Limited Review Application

State of New York Department of Health
Office of Primary Care and Health Systems Management

LRA Cover Sheet

Project to be Proposed/Applicant Information

This application is for those projects subject to a limited review pursuant to 10 NYCRR 710.1(c)(5)-(7). Please check the appropriate box(es) reflective of the project being proposed by your facility (**NOTE** – Some projects may involve requisite "Construction". If so, and ***total*** project costs are below designated thresholds, then **both boxes** must be checked and necessary LRA Schedules submitted). ***Please read the LRA Instructions to ensure submission of an appropriate and complete application:***

☐ **Minor Construction** – Minor construction project with total project costs of up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities, if not relating to clinical space – check "Non-Clinical" box below).

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, and 6.

☐ **Equipment** – Project related to the acquisition, relocation, installation or modification of certain medical equipment, with total project costs of up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (**NOT** necessary for "1-for-1" replacement of existing equipment without construction, pursuant to Chapter 174 of the Laws of 2011 amending Article 28 of the Public Health law to eliminate limited review and CON review for one for one equipment replacement)
Necessary LRA Schedules: Cover Sheet, 2, 3, 4, and 5.

☒ **Service Delivery** – Project to decertify a facility's beds/services; add services which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities; or convert beds within approved categories. (*If construction associated, also check "Construction" above.*)
Necessary LRA Schedules: Cover Sheet, 2, 6, 7, 8, 10, and 12. **If proposing to decertify beds within a nursing home, provide a description of the proposed alternative use of the space including a detailed sketch (unless the decertification is being accomplished by eliminating beds in multiple-bedded rooms). If proposing to convert beds within approved categories, an LRA Schedule 6 and all supporting documentation are required to confirm appropriate space for the new use.*

☐ **Cardiac Services** – Project by an appropriately certified facility to add electrophysiology (EP) services; or add, upgrade or replace a cardiac catheterization laboratory or equipment. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 7, 8, 10, and 12.

☐ **Relocation of Extension Clinic** – Project to relocate an extension clinic within the same service area which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, 6 and 7. Also include a Closure Plan for vacating extension clinic.

☐ **Part-Time Clinic** – Project to operate, change services offered, change hours of operation or relocate a part-time clinic site – for applicants already certified for "part-time clinic". (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 8, 10, 11, and 12.

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
[redacted]	Servants of Relief for Incurable Cancer	Voluntary RHCF

OPERATOR ADDRESS – STREET & NUMBER 600 Linda Avenue		PFI [redacted]	NAME AND TITLE OF CONTACT PERSON [redacted], Administrator		
CITY Hawthorne	COUNTY Westchester	ZIP 10532	STREET AND NUMBER Rosary Hill Home 600 Linda Avenue		
PROJECT SITE ADDRESS – STREET & NUMBER Same		PFI 1141	CITY Hawthorne	STATE NY	ZIP 10532
CITY Same	COUNTY Same	ZIP	TELEPHONE NUMBER 914-769-0114	FAX NUMBER 914-769-3916	
TOTAL PROJECT COST: $ 0.00			CONTACT E-MAIL: [redacted]		

(Rev 09/2019)

Application Number: 241262

Facility Name: Rosary Hill Home

Project Description: Decertify 12 RHCF beds to turn 3-bedded rooms into 2-bedded, and make space for a Nurse Aide Training Program

Executive Summary

Rosary Hill Home, operated by the Dominican Sisters of Hawthorne, is a 54-bed licensed, voluntary RHCF dedicated to providing palliative care to indigent, terminally ill cancer patients. The Home does not participate in either the Medicare or Medicaid program. Our daily census has not exceeded 30 patients in over 5 years, and we currently do not anticipate a significant increase in the near future. It is this persistent low utilization experience and expectation that motivates our request for the **decertification of 12 beds**. All the beds being decertified are located in what presently are 3-bedded resident rooms (wards). Once the 12 beds are decertified, 9 of the 10 3-bedded rooms will be downsized to 2 beds. The last 3-bedded room we hope to turn into a training room for a Nurse Aide Training Program (NATP) we are seeking approval for. **These changes will ultimately improve our infection prevention efforts and the living and working space for our patients and staff.**

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 2

NOT APPLICABLE

Total Project Cost

ITEM	ESTIMATED PROJECT COST	
1.1 Land Acquisition (*attach documentation*)	$	0.00
1.2 Building Acquisition	$	0.00
	1.1-1.2 Subtotal: 0.00	
2.1 New Construction	$	0.00
2.2 Renovation and Demolition	$	0.00
2.3 Site Development	$	0.00
2.4 Temporary Power	$	0.00
	2.1-2.4 Subtotal: 0.00	
3.1 Design Contingency	$	0.00
3.2 Construction Contingency	$	0.00
	3.1-3.2 Subtotal: 0.00	
4.1 Fixed Equipment (NIC)	$	0.00
4.2 Planning Consultant Fees	$	0.00
4.3 Architect/Engineering Fees (incl. computer installation, design, etc.)	$	0.00
4.4 Construction Manager Fees	$	0.00
4.5 Capitalized Licensing Fees	$	0.00
4.6 Health Information Technology Costs	$	0.00
4.6.1 Computer Installation, Design, etc.	$	0.00
4.6.2 Consultant, Construction Manager Fees, etc.	$	0.00
4.6.3 Software Licensing, Support Fees	$	0.00
4.6.4 Computer Hardware/Software Fees	$	0.00
4.7 Other Project Fees (Consultant, etc.)	$	0.00
	4.1-4.7 Subtotal: 0.00	
5.1 Movable Equipment	$	0.00
6.1 Total Basic Cost of Construction	**$**	**0.00**
7.1 Financing Cost (points, fees, etc.)	$	0.00
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount $ @ % for months		0.00
7.3 Application Fee	$	0
8.1 Estimated Total Project Cost (Total 6.1 – 7.3)	**$**	**0.00**

If this project involves construction enter the following anticipated construction dates on which your cost estimates are based.

Construction Start Date ____________________

Construction Completion Date ____________________

(Rev. 1/31/2013)

Schedule 6
Architectural/Engineering Submission

Contents:

- **Schedule 6 – Architectural/Engineering Submission**

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.

<table>
<tr><th colspan="2">Project Description</th></tr>
<tr><td>Schedule 6 submission date:
8/12/2024</td><td>Revised Schedule 6 submission date:
Click to enter a date.</td></tr>
<tr><td colspan="2">Does this project amend or supersede prior CON approvals or a pending application? No
If so, what is the original CON number? Click here to enter text.</td></tr>
<tr><td colspan="2">Intent/Purpose:
The conversion of a patient room to a room for the training of nurse's aides. The removal of 12 patient beds.</td></tr>
<tr><td colspan="2">Site Location:
600 Linda Avenue, Hawthorne, NY 10532</td></tr>
</table>

Brief description of current facility, including facility type: Skilled Nursing Facility dedicated to the palliative care of incurable cancer patients. Not CMS certified and charges nothing to the patients or insurance.	
Brief description of proposed facility: No change.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. Room 102 – Occupancy Type: Classroom (Nurses Aid Training Room)	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: N/A	
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: N/A	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. N/A	
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. Click here to enter text.	Not Applicable
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. N/A	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. N/A	
Describe existing and or new work for fire detection, alarm, and communication systems: N/A	
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. N/A	
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. N/A	
Does the project comply with ADA? If no, list all areas of noncompliance. Room 102 complies with ADA. The restroom in room 102 is not fully ADA compliant, but the facility contains other compliant ADA restrooms.	
Other pertinent information: There is not any construction or physical alterations to the facility associated with this application.	

Project Work Area	**Response**
Type of Work	Alteration
Square footages of existing areas, existing floor and or existing building.	436 sq. ft.
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	N/A
Does the work area exceed more than 50% of the smoke compartment, floor or building?	Less than 50% of the floor
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type II (111)

Building Height	+/- 50' (Varies)
Building Number of Stories	3
Which edition of FGI is being used for this project?	Choose an item. Not Applicable (No Construction Involved)
Is the proposed work area located in a basement or underground building?	Grade Level
Is the proposed work area within a windowless space or building?	No
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?	Chapter 38 New Business Occupancy
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. Click here to enter text.	Decrease
Changes in the number of occupants? If yes, what is the new number of occupants? 42	Yes
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Type 2	Yes
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.	Yes
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?	Choose an item.
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

SULLIVAN ARCHITECTURE, PC

ARCHITECTURE
SITE PLANNING
URBAN DESIGN

August 12, 2024

NYS Department of Health / Office of Health Systems Management
Center for Health Care Facility Planning, Licensure and Finance
Bureau of Architecture and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

Re: Rosary Hill Home

To Whom It May Concern,

We as architects, have been retained by the Rosary Hill Home to document a minor change in use at their existing facility in Hawthorne, NY. This letter serves as an "Architectural Narrative," as is outlined and required by the "New York State Department of Health – Schedule 6 – Certificate of Need Application".

The Rosary Hill Home is proposing to change the use of an existing patient room (Room 102) to a classroom for the training of nurse aids. There is no proposed construction or physical alteration of the room, or any other part of the facility, as part of this application.

Room 102 currently serves as a patient ward that contains (3) patient beds. The proposed training room will retain (2) beds for training purposes, (4) movable desks, and a markerboard for instruction. (reduction of (3) patient beds)

<u>Functional Space Program – Room 102</u>

Floor:	1 (Level "B")
Gross Floor Area:	485 sq. ft.
Clear Floor Area:	436 sq. ft.

The Rosary Hill Home is also proposing a bed count change to the following patient ward rooms, which does not include any construction or physical alternations:

<u>Floor 1 (Level "B")</u>

Room 103 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 151 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 152 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 153 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)

<u>Floor 2 (Level "C")</u>

Room 202 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 203 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 251 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 252 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)
Room 253 - (3) Patient Beds to (2) Patient Beds	(Reduction of (1) Patient Bed)

Total Reduction of patient beds: (12)

Per the "Required Attachment Table" for schematic design submission, please see the following:

31 Mamaroneck Avenue
White Plains, New York 10601
(914) 761-6006 Fax: (914) 761-4919
E-mail: jpsfaia@sullivanarch.com
www.sullivanarch.com

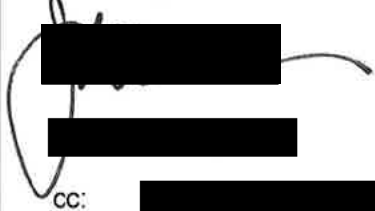
SULLIVAN ARCHITECTURE, PC

ARCHITECTURE
SITE PLANNING
URBAN DESIGN

• Architectural Narrative:	This Letter
• Functional Space Program:	This Letter
• Architect Certification Form:	See Attached
• FEMA BFE Certificate	Not Applicable
• Architectural/Life Safety Drawings:	See Attached (A1.0)
• Exterior Elevations:	Not Applicable (No Change)
• Vertical Circulation:	Shown on Drawing (A1.0)
• Reflected Ceiling Plans:	Not Applicable (No Change)

If you should have any questions or require any other information, please do not hesitate to contact our office.

Sincerely,



cc: Administrator

31 Mamaroneck Avenue
White Plains, New York 10601
(914) 761-6006 Fax: (914) 761-4919
E-mail: jpsfaia@sullivanarch.com
www.sullivanarch.com

SULLIVAN ARCHITECTURE, PC

ARCHITECTURE
SITE PLANNING
URBAN DESIGN

August 21, 2024

[redacted]
NYS Department of Health / Office of Health Systems Management
Center for Health Care Facility Planning, Licensure and Finance
Bureau of Architecture and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

Re: Rosary Hill Home – Nurse Aide Training Room

Dear [redacted],

We are in receipt of your letter dated August 20th, 2024, addressed to [redacted] in reference to the room change at the Rosary Hill facility. As a clarification, the proposed change of the existing patient room to a nurse-aide training room will be for the use of facility staff only and therefore would qualify as incidental instruction. There will be no use of this space by the outside public.

Please find attached revised drawing A1.0, with clouded changes that further illustrates this clarification.

If you should have any questions or require any other information, please do not hesitate to contact our office.

Sincerely,

[redacted]

[redacted]

cc: [redacted]

31 Mamaroneck Avenue
White Plains, New York 10601
(914) 761-6006 Fax: (914) 761-4919
E-mail: jpsfaia@sullivanarch.com
www.sullivanarch.com

Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

CERTIFICATION LETTER FOR INSPECTING EXISTING BUILDINGS FOR ARCHITECTS/ENGINEERS

Date: 8.21.24
CON Number: 241262
Facility Name: ROSARY HILL HOME
Facility ID Number: 1141
Facility Address: 600 LINDA AVE. HAWTHORNE, NY 10532

NYS Department of Health/Office of Health Systems Management
Center for Health Care Facility Planning, Licensure and Finance
Bureau of Architectural and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

To The New York State Department of Health:

I hereby certify that:

1. I have been retained to evaluate the aforementioned facility for compliance with all applicable codes and regulations that are in effect at the time this application is being submitted.
2. I have ascertained that, to the best of my knowledge, information and belief, the existing structure is compatible with the programmatic features for the referenced project and in accordance with any project definitions, modifications and or revisions approved or required by the New York State Department of Health.
3. The above-reference structure is in compliance with all applicable local, state, and federal codes, statutes, and regulations, and the applicable provisions of the State Hospital Code -- 10 NYCRR Part 711 (General Standards for Construction) and Parts (check all that apply):
   a. __712 (Standards of Construction for General Hospital Facilities)
   b. ✓713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. __715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:
   THERE IS NO PROPOSED CONSTRUCTION OR PHYSICAL ALTERATION OF ANY PART OF THE FACILITY AS PART OF THIS APPLICATION.

4. I understand that if upon evaluation of the facility a component is inconsistent with the State Hospital Code (10 NYCRR Parts 711, 712, 713, 714, 715, 716, or 717), I shall bring this to the

attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department of Health for compliance resolution.

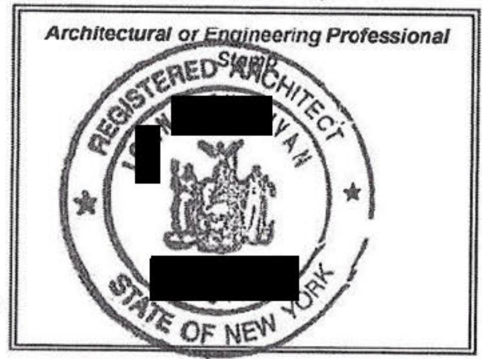
5. I understand non-article 28 areas, spaces, rooms and facilities being converted to Article 28 facilities shall be evaluated and shall be brought into compliance for new construction standards as indicated with applicable requirements of 10 NYCRR Parts 711, 712, 713, 714, 715, 716 and 717 shall be met.
6. I understand that upon completion of evaluation, the costs of any subsequent corrections necessary to achieve compliance with applicable requirements of 10 NYCRR Parts 711, 712, 713, 714, 715, 716 and 717, when the prior work was not completed properly as certified herein, may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office.

Project Name: ROSARY HILL HOME

Location: 600 LINDA AVE. HAWTHORNE, NY 10532

Description: THE CONVERSION OF A PATIENT ROOM INTO A TRAINING ROOM



Signature of NYS Licensed Architect/Engineer

Name of Architect/Engineer (Print)

Professional New York State License Number

31 MAMARONECK AVE. WHITE PLAINS, NY 10601
Business Address

The undersigned applicant understands and agrees that, notwithstanding this architectural/engineering certification the Department of Health shall have continuing authority to (a) review the plans in existence and/or inspect the project with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the Department to comply with existing and future codes and regulations.

Authorized Signature for Applicant

8/23/2024
Date

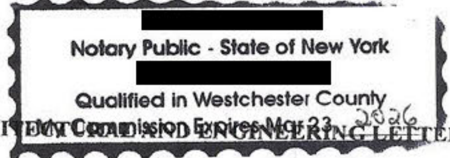
Name (Print) Title

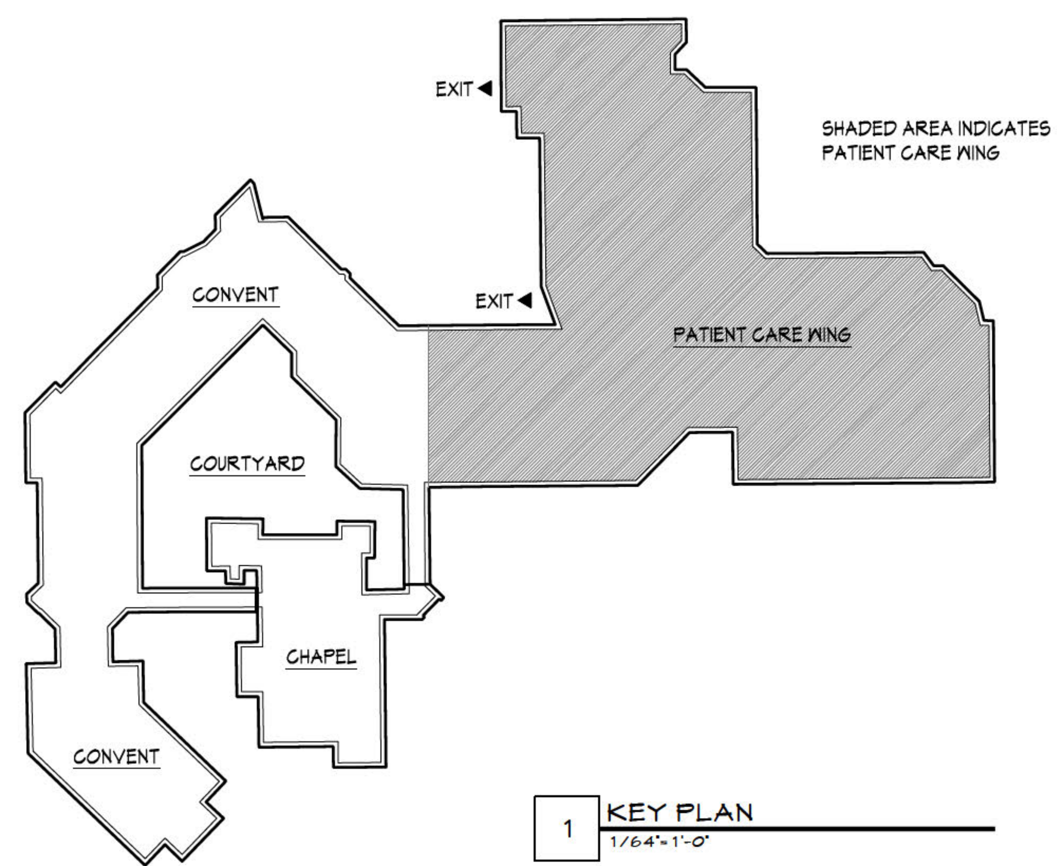
Notary signing required for the applicant

STATE OF NEW YORK)
) SS:
County of WESTCHESTER)

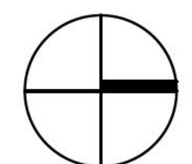
On the 23rd day of AUGUST 2024, before me personally appeared [redacted] to me known, who being by me duly sworn, did depose and say that ~~he~~/she is the ADMINISTRATOR of the ROSARY HILL HOME NURSING FACILITY, the facility described herein which executed the foregoing instrument; and that ~~he~~/she signed ~~his~~/her name thereto by order of the governing authority of said facility.

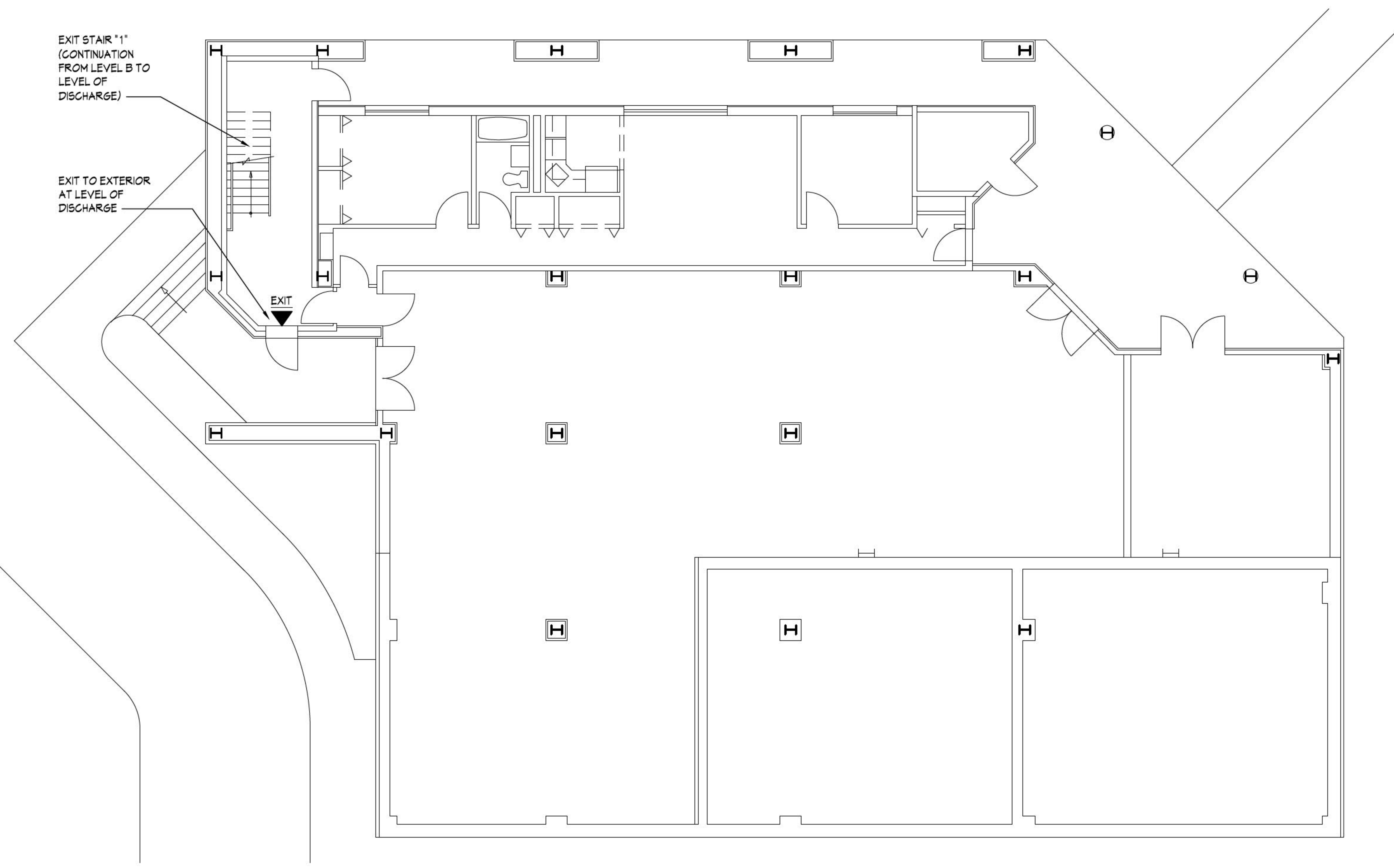
(Notary)



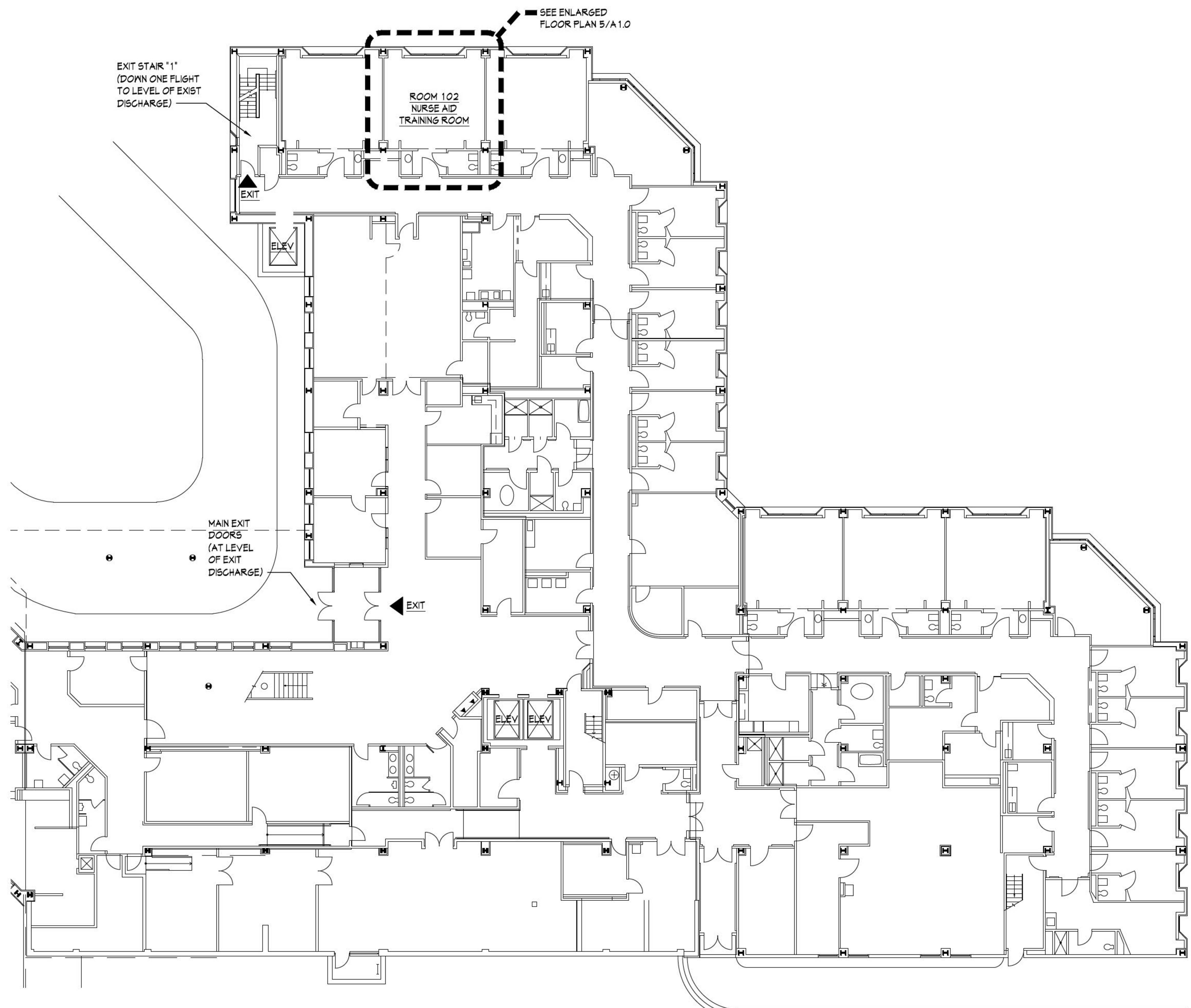


1 KEY PLAN
1/64"=1'-0"

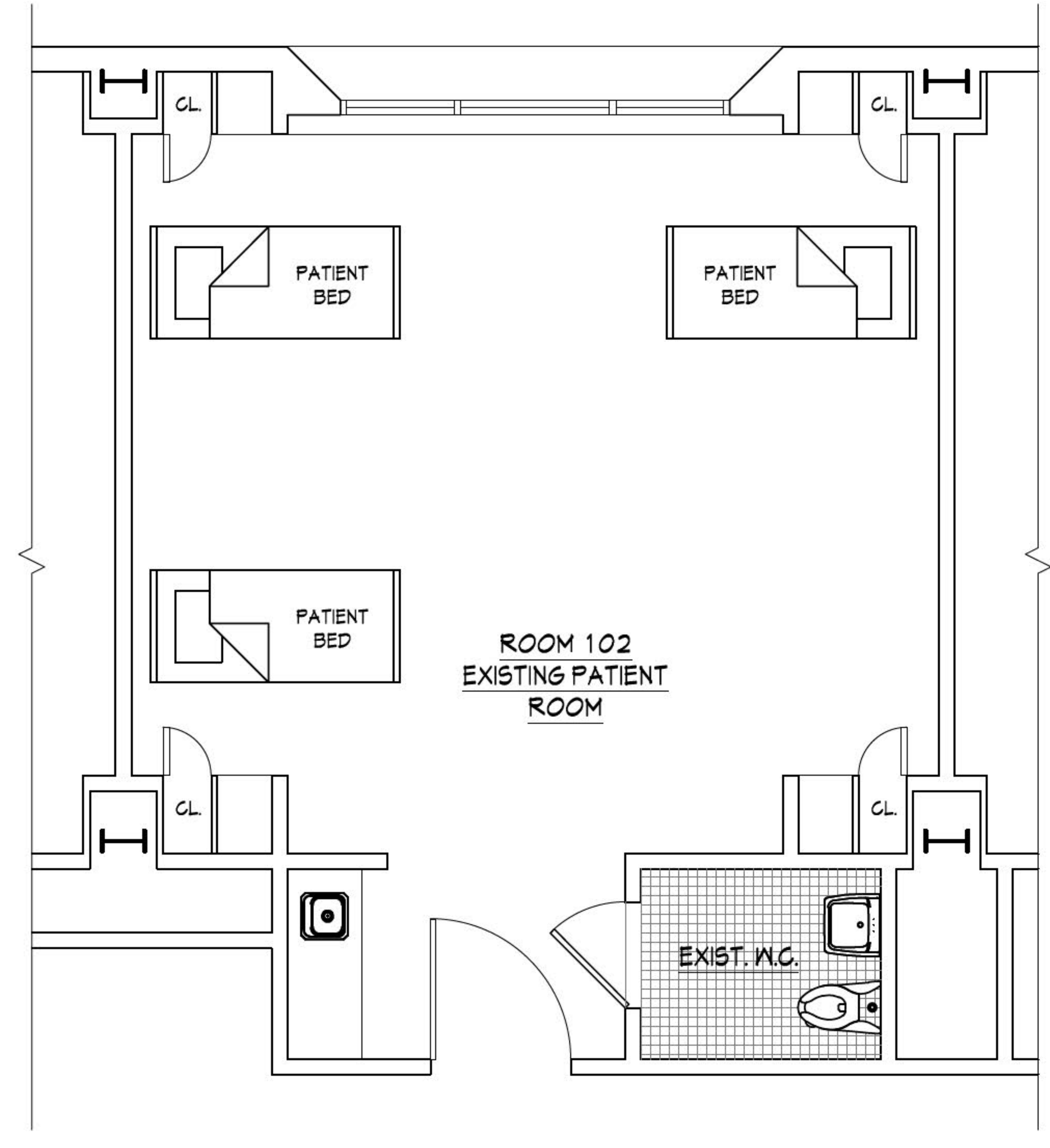




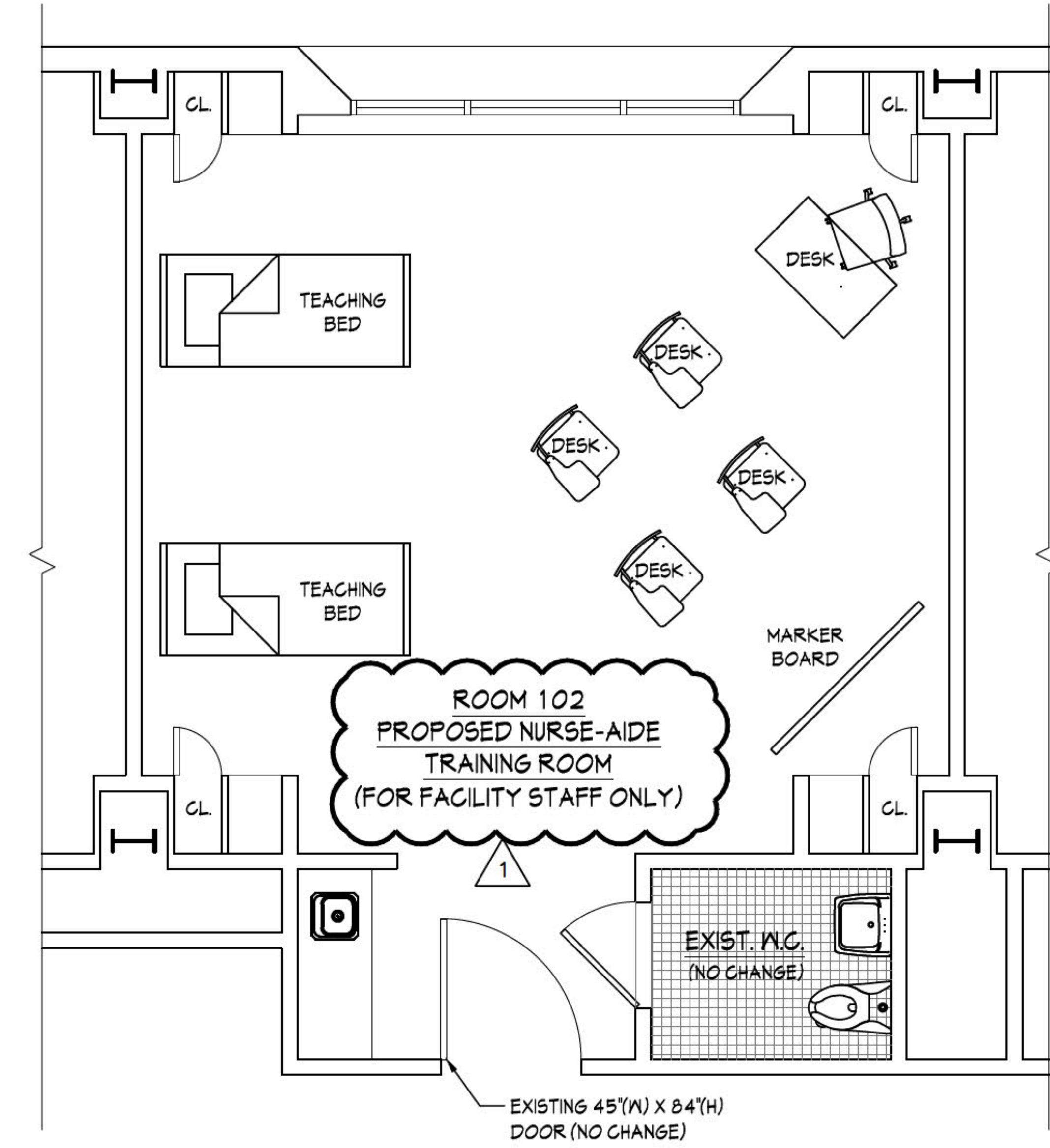
3 LEVEL "A" FLOOR PLAN - PATIENT CARE WING
1/16"=1'-0"



2 LEVEL "B" FLOOR PLAN - PATIENT CARE WING
1/16"=1'-0"



4 ENLARGED FLOOR PLAN - ROOM 102 (EXIST. PATIENT RM.)
1/4"=1'-0"



5 ENLARGED FLOOR PLAN - ROOM 102 (PROPOSED CLASSROOM)
1/4"=1'-0"

GENERAL NOTES:

- ROOM 108 SHOWN WITH PROPOSED FURNITURE LAYOUT FOR NURSE AID TRAINING USE - ANTICIPATED NOT TO EXCEED (4) STUDENTS AND (1) INSTRUCTOR AT ANY TIME
- THERE ARE NO PROPOSED CONSTRUCTION CHANGES OR PHYSICAL ALTERATIONS TO THE EXISTING ROOM ASSOCIATED WITH THE CONVERSION OF THE PATIENT CARE ROOM TO A TRAINING ROOM
- CLASSROOM PERMITTED OCCUPANCY:
  - CLASSROOM AREA: 20 NET (TABLE 1004.5 - 2020 BUILDING CODE OF NEW YORK STATE)
  - CLEAR FLOOR AREA= 436 SQ. FT.
  - 436/20= 21.8 (21 TOTAL PERMITTED OCCUPANTS)
- SEE ENLARGED FLOOR PLANS FOR EXITS TO LEVELS OF DISCHARGE

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Sullivan Architecture, P.C.
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White Plains, New York 10601
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John P. Sullivan, FAIA - Lisc. # 017185 Registered through 4/30/24

Project Title	Date Issue	Project No.	2411
Rosary Hill Home	08.12.24 N.Y.S. D.O.H. SUBMISSION	Date	08.02.2024
600 Linda Avenue, Hawthorne, NY 10532	08.21.24 N.Y.S. D.O.H. COMMENTS 1	Drawing By	cjp
		Scale	AS NOTED

Drawing Title: CONVERSION OF ROOM 102 TO FACILITY STAFF TRAINING ROOM

Drawing No. A1.0

Limited Review Application

Schedule LRA 7

State of New York Department of Health
Office of Primary Care and Health Systems Management

NOT APPLICABLE

Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue	0	0	$0.00
Grants Funds	0	0	$0.00
Foundation	0	0	$0.00
Other	0	0	$0.00
Fees	0	0	$0.00
Other Income			
(1) Total Revenues	$	$	$
Expenses			
Salaries and Wage Expense	0	0	$0.00
Employee Benefits	0	0	$0.00
Professional Fees	0	0	$0.00
Medical & Surgical Supplies	0	0	$0.00
Non-Medical Equipment	0	0	$0.00
Purchased Services	0	0	$0.00
Other Direct Expense	0	0	$0.00
Utilities Expense	0	0	$0.00
Interest Expense	0	0	$0.00
Rent Expense	0	0	N/A
Depreciation Expense			
Other Expenses			
(2) Total Expense	$	$	$
Net Total - (1-2) →	***$***	***$***	***$***

(Rev. 7/2015)

Limited Review Application

Schedule LRA 7A

State of New York Department of Health
Office of Primary Care and Health Systems Management

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 ☐ Patient discharges ☐

Inpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Patient Days or dis-charges	Net Revenue*		Patient Days or dis-charges	Net Revenue*		Patient Days or dis-charges	Net Revenue*	
			%	Dollars ($)		% based on days or discharges	Dollars-$		% based on days or discharges	Dollars-$
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total			100%			100%			100%	

Outpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue*		Visits	Net Revenue*		Visits	Net Revenue*	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total			100%			100%			100%	

Total of Inpatient and Outpatient Services									

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.		
2. In an attachment, provide the basis for charity care.		

*Net of Deductions from Revenue

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 8

Staffing

Not Applicable

Staffing Categories	Number of FTEs to the Nearest Tenth		
	Current Year*	First Year of implementation	Third Year of implementation
Health Providers:**			
Support Staff*:**			
Total Number of Employees			

* Last complete year prior to submitting application

** "Health Providers" includes all providers serving patients at the site. A Health Provider is any staff who can provide a billable service – physician, dentist, dental hygienist, podiatrist, physician assistant, physical therapist, etc.

*** All other staff.

Describe how the number and mix of staff were determined:

PLEASE COMPLETE THE FOLLOWING:

1. Are staff paid and on Payroll? ☐ Yes ☐ No
2. Provide copies of contracts for any independent contractor.
3. Please attach the Medical Doctors C.V.
4. Is this facility affiliated with any other facilities? (If yes, please describe affiliation and/or agreement.) ☐ Yes ☐ No

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 10

The Sites Tab in NYSE-CON has replaced Schedule LRA 10. Schedule LRA 10 is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval. *However, due to programming issues, you may still be required to upload a blank Schedule LRA 10 to submit a Service Delivery LRA application.*

Impact of Limited Review Application on Operating Certificate (services specific to the site)

Instructions:
"Current" Column: Mark "x" in the box only if the service ***currently*** appears on the operating certificate (OpCert), prior to any requested changes
"Add" Column: Mark "x" in the box if this CON application seeks to add.
"Remove" Column: Mark "x" in the box if this CON application seeks to decertify.
"Proposed" Column: Mark "x" in the boxes corresponding to all the services that will ultimately appear on the OpCert if this CON application is approved.

Category/Authorized Service	Code	Current	Add	Remove	Proposed
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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

☐ No

☐ Yes *(Enter CON numbers to the right)* ________ ________ ________

Limited Review Application

Schedule LRA 12

State of New York Department of Health/Office of Health Systems Management

Assurances

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 (Title 10).

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 insure 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.

06/09/2024
Date

Signature

Name (Please Type)

Administrator
Title (Please Type)

New York State Department of Health
Health Equity Impact Assessment Requirement Criteria

Effective June 22, 2023, a Health Equity Impact Assessment (HEIA) will be required as part of Certificate of Need (CON) applications submitted by facilities (Applicant), pursuant to Public Health Law (PHL) § 2802-b and corresponding regulations at Title 10 New York Codes, Rules and Regulations (NYCRR) § 400.26. This form must be used by the Applicant to determine if a HEIA is required as part of a CON application.

Section A. Diagnostic and Treatment Centers (D&TC) - ***This section should only be completed by D&TCs, all other Applicants continue to Section B.***

Table A.

Diagnostic and Treatment Centers for HEIA Requirement	Yes	No
Is the Diagnostic and Treatment Center's patient population less than 50% patients enrolled in Medicaid and/or uninsured (combined)?		
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?		

- ***If you checked "no" for both questions in Table A,*** you do not have to complete Section B – this CON application is considered exempt from the HEIA requirement. This form with the completed Section A is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section A, along with the CON application to acknowledge that a HEIA is not required.
- ***If you checked "yes" for either question in Table A***, proceed to Section B.

Section B. All Article 28 Facilities

Table B.

Construction or equipment	Yes	No
Is the project minor construction or the purchase of equipment, subject to Limited Review, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours? *Per the Limited Review Application Instructions: Pursuant to 10 NYCRR 710.1(c)(5), minor construction projects with a total project cost of less than or equal $15,000,000 for general hospitals and*		✓

less than or equal to $6,000,000 for all other facilities are eligible for a Limited Review.		
Establishment of an operator (new or change in ownership)	**Yes**	**No**
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		✓
Mergers, consolidations, and creation of, or changes in ownership of, an active parent entity	**Yes**	**No**
Is the project a transfer of ownership in the facility that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		✓
Acquisitions	**Yes**	**No**
Is the project to purchase a facility that provides a new or similar range of services or care, that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		✓
All Other Changes to the Operating Certificate	**Yes**	**No**
Is the project a request to amend the operating certificate that will result in one or more of the following: a. Elimination of services or care; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours, and/or; d. Change in location of services or care?	✓	

*Calculate the percentage change from the number of certified/authorized beds and/or certified/authorized services (as indicated on the facility's operating certificate) specific to the category of service or care. For example, if a residential health care facility adds two ventilator-dependent beds and the facility had none previously, this would exceed the 10% threshold. If a hospital removes 5 out of 50 maternity certified/authorized beds, this would meet the 10% threshold.

- ***If you checked "yes" for one or more questions in Table B***, the following HEIA documents are required to be completed and submitted along with the CON application:
  - HEIA Requirement Criteria with Section B completed
  - HEIA Conflict-of-Interest

- HEIA Contract with Independent Entity
  - HEIA Template
  - HEIA Data Tables
  - Full version of the CON Application with redactions, to be shared publicly

- ***If you checked "no" for all questions in Table B***, this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.