Schedule 1

General Information - All Applicants

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Schedule 1

Certificate of Need Application	•
Is the applicant part of an "established article 28* network" as defined in section 401.1(j) of 10 nycrr? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart, if available.	Please refer to the
Type of Application: Establishment ☐ Construction ☒ A	dministrative ☐ Limited ☐
Total Project Cost: (CRFP-Funded Project)(Article 28 only Amount of Application Fee (see Schedule 8)	- -
Acknowledgement And Atte I hereby certify, under penalty of perjury, that I am duly authorized to sub the applicant: St. Luke's Healthcare St. Luke's Division / St. Elizabeth Me	scribe and submit this application on behalf
I further certify that the information contained in this application and its ac accurate, true and complete in all material respects. I acknowledge and accordance with the provisions of articles 28, 36 and 40 of the public healaw, and implementing regulations, as the case may be.	ccompanying schedules and attachments ar
SIGNATURE:	DATE
I dell'isone	11/4/17
PRINT OR TYPE NAME	TITLE
Scott Perra	President and CEO, Mohawk Valley Health System

Schedule 1

Applicant should identify the operator's chief executive officer, or equivalent official, to whom all official correspondence from DOH about this application should be addressed

IVE	NAME AND TITLE OF CHIEF EXECUTIVE							
	Mr. Scott Perra, F.A.C.H.E., President and CEO, Mohawk Valley Health System							
5		STREET & NUMBER						
EXECU	1656 Champlin Avenue							
Û	CITY	STATE	STATE '					
SHE	Utica	New York	13502					
」	TELEPHONE	FAX NUMBER		E-MAIL ADDRESS				
<u> </u>	(315) 624-6001	(315) 624-6956	sperra@m	vhealthsystem.org				

Applicant may designate a second person to whom copies of all official correspondence from DOH about this application should be addressed. (This could be the applicant's attorney, or a consultant)

	CONTACT PERSON'S COMPANY Mohawk Valley Health System		NAME AND TITLE OF CONTACT PERSON				
z			Ms. Sharon Palmer, AVP	Facilities Services			
片			STREET & NUMBER				
TAC	1656 Champlin Avenue						
	CITY		STATE		ZIP		
O <u>II</u>	Utica	New York		13502			
=	TELEPHONE		FAX NUMBER		E-MAIL ADDRESS		
	(315) 624-6298	(315) 624-6	230	spalmer@m	nvhealthsystem.org		

The applicant's lead attorney should be identified:

			NAME			
	Traci Boris, Esq.					
ΕY		STREE	T & NUMBER			
RN	1656 Champlin Avenue					
5	CITY	STATE		ZIP		
ΑT	Utica	New York	13502			
	TELEPHONE	FAX NUMBER		E-MAIL ADDRESS		
	(315) 624-5050	(315) 624-5051	tboris@mvhea	althsystem.org		

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

_	NAME						
	Frank M. Cicero, Cicero Consulting Associates						
A	STREET & NUMBER						
🖺	701 Westchester Avenue, Suite 210W						
	CITY	STATE		ZIP			
N	White Plains	New York	10604				
၂ ပ	TELEPHONE	FAX NUMBER		E-MAIL ADDRESS			
	(914) 682-8657	(914) 682-8895	conadmin@cid	ceroassociates.com			

New York State Department of Health Certificate of Need Application The applicant's lead accountant should be identified:

Schedule 1

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TELEPHONE [315] 624-6143 [315] 624-6956 [AIELLO1@mvhealthsystem.org Please list all Architects and Engineer contacts.		Z		STREET & NUMBER					
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Schedule 1

Checklist of Schedules Included in This Application

Schedule Number	Schedule Name	Required	Included
1	Forms Required for all CON Applications		
2 (A-D)	Personal Qualifying and Disclosure Information-All Establishment Applications		
3 (A-B)	CON Forms Related to Legal Issues		
4 (A-B)	Legal Information for Ownership Transfers		
5	CON Form Regarding Working Capital Plan		
6	CON Form Regarding Architectural Submission		
7	CON Forms Regarding Environmental Issues		
8 (A-B)	Project & Subproject Cost Summary		×
9	CON Forms Regarding Project Financing		X
10	Space & Construction Cost Distribution		
11	Moveable Equipment		
	CON Forms Specific to Adult Care Facilities		
	CON Forms Applicable to all Article 28 Facilities		
14 (A-D)	Additional Legal Information-Article 28		
15	Additional Legal Information-Article 28-Ownership Transfers		
16 (A-F)	CON Forms Specific to Hospitals-Article 28		
	CON Forms Specific to Diagnostic & Treatment Centers-Article 28		
18 (A-E)	CON Forms Specific to Residential Health Care Facilities-Article 28		
	CON Forms Specific to Adult Day Health Care Programs		
20 (A-C)	CON Forms Specific to Programs of OMH, OASAS, and OMRDD (If Applicable)	$\overline{\boxtimes}$	
21 (A-G)	CON Forms Specific to CHHA and LTHHCP Programs-Article 36		
	CON Forms Specific to Hospices-Article 40		
23	CON Forms Specific to all Projects Incorporating Health IT		

Other Facilities Owned or Controlled by the Applicant

(Establishment Applications only)

<u>N/A</u>

Does the applicant 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 CODE	
Hospital	HOS	Yes 🗌 No 🗌
Nursing Home	NH	Yes 🗌 No 🗌
Diagnostic and Treatment Center	DTC	Yes 🗌 No 🗌
Licensed Home Care Services Agency	LHH	Yes 🗌 No 🗌
Certified Home Health Agency	СНН	Yes 🗌 No 🗍
Hospice	HSP	 Yes □ No □
Adult Home	ADH	Yes 🗌 No 🗍
Assisted Living Program	ALP	Yes 🗌 No 🗍
Long Term Home Health Care Program	LTC	Yes ☐ No ☐
Enriched Housing Program	EHP	Yes 🗌 No 🗍
Health Maintenance Organization	НМО	Yes 🔲 No 🗍
Other	ОТН	Yes 🗌 No 🗌

For each facility or agency referenced above, enter the name, the PFI and facility type in the chart below.

	FACILITY NAME:	PFI	FACILITY TYPE
1			<u> </u>
2			
3			
4			
5			
6		-	
7			···
8			
9			"
10			

Attach additional sheet if necessary.

Schedule 1

In addition to the information provided on the above chart, provide a complete 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 corporation, as well as with parent, member and subsidiary corporations. For each health care entity identified, provide the full name, address, and type of services provided. In conjunction with this list, 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 years (or for the period of the affiliation, whichever is shorter). To assist you in securing this information, a recommended form and a sample letter of inquiry are provided in Schedule 2 D.

Please list the facilities outside of New York State that are owned or controlled by the applicant:

N/A

	FACILITY NAME AND ADDRESS:	Services provided:	STATE/ COUNTRY	FACILITY TYPE
1				
2			<u>-11.</u>	
3			**	
4				
5				
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9			,	
10			w.	