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: Strong Memorial Hospital Facility Id. 413

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
Kathleen Parrinello	5/22/24
PRINT OR TYPE NAME	TITLE
Kathleen Parrinello	COO

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 ☐	Board Resolution
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES ☒ NO ☐	

Contacts

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

Primary Contact			
NAME AND TITLE OF CONTACT PERSON		CONTACT PERSON'S COMPANY	
Marc Guerrie, Assistant Director		University of Rochester Medical Center	
BUSINESS STREET ADDRESS			
601 Elmwood Avenue, Box 612			
CITY		STATE	ZIP
Rochester		NY	14642
TELEPHONE		E-MAIL ADDRESS	
(585) 275-1888		Marc_guerrie@urmc.rochester.edu	

Alternate Contact			
NAME AND TITLE OF CONTACT PERSON		CONTACT PERSON'S COMPANY	
James Seeger, Program Manager		University of Rochester Medical Center	
BUSINESS STREET ADDRESS			
601 Elmwood Avenue, Box 623			
CITY		STATE	ZIP
Rochester		NY	14642
TELEPHONE		E-MAIL ADDRESS	
(585) 276-4975		jseeger@facilities.rochester.edu	

New York State Department of Health
Certificate of Need Application

Schedule 1

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Steven I. Goldstein, President & CEO of Strong Memorial Hospital and Highland Hospital			
BUSINESS STREET ADDRESS			
601 Elmwood Avenue, Box 612			
CITY	STATE	ZIP	
Rochester	NY	14642	
TELEPHONE	E-MAIL ADDRESS		
(585) 275-7895	Steven_goldstein@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	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

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

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

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

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

n/a

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*
n/a	n/a

Schedule 6
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 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

Instructions

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for 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.
  - FEMA Elevation Certificate and Instructions.pdf
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - Physicist's Letter of Certification (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews
  - DSG-1.0 Schematic Design & Design Development Submission Requirements
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: 5/31/2024	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? **No** If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: **To convert a portion of the second floor of the 1972 building at St. John's Home into an outpatient dialysis facility**	
Site Location: **150 Highland Ave, Rochester, NY 14620**	

Brief description of current facility, including facility type: **Nursing Home, I-2 Occupancy** Click here to enter text.	
Brief description of proposed facility: **A portion of the second floor of the 1972 building at St. John's Home is to be renovated into an outpatient dialysis center**	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. **Project area is a portion of the nursing home's 2nd floor of the 1972 building. The existing occupancy is I-2 and the project area occupancy is B**	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: **2 hour separation between the project's Business occupancy and the existing I-2 occupancy**	
If this is an existing facility, is it currently a licensed Article 28 facility?	**Yes**
Is the project space being converted from a non-Article 28 space to an Article 28 space?	**No**
Relationship of spaces conforming with Article 28 space and non-Article 28 space: **Entire building is Article 28**	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. **FGI 2018**	
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. **Existing heating, ventilating and air conditioning systems will be modified to serve the rooms within the project space. Electrical receptacles, lighting, and equipment connections will be modified within project area. Existing plumbing system will be modified to serve new toilet rooms and hand sinks within the project area.**	**Yes**
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. **The building heat source system is 3 natural gas fired firetube hot water boilers with power burners. There is a water cooled chiller and (2) central station air handling units. Existing water service is a 6" with a 6" meter and isolating valving. Domestic hot water is generated by gas fired units. The building has a separate fire protection water service. The building is supplied by three phase four wire secondary unit substation in the basement. The building has a generator.**	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. **The project will include a roof mounted DOAS unit with supply and exhaust fan sections, DX cooling section with modulating hot gas reheat, enthalpy heat recovery wheel, hot water coil section, MERV 13 filter sections and access section. There will be concealed fan coil units as well as radiant ceiling panels. There will also be a new roof mounted exhaust fan. Water, sanitary, and vent systems will connect to existing risers. A 2" connection will be made to the main water piping down stream of the booster system in the basement to accommodate the RO system. Dialysis wall box drains to be routed to a neutralizing tank in the basement and then to the building main sanitary line. The existing fire protection system will be modified to accommodate the new layout in accordance with NFPA 13. Existing normal power branch circuit panelboard to be reused for project area. The RO system and some equipment will be on emergency power. The area will receive new LED lighting**.	
Describe existing and or new work for fire detection, alarm, and communication systems: **The existing fire alarm system main will be reused and new detection and notification devices installed at the project area. Low voltage cabling will be entirely new as part of the project**.	

If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. **N/A**
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. **N/A**
Does the project comply with ADA? If no, list all areas of noncompliance. **Yes**
Other pertinent information: Click here to enter text.

Project Work Area	**Response**
Type of Work	**Alteration**
Square footages of existing areas, existing floor and or existing building.	**2nd floor: 18,717 SF**
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	**Approx. 6,900 SF**
Does the work area exceed more than 50% of the smoke compartment, floor or building?	**Exceeds 50% of the smoke compartment**
Sprinkler protection per NFPA 101 Life Safety Code	**Sprinklered throughout**
Construction Type per NFPA 101 Life Safety Code and NFPA 220	**Type 1 (332)**
Building Height	**70'-0"**
Building Number of Stories	**7**
Which edition of FGI is being used for this project?	**2018 Edition of FGI**
Is the proposed work area located in a basement or underground building?	**Not Applicable**
Is the proposed work area within a windowless space or building?	**No**
Is the building a high-rise?	**No**
If a high-rise, does the building have a generator?	**Not Applicable**
What is the Occupancy Classification per NFPA 101 Life Safety Code?	**Chapter 38 New Business Occupancy**
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. **I-2 Nursing Home**	**Yes**
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	**No**
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	**No**
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	**No**
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	**No**
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	**No**
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	**No**
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	**Not Applicable**
Changes in the number of occupants? If yes, what is the new number of occupants? **69 occupants at new B occupancy**	**Yes**
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	**Yes**
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	**No**

Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	**No**
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	**No**
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	**Not Applicable**
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	**Not Applicable**
Does the project involve a pool?	**No**

REQUIRED ATTACHMENT TABLE			
SCHEMATIC DESIGN SUBMISSION for **CONTINGENT APPROVAL**	DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for **CONTINGENCY SATISFACTION**	**Title of Attachment**	**File Name in PDF format**
•		Architectural/Engineering Narrative	A/E Narrative.PDF
•		Functional Space Program	FSP.PDF
•		Architect/Engineer Certification Form	A/E Cert Form. PDF
•		FEMA BFE Certificate	FEMA BFE Cert.PDF
•		Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Plans including level of exit discharge, and NFPA 101-2012 Code Analysis	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details. Illustrate FGI compliance on plans.	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
optional	•	Wall Sections and Partition Types	A500.PDF
optional	•	Interior Elevations, Enlarged Plans and Details	A600.PDF
	•	Fire Protection	FP100.PDF
	•	Mechanical Systems	M100.PDF
	•	Electrical Systems	E100.PDF
	•	Plumbing Systems	P100.PDF
	•	Physicist's Letter of Certification and Report	X100.PDF

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS
ARCHITECTS & ENGINEERS

(For projects not meeting the prerequisites for Self-Certification submission.)

Date: 5/31/2024
CON Number:
Facility Name: Outpatient Dialysis Clinic
Facility ID Number:
Facility Address: 150 Highland Avenue, Rochester, NY 14620,
Monroe County
NYS Department of Health/Office of Health Systems Management
Center for Health Care Facility Planning, Licensure, and Finance
Bureau of Architectural and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

To The New York State Department of Health:

I hereby certify that:

1. I have been retained by the aforementioned facility, to provide professional architectural/engineering services related to the design and preparation of construction documents, including drawings and specifications for the aforementioned project. During the course of construction, periodic site observation visits will be performed, and the necessary standard of care, noting progress, quality and ensuring conformance of the work with documents provided for all regulatory approvals associated with the aforementioned project.

2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed, in accordance with the functional program for the referenced construction project and in accordance with any project definitions, waivers or revisions approved or required by the New York State Department of Health.

3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations, and the applicable provisions of the State Hospital Code -- 10 NYCRR Part 711 (General Standards for Construction) and Parts (check all that apply):

   a. X 712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. __715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:
   FGI Guidelines 2018

4. I understand that as the design of this project progresses, if a component of this project is inconsistent with the State Hospital Code (10 NYCRR Parts 711, 712, 713, 714, 715, 716, or 717), I shall bring this to the attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department of Health prior to or upon submitting final drawings for compliance resolution.

5. I understand that upon completion of construction, the costs of any subsequent corrections necessary to achieve compliance with applicable requirements of 10 NYCRR Parts 711, 712, 713, 714, 715, 716 and 717, when the prior work was not completed properly as certified herein, may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

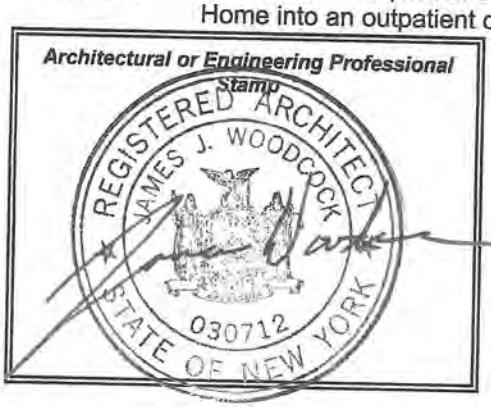
This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative, full review, self-certification and reviews performed and completed by DASNY.

Project Name: Outpatient Dialysis Clinic

Location: 150 Highland Ave, Rochester, NY 14620, Monroe County

Description: Renovation of a portion of the 2nd floor at St. John's Home into an outpatient dialysis facility

Architectural or Engineering Professional Stamp



Signature of Architect or Engineer

James Woodcock
Name of Architect or Engineer (Print)

030712
Professional New York State License Number

85 Allen St., Suite 210, Rochester, NY 14608
Business Address

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

Authorized Signature for Applicant

5/22/2024
Date

Kathy Parrinello — Name (Print)

COO — Title

Notary signing required for the applicant

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

On the 22nd day of May 2024, before me personally appeared Kathy Parrinello, to me known, who being by me duly sworn, did depose and say that he/she is the COO of the Strong 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.

(Notary) Constance R. Williams

Constance R. Williams
Notary Public - State of New York
No. 01WI6351321
Qualified in Monroe County
My Commission Expires 11/28/2024

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.

FEMA **Elevation Certificate** and Instructions

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	$11,394,725	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$11,394,725	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$1,147,216	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	n/a	Schedule 10
Cost/Per Square Foot for Renovation Construction	$1,128	Schedule10
Total Operating Cost	$3,225,830	Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.00%	Schedule 9
Depreciation Life (in years)	17 for Renovation 10 for Equipment	

2) Construction Dates

Anticipated Start Date	2/1/2025	Schedule 8B
Anticipated Completion Date	1/31/2026	

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 applicatio

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	10.00%	Normally 10%
Construction Contingency - Renovation Work	10.00%	Normally 10%
Anticipated Construction Start Date:	2/1/2025	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	8/2/2025	as mm/dd/yyyy
Anticipated Completion of Construction Date	1/31/2026	as mm/dd/yyyy
Year used to compute Current Dollars:	2024	

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	$7,300,000	$0	$7,300,000
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$480,000	$0	$480,000
3.1 Design Contingency	$257,884	$0	$257,884
3.2 Construction Contingency	$778,000	$0	$778,000
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$400,000	$0	$400,000
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$650,501	$0	$650,501
Subtotal (Total 1.1 thru 4.5)	$9,866,385	$0	$9,866,385
5.1 Movable Equipment (from Sched 11)	$1,147,216	$0	$1,147,216
5.2 Telecommunications	$381,124	$0	$381,124
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$11,394,725	$0	$11,394,725
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	$11,394,725	$0	$11,394,725
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	$34,184	$0	$34,184
10 Total Project Cost with fees	$11,430,909	$0	$11,430,909

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	$11430909
☐	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)	$11430909

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).	☐	Lease
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.	☐	Letters
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	$11430909
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$
TOTAL CASH	$11430909

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☒	
2. Attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations. 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.	☐	SMH Financials
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☒	
4. Attach a full and complete description of the assets to be sold, if applicable.	☒	
5. If amounts are listed in "Gifts (fundraising program)": • Provide a breakdown of total amount expected, amount already raised, and any terms and conditions affixed to pledges. • If a professional fundraiser has been engaged, submit fundraiser's contract and fundraising plan. • Provide a history of recent fund drives, including amount pledged and amount collected	☒	

	N/A	Title of Attachment
6. If amounts are listed in "Government Grants": • List the grant programs which are to provide the funds with corresponding amounts. Include the date the application was submitted. • Provide documentation of eligibility for the funds. • Attach the name and telephone number of the contact person at the awarding Agency(ies).	☒	
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	☒	
8. Current Department policy expects a minimum equity contribution of 10% of total project cost (Schedule 8b line 10)) for all Article 28 facilities with the exception of Residential Health Care Facilities that require 25% of total project cost (Schedule 8b, line 10). Public facilities require 0% equity.	☒	
9. Provide an equity analysis for member equity to be provided. Indicate if a member is providing a disproportionate share of equity. If disproportioned equity shares are provided by any member, check this box ☐	☒	

C. Mortgage, Notes, or Bonds

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

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

D. Land

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

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

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

E. Other

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

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

F. Refinancing

	N/A	Title of Attachment
1. Provide a breakdown of the terms of the refinancing, including principal, interest rate, and term remaining.	☒	
2. Attach a description of the mortgage to be refinanced. Provide full details of the existing debt and refinancing plan inclusive of original and current amount, term, assumption date, and refinancing fees. The term of the debt to be refunded may not exceed the remaining average useful life of originally financed assets. If existing mortgage debt will not be refinanced, provide documentation of consent from existing lien holders of the proposed financing plan.	☒	

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
		2	423	Chronic Renal Dialysis O/P	6900	$1,127.54	$7,780,000	
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				

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

A		B	D	E	F	G	H	I
Location								
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
				#N/A				
Totals for Whole Project:					**6900**	**1128**	**7780000**	

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

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

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

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

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

SIGNATURE			DATE
Marc Guerrie			5/22/24
PRINT NAME			TITLE
Marc Guerrie			Assistant Director
NAME OF FIRM			
Strong Memorial Hospital			
STREET & NUMBER			
601 Elmwood Avenue			
CITY	STATE	ZIP	PHONE NUMBER
Rochester	NY	14642	585-275-1888

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
		Dialysis Machines		P		627216
		Medical Equipment		P		250000
		Furniture		P		270000

Total lease and purchase costs: Subproject 1	1147216
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:	1147216

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

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 5/22/2024

Kathy Parrinello
Signature:

Kathy Parrinello
Name (Please Type)

Chief Operating Officer, Strong Memorial Hospital
Title (Please type)

Schedule 13 B-1. Staffing

See "Schedules Required for Each Type of CON" to determine when this form is required. Use the "Other" categories for providers, such as dentists, that are not mentioned in the staff categories. If a project involves multiple sites, please create a staffing table for each site.

☒ Total Project or ☐ Subproject number

A	B	C	D
	Number of FTEs to the Nearest Tenth		
Staffing Categories	Current Year*	First Year Total Budget	Third Year Total Budget
1. Management & Supervision	0.1	1.0	1.0
2. Technician & Specialist	0.2	2.0	3.0
3. Registered Nurses	0.8	2.0	3.0
4. Licensed Practical Nurses	0.1	3.0	4.0
5. Aides, Orderlies & Attendants			
6. Physicians		1.0	1.0
7. PGY Physicians			
8. Physicians' Assistants			
9. Nurse Practitioners		1.0	1.0
10. Nurse Midwife			
11. Social Workers and Psychologist**		1.0	1.0
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		1.0	1.0
17. Clerical & Other Administrative		1.0	2.0
18. Other Billing Specialist		0.5	1.0
19. Other			
20. Other			
21. Total Number of Employees	1.2	13.5	18.0

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

Describe how the number and mix of staff were determined:

Strong Memorial Hospital bases staffing on existing dialysis services.

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	
o Distance in miles from the proposed facility to the Hospital affiliate.	
o Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	
o 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	
o Distance in miles from the proposed facility to the nearest hospital.	
o Distance in minutes of travel time from the proposed facility to the nearest hospital.	

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

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

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

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

Schedule 13 C. Annual Operating Costs

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

Use the below tables or upload a spreadsheet as an attachment to this Schedule that matches the structure of the tables (Attachment Title:) to summarize the first and third full year's total cost for the categories, which are affected by this project. The first full year is defined as the first 12 months of full operation after project completion. Year 1 and 3 should represent projected total budgeted costs expressed in current year dollars. Additionally, you must upload the required attachments indicated below.

Required Attachments

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis for determining budgeted expenses, including details for how depreciation and rent / lease expenses were calculated.	Rent and Depreciation	Rent and Depreciation
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital	n/a	n/a

☒ Total Project or ☐ Subproject Number

Table 13C - 1

	a	b	c
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	7/1/2023	7/1/2026	7/1/2028
1. Salaries and Wages	112960	1095534	1403838
1a. FTEs	1	14	18
2. Employee Benefits	38489	376864	482920
3. Professional Fees			
4. Medical & Surgical Supplies	29822	465007	579941
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services	1962	17818	13997
8. Other Direct Expenses	1529	80000	84872
9. Subtotal (total 1-8)	184762	2035223	2565568
10. Interest (details required below)			
11. Depreciation (details required below)	0	1033107	1033107
12. Rent / Lease (details required below)	0	157500	161930
13. Total Operating Costs	184762	3225830	3726908

Table 13C - 2

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

Table 13C - 3

	a	b	c
Outpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	7/1/2023	7/1/2026	7/1/2028
1. Salaries and Wages	112960	1095534	1403838
1a. FTEs	1	14	18
2. Employee Benefits	38489	376864	482920
3. Professional Fees			
4. Medical & Surgical Supplies	29822	465007	579941
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services	1962	17818	13997
8. Other Direct Expenses	1529	80000	84872
9. Subtotal (total 1-8)	184762	2035223	2565568
10. Interest (details required below)			
11. Depreciation (details required below)	0	1033107	1033107
12. Rent / Lease (details required below)	0	157500	161930
13. Total Outpatient Operating Costs	184762	3225830	3760605

Any approval of this application is not to be construed as an approval of any of the above indicated current or projected operating costs. Reimbursement of any such costs shall be in accordance with and subject to the provisions of Part 86 of 10 NYCRR. Approval of this application does not assure reimbursement of any of the costs indicated therein by payers under Title XIX of the Federal Social Security Act (Medicaid) or Article 43 of The State Insurance Law or by any other payers.

Schedule 13 D: Annual Operating Revenues

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

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

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

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

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

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

Required Attachments

	N/A	Title of Attachment	Filename of Attachment
1. Provide a cash flow analysis for the first year of operations after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project.	☒		
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	Revenue Calculation	Revenue Calculation
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

	a	b	c
Categories	Current Year	Year 1 Total Revenue Budget	Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)	7/1/2023	7/1/2026	7/1/2028
1. Inpatient Services			
2. Outpatient Services	207577	1243213	2637563
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered	207577	1243213	2637563
5. Deductions from Revenue			
6. Net Patient Care Services Revenue	207577	1243213	2637563
7. Other Operating Revenue (Identify sources)			
8. Total Operating Revenue (Total 1-7)	207577	1243213	2637563
9. Non-Operating Revenue			
10. Total Project Revenue	207577	1243213	2637563

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	55	$49,900	$907.27	261	$63,680	$244.39	521	$135,117	$259.27
	Managed Care	1	$698	$698.33	0	$0	$0.00	0	$0	$0.00
Medicare	Fee for Service	63	$24,396	$387.24	2,997	$808,146	$269.65	5,993	$1,714,438	$286.07
	Managed Care	175	$66,043	$377.39	812	$193,918	$238.71	1,625	$411,455	$253.25
Medicaid	Fee for Service	38	$9,619	$253.13	91	$25,912	$284.92	182	$54,979	$302.27
	Managed Care	62	$55,250	$891.13	327	$85,579	$261.72	654	$181,582	$277.66
Private Pay		2	$242	$121.00						
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other		4	$1,439	$357.25	193	$65,978	$341.63	386	$139,992	$362.44
Total		400	$207,577	$518.94	4,680	$1,243,213	$265.64	9,360	$2,637,563	$281.79

Total of Inpatient and Outpatient Services		$207,577			$1,243,213			2,637,563	

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.

Strong Memorial Hospital (SMH) has well established policies and procedures in place to ensure compliance with all state and federal regulations. Additional oversight and monitoring of the clinical aspects of medical services are carried out through the SMH Quality Assurance/Quality Improvement process, consistent with the SMH Quality Plan. All SMH faculty provide the highest quality of care to its patients. Faculty and staff monitor and evaluate the quality and appropriateness of patient care and clinical performance, pursue opportunities to improve care and resolve identified problems.

The Office of Corporate Compliance promotes and supports a culture which builds compliance consciousness into daily activities and encourages all employees to conduct business with the highest standards of honesty and integrity. In turn, they implement and maintain a corporate compliance program to effectively monitor adherence to applicable statues, regulations, program requirements; and to correct non-compliance.

Additionally, the URMC Board has established the Audit & Risk Committee. The Committee has oversight responsibilities that are fulfilled by reviewing the procedures in place to assess and minimize significant risks, overseeing the quality and integrity of financial reporting practices (including the underlying system of internal controls, policies and procedures, regulatory compliance programs, and ethical code of conduct), and overseeing and advising the University of Rochester Medical Center Board and the University of Rochester Board of Trustees with respect to the overall audit process.

The hours of operation of the clinic will be Monday, Wednesday, and Friday from 7 am to 7 pm in years 1-2 then hopefully expand to Monday through Saturday in year 3.

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.)

See Attachment L.

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

See Attachment L.

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

The anticipated volumes are presented in Schedule 16D.

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

The project will establish outpatient chronic dialysis treatment to ALC patients needing HD which will allow them to be placed at Skilled Nursing Facilities or return home depending on their situation. It will also provide an established routine for patients that no longer have the ability to dialyze in the local outpatient dialysis facilities. These patients currently come to the emergency department three times each week for treatment.

(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.

The project will serve all patients needing care regardless of their ability to pay or the source of payment.

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

Services are currently provided on an inpatient basis to our ALC status patients as well as through the Emergency Department for patients that have no other options available to them for treatment.

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.

St. John's Chronic Dialysis unit will provide services to complex care patients that have a multitude of comorbidities and subacute healthcare needs that cannot be provided at other institutions. For example, potential patients requiring tracheostomy, Left-ventricular assistive devices (LVAD), neurological deficits (post-stroke, congenital neurological defects, etc.) in conjunction with chronic dialysis needs.

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: 150 Highland Ave, Rochester, NY 14620 *(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]	2	12	_____	14
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	2	12		14

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	400	611	607

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.

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Revenue	1,243,213	1,280,509	2,637,563	2,716,689	2,798,189
Total Expenses	3,225,830	3,226,744	3,760,605	3,830,728	3,898,940

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.

This unit is designed specifically to address this concern. Currently, there is a disparity of chronic dialysis care to underserved groups which rely solely on acute care facilities. This facility will have a liberal acceptance practice, taking in all patients that do not currently have outpatient chronic dialysis services. Our staff will be trained to treat medically complex conditions that are concurrent with ESRD. Most outpatient chronic dialysis units only provide hemodialysis services, and offer no other medical services that patients may need while receiving routine RRT. Our ability to provide these services will distinguish us and provide relief mechanism for the local health care network. We will utilize our partnership with St. John's Nursing Home and the affiliate hospitals to facilitate expedient and accessible care to these patient populations.

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.

The hours of operation will be flexible in regard to the needs of the community. There will be a percentage of the population that does not work, as they will be St. John's Nursing Home residents, disabled, etc., thereby allowing us to accommodate those patients that are able to continue employment. Also, an independent facility such as the proposed St. John's Nursing Home unit will have more autonomy than the massive, corporate for-profit entities—meaning we could adjust the hours of operation to better serve the community without hinderance from an out-of-touch corporate headquarters.

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

We are successfully operating four acute hemodialysis programs and one chronic hemodialysis program. We have almost a decade of experience (UR Dialysis established in 2015) in managing these programs.

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.

The evidence that our proposed facility will not jeopardize the quality of care or the financial viability of existing dialysis facilities lies in the fact that there are patients in our community without services that cannot (or will not) be accepted by other facilities. Our community lost a key dialysis facility when the unit at Monroe Community Hospital, operated by Fresenius Kidney Care, was permanently closed. Fresenius did its best to absorb those patients into other clinics. However, the Monroe Community Hospital clinic specialized in medically complex HD patients. Since it's closure, the role of the Monroe Community Hospital2 clinics to provide ESRD care for highly medically complex patients has fallen strictly on the acute dialysis facilities, which places an additional burden on the already over-extended hospitals.

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	400	4,680	9,360
OTHER SERVICES			
Total	400	4,680	9,360

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		
		Inpatient	OPD	ER
Payment Source				
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	
	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions
Primary Payment Source						
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.