Schedule 1
All CON Applications

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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: Jones Memorial Hospital

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
	12/7/23
PRINT OR TYPE NAME	TITLE
Boyd Chappell	VP of Finance/CFO

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 ☒	
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		
James Helms, CEO	Jones Memorial Hospital		
BUSINESS STREET ADDRESS			
191 N. Main Street			
CITY	STATE	ZIP	
Wellsville	NY	14895	
TELEPHONE	E-MAIL ADDRESS		
585-596-4002	James_Helms@URMC.Rochester.edu		

Alternate Contact			
NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY		
BUSINESS STREET ADDRESS			
191 N. Main Street			
CITY	STATE	ZIP	
Wellsville	NY	14895	
TELEPHONE	E-MAIL ADDRESS		

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			
James Helms			
BUSINESS STREET ADDRESS			
191 N. Main Street			
CITY	STATE	ZIP	
Wellsville	NY	14895	
TELEPHONE	E-MAIL ADDRESS		
585-596-4002	James_Helms@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	
J. Joseph Hanss II	CPL	205 St. Paul Street	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Rochester, NY 14604	585-402-7544	jhanss@CPLteam.com	

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

New York State Department of Health
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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.

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 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 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*

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

Jones Memorial Hospital (JMH) will use Hospital expects to finance the project with a note payable to University of Rochester Medical Center he project.with interest rate of 5.5% for a 120 month term. Year 1-Year 2 Cash flow attached: Jones Sch 05

2. Pro Forma Balance Sheet

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

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

Jones Memorial Hospital
Cash Flow Projection
(Not Inclusive of Foundation or PC)
Hornell Infusion Project

		YR 1 Fiscal Year 2025	Fiscal Year 2026	YR 3 Fiscal Year 2027
	Total Net Patient Revenue	2,131,248	2,212,888	2,297,509
	Other Operating Revenue			
	Total Operating Revenue	$ 2,131,248	$ 2,212,888	$ 2,297,509
Operating Expenses				
	Salaries and Wages	356,168	319,613	281,793
	Fringe Benefits	71,234	63,923	56,359
	Physicians Fees	8,440	8,456	8,472
	Purchased Services			
	Supply Expense	1,600	1,651	1,704
	Pharmaceutical Supplies	1,131,080	1,223,863	1,324,222
	Utilities	6,770	6,986	7,209
	Repairs and Maintenance			
	Insurance Expense			
	All Other Operating Expenses	3,827	3,834	3,841
	Leases and Rentals	186,365	196,701	207,194
	Depreciation	177,509	177,509	177,509
	Interest Expense (Non-Governmental Providers)	91,503	83,481	75,421
	Total Operating Expenses	$ 2,034,497	$ 2,086,018	$ 2,143,725
	Net Operating Income	96,751	- 126,870	- 153,784
	Add Back Depreciation	274,260	- 304,379	- 331,293
	Net Cash Flow	274,260	- 304,379	- 331,293
	Total Beginning Cash	188,551	462,812	767,191
	Ending Cash	462,812	767,191	1,098,484

Limited Review Application

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

Attachment A.1

Project Narrative

Name:	Jones Memorial Hospital Outpatient Infusion & Clinic
Location:	7309 Seneca Road, Hornell, NY 14843
Purpose:	New outpatient infusion & clinic

I. ARCHITECTURAL

The Jones Memorial Hospital is proposing to build a new outpatient infusion & clinic at the Hornell Medical Office Building in compliance with NYS Public Health Law Article 28.

1. CODES AND REGULATIONS

The new clinic will comply with the rules and regulations standards for outpatient health facilities subject to New York's Public Health Law Article 28 and Title 10 of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR) Parts 711, Section 711.2 Pertinent technical Standards. Specifically, the following:

1. 2018 FGI Guidelines for Design and Construction of Outpatient Facilities *(Exception to NYDOH Reference Standards)*
2. 2020 New York State Building Code (IBC 2020)
3. 2012 Edition NFPA 101 Life Safety Code

2. SUMMARY

The new facility will be located at the southwest corner of the existing outpatient building. The proposed suite is organized into two patient areas; one for 6 infusion chairs and a second with 6 exam rooms, plus common rooms; one for patients (waiting room, reception, public toilet, and phlebotomy-lab room) and another for staff (offices, staff conference-lounge, and toilet).
Not included in this application, the owner of the building will provide a new entrance to building closer to the to the new suite.

3. EXISTING CONDITIONS:

1. The existing medical office building is a one-story 130,000 SF building, originally designed as a shopping plaza and recently refurbished as part of the Hornell Medical Village, adjacent to the new hospital building. The building is divided into two Fire areas. The building is classified for Business occupancy.
2. The existing clinic will be accessed directly from grade from the parking lot. The parking lot that fronts this portion of the building has 190 standard and 38 handicap parking spaces. The building access complies with ADA accessibility standards.
3. The existing building structure is comprised of steel columns, girders, beams or open web joists, and metal deck roofing.
4. The sides and rear exterior walls are concrete masonry construction. The front wall is a steel stud frame construction with EIFS finish and interior drywall.
5. There are no existing interior partitions in the proposed suite (is a shell space).
6. The building construction type classification is 2 B (by NYSBC/IBC), and II(000) (by NFPA).

4. NEW CONSTRUCTION:

This application is limited to the new construction works inside the suite including new window openings in the south wall; the suite's perimeter partitions, public corridors, and new exterior entrance will be the building's owner.

Architectural Program

Based on "Guidelines for Design and Construction of Outpatient Facilities" FGI 2018 Edition (exception to NYDOH referenced standards)

Room Name	No	Unit Area	Area	FGI 2018 Edition - Section
Public Areas				
Reception/Registrar Workstation	1	108	108	2.1-6.2.2/ 2.2-3.64.3(1)
Patient/Visitor Waiting Area	1	297	297	2.1-6.2.3/ 2.2-3.10.8.1
Unisex Public Toilet Room:	1	46	46	2.1-6.2.4/ 2.2-3.10.8.1(1)
Subtotal			**451**	**Public Areas**
Clinical Common Areas				
Patient Vitals Alcove	1	15	15	Patient Scale
Blood Draw Station & Lab	1	80	80	2.1-4.1.2.1/ 2.1-4.1.8.2(3)
Patient Toilet Room	1	45	45	2.2-3.10.2.6
Clinic Suite				
Exam Room (110 to 112 SF)	6	110	660	2.1-3.2.1.2 Single patient exam rooms
Nurse Station	1	110	110	2.1-3.8.2 - 2.1-3.8.8.2 (2)(i)(iii)
Infusion Suite				
Treatment bays (min 70 SF)	6	72	432	2.6-3.1.2.1(1) Includes patient storage
Nurse Station & Cart Alcove	1	87	87	2.6-3.8.2/ 2.1-3.8.2
Patient Toilet Room	1	47	47	2.6-3.1.6.1
Medication Preparation Room	1	49	49	2.6-3.8.8/ 2.1-3.8.8.2
Carts storage	1	49	49	
Nourishment Station Alcove	1	32	32	2.6-3.8.9/ 2.1-3.8.9/2.1
Patient Support (common)				
Clean Supply Storage Room	1	83	83	2.6-3.8.11/2.1-3.8.11
Soiled Workroom	1	74	74	2.6-3.8.12/ 2.1-3.8.12
Subtotal			**1,763**	**Clinical Areas**
Staff/Administrative Space				
Staff Conference/Lounge (including lockers & coat rack)	1	170	170	2.1-6.4.1, 2.1-6.4.2 2.1-6.4.2
Providers Office	2	80	160	2.1-6.3.3
Adm. Offices (shared office)	1	80	80	2.1-6.3.3
Staff Toilet	1	41	41	2.2-3.6.7.1
Subtotal			**451**	**Staff/Administrative Space**
Support				
Mechanical & Electrical Room	1	80	80	2.1-5.4.2.1
EVS (Janitor)	1	40	40	2.2-3.6.4.3(8)/2.1-5.3.1.2
Subtotal			**140**	**Support**
Net Square Foot Total			**2785**	
Circulation & Interior partitions			1025	
Gross Square Foot Total			**3,810**	

II. MECHANICAL

PROPOSED HORNELL CLINIC FACILITY HVAC SYSTEM

1. GENERAL DESIGN CRITERIA

- All engineering design and construction work will comply with the following codes and standards.
  - The Building Code of New York State (2020)
  - Mechanical Code of New York State (2020)
  - Energy Conservation Construction Code of New York State (2020)
  - ANSI/ASHRAE/ASHE Standard 170-2017, Ventilation of Health Care Facilities (2020)
- Installation of all mechanical equipment, rails and curbs shall conform to wind restraint requirements of the NYS Building Code.
- Indoor, concealed, round duct insulation shall be mineral-fiber blanket: 1-1/2 inches thick and 1.5-lb/cu. ft. nominal density.
- Indoor, concealed, rectangular duct insulation shall be mineral-fiber blanket: 2 inches thick and 1.5-lb/cu. ft. nominal density.
- All penetrations through fire rated walls shall be fire stopped.
- All equipment will be selected with directly-driven fan motors with VFD's or electronically commutated motors where possible.
- Ductwork shall be per SMACNA standards.
- Return ductwork for rooftop units (RTU's) with plenum returns shall be lined with two-inch flexible elastomeric lining.
- Hot-water heating piping NPS 2 and smaller, shall be Type L drawn-temper copper tubing, wrought-copper fittings, and soldered joints. Condensate-Drain Piping: Type DWV, drawn-temper copper tubing, wrought-copper fittings, and soldered joints.
- Heating hot water piping size NPS 1-1/4: Insulation shall be mineral-fiber, preformed pipe, Type I: 1-1/2 inches thick.
- Provide a new, light commercial, building management system to provide control for the Hornell Clinic HVAC equipment.

2. EXISTING BUILDING HVAC DEMOLITION

- The existing gas unit heater in the space will be demolished by the building owner prior to construction, including gas piping and vent through roof.

3. GENERAL MECHANICAL/ HVAC DESIGN INFORMATION

- Return and exhaust/relief: -2" w.c.
- Supply: +2 w.c.
- Ductwork will be insulated according to the following schedule:
  - Exhaust and Relief Ducts Within 10 ft of Exterior Openings:
  - Flexible Glass Fiber Duct Insulation: 1-1/2 inches thick.
  - Rigid Glass Fiber Duct Insulation: 1-1/2 inches thick.
- Supply Ducts:
  - First 10 ft from unit supply/return connections
    - Duct Liner
  - Other than first 10 ft from supply connection

  - Flexible Glass Fiber Duct Insulation:
    - Thickness required to provide an R value not less than R-6.
  - Rigid Glass Fiber Duct Insulation:
    - Thickness required to provide an R value not less than R-6.
- Smoke and fire dampers shall be installed per code requirements and based on the wall ratings indicated in the Architectural drawings.
- All penetrations through fire rated walls shall be fire stopped.
- Condensate drain piping shall be Type DWV drawn-temper copper tubing with soldered joints. Insulate condensate piping with ¾" flexible elastomer pre-formed insulation.

4. PROPOSED HVAC SYSTEM

- In conjunction with a hydronic heating system, rooftop units (RTU's) will provide heating, ventilation, and air conditioning to all occupied spaces. One (1) rooftop unit is anticipated in the design. RTU shall have direct-expansion (DX) cooling, with gas-fired heating. Energy recovery shall be incorporated where required by code. A hot water boiler plant shall be provided to serve VAV terminal units, unit heaters and cabinet unit heaters. The boiler plant and airside systems are detailed below.

- **WALL-HUNG BOILER:**
  - The boiler plant shall consist of (1) wall-hung boiler, (1) associated boiler pump, (2) lead-lag zone circulation pumps, air separator, compression tank, make-up water connection, and distribution piping throughout the clinic. Boiler basis of design: Navien NHB.
  - All heating hot water piping shall be indoors and will serve VAV terminals and unit heaters.
  - Heating hot water temperatures will be designed for 160°F supply with a 30°F ΔT to optimize the system efficiency.
  - The boiler shall be direct vent with intake air from the roof through PVC or a listed polypropylene venting system.
  - The boiler venting material shall be a listed polypropylene venting system.
  - The hydronic pumping equipment shall be an inline circulator. Pumps shall be driven by premium efficiency, ECM motors. The pumps shall have a basis of design of Grundfos.

- **Roof Top Units:**
  - The proposed clinic space will be provided with (1) variable speed, vertical roof top air handling unit (RTU) to provide HVAC. The RTU will provide approximately 5-tons of cooling. The RTU will also have a gas heat exchanger to provide heating. RTU Basis of Design: Daikin.
  - If required by code, the RTU shall come with a desiccant energy wheel with a total effectiveness of 70% or higher energy recovery section. The ERV shall be AHRI certified. Unit shall feature double wall exterior construction to minimize air minimize air leakage and have a higher thermal efficiency. Fan motors shall be of the premium efficiency electronically commutated motors (ECM) type with built-in variable speed capabilities.
  - The RTU will provide the required ventilation air. The ventilation air requirements are determined using ASHRAE Standard 170 for all clinic spaces as well as the NYS Mechanical Code, and ASHRAE Standard 62.1 – Ventilation for Acceptable Indoor Air Quality for all non-clinic spaces. Ventilation air will be derived from the clinic load analysis program in addition to that air that is required by code for exhaust air. Depending on the final configuration, it is estimated that the RTU will provide a total of approximately 2000 cfm of supply air to the spaces with 550 cfm of outside air to the space. The RTU will supply required ventilation air to the VAV boxes to

allow zone temperature control. Building relief air will be ducted through the RTU's Energy Recovery section to extract and recover energy from the air stream.

- **Variable Air Volume Boxes:**
  - Multiple above ceiling mounted, variable air volume boxes will be provided throughout the clinic to provide air quantity and temperature control. Currently, we are estimating 8 zones, with one VAV box per zone. Each VAV will modulate the amount of ducted supply air to meet the space needs.

- **Exhaust Fans:**
  - Roof mounted exhaust fans will be designed to exhaust toilet rooms, janitor closets, and other spaces requiring exhaust per the mechanical code and ASHRAE 170.

- **Controls and Building Management System**
  - All temperature controls will be integrated into the existing clinic, direct digital control system.
  - The procurement of all hardware and software costs, the procurement and installation of control devices, such as control valves, actuators, dampers, sensors, relays, control panel enclosures, control transformers, terminal strips, and all other end control devices, shall be described in the bid documents.
  - The control system shall consist of a high-speed, peer-to-peer network of direct digital control (DDC) controllers and a web-based operator interface. The control system shall depict each mechanical system and building floor plan by a point-and-click graphic. A web server with a network interface card shall gather data from this system and generate web pages accessible through a conventional web browser on each PC connected to the network. Operators shall be able to perform all normal operator functions through the web browser interface.
  - The control system shall directly control HVAC equipment as specified in Sequence of Operation specification. Each zone controller shall provide occupied and unoccupied modes of operation by individual zone. The system shall furnish energy conservation features such as optimal start and stop, night setback, request-based logic, and demand level adjustment of set points as specified Sequence of Operation specification.

III. PLUMBING

1. GENERAL DESIGN CRITERIA

1. Design shall meet the following codes and standards:
   - 2020 New York State Building Codes
   - 2018 Facilities Guidelines Institute Guidelines for Design and Construction of Outpatient Facilities
   - 2016 NFPA 13 Standard for the Installation of Sprinkler Systems
2. All penetrations through fire rated walls will be fire stopped.

2. WATER SYSTEMS

1. The existing building water service is provided with dual reduced pressure zone backflow preventers. The water service is approximately 75-80 psi without a domestic water boosting system. The building owner will provide 2" domestic water up to the fit-out space.
2. The new domestic water piping shall be Type L copper tubing with solder fittings and fiberglass insulation.

3. Domestic hot water shall be provided by an electric tank type water heater within the new fit-out space mechanical room. An electronically commutated motor hot water recirculation pump system and automatic flow control balance valves will provide hot water recirculation to the plumbing fixtures. The hot water system will have a digital mixing valve to control supply water temperature, matching what is currently installed in the adjacent Jones Memorial clinic space.

3. FIRE PROTECTION SYSTEMS

1. There currently is a light hazard fire protection system in the open shell space.
2. The existing upright heads will be removed with new return bends provided for surface mounted, concealed pendant sprinkler heads in the new lay-ceiling system.

4. MEDICAL GAS SYSTEMS

1. Medical gas systems will not be required for this building based upon intended use.

5. GAS SYSTEMS

1. The building is supplied with a gas service that is metered to multiple tenants. The gas service to the entire building is regulated to 10.7" water column. The existing Jones Memorial gas service has 2" gas service supplying a RTU and a boiler. The meter is located outside the building with distribution piping on the roof.
2. The gas service will need to be coordinated with the utility to additional flow through the existing Jones Memorial meter. Existing gas piping on the roof will be replaced where it necks down to 1-1/2" to provide capacity to the new RTU and boiler.

6. DRAINAGE SYSTEMS

1. The building sanitary piping is PVC below grade and will be extended to the back of the fit-out space by the building owner. The building sanitary is drained to existing building sewage ejector pumps that are powered from the building owner's emergency generator.
2. Below grade sanitary and vent piping will be replaced with PVC DWV pipe. New below grade sanitary and vent piping will require saw-cutting and excavation of existing concrete floor slab.
3. Above grade sanitary and vent piping will be either no-hub cast-iron soil pipe or copper DWV piping. Sanitary vents will combine and will be vented through the roof.
4. Standpipes will be provided for HVAC condensate drains.
5. The building existing storm drainage system is provided by existing roof drains that are not located in the fit-out space.

7. PLUMBING FIXTURES

1. Exam rooms, draw lab, meds room, and pantry will have ADA-compliant stainless-steel sinks and manual gooseneck faucets.
2. Lavatories will have ADA-compliant, wall mounted vitreous china fixtures with concealed carriers and manual faucets. Lavatory in Patient of Size Toilet room to be wall mount, solid surface capable of withstanding 1000 pounds at front of lavatory.
3. Water closets will be ADA compliant, floor mounted vitreous china fixtures with flush valve. Toilet in Patient of Size Toilet room to be rated for 750 pound bariatric use.
4. EVS room will be provided with a mop service basin with check valves in the water supplies per FGI.

IV. ELECTRICAL

1. GENERAL DESIGN CRITERIA

- All engineering design and construction work will comply with the following codes and standards.
  a. The Building Code of New York State (2020)
  b. FGI Guidelines for Design and Construction of Residential Health, Care and Support Facilities 2022 Edition
  c. Americans with Disabilities Act (ADA)
  d. Underwriter's Laboratory (UL)
  e. Energy Conservation Construction Code of New York State (2020).
  f. All applicable chapters of NFPA, including, but not limited to:
    - NFPA 70 – National Electrical Code
    - NFPA 72 – National Fire Alarm Code
    - NFPA 101 – Life Safety Code
    - NFPA 110 – Emergency and Standby Power Systems
- All penetrations through fire rated walls shall be fire stopped.

Basic Electrical Materials and General Electrical Design Information:

- Branch circuit and feeder wiring:
  - Stranded copper 600V conductors with type THHN insulation.
  - Minimum conductor size shall be #12 AWG.
  - Maximum conductor size shall be #500 kcmil
  - A separate neutral and equipment ground conductor shall be installed for each branch circuit and feeder as required.
  - Interior conduits in dry areas shall be EMT with set-screw fittings.
  - Exterior exposed conduits shall be threaded rigid galvanized steel.
  - Minimum size branch circuit and systems cabling conduit shall be 3/4".
  - Liquid-tight flexible conduit shall be used for final connections to vibrating equipment in 6'-0" maximum length.
- Low voltage wiring for voice/data shall be open-air systems supported via j-hooks and bridal rings. Fire rated electrical sleeves and EZ- path units shall be installed where system wiring penetrates walls and/or floors.
- Electrical distribution equipment such as branch circuit and lighting panelboards, dry-type transformer, etc. basis of design shall be Square D. All panelboards shall contain copper bussing, equipment ground bars, hinged doors and front covers and be fully rated.
- All duplex and double-duplex receptacles shall be of hospital grade construction, tamper resistant and contain plug-tails. Wiring devices basis of design shall be Pass and Seymour. Devices shall be white in color with brushed type 302 stainless steel faceplates.
- The new LED lighting systems installed in renovated areas and new addition shall comply with all requirements of the State of New York Energy Conservation Construction Code for lighting controls and power density. Proposed Lighting Controls shall be as follows:
  - Combination switchbox mounted 0-10V dimmer/vacancy sensors. (manual on/auto off).
  - Dual-Technology ceiling and wall mounted vacancy and occupancy sensors.

- Automatic photocontrol for control of lighting based on incoming ambient conditions in waiting areas that meet the requirements of lighting load within ambient lighting zones.
- Specification grade wall mounted dimmer switches.
- Specification grade single pole and 3-way toggle switches

- All fire alarm work shall be coordinated with owner preferred vendor, Davis Ulmer. Fire alarm system work shall be an expansion of the existing Edwards iO Series point addressable system and shall consist of initiation and notification devices.
- New fire alarm initiation devices shall consist of point addressable manual pull stations, addressable area smoke detectors and duct smoke detectors.
- New fire alarm notification devices shall consist of combination horn/strobes and strobes. All strobes shall be synchronized and all audio devices shall match the existing system tone. Notification appliance power supply panels shall be provided as required to serve new devices.
- Automatic shut-down of HVAC equipment through the fire alarm system shall be determined during design phases and shall be in compliance with all NFPA requirements for systems with 2,000cfm or greater supplies and 15,000 cfm and greater return systems. New mechanical system smoke dampers shall be controlled via addressable relays to de-energize and close dampers upon activation of the system.
- All fire alarm cabling shall be installed in EMT conduit. All fire alarm system junction boxes shall be red in color with stencil lettering indicating "Fire Alarm System"
- New voice/data drops shall be provided within the renovation area and addition, each consisting of a flush mount 4" square box with single gang mud ring. A 1" EMT conduit with nylon pull string and plastic end bushing shall be run from the box and elbowed above accessible finished ceiling space. All voice/data horizontal cabling shall be provided, installed, terminated and tested by UR IT Department
- Wireless access points shall be provided in the renovation area consisting of a Cat 6 cable with 25' service loop coiled above finished ceiling space. Access point hardware and cabling shall be provided by the owner.
- Cable TV (CATV) drops shall consist of a flush mount 4" square box with single gang mud ring with 1" EMT conduit with plastic end bushing elbowed above accessible finished ceiling space. CATV drops locations shall be determined with owner during design phases. Each CATV drop location shall contain a coaxial F-connector and RG6 coaxial cabling run to the nearest cable floor TV demark. All drop locations shall be coordinated between CPL and UR during design phases.
- Access control and CCTV systems shall be installed as required. As a minimum, the access control system shall contain card readers, door interface controllers and electric strikes at select exterior doors. IP based CCTV cameras shall be located per direction of the owner and cabled back to PoE switches in the nearest data closet via Category 6 cabling. All access control and CCTV requirements shall be coordinated with UR and hospital preferred vendor during design phases.

2. EXISTING BUILDING ELECTRICAL DEMOLITION

- Existing miscellaneous items within the renovation area such unit heaters shall have their associated branch circuiting disconnected and removed back to source.

3. PROPOSED POWER DISTRIBUTION

- The building main electrical room contains an Eaton Pow-R-Line PRL-C switchboard containing utility meter cubicles and associated load side circuit breakers.
- The existing switchboard contains a 400A and 200A spare meter sections.

- A new 277/480V, 225A MLO, 42 circuit panelboard "HPP" shall be installed in the renovated area Electrical Room and fed from the spare 200/3 switchboard breaker with (4) #3/0, #6 Gnd in 2" EMT conduit.
- Panelboard "HPP" shall serve loads such as lighting, exit signage and HVAC equipment.
- Panelboard "HPP" shall serve a floor mount 30kVA dry-type transformer which will serve an adjacent 120/208V, 100A MCB, 42 circuit panelboard "LPP".
- Panelboard "LPP" shall serve loads such as receptacles, fractional horsepower HVAC equipment, building systems/controls and owner equipment.

4. PROPOSED LIGHTING SYSTEM

- New LED fixtures shall be installed in the renovated area as follows:
  - Corridors - 2x2 architectural edge-lit recessed LED troffers.
  - Offices, Nurse Stations and reception spaces - 2x2 architectural edge-lit recessed LED troffer with 0-10v dimming.
  - Waiting Areas – 2x2 architectural edge-lit recessed LED troffer and 6" recessed LED downlights all with 0-10v dimming
  - Exam and Blood/Lab Rooms – 2x4 lensed back-lit LED troffers with 0-10v dimming and switchable lumen level.
  - Staff Lounge - 2x4 lensed back-lit LED troffer with 0-10v dimming.
  - Toilet Rooms – 6" recessed LED downlight(s) and 24" over-mirror LED sconce.
  - Supply, Carts, Soiled, EVSand Meds - 2x4 lensed back-lit LED troffer.
  - Exit Signs – Surface mount architectural edge-lit LED exit signs with battery back-up and self-diagnostics
- Emergency egress lighting shall consist of dual-head LED wall mount units with battery back-up and self-diagnostics.
- Exterior building mounted LED decorative wallpack style fixtures shall be installed at each exit door. Fixtures shall contain integral battery backup for the required 90 minute exterior path of egress.

5. PROPOSED PATIENT CALL SYSTEM

- An emergency call system shall be provided consisting of an emergency call station in each patient toilet room with audible/visual notification at the Nurse Station. System manufacturer shall be Edwards Signaling or approved equivalent.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

SELF-CERTIFICATION FORM FOR ARCHITECTS AND ENGINEERS

Date: September 25, 2023
CON Number:
Facility Name: Jones Memorial Hospital - Outpatient Infusion & Clinic
Facility ID Number:
Facility Address: 7309 Seneca Road, Hornell, NY 14843

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 above-named facility, to provide services related to the design and preparation of construction documents and specifications for the aforementioned construction project, and, as applicable, to make periodic visits to the site during construction, and perform such other required services to familiarize myself with the general progress, quality and conformance of the work.

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 programmatic requirements for the aforementioned and in accordance with any project definitions, modifications and or revisions approved or required by the New York State Department of Health.

3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations, and the applicable provisions of the State Hospital Code -- 10 NYCRR Part 711 (General Standards for Construction) and Parts (check all that apply):
   a. __712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. X 715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

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 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.
   Exception to NYDOH Reference Standard 2018 FGI Guidelines for Design and Construction of Outpatient Facilities
5. I understand that upon completion of construction, the costs of any subsequent corrections necessary to address the pre-opening survey findings of deficiencies by the NYSDOH Regional Office, 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.

6. I have reviewed and acknowledged the Supplemental Self-Certification Eligibility Checklist Page 4 of this document and evaluated and determined this project does meet the prerequisite requirements for Self-Certification. I understand and agree, if the project is deemed by NYSDOH not meeting the criteria allowable for self-certification, I will be required to be resubmit the project documents for an AER review.

   This self-certification is being submitted to facilitate the Architectural CON process and is in lieu of a plan review. 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, prior to construction.

Project Name: JMH- Outpatient Clinic

Location: 7309 Seneca Road, Hornell, NY 14843

Description: New construction outpatient infusion & clinic.

Signature of NYS Licensed Architect/Engineer

John Joseph Hanss II

Name of Architect/Engineer (Print)

029607

Professional New York State License Number

255 Woodcliff Dr, Suite 200, Fairport, NY 14450

Business Street Address, City, State, Zip Code

Architectural or Engineering Professional Stamp

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

Authorized Signature for Applicant

12/6/23
Date

Boyd Chappell / CFO
Name (Print) Title

Notary signing required for the applicant

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

On the 6 day of December 2023 before me personally appeared Boyd Chappell, to me known, who being by me duly sworn, did depose and say that he/she is the VP for Finance / CFO of the Jones Memorial Hospital, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

TERI A. MONROE
Notary Public No. 01MO6376125
Allegany County, New York
My Commission Expires June 4, 2026

(Notary) Teri A Monroe

Project Eligibility Checklist for Architectural/Engineering Self-Certification			
	Does the project include any of the following?	YES If Yes, project is not eligible for Self-Certification and is required to be submitted for an AER review.	NO
1.	Is a waiver or exceptions required?		X
2.	Will the project costs exceed $15,000,000.00 (fifteen million dollars.)?		X
3.	Is Bulk Oxygen /Medical Gas Storage associated with this project? Examples of Bulk Oxygen /Medical Gas Storage projects include but not limited to the following:		X
	a. Hyperbaric Chambers		
	b. Bulk Systems include Nitrous Oxide System and Oxygen System: Definitions as defined below:		
	Bulk Nitrous Oxide System. An assembly of equipment as described in the definition of bulk oxygen system that has a storage capacity of more than 3200 lb (1452 kg) [approximately 28,000 ft³ (793 m³) (NTP)] of nitrous oxide. (PIP)ground		
	Bulk Oxygen System* An assembly of equipment such as oxygen storage containers, pressure regulators, pressure relief devices, vaporizers, manifolds, and interconnecting piping that has a storage capacity of more than 20,000 ft³ (566 m³) of oxygen (NTP) including unconnected reserves on hand at the site. The bulk oxygen system terminates at the point where oxygen at service pressure first enters the supply line. (PIP)		
4.	Will this project have Locked or Secured Units? Examples of Locked or Secured Units include but not limited to the following:		X
	a. Observation Units for behavioral health in ED's.		
	b. Behavioral health located within inpatient settings.		
	c. Nursing Homes or other facilities with Dementia Units that are locked.		
	d. Corrections and Detention Facilities located in Hospitals, Ambulatory Health Care Occupancies and Business Occupancies where healthcare is provided.		
5.	Will this project involve construction of new procedure rooms, new operating rooms, renovations and or alterations to existing procedure rooms and or operating rooms, including modifications made to existing support systems, including, but not limited to heating, cooling, plumbing, electrical systems, medical gas systems, fire detection and fire protection systems, located in hospitals and existing ambulatory surgery centers? Examples, include but not limited to the following.		X
	a. Endoscopy Procedure Rooms		
	b. Procedure Rooms		
	c. Operating Rooms		
	d. Interventional Imaging *i.* Located in procedure rooms *ii.* Located in operating rooms		
6.	Is this a project requiring construction that is required to comply with New Ambulatory Health Care Occupancies as indicated in Chapter 20 of NFPA 101, 2012 edition requirements? Examples, include but not limited to the following:		X
	a. New Ambulatory Surgery Center		
	b. Endoscopy Centers and or Other Procedure Rooms		
	c. Free Standing Emergency Departments providing Definitive Care.		
7.	Is this project intended to provide Ventilator units for patients located in nursing homes?		X
8.	Does this project involve Airborne infection isolation (AII) room?		X
9.	Does this project involve Protective environment (PE) room?		X

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:		
	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:			
	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.

https://www.fema.gov/media-library-data/1582295171786-6506170c5f54026f585e44e2fc94950d/FF086033_ElevCert_FormOnly_RE_11Feb2020.pdf

New York State Department of Health
Certificate of Need Application
Schedule 8A Summarized Project Cost and Construction Dates

This schedule is required for all Full or Administrative review applications except Establishment-Only applications.

1.) Project Cost Summary data:

	Total	Source
Project Description:		
Project Cost	$1,841,770	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$1,841,770	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$156,377	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	$303	Schedule 10
Cost/Per Square Foot for Renovation Construction	$0	Schedule10
Total Operating Cost	$1,801,150	Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.00%	Schedule 9
Depreciation Life (in years)	15	

2) Construction Dates

Anticipated Start Date	1/1/2024	Schedule 8B
Anticipated Completion Date	5/1/2024	

New York State Department of Health
Certificate of Need Application
Schedule 8B - Total Project Cost - For Projects without Subprojects.

This schedule is required for all Full or Administrative review applications except Establishment-Only applications

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	0.00%	Normally 10%
Construction Contingency - Renovation Work	0.00%	Normally 10%
Anticipated Construction Start Date:	1/1/2024	as mm/dd/yyyy
Anticipated Midpoint of Construction Date		as mm/dd/yyyy
Anticipated Completion of Construction Date	5/1/2024	as mm/dd/yyyy
Year used to compute Current Dollars:	2023	

Subject of attachment	Attachment Number	Filename of attachment - PDF
For new construction and addition, at the schematic stage the design contingency will normally be 10% and the construction contingency will be 5%. If your percentages are otherwise, please explain in an attachment.		
For renovation, the design contingency will normally be 10% and the construction contingency will be 10%. If your percentages are otherwise, please explain in an attachment.		

New York State Department of Health
Certificate of Need Application
Schedule 8B - Total Project Cost - For Projects without Subprojects.

	A	B	C
Item	**Project Cost in Current Dollars**	**Escalation amount to Mid-point of Construction**	**Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$1,155,000	$0	$1,155,000
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	$115,500	$0	$115,500
3.2 Construction Contingency	$70,243	$0	$70,243
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$41,750	$0	$41,750
4.3 Architect/Engineering Fees	$132,000	$0	$132,000
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$17,900	$0	$17,900
Subtotal (Total 1.1 thru 4.5)	$1,532,393	$0	$1,532,393
5.1 Movable Equipment (from Sched 11)	$156,377	$0	$156,377
5.2 Telecommunications	$153,000	$0	$153,000
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$1,841,770	$0	$1,841,770
7.1 Financing Costs (Points etc)	$0		$0
7.2 Interim Interest Expense:: $ [ ] At [ ] % for [ ] months	$0		$0
8. Total Project Cost: w/o CON fees Total 6 thru 7.2	$1,841,770	$0	$1,841,770
Application fees: 9.1 Application Fee. Articles 28, 36 and 40. See Web Site.	$2,000		$2,000
9.2 Additional Fee for projects with capital costs. Not applicable to "Establishment Only" projects. See Web Site for applicable fees. (Line 8, multiplied by the appropriate percentage.) Enter Multiplier ie: .25% = .0025 --> 0.003	$5,525	$0	$5,525
10 Total Project Cost with fees	$1,849,295	$0	$1,849,295

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	$49295
☒	C. Mortgage, Notes, or Bonds	$1800000
☐	D. Land	$
☐	E. Other	$
☐	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$1849295

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.	☐	Hornell Infusion.pdf
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	☐	Lease Agreement-markups Hornell Infusion
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.	☐	Jones_CON_Hornell Infusion Programs-- CON Summary 11.23
6. Attach two letters from independent realtors verifying square footage rate.	☐	Seneca Road_7309_Hornell Jones Lease FMV_10272023.pdf & TJW-Write CON 7309 Seneca Road Hornellsville 2023-11-1 FMV Letter.pdf
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	$1849295
TOTAL CASH	$1849295

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	JMH SCH 9 B1 Cash Sources Breakdown Hornell Infusion.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.	☐	2023 Jones Memorial Hospital AFS.pdf & Oct 2023 JMH Monthly Financial Presentation.pdf
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.	☐	JMH SCH 9 B1 Cash Sources Breakdown Hornell Infusion.xls
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.	☐	Funding the full project
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	5.5	%
Term	10	Years
Payout Period		Years
Principal	1800000	$

	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.	☐	CON Hornell Oncology Rheumatology Resolution.pdf
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.	☐	

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 43). Codes for completing this table are found in the Functional Codes Lookups sheet (see tab below).

Indicate if this project is: New Construction: [X] OR Renovation: [ ]

A		B	D	E	F	G	H	I
Location								
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* sch.8B col.A (un-escalated)	Alterations, Scope of work
			419	Primary Medical Care O/P	3810	$303.15	$1,155,000	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

A			B	D	E	F	G	H	I
Location									
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* sch.8B col.A (un-escalated)	Alterations, Scope of work
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**3810**	**303**	**1155000**	

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

If additional sheets are necessary, go to the toolbar, select "Edit", select "Move or copy sheet", make sure the "create a copy" box is checked, and select this document as the destination for the copy then select "OK". An additional worksheet will be added to this spreadsheet

	YES	NO
1. If New Construction is Involved, is it "freestanding?	X	

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:			X

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
Boyd Chappell			12/7/23
PRINT NAME			TITLE
Boyd Chappell			CFO
NAME OF FIRM			
Jones Memorial Hospital			
STREET & NUMBER			
191 N. Main Street			
CITY	STATE	ZIP	PHONE NUMBER
Wellsvlle	NY	14895	585-596-4002

New York State Department of Health
Certificate of Need Application
Schedule 11 - Moveable Equipment
For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review *

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
		See attached Schedule 11 Jones Hornell Rheumatology Detail Equip.xls				
					Total lease and purchase costs: Subproject 1	156377.72
					Total lease and purchase costs: Subproject 2	
					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:	156377.72

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

Table 2 - Equipment being replaced:

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

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and 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

questions

Jones Rheumatology - Hornell | MEDICAL EQUIPMENT/OTHER FF&E (DRAFT BUDGET)							9/22/2023
Room Type	Equip.Description	Room Name	Existing Qty.	Qty to Order.	Cost per unit	Cost	Comments
Infusion (6 Total)							
	Infusion Pumps	Infusion 1-6	6	0	$ -	$ -	
	Infusion Chair	Infusion 1-6	0	6	$ 5,150.00	$ 30,900.00	
	IV Poles	Infusion 1-6	0	6	$ 180.00	$ 1,080.00	
	Guest chair with arms	Infusion 1-6	0	6	$ 350.00	$ 2,100.00	Need additional?
	Television	Infusion 1-6	0	6	$ 225.00	$ 1,350.00	
	TV mounts	Infusion 1-6	0	6	$ 50.00	$ 300.00	
	Garbage receptacle	Infusion 1-6	0	6	$ 10.00	$ 60.00	
	Stools	Infusion 1-6	0	6	$ 253.12	$ 1,518.72	
	Tap Bells	Infusion 1-6	0	6	$ 7.50	$ 45.00	
	Clocks	Infusion (General)	0	2	$ 25.00	$ 50.00	
	Privacy Curtains in Construction	Infusion 1-6	0	0	$ -	$ -	
	Sanitizer	Infusion 1-6	0	6	$ -	$ -	
Exam Rooms (6 Total)							
	Exam Table - Hi/Low	Exam Room 1	0	1	$ 9,000.00	$ 9,000.00	
	Exam Table - Standard	Exam Room 2 - 6	0	5	$ 2,000.00	$ 10,000.00	
	Oto /ophthalmoscope	Exam Room 1 - 6	0	6	$ 950.00	$ 5,700.00	
	Sharps Container	Exam Room 1 - 6	0	6	$ 15.00	$ 90.00	
	Trash Receptacle	Exam Room 1 - 6	0	6	$ 10.00	$ 60.00	
	Glove Box Holder in Construction	Exam Room 1 - 6	0	0	$ -	$ -	
	Soap Dispenser	Exam Room 1 - 6	0	6	$ -	$ -	
	Sanitizer	Exam Room 1 - 6	0	6	$ -	$ -	
	Paper Towel Dispenser	Exam Room 1 - 6	0	6	$ 20.00	$ 120.00	
	Clocks	Exam Room 1 - 6	0	6	$ 25.00	$ 150.00	
	Guest Chairs (with arms)	Exam Room 1 - 6	0	6	$ 350.00	$ 2,100.00	
	Guest Chairs (without arms)	Exam Room 1 - 6	0	6	$ 350.00	$ 2,100.00	
	Stool for provider	Exam Room 1 - 6	0	6	$ 250.00	$ 1,500.00	
Med Alcove							
	Undercounter Med Refrigerator	Med Room	0	1	$ 3,500.00	$ 3,500.00	
	Narcotics cabinet	Med Room	0	1	$ 300.00	$ 300.00	
	Paper Towel Dispenser	Med Room	0	1	$ 20.00	$ 20.00	
	Soap Dispenser	Med Room	0	1	$ -	$ -	
	Sanitizer	Med Room	0	1	$ -	$ -	
	Trash Can	Med Room	0	1	$ 10.00	$ 10.00	
	Glove Box Holder in Construction	Med Room	0	0	$ -	$ -	
	Large waste trolleys yellow chemo	Med Room	0	1	$ 500.00	$ 500.00	
	Large waste trolleys red chemo	Med Room	0	1	$ 500.00	$ 500.00	

Carts						
	Infusion Carts	Carts	2	**0**	$ -	$ -
	Trash Receptacle	Carts	0	**1**	$ 25.00	$ 25.00
	Paper Towel Dispenser	Carts	0	**1**		$ -
	Soap Dispenser	Carts	0	**1**		$ -
	Sanitizer	Carts	0	**1**		$ -
Clean Supply						
	Shelving Allowance	Clean Supply	0	**1**	$ 2,500.00	$ 2,500.00
Soiled Work/Holding						
	Soap Dispenser	Soiled Work/Hold	0	**1**	$ -	$ -
	Sanitizer	Soiled Work/Hold	0	**1**	$ -	$ -
	Paper Towel Dispenser	Soiled Work/Hold	0	**1**	$ 20.00	$ 20.00
	Rolling linen carts	Soiled Work/Hold	0	**2**	$ 200.00	$ 400.00
	Step on garbage can w/ lid	Soiled Work/Hold	0	**1**	$ 75.00	$ 75.00
Scale/Intake						
	Temporal Thermometer	Scale/Intake	0	**1**	$ 100.00	$ 100.00
	Floor Scale (inc. height bar)	Scale/Intake	0	**1**	$ 500.00	$ 500.00
Nourishment						
	Ice & Water machine	Nourishment	0	**1**	$ 3,500.00	$ 3,500.00
	Refrigerator - Undercounter	Nourishment	0	**1**	$ 250.00	$ 250.00
	Microwave	Nourishment	0	**1**	$ 200.00	$ 200.00
	Keurig	Nourishment	0	**1**	$ 200.00	$ 200.00
	Keurig Holder	Nourishment	0	**1**	$ 25.00	$ 25.00
	Paper Towel Dispenser	Nourishment	0	**1**	$ 20.00	$ 20.00
	Soap Dispenser	Nourishment	0	**1**	$ -	$ -
	Sanitizer	Nourishment	0	**1**	$ -	$ -
	Trash Receptacle	Nourishment	0	**1**	$ 25.00	$ 25.00
Nurse Station Infusion						
	Task Chairs	Nurse Station	0	**3**	$ 425.00	$ 1,275.00
	Dinamap - Needs bp, pulse o2 and arterial temporal thermometer	Nurse Station	0	**2**	$ 3,500.00	$ 7,000.00
	Dinamap rollstand	Nurse Station	0	**2**	$ 325.00	$ 650.00
	Thermometer (handheld oral)	Nurse Station	0	**1**	$ 450.00	$ 450.00
	Soap Dispenser	Nurse Station	0	**1**	$ -	$ -
	Paper Towel Dispenser	Nurse Station	0	**1**	$ 20.00	$ 20.00
	Hand sanitizer	Nurse Station	0	**1**	$ -	$ -
	Trash Receptacles	Nurse Station	0	**3**	$ 10.00	$ 30.00
	Recycle Receptacle	Nurse Station	0	**1**	$ 10.00	$ 10.00
	Mobile Ped File Cabinets	Nurse Station	0	**3**	$ 275.00	$ 825.00
Nurse Station Clinical						
	Task Chairs	Nurse Station	0	**3**	$ 425.00	$ 1,275.00

	Dinamap - Needs bp, pulse o2 and arterial temporal thermometer	Scale/Intake	0	2	$ 3,500.00	$ 7,000.00
	Dinamap rollstand	Scale/Intake	0	2	$ 325.00	$ 650.00
	Shred Bin	Nurse Station	0	1	$ -	$ -
	Trash Receptacles	Nurse Station	0	3	$ 10.00	$ 30.00
	Recycle Receptacle	Nurse Station	0	1	$ 10.00	$ 10.00
	Mobile Ped File Cabinets	Nurse Station	0	3	$ 275.00	$ 825.00
Env. Service						
	Housekeeping cart	Env. Service	0	1	$ -	$ -
Draw/Lab						$ -
	Draw chair	Draw/Lab	0	1	$ 1,100.00	$ 1,100.00
	Small refrigerator w/freezer (undercounter)	Draw/Lab	0	1	$ 1,750.00	$ 1,750.00
	Temp. monitoring	Draw/Lab	0	1	$ 85.00	$ 85.00
	Stool	Draw/Lab	0	1	$ 250.00	$ 250.00
	Small table	Draw/Lab	0	1	$ 300.00	$ 300.00
	Soap Dispenser	Draw/Lab	0	1	$ -	$ -
	Sanitizer	Draw/Lab	0	1	$ -	$ -
	Paper Towel Dispenser	Draw/Lab	0	1	$ 20.00	$ 20.00
	Phl. Container	Draw/Lab	0	1	$ 5.00	$ 5.00
	Glove Box Holder in Construction	Draw/Lab	0	0		$ -
	Trash can	Draw/Lab	0	1	$ 10.00	$ 10.00
	Red bag Trash Can	Draw/Lab	0	1	$ 75.00	$ 75.00
Office 13L						
	Task Chair	Office 13L	0	1	$ 425.00	$ 425.00
	Desk or counter	Office 13L	0	1	$ 3,000.00	$ 3,000.00
	Mobile Ped File Cabinet	Office 13L	0	1	$ 275.00	$ 275.00
	Guest Chairs	Office 13L	0	2	$ 350.00	$ 700.00
	Trash Receptacle	Office 13L	0	1	$ 10.00	$ 10.00
	Recycle Receptacle	Office 13L	0	1	$ 10.00	$ 10.00
Office 13EE						
	Task Chair	Office 13L	0	1	$ 425.00	$ 425.00
	Desk or counter	Office 13L	0	1	$ 3,000.00	$ 3,000.00
	Mobile Ped File Cabinet	Office 13L	0	1	$ 275.00	$ 275.00
	Guest Chairs	Office 13L	0	2	$ 350.00	$ 700.00
	Trash Receptacle	Office 13L	0	1	$ 10.00	$ 10.00
	Recycle Receptacle	Office 13L	0	1	$ 10.00	$ 10.00
Office 13K						
	Task Chair	Office 13K	0	1	$ 425.00	$ 425.00
	Desk or counter	Office 13K	0	1	$ 3,000.00	$ 3,000.00
	Mobile Ped File Cabinet	Office 13K	0	1	$ 275.00	$ 275.00

	Guest Chairs	Office 13K	0	2	$ 350.00	$ 700.00	
	Trash Receptacle	Office 13K	0	1	$ 10.00	$ 10.00	
	Recycle Receptacle	Office 13K	0	1	$ 10.00	$ 10.00	
Staff Toilet							
	Step on garbage can w/ lid	Staff Toilet	0	1	$ 100.00	$ 100.00	
	Soap Dispenser	Staff Toilet	0	1	$ -	$ -	
	Paper Towel Dispenser	Staff Toilet	0	1	$ 20.00	$ 20.00	
Patient Toilet (3 total)							
	Step on garbage can w/ lid	Patient Toilet 1 - 3	0	3	$ 100.00	$ 300.00	
	Soap Dispenser	Patient Toilet 1 - 3	0	3	$ -	$ -	
	Paper Towel Dispenser	Patient Toilet 1 - 3	0	3	$ 20.00	$ 60.00	
Reception/Reg.							
	Task Chairs	Check-in	0	3	$ 425.00	$ 1,275.00	
	Trash Receptacles	Check-in	0	3	$ 10.00	$ 30.00	
	Recycle Receptacles	Check-in	0	1	$ 10.00	$ 10.00	
	Mobile Ped File Cabinets	Check-in	0	3	$ 275.00	$ 825.00	
	Shred Bin	Check-in	0	1	$ -	$ -	
Staff Lounge/Conference							
	Tables	Staff Lounge	0	1	$ 1,000.00	$ 1,000.00	
	Chairs	Staff Lounge	0	8	$ 400.00	$ 3,200.00	
	Television	Staff Lounge	0	1	$ 375.00	$ 375.00	
	TV mount	Staff Lounge	0	1	$ 85.00	$ 85.00	
	White Board	Staff Lounge	0	1	$ 200.00	$ 200.00	
	Bulletin Board	Staff Lounge	0	1	$ 70.00	$ 70.00	
	Soap Dispenser	Staff Lounge	0	1	$ -	$ -	
	Sanitizer	Staff Lounge	0	1	$ -	$ -	
	Paper Towel Dispenser	Staff Lounge	0	1	$ 20.00	$ 20.00	
	Trash receptacle	Staff Lounge	0	1	$ 10.00	$ 10.00	
	Keurig	Staff Lounge	0	1	$ 200.00	$ 200.00	
	Keurig Holder	Staff Lounge	0	1	$ 29.00	$ 29.00	
	Microwave	Staff Lounge	0	1	$ 200.00	$ 200.00	
	Refrigerator (full sized)	Staff Lounge	0	1	$ 935.00	$ 935.00	
Waiting Room							
	Guest chairs with arms	Waiting Room	0	16	$ 350.00	$ 5,600.00	Per 9/19 plan
	Bariatric Chair	Waiting Room	0	1	$ 500.00	$ 500.00	
	Side/End table	Waiting Room	0	2	$ 350.00	$ 700.00	
	Trash Receptacle	Waiting Room	0	1	$ 50.00	$ 50.00	
	Television	Waiting Room	0	1	$ 500.00	$ 500.00	
	TV mount	Waiting Room	0	1	$ 75.00	$ 75.00	
Miscellaneous							
	O2 Cylinder stand		1	0	$ -	$ -	

	Oxygen Tanks		1	**0**	$ -	$ -
	O2 concentrator		0	**1**	$ 1,000.00	$ 1,000.00
	Blood collection monitor & Case		0	**1**	$ 1,650.00	$ 1,650.00
	Pole Pedestal Stand for blood collection monitor		0	**1**	$ 125.00	$ 125.00
	AED		0	**1**	$ 1,900.00	$ 1,900.00
	Artwork Allowance	Throughout space	0	**1**	$ 2,000.00	$ 2,000.00
	Sanitizer	Throughout space	0	**6**	$ -	$ -
	Office supplies Allowance	Throughout space	0	**1**	$ 500.00	$ 500.00
	Misc. Item Allowance	Throughout space	0	**1**	$ 5,000.00	$ 5,000.00
	Bariatric Wheel Chair		0	**1**	$ 535.00	$ 535.00
Freight						
	Exam Table Placeholder		0	**1**	$ 1,500.00	$ 1,500.00
	Furniture freight / delivery		0	**1**	$ 5,500.00	$ 5,500.00
	Misc. freight Allowance		0	**1**	$ 2,500.00	$ 2,500.00
						$ -
						$ -
					TOTAL:	**$ 156,377.72**

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 1/4/24

Signature:

Boyd Chappell
Name (Please Type)

CFO
Title (Please type)

New York State Department of Health
Certificate of Need Application

Schedule 13B

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	0.2	0.2	0.2
2. Technician & Specialist			
3. Registered Nurses	1.2	1.2	1.2
4. Licensed Practical Nurses	1.2	1.2	1.2
5. Aides, Orderlies & Attendants			
6. Physicians	0.4	0.8	0.8
7. PGY Physicians			
8. Physicians' Assistants			
9. Nurse Practitioners		0.2	0.2
10. Nurse Midwife			
11. Social Workers and Psychologist**			
12. Physical Therapists and PT Assistants			
13. Occupational Therapists and OT Assistants			
14. Speech Therapists and Speech Assistants			
15. Other Therapists and Assistants			
16. Infection Control, Environment and Food Service			
17. Clerical & Other Administrative	1.0	1.0	1.0
18. Other			
19. Other			
20. Other			
21. Total Number of Employees	4.0	4.6	4.6

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

Describe how the number and mix of staff were determined:

Base on current need and schedule day\times in the Hornell Clinic.

New York State Department of Health
Certificate of Need Application

Schedule 13C

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.	Jones Hornell Infusion Depreciation Schedule	JMH_Hornell Infusion Depreciation Schedule 12.2023.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)	7/1/2023	7/1/2024	7/1/2026
1. Salaries and Wages	140091	356168	281793
1a. FTEs	4	5	5
2. Employee Benefits	28018	71234	56359
3. Professional Fees	9351	8440	8472
4. Medical & Surgical Supplies	580995	1132680	1325926
5. Non-med., non-surg. Supplies			
6. Utilities	3641	6770	7209
7. Purchased Services			
8. Other Direct Expenses	2120	3828	3842
9. Subtotal (total 1-8)	764216	1579120	1683601
10. Interest (details required below)		91503	75421
11. Depreciation (details required below)	19080	177509	177509
12. Rent / Lease (details required below)	23488	186365	207194
13. Total Operating Costs	806784	2,034497	2143725

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)			
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
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)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs			

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)	7/1/2023	7/1/2024	7/1/2026
1. Salaries and Wages	140091	356168	281793
1a. FTEs	3	5	5
2. Employee Benefits	28018	71234	56359
3. Professional Fees	9351	8440	8472
4. Medical & Surgical Supplies	580995	1132680	1325926
5. Non-med., non-surg. Supplies			
6. Utilities	3641	6770	7209
7. Purchased Services			
8. Other Direct Expenses	2120	3828	3842
9. Subtotal (total 1-8)	764216	1579120	1683601
10. Interest (details required below)		91503	75421
11. Depreciation (details required below)	19080	177509	177509
12. Rent / Lease (details required below)	23488	186,365	207194
13. Total Outpatient Operating Costs	806784	2,034,497	2143725

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.	☐	Hornell Clinc Year 1 Cash Flow	YR1 Jones Infusion Clinic Cash flow.xls
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	Financial Summary	Financial Summary.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.*	☐	Jones Hornell Infusion 13D3	Jones Hornell Infusion 13D3.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	7/1/2026
1. Inpatient Services	0	0	0
2. Outpatient Services	2601189	6268375	6757379
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered	2601189	6268375	6757379
5. Deductions from Revenue	1716785	4137127	4459870
6. Net Patient Care Services Revenue	884404	2131248	2297509
7. Other Operating Revenue (Identify sources)			
8. Total Operating Revenue (Total 1-7)	884404	2131248	2297509
9. Non-Operating Revenue			
10. Total Project Revenue	884404	2131248	2297509

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									
	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										

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	450	355713	790.92	1111	849600	764.80	1119	921643	817.85
	Managed Care	42	12734	305.77	103	31453	305.77	104	32975	318.12
Medicare	Fee for Service	575	372161	647.60	1419	895143	652.68	1430	962810	673.12
	Managed Care	420	134028	318.93	1038	330912	329.32	1046	354792	339.19
Medicaid	Fee for Service	0								
	Managed Care	85	9066	107.23	209	22394	109.37	210	23477	111.56
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		7	702	106.02	16	1746	115.38	16	1812	109.86
Total		1577	2131248	560.64	3896	2131248	546.97	3925	2297509	585.35

Total of Inpatient and Outpatient Services		2131248			2131248			2297509	

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.

The Certificate of Need application for the request to add an extension clinic in Hornell NY that will serve Rheumatology clinic visit and outpatient infusion in Jones Memorial Hospital (JMH) primary service area in Hornell. Jones already provides GYN Clinic Services in Hornell. Jones will lease space and construct in the Hornell Medical Office Buidling at 7309 Seneca Road. The 3810 square foot suite is organized into two patient areas; one for 6 infusion chairs and a second with 6 exam rooms, pluscommon rooms; one for patients (waiting room, reception, public toilet, and phlebotomy-lab room) andanother for staff (offices, staff conference-lounge, and will be business occupancy and article 28 compliant. Clinic Hous of operation are Monday- Friday 9 am - 5 pm. The clinic is located 26 miles (37 minute drive) from the main hospital campus. The hospital Vice President will ensure credentialing, ulization and quality assurance monitoring in align with the hospital policies.

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.)

Jones Memorial Hospital (JMH) is a sole community provider and safety net hospital. Jones is located in Wellsville, N.Y., in Allegany County. JMH serves 76,866 people including the 46,0911 residents of Allegany County (2019 US Census), where JMH is located, as well as the 13,043 residents of Hornell and 14,872 residents of other surrounding small towns of Steuben County with essential services like women's health and pulmonary medicine.

Allegany County has the lowest median household income ($42,095) in NYS, with over 17% of their residents living below the poverty threshold and 8.8% unemployed. (Source: FLPPS CNA, Table 27, p.33) As noted in Table 1 above, the population that is uninsured or covered by Medicaid has grown to 26%, with Medicare (42%) and commercial insurers (32%) covering the remainder.

The NYS county health outcomes rankings, based on length and quality of life, place Allegany County at 48th and Steuben County at 31st out of 62 counties in New York State. They are ranked 44th and 48th respectively for health factors that are based on health behaviors, clinical care, socioeconomic factors and the physical environment. Some of the specific disparities are noted below.

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

Jones Memorial Hospital has always provided a significant level of care to low-income, uninsured, and vulnerable populations. For the ten-year period 2010-2020, population growth in the Jones service area has decrease. The population is more elderly and less affluent compared with populations across New York State and slighly higher than Western NY. The proportion of elderly residents is projected to be nearly 15-30% higher per the 2019 US census; 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 Allegany 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, Jones is the only

provider of outpatient services in Allegany County, with the next closest provide Cuba is a 6 bed critical access hospital that is 26.8 miles and 35 minutes travel time from JMH. This hospital is limited to urgent /emergent triage, because there are no lab services or operating rooms on-site and limited imaging modalities.

Additionally,the closest hospital provider in NY State is generally Olean General, which is about 45-60 minutes west. This is a significant burden on large segments of the Medicaid and Medicare population which may not have access to transportation, particularly during business hours, when their friends and family members may be at work. UPMC Cole Memorial transfers complex patients to Pittsburgh and Olean General transfers complex patients to Buffalo, both of which put patients further away from their families, who are important in helping them quickly recover. UR Medicine's Strong Memorial Hospital is 90 miles north and the travel time is just under 2 hours. However, the integration of a common EMR across our system, the use of telemedicine, and our specialists' knowledge of and commitment to the rural communities we serve, including Allegany County, allows URMC and JMH providers to collaborate in the care of patients, so that as many as possible can receive their care in Allegany county

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

As noted in the FLPPS Community Needs Assessment of 2014, one of the most effective ways to reduce preventable ED use, is to insure that there is adequate access to primary care and behavioral health (p.26). The project expands primary care in alignment with NYS and FLPPS DSRIP initiatives. Primary care is particularly important in rural communities, wh

The project allows for additional speciality care in Rheumatology and infusion services to be located in a rural area within Jones Memorial Hospital Primary service area but offers community members less need to travel for their routine preventative care and chronic disease management. The project provides JMH the ability to have subspecialities support the need in the Hornell community.

Chronic disease management of Rheumatology has a growing demand. Patient treatment plans required infusion medication management. Expanding this services in the Hornell community will meet a very underserve need. This reduce patient need to travel 60 plus miles to surrounding city or to Wellsville main campus when their home community is Hornell or surrouding area.

(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, JMH serves all patients no matter of their ability to pay. Our mission is committed to ensuring access to the highest quality for our community in a caring manner. JMH value of commitment to deliver quality patient care in a respectful and responsiveanner regardless of ability to pay. Services are provided with the highest level of integrity and honesty, guided by good business practices.

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

Jones Memorial Hospital is committed to ensuring access to the highest quality healthcare for our community in a caring manner. The hospital has 49 licensed beds.

JMH provides emergency medicine and can admit or transfer patients within the URMC system for the full range of healthcare services. Our local admissions are concentrated in women's health, respiratory care, cardiovascular, and sepsis (including uro-sepsis) and we act as a regional hub to 177,626 residents for women's health & respiratory.

JMH and URMC own and operate primary care (Family Medicine, Internal Medicine & Pediatric, Speciality Care) practices that serve 18K patients. There are approximately 5,400 patients served by private practices. We also own the only Women's Health practice to serve the residents of Allegany County and that practice has extended services into Hornell in western Steuben County, providing care to about 2,800 women / year.

JMH provides a growing complement of outpatient services and increasingly JMH or URMC own the specialty practices that provide those services, including: General Surgery, Cardiology, Cancer (Medical Oncology), ENT, Neurology, Pulmonary & Sleep Medicine, & Orthopaedics, Rheumatology and primary care. Several private practices also continue to serve our residents in ophthalmology, orthopaedics, & urology.

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.

Based on the community needs assessment, Jones Memorial Hospital needs to:

1. Expand essential Rheumatology services, in order to maintain and expand access to basic healthcare which is critical to improving the general health of the population and reducing years of potential life lost to the NYS average or better.

JMH will do this by the creation of Rheumatology & Infusion setting in Hornell NY that will have the physical space to bring access to their services into Steuben County to support meeting the needs above.

New York State Department of Health
Certificate of Need Application

Schedule 16C

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

C. Impact of CON Application on Hospital Operating Certificate

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

LOCATION:

(Enter street address of facility)

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		☐	☐	
PRISONER				☐	
PSYCHIATRIC**	08		☐	☐	
RESPIRATORY				☐	
SPECIAL USE				☐	
SWING BED PROGRAM				☐	
TRANSITIONAL CARE	33		☐	☐	
TRAUMATIC BRAIN INJURY	11		☐	☐	
	TOTAL		☐	☐	

*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 number(s) to the right)*

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:
(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]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐

[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] Must be certified for Home Hemodialysis Training & Support

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-2 LICENSED SERVICES *(cont.)*	Current	Add	Remove	Proposed
RADIOLOGY-THERAPEUTIC [5]	☐	☐	☐	☐
RENAL DIALYSIS, ACUTE	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b)	____	____	____	____
TRANSPLANT				
HEART - ADULT	☐	☐	☐	☐
HEART - PEDIATRIC	☐	☐	☐	☐
KIDNEY	☐	☐	☐	☐
LIVER	☐	☐	☐	☐
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

The Sites Tab in NYSE-CON has replaced the beds and services Tables of Schedule 16C. The Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

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

LOCATION: 7309 Seneca Road North, HOrnell NY *(Enter street address of facility)*				**Check if this is a mobile van/clinic** ☐
	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]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐
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[8]				
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] Must be certified for Home Hemodialysis Training & Support
[8] OFF-CAMPUS EMERGENCY DEPARTMENTS must meet all relevant Federal Conditions of Participation for a hospital per CMS S&C-08-08

END STAGE RENAL DISEASE (ESRD)

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.

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

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

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

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

Schedule 16 D. Hospital Outpatient Department - Utilization projections

a	b	d	f
	Current Year *Visits**	First Year *Visits**	Third Year *Visits**
CERTIFIABLE SERVICES			
MEDICAL SERVICES – PRIMARY CARE			
MEDICAL SERICES – OTHER MEDICAL SPECIALTIES			
AMBULATORY SURGERY			
SINGLE SPECIALTY -- GASTROENTEROLOGY			
SINGLE SPECIALTY – OPHTHALMOLOGY			
SINGLE SPECIALTY – ORTHOPEDICS			
SINGLE SPECIALTY – PAIN MANAGEMENT			
SINGLE SPECIALTY -- OTHER			
MULTI-SPECIALTY			
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC			
ELECTROPHYSIOLOGY			
PEDIATRIC DIAGNOSTIC			
PEDIATRIC INTERVENTION ELECTIVE			
PERCUTANEOUS CORONARY INTERVENTION (PCI)			
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			
EMERGENCY DEPARTMENT			
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT			
HOME HEMODIALYSIS TRAINING & SUPPORT			
INTEGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY			
METHADONE MAINTENANCE O/P			
NURSING HOME HEMODIALYSIS			
RADIOLOGY-THERAPEUTIC			
RENAL DIALYSIS, CHRONIC			
OTHER SERVICES			
Total			

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.

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:		1st Year Start date:		3rd Year Start date:	
	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						
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL						

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.