New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: ☐

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

SIGNATURE:	DATE
Wendy Disbrow	07.05.2023
PRINT OR TYPE NAME	TITLE
Wendy Disbrow	President & CEO

General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project.	YES ☒ NO ☐	SJH –Board Resolution Swing Bed 06.2023
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES ☐ NO ☒	

Contacts

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

Primary Contact			
NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY		
Wendy Disbrow, President & CEO	St. James Hospital		
BUSINESS STREET ADDRESS			
7329 Seneca Road North			
CITY	STATE	ZIP	
Hornell	NY	14843	
TELEPHONE	E-MAIL ADDRESS		
607-247-2550	Wendy_Disbrow@URMC.Rochester.edu		

Alternate Contact			
NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY		
Denise Becher, Executive Vice President	St. James Hospital		
BUSINESS STREET ADDRESS			
7329 Seneca Road North			
CITY	STATE	ZIP	
Hornell	NY	14843	
TELEPHONE	E-MAIL ADDRESS		
607-385-3960	Denise_Becher@URMC.Rochester.edu		

New York State Department of Health
Certificate of Need Application

Schedule 1

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Denise Becher, Executive Vice President			
BUSINESS STREET ADDRESS			
7329 Seneca Road North			
CITY	STATE	ZIP	
Hornell	NY	14843	
TELEPHONE	E-MAIL ADDRESS		
607-385-3960	Denise_Becher@URMC.Rochester.edu		

The applicant's lead attorney should be identified:

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

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

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

The applicant's lead accountant should be identified:

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

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER			
NAME	FIRM		BUSINESS STREET ADDRESS
Mohamed Razak	Razak Associates		255 East Avenue, Suite 306
CITY, STATE, ZIP	TELEPHONE		E-MAIL ADDRESS
Rochester, NY 14604	585-388-6710		mrazak@razak.net

ARCHITECT and/or ENGINEER			
NAME	FIRM		BUSINESS STREET ADDRESS
CITY, STATE, ZIP	TELEPHONE		E-MAIL ADDRESS

New York State Department of Health
Certificate of Need Application

Schedule 1

Other Facilities Owned or Controlled by the Applicant

Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

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

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

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

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

Out-of-State Affiliated Facilities/Agencies

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

Facility Type	Name	Address	State/Country	Services Provided

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

Razak

Razak Associates

Architecture
Interiors
Planning
Landscape

January 5, 2024

UR MEDICINE – ST. JAMES HOSPITAL

Schedule 6: CON Administratve Review Application
Architectural Submission / Narrative
Schematic Design

Re: UR Medicine – St. James Hospital
Hornellsville, NY

Long Term Care Swing Beds
Patient Rooms 2120A & 2120U

Step-up Patient Care Beds
Patient Rooms 2120J & 2120H

1. Intent:

It is the intent of UR Medicine/ St. James Hospital, an Acute Care General Hospital to use existing Patient Room 2120A and Patient Room 2120U for skilled nursing swing beds and Patient Room 2120J and Patient Room 2021H as a "Step-Up" Bed. The "Step-Up" Bed is intended to accommodate patients that are in need of Step-Up care, e.g. keeping patients on a mechanical ventilation up to 36 hours but no more than 96 hours. This approach creates the flexibility to switch from in-patient to skilled care status or in-patient to Step-Up care when applicable for patient care on the medical surgical unit.

These rooms were originally constructed as medical-surgical patient rooms in conformance with FGI 2010.

2. Scope of Work:

No construction work is proposed for the Long Term Care Swing Beds will not require any construction . The rooms will be modified by rearranging the furniture in the required configuration to accommodate the functions and meet the necessary clearances. Mechanical, electrical, and plumbing systems will remain unchanged.

Step-Up Beds require construction to meet a higher level of care within these rooms. These rooms are ideally located within line of sight from the nurse station. To improve visibility and opening access the door will be changed out to be a sliding, telescopic glass door. There will also be upgrades to the headwall gases and electrical within the room.

3. Facility Description:

UR Medicine St. James Hospital is a recently constructed hospital building located in Hornellsville, New York.

A. Codes/References Original Construction:
   1. IBC 2015, I2 institutional
   2. NFPA 101 2000 Life Safety Code, New Healthcare occupancy
   3. FGI 2010 guidelines
B. Codes/References for Proposed Work:
   1. IBC 2015, I2 institutional
   2. NFPA 101 2012 Life Safety Code, Existing Healthcare occupancy

3. FGI 2018 guidelines

C. Building Height: 55 feet
D. Number of Stories: (3 Stories) Two Floors and Third Floor Penthouse
E. Square Footage Existing Areas
   1. First Floor Area: 39,178 SF
   2. Second Floor Area: 38,036 SF
   3. Third Floor Area: (Penthouse) 10,086 SF

   Total Building Area: 87,300 SF

4. Project Area Existing Conditions:

These rooms were originally constructed to as Med/Surg Beds. This includes meeting the spatial, mechanical ventilation, and medical gas requirements. These rooms were designed to meet FGI 2010. Hand sinks were installed inside these rooms for use.

A. Existing Floor Area:

1. Patient Rooms 2120A & 2120U (Proposed Swing Beds)
   Floor Area: 235 sf.

2. Patient Rms #2120J & 2120H (Proposed Step-Up)
   Floor Area: 233 sf.

B. Existing Medical Gases:

1. Patient Rms 2120A &2120U (Proposed Swing Beds); each provided with (2) Oxygen, (2) Vacuum, (1) Medical Air.

2. Patient Rms 2120J and 2120H (Proposed Step-Up Beds); each provided with (2) Oxygen, (2) Vacuum, (1) Medical Air.

C. Existing Heating, Ventilating and Air Conditioning (HVAC):

1. Designed per FGI 2010; in reference to ASHREA Standard 170

D. Existing Electrical

1. Normal, Critical, and Isolation power is provided at each room.

5. Proposed Renovations

1. Patient Rooms 2120A & 2120U (Proposed Swing Beds)
   No construction work; just rearrangement of furniture.

2. Patient Rms #2120J & 2120H (Proposed Step-Up)
   a. Room Size/Clearances: Meets min. square footage. Clear space from the foot of the bed to the wall is 4'-0-".
   b. Doors: Sliding, telescopic glass door to be provided; will allow for a minimum clearance of 45.5" in width and 83.5" in height
   c. Med/Gas: each headwall will be provided with (3) Oxygen, (3) Vacuum, (1) Medical Air.
   d. Electrical: Some electrical will need to be reworked to allow for the proposed sliding door. This will include relocation of room switches. An additional 4 electrical outlets to be added to the headwall to meet requirements.

(END)

Schedule 5
Working Capital Plan

Contents:

Working Capital Financing Plan

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

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

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

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

This project will require not construction or revenations for swing beds. We will need to purchase two (2) additional medial beds. Step-Up Beds require construction to meet a higher level of care within these rooms. These rooms are ideally located within line of sight from the nurse station. To improve visibility and opening access the door will be changed out to be a sliding, telescopic glass door. There will also be upgrades to the headwall gases and electrical within the room. St James Hospital will use current operating funds to purchase the additional Stryer medical bed, the two telescopic Glass door and addition electrical s to support this project.

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

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

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☒
2.15	Will the project result in a major adverse effect on air quality?	☐	☒
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	☒
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	☒
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	☒
2.19	Will the project have any adverse impact on health or safety?	☐	☒
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	☒
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	☒
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	☒
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☒

Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☒	☐

Agency Name:	Town of Hornellsville
Contact Name:	Robert Mooney
Address:	4 Park Ave. PO Box 1, Arkport
State and Zip Code:	NY 14807
E-Mail Address:	
Phone Number:	607-295-9660
Agency Name:	
Contact Name:	
Address:	
State and Zip Code:	
E-Mail Address:	
Phone Number:	
Agency Name:	
Contact Name:	

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

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

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

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

FEMA **Elevation Certificate** and Instructions

Schedule 9
Project Financing

Contents:

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	$40264
☐	C. Mortgage, Notes, or Bonds	$
☐	D. Land	$
☐	E. Other	$
☐	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$40264

If refinancing is used, please complete area below.

☐	Refinancing	$
☐	Total Mortgage/Notes/Bonds (Sum E + Refinancing)	$

II. Details

A. Leases

	N/A	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.	☒	

B. Cash

Type	Amount
Accumulated Funds	$
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$40264
TOTAL CASH	$

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	Sch 0-Sources of Cash.xls
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. 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 **the subject facility and all 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 (or to be implemented in the case of the subject facility) to improve operations.	☐	St. James Hospital, Inc. and Affilates 2022 FS Final.pdf &SJH Internal FS 05-23.xls
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☒	
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	☒	

	N/A	Title of Attachment
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).	☒	
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 expects 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 total project cost (Schedule 8b, line 10). Public facilities require 0% equity.	☒	
9. Provide an equity analysis for member equity to be provided. Indicate if a member is providing a disproportionate share of equity. If disproportioned equity shares are provided by any member, check this box ☐	☒	

C. Mortgage, Notes, or Bonds

	Total Project	Units
Interest		%
Term		Years
Payout Period		Years
Principal		$

	N/A	Title of Attachment
1. Attach a copy of a letter of interest from the intended source of permanent financing that indicates principal, interest, term, and payout period.	☐	
2. If New York State Dormitory Authority (DASNY) financing, then attach a copy of a letter from a mortgage banker.	☐	
3. Provide details of any DASNY bridge financing to HUD loan.	☐	
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

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	$
Purchase Price	$
Other	

	N/A	Title of Attachment
1. If amounts are listed in "Other", attach documentation and a description as applicable.	☐	
2. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	☐	
3. Submit a copy of the proposed purchase/option agreement.	☐	
4. Provide an affidavit indicating any and all relationships between seller and the proposed operator/owner.	☐	

E. Other

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

	N/A	Title of Attachment
Attach documentation and a description of the method of financing	☐	

F. Refinancing

	N/A	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 13
All Article 28 Facilities

Contents:

Schedule 13 A. Assurances from Article 28 Applicants

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

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

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

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

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

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

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

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

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

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

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

Date: 07.06.2023

Wendy Disbrow
Signature:

Wendy Disbrow
Name (Please Type)

President & CEO
Title (Please type)

Schedule 13 B-1. Staffing

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.

☐ Total Project or ☐ Subproject number

A	B	C	D
	Number of FTEs to the Nearest Tenth		
Staffing Categories	Current Year*	First Year Total Budget	Third Year Total Budget
1. Management & Supervision			
2. Technician & Specialist			
3. Registered Nurses			
4. Licensed Practical Nurses			
5. Aides, Orderlies & Attendants			
6. Physicians			
7. PGY Physicians			
8. Physicians' Assistants			
9. Nurse Practitioners			
10. Nurse Midwife			
11. Social Workers and Psychologist**			
12. Physical Therapists and PT Assistants			
13. Occupational Therapists and OT Assistants			
14. Speech Therapists and Speech Assistants	0.0	0.5	0.5
15. Other Therapists and Assistants			
16. Infection Control, Environment and Food Service			
17. Clerical & Other Administrative			
18. Other			
19. Other			
20. Other			
21. Total Number of Employees	0.0	0.5	.5

Last complete year prior to submitting application
***Only for RHCF and D&TC proposals*

Describe how the number and mix of staff were determined:

St. James Hospital, an Acute Care General Hospital to use existing Patient Room 2140A and Patient Room 2140C for skilled nursing swing beds. This approach creates the flexibility to switch from in-patient to skilled care status when applicable for patient care on the medical surgical unit. This project does not require us to add additional resources from a provider, nursing, or management. We currently do not have enough Speech Therapist support. Therefore, the incremental cost to this CON request is limited to this. and Patient Room 2120J and Patient Room 2021H as a "Step-Up" Bed. ~~The "Step-Up" Bed is intended to accommodate patients that are in need of Step-Up care, e.g.~~ keeping patients on a mechanical ventilation up to 36 hours but no more than 96 hours. This approach creates the flexibility to switch from in-patient to skilled care status or in-patient to Step-Up care when applicable for patient care on the medical surgical unit.

Schedule 13 B-2. Medical/Center Director and Transfer Agreements

All diagnostic and treatment centers and midwifery birth centers should complete this section when requesting a new location. DTCs are required to have a Medical Director who is a physician. MBCs may have a Center Director who is a physician or a licensed midwife.

Medical/Center Director	
Name of Medical/Center Director:	
License number of the Medical/Center Director	

	Not Applicable	Title of Attachment	Filename of attachment
Attach a copy of the Medical/Center Director's curriculum vitae	☐		

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	
○ Distance in miles from the proposed facility to the Hospital affiliate.	
○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	
○ Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.	N/A ☐ Attachment Name:
Name of the **nearest** Hospital to the proposed facility	
○ Distance in miles from the proposed facility to the nearest hospital.	
○ Distance in minutes of travel time from the proposed facility to the nearest hospital.	

Schedule 13 B-3. AMBULATORY SURGERY CENTERS ONLY - Physician Commitments

Upload a spreadsheet or chart as an attachment to this Schedule of all practitioners, including surgeons, dentists, and podiatrists who have expressed an interest in practicing at the Center. The chart must include the information shown in the template below.

Additionally, upload copies of letters from each practitioner showing the number and types of procedures he/she expects to perform at the Center per year.

Practitioner's Name	License Number	Specialty/(s)	Board Certified or Eligible?	Expected Number of Procedures	Hospitals where Physician has Admitting Privileges	Title and File Name of attachment

Schedule 13 C. Annual Operating Costs

See "Schedules Required for Each Type of CON" to determine when this form is required. One schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule that matches the structure of the tables (Attachment Title:) to summarize the first and third full year's total 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. Year 1 and 3 should represent projected total budgeted costs expressed in current year dollars. Additionally, you must upload the required attachments indicated below.

Required Attachments

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis for determining budgeted expenses, including details for how depreciation and rent / lease expenses were calculated.	Swing Bed Depreciation Schedule	SJH Swing Beds-Depreciation Schedule.xls
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital	N/A	

☐ Total Project or ☐ Subproject Number

Table 13C - 1

	a	b	c
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)			
1. Salaries and Wages	22401	44803	46147
1a. FTEs		0	0
2. Employee Benefits	4917	9834	10129
3. Professional Fees			
4. Medical & Surgical Supplies	4504	18014	36029
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)	0	0	0
11. Depreciation (details required below)	1815	4367	4367
12. Rent / Lease (details required below)	0	0	0
13. Total Operating Costs	33637	77018	96672

Table 13C - 2

	a	b	c
Inpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	7/1/2023	7/1/2024	7/1/2026
1. Salaries and Wages	22401	44803	46147
1a. FTEs	0	.5	0
2. Employee Benefits	4917	9834	10129
3. Professional Fees	0	0	0
4. Medical & Surgical Supplies	4504	18014	36029
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)	0	0	0
11. Depreciation (details required below)	1815	4367	4367
12. Rent / Lease (details required below)	0	0	0
13. Total Operating Costs	33637	77018	96672

Table 13C - 3

	a	b	c
Outpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)			
1. Salaries and Wages	0	0	0
1a. FTEs	0	0	0
2. Employee Benefits	0	0	0
3. Professional Fees	0	0	0
4. Medical & Surgical Supplies	0	0	0
5. Non-med., non-surg. Supplies	0	0	0
6. Utilities	0	0	0
7. Purchased Services	0	0	0
8. Other Direct Expenses	0	0	0
9. Subtotal (total 1-8)	0	0	0
10. Interest (details required below)	0	0	0
11. Depreciation (details required below)	0	0	0
12. Rent / Lease (details required below)	0	0	0
13. Total Outpatient Operating Costs	0	0	0

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.

Schedule 13 D: Annual Operating Revenues

See "Schedules Required for Each Type of CON" to determine when this form is required. If required, one schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule (Attachment Title:) to summarize the current year's operating revenue, and the first and third year's budgeted operating revenue (after project completion) for the categories that are affected by this project.

Table 1. Enter the current year data in column 1. This should represent the total revenue for the last complete year before submitting the application, using audited data. Project the first and third year's total budgeted revenue in current year dollars

Tables 2a and 2b. Enter current year data in the appropriate block. This should represent revenue by payer for the last complete year before submitting the application, using audited data.

Indicate in the appropriate blocks total budgeted revenues (i.e., operating revenues by payer to be received during the first and third years of operation after project completion). As an attachment, provide documentation for the rates assumed for each payer. Where the project will result in a rate change, provide supporting calculations. For managed care, include rates and information from which the rates are derived, including payer, enrollees, and utilization assumptions.

The Total of Inpatient and Outpatient Services at the bottom of Tables 13D-2A and13D-2B should equal the totals given on line 10 of Table 13D-1.

Required Attachments

	N/A	Title of Attachment	Filename of Attachment
1. Provide a cash flow analysis for the first year of operations after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project.	☒		
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	Swing Bed Analysis	SJH_CON_Financial Projection Summary Assumptions-Swing.doc
3. Provide the basis for charity care revenue assumptions used in Year 1 and 3 Budgets ((Table 13D-2B). *If less than 2%, provide a reason why a higher level of charity care cannot be achieved and remedies that will be implemented to increase charity care.*	☐	Charity Care explanation	SJH_CON_Charity Care- Swing.doc

Table 13D - 1

	a	b	c
Categories	Current Year	Year 1 Total Revenue Budget	Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)	7/1/2023	7/1/2024	7/01/2026
1. Inpatient Services	156728	626911	1291437
2. Outpatient Services	0	0	0
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered	156728	626911	1291437
5. Deductions from Revenue	81447	325786	682684
6. Net Patient Care Services Revenue	75281	301125	608753
7. Other Operating Revenue (Identify sources)			
8. Total Operating Revenue (Total 1-7)	0	0	0
9. Non-Operating Revenue	0	0	0
10. Total Project Revenue	75281	301125	608753

Table 13D – 2A

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 ☐ or Patient Discharges ☒

Inpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
			Net Revenue			Net Revenue			Net Revenue	
		(A) Patient Days or dis-charges	(B) Dollars ($)	$ per Patient Day or dis-charge (B)/(A)	(C) Patient Days or dis-charges	(D) Dollars ($)	$ per Patient Day or dis-charge (D)/(C)	(E) Patient Days or dis-charges	(F) Dollars ($)	$ per Patient Days or dis-charges (F)/(E)
Commercial	Fee for Service	1	3982	3982	4	15993	3998	9	36913	4101
	Managed Care	0	0	0	0	0	0	0	0	0
Medicare	Fee for Service	10	33000	3300	39	131508	3372	75	254925	3399
	Managed Care	11	36300	3300	42	141624	3372	85	288915	3399
Medicaid	Fee for Service	0			1	2000	2000	3	6000	2000
	Managed Care	1	2000	2000	5	10000	2000	11	22000	2000
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total		23	75281	3273	91	301125	3309	183	608753	3327

Table 13D – 2B

Various outpatient services may be reimbursed as visits or procedures. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Visits (V) ☐ or Procedures (P) ☐

Outpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
			Net Revenue			Net Revenue			Net Revenue	
		(A) V/P	**(B)** Dollars ($)	$ per V/P **(B)/(A)**	**(C)** V/P	**(D)** Dollars ($)	$ per V/P **(D)/(C)**	**(E)** V/P	**(F)** Dollars ($)	$ per V/P **(F)/(E)**
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										

Total of Inpatient and Outpatient Services									

Schedule 16
CON Forms Specific to Hospitals Article 28

Contents:

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.

St. James Hospital, an Acute Care General Hospital plans to use existing Patient Room 2140A and Patient Room 2120U for skilled nursing swing beds and Patient Room 2120J and Patient Room 2021H as a ("Step-Up") ICU Bed. The ("Step-Up") ICU Bed is intended to accommodate patients that are in need of Step-Up care, e.g. keeping patients on a mechanical ventilation up to 36 hours but no more than 96 hours. This approach creates the flexibility to switch from in-patient to skilled care status or in-patient to Step-Up care when applicable for patient care on the medical surgical unit.

For Hospital-Based -Ambulatory Surgery Projects:
Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category

For Hospital-Based -Ambulatory Surgery Projects:
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:

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.)

St. James Hospital (SJH) is a sole community provider and safety net hospital. SJH is located in Hornell, N.Y., in western Steuben County in the rural Southern Tier of New York State. SJH's primary service area is a 15-mile radius from Hornell, with a population of 36,090. The secondary service area is a 30-mile radius from Hornell with a population of 161,866.

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

St. James Hospital has always provided a significant level of care to low-income, uninsured, and vulnerable populations. For the five-year period 2013-2018, population growth in the SJH service area is projected to be flat to negative. The population is more elderly and less affluent compared with populations across New York State and the United States: by 2018, the proportion of elderly residents is projected to be nearly 27% higher than the national average; and the proportion of households at lower to middle-income levels is higher compared with state and national averages.

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.

Considering the prevalent healthcare factors affecting Steuben County, demand for outpatient procedures will continue to rise. Market projections for outpatient procedures by site of care in the the region show significant growth across all sites, especially emergency services and ambulatory surgery. Currently, SJH is the largest provider of outpatient services in Steuben County, with 15.2% of the market seeking care at SJH (Corning Hospital is the second largest provider with 14.5%).

Additionally, in 2012 SJH was the top ambulatory surgery provider in the 15-mile radius primary service area, with nearly double the volume (30.1%) of its closest competitor (Noyes Memorial Hospital, at 16.8%). The forecast for outpatient procedure growth for the 15-mile radius market area over the next 10 years is positive (16.9% growth overall). The plan is to open a Federally Qualified Health Center (FQHC), Oak Orchard Health (Oak Orchard), in Hornell to care for Medicaid patients who have limited access to primary care physicians via a business model that can provide this care in a more

financially viable manner, with behavioral health and wraparound services from community based organizations integrated into their model.

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

Our community has both economic and healthcare needs. The healthcare needs of our community reflected in the DSRIP Finger Lakes Performing Provider System (FLPPS) Community Need include: (i) development of an Integrated Delivery System to address chronic healthcare conditions by preventing obesity,diabetes and substance abuse, and promoting mental health. The Steuben Comprehensive Regional Community Health Assessment 2022, report concerns with the elderly population living in poverty and not have readily available resources for help in the home when health concerns keep them from remaining at home without caregiver cost.

(b) 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.

Yes, the hospital would and has been providing support and rehabliation services for patient that are no longer medical necessary for inpatient acute care services, but need a short term rehabilation service before going back home. The hospital provider services withour discrimation and offer financial assistance program when applicable.

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

St. James Hospital currently provides theses services (inpatient and outpatient services, including emergency, acute medical and surgical, imaging, and laboratory. Special services include cardiac and pulmonary rehabilitation; and physical therapies. St. James Hospital also runs an Urgent Care, Primary Care, and orthopedics. This project provides for other community services (i.e. primary care and specialist) to come together on one healthcare campus.

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.

The Finger Lakes Performing Provider System (FLPPS) Community Needs Assessment (CNA) provides pieces of information supporting the need for a swing bed access, where our community members are unable to get the support they need at home to allow them to go home after a direct inpatient hospital visit. The Steuben Comprehensvie Regional Community Health Assessment 2022, support the increase concerns that challenge our elderly population with ability to get the care they need at home, living on social security limiting ability to pay for home health services. The counties limited ablity to provider home health and aid services. The rising age living expectancy and the increase need for rehabiliation beds. Access to short term rehabilitation services has been a strain on health care facilities and caregivers.

The county has several health factors that contribute to the members of the community needing additional support to strenght and conditioning the member to be able to remain in the home longer.

Steuben County ranks as one of New York State's neediest counties — 52nd of 62 counties in health factors rankings.

Obesity Prevalence-In Steuben County the age-adjusted percentage of adults who are obese (BMI 25 or higher) is 66% compared to the New York State rate of 59%.

Diabetes-The PQI Rate for diabetes is > 372/100K (map 11, p. 62 of FLPPS CNA)

Cardiovascular Disease Prevalence-The prevalence of cardiovascular disease among adults in Steuben County is 8.5% compared to 7.7% statewide.

Additionally, Steuben County's death rate / 100,000 is higher than the state rate for cardiovascular disease (236 vs. 221); cerebrovascular disease (49 vs. 36); and chronic lower respiratory disease (67 vs. 36).

Tobacco Use Prevalence

The age-adjusted percentage of adults who smoke cigarettes in Steuben County is 22% compared to the upstate New York rate of 18%. The prevalence / 100,000 of lung cancer among men in Steuben County is 114 compared to the New York State rate of 76; the county smoking rate for women is 64% compared to 54% in the state

Demographics

Educational Status The educational status, which impacts socioeconomic status, is significantly worse than NYS average with 70% of the Steuben County residents not holding a college degree. 50% have not gone beyond high school education.

Socioeconomic Status 15% of Steuben County residents live below the poverty line and 9% are unemployed – both higher rates than the NYS average.

Insurance Status-36% have public insurance; 11% are uninsured

Schedule 16 E. Utilization/discharge and patient days

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

This schedule is for hospital inpatient projects only. This schedule is required if hospital discharges or patient days will be affected by ± 5% or more, or if this utilization is created for the first time by your proposal.

Include only those areas affected by your project. Current year data, as shown in columns 1 and 2, should represent the last complete year before submitting the application. Enter the starting and ending month and year in the column heading.

Forecast the first and third years after project completion. The first year is the first twelve months of operation after project completion. Enter the starting and ending month and year being reported in the column headings.

For hospital establishment applications and major modernizations, submit a summary business plan to address operations of the facility upon project completion. All appropriate assumptions regarding market share, demand, utilization, payment source, revenue and expense levels, and related matters should be included. Also, include your strategic plan response to the escalating managed care environment. Provide a complete answer and indicate the hospital's current managed care situation, including identification of contracts and services.

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

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date: 7/1/2023		1st Year Start date: 7/1/2024		3rd Year Start date:07/01/2026	
	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						
INTENSIVE CARE						
MATERNITY						
MED/SURG						
NEONATAL CONTINUING CARE						
NEONATAL INTENSIVE CARE						
NEONATAL INTERMEDIATE CARE						
PEDIATRIC						
PEDIATRIC ICU						
PHYSICAL MEDICINE & REHABILITATION						
PRISONER						
PSYCHIATRIC						
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM	23	183	91	730	183	1,460
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL	23	183	91	730	183	1,460

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