

2025 Michigan Certificate of Need Annual Survey

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Please Note: Section Q- New Section for NICU has been added to the survey.

If a hospital offering NICU services also operates a separate SCN unit with unlicensed SCN bassinets that is separate from the NICU, please also complete Section O for SCN Services.

No other changes to this section from last year.

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[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION A: Main Facility Data and Organizational Structure	Next
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Data Collection Notice
Authority: Act 368, P.A. 1978 as amended - sections 20141(5), 20143, 20165(5), and 22237; Act 186, P.A. 1986 - Section 10102(a)(5).
Penalty: Failure to file may result in compliance action against a facility's license or may delay Certificate(s) of Need decisions.

Facility Information		
Facility Name	TEST FACILITY	H1_1
Facility Street		H1_2
Facility City	EAST LANSING	H1_3
Facility State		H1_4
Facility Zip Code		H1_5
Facility County	MACOMB	CO_NAME
Facility Phone	###-###-####	H1_A3
Facility Fax	###-###-####	HA_FFAX
Facility Administrator		HA_FADMIN
Facility Admin E-mail		H1_A4
Facility Website URL		HA_WEB

Data Contact Information (Person responsible for the accuracy of this survey data.)		
Contact Name		HA_CNAME
Contact E-mail		HA_CEMAIL
Contact Phone	###-###-####	HA_CPHONE
Contact Fax	###-###-####	HA_CFAX
Alternate Contact E-mail		HA_CEMAIL2

Provide system headquarters information		
Headquarters Name		H2_A4B
Headquarters Address		H2_A4C
Headquarters City, St, Zip		H2_A4D

Additional Facility Information

Facility type of ownership:	<input type="text" value="1"/>	H2_A5
1:Non-profit Entity 2:Government (includes authorities and county-owned facilities) 3:For-profit Entity		
Facility Type:	<input type="text" value="1"/>	H2_A6
Hospital Facility Types: 1: Hospital (acute care hospitals may include psych, rehab, and substance abuse units) 2: Psychiatric Hospital (only) 4: Rehabilitation Hospital (only) 5: Nursing Home/Hospital LTCU 6: Long-Term Acute Care (LTAC) Hospital 10: Inpatient Rehabilitation Facility Hospital Freestanding/Mobile Facility Types: 7: Freestanding Surgical Facility (FSOF, ASC) 8: Other freestanding medical facility (CT, MRT, other imaging, etc.) 9: Central Service Coordinator (mobile, air ambulance provider)		
Facility HSA:	<input type="text" value="1"/>	HSA

Title XIX (Medicaid) Participation		
1. Did this site participate in the Medicaid program during 2025 (Y/N)?	<input type="text" value="Y"/>	HA_M1
2. Did you treat at least one Medicaid patient (Y/N)?	<input type="text" value="Y"/>	HA_M2A
3. Have you treated one or more patients without the ability to pay (Y/N)?	<input type="text" value="Y"/>	HA_M3

Was the facility operational during calendar year 2025? (REQUIRED: Please enter 'Y' or 'N') <i>Entering 'Y' to this question opens the Con Covered Services questions.</i>	<input type="text" value="Y"/>	HA_OP15
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CON Covered Services (Please answer YES (Y) or NO (N) to identify the CON covered beds or services offered to patients during calendar year 2025. The required sections for each offered service will be available for completion after submitting this Section and selecting the Next button. Compare last year's sections (grayed/not able to edit) to this year's selected sections. If there are differences in reporting from last year to the current year, you will need to attest the reported information is correct. Also, please provide a comment within the data comment box explaining the change.			Required Sections
1. Inpatient Hospital Beds	<input type="text" value="Y"/>	HA_CON01	Section L,S,Z
2. Neonatal Intensive Care Unit (NICU) Beds <i>Answering "yes" to this question will open the New Section Q for NICU</i>	<input type="text" value="Y"/>	HA_CON02	Section Q,Z
3. Short-Term Nursing Care Program (Swing) Beds	<input type="text" value="Y"/>	HA_CON03	Section L
4. Adult Inpatient Psychiatric Beds	<input type="text" value="Y"/>	HA_CON04	Section M,Z
5. Child/Adolescent Inpatient Psychiatric Beds	<input type="text" value="Y"/>	HA_CON05	Section M,Z
6. Hospital Long-Term-Care-Unit Beds	<input type="text" value="Y"/>	HA_CON06	Section N,Z
7. Nursing Home Beds	<input type="text" value="Y"/>	HA_CON20	Section N,Z
8. Urinary Lithotripsy Services (UESWL)	<input type="text" value="Y"/>	HA_CON07	Section B,Z
9. Megavoltage Radiation Therapy (MRT) Services	<input type="text" value="Y"/>	HA_CON11	Section F,Z
10. Computed Tomography (CT) Scanner Services	<input type="text" value="Y"/>	HA_CON08	Section D,Z
11. Magnetic Resonance Imaging (MRI) Services	<input type="text" value="Y"/>	HA_CON09	Section C,Z
12. Positron Emission Tomography (PET) Services	<input type="text" value="Y"/>	HA_CON18	Section P,Z
13. Cardiac Catheterization Services	<input type="text" value="Y"/>	HA_CON10	Section E,Z
14. Surgical Services (operating rooms)	<input type="text" value="Y"/>	HA_CON12	Section G,Z
15. Open Heart Surgery Services	<input type="text" value="Y"/>	HA_CON13	Section J,Z
16. Pancreas Transplantation Services	<input type="text" value="Y"/>	HA_CON15	Section K
17. Heart, Lung and Liver Transplantation Services	<input type="text" value="Y"/>	HA_CON16	Section K,Z
18. Bone Marrow Transplantation (BMT) Services	<input type="text" value="Y"/>	HA_CON14	Section K,Z

18. Bone marrow transplantation (BMT) Services	<input type="checkbox"/>	HA_CON18	Section H, Z
19. Emergency Department Services (hospital sites only)	<input checked="" type="checkbox"/>	HA_CON19	Section H, S
20. Special Newborn Nursing Services	<input checked="" type="checkbox"/>	HA_CON21	Section O, Z
2025 CON Covered Services Change Attestation. Please type your First and Last Name			<input type="text"/> SVC_CHG_SIG

Special Section Access

Section J Access: Set to Y if this site utilizes a pediatric open heart program. N

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HA_COMMENTS

Administrator Facility Comments

ADMIN_COMMENTS

Data Collection Status for this Section Last Updated on 2026-02-17 10:17:14

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? N HA_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

Print this section to PDF:

General Info / FAQ

No changes to this section from last year

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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION B: Urinary Extra Corporeal Shock Wave Lithotripsy (UESWL) Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	HB_CNAME
Contact E-mail	HB_CEMAIL
Contact Phone	HB_CPHONE
Contact Fax	HB_CFAX

Instructions:

- Report data as outlined below for the relevant type of service offered:
 - Fixed UESWL units - Report the number of unit(s), procedures, and retreatments completed on the fixed unit(s).
 - Host Site - Report the procedures and retreatments completed on each the mobile route(s) separately.
 - Central Service Coordinator of UESWL Mobile Route - Report the number of unit(s), procedures and retreatments.
- DO NOT DUPLICATE** any utilization data from Section B (UESWL Services) within Section G (Surgical Services) pursuant to the Surgical Services Review Standards, section 3 subsection (2)(a)(iii).
- Report the number of percutaneous nephrostomy procedures completed.
- Report if the facility has met the terms of approval and the project delivery requirements. If the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Central Service Coordinator (CSC) means the organization that owns the mobile equipment and has operational responsibilities for that equipment.

Host Site means a facility approved to offer the service at that site through a contract with the Central Service Coordinator which owns the mobile equipment.

Percutaneous Nephrostomy means a surgical procedure that allows a physician to remove stones from the kidney, renal pelvis, and upper urinary tract through a percutaneous channel called a nephrostoma established through a patient's skin.

Retreatment means a UESWL procedure performed on the same side of the same patient within 6 months of a previous UESWL procedure performed at the same UESWL service. In the case of a mobile unit, the initial treatment and retreatment were performed by the same service, even though they may have been performed at a different host site.

Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) means a procedure for the removal of kidney stones which involves focusing shock waves on kidney stones so that they are pulverized into sand-like particles which may then be passed through the urinary tract.

Lithotripsy Equipment and Mobile Services		
1. Total number of fixed lithotripsy units.	0	HB_1
2. Total number of mobile lithotripsy units (CSC operators only).	0	HB_2
3. If service is provided by a mobile provider, enter all of the mobile route numbers providing lithotripsy service at your facility (CSC and Host sites)		
1st Route #	Select one...	H3_B10
2nd Route #	Select one...	H3_B11
3rd Route #	Select one...	H3_B12

Lithotripsy Utilization Data		ICD9/ICD10	
4. Fixed units			
Total number of UESWL procedures.	<input type="text" value="0"/>	H3_B1A1	98.51
How many of the above procedures were retreatments ?	<input type="text" value="0"/>	H3_B2A	98.51
5. Host sites for mobile services			
1st Route			
Total number of UESWL procedures.	<input type="text" value="0"/>	H3_B1B2	98.51
How many of the above procedures were retreatments ?	<input type="text" value="0"/>	H3_B2E	98.51
2nd Route			
Total number of UESWL procedures.	<input type="text" value="0"/>	H3_B1B3	98.51
How many of the above procedures were retreatments ?	<input type="text" value="0"/>	H3_B2F	98.51
3rd Route			
Total number of UESWL procedures.	<input type="text" value="0"/>	H3_B1B4	98.51
How many of the above procedures were retreatments ?	<input type="text" value="0"/>	H3_B2G	98.51
6. Central Service Coordinator (CSC)			
Total number of UESWL procedures.	<input type="text" value="0"/>	H3_B1C1	98.51
How many of the above procedures were retreatments ?	<input type="text" value="0"/>	H3_B2D	98.51
7. Number of Percutaneous Nephrostomy Procedures.	<input type="text" value="0"/>	H3_B3D	55.04

Terms of Approval and Project Delivery Requirements		
8. Have either on-site or through a contractual agreement with another health facility, IV supplies and materials for infusions and medications, blood and blood products, and pharmaceuticals, including vasopressor medications, antibiotics, and fluids and solutions.	<input type="text" value="Select one..."/>	HB_6YN
9. Have on-site general anesthesia, EKG, cardiac monitoring, blood pressure, pulse oximeter, ventilator, general radiography and fluoroscopy, cystoscopy, and laboratory services.	<input type="checkbox"/>	HB_7YN
10. Have on-site cardiac intensive care unit or a written transfer agreement with a hospital that has a cardiac intensive care unit.	<input type="checkbox"/>	HB_8YN
11. Have either on-site or through a contractual agreement with another health facility, a 23-hour holding unit.	<input type="text" value="Select one..."/>	HB_9YN
12. Have policy or protocol for credentialing urologists approved to perform UESWL procedures.	<input type="checkbox"/>	HB_10YN
13. Have on-site crash cart.	<input type="checkbox"/>	HB_11YN
14. When was the last date throughout CY 2025 that UESWL services were provided by this facility/mobile route?	<input type="text" value="MM/DD/20YY"/>	HB_12YN

Data Comments for this Section (Optional)
<p>Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:</p> <div style="border: 1px solid gray; height: 50px; width: 100%;"></div>
HB_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:08:05
By entering an N in the text box and clicking the Save button, you are certifying that further editing or additional information is required to complete the data for this section.	
By entering a Y in the text box and clicking the Submit button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.	
Is the data for this section complete (Y/N)?	<input type="text" value="N"/> HB_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION C: Magnetic Resonance Imaging (MRI) Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	<input type="text"/> HC_CNAME
Contact E-mail	<input type="text"/> HC_CEMAIL
Contact Phone	<input type="text"/> HC_CPHONE
Contact Fax	<input type="text"/> HC_CFAX

Instructions

- Report all fixed units that were operational in the reporting period. Do not include units that are approved but not yet operational.
 - Report the number of mobile MRI units on mobile route.
 - Report all mobile route numbers that serviced your facility during the reporting period.
 - Report if the facility is a teaching facility. If so, please email appropriate documentation to MRIQuarterlyData@michigan.gov.
 - Report if the facility has met the terms of approval and the project delivery requirements:
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.
- Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Central Service Coordinator (CSC) means the organization that owns the mobile equipment and has operational responsibilities for that equipment.

MRI Units mean the magnetic resonance system consisting of an integrated set of machine and related equipment necessary to produce the images and/or spectroscopic quantitative data from scans. The term does not include MRI simulators used solely for treatment planning purposes in conjunction with MRT unit.

Dedicated Pediatric MRI means an MRI unit on which at least 80% of the MRI procedures are performed on patients under 18 years of age.

Dedicated Research MRI means an MRI unit used exclusively for research and operates under the protocol approved by the facility's IRB.

Intra-operative magnetic resonance imaging (IMRI) means the integrated use of MRI technology during surgical and interventional procedures within a licensed operative environment.

MRI-guided electrophysiology intervention (MRI-guided EPI) means equipment specifically designed for the integrated use of MRI technology for the purposes of electrophysiology interventional procedures within a cardiac catheterization lab.

Teaching Facility means a licensed hospital site, or other location, that provides either fixed or mobile MRI services and at which residents or fellows of a training program in diagnostic radiology engage in the care of a patient (including protocoling/interpretations of studies), and that is approved by the Accreditation Council on Graduate Medical Education or American Osteopathic Association, are assigned. A teaching facility shall be identified as meeting the definition if at least one (1) of the following is true:

- The participating hospital site or other location's facility name is listed on the Accreditation Council on Graduate Medical Education or American Osteopathic Association's accreditation letter as having a training program in diagnostic radiology.
- The participating hospital site or other location is owned by an entity that is listed on the Accreditation Council on Graduate Medical Education or American Osteopathic Association's accreditation letter as having a training program in diagnostic radiology.

Updated definition

DEDICATED PEDIATRIC AND RESEARCH MRI SCAN DATA		
1. Number of fixed MRI Units (excluding dedicated pediatric and dedicated research MRI units).	<input type="text" value="0"/>	HC_01
2. Number of fixed dedicated pediatric MRI Units	<input type="text" value="0"/>	HC_02
3. Number of fixed dedicated research MRI Units	<input type="text" value="0"/>	HC_03
4. Number of fixed open MRI Units .	<input type="text" value="0"/>	HC_05
5. Number of fixed IMRI units .	<input type="text" value="0"/>	HC_06
6. Number of MRI-guided EPI units .	<input type="text" value="0"/>	HC_07
7. Number of mobile MRI Units (CSC operators only) .	<input type="text" value="0"/>	HC_04
8. If MRI service is provided by mobile MRI units, enter all of the mobile route numbers that are providing service at your facility (CSC and Host sites):		
1st Route #	<input type="text" value="Select one..."/>	HC_R1
2nd Route #	<input type="text" value="Select one..."/>	HC_R2
3rd Route #	<input type="text" value="Select one..."/>	HC_R3
4th Route #	<input type="text" value="Select one..."/>	HC_R4
5th Route #	<input type="text" value="Select one..."/>	HC_R5
6th Route #	<input type="text" value="Select one..."/>	HC_R6
7th Route #	<input type="text" value="Select one..."/>	HC_R7
8th Route #	<input type="text" value="Select one..."/>	HC_R8
9th Route #	<input type="text" value="Select one..."/>	HC_R9
10th Route #	<input type="text" value="Select one..."/>	HC_R10
9. Is this facility a Teaching Facility (Y/N)?	<input type="checkbox"/>	HC_TFYN

DEDICATED PEDIATRIC AND RESEARCH MRI SCAN DATA		
10. Total number of MRI scans performed on the dedicated pediatric MRI unit(s).	<input type="text" value="0"/>	HC_DP1
11. Total number of MRI scans on patients under 18 years of age performed on the dedicated pediatric MRI unit(s).	<input type="text" value="0"/>	HC_DP2
12. Total number of MRI scans performed on the dedicated research MRI unit(s).	<input type="text" value="0"/>	HC_DR1
13. Total number of MRI scans performed for research purposes only on the dedicated research MRI unit(s).	<input type="text" value="0"/>	HC_DR2

Terms of Approval and Project Delivery Requirements		
14. Have a physician that has had at least 60 hours of training in MRI physics, MRI safety, and MRI instrumentation in a program that is part of an imaging program accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association?	<input type="checkbox"/>	HC_TA01
15. Does the physician identified in question 14 above work onsite or is available on-call?	<input type="text" value=""/>	HC_TA02
16. Have an MRI technologist who is registered by the American Registry of Radiologic Technicians or by the American Registry of Magnetic Resonance Imaging Technologists (ARMRIT)?	<input type="checkbox"/>	HC_TA03
17. Have an MRI physicist/engineer on staff either full time or part time?	<input type="text" value=""/>	HC_TA04
18. Have equipment and supplies to handle clinical emergencies that might occur in the unit that includes all of the following: <ul style="list-style-type: none"> MRI service staff trained in CPR and other appropriate emergency interventions. A Physician, Nurse Practitioner or Physician Assistant trained in the management of hypersensitivity and physiologic drug reactions to MRI contrast materials on-site when patients are receiving intravenous contrast. 	<input type="text" value="Updated Q. 18"/>	HC_TA05
19. For facilities receiving mobile services, have a means for patients to enter the vehicle without going outside such as a canopy or an enclosed corridor?	<input type="text" value=""/>	HC_TA06
20. When was the last date throughout CY 2025 that MRI services were provided by this facility/mobile route?	<input type="text" value="MM/DD/20YY"/>	HC_TA07

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HC_COMMENTS

Data Collection Status for this Section

Last Updated on 2026-02-17 10:08:48

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)?

N

HC_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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No changes to this section from last year

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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION D: Computed Tomography (CT) Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.		
Contact Name	<input type="text"/>	HD_CNAME
Contact E-mail	<input type="text"/>	HD_CEMAIL
Contact Phone	<input type="text"/>	HD_CPHONE
Contact Fax	<input type="text"/>	HD_CFAX

Instructions:

- Report data as outlined below for the relevant type of service offered:
 - Fixed CT Scanners - Report the number of scanner(s) and scans by scan type.
 - Central Service Coordinator of CT Mobile Route - Report the number of scanners(s) and the number of scans by scan type.
 - Host Site - Report the number of scans by scan type completed on each the mobile route(s) separately.
- Do not report CT volume performed on PET/CT scanners in this section. This data is reported in the PET section.
- The CT Volume by Referring Physician excel spreadsheet must be completed by all facilities, except facilities with only dental CT scanner services.

Physician Volume File Instructions
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Body CT Scans are all spinal CT scans and any CT scan of an anatomical site below and including the neck.

Bundled Body Scan means two or more body scans billed as one CT procedure.

Central Service Coordinator (CSC) is the organization that owns the mobile equipment and has operational responsibilities for that equipment.

CT-Angio Hybrid Unit means an integrated system comprised of both CT and angiography equipment sited in the same room that is designed specifically for interventional radiology or cardiac procedures. The CT unit is a guidance mechanism and is intended to be used as an adjunct to the procedure. The CT unit shall not be used for diagnostic studies unless the patient is currently undergoing a CT-Angio hybrid procedure and needs a secondary diagnostic study.

CT-Guided Ablation means any invasive procedure performed in a CT scanner requiring CT guidance of a needle or other device to treat a tumor.

CT-Guided Non-Ablation Procedure means any invasive procedure, requiring CT guidance, performed in the CT scanner other than CT-guided ablations.

Dedicated Pediatric CT Scanner means a fixed CT scanner on which at least 70% of the CT procedures are performed on patients under 18 years of age. If you are unsure if your facility has a CON approved for this scanner type, please contact Amanda Curtis (Curtis6@michigan.gov) or Christopher Tyranski (TyranskiC@Michigan.gov) at 517-284-8974.

Dedicated Research Fixed CT Scanner means a scanner approved by the department and a minimum of 70% of CT scans are performed for research purposes only.

Head CT Scans are defined head or brain CT scans; including the maxillofacial area; the orbit, sella, or posterior fossa; or the outer, middle, or inner ear; or any other CT scan occurring above the neck.

Hospital-based Portable CT Scanner means a CT scanner capable of being transported into patient care areas and data should only be completed if your facility holds a special CON approval for a portable scanner. Please check with Amanda Curtis (Curtis6@michigan.gov) or Christopher Tyranski (TyranskiC@Michigan.gov) at 517-284-8974 to confirm if you are unsure.

Host Site is approved to offer the service at that site through a contract with a Central Service Coordinator which owns the mobile equipment.

Pediatric Patient means any patient less than 18 years of age.

Special Needs Patient means a non-sedated patient, either pediatric or adult, with any of the following conditions: Down Syndrome, Autism, Attention Deficit Hyperactivity Disorder (ADHD), Developmental Delay, Malformation Syndromes, Hunter's Syndrome, multi-system disorders, psychiatric disorders, and other conditions that make the patient unable to comply with the positional requirements of the exam.

CT Equipment and Mobile Services		
1. Number of Fixed CT Scanners (exclude specialty scanners reported in 2 - 5).	<input type="text" value="0"/>	H5_D1G1
2. Number of Portable CT Scanners .	<input type="text" value="0"/>	H5_D3G1
3. Number of Dedicated Pediatric CT Scanners .	<input type="text" value="0"/>	H5_D4G2
4. Number of (CT-Angio Hybrid Scanners).	<input type="text" value="0"/>	H5_D4G3
5. Number of (Dedicated Research Fixed CT Scanners).	<input type="text" value="0"/>	H5_D4G4
Total of CT Scanners	<input type="text" value="0"/>	HD_1
6. Total number of Mobile CT Scanners (CSC operators only).	<input type="text" value="0"/>	HD_2
7. If CT service is provided by mobile CT unit(s), enter all of the mobile route numbers that are providing CT service at your facility (CSC and Host sites):		
1st Route #	<input type="text" value="Select one..."/>	H5_D1H1
2nd Route #	<input type="text" value="Select one..."/>	H5_D1H2
3rd Route #	<input type="text" value="Select one..."/>	H5_D1H3

Dedicated Research Fixed CT Scanners Utilization Data		
8. Total number of CT scans performed on the Dedicated Research Fixed CT scanner(s) .	<input type="text" value="0"/>	H5_DRF1
9. Total number of CT scans performed for research purposes only on the Dedicated Research Fixed CT scanner(s) .	<input type="text" value="0"/>	H5_DRF2

CT Utilization Data - CSC	ADULT		PEDIATRIC	
Head CT Scans				
Head scans without contrast:	<input type="text" value="0"/>	H5_M1A	<input type="text" value="0"/>	H5_M2A
Head scans with contrast:	<input type="text" value="0"/>	H5_M1B	<input type="text" value="0"/>	H5_M2B
Head scans without and with contrast:	<input type="text" value="0"/>	H5_M1C	<input type="text" value="0"/>	H5_M2C
Body CT Scans				
Body scans without contrast:	<input type="text" value="0"/>	H5_M1D	<input type="text" value="0"/>	H5_M2D
Body scans with contrast:	<input type="text" value="0"/>	H5_M1E	<input type="text" value="0"/>	H5_M2E
Body scans without and with contrast:	<input type="text" value="0"/>	H5_M1F	<input type="text" value="0"/>	H5_M2F
Bundled Body Scans	<input type="text" value="0"/>	H5_M1G	<input type="text" value="0"/>	H5_M2G
How many adult special needs bundled body scans reported in the CT scans above?			<input type="text" value="0"/>	H5_M3SN
How many adult special needs for all other scans?			<input type="text" value="0"/>	H5_M4SN
CT Guided Non-Ablation Procedure	<input type="text" value="0"/>	H5_M1H	<input type="text" value="0"/>	H5_M2H
CT Guided Ablation Procedure	<input type="text" value="0"/>	H5_M1I	<input type="text" value="0"/>	H5_M2I

CT Utilization Data - Adult Fixed	Fixed CT		Portable CT		Dedicated Pediatric CT	
ADULT Head CT Scans						
Head scans without contrast:	<input type="text" value="0"/>	H5_D1A1	<input type="text" value="0"/>	H5_D1A3	<input type="text" value="0"/>	H5_D1A4
Head scans with contrast:	<input type="text" value="0"/>	H5_D1B1	<input type="text" value="0"/>	H5_D1B3	<input type="text" value="0"/>	H5_D1B4
Head scans without and with contrast:	<input type="text" value="0"/>	H5_D1C1	<input type="text" value="0"/>	H5_D1C3	<input type="text" value="0"/>	H5_D1C4
ADULT Body CT Scans						
Body scans without contrast:	<input type="text" value="0"/>	H5_D1D1	<input type="text" value="0"/>	H5_D1D3	<input type="text" value="0"/>	H5_D1D4
Body scans with contrast:	<input type="text" value="0"/>	H5_D1E1	<input type="text" value="0"/>	H5_D1E3	<input type="text" value="0"/>	H5_D1E4
Body scans without and with contrast:	<input type="text" value="0"/>	H5_D1F1	<input type="text" value="0"/>	H5_D1F3	<input type="text" value="0"/>	H5_D1F4
Bundled Body Scans	<input type="text" value="0"/>	H5_D1J1	<input type="text" value="0"/>	H5_D1J3	<input type="text" value="0"/>	H5_D1J4
How many adult special needs bundled body scans reported in the CT scans above?					<input type="text" value="0"/>	H5_D2SN1

How many adult special needs for all other scans?	<input type="text" value="0"/>				<input type="text" value="0"/>	H5_D2SN2
CT Guided Non-Ablation Procedure	<input type="text" value="0"/>	H5_D1K1	<input type="text" value="0"/>	H5_D1K3	<input type="text" value="0"/>	H5_D1K4
CT Guided Ablation Procedure	<input type="text" value="0"/>	H5_D1L1	<input type="text" value="0"/>	H5_D1L3	<input type="text" value="0"/>	H5_D1L4

CT Utilization Data - Adult Mobile Host Site Services	Mobile CT		Mobile CT		Mobile CT	
ADULT Head CT Scans	1st Route		2nd Route		3rd Route	
Head scans without contrast:	<input type="text" value="0"/>	H5_D1A2A	<input type="text" value="0"/>	H5_D1A2B	<input type="text" value="0"/>	H5_D1A2C
Head scans with contrast:	<input type="text" value="0"/>	H5_D1B2A	<input type="text" value="0"/>	H5_D1B2B	<input type="text" value="0"/>	H5_D1B2C
Head scans without and with contrast:	<input type="text" value="0"/>	H5_D1C2A	<input type="text" value="0"/>	H5_D1C2B	<input type="text" value="0"/>	H5_D1C2C
ADULT Body CT Scans	1st Route		2nd Route		3rd Route	
Body scans without contrast:	<input type="text" value="0"/>	H5_D1D2A	<input type="text" value="0"/>	H5_D1D2B	<input type="text" value="0"/>	H5_D1D2C
Body scans with contrast:	<input type="text" value="0"/>	H5_D1E2A	<input type="text" value="0"/>	H5_D1E2B	<input type="text" value="0"/>	H5_D1E2C
Body scans without and with contrast:	<input type="text" value="0"/>	H5_D1F2A	<input type="text" value="0"/>	H5_D1F2B	<input type="text" value="0"/>	H5_D1F2C
Bundled Body Scans	<input type="text" value="0"/>	H5_D1G2A	<input type="text" value="0"/>	H5_D1G2B	<input type="text" value="0"/>	H5_D1G2C
How many adult special needs bundled body scans reported in the CT scans above?	<input type="text" value="0"/>	H5_D2SNA1	<input type="text" value="0"/>	H5_D2SNA2	<input type="text" value="0"/>	H5_D2SNA3
How many adult special needs for all other scans?	<input type="text" value="0"/>	H5_D3SNA1	<input type="text" value="0"/>	H5_D3SNA2	<input type="text" value="0"/>	H5_D3SNA3
CT Guided Non-Ablation Procedure	<input type="text" value="0"/>	H5_D1H2A	<input type="text" value="0"/>	H5_D1H2B	<input type="text" value="0"/>	H5_D1H2C
CT Guided Ablation Procedure	<input type="text" value="0"/>	H5_D1J2A	<input type="text" value="0"/>	H5_D1J2B	<input type="text" value="0"/>	H5_D1J2C

CT Utilization Data - Pediatric Fixed	Fixed CT		Portable CT		Dedicated Pediatric CT	
PEDIATRIC Head CT Scans						
Head scans without contrast:	<input type="text" value="0"/>	H5_D1M1	<input type="text" value="0"/>	H5_D1M3	<input type="text" value="0"/>	H5_D1M4
Head scans with contrast:	<input type="text" value="0"/>	H5_D1N1	<input type="text" value="0"/>	H5_D1N3	<input type="text" value="0"/>	H5_D1N4
Head scans without and with contrast:	<input type="text" value="0"/>	H5_D1P1	<input type="text" value="0"/>	H5_D1P3	<input type="text" value="0"/>	H5_D1P4
PEDIATRIC Body CT Scans						
Body scans without contrast:	<input type="text" value="0"/>	H5_D1R1	<input type="text" value="0"/>	H5_D1R3	<input type="text" value="0"/>	H5_D1R4
Body scans with contrast:	<input type="text" value="0"/>	H5_D1S1	<input type="text" value="0"/>	H5_D1S3	<input type="text" value="0"/>	H5_D1S4
Body scans without and with contrast:	<input type="text" value="0"/>	H5_D1T1	<input type="text" value="0"/>	H5_D1T3	<input type="text" value="0"/>	H5_D1T4
Bundled Body Scans	<input type="text" value="0"/>	H5_D1U1	<input type="text" value="0"/>	H5_D1U3	<input type="text" value="0"/>	H5_D1U4
How many special needs scans were reported in the pediatric CT scans above?					<input type="text" value="0"/>	H5_D1SNP
CT Guided Non-Ablation Procedure	<input type="text" value="0"/>	H5_D1V1	<input type="text" value="0"/>	H5_D1V3	<input type="text" value="0"/>	H5_D1V4
CT Guided Ablation Procedure	<input type="text" value="0"/>	H5_D1X1	<input type="text" value="0"/>	H5_D1X3	<input type="text" value="0"/>	H5_D1X4

CT Utilization Data - Pediatric Mobile Host Site Services	Mobile CT		Mobile CT		Mobile CT	
PEDIATRIC Head CT Scans	1st Route		2nd Route		3rd Route	
Head scans without contrast:	<input type="text" value="0"/>	H5_D1M2A	<input type="text" value="0"/>	H5_D1M2B	<input type="text" value="0"/>	H5_D1M2C
Head scans with contrast:	<input type="text" value="0"/>	H5_D1N2A	<input type="text" value="0"/>	H5_D1N2B	<input type="text" value="0"/>	H5_D1N2C
Head scans without and with contrast:	<input type="text" value="0"/>	H5_D1P2A	<input type="text" value="0"/>	H5_D1P2B	<input type="text" value="0"/>	H5_D1P2C
PEDIATRIC Body CT Scans	1st Route		2nd Route		3rd Route	
Body scans without contrast:	<input type="text" value="0"/>	H5_D1R2A	<input type="text" value="0"/>	H5_D1R2B	<input type="text" value="0"/>	H5_D1R2C
Body scans with contrast:	<input type="text" value="0"/>	H5_D1S2A	<input type="text" value="0"/>	H5_D1S2B	<input type="text" value="0"/>	H5_D1S2C
Body scans without and with contrast:	<input type="text" value="0"/>	H5_D1T2A	<input type="text" value="0"/>	H5_D1T2B	<input type="text" value="0"/>	H5_D1T2C
Bundled Body Scans	<input type="text" value="0"/>	H5_D1U2A	<input type="text" value="0"/>	H5_D1U2B	<input type="text" value="0"/>	H5_D1U2C
How many special needs scans were reported in the pediatric CT scans above?						

How many special needs scans were reported in the pediatric CT scans above	<input type="text" value="0"/>	H5_D1SNP1	<input type="text" value="0"/>	H5_D1SNP2	<input type="text" value="0"/>	H5_D1SNP3
CT Guided Non-Ablation Procedure	<input type="text" value="0"/>	H5_D1V2A	<input type="text" value="0"/>	H5_D1V2B	<input type="text" value="0"/>	H5_D1V2C
CT Guided Ablation Procedure	<input type="text" value="0"/>	H5_D1X2A	<input type="text" value="0"/>	H5_D1X2B	<input type="text" value="0"/>	H5_D1X2C

CT Volume by Referring Physician (Please see #3 in the instruction section for details.)	
Click the button to the right to download a copy of the physician volume template.	<input type="button" value="Get Template"/>
Click Browse button to select the completed Excel file to be uploaded. (Click the SAVE button at the bottom of the page to upload the Excel file. This is required to submit this Section.)	
Has the CT Volume by Referring Physician file been uploaded? <i>Set to 'D' to delete the Excel file for this facility from the server.</i>	<input type="text" value="N"/> HD_EX01

Terms of Approval and Project Delivery Requirements	
10. Employs or has a contract with a radiation physicist to review the quality and safety of the operation of the CT scanner?	<input type="checkbox"/> HD_TA01
11. Have equipment and supplies to handle clinical emergencies, staff trained in CPR and other appropriate emergency interventions, and a physician on site in or immediately available to the CT scanner at all times when patients are undergoing scans?	<input type="checkbox"/> HD_TA02
12. CT scanner services are available 24 hours a day for emergency patients?	<input type="checkbox"/> HD_TA03
13. Have a formal program of utilization review and quality assurance?	<input type="checkbox"/> HD_TA04
14. If dedicated Pediatric provider, all radiologists, technologists and nursing staff working with CT patients have continuing education or in-service training on pediatric low-dose CT?	<input type="checkbox"/> HD_TA05
15. If dedicated Pediatric provider, have defined low-dose pediatric CT protocols?	<input type="checkbox"/> HD_TA06
16. For facilities receiving mobile services, have a means for patients to enter the vehicle without going outside such as a canopy or an enclosed corridor?	<input type="text"/> HD_TA07
17. Have a communication system between the mobile vehicle and the host facility to provide for immediate notification of emergency medical situations?	<input type="text"/> HD_TA08
18. Number of studies performed using a portable CT on the same patient while that patient is in an ICU.	<input type="text" value="0"/> HD_TA09
19. When was the last date throughout CY 2025 that CT services were provided by this facility/mobile route?	<input type="text" value="MM/DD/20YY"/> HD_TA10

Data Comments for this Section (Optional)
Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:
<div style="border: 1px solid gray; height: 40px; width: 100%;"></div>
HD_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:09:40
By entering an N in the text box and clicking the Save button, you are certifying that further editing or additional information is required to complete the data for this section.	
By entering a Y in the text box and clicking the Submit button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.	
Is the data for this section complete (Y/N)?	<input type="text" value="N"/> HD_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

<input type="button" value="Save"/>	<input type="button" value="Submit"/>	<input type="button" value="Submit"/>	<input type="checkbox"/> Print this section to PDF: <input type="checkbox"/>
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<input type="button" value="Logout"/>	<input type="button" value="Next"/>	<input type="button" value="Browse"/>	<input type="button" value="Feedback"/>	General Info / FAQ
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2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION E: Cardiac Catheterization Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	HE_CNAME
Contact E-mail	HE_CEMAIL
Contact Phone	HE_CPHONE
Contact Fax	HE_CFAX

Instructions:

- Report number of Cardiac Catheterization Laboratories.
- Report each session once in the appropriate category. A session will be reported in the category based on the most complex procedure performed during the session.
- Report appropriate physician credentials. Each physician will be counted once in the physician volume questions.
- The Cardiac Catheterization Volume by Physician excel spreadsheet must be completed by all facilities.

Physician Volume File Instructions
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.
- If a physician credentialed to perform Cardiac Cath procedures does not meet the volume requirement at this facility, then confirm with the physician to determine if the minimum case volume has been reached by including the volume from other facilities where the physician performs Cardiac Cath procedures. If the physician still falls below the required volume, then the physician should not be counted as meeting the required volume and additional explanation should be provided in the data comments.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions: Updated and added the below highlighted definitions

Adult Cardiac Catheterization Service means providing cardiac catheterization services on an organized, regular basis to patients age 18 and above, and for electrophysiology procedures to patients age 15 and older.

Cardiac Catheterization Laboratory (CCL) means an individual radiological room equipped with a variety of x-ray machines and devices such as electronic image intensifiers and digital subtraction units to assist in performing diagnostic or therapeutic cardiac catheterizations or electrophysiology studies.

Cardiac Catheterization Procedures means any cardiac procedure, including diagnostic, therapeutic, and electrophysiology studies performed on a single patient during a single session in a CCL.

Cardiac Catheterization Session means a continuous time period during which a patient may undergo one or more diagnostic or therapeutic cardiac or peripheral procedures in a cardiac catheterization laboratory. The term session applies to both adult and pediatric/congenital catheterizations.

Cardiac Implantable Electronic Device (CIED) means any procedure involving the implantation, revision, relocation, or extraction of a pacemaker or ICD device, except leadless pacemakers. The term also includes all generator changes. The term also includes the insertion, revision, relocation, or extraction of all leads, except for procedures involving leads greater than 12 months old. A facility that provides CIED procedures may also perform right-sided cardiac ablation procedures except ventricular tachycardia ablations.

Complex Therapeutic Session means a continuous time period during which a patient undergoes one or more of the following procedures:

- PCI for chronic total occlusion
- TAVR, mitral/pulmonary/tricuspid valve repair or replacement, paravalvular leak closure

(iii) ablation for atrial fibrillation (AF) or ventricular tachycardia (VT), pacemaker or ICD lead extraction.

Coronary Atherectomy means orbital or rotational atherectomy for calcium modification.

Diagnostic Cardiac Catheterization Procedure includes right heart catheterization, left heart catheterization, coronary angiography, coronary artery bypass graft angiography, intracoronary administration of drugs, fractional flow reserve (FFR), intra-coronary imaging such as intravascular ultrasound (IVUS), optical coherence tomography (OCT), or near-infrared spectroscopy (NIRS) when performed without a therapeutic procedure, intra-cardiac echocardiography, and diagnostic electrophysiology study.

Diagnostic Cardiac Catheterization Service means providing diagnostic cardiac catheterization procedures on an organized, regular basis in a laboratory to diagnose anatomical and/or physiological problems in the heart.

- i. A hospital that has CON approval for diagnostic cardiac catheterization services may also perform CIED procedures.
- ii. A FSOF that has CON approval for diagnostic cardiac catheterization and CIED procedures may also perform CIED procedures.
- iii. A facility that has CON approval for diagnostic cardiac catheterization services may also perform mechanical circulatory support, (e.g., IABP, Impella, etc.) pericardiocentesis, transvenous pacemaker, on an urgent or emergent basis to stabilize a patient.

Diagnostic Cardiac Catheterization Session means a continuous time period during which a patient may undergo one or more diagnostic cardiac catheterization procedures.

Diagnostic Peripheral Procedure includes angiography or hemodynamic measurements in the arterial or venous circulation (excluding the heart).

Diagnostic Peripheral Session means a continuous time period during which a patient may undergo one or more diagnostic peripheral procedures in a cardiac catheterization laboratory.

Elective PCI Services without on-site OHS means performing PCI on an organized, regular basis in a hospital having a diagnostic cardiac catheterization service and a primary PCI service but not having OHS on-site and adhering to patient selection as outlined in the SCAI expert consensus statement on percutaneous coronary intervention without on-site surgical backup (Grines et al, JSCAI Grines, Journal of the Society for Cardiovascular Angiography & Interventions, volume 2, issue 2, 2023) and its update or further guideline changes. A hospital that provides elective PCI without on-site OHS may also perform leadless pacemaker procedures, coronary atherectomy, and cardiac ablation procedures except ventricular tachycardia ablations. A facility that provides elective PCI without on-site OHS may also perform myocardial biopsy only on patients who have undergone a previous heart transplant.

Hybrid Operating Room/Cardiac Catheterization Laboratory means an operating room located on a sterile corridor and equipped with an angiography system performing minimally invasive procedures of the heart and blood vessels with full anesthesia capabilities. A case performed in this room shall be counted only once as either surgical volume in Section G or therapeutic catheterization volume in Section E for the facility.

Pediatric/Congenital Cardiac Catheterization Service means providing cardiac and electrophysiology catheterization services on an organized, regular basis to infants and children ages 18 and below and patients born with congenital heart disease.

Primary PCI Service without on-site OHS means performing primary PCI on an emergent basis in a hospital having a diagnostic cardiac catheterization service. A hospital that provides primary PCI without on-site OHS may also perform leadless pacemaker procedures and cardiac ablation procedures except ventricular tachycardia ablations.

Prolonged Therapeutic Session means cardiac therapeutic sessions that are greater than 6 hours.

Therapeutic Cardiac Catheterization Service means providing therapeutic cardiac catheterizations on an organized, regular basis in a laboratory to treat and resolve anatomical and/or physiological problems in the heart.

Therapeutic Cardiac Catheterization Session may include: cardioMEMS, PCI (elective, emergent), pericardiocentesis, cardiac ablation, structural heart procedures, pacemaker, ICD, lead, generator procedures, or myocardial biopsy. This also includes implantation of a circulatory support device such as IABP, Impella, ECMO or TandemHeart where this is the only therapeutic procedure. when PCI is performed in more than one coronary artery during the same setting, this is counted as one session.

Therapeutic Peripheral Procedure means a therapeutic catheterization procedure to resolve anatomic and/or physiologic problems in the arterial or venous circulation (excluding the heart). Procedures may include percutaneous transluminal angioplasty (PTA), atherectomy, drug eluting balloon, laser, stent implantation, IVC filter implantation or retrieval, catheter-directed ultrasound/thrombolysis, and thrombectomy.

Therapeutic Peripheral Session means a continuous time period during which a patient may undergo one or more therapeutic peripheral procedures in a cardiac catheterization laboratory.

Therapeutic Pediatric/Congenital Cardiac Catheterization Session may include: structural heart procedure (as listed above), pulmonary artery angioplasty/stent implantation, pulmonary valve perforation, angioplasty/stent implantation for aortic coarctation, cardiac ablation, pacemaker/ICD implantation, and PCI.

Cardiac Catheterization Laboratories

1. Number of Adult CCL?	<input type="text" value="0"/>	H7_EA1
2. Number of Adult CCL identified in question 1 above that are Hybrid Operating Room/Cardiac Catheterization Laboratory (as approved by CON)?	<input type="text" value="0"/>	H7_EA1A
3. Number of Dedicated Pediatric/Congenital CCL?	<input type="text" value="0"/>	H7_EA2

Level of Cardiac Catheterization Services:

NOTE: You are providing the facilities reported BMC2 data at this time, however, once the 4th quarter of BMC2 data is returned, updates may need to occur. If the reported Annual Survey data (Q's 6 & 7) have changed, the Facility needs to provide the corrected data for the Department to update.

4. What is the Facility Type?	<input type="text"/>	H7_CCFT
5. Identify the highest level of Cardiac Catheterization Service offered at the facility.	<input type="text"/>	H7_CCS1
6. For Diagnostic with Primary PCI, report the number of Primary PCI sessions reported to BMC2 (Must report even for Therapeutic level)		

even for Therapeutic level).	<input type="text" value="0"/>	H7_CCS2
Calculation Example		
7. For Diagnostic with Elective PCI, report the number of Elective PCI sessions reported to BMC2 (Must report even for Therapeutic level)	<input type="text" value="0"/>	H7_PCI1
Calculation Example		

CARDIAC CATHETERIZATION UTILIZATION DATA - ADULT CCL	No. of Sessions	
8. Diagnostic Cardiac Catheterization Session	<input type="text" value="0"/>	H7_DCCS1
9. Diagnostic Peripheral Session	<input type="text" value="0"/>	H7_DPS1
10. Therapeutic Cardiac Catheterization Session	<input type="text" value="0"/>	H7_TCCS1
11. Therapeutic Peripheral Session	<input type="text" value="0"/>	H7_TPS1
12. Complex Therapeutic Session	<input type="text" value="0"/>	H7_CPVS1
13. Prolonged Therapeutic Session	<input type="text" value="0"/>	H7_PTS1
14. How many of the cardiac catheterization sessions identified in questions 8 - 13 were performed on pediatric age patients (under 18 years for cardiac catheterizations and or under 14 years for age for electrophysiology studies)?	<input type="text" value="0"/>	H7_PCCEP
15. How many adult CIED procedures were performed within those sessions reported in questions 8 - 13?	<input type="text" value="0"/>	H7_CIEDA
16. How many adult right-sided ablation procedures were performed within those sessions reported in questions 8 - 13?	<input type="text" value="0"/>	H7_RSA1
17. How many adult left-sided ablation procedures were performed within those sessions reported in questions 8 - 13?	<input type="text" value="0"/>	H7_LSA1

New questions added to survey, not on PVF

CARDIAC CATHETERIZATION UTILIZATION DATA - DEDICATED PEDIATRIC/CONGENITAL CCL	No. of Sessions	
18. Diagnostic Cardiac Catheterization Session	<input type="text" value="0"/>	H7_DCCS2
19. Diagnostic Peripheral Session	<input type="text" value="0"/>	H7_DPS2
20. Therapeutic Cardiac Catheterization Session	<input type="text" value="0"/>	H7_TCCS2
21. Therapeutic Peripheral Session	<input type="text" value="0"/>	H7_TPS2
22. Complex Therapeutic Session	<input type="text" value="0"/>	H7_CPVS2
23. Prolonged Therapeutic Session	<input type="text" value="0"/>	H7_PTS2
24. How many pediatric/congenital CIED procedures were performed within those sessions reported in questions 18 - 23?	<input type="text" value="0"/>	H7_CIEDP
25. How many pediatric right-sided ablation procedures were performed within those sessions reported in questions 18 - 23?	<input type="text" value="0"/>	H7_RAP1
26. How many pediatric left-sided ablation procedures were performed within those sessions reported in questions 18 - 23?	<input type="text" value="0"/>	H7_LAP1

New questions added to survey, not on PVF

CARDIAC CATHETERIZATION PHYSICIAN VOLUME (Please see #6 in the instructions section for details)	Number of Physicians	
27. Number of physicians credentialed to perform only adult diagnostic cardiac catheterizations.	<input type="text" value="0"/>	H7_E1I1
28. How many physicians did not meet the individual volume requirement of 50 adult diagnostic catheterization sessions involving a left-heart cath or coronary angiography per year?	<input type="text" value="0"/>	H7_E1I2
29. Number of physicians credentialed to perform adult therapeutic cardiac catheterizations.	<input type="text" value="0"/>	H7_E2I1
30. How many physicians did not meet the individual volume requirement of 50 adult therapeutic sessions?	<input type="text" value="0"/>	H7_E3I2
31. Number of physicians credentialed to perform only pediatric/congenital cardiac catheterizations.	<input type="text" value="0"/>	H7_E4I1
32. How many physicians did not meet the individual volume requirement of 50 pediatric/congenital cardiac catheterization sessions?	<input type="text" value="0"/>	H7_E5I2
33. Number of physicians credentialed to perform PCI?	<input type="text" value="0"/>	H7_E5I3
34. How many physicians did not meet the individual requirement of 50 PCI sessions per year?	<input type="text" value="0"/>	H7_E5I4

CARDIAC CATHETERIZATION PHYSICIAN VOLUME - ADDITIONAL PROCEDURES (Please see #6 in the instructions section for details)	Number of Physicians	
35. For FSOF/ ASC only; number of physicians (electrophysiologist) credentialed to perform CIED procedures?	<input type="text" value="0"/>	H7_E515
36. For FSOF/ ASC only; how many physicians credentialed to perform CIED procedures did not perform at least 75 device implants in the previous 24-month period?	<input type="text" value="0"/>	H7_E516
37. Number of physicians credentialed to perform Coronary Atherectomy procedures?	<input type="text" value="0"/>	H7_ECA1
38. How many physicians did not meet the individual requirement of 10 Coronary Atherectomy procedures for Elective PCI Hospitals as the primary operator per year?	<input type="text" value="0"/>	H7_ECA2
39. Number of physicians credentialed to perform Left-Sided Ablations?	<input type="text" value="0"/>	H7_ELA1
40. How many physicians did not meet the individual requirement of 50 adult Left-Sided Ablations for Primary or Elective Hospitals as the primary operator per year?	<input type="text" value="0"/>	H7_ELA2
41. Number physicians credentialed to perform Right-Sided Ablations?	<input type="text" value="0"/>	H7_ERA1
42. How many physicians identified in question 41 did not perform at least 150 Ablations as the primary operator in the previous 24-month period?	<input type="text" value="0"/>	H7_EAB1

Cardiac Catheterization Volume by Physician (Please see #4 in the instruction section for details.)

Click the button to the right to download a copy of the physician volume template.

Click Browse button to select the completed Excel file to be uploaded.
 (Click the **SAVE** button at the bottom of the page to upload the Excel file. This is required to submit this Section.)

Has the Catheterization Volume by Physician file been uploaded? HE_EX01
 Set to 'D' to delete the Excel file for this facility from the server.

Terms of Approval and Project Delivery Requirements For All Cardiac Catheterization Programs

43. Have sufficient medical, nursing, technical and other personnel to permit regular scheduled hours of operation and continuous 24-hour on-call availability?	<input type="checkbox"/>	HE_TA01
44. For dedicated pediatric CCL, have the standardized equipment as defined in the most current American Academy of Pediatrics (AAP) guidelines for pediatric cardiovascular centers?	<input type="checkbox"/>	HE_TA02
45. Have an appropriately trained physician as the director of the cardiac catheterization services who has completed at least 100 cardiac catheterization sessions per year for the last five years?	<input type="checkbox"/>	HE_TA03
46. When was the last date throughout CY 2025 Cardiac Catheterization Services were provided at this facility?	<input type="text" value="MM/DD/20YY"/>	HE_TA07

Terms of Approval and Project Delivery Requirements For Diagnostic Programs with Primary and Elective PCI

47. Is accredited through ACE, ACC, IAC or Corazon?	<input type="text" value=""/>	HE_TA04
48. Participates with BMC2 data registry?	<input type="checkbox"/>	HE_TA05
49. Cardiac catheterization laboratory and collaborative cardiologists-heart surgeon relationship requirements shall conform to all SCAI/ACC Guidelines for PCI including the SCAI/ACC/AHA Expert Consensus Document?	<input type="checkbox"/>	HE_TA06

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HE_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:10:21	Last Updated on 2026-02-17 10:10:21
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By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? HE STATUS

to the data for this section complete (1/17)

RE_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

Save

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2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION F: Megavoltage Radiation Therapy (MRT) Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	<input type="text"/> HF_CNAME
Contact E-mail	<input type="text"/> HF_CEMAIL
Contact Phone	<input type="text"/> HF_CPHONE
Contact Fax	<input type="text"/> HF_CFAX

Instructions:

- Report the number of MRT units by type that were in operation during the survey year.
- Report the number of **treatment visits** completed by treatment type, as defined within the CON Review Standards for MRT Services, on either a non-special MRT or a special MRT unit

Removed ICD 9/10 codes and updated instruction no. 2
- The MRT Volume by Treating Physician excel spreadsheet must be completed by all facilities.

Physician Volume File Instructions
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Course of treatment means the planned series of visits that compose a plan for treatment of one or more cancer sites for a single patient

Dedicated Research MRT unit means a unit approved by the department and a minimum of 70% of MRT treatments are performed for research purposes only

Dedicated stereotactic radiosurgery/stereotactic body radiation therapy (SRS/SBRT) unit means an MRT unit for which more than 90 percent of cases will be treated with radiosurgery and/or SBRT

Gating or Internal Tracking with Beam Hold is the continuous capturing and monitoring of a target, fiducial, or a surrogate that is synchronized with the patient's respiratory or organ motion during radiation treatment with modulation of the radiation beam to deliver radiation more precisely to the target and/or decrease the radiation dose to the surrounding normal tissue

HMRT Unit means a heavy particle accelerator or any other MRT unit operating at an energy level equal to or greater than 30.0 million electron volts (megavolts or MEV)

In-Room Contrast or Tracer Injection is the intravenous injection of a contrast agent or tracer while the patient is in the MRT treatment room and during an MRT treatment visit

In-Room Adaptive Treatment Plan signifies a distinct visit wherein a three-dimensional (3d) dataset is acquired within the MRT treatment room just prior to the commencement of an MRT visit. Said acquired images are subsequently utilized to generate and evaluate an original radiation therapy plan, while the patient remains present within the treatment room. The resultant adaptive treatment plan, regardless of its clinical implementation or the utilization of the standard plan, is required to undergo a documented assessment by a physician prior to the initiation of MRT treatment, for it to be considered and accounted for. MR-Guided real time tracking radiation without adaptive

Isocenter means the virtual point in space about which the MRT unit operates and is placed at the center of the tumor for the delivery of the radiation treatment

Additional Isocenter Isocenter is each additional unique set of treatment beams designed to target one or more additional lesions. There is a maximum of five visits per course of treatment. After the first isocenter, each additional isocenter receives 1.33 equivalent treatment visits

MRT Unit means a CON approved linear accelerator; cobalt unit; or other piece of medical equipment operating at an energy level equal to or greater than 1.0 million electron volts (megavolts or MEV) for the purpose of delivering doses of radiation to patients with cancer, other neoplasms, or cerebrovascular system abnormalities.

Non-Standard Image Guidance is the process of acquiring and utilizing an internal anatomical imaging modality with the objective of guiding images, taking place exclusively within the designated MRT treatment room, as delineated below. The following techniques shall be classified as nonstandard image guidance: 1) 4dct, 2) 3d MR imaging, and 3) 3d gamma-ray imaging. These aforementioned imaging techniques are deemed to fall within the scope of non-standard image guidance. This should take place during an MRT treatment visit

Non-Special MRT Unit means an MRT unit other than an MRT unit meeting the definition of a special purpose MRT unit or an HMRT unit

Patient specific QA for IMRT means verification of radiation delivered dose and/or fluence through physical measurement with a dosimetry phantom and/or detector array in the treatment room

Patient specific QA for SRS/SBRT means verification of radiation delivered dose and/or fluence through physical measurement with a dosimetry phantom and/or detector array in the treatment room

Special Purpose MRT Unit means any of the following types of MRT units: (i) dedicated stereotactic radiosurgery unit, (ii) dedicated total body irradiator (TBI), or (iii) an OR-based IORT unit

Treatment Visit means one patient encounter during which MRT is administered and billed. One treatment visit may involve one or more treatment ports or fields. Each separate encounter by the same patient at different times of the same day shall be counted as a separate treatment visit.

Updated definition

Virtual or Electron Simulation refers to a session prior to the commencement of an MRT course, wherein a patient is positioned within an MRT treatment room in accordance with predetermined treatment parameters, simulating the conditions as if the patient were to undergo a planned treatment, without the actual administration of treatment

Megavoltage Radiation Therapy Units		
1. Number of cobalt units	<input type="text" value="0"/>	H12_FD1A
2. Number linear accelerator (exclude those reported in 3 - 6) units	<input type="text" value="0"/>	H12_FD2A
3. Number of dedicated stereotactic radio-surgery	<input type="text" value="0"/>	H12_FD4A
4. Number of operating room based linear accelerator units	<input type="text" value="0"/>	H12_FD6A
5. Number of dedicated total body irradiator units	<input type="text" value="0"/>	H12_FD7A
6. Number of High Megavoltage Radiation Therapy (HMRT) units	<input type="text" value="0"/>	H12_FD9A
7. Number of Dedicated Research MRT units	<input type="text" value="0"/>	H12_FD10A

Non-Special MRT Unit Utilization Data		
8. Simple	<input type="text" value="0"/>	H11_FA1A
9. Intermediate	<input type="text" value="0"/>	H11_FA2A
10. Complex	<input type="text" value="0"/>	H11_FA3A
11. Intensity Modulated Radiation Therapy (IMRT) - report all courses of IMRT treatments	<input type="text" value="0"/>	H11_FA49T
12. Intensity Modulated Radiation Therapy (IMRT) - report the total number of IMRT treatment visits .	<input type="text" value="0"/>	H11FA49A
13. Total Body Irradiation . [Note: Do not include these treatments within question 10 Complex.]	<input type="text" value="0"/>	H11FA50A
14. Stereotactic radio-surgery/stereotactic body radiation therapy (SRS/SBRT)- report all courses of SRS/SBRT treatment.	<input type="text" value="0"/>	H11FA52A
15. Stereotactic radio-surgery/stereotactic body radiation therapy (SRS/SBRT) – report the total number of SRS/SBRT treatment visits . [Rev. 2019] [*Max. 5 visits per course of treatment].	<input type="text" value="0"/>	H11FA53A
16. Stereotactic radio-surgery/stereotactic body radiation therapy (SRS/SBRT) – report the total number of isocenters for the SRS/SBRT visits reported in 15. [Rev. 2019]	<input type="text" value="0"/>	H11FA54A
17. How many of the visits in this section were for patients less than 5 years of age?	<input type="text" value="0"/>	H11_FAC5
18. How many of the visits in this section were performed with Gating or Internal Tracking with Beam Hold ? [Not to exceed once per visit]	<input type="text" value="0"/>	H11_FGA1
19. How many of the IMRT visits in this section were performed with patient specific QA for IMRT ? [Not to exceed more than twice per course of treatment]	<input type="text" value="0"/>	H11_FA49Q
20. How many of the SRS/SBRT visits in this section were performed with patient specific QA for SRS/SBRT ? [Not to exceed more than twice per course of treatment.]	<input type="text" value="0"/>	H11_FA53Q
21. How many of the visits in this section were performed with Non-Standard Image Guidance ? [not to exceed once per MRT treatment visit]	<input type="text" value="0"/>	H11_FA72A
22. How many of the visits in this section utilized an In-Room Contrast or Tracer Injection ? [not to exceed once per MRT treatment visit]	<input type="text" value="0"/>	H11_FA72B

23. How many of the visits in this section were performed with an In-Room Adaptive Treatment Plan ? [not to exceed once per MHI treatment visit]	<input type="text" value="0"/>	H11_FA72C
24. How many of the visits in this section were performed with Virtual or Electron Simulation ? [not to exceed twice per MRT treatment visit]	<input type="text" value="0"/>	H11_FA72D

Special Purpose MRT Unit Utilization Data		
25. Total Body Irradiation	<input type="text" value="0"/>	H11FA41A
26. Stereotactic radio-surgery/stereotactic body radiation therapy (SRS/SBRT) - report all courses of SRS/SBRT treatment.	<input type="text" value="0"/>	H11FA45A
27. Stereotactic radio-surgery/stereotactic body radiation therapy (SRS/SBRT) – report the total number of SRS/SBRT treatment visits . [Rev. 2019] [*Max. 5 visits per course of treatment].	<input type="text" value="0"/>	H11FA48A
28. Stereotactic radio-surgery/stereotactic body radiation therapy (SRS/SBRT) – report the total number of isocenters for the SRS/SBRT visits reported in 27. [Rev. 2019]	<input type="text" value="0"/>	H11FB48A
29. How many of the visits in this section were for patients less than 5 years of age?	<input type="text" value="0"/>	H11_FAC6
30. How many of the visits in this section were performed with Gating or Internal Tracking with Beam Hold ? [Not to exceed once per visit]	<input type="text" value="0"/>	H11_FGA2
31. How many of the SRS/SBRT visits in this section were performed with patient specific QA for SRS/SBRT ? [Not to exceed more than twice per course of treatment]	<input type="text" value="0"/>	H11_FA48V
32. How many of the visits in this section were performed with Non-Standard Image Guidance ? [Not to exceed once per MRT treatment visit]	<input type="text" value="0"/>	H11_FA73A
33. How many of the visits in this section utilized an In-Room Contrast or Tracer Injection ? [Not to exceed once per MRT treatment visit]	<input type="text" value="0"/>	H11_FA73B
34. How many of the visits in this section were performed with an In-Room Adaptive Treatment Plan ? [Not to exceed once per MRT treatment visit]	<input type="text" value="0"/>	H11_FA73C
35. How many of the visits in this section were performed with Virtual or Electron Simulation ? [Not to exceed twice per MRT treatment visit]	<input type="text" value="0"/>	H11_FA73D

High MRT(HMRT) Unit		
36. HMRT Visits	<input type="text" value="0"/>	H11FA57A
37. How many of the visits in this section were for patients less than 5 years of age?	<input type="text" value="0"/>	H11FA57P

Dedicated Research MRT Unit Utilization Data		
38. Total number of MRT visits completed on the Dedicated Research MRT unit(s).	<input type="text" value="0"/>	H11_DR1
39. Total number of MRT visits performed for research purposes only on the Dedicated Research MRT unit(s).	<input type="text" value="0"/>	H11_DR2

MRT Course of Treatment		
40. Number of individual patients treated	<input type="text" value="0"/>	H12_FC1A
41. Number of Course of treatment	<input type="text" value="0"/>	H12_FC2A

Intraoperative Treatment Visits		
An intraoperative treatment visit (IORT) is defined as a procedure where a dose of megavoltage radiation is delivered to a surgically exposed neoplasm or cancerous organ/site using a dedicated unit.		
42. Enter the number of IORT's performed at your hospital.	<input type="text" value="0"/>	H12_IORT

MRT Simulator Equipment		
43. Identify the number of CT Simulators used in coordination with the MRT unit(s).	<input type="text" value="0"/>	H12_FS1A
44. Identify the number of MRI Simulators used in coordination with MRT unit(s).	<input type="text" value="0"/>	H12_FS2A

MRT Volume by Treating Physician (Please see #3 in the instruction section for details.)		
Click the button to the right to download a copy of the physician volume template.	<input type="button" value="Get Template"/>	
Click Browse button to select the completed Excel file to be uploaded. <i>(Click the SAVE button at the bottom of the page to upload the Excel file. This is required to submit this Section.)</i>		
Has the MRT Volume by Referring Physician file been uploaded? <i>Set to 'D' to delete the Excel file for this facility from the server.</i>	<input type="text" value="N"/>	HF_EX01

Terms of Approval and Project Delivery Requirements

45. Have at least one radiation oncologist immediately available during the operation of the MRT unit(s).	<input type="checkbox"/>	HF_TA01
46. Have staff trained in CPR and other appropriate emergency interventions and on-site in the MRT unit at all times when patients are treated.	<input type="checkbox"/>	HF_TA02
47. Have accreditation by the American College of Surgeons Commission on Cancer, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or the Healthcare Facilities Accreditation Program (HFAP).	<input type="checkbox"/>	HF_TA03
48. Have accreditation by the American College of Radiology/American Society for Radiation Oncology (ACR/ASTRO) or the American College of Radiation Oncology (ACRO).	<input type="checkbox"/>	HF_TA04
49. Have simulation capability at the same location.	<input type="checkbox"/>	HF_TA05
50. When was the last date throughout CY 2025 that MRT services were provided by this facility?	<input type="text" value="MM/DD/20YY"/>	HF_TA06

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HF_COMMENTS

Data Collection Status for this Section **Last Updated on 2026-02-17 10:11:19**

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? HF_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

Print this section to PDF:

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION G: Surgical Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	<input style="width: 80%;" type="text"/> HG_CNAME
Contact E-mail	<input style="width: 80%;" type="text"/> HG_CEMAIL
Contact Phone	<input style="width: 80%;" type="text"/> HG_CPHONE
Contact Fax	<input style="width: 80%;" type="text"/> HG_CFAX

Instructions

1. Report appropriate level of hospital certifications.
2. Report all operating room(s) that were operational during the reporting period only once, and under appropriate dedicated classification.
3. Report all surgical cases and hours by operating room type.
 - a. Open heart and transplant surgery cases and hours will be counted in question 11. The cases also will be reported in the appropriate questions in Sections J and K, respectively.
 - b. Report all obstetrical cases, hours of use, and rooms located in an area primarily designated for obstetrical services only in question 9 and 15.
4. **DO NOT DUPLICATE** any utilization data from Section B (UESWL Services) within Section G (Surgical Services) pursuant to the Surgical Services Review Standards, section 3 subsection (2)(a)(iii).
5. Please note that reporting dedicated endoscopy or cystoscopy room(s) shall serve as notice to the Department. This may result in the facility having to file an application in the future to change from the reported dedicated endoscopy or cystoscopy room(s) to general operating room(s).
6. Report if the facility has met the terms of approval and the project delivery requirements.
 - a. For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - b. If additional explanation of project delivery requirements, please put information in the data comment box at the bottom of this Section.
7. The Surgical Volume by Physician excel spreadsheet must be completed by all facilities.

Physician Volume File Instructions
8. For facilities that perform kidney and pancreas transplant surgeries please enter the number of kidney transplants and number of pancreas transplant surgeries performed at your facility in questions #26 and #27 below.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions: Added new definition and updated definition below

Dedicated Dialysis Access Center means a FSOF or ASC used exclusively for dialysis access cases.

Dedicated Endoscopy or Cystoscopy Operating Room means a room used exclusively for endoscopy or cystoscopy cases.

FSOF/ASC exclusively used for dedicated endoscopy and/or cystoscopy means a health facility licensed under Part 208 of the Code that is constructed and equipped to exclusively perform only outpatient endoscopy or cystoscopy cases, per Section 2 of the Surgical Standards.

FSOF/ASC not exclusively used for dedicated endoscopy and/or cystoscopy means a health facility licensed under Part 208 of the Code that is constructed and equipped to perform outpatient surgical cases within operating rooms located on a sterile corridor that are not exclusively used for endoscopy or cystoscopy cases, per Section 2 of the Surgical Standards.

Hospital Based means a health facility licensed under Part 215 of the Code that is authorized to provide inpatient or outpatient surgery, per Section 2 of the Surgical Standards.

Hospital Burn Care Certification means surgical services provided to burn patients in a licensed hospital site that has been verified as meeting the Guidelines for Developmental and Operation of Burn Center issued by the American Burn Association in March 1988, or equivalent standards for a burn center.

Hospital Trauma Certification means surgical services provided to a trauma patient in a licensed hospital site that has been verified as meeting the standards of the American College of Surgeons for a Level I or Level II trauma center, or equivalent standards.

Hybrid Operating Room/Cardiac Catheterization Laboratory means an operating room located on a sterile corridor and equipped with an angiography system performing minimally invasive procedures of the heart and blood vessels with full anesthesia capabilities. A case performed in this room shall be counted only once as either surgical volume in Section G or therapeutic catheterization volume in Section E for the facility.

Operating room or "OR" means a room in a surgical facility constructed and equipped to perform surgical cases and located on a sterile corridor. The term also includes a room constructed and equipped to perform surgical cases on a nonsterile corridor if the room is located in an FSOF or ASC that is used exclusively for endoscopy or cystoscopy cases. This term does not include procedure rooms.

Procedure room means a room in a surgical facility constructed and equipped to perform surgical procedures and not located on a sterile corridor. Procedures conducted in procedure rooms are not considered surgical cases.

Surgical case means a single visit to an operating room during which one or more surgical procedures are performed in a CON-approved operating room.

Surgical Hours means the time from when the patient enters the operating room until the patient leaves the operating room. Do not count or include pre- or post-operative time.

FACILITY DESIGNATION TYPE	
1. Type of Surgical Services Facility	<input type="text" value="Dedicated Dialysis Access Center"/> H14_SSFT

SURGICAL SERVICES CERTIFICATION	
2. Has Hospital Trauma Certification Level I or II and an exclusively dedicated Operating room or "OR" for trauma care patients? (Y/N)	<input type="checkbox"/> H14_TOR1
3. Has Hospital Trauma Certification Level I or II , but trauma care is provided in non-dedicated Operating room or "OR" ? (Y/N)	<input type="checkbox"/> H14_TOR2
4. Has Hospital Burn Care Certification and an exclusively dedicated Operating room or "OR" for burn care patients? (Y/N)	<input type="checkbox"/> H14_BOR1
5. Has Hospital Burn Care Certification , but burn care is provided in non-dedicated Operating room or "OR" ? (Y/N)	<input type="checkbox"/> H14_BOR2

OPERATING ROOMS (Please don't include volume from room(s) not located on the sterile corridor)	
6. Number of operating rooms located on a sterile corridor (include both inpatient and outpatient ORs). * DO NOT INCLUDE dedicated endoscopy and/or cystoscopy rooms reported under Question 7 or Dedicated Dialysis Access Center rooms reported under Question 8.	<input type="text"/> H14_G1A1
7. Number of Dedicated Endoscopy or Cystoscopy Operating Room located on a sterile corridor.	<input type="text"/> H14_G3B1
8. Number of Dedicated Dialysis Access Center operating rooms located on a sterile corridor. New question added	<input type="text"/> H14_GDA1
9. Number of dedicated Cesarean Section operating room(s) not part of the surgical suite, but on a sterile corridor.	<input type="text" value="0"/> H14_G7A1
10. Number of operating rooms identified in question 6 above that are Hybrid Operating Room/Cardiac Catheterization Laboratory (as approved by CON).	<input type="text" value="0"/> H14_G8A1

SURGICAL SERVICES UTILIZATION DATA	CASES	HOURS
11. For all operating rooms, record only inpatient surgery, including open heart and transplant surgeries. Exclude data reported in questions 13 through 15 below.	<input type="text"/> H14G1A2I	<input type="text" value="0"/> H14G1A3I
12. For all operating rooms record only outpatient surgery. Exclude data reported in questions 13 and 14 below.	<input type="text" value="0"/> H14G1A2O	<input type="text" value="0"/> H14G1A3O
13. For all Dedicated Endoscopy or Cystoscopy Operating Rooms located on a sterile corridor. Report both inpatient and outpatient use.	<input type="text" value="0"/> H14_G3B2	<input type="text" value="0"/> H14_G3B3
14. For all Dedicated Dialysis Access Center operating rooms located on a sterile corridor. Report both inpatient and outpatient use. New question added, also added to PVF	<input type="text"/> H14_G3C2	<input type="text" value="0"/> H14_G3C3
15. Dedicated Cesarean Section operating room(s) not part of the surgical suite, but located on a sterile corridor.	<input type="text" value="0"/> H14_G7A2	<input type="text" value="0"/> H14_G7A3

SERVICE LEVELS	
16. Are the surgical services at this facility offered 24 hours per day, 7 days per week?	<input type="checkbox"/> H14_EMS1
17. Does the facility receive patients via ambulance transport from the scene of an emergency?	<input type="checkbox"/> H14_EMS2

Surgical Volume by Physician (Please see #6 in the instruction section for details.)	
Click the button to the right to download a copy of the physician volume template.	<input type="button" value="Get Template"/>
Click Browse button to select the completed Excel file to be uploaded.	

(Click the **SAVE** button at the bottom of the page to upload the Excel file. This is required to submit this Section.)

Has the Surgical Volume by Physician file been uploaded?
 Set to 'D' to delete the Excel file for this facility from the server.

N

HG_EX01

Terms of Approval and Project Delivery Requirements		
18. Have provisions for handling all types of in-house emergencies, including cardiopulmonary resuscitation.	<input type="checkbox"/>	HG_TA01
19. All surgeons who perform surgery within the facility have admitting privileges or written arrangements with other physicians for patient admissions at a local hospital.	<input type="checkbox"/>	HG_TA02
20. Have an established procedure, including a transfer agreement that provides for the immediate transfer of a patient requiring emergency care beyond the capabilities of the surgical facility to a hospital that is capable of providing the necessary inpatient services and is located within 30 minutes of the surgical facility. Or if no hospital is located within 30 minutes, a transfer agreement with the nearest hospital having such capability.	<input type="checkbox"/>	HG_TA03
21. Have process for credentialing individuals authorized to perform surgery or provide anesthesia services at the surgical facility.	<input type="checkbox"/>	HG_TA04
22. Provide laboratory, diagnostic imaging, pathology and pharmacy (including biologicals) services, either on-site or through contractual arrangements.	<input type="checkbox"/>	HG_TA05
23. Number of credentialed physicians who performed surgery at the facility.	<input type="text"/>	HG_TA06
24. Please list any of the following accreditations the facility maintains: Joint Commission on the Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, or certified by Medicare as an ambulatory surgical center.	<input type="text"/>	HG_TA07
25. When was the last date throughout CY 2025 Surgical Services were provided by this facility?	<input type="text"/>	HG_TA08

Kidney and Pancreas Transplant Utilization Data	CASES	ICD9/ICD10 CM
26. Kidney Transplants	<input type="text" value="0"/> H15_K3G	55.69 & 55.61
27. Pancreas Transplants	<input type="text" value="0"/> H15_K3E	52.80-52.83

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HG_COMMENTS

Data Collection Status for this Section Last Updated on 2026-02-17 09:07:35

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? HG_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

Print this section to PDF:

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No changes to this section from last year

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION H: Emergency Department Services (Hospital sites only)	Next
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Contact information for the person responsible for completing this section: Check here if same as Section A.

Contact Name	<input type="text"/>	HH_CNAME
Contact E-mail	<input type="text"/>	HH_CEMAIL
Contact Phone	<input type="text"/>	HH_CPHONE
Contact Fax	<input type="text"/>	HH_CFAX

Instructions:

- Report the number of ER visits by the age of the patient and type.
- Break the visits reported in question 1 down by diagnosis ICD10 Codes.
[View ICD9 to ICD10 conversion chart](#)
- Report the level of staff in the ER.

Definitions:

Trauma - Please refer to these guidelines when completing the question relating to trauma visits.

Inclusion - all admitted patients with discharge diagnoses ICD-9-CM codes between 800.00 through 959.9. Also includes smoke inhalation - ICD-9-CM code 987.9, AIS 3, 4, and 5; all Emergency Department deaths (including DOAs) and with diagnoses ICD-9-CM codes between 800 through 959.9.

Exclusion - The following are visits that are not to be included under the "trauma" portion of this section; however, they may be counted under another classification.

- All patients seen, treated, and released from the ED or transferred to another facility.
- Drowning with asphyxiation
- Hanging with asphyxiation
- Ingestion without injury
- Foreign body swallowing without injury
- Poisoning unless other associated injury
- Pre-scheduled operations for sports injuries
- Patients with initial presentation > 7 days from injury date, excluding burns
- Drug overdoses
- Elective surgery
- Late effect of injury
- Old fractures
- Pathological fractures

EMERGENCY SERVICES UTILIZATION DATA				
	Adult Visits Age 15 & Older		Pediatric Visits Age 14 & Younger	
1. Number of emergency department visits.	<input type="text" value="0"/>	H17_H1A	<input type="text" value="0"/>	H17_H2A
2. Of those reported in 1, how many were admitted?	<input type="text" value="0"/>	H17_H1B	<input type="text" value="0"/>	H17_H2B

EMERGENCY SERVICES UTILIZATION DATA BY DIAGNOSIS CODE

Report ED patients in the categories below, including patients subsequently admitted.

ED visits are to be recorded in only ONE category.	Adult Visits Age 15 & Older		Pediatric Visits Age 14 & Younger		ICD-9-CM/ICD-10-CM Codes
3. Trauma (admitted patients and ED deaths only-see definition above).	<input type="text" value="0"/>	H18H1A1A	<input type="text" value="0"/>	H18H1A1B	See Definition Above
4. Cardiac.	<input type="text" value="0"/>	H18H1A2A	<input type="text" value="0"/>	H18H1A2B	410.0-415.1 424.1-428.9
5. Obstetric.	<input type="text" value="0"/>	H18H1A3A	<input type="text" value="0"/>	H18H1A3B	630-676.9
6. Psychiatric.	<input type="text" value="0"/>	H18H1A7A	<input type="text" value="0"/>	H18H1A7B	290-302 306-316
7. Asthma.	<input type="text" value="0"/>	H18H1A8C	<input type="text" value="0"/>	H18H1A8D	493.0-493.9
8. Allergy.	<input type="text" value="0"/>	H18H1A8E	<input type="text" value="0"/>	H18H1A8F	287.0, 346.2, 360.19, 370.62, 372.14, 477.0-477.9, 495.2-495.9, 500-508, 518.3, 535.4, 558.9, 597.89, 691.8, 692.5, 692.9, 693.1, 708.0, 716.2, 995.1-995.4, 995.6
9. Chronic Obstructive Pulmonary Disease.	<input type="text" value="0"/>	H18H1A8G	<input type="text" value="0"/>	H18H1A8H	490-492, 496
10. Upper Respiratory Infections.	<input type="text" value="0"/>	H18H1A9A	<input type="text" value="0"/>	H18H1A9B	460-476
11. Diabetes and related conditions.	<input type="text" value="0"/>	H18H1A9C	<input type="text" value="0"/>	H18H1A9D	250.00-250.93
12. Ischemic Stroke.	<input type="text" value="0"/>	H18H1A9E	<input type="text" value="0"/>	H18H1A9F	433.10, 433.x1, 434.00, 434.x1, 430, 431, 435.0-435.9

EMERGENCY SERVICES STAFFING	
13. From the list below enter the number that best describes your Emergency Department staffing (1-7):	<input type="text" value="5"/> H19_H2
1 = Physicians in the Emergency Department on a continuous basis 24 hours per day, 7 days per week. 2 = Physicians in the Emergency Department less than 24 hours per day, 7 days per week but supplemented by physicians on call to provide continuous coverage. 3 = Physicians on call on a continuous basis 24 hours per day, 7 days per week. 4 = Physicians on call less than 24 hours per day, daytime hours only. 5 = Physicians on call less than 24 hours per day, evening hours only. 6 = Physicians on call less than 24 hours per day, night hours only. 7 = Other Staffing Arrangements.	

EMERGENCY SERVICES UTILIZATION DATA – COVID-19	
14. How many patients were brought to the ED with COVID-19 as any part of their diagnosis?	<input type="text" value="0"/> H20_COV1
15. How many patients were admitted through the ED with COVID-19 as any part of their diagnosis?	<input type="text" value="0"/> H20_COV2

Data Comments for this Section (Optional)
Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference: <div style="border: 1px solid gray; height: 100px; width: 100%;"></div>
HH_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:11:37
By entering an N in the text box and clicking the Save button, you are certifying that further editing or additional information is required to complete the data for this section.	
By entering a Y in the text box and clicking the Submit button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.	
Is the data for this section complete (Y/N)?	<input type="text" value="N"/> HH_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for

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2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION J: Open Heart Surgery	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	[Text Input]
Contact E-mail	[Text Input]
Contact Phone	[Text Input]
Contact Fax	[Text Input]
	HJ_CNAME HJ_CEMAIL HJ_CPHONE HJ_CFAX

Instructions

- Report all open heart surgery cases and hours reported to **STS** by patient age and type. These cases also will be reported in the overall surgical volume in the appropriate questions in Section G.
- Report the number of open heart surgery services physicians. If a physician credentialed to perform adult open heart surgery does not meet the volume requirement at this hospital, then confirm with the physician to determine if the minimum case volume has been reached by including the volume from other hospital sites where the physician performs open heart surgical cases. If the surgeon still falls below the required cases volume, then the surgeon should not be counted as meeting the required case volume and additional explanation should be provided in the data comments.
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements, please put information in the data comment box at the bottom of this Section.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Adult Open Heart Surgery means open heart surgery offered and provided to individuals age 15 and older.

Cardiac Surgical Team means the designated specialists and support personnel who consistently work together in the performance of open heart surgery.

Open Heart Surgery means any cardiac surgical procedure involving the heart and/or thoracic great vessels (excluding organ transplantation) that is intended to correct congenital and acquired cardiac and coronary artery disease and/or great vessels and often uses a heart-lung pump (pumps and oxygenates the blood) or its equivalent to perform the functions of circulation during surgery. These procedures may be performed off-pump (beating heart), although a heart-lung pump is still available during the procedure.

Pediatric Open Heart Surgery means open heart surgery offered and provided to infants and children age 14 and below, and to other individuals with congenital heart disease as defined by ICD-9-CM codes of 745.0 through 747.99.

Society of Thoracic Surgeons (STS) means the national database that has been designated for monitoring quality and risk adjusted outcomes for open heart surgery.

Surgical Hours means the time from when the patient enters the operating room until the patient leaves the operating room. Do not count or include pre- or post-operative time.

For guidance only, please see the ICD-9-CM/ICD-10 codes for open heart surgery

[See Hyperlink for ICD-10-CM Codes](#)

[Pediatric and Congenital ICD 9-CM codes 745.0 through 747.99](#)

OPEN HEART SURGERY UTILIZATION DATA	CASES		HOURS	
1. Adult Open Heart Surgery cases reported to STS for patients age 15 and older. (Exclude cases report in 4	0	H16_J4A	0	H16_J4B

below)				
2. Pediatric Open Heart Surgery cases reported to STS for patients age 14 and younger completed at a hospital with a pediatric open heart program.	<input type="text" value="0"/>	H16_J4D1	<input type="text" value="0"/>	H16_J4D1H
3. Pediatric Open Heart Surgery cases reported to STS for patients age 14 and younger completed at a hospital with only an adult open heart program.	<input type="text" value="0"/>	H16_J4D2	<input type="text" value="0"/>	H16_J4D2H
4. Adult Open Heart Surgery cases reported to STS for patients age 15 and older with congenital heart disease defined by ICD-9-CM codes 745.0 - 747.99.	<input type="text" value="0"/>	H16_J4G	<input type="text" value="0"/>	H16_J4GH

OPEN HEART SURGERY SERVICES PHYSICIAN VOLUME				
5. Number of surgeons credentialed by the hospital to perform Adult Open Heart Surgery cases as the attending surgeon?	<input type="text" value="0"/>		<input type="text" value="0"/>	H16_J4I
6. How many of these surgeons are performing less than 50 Adult Open Heart Surgical Cases as the attending surgeon?	<input type="text" value="0"/>	Updated Q.s 5 and 7	<input type="text" value="0"/>	H16_J4J
7. Number of surgeons credentialed by the hospital to perform Pediatric Open Heart Surgery cases as the attending surgeon?	<input type="text" value="0"/>		<input type="text" value="0"/>	H16_J4K

Terms of Approval and Project Delivery Requirements				
8. Participates in the STS National Database and the Michigan Society of Thoracic and Cardiovascular Surgeons (MSTCVS) Quality Collaborative and Database?	<input type="checkbox"/>			HJ_TA01
9. The STS composite star rating for coronary artery bypass graft (CABG)? (If Not Participating or Participating but No Rating was selected, a comment is required in the data comments section below.)	<input type="text"/>			HJ_TA02
10. The STS composite star rating for aortic valve replacement (AVR)? (If Not Participating or Participating but No Rating was selected, a comment is required in the data comments section below.)	<input type="text"/>			HJ_TA03
11. Have the Cardiac Surgical Team available on call for emergency cases 24 hours a day and 7 days a week?	<input type="checkbox"/>			HJ_TA04
12. When was the last date throughout CY 2025 Open Heart Surgery Services were provided by this facility?	<input type="text" value="MM/DD/20YY"/>			HJ_TA05

Data Comments for this Section (Optional)
Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:
<div style="border: 1px solid gray; height: 50px; width: 100%;"></div>
HJ_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:11:59
By entering an N in the text box and clicking the Save button, you are certifying that further editing or additional information is required to complete the data for this section.	
By entering a Y in the text box and clicking the Submit button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.	
Is the data for this section complete (Y/N)?	<input type="text" value="N"/> HJ_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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Print this section to PDF:
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No changes to this section from last year

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION K: Transplant Services (BMT, HLL, and Pancreas)	Next
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Contact information for the person responsible for completing this section: Check here if same as Section A.

Contact Name	<input type="text"/>	HK_CNAME
Contact E-mail	<input type="text"/>	HK_CEMAIL
Contact Phone	<input type="text"/>	HK_CPHONE
Contact Fax	<input type="text"/>	HK_CFAX

Instructions

- Report all transplantation cases by type. These cases also will be reported in the overall surgical volume in the appropriate questions in Section G
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.

Definitions:

Autologous means transplantation in which the donor and recipient are the same individual.

Allogeneic means transplantation between genetically non-identical individuals of the same species

Organ Procurement and Transplantation Network (OPTN) means the organization contracted by the Federal Department of Health and Human Services to operate the Organ Procurement and Transplantation Network.

Organ Procurement Organization (OPO) means an organ procurement organization as defined by CFR Title 42, Part 485.302.

Bone Marrow Transplant Utilization Data	CASES	ICD9/ICD10 CM
1. Autologous Transplants for Ages 0-17	<input type="text" value="0"/>	H15_K2F1 41.01
2. Autologous Transplants for Ages 18-20	<input type="text" value="0"/>	H15_K2F2 41.01
3. Autologous Transplants for Ages: Ages 21 and greater	<input type="text" value="0"/>	H15_K2F3 41.01
4. Allogeneic Transplants for Ages Ages 0-17	<input type="text" value="0"/>	H15_K2F4 41.02 & 41.03
5. Allogeneic Transplants for Ages Ages 18-20	<input type="text" value="0"/>	H15_K2F5 41.02 & 41.03
6. Allogeneic Transplants for Ages Ages 21 and greater	<input type="text" value="0"/>	H15_K2F6 41.02 & 41.03

Heart/Lung and Liver Transplant Utilization Data	CASES	ICD9/ICD10 CM
7. Heart Transplants	<input type="text" value="0"/>	H15_K3A 37.5
8. Heart/Lung Transplants	<input type="text" value="0"/>	H15_K3B 33.6
9. Lung Transplants	<input type="text" value="0"/>	H15_K3C 33.5

10. Liver Transplants	<input type="text" value="0"/>	H15_K3D	50.51 & 50.59
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Pancreas Transplant Utilization Data	CASES	ICD9/ICD10 CM
11. Kidney Transplants	<input type="text" value="0"/>	H15_K3G 55.69 & 55.61
12. Pancreas Transplants	<input type="text" value="0"/>	H15_K3E 52.80-52.83

Terms of Approval and Project Delivery Requirements for Bone Marrow Transplant		
13. Participates in the Michigan Cancer Surveillance Program?	<input type="checkbox"/>	HK_TA01
14. Have accreditation with the National Marrow Donor Program (NMDP) or the Foundation for the Accreditation of Cell Therapy (FACT), identify which organization?	<input type="text"/>	HK_TA02
15. Have a histocompatibility laboratory that meets the standards of the American Society for Histocompatibility and Immunogenetics, or an equivalent organization, either on-site or through written agreement?	<input type="checkbox"/>	HK_TA03

Terms of Approval and Project Delivery Requirements for Heart/Lung and Liver Transplant		
16. Have a histocompatibility laboratory that meets the standards of the American Society for Histocompatibility and Immunogenetics, or an equivalent organization, either on-site or through written agreement?	<input type="checkbox"/>	HK_TA04
17. Have a written transplant agreement with Michigan's federally designated OPO to promote organ donation at the hospital?	<input type="checkbox"/>	HK_TA05
18. Maintains good standing with OPTN ?	<input type="checkbox"/>	HK_TA06
19. Is Medicare approved and complies with Center for Medicare and Medicaid Services standards?	<input type="checkbox"/>	HK_TA07
20. Maintains a multi-disciplinary research program related to the specific transplantation services offered at the facility?	<input type="checkbox"/>	HK_TA08
21. Maintains compliance with MCL Section 333.10101, the Uniform Anatomical Gift Law?	<input type="checkbox"/>	HK_TA09
22. When was the last date throughout CY 2025 Transplant Services were provided by this facility?	<input type="text" value="MM/DD/20YY"/>	HK_TA10

Data Comments for this Section (Optional)
Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:
<input type="text"/>
HK_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:12:50
By entering an N in the text box and clicking the Save button, you are certifying that further editing or additional information is required to complete the data for this section.	
By entering a Y in the text box and clicking the Submit button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.	
Is the data for this section complete (Y/N)?	<input type="checkbox"/> HK_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

<input type="button" value="Save"/>	<input type="button" value="Submit"/>	<input type="checkbox"/> Print this section to PDF: <input type="checkbox"/>
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<input type="button" value="Logout"/>	<input type="button" value="Next"/>	<input type="button" value="Browse"/>	<input type="button" value="Feedback"/>
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General Info / FAQ

Removed NICU beds and questions from this section, no other changes made

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION L: Licensed Inpatient Hospital Beds	Next
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Contact information for the person responsible for completing this section: Check here if same as Section A.

Contact Name	<input type="text"/>	HL_CNAME
Contact E-mail	<input type="text"/>	HL_CEMAIL
Contact Phone	<input type="text"/>	HL_CPHONE
Contact Fax	<input type="text"/>	HL_CFAX

Instructions:

- Report the number of inpatients that were discharged from the hospital during the survey year by bed type. If discharges are not available, please provide the number of admissions by bed type.
- Report the number of inpatient patient days of care by bed type, as defined by the hospital bed standards, provided by the facility during the survey year.
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.
- Discharges/Patient Days of Care from additional Emergency CON Beds approved pursuant to MCL 333.22235 and licensed under a temporary license are not included in the utilization data in Section L.

*** Please note: Neonatal Intensive Care Services (NICU) data has moved to Section Q. ***

Definitions:

Discharges mean the number of inpatients who expire or are released from the hospital.

Hospital Bed means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code, (ii) unlicensed newborn bassinets, and (iii) unlicensed beds.

Medical/Surgical Beds includes intensive care, cardiac care, rehabilitation, acute substance abuse, and tuberculosis beds.

Inpatient Days means the number of days that the licensed beds were occupied by an inpatient.

Bed Types	Discharges**		Inpatient Days	
1. Medical/Surgical	<input type="text"/>	H25_L1D	<input type="text"/>	H25_L1B
2. Pediatrics (include NICU)	<input type="text"/>	H25_L2A6	<input type="text"/>	H25_L2A5
3. Obstetrics	<input type="text"/>	H25_L3D	<input type="text"/>	H25_L3B
4. Swing Beds	<input type="text"/>	H25_L1D1	<input type="text"/>	H25_L1B1
**Discharge counts were unavailable so Admissions were substituted (Y/N).			<input type="text"/>	H25_L1

Terms of Approval and Project Delivery Requirements for Hospital Beds

5. Participates and submitted data to the Michigan Inpatient Data Base?	<input type="checkbox"/>	HL_TA01
6. When was the last date any listed types of Hospital Beds were utilized at this facility throughout CY 2025?	<input type="text" value="MM/DD/20YY"/>	HL_TA06

THIS SECTION IS FOR REFERENCE ONLY

The beds and changes reported reflect information from the Licensing and Certification Division, BHCS, LARA. If you disagree with the information provided, please contact Amanda Curtis at 517-284-4264 or Christopher Tyranski at 517-284-8974.

Number of days the facility was operational during the reporting period			365	H1_A2D
Bed Types	Licensed/Certified Beds		Licensed/Certified Bed Days	
1. Medical/Surgical	10	H25_L1E	3650	H25_L1G
2. Pediatrics	10	H25_L2C5	3650	H25_L2C7
3. Obstetrics	10	H25_L3E	3650	H25_L3G
4. Swing Beds	10	H25_L6E	3650	H25_L6F
Total Acute Care	30	H25_L4E	10950	H25_L4G

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HL_COMMENTS

Data Collection Status for this Section

Last Updated on 2026-02-17 10:16:02

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)?

 HL_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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General Info / FAQ

No changes to this section from last year

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION M: Licensed Psychiatric Beds	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.		
Contact Name	<input type="text"/>	HM_CNAME
Contact E-mail	<input type="text"/>	HM_CEMAIL
Contact Phone	<input type="text"/>	HM_CPHONE
Contact Fax	<input type="text"/>	HM_CFAX

Instructions:

- Report all patient days of care and discharges provided during the calendar year by adult or child/adolescent patients in the Psychiatric Bed Utilization Data box. Days of care and discharges provided in the Flex Bed Unit will be counted in both the total days of care and discharges in the Psychiatric Bed Utilization Data and then it will be broken out in the Flex Bed Utilization Data.
- Report the number of patient days of care and discharges which were for the treatment of the public patient in the Public Patient Utilization Data box.
- Report the number of patient days of care and discharges which were provided in the Flex Bed Unit by adult or child/adolescent patients in the Flex Bed Unit Utilization Data box.
- Report the number of patient days of care and discharges which were provided in the psych special pool bed units, Geriatric, Developmental Disability (adult or child/adolescent patients), Medical Psychiatric (adult or child/adolescent patients), in the appropriate special pool Unit Utilization Data boxes only.
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section
 - If additional explanation of project delivery requirements, please put information in the data comment box at the bottom of this Section.
- Discharges/Patient Days of Care from additional Emergency CON Beds approved pursuant to MCL 333.22235 and licensed under a temporary license are not included in the utilization data in Section M.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Adult means any individual aged 18 years or older

Child/Adolescent means any individual less than 18 years of age.

Community Mental Health Board (CMH) means the board of a county(s) community mental health board as referenced in the provisions of MCL 330.1200 to 330.1246.

Developmental Disability Unit means a unit designed for psychiatric patients (adult or child/adolescent as applicable) who have been diagnosed with a severe, chronic disability as outlined in Section 102, 42 USC 15002, of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) and its update or future guideline changes.

Discharges mean the number of patients who expire or are released from the hospital.

Flex Bed means an adult psychiatric bed converted to a child/adolescent psychiatric bed in an existing child/adolescent psychiatric service to accommodate during peak periods and meet patient demand.

Geriatric Psychiatric Unit means a unit designed for psychiatric patients aged 65 and over.

High Acuity Psychiatric Unit means a distinct psychiatric unit for individuals who are currently exhibiting three or more to a moderate degree or two or more to a severe degree of the following: confusion, irritability, boisterousness, poor impulse control, uncooperativeness, hostility, verbal threats, physical threats, or attacking objects. This term also includes patients who are unwilling or unable to stop attempts of self-harm or suicide or patients who have a history of violence to self or others on an inpatient psychiatric unit.

Medical Psychiatric Unit means a unit designed for psychiatric patients (adult or child/adolescent as applicable) who have also been diagnosed with a medical

comorbidity requiring either: (i) acute medical nursing intervention and monitoring, or (ii) treatment with daily direction or supervision of a physician other than a psychiatrist (e.g., patients who may be on dialysis, require wound care or need intravenous or tube feeding) except as follows:

- (i) A medical psychiatric unit located in a hospital licensed under part 215 of the code, may be used for psychiatric patients not diagnosed with a medical illness up to a maximum of 146 patient days per year per bed pursuant to the limitations detailed in section 9(4)(j).

Patient Days of Care means the number of days the licensed beds were occupied by a patient.

Public patient means an individual approved for mental health services by a CMH or an individual who is admitted as a patient under the Mental Health Code, Act No. 258 of the Public Acts of 1974, being Sections 330.1423, 330.1429, and 330.1438 of the Michigan Compiled Laws.

Psychiatric Bed Utilization Data		
1. Adult Patient Days of Care	<input type="text" value="0"/>	H25_M5A2
2. Adult Discharges	<input type="text" value="0"/>	H25_M5A4
3. Child/Adolescent Patient Days of Care	<input type="text" value="0"/>	H25_M5B2
4. Child/Adolescent Discharges	<input type="text" value="0"/>	H25_M5B4

Public Patient Utilization Data		
5. Adult Patient Days of Care for Public Patient	<input type="text" value="0"/>	HM_PP01
6. Adult Discharges for Public Patients	<input type="text" value="0"/>	HM_PP02
7. Child/Adolescent Patient Days of Care for Public Patients	<input type="text" value="0"/>	HM_PP03
8. Child/Adolescent Discharges for Public Patients	<input type="text" value="0"/>	HM_PP04

Flex Bed Utilization Data		
9. Adult Patient Days of Care in Flex Bed Unit	<input type="text" value="0"/>	HM_FB01
10. Adult Discharges in Flex Bed Unit	<input type="text" value="0"/>	HM_FB02
11. Child/Adolescent Patient Days in Flex Bed Unit	<input type="text" value="0"/>	HM_FB03
12. Child/Adolescent Discharges in Flex Bed Unit	<input type="text" value="0"/>	HM_FB04
13. How many days of the year did the flex bed serve child/adolescent patients?	<input type="text" value="0"/>	HM_FB05

Geriatric Psychiatric Utilization Data (Special Pool Bed Data Only)		
14. Adult Patient Days of Care for Geriatric Psychiatric Unit	<input type="text" value="0"/>	HM_GP01
15. Adult Discharges in Geriatric Psychiatric Unit	<input type="text" value="0"/>	HM_GP02

Medical Psychiatric Utilization Data (Special Pool Bed Data Only)		
16. Adult Patient Days of Care for Medical Psychiatric Unit.	<input type="text" value="0"/>	HM_MP01
17. Adult Patient Days of Care for Medical Psychiatric Unit reported in question 16 above where the patient was not diagnosed with a medical illness.	<input type="text" value="0"/>	HM_MP05
18. Adult Discharges for Medical Psychiatric Unit	<input type="text" value="0"/>	HM_MP02
19. Adult Discharges for Medical Psychiatric Unit reported in question 18 where the patient was not diagnosed with a medical illness.	<input type="text" value="0"/>	HM_MP06
20. Child/Adolescent Patient Days of Care for Medical Psychiatric Unit	<input type="text" value="0"/>	HM_MP03
21. Child/Adolescent Patient Days of Care for Medical Psychiatric Unit reported in question 20 where the patient was not diagnosed with a medical illness.	<input type="text" value="0"/>	HM_MP07
22. Child/Adolescent Discharges for Medical Psychiatric Unit	<input type="text" value="0"/>	HM_MP04
23. Child/Adolescent Discharges for Medical Psychiatric Unit reported in question 22 where the patient was not diagnosed with a medical illness.	<input type="text" value="0"/>	HM_MP08

Developmental Disabilities Psychiatric Utilization Data (Special Pool Bed Data Only)		
24. Adult Patient Days of Care for Developmental Disability Unit	<input type="text" value="0"/>	HM_DD01

25. Adult Discharges for Developmental Disability Unit	<input type="text" value="0"/>	HM_DD02
26. Child/Adolescent Patient Days of Care for Developmental Disability Unit	<input type="text" value="0"/>	HM_DD03
27. Child/Adolescent Discharges for Developmental Disability Unit	<input type="text" value="0"/>	HM_DD04

High Acuity Psychiatric Unit		
28. Adult Patient Days of Care for High Acuity Psychiatric Unit	<input type="text" value="0"/>	HM_HA01
29. Adult Discharges for High Acuity Psychiatric Unit	<input type="text" value="0"/>	HM_HA02
30. Child/Adolescent Patient Days of Care for High Acuity Psychiatric Unit	<input type="text" value="0"/>	HM_HA03
31. Child/Adolescent Discharges for High Acuity Psychiatric Unit	<input type="text" value="0"/>	HM_HA04

Terms of Approval and Project Delivery Requirements for Adult Psychiatric Services		
32. Name the CMH boards that the facility has an active contract with.	<div style="border: 1px solid gray; height: 100px; width: 100%;"></div>	HM_TA01
33. Number of adult psychiatric beds allocated for treatment of public patients.	<input type="text" value="0"/>	HM_TA02
34. When was the last date any listed types of Adult Psychiatric Beds were utilized at this facility throughout CY 2025? <i>(Leave blank if not applicable to facility)</i>	<input type="text" value="MM/DD/20YY"/>	HM_TA15

Terms of Approval and Project Delivery Requirements for Child/Adolescent Psychiatric Services		
35. Number of child/adolescent psychiatric beds allocated for treatment of public patients	<input type="text" value="0"/>	HM_TA03
36. Have a Child/Adolescent Psychiatrist directly employed or available via contract?	<input type="checkbox"/>	HM_TA04
37. Have a Child Psychologist directly employed or available via contract?	<input type="checkbox"/>	HM_TA05
38. Have a Psychiatric Nurse directly employed or available via contract?	<input type="checkbox"/>	HM_TA06
39. Have a Psychiatric Social Worker directly employed or available via contract?	<input type="checkbox"/>	HM_TA07
40. Have an Occupational Therapist or Recreational Therapist directly employed or available via contract?	<input type="checkbox"/>	HM_TA08
41. Have a Pediatrician employed on full time basis or on a consulting basis?	<input type="checkbox"/>	HM_TA09
42. Have a Child Neurologist employed on full time basis or on a consulting basis?	<input type="checkbox"/>	HM_TA10
43. Have a Neuropsychologist employed on full time basis or on a consulting basis?	<input type="checkbox"/>	HM_TA11
44. Have a Speech and Language Therapist employed on full time basis or on a consulting basis?	<input type="checkbox"/>	HM_TA12
45. Have an Audiologist employed on full time basis or on a consulting basis?	<input type="checkbox"/>	HM_TA13
46. Have a Dietician employed on full time basis or on a consulting basis?	<input type="checkbox"/>	HM_TA14
47. When was the last date any listed types of Child/Adolescent Psychiatric Beds were utilized at this facility throughout CY 2025? <i>(Leave blank if not applicable to facility)</i>	<input type="text" value="MM/DD/20YY"/>	HM_TA16

THIS SECTION IS FOR REFERENCE ONLY

The beds and changes reported reflect information from the Licensing and Certification Division, BHCS, LARA. If you disagree with the information provided, please contact Amanda Curtis at 517-284-4264 or Christopher Tyranski at 517-284-8974.

Number of days the facility was operational during the reporting period	<input type="text" value="365"/>	H1_A2D
Bed Types	Licensed/Certified Beds	Licensed/Certified Bed Days
Adult Psychiatric	<input type="text" value="10"/> H25_L5EA	<input type="text" value="3650"/> H25_L5GA
Adult Psychiatric Flex	<input type="text" value="10"/> H25_LF1EA	<input type="text" value="3650"/> H25_LF1GA

Child/Adolescent Psychiatric	<input type="text" value="10"/>	H25_L5EP	<input type="text" value="3650"/>	H25_L5GP
Geriatric Psychiatric (Special Pool Bed Data Only)	<input type="text" value="10"/>	H25_L9EG	<input type="text" value="3650"/>	H25_L9GG
Adult Medical Psychiatric (Special Pool Bed Data Only)	<input type="text" value="10"/>	H25_L10MA	<input type="text" value="3650"/>	H25_L10GA
Child/Adolescent Medical Psychiatric (Special Pool Bed Data Only)	<input type="text" value="10"/>	H25_L10MP	<input type="text" value="3650"/>	H25_L10GP
Adult Developmental Disability Psychiatric (Special Pool Bed Data Only)	<input type="text" value="10"/>	H25_L11DA	<input type="text" value="3650"/>	H25_L11GA
Child/Adolescent Developmental Disability Psychiatric (Special Pool Bed Data Only)	<input type="text" value="10"/>	H25_L11DP	<input type="text" value="3650"/>	H25_L11GP
Adult High Acuity Psychiatric Licensed	<input type="text" value="10"/>	H25_L12A	<input type="text" value="3650"/>	H25_L12P
Child/Adolescent High Acuity Psychiatric Licensed	<input type="text" value="10"/>	H25_L13A	<input type="text" value="3650"/>	H25_L13P

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HM_COMMENTS

Data Collection Status for this Section **Last Updated on 2026-02-17 10:13:51**

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? HM_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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[General Info / FAQ](#)

No changes to this section from last year

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION N: Nursing Home Services / Hospital Long-Term Care Units	Next
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Contact information for the person responsible for completing this section: Check here if same as Section A.

Contact Name	<input type="text"/>	HN_CNAME
Contact E-mail	<input type="text"/>	HN_CEMAIL
Contact Phone	<input type="text"/>	HN_CPHONE
Contact Fax	<input type="text"/>	HN_CFAX

Instructions:

- Report the total actual patient days of care provided by the facility during the survey year.
- Take the number of patient days of care provided in question 1 and break the days down by the age of the patient. All patient days of care must be counted, not just patient days of care for the discharged patients. The Department will be using this data to calculate the facility occupancy rate.
- Total discharges and patient days will automatically sum from the data supplied in the age groups. Verify that the total is accurate for the facility.
- The survey tool will also automatically calculate the average occupancy rate of the facility. Verification will be required prior to submission of this Section.
- Report if the facility has met the terms of approval and the project delivery requirements
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this section.
- Discharges/Patient Days of Care from additional Emergency CON Beds approved pursuant to MCL 333.22235 and licensed under a temporary license are not included in the utilization data in Section N.

Definitions:

Average Occupancy Rate means the percentage which expresses the ratio of the actual number of patient days of care provided at the facility divided by the total number of licensed bed days for the calendar year. Total licensed bed days is calculated by summing the number of licensed and multiplying these beds by the number of days the beds were licensed. [Total Patient Days of Care (HN_2D7)/Total Licensed Bed Days (H25_L7G or H25_L8G)]

Discharges mean the number of patients who expire or are released from the Nursing Home/Hospital Long-Term-Care Unit. Do not count a patient as a discharge, if the patient's bed is held for them while hospitalized and they return to that bed.

Patient Days means the number of days that the licensed beds were occupied by a patient.

Total Patient Days of Care

1. Report the total actual patient days of care provided by the facility. HN_PDC1

Age Group	Patient Days	Discharges**
2. 0 to 64 Years	<input type="text"/>	HN_2D2 <input type="text"/> HN_1D2
3. 65 to 74 Years	<input type="text"/>	HN_2D3 <input type="text"/> HN_1D3
4. 75 to 84 Years	<input type="text"/>	HN_2D4 <input type="text"/> HN_1D4
5. 85 Years and older	<input type="text"/>	HN_2D5 <input type="text"/> HN_1D5
Total	<input type="text"/>	HN_2D7 <input type="text"/> HN_1D7

**Discharge counts were unavailable so Admissions were substituted (Y/N).

H25_L1

Average Occupancy Rate (For Administrative Use Only)

6. Calculated Average Occupancy Rate	<input type="text"/>	HN_OCC1
7. The calculated Average Occupancy Rate in HN_OCC1 above has been certified as accurate. (Populated on Submit)	<input type="text"/>	HN_OCC2

Medicaid and Medicare Utilization

8. Of the total patient days reported in the Age Group box above, how many patient days of care did Medicaid pay for?	<input type="text"/>	HN_MD1
9. Of the total patient days reported in the Age Group box above, how many patient days of care did Medicare pay for?	<input type="text"/>	HN_MA1

Terms of Approval and Project Delivery Requirements

10. How many of the licensed beds at the facility are utilized exclusively for short-term rehab patients?	<input type="text"/>	HN_TA01
11. Identify the culture change models the facility actively participates in from the following: The Eden Alternative, LEAP, The Coaching Approach, Household, Planetree Continuing Care, or Green House	<input type="text"/>	HN_TA02
12. Identify the number of each patient room configuration in the facility as of last day of the survey period		
* Private Rooms	<input type="text"/>	HN_TA03
* Semi-private Rooms	<input type="text"/>	HN_TA04
* 3-Bed Wards	<input type="text"/>	HN_TA05
* 4-Bed Wards	<input type="text"/>	HN_TA06
13. When was the last date throughout CY 2025 Licensed Nursing Home/ LTC Beds were utilized at this facility?	<input type="text" value="MM/DD/20YY"/>	HN_TA07

THIS SECTION IS FOR REFERENCE ONLY

The beds and changes reported reflect information from the Licensing and Certification Division, BHCS, LARA. If you disagree with the information provided, please contact Amanda Curtis at 517-284-4264 or Christopher Tyranski at 517-284-8974.

Number of days the facility was operational during the reporting period	<input type="text" value="365"/>	H1_A2D
Bed Types	Licensed/Certified Beds	Licensed/Certified Bed Days
Hospital Long-Term Care	<input type="text" value="10"/> H25_L7E	<input type="text" value="3650"/> H25_L7G
Nursing Home	<input type="text" value="10"/> H25_L8E	<input type="text" value="3650"/> H25_L8G

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HN_COMMENTS

Data Collection Status for this Section

Last Updated on 2026-02-09 08:47:34

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? HN_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for

Note: A section is not completed until it is selected and submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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No changes to this section from last year

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION O: Special Care Nursery Services	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.		
Contact Name	<input type="text"/>	HO_CNAME
Contact E-mail	<input type="text"/>	HO_CEMAIL
Contact Phone	<input type="text"/>	HO_CPHONE
Contact Fax	<input type="text"/>	HO_CFAX

Instructions

- Report all of the live births at the hospital, the number of neonates transferred to another hospital, patient days of care and discharges of the neonates treated during the calendar year in **Special Care Nursery Services** beds in the SCN Utilization Data box.
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements, please put information in the data comment box at the bottom of this Section.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Discharges mean the number of neonates who expire or are released from the hospital.

Live Birth means a birth for which a birth certificate for a live birth has been prepared and filed pursuant to Section 333.2821(2) of the Michigan Compiled Laws.

Neonate means an individual up to 28 days of age.

Patient Days means the number of days that the SCN beds were occupied by a neonate.

Special Care Nursery Services or SCN Services means provisions of services for infants with problems that are expected to resolve rapidly and who would not be anticipated to need subspecialty services on an urgent basis. These services are:

- Care for infants born greater than or equal to 32 weeks gestation and/or weighing greater than or equal to 1,500 grams;
- Enteral tube feedings;
- Cardio-respiratory monitoring to document maturity of respiratory control or treatment of apnea;
- Extended care following an admission to a neonatal intensive care unit for an infant not requiring ventilatory support;
- Continuous positive airway pressure and high flow nasal (HFNC); and
- Mechanical ventilation for a brief duration (up to 24 hours)

For babies requiring mechanical ventilation exceeding 24 hours, SCNs shall request transfer to a NICU by the 24th hour of mechanical ventilation. Referral to a higher level of care should also occur for all infants who need pediatric surgical or medical subspecialty intervention. Infants receiving transitional care or being treated for developmental maturation may have formerly been treated in a neonatal intensive care unit in the same hospital or another hospital. For purposes of these standards, SCN Services are special newborn nursing services.

Telemedicine means the use of an electronic media to link patients with health care professionals in different locations.

Well Newborn Nursery Services means providing the following services and does not require a certificate of need:

- The capability to perform neonatal resuscitation at every delivery;
- Evaluate and provide postnatal care for stable term newborn infants;
- Stabilize and provide care for infants born at 35 to 37 weeks' gestation who remain physiologically stable;
- Stabilize newborn infants who are ill and those born less than 35 weeks of gestation until they can be transferred to a higher level of care facility.

SCN Utilization Data:

1. Number of Live Births by gestational age at the time of birth for the hospital.		
Less than 32 weeks	<input type="text" value="0"/>	HO_LB01
32 weeks to 34 6/7 weeks	<input type="text" value="0"/>	HO_LB02
35 weeks or greater	<input type="text" value="0"/>	HO_LB03
2. Of the Live Births reported in number 1, identify the number of Neonates that were transferred to another hospital for NICU services by gestational age at the time of birth.		
Less than 32 weeks	<input type="text" value="0"/>	HO_NE01
32 weeks to 34 6/7 weeks	<input type="text" value="0"/>	HO_NE02
35 weeks or greater	<input type="text" value="0"/>	HO_NE03
3. Of the Neonates transferred to another hospital for NICU services reported in number 2, break the Neonates down by the age of the Neonate in hours at the time of transfer.		
0 to 6 hours	<input type="text" value="0"/>	HO_NT01
7 to 12 hours	<input type="text" value="0"/>	HO_NT02
13 to 24 hours	<input type="text" value="0"/>	HO_NT03
25 to 48 hours	<input type="text" value="0"/>	HO_NT04
49 hours or above	<input type="text" value="0"/>	HO_NT05
4. Of the Live Births reported in number 1, how many neonates were treated and/or observed as a SCN patient?	<input type="text" value="0"/>	HO_SC01
5. Of the treated Neonates reported in number 4, how many received more than 24 hours of mechanical ventilation? [If the answer is more than 0, provide a comment in Data Comment Section below.]	<input type="text" value="0"/>	HO_SC02
6. Of the treated Neonates reported in number 4, how many received high flow nasal cannula?	<input type="text" value="0"/>	HO_SC08
7. Of the treated Neonates reported in number 4, how many received continuous positive airway pressure?	<input type="text" value="0"/>	HO_SC09
8. Of the treated Neonates reported in number 4, how many received enteral tube feedings?	<input type="text" value="0"/>	HO_SC03
9. Of the treated Neonates reported in number 4, how many received cardio-respiratory monitoring to document maturity of respiratory control or the treatment of sleep apnea?	<input type="text" value="0"/>	HO_SC04
10. Number of SCN bassinets on December 31, 2025	<input type="text" value="0"/>	HO_SC05
11. Number of SCN Patient Days of Care.	<input type="text" value="0"/>	HO_SC06
12. Number of SCN Discharges .	<input type="text" value="0"/>	HO_SC07

Terms of Approval and Project Delivery Requirements		
13. Have an established discharge planning process for SCN patients?	<input type="checkbox"/>	HO_TA01
14. Of the treated Neonates reported in number 4, identify the number of Neonates with the following conditions.		
A. Grade 3 or 4 intraventricular hemorrhage	<input type="text" value="0"/>	HO_TA02
B. Stage 3 or 4 retinopathy of prematurity	<input type="text" value="0"/>	HO_TA03
C. Chronic lung disease with oxygen dependency at 36 weeks gestation	<input type="text" value="0"/>	HO_TA04
D. Necrotizing enterocolitis	<input type="text" value="0"/>	HO_TA05
E. Pneumothorax	<input type="text" value="0"/>	HO_TA06
15. Have a board certified neonatologist serving as the program director?	<input type="checkbox"/>	HO_TA07
16. Have respiratory therapists, radiology technicians, laboratory technicians and specialized nurses with experience caring for premature infants?	<input type="checkbox"/>	HO_TA09
17. Have provisions for Physician Consultation Services related to cardiology, ophthalmology, surgery and neurosurgery?	<input type="text" value=""/>	HO_TA10
18. Have pediatric physicians and/or neonatal nurse practitioners?	<input type="text" value=""/>	HO_TA08

19. How many Neonatal Nurse Practitioners are utilized within the SCN unit(s)?	<input type="text" value="0"/>	HO_TA11
20. When was the last date throughout CY 2025 Special Newborn Nursery Services were provided at this facility?	<input type="text" value="MM/DD/20YY"/>	HO_TA12

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HO_COMMENTS

Data Collection Status for this Section **Last Updated on 2026-02-17 10:14:53**

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)? HO_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

Print this section to PDF:

General Info / FAQ

No changes to this section from last year

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION P: Positron Emission Tomography (PET) Services Next

Contact information for the person responsible for completing this section: Check here if same as Section A.

Contact Name	<input type="text"/>	HP_CNAME
Contact E-mail	<input type="text"/>	HP_CEMAIL
Contact Phone	<input type="text"/>	HP_CPHONE
Contact Fax	<input type="text"/>	HP_CFAX

Instructions:

- Report the data as outlined below for the type of service offered. Report only scanner(s) that were operational during the reporting period, do not include scanner(s) that are approved but not yet operational:
 - Fixed PET scanner - Report the number of scanner(s) by type and the number of scans completed on each fixed PET scanner by scan type.
 - Central Service Coordinator of PET mobile route - Report the number of scanner(s) and the number of scans completed by scan type.
 - Host Site- Report the mobile route number(s) and the scans completed by each mobile route(s) separately by scan type.
- Report the number of diagnostic CT scans performed on PET/CT that were not done in conjunction with a PET scan.
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all of the requirements in the question, please answer Yes. If the facility has not met all of the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is necessary, please put information in the data comment box at the bottom of this Section.
- Within the dedicated research section, report all PET scans performed on the dedicated research PET scanner.
- Within the dedicated pediatric section, report all PET scans performed on the dedicated pediatric PET scanner.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Central Service Coordinator (CSC) means the organization that owns the mobile equipment and had operational responsibilities for the equipment.

Complex Scan means inpatient, radiation treatment when patient position device is used, cardiac rest/stress perfusion and metabolism, standard study with additional limited scan, pediatric, and total body scans.

Dedicated Pediatric PET Scanner means a scanner approved by the department and a minimum of 70% of PET scans are performed on patients 18 years of age and younger.

Dedicated Research PET Scanner means a scanner approved by the department and a minimum of 70% of PET scans are performed for research purposes only.

Host Site means a facility approved to offer the service at that site through a contract with the Central Service Coordinator which owns the mobile equipment.

Positron Emission Mammography (PEM) Scanner means a scanner dedicated to performing PET mammography scans.

Scan means one (1) or more PET procedures performed during a single patient visit.

Simple Scan means brain or single cardiac scans.

Standard Scan means mid-skull to mid-light scans.

PET Equipment and Mobile Services		
Type of PET scanner and mobile services		
1. Number of fixed PET scanners (exclude dedicated research, dedicated pediatric, and PEM scanners).	<input type="text" value="0"/>	HP_1A

2. Number of fixed Dedicated Research PET Scanner(s) .	<input type="text" value="0"/>	HP_1B
3. Number of fixed Dedicated Pediatric PET Scanner(s) .	<input type="text" value="0"/>	HP_1C
4. Number of fixed PEM scanner(s) .	<input type="text" value="0"/>	HP_1D
5. Number of mobile PET scanner(s) (CSC operators only).	<input type="text" value="0"/>	HP_2
6. If PET service is provided by mobile PET routes, enter all of the mobile route numbers that provided service to your facility (CSC and Host Sites):		
1st Route #	<input type="text" value="Select one..."/>	HP_2A
2nd Route #	<input type="text" value="Select one..."/>	HP_2B
3rd Route #	<input type="text" value="Select one..."/>	HP_2C
7. Total number of diagnostic CT scans performed on a PET/CT scanner not done in conjunction with a PET scan.	<input type="text" value="0"/>	HP_3D1
8. Total number of diagnostic MRI scans performed on a PET/MRI scanner not done in conjunction with a PET scan?	<input type="text" value="0"/>	HP_3D2

Dedicated Pediatric and Dedicated Research PET Scan Data		
9. Total number of PET scans performed for research purposes only on the Dedicated Research PET Scanner(s).	<input type="text" value="0"/>	HP_RS4
10. Total number of PET scans on patients under 18 years of age performed on the Dedicated Pediatric PET Scanner(s).	<input type="text" value="0"/>	HP_DP4

PET Utilization Data - Fixed Scanners								
Scan Type	Fixed		Dedicated Research		Dedicated Pediatric		PEM Scanner	
Simple	<input type="text" value="0"/>	H3_FS1	<input type="text" value="0"/>	H3_RS1	<input type="text" value="0"/>	H3_DP1	<input type="text" value="0"/>	H3_PEM1
Standard	<input type="text" value="0"/>	H3_FS2	<input type="text" value="0"/>	H3_RS2	<input type="text" value="0"/>	H3_DP2	<input type="text" value="0"/>	H3_PEM2
Complex	<input type="text" value="0"/>	H3_FS3	<input type="text" value="0"/>	H3_RS3	<input type="text" value="0"/>	H3_DP3	<input type="text" value="0"/>	H3_PEM3

PET Utilization Data - Mobile Services								
Scan Type	CSC		Host Site - 1st Route		Host Site - 2nd Route		Host Site - 3rd Route	
Simple	<input type="text" value="0"/>	H3_CSC1	<input type="text" value="0"/>	H3_1M1	<input type="text" value="0"/>	H3_2M1	<input type="text" value="0"/>	H3_3M1
Standard	<input type="text" value="0"/>	H3_CSC2	<input type="text" value="0"/>	H3_1M2	<input type="text" value="0"/>	H3_2M2	<input type="text" value="0"/>	H3_3M2
Complex	<input type="text" value="0"/>	H3_CSC3	<input type="text" value="0"/>	H3_1M3	<input type="text" value="0"/>	H3_2M3	<input type="text" value="0"/>	H3_3M3

Terms of Approval and Project Delivery Requirements		
11. Have on-site source of radiopharmaceuticals or a contract for a reliable supply of radiopharmaceuticals?	<input type="checkbox"/>	HP_TA01
12. Have on-site services or contract(s) with a hospital(s) within same planning area or 25-mile radius for each of the following services: nuclear medicine services as documented by a certificate from the US Nuclear Regulatory Commission, single photon emission computed tomography (SPECT) services, computed tomography (CT) scanning services, magnetic resonance imaging (MRI) services, cardiac catheterization services, open heart surgery, thoracic surgery, cardiology, oncology, radiation oncology, neurology, neurosurgery, and psychiatry?	<input type="checkbox"/>	HP_TA02
13. Have a physicist who is board certified or eligible for certification by the American Board of Radiology or an equivalent organization?	<input type="checkbox"/>	HP_TA03
14. Have a physician on-site or immediately available to the PET scanner service at all times when patients are undergoing PET procedures?	<input type="checkbox"/>	HP_TA04
15. For facilities receiving mobile services, have a means for patients to enter the vehicle without going outside such as a canopy or an enclosed corridor?	<input type="text" value=""/>	HP_TA05
16. When was the last date throughout CY 2025 PET Services were provided at this facility?	<input type="text" value="MM/DD/20YY"/>	HP_TA06

Data Comments for this Section (Optional)
Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:
<input type="text" value=""/>

HP_COMMENTS

Data Collection Status for this Section

Last Updated on 2026-02-17 10:15:24

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

By entering a **Y** in the text box and clicking the **Submit** button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.

Is the data for this section complete (Y/N)?

N

HP_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.

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New Section Added

2025 Michigan Certificate of Need Annual Survey

[Admin]	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Facility Filter
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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION Q: Neonatal Intensive Care Services (NICU)	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	HQ_CNAME
Contact E-mail	HQ_CEMAIL
Contact Phone	HQ_CPHONE
Contact Fax	HQ_CFAX

Instructions:

- Report the total number of inpatients that were discharged from the hospital's licensed NICU during the survey year. If discharges are not available, please provide the number of admissions.
- Report the total number of inpatient patient days of care from the hospital's licensed NICU, as defined by the Hospital Bed and NICU CON Standards, provided by the facility during the survey year.
- For question 1, report inpatient days of care and discharges only for Neonates receiving care in a licensed NICU bed.
- For questions 2-5, report the total inpatient days and total number of Neonates treated. All inpatient days reported within question 2-5 should equal the total inpatient days reported in question 1.
- Report how many Neonates met each category of the NICU services definition during the calendar year in the NICU Utilization Data box. (Please note: if a Neonate received more than one itemized service during their stay in the NICU, please select all that apply for a single Neonate.)
- Report if the facility has met the terms of approval and the project delivery requirements.
 - For Yes/No questions, if the facility has met all the requirements in the question, please answer Yes. If the facility has not met all the requirements in the question, please answer No and explain why not in the data comment box at the bottom of this Section.
 - If additional explanation of project delivery requirements is needed, please put information in the data comment box at the bottom of this Section.

Hover mouse cursor over word or phrase in **bold** to view definitions.

Definitions:

Discharges mean the number of inpatients who expire or are released from the hospital's NICU.

Hospital Bed means a bed within the licensed bed complement at a licensed site of a hospital licensed under Part 215 of the Code, excluding (i) hospital beds certified for long-term care as defined in Section 20106(6) of the Code, (ii) unlicensed newborn bassinets, and (iii) unlicensed beds.

Inpatient Days means the number of days that the licensed beds were occupied by an inpatient.

Live Births means a birth for which a birth certificate for a live birth has been prepared and filed pursuant to Section 333.2821(2) of the Michigan Compiled Laws.

Neonatal Intensive Care Unit or NICU means a specially designed, equipped, and staffed unit of a hospital which is both capable of providing Neonatal Intensive Care Services and is composed of licensed s designated as NICU. This term does not include unlicensed SCN beds.

Neonatal Intensive Care Services or NICU Services or NICU means the provision of any of the following services:

- Constant nursing care and continuous cardiopulmonary and other support services for severely ill infants
- Care for neonates weighing less than 1,500 grams at birth, and/or less than 32 weeks gestation
- Ventilatory support beyond that needed for immediate ventilatory stabilization
- Surgery and post-operative care during the neonatal period
- Pharmacologic stabilization of heart rate and blood pressure
- Total parenteral nutrition

Neonate means an individual up to 28 days of age

neonates means an individual up to 28 days of age.

Special Care Nursery Services or SCN Services or SCN means provisions of services for infants with problems that are expected to resolve rapidly and who would not be anticipated to need subspecialty services on an urgent basis. These services are:

- Care for infants born greater than or equal to 32 weeks gestation and/or weighing greater than or equal to 1,500 grams;
- Enteral tube feedings;
- Cardio-respiratory monitoring to document maturity of respiratory control or treatment of apnea;
- Extended care following an admission to a neonatal intensive care unit for an infant not requiring ventilatory support;
- Continuous positive airway pressure and high flow nasal (HFNC); and
- Mechanical ventilation for a brief duration (up to 24 hours)

For babies requiring mechanical ventilation exceeding 24 hours, SCNs shall request transfer to a NICU by the 24th hour of mechanical ventilation. Referral to a higher level of care should also occur for all infants who need pediatric surgical or medical subspecialty intervention. Infants receiving transitional care or being treated for developmental maturation may have formerly been treated in a neonatal intensive care unit in the same hospital or another hospital. For purposes of these standards, SCN Services are special newborn nursing services.

Bed Type	Discharges**	Inpatient Days	
1. NICU	<input type="text" value="0"/>	H25_L2B4	<input type="text" value="0"/>
			H25_L2B2
**Discharge counts were unavailable so Admissions were substituted (Y/N).			<input type="text"/>
			Q25_L1

Licensed NICU Beds and Number of Neonates

Break down the Total **Inpatient Days** and Total number of **Neonates** treated for Questions 2 – 5. Total **Inpatient Days** should equal Q1.

Example: A **Neonate** was admitted to **NICU** at **NICU** level and received **NICU Service** for 5 days, then the **Neonate** was determined to be **SCN** level and received **SCN Service** for 3 more days in the **NICU**, after that the **Neonate** was determined to be well-newborn and received service for 2 more days in the **NICU**; for Q2 report 5 days and 1 **Neonate**, for Q3 report 3 days and 1 **Neonate**, for Q4 report 0 days and 0 **Neonate**, and for Q5 report 2 days and 1 **Neonate**; and for Q1, report total of 10 days for this **Neonate** and 1 discharge.

Licensed NICU Beds Only (Questions 2-5)	Inpatient Days		Number of Neonates	
2. Report the number of Inpatient Days and number of Neonates treated who meet the definition of the NICU Services as above.	<input type="text" value="0"/>	HQ_IPD1	<input type="text" value="0"/>	HQ_NN1
3. Report the number of Inpatient Days and number of Neonates treated who meet the definition of the SCN Services as above but was initially admitted as NICU patient.	<input type="text" value="0"/>	HQ_IPD2	<input type="text" value="0"/>	HQ_NN2
4. Report the number of Inpatient Days and number of Neonates treated who meet the definition of the SCN Services as above but were not initially admitted as NICU patient.	<input type="text" value="0"/>	HQ_IPD3	<input type="text" value="0"/>	HQ_NN3
5. Report the number of Inpatient Days and number of Neonates treated for all other Neonates who do not meet either the NICU Services or the SCN Services definition as above.	<input type="text" value="0"/>	HQ_IPD4	<input type="text" value="0"/>	HQ_NN4
TOTAL	<input type="text" value="0"/>	HQ_IPDT	<input type="text" value="0"/>	HQ_NNT
6. Does the hospital operate a separate unlicensed SCN unit with unlicensed SCN bassinets that is separate from the NICU ? Note: If you answered Y, please complete Survey Section O – Special Care Nursery Services.	<input type="text"/>		<input type="text"/>	HQ_SCN1

NICU Utilization Data

7. Number of **Live Births** by gestational age at the time of birth for the hospital.

Less than 32 weeks	<input type="text" value="0"/>	HQ_LB1
32 weeks to 34 6/7 weeks	<input type="text" value="0"/>	HQ_LB2
35 weeks or greater	<input type="text" value="0"/>	HQ_LB3
8. Of the Live Births reported in number 7, how many Neonates were treated as a NICU patient as defined above in the licensed NICU ?	<input type="text" value="0"/>	HQ_LBN1
9. Of the Live Births reported in number 7, how many Neonates were treated as a SCN patient as defined above in the licensed NICU ?	<input type="text" value="0"/>	HQ_LBN2
10. Of the Live Births reported in number 7, how many Neonates were treated for services not defined as NICU or SCN as defined above in the licensed NICU ?	<input type="text" value="0"/>	HQ_LBN3
11. Of the Live Births reported in number 7, how many Neonates required constant nursing care and continuous cardiopulmonary and other support services for severely ill infants?	<input type="text" value="0"/>	HQ_LBN4
12. Of the Live Births reported in number 7, how many patients were Neonates weighing less than 1,500 grams at birth, and/or less than 32 weeks gestation?	<input type="text" value="0"/>	HQ_LBN5
13. Of the Live Births reported in number 7, how many Neonates required ventilatory support beyond that needed for immediate ventilatory stabilization?	<input type="text" value="0"/>	HQ_LBN6
14. Of the Live Births reported in number 7, how many Neonates required surgery and post-operative care during the neonatal period?	<input type="text" value="0"/>	HQ_LBN7
15. Of the Live Births reported in number 7, how many Neonates required pharmacologic stabilization of heart rate and blood pressure?	<input type="text" value="0"/>	HQ_LBN8

16. Of the **Live Births** reported in number 7, how many **Neonates** required total parenteral nutrition? HQ_LBN9

Terms of Approval and Project Delivery Requirements for NICU Beds		
17. Have a follow up program for NICU graduates?	<input type="checkbox"/>	HL_TA02
18. Have a neonatal transport system?	<input type="checkbox"/>	HL_TA03
19. The director of neonatal services is a board certified neonatologist?	<input type="checkbox"/>	HL_TA04
20. Have provisions for on-site physician consultation services in at least the following neonatal/pediatric specialties Cardiology, ophthalmology, surgery and neurosurgery?	<input type="checkbox"/>	HL_TA05
21. How many Neonatal Nurse Practitioners are utilized within the NICU unit(s)?	<input type="text" value="0"/>	HL_TA07
22. When was the last date any listed types of NICU Beds were utilized at this facility throughout CY 2025? (Leave blank if not applicable to facility)	<input type="text" value="MM/DD/20YY"/>	HL_TA08

THIS SECTION IS FOR REFERENCE ONLY				
The beds and changes reported reflect information from the Licensing and Certification Division, BHCS, LARA. If you disagree with the information provided, please contact Amanda Curtis at 517-284-4264 or Christopher Tyranski at 517-284-8974.				
Number of days the facility was operational during the reporting period			<input type="text" value="365"/>	H1_A2D
Bed Types	Licensed/Certified Beds	Licensed/Certified Bed Days		
1. NICU	<input type="text" value="10"/>	H25_L2B5	<input type="text" value="3650"/>	H25_L2B7

Data Comments for this Section (Optional)

Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:

HQ_COMMENTS

Data Collection Status for this Section Last Updated on 2026-02-17 10:16:02

By entering an **N** in the text box and clicking the **Save** button, you are certifying that further editing or additional information is required to complete the data for this section.

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Is the data for this section complete (Y/N)? HQ_STATUS

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Print this section to PDF:

General Info / FAQ

No changes to this section from last year

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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION S: Special Research Questions	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	<input type="text"/> HS_CNAME
Contact E-mail	<input type="text"/> HS_CEMAIL
Contact Phone	<input type="text"/> HS_CPHONE
Contact Fax	<input type="text"/> HS_CFAX

Instructions:
Report the emergency room data if available. If the data is not available, please leave data fields blank and submit this section. Submitting data within this section is voluntary. However, the page will still need to be submitted in order to complete the Annual Survey.

Traumatic Amputations (to be completed on only ER patients and services)	
Do you have data for questions 1 or 2 that you wish to report?	<input type="checkbox"/> HS_NATA
1. How many ED visits had a principal diagnosis code of 885-887 and 895-897? ICD9/ICD10	
Number of ED visits with specified diagnosis codes.	<input type="text" value="0"/> HS_1A
2. Of the visits above, how many had a payer source of workers compensation?	
Number of those visits with a workers compensation payer.	<input type="text" value="0"/> HS_2A

Sickle Cell Disease (to be completed on only ER patients and services)	
Do you have data for questions 3-5 that you wish to report?	<input type="checkbox"/> HS_NASC
3. How many ED claims for hemoglobinopathies [sickle cell disease (SCD), thalassemia, etc.] were there during the reporting period (ICD-9 coding: Sickle cell disease = 282.6x, Thalassemia = 282.4x, and hemoglobinopathy = 282.7x)?	
	<input type="text" value="0"/> HS_3A
4. How many unique hemoglobinopathy patients were seen in the ED during the reporting period?	
	<input type="text" value="0"/> HS_3B
5. Does the ED have a protocol for Sickle Cell Disease (SCD) patients (Y/N)?	
	<input type="checkbox"/> HS_5YN

Cancer Care (to be completed on hospital wide services)	
Do you have data questions 6-8 that you wish to report?	<input type="checkbox"/> HS_NACC
6. Do you have a patient navigator or nurse navigator on staff providing navigation services?	
	<input type="checkbox"/> HS_6YN
If yes, please provide:	
Staff Name	<input type="text"/> HS_NNAME
Email Address	<input type="text"/> HS_EMAIL
7. Do you provide treatment summaries to cancer patients at the end of their treatment?	
	<input type="checkbox"/> HS_7YN
8. Do you provide survivorship care plans to cancer patients at the end of treatment?	
	<input type="checkbox"/> HS_8YN

OB Services (to be completed by hospitals)			
Do you have data questions 9 or 10 that you wish to report?		<input type="checkbox"/>	HS_NAOB
9. Does the hospital offer OB services?		<input type="checkbox"/>	HS_9A
10. If yes, report the number of live births by gestational age at the time of birth:			
	32 weeks or less	<input type="text" value="0"/>	HS_10A
	33 weeks	<input type="text" value="0"/>	HS_10B
	34 weeks	<input type="text" value="0"/>	HS_10C
	35 weeks	<input type="text" value="0"/>	HS_10D
	36 weeks	<input type="text" value="0"/>	HS_10E
	37 weeks	<input type="text" value="0"/>	HS_10F
	38 weeks or greater	<input type="text" value="0"/>	HS_10G

Vaping Related Incidents admitted to ER		Adult Visits Age 15 & Older	Pediatric Visits Age 14 & Younger
Do you have data for question 11 that you wish to report?		<input type="checkbox"/>	HS_NAVP
11. How many patients were seen in the ED for vaping related illness? [The attached ICD9/ICD10 does not cover Vaping specifically, please do your best to answer. If unable to answer, may leave blank.]		<input type="text" value="0"/>	HS_11A
		<input type="text" value="0"/>	HS_11B

Data Comments for this Section (Optional)
Please provide any explanation, comments, or other information that is relevant to the information reported in this section. This information will be saved for future reference:
<div style="border: 1px solid gray; height: 100px; width: 100%;"></div>
HS_COMMENTS

Data Collection Status for this Section	Last Updated on 2026-02-17 10:16:30
By entering an N in the text box and clicking the Save button, you are certifying that further editing or additional information is required to complete the data for this section.	
By entering a Y in the text box and clicking the Submit button, you are certifying that to the best of your knowledge and belief, the data supplied and any applicable uploaded documents are true and correct. You further understand that the submitted data will be used for the Certificate of Need application process and calculation of relevant need methodologies contained within the standards. Michigan statute, including MCL 333.22237 and 333.22225, requires completion of this survey. Failure to complete the survey in a timely manner or providing inaccurate data may result in enforcement action pursuant to MCL 333.22247.	
Is the data for this section complete (Y/N)?	<input type="text" value="n"/> HS_STATUS

Note: A section is not completed until Y is selected and Submit has been clicked. All required sections must be submitted in this manner for MDHHS to consider the survey completed for review.
<input type="button" value="Save"/> <input type="button" value="Submit"/> <input type="checkbox"/> Print this section to PDF: <input type="checkbox"/>

<input type="button" value="Logout"/>	<input type="button" value="Next"/>	<input type="button" value="Browse"/>	<input type="button" value="Feedback"/>	General Info / FAQ
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2025 Michigan Certificate of Need Annual Survey

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000025	TEST FACILITY	EAST LANSING	HOSPITAL
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SECTION Z: 2025 CON Annual Survey Fee Invoice	Next
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Contact information for the person responsible for completing this section: <input type="checkbox"/> Check here if same as Section A.	
Contact Name	<input style="width: 80%;" type="text"/>
Contact E-mail	<input style="width: 80%;" type="text"/>
Contact Phone	<input style="width: 80%;" type="text"/>
Contact Fax	<input style="width: 80%;" type="text"/>
	HZ_CNAME
	HZ_CEMAIL
	HZ_CPHONE
	HZ_CFAX

Instructions:

PAYMENT PROCESS: PLEASE READ AND FOLLOW INSTRUCTIONS LISTED BELOW OR PAYMENT MAY BE RETURNED AND SECTION Z WILL NOT BE MARKED AS COMPLETE.

- The Services Offered in the 2025 field in the invoice below is auto-filled from the CON Covered Services questions in Section A. If there is an error, return to Section A to correct the CON Covered Services questions. Then the invoice will be corrected when you return to Section Z.
- Checks are to be made payable to: **"State of Michigan"** Checks should **never** be made out to an individual. Include the following information within the check memo, or comment, portion in this format:
 Annual Survey Facility No.: XX-XXXX
 Facility Name Check is for: XXXXXX (If not on the check)
 Payment for: 2025 Annual Survey
- Please send all payments (checks) to:

 MDHHS Cashier Office, Suite 801
 Certificate of Need
 P.O. Box 30437 Lansing MI 48909 Updated Zip Code
- Section Z cannot be marked completed and submitted by the facility. The Department will mark Section Z completed when the check is received AND all other sections have been submitted/marked complete.

CON Covered Services	Please note: no facility will be charged for both NICU and SCN Services	Service Offered in 2025	Annual Survey Fee
Inpatient Hospital Beds		Yes	\$100
NICU Beds		Yes	\$100
Swing Beds		Yes	\$0
Psychiatric Beds		Yes	\$100
Nursing Home/Hospital Long-Term-Care Units		Yes	\$100
Litho Services		Yes	\$100
CT Scanner Services		Yes	\$100
MRI Services		Yes	\$100
Cardiac Catheterization Services		Yes	\$100
MRT Services		Yes	\$100
Surgical Services		Yes	\$100
Open Heart Surgical Services		Yes	\$100
BMT Services		Yes	\$100
Pancreas Transplantation Services		Yes	\$0
Heart, Lung and Liver Transplantation Services		Yes	\$100

PET Services	Yes	\$100
Emergency Room Services	Yes	\$0
Special Care Nursery Services (Fee waived)	Yes	\$0
Total Annual Survey Fee		\$1,400

For Department Use Only

Check Received Date (YYYY-MM-DD)	<input type="text"/>	HZ_CK01
Check Number	<input type="text"/>	HZ_CK02
Check Amount (format:### or ###.##) \$	<input type="text"/>	HZ_CK03
Comments	<input type="text"/>	
Section complete (Y/N)?	<input type="checkbox"/>	HZ_STATUS

Note: The invoice cannot be printed until contact information is entered and the save button has been clicked. **Print Invoice**

<input type="button" value="Save"/>	<input type="button" value="Submit"/>
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<input type="button" value="Logout"/>	<input type="button" value="Next"/>	<input type="button" value="Browse"/>	<input type="button" value="Feedback"/>	General Info / FAQ
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