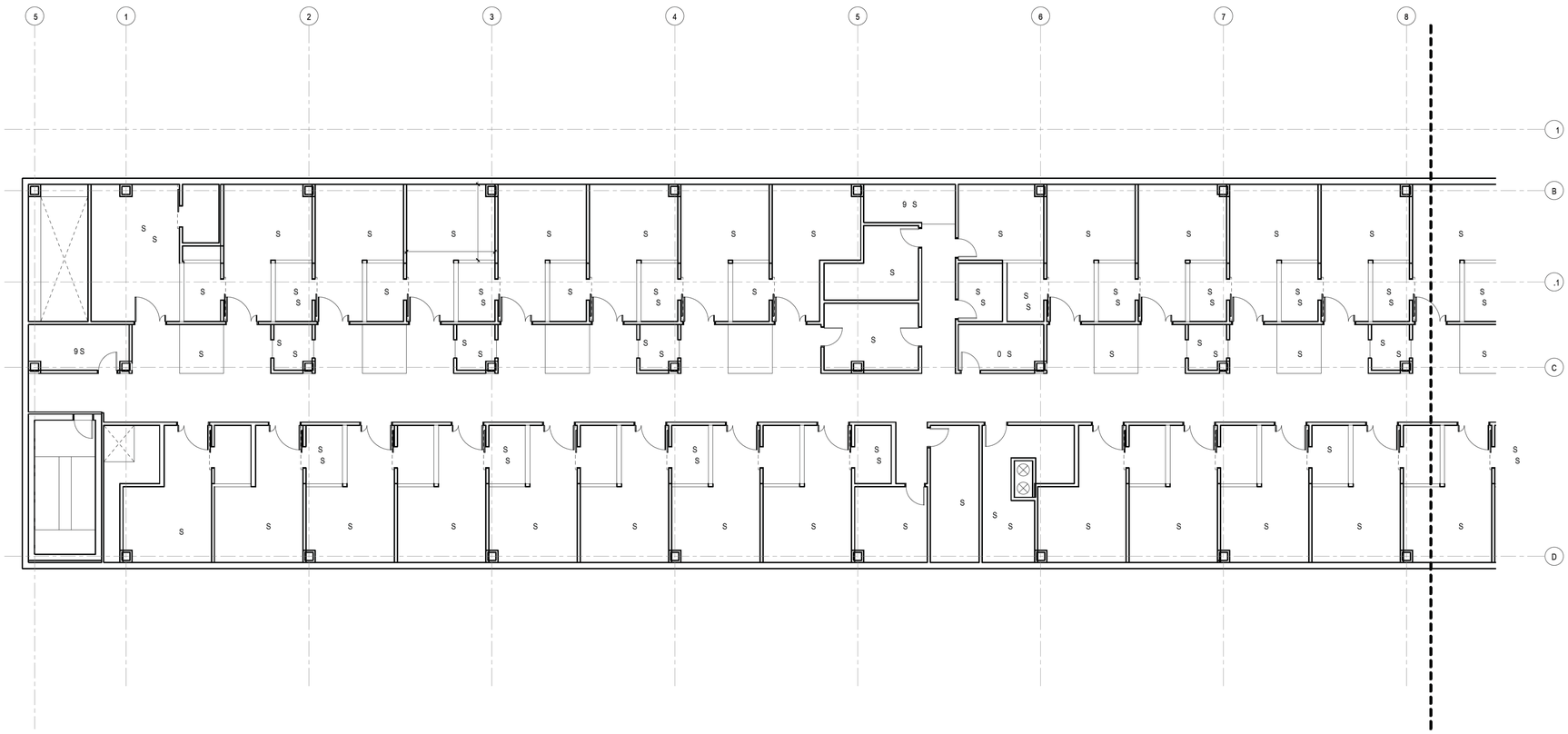

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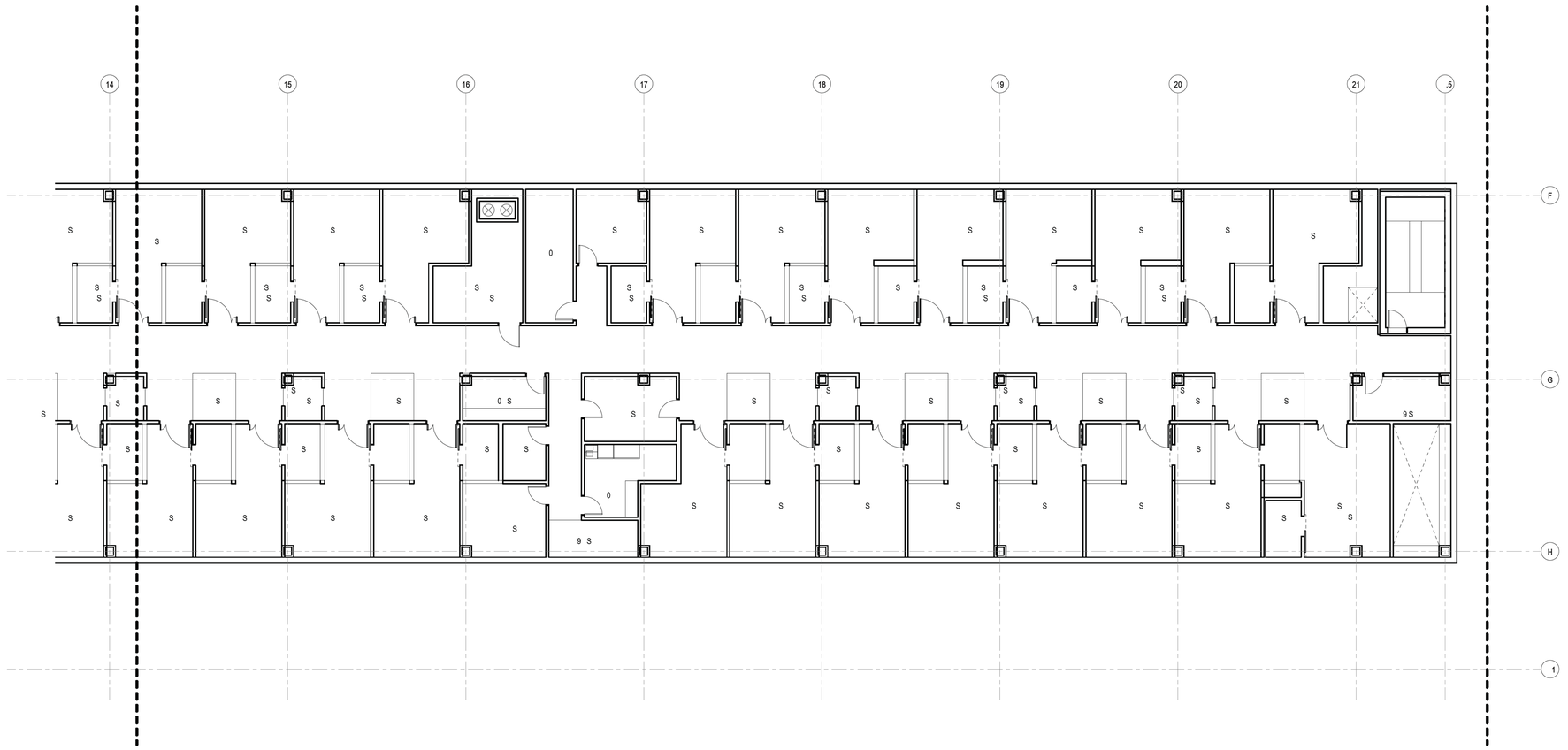

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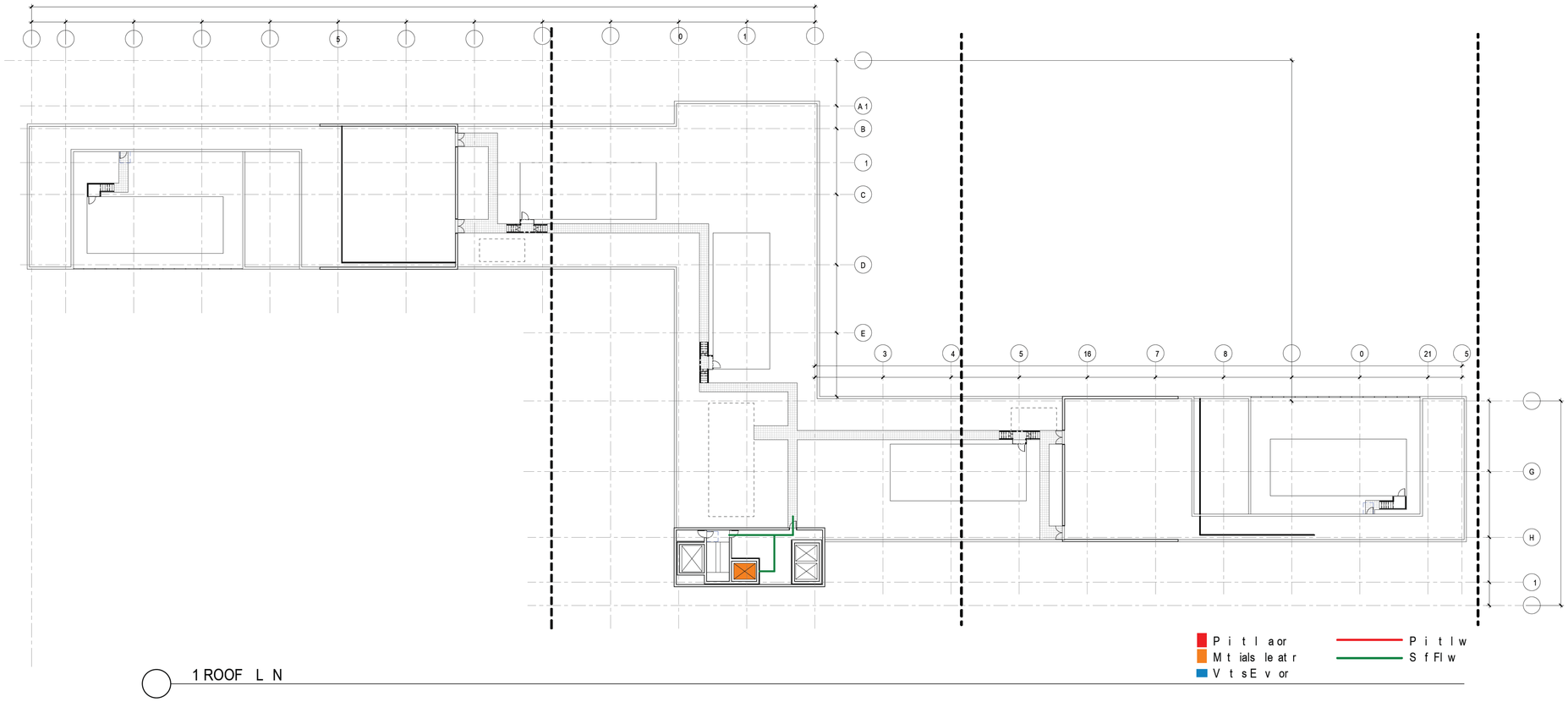

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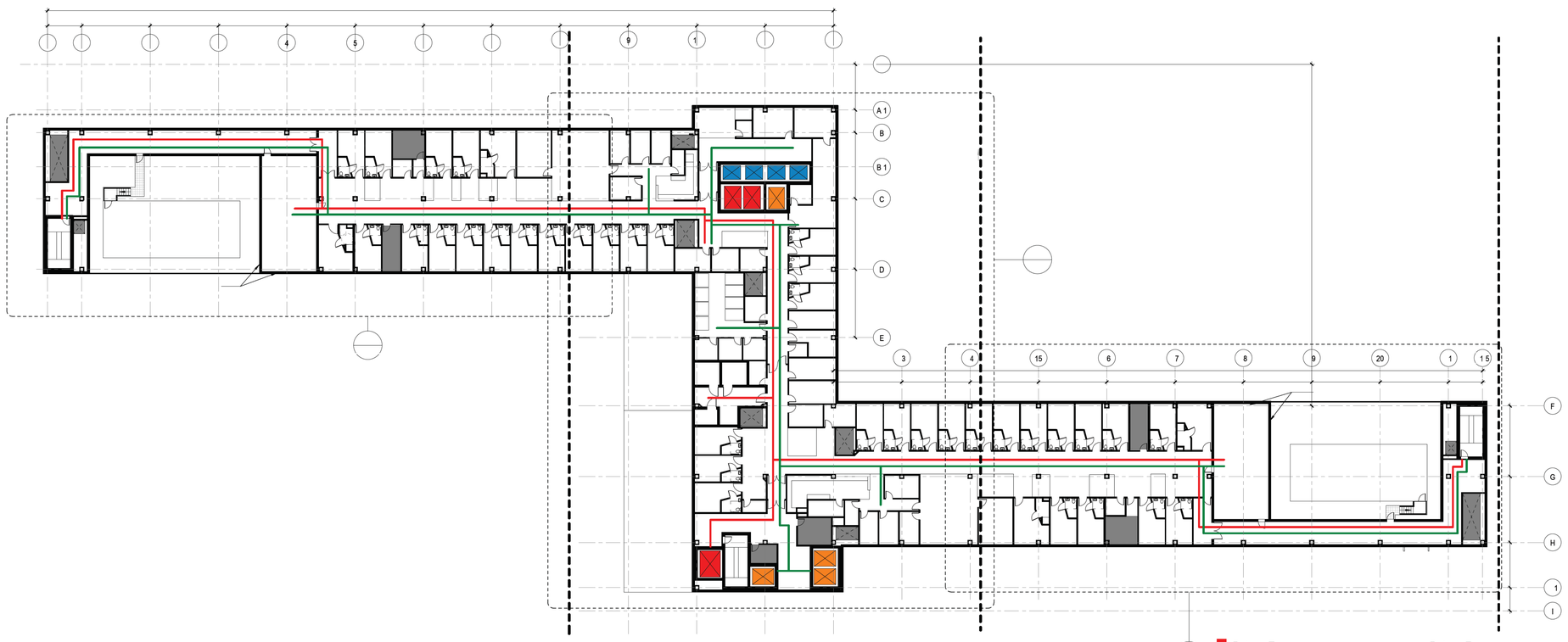

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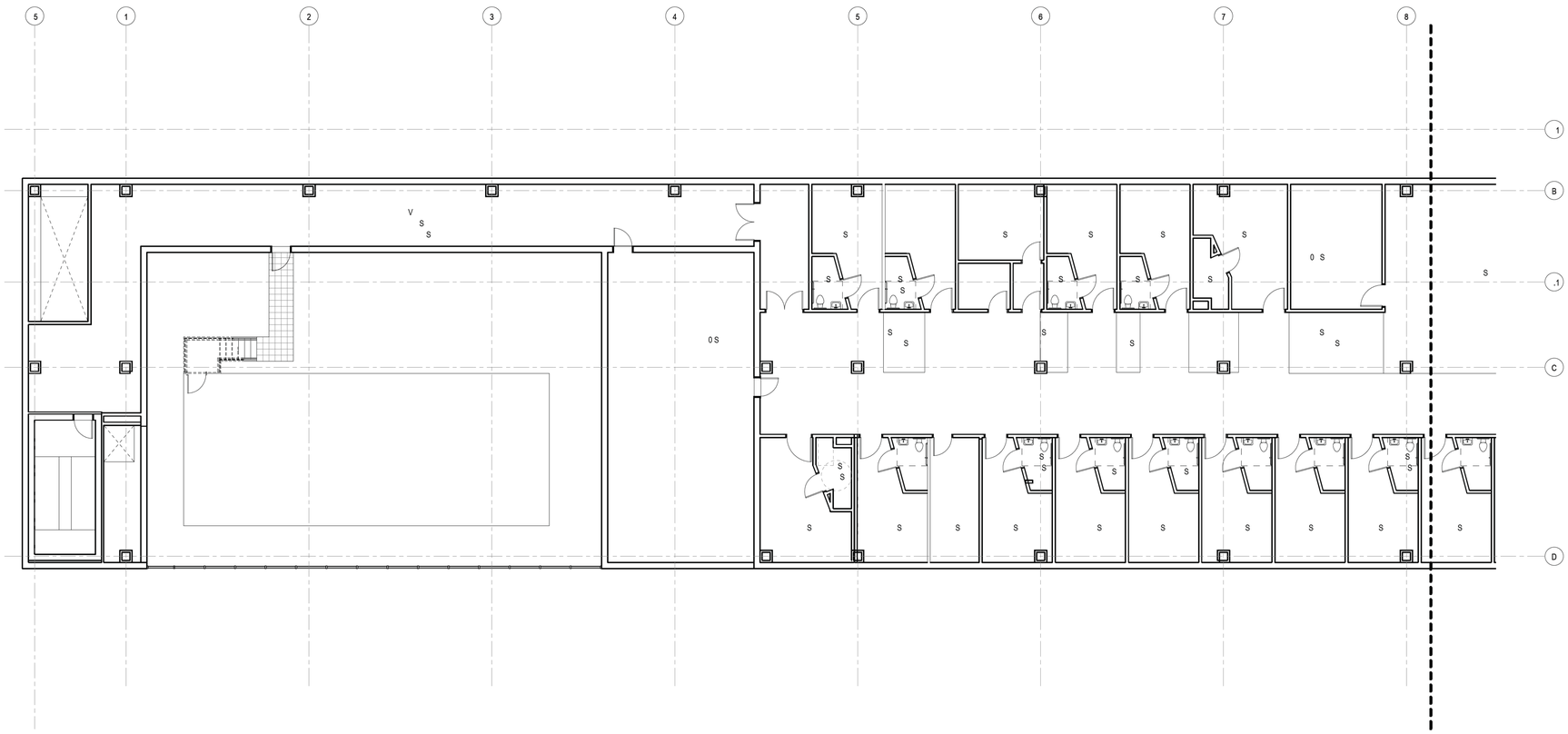

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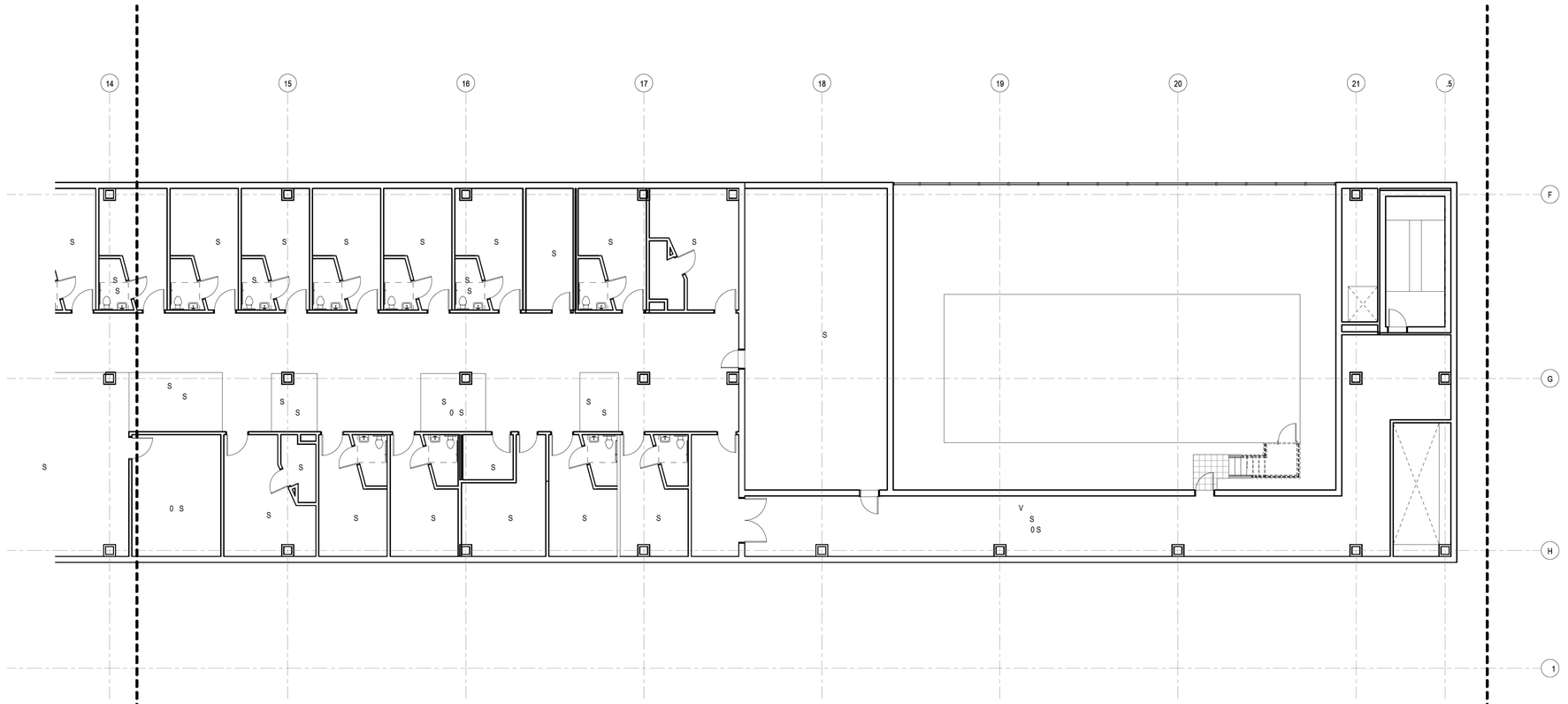

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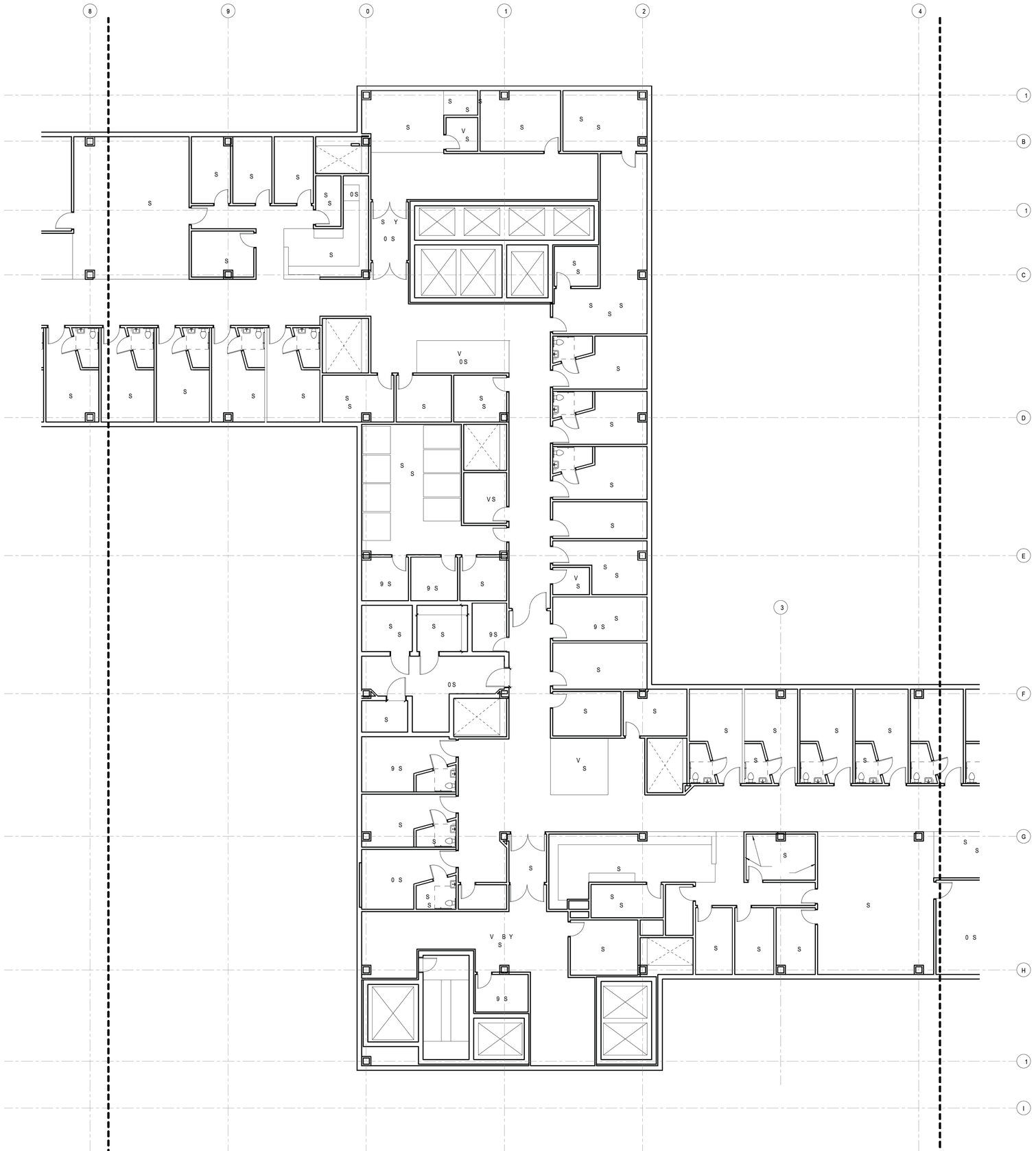

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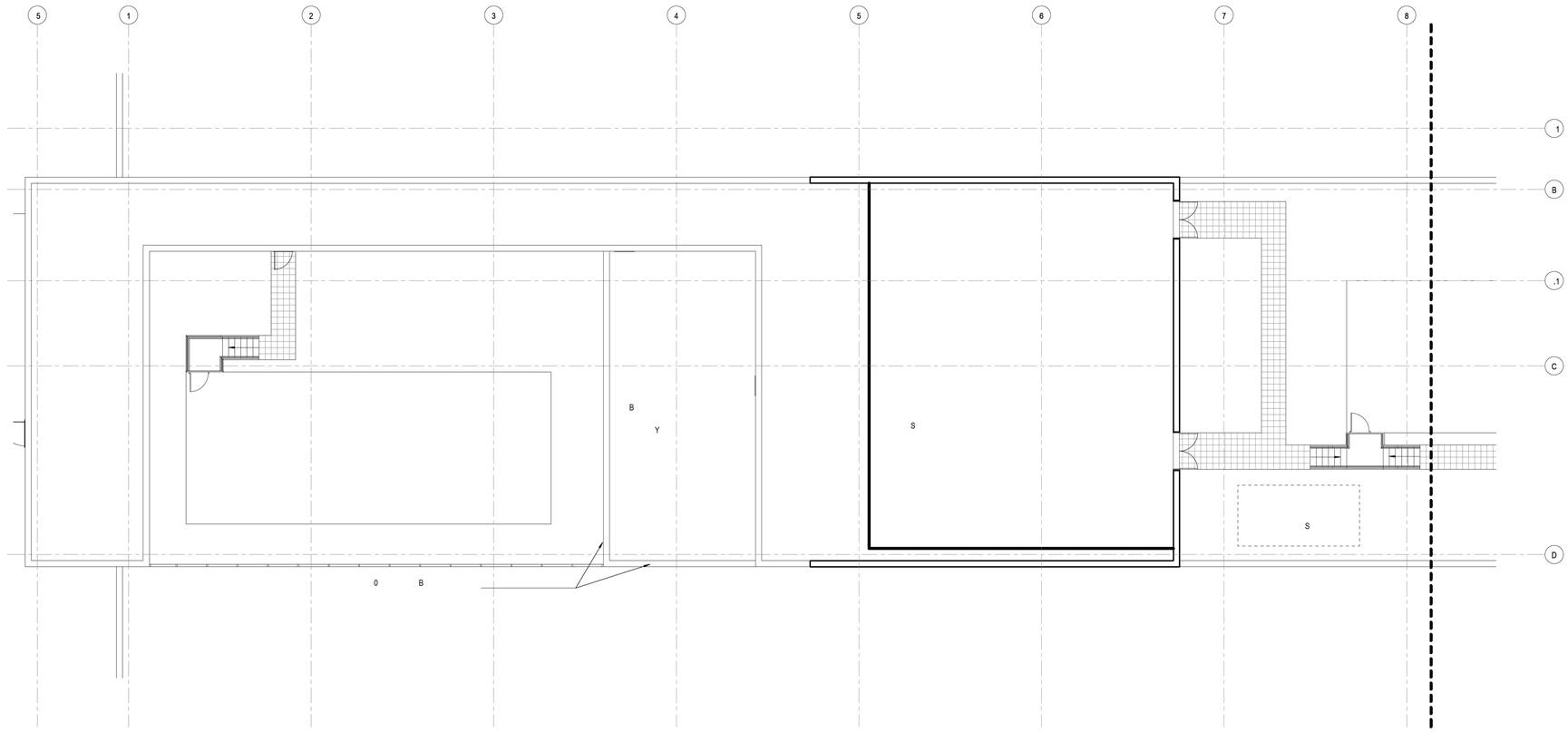

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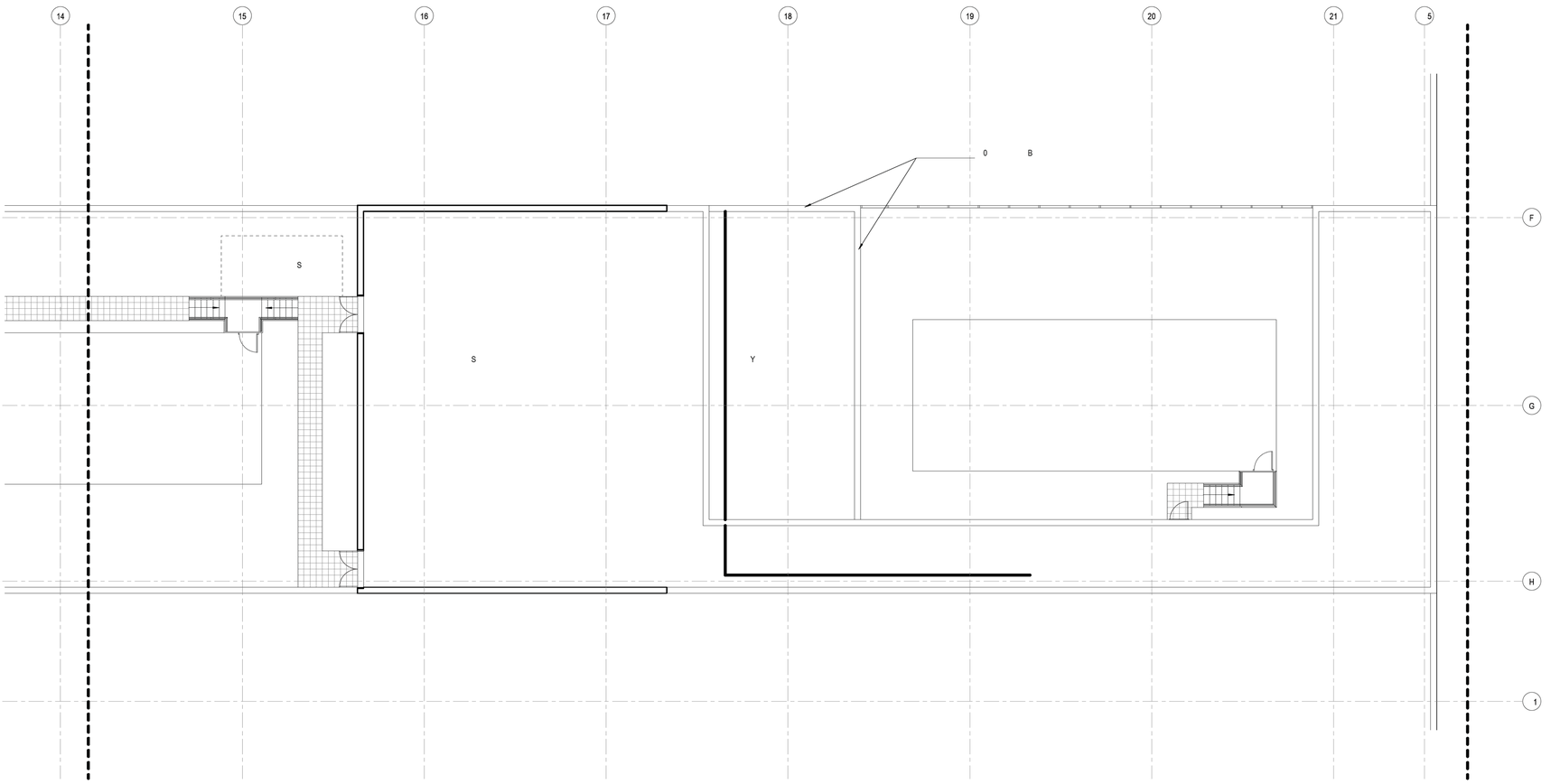

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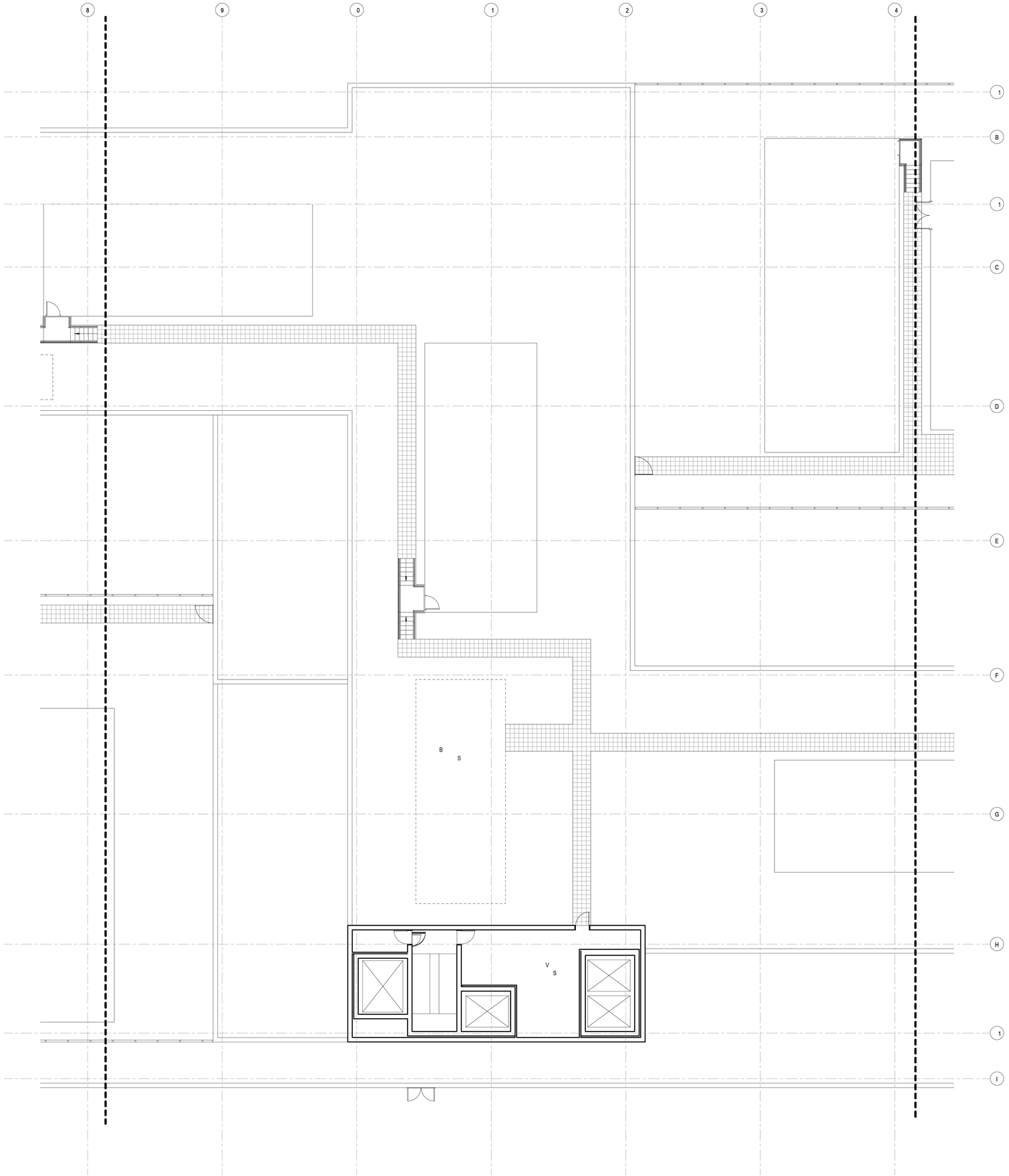

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Environmental Assessment

Part I.

The following questions help determine whether the project is "significant" from an environmental standpoint.

		Yes	No
1.1	If this application involves establishment, will it involve more than a change of name or ownership only, or a transfer of stock or partnership or membership interests only, or the conversion of existing beds to the same or lesser number of a different level of care beds? *This project does not involve establishment.*	☐ NA	☐
1.2	Does this plan involve construction and change land use or density?	☒	☐
1.3	Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved? *The plan involves the construction of a new hospital facility and attendant features in a previously developed and disturbed urban area.*	☒	☐
1.4	Does this plan involve construction and require work related to the disposition of asbestos?	☒	☐

Part II.

If any question in Part I is answered "yes" the project may be significant and Part II must be completed If all questions in Part II are answered "no" it is likely that the project is not significant.

2.1	Does the project involve physical alteration of ten acres or more?	☒	☐
2.2	If an expansion of an existing facility, is the area physically altered by the facility expanding by more than 50% and is the total existing and proposed altered area ten acres or more? *This is not an expansion project*	☐ NA	☐
2.3	Will the project involve use of ground or surface water or discharge of wastewater to ground or surface water in excess of 2,000,000 gallons per day?	☐	☒
2.4	If an expansion of an existing facility, will use of ground or surface water or discharge of wastewater by the facility increase by more than 50% and exceed 2,000,000 gallons per day?	☐	☒
2.5	Will the project involve parking for 1,000 vehicles or more?	☒	☐
2.6	If an expansion of an existing facility, will the project involve a 50% or greater increase in parking spaces and will total parking exceed 1000 vehicles? *This is not an expansion project*	☐ NA	☐
2.7	In a city, town, or village of 150,000 population or fewer, will the project entail more than 100,000 square feet of gross floor area?	☒	☐
2.8	If an expansion of an existing facility in a city, town, or village of 150,000 population or fewer, will the project expand existing floor space by more than 50% so that gross foor area exceeds 100,000 square feet? *This is not an expansion project*	☐ NA	☐
2.9	In a city, town or village of more than 150,000 population, will the project entail more than 240,000 square feet of gross floor area? *Utica population 62,235 (2010 Census)*	☐ NA	☐

2.10	If an expansion of an existing facility in a city, town, or village of more than 150,000 population, will the project expand existing floor space by more than 50% so that gross foor area exceeds 240,000 square feet? *This is not an expansion project*	☐	☐ *NA*
2.11	In a locality without any zoning regulation about height, will the project contain any structure exceeding 100 feet above the original ground area? *There is no restriction in the Code. The Historic Canal Gateway District overlay has guidelines of 7 stories and 70 feet. Approx. height of new facility is 165 feet.*	☒	☐
2.12	Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303?	☐	☒
2.13	Will the project significantly affect drainage flow on adjacent sites? *Drainage will be directed to new/existing storm sewers or to new green infrastructure constructed as part of the project*	☐	☒
2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☒
2.15	Will the project result in a major adverse effect on air quality? *This question will be examined as part of the Environmental Impact Statement (EIS).*	☐	☐ *EIS pending*
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community? *This question will be examined as part of the EIS.*	☐	☐ *EIS pending*
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems? *This question will be examined as part of the EIS.*	☐	☐ *EIS pending*
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation? *This question will be examined as part of the EIS.*	☐	☐ *EIS pending*
2.19	Will the project have any adverse impact on health or safety? *This question will be examined as part of the EIS.*	☐	☐ *EIS pending*
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood? *This question will be examined as part of the EIS.*	☐	☐ *EIS pending*
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☒	☐
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation? *This question will be examined as part of the EIS.*	☐	☐ *EIS pending*
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☒

Part III.

Must be completed if any question on Part II was answered "Yes".

3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in **Contact Information to Question 3.1 below**.	☒	☐
3.2	Has any other agency made an environmental review of this project? If so, give name.	☐	☒
3.3	Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.	☒	☐
A group No Hospital Downtown was formed. Some of the concerns expressed by this group are related to public costs for parking garage, fate of police and courthouse buildings, demolition of historical buildings, loss of tax dollars, proximity to CSX rail lines, and consistency with Master Plan and Gateway Historic Canal District planning.			

Contact Information to Question 3.1

Agency Name:	City of Utica
Contact Name:	Brian Thomas, Commissioner UED; J. Michael Mahoney, Deputy Eng
Address:	1 Kennedy Plaza, Utica
State and Zip Code:	NY, 13502
E-Mail Address:	bthomas@cityofutica.com; mmahoney@cityofutica.com
Phone Number:	315-792-0181 UED; 315-792-0152 Engineering
Agency Name:	NYSDEC
Contact Name:	Thomas M. Vigneault, P.E., Regional Water Engineer
Address:	207 Genesee Street, Utica
State and Zip Code:	NY, 13501
E-Mail Address:	thomas.vigneault@dec.ny.gov
Phone Number:	315-793-2796
Agency Name:	NYSDOT
Contact Name:	Brian Hoffmann, Regional Design Engineer
Address:	207 Genesee Street, Utica
State and Zip Code:	NY, 13501
E-Mail Address:	brian.hoffmann@dot.ny.gov
Phone Number:	315-793-2429
Agency Name:	State Historic Preservation Office
Contact Name:	Anthony Opalka, Historic Preservation Program Analyst
Address:	Peebles Island State Park, P.O. Box 189, Waterford
State and Zip Code:	NY, 12188-0189
E-Mail Address:	Anthony.Opalka@parks.ny.gov
Phone Number:	518-268-2177
Agency Name:	Mohawk Valley Water Authority
Contact Name:	Dick Goodney P.E., Director of Engineering
Address:	1 Kennedy Plaza, Utica
State and Zip Code:	NY, 13502
E-Mail Address:	rgoodney@mvwa.us
Phone Number:	315-792-0336

Agency Name:	Oneida County Department of Health
Contact Name:	Daniel W. Gilmore, Ph.D, Environmental Health Director
Address:	185 Genesee Street, 4th Floor
State and Zip Code:	NY, 13501
E-Mail Address:	environmentalhealth@ocgov.net

Part IV. Storm and Flood Mitigation

Please use the FEMA Flood Designations scale below as a guide to answering Part IV. Refer to Attachment A on page 5.

1.	Are you in a flood plain? If so, what classification? a. Moderate to Low Risk Area _____ b. High Risk Area _____ c. High Risk Coastal Area _____ d. Undetermined Risk Area _____	☐	☒
2.	Are you in a designated evacuation zone? If so, which zone _____	☐	☒
3.	Does this project reflect the post Hurricane Lee, and or Irene, and Superstorm Sandy mitigation standards? 100-Year Floodplain _____ 500-Year Floodplain _____	☐	☒

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

http://www.fema.gov/media-library-data/20130726-1437-20490-3457/f_053_elevationcertificate_jan13.pdf

Attachment A - FEMA Flood Designations

Definitions of FEMA Flood Zone Designations

Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.

Moderate to Low Risk Areas

In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:

ZONE	DESCRIPTION
B and X	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.
C and X	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.

High Risk Areas

In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all of these zones:

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

High Risk - Coastal Areas

In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all of these zones:

ZONE	DESCRIPTION
V	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones.
VE, V1 - 30	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.

Undetermined Risk Areas

ZONE	DESCRIPTION

New York State Department of Health
Certificate of Need Application
Schedule 8A Summarized Project Cost and Construction Dates

This schedule is required for all Establishment Applications and Full or Administrative Review Construction Applications.

1.) Project & Subject Cost Summary data:

	Total	Subproject 1	Subproject 2	Source
Project/Subproject Descritption:		Article 28 - New Hospital Campus	Non-Article 28 - Masonic Medical Research Laboratory	
Project/Subproject Cost	$478,744,035	$477,372,452	$1,371,583	Schedule 8b or 8c, column C, line 8
Total Basic Cost of Construction	$464,744,035	$463,372,452	$1,371,583	Schedule 8b or 8c column C, line 6
Total Cost of Moveable Equipment	$29,275,000	$29,275,000	$0	Schedule 8b or 8c, column C, line 5.1
Cost/Per Square Foot for New Construction	$291.44	$448.01	$477.09	Schedule 10
Cost/Per Square Foot for Renovation Construction	N/A	N/A	N/A	Schedule10
Total Incremental Operating Cost	$575,213,089	---	---	Schedule 13c, 17c or 19d
Amount Financed ($)	$150,000,000	$150,000,000	$0	Schedule 9
Percentage Financed as % of Total Cost	31.2%	31.3%	0.0%	Schedule 9
Depreciation Life (in years)				
2) Construction Dates				
Anticipated Start Date	1/1/2019	1/1/2019	1/1/2019	Schedule 8b
Anticipated Completion Date	5/1/2022	5/1/2022	5/1/2022	Schedule 8b

Certificate of Need Application

Schedule 8B - Total Project Cost - For Projects with up to 8 Subprojects

For Article 28, 36, and 40 Establishment & Construction Requiring Full, Administrative or Limited Review *
For Limited Review, complete column C only.

Constants:	Value	Comments:
Design Contingency - New Construction as %		Normally 10%
Construction Contingency - New Construction as %	See	Normally 10%
Design Contingency - Renovation as %	Information	Normally 10%
Construction Contingency - Renovation work as %	for Various	Normally 10%
Construction Start Date:	Sub-Projects	as mm/dd/yy
Midpoint of Construction Date		as mm/dd/yy
Completion of Construction Date		as mm/dd/yy
Year used to compute Current Dollars:		

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

Certificate of Need Application
Schedule 8B - Total Project Cost - For Projects with up to 8 Subprojects

	A	B	C
Item	**Project Cost in**	**Escalation amount to**	**Estimated Project**
Source:	Schedule 10 Col .7	Computed by applicant	(A + B)
1.1 Land Acquisition	$12,000,000		$12,000,000
1.2 Building Acquisition	$0		$0
2.1 New Construction	$301,887,630	$18,113,258	$320,000,888
2.2 Renovation & Demolition	$1,603,774	$96,226	$1,700,000
2.3 Site Development	$27,028,302	$1,621,698	$28,650,000
2.4 Temporary Utilities	$2,839,623	$170,377	$3,010,000
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$9,732,214	$684,122	$10,416,336
3.2 Construction Contingency	$9,680,283	$630,911	$10,311,194
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$698,491	$41,909	$740,400
4.3 Architect/Engineering Fees	$17,670,005	$1,060,200	$18,730,205
4.4 Construction Manager Fees	$3,325,943	$199,557	$3,525,500
4.5 Other Fees (Consultant, etc.)	$15,315,577	$918,935	$16,234,512
Subtotal (Total 1.1 thru 4.5)	$401,781,842	$23,537,193	$425,319,035
5.1 Movable Equipment (Sched 11)	$29,275,000	$0	$29,275,000
5.2 Telecommunications	$10,150,000	$0	$10,150,000
6. Total Basic Cost of Construction(total 1.1 thru 5)	$441,206,842	$23,537,193	$464,744,035
7.1 Financing Costs (Points etc)	$3,500,000		$3,500,000
7.2 Interim Interest Expense:: $150,000,000 At 5.25% for 32 months	$10,500,000		$10,500,000
8. Total Project Cost: w/o CON fees - Total 6 thru 7.2	$455,206,842	$23,537,193	$478,744,035
Application fees: 9.1 Application Fee $2,000. Only applies to Article 28.	$2,000		$2,000
9.2 Additional Processing Fee for Article 28 projects involving Construction. (.005 x line 8) Only applies to Article 28	$2,625,548		$2,625,548
10 Total Project Cost with CON fees	$457,834,390	$23,537,193	$481,371,583

Schedule 8B - Sub Project Cost **Subproject Number** 1

Subproject title: **Article 28 - New Hospital Campus**

For Article 28, 36, and 40 Establishment & Construction Requiring Full, Administrative or Limited Review *
For Limited Review, escalation values may be entered as "0"

Constants:	Value	Comments:
Design Contingency - New Construction (%)	3.20%	Normally 10%
Construction Contingency - New Construction (%)	3.20%	Normally 5%
Design Contingency - Renovation Work (%)	N/A	Normally 10%
Contruction Contingency - Renovation (%)	N/A	Normally 10%
Subproject Construction Start Date:	1/1/2019 (on or before)	as mm/dd/yyyy
Midpoint of Subproject Construction	9/1/2020 (on or before)	as mm/dd/yyyy
Completion of Subproject Construction Date	5/1/2022 (on or before)	as mm/dd/yyyy
Year used to compute Current Dollars:	2017	

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

Subproject : 1 Article 28 - New Hospital Campus

Item	A Project Cost in	B Escalation amount to	C Estimated Project
Source:	Schedule 10 Col .7	Computed by applicant	(A + B)
1.1 Land Acquisition	$12,000,000		$12,000,000
1.2 Building Acquisition	$0		$0
2.1 New Construction	$300,885,743	$18,053,145	$318,938,888
2.2 Renovation & Demolition*	$1,603,774	$96,226	$1,700,000
2.3 Site Development	$27,028,302	$1,621,698	$28,650,000
2.4 Temporary Utilities	$2,839,623	$170,377	$3,010,000
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$9,632,025	$577,922	$10,209,947
3.2 Construction Contingency	$9,630,189	$577,811	$10,208,000
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$698,491	$41,909	$740,400
4.3 Architect/Engineering Fees	$17,670,005	$1,060,200	$18,730,205
4.4 Construction Manager Fees	$3,325,943	$199,557	$3,525,500
4.5 Other Fees (Consultant, etc.)**	$15,315,577	$918,935	$16,234,512
Subtotal (Total 1.1 thru 4.5)	$400,629,672	$23,317,780	$423,947,452
5.1 Movable Equipment (From Sched 11)	$29,275,000	$0	$29,275,000
5.2 Telecommunications***	$10,150,000	$0	$10,150,000
6. Total Basic Cost of Construction(total 1.1 thru 5)	$440,054,672	$23,317,780	$463,372,452
7.1 Financing Costs (Points etc)	$3,500,000		$3,500,000
7.2 Interim Interest Expense: $150,000,000 At 5.25% for 32 months	$10,500,000		$10,500,000
8. Estimated SubProject Cost: Total 6 thru 7.2	$454,054,672	$23,317,780	$477,372,452

* Represents demolition of the existing building structures on the new hospital campus.
** Please refer to the Schedule 8 Attachment for a detailed breakdown of these capital costs.
*** Please refer to the Schedule 11 Attachment for a New Telecommunications Equipment List.

Schedule 8B - Sub Project Cost **Subproject Number** 2

Subproject title: **Non-Article 28 - Masonic Medical Research Laboratory**

For Article 28, 36, and 40 Establishment & Construction Requiring Full, Administrative or Limited Review *
For Limited Review, escalation values may be entered as "0"

Constants:	Value	Comments:
Design Contingency - New Construction (%)	10.00%	Normally 10%
Construction Contingency - New Construction (%)	5.00%	Normally 5%
Design Contingency - Renovation Work (%)	N/A	Normally 10%
Contruction Contingency - Renovation (%)	N/A	Normally 10%
Subproject Construction Start Date:	1/1/2019 (on or before)	as mm/dd/yyyy
Midpoint of Subproject Construction	9/1/2020 (on or before)	as mm/dd/yyyy
Completion of Subproject Construction Date	5/1/2022 (on or before)	as mm/dd/yyyy
Year used to compute Current Dollars:	2017	

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

Subproject : 2 Non-Article 28 - Masonic Medical Research Laboratory

	A	B	C
Item	**Project Cost in**	**Escalation amount to**	**Estimated Project**
Source:	Schedule 10 Col .7	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$1,001,887	$60,113	$1,062,000
2.2 Renovation & Demolition	$0	$0	$0
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$100,189	$106,200	$206,389
3.2 Construction Contingency	$50,094	$53,100	$103,194
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$0	$0	$0
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$0	$0	$0
Subtotal (Total 1.1 thru 4.5)	$1,152,170	$219,413	$1,371,583
5.1 Movable Equipment (From Sched 11)	$0	$0	$0
5.2 Telecommunications	$0	$0	$0
6. Total Basic Cost of Construction(total 1.1 thru 5)	$1,152,170	$219,413	$1,371,583
7.1 Financing Costs (Points etc)	$0		$0
7.2 Interim Interest Expense: $ [ ] At [ ] % for [ ] months	$0		$0
8. Estimated SubProject Cost: Total 6 thru 7.2	$1,152,170	$219,413	$1,371,583

SCHEDULE 8 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

BREAKDOWN OF "OTHER FEES"
(SUB-PROJECT #1)

MOHAWK VALLEY HEALTH SYSTEM

NEW HOSPITAL CAMPUS

BREAKDOWN OF "OTHER FEES" (SUB-PROJECT #1)

	Description	Unescalated Costs	Escalation	Escalated Costs
102 -- Other Owner Construction				
11000	Mockup Construction	$ 141,509	$ 8,491	$ 150,000
11020	Construction Document Printing	$ 94,340	$ 5,660	$ 100,000
103 -- Owner Background Information				
11500	Site Surveys / ALTA Survey	$ 94,340	$ 5,660	$ 100,000
11520	Environmental Reports	$ 94,340	$ 5,660	$ 100,000
11540	Environmental Impact Study	$ 94,340	$ 5,660	$ 100,000
11570	Traffic/Parking Studies	$ 47,170	$ 2,830	$ 50,000
11580	Utility Assessment Study	$ 188,679	$ 11,321	$ 200,000
11590	Other Studies	$ 235,849	$ 14,151	$ 250,000
107 -- Other Consulting Services & Misc. Cost				
13520	Signage Consultant	$ 77,830	$ 4,670	$ 82,500
13590	Peer Eval -- Enclosure	$ 141,509	$ 8,491	$ 150,000
13630	Building Commissioning	$ 613,208	$ 36,792	$ 650,000
13640	Test & Balance	$ 523,868	$ 31,432	$ 555,300
13660	Radiation Shielding / Physicist	$ 70,755	$ 4,245	$ 75,000
13670	Other Consultants (Dietary)	$ 165,094	$ 9,906	$ 175,000
13670	Other Consultants (Medical Equipment Planning)	$ 424,528	$ 25,472	$ 450,000
13670	Other Consultants (IT / IS Planning)	$ 400,943	$ 24,057	$ 425,000
13670	Other Consultants (Signage / Graphics Planning)	$ 127,358	$ 7,642	$ 135,000
13680	Reimbursable Expenses	$ 165,528	$ 9,932	$ 175,460
111 -- Other Project Cost				
15500	Construction Testing	$ 523,868	$ 31,432	$ 555,300
15710	Movers	$ 235,849	$ 14,151	$ 250,000
15740	Builder's Risk	$ 471,698	$ 28,302	$ 500,000
15780	Independent Financial Audit	$ 94,340	$ 5,660	$ 100,000
113 -- Jurisdictional Cost				
16500	Planning & Zoning Fees	$ 141,509	$ 8,491	$ 150,000
16510	Plan Review Fees	$ 94,340	$ 5,660	$ 100,000
16520	Building Permit	$ 103,774	$ 6,226	$ 110,000
16690	Legal / Consultant Assistance Fees	$ 249,483	$ 14,969	$ 264,452
15700	Other (FAA Fees)	$ 28,302	$ 1,698	$ 30,000
116- Furniture, Fixtures and Equipment				
18000	Planning & Zoning Fees	$ 5,778,302	$ 346,698	$ 6,125,000
18030	Plan Review Fees	$ 330,189	$ 19,811	$ 350,000
18050	Building Permit	$ 94,340	$ 5,660	$ 100,000
18250	Legal / Consultant Assistance Fees	$ 1,675,943	$ 100,557	$ 1,776,500
18310	Legal / Consultant Assistance Fees	$ 943,396	$ 56,604	$ 1,000,000
18320	Legal / Consultant Assistance Fees	$ 283,019	$ 16,981	$ 300,000
18330	Other (FAA Fees)	$ 566,038	$ 33,962	$ 600,000
	Sub-Total - "Other Fees"	**$ 15,315,577**	**$ 918,935**	**$ 16,234,512**

Schedule 9 Proposed Plan for Project Financing:

I. Summary of Proposed Financial plan:

Check all that apply and fill in corresponding amounts.

	Type	Amount
☐	A. Lease	
☒	B. Cash	$331,371,583
☐	C. Land	
☐	D. Other	
☒	E. Mortgage, Notes, or Bonds	$150,000,000
☒	Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$481,371,583

If refinancing is used, please complete area below.

☐	Refinancing	
☐	Total Mortgage/Notes/Bonds (Sum E) plus Refinancing:	

II. Details

A. Leases N/A

	Not Applicable	Title of attachment
1. List each lease with corresponding cost as if purchased each leased item. Breakdown each lease by total project cost and subproject costs, if applicable.	☒	
2. Attach a copy of the proposed lease(s).	☒	
3. Submit an affidavit indicating any business or family relationships between principals of the landlord and tenant.	☒	
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	☒	
5. If applicable, identify separately the total square footage to be occupied by the Article 28 facility and the total square footage of the building.	☒	
6. Attach two letters from independent realtors verifying square footage rate.	☒	
7. For all capital leases as defined by FASB Statement No. 13, "Accounting for Leases", provide the net present value of the monthly, quarterly or annual lease payments.	☒	

New York State Department of Health
Certificate of Need Application

Schedule 9

B. Cash - Not required for limited review

Type	Amount
Accumulated Funds	$31,371,583
Sale of Existing Assets	
Gifts (fundraising program)	
Government Grants – **Oneida County Transformation**	$300,000,000
Other	
TOTAL CASH	$331,371,583

	Not Applicable	Title of attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	See Table Above
2. .Attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations. 2a. In establishment applications for Residential Health Care Facilities, attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date for affiliated Residential Health Care Facilities. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations.	☐	Please refer to the Schedule 9 Attachment
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☐	Please refer to the Schedule 9 Attachment
4. Attach a full and complete description of the assets to be sold, if applicable.	☒	
5. If amounts are listed in "Gifts (fundraising program)": • Provide a breakdown of total amount expected, amount already raised, and any terms and conditions affixed to pledges. • If a professional fundraiser has been engaged, submit fundraiser's contract and fundraising plan. • Provide a history of recent fund drives, including amount pledged and amount collected	☒	
6. If amounts are listed in "Government Grants": • List the grant programs which are to provide the funds with corresponding amounts. Include the date the application was submitted. • Provide documentation of eligibility for the funds. • Attach the name and telephone number of the contact person at the awarding Agency(ies).	☐	Please refer to the Schedule 9 Attachment (NYSDOH Grant Award Letter)
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	☒	
8. Current Department policy requires a minimum equity contribution of 10% of total project cost (Schedule 8b line 10), for all Article 28 facilities with the exception of Residential Health Care Facilities that require 25% of the total project cost (Schedule 8b, line 10).	☐	10% Equity Met

C. Mortgage, Notes, or Bonds - Not required for limited review

1. Provide a breakdown of the terms of the mortgage. See sample table below.

	Total Project	Units
Interest	5.25%	%
Term	25	Years
Payout Period	25	Years
Principal	$150,000,000	$

	Not Applicable	Title of attachment
2. Attach a copy of a letter of interest from the intended source of permanent financing that indicates principal, interest, term, and payout period.	☐	Please refer to the Schedule 9 Attachment
3. If New York State Dormitory Authority (DASNY) financing, then attach a copy of a letter from a mortgage banker.	☒	
4. If the financing of this project becomes part of a larger overall financing, then a new business plan inclusive of a feasibility package for the overall financing will be required for DOH review prior to proceeding with the combined financing.	☒	

D. Land: Not required for limited review **N/A**

1. Provide details for the land including but not limited to; appraised value, historical cost, and purchase price. See sample table below.

	Total Project
Appraised Value	
Historical Cost	N/A
Purchase Price	
Other	

	Not Applicable	Title of attachment
2. If amounts are listed in "Other", attach documentation and a description as applicable.	☒	
3. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	☒	N/A
4. Submit a copy of the proposed purchase/option agreement.	☒	
5. Provide an affidavit indicating any and all relationships between seller and the proposed operator/owner.	☒	

E. Other - Not required for limited review **N/A**

1. Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	N/A
Other	

	Not Applicable	Title of attachment
2. Attach documentation and a description of the method of financing.	☒	

F. Refinancing - Not required for limited Review **N/A**

	Not Applicable	Title of attachment
1. Provide a breakdown of the terms of the refinancing, including principal, interest rate, and term remaining.	☒	
2. Attach a description of the mortgage to be refinanced. Provide full details of the existing debt and refinancing plan inclusive of original and current amount, term, assumption date, and refinancing fees. The term of the debt to be refunded may not exceed the remaining average useful life of originally financed assets. If existing mortgage debt will not be refinanced, provide documentation of consent from existing lien holders of the proposed financing plan.	☒	

SCHEDULE 9 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

FINANCIAL AND SPACE DOCUMENTS

1. Financial Narrative
2. 2017 Internal Financial Statement – MVHS
3. 2016 Audited Financial Statement – St. Luke's
4. 2016 Audited Financial Statement – St. Elizabeth
5. Oneida County Transformation Grant Award Letter
6. Memorandum of Agreement (Parking)
7. Financing Letter of Interest

MOHAWK VALLEY HEALTH SYSTEM

FINANCIAL NARRATIVE

Proposal

Mohawk Valley Health System (MVHS) is submitting this Full Review Certificate of Need (C.O.N.) Application that seeks approval for the construction of a new hospital campus. MVHS is the active parent and co-operator of St. Elizabeth Medical Center (SEMC) and of Faxton St. Luke's Healthcare St. Luke's Division (St. Luke's). St. Luke's is currently located at 1656 Champlin Avenue, Utica (Oneida County), New York 13502. St. Elizabeth Medical Center is currently located at 2209 Genesee Street, Utica (Oneida County), New York 13501. Cardiac PCI and cardiac surgery services currently offered through the Mohawk Valley Heart Institute are also provided on the campus of St. Elizabeth at 2209 Genesee Street, Utica (Oneida County), New York 13501. This C.O.N. Application will be funded, in part, through the **Health Care Facility Transformation Program: Oneida County** grant awarded to MVHS specifically for this purpose. This project is one (1) of at least two (2) Applications being submitted to the New York State Department of Health (NYSDOH) for the transformation of services within the Oneida County region, as described in detail below.

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 (i.e., the creation of a new hospital campus), which will result in the transformation of healthcare services in the region.

Current Situation

MVHS is currently the active parent and co-operator of St. Luke's and St. Elizabeth. In addition, cardiac PCI and cardiac surgery services currently offered through the Mohawk Valley Heart Institute are provided on the campus of St. Elizabeth at 2209 Genesee Street, Utica (Oneida County), New York 13501. The location and NYSDOH identifying information for these facilities are as follows:

- Faxton St. Luke's Healthcare St. Luke's Division – Operating Certificate #3202003H; PFI #0599 – 1656 Champlin Avenue, Utica (Oneida County), New York 13502.
- St. Elizabeth Medical Center – Operating Certificate #3202002H; PFI #0598 – 2209 Genesee Street, Utica (Oneida County), New York 13501.
- Mohawk Valley Heart Institute (MVHI) – Operating Certificate #3202004H; PFI #7528 – 2209 Genesee Street, Utica (Oneida County), New York 13501.

Future Situation

This C.O.N. Application is the first in a series of (at least two (2)) Applications that Mohawk Valley Health System and its two (2) related facilities (St. Elizabeth and St. Luke's) will be submitting that will lead to the merger of St. Elizabeth and St. Luke's, and the relocation and consolidation of the majority of services comprising St. Elizabeth and St. Luke's to the new hospital campus in Utica, New York. A description of the expected Application submissions is as follows:

- Application #1 – Full Review C.O.N. Application (Subject of this Application) – Construction of a new hospital campus. The new, consolidated hospital campus will be located on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street.[1] Please refer to **Appendix I** for a map of the proposed campus. An address has not yet been assigned to the site.

[1] The proposed property is comprised of several land parcels, some of which have structures on them that will need to be demolished. Mohawk Valley Health System is in the process of working with the property owners to attempt to purchase the parcels of land for the proposed new hospital campus. Should an owner of a parcel of land elect not to negotiate with MVHS, the Hospital may need to proceed through the eminent domain process to secure the parcel.

Through this C.O.N. Application, all inpatient and most outpatient services from the current St. Elizabeth campus will be relocated to the new hospital campus, which will be known as the "Mohawk Valley Health System Campus". A separate "merger" C.O.N. Application will be submitted, as described in the next bullet point.[2]

The following programs and services will remain on the St. Elizabeth site, with no construction or relocation necessary:

- Article 28 Services – The St. Elizabeth site will be converted into an outpatient extension clinic to be known as "St. Elizabeth Campus". MVHS prefers that this site maintain its current PFI number. In particular, sleep center services (Mohawk Valley Sleep Disorders Center), cardiac and thoracic surgery-related services (all of which are medical-only services; no surgical services will be provided at this site), primary care and laboratory patient services center (PSC) services will continue to be provided at this site.

  The Mohawk Valley Sleep Disorders Center and some primary care services are currently located on the campus located at 2209 Genesee Street, Utica (Oneida County), New York 13501. The cardiac and thoracic surgery offices, other primary care services and the laboratory patient service center (PSC) services are located within the Marian Medical Building at 2209 Genesee Street, Utica (Oneida County), New York 13501. This site will become an extension clinic, with no construction needed. [3] MVHS prefers that a new

[2] Upon implementation of the merger project, which will result in MVHS having a single operating certificate number and PFI number through which the two (2) hospital sites will operate as divisions, MVHS will relocate all inpatient and outpatient services from the St. Elizabeth and the St. Luke's sites to the new hospital campus (with the exception of 24 PM&R beds at the St. Luke's Campus and some other outpatient services as described within this C.O.N. Application).

[3] For purposes of this C.O.N. Application, we are assuming that, although these services will be located in different buildings, they will remain in their current locations and MVHS prefers that they share the same Operating Certificate and PFI numbers. MVHS is willing to discuss this issue with the State Health Department, should the Department prefer to certify the sleep center and outpatient cardiac/thoracic services, primary care practice and laboratory PSC as separate extension clinics.

operating certificate be created for the extension clinic while maintaining its current PFI number and being certified for the services of "Medical Services – Primary Care" and "Medical Services – Other Medical Specialties".

- Non-Article 28 Services (St. Elizabeth College of Nursing) – This program is not an Article 28 service, but it will remain on the current site of St. Elizabeth.

➢ Application #2 – Full Review C.O.N. Application – This project will represent the "merger" C.O.N. Application through which St. Elizabeth and St. Luke's will be merged to become a single hospital entity, preferably with a single operating certificate number and new PFI number. St. Luke's will become a division of MVHS. In addition, through that C.O.N. Application, the majority of services from the St. Luke's and St. Elizabeth sites will be relocated to the new hospital campus. The "merger" project is expected to be implemented while the new hospital campus is being constructed.

The following programs and services will remain on the St. Luke's campus, with no construction or relocation necessary after the merger:

- Article 28 Services – The St. Luke's site, which will be a hospital "division", will retain the following services, with no construction needed: 24 certified, inpatient PM&R beds, laboratory PSC service, outpatient primary care and obstetrics services, and outpatient surgeon offices for medical visits/services.

  This site will be known as the "St. Luke's Campus". As part of this C.O.N. Application, the majority of the inpatient and outpatient services will relocate to the new hospital campus, leaving behind the 24 PM&R beds and other outpatient servicesat 1656 Champlin Avenue, Utica (Oneida County), New York 13502. The laboratory PSC, primary care, obstetrics, and

outpatient surgeon offices will continue to be located within a Physician Office Building on the St. Luke's Campus.[5] This campus will be certified for 24 inpatient PM&R beds and the certified services of "Medical Services – Primary Care" and "Medical Services – Other Medical Specialties".

- Article 28 Services – The Operating Certificates of all extension clinics of MVHS (St. Elizabeth and St. Luke's) will be consolidated under the single operating certificate of the operator. In addition, some of the extension clinic sites with different operating certificates have the same addresses. These sites will need to be consolidated to a single operating certificate for each extension clinic.

- Article 28 Services – To maintain service continuity, PCI and Cardiac Surgery services currently offered through Mohawk Valley Heart Institute will be provided on the new hospital campus. MVHS will work with the NYSDOH to determine how to handle the services offered though the Mohawk Valley Heart Institute, and if this entity can be eliminated.

- Other Article 28 and Article 36 Services
  - St. Luke's Home – A 202-bed residential health care facility (RHCF) with an Adult Day Health Care Program (ADHCP) affiliated with MVHS.
  - Mohawk Valley Home Care – A licensed home care services agency (LHCSA) affiliated with MVHS.
  - Visiting Nursing Association of Utica and Oneida County – A certified home health agency (CHHA) and a long-term home health care program (LTHHCP) affiliated with MVHS.

[5] For purposes of this C.O.N. Application, we are assuming that, although the inpatient PM&R beds and the outpatient services will be located in different buildings, they will remain in their same locations and will continue to share the same Operating Certificate and PFI numbers. MVHS is willing to discuss this issue with the State Health Department, should the Department prefer to certify the outpatient services as a separate extension clinic from the PM&R bed hospital division.

The new hospital campus will have the following inpatient bed complement: coronary care (eight (8) beds); intensive care (42 beds); maternity (23 beds); medical/surgical (232 beds); neonatal intermediate care (eight (8) beds); pediatric (16 beds); and psychiatric (44 beds). In addition, the St. Luke's campus will retain 24 physical medicine and rehabilitation beds. In total, MVHS (inclusive of its two (2) divisions) will reduce its overall inpatient bed complement by 174 beds, from 571 beds to 397 beds (including 373 beds at the new hospital campus and 24 PM&R beds at its St. Luke's Campus).

Project Funding

The Total Project Cost for this project is estimated to be $481,371,583, which is broken down into the following two (2) sub-projects:

- Sub-Project No. 1 – Article 28 New Hospital Campus ($480,000,000, including C.O.N. Application and Processing Fees). This amount will be funded through the Oneida County Heath Care Transformation Program grant funds that MVHS was awarded (in the amount of $300,000,000), as well as financing (in the amount of $150,000,000) and existing cash equity (in the amount of $30,000,000).

- Sub-Project No. 2 – Non-Article 28 Masonic Medical Research Lab ($1,371,583) – This amount will be funded through existing cash equity of MVHS. The Masonic Medical Research Lab will lease certain space on the new hospital campus, within the new hospital building structure, from MVHS.

Please refer to **this Attachment** for the Financial Narrative, a recent 2017 Internal Financial Statement for MVHS, the 2016 Audited Financial Statement for St. Luke's, the 2016 Audited Financial Statement of St. Elizabeth, the Oneida County Transformation Grant Award Letter, the Memorandum of Agreement (Parking) and the Financing Letter of Interest. For purposes of the

financial analysis for this project, we have assumed a 30-year term and a fixed rate of 5.25%, which is higher than the 4.00% tax-exempt interest rate noted in the Loan Letter of Interest.

Working capital needs will be funded through existing cash equity and ongoing operations. Please refer to **this Attachment** for the Financial Narrative, a recent 2017 Internal Financial Statement for MVHS, the 2016 Audited Financial Statement for St. Luke's, the 2016 Audited Financial Statement of St. Elizabeth.

Basis for Utilization, Revenues and Expenses

The operating budget for this project aligns with the operating budget approved within the Oneida County Health Care Transformation Program grant application of MVHS. In particular, the incremental utilization is based upon the expected growth of services upon the consolidation and relocation of services to the new hospital campus, given the historical experience of the hospital. Incremental expenses are related to capital depreciation and interest, as well as the incremental utilization associated with the operating budget. Likewise, the incremental revenues are related to the incremental utilization projected for this project, in line with the reimbursement experience of Mohawk Valley Health System. Please refer to the backup Operating Budget documents under the **Schedule 13 Attachment** for additional information.

MOHAWK VALLEY HEALTH SYSTEM
HOSPITAL STATEMENTS OF OPERATIONS
SEPTEMBER 2017

	YTD ACTUAL Faxton-St. Luke's	YTD ACTUAL St. Elizabeth	YTD ACTUAL Hospital Combined
Net Patient Service Revenue	213,912,443	160,137,998	374,050,441
Bad Debts	(4,604,442)	(5,260,156)	(9,864,598)
Patient Service Revenue Net of Bad Debts	209,308,001	154,877,842	364,185,843
Other Operating Revenue	17,160,374	5,446,247	22,606,621
Total Operating Revenue	226,468,375	160,324,089	386,792,464
Operating Expenses:			
Salaries & Wages	88,513,514	65,169,275	153,682,789
Provider Salaries	17,932,181	12,486,018	30,418,199
Employee benefits	25,188,576	19,268,642	44,457,218
Medical Supplies	19,039,499	27,979,006	47,018,505
Non-Medical Supplies	2,845,944	2,640,534	5,486,478
Purchased Services	23,131,457	12,605,006	35,736,463
Utilities	2,600,450	1,453,929	4,054,379
Drugs	17,887,892	4,659,779	22,547,671
Other Expenses	17,163,033	8,147,581	25,310,614
Depreciation & amortization	10,503,157	7,649,625	18,152,782
Taxes	1,001,202	495,019	1,496,221
Interest Expense	1,234,412	935,879	2,170,291
Total Operating Expenses	227,041,317	163,490,294	390,531,611
Income (loss) from Operations	(572,942)	(3,166,205)	(3,739,147)
Operating Margin	-0.25%	-1.97%	-0.97%
Realized Investment gain(loss) & interest income	1,367,453	405,825	1,773,278
Contributions for operations	934	27,165	28,099
Net excess (deficiency)	795,445	(2,733,215)	(1,937,770)
Bottom Line Margin	0.35%	-1.70%	

MOHAWK VALLEY HEALTH SYSTEM
❖ HOSPITAL BALANCE SHEETS
SEPTEMBER 2017

	SEP 2017	DEC 2016	CHANGE YTD
CURRENT ASSETS:			
Cash and cash equivalents	4,616,180	14,359,772	(9,743,593)
Unrestricted Investments	101,629,213	92,830,863	8,798,350
Patient accounts receivable, net	60,857,634	55,602,157	5,255,477
Insurances, related party, grants, & other receivables	18,656,938	12,649,460	6,007,478
Inventory	12,461,624	12,072,827	388,797
Prepaid & other assets	6,059,962	4,914,649	1,145,313
Total Current Assets	204,281,550	192,429,729	11,851,821
Investment in Foundations	(388)	-	(388)
Investment in Paraffin	91,322	86,480	4,842
Investment in MVEC	845,544	907,544	(62,000)
Assets limited as to use	4,165,471	2,557,473	1,607,998
Investments	6,195,050	5,802,337	392,713
Property & equipment, net	133,258,493	142,957,146	(9,698,653)
Unamortized debt issuance	862,136	947,630	(85,494)
Insurances, direct financing lease, goodwill, & other	24,153,760	23,999,738	154,022
Total Assets	373,852,938	369,688,079	4,164,860
LIABILITIES AND NET ASSETS			
Short term borrowings	1,184,000	-	1,184,000
Current long-term debt	4,521,211	4,805,456	(284,245)
Capital lease obligations- current	4,267,065	4,420,488	(153,423)
Self-insured liabilities- current	11,841,850	10,464,039	1,377,811
Accounts payable	32,905,096	31,728,676	1,176,420
Accrued payroll, taxes	17,305,714	19,967,695	(2,661,981)
Due to (from) third party	4,818,005	1,905,967	2,912,038
Other current liabilities	5,411,664	4,735,614	676,050
Total Current Liabilities	82,254,605	78,027,935	4,226,670
Notes payable	4,925,830	6,710,970	(1,785,140)
Civic facility revenue bonds	37,833,358	38,542,029	(708,671)
Capital lease obligations	3,827,281	6,068,949	(2,241,668)
Insurances, accrued ESLB, interest rate swaps	37,712,738	37,557,042	155,696
Estimated self-insured liabilities, net	5,010,172	5,726,525	(716,353)
Deferred pension liability	46,002,341	46,815,314	(812,973)
Total Liabilities	217,566,325	219,448,764	(1,882,439)
Unrestricted	146,492,426	140,466,157	6,026,270
Restricted	9,794,187	9,773,158	21,029
Total Net Assets	156,286,613	150,239,314	6,047,299
Total Liabilities and Net Assets	373,852,938	369,688,079	4,164,860

❖ Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center combined. Does not include eliminations.

MOHAWK VALLEY HEALTH SYSTEM
AFFILIATE BALANCE SHEETS
SEPTEMBER 2017

	SEP 2017 Faxton-St. Luke's	DEC 2016 Faxton-St. Luke's	Change YTD Faxton-St. Luke's	SEP 2017 St. Elizabeth	DEC 2016 St. Elizabeth	Change YTD St. Elizabeth
CURRENT ASSETS:						
Cash and cash equivalents	(417,991)	5,706,867	(6,124,858)	5,034,171	8,652,905	(3,618,735)
Unrestricted Investments	91,399,706	83,176,139	8,223,567	10,229,507	9,654,724	574,783
Patient accounts receivable, net	36,978,688	31,329,584	5,649,104	23,878,946	24,272,573	(393,627)
Insurances, related party, grants, & other receivables	17,191,609	12,043,722	5,147,887	1,465,329	605,738	859,591
Inventory	6,237,925	6,280,789	(42,864)	6,223,699	5,792,038	431,661
Prepaid & other assets	4,132,102	3,335,551	796,551	1,927,860	1,579,098	348,762
Total Current Assets	155,522,039	141,872,653	13,649,386	48,759,511	50,557,076	(1,797,565)
Investment in Foundations	-	-	-	(388)	-	(388)
Investment in Paraffin	91,322	86,480	4,842	-	-	-
Investment in MVEC	422,772	453,772	(31,000)	422,772	453,772	(31,000)
Assets limited as to use	25,233	25,233	-	4,140,238	2,532,240	1,607,998
Investments	5,064,412	4,706,529	357,883	1,130,638	1,095,808	34,830
Property & equipment, net	71,786,092	78,352,207	(6,566,115)	61,472,401	64,604,939	(3,132,538)
Unamortized debt issuance	351,323	370,486	(19,163)	510,813	577,144	(66,331)
Insurances, direct financing lease, goodwill, & other	24,153,760	23,999,738	154,022	-	-	-
Total Assets	257,416,953	249,867,100	7,549,854	116,435,985	119,820,979	(3,384,994)
LIABILITIES AND NET ASSETS						
Short term borrowings	1,184,000	-	1,184,000	-	-	-
Current long-term debt	2,895,208	3,186,208	(291,000)	1,626,003	1,619,248	6,755
Capital lease obligations- current	3,161,470	4,076,663	(915,193)	1,105,595	343,825	761,770
Self-insured liabilities- current	5,951,052	4,623,655	1,327,397	5,890,798	5,840,384	50,414
Accounts payable	16,627,445	14,960,206	1,667,239	16,277,651	16,768,470	(490,819)
Accrued payroll, taxes	10,965,989	12,098,897	(1,132,908)	6,339,725	7,868,798	(1,529,073)
Due to (from) third party	347,890	(1,948,925)	2,296,815	4,470,115	3,854,892	615,223
Other current liabilities	4,464,634	4,485,150	(20,516)	947,030	250,464	696,566
Total Current Liabilities	45,597,688	41,481,854	4,115,834	36,656,917	36,546,081	110,836
Notes payable	3,829,184	5,218,968	(1,389,784)	1,096,646	1,492,002	(395,356)
Civic facility revenue bonds	13,800,000	14,520,000	(720,000)	24,033,358	24,022,029	11,329
Capital lease obligations	3,313,062	5,483,061	(2,169,999)	514,219	585,888	(71,669)
Insurances, accrued ESLB, interest rate swaps	37,034,240	36,878,544	155,696	678,498	678,498	-
Estimated self-insured liabilities, net	4,341,339	5,057,692	(716,353)	668,833	668,833	-
Deferred pension liability	-	-	-	46,002,341	46,815,314	(812,973)
Total Liabilities	107,915,513	108,640,119	(724,606)	109,650,812	110,808,646	(1,157,834)
Unrestricted	141,144,147	132,869,688	8,274,459	5,348,279	7,596,469	(2,248,190)
Restricted	8,357,293	8,357,293	-	1,436,894	1,415,865	21,029
Total Net Assets	149,501,440	141,226,981	8,274,459	6,785,173	9,012,334	(2,227,161)
Total Liabilities and Net Assets	257,416,953	249,867,100	7,549,854	116,435,985	119,820,979	(3,384,994)

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidated Financial Statements

December 31, 2016 and 2015

Fust Charles Chambers LLP
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

The Board of Directors
Mohawk Valley Health System:

We have audited the accompanying consolidated financial statements of Faxton-St. Luke's Healthcare and Affiliate, which comprise the consolidated balance sheets as of December 31, 2016 and 2015, and the related consolidated statements of operations and changes in net assets and consolidated cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

(Continued)

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Faxton-St. Luke's Healthcare and Affiliate as of December 31, 2016 and 2015, and the results of its operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating information in Schedules 1 and 2 is presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations and changes in net assets of the individual organizations, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Fust Charles Chambers LLP

May 31, 2017

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidated Balance Sheets

December 31, 2016 and 2015

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 5,802,574	1,458,858
Investments and assets limited as to use	83,284,031	78,379,823
Patient accounts receivable, net of reserve for doubtful accounts of approximately $7,711,000 in 2016 and $7,727,000 in 2015	31,516,572	38,999,629
Pledges receivable	335,273	571,367
Other current assets	6,853,883	5,424,254
Inventories	6,280,789	5,873,362
Prepaid expenses	3,335,552	3,003,276
Due from affiliates, net	1,367,027	4,044,954
Estimated third-party payor settlements, net	1,948,925	1,649,371
Total current assets	140,724,626	139,404,894
Investment in affiliates	86,480	830,969
Due from affiliates, net	2,004,544	1,955,488
Investments	4,528,164	4,528,164
Beneficial interest in charitable trusts	1,483,000	1,265,000
Property and equipment, net	78,352,206	77,976,553
Other assets	24,453,511	18,589,053
Total assets	$ 251,632,531	244,550,121

Liabilities and Net Assets	2016	2015
Current liabilities:		
Revolving note payable	$ -	5,623,000
Current portion of long-term debt	3,186,209	3,752,367
Current portion of capital lease obligations	4,076,665	3,825,676
Accounts payable and accrued expenses	15,150,872	15,134,168
Accrued payroll, payroll taxes and benefits	12,095,220	10,392,132
Current portion of estimated insurance liabilities	4,623,654	5,798,357
Other current liabilities	4,650,197	3,032,187
Total current liabilities	43,782,817	47,557,887
Long-term debt, net of current portion:		
Notes payable	5,218,968	4,463,569
Civic facility revenue bonds	14,149,514	14,723,963
Capital lease obligations	5,483,062	6,284,814
Total long-term debt, net of current portion	24,851,544	25,472,346
Other liabilities	36,713,497	30,846,580
Estimated insurance liabilities, net of current portion	5,057,692	3,994,434
Total liabilities	110,405,550	107,871,247
Net assets:		
Unrestricted	132,869,688	127,892,575
Temporarily restricted	3,829,129	4,258,135
Permanently restricted	4,528,164	4,528,164
Total net assets	141,226,981	136,678,874
Commitments and contingencies (notes 6 and 9)		
Total liabilities and net assets	$ 251,632,531	244,550,121

See accompanying notes to consolidated financial statements.

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2016 and 2015

	2016	2015
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 273,563,013	267,603,957
Provision for bad debts	(5,277,188)	(5,387,923)
Net patient service revenue less provision for bad debts	268,285,825	262,216,034
Other operating revenue	16,830,683	13,985,931
Net assets released from restrictions used for operations	741,271	900,853
Total unrestricted revenues, gains and other support	285,857,779	277,102,818
Expenses:		
Salaries and wages	138,026,697	129,371,185
Employee benefits	24,984,148	26,411,289
Supplies and other	105,957,486	101,516,920
Depreciation and amortization	14,272,748	16,078,436
Interest	1,743,087	1,998,101
New York State gross receipts taxes	1,102,309	1,069,659
Total expenses	286,086,475	276,445,590
Net income (loss) from operations	(228,696)	657,228
Other revenue (expense):		
Contributions and other unrestricted revenue (expense)	(78,867)	(1,465,539)
Investment income, net of fees	1,158,178	2,997,110
Total other revenue, net	1,079,311	1,531,571
Excess of revenues over expenses	$ 850,615	2,188,799

(Continued)

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidated Statements of Operations and Changes in Net Assets, Continued

Years ended December 31, 2016 and 2015

	2016	2015
Unrestricted net assets:		
Excess of revenues over expenses	$ 850,615	2,188,799
Change in fair value of interest rate swaps	633,888	241,570
Net assets released for capital acquisitions	1,342,078	780,004
Contributions used for capital acquisitions	41,750	85,094
Transfer to affiliate	-	(450,000)
Reserve for doubtful accounts due from affiliate	(1,665,000)	-
Change in net unrealized gains and losses on investments	3,773,782	(6,822,127)
Increase (decrease) in unrestricted net assets	4,977,113	(3,976,660)
Temporarily restricted net assets:		
Contributions	1,436,343	1,998,338
Change in value of charitable trusts	218,000	(13,000)
Net assets released from restrictions	(2,083,349)	(1,680,857)
Increase (decrease) in temporarily restricted net assets	(429,006)	304,481
Total increase (decrease) in net assets	4,548,107	(3,672,179)
Net assets at beginning of year	136,678,874	140,351,053
Net assets at end of year	$ 141,226,981	136,678,874

See accompanying notes to consolidated financial statements.

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidated Statements of Cash Flows

Years ended December 31, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ 4,548,107	(3,672,179)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	14,272,748	16,078,436
Amortization of debt issuance costs	25,551	25,551
Provision for bad debts	5,277,188	5,387,923
Change in net unrealized gains and losses on investments	(3,773,782)	6,822,127
Change in fair value of interest rate swaps	(633,888)	(241,570)
Amortization of unearned lease income	(177,826)	(204,213)
Net realized gain on sale of investments	(396,312)	(1,585,939)
Change in value of charitable trusts	(218,000)	13,000
Loss on disposition of property and equipment	201,655	47,309
Gain in earnings of investees	(194,562)	(54,459)
Contributions for capital acquisitions	(41,750)	(85,093)
Changes in operating assets and liabilities:		
Patient accounts receivable	2,205,869	(5,715,036)
Inventories, prepaid expenses and other current assets	(210,108)	1,909,981
Due from affiliates, net	(1,096,662)	116,913
Accounts payable, accrued expenses and other liabilities	1,124,505	150,864
Estimated insurance liabilities	(111,445)	3,303,802
Estimated third-party payor settlements	(299,554)	4,470,266
Net cash provided by operating activities	20,501,734	26,767,683
Cash flows from investing activities:		
Purchases of property and equipment	(7,183,101)	(5,852,421)
Proceeds from sale of property and equipment	11,438	49,401
Purchases of investments, net	(734,114)	(1,492,637)
Change in other assets	177,441	2,085,986
Net cash used in investing activities	(7,728,336)	(5,209,671)
Cash flows from financing activities:		
Payments on revolving note payable, net	(5,623,000)	(10,377,000)
Changes in advances to affiliates, net	3,750,000	(4,250,000)
Proceeds from long-term debt	-	1,397,636
Principal payments on long-term debt and capital lease obligations	(7,145,548)	(9,183,937)
Minimum direct financing lease payments received	547,116	547,116
Contributions for capital acquisitions	41,750	85,093
Net cash used in financing activities	(8,429,682)	(21,781,092)
Increase (decrease) in cash and cash equivalents	4,343,716	(223,080)
Cash and cash equivalents at beginning of year	1,458,858	1,681,938
Cash and cash equivalents at end of year	$ 5,802,574	1,458,858

See accompanying notes to consolidated financial statements.

(1) Description of Organization and Summary of Significant Accounting Policies

(a) Organization

Faxton-St. Luke's Healthcare (Healthcare), located in Utica, New York, is a not-for-profit healthcare delivery system providing inpatient, outpatient, emergency care, cancer treatment, rehabilitation, dialysis, maternity, child care, long term care, surgical, psychiatric and community services to residents of the Mohawk Valley Region. Admitting physicians are primarily practitioners in the local area.

Faxton-St. Luke's Healthcare Foundation (Foundation) is a not-for-profit, tax-exempt corporation that carries out fund raising activities which benefit Healthcare and certain affiliates. Healthcare is the sole member of the Foundation.

Mohawk Valley Health System (MVHS), a not-for-profit corporation, is the sole corporate member of Healthcare and various other organizations involved in providing health care services to the Mohawk Valley Region.

(b) Basis of Accounting

The accompanying consolidated financial statements include the consolidated accounts of Healthcare and Foundation (the Corporation). Included on the equity method of accounting are SLM Medical Office Building, Inc. (SLM), whose stock is owned by a trust, of which Healthcare is the sole beneficiary, and Paraffin, LLC (Paraffin), of which Healthcare is the sole member. All significant intercompany balances and transactions have been eliminated in the consolidated financial statements.

SLM, is a for-profit corporation that promotes, encourages and aids in the acquisition and construction of a medical office building to promote the operations of Healthcare. During 2016, Healthcare assumed the assets and liabilities of SLM, which primarily consisted of debt and fixed assets. Paraffin is a not-for-profit limited liability company that provides laboratory services to a local hospital.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(b) Basis of Accounting, Continued

As a member of MVHS, Healthcare is affiliated with and transacts business with other healthcare providers in the MVHS network. St. Elizabeth Medical Center (SEMC), a subsidiary of MVHS, provides acute care. Senior Network Health, LLC (SNH), a wholly owned subsidiary of MVHS, provides Medicaid managed care to seniors. Mohawk Valley Home Care, LLC (MVHC), a wholly owned subsidiary of MVHS, provides nursing services. Visiting Nurse Association of Utica and Oneida County, Inc. (VNA), a wholly owned subsidiary of MVHS, provides home health care services.

(c) New Accounting Pronouncement

In April 2015, the FASB issued ASU 2015-03, "Interest - Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs," which simplifies the presentation of debt issuance costs to be presented as a deduction from the corresponding debt liability. Amortization of debt issuance costs shall be reported as interest expense. ASU 2015-03 is effective for consolidated financial statements issued for fiscal years beginning after December 15, 2015 and is to be applied on a retrospective basis for all previous periods presented. Healthcare adopted ASU 2015-03 as of and for the year ended December 31, 2016. The retrospective adoption of ASU 2015-03 resulted in a decrease to long-term assets, and long-term liabilities of approximately $396,000 on the balance sheet for the year ended December 31, 2015, a reclassification of approximately $26,000 of amortization of debt issuance costs from depreciation and amortization to interest expense on the consolidated statement of operations and changes in net assets and consolidated cash flows (cash flows from operations) for the year ended December 31, 2015, but had no effect on excess of revenues over expenses or net assets as of or for the year ended December 31, 2015.

(d) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(e) Collective Bargaining Agreements

At December 31, 2016, Healthcare has approximately 63% of its employees working under collective bargaining agreements. The agreements will expire in June 2017.

(f) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturity of three months or less, excluding temporary investments included in investments.

(g) Investments and Assets Limited as to Use

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value which is determined utilizing quoted market prices. Investments in insurance group fixed annuity contracts (Guaranteed Investment Contracts) are valued at contract value, which is considered the best representation of fair value. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses since none of the investments are classified as trading securities.

Certain investments that do not have readily determinable fair values are valued by using the net asset value (NAV) per share (or its equivalent), as a practical expedient permitted under the Fair Value Measurement Topic of the FASB Accounting Standards Codification.

The Corporation invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the Corporation's net assets.

Assets limited as to use are comprised of cash held by a financial institution as required for the Corporation's malpractice insurance.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(h) Inventories

Inventories are stated at the lower of average cost or net realizable value.

(i) Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is calculated over the estimated useful life of each class of depreciable asset ranging from 3 - 40 years using the straight-line method. Property and equipment under capital leases and leasehold improvements are amortized on the straight-line method over the lesser of the lease term or the estimated useful life of the asset. Amortization of equipment under capital leases and leasehold improvements is included in depreciation and amortization expense.

Gifts of long-lived assets, such as land, buildings or equipment are reported as unrestricted support and are excluded from the excess of revenues over expenses, unless explicit donor stipulations specify how the donated asset must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(j) Unamortized Debt Issuance Costs

Debt issuance costs are amortized using the straight-line method, which approximates the effective interest method, over the terms of the related debt. Accumulated amortization of approximately $269,000 and $243,000 was recorded at December 31, 2016 and 2015, respectively. Amortization expense amounted to approximately $26,000 in 2016 and 2015, and is included in interest expense within the consolidated statements of operations and change in net assets.

(k) Insurance Claims and Related Recoveries

The Corporation recognizes liabilities associated with malpractice claims or similar contingent liabilities when the incidents that give rise to the claims occur. Further, the liability shall not be presented net of anticipated insurance recoveries. Any amounts expected to be reimbursed from an insurance company are presented in other assets.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(l) Pledges Receivable

Pledges receivable are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts through a provision for bad debts and an adjustment to a valuation allowance based on its assessment of the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the valuation allowance and a credit to pledges receivable. At December 31, 2016 and 2015, no allowance was recorded. The original pledge amount at December 31, 2016 was discounted approximately $8,000 using a discount rate of 1.91% to reflect the net present value. The original pledge amount at December 31, 2015 approximated the net present value. The pledges receivable, net of discount, due to be collected during 2017 is approximately $171,000 and during 2018-2020 is approximately $164,000.

(m) Beneficial Interest in Charitable Trusts

The Foundation has beneficial interests in various irrevocable split-interest agreements that are administered by independent trustees which consist of charitable remainder unitrusts. The Foundation's interest in these trusts is recorded at the present value of the estimated future cash flows from the trust's assets using a discount rate that reflects current market conditions and is included in temporarily restricted net assets for renovations and equipment. At December 31, 2016, the value of the beneficial interest in these agreements approximated net present value as a result of the death of one of the unitrust holders. The Foundation used a discount rate of 2.0% at 2015. Changes in the fair value of the beneficial interest are reflected as change in value of charitable trusts in the consolidated statement of changes in net assets.

(n) Temporarily Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(o) Permanently Restricted Net Assets (Endowment Funds)

The Corporation maintains various donor-restricted and board-designated funds whose purpose is to provide long-term support for its charitable programs. In classifying such funds for consolidated financial statement purposes as either permanently restricted, temporarily restricted or unrestricted net assets, the Board of Directors looks to the explicit directions of the donor where applicable and the provisions of the laws of the State of New York. To constitute an endowment under New York State law, the restriction must arise from a clearly expressed donor limitation, not a limitation from within the beneficiary organization. The Board of Directors has determined that, absent donor stipulations to the contrary, the provisions of New York State law do not impose either a permanent or temporary restriction on the income or capital appreciation derived from the original gift. Therefore, all income and appreciation derived from the original gift are transferred to unrestricted net assets absent any restrictions on the use made by the donor. Permanently restricted net assets consist of endowment funds of $4,528,164 at December 31, 2016 and 2015, and are included in long-term investments in the consolidated balance sheets.

The Corporation utilizes an investment strategy that emphasizes preservation of principal and total return consistent with prudent levels of risk. Investments are allocated over a diversified portfolio of multiple asset classes of domestic and international equities and pooled investment funds.

Interpretation of Relevant Law

Prior to September 17, 2010, New York State law required the preservation of an endowment fund's historic dollar value. Historic dollar value is defined as the aggregate fair value in dollars of an endowment fund at the time it becomes an endowment fund, each subsequent donation to the fund at the time it is made and each accumulation made pursuant to a direction in applicable gift instrument at the time an accumulation is added to the fund. The law permitted an organization to spend the income earned by an endowment fund (i.e. interest, dividends), as well as the net appreciation (realized with respect to all assets and unrealized with respect to readily marketable assets) of such fund.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(o) Permanently Restricted Net Assets (Endowment Funds), Continued

Interpretation of Relevant Law, Continued

On September 17, 2010, the New York Prudent Management of Institutional Funds Act (NYPMIFA) was signed into New York State law. The most prominent feature of NYPMIFA is the elimination of the requirement to preserve an endowment fund's historic dollar value which allows an organization to spend from an endowment whose market value has dropped below the historic dollar value, as long as it is deemed prudent under the organization's policies. In accordance with NYPMIFA, an organization must consider the following factors in exercising a standard of prudence:

1. The duration and preservation of the endowment fund
2. The purposes of the organization and the donor-restricted endowment fund
3. General economic conditions
4. The possible effect of inflation and deflation
5. The expected total return from income and the appreciation of investments
6. Other resources of the organization
7. The investment policies of the organization
8. Where appropriate, alternatives to spending from the endowment fund and the possible effects of those alternatives on the organization

NYPMIFA requires compliance with donor intent when making investment or spending decisions with respect to an endowment fund. In addition, NYPMIFA creates a restriction on the portion of an endowment fund that is not classified as permanently restricted net assets, even in the absence of a donor restriction. Such portion is classified as temporarily restricted net assets until appropriated for expenditure by the organization.

The Corporation has interpreted NYPMIFA as requiring the preservation of the purchasing power of the donor restricted endowment funds absent explicit donor stipulations to the contrary. As a result, Healthcare continues to classify permanently restricted net assets at the historic dollar value of the fund in accordance with donor instructions.

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or NYPMIFA requires the Corporation to retain as a fund of perpetual duration. If the situation were to occur, the deficiency would be recorded in the Corporation's unrestricted net assets. A deficiency did not exist at December 31, 2016 or 2015.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(o) Permanently Restricted Net Assets (Endowment Funds), Continued

Return Objectives, Strategies, Spending Policy and Investment Objectives

The Corporation has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment. Under this policy, as approved by the Board of Directors, the endowment assets are to be invested in a well-diversified asset mix that can be expected to generate acceptable long-term returns at an acceptable level of risk. The Corporation targets a diversified asset allocation that places a greater emphasis on equity-based investments and bonds to achieve its long-term return objectives within prudent risk constraints.

Changes in Endowment Net Assets

	2016		
	Unrestricted	Permanently restricted	Total
Endowment net assets, January 1	$ 44,788	4,528,164	4,572,952
Investment return:			
Investment income	-	138,564	138,564
Disbursements	-	(299,005)	(299,005)
Net gain (realized and unrealized)	-	294,018	294,018
Transfer of earnings over historical value	133,577	(133,577)	-
Endowment net assets, December 31	$ 178,365	4,528,164	4,706,529

	2015		
	Unrestricted	Permanently restricted	Total
Endowment net assets, January 1	$ 328,656	4,528,164	4,856,820
Investment return:			
Investment income	-	111,478	111,478
Net loss (realized and unrealized)	-	(395,346)	(395,346)
Transfer of earnings over historical value	(283,868)	283,868	-
Endowment net assets, December 31	$ 44,788	4,528,164	4,572,952

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Net Patient Service Revenue and Patient Accounts Receivable

Healthcare has agreements with third-party payors that provide for payments to the various organizations within its healthcare delivery system at amounts different from their established rates. Payment arrangements include prospectively determined rates per discharge or visit, cost-based reimbursement, discounted charges, per diem payments and fee-for-service payments. Healthcare recognizes patient service revenue associated with services provided to patients who have third-party coverage on the basis of contractual rates for the services rendered, including estimated retroactive adjustments due to future audits, reviews and investigations. Retroactive adjustments are included in the recognition of revenue on an estimated basis in the period the related services are rendered and adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews and investigations. Healthcare recognizes revenue for uninsured patients who do not qualify for charity care at standard rates, less a 40% self-pay discount. On the basis of historical experience, a significant portion of Healthcare's uninsured patients will be unable or unwilling to pay for the services provided. Thus, Healthcare records a provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts) from these major payor sources, is as follows for the years ended December 31:

	2016			
	Government payors	Commercial insurance and others	Self-pay	Total
Patient service revenue (net of contractual allowances and discounts)	$ 163,075,720	108,638,348	1,848,945	273,563,013

	2015			
	Government payors	Commercial insurance and others	Self-pay	Total
Patient service revenue (net of contractual allowances and discounts)	$ 151,712,147	112,022,692	3,869,118	267,603,957

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Net Patient Service Revenue and Patient Accounts Receivable, Continued

Revenue from the Medicare and Medicaid programs accounted for approximately 60% and 57% of Healthcare's patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts) for 2016 and 2015, respectively. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Patient service revenue increased approximately $1,443,000 and $60,000 in 2016 and 2015, respectively, related to either settlement of prior year issues or changes in estimates associated with third-party issues. As of December 31, 2016, all cost reports through 2015 have been filed and Medicare cost reports through 2012 have been final settled.

Healthcare grants unsecured credit to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31 was as follows:

	2016	2015
Medicare	33%	37%
Medicaid	18%	19%
Private payors	4%	3%
Insurance and all others	45%	41%
	100%	100%

Patient accounts receivable are reduced by a reserve for doubtful accounts. In evaluating the collectability of patient accounts receivable, Healthcare analyzes past payment history and identifies trends for each of its major payor sources of revenue to estimate the appropriate reserve for doubtful accounts and provision for bad debts. For receivables associated with patients who have third-party coverage, Healthcare analyzes contractually due amounts and provides a reserve for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), Healthcare records a reserve for doubtful accounts and a provision for bad debts in the period of service based on its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amount actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(p) Net Patient Service Revenue and Patient Accounts Receivable, Continued

Healthcare's reserve for doubtful accounts was approximately 79% and 82% of self-pay accounts receivable at December 31, 2016 and 2015, respectively. Healthcare has not changed its charity care policy during 2016 or 2015. Healthcare does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

(q) Charity Care

Healthcare provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because Healthcare does not pursue collection of such amounts, they are not reported as net patient service revenue. During 2016 and 2015, costs incurred by Healthcare in the provision of charity care were based on the ratio of Healthcare's costs to gross charges and approximated $490,000 and $350,000, respectively.

(r) Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. Contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions. Donor restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the consolidated statements of operations and changes in net assets.

Conditional contributions or intents to give are recoded when donor-imposed stipulations have been substantially met.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(s) Excess of Revenues over Expenses

The consolidated statements of operations and changes in net assets include excess of revenues over expenses. Changes in unrestricted net assets which are excluded from excess of revenues over expenses, consistent with industry practice, include changes in unrealized gains and losses on investments other than trading securities, the effective portion of gains and losses on derivative instruments, permanent transfers of assets to and from affiliates for other than goods and services and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purpose of acquiring such assets).

(t) Income Taxes

Healthcare and the Foundation are not-for-profit corporations and have been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code. As of December 31, 2016 and 2015, Healthcare and the Foundation did not have any unrecognized tax benefits or any related accrued interest or penalties. The tax years open to examination by federal and state taxing authorities are 2013 through 2016. Healthcare and the Foundation do not anticipate the total unrecognized tax benefits will change in the next twelve months.

(u) Concentration of Credit Risk

The Corporation invests cash and cash equivalents with financial institutions, and has determined that the amount of credit exposure at any one financial institution is immaterial to the Corporation's financial position.

(v) Subsequent Events

In April 2017, MVHS was notified by the New York State Department of Health of an award of $300 million granted under the Statewide Health Care Facility Transformation Program. This program provides funds to health care providers for the purpose of strengthening and protecting continued access to health care services in communities throughout New York State which are associated with a merger, consolidation or significant corporate restructuring activity that is part of an overall transformation plan intended to create a financially sustainable system of care. This award will be used by MVHS to consolidate inpatient care from Healthcare and SEMC into one, new integrated health campus. The cost projection for the new campus is estimated to be $480 million for a 750,000 square-foot facility. The remaining $180 million will come from MVHS capital, bonds and fundraising. The planning and construction for this project is expected to take approximately 5 years.

Subsequent events have been evaluated through May 31, 2017, which is the date consolidated financial statements were issued.

(Continued)

(2) Investments and Assets Limited as to Use

At December 31, investments and assets limited as to use, at fair value, are comprised of the following:

	2016	2015
Investments:		
Cash and cash equivalents	$ 377,336	812,716
Mutual funds	49,664,271	44,593,424
Common stock	2,516,036	2,227,704
Pooled investment funds	35,325,259	35,360,634
	87,882,902	82,994,478
Accrued investment income	-	353,578
Total investments	87,882,902	83,348,056
Assets limited as to use - cash and cash equivalent	250,000	250,000
Total investments and assets limited as to use	$ 88,132,902	83,598,056

The above amounts are included in the accompanying consolidated financial statements as follows:

	2016	2015
Investments and assets limited as to use - current assets	$ 83,284,031	78,379,823
Cash and cash equivalents	320,707	690,069
Investments - long term	4,528,164	4,528,164
	$ 88,132,902	83,598,056

Investment income (loss) and gains (losses) on investments are comprised of the following for the years ended December 31:

	2016	2015
Investment income:		
Interest income and dividends, net of fees	$ 761,866	1,411,171
Realized gains	396,312	1,585,939
	1,158,178	2,997,110
Change in net unrealized gains and losses on investments	3,773,782	(6,822,127)
	$ 4,931,960	(3,825,017)

(Continued)

(2) Investments and Assets Limited as to Use, Continued

The Corporation continually reviews investments for other-than-temporary impairment whenever the fair value of an investment is less than amortized cost and evidence indicates that an investment's carrying amount is not recoverable within a reasonable period of time. In the evaluation of whether an impairment is other-than-temporary, the Corporation considers the reasons for the impairment, its ability and intent to hold the investment until the market price recovers or the investment matures, compliance with its investment policy, the severity and duration of the impairment, and expected future performance.

The Corporation's investments in common stocks, mutual funds and pooled investment funds consist of investments diversified in several different industries. The Corporation evaluated the near-term prospects of the issuer in relation to the severity and duration of impairment. Based upon the evaluation and the Corporation's ability and intent to hold the securities for a reasonable period of time sufficient for a forecasted recovery of fair value, the Corporation does not consider the securities in an unrealized loss position to be other-than-temporarily impaired at December 31, 2016 or 2015.

The following table presents the gross unrealized losses and fair value of the Corporation's investment portfolio with unrealized losses that are not deemed to be other-than-temporarily impaired, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2016 and 2015:

	2016					
	Less than Twelve Months		Twelve Months or Greater		Total	
Securities	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
Mutual funds	$ -	-	22,076,737	(1,623,864)	22,076,737	(1,623,864)
Common stocks	301,948	(19,785)	203,942	(55,044)	505,890	(74,829)
Pooled investment funds	-	-	2,523,034	(1,355,619)	2,523,034	(1,355,619)
	$ 301,948	(19,785)	24,803,713	(3,034,527)	25,105,661	(3,054,312)

	2015					
	Less than Twelve Months		Twelve Months or Greater		Total	
Securities	Fair value	Unrealized losses	Fair value	Unrealized losses	Fair value	Unrealized losses
Mutual funds	$ 13,733,281	(1,048,785)	8,719,906	(1,892,951)	22,453,187	(2,941,736)
Common stocks	720,636	(124,472)	220,999	(117,152)	941,635	(241,624)
Pooled investment funds	1,034,462	(65,538)	2,013,311	(1,515,042)	3,047,773	(1,580,580)
	$ 15,488,379	(1,238,795)	10,954,216	(3,525,145)	26,442,595	(4,763,940)

(Continued)

(3) Property and Equipment

Property and equipment is comprised of the following at December 31:

	2016	2015
Land and land improvements	$ 7,661,125	7,496,286
Buildings	124,904,575	118,577,613
Fixed equipment	46,193,246	42,961,551
Movable equipment	118,574,318	123,654,847
Property and equipment under capitalized leases	21,877,952	20,118,609
	319,211,216	312,808,906
Less accumulated depreciation and amortization	(242,097,684)	(236,445,605)
	77,113,532	76,363,301
Construction-in-progress	1,238,674	1,613,252
Property and equipment, net	$ 78,352,206	77,976,553

Depreciation and amortization expense amounted to approximately $14,273,000 and $16,078,000 for the years ended December 31, 2016 and 2015, respectively.

(4) Direct Financing Lease

In 2001, Healthcare completed construction of a medical office building with a cost of approximately $5 million on land owned by an affiliate of Slocum-Dickson Medical Group, P.C. (SDMG). The building is leased to SDMG under a direct financing lease for minimum lease payments of approximately $45,000 per month through November 2021.

The consolidated balance sheet presentation of the direct financing lease at December 31 is as follows:

	2016	2015
Minimum lease payments receivable	$ 2,671,015	3,218,131
Unearned lease income	(436,342)	(614,168)
Net investment in direct financing lease	2,234,673	2,603,963
Less current portion, included in other current assets	547,116	547,116
Long-term net investment in direct financing lease, included in other assets	$ 1,687,557	2,056,847

(Continued)

(5) Extended Sick Leave

The Corporation employees are permitted to accumulate unused extended sick leave time up to specified maximum amounts. The Corporation accrues the estimated expense related to extended sick leave based on pay rates currently in effect. Upon retirement, employees who have met certain criteria shall have the option to receive payment or receive sick leave credits to pay for post-employment health insurance payments based upon the formula in place. The Corporation has accrued an estimated liability of approximately $11,405,000 and $10,893,000 at December 31, 2016 and 2015, respectively, for these anticipated termination payments.

Amounts are included in the accompanying consolidated financial statements as follows at December 31:

	2016	2015
Accrued payroll, payroll taxes and benefits	$ 580,000	658,000
Other liabilities	10,825,000	10,235,000
	$ 11,405,000	10,893,000

(6) Long-Term Debt and Lease Obligations

Long-term debt consists of the following at December 31:

	2016	2015
Variable rate demand 2006 Civic Facility Revenue Bonds (a)	$ 15,120,000	15,740,000
Revolving note payable (b)	-	5,623,000
Note payable in monthly principal installments of $75,000, maturing April 2018 (c)	1,200,000	2,100,000
Note payable in monthly installments beginning July 2016 of $65,617 at a fixed rate of 2.6% maturing May 2021 (d)	3,338,027	1,174,189
Mortgage payable in monthly installments of $44,248 at a fixed rate of 4.5%, maturing January 2020 and collateralized by the related building	1,413,214	1,830,328

(Continued)

(6) Long-Term Debt and Lease Obligations, Continued

	2016	2015
Note payable in monthly installments of $27,664 at a fixed rate of 4.0%, maturing October 2018	585,646	887,116
Note payable in monthly installments of $15,249 at a fixed rate of 5.5% through March 2017	55,773	230,316
Note payable in monthly installments of $9,223 at a fixed rate of 4.0% maturing July 2020	368,003	461,627
Note payable in monthly installments beginning April 2016 of $9,137 at an adjustable fixed rate of 4.0% (through March 2021) maturing March 2026	844,514	900,000
Other	-	12,360
Capital lease obligations (interest rates ranging from 2.6% to 8.0%)	9,559,727	10,110,490
	32,484,904	39,069,426
Less unamortized debt issuance costs	(370,486)	(396,037)
	32,114,418	38,673,389
Less current portion:		
Revolving note payable	-	(5,623,000)
Debt	(3,186,209)	(3,752,367)
Capital lease obligations	(4,076,665)	(3,825,676)
Long-term debt, net of current portion and unamortized debt issuance costs	$ 24,851,544	25,472,346

(a) Healthcare, through the Oneida County Industrial Development Agency (OCIDA), has issued serial and term Civic Facility Revenue Bonds as follows:

Series	Term	Annual principal payments
Faxton-St. Luke's Healthcare:		
2006E - tax-exempt	2031	$250,000 - $525,000
2006F - taxable	2031	$350,000 - $955,000

(Continued)

(6) Long-Term Debt and Lease Obligations, Continued

The bonds are insured and are collateralized by Healthcare's gross receipts (as defined), including all rights to receive such receipts whether in the form of accounts receivable, contract rights or other rights. Healthcare entered into a lease agreement with OCIDA, which also acts as security for payment of the revenue bonds. Additional security is provided by a Master Trust Indenture under which the initial Members of the Obligated Group (Healthcare and MVHS) are jointly and severally responsible for payment of the bonds. Various agreements relating to the bonds establish covenants with which Healthcare has agreed to comply, including provisions regarding liquidity ratio, minimum debt service coverage ratio and liquidity to funded debt. At December 31, 2016 and 2015, the Obligated Group was in compliance with the covenants that are considered events of default.

The bonds bear interest based on one of three modes - the weekly rate, the term rate, or the fixed rate - for periods selected by Healthcare. The interest rate for each mode will be the current market interest rate as determined by the remarketing agent of the bonds. Healthcare used the weekly rate during 2016 and 2015. At December 31, 2016, the bonds carried interest at rates of 0.83% (tax-exempt) and 0.88% (taxable). At December 31, 2015, the bonds carried interest at rates of 0.03% (tax-exempt) and 0.40% (taxable).

The bonds are remarketed by a remarketing agent in accordance with the terms of a remarketing agreement. The bonds will be remarketed whenever a new interest rate is in effect. If the bonds cannot be remarketed, they would be due and payable under the terms of the remarketing agreement; however, the bonds are credit-enhanced by an irrevocable letter of credit, which is set to expire June 26, 2018. In the event that the remarketing agent is unable to remarket the bonds, the bond trustee will make a draw on the letter of credit and the tendered variable rate bonds will become bank bonds.

(Continued)

(6) Long-Term Debt and Lease Obligations, Continued

As a result of the aforementioned 2006 bond issuances, Healthcare has entered into two interest rate swap contracts to reduce its risk of exposure to changes in interest rates. The interest rate swaps effectively convert the variable rates of the 2006 bonds to fixed rates of 5.938% and 4.216% through June 2031. The swaps have been designated as cash flow hedges of the variable interest rates and are recorded at fair value as a liability of $3,964,349 in other liabilities on the accompanying consolidated balance sheet as of December 31, 2016. The amounts exchanged are based on the notional amounts whereby Healthcare pays the swap counter-party interest at a fixed rate (4.216% - tax-exempt, 5.938% - taxable) and the swap counter-party pays Healthcare a variable rate (based on 70% of 1 month LIBOR tax-exempt, BMA Rate - taxable). The notional amounts and fair values based on quoted market prices, of Healthcare's interest rate swaps are as follows at December 31, 2016:

	Notional amount	Liability fair value
Healthcare - Series E	$ 5,660,000	1,166,636
Healthcare - Series F	9,460,000	2,797,713
	$ 15,120,000	3,964,349

The mark-to-market adjustments resulted in an increase of approximately $634,000 and $239,000 in unrestricted net assets for the years ended December 31, 2016 and 2015, respectively. Changes in value of the swaps determined to arise from ineffectiveness of the instruments, as determined through the hypothetical derivative method, are recorded as a component of interest expense in the consolidated statements of operations and changes in net assets. For the years ended December 31, 2016 and 2015, there was no significant ineffectiveness. Healthcare expects that the loss existing in unrestricted net assets to be reclassified into net loss from operations within the next 12 months will not be significant.

(Continued)

(6) Long-Term Debt and Lease Obligations, Continued

(b) At December 31, 2016 and 2015, Healthcare had a $24,500,000 revolving note payable with a bank, collateralized by certain investments. The revolving note payable on short-term borrowings bears a daily interest rate at prime (3.75% at December 31, 2016). The revolving note payable on long-term borrowings bears a monthly interest rate at 1 month LIBOR plus 95 basis points (1.72% at December 31, 2016). The revolving note payable is available through July 2017. At December 31, 2016, a portion of the revolving note payable was reserved for four letters of credit totalling approximately $7,317,000 primarily related to self-insured liabilities. At December 31, 2015, Healthcare had $623,000 outstanding on the short-term borrowings. At December 31, 2016 and 2015, Healthcare had $0 and $5,000,000 outstanding on the long-term borrowings, respectively. The revolving note payable contains financial covenants including a debt service coverage ratio requirement, a days cash on hand requirement and a minimum unrestricted liquidity to funded debt ratio. At December 31, 2016 and 2015, Healthcare was in compliance with the covenants that are considered events of default.

(c) The note payable bears interest at a rate of 1 month LIBOR plus 2.15% (2.92% at December 31, 2016). In connection with the note payable, Healthcare has entered into an interest rate swap contract to reduce its risk of exposure to changes in interest rates. The interest rate swap effectively converts the variable rates of the note payable to a fixed rate of 3.0% through April 2018. The swap has been designated as a cash flow hedge of the variable interest rate and is recorded at fair value as a liability of $2,201 in other liabilities on the accompanying consolidated balance sheet as of December 31, 2016. The amounts exchanged are based on the notional amounts whereby Healthcare pays the swap counter-party interest at a fixed rate (3.0%) and the swap counter-party pays Healthcare a variable rate. The notional amount and fair value based on quoted market prices, of Healthcare's interest rate swap is as follows at December 31, 2016:

	Notional amount	Liability fair value
Healthcare - note payable	$ 1,200,000	2,201

The mark-to-market adjustments resulted in an increase of $2,713 in unrestricted net assets for the year ended December 31, 2015. Healthcare did not record mark-to-market adjustments for the year ended December 31, 2016. Changes in value of the swap determined to arise from ineffectiveness of the instrument, as determined through the hypothetical derivative method, is recorded as a component of interest expense in the consolidated statements of operations and changes in net assets. For the years ended December 31, 2016 and 2015, there was no significant ineffectiveness. Healthcare expects that the loss existing in unrestricted net assets to be reclassified into net loss from operations within the next 12 months will not be significant.

(6) Long-Term Debt and Lease Obligations, Continued

(d) In May 2016, SLM's note payable, with principal balance of $3,683,334, of which approximately $1,100,000 was already allocated and recorded by Healthcare, was assigned to Healthcare. In conjunction with the assignment, the bank agreed to extend the maturity date of loan through May 2021. The note payable is collateralized by the building constructed with the original funds. The note payable agreement contains various covenants including provisions regarding minimum days cash on hand, minimum debt service coverage ratio, and minimum unrestricted liquidity to funded debt ratio. At December 31, 2016, Healthcare was in compliance with the financial covenants that are considered events of default.

Healthcare leases certain equipment under capital leases. Healthcare also leases equipment and facilities under noncancellable operating leases, including leases with affiliates. The net book value of the equipment capitalized under lease agreements at December 31, 2016 and 2015 amounted to approximately $10,303,000 and $10,691,000, respectively.

The table below reflects principal payments and the present value of future minimum capital lease payments over the next five years and beyond and assumes that the letter of credit related to the 2006 Series E and F Bonds are renewed in 2018 and that Bank of New York does not exercise its put option for the 2006 Series Bonds in 2018. If the letter of credit is not renewed, the outstanding of the 2006 Series Bonds would be due on demand, as described above, in 2018.

	Long-term debt	Capital lease obligations	Operating leases Affiliates	Operating leases Other
Years ended December 31:				
2017	$ 3,186,209	4,354,004	624,413	2,530,891
2018	2,675,447	2,844,022	624,413	1,627,291
2019	2,184,324	1,337,161	624,413	475,312
2020	1,670,431	937,621	624,413	428,956
2021	1,301,287	446,030	624,413	262,623
Thereafter	11,907,479	266,084		
Total payments	$ 22,925,177	10,184,922		
Less amounts representing interest		625,195		
Present value of capital lease obligations		9,559,727		
Less current portion		4,076,665		
Capital lease obligations, net of current portion		$ 5,483,062		

Rent expense under operating leases amounted to approximately $5,619,000 and $5,767,000 in 2016 and 2015, respectively.

(Continued)

(7) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes at December 31:

	2016	2015
Funds held in trust by others (for capital)	$ 1,483,000	1,265,000
Children's Miracle Network	795,729	636,974
Continuous Learning Center	117,978	115,827
Scholarship assistance	31,199	31,199
Programs	511,354	709,973
Renovations	889,869	1,499,162
	$ 3,829,129	4,258,135

Permanently restricted net assets at December 31 are restricted to:

	2016	2015
Investments to be held in perpetuity, the income from which is to support charity care, health care services, scholarships and facility maintenance	$ 4,528,164	4,528,164

(8) Pension Plans

The Corporation sponsors a 401(k) plan that covers substantially all full-time non-union employees. The Corporation contributes 4% of eligible compensation to the plan (5% for employees hired before December 1, 2001). The Corporation also makes a matching contribution up to 100% of the first 4% of employee contributions to the 401(k) plan. The Corporation also sponsors a 403(b) plan that covers union and certain other employees. The Corporation contributes 5% of eligible compensation to the plan and also makes a matching contribution for employees with 5 years of service, up to 100% of the first 5% of employee contributions to the 403(b) plan.

Pension expense under all plans aggregated approximately $6,486,000 in 2016 and approximately $6,166,000 in 2015.

(Continued)

(9) Contingencies

Professional Liability Insurance

Malpractice insurance coverage is provided under a claims-made based policy, which provides for $1,000,000 coverage for each claim, not to exceed $3,000,000 in aggregate annual coverage. Additionally, the insurance policy includes a per claim $50,000 uninsured deductible, not to exceed $250,000 in aggregate annual coverage. A deposit for the $250,000 has been established as required. In addition, the Corporation has purchased excess insurance policies. Claims alleging malpractice have been asserted against the Corporation and are currently in various stages of litigation. There are known claims and incidents that may result in the assertion of additional claims, as well as claims from unknown incidents that may be asserted relating to services provided to patients. Accrued malpractice losses in management's opinion provide an adequate reserve for loss contingencies. The Corporation has accrued a liability included in other liabilities of approximately $18,935,000 and $12,012,000 at December 31, 2016 and 2015, respectively. A corresponding receivable included in other assets of approximately $16,575,000 and $9,152,000, respectively, has been recorded to record anticipated recoveries from the insurance company.

Self-Insured Risks

The Corporation and certain affiliates are self-insured for employee healthcare costs. The group has obtained a stop loss coverage policy for healthcare costs to supplement its self-insurance coverage. An accrual for healthcare claims, including those incurred but not reported, is included in the current portion of estimated self-insured liabilities.

Workers' Compensation Insurance

The Corporation is primarily self-insured for employee workers' compensation and disability claims along with certain of its affiliates for certain years 2007 and prior. During 2016 and 2015, the Corporation and certain of its affiliates were enrolled in a high deductible plan with an insurance company with a deductible of $500,000 for each employee and occurrence, and an aggregate deductible of $7,900,000. Self-insured and high deductible liabilities are based on claims filed and estimates for claims incurred but not reported. As required by the State of New York Workers' Compensation Board, the Corporation has purchased letters of credit to guarantee payment of workers' compensation claims. Stop loss insurance for losses exceeding certain amounts has been purchased for workers' compensation. Each affiliate is jointly and severally liable for the satisfaction of all obligations. These liabilities are recorded at discounted amounts using a 3% and 4% interest rate in 2016 and 2015, respectively. From 2010 to 2014, the Corporation and certain of its affiliates were insured in a retrospectively rated workers' compensation and disability policy and premiums are accrued based on the ultimate cost of the experience to date of the Corporation and its affiliates. The Corporation has accrued a liability included in other liabilities and a corresponding receivable in other receivables for anticipated recoveries from the insurance company of approximately $7,353,000 and $6,642,000 as of December 31, 2016 and 2015, respectively.

(Continued)

(10) Affiliated Entities

The following represents summarized financial information from the consolidated financial statements of the Corporation's affiliates that are included in the accompanying consolidated financial statements on the equity method of accounting.

2016		SLM	Paraffin
Total assets	$	-	244,868
Total liabilities		-	158,388
Net assets	$	-	86,480
Total revenues		1,231,651	1,936,962
Total expenses		(1,140,472)	(1,833,579)
Excess of revenues over expenses	$	91,179	103,383

2015		SLM	Paraffin
Total assets	$	4,648,163	146,745
Total liabilities		3,800,291	163,648
Net assets (deficit)	$	847,872	(16,903)
Total revenues		1,356,118	1,838,798
Total expenses		(1,238,396)	(1,902,061)
Excess (deficiency) of revenues over expenses	$	117,722	(63,263)

The following are approximate dollar amounts of significant transactions and balances with affiliated entities.

St. Elizabeth Medical Center

During 2016 and 2015, Healthcare advanced funds to the Medical Center. As of December 31, 2015, there was $3,750,000 outstanding on this advance which is included within current portion of due from affiliates. There were no amounts outstanding at December 31, 2016. Total interest charged in 2016 and 2015 amounted to approximately $28,000 and $13,000, respectively.

(Continued)

(10) Affiliated Entities, Continued

St. Elizabeth Medical Center, Continued

Healthcare has contracted with the Medical Center to provide certain operational services, including shared employment, provider coverage, patient care, rental of office space, and other shared services as needed. In 2016 and 2015, Healthcare purchased services totalling approximately $2,609,000 and $1,420,000 respectively, from the Medical Center and sold services totalling approximately $3,968,000 and $2,115,000 respectively.

During 2015, Healthcare forgave a $450,000 liability payable from the Medical Center which related to a joint venture prior to their affiliation. This was recorded as a transfer to affiliate for the year ended December 31, 2015.

St. Luke's Home

Healthcare has contracted with the Home to provide certain operational services. In 2016 and 2015, Healthcare purchased approximately $1,233,000 and $1,152,000, respectively for services rendered and rental of space within the Home. Healthcare billed the Home for services totalling approximately $495,000 and $469,000, respectively.

Visiting Nurses Association

Healthcare charges VNA for certain shared operating expenses paid on its behalf. Additionally, during 2015, Healthcare advanced funds to VNA to pay down the outstanding balance on their short-term borrowing arrangement. At December 31, 2016 and 2015, there was $500,000 outstanding on this advance. Healthcare charged interest on a monthly basis through May 2016 using a monthly LIBOR rate plus 70 basis points. Total interest charged in 2016 and 2015 amounted to approximately $2,000. The net receivable, before reserve, as of December 31, 2016 and 2015 was approximately $3,280,000 and $1,602,000, respectively. In 2016, Healthcare recorded a reserve for $1,665,000 on the amounts due from VNA based on management's evaluation of VNA's historical and expected future cash flows. This reserve for doubtful accounts was recorded in the consolidated statements of operations and consolidated changes in net assets as a reduction of unrestricted net assets.

Healthcare billed VNA for certain shared services totalling approximately $47,000 and $109,000 in 2016 and 2015, respectively.

(Continued)

(10) Affiliated Entities, Continued

Senior Network Health

During 2016, Healthcare paid in full amounts previously loaned from SNH. The balance of the loan was approximately $301,000 at December 31, 2015.

Healthcare billed SNH for certain shared services totalling approximately $169,000 and $220,000 in 2016 and 2015, respectively.

New Hartford Scanner Associates

New Hartford Scanner Associates (NHSA) is a joint venture between Healthcare and several radiologists to provide CT scan services. Healthcare receives income from NHSA, which amounted to approximately $563,000 and $621,000 in 2016 and 2015, respectively. Healthcare charges NHSA for equipment, which amounted to approximately $120,000 in 2016 and 2015.

Mohawk Valley EC, LLC

Faxton-St. Luke's Healthcare, St. Elizabeth Medical Center and Mohawk Valley EC Holdings, LLC entered into an agreement for the purpose of owning and operating a single-specialty ambulatory surgery center, exclusively providing gastroenterology services in Oneida County. As part of the agreement, the three members formed the Mohawk Valley EC, LLC (MVEC), a New York limited liability company. Healthcare maintains a 20% interest and sharing ratio in MVEC. The amount recognized as income based on Healthcare's share is approximately $219,000 and $210,000 for the years ended December 31, 2016 and 2015, respectively.

Healthcare recognizes income from these joint ventures in other revenue.

(10) Affiliated Entities, Continued

Net receivables (payables) at December 31 from (to) affiliates for loans and advances, services performed and billing of other pass-through expenses to and from the Corporation were approximately as follows:

	2016	2015
Home	$ (1,209,000)	(1,214,000)
MVHS	486,000	436,000
SEMC	1,939,000	5,119,000
New Hartford Scanner Associates	289,000	399,000
VNA	3,280,000	1,602,000
SLM	-	(64,000)
Paraffin	(74,000)	19,000
SNH	311,000	(395,000)
MVHC	15,000	99,000
	5,037,000	6,001,000
Reserve for doubtful accounts	(1,665,000)	-
	$ 3,372,000	6,001,000

(11) Statements of Cash Flows - Supplemental Disclosures

The Corporation's non-cash investing and financing activity and cash payments for interest for the years ended December 31 were as follows:

	2016	2015
Capital lease obligations issued for property and equipment	$ 3,674,880	1,026,801
Cash paid for interest	1,720,080	1,972,500
SLM Transfer:		
Debt obligations assumed, net	2,509,145	-
Net book value of fixed asset assumed	3,423,729	-

(12) Functional Expenses

The Corporation provides general health care services to residents of the Mohawk Valley Region. Expenses related to providing these services are as follows:

	2016	2015
Health care services	$ 247,801,023	238,200,885
General and administrative	37,490,599	37,269,742
Fundraising	794,853	974,963
	$ 286,086,475	276,445,590

(Continued)

(13) Fair Value of Financial Instruments

The Fair Value Measurement Topic of the FASB Accounting Standards Codification requires disclosures that categorize assets and liabilities measured at fair value based on a fair value hierarchy. The hierarchy prioritizes the inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels which is determined by the lowest level input that is significant to the fair value measurement in its entirety.

The following methods and assumptions were used by the Corporation in estimating the fair value of its financial instruments:

Cash and Cash Equivalents: The amount reported on the balance sheet for cash and cash equivalents approximates fair value.

Mutual Funds and Common Stock: The fair values, which are the amounts reported on the consolidated balance sheets, are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.

Pooled Investment Funds: Fair values are based on NAV per share as determined by the fund's investment manager or general partner.

Estimated Third-Party Payor Settlements: The amount reported on the consolidated balance sheet for estimated third-party payor settlements approximates its fair value.

Long-Term Debt: The fair value of fixed rate issues was determined by price quotes from an investment banker or estimated using discounted cash flow analysis, based on the current incremental borrowing rate of similar types of borrowing arrangements (considered a Level 2 input). The fair value of variable rate debt approximates its reported value on the consolidated balance sheet. Fixed rate long-term debt is the only financial instrument with a difference between recorded and fair value. The recorded value of fixed rate long-term debt on the consolidated balance sheet at December 31, 2016 approximates its fair value.

The following tables present information about assets and liabilities that are measured at fair value on a recurring basis as of December 31 and indicate the fair value hierarchy of the valuation techniques utilized to determine such fair value. In general, fair values determined by Level 1 inputs utilize quoted prices in active markets for identical assets or liabilities. The Corporation considers a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Investments valued using NAV as a practical expedient are classified as Level 2 if the investment is redeemable at NAV (as adjusted for subsequent gains or losses through the effective date of redemption) in the near-term (generally within a 3-month period) without significant restrictions on redemption. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability. Investments valued using NAV as a practical expedient are classified as Level 3 if the investment is not redeemable in the near-term or has significant restrictions.

(Continued)

(13) Fair Value of Financial Instruments, Continued

	Total	Fair value measurements at December 31, 2016 Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 320,707	320,707	-	-
Asset limited as to use - cash and cash equivalents	250,000	250,000	-	-
Investments:				
Cash and cash equivalents	56,629	56,629	-	-
Mutual funds:				
U.S. large cap	29,383,132	29,383,132	-	-
U.S. mid cap	6,721,491	6,721,491	-	-
Emerging markets	2,346,271	2,346,271	-	-
Fixed income funds	10,914,537	10,914,537	-	-
Other	298,840	298,840	-	-
	49,664,271	49,664,271	-	-
Common stock:				
Consumer	319,857	319,857	-	-
Energy	323,899	323,899	-	-
Financial	557,014	557,014	-	-
Healthcare	351,154	351,154	-	-
Industrial	336,418	336,418	-	-
Information technology	161,670	161,670	-	-
Materials	213,108	213,108	-	-
Utilities	252,916	252,916	-	-
	2,516,036	2,516,036	-	-
Pooled investment funds:				
Hedge funds	16,597,116	-	16,597,116	-
Real estate funds	4,988,137	-	4,988,137	-
Bond funds	4,102,897	-	4,102,897	-
Foreign equity funds	9,637,109	-	9,637,109	-
	35,325,259	-	35,325,259	-
Beneficial interest in charitable trust	1,483,000	-	1,483,000	-
Total assets at fair value	$ 89,615,902	52,807,643	36,808,259	-
Cash and cash equivalents	320,707	320,707	-	-
Investments	89,295,195	52,486,936	36,808,259	-
Total	$ 89,615,902	52,807,643	36,808,259	-
Liabilities:				
Interest rate swaps	$ 3,966,550	-	3,966,550	-

(Continued)

(13) Fair Value of Financial Instruments, Continued

	Total	Fair value measurements at December 31, 2015 Level 1	Level 2	Level 3
Assets:				
Cash and cash equivalents	$ 690,069	690,069	-	-
Assets limited as to use - cash and cash equivalents	250,000	250,000	-	-
Investments:				
Cash and cash equivalents	122,647	122,647	-	-
Mutual funds:				
U.S. large cap	24,838,160	24,838,160	-	-
U.S. mid cap	5,174,798	5,174,798	-	-
Emerging markets	3,285,255	3,285,255	-	-
Fixed income funds	11,023,237	11,023,237	-	-
Other	271,974	271,974	-	-
	44,593,424	44,593,424	-	-
Common stock:				
Consumer	380,963	380,963	-	-
Energy	144,405	144,405	-	-
Financial	532,409	532,409	-	-
Healthcare	203,332	203,332	-	-
Industrial	335,455	335,455	-	-
Information technology	133,569	133,569	-	-
Materials	202,514	202,514	-	-
Utilities	295,057	295,057	-	-
	2,227,704	2,227,704	-	-
Pooled investment funds:				
Hedge funds	19,124,150	-	19,124,150	-
Real estate funds	4,806,977	-	4,806,977	-
Bond funds	3,956,277	-	3,956,277	-
Foreign equity funds	7,473,230	-	7,473,230	-
	35,360,634	-	35,360,634	-
Beneficial interest in charitable trust	1,265,000	-	1,265,000	-
Total assets at fair value	$ 84,509,478	47,883,844	36,625,634	-
Cash and cash equivalents	690,069	690,069	-	-
Investments	83,819,409	47,193,775	36,625,634	-
Total	$ 84,509,478	47,883,844	36,625,634	-
Liabilities:				-
Interest rate swaps	$ 4,600,438	-	4,600,438	-

(Continued)

(13) Fair Value of Financial Instruments, Continued

The following is a summary of the investments whose NAV approximates fair value and the related redemption restrictions associated with each major category at December 31:

	2016		
Pooled investment funds	Total fair value	Redemption frequency	Redemption notice periods
Hedge funds	$ 16,597,116	Monthly	90 days
Real estate funds	4,988,137	Monthly	None
Bond funds	4,102,897	Monthly	10 days
Foreign equity funds	9,637,109	Monthly	10 days
	$ 35,325,259		

	2015		
Pooled investment funds	Total fair value	Redemption frequency	Redemption notice periods
Hedge funds	$ 19,124,150	Monthly	90 days
Real estate funds	4,806,977	Monthly	None
Bond funds	3,956,277	Monthly	10 days
Foreign equity funds	7,473,230	Monthly	10 days
	$ 35,360,634		

Hedge Funds

Hedge fund strategies involve funds with investment managers who have the authority to invest in various asset classes at their discretion and who have the ability to employ multiple investments strategies within their respective portfolios. Investment strategies may include the following categories: merger arbitrage, distressed, long/short credit, fixed income arbitrage and convertible arbitrage. These funds attempt to reduce individual manager risk by allocating capital among multiple investment managers. Funds with hedged strategies generally hold securities or other financial instruments for which a ready market exists and may include stocks, bonds, put or call options, swaps, currency hedges, and other instruments, and are valued accordingly.

(13) Fair Value of Financial Instruments, Continued

Real Estate Funds

Real estate funds hold interests in publicly traded equity securities issued by real estate investment trusts ("REIT"), private real estate partnerships, and privately held REIT's. Strategies of these funds often require the estimation of fair values by the fund managers in the absence of readily determinable market values. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed, and the differences could be material. Such valuations are determined by fund managers and generally consider variables such as operating results, comparable earnings multiples, projected cash flows, recent sales prices, and other pertinent information, and may reflect discounts for the illiquid nature of certain investments held. Moreover, the fair values of the Corporation's interests in shares or units of these funds, because of the liquidity and capital commitment terms that vary depending on the specific fund or partnership agreement, may differ from the fair value of the funds' underlying net assets.

Bond Funds

Bond funds are invested in a globally diversified portfolio of primarily debt and debt-like securities. The funds are controlled by an investment manager. The investment manager generally will acquire positions in debt securities and currencies that are rated investment grade by Standard & Poor's Credit Market Services, or if unrated, an equivalent rating determined by the investment manager at its sole discretion.

Foreign Equity Funds

Foreign equity funds are invested in a diversified portfolio of equity securities of companies ordinarily located in any country other than the United States and Canada. The funds are controlled by an investment manager.

Schedule 1

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidating Balance Sheet

December 31, 2016
with comparative consolidated amounts for 2015

Assets	Faxton-St. Luke's Healthcare	Faxton-St. Luke's Healthcare Foundation	Eliminations	Consolidated 2016	Consolidated 2015
Current assets:					
Cash and cash equivalents	$ 5,450,066	352,508	-	5,802,574	1,458,858
Investments and assets limited as to use	79,476,377	3,807,654	-	83,284,031	78,379,823
Patient accounts receivable, net of reserve for doubtful accounts of approximately $7,711,000 in 2016 and $7,727,000 in 2015	31,516,572	-	-	31,516,572	38,999,629
Pledges receivable	-	335,273	-	335,273	571,367
Other current assets	6,853,883	-	-	6,853,883	5,424,254
Inventories	6,280,789	-	-	6,280,789	5,873,362
Prepaid expenses	3,283,008	52,544	-	3,335,552	3,003,276
Due to affiliates, net	1,531,083	-	(164,056)	1,367,027	4,044,954
Estimated third-party payor settlements, net	1,948,925	-	-	1,948,925	1,649,371
Total current assets	136,340,703	4,547,979	(164,056)	140,724,626	139,404,894
Interest in Faxton-St. Luke's Healthcare Foundation	6,638,537	-	(6,638,537)	-	-
Investment in affiliates	86,480	-	-	86,480	830,969
Due from affiliates, net	2,004,544	-	-	2,004,544	1,955,488
Investments	4,528,164	-	-	4,528,164	4,528,164
Beneficial interest in charitable trusts	-	1,483,000	-	1,483,000	1,265,000
Property and equipment, net	77,417,624	934,582	-	78,352,206	77,976,553
Other assets	24,453,511	-	-	24,453,511	18,589,053
Total assets	$ 251,469,563	6,965,561	(6,802,593)	251,632,531	244,550,121

(Continued)

Schedule 1

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidating Balance Sheets, Continued

December 31, 2016
with comparative consolidated amounts for 2015

Liabilities and Net Assets	Faxton-St. Luke's Healthcare	Faxton-St. Luke's Healthcare Foundation	Eliminations	Consolidated 2016	Consolidated 2015
Current liabilities:					
Revolving note payable	$ -	-	-	-	5,623,000
Current portion of long-term debt	3,186,209	-	-	3,186,209	3,752,367
Current portion of capital lease obligations	4,076,665	-	-	4,076,665	3,825,676
Accounts payable and accrued expenses	15,119,400	31,472	-	15,150,872	15,134,168
Accrued payroll, payroll taxes and benefits	12,095,220	-	-	12,095,220	10,392,132
Current portion of estimated insurance liabilities	4,623,654	-	-	4,623,654	5,798,357
Due to affiliates, net	-	164,056	(164,056)	-	-
Other current liabilities	4,518,701	131,496	-	4,650,197	3,032,187
Total current liabilities	43,619,849	327,024	(164,056)	43,782,817	47,557,887
Long-term debt, net of current portion:					
Notes payable	5,218,968	-	-	5,218,968	4,463,569
Civic facility revenue bonds	14,149,514	-	-	14,149,514	14,723,963
Capital lease obligations	5,483,062	-	-	5,483,062	6,284,814
Total long-term debt, net of current portion	24,851,544	-	-	24,851,544	25,472,346
Other liabilities	36,713,497	-	-	36,713,497	30,846,580
Estimated insurance liabilities, net of current portion	5,057,692	-	-	5,057,692	3,994,434
Total liabilities	110,242,582	327,024	(164,056)	110,405,550	107,871,247
Net assets:					
Unrestricted	132,869,688	2,840,607	(2,840,607)	132,869,688	127,892,575
Temporarily restricted	3,829,129	3,797,930	(3,797,930)	3,829,129	4,258,135
Permanently restricted	4,528,164	-	-	4,528,164	4,528,164
Total net assets	141,226,981	6,638,537	(6,638,537)	141,226,981	136,678,874
Commitments and contingencies (notes 6 and 9)					
Total liabilities and net assets	$ 251,469,563	6,965,561	(6,802,593)	251,632,531	244,550,121

See accompanying independent auditor's report.

Schedule 2

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidating Statements of Operations and Changes in Net Assets

Year ended December 31, 2016
with comparative consolidated amounts for 2015

	Faxton-St. Luke's Healthcare	Faxton-St. Luke's Healthcare Foundation	Eliminations	Consolidated 2016	Consolidated 2015
Unrestricted revenues, gains and other support:					
Patient service revenue (net of contractual allowances and discounts)	$ 273,563,013	-	-	273,563,013	267,603,957
Provision for bad debts	(5,277,188)	-	-	(5,277,188)	(5,387,923)
Net patient service revenue less provision for bad debts	268,285,825	-	-	268,285,825	262,216,034
Other operating revenue	16,830,683	-	-	16,830,683	13,985,931
Net assets released from restrictions used for operations	293,032	2,083,349	(1,635,110)	741,271	900,853
Total unrestricted revenues, gains and other support	285,409,540	2,083,349	(1,635,110)	285,857,779	277,102,818
Expenses:					
Salaries and wages	137,717,892	308,805	-	138,026,697	129,371,185
Employee benefits	24,912,686	71,462	-	24,984,148	26,411,289
Supplies and other	105,543,613	2,048,983	(1,635,110)	105,957,486	101,516,920
Depreciation and amortization	14,272,035	713	-	14,272,748	16,078,436
Interest	1,743,087	-	-	1,743,087	1,998,101
New York State gross receipts taxes	1,102,309	-	-	1,102,309	1,069,659
Total expenses	285,291,622	2,429,963	(1,635,110)	286,086,475	276,445,590
Net income (loss) from operations	117,918	(346,614)	-	(228,696)	657,228
Other revenue (expense):					
Contributions and other unrestricted revenue (expense)	(191,716)	112,849	-	(78,867)	(1,465,539)
Investment income, net of fees	1,032,218	125,960	-	1,158,178	2,997,110
Total other revenue, net	840,502	238,809	-	1,079,311	1,531,571
Excess (deficiency) of revenues over expenses	$ 958,420	(107,805)	-	850,615	2,188,799

(Continued)

Schedule 2

FAXTON-ST. LUKE'S HEALTHCARE AND AFFILIATE

Consolidating Statements of Operations and Changes in Net Assets, Continued

Year ended December 31, 2016
with comparative consolidated amounts for 2015

	Faxton-St. Luke's Healthcare	Faxton-St. Luke's Healthcare Foundation	Eliminations	Consolidated 2016	Consolidated 2015
Unrestricted net assets:					
Excess (deficiency) of revenues over expenses	$ 958,420	(107,805)	-	850,615	2,188,799
Change in fair value of interest rate swaps	633,888	-	-	633,888	241,570
Change in interest in unrestricted net assets of Foundation	61,219	-	(61,219)	-	-
Net assets released for capital acquisitions	1,342,078	-	-	1,342,078	780,004
Contributions used for capital acquisitions	41,750	-	-	41,750	85,094
Transfer to affiliate	-	-	-	-	(450,000)
Reserve for doubtful accounts due from affiliate	(1,665,000)	-	-	(1,665,000)	-
Change in net unrealized gains and losses on investments	3,604,758	169,024	-	3,773,782	(6,822,127)
Increase (decrease) in unrestricted net assets	4,977,113	61,219	(61,219)	4,977,113	(3,976,660)
Temporarily restricted net assets:					
Contributions	-	1,436,343	-	1,436,343	1,998,338
Change in value of charitable trusts	-	218,000	-	218,000	(13,000)
Net assets released from restrictions	-	(2,083,349)	-	(2,083,349)	(1,680,857)
Change in interest in temporarily restricted net assets of Foundation	(429,006)	-	429,006	-	-
Increase (decrease) in temporarily restricted net assets	(429,006)	(429,006)	429,006	(429,006)	304,481
Total increase (decrease) in net assets	4,548,107	(367,787)	367,787	4,548,107	(3,672,179)
Net assets at beginning of year	136,678,874	7,006,324	(7,006,324)	136,678,874	140,351,053
Net assets at end of year	$ 141,226,981	6,638,537	(6,638,537)	141,226,981	136,678,874

See accompanying independent auditor's report.

ST. ELIZABETH MEDICAL CENTER
AND AFFILIATE

Consolidated Financial Statements

December 31, 2016 and 2015

Fust Charles Chambers LLP
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

The Board of Directors
Mohawk Valley Health System:

We have audited the accompanying consolidated financial statements of St. Elizabeth Medical Center and Affiliate, which comprise the consolidated balance sheets as of December 31, 2016 and 2015, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

5784 Widewaters Parkway ▪ Syracuse, NY 13214 ▪ P: 315-446-3600 ▪ F: 315-446-3899 ▪ www.fcc-cpa.com

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of St. Elizabeth Medical Center and Affiliate as of December 31, 2016 and 2015, and the results of its operations, changes in net assets and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Fust Charles Chambers LLP

May 22, 2017

ST. ELIZABETH MEDICAL CENTER
AND AFFILIATE

Consolidated Balance Sheets

December 31, 2016 and 2015

Assets	2016	2015
Current assets:		
Cash and cash equivalents	$ 8,200,918	5,902,557
Assets limited as to use	109,549	63,909
Investments	9,690,864	9,391,986
Patient accounts receivable, net of allowance for doubtful accounts of approximately $5,400,000 in 2016 and $6,300,000 in 2015	24,272,573	25,942,360
Other current assets	2,122,661	1,738,811
Inventories	5,792,039	5,590,544
Prepaid expenses	1,579,098	1,390,560
Total current assets	51,767,702	50,020,727
Assets limited as to use	3,934,345	4,003,224
Property and equipment, net	64,604,940	70,615,095
Other assets	816,347	1,260,723
Total assets	$ 121,123,334	125,899,769
Liabilities and Net Assets		
Current liabilities:		
Current portion of long-term debt	1,619,248	1,550,550
Current portion of capital lease obligations	343,825	404,670
Current portion of estimated insurance liabilities	2,843,746	1,236,428
Accounts payable and accrued expenses	16,768,469	18,864,923
Accrued payroll, payroll taxes and benefits	7,868,797	7,724,790
Estimated third-party payor settlements, net	3,854,892	3,545,389
Due to affiliates, net	1,879,496	5,181,453
Other current liabilities	250,466	316,380
Total current liabilities	35,428,939	38,824,583
Accrued pension liability	46,815,314	50,183,961
Long-term portion of debt	24,936,889	26,452,589
Capital lease obligations	585,888	929,713
Estimated insurance liabilities	3,665,471	4,381,699
Other long-term liabilities	678,498	536,284
Total liabilities	112,110,999	121,308,829
Net assets:		
Unrestricted	7,596,468	3,250,882
Temporarily restricted	469,561	421,769
Permanently restricted	946,306	918,289
Total net assets	9,012,335	4,590,940
Commitments and contingencies (notes 5 and 8)		
Total liabilities and net assets	$ 121,123,334	125,899,769

See accompanying notes to the consolidated financial statements.

ST. ELIZABETH MEDICAL CENTER
AND AFFILIATE

Consolidated Statements of Operations and Changes in Net Assets

Years ended December 31, 2016 and 2015

	2016	2015
Unrestricted revenues, gains and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 217,633,469	205,681,545
Provision for bad debts	(6,268,979)	(7,845,812)
Net patient service revenue less provision for bad debts	211,364,490	197,835,733
Other operating revenue	6,225,037	6,701,146
Net assets released from restrictions used for operations	21,250	40,469
Total unrestricted revenues, gains and other support	217,610,777	204,577,348
Expenses:		
Salaries and wages	103,019,932	101,720,950
Employee benefits	22,809,678	21,560,839
Supplies and other	78,642,213	73,080,786
Depreciation and amortization	10,454,515	10,605,624
Interest	1,427,239	1,554,662
New York State gross receipts taxes	674,428	614,897
Total expenses	217,028,005	209,137,758
Gain (loss) from operations	582,772	(4,560,410)
Other revenue:		
Contributions and other unrestricted revenue	73,237	96,477
Investment income, net of fees	355,557	342,288
Total other income	428,794	438,765
Excess (deficiency) of revenues over expenses	1,011,566	(4,121,645)
Change in net unrealized gains and losses on investments	205,781	(261,537)
Pension related changes other than net periodic pension cost	2,672,766	270,191
Contribution from affiliate	-	450,000
Investment income (loss) on board designated net assets	261,472	(56,094)
Net assets released from restrictions used for capital purposes	194,001	519,162
Increase (decrease) in unrestricted net assets	4,345,586	(3,199,923)

(Continued)

ST. ELIZABETH MEDICAL CENTER
AND AFFILIATE

Consolidated Statements of Operations and Changes in Net Assets, Continued

	2016	2015
Temporarily restricted net assets:		
Contributions	227,191	409,435
Change in net unrealized gains and losses on investments	22,510	42,548
Interest income on permanently restricted net assets	13,342	14,619
Net assets released from restrictions	(215,251)	(559,631)
Increase (decrease) in temporarily restricted net assets	47,792	(93,029)
Permanently restricted net assets:		
Contributions	28,017	34,258
Increase in permanently restricted net assets	28,017	34,258
Total increase (decrease) in net assets	4,421,395	(3,258,694)
Net assets at beginning of year	4,590,940	7,849,634
Net assets at end of year	$ 9,012,335	4,590,940

See accompanying notes to the consolidated financial statements.

ST. ELIZABETH MEDICAL CENTER
AND AFFILIATE

Consolidated Statements of Cash Flows

Years ended December 31, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Change in net assets	$ 4,421,395	(3,258,694)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	10,454,515	10,605,624
Provision for bad debts	6,268,979	7,845,812
Amortization of debt issuance costs	88,441	88,441
Contribution from affiliate	-	(450,000)
Decrease in pension related changes other than net periodic pension cost	(2,672,766)	(270,191)
Change in net unrealized gains and losses on investments	(205,781)	261,537
Investment (loss) income on board designated net assets	(261,472)	56,094
(Gain) loss on sale of assets	(15,388)	22,424
Contributions received for long-term purposes	(194,001)	(443,543)
Changes in operating assets and liabilities:		
Patient accounts receivable	(4,599,192)	(5,726,271)
Inventories	(201,495)	(495,408)
Due to affiliate, net	448,043	1,594,550
Prepaid expenses	(188,538)	(486,799)
Other assets	60,526	(622,515)
Accounts payable and accrued expenses	(2,645,017)	(1,180,713)
Estimated third-party payors settlements, net	309,503	110,125
Accrued pension liability	(695,881)	(60,483)
Other liabilities	967,390	(150,986)
Net cash provided by operating activities	11,339,261	7,439,004
Cash flows from investing activities:		
Purchases of property and equipment	(3,751,790)	(5,968,754)
Proceeds from sale of property and equipment	15,388	-
Change in assets limited as to use	490,492	(314,742)
Change in investments, net	(298,878)	631,082
Net cash used in investing activities	(3,544,788)	(5,652,414)
Cash flows from financing activities:		
Short-term borrowings paid off	-	(4,000,000)
Proceeds from (payments on) affiliate advances	(3,750,000)	3,750,000
Proceeds from long-term debt	-	500,000
Principal payments of long-term debt and capital lease obligations	(1,940,113)	(1,945,900)
Contributions received for long-term purposes	194,001	443,543
Net cash used in financing activities	(5,496,112)	(1,252,357)
Net increase in cash and cash equivalents	2,298,361	534,233
Cash and cash equivalents at beginning of year	5,902,557	5,368,324
Cash and cash equivalents at end of year	$ 8,200,918	5,902,557

See accompanying notes to the consolidated financial statements.

(1) Description of Organization and Summary of Significant Accounting Policies

(a) Organization

St. Elizabeth Medical Center (the Medical Center) is a voluntary not-for-profit acute care facility located in Utica, New York. The Medical Center provides medical, surgical, and psychiatric inpatient services. In addition, the Medical Center offers outpatient general diagnostic, ambulatory care, physical therapy, and emergency care services.

St. Elizabeth Medical Center Foundation, Inc. (the Foundation) is a not-for-profit organization whose primary purpose is to solicit, collect, and invest funds on behalf of the Medical Center.

Mohawk Valley Health System (MVHS), a not-for-profit corporation, and Partners in Ministries, Inc., which is sponsored by the Sisters of St. Francis of the Neumann Communities, are co-members of the Medical Center. MVHS is also the sole corporate member of various other organizations involved in providing healthcare services to the Mohawk Valley Region.

(b) New Accounting Pronouncement

In April 2015, the FASB issued ASU 2015-03, "Interest - Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs", which simplifies the presentation of debt issuance costs to be presented as a deduction from the corresponding debt liability. Amortization of debt issuance costs shall be reported as interest expense. ASU 2015-03 is effective for financial statements issued for fiscal years beginning after December 15, 2015 and is to be applied on a retrospective basis for all previous periods presented. The Medical Center adopted ASU 2015-03 as of and for the year ended December 31, 2016. The retrospective adoption of ASU 2015-03 resulted in a decrease to long-term assets, and long-term liabilities of $665,584 on the balance sheet for the year ended December 31, 2015, a reclassification of $88,441 of amortization of debt issuance costs from depreciation and amortization to interest expense on the consolidated statements of operations and changes in net assets and cash flows (cash flows from operations) for the year ended December 31, 2015, but had no effect on deficiency of revenues over expenses or net assets as of or for the year ended December 31, 2015.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(c) Basis of Accounting

The accompanying consolidated financial statements include the accounts of the Medical Center and the Foundation. The Medical Center is the sole corporate member of the Foundation. For financial reporting purposes, the Medical Center is considered the reporting entity. All significant intercompany balances and transactions have been eliminated in the consolidated financial statements.

As a member of MVHS, the Medical Center is affiliated with and transacts business with other healthcare providers in the MVHS network. Faxton-St. Luke's Healthcare (Healthcare), provides acute care. Senior Network Health, LLC (SNH), provides Medicaid managed care to seniors. St. Luke's Residential Healthcare Facility (SLH), provides long-term healthcare. Mohawk Valley Home Care, LLC (MVHC), provides nursing services. Visiting Nurse Association of Utica and Oneida County, Inc. (VNA), provides home health care services.

(d) Use of Estimates

The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(e) Collective Bargaining Agreements

At December 31, 2016, the Medical Center had approximately 58% of its employees working under collective bargaining agreements. Certain agreements expire in September 2017. One agreement expires in June 2019.

(f) Cash and Cash Equivalents

Cash and cash equivalents include certain investments in highly liquid debt instruments with original maturity of three months or less at date of purchase excluding amounts classified as assets limited as to use.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(g) Investments and Assets Limited as to Use

Investments, assets limited as to use and pension plan assets are reported at fair value. FASB ASC No. 820, Fair Value Measurement (ASC 820), defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. See note 12 for discussion on fair value measurements.

Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in the excess (deficiency) of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess (deficiency) of revenues over expenses since none of the investments are classified as trading securities.

The Medical Center invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the Medical Center's net assets.

(h) Inventories

Inventories are stated at the lower of average cost or net realizable value.

(i) Property and Equipment

Property and equipment acquisitions are recorded at cost, if purchased, or at fair value at the date of acquisition when acquired by gift. Property and equipment which is purchased under capital leases is stated at the lower of the present value of minimum lease payments at the beginning of the lease term or the fair market value at the inception of the lease.

Depreciation of property and equipment is calculated over the estimated useful life of each class of depreciable asset ranging from 2-40 years using the straight-line method. Property and equipment held under capital leases is amortized on the straight-line method over the lesser of the estimated useful life of the asset or the lease term. Amortization of equipment under capital leases is included in depreciation and amortization expense.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(i) Property and Equipment, Continued

Gifts of long-lived assets, such as land, buildings or equipment are reported as unrestricted support and are excluded from the excess (deficiency) of revenues over expenses, unless explicit donor stipulations specify how the donated asset must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

(j) Unamortized Debt Issuance Costs

Debt issuance costs are amortized using the straight-line method, which approximates the effective interest method over the terms of the related debt obligations. At December 31, 2016 and 2015, the accumulated amortization on the debt issuance costs was approximately $1,255,000 and $1,167,000, respectively. Amortization expense amounted to approximately $88,000 in 2016 and 2015, respectively, and is included in interest expense within the consolidated statements of operations and changes in net assets.

(k) Temporarily Restricted Net Assets

Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose.

(l) Permanently Restricted Net Assets (Endowment Funds)

The Medical Center maintains various donor-restricted and board-designated funds whose purpose is to provide long-term support for its charitable programs. In classifying such funds for financial statement purposes as either permanently restricted, temporarily restricted or unrestricted net assets, the Board of Directors looks to the explicit directions of the donor where applicable and the provisions of the laws of the State of New York. To constitute an endowment under New York State law, the restriction must arise from a clearly expressed donor limitation, not a limitation from within the beneficiary organization. The Board of Directors has determined that, absent donor stipulations to the contrary, the provisions of New York State law do not impose either a permanent or temporary restriction on the income or capital appreciation derived from the original gift. Therefore, all income and appreciation derived from the original gift are transferred to unrestricted net assets absent any restrictions on the use made by the donor. Permanently restricted net assets consist of endowment funds of $528,864 and $512,105 at December 31, 2016 and 2015, respectively, and are included in assets limited as to use in the consolidated balance sheets.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(l) Permanently Restricted Net Assets (Endowment Funds)

The Medical Center utilizes an investment strategy that emphasizes preservation of principal and total return consistent with prudent levels of risk. Investments are allocated over a diversified portfolio of multiple asset classes.

Interpretation of Relevant Law

Prior to September 17, 2010, New York State law required the preservation of an endowment fund's historic dollar value. Historic dollar value is defined as the aggregate fair value in dollars of an endowment fund at the time it becomes an endowment fund, each subsequent donation to the fund at the time it is made and each accumulation made pursuant to a direction in applicable gift instrument at the time an accumulation is added to the fund. The law permitted an organization to spend the income earned by an endowment fund (i.e. interest, dividends), as well as the net appreciation (realized with respect to all assets and unrealized with respect to readily marketable assets) of such fund.

On September 17, 2010, the New York Prudent Management of Institutional Funds Act (NYPMIFA) was signed into New York State law. The most prominent feature of NYPMIFA is the elimination of the requirement to preserve an endowment fund's historic dollar value which allows an organization to spend from an endowment whose market value has dropped below the historic dollar value, as long as it is deemed prudent under the organization's policies. In accordance with NYPMIFA, an organization must consider the following factors in exercising a standard of prudence:

1. The duration and preservation of the endowment fund
2. The purposes of the organization and the donor-restricted endowment fund
3. General economic conditions
4. The possible effect of inflation and deflation
5. The expected total return from income and the appreciation of investments
6. Other resources of the organization
7. The investment policies of the organization
8. Where appropriate, alternatives to spending from the endowment fund and the possible effects of those alternatives on the organization

NYPMIFA requires compliance with donor intent when making investment or spending decisions with respect to an endowment fund. In addition, NYPMIFA creates a restriction on the portion of an endowment fund that is not classified as permanently restricted net assets, even in the absence of a donor restriction. Such portion is classified as temporarily restricted net assets until appropriated for expenditure by the organization.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(l) Permanently Restricted Net Assets (Endowment Funds), Continued

Interpretation of Relevant Law, Continued

The Medical Center has interpreted NYPMIFA as requiring the preservation of the purchasing power of the donor restricted endowment funds absent explicit donor stipulations to the contrary. As a result, the Medical Center continues to classify permanently restricted net assets at the historic dollar value of the fund in accordance with donor instructions.

Funds with Deficiencies

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the level that the donor or NYPMIFA requires the Medical Center to retain as a fund of perpetual duration. If the situation were to occur, the deficiency would be recorded in the Medical Center's unrestricted net assets. A deficiency did not exist at December 31, 2016 or 2015.

Return Objectives, Strategies, Spending Policy and Investment Objectives

The Medical Center has adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment. Under this policy, as approved by the Board of Directors, the endowment assets are to be invested in a well-diversified asset mix that can be expected to generate acceptable long-term returns at an acceptable level of risk. The Medical Center targets a diversified asset allocation that places a greater emphasis on equity-based investments and bonds to achieve its long-term return objectives within prudent risk constraints.

(m) Insurance Claims and Related Recoveries

The Medical Center recognizes liabilities associated with malpractice claims or similar contingent liabilities when the incidents that give rise to the claims occur. Further, the liability shall not be presented net of anticipated insurance recoveries. Any amounts expected to be reimbursed from an insurance company are presented in other assets. For the years ended December 31, 2016 and 2015, $375,000 and $708,000, respectively, has been recognized in these statements as a liability and a corresponding asset has been recorded to account for the anticipated recovery from the insurance company.

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(n) Net Patient Service Revenue and Patient Accounts Receivable

The Medical Center has agreements with third-party payors that provide for payments at amounts different from their established rates. Inpatient acute care services rendered are paid at prospectively determined rates per discharge in accordance with the Federal Prospective Payment System (PPS) for Medicare and generally at negotiated or otherwise pre-determined amounts under the provisions of the New York Health Care Reform Act (HCRA) and related legislation for all other payors. Reimbursement rates for Medicaid, Workers' Compensation, and No-Fault are determined on a prospective basis defined by HCRA that is based on clinical, diagnostic, and other factors. Inpatient nonacute and outpatient services are paid at various rates under different arrangements with third-party payors, commercial insurance carriers and health maintenance organizations. The basis for payment under these agreements includes prospectively determined per diem and per visit rates, discounts from established charges, fee schedules, and reasonable cost. Medicare outpatient services are paid under a prospective payment system whereby services are reimbursed on a predetermined amount for each outpatient procedure, subject to various mandated modifications.

Net patient service revenue is recognized in the period services are performed, is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered and includes estimated retroactive revenue adjustments due to future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

In addition, under HCRA, all Non-Medicare payors are required to make surcharge payments for the subsidization of indigent care and other health care initiatives. The percentage amounts of the surcharge varies by payor and applies to a broader array of health care services. Also, certain payors are required to make a covered lives payment to further fund the indigent care pools and other health care initiatives for inpatient services or through voluntary election to pay a covered lives assessment directly to the New York State Department of Health (DOH). The funds are distributed to the hospitals based on each hospital's level of bad debt in relation to all other hospitals. The Medical Center recorded distributions of approximately $1,165,000 and $1,260,000 for the years ended December 31, 2016 and 2015, respectively, from the indigent care pool.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(n) Net Patient Service Revenue and Patient Accounts Receivable, Continued

Both federal and New York State regulations provide for certain adjustments to current and prior years' payment rates and indigent care pool distributions based on industry-wide and hospital-specific data. The Medical Center has established estimates based on information presently available of the amounts due to or from Medicare, Medicaid, workers' compensation and no-fault payors and amounts due from the indigent care pool for such adjustments. Those adjustments which can be reasonably estimated have been provided for in the accompanying consolidated financial statements. The Medical Center has estimated the potential impact of such adjustments based on the most recent information available.

The Medical Center is required to prepare and file various reports of actual and allowable costs annually. Provisions have been made in the consolidated financial statements for prior and current years' estimated final settlements to the Medicare program and other third-party payors. The difference between the amount provided and the actual final settlement is recorded as an adjustment to net patient service revenue in the year the final settlement is determined. The Medical Center recorded adjustments for estimated settlements with third-party payors related to either settlement of prior year issues or changes in estimates resulting in an increase of approximately $3,640,000 and $987,000 in net patient service revenue for the years ended December 31, 2016 and 2015, respectively. The laws and regulations governing the reimbursement for healthcare services are extremely complex and subject to interpretation. Third-party payors retain the right to review and propose adjustments to amounts requested and recorded by the Medical Center. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near future. As of December 31, 2016, all cost reports through 2015 have been filed and Medicare cost reports through 2013 have been final settled. In accordance with FASB ASC Topic 954 any amounts recognized as bad debt reduces net patient service revenue in the period in which the bad debt is recognized.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(n) Net Patient Service Revenue and Patient Accounts Receivable, Continued

For the years ended December 31, 2016 and 2015, revenue from the Medicare and Medicaid programs accounted for approximately 61% and 63%, respectively, of the Medical Center's net patient service revenue. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts) from these major payor sources, is as follows for the years ended December 31:

	2016			
	Government payors	Commercial insurance and others	Self-pay	Total
Patient service revenue (net of contractual allowances and discounts)	$ 133,032,718	76,830,529	7,770,222	217,633,469

	2015			
	Government payors	Commercial insurance and others	Self-pay	Total
Patient service revenue (net of contractual allowances and discounts)	$ 128,793,101	70,366,060	6,522,384	205,681,545

Additions to the allowance for doubtful accounts are made by means of the provision for bad debts. Accounts written off as uncollectible are deducted from the allowance and subsequent recoveries are added. The amount of the provision for doubtful accounts is based upon management's assessment of historical expected net collections, business and economic conditions, trends in federal and state governmental health care coverage and other collection indicators. Services rendered to individuals when payment is expected and ultimately not received are written off to the allowance for doubtful accounts.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(n) Net Patient Service Revenue and Patient Accounts Receivable, Continued

The Medical Center grants unsecured credit to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of gross receivables from patients and third-party payors at December 31 was as follows:

	2016	2015
Medicare	49%	42%
Medicaid	14%	18%
Self-pay	12%	13%
Insurance and all others	25%	27%
	100%	100%

The Medical Center's reserve for doubtful accounts was approximately 78% of self-pay accounts receivable at December 31, 2016 and 2015. The Medical Center has not changed its charity care policy during 2016 or 2015. The Medical Center does maintain and allowance for doubtful accounts of approximately 5% at December 31, 2016 and 2015 from third-party payors.

(o) Charity Care

The Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The Medical Center's policy is not to pursue collection of amounts determined to qualify as charity care; therefore, these amounts are not reported in net patient service revenue. During 2016 and 2015, costs incurred by the Medical Center in the provision of charity care were based on the ratio of the Medical Center's costs to gross charges and approximated $340,000 and $225,000 for the years ended December 31, 2016 and 2015, respectively.

(p) Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received, which then are treated as cost. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. Contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restrictions.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(q) Medicare and Medicaid Electronic Health Record Incentive Program

The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH). The provisions were designed to increase the use of electronic health record (EHR) technology and to establish the requirements for a Medicare and Medicaid incentive payment program beginning in 2011 for eligible providers that adopt and meaningfully use certified EHR technology. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. Initial Medicaid payments are available to providers that adopt, implement or upgrade certified EHR technology. Providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional Medicaid incentive payments.

The Medical Center uses a grant accounting model to recognize revenue for the Medicare and Medicaid EHR incentive payments. EHR incentive payments are recognized as revenue when it is reasonably assured that the meaningful use criteria for the required period of time have been achieved and the revenue will be received. The Medical Center recognized Medicare incentive payments totalling approximately $1,131,000 for the year ended December 31, 2015 as other operating revenue in the accompanying consolidated statements of operations and changes in net assets. The Medical Center did not recognize any incentive payments in 2016. Income from Medicare incentive payments will be subject to retrospective adjustment upon final settlement of the applicable cost report from which payments are calculated. Additionally, the Medical Center's compliance with the meaningful use criteria is subject to audit by the federal and New York State governments.

(r) Excess (Deficiency) of Revenues Over Expenses

The consolidated statements of operations and changes in net assets include excess (deficiency) of revenues over expenses. Changes in unrestricted net assets which are excluded from excess (deficiency) of revenues over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from affiliates for other than goods and services, contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets), and pension liability adjustments in accordance with FASB ASC Subtopic 715-30, Compensation-Retirement Benefits, Defined Benefit Plans - Pension.

(Continued)

(1) Description of Organization and Summary of Significant Accounting Policies, Continued

(s) Income Taxes

The Medical Center and the Foundation have been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code. As of December 31, 2016 and 2015, the Medical Center and the Foundation did not have any unrecognized tax benefits or any related accrued interest or penalties. The tax years open to examination by federal and state taxing authorities are 2013 through 2016. The Medical Center does not anticipate the total unrecognized tax benefits will change in the next twelve months.

(t) Concentration of Credit Risk

The Medical Center invests cash and cash equivalents with financial institutions, and has determined that the amount of credit exposure at any one financial institution is immaterial to the Medical Center's financial position.

(u) Reclassifications

Certain 2015 amounts have been reclassified to conform to the 2016 consolidated financial statement presentation.

(v) Subsequent Events

Subsequent events have been evaluated through May 22, 2017, which is the date consolidated financial statements were available to be issued.

In April 2017, MVHS was notified by the New York State Department of Health of an award of $300 million granted under the Statewide Health Care Facility Transformation Program. This program provides funds to health care providers for the purpose of strengthening and protecting continued access to health care services in communities throughout New York State which are associated with a merger, consolidation or significant corporate restructuring activity that is part of an overall transformation plan intended to create a financially sustainable system of care. This award will be used by MVHS to consolidate inpatient care from Healthcare and the Medical Center into one, new integrated health campus. The cost projection for the new campus is estimated to be $480 million for a 750,000 square-foot facility. The remaining $180 million will come from MVHS capital, bonds and fundraising. The planning and construction for this project is expected to take approximately 5 years.

(Continued)

(2) Assets Limited as to Use and Investments

The composition of assets limited as to use and investments, at fair value, at December 31, 2016 and 2015 is set forth in the tables below:

		2016	2015
Under bond indenture agreements:			
Cash and cash equivalents	$	-	62,320
Commercial paper		2,532,239	2,502,954
		2,532,239	2,565,274
Less current portion for bond interest fund		109,549	63,909
Debt service reserve fund		2,422,690	2,501,365
Restricted by donors:			
Cash and cash equivalents		565,744	585,191
Common stock		240,065	202,529
Domestic equity mutual funds		215,921	214,521
U.S. government and agency debt securities		37,938	48,670
Total restricted by donors		1,059,668	1,050,911
Held in escrow - cash and cash equivalents		451,987	450,948
Total assets limited as to use - long-term	$	3,934,345	4,003,224
Investments:			
Cash and cash equivalents	$	89,811	122,128
Certificates of deposit		140,135	199,601
Common stock		3,641,024	3,415,134
Exchange traded funds		402,870	341,339
Mutual funds		2,152,960	1,758,290
U.S. government and agency debt securities		25,353	581,091
Domestic corporate bonds		2,830,340	2,420,615
Municipal bonds		408,371	553,788
Total investments	$	9,690,864	9,391,986

(Continued)

(2) Assets Limited as to Use and Investments, Continued

Investment income, excluding temporarily restricted, is as follows for the years ended December 31:

		2016	2015
Investment income:			
Interest and dividends, net of fees	$	326,893	345,620
Realized gain (loss) on sale of investments		28,664	(3,332)
		355,557	342,288
Change in net unrealized gains and losses and investments		205,981	(261,537)
	$	561,538	80,751

The Medical Center continually reviews investments for other-than-temporary impairment whenever the fair value of an investment is less than amortized cost and evidence indicates that an investment's carrying amount is not recoverable within a reasonable period of time. In the evaluation of whether an impairment is other-than-temporary, the Medical Center considers the reasons for the impairment, its ability and intent to hold the investment until the market price recovers or the investment matures, compliance with its investment policy, the severity and duration of the impairment, and expected future performance.

The Medical Center's investments in common stocks, mutual funds, debt securities and corporate bonds consist of investments diversified in several different industries. The Medical Center evaluated the near-term prospects of the issuer in relation to the severity and duration of impairment. Based upon the evaluation and the Medical Center's ability and intent to hold the securities for a reasonable period of time sufficient for a forecasted recovery of fair value, the Medical Center does not consider the securities in an unrealized loss position to be other-than-temporarily impaired at December 31, 2016 or 2015.

(Continued)

(3) Property and Equipment

Property and equipment at December 31 are as follows:

	2016	2015
Land	$ 768,605	768,605
Land improvements	6,014,329	5,964,923
Buildings	75,731,932	74,610,510
Fixed equipment	55,732,449	55,518,219
Moveable equipment	65,948,782	63,151,979
Property and equipment under capitalized leases	3,717,904	3,717,904
	207,914,001	203,732,140
Less accumulated depreciation and amortization	144,244,469	133,840,376
	63,669,532	69,891,764
Construction-in-progress	935,408	723,331
Property and equipment, net	$ 64,604,940	70,615,095

Depreciation and amortization expense for 2016 and 2015 was approximately $10,455,000 and $10,606,000, respectively.

Construction-in-progress at December 31, 2016 consists of various infrastructure and information technology projects at the Medical Center.

(4) Short-Term Borrowings

The Medical Center maintains a line of credit with a lender which provides for borrowings up to $6,000,000 at December 31, 2016 secured by the Medical Center's College of Nursing building and up to $7,000,000 of eligible accounts receivable, as defined. Borrowings against this line of credit are payable on demand and bear interest at the lender's prime rate. There were no borrowings on the line as of December 31, 2016 and 2015.

(Continued)

(5) Long-Term Debt and Lease Obligations

Long-term debt at December 31 is as follows:

	2016	2015
Series 1999-A Bonds ($11,540,000 and $12,080,000 principal amount less unamortized discount of $64,686 and $71,983 at December 31, 2016 and 2015, respectively)(a)	$ 11,475,314	12,008,017
Series 1999-B Bonds ($5,720,000 and $6,220,000 principal amount less unamortized discount of $73,236 and $80,636 at December 31, 2016 and 2015, respectively) (b)	5,646,764	6,139,364
Series 2006-A Bonds (c)	8,000,000	8,000,000
Term loan (d)	632,062	844,807
Loans payable to Sisters (e)	1,379,140	1,676,535
	27,133,281	28,668,723
Less unamortized debt issuance costs	577,143	665,584
Less current portion	1,619,248	1,550,550
Long-term debt, net	$ 24,936,889	26,452,589

(a) In April 1999, the Medical Center obtained financing of $15,000,000 through the placement of Oneida County Industrial Development Agency Civic Facility Revenue Bonds, Series 1999-A (the Series 1999-A Bonds). The Series 1999-A Bonds mature as follows: $1,965,000 through December 2019 with interest payable semiannually at an annual rate of 5.750%; and an additional $9,575,000 through December 2029 with interest payable semiannually at an annual rate of 5.875%. The Medical Center is required to make annual sinking fund payments to be used for mandatory redemption of the Series 1999-A Bonds ranging from $620,000 to $1,220,000 through December 2029. The Medical Center is also required to maintain certain covenants under the Bond agreement including minimum debt service coverage. The Medical Center is in compliance with its covenants at December 31, 2016 and 2015.

(Continued)

(5) Long-Term Debt and Lease Obligations, Continued

(b) In June 1999, the Medical Center obtained additional financing of $15,000,000 through the placement of Oneida County Industrial Development Agency Civic Facility Revenue Bonds, Series 1999-B (the Series 1999-B Bonds). The Series 1999-B Bonds mature as follows: $465,000 through December 2019 with interest payable semiannually at an annual rate of 6.00%; and an additional $5,255,000 through December 2029 with interest payable semiannually at an annual rate of 6.00%. The Medical Center is required to make annual sinking fund payments to be used for mandatory redemption of the Series 1999-B Bonds ranging from $190,000 to $770,000 through December 2029. The Medical Center is also required to maintain certain covenants under the Bond agreement including minimum debt service coverage. The Medical Center is in compliance with its covenants at December 31, 2016 and 2015.

(c) In June 2006, the Medical Center obtained additional financing of $14,000,000 through the placement of Oneida County Industrial Development Agency Multi-Mode Variable Rate Civic Facility Revenue Bonds Series 2006-A (the Series 2006-A Bonds). The 2006-A Bonds were issued on a parity basis with the 1999-A and 1999-B bonds. The Series 2006-A bonds mature in June 2026. Interest is paid monthly based on the Securities Industry and Financial Markets Association Municipal Swap Index. The average rate was 0.77% and 0.09% at December 31, 2016 and 2015, respectively. The Medical Center is required to make sinking fund payments to provide for the redemption of the Series 2006-A Bonds ranging from $740,000 to $1,020,000 through 2026. Using both philanthropic funds raised through the Foundation and proceeds from the sale of a building, the Medical Center has made early sinking fund payments. As further security for the Bonds, the Medical Center has entered into a Reimbursement Agreement with HSBC Bank USA, pursuant to which the Bank has issued an irrevocable direct-pay letter of credit aggregating the principal amount. The letter of credit will expire on June 21, 2018. The Medical Center is also required to maintain certain covenants under the Bond agreement including minimum debt service coverage and minimum day's cash on hand. The Medical Center is in compliance with its covenants at December 31, 2016 and 2015.

(d) In September 2014, the Medical Center obtained financing through a term note, for equipment, with a bank in the amount of $1,100,000. The note is collateralized by the related equipment. The term note is payable in monthly installments including interest fixed at 3.95%. The term note matures in September 2019. The Medical Center is also required to maintain certain covenants including minimum debt service coverage. The Medical Center is in compliance with its covenants at December 31, 2016 and 2015.

(Continued)

(5) Long-Term Debt and Lease Obligations, Continued

(e) The Medical Center has loans outstanding with the Sisters of St. Francis of the Neumann Communities. All loans are interest free through 2022. Expected principal payments are approximately $297,000 for 2017, $350,000 for 2018 and $183,000 for 2019 through terms of agreements. In the event that timely principal payments are not made, the Medical Center will be charged interest at 5%.

Under the indenture of Trust for the Series 1999-A, Series 1999-B, and Series 2006-A Bonds, the Medical Center is required to maintain certain levels of reserve accounts with the trustee. Amounts under this agreement have been classified as either current or noncurrent based upon the anticipated release date of such funds or contractual obligation. The Series 1999-A Bonds, Series 1999-B Bonds, and Series 2006-A Bonds, described in (a), (b) and (c), respectively, are secured by a mortgage lien on the property and equipment of the Medical Center, as a security interest in assets limited as to use.

Future annual principal payments on long-term debt are summarized as follows:

2017	$ 1,619,248
2018	2,365,591
2019	2,397,360
2020	2,323,016
2021	2,433,016
Thereafter	15,995,050
	$ 27,133,281

The Medical Center leases various buildings and equipment from vendors with renewable lease options. The leases were determined to be capital type leases, pursuant to generally accepted accounting principles. The leases have expiration dates from 2017 through 2022 and interest rates ranging from 1.63% - 10.72%.

The net book value of the equipment capitalized under lease agreements at December 31, 2016 and 2015 amounted to approximately $1,424,000 and $1,756,000, respectively. Total future principal and interest payments on these obligations amount to approximately $1,170,000 of which approximately $240,000 represents interest at December 31, 2016.

(5) Long-Term Debt and Lease Obligations, Continued

Future minimum lease principal payments under noncancellable operating leases (with initial or remaining lease terms in excess of one year) and future minimum capital lease payments as of December 31, 2016 are:

		Capital leases		Operating leases
2017	$	343,825		748,850
2018		96,848		363,994
2019		107,633		273,504
2020		119,619		273,504
2021		132,940		273,504
Thereafter		128,848		660,968
Total minimum lease payments		929,713	$	2,594,324
Less current portion		343,825		
	$	585,888		

Total rental expense for the years ended December 31, 2016 and 2015 for all operating leases was approximately $988,000 and $1,067,000, respectively.

(6) Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets, consisting of cash and cash equivalents and short-term investments at December 31 are available for the following purposes:

		2016	2015
Capital improvements and other	$	209,178	237,225
Scholarships		128,751	110,310
Donor-restricted endowments		131,632	74,234
	$	469,561	421,769

Permanently restricted net assets, consisting of cash and cash equivalents and long-term investments at December 31 are available for the following purposes:

		2016	2015
Endowments for scholarships	$	417,442	406,184
Foundation endowment funds		528,864	512,105
	$	946,306	918,289

(Continued)

(7) Pension Plans

The Medical Center has a noncontributory defined benefit plan which covers substantially all employees. Benefits are based on compensation and years of service. In 2003, the Medical Center applied for and received a favorable determination that its defined benefit plan is that of a nonelecting church plan under Section 410(d) of the Internal Revenue Code. Under status as a church plan, the Medical Center has elected to contribute the minimum amounts calculated as if the plan were subject to ERISA funding requirements.

Effective December 31, 2010, the Plan was amended to freeze benefit accruals for non-bargaining unit members. Effective January 1, 2012, the Plan was amended to freeze benefit accruals for the employees of one of the collective bargaining units. Effective April 1, 2013, the Plan was amended to freeze benefit accruals for the final collective bargaining unit.

The following tables present the changes in the Medical Center's benefit obligation and plan assets and funded status as of December 31:

	2016	2015
Change in benefit obligation:		
Benefit obligation at beginning of year	$ 106,440,336	108,603,253
Interest cost	5,556,747	5,314,583
Actuarial gain	(672,053)	(4,604,055)
Benefits paid	(3,184,420)	(2,873,445)
Benefit obligation at end of year	$ 108,140,610	106,440,336
Change in plan assets:		
Fair value of plan assets at beginning of year	55,999,375	58,088,618
Actual return on plan assets, net	5,271,936	(1,905,835)
Employer contributions	3,372,500	2,817,000
Benefits and administrative expenses paid	(3,318,515)	(3,000,408)
Fair value of plan assets at end of year	61,325,296	55,999,375
Funded status and accrued pension liability	$ (46,815,314)	(50,440,961)

The Medical Center made a contribution to the Plan in the amount of $257,000, which was in-transit as of December 31, 2015 and has been recorded as a reduction of the accrued pension liability.

(Continued)

(7) Pension Plans, Continued

The Medical Center had $31,346,378 and $34,336,144 of actuarial net losses in unrestricted net assets as of December 31, 2016 and 2015, respectively, which have not yet been recognized as a component of net periodic pension cost. The estimated net loss expected to be amortized from unrestricted net assets into net periodic pension cost over the next fiscal year is $1,774,038.

The components of net periodic pension cost for the years ended December 31:

		2016	2015
Administrative costs	$	127,000	86,000
Interest cost		5,556,747	5,314,583
Expected return on plan assets		(4,921,117)	(4,718,516)
Amortization of unrecognized net loss		1,973,989	2,331,450
Net periodic pension cost	$	2,736,619	3,013,517

The weighted average assumptions used to determine projected benefit obligations at December 31 are as follows:

	2016	2015
Discount rate	5.24%	5.31%
Expected long-term return on plan assets	7.50%	8.00%

The weighted average assumptions used to determine net periodic benefit cost for the years ended December 31 are as follows:

	2016	2015
Discount rate	5.31%	4.97%
Expected long-term return on plan assets	8.00%	8.00%

(Continued)

(7) Pension Plans, Continued

The Medical Center's defined benefit plan's investment objectives are to emphasize total return specifically through long-term growth of capital while avoiding excessive risk, and to achieve a balanced return of current income and modest growth of principal. In order to achieve these objectives, the Medical Center has established the following asset allocation guidelines:

Asset Class	Minimum	Maximum	Preferred
Large cap equity	30%	50%	41%
Small cap equity	-	15%	5%
Mid cap equity	-	15%	6%
International equity	-	25%	16%
Fixed income	20%	80%	32%
Cash and cash equivalents	-	5%	-

The expected long-term rate of return on plan assets is reviewed annually, taking into consideration the asset allocation, historical returns on the types of assets held, and the current economic environment. Based on these factors, it is expected that the pension assets will earn an average of 7.50% per annum.

Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at December 31, 2016 or 2015.

Money market fund: Valued at amortized cost which approximates fair value.

Common stocks: Valued at the closing price reported on the active market on which the individual securities are traded.

Mutual funds: Valued at the daily closing price as reported by the fund. Mutual funds held by the Plan are open-end and closed-end mutual funds that are registered with the U.S. Securities and Exchange Commission. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The mutual funds held by the Plan are deemed to be actively traded.

Common trust: Valued based on the NAV per unit, without further adjustment. NAV is based upon the fair value of the underlying investments.

Alternative investments: The investments consist of partnership and hedge funds. These securities are estimated using current information obtained from the general partner or investment manager for the respective funds. Investments in private equity partnerships are generally estimated using partner's capital balances, and their fair value of investments are generally estimated using the NAV.

(Continued)

(7) Pension Plans, Continued

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table presents by level, within the fair value hierarchy, the Plan's assets as of December 31:

	Assets at fair value as of December 31, 2016			
	Level 1	Level 2	Level 3	Total
Money market fund	$ -	943,520	-	943,520
Mutual funds	43,722,769	-	-	43,722,769
Common trust	-	4,886,311	-	4,886,311
Alternative investments	-	7,612,313	4,160,383	11,772,696
	$ 43,722,769	13,442,144	4,160,383	61,325,296

	Assets at fair value as of December 31, 2015			
	Level 1	Level 2	Level 3	Total
Cash and cash equivalents	$ 2,000,000	-	-	2,000,000
Money market fund	-	478,559	-	478,559
Common stocks	893,767	-	-	893,767
Mutual funds	33,063,571	-	-	33,063,571
Common trust	-	5,000,000	-	5,000,000
Alternative investments	-	10,479,778	4,083,700	14,563,478
	$ 35,957,338	15,958,337	4,083,700	55,999,375

(Continued)

(7) Pension Plans, Continued

The following table sets forth a summary of changes in the fair value of the Plan's level 3 assets for the years ended December 31:

	Alternative investments	
	2016	2015
Fair value at January 1	$ 4,083,700	4,059,197
Unrealized gain, net	76,683	24,503
Fair value at December 31	$ 4,160,383	4,083,700

The Medical Center expects to contribute $3,948,000 to its defined benefit plan in 2017.

The following approximate benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

	Benefit payments
2017	$ 3,948,000
2018	4,275,000
2019	4,603,000
2020	4,899,000
2021	5,237,000
2022 - 2026	30,814,000

(Continued)

(7) Pension Plans, Continued

The Medical Center also offers a 401(k) defined contribution retirement plan to substantially all of its non-union employees. Members of UFCW collective bargaining unit received contributions equal to other participants, however their plan assets are administered by representatives selected by UFCW. Effective March 3, 2013, members of the New York State Nurses Association were admitted to the plan in conjunction with the freezing of the defined benefit plan as discussed above. Each year participants may contribute up to 75% of eligible pre-tax compensation, as defined in the Plan, subject to maximum annual additions allowed by law. Employees that are not covered by UFCW collective bargaining unit are eligible to receive a safe harbor contribution equal to 3% of compensation. Further, for 2016 and 2015 non-union employees are eligible for a discretionary match on their contributions based on years of service as detailed below:

Years of service	% of employer contribution (up to 4%)
1 - 9	50% (or 2% in most cases)
10 - 19	75% (or 3% in most cases)
20+	100% (or 4% in most cases)

Contributions to this plan approximated $4,141,000 and $4,196,000 for the years ended December 31, 2016 and 2015, respectively.

The Medical Center also offers a 457(b) plan covering certain highly compensated employees. Participants may contribute amounts up to statutory limits on an annual basis. Under the plan the Medical Center contributes between 2% and 4% of earnings over the 401(k) annual maximum amount depending on the employee's years of service. The Medical Center's contributions to the plan approximated $27,000 for the year ended December 31, 2016. There were no contributions made by the Medical Center for the year ended December 31, 2015. An asset and liability representing the total amount invested in the 457(b) plan totalling approximately $560,000 and $388,000 has been recorded as an other long-term asset and other long-term liability at December 31, 2016 and 2015, respectively.

(8) Contingencies

Professional Liability Insurance

Since 1986, the Medical Center's exposure for medical malpractice risk has been insured under a claims-made policy, which provides for $1,000,000 coverage for each claim, not to exceed $3,000,000 in aggregate annual coverage. In addition, the Medical Center has purchased excess insurance policies. If the claims-made policy is not renewed or replaced with equivalent insurance, claims based on occurrences during the claims-made coverage period but reported subsequent to such a change will be uninsured. The Medical Center has a right under its present policy to acquire extended coverage if it decides to terminate its claims-made coverage, nor does it expect any difficulty in renewing the policies as they become due.

(Continued)

(8) Contingencies, Continued

Professional Liability Insurance, Continued

In the ordinary course of operations, the Medical Center is named as a defendant in various lawsuits, or events occur which could lead to litigation, claims, or assessments. Although the outcome of such matters cannot be predicted with certainty, management believes that insurance coverage is sufficient to cover current or potential claims, or that the final outcomes of such matters will not have a material adverse effect on the financial position of the Medical Center.

Workers' Compensation Insurance

Prior to January 1, 2012, the Medical Center obtained coverage for workers compensation insurance through the Healthcare Underwriters Mutual Risk Management Group (Group). The Medical Center is one of four members of the Group. The Group is an unincorporated association of healthcare providers in the upstate region of New York State and was organized under a trust agreement for the purpose of establishing a workers' compensation self-insurance group. The Group is governed by a board of trustees consisting of one trustee for each member. Members of the Trust are jointly and severally liable for Group activities and liabilities. The Group is no longer active and has been in the process of settling outstanding claims since December 31, 2011. At December 31, 2016 and 2015, the Medical Center has not been notified of any assessments resulting from participation in the Trust however has accrued approximately $1,083,000 and $587,000, respectively, in long-term portion of estimated insurance liabilities to cover any future assessments.

Since January 1, 2012, the Medical Center has been self-insured for these liabilities. Losses from asserted and unasserted workers compensation claims are accrued based on actuarial estimates that incorporate the Medical Center's past experience, the nature of each claim or incident, relevant trend factors, and estimated recoveries, if any, on unsettled claims. The Medical Center has accrued approximately $3,996,000 and $3,368,000 for the years ended December 31, 2016 and 2015, respectively. These accruals are part of estimated insurance liabilities on the consolidated balance sheet. In conjunction with the self-insurance program, the Medical Center is required to post a letter of credit with the State of New York Workers Compensation Board. This letter of credit totalled $1,542,515 as of December 31, 2016 and 2015.

Health Insurance

Effective January 1, 2015, the Medical Center is self-insured for medical benefits. Based on claims experience, the Medical Center has accrued approximately $762,000 and $600,000, respectively, in current portion of estimate insurance liabilities as December 31, 2016 and 2015, respectively, to cover non-domestic claims to be paid after year end.

(Continued)

(9) Affiliated Entities

Faxton-St. Luke's Healthcare

During 2016 and 2015, Healthcare advanced funds to the Medical Center to pay down the outstanding balance on their short-term borrowing arrangement. As of December 31, 2015, there was $3,750,000 outstanding on this advance which is included within current portion of due to affiliates. There were no amounts outstanding at December 31, 2016. Total interest charged in 2016 and 2015 amounted to approximately $28,000 and $13,000, respectively.

The Medical Center and Healthcare have contracted with each other to provide certain operational services, including shared employment, provider coverage, patient care, rental of office space, and other shared services. In 2016 and 2015, the Medical Center purchased services totalling approximately $3,968,000 and $2,115,000, respectively, from Healthcare and sold services totalling approximately $2,609,000 and $1,420,000, respectively.

During 2015, Healthcare forgave a $450,000 liability payable from the Medical Center which related to a joint venture prior to their affiliation. This was recorded as a contribution from affiliate for the year ended December 31, 2015.

Net receivables (payables) at December 31 from (to) affiliates for services performed and billing of other pass through expenses to and from the Medical Center are as follows:

	2016	2015
Due to affiliates:		
Healthcare (advance)	$ -	(3,750,000)
Healthcare	(9,023,436)	(4,508,620)
Other	(13,913)	(64,457)
	(9,037,349)	(8,323,077)
Due from affiliates:		
Healthcare	7,085,001	3,139,916
Other	72,852	1,708
	7,157,853	3,141,624
	$ (1,879,496)	(5,181,453)

(Continued)

(9) Affiliated Entities. Continued

Mohawk Valley EC, LLC

The Medical Center, Healthcare and Mohawk Valley EC Holdings, LLC entered into an agreement for the purpose of owning and operating a single-specialty ambulatory surgery center, exclusively providing gastroenterology services in Oneida County. As part of the agreement, the three members formed the Mohawk Valley EC, LLC (MVEC), a New York limited liability company. The Medical Center will maintain a 20% interest and sharing ratio in MVEC. The amount recognized as income based on the Medical Center's share is approximately $219,000 and $210,000 for the years ended December 31, 2016 and 2015, respectively.

(10) Statement of Cash Flow Supplemental Disclosures

The Medical Center's cash payments for interest and noncash investing and financing activities for the years ended December 31 were as follows:

	2016	2015
Cash paid during the year for interest	$ 1,327,756	1,444,941
Property and equipment acquisitions included in accounts payable	692,570	656,967

(11) Functional Expenses

The Medical Center provides general health care services to residents of Utica, New York. Expenses related to providing these services are as follows:

	2016	2015
Healthcare services	$ 195,587,790	188,272,676
General and administrative	21,440,215	20,865,082
	$ 217,028,005	209,137,758

(Continued)

(12) Fair Value of Financial Instruments

The Fair Value Measurement Topic of the FASB Accounting Standards Codification requires disclosures that categorize assets and liabilities measured at fair value based on a fair value hierarchy. The hierarchy prioritizes the inputs into three levels based on the extent to which inputs used in measuring fair value are observable in the market. Each fair value measurement is reported in one of the three levels which is determined by the lowest level input that is significant to the fair value measurement in its entirety.

The following methods and assumptions were used by the Medical Center in estimating the fair value of its financial instruments:

Cash and cash equivalents: consists of money market funds that are valued at the net asset value (NAV) reported by the financial institution.

Certificates of deposit: consists of fixed-maturity certificates of deposit that are valued based on discounted future cash flows using the rates currently offered for deposits of similar remaining maturities.

Common stock, exchange traded funds and mutual funds: consists of actively traded equity securities and the Medical Center's investment in publicly traded mutual funds. Actively traded equity securities are valued on a continuous basis and mutual funds are valued at the closing price reported on an active market on which the individual securities are traded.

U.S. Government and agency debt securities, domestic corporate bonds, and municipal bonds: Consists of the Medical Center's directly owned securities and the Medical Center's investment in securities that are issued by the U.S. government or publicly owned government-sponsored enterprises. Securities owned directly by the Medical Center and securities issued by the U.S. government or publicly owned government-sponsored enterprises are valued based on quoted market prices or dealer quotes where available (Level 1 measurements). If quoted market prices are not available, fair values are based on quoted market prices of comparable instruments or, if necessary, matrix pricing from a third party pricing vendor to determine fair value (Level 2 measurements). Matrix prices are based on quoted prices for securities with similar coupons, ratings, and maturities, rather than on specific bids and offers for the designated security.

(Continued)

(12) Fair Value of Financial Instruments, Continued

The following tables present information about assets and liabilities that are measured at fair value on a recurring basis as of December 31 and indicate the fair value hierarchy of the valuation techniques utilized to determine such fair value. In general, fair values determined by Level 1 inputs utilize quoted prices in active markets for identical assets or liabilities. The Medical Center considers a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Investments valued using NAV as a practical expedient are classified as Level 2 if the investment is redeemable at NAV (as adjusted for subsequent gains or losses through the effective date of redemption) in the near-term (generally within a 3-month period) without significant restrictions on redemption. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability. Investments valued using NAV as a practical expedient are classified as Level 3 if the investment is not redeemable in the near-term or has significant restrictions.

The Medical Center's financial assets recognized at fair value in the consolidated financial statements on a recurring basis consist of investments and assets limited as to use. The Medical Center's consolidated financial statements do not contain financial liabilities or nonfinancial assets and liabilities that are recognized at fair value on a recurring basis. In general, and where applicable, management used quoted prices in active markets for identical assets to determine fair value.

(Continued)

(12) Fair Value of Financial Instruments, Continued

	Fair value measurements at December 31, 2016			
	Total	Level 1	Level 2	Level 3
Assets:				
Assets limited as to use:				
Under bond indenture agreements:				
Commercial paper	$ 2,532,239	2,532,239	-	-
Restricted by donors:				
Cash and cash equivalents	565,744	565,744	-	-
Exchange traded funds	240,065	240,065	-	-
Domestic equity mutual funds	215,921	215,921	-	-
U.S. government and agency debt securities	37,938	-	37,938	-
Total assets limited as to use	3,591,907	3,553,969	37,938	-
Investments:				
Cash and cash equivalents	89,811	89,811	-	-
Certificates of deposit	140,135	-	140,135	-
Common stock	3,641,024	3,641,024	-	-
Exchange traded funds	402,870	402,870	-	-
Mutual funds:				
Domestic equity	1,445,508	1,445,508	-	-
Internationally developed equity	474,082	474,082	-	-
Emerging markets equity	223,528	223,528	-	-
Real estate fund	9,842	9,842	-	-
Total mutual funds	2,152,960	2,152,960	-	-
U.S. government and agency debt securities	25,353	-	25,353	-
Domestic corporate bonds	2,830,340	-	2,830,340	-
Municipal bonds	408,371	-	408,371	-
Total investments	9,690,864	6,286,665	3,404,199	-
Total assets	$ 13,282,771	9,840,634	3,442,137	-

(Continued)

(12) Fair Value of Financial Instruments, Continued

	Fair value measurements at December 31, 2015			
	Total	Level 1	Level 2	Level 3
Assets:				
Assets whose use is limited:				
Under bond indenture agreements:				
Cash and cash equivalents	$ 62,320	62,320	-	-
Exchange traded funds	2,502,954	2,502,954	-	-
Restricted by donors:				
Cash and cash equivalents	585,191	585,191	-	-
Common stock	202,529	202,529	-	-
Domestic equity mutual funds	214,521	214,521	-	-
U.S. government and agency debt securities	48,670	-	48,670	-
Total assets limited as to use	3,616,185	3,567,515	48,670	-
Investments:				
Cash and cash equivalents	122,128	122,128	-	-
Certificates of deposit	199,601	-	199,601	-
Common stock	3,415,134	3,415,134	-	-
Exchange traded funds	341,339	341,339	-	-
Mutual funds:				
Domestic equity	1,241,380	1,241,380	-	-
Internationally developed equity	350,611	350,611	-	-
Emerging markets equity	137,509	137,509	-	-
Real estate fund	28,790	28,790	-	-
Total mutual funds	1,758,290	1,758,290	-	-
U.S. government and agency debt securities	581,091	-	581,091	-
Domestic corporate bonds	2,420,615	-	2,420,615	-
Municipal bonds	553,788	-	553,788	-
Total investments	9,391,986	5,636,891	3,755,095	-
Total assets	$ 13,008,171	9,204,406	3,803,765	-

The Medical Center's accounting policy is to recognize transfers between levels of the fair value hierarchy on the date of the event or change in circumstances that caused the transfer. There were no significant transfers into or out of Level 1 or Level 2 for the year ended December 31, 2016.

(Continued)

(12) Fair Value of Financial Instruments, Continued

Various assets and liabilities are not required to be measured at fair value on a recurring basis. The fair value of the Medical Center's long-term debt approximates carrying value at December 31, 2016 and 2015. These fair values are estimated using discounted cash flow analysis, based on the Medical Center's current incremental borrowing rate for similar types of borrowing arrangements. The carrying value of all remaining financial assets and liabilities not required to be measured at fair value on a recurring basis approximate fair value at December 31, 2016 and 2015.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

HOWARD A. ZUCKER M.D., J.D.
Commissioner – DOH

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner - DOH

ANDREW M. CUOMO
Governor

NEW YORK STATE OF OPPORTUNITY. | DASNY

GERRARD P. BUSHELL
President – DASNY

ALFONSO L. CARNEY, JR.
Chair – DASNY

April 3, 2017

VIA EMAIL & REGULAR MAIL

Ms. Sharon Palmer
Assistant Vice President
Mohawk Valley Health System
P.O. Box 4308
Utica, NY 13504

Re: RFA# 1505060325, Health Care Facility Transformation Program (HCFTP): Oneida County

Dear Ms. Palmer:

We are pleased to inform you that, based on the application Mohawk Valley Health System submitted under the above referenced RFA that was released in November 2016, you have been awarded a grant amount up to $300,000,000.

Please note that this letter is not a final commitment to provide funds, but rather is evidence of the intention on the part of the Department of Health (DOH) to enter into a Master Grant Contract (MGC) with Mohawk Valley Health System subject to compliance with the conditions set forth in the RFA and the attached Addendum. The final amount to be awarded is subject to compliance with these conditions, and may be less than the grant amount set forth above. Master Grant Contracts are also contingent upon approval of the Attorney General and the Office of the State Comptroller.

Conditions to this award are listed in the Addendum and must be completed prior to the execution of your MGC with DOH and distribution of grant proceeds.

Should you have any questions concerning HCFTP: Oneida County or this Award Letter, please address your inquiry to oneidacounty@health.ny.gov. In order to properly address your questions, please also include a contact person, contact e-mail, and contact phone number in the body of your e-mail.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner
New York State Department of Health

Gerrard P. Bushell
President
Dormitory Authority of the State of New York

Addendum

The following conditions must be satisfied before the Master Grant Contract is finalized and executed:

- The sole source of funds for the HCFTP: Oneida County capital grant program will be bond proceeds, which by law may only be used for certain eligible capital works or purposes. Therefore, tax and bond counsel to the Dormitory Authority of the State of New York (DASNY) must confirm that the grant expenditures identified in your application are capital costs that are eligible to be funded from proceeds of State-supported bonds as described in the Request for Applications Section III. C. This award is subject to review of detailed project budgets to ascertain that bond proceeds will only be used for capital costs for federal income tax purposes and that comprise capital works or purposes under the State Finance Law. In addition, it is subject to review of the use of matching funds proposed by MVHS to determine whether all non-qualifying costs can be paid with the match. If the Project includes IT or other technology equipment, the estimate, quote or bid must clearly distinguish among the hardware, software, licenses, training, intellectual property, and other Project components. All components should be clearly identified and described. In addition, the amount of grant funds to be spent on each component must be stated.

  If the above condition is not satisfied within 60 days of this notification, this award letter will expire. Upon written request from the applicant and an explanation acceptable to the Department of Health (DOH) as to why the required information cannot be provided to allow DASNY tax and bond counsel to conclude its review within 60 days, the DOH may, in its sole discretion, grant an extension to allow more time to provide the information necessary to make a final determination of the grant award.

- DOH shall have determined that the applicant and/or the Project have obtained, or are eligible to obtain, all necessary regulatory approvals and/or waivers such as DOH Certificate of Need (CON) approval, if required. In order to expedite the CON process, CON/DOH requirements should be considered as soon as possible.

- Professional estimates, quotes, bids, or other indicia from a design professional or equipment vendor setting forth the total Project cost. If the Project includes IT or other technology equipment, the estimate, quote or bid must clearly distinguish among the hardware, software, licenses, training, intellectual property, and other Project components. All components should be clearly identified and described. In addition, the amount of grant funds to be spent on each component must be stated.

- Evidence of the completion of a review pursuant to the State Environmental Quality Review Act ("SEQRA"). A DASNY representative will contact you in order to determine the appropriate level of review to be conducted.

- If the Project is comprised of multiple and/or phased components, DOH may, after consultation with DASNY, enter into a MGC for those components of a Project that are Type II and may be properly segmented, including but not limited to planning, design or engineering costs, or for which a SEQRA review has been completed, so long as all other conditions of the Award Letter have been satisfied.

- If the Project consists of the purchase of real property, an appraisal meeting the Uniform Standards of Professional Appraisal Practice ("USPAP") standards for the real property to be acquired with grant funds must be provided, along with a completed Real Property and Fixed Asset Certification from the applicant in the form attached hereto.

- Financial Commitments in an amount sufficient to finance the full project cost less HCFTP: Oneida County grant proceeds must be provided. Examples of acceptable commitments include:
    - Bank account and investment account statements;
    - Contractual agreements for the provision of such funds;
    - Board Resolution authorizing institutional funds to be utilized for purposes of the project;
    - Signed, notarized letter from a Senior Authorized Officer of the organization authorizing institutional funds to be utilized for purposes of the project;
    - Donor pledges, agreements and receipts;
    - Grant award letters, agreements and contracts;
    - Updated Letter of Interest including terms and conditions from a recognized lending institution, consistent with what was provided in your RFA submission;
    - Bond documents; or
    - Other documentation demonstrating that sufficient funds for project completion have been secured.

  Please note that pledges, award letters with unsatisfied contingencies, grant applications, pending loan applications, and other non-final commitments do not constitute secured sources of funding. You may utilize this Award Letter to assist you in obtaining other sources of financing for the project value less the final grant award.

- The Project shall have been approved by the Public Authorities Control Board.

- Pursuant to the Request for Applications Section IV. G., the New York State Department of Health established a Minority and Women Owned Business participation goal of **30%** on any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing greater than $25,000 under a contract awarded from this solicitation. All grantees must submit an acceptable MWBE Utilization plan reflective of this goal. In addition, successful awardees are required to certify they have an acceptable Equal Employment Opportunity policy statement.

- **Master Grant Contracts are also contingent upon approval of the Attorney General and the Office of the State Comptroller.**

APPLICANT LETTERHEAD

REAL PROPERTY AND FIXED ASSET CERTIFICATION OF MOHAWK VALLEY HEALTH SYSTEM

In connection with the receipt by **Mohawk Valley Health System** (the "**Grantee**") of a Health Care Facility Transformation Program (HCFTP): Oneida County grant in the amount of **$300,000,000** (the "**Grant**") to fund **Mohawk Valley Health System Oneida County** (the "**Project**"), which includes the acquisition of real property located at [ ](the "**Property**"), the undersigned, an authorized officer of the Grantee, does hereby certify under penalty of perjury, that the following statements are true and correct:

1. Grantee has engaged an independent third party appraiser to conduct an appraisal of the Property to be acquired with the proceeds of the Grant (the "**Appraisal**"). The Appraisal was prepared in accordance with the Uniform Standards of Professional Appraisal Practice ("USPAP"). A copy of the Appraisal is attached hereto.

2. The Grantee's acquisition of the Property and the seller's sale of the Property constitutes an arms-length transaction. The Grantee covenants that it will not utilize Grant proceeds to pay more than the appraised value of the Property as set forth in the Appraisal.

3. The Grantee and its affiliates, and the seller of the Property and its affiliates, have no relationship to each other and have each acted independently of the other in connection with the Grantee's acquisition of the Property. During the negotiation for the acquisition of the Property by the Grantee, neither the Grantee nor the seller was subject to any pressure or duress from the other party, nor from any third party.

4. Proceeds of the Grant will not be used to make payments to any firm, company, association, corporation or organization owning the Property, if any member of the Grantee's Board of Directors or other governing body, or any officer or employee of the Grantee, or a member of the immediate family of any member of the Grantee's Board of Directors or other governing body, officer, or employee of the Grantee has any ownership, control or financial interest in the Property, including but not limited to an officer or employee directly or indirectly responsible for the preparation or the determination of the terms of the purchase and sale contract between the Grantee and the seller or other arrangement pursuant to which the Property is to be acquired. For purposes of this paragraph, "ownership" means ownership, directly or indirectly, of more than five percent (5%) of the assets, stock, bonds or other dividend or interest bearing securities; and "control" means serving as a member of the board of directors or other governing body, or as an officer in any of the above.

By: Authorized Officer

Name of Grantee:

ONEIDA COUNTY DEPARTMENT OF LAW

Oneida County Office Building
800 Park Avenue • Utica, New York 13501-2975
(315) 798-5910 • Fax (315) 798-5603

ANTHONY J. PICENTE JR.
COUNTY EXECUTIVE

PETER M. RAYHILL
COUNTY ATTORNEY

September 21, 2017

Scott H. Perra
President and CEO
Mohawk Valley Health Sysatem
1656 Champlin Ave.
New Hartford, New York 13502

Re: Memorandum of Agreement between
Mohawk Valley Health System,
City of Utica and County of Oneida

Dear Mr. Perra:

Enclosed for your records is one fully executed copy of the Memorandum of Agreement relative to parking for the consolidated hospital campus facility.

Sincerely,

Laura E. Clive
Executive Secretary to the County Attorney
Oneida County Department of Law
800 Park Avenue
Utica, New York 13501

MEMORANDUM OF AGREEMENT

This Memorandum of Agreement (hereafter "MOA") is signed this 22 day of August, 2017 by and between Mohawk Valley Health System, (hereafter "MVHS") a New York Not For Profit Corporation with offices at 1656 Champlin Avenue, New Hartford, New York 13502, the City of Utica, New York, (hereafter "City") a municipal corporation under the laws of the State of New York with offices at 1 Kennedy Plaza, Utica, New York 13502, and the County of Oneida, (hereafter "County") a municipal corporation under the laws of the State of New York with offices at 800 Park Avenue, Utica, New York 13501.

RECITALS

1. **Purpose:** MVHS is a not for profit corporation and legal affiliation of Faxton-St. Luke Healthcare and St. Elizabeth Medical Center engaged in providing hospital and related medical services to residents in both Oneida County and throughout the general region. MVHS presently operates and provides medical services at St. Elizabeth Medical Center located in the City of Utica, and Faxton-St. Luke's Healthcare composed of the former Faxton Hospital campus in Utica, New York and the St. Luke's Hospital Campus in New Hartford, New York. The 2016-2017 New York State Budget has made available to MVHS funding in the amount of three hundred million dollars ($300,000,000) for the purpose of developing and constructing a consolidated, up to date hospital facility in downtown Utica to replace existing structures which have become outmoded. ("the new hospital project").The estimated cost for the project is five hundred twenty three million five hundred seventeen thousand eight hundred seventy five and no/100ths dollars ($523,517,875), which includes the refurbishment of Kennedy Garage and the development of the proposed parking facility discussed herein, with funding above and in addition to the state grant to be from additional public and private funding to be secured by MVHS with the assistance of City, County, and Mohawk Valley EDGE.

The development of such a consolidated hospital campus will achieve operational efficiencies and create opportunities for greater development of clinical research and medical education programs. Further, it has been determined that locating the new, consolidated hospital campus in downtown Utica would present opportunities for enhanced medical care for the community as well as economic revitalization of the downtown area. The proposed hospital site has generally been identified as the area bounded by Oriskany, Columbia and State Streets, and Broadway. The signatories to this MOA seek to identify and commit to ways in which they can cooperate to fulfill these purposes.

2. **Intent of this MOA:** This MOA is to be signed by Scott H. Perra in his capacity as Chief Executive Officer of MVHS, Robert M. Palmieri in his capacity as Mayor of the City of Utica, and Anthony J. Picente, Jr. in his capacity as County Executive of Oneida County. It is the intent of this MOA to identify, delineate, and agree to a plan for cooperation by and among MVHS, City, and County to further the purpose of a consolidated and new hospital campus in downtown Utica, to work cooperatively toward that purpose, and to contribute financially, through in kind and monetary contributions, and otherwise toward that purpose. All of the signatories to this MOA acknowledge and agree that the primary purpose of this MOA is to specify, give definition, and agree to ways and means by which the parties may cooperate and contribute to achieve the purpose of a new hospital campus. It is understood and agreed that at this time various elements of funding the proposed parking garage hereafter mentioned are dependent upon completion of a process of application, award, and release of funding. Once this information becomes known, the parties will enter into an agreement or agreements (the "Definitive Agreement(s)") more specifically identifying funding sources and amounts, together with further schedules and details with regard to mutual obligations of the parties with regard to contributions towards, and payment of, debt service.

3. **Cooperative Parking Agreement:**

General Description: The parties to this MOA recognize that the effective and convenient utilization of a downtown Utica site for the new hospital project will require additional parking. Further, the parties recognize and acknowledge that in addition to the needs of hospital staff, related medical personnel that locate within the medical office facility, patients, visitors, and others conducting business within the hospital, that additional parking in downtown Utica would confer significant public benefits upon City and County to meet the needs of the general public availing themselves of professional, commercial, entertainment, recreational and government services concentrated in the downtown Utica area. Accordingly, the parties recognize that the new hospital project together with existing and projected increased parking needs for the general public would create a need for a municipal parking facility providing approximately 1550 new parking stalls, which would be approximately apportioned between 1150 parking stalls for hospital use and public use for other outpatient services that would be part of the MVHS project, and 400 parking stalls for general public use including persons visiting or doing business with physicians in the facility used for private medical practices.

This is in addition to another 2,000 ± surface parking spaces that will be incorporated into the overall site plan for the MVHS downtown campus and the refurbishment of Kennedy Garage that would support supplemental parking needs for one or more Medical Office Buildings that would be developed by MVHS or by private developers working collaboratively with MVHS and provide additional parking that is proximal to the new MVHS healthcare facility.

The location for the proposed parking facility will be determined by mutual agreement of MVHS, City and County with the primary objective being to situate the parking facility so that it optimizes, in order of priority, the parking needs for MVHS and then the

downtown Utica general public. The location for the parking facility will be incorporated into the Definitive Agreement(s).

4. **Estimated Cost:** The parties understand and agree that the current estimated cost of such a parking facility is forty million five hundred and seventeen thousand eight hundred seventy five dollars ($40,517,875.00). Additionally, the parties also agree to work cooperatively to repair and restore the Kennedy Parking Garage at an estimated cost of three million dollars ($3,000,000.00).

5. **Sources of Funding:**

(a.) The parties agree that there will be a debt financing component estimated at thirty seven million five hundred seventeen thousand eight hundred seventy five dollars ($37,517,875.00), consisting of twenty seven million four hundred five thousand eight hundred fifty three dollars ($27,405,853.00) in general obligation bonds to be issued by County and ten million one hundred twelve thousand twenty two dollars ($10,112,022.00) in funding generated from the allocation of New Market Tax Credits (NMTC) or other funds obtained for the project.

County and City will in the Definitive Agreement apportion the annual debt service on the project between them with County paying sixty (60%) per cent and City (40%) forty per cent. The Definitive Agreement(s) shall set forth the time and manner of City's payments to County.

(b.) City shall reprogram an existing one million five hundred thousand dollars ($1,500,000.00) grant through Empire State Development Program to City to be used for the parking facility project. Additionally, a New York State Assembly sponsored one million dollar ($1,000,000.00) grant from the State Assistance Municipal Program (SAM) and five hundred thousand dollars ($500,000.00) from an expected Upstate Revitalization Initiative Grant (URI) shall be used for the parking facility project.

(c.) An additional three million dollars ($3,000,000.00) will be allocated from the expected URI grant for repair and restoration of Kennedy Parking Garage.

6. **Cooperative Municipal Parking Program:** The parties to this agreement agree to support a cooperative parking program, the designated roles of each party being contemplated as follows:

(a.) County will act as the primary developer to arrange necessary financing for the parking facility and to oversee its construction. County will hold the fee title to the parking facility. Under a lease agreement with County or other suitable arrangement, MVHS will operate the parking facility for its needs and the needs of members of the general public conducting business, recreational or personal pursuits in the downtown Utica area. The facility will be open and available for use on a 365 day per year/twenty four hour per day basis.

(b.) MVHS shall, in consultation with County and City establish a general municipal parking agreement and plan which may include a parking fee structure. MVHS shall receive all revenue generated by the operation of the garage and be responsible for the costs for maintenance and operation of the garage as well as establishing a reasonable repair and capital reserve fund

(c.) MVHS, City, and County agree to negotiate in good faith a plan for the disposition and sharing between City and County of any parking facility generated revenues over and above costs of operation, maintenance and reasonable contributions to a capital reserve fund ("the excess revenues."). Such excess revenues shall be allocated in the same proportion as City and County's respective contributions to debt service for the parking facility (60/40 as discussed in section 5a. above). The parties agree that the method of calculating such revenue and its allocation, the method and frequency of payment, the term of the agreement and any renewal and/or extension provisions and remedies of the parties in the event of any breach of the agreement to share the excess revenues shall be incorporated in the Definitive Agreement(s).

(d) City is the owner of Kennedy Garage and will act as the developer and oversee the improvements to Kennedy Garage. The parties hereto agree to work together to include Kennedy Garage in the general municipal parking plan mentioned above.

(d.) It is understood that the utilization of New Market Tax Credits and other funding mechanisms may require the establishment of one or more Community Development Corporations or the creation of collaborations between new and existing Community Development Corporations. The parties to this MOA agree to work cooperatively to establish this framework.

7. **Dedication of Existing City-Owned Properties:** City is the owner of certain properties which have been acquired by the foreclosure of tax liens and by other means which are within the potential footprint of the proposed new hospital project.. In recognition of the general public benefit which will be conferred by the establishment of the new facility, City agrees to transfer all of its right title and interest in such properties to MVHS or any designated appropriate entity to be used for the sole purpose of establishing the new hospital facility and ancillary improvements related thereto. A list of these properties is attached hereto as **Exhibit A**. It is understood and agreed that this list (Exhibit A) may need to be modified according to the needs of the new hospital project and the parties agree to negotiate in good faith toward such end.

8. **Cooperation With Regard to Additional Funding:** The parties agree to work cooperatively to identify other public and/or private sources of funding which are or may become available for the new hospital facility project and related ancillary improvements. When such a funding source is or may be identified, the parties to this agreement, to the extent one or more of them may be a qualified applicant, shall agree to serve as such applicant and the parties shall cooperatively work to complete the appropriate application process.

9. **Additional items of Assistance to be Provided by County:** In addition to the other items set forth more specifically above, County shall provide the following assistance to the new hospital project at County's expense:

(a.) Provide a Planner in the Oneida County Planning Department assigned to the new hospital project and tasked with coordinating planning activities among City, County, the State of New York and other government entities; co-support and work with City on Planning of area Master Planning.

(b.) Coordinate and work with New York State Department of Transportation to provide full access at the intersection of Oriskany and Cornelia Streets.

(c.) Waive all applicable County fees or charges associated with construction and installation of improvements including but not limited to plan review, permits, impact fees, mitigation charges and the like.

10. **Additional Items of Assistance to be Provided by City:** In addition to the items set forth more specifically above, City shall provide the following assistance to the new hospital project at City's expense:

(a.) Contribute City-owned land within the boundaries of the new hospital campus as set forth above.

(b.) Provide appraisals for all City-owned land within the new hospital campus boundaries.

(c.) Relocate current parking west of Pine Street which is utilized for police parking and relocate to land to be contributed by MVHS (current Brandeles Property 50+/- spaces and reminder in the new parking garage facility (57+/- parking stalls).

(d.) Discontinue portions of Lafayette, Lee and Cornelia Streets within the new hospital boundaries and transfer to MVHS.

(e.) Enter into discussions to include in the Definitive Agreement plans to reroute existing City-owned utilities within the new hospital project boundaries, remove utilities and terminate use of existing easements and rights of way.

(f.) Consider in the development of the parking plan mentioned above, the dedication of at least 200 of the 450 parking stalls in Kennedy Parking Garage for Hospital use.

(g.) Assist displaced and affected businesses in relocating to other suitable locations within the City of Utica.

(h.) In view of the requirement of the New York State Department of Health and the Dormitory Authority of the State of New York to provide building and construction inspection, review and permitting, waive all fees for any building or zoning permits or any other such fee, at least to the extent such fees do not reflect actual costs necessarily incurred by City.

(i.) To the extent necessary, cooperate to secure necessary approvals for rezoning of MVHS property acquired for the new hospital project and adjacent strategic parcels to a PD-E classification which will meet the needs for current and future development.

(j.) Enter into discussions to provide in the Definitive Agreement(s) necessary improvements to Broadway, State Street, and Columbia Street such as new pavement, curbs, sidewalks, lighting and utilities.

(k.) Engage in conducting Strategic Master Planning study of downtown area adjacent to and surrounding the MVHS site in cooperation and coordination with the assigned County Planner.

(l) Provide a Planner assigned to the new hospital project and coordinate activities with County, State of New York and other governmental entities.

11. **Definitive Agreement(s):** The terms and provisions of this MOA are for the purpose of demonstrating the commitment and agreement of the parties with regard to supporting the proposed hospital project, and most particularly, the financing of the parking garage and the development and implementation of the general municipal parking plan. As available funding, costs, location of the proposed parking facility, and other factors related to the hospital project and the overall parking plan clarify and become known, the parties will enter into one or more Definitive Agreements setting forth those specifics.

12. **Publication and Publicity:** Releases to the news and media and any publicity or other communications shall be coordinated through MVHS and mutually agreed upon.

13. **Confidentiality:** The parties acknowledge and agree that City and County are public entities subject to the New York State Freedom of Information Law (FOIL). The parties agree to work cooperatively to keep as confidential information which may be subject to exceptions under FOIL including but not limited to proprietary information belonging to MVHS, discussions or negotiations concerning the value and acquisition of real property for the new hospital project and the like. The parties each agree to give each other prompt notice of any request for information related to the subject matters contained in this MOA or subsequent definitive agreements and to give all other parties a reasonable opportunity to make any objection which they may have to disclosure of such information.

14. **Governing Law:** This MOA shall be governed and interpreted under the laws of the State of New York.

15. **Notices and Communications:** All communications, notices and disclosures under this MOA shall be mailed or hand delivered as follows:

To MVHS:

Scott H. Perra
President and CEO
Mohawk Valley Health System
1656 Champlin Avenue
New Hartford, New York 13502

With a copy (not constituting notice) to: General Counsel

To County of Oneida:

Anthony J. Picente, Jr.
County Executive
County of Oneida
800 Park Avenue
Utica, New York 13501

With a copy (not constituting notice) to: Office of the County Attorney

To City of Utica:

Robert M. Palmieri
Mayor
City of Utica
One Kennedy Plaza
Utica, New York 13502

With a copy (not constituting notice): Office of the Corporation Counsel.

SIGNATURE PAGE FOLLOWS:

In Witness Whereof, each party has caused this Memorandum of Agreement to be executed on the dates hereafter set forth:

MVHS

Mohawk Valley Health System

By:_____
Scott H. Perra
President and CEO

Date: 8/22/17

County of Oneida

County of Oneida

By:_____
Anthony J. Picente, Jr.
County Executive

Date: 9/19/17

City of Utica

City of Utica

By:_____
Robert M. Palmieri
Mayor

Date: 8/21/17

Exhibit A

Tax Parcel ID No.	Address
318.034-1-37	401 State Street
318.034-1-24	414-416 Lafayette Street
318.041-2-34	509 State Street
318.042-1-30	336 Columbia Street
318.042-1-29	326 334 Columbia Street
318.042-1-2	324 Lafayette Street
318.042-1-13	322 Lafayette Street
318.042-1-14	326 330 Lafayette Street
318.42-1-10	318 Lafayette Street
318.42-1-2./2	417 Oriskany Street West
318.34-1-37	401 State Street

GAVIN AND LAVIGNE INCORPORATED

HUD HEALTHCARE CAPITAL FINANCING SPECIALISTS
87 RAILROAD PLACE, UNIT 603, SARATOGA SPRINGS, NEW YORK 12866

JAMES C. LAVIGNE
(518) 587-2472
[redacted]

MARY C. GAVIN
(518) 587-2070
[redacted]

JAROD LAVIGNE
(518) 587-9062
[redacted]

October 24, 2017

Louis Aiello
Senior Vice President and Chief Financial Officer
Mohawk Valley Health System
1656 Champlin Avenue
Utica, NY 13502

Re: Mortgage Financing – Hospital Replacement Project

Dear Mr. Aiello:

By this letter, Gavin and LaVigne, Inc. expresses its interest in arranging an FHA-insured mortgage for the proposed replacement hospital project for Mohawk Valley Health System.

We understand you need a mortgage loan in the approximate amount of $150 million or such other amount as may be approved by the Department of Health and HUD. If placed today, interest on that loan, would approximate 4.25% during the construction term and 4.25% during the amortization period, with a twenty-five-year amortization commencing after the construction term. However, to protect against market fluctuations, we recommend that you include 5.00% in your Certificate of Need Application.

In today's market, we would use taxable GNMA securities for the loan's placement. It is possible that changes in market conditions could make tax-exempt bond financing a more cost effective means of loan placement. We will evaluate both methods of placement as the deal progresses and select the option that provides the greatest benefit to the Hospital.

Very truly yours,

Mary C. Gavin
President

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution with Subprojects

For Article 28, 36, and 40 Construction Projects Requiring Full, Administrative or Limited Review *
Codes for completing this table are found in Schedule 10 lookups sheet.(see tab below)

Indicate if this project is: New Construction: [X] Renovation: [ ]

A		B	C	D	E	F	G	H	I
Location									
Sub project	Building	Floor	section	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction cost per SF	Total construction cost	Alterations, Scope of work
1	New Hospital Campus	5	---	101	Acute Renal Dialysis	3,900 sf	$356.10/sf	$1,388,778	---
1	New Hospital Campus	1	---	106	Emergency Department	39,079 sf	$509.97/sf	$19,928,963	---
1	New Hospital Campus	3	---	107	Critical Care	34,475 sf	$492.38/sf	$16,974,836	---
1	New Hospital Campus	4	---	110	Neonatal Intermediate Care	6,098 sf	$507.77/sf	$3,096,369	---
1	New Hospital Campus	2	---	203	Cardiac Catheterization - Adult	17,946 sf	$637.46/sf	$11,439,813	---
1	New Hospital Campus	1	---	210	Diagnostic Radiology	22,762 sf	$580.31/sf	$13,208,930	---
1	New Hospital Campus	4	---	214	Maternity	39,552 sf	$430.83/sf	$17,040,322	---
1	New Hospital Campus	6	---	218	Pediatric	402 sf	$461.61/sf	$185,566	---
1	New Hospital Campus	9	---	221	Psychiatric	30,151 sf	$417.64/sf	$12,592,403	---
1	New Hospital Campus	3	---	226	Respiratory Care	1,981 sf	$487.98/sf	$966,698	---
1	New Hospital Campus	6,7	---	302	Medical Rehabilitation	2,838 sf	$360.49/sf	$1,023,080	---
1	New Hospital Campus	1	---	733	Baseline Clinical Laboratory Service	15,520 sf	$593.49/sf	$9,211,042	---

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution with Subprojects

A		B	C	D	E	F	G	H	I
Location									
Sub project	Building	Floor	section	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction cost per SF	Total construction cost	Alterations, Scope of work
1	New Hospital Campus	1	---	734	Baseline Dietetic	15,192 sf	$655.04/sf	$9,951,407	---
1	New Hospital Campus	5-8	---	736	Baseline Medical/Surgical	166,524 sf	$439.63/sf	$73,208,265	---
1	New Hospital Campus	2	---	741	Baseline Operating Room	40,970 sf	$637.46/sf	$26,116,636	---
1	New Hospital Campus	2	---	742	Baseline Pharmaceutical Service	8,041 sf	$448.42/sf	$3,605,733	---
1	New Hospital Campus	2	---	744	Baseline Recovery Room	34,323 sf	$479.19/sf	$16,447,315	---
1	New Hospital Campus	2	---	901	Administration (Routine)	20,269 sf	$316.53/sf	$6,415,760	---
1	New Hospital Campus	1	---	903	Admitting	1,212 sf	$329.72/sf	$399,620	---
1	New Hospital Campus	1	---	920	Public Areas	16,675 sf	$373.68/sf	$6,231,148	---
1	New Hospital Campus	1	---	922	Chapel/Meditation	1,091 sf	$329.72/sf	$359,724	---
1	New Hospital Campus	1	---	930	Education/Research	6,593 sf	$290.15/sf	$1,912,979	---
1	New Hospital Campus	1-10	---	940	Industrial/Service Functions	41,729 sf	$312.13/sf	$13,025,056	---
1	New Hospital Campus	2	---	941	Central Sterile and Supply	9,425 sf	$633.06/sf	$5,966,603	---
1	New Hospital Campus	1-2	---	943	Maintenance/Housekeeping	5,765 sf	$329.72/sf	$1,900,833	---
1	New Hospital Campus	1-9	---	943	Maintenance/Housekeeping	12,457 sf	$307.74/sf	$3,833,494	---

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution with Subprojects

A		B	C	D	E	F	G	H	I
Location									
Sub project	Building	Floor	section	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction cost per SF	Total construction cost	Alterations, Scope of work
1	New Hospital Campus	1,2	---	948	Equipment Maintenance (includes Biomedical Engineering Service)	3,287 sf	$316.53/sf	$1,040,436	---
1	New Hospital Campus	1-10	---	960	Building System	51,258 sf	$312.13/sf	$15,999,385	---
1	New Hospital Campus	3,10	---	967	Electrical System	12,000 sf	$351.70/sf	$4,220,409	---
1	New Hospital Campus	1-10	---	968	Vertical & Horizontal Mechanized Movement (elevators, cart system)	1,659 sf	$312.13/sf	$517,831	---
1	New Hospital Campus	9	---	980	Other Functions	5,612 sf	$312.13/sf	$1,751,698	---
1	New Hospital Campus	3	---	982	Housing on Call (Interns, residents, physicians)	806 sf	$364.89/sf	$294,101	---
1	New Hospital Campus	2	---	902	General Administration	2,020 sf	$312.13/sf	$630,511	---
					SUB-TOTAL (Sub-Project #1)	**671,612 sf**	**$448.01/sf**	**$300,885,743**	
2	Masonic Medical Research Laboratory	1/3	---	930	Education/Research	2,100 sf	$477.09/sf	$1,001,887	---
					SUB-TOTAL (Sub-Project #2)	**2,100 sf**	**$477.09/sf**	**$1,001,887**	
Raw totals for whole project:						**673,712 sf**	**$448.10/sf**	**$301,887,630**	

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution with Subprojects

Subtotals for Sub Project 1	671,612 sf	$448.01/sf	$300,885,743	
Subtotals for Sub Project 2	2,100 sf	$477.09/sf	$1,001,887	
Subtotals for Sub Project 3				
Subtotals for Sub Project 4				
Subtotals for Sub Project 5				
Subtotals for Sub Project 6				
Subtotals for Sub Project 7				
Subtotals for Sub Project 8				
Totals for Whole Project:	**673,712 sf**	**$448.10/sf**	**$301,887,630**	

1. If New Construction is Involved, is it "freestanding?	YES	NO
Sub Project 1	X	
Sub Project 2	X	
Sub Project 3		
Sub Project 4		
Sub Project 5		
Sub Project 6		
Sub Project 7		
Sub Project 8		
Totals for Whole Project:		

2. Check the box that best describe\s the location of the facilities affected by this project:	Dense Urban	Other metropolitan or suburban	Rural
Sub Project 1		X	
Sub Project 2		X	
Sub Project 3			
Sub Project 4			
Sub Project 5			
Sub Project 6			
Sub Project 7			
Sub Project 8			
Totals for Whole Project:			

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE	DATE
	11/16/17
PRINT NAME: Scott Perra	TITLE: President and CEO
NAME OF FIRM: Mohawk Valley Health System	
STREET & NUMBER: 1656 Champlin Avenue	
CITY: Utica	STATE: New York / ZIP: 13502 / PHONE NUMBER: (315) 624-6001

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution with Subprojects

For Article 28, 36, and 40 Construction Projects Requiring Full, Administrative or Limited Review *
Codes for completing this table are found in Schedule 10 lookups sheet.(see tab below)

Indicate if this project is: New Construction: ☐ Renovation: ☒

A		B	C	D	E	F	G	H	I
Location									
Sub project	Building	Floor	section	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction cost per SF	Total construction cost	Alterations, Scope of work
1	---	---	---	---	Demolition of existing structures on new hospital campus	N/A	N/A	$1,603,774	N/A
					SUB-TOTAL (Sub-Project #1)	**N/A**	**N/A**	**$1,603,774**	**N/A**
Raw totals for whole project: (NOTE: EXCLUDES DEMOLITION)						**N/A**	**N/A**	**$1,603,774**	**N/A**

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution with Subprojects

Subtotals for Sub Project 1	N/A	N/A	$1,603,774
Subtotals for Sub Project 2	N/A	N/A	N/A
Subtotals for Sub Project 3			
Subtotals for Sub Project 4			
Subtotals for Sub Project 5			
Subtotals for Sub Project 6			
Subtotals for Sub Project 7			
Subtotals for Sub Project 8			
Totals for Whole Project: (NOTE: EXCLUDES DEMOLITION)	**N/A**	**N/A**	**$1,603,774**

1. If New Construction is Involved, is it "freestanding?	YES	NO
Sub Project 1		
Sub Project 2		
Sub Project 3		
Sub Project 4		
Sub Project 5		
Sub Project 6		
Sub Project 7		
Sub Project 8		
Totals for Whole Project:		

N/A

2. Check the box that best describe\s the location of the facilities affected by this project:	Dense Urban	Other metropolitan or suburban	Rural
Sub Project 1		X	
Sub Project 2		X	
Sub Project 3			
Sub Project 4			
Sub Project 5			
Sub Project 6			
Sub Project 7			
Sub Project 8			
Totals for Whole Project:			

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE	DATE
	11/6/17
PRINT NAME: Scott Perra	TITLE: President and CEO
NAME OF FIRM: Mohawk Valley Health System	
STREET & NUMBER: 1656 Champlin Avenue	
CITY: Utica	STATE: New York
ZIP: 13502	PHONE NUMBER: (315) 624-6001

New York State Department of Health
Certificate of Need Application
Schedule 11 - Moveable Equipment
For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review

Table I: New Equipment Description

Sub project Number	Functional Code	Description, including model, manufacturer, year of manufactor where applicable.	Number of units	Lease or purchase?	Date of the end of the lease period	Lease Amount or Purchase Price
1	---	Please refer to the Schedule 11 Attachment for the New Moveable Equipment List.	---	---	---	$29,275,000
2	---	N/A	---	---	---	$0
Total lease and purchase costs: Subproject 1						$29,275,000
Total lease and purchase costs: Subproject 2						$0
Total lease and purchase costs: Subproject 3						
Total lease and purchase costs: Subproject 4						
Total lease and purchase costs: Subproject 5						
Total lease and purchase costs: Subproject 6						
Total lease and purchase costs: Subproject 7						
Total lease and purchase costs: Subproject 8						
Total lease and purchase costs: Whole Project:						$29,275,000

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

Table 2 - Equipment being replaced: N/A

Sub project Number	Functional Code	Description, including model, manufacturer year of manufactor where applicable.	Number of units	Disposition:	Estimated Current Value
Total estimated value of equipment being replaced: Subproject 1					
Total estimated value of equipment being replaced: Subproject 2					
Total estimated value of equipment being replaced: Subproject 3					
Total estimated value of equipment being replaced: Subproject 4					
Total estimated value of equipment being replaced: Subproject 5					
Total estimated value of equipment being replaced: Subproject 6					
Total estimated value of equipment being replaced: Subproject 7					
Total estimated value of equipment being replaced: Subproject 8					
Total estimated value of equipment being replaced: Whole Project:					$0

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Patricia Smith
701 Westchester Avenue, Suite 210W
White Plains, NY 10604

November 27, 2017
RE: 14 Day Letter
Mohawk Valley Health Systems
CON- 172305 – Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica.

Dear Ms. Smith:

Review of the above application has revealed the need for the additional information requested in the enclosure from the Bureau of Financial Analysis. In preparing answers to the questions, please repeat each question and then provide the answer. Please submit your response via your New York State Electronic Certificate of Need account within 14 days of the date of this letter in accordance with 10 NYCRR, 710.3-(a).

Processing of your application by the Bureau of Financial Analysis cannot be completed until the information is received and reviewed. Also, if this project requires review by the Public Health and Health Planning Council, such review may have to be delayed if the requested information is not received promptly. Accordingly, while you have 14 days to respond, you are encouraged to submit the response at your earliest opportunity.

If you have any questions on the information being requested, please contact Kenneth Glindmyer at 518-457-5070.

The following information is required to complete the review of the above referenced application.

Sincerely,

Kenneth Glindmyer, BFA
DOH

Please note that if any data has changed on the application schedules, they must be resubmitted in the appropriate location. For example, if Schedule 13's data has changed, you must resubmit a new schedule 13 in the schedule 13 location so that all other Bureaus have the most up to date information.

1) Provide an organizational chart of Mohawk Valley Health System

2) Provide an explanation for the net operating losses for both Faxton-St Lukes's and St. Elizabeth's September 2017 Internal Financial Statements. Indicate what the hospitals are doing to better their current financial position.

3) Schedule 8
    a. Provide back up to tie into Interim Interest Expense of $10,500,000. Information provided of $150,000,000 interim loan at 5.25% for 32 months = $21,000,000. We will need to tie into the $10,500,000.

4) Schedule 9 –
    a. Land. Applicant stated N/A but on Schedule 8, $12,000,000 was listed under land. Please reevaluate Schedule 9 – Section D Land and fill out the appropriate fields. Please note that no items should be filled out as N/A. This includes providing us with:
        i. Appraisal of the land by a NYS Certified Agent
        ii. Copy of the proposed/executed purchase agreement
        iii. Affidavit indicating any and all relationships between the seller and the proposed operator/owner.
    b. Interim Loan – Please indicate what will be used for the interim loan, and if bridge financing is being obtained, provide a letter of interest addressing the terms of the loan.

5) Schedule 13 –
    a. Table 13d does not have inpatient information for both hospitals and projected year 1 and 3, please provide similar to how outpatient was provided.
    b. What operational efficiencies will be gained as a result of this project and how much savings per efficiency?
    c. It appears that all expenses will be increased in projected year 1, please explain based on answer to question above.

SCHEDULE 11 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

NEW MOVEABLE EQUIPMENT LIST
(SUB-PROJECT #1)

AND

NEW TELECOMMUNICATIONS EQUIPMENT LIST
(SUB-PROJECT #1)

MVHS

Integrated Healthcare Campus

Medical Equipment Budget

Description	Qty	Unit Cost	Total Cost
Inpatient Bed - M/S	192	$13,500	$2,592,000
Inpatient Bed - ICU/CCU	42	$18,000	$756,000
Intermediate	64	$16,000	$1,024,000
Family Birthing			
Labor / Delivery	8	$75,000	$600,000
Post Partum/ante Partum	42	$40,000	$1,680,000
C-Section	2	$100,000	$200,000
NICU	8	$15,000	$120,000
Behavioral Health	44	$4,000	$176,000
Emergency			
Emergent Care	42	$18,000	$756,000
Trauma	2	$65,000	$130,000
Behavioral	6	$20,000	$120,000
Fast Track	4	$15,000	$60,000
Surgery			
General	10	$600,000	$6,000,000
Cardiology	2	$750,000	$1,500,000
Orthopedic	2	$975,000	$1,950,000
PACU	18	$39,964	$719,353
Pre/Recovery	48	$12,000	$576,000
Central Sterile Process	1	$800,000	$800,000
Endoscopy	5	$250,000	$1,250,000
Interventional Cardiac Cath	3	$1,700,000	$5,100,000
IP/ER/Special Procedures	4	$1,800,000	$7,200,000
Imaging			
MRI *	1	$0	$0
CT	2	$850,000	$1,700,000
Radiography/ Fluor	4	$400,000	$1,600,000
Nuclear Medicine	2	$600,000	$1,200,000
Ultrasound	4	$206,000	$824,000
PFT	1		
Laboratory	1	$1,200,000	$1,200,000
Pharmacy	1	$800,000	$800,000
Respiratory Care	1	$200,000	$200,000
Physiological Monitoring	1	$1,500,000	$1,500,000
Materials Management	1	$170,000	$170,000
Environmental Services	1	$200,000	$200,000
Subtotal			$42,703,353
Discount	-19.00%		($14,730,805)
Freight	1.55%		$661,902
Receiving/Storage/Installation	1.50%		$640,550
Inflation	included		
Grand Total			**$29,275,000**

* Consistent with its current experience, MVHS is expected to have an agreement with a 3rd party entity for assistance in the operation of an MRI unit. The cost of the MRI unit will be borne by the 3rd party entity, although the construction will be the responsibility of the Hospital.

MVHS

Integrated Healthcare Campus

Information Systems & Low Voltage

Description	Units	Unit Cost	Total Cost
Security Systems			$0
Camera	200	$1,200	$240,000
Head-end Equipment	200	$150	$30,000
Access Control Systems			0
Controlled Doors	325	$1,500	$487,500
Head-end Equipment	1	$250,000	$250,000
Duress / Emergency Lockdown	1	$50,000	$50,000
Infant abduction	1	$50,000	$50,000
			0
Network & Communications			0
Telephone System	1,600	$300	$480,000
Head-end Equipment	1,150	$300	$345,000
Handsets (staff)	450	$100	$45,000
Wireless Access Points	990	$775	$767,250
Distributed Antenna System (DAS)	600,000	$2	$1,200,000
			0
Structure Cabling System			0
Horizontal Cabling	8,900	$250	$ 2,225,000
Telecom Room Build-out	1	$3,500	$3,500
HC/# Build-out	5,040	$25	$126,000
Network Electronics			$0
Edge Switches	180	$7,500	$1,350,000
Core Switches	2	$225,000	$450,000
Servers			$0
Storage			$0
Office Equipment	400	$2,200	$880,000
PC's	1,500	$650	$975,000
PC's Charting Station Mounts	880	$450	$396,000
Nurse Call			$0
Patient Rooms	370	$3,000	$1,110,000
Other Rooms	300	$ 1,500	$450,000
Custom Integration	4	$90,000	$360,000
Mobile Handsets	500	$600	$300,000
Audio/Video Systems			$0
Small Conference	17	$3,000	$51,000
Medium Conference	4	$7,000	$28,000
Large Conference	0	$15,000	$2,250
AV Systems - Portable			$0
Televisions	500	$500	$250,000
Patient Education / Entertainment	1	100,000	$100,000
Video/Web Conferencing			0
Building & Miscellaneous Systems			$0
Wireless Clocks	1	$300,000	$300,000
Time & Attendance	20	$2,000	$40,000
Overhead Paging			$0

Asset Tags	7,500	$30	$225,000
Head-end Software	1	$100,000	$100,000
Intercom (Point to Point)			$0
Licensing	10	$1,050.00	$10,500.00
EMS Radio	1	$75,000	$75,000
Subtotal			$13,752,000
Discount	-18%		($4,127,498)
Freight	0	$0	$325,498
Receiving/Storage/Installation	0		$200,000
Inflation/escalation	included		$0
Grand Total			$10,150,000

Schedule 13 A. Assurances From Article 28 Applicants

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

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

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

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

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

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

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

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

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

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

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

Date 11/6/17

Signature:

Scott Perra
Name (Please Type)

President and Chief Executive Officer
Mohawk Valley Health System
Title (Please type)

Schedule 13 B. Staffing

Table 13B - 1: See "Schedules Required for Each Type of CON" to determine when this form is required. Use the "Other" categories for providers, such as dentists, that are not mentioned in the staff categories. If a project involves multiple sites please create a staffing table for each site.

[X] Total Project [ ] Subproject number _____

A				B	C	D
				Number of FTEs to the Nearest Tenth		
	Staffing Categories	FSLH	SEMC	Current Year*	First Year incremental	Third Year incremental
1.	Management & Supervision	96.6	48.2	144.8	134.8	134.8
2.	Technician & Specialist	152.7	99.9	252.6	220.0	220.0
3.	Registered Nurses	630.5	489.6	1,120.1	1,068.8	1,068.8
4.	Licensed Practical Nurses	48.2	25.7	73.9	70.1	70.1
5.	Aides, Orderlies & Attendants	132.6	170.6	303.2	285.6	285.6
6.	Physicians	38.0	36.0	74.0	74.0	74.0
7.	PGY Physicians		34.1	34.1	34.1	34.1
8.	Physicians' Assistants	13.7	10.4	24.1	24.1	24.1
9.	Nurse Practitioners	40.0	11.5	51.5	51.5	51.5
10.	Nurse Midwife			-	-	-
11.	Social Workers and Psychologist**	24.9	15.5	40.4	40.4	40.4
12.	Physical Therapists and PT Assistants	31.7	13.3	45.0	43.2	43.2
13.	Occupational Therapists and OT Assistants	28.1	8.3	36.4	34.9	34.9
14.	Speech Therapists and Speech Assistants	8.8	2.0	10.8	7.9	7.9
15.	Other Therapists and Assistants	23.0	28.0	51.0	46.6	46.6
16.	Infection Control, Environment and Food Service	111.8	93.3	205.1	181.3	181.3
17.	Clerical & Other Administrative	403.0	166.0	569.0	543.7	543.7
18.	Other: Pharmacists	50.0	13.4	63.4	57.4	57.4
19.	Other: Dieticians	2.0	1.0	3.0	3.0	3.0
20.	Other: Other	292.6	428.2	720.8	717.7	717.7
21.	Total Number of Employees	**2,128.2**	**1,695.0**	**3,823.2**	**3,639.1**	**3,639.1**

* Last complete year prior to submitting application

** Use only for RHCF and D and T Center proposals

Describe how the number and mix of staff were determined:

The number and mix of staff were based on the projected utilization, given comparable facilities with similar volumes for FTEs that would be needed after the two (2) hospitals are physically combined.

1.) All diagnostic and treatment centers should complete the following section: **N/A**

Name of medical director:	
License number of the Medical Director	

	Not Applicable:	Title of Attachment	Filename of attachment
Attach a copy of the medical director's curriculum vitae.	☐		

Acute care facility with which an affiliation agreement is being negotiated:	
In the space below, Indicate the status of those negotiations:	

Distance in miles from the proposed facility to the acute care affiliate.	
Distance in minutes of travel time from the proposed facility to the acute care affiliate.	
Name of the acute care facility, nearest the proposed facility:	
Distance in miles from the proposed facility to the nearest acute care facility:	
Distance in minutes of travel time from the proposed facility to the nearest acute care facility.	

	Not Applicable:	Title of Attachment	Filename of attachment
Attach a copy of a letter of intent or the affiliation agreement, if appropriate.	☐		

Table 13B - 2. Ambulatory surgery centers should complete the following Table: N/A

List all practitioners -- including surgeons, Dentists and Podiatrists, who have expressed an interest in practicing at the Center.
NOTE: Attach copies of letters from each giving the number and type of procedures he or she expects to perform per year.

Practitioner's Name	License No.	Specialty (s)	Board Certified or Eligible	Expected Number of Procedures	List hospitals where Physician has Admitting Privileges:	Title and File Name of attachment
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			
			YES ☐ NO ☐			

Schedule 13 C. Annual Operating Costs

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

Use this schedule to summarize the first full year's incremental cost for the categories, which are affected by this project. The first full year is defined as the first 12 months of full operation after project completion. Project the first and third full year's total incremental costs in current year dollars. Current year costs added to first year incremental cost impact should equal total first year budget. Current year costs added to third year incremental budget should equal total third year budget. Show cost reductions in parentheses.

[X] Total Project

[ ] Subproject Number [ ]

Table 13C - 1

Categories	FSLH*	SEMC*	a Current Year	b Year 1 Incremental Cost Impact**	c Year 3 Incremental Cost Impact**
Start date of year in question: (m/d/yyyy)	1/1/2016	1/1/2016	1/1/2016	1/1/2022	1/1/2024
1. Salaries and Wages	$138,026,697	$103,019,932	$241,046,629	$263,219,105	$273,933,708
1a. FTEs	2,128.20	1,695.00	3,823.20	3,639.09	3,639.09
2. Employee Benefits	$24,984,148	$22,809,678	$47,793,826	$58,221,865	$60,591,846
3. Professional Fees	$9,088,221	$4,334,603	$13,422,824	$18,488,500	$19,141,260
4. Medical & Surgical Supplies	$24,294,916	$41,477,220	$65,772,136	$75,182,755	$77,455,153
5. Non-med., non-surg. Supplies	$3,790,582	$3,570,827	$7,361,409	$7,802,358	$7,959,186
6. Utilities	$3,314,606	$1,748,492	$5,063,098	$5,694,339	$5,924,391
7. Purchased Services	$20,290,401	$10,104,192	$30,394,593	$30,953,776	$32,046,638
8. Other Direct Expenses	$39,560,373	$16,227,781	$55,788,154	$72,681,383	$77,850,573
9. Subtotal (total 1-8)	$ 263,349,944	$ 203,292,725	$ 466,642,669	$ 532,244,081	$ 554,902,755
10. Interest	$1,743,087	$1,427,239	$3,170,326	$9,172,114	$8,520,695
11. Depreciation and Rent	$19,891,135	$11,633,613	$31,524,748	$33,796,894	$35,593,402
12. Total Incremental Operating Costs	$ 284,984,166	$ 216,353,577	$ 501,337,743	$ 575,213,089	$ 599,016,852

* Information taken directly from the 2016 Audited Financial Statement. Please note that the New York State gross tax receipts are classified as an offset to revenue in order to be consistent with the cost report classification.

** Represents the combined facilities upon the implementation of the new hospital campus. Both Year 1 and Year 3 expenses align with the expenses proposed in the Oneida County Transformation Grant Application of MVHS.

Table 13C - 2

			a	b	c
Inpatient Categories	FSLH*	SEMC*	Current Year	Year 1 Incremental Cost Impact**	Year 3 Incremental Cost Impact**
Start date of year in question: (m/d/yyyy)	1/1/2016	1/1/2016	1/1/2016	1/22/2016	1/24/2016
1. Salaries and Wages	$67,633,082	$50,479,767	$118,112,849	$125,292,294	$130,392,445
1a. FTEs	1,042.82	830.55	1,873.37	1,732.00	1,732.00
2. Employee Benefits	$12,242,233	$11,176,742	$23,418,975	$27,713,608	$28,841,719
3. Professional Fees	$4,453,228	$2,123,955	$6,577,183	$8,800,526	$9,111,240
4. Medical & Surgical Supplies	$11,904,509	$20,323,838	$32,228,347	$35,786,991	$36,868,653
5. Non-med., non-surg. Supplies	$1,857,385	$1,749,705	$3,607,090	$3,713,922	$3,788,573
6. Utilities	$1,624,157	$856,761	$2,480,918	$2,710,505	$2,820,010
7. Purchased Services	$9,942,296	$4,951,054	$14,893,350	$14,733,997	$15,254,200
8. Other Direct Expenses	$19,384,583	$7,951,613	$27,336,196	$34,596,338	$37,056,873
9. Subtotal (total 1-8)	$129,041,473	$99,613,435	$228,654,908	$253,348,181	$264,133,713
10. Interest	$854,113	$699,347	$1,553,460	$4,365,926	$4,055,851
11. Depreciation and Rent	$9,746,656	$5,700,470	$15,447,126	$16,087,322	$16,942,459
12. Total Incremental Inpatient Operating Costs	$139,642,242	$106,013,252	$245,655,494	$273,801,429	$285,132,023

Table 13C - 3

			a	b	c
Outpatient Categories	FSLH*	SEMC*	Current Year	Year 1 Incremental Cost Impact**	Year 3 Incremental Cost Impact**
Start date of year in question: (m/d/yyyy)	1/1/2016	1/1/2016	1/1/2016	1/22/2016	1/24/2016
1. Salaries and Wages	$70,393,615	$52,540,165	$122,933,780	$137,926,811	$143,541,263
1a. FTEs	1,085.38	864.45	$1,950	1,907.09	1,907.09
2. Employee Benefits	$12,741,915	$11,632,936	$24,374,851	$30,508,257	$31,750,127
3. Professional Fees	$4,634,993	$2,210,648	$6,845,641	$9,687,974	$10,030,020
4. Medical & Surgical Supplies	$12,390,407	$21,153,382	$33,543,789	$39,395,764	$40,586,500
5. Non-med., non-surg. Supplies	$1,933,197	$1,821,122	$3,754,319	$4,088,436	$4,170,613
6. Utilities	$1,690,449	$891,731	$2,582,180	$2,983,834	$3,104,381
7. Purchased Services	$10,348,105	$5,153,138	$15,501,243	$16,219,779	$16,792,438
8. Other Direct Expenses	$20,175,790	$8,276,168	$28,451,958	$38,085,045	$40,793,700
9. Subtotal (total 1-8)	$134,308,471	$103,679,290	$237,987,761	$278,895,900	$290,769,042
10. Interest	$888,974	$727,892	$1,616,866	$4,806,188	$4,464,844
11. Depreciation and Rent	$10,144,479	$5,933,143	$16,077,622	$17,709,572	$18,650,943
12. Total Incremental Outpatient Operating Costs	$145,341,924	$110,340,325	$255,682,249	$301,411,660	$313,884,829

* Information taken directly from the 2016 Audited Financial Statement. Please note that the New York State gross tax receipts are classified as an offset to revenue in order to be consistent with the cost report classification.

** Represents the combined facilities upon the implementation of the new hospital campus. Both Year 1 and Year 3 expenses align with the expenses proposed in the Oneida County Transformation Grant Application of MVHS.

	Title of Attachment	Title of Attachment
1. In an attachment, provide the basis and supporting calculations for depreciation and rent expense	Please refer to the Schedule 13 Attachment	N/A
2. In an attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital	Please refer to the Schedule 13 Attachment	N/A

Any approval of this application is not to be construed as an approval of any of the above indicated current or projected operating costs. Reimbursement of any such costs shall be in accordance with and subject to the provisions of Part 86 of 10 NYCRR. Approval of this application does not assure reimbursement of any of the costs indicated therein by payers under Title XIX of the Federal Social Security Act (Medicaid) or Article 43 of The State Insurance Law or by any other payers.

Table 13D - 1

Categories	FSLH*	SEMC*	a Current Year	b Year 1 Incremental Revenue Impact**	c Year 3 Incremental Revenue Impact**
Start date of year in question: (m/d/yyyy)	1/1/2016	1/1/2016	1/1/2016	1/1/2022	1/1/2024
1. Daily Hospital Services	$145,141,809	$108,537,434	$253,679,243	$347,585,051	$390,546,563
2. Ambulatory Services	$121,080,555	$117,659,573	$238,740,128	$256,121,845	$287,778,505
3. Ancillary Services	$547,240,668	$407,283,100	$954,523,768	$1,367,221,407	$1,536,209,972
4. Total Gross Patient Care Services Rendered	$813,463,032	$633,480,107	$1,446,943,139	$1,970,928,303	$2,214,535,040
5. Deductions from Revenue	$546,279,516	$422,790,045	$969,069,561	$1,420,349,514	$1,641,544,378
6. Net Patient Care Services Revenue	$267,183,516	$210,690,062	$477,873,578	$550,578,789	$572,990,662
7. Other Operating Revenue (Identify sources)			$23,818,241	$28,359,485	$28,359,485
340B Drug Program	$6,801,537		$6,801,537	$8,098,335	$8,098,335
Retail Pharmacy	$4,069,343		$4,069,343	$4,845,214	$4,845,214
Bad Debt Charity Pool	$3,136,047		$3,136,047	$3,733,973	$3,733,973
Other	$3,565,027	$6,246,287	$9,811,314	$11,681,963	$11,681,963
8. Total Operating Revenue (Total 1-7)	$284,755,470	$216,936,349	$501,691,819	$578,938,274	$601,350,147
9. Non-Operating Revenue	$1,079,311	$428,794	$1,508,105	$1,194,425	$1,242,680
10. Total Project Revenue	$285,834,781	$217,365,143	$503,199,924	$580,132,699	$602,592,827

* Information taken directly from the facility's 2016 Audited Financial Statement. Please note that the New York State gross tax receipts are classified as an offset to revenue in order to be consistent with the cost report classification.

** Represents the combined facilities upon the implementation of the new hospital campus. Both Year 1 and Year 3 revenues align with the revenues proposed in the Oneida County Transformation Grant Application of MVHS.

Table 13D - 3

St. Luke's

* Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ Patient Discharges ☒

Inpatient Services Source of Revenue		Total Current Year**			First Year Incremental***			Third Year Incremental***		
			Net Revenue			Net Revenue			Net Revenue	
		Patient Days or discharges*	%	Dollars ($)	Patient Days or discharges*	% based on days or discharges	Dollars-($)	Patient Days or discharges*	% based on days or discharges	Dollars-($)
Commercial	Fee for Service	350	2.7%	$4,097,475	563	2.5%	$12,489,594	563	2.5%	$12,997,995
	Managed Care	2,454	18.9%	$28,682,328	4,144	18.1%	$87,427,165	4,144	18.1%	$90,985,977
Medicare	Fee for Service	4,264	32.8%	38,048,096	8,347	36.5%	$83,938,495	8,347	36.5%	$87,355,298
	Managed Care	1,928	14.8%	$18,045,607	3,728	16.3%	$40,394,368	3,728	16.3%	$42,038,662
Medicaid	Fee for Service	622	4.8%	$5,280,453	989	4.3%	$5,127,513	989	4.3%	$5,336,233
	Managed Care	2,893	22.2%	$21,114,053	4,023	17.6%	$29,843,804	4,023	17.6%	$31,058,627
Private Pay		72	0.6%	$898,332	133	0.6%	$808,913	133	0.6%	$841,841
OASAS										
OMH										
Charity Care		223	1.7%	($532,391)	329	1.4%	($1,344,274)	329	1.4%	($1,398,994)
Bad Debt										
All Other		208	1.6%	1,706,634	584	2.6%	$10,598,846	584	2.6%	$11,030,283
Total		**13,014**	**100.0%**	**$117,340,587**	**22,840**	**100.0%**	**$269,284,424**	**22,840**	**100.0%**	**$280,245,922**

** Information taken directly from the facility's 2016 Cost Report.

*** Represents the combined facilities upon the implementation of the new hospital campus. Both Year 1 and Year 3 revenues and utilization align with the revenues and utilization proposed in the Oneida County Transformation Grant Application of MVHS.

Table 13D - 3

St. Elizabeth

* Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ Patient Discharges ☒

Inpatient Services Source of Revenue		Total Current Year**			First Year Incremental***			Third Year Incremental***		
			Net Revenue			Net Revenue			Net Revenue	
		Patient Days or discharges*	%	Dollars ($)	Patient Days or discharges*	% based on days or discharges	Dollars-($)	Patient Days or discharges*	% based on days or discharges	Dollars-($)
Commercial	**Fee for Service**	204	1.9%	6,640,411						
	Managed Care	1,431	13.3%	46,482,875						
Medicare	**Fee for Service**	4,209	39.0%	32,962,430			See			See
	Managed Care	2,151	19.9%	16,595,076			Note			Note
Medicaid	**Fee for Service**	484	4.5%	2,062,566			Below			Below
	Managed Care	1,493	13.8%	8,881,345			***			***
Private Pay		163	1.5%	365,991						
OASAS										
OMH			0.0%							
Charity Care		393	3.6%	(669,619)						
Bad Debt										
All Other		265	2.5%	3,346,764						
Total		10,793	100.0%	$116,667,839						

** Information taken directly from the facility's 2016 Cost Report.

*** Please refer to the Table 13D-3 for St. Luke's, which represents the combined facilities upon the implementation of the new hospital campus.

Table 13D - 4

St. Luke's + St. Elizabeth

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	**Fee for Service**	27,393	4.0%	$16,272,167	28,426	4.0%	$18,769,672	28,426	4.0%	$19,533,711
	Managed Care	155,224	22.6%	$92,208,949	161,076	22.6%	$106,361,477	161,076	22.6%	$110,691,030
Medicare	**Fee for Service**	180,020	26.2%	$50,645,409	186,807	26.2%	$58,418,630	186,807	26.2%	$60,796,620
	Managed Care	97,049	14.1%	$33,480,757	100,708	14.1%	$38,619,492	100,708	14.1%	$40,191,538
Medicaid	**Fee for Service**	25,778	3.7%	$758,533	26,750	3.7%	$874,955	26,750	3.7%	$910,571
	Managed Care	158,825	23.1%	$37,051,409	164,813	23.1%	$42,738,179	164,813	23.1%	$44,477,880
Private Pay		20,808	3.0%	$9,490,695	21592	3.0%	$10,947,358	21592	3.0%	$11,392,981
OASAS										
OMH										
Charity Care		1,996	0.3%	($42,154)	2,071	0.3%	($48,624)	2,071	0.3%	($50,603)
Bad Debt										
All Other		20,538	3.0%	$3,999,387	21,312	3.0%	$4,613,226	21,312	3.0%	$4,801,012
Total		**687,631**	**100.0%**	**$243,865,152**	**713,555**	**100.0%**	**$281,294,365**	**713,555**	**100.0%**	**$292,744,740**

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services				**$477,873,578**			**$550,578,789**			**$572,990,662**

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of St. Elizabeth and St. Luke's	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of St. Elizabeth and St. Luke's	N/A

SCHEDULE 13 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

FINANCIAL DOCUMENTATION

1. Calculation of Depreciation and Rent (Total)
2. Long Term Debt Projections
3. Calculation of Interest (Project-Specific)

Mohawk Valley Health System
Calculation of Depreciation and Rent (Total)

				Final	Final	Budget				PROJECTED			
				2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
FSLH Runout							11,290,432	8,229,561	6,157,578	4,852,385	4,229,654	3,624,337	3,154,555
SEMC Runout							7,502,761	6,384,088	5,292,248	3,960,233	3,156,708	2,678,538	2,494,763
'17 Additions depreciation not in FAR							2,333,333	2,333,333	2,333,333	2,333,333	2,333,333	2,333,333	2,333,333
Total				26,762,289	24,727,263	24,943,755	21,126,527	16,946,983	13,783,160	11,145,951	9,719,696	8,636,208	7,982,651
Additions													
2018	Normal replacement	14,000,000					1,076,923	2,153,846	2,153,846	2,153,846	2,153,846	2,153,846	2,153,846
2019	Normal replacement	12,000,000						923,077	1,846,154	1,846,154	1,846,154	1,846,154	1,846,154
2020	Normal replacement	10,000,000							769,231	1,538,462	1,538,462	1,538,462	1,538,462
2021	Normal replacement	8,000,000								615,385	1,230,769	1,230,769	1,230,769
2022	Normal replacement	6,000,000									461,538	923,077	923,077
	New hospital	450,000,000	$480 minus $30 for land								15,000,000	15,000,000	15,000,000
	Loss on Impairment	(50,000,000)									(5,539,772)	(4,727,156)	(4,236,988)
	Captalized interest	13,810,897									460,363	460,363	460,363
	Bond Issue Cost	3,750,000									125,000	125,000	125,000
2023	Normal replacement	7,000,000										538,462	1,076,923
2024	Normal replacement	9,000,000											692,308
2025	Normal replacement	11,000,000											
2026	Normal replacement	11,000,000											
	Total Depreciation				24,727,263	24,943,755	22,203,450	20,023,906	18,552,391	17,299,797	26,996,056	27,725,185	28,792,564
	Rent Equipment				3,754,779	3,756,631	3,756,631	3,756,631	3,756,631	3,756,631	3,756,631	3,756,631	3,756,631
	Rent Buildings				3,042,706	3,044,206	3,044,206	3,044,206	3,044,206	3,044,206	3,044,206	3,044,206	3,044,206
					31,524,748	31,744,592	29,004,287	26,824,743	25,353,228	24,100,634	33,796,893	34,526,022	35,593,401

MVHS

Long Term Debt Projections

G/L Account #		Account Description	Interest Rate	12/31/16	Added	2017 Principal	2017 Interest	2018 Principal	2018 Interest	2019 Principal	2019 Interest	2020 Principal	2020 Interest	2021 Principal	2021 Interest	2022 Principal	2022 Interest	2023 Principal	2023 Interest	2024 Principal	2024 Interest	Thereafter Principal
CAPITAL LEASES:																						
[redacted]	FSLH	CO-Gen	8.02%	583,692		58,273	44,727	63,125	39,875	68,381	34,619	74,075	28,925	80,243	22,757	86,924	16,076	94,162	8,838	58,508	1,575	
	FSLH	M&T LEASE NO.5	3.46%	170,989		170,589	3,221	-	-	-	-											
	FSLH	M&T LEASE NO.7	4.36%	21,423		21,423	117	-	-	-	-											
	FSLH	M&T LEASE NO.6	4.35%	23,885		23,885	260	-	-	-	-											
	FSLH	BOFA LEASE #14 2012	3.47%	278,056		278,056	3,606	-	-	-	-											
	FSLH	BOFA SALE LEASEBACK 2012	2.86%	159,863		159,863	1,879	-	-	-	-											
	FSLH	BOFA LEASE #15 2013	3.00%	560,758		446,922	10,698	113,836	589	-	-											
	FSLH	BOFA LEASE #17 2013	3.34%	434,357		304,473	9,885	129,895	1,088	-	-											
	FSLH	BOFA LEASE #18 2013	2.84%	652,195		387,614	13,492	264,581	2,823	-	-											
	FSLH	BOFA LEASE #20 2013	3.33%	349,635		186,066	8,788	163,569	2,426	-	-											
	FSLH	M&T LEASE #8 2013	3.50%	296,672		207,887	7,065	88,785	728	-	-											
	FSLH	BOFA LEASE #19 2014	3.89%	624,858		320,409	17,649	304,250	5,636	-	-											
	FSLH	BOFA LEASE #21 2014	3.95%	637,190		256,330	20,538	266,628	10,240	114,232	1,129											
	FSLH	BOFA LEASE #22 2014	3.95%	809,162		324,706	26,017	337,752	12,971	144,704	1,430											
	FSLH	BOFA LEASE #28 2015	3.33%	426,837		121,564	15,647	126,676	10,565	131,969	5,271	46,658	582									
	FSLH	HP LEASE 2015		253,175		101,561	8,974	106,053	4,482	45,561	495											
	FSLH	BofA Lease #24 2016	2.55%	2,003,942		460,786	46,627	472,653	34,759	484,826	22,586	497,313	10,099	88,354	536							
	FSLH	BOFA LEASE 2016 ARTIS ZEE	2.77%	1,275,165		242,435	39,522	250,791	31,167	259,484	22,528	268,376	13,582	254,129	4,332							
	FSLH	LEASE 2017 PANTHEON ARTIS ZEE	3.22%		839,095	38,829	6,649	158,474	23,438	163,652	18,260	168,999	12,913	174,520	7,392	134,622	1,512					
	SEMC	SIEMENS STREAMLAB EQUIP	1.63%	117,307		117,307	1,037															
	SEMC	SIEMENS ADVIA CENTAUR	1.63%	21,813		21,813	163															
	SEMC	SIEMENS VISTA 1500	1.63%	117,567		117,567	1,039															
	SEMC	MRI- BUILDING 2212 GEN		673,031		87,143	67,857	98,848	58,152	107,833	47,367	110,619	35,361	132,940	22,060	128,848						
		IT System		-		-		-														
				10,469,437	839,095	4,427,924	355,477	2,941,915	236,019	1,520,364	153,681	1,175,640	101,452	730,198	57,077	350,394	17,588	94,162	8,838	58,508	1,575	-
LONG TERM DEBT:																						
[redacted]	FSLH	Mortgage Payable - Herkimer	Ceiling/Floor (4.5% '12)	1,413,214		432,007	66,405	456,365	43,103	492,466	16,892	41,426	14,707									
	FSLH	NBT Note Payable 2012 - 73560	5.50%	55,773		55,772	617	-		-						1						
	FSLH	NBT NOTE 2013	3.10%	1,200,000		900,000		300,000		-												
	FSLH	NBT 1.5M NOTE 2013	4.00%	585,647		314,022	17,844	271,625	4,971	-												
	NBT Equip Note 2015 MVO		4.00%	388,002		97,729	12,641	101,710	8,960	105,854	4,815	82,700	829									
	NBT Const Note 2015 MVO		4.00%	844,514		78,814	32,838	79,988	29,664	83,293	26,359	86,675	22,977	90,266	19,386	94,006	15,646	97,901	10,639	101,957	7,684	133,616
	FSLH	BOFA SLM 2016	2.60%	3,338,028		707,930	79,470	726,818	60,581	746,211	41,188	766,046	21,353	391,021	2,679							
	SEMC	SISTERS SCHOOL OF NURSING		454,129		58,866		79,452		79,452		79,452		79,452		79,456						
	SEMC	SISTERS LOAN PARKING GARAGE		591,681		73,960		103,564		103,564		103,564		103,564		103,562						
	SEMC	ADIRONDACK ARTLS ZEE		632,107		221,456	21,278	230,908	12,225	179,343	3,007											
	SEMC	CONVENT		333,333		166,667		166,667														
		Total		9,816,426	-	3,104,422	230,493	2,517,117	169,503	1,780,213	92,362	1,139,874	59,866	864,303	22,065	277,025	15,646	97,901	10,639	101,957	7,684	133,616
BONDS:																						
[redacted]	FSLH	2006 Taxable Bonds	Variable w/Swap	9,480,000		350,000	678,281	490,000	649,036	440,000	616,536	460,000	593,657	500,000	548,564	535,000	510,774	545,000	471,325	630,000	428,387	5,550,000
	FSLH	2006 Tax Exempt Bonds	Variable w/Swap	5,660,000		250,000	307,370	290,000	297,308	285,000	278,404	295,000	260,297	320,000	243,215	330,000	226,188	340,000	206,580	375,000	186,700	3,175,000
	SEMC	1998A SERIES		11,804,666		620,000	675,519	655,000	639,869	690,000	602,206	730,000	562,531	775,000	519,644	820,000	474,113	865,000	425,936	920,000	375,119	5,529,666
	SEMC	1998B SERIES		5,720,000		460,000	343,133	510,000	314,333	540,000	283,733	575,000	251,333	605,000	216,833	645,000	180,533	685,000	141,833	720,000	100,733	960,000
	SEMC	2006A SERIES		8,000,000			240,000	520,000	224,400	805,000	200,250	835,000	175,200	870,000	149,100	905,000	121,950	945,000	93,600	990,000	64,200	2,140,000
		New Bond Issue			153,750,000							1,099,783	4,024,296	2,225,491	7,962,667	2,345,182	7,842,976	2,471,311	7,718,848	2,604,223	7,583,936	143,034,010
		Total		40,444,666	153,750,000	1,700,000	2,244,303	2,425,000	2,120,004	2,760,000	1,979,131	3,964,783	5,657,315	5,295,491	9,640,043	5,580,182	9,355,511	5,691,311	9,056,102	6,229,223	8,736,075	160,388,666
		Total Debt Service				5,262,346	2,830,273	7,884,032	2,518,531	6,060,607	2,225,174	6,279,696	6,018,662	6,589,991	9,719,184	6,207,602	9,371,048	6,043,374	9,075,579	6,389,687	8,740,344	160,522,312
		Total of Debt Outstanding		60,730,549	154,589,095	51,468,203		48,604,172		37,543,565		185,013,869		128,323,878		122,116,275		166,072,963		159,683,215		(835,097)

Amortization Table

The amortization table at the end of this worksheet calculates the principal and interest payments, ending balance, and cumulative interest for any 48 consecutive payment periods of a loan.

- To use the table, change the values in the Inital Data section of the worksheet.
- To print the table, choose Print from the File menu. The print area is set to A1:G77.
- If you increase the term of the loan or the number of payments, you will need to add more payment periods to the table. Select cells A75:G77, then drag the Fill handle (+) into the cells below the table.
- Most formulas on this worksheet are contained in defined names. To see the names and formulas, choose Name from the Insert menu, and then choose Define. Select a name from the list ('Amortization Table'!Interest, for example).

Initial Data

LOAN DATA

Loan amount:	$150,000,000.00
Annual interest rate:	5.25000%
Term in years:	30
Payments per year:	12
First payment due:	7/1/2020

TABLE DATA

Table starts at date:	7/1/2020
or at payment number:	1

PERIODIC PAYMENT

Entered payment:	$0.00
Calculated payment:	$828,305.55

The table uses the calculated periodic payment amount, unless you enter a value for "Entered payment."

CALCULATIONS

Use payment of:	$828,305.55	Beginning balance at payment 1:	$150,000,000.00
1st payment in table:	1	Cumulative interest prior to payment 1:	$0.00

Table

No.	Payment Date	Beginning Balance	Interest	Principal	Ending Balance	Cumulative Interest
1	7/1/2020	150,000,000.00	656,250.00	172,055.55	149,827,944.45	656,250.00
2	8/1/2020	149,827,944.45	655,497.26	172,808.30	149,655,136.15	1,311,747.26
3	9/1/2020	149,655,136.15	654,741.22	173,564.33	149,481,571.82	1,966,488.48
4	10/1/2020	149,481,571.82	653,981.88	174,323.68	149,307,248.14	2,620,470.35
5	11/1/2020	149,307,248.14	653,219.21	175,086.34	149,132,161.80	3,273,689.56
6	12/1/2020	149,132,161.80	652,453.21	175,852.35	148,956,309.45	3,926,142.77
7	1/1/2021	148,956,309.45	651,683.85	176,621.70	148,779,687.75	4,577,826.63
8	2/1/2021	148,779,687.75	650,911.13	177,394.42	148,602,293.33	5,228,737.76
9	3/1/2021	148,602,293.33	650,135.03	178,170.52	148,424,122.82	5,878,872.79
10	4/1/2021	148,424,122.82	649,355.54	178,950.02	148,245,172.80	6,528,228.33
11	5/1/2021	148,245,172.80	648,572.63	179,732.92	148,065,439.88	7,176,800.96
12	6/1/2021	148,065,439.88	647,786.30	180,519.25	147,884,920.62	7,824,587.26
13	7/1/2021	147,884,920.62	646,996.53	181,309.03	147,703,611.60	8,471,583.79
14	8/1/2021	147,703,611.60	646,203.30	182,102.25	147,521,509.35	9,117,787.09
15	9/1/2021	147,521,509.35	645,406.60	182,898.95	147,338,610.40	9,763,193.69
16	10/1/2021	147,338,610.40	644,606.42	183,699.13	147,154,911.26	10,407,800.11
17	11/1/2021	147,154,911.26	643,802.74	184,502.82	146,970,408.45	11,051,602.85
18	12/1/2021	146,970,408.45	642,995.54	185,310.02	146,785,098.43	11,694,598.39
19	1/1/2022	146,785,098.43	642,184.81	186,120.75	146,598,977.68	12,336,783.19
20	2/1/2022	146,598,977.68	641,370.53	186,935.03	146,412,042.66	12,978,153.72
21	3/1/2022	146,412,042.66	640,552.69	187,752.87	146,224,289.79	13,618,706.41
22	4/1/2022	146,224,289.79	639,731.27	188,574.29	146,035,715.50	14,258,437.68
23	5/1/2022	146,035,715.50	638,906.26	189,399.30	145,846,316.21	14,897,343.93
24	6/1/2022	145,846,316.21	638,077.63	190,227.92	145,656,088.29	15,535,421.56
25	7/1/2022	145,656,088.29	637,245.39	191,060.17	145,465,028.12	16,172,666.95
26	8/1/2022	145,465,028.12	636,409.50	191,896.06	145,273,132.06	16,809,076.45
27	9/1/2022	145,273,132.06	635,569.95	192,735.60	145,080,396.46	17,444,646.40
28	10/1/2022	145,080,396.46	634,726.73	193,578.82	144,886,817.65	18,079,373.14
29	11/1/2022	144,886,817.65	633,879.83	194,425.73	144,692,391.92	18,713,252.96
30	12/1/2022	144,692,391.92	633,029.21	195,276.34	144,497,115.58	19,346,282.18
31	1/1/2023	144,497,115.58	632,174.88	196,130.67	144,300,984.91	19,978,457.06
32	2/1/2023	144,300,984.91	631,316.81	196,988.74	144,103,996.16	20,609,773.87
33	3/1/2023	144,103,996.16	630,454.98	197,850.57	143,906,145.59	21,240,228.85
34	4/1/2023	143,906,145.59	629,589.39	198,716.17	143,707,429.43	21,869,818.24
35	5/1/2023	143,707,429.43	628,720.00	199,585.55	143,507,843.88	22,498,538.24
36	6/1/2023	143,507,843.88	627,846.82	200,458.74	143,307,385.14	23,126,385.06
37	7/1/2023	143,307,385.14	626,969.81	201,335.74	143,106,049.40	23,753,354.87
38	8/1/2023	143,106,049.40	626,088.97	202,216.59	142,903,832.81	24,379,443.83

39	9/1/2023	142,903,832.81	625,204.27	203,101.28	142,700,731.53	25,004,648.10
40	10/1/2023	142,700,731.53	624,315.70	203,989.85	142,496,741.67	25,628,963.80
41	11/1/2023	142,496,741.67	623,423.24	204,882.31	142,291,859.37	26,252,387.05
42	12/1/2023	142,291,859.37	622,526.88	205,778.67	142,086,080.70	26,874,913.93
43	1/1/2024	142,086,080.70	621,626.60	206,678.95	141,879,401.75	27,496,540.54
44	2/1/2024	141,879,401.75	620,722.38	207,583.17	141,671,818.58	28,117,262.92
45	3/1/2024	141,671,818.58	619,814.21	208,491.35	141,463,327.23	28,737,077.12
46	4/1/2024	141,463,327.23	618,902.06	209,403.50	141,253,923.73	29,355,979.18
47	5/1/2024	141,253,923.73	617,985.92	210,319.64	141,043,604.10	29,973,965.10
48	6/1/2024	141,043,604.10	617,065.77	211,239.79	140,832,364.31	30,591,030.87
49	7/1/2024	140,832,364.31	616,141.59	212,163.96	140,620,200.35	31,207,172.46
50	8/1/2024	140,620,200.35	615,213.38	213,092.18	140,407,108.18	31,822,385.84
51	9/1/2024	140,407,108.18	614,281.10	214,024.45	140,193,083.72	32,436,666.93
52	10/1/2024	140,193,083.72	613,344.74	214,960.81	139,978,122.91	33,050,011.68
53	11/1/2024	139,978,122.91	612,404.29	215,901.27	139,762,221.64	33,662,415.96
54	12/1/2024	139,762,221.64	611,459.72	216,845.83	139,545,375.81	34,273,875.68
55	1/1/2025	139,545,375.81	610,511.02	217,794.53	139,327,581.28	34,884,386.70
56	2/1/2025	139,327,581.28	609,558.17	218,747.39	139,108,833.89	35,493,944.87
57	3/1/2025	139,108,833.89	608,601.15	219,704.40	138,889,129.49	36,102,546.02
58	4/1/2025	138,889,129.49	607,639.94	220,665.61	138,668,463.87	36,710,185.96
59	5/1/2025	138,668,463.87	606,674.53	221,631.02	138,446,832.85	37,316,860.49
60	6/1/2025	138,446,832.85	605,704.89	222,600.66	138,224,232.19	37,922,565.38
61	7/1/2025	138,224,232.19	604,731.02	223,574.54	138,000,657.65	38,527,296.40
62	8/1/2025	138,000,657.65	603,752.88	224,552.68	137,776,104.98	39,131,049.28
63	9/1/2025	137,776,104.98	602,770.46	225,535.09	137,550,569.88	39,733,819.74
64	10/1/2025	137,550,569.88	601,783.74	226,521.81	137,324,048.07	40,335,603.48
65	11/1/2025	137,324,048.07	600,792.71	227,512.84	137,096,535.23	40,936,396.19
66	12/1/2025	137,096,535.23	599,797.34	228,508.21	136,868,027.02	41,536,193.53
67	1/1/2026	136,868,027.02	598,797.62	229,507.94	136,638,519.08	42,134,991.15
68	2/1/2026	136,638,519.08	597,793.52	230,512.03	136,408,007.05	42,732,784.67
69	3/1/2026	136,408,007.05	596,785.03	231,520.52	136,176,486.53	43,329,569.70
70	4/1/2026	136,176,486.53	595,772.13	232,533.42	135,943,953.10	43,925,341.83
71	5/1/2026	135,943,953.10	594,754.79	233,550.76	135,710,402.35	44,520,096.62
72	6/1/2026	135,710,402.35	593,733.01	234,572.54	135,475,829.80	45,113,829.63
73	7/1/2026	135,475,829.80	592,706.76	235,598.80	135,240,231.01	45,706,536.39
74	8/1/2026	135,240,231.01	591,676.01	236,629.54	135,003,601.46	46,298,212.40
75	9/1/2026	135,003,601.46	590,640.76	237,664.80	134,765,936.67	46,888,853.16
76	10/1/2026	134,765,936.67	589,600.97	238,704.58	134,527,232.09	47,478,454.13
77	11/1/2026	134,527,232.09	588,556.64	239,748.91	134,287,483.17	48,067,010.77
78	12/1/2026	134,287,483.17	587,507.74	240,797.81	134,046,685.36	48,654,518.51
79	1/1/2027	134,046,685.36	586,454.25	241,851.30	133,804,834.05	49,240,972.76
80	2/1/2027	133,804,834.05	585,396.15	242,909.40	133,561,924.65	49,826,368.91
81	3/1/2027	133,561,924.65	584,333.42	243,972.13	133,317,952.52	50,410,702.33
82	4/1/2027	133,317,952.52	583,266.04	245,039.51	133,072,913.01	50,993,968.37
83	5/1/2027	133,072,913.01	582,193.99	246,111.56	132,826,801.45	51,576,162.36
84	6/1/2027	132,826,801.45	581,117.26	247,188.30	132,579,613.15	52,157,279.62
85	7/1/2027	132,579,613.15	580,035.81	248,269.75	132,331,343.40	52,737,315.43
86	8/1/2027	132,331,343.40	578,949.63	249,355.93	132,081,987.48	53,316,265.05
87	9/1/2027	132,081,987.48	577,858.70	250,446.86	131,831,540.62	53,894,123.75
88	10/1/2027	131,831,540.62	576,762.99	251,542.56	131,579,998.06	54,470,886.74
89	11/1/2027	131,579,998.06	575,662.49	252,643.06	131,327,355.00	55,046,549.23
90	12/1/2027	131,327,355.00	574,557.18	253,748.38	131,073,606.62	55,621,106.41
91	1/1/2028	131,073,606.62	573,447.03	254,858.52	130,818,748.10	56,194,553.44
92	2/1/2028	130,818,748.10	572,332.02	255,973.53	130,562,774.57	56,766,885.46
93	3/1/2028	130,562,774.57	571,212.14	257,093.41	130,305,681.15	57,338,097.60
94	4/1/2028	130,305,681.15	570,087.36	258,218.20	130,047,462.95	57,908,184.96
95	5/1/2028	130,047,462.95	568,957.65	259,347.90	129,788,115.05	58,477,142.61
96	6/1/2028	129,788,115.05	567,823.00	260,482.55	129,527,632.50	59,044,965.61
97	7/1/2028	129,527,632.50	566,683.39	261,622.16	129,266,010.34	59,611,649.00
98	8/1/2028	129,266,010.34	565,538.80	262,766.76	129,003,243.58	60,177,187.80
99	9/1/2028	129,003,243.58	564,389.19	263,916.36	128,739,327.22	60,741,576.99
100	10/1/2028	128,739,327.22	563,234.56	265,071.00	128,474,256.22	61,304,811.54
101	11/1/2028	128,474,256.22	562,074.87	266,230.68	128,208,025.54	61,866,886.41
102	12/1/2028	128,208,025.54	560,910.11	267,395.44	127,940,630.10	62,427,796.53
103	1/1/2029	127,940,630.10	559,740.26	268,565.30	127,672,064.80	62,987,536.78
104	2/1/2029	127,672,064.80	558,565.28	269,740.27	127,402,324.53	63,546,102.07
105	3/1/2029	127,402,324.53	557,385.17	270,920.38	127,131,404.15	64,103,487.24
106	4/1/2029	127,131,404.15	556,199.89	272,105.66	126,859,298.49	64,659,687.13
107	5/1/2029	126,859,298.49	555,009.43	273,296.12	126,586,002.37	65,214,696.56
108	6/1/2029	126,586,002.37	553,813.76	274,491.79	126,311,510.57	65,768,510.32
109	7/1/2029	126,311,510.57	552,612.86	275,692.69	126,035,817.88	66,321,123.18
110	8/1/2029	126,035,817.88	551,406.70	276,898.85	125,758,919.03	66,872,529.88

111	9/1/2029	125,758,919.03	550,195.27	278,110.28	125,480,808.75	67,422,725.15
112	10/1/2029	125,480,808.75	548,978.54	279,327.01	125,201,481.73	67,971,703.69
113	11/1/2029	125,201,481.73	547,756.48	280,549.07	124,920,932.66	68,519,460.17
114	12/1/2029	124,920,932.66	546,529.08	281,776.47	124,639,156.19	69,065,989.25
115	1/1/2030	124,639,156.19	545,296.31	283,009.24	124,356,146.94	69,611,285.56
116	2/1/2030	124,356,146.94	544,058.14	284,247.41	124,071,899.53	70,155,343.71
117	3/1/2030	124,071,899.53	542,814.56	285,490.99	123,786,408.54	70,698,158.27
118	4/1/2030	123,786,408.54	541,565.54	286,740.02	123,499,668.52	71,239,723.80
119	5/1/2030	123,499,668.52	540,311.05	287,994.50	123,211,674.02	71,780,034.85
120	6/1/2030	123,211,674.02	539,051.07	289,254.48	122,922,419.54	72,319,085.93
121	7/1/2030	122,922,419.54	537,785.59	290,519.97	122,631,899.57	72,856,871.51
122	8/1/2030	122,631,899.57	536,514.56	291,790.99	122,340,108.58	73,393,386.07
123	9/1/2030	122,340,108.58	535,237.98	293,067.58	122,047,041.00	73,928,624.05
124	10/1/2030	122,047,041.00	533,955.80	294,349.75	121,752,691.25	74,462,579.85
125	11/1/2030	121,752,691.25	532,668.02	295,637.53	121,457,053.73	74,995,247.88
126	12/1/2030	121,457,053.73	531,374.61	296,930.94	121,160,122.78	75,526,622.49
127	1/1/2031	121,160,122.78	530,075.54	298,230.02	120,861,892.77	76,056,698.02
128	2/1/2031	120,861,892.77	528,770.78	299,534.77	120,562,357.99	76,585,468.81
129	3/1/2031	120,562,357.99	527,460.32	300,845.24	120,261,512.76	77,112,929.12
130	4/1/2031	120,261,512.76	526,144.12	302,161.43	119,959,351.32	77,639,073.24
131	5/1/2031	119,959,351.32	524,822.16	303,483.39	119,655,867.93	78,163,895.40
132	6/1/2031	119,655,867.93	523,494.42	304,811.13	119,351,056.80	78,687,389.82
133	7/1/2031	119,351,056.80	522,160.87	306,144.68	119,044,912.12	79,209,550.70
134	8/1/2031	119,044,912.12	520,821.49	307,484.06	118,737,428.06	79,730,372.19
135	9/1/2031	118,737,428.06	519,476.25	308,829.31	118,428,598.75	80,249,848.44
136	10/1/2031	118,428,598.75	518,125.12	310,180.43	118,118,418.32	80,767,973.56
137	11/1/2031	118,118,418.32	516,768.08	311,537.47	117,806,880.85	81,284,741.64
138	12/1/2031	117,806,880.85	515,405.10	312,900.45	117,493,980.40	81,800,146.74
139	1/1/2032	117,493,980.40	514,036.16	314,269.39	117,179,711.01	82,314,182.90
140	2/1/2032	117,179,711.01	512,661.24	315,644.32	116,864,066.69	82,826,844.14
141	3/1/2032	116,864,066.69	511,280.29	317,025.26	116,547,041.43	83,338,124.43
142	4/1/2032	116,547,041.43	509,893.31	318,412.25	116,228,629.18	83,848,017.74
143	5/1/2032	116,228,629.18	508,500.25	319,805.30	115,908,823.88	84,356,517.99
144	6/1/2032	115,908,823.88	507,101.10	321,204.45	115,587,619.43	84,863,619.09
145	7/1/2032	115,587,619.43	505,695.84	322,609.72	115,265,009.71	85,369,314.93
146	8/1/2032	115,265,009.71	504,284.42	324,021.14	114,940,988.58	85,873,599.35
147	9/1/2032	114,940,988.58	502,866.83	325,438.73	114,615,549.85	86,376,466.17
148	10/1/2032	114,615,549.85	501,443.03	326,862.52	114,288,687.33	86,877,909.20
149	11/1/2032	114,288,687.33	500,013.01	328,292.55	113,960,394.78	87,377,922.21
150	12/1/2032	113,960,394.78	498,576.73	329,728.83	113,630,665.95	87,876,498.94
151	1/1/2033	113,630,665.95	497,134.16	331,171.39	113,299,494.56	88,373,633.10
152	2/1/2033	113,299,494.56	495,685.29	332,620.26	112,966,874.30	88,869,318.39
153	3/1/2033	112,966,874.30	494,230.08	334,075.48	112,632,798.82	89,363,548.46
154	4/1/2033	112,632,798.82	492,768.49	335,537.06	112,297,261.76	89,856,316.96
155	5/1/2033	112,297,261.76	491,300.52	337,005.03	111,960,256.73	90,347,617.48
156	6/1/2033	111,960,256.73	489,826.12	338,479.43	111,621,777.30	90,837,443.60
157	7/1/2033	111,621,777.30	488,345.28	339,960.28	111,281,817.02	91,325,788.88
158	8/1/2033	111,281,817.02	486,857.95	341,447.60	110,940,369.42	91,812,646.83
159	9/1/2033	110,940,369.42	485,364.12	342,941.44	110,597,427.98	92,298,010.94
160	10/1/2033	110,597,427.98	483,863.75	344,441.81	110,252,986.18	92,781,874.69
161	11/1/2033	110,252,986.18	482,356.81	345,948.74	109,907,037.44	93,264,231.51
162	12/1/2033	109,907,037.44	480,843.29	347,462.26	109,559,575.17	93,745,074.79
163	1/1/2034	109,559,575.17	479,323.14	348,982.41	109,210,592.76	94,224,397.94
164	2/1/2034	109,210,592.76	477,796.34	350,509.21	108,860,083.55	94,702,194.28
165	3/1/2034	108,860,083.55	476,262.87	352,042.69	108,508,040.86	95,178,457.14
166	4/1/2034	108,508,040.86	474,722.68	353,582.87	108,154,457.99	95,653,179.82
167	5/1/2034	108,154,457.99	473,175.75	355,129.80	107,799,328.19	96,126,355.58
168	6/1/2034	107,799,328.19	471,622.06	356,683.49	107,442,644.70	96,597,977.64
169	7/1/2034	107,442,644.70	470,061.57	358,243.98	107,084,400.72	97,068,039.21
170	8/1/2034	107,084,400.72	468,494.25	359,811.30	106,724,589.42	97,536,533.46
171	9/1/2034	106,724,589.42	466,920.08	361,385.47	106,363,203.94	98,003,453.54
172	10/1/2034	106,363,203.94	465,339.02	362,966.54	106,000,237.40	98,468,792.56
173	11/1/2034	106,000,237.40	463,751.04	364,554.51	105,635,682.89	98,932,543.60
174	12/1/2034	105,635,682.89	462,156.11	366,149.44	105,269,533.45	99,394,699.71

175	1/1/2035	105,269,533.45	460,554.21	367,751.34	104,901,782.11	99,855,253.92
176	2/1/2035	104,901,782.11	458,945.30	369,360.26	104,532,421.85	100,314,199.21
177	3/1/2035	104,532,421.85	457,329.35	370,976.21	104,161,445.64	100,771,528.56
178	4/1/2035	104,161,445.64	455,706.32	372,599.23	103,788,846.41	101,227,234.88
179	5/1/2035	103,788,846.41	454,076.20	374,229.35	103,414,617.06	101,681,311.09
180	6/1/2035	103,414,617.06	452,438.95	375,866.60	103,038,750.46	102,133,750.04
181	7/1/2035	103,038,750.46	450,794.53	377,511.02	102,661,239.44	102,584,544.57
182	8/1/2035	102,661,239.44	449,142.92	379,162.63	102,282,076.81	103,033,687.49
183	9/1/2035	102,282,076.81	447,484.09	380,821.47	101,901,255.34	103,481,171.58
184	10/1/2035	101,901,255.34	445,817.99	382,487.56	101,518,767.78	103,926,989.57
185	11/1/2035	101,518,767.78	444,144.61	384,160.94	101,134,606.84	104,371,134.18
186	12/1/2035	101,134,606.84	442,463.90	385,841.65	100,748,765.19	104,813,598.09
187	1/1/2036	100,748,765.19	440,775.85	387,529.71	100,361,235.48	105,254,373.93
188	2/1/2036	100,361,235.48	439,080.41	389,225.15	99,972,010.33	105,693,454.34
189	3/1/2036	99,972,010.33	437,377.55	390,928.01	99,581,082.33	106,130,831.88
190	4/1/2036	99,581,082.33	435,667.24	392,638.32	99,188,444.01	106,566,499.12
191	5/1/2036	99,188,444.01	433,949.44	394,356.11	98,794,087.90	107,000,448.56
192	6/1/2036	98,794,087.90	432,224.13	396,081.42	98,398,006.48	107,432,672.70
193	7/1/2036	98,398,006.48	430,491.28	397,814.27	98,000,192.20	107,863,163.97
194	8/1/2036	98,000,192.20	428,750.84	399,554.71	97,600,637.49	108,291,914.81
195	9/1/2036	97,600,637.49	427,002.79	401,302.76	97,199,334.73	108,718,917.60
196	10/1/2036	97,199,334.73	425,247.09	403,058.46	96,796,276.26	109,144,164.69
197	11/1/2036	96,796,276.26	423,483.71	404,821.84	96,391,454.42	109,567,648.40
198	12/1/2036	96,391,454.42	421,712.61	406,592.94	95,984,861.48	109,989,361.02
199	1/1/2037	95,984,861.48	419,933.77	408,371.78	95,576,489.69	110,409,294.78
200	2/1/2037	95,576,489.69	418,147.14	410,158.41	95,166,331.28	110,827,441.93
201	3/1/2037	95,166,331.28	416,352.70	411,952.85	94,754,378.43	111,243,794.63
202	4/1/2037	94,754,378.43	414,550.41	413,755.15	94,340,623.28	111,658,345.03
203	5/1/2037	94,340,623.28	412,740.23	415,565.33	93,925,057.96	112,071,085.26
204	6/1/2037	93,925,057.96	410,922.13	417,383.42	93,507,674.53	112,482,007.39
205	7/1/2037	93,507,674.53	409,096.08	419,209.48	93,088,465.05	112,891,103.46
206	8/1/2037	93,088,465.05	407,262.03	421,043.52	92,667,421.54	113,298,365.50
207	9/1/2037	92,667,421.54	405,419.97	422,885.58	92,244,535.95	113,703,785.47
208	10/1/2037	92,244,535.95	403,569.84	424,735.71	91,819,800.24	114,107,355.31
209	11/1/2037	91,819,800.24	401,711.63	426,593.93	91,393,206.32	114,509,066.94
210	12/1/2037	91,393,206.32	399,845.28	428,460.28	90,964,746.04	114,908,912.22
211	1/1/2038	90,964,746.04	397,970.76	430,334.79	90,534,411.25	115,306,882.98
212	2/1/2038	90,534,411.25	396,088.05	432,217.50	90,102,193.75	115,702,971.03
213	3/1/2038	90,102,193.75	394,197.10	434,108.46	89,668,085.29	116,097,168.13
214	4/1/2038	89,668,085.29	392,297.87	436,007.68	89,232,077.61	116,489,466.00
215	5/1/2038	89,232,077.61	390,390.34	437,915.21	88,794,162.40	116,879,856.34
216	6/1/2038	88,794,162.40	388,474.46	439,831.09	88,354,331.31	117,268,330.80
217	7/1/2038	88,354,331.31	386,550.20	441,755.35	87,912,575.95	117,654,881.00
218	8/1/2038	87,912,575.95	384,617.52	443,688.03	87,468,887.92	118,039,498.52
219	9/1/2038	87,468,887.92	382,676.38	445,629.17	87,023,258.75	118,422,174.90
220	10/1/2038	87,023,258.75	380,726.76	447,578.80	86,575,679.95	118,802,901.66
221	11/1/2038	86,575,679.95	378,768.60	449,536.95	86,126,143.00	119,181,670.26
222	12/1/2038	86,126,143.00	376,801.88	451,503.68	85,674,639.32	119,558,472.14
223	1/1/2039	85,674,639.32	374,826.55	453,479.01	85,221,160.32	119,933,298.68
224	2/1/2039	85,221,160.32	372,842.58	455,462.98	84,765,697.34	120,306,141.26
225	3/1/2039	84,765,697.34	370,849.93	457,455.63	84,308,241.71	120,676,991.18
226	4/1/2039	84,308,241.71	368,848.56	459,457.00	83,848,784.72	121,045,839.74
227	5/1/2039	83,848,784.72	366,838.43	461,467.12	83,387,317.60	121,412,678.18
228	6/1/2039	83,387,317.60	364,819.51	463,486.04	82,923,831.56	121,777,497.69
229	7/1/2039	82,923,831.56	362,791.76	465,513.79	82,458,317.77	122,140,289.45
230	8/1/2039	82,458,317.77	360,755.14	467,550.41	81,990,767.35	122,501,044.59
231	9/1/2039	81,990,767.35	358,709.61	469,595.95	81,521,171.41	122,859,754.20
232	10/1/2039	81,521,171.41	356,655.12	471,650.43	81,049,520.98	123,216,409.33
233	11/1/2039	81,049,520.98	354,591.65	473,713.90	80,575,807.08	123,571,000.98
234	12/1/2039	80,575,807.08	352,519.16	475,786.40	80,100,020.68	123,923,520.14
235	1/1/2040	80,100,020.68	350,437.59	477,867.96	79,622,152.72	124,273,957.73
236	2/1/2040	79,622,152.72	348,346.92	479,958.64	79,142,194.09	124,622,304.64
237	3/1/2040	79,142,194.09	346,247.10	482,058.45	78,660,135.63	124,968,551.74
238	4/1/2040	78,660,135.63	344,138.09	484,167.46	78,175,968.17	125,312,689.84

239	5/1/2040	78,175,968.17	342,019.86	486,285.69	77,689,682.48	125,654,709.70
240	6/1/2040	77,689,682.48	339,892.36	488,413.19	77,201,269.29	125,994,602.06
241	7/1/2040	77,201,269.29	337,755.55	490,550.00	76,710,719.29	126,332,357.61
242	8/1/2040	76,710,719.29	335,609.40	492,696.16	76,218,023.13	126,667,967.01
243	9/1/2040	76,218,023.13	333,453.85	494,851.70	75,723,171.43	127,001,420.86
244	10/1/2040	75,723,171.43	331,288.88	497,016.68	75,226,154.75	127,332,709.73
245	11/1/2040	75,226,154.75	329,114.43	499,191.13	74,726,963.62	127,661,824.16
246	12/1/2040	74,726,963.62	326,930.47	501,375.09	74,225,588.54	127,988,754.63
247	1/1/2041	74,225,588.54	324,736.95	503,568.60	73,722,019.93	128,313,491.58
248	2/1/2041	73,722,019.93	322,533.84	505,771.72	73,216,248.22	128,636,025.41
249	3/1/2041	73,216,248.22	320,321.09	507,984.47	72,708,263.75	128,956,346.50
250	4/1/2041	72,708,263.75	318,098.65	510,206.90	72,198,056.85	129,274,445.15
251	5/1/2041	72,198,056.85	315,866.50	512,439.05	71,685,617.80	129,590,311.65
252	6/1/2041	71,685,617.80	313,624.58	514,680.98	71,170,936.82	129,903,936.23
253	7/1/2041	71,170,936.82	311,372.85	516,932.70	70,654,004.12	130,215,309.08
254	8/1/2041	70,654,004.12	309,111.27	519,194.29	70,134,809.83	130,524,420.35
255	9/1/2041	70,134,809.83	306,839.79	521,465.76	69,613,344.07	130,831,260.14
256	10/1/2041	69,613,344.07	304,558.38	523,747.17	69,089,596.90	131,135,818.52
257	11/1/2041	69,089,596.90	302,266.99	526,038.57	68,563,558.33	131,438,085.51
258	12/1/2041	68,563,558.33	299,965.57	528,339.99	68,035,218.35	131,738,051.08
259	1/1/2042	68,035,218.35	297,654.08	530,651.47	67,504,566.87	132,035,705.16
260	2/1/2042	67,504,566.87	295,332.48	532,973.07	66,971,593.80	132,331,037.64
261	3/1/2042	66,971,593.80	293,000.72	535,304.83	66,436,288.97	132,624,038.36
262	4/1/2042	66,436,288.97	290,658.76	537,646.79	65,898,642.18	132,914,697.12
263	5/1/2042	65,898,642.18	288,306.56	539,998.99	65,358,643.19	133,203,003.68
264	6/1/2042	65,358,643.19	285,944.06	542,361.49	64,816,281.70	133,488,947.75
265	7/1/2042	64,816,281.70	283,571.23	544,734.32	64,271,547.38	133,772,518.98
266	8/1/2042	64,271,547.38	281,188.02	547,117.53	63,724,429.84	134,053,707.00
267	9/1/2042	63,724,429.84	278,794.38	549,511.17	63,174,918.67	134,332,501.38
268	10/1/2042	63,174,918.67	276,390.27	551,915.28	62,623,003.39	134,608,891.65
269	11/1/2042	62,623,003.39	273,975.64	554,329.91	62,068,673.47	134,882,867.29
270	12/1/2042	62,068,673.47	271,550.45	556,755.11	61,511,918.37	135,154,417.73
271	1/1/2043	61,511,918.37	269,114.64	559,190.91	60,952,727.46	135,423,532.38
272	2/1/2043	60,952,727.46	266,668.18	561,637.37	60,391,090.09	135,690,200.56
273	3/1/2043	60,391,090.09	264,211.02	564,094.53	59,826,995.55	135,954,411.58
274	4/1/2043	59,826,995.55	261,743.11	566,562.45	59,260,433.10	136,216,154.68
275	5/1/2043	59,260,433.10	259,264.39	569,041.16	58,691,391.95	136,475,419.08
276	6/1/2043	58,691,391.95	256,774.84	571,530.71	58,119,861.23	136,732,193.92
277	7/1/2043	58,119,861.23	254,274.39	574,031.16	57,545,830.07	136,986,468.31
278	8/1/2043	57,545,830.07	251,763.01	576,542.55	56,969,287.53	137,238,231.32
279	9/1/2043	56,969,287.53	249,240.63	579,064.92	56,390,222.60	137,487,471.95
280	10/1/2043	56,390,222.60	246,707.22	581,598.33	55,808,624.28	137,734,179.18
281	11/1/2043	55,808,624.28	244,162.73	584,142.82	55,224,481.45	137,978,341.91
282	12/1/2043	55,224,481.45	241,607.11	586,698.45	54,637,783.01	138,219,949.01
283	1/1/2044	54,637,783.01	239,040.30	589,265.25	54,048,517.75	138,458,989.31
284	2/1/2044	54,048,517.75	236,462.27	591,843.29	53,456,674.47	138,695,451.58
285	3/1/2044	53,456,674.47	233,872.95	594,432.60	52,862,241.86	138,929,324.53
286	4/1/2044	52,862,241.86	231,272.31	597,033.25	52,265,208.62	139,160,596.84
287	5/1/2044	52,265,208.62	228,660.29	599,645.27	51,665,563.35	139,389,257.13
288	6/1/2044	51,665,563.35	226,036.84	602,268.71	51,063,294.64	139,615,293.96
289	7/1/2044	51,063,294.64	223,401.91	604,903.64	50,458,391.00	139,838,695.88
290	8/1/2044	50,458,391.00	220,755.46	607,550.09	49,850,840.91	140,059,451.34
291	9/1/2044	49,850,840.91	218,097.43	610,208.12	49,240,632.78	140,277,548.77
292	10/1/2044	49,240,632.78	215,427.77	612,877.78	48,627,755.00	140,492,976.54
293	11/1/2044	48,627,755.00	212,746.43	615,559.13	48,012,195.87	140,705,722.97
294	12/1/2044	48,012,195.87	210,053.36	618,252.20	47,393,943.68	140,915,776.32
295	1/1/2045	47,393,943.68	207,348.50	620,957.05	46,772,986.63	141,123,124.83
296	2/1/2045	46,772,986.63	204,631.82	623,673.74	46,149,312.89	141,327,756.64
297	3/1/2045	46,149,312.89	201,903.24	626,402.31	45,522,910.58	141,529,659.89
298	4/1/2045	45,522,910.58	199,162.73	629,142.82	44,893,767.76	141,728,822.62
299	5/1/2045	44,893,767.76	196,410.23	631,895.32	44,261,872.44	141,925,232.85
300	6/1/2045	44,261,872.44	193,645.69	634,659.86	43,627,212.58	142,118,878.55
301	7/1/2045	43,627,212.58	190,869.06	637,436.50	42,989,776.08	142,309,747.60
302	8/1/2045	42,989,776.08	188,080.27	640,225.28	42,349,550.80	142,497,827.87

303	9/1/2045	42,349,550.80	185,279.28	643,026.27	41,706,524.53	142,683,107.16
304	10/1/2045	41,706,524.53	182,466.04	645,839.51	41,060,685.02	142,865,573.20
305	11/1/2045	41,060,685.02	179,640.50	648,665.06	40,412,019.97	143,045,213.70
306	12/1/2045	40,412,019.97	176,802.59	651,502.97	39,760,517.00	143,222,016.29
307	1/1/2046	39,760,517.00	173,952.26	654,353.29	39,106,163.71	143,395,968.55
308	2/1/2046	39,106,163.71	171,089.47	657,216.09	38,448,947.62	143,567,058.01
309	3/1/2046	38,448,947.62	168,214.15	660,091.41	37,788,856.22	143,735,272.16
310	4/1/2046	37,788,856.22	165,326.25	662,979.31	37,125,876.91	143,900,598.40
311	5/1/2046	37,125,876.91	162,425.71	665,879.84	36,459,997.07	144,063,024.12
312	6/1/2046	36,459,997.07	159,512.49	668,793.07	35,791,204.00	144,222,536.60
313	7/1/2046	35,791,204.00	156,586.52	671,719.04	35,119,484.97	144,379,123.12
314	8/1/2046	35,119,484.97	153,647.75	674,657.81	34,444,827.16	144,532,770.87
315	9/1/2046	34,444,827.16	150,696.12	677,609.43	33,767,217.72	144,683,466.99
316	10/1/2046	33,767,217.72	147,731.58	680,573.98	33,086,643.75	144,831,198.56
317	11/1/2046	33,086,643.75	144,754.07	683,551.49	32,403,092.26	144,975,952.63
318	12/1/2046	32,403,092.26	141,763.53	686,542.02	31,716,550.24	145,117,716.16
319	1/1/2047	31,716,550.24	138,759.91	689,545.65	31,027,004.59	145,256,476.07
320	2/1/2047	31,027,004.59	135,743.15	692,562.41	30,334,442.18	145,392,219.21
321	3/1/2047	30,334,442.18	132,713.18	695,592.37	29,638,849.81	145,524,932.40
322	4/1/2047	29,638,849.81	129,669.97	698,635.59	28,940,214.23	145,654,602.36
323	5/1/2047	28,940,214.23	126,613.44	701,692.12	28,238,522.11	145,781,215.80
324	6/1/2047	28,238,522.11	123,543.53	704,762.02	27,533,760.09	145,904,759.34
325	7/1/2047	27,533,760.09	120,460.20	707,845.35	26,825,914.74	146,025,219.54
326	8/1/2047	26,825,914.74	117,363.38	710,942.18	26,114,972.57	146,142,582.91
327	9/1/2047	26,114,972.57	114,253.00	714,052.55	25,400,920.02	146,256,835.92
328	10/1/2047	25,400,920.02	111,129.03	717,176.53	24,683,743.49	146,367,964.94
329	11/1/2047	24,683,743.49	107,991.38	720,314.18	23,963,429.31	146,475,956.32
330	12/1/2047	23,963,429.31	104,840.00	723,465.55	23,239,963.76	146,580,796.32
331	1/1/2048	23,239,963.76	101,674.84	726,630.71	22,513,333.05	146,682,471.17
332	2/1/2048	22,513,333.05	98,495.83	729,809.72	21,783,523.33	146,780,967.00
333	3/1/2048	21,783,523.33	95,302.91	733,002.64	21,050,520.69	146,876,269.91
334	4/1/2048	21,050,520.69	92,096.03	736,209.53	20,314,311.17	146,968,365.94
335	5/1/2048	20,314,311.17	88,875.11	739,430.44	19,574,880.73	147,057,241.05
336	6/1/2048	19,574,880.73	85,640.10	742,665.45	18,832,215.28	147,142,881.15
337	7/1/2048	18,832,215.28	82,390.94	745,914.61	18,086,300.66	147,225,272.10
338	8/1/2048	18,086,300.66	79,127.57	749,177.99	17,337,122.68	147,304,399.66
339	9/1/2048	17,337,122.68	75,849.91	752,455.64	16,584,667.03	147,380,249.57

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.

New York State Department of Health
Certificate of Need Application

Schedule 20A

Office of Mental Health Program

This information is **required of Article 28 hospitals and diagnostic and treatment centers for projects that include mental health programs** subject to an operating certificate or prior approval by the Office of Mental Health under Article 31 of the Mental Hygiene Law (MHL). These projects include a new mental health program, or a new site, or modification to an existing program. Per MHL Article 31, prior consultation with the Local Government Unit and local Office of Mental Health Field Office is required before submission of the Article 28 application.

Section A - Attachments for New Program or New Satellite Location

N/A – No New Program or New Satellite Location

1. **Program and Service Area**
   a. Identify the type of mental health program to be provided.
   b. Define the geographic or political boundaries of the area to be served by the proposed program.
   c. Describe how the proposed program will function within the mental health system in the area to be served.

   N/A

2. **Problems and Needs**
   a. Describe the target population for the program qualitatively and quantitatively. Describe problems of the target population and their families, and describe how the proposed program will address these problems.
   b. Describe how your organization currently serves the target population (if applicable).
   c. Provide any other information supporting need for the proposed program.

   N/A

3. **Access**
   a. Describe how the program will serve the poor and the medically indigent.
   b. Describe the mechanisms by which the program will address the cultural and ethnic backgrounds in the treatment of the population in the service area.
   c. Describe the mechanisms for participation of consumer representation within the governing body (if applicable).
   d. Describe plans to enable persons with physical disabilities to access services, consistent with the characteristics of the population to be served.
   e. Indicate the transportation arrangements through which individuals will access the program.

   N/A

4. **Continuity of Care**
   a. Describe a plan to ensure continuity of care within the mental health system and with other service systems. Identify specific providers to ensure linkages among programs.
   b. For outpatient programs, describe a plan by which patients in the program will be assisted during hours when the program is not in operation.

   N/A

5. **Implementation**
Describe start-up or phase-in activities necessary to implement the program. Include timeframes in your description.

N/A

6. **Functional Program**
   a. Mission - Provide an overview of the proposed program and describe the treatment philosophy.
   b. Organization - Describe the lines of authority from the governing body to the proposed program. Indicate the relationship of the program to other programs operated by your agency.
   c. Goals and Objectives - Describe the goals, objectives, and expected outcomes of the program. Indicate average length of stay.
   d. Admission - Describe admission criteria, policies, and procedures. Include inclusionary and exclusionary criteria, process, timeframes, record keeping, and procedures for notifying families and programs in which recipients are currently admitted.
   e. Discharge - Describe discharge criteria, policies, and procedures. Include process, timeframes, record keeping, and procedures for notifying families and programs to which recipients will be referred for further services.
   f. Services - Provide a detailed description of all services available to recipients admitted to the program. Specify how these services will be provided and the staff position responsible for providing the service. Identify the provider of any services to be delivered by other than the proposed program. For programs serving children, describe plans to coordinate with the family and the school.
   g. Staffing - Provide a staffing plan for the program. Include descriptions of the qualifications and duties for each staff position.
   h. Quality Assurance/Improvement - Describe your plans for utilization review, incident management, and internal monitoring.
   i. Premises - Provide a description of the premises to be used by the program. Include appropriately labeled sketch drawings showing use and dimensions of rooms.
   j. Waivers - Identity any waiver requests and provide justification for the request. Indicate the effect on your proposed program if the request is denied.

N/A

7. **Fiscal**
   a. Unless provided elsewhere in this application, submit a proposed budget for the first and second year of full operation of the mental health program.
   b. If Medicaid revenue is included, indicate the source and availability of the state share of Medicaid for projects other than Article 31 Clinics.

N/A

Section B - Attachments for Program Expansion at Existing Program or Site

N/A – No Program Expansion

1. Identify the program.

N/A

2. Provide justification and data supporting the need for the expansion.

N/A

3. Describe the impact of the expansion on services, staffing, caseload and space.

N/A

4. Provide a detailed description of services available to recipients as a result of the proposed expansion. Specify how these services will be provided and the staff positions responsible for providing the service. Identify the provider of any services to be delivered by other than the provider of the licensed program. For programs expanding to serve children, describe plans to coordinate with the family and the school.

N/A

5. Indicate the fiscal impact of the expansion. Provide the incremental increases to expenses and revenues. If additional Medicaid is proposed to support the expansion, for projects other than Article 31 clinics, indicate the source and availability of the state share of Medicaid.

N/A

Section C - Attachments for Other Projects Requiring Prior Approval of OMH
In all projects, identify the program affected.

1. **Reduce Existing Program**

   a. Indicate proposed effective date for reduction.
   b. Describe the reasons for the reduction and the impact (if any) on individuals currently receiving services.

Mohawk Valley Health System (MVHS) is currently certified to operate 24 adult psychiatric beds at St. Elizabeth Medical Center (St. Elizabeth) and 26 adult psychiatric beds at Faxton-St. Luke's Hospital (St. Luke's), for a total of 50 adult psychiatric beds. Through its overall transformation project, MVHS will relocate the inpatient psychiatric beds at St. Elizabeth and St. Luke's to the new hospital campus, and it will decertify six (6) of the adult psychiatric beds, resulting in the operation of 44 adult psychiatric beds on the new campus.

a. **The effective date of the reduction of the adult inpatient psychiatric beds is January 1, 2022, which represents the beginning to Year 1 of operations for this project.**

b. **When the inpatient utilization of both St. Elizabeth's and St. Luke's is combined, in 2016, the facilities have an overall occupancy rate of 71.5%, given the 50 certified inpatient psychiatric beds at the combined facilities. Given the same utilization statistics and the proposed number of psychiatric beds (44), the combined facilities have an estimated 81.3% occupancy. Please refer to these statistics in the following table:**

	Occupancy Rate	
	Current Beds (50)	Proposed Beds (44)
Psychiatric	71.5%	81.3%

Through the overall project, MVHS will decertify six (6) inpatient psychiatric beds (i.e., from 50 to 44 beds). Not only is this decertification supported by the historical occupancy rates for inpatient psychiatric beds noted in the table above, it is also supported by the following statistics:

- **Although the number of patient days for inpatient psychiatric patients at the two (2) combined MVHS facilities increased from 2012 to its peak in 2015, it has decreased considerably since 2015. Based upon 2017 data through September 30, 2017, the occupancy rate of the 50 inpatient psychiatric beds was 69.6% (down from the peak occupancy rate of 81.8% in 2015), meaning that about 15 beds remained unused, on average, during this time in 2017.**

- **A large and growing percentage of inpatient psychiatric cases are originating from outside of Oneida and Herkimer Counties, which means that residents are likely bypassing other inpatient psychiatric units that are closer to home for many residents. These statistics are as follows:**

Number and Percentage of MVHS Inpatient Psychiatric Discharges from Oneida/Herkimer Counties vs. All Other Counties, 2012-YTD 2017

	2012	2013	2014	2015	2016	YTD 2017*
Oneida/Herkimer Counties	1,812	1,707	1,728	1,803	1,766	1,172
All Other Counties	397	450	548	611	540	521
TOTAL	2,209	2,157	2,276	2,414	2,306	1,693

Oneida/Herkimer Counties	82.0%	79.1%	75.9%	74.7%	76.6%	69.2%
All Other Counties	18.0%	20.9%	24.1%	25.3%	23.4%	30.8%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Mohawk Valley Health System

In 2012, only 18.0% of the inpatient psychiatric cases at MVHS were from patients residing outside of Oneida and Herkimer Counties. By 2017 (using data through September 30, 2017), 30.8% of the inpatient psychiatric cases at MVHS were from patients residing outside of Oneida and Herkimer Counties. Based upon a review of inpatient psychiatric bed projects within the "Central New York" and the "Northeast" areas of New York State on NYSE-CON (which includes Oneida and Herkimer Counties, as well as the surrounding region), since 2012, the only inpatient psychiatric project that was implemented was the addition of one (1) psychiatric bed at Rome Memorial Hospital (Oneida County), which went from 11 beds to 12 beds through Project No. 132140. The fact that no psychiatric beds were decertified means that many of the patients who travel from outside of Oneida or Herkimer Counties to receive inpatient psychiatric care at MVHS can likely be served on inpatient psychiatric units located closer to their homes. Nevertheless, it is clear that they are attracted to MVHS facilities for various reasons (one of which is likely the high quality of care provided at its facilities).

- **MVHS expects to continue to experience a decrease in its inpatient psychiatric utilization, largely due to the transition of care from the inpatient realm to the outpatient realm, and from the expanded use of front-line outpatient behavioral health services. To this end, MVHS and its two (2) hospital facilities operate numerous extension clinics throughout Utica and the surrounding region that provide outpatient behavioral health services. MVHS is continuing to work with its partners through the DSRIP program to integrate behavioral health services into the primary care setting.**

Please also refer to the Project Narrative (under the Schedule 1 Attachment) for additional information.

2. **Closure of Program or Site**

a. Indicate proposed effective date of closure.
b. Describe the reasons for closing the program or site.
c. Submit a transition plan showing that recipients will be linked to appropriate alternative programs, the alternative programs have agreed to accept the referrals, recipient transportation needs will be addressed, and follow-up will occur to confirm recipient linkage to programs.
d. If the rationale for closure includes fiscal considerations, provide documentation to substantiate the lack of fiscal viability in the long-term.
e. Submit a plan for safeguarding recipient records and financial accounts.
f. Describe the process and timeframe for evaluation and placement of recipients and completion of other activities to conclude the affairs of the program.

a. **The effective date of the "closure" of the adult inpatient psychiatric beds at St. Elizabeth and St. Luke's is January 1, 2022, which represents the beginning to Year 1 of operations for this project. As noted above, the inpatient psychiatric units at St. Elizabeth and St. Luke's will not be "closed". Instead, they will be relocated to the new hospital campus.**

b. **As noted above, the inpatient psychiatric units at St. Elizabeth and St. Luke's will not be "closed". Instead, they will be relocated to the new hospital campus.**

c. **All inpatient psychiatric patients will be relocated to the new hospital campus, upon its opening.**

These patients will be given a choice to continue to be served by MVHS at its new hospital campus, or to be transferred to another inpatient psychiatric unit such as the 12-bed unit at Rome Memorial Hospital in Rome (Oneida County), New York. Please refer to the Schedule 20 Attachment for two (2) Transition Plans – one for St. Elizabeth and one for St. Luke's – associated with this project.

d. N/A – The applicant believes that the proposed 44 inpatient psychiatric beds at its new hospital campus are sufficient to accommodate the needs of the behavioral health population. Utilization concerns are the primary rationale to reduce its inpatient psychiatric beds from 50 to 44.

e. Hard-copies of all recipient records and financial accounts will be relocated to the new hospital campus. All electronic recipient records and financial accounts will be maintained by MVHS. Please refer to the Schedule 20 Attachment for the two (2) Transition Plans that include information pertaining to the safeguarding of recipient records and financial accounts.

f. The inpatient psychiatric program of MVHS will not be closed. The inpatient beds of both St. Elizabeth and St. Luke's will be relocated from their current locations to the new hospital campus in Utica.

3. **Change in Location**

a. Indicate proposed effective date of relocation.
b. Identify the new location.
c. Describe the reasons for the relocation.
d. Describe how access and transportation needs will be addressed.
e. Provide a description of the premises to be used. Include appropriately labeled sketch drawings showing use and dimensions of rooms.
f. Provide a Certificate of Occupancy or equivalent from the local buildings jurisdiction prior to occupancy.
g. If program relocates to new county or borough, complete Section A (1-7).

a. The effective date of relocation is January 1, 2022, which represents the beginning to Year 1 of operations for this project (i.e., it represents the date that the new hospital campus, including the 44 inpatient psychiatric beds, will be opened).

b. MVHS is currently certified to operate 24 adult psychiatric beds at St. Elizabeth Medical Center (St. Elizabeth) and 26 adult psychiatric beds at Faxton-St. Luke's Hospital (St. Luke's), for a total of 50 adult psychiatric beds. Through this project, MVHS will relocate the inpatient psychiatric beds at St. Elizabeth and St. Luke's to the new hospital campus, and it will decertify six (6) of the adult psychiatric beds, resulting in the operation of 44 adult psychiatric beds on the new campus. The new, consolidated hospital campus will be located on a 25-acre parcel of land bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street.

c. 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 (i.e., the creation of a new hospital campus), which will result in the transformation of healthcare services in the region.

d. **The proposed new hospital campus will be located close to major roads, including Route 90 (New York State Thruway), Route 790, Route 12 and Route 5A (Oriskany Street), and it will be highly accessible to a number of routes in the Central New York Regional Transportation Authority (Centro) bus system in Utica.**

e. **Please refer to the Schedule 6 Attachment for architectural documents, including an architectural narrative, functional space program, schematic drawings and other architectural items associated with this project.**

f. **MVHS will provide a Certificate of Occupancy to the NYSOMH/NYSDOH prior to occupancy of the new hospital campus.**

g. **N/A – The new hospital campus will be located within the same county (Oneida County) as both St. Elizabeth Medical Center and Faxton-St. Luke's Hospital.**

4. **Change of Sponsor**
   a. Identify new sponsor and current sponsor.
   b. Describe the reasons for changing sponsorship of the program(s).
   c. Include written concurrence from the current sponsor for transfer of the program(s). If current sponsor is a corporation include resolution from the Board of Directors.
   d. Describe any changes to be made in operation of the program(s).
   e. Describe the qualifications of the new sponsor for the operation of mental health programs.
   f. Indicate any financial considerations involved in the change of sponsor.
   g. Submit a transition plan, including timeframes, for the change of sponsor.

N/A – No Change of Sponsor

5. **Capital Project**
   a. Describe the reasons for the project.

Not only is this decertification supported by the historical occupancy rates for inpatient psychiatric beds noted in the response to Question 1(b) above, it is also supported by the following statistics:

- **Although the number of patient days for inpatient psychiatric patients at the two (2) combined MVHS facilities increased from 2012 to its peak in 2015, it has decreased considerably since 2015. Based upon 2017 data through September 30, 2017, the occupancy rate of the 50 inpatient psychiatric beds was 69.6% (down from the peak occupancy rate of 81.8% in 2015), meaning that about 15 beds remained unused, on average, during this time in 2017.**

- **A large and growing percentage of inpatient psychiatric cases are originating from outside of Oneida and Herkimer Counties, which means that residents are likely bypassing other inpatient psychiatric units that are closer to home for many residents. These statistics are as follows:**

Number and Percentage of MVHS Inpatient Psychiatric Discharges from Oneida/Herkimer Counties vs. All Other Counties, 2012-YTD 2017

	2012	2013	2014	2015	2016	YTD 2017*
Oneida/Herkimer Counties	1,812	1,707	1,728	1,803	1,766	1,172
All Other Counties	397	450	548	611	540	521

TOTAL	2,209	2,157	2,276	2,414	2,306	1,693
Oneida/Herkimer Counties	82.0%	79.1%	75.9%	74.7%	76.6%	69.2%
All Other Counties	18.0%	20.9%	24.1%	25.3%	23.4%	30.8%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Mohawk Valley Health System

In 2012, only 18.0% of the inpatient psychiatric cases at MVHS were from patients residing outside of Oneida and Herkimer Counties. By 2017 (using data through September 30, 2017), 30.8% of the inpatient psychiatric cases at MVHS were from patients residing outside of Oneida and Herkimer Counties. Based upon a review of inpatient psychiatric bed projects within the "Central New York" and the "Northeast" areas of New York State on NYSE-CON (which includes Oneida and Herkimer Counties, as well as the surrounding region), since 2012, the only inpatient psychiatric project that was implemented was the addition of one (1) psychiatric bed at Rome Memorial Hospital (Oneida County), which went from 11 beds to 12 beds through Project No. 132140. The fact that no psychiatric beds were decertified means that many of the patients who travel from outside of Oneida or Herkimer Counties to receive inpatient psychiatric care at MVHS can likely be served on inpatient psychiatric units located closer to their homes. Nevertheless, it is clear that they are attracted to MVHS facilities for various reasons (one of which is likely the high quality of care provided at its facilities).

- **MVHS expects to continue to experience a decrease in its inpatient psychiatric utilization, largely due to the transition of care from the inpatient realm to the outpatient realm, and from the expanded use of front-line outpatient behavioral health services. To this end, MVHS and its two (2) hospital facilities operate numerous extension clinics throughout Utica and the surrounding region that provide outpatient behavioral health services. MVHS is continuing to work with its partners through the DSRIP program to integrate behavioral health services into the primary care setting.**

Please also refer to the Project Narrative (under the Schedule 1 Attachment) for additional information. Please also refer to the C.O.N. Schedule 8B for capital cost information associated with the new hospital campus project.

6. **Change in Population Served**
   b. Describe the population currently served in the program. Include quantitative and qualitative data.
   c. Describe the population being added to or deleted from the program. Include quantitative and qualitative data.
   d. Explain the reasons for the change in population.
   e. If adding population, provide justification and data to support the need to serve this population.
   f. Describe the impact of the addition or deletion on the existing program in terms of services, staffing, staff expertise, linkages, space, capacity or caseload, and fiscal (including the impact on the state share of Medicaid, for projects other than Article 31 Clinics).

N/A – No Change in Population Served

7. **Other Projects**
   a. Describe the project and the reasons for requesting approval. If an emergency situation, fully describe the nature of the emergency and the necessity for approval.
   b. If a management contract or clinical services contract, provide:
      I. Reasons for entering into the proposed contract
      II. Copy of the proposed contract.
      III. Background on the principals, officers, and directors of the organization.
      IV. Information in sufficient detail to enable review of the project pursuant to Part

551.7(a)(15) of Title14 NYCRR.

N/A – See Responses to Question Nos. 1, 2, 3 and 5.

New York State Department of Health
Certificate of Need Application

Schedule 20B

Office of Alcoholism and Substance Abuse Services Program

NOT APPLICABLE

This information is required of Article 28 hospitals and diagnostic and treatment centers for projects that include Chemical Dependency (CD) programs subject to an operating certificate or prior approval by the Office of Alcoholism and Substance Abuse Services (OASAS) under Article 32 of the Mental Hygiene Law (MHL). These projects include a new Chemical Dependency (CD) program, or a new site, or a modification to an existing program. Per MHL Article 32, prior consultation with the Local Governmental Unit (LGU) and local OASAS Field Office is required before submission of the Article 28 application.

Section A – Attachments for New Service, New Additional Location or Capacity Increase of beds

1 Program and Service Area
- a) Identify the type CD treatment service to be provided.
- b) Provide a description of the area where the applicant plans to provide CD services.
- c) Describe how the proposed program will function within the network of CD provider in this area.

N/A

2 Need
- a) Provide an assessment of the need for the services requested.
- b) Describe how your organization currently serves the target population (if applicable).
- c) Provide any other information supporting need for the proposed program.

N/A

3 Functional Program
- a) Mission - Describe the applicant's approach/philosophy regarding the treatment of chemical dependence; include use of self-help services, medication, individual/group counseling and other treatment techniques.
- b) Organization – Describe the lines of authority from the governing body to the proposed program. Indicate the relationship of the program to other programs operated by your agency.
- c) Goals and Objectives - Provide a detailed list including, but not limited to: expected outcomes for patients, planned numbers and frequency of service delivery, planned length of stay and other proposed measures of success.
- d) Policies and Procedures – Submit detailed CD operational policies and procedures in accord with the proposed services to be provided. (not required when adding an additional location or a capacity increase of beds)
- e) Additional Locations – Indicate current annual number units of services at main location and projected annual number units of services at the additional location.
- f) Services – Describe the proposed operating schedule including days and hours.
- g) Staffing – Provide a staffing plan for the program. Include descriptions of qualifications and duties for each staff person.
- h) Premises – Provide a description of the premises to be used by the program. Include floor plan sketches drawn to scale.
- i) Provide a Certificate of Occupancy or equivalent from the local buildings jurisdiction.

N/A

4 Fiscal

a) Submit a proposed budget for pre-operational expenses and first year of full operation.

N/A

5 Implementation

Describe start-up or phase-in activities necessary to implement the program. Include timeframes in your description.

N/A

Section B – Relocation an existing service.

1 Change in Location

a) Indicate the proposed effective date of relocation.
b) Identify the new location.
c) Describe the reasons for the relocation.
d) Describe how access and transportation needs will be addressed.
e) Provide a description of the premises to be used by the program. Include floor plan sketches drawn to scale.
f) Provide a Certificate of Occupancy or equivalent from the local buildings jurisdiction.
g) If the program relocates to a new county or borough, Complete Section A (1).

N/A

Section C – Change of Sponsor

1 Change in Sponsor

a) Identify the new sponsor and the current sponsor.
b) Describe the reasons for changing sponsorship of the program(s).
c) Include written concurrence from the current sponsor for transfer of the program(s). If current sponsor is a corporation, include a resolution from the Board of Directors.
d) Describe any changes to be made in the operation of the program(s).
e) Describe the qualifications of the new sponsor for the operation of CD programs.
f) Indicate any financial considerations involved in the change of sponsor.
g) Submit a transition plan, including timeframes, for the change of sponsor.

N/A

SCHEDULE 20 ATTACHMENT

MOHAWK VALLEY HEALTH SYSTEM

TRANSITION PLANS (INPATIENT PSYCHIATRIC UNITS)

1. St. Elizabeth Medical Center
2. Faxton-St. Luke's Hospital

TRANSITION PLAN

ST. ELIZABETH MEDICAL CENTER

24-BED INPATIENT PSYCHIATRIC UNIT

Purpose

To ensure the smooth transition of inpatient psychiatric treatment as the 24-bed inpatient psychiatric unit is relocated from its current location at 2209 Genesee Street, Utica (Oneida County), New York 13501 to a new hospital campus on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street. St. Elizabeth Medical Center (SEMC) / Mohawk Valley Health System (MVHS), the New York State Department of Health (NYSDOH) and the New York State Office of Mental Health (NYSOMH) will work collaboratively during the transition process.

Anticipated Date of Transition

The date of transition to the new hospital campus is anticipated to be on or about January 1, 2022 and is dependent on Mohawk Valley Health System receiving all necessary approvals from NYSDOH and NYSOMH for it to construct a new hospital campus in Utica, New York. Furthermore, this date is based upon the timing of the actual construction of the new hospital campus.

Proposed Schedule for Phasing of Transition

Based on the construction timing for the project, SEMC/MVHS will work to identify patients who can appropriately be discharged to community care from the inpatient unit on the existing SEMC campus, to lessen the number of patients who need to be transferred to the new hospital campus on the actual date of transition.

Notification

Once the C.O.N. Application to construct the new hospital campus is approved by the NYSDOH and the construction of the new facility is nearing its end, SEMC/MVHS will begin to provide notice to all constituent populations, including staff, providers, patients and elected officials, that the transition of the inpatient service to the new hospital campus will be occurring with an anticipated date on or about January 1, 2022. Signage will also be placed in prominent locations at SEMC, notifying people of the pending transition and providing them with a contact number.

Maintenance, Storage and Retrieval of Records, including Medical Records

There will be no change to the maintenance of records, including medical records, of patients. All records will continue to be maintained by Mohawk Valley Health System in compliance with State and Federal statutes. Patients will be advised on how to obtain copies of their medical record from the Health Information Management Department at SEMC/MVHS.

Proposer Disposal of Medications, Biologicals, Chemicals and Medical Supplies

Unused medical supplies will be brought to the new hospital campus.

Disposition of Equipment

Equipment from the inpatient psychiatric unit at the existing SEMC campus will be used, as appropriate, within other inpatient unit at the new hospital campus. Equipment that is beyond its useful life will be disposed of according to policy.

Link to Alternative Programs

The inpatient unit at SEMC is part of the larger behavioral health service delivery system in and around Oneida County, which includes other providers and community-based organizations that provide behavioral health services to the residents of the service area. Hospital staff, which is knowledgeable of these resources, programs and how to access them, will refer to and provide linkages to such programs/providers as:

- New Hospital Campus of MVHS
- Mohawk Valley Psychiatric Center
- Rome Memorial Hospital
- Cath Char RC Dio/Syr, NY, Inc-Oneida/Madison
- Center for Family Life and Recovery, Inc.
- Central New York Psychiatric Center
- Central New York Services, Inc.
- House of the Good Shepherd
- Human Technologies Corporation
- NYS ARC Oneida-Lewis County Chapter
- Oneida County Department of Mental Health
- Rescue Mission of Utica, Inc.
- Resource Center for Independent Living
- The Neighborhood Center, Inc.
- Upstate Cerebral Palsy, Inc.

As it has done successfully in the past, SEMC/MVHS will continue to work with these entities in order to ensure that patients receive needed behavioral health services. This includes making sure that alternative programs have agreed to accept the referral, that the patient has appropriate transportation, and that follow-up occurs to confirm recipient linkage to the programs.

TRANSITION PLAN

FAXTON-ST. LUKE'S HEATHCARE ST. LUKE'S DIVISION

24-BED INPATIENT PSYCHIATRIC UNIT

Purpose

To ensure the smooth transition of inpatient psychiatric treatment as the 26-bed inpatient psychiatric unit is relocated from its current location at 1656 Champlin Avenue, Utica (Oneida County), New York 13502 to a new hospital campus on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street. Faxton-St. Luke's Hospital (FSLH) / Mohawk Valley Health System (MVHS), the New York State Department of Health (NYSDOH) and the New York State Office of Mental Health (NYSOMH) will work collaboratively during the transition process.

Anticipated Date of Transition

The date of transition to the new hospital campus is anticipated to be on or about January 1, 2022 and is dependent on Mohawk Valley Health System receiving all necessary approvals from NYSDOH and NYSOMH for it to construct a new hospital campus in Utica, New York. Furthermore, this date is based upon the timing of the actual construction of the new hospital campus.

Proposed Schedule for Phasing of Transition

Based on the construction timing for the project, FSLH/MVHS will work to identify patients who can appropriately be discharged to community care from the inpatient unit on the existing FSLH campus, to lessen the number of patients who need to be transferred to the new hospital campus on the actual date of transition.

Notification

Once the C.O.N. Application to construct the new hospital campus is approved by the NYSDOH and the construction of the new facility is nearing its end, FSLH/MVHS will begin to provide notice to all constituent populations, including staff, providers, patients and elected officials, that the transition of the inpatient service to the new hospital campus will be occurring with an anticipated date on or about January 1, 2022. Signage will also be placed in prominent locations at FSLH, notifying people of the pending transition and providing them with a contact number.

Maintenance, Storage and Retrieval of Records, including Medical Records

There will be no change to the maintenance of records, including medical records, of patients. All records will continue to be maintained by Mohawk Valley Health System in compliance with State and Federal statutes. Patients will be advised on how to obtain copies of their medical record from the Health Information Management Department at FSLH/MVHS.

Proposer Disposal of Medications, Biologicals, Chemicals and Medical Supplies

Unused medical supplies will be brought to the new hospital campus.

Disposition of Equipment

Equipment from the inpatient psychiatric unit at the existing FSLH campus will be used, as appropriate, within other inpatient unit at the new hospital campus. Equipment that is beyond its useful life will be disposed of according to policy.

Link to Alternative Programs

The inpatient unit at FSLH is part of the larger behavioral health service delivery system in and around Oneida County, which includes other providers and community-based organizations that provide behavioral health services to the residents of the service area. Hospital staff, which is knowledgeable of these resources, programs and how to access them, will refer to and provide linkages to such programs/providers as:

- New Hospital Campus of MVHS
- Mohawk Valley Psychiatric Center
- Rome Memorial Hospital
- Cath Char RC Dio/Syr, NY, Inc-Oneida/Madison
- Center for Family Life and Recovery, Inc.
- Central New York Psychiatric Center
- Central New York Services, Inc.
- House of the Good Shepherd
- Human Technologies Corporation
- NYS ARC Oneida-Lewis County Chapter
- Oneida County Department of Mental Health
- Rescue Mission of Utica, Inc.
- Resource Center for Independent Living
- The Neighborhood Center, Inc.
- Upstate Cerebral Palsy, Inc.

As it has done successfully in the past, FSLH/MVHS will continue to work with these entities in order to ensure that patients receive needed behavioral health services. This includes making sure that alternative programs have agreed to accept the referral, that the patient has appropriate transportation, and that follow-up occurs to confirm recipient linkage to the programs.

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 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		23		23
MEDICAL/SURGICAL	01		232		232
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		373		373

*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*) _____ _____ _____

Cicero Consulting Associates

VCC, Inc.

701 Westchester Ave. • Suite 210W • White Plains, NY 10604
Tel: (914) 682-8657 • Fax: (914) 682-8895
cicero@ciceroassociates.com

White Plains Unit
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Rose Murphy
Michael D. Ungerer
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Frank T. Cicero, M.D.

Michael P. Parker, Sr.
(1941-2011)
Anthony J. Maddaloni
(1952-2014)

January 3, 2018

Mr. Brad Frazee
Construction Cost Control
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1861
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Mr. Frazee,

On behalf of our client, Mohawk Valley Health System (MVHS), we are responding to your December 14, 2017 request for additional information for the project referenced above. Our response is as follows:

1. **Thank you for the update of "Other Fees". The revised listing satisfies the original question related to item 18000 previously labeled Planning & Zoning Fees.**

   The update however brings into question another "Other Fees" item, 18250 now labeled "Security Access and Control" totaling $1,776,500 (previously labeled as "Legal / Consultant Assistance Fees").

   The costs for "Security Access and Control" are already accounted for and appear to be included in the Telecommunications budget, line 5.2 of Schedule 8B. Schedule 11 attachment for New Telecommunications Equipment provides a detailed listing of equipment and costs already included in the project for this item.

   Kindly review and submit a revised Schedule 8B - Line 4.5 "Other Fees" costs or Line 5.2 Telecommunications costs to eliminate duplication of costs for this item.

RESPONSE:

Per the applicant, there is no duplication of costs associated with the items noted above. The security and access control equipment noted on Line 5.2 (under "Telecommunications Equipment") represents the actual, physical equipment associated with such functions, including an infant abduction system and a behavioral health system. Line 4.5 (under "Other Fees") represents the vendor costs for design, installation and testing of these various systems. The $1,776,500 cost associated with Line 4.5 typically represents an owner-furnished system that is installed by an associated vendor, so it is carried in this line item.

Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero MDN

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

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January 3, 2018

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NEW YORK STATE DEPARTMENT OF HEALTH
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   The update however brings into question another "Other Fees" item, 18250 now labeled "Security Access and Control" totaling $1,776,500 (previously labeled as "Legal / Consultant Assistance Fees").

   The costs for "Security Access and Control" are already accounted for and appear to be included in the Telecommunications budget, line 5.2 of Schedule 8B. Schedule 11 attachment for New Telecommunications Equipment provides a detailed listing of equipment and costs already included in the project for this item.

   Kindly review and submit a revised Schedule 8B - Line 4.5 "Other Fees" costs or Line 5.2 Telecommunications costs to eliminate duplication of costs for this item.

RESPONSE:

Per the applicant, there is no duplication of costs associated with the items noted above. The security and access control equipment noted on Line 5.2 (under "Telecommunications Equipment") represents the actual, physical equipment associated with such functions, including an infant abduction system and a behavioral health system. Line 4.5 (under "Other Fees") represents the vendor costs for design, installation and testing of these various systems. The $1,776,500 cost associated with Line 4.5 typically represents an owner-furnished system that is installed by an associated vendor, so it is carried in this line item.

Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero MDN

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cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

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November 28, 2017

Ms. Donna Wang
Division of Certification and Surveillance
NEW YORK STATE DEPARTMENT OF HEALTH
875 Central Avenue
Albany, NY 12206

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Ms. Wang:

On behalf of our client, Mohawk Valley Health System (MVHS), we are responding to your November 28, 2017 request for additional information for the project referenced above. Our response is as follows:

1. **Please clarify what types of "cardiac and thoracic surgery-related services" will continue to be provided at the St. Elizabeth site after conversion to an outpatient extension clinic.**

   RESPONSE:
   The cardiac and thoracic surgery-related services that will continue to be provided at the St. Elizabeth site after its conversion to an outpatient extension clinic will be outpatient, medical-only visits (i.e., pre- and post-surgical visits). No surgical services will be provided at the St. Elizabeth site after its conversion to an extension clinic.

Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, Mohawk Valley Health System

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Michael P. Parker, Sr.
(1941-2011)
Anthony J. Maddaloni
(1952-2014)

November 28, 2017

State Environmental Quality Review
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1882
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

To Whom It May Concern:

On behalf of our client, Mohawk Valley Health System (MVHS), we are responding to your November 14, 2017 request for additional information for the project referenced above. Our response is as follows:

1. **In accordance with 10 NYCRR 97.14 and 6 NYCRR 617.4, the proposed project appears to be a State Environmental Quality Review (SEQR) Type I Action. Please provide the SEQR Summary of Findings for the project upon completion of the SEQR.**

   RESPONSE:
   Per a discussion with the applicant, the issuance of SEQR findings is expected to occur around October 2018. Please see the attached preliminary schedule of SEQR activities for this project. At this time, we are asking that the project continue to be reviewed by State Health Department staff and, if necessary, we respectfully request that the submission of the Summary of Findings be made a contingency on approval for the project.

Thank you for your consideration in this matter.

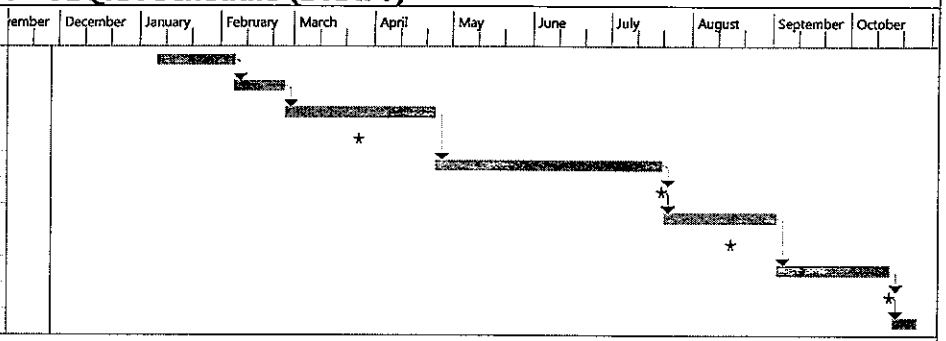
Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, Mohawk Valley Health System

MVHS Integrated Health Campus - SEQRA Schedule (DRAFT)

ID	Task Mode	Task Name	Duration	Start	Finish
1		Lead Agency Coordination	30 days	Mon 1/8/18	Mon 2/5/18
2		Notice of Determination [Positive Declaration] (Filing)	20 days	Tue 2/6/18	Sun 2/25/18
3		Public & Agency Scoping Process	60 days	Sun 2/25/18	Tue 4/24/18
4		Scoping Meeting	1 day	Mon 3/26/18	Mon 3/26/18
5		Draft EIS (DEIS) Preparation	90 days	Tue 4/24/18	Fri 7/20/18
6		Notice of Completion of DEIS and Public Hearing (Filing)	1 day	Fri 7/20/18	Sat 7/21/18
7		DEIS Comment Period	45 days	Sat 7/21/18	Sun 9/2/18
8		DEIS Public Hearing	1 day	Thu 8/16/18	Thu 8/16/18
9		Final EIS (FEIS) Preparation	45 days	Sun 9/2/18	Mon 10/15/18
10		Notice of Completion of FEIS (Filing)	1 day	Tue 10/16/18	Tue 10/16/18
11		Issuance of Findings (End of SEQRA Process)	10 days	Wed 10/17/18	Fri 10/26/18



Cicero Consulting Associates
VCC, Inc.

701 Westchester Ave. • Suite 210W • White Plains, NY 10604
Tel: (914) 682-8657 • Fax: (914) 682-8895
cicero@ciceroassociates.com

White Plains Unit
Frank M. Cicero
Charles F. Murphy, Jr.
James Psarianos
Rose Murphy
Michael D. Ungerer
Noelia Chung
Brian Baldwin
Michael F. Cicero
Karen Dietz
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December 13, 2017

Mr. Brad Frazee
Construction Cost Control
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1861
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Mr. Frazee,

On behalf of our client, Mohawk Valley Health System (MVHS), we are responding to your November 22, 2017 request for additional information for the project referenced above. Our response is as follows:

1. **Please provide additional detail for Schedule 8B budget line 4.5 "Other Fees" (sub-project #1). Specifically, please provide a detailed accounting (copies of consultant estimates, proposals, or contracts etc.) for fees associated with item 116 - Furniture, Fixtures and Equipment - 18000 Planning & Zoning Fees totaling $6,125,000 (escalated cost) and reflected on the Schedule 8 attachment detailing the "Other Fees".**

   RESPONSE:
   After discussions with the Project Manager, Hammes Co., it has come to the attention of MVHS that all items listed under Item #116 (Furniture, Fixtures and Equipment) were mislabeled. To this end, please refer to **Attachment No. 1** for a revised "Breakdown of Other Fees" (Schedule 8 Attachment) document. Note that all cost categories listed under Item 116 have been revised to reflect the corrected cost categories. More specific to the question above, Line Item #18000 represents a furniture budget for the project. Please also refer to **Attachment No. 2** for a letter from Hammes Co. that explains how it estimated capital costs for some components of this project, including the furniture budget.

Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

ATTACHMENT NO. 1

MOHAWK VALLEY HEALTH SYSTEM

SCHEDULE 8 ATTACHMENT ("BREAKDOWN OF OTHER FEES")

MOHAWK VALLEY HEALTH SYSTEM

NEW HOSPITAL CAMPUS

BREAKDOWN OF "OTHER FEES" (SUB-PROJECT #1)

	Description	Unescalated Costs	Escalation	Escalated Costs
102 -- Other Owner Construction				
11000	Mockup Construction	$ 141,509	$ 8,491	$ 150,000
11020	Construction Document Printing	$ 94,340	$ 5,660	$ 100,000
103 -- Owner Background Information				
11500	Site Surveys / ALTA Survey	$ 94,340	$ 5,660	$ 100,000
11520	Environmental Reports	$ 94,340	$ 5,660	$ 100,000
11540	Environmental Impact Study	$ 94,340	$ 5,660	$ 100,000
11570	Traffic/Parking Studies	$ 47,170	$ 2,830	$ 50,000
11580	Utility Assessment Study	$ 188,679	$ 11,321	$ 200,000
11590	Other Studies	$ 235,849	$ 14,151	$ 250,000
107 -- Other Consulting Services & Misc. Cost				
13520	Signage Consultant	$ 77,830	$ 4,670	$ 82,500
13590	Peer Eval -- Enclosure	$ 141,509	$ 8,491	$ 150,000
13630	Building Commissioning	$ 613,208	$ 36,792	$ 650,000
13640	Test & Balance	$ 523,868	$ 31,432	$ 555,300
13660	Radiation Shielding / Physicist	$ 70,755	$ 4,245	$ 75,000
13670	Other Consultants (Dietary)	$ 165,094	$ 9,906	$ 175,000
13670	Other Consultants (Medical Equipment Planning)	$ 424,528	$ 25,472	$ 450,000
13670	Other Consultants (IT / IS Planning)	$ 400,943	$ 24,057	$ 425,000
13670	Other Consultants (Signage / Graphics Planning)	$ 127,358	$ 7,642	$ 135,000
13680	Reimbursable Expenses	$ 165,528	$ 9,932	$ 175,460
111 -- Other Project Cost				
15500	Construction Testing	$ 523,868	$ 31,432	$ 555,300
15710	Movers	$ 235,849	$ 14,151	$ 250,000
15740	Builder's Risk	$ 471,698	$ 28,302	$ 500,000
15780	Independent Financial Audit	$ 94,340	$ 5,660	$ 100,000
113 -- Jurisdictional Cost				
16500	Planning & Zoning Fees	$ 141,509	$ 8,491	$ 150,000
16510	Plan Review Fees	$ 94,340	$ 5,660	$ 100,000
16520	Building Permit	$ 103,774	$ 6,226	$ 110,000
16690	Legal / Consultant Assistance Fees	$ 249,483	$ 14,969	$ 264,452
15700	Other (FAA Fees)	$ 28,302	$ 1,698	$ 30,000
116- Furniture, Fixtures and Equipment				
18000	Dept furniture	$ 5,778,302	$ 346,698	$ 6,125,000
18030	Artwork	$ 330,189	$ 19,811	$ 350,000
18050	Plants and accessories	$ 94,340	$ 5,660	$ 100,000
18250	Security and access control	$ 1,675,943	$ 100,557	$ 1,776,500
18310	Kitchen Equipment	$ 943,396	$ 56,604	$ 1,000,000
18320	Exterior signage	$ 283,019	$ 16,981	$ 300,000
18330	Interior signage	$ 566,038	$ 33,962	$ 600,000
	Sub-Total - "Other Fees"	**$ 15,315,577**	**$ 918,935**	**$ 16,234,512**

ATTACHMENT NO. 2

MOHAWK VALLEY HEALTH SYSTEM

LETTER FROM HAMMES CO.

Hammes Company

100 Cummings Center, Suite 207-P
Beverly, MA 01915

December 13, 2017

Dear Mr. Ungerer,

This letter is to describe Hammes Company ("Hammes") and our process for establishing budgets for our client.

Hammes is a national leader in healthcare development. We work solely on healthcare projects ranging from medical office buildings to large acute care hospitals. We specifically have managed the planning and development of more than 46 hospitals in the last twenty years. Our primary role is as a Program Manager directly for the healthcare system ("Owner") representing and advising them on complex projects. Based on this experience, our firm has developed an extensive and proprietary database of costs which we use in conceptual design to develop a preliminary budget and inform the Owner's decisions. We typically then take the conceptual budget and validate it with several outside construction firms to ensure that the budget has accuracy and is balanced for regional costs and trends. We followed this process for the Mohawk Valley Health System

As the project progresses into design, our team then "builds" the budgets in Budget Builder (our database), which is supported by e-builder, a leading project management software (https://www.e-builder.net/). The initial budget build includes:

1. Square footage
2. Type of Facility
3. Departments
4. Existing or replacement Facility
5. On Campus or off

Once this is established, the total project budget is uploaded into the system, allowing the Owner to have a comprehensive understanding of the entire budget, beyond just design and construction. These categories include:

1. Construction Cost
2. AE fees
3. Jurisdictional costs
   a) Local
   b) State
   c) Other
4. Land acquisition
5. Site investigation

   d) On site costs
   e) Off site costs
6. Hazardous/environmental Investigation
7. FFE
8. Financing
9. Contingency
10. Marketing Costs

Each of the above categories consist of subsets assuring we capture all relevant costs associated with the project.

The initial budget is continually validated throughout design and into construction with the specific technical vendors and expertise.

On no less than a monthly basis, we will report to the Owner the budget progress, which illustrates the initial budget, actual costs, cash flow and "cost to complete" which is project progress based on spend. Finally, this system is synced with finance, allowing our teams to complete a monthly draw review for payment of all vendors and consultants; in addition to ensuring that all project costs are reconciled with the Owner's financial accounting system for accuracy.

In particular, the Department Furniture budget, line 18000 calculated at $6,125,000 or $9.13 per square foot. Upon review, this is in line with industry standards we find in our other projects. Of course as the project develops, there will be additional factors such as reuse of furniture once evaluated, planned decommissioning, etc. that will be factors in the budget development.

Please let me know if you have any questions or need additional information.

Sincerely,

Mike Solak
Regional Vice President
Hammes Company

Cicero Consulting Associates
VCC, Inc.

701 Westchester Ave. • Suite 210W • White Plains, NY 10604
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December 19, 2017

Ms. Barbara DelCogliano, Deputy Director
Division of Planning & Licensure
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1842
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Ms. DelCogliano:

On behalf of our client, Mohawk Valley Health System, we are providing a set of hard-copy plans prepared by the project architect in response to two (2) separate December 6, 2017 requests for information from the Bureau of Architectural & Engineering Review – one from Mr. Robert Lis (Life Safety) and one from Mr. Michael Clary (2014 FGI Guidelines), regarding the project referenced above. The enclosed drawings reflect changes referenced in both letters. The applicant has uploaded separate responses to the two (2) letters, along with a PDF of the drawings, onto NYSE-CON.

Please feel free to contact me if you have any questions. Thank you.

Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

December 18, 2017

Project Management Unit, New York State Department of Health
Corning Tower, Room 1842,
Empire State Plaza, Albany, New York 12237
Michael Clary, Health Facilities Planner
Bureau of Architectural & Engineering Review

172305 C
Faxton-St Luke's Healthcare St Luke's Division (Oneida)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

---

(DSG 1)
1. General Comments: Fixtures
2. Referenced Standard: DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.1 Action Required: Please indicate fixtures such as toilets, hand washing sinks and clinical sinks. Please revise and resubmit drawing(s).
RESPONSE: Toilets, Handwash sinks, clinical sinks, showers and housekeeping closets have been indicated on the floor plans – plans are being reissued as part of this response. NOTE: fixture type may change as the design is developed.

(DSG 2)
3. General Comments: ADA Clearances in Toilet Rooms
4. Referenced Standard: DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.2 Action Required: Please indicate ADA clearances in a typical toilet room. Please revise and resubmit drawing(s).
RESPONSE: ADA clearances have been indicated in toilet rooms -- plans are being reissued as part of this response.

(DSG 3)
5. General Comments: Room Numbers
6. Referenced Standard: DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.3 Action Required: Please indicate room numbers for all schematic design drawings. Please revise and resubmit drawings.

RESPONSE: Room numbers have been provided on the plans -- plans are being reissued as part of this response. NOTE: Room numbers will likely be modified as the design is refined and the numbers are coordinated with the signage consultant -- plans are being reissued as part of this response.

(ARCH 1)
7. General Comments: **Public Waiting Area**
8. Referenced Standard: FGI 2014
a. Chapter: 2.2.3-1.2.4
b. Trade: Architecture
c. Drawing Sheet: F1 (A)
d. Floor: Emergency Department
2.4 Action Required: Please indicate access to drinking water. Revise and resubmit drawing.
RESPONSE: A drinking Fountain (EWC) has been added outside room 1200B, sheet AE101-A

(ARCH 2)
1. General Comments: **EMS Communication**
2. Referenced Standard: FGI 2014
a. Chapter: 2.2-3.1.2.5
b. Trade: Architecture
c. Drawing Sheet: F1 (A)
d. Floor: Emergency Department
2.5 Action Required: Indicate the EMS Communication Room. Revise and resubmit drawing.
RESPONSE: The EMS communication Room is located in the Emergency Department – room 1308, sheet AE101-A

(ARCH 3)
1. General Comments: **Reception and Triage Area**
2. Referenced Standard: FGI 2014
a. Chapter: 2.2-3.1.3.3
b. Trade: Architecture
c. Drawing Sheet: F1 (A)
d. Floor: Emergency Department
2.6 Action Required: Please indicate the handwashing stations in the triage area. Revise and resubmit drawing.
RESPONSE: Handwashing stations have been added

(ARCH 4)
1. General Comments: **Trauma Rooms**
2. Referenced Standard: FGI 2014

a. Chapter: 2.2-3.2.3.6
b. Trade: Architecture
c. Drawing Sheet: F1 (A)

2.7 Action Required: Please consider relocating the trauma rooms in closer proximity to the emergency entrance. Revise and resubmit drawing.

RESPONSE: The trauma room location is based on discussions with the hospital physician and nursing staff. The room is located so that it is in between the entry to the Emergency Department and the oversized elevator (Megavator) used to transfer ER patients to the Surgery/Invasive Cardiology and Critical Unit as well as Psychiatric patients from the Emergency Department to the 9th Floor behavior Health Nursing Unit -- plans are being reissued as part of this response.

(ARCH 5)

1. General Comments: **Bariatric / Pediatric Treatment Area**
2. Referenced Standard: FGI 2014
   a. Chapter: 2.2-3.2.3.6
   b. Trade: Architecture
   c. Drawing Sheet: F1 (A)

2.8 Action Required Indicate the dedicated Bariatric and Pediatric treatment areas. Revise and resubmit drawing.

RESPONSE: The bariatric and Pediatric treatment area in the Emergency Department have been labeled -- plans are being reissued as part of this response.

(ARCH 6)

1. General Comments: **Food Production**
2. Referenced Standard: FGI 2014
   a. Chapter: 2.1-4.3
   b. Trade: Architecture
   c. Drawing Sheet: F1 (B)

2.9 Action Required: Not enough information to review. Please review the section of the FGI. Revise and resubmit drawing.

RESPONSE: A preliminary layout for the food service department has been provided and exiting indicated. The final layout of the department will be refine as the Food Service Consultant is selected -- plans are being reissued as part of this response.

(ARCH 7)

1. General Comments: **Clinical Lab Services**

2. Referenced Standard: FGI 2014
    a. Chapter: 2.1-4
    b. Trade: Architecture
    c. Drawing Sheet: F1 (C)

2.10 Action Required: Not enough information to review. Please review the section of the FGI. Revise and resubmit drawing.

RESPONSE: Per 12/8/17 email "As for casework fixtures for the lab; we can wait for the 60% State Hospital Code submission to review."

(ARCH 8)

1. General Comments: **Room Names**
2. Referenced Standard: FGI 2014
    a. Chapter: 1.2-2.1 /1.2-2.1.3.1 /1.2-2.1.3.2
    b. Trade: Architecture
    c. Drawing Sheet: All

2.11 Action Required: The names for spaces and departments used in the functional program shall be consistent with those used in the Guidelines for Design and Construction of Hospital and Outpatient Facilities. If acronyms are used, they shall be defined clearly. Please provide a key for all acronyms shown on the submitted drawings. Revise and resubmit drawings.

RESPONSE: A list of room names corresponding to the abbreviations indicated on the floor plans is provided on new drawing sheet GC001 General Requirements Notes.

In addition to the items noted above in order to make the Typical Room Dimensions easier to find we placed a heavy dashed line around "typical rooms" and noted that the dimensions are typical for the room type. This is in response to a concern that we discussed in our conference call that there were not adequate dimensions indicated – at this time the typical room dimensions are to be used for similar rooms unless noted otherwise.

Sincerely,

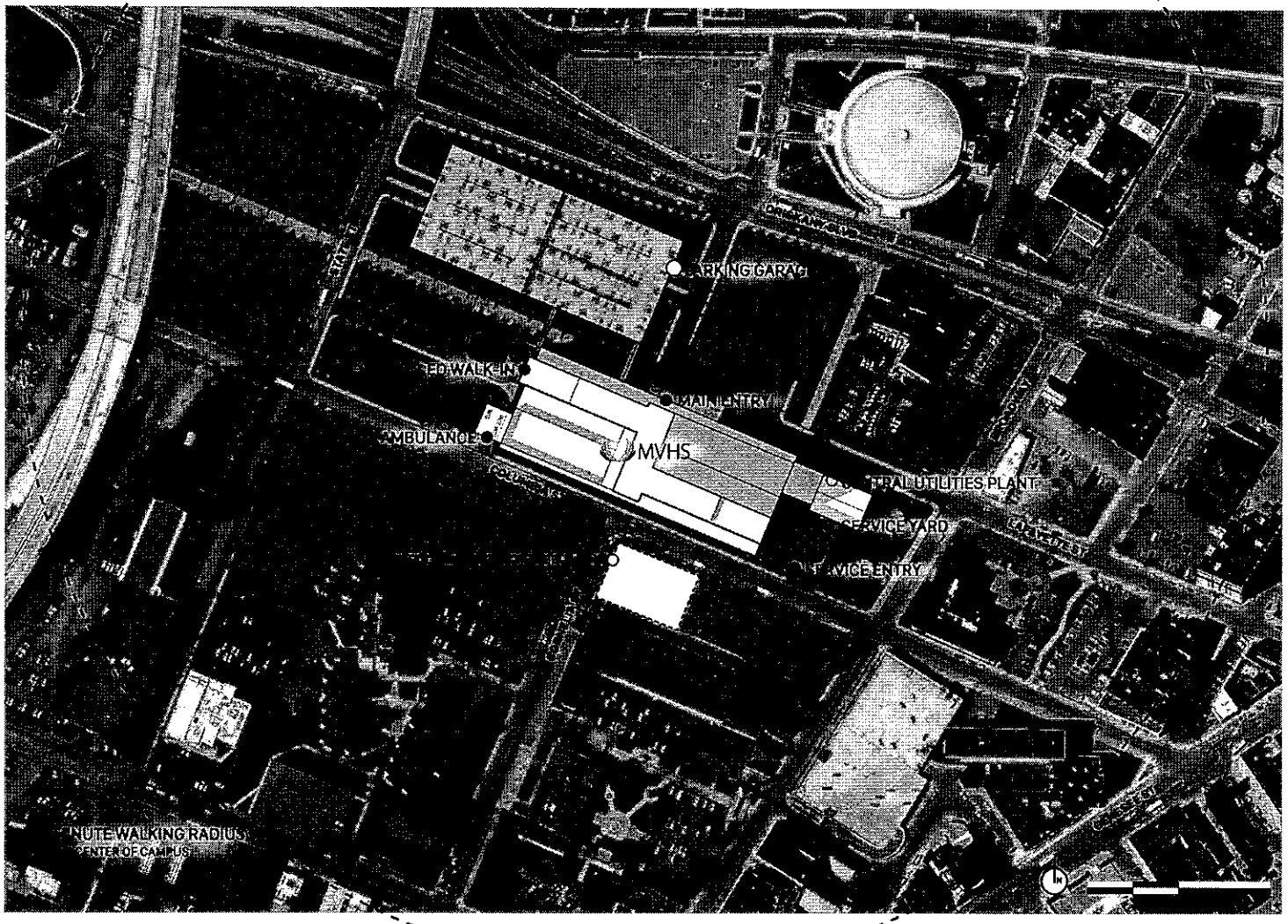
Steven M. Kopf AIA
NBBJ
250 South High Street

nbbj

Suite 300
Columbus, Ohio 43215

CON - SD SUBMITTAL

NOVEMBER 1, 2017
CON - SD RFI RESPONSE: DECEMBER 19, 2017



LIST OF SHEETS

GC000	COVER SHEET
GC001	GENERAL REQUIREMENTS NOTES
AS101	ARCHITECTURAL SITE PLAN
AS102	STACKING DIAGRAM
GI101	F1 LIFE SAFETY PLAN
GI102	F2 LIFE SAFETY PLAN
GI103	F3, F4 LIFE SAFETY PLANS
GI105	F5, F6 LIFE SAFETY PLANS
GI107	F7, F8 LIFE SAFETY PLANS
GI109	F9, ROOF LIFE SAFETY PLAN
GI201	F1, CEP F1-F3 FUNCTIONAL AREA PLAN
GI202	F2 FUNCTIONAL AREA PLAN
GI203	F3, F4 FUNCTIONAL AREA PLAN
GI205	F5, F6 FUNCTIONAL AREA PLAN
GI207	F7, F8 FUNCTIONAL AREA PLAN
GI209	F9, F10 ROOF FUNCTIONAL AREA PLAN
AE101	F1 OVERALL & CEP FLOOR PLANS
AE101-A	F1 FLOOR PLAN - AREA A
AE101-B	F1 FLOOR PLAN - AREA B
AE101-C	F1 FLOOR PLAN - AREA C
AE101-D	F1 FLOOR PLAN - AREA D
AE102	F2 OVERALL FLOOR PLAN
AE102-A	F2 FLOOR PLAN - AREA A
AE102-B	F2 FLOOR PLAN - AREA B
AE102-C	F2 FLOOR PLAN - AREA C
AE103	F3, F4 OVERALL FLOOR PLANS
AE103-AC	F3 FLOOR PLAN - AREA A & C
AE103-B	F3 FLOOR PLAN - AREA B
AE104-AC	F4 FLOOR PLAN - AREA A & C
AE104-B	F4 FLOOR PLAN - AREA B
AE105	F5, F6 OVERALL FLOOR PLANS
AE105-AC	F5 FLOOR PLAN - AREAS A & C
AE105-B	F5 FLOOR PLAN - AREA B
AE106-AC	F6 FLOOR PLAN - AREA A & C
AE106-B	F6 FLOOR PLAN - AREA B
AE107	F7, F8 OVERALL FLOOR PLANS
AE107-AC	F7 FLOOR PLAN - AREA A & C
AE107-B	F7 FLOOR PLAN - AREA B
AE108-AC	F8 FLOOR PLAN - AREA A & C
AE108-B	F8 FLOOR PLAN - AREA B
AE109	F9 OVERALL FLOOR PLAN, ROOF PLAN
AE109-AC	F9 FLOOR PLAN - AREA A & C
AE109-B	F9 FLOOR PLAN - AREA B
AE110-AC	R1 ROOF PLAN - AREA A & C
AE110-B	R1 ROOF PLAN - AREA B

MVHS

MOHAWK VALLEY HEALTH SYSTEM

UTICA, NY

12/14/2017 6:25:00 PM

nbbj
250 S. HIGH STREET SUITE 300 COLUMBUS, OH 43215
PHONE 614.224.7145
www.nbbj.com

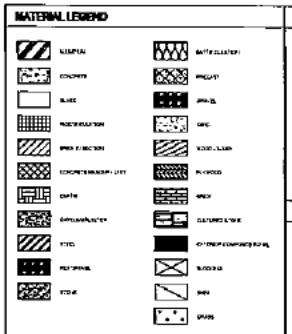
Code Compliance Notes

Occupancy Classifications	
Hospital - Ig Institutional	
Central Energy Plant - Special Purpose Industrial	
Sprinkler coverage	
Fully sprinklered	
Construction Classification	
Type 2(01) (IBC 2021 - 2015)	
Allowable Building Height	
Height Unlimited	
Area Unlimited	
Fire Resistance Rating Requirements	
Floor and vertical openings assembly	2 hours
Wall Construction and Vertical Assembly, Partitions	1 or 2 hours
Exterior walls - separation greater than 30'	3 hours
Exit stairs	2 hours
Shaft Connecting 3 or more floors	2 hours
Smoke Barrier	1 hour
Horizontal Exit Openings	2 hours
Corridor walls (NFPA)	2 hours
Corridor	30 hours, smoke tight
Walls - separation	30 hours, smoke tight
Hazard Prohibitions	
Physical Classification Area	1 hour
Rooms with solid fuel volume greater than 60 gallons	1 hour
Storage room from 50 to 100sf and doors combustible materials	no rating but self closing and s
Storage room greater than 100sf	1 hour
Hazardous materials greater than 64 gallons	1 hour
Medical Gas Storage	Per NFPA 99
Means of Egress	
Occupant Density - Main	0.3 sq ft/occupant
Occupant Density - Level Concourse	0.2 sq ft/occupant
Means of Egress Arrangement	
Travel Distance to exit - sprinklered	200feet
Travel Distance - any point in a patient sleeping room and an exit access door in that room	50feet not exceed 100feet
Rooms/areas of exits, where two exits are required, they shall be located from one another not less than one half of the length of the maximum over diag and dimension of the building or area served, measured in a straight line between the nearest edge of the exits (NFPA) 4.4.4.2.2	
Dead End Corridors - sprinklered	30feet
Common Path of Travel	100feet
Toilets	
Patient Care Area Sleeping Unit	1 to 6/15
Travel Distance within a non-sleeping suite to an exit from suite shall not exceed 100feet	
Travel distance between any point in a non sleeping suite and an exit shall not exceed 200feet	
Patient Care Sleeping	1 to 6/15
Travel Distance within a sleeping suite to an exit from suite shall not exceed 100feet	
Travel distance in run to any point in a sleeping suite and an exit shall not exceed 200feet	

CEILING HEIGHTS & SURFACES

Department	Space Type	Ceiling Height	Ceiling Finish	FGI Citations
ACC Lobby	All	9'-0" where higher as noted	Water, smooth acoustic ceiling tile with regular grid with recessed GWB soffit...	2.1-7.2.2.2
All Areas	Inpatient Building	9' - 0"	GWB, semigloss paint	2.1-7.2.3.3
All Areas	Entertainment Rooms	9' - 0"	Smooth APC, regular grid	2.1-7.2.3.3
Surgical Services	Operating Room, Interventional OR, All restricted areas	9' - 0" min.	GWB, epoxy paint	2.1-7.2.2.2 2.1-7.2.3.3
Surgical Services	Procedure	9' - 0" min.	GWB, epoxy paint or Classroom ACT with grid of vinyl pressure grid	2.1-7.2.2.2
Surgical Services	Pre/Post Recovery Bays	9' - 0"	Smooth APC, regular grid, mortar GWB soffits	2.1-7.2.3.3
Surgical Services	All Semi-restricted areas	9'-0" where higher as noted		2.1-7.2.3.3
Endoscopy	Procedure, treatment and recovering, decontamination	9' - 0" min.	GWB, epoxy paint or Classroom ACT with grid of vinyl clean room grid and tiles...	2.1-7.2.2.2
Imaging	Gen Rad, CT, MRI, (non-interventional)	9' - 0" min.	Smooth ACT, GWB soffits	2.1-7.2.3.4 2.1-7.2.3.3
IDS	Lasso & Delivery Rooms	9' - 0" min.	GWB, epoxy paint or Classroom ACT with grid to steel abatement grid an...	2.1-7.2.3.3 2.1-7.2.3.3
IDS	Collection IDS	9' - 0" min.	GWB, epoxy paint	2.1-7.2.2.2 2.1-7.2.3.3
IDS	Post-Partum Rooms	9' - 0"		2.1-7.2.3.3
Psychiatric Nursing Unit	Seclusion Room, Ambulatory Patient Toilet Rooms, Patient Bathing	9' - 0" min.	GWB, epoxy paint	2.1-7.2.2.2 2.1-7.2.3.3
Food and Nutrition Services	Servery	10'- 0" (except where 8' - 0")	GWB, epoxy paint	2.1-7.2.2.2
Food and Nutrition Services	Food production areas	9' - 0"	GWB, epoxy paint or Classroom ACT with grid to steel abatement grid an...	2.1-7.2.3.3
Food and Nutrition Services	Nutrition storage areas	9' - 0"	GWB, epoxy paint or Classroom ACT with grid to steel abatement grid an...	2.1-7.2.2.2
Plant Maintenance	Clean workshop	9' - 0"	Smooth APC, regular grid	2.1-7.2.3.3
Plant Maintenance	Clean warehouse	9' - 0"	GWB, epoxy paint or Classroom ACT with grid to steel abatement grid an...	2.1-7.2.3.3
Pharmacy	Sterile Compounding, IV Prep	9' - 0"	GWB, epoxy paint	2.1-7.2.3.3
Pharmacy	Kitchen areas areas	9' - 0"	Smooth APC, regular grid	2.1-7.2.3.3
Central Services (CPD)	All areas	9' - 0"	GWB, epoxy paint	2.1-7.2.3.3
Laboratory Services	All areas (except offices)	9' - 0"	Smooth APC, regular or recess valley grid	2.1-7.2.3.3
Medical/Surgical	Inpatient Rooms	9' - 0"	Smooth APC with regular grid and GWB soffits	2.1-7.2.3.3
Emergency Services	Treatment Rooms	9' - 0"	Smooth APC, regular or recess valley grid	2.1-7.2.3.3
Medical/Surgical	Inpatient A.I.I. Rooms	9' - 0"	GWB, epoxy paint	2.1-7.2.3.3

MATERIAL LEGEND

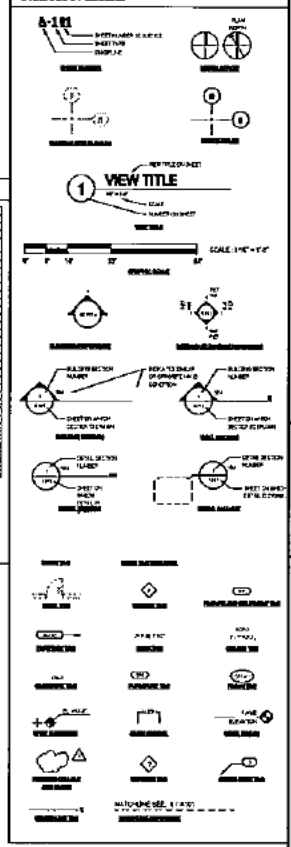


ABBREVIATIONS

GENERAL NOTES

1. CONTRACTOR SHALL FIELD VERIFY ALL DIMENSIONS AND CONDITIONS PRIOR TO BIDDING AND CONSTRUCTION. NOTIFY ARCHITECT OF ANY DISCREPANCIES BEFORE PROCEEDING WITH WORK.
2. DO NOT SCALE DRAWINGS. USE FIGURED DIMENSIONS ONLY.
3. ALL WORK SHALL COMPLY WITH APPLICABLE CODES, ORDINANCES, AND REGULATIONS.
4. COORDINATE ALL TRADES BEFORE INSTALLATION OF ANY WORK.
5. PROVIDE BLOCKING, BACKING, AND SUPPORTS AS REQUIRED FOR ALL EQUIPMENT, FIXTURES, AND FINISHES.
6. ALL DIMENSIONS ARE TO FACE OF STUD, FACE OF CONCRETE, OR CENTERLINE OF COLUMN GRID UNLESS NOTED OTHERWISE.
7. REFER TO SPECIFICATIONS FOR MATERIAL AND WORKMANSHIP REQUIREMENTS.
8. PROTECT EXISTING CONSTRUCTION AND FINISHES TO REMAIN DURING DEMOLITION AND CONSTRUCTION.
9. PATCH AND REPAIR ALL DISTURBED SURFACES TO MATCH ADJACENT FINISHES.
10. COORDINATE LOCATION OF ALL PENETRATIONS THROUGH RATED ASSEMBLIES WITH MECHANICAL AND ELECTRICAL TRADES.
11. ALL FIRE-RATED ASSEMBLIES SHALL BE INSTALLED PER TESTED DESIGN.
12. PROVIDE FIRESTOPPING AT ALL PENETRATIONS OF RATED ASSEMBLIES.
13. VERIFY ROUGH OPENING SIZES FOR DOORS, WINDOWS, AND EQUIPMENT BEFORE FRAMING.
14. ALL DOORS SHALL BE INSTALLED WITH HARDWARE AS SCHEDULED.
15. PROVIDE SMOKE AND CARBON MONOXIDE DETECTORS PER CODE REQUIREMENTS.
16. ALL EXIT DOORS SHALL BE READILY OPENABLE FROM THE EGRESS SIDE WITHOUT A KEY, SPECIAL KNOWLEDGE, OR EFFORT.
17. MAINTAIN MINIMUM CLEAR WIDTH OF EXIT ACCESS AND EGRESS PATHS AS REQUIRED BY CODE.
18. PROVIDE EMERGENCY LIGHTING AND EXIT SIGNAGE PER CODE.
19. ALL FINISHES SHALL MEET FLAME SPREAD AND SMOKE DEVELOPED RATINGS REQUIRED BY CODE.
20. CONTRACTOR SHALL MAINTAIN A CLEAN AND SAFE JOB SITE AT ALL TIMES.

SYMBOLOGY LEGEND



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250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7116
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

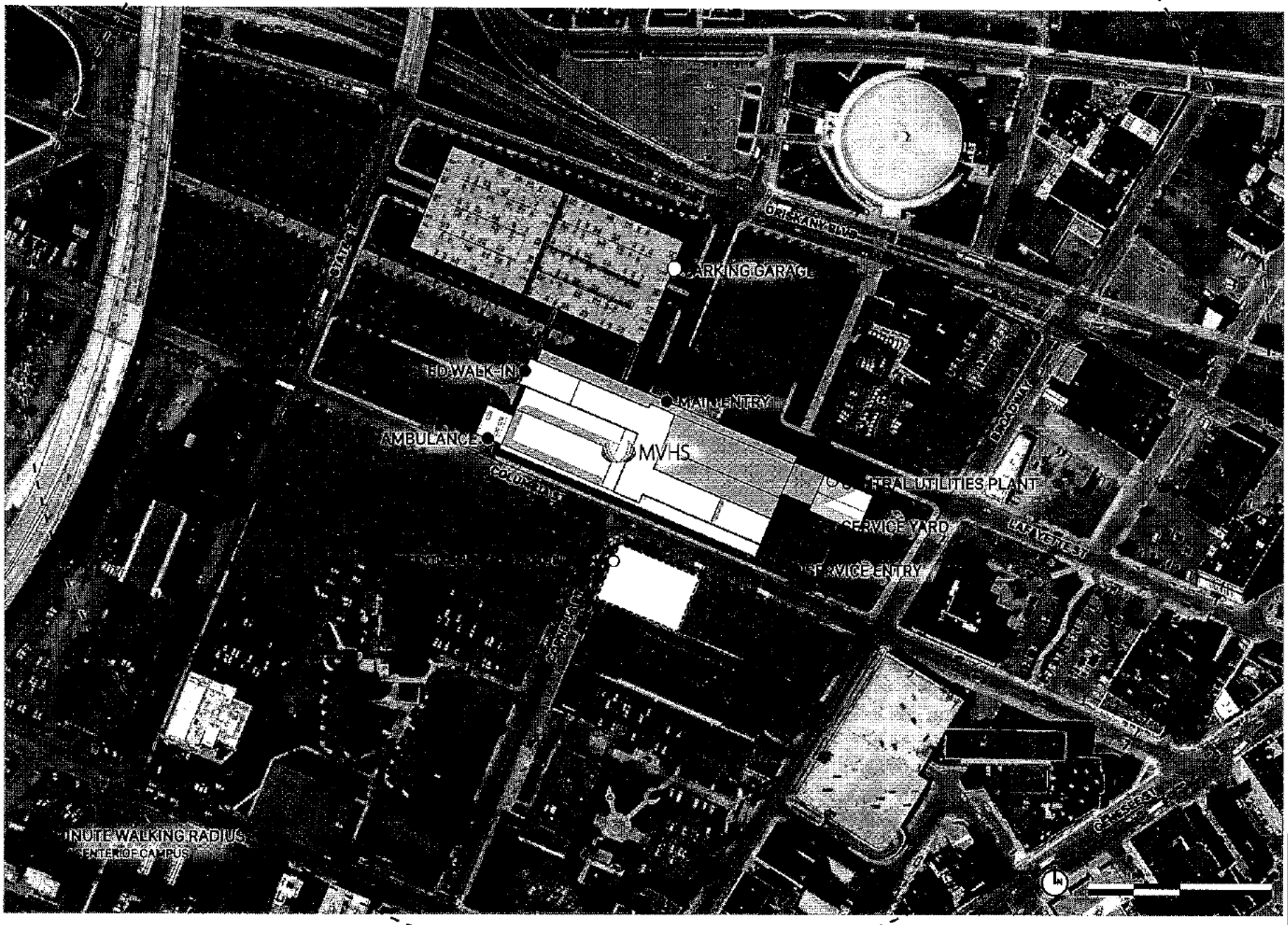
CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE: Architect | PROJECT ARCHITECT: Designer
PROJECT NUMBER: 190XXX
DATE:

SHEET NAME
GENERAL REQUIREMENTS NOTES

SHEET NUMBER
GC001



nbbj
223 YALE AVENUE NORTH
SEATTLE, WASHINGTON 98109
PHONE 206 223 5555
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 6, 2017

MARK	DATE	DESCRIPTION

SCALE

PROJECT ARCHITECT

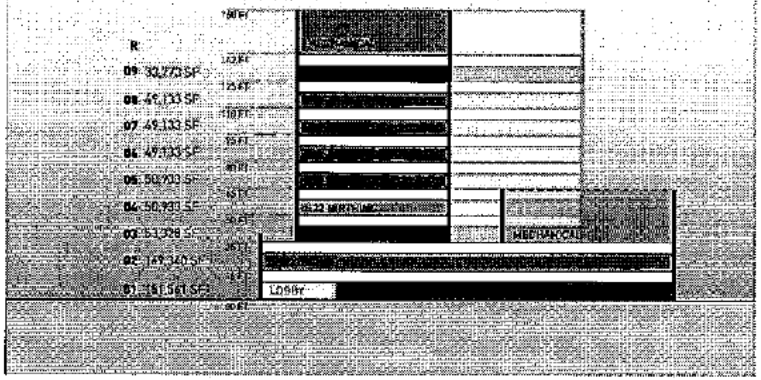
PROJECT NUMBER

DATE

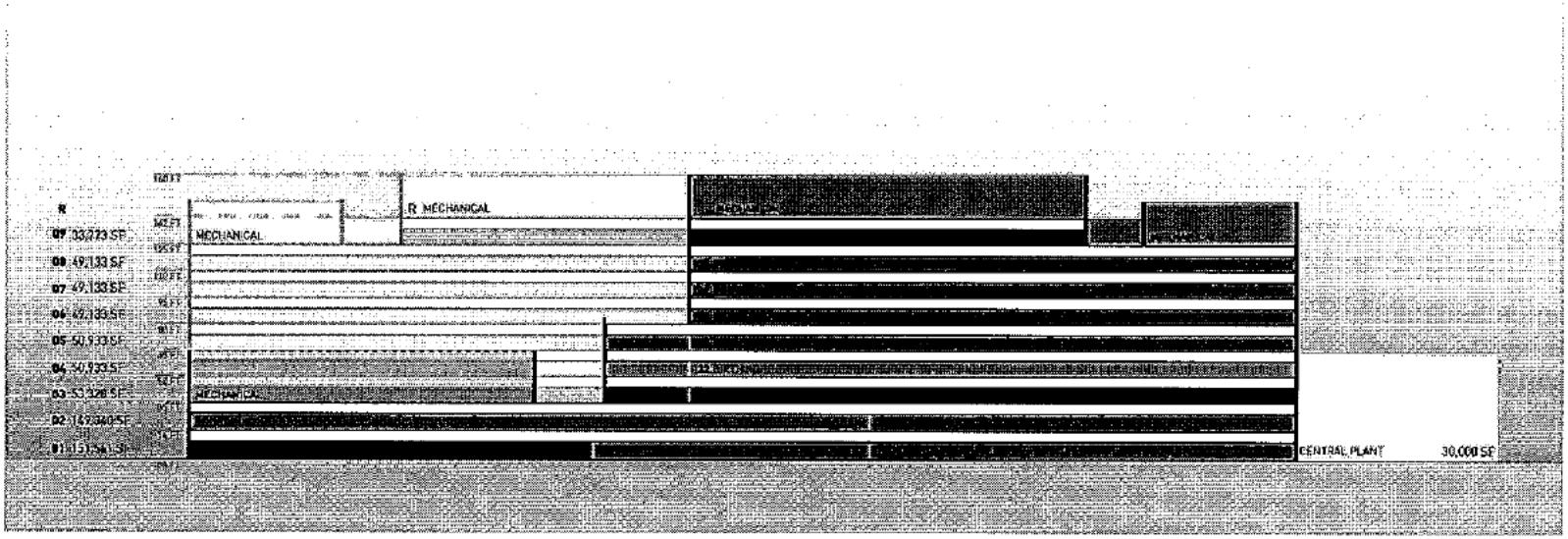
ARCHITECTURAL SITE PLAN

SHEET NUMBER

AS101



NORTH : SOUTH SECTION – LOOKING EAST



WEST : EAST SECTION – LOOKING NORTH

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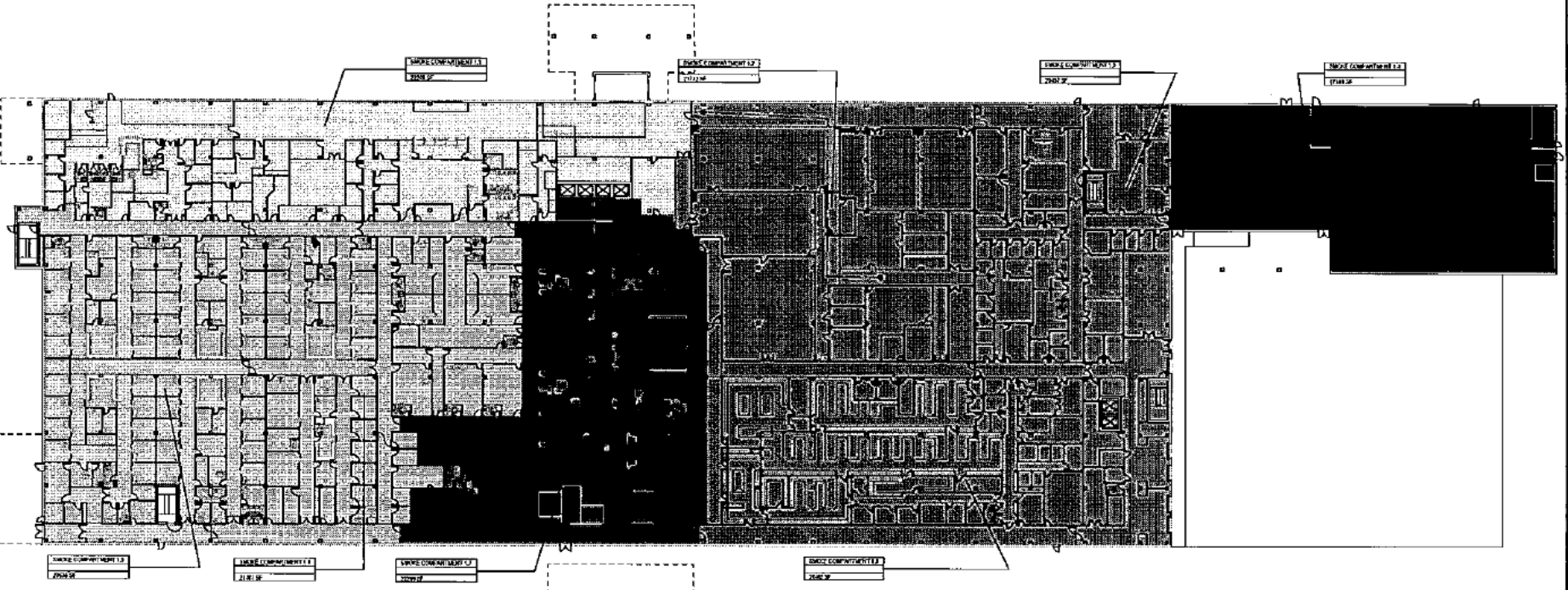
MOHAWK VALLEY HEALTH SYSTEM

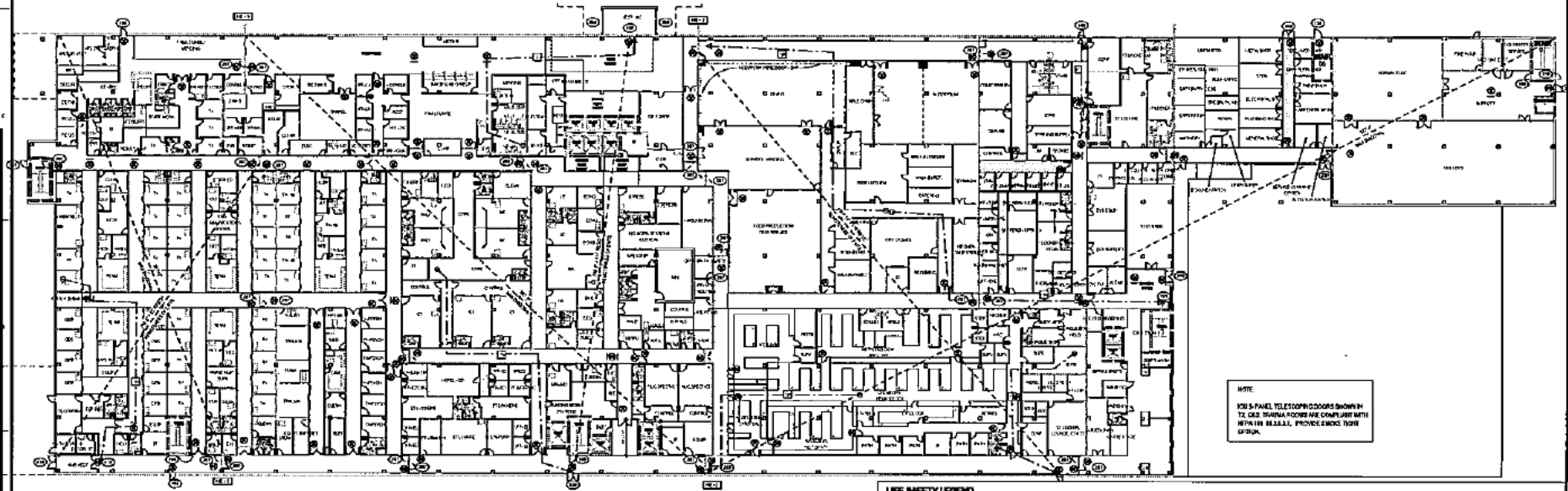
CON - SD SUBMITTAL

STACKING DIAGRAM

AS102



2 F1 SMOKE COMPARTMENTS



1 F1 LIFE SAFETY PLAN

LIFE SAFETY LEGEND

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COLUMBUS, OH 43215
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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

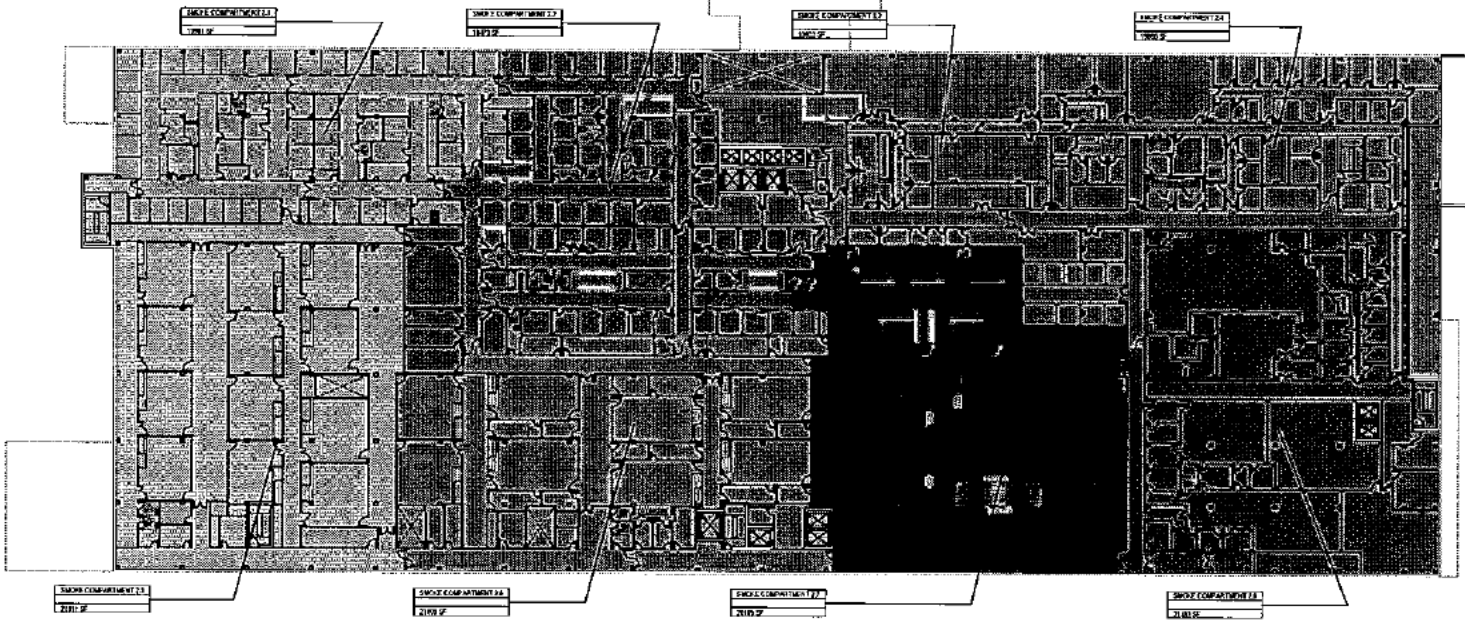
NO.	DATE	DESCRIPTION

SCALE: 1" = 50'-0"

PROJECT NUMBER: 170101.00

DRAWING TITLE: F1 LIFE SAFETY PLAN

SHEET NUMBER: GI101



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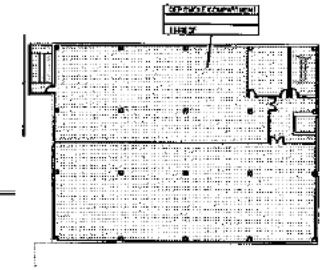

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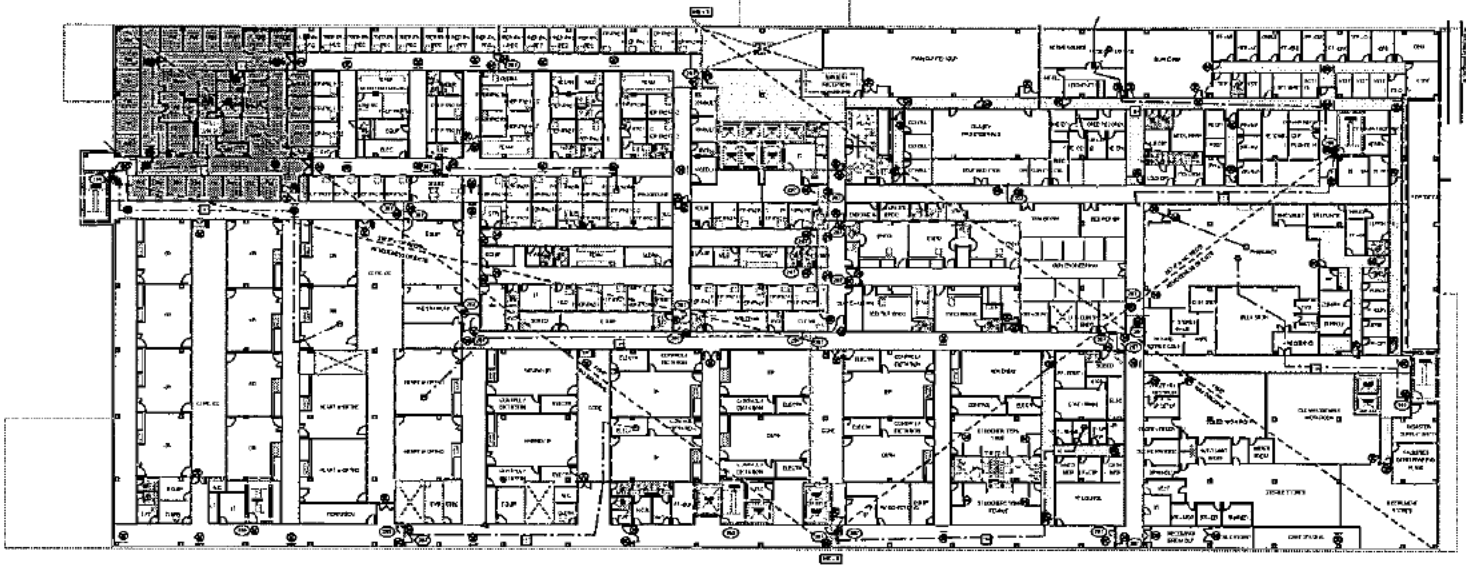
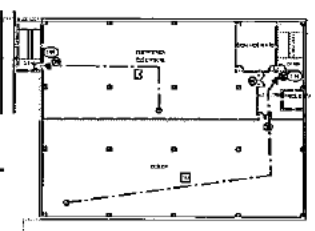
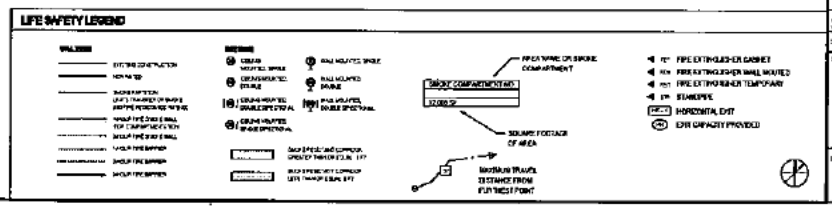


1 F2 LIFE SAFETY PLAN



F2 CEP LIFE SAFETY

LIFE SAFETY LEGEND



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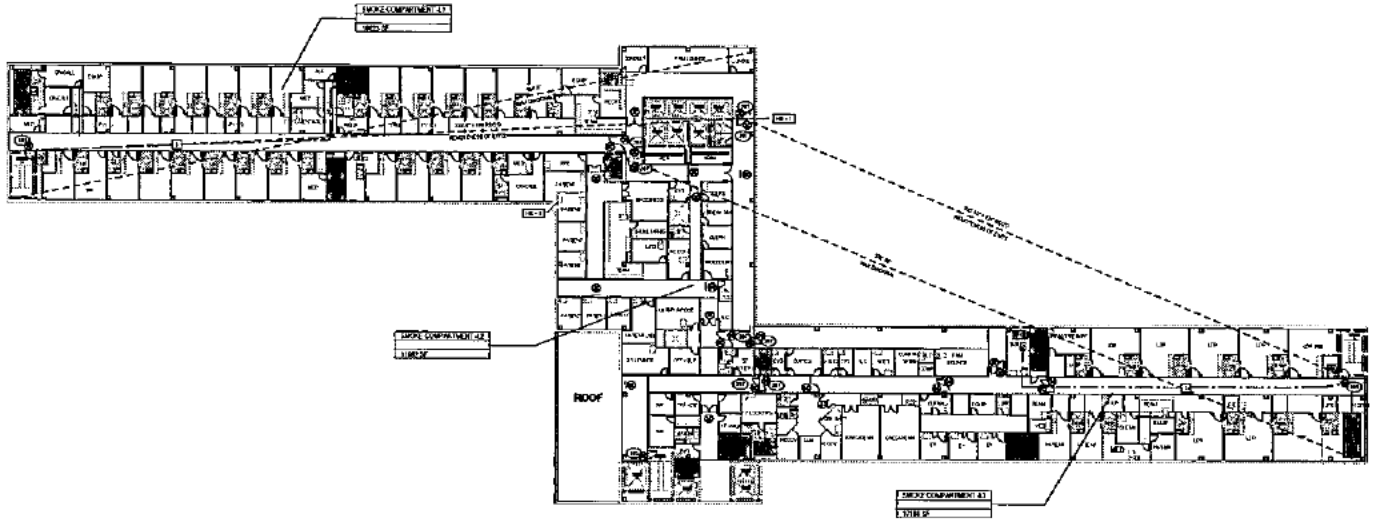
MOHAWK VALLEY HEALTH SYSTEM

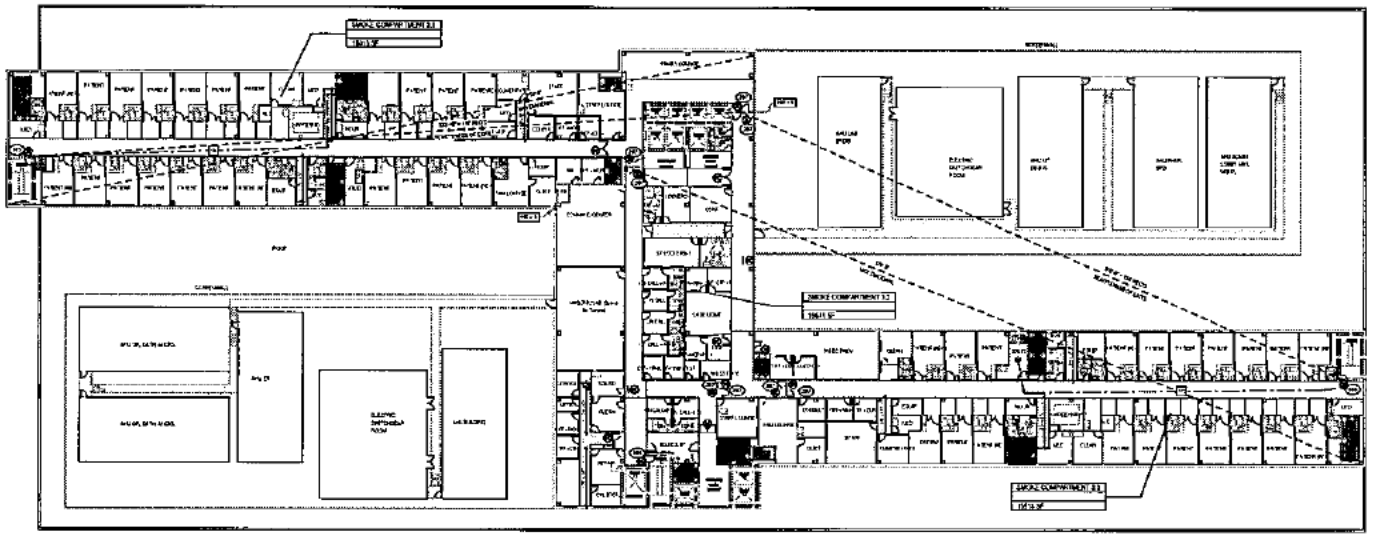
CON - SD SUBMITTAL

F2 LIFE SAFETY PLAN

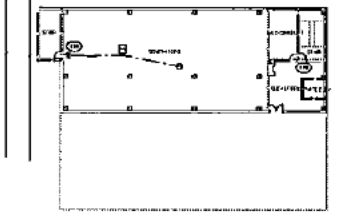
GI102



2 F4 LIFE SAFETY PLAN



1 F3 LIFE SAFETY PLAN



F3 CEP LIFE SAFETY

LIFE SAFETY LEGEND

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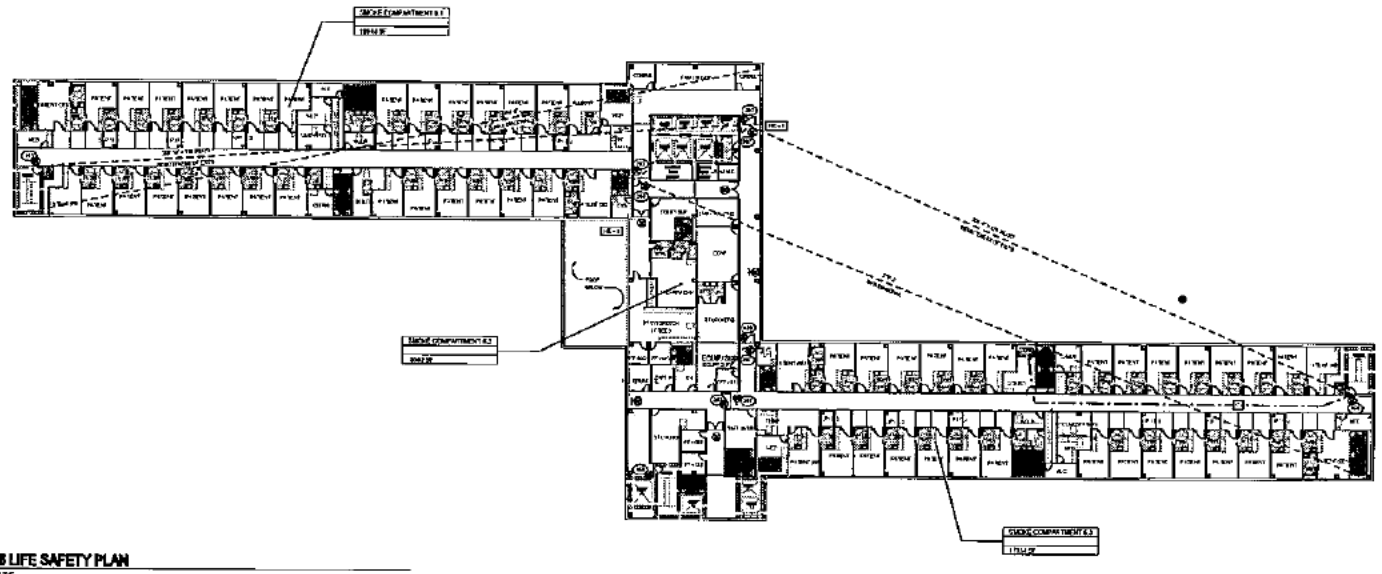
COLUMBUS, OH 43215
PHONE 614.224.1145

MOHAWK VALLEY HEALTH SYSTEM

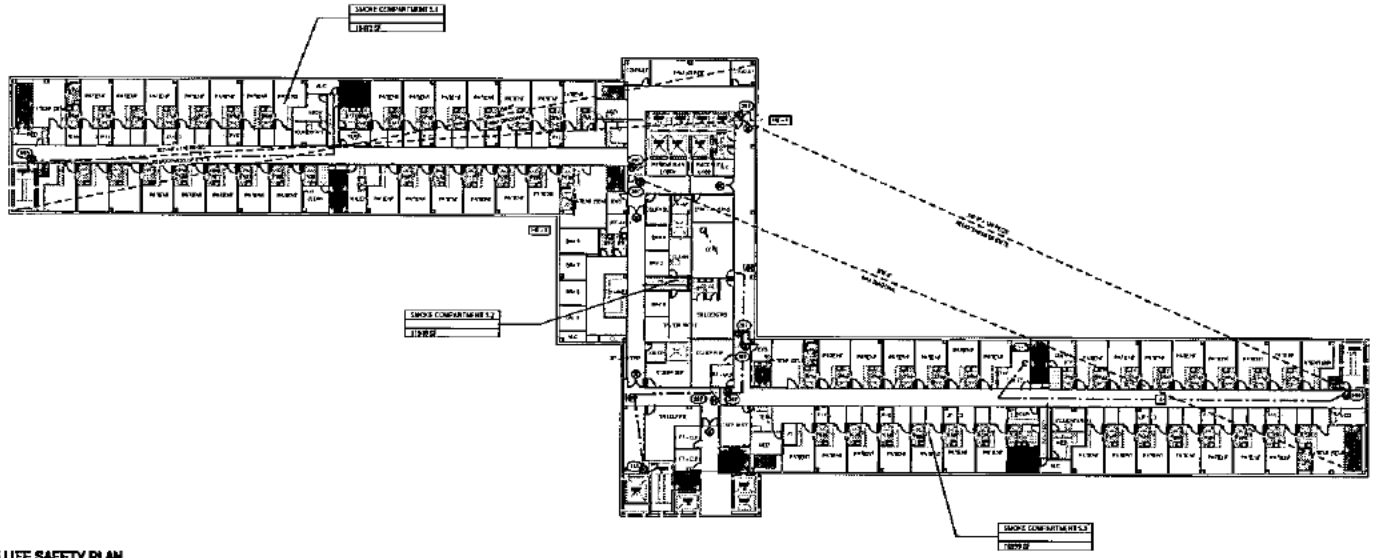
CON - SD SUBMITTAL

F3, F4 LIFE SAFETY PLANS

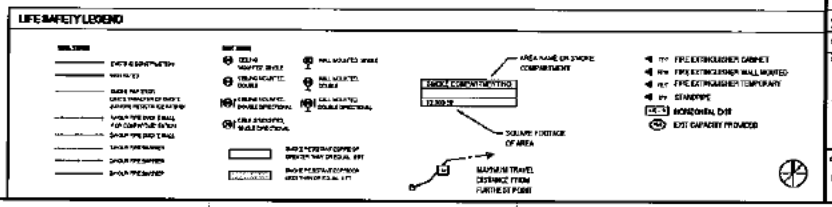
GI103



1 F8 LIFE SAFETY PLAN



2 F5 LIFE SAFETY PLAN



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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

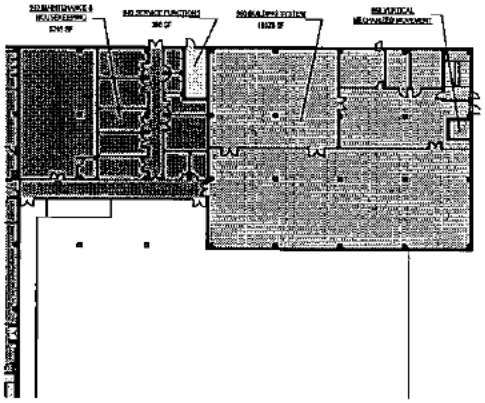
F5, F8 LIFE SAFETY PLANS

GI105

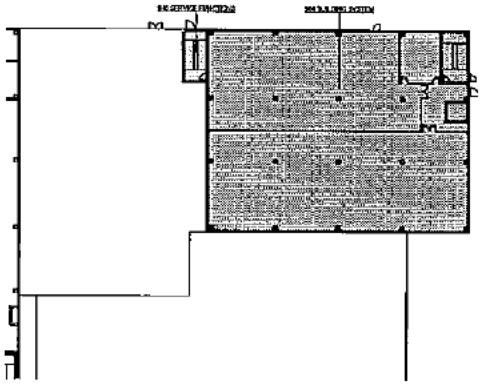
nbbj

FUNCTIONAL AREA CODE LEGEND

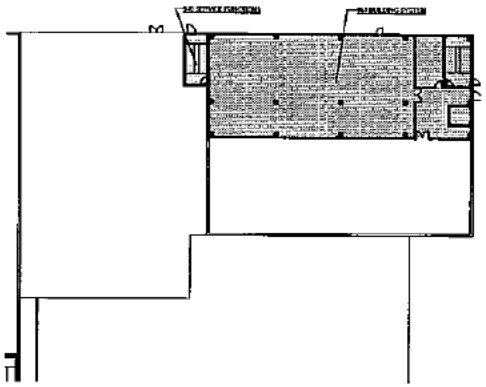
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM
- 968 VERTICAL MECHANIZED MOVEMENT



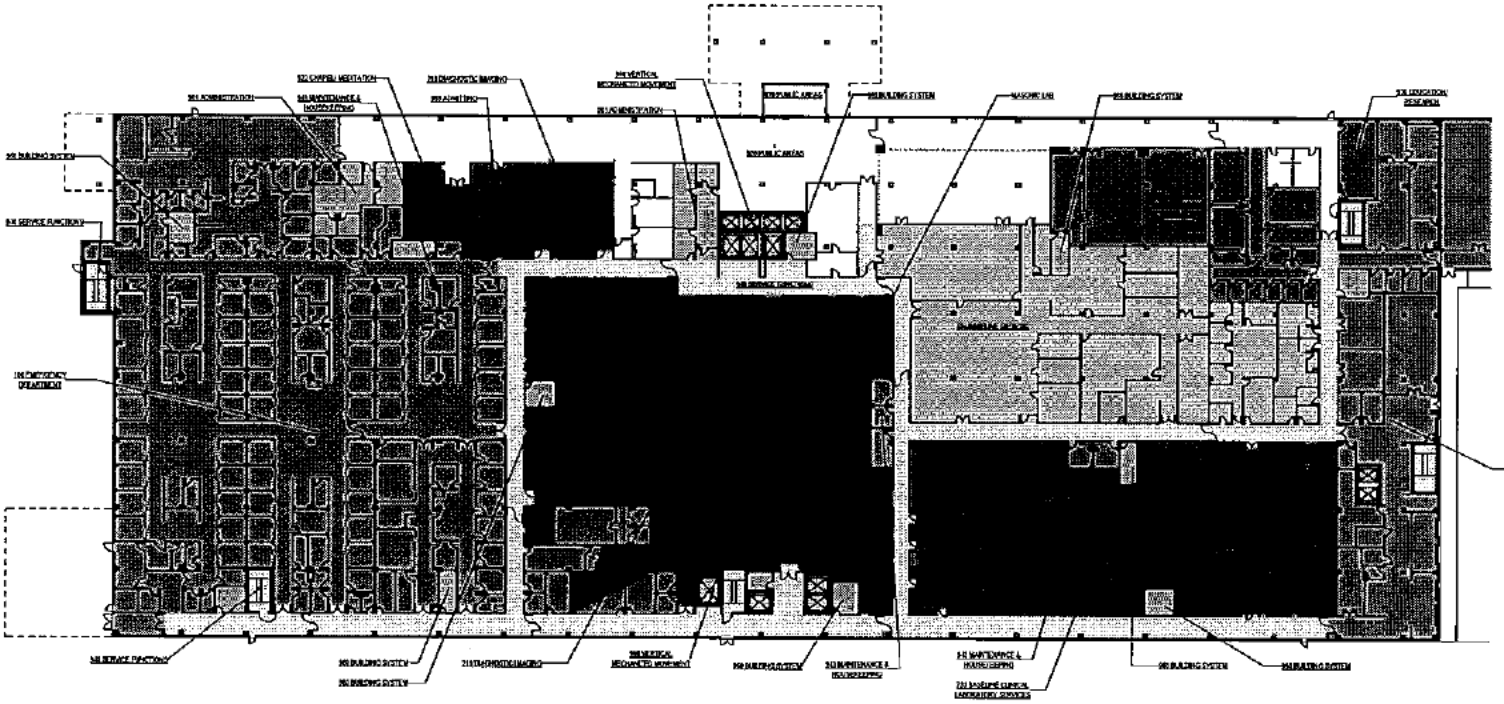
2 F1 FUNCTIONAL AREA PLAN - ANNEX/ CEP



3 F2 FUNCTIONAL AREA PLAN - CEP



4 F3 FUNCTIONAL AREA PLAN - CEP



FUNCTIONAL AREA CODE LEGEND

- 106 EMERGENCY DEPARTMENT
- 210 DIAGNOSTIC IMAGING
- 733 BASELINE CLINICAL LABORATORY SERVICES
- 734 BASELINE DIETETIC
- 901 ADMINISTRATION
- 903 ADMITTING
- 920 PUBLIC AREAS
- 922 CHAPEL/ MEDITATION
- 930 EDUCATION/ RESEARCH
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM
- 968 VERTICAL MECHANIZED MOVEMENT
- MASONIC LAB

1 F1 FUNCTIONAL AREA PLAN

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F1, CEP F1-F3 FUNCTIONAL AREA PLAN

G1201

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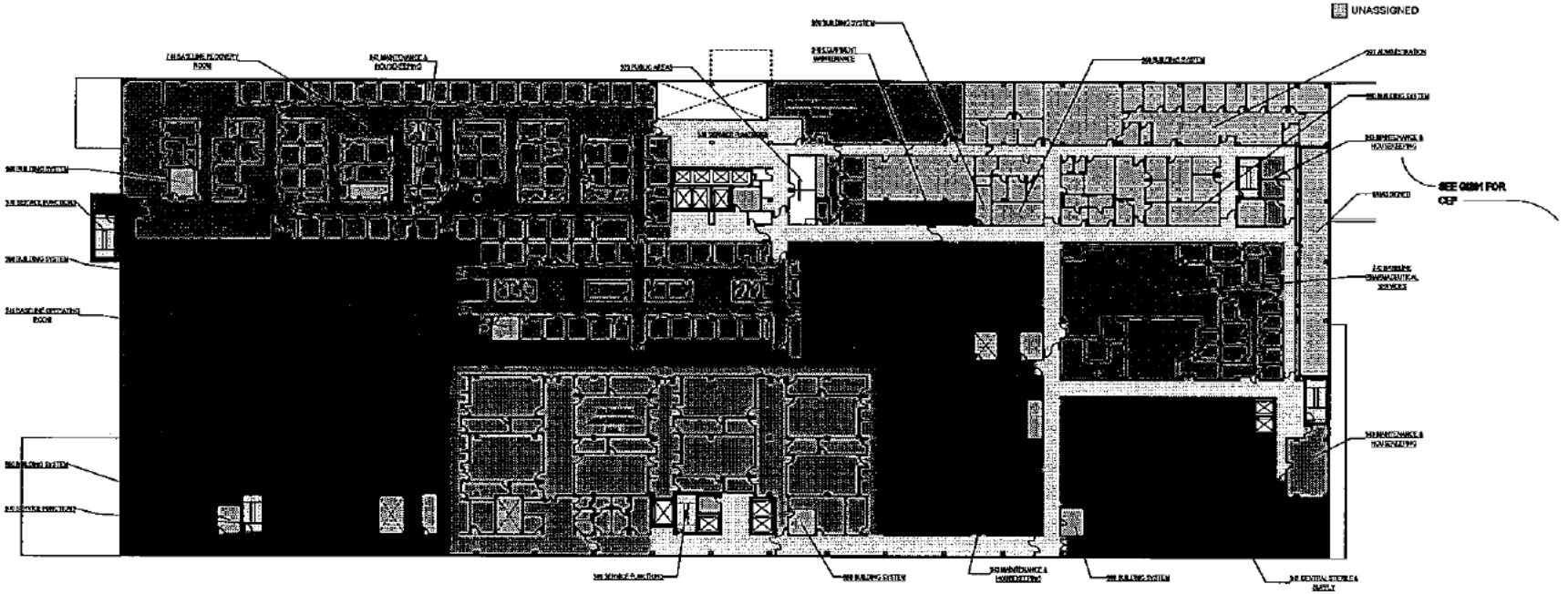
PHONE: 614.224.11.46
www.nbbj.com

FUNCTIONAL AREA CODE LEGEND

- 203 CARDIAC CATHETERIZATION- ADULT
- 741 BASELINE OPERATING ROOM
- 742 BASELINE PHARMACEUTICAL SERVICES
- 744 BASELINE RECOVERY ROOM
- 901 ADMINISTRATION
- 920 PUBLIC AREAS
- 940 SERVICE FUNCTIONS
- 941 CENTRAL STERILE & SUPPLY
- 943 MAINTENANCE & HOUSEKEEPING
- 948 EQUIPMENT MAINTENANCE
- 960 BUILDING SYSTEM
- UNASSIGNED



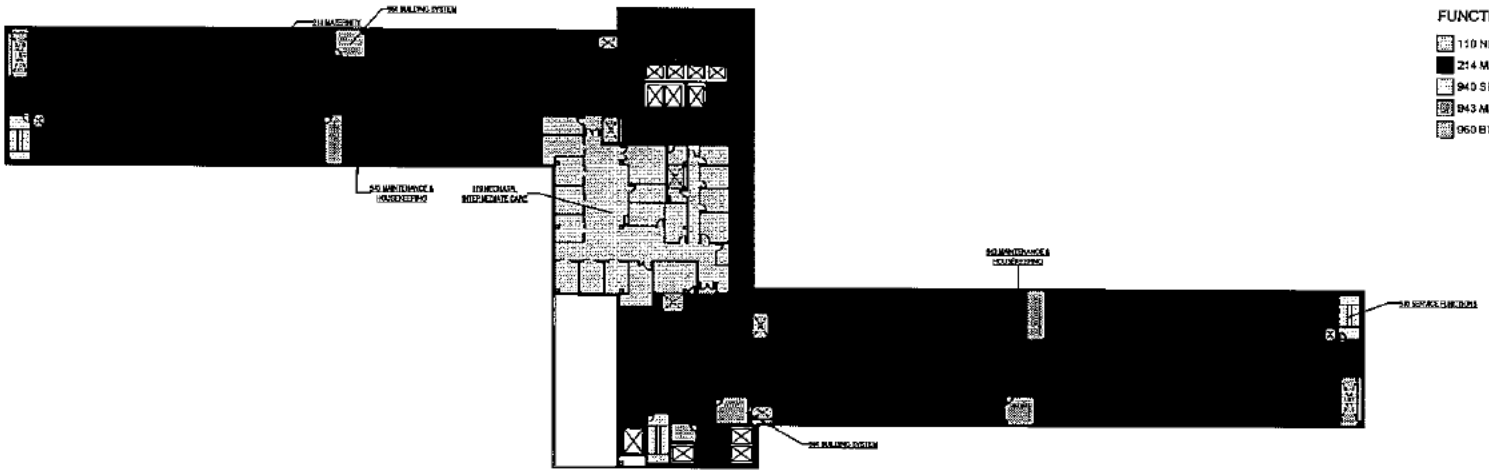
1 F2 FUNCTIONAL AREA PLAN

MOHAWK VALLEY HEALTH SYSTEM

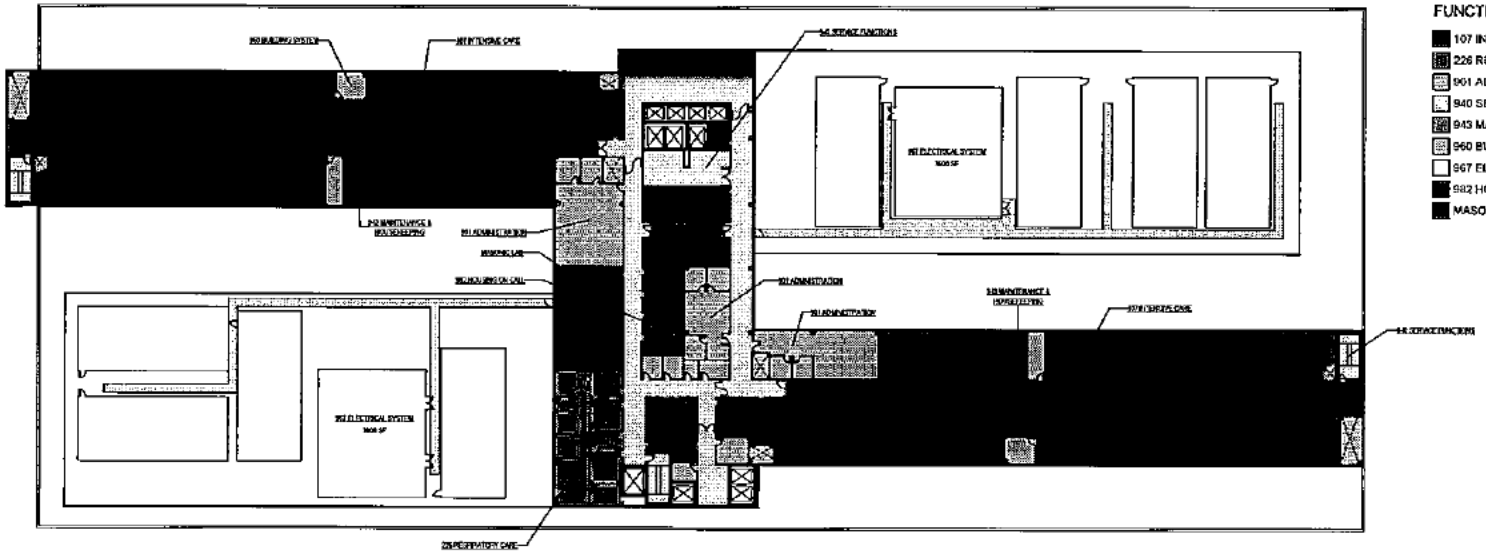
CON - SD SUBMITTAL

F2 FUNCTIONAL AREA PLAN

G1202



2 F4 FUNCTIONAL AREA PLAN



1 F3 FUNCTIONAL AREA PLAN

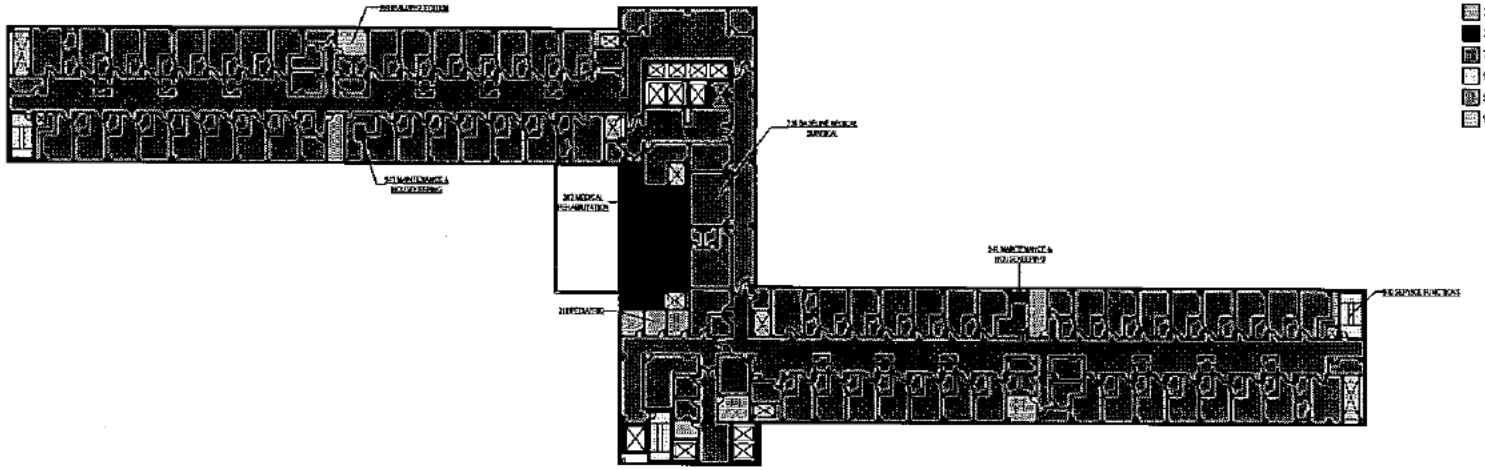
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F3, F4 FUNCTIONAL AREA PLAN

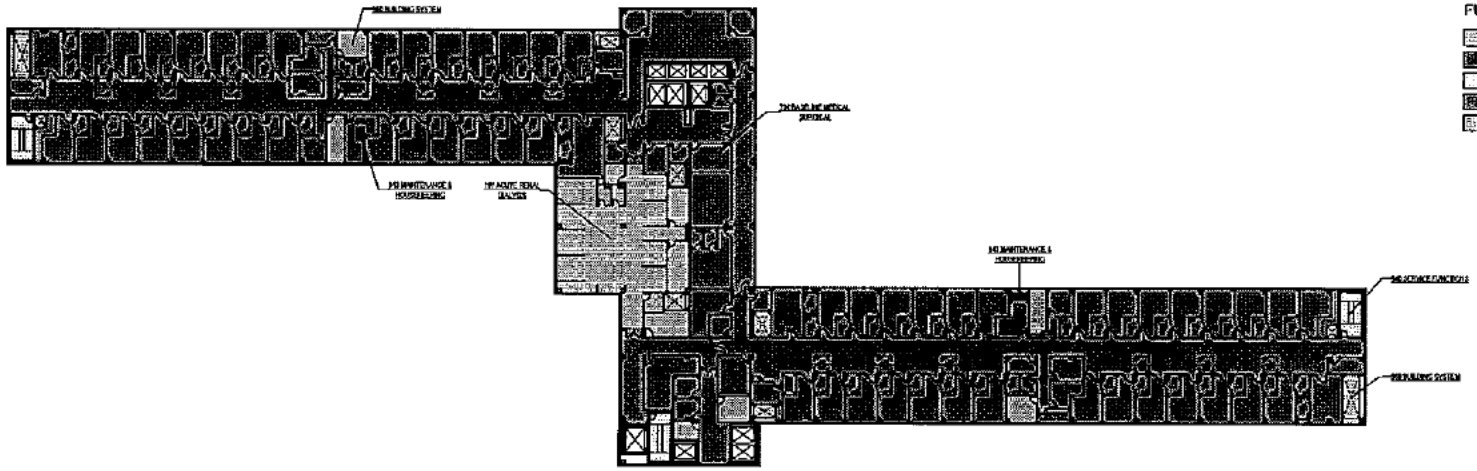
GI203



FUNCTIONAL AREA CODE LEGEND

- 216 PEDIATRIC
- 302 MEDICAL REHABILITATION
- 736 BASELINE MEDICAL SURGICAL
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

2 F8 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 101 ACUTE RENAL DIALYSIS
- 736 BASELINE MEDICAL SURGICAL
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

1 F5 FUNCTIONAL AREA PLAN

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295 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7165

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 9, 2017

Mark	DATE	DESCRIPTION

SCALE 1" = 30'-0"

PROJECT MONITOR Designer

PROJECT NUMBER 170911.00

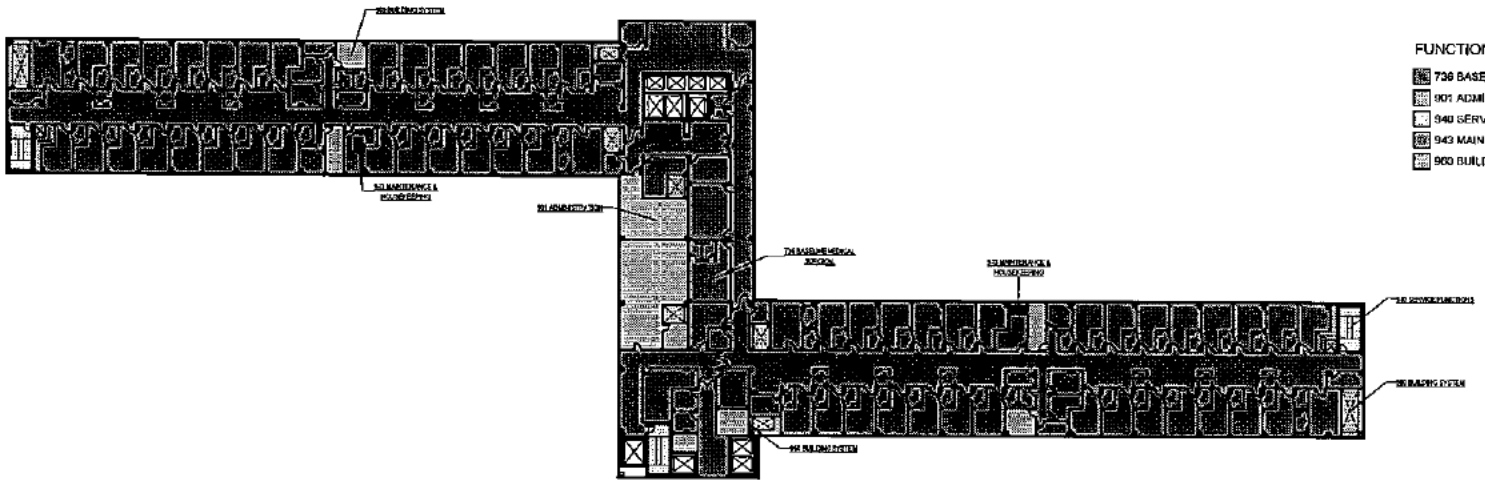
DATE 11/9/17

SHEET NAME

F5, F8 FUNCTIONAL AREA PLAN

SHEET NUMBER

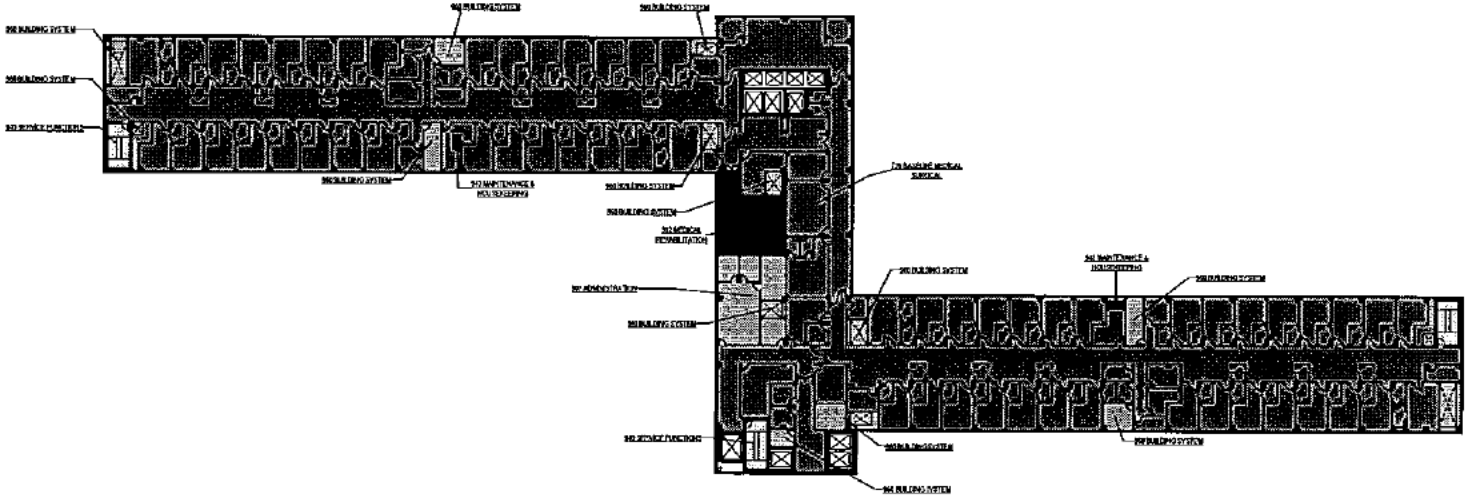
G0205



FUNCTIONAL AREA CODE LEGEND

- 736 BASELINE MEDICAL SURGICAL
- 901 ADMINISTRATION
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

2 F8 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 302 MEDICAL REHABILITATION
- 736 BASELINE MEDICAL SURGICAL
- 901 ADMINISTRATION
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

1 F7 FUNCTIONAL AREA PLAN

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COLUMBUS, OH 43215
PHONE 614 224 2146
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

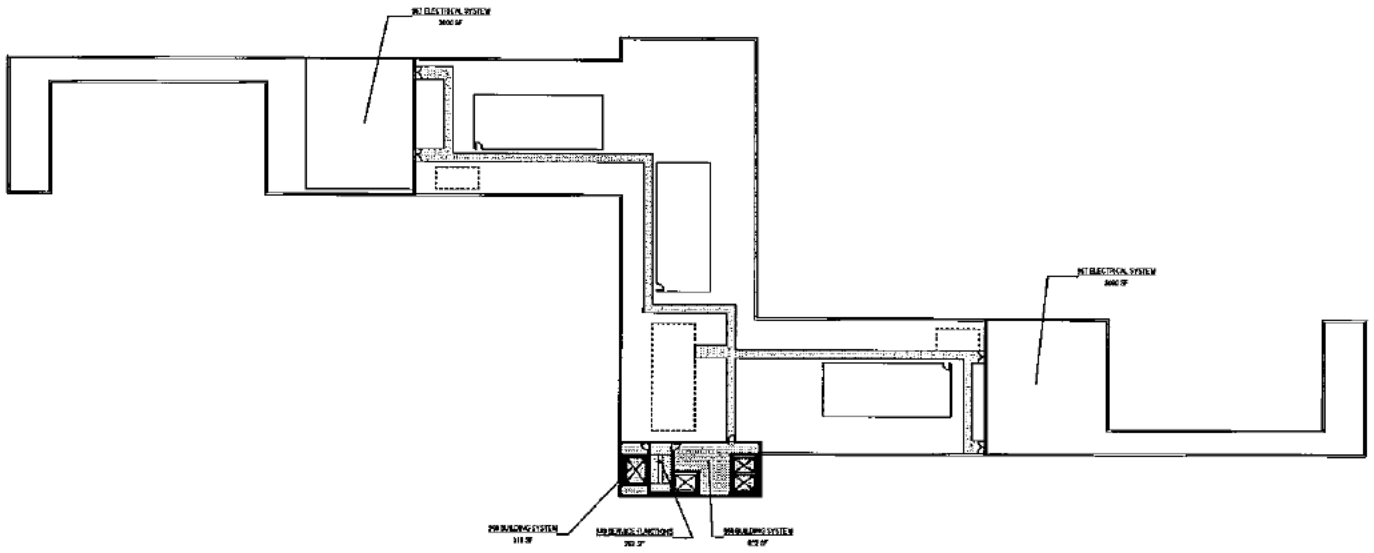
SCALE 1" = 20'-0"

PROJECT NUMBER 170103.00

DATE 10/20/17

SHEET NAME
F7, F8 FUNCTIONAL AREA PLAN

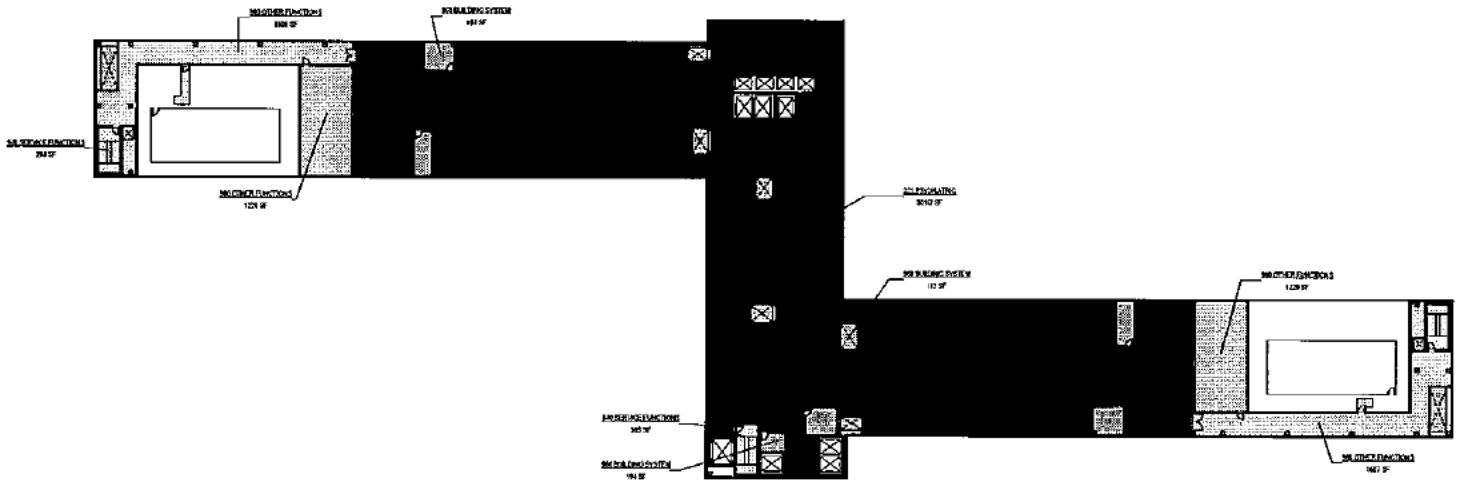
SHEET NO.
GI207



FUNCTIONAL AREA CODE LEGEND

- 940 SERVICE FUNCTIONS
- 960 BUILDING SYSTEM
- 967 ELECTRICAL SYSTEM

2 R1 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 221 PSYCHIATRIC
- 940 SERVICE FUNCTIONS
- 960 BUILDING SYSTEM
- 950 OTHER FUNCTIONS

1 F9 FUNCTIONAL AREA PLAN

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COLUMBUS, OH 43215
PHONE: 614.224.7125

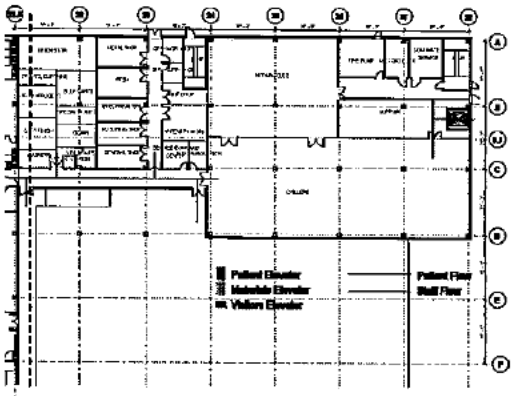
MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

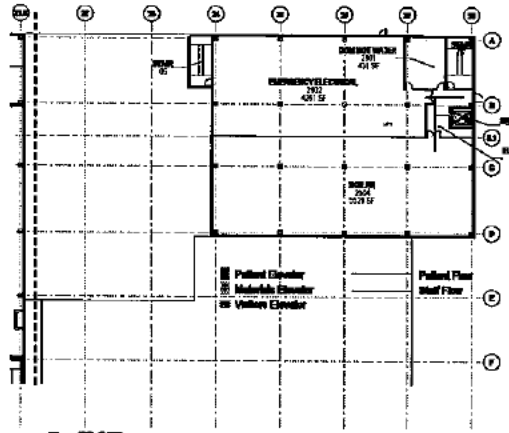
NOVEMBER 1, 2017

F9, F10 ROOF FUNCTIONAL AREA PLAN

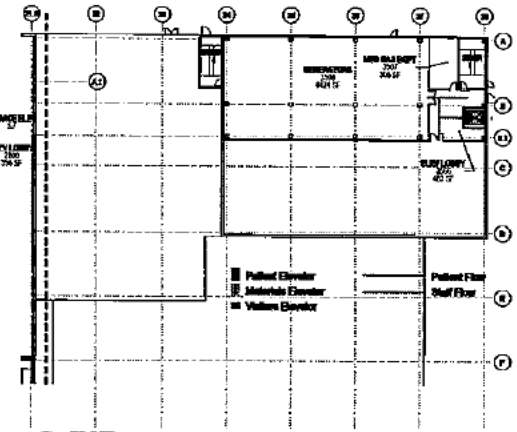
G1208



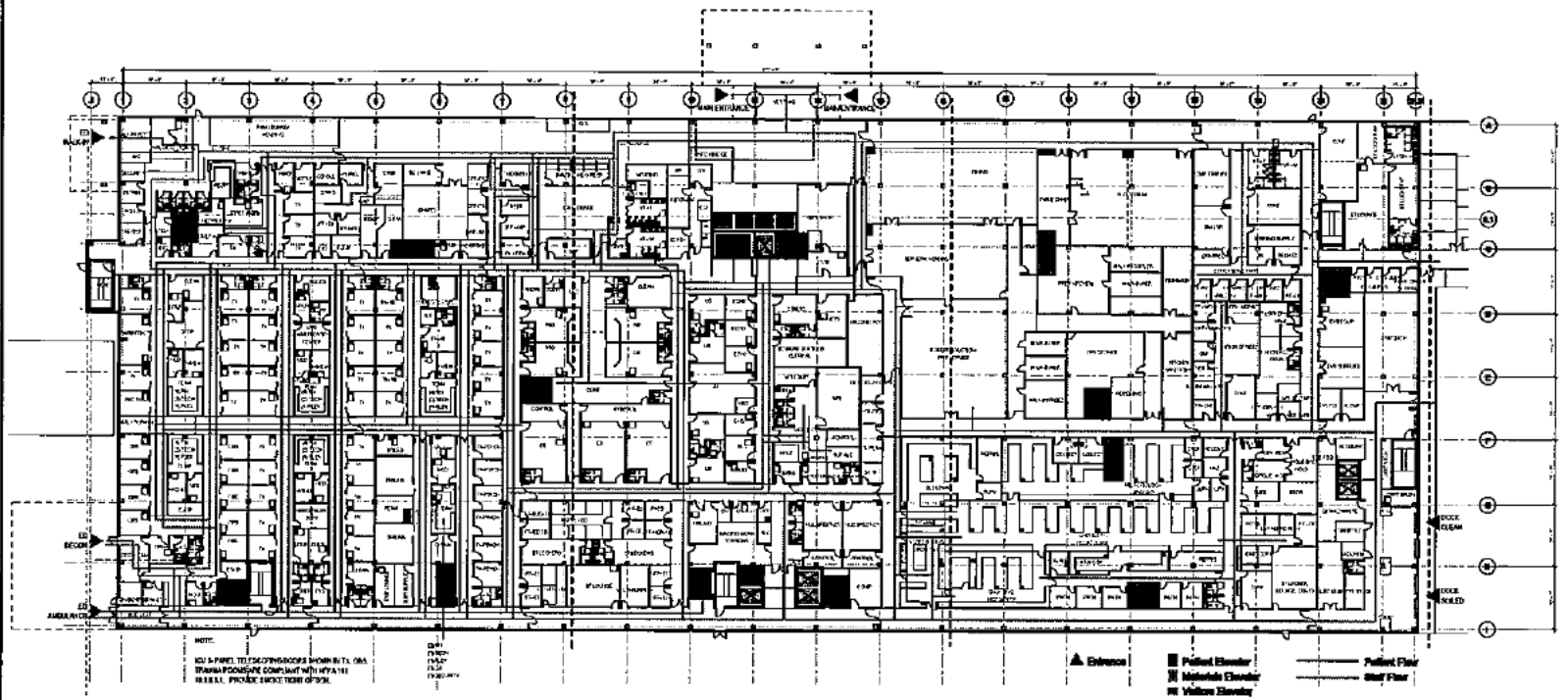
2 F1 ANNEX & CEP



3 F2 CEP



4 F3 CEP



1 F1 FLOOR PLAN

KEYPLAN

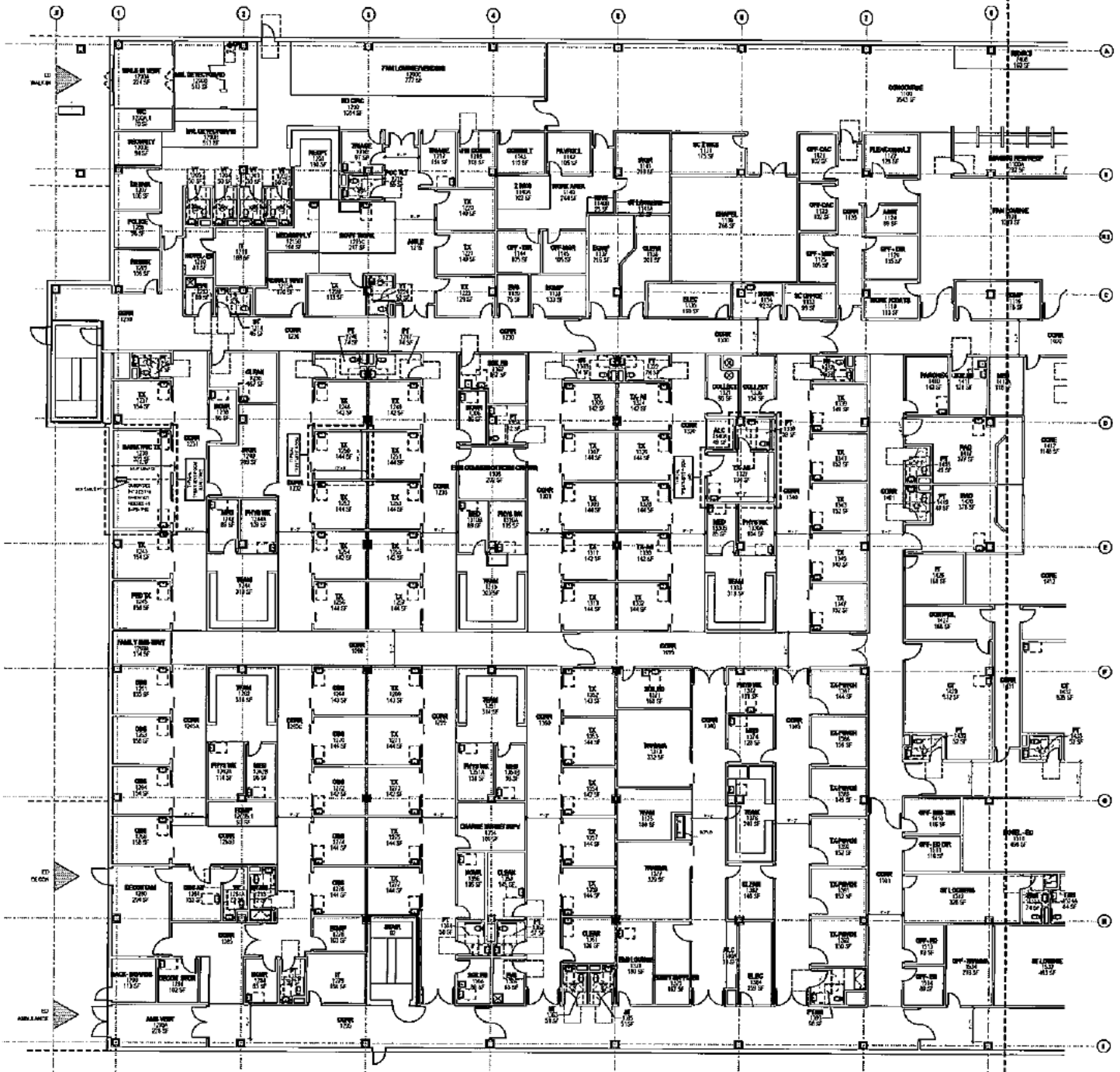
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F1 OVERALL & CEP FLOOR PLANS

AE101



nbbj

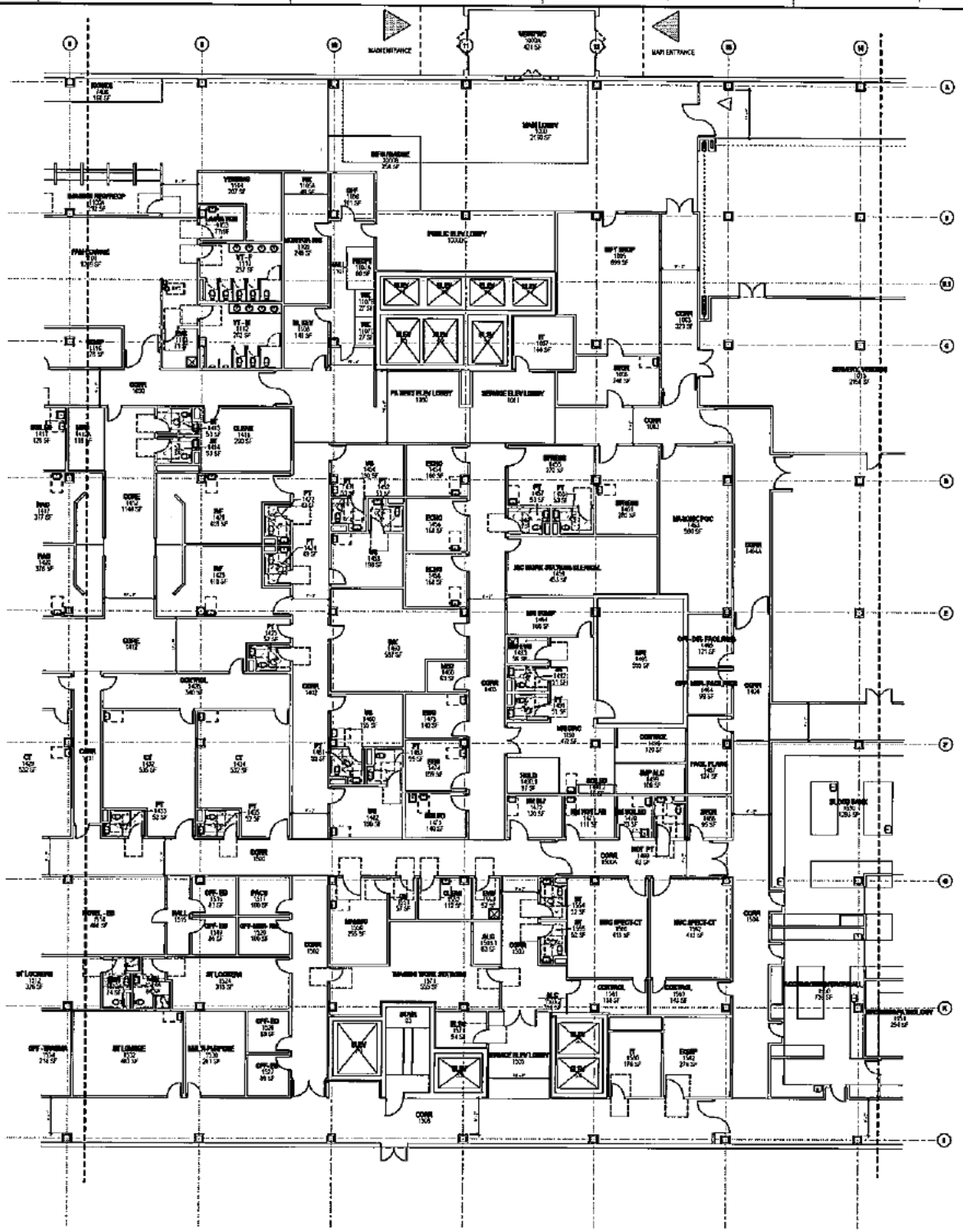
MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

KEYPLAN

F1 FLOOR PLAN - AREA A

AE101-A



KEYPLAN

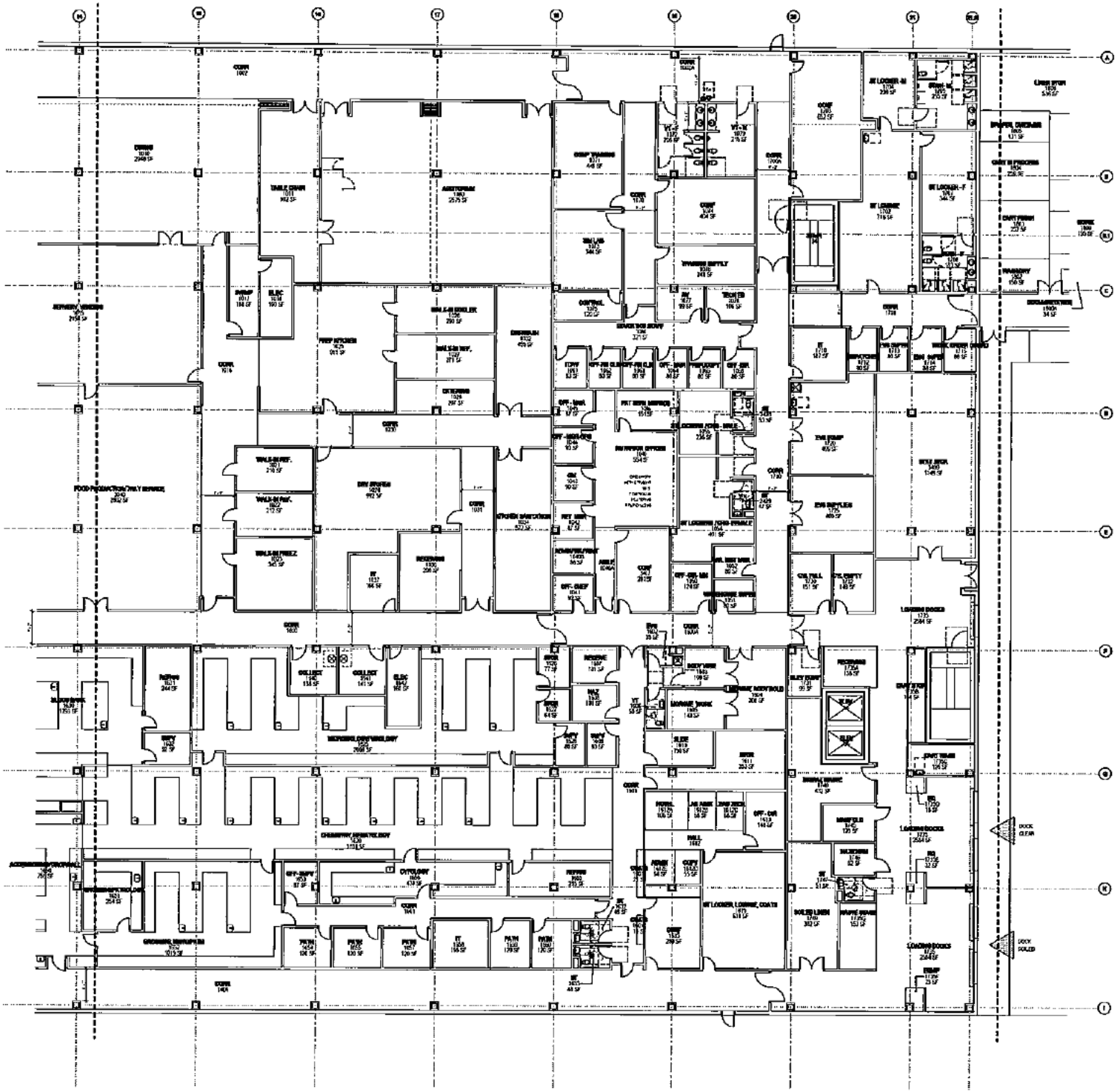
nbbj

MOHAWK VALLEY HEALTH SYSTEM

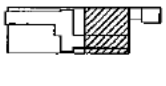
CON - SD SUBMITTAL

F1 FLOOR PLAN - AREA B

AE101-B



KEYPLAN



nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 1545
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

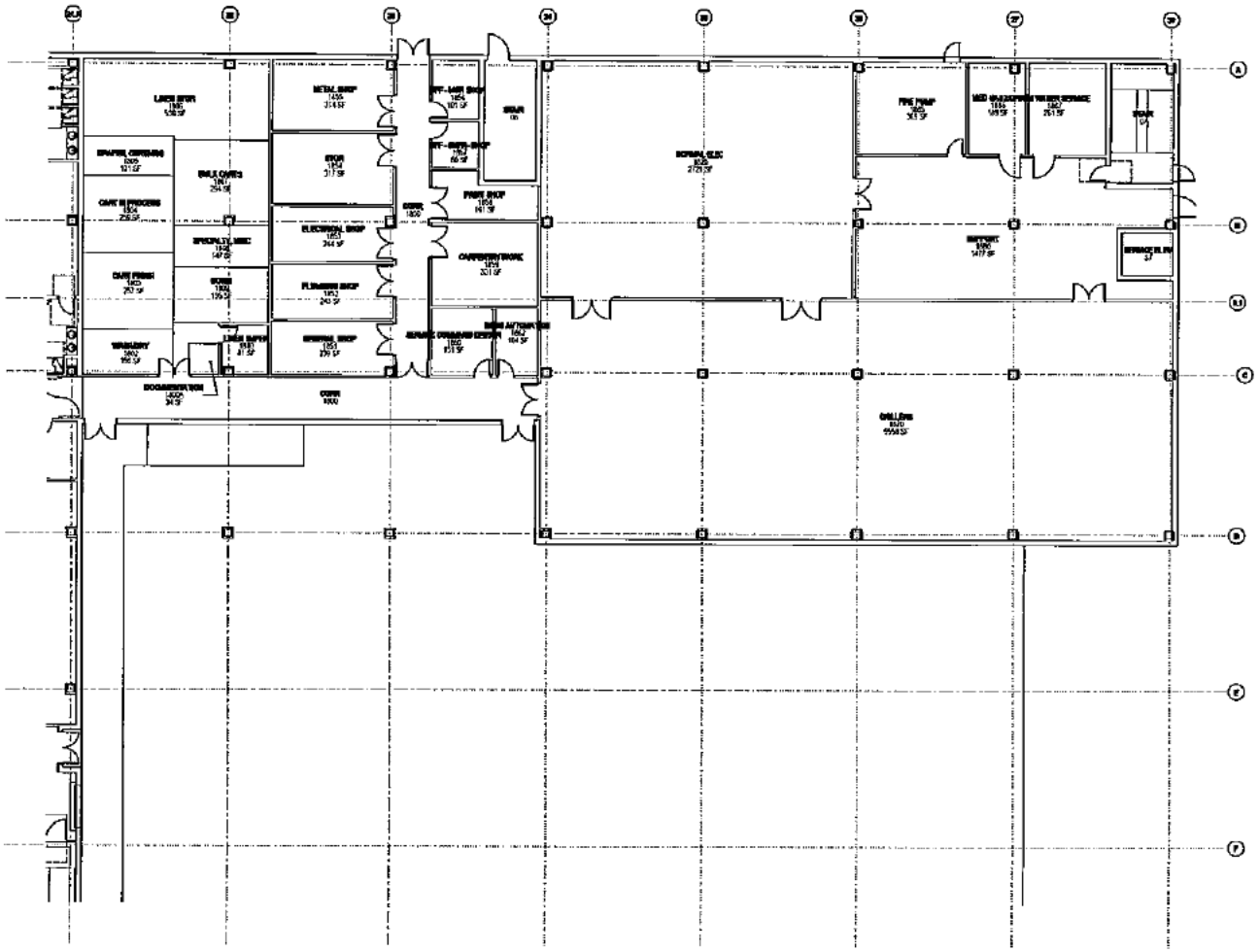
CON - SD SUBMITTAL

NOVEMBER 3, 2017

mark	DATE	DESCRIPTION

F1 FLOOR PLAN - AREA C

AE101-C



KEYPLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 2145
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 9, 2017

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"

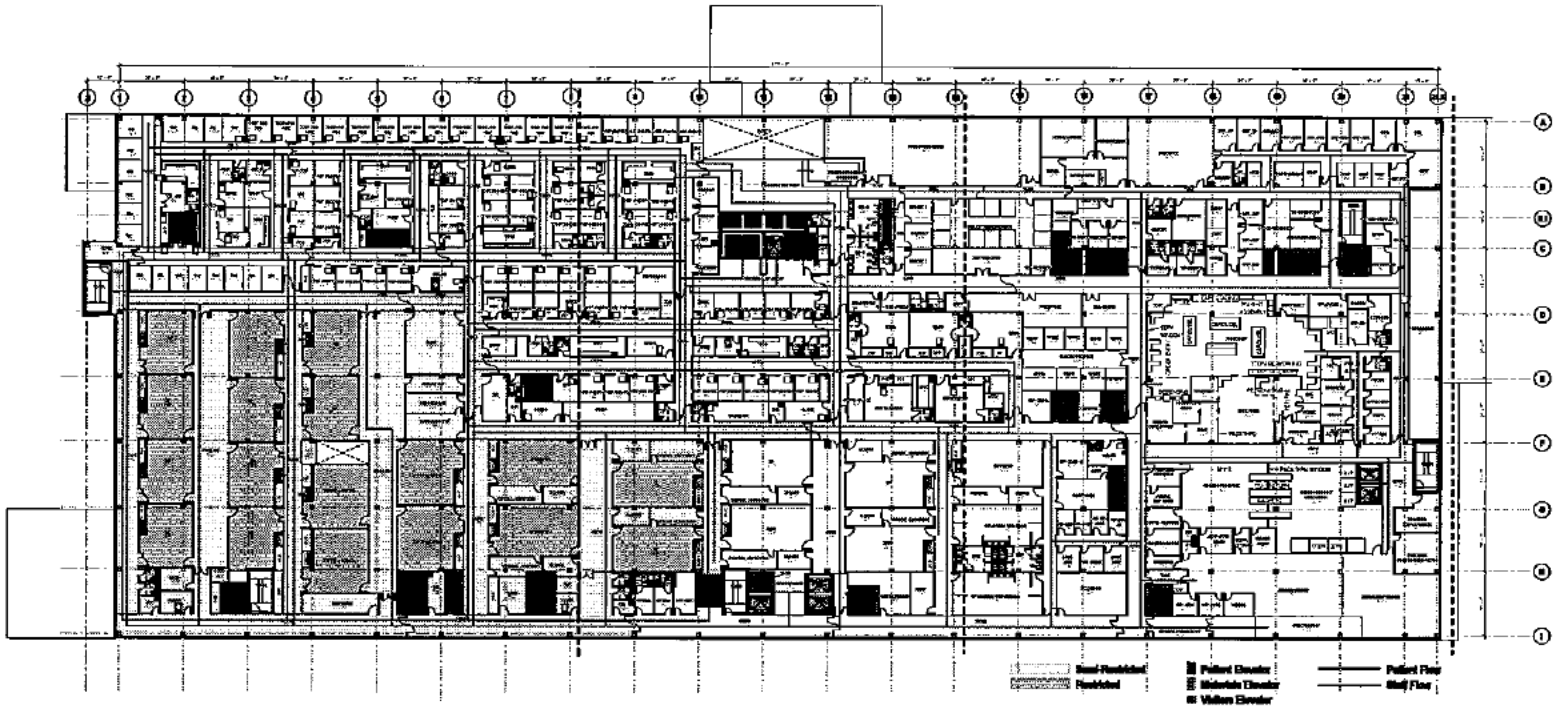
PROJECT LEAD: Bridgard

PROJECT NO.: 170104.00

DATE: 11/9/2017

SHEET NAME
F1 FLOOR PLAN - AREA D

SHEET NUMBER
AE101-D



1 F2 FLOOR PLAN

KEYPLAN

nbbj
204 N. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7185
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

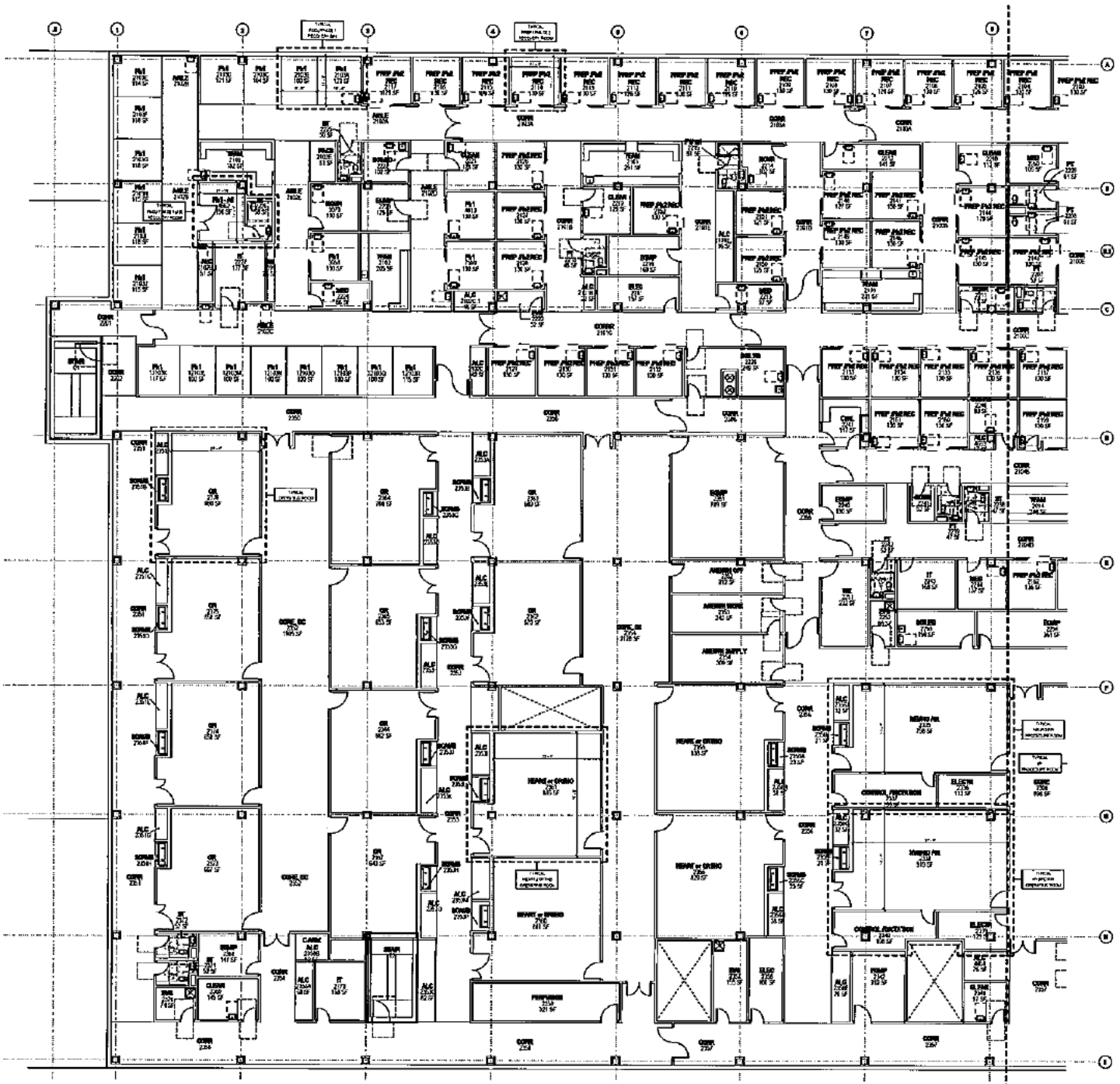
SCALE 1" = 30'-0"

PROJECT NUMBER 160813.00

DATE

SHEET NAME
F2 OVERALL FLOOR PLAN

SHEET NUMBER
AE102



KEYPLAN

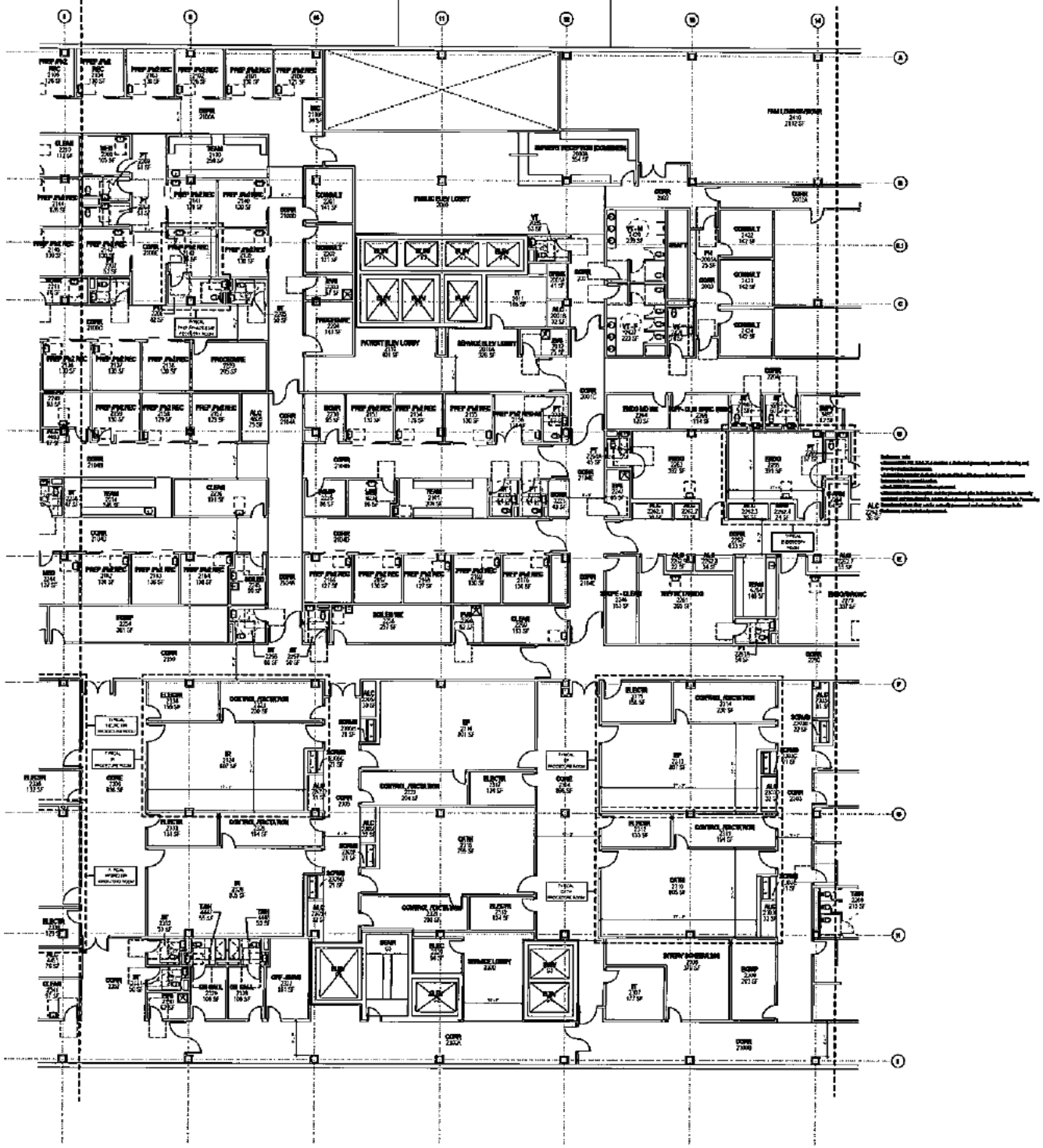
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F2 FLOOR PLAN - AREA A

AE102-A



nbbj

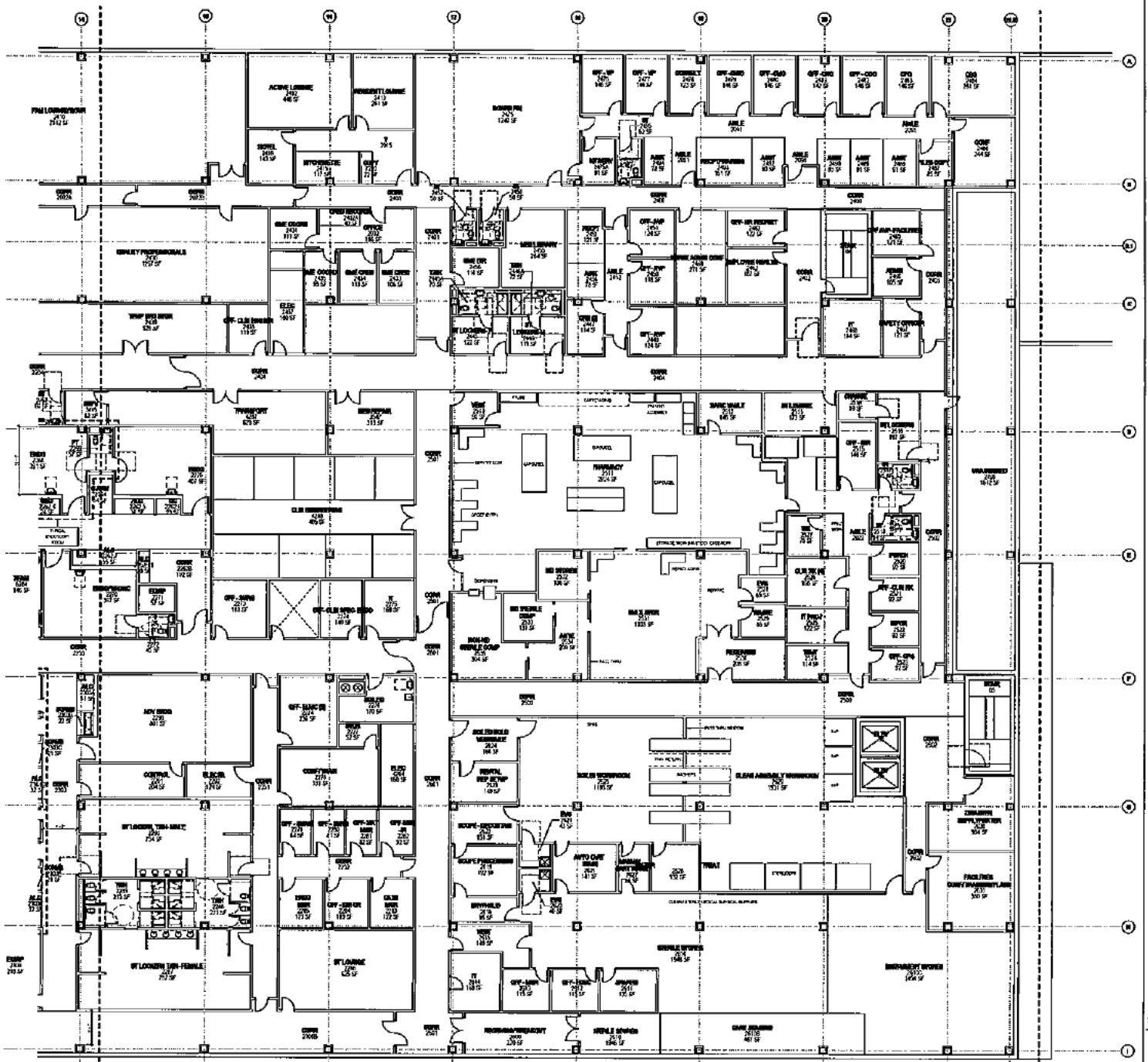
MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

KEYPLAN

F2 FLOOR PLAN - AREA B

AE102-B



KEYPLAN

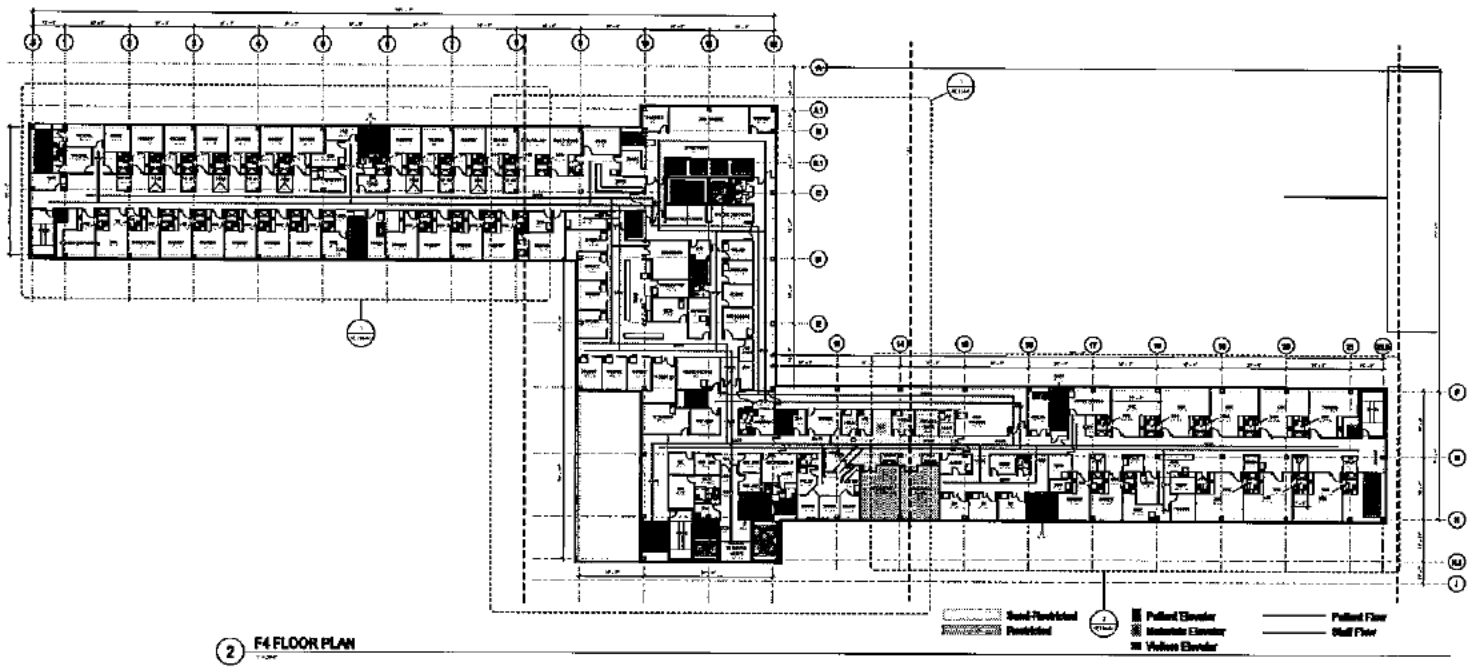
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

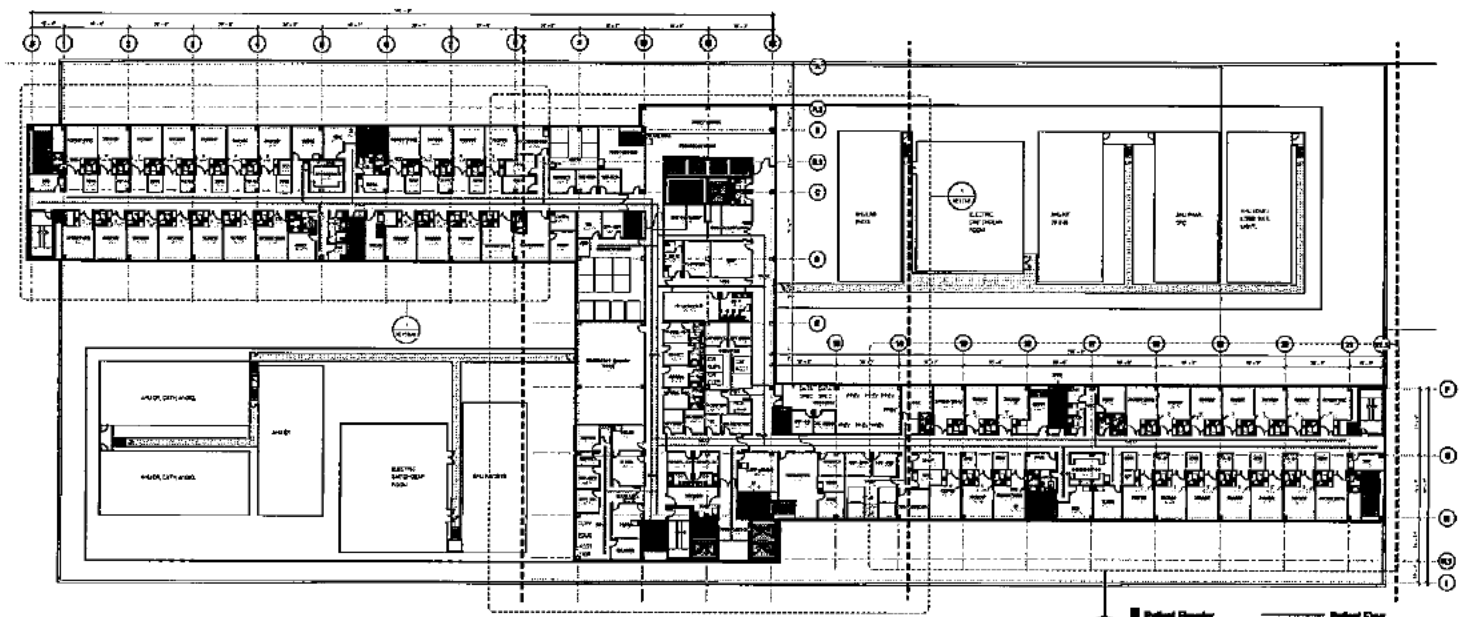
F2 FLOOR PLAN - AREA C

AE102-C



Semi-Restricted
Restricted
Patient Elevator
Materials Elevator
Visitors Elevator
Patient Flow
Staff Flow

2 F4 FLOOR PLAN



Patient Elevator
Materials Elevator
Visitors Elevator
Patient Flow
Staff Flow

1 F3 FLOOR PLAN

nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

SCALE 1"=20'-0"

PROJECT ARCHITECT Designer

PROJECT NUMBER

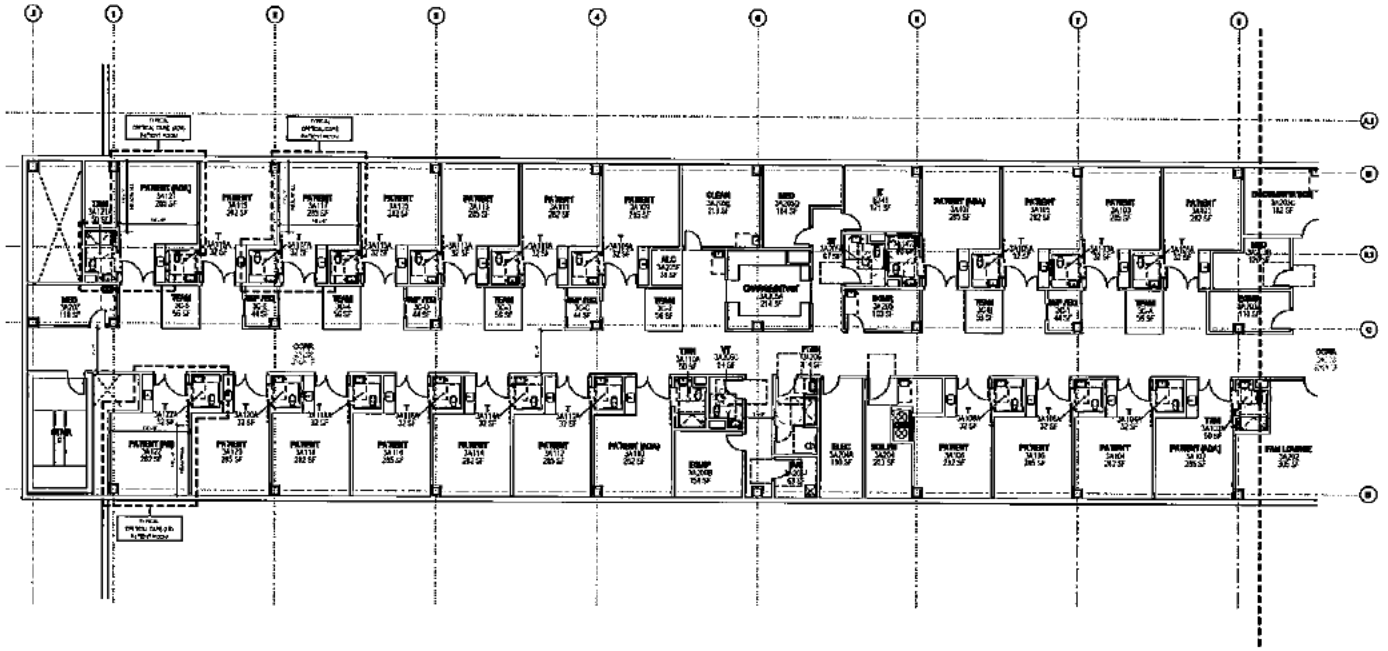
DATE

SHEET TITLE

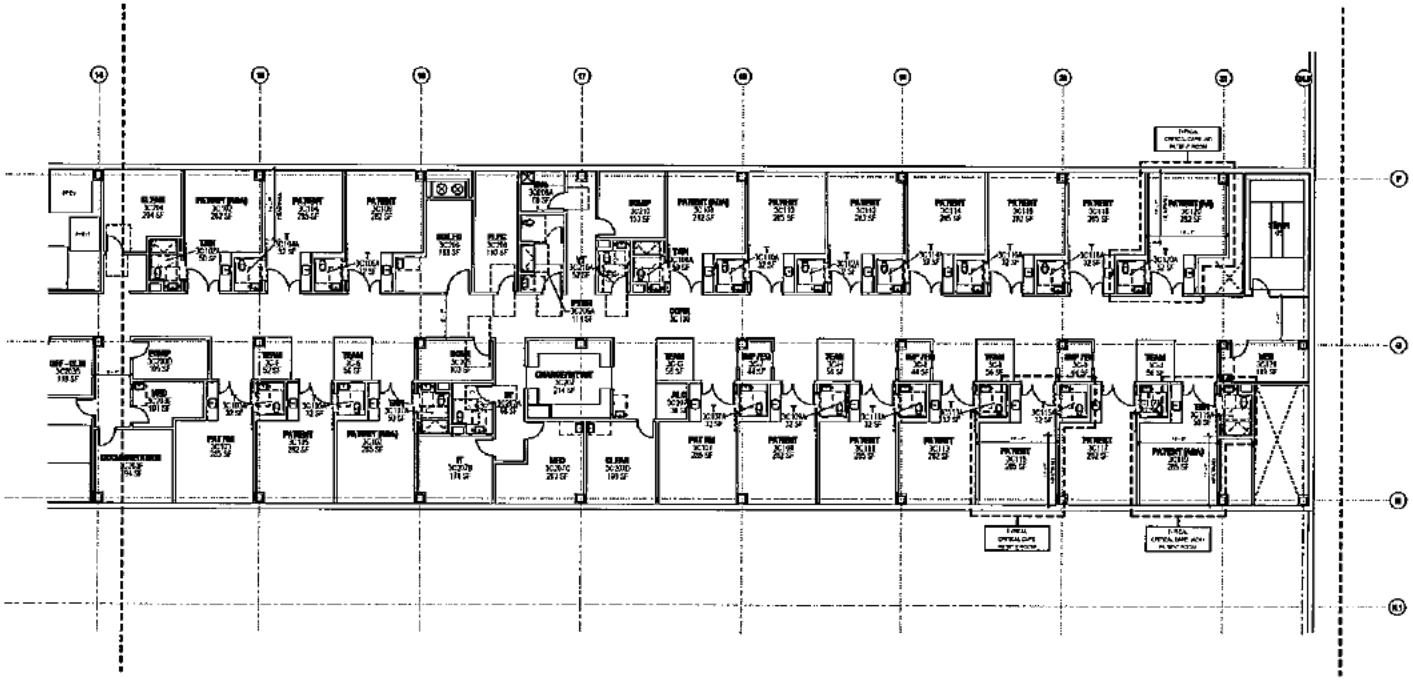
F3, F4 OVERALL FLOOR PLANS

SHEET NUMBER

AE103

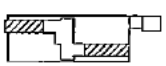


1 F3 - AREA A



2 F3 - AREA C

KEYPLAN



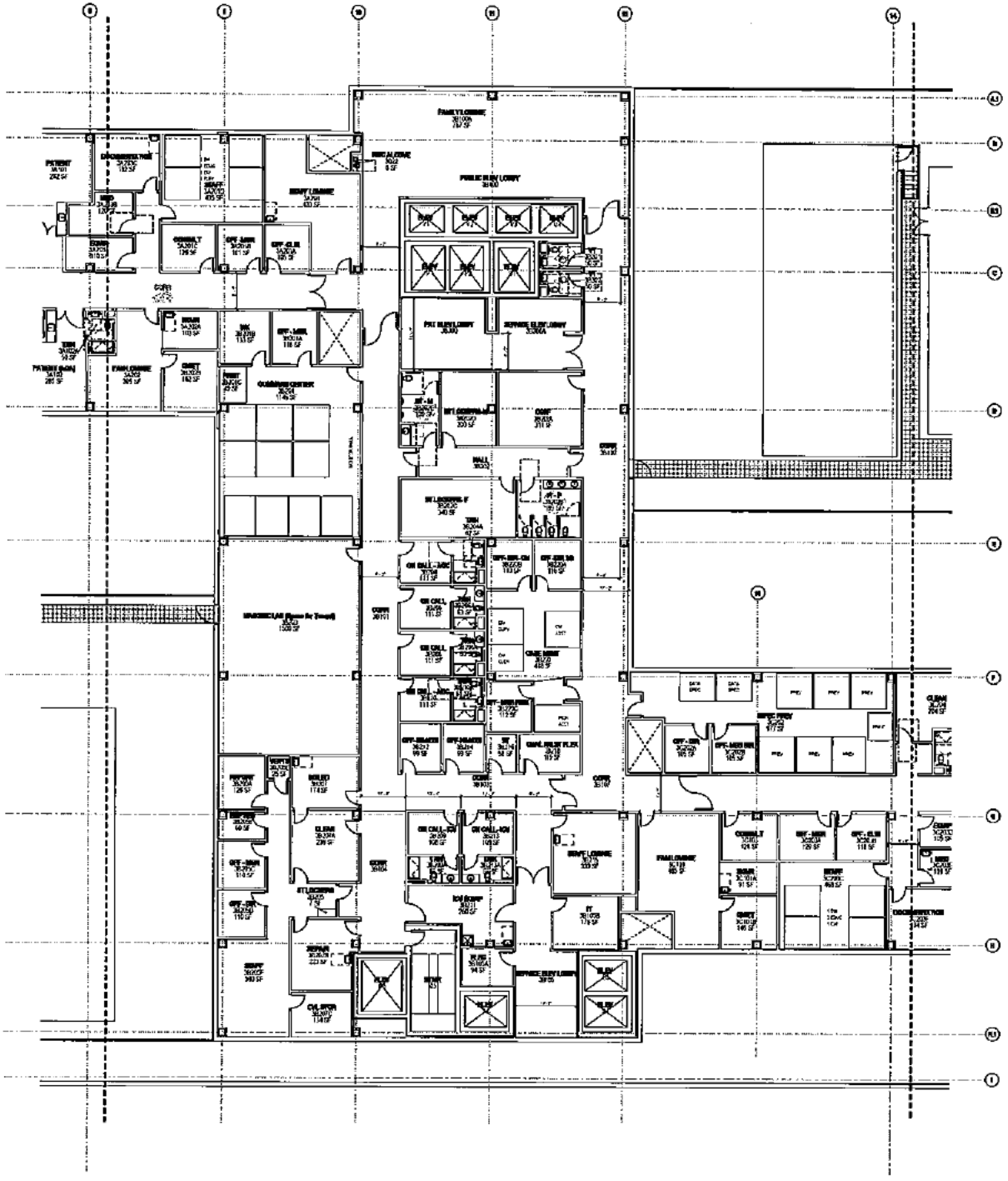
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

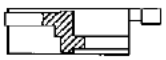
F3 FLOOR PLAN - AREA A & C

AE103-AC



1 F3 - AREA B

KEYPLAN



nbbj
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COLUMBUS, OH 43215
PHONE 614.224.2112
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"

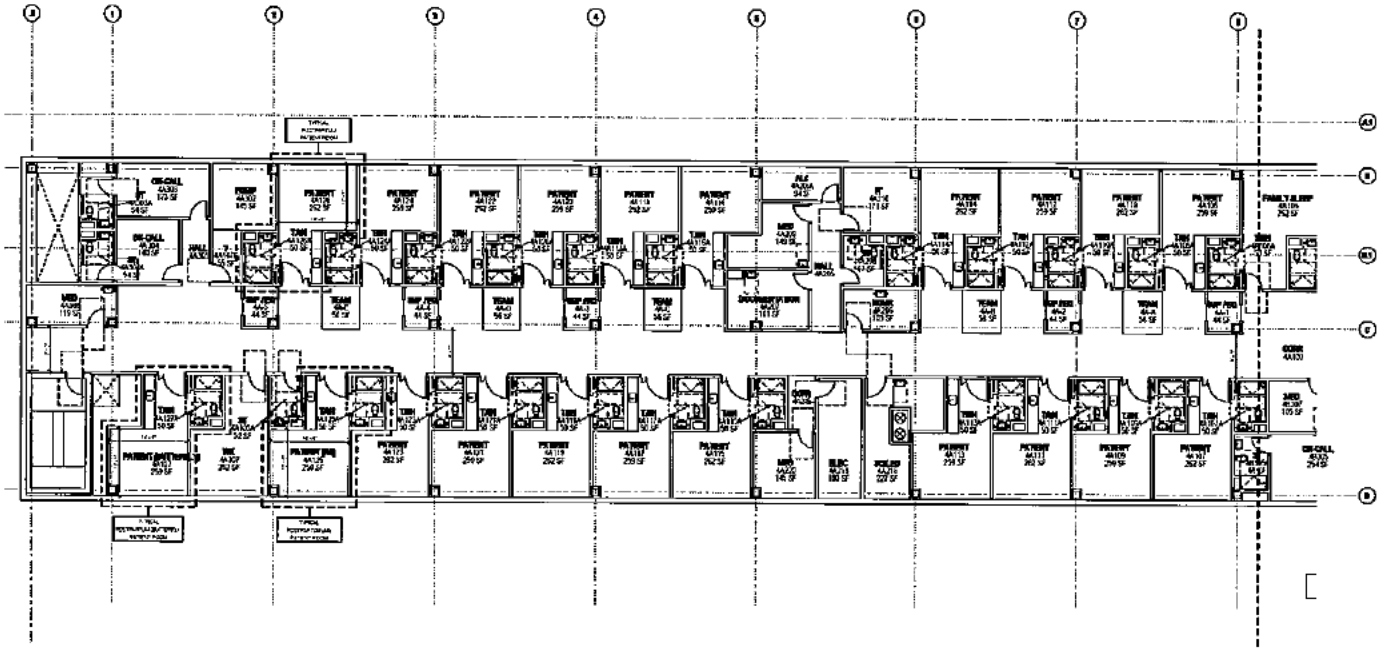
PROJECT NUMBER: 2016.0

PROJECT: MVHS-ELIS

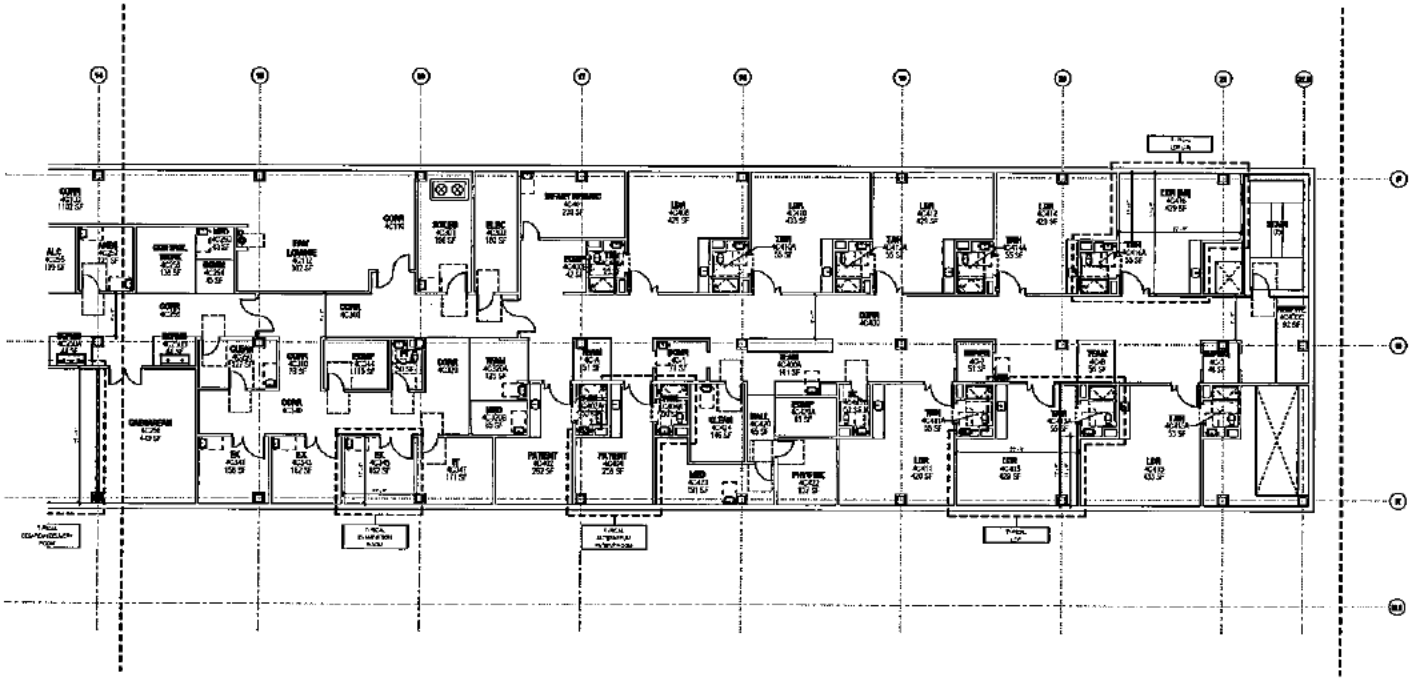
DATE: 11/1/2017

SHEET NAME: F3 FLOOR PLAN - AREA B

SHEET NUMBER: AE103-B

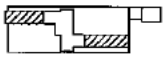


1 F4 - AREA A



2 F4 - AREA C

KEYPLAN



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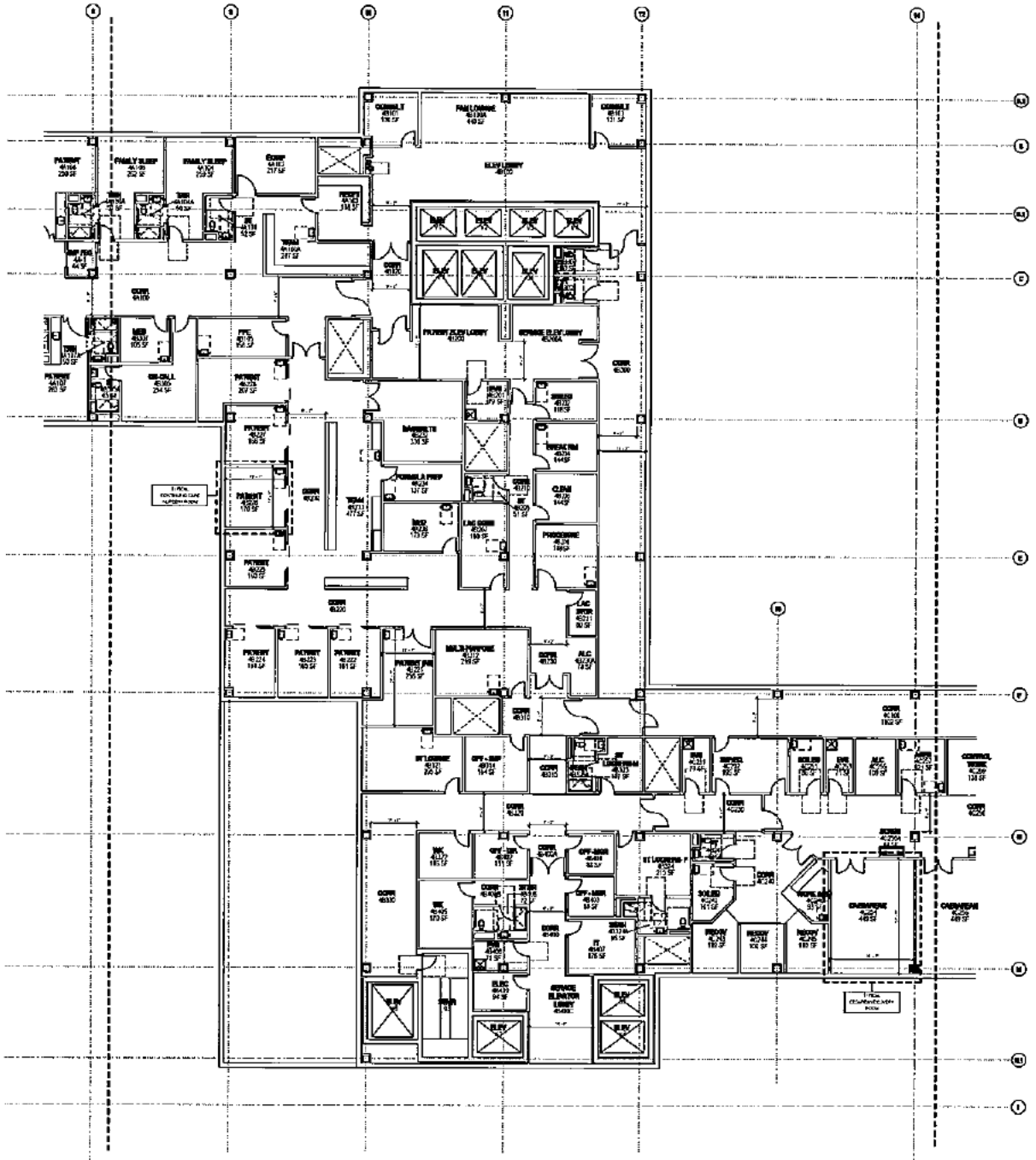
MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

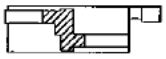
F4 FLOOR PLAN - AREA A & C

AE104-AC



1 F4 - AREA B

KEYPLAN



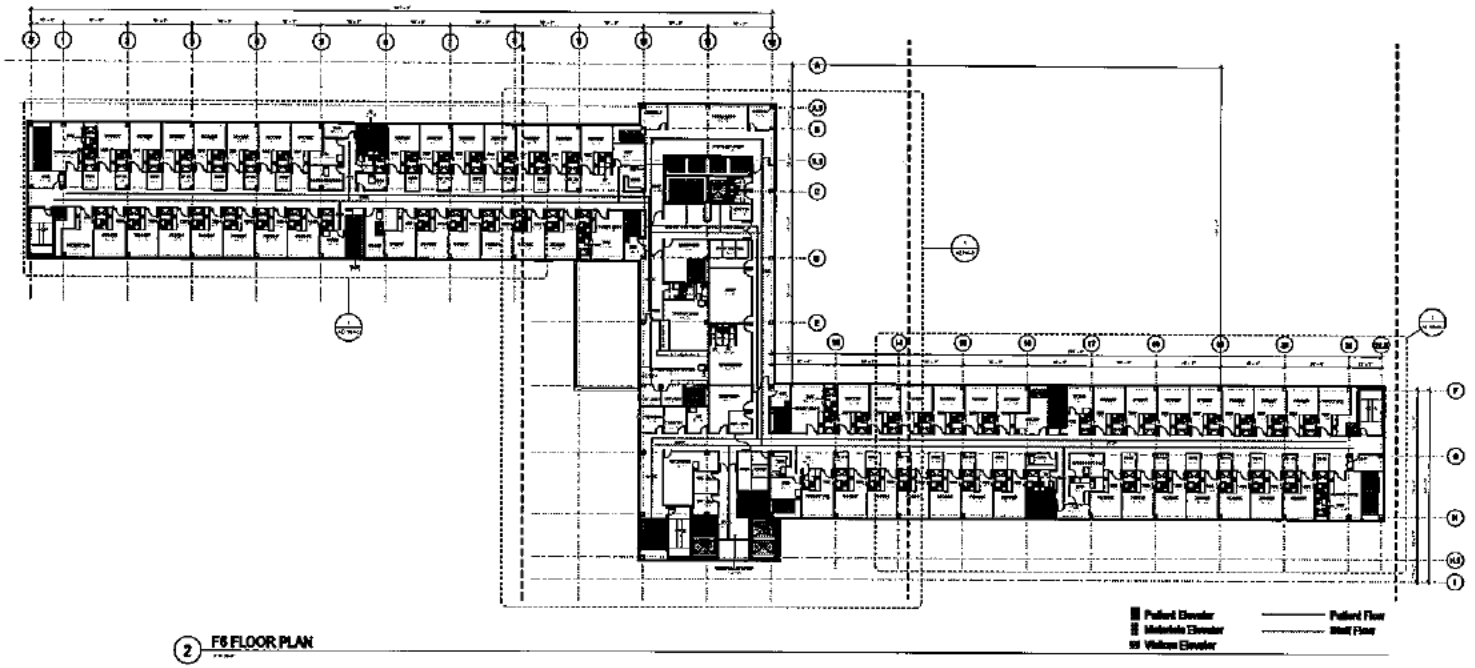
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

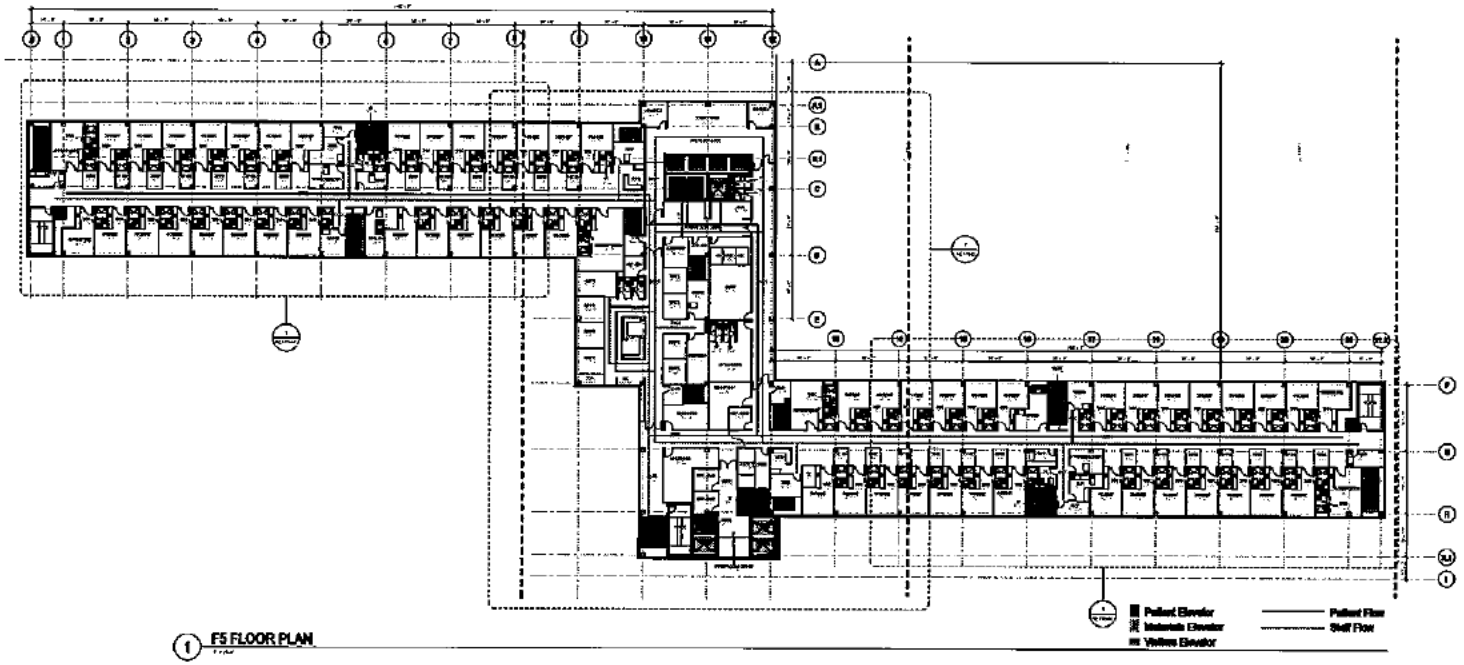
F4 FLOOR PLAN - AREA B

AE104-B



Patient Elevator
Materials Elevator
Visitors Elevator
Patient Flow
Staff Flow

2 F6 FLOOR PLAN



Patient Elevator
Materials Elevator
Visitors Elevator
Patient Flow
Staff Flow

1 F5 FLOOR PLAN

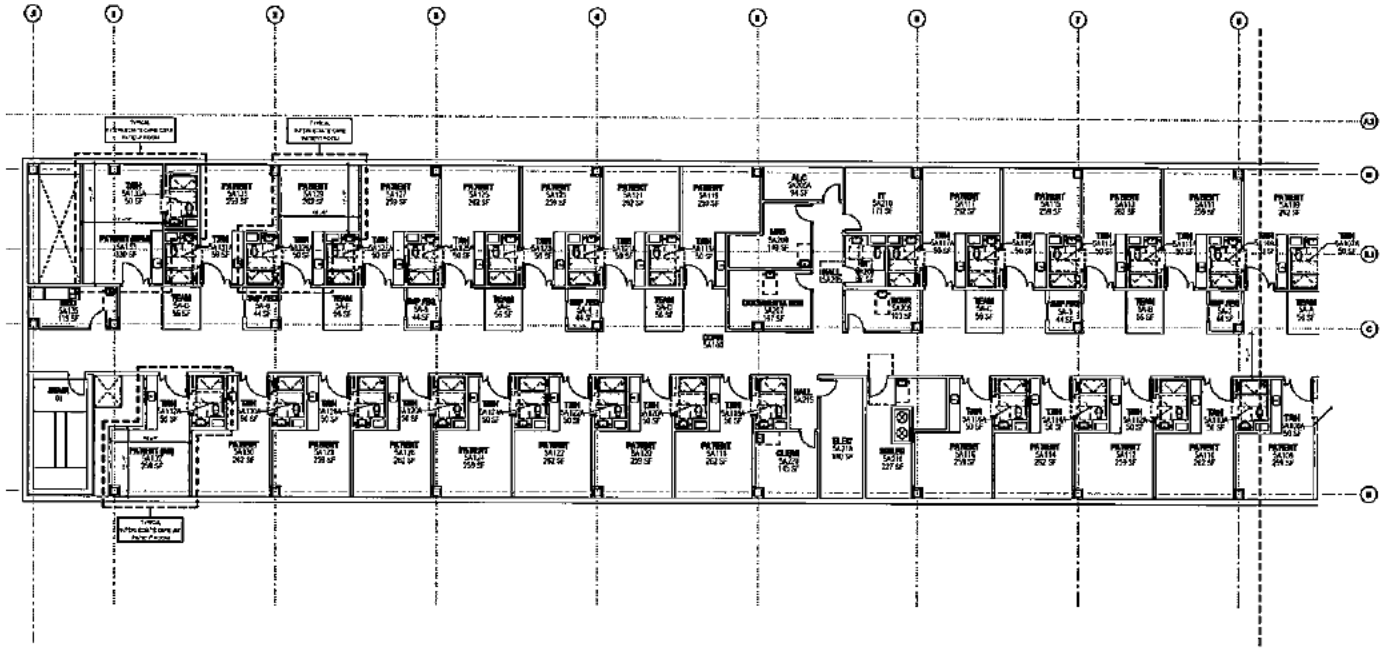
nbbj

MOHAWK VALLEY HEALTH SYSTEM

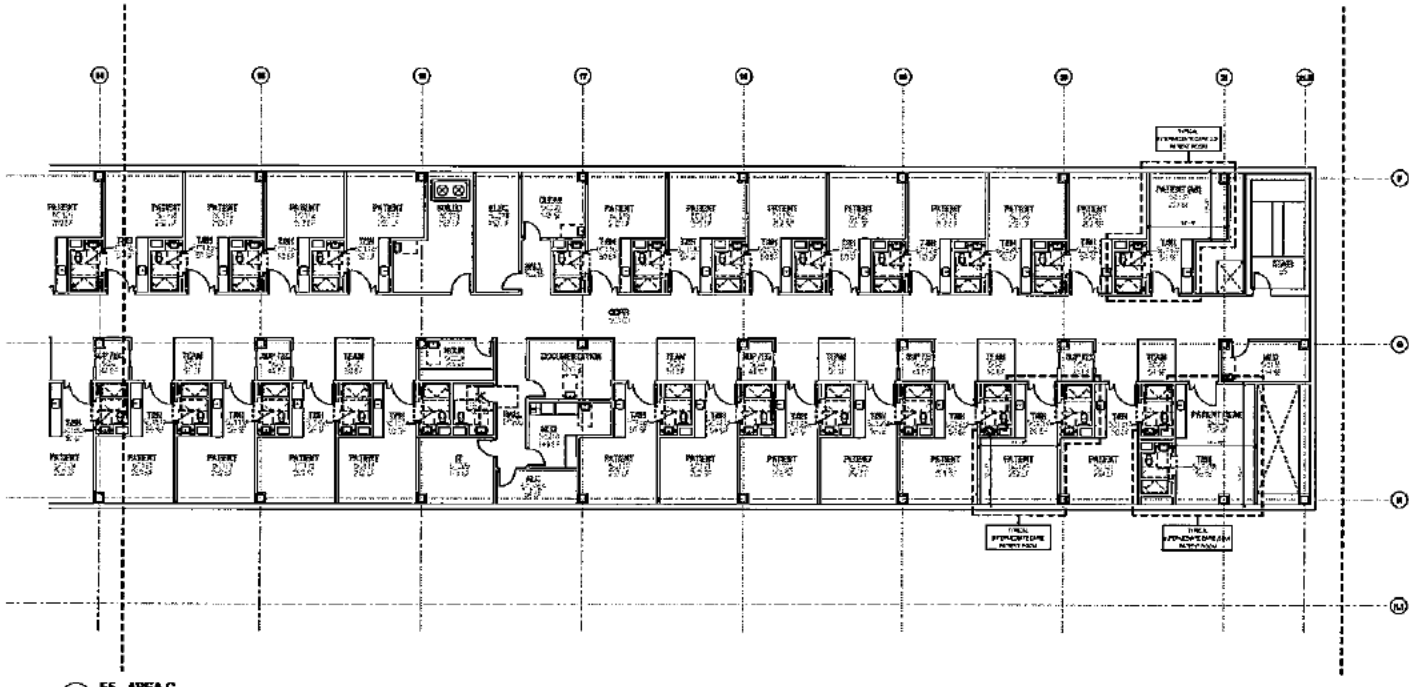
CON - SD SUBMITTAL

F5, F6 OVERALL FLOOR PLANS

AE105



1 F5 - AREA A



2 F5 - AREA C

KEYPLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 7345
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

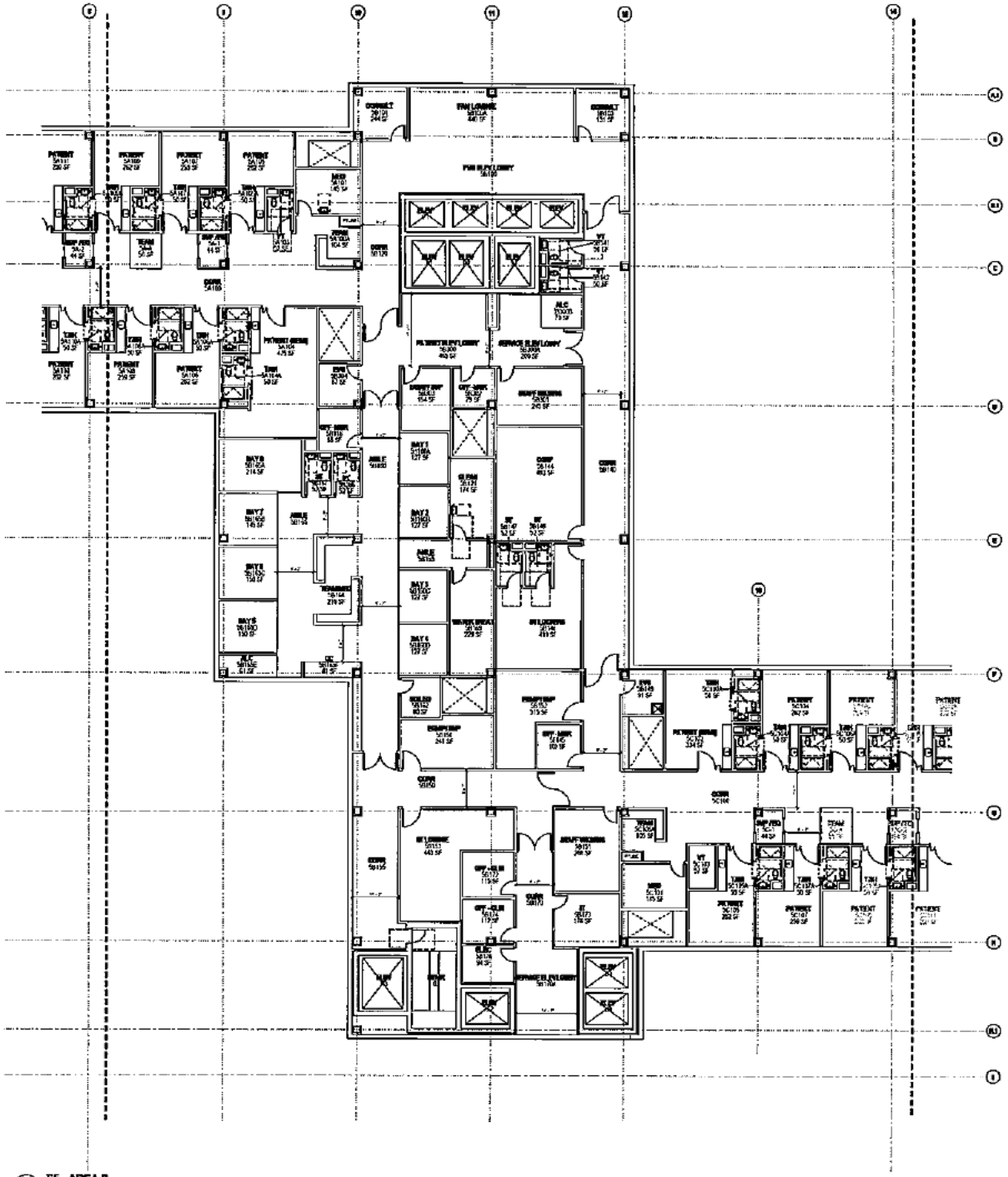
CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"
PROJECT ARCHITECT: Designer
PROJECT NUMBER: 70000.00
DATE: 10/08/07

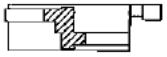
SHEET NAME: F5 FLOOR PLAN - AREAS A & C

SHEET NUMBER: AE105-AC



1 F5 - AREA B

KEYPLAN



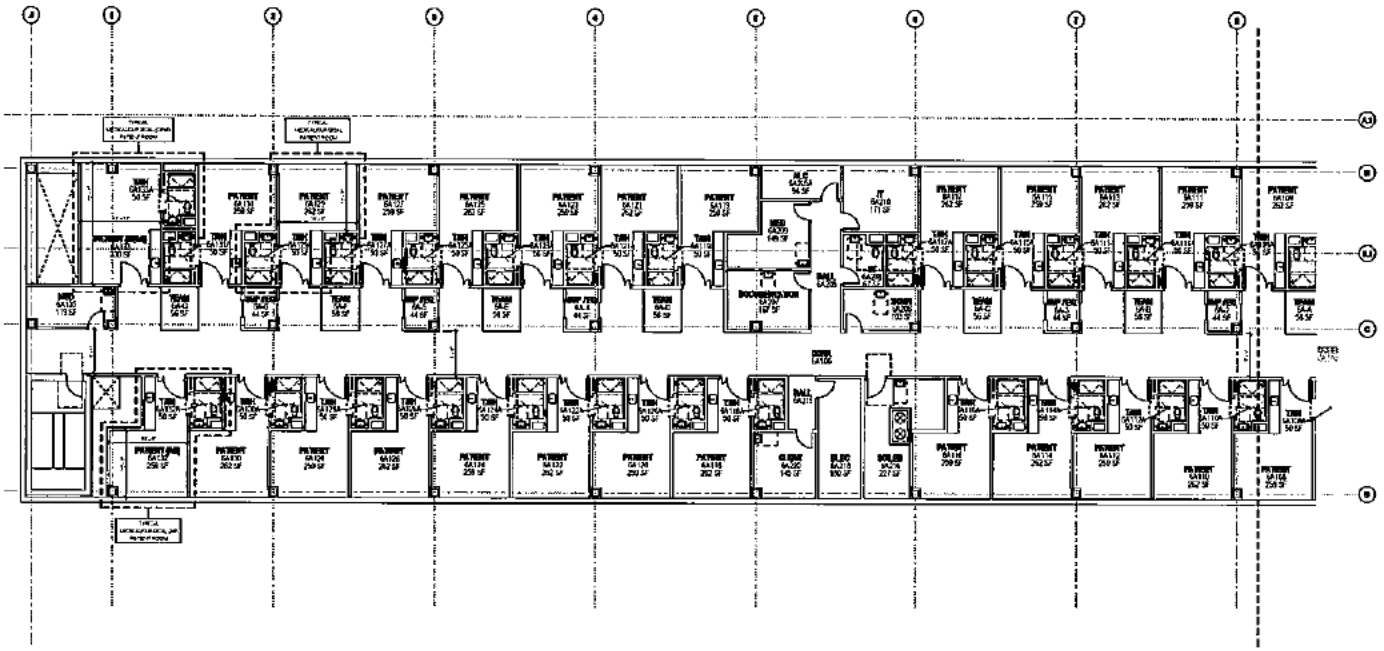
nbbj

MOHAWK VALLEY HEALTH SYSTEM

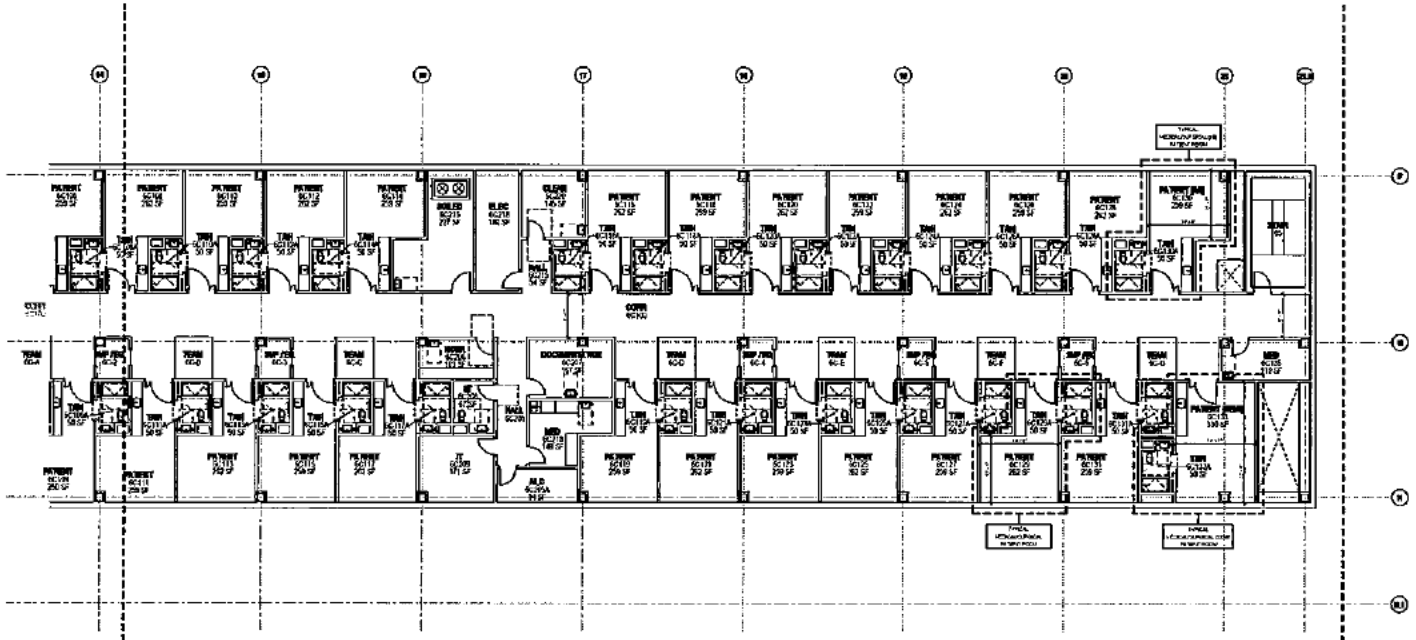
CON - SD SUBMITTAL

F5 FLOOR PLAN - AREA B

AE105-B



1 F6 - AREA A



2 F6 - AREA C

KEYPLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7135
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

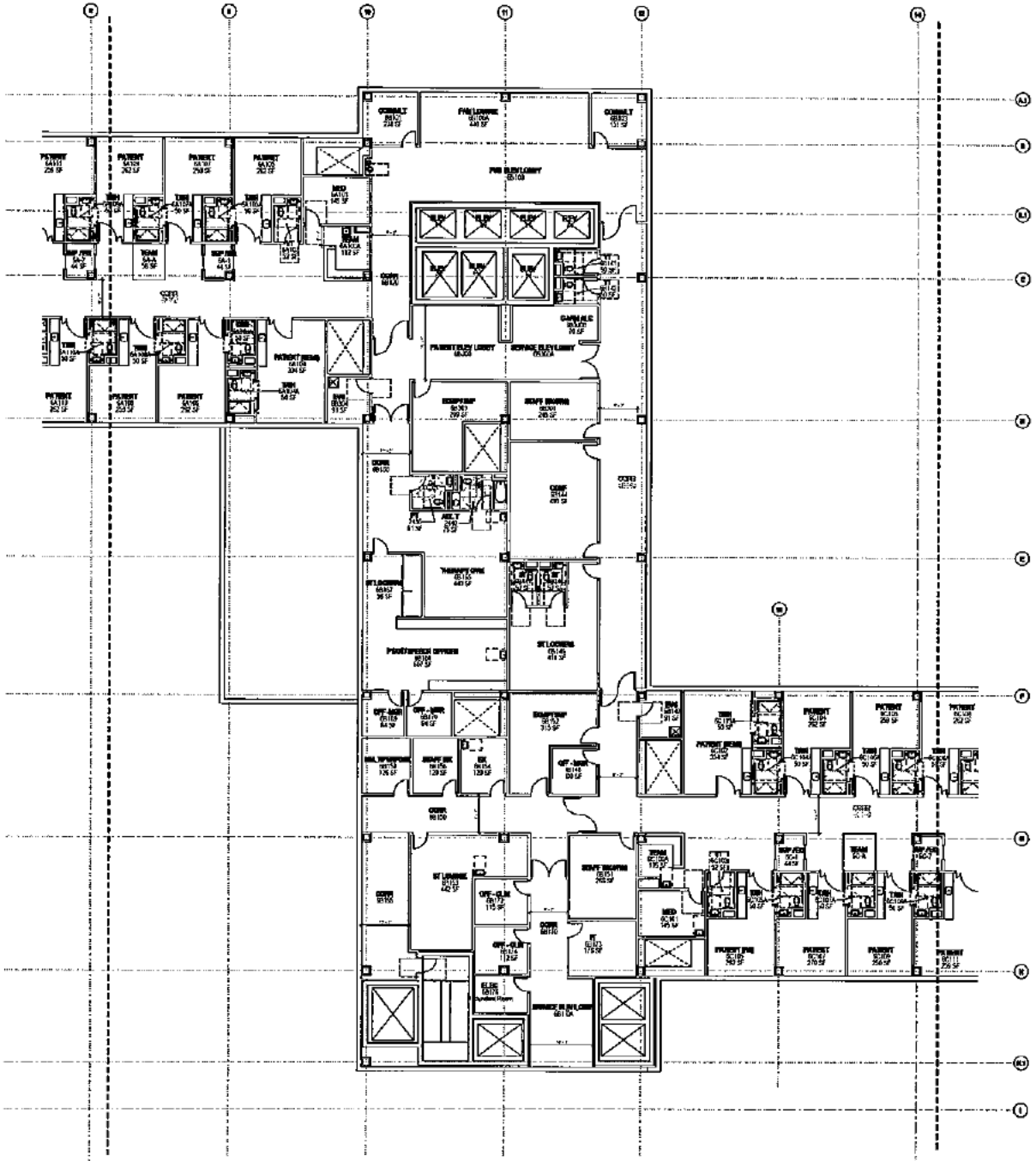
CON - SD SUBMITTAL

NO.	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"

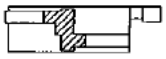
F6 FLOOR PLAN - AREA A & C

SHEET NUMBER: AE106-AC



1 F6 - AREA B

KEYPLAN



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250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7545
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 9, 2017

MARK	DATE	DESCRIPTION

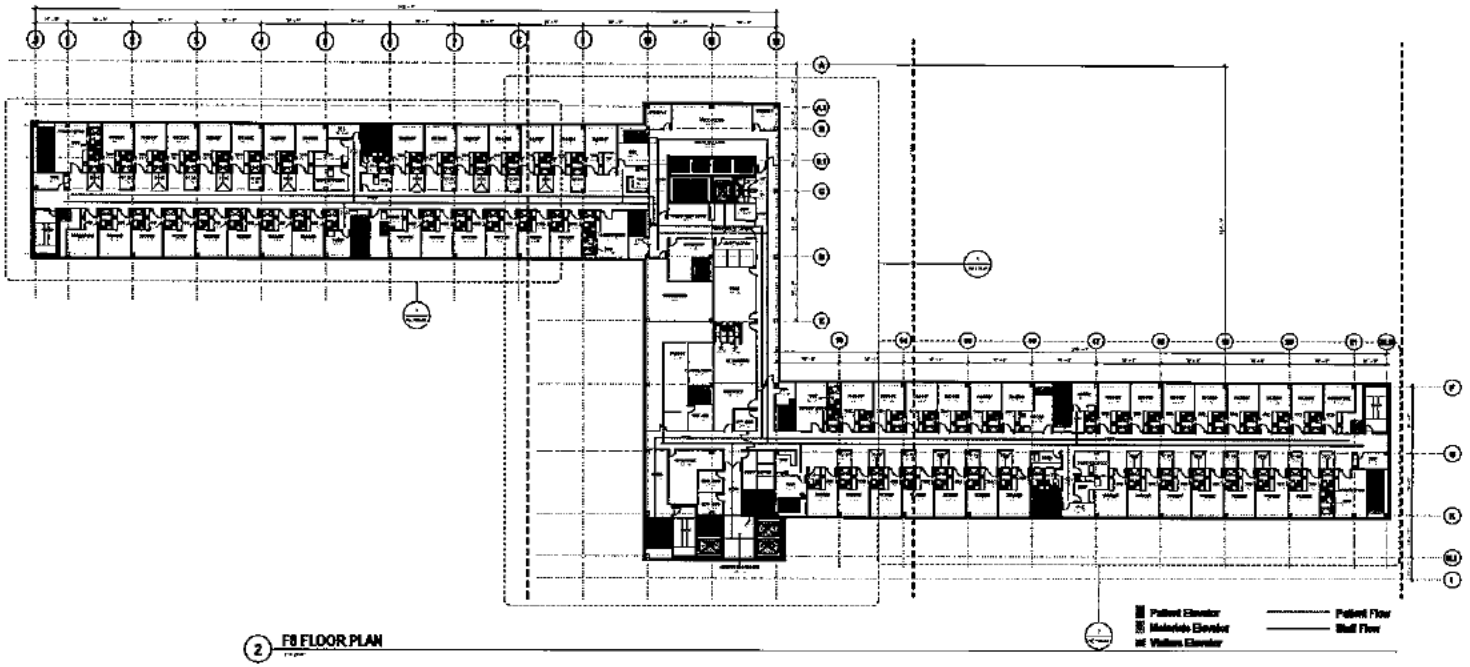
SCALE: 1/8" = 1'-0"

PROJECT NUMBER: 1999MVH

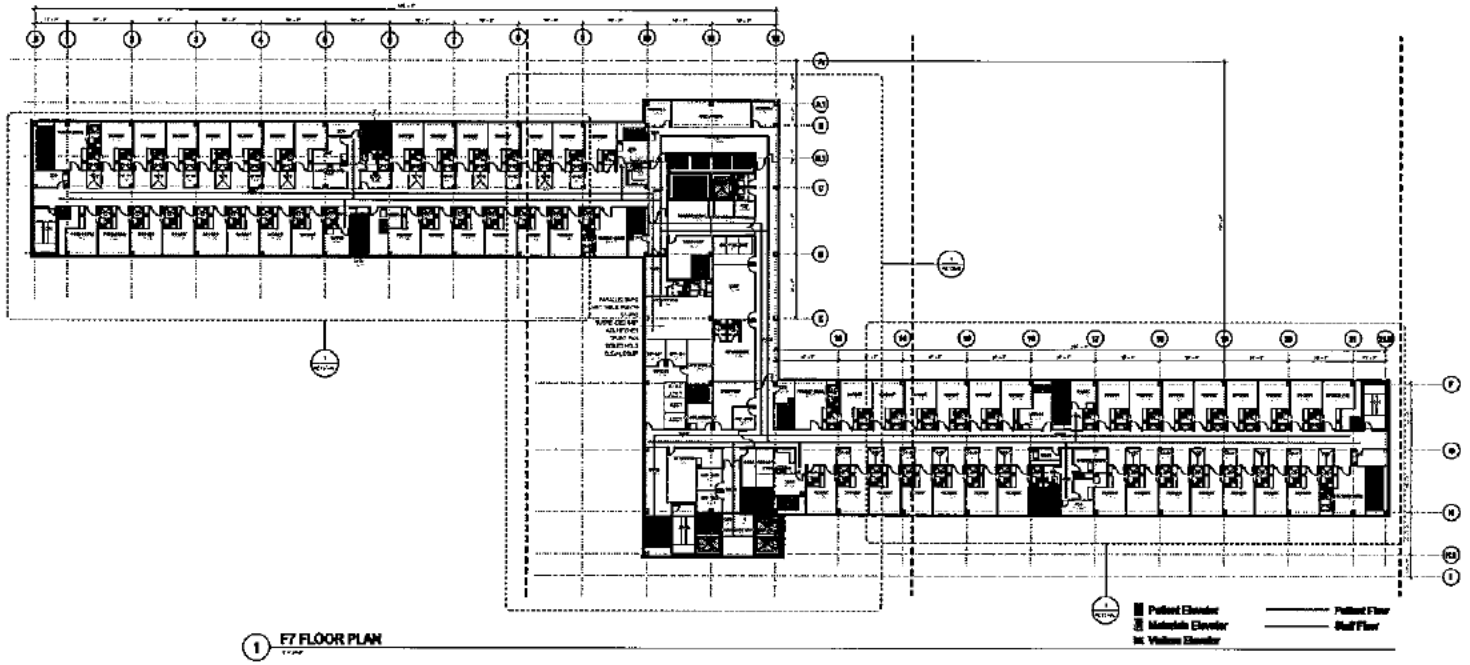
DATE: 11/9/17

F6 FLOOR PLAN - AREA B

SHEET NUMBER: AE106-B



2 F8 FLOOR PLAN



1 F7 FLOOR PLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 1126

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

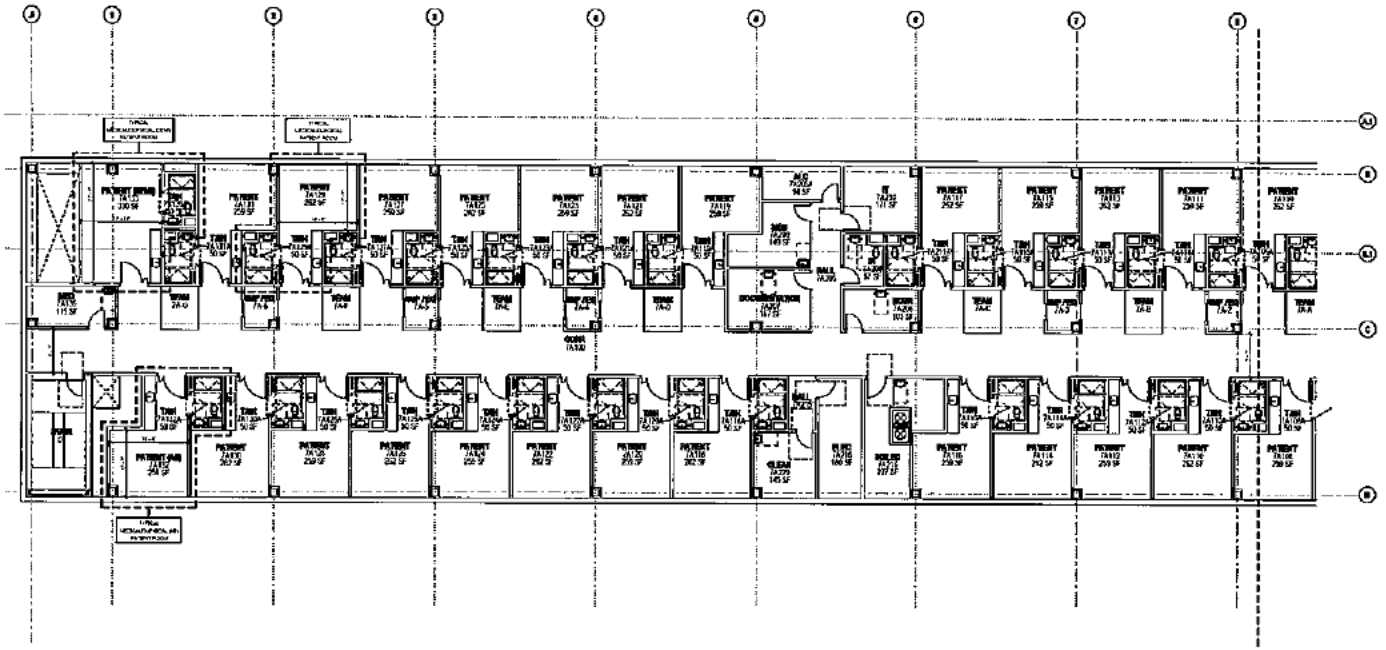
SCALE 1" = 20'-0" | DRAWN BY Author

PROJECT NUMBER 1616.20

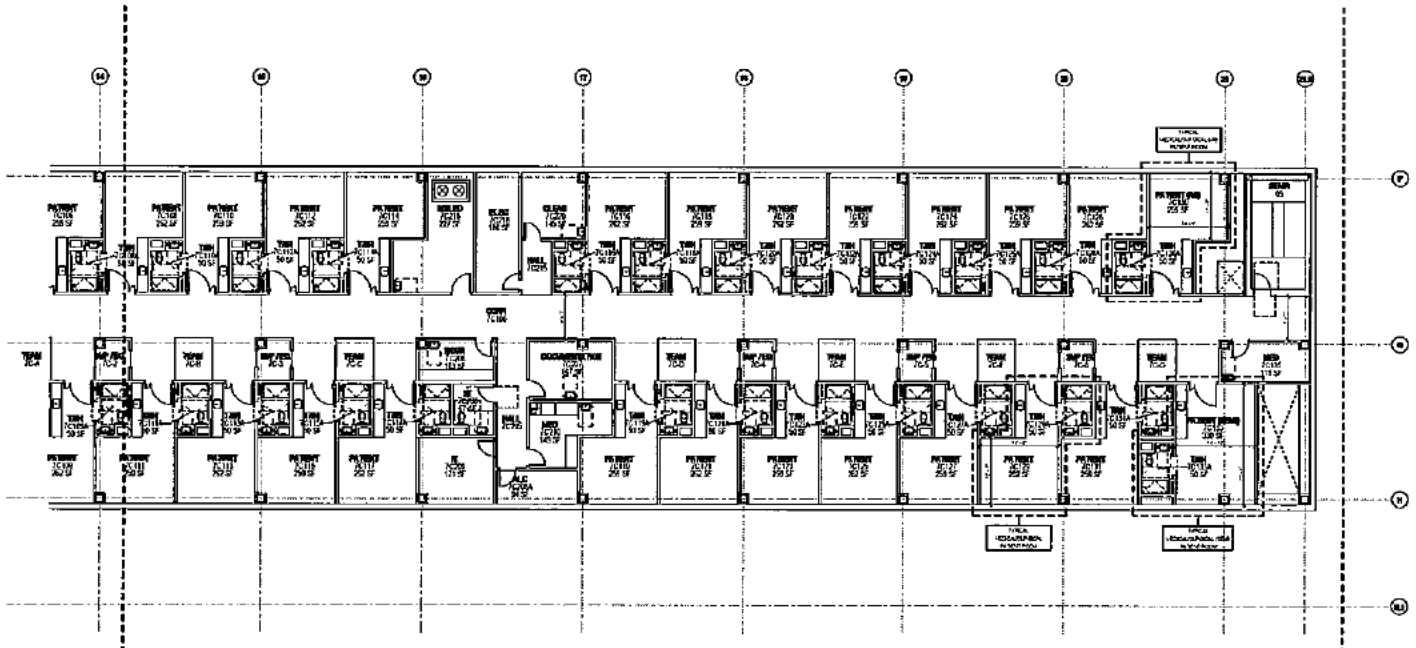
DATE 10/27/17

SHEET TITLE
F7, F8 OVERALL FLOOR PLANS

SHEET NUMBER
AE107

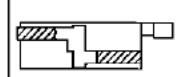


1 F7 - AREA A



2 F7 - AREA C

KEYPLAN



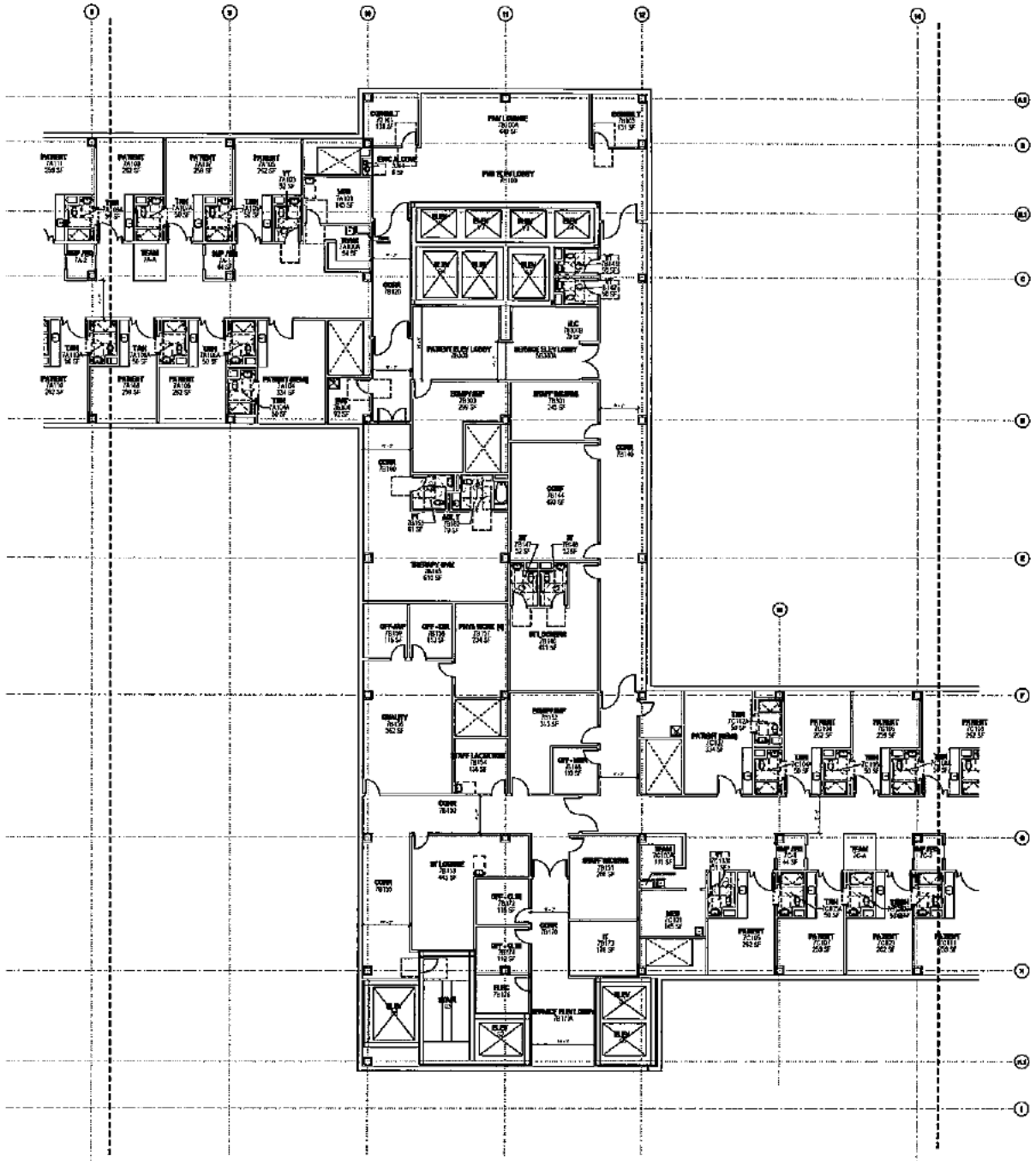
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

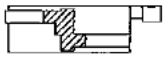
F7 FLOOR PLAN - AREA A & C

AE107-AC



1 F7 - AREA B

KEYPLAN



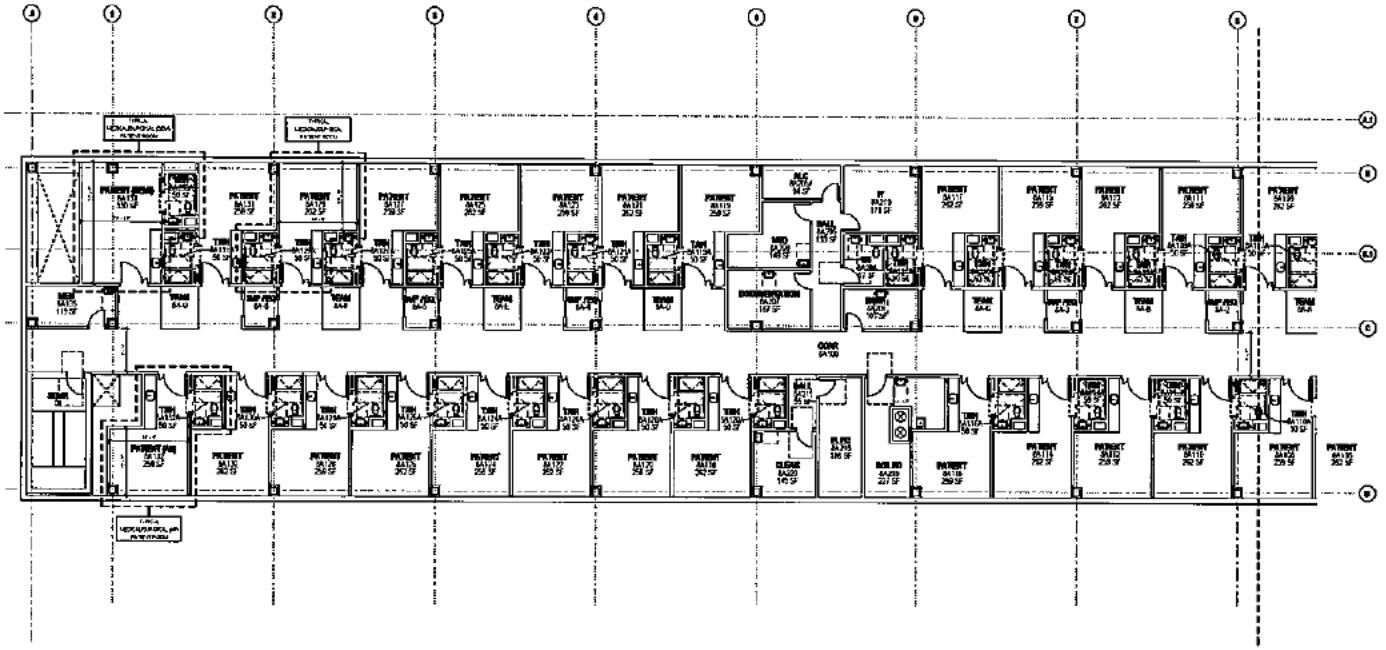
nbbj
254 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE: 614 224 1643

MOHAWK VALLEY HEALTH SYSTEM

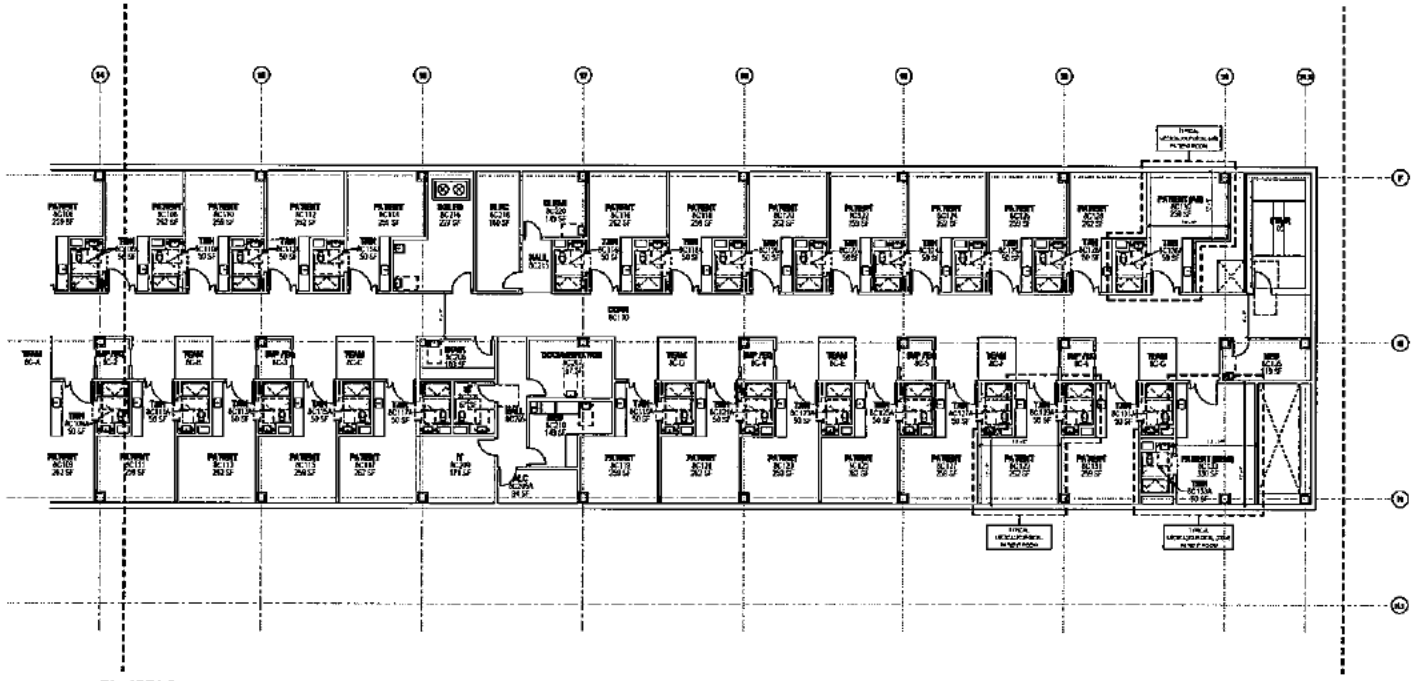
CON - BD SUBMITTAL

F7 FLOOR PLAN - AREA B

AE107-B



1 F8 - AREA A



2 F8 - AREA C

KEYPLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 7145
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MOHAWK VALLEY HEALTH SYSTEM

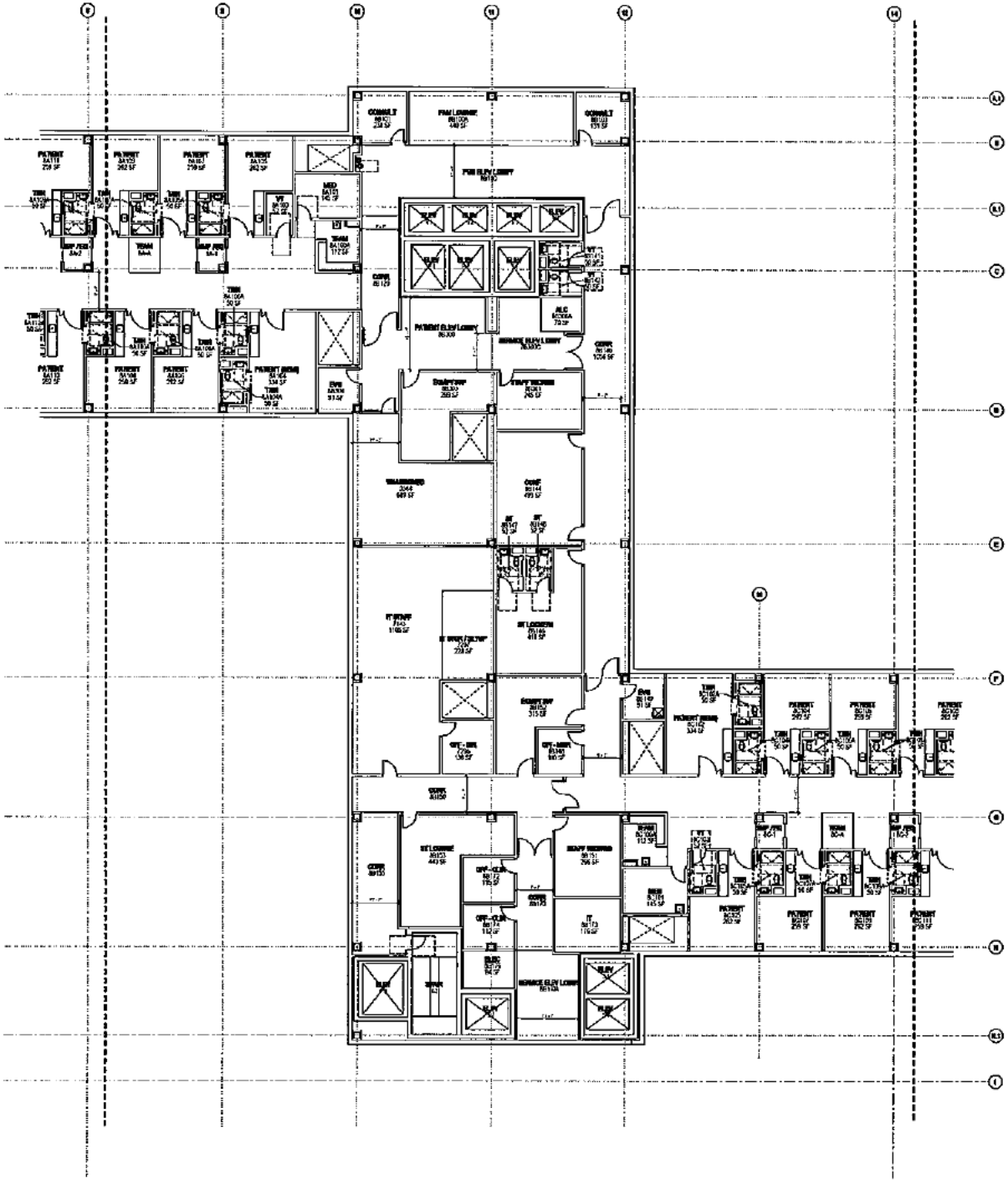
CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"
PROJECT ARCHITECT: Designer
PROJECT NUMBER: [illegible]
DATE: [illegible]

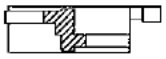
SHEET NAME: F8 FLOOR PLAN - AREA A & C

SHEET NUMBER: AE108-AC



1 F8 - AREA B

KEYPLAN



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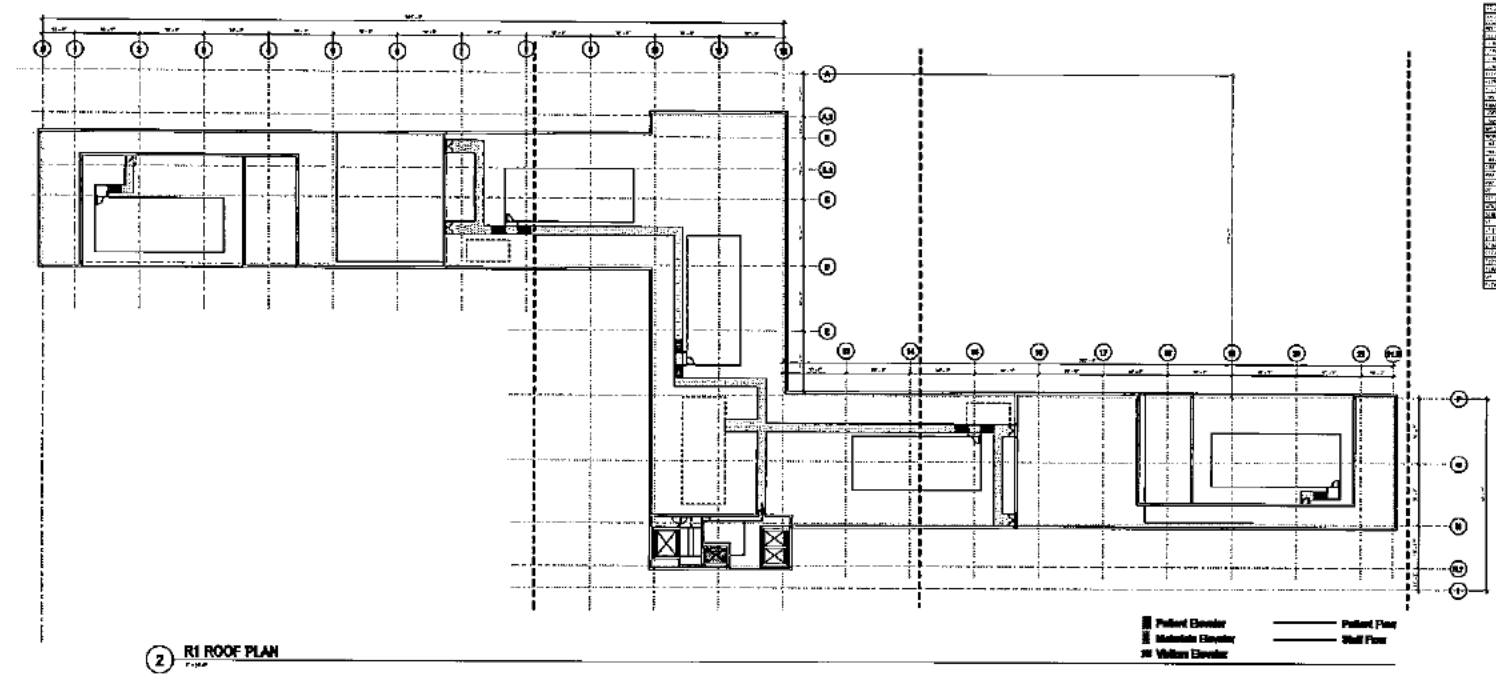
MOHAWK VALLEY HEALTH SYSTEM

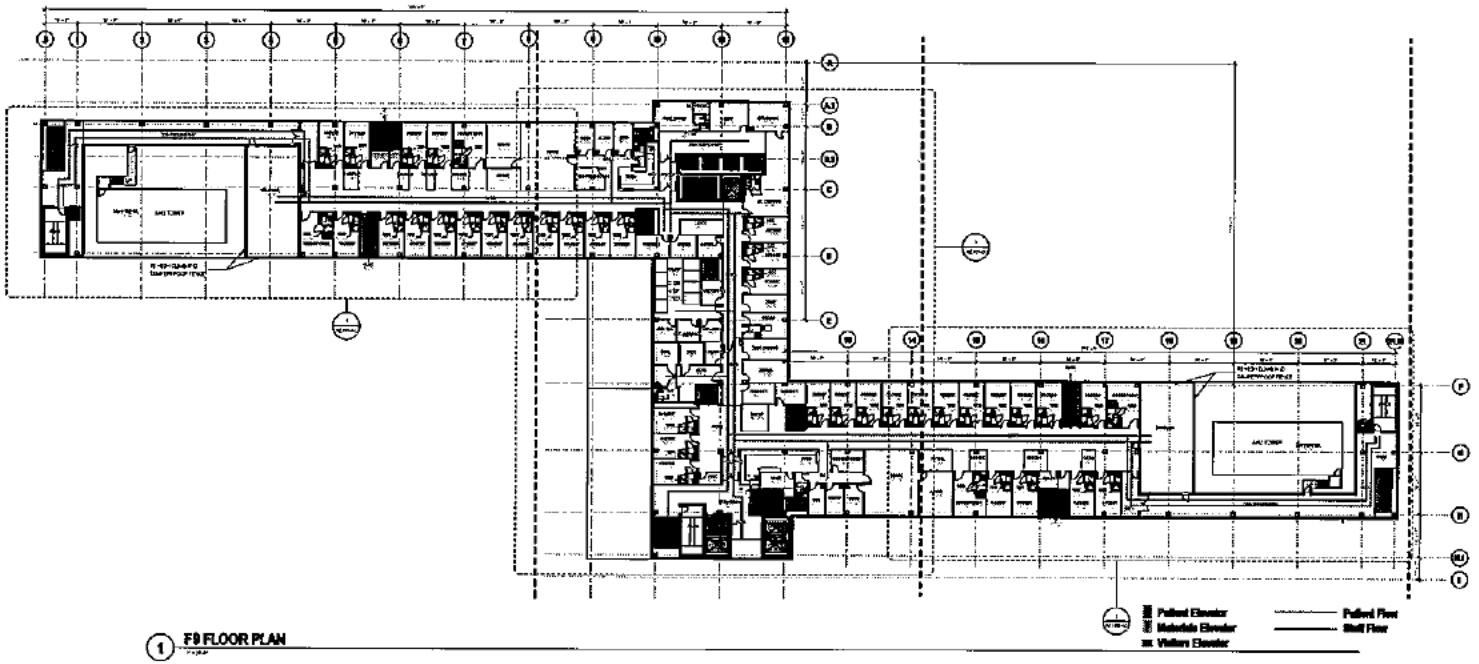
CON - SD SUBMITTAL

F8 FLOOR PLAN - AREA B

AE106-B



2 R1 ROOF PLAN



1 F9 FLOOR PLAN

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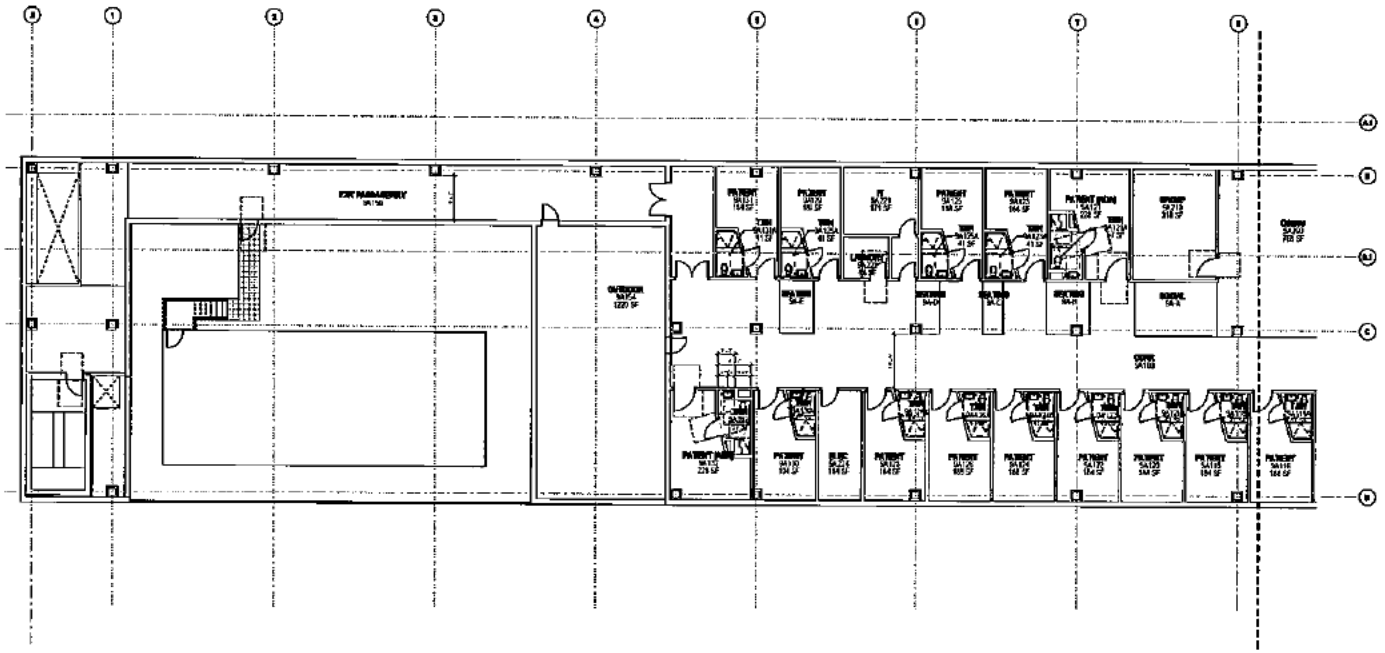
MOHAWK VALLEY HEALTH SYSTEM

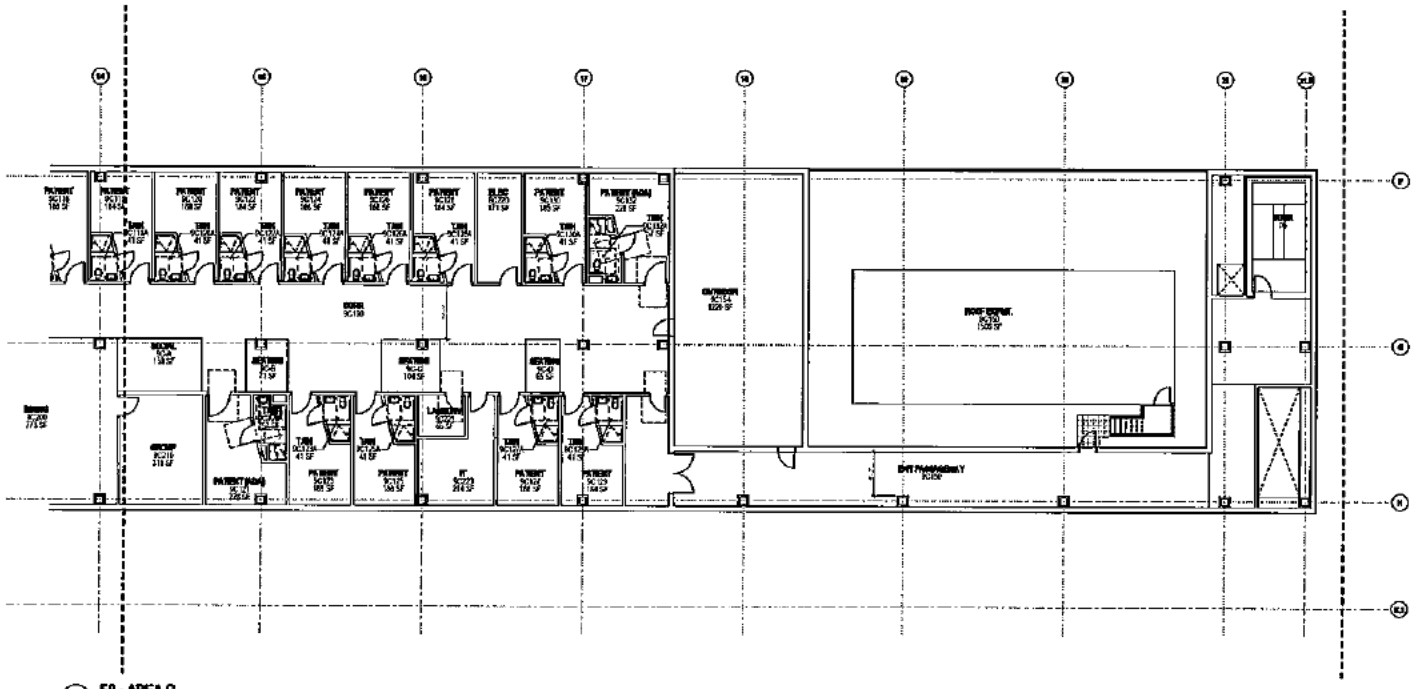
CON - SD SUBMITTAL

F9 OVERALL FLOOR PLAN, ROOF PLAN

AE109

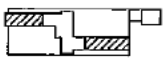


1 F9 - AREA A



2 F9 - AREA C

KEYPLAN



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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 5, 2021

MARK	DATE	DESCRIPTION

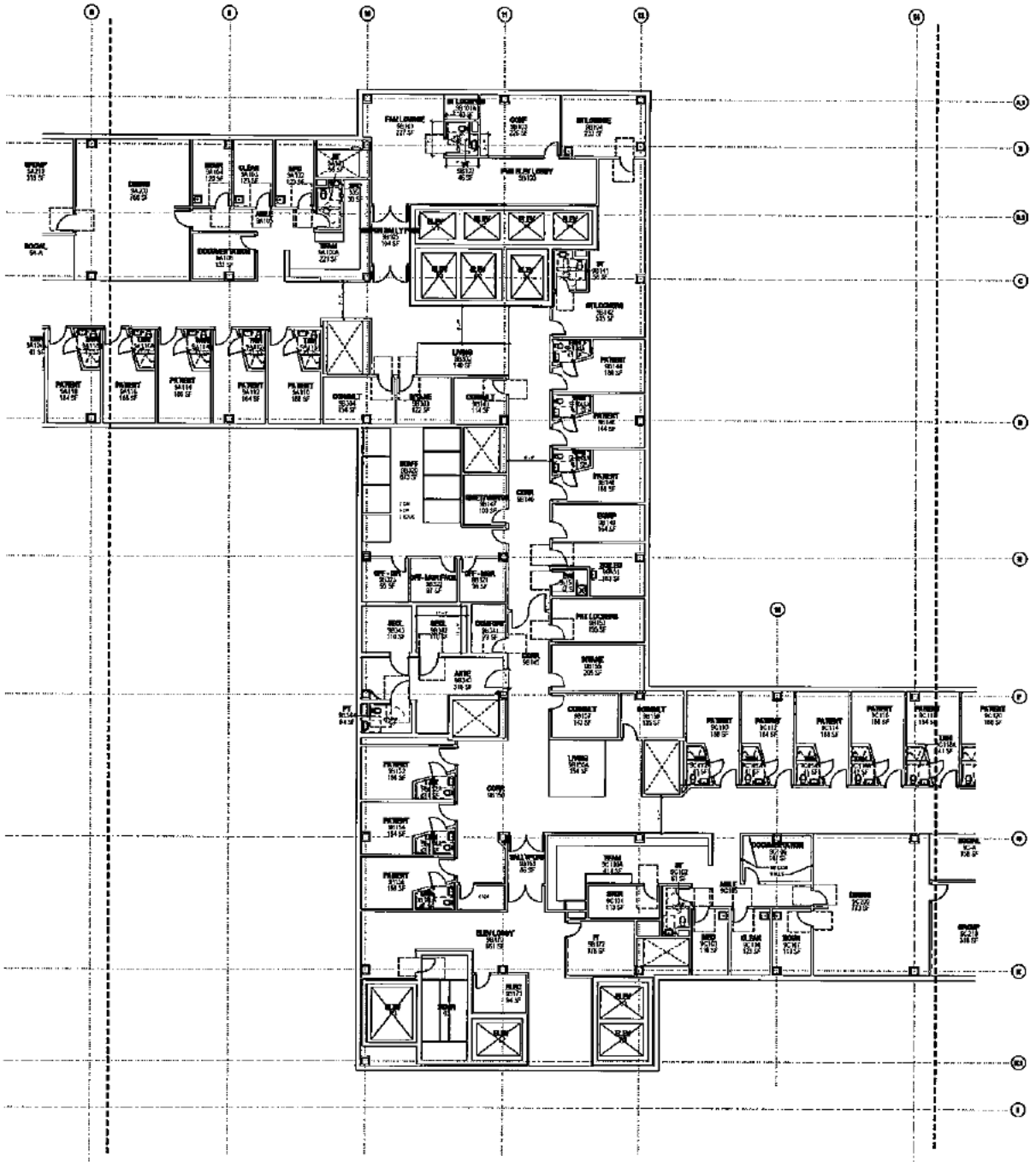
SCALE: 1/8" = 1'-0"

PROJECT NUMBER: 190000.00

DATE: 10/29/2021

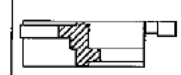
SHEET NAME
F9 FLOOR PLAN - AREA A & C

SHEET NUMBER
AE109-AC



1 F9 - AREA B

KEYPLAN



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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

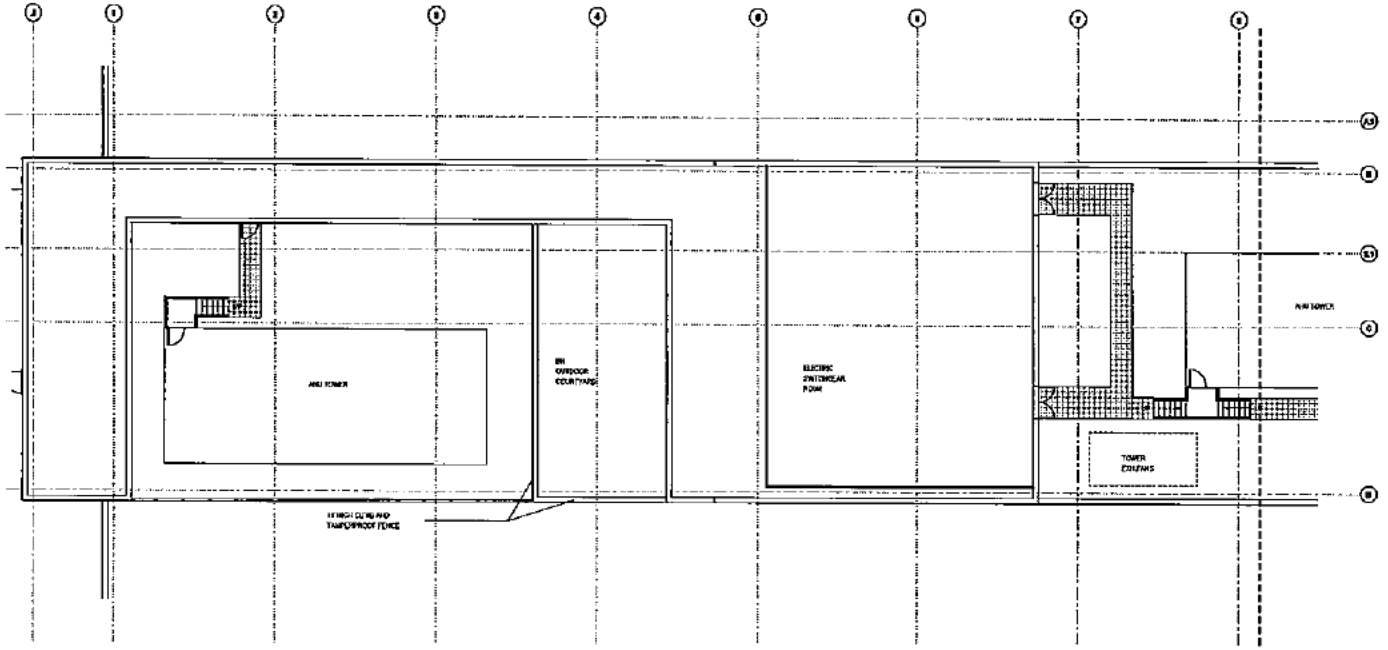
NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

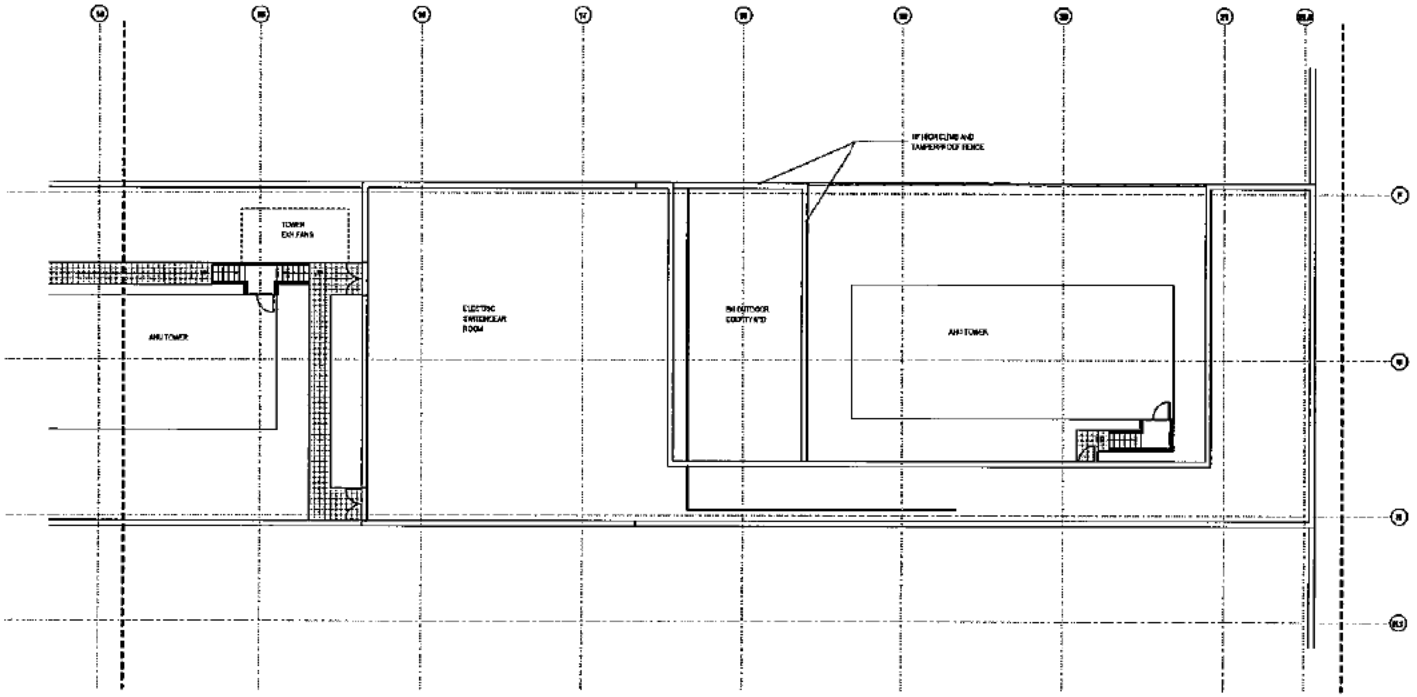
SCALE 1/8" = 1'-0"
PROJECT MANAGER: [illegible]
PROJECT NUMBER: [illegible]
DATE: [illegible]

SHEET NAME: F9 FLOOR PLAN - AREA B

SHEET NUMBER: AE109-B



1 R1 - AREA A



2 R1 - AREA C

KEYPLAN

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COLUMBUS, OH 43215
PHONE 614 2347145

MOHAWK VALLEY HEALTH SYSTEM

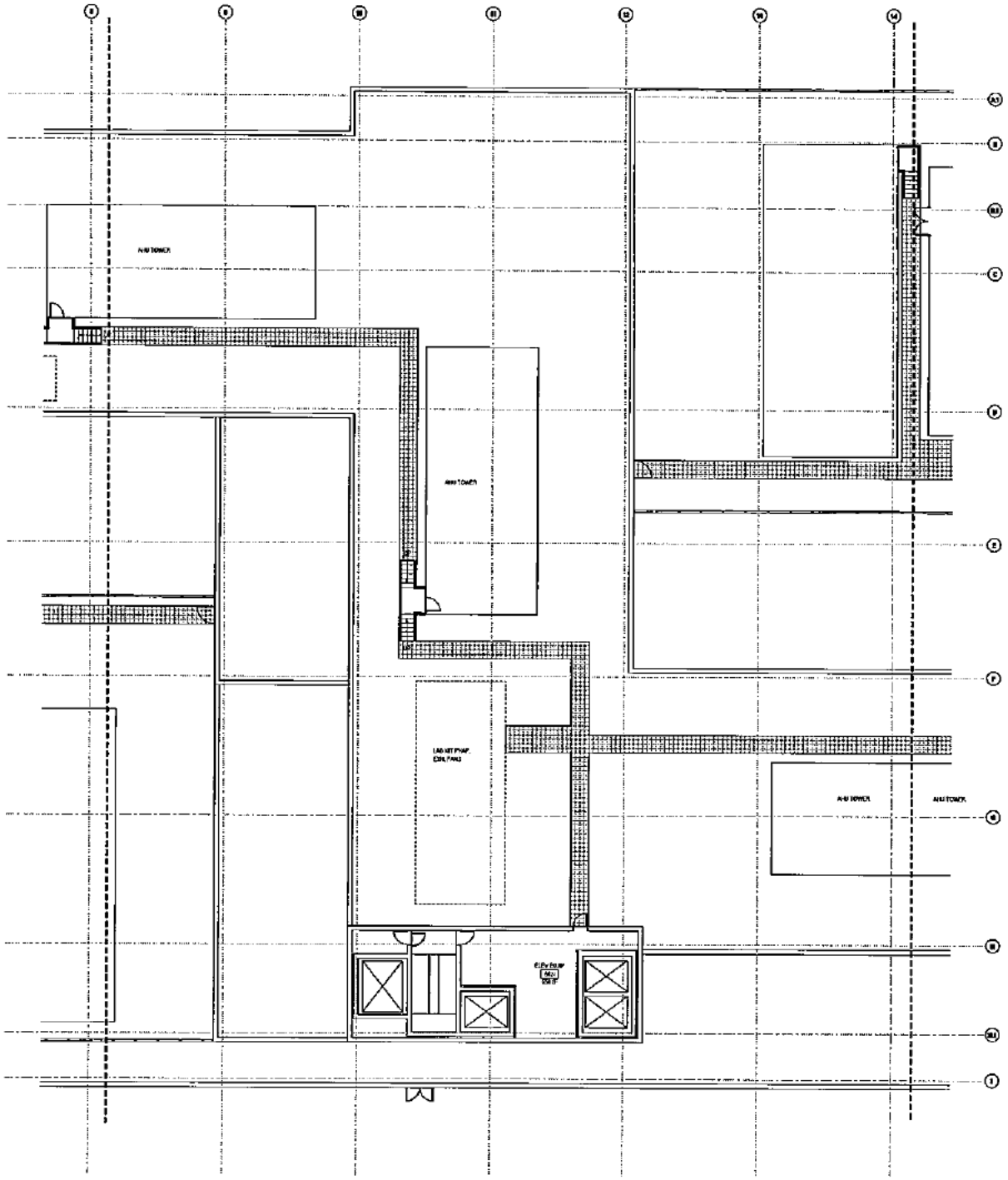
CON - 80 SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE 1/8" = 1'-0"

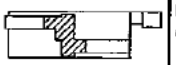
R1 ROOF PLAN - AREA A & C

SHEET NUMBER AE110-AC



1 R1- AREA B

KEYPLAN



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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

R1 ROOF PLAN - AREA B

AE110-B

Cicero Consulting Associates

VCC, Inc.

701 Westchester Ave. • Suite 210W • White Plains, NY 10604
Tel: (914) 682-8657 • Fax: (914) 682-8895
cicero@ciceroassociates.com

White Plains Unit
Frank M. Cicero
Charles F. Murphy, Jr.
James Psarianos
Rose Murphy
Michael D. Ungerer
Noelia Chung
Brian Baldwin
Michael F. Cicero
Karen Dietz
Evelyn Branford
Michael C. Malale
Linda Cammisa, R.N.

Albany Unit
William B. Carmello
Joseph F. Pofit
Albert L. D'Amato
Mark Van Guysling
Rosemarie Porco-Nash
Daniel Rinaldi, Jr.
Mary Ann Anglin

Emeritus Consultants
Nicholas J. Mongiardo
Joan Greenberg
Martha H. Pofit
Frank T. Cicero, M.D.

Michael P. Parker, Sr.
(1941-2011)
Anthony J. Maddaloni
(1952-2014)

December 19, 2017

Mr. Robert Lis
Bureau of Architectural & Engineering Review
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1861
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Mr. Lis:

On behalf of our client, Mohawk Valley Health System (MVHS), please find enclosed documentation prepared by the project architect in response to your letter of December 6, 2017, regarding the project referenced above. This documentation includes a response letter and an updated PDF of drawings. Hard-copy drawings are being sent under a separate letter to the Department (one set of drawings is being provided in response to two (2) separate requests for additional information from the Bureau of Architectural & Engineering Facility Planning – one from you and one from Mr. Clary).

Please feel free to contact me if you have any questions. Thank you.

Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

December 18, 2017

Project Management Unit, New York State Department of Health
Corning Tower, Room 1842,
Empire State Plaza, Albany, New York 12237
Michael Clary, Health Facilities Planner
Bureau of Architectural & Engineering Review

172305 C
Faxton-St Luke's Healthcare St Luke's Division (Oneida)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

---

(DSG 1)
1. General Comments: Fixtures
2. Referenced Standard: DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.1 Action Required: Please indicate fixtures such as toilets, hand washing sinks and clinical sinks. Please revise and resubmit drawing(s).
RESPONSE: Toilets, Handwash sinks, clinical sinks, showers and housekeeping closets have been indicated on the floor plans – plans are being reissued as part of this response. NOTE: fixture type may change as the design is developed.

(DSG 2)
3. General Comments: ADA Clearances in Toilet Rooms
4. Referenced Standard: DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.2 Action Required: Please indicate ADA clearances in a typical toilet room. Please revise and resubmit drawing(s).
RESPONSE: ADA clearances have been indicated in toilet rooms -- plans are being reissued as part of this response.

(DSG 3)
5. General Comments: Room Numbers
6. Referenced Standard: DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.3 Action Required: Please indicate room numbers for all schematic design drawings. Please revise and resubmit drawings.

RESPONSE: Room numbers have been provided on the plans -- plans are being reissued as part of this response. NOTE: Room numbers will likely be modified as the design is refined and the numbers are coordinated with the signage consultant -- plans are being reissued as part of this response.

(ARCH 1)
7. General Comments: **Public Waiting Area**
8. Referenced Standard: FGI 2014
a. Chapter: 2.2.3-1.2.4
b. Trade: Architecture
c. Drawing Sheet: F1 (A)
d. Floor: Emergency Department
2.4 Action Required: Please indicate access to drinking water. Revise and resubmit drawing.
RESPONSE: A drinking Fountain (EWC) has been added outside room 1200B, sheet AE101-A

(ARCH 2)
1. General Comments: **EMS Communication**
2. Referenced Standard: FGI 2014
a. Chapter: 2.2-3.1.2.5
b. Trade: Architecture
c. Drawing Sheet: F1 (A)
d. Floor: Emergency Department
2.5 Action Required: Indicate the EMS Communication Room. Revise and resubmit drawing.
RESPONSE: The EMS communication Room is located in the Emergency Department – room 1308, sheet AE101-A

(ARCH 3)
1. General Comments: **Reception and Triage Area**
2. Referenced Standard: FGI 2014
a. Chapter: 2.2-3.1.3.3
b. Trade: Architecture
c. Drawing Sheet: F1 (A)
d. Floor: Emergency Department
2.6 Action Required: Please indicate the handwashing stations in the triage area. Revise and resubmit drawing.
RESPONSE: Handwashing stations have been added

(ARCH 4)
1. General Comments: **Trauma Rooms**
2. Referenced Standard: FGI 2014

a. Chapter: 2.2-3.2.3.6
b. Trade: Architecture
c. Drawing Sheet: F1 (A)

2.7 Action Required: Please consider relocating the trauma rooms in closer proximity to the emergency entrance. Revise and resubmit drawing.

RESPONSE: The trauma room location is based on discussions with the hospital physician and nursing staff. The room is located so that it is in between the entry to the Emergency Department and the oversized elevator (Megavator) used to transfer ER patients to the Surgery/Invasive Cardiology and Critical Unit as well as Psychiatric patients from the Emergency Department to the 9th Floor behavior Health Nursing Unit -- plans are being reissued as part of this response.

(ARCH 5)

1. General Comments: **Bariatric / Pediatric Treatment Area**
2. Referenced Standard: FGI 2014
   a. Chapter: 2.2-3.2.3.6
   b. Trade: Architecture
   c. Drawing Sheet: F1 (A)

2.8 Action Required Indicate the dedicated Bariatric and Pediatric treatment areas. Revise and resubmit drawing.

RESPONSE: The bariatric and Pediatric treatment area in the Emergency Department have been labeled -- plans are being reissued as part of this response.

(ARCH 6)

1. General Comments: **Food Production**
2. Referenced Standard: FGI 2014
   a. Chapter: 2.1-4.3
   b. Trade: Architecture
   c. Drawing Sheet: F1 (B)

2.9 Action Required: Not enough information to review. Please review the section of the FGI. Revise and resubmit drawing.

RESPONSE: A preliminary layout for the food service department has been provided and exiting indicated. The final layout of the department will be refine as the Food Service Consultant is selected -- plans are being reissued as part of this response.

(ARCH 7)

1. General Comments: **Clinical Lab Services**

2. Referenced Standard: FGI 2014
    a. Chapter: 2.1-4
    b. Trade: Architecture
    c. Drawing Sheet: F1 (C)

2.10 Action Required: Not enough information to review. Please review the section of the FGI. Revise and resubmit drawing.

RESPONSE: Per 12/8/17 email "As for casework fixtures for the lab; we can wait for the 60% State Hospital Code submission to review."

(ARCH 8)

1. General Comments: **Room Names**
2. Referenced Standard: FGI 2014
    a. Chapter: 1.2-2.1 /1.2-2.1.3.1 /1.2-2.1.3.2
    b. Trade: Architecture
    c. Drawing Sheet: All

2.11 Action Required: The names for spaces and departments used in the functional program shall be consistent with those used in the Guidelines for Design and Construction of Hospital and Outpatient Facilities. If acronyms are used, they shall be defined clearly. Please provide a key for all acronyms shown on the submitted drawings. Revise and resubmit drawings.

RESPONSE: A list of room names corresponding to the abbreviations indicated on the floor plans is provided on new drawing sheet GC001 General Requirements Notes.

In addition to the items noted above in order to make the Typical Room Dimensions easier to find we placed a heavy dashed line around "typical rooms" and noted that the dimensions are typical for the room type. This is in response to a concern that we discussed in our conference call that there were not adequate dimensions indicated – at this time the typical room dimensions are to be used for similar rooms unless noted otherwise.

Sincerely,

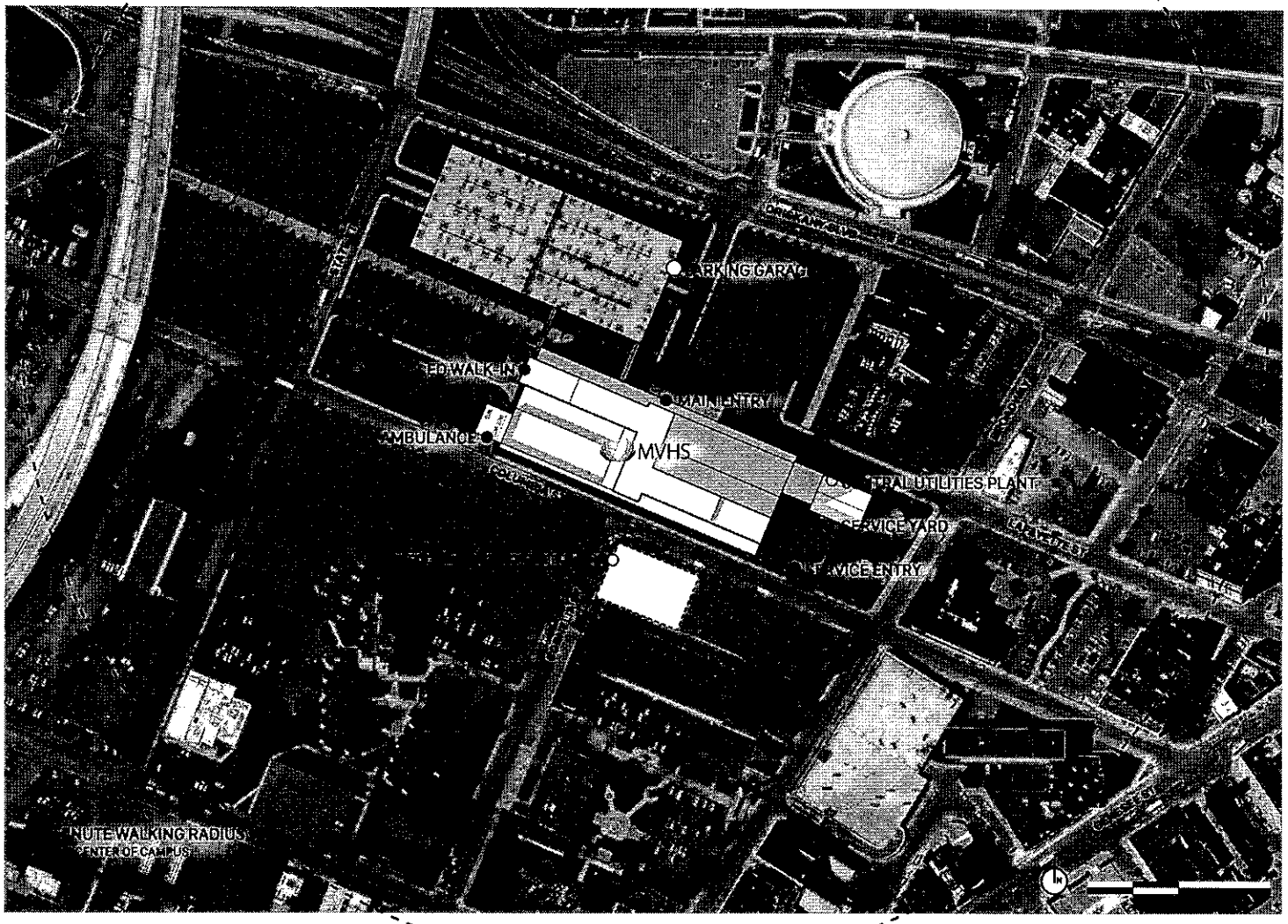
Steven M. Kopf AIA
NBBJ
250 South High Street

nbbj

Suite 300
Columbus, Ohio 43215

CON - SD SUBMITTAL

NOVEMBER 1, 2017
CON - SD RFI RESPONSE: DECEMBER 19, 2017



LIST OF SHEETS

GC000	COVER SHEET
GC001	GENERAL REQUIREMENTS NOTES
AS101	ARCHITECTURAL SITE PLAN
AS102	STACKING DIAGRAM
GI101	F1 LIFE SAFETY PLAN
GI102	F2 LIFE SAFETY PLAN
GI103	F3, F4 LIFE SAFETY PLANS
GI105	F5, F6 LIFE SAFETY PLANS
GI107	F7, F8 LIFE SAFETY PLANS
GI109	F9, ROOF LIFE SAFETY PLAN
GI201	F1, CEP F1-F3 FUNCTIONAL AREA PLAN
GI202	F2 FUNCTIONAL AREA PLAN
GI203	F3, F4 FUNCTIONAL AREA PLAN
GI205	F5, F6 FUNCTIONAL AREA PLAN
GI207	F7, F8 FUNCTIONAL AREA PLAN
GI209	F9, F10 ROOF FUNCTIONAL AREA PLAN
AE101	F1 OVERALL & CEP FLOOR PLANS
AE101-A	F1 FLOOR PLAN - AREA A
AE101-B	F1 FLOOR PLAN - AREA B
AE101-C	F1 FLOOR PLAN - AREA C
AE101-D	F1 FLOOR PLAN - AREA D
AE102	F2 OVERALL FLOOR PLAN
AE102-A	F2 FLOOR PLAN - AREA A
AE102-B	F2 FLOOR PLAN - AREA B
AE102-C	F2 FLOOR PLAN - AREA C
AE103	F3, F4 OVERALL FLOOR PLANS
AE103-AC	F3 FLOOR PLAN - AREA A & C
AE103-B	F3 FLOOR PLAN - AREA B
AE104-AC	F4 FLOOR PLAN - AREA A & C
AE104-B	F4 FLOOR PLAN - AREA B
AE105	F5, F6 OVERALL FLOOR PLANS
AE105-AC	F5 FLOOR PLAN - AREAS A & C
AE105-B	F5 FLOOR PLAN - AREA B
AE106-AC	F6 FLOOR PLAN - AREA A & C
AE106-B	F6 FLOOR PLAN - AREA B
AE107	F7, F8 OVERALL FLOOR PLANS
AE107-AC	F7 FLOOR PLAN - AREA A & C
AE107-B	F7 FLOOR PLAN - AREA B
AE108-AC	F8 FLOOR PLAN - AREA A & C
AE108-B	F8 FLOOR PLAN - AREA B
AE109	F9 OVERALL FLOOR PLAN, ROOF PLAN
AE109-AC	F9 FLOOR PLAN - AREA A & C
AE109-B	F9 FLOOR PLAN - AREA B
AE110-AC	R1 ROOF PLAN - AREA A & C
AE110-B	R1 ROOF PLAN - AREA B

MVHS

MOHAWK VALLEY HEALTH SYSTEM

UTICA, NY

12/14/2017 6:25:00 PM

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PHONE 614.224.7145
www.nbbj.com

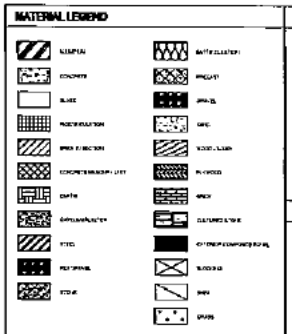
Code Compliance Notes

Occupancy Classifications	
Hospital - I-2 Occupancy	
Central Energy Plant - Special Purpose Industrial	
Sprinkler coverage	
Fully sprinklered	
Construction Classification	
Type 2B (2018 IBC/NFPA 220 - 2015)	
Allowable Building Height	
Height Unlimited	
Area Unlimited	
Fire Resistance Rating Requirements	
Floor and vertical openings - secondary separation	2 hours
Wall Construction and Utility Separation - Part 3	1 - 1/2 hours
Exterior walls - separation greater than 30'	3 hours
Exit stairs	2 hours
Smoke Compartment Separation Walls	2 hours
Smoke Barrier	1 hour
Horizontal Exit Openings	2 hours
Corridor separation	2 hours
Corridor	0 hours, sprinklered
Other separations	0 hours, sprinklered
Means of Egress Illumination	
Required Duration - Main	1.5 minimum
Required Duration - Level Discharge	0.2 minimum
Means of Egress Arrangement	
Travel Distance to exit - sprinklered	200 feet
Travel Distance - any point in a patient sleeping room and an exit access door in that room	50 feet
Dead ends	Shall not exceed 50 feet
Remoteness of exits, where two exits are required, they shall be located from one another not less than one half of the length of the maximum overall diagonal dimension of the building or area served, measured in a straight line between the nearest edge of the exit doorway openings.	
Dead End Corridors - sprinklered	50 feet
Common Path of Travel	100 feet
Toilets	
Patient Care Non-Sleeping Toilet	15 minutes
Travel Distance within a non-sleeping suite to an exit from suite shall not exceed 100 feet	
Travel distance between any point in a non-sleeping suite and an exit shall not exceed 200 feet	
Patient Care Sleeping	7.5 seconds
Travel Distance within a sleeping suite to an exit from suite shall not exceed 100 feet	
Travel distance shall not exceed 200 feet	

CEILING HEIGHTS & SURFACES

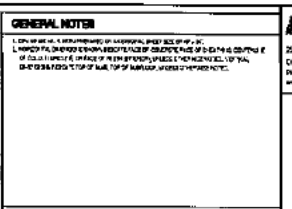
Department	Space Type	Ceiling Height	Ceiling Finish	FGI Citations
AE Garage	All	8'-0" where higher as noted	Water, vermin accessible ceiling tile with impaler grid with moisture GWB soffit	2.1-7.2.2.2
All Areas	Inpatient Building	8' - 0"	GWB, semigloss paint	2.1-7.2.3.3
All Areas	Entertainment Rooms	8' - 0"	Smooth AFC, impaler grid	2.1-7.2.3.3
Surgical Services	Operating Room, Interventional OR, All restricted areas	8' - 0" min.	GWB, epoxy paint	2.1-7.2.2.2 2.1-7.2.3.3
Surgical Services	Procedure	8' - 0" min.	GWB, epoxy paint or Cleanroom ACT with gasketed and pressure grid	2.1-7.2.2.3
Surgical Services	Pre/Post Recovery Bays	8' - 0"	Smooth AFC, impaler grid, mortar GWB soffit	2.1-7.2.3.3
Surgical Services	All Semi-restricted areas	8'-0" where higher as noted		2.1-7.2.3.3
Endoscopy	Procedure, treatment and recovering, decontamination	8' - 0" min.	GWB, epoxy paint or Cleanroom ACT with gasketed and pressure grid and ballistic	2.1-7.2.2.3
Imaging	Gen Rad, CT, MRI, (non-interventional)	8' - 0" min.	Smooth ACT, GWB soffit	2.1-7.2.3.4 2.1-7.2.3.3
ICU	Latex & Delivery Rooms	9' - 0" min.	GWB, epoxy paint or Cleanroom ACT with gasketed and pressure grid as...	2.1-7.2.3.3 2.1-7.2.3.3
ICU	Collection Cath	9' - 0" min.	GWB, epoxy paint	2.1-7.2.3.4 2.1-7.2.3.3
ICU	Post-Partum Rooms	8' - 0"		2.1-7.2.3.3
Psychiatric Nursing Unit	Seclusion Room, Restrained, Patient Toilet Rooms, Patient Suites	9' - 0" min.	GWB, epoxy paint	2.1-7.2.2.2 2.1-7.2.3.3
Food and Nutrition Services	Servery	10'- 0" (except within 8' - 0")	GWB, epoxy paint	2.1-7.2.2.2
Food and Nutrition Services	Food production areas	8' - 0"	GWB, epoxy paint or Cleanroom ACT with gasketed cleanroom grid an...	2.1-7.2.3.3
Food and Nutrition Services	Nutrition storage areas	8' - 0"	GWB, epoxy paint or Cleanroom ACT with gasketed cleanroom grid an...	2.1-7.2.2.6
Plant Maintenance	Clean workshop	8' - 0"	Smooth AFC, impaler grid	2.1-7.2.3.3
Plant Maintenance	Clean warehouse	8' - 0"	GWB, epoxy paint or Cleanroom ACT with gasketed cleanroom grid an...	2.1-7.2.3.3
Pharmacy	Sterile Compounding, IV Prep	9' - 0"	GWB, epoxy paint	2.1-7.2.3.3
Pharmacy	Kitchen prep areas	8' - 0"	Smooth AFC, impaler grid	2.1-7.2.3.3
Central Services (CPD)	All areas	8' - 0"	GWB, epoxy paint	2.1-7.2.3.3
Laboratory Services	All areas (except offices)	8' - 0"	Smooth AFC, impaler or recess valley grid	2.1-7.2.3.3
Medical/Surgical	Inpatient Rooms	8' - 0"	Smooth AFC with impaler grid and GWB soffit	2.1-7.2.3.3
Emergency Services	Treatment Rooms	8' - 0"	Smooth AFC, impaler or recess valley grid	2.1-7.2.3.3
Medical/Surgical	Inpatient A.I.I. Rooms	8' - 0"	GWB, epoxy paint	2.1-7.2.3.3

MATERIAL LEGEND

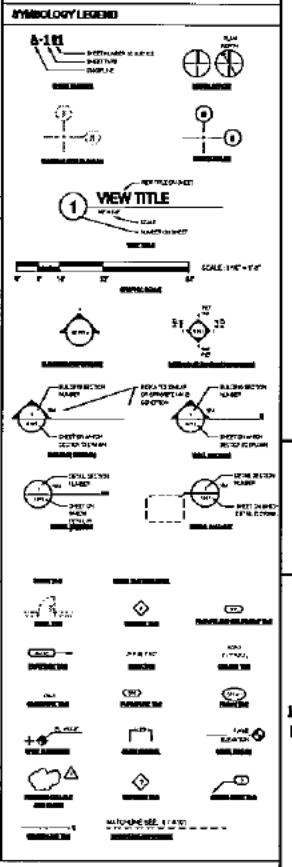


ABBREVIATIONS

GENERAL NOTES



SYMBOLOGY LEGEND



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PHONE 614.224.7136
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

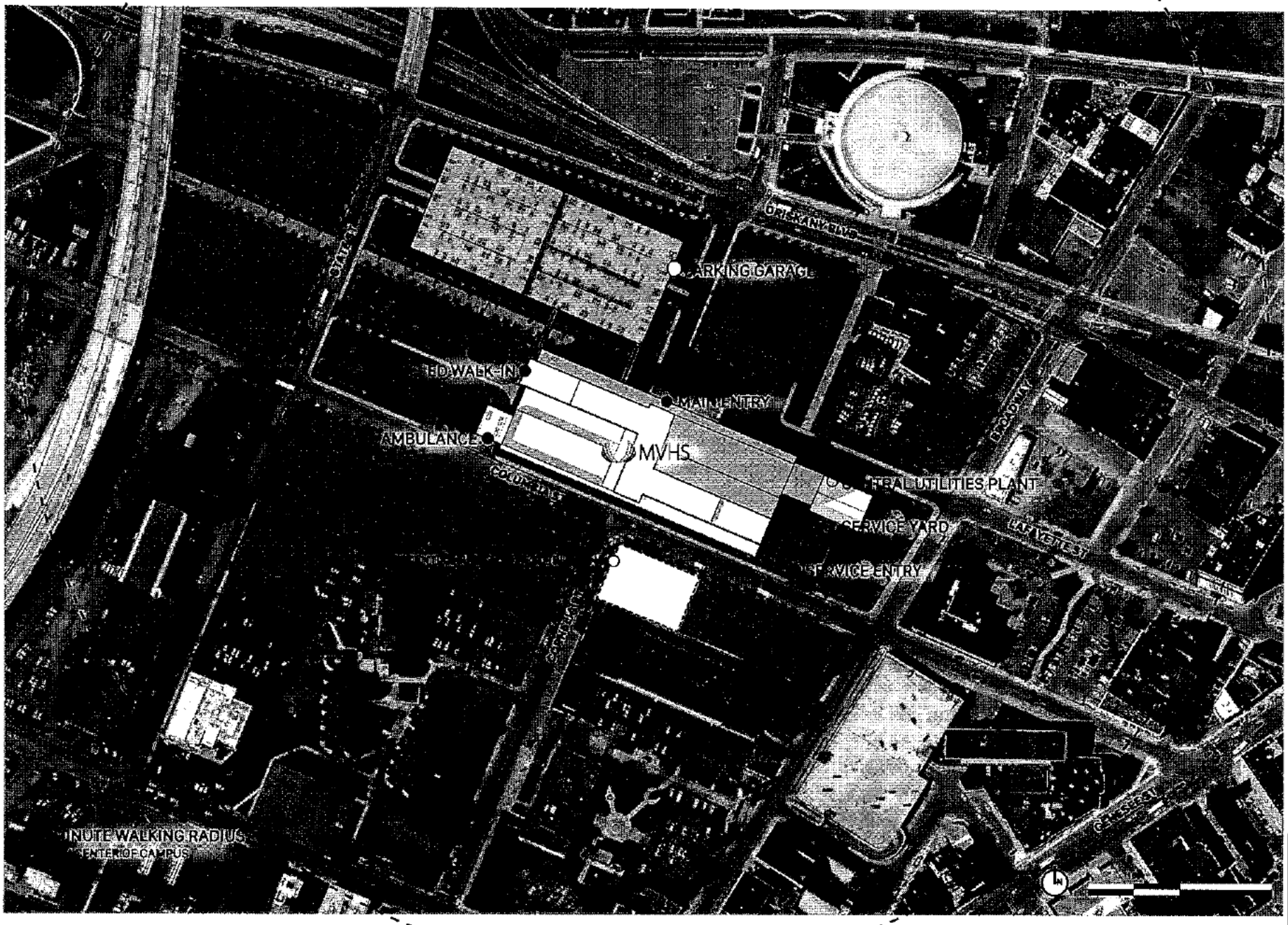
CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE: Architect | PROJECT DIRECTOR: Designer
PROJECT NUMBER: 190828.00
DATE:

SHEET TITLE
GENERAL REQUIREMENTS NOTES

SHEET NUMBER
GC001



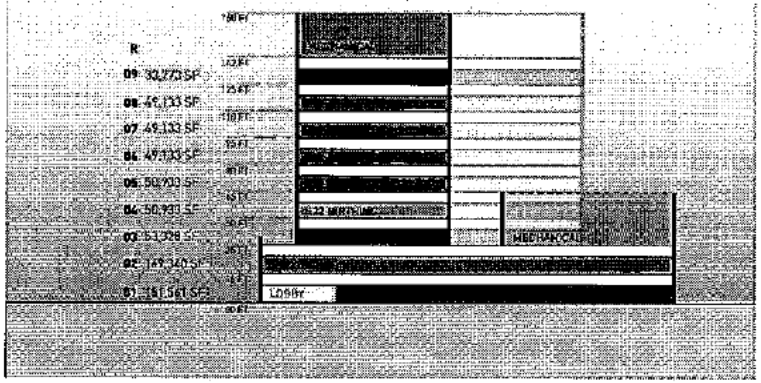
nbbj

MOHAWK VALLEY HEALTH SYSTEM

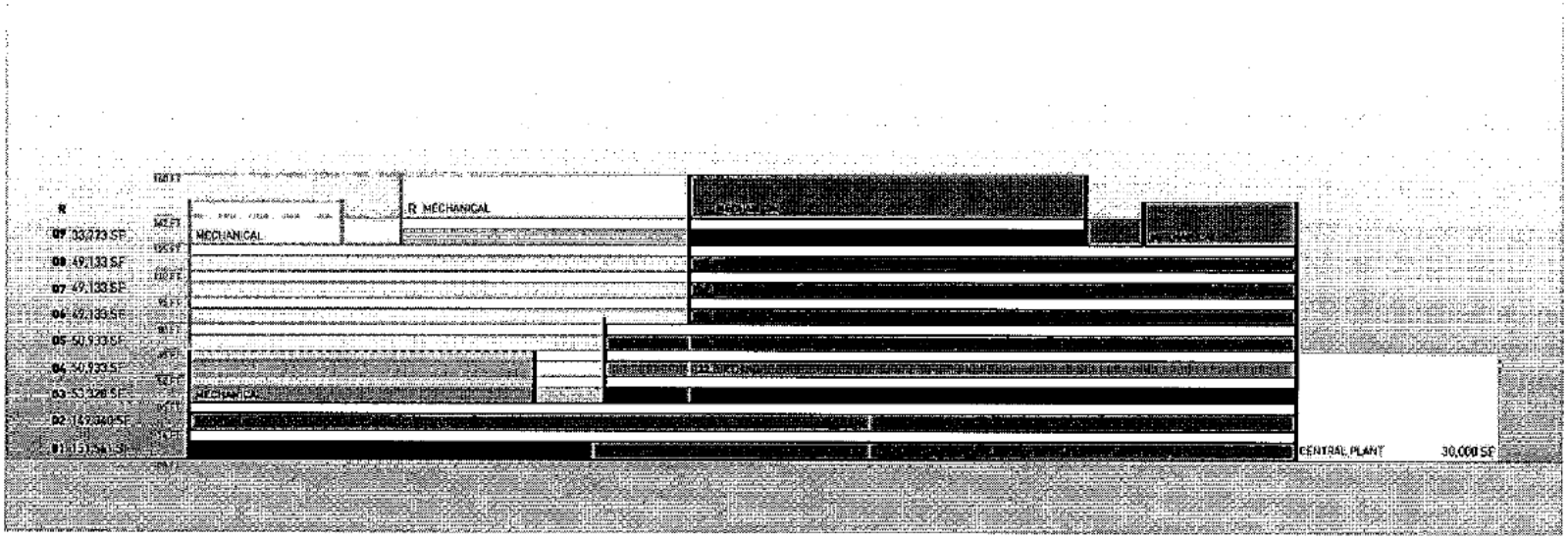
CON - SD SUBMITTAL

ARCHITECTURAL SITE PLAN

AS101



NORTH : SOUTH SECTION – LOOKING EAST



WEST : EAST SECTION – LOOKING NORTH

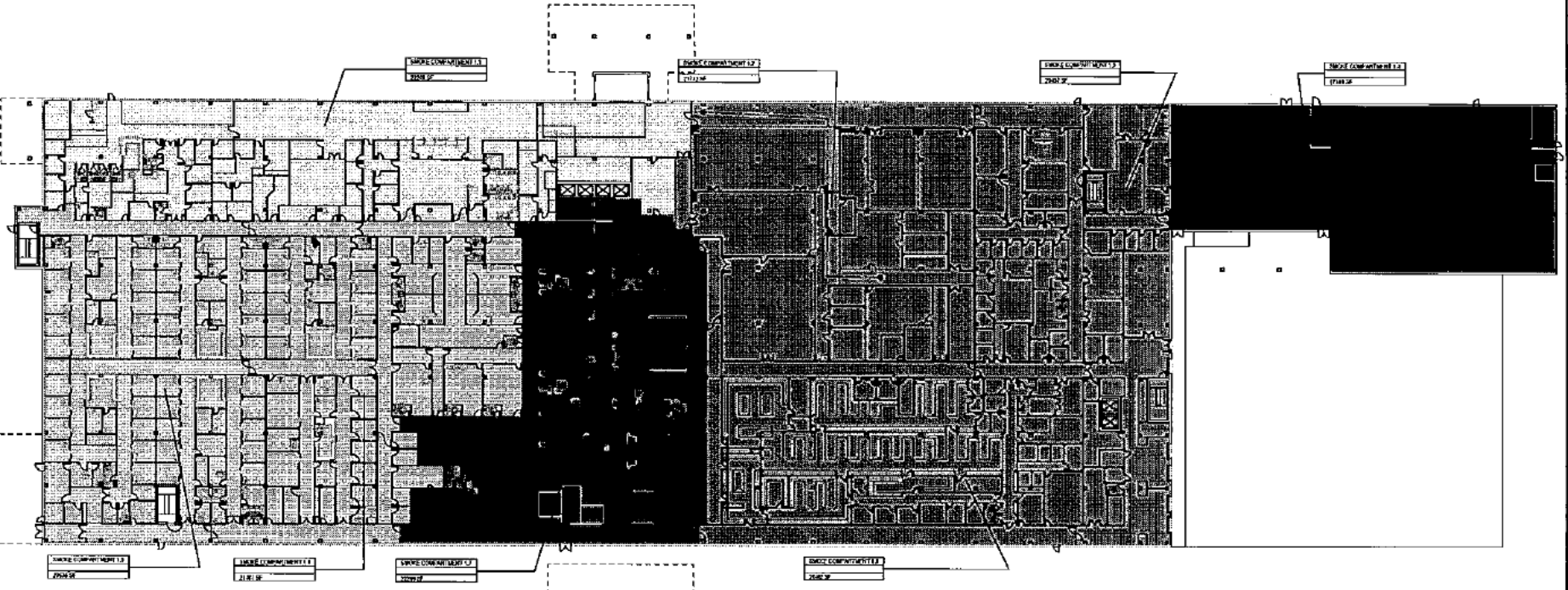
nbbj

MOHAWK VALLEY HEALTH SYSTEM

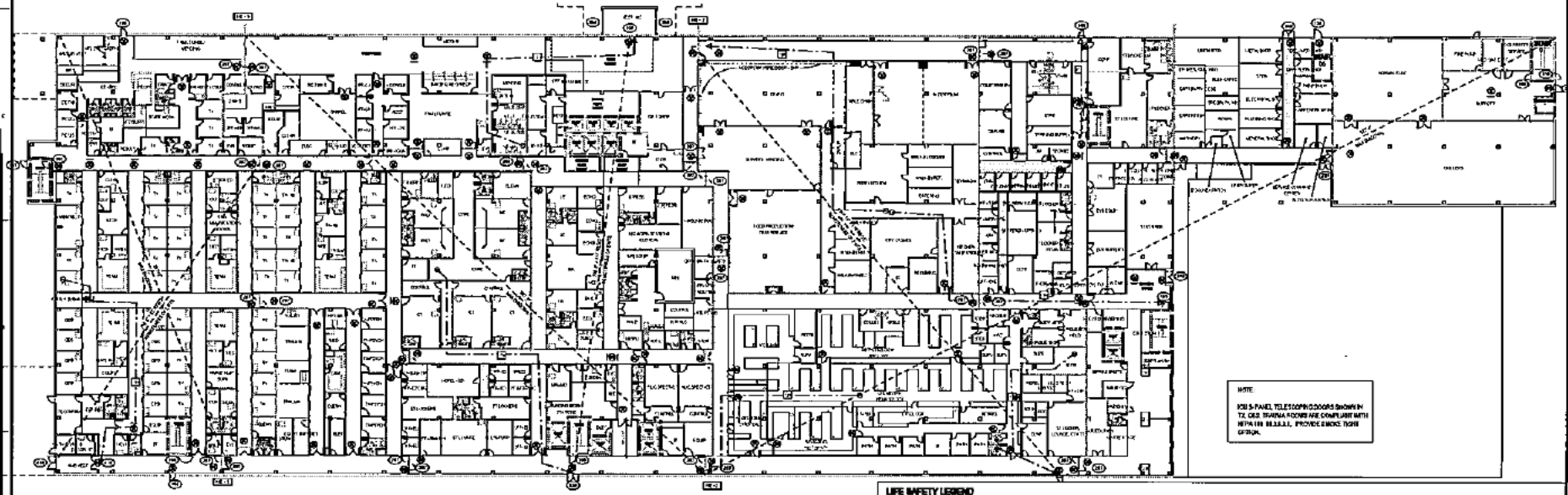
CON - SD SUBMITTAL

STACKING DIAGRAM

AS102



2 F1 SMOKE COMPARTMENTS



1 F1 LIFE SAFETY PLAN

LIFE SAFETY LEGEND

nbbj
260 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE: 614.224.7005
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

SCALE: 1" = 50'-0"

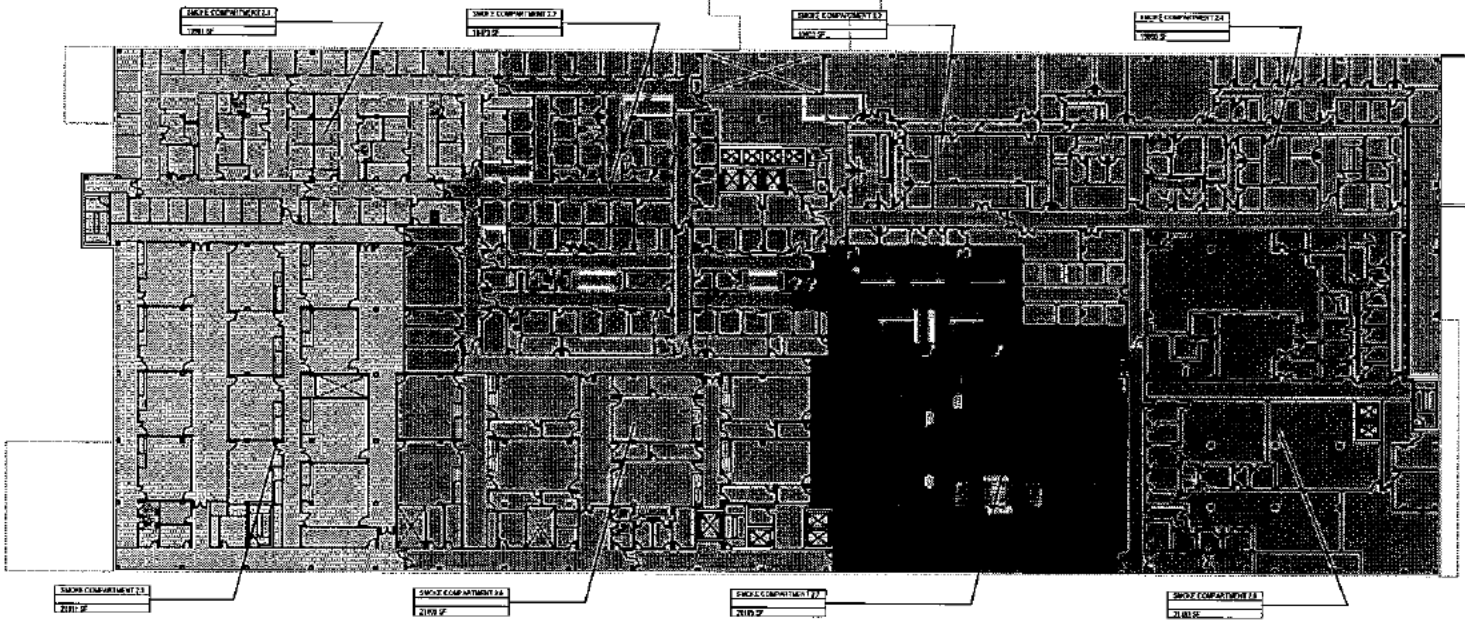
PROJECT NUMBER: 170000.00

DRAWN BY: Author

CHECKED BY:

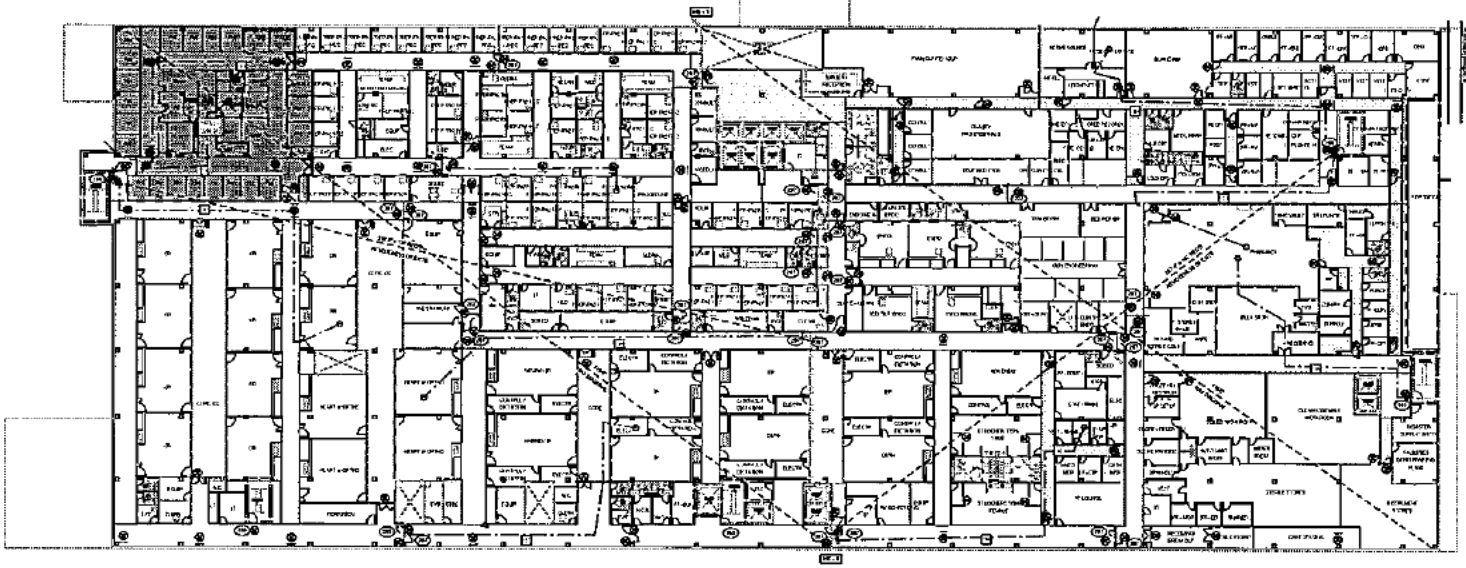
SHEET NAME: F1 LIFE SAFETY PLAN

SHEET NUMBER: GI101



CEP SMOKE COMPARTMENT

2 F2 SMOKE COMPARTMENTS



F2 CEP LIFE SAFETY

1 F2 LIFE SAFETY PLAN

LIFE SAFETY LEGEND

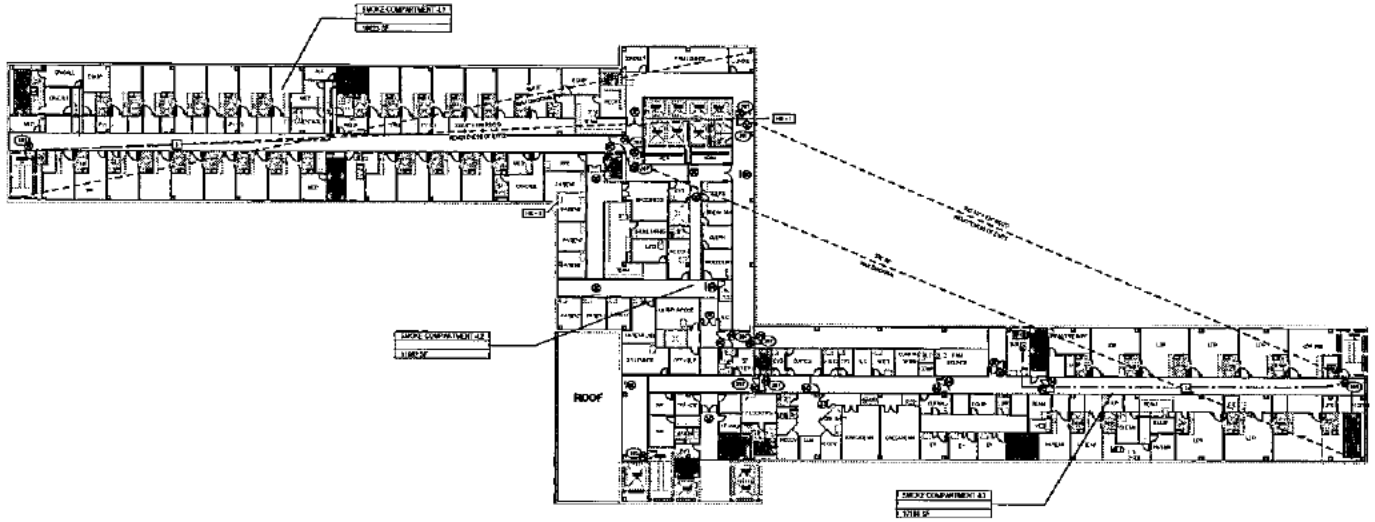
nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE: 614 224 7748

MOHAWK VALLEY HEALTH SYSTEM

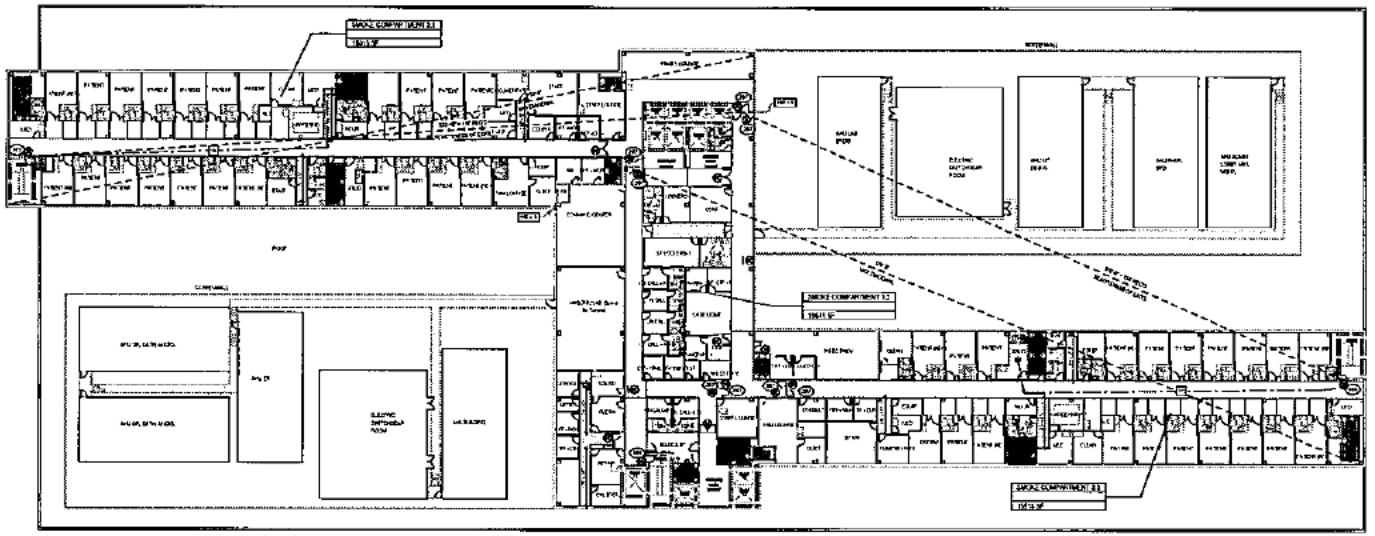
CON - SD SUBMITTAL

F2 LIFE SAFETY PLAN

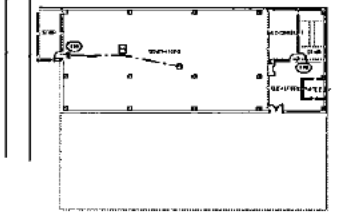
G102



2 F4 LIFE SAFETY PLAN



1 F3 LIFE SAFETY PLAN



F3 CEP LIFE SAFETY

LIFE SAFETY LEGEND

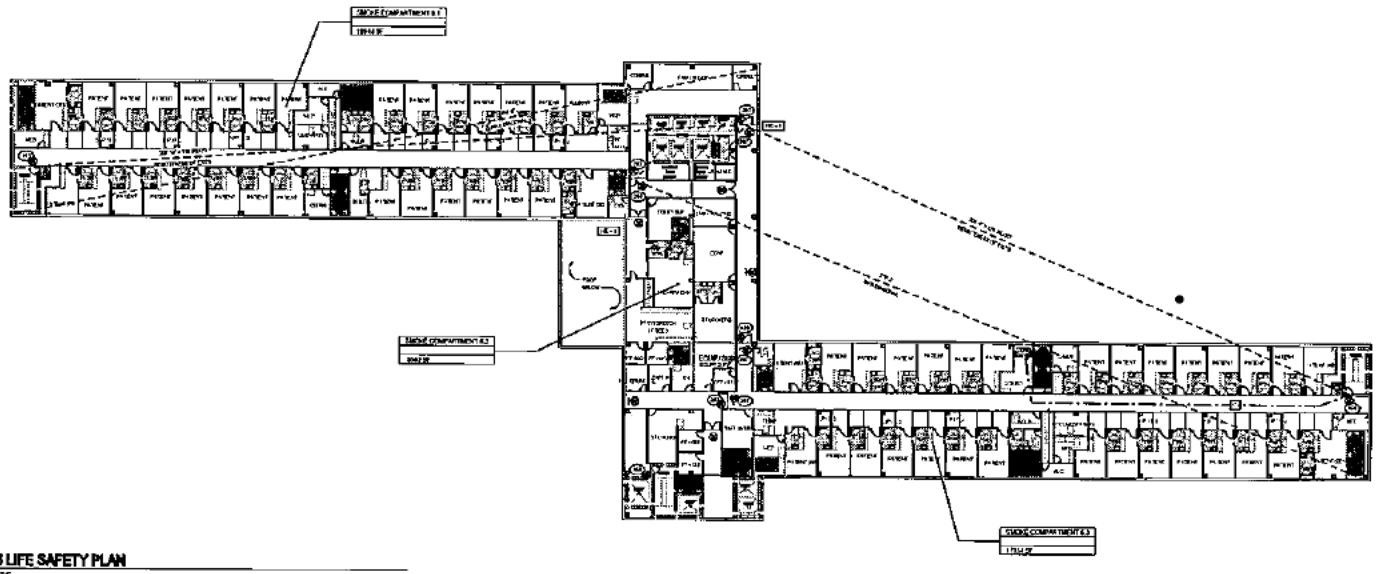
nbbj
250 S. HIGH STREET SUITE 305
COLUMBUS, OH 43215
PHONE 614.334.1145

MOHAWK VALLEY HEALTH SYSTEM

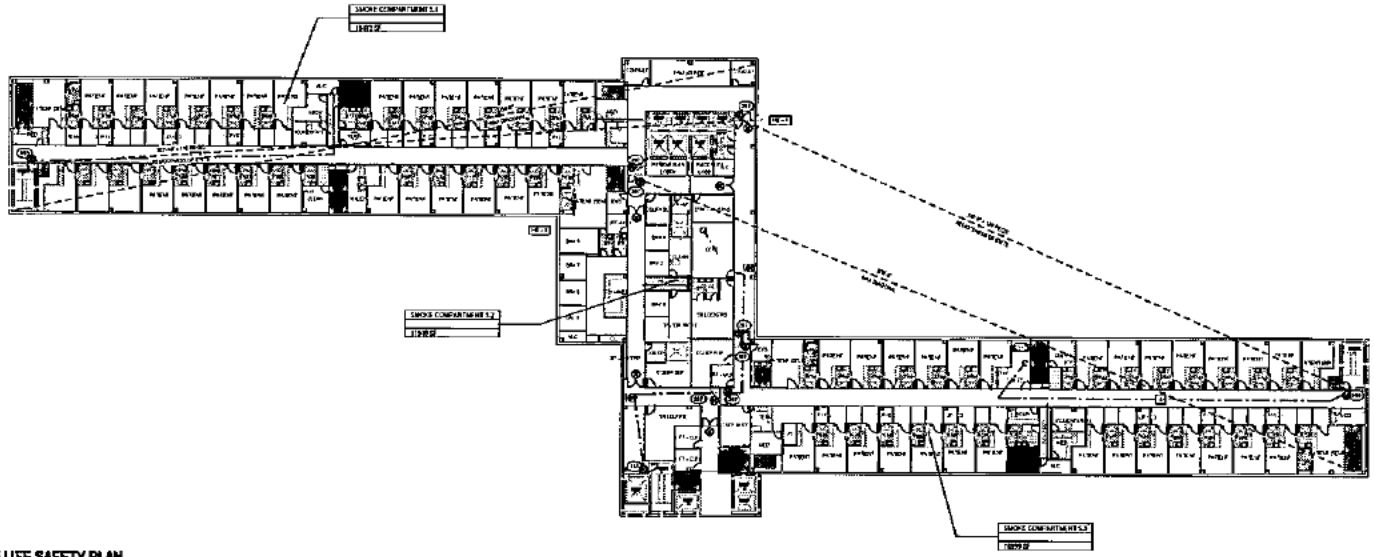
CON - SD SUBMITTAL

F3, F4 LIFE SAFETY PLANS

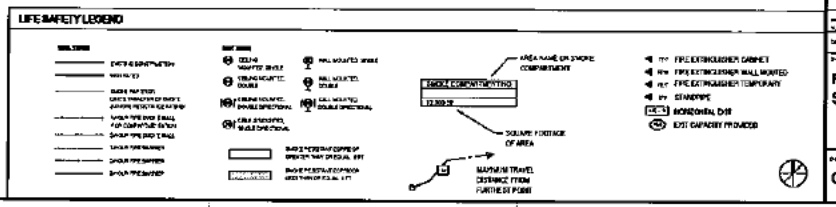
GI103



1 F8 LIFE SAFETY PLAN



2 F5 LIFE SAFETY PLAN



nbbj
250 SUMMIT STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 7448
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

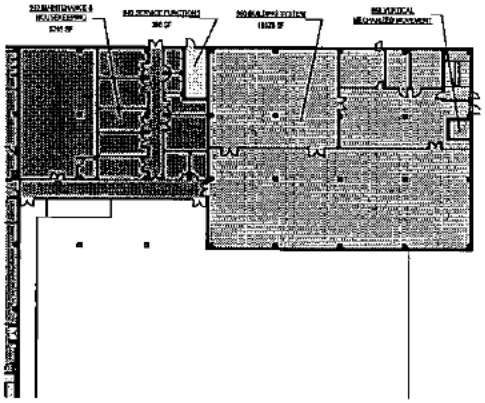
F5, F8 LIFE SAFETY PLANS

GI105

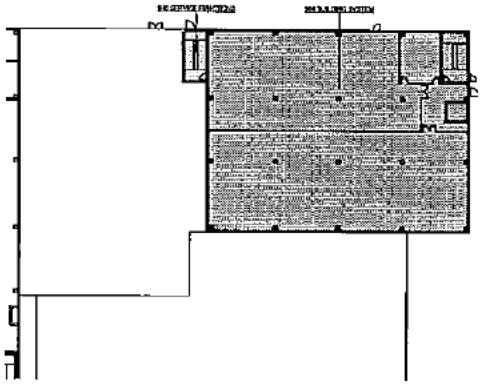
nbbj

FUNCTIONAL AREA CODE LEGEND

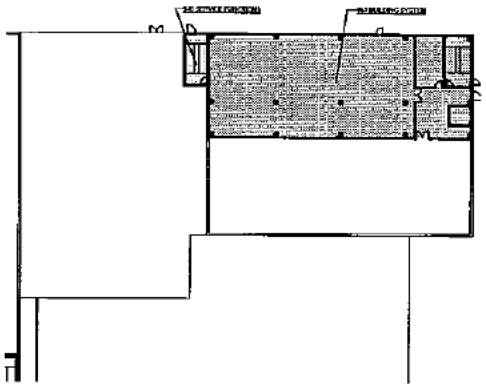
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM
- 968 VERTICAL MECHANIZED MOVEMENT



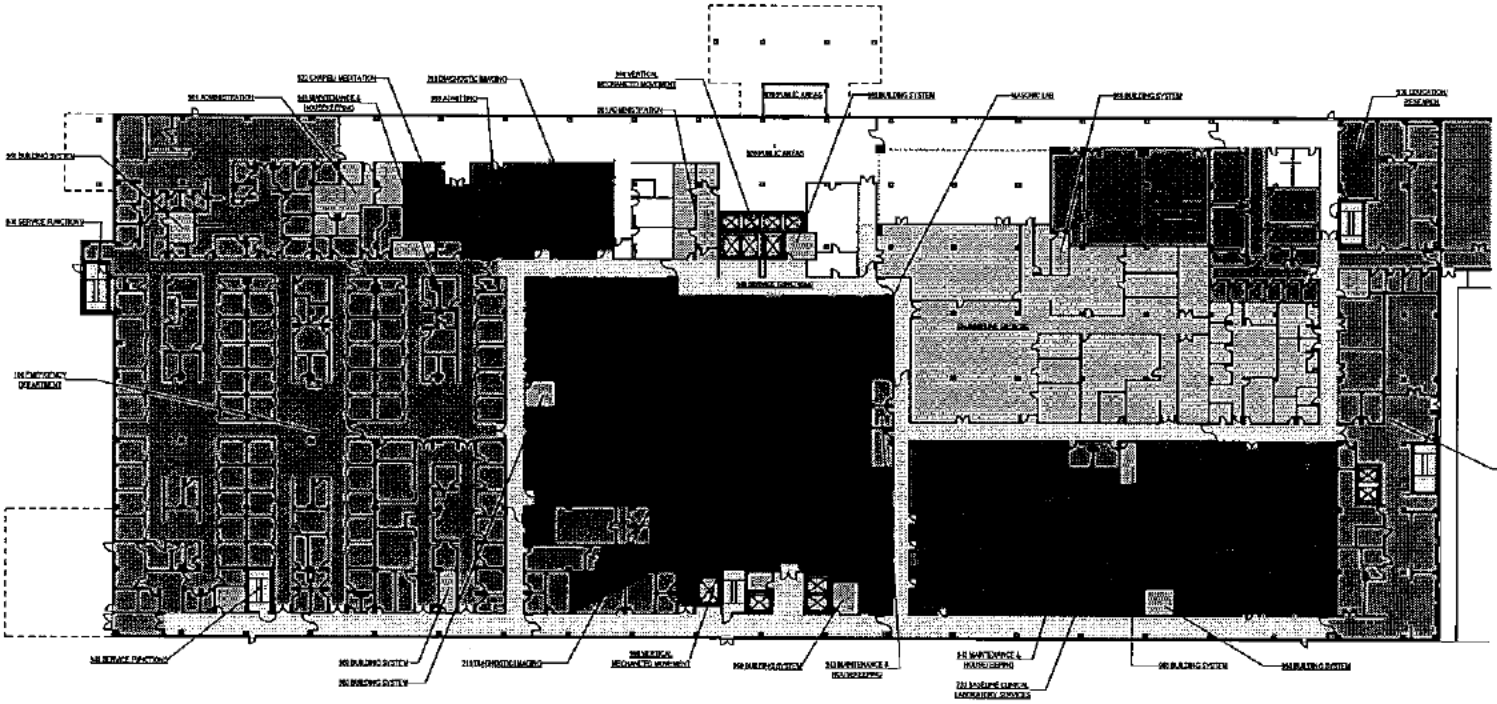
F1 FUNCTIONAL AREA PLAN - ANNEX/ CEP



F2 FUNCTIONAL AREA PLAN - CEP



F3 FUNCTIONAL AREA PLAN - CEP



FUNCTIONAL AREA CODE LEGEND

- 106 EMERGENCY DEPARTMENT
- 210 DIAGNOSTIC IMAGING
- 733 BASELINE CLINICAL LABORATORY SERVICES
- 734 BASELINE DIETETIC
- 901 ADMINISTRATION
- 903 ADMITTING
- 920 PUBLIC AREAS
- 922 CHAPEL/ MEDITATION
- 930 EDUCATION/ RESEARCH
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM
- 968 VERTICAL MECHANIZED MOVEMENT
- MASONIC LAB

F1 FUNCTIONAL AREA PLAN

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

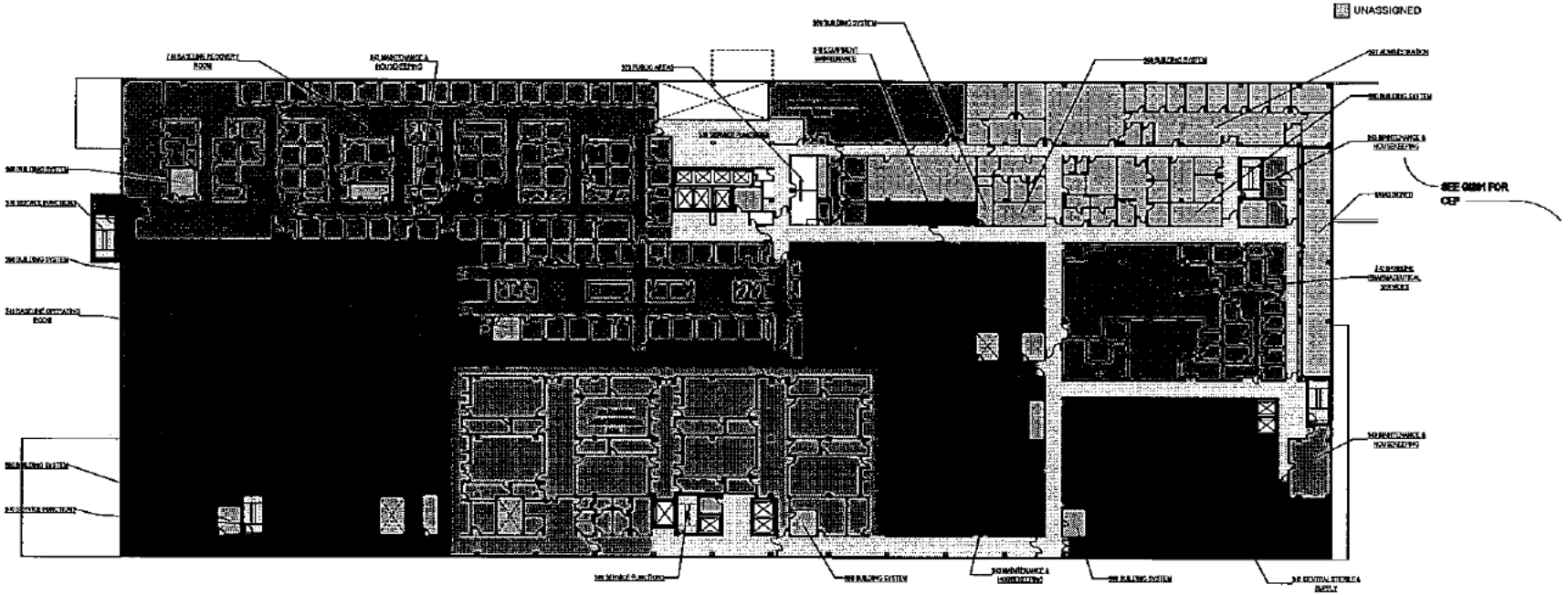
F1, CEP F1-F3 FUNCTIONAL AREA PLAN

GI201

nbbj
250 A. HIGH STREET, SUITE 300
COLUMBUS, OH 43215
PHONE: 614.224.11.46
www.nbbj.com

FUNCTIONAL AREA CODE LEGEND

- 203 CARDIAC CATHETERIZATION- ADULT
- 741 BASELINE OPERATING ROOM
- 742 BASELINE PHARMACEUTICAL SERVICES
- 744 BASELINE RECOVERY ROOM
- 901 ADMINISTRATION
- 920 PUBLIC AREAS
- 940 SERVICE FUNCTIONS
- 941 CENTRAL STERILE & SUPPLY
- 943 MAINTENANCE & HOUSEKEEPING
- 948 EQUIPMENT MAINTENANCE
- 960 BUILDING SYSTEM
- UNASSIGNED



1 F2 FUNCTIONAL AREA PLAN

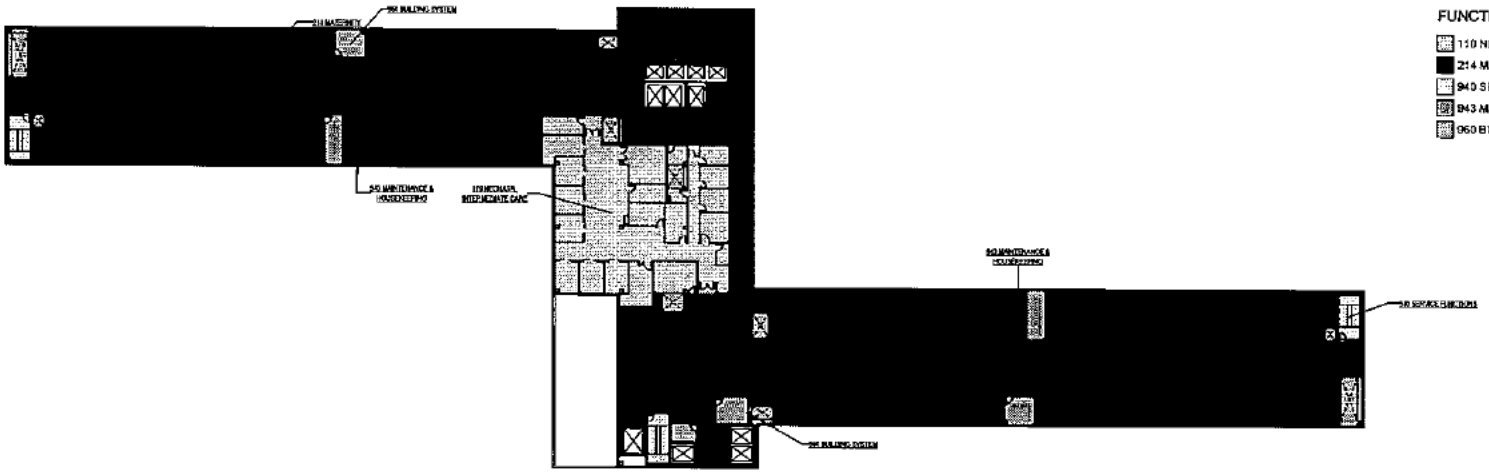
MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

F2 FUNCTIONAL AREA PLAN

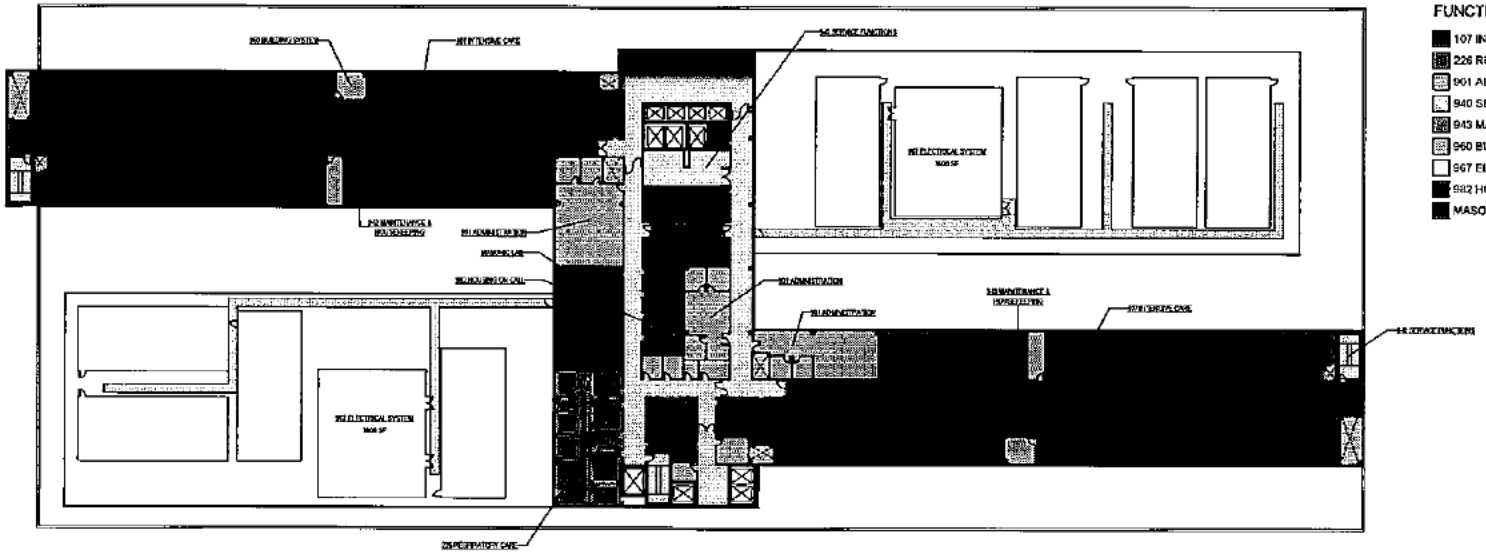
G1202



FUNCTIONAL AREA CODE LEGEND

- 110 NEONATAL INTERMEDIATE CARE
- 214 MATERNITY
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

2 F4 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 107 INTENSIVE CARE
- 226 RESPIRATORY CARE
- 901 ADMINISTRATION
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM
- 967 ELECTRICAL SYSTEM
- 982 HOUSING ON CALL
- MASONIC LAB

1 F3 FUNCTIONAL AREA PLAN

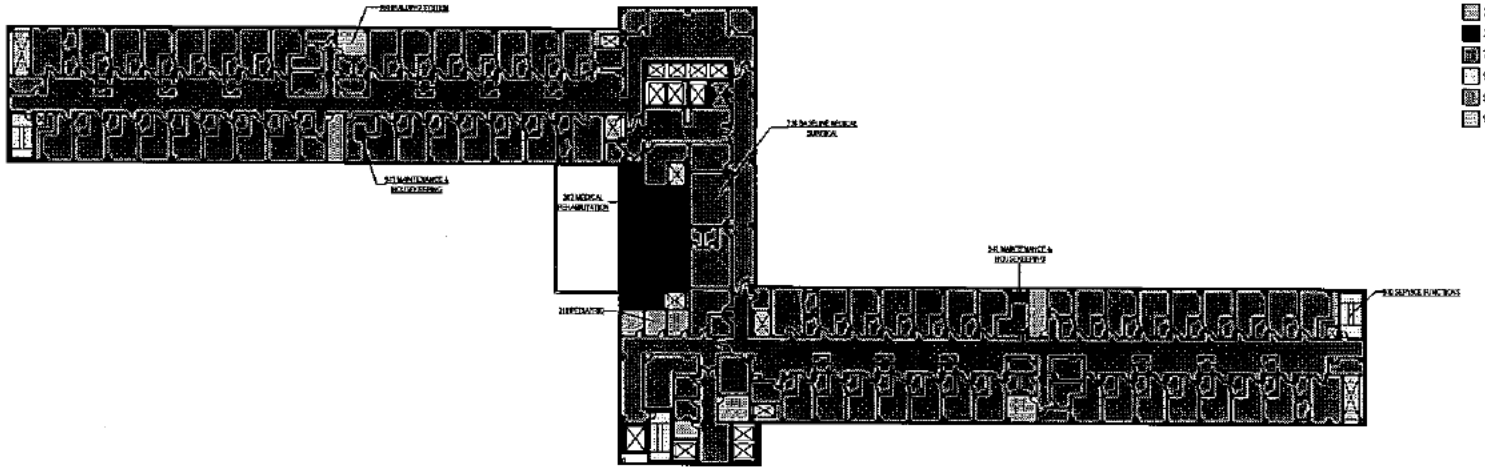
nbbj
216 S. HIGH STREET, SUITE 240
COLUMBUS, OH 43215
PHONE: 614.224.7345

MOHAWK VALLEY HEALTH SYSTEM

CON - 60 SUBMITTAL

F3, F4 FUNCTIONAL AREA PLAN

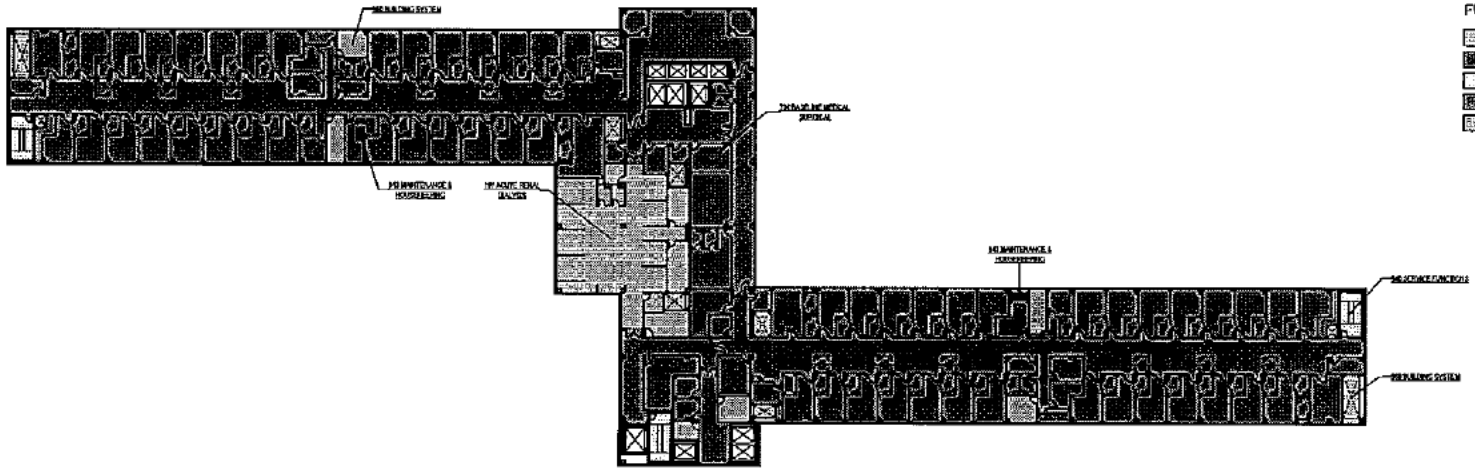
G1203



FUNCTIONAL AREA CODE LEGEND

- 216 PEDIATRIC
- 302 MEDICAL REHABILITATION
- 736 BASELINE MEDICAL SURGICAL
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

2 F6 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 101 ACUTE RENAL DIALYSIS
- 736 BASELINE MEDICAL SURGICAL
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

1 F5 FUNCTIONAL AREA PLAN

nbbj
295 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7165

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 9, 2017

Mark	DATE	DESCRIPTION

SCALE 1" = 30'-0"

PROJECT MONITOR Designer

PROJECT NUMBER 170815.00

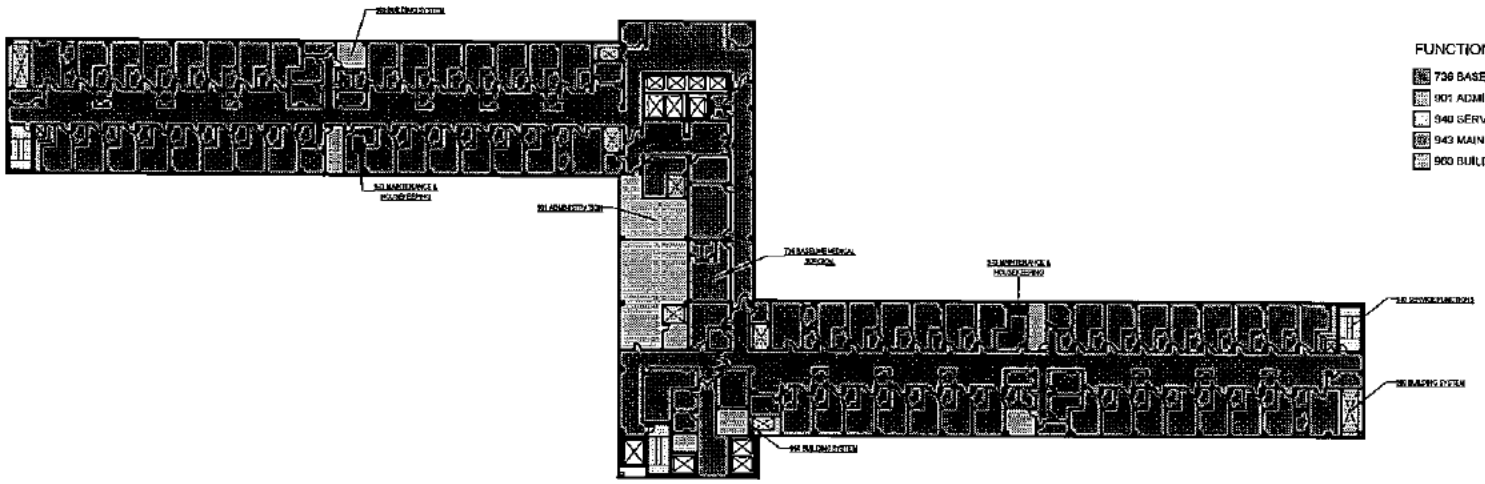
DATE 11/9/17

SHEET NAME

F5, F6 FUNCTIONAL AREA PLAN

SHEET NUMBER

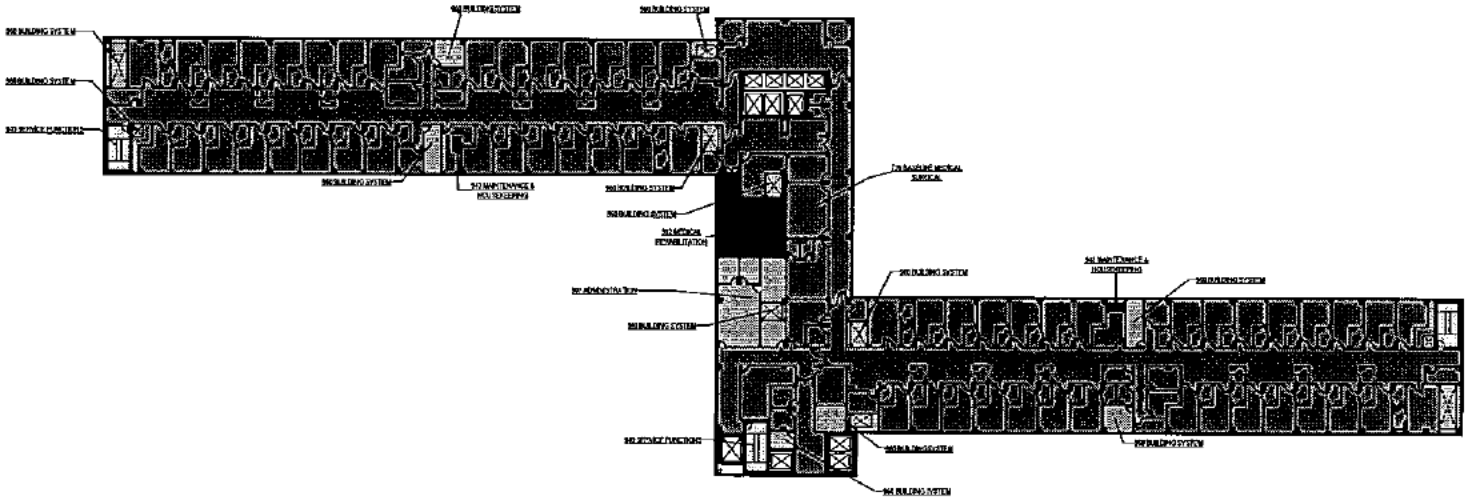
G6205



FUNCTIONAL AREA CODE LEGEND

- 736 BASELINE MEDICAL SURGICAL
- 901 ADMINISTRATION
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

2 F8 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 302 MEDICAL REHABILITATION
- 736 BASELINE MEDICAL SURGICAL
- 901 ADMINISTRATION
- 940 SERVICE FUNCTIONS
- 943 MAINTENANCE & HOUSEKEEPING
- 960 BUILDING SYSTEM

1 F7 FUNCTIONAL AREA PLAN

nbbj
250 S HIGH STREET SUITE 900
COLUMBUS, OH 43215
PHONE 614 224 7145
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

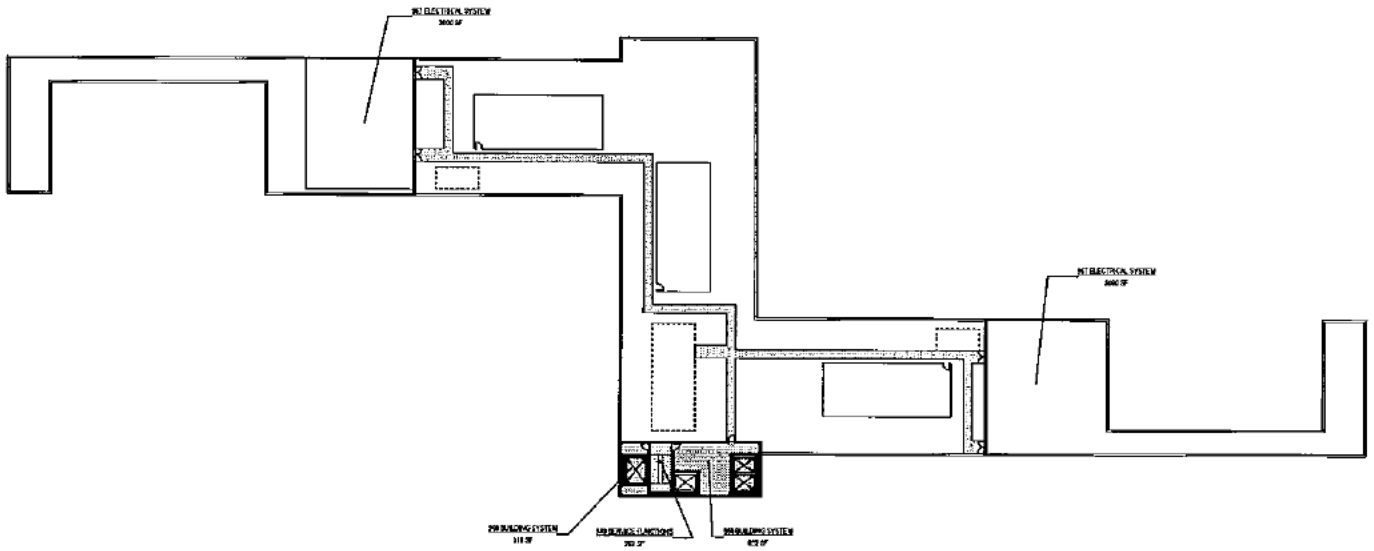
SCALE 1" = 20'-0"

PROJECT NUMBER 170103.00

DATE 10/20/17

F7, F8 FUNCTIONAL AREA PLAN

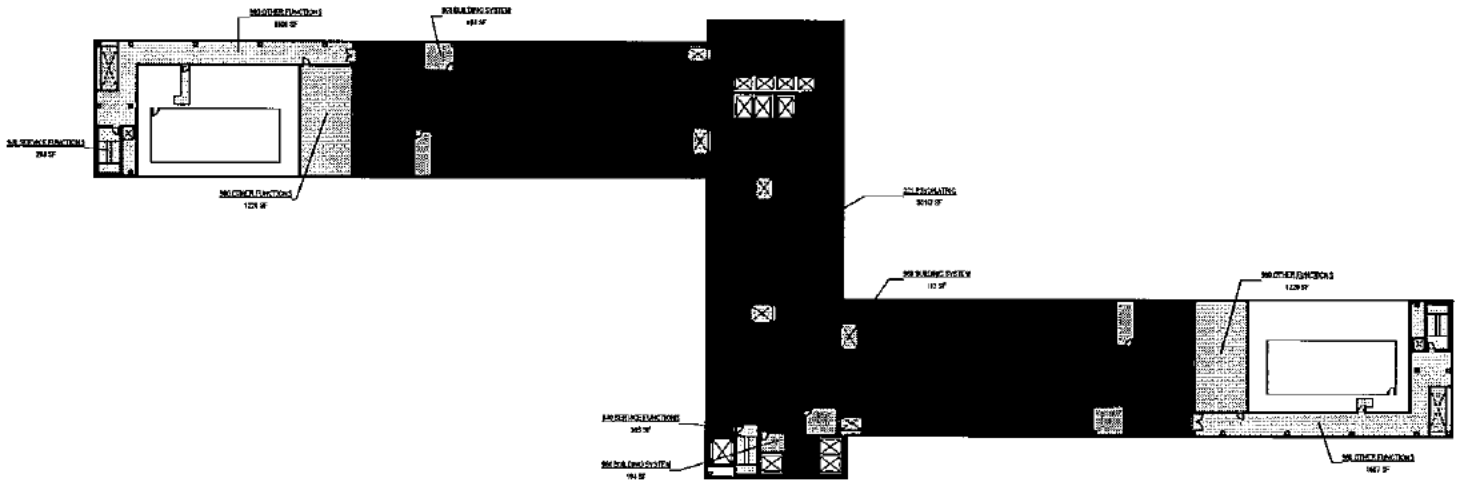
SHEET NO. G1207



FUNCTIONAL AREA CODE LEGEND

- 940 SERVICE FUNCTIONS
- 960 BUILDING SYSTEM
- 967 ELECTRICAL SYSTEM

2 R1 FUNCTIONAL AREA PLAN



FUNCTIONAL AREA CODE LEGEND

- 221 PSYCHIATRIC
- 940 SERVICE FUNCTIONS
- 960 BUILDING SYSTEM
- 950 OTHER FUNCTIONS

1 F9 FUNCTIONAL AREA PLAN

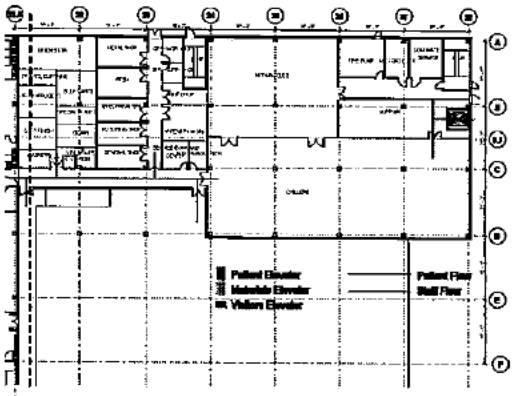
nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7125

MOHAWK VALLEY HEALTH SYSTEM

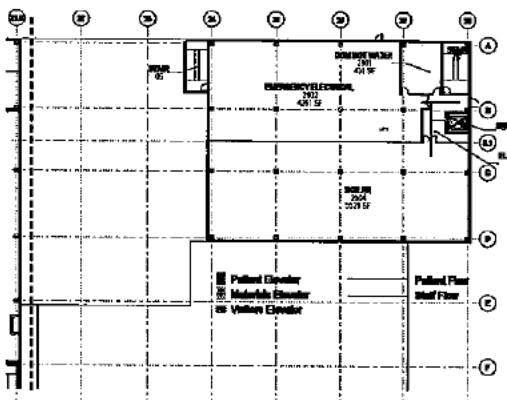
CON - SD SUBMITTAL

F9, F10 ROOF FUNCTIONAL AREA PLAN

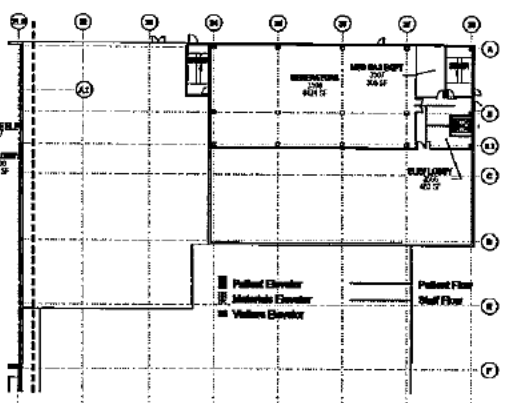
G1208



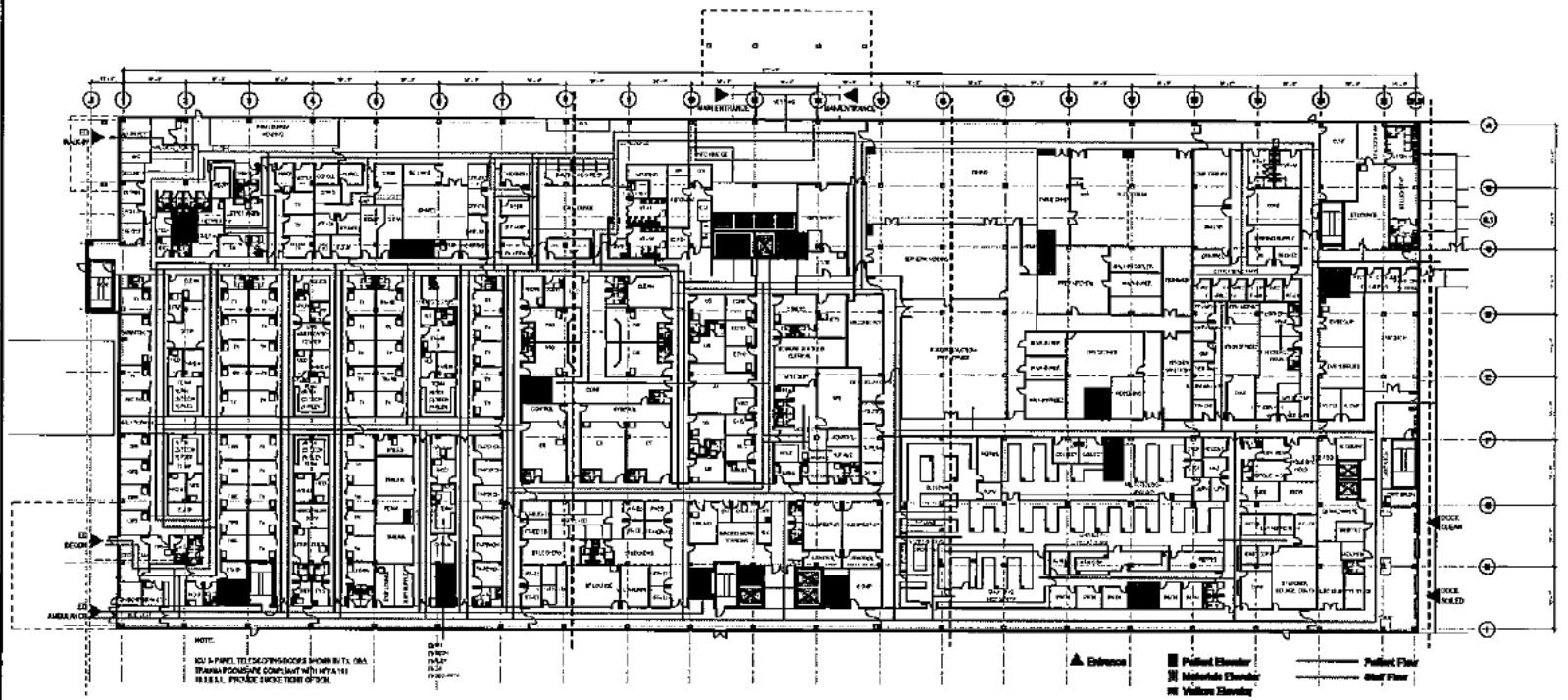
2 F1 ANNEX & CEP



3 F2 CEP



4 F3 CEP



1 F1 FLOOR PLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 71 6

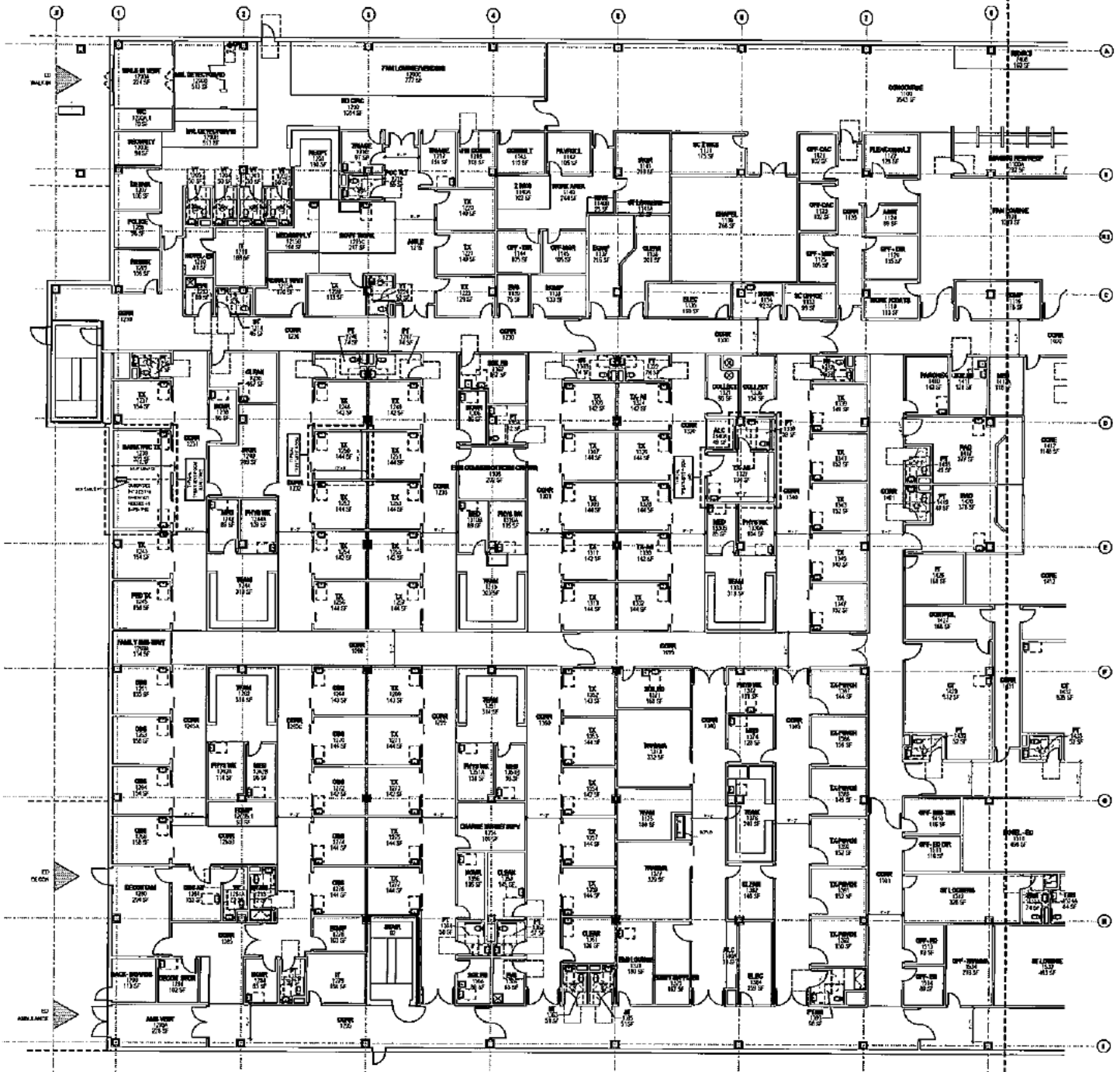
MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

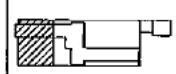
KEYPLAN

F1 OVERALL & CEP FLOOR PLANS

AE101



KEYPLAN



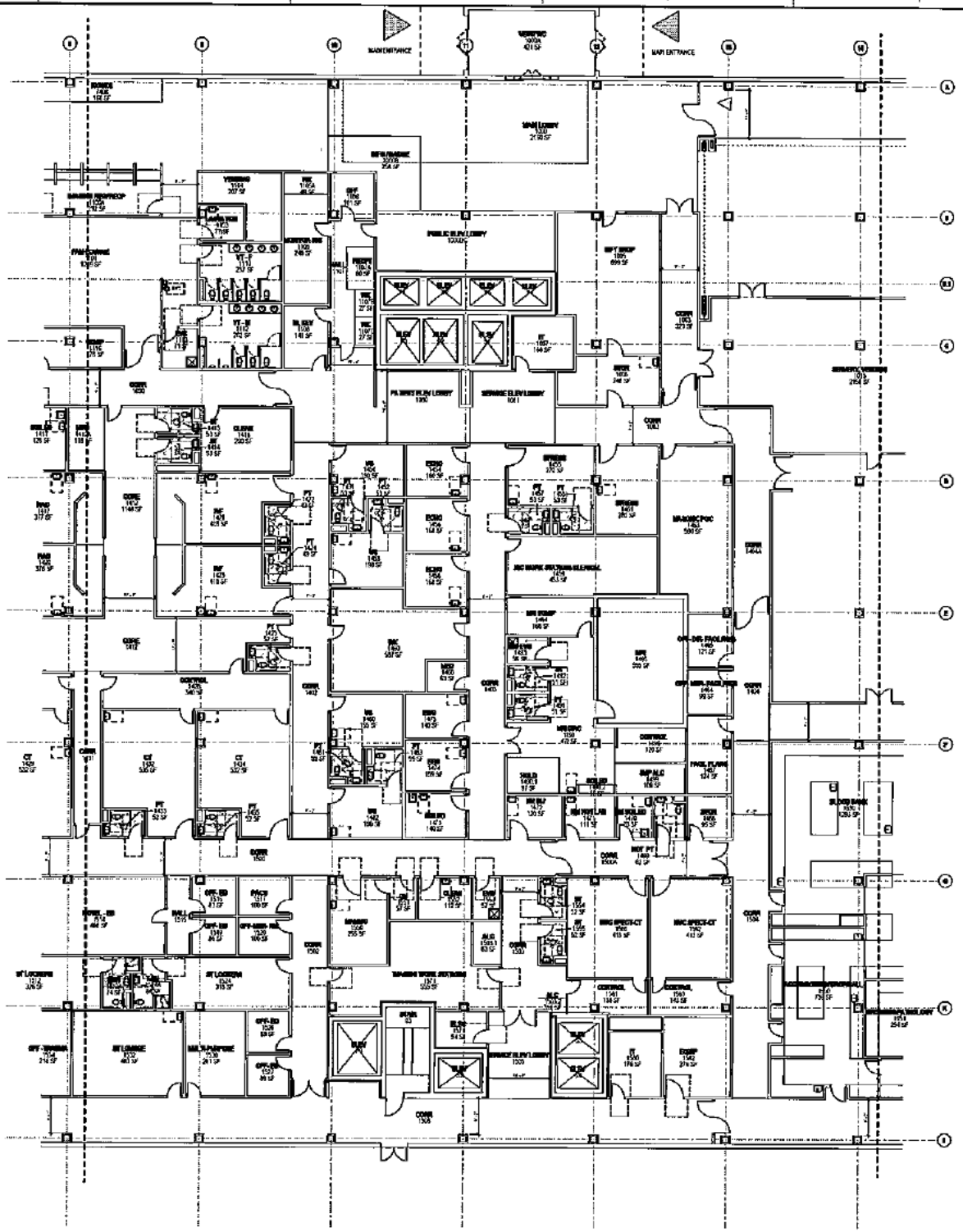
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F1 FLOOR PLAN - AREA A

AE101-A



KEYPLAN

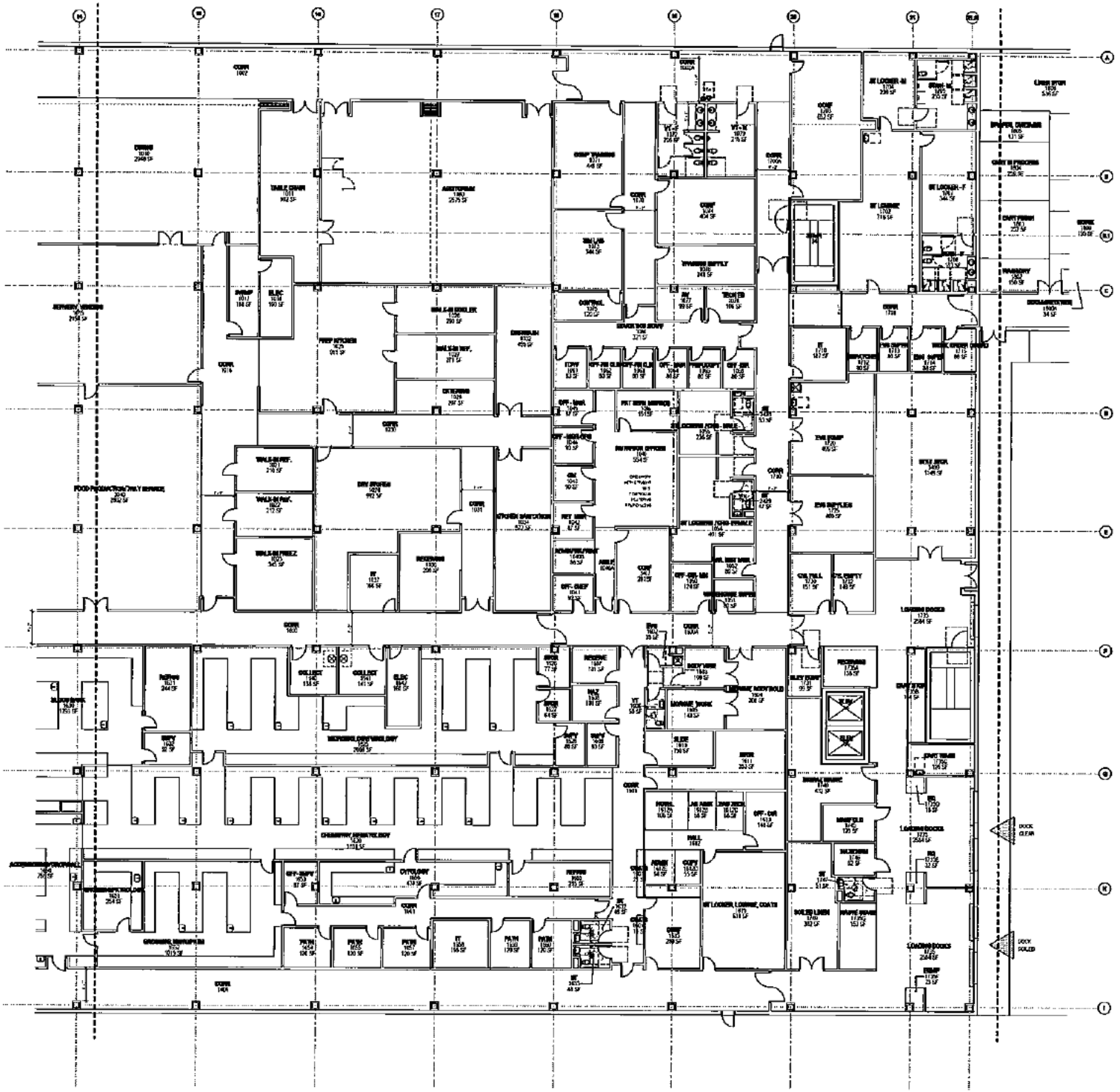
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F1 FLOOR PLAN - AREA B

AE101-B



nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 6116
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

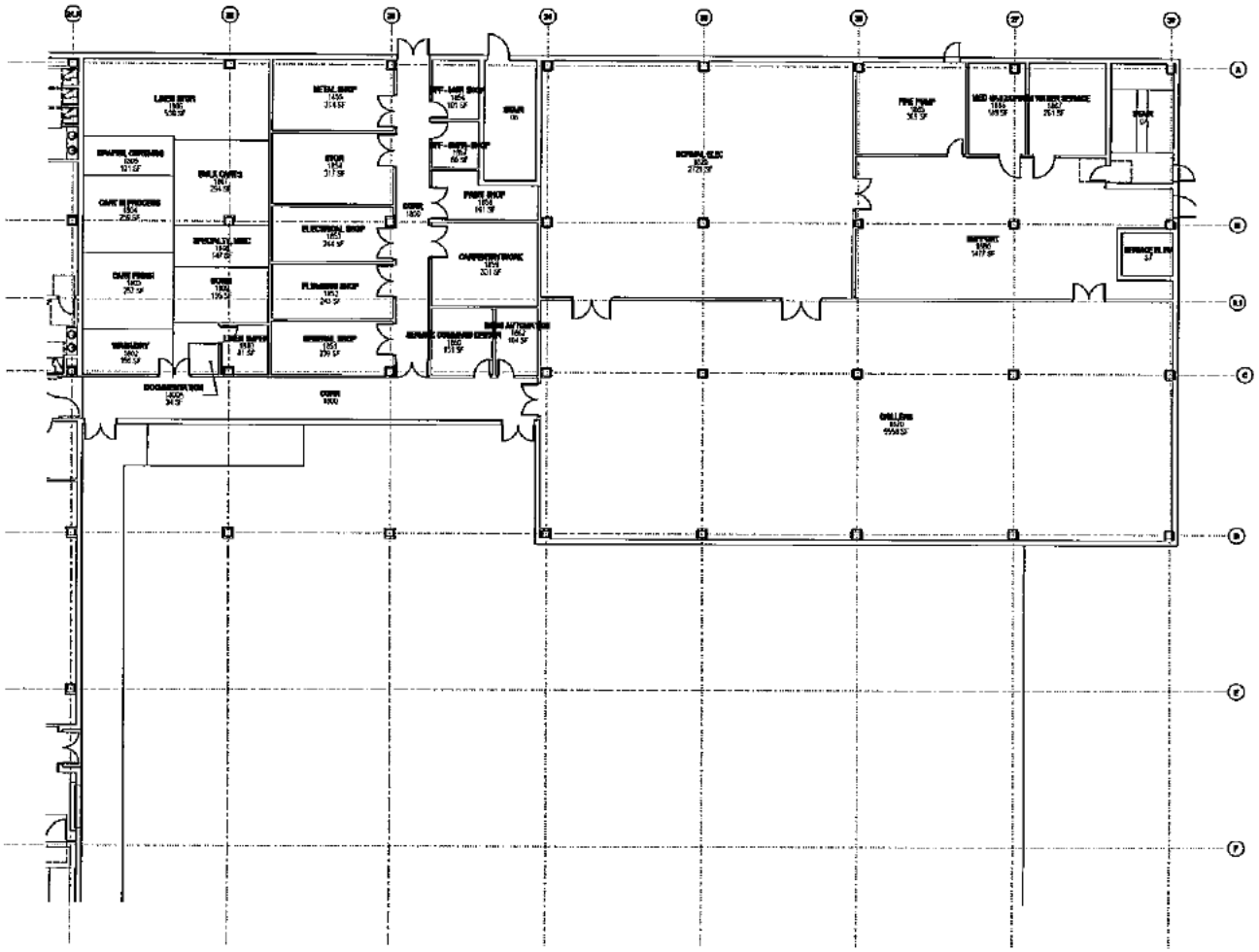
NOVEMBER 3, 2017

mark	DATE	DESCRIPTION

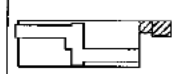
KEYPLAN

F1 FLOOR PLAN - AREA C

AE101-C



KEYPLAN



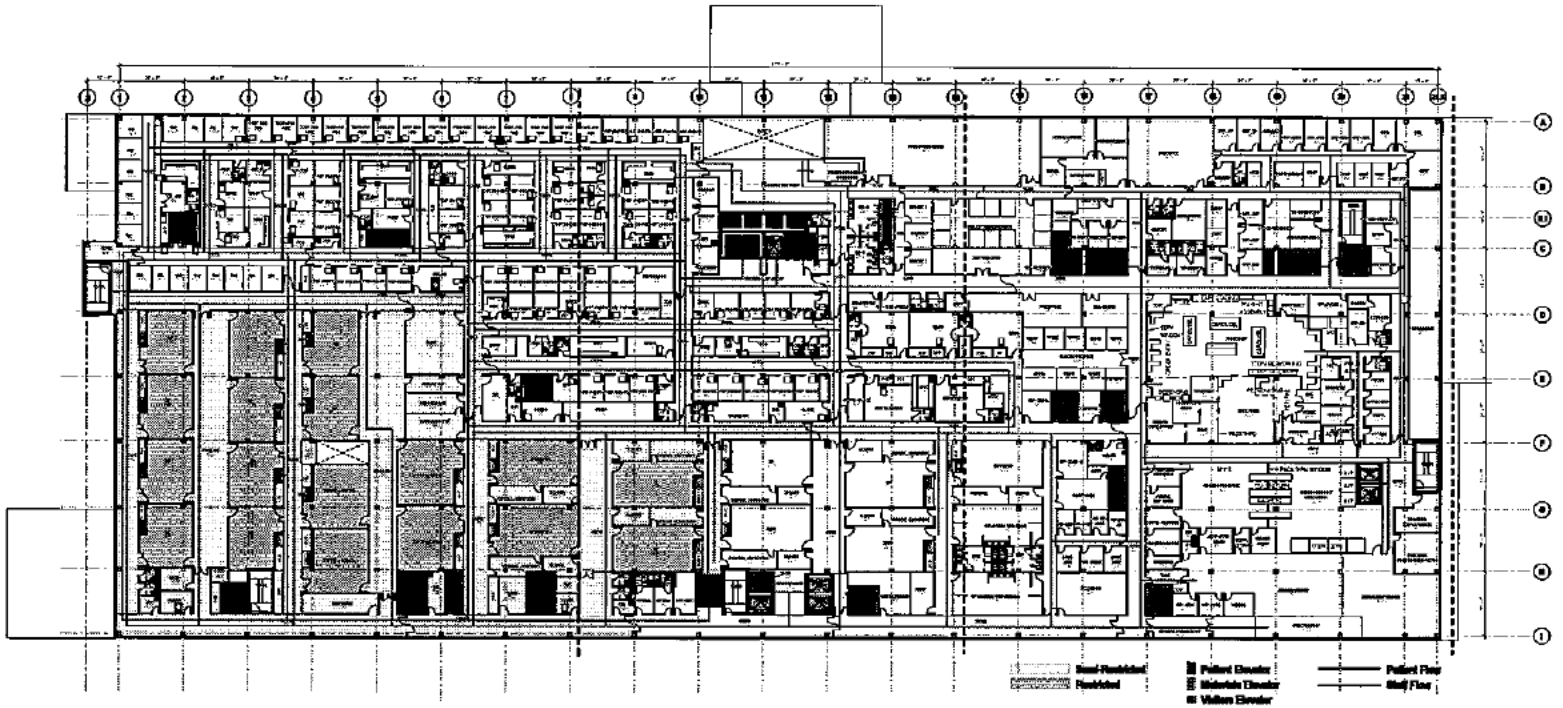
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F1 FLOOR PLAN - AREA D

AE101-D



1 F2 FLOOR PLAN

KEYPLAN

nbbj
204 N. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614.224.7185
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

SCALE 1" = 30'-0"

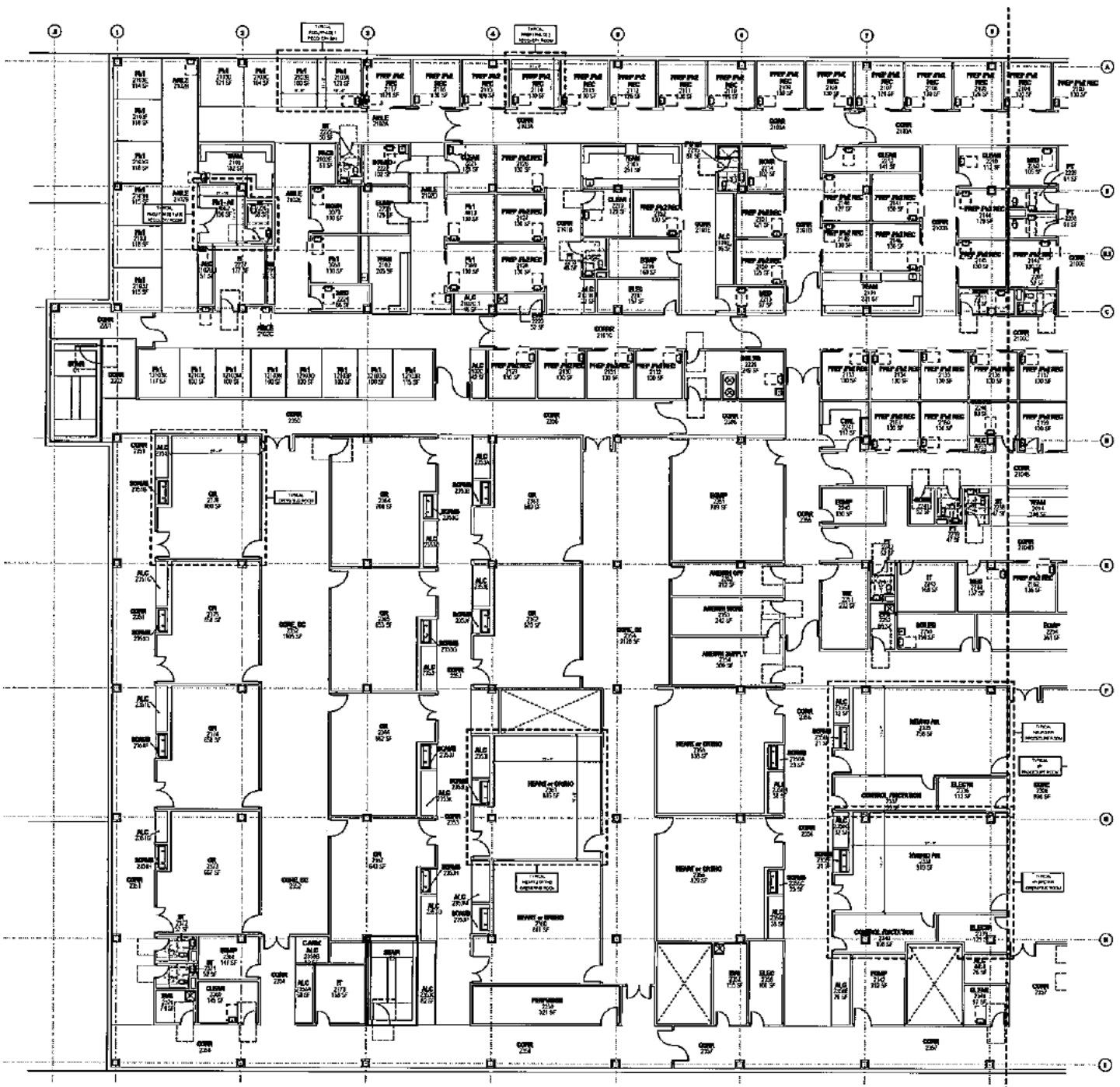
PROJECT ARCHITECT Rodgers

PROJECT NUMBER 160611.00

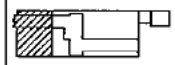
DATE

SHEET NAME
F2 OVERALL FLOOR PLAN

SHEET NUMBER
AE102



KEYPLAN



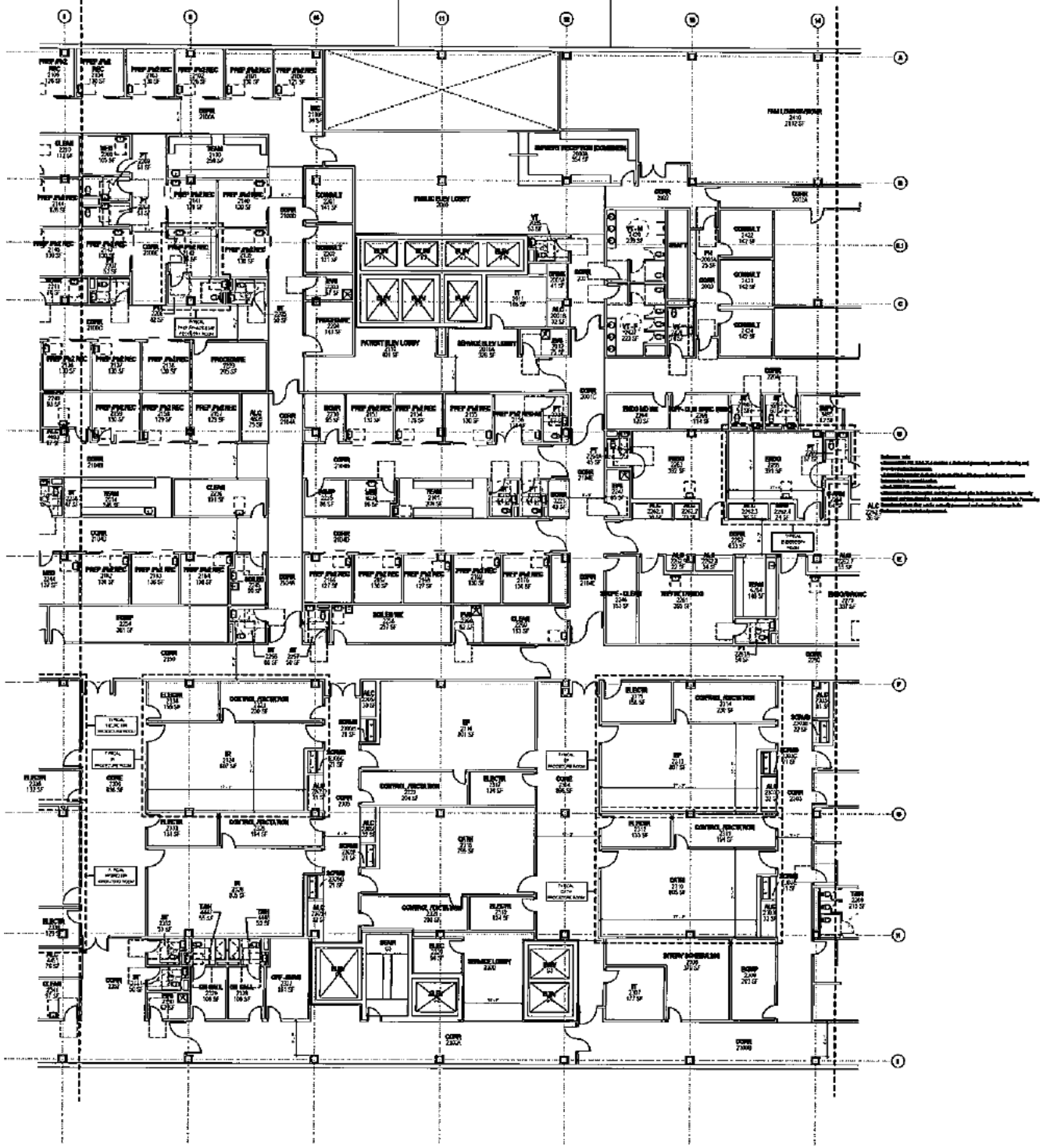
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F2 FLOOR PLAN - AREA A

AE102-A



KEYPLAN

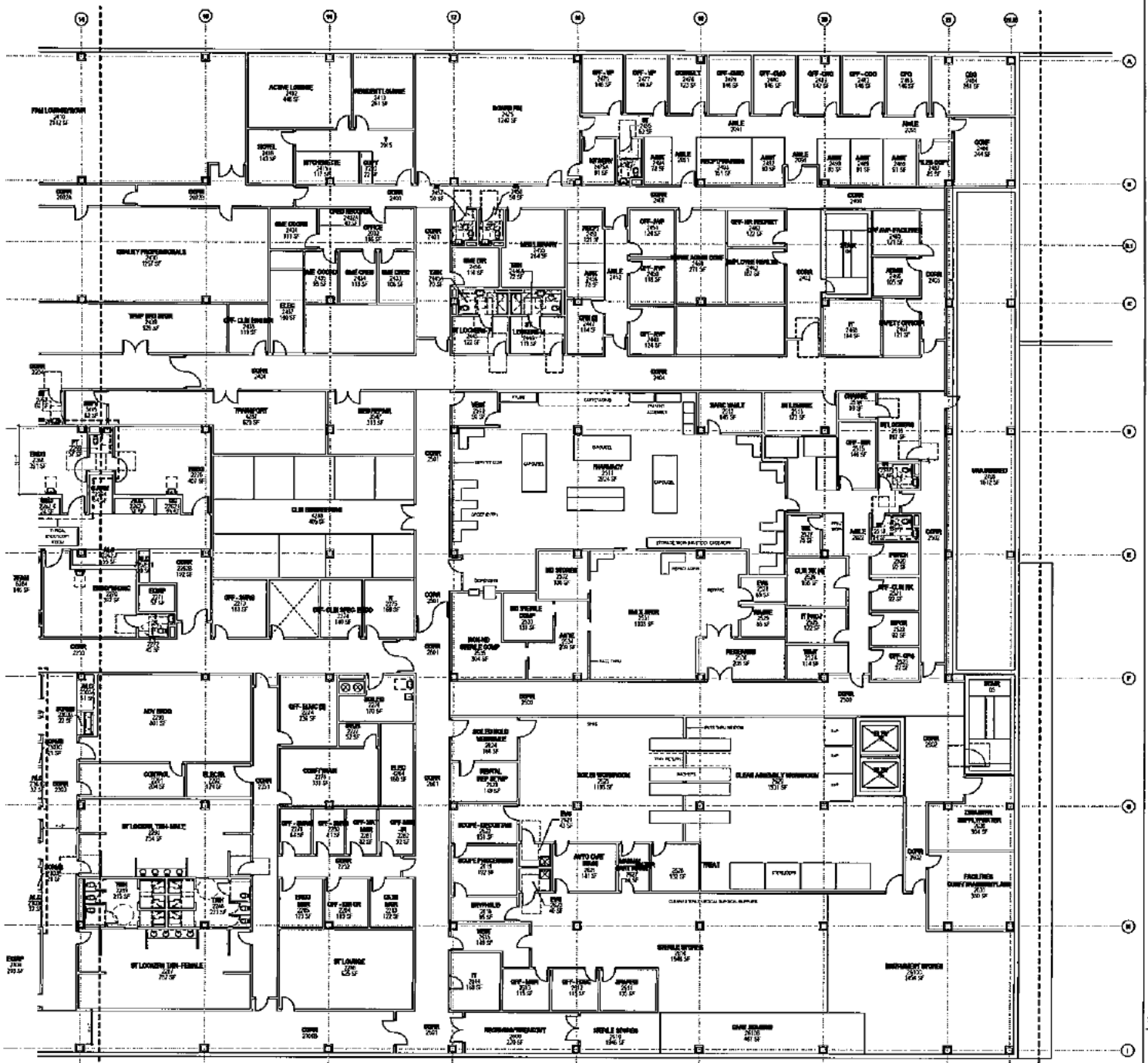
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

F2 FLOOR PLAN - AREA B

AE102-B



KEYPLAN

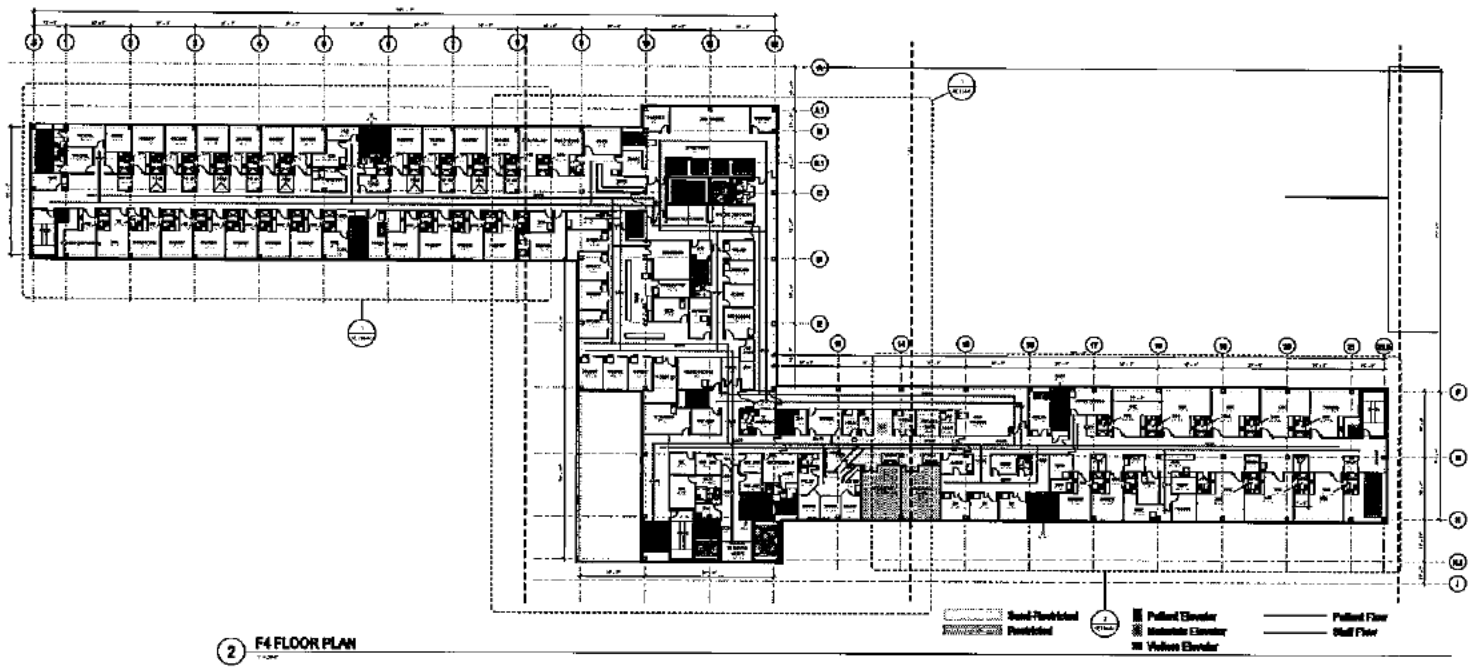
nbbj

MOHAWK VALLEY HEALTH SYSTEM

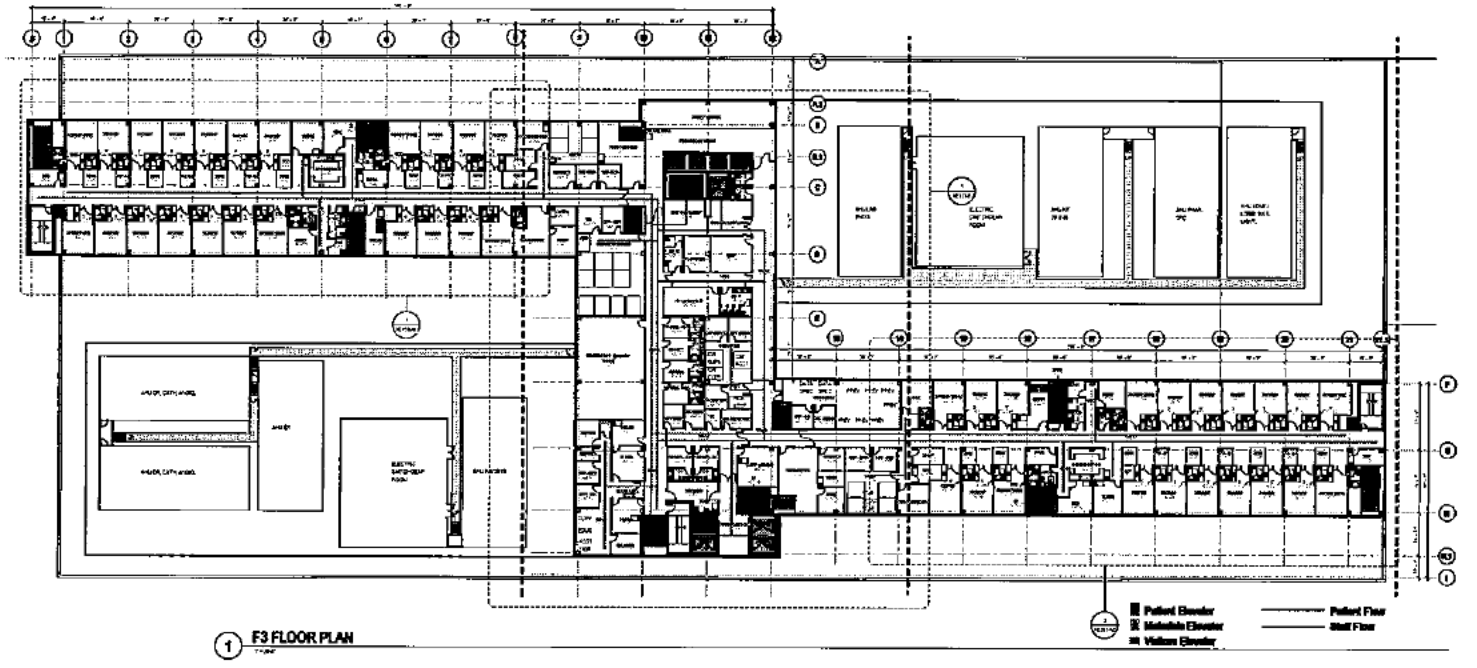
CON - SD SUBMITTAL

F2 FLOOR PLAN - AREA C

AE102-C



2 F4 FLOOR PLAN



1 F3 FLOOR PLAN

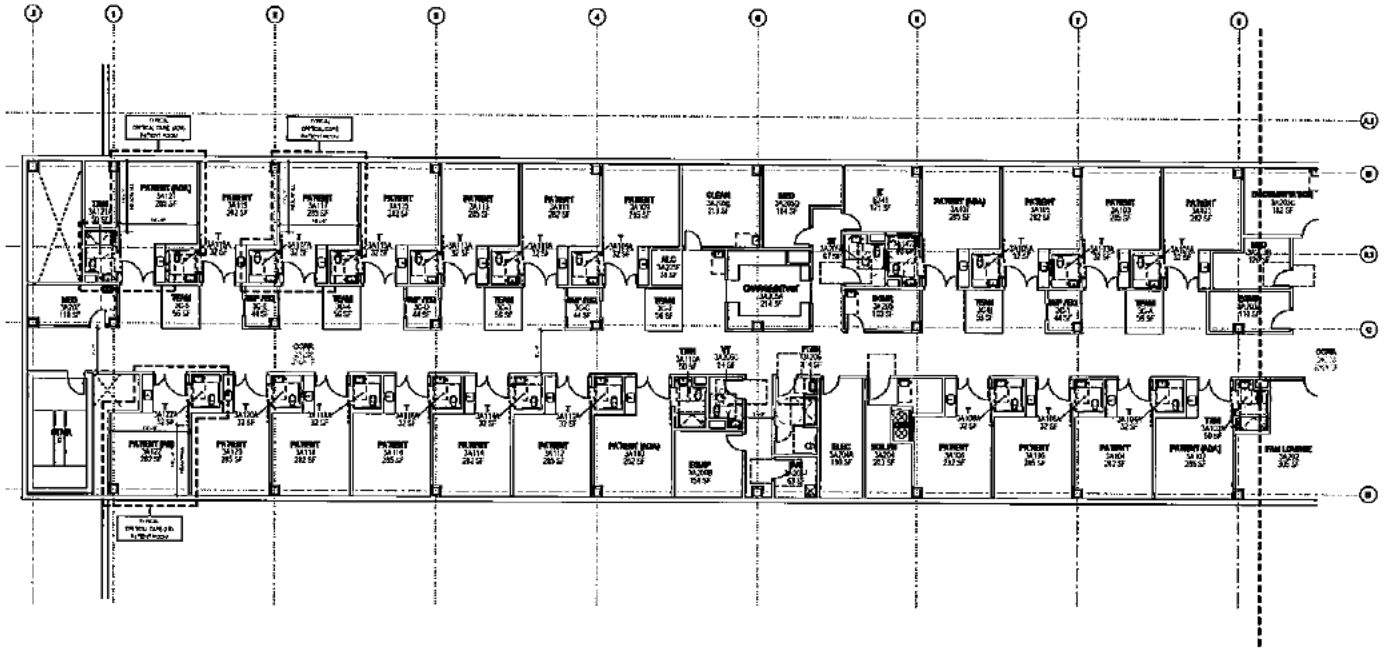
nbbj

MOHAWK VALLEY HEALTH SYSTEM

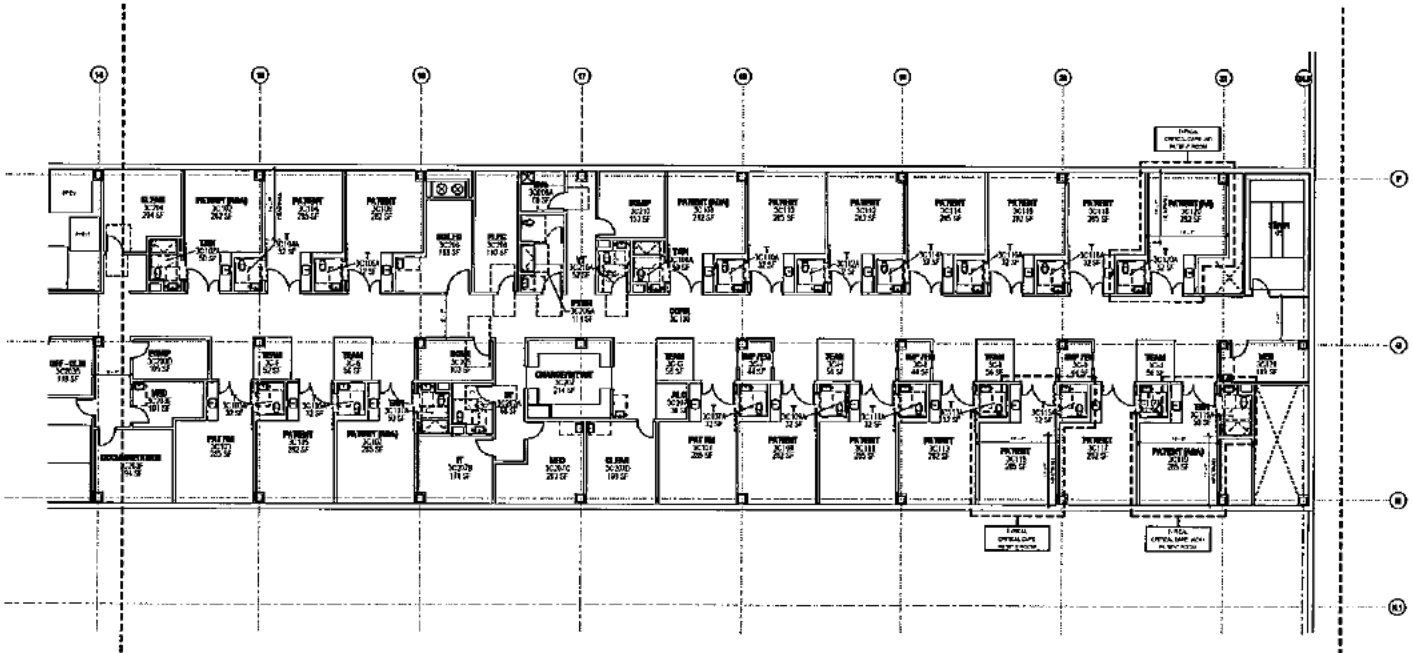
CON - SD SUBMITTAL

F3, F4 OVERALL FLOOR PLANS

AE103

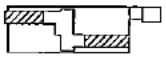


1 F3 - AREA A



2 F3 - AREA C

KEYPLAN



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PHONE 614.224.7145
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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE 1/8" = 1'-0"

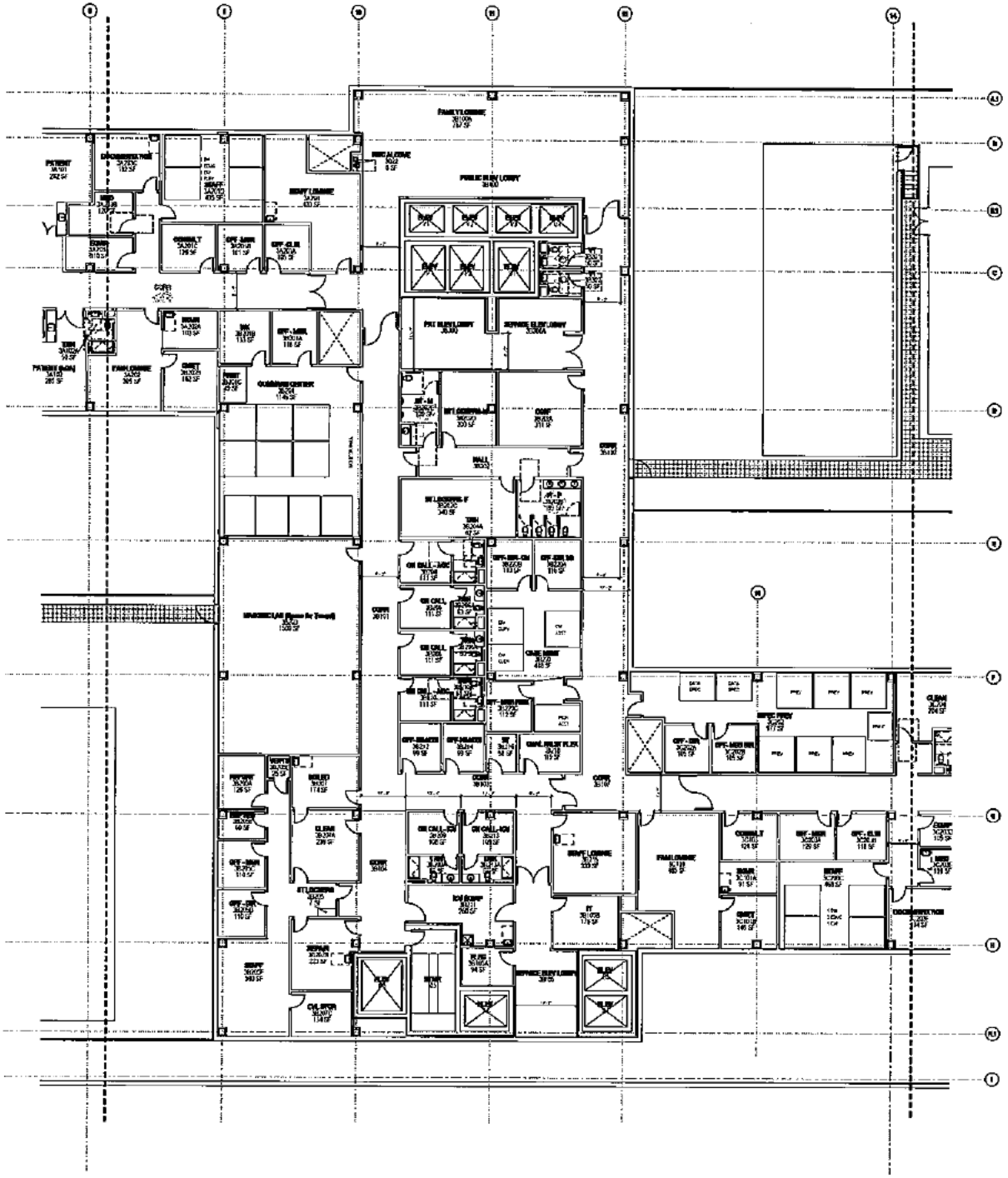
PROJECT MONITOR Designer

PROJECT NUMBER 19000000

DATE 10/28/21

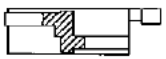
F3 FLOOR PLAN - AREA A & C

SHEET NUMBER AE103-AC



1 F3 - AREA B

KEYPLAN



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COLUMBUS, OH 43215
PHONE 614.224.2112
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MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"

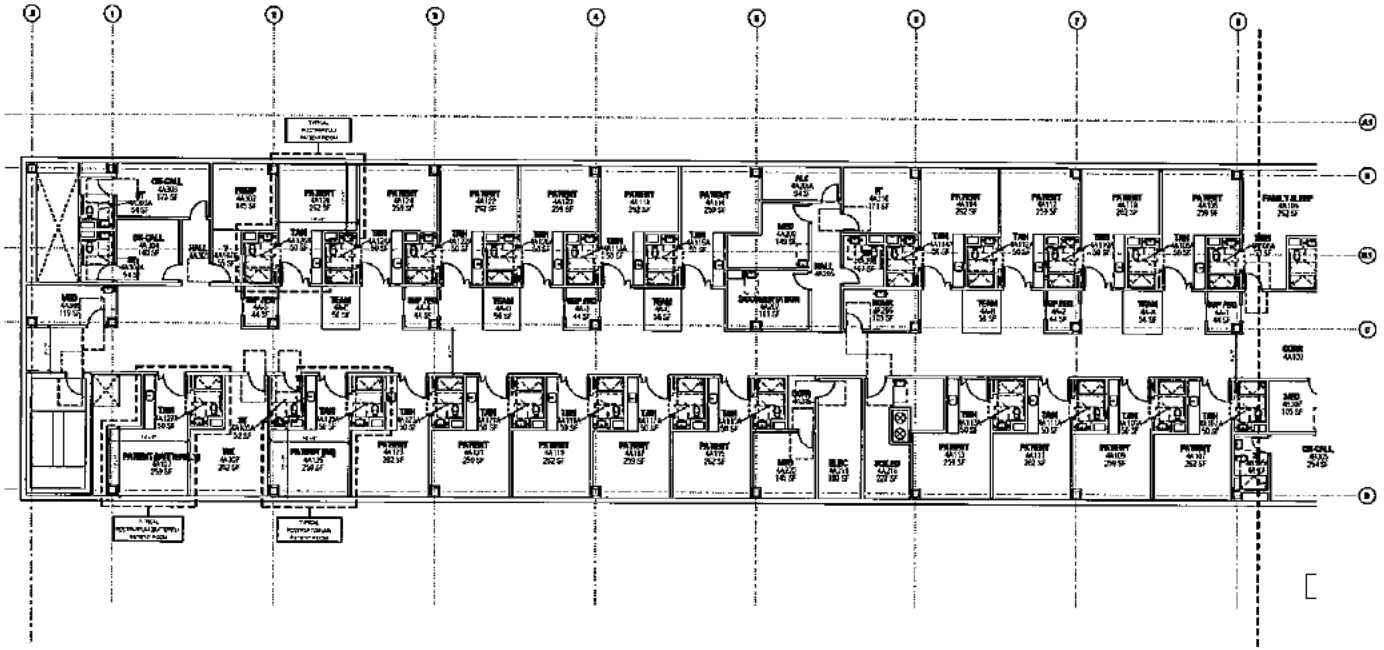
PROJECT NUMBER: Designer

PROJECT: 17000.00

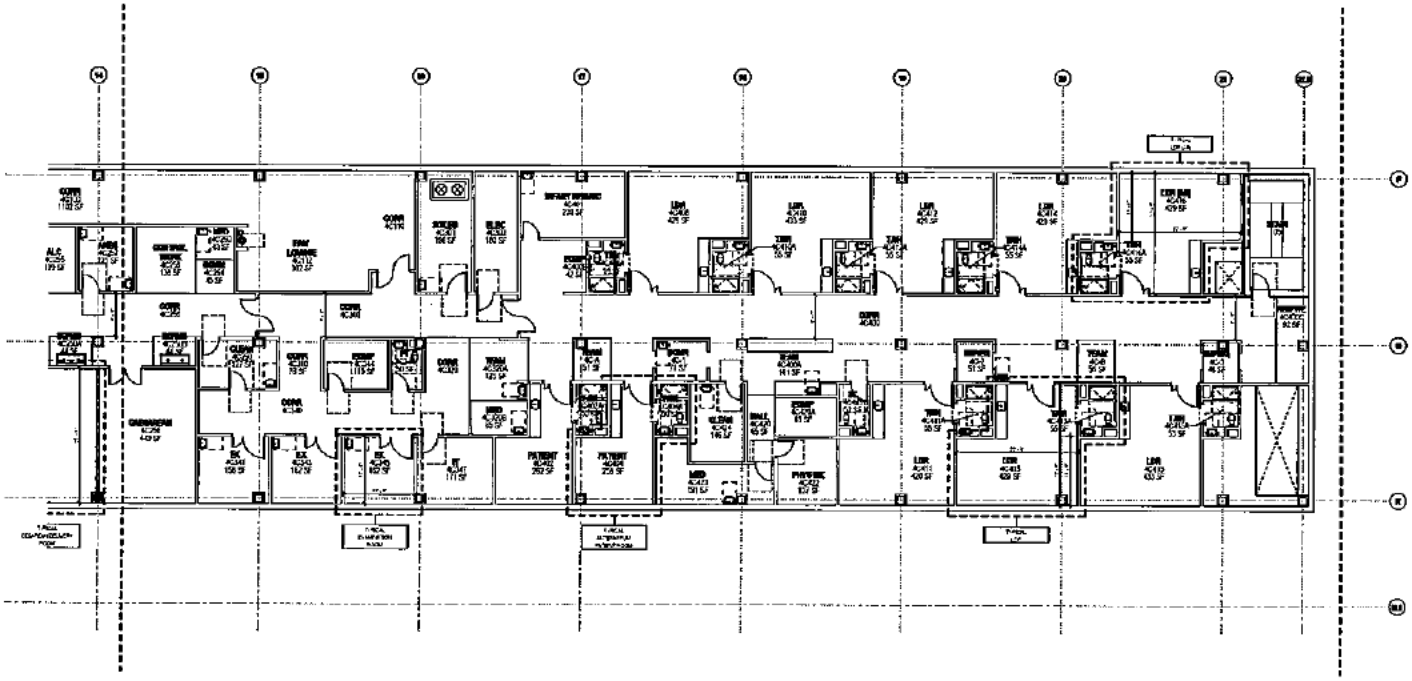
DATE: 11/1/2017

SHEET NAME: F3 FLOOR PLAN - AREA B

SHEET NUMBER: AE103-B

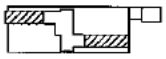


1 F4 - AREA A



2 F4 - AREA C

KEYPLAN



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250 S. HIGH STREET SUITE 500
COLUMBUS, OH 43215
PHONE 614 224 2145

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 5, 2021

MARK	DATE	DESCRIPTION

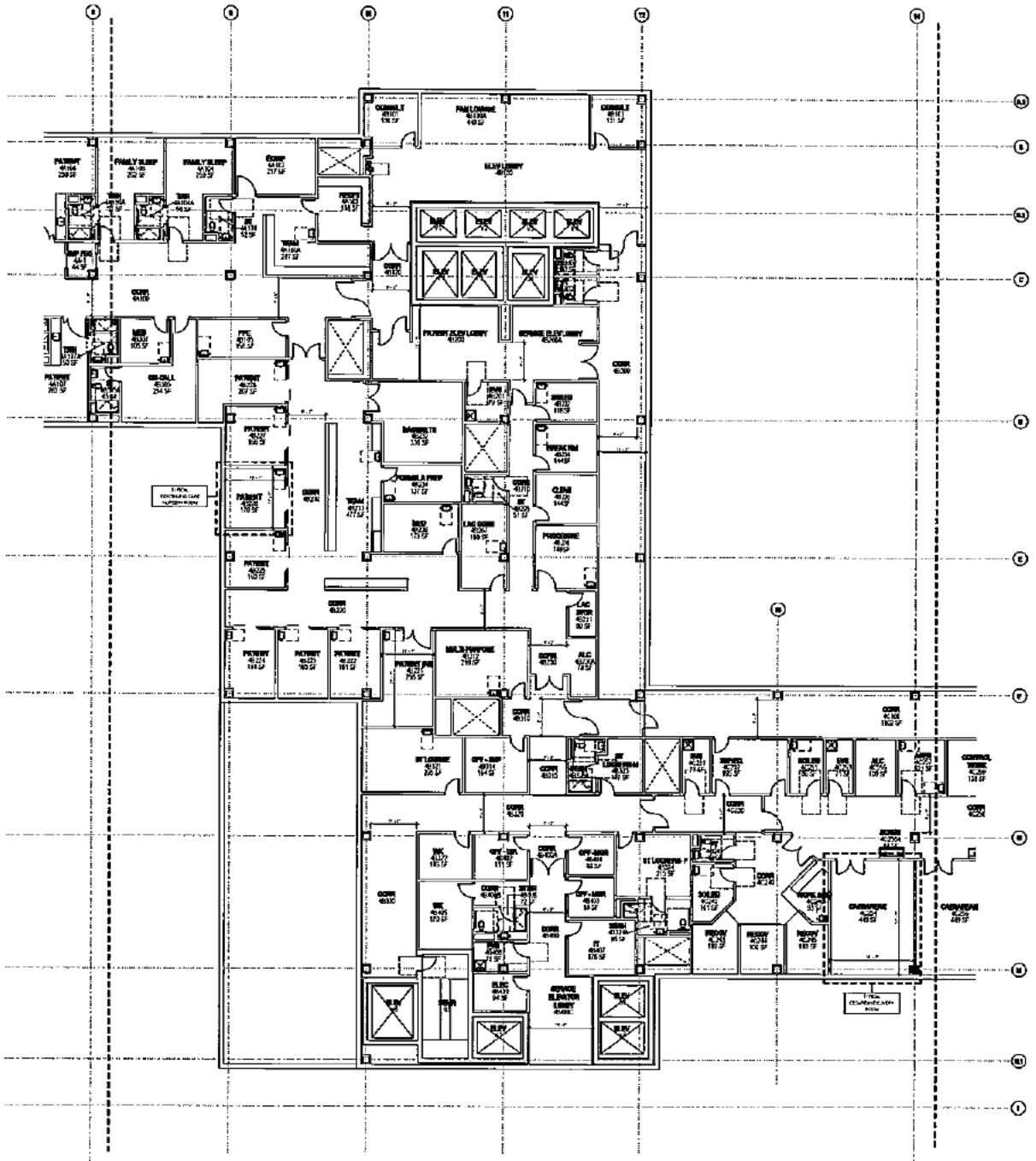
SCALE 1/8" = 1'-0" PROJECT NORTH Designer

PROJECT NUMBER 190618

DATE 10/29/21

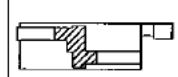
F4 FLOOR PLAN - AREA A & C

SHEET NUMBER AE104-AC



1 F4 - AREA B

KEYPLAN



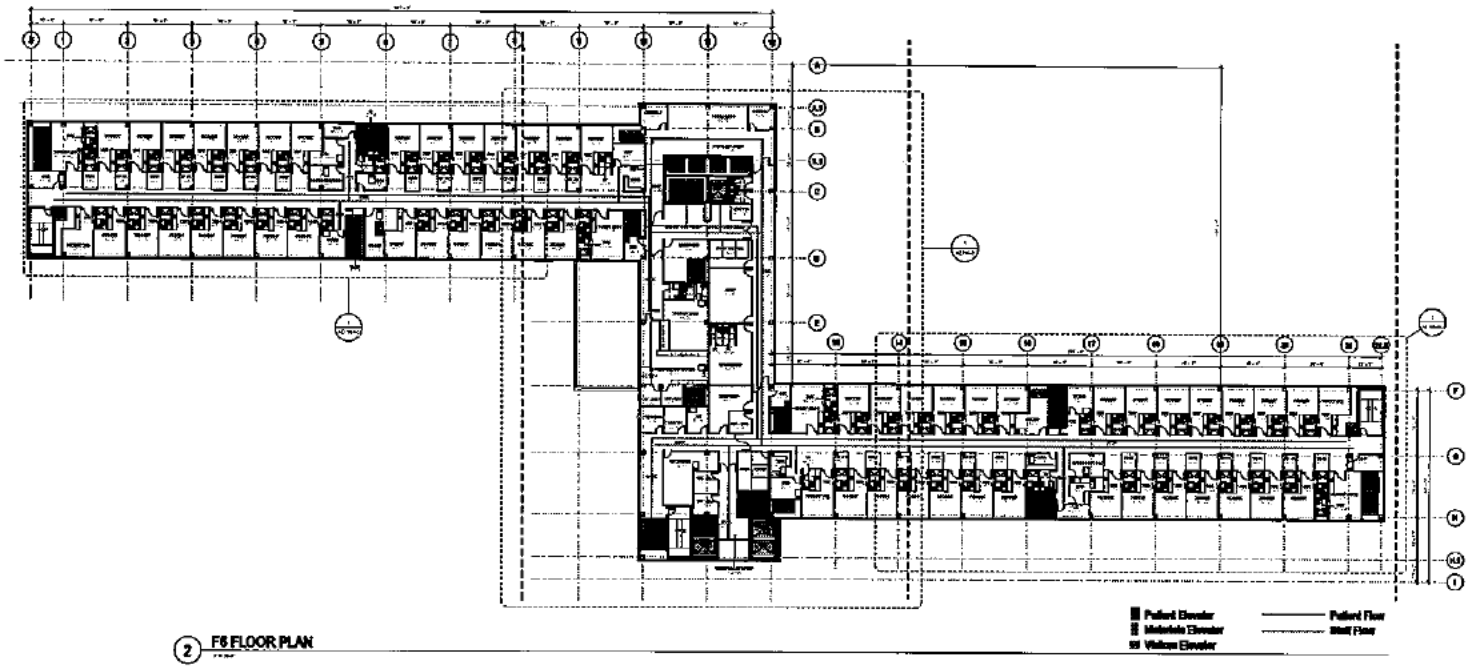
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

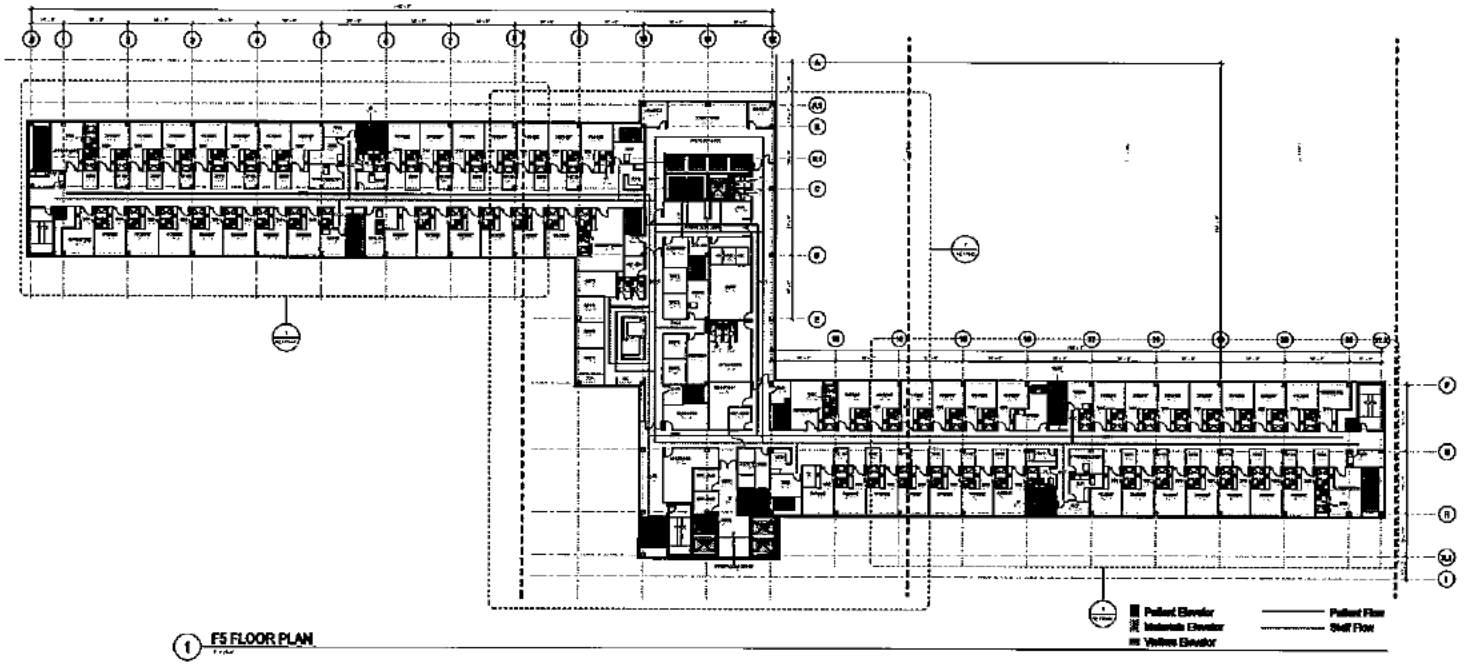
F4 FLOOR PLAN - AREA B

AE104-B



Patient Elevator
Materials Elevator
Visitors Elevator
Patient Flow
Staff Flow

2 F6 FLOOR PLAN



Patient Elevator
Materials Elevator
Visitors Elevator
Patient Flow
Staff Flow

1 F5 FLOOR PLAN

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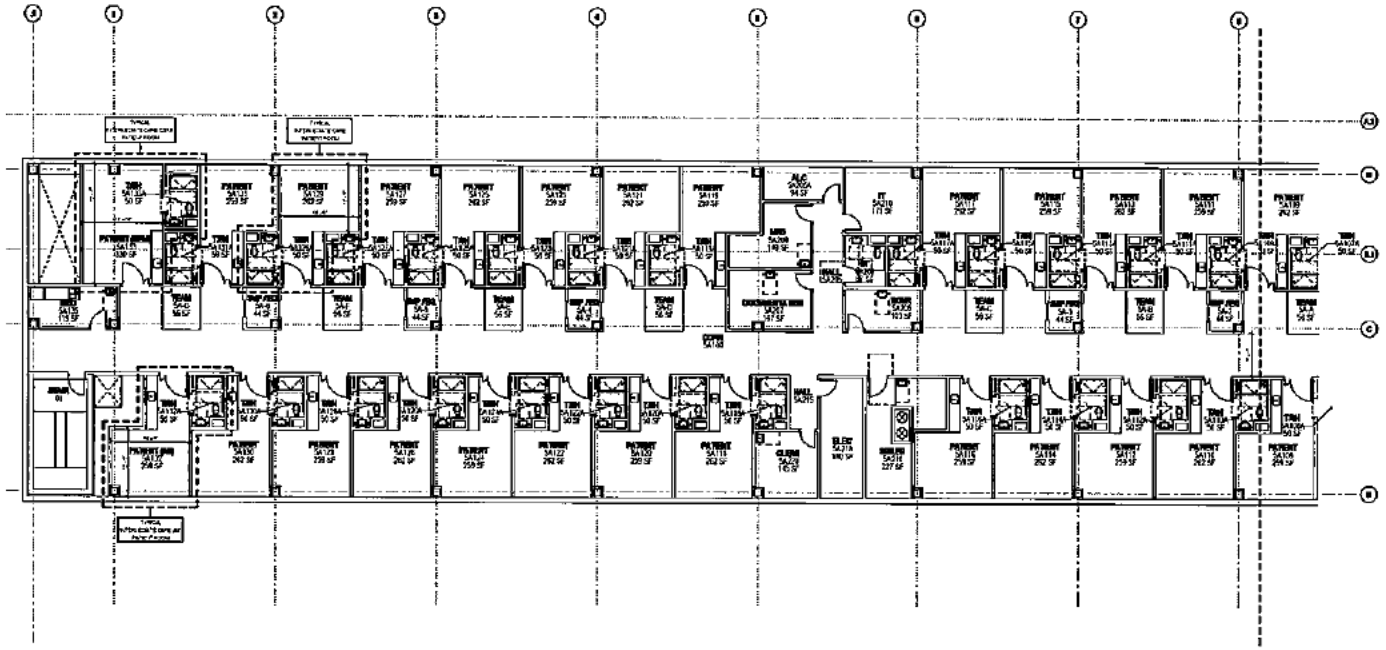
MOHAWK VALLEY HEALTH SYSTEM

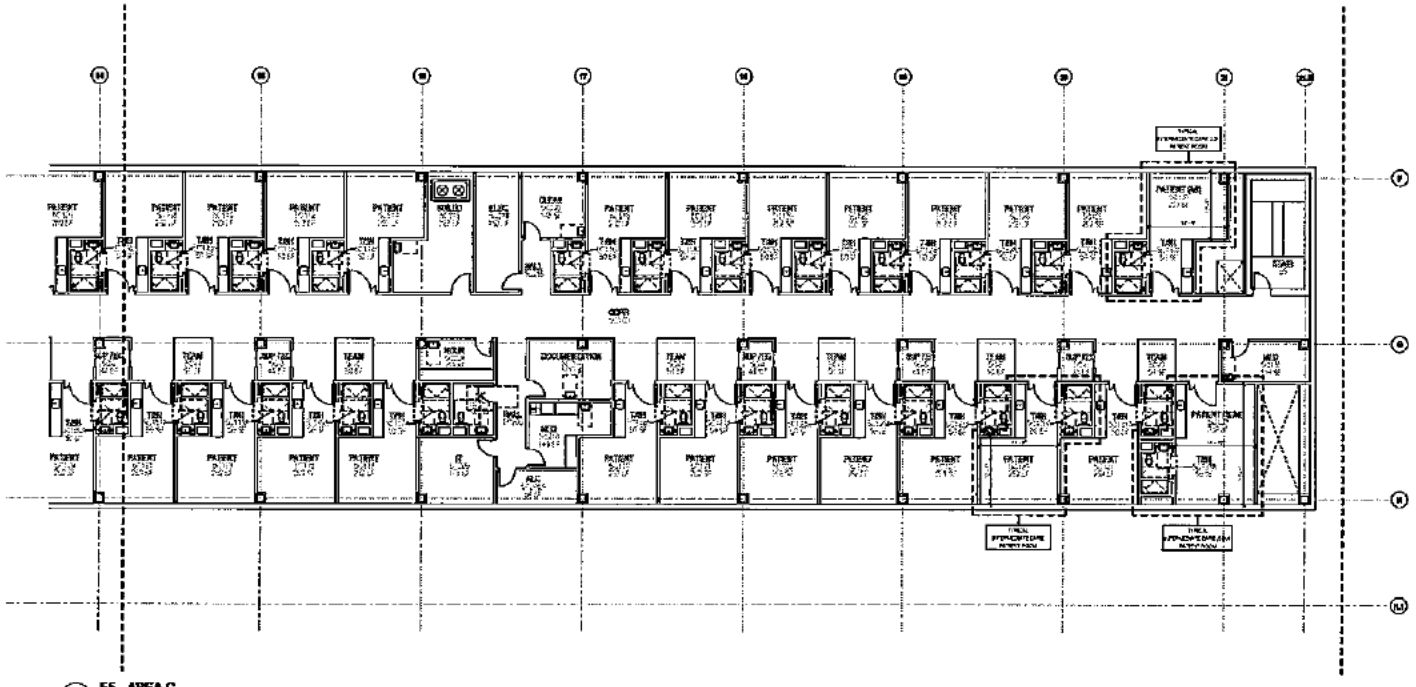
CON - SD SUBMITTAL

F5, F6 OVERALL FLOOR PLANS

AE105

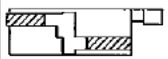


1 F5 - AREA A



2 F5 - AREA C

KEYPLAN



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MOHAWK VALLEY HEALTH SYSTEM

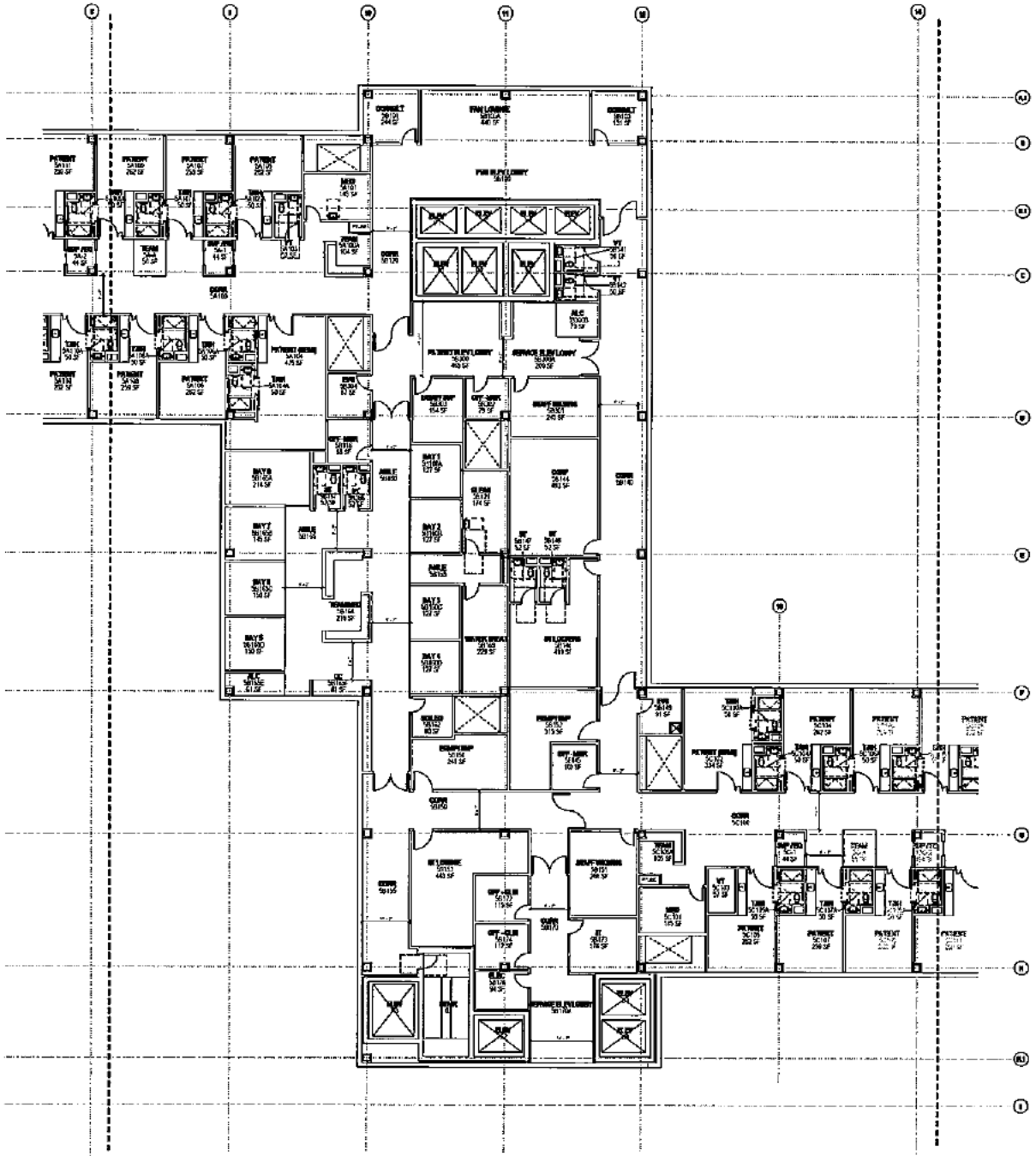
CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"
PROJECT ARCHITECT: Designer
PROJECT NUMBER: 70000.00
DATE: 10/08/07

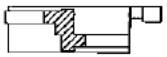
SHEET NAME: F5 FLOOR PLAN - AREAS A & C

SHEET NUMBER: AE105-AC



1 F5 - AREA B

KEYPLAN



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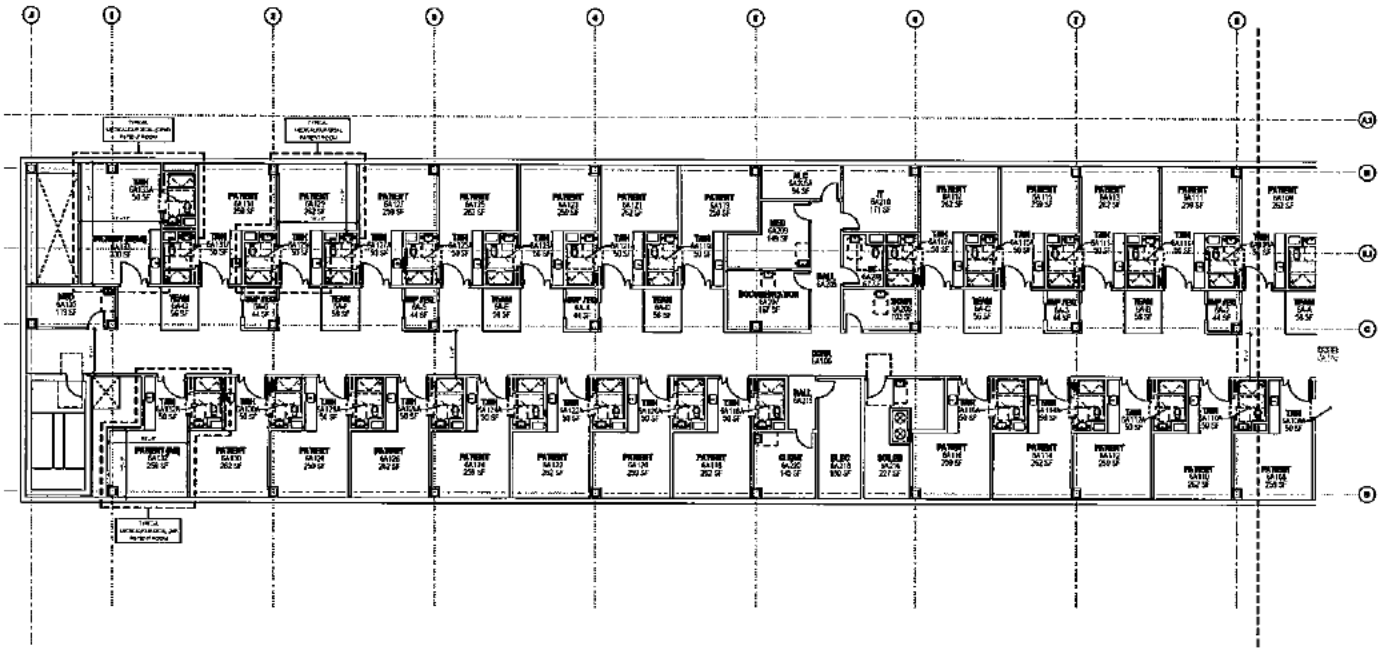
MOHAWK VALLEY HEALTH SYSTEM

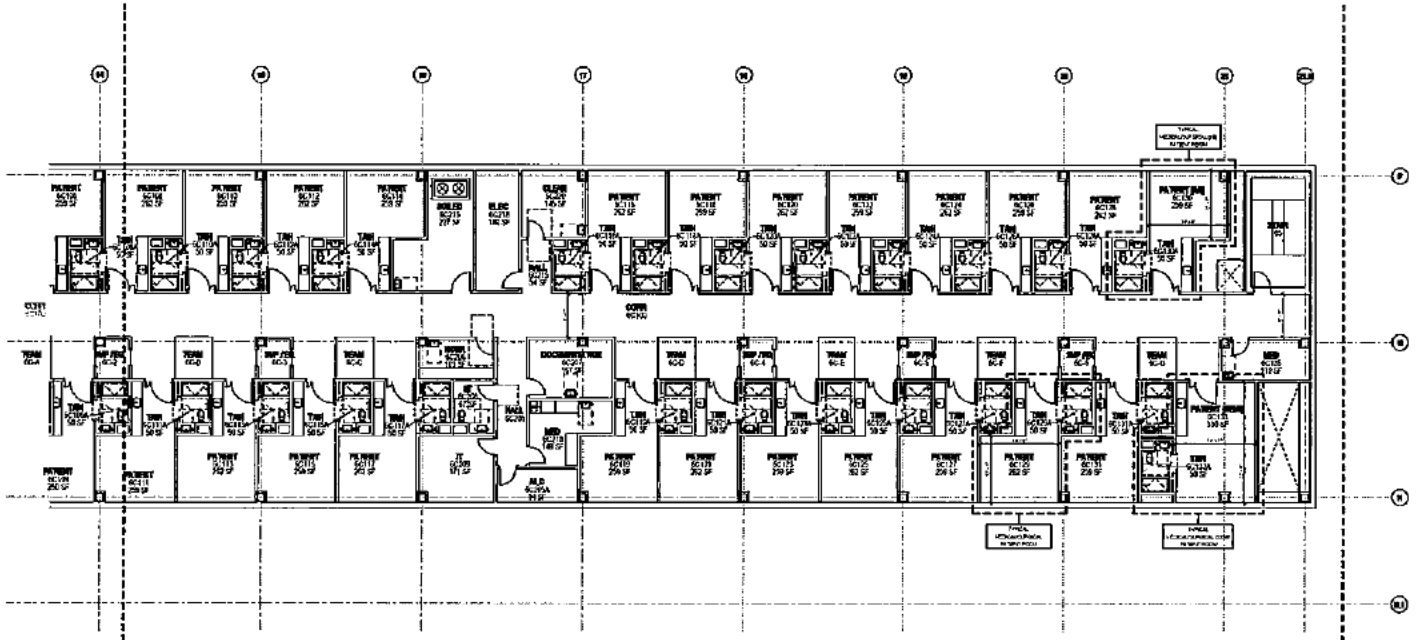
CON - SD SUBMITTAL

F5 FLOOR PLAN - AREA B

AE105-B



1 F6 - AREA A



2 F6 - AREA C

KEYPLAN

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COLUMBUS, OH 43215
PHONE 614.224.7135
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MOHAWK VALLEY HEALTH SYSTEM

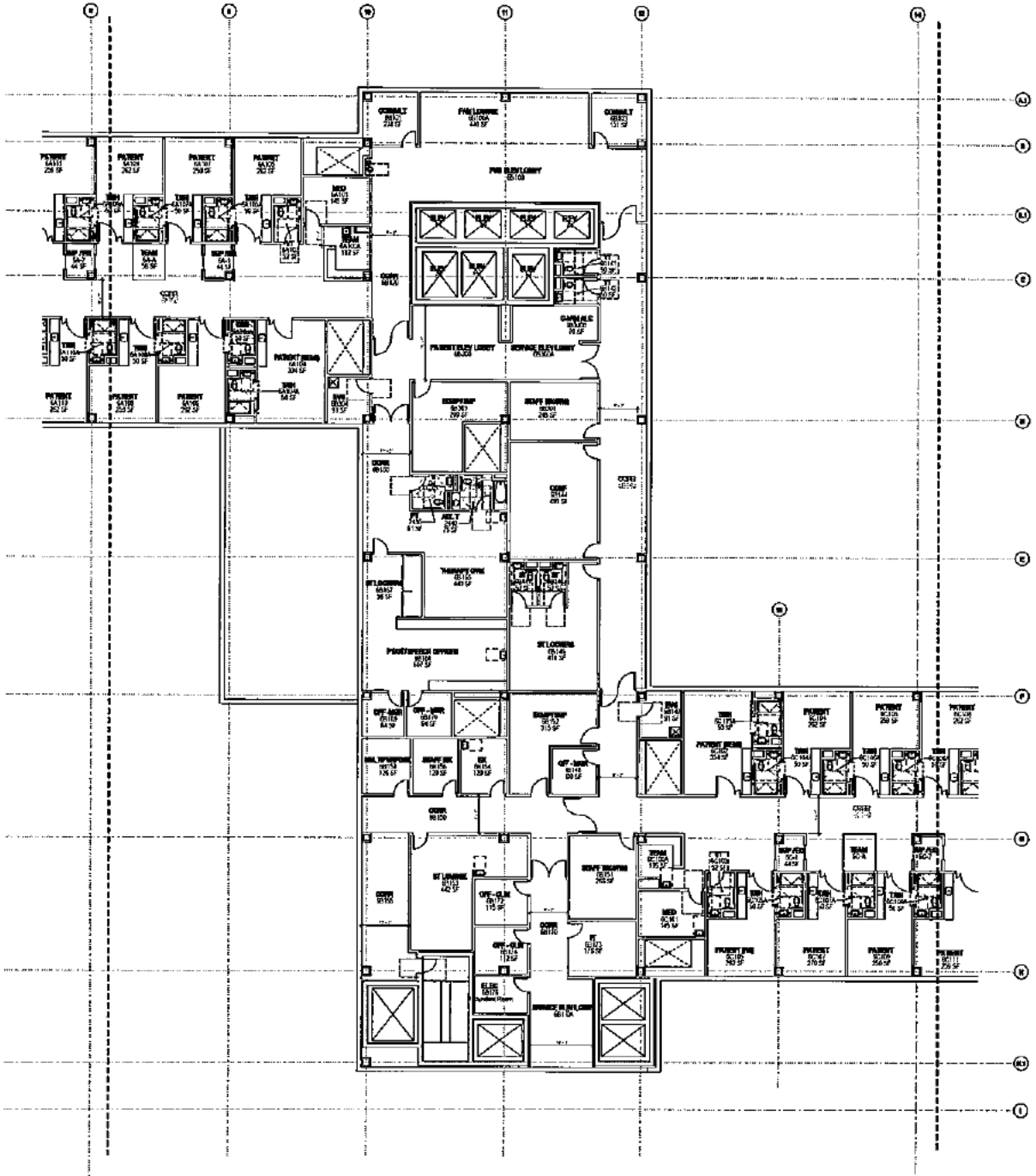
CON - SD SUBMITTAL

NUM	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"
PROJECT DIRECTOR: Rodgers
PROJECT NUMBER: 190008.00
DATE: 7/30/2021

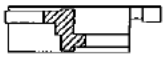
F6 FLOOR PLAN - AREA A & C

SHEET NUMBER: AE106-AC



1 F6 - AREA B

KEYPLAN



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COLUMBUS, OH 43215
PHONE 614.224.7545
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 9, 2017

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"

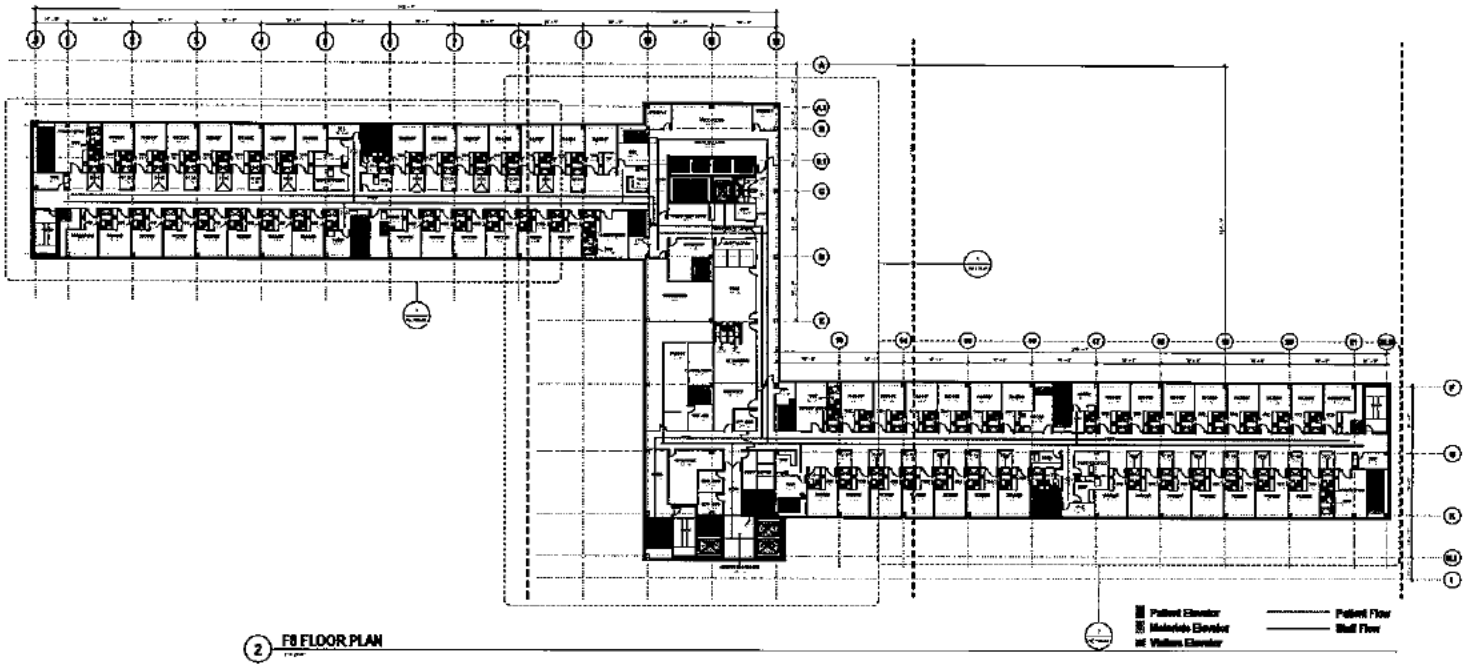
PROJECT ARCHITECT: Developer

PROJECT NUMBER: 1000000

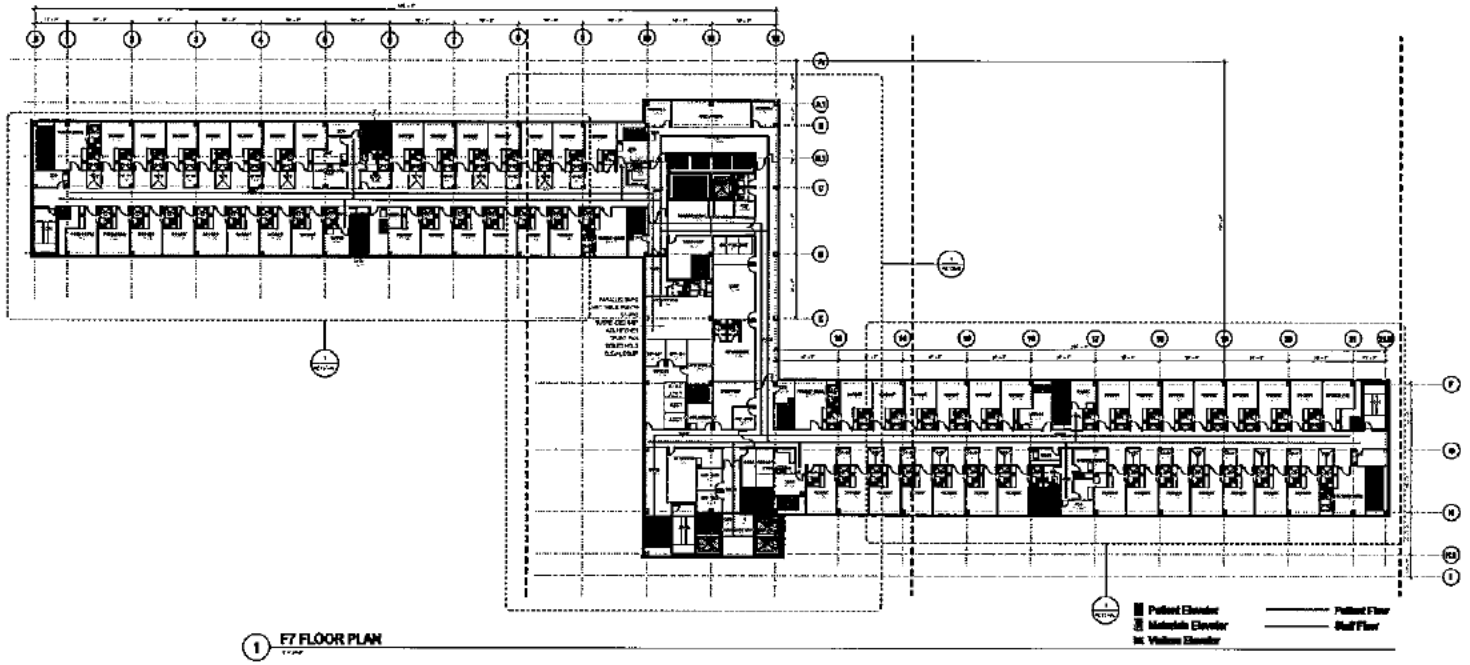
DATE: 10/20/17

SHEET NAME: F6 FLOOR PLAN - AREA B

SHEET NUMBER: AE106-B



2 F8 FLOOR PLAN



1 F7 FLOOR PLAN

nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 1126

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

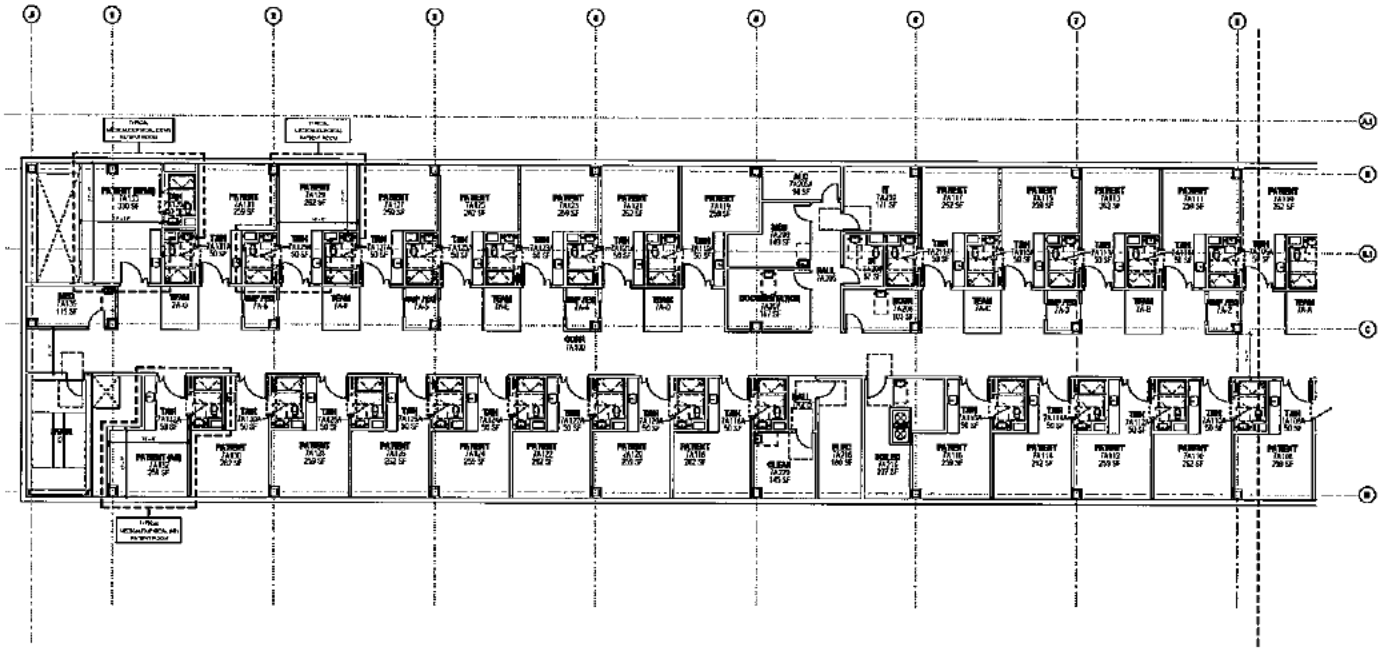
SCALE 1" = 20'-0" | DRAWN BY Author

PROJECT NUMBER 1616.00

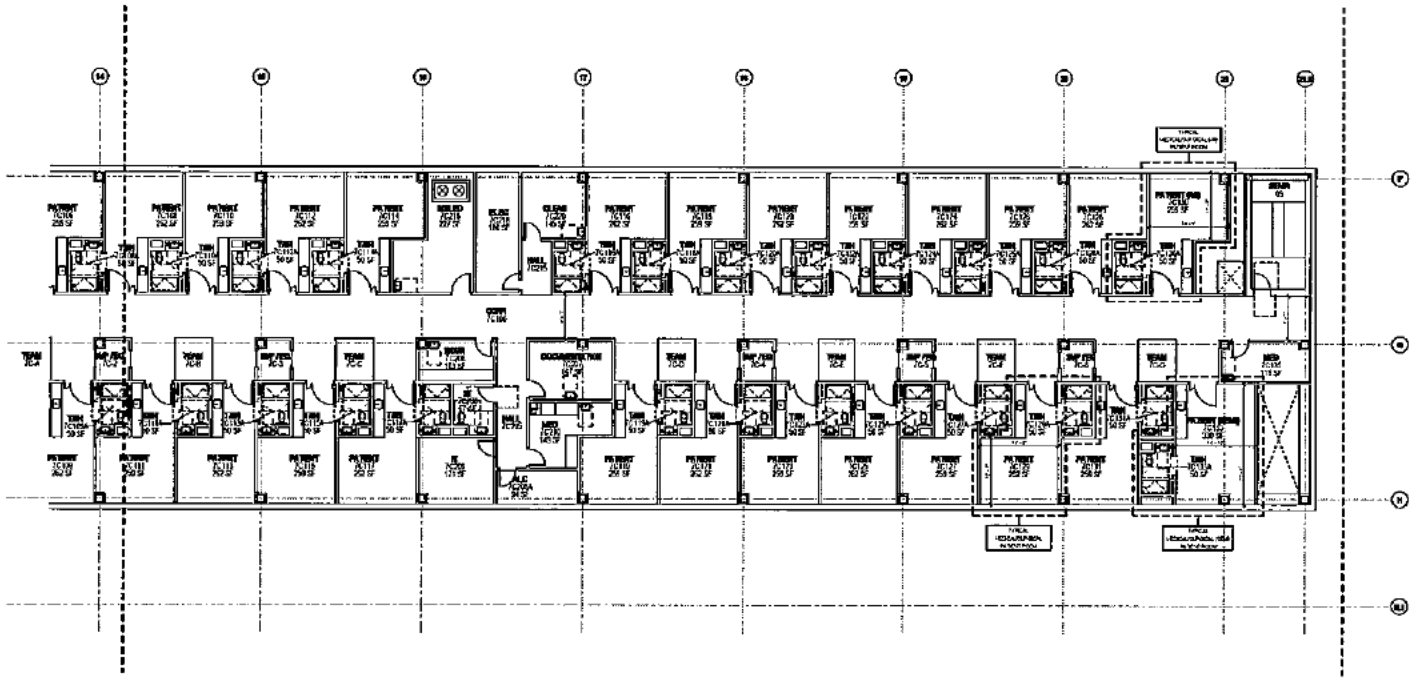
DATE 10/27/17

SHEET TITLE
F7, F8 OVERALL FLOOR PLANS

SHEET NUMBER
AE107

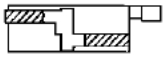


1 F7 - AREA A



2 F7 - AREA C

KEYPLAN



nbbj
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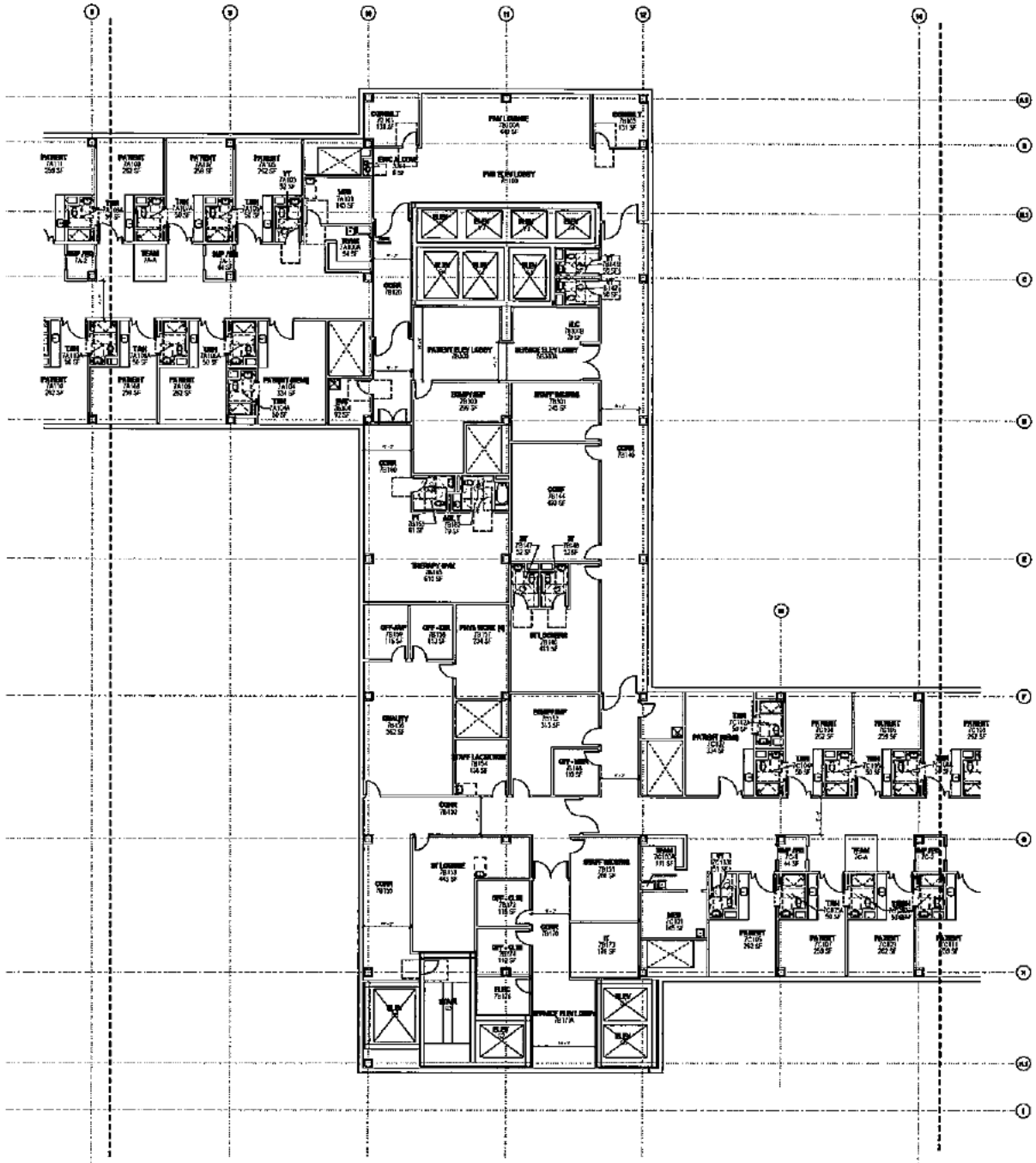
COLUMBUS, OH 43215
PHONE 614.224.7113

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

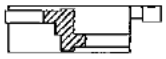
F7 FLOOR PLAN - AREA A & C

AE107-AC



1 F7 - AREA B

KEYPLAN



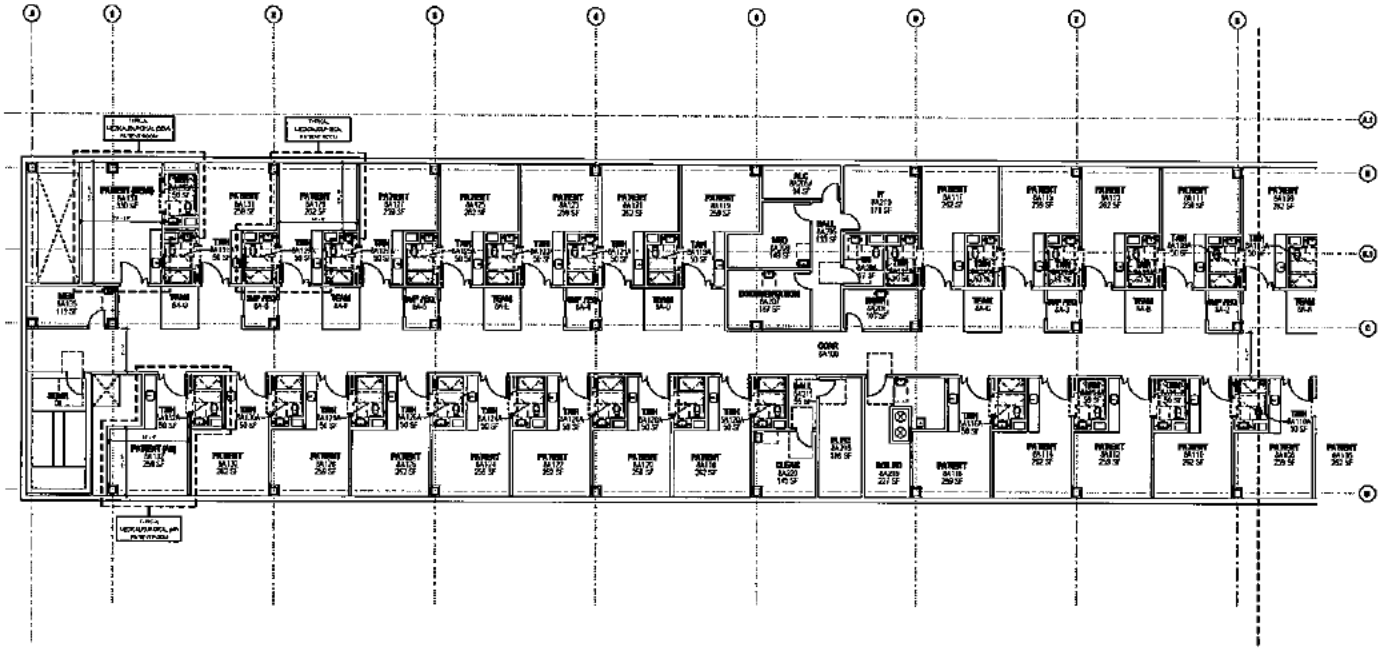
nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE: 614 224 1643

MOHAWK VALLEY HEALTH SYSTEM

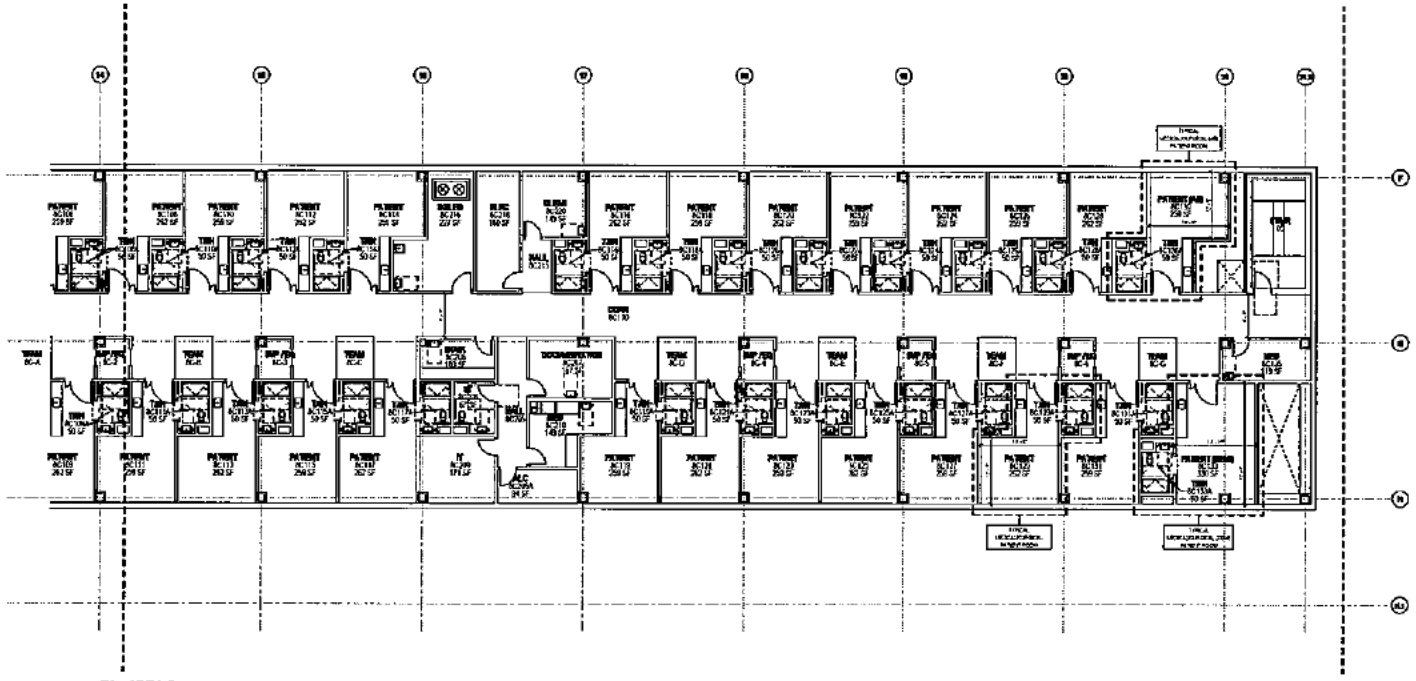
CON - BD SUBMITTAL

SHEET NAME
F7 FLOOR PLAN - AREA B

SHEET NUMBER
AE107-B



1 F8 - AREA A



2 F8 - AREA C

KEYPLAN

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COLUMBUS, OH 43215
PHONE 614 224 7145
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

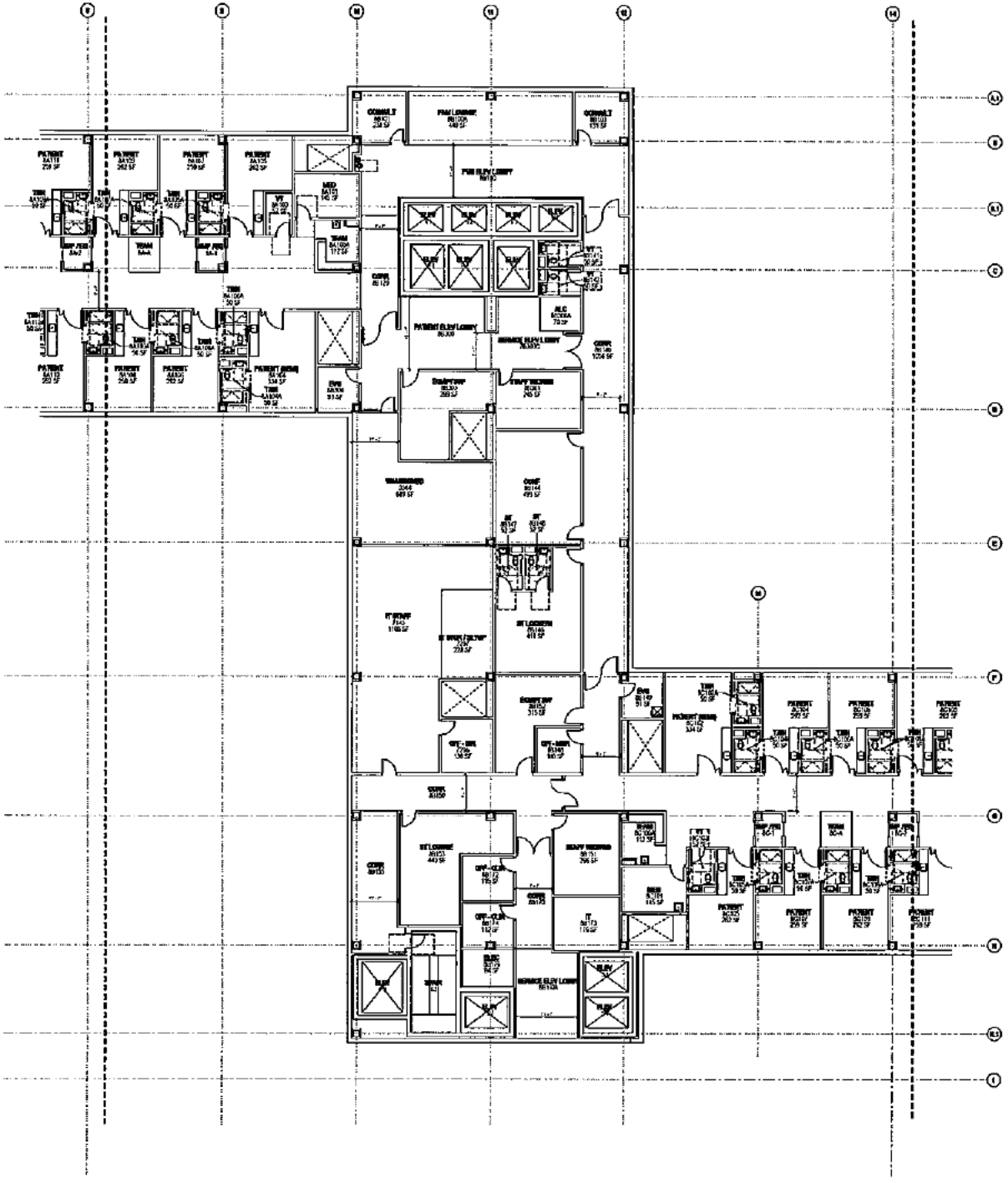
CON - SD SUBMITTAL

MARK	DATE	DESCRIPTION

SCALE: 1/8" = 1'-0"
PROJECT ARCHITECT: Designer
PROJECT NUMBER: [illegible]
DATE: [illegible]

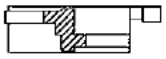
SHEET NAME: F8 FLOOR PLAN - AREA A & C

SHEET NUMBER: AE108-AC



1 F8 - AREA B

KEYPLAN



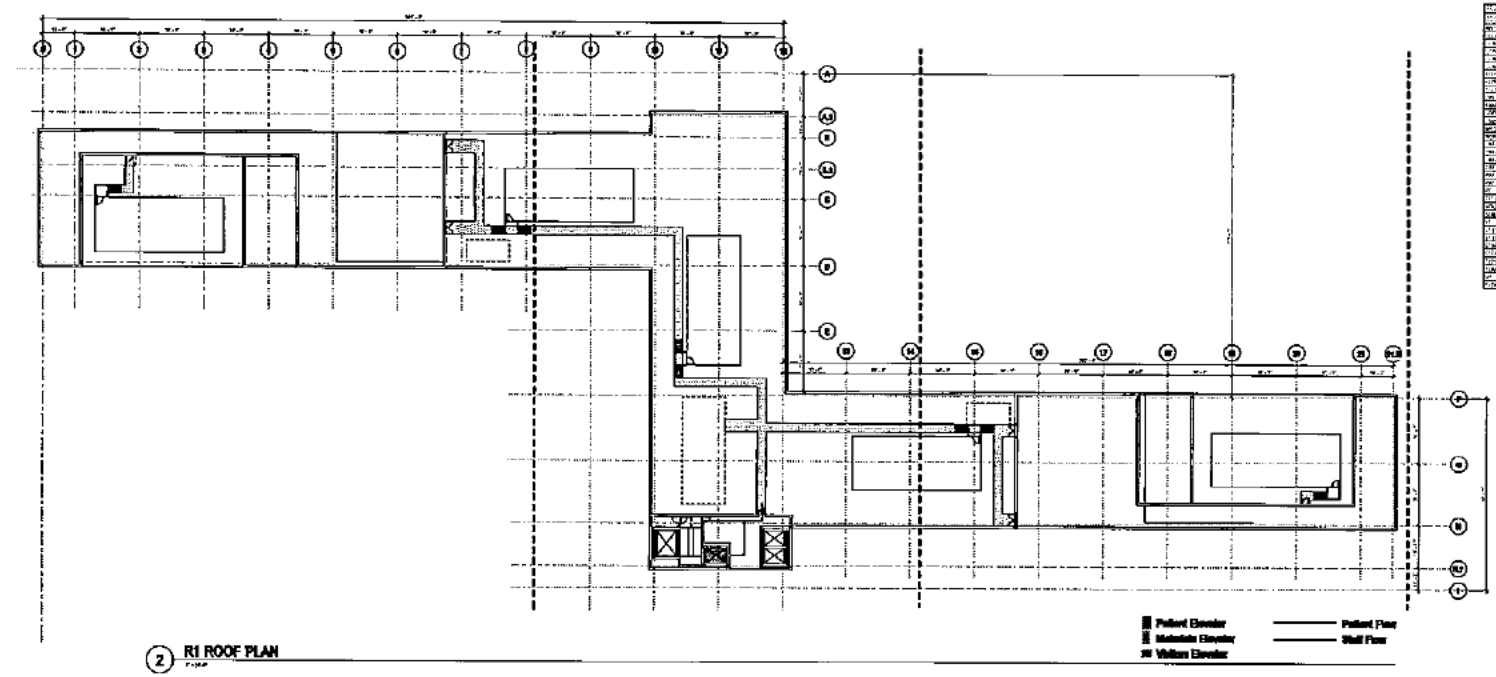
nbbj

MOHAWK VALLEY HEALTH SYSTEM

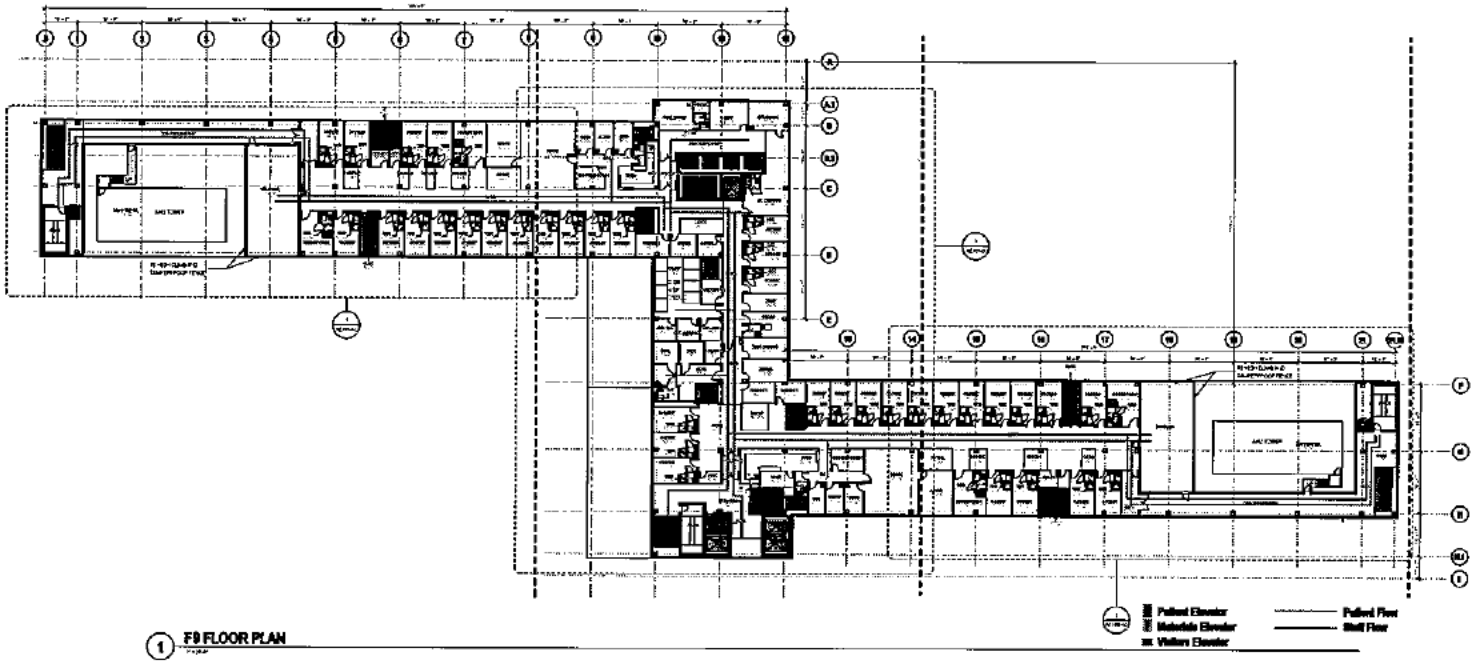
CON - SD SUBMITTAL

F8 FLOOR PLAN - AREA B

AE106-B



2 R1 ROOF PLAN



1 F9 FLOOR PLAN

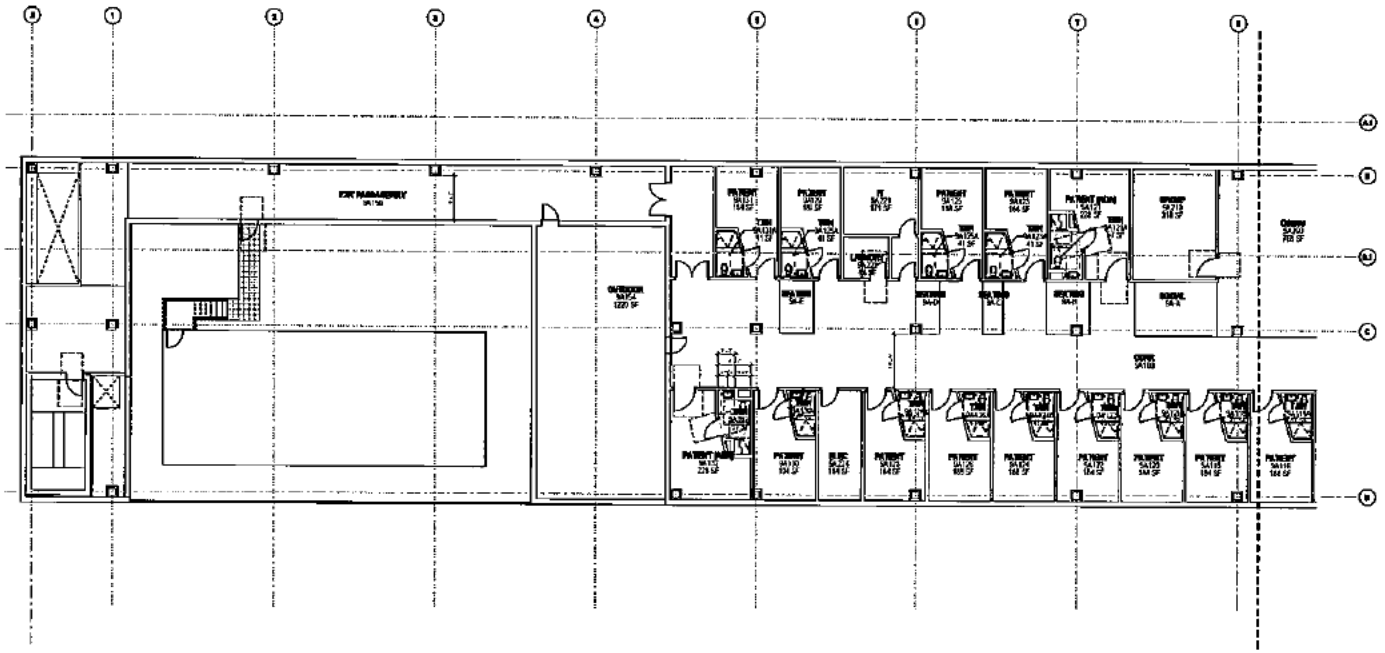
nbbj
216 SUMMIT STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 228 7542
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

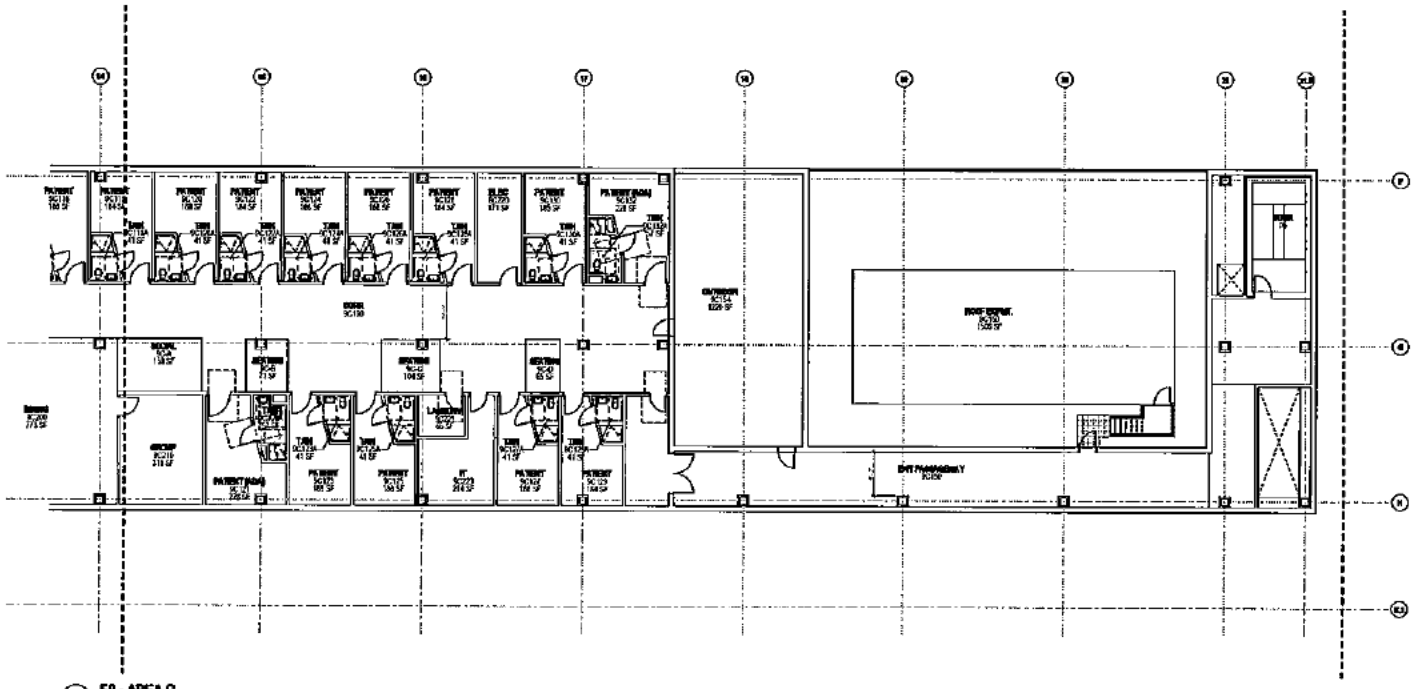
CON - SD SUBMITTAL

F9 OVERALL FLOOR PLAN, ROOF PLAN

AE109

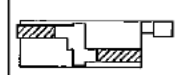


1 F9 - AREA A



2 F9 - AREA C

KEYPLAN



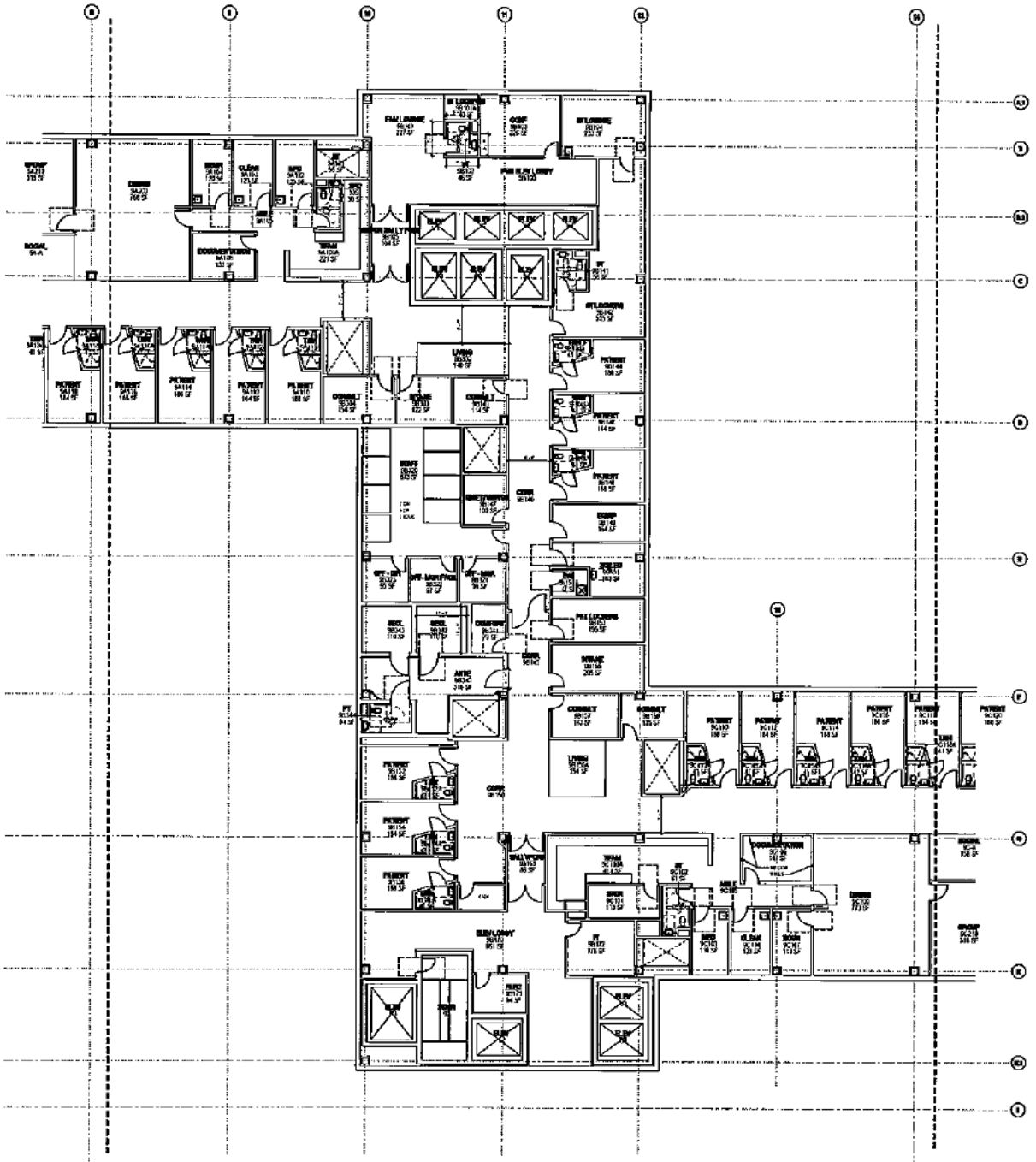
nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

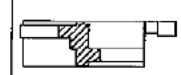
F9 FLOOR PLAN - AREA A & C

AE109-AC



1 F9 - AREA B

KEYPLAN



nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 224 7140
www.nbbj.com

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

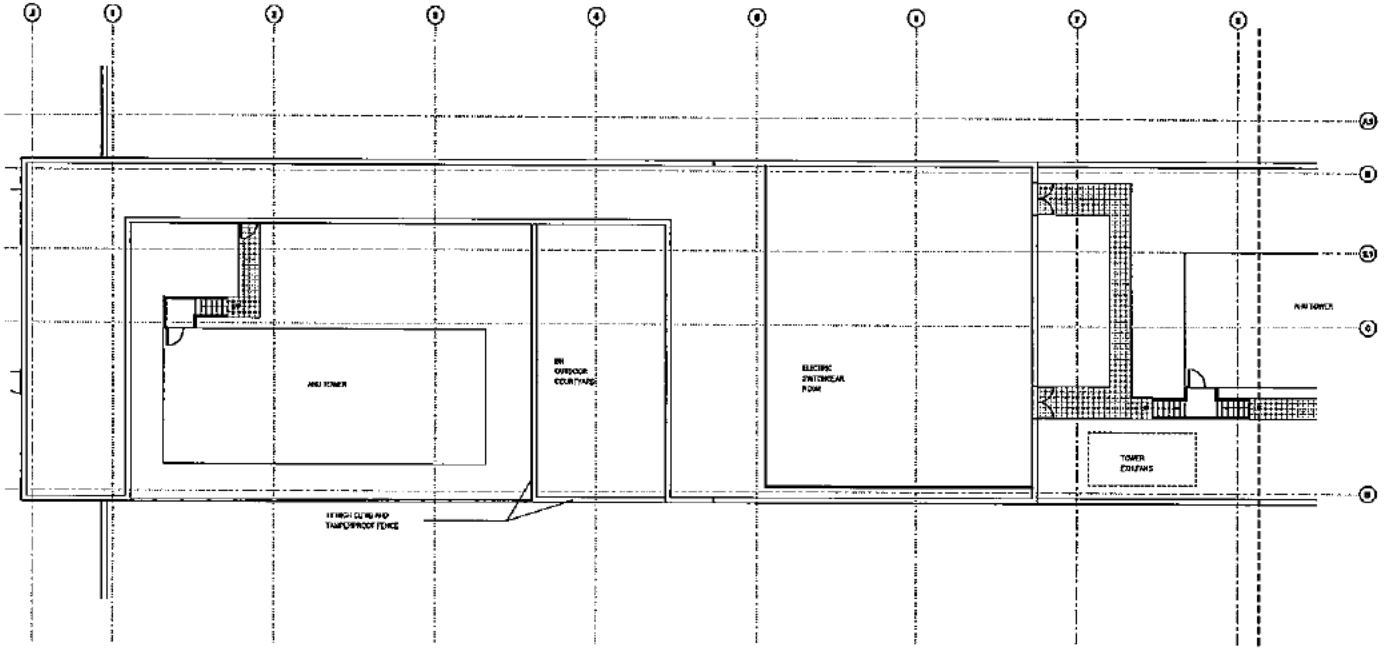
NOVEMBER 1, 2017

MARK	DATE	DESCRIPTION

SCALE 1/8" = 1'-0"
PROJECT ENGINEER
PROJECT NUMBER
DATE

SHEET NAME
F9 FLOOR PLAN - AREA B

SHEET NUMBER
AE109-B



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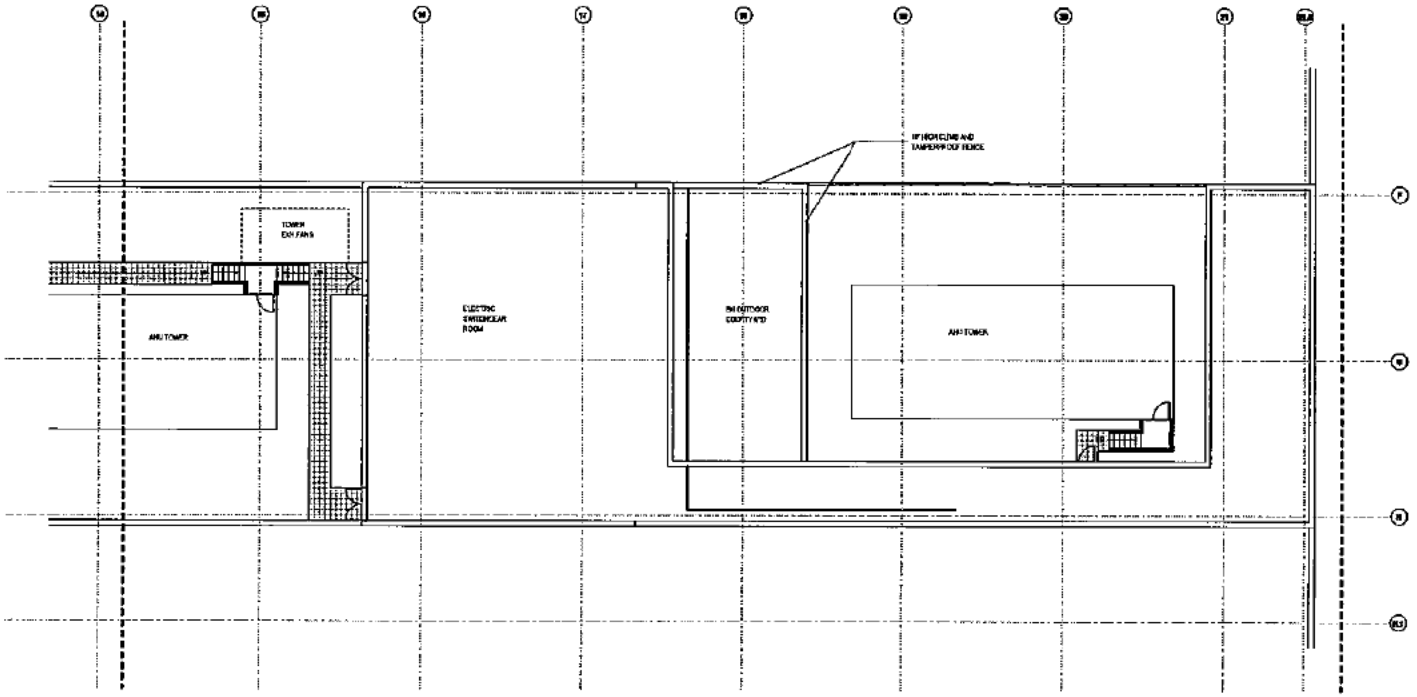


2 R1 - AREA C

KEYPLAN

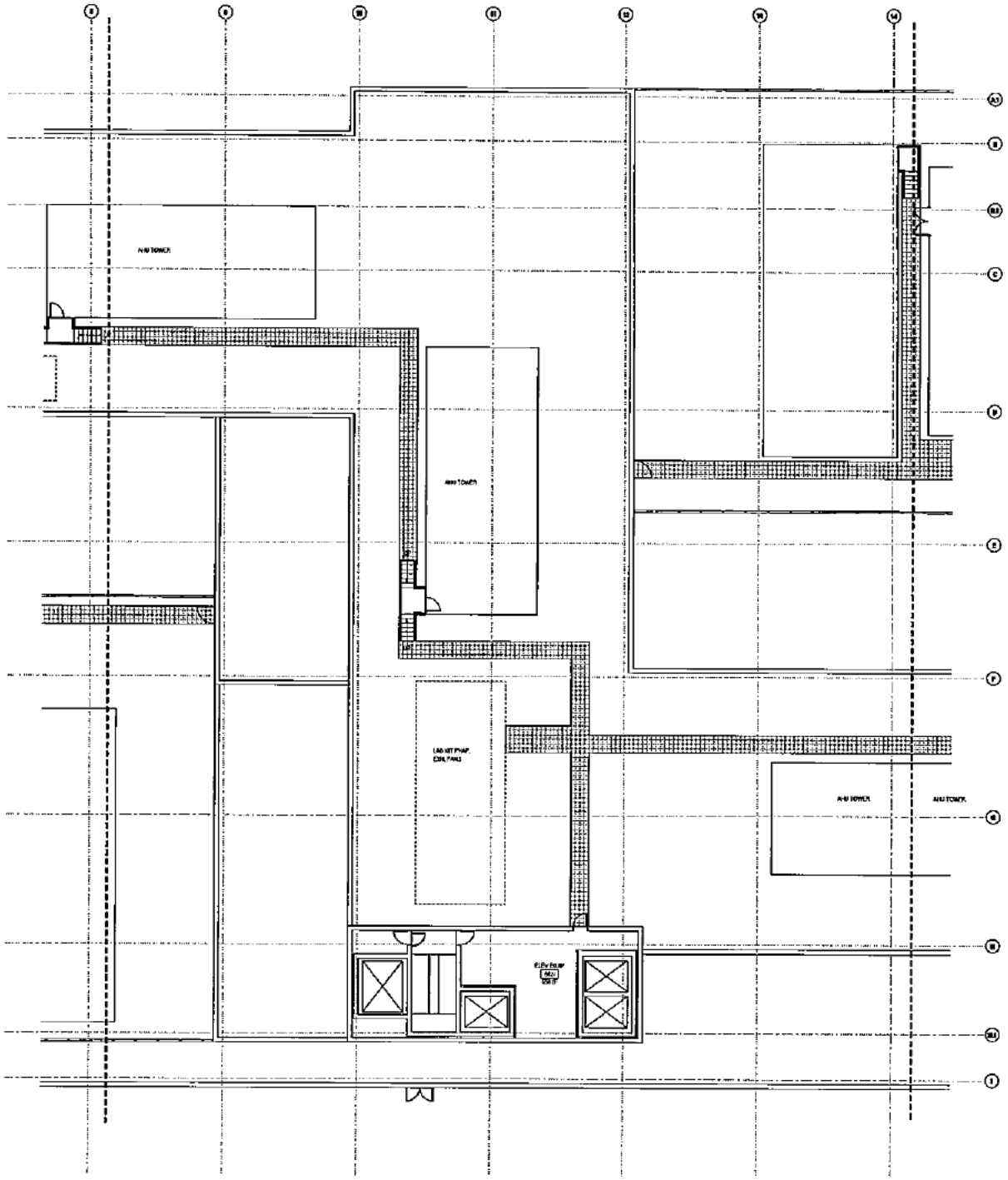
nbbj
250 S. HIGH STREET SUITE 300
COLUMBUS, OH 43215
PHONE 614 2347145

MOHAWK VALLEY HEALTH SYSTEM

CON - BD SUBMITTAL

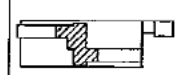
R1 ROOF PLAN - AREA A & C

AE110-AC



1 R1- AREA B

KEYPLAN



nbbj

MOHAWK VALLEY HEALTH SYSTEM

CON - SD SUBMITTAL

R1 ROOF PLAN - AREA B

AE110-B

Cicero Consulting Associates

VCC, Inc.

701 Westchester Ave. • Suite 210W • White Plains, NY 10604
Tel: (914) 682-8657 • Fax: (914) 682-8895
cicero@ciceroassociates.com

White Plains Unit
Frank M. Cicero
Charles F. Murphy, Jr.
James Psarianos
Rose Murphy
Michael D. Ungerer
Noelia Chung
Brian Baldwin
Michael F. Cicero
Karen Dietz
Evelyn Branford
Michael C. Maiale
Linda Cammisa, R.N.

Albany Unit
William B. Carmello
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Martha H. Pofit
Frank T. Cicero, M.D.

Michael P. Parker, Sr.
(1941-2011)
Anthony J. Maddaloni
(1952-2014)

February 2, 2018

Mr. Kenneth Glindmyer, BFA
Bureau of Financial Analysis
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1882
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Mr. Glindmyer,

On behalf of our client, Mohawk Valley Health System (MVHS), we are responding to your January 30, 2018 request for additional information for the project referenced above. Our responses are as follows:

1. **Please provide the latest financial statements that are within 6-months of the April 2018 PHHPC agenda meeting. Provide an explanation for any net operating losses, negative net assets, or negative working capital for both Faxton-St Luke's and St. Elizabeth's and indicate what the hospitals are doing to better their current financial position.**

   RESPONSE:
   Please refer to **Attachment No. 1** for the December 2017 internal financial statement for Mohawk Valley Health System, including both St. Elizabeth Medical Center (SEMC) and Faxton-St. Luke's Healthcare St. Luke's Division (St. Luke's).

   In 2017, St. Elizabeth experienced a net loss from operations of about $3.4 million, and St. Luke's experienced a net loss from operations of about $1.9 million. Per the applicant, these losses were mainly due to lower-than-projected volumes, mainly in outpatient surgery and the cardiac catheterization laboratory. In 2017, MVHS also needed to use a higher amount of medical specialists and agency staffing in other areas such as trauma, ICU, emergency, urgent care, orthopedic surgery and pediatric hospitalists, as well as for anesthesia services.

In order to reduce this deficit, MVHS has been working on a recruitment strategy for providers to strengthen the medical staff. The applicant hired two (2) general surgeons and an orthopedic surgeon. In addition, MVHS has brought in other specialists over the last 14 months, and the Hospital is working with them to establish their practices. MVHS anticipates favorable financial results from these services in 2018. In addition, MVHS has contracted with Prism Consulting Group (Prism), a nation-wide consulting firm that provides healthcare consulting services in a variety of functional practice areas. The applicant is working with Prism to implement an inpatient clinical documentation improvement program, as well as a labor productivity monitoring system. These combined efforts are expected to produce an improvement to a break-even operating margin in 2018. Lastly, the applicant is exploring opportunities for clinical consolidation prior to moving into the new acute care facility that would bring operating and clinical efficiencies to MVHS.

It should be noted that both St. Elizabeth's and St. Luke's had positive net assets and positive working capital in 2017, per the December 2017 financial statement.

Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

ATTACHMENT NO. 1

MOHAWK VALLEY HEALTH SYSTEM

RECENT INTERNAL FINANCIAL STATEMENT

MOHAWK VALLEY HEALTH SYSTEM
❖ HOSPITAL BALANCE SHEETS
DECEMBER 2017

	UNAUDITED DEC 2017	DEC 2016	CHANGE YTD
CURRENT ASSETS:			
Cash and cash equivalents	11,439,439	14,359,772	(2,920,333)
Unrestricted Investments	101,151,562	92,830,863	8,320,699
Patient accounts receivable, net	60,401,470	55,602,157	4,799,313
Insurances, related party, grants, & other receivables	18,841,870	12,649,460	6,192,410
Inventory	12,251,003	12,072,827	178,176
Prepaid & other assets	8,924,015	4,914,649	4,009,366
Total Current Assets	213,009,359	192,429,729	20,579,631
Investment in Foundations	(10,393)	-	(10,393)
Investment in Paraffin	91,322	86,480	4,842
Investment in MVEC	885,544	907,544	(22,000)
Assets limited as to use	4,557,707	2,557,473	2,000,234
Investments	6,331,300	5,802,337	528,963
Property & equipment, net	129,617,503	142,957,146	(13,339,643)
Unamortized debt issuance	833,639	947,630	(113,991)
Insurances, direct financing lease, goodwill, & other	23,966,258	23,999,738	(33,480)
Total Assets	379,282,240	369,688,079	9,594,161
LIABILITIES AND NET ASSETS			
Short term borrowings	-	-	-
Current long-term debt	4,248,629	4,805,456	(556,827)
Capital lease obligations- current	2,972,824	4,420,488	(1,447,664)
Self-insured liabilities- current	12,203,041	10,464,039	1,739,002
Accounts payable	35,813,844	31,728,676	4,085,168
Accrued payroll, taxes	20,836,364	19,967,695	868,669
Due to (from) third party	3,337,068	1,905,967	1,431,101
Other current liabilities	5,236,596	4,735,614	500,982
Total Current Liabilities	84,648,366	78,027,935	6,620,431
Notes payable	4,504,595	6,710,970	(2,206,375)
Civic facility revenue bonds	37,837,135	38,542,029	(704,894)
Capital lease obligations	3,965,396	6,068,949	(2,103,553)
Insurances, accrued ESLB, interest rate swaps	37,694,046	37,557,042	137,004
Estimated self-insured liabilities, net	4,699,408	5,726,525	(1,027,117)
Deferred pension liability	45,664,318	46,815,314	(1,150,996)
Total Liabilities	219,013,264	219,448,764	(435,500)
Unrestricted	150,469,309	140,466,158	10,003,152
Restricted	9,799,667	9,773,158	26,510
Total Net Assets	160,268,976	150,239,315	10,029,661
Total Liabilities and Net Assets	379,282,240	369,688,079	9,594,161

❖ Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center combined. Does not include eliminations.

MOHAWK VALLEY HEALTH SYSTEM
AFFILIATE BALANCE SHEETS
DECEMBER 2017

	UNAUDITED DEC 2017	DEC 2016	Change YTD	UNAUDITED DEC 2017	DEC 2016	Change YTD
	Faxton-St. Luke's	Faxton-St. Luke's	Faxton-St. Luke's	St. Elizabeth	St. Elizabeth	St. Elizabeth
CURRENT ASSETS:						
Cash and cash equivalents	2,421,993	5,706,867	(3,284,874)	9,017,446	8,652,905	364,541
Unrestricted investments	95,627,198	83,176,139	12,451,059	5,524,364	9,654,724	(4,130,360)
Patient accounts receivable, net	35,867,658	31,329,584	4,538,074	24,533,812	24,272,573	261,239
Insurances, related party, grants, & other receivables	17,823,919	12,043,722	5,780,197	1,017,951	605,738	412,213
Inventory	6,304,140	6,280,789	23,351	5,946,863	5,792,038	154,825
Prepaid & other assets	3,708,143	3,335,551	372,592	5,215,872	1,579,098	3,636,774
Total Current Assets	161,753,051	141,872,653	19,880,398	51,256,308	50,557,076	699,232
Investment in Foundations	(4,701)	-	(4,701)	(5,692)	-	(5,692)
Investment in Paraffin	91,322	86,480	4,842	-	-	-
Investment in MVEC	442,772	453,772	(11,000)	442,772	453,772	(11,000)
Assets limited as to use	25,233	25,233	(0)	4,532,474	2,532,240	2,000,234
Investments	5,196,888	4,706,529	490,359	1,134,412	1,095,808	38,604
Property & equipment, net	69,283,867	78,352,207	(9,068,340)	60,333,636	64,604,939	(4,271,303)
Unamortized debt issuance	344,936	370,486	(25,550)	488,703	577,144	(88,441)
Insurances, direct financing lease, goodwill, & other	23,966,258	23,999,738	(33,480)	-	-	-
Total Assets	261,099,626	249,867,100	11,232,527	118,182,613	119,820,979	(1,638,366)
LIABILITIES AND NET ASSETS						
Short term borrowings	-	-	-	-	-	-
Current long-term debt	2,620,329	3,186,208	(565,879)	1,628,300	1,619,248	9,052
Capital lease obligations- current	2,875,976	4,076,663	(1,200,687)	96,848	343,825	(246,977)
Self-insured liabilities- current	6,306,966	4,623,655	1,683,311	5,896,075	5,840,384	55,691
Accounts payable	17,958,164	14,960,206	2,997,958	17,855,680	16,768,470	1,087,210
Accrued payroll, taxes	12,519,808	12,098,897	420,911	8,316,556	7,868,798	447,758
Due to (from) third party	(87,125)	(1,948,925)	1,861,800	3,424,193	3,854,892	(430,699)
Other current liabilities	4,476,164	4,485,150	(8,986)	760,432	250,464	509,968
Total Current Liabilities	46,670,282	41,481,854	5,188,428	37,978,084	36,546,081	1,432,003
Notes payable	3,540,893	5,218,968	(1,678,075)	963,702	1,492,002	(528,300)
Civic facility revenue bonds	13,800,000	14,520,000	(720,000)	24,037,135	24,022,029	15,106
Capital lease obligations	3,476,355	5,483,061	(2,006,706)	489,041	585,888	(96,847)
Insurances, accrued ESLB, interest rate swaps	37,015,548	36,878,544	137,004	678,498	678,498	-
Estimated self-insured liabilities, net	4,030,575	5,057,692	(1,027,117)	668,833	668,833	0
Deferred pension liability	-	-	-	45,664,318	46,815,314	(1,150,996)
Total Liabilities	108,533,653	108,640,119	(106,466)	110,479,611	110,808,646	(329,034)
Unrestricted	144,208,680	132,869,688	11,338,992	6,260,628	7,596,469	(1,335,841)
Restricted	8,357,293	8,357,293	-	1,442,374	1,415,865	26,509
Total Net Assets	152,565,973	141,226,981	11,338,992	7,703,002	9,012,334	(1,309,332)
Total Liabilities and Net Assets	261,099,626	249,867,100	11,232,527	118,182,613	119,820,979	(1,638,366)

MOHAWK VALLEY HEALTH SYSTEM
HOSPITAL STATEMENTS OF OPERATIONS
DECEMBER 2017

	YTD UNAUDITED Faxton-St. Luke's	YTD UNAUDITED St. Elizabeth	YTD UNAUDITED Hospital Combined
Net Patient Service Revenue	286,411,249	215,688,967	502,100,216
Bad Debts	(6,069,068)	(7,576,215)	(13,645,283)
Patient Service Revenue Net of Bad Debts	280,342,181	208,112,752	488,454,933
Other Operating Revenue	23,068,091	7,507,805	30,575,896
Total Operating Revenue	303,410,272	215,620,557	519,030,829
Operating Expenses:			
Salaries & Wages	118,902,542	87,219,586	206,122,128
Provider Salaries	24,121,562	17,007,636	41,129,198
Employee benefits	33,574,399	25,251,489	58,825,888
Medical Supplies	24,858,398	37,564,673	62,423,071
Non-Medical Supplies	3,810,541	3,583,995	7,394,536
Purchased Services	32,070,455	17,169,437	49,239,892
Utilities	3,494,942	2,037,907	5,532,849
Drugs	24,422,231	6,297,448	30,719,679
Other Expenses	23,137,711	10,866,425	34,004,136
Depreciation & amortization	13,967,365	10,169,784	24,137,149
Taxes	1,329,498	642,445	1,971,943
Interest Expense	1,598,795	1,247,256	2,846,051
Total Operating Expenses	305,288,439	219,058,081	524,346,520
Income (loss) from Operations	(1,878,167)	(3,437,524)	(5,315,691)
Operating Margin	-0.62%	-1.59%	-1.02%
Realized Investment gain(loss) & interest income	1,330,028	1,969,604	3,299,632
Contributions for operations	11,202	77,719	88,921
Net excess (deficiency)	(536,937)	(1,390,201)	(1,927,138)
Bottom Line Margin	-0.18%	-0.64%	-0.37%

Cicero Consulting Associates

VCC, Inc.

701 Westchester Ave. • Suite 210W • White Plains, NY 10604
Tel: (914) 682-8657 • Fax: (914) 682-8895
cicero@ciceroassociates.com

White Plains Unit
Frank M. Cicero
Charles F. Murphy, Jr.
James Psarianos
Rose Murphy
Michael D. Ungerer
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Martha H. Pofit
Frank T. Cicero, M.D.

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(1952-2014)

December 11, 2017

Mr. Kenneth Glindmyer, BFA
Bureau of Financial Analysis
NEW YORK STATE DEPARTMENT OF HEALTH
Corning Tower, Room 1882
Empire State Plaza
Albany, New York 12237

RE: MOHAWK VALLEY HEALTH SYSTEM
PROJECT NO. 172305-C
(Oneida County)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica
ONEIDA COUNTY TRANSFORMATION GRANT-FUNDED PROJECT

Dear Mr. Glindmyer,

On behalf of our client, Mohawk Valley Health System (MVHS), we are responding to your November 27, 2017 request for additional information for the project referenced above. Our responses are as follows:

1. **Provide an organizational chart of Mohawk Valley Health System.**

   RESPONSE:
   Please refer to **Attachment No. 1** for an organizational chart of Mohawk Valley Health System.

2. **Provide an explanation for the net operating losses for both Faxton-St Lukes's and St. Elizabeth's September 2017 Internal Financial Statements. Indicate what the hospitals are doing to better their current financial position.**

   RESPONSE:
   Per the applicant, revenue has declined due to lower-than-projected volumes, mainly in outpatient surgery and the cardiac catheterization laboratory. In 2017, MVHS has also needed to use a higher amount of medical specialists and agency staffing in other areas such as trauma, ICU, emergency, urgent care, orthopedic surgery and pediatric hospitalists, as well as for anesthesia services. Together, these issues have resulted in a $3.5M loss year-to-date in 2017.

In order to reduce this deficit, MVHS has been working on a recruitment strategy for providers to strengthen the medical staff. The applicant recently hired two (2) general surgeons and an orthopedic surgeon. In addition, MVHS has brought in other specialists over the last 12 months, and the Hospital is working with them to establish their practices. MVHS anticipates favorable financial results from these services in 2018. In addition, MVHS has contracted with Prism Consulting Group (Prism), a nation-wide consulting firm that provides healthcare consulting services in a variety of functional practice areas. The applicant is working with Prism to implement an inpatient clinical documentation improvement program, as well as a labor productivity monitoring system. These combined efforts are expected to produce an improvement to a break-even operating margin in 2018. Lastly, the applicant is exploring opportunities for clinical consolidation prior to moving into the new acute care facility that would bring operating and clinical efficiencies to MVHS.

3. **Schedule 8**

   a. **Provide back up to tie into Interim Interest Expense of $10,500,000. Information provided of $150,000,000 interim loan at 5.25% for 32 months = $21,000,000. We will need to tie into the $10,500,000.**

RESPONSE:
Per the budgeted cash flow for this project, MVHS anticipates issuing debt in 2020. The initial $300M of cost of this project will be covered by the $300M Oneida County Transformation grant. If debt is issued on 09/01/2020, there will be an estimated 16 months of interest capitalized until project completion on 01/01/2021. A $150,000,000 interim loan at 5.25% for 16 months = $10,500,000. This is calculated as follows: $150,000,000 x (5.25%/12) x 16 = $10,500,000.

4. **Schedule 9**

   a. **Land – Applicant stated N/A but on Schedule 8, $12,000,000 was listed under land. Please reevaluate Schedule 9 – Section D Land and fill out the appropriate fields. Please note that no items should be filled out as N/A. This includes providing us with:**

      i. **Appraisal of the land by a NYS Certified Agent**
      ii. **Copy of the proposed/executed purchase agreement**
      iii. **Affidavit indicating any and all relationships between the seller and the proposed operator/owner.**

   b. **Interim Loan – Please indicate what will be used for the interim loan, and if bridge financing is being obtained, provide a letter of interest addressing the terms of the loan.**

RESPONSE:

Regarding Question 4(a), MVHS will be purchasing land through this project. MVHS has estimated that it will spend about $12 million to acquire the various parcels of land. The Hospital does not already own the property, so it cannot be used as a "source" of funding on C.O.N. Schedule 9, which is why the "land" section on C.O.N. Schedule 9 was not completed. Nevertheless, we are providing the Department with the following update on the status of the land purchase process:

A total of 91 tax parcels were initially identified for potential inclusion in the project site. Of those parcels, 10 are owned by the City of Utica. The remaining parcels represent 39 owners and resulted in a total of 49 appraisals being performed by one of the New York State Certified appraisal firms listed as follows:

CNY Pomeroy Appraisers, Inc.
100 East Seneca Street, Suite 200
Manlius, New York 13104

Emminger Newton Pigeon & Magyar, Inc.
60 Lakefront Boulevard, Suite 120
Buffalo, New York 14202

Goodman Marks
420 Lexington Avenue, Suite 225
New York, New York 10170

The completed appraisals were forwarded to DASNY for review and acceptance. Of the 49 appraisals conducted, a total of 38 appraisals were accepted as presented. Subsequently, MVHS has determined that three (3) of the 38 properties were outside the footprint of the project and MVHS has notified the three (3) property owners involved that MVHS will not be seeking to purchase their properties for this project. MVHS is finalizing a letter of intent and purchase offer and will be presenting them to the property owners of the 35 accepted appraisals. MVHS respectfully requests that either the Department request the appraisals directly from DASNY or that the submission of appraisals for all final properties purchased be made a contingency on approval of the project. Furthermore, please refer to **Attachment No. 2** for an Affidavit from Tracy A. Boris, Esq., General Counsel for Mohawk Valley Health System, documenting known relationships between the property owners and MVHS.

Eight (8) of the 49 appraisals submitted to DASNY were pended as they were missing an interior finish and condition assessment due to lack of access to the building. MVHS is in the process of reaching out to the eight (8) property owners to confirm whether access will be allowed at this time, and if so, the initial appraisal firm will be requested to return for the interior appraisal. Once performed, the completed appraisal will be returned to DASNY for review.

DASNY rejected the remaining three (3) appraisal reports as they determined that the assessment did not adequately support the indicated market value. For these three (3) properties, MVHS has hired a fourth New York State-certified appraisal firm, Stropp Appraisal (9535 Money Road, Brewerton, NY) to conduct an independent appraisal. It is anticipated that the reappraisals and the interior appraisals, whereby the appraisers are allowed access, will be completed and submitted to DASNY before the end of January 2018.

Regarding Question 4(b), Faxton-St. Luke's Healthcare currently has a $17,000,000 line of credit available through Bank of America bearing interest at 3.75%. In addition, St. Elizabeth Medical Center has a $4,500,000 line of credit available through Bank of Utica bearing interest at the prime rate. There are currently no borrowings on either of these lines. To the extent necessary, these lines of credit may be used by MVHS to fund portions of the project as MVHS waits for reimbursement through the Oneida County Transformation Grant program. Nevertheless, MVHS does not expect to access these lines of credit for that purpose.

5. Schedule 13

a. Table 13d does not have inpatient information for both hospitals and projected year 1 and 3, please provide similar to how outpatient was provided.

RESPONSE:
Please refer to **Attachment No. 3** for a revised Table 13D-4 that includes the "Current Year" (2016) broken out for both St. Luke's and St. Elizabeth. We are also providing the Table 13D-4 for the combined facilities (St. Luke's and St. Elizabeth) that includes information from the Current Year, Year 1 and Year 3 (this document has not changed from the original C.O.N. submission but is being provided for comparison only).

b. What operational efficiencies will be gained as a result of this project and how much savings per efficiency?

RESPONSE:
The affiliation of MVHS with St. Elizabeth and St. Luke's, which occurred in 2014 (under Project No. 132204), began a process of assessing the current operations of both hospitals and developing a plan to reduce/eliminate the duplication of clinical and building services. A number of services were consolidated to one (1) hospital location, which resulted in a reduction of operational costs, as well as improved patient experiences and staffing efficiencies. However, other programs and services such as inpatient care, emergency services, diagnostic imaging and surgery remained at both campuses because they are needed to help operate a full-service acute care facility. A significant number of support services, including dietary, pharmacy, laboratory, administration, materials management, housekeeping, security, and engineering and maintenance staff – all needed to operate two (2) aging facilities – are currently duplicated at the two (2) sites, less than two (2) miles apart.

Multiple facility options were analyzed, including: (1) maintaining both hospital sites; (2) consolidating one facility into the other facility based upon available land, feasibility with phasing and logistics; and (3) consolidating both facilities to a brand new campus. Based upon its analysis, MVHS decided that the option of consolidating both facilities to a new campus would be the most effective option. First, it would give MVHS the opportunity to improve patient access to serve the County's largest population center, which includes the 4th largest refugee program in the United States. Second, consolidating all services to a single site would improve operational efficiency and maximize resources (including physicians and employees). Third, a new, consolidated site will enable MVHS to reduce infrastructure and energy cost/consumption for decades to come. The existing St. Elizabeth and St. Luke's facilities were constructed in 1917 and 1957, respectively. A single campus would reduce the overall building square footage from 928,000 square feet to approximately 672,000 square feet (a 28% decrease).

The current configuration of two (2) hospital campuses brought together as part of an affiliation is not sustainable over an extended time period due to the aging infrastructures, inefficiencies of duplication of staff, supplies, facilities and services, non-productive travel between campuses and higher energy cost due to inefficient, aging equipment and the large square footages of the two (2) facilities as compared to a single, new, state-of-the-art hospital. Energy savings will accrue, and a new facility will have improved environments for ventilation and air filtration relative to current industry standards. Savings will also be achieved on all of the identified existing facility issues, but more importantly, savings will be achieved through the efficiency of care, which will improve outcomes by operational excellence and efficiently planned layouts.

The ability to fundamentally transform the processes, systems and culture of two (2) hospitals into one (1) integrated team working together will contribute to improved patient care metrics. Measured results will be documented by reduced energy consumption, reduction of redundant workflow and staffing, as well as reduced maintenance costs for both materials and manpower that are required by facilities. The more important measurements that will bring the return on investment will be in the form of patient outcomes – satisfaction, reduced infection, reduced length of stay, falls prevention, and reduced medical errors and readmissions. MVHS is projecting a savings of approximately $15 million annually in operating costs when the project is complete, while also achieving clinical integration and improved quality, safety and patient satisfaction. It is anticipated that MVHS will reduce avoidable Emergency Department visits, primarily by the Medicaid population, by 3,370 per year, and reduce avoidable admissions by 230 admissions per year, which will result in an overall savings of approximately $4 million over three (3) years for the overall healthcare system. These savings will be achieved through the programmatic and operational changes sustained through DSRIP project implementation.

c. **It appears that all expenses will be increased in projected year 1, please explain based on answer to question above.**

RESPONSE:
Per the Hospital, most of this increase is due to a significant addition of both interest and depreciation due to the project. Furthermore, in order to maintain consistency with the budget provided as part of the Oneida County Transformation Grant, MVHS has also factored in 1.0% to 4.5% increases annually for inflation based on historical market increases for each of the expense categories. Over the long run, total expense will be reduced as debt is repaid. In the short run, cash flow will be significantly more positive due to a major part of the expense being the non-cash item depreciation.

Thank you for your consideration in this matter.

Sincerely,

Frank M. Cicero

cc: Ms. Sharon A. Palmer, MSBA, Assistant Vice President, Facilities Services, MVHS

ATTACHMENT NO. 1

MOHAWK VALLEY HEALTH SYSTEM

ORGANIZATIONAL CHART

MVHS

Governance Structure

Mohawk Valley Health System

- St. Elizabeth Medical Center (SEMC)
  - SEMC Foundation, Inc.
  - SEMC College of Nursing
  - MVHS Support Services
- Faxton St. Luke's Healthcare (FSLH)
  - FSLH Foundation
- Mohawk Valley Heart Institute (MVHI)
- Senior Network Health
- St. Luke's Home
- Visiting Nurse Association of Utica & Oneida County
- Mohawk Valley Home Care (Home Care Services)

ATTACHMENT NO. 2

MOHAWK VALLEY HEALTH SYSTEM

AFFIDAVIT

State of New York
Oneida County

Mohawk Valley Health System
CON – 172305 – construct a new replacement hospital

AFFIDAVIT

I, Traci A. Boris, being duly sworn, depose and say that:

1. I am the General Counsel for the Mohawk Valley Health System (MVHS), which is an affiliation of Faxton-St. Luke's Healthcare (FSLH) and St. Elizabeth Medical Center (SEMC). As such, I also serve in the role of General Counsel for both FSLH and SEMC.

2. By letter dated November 27, 2017, the NYS Department of Health sent a 14-day letter seeking responses to various queries. As part thereof the Department of Health sought an Affidavit relative to any relationships between the seller and the proposed operator/owner.

3. In my role as the General Counsel I have reviewed contract databases and reached out to pertinent departments and personnel to ascertain the relationships between MVHS and any of the property owners within the hospital's site plans. Based upon that review and those discussions I have determined that there is no conflict of interest between any of the property owners and MVHS. However, MVHS has the following relationships with property owners whose property is within the site plan and intended for acquisition:

a. The following property owners are, or have been in the past, third party vendors who provide services and/or products that are used for hospital operations:
   i. Schmalz Mechanical (unsure of relationship to property owner [redacted]
   ii. Urbanik Paint (owned by Greg Urbanik)
   iii. Niagara Mohawk
   iv. Cavo's on Jefferson (unsure of relationship to property owner [redacted]
   v. Park Outdoor Advertising
   vi. Clemente's
   vii. City of Utica
   viii. O'Brien in Rome (unsure of relationship to property owne[redacted]
   ix. Mohawk Hospital Equipment
   x. H.J. Brandeles

b. The Board Chair for Resource Center For Independent Living is the [redacted] of an MVHS Board Member.

c. The owner of Mohawk Hospital is a Board Member on the SEMC Foundation and FSLH Foundation Boards.

d. SEMC has a Power Purchase Agreement with Niagara Mohawk for power generated by SEMC's co-generation plant.

4. It is important to note that at this stage the property owners' list was developed by use of county databases and tax record searches. As property acquisition moves forward ownership will be verified and if there are any changes relative to relationships between any owners and MVHS, we consider this a continuing obligation and will notify DOH of any of those changes.

Dated: December 8, 2017

Traci A. Boris

Traci A. Boris, Esq,
General Counsel

Sworn to before me this 8th day
of December, 2017

Margaret H. Jacobsen

Notary Public

MARGARET H. JACOBSEN
Notary Public, State of New York
Appointed in Oneida County
My Commission Expires 2/18/2018

ATTACHMENT NO. 3

MOHAWK VALLEY HEALTH SYSTEM

SCHEDULE 13D (TABLE 13D-4) DOCUMENTATION

Table 13D - 4

St. Luke's

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	**Fee for Service**	12,746	3.9%	9,644,640						
	Managed Care	63,611	19.3%	67,512,664						
Medicare	**Fee for Service**	104,623	31.8%	31,630,624						
	Managed Care	46,186	14.0%	17,636,624						
Medicaid	**Fee for Service**	15,375	4.7%	1,168,743						
	Managed Care	68,268	20.8%	20,704,849						
Private Pay		4,525	1.4%	283,970						
OASAS										
OMH										
Charity Care		1,911	0.6%	319						
Bad Debt										
All Other		11,664	3.5%	1,260,496						
Total		**328,909**	**100.0%**	**$149,842,929**						

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services			**$267,183,516**							

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of SEMC and FSLH.	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of SEMC and FSLH.	N/A

Table 13D - 4

St. Elizabeth

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	**Fee for Service**	16,925	4.7%	3,915,499						
	Managed Care	90,540	25.2%	27,408,493						
Medicare	**Fee for Service**	75,090	20.9%	19,014,785						
	Managed Care	50,621	14.1%	15,844,133						
Medicaid	**Fee for Service**	10,450	2.9%	(410,210)						
	Managed Care	89,815	25.0%	16,346,560						
Private Pay		16,303	4.5%	9,206,725						
OASAS										
OMH										
Charity Care		129	0.0%	(73,066)						
Bad Debt										
All Other		8,849	2.5%	2,769,304						
Total		**358,722**	**100.0%**	**$94,022,223**						

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services				**$210,690,062**						

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of SEMC and FSLH.	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of SEMC and FSLH.	N/A

Table 13D - 4

St. Luke's + St. Elizabeth

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	Fee for Service	27,393	4.0%	$16,272,167	28,426	4.0%	$18,769,672	28,426	4.0%	$19,533,711
	Managed Care	155,224	22.6%	$92,208,949	161,076	22.6%	$106,361,477	161,076	22.6%	$110,691,030
Medicare	Fee for Service	180,020	26.2%	$50,645,409	186,807	26.2%	$58,418,630	186,807	26.2%	$60,796,620
	Managed Care	97,049	14.1%	$33,480,757	100,708	14.1%	$38,619,492	100,708	14.1%	$40,191,538
Medicaid	Fee for Service	25,778	3.7%	$758,533	26,750	3.7%	$874,955	26,750	3.7%	$910,571
	Managed Care	158,825	23.1%	$37,051,409	164,813	23.1%	$42,738,179	164,813	23.1%	$44,477,880
Private Pay		20,808	3.0%	$9,490,695	21592	3.0%	$10,947,358	21592	3.0%	$11,392,981
OASAS										
OMH										
Charity Care		1,996	0.3%	($42,154)	2,071	0.3%	($48,624)	2,071	0.3%	($50,603)
Bad Debt										
All Other		20,538	3.0%	$3,999,387	21,312	3.0%	$4,613,226	21,312	3.0%	$4,801,012
Total		**687,631**	**100.0%**	**$243,865,152**	**713,555**	**100.0%**	**$281,294,365**	**713,555**	**100.0%**	**$292,744,740**

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services				**$477,873,578**			**$550,578,789**			**$572,990,662**

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of St. Elizabeth and St. Luke's	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of St. Elizabeth and St. Luke's	N/A

MOHAWK VALLEY HEALTH SYSTEM
❖ HOSPITAL BALANCE SHEETS
DECEMBER 2017

	UNAUDITED DEC 2017	DEC 2016	CHANGE YTD
CURRENT ASSETS:			
Cash and cash equivalents	11,439,439	14,359,772	(2,920,333)
Unrestricted Investments	101,151,562	92,830,863	8,320,699
Patient accounts receivable, net	60,401,470	55,602,157	4,799,313
Insurances, related party, grants, & other receivables	18,841,870	12,649,460	6,192,410
Inventory	12,251,003	12,072,827	178,176
Prepaid & other assets	8,924,015	4,914,649	4,009,366
Total Current Assets	213,009,359	192,429,729	20,579,631
Investment in Foundations	(10,393)	-	(10,393)
Investment in Paraffin	91,322	86,480	4,842
Investment in MVEC	885,544	907,544	(22,000)
Assets limited as to use	4,557,707	2,557,473	2,000,234
Investments	6,331,300	5,802,337	528,963
Property & equipment, net	129,617,503	142,957,146	(13,339,643)
Unamortized debt issuance	833,639	947,630	(113,991)
Insurances, direct financing lease, goodwill, & other	23,966,258	23,999,738	(33,480)
Total Assets	379,282,240	369,688,079	9,594,161
LIABILITIES AND NET ASSETS			
Short term borrowings	-	-	-
Current long-term debt	4,248,629	4,805,456	(556,827)
Capital lease obligations- current	2,972,824	4,420,488	(1,447,664)
Self-insured liabilities- current	12,203,041	10,464,039	1,739,002
Accounts payable	35,813,844	31,728,676	4,085,168
Accrued payroll, taxes	20,836,364	19,967,695	868,669
Due to (from) third party	3,337,068	1,905,967	1,431,101
Other current liabilities	5,236,596	4,735,614	500,982
Total Current Liabilities	84,648,366	78,027,935	6,620,431
Notes payable	4,504,595	6,710,970	(2,206,375)
Civic facility revenue bonds	37,837,135	38,542,029	(704,894)
Capital lease obligations	3,965,396	6,068,949	(2,103,553)
Insurances, accrued ESLB, interest rate swaps	37,694,046	37,557,042	137,004
Estimated self-insured liabilities, net	4,699,408	5,726,525	(1,027,117)
Deferred pension liability	45,664,318	46,815,314	(1,150,996)
Total Liabilities	219,013,264	219,448,764	(435,500)
Unrestricted	150,469,309	140,466,158	10,003,152
Restricted	9,799,667	9,773,158	26,510
Total Net Assets	160,268,976	150,239,315	10,029,661
Total Liabilities and Net Assets	379,282,240	369,688,079	9,594,161

❖ Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center combined. Does not include eliminations.

MOHAWK VALLEY HEALTH SYSTEM
AFFILIATE BALANCE SHEETS
DECEMBER 2017

	UNAUDITED DEC 2017	DEC 2016	Change YTD	UNAUDITED DEC 2017	DEC 2016	Change YTD
	Faxton-St. Luke's	Faxton-St. Luke's	Faxton-St. Luke's	St. Elizabeth	St. Elizabeth	St. Elizabeth
CURRENT ASSETS:						
Cash and cash equivalents	2,421,993	5,706,867	(3,284,874)	9,017,446	8,652,905	364,541
Unrestricted investments	95,627,198	83,176,139	12,451,059	5,524,364	9,654,724	(4,130,360)
Patient accounts receivable, net	35,867,658	31,329,584	4,538,074	24,533,812	24,272,573	261,239
Insurances, related party, grants, & other receivables	17,823,919	12,043,722	5,780,197	1,017,951	605,738	412,213
Inventory	6,304,140	6,280,789	23,351	5,946,863	5,792,038	154,825
Prepaid & other assets	3,708,143	3,335,551	372,592	5,215,872	1,579,098	3,636,774
Total Current Assets	161,753,051	141,872,653	19,880,398	51,256,308	50,557,076	699,232
Investment in Foundations	(4,701)	-	(4,701)	(5,692)	-	(5,692)
Investment in Paraffin	91,322	86,480	4,842	-	-	-
Investment in MVEC	442,772	453,772	(11,000)	442,772	453,772	(11,000)
Assets limited as to use	25,233	25,233	(0)	4,532,474	2,532,240	2,000,234
Investments	5,196,888	4,706,529	490,359	1,134,412	1,095,808	38,604
Property & equipment, net	69,283,867	78,352,207	(9,068,340)	60,333,636	64,604,939	(4,271,303)
Unamortized debt issuance	344,936	370,486	(25,550)	488,703	577,144	(88,441)
Insurances, direct financing lease, goodwill, & other	23,966,258	23,999,738	(33,480)	-	-	-
Total Assets	261,099,626	249,867,100	11,232,527	118,182,613	119,820,979	(1,638,366)
LIABILITIES AND NET ASSETS						
Short term borrowings	-	-	-	-	-	-
Current long-term debt	2,620,329	3,186,208	(565,879)	1,628,300	1,619,248	9,052
Capital lease obligations- current	2,875,976	4,076,663	(1,200,687)	96,848	343,825	(246,977)
Self-insured liabilities- current	6,306,966	4,623,655	1,683,311	5,896,075	5,840,384	55,691
Accounts payable	17,958,164	14,960,206	2,997,958	17,855,680	16,768,470	1,087,210
Accrued payroll, taxes	12,519,808	12,098,897	420,911	8,316,556	7,868,798	447,758
Due to (from) third party	(87,125)	(1,948,925)	1,861,800	3,424,193	3,854,892	(430,699)
Other current liabilities	4,476,164	4,485,150	(8,986)	760,432	250,464	509,968
Total Current Liabilities	46,670,282	41,481,854	5,188,428	37,978,084	36,546,081	1,432,003
Notes payable	3,540,893	5,218,968	(1,678,075)	963,702	1,492,002	(528,300)
Civic facility revenue bonds	13,800,000	14,520,000	(720,000)	24,037,135	24,022,029	15,106
Capital lease obligations	3,476,355	5,483,061	(2,006,706)	489,041	585,888	(96,847)
Insurances, accrued ESLB, interest rate swaps	37,015,548	36,878,544	137,004	678,498	678,498	-
Estimated self-insured liabilities, net	4,030,575	5,057,692	(1,027,117)	668,833	668,833	0
Deferred pension liability	-	-	-	45,664,318	46,815,314	(1,150,996)
Total Liabilities	108,533,653	108,640,119	(106,466)	110,479,611	110,808,646	(329,034)
Unrestricted	144,208,680	132,869,688	11,338,992	6,260,628	7,596,469	(1,335,841)
Restricted	8,357,293	8,357,293	-	1,442,374	1,415,865	26,509
Total Net Assets	152,565,973	141,226,981	11,338,992	7,703,002	9,012,334	(1,309,332)
Total Liabilities and Net Assets	261,099,626	249,867,100	11,232,527	118,182,613	119,820,979	(1,638,366)

MOHAWK VALLEY HEALTH SYSTEM
HOSPITAL STATEMENTS OF OPERATIONS
DECEMBER 2017

	YTD UNAUDITED Faxton-St. Luke's	YTD UNAUDITED St. Elizabeth	YTD UNAUDITED Hospital Combined
Net Patient Service Revenue	286,411,249	215,688,967	502,100,216
Bad Debts	(6,069,068)	(7,576,215)	(13,645,283)
Patient Service Revenue Net of Bad Debts	280,342,181	208,112,752	488,454,933
Other Operating Revenue	23,068,091	7,507,805	30,575,896
Total Operating Revenue	303,410,272	215,620,557	519,030,829
Operating Expenses:			
Salaries & Wages	118,902,542	87,219,586	206,122,128
Provider Salaries	24,121,562	17,007,636	41,129,198
Employee benefits	33,574,399	25,251,489	58,825,888
Medical Supplies	24,858,398	37,564,673	62,423,071
Non-Medical Supplies	3,810,541	3,583,995	7,394,536
Purchased Services	32,070,455	17,169,437	49,239,892
Utilities	3,494,942	2,037,907	5,532,849
Drugs	24,422,231	6,297,448	30,719,679
Other Expenses	23,137,711	10,866,425	34,004,136
Depreciation & amortization	13,967,365	10,169,784	24,137,149
Taxes	1,329,498	642,445	1,971,943
Interest Expense	1,598,795	1,247,256	2,846,051
Total Operating Expenses	305,288,439	219,058,081	524,346,520
Income (loss) from Operations	(1,878,167)	(3,437,524)	(5,315,691)
Operating Margin	-0.62%	-1.59%	-1.02%
Realized Investment gain(loss) & interest income	1,330,028	1,969,604	3,299,632
Contributions for operations	11,202	77,719	88,921
Net excess (deficiency)	(536,937)	(1,390,201)	(1,927,138)
Bottom Line Margin	-0.18%	-0.64%	-0.37%

Application Number:	172305
Facility Name:	Faxton-St Lukes Healthcare St Lukes Division
Project Description:	Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Created By:	Michael Clary , Architectural and Engineering Facility Planning **on** 12/06/2017
Correspondence Type:	Request for Additional Information
Recipient:	Applicant
Correspondence Visible To:	All

Message:

Dear Ms. Smyth,

Please review and respond to the attached requests for additional information within (14) days. If you have any questions; I may be reached at (518) 402 0904.

Respectfully,

Robert Lis

Health Facilities Planner

Attachments:

CON 172305 (LSC_RFI) 12_6_17.PDF **

CON 172305 (FGI RFI) 12_6_17.PDF **

Created By: Applicant **on** 12/19/2017
Correspondence Type: Request for Additional Information
Recipient: Architectural and Engineering Facility Planning
Correspondence Visible To: All
Message:
Please find attached, responses to both Mr. Michael Clary and Mr. Robert Lis from their December 6, 2017 request for additional information. Hard copies are being sent to the Department today via UPS.
Attachments:
172305 - MVHS (Clary) Response 12-19-17.PDF **
A - Arch - Drawing Part-1 of 4.pdf **
A - Arch - Drawing Part-2 of 4.pdf **
A - Arch - Drawing Part-3 of 4.pdf **
A - Arch - Drawing Part-4 of 4.pdf **

172305 - MVHS (Lis) Response 12-19-17.pdf **

Application Number:	172305
Facility Name:	Faxton-St Lukes Healthcare St Lukes Division
Project Description:	Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Created By:	Kenneth Glindmyer , Financial Analysis and Review **on** 11/27/2017
Correspondence Type:	Request for Additional Information
Recipient:	Applicant
Correspondence Visible To:	All

Message:

See attached

Attachments:

14 Day Letter.docx **

Created By: Applicant **on** 12/11/2017
Correspondence Type: Request for Additional Information
Recipient: Financial Analysis and Review
Correspondence Visible To: All
Message:
Please find attached, a response to Mr. Kenneth Glindmyer's November 27, 2017 request for additional information. We are also adding a Schedule 1 Attachment, Schedule 9 Attachment and a Revised Schedule 13D to the Application Tab.
Attachments:
172305 - MVHS Response 12-11-17.PDF **

Created By: Applicant **on** 12/11/2017
Correspondence Type: Request for Additional Information
Recipient: Financial Analysis and Review
Correspondence Visible To: All
Message:
Please find attached, a response to Mr. Kenneth Glindmyer's November 27, 2017 request for additional information. We are also adding a Schedule 1 Attachment, Schedule 9 Attachment and a Revised Schedule 13D to the Application Tab.
Attachments:
172305 - MVHS Response 12-11-17.PDF **

[redacted]

Created By: Kenneth Glindmyer , Financial Analysis and Review **on** 01/30/2018
Correspondence Type: Request for Additional Information
Recipient: Applicant
Correspondence Visible To: All
Message:
Please provide the latest financial statements that are within 6-months of the April 2018 PHHPC agenda meeting. Provide an explanation for any net operating losses, negative net assets, or negative working capital for both Faxton-St Lukes's and St. Elizabeth's and indicate what the hospitals are doing to better their current financial position.

Created By: Applicant **on** 02/02/2018
Correspondence Type: Request for Additional Information
Recipient: Financial Analysis and Review
Correspondence Visible To: All
Message:
Please find attached, a response to Mr. Kenneth Glindmyer's Januray 30, 2018 request for additional information. We are also uploading the Financials as a Schedule 9 Attachment on the Application Tab.
Attachments:
172305 - MVHS Response 2-2-18.PDF **

Application Number:	172305
Facility Name:	Faxton-St Lukes Healthcare St Lukes Division
Project Description:	Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Created By:	Bradley Frazee , Construction Cost Control **on** 11/22/2017
Correspondence Type:	Request for Additional Information
Recipient:	Applicant
Correspondence Visible To:	All

Message:

Please provide additional detail for Schedule 8B budget line 4.5 "Other Fees" (sub-project #1). Specifically, please provide a detailed accounting (copies of consultant estimates, proposals, or contracts etc.) for fees associated with item 116 - Furniture, Fixtures and Equipment - 18000 Planning & Zoning Fees totaling $6,125,000 (escalated cost) and reflected on the Schedule 8 attachment detailing the "Other Fees".

Should you have any questions related to this request you may contact me at 518 402-0904.

Sincerely, Brad Frazee

Created By: Applicant **on** 12/13/2017
Correspondence Type: Request for Additional Information
Recipient: Construction Cost Control
Correspondence Visible To: All
Message:
Please find attached, a response to Mr. Brad Frazee's November 22, 2017 request for additional information. We are also uploading Schedule 8 Attachments to the Application Tab.
Attachments:
172305 - MVHS Response 12-13-17.PDF **

Created By: Construction Cost Control **on** 12/14/2017
Correspondence Type: Request for Additional Information
Recipient: Smyth, Patricia E
Correspondence Visible To: All
Message:
Thank you for the update of "Other Fees". The revised listing satisfies the original question related to item 18000 previously labeled Planning & Zoning Fees.

The update however brings into question another "Other Fees" item, 18250 now labeled "Security Access and Control" totaling $1,776,500 (previously labeled as "Legal / Consultant Assistance Fees").

The costs for "Security Access and Control" are already accounted for and appear to be included in the Telecommunications budget, line 5.2 of Schedule 8B. Schedule 11 attachment for New Telecommunications Equipment provides a detailed listing of equipment and costs already included in the project for this item.

Kindly review and submit a revised Schedule 8B - Line 4.5 "Other Fees" costs or Line 5.2 Telecommunications costs to eliminate duplication of costs for this item.

Should you have any questions, you may contact me at 518 402-0904.

Sincerely, B. Frazee

Created By: Applicant **on** 01/03/2018
Correspondence Type: Request for Additional Information
Recipient: Construction Cost Control
Correspondence Visible To: All
Message:
Attached please find a response to Mr. Frazee's 12/14/17 request for additional information.
Attachments:
172305 - Mohawk Valley 1-3-18.PDF **

Created By: Bradley Frazee , Construction Cost Control **on** 01/03/2018
Correspondence Type: Request for Additional Information
Recipient: Applicant
Correspondence Visible To: All
Message:
The Construction Cost Control review and approval is on hold pending receipt of a satisfactory response to our 12/14/17 request for additional information.

Your response is required ASAP. Should you have any questions you may contact me at 518 402-0904.

Sincerely, Brad Frazee

Created By: Applicant **on** 01/04/2018
Correspondence Type: Request for Additional Information
Recipient: Construction Cost Control
Correspondence Visible To: All
Message:
Attached please find a response to Mr. Frazee's 12/14/17 request for additional information.
Attachments:
172305 - Mohawk Valley 1-3-18.PDF **

Application Number:172305

Facility Name: Faxton-St Lukes Healthcare St Lukes Division

Project Description: Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Executive Summary

Mohawk Valley Health System (MVHS) is submitting this Full Review Certificate of Need (C.O.N.) Application that seeks approval for the construction of a new hospital campus. MVHS is the active parent and co-operator of St. Elizabeth Medical Center (St. Elizabeth) and Faxton St. Luke's Healthcare St. Luke's Division (St. Luke's). St. Luke's (Operating Certificate #3202003H; PFI #0599) is currently located at 1656 Champlin Avenue, Utica (Oneida County), New York 13502. St. Elizabeth Medical Center (Operating Certificate #3202002H; PFI #0598) is currently located at 2209 Genesee Street, Utica (Oneida County), New York 13501. Cardiac PCI and cardiac surgery services currently offered through the Mohawk Valley Heart Institute (Operating Certificate #3202004H; PFI #7528) are also provided on the campus of St. Elizabeth at 2209 Genesee Street, Utica (Oneida County), New York 13501. This C.O.N. Application will be funded, in part, through the **Health Care Facility Transformation Program: Oneida County** grant awarded to MVHS specifically for this purpose. This project is one (1) of at least two (2) Applications being submitted to the New York State Department of Health (NYSDOH) for the transformation of services within the Oneida County region, as described in detail below.

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 (i.e., the creation of a new hospital campus), which will result in the transformation of healthcare services in the region.

This C.O.N. Application is the first in a series of (at least two (2)) Applications that Mohawk Valley Health System and its two (2) related facilities (St. Elizabeth and St. Luke's) will be submitting that will lead to the merger of St. Elizabeth and St. Luke's, and the relocation and consolidation of the majority of services comprising St. Elizabeth and St. Luke's to the new hospital campus in Utica, New York.

The new, consolidated hospital campus will be located on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13501: State Street, Broadway, Oriskany Street West, and Columbia Street. An address has not yet been assigned to the site. The new hospital campus will have the following inpatient bed complement: coronary care (eight (8) beds); intensive care (42 beds); maternity (23 beds); medical/surgical (232 beds); neonatal intermediate care (eight (8) beds); pediatric (16 beds); and psychiatric (44 beds). In addition, the St. Luke's campus will retain 24 physical medicine and rehabilitation beds. In total, MVHS (inclusive of its two (2) campuses) will reduce its overall inpatient bed complement by 174 beds, from 571 beds to 397 beds (including 373 beds at the new hospital campus and 24 PM&R beds at its St. Luke's campus).

Through this C.O.N. Application, all inpatient and most outpatient services from the current St. Elizabeth campus will be relocated to the new hospital campus, which will be known as the "Mohawk Valley Health System Campus". The current St. Luke's site will become a division of the Mohawk Valley Health System under this Application and will relocate all inpatient and outpatient services from the St. Luke's site to the new hospital campus (with the exception of 24 PM&R beds and some other outpatient services).

The St. Elizabeth site will be converted into an outpatient extension clinic to be known as "St. Elizabeth Campus". As a new extension clinic site, it is expected to maintain its existing PFI number. In particular, sleep center services (Mohawk Valley Sleep Disorders Center), cardiac and thoracic surgery-related services (all of which are medical-only services; no surgical services will be provided at this site), primary care services and a laboratory patient service center (PSC) will continue to be provided at this site.

The Total Project Cost for this project is estimated to be $481,371,583, which is broken down into the following two (2) sub-projects:

- Sub-Project No. 1 – Article 28 New Hospital Campus ($480,000,000, including C.O.N. Application and Processing Fees).This amount will be funded through the Oneida County Heath Care Transformation Program grant funds that MVHS was awarded (in the amount of $300,000,000), as well as financing (in the amount of $150,000,000) and existing cash equity (in the amount of $30,000,000).
- Sub-Project No. 2 – Non-Article 28 Masonic Medical Research Lab ($1,371,583) – This amount will be funded through existing cash equity of MVHS.The Masonic Medical Research Lab will lease certain space on the new hospital campus, within the new hospital building structure, from MVHS.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Center for Health Care Facility Planning, Licensure and Finance - Bureau of Architecture & Engineering Facility Planning

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D. Acting Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

TYPE I SEQR ACTION

CONTINGENT APPROVAL

CON#: 172305 **FACILITY NAME:** Faxton-St Lukes Healthcare St Lukes Division

DESCRIPTION: Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

TOTAL PROJECT COST: $480,000,000.00

CONTINGENCY: Submission of State Environmental Quality Review Act (SEQRA) Summary of Findings pursuant to 6 NYCRR Part 617.4, and 10NYCRR 97.14.

CONTINGENCY DETERMINATION: In accordance with 10 NYCRR 97.14 and 6 NYCRR 617.4, Type I Actions are presumed to have a significant adverse impact on the environment. Accordingly, Environmental Impact Statement (EIS) is required. The proposed action for **CON Number** 172305, **Facility Name** Faxton-St Lukes Healthcare St Lukes Division, falls under the category of Type I Action as indicated in Schedule 7. Therefore, the applicant is required to submit State Environment Quality Review Act (SEQRA) Findings related to this project.

Applicant Response to SEQRA Request for Additional Information: See next two Pages.

Application Number:	172305
Facility Name:	Faxton-St Lukes Healthcare St Lukes Division
Project Description:	Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Created By:	Donna Wang , Certification and Surveillance - Hospital Services **on** 11/28/2017
Correspondence Type:	Request for Additional Information
Recipient:	Applicant
Correspondence Visible To:	All

Message:

Please clarify what types of "cardiac and thoracic surgery-related services" will continue to be provided at the St. Elizabeth site after conversion to an outpatient extension clinic. Thank you. Donna Wang ph.518-408-5867

Created By: Applicant **on** 11/28/2017
Correspondence Type: Request for Additional Information
Recipient: Certification and Surveillance - Hospital Services
Correspondence Visible To: All
Message:
Please find attached, a response to Ms. Donna Wang's November 28, 2017 request for additional information.
Attachments:
172305 - Mohawk Valley Response 11-28-17.PDF **

Application Number:	172305
Facility Name:	Faxton-St Lukes Healthcare St Lukes Division
Project Description:	Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Created By:	Mark Ciotti , Project Management **on** 11/10/2017
Correspondence Type:	Incomplete Application Letter
Recipient:	Applicant
Correspondence Visible To:	All

Message:

During the initial review of the application we found that the number of beds to be certifed at the new building differ between the Executive Summary and Schedule 17C. Please make the necessary changes to rectify this problem.

Thank you

Created By: Applicant **on** 11/10/2017
Correspondence Type: Incomplete Application Letter
Recipient: Project Management
Correspondence Visible To: All
Message:
Please find attached, a revsed page 1 of Schedule 16C. We will also replace on the Application Tab.
Attachments:
172305 - Faxton St. Lukes rev. 16C 11-10-17.PDF **

Dear Governor Cuomo:
Thank you for all you have done for the betterment of NY Citizens. I admire your stances for Net Neutrality, for the NY State of Health (kudos!!), and for the SAFE Act.
I am concerned, however, by the rumors I keep hearing that the proposed new Hospiital for the Utica area was mandated to be placed in downtown Utica (and only in downtown).
This, in my opinion, (and those of many others) is a very bad idea. The new hospital should be placed on the current St. Luke's campus (where there is ample room and inftrastructure already in place) and will not require the purchase and rehabilitation of vast swaths of land.
A hospital should not be perceived only as an "engine for economic growth". The goal of a hospital should be to provide excellent health care -- as the MVHS is already doing.
I would rather have the state's $300 million investment be used for replacing lead pipes in the Mohawk Valley water system. THAT would be a significant investment in our health (and also would result in economic growth in the long term).
I know our elected officials all have the best interests of their constituents in mind, but the process that this site selection has gone through has not been open and too many people are affected by it that seem to have no input into the process.
Please ask that all officials involved in this project (Oneida County, the City of Utica, MV EDGE, included) address these important concerns.
THANK YOU!
[redacted]

?Any change should be welcome...? This sentiment sums up the typical reply to my first post questioning the downtown proposal. It also is, based on many conversations, typical of many residents. To be honest, it reflects my initial response as well. However, after taking time to look into it, I could only reach one conclusion: the Downtown Utica Hospital proposal is the most misguided, short sighted and irresponsible plan ever put forward in Utica?s nearly 200 year history. Given that they're trying to fast-track

it before more sensible minds prevail, I thought writing a response to the ?any-change-should-be-welcome? sentiment was not only urgent- but also a responsibility. So here it be . . .

While a knee-jerk ?any change is good ? response to the Downtown Utica Hospital proposal is understandable, given the probable magnitude of its irreversible consequences, it is also irresponsible. Any plan calling for the demolition of a third of any city's downtown, warrants a respectable amount of consideration, debate, and dialogue, before being matter-of-factly embraced as progress by residents or community leaders.

Proponents of the downtown hospital would like you focused on a single long-neglected Columbia Street block, but the truth is that the block they're exploiting represents only a tiny fraction of what the project will consume. The proposal (almost unbelievably) calls for bulldozing an entire 25 - 35 acre span of Downtown Utica. It is massive, reactionary, and, most importantly, irreversible. It stretches north to south- from Oriskany Boulevard to Columbia Street, and, east to west- from Broadway (Bengees) to the Arterial overpasses on Lafayette, and Columbia Streets! Pointing to a single long-neglected block as justification for the magnitude of demolition they're talking about is misleading and deceitful. Let there be no mistake: what?s being proposed is the most massive and consequential demolition in Utica?s nearly 200 year history.

It's difficult to get an actual count as to the number of buildings proposed for demolition. That number, and the site's most southern and northern borders, seem to be purposely kept vague. Most likely, to help maintain the prevailing "any change is good-change" sentiment. Whether the number is 50 or 150, in spite of what they'd like you to believe, the vast majority of these buildings are indeed occupied and on the city tax-rolls!

At the heart of the proposed site, are a myriad of under-appreciated historic structures scattered in and around a couple of alleyways. One can even argue that the alleys themselves can be considered increasingly-rare historic artifacts, without which, the bustling downtown storefronts of yesteryear would not have been possible. Hell, just on the western edge of the site alone, slated for demolition, are: the grand turn-of-the-century building that once housed the landmark ?Columbia Restaurant,? the Witzeberger Building on Columbia and State (an undisputed architectural treasure in it's own right), the lovely group of historic turn-of-the-century "Row Houses? on Lafayette, near the corner of State, (which, miraculously managed to survive for all these years), and even the Urbanik's Paint building! All slated to be bull-dozed just to make way for over-flow parking! Insanity.

The number of small businesses being forced to close or re-locate is also kept vague. From what I could gather, that number is between 30 and 50. Among them, some of downtown Utica's most well-known and established: Clemente Novelties, Wilcor International, Urbanik's Paint, Metzler Printing, Rockford Auto and Glass, Eggers, Caryl & Corrigan, North Country Books, etc. Several of these business owners are nearing retirement. I personally know three who,

rather than going through the struggle of moving, plan on calling it quits after getting their appraisal and re-location checks. Two others I know are currently scouting locations outside of Utica. How this can be considered "growth" is beyond me.

What boggles my mind is the fact that the proposal ever even made it off of the drawing room table. That it's now actually being sold to everyone as a reasonable option, is an insult to all of us.

You know, there's another downtown Utica block (not in the current proposal's footprint) that, for many years, was also similarly dismissed as a hopelessly

neglected urban wasteland. I'm referring to the Genesee Street block between Oriskany Blvd and lower Whitesboro Street, now commonly referred to as Baggs Square West. It really wasn't all that long ago when it, too, sat dormantnothing more than a crippled single sided block of mostly vacant buildings that survived the disastrous "Urban Renewal" projects of the 1960?s and 70's. In fact, If it wasn?t for what it would've cost to demolish the 10 story Utica City National Bank Building there, that block, too, would be gone. Like the Columbia Street block now being exploited by the proposal's supporters, this block was regarded as nothing more than an dreary and desolate ghost-like remnant of the downtown that once was.

Well here we are some 40 years later. All it took were a few young entrepreneurs and dreamers to roll-up their sleeves. While everyone else saw nothing but a decaying urban wasteland, a few dreamers looked at that block and instead saw a unique urban asset, ripe with abundant possibilities and potential.

Today, that lower Genesee Street block houses some of the most progressive and successful newer small businesses in Utica: The Utica Bread Co., The Utica Coffee Roasting Company, and the Tailor and Cook restaurant. That?s what real urban progress is about - character and spirit. the two traits that play the most important role in defining any city. Not a massive and short sighted proposal calling for the bull-dozing of a full third of downtown.

No one is refuting the desperate need to regenerate that Columbia Street section of downtown Utica. What's needed is a reasonable proposal that doesn't require the senseless "collateral" demolition of an entire 25-35 acre swatch. In the meantime, we've had to live with that block being in decay for some 30 years now, and we certainly can wait a few more. If the politicians can't get their act together, one day the right mix of young dreamers and entrepreneurs will undoubtedly come along and see it as a unique urban asset, with an abundance of possibilities and potential. As far as the current proposal goes, we would be much wiser preserving the neighborhood, blemishes and all, for future dreamers and entrepreneurs. We owe it to them and to the future of Utica to do so.

Why would such a ridiculous proposal ever be put forward in the first place? It's an interesting question. The only thing I can figure is that it was to give local politicians a way to save face in view of the failure of the Marcy Nano Center to materialize. While I can understand and sympathize with their dilemma, sacrificing a third of Downtown Utica to help them save face, is simply too high of a price for Utica to pay.

To be honest, just the total hell that downtown business would have to endure during the minimum 5 years of destruction and construction is, in itself, unacceptable- particularly for a project that, while being sold as "growth" is, in reality, a dramatic downsizing.

There's no doubt that the proponents counted on the knee-jerk

"any-change-is-good" sentiment to move the proposal forward. Their challenge has always been to maintain that sentiment long enough to carry the proposal to the point of no return. There is no other explanation for the secrecy, lack of substantial public hearings, lack of details, and the invitation-only unveiling of its master plan. It's also pretty telling that a day after the first "real" public hearing, where 60% of those polled were in favor of the St. Luke's site, letters of intent-to-purchase went out to downtown Utica building owners. So, exactly what was the purpose of the so-called public hearing if there never was any intention for the public's input to matter?
No one is against building a new regional state-of-the-art hospital. It just doesn't take a brain scientist to conclude that the most suitable location

would be the present site of St Lukes. Plenty of land, minimal disruption due to construction, etc, etc. Choosing downtown Utica was just a PR stunt to bolster the visibility of the project for the sake of politicians.
The assertion that a downtown hospital will have a huge positive economic impact on the city is such political nonsense that I hate even addressing the myth. Think Fort Stanwix in Rome. The (in perpetuity) loss to the city tax rolls alone would ultimately amount to millions of dollars (lasting forevermore, and not just 1 year). Hospitals are tax exempt and self-contained. They come complete with their own cafeterias, gift shops, and florists. Other cities have regretfully taken this route. If you?re so inclined, there are many studies verifying the lack of economic impact that these recently built facilities have had on the communities they?ve been built in. Keep in mind that the proposal combines EXISTING local hospitals. No new jobs would be created. In fact, mergers usually result in job losses. And as far as the temporary construction jobs created, just like the Rt. 12 Arterial Project, large outside firms with New York State connections will be called in. Either way, any regional economic boost stemming from actual construction, will occur whether the hospital is built in Utica or the obviously more sensible, St Luke?s location.
In fact, studies of the impact of similar urban projects show that the only "real" economic benefit (which is dramatically offset by the over-the-years loss to city tax rolls) will be reaped by bar owners within 5 blocks of the facility, serving after work drinks to hospital employees. While this may indeed be something to raise a glass to- once again, it 's certainly not a good reason to tear down a third of downtown Utica

Dear Mr. Cuomo:
I just found out that the 300-million-dollar grant, or whatever it's called, specifies that the new hospital must be located in "the largest population center" in Oneida County. First of all, why the double talk about the largest population center, as if there is any question about what that is? Why not just say this hospital must be built within the boundaries of Utica, NY? But, the most important question, what is the reasoning behind tying this grant to a Utica location only? Being the cynic that I am, I could suggest some possible reasons, but I would like to see what yours are.
Best regards,

December 6, 2017

New York State Health Department
Corning Tower
Empire State Plaza
Albany, New York 12237

Greetings:

I oppose the building of a new hospital downtown. We don't need a new hospital.
A few of my concerns:

Why is it that one or two people are making the decision about a new hospital that the Utica tax papers have to pay taxes for the hospital? Why would they make this huge decision for the people of this area? Who will be paying for the parking garage we the taxpayers will have to pay for the garage?

The buildings in the city where the hospital will be built has old buildings and we will have to pay for the demolition who will pay for the cost of the demolition, plus removing the lead and asbestos in the buildings.

Because of the thinking of a few people, they are considering brand new, co-located and combined DPW/Parks Department/Police Station/City Courts (the tax papers are still paying for the Police Maintenance facility which was built in 2005 all at the City's taxpayers' expense.

What if there was a disaster one hospital?

A personal friend of mine has a [redacted] and has to be treated out of Utica because we don't have the facility to deal with children.

What about the red zone evacuation?

What will happen to the St. Elizabeth's and St. Luke's hospital buildings – leave them empty.

By putting the hospital downtown, they think the city will be rebirth.

The number of the two hospitals combined is not enough now and having one hospital with less beds is crazy! How many ER beds will be available?

Employees will be laid off if we build a new hospital.

Sincerely,

[redacted]

There is growing unhappiness in Oneida County and the City of Utica over the continued march to place a hospital into Downtown Utica. We have documented three years of concerns and this discontent here: www.NoHospitalDowntown.com

We see a Downtown Utica that is rebounding without a hospital and realize future nanotechnology workers, while wanting a new facility for healthcare, seek an interesting city life. A hospital in Utica's urban core is much more likely to become a poor and blighted neighborhood like that surrounding

Syracuse's St. Joseph hospital - and most urban hospitals are surrounded by lower value properties and demographic.

Utica is poor, our childhood poverty rates prove this. Downtown is no place for this "hospital as economic development" experiment. I'm worried that the Mohawk Valley Health Systems has continued to fail in providing a list of urban hospitals that have revitalized downtowns. It is probably the case because no such list exists!

Would you please write me with your personal answers to three questions:

1) Do you support a Downtown Utica hospital?

2) Is the $300 million in funding for the Oneida County hospital only for use in downtown?

3) Do you support government's taking private property only turn around and making it available to another private business?

Thank you in advance for your time and consideration.

[redacted]

#NoHospitalDowntown

PS- We are positioned for a long eminent domain court battle should local leaders continue to ignore taxpayers and residents.

Dear Governor Cuomo:
I ask that you please pay attention to the majority of taxpayers and voters in CNY. This is what we are up against with facing a downtown hospital that the majority of taxpayers and voters are against. Please, pay attention as

we are all referred to as idiots and a few comments referring to you as an idiot that I will let you look up yourself.
http://www.uticaod.com/assets/pdf/NY29824111.PDF
The evidence is very clear, politicians, MV EDGE, lawyers/lobbyist/ and other vendors "pushed and cajoled" the hospital team into downtown. This while believing and marketing the Columbia Lafayette Neighborhood is a dump, a "teardown start over area" anad that a hospital could rejuvenate it. This without NOT ONE example of an any urban hospital that has revitalized a downtown neighborhood (Hey "yes people", we're still waiting for that list).
This aside, never thought caring for my downtown would bring such scorn! Just two emails (a cut and pasted from page 559), that appear just after MVHS announces in the UticaOD, "Hospital Going Downtown" and as Mr Brindisi is explaining that government officials should quickly prepare a follow-up letter for the UticaOD print...
On Tuesday, September 22, 2015, Steven DiMeo wrote:
What kind of reaction are you getting to the hospital announcement?
From: Anthony Brindisi
Sent: Wednesday, September 23, 2015 6:38 AM
To: Steven DiMeo
Cc: Picente, Anthony
Subject: Re: Hospital
I'm getting mostly positive comments. I spoke to several business owners downtown who were very excited. There are some comments on my FB page about traffic, why a new hospital, loss of tax base, etc. These comments can easily be combated in a thoughtful response. That's why I think the op-Ed is a good start. If we don't have a communication strategy, the idiots will fill the vacuum left by our silence.

Worst proposal in Utica's 200 year history!!!!

[redacted]

Wed 12/13/2017 9:34 AM

To doh sm.CONS <cons@health.ny.gov>;

ATTENTION: This email came from an external source. Do not open attachments or click on links from unknown senders or unexpected emails.

While a knee-jerk “any change is good ” response to the Downtown Utica Hospital proposal is understandable, given the probable magnitude of its irreversible consequences, it is also irresponsible. Any plan calling for the demolition of a third of any city's downtown, warrants a respectable amount of consideration, debate, and dialogue, before being matter-of-factly embraced as progress by residents or community leaders.

Proponents of the downtown hospital would like you focused on a single long-neglected Columbia Street block, but the truth is that the block they're exploiting represents only a tiny fraction of what the project will consume. The proposal (almost unbelievably) calls for bulldozing an entire 25 - 35 acre span of Downtown Utica. It is massive, reactionary, and, most importantly, irreversible. It stretches north to south- from Oriskany Boulevard to Columbia Street, and, east to west- from Broadway (Bengees) to the Arterial overpasses on Lafayette, and Columbia Streets! Pointing to a single long-neglected block as justification for the magnitude of demolition they're talking about is misleading and deceitful. Let there be no mistake: what’s being proposed is the most massive and consequential demolition in Utica’s nearly 200 year history.

It's difficult to get an actual count as to the number of buildings proposed for demolition. That number, and the site's most southern and northern borders, seem to be purposely kept vague. Most likely, to help maintain the prevailing "any change is good-change" sentiment. Whether the number is 50 or 150, in spite of what they'd like you to believe, the vast majority of these buildings are indeed occupied and on the city tax-rolls!

At the heart of the proposed site, are a myriad of under-appreciated historic structures scattered in and around a couple of alleyways. One can even argue that the alleys themselves can be considered increasingly-rare historic artifacts, without which, the bustling downtown storefronts of yesteryear would not have been possible. Hell, just on the western edge of the site alone, slated for demolition, are: the grand turn-of-the-century building that once housed the landmark “Columbia Restaurant,” the Witzeberger Building on Columbia and State (an undisputed architectural treasure in it's own right), the lovely group of historic turn-of-the-century "Row Houses” on Lafayette, near the corner of State, (which, miraculously managed to survive for all these years), and even the Urbanik's Paint building! All slated to be bull-dozed just to make way for over-flow parking! Insanity.

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What boggles my mind is the fact that the proposal ever even made it off of the drawing room table. That it's now actually being sold to everyone as a reasonable option, is an insult to all of us.

You know, there's another downtown Utica block (not in the current proposal's footprint) that, for many years, was also similarly dismissed as a hopelessly neglected urban wasteland. I'm referring to the Genesee Street block between Oriskany Blvd and lower Whitesboro Street, now commonly referred to as Baggs Square West. It really wasn't all that long ago when it, too, sat dormant- nothing more than a crippled single sided block of mostly vacant

buildings that survived the disastrous "Urban Renewal" projects of the 1960's and 70's. In fact, If it wasn't for what it would've cost to demolish the 10 story Utica City National Bank Building there, that block, too, would be gone. Like the Columbia Street block now being exploited by the proposal's supporters, this block was regarded as nothing more than an dreary and desolate ghost-like remnant of the downtown that once was.

Well here we are some 40 years later. All it took were a few young entrepreneurs and dreamers to roll-up their sleeves. While everyone else saw nothing but a decaying urban wasteland, a few dreamers looked at that block and instead saw a unique urban asset, ripe with abundant possibilities and potential.

Today, that lower Genesee Street block houses some of the most progressive and successful newer small businesses in Utica: The Utica Bread Co., The Utica Coffee Roasting Company, and the Tailor and Cook restaurant. That's what real urban progress is about - character and spirit. the two traits that play the most important role in defining any city. Not a massive and short sighted proposal calling for the bull-dozing of a full third of downtown.

No one is refuting the desperate need to regenerate that Columbia Street section of downtown Utica. What's needed is a reasonable proposal that doesn't require the senseless "collateral" demolition of an entire 25-35 acre swatch. In the meantime, we've had to live with that block being in decay for some 30 years now, and we certainly can wait a few more. If the politicians can't get their act together, one day the right mix of young dreamers and entrepreneurs will undoubtedly come along and see it as a unique urban asset, with an abundance of possibilities and potential. As far as the current proposal goes, we would be much wiser preserving the neighborhood, blemishes and all, for future dreamers and entrepreneurs. We owe it to them and to the future of Utica to do so.

Why would such a ridiculous proposal ever be put forward in the first place? It's an interesting question. The only thing I can figure is that it was to give local politicians a way to save face in view of the failure of the Marcy Nano Center to materialize. While I can understand and sympathize with their dilemma, sacrificing a third of Downtown Utica to help them save face, is simply too high of a price for Utica to pay.

To be honest, just the total hell that downtown business would have to endure during the minimum 5 years of destruction and construction is, in itself, unacceptable- particularly for a project that, while being sold as "growth" is, in reality, a dramatic downsizing.

There's no doubt that the proponents counted on the knee-jerk "any-change-is-good" sentiment to move the proposal forward. Their challenge has always been to maintain that sentiment long enough to carry the proposal to the point of no return. There is no other explanation for the secrecy, lack of substantial public hearings, lack of details, and the invitation-only unveiling of its master plan. It's also pretty telling that a day after the first "real" public hearing, where 60% of those polled were in favor of the St. Luke's site, letters of intent-to-purchase went out to downtown Utica building owners. So, exactly what was the purpose of the so-called public hearing if there never was any intention for the public's input to matter?

No one is against building a new regional state-of-the-art hospital. It just doesn't take a brain surgeon to conclude that the most suitable location would be the present site of St Lukes. Plenty of land, minimal disruption due to construction, etc, etc. Choosing downtown Utica was just a PR stunt to bolster the visibility of the project for the sake of politicians.

The assertion that a downtown hospital will have a huge positive economic impact on the city is such political nonsense that I hate even addressing the myth. Think Fort Stanwix in Rome. The (in perpetuity) loss to the city tax rolls alone would ultimately amount to millions of dollars (lasting forevermore, and not just 1 year). Hospitals are tax exempt and self-contained. They come complete with their own cafeterias, gift shops, and florists. Other cities have regretfully taken this route. If you're so inclined, there are many studies verifying the lack of economic impact that these recently built facilities have had on the communities they've been built in. Keep in mind that the proposal combines EXISTING local hospitals. No new jobs would be created. In fact, mergers usually result in job losses. And as far as the temporary construction jobs created, just like the Rt. 12 Arterial Project, large outside firms with New York State connections will be called in. Either way, any regional economic boost stemming from actual construction, will occur whether the hospital is built in Utica or the obviously more sensible, St Luke's location.

In fact, studies of the impact of similar urban projects show that the only "real" economic benefit (which is dramatically offset by the over-the-years loss to city tax rolls) will be reaped by bar owners within 5 blocks of the facility, serving after work drinks to hospital employees. While this may indeed be something to raise a glass to- once again, it 's certainly not a good reason to tear down a third of downtown Utica.

[redacted]

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The Utica Custom Shirt Company
315/731-7845

Application Number:	172305
Facility Name:	Faxton-St Lukes Healthcare St Lukes Division
Project Description:	Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Created By:	Henry Joseph , State Environmental Quality Review **on** 11/14/2017
Correspondence Type:	Request for Additional Information
Recipient:	Applicant
Correspondence Visible To:	All

Message:

Dear Applicant: In accordance with 10 NYCRR 97.14 and 6 NYCRR 617.4, the proposed project appears to be a State Environmental Quality Review (SEQR) Type I Action. Please provide the SEQR Summary of Findings for the project upon completion of the SEQR. Should you have any questions, please call 518-402-0904.

Created By: Applicant **on** 11/28/2017
Correspondence Type: Request for Additional Information
Recipient: State Environmental Quality Review
Correspondence Visible To: All
Message:
Please find attached, a response to the State Environmental Quality Review's November 14, 2017 request for additional information.
Attachments:
172305 - Mohawk Valley SEQR Response 11-28-17.PDF **

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

November 10, 2017

Ms. Patricia Smyth
Cicero Consulting Associates
701 Westchester Avenue, Suite 210W
White Plains, New York 10604

Re: 172305-C
Faxton-St Lukes Healthcare St Lukes Division
(Oneida County)
Construct a new 373-bed replacement hospital
on a 25-acre parcel in Utica

Dear Ms. Smyth:

The above referenced Certificate of Need application, for which you have been designated the contact person, has been received by the Bureau of Project Management for processing and has been distributed to all necessary reviewing units and, if operating, your local health systems agency, in accordance with 10 NYCRR 710. Please refer to the enclosed Important Notice for further information with respect to this process.

The mandatory review of your project for the criteria required by the Public Health Law may determine that the proposal is not approvable. Therefore, prior to entering into any contractual commitments or commencing construction, the final determination of the Director of the Offices of Primary Care and Health Systems Management or the Public Health and Health Planning Council must be obtained.

If you have any questions regarding this project, please do not hesitate to contact me or my staff at (518) 402-0911.

Sincerely,

Barbara DelCogliano
Deputy Director
Division of Planning and Licensure

Enclosure
BD/MRC/ss

IMPORTANT NOTICE

TO: Applicants

FROM: Bureau of Project Management

SUBJECT: Additional Information Concerning the Processing of Your CON Application

All correspondence from the Department of Health (DOH) will be directed to the contact person identified in this application. Should the contact person change during processing, written notification should be made to the Bureau of Project Management. Please identify all subsequent submissions (correspondence, plans, additional information, etc.) with the assigned project number.

You may receive requests for additional information from DOH. Please respond within the time frame noted to assure that further processing is not delayed. You may also voluntarily submit any additional information which you believe might facilitate the review of your proposal, unless specific deadlines have otherwise been established. 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 revising the project. If your application is required to be presented at the Public Health and Health Planning Council, the transmission of additional information must be received sufficiently in advance of the application's presentation to enable distribution and review, since it is the desire of DOH not to defer action on applications that are scheduled for council meetings.

Questions or comments with respect to this application should be addressed to the Bureau of Project Management at (518) 402-0911.

Revised: 12/30/2010

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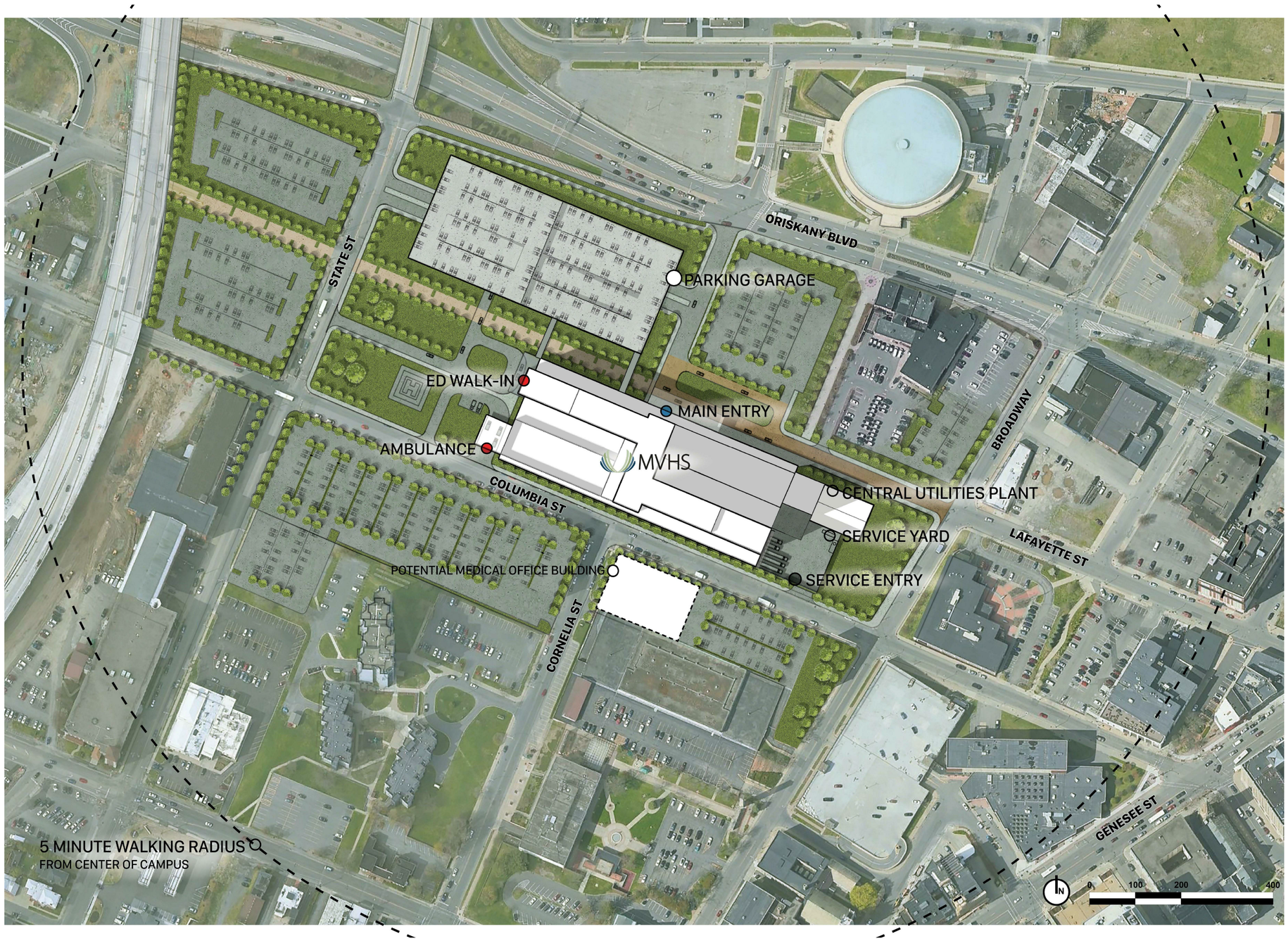

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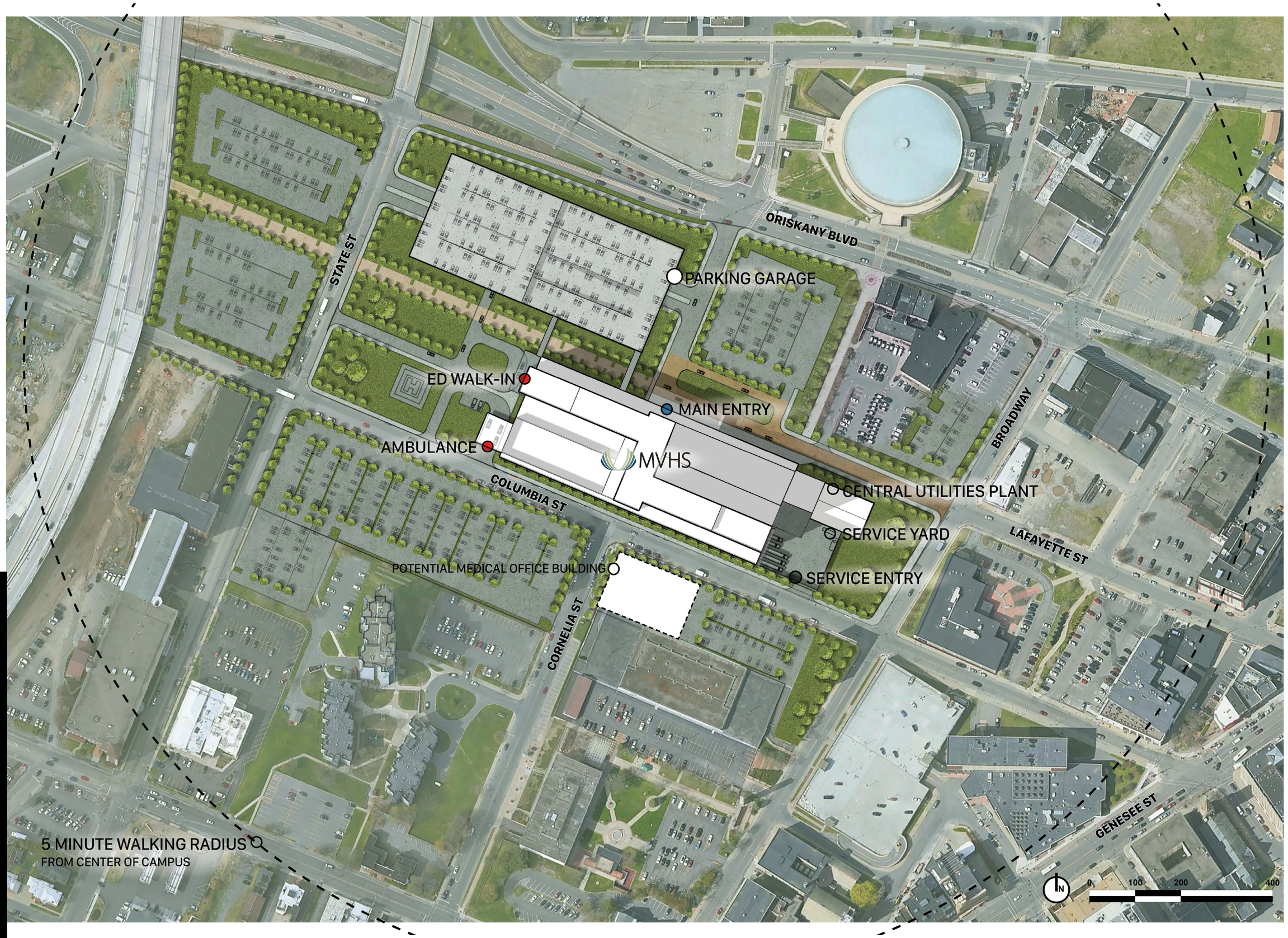

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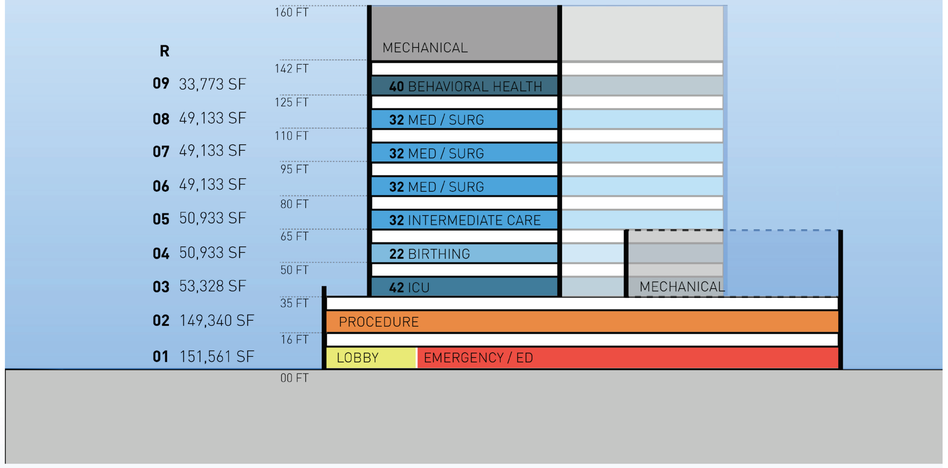

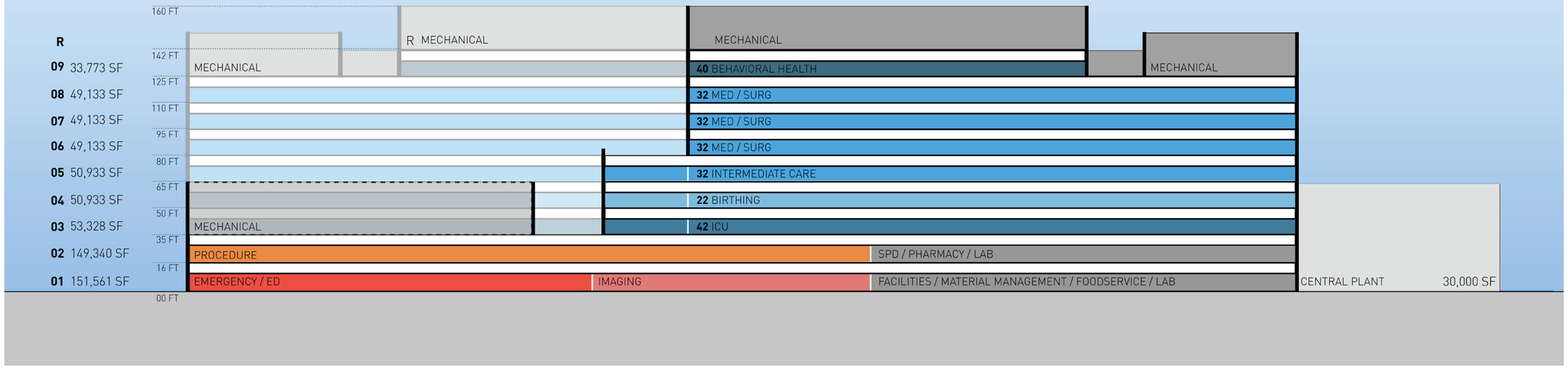

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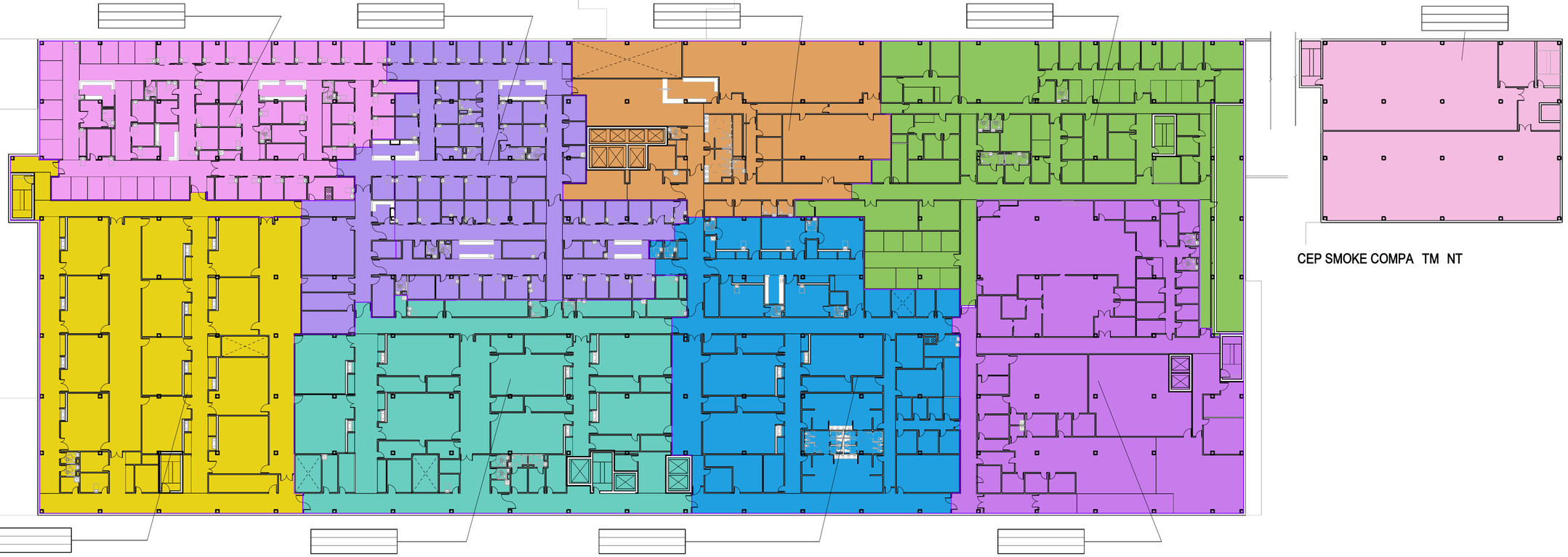

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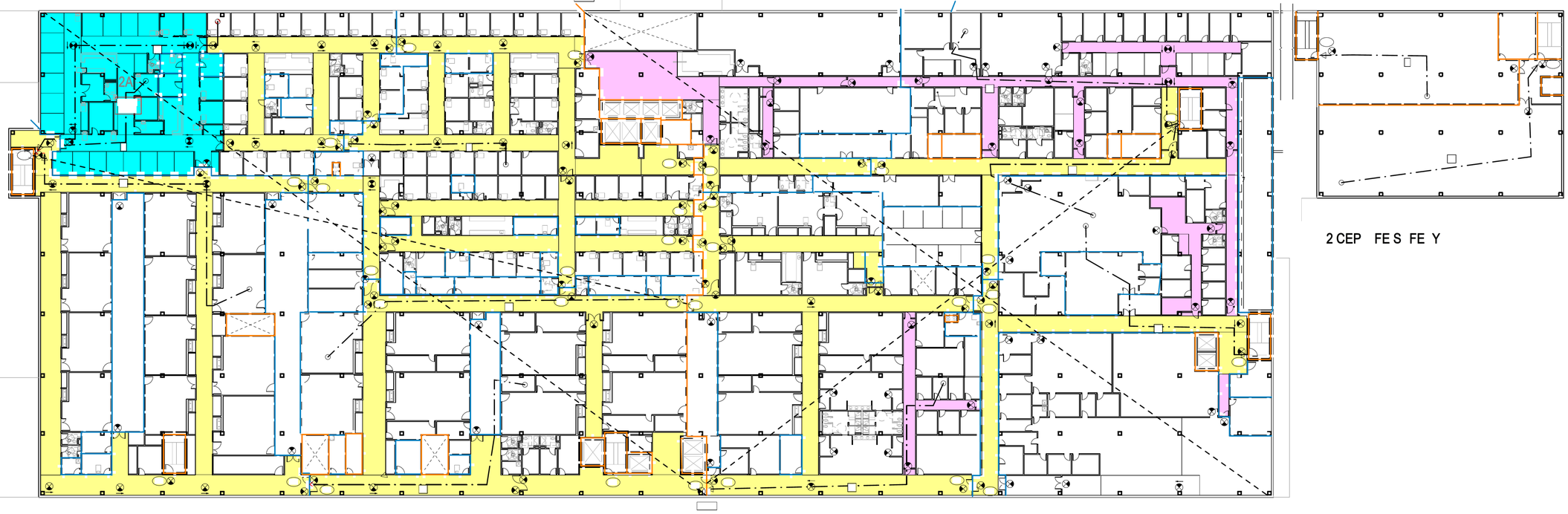

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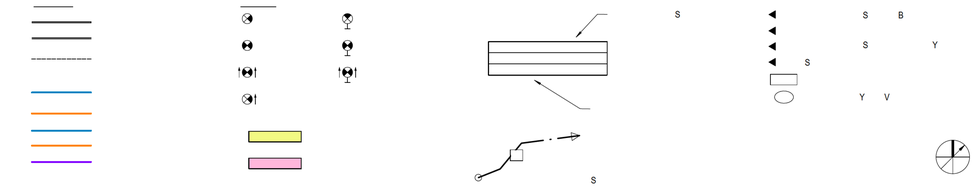

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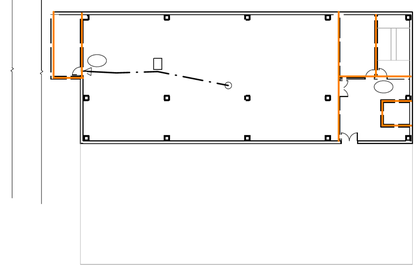

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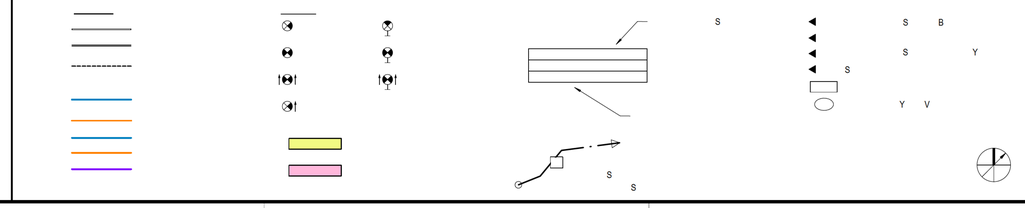

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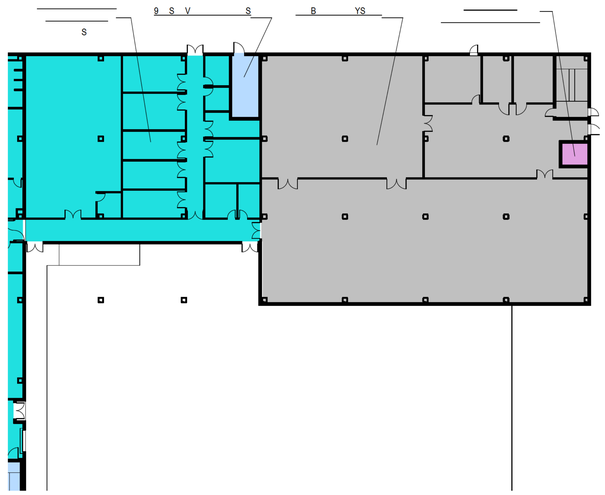

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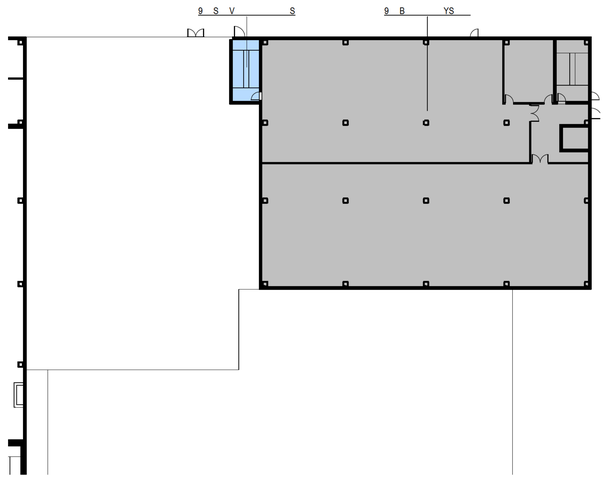

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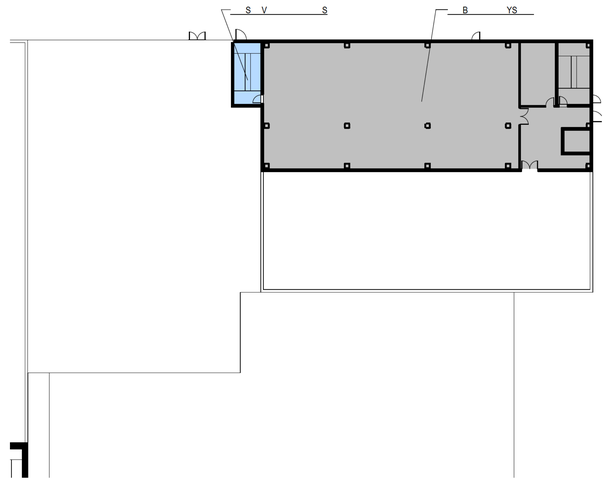

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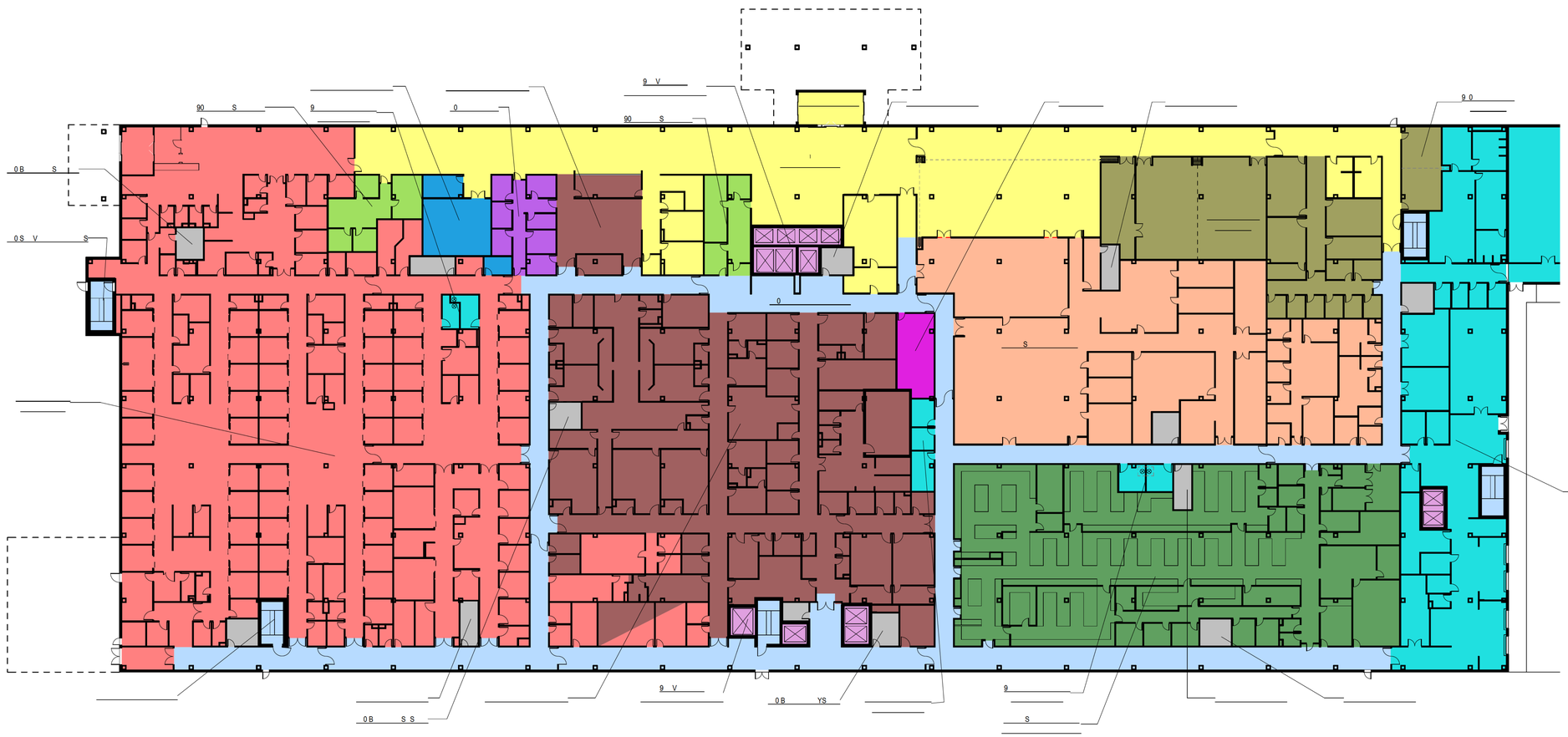

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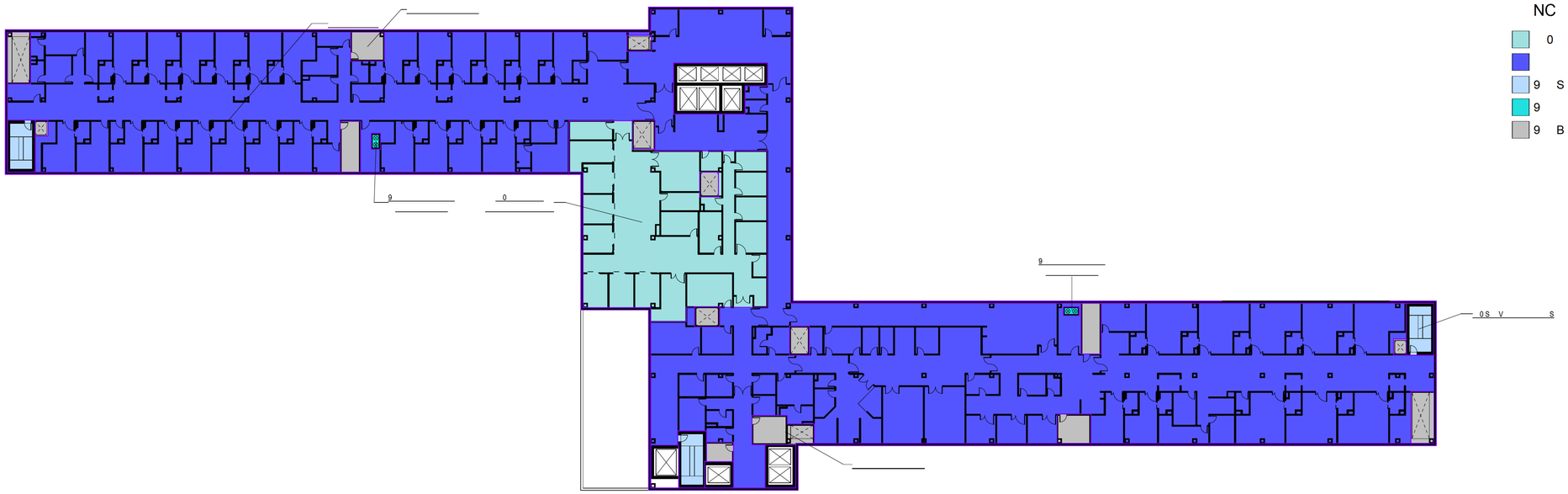

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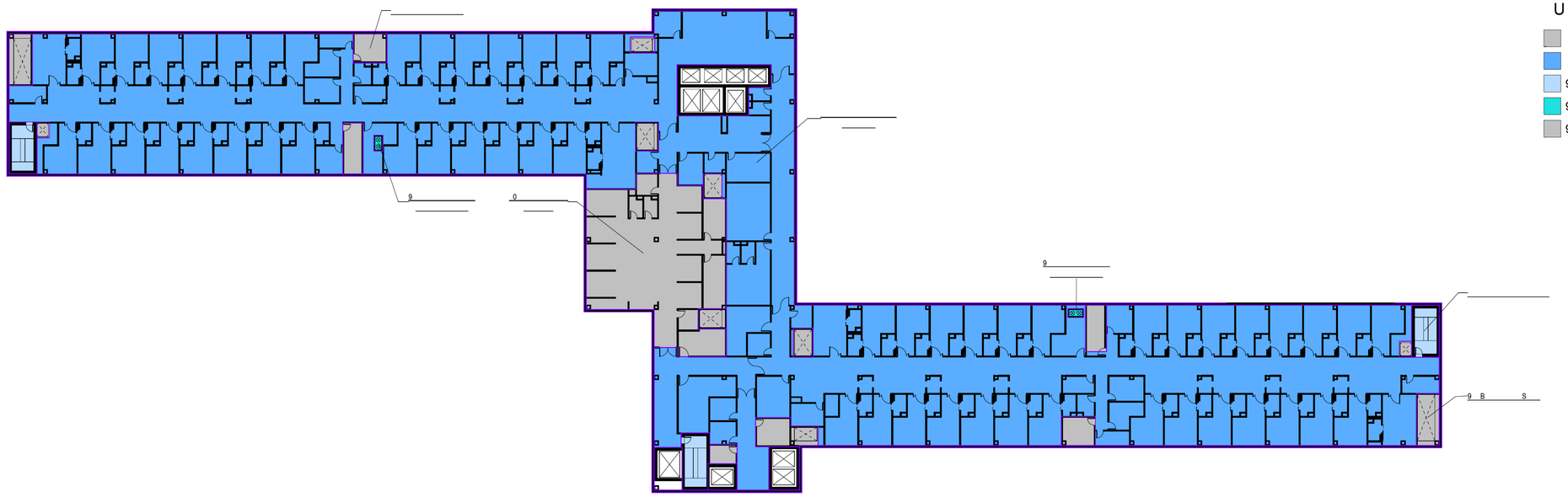

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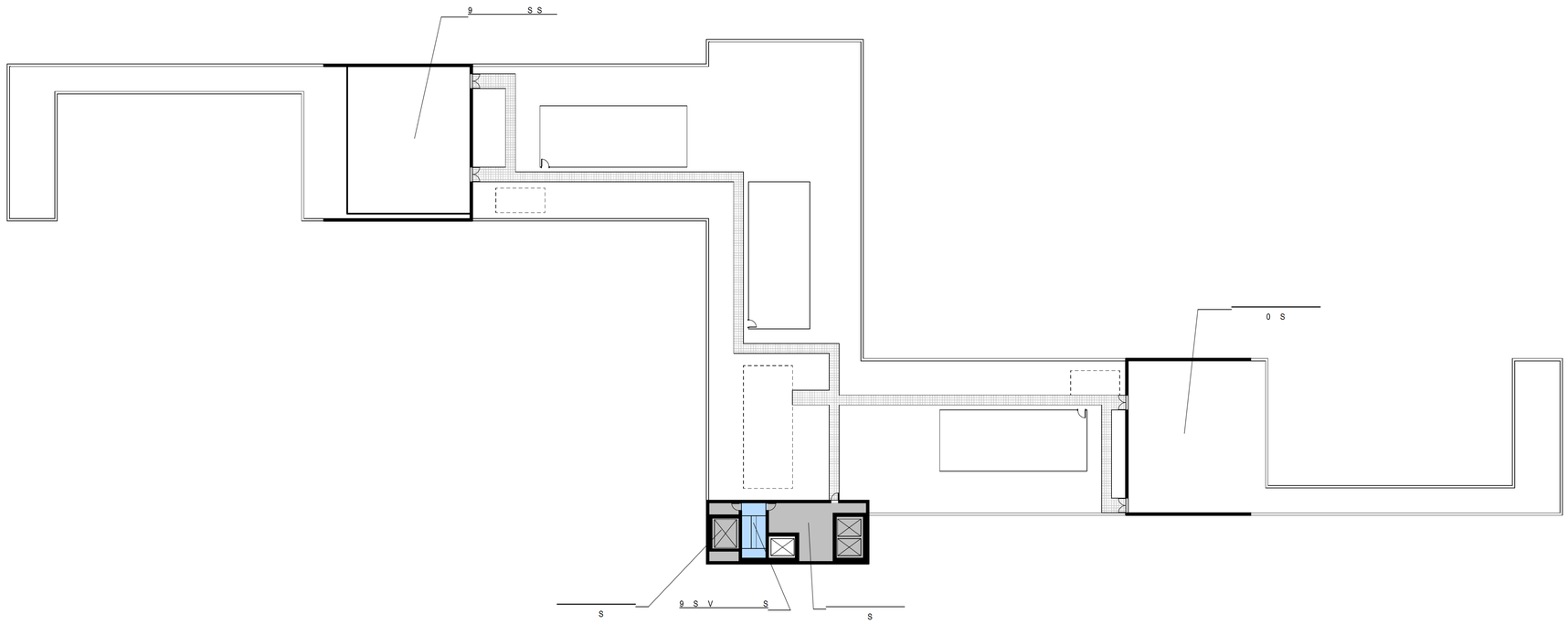

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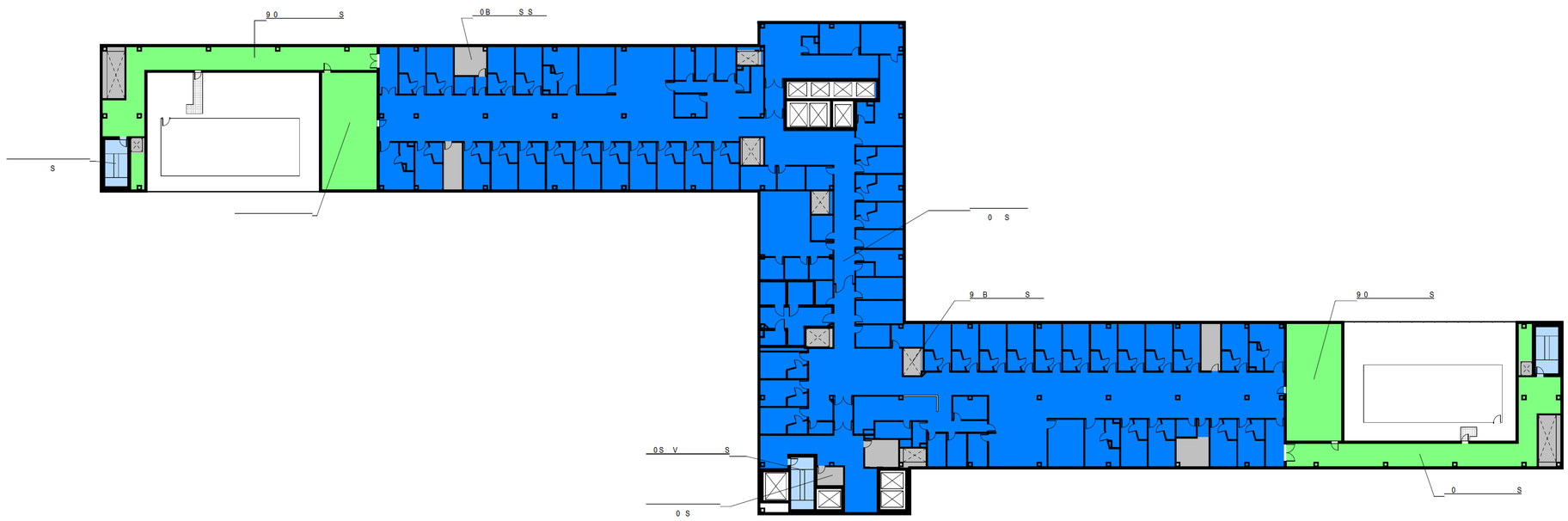

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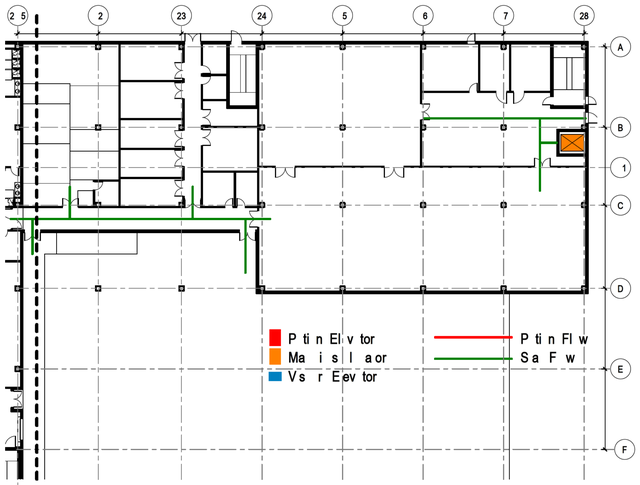

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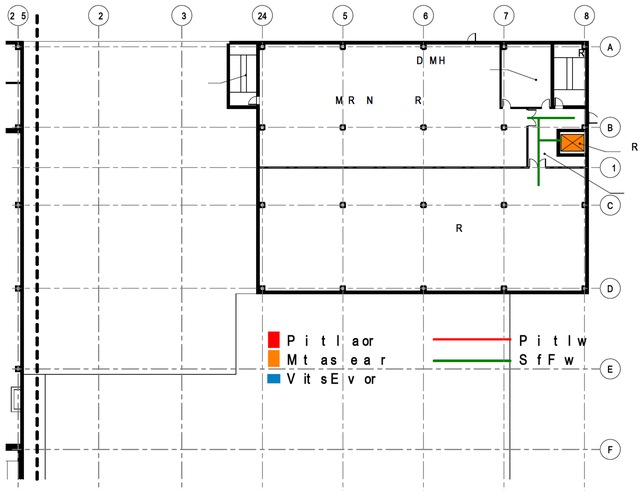

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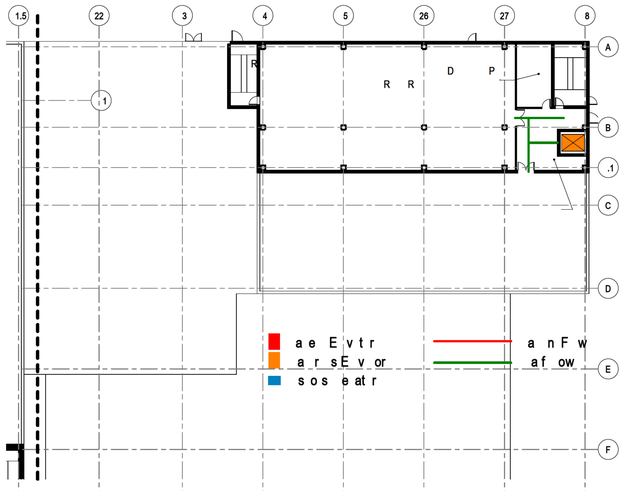

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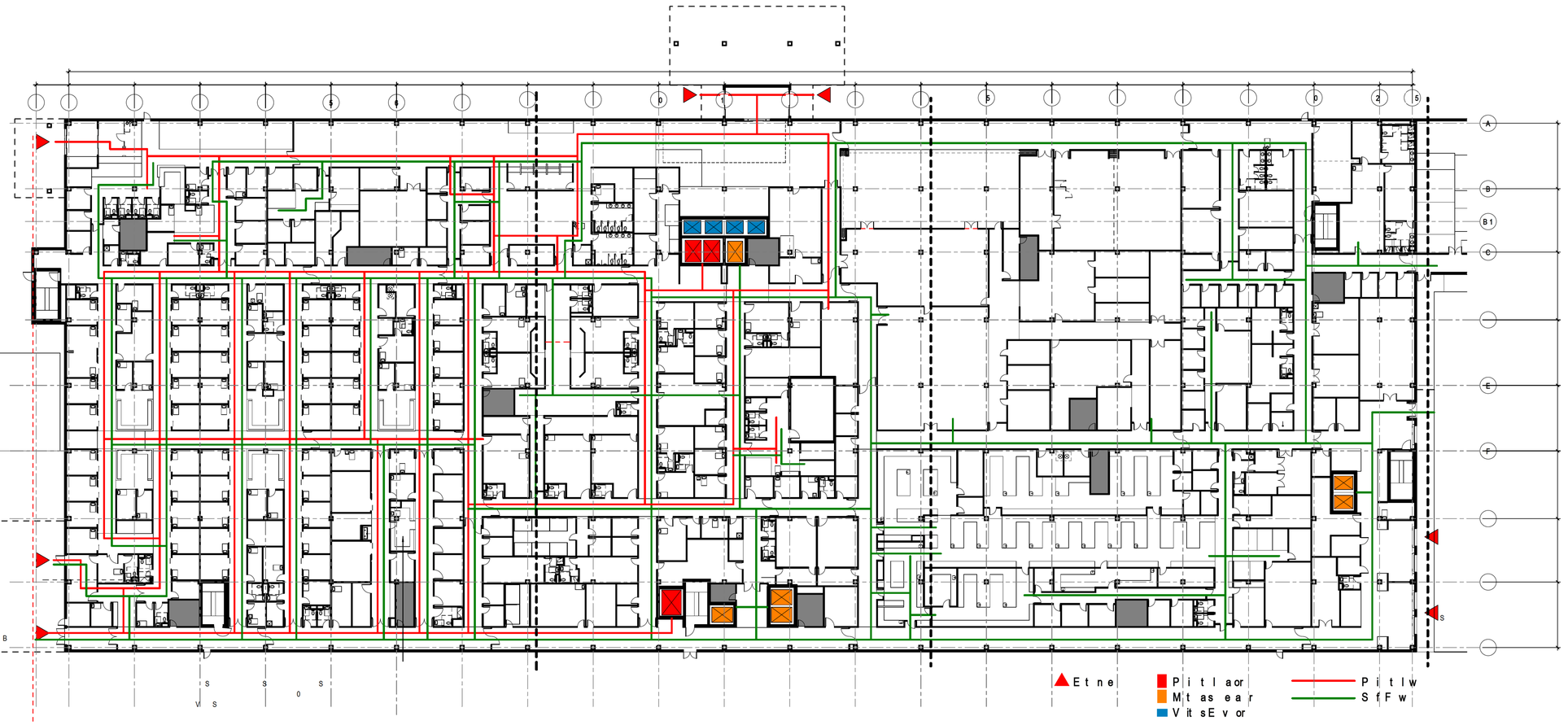

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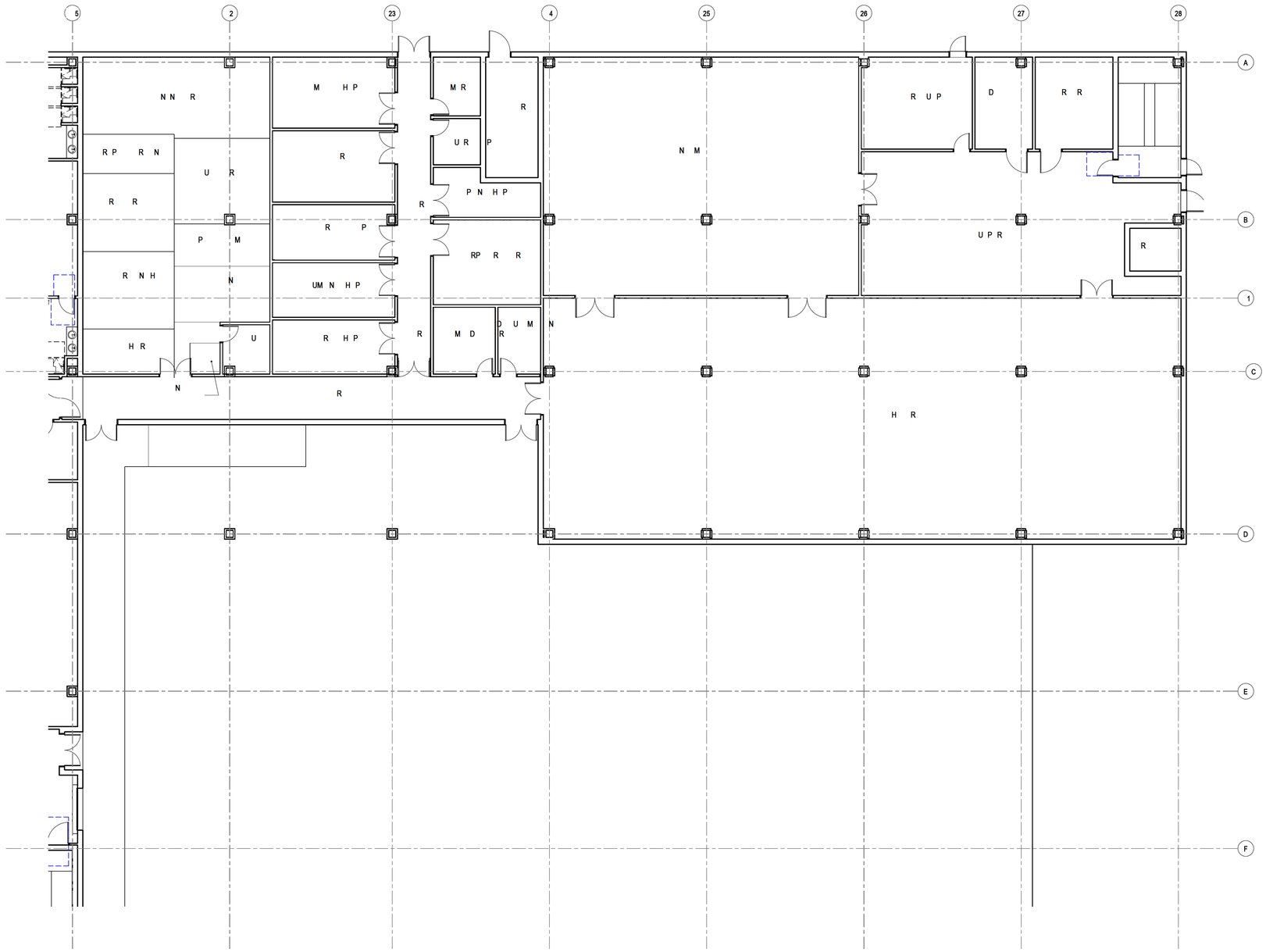

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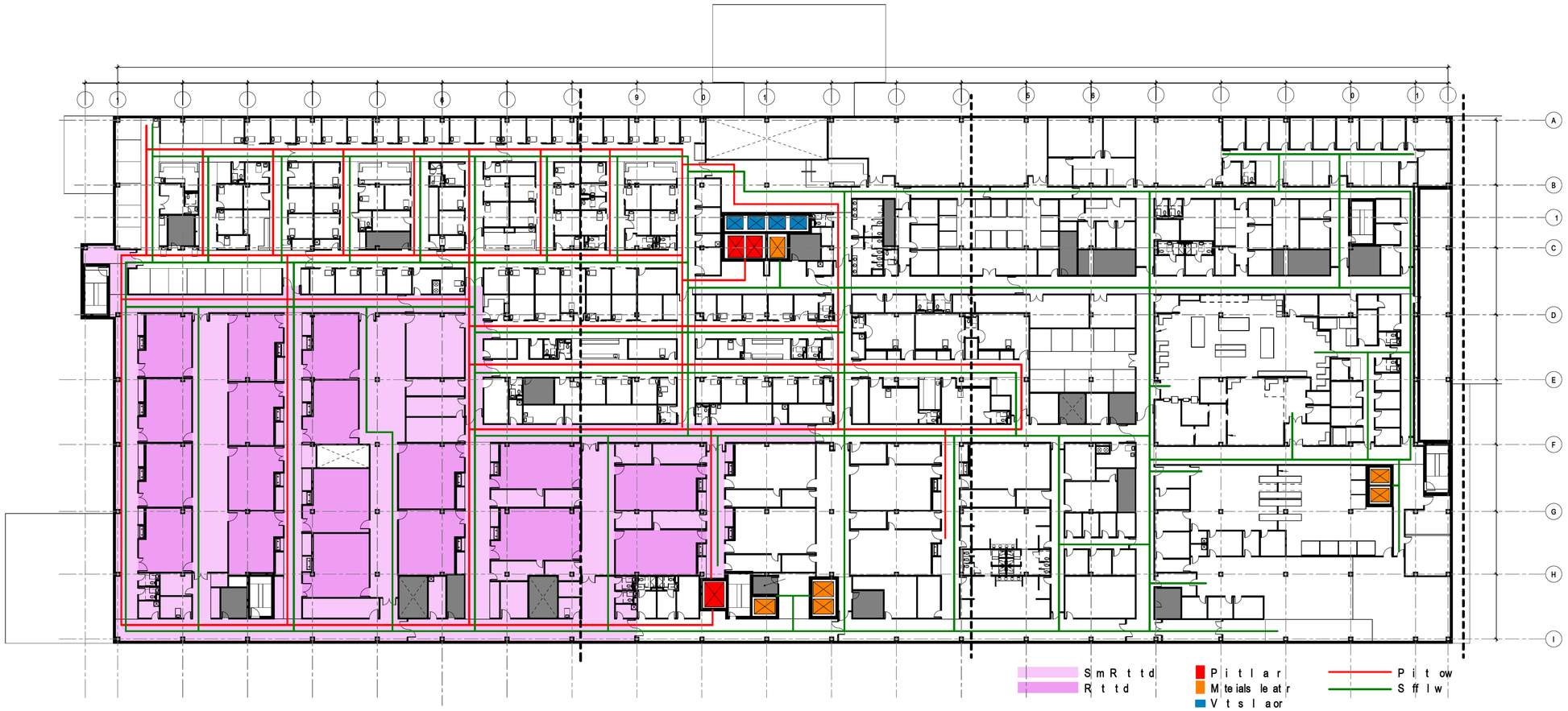

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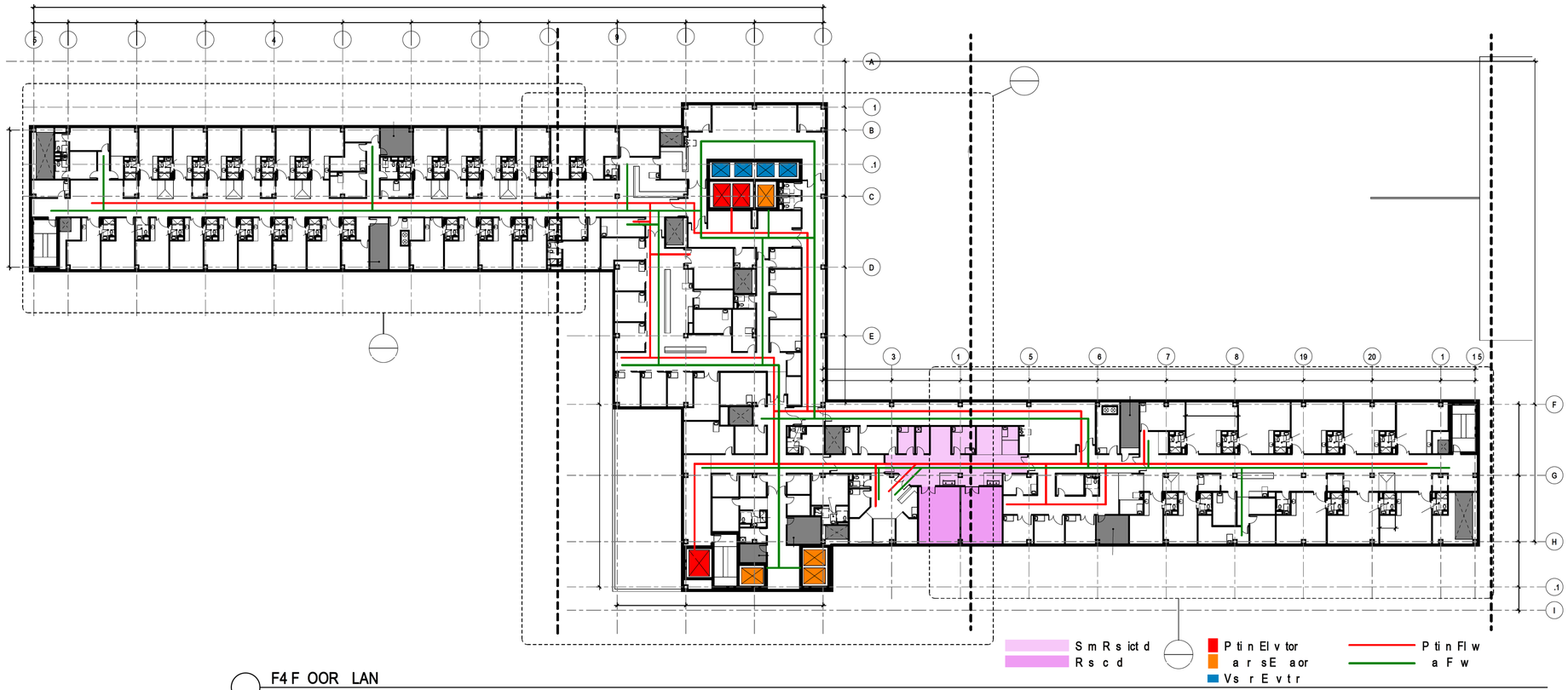

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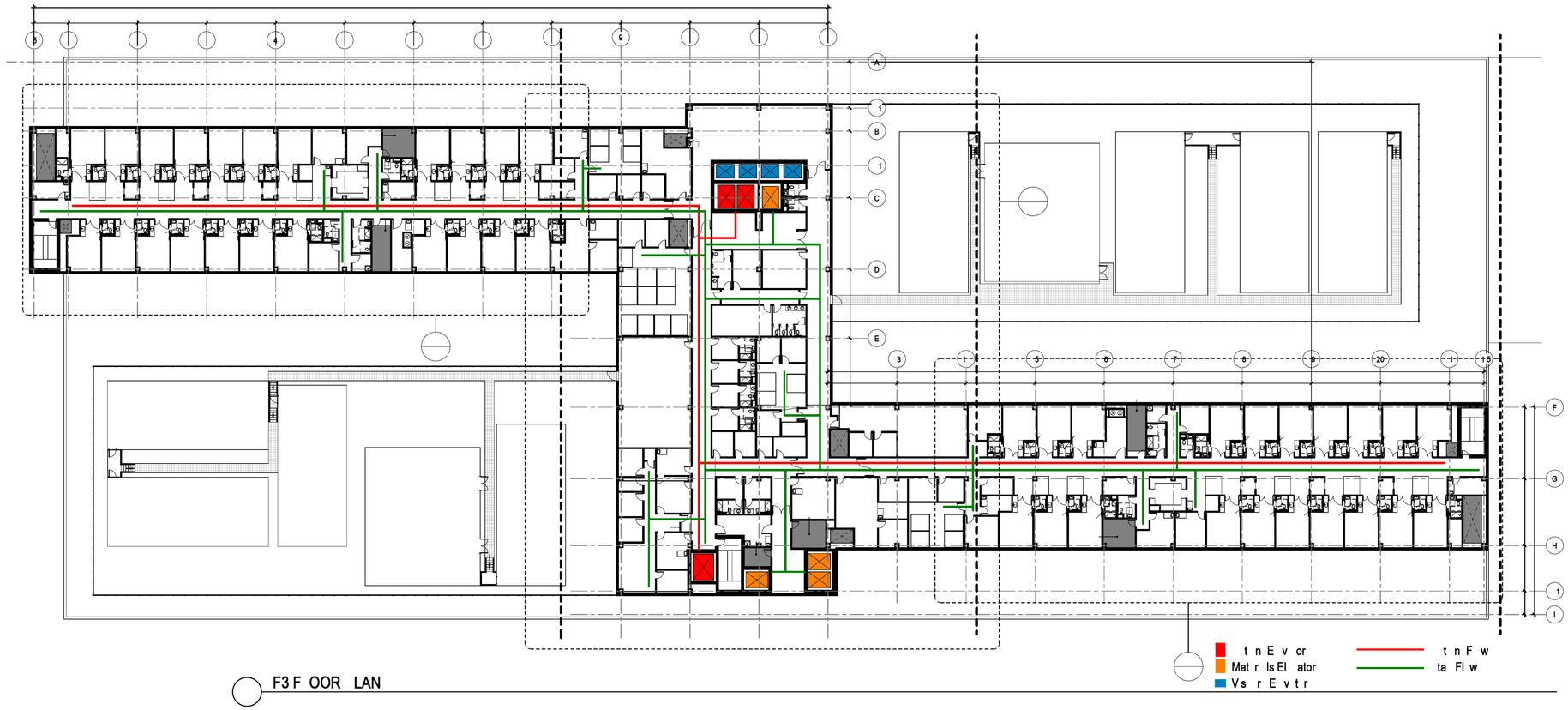

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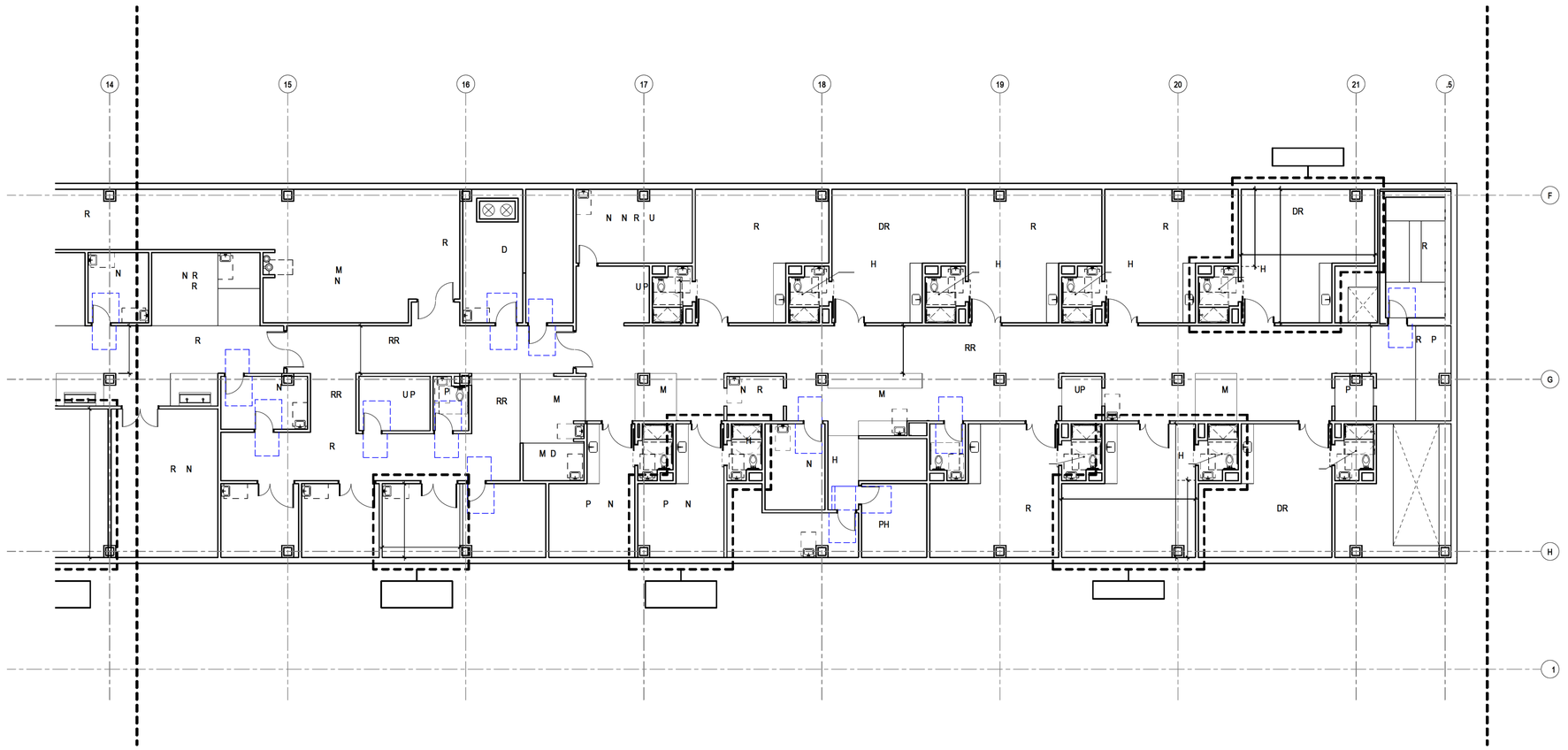

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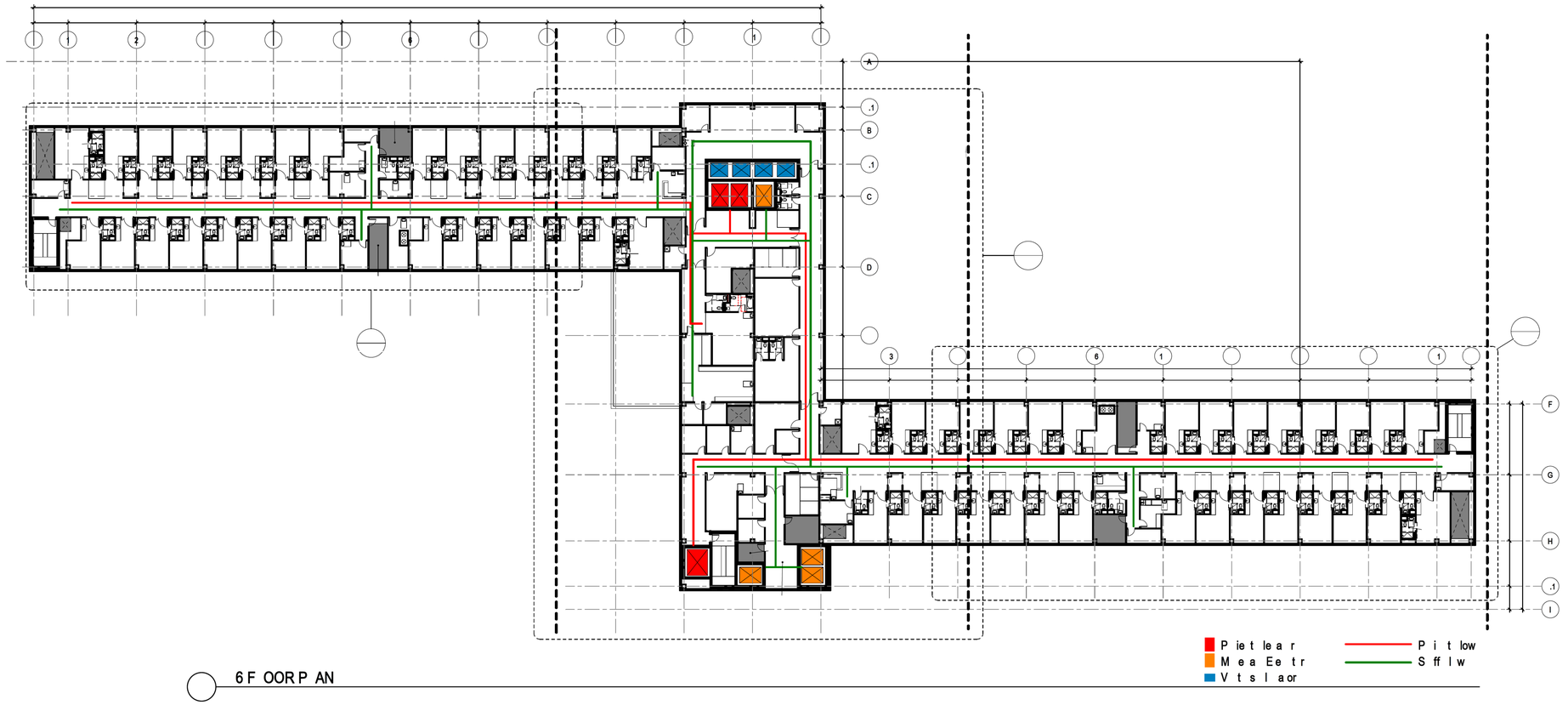

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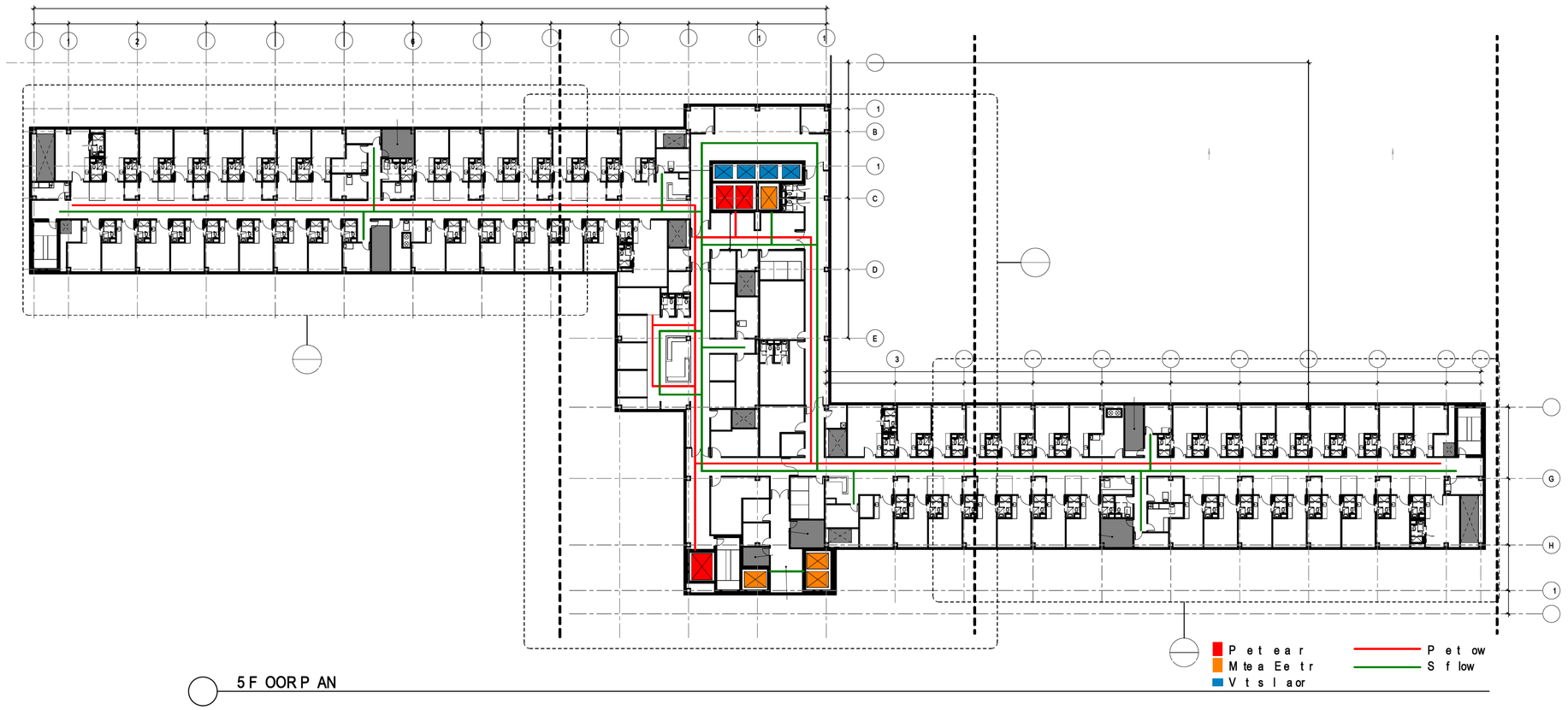

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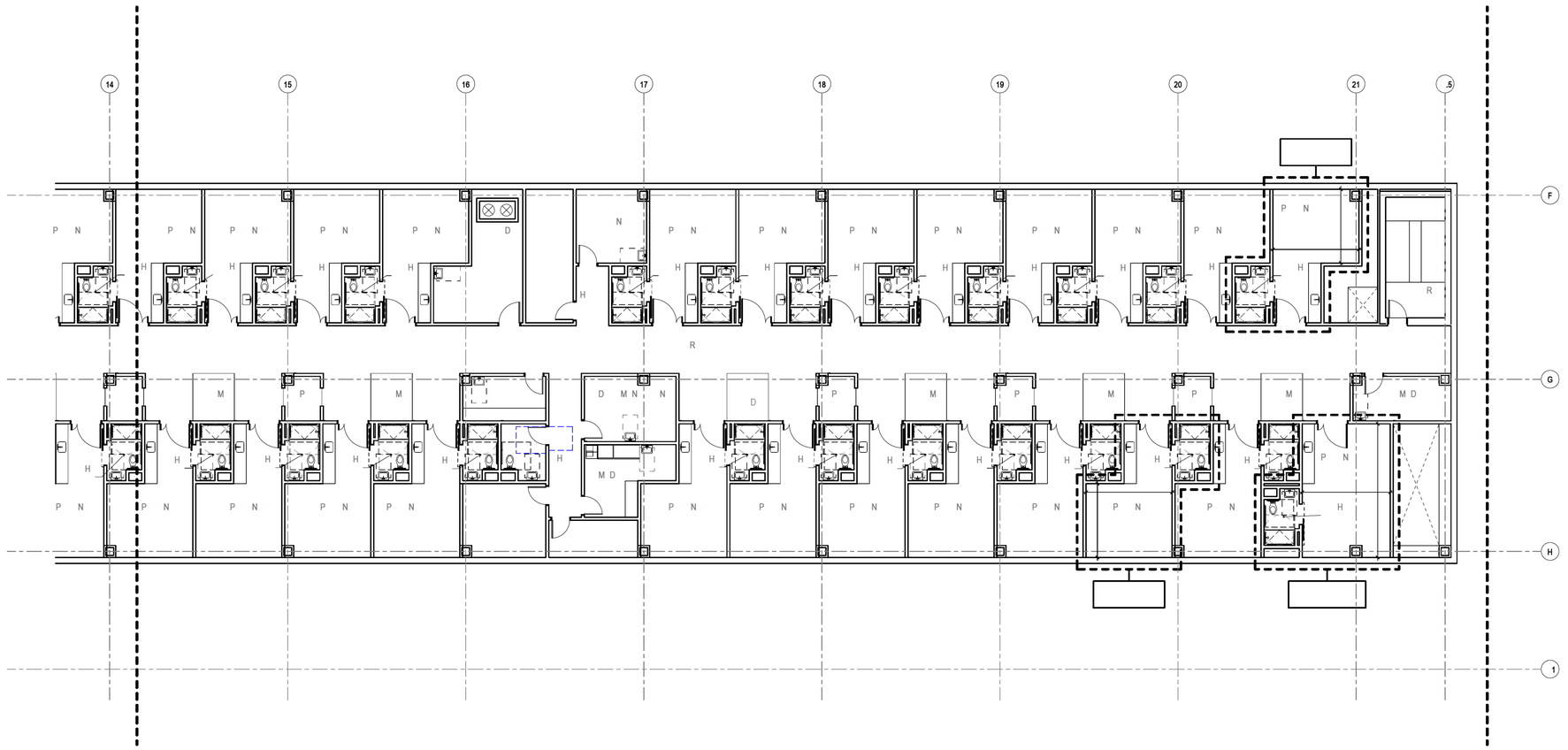

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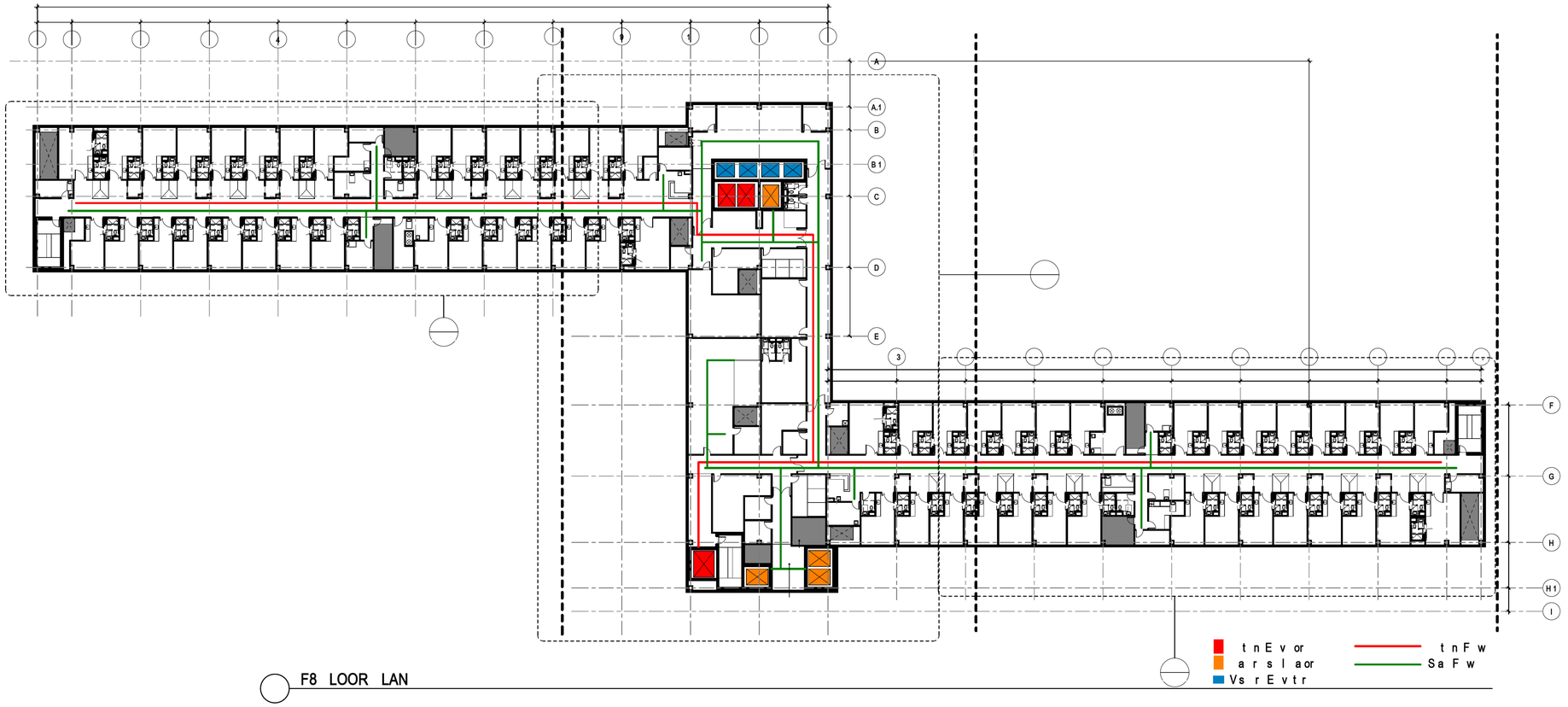

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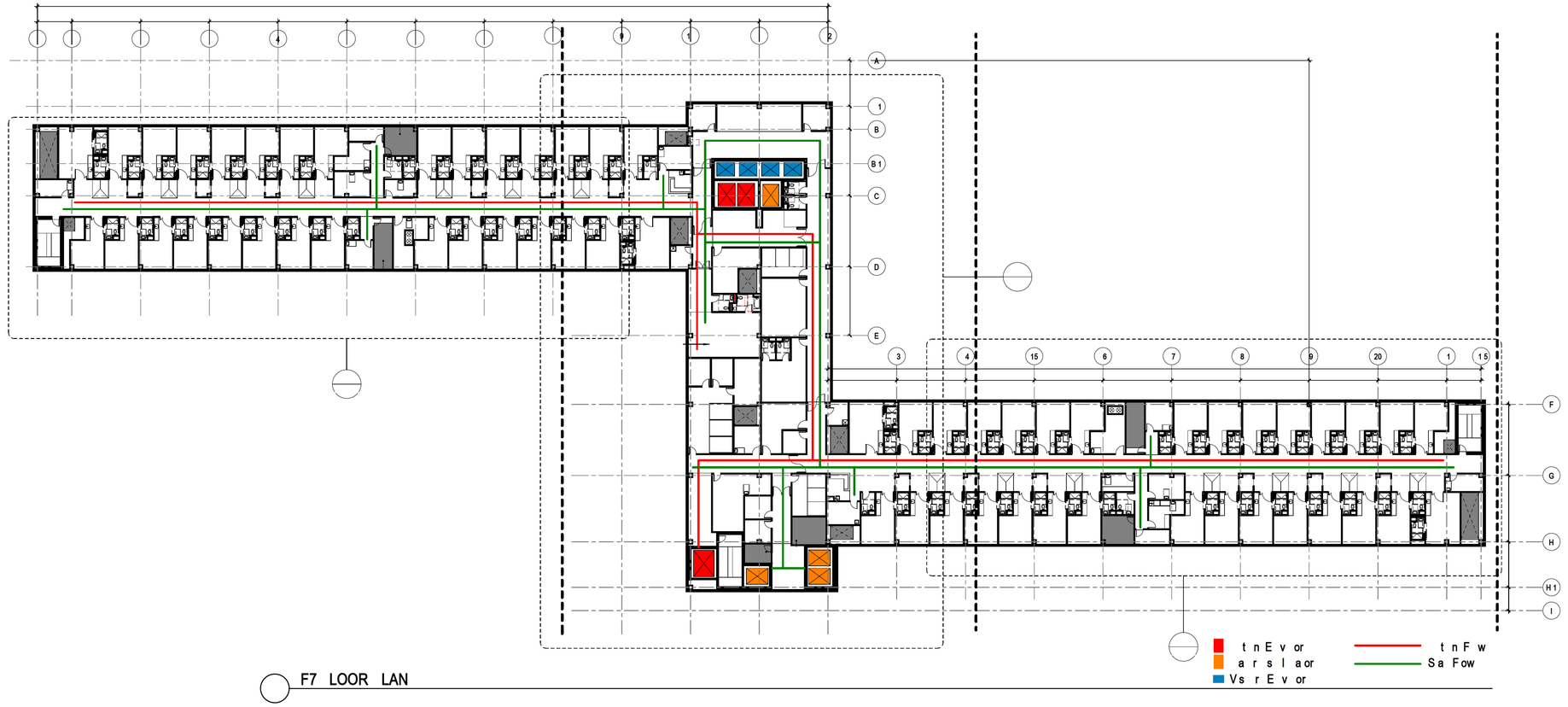

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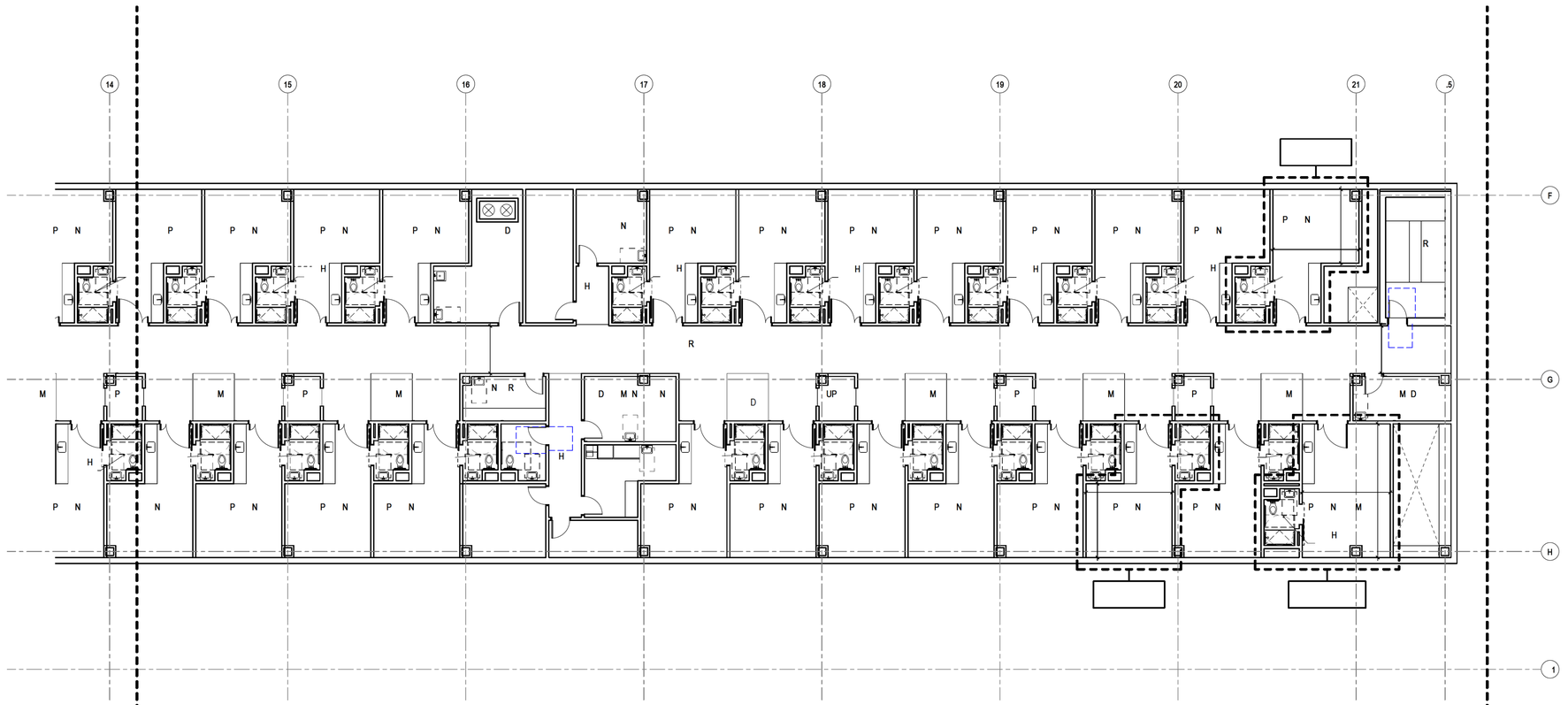

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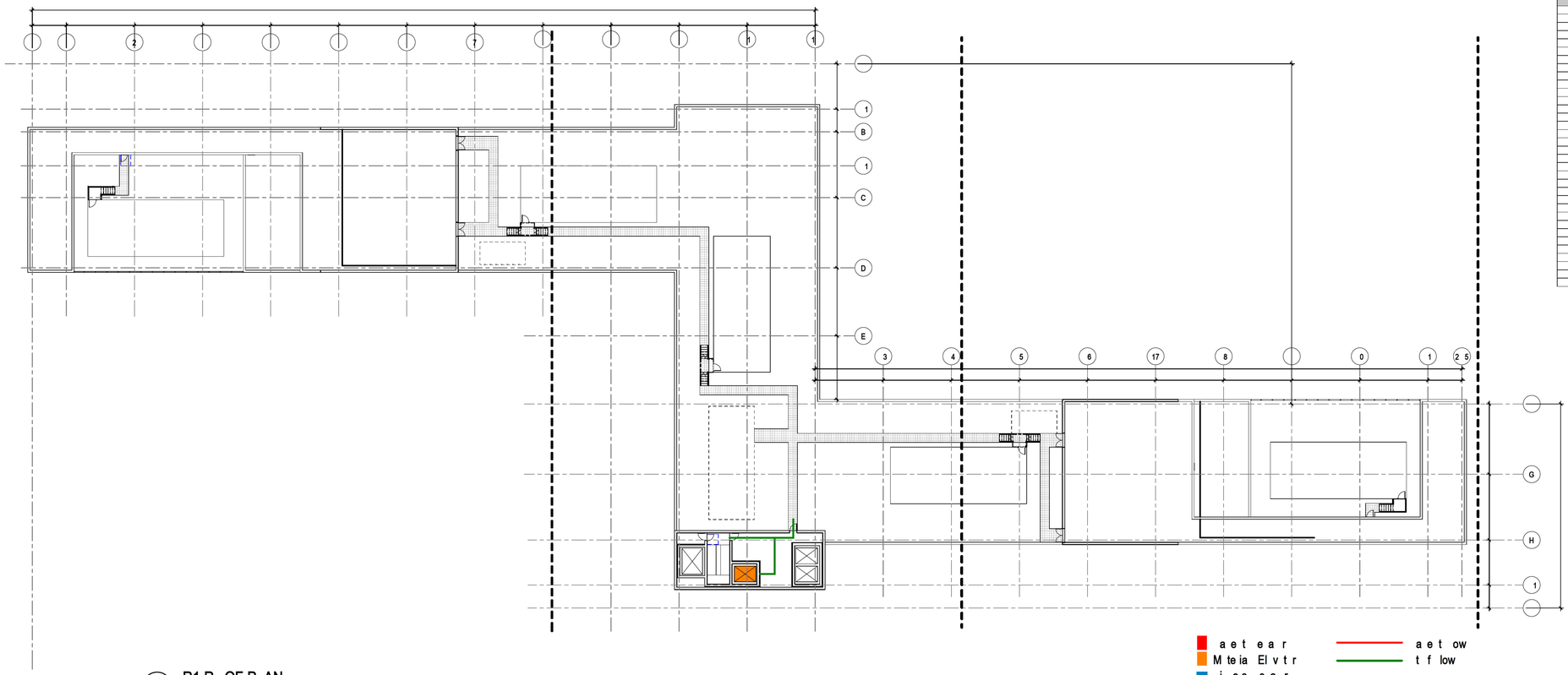

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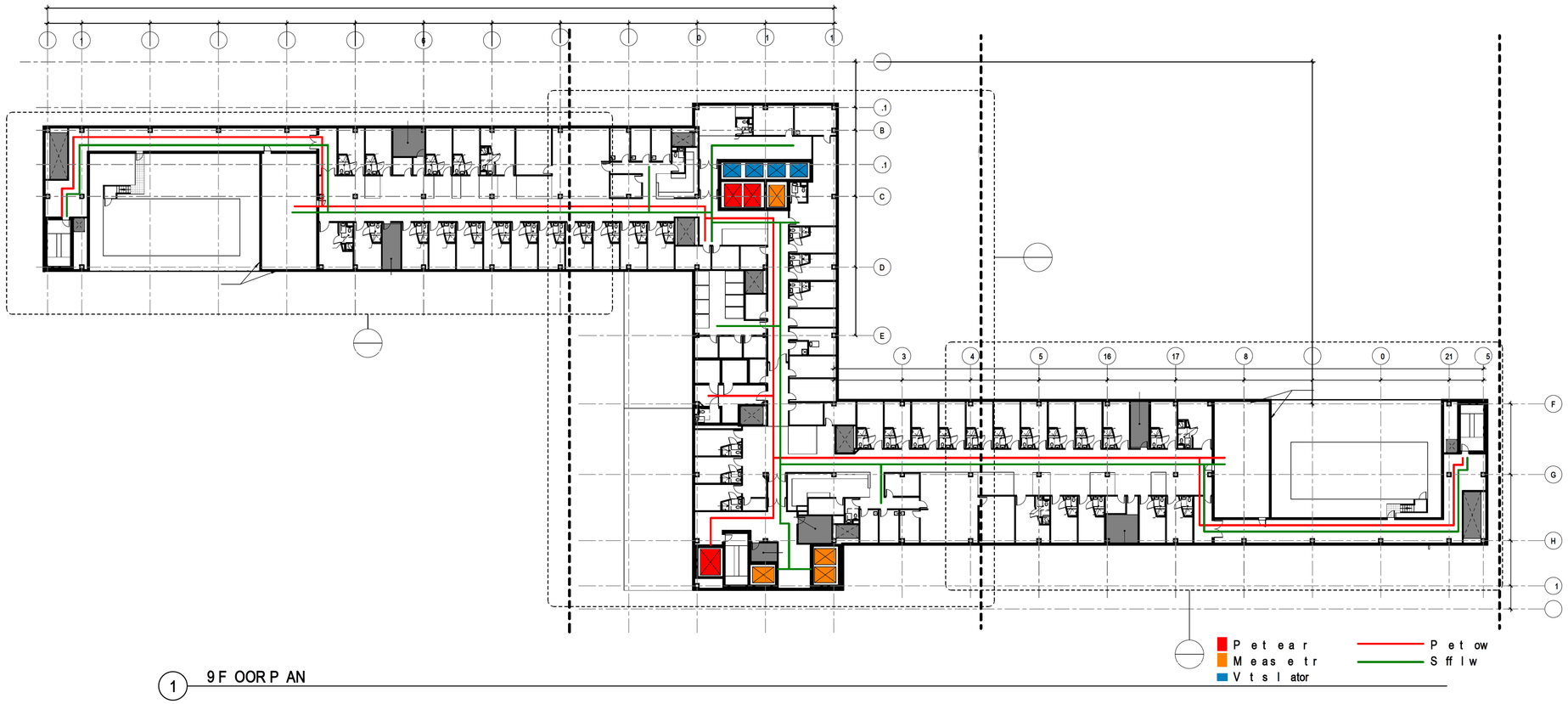

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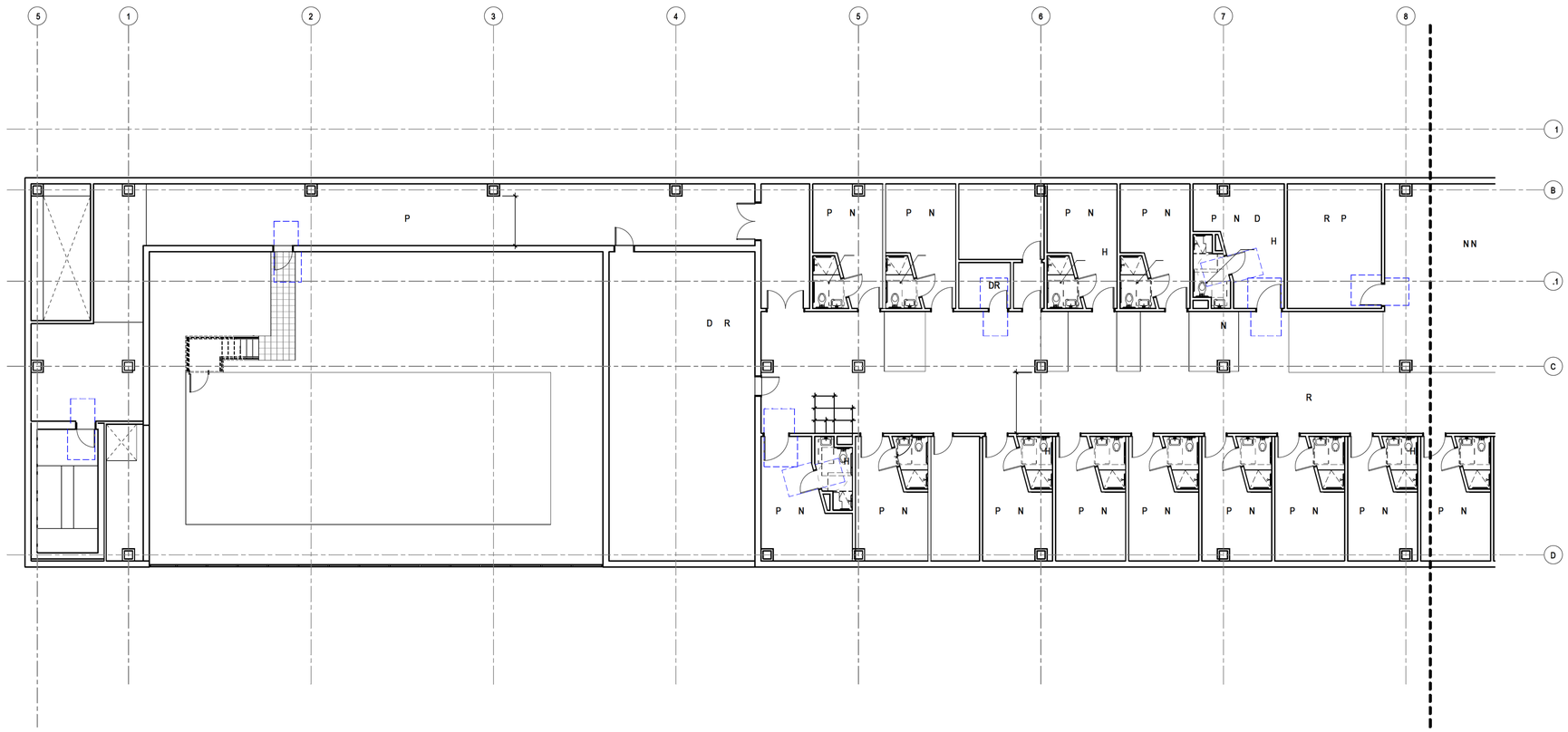

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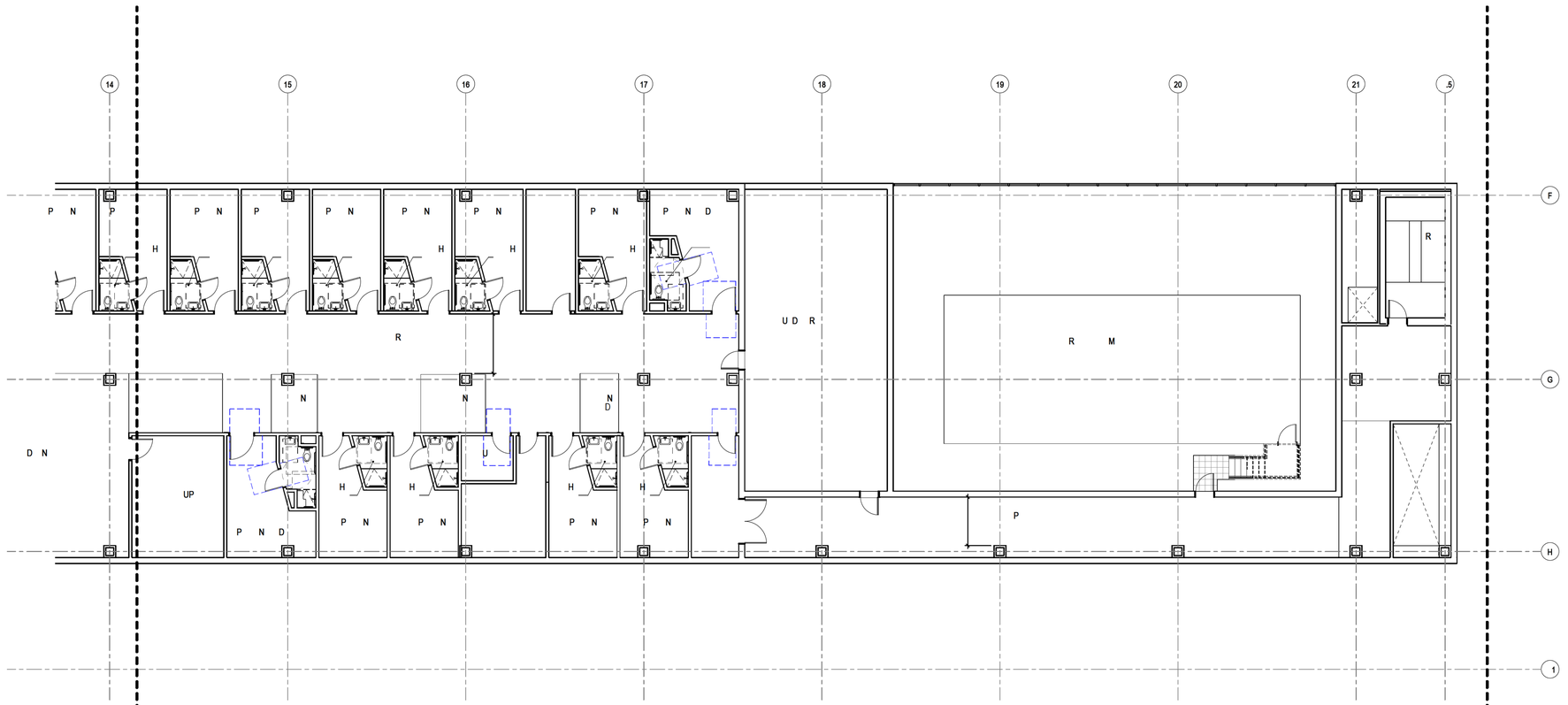

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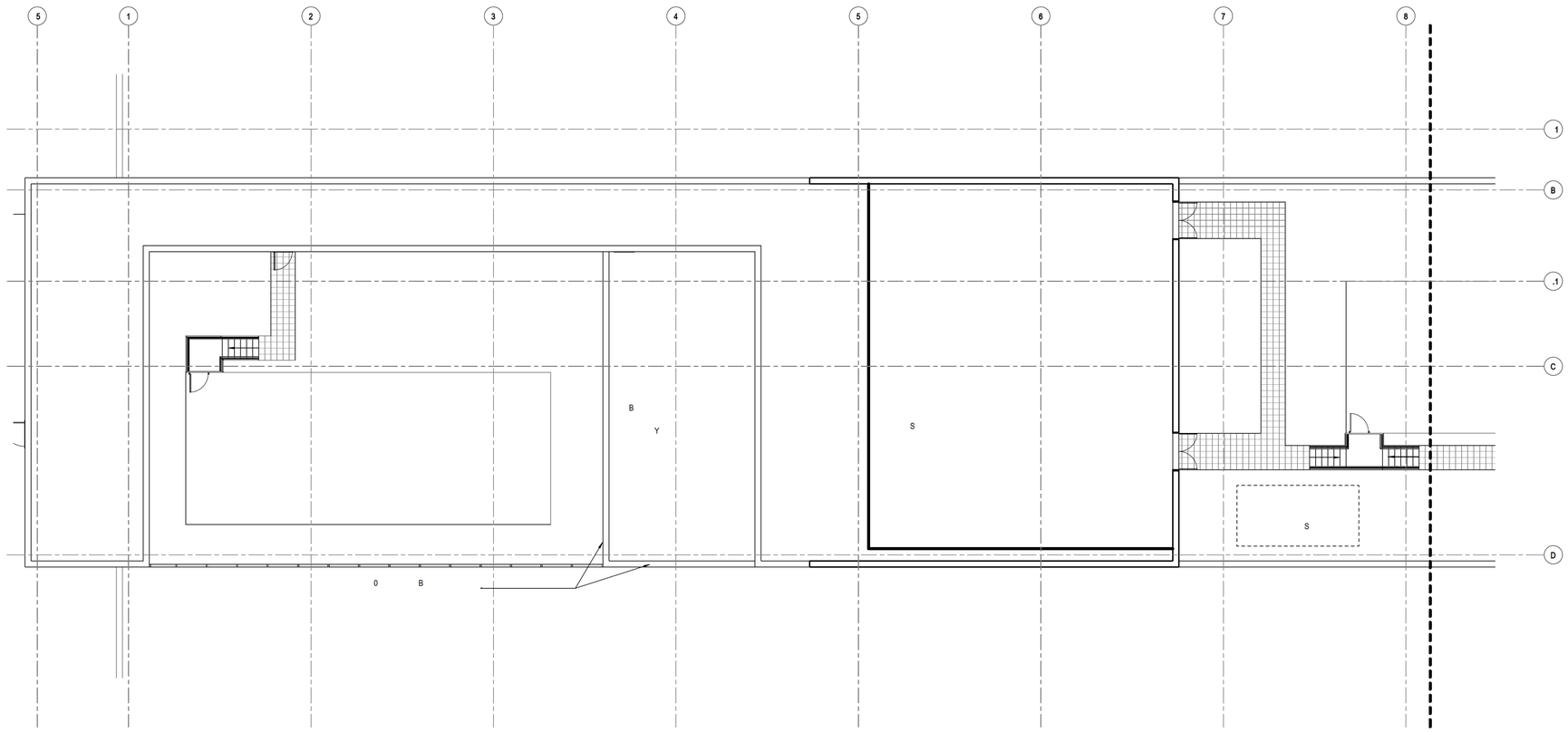

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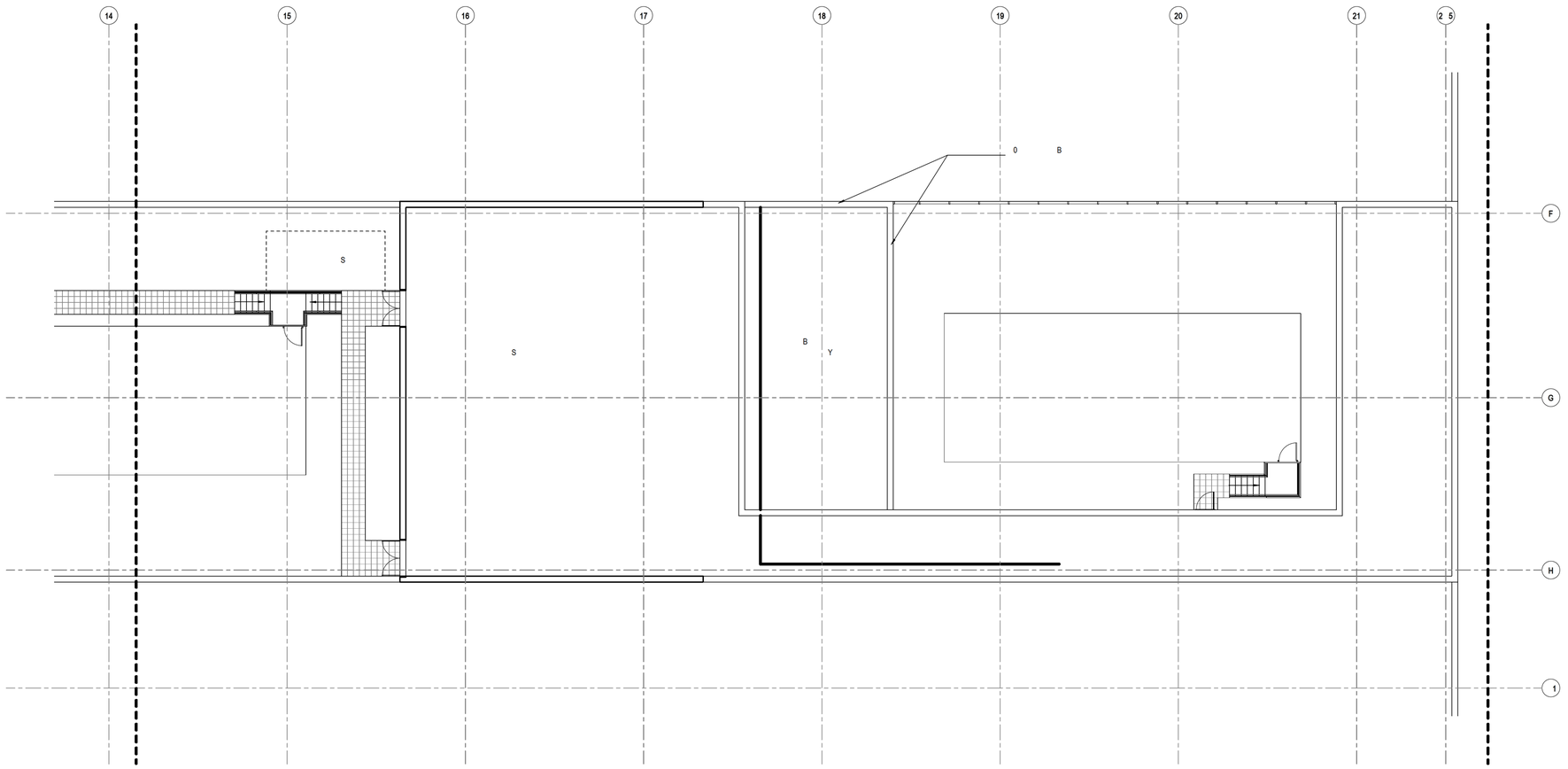

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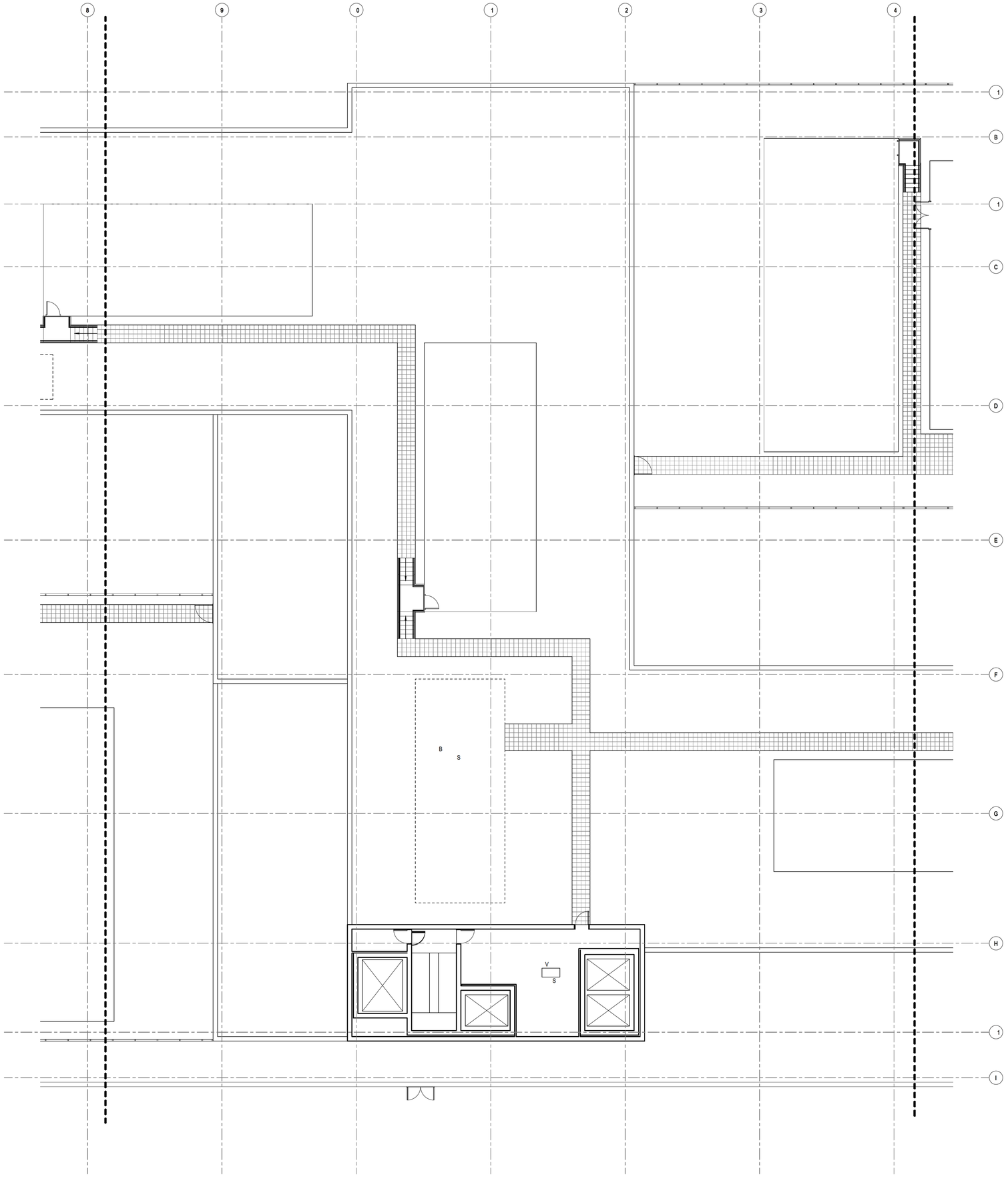

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NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 6, 2017

Ms. Patricia Smyth

Cicero Consulting Associates
701 Westchester Avenue, Suite 210W
White Plains, New York 10604

RE: 172305 C
Faxton-St Lukes Healthcare St Lukes Division
(Oneida)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Dear Ms. Smyth:

The Bureau of Architectural and Engineering Review is currently reviewing the submitted CON application as referenced above.

The cited sections indicated below, may not meet the requirements of the NYSDOH referenced standards or have not been clearly demonstrated to comply.

Please provide a response to each comment, demonstrating how compliance is achieved.

When replying to the request for additional information, all responses shall address each comment and indicate the action to be taken for each comment.

Your response to all the comments, is required within 14 (fourteen) calendar days of the date of this letter in accordance with 10 NYCRR 710.3(a).

The Bureau of Architectural and Engineering Review cannot continue to process or review the application as submitted, until the requested information is received and reviewed for compliance.

Delayed responses for projects that are submitted as full reviews, may potentially delay or postpone a timely recommendation from the Public Health and Health Planning Council. Accordingly, you are encouraged to submit the response at your earliest opportunity via your New York State Electronic Certificate of Need (NYSE-CON) account.

If drawings are requested, one copy of the requested drawings should be sent directly to the Project Management Unit, New York State Department of Health, Corning Tower, Room 1842, Empire State Plaza, Albany, New York 12237. Please include the CON number on the transmittal letter and on the drawings.

(DSG 1)

1. **General Comments**: Fixtures
2. **Referenced Standard:** DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.1 Action Required: Please indicate fixtures such as toilets, hand washing sinks and clinical sinks. Please revise and resubmit drawing(s).

(DSG 2)

3. **General Comments**: ADA Clearances in Toilet Rooms
4. **Referenced Standard:** DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.2 Action Required: Please indicate ADA clearances in a typical toilet room. Please revise and resubmit drawing(s).

(DSG 3)

5. **General Comments**: Room Numbers
6. **Referenced Standard:** DSG 1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.3 Action Required: Please indicate room numbers for all schematic design drawings. Please revise and resubmit drawings.

(ARCH 1)

7. **General Comments**: Public Waiting Area
8. **Referenced Standard:** FGI 2014
    a. Chapter: 2.2.3-1.2.4
    b. Trade: Architecture
    c. Drawing Sheet: F1 (A)
    d. Floor: Emergency Department

2.4 Action Required: Please indicate access to drinking water. Revise and resubmit drawing.

(ARCH 2)

1. **General Comments**: EMS Communication
2. **Referenced Standard:** FGI 2014
    a. Chapter: 2.2-3.1.2.5
    b. Trade: Architecture
    c. Drawing Sheet: F1 (A)
    d. Floor: Emergency Department

2.5 Action Required: Indicate the EMS Communication Room. Revise and resubmit drawing.

(ARCH 3)

1. **General Comments**: Reception and Triage Area
2. **Referenced Standard:** FGI 2014
    a. Chapter: 2.2-3.1.3.3
    b. Trade: Architecture
    c. Drawing Sheet: F1 (A)
    d. Floor: Emergency Department

2.6 Action Required: Please indicate the handwashing stations in the triage area. Revise and resubmit drawing.

(ARCH 4)

1. **General Comments**: Trauma Rooms
2. **Referenced Standard:** FGI 2014
    a. Chapter: 2.2-3.2.3.6
    b. Trade: Architecture
    c. Drawing Sheet: F1 (A)

2.7 Action Required: Please consider relocating the trauma rooms in closer proximity to the emergency entrance. Revise and resubmit drawing.

(ARCH 5)

1. **General Comments**: Bariatric / Pediatric Treatment Area
2. **Referenced Standard:** FGI 2014
    a. Chapter: 2.2-3.2.3.6
    b. Trade: Architecture
    c. Drawing Sheet: F1 (A)

2.8 Action Required Indicate the dedicated Bariatric and Pediatric treatment areas. Revise and resubmit drawing.

(ARCH 6)

1. **General Comments**: Food Production
2. **Referenced Standard:** FGI 2014
    a. Chapter: 2.1-4.3
    b. Trade: Architecture
    c. Drawing Sheet: F1 (B)

2.9 Action Required: Not enough information to review. Please review the section of the FGI. Revise and resubmit drawing.

(ARCH 7)

1. **General Comments**: Clinical Lab Services
2. **Referenced Standard:** FGI 2014
    a. Chapter: 2.1-4
    b. Trade: Architecture
    c. Drawing Sheet: F1 (C)

2.10 Action Required: Not enough information to review. Please review the section of the FGI. Revise and resubmit drawing.

(ARCH 8)

1. **General Comments**: Room Names
2. **Referenced Standard:** FGI 2014
    a. Chapter: 1.2-2.1 / 1.2-2.1.3.1 / 1.2-2.1.3.2
    b. Trade: Architecture
    c. Drawing Sheet: All

2.11 Action Required: The names for spaces and departments used in the functional program shall be consistent with those used in the *Guidelines for Design and Construction of Hospital and Outpatient Facilities*. If acronyms are used, they shall be defined clearly. Please provide a key for all acronyms shown on the submitted drawings. Revise and resubmit drawings.

Should you have any questions or comments regarding his review, please contact Michael Clary at 518-402-0904.

Sincerely,

Michael Clary

Michael Clary
Health Facilities Planner
Bureau of Architectural & Engineering Review

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 6, 2017

Ms. Patricia Smyth

Cicero Consulting Associates
701 Westchester Avenue, Suite 210W
White Plains, New York 10604

RE: 172305 C
Faxton-St Lukes Healthcare St Lukes Division
(Oneida)
Construct a new 373-bed replacement hospital on a 25-acre parcel in Utica

Dear Ms. Smyth:

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Please provide a response to each comment, demonstrating how compliance is achieved.

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If drawings are requested, one copy of the requested drawings should be sent directly to the Project Management Unit, New York State Department of Health, Corning Tower, Room 1842, Empire State Plaza, Albany, New York 12237. Please include the CON number on the transmittal letter and on the drawings.

1. **General Comments**: Dead-End Corridors
2. **Referenced Standard:** NFPA 101-2012
    a. Chapter: 18.2.5 / 7.5.1.5
    b. Trade: Architecture
    c. Drawing Sheet: AE102 / F2 LSC
    d. Room Name: IR and Cath / Ed Research
    e. Floor: F2

2.1 Action Required: Please review the NFPA 2012 Life Safety Code. Please revise and resubmit drawings.

1. **General Comments**: Dead-End Corridor
2. **Referenced Standard:** NFPA 101-2012
    a. Chapter: 18.2.5 / 7.5.1.5
    b. Trade: Architecture
    c. Drawing Sheet: AE102 / F2 LSC
    d. Room Name: 2nd Floor Elevator Lobbies
    e. Floor: F2

2.2 Action Required: Please review the NFPA 2012 Life Safety Code. Please revise and resubmit drawings.

1. **General Comments**: Dead-End Corridors
2. **Referenced Standard:** NFPA 101-2012
    a. Chapter: 18.2.5 / 7.5.1.5
    b. Trade: Architecture
    c. Drawing Sheet: AE101 / F1 LSC
    d. Room Name: Sim Lab / Comp Train
    e. Floor: F1 (C)

2.3 Action Required: Please review the NFPA 2012 Life Safety Code. Please revise and resubmit drawings.

1. **General Comments**: Staff Locker Doors
2. **Referenced Standard:** ADA 2010
    a. Chapter: 404.2.6
    b. Trade: Architecture
    c. Drawing Sheet: AE102 / F2 LSC
    d. Room Name:
    e. Floor: F2 (C)

2.4 Action Required: Doors in series lack the 48" clearance. Please review the 2010 ADA Standards for Accessible Design. Please revise and resubmit drawings.

1. **General Comments**: Corridors
2. **Referenced Standard:** NFPA 101-2012
    a. Chapter: 18.2.3.4
    b. Trade: Architecture
    c. Drawing Sheet: All

2.5 Action Required: Please indicate all 8.0' corridors. Revise and resubmit drawings.

1. **General Comments**: Exit Signage
2. **Referenced Standard:** NFPA 101-2012
    a. Chapter: 18.2.10
    b. Trade: Architecture
    c. Drawing Sheet: Life Safety Plans

2.6 Action Required: Please indicate all exit sign locations. Revise and resubmit drawings.

1. **General Comments**: Construction Type / Automatic Sprinklered
2. **Referenced Standard:** NFPA 101-2012
    a. Chapter: 9.7 / 18.1.6.1 / 7.5.1.3.3
    b. Trade: Architecture
    c. Drawing Sheet: Code Analysis

2.7 Action Required: Please indicate construction type review the 2010 ADA Standards for Accessible Design. Please revise and resubmit drawings.

1. **General Comments**: Ceiling Heights
2. **Referenced Standard:** DSG-1.0
    a. Trade: Architecture
    b. Drawing Sheet: All

2.8 Action Required: Please indicate typical ceiling heights. Please revise and resubmit drawings.

Should you any questions or comments regarding this review, please contact Robert Lis at 518-402-0904.

Sincerely,

Robert Lis
Health Facilities Planner
Bureau of Architectural & Engineering Review

MVHS

Governance Structure

Mohawk Valley Health System

- St. Elizabeth Medical Center (SEMC)
  - SEMC Foundation, Inc.
  - SEMC College of Nursing
  - MVHS Support Services
- Faxton St. Luke's Healthcare (FSLH)
  - FSLH Foundation
- Mohawk Valley Heart Institute (MVHI)
- Senior Network Health
- St. Luke's Home
- Visiting Nurse Association of Utica & Oneida County
- Mohawk Valley Home Care (Home Care Services)

ATTACHMENT NO. 1

MOHAWK VALLEY HEALTH SYSTEM

SCHEDULE 8 ATTACHMENT ("BREAKDOWN OF OTHER FEES")

MOHAWK VALLEY HEALTH SYSTEM

NEW HOSPITAL CAMPUS

BREAKDOWN OF "OTHER FEES" (SUB-PROJECT #1)

	Description	Unescalated Costs	Escalation	Escalated Costs
102 -- Other Owner Construction				
11000	Mockup Construction	$ 141,509	$ 8,491	$ 150,000
11020	Construction Document Printing	$ 94,340	$ 5,660	$ 100,000
103 -- Owner Background Information				
11500	Site Surveys / ALTA Survey	$ 94,340	$ 5,660	$ 100,000
11520	Environmental Reports	$ 94,340	$ 5,660	$ 100,000
11540	Environmental Impact Study	$ 94,340	$ 5,660	$ 100,000
11570	Traffic/Parking Studies	$ 47,170	$ 2,830	$ 50,000
11580	Utility Assessment Study	$ 188,679	$ 11,321	$ 200,000
11590	Other Studies	$ 235,849	$ 14,151	$ 250,000
107 -- Other Consulting Services & Misc. Cost				
13520	Signage Consultant	$ 77,830	$ 4,670	$ 82,500
13590	Peer Eval -- Enclosure	$ 141,509	$ 8,491	$ 150,000
13630	Building Commissioning	$ 613,208	$ 36,792	$ 650,000
13640	Test & Balance	$ 523,868	$ 31,432	$ 555,300
13660	Radiation Shielding / Physicist	$ 70,755	$ 4,245	$ 75,000
13670	Other Consultants (Dietary)	$ 165,094	$ 9,906	$ 175,000
13670	Other Consultants (Medical Equipment Planning)	$ 424,528	$ 25,472	$ 450,000
13670	Other Consultants (IT / IS Planning)	$ 400,943	$ 24,057	$ 425,000
13670	Other Consultants (Signage / Graphics Planning)	$ 127,358	$ 7,642	$ 135,000
13680	Reimbursable Expenses	$ 165,528	$ 9,932	$ 175,460
111 -- Other Project Cost				
15500	Construction Testing	$ 523,868	$ 31,432	$ 555,300
15710	Movers	$ 235,849	$ 14,151	$ 250,000
15740	Builder's Risk	$ 471,698	$ 28,302	$ 500,000
15780	Independent Financial Audit	$ 94,340	$ 5,660	$ 100,000
113 -- Jurisdictional Cost				
16500	Planning & Zoning Fees	$ 141,509	$ 8,491	$ 150,000
16510	Plan Review Fees	$ 94,340	$ 5,660	$ 100,000
16520	Building Permit	$ 103,774	$ 6,226	$ 110,000
16690	Legal / Consultant Assistance Fees	$ 249,483	$ 14,969	$ 264,452
15700	Other (FAA Fees)	$ 28,302	$ 1,698	$ 30,000
116- Furniture, Fixtures and Equipment				
18000	Dept furniture	$ 5,778,302	$ 346,698	$ 6,125,000
18030	Artwork	$ 330,189	$ 19,811	$ 350,000
18050	Plants and accessories	$ 94,340	$ 5,660	$ 100,000
18250	Security and access control	$ 1,675,943	$ 100,557	$ 1,776,500
18310	Kitchen Equipment	$ 943,396	$ 56,604	$ 1,000,000
18320	Exterior signage	$ 283,019	$ 16,981	$ 300,000
18330	Interior signage	$ 566,038	$ 33,962	$ 600,000
	Sub-Total - "Other Fees"	**$ 15,315,577**	**$ 918,935**	**$ 16,234,512**

ATTACHMENT NO. 2

MOHAWK VALLEY HEALTH SYSTEM

LETTER FROM HAMMES CO.

Hammes Company

100 Cummings Center, Suite 207-P
Beverly, MA 01915

December 13, 2017

Dear Mr. Ungerer,

This letter is to describe Hammes Company ("Hammes") and our process for establishing budgets for our client.

Hammes is a national leader in healthcare development. We work solely on healthcare projects ranging from medical office buildings to large acute care hospitals. We specifically have managed the planning and development of more than 46 hospitals in the last twenty years. Our primary role is as a Program Manager directly for the healthcare system ("Owner") representing and advising them on complex projects. Based on this experience, our firm has developed an extensive and proprietary database of costs which we use in conceptual design to develop a preliminary budget and inform the Owner's decisions. We typically then take the conceptual budget and validate it with several outside construction firms to ensure that the budget has accuracy and is balanced for regional costs and trends. We followed this process for the Mohawk Valley Health System

As the project progresses into design, our team then "builds" the budgets in Budget Builder (our database), which is supported by e-builder, a leading project management software (https://www.e-builder.net/). The initial budget build includes:

1. Square footage
2. Type of Facility
3. Departments
4. Existing or replacement Facility
5. On Campus or off

Once this is established, the total project budget is uploaded into the system, allowing the Owner to have a comprehensive understanding of the entire budget, beyond just design and construction. These categories include:

1. Construction Cost
2. AE fees
3. Jurisdictional costs
   a) Local
   b) State
   c) Other
4. Land acquisition
5. Site investigation

   d) On site costs
   e) Off site costs
6. Hazardous/environmental Investigation
7. FFE
8. Financing
9. Contingency
10. Marketing Costs

Each of the above categories consist of subsets assuring we capture all relevant costs associated with the project.

The initial budget is continually validated throughout design and into construction with the specific technical vendors and expertise.

On no less than a monthly basis, we will report to the Owner the budget progress, which illustrates the initial budget, actual costs, cash flow and "cost to complete" which is project progress based on spend. Finally, this system is synced with finance, allowing our teams to complete a monthly draw review for payment of all vendors and consultants; in addition to ensuring that all project costs are reconciled with the Owner's financial accounting system for accuracy.

In particular, the Department Furniture budget, line 18000 calculated at $6,125,000 or $9.13 per square foot. Upon review, this is in line with industry standards we find in our other projects. Of course as the project develops, there will be additional factors such as reuse of furniture once evaluated, planned decommissioning, etc. that will be factors in the budget development.

Please let me know if you have any questions or need additional information.

Sincerely,

Mike Solak
Regional Vice President
Hammes Company

State of New York
Oneida County

Mohawk Valley Health System
CON – 172305 – construct a new replacement hospital

AFFIDAVIT

I, Traci A. Boris, being duly sworn, depose and say that:

1. I am the General Counsel for the Mohawk Valley Health System (MVHS), which is an affiliation of Faxton-St. Luke's Healthcare (FSLH) and St. Elizabeth Medical Center (SEMC). As such, I also serve in the role of General Counsel for both FSLH and SEMC.

2. By letter dated November 27, 2017, the NYS Department of Health sent a 14-day letter seeking responses to various queries. As part thereof the Department of Health sought an Affidavit relative to any relationships between the seller and the proposed operator/owner.

3. In my role as the General Counsel I have reviewed contract databases and reached out to pertinent departments and personnel to ascertain the relationships between MVHS and any of the property owners within the hospital's site plans. Based upon that review and those discussions I have determined that there is no conflict of interest between any of the property owners and MVHS. However, MVHS has the following relationships with property owners whose property is within the site plan and intended for acquisition:

a. The following property owners are, or have been in the past, third party vendors who provide services and/or products that are used for hospital operations:
   i. Schmalz Mechanical (unsure of relationship to property owner [redacted]
   ii. Urbanik Paint (owned by Greg Urbanik)
   iii. Niagara Mohawk
   iv. Cavo's on Jefferson (unsure of relationship to property owner [redacted]
   v. Park Outdoor Advertising
   vi. Clemente's
   vii. City of Utica
   viii. O'Brien in Rome (unsure of relationship to property owne[redacted]
   ix. Mohawk Hospital Equipment
   x. H.J. Brandeles

b. The Board Chair for Resource Center For Independent Living is the [redacted] of an MVHS Board Member.

c. The owner of Mohawk Hospital is a Board Member on the SEMC Foundation and FSLH Foundation Boards.

d. SEMC has a Power Purchase Agreement with Niagara Mohawk for power generated by SEMC's co-generation plant.

4. It is important to note that at this stage the property owners' list was developed by use of county databases and tax record searches. As property acquisition moves forward ownership will be verified and if there are any changes relative to relationships between any owners and MVHS, we consider this a continuing obligation and will notify DOH of any of those changes.

Dated: December 8, 2017

Traci A. Boris

Traci A. Boris, Esq,
General Counsel

Sworn to before me this 8th day
of December, 2017

Margaret H. Jacobsen

Notary Public

MARGARET H. JACOBSEN
Notary Public, State of New York
Appointed in Oneida County
My Commission Expires 2/18/2018

Table 13D - 4

St. Luke's

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	**Fee for Service**	12,746	3.9%	9,644,640						
	Managed Care	63,611	19.3%	67,512,664						
Medicare	**Fee for Service**	104,623	31.8%	31,630,624						
	Managed Care	46,186	14.0%	17,636,624						
Medicaid	**Fee for Service**	15,375	4.7%	1,168,743						
	Managed Care	68,268	20.8%	20,704,849						
Private Pay		4,525	1.4%	283,970						
OASAS										
OMH										
Charity Care		1,911	0.6%	319						
Bad Debt										
All Other		11,664	3.5%	1,260,496						
Total		**328,909**	**100.0%**	**$149,842,929**						

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services			**$267,183,516**							

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of SEMC and FSLH.	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of SEMC and FSLH.	N/A

Table 13D - 4

St. Elizabeth

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	**Fee for Service**	16,925	4.7%	3,915,499						
	Managed Care	90,540	25.2%	27,408,493						
Medicare	**Fee for Service**	75,090	20.9%	19,014,785						
	Managed Care	50,621	14.1%	15,844,133						
Medicaid	**Fee for Service**	10,450	2.9%	(410,210)						
	Managed Care	89,815	25.0%	16,346,560						
Private Pay		16,303	4.5%	9,206,725						
OASAS										
OMH										
Charity Care		129	0.0%	(73,066)						
Bad Debt										
All Other		8,849	2.5%	2,769,304						
Total		**358,722**	**100.0%**	**$94,022,223**						

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services				**$210,690,062**						

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of SEMC and FSLH.	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of SEMC and FSLH.	N/A

Table 13D - 4

St. Luke's + St. Elizabeth

Oupatient Services** Source of Revenue		Total Current Year*			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue		Visits	Net Revenue		Visits	Net Revenue	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	Fee for Service	27,393	4.0%	$16,272,167	28,426	4.0%	$18,769,672	28,426	4.0%	$19,533,711
	Managed Care	155,224	22.6%	$92,208,949	161,076	22.6%	$106,361,477	161,076	22.6%	$110,691,030
Medicare	Fee for Service	180,020	26.2%	$50,645,409	186,807	26.2%	$58,418,630	186,807	26.2%	$60,796,620
	Managed Care	97,049	14.1%	$33,480,757	100,708	14.1%	$38,619,492	100,708	14.1%	$40,191,538
Medicaid	Fee for Service	25,778	3.7%	$758,533	26,750	3.7%	$874,955	26,750	3.7%	$910,571
	Managed Care	158,825	23.1%	$37,051,409	164,813	23.1%	$42,738,179	164,813	23.1%	$44,477,880
Private Pay		20,808	3.0%	$9,490,695	21592	3.0%	$10,947,358	21592	3.0%	$11,392,981
OASAS										
OMH										
Charity Care		1,996	0.3%	($42,154)	2,071	0.3%	($48,624)	2,071	0.3%	($50,603)
Bad Debt										
All Other		20,538	3.0%	$3,999,387	21,312	3.0%	$4,613,226	21,312	3.0%	$4,801,012
Total		**687,631**	**100.0%**	**$243,865,152**	**713,555**	**100.0%**	**$281,294,365**	**713,555**	**100.0%**	**$292,744,740**

* Information taken directly from the facility's 2016 Cost Report.

Total of Inpatient and Outpatient Services				**$477,873,578**			**$550,578,789**			**$572,990,662**

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based upon the experience of St. Elizabeth and St. Luke's	N/A
2. In an attachment, provide the basis for charity care.	Based upon the experience of St. Elizabeth and St. Luke's	N/A