Schedule 1
All CON Applications

Contents:

- **Acknowledgement and Attestation**
- **General Information**
- **Contacts**
- **Affiliated Facilities/Agencies**

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: M

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
Is	11/19/2024
PRINTORTIPE NAME	iIIILE
Rodney Buchanan	dministrator

General Information

		T[tle of Attachment:
Is the applicant an existing facHity? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the oroiect.	YES xNO ☐	
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1 U) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YESxNO D	

Contacts

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

	NAME AND TITLE OF CONTACT PERSON	K;ONTACT PERSON'S COMPANY	
	Rodney Buchanan, Administrator	Westfield Memorial Hospital	
	BUSINESS STREET ADDRESS		
	189 East Main Street		
	CITY	STATE	ZIP
	Westfield	Y	114787
	TELEPHONE	E-MAIL ADDRESS	

	NAME AND TITLE OF CONTACT PERSON	♦ONTACT PERSON'S COMPANY	
	Henry Ward, Project Manager	Westfield Memorial Hospital	
	BUSINESS STREET ADDRESS		
	189 East Main Street		
	CITY	STATE	ZIP
	Nestfield	t-,Jv	114787
	TELEPHONE	E-MAIL ADDRESS	

The applicant must identifv the operator's chief executive officer, or eauivalent official.

EXECUTIVE OFFICER	NAME AND TITLE		
	Chris Clark, President and CEO		
	BUSINESS STREET ADDRESS		
	189 East Main Street		
	CITY	STATE	ZIP
	Westfield	NY	114787
	TELEPHONE	E-MAIL ADDRESS	

The applicant's lead attorney should be identified:

	NAME	FIRM	BUSINESS STREET ADDRESS
	Jackie Bauer	Highmark Health	5th Ave Place, 120 5th Ave Suite 12900
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
	Pittsburgh, PA 15222		

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

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

The applicant's lead accountant should be identified:

CONTACT	NAME	FIRM	BUSINESS STREET ADDRESS
	Rand Levis	AHN Saint Vincent	232 West 25th Street
	CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS
	Erie, PA 16502		

Please list all Architects and Engineer contacts:

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

	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	Yesx No ☐
NursinQ Home	NH	Yes ☐ No ☐
Diagnostic and Treatment Center	OTC	Yes ☐ No ☐
Midwifery Birth Center	MBC	Yes ☐ No ☐
Licensed Home Care Services Agencv	LHCSA	Yes ☐ No ☐
Certified Home Health Agency	CHHA	Yes ☐ No ☐
Hospice	HSP	Yes ☐ No ☐
Adult Home	ADH	Yes ☐ No ☐
Assisted Livinq Proqram	ALP	Yes ☐ No ☐
Long Term Home Health Care Program	LTHHCP	Yes ☐ No ☐
Enriched Housing Program	EHP	Yes ☐ No ☐
Health Maintenance Omanization	HMO	Yes ☐ No ☐
Other Health Care Entity	0TH	YesD 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 20.

Westfield Memorial Hospital Certificate of Need
Schedule 1 Attachments

- Project Summary
- General Information
- Westfield Memorial Hospital Operating Certificate
- Westfield Memorial Hospital Organizational Chart
- Board Resolution
- AHN Saint Vincent Facilities and Services

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SIGNATURE:	DATE
1:s.	11/19/2024
DRitiTORTIPt Nk'-IE	TITLE
Rodney Buchanan	Administrator

General Information

		Title of Attachment·
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	BUSINESS STREET ADDRESS		
	189 East Main Street		
	CITY	STATE	ZIP
	Westfield	y	114787
	TELEPHONE	E-MAIL ADDRESS	
	i	l	

New York State Department of Health
Certificate of Need Application

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

CHIEF EXECUTIVE			
NAME AND TITLE			
Chris Clark, President and CEO			
BUSINESS STREET ADDRESS			
189 East Main Street			
CITY	STATE	ZIP	
Westfield	NY	14787	
TELEPHONE	E-MAIL ADDRESS		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM	BUSINESS STREET ADDRESS	
Jackie Bauer	Highmark Health	5th Ave Place, 120 5th Ave Suite 2900	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Pittsburgh, PA 15222			

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

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

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ACCOUNTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
Rand Levis	AHN Saint Vincent	232 West 25th Street	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Erie, PA 16502			

Please list all Architects and Engineer contacts:

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

T			
NAME	FIRM	BUSINESS STREET 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 x 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:

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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

Westfield Memorial Hospital Certificate of Need
Schedule 1 Attachments

- Project Summary
- General Information
- Westfield Memorial Hospital Operating Certificate
- Westfield Memorial Hospital Organizational Chart
- Board Resolution
- AHN Saint Vincent Facilities and Services

Project Summary

Westfield Memorial Hospital (WMH), located in Westfield, New York, has been serving the community since 1942. Westfield Memorial Hospital is committed to delivering compassionate and high-quality care to meet the health needs of its surrounding communities of Westfield, Ripley, Brocton, Sherman, Clymer, Bemus Point, Mayville, Chautauqua, Stockton, Portland, Dewittville, Hartfield, and Ashville.

Westfield Memorial is a member of the Allegheny Health Network (AHN), an eight-hospital health system based in Pittsburgh, Pennsylvania, serving 29 counties in Pennsylvania, portions of New York, Ohio, and West Virginia. Westfield Memorial Hospital is currently a 4-bed, not-for-profit, short-term acute care hospital, that provides inpatient care, emergency medicine, outpatient surgery, medical imaging, laboratory, physical therapy, specialty care clinics and women's health services. The hospital is equipped with advanced technology and offers diagnostic services including imaging, laboratory testing, and telemedicine.

WMH is pursuing Rural Emergency Hospital (REH) designation as a preferred operating structure. The Centers for Medicare and Medicaid Services (CMS) has developed this new provider type to support small rural hospitals to align outpatient services to community

Hospital will follow all New York State Department of Health (NYSDOH) guidelines and requirements throughout the review process in order to achieve REH designation

Schedule 1--General Information

Statement

Westfield Memorial Hospital, Inc. (the "Corporation") is a rural, private, voluntary not- for-profit acute primary care hospital operated mainly for the benefit of patients needing medical care in Northern Chautauqua County, New York and surrounding areas. The Corporation strives to provide care in accordance with the operating certificate issued by the New York State Department of Health. In its efforts to contain costs, it will manage its resources judiciously and attempt to enter into shared service relationships with other health care providers. The importance of continuity of care will be recognized in transfer agreements with nursing homes and with acute care facilities providing secondary and tertiary levels of care. It shall also be the policy of the Corporation not to permit on its premises the elective termination of pregnancy.

Corporation

The purposes of the Corporation shall be those set forth in its Certificate of Incorporation, as amended from time to time. The Corporation shall comply with all applicable federal, state and local laws, including, without limitation, the New York State Public Health Law, Mental Hygiene Law, and Education Law. Its principal office is located at Westfield, New York, and its designated agent for the service of process shall be the Secretary of State.

Power

The Corporation shall have such powers as set forth in its Certificate of Incorporation, as amended from time to time, and shall have and exercise such powers in furtherance of its purposes as are now or may hereinafter be set forth in its Certificate of Incorporation or under the laws of the State of New York as they may now or may hereafter exist

Facility Id. 111
Certificate No. 0632000H

Certified **Beds - Total** 4
Medical / Surgical 4

State of New York
Department of Health
Office of Primary Care and Health Systems Managen

OPERATING CERTIFICATE
Hospital

Westfield Memorial Hospital Inc
189 E Main Street
Westfield, New York 14787

Operator: Westfield Memorial Hospital Inc
Co-Operator: St. Vincent's Health System
Operator Class: Voluntary Not for Profit Corporation

Has been granted this Operating Certificate pursuant to Article 28 of the Public Health Law for the service(s) specified.

Ambulatory **Surgery - Multi Specialty**
Clinic Part Time Services
Clinical Laboratory Service
Coronary Care
Medical Services - Other Medical Specialties
Medical Services - Primary Care
Medical Social Services
Medical/Surgical

Other Authorized Locations

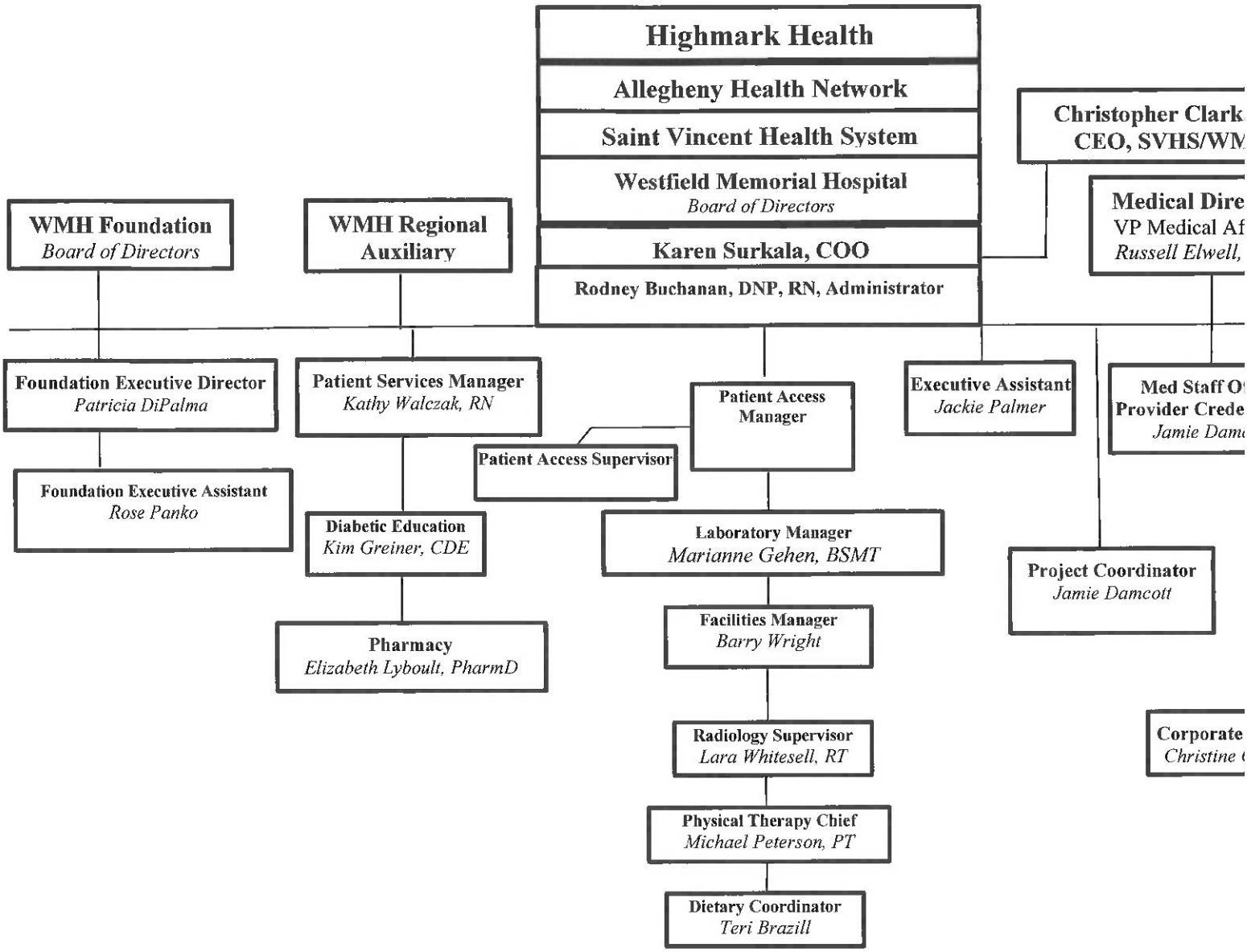
Hospital Extension Clinic
WMH Chautauqua Clinic
21 Roberts Avenue
Chautauqua, New York 14722

Keith W Lewis

20160323

Deputy Director Office of Primary Care and Health Systems Management

This certificate must be conspicuously displayed on the premises.


Highmark Health
Allegheny Health Network
Saint Vincent Health System
Westfield Memorial Hospital
Board of Directors
Karen Surkala, COO
Rodney Buchanan, DNP, RN, Administrator
Christopher Clark
CEO, SVHS/WM
Medical Dire
VP Medical Af
Russell Elwell,
WMH Foundation
Board of Directors
WMH Regional Auxiliary
Foundation Executive Director
Patricia DiPalma
Foundation Executive Assistant
Rose Panko
Patient Services Manager
Kathy Walczak, RN
Diabetic Education
Kim Greiner, CDE
Pharmacy
Elizabeth Lyboult, PharmD
Patient Access Manager
Patient Access Supervisor
Laboratory Manager
Marianne Gehen, BSMT
Facilities Manager
Barry Wright
Radiology Supervisor
Lara Whitesell, RT
Physical Therapy Chief
Michael Peterson, PT
Dietary Coordinator
Teri Brazill
Executive Assistant
Jackie Palmer
Project Coordinator
Jamie Damcott
Med Staff O
Provider Crede
Jamie Dam
Corporate
Christine

SAINT VINCENT HEALTH SYSTEM

Pursuant to the delegation of powers and authority granted to me by the Board of Directors of Saint Vincent Health System ("SVHS"), as President of SVHS, I hereby exercise the power of SVHS to vote the interests of SVHS to authorize Westfield Memorial Hospital (the "Hospital") to transition from a Prospective Payment System ("PPS") hospital to a Rural Emergency hospital ("REH") and to authorize the Hospital to obtain all required State and Federal approvals to effectuate the transition, such authorizations to be effective October 22, 2024.

SAINT VINCENT HEALTH SYSTEM

Chris Clark (Oct 23, 2024 10:44 EDT)

Christopher Clark, D.O.
President

Jacqueline M. Bauer
Jacqueline M. Bauer (Oct 23, 2024 15:40 EDT)

Reviewed by AHN Legal Counsel

Facility Type	Facility Name	Address	State/County	S
General Medical and Surgical	Saint Vincent Hospital	232 West 25th Street Erie, PA 16544	PA/Erie	Infant/Neontal Ut Comprehensive M Chemotherapy Clinical Laborator Hyperberic Chamb Neurology Neurosurgery Occupational Ther Physical Therapy Rehabilitation Obstetrics and Gy Neonatal Level III Pediatric Psychiatric >17 ye Medical Surgical Specialty Care-Car Special Care- Inter Special Care- Mixe Podiatry Diagnostic Visuali Electrophysiologic Therapeutic Proce Extracorporeal Sh Hemodialysis Radiology/Nuclear Surgical Services Emergency Depart
Endoscopy Center	Saint Vincent Endoscopy Center	2501 West 12th Street Ste. 8 Erie, PA 16505	PA/Erie	procedure Pre-Admin Recovery Bay Recliners

Cancer Institute	Saint Vincent Health Center DBA AHN Cancer Institute at Saint Vincent	2508 Myrtle Street Ste. 100 and 200 Erie, PA 16502	PA/Erie	Medical Oncology Office Side of Medi Laboratory Service Supportive Care (Palliative Care) Jus Pharmacy Interventional Radi Surgical Oncology Gynecological Onc Behavioral Health PET CT - Imaging Radiation Oncolog
Imaging Center	Saint Vincent Imaging Center	4247 West 26th Street Erie, PA 16506	PA/Erie	MRI CT Ultrasound Mammography DEXA X-ray rooms
Saint Vincent Outpatient Center	Saint Vincent Outpatient Center-Union City	130 North Main Street Union City, PA 16438	PA/Erie	Rehab Therapy Cardiac Testing Imaging/Dexa Scar Respiratory Functi
Surgery Center	Saint Vincent Surgery Center	312 West 12th Street Erie, PA 16502	PA/Erie	ORs Procedure Procedure-Pain Procedure- Laser

Schedule 5
Working Capital Plan

Contents:

Working Capital Financing Plan

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

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

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

N/A

2. Pro Forma Balance Sheet

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

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

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

Schedule applies to all projects with construction, including Articles 28 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

Instructions

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Projects over $15 Million, or Projects Requiring a Waiver (PDF)
  - Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY. (PDF) (Not to Be Submitted with Self-Certification Projects)
  - Architect's Letter of Certification for Completed Projects (PDF)
  - Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings (PDF)
- Provide FEMA BFE Certificate. Applies only to Hospitals and Nursing Homes.
  - FEMA Elevation Certificate and Instructions.pdf
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - Physicist's Letter of Certification (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews
  - DSG-1.0 Schematic Design & Design Development Submission Requirements
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: Click to enter a date.	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: The intent is do decertify 4 inpatient beds to apply for Rural Emergency Hospital designation through the Centers for Medicare and Medicaid Services	
Site Location: 189 East Main Street, Westfield, NY 14787	
Brief description of current facility, including facility type: Acute care hospital	

Brief description of proposed facility: N/A	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. No project and no physical changes to the existing facility	
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. No	Choose an item.
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. No proposed space or physical change to the facility	
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. Click here to enter text.	
Does the project comply with ADA? If no, list all areas of noncompliance. No project, but the facility is ADA compliant	
Other pertinent information: This is a project to decertify 4 acute inpatient beds. No project or physical change to the facility or other services	

Project Work Area	**Response**
Type of Work	Choose an item.
Square footages of existing areas, existing floor and or existing building.	Click here to enter text.
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	Click here to enter text.
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Choose an item.
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Choose an item.
Building Height	Click here to enter text.
Building Number of Stories	2
Which edition of FGI is being used for this project?	Choose an item.
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?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Choose an item.
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.	Decrease
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:

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		Schedule 10
Cost/Per Square Foot for Renovation Construction		Schedule10
Total Operating Cost		Schedule 13C, column B
Amount Financed (as $)		Schedule 9
Percentage Financed as % of Total Cost		Schedule 9
Depreciation Life (in years)		

2) Construction Dates

Anticipated Start Date		Schedule 8B
Anticipated Completion Date		

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

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

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

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

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

	A	B	C
Item	**Project Cost in Current Dollars**	**Escalation amount to Mid-point of Construction**	**Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$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 --> [ ]	$0	$0	$0
10 Total Project Cost with fees	$2,000	$0	$2,000

Schedule 9
Project Financing

Contents:

Schedule 9 Proposed Plan for Project Financing:

I. Summary of Proposed Financial plan

Check all that apply and fill in corresponding amounts.

	Type	Amount
☐	A. Lease	$
☐	B. Cash	$2000
☐	C. Mortgage, Notes, or Bonds	$
☐	D. Land	$
☐	E. Other	$
☐	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$

If refinancing is used, please complete area below.

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

II. Details

A. Leases

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

B. Cash

Type	Amount
Accumulated Funds	$
Sale of Existing Assets	$
Gifts (fundraising program)	$
Government Grants	$
Other	$2000
TOTAL CASH	$

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	Operating Budget
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.	☐	Audited Financial Reports
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	☒	
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).	☒	

	N/A	Title of Attachment
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	☐	Operating Budget
8. Current Department policy expects a minimum equity contribution of 10% of total project cost (Schedule 8b line 10)) for all Article 28 facilities with the exception of Residential Health Care Facilities that require 25% of total project cost (Schedule 8b, line 10). Public facilities require 0% equity.	☒	
9. Provide an equity analysis for member equity to be provided. Indicate if a member is providing a disproportionate share of equity. If disproportioned equity shares are provided by any member, check this box ☐	☒	

C. Mortgage, Notes, or Bonds

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

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

D. Land

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

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

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

E. Other

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

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

F. Refinancing

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

Schedule 9

Westfield Memorial Hospital Administrative Review CON#

Cash for payment of the New York State Certificate of Need application came from the administrative operational budget

The $2,000.00 application fee is the only cost associated with this project request.

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				

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:	☐	☐	☒

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
			11/19/2024
PRINT NAME			TITLE
Rodney Buchanan			Administrator
NAME OF FIRM			
Westfield Memorial Hospital			
STREET & NUMBER			
187 East Main Street			
CITY	STATE	ZIP	PHONE NUMBER
Westfield	NY	14787	

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				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
Sub project	Building	Floor	Functional Code					
				#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
PRINT NAME			TITLE
NAME OF FIRM			
STREET & NUMBER			
CITY	STATE	ZIP	PHONE NUMBER

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
110	Neonatal Intermediate Care
303	Occupational Therapy

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

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)
416	Pediatric O/P
478	Pharmaceutical Service O/P
455	Physical Therapy O/P
417	Podiatry O/P

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

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

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

Functional Codes	Service Description:

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

	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	Audiology
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)
	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.

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

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

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

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

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

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
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

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

	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

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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
					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
				Total estimated value of equipment being replaced: Subproject 1	
				Total estimated value of equipment being replaced: Subproject 2	
				Total estimated value of equipment being replaced: Subproject 3	
				Total estimated value of equipment being replaced: Subproject 4	
				Total estimated value of equipment being replaced: Subproject 5	
				Total estimated value of equipment being replaced: Subproject 6	
				Total estimated value of equipment being replaced: Subproject 7	
				Total estimated value of equipment being replaced: Subproject 8	
				Total estimated value of equipment being replaced: Whole Project:	0

Schedule 13
All Article 28 Facilities

Contents:

Schedule 13 A. Assurances from Article 28 Applicants

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

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

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

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

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

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

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

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

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

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

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

Date: 11/19/2024

Signature:

Rodney Buchanan
Name (Please Type)

Adminstrator
Title (Please type)

Schedule 13 B-1. Staffing

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

☐ Total Project or ☐ Subproject number

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

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

Describe how the number and mix of staff were determined:

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. Russell Elwell
License number of the Medical/Center Director	115079-01

	Not Applicable	Title of Attachment	Filename of attachment
Attach a copy of the Medical/Center Director's curriculum vitae	☐	Russell S. Elwell, MD - CV	RSE-CV.pdf

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	AHN Saint Vincent Hospital
○ Distance in miles from the proposed facility to the Hospital affiliate.	35
○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	45
○ Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.	N/A ☐ Attachment Name: Transfer Agreement - St. Vincent
Name of the **nearest** Hospital to the proposed facility	Brooks Memorial Hospital
○ Distance in miles from the proposed facility to the nearest hospital.	18
○ Distance in minutes of travel time from the proposed facility to the nearest hospital.	25

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.	13C-1 Assumptions	13C-1 Assumptions
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)	1/1/2023	1/1/2026	1/1/2028
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs			

Table 13C - 2

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

Table 13C - 3

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

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.	☐	Schedule 13D-2A & 13D-2B Assumptions	Schedule 13D-2A & 13D-2B Assumptions
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. Inpatient Services			
2. Outpatient Services			
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered			
5. Deductions from Revenue			
6. Net Patient Care Services Revenue			
7. Other Operating Revenue (Identify sources)			
8. Total Operating Revenue (Total 1-7)			
9. Non-Operating Revenue			
10. Total Project Revenue			

Table 13D – 2A
Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ or Patient Discharges ☐

Inpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
			Net Revenue			Net Revenue			Net Revenue	
		(A) Patient Days or dis-charges	**(B)** Dollars ($)	$ per Patient Day or dis-charge **(B)/(A)**	**(C)** Patient Days or dis-charges	**(D)** Dollars ($)	$ per Patient Day or dis-charge **(D)/(C)**	**(E)** Patient Days or dis-charges	**(F)** Dollars ($)	$ per Patient Days or dis-charges **(F)/(E)**
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										

Table 13D – 2B
Various outpatient services may be reimbursed as visits or procedures. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Visits (V) ☐ or Procedures (P) ☐

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

Total of Inpatient and Outpatient Services									

Schedule 16
CON Forms Specific to Hospitals Article 28

Contents:

Schedule 16 A. Hospital Program Information

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

Instructions: Briefly indicate how the facility intends to comply with state and federal regulations specific to the services requested, such as cardiac surgery, bone marrow transplants. For clinic services, please include the hours of service for each day of operation, name of the hospital providing back-up services (indicating the travel time and distance from the clinic) and how the facility intends to provide quality oversight including credentialing, utilization and quality assurance monitoring.

See Attached

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

List of Proposed Ambulatory Surgery Category

For Hospital-Based -Ambulatory Surgery Projects:
Please provide the following information:

Number and Type of Operating Rooms:

- Current:
- To be added:
- Total ORs upon Completion of the Project:

Number and Type of Procedure Rooms:

- Current:
- To be added:
- Total Procedure Rooms upon Completion of the Project:

Schedule 16 B. Community Need

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

Public Need Summary:
Briefly summarize on this schedule why the project is needed. Use additional paper, as necessary. If the following items have been addressed in the project narrative, please cite the relevant section and pages.

1. Identify the relevant service area (e.g., Minor Civil Division(s), Census Tract(s), street boundaries, Zip Code(s), Health Professional Shortage Area (HPSA) etc.)

See Attached

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

See Attached

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.

See Attached

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

See Attached

(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.

See Attached

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

See Attached

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.

See Attached

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.

See Attached

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

See Attached

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

See Attached

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

See Attached

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:
189 East Main Street, Westfield, NY 14787
(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	4	☐	☒	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			☐	☐	

*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)*

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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 th is 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

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

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

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

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

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

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

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

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

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

Schedule 16 D. Hospital Outpatient Department - Utilization projections

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

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

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

Schedule 16 E. Utilization/discharge and patient days

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

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

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

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

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

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

Schedule 16 E. Utilization/Discharge and Patient Days

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

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

Schedule 16 F. Facility Access

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

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

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

Westfield Memorial Hospital Certificate of Need
Schedule 16 Attachments

16A

- Schedule 16A Hospital Program Information

16B

- Schedule 16B Community Need

16D

- Schedule 16D Hospital Outpatient

16E

- Schedule 16E Utilization/Discharge and Patient Days

Financial Assistance Policy

16 A Hospital Program Information

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.*

Westfield Memorial Hospital ("WMH") follows Federal and State regulations required to operate as a general acute care hospital. WMH meets the Federal requirements set forth in the Medicare Conditions of Participation (CoP), 42 CFR Part 482, to receive Medicare/Medicaid payment. In addition. WMH meets the minimum standards as required by Title 10 of the New York Codes of Rules and Regulations section 405, Article 28, and Section 3401 of the Public Health Law. All personnel at WMH who require a license by the State have a current license. Continued compliance with Federal and State regulations for operation as an acute care hospital is a priority for WMH.

Westfield Memorial Hospital will continue to operate a part-time extension clinic at the Chautauqua Institution. The hours of operation are Monday-Friday 0800 to

1630 from June through August.

Westfield Memorial Hospital has a longstanding relationship and transfer agreement in place with AHN Saint Vincent Hospital in Erie, PA. AHN Saint Vincent Hospital is 35 miles and a 45 minute travel time from Westfield Memorial Hospital.

WMH has an established quality infrastructure that supports the organization's quality and patient safety programs. WMH tracks and monitors key quality and patient safety metrics such as infection and fall rates and patient satisfaction for quality assurance and as a CMS CoP requirement WMH has a Quality Assurance Performance Improvement (QAPI) program in place. WMH ' s commitment to the delivery of safe and quality care is supported by a team of competent clinical staff.

Schedule 16 B Community Need (1-6)

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 communities that Westfield Memorial Hospital serves are Westfield (14787), Ripley (14775), Brocton (14716), Sherman (14781), Clymer (14724), Bemus Point (14712), Mayville (14757), Chautauqua (14722), Stockton (14784), Portland (14769), Dewittville (14728), and Ashville (14710).

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

Like most rural populations WMH' s PSA is expected to decrease in size from a current population of 14,405 in 2021 to 14,140 by 2026 representing a-1.8% decline (265 people). However, the 65+ age cohort is projected to grow by 8.5% (271 people) by 2026 Additionally, individuals who are 65+ comprise 22% of the current PSA population which is above the national average of 17% in 2020.. Due to growth in WMH's PSA older population over the next five years there will likely be greater reliance on healthcare services and a greater incidence of chronic illnesses.

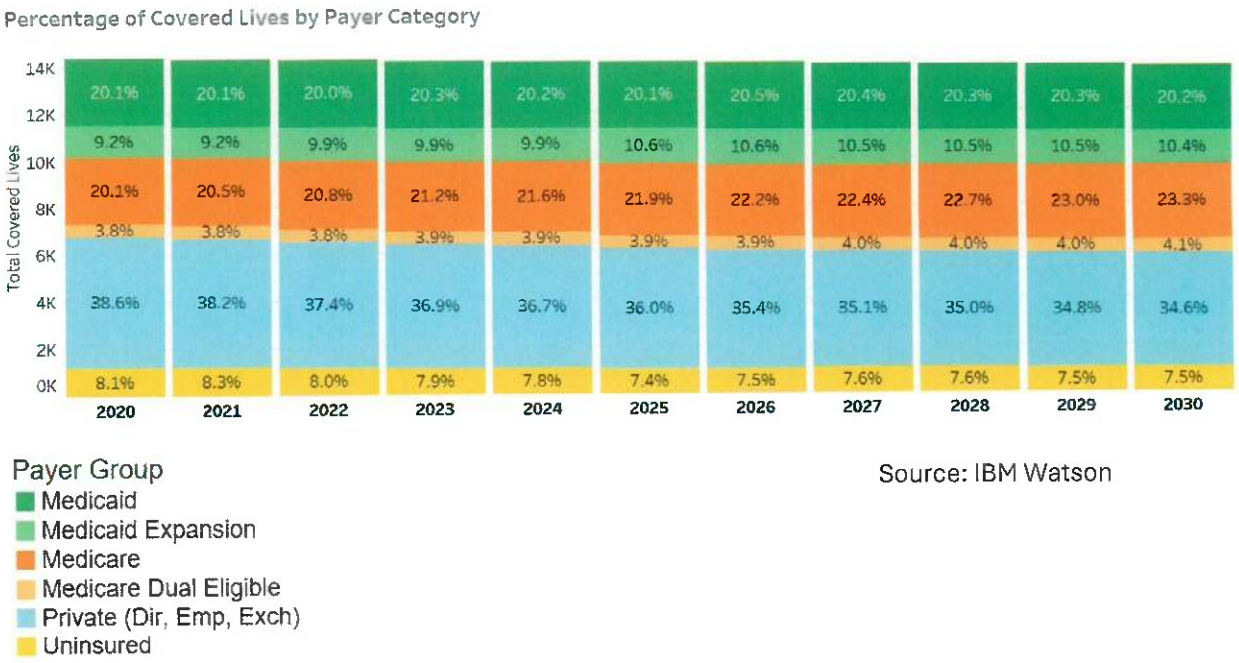
Primary Service Area

Age Group	Current	5-Year	# Chg	% Chg
<18	2,800	2,712	(88)	-3.1%
18-44	4,531	4,530	(1)	0.0%
45-64	3,895	3,448	(447)	-11.5%
65+	3,179	3,450	271	8.5%
Total	**14,405**	**14,140**	**(265)**	**-1.8%**

Total Service Area

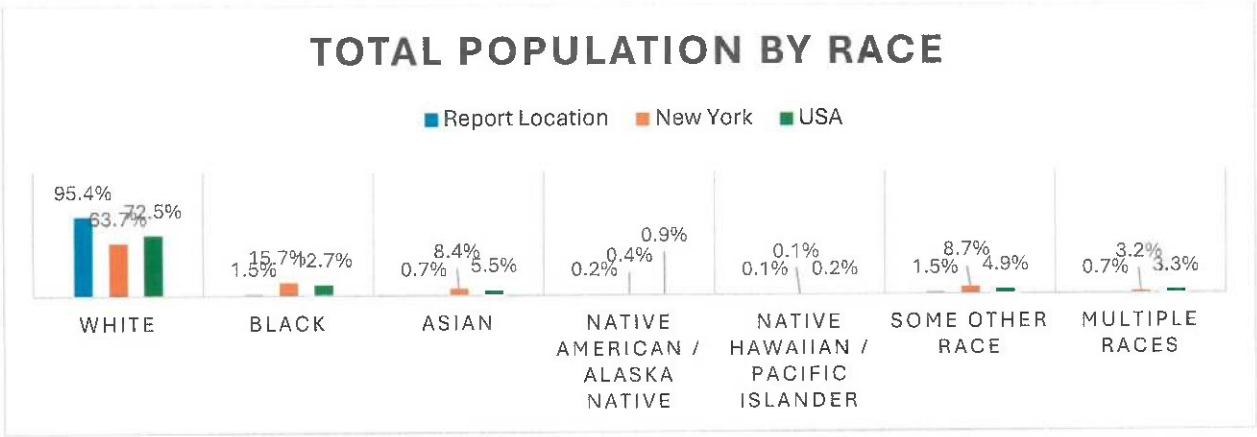
Age Group	Current	5-Year	# Chg	% Chg
<18	6,127	5,920	(207)	-3.4%
18-44	8,977	9,005	28	0.3%
45-64	8,271	7,352	(919)	-11.1%
65+	6,475	7,058	583	9.0%
Total	**29,850**	**29,335**	**(515)**	**-1.7%**

Due to its aging population WMH has a growing Medicare and Medicaid dual eligible population. Currently, 54.5% of the payor mix is Medicare or Medicaid patients with 37.4% private payor. By 2030 58% of the payor mix will be Medicaid or Medicare patients, with only 34.6% private payers. This equates to the largest compound annual growth rate of any payor group over the next ten years at 1.4%

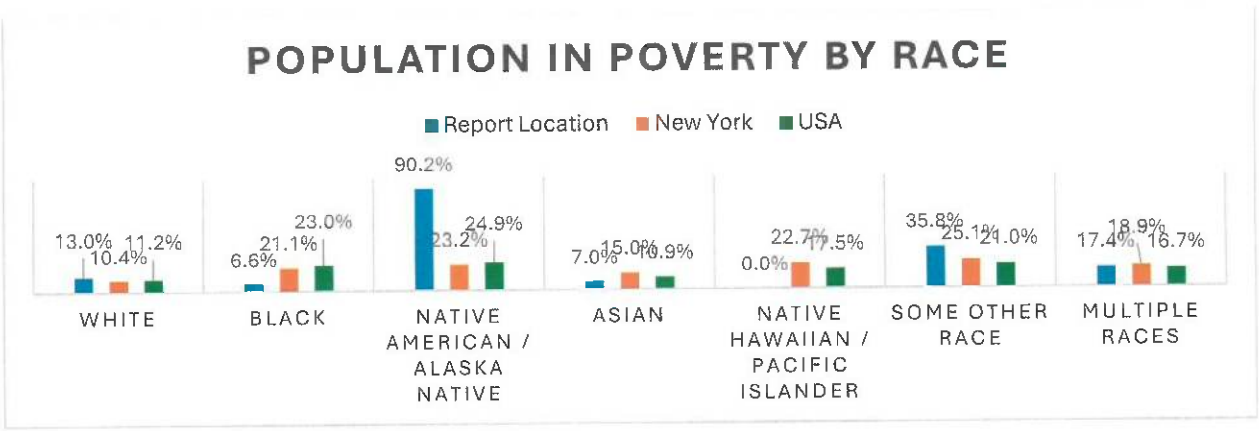


Source: IBM Watson

WMH serves a largely white, low-income population. 95.4% of WMH's population is white compared to 55.6% of the state, and 60.7% of the nationalpopulation. 35% of WMH' s population is below 200% of the federal poverty level which is greater than both New York state (29.72%) and national averages (30.86%). Of the 95.4% (28,476 individuals) of the population in the WMH service area that are white, 13% or 3,702 individuals are living in poverty.



Source: SparkMap product of CARES University of Missouri Extension



Source: SparkMap product of CARES University of Missouri Extension

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 DOHneed methodology, demonstrate how the proposed service is consistent with it.*

Westfield Memorial Hospital has seen an 7.0% increase in outpatient cases since 2021. The highest growth areas were in the number of Emergency Room patients, Physical Therapy patients and Heart & Vascular tests. The growth in these specific outpatient services can be attributed to the demographic changes related to the shift to an older population with in the WMH primary service area. The demographic shift to an overall older population is expected to continue over the next five years. This continued demographic shift is projected to result in continued growth in Emergency Room utilization along with other outpatient services such as Imaging, Physical Therapy and Diagnostic Testing.

	2021	2022	2023	2021 to 2023
ER Treated and Released	7,564	8,486	9,110	17.0%
Imaging	7,244	7,441	7,590	4.6%
Lab	2,093	1,923	1,944	-7.7%
Physical Therapy	1,508	1,953	1,872	19.4%
Heart & Vacular Testing	1,020	1,059	1,159	12.0%
All Other OP Services	3,079	3,217	2,523	-22.0%
Total Outpatients	**22,508**	**24,079**	**24,198**	7.0%

The transition to a Rural Emergency Hospital will align resources to the meet the demand for outpatient services in the WMH service area.

Westfield Memorial Hospital will continue to make investments in staffing, technology, equipment and facilities to support the health care programs and

services required for the population.

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

Having the CMS designation as a Rural Emergency Hospital will allow Westfield Memorial Hospital to continue to serve the community as a vital access point for healthcare services.

Health Care Safety Net

According to the 2022-2024 Chautauqua County Community Health Assessment, "The safety net in Chautauqua County consists of three emergency departments – Alleghany Health Network-affiliated Westfield Memorial Hospital, Brooks-TLC Hospital System, Inc. and UPMC Chautauqua, and four NYSDOH Article 28 clinics, which includes one Federally Qualified Health Center (FQHC). During the 2019- health assessment, local emergency departments indicated that about half of departmental visits were for minor acute illnesses and ambulatory care sensitive conditions. Recent (2022) anecdotal report from local emergency rooms indicate that there has been a shift in the patient population. While no specific data points were available, personnel indicate that they have seen a greater proportion of higher acuity cases and a decrease in minor acute illnesses and ambulatory acute sensitive conditions over the last three years."

Providing access to emergency care to the WHM service area is critical to the Chautauqua County health care safety net.

Access to Care

According to the 2022-2024 Chautauqua County Community Health Assessment "There are a limited number of physicians and a high volume of individuals needing care, physicians are selective in terms of whom they continue to treat. There are very few primary care, medical specialty care, or dental providers in the County who are willing to serve low-income, Medicaid insured or uninsured adult patients in significant numbers on a routine basis."

The health care services provided by Westfield Memorial Hospital are available to all patients regardless of their ability to pay.

4.(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.

WMH is subject to AHN's Financial Assistant Policy (the "Policy") which states that AHN "will provide, without discrimination, care for emergency medical conditions to individuals regardless of their ability to pay.

This Policy applies to all emergency and other medically necessary care provided by AHN hospitals, including care provided in those hospitals by any substantially related entity (as defined by the Internal Revenue Service)".

Financial Policy attached

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

The healthcare services provided by Westfield Memorial Hospital are located at 189 East Main Street, Westfield, NY

Emergency services are available 24 hours a day seven days a week. Westfield Memorial Hospital coordinates the transportation of emergency patients requiring transfer to a higher level of care with local EMS ground and air transport services.

Outpatient services and programs are available weekdays. Some services are available on a walk-in basis and all services are available via appointments through central scheduling.

Telemedicine services that connect patients to specialty care visits are also provided at the hospital.

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.*

As a rural emergency hospital, Westfield Memorial Hospital will be able to continue to provide program and services to address the community health needs.

Examples of identified community health needs being addressed through the WMH community health needs implementation plan include substance abuse disorders, chronic diseases and health equity needs.

Substance Abuse Disorders

Westfield Memorial Hospital partners with the Chautauqua County Health Department on a Medication Assisted Therapy program. The goal of this program is to establish a protocol to treat eligible overdose patients with Medication Assisted Therapy (MAT). The desired impact of this program is to increase awareness of treatment for overdose complications; and increase services for overdose cases.

Strategy - Begin medicating patients that meet criteria with first dose of Buprenorphine and transition to Medication Assisted Treatment (MAT) for detox.

Action Steps - Screen overdose patients in the emergency department for MAT criteria.

Measures - Number of patients that participate in MAT program.

Period	# of Patients Participating
Jan-Dec 2023	3
Jan-Dec 2024	6

Chronic Disease – Cancer

Westfield Memorial Hospital partners with the local primary care physician offices on a low dose CT lung cancer screening program. The goal of this program is to increase the number of adults who receive age-appropriate screenings. The desired impact of this program is to increase the number of lung screenings and increase the number of early lung cancer detections.

Action Steps – Provide low dose CT lung screenings for eligible patients.

Measures - Number of patients receiving CT lung screenings.

Period	# of Screenings	# of Significant Findings	# of Cancer Findings
Jan-Dec 2022	208	0	0
Jan-Dec 2023	314	30	1
Jan-Jun 2024	149	16	1

Chronic Disease – Diabetes

Westfield Memorial Hospital works with community organizations to provide free health screenings to community members. The goal is to improve quality outcomes associated with diabetes The desired impact is to promote diabetes prevention in the community.

Action Steps - Host screening and education events.

Measures – Number of community events

Period	# Events	# of Screenings
Sep-Dec 2022	1	20
Jan-Dec 2023	5	71
Jan-Sep 2024	5	44

Health Equity

Westfield Memorial Hospital has several Amish communities in it service area. WMH partners with the Chautauqua County Health Department in providing preventative health screenings to the Amish communities. The goal of the program is to improve the preventative care in the Amish communities.

Action Steps – Host community health screening events in Amish communities

Measures – Number of health screenings

Period	# Events	# of Screenings
Jan-Dec 2023	4	84
Jan-Sep 2024	5	150

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

The Community Health Need Assessment has identified a need for chronic disease management and access to behavioral health services. As part of the Community Health Needs Implementation plan, Westfield Memorial Hospital partners with the Chautauqua County Health Department and Chautauqua County Mental Hygiene (CCMH) on the following community health initiatives:

- Preventative health screening clinics for area Amish communities
- Coordinating the care for patients presenting to the emergency room in crisis to the mobile crisis service program
- Screen overdose patients in the emergency department for Medication Assisted Treatment (MAT) for detox.

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

The 2022 Chautauqua County Community Health Assessment has identified the need for prevention of chronic diseases, promoting well-being, prevention of mental health and substance abuse disorders, and care for women, infants and children.

Westfield Memorial Hospital has implemented programs or provider collaborations to address post-partum depression, care coordination for patients in mental health crisis, lung cancer screenings, diabetes screening programs and preventative health clinics.

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

WMH is actively involved in the not only the WMH Community Health Needs Assessment, but also the Chautauqua County Community Health Assessment. WMH utilizes this communication channel to aid in addressing the local public health priorities.

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

WMH uses a variety of data sources to track progress including but not limited to:

- The Healthcare Association of New York State ("HANYS"),
- Centers for Medicare and Medicaid Services
- Centers for Disease Control and Prevention
- National Vital Statistics
- New York State Department of Health
- U.S Department of Health and Human Services
- U.S Department of Labor

Many of these sources were included in the Community Health Needs Assessment published by WMH and its partner Allegheny Health Network ("AHN") in April of2022.

Through its partnership with AHN, WMH has consistent access to a broader network of data sources and the ability to process data efficiently.

Allegheny Health Network

Westfield Memorial Hospital

Financial Assistance Policy

Westfield Memorial Hospital follows the policies developed by the Allegheny Health Network regarding patient financial assistance, including charity care. Allegheny Health Network promises to provide medically necessary services to patients no matter how much they can pay. To fulfill our promise, we work with patients to help them meet their financial obligations for services we provide. Allegheny Health Network may be able to offer financial assistance to patients who qualify under the financial assistance policy outlined on the following pages.

Specific to Westfield Memorial Hospital, if a patient reaches out directly to Westfield expressing inability or difficulty paying their bills, staff provide a Financial Assistance application to the patient and provide the toll free telephone number dedicated to the Financial Advocates (855) 493-2500 open Monday – Friday from 830am – 430 pm. The person assisting the patient also forwards the patient information to a dedicated email address sent to all Financial Advocates who can then reach out directly to the patient.

Included below is the Allegheny Health Network statement on financial assistance, the financial assistance policy, and the application for financial assistance, all available to the public on our website www.ahn.org.

Allegheny
Health Network

Financial Assistance with AHN Bills

Allegheny Health Network (AHN) promises to provide medically necessary services to patients not matter how much they can pay. To fulfill our promise, we work with patients to help them meet their financial obligations for the services we provide.

Who may qualify for financial assistance with their AHN bills?

Allegheny Health Network may be able to offer financial assistance with their AHN bills to patients:

- With no or limited medical insurance
- Who are not eligible for Medicare or Medicaid
- Who are United States citizens or lawful permanent resident of the United States of America
- Who live in the AHN's primary service area
- Who document financial need

How do I find out if I qualify for financial assistance?

Each patient must apply for financial assistance with A HN bills. To apply:

- Download and print the Allegheny Health Network Financial Assistance Application (form and instructions) from the following website, https://www.ahn.org/financial-assistance-ahn-bills.
- Complete the form and submit it with required proofs of income.
- If you cannot download or print the form, need assistance filling out your application, or need help with the financial assistance process for the following hospitals, Allegheny General Hospital, Allegheny Valley Hospital, Canonsburg Hospital, Forbes Hospital, Grove City Medical Center, Jefferson Hospital, Saint Vincent Hospital, Westfield Memorial Hospital, West Penn Hospital, Wexford Hospital, AHN Harmar Neighborhood Hospital, AHN McCandless Neighborhood Hospital, AHN Brentwood Neighborhood Hospital or AHN Hempfield Neighborhood Hospital please call the Financial Advocacy department at 1-855-493-2500 or visit the admissions office at the AHN hospital where your received services.
- Mail in a request for a free copy of the Allegheny Health Network Financial Assistance Policy and Application to the address listed below:

  Financial Advocacy Department
  4 Allegheny Center, 4th Floor
  Pittsburgh, Pa 15205
  or email us at FinancialAdvocates@AHN.org

AHN reviews each Financial Assistance Application promptly. AHN will send a letter to the patient if more information is needed.

Allegheny Health Network will notify the patient, or the patient's guarantor, or representative of the decision, in writing.

Allegheny Health Network Financial Assistance Policy

The hospitals and physicians of the Allegheny Health Network (AHN) are committed to improving the health of our patients and the communities we serve. It is our policy to offer, without discrimination, medical care to all patients, including those who may have difficulty paying for services due to limited income. AHN limits the amounts charged for emergency or other medically necessary care provided to individuals eligible for financial assistance. These individuals are not to be charged more than the amounts generally billed (AGB) to individuals covered by insurance. To address community need, AHN offers a Financial Assistance program.

AHN's financial assistance program is described fully in the Allegheny Health Network Financial Assistance and Collection Policy that became effective Jan 1, 2018. This policy applies to AHN providers and controlled affiliates, including employed physicians. Here is a summary of the policy, which defines:

- Who is eligible, based on income guidelines, for financial assistance from AHN
- What AHN services are included and excluded under the policy
- How a patient applies for financial assistance from AHN

Who is eligible for financial assistance?

It is AHN's policy to provide financial assistance to patients:

- Who have no or limited medical insurance
- Who are not eligible for Medicare or Medicaid
- Who are United States citizens or lawful permanent resident of the United States of America
- Who live in AHN's primary service area
- Who document financial need

What are the income guidelines for financial assistance?

The income guidelines for financial assistance are between 100% and 200% of the latest federal poverty guidelines.

2021 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia

	Income Range	
Household Size	*100%*	*200%*
1	$12,760.00	$25,520.00
2	$17,240.00	$34,480.00
3	$21,720.00	$43,440.00
4	$26,200.00	$52,400.00
5	$30,680.00	$61,360.00
6	$35,160.00	$70,320.00
7	$39,640.00	$79,280.00
8	$44,120.00	$88,240.00

**Based on two times the current poverty guidelines. For families/household with more than 8 persons, add $4,540 for each additional person.*

For Westfield Memorial Hospital, eligible income range goes up to 300% of the Federal Poverty Guidelines. Please refer to Appendix E of the Financial Assistance Policy for the complete table ranges.

What services are eligible for financial assistance?

Financial Assistance is available to eligible patients for these services:

- Emergency medical services
- Medically necessary (not elective) services for urgent life-threatening conditions provided outside the Emergency Department
- Other medically necessary services as determined on a case-by-case basis

Financial assistance is not available from AHN for services such as:

- Services deemed "no covered" by Medicare
- Services deemed not medically necessary, including but to limited to the following:
  - Cosmetic services
  - Elective services related to reproduction, such as in vitro fertilization or vasectomy/vasectomy reversal
  - Transplant surgery and related services
  - Bariatric (weight loss) surgery and related services
  - Complementary/alternative medicine services such as acupuncture
  - Routine eye examinations
  - Contact lenses, hearing aids, cochlear implants
  - Deep-brain stimulation
  - LDL apheresis
  - Services covered by non-AHN programs or grants such as the Ryan White program for HIV/AIDS care

How do I apply for financial assistance with AHN bills?

To apply for financial assistance with AHN bills, the patient or representative must complete and submit the Allegheny Health Network Financial Assistance Application and the required proofs of income. The application and proofs of income must be received by AHN within 240 days of the date the patient received medical services from AHN.

Provided on the website, https://www.ahn.org/financial-assistance-ahn-bills, the financial assistance policy, plain language summary, and application are translated into the following languages:

- German
- Italian
- Polish
- Russian
- Ukrainian
- Chinese
- Japanese
- Korean
- Maithili
- Urdu
- Uzbek
- Vietnamese
- Spanish
- Portuguese
- French
- Turkish
- Filipino
- Persian
- Hindi

AHN Patient Financial Services

If you have questions, need assistance filling out your application, need a paper copy, or want more information about your Allegheny Health Network bill or our Financial Assistance program, please see the contact information below or go to the hospital registration area:

Customer Care Center: 1-844-801-8400

Financial Advocacy: 1-855-493-2500 or email at FinancialAdvocates@AHN.org

Allegheny Health Network

PURPOSE

The purpose of this policy is to provide patients with information on the Allegheny Health Network (AHN) Financial Assistance Policy (the "Policy"). The Policy outlines the process for determining a patient's eligibility for financial assistance related to their medical bill at AHN, the types of financial assistance available to qualified patients, and the services that are included and excluded under this Policy, as well as the billing and collection policy that relate to patients who are eligible for financial assistance. In addition, the Policy also outlines certain elements of the patient billing and collection process that are relevant to patients who seek and receive assistance under this Policy.

SCOPE

The mission at AHN includes offering individuals in the community access to medical care, including those who may have difficulty paying for services due to limited financial resources and income. AHN will provide, without discrimination, care for emergency medical conditions to individuals regardless of their ability to pay. This Policy applies to all emergency and other medically necessary care provided by AHN hospitals, including care provided in those hospitals by any substantially-related entity (as defined by the Internal Revenue Service).

The AHN hospitals that are subject to this policy are Allegheny General Hospital, Allegheny Valley Hospital, Canonsburg Hospital, Forbes Hospital, Grove City, Jefferson Hospital, Saint Vincent Hospital, West Penn Hospital, Westfield Memorial Hospital, Wexford Hospital, AHN Harmar Neighborhood Hospital, AHN McCandless Neighborhood Hospital, AHN Brentwood Neighborhood Hospital, and AHN Hempfield Neighborhood Hospital. See Appendix C for a complete list of providers for whom this Policy applies and for whom this Policy does not apply. Additional and separate requirements for the Westfield, New York, service area are set forth in Appendix E.

This Policy is subject to periodic review and may be revised at any time as business needs require. This Policy has been adopted by the AHN Board of Directors and the applicable AHN hospital Board of Directors and such Boards must approve any material changes to this Policy; provided, however, the Boards of AHN and the AHN hospitals have authorized the Chief Financial Officer of AHN to make any changes to the Policy that are required for the Policy to be compliant with applicable law and any other non-material changes he/she determines to be necessary or desirable.

DEFINITIONS

Amounts Generally Billed (AGB): AGB is defined as the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care determined in accordance with section 1.501(r)-5(b).

Consistent with the requirements of the Internal Revenue Code Section 501(r), AHN uses the "Look-Back" method to determine AGB for emergency or other medically necessary care, as per 26 C.F.R. Parts 1, 53, and 602. The AGB is calculated by dividing the sum of the amounts of all of AHN's claims for emergency and other medically necessary care that have been allowed by private insurers, Medicare fee-for-services, and Medicaid during a prior 12-month period by the sum of the associated gross charges for those claims. Refer to Appendix D for hospital AGB calculations.

Based on guidelines of the Internal Revenue Code Section 501(r), AHN limits the amounts charged for emergency or other medically necessary care provided to individuals eligible for Financial Assistance. Following a determination of eligibility for Financial Assistance, these individuals are not to be charged more than the AGB.

The public may readily obtain information regarding the AGB and the manner in which it is calculated in writing and free of charge by visiting the following website [https://www.ahn.org/financial-assistance-ahn-bills] or submitting a request, in writing, to the following address:

Charity Care Policy
Director Financial Advocacy
Allegheny Health Network
10th Floor, 4 Allegheny Center
Pittsburgh, PA 15212

Certain Assets Excluded from Financial Assistance Consideration: Retirement funds segregated in pension funds, 401(k) or other similar retirement investment accounts, primary residence, and primary vehicle will not be included as part of the calculations to determine eligibility for Financial Assistance.

Emergency Medical Condition: Defined within section 1867 of the Social Security Act (42 U.S.C. 1395dd). An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of an individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunctions of any bodily organ or part.

Extraordinary Collection Actions (ECAs): Defined to include the following under the Internal Revenue Code Section 501(r):

- Selling debt to another party, except under certain exceptions

- Reporting adverse information to consumer credit reporting agencies or credit bureaus
- Taking actions that require a legal or judicial process, including but not limited to the following:
    - Placing a lien on property (with certain exceptions)
    - Foreclosing on real property
    - Attaching or seizing a bank account or any other personal property
    - Commencing a civil action
    - Causing an individual's arrest
    - Subjecting an individual to a writ of body attachment
    - Wage garnishments

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of Financial Assistance under this Policy.

Federal Poverty Guidelines: Federal Poverty Guidelines are those guidelines which are updated annually in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Financial Assistance: Full or partial adjustment of charges for services provided to patients by AHN hospitals, employed physicians, and non-employed physicians and other affiliated organizations that are listed in Appendix C, determined by program eligibility, which is based on AHN qualification criteria.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill or debt if the patient fails or is unable to pay the bill or debt.

Gross Charges: AHN's fully established rates and total charges for the provision of patient care services before contractual allowances (including negotiated discounts), other deductions from revenue, and payments are applied.

Income: Family income shall include salaries, wages unemployment compensation, child support, any medical support obligations, alimony, social security income, disability payments, pension or retirement income, rents, royalties, income from estates and trusts, legal judgments, dividends, and interest earnings as well as any other form of taxable income unless specifically excluded as noted herein. Certain items shall be excluded from consideration in the testing done pursuant to this Policy including equity in a primary residence, retirement plan accounts, and irrevocable trusts for burial purposes, and federal or state administered college savings plans. For patients under 18 years of age, family income includes that of the parents and/or step-parents, unmarried or domestic partners (who may or may not live with the minor).

Annual Income, for purposes of this Policy, is a determination of Income on an annual basis using Income information provided by the patient. Generally, Annual Income shall be derived by reviewing the latest official tabulation of such amounts through review of tax returns, W-2's, pay stubs and/or other

relevant supporting documents and information provided to AHN during the application process. If applicable, AHN may apply a reasonable methodology to that income information in order to derive an estimate of Annual Income when income information is not available for a recent full year or when recent changes in a patient's income warrant review.

Recent circumstances such as a job loss, job attainment, job change, etc. along with the application of reasonable judgment by AHN, may, at AHN's sole discretion, be taken into account when calculating Annual Income and determining eligibility for Financial Assistance under this Policy.

Liquid Assets: Liquid assets include cash, checking, savings and money market accounts, certificates of deposit, mutual funds, bonds and other similar financial instruments held by the patient or guarantor. Liquid assets in excess of amounts shown in Appendix F must be applied to any bill or indebtedness owed to AHN prior to consideration for Financial Assistance.

Medical Hardship: For purposes of this Policy, an individual whose patient responsible balances, after exhaustion of all liquid assets, insurance and other third party benefits, meets or exceeds 25% of the individual's Annual Income shall be deemed to have suffered a Medical Hardship.

Medically Necessary: Defined by the Centers for Medicare and Medicaid Services as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

CRITERIA FOR QUALIFYING (AND PROCESS FOR OBTAINING) FINANCIAL ASSISTANCE

1. **Overview of the Process**

Patients who seek Financial Assistance will engage in a series of important steps that are generally categorized below.

A. Patient Obtains an Understanding of the Criteria for Qualification and the Level of Financial Assistance Available Under the Policy
B. Patient Completes the Application Process
C. AHN Completes the Financial Assistance Determination
D. If Approved, Financial Assistance is Applied to the Patient Account

2. **Criteria for Qualification and Financial Assistance Available**

Residence: A patient must be a citizen of the United States of America or a lawful permanent resident of the United States of America, and a resident of the Commonwealth of Pennsylvania, or New York State for Westfield Memorial Hospital. International patients or unauthorized immigrants may qualify for Financial Assistance if they are eligible for Medicaid. There may be special circumstances for out-of-state and international patients (e.g., auto accident, emergent illness) under which, at AHN's sole discretion, such individuals could be considered for qualification for Financial Assistance under the Policy.

Patient Requirement to Pursue Other Available Funding Sources First: The patient must be able to demonstrate a good faith effort in having applied for, and complied with, available and affordable healthcare benefit alternatives (e.g., Medicaid eligibility and other Affordable Care Act subsidized healthcare benefit programs), or provide evidence/proof that the patient would fail to meet the eligibility requirements for coverage of Medicaid or other programs.

- Refusal to Seek Other Funding Sources: Financial Assistance will not be available to patients who refuse to use insurance options available to them and to patients who have not exhausted all sources of insurance payment (e.g., Medicare lifetime reserve days).

Types of Services that are Covered Under Financial Assistance: Financial Assistance will only apply to emergency and other medically necessary services. Certain services not covered by Financial Assistance under this Policy are outlined in Appendix A. Financial Assistance will not be available for obligations incurred when a patient refuses discharge and incurs additional charges that are considered medically unnecessary. Regarding pharmaceutical costs, Financial Assistance discounts apply only to drugs administered by AHN during an inpatient stay or outpatient service. These discounts do not apply to any other drugs or mail order prescriptions. Financial Assistance does not apply to services that are covered by an insurance carrier that has denied services due to litigation, lack of cooperation from the patient, or receipt of (or reliance on) erroneous information provided by the patient.

Financial Requirement Threshold Criteria and Calculation: There are three principal financial criteria that are applied as follows in order to determine whether a patient has economic means to pay and whether that patient meets eligibility for Financial Assistance under this Policy, assuming other criteria in the Policy (such as residency) are also met.

1. First, a patient's liquid assets are determined (see earlier definition of liquid assets). If liquid assets exceed the calculated threshold level indicated in Appendix F, then all liquid assets above the threshold level must first be used to satisfy any outstanding balance owed to AHN by a patient.

2. Once step one has been completed, if the patient still owes a balance, then the patient will be evaluated on an income basis. If the patient and/or guarantor's household income is at or below 200% of the Federal Poverty Level (FPL) Guidelines, then 100% of the balance for which the patient is still responsible and for which Financial Assistance is available under this Policy, will be forgiven by AHN. No Financial Assistance is available for a patient or a guarantor whose Annual Income is greater than 200% of the FPL unless they qualify under Medical Hardship as described below. See Appendix B for current guidelines and FPL table.

3. As an alternative to step 2, a patient may demonstrate Medical Hardship. Patients that meet Medical Hardship criteria qualify for the same Financial Assistance benefit as individuals whose income is at or below 200% of the FPL Guidelines.

Generally AHN does not provide Financial Assistance to patients whose income exceeds 200% of the FPL unless they meet the criteria for Medical Hardship.

AHN does not use any previous Financial Assistance eligibility determinations to presumptively approve a patient for Financial Assistance. When a patient's Financial Assistance has terminated, the patient must reapply for Financial Assistance. Generally, once qualified, an individual qualifies and remains eligible for Financial Assistance for a six month period before requiring re-qualification for Financial Assistance under the Policy. In addition, a Financial Assistance application filed and approved at any AHN hospital shall apply to all AHN hospitals with the exception of Westfield Memorial Hospital.

3. **Application Process**

Patients generally must complete the AHN Financial Assistance application form in order to be considered under the Policy.

Patients must submit one or more of the forms of supporting documentation listed below as proof of income and/or assets:

- Federal Income Tax form 1040 or other Federal Form(s) used to report taxes for the previous year (with explanation of any significant income changes)
- Pay stub copies (for the past 30 days)
- Written verification of any other income received (e.g., alimony, child support, disability compensation, pensions, rental income, self-employment income verification (profit and loss statement for the last month), social security, unemployment compensation, VA benefits, workmen's compensation may be requested as part of the application process)
- Bank statements from the most recent month prior to Financial Assistance application date
- Bankruptcy notices that result in dates of service being considered in the bankruptcy process
- Formal affidavit that supports patient's/guarantor's income/asset information that would qualify him/her for Financial Assistance
- If applicable and available, proof of residence at a homeless shelter or homelessness indication

Applications must be received within 240 days from the date that AHN first sent a post-discharge billing statement to the patient (the "application period"). Failure by the patient to submit a complete application or failure to return the application including all required supporting documentation within such application period may result in a denial of Financial Assistance.

- The notification period is the period during which AHN must notify an individual about this Policy. This period begins on the date care is provided to the individual and ends on the 120th day after AHN provides the individual with the first post-discharge billing statement. If the patient has failed to submit an application for Financial Assistance by the end of the

notification period, AHN may engage in Extraordinary Collection Actions (ECAs) for purposes of collecting on the patient account

- AHN will accept and process applications submitted by an individual during the longer application period that ends on the 240th day after AHN provides the patient with the first post-discharge billing statement
- Any applications requiring additional information will result in a letter being mailed to the patient requesting the additional information. Also, a phone call may be made to the applicant to notify them of the additional information that is needed. If all information necessary to qualify a patient is not received within the 240 day application period, the application for Financial Assistance may be denied by AHN
- Complete Financial Assistance applications with complete accompanying documentation are to be submitted to the following address. The Financial Advocacy Department can provide information regarding this Policy and is responsible for working with patients to determine their eligibility for Financial Assistance

AHN Revenue Cycle Operations
Financial Advocacy
4 Allegheny Center, 10th Floor
Pittsburgh, Pa 15212

Patients requiring information about this Policy or assistance related to the completion of an application should contact the AHN Financial Advocacy Department at 1-855-493-2500.

4. **Financial Assistance Determination**

Once a patient is approved, Financial Assistance is granted for a period of six months beginning on the date of approval. AHN will apply Financial Assistance adjustments to prior accounts that are within 240 days from the first post-discharge patient billing statement that triggered the Financial Assistance application. However, AHN reserves the right to limit retroactive application of Financial Assistance for time frames in excess of what is generally required under 501(r). Generally, this limitation would only apply when extraordinary differences exist between the patient's current financial condition and their financial condition in the six month period prior to approval and when such differences are also accompanied by a clear indication that sufficient funds or income were available in the prior period to pay outstanding medical bills.

Financial Assistance discounts apply to patient responsible amounts only; no amounts due from insurance carriers will be included. A determination of whether an individual is eligible for Financial Assistance may include a number of different circumstances, including the following:

- The patient does not have Medical Assistance or adequate insurance coverage
- The patient has exhausted insurance benefits
- Primary insurance has rendered payment but a secondary liability exists
- The patient is considered indigent due to medical hardship
- A deceased patient's estate will exhaust (be depleted) based on the amounts owed

- The patient has provided a formal bankruptcy judgment that impacts the obligation of a patient to pay for the services provided on the dates in question
- The patient is homeless or has proven residence in a homeless shelter

AHN shall promptly process all requests for Financial Assistance and send a notification of its determination as to a patient or applicant's eligibility for Financial Assistance to the patient or applicant in writing within 14 days of receipt of a **completed** application.

AHN will not deny an application based on an applicant's failure to provide information or documentation, other than information or documentation described in this Policy or the Financial Assistance application form.

The patient may ask for a review of any decision by AHN to deny Financial Assistance. The patient must submit a request for review orally or in writing within 30 days of receiving the denial of Financial Assistance. Once a request for review has been received by AHN, the review will be done by a member of the Financial Advocacy Department management or his/her designee within 30 days pending receipt and verification of any additional information required to complete the requested reconsideration review.

If an approval for Financial Assistance creates a credit balance on a patient account (a credit that results directly from a previous payment made by the patient or on behalf of the patient for a patient responsible portion of the bill), then the patient or related payee (as the case may be) will be refunded all related patient payments arising from care delivered during the period for which Financial Assistance is approved but only for accounts or services dates to which Financial Assistance is specifically applicable.

Any patient account adjustment arising from approval for Financial Assistance must be approved by the appropriate authorized personnel at AHN. Patient account adjustments (based on gross charges) proposed under this Policy must have the following levels of approval:

Financial Advocacy Designee	**$0-$10,000**
Financial Advocacy Director	**$10,001 to $50,000**
Revenue Cycle Vice President	**$50,001 to $100,000**
Chief Revenue Cycle Officer	**$100,001 to $250,000**

The AHN Chief Financial Officer or his designee shall review and approve all patient account adjustments that exceed $250,000 related to Financial Assistance.

5. **Presumptive Eligibility Determination**

AHN understands that certain patients may be unable to complete a Financial Assistance application, comply with requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient's qualification for Financial Assistance is established without completing the formal Financial Assistance application. Under these circumstances,

AHN hospitals may utilize other sources of information to make an individual assessment of financial need. This information may enable AHN to make an informed decision of the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

AHN may utilize a third-party to conduct a review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets, and liquidity. The technology is designed to assess each patient utilizing the standards that we generally apply under this Policy and is used when specific information is not available from the patient.

AHN shall take measures to review this presumptive process from time to time and consider whether it results in application determinations for Financial Assistance acceptable to AHN in the absence of a patient's ability to complete a traditional application process.

When such third-party technology is used as the basis for presumptive eligibility, the discount afforded under this Policy will be granted for eligible services for a specific date of service only and the patient shall be informed of such determination and benefit in circumstances where such communication is required under regulation.

6. **Certain Aspects of Billing and Collections as They Relate to Financial Assistance**

AHN strives to obtain all appropriate third party reimbursement that is due for services rendered so as to reduce the financial burden on the patient and AHN. When third party coverage fails to cover the services rendered, or no third party coverage is in effect, AHN expects appropriate payment by the patient for services rendered unless the patient receives Financial Assistance under this Policy. AHN's billing and collection policies shall comply with federal and state regulations and laws governing healthcare billing and collections.

AHN may pursue normal collection actions (as well as ECAs) against patients found ineligible for Financial Assistance, or patients who are no longer cooperating in good faith to pay amounts due.

AHN generally applies a routine collection process to the patient responsible portion of an account. If the patient responsible portion remains unpaid after normal collection efforts, the AHN Revenue Cycle Office will assign or recommend assignment of the unpaid balance to bad debt status in accordance with its established policies and procedures.

Once an account is classified as a bad debt, AHN may take various steps to continue the collection process. AHN may use one or more ECAs to collect the account. However, AHN, at in its sole discretion, may elect to use presumptive eligibility techniques to determine eligibility for Financial Assistance prior to pursuing any ECAs related to accounts where no Financial Assistance application has been made by the patient. If a patient meets presumptive eligibility requirements for Financial Assistance then no ECAs will be initiated and collection efforts will be discontinued on the account.

Patient accounts granted presumptive eligibility ultimately will be classified as charity care under this Policy. Such accounts will not be sent to collections, will not be subject to further collection actions, and will not be included in the hospital's bad debt expense.

AHN's Policy regarding care for emergency medical conditions prohibits collection of payment prior to receiving services or collection activities that could interfere with provisions of emergency medical care. No ECAs will be pursued against any patient within 120 days of sending the first post-discharge billing statement and without first making reasonable efforts to determine whether that patient is eligible for Financial Assistance. The AHN Financial Advocacy Department is responsible for the determination that reasonable efforts have been made to determine if a patient is eligible for Financial Assistance prior to initiation of any ECAs. Reasonable efforts shall include, but are not limited to:

- Validating that the patient owes the unpaid bills and that all sources of third-party payments have been identified and billed by AHN
- Instituting a prohibition on collection actions pursued against an uninsured patient until the patient has been made aware of this Policy and has had the opportunity to apply for Financial Assistance
- Notifying the patient in writing of any additional information or documentation that must be submitted for determination of eligibility for Financial Assistance
- Confirming whether the patient submitted an application for health coverage under Medicaid, or other publicly sponsored health care programs and obtaining documentation of such submission
- AHN will not pursue ECAs while this application for health care coverage is pending, but once coverage is determined, normal collection actions will ensue, provided that no other benefits under this Policy are available to the patient
- Sending the patient written notice of the ECAs that AHN may initiate or resume if the patient does not complete the Financial Assistance application
- Sending patient written notice of the ECAs that AHN may initiate or resume if payment due is not received by 30 days after the written notice

Under federal guidelines, AHN is permitted to undertake ECAs after a 120 day notification period from the date of the first post-discharge billing statement sent to the patient. However, at any time during the 120 days after the initial 120 day notification period, AHN will accept and process a Financial Assistance application from a patient, and ECA efforts will cease during that period until such time as a determination is made whether the patient is eligible for Financial Assistance. Accordingly, the total period during which AHN will accept and process Financial Assistance applications is 240 days from the date of the first post-discharge billing statement sent to the patient.

No collection agency, law firm, or individual may initiate legal action against a patient for non-payment of an AHN bill without the written approval of AHN's Chief Revenue Cycle Officer or designee.

In the event of patient bankruptcy, once AHN receives evidence of a bankruptcy filing, collection actions will immediately cease for outstanding balances incurred for all services provided prior and up to the bankruptcy filing date.

FINANCIAL ASSISTANCE REPORTING

AHN shall comply with all federal, state, and local laws, rules and regulations and reporting requirements that apply to activities conducted pursuant to this Policy.

Financial Assistance processes and procedures will be reviewed periodically to ensure that this Policy is being administered as defined herein.

Financial Advocacy Department Management is the principal internal department responsible for collecting, documenting, and reporting related to Financial Assistance, under the supervision of the Chief Revenue Cycle Officer and in conjunction with AHN's controller.

PUBLICATION OF THE POLICY

This Policy shall be available in the primary languages of each covered AHN hospital's service area. Paper copies of this Policy, the application form, and plain language summary of this Policy will be available upon request and without charge in designated public locations in the hospital facilities, including at a minimum in the emergency room (if any) and admissions areas, and by mail. AHN shall use standard signage, and brochures to inform our patients and visitors of their availability in a manner reasonably expected to reach those members of the community who are most likely to require Financial Assistance. In addition, this Policy, along with an application form, and a plain language summary are available on the AHN website (https://www.ahn.org/financial-assistance-ahn-bills).

REFERENCES

Internal Revenue Code section 501(r)

26 Code of Federal Regulations 1.501(r)-1 through 1.501(r)-7

AHN Emergency Medical Treatment and Labor Act Policy (Policy stat ID 2538428).

ATTACHMENTS

Appendix A: Services Not Covered by the Financial Assistance Policy
Appendix B: Federal Poverty Guidelines
Appendix C: List of Providers Delivering Emergency or Other Medically Necessary Care
Appendix D: Allegheny Health Network Facility AGB Calculation
Appendix E: Separate and Additional requirements for Westfield Memorial Hospital Financial Assistance
Appendix F: Liquid Asset Amounts

Signature/ Date
Chief Financial Officer

Rachel S Verrill 11/12/21
Signature/ Date
Chief Revenue Cycle Officer

Appendix E: Separate and Additional Requirements for Westfield Memorial Hospital Financial Assistance

Procedure for Application

Patients that have an income of 100% or less of the Federal Poverty Guidelines, their patient liability balances will be forgiven at 100%. For patients with income between 101%-300% of the Federal Poverty Guidelines, a sliding fee schedule will be applied with a range of 85% to 95% discount based off the maximum payment amount (MPA). Assets will not be used in determining a patient's income level. Examples of assets not considered are a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings account, or cars used regularly by a patient or immediate family members.

2020 Federal Poverty Guidelines as of January 29, 2021 as published in the Federal Register [FR Doc.2021-01969 Filed 01-29-21: 8:45 am]

100 % Discount	Income Range
Household Size	100%
1	$12,880.00
2	$17,420.00
3	$21,960.00
4	$26,500.00
5	$31,040.00
6	$35,580.00
7	$40,120.00
8	$44,660.00

95 % Discount	Income Range	
Household Size	101%	150%
1	$13,008.80	$19,320.00
2	$17,594.20	$26,130.00
3	$22,179.60	$32,940.00
4	$26,765.00	$39,750.00
5	$31,350.40	$46,560.00
6	$35,935.80	$53,370.00
7	$40,521.20	$60,180.00
8	$45,106.60	$66,990.00

90 % Discount	Income Range	
Household Size	151%	250%
1	$19,448.80	$32,200.00
2	$26,304.20	$43,550.00
3	$33,159.60	$54,900.00
4	$40,015.00	$66,250.00
5	$46,870.40	$77,600.00
6	$53,725.80	$88,950.00
7	$60,581.20	$100,300.00
8	$67,436.60	$111,650.00

85 % Discount	Income Range	
Household Size	251%	300%
1	$32,328.80	$38,640.00
2	$43,724.20	$52,260.00
3	$55,119.60	$65,880.00
4	$66,515.00	$79,500.00
5	$77,910.40	$93,120.00
6	$89,305.80	$106,740.00
7	$100,701.20	$120,360.00
8	$112,096.60	$133,980.00

*For families/household with more than 8 persons, add $4,480 for each additional person.

Payment (Installment) Plans

Payment plans are available, upon approval, for Westfield Memorial Hospital services. Payment plans are reasonable to the industry standards, not to exceed 10% of the patient/guarantor's monthly gross income. No interest will be applied to the patient balance. Accelerated payment schedules are not used at Westfield Memorial Hospital.

Billing and Collections

Westfield Memorial Hospital will not engage in extraordinary collection actions (ECAs) involving forced sale or foreclosure of a patient's primary residence.

AHN

Instructions for Financial Assistance Application

Allegheny Health Network (AHN) may be able to reduce or forgive an AHN bill for medically necessary services for patients who:

- Have no or limited medical insurance
- Have been denied Medicaid
- Are United States citizens
- Show financial need on the AHN Financial Assistance Application

Payment plans may also be available to help patients pay their AHN bills.

The patient or guarantor or representative must apply for financial assistance within 240 days of receiving the AHN bill. To apply:

- Obtain an AHN "Financial Assistance Application" form for each patient.
- Complete each patient's application within 30 days of receiving the form.
- Make **copies** of the "proofs of income" needed (see the list below).
- Send the signed application and copies of proofs of income to the address below for bills from:

Allegheny Health Network (AHN)
Allegheny General Hospital
Allegheny Valley Hospital
AHN Brentwood Neighborhood Hospital
AHN Harmar Neighborhood Hospital
AHN Hempfield Neighborhood Hospital
AHN McCandless Neighborhood Hospital

Canonsburg Hospital
Forbes Hospital
Grove City Medical Center
Jefferson Hospital
Saint Vincent Hospital
West Penn Hospital
Westfield Memorial Hospital
Wexford Hospital

AHN Revenue Cycle Operations
Financial Advocacy Department
4 Allegheny Center, 10th Floor
Pittsburgh, Pa 15212

"Proofs of income" documents:

Attach copies of these documents to the application (documents cannot returned):

- ☐ **Copies** of federal tax forms (IRS1040, etc.) for the past year
- ☐ For bank accounts, **copies** of all pages of the most recent statement
- ☐ For investment accounts, **copies** of all pages of the most recent statement
- ☐ For wages, **copies** of paystubs (for the past 30 days)
- ☐ For self-employment income, **copies** of Schedule C or profit/loss statements for the past month
- ☐ For other types of income, **copies** of proofs of income, such as:
  - ○ Social Security 1099 form
  - ○ Pension or other retirement income statement
  - ○ Alimony, child/spousal support agreement
  - ○ Rental or royalty income agreement
  - ○ Veterans/disability award letter
  - ○ Unemployment Compensation or Workers' Compensation award letter
- ☐ For patients with no income: **Letter of support** signed by person who provides support
- ☐ To show Medical Assistance denial: **Copies** of form PA-162 for all services denied (for PA residents only)
- ☐ Bankruptcy notices that impact dates of services being considered in addition to income information
- ☐ Proof of homelessness or residence at a homeless shelter

AHN will review the Financial Assistance Application promptly. AHN will send a letter if more information is needed. AHN must receive additional information within 30 days or the application will be denied.

AHN will notify the patient or the patient's guarantor or representative of the decision in writing within 14 days of receiving the **completed** application. Any financial assistance provided applies to the current AHN bill(s) and may also apply to bills for medically necessary services for the next six (6) months.

AHN

Financial Assistance Application

Patient name: _____ **Birthdate:** ____/____/____
(first, middle initial, last)

SSN: ____-____-____

Home address: _____
(number and street, apt. no. city state zip code)

Phones: Day_____ Other_____

Employer name: _____ Phone:_____

Marital status: ❑Married ❑Divorced ❑Separated ❑Widowed ❑Single

Spouse/Guarantor Name: _____Relationship to patient:_____

Guarantor address: _____
(number and street, apt. no. city state zip code)

Guarantor phones: Day_____ Other_____

Household members: *List all in the patient's household who are claimed on IRS form 1040*

Name	Relationship to patient	Age

Home: *Please check, patient/guarantor:* ❑Owns home ❑Rents home ❑No home

The following asset information not required for Westfield Memorial Hospital.

If home is owned, please list:

Assessed value: $_____ Amount still owed on mortgage: $_____

If patient/guarantor has an interest in other real estate, please list:

Address: _____
(number and street city state zip code)

Names of co-owners:_____

Assessed value: $_____ Amount still owed on mortgage: $_____

Motor vehicles: *Please list make, model and year of each motor vehicle:*

_____ ❑Owned ❑Lease

_____ ❑Owned ❑Lease

Bank accounts: *Please list the following information and attach 2 months of statements for each bank account such as checking, savings, certificates of deposit (CDs), money market, etc.*

Account type	Bank or financial institution name	Account no.	Current balance
			$
			$
			$

Investments: *Please list the following information and attach 2 months of statements for each investment, such as stocks, bonds, mutual funds, etc.*

Investment type	Bank or financial institution name	Current value
		$
		$

Total household monthly income: *Include the total for the household (patient and all others) for all income, including wages, Social Security, pension or other retirement income, alimony, child/spousal support, rent/royalty/self-employment income, veterans/disability payments, unemployment compensation, worker compensation and investment (interest, dividend) income. Proof of income must be supplied as listed on the instruction page.*

Total household wages:	$ _____	Total worker comp:	$_____
Total Social Security:	$ _____	Total alimony/child support:	$_____
Total pension, other retirement:	$ _____	Total other income (please describe):	
Total rent/royalty income:	$ _____	_____	$_____
Total dividends and interest:	$ _____	_____	$_____
Total unemployment income:	$ _____	_____	$_____

Expenses: Please list household monthly expenses for:

Mortgage or rent:	$ _____	Prescriptions:	$_____
Real estate taxes:	$ _____	Medical supplies:	$_____
Utilities:	$ _____	Other AHN bills:	$_____
Motor vehicle payment:	$ _____	Other expenses (please describe):	
Motor vehicle insurance:	$ _____	_____	$_____
Food:	$ _____	_____	$_____

Other information

Have you applied for Medical Assistance? ❑No ❑Yes (If yes, please provide copies of your application and the determination letter)

Are you a citizen of the United States? ❑No ❑Yes

Did you have health insurance at the time of your treatment? ❑No ❑Yes

Authorization and verification

I, _____, attest that the information provided in this form is true and correct to the best of my knowledge. I understand that this form and the proofs of my income and expenses will not be returned. I authorize Allegheny Health Network to verify the information and to ask for a credit rating, if needed, to decide if I am eligible for financial assistance. I understand that if any information is found to be false, I may be denied financial assistance, may be solely responsible to pay my bill in full, and may not be eligible for future financial assistance. I understand that my eligibility for financial assistance may be re-evaluated for subsequent hospital services.

Patient or representative/
guarantor signature _____ Date_____

Print patient or representative/guarantor name _____

Relationship to patient: _____