ATTACHMENT A

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Home and Community Based Care
Bureau of Licensure and Certification
161 Delaware Avenue
Delmar, New York 12054

RHCF Rightsizing Application

Facility Information

Facility Name	Operating Certificate No.	PFI No.
Facility Address (Street and Number, Building and Floor)	City	Zip Code
	County	

Contact Information

Name	Title	
Address (Street and Number, Building and Floor)	City	Zip Code
	Telephone No.	E-Mail Address

A. Current Bed Complement

#	Type/Service
	Standard RHCF
	AIDS
	Pediatric
	TBI
	Ventilator Dependant
	Neuro/Behavioral Intervention
	Other (Please describe)
	TOTAL

B-1: Rightsizing Option Being Requested
Temporary Decertification of RHCF Beds

#	Type/Service
	Standard RHCF
	AIDS
	Pediatric
	TBI
	Ventilator Dependant
	Neuro/Behavioral Intervention
	Other (Please describe)
	TOTAL

B-2: Rightsizing Option Being Requested (continued)

Permanent Decertification of RHCF Beds via Conversion to alternate level of care

#	(-)	New Cap.	Type	
			Standard RHCF	Proposed Conversion to: _____
			AIDS	Proposed Conversion to: _____
			Pediatric	Proposed Conversion to: _____
			TBI	Proposed Conversion to: _____
			Ventilator Dependant	Proposed Conversion to: _____
			Neuro/Behavioral Interv.	Proposed Conversion to: _____
			Other (please describe)	Proposed Conversion to: _____
			Total	

C. Financial Information (Please attach additional background material as necessary)

1. Attach a summary of the estimated facility cost reductions resulting from the proposed temporary decertification or permanent conversion of RHCF beds. Provide an explanation of all assumptions behind the estimates. Include a detailed description and computation of the proposal's cost savings to the Medicaid program.

2. a) Please estimate the anticipated change(s) to the nursing facility's Medicaid reimbursement rate(s) to reflect proposed bed modifications. Explain all assumptions and calculations.

	Current Medicaid Per Diem	Estimated Medicaid Per Diem
Operating Component	$	$
Capital Component	$	$
Total	**$**	**$**

b) If there are project capital costs associated with the proposal, describe fully.

3. Provide the facility's average number of Medicaid eligible bed hold/reserve days for most current three year period

Year	Medicaid Eligible Bed Hold Days

4. Submit first and third year operating budgets to reflect revenues and expenses resulting from the temporary decertification or conversion of beds. Include all pertinent revenue and expense assumptions.

5. Please assess the potential for improving the financial viability of the facility as a result of the requested rightsizing initiative.

6. Include certified financial statements for the last two years.

D. Programmatic Information (Please attach additional background material as necessary)

1. Describe the impact of the proposal on quality of care and quality of life for consumers.

2. List the availability and resource of less restrictive/institutional long-term care programs and services in your planning area.

3. Appropriate CON application attached for alternate services requested (Permanent Conversion only)

Yes ☐ **No** ☐

- *All applications must be received by March 17, 2008*