Schedule 1
All CON Applications

Contents:

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
[signature]	10/10/23
PRINT OR TYPE NAME	TITLE
Boyd Chappell	VP for 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.

	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Primary Contact	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	

	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Alternate Contact	Boyd Chappell, Vice President of Finance/CFO	Jones Memorial Hospital	
	BUSINESS STREET ADDRESS		
	191 N. Main Street		
	CITY	STATE	ZIP
	Wellsville	NY	14895
	TELEPHONE	E-MAIL ADDRESS	
	585-596-4002	Boyd-Chappell@URMC.Rochester.edu	

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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

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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 captial reserve of $5.2M to complete the project. 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*

Schedule 6 -
CON Form Regarding
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

- Provide Narrative using format below.
- Provide Architect/Engineering Certification Form
  List of Architectural or Engineering Certification Forms
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Full Review Projects, Projects over $15 Million, or Projects Requiring a Waiver (PDF)
  - Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY. (PDF) (Not to Be Submitted with Self-Certification Projects)
  - Architect's Letter of Certification for Completed Projects (PDF)
  - Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings (PDF)
- Provide FEMA BFE Certificate (Applies only to Hospitals and Nursing Homes)
  - **Error! Hyperlink reference not valid.**
- Functional Space Program: A record of the key environment of care considerations and facility functional and operational parameters that drive the space program for a project. Note: The governing body or its delegate develops the functional program, which is intended to inform the designers of record, authority having jurisdiction, and users of the facility. The size and complexity of the project will determine the length and complexity of the functional program.
- Provide Architecture/Engineering Drawings in PDF format for review. Refer to Electronic Review Guidance Document for instructions for providing drawings for CON review.
- Provide Physicist's Report and the supporting information including drawings, details and supporting information.
  - Physicist's Letter of Certification (PDF)
- Required attachments must be submitted as separate documents and labeled accordingly.
- If any of the attachments require to be updated, provide an updated Schedule 6 form with the revised dates indicated on the form, in the date column.
- Do not combine the narrative, A/E Cert Form and FEMA BFE Certificate into one document.
- Refer to the Contingent Approval or Contingency Satisfaction for Submission Table requirements listed below.

Format

- Refer to "NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews" located on the NYSDOH Website. (Drawing files less than 100 MB can be uploaded into one file and bookmarked in PDF format.)

"Architecture/Engineering Narrative"

Narrative shall include but not limited to the following information. Please address all items in the narrative located in the response column. Incomplete responses will not be accepted.

Description	
Original Schedule 6 Date:6/22/2022	Revised Schedule 6 Date: Click or tap to enter a date.
Has this project received Contingent Approval or State Hospital Code Approvals? No	If so, what is the original CON number? Click or tap here to enter text.

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Schedule 6

Description	
Intent/Purpose: Outpatient clinic for primary care	
Site Location: Alfred, New York	
Brief description of current facility, including Facility Type: Minor alteration of an existing medical office	
Brief description of proposed facility: Typical primary care facility with Exam Rooms, Patient and Staff Support spaces.	
Location of proposed spaces or spaces. (Occupancy type for each occupied space.) 38 Business	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Please describe the required smoke and fire separations between occupancies: No separation same Business occupancy	
If this is an existing facility, is it currently a licensed Article 28 Facility?	No
Is this facility being converted from a Non-Article 28 Facility to an Article 28 Facility.	Yes
Relationship of spaces conforming with Article 28 space and Non-Article 28 space: They are in separated (different floor)	
List all Exceptions to the NYSDOH referenced standards. (Also, to be noted on the exceptions portion of the Architecture/Engineering Certification Form. 1. 2018 FGI Guidelines for Design and Construction of Health Care Facilities	
List all Requests for equivalencies. (Also, to be noted on the exceptions portion of the Architecture/Engineering Certification Form. No equivalencies requested	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. No	No such spaces are proposed for this facility
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, fire protection, plumbing, etc. See architectural narrative for the descriptions of the proposed MEP System	
Describe scope of work involved in building system upgrades and or replacements, fire protection systems, HVAC systems, Sprinkler, etc. Not applicable, the building is not sprinkled	
Fire Detection, Alarm and Communication System: Describe existing system: See architectural narrative for the descriptions of the proposed Electrical Systems	
Is the work involved associated with a waiver provided by NYSDOH and or CMS? No If yes, provide waiver number.	
Provide a FEMA BFE Certificate from the FEMA website link www.fema.gov if located in a flood zone. (Applies only to Hospitals and Nursing Homes) What type of work will be associated to mitigate damage and provide the ability to maintain operations if located in a Flood Zone? Not located in a flood zone	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe equipment. No, it does not contain imaging equipment	
If yes, provide Physicist's Report and the respective drawings and information shall be submitted for review at the Design Development phase of review.	
Compliance with ADA. List any areas of noncompliance. The alteration areas of building is fully compliant with ADA	
Any other additional information? No	

Description	Response
Type of Work:	Alteration

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Schedule 6

Description	
Square footages of existing areas of work, existing floor and or existing building.	Total Existing Building 5,747 SF
Square footages of the proposed work area or areas. Provide the total aggregated sum of the work area	3,755 SF Ground Floor
Does the area of work exceed more than 50% of the area, floor or building?	Exceeds 50% of the area
Square Footage of Proposed Spaces.	3,755 SF
Sprinklered	Non-Sprinklered
Construction Types for the Existing Building and or Proposed Building (NFPA 101 per occupancy, NFPA 220)	Type V (000)
Building Height	13'
Number of Stories	1 Story
Is the proposed Article 28 space located in a basement or underground building?	Not Applicable (partial)
Is the proposed Article 28 space windowless space, area or building?	Yes (most of the area)
Is the building a High Rise?	No
Does the high-rise building have a generator?	Not Applicable
What is the occupancy of this project per NFPA 101 Life Safety Code Handbook?	38 New Business
List other occupancies types that are adjacent or within this facility: Ensure those spaces are designated on the plans. – The first and second floor are Business Occ., and do not communicate between	
Will the project construction be phased?	Yes
If yes, how many phases and what is the duration for each phase? two	
Does the project contain shell space?	No
Describe propose shell space. Existing vacant space	
Will spaces be temporarily relocated during the construction of this project.	Not Applicable
If yes, where will the temporary space be? Click or tap here to enter text.	
Does the temporary space meet the current DOH referenced standards?	Not Applicable
Will spaces be permanently relocated to allow the construction of this project.	Not Applicable
If yes, where will this space be? Click or tap here to enter text.	
Does the proposed temporary space meet the current DOH referenced standards? If no, please describe in detail how the space does not comply.	Not Applicable
Is there a companion CON associated with the temporary space? If so, provide the associated CON number. Click or tap here to enter text.	Not Applicable
Which edition of FGI is being used for this project? Exception to NYDOH Standards	2018 Edition of FGI
Changes in bed capacity? If yes, please describe. Click or tap here to enter text.	Not Applicable
Changes in the number of occupants? If yes, what is new number of occupants? Click or tap here to enter text.	Not Applicable
Does the facility have an EES system? If yes, what type? Click or tap here to enter text.	No
Is the existing EES Type 1 and does it meet the current referenced standards?	No
Does the project involve Operating Room alterations, renovations or rehabilitation? Click or tap here to enter text.	No
Does the existing EES system have the capacity for the additional electrical loads? Click or tap here to enter text.	No
Does the Project involve Bulk Oxygen Systems? If yes, provide brief description. Click or tap here to enter text.	No
Does the existing Bulk Oxygen System have the capacity for additional loads for without bringing in additional supplemental systems? Click or tap here to enter text.	No

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Schedule 6

Description	
Does the project involve a pool?	No

REQUIRED ATTACHMENT TABLE			
CONTINGENT APPROVAL	CONTINGENCY APPROVAL	Title of Attachment	Attachment File Name in PDF format
•	•	Architectural/Engineering Narrative	A/E Narrative
•	•	Functional Space Program	Space Program (See A/E Narrative)
•	•	Architect/Engineer Certification Form	A/E Cert Form
•	•	FEMA BFE Certificate	N/A
•	•	Article 28 Space/Non-Article 28 Space Plans	N/A
•	•	Site Plans	N/A
•	•	Life Safety Code Plans (Floor plans and reflected ceiling plans.)	LSC100 Life Safety Plan
•	•	Architectural Floor Plans, Roof Plans and Details	A100 FLOOR PLANS Includes Demolition/Existing Plan, Proposed Plan, DOH/FGI plan & Ceiling Plan.
•	•	Exterior Elevations and Building Sections	N/A- Existing building not included
•	•	Vertical Circulation	N/A
•	•	Reflected Ceiling Plans and Details	See Drawing A100
Optional	•	Wall Sections and Details	N/A
Optional	•	Interior Elevations, Enlarged Plans and Details	N/A
	•	Fire Protection	N/A
	•	Mechanical Systems	N/A
	•	Electrical Systems	N/A
	•	Plumbing Systems	N/A
	•	Physicist's Report and the respective drawings and information	N/A

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 Clinic
Location:	35 Glen Street, Alfred, NY 14802
Purpose:	Upgrade existing outpatient clinic

I. ARCHITECTURAL

The Jones Memorial Hospital is proposing to upgrade an existing outpatient clinic in Alfred, New York for compliance with NYS Public Health Law Article 28.

1. CODES AND REGULATIONS

The upgraded 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 Health Care 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 existing facility will be upgraded in the following areas:

1. Alter two existing toilets (one Public and one patient toilets) to comply with ADA clearances.
2. Convert two private offices into Exam rooms.
3. Convert and expand existing supply room to an exam room.
4. Build a new Clean Supply room adjacent to the nurse station.
5. Replace all existing hand-washing stations and sinks countertops with materials impervious to water.
6. Replace existing door handles with lever type to comply with ADA requirements.
7. Replace existing drywall ceiling to access attic space in order to upgrade HVAC and Electrical systems.

3. EXISTING CONDITIONS:

1. The existing building is a two-story building, designed for an office (Business) occupancy. The existing clinic occupies the full (partial) underground level (two sides are open to grade). The total building area is 5,632 SF (Ground floor 4,072 SF and 1st floor 1,560 SF). There is no communicating stair between the first and second floor (each floor has independent access).
2. The existing clinic is accessed directly from grade from the parking lot. There are 20 parking spaces; two of those are designated for handicap parking. The building access complies with ADA accessibility standards.
3. The building construction is comprised of exterior wood framing bearing walls, reinforced concrete retaining wall (two sides), slab on grade, wood floor, and roof wood trusses. Additionally, there are a series of interior steel tube columns. The building type classification is V B (by NYSBC/IBC), and V (000) (by NFPA).
4. Interior existing partitions are gypsum drywall on metal studs.

4. NEW WORK UPGRADES:

The works upgrades will be limited in order to comply with the requirements of New York's Public Health Law Article 28, and will include the following:

1. Modify two existing toilets to comply with the handicap clearances.
2. Convert two private offices into Exam rooms.
3. Convert and expand existing supply room to an exam room.

4. Build a new Clean Supply room adjacent to the nurse station.
5. Replace all existing counters with handwashing sinks with a solid surface counter with integral sinks.
6. Replace existing door handles with lever type to comply with ADA requirements.
7. Remove existing drywall ceiling and insulation in order to upgrade the HVAC and Electrical systems. Provide new insulation under roof between trusses and install new acoustical gypsum board anchored to wood trusses.
8. Provide new exit signs, and new handicap parking sign.
9. Renovate existing interior finishes.

Jones Memorial Hospital Outpatient Clinic – Alfred, NY

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 Section
Public Areas				
Vestibule	1	70	70	2.1-6.2.1.1
Reception/Registrar	1	353	353	2.1-6.2.2
Patient/Visitor Waiting Area	1	191	191	2.1-6.2.3
Unisex Public Toilet Room:	1	38	38	2.1-6.2.4
Clinical Areas				
Exam Rooms	10	86-100	975	2.1-3.2.1.2
Exam/ Treatment Room	1	151	151	2.1-3.2.1.2
Nurse Stations/ Work areas	1	230	230	2.1-3.8.2
Medication Area (inside the Nurse St.)	1			2.2-3.10.6.6
Clean Supply Storage Room	1	67	67	2.1-3.8.11
Soiled	1	30	30	2.1-3.8.12
Patient Toilet	2	36	72	2.1-3.10.2
Staff/Administrative Space				
Physician Office	2	81-98	179	2.1-6.3.3
Adm. Offices	1	54	54	2.1-6.3.3
Staff Lounge	1	82	82	2.1-4.1.9.1
Staff Toilet:	1	34	34	2.1-3.9.4.1(2)
Support				
Mechanical & Electrical Room	2	39-91	120	2.1-5.4.2.1
EVS (Janitor)	1	35	35	2.1-6.2.4
Net Square Foot Total			2916	
Circulation & Interior partitions			1156	
Gross Square Foot Total			4072	

II. MECHANICAL

1. General

1. Design shall meet the following codes and standards:
    - 2020 New York State Building Codes

4. 2018 Facilities Guidelines Institute Guidelines for Design and Construction of Outpatient Facilities *(Exception to NYDOH Reference Standards)*
    - 2017 ASHRAE 170 Ventilation of Health Care Facilities
2. Direct Digital Controls (DDC) will be provided to control HVAC equipment.
3. All penetrations through fire rated walls will be fire stopped. Fire damper will be provided as required to maintain fire ratings.

2. Heating, Cooling, and Ventilation System:

1. The clinic space is conditioned by (3) gas-furnace, each with remote DX cooling.
2. The proposed clinic space will be provided with (2) variable speed, vertical air handling units (AHU's) to provide HVAC. Each AHU will provide approximately 5-tons of cooling and will have air-to-air heat pumps for cooling and heating down to approximately 35 degrees F. The AHU's will be located in the (2) mechanical rooms. The AHU's will also have a high efficiency, gas heat exchanger to provide heating below 35 degrees F. Air handling Unit Basis of Design: Aaon V3 Series.
3. Each AHU will be provided with outdoor air from louvers in the exterior wall. Relief air will be provided by a ducted return fan for each AHU.
4. Zone temperature control will be provided with variable air volume (VAV) boxes with hot water reheat. There will be approximately (8) zones each with the ability to raise the supply air temperature 15 degrees F. The VAV boxes will be located in the clinic space ceilings.
5. Hot water for VAV boxes will be provided by a wall hung 110 MBH, high-efficiency boiler with integral circulation pump. The boiler will be located in the larger of the two mechanical rooms. Basis of design: Navien NBH-110.
6. The hot water will be circulated by (2) fractional horsepower, high efficiency, variable speed pumps. Basis of design: Grundfos Alpha.
7. The ductwork system will be fully ducted and located in the ceiling. Air will be supplied with ceiling diffusers and returned with registers in the ceiling.
8. All pumps and return fan motors will have electronically commutated motors.
9. Hot water piping will be insulated with fiberglass insulation.
10. Refrigerant piping will be insulated with flexible elastomeric insulation and aluminum jacketing where installed outdoors.
11. The entry vestibule will be provided with a hot water cabinet unit heater without cooling capability.

III. PLUMBING

1. General

1. Design shall meet the following codes and standards:
    - 2020 New York State Building Codes

5. 2018 Facilities Guidelines Institute Guidelines for Design and Construction of Outpatient Facilities *(Exception to NYDOH Reference Standards)*
    - 2017 ASHRAE 170 Ventilation of Health Care Facilities
2. All penetrations through fire rated walls will be fire stopped.

2. Water Systems

1. The water service appears to enter the building from the northeast corner of the building. The water service enters the existing janitors closet and splits to (3) meters to serve the (3) tenant spaces within the building. The water service is ¾" copper pipe with (3) 5/8" water meters. There is no backflow preventer installed on the water service. There is no fire protection system. The water distribution piping is copper piping. A reduced pressure zone backflow preventer will be added to the water service.
2. Part of the lower level tenant space is served by a 40-gallon, electric domestic water heater located in the janitors closet. The remainder of the lower level tenant space is served by a 19-gallon domestic, electric water heater. The water heater appears to be in fair condition and will be re-used.

3. Gas Systems

1. The gas service is located on the north side of the building with a 1-1/2" gas main. The main supplies (3) gas meters, each with 1" services to the building's furnaces. There is no pressure regulator on the gas service. Gas piping is both black steel pipe.
2. Gas piping will be re-used where possible and modified to supply the (2) air handling units and (1) hot water boiler.

4. Drainage Systems

1. The building is slab-on-grade. Storm drainage is provided by gutters to splash blocks.
2. The floor will need to be saw-cut and below grade sanitary modified in select locations to support new toilet room design.

5. Plumbing Fixtures

1. Janitors Sink: Existing 24" square mop service basin with manual service basin faucet with wall support bracket is in good condition and will remain for re-use.
2. Electric water cooler: Existing ADA-compliant, single level electric water cooler is in good condition and will remain for re-use.
3. Staff Sinks: Existing manual operation swing type faucets with non-ADA compliant single handle located with a centerline of 12-15" from the adjacent wall. Stainless steel bowl inside dimensions are 12" by 12" by 7" or 12" by 12" by 7". The sinks will be replaced with new sinks with stainless steel bowls, rigid gooseneck faucets with 4" wristblades, and new drain and supplies. New sinks to be installed a minimum 15" from the adjacent wall to the centerline of the sink.
4. Water closets: Existing ADA-compliant tank type, bottom outlet will be removed and replaced in kind in new locations per the updated floor plan.
5. Lavatories: ADA compliant wall mount vitreous china lavatory with manual operation faucet with 4" wrist blades. Some faucets are not-ADA compliant. Drain is not offset and drain and exposed supplies are not insulated per ADA requirements. Lavatories will be removed and replaced with wall mounted, ADA-compliant lavatories with sensor operated faucets. Drains will have offset drains and ADA-compliant enclosures will enclose the drain and supplies below the lavatories.

IV. ELECTRICAL

1. General

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 *(Exception to NYDOH Reference Standards)*
    - 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

- Americans with Disabilities Act (ADA)
- Underwriters Laboratory (UL)

2. Electrical Demolition

1. All existing ceiling mount light fixtures throughout the facility shall be removed to accommodate HVAC work scope ceiling removals. Existing lighting branch circuits shall be removed back to convenient locations and prepped for re-use. Existing lighting circuits shall serve new lighting layout.

3. Power Distribution System

1. The incoming electrical service originates at an adjacent power pole with a utility owner transformer. An underground secondary feeder runs underground through a building mounted feed-thru meter to an interior service panelboard.
2. The incoming service panelboard is a 120/240V, single phase, 3-wire Challenger panelboard with 200/2 main circuit breaker. This panelboard is in good condition and shall.
3. A new 60/2 circuit breaker shall be added to the serve panelboard to serve a new 24 circuit 120/240V load center for serving of new HVAC equipment.
4. New HVAC equipment to be served from new panelboard is as follows:
    - Two (2) variable speed, vertical air handling units
    - Wall hung 110 MBH, high-efficiency boiler
    - Two (2) fractional horsepower, high efficiency, variable speed hot water pumps.
    - Vestibule hot water cabinet unit heater.

4. Lighting

1. The existing interior fluorescent lighting system shall be replaced with new LED technology fixtures and exit signs throughout.
2. All public, staff and clinical spaces shall receive 2x2 surface mount LED flat panel fixtures. The main waiting room shall receive 6" LED recessed downlights.
3. 2x2 surface flat panels shall be Columbia VSY22 Series with surface mount kit. Recessed downlights shall be Prescolite LTR-6RD Series.
4. New Exit signs shall be combinations LED emergency/exit sign luminaires. Dual Lite EVC Series.
5. Automatic lighting controls shall be provided throughout for compliance with NYS Energy Code consisting of ceiling and wall mounted occupancy/vacancy sensors.

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 30, 2023
CON Number:
Facility Name: Jones Memorial Hospital - Outpatient Clinic
Facility ID Number:
Facility Address: 35 Glen Street, Alfred, NY 14802

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: 35 Glen Street, Alfred, NY 14802

Description: New construction outpatient 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

October 10, 2023
Date

Boyd Chappell, VP for Finance / CFO
Name (Print) Title

Notary signing required for the applicant

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

On the 10 day of October 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	$769,167	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$769,167	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$21,490	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction		Schedule 10
Cost/Per Square Foot for Renovation Construction	$111	Schedule10
Total Operating Cost		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	12/1/2023	Schedule 8B
Anticipated Completion Date	2/1/2024	

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:		as mm/dd/yyyy
Anticipated Midpoint of Construction Date		as mm/dd/yyyy
Anticipated Completion of Construction Date		as mm/dd/yyyy
Year used to compute Current Dollars:		

Subject of attachment	Attachment Number	Filename of attachment - PDF
For new construction and addition, at the schematic stage the design contingency will 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	$0	$0	$0
2.2 Renovation & Demolition	$450,000	$0	$450,000
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	$45,000	$0	$45,000
3.2 Construction Contingency	$45,000	$0	$45,000
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$58,000	$0	$58,000
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$38,500	$0	$38,500
Subtotal (Total 1.1 thru 4.5)	$636,500	$0	$636,500
5.1 Movable Equipment (from Sched 11)	$21,490	$0	$21,490
5.2 Telecommunications	$111,177	$0	$111,177
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$769,167	$0	$769,167
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	$769,167	$0	$769,167
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		$2,308	$2,308
10 Total Project Cost with fees	$771,167	$2,308	$773,475

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	$773475
☐	C. Mortgage, Notes, or Bonds	$
☐	D. Land	$
☐	E. Other	$
☐	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$

If refinancing is used, please complete area below.

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

II. Details

A. Leases

	N/A	Title of Attachment
1. List each lease with corresponding cost as if purchased each leased item. Breakdown each lease by total project cost and subproject costs, if applicable.	☒	
2. Attach a copy of the proposed lease(s).	☒	
3. Submit an affidavit indicating any business or family relationships between principals of the landlord and tenant.	☒	
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	☒	
5. If applicable, identify separately the total square footage to be occupied by the Article 28 facility and the total square footage of the building.	☒	
6. Attach two letters from independent realtors verifying square footage rate.	☒	
7. For all capital leases as defined by FASB Statement No. 13, "Accounting for Leases", provide the net present value of the monthly, quarterly or annual lease payments.	☒	

B. Cash

Type	Amount
Accumulated Funds	$
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$773475
TOTAL CASH	$773475

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	JMH SCH 9 B1Cash Source Breakdown.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.	☐	FY 2022 JMH Audited Financial Statements.pdf & JMH Interim Financial Statements July 2023.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 B1Cash Source Breakdown.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		%
Term		Years
Payout Period		Years
Principal		$

	N/A	Title of Attachment
1. Attach a copy of a letter of interest from the intended source of permanent financing that indicates principal, interest, term, and payout period.	☐	
2. If New York State Dormitory Authority (DASNY) financing, then attach a copy of a letter from a mortgage banker.	☐	
3. Provide details of any DASNY bridge financing to HUD loan.	☐	
4. If the financing of this project becomes part of a larger overall financing, then a new business plan inclusive of a feasibility package for the overall financing will be required for DOH review prior to proceeding with the combined financing.	☐	

D. Land

Provide details for the land including but not limited to; appraised value, historical cost, and purchase price. See sample table below.

	Total Project
Appraised Value	$
Historical Cost	$
Purchase Price	$
Other	

	N/A	Title of Attachment
1. If amounts are listed in "Other", attach documentation and a description as applicable.	☒	
2. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	☒	
3. Submit a copy of the proposed purchase/option agreement.	☐	35 Glen Street Alfred Closing documents - Proof of ownership.pdf
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: [ ] OR Renovation: [X]

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
	1	1	419	Primary Medical Care O/P	4072	$110.51	$450,000		
				#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 coLA (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:					**4072**	**110.51**	450000	

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?	☐	☒

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

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE			DATE
Boyd Chappell			11/13/23
PRINT NAME			TITLE
Boyd Chappell			CFO
NAME OF FIRM			
Jones Memorial Hospital			
STREET & NUMBER			
191 N. Main Street			
CITY	STATE	ZIP	PHONE NUMBER
Wellsville	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 SCH 11 JMH Alfred Detail Equipment list.xls				
					Total lease and purchase costs: Subproject 1	21490
					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:	21490

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

Alfred FF&E List - DOH

Item	Amount	Cost per Item	Extended Cost
Lead Care II meter	1	$ 3,500.00	$ 3,500.00
privacy track and curtains x 4	8	$ 750.00	$ 6,000.00
Hemocue	1	$ 800.00	$ 800.00
Counter height chair for nurses station	1	$ 500.00	$ 500.00
Exam stool - beige	1	$ 315.00	$ 315.00
waiting room chairs	12	$ 400.00	$ 4,800.00
end tables	3	$ 300.00	$ 900.00
Oximeter	1	$ 50.00	$ 50.00
thermometer oral / rectal	1	$ 525.00	$ 525.00
service cart (2) for EKG and Infant scale	2	$ 500.00	$ 1,000.00
Misc. supplies, etc.	1	$ 2,500.00	$ 2,500.00
Enclosed bulletin board	1	$ 600.00	$ 600.00
		TOTAL	$ 21,490.00

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 12/6/23

Signature:

Boyd Chappell

VP for Finance / CFO

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		.30	0.3
2. Technician & Specialist			
3. Registered Nurses			
4. Licensed Practical Nurses		1.6	1.6
5. Aides, Orderlies & Attendants			
6. Physicians		1.0	1.0
7. PGY Physicians			
8. Physicians' Assistants		0.6	0.6
9. Nurse Practitioners			
10. Nurse Midwife			
11. Social Workers and Psychologist**			
12. Physical Therapists and PT Assistants			
13. Occupational Therapists and OT Assistants			
14. Speech Therapists and Speech Assistants			
15. Other Therapists and Assistants			
16. Infection Control, Environment and Food Service			
17. Clerical & Other Administrative		1.0	1.0
18. Other			
19. Other			
20. Other			
21. Total Number of Employees		4.5	4.50

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

Describe how the number and mix of staff were determined:

Evaluation of the area need for provider support 1.60 FTE, that determines the mix of clinical and clerical support.

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

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

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

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

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

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

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

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

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

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.	Alfred Depreciation Schedule	JMH_ALfred Depreciation Schedule 10.2023.xls
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital	NA	

☐ 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)		7/1/2024	7/1/2026
1. Salaries and Wages		376000	384605
1a. FTEs		4	4
2. Employee Benefits		75200	76921
3. Professional Fees		4700	4986
4. Medical & Surgical Supplies		140000	148526
5. Non-med., non-surg. Supplies			
6. Utilities		9500	10079
7. Purchased Services			
8. Other Direct Expenses		7500	7957
9. Subtotal (total 1-8)		612900	633074
10. Interest (details required below)		0	
11. Depreciation (details required below)		59827	59827
12. Rent / Lease (details required below)			
13. Total Operating Costs		672727	692901

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)		7/1/2024	7/1/2026
1. Salaries and Wages		376000	384605
1a. FTEs		4	4
2. Employee Benefits		75200	76921
3. Professional Fees		4700	4986
4. Medical & Surgical Supplies		140000	148526
5. Non-med., non-surg. Supplies			
6. Utilities		9500	10079
7. Purchased Services			
8. Other Direct Expenses		7500	7957
9. Subtotal (total 1-8)		612900	633074
10. Interest (details required below)			
11. Depreciation (details required below)		59827	59827
12. Rent / Lease (details required below)			
13. Total Outpatient Operating Costs		672727	69290 1

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.	☐	Jones Alfred Clinic YR 1 Cash Flow	JMH_Yr 1 FY2025_Cash Flow Analysis Schedule 13.xls
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	Financial Summary	JMH_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.*	☐		

Table 13D - 1

Categories	a Current Year	b Year 1 Total Revenue Budget	c Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)		7/1/2024	7/1/2026
1. Inpatient Services			
2. Outpatient Services		1026327	1046956
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered		1026327	1046956
5. Deductions from Revenue		418907	427327
6. Net Patient Care Services Revenue		607420	619629
7. Other Operating Revenue (Identify sources)			
340B Contract Pharmacy		0	90000
8. Total Operating Revenue (Total 1-7)		607420	709629
9. Non-Operating Revenue			
10. Total Project Revenue		607420	709629

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				1159	209,625	180.94	1159	217,856	182.75
	Managed Care				246	23,841	96.98	246	24,079	97.95
Medicare	Fee for Service				1498	137,928	92.10	1498	139,307	93.02
	Managed Care				1084	99,802	92.10	1084	100,800	93.02
Medicaid	Fee for Service				56	4,844	86.80	56	4,892	87.67
	Managed Care				1181	102,521	86.80	1181	103,546	87.67
Private Pay					244	23,635	96.98	244	23,871	97.95
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other					56	5,224	93.61	56	5,276	94.55
Total					5522	607,440	110.00	5522	619,629	112.21

Total of Inpatient and Outpatient Services					607,420			619,629	

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 Alfred NY that will serve primary care in Jones Memorial Hospital (JMH) primary service area. JMH will renovate an existing two-story building to business occupancy and article 28 compliant. Clinic Hous of operation are Monday- Friday 9 am - 5 pm. The clinic is located 15.2 miles (21 minute drive) from the main hospital campus. The hospital Vice President of Practice Management 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.

The project allows for a primary care setting 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 rotate on a limited time bases to the community.

The 2014 FLPPS Community Needs Assessment identified the leading causes of death in our region as cancer, heart disease, COPD, unintentional injury and stroke. These same conditions as well as perinatal conditions and suicide contribute to years of potential life lost (p38-39).

The primary care clinc wil treat the most prevalent chronic diseases in our community, thereby reducing potentially preventable ED visits and admissions.

(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 responsive manner 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) practices that serve 13K 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 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. Preserve and expand essential Primary Care 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 Primary care setting in Alfred NY that will have the physical space necessary support the two colleges (Alfred University and Alfred State College) student population get access to care during there time at school and to expanded access to their services into Allegany County to support meeting the needs above.

ONLY for Hospital Applicants submitting Full Review CONs

Non-Public Hospitals

7. (a) Explain how the proposed project advances local Prevention Agenda priorities identified by the community in the most recently completed Community Health Improvement Plan (CHIP)/Community Service Plan (CSP). *Do not submit the CSP.* Please be specific in which priority(ies) is/are being addressed.

(b) If the Project does not advance the local Prevention Agenda priorities, briefly summarize how you are advancing local Prevention Agenda priorities.

8. Briefly describe what interventions you are implementing to support local Prevention Agenda goals.

9. Has your organization engaged local community partners in its Prevention Agenda efforts, including the local health department and any local Prevention Agenda coalition?

10. What data from the Prevention Agenda dashboard and/or other metrics are you using to track progress to advance local Prevention Agenda goals?

11. In your most recent Schedule H form submitted to the IRS, did you report any Community Benefit spending in the Community Health Improvement Services category that supports local Prevention Agenda goals? (Y/N question)

ONLY for Hospital Applicants submitting Full Review CONs

Public Hospitals

12. Briefly summarize how you are advancing local public health priorities identified by your local health department and other community partners.

13. Briefly describe what interventions you are implementing to support local public health priorities.

14. Have you engaged local community partners, including the local health department, in your efforts to address local public health priorities?

15. What data are you using to track progress in addressing local public health priorities?

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: *(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.

Schedule 16 F. Facility Access

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

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

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

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

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

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

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

Yes ☐ No ☐

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

1. Is your facility currently obligated to provide uncompensated service under the Public Health Service Act?

   Yes ☐ No ☐

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

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

   Yes ☐ No ☐

   If no, provide an explanation.

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

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