Schedule 13
All Article 28 Facilities

Contents:

- **Schedule 13 A - Assurances**
- **Schedule 13 B - Staffing**
- **Schedule 13 C - Annual Operating Costs**
- **Schedule 13 D - Annual Operating Revenue**

Schedule 13 A. Assurances from Article 28 Applicants

Article 28 applicants seeking combined establishment and construction or construction-only approval must complete this schedule.

The undersigned, as a duly authorized representative of the applicant, hereby gives the following assurances:

a) The applicant has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way sufficient to assure use and possession for the purpose of the construction and operation of the facility.

b) The applicant will obtain the approval of the Commissioner of Health of all required submissions, which shall conform to the standards of construction and equipment in Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.

c) The applicant will submit to the Commissioner of Health final working drawings and specifications, which shall conform to the standards of construction and equipment of Subchapter C of Title 10, prior to contracting for construction, unless otherwise provided for in Title 10.

d) The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.

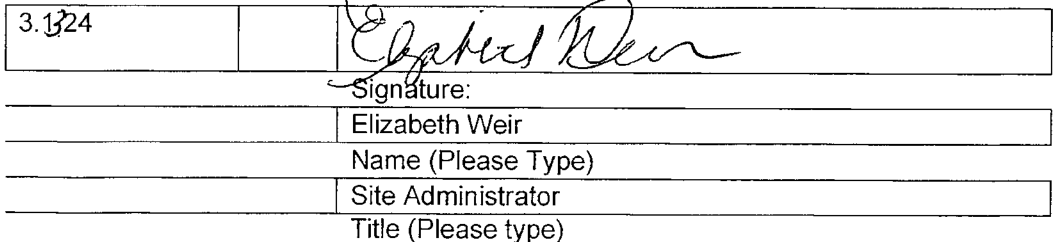
e) The applicant will provide and maintain competent and adequate architectural and/or engineering inspection at the construction site to ensure that the completed work conforms to the approved plans and specifications.

f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.

g) The facility will be operated and maintained in accordance with the standards prescribed by law.

h) The applicant will comply with the provisions of the Public Health Law and the applicable provisions of Title 10 with respect to the operation of all established, existing medical facilities in which the applicant has a controlling interest.

i) The applicant understands and recognizes that any approval of this application is not to be construed as an approval of, nor does it provide assurance of, reimbursement for any costs identified in the application. Reimbursement for all cost shall be in accordance with and subject to the provisions of Part 86 of Title 10.



Date 3.1[illegible]24

Signature:

Elizabeth Weir

Name (Please Type)

Site Administrator

Title (Please type)

Schedule 13 B-1. Staffing

See "Schedules Required for Each Type of CON" to determine when this form is required. Use the "Other" categories for providers, such as dentists, that are not mentioned in the staff categories. If a project involves multiple sites, please create a staffing table for each site.

☒ Total Project or ☐ Subproject number

A		B	C	D
		Number of FTEs to the Nearest Tenth		
Staffing Categories		Current Year*	First Year Total Budget	Third Year Total Budget
1. Management & Supervision		11.0	11.0	11.0
2. Technician & Specialist		3.0	3.0	3.0
3. Registered Nurses		29.6	32.0	33.0
4. Licensed Practical Nurses		2.0	2.0	2.0
5. Aides, Orderlies & Attendants		6.0	6.0	6.0
6. Physicians		130.0	130.0	130.0
7. PGY Physicians		0.0	0.0	0.0
8. Physicians' Assistants		3.0	4.0	4.0
9. Nurse Practitioners		1.0	1.0	1.0
10. Nurse Midwife		0.0	0.0	0.0
11. Social Workers and Psychologist**		2.0	2.0	2.0
12. Physical Therapists and PT Assistants		4.0	5.0	5.0
13. Occupational Therapists and OT Assistants		0.0	0.0	0.0
14. Speech Therapists and Speech Assistants		0.0	0.0	0.0
15. Other Therapists and Assistants		0.0	0.0	0.0
16. Infection Control, Environment and Food Service		32.0	34.0	34.0
17. Clerical & Other Administrative		2.0	3.0	3.0
18. Other	Facility Maintenance	4.0	4.0	4.0
19. Other	lab and radiology	18.4	19.0	20.0
20. Other				
21. Total Number of Employees		248.0	256.0	258.0

**Last complete year prior to submitting application*
***Only for RHCF and D&TC proposals*

)escribe how the number and mix of staff were determined:

Staffing is based upon patient volume and acuity, utilizing historical data. Please note that the physician count includes contracted telemedicine providers that are not diretly employed, but are credentialed and provide services.

Schedule 13 B-2. Medical/Center Director and Transfer Agreements

All diagnostic and treatment centers and midwifery birth centers should complete this section when requesting a new location. DTCs are required to have a Medical Director who is a physician. MBCs may have a Center Director who is a physician or a licensed midwife.

Medical/Center Director	
Name of Medical/Center Director:	Dr. Dennis O'Connor
License number of the Medical/Center Director	149768

	Not Applicable	Title of Attachment	Filename of attachment
Attach a copy of the Medical/Center Director's curriculum vitae	☐	O'Connor CV	O'Connor CV

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	Arnot Ogden Medical Center and University of Rochester
○ Distance in miles from the proposed facility to the Hospital affiliate.	45 and 81 miles
○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	55 minutes and 1 hour and 15 minutes
○ Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.	N/A ☐ Attachment Name: AOMC IDMH patient transfer agreement; 2023 11 07 Fulle Executed URMC & IRA Davenport Trauma Patient Transfer Agreement
Name of the **nearest** Hospital to the proposed facility	NA
○ Distance in miles from the proposed facility to the nearest hospital.	
○ Distance in minutes of travel time from the proposed facility to the nearest hospital.	

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

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

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

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

Schedule 13 C. Annual Operating Costs

See "Schedules Required for Each Type of CON" to determine when this form is required. One schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule that matches the structure of the tables (Attachment Title:1.IDMH Budget Expenses Admin CON.doc 2. IDMH Interest Expense ADMIN CON.doc 3. IDMH Schedule 13D Cash Flow Analysis ADMIN CON.doc 4. IDMH Schedule 13D Utilization by payor ADMIN CON.doc 5. IDMH Sch 13D Charity Care ADMIN CON.doc) to summarize the first and third full year's total cost for the categories, which are affected by this project. The first full year is defined as the first 12 months of full operation after project completion. Year 1 and 3 should represent projected total budgeted costs expressed in current year dollars. Additionally, you must upload the required attachments indicated below.

Required Attachments

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis for determining budgeted expenses, including details for how depreciation and rent / lease expenses were calculated.	IDMH Budget Expenses ADMIN CON	IDMH Budget Expenses ADMIN CON. doc
2. In a sperate attachment, provide the basis for interest cost. Separately identify, with supporting calculations, interest attributed to mortgages and working capital	IDMH Interest Expense ADMIN CON	IDMH Interest Expense ADMIN CON. doc

☑ Total Project or ☐ Subproject Number

Table 13C - 1

	a	b	c
Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	1/1/2024	1/1/2025	1/1/2027
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs			

Table 13C - 2

	a	b	c
Inpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	1/1/2024	1/1/2025	1/1/2027
1. Salaries and Wages	0	0	0
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Operating Costs	0	0	0

Table 13C - 3

	a	b	c
Outpatient Categories	Current Year	Year 1 Total Budget	Year 3 Total Budget
Start date of year in question:(m/d/yyyy)	1/1/2024	1/1/2025	1/1/2027
1. Salaries and Wages			
1a. FTEs			
2. Employee Benefits			
3. Professional Fees			
4. Medical & Surgical Supplies			
5. Non-med., non-surg. Supplies			
6. Utilities			
7. Purchased Services			
8. Other Direct Expenses			
9. Subtotal (total 1-8)			
10. Interest (details required below)			
11. Depreciation (details required below)			
12. Rent / Lease (details required below)			
13. Total Outpatient Operating Costs			

Any approval of this application is not to be construed as
projected operating costs. Reimbursement of any such c
provisions of Part 86 of 10 NYCRR. Approval of this application does not assure reimbursement of any
costs indicated therein by payers under Title XIX of the Federal Social Security Act (Medicaid) or Article 43 of The State Insurance Law or by any other payers.

Schedule 13 D: Annual Operating Revenues

See "Schedules Required for Each Type of CON" to determine when this form is required. If required, one schedule must be completed for the total project and one for each of the subprojects. Indicate which one is being reported by checking the appropriate box at the top of the schedule.

Use the below tables or upload a spreadsheet as an attachment to this Schedule (Attachment Title:) to summarize the current year's operating revenue, and the first and third year's budgeted operating revenue (after project completion) for the categories that are affected by this project.

Table 1. Enter the current year data in column 1. This should represent the total revenue for the last complete year before submitting the application, using audited data. Project the first and third year's total budgeted revenue in current year dollars

Tables 2a and 2b. Enter current year data in the appropriate block. This should represent revenue by payer for the last complete year before submitting the application, using audited data.

Indicate in the appropriate blocks total budgeted revenues (i.e., operating revenues by payer to be received during the first and third years of operation after project completion). As an attachment, provide documentation for the rates assumed for each payer. Where the project will result in a rate change, provide supporting calculations. For managed care, include rates and information from which the rates are derived, including payer, enrollees, and utilization assumptions.

The Total of Inpatient and Outpatient Services at the bottom of Tables 13D-2A and13D-2B should equal the totals given on line 10 of Table 13D-1.

Required Attachments

	N/A	Title of Attachment	Filename of Attachment
1. Provide a cash flow analysis for the first year of operations after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project.	☐	IDMH Schedule 13D Cash Flow Analysis ADMIN CON	IDMH Schedule 13D Cash Flow Analysis ADMIN CON.doc
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	IDMH Schedule 13D Utilization by payor ADMIN CON	IDMH Schedule 13D utilization by payor ADMIN CON.doc
3. Provide the basis for charity care revenue assumptions used in Year 1 and 3 Budgets ((Table 13D-2B). *If less than 2%, provide a reason why a higher level of charity care cannot be achieved and remedies that will be implemented to increase charity care.*	☐	IDMH Schedule 13D Charity Care ADMIN CON	IDMH Schedule 13D Charity Care ADMIN CON.doc

Table 13D - 1

	a	b	c
Categories	Current Year	Year 1 Total Revenue Budget	Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)			
1. Inpatient Services			
2. Outpatient Services			
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered			
5. Deductions from Revenue			
6. Net Patient Care Services Revenue			
7. Other Operating Revenue (Identify sources)			
SNF & Other			
Grants			
8. Total Operating Revenue (Total 1-7)			
9. Non-Operating Revenue			
10. Total Project Revenue			

Table 13D – 2A
Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ or Patient Discharges ☑

Inpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
			Net Revenue			Net Revenue			Net Revenue	
		(A) Patient Days or dis-charges	**(B)** Dollars ($)	$ per Patient Day or dis-charge **(B)/(A)**	**(C)** Patient Days or dis-charges	**(D)** Dollars ($)	$ per Patient Day or dis-charge **(D)/(C)**	**(E)** Patient Days or dis-charges	**(F)** Dollars ($)	$ per Patient Days or dis-charges **(F)/(E)**
Commercial	Fee for Service	0	0	0	0	0	0	0	0	0
	Managed Care	0	0	0	0	0	0	0	0	0
Medicare	Fee for Service	0	0	0	0	0	0	0	0	0
	Managed Care	0	0	0	0	0	0	0	0	0
Medicaid	Fee for Service	0	0	0	0	0	0	0	0	0
	Managed Care	0	0	0	0	0	0	0	0	0
Private Pay		0	0	0	0	0	0	0	0	0
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total		0	0	0	0	0	0	0	0	0

IDMH Schedule 13C – Annual Operating Costs

Basis for interest.

This question is not applicable for IDMH.

IDMH schedule 13D Annual Operating Revenues

Charity Care

Charity Care is based on historical utilization and the conversion to REH will not result in any changes.

IDMH Schedule 13D annual Operating Revenues

Utilization of revenues by payor mix

Payor mix assumptions based on historical utilization and the conversion to REH will not change it.

Schedule 16
CON Forms Specific to Hospitals
Article 28

Contents:

- Schedule 16 A - Hospital Program Information
- Schedule 16 B - Hospital Community Need
- Schedule 16 C - Impact of CON Application on Hospital Operating Certificate
- Schedule 16 D - Hospital Outpatient Departments
- Schedule 16 E - Hospital Utilization
- Schedule 16 F - Hospital Facility Access

Schedule 16 A. Hospital Program Information

See "Schedules Required for Each Type of CON" to determine when this form is required.

Instructions: Briefly indicate how the facility intends to comply with state and federal regulations specific to the services requested, such as cardiac surgery, bone marrow transplants. For clinic services, please include the hours of service for each day of operation, name of the hospital providing back-up services (indicating the travel time and distance from the clinic) and how the facility intends to provide quality oversight including credentialing, utilization and quality assurance monitoring.

Ira Davenport Memorial Hospital (IDMH) will continue to operate as a community hospital with 24 hour emergency services, pharmacy, laboratory, radiology, observation, and social work capabilities. Surgical services will continue as present - Monday - Friday 7-3:30. Arnot Ogden Medical Center (AOMC) is the parent organization for IDMH and will continue to provide back-up services as needed. AOMC is 45 miles distance and approximately 55 minutes travel time from IDMH. All quality oversight, continuous quality improvement and provider credentialing will continue as present and reports up through the IDMH Board of Directors.

For Hospital-Based -Ambulatory Surgery Projects:
Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category

For Hospital-Based -Ambulatory Surgery Projects:
Please provide the following information:

Number and Type of Operating Rooms:

- Current:
- To be added:
- Total ORs upon Completion of the Project:

Number and Type of Procedure Rooms:

- Current:

- To be added:
- Total Procedure Rooms upon Completion of the Project:

Schedule 16 B. Community Need

See "Schedules Required for Each Type of CON" to determine when this form is required.

Public Need Summary:
Briefly summarize on this schedule why the project is needed. Use additional paper, as necessary. If the following items have been addressed in the project narrative, please cite the relevant section and pages.

1. Identify the relevant service area (e.g., Minor Civil Division(s), Census Tract(s), street boundaries, Zip Code(s), Health Professional Shortage Area (HPSA) etc.)

14810 14840 14809 14873 14879 14821 14843 14815 as identifed by our Health Equity Impact Assessment. IDMH is a federally designated primary healthcare and mental health care provider shortage area.

2. Provide a quantitative and qualitative description of the population to be served. Data may include median income, ethnicity, payor mix, etc.

According to the Steuben County Community Health Needs Assessment, 14% of individuals residing in Steuben County live below the poverty level. Racial and ethnic make up are as follows: 93.3% non-hispanic/White; 1.6% Black; 0.3% Native American; 1.6% Asian; 1.8% Hispanic. Women were approximately 58.7% of the patient population for IDMH. 15.4% of the population live with a disabilty, including cognitive, ambulatory and hearing. The population served by the IDMH is typically rural, elderly with a chronic medical condition and are challenged with a lack of easily available transportation

3. Document the current and projected demand for the proposed service in the population you plan to serve. If the proposed service is covered by a DOH need methodology, demonstrate how the proposed service is consistent with it.

There is no anticipated significant impact to demand or accessibilty due to the decertification of inpatient or swing bed status. Patient Emergency Room visits have been consistenly between 8500 and less than 10,000 for the past four years. IDMH serves as a vital point of entry into healthcare for acute and chronic medical conditions.

4. (a) Describe how this project responds to and reflects the needs of the residents in the community you propose to serve.

The application for CMS designation as a Rural Emergency Hospital will allow for this community hospital to continue to serve the community with vital access to healthcare resources. The REH designation allows for increased Medicare reimbursement and a monthly financial stipend to allow for financial stability.

(b) Will the proposed project serve all patients needing care regardless of their ability to pay or the source of payment? If so, please provide such a statement.

Yes, the IDMH serves all patient populations regardless of ability to pay and will continue to do so. for the following situations: 1.) Emergency medical services, 2.)

services for life-threatening conditions 3.) non-elective services for life threatening circumstances in a non-emergency room setting and 4.) medically necessary.

5. Describe where and how the population to be served currently receives the proposed services.

IDMH provides multiple outpatient services such as Emergency Care, laboratory, radiology, surgical services, social work and nursing care at the hospital campus located at 7571 State Route 54, Bath, New York 14810. Patients may make appointments or access care by coming to the Emergency Department.

6. Describe how the proposed services will be address specific health problems prevalent in the service area, including any special experience, programs or methods that will be implemented to address these health issues.

All current services provided by the IDMH will continue to be available to all patients with the exception of inpatient and swing bed. Post REH designation, patients needing inpatient, higher level of care will be transferred to our parent organization Arnot Ogden Medical Center, or University of Rochester with whom we have transfer agreements. Should both of these entities be unable to accept, IDMH will secure another appropriate accepting facility as is our practice currently.

ONLY for Hospital Applicants submitting Full Review CONs

Non-Public Hospitals

7. (a) Explain how the proposed project advances local Prevention Agenda priorities identified by the community in the most recently completed Community Health Improvement Plan (CHIP)/Community Service Plan (CSP). *Do not submit the CSP.* Please be specific in which priority(ies) is/are being addressed.

(b) If the Project does not advance the local Prevention Agenda priorities, briefly summarize how you are advancing local Prevention Agenda priorities.

8. Briefly describe what interventions you are implementing to support local Prevention Agenda goals.

9. Has your organization engaged local community partners in its Prevention Agenda efforts, including the local health department and any local Prevention Agenda coalition?

10. What data from the Prevention Agenda dashboard and/or other metrics are you using to track progress to advance local Prevention Agenda goals?

11. In your most recent Schedule H form submitted to the IRS, did you report any Community Benefit spending in the Community Health Improvement Services category that supports local Prevention Agenda goals? (Y/N question)

ONLY for Hospital Applicants submitting Full Review CONs

Public Hospitals

12. Briefly summarize how you are advancing local public health priorities identified by your local health department and other community partners.

13. Briefly describe what interventions you are implementing to support local public health priorities.

14. Have you engaged local community partners, including the local health department, in your efforts to address local public health priorities?

15. What data are you using to track progress in addressing local public health priorities?

New York State Department of Health
Certificate of Need Application

Schedule 16C

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

C. Impact of CON Application on Hospital Operating Certificate

Note: If the application involves an extension clinic, indicate which services should be added or removed from the certificate of the extension clinic alone, rather than for the hospital system as a whole. If multiple sites are involved, complete a separate 16C for each site.

TABLE 16C-1 AUTHORIZED BEDS

LOCATION:
7571 State Route 54 Bath, New York 14810
(Enter street address of facility)

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30		☐	☐	
BONE MARROW TRANSPLANT	21		☐	☐	
BURNS CARE	09		☐	☐	
CHEMICAL DEPENDENCE-DETOX *	12		☐	☐	
CHEMICAL DEPENDENCE-REHAB *	13		☐	☐	
COMA RECOVERY	26		☐	☐	
CORONARY CARE	03		☐	☐	
INTENSIVE CARE	02		☐	☐	
MATERNITY	05		☐	☐	
MEDICAL/SURGICAL	01	35	☐	☒ 35	0
NEONATAL CONTINUING CARE	27		☐	☐	
NEONATAL INTENSIVE CARE	28		☐	☐	
NEONATAL INTERMEDIATE CARE	29		☐	☐	
PEDIATRIC	04		☐	☐	
PEDIATRIC ICU	10		☐	☐	
PHYSICAL MEDICINE & REHABILITATION	07		☐	☐	
PRISONER				☐	
PSYCHIATRIC**	08		☐	☐	
RESPIRATORY				☐	
SPECIAL USE				☐	
SWING BED PROGRAM				☒ 15	
TRANSITIONAL CARE	33		☐	☐	
TRAUMATIC BRAIN INJURY	11		☐	☐	
TOTAL			☐	☐	

*CHEMICAL DEPENDENCE: Requires additional approval by the Office of Alcohol and Substance Abuse Services (OASAS)
**PSYCHIATRIC: Requires additional approval by the Office of Mental Health (OMH)

Does the applicant have previously submitted Certificate of Need (CON) applications that have not been completed involving addition or decertification of beds?

☒ No ☐ Yes (*Enter CON number(s) to the right*) [ ] [ ] [ ]

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

LOCATION:

(Enter street address of facility)

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
AMBULATORY SURGERY				
MULTI-SPECIALTY	☐	☐	☐	☐
SINGLE SPECIALTY – GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
CARDIAC CATHETERIZATION				
ADULT DIAGNOSTIC	☐	☐	☐	☐
ELECTROPHYSIOLOGY (EP)	☐	☐	☐	☐
PEDIATRIC DIAGNOSTIC	☐	☐	☐	☐
PEDIATRIC INTERVENTION ELECTIVE	☐	☐	☐	☐
PERCUTANEOUS CORONARY INTERVENTION (PCI)	☐	☐	☐	☐
CARDIAC SURGERY ADULT	☐	☐	☐	☐
CARDIAC SURGERY PEDIATRIC	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
CLINIC PART-TIME SERVICES	☐	☐	☐	☐
COMPREHENSIVE PSYCH EMERGENCY PROGRAM	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
EMERGENCY DEPARTMENT	☐	☐	☐	☐
EPILEPSY COMPREHENSIVE SERVICES	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐

[1] A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.
[2] A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.
[4] DIALYSIS SERVICES require additional approval by Medicare
[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators
[6] PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric
[7] Must be certified for Home Hemodialysis Training & Support

The Sites Tab in NYSE-CON has replaced the Authorized Beds and Licensed Services Tables of Schedule 16C. The Authorized Beds and Licensed Services Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-2 LICENSED SERVICES *(cont.)*	Current	Add	Remove	Proposed
RADIOLOGY-THERAPEUTIC [5]	☐	☐	☐	☐
RENAL DIALYSIS, ACUTE	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b)	____	____	____	____
TRANSPLANT				
HEART - ADULT	☐	☐	☐	☐
HEART - PEDIATRIC	☐	☐	☐	☐
KIDNEY	☐	☐	☐	☐
LIVER	☐	☐	☐	☐
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

The Sites Tab in NYSE-CON has replaced the beds and services Tables of Schedule 16C. The Tables in Schedule 16C are only to be used when submitting a Modification, in hardcopy, after approval or contingent approval.

TABLE 16C-3 LICENSED SERVICES FOR HOSPITAL EXTENSION CLINICS and OFF-CAMPUS EMERGENCY DEPARTMENTS

LOCATION: *(Enter street address of facility)*	**Check if this is a mobile van/clinic** ☐

	Current	Add	Remove	Proposed
MEDICAL SERVICES – PRIMARY CARE [6]	☐	☐	☐	☐
MEDICAL SERVICES – OTHER MEDICAL SPECIALTIES	☐	☐	☐	☐
AMBULATORY SURGERY				
SINGLE SPECIALTY -- GASTROENTEROLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – OPHTHALMOLOGY	☐	☐	☐	☐
SINGLE SPECIALTY – ORTHOPEDICS	☐	☐	☐	☐
SINGLE SPECIALTY – PAIN MANAGEMENT	☐	☐	☐	☐
SINGLE SPECIALTY – OTHER (SPECIFY)	☐	☐	☐	☐
MULTI-SPECIALTY	☐	☐	☐	☐
CERTIFIED MENTAL HEALTH O/P [1]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - REHAB [2]	☐	☐	☐	☐
CHEMICAL DEPENDENCE - WITHDRAWAL O/P [2]	☐	☐	☐	☐
DENTAL	☐	☐	☐	☐
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
HOME HEMODIALYSIS TRAINING & SUPPORT[4]	☐	☐	☐	☐
INTEGRATED SERVICES – MENTAL HEALTH	☐	☐	☐	☐
INTEGRATED SERVICES – SUBSTANCE USE DISORDER	☐	☐	☐	☐
LITHOTRIPSY	☐	☐	☐	☐
METHADONE MAINTENANCE O/P [2]	☐	☐	☐	☐
NURSING HOME HEMODIALYSIS[7]	☐	☐	☐	☐
RADIOLOGY-THERAPEUTIC[5]	☐	☐	☐	☐
RENAL DIALYSIS, CHRONIC [Complete the ESRD section 16C-3(a)&(b) below][4]	____	____	____	____
TRAUMATIC BRAIN INJURY	☐	☐	☐	☐
FOR OFF-CAMPUS EMERGENCY DEPARTMENTS ONLY[8]				
EMERGENCY DEPARTMENT	☐	☐	☐	☐

[1] A separate licensure application must be filed with the NYS Office of Mental Health in addition to this CON.
[2] A separate licensure application must be filed with the NYS Office of Alcoholism and Substance Abuse Services in addition to this CON.
[4] DIALYSIS SERVICES require additional approval by Medicare
[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators
[6] PRIMARY CARE includes one or more of the following: Family Practice, Internal Medicine, Ob/Gyn or Pediatric
[7] Must be certified for Home Hemodialysis Training & Support
[8] OFF-CAMPUS EMERGENCY DEPARTMENTS must meet all relevant Federal Conditions of Participation for a hospital per CMS S&C-08-08

END STAGE RENAL DISEASE (ESRD)

TABLE 16C-3(*a*) CAPACITY	Existing	Add	Remove	Proposed
CHRONIC DIALYSIS				

If application involves dialysis service with existing capacity, complete the following table:

TABLE 16C-3(b) TREATMENTS	Last 12 mos	2 years prior	3 years prior
CHRONIC DIALYSIS			

All Chronic Dialysis applicants must provide the following information in compliance with 10 NYCRR 670.6.

1. Provide a five-year analysis of projected costs and revenues that demonstrates that the proposed dialysis services will be utilized sufficiently to be financially feasible.

2. Provide evidence that the proposed dialysis services will enhance access to dialysis by patients, including members of medically underserved groups which have traditionally experienced difficulties obtaining access to health care, such as; racial and ethnic minorities, women, disabled persons, and residents of remote rural areas.

3. Provide evidence that the hours of operation and admission policy of the facility will promote the availability of dialysis at times preferred by the patients, particularly to enable patients to continue employment.

4. Provide evidence that the facility is willing to and capable of safely serving patients.

5. Provide evidence that the proposed facility will not jeopardize the quality of care or the financial viability of existing dialysis facilities. This evidence should be derived from analysis of factors including, but not necessarily limited to current and projected referral and use patterns of both the proposed facility and existing facilities. A finding that the proposed facility will jeopardize the financial viability of one or more existing facilities will not of itself require a recommendation to of disapproval.

Schedule 16 D. Hospital Outpatient Department - Utilization projections

a	b	d	f
	Current Year *Visits**	First Year *Visits**	Third Year *Visits**
CERTIFIABLE SERVICES			
MEDICAL SERVICES – PRIMARY CARE			
MEDICAL SERICES – OTHER MEDICAL SPECIALTIES			
AMBULATORY SURGERY			
SINGLE SPECIALTY – GASTROENTEROLOGY			
SINGLE SPECIALTY – OPHTHALMOLOGY			
SINGLE SPECIALTY – ORTHOPEDICS			
SINGLE SPECIALTY – PAIN MANAGEMENT			
SINGLE SPECIALTY – OTHER			
MULTI-SPECIALTY			
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC			
ELECTROPHYSIOLOGY			
PEDIATRIC DIAGNOSTIC			
PEDIATRIC INTERVENTION ELECTIVE			
PERCUTANEOUS CORONARY INTERVENTION (PCI)			
CERTIFIED MENTAL HEALTH O/P			
CHEMICAL DEPENDENCE - REHAB			
CHEMICAL DEPENDENCE - WITHDRAWAL O/P			
CLINIC PART-TIME SERVICES			
CLINIC SCHOOL-BASED SERVICES			
CLINIC SCHOOL-BASED DENTAL PROGRAM			
COMPREHENSIVE EPILEPSY CENTER			
COMPREHENSIVE PSYCH EMERGENCY PROGRAM			
DENTAL			
EMERGENCY DEPARTMENT			
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT			
HOME HEMODIALYSIS TRAINING & SUPPORT			
INTEGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY			
METHADONE MAINTENANCE O/P			
NURSING HOME HEMODIALYSIS			
RADIOLOGY-THERAPEUTIC			
RENAL DIALYSIS, CHRONIC			
OTHER SERVICES			
Total			

Note: In the case of an extension clinic, the service estimates in this table should apply to the site in question, not to the hospital or network as a whole.
*The 'Total' reported MUST be the SAME as those on Table 13D-4.

Schedule 16 E. Utilization/discharge and patient days

See "Schedules Required for Each Type of CON" to determine when this form is required

This schedule is for hospital inpatient projects only. This schedule is required if hospital discharges or patient days will be affected by ± 5% or more, or if this utilization is created for the first time by your proposal.

Include only those areas affected by your project. Current year data, as shown in columns 1 and 2, should represent the last complete year before submitting the application. Enter the starting and ending month and year in the column heading.

Forecast the first and third years after project completion. The first year is the first twelve months of operation after project completion. Enter the starting and ending month and year being reported in the column headings.

For hospital establishment applications and major modernizations, submit a summary business plan to address operations of the facility upon project completion. All appropriate assumptions regarding market share, demand, utilization, payment source, revenue and expense levels, and related matters should be included. Also, include your strategic plan response to the escalating managed care environment. Provide a complete answer and indicate the hospital's current managed care situation, including identification of contracts and services.

NOTE: Prior versions of this table referred to "incremental" changes in discharges and days. The table now requires the full count of discharges and days.

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date: 1/1/2024		1st Year Start date: 1/1/2025		3rd Year Start date:1/1/2026	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
AIDS						
BONE MARROW TRANSPLANT						
BURNS CARE						
CHEMICAL DEPENDENCE - DETOX						
CHEMICAL DEPENDENCE - REHAB						
COMA RECOVERY						
CORONARY CARE						
INTENSIVE CARE						
MATERNITY						
MED/SURG					0	0
NEONATAL CONTINUING CARE						
NEONATAL INTENSIVE CARE						
NEONATAL INTERMEDIATE CARE						
PEDIATRIC						
PEDIATRIC ICU						
PHYSICAL MEDICINE & REHABILITATION						
PRISONER						
PSYCHIATRIC						
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM					0	0
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL					0	0

NOTE: Prior versions of this table referred to "incremental" changes in discharges and days. The table now requires the full count of discharges and days.

Schedule 16 F. Facility Access

See "Schedules Required for Each Type of CON" to determine when this form is required.

Complete Table 1 to indicate the method of payment for inpatients and for inpatients and outpatients who were transferred to other health care facilities for the calendar year immediately preceding this application.
Start date of year for which data applies (m/c/yyyy): 1/1/2023

Table 1. Patient Characteristics	Total Number of Inpatients	Number of Patients Transferred		
Payment Source		Inpatient	OPD	ER
Medicare	[illegible]	[illegible]		
Blue Cross				
Medicaid				
Title V				
Workers' Compensation				
Self Pay in Full				
Other (incl. Partial Pay)				
Free				
Commercial Insurance				
Total Patients	[illegible]		[illegible]	

Complete Table 2 to indicate the method of payment for outpatients.

Table 2. Outpatient Characteristics	Emergency Room		Outpatient Clinic		Community MH Center	
Primary Payment Source	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions	Visits	Visits Resulting in Inpatient Admissions
Medicare				0	0	0
Blue Cross				0	0	0
Medicaid				0	0	0
Title V				0	0	0
Workers' Compensation				0	0	0
Self Pay in Full				0	0	0
Other (incl. Partial Pay)				0	0	0
Free				0	0	0
Commercial Insurance				0	0	0
Total Patients				0	0	0

A. Attach a copy of your discharge planning policy and procedures.

B. Is your facility a recipient of federal assistance under Title VI or XVI of the Public Health Service? Act (Hill-Burton)?

Yes ☐ No ☒

If yes, answer the following questions and attach the most recent report on Hill-Burton compliance from the Federal Department of Health and Human Services.

1. Is your facility currently obligated to provide uncompensated service under the Public Health Service Act?

   Yes ☒ No ☐

   If yes, provide details on how your facility has met such requirement for the last three fiscal years - including notification of the requirement in a newspaper of general circulation. Also, list any restricted trusts and endowments that were used to provide free, below-cost or charity care services to persons unable to pay.

   For the years 2020, 2021 and 2022 the amount of charity care and bad debt shouldered by IDMH were [redacted] respectively. Per organizational policy, the following health care services are available for charity care: 1.) emergency medical services provided in an emergency room setting; 2.) services for a condition which, if not promptly treated, would lead to an adverse change in health status; 3.) non-elective services provided in response to a life-threatening circumstance a non-emergency room setting and 4.) medically necessary.

2. With respect to all or any portion of the facility which has been constructed, modernized, or converted with Hill-Burton assistance, are the services provided therein available to all persons residing in your facility's service area without discrimination on the basis of race, color, national origin, creed, or any basis unrelated to an individual's need for the service or the availability of the needed service in the facility?

   Yes ☒ No ☐

   If no, provide an explanation.

3. Does the facility have a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility?

   Yes ☐ No ☒

4. Do Medicaid beneficiaries have full access to all of your facility's health services?

   Yes ☒ No ☐

   If no, provide a list of services where access by Medicaid beneficiaries is denied or limited.

ArnotHealth

Inpatient Transfer Agreement

Arnot Ogden Medical Center of 600 Roe Avenue in Elmira, New York, hereinafter referred to as AOMC and Ira Davenport Memorial Hospital of 7571 State Route 54, Bath, New York, hereinafter referred to as IDMH agree as follows:

1) From time to time an inpatient of one facility may be clinically required to be transported for a test or procedure to the other facility and then returned on the same day to the original facility to complete their inpatient stay.

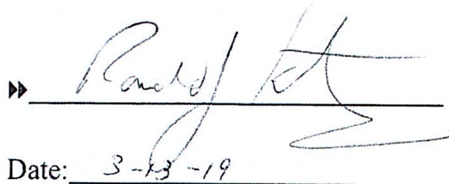
2) Certain payers like Medicare, Medicaid and Blue Cross pay a fixed DRG rate and will not pay the second facility for any testing or procedures while the patient is an inpatient at another facility. In these cases the second facility is required to bill the original facility for patient services rendered.

3) In these situations, AOMC and IDMH agree to bill each other (as applicable) at the proxy rate at which that hospital would have been paid by the patient's insurance coverage for an outpatient procedure. For example, if a patient with Medicare coverage is admitted to IDMH and sent to AOMC for a test and then returned to IDMH. AOMC agrees to bill, and IDMH agrees to pay AOMC the AOMC Medicare outpatient rate for the test that was completed by AOMC.

4) The Blue Cross rate shall be 49% of the facility's usual and customary charge. The Medicare and Medicaid rate shall be 26% of the facility's usual and customary charge.

5) **TERM:**
   - Effective: January 1, 2019 and may be cancelled by either party with 30 days advanced written notice.

Arnot Ogden Medical Center

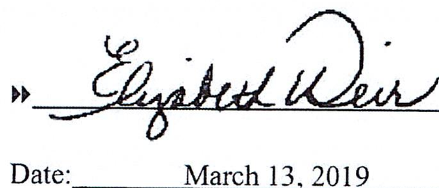


Date: 3-13-19

Ronald J. Kintz

CFO

Ira Davenport Memorial Hospital



Date: March 13, 2019

Elizabeth Weir, MSN RN CCRN
Site Administrator/VP of Nursing

TRAUMA PATIENT TRANSFER AGREEMENT

THIS AGREEMENT, is entered into this 24th day of October, 2023 by and between the University of Rochester Medical Center, on behalf of its Adult and Pediatric Trauma Program, located at 601 Elmwood Avenue, Rochester, New York, a division of the University of Rochester, a New York educational institution organized and existing under the laws of the State of New York, and The Ira Davenport Memorial Hospital, Inc., a New York not-for-profit corporation located at 7571 State Route 54, Bath, New York 14810.

WHEREAS, the parties wish to further their interests in providing high quality patient care for the patients of their respective facilities; and

WHEREAS, the University of Rochester Medical Center is a dedicated level 1 adult and pediatric trauma center and provides comprehensive care to injured patients of all ages from the time of acute injury through long-term rehabilitation; and

WHEREAS, it is the policy of The Ira Davenport Memorial Hospital and the University of Rochester Medical Center to admit and treat all patients in accordance with their operating certificate; and without regard to race, mental status, marital status, color, creed, religion, national origin, sex, disability, sexual orientation, handicap, employment, age, blindness or sponsor; and

WHEREAS, the parties hereto wish to ensure consistent medical care and treatment for injured patients, assuring care and treatment most suited and appropriate to the patients' needs; and

WHEREAS, the parties wish to provide for an orderly transfer of adult and pediatric trauma patients from one facility to the other in accordance with the needs of the patients and subject to all applicable laws, rules, and regulations;

NOW, THEREFORE, in consideration of the promises hereinafter contained, the parties hereto agree as follows:

Section 1. Transfer of Patients

(a.1) Subject to bed availability and the terms and conditions of this Agreement The Ira Davenport Memorial Hospital may refer and/or transfer to the University of Rochester Medical Center, the regional adult and pediatric trauma center, and the University of Rochester Medical Center may accept for admission, those patients for whom treatment and care at a tertiary hospital with a dedicated trauma center and academic medical center is medically indicated and appropriate.

(a. 2) The University of Rochester Medical Center acknowledges and represents that it has services available 24 hours/day, seven days/week and that such service is at all times appropriately staffed and equipped to accommodate and treat any trauma patient transferred hereunder.

(b.) The University of Rochester Medical Center and The Ira Davenport Memorial Hospital agree that there shall be a timely transfer of trauma patients whenever a) the provider responsible for the patient's medical care at The Ira Davenport Memorial Hospital has determined that the patient is medically stable and transfer would be medically appropriate and b) the receiving provider at the University of Rochester Medical Center has agreed to the transfer and to accept care of the patient upon arrival.

(c.) No patient shall be transferred from one institution to the other unless: a) the appropriate provider at the transferring institution has contacted his or her counterpart at the receiving institution and the receiving institution has agreed to accept the patient and has the facilities available to provide the care and treatment that the patient requires, b) the transferring provider has determined that the patient is stable enough to be transported, and c) all requirements of state and federal law have been met including, but not limited to, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), in effectuating the transfer.

(d.) Patient injuries that should be referred to the regional trauma center include, but are not limited to, the following:

1) Age specific hypotension attributed to an injury.
2) Gunshot wound to neck, torso, groin, buttock, or junctional areas.
3) Respiratory compromise or need for intubation.
4) Glasgow Coma Scale equal to or less than 8 attributed to trauma.
5) History of CPR following trauma.
6) Gunshot wound to head.
7) Gunshot wound to arm or leg proximal to elbow or knee.
8) Stab wound to neck, torso, groin, buttock, or junctional areas.
9) Active bleeding requiring a tourniquet or wound packing.
10) Suspected spinal injury with any motor or bilateral sensory change.
11) Two or more suspected proximal bone fracture (to include pelvis)
12) Suspicion of child physical abuse with injuries requiring admission.
13) Significant injury with existing active medical co-morbidity or extremes of age.
14) Significant head injury (skull fracture or intracranial hemorrhage with torso or extremity trauma.
15) Multiple rib fractures or flail chest.
16) Pelvic fracture due to trauma.
17) Pregnancy of greater than 20 gestational weeks with abdominal trauma.
18) Discretion of attending.
19) Single system injury with significant mechanism which may include:
    i. Partial or complete ejection or vehicle rollover.
    ii. Fall greater than 10 feet (all ages).

iii. Death in same passenger compartment
iv. Pedestrian, bicyclist, rider thrown or run over with significant impact.
v. High speed motor vehicle crash with significant vehicular intrusion.
vi. Need for extrication for entrapped patient.
vii. Explosion or blast injury.

(e.) Except as provided in Section 2 of this Agreement, in the event the patient's condition is such, after transfer, as to warrant his or her return to the transferring institution, there shall be no automatic readmission, but rather, the patient's readmission shall be in accordance with the customary admitting policies of the original transferring institution.

Section 2. Agreement to Transfer. No patient shall be transferred from one party to the other unless the transferring institution shall have obtained the agreement of the patient or the patient's legally authorized decision-maker to transfer. In the case of an emergency where the patient is unable to agree and no legally authorized decision maker has been appointed, The Ira Davenport Memorial Hospital shall determine whether transfer is in the patient's best medical interests (in consultation with the patient's next of kin or representative if available).

Section 3. Provision of Medical and Related Information/Sharing of Diagnostic and Other Services. The transferring institution shall provide to the receiving institution copies of all medical and other information, including but not limited to medical, social, radiographic studies, nursing and other care plans, as may be relevant to enable the receiving institution to provide proper care. Such information may include, but would not necessarily be limited to: current medical findings, diagnosis and a summary of course of treatment. As required by 10 N.Y.C.R.R. Section 400.9, the Parties agree to share diagnostic and other services when such sharing is in the interest of efficiency, economy and quality of care.

Section 4. Transportation of Patient. In the event that it becomes necessary to physically transport a patient between the parties of this Agreement, it shall be the exclusive responsibility of the transferring institution to provide or arrange for the transportation of the patient to the receiving institution. The method of physically transporting the patient shall be safe, timely, and shall be medically approved by the responsible provider at the transferring institution.

Section 5. Ownership of Medical Records. The medical records for transferred patients which are maintained by each institution shall remain the property of that institution.

Section 6. Patient's Personal Property. In the event that it becomes necessary to transfer a patient between the parties, simultaneously with such transfer, the transferring institution may arrange for the transfer of the patient's personal effects and valuables to the receiving institution. Personal effects, especially monies and valuables, shall be transported safely and shall be stored in a safe place that is reasonably accessible to the patient or person or agency legally authorized to act on behalf of the patient. The responsibility of the receiving institution hereunder shall be limited to patient items actually transferred from the transferring institution. The receiving

institution shall not be responsible for any items retained by the patient or a family member, or for any items retained by the transferring institution. The parties to this Agreement may develop further policies and procedures to effectuate this Section.

Section 7. Consultations, Care and Treatment.

(a) The provider of the transferring institution shall be available to the providers of the receiving institution for consultation with respect to the care and treatment of any patient who transferred pursuant to this Agreement.

(b) Notwithstanding any provision in this Agreement to the contrary, this Agreement grants no right to the provider in the transferring institution to participate in or control the care and treatment of a patient who transferred pursuant to this Agreement, once the patient has arrived and has been admitted to the University of Rochester Medical Center. Any provider who is permitted to participate in the care and treatment of a patient, following transfer pursuant to this Agreement, must comply with the bylaws, rules and regulations of the receiving institution.

Section 8. Autonomy of Each Institution.

(a) This Agreement shall not alter the fact that the parties to this Agreement remain in exclusive control of their respective policies, management, assets and affairs. All services rendered hereunder and all admissions to or acceptance for treatment by either institution shall be subject to the bylaws, rules, and regulations of such institution and its medical staff. Neither institution shall, by virtue of this Agreement, assume any liability or obligation of the other institution. Each institution shall be individually responsible for billing and collecting charges for the services it has rendered.

(b) Notwithstanding any other provision of this Agreement, each facility remains responsible for ensuring that any services provided pursuant to this Agreement comply with all pertinent provisions of Federal, State, and local statutes, rules and regulations.

(c) Each party shall be solely responsible for the submission of any and all claims for payment for any services it provides.

(d) The Ira Davenport Memorial Hospital shall indemnify, defend, and hold harmless the University of Rochester Medical Center, its employees, and agents at all times during and after the term of this Agreement, against any claims, demands, losses, liability, damages or expenses (including without limitation, any settlement payment, reasonable legal fees and other expenses incurred in litigation or settlement of any claims) of whatever nature, arising from or in any way connected with a breach by The Ira Davenport Memorial Hospital of any term or condition contained in this Agreement or the negligent or intentional acts of The

Ira Davenport Memorial Hospital, its directors, officers, employees, agents, or independent contractors acting on its behalf.

The University of Rochester Medical Center shall indemnify, defend, and hold harmless The Ira Davenport Memorial Hospital, its employees and agents, at all times during and after the term of this Agreement, against any claims, demands, losses, liability, damages or expenses (including without limitation, any settlement payment, reasonable legal fees and other expenses incurred in litigation or settlement of any claims) of whatever nature, arising from or in any way connected with a breach by the University of Rochester Medical Center of any term or condition contained in this Agreement, or the negligent or intentional acts of the University of Rochester Medical Center, its directors, officers, employees, agents, or independent contractors acting on its behalf.

Section 9. Non-Exclusivity. Nothing in this Agreement shall prohibit either institution from affiliating or contracting with any other hospital or facility for this same or any other purpose whatsoever.

Section 10. Use of Name. Neither party to this Agreement shall use the name of the other institution in any promotional or advertising materials without first obtaining written approval from the institution whose name is to be used.

Section 11. Non-discrimination and Non-referral:

(a) The Ira Davenport Memorial Hospital and the University of Rochester Medical Center agree that services to pediatric trauma patients will be provided regardless of patient's ability to pay or source of payment. Both parties commit to serving the underserved populations.

(b) Notwithstanding any other provisions of this Agreement, neither The Ira Davenport Memorial Hospital, nor any of its medical staff are required to refer any patients to the University of Rochester Medical Center, and neither the University of Rochester Medical Center nor any of its medical staff are required to refer any patients to The Ira Davenport Memorial Hospital.

Section 12. Term and Termination.

(a) This Agreement shall remain in force for five (5) years from the date first written above unless terminated as hereinafter provided. This Agreement shall automatically renew for successive one (1) year terms, unless earlier terminated as hereinafter provided.

(b) This Agreement may be terminated by either party upon not less than ninety (90) days written notice to the other party, or by mutual consent of the parties at any

time. The parties may, by amendment to this Agreement, specify other provisions regarding termination as to any service to be provided hereunder.

(c) In the event that either party shall lose its accreditation, operating certificate, or licensure, it shall immediately notify the other party of that fact in writing. The other party may, upon written notice, terminate this Agreement immediately and the requirement of ninety (90) days written notice or mutual consent shall not apply.

Section 13. Notices:

All notices required to be made hereunder shall be in writing signed by the party giving it and, except in the case of a notice to change address which will be completed when the notice is received, shall be deemed to have been duly given if delivered or mailed postage prepared by registered or certified mail, return receipt requested, as follows:

In the case of The Ira Davenport Memorial Hospital:
7571 State Route 54,
Bath, New York 14810
ATTN: Elizabeth Weir, VP of Nursing

In the case of the University of Rochester Medical Center:
Adult and Pediatric Trauma Center
Strong Memorial Hospital
601 Elmwood Avenue, Box SURG
Rochester, NY 14642
Attn: Trauma Medical Director

In the case of the University of Rochester Medical Center:
Strong Memorial Hospital
601 Elmwood Avenue,
Rochester, NY 14642
Attn: Kathy Parrinello, COO & Executive VP

Section 14. Applicable Law. This Agreement shall be construed in accordance with the laws of the State of New York. Venue for any dispute arising out of this Agreement shall be in Monroe County, New York.

Section 15. HIPAA Compliance. The parties acknowledge that both are bound by the provisions of the Health Care Portability and Accountability Act of 1996 ("HIPAA") and each is responsible for its own compliance therewith.

Section 16. Counterparts. This Agreement may be executed in two (2) counterparts, each of which shall be considered an original for all purposes.

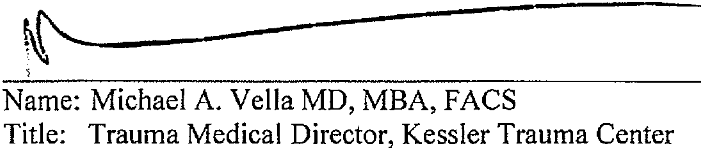
Section 17. Entire Agreement: Modification. This agreement contains the entire understanding between the parties and no alteration or modification hereof shall be effective except in a subsequent written instrument executed by both parties.

Section 18. Severability. If any provision of this Agreement is determined to be invalid or unenforceable, in whole or in part, the remaining provisions shall remain binding and enforceable.

Section 19. Insurance. Each Party shall maintain General Liability and Professional Liability Insurance with limits of $1,000,000 per occurrence and $3,000,000 annual aggregate. Any coverage amounts may be achieved by either traditional insurance risk transfer with an insurance carrier carrying an AM Best Rating of A- or better, a risk retention group, or other self-insurance arrangement. Limits may be satisfied by a combination of primary and excess policies.

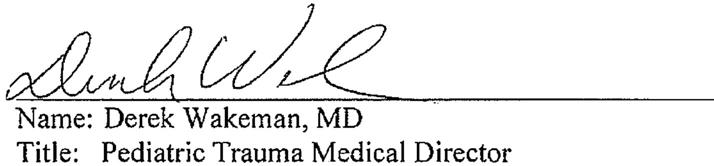
IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date and year first written above:

The University of Rochester Medical Center
Adult and Pediatric Trauma Center:



Name: Michael A. Vella MD, MBA, FACS
Title: Trauma Medical Director, Kessler Trauma Center

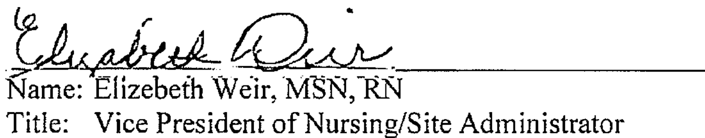
11/3/23
Date:



Name: Derek Wakeman, MD
Title: Pediatric Trauma Medical Director

11/6/23
Date:

The Ira Davenport Memorial Hospital, Inc.:



Name: Elizebeth Weir, MSN, RN
Title: Vice President of Nursing/Site Administrator

11/1/23
Date:

Status Active PolicyStat ID 14178365

Origination	10/2013	Owner	Susan Steadle: Systems Director Case Management
Last Approved	09/2023	Area	Continuum of Care
Effective	09/2023	Locations	AOMC, IDMH, SJH
Last Revised	09/2023		
Next Review	09/2025		

Discharge Planning

COPY

POLICY:

1. Discharge planning is a coordinated multidisciplinary process in which patients and families, medical staff, nursing staff, social workers, case managers and other disciplines collaborate and coordinate care to ensure that the patient's care needs are met during and following the hospital stay.
2. Discharge planning begins on admission, continues throughout the hospitalization, is individualized to the patient, and is the responsibility of all team members.
   a. Discharge planning begins with physician and nursing assessment upon admission to inpatient or observation status.
   b. When a high risk patient is identified by Nursing/MD in the emergency department nursing will refer to Case Management/Social Work.
   c. ED Utilization Review Case Manager or reviewing Case Manager will complete an initial evaluation to assess for potential discharge needs. Discharge screen will be based on information available at time of review.
   d. COC Department will follow patients through multidisciplinary rounds as a continuation to assess for potential discharge needs. As discharge needs are identified, the COC Department will address with the patient and/or family or caregiver, as appropriate.
   e. If discharge needs are identified at time of discharge by nursing, MD, patient and/or family or caregiver, nursing will refer to a member of the COC Department prior to patient's discharge.
3. Members of the multidisciplinary process team:
   a. Participate in multidisciplinary bed huddles, and discharge planning meetings.

b. Initiate referrals to other disciplines as patient needs become evident.
c. Are responsible for assessing the patient on a continuing basis to identify changes in clinical condition or family dynamics with the potential to alter the discharge plan.
d. Are responsible for working with the attending physician in developing the discharge plan, including the completion of all consults, labs, imaging and the discharge orders.
e. Must offer patients a choice when making post-discharge arrangements for SNF or Home Care services as described in the "Patient Choice of Post Discharge Services" policy COC.130, to ensure compliance with Federal regulations.

4. Initial and continued assessments could include:
    a. Functional status – the ability to carry out activities of daily living and live independently
    b. Cognitive status – the ability to participate in the discharge planning process and the ability to learn new information
    c. Psychological status of the patient
    d. Patient's perception of self-care ability
    e. Capabilities of family/care giver to support and give care to the patient
    f. Prior link to community services and post-acute health services
    g. History of readmissions to the hospital
5. Assessment factors and diagnosis indicative of more complex discharge planning needs include:
    a. Inability to care for self
    b. Confusion/disorientations
    c. Homelessness
    d. History of falls
    e. Complex or new post-discharge needs, such as TPN, complex wound care/wound vac, IV therapies, ostomies, tube feeding or pain control issues
    f. Pattern of readmissions within 30 days
    g. Suspected abuse or neglect of child or adult
    h. Weak/poor support system, where primary caregiver is either unavailable or unreliable
    i. Respiratory failure and ventilator dependency
    j. Chronic illness, including renal disease, CHF, COPD or new or uncontrolled diabetes
    k. Head injury, paralysis, or CVA
    l. Terminal illness
    m. Trauma or burns
    n. Attempted suicide

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o. Drug or alcohol abuse

p. Amputation

6. The Case Manager or Social Worker play a unique role in the discharge planning process by:
    a. Identifying current and anticipated post acute services and community services available to the patient.
    b. Monitoring the patients discharge plans and assure they are consistent with the patient's insurance and resources.
    c. Identifying a post discharge caregiver(s) as needed and assessing their willingness and ability to meet the patient's needs.
    d. Actively coordinating the plan when psycho/social complexities are present.
    e. COC Department is responsible for documenting discharge plan after final assessment is completed with those patients identified with a discharge need.
7. Any member of the team may make a referral to Social Work when case complexity is high or psychosocial needs present.
    a. Social Work will respond to a referral within 24 hours or the next business day. Cases generally referred to Social Work can be found in the "High Risk Screen for Social Work" policy COC.060.
    b. The Case Manager, in collaboration with the health care team, is responsible for determining the most appropriate level of care for each patient. Using discharge screens and post-acute guidelines, the Case Manager will recommend the appropriate level of care. The Case Manager also will refer to the individual health plan guidelines and preferred providers.
    c. Refer to "Case Manager High Risk Screen" policy COC.050.
8. The following is a sampling of the levels of care:
    a. Hospital Level/Acute Rehabilitation
    b. Long-Term Acute Care
    c. Sub-acute Rehab (SAR)
    d. Skilled Nursing Facility
    e. Hospice Patient
    f. Home Health Care
    g. Disease Management

* There is an exception on Ira Davenport's campus. Ira campus case management is performed by the day charge RN in conjunction with the Utilization Reviewer (Director of Quality & Patient Safety) and Social Services.

POLICY #: COC.030

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Approval Signatures

Step Description	Approver	Date
Approver	John Mallia: Chief Financial Officer	09/2023
	Susan Steadle: Systems Director Case Management	08/2023

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