Executive Summary Information

The Ira Davenport Memorial Hospital, part of the Arnot Health system, located in Bath, New York has assessed the advantages of becoming a Rural Emergency Hospital (REH).

The REH is a new provider type designed by the Centers for Medicare and Medicaid Services (CMS) to minimize rural hospital closures by implementing innovative payment reform and prioritizing the alignment of outpatient services and community healthcare needs. Rural hospitals can now pursue a more secure future for their communities with this designation.

Over the past few months, we have presented the prospect of becoming an REH to our Board of Directors, our staff, local independent providers, and our community in the form of a town hall. There has been support for this resolution in all venues. We are passionate about forging a path to a better future together by creating value-based healthcare advancements through this new designation.

Key components for qualifying for the REH designation include maintaining 24-hour operation of our Emergency Department, Pharmacy availability, Imaging and Laboratory services, and Social Work services for discharge planning. REH status allows for the care of "observation" status patients, but we must transfer patients who meet inpatient criteria. Ira Davenport Memorial Hospital is currently licensed for 35 inpatient beds. Average daily census of inpatients is one.

Under this new designation, we are also required to discontinue our "Swing Bed" program. We have worked with established community healthcare partners to provide support and acceptance for patients needing a higher level of care. We remain confident that the Rural Emergency Hospital designation will enable IDMH to continue to meet the most essential community healthcare needs in an efficient and sustainable manner while maintaining access to higher levels of care when required. Current number of swing beds on operating certificate is 15. Use of these swing beds is intermittent.

Addendum 4/1/2024 - To obtain a clean certificate of operations, the Ira Davenport Memorial Hospital will also seek to remove outpatient dental and maternity care from the operating certificate, as these services have not been available for a period of over 10 years.

Please accept this as notification of our intent to decertify our inpatient and swing beds on April 6, 2024. This date is pending acceptance of our Closure Plan submitted to the New York State Department of Health Western Region Program Director, Division of Hospitals and Diagnostic & Treatment Centers, and CMS final approval. All current outpatient services will remain open and fully operational. There will be no alternate use of this space, as the hospital will care for observation status patients.

We are grateful for your support of this initiative and invite you to contact me with any questions or concerns.

Elizabeth Weir, Site Administrator

Schedule 1
All CON Applications

Contents:

New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant: x

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and implementing regulations, as applicable.

SIGNATURE:	DATE
Elizabeth Weir	3.4.24
PRINT OR TYPE NAME	TITLE
Elizabeth Weir	Site Administrator

General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project.	YES x☐ NO ☐	IDMH Board of Directors 2024
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES x☐ NO ☐	IDMH Org Chart 2024

Contacts

The Primary and Alternate contacts are the only two contacts who will receive email notifications of correspondence in NYSE-CON. ***At least one of these two contacts should be a member of the applicant.*** The other may be the applicant's representative (e.g., consultant, attorney, etc.). What is entered here for the Primary and Alternate contacts should be the same as what is entered onto the General Tab in NYSE-CON.

Primary Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Elizabeth Weir	Ira Davenport Memorial Hospital/Arnot Health	
BUSINESS STREET ADDRESS		
7571 State Route 54		
CITY	STATE	ZIP
Bath	New York	14810
TELEPHONE	E-MAIL ADDRESS	
607-776-8670	Elizabeth.weir@arnothealth.org	

Alternate Contact

NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
Ronette Wiley	Arnot Health	
BUSINESS STREET ADDRESS		
601 Roe Ave		
CITY	STATE	ZIP
Elmira	New York	14905
TELEPHONE	E-MAIL ADDRESS	
607.737.4100	Ronette.wiley@arnothealth.org	

New York State Department of Health
Certificate of Need Application

Schedule 1

The applicant must identify the operator's chief executive officer, or equivalent official.

CHIEF EXECUTIVE			
NAME AND TITLE			
Jonathan Lawrence Chief Executive Officer			
BUSINESS STREET ADDRESS			
601 Roe Avenue			
CITY	STATE	ZIP	
Elmira	NY	14905	
TELEPHONE	E-MAIL ADDRESS		
607.737.4100	Jonathan.lawrence@arnothealth.org		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM	BUSINESS STREET ADDRESS	
John Alexander	Sayles and Evans	1 West Church Street	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Elmira, NY 14905	607.734.2271	John R Alexander" <jalexander@saylesevans.com>	

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

CONSUTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

The applicant's lead accountant should be identified:

ACCOUNTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
John Mallia	NA CFO	601 Roe Ave	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Elmira, NY 14905	607.737.4100	John.mallia@arnothealth.org	

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER			
NAME	FIRM	BUSINESS STREET ADDRESS	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

ARCHITECT and/or ENGINEER			
NAME	FIRM	BUSINESS STREET ADDRESS	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

Other Facilities Owned or Controlled by the Applicant

Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies

Does the applicant legal entity or any related entity (parent, member or subsidiary corporation) operate or control any of the following in New York State?

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE	
Hospital	HOSP	Yes x☐ No ☐
Nursing Home	NH	Yes ☐ No ☐
Diagnostic and Treatment Center	DTC	Yes ☐ No ☐
Midwifery Birth Center	MBC	Yes ☐ No ☐
Licensed Home Care Services Agency	LHCSA	Yes ☐ No ☐
Certified Home Health Agency	CHHA	Yes ☐ No ☐
Hospice	HSP	Yes ☐ No ☐
Adult Home	ADH	Yes ☐ No ☐
Assisted Living Program	ALP	Yes ☐ No ☐
Long Term Home Health Care Program	LTHHCP	Yes ☐ No ☐
Enriched Housing Program	EHP	Yes ☐ No ☐
Health Maintenance Organization	HMO	Yes ☐ No ☐
Other Health Care Entity	OTH	Yes ☐ No ☐

Upload as an attachment to Schedule 1, the list of facilities/agencies referenced above, in the format depicted below:

Facility Type	Facility Name	Operating Certificate or License Number	Facility ID (PFI)

Out-of-State Affiliated Facilities/Agencies

In addition to in-state facilities, please upload, as an attachment to Schedule 1, a list of all health care, adult care, behavioral, or mental health facilities, programs or agencies located outside New York State that are affiliated with the applicant legal entity, as well as with parent, member and subsidiary corporations, in the format depicted below.

Facility Type	Name	Address	State/Country	Services Provided

In conjunction with this list, you will need to provide documentation from the regulatory agency in the state(s) where affiliations are noted, reflecting that the facilities/programs/agencies have operated in substantial compliance with applicable codes, rules and regulations for the past ten (10) years (or for the period of the affiliation, whichever is shorter). More information regarding this requirement can be found in Schedule 2D.

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

Schedule applies to all projects with construction, including Articles 28 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

Instructions

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Projects over $15 Million, or Projects Requiring a Waiver (PDF)
  - Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY. (PDF) (Not to Be Submitted with Self-Certification Projects)
  - Architect's Letter of Certification for Completed Projects (PDF)
  - Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings (PDF)
- Provide FEMA BFE Certificate. Applies only to Hospitals and Nursing Homes.
  - FEMA Elevation Certificate and Instructions.pdf
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - Physicist's Letter of Certification (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews
  - DSG-1.0 Schematic Design & Design Development Submission Requirements
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

Architecture/Engineering Narrative

Narrative shall include but not limited to the following information. Please address all items in the narrative including items located in the response column. Incomplete responses will not be accepted.

Project Description	
Schedule 6 submission date: 3/1/2024	Revised Schedule 6 submission date: 3/1/2024
Does this project amend or supersede prior CON approvals or a pending application? Not Applicable If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: The intent is to decertify inpatient and swing beds to apply for Rural Emergency Hospital designation through Centers for Medicare and Medicaid Services.	
Site Location: Ira Davenport Memorial Hospital 7571 State Route 54 Bath, NY 14810	

Brief description of current facility, including facility type: Acute care hospital	
Brief description of proposed facility: Not applicable	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. No project and no physical changes to existing facility	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: NA	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	No
Relationship of spaces conforming with Article 28 space and non-Article 28 space: NA	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. NA	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. NO	Choose an item.
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. No proposed space or physical change to facility	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. NA	
Describe existing and or new work for fire detection, alarm, and communication systems: Existing fire panel with automatic call to fire department.	
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. NA	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. Click here to enter text.	
Does the project comply with ADA? If no, list all areas of noncompliance. No project, but facility is ADA compliant	
Other pertinent information: This is a request to decertify inpatient and swing beds. No project or physical change to facility or other services.	

Project Work Area	**Response**
Type of Work	Choose an item.
Square footages of existing areas, existing floor and or existing building.	Click here to enter text.
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	NA
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Choose an item.
Sprinkler protection per NFPA 101 Life Safety Code	Partially Sprinklered
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Choose an item.
Building Height	Click here to enter text.

Building Number of Stories	2
Which edition of FGI is being used for this project?	Choose an item.
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	Not Applicable
Is the building a high-rise?	No
If a high-rise, does the building have a generator?	Not Applicable
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Choose an item.
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Click here to enter text.	Not Applicable
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	Not Applicable
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	Not Applicable
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	Not Applicable
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	Not Applicable
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Decertify 35 inpatient and 15 swing beds	Decrease
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	Not Applicable
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	Not Applicable
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Not Applicable
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	Not Applicable
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	Not Applicable
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Not Applicable
Does the project involve a pool?	Not Applicable

REQUIRED ATTACHMENT TABLE			
SCHEMATIC DESIGN SUBMISSION for **CONTINGENT APPROVAL**	DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for **CONTINGENCY SATISFACTION**	**Title of Attachment**	**File Name in PDF format**
•		Architectural/Engineering Narrative	A/E Narrative.PDF
•		Functional Space Program	FSP.PDF
•		Architect/Engineer Certification Form	A/E Cert Form. PDF
•		FEMA BFE Certificate	FEMA BFE Cert.PDF
•		Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Plans including level of exit discharge, and NFPA 101-2012 Code Analysis	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details. Illustrate FGI compliance on plans.	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
optional	•	Wall Sections and Partition Types	A500.PDF
optional	•	Interior Elevations, Enlarged Plans and Details	A600.PDF
	•	Fire Protection	FP100.PDF
	•	Mechanical Systems	M100.PDF
	•	Electrical Systems	E100.PDF
	•	Plumbing Systems	P100.PDF
	•	Physicist's Letter of Certification and Report	X100.PDF