Schedule 1
All CON Applications

Contents:

- **Acknowledgement and Attestation**
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New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

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

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
PRINT OR TYPE NAME	TITLE
Jeffrey Messenger	Project Manager

General Information

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

Contacts

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

Primary Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Dierdra Sorrell	Clifton-Fine Hospital	
BUSINESS STREET ADDRESS		
1014 Oswegatchie Trail		
CITY	STATE	ZIP
Star Lake	NY	13690
TELEPHONE	E-MAIL ADDRESS	
(315) 848-4260	dsorrell@cfhis.org	

Alternate Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Jeffrey Messenger- Project Manager	Samaritan Medical Center	
BUSINESS STREET ADDRESS		
830 Washington St.		
CITY	STATE	ZIP
Watertown	NY	13601
TELEPHONE	E-MAIL ADDRESS	
(315) 785-5777	jmessenger@shsny.com	

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			
Dierdra Sorrell- CEO			
BUSINESS STREET ADDRESS			
1014 Oswegatchie Trail			
CITY	STATE	ZIP	
Star Lake	NY	13690	
TELEPHONE	E-MAIL ADDRESS		
(315) 848-3351	dsorrell@cfhis.org		

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	
RaeAnne Lafave	Samaritan Medical Center	104 Paddock Street	
Watertown, NY 13601	TELEPHONE	E-MAIL ADDRESS	
	315-782-7148	rlafave@shsny.com	

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	

New York State Department of Health Certificate of Need Application

Schedule 1

Other Facilities Owned or Controlled by the Applicant

Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

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

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

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

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

Out-of-State Affiliated Facilities/Agencies

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

Facility Type	Name	Address	State/Country	Services Provided

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

Schedule 5
Working Capital Plan

Contents:

- **Schedule 5 - Working Capital Plan**

Working Capital Financing Plan

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

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

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

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

There is no cost associated with the designation change so there will be no financing.

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	

Schedule 6
Architectural/Engineering Submission

Contents:

- **Schedule 6 – Architectural/Engineering Submission**

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: 2/23/2024	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: Designation change from Critical Access to REH	
Site Location: Clifton Fine hospital 1014 Oswegatchie Trail, Star Lake, NY 13690	
Brief description of current facility, including facility type: Critical Access Hospital	

Click here to enter text.	
Brief description of proposed facility: Changing from Critical Access Hospital to a Rural Emergency Hospital	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. REH	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: N/A	
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: N/A	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. N/A	
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. Click here to enter text.	Not Applicable
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. N/A	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. N/A	
Describe existing and or new work for fire detection, alarm, and communication systems: N/A	
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. No	
Does the project comply with ADA? If no, list all areas of noncompliance. N/A	
Other pertinent information: This application is for a designation change so there isn't any construction involved.	

Project Work Area	**Response**
Type of Work N/A Change in designation w/o construction	Alteration
Square footages of existing areas, existing floor and or existing building.	28415
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	N/A
Does the work area exceed more than 50% of the smoke compartment, floor or building? N/A Change in designation w/o construction	Less than 50% of the smoke compartment
Sprinkler protection per NFPA 101 Life Safety Code	Partially Sprinklered
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type I (443)
Building Height	36'
Building Number of Stories	2

Which edition of FGI is being used for this project? N/A Change in designation w/o construction	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?	Not Applicable
Is the building a high-rise?	Not Applicable
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 18 New Health Care 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. Click here to enter text.	Not Applicable
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	Not Applicable
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.	Not Applicable
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	Not Applicable
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.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	Not Applicable
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? Click here to enter text.	Not Applicable
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	Not Applicable
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Not Applicable
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	Not Applicable
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?	Not Applicable

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

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

Schedule LRA 4/Schedule 7 - Environmental Assessment

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	$0	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$0	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$0	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	$0	Schedule 10
Cost/Per Square Foot for Renovation Construction	$0	Schedule10
Total Operating Cost		Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.00%	Schedule 9
Depreciation Life (in years)	0	

2) Construction Dates

Anticipated Start Date	N/A	Schedule 8B
Anticipated Completion Date	N/A	

Schedule 9
Project Financing

Contents:

- **Schedule 9 - Proposed Plan for Project Financing**

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

If refinancing is used, please complete area below.

☐	Refinancing	$
☐	Total Mortgage/Notes/Bonds (Sum E + Refinancing)	$0

II. Details

A. Leases

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

B. Cash

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

	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.	☒	
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 8B - Total Project Cost - For Projects without Subprojects.

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

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

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

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

	A	B	C
Item	**Project Cost in Current Dollars**	**Escalation amount to Mid-point of Construction**	**Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$0	$0	$0
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$0	$0	$0
3.2 Construction Contingency	$0	$0	$0
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$0	$0	$0
4.4 Construction Manager Fees	$0	$0	$0
4.5 Other Fees (Consultant, etc.)	$0	$0	$0
Subtotal (Total 1.1 thru 4.5)	$0	$0	$0
5.1 Movable Equipment (from Sched 11)	$0	$0	$0
5.2 Telecommunications	$0	$0	$0
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$0	$0	$0
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	$0	$0	$0
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 -->	N/A	#VALUE!	$0
10 Total Project Cost with fees	$2,000	#VALUE!	$2,000

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: ☐

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				
				#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:					**0**	**0**	**0**	

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

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

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

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	☐	☐	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
DocuSigned by: [signature]	2/23/2024

PRINT NAME	TITLE
Jeffrey Messenger	Project Manager

NAME OF FIRM
Samaritan Medical Center

STREET & NUMBER
830 Washington St.

CITY	STATE	ZIP	PHONE NUMBER
Watertown	NY	13601	315-785-5777

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

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 91). Codes for completing this table are found in the Functional Code Lookups sheet (see tab below).

Indicate if this project is: New Construction: | **OR** Renovation: |

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

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				
Raw totals for whole project:					**0**	**0**	**0**	

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

Subtotals for Sub Project 1		0		
Subtotals for Sub Project 2		0		
Subtotals for Sub Project 3		0		
Subtotals for Sub Project 4		0		
Subtotals for Sub Project 5		0		
Subtotals for Sub Project 6		0		
Subtotals for Sub Project 7		0		
Subtotals for Sub Project 8		0		
Totals for Whole Project:	**0**	**0**	**0**	

1. If New Construction is Involved, is it "freestanding?	YES	NO
Sub Project 1		
Sub Project 2		
Sub Project 3		
Sub Project 4		
Sub Project 5		
Sub Project 6		
Sub Project 7		
Sub Project 8		
Totals for Whole Project:		

2. Check the box that best describe\s the location of the facilities affected by this	Dense Urban	Other metropolitan or suburban	Rural
Sub Project 1			
Sub Project 2			
Sub Project 3			
Sub Project 4			
Sub Project 5			
Sub Project 6			
Sub Project 7			
Sub Project 8			
Totals for Whole Project:			

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

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A

For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE
This appendix lists the functional areas and services, beds and equipment, by facility type, which should be used in describing your proposals. In listing these services in the application, do not include any description inside parentheses.

HOSPITAL including Extension Clinics

Use the following listing for hospital proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
701	General Baseline Services (includes Anesthesia, Emergency Procedures, Nursing and Physician Services)
733	Baseline Clinical Laboratory Service
734	Baseline Dietetic
736	Baseline Medical/Surgical
741	Baseline Operating Room
742	Baseline Pharmaceutical Service
744	Baseline Recovery Room
	INPATIENT SERVICES
101	Acute Renal Dialysis
151	Alcohol Detoxification
152	Alcohol Rehabilitation
102	Ambulance
301	Audiology
201	Blood Services
103	Burn Center
104	Burn Program
203	Cardiac Catheterization - Adult
204	Cardiac Catheterization - Pediatric
205	Cardio-Pulmonary Function Analysis
206	Cleft Palate Center
105	Coronary Care
208	Cystoscopy
209	Dental
210	Diagnostic Radiology
153	Drug Detoxification
154	Drug Rehabilitation
106	Emergency Department
107	Intensive Care
213	Kidney Transplantation
214	Maternity
302	Medical Rehabilitation
108	Neonatal Continuing Care
109	Neonatal Intensive Care

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

110	Neonatal Intermediate Care
303	Occupational Therapy
215	Cardiac Surgery - Adult
216	Cardiac Surgery - Pediatric
356	Pathology Laboratory
218	Pediatric
111	Pediatric - ICU
304	Physical Therapy
112	Poison Control Center
221	Psychiatric
222	Psychiatric - Day/Night
230	Radioactive Materials - Diagnostic
231	Radioactive Materials - Therapeutic
224	Radioisotope Implantation
226	Respiratory Care
227	Respiratory Therapy
361	Self Care
362	Social Work Service
305	Speech-Language Pathology
228	Therapeutic Radiology
306	Vocational Rehabilitation
	OUTPATIENT SERVICES
491	Alcohol Rehabilitation O/P
402	Ambulatory Surgery
451	Audiology O/P
452	C.O.R.F.
423	Chronic Renal Dialysis O/P
406	Clinical Laboratory Service
407	Dental O/P
492	Drug Abuse Screening O/P
495	Drug Detoxification O/P
493	Drug Rehabilitation O/P
471	Family Planning O/P
472	Health Education O/P
473	Home Dialysis Training O/P
453	Medical Rehabilitation O/P
494	Methadone Maintenance O/P
413	Multiphasic Screening O/P
476	Nutritional O/P
454	Occupational Therapy O/P
414	Optometry O/P
425	Organized Outpatient Department
415	Outpatient Surgery
477	Part-Time Clinic(s)

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P
418	Prenatal O/P
419	Primary Medical Care O/P
420	Psychiatric O/P
421	Psychological O/P
424	Respiratory Therapy O/P
479	Social Work Service O/P
457	Speech-Language Pathology O/P
458	Vocational Rehabilitation O/P

BED TYPE

151	Alcohol Detoxification
152	Alcohol Rehabilitation
103	Burns Care
105	Coronary Care
153	Drug Detoxification
154	Drug Rehabilitation
107	Intensive Care
214	Maternity
302	Medical Rehabilitation
701	Medical/Surgical
221	Psychiatric
108	Neonatal Continuing Care
109	Neonatal Intensive Care
110	Neonatal Intermediate Care
218	Pediatric
111	Pediatric ICU
220	Prisoner
226	Respiratory
361	Self Care
364	Special Use

EQUIPMENT TYPE

423	Chronic Renal Dialysis Stations
501	CT Scanner
502	Cobalt Unit
503	Echo Cardiograph
504	Hyperbaric Chamber
505	Linear Accelerator
506	Megavoltage Unit
508	Ultrasound
601	Nuclear Magnetic Resonance Demonstration

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

RESIDENTIAL HEALTH CARE FACILITY
Use the following listing for Residential Health Care Facilities

Functional Codes	Service Description:
	BASELINE SERVICES
702	General Baseline Services - HRF's (includes Medical Services)
703	General Baseline Services - SNF's (includes Medical Services)
731	Baseline Activities Program
734	Baseline Dietetic
737	Baseline Nursing
742	Baseline Pharmaceutical Service
746	Baseline Social Work Service
	OPTIONAL SERVICES
301	Audology
352	Clinical Laboratory Service
209	Dental
210	Diagnostic Radiology
474	Non-Occupant Services
303	Occupational Therapy
217	Optometry
304	Physical Therapy
357	Physician Services
219	Podiatry
223	Psychological
359	Religious Services and Counseling
227	Respiratory Therapy
305	Speech-Language Pathology
	BED TYPES
703	SRF
	EQUIPMENT TYPES
501	CT Scanner
503	ECHO Cardiograph
508	Ultrasound

DIAGNOSTIC AND TREATMENT CENTER including Extension Clinics
Use the following listing for Diagnostic and Treatment Center proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
704	General Baseline (Includes Medical Staff)

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

	OPTIONAL SERVICES
401	Abortion O/P
491	Alcohol Rehabilitation O/P
402	Ambulatory Surgery
451	Audiology O/P
406	Clinical Laboratory Service
452	C.O.R.F.
423	Chronic Renal Dialysis O/P
407	Dental O/P
408	Diagnostic Radiology O/P
492	Drug Abuse Screening O/P
495	Drug Detoxification O/P
493	Drug Rehabilitation O/P
471	Family Planning O/P
472	Health Education O/P
473	Home Dialysis Training O/P
453	Medical Rehabilitation O/P
494	Methadone Maintenance O/P
413	Multiphasic Screening O/P
475	Nursing O/P
476	Nutritional O/P
454	Occupational Therapy O/P
414	Optometry O/P
477	Part-Time Clinic(s)
416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P
418	Prenatal O/P
419	Primary Medical Care O/P
420	Psychiatric O/P
421	Psychological O/P
479	Social Work Service O/P
457	Speech-Language Pathology O/P
427	Therapeutic Radiology O/P
	EQUIPMENT
423	Chronic Renal Dialysis Stations
502	Cobalt Unit
501	CT Scanner
503	Echo Cardiograph
505	Linear Accelerator
506	Megavoltage Unit
508	Ultrasound

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A
For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

MIDWIFERY BIRTH CENTER including Extension Clinics
Use the following listing for Midwifery Birth Center proposals:

Functional Codes	Service Description:
416	Pediatric O/P
418	Prenatal O/P
419	Primary Medical Care O/P

HOME HEALTH AGENCY
Use the following listing for Home Health Agency proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
705	General Baseline (includes Home Health Aide and Medical Supplies, Equipment and Appliances)
738	Baseline Nursing (Contract)
739	Baseline Nursing (Direct)
	OPTIONAL SERVICES
481	Medical Social Services O/P
476	Nutritional O/P
454	Occupational Therapy O/P
455	Physical Therapy O/P
482	Personal Care
483	Physicians Services
424	Respiratory Therapy
457	Speech-Language Pathology O/P

LONG-TERM HOME HEALTH CARE PROGRAM
Use the following listing for Long-Term Home Health Care Program Proposals

Functional Codes	Service Description:
	BASELINE SERVICES
707	General Baseline Services (includes Audiology; Home Health Aide; Homemaker, Housekeeper; Medical Social Work; Medical Supplies; Equipment And Appliances; Nutritional; Occupational Therapy; Personal Care; Physical Therapy; Respiratory Therapy; and Speech-L
738	Baseline Nursing (Contract)
739	Baseline Nursing (Direct)
	OPTIONAL SERVICES
357	Physician Services

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A

For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

	PATIENT CAPACITY
707	Designated patient capacity

HOSPICE

Use the following listing for Hospice Proposals:

Functional Codes	Service Description:
	BASELINE SERVICES
706	General Baseline Services (includes Bereavement, Home Health Aide, Homemaker, Housekeeper, Nursing, Medical Supplies, Equipment & Appliances, Nutritional, Pastoral Care, Personal Care, Physician Services and Psychological)
732	Baseline Audiology
733	Baseline Clinical Laboratory Service
735	Baseline Inpatient Services
740	Baseline Occupational Therapy
742	Baseline Pharmaceutical Service
743	Baseline Physical Therapy
745	Baseline Respiratory Therapy
746	Baseline Social Work Service
747	Baseline Speech-Language Pathology
	BEDS
706	Hospice beds

NON-MEDICAL FUNCTIONAL AREAS

Use these codes for all health care facilities to describe non-medical functional areas:

Functional Codes	Service Description:
	NON-MEDICAL SERVICES
901	Administration (Routine)
902	General Administration
903	Admitting
904	Accounting/Financial Service
905	Administrative Personnel
906	Data Processing
907	Fund Appeal/Volunteers
908	Medical/Social Services
909	Energy Proposal
910	Telephone System
920	Public Areas
921	Cafeteria
922	Chapel/Meditation
923	Lobby/Waiting/Public Entrance
924	Coffee/Gift Shop/Flower/Canteen/Snack Bar

New York State Department of Health
Certificate of Need Application
Space & Construction Cost Distribution - Appendix A

For all Full or Administrative review applications, except Establishment-Only applications.

LIST OF FUNCTIONAL AREAS AND SERVICES, BEDS & EQUIPMENT BY FACILITY TYPE

930	Education/Research
931	Supervising Physicians' Offices (Hospital Physicians involved in
932	Nursing School
933	Medical Laboratory/Auditorium
934	Research (Laboratory areas)
935	Medical Teaching (for residents and interns; Classrooms)
940	Industrial/Service Functions
941	Central Sterile and Supply
942	Laundry/Linen
943	Maintenance/Housekeeping
944	Medical Supplies/Central Services/Storage
945	Parking Structures (free-standing structures)
946	Staff Lockers
947	Tunnels, Bridges and Other Enclosed Circulation Spaces
948	Equipment Maintenance (includes Biomedical Engineering Service)
960	Building System
961	Site Work (Replant grass, signs, etc.)
962	On-site Parking, Excluding Garage Structure (parking lot)
963	Outside Utilities (water, sprinkler, lights, Outside sewer, etc.)
964	Structure, Including Finisher (Paint building, etc.)
965	Heating/Ventilation/Air Conditioning (HVAC)
966	Sanitary System (Inner plumbing and ventilation)
967	Electrical System
968	Vertical & Horizontal Mechanized Movement (elevators, cart system)
980	Other Functions
981	Private Physicians Offices
982	Housing on Call (Interns, residents, physicians)
983	Housing Other (for parents of young patients, visitors, etc.)
984	Medically Related Computer

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
		No equipment being purchased as part of this designation change				

Total lease and purchase costs: Subproject 1	
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:	0

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
		No equipment being decommissioned as part of this designation change.			

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**
- **Schedule 13 B - Staffing**
- **Schedule 13 C - Annual Operating Costs**
- **Schedule 13 D - Annual Operating Revenue**

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
05/01/2024 | 11:28:38 AM EDT

DocuSigned by:
98FEC3EAC38040F...
Signature:

Jeffrey Messenger
Name (Please Type)

Project Manager
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		11.2	9.0	9.0
2. Technician & Specialist		7.8	5.8	5.8
3. Registered Nurses		6.1	4.0	4.0
4. Licensed Practical Nurses		6.5	4.0	4.0
5. Aides, Orderlies & Attendants		11.8	7.9	7.9
6. Physicians		0.3	1.0	1.0
7. PGY Physicians				
8. Physicians' Assistants		4.4	2.1	2.1
9. Nurse Practitioners		1.4	2.1	2.1
10. Nurse Midwife				
11. Social Workers and Psychologist**		0.1	0.1	0.1
12. Physical Therapists and PT Assistants		3.0	1.8	1.8
13. Occupational Therapists and OT Assistants		0.3	0.3	0.3
14. Speech Therapists and Speech Assistants				
15. Other Therapists and Assistants				
16. Infection Control, Environment and Food Service		7.2	4.5	4.0
17. Clerical & Other Administrative		14.6	9.9	9.9
18. Other	Licensed Mental Health Counselor	1.00	1.0	1.0
19. Other	Pharmacist	0.4		
20. Other				
21. Total Number of Employees		76	52.9	52.9

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

Describe how the number and mix of staff were determined:

Current staffing was determined using Clifton Fine's payroll statistical information, and projected staffing was based on REH staffing requirements.

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:	Dr. Victoria
License number of the Medical/Center Director	208358-01

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

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	Samaritan Medical Center
○ Distance in miles from the proposed facility to the Hospital affiliate.	58
○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	60
○ Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.	N/A ☐ Attachment Name: SMC Affiliation Agreement
Name of the **nearest** Hospital to the proposed facility	Gouverneur Hospital
○ Distance in miles from the proposed facility to the nearest hospital.	25 miles
○ Distance in minutes of travel time from the proposed facility to the nearest hospital.	30

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.		
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital		

☒ Total Project or ☐ Subproject Number ☐

Table 13C - 1

	a	b	c
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	1/1/2022	12/31/2025	12/31/2027
1. Salaries and Wages	4966626	4201417	4453502
1a. FTEs	76	53	53
2. Employee Benefits	1024365	882298	935235
3. Professional Fees	3164042	1232608	1232608
4. Medical & Surgical Supplies	559146	399035	422976
5. Non-med., non-surg. Supplies	100277	38234	40528
6. Utilities	127983	142771	157405
7. Purchased Services	128800	74760	74760
8. Other Direct Expenses	842916	657137	657137
9. Subtotal (total 1-8)	10914154	7780770	8135814
10. Interest (details required below)	63234	47586	42984
11. Depreciation (details required below)	3255925	840398	840398
12. Rent / Lease (details required below)	31488	59712	59712
13. Total Operating Costs	11334468	8817776	9357669

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)	1/1/2022		
1. Salaries and Wages	2585067		
1a. FTEs	43		
2. Employee Benefits	516893		
3. Professional Fees	1543616		
4. Medical & Surgical Supplies	272786		
5. Non-med., non-surg. Supplies	48921		
6. Utilities	62438		
7. Purchased Services	62836		
8. Other Direct Expenses	411227		
9. Subtotal (total 1-8)	5503784		
10. Interest (details required below)	30850		
11. Depreciation (details required below)	158844		
12. Rent / Lease (details required below)	15362		
13. Total Operating Costs	5708840		

Table 13C - 3

	a	b	c
Outpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	1/1/2022	1/1/2025	1/1/2027
1. Salaries and Wages	2381557	4369474	4719032
1a. FTEs	31	53	53
2. Employee Benefits	507473	917589	990997
3. Professional Fees	1620425	1269586	1345761
4. Medical & Surgical Supplies	286359	399034	422976
5. Non-med., non-surg. Supplies	51355	38234	40528
6. Utilities	65544	142771	157048
7. Purchased Services	65963	76255	79305
8. Other Direct Expenses	431689	657137	657137
9. Subtotal (total 1-8)	5410365	7870080	8412784
10. Interest (details required below)	32385	47586	42984
11. Depreciation (details required below)	166748	840398	840398
12. Rent / Lease (details required below)	16126	59712	59712
13. Total Outpatient Operating Costs	5625624	8817776	9357669

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.	☐		
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)	1/1/2022	1/1/2025	1/1/2027
1. Inpatient Services	3194739		
2. Outpatient Services	7488198	7023125	7403510
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered	10682936	7023125	7403510
5. Deductions from Revenue	-1607928	-2096346	2221874
6. Net Patient Care Services Revenue	9075008	4931007	4502490
7. Other Operating Revenue (Identify sources)			
Other Operating Rvenue	301052	244042	244042
Net assets released	313186		
Additional Facility Payment		3470430	3667495
8. Total Operating Revenue (Total 1-7)	9679246	8641250	9093173
9. Non-Operating Revenue	52787	52787	52787
10. Total Project Revenue	9732003	8694037	9145960

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	467	986342	2112						
	Managed Care									
Medicare	Fee for Service	1064	3203437	3011						
	Managed Care									
Medicaid	Fee for Service	2699	466388	173						
	Managed Care									
Private Pay		449	21513	48						
OASAS										
OMH										
Charity Care										
Bad Debt			-17090							
All Other										
Total		4679	4660591							

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	4762	1577091	331	4733	2076852	439	4733	2201463	465
	Managed Care									
Medicare	Fee for Service	4444	1827334	411	3713	1640102	442	3713	1738508	468
	Managed Care									
Medicaid	Fee for Service	2612	1023010	392	2432	526361	216	2432	557943	229
	Managed Care									
Private Pay		405	31268	77	391	194510	497	391	206181	527
OASAS										
OMH										
Charity Care			-4229			-4229			-4229	
Bad Debt			-40056			-190192			-201604	
All Other						683375			683375	
Total			4454474			4926779			5181637	

Total of Inpatient and Outpatient Services		9075008			4926779			5181637	

Schedule 16
CON Forms Specific to Hospitals
Article 28

Contents:

- **Schedule 16 A - Hospital Program Information**
- **Schedule 16 B - Hospital Community Need**
- **Schedule 16 C - Impact of CON Application on Hospital Operating Certificate**
- **Schedule 16 D - Hospital Outpatient Departments**
- **Schedule 16 E - Hospital Utilization**
- **Schedule 16 F - Hospital Facility Access**

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.

Clifton-Fine Hospital is a 20-bed Primary Care-Crital Access Hospital (CAH) serving rural communities in southern St. Lawrence County. Established in 1951, the hospital is located in Star Lake, New York, in the Adirondack Park. Clifton-Fine Hospital is affiliated with Samaritan Medical Center, a 290-bed acute care hospital located in the small city of Watertown, New York, 55 miles from Star Lake.

CFH is applying to change designation to a Rural Emergency Hospital (REH). As an REH Clifton-Fine will maintain all current out-patient services (Lab, Radiology, Primary Care, and Rehabilitation). The only change proposed is to close the in-patient unit which is located on the 2nd floor of the hospital.

As a CAH and a REH Clifton-Fine Hospital is and will be in full compliance with state and federal regulations governing hospitals. In addition to certification by the federal Centers for Medicare and Medicaid Services and the New York State Department of Health, the hospital is in conformance with mandates prescribed by the federal Occupational Safety and Health Administration.

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.)

The hospital's service area includes the census tracts for Cranberry Lake (12927), Fine (13639), Newton Falls (13666) and Star Lake (13690). The hospital is located in St. Lawrence County, a federally designated Healthcare Professional Shortage Area (HPSA) for primary care, dental health and mental health. The service area is situated on the western side of the six million-acre Adirondack Park. While the service area is heavily forested and sparsely populated, it is greatly trafficked by vacationers and other visitors traveling through the Adirondacks.

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

Population of the zip codes defining Clifton-Fine Hospital's primary service area is 1,322 persons according to US Census 2019 American Community Survey. In addition, the hospital provides medical services to seasonal residents who own/rent properties in the area, as well as tourists and and other visitors traveling through the Adirondacks. CFH estimates 5,000 to 10,000 additional people travel through/visit the hospital's service area each year.

According to aggregated data provided by the Fort Drum Regional Healthcare Planning Organization, of those living in the CFH service area, 95.11% are white. Less than one percent are categorized as black/African American, American Indian/Alaskan Native or Asian. Additionally, 2.55% identify as members of two or more races. By ethnicity, 2.34% are Hispanic/Latino; the rest are non-Hispanic.

Males account for 52.98% of the population. Those under 18 years of age make up 18.3%, while those 65 and older account for 23.4%. Median population age is 46 years.

Median household income is $68,303. Of family households, 16.54% have incomes below the poverty line. Median value of owner-occupied housing units is $87,923; average value is $156,211. Over one sixth of the county's population lives below the poverty level (18%) which equates to 3,127 families.

The unemployment rate for the service area's civilian population over the age of 16 is 2.22%.

Of the population over age 25, the highest level of educational attainment reached is as follows: 14.2% did not complete high school; 45.74% are high school graduates; 11.36% have some college education but did not earn a degree; 12.5% earned associate degrees; and the remaining 16.2% a bachelor degree or higher.

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

The services affected by this project is the closure of in-patient medical beds. Clifton-Fine Hospital current demand for in-patient services:

Utilization	2021	2022	2023
Acute Admissions	47	47	22
Swing Bed Days	1123	1005	582

CFH Out-Patient Stats	2021	2022	2023
Clinic Visits	4616	5088	4394
Behavior Health Visits	429	253	569
CT Scans	602	525	521
ED visits	1361	1491	1382
Laboratory tests	23876	24954	25486
Observation days	46	11	7
PT Treatments	6315	7362	7373
OT Treatments	701	2794	2574
Radiology Exams	1076	1266	1165

The change ot REH will ensure that we can prevent closure of the hospital and maintain all out-patient services.

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

Maintaing primary care and out-patient services is vital to the community we service. 64% of St. Lawence county residents report being diagnosed with any of the 8 studied chronic health conditions; 30% report experiencing challenges in receiving primary care and dental services locally; 27% report their physical health "less than good" and 22% respondants with children report challenges receiving primary care.

(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.

This 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.

The population served by Clifton-Fine Hospital currently receives the services affected by this project at Clifton-Fine Hospital. If patients require a higher level of care, they are transferred to one of our surrounding hospitals.

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.

Clifton-Fine Hospital is an active member of the Bridge to Wellness coalition, a partnership of hospitals, public health and community agencies which developed St. Lawrence County's 2019-2021 Community Health Improvement Plan (CHIP). This plan aligns with New York State's 2019-2024 Prevention Agenda (the statewide health improvement plan). To collect data for development of the county's CHIP, Bridge to Wellness worked with the Fort Drum Health Planning Organization to conduct a 2019 Community Health Assessment (CHA) which identified specific community health problems and disparities.

According to the CHA, St. Lawrence County's population has: high numbers of overweight adults and a growing rate of obesity, factors which contribute to heart disease, stroke, cancer, diabetes and kidney disease; hospitalization rates for heart attack and failure well above state averages; and high rates of diabetes. The CHA also reported an increasing suicide rate. Emergency department visits and hospitalization rates for mental diseases and disorders also exceed statewide averages. Emergency department visits particularly due to opioid overdose and hospital discharges due to opioid use are both significantly higher that statewide averages excluding New York City. Diseases of the circulatory system rank as the highest cause of death in St. Lawrence County, followed by neoplasms, diseases of the respiratory system, and external causes of mortality.

As explained earlier, emergency and other hospital services will have no impact by this project. No new services are proposed at this time, however given the community's prevalent health problems as identified in the CHA, and no restrictions on future out-patient projects, CHF will continue to analyze health data and expand out-patient serves to address specific community health issues as needed.

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	20	☐	☒	0
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	20	☐	☐	0

*CHEMICAL DEPENDENCE: Requires additional approval by the Office of Alcohol and Substance Abuse Services (OASAS)
**PSYCHIATRIC: Requires additional approval by the Office of Mental Health (OMH)

Does the applicant have previously submitted Certificate of Need (CON) applications that have not been completed involving addition or decertification of beds?

☒ No | ☐ Yes (*Enter CON number(s) to the right)*

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

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:

(Enter street address of facility)

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☒	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
AMBULATORY SURGERY				
MULTI-SPECIALTY	☐	☐	☐	☐
SINGLE SPECIALTY – GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
CARDIAC CATHETERIZATION				
ADULT DIAGNOSTIC	☐	☐	☐	☐
ELECTROPHYSIOLOGY (EP)	☐	☐	☐	☐
PEDIATRIC DIAGNOSTIC	☐	☐	☐	☐
PEDIATRIC INTERVENTION ELECTIVE	☐	☐	☐	☐
PERCUTANEOUS CORONARY INTERVENTION (PCI)	☐	☐	☐	☐
CARDIAC SURGERY ADULT	☐	☐	☐	☐
CARDIAC SURGERY PEDIATRIC	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
CLINIC PART-TIME SERVICES	☐	☐	☐	☐
COMPREHENSIVE PSYCH EMERGENCY PROGRAM	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
EMERGENCY DEPARTMENT	☒	☐	☐	☐
EPILEPSY COMPREHENSIVE SERVICES	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐

[1] A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.
[2] A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.
[4] DIALYSIS SERVICES require additional approval by Medicare
[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators
[6] PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric
[7] Must be certified for Home Hemodialysis Training & Support

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

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

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

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

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

LOCATION: *(Enter street address of facility)*	**Check if this is a mobile van/clinic** ☐			
	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
AMBULATORY SURGERY				
SINGLE SPECIALTY -- GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
MULTI-SPECIALTY	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐
RADIOLOGY-THERAPEUTIC[5]	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b) below][4]	_____	_____	_____	_____
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐
FOR OFF-CAMPUS EMERGENCY DEPARTMENTS ONLY[8]				
EMERGENCY DEPARTMENT	☐	☐	☐	☐

[1] A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.
[2] A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.
[4] DIALYSIS SERVICES require additional approval by Medicare
[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators
[6] PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric
[7] Must be certified for Home Hemodialysis Training & Support
[8] OFF-CAMPUS EMERGENCY DEPARTMENTS must meet all relevant Federal Conditions of Participation for a hospital per CMS S&C-08-08

END STAGE RENAL DISEASE (ESRD)

TABLE 16C-3*(a)* CAPACITY	Existing	Add	Remove	Proposed
CHRONIC DIALYSIS				

If application involves dialysis service with existing capacity, complete the following table:

TABLE 16C-3(b) TREATMENTS	Last 12 mos	2 years prior	3 years prior
CHRONIC DIALYSIS			

All Chronic Dialysis applicants must provide the following information in compliance with 10 NYCRR 670.6.

1. Provide a five-year analysis of projected costs and revenues that demonstrates that the proposed dialysis services will be utilized sufficiently to be financially feasible.

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

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

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

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

Schedule 16 D. Hospital Outpatient Department - Utilization projections

a	b	d	f
	Current Year *Visits**	First Year *Visits**	Third Year *Visits**
CERTIFIABLE SERVICES			
MEDICAL SERVICES – PRIMARY CARE			
MEDICAL SERICES – OTHER MEDICAL SPECIALTIES			
AMBULATORY SURGERY			
SINGLE SPECIALTY -- GASTROENTEROLOGY			
SINGLE SPECIALTY – OPHTHALMOLOGY			
SINGLE SPECIALTY – ORTHOPEDICS			
SINGLE SPECIALTY – PAIN MANAGEMENT			
SINGLE SPECIALTY -- OTHER			
MULTI-SPECIALTY			
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC			
ELECTROPHYSIOLOGY			
PEDIATRIC DIAGNOSTIC			
PEDIATRIC INTERVENTION ELECTIVE			
PERCUTANEOUS CORONARY INTERVENTION (PCI)			
CERTIFIED MENTAL HEALTH O/P			
CHEMICAL DEPENDENCE - REHAB			
CHEMICAL DEPENDENCE - WITHDRAWAL O/P			
CLINIC PART-TIME SERVICES			
CLINIC SCHOOL-BASED SERVICES			
CLINIC SCHOOL-BASED DENTAL PROGRAM			
COMPREHENSIVE EPILEPSY CENTER			
COMPREHENSIVE PSYCH EMERGENCY PROGRAM			
DENTAL			
EMERGENCY DEPARTMENT			
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT			
HOME HEMODIALYSIS TRAINING & SUPPORT			
INTEGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY			
METHADONE MAINTENANCE O/P			
NURSING HOME HEMODIALYSIS			
RADIOLOGY-THERAPEUTIC			
RENAL DIALYSIS, CHRONIC	0		
OTHER SERVICES			
Total			

Note: In the case of an extension clinic, the service estimates in this table should apply to the site in question, not to the hospital or network as a whole.

*The 'Total' reported MUST be the SAME as those on Table 13D-4.

Schedule 16 E. Utilization/discharge and patient days

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

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

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

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

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

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

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date:		1st Year Start date:		3rd Year Start date:	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
AIDS						
BONE MARROW TRANSPLANT						
BURNS CARE						
CHEMICAL DEPENDENCE - DETOX						
CHEMICAL DEPENDENCE - REHAB						
COMA RECOVERY						
CORONARY CARE						
INTENSIVE CARE						
MATERNITY						
MED/SURG						
NEONATAL CONTINUING CARE						
NEONATAL INTENSIVE CARE						
NEONATAL INTERMEDIATE CARE						
PEDIATRIC						
PEDIATRIC ICU						
PHYSICAL MEDICINE & REHABILITATION						
PRISONER						
PSYCHIATRIC						
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM						
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL						

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

Schedule 16 F. Facility Access

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

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

Table 1. Patient Characteristics	Total Number of Inpatients	Number of Patients Transferred		
		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.