New York State Department of Health
Certificate of Need Application
General Information - All Applicants

Schedule 1

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Main Site*	0599	00384309	Hospital	Mohawk Valley Health System/ Faxton-St. Luke's Healthcare St. Luke's Division
	STREET & NUMBER			
	1656 Champlin Avenue			
	CITY		COUNTY	ZIP
	Utica		Oneida	13502

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Project Site #1*	To Be Determined	To Be Determined	Hospital	Mohawk Valley Health System Campus
	STREET & NUMBER			
	To Be Determined**			
	CITY		COUNTY	ZIP
	Utica		Oneida	13502

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Project Site #2*	0598	00279901	Hospital – Extension Clinic	Mohawk Valley Health System/St. Elizabeth Campus
	STREET & NUMBER			
	2209 Genesee Street, Utica (Oneida County), New York 13501			
	CITY		COUNTY	ZIP
	Utica		Oneida	13501

	MAIN SITE PFI	MEDICAID PROVIDER ID	TYPE OF FACILITY	MAIN SITE NAME
Project Site #3*	0599	00384309	Hospital	Mohawk Valley Health System/ St. Luke's Campus
	STREET & NUMBER			
	1656 Champlin Avenue			
	CITY		COUNTY	ZIP
	Utica		Oneida	13502

	OPERATING CERTIFICATE NUMBER	TYPE OF FACILITY	LEGAL ENTITY THAT WILL OPERATE OF THE FACILITY (or proposed operator)
Operator Information*	3202002H/ 3202003H	Hospitals	St. Elizabeth Medical Center / Faxton-St. Luke's Healthcare St. Luke's Division Mohawk Valley Health System
	STREET & NUMBER		
	2209 Genesee Street / 1656 Champlin Avenue		
	CITY	COUNTY	ZIP
	Utica	Oneida	13501/13502

*** Please refer to the Project Narrative under the Schedule 1 Attachment for a description of this project.**
**** The new, consolidated hospital campus will be located on a 25-acre parcel of land generally bordered by the following streets in Utica (Oneida County), New York 13502: State Street, Broadway, Oriskany Street West, and Columbia Street. An address has not yet been assigned to the site.**

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution of partners, corporate directors, or LLC managers, as the case may be, authorizing the project.	YES ☒ NO ☐	Please refer to the Schedule 1 Attachment

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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.	YES ☒ NO ☐	Please refer to the Schedule 1 Attachment

Type of Application: Establishment ☐ Construction ☒ Administrative ☐ Limited ☐

Total Project Cost: ***(CRFP-Funded Project)(Article 28 only)***	$480,000,000
Amount of Application Fee (see Schedule 8)	$2,000/$2,627,548

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: St. Luke's Healthcare St. Luke's Division / St. Elizabeth Medical Center / Mohawk Valley Health System

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/or article 7 of the social services law, and implementing regulations, as the case may be.

SIGNATURE:	DATE
	11/6/17
PRINT OR TYPE NAME	TITLE
Scott Perra	President and CEO, Mohawk Valley Health System

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Contacts:

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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

CHIEF EXECUTIVE			
NAME AND TITLE OF CHIEF EXECUTIVE			
Mr. Scott Perra, F.A.C.H.E., President and CEO, Mohawk Valley Health System			
STREET & NUMBER			
1656 Champlin Avenue			
CITY	STATE	ZIP	
Utica	New York	13502	
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS	
(315) 624-6001	(315) 624-6956	sperra@mvhealthsystem.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 INFORMATION		
CONTACT PERSON'S COMPANY	NAME AND TITLE OF CONTACT PERSON	
Mohawk Valley Health System	Ms. Sharon Palmer, AVP Facilities Services	
STREET & NUMBER		
1656 Champlin Avenue		
CITY	STATE	ZIP
Utica	New York	13502
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
(315) 624-6298	(315) 624-6230	spalmer@mvhealthsystem.org

The applicant's lead attorney should be identified:

ATTORNEY		
NAME		
Traci Boris, Esq.		
STREET & NUMBER		
1656 Champlin Avenue		
CITY	STATE	ZIP
Utica	New York	13502
TELEPHONE	FAX NUMBER	E-MAIL ADDRESS
(315) 624-5050	(315) 624-5051	tboris@mvhealthsystem.org

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

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

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The applicant's lead accountant should be identified:

ACCOUNTANT

NAME		
Mr. Louis Aiello		
STREET & NUMBER		
1656 Champlin Avenue		
CITY	**STATE**	**ZIP**
Utica	New York	13502
TELEPHONE	**FAX NUMBER**	**E-MAIL ADDRESS**
(315) 624-6143	(315) 624-6956	LAIELLO1@mvhealthsystem.org

Please list all Architects and Engineer contacts.

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
Mitzi D'Amico	NBBJ	250 S. High Street; Suite 300
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**
Columbus, OH 43215	(614) 232-3033	mdamico@nbbj.com

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
N/A		
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
N/A		
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**

ARCHITECT and/or ENGINEER

NAME	FIRM	STREET & NUMBER
N/A		
CITY, STATE, ZIP	**TELEPHONE**	**E-MAIL ADDRESS**

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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	☒	☒
10	Space & Construction Cost Distribution	☒	☒
11	Moveable Equipment	☒	☒
12 (A-G)	CON Forms Specific to Adult Care Facilities	☐	☐
13 (A-D)	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	☒	☒
17 (A-E)	CON Forms Specific to Diagnostic & Treatment Centers-Article 28	☐	☐
18 (A-E)	CON Forms Specific to Residential Health Care Facilities-Article 28	☐	☐
19 (A-B)	CON Forms Specific to Adult Day Health Care Programs	☐	☐
20 (A-C)	CON Forms Specific to Programs of OMH, OASAS, and OMRDD (If Applicable)	☒	☒
21 (A-G)	CON Forms Specific to CHHA and LTHHCP Programs-Article 36	☐	☐
22 (A-F)	CON Forms Specific to Hospices-Article 40	☐	☐
23	CON Forms Specific to all Projects Incorporating Health IT	☐	☐

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Other Facilities Owned or Controlled by the Applicant

(Establishment Applications only)

N/A

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	CHH	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	HMO	Yes ☐ No ☐
Other	OTH	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			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Attach additional sheet if necessary.

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				
3				
4				
5				
6				
7				
8				
9				
10				