

Scott H. Perra, FACHE, President/CEO



www.faxtonstlukes.com

2/20/2020
Gary McCullough
317 Washington Street
Watertown NY 13601



Re: Annual Report

Greetings Gary McCullough

Please find enclosed the Faxton-St. Lukes Healthcare Regulated Medical Waste Annual report for 2019. If you have any questions or concerns please contact me at the following number 315-624-6186.

Sincerely,

A handwritten signature in black ink that reads "John Cloutier".

John Cloutier
Energy Center Supervisor
Faxton-St. Lukes Healthcare

Corporate Address
PO Box 479
Utica, NY 13503-0479
(315)624-6000

St. Luke's Campus
1656 Champlin Avenue
Utica, NY 13502
(315)624-6000

Faxton Campus
1676 Sunset Avenue
Utica, NY 13502
(315)624-6000

**Division of Materials Management
New York State Department of Environmental Conservation
Albany, New York 12233-7260**

REGULATED MEDICAL WASTE FACILITIES

Annual Report

Submit the Annual Report no later than March 1, 2020.

Reporting of the information indicated on this Regulated Medical Waste Annual Report form is required pursuant to 6 NYCRR 360-1.4(c); 360-1.8(e)(1)(ii), (h)(8); 360-1.14(e)(2), (i)(1); 360-11.1(a), (b)(1)(viii); 360-11.4(h) and (j); 360-17.4(e)(2), (e)(3). Failure to provide the required information requested is a violation of Environmental Conservation Law. Timely submission of a properly completed form to the Department's Regional Office that has jurisdiction over your facility and to the Department's Central Office is required to meet the Annual Report requirements of 6 NYCRR Part 360 and Part 365.

Where the Annual Report requirements have been modified, appropriate Sections (as necessary to reflect the modification) must be completed and submitted with a copy of the Department's written notification which allows the modification.

Entries on the report forms should be either typewritten or neatly printed in black ink. Attach additional sheets if space on the pages is insufficient or supplementary information is required or appropriate.

INSTRUCTIONS FOR COMPLETING THE FORM:

SECTION 1: Provide facility information and identify whether the facility operated waste during the year.

SECTION 2: Identify the amount of each type of waste generated and treated on-site (if a generator permitted to treat on-site), or if a commercial facility, the amount received by the facility from the generators and how it was processed. If transferred off-site by the generator or if a transfer facility, identify the treatment facility where the waste was sent.

SECTION 3: If a treatment facility, identify the names and addresses of disposal facilities where treated waste was disposed.

SECTION 4: Identify any unauthorized waste that was received at the facility.

SECTION 5: If required, provide updated cost estimates and financial assurance documentation.

SECTION 6: Identify any problems which occurred at the facility.

SECTION 7: Identify any changes from the approved permit or permit documentation.

SECTION 8: Identify any additional permit or consent order reporting requirements.

SECTION 9: Sign and date the form and follow the instructions provided for submission of form.



ANNUAL REPORT

This Regulated Medical Waste Facility Annual Report is for the year of operation from January 01, 2019 to December 31, 2019

SECTION 1 – FACILITY INFORMATION

FACILITY INFORMATION			
FACILITY NAME: Faxton-St. Lukes Healthcare			
FACILITY LOCATION ADDRESS: 1656 Champlin Ave	FACILITY CITY: New Hartford	STATE: N.Y.	ZIP CODE: 13413
FACILITY TOWN: New Hartford	FACILITY COUNTY: Oneida	FACILITY PHONE NUMBER: 315-624-6186	
FACILITY NYS PLANNING UNIT: (Allist of NYS Planning Units can be found at the end of this report). R-6			NYSDEC REGION #: R-6
360 PERMIT #: 6-3048-00127/02001	DATE ISSUED: 10/9/2014	DATE EXPIRES: 9/30/2024	NYS DEC ACTIVITY CODE OR REGISTRATION NUMBER: 33H01
FACILITY CONTACT: John Cloutier	<input checked="" type="checkbox"/> public <input type="checkbox"/> private	CONTACT PHONE NUMBER: 315-624-6186	CONTACT FAX NUMBER: 315-624-6943
CONTACT EMAIL ADDRESS: jcloutie@mvhealthsystem.org			
OWNER INFORMATION			
OWNER NAME: Faxton-St. Lukes Health	OWNER PHONE NUMBER: 315-624-6186	OWNER FAX NUMBER: 315-624-6943	
OWNER ADDRESS: 1656 Champlin Ave	OWNER CITY: New Hartford	STATE: N.Y.	ZIP CODE: 13413
OWNER CONTACT: John Cloutie	OWNER CONTACT EMAIL ADDRESS: jcloutie@mvhealthsystem.org		
OPERATOR INFORMATION			
OPERATOR NAME:	<input checked="" type="checkbox"/> <i>same as owner</i>	<input checked="" type="checkbox"/> public <input type="checkbox"/> private	
PREFERENCES			
Preferred address to receive correspondence: <input checked="" type="checkbox"/> Facility location address <input type="checkbox"/> Owner address <input type="checkbox"/> Other (provide):			
Preferred email address: <input checked="" type="checkbox"/> Facility Contact <input type="checkbox"/> Owner Contact <input type="checkbox"/> Other (provide):			
Preferred individual to receive correspondence: <input checked="" type="checkbox"/> Facility Contact <input type="checkbox"/> Owner Contact <input type="checkbox"/> Other (provide):			

Did you operate in 2019? Yes; Complete this form.

No; Complete and submit Sections 1 and 10. If you no longer plan to operate and wish to relinquish your permit/registration associated with this solid waste management activity, also complete the "Inactive Solid Waste Management Facility or Activity Notification Form" located at: <http://www.dec.ny.gov/chemical/52706.html>.

SECTION 2 – PERMITTED RMW WASTE TRANSFER OR TREATMENT FACILITIES

	AMOUNT GENERATED OR RECEIVED FOR PROCESSING (tons)	AMOUNT TRANSFERRED TO TREATMENT FACILITY (tons)	AMOUNT TREATED (tons)	AMOUNT BYPASSED (tons)	AMOUNT OF SHARPS OR DEVICES PROCESSED FOR RECYCLING (tons)	IF WASTE IS TRANSFERRED, THE NAME AND ADDRESS OF TREATMENT FACILITY (include county and state)	NYS PLANNING UNIT (See Attached List of NYS Planning Units)
RMW (Including: Cultures and Stocks, Human Pathological Waste, Human Blood and Blood Products, Sharps, and Animal Waste)	465.7705		462.02	3.7505		FUTURE HEALTHCARE SYSTEM INC. 700 SOUTH AVE BRIDGEPORT CT. 06604 ID# 012012036 PCO FAIRFIELD COUNTY	BRIDGEPORT CT.
Other Infectious Waste (specify amount for each contaminated material including infectious incident waste, human remains management waste, etc.)							
Radioactive Waste (specify for each very short lived, short lived or long lived)							
Pharmaceutical Waste							
Hazardous Waste							
Other (specify amount for each material including hydrolysate, ash, C&D, etc. requiring further processing.)							
TOTAL	465.7705						

SECTION 3 – DISPOSAL DESTINATION

WASTE TYPE	AMOUNT (tons)	FACILITY NAME AND ADDRESS	STATE	COUNTY	NYS PLANNING UNIT <small>(See Attached List of NYS Planning Units)</small>
Treated Waste	401.98	Oneida herkimer solid waste authority	N.Y.	Oneida County	Oneide-Herkimer Solid Waste Authority (OHSWA)
TOTAL WASTE	401.98				

SECTION 4 – UNAUTHORIZED SOLID WASTE

Has unauthorized solid waste been received at the facility during the reporting period? Yes No

If yes, give information below for each incident (attach additional sheets if necessary):

Date Received	Type Received	Date Disposed	Disposal Method & Location

SECTION 5 - COST ESTIMATES AND FINANCIAL ASSURANCE DOCUMENTS

Are there required cost estimates and financial assurance documents for closure?

Yes No If yes, attach additional sheets reflecting annual adjustments for inflation and any changes to the Closure Plan?

SECTION 6 -- PROBLEMS

Were any problems encountered during the reporting period (e.g., specific occurrences which have led to changes in facility procedures)?

Yes No If yes, attach additional sheets identifying each problem and the methods for resolution of the problem.

SECTION 7 – CHANGES

Were there any changes from approved reports, plans, specifications, and permit conditions?

Yes No If yes, attach additional sheets identifying changes with a justification for each change.

SECTION 8 - PERMIT/CONSENT ORDER REPORTING REQUIREMENTS

Are there any additional permit/consent order reporting requirements not covered by the previous sections of this form?

Yes No If yes, attach additional sheets identifying the reporting requirements with their respective responses.

SECTION 9 - SIGNATURE AND DATE BY OWNER OR OPERATOR

Owner or Operator must sign, date and submit the completed form by email or mail to the appropriate Regional Office (See attachment for Regional Office email & mailing addresses and Solid Waste Contacts.)

The Owner or Operator must also submit one copy by email, fax or mail to:

**New York State Department of Environmental Conservation
Division of Materials Management
Bureau of Permitting and Planning
625 Broadway
Albany, New York 12233-7260
Fax 518-402-9041
Email address: SWMFannualreport@dec.ny.gov**

I hereby affirm under penalty of perjury that information provided on this form and attached statements and exhibits was prepared by me or under my supervision and direction and is true to the best of my knowledge and belief, and that I have the authority to sign this report form pursuant to 6 NYCRR Part 360. I am aware that any false statement made herein is punishable as a Class A misdemeanor pursuant to Section 210.45 of the Penal Law.


Signature

2/20/2020
Date

John Cloutier
Name (Print or Type)

supervisor
Title (Print or Type)

Jcloutie@mvnhealth.org
Email (Print or Type)

1656 Champlin Ave
Address

New Hartford
City

N.Y. 13413
State and Zip

(315) 624-6186
Phone Number

ATTACHMENTS: YES NO