**Schedule 13**

**All Article 28 Facilities**

**Contents:**

* **Schedule 13 A - Assurances**
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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:

1. 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.
2. 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.
3. 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.
4. The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.
5. 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.
6. 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.
7. The facility will be operated and maintained in accordance with the standards prescribed by law.
8. 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.
9. 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 |  |  |  |
|  |  |  | Signature: |
|  |  |  |  |
|  |  |  | Name (Please Type) |
|  |  |  |  |
|  |  |  | 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 |  |  |  | |  | |
| 19. Other |  |  |  | |  | |
| 20. Other |  |  |  | |  | |
| 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*.**

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|  |  |  |  |
| --- | --- | --- | --- |
| **Medical/Center Director** | | | |
| Name of Medical/Center Director: |  | | |
| License number of the Medical/Center Director |  | | |
|  | **Not Applicable** | **Title of Attachment** | **Filename of attachment** |
| Attach a copy of the Medical/Center Director's curriculum vitae |  |  |  |

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

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

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

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

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

**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. |  |  |
| 1. 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. 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. |  |  |  |
| 1. Provide the basis and supporting calculations for all utilization and revenues by payor. |  |  |  |
| 1. 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 | | |
| **(A)**  Patient  Days or dis-  charges | Net Revenue | | **(C)**  Patient  Days or dis-  charges | Net Revenue | | **(E)**  Patient  Days or dis-  charges | Net Revenue | |
| **(B)**  Dollars  ($) | $ per Patient  Day or dis-  charge  **(B)/(A)** | **(D)**  Dollars  ($) | $ per Patient  Day or dis-  charge  **(D)/(C)** | **(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 | | |
| **(A)**  V/P | Net Revenue | | **(C)**  V/P | Net Revenue | | **(E)**  V/P | Net Revenue | |
| **(B)**  Dollars ($) | $ per V/P  **(B)/(A)** | **(D)**  Dollars ($) | $ per V/P  **(D)/(C)** | **(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 | | |  |  |  |  |  |  |  |  |  |