DCAB Report
Appendices 1 and 2

Appendix 1 DCAB Charge and Mission

05/15/2025 01:56PM, the Laws database is current through 2025 Chapters 1-49, 55-59, 61-127

Executive

§ 996. Community advisory board for the modernization and revitalization of SUNY Downstate health sciences university. 1. Advisory board established. (a) There shall be established the advisory board for the modernization and revitalization of SUNY Downstate (hereinafter referred to as "the advisory board"). The advisory board shall review and examine a variety of options to strengthen SUNY Downstate and promote longer term viability for its dual education and healthcare mission. In conducting its study, the advisory board will consider the following factors:

(i) Overall healthcare service delivery trends and models;

(ii) Historic and projected financials for the hospital and the campus;

(iii) Current state of building infrastructure and capital needs;

(iv) Community healthcare needs, outcomes, and health disparities;

(v) Existing inpatient and outpatient service offerings and health outcomes;

(vi) Capacity and availability of inpatient and outpatient services in the broader primary and secondary service areas;

(vii) Efficiency of operations and quality of healthcare services benchmarking; and

(viii) Training needs for students and employment outcomes.

2. Advisory board members. The advisory board shall consist of the following members: (a) the commissioner of the department of health; (b) one representative of organized labor representing employees at the state university of New York pursuant to article fourteen of the civil service law, who shall be appointed by the governor upon recommendation of the president of the union representing the greatest number of employees at SUNY Downstate; (c) one member appointed by the temporary president of the senate; (d) one member appointed by the speaker of the assembly; (e) three members appointed by the governor; (f) one member appointed by the governor upon the joint recommendation of Brooklyn community boards 9 and 17; and (g) the chancellor of the state university of New York.

3. Outreach. The advisory board shall solicit recommendations from healthcare experts, county health departments, community-based organizations, state and regional healthcare industry associations, labor unions, experts in hospital operations, and other interested parties. The advisory board shall hold no less than three public hearings with requisite public notice to solicit input and recommendations from any interested party.

4. Compensation. The members of the advisory board shall receive no compensation for their service as members, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

5. Recommendations and report. (a) The advisory board shall complete a study and provide written recommendations to prioritize healthcare services provided in the SUNY Downstate service area. The written recommendations shall include a reasonable, scalable and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate; provided, however, that such plan shall incorporate utilization of all available state and federally available appropriated amounts, and shall not exceed more than two hundred fifty percent of such amounts.

(b) A report of the advisory board's recommendations shall be provided to the governor, the temporary president of the senate, and the speaker of the assembly no later than April first, two thousand twenty-five.

6. Certificate of need. The public health and health planning council and the commissioner of health are prohibited from reviewing or

approving any certificate of need application related to a reduction in inpatient services pursuant to any article of law or regulation that may affect a change to inpatient services at SUNY Downstate health sciences university until at least April first, two thousand twenty-five.

Education (/keywords/education) Health (/keywords/health)

NOVEMBER 25, 2024 | Albany, NY

Governor Hochul Announces Appointees to SUNY Downstate Community Advisory Board

Advisory Board Tasked With Developing Fiscally Responsible, Long-Term Plan for a Stronger SUNY Downstate

Board May Consider up to 250 Percent of New York State's Capital Commitment and Secured Federal Dollars for Investment

Governor Kathy Hochul today announced eight appointees who will sit on the community advisory board tasked with making recommendations to develop a reasonable, scalable, and fiscally responsible plan for the financial health, viability, and sustainability of SUNY Downstate Hospital and SUNY Downstate Health Sciences University. The advisory board may consider up to 250 percent of New York State's Capital Commitment and secured federal dollars for investment.

"For months, my Administration has engaged in conversations with the Brooklyn community to ensure that the right individuals have been selected to help secure the long-term fiscal stability of SUNY Downstate," **Governor Hochul said.** "I am confident that the SUNY Downstate advisory board will conduct a robust community engagement process and develop comprehensive recommendations to help ensure high-quality health care at a modernized facility for the Central Brooklyn community."

Governor Hochul appointed Citizens Budget Commission President Andrew Rein, Pastor Louis Hilton Straker Jr. and Dr. Lesly Kernisant, Brooklyn Plaza Medical Center (retired) to the community advisory board.

Senate Majority Leader Andrea Stewart-Cousins appointed SUNY Downstate Chair of the Department of Family and Community Health Dr. Enitza George, M.D., MBA, MSAI. Assembly Speaker Carl Heastie appointed Dr. Donald Moore, Former Attending Physician at New York Presbyterian Brooklyn Methodist Hospital.

United University of Professions President Fred Kowal will serve as a representative on behalf of organized labor.

They will be joined by New York State Health Commissioner James V. McDonald, MD, MPH and State University of New York Chancellor John B. King Jr.

SUNY Downstate Hospital and SUNY Downstate Health Sciences University have provided Central Brooklyn with vital healthcare services and trained generations of civic-minded, diverse medical professionals for a century. However, SUNY Downstate Hospital has also endured years of financial instability – including an annual operating shortfall of nearly $100 million – and continues to grapple with a facility in disrepair. To address these challenges, Governor Hochul and the state legislature announced a historic investment of $300 million in capital funding and $100 million in operating funding to close the deficit, as well as a community advisory board for the modernization and revitalization of SUNY Downstate, which must include a reasonable, scalable and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate.

The board will hold three public hearings and submit written recommendations to Governor Hochul and the legislature by April 1, 2025.

State Health Commissioner James McDonald M.D., M.P.H. said, "SUNY Downstate Hospital and SUNY Downstate Health Sciences University are two of Central Brooklyn's most fundamental healthcare institutions that will be addressing the complex health needs of one of the most diverse communities in our state. I look forward to collaborating with this advisory board to ensure we lay the groundwork for SUNY Downstate's long-term sustainability leveraging up to $750 million in capital investment, allowing it to continue delivering exceptional medical education and healthcare services for years to come."

SUNY Chancellor John B. King Jr said, "Guided by the work this community advisory board will be conducting between now and April 1 and building on extensive community engagement over the past year, SUNY Downstate Health Sciences University and SUNY Downstate Hospital will be able to continue their respective missions of training the next generation of diverse, world-class medical professionals and scientists and delivering high-quality healthcare to Central Brooklyn. I look forward to working with the other members of the community advisory board to develop recommendations up to an unprecedented $750 million in capital investment for a reasonable, scalable, and fiscally responsible plan for the financial health, viability, and sustainability of SUNY Downstate."

Pastor Louis Hilton Straker Jr. said, "SUNY Downstate Hospital is more than a healthcare provider; together with SUNY Downstate Health Sciences University, it is a pillar of hope and opportunity for our community. SUNY Downstate has been critical in uplifting families and our Central Brooklyn community. I am deeply committed to working with this board to ensure SUNY Downstate remains a source of strength and sustainability for future generations and am grateful for the opportunity to help shape a historic investment of up to $750 million in Downstate's future."

United University of Professions President Fred Kowal said, "SUNY Downstate Hospital and SUNY Downstate Health Sciences University faculty and staff not only provide medical services that maintain the health and well-being of Brooklyn residents, but also train the next generation of healthcare professionals who will expand the healthcare workforce. I am eager to work together with the community and leaders in healthcare and education to develop the best path forward to strengthen the institution, maximize the impact of up to $750 million in state capital funding, and ensure SUNY Downstate's long-term security and stability consistent with the advisory board's mandate."

Citizens Budget Commission President Andrew Rein said, "For generations, SUNY Downstate Health Sciences University has educated a diverse group of healthcare professionals and been a crucial part of delivering needed healthcare. I look forward to being a part of this advisory board and helping to identify a fiscally sustainable path that ensures SUNY Downstate's education and health missions are met and Brooklynites have access to the quality care they deserve."

Dr. Lesly Kernisant said, "As a lifelong healthcare professional, I have seen firsthand the role that SUNY Downstate Health Sciences University and SUNY Downstate Hospital play in improving the health outcomes of Central Brooklyn. It is a privilege to help guide a plan that will not only secure SUNY Downstate's financial health but also empower it – aided by up to $750 million in capital funding – to continue its commitment to training the next generation of diverse healthcare leaders."

SUNY Downstate Chair of the Department of Community and Family Health Dr. Enitza George, M.D., MBA, MSAI. said, "At SUNY Downstate Health Sciences University, we are a cornerstone of healthcare and medical education in Central Brooklyn, and our impact reaches far beyond the walls of the institution. I am deeply committed to ensuring that we continue to deliver high-quality, compassionate care that meets the needs of our community through a historic investment of up to $750 million in a sustainable future for SUNY Downstate."

Dr. Donald Moore said, "As a physician who has worked with SUNY Downstate Hospital and SUNY Downstate Health Sciences University for decades, I know the instrumental role SUNY Downstate has served in developing our essential healthcare workforce across Brooklyn and beyond. The financial stability of SUNY Downstate is vital to the well-being of our community, and I am honored to contribute to this advisory board and help ensure that through up to $750 million in capital funding SUNY Downstate can continue its mission to deliver high-quality care and education."

State Senator Zellnor Myrie said, "Our community expects and deserves a true engagement process on the future of SUNY Downstate and a real plan to improve access to high-quality healthcare, and I'm grateful the Governor is launching this advisory board. I am especially pleased at the appointment of Dr. Enitza George, who is deeply familiar with our community's healthcare needs and Downstate's role in supporting them. We are eager for the board to begin its work and look forward to reviewing its recommendations."

Assemblymember Brian Cunningham said, "I am thrilled to contribute to the financial security of Downstate Medical Center and to work alongside esteemed members of the commission to ensure the center's future, with the resources, staff, and technology needed to support our residents. The hospital serves hundreds of thousands of people each year, many of whom live in my district, including low-income families and those from historically marginalized communities. It is a lifeline for building healthier neighborhoods by expanding access to care that prioritizes and elevates prevention services."

Chair of Brooklyn Community Board #9 Fred Baptiste said, "SUNY Downstate Hospital and SUNY Downstate Health Sciences University are integral parts of the fabric of Central Brooklyn, serving as both a healthcare provider and an educational institution that uplifts our neighborhood. We look forward to having thoughtful conversations to ensure that SUNY Downstate remains financially sustainable and continues to serve as a vital resource for our community's health and well-being."

Chair of Brooklyn Community Board #14 Karl-Henry Cesar said, "A revitalized and fully supported SUNY Downstate Brooklyn Hospital would be a needed sign of respecting and valuing the lives of people in Central Brooklyn. So, I hope the community advisory board is fully empowered and supported to take as much time as needed to talk with the community and faithfully execute its mission in support of this future."

Chair of Brooklyn Community Board #17 Rodrick Daley said, "Community Board 17 welcomes the CAB. We will work diligently together to ensure the people of central Brooklyn get the best possible outcomes with an open Downstate. There have been too many changes with the other hospitals around us. This CAB will work to build back better."

Contact the Governor's Office

Contact us by phone:

Albany: (518) 474-8418
New York City: (212) 681-4640

Contact us by email:

Press.Office@exec.ny.gov

Translations

Arabic Translation
الترجمة إلى العربية

(https://www.governor.ny.gov/sites/default/files/2024-11/11.25.24.rel_.appointees_arabic.pdf)

Bengali Translation
বাংলা অনুবাদ

(https://www.governor.ny.gov/sites/default/files/2024-11/11.25.24.rel_.appointees_bengali.pdf)

Chinese Translation
中文翻譯

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French Translation
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Haitian-Creole Translation
Tradiksyon kreyòl ayisyen

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Italian Translation
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Korean Translation
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Polish Translation
Polskie tłumaczenie

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Russian Translation

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Spanish Translation
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Urdu Translation
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Yiddish Translation
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Budget (/keywords/budget) Education (/keywords/education) Health (/keywords/health)

JANUARY 22, 2025 | Albany, NY

Governor Hochul Commits Nearly $1 Billion for SUNY Downstate Transformation

Community Advisory Board Held Its First of Three Public Hearings Today To Develop a Fiscally Responsible, Long-Term Plan for SUNY Downstate's Future

Governor Hochul Highlighted $550 Million for the Facility Included in the FY 2026 Executive Budget, Building on Last Year's $400 Million Investment

Advisory Board May Consider Up to $750 Million in New York State Capital Funding for

Investment

Governor Kathy Hochul today highlighted $450 million in capital funding and $100 million in operating support for SUNY Downstate in the FY 2026 Executive Budget during the Community Advisory Board's first of three public hearings. This funding is in addition to the $300 million in capital funding and $100 million in operating funding included in the FY 2025 Enacted Budget, making for a $950 million total commitment for the facility. The Community Advisory Board, established by Governor Hochul and the Legislature under the FY 2025 Enacted Budget, is tasked with developing recommendations to ensure the long term financial health and stability of the facility and may consider recommendations for up to $750 million in New York State capital funding for investment.

"The Downstate Community Advisory Board has begun the critical work of helping to secure the long-term fiscal stability of SUNY Downstate," **Governor Hochul said.** "These public hearings are an essential step in engaging the Central Brooklyn community and building a sustainable plan that ensures SUNY Downstate continues to deliver health care in its community and train a diverse health care workforce for generations to come."

The advisory board held the first of three public hearings on Wednesday, January 22, 2025, at 6 p.m. at SUNY Downstate Health Sciences University to hear from community members and other stakeholders as part of its process. Details for the remaining public hearings will be announced in the coming weeks.

Downstate's hospital provides inpatient and outpatient health care services in Central Brooklyn and leads in research and scholarship to address health disparities in New York City and across the state.

Last year, SUNY Downstate's hospital faced a $100 million annual deficit and was at risk of being unable to operate without additional funding, while contending with a hospital facility in disrepair and vulnerable to major crises, including recent major infrastructure incidents.

In response, Governor Hochul worked with the Legislature and SUNY to develop a plan to engage community leaders in developing a sustainable future for Downstate and provided a historic capital investment, which will be guided by the advisory board's work.

Last year's Enacted Budget tasked the Advisory Board to consider recommendations of up to $750 million in capital investments to establish a reasonable, scalable and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate.

To develop its recommendations, the advisory board will consider overall healthcare service delivery trends and models; historic and projected financials for the hospital and the campus; the current state of building infrastructure and capital needs; community healthcare needs, outcomes, and health disparities; existing inpatient and outpatient service offerings and health outcomes; capacity and availability of inpatient and outpatient services in the broader primary and secondary service areas; efficiency of operations and quality of healthcare services benchmarking; and training needs for students and employment outcomes.

Members will use these public hearings to gather input and ideas directly from the community. Written recommendations will be submitted to the Governor and the Legislature by April 1, 2025.

State Health Commissioner James McDonald, M.D., M.P.H. said, "As the public hearings begin, we have a unique opportunity to chart the long-term trajectory of SUNY Downstate Hospital. Downstate is vital to Central Brooklyn, and this process will allow us to hear directly from the community about their needs and priorities. I am committed to working with the advisory board to develop a plan that strengthens Downstate's capacity to deliver quality healthcare and education for years to come."

SUNY Chancellor John B. King Jr. said, "Building on the extensive community engagement that has taken place over the past year, the launch of these public hearings marks a critical step in shaping the future of SUNY Downstate Hospital. We will continue to be guided by input from diverse stakeholders so that we can ensure that SUNY Downstate remains a leader in training diverse medical professionals and providing the healthcare the community needs. I look forward to working with the community advisory board to develop recommendations up to an unprecedented $750 million in capital investment for a reasonable, scalable, and fiscally responsible plan for the financial health, viability, and sustainability of SUNY Downstate."

Dr. Enitza George, M.D., MBA, MSAI said, "Every day we come to the hospital, our main priority is providing the best care for the patients we serve. And to build a sustainable hospital that continues to provide the best care to our neighborhood, the community will have an important role in guiding how we invest the historic $750 million, starting with these public hearings."

Dr. Lesly Kernisant said, "These hearings are an opportunity to hear directly from the residents of Brooklyn who SUNY Downstate serves, and these discussions will help shape a future where SUNY Downstate is both financially strong and equipped to continue its mission of training healthcare leaders and improving health outcomes across Central Brooklyn."

Dr. Donald Moore said, "The community demands that Downstate fulfill its promise as the University Hospital for Brooklyn. The $850M investment is a vital first step to revitalizing this neglected facility. I will collaborate with my fellow board members to provide strong recommendations to the governor, restoring Downstate to its rightful place in serving our community."

Citizens Budget Commission President Andrew Rein said, "As the community hearings begin, I am eager to hear the perspectives of my fellow Brooklynites and other stakeholders on how this Board can help ensure that Brooklynites continue to have access to the quality care they deserve, and that the critical education for a diverse set of health care professionals continues here at Downstate."

Pastor Louis Hilton Straker Jr. said, "SUNY Downstate is a cornerstone for Central Brooklyn's health and vitality. These hearings give our community the opportunity to shape its future and ensure it continues to uplift families and serve as a foundation for growth and equity."

State Senator Zellnor Myrie said, "This community has made it clear we expect a transparent, open process to shape Downstate's future and address Brooklyn's healthcare needs. Over the coming weeks and months, I look forward to working with colleagues and neighbors to protect this vital institution and ensure it remains open to serve our community."

Chair of Brooklyn Community Board #9, Fred Baptiste said, "The start of these hearings marks the opportunity to chart a sustainable future for SUNY Downstate. This process is a vital step in ensuring the institution continues to deliver high-quality, compassionate care that meets the needs of our community while training future generations of healthcare professionals."

New York City Councilmember Rita Joseph said, "With up to $750 million of state funding for the Community Advisory Board to consider, I'm proud to see Governor Hochul's commitment to delivering quality health care to our community. As the board begins this public hearing process, we are moving in the right direction leading into long term financial stability for SUNY Downstate and to ensure that health care remains accessible in Central Brooklyn."

New York City Councilmember Mercedes Narcisse said, "I commend Governor Hochul for her historic commitment of nearly $1 billion to the transformation of SUNY Downstate Hospital. Downstate came through for us during the pandemic, and now it's our turn to come through for them. This funding represents a bright new future for SUNY Downstate, and I look forward to working with the Governor, the Community Advisory Board, and all stakeholders to ensure these resources are utilized to build a stronger, more sustainable future for this essential hospital."

Assemblymember Brian Cunningham said, "The community hearings for SUNY Downstate are a testament to the importance of engaging with residents and stakeholders in determining the hospital and university's future. This is a critical opportunity to ensure that the hospital and health sciences university have the resources, staff, and support needed to serve Brooklyn's diverse communities for years to come."

Brooklyn Community Board #17 Chair Rodrick Daley said, "By empowering the advisory board to engage with the community, we have the opportunity to reimagine SUNY Downstate in a way that

best serves the people of Central Brooklyn. Together, we will work to ensure that Downstate continues to provide high-quality education and stand as a crucial resource for our community's health and well-being."

Former NYC Health and Hospitals Executive Claire Patterson said, "SUNY Downstate has been a lifeline for Central Brooklyn, providing critical healthcare services and educational opportunities that uplift our community. These hearings give us the chance to ensure that Downstate's future reflects the priorities of the people it serves, while strengthening its ability to care for our families and train the next generation of healthcare professionals."

Contact the Governor's Press Office

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Haitian-Creole Translation
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Spanish Translation
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Urdu Translation
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Yiddish Translation
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Appendix 2 Outreach

A STRONGER DOWNSTATE PUBLIC HEARING

Help Shape the Future of SUNY Downstate

Join us for the first of three public hearings to discuss the financial health, sustainability, and future of **SUNY Downstate Hospital**.

With up to $750 million in potential investments, this is your chance to help guide plans that will modernize facilities and essential healthcare services for Central Brooklyn. Your input will shape the **Downstate Community Advisory Board's** recommendations to Governor Kathy Hochul and the state legislature.

WEDNESDAY JANUARY 22, 2025 6 PM - 8 PM

SUNY DOWNSTATE HEALTH SCIENCES UNIVERSITY
395 LENOX ROAD, BROOKLYN, NY 11203

Want to Speak or Submit Written Feedback
https://bit.ly/downstatepublichearing1

or email publichearing@adenaconsultinggroup.com

Be part of this critical conversation and ensure your voice is heard!

Learn More:
https://www.nysenate.gov/legislation/laws/EXC/996

PUBLIC HEARING #2

THURSDAY
February 27, 2025

START AT
6:00PM - 9:00PM

Medgar Evers College, Founders Auditorium
1650 Bedford Avenue, Brooklyn, NY 11225

HELP GUIDE THE FUTURE OF SUNY DOWNSTATE HOSPITAL

Join us for the second in a series of public hearings addressing critical plans for the financial health and sustainability of SUNY Downstate Hospital.
With an investment of $750 million, this is your opportunity to:

- *Influence plans for modernization of hospital facilities*
- *Protect vital healthcare services in Central Brooklyn*

Your input will directly impact Downstate Community Advisory Board recommendations to Governor Kathy Hochul and the state legislature. Let's shape the future of healthcare together!

WANT TO SPEAK OR SUBMIT WRITTEN FEEDBACK:
HTTPS://BIT.LY/DOWNSTATEPUBLICHEARING2

A Stronger Downstate

PUBLIC HEARING #3

The Downstate Community Advisory Board (DCAB) will host the third public hearing on the future capital plans, financial health, and sustainability of SUNY Downstate Hospital.
Let's shape the future of healthcare in our community together!!

SCAN QR CODE TO REGISTER

THURSDAY, MARCH 13, 2025

6:00PM

SUNY Downstate Health Sciences University
395 Lenox Road, Brooklyn, NY 11203

For More Information
https://downstateadvisoryboard.org/

A Stronger Downstate

PUBLIC HEARING #4

The Downstate Community Advisory Board (DCAB) invites community members, healthcare professionals, and stakeholders to the fourth public hearing regarding the future of SUNY Downstate Hospital.

Monday
April 28, 2025

Start Time:
6:00PM

Medgar Evers College, Founders Auditorium
1650 Bedford Avenue, Brooklyn, NY 11225

To sign up to provide oral or written statements, please register online using the QR Code:
Register Online

or email Publichearing@adenaconsultinggroup.com

Community welcomed to walk-in and sign up to speak.

Note: A recording of the Public Hearing and written testimonies will be posted to our public website. Live stream will be available.

For more information **https://downstateadvisoryboard.org/**

Downstate Community Advisory Board Hearing #1

January 22, 2025

Downstate Community Advisory Board (DCAB) Charge
Section 996 of the NYS Executive Law

- The advisory board shall complete a study and provide written recommendations that shall:
  - Include a reasonable, scalable and fiscally responsible plan for the financial health, viability and sustainability of SUNY Downstate; and
  - Recommendations must
    - Not exceed more than 250% of state and federally available appropriated amounts -- Given new capital appropriation this means a range of capital funding recommendation of between $300 million and $750 million
- The report will be provided to the governor, the temporary president of the senate, and the speaker of the assembly no later than April 1, 2025
- No less than 3 public hearings will be held -- DCAB will solicit recommendations from healthcare experts, county health departments, community-based organizations, state and regional healthcare industry associations, labor unions, experts in hospital operations, and other interested parties

Downstate Community Advisory Board (DCAB) Charge
Section 996 of the NYS Executive Law

- Review and examine a variety of options to strengthen SUNY Downstate and promote longer term viability for its education and healthcare mission

Factors to be considered include:

- Overall healthcare service delivery trends and models
- Historic and projected financials for the hospital and the campus
- Current state of building infrastructure and capital needs
- Community healthcare needs, outcomes, and health disparities
- Existing inpatient and outpatient service offerings and health outcomes
- Capacity and availability of inpatient and outpatient services in the broader primary and secondary service areas (PSA + SSA)
- Efficiency of operations and quality of healthcare services benchmarking
- Training needs for students and employment outcomes

We Want to Hear From You

Hearing #1	Hearing #2	Hearing #3
• January 22, 2025 – 6pm • Location: SUNY Downstate	• February 27, 2025 – 6pm • Location: TBD	• March 13, 2025 • Location: SUNY Downstate

- Thanks to Governor Hochul and the Legislature, there are historic capital resources available to support SUNY Downstate Hospital's mission to deliver quality care to Central Brooklyn and tackle systemic health inequities

- Community input is a critical piece of the DCAB process

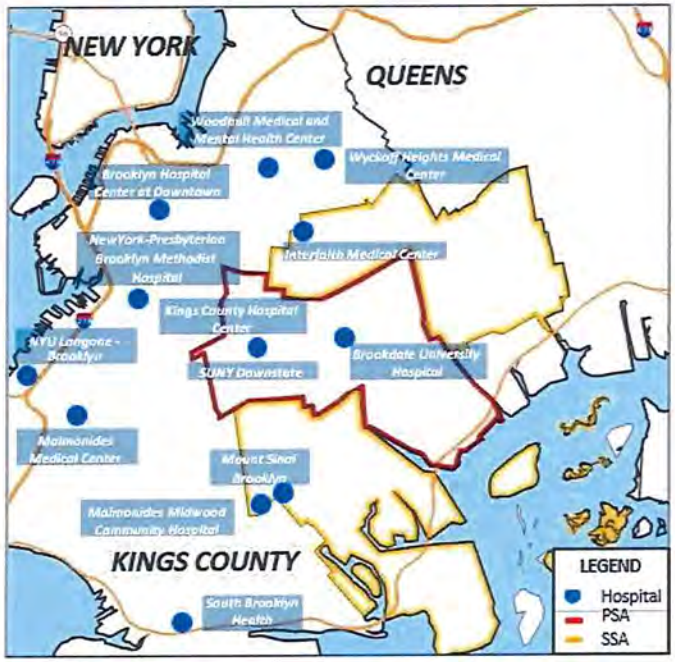
How can the available investments be directed to best support the healthcare needs of the community?

SUNY Downstate Infrastructure Challenges

- SUNY Downstate Hospital was constructed in 1966 and is certified by the Department of Health for 342 beds
- The hospital is comprised of an 8-story wing and an attached 3 story section of building totaling 693,000 gross square feet
- Historically, the building has received limited rehabilitative work and is deteriorating
- Most of the mechanical, electrical, plumbing, fire protection systems, and physical program spaces need major rehabilitation or replacement

SUNY Downstate Service Areas

SUNY DOWNSTATE PRIMARY & SECONDARY SERVICE



Source: SUNY Downstate internal service area definition; Definitive Healthcare (2024)

DEFINING THE PSA & SSA

- A **primary service area (PSA)** is the geographic region from where a healthcare provider draws most of its patients
  - ✓ SUNY Downstate's PSA is defined as zip codes 11203,11212, 11225, 11226, and 11236
- A **secondary service area (SSA)** is the surrounding region that provides an additional percentage of patients
  - ✓ SUNY Downstate's SSA is defined as zip codes 11207,11208, 11210, 11213, 11233, and 11234
- There are 6 hospitals in SUNY Downstate's PSA + SSA
- There are 13 hospitals in Kings County overall

SUNY Downstate Hospital Services

Downstate Designations:

- AIDS Center
- Regional Perinatal Center (RPC)
  - RPC is the most advanced perinatal center designation
- Primary Stroke Center
  - Primary is the most basic stroke center designation

Inpatient Services		
Anesthesia Service	Gynecologic Surgeries	Nephrology
Cardiac Care Unit	Inpatient Hospice	Obstetric Cases Including C-Section
Dialysis	Inpatient Stroke Services	Orthopedic Service
Epilepsy Monitoring Unit Services	Kidney Transplant[1]	Pediatric Critical Care
Family Medicine Inpatient Service	Medical Intensive Care	Pediatric Inpatient Medicine
Gastroenterology	Neonatal Critical Care (level 3)	Pharmacy[2]
General Internal Medicine, Hospitalist & Community Physician services	Neonatal Nursery	Rehabilitation Unit
	Neonatal Stepdown	Stepdown
General Surgery	Neonatal-Perinatal Medicine	Vascular Surgery

Outpatient Services		
Adult Neurosurgery	General Surgery	Neurodevelopment
Dialysis	Gynecologic Colposcopy	Obstetrics & Gynecology
Dermatology	Hepatology	Pediatrics Infectious Disease
Diabetes Clinic	Infectious Disease	Pediatrics Pulmonology
Endocrinology	Infusion	Podiatry
ENT & Head and Neck	Internal Medicine	Reproductive Endocrinology
Family Medicine	Kidney Transplant[1]	Rheumatology
Family Medicine - Behavioral Health	Nephrology	Urology
General Pediatrics & Adolescent	Neurology	Vascular

Note: (1) Adult and Pediatric Kidney Transplant. (2) Retail Pharmacy also available. (3) Other services include Radiology and Laboratory Services. **Sources:** NYS Health Profiles; SUNY Downstate internal

Diverse Medical Education at SUNY Downstate

SUNY Downstate Medical School Profile	
Medical School Class Enrollment (2024)	**861**
% African American Students **(Downstate | National)**	*14% | 10%*
% Hispanic/Latino Students **(Downstate | National)**	*15% | 12%*
National percentile of African-American graduates	*93rd*
Match Rates (2024)	
% Staying in NY State	*74%*
% Staying in NYC	*51%*
% Matched to SUNY Downstate	*16%*

- By enrollment and graduates, SUNY Downstate is the largest medical school in NYC and second in New York State
- Downstate had the most "underrepresented in medicine (URIM)" medical school graduates in New York State in the class of 2024
- SUNY Downstate has the 25th largest medical school in the nation out of 155 accredited US medical schools
- Ranked #6 by number of African-American faculty members among U.S. medical schools[1]
- Recipient of 2021 AΩA Award for Excellence in Inclusion, Diversity, and Equity in Medical Education and Patient Care[1]
- Though just 20% of U.S. nurses are minorities, 70% of SUNY Downstate's nursing students come from diverse populations[2]

Note: (1) These statements are sourced from 2021. (2) This statement is sourced from 2023; all other data points reflect 2024. (3) 2024 data has been requested from SUNY Downstate School of Medicine. More recent information to be forthcoming upon receipt. **Sources: Internal SUNY Downstate Medical School data;** SUNY Downstate website; AAMC 2024.

Downstate Community Advisory Board (DCAB)

Update for Hearing #3

Oma Holloway, Founder and Chief Strategist, ADENA Consulting Group

March 13, 2025

SUNY Downstate

- SUNY Downstate Hospital was constructed in 1966 and is certified by the Department of Health for 342 beds (double occupancy)
- The hospital is comprised of an 8-story wing and an attached 3 story section of building totaling 693,000 gross square feet
- The building needs major capital rehabilitative work

DCAB's Charge & Updates

- The Advisory Board is a nine member appointed Board pursuant to legislation enacted last year
- The Advisory Board for the modernization and revitalization of SUNY Downstate shall complete a study and provide written recommendations to prioritize healthcare services in the SUNY Downstate area
- Recommendations must be reasonable, scalable and *fiscally responsible plan for the financial health, viability and sustainability* of SUNY Downstate
- Originally, capital funding was *not to exceed* approximately $750 million with a report deadline of April 1, 2025
- Thanks to Governor Hochul, *now the full* $750 million in capital funding will be available
- And, given the complexity of the situation and the desire for additional feedback, the report deadline has been extended to on or before June 1, 2025

Factors DCAB is Considering

- Overall healthcare service delivery trends and models
- Historic and projected financials for the hospital and the campus
- Current state of building infrastructure and capital needs
- Community healthcare needs, outcomes, and health disparities
- Existing inpatient and outpatient service offering and health outcomes
- Capacity and availability of inpatient and outpatient services in the broader primary and secondary service area
- Efficiency of operations and quality of healthcare services benchmarking
- Training needs for students and employment outcomes

DCAB Outreach

Overall attendance: approximately 375

Heard from:

- 56 individuals
- 12 elected officials

Overall attendance: approximately 150

Heard from:

- 25 individuals
- 11 elected officials

DCAB has also met with SUNY Downstate president, College of Medicine chairs, interim CEO of the hospital, H&H, Kings County, Maimonides, One Brooklyn Health and Brooklyn for Downstate

Feedback We've Heard

(not an exhaustive list)

Public Hearing 1 & 2 Written Testimonies Key Words Compilation, after accounting for clarification the hospital is not closing

Feedback We've Heard - Services
(not an exhaustive list)

- Inpatient, ambulatory care, outpatient, and emergency services emphasized
- Community health needs have introduced several service lines into discussion, with frequent references to:
  - Oncology, maternal health, preventative health & primary care, chronic disease treatment, kidney transplant, cardiology, and many more
- Increasing case mix, electronic health records (EHR), and stronger collaboration and strategic partnerships with nearby hospitals were also areas of focus

Public Hearing 1 & 2 Written Testimonies - Services Compilation

Key Issues

What does the community need most that Downstate is best positioned to provide?

What should be the mix of inpatient services and what should be the mix of outpatient services?

What is operationally financially feasible?

How much and what type of space is needed for the various inpatient and outpatient services?

How should the available capital funding be invested?

DCAB Consultants

ADENA Consulting Group

Kaufman Hall

EWINGCOLE

QPK

Ramboll

Strengths

Hospital is Valued

- Provides important inpatient services like kidney transplants
- Vital services like regional perinatal care and more
- Has the trust of the community

Trains Diverse Workforce

- Large, high-quality medical school and health professions programs
- Medical school classes are more diverse than the national average, at 93rd percentile for African-American graduates
- Graduates tend to stay and work in the community
- Concordant care improves health outcomes

Health Disparities

- Work of the hospital and clinicians addresses health disparities
- Ensures access as a safety-net institution
- Community-informed and action-oriented disparities and health equity research

Challenges

Community Health Needs Are Vast

- High rates of chronic conditions, maternal and infant mortality, cancer, and high ED utilization
- Shortage of primary and preventive care contributes to avoidable hospitalizations
- Trend is toward outpatient care, with outpatient services expected to grow 16% nationally over next ten years compared to a 2% projected growth in inpatient volume

SUNY Downstate Hospital Under-Utilization

- The average daily census is about 160 patients
- About one third of Brooklynites leave the borough for inpatient hospital care
- SUNY Downstate accounts for 9% of inpatient volume in its primary service area
- Only 1 in 10 hospital admissions are elective and not through the ED
- Hospital volume is correlated with better patient outcomes

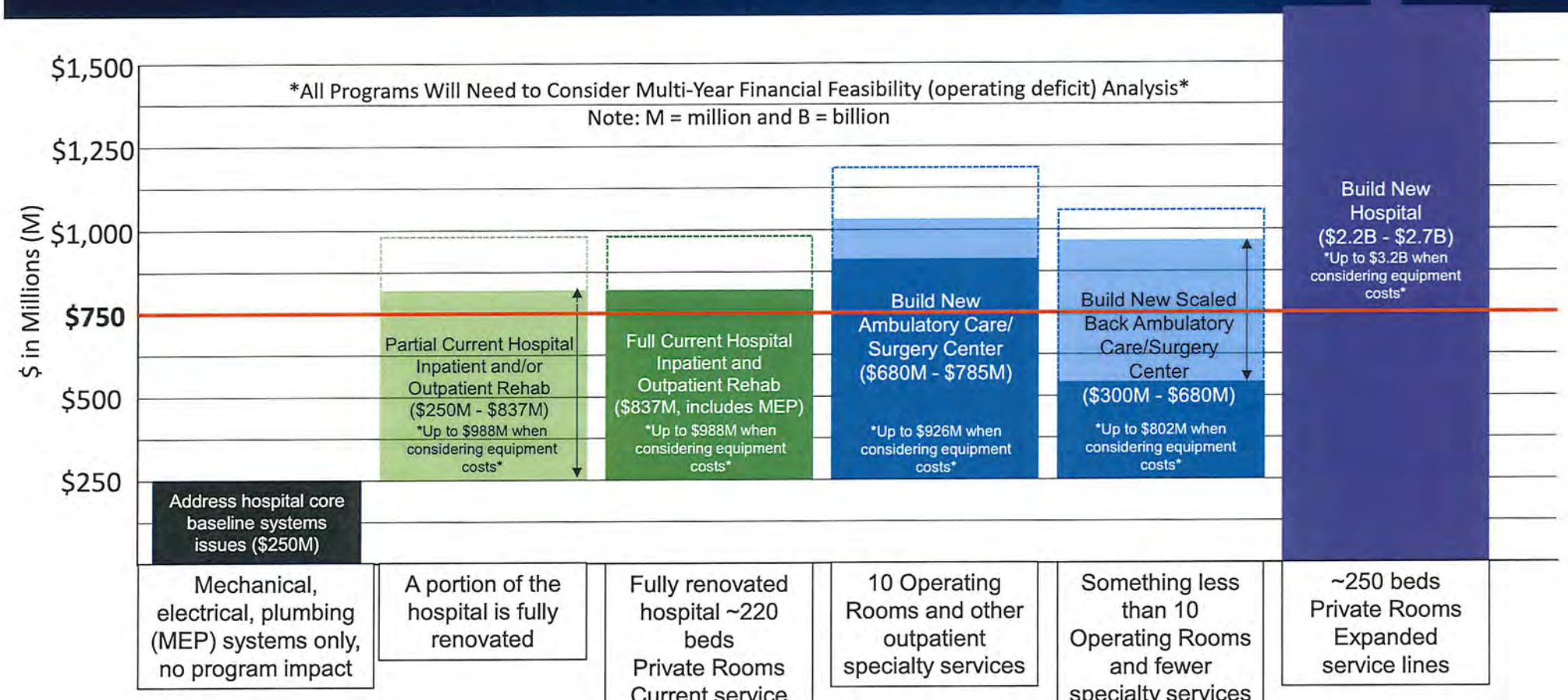
Financial Feasibility

- The hospital has been running a deficit of around $80M to $100M without temporary state support
- Government payors account for more than 80% of revenue
  - DSH helps significantly with Medicaid
- Small stand-alone hospital needing referrals and economies of scale
- Infrastructure is aging and needs investment

Inpatient & Outpatient Services

- DCAB is exploring and analyzing a variety of options and service lines based on feedback from the community and advice of consultants
- Including provision of urgent care, emergency care, level of emergency care, ambulatory care and ambulatory surgery, and many other areas of potential specialty service line expansions based on community need

Infrastructure Examples



* Estimates do not include design/planning costs
* Modeling timelines assume 5 years. If projects take longer, costs increase
* No programs include additional parking

DCAB Wants to Continue Hearing from You

We are pleased to announce DCAB anticipates another public hearing in April/May – Date TBD

This Slide Deck

This slide deck is posted on the DCAB public website
Visit: www.downstateadvisoryboard.org

Downstate Community Advisory Board (DCAB)

Update for Hearing #4

Oma Holloway, Founder and Chief Strategist, ADENA Consulting Group

April 28, 2025

SUNY Downstate

- SUNY Downstate Hospital was constructed in 1966 and is certified by the Department of Health for 342 beds (double occupancy)
- The hospital is comprised of an 8-story wing and an attached 3 story section of building totaling 693,000 gross square feet
- The building needs major capital rehabilitative work

DCAB's Charge & Updates

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Public Hearing 1 & 2 Written Testimonies - Services Compilation

Key Issues

What does the community need most that Downstate is best positioned to provide?

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What is operationally financially feasible?

How much and what type of space is needed for the various inpatient and outpatient services?

How should the available capital funding be invested?

DCAB Consultants

ADENA Consulting Group

Kaufman Hall

EWINGCOLE

QPK

Ramboll

Deloitte Consulting has been added to provide a review of financial feasibility estimations

Strengths

Hospital is Valued

- Provides important inpatient services like kidney transplants
- Vital services like regional perinatal care and more
- Has the trust of the community

Trains Diverse Workforce

- Large, high-quality medical school and health professions programs
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- The average daily census is about 165 patients
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- Only 1 in 10 hospital admissions are elective and not through the ED
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Financial Feasibility

- The hospital has been running a deficit of around $80M to $100M without temporary state support
- Government payors account for more than 80% of revenue
  - DSH helps significantly with Medicaid
- Small stand-alone hospital needing referrals and economies of scale
- Infrastructure is aging and needs investment

Some Potential Scenarios

- DCAB is exploring and analyzing a variety of options and service lines based on feedback from the community and review of information and data from consultants
- DCAB is sharing some of the scenarios being modeled as the different options are being evaluated
- No decisions on recommendations have been made
- Analysis will continue and be refined so the following information is preliminary and a work in progress

Some of the Potential Scenarios Being Modeled and Explored

Scenario Description	Inpatient Infrastructure	Outpatient Infrastructure	Clinical Services	Estimated Capital Cost*
New Hospital Tower and Some Hospital Rehab Consistent with information received from Brooklyn for Downstate as of 4/28/25	• Build new 250-bed inpatient tower on existing shorter part of hospital footprint • Address mechanical, electric, and plumbing (MEP) issues in current hospital • Rehab first 3 floors of shorter part of hospital	• Enhance the ED • Additional space for ambulatory care in hospital	• Continue existing inpatient and outpatient services • Expand both inpatient and outpatient services in many areas • Add urgent care • Support upgrade of ED to level 1 or 2 trauma center	$2.2 - $2.7 billion 10 + years
New Advanced Ambulatory Surgery Center & New Hospital Tower & Limited Hospital Rehab	• Build new 100 – 200 inpatient bed tower • Address MEP issues in current hospital	• Maintain existing ED with minimal changes • Build large advanced ambulatory surgery center • Includes parking	• Continue existing inpatient and outpatient services • Expand outpatient state of the art surgery and focus on expanding many quaternary and specialty services	$1.9 - $2.5 billion 5 – 7 years
Partial Hospital Rehab & New Ambulatory Surgery Center	• Address MEP issues in current hospital • Convert approximately 45 double occupancy rooms to single rooms with bathroom and shower	• Modernize the ED • Build new medium sized ambulatory surgery center	• Continue existing inpatient and outpatient services • Expand outpatient surgery and focus on expanding two specialty services (cardiology & oncology)	$750 – $850 million 5 - 7 years
Partial Hospital Rehab & New Ambulatory Surgery Center plus varying levels of collaboration with H+H	• Address MEP issues in current hospital • Convert approximately 45 double occupancy rooms to single rooms with bathroom and shower	• Modernize the ED • Build new medium sized ambulatory surgery center	• Continue vast majority of inpatient and outpatient services and coordinate reciprocal changes based on clinical focus areas	$750 – $850 million 5 - 7 years

*Estimates do not include costs of fixtures & equipment, design & planning, permitting, CON, etc. which will increase the capital estimates above

Some Potential Scenarios

- For the four prior scenarios, the operating deficit worsens and for the first two scenarios it significantly worsens
- Annual operating deficit reflects projections for steady state operations based on SUNY Downstate's recent performance to predict the future
- For any of the prior scenarios to approach financial sustainability, all of the following must occur:
  - The share of patients on commercial insurance must dramatically increase (currently 10% at SUNY Downstate, but 22% in the combined primary and secondary service areas)
  - Commercial payment rates must improve
  - SUNY Downstate's cost structure must be substantially reduced (increased productivity, lower overhead expenses, etc.)

DCAB Wants to Continue Hearing from You

DCAB Wants to Continue Hearing from You

This slide deck can be accessed using this QR code
It is also posted on the DCAB public website
Visit: www.downstateadvisoryboard.org

DCAB encourages submission of questions and comments to publichearing@adenaconsultinggroup.com

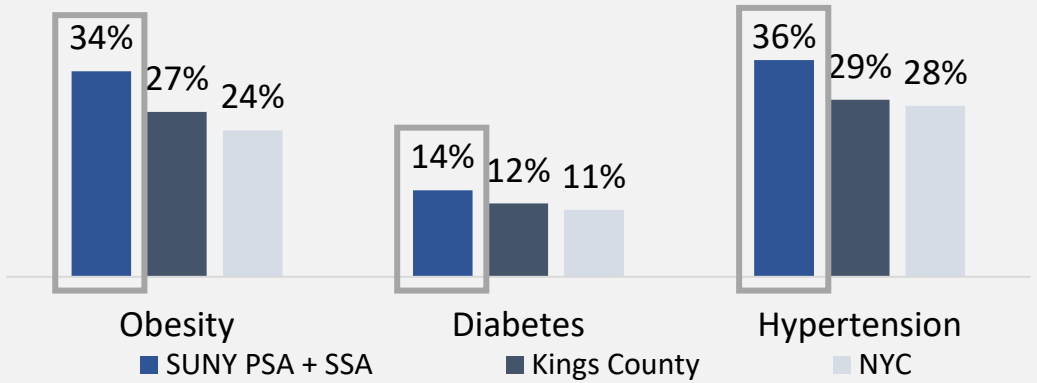
Video of public hearing 4 will also be posted to the public website

DCAB Report
Appendices
3-A through 3-F
3-H through 3-I

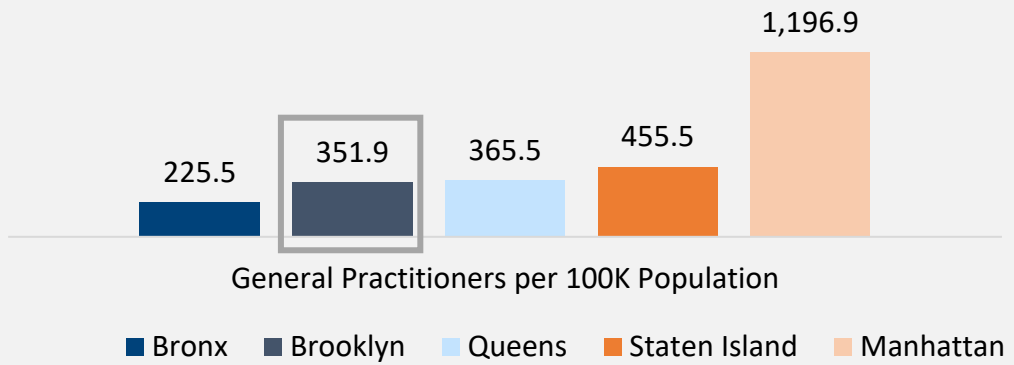
Appendix 3-A Detailed Findings Community Healthcare Needs, Outcomes, and Health Disparities

Brooklyn Faces High Rates of Chronic Conditions, Limited and Expensive Healthcare Access, and Challenging Socioeconomic Factors

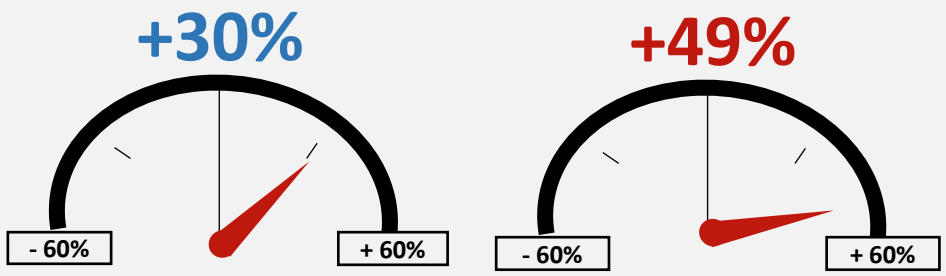
% of Adults With Chronic Conditions



Number of General Practitioners per 100K Population



New York, NY Healthcare Price & Utilization Benchmarking



Price Index
New York healthcare pricing +30% above nat'l median

Utilization Index
New York healthcare utilization +49% above nat'l median

Socioeconomic Indicators

More favorable than state/nat'l
Less favorable than state/nat'l

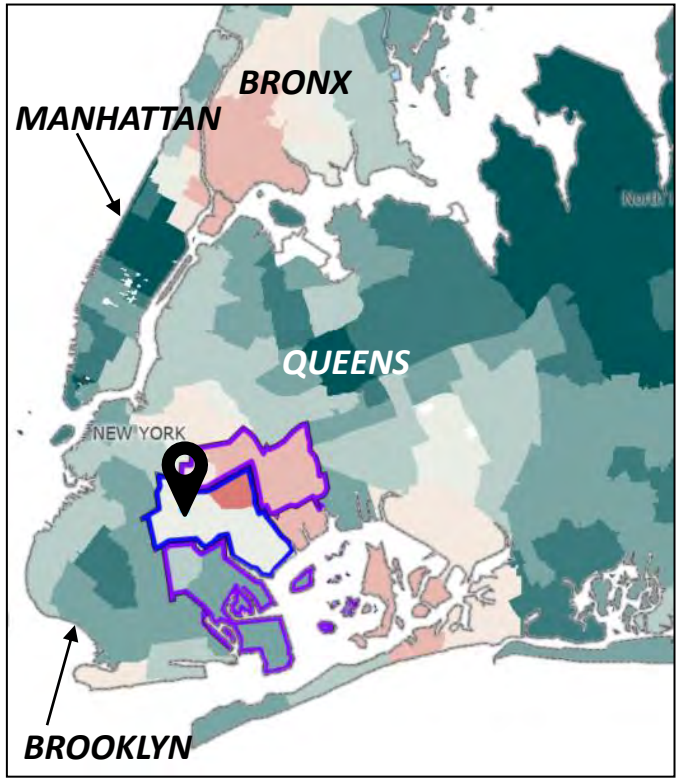
	Kings County	New York State	USA
Median Household Income	$64.0 K	$81.4 K	$75.1 K
Households without internet access	17%	12%	12%
Population living below the poverty line	18%	17%	11%
High school graduate or higher	83%	88%	89%

Sources: Brooklyn Borough Health Equity Report 2021; The Health Sciences Center at Brooklyn Foundation, Ambulatory Care Center (ACC) Market Assessment, April 2021; NYC Economic Development Corporation; U.S. Census; New York State of Health – Brooklyn report, 2022; Healthcare Cost Institute, 2021.

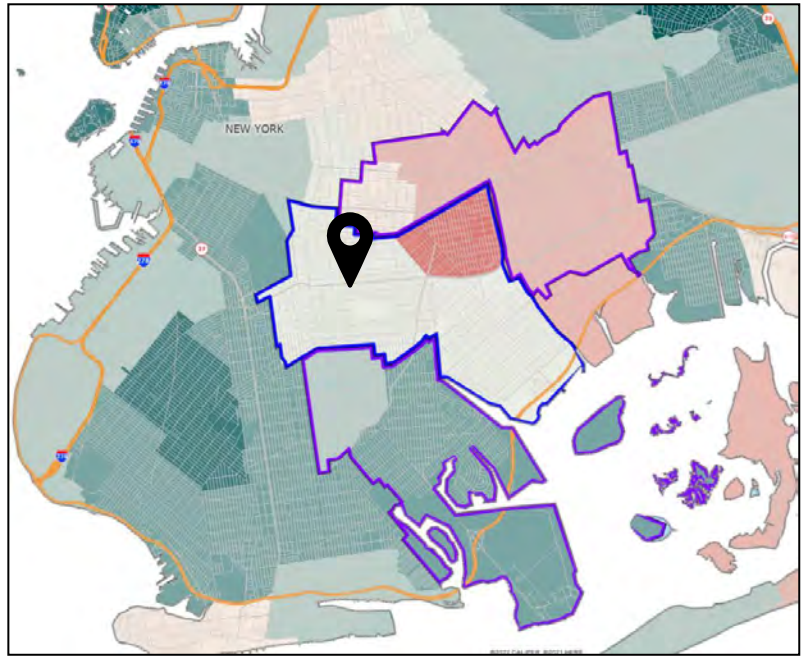
The Vizient Vulnerability Index Highlights Social Vulnerabilities in SUNY Downstate's Service Area

Vizient Vulnerability Index

New York City



Brooklyn



SUNY Downstate

SUNY Downstate PSA

SUNY Downstate SSA

Less Vulnerable *(Scores <0)*

More Vulnerable *(Scores >0)*

Brooklyn – specifically SUNY's service area – is home to some of the most vulnerable zip codes in New York City

Data Definition & Methodology

- Vizient® Vulnerability Index™ identifies social needs and obstacles to care that may influence a person's overall health
- Vizient reports the vulnerability index for each zip code nationally
- Any neighborhood scoring 1+ is considered an area of "high vulnerability"[1]

Notes: (1) "High vulnerability" or a score greater than 1 indicates a region that experiences specific obstacles to care greater than one standard deviation above the national mean. Sources: Vizient Vulnerability Index.

Leading Causes of Death – U.S., New York State & Brooklyn (2023) in Rank Order

United States:

- Heart Disease – 680,981 deaths
- Cancer – 613,352 deaths
- Accidents (Unintentional Injuries) – 222,698 deaths
- Stroke (Cerebrovascular Diseases) – 162,639 deaths
- Chronic Lower Respiratory Diseases – 145,357 deaths
- Alzheimer's Disease – 114,034 deaths
- Diabetes- 95,190

New York State:

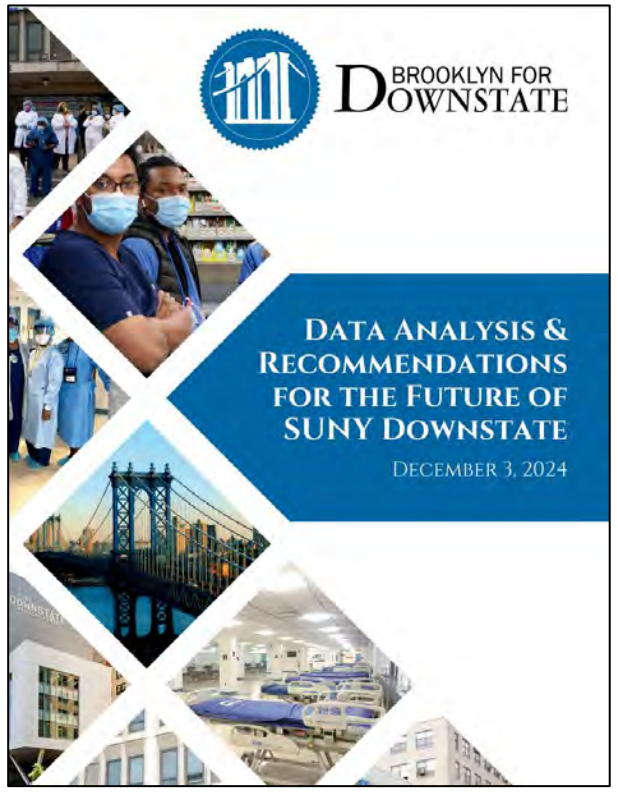
- Heart Disease – 41,172 deaths
- Cancer – 32,279 deaths
- Accidents (Unintentional Injuries) – 10,671 deaths
- Stroke (Cerebrovascular Diseases) – 6,419 deaths
- Chronic Lower Respiratory Diseases – 6,117 deaths
- Diabetes- 4,486 deaths
- Influenza and Pneumonia – 4,009 deaths

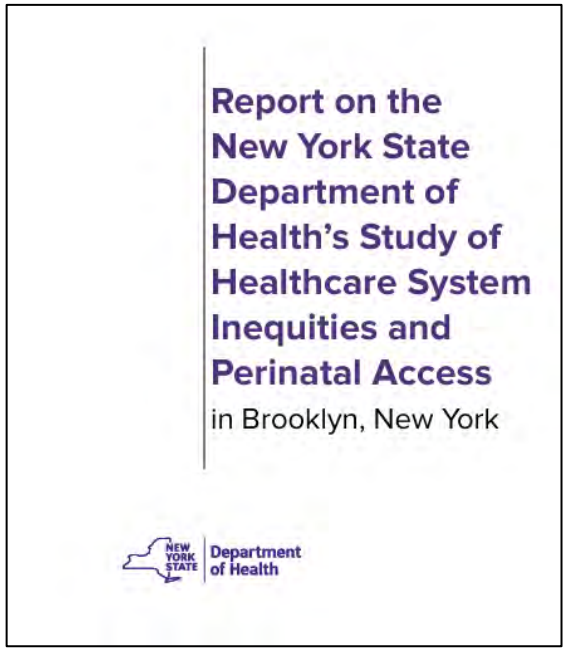
Brooklyn (Kings County):

- Heart Disease – 4,853 deaths
- Cancer – 3,171 deaths
- Accidents (Unintentional Injuries) – 1,100 deaths
- Stroke (Cerebrovascular Diseases) – 586 deaths
- Influenza and Pneumonia – 566 deaths
- Diabetes– 518 deaths
- Chronic Lower Respiratory Diseases – 344 deaths

Provisional Mortality Statistics, 2018 through Last Week Request

Additional Resources Reviewed by DCAB





Appendix 3-B Detailed Findings Overall Healthcare Service Delivery Trends and Models

Despite The Challenges Since The Onset of The Pandemic, The Healthcare Ecosystem is Normalizing

CRISIS
2020-2022

A prolonged operational and monetary shock.

CHARACTERIZED BY:

- Major stimulus spending (approx. $5 trillion)
- Accommodative Federal Reserve monetary policy
- Heavy focus on clinical and operational performance
- Staffing shortages and surging inflation (including wages and supplies)

STABILIZATION
2023

Adjusting to the outcomes of the crisis stage.

CHARACTERIZED BY:

- Tightening monetary policy and rising interest rates, which is driving market volatility
- Concern on financial performance amidst renewed focus on strategic trajectory
- Aggressive cost containment

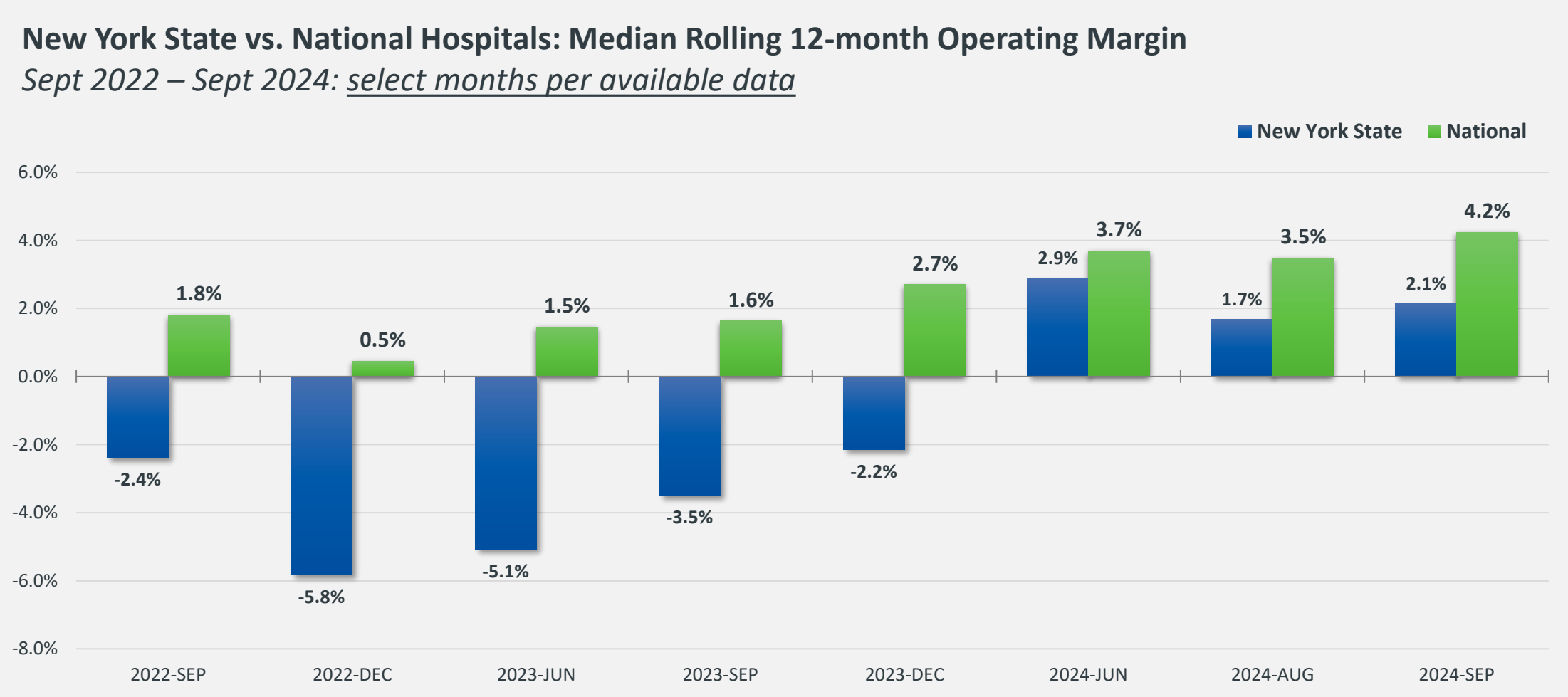
NORMALIZATION
2024-beyond

What will performance look like in a normalized state?

EXPECTED TO INCLUDE:

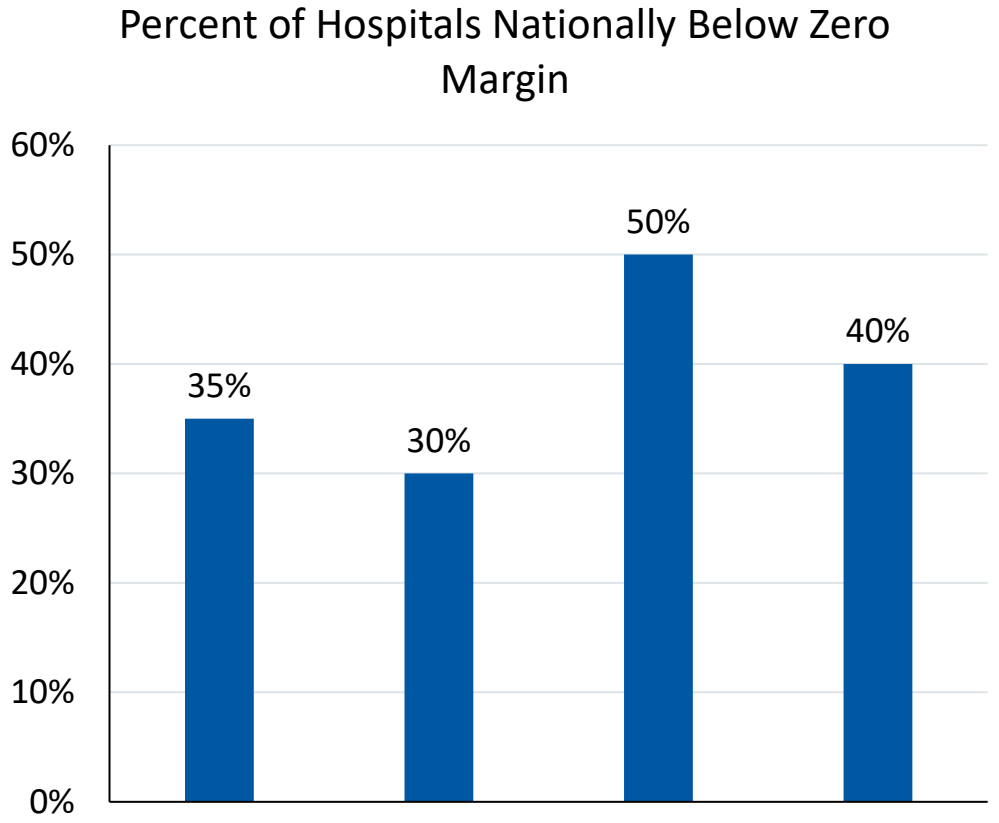
- Recalibrated or stabilized workforce environment
- Return from an erratic interest rate environment
- Return of normalized strategic capital investments
- Revival of strategic initiatives driving the new core business

New York State Hospital Operating Margins Have Improved Since Low Point in 2022 – But Not As Much As National Averages



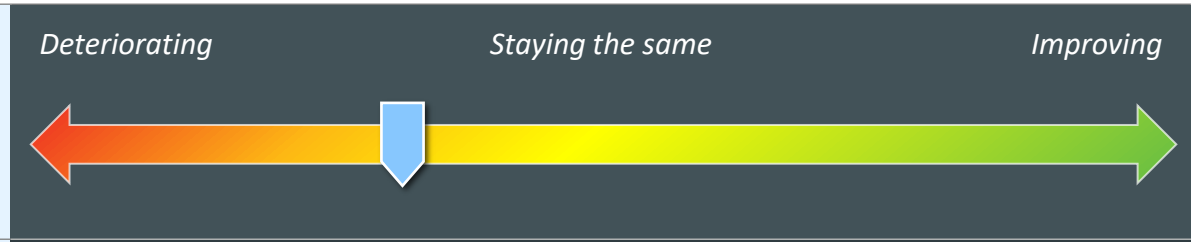
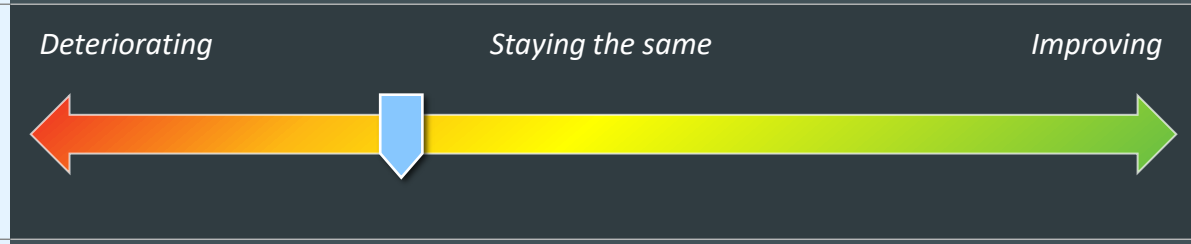
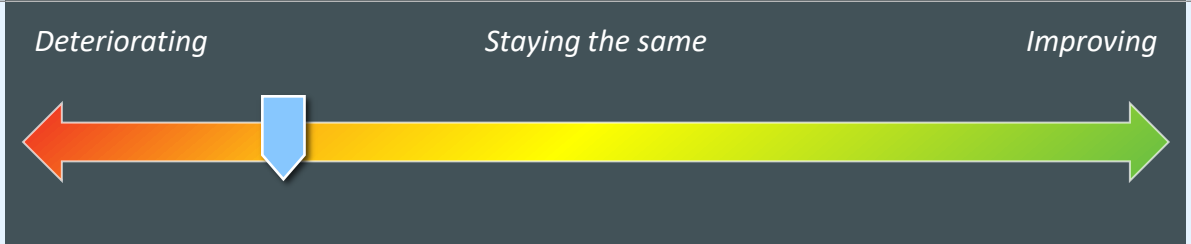
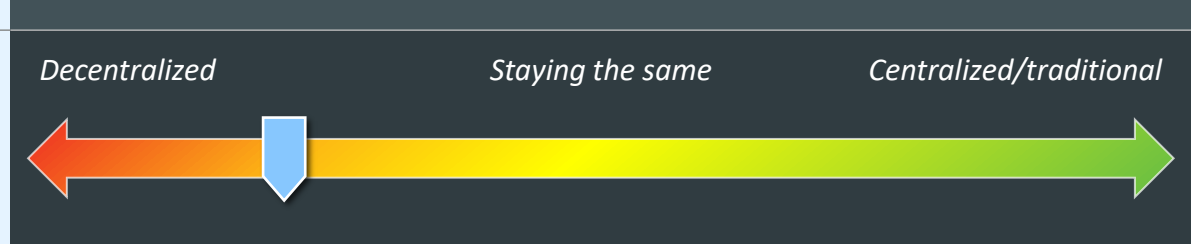
Source: Kaufman Hall hospital flash report data (2022-2024).

Deeper Dive Into The Data Shows That 40% of Hospitals Nationally Continue to Lose Money



The gap between higher and lower performing organizations persists and is widening

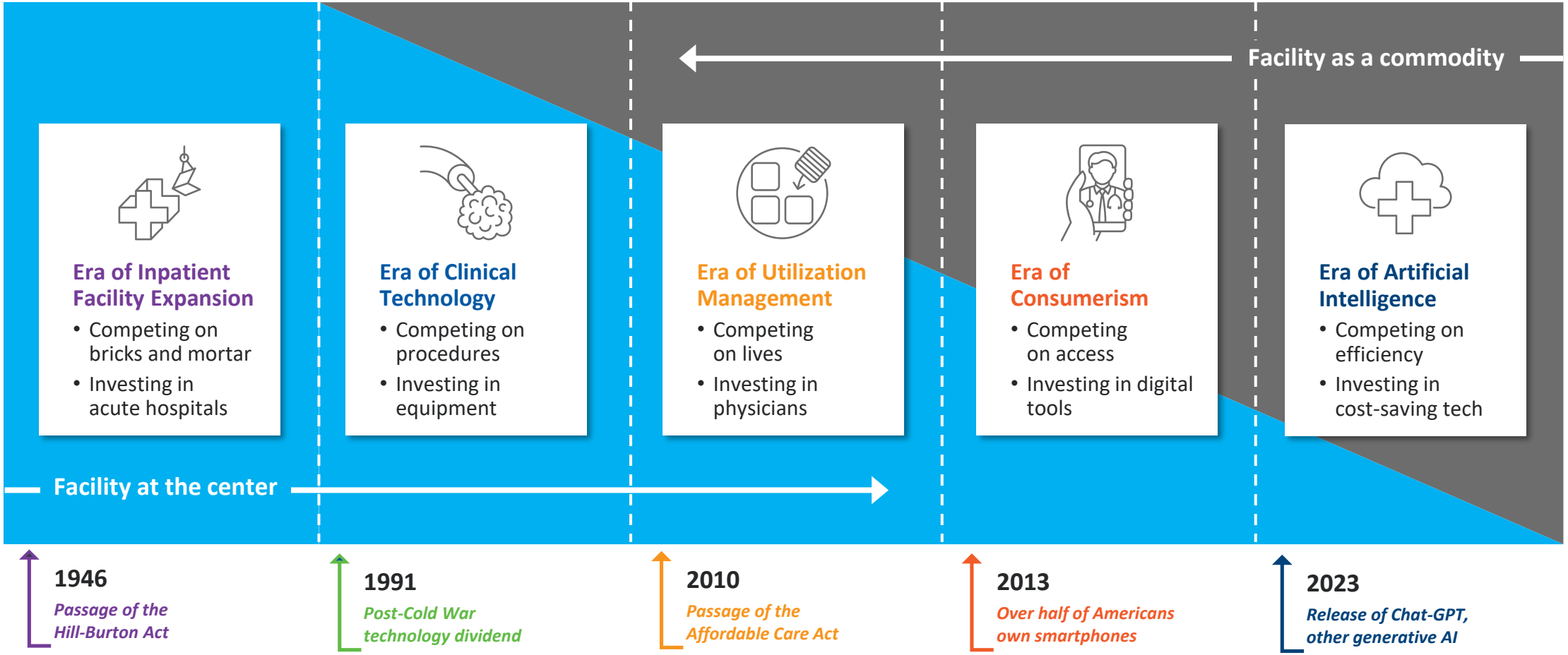
Despite an Improving Environment, Pressures Are Here to Stay

PRESSURES	OUTLOOK	RATIONALE/DISCUSSION
Clinical Labor Cost		**Labor expenses increased 21%** from Aug 2021 to Aug 2024[1]
Medical Inflation[2]		**After lagging general inflation in early 2024, medical inflation surpassed general inflation in mid 2024**
Payer Mix (percentage of patients covered by private vs. government insurers)		**Payer mix will continue to shift to lower paying government lines of business** increasing financial pressure on hospitals and health systems
Decentralization of Healthcare (accelerated shift to outpatient care)		**Shift in care delivery settings** to outpatient care likely to continue, leaving health systems with a smaller, more acute service mix

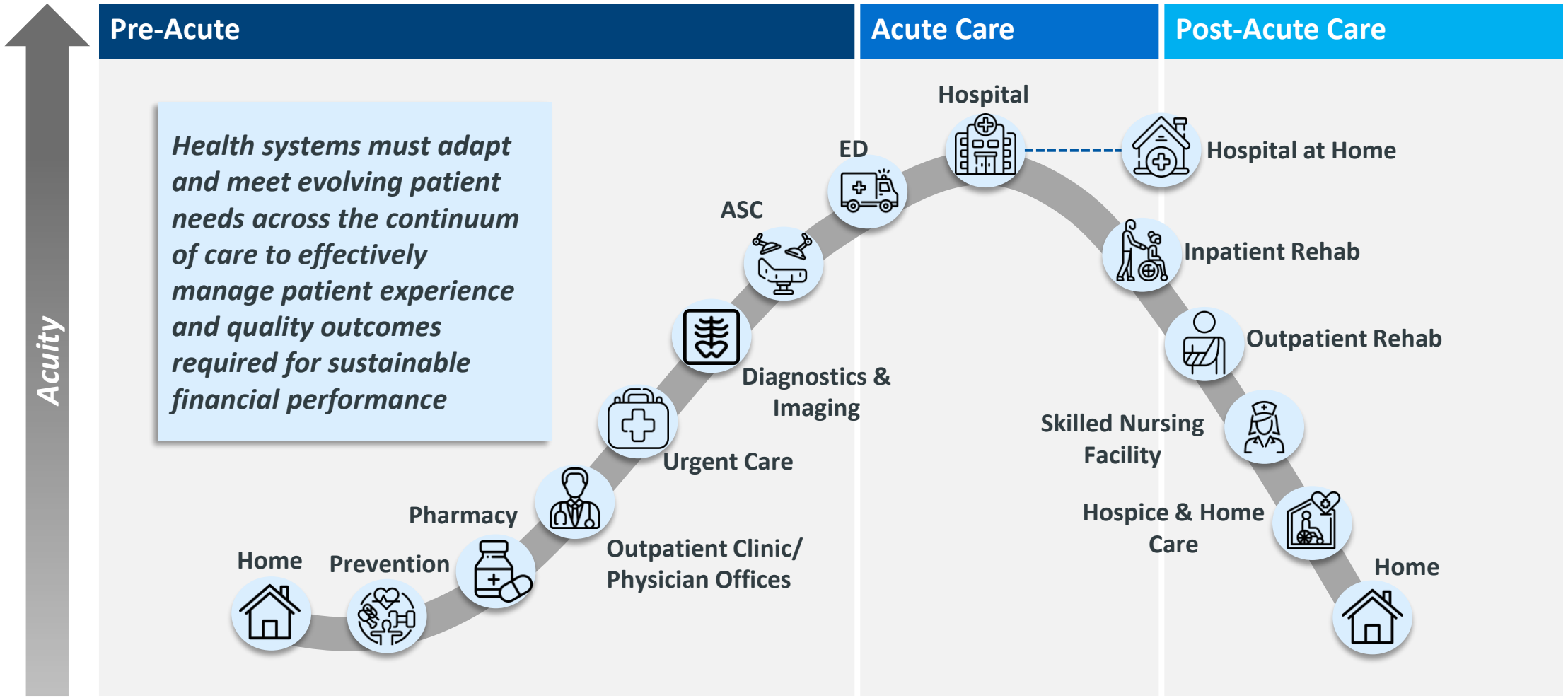
Source: (1) Kaufman Hall National Hospital Flash Report (April 2024 Report as of March 2024); (2) https://www.usinflationcalculator.com/inflation/health-care-inflation-in-the-united-states/

The Industry Is Moving Away from a Facility-Centric Model

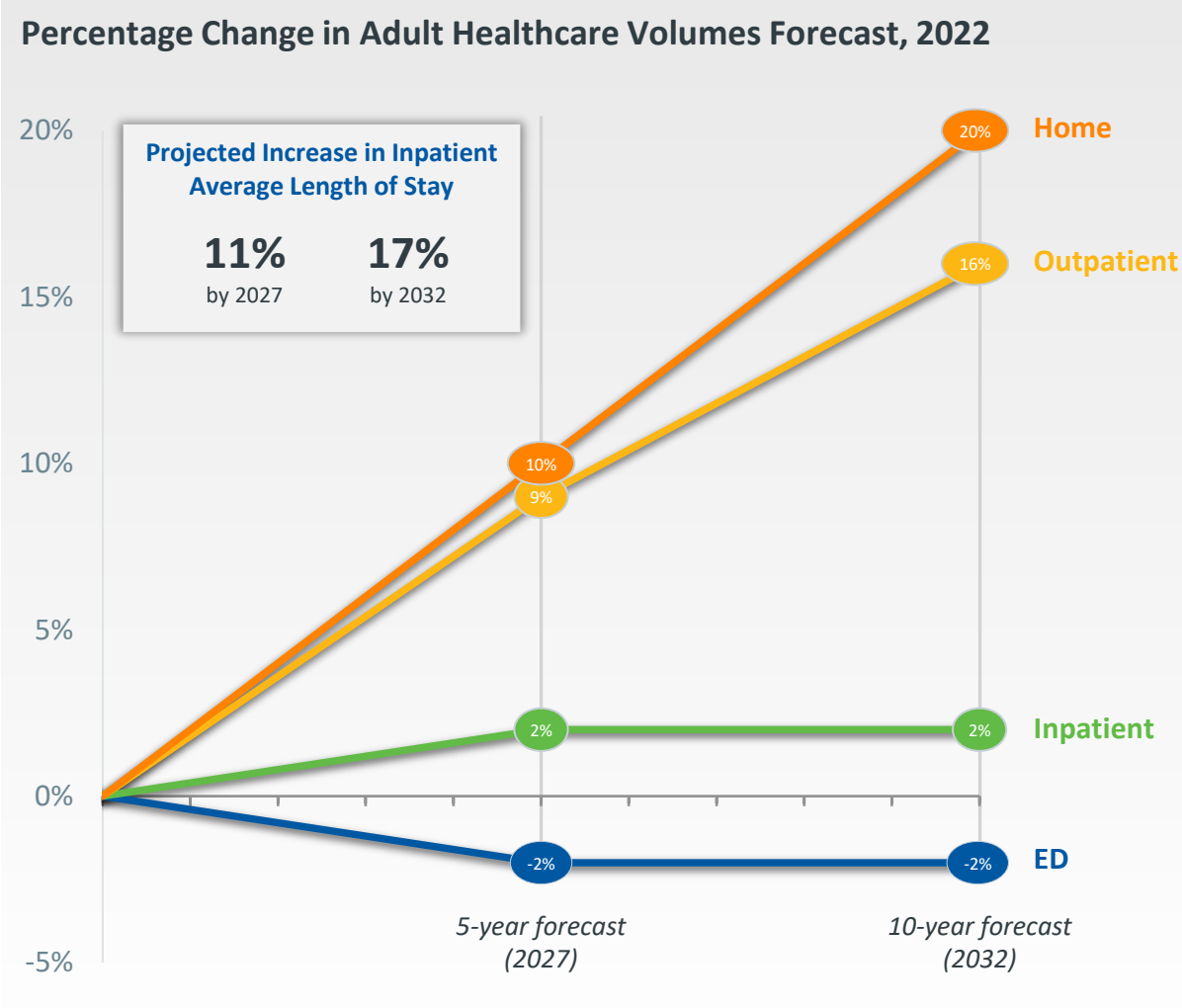
Lower Cost Access Points, Data-Driven Approaches, and "Value" Shifting the Nexus of Care

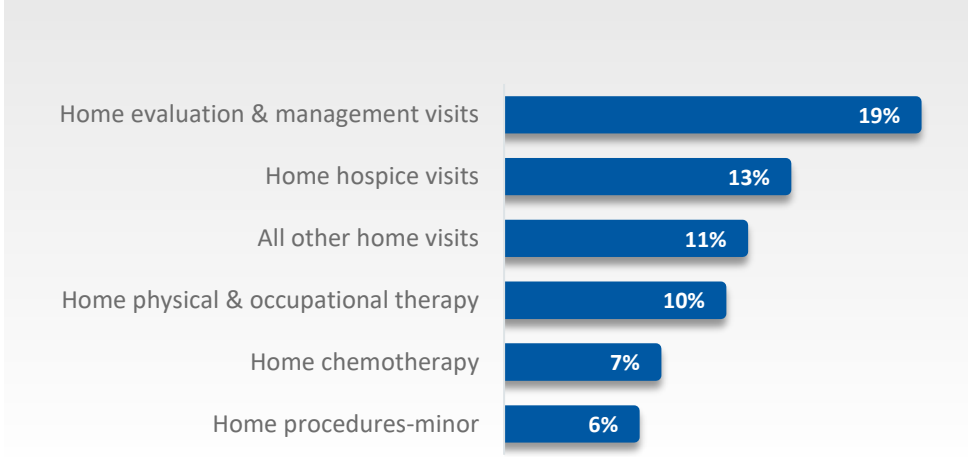


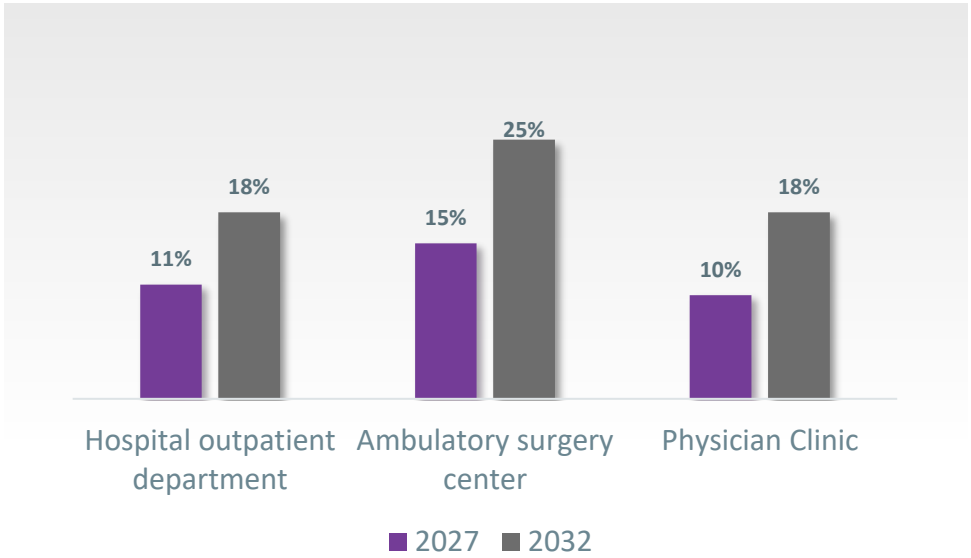
Health Systems Are Increasingly Being Asked to Meet Patients Along the Care Continuum, Including in Pre- and Post-Acute Care Settings



Home and Outpatient Care Settings Are Projected to be Fastest Growing Sites of Care Over Next Decade





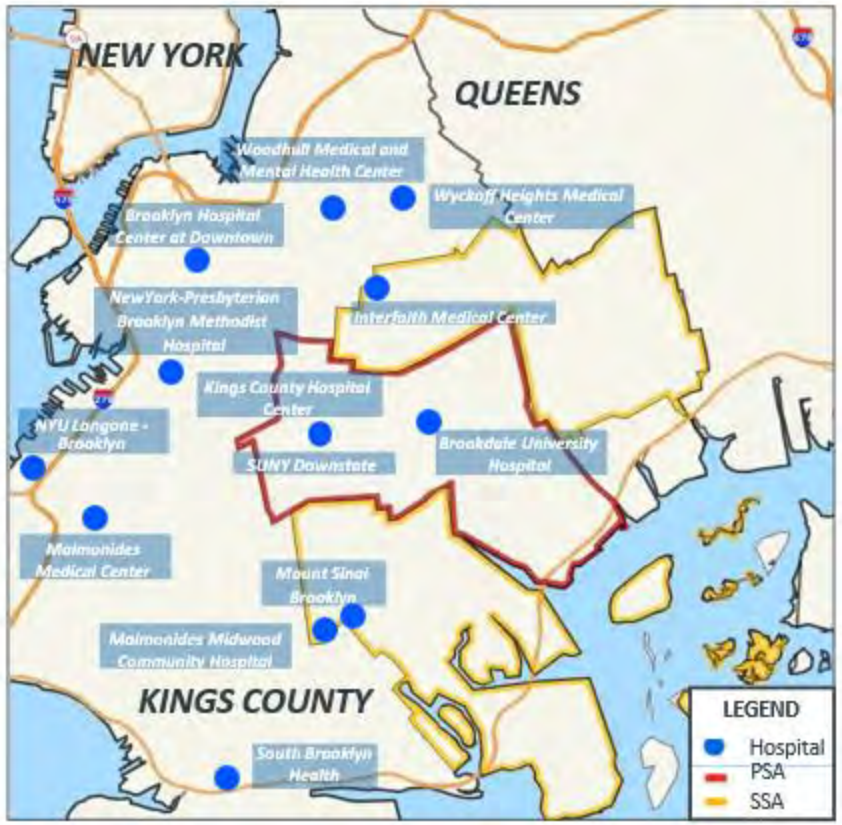


Source: Giese, C. et. al., "2022 Impact of Change® Forecast Highlights", Sg2, Jun. 2022; Gist Weekly at Kaufman Hall analysis.

Appendix 3-C Detailed Findings Existing Inpatient and Outpatient service Offerings and Health Outcomes

SUNY Downstate Service Areas

SUNY DOWNSTATE PRIMARY & SECONDARY SERVICE

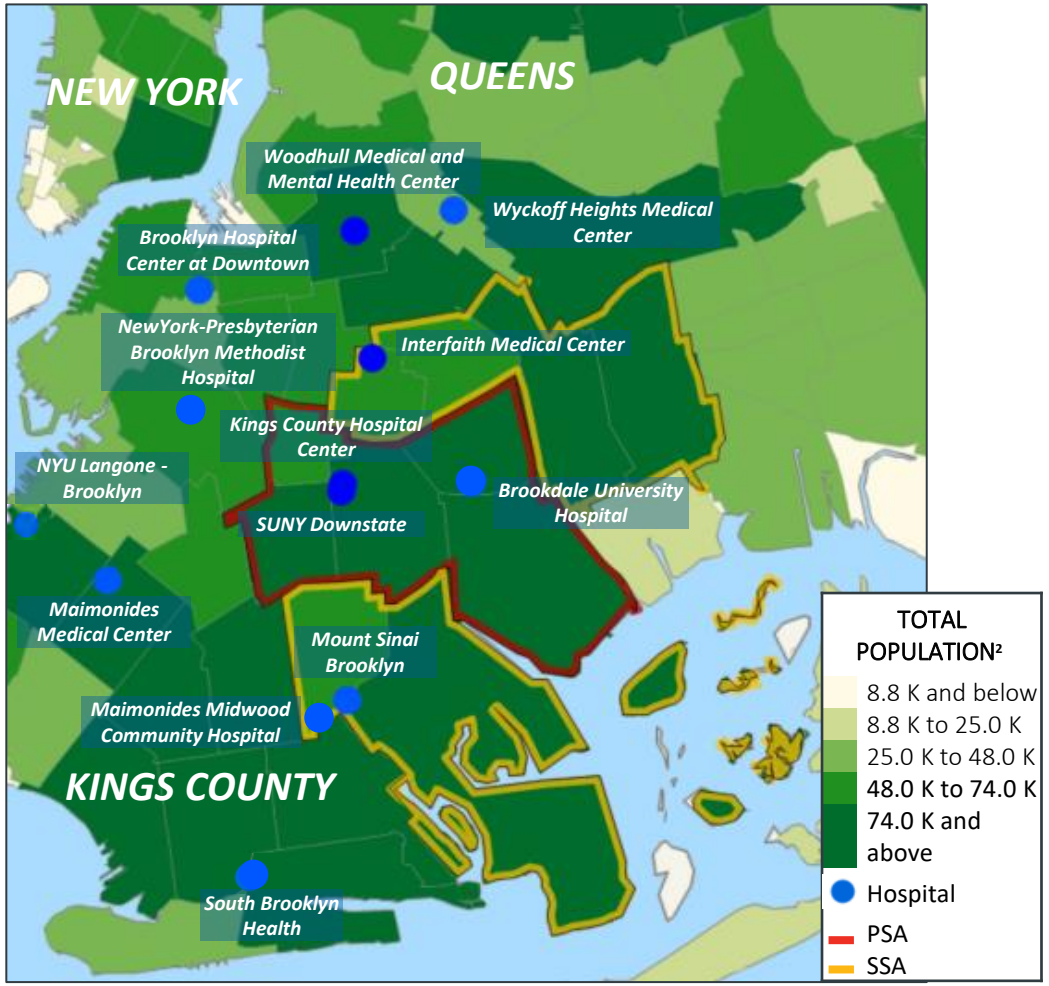


DEFINING THE PSA & SSA

- A **primary service area (PSA)** is the geographic region from where a healthcare provider draws most of its patients
  - ✓ SUNY Downstate's PSA is defined as zip codes 11203,11212, 11225, 11226, and 11236
- A **secondary service area (SSA)** is the surrounding region that provides an additional percentage of patients
  - ✓ SUNY Downstate's SSA is defined as zip codes 11207,11208, 11210, 11213, 11233, and 11234
- There are 6 hospitals in SUNY Downstate's PSA + SSA
- There are 13 hospitals in Kings County overall

Source: SUNY Downstate internal service area definition; Definitive Healthcare (2024)

SUNY Downstate's PSA is Home to a Slightly Declining Overall Population, With Growth in the 65+ Age Cohort



Age Cohort	2024	2029	5-Year CAGR
0-17	81 K	78 K	(0.8%)
18-34	100 K	89 K	(2.3%)
35-64	161 K	164 K	0.3%
65+	67 K	74 K	1.9%
Total	**410 K**	**406 K**	**(0.2%)**

SSA DEMOGRAPHIC TRENDS

Age Cohort	2024	2029	5-Year CAGR
0-17	103 K	97 K	(1.0%)
18-34	120 K	109 K	(1.8%)
35-64	179 K	182 K	0.3%
65+	70 K	78 K	2.2%
Total	**472 K**	**467 K**	**(0.2%)**

KINGS COUNTY DEMOGRAPHIC TRENDS

Age Cohort	2024	2029	5-Year CAGR
0-17	551 K	533 K	(0.7%)
18-34	679 K	607 K	(2.2%)
35-64	973 K	1,011 K	0.8%
65+	381 K	412 K	1.6%
Total	**2,583 K**	**2,564 K**	**(0.2%)**

Note: (1) SUNY Downstate's PSA is defined as zip codes 11203, 11212, 11225, 11226, and 11236. The SSA is defined as zip codes 11207, 11208, 11210, 11213, 11233, and 11234. (2) 2024 population used in the map. Source: Claritas 2024.

SUNY Downstate Hospital Services

Downstate Designations:

- AIDS Center
- Regional Perinatal Center (RPC)
  - RPC is the most advanced perinatal center designation
- Primary Stroke Center
  - Primary is the most basic stroke center designation

Inpatient Services		
Anesthesia Service	Gynecologic Surgeries	Neonatal-Perinatal Medicine
Cardiac Care Unit	Inpatient Hospice	Obstetric Cases Including C-Section
Epilepsy Monitoring Unit Services	Inpatient Stroke Services	Orthopedic Service
Family Medicine Inpatient Service	Kidney Transplant	Pediatric Critical Care
General Internal Medicine – Hospitalist and Community Physician services	Medical Intensive Care	Pediatric Inpatient Medicine
	Neonatal Critical Care (level 3)	Rehabilitation Unit
	Neonatal Nursery	Stepdown
General Surgery	Neonatal Stepdown	Vascular Surgery

Outpatient Services		
Adult Neurosurgery	Gynecologic Colposcopy	Pediatrics Infectious Disease
Dermatology	Hepatology	Pediatrics Pulmonology
Diabetes Clinic	Infectious Disease	Pediatrics Transplant
Endocrinology	Infusion	Podiatry
ENT & Head and Neck	Internal Medicine	Reproductive Endocrinology
Family Medicine	Neurology	Rheumatology
Family Medicine - Behavioral Health	Neurodevelopment	Transplant
General Pediatrics	Obstetrics & Gynecology	Urology
General Surgery	Pediatrics & Adolescent	Vascular

Source: *SUNY Downstate internal*

Terminology: Beds and Occupancy

- **Licensed / Certified Beds:** The maximum number of beds a hospital is licensed to operate, as approved by a licensing agency. These beds are not necessarily physically available.
- **Staffed Beds:** The number of licensed beds that are physically available *and* have staff on hand to care for patients. This includes both occupied and vacant beds. Beds that are unavailable due to renovations or lack of staff are not included.
- **Occupied Beds:** The actual number of patients occupying beds in the hospital

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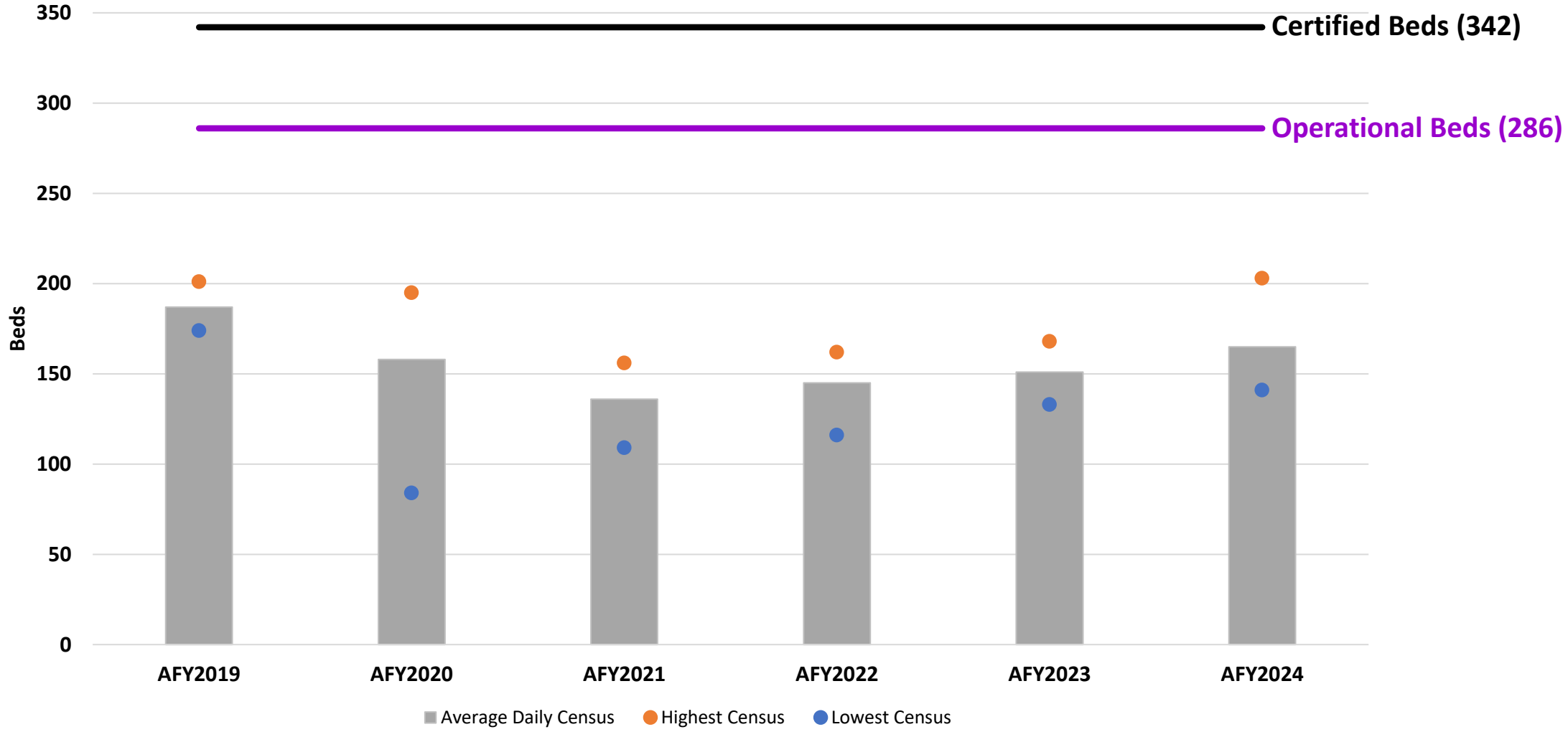
- ***Note***: To understand true available capacity at a hospital, it is critical to calculate occupancy *at the nursing unit level*.
  - For example, a hospital may have capacity available at the overall hospital level, but if their Intensive Care Unit ("ICU") is at max capacity, it still creates operational issues for the facility.

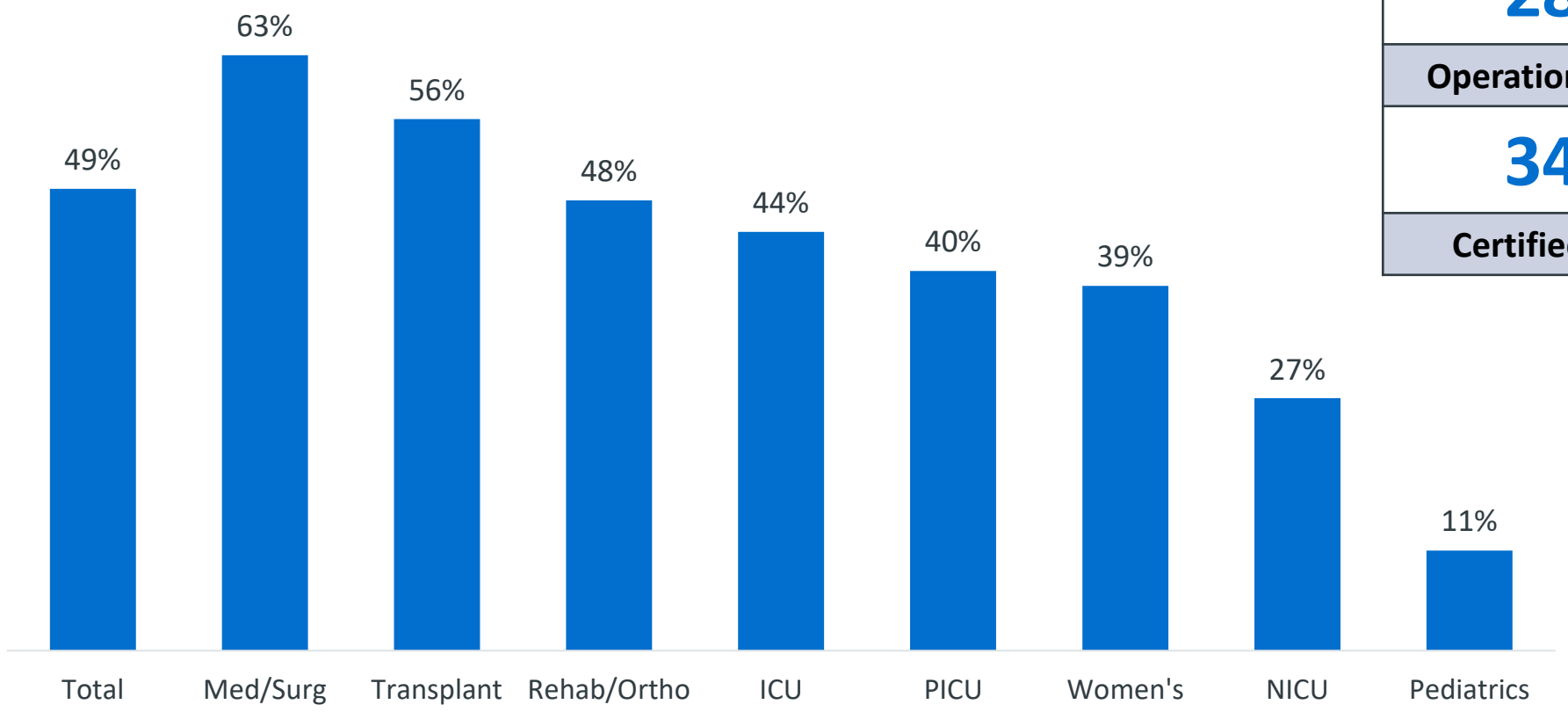
SUNY Downstate's Occupancy



SUNY Downstate Hospital Occupancy Varies by Nursing Unit

SUNY DOWNSTATE OCCUPANCY BY NURSING UNIT

Based on Operational Beds, 2023



286
Operational Beds
342
Certified Beds

Source: SUNY Downstate internal patient days and beds data, CY2023.

Appendix 3-D Detailed Findings Capacity and Availability of Services in the Broader Primary and Secondary Service Areas

Data Disclaimer

Note: New York Statewide Planning and Research Cooperative System (SPARCS) data is a source that should be interpreted directionally to gain a high-level understanding of market dynamics – it should not be interpreted as a definitive source on market volumes

- SPARCS does not receive 100% volume data from reporting hospitals (SPARCS mandates a submission of 80%+ of prior year numbers)
- Billing/coding nuances create discrepancies

SPARCS Data vs. Hospital Audits / Definitive Healthcare Data

SPARCS data typically reports ~10-20% lower volume than is reported in system audits

Year of Data	Facility	% Difference: *SPARCS relative to Audit or DefHC (if audit isn't available)*
2023	NYC Health and Hospitals - Kings County	-7% (A)
2023	NYC Health and Hospitals - Woodhull	-20% (A)
2022	Brooklyn Hospital Center at Downtown Campus	-10% (B)
2022	Maimonides Medical Center	2% (A)
2022	University Hospital at Downstate	-22% (C)
2022	Wyckoff Heights Medical Center	-35% (B)
2022	NYC Health and Hospitals - Kings County	-17% (A)
2022	NYC Health and Hospitals - Woodhull	-20% (A)

LEGEND:

- **(A) Sourced from audited financials/operational statements:** audits are considered the "gold standard" for accurate sources for health system volume data. However, recent audited statements are not always publicly available.
- **(B) Source from Definitive Healthcare:** for systems where audits weren't available, Kaufman Hall utilized Definitive Healthcare data as a comparison point, which reports data from CMS. This source is also considered highly reliable.
- **(C) Internal SUNY Downstate data**

Sources: SPARCS 2019-2023 state database; health system audited disclosures.

Brooklyn-Based Hospitals: At a Glance

KEY STATISTICS ACROSS BROOKLYN BASED HOSPITALS, 2023

Data indicative of patients originating in Kings County only.

System	Hospital	Discharges	Avg Length of Stay	Case Mix Index *(Higher CMI = more acute)*	% Medical Services / OB / Surgical Services	Occupancy *Based on certified beds (not staffed beds)*	Deliveries
Maimonides Medical Center	Maimonides Medical Center	27.5 K	5.7	1.7	62% / 20% / 18%	60%	5.1 K
	Maimonides Midwood Community Hospital	4.2 K	5.6	1.5	85% / 0% / 14%	48%	0.0 K
Mount Sinai	Mount Sinai Brooklyn	8.8 K	6.6	1.5	84% / 0% / 15%	75%	0.0 K
NewYork-Presbyterian	NYP Brooklyn Methodist Hospital	23.6 K	5.7	1.6	63% / 16% / 20%	63%	3.6 K
NYC HEALTH+ HOSPITALS	NYC Health + Hospitals/Kings County	15.9 K	8.8	1.5	77% / 9% / 14%	61%	1.3 K
	NYC Health + Hospitals/South Brooklyn Health	12.0 K	7.9	1.5	73% / 12% / 15%	74%	1.3 K
	NYC Health + Hospitals/Woodhull	6.2 K	7.9	1.4	72% / 18% / 10%	42%	1.1 K
NYU Langone	NYU Langone Hospital - Brooklyn	23.4 K	4.7	1.6	67% / 16% / 17%	68%	3.5 K
OBH One Brooklyn Health	Brookdale Hospital Medical Center	11.4 K	7.0	1.6	77% / 6% / 17%	41%	0.5 K
	Interfaith Medical Center	5.0 K	8.6	1.3	92% / 0% / 8%	41%	0.0 K
The Brooklyn Hospital Center *Keeping Brooklyn Healthy*	The Brooklyn Hospital Center	10.1 K	6.0	1.4	68% / 13% / 19%	35%	1.1 K
Wyckoff	Wyckoff Heights Medical Center	7.6 K	4.2	1.4	73% / 9% / 18%	27%	0.5 K
DOWNSTATE HEALTH SCIENCES UNIVERSITY	University Hospital SUNY Downstate	6.5 K	6.6	1.5	73% / 10% / 17%	41%	0.5 K

Notes: (1) SPARCS data should be interpreted directionally rather than as a definitive source on market volumes; (2) Above excludes MS-DRG code 795 – Normal Newborns; (3) Data reflects patients originating in Kings County and hospitals located in Kings County *only*. Source: SPARCS 2023 state database.

Note: Highlighted hospitals are in Downstate's PSA and SSA

Brooklyn-Based Hospitals: Select Designations

SELECT DESIGNATIONS ACROSS BROOKLYN BASED HOSPITALS, 2024

Hospital	Trauma Center *Level I is highest*	NICU *Level IV is highest*	Stroke Center *Primary is most basic; Thrombectomy Capable intermediate; Comprehensive most advanced*	AIDS Center
Maimonides Medical Center	Level I	Level IV	Comprehensive	-
Maimonides Midwood Community Hospital	-	-	Primary	-
Mount Sinai Brooklyn	-	-	Primary	-
NYP Brooklyn Methodist Hospital	Level II	Level III	Thrombectomy Capable	-
NYC Health + Hospitals/Kings County	Level I	Level III	Thrombectomy Capable	✓
NYC Health + Hospitals/South Brooklyn Health	-	Level II	Primary	✓
NYC Health + Hospitals/Woodhull	-	Level III	Primary	✓
NYU Langone Hospital - Brooklyn	Level I	Level II	Comprehensive	✓
Brookdale Hospital Medical Center	Level II	Level III	Thrombectomy Capable	✓
Interfaith Medical Center	-	-	-	✓
The Brooklyn Hospital Center	-	Level III	Primary	✓
Wyckoff Heights Medical Center	-	Level III	Primary	-
University Hospital SUNY Downstate	-	Level III	Primary	✓

Note: Highlighted hospitals are in Downstate's PSA and SSA

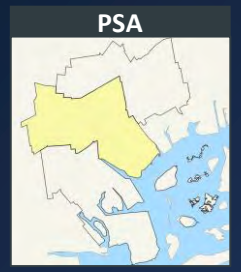
Source: NYS Health Profiles; Health system websites

There Is Programmatic Fragmentation for Select Services Across Brooklyn Hospitals

Services Offered		Maimonides Medical Center	NYC HEALTH+ HOSPITALS | Kings County	OBH One Brooklyn Health
Discharges	6.5k	31.7k	15.9k	16.8k
Average Length of Stay	6.6	5.7	8.8	7.7
Certified Beds	342	845	624	817
% Surgical IP Discharges	17%	18%	14%	14%
Amb. Surgery Volume	5.9k	24.1k	6.0k	8.4k
Emergency Visits	35.0k	92.2k	94.4k	91.6k
Programmatic Fragmentation: Examples				
Pediatric ICU Beds	5 beds	11 beds	7 beds	5 beds
Neonatal ICU Level	Level III	Level IV	Level III	Level III
OBGYN	<2 births per day	~14 births per day	~4 births per day	<2 births per day

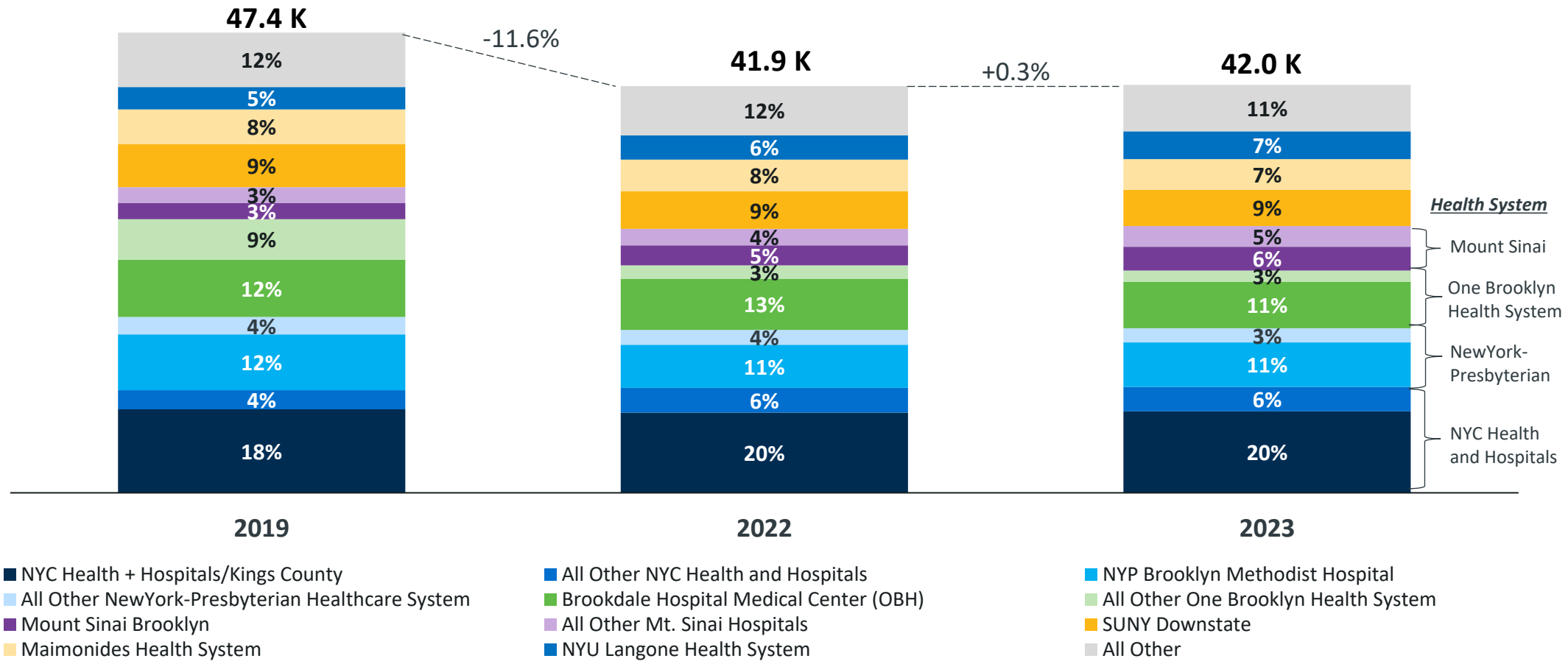
Note: Above data reflects Brooklyn-based facilities only *(i.e. NYC Health + Hospital data reflects Kings County facility only; OBH data reflects all three Brooklyn facilities)*

Notes: OBH includes Interfaith Medical Center and Brookdale University Hospital Medical Center. SPARCS data should be interpreted directionally rather than as a definitive source on market volumes. **Sources**: Health system websites; 2023 SPARCS inpatient market database; 2023 SPARCS ED visit database; 2023 SPARCS ASC database; NYS Department of Health Hospital Bed Capacity.



There Has Been Little Change in the PSA's Inpatient Market Size or Competitive Landscape in 2023 Relative to 2022

SUNY DOWNSTATE PSA INPATIENT MARKET SHARE, *2019-2023*

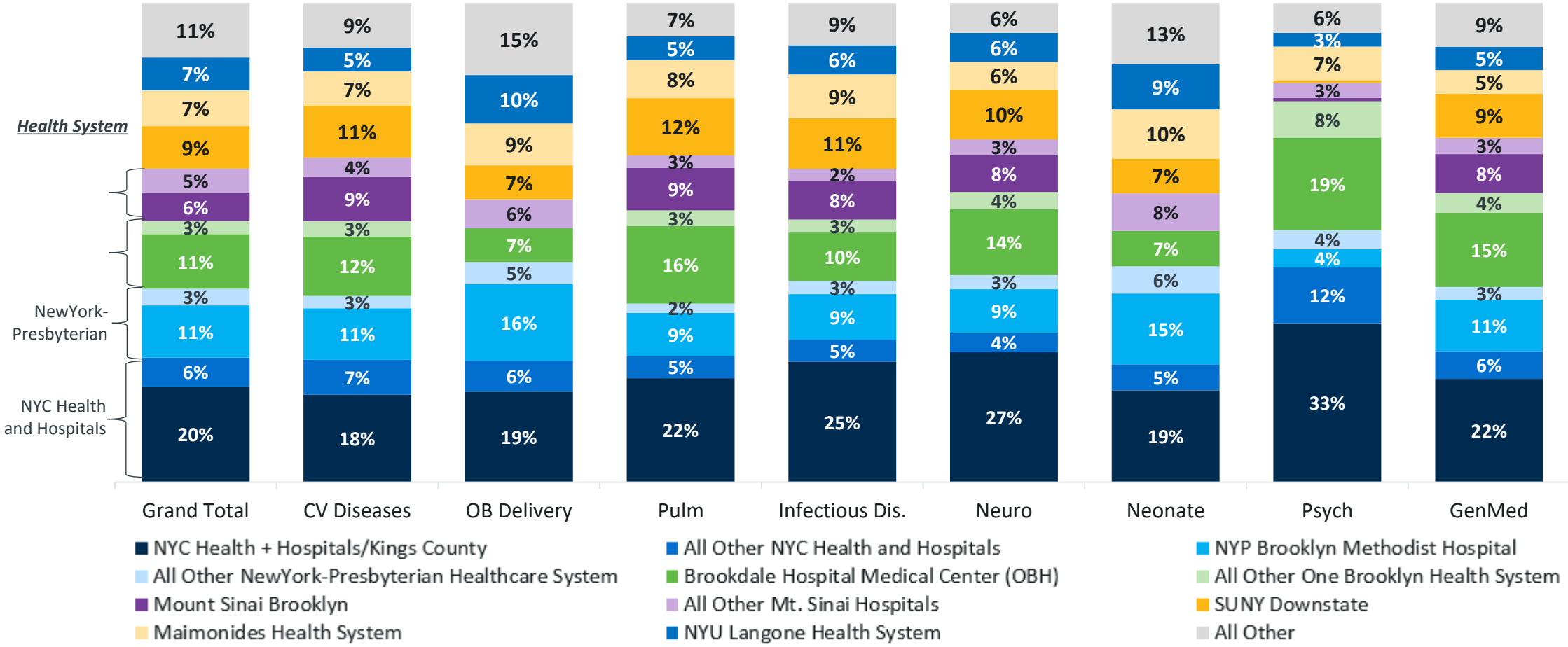


Note: (1) SPARCS data should be interpreted directionally rather than as a definitive source on market volumes; (2) OBH closed Kingsbrook Jewish Medical Center in 2021, transitioning to OP care only
Source: SPARCS 2019-2023 state database.

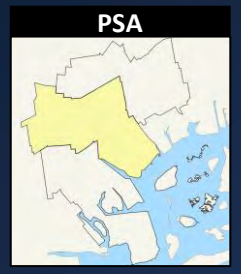
NYC Health + Hospitals and OBH Lead the Psych Market; NYP Is Strong in OB & Neonatology; SUNY Downstate's Market Share Is Consistent Across Services

SUNY DOWNSTATE PSA INPATIENT MARKET SHARE BY SERVICE LINE, 2023

Total PSA inpatient market + top 8 inpatient service lines by PSA market volume

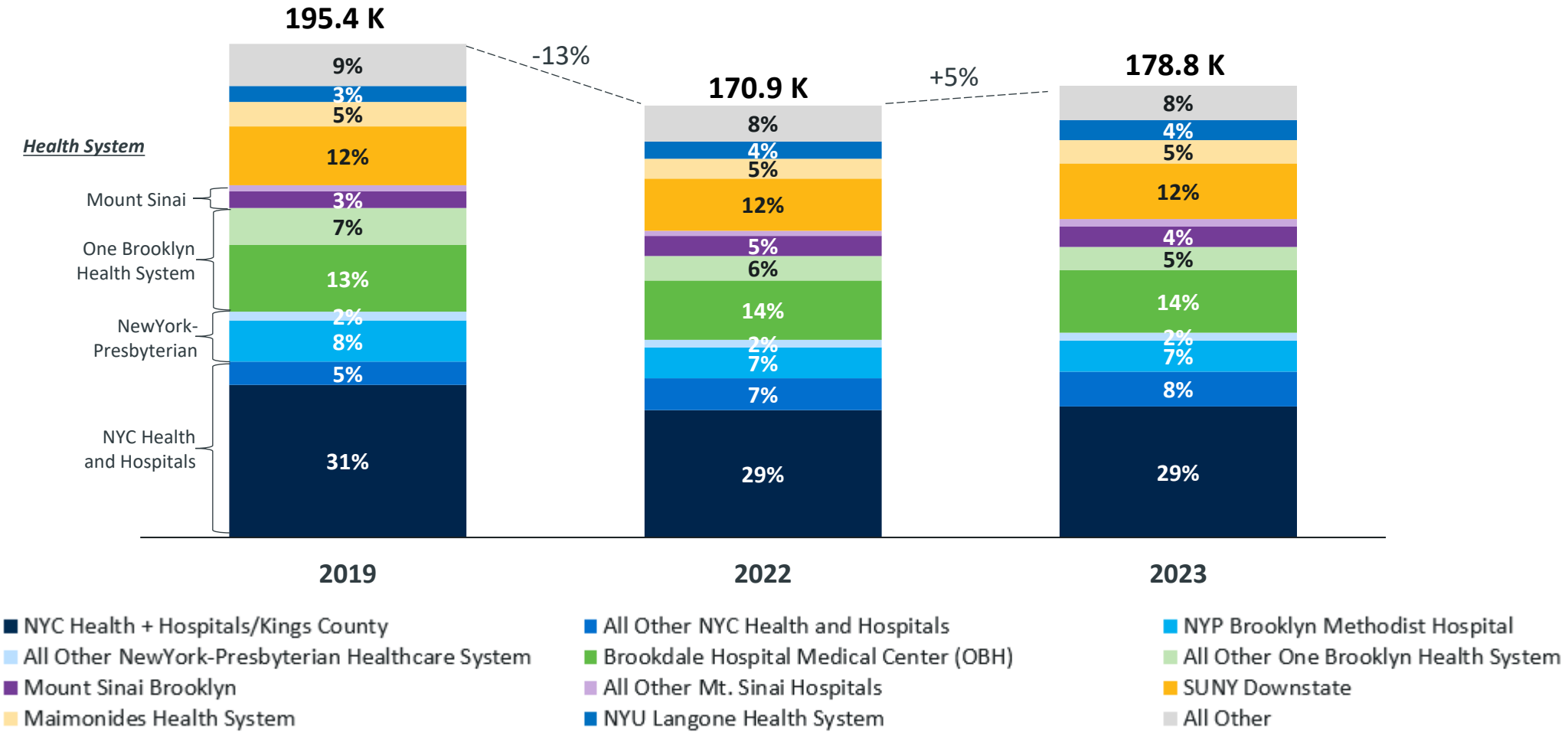


Sources: SPARCS 2023 state database. Note: SPARCS data should be interpreted directionally rather than as a definitive source on market volumes



Even as the Emergency Dept Market in the PSA Has Expanded & Contracted Over Past Several Years, Downstate Market Share Has Stayed Consistent

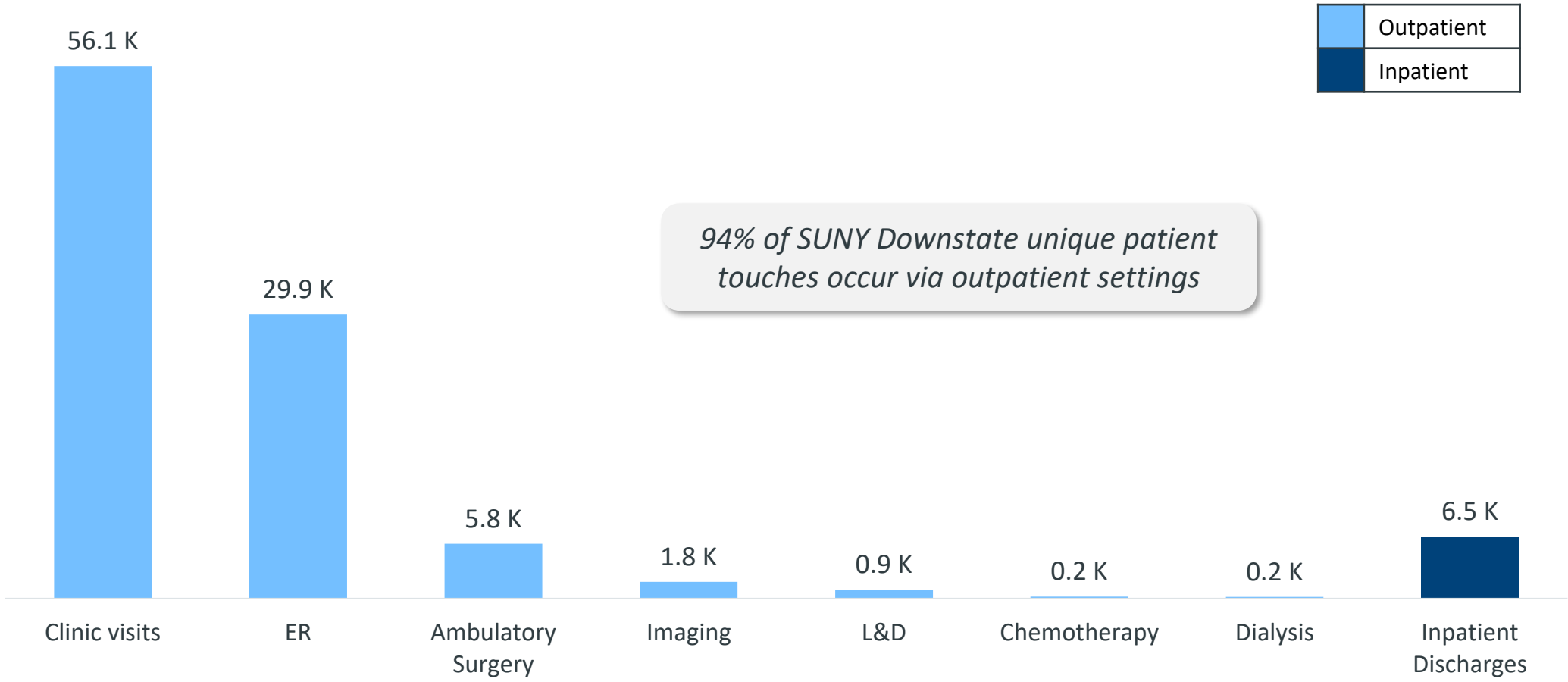
SUNY DOWNSTATE PSA EMERGENCY DEPT VISITS MARKET SHARE, 2019-2023



Note: (1) SPARCS data should be interpreted directionally rather than as a definitive source on market volumes. Source: SPARCS 2019-2023 ED state database.

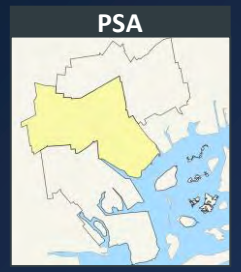
Over 90% of SUNY Downstate's Patients Are Reached via Outpatient Care Settings, Predominantly the Clinic and the Emergency Dept

SUNY DOWNSTATE UNIQUE PATIENTS TREATED BY CARE SETTING, *2023*



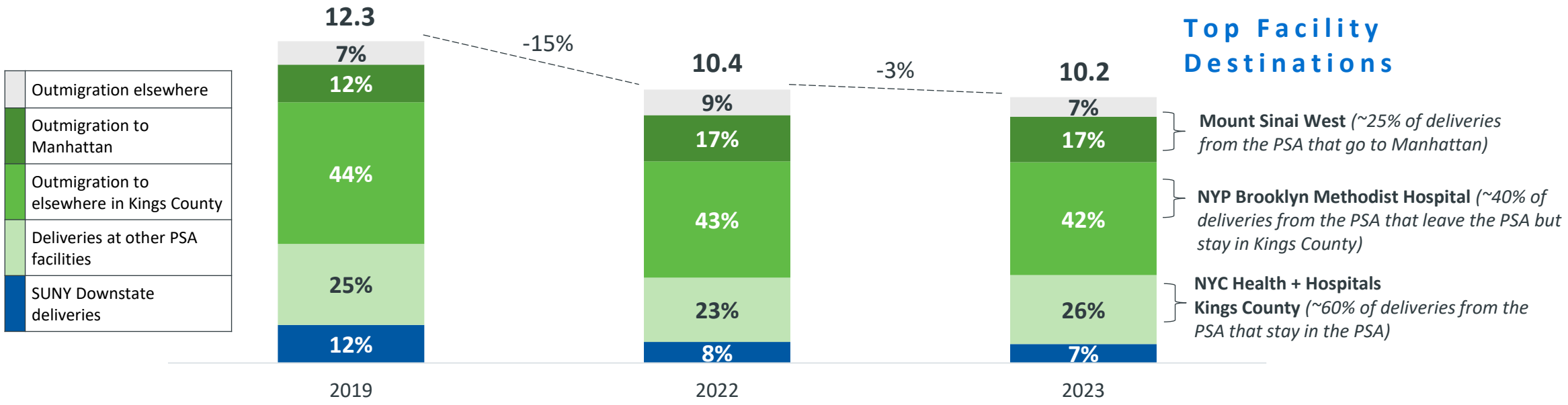
94% of SUNY Downstate unique patient touches occur via outpatient settings

Source: SUNY Downstate internal unique patient data (CY2023).



Delivery Volume from the PSA Has Declined Across the Market and at SUNY Downstate Specifically

Deliveries per Day Originating in SUNY Downstate's PSA | 2019-2023



Top Facility Destinations

Mount Sinai West *(~25% of deliveries from the PSA that go to Manhattan)*

NYP Brooklyn Methodist Hospital *(~40% of deliveries from the PSA that leave the PSA but stay in Kings County)*

NYC Health + Hospitals Kings County *(~60% of deliveries from the PSA that stay in the PSA)*

SUNY Downstate Deliveries per Day, by Origin | 2019-2023

	2019	2022	2023
PSA	1.5	0.8	0.7
SSA	0.9	0.4	0.5
Broader Kings County	0.3	0.2	0.2
Total SUNY Downstate Deliveries (Kings county patients only)	***2.6***	***1.5***	***1.4***

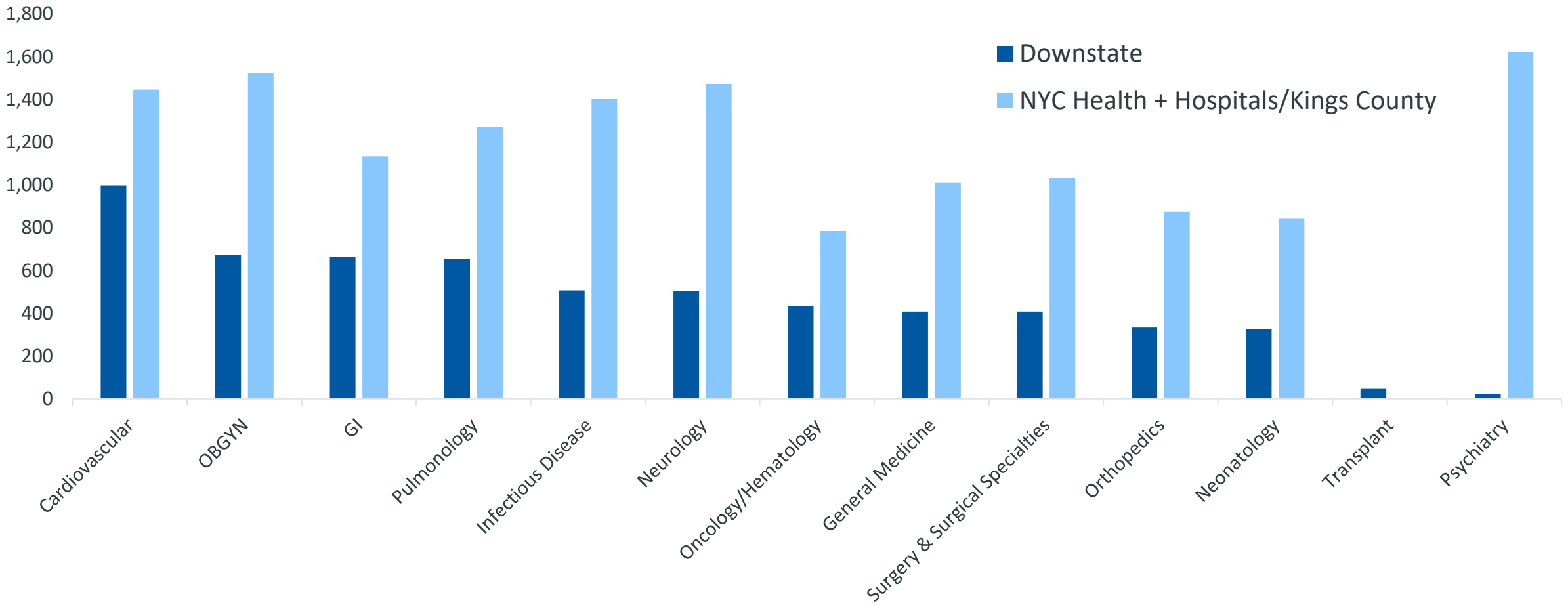
In 2023, across the 10 Kings County hospitals that do deliveries, the county experienced ~83 deliveries per day

Note: (1) SPARCS data should be interpreted directionally rather than as a definitive source on market volumes. Source: SPARCS 2019-2023 state database.

Across Service Lines, NYC H+H Kings County Hospital Center Operates at a Larger Scale Than SUNY Downstate

SUNY DOWNSTATE VS. NYC HEALTH + HOSPITALS/KINGS COUNTY

Volume By Service Line ***(Select Service Lines Displayed Below),*** *2023*

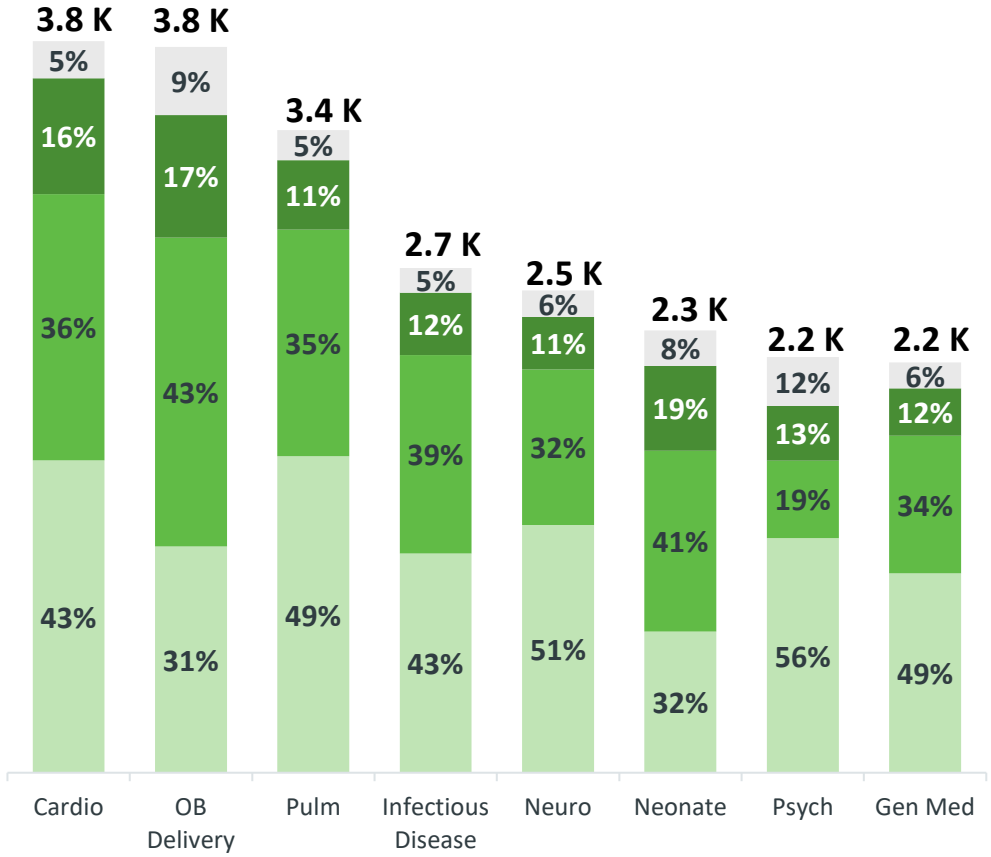


Note: (1) SPARCS data should be interpreted directionally rather than as a definitive source on market volumes. Source: SPARCS 2023 inpatient state database.

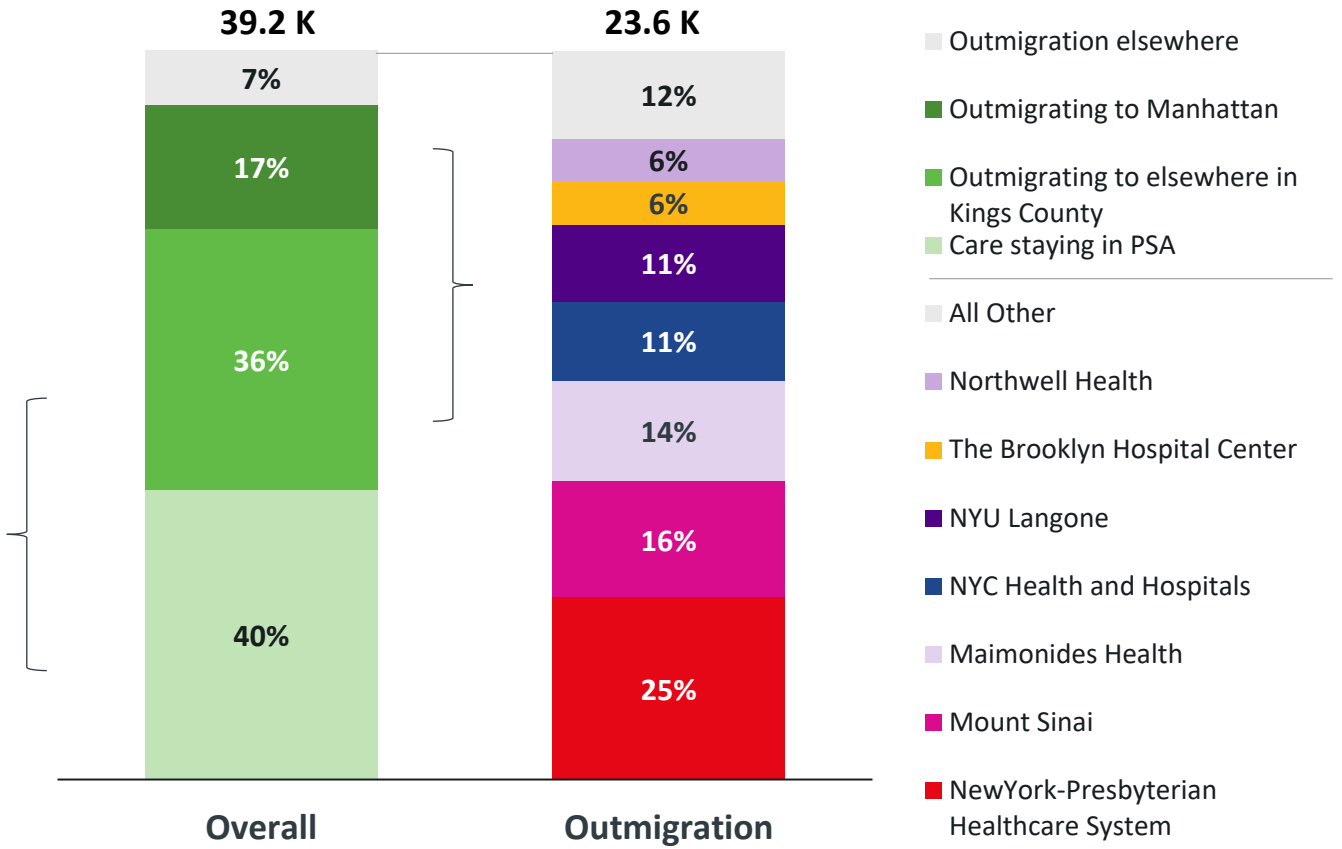
60% of Patients in the SUNY Downstate Primary Service Area Out-migrate for Care, Primarily to Manhattan (17%) or Other Brooklyn Hospitals (36%)

PSA OUTMIGRATION BY SERVICE LINE, 2022

Top 8 Service Lines By Volume Outmigration



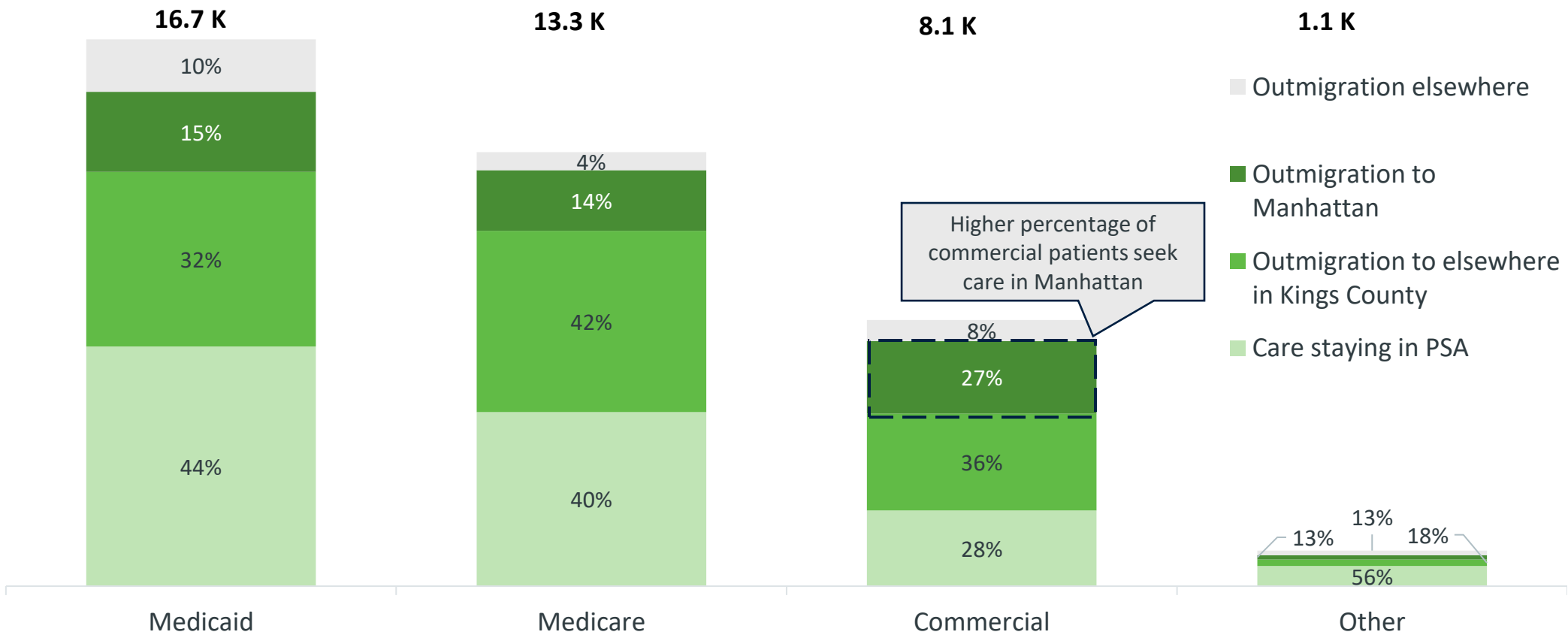
PSA OUTMIGRATION SHARE BY DESTINATION HOSPITAL, 2022



Sources: SPARCS 2022 state database.

Commercial Patients Seek Inpatient Care in Manhattan at Almost Twice the Rate (27%) of Governmental Patients (14% To 15%)

PSA INPATIENT DISCHARGE OUTMIGRATION SHARE BY PAYOR, *2022*

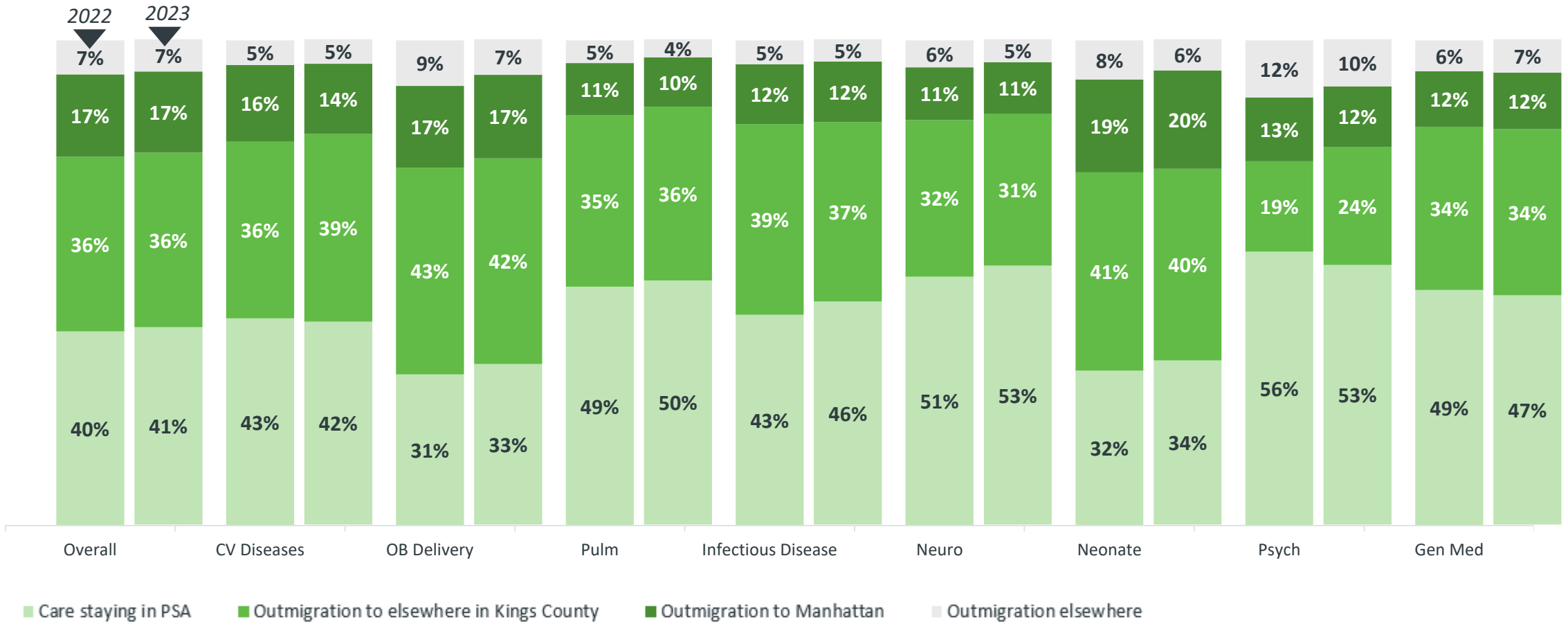


Sources: SPARCS 2022 state database.

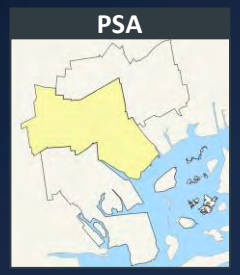
60% of Patients in the SUNY Downstate Primary Service Area Out-migrate for Care– This Trend Stayed Consistent in 2023 Relative to 2022

PSA OUTMIGRATION BY SERVICE LINE, *2022- 2023*

Top 8 Service Lines By Volume (2022)

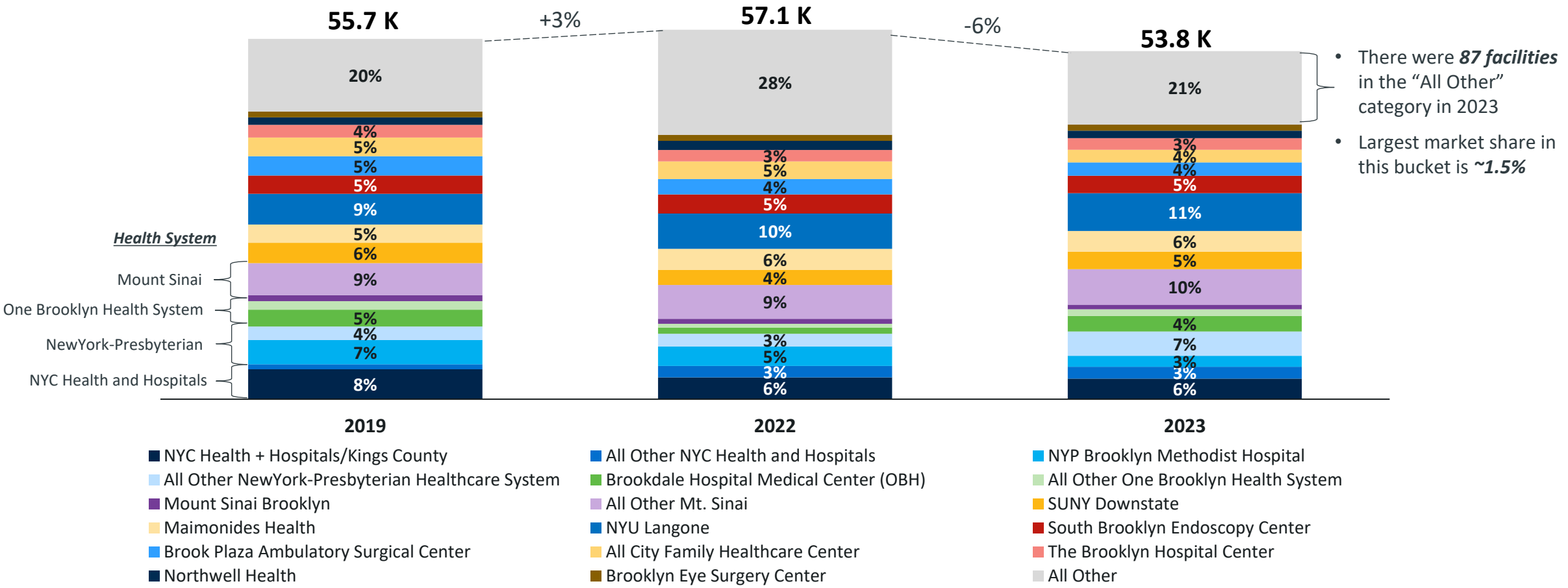


Sources: SPARCS 2022 state database. Note: SPARCS data should be interpreted directionally rather than as a definitive source on market volumes.



The Outpatient Surgery Market in the PSA Is Fragmented Across Many Health System and Independent Providers

SUNY DOWNSTATE PSA AMBULATORY SURGERY MARKET SHARE, 2019-2023



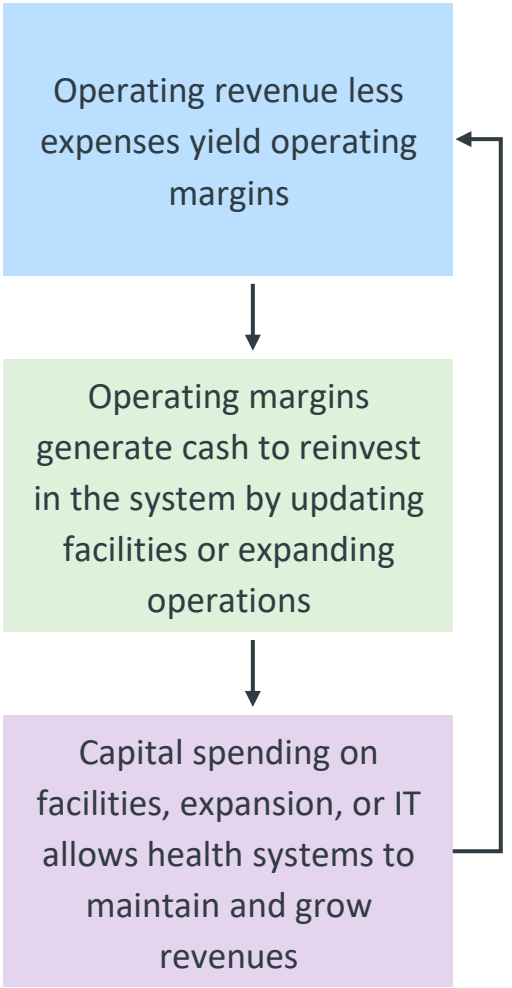
- There were ***87 facilities*** in the "All Other" category in 2023
- Largest market share in this bucket is ***~1.5%***

Note: (1) SPARCS data should be interpreted directionally rather than as a definitive source on market volumes. Source: SPARCS 2019-2023 ambulatory surgery state database.

Appendix 3-E Detailed Findings Historic and Projected Financials for the Hospital and Campus

Key Financial Terms

- **Total operating revenue**: the total income generated from providing medical services ("Net Patient Service Revenue") as well as other sources of revenue, including support from the state and federal governments.
- **Disproportionate share hospital (DSH) revenue**: federal funding for hospitals that serve a high number of Medicaid and uninsured patients.
- **Vital Access Provider Assurance Program (VAPAP) revenue**: state funding to provide additional support to financially distressed hospitals with critical cash flow needs
- **State appropriations**: funding from New York State to support hospital operations; SUNY Downstate receives funding to help pay staff, cover expenses due to Covid impacts, and maintain access to vital services.
- **Operating margin**: the share of total operating revenue that a hospital retains after paying for all expenses. Sustainable health systems typically generate 2%-4% operating margins
- **Operating EBIDA margin**: share of total operating revenue that a hospital retains after expenses, but before paying interest and depreciation. Sustainable health systems typically generate 8%-10% EBIDA margins.
- **Net income margin**: share of total revenue that a hospital retains after paying expenses and after accounting for non-operating items like state funding sources and investments.
- **Capital spending**: the money spent on purchasing or repairing physical assets such as new buildings, building renovations or medical equipment.



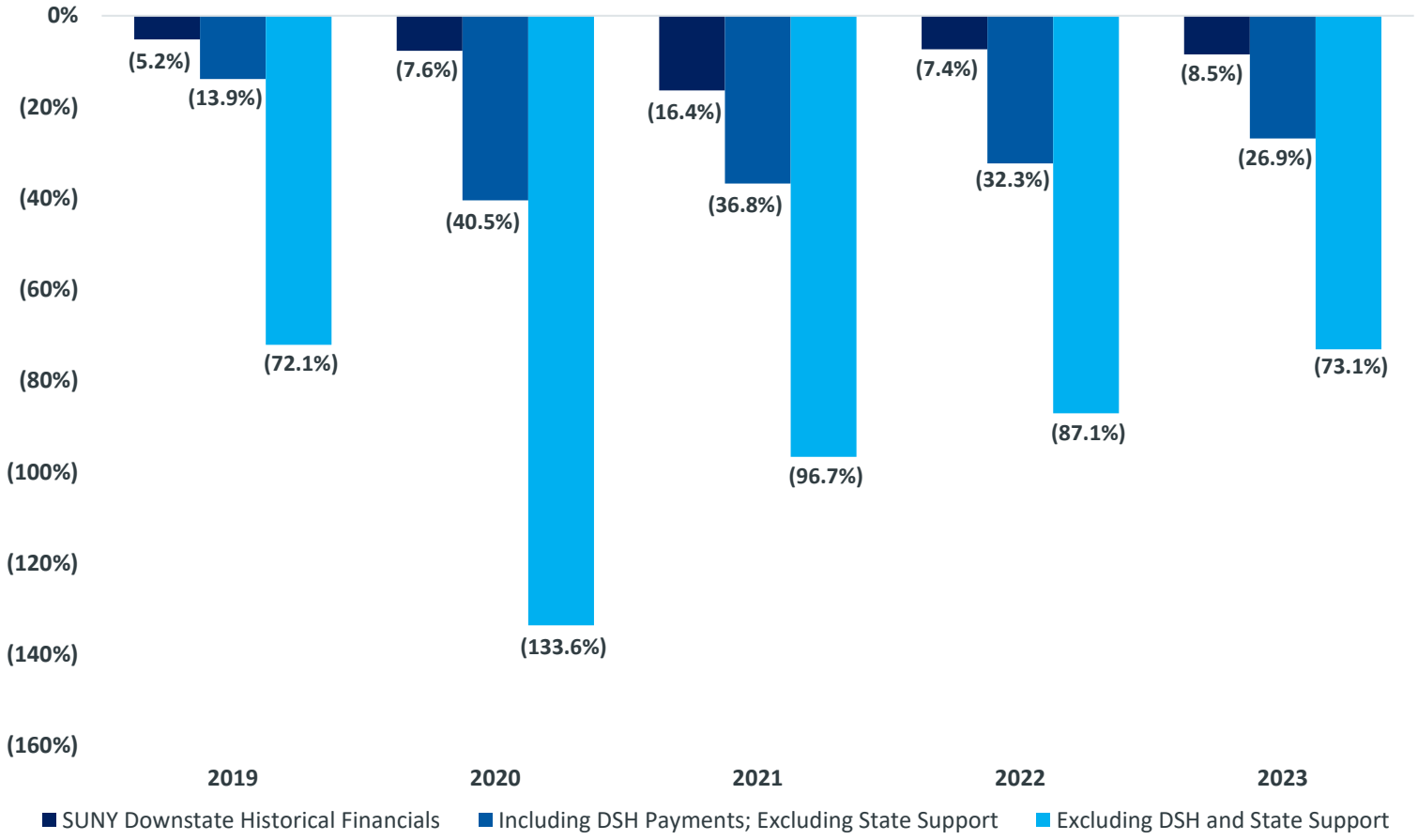
SUNY Downstate's Net Income Has Remained Negative

($ in Millions)	2019	2020	2021	2022	2023	5-Year Growth Rate[B]	2025 Financial Forecast[E]
Timeline:	*Jan – Dec 2019*	*Jan – Dec 2020*	*Jan – Dec 2021*	*Jan – Dec 2022*	*Jan – Dec 2023*		*Apr '24 – Mar '25*
Revenue							
Net Patient Service Revenue	$283.8	$226.9	$255.3	$273.9	$297.6	*1.2%*	$275.6
DSH Revenue	155.0	161.4	120.4	122.6	123.0[A]	*(5.6%)*	$121.4
Net Patient Revenue	**$438.8**	**$388.3**	**$375.7**	**$396.5**	**$420.6**	***(1.1%)***	**$397.0**
Other Operating Revenue	$22.6	$22.3	$26.0	$28.6	$46.5	*19.7%*	$40.7
Total Operating Revenue	**$461.4**	**$410.6**	**$401.7**	**$425.1**	**$467.1**	***0.3%***	**$437.7**
Expenses							
Salaries and Benefits	$364.8	$409.3	$373.2	$389.6	$408.8	*2.9%*	$371.8
Supplies and Other Expense	140.2	142.7	150.0	141.8	148.8	*1.5%*	$163.7
Depreciation and Amortization	16.6	16.7	17.2	22.9	27.5	*13.5%*	---[F]
Total Operating Expenses	**$521.6**	**$568.7**	**$540.4**	**$554.2**	**$585.1**	***2.9%***	**$535.5**[F]
Operating Income	**($60.2)**	**($158.1)**	**($138.7)**	**($129.1)**	**($118.0)**		**($98.0)**[F]
% Margin	*(13.0%)*	*(38.5%)*	*(34.5%)*	*(30.4%)*	*(25.3%)*		*(22.4%)*
Non-Operating Items							
State Appropriations	$37.9	$52.4	$50.2	$65.7	$67.7	*15.6%*	---[F]
VAPAP and Provider Relief Funding	0.0	71.0	19.0	31.7	10.6	*(46.9%)*[C]	---[F]
Interest Expense	(6.5)	(6.4)	(6.7)	(7.0)	(7.6)	*4.0%*[D]	($0.0)
Other Non-Operating Expenses	---	---	---	---	---	---	($1.9)
Investment Income	3.2	0.7	0.2	0.7	1.5	*(16.8%)*	---[F]
Total Non-Operating Income	**$34.6**	**$117.7**	**$62.7**	**$91.1**	**$72.2**	***18.1%***	**($1.9)**[F]
Net Income	**($25.6)**	**($40.4)**	**($76.0)**	**($38.0)**	**($45.7)**		**($99.9)**[F]
% Margin	*(5.2%)*	*(7.6%)*	*(16.4%)*	*(7.4%)*	*(8.5%)*		*(22.8%)*

Sources: SUNY Downstate Audited Financial Statements, 2021-2023; SUNY Downstate 2025 Final Budget from November 2024 Notes: (A): Net of $73M one-time DSH settlement; (B) Growth rates are all five-year compound annual growth rates (CAGRs) unless otherwise noted; (C): 4-year growth rate; (D) Growth rate based on treating interest expenses as positive values; (E) 2025 Financial Plan is based on state's fiscal year, running from April 2024-March 2025. All other years are calendar years; (F) Financial plan is cash only and does not include depreciation and amortization, state appropriations, or investment income, which adjusts operating income and net income as a result.

Without Government Financial Support, SUNY Downstate's Net Income Margins Decrease Sharply

Historical Net Income Margin Inclusive and Exclusive of Government Support Revenue

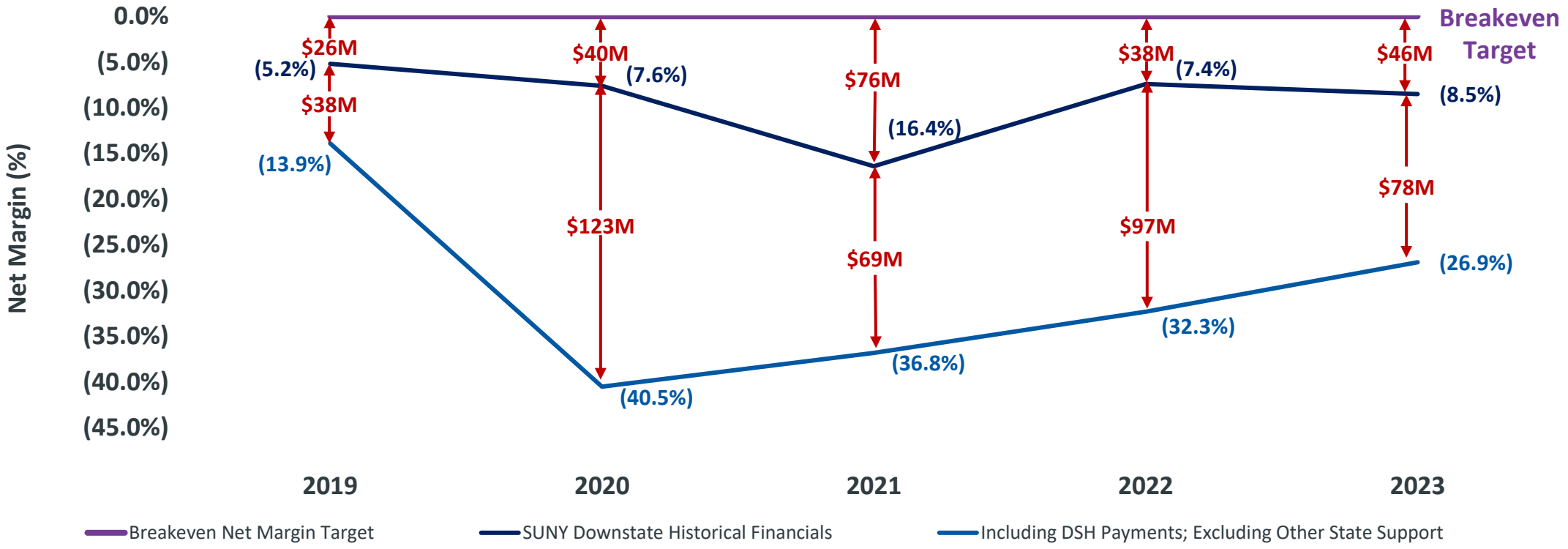


Note: State Support includes State Appropriations and VAPAP funding from slide 12.

OBSERVATIONS

- Net income margin is on a broadly downward trajectory, with a notable negative outlier in 2021
- In both scenarios shown, SUNY Downstate's margins are highly negative, indicating a high reliance on government funding sources at the State and Federal level
- Exclusion of DSH revenue leads to a significantly lower margin, indicating a very high reliance on this funding to help compensate for SUNY Downstate's challenging payor mix and low insurance reimbursement rates

Without State Support, SUNY Downstate's Annual Gap to a Breakeven Net Income Margin is Nearly $125M

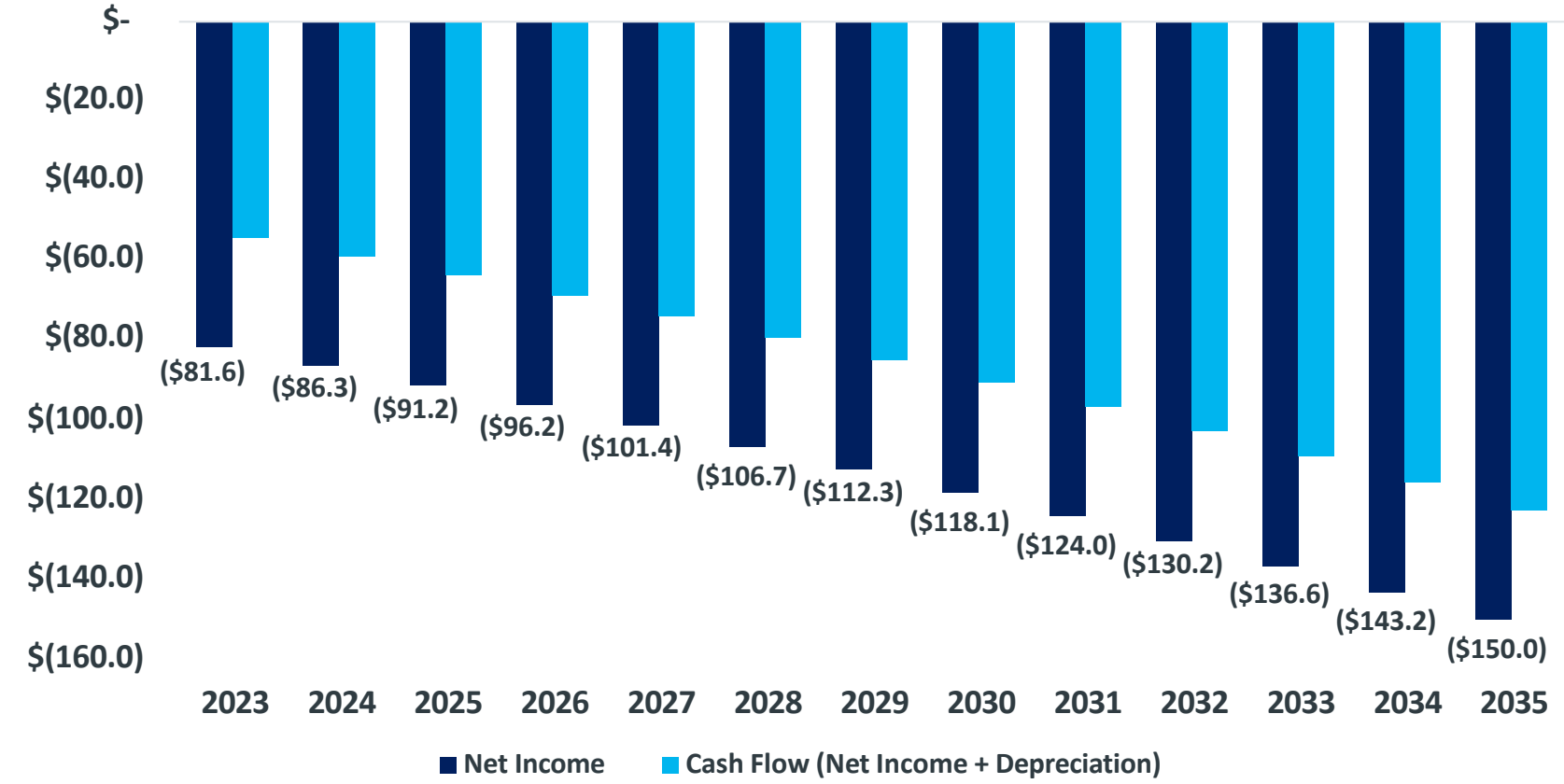


Gap to Breakeven Net Margin as a Percentage of Cash Operating Expenses

SUNY Downstate Historical Financials	5.1%	7.3%	14.5%	7.2%	8.2%
Financials Without State Support, but Including DSH	12.6%	29.7%	27.8%	25.5%	22.2%

SUNY Downstate's Baseline Financial Projections Demonstrate Net Income and Cash Flow Degradation Over Time Absent Supplemental State Support ($ in millions)

SUNY Downstate's Baseline Net Income Inclusive of DSH; Excluding VAPAP



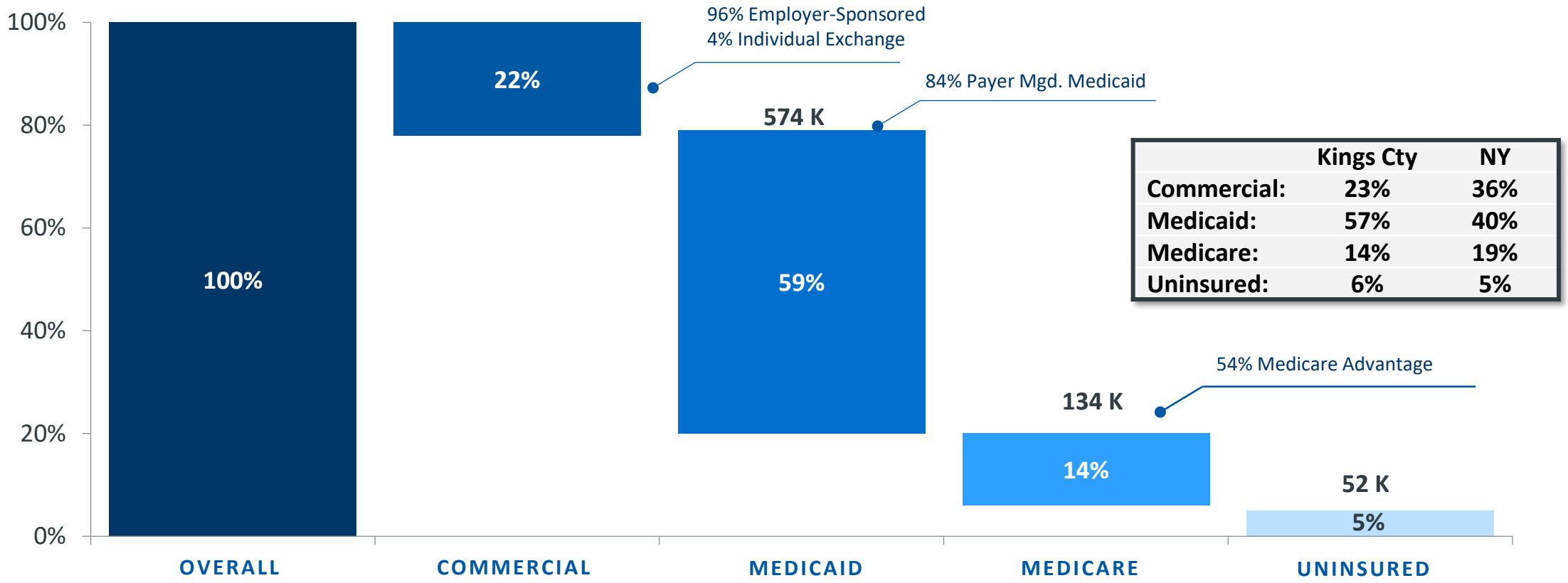
Source: SUNY Downstate's 2023 Audited Financials. Accounting is accrual and reported in calendar years.
Notes: Baseline projection based on 2023 Adjusted Audited Financials

OBSERVATIONS

- SUNY Downstate's baseline projection shows a steady decline in net income over the projection period as expense growth outpaces anticipated revenue growth
- This projection excludes VAPAP funding, which is considered a temporary revenue source, but includes DSH and other state grants and appropriations
- This projection outperforms recent performance, with revenue growing faster than the 0.3% annual growth rate of the past three years
- As a result, some level of performance improvement will be required to meet these projections

SUNY Downstate's PSA and SSA Have a High Medicaid and Low Commercial Population Mix Compared to the New York Average

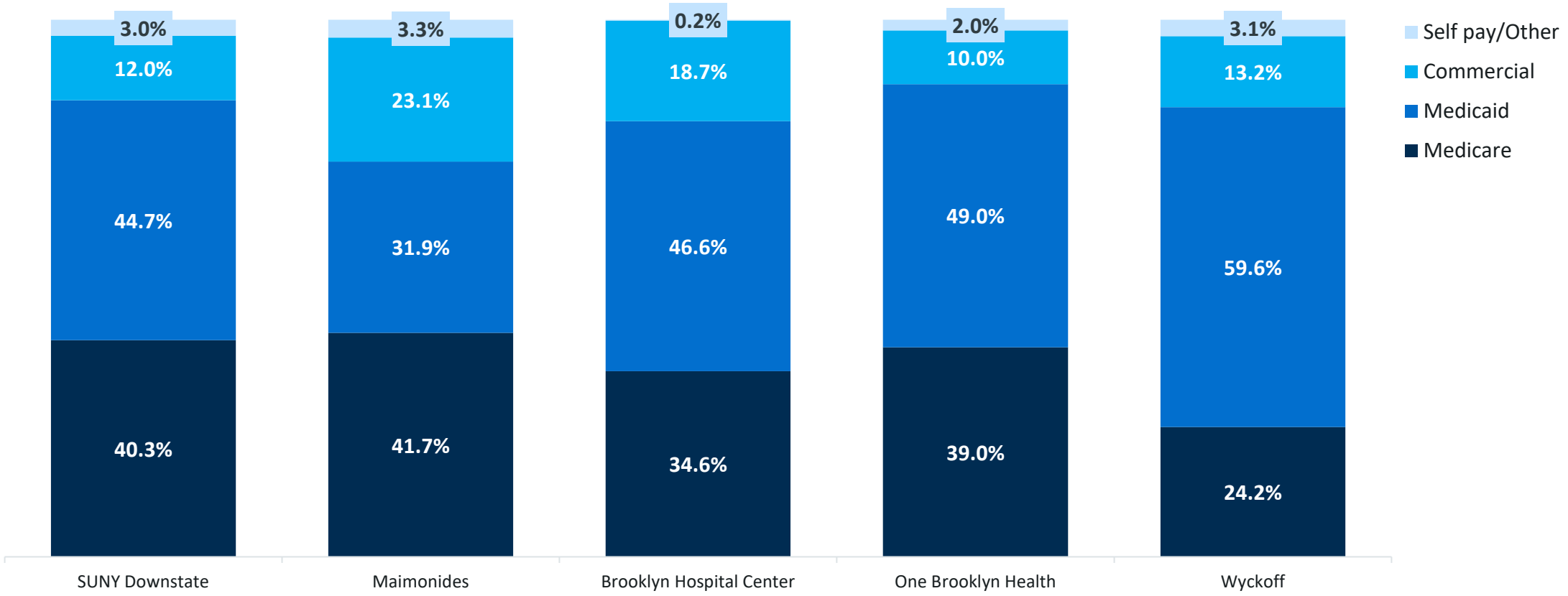
SUNY DOWNSTATE PSA + SSA[1] PAYOR MIX[2], *July 2023*



	Kings Cty	NY
Commercial:	23%	36%
Medicaid:	57%	40%
Medicare:	14%	19%
Uninsured:	6%	5%

Note: (1) SUNY Downstate's PSA is defined as zip codes 11203, 11212, 11225, 11226, and 11236. The SSA is defined as zip codes 11207, 11208, 11210, 11213, 11233, and 11234 (2) Dual Eligibles included in Medicare only. Source: July 2023 MMS DRG.

SUNY Downstate's Payor Mix is Comparable to Other Brooklyn Hospitals but has High Reliance on Government Payors

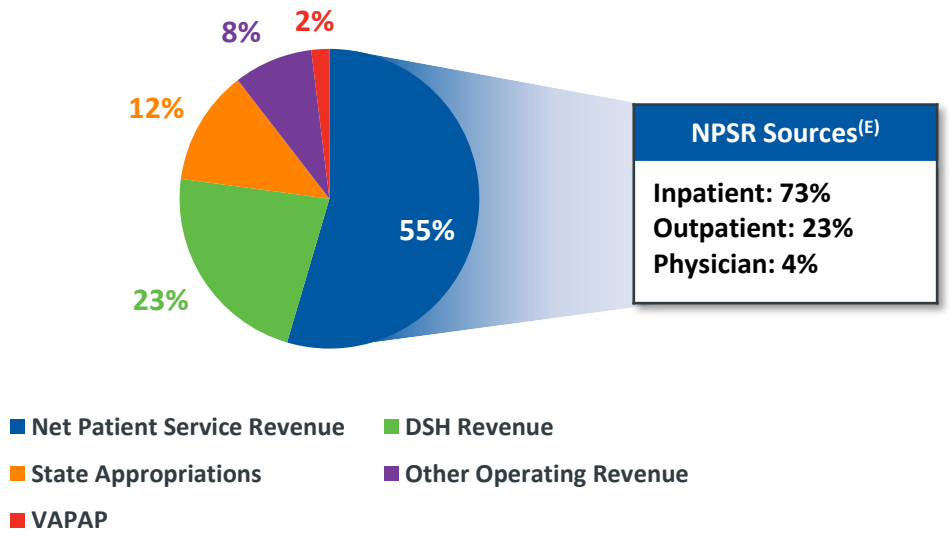


- SUNY Downstate has a similar payor mix to other hospitals and health systems in Brooklyn, dominated by government insurers, which typically reimburse at lower rates than commercial payors
- Larger health systems with presences in Brooklyn serve a larger commercial population, supporting their financial performance

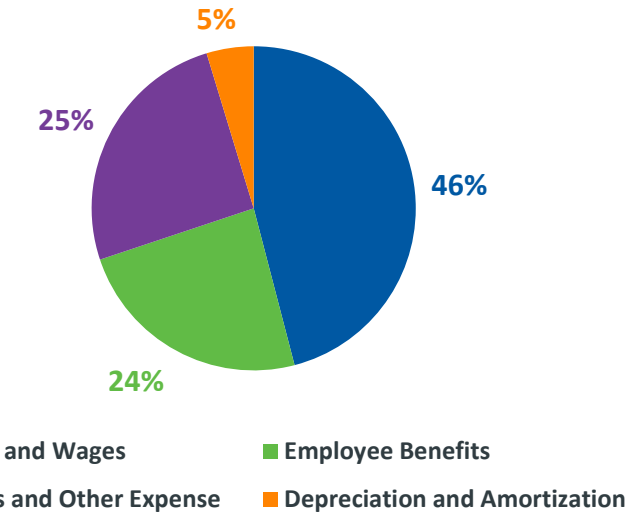
Sources: Competitor Audited Financial Statements, 2022; SUNY Downstate Unaudited Financials, June 2022

SUNY Downstate's Income Statement Demonstrates a High Reliance on Government Funding with a Labor-Heavy Expense Base

Revenue Sources by Category, 2023(D)



Operating Expense by Category, 2023(D)



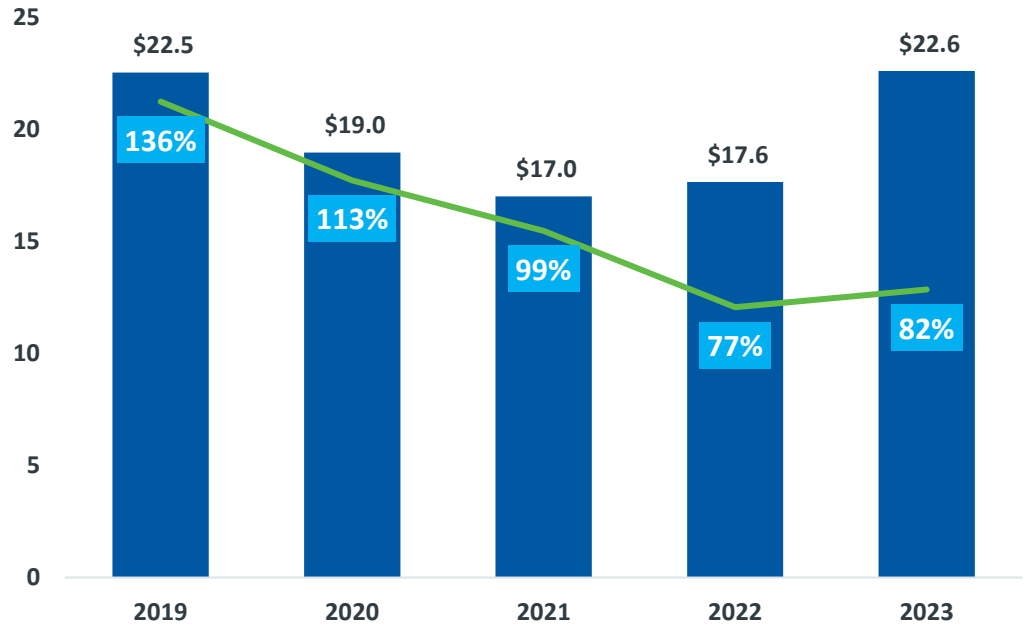
OBSERVATIONS

- Net patient service revenue accounts for just over half of all total revenue, while government funding accounts for 37% across DSH, VAPAP, and state appropriations
- Salaries and benefits are the greatest portion of SUNY Downstate's expenses, and its share of total expenses has grown over the past five years

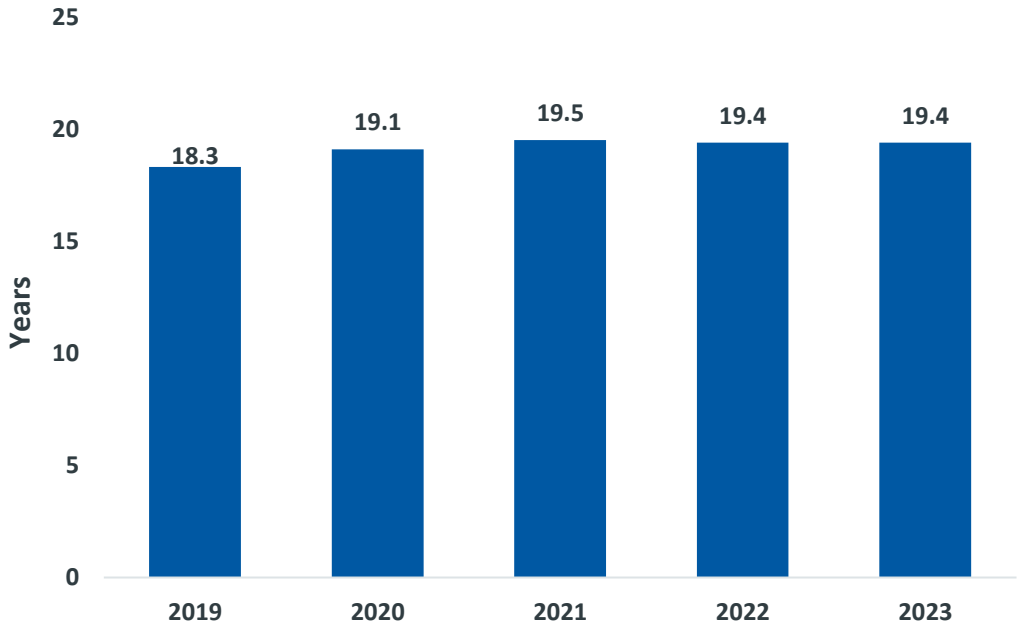
Sources: SUNY Downstate Audited and Unaudited Financial Statements, 2021-2023
Note (A): Total revenue excludes $73M one-time adjustment to DSH in 2023; includes DSH revenue of $155M in 2019, $161M in 2020, $120M in 2021, $123M in 2022, and $123M in 2023 (excludes one-time adjustment)
Note (B): State appropriations include Provider Relief Fund grants, State of New York appropriations excluding professional liability, and VAPAP funding
Note (C): Other Revenue consists of other operating revenue, investment income, and interest expense;
Note (D): Based on 2023 Audited Financials
Note (E): Based on December 2022, June 2023, and December 2023 Unaudited Financials

SUNY Downstate Faces Challenges Associated with Aging Facilities along with Low Capital Spend

Capital Spending and Capital Spending Ratio ($, millions)



Average Age of Plant[(A)]



OBSERVATIONS

- Although capital spending has increased the past three years, SUNY Downstate's capital spending ratio has decreased over the past five years, with depreciation outpacing capital spending
- Average age of plant remained close to 20 years over the last 5 years, indicating that significant capital investment will be needed to update the facilities

Sources: SUNY Downstate Audited and Unaudited Financial Statements, 2021-2023
Note (A): Sourced from June 2022-2024 Unaudited Financial Statements

SUNY Downstate's Financial Performance Lags Service Area and Broader Market Competitors ($ in millions)

Metric	SUNY The State University of New York	The Brooklyn Hospital Center	NYC HEALTH+ HOSPITALS	OBH One Brooklyn Health	NYU Langone Health	NewYork-Presbyterian	Northwell Health
Net Patient Revenue	$421	$435	$8,212	$821	$7,124	$10,841	$15,126
Total Operating Revenue[1,2]	$467	$497	$10,531	$1,314	$8,181	$12,441	$16,827
Operating Margin[1]	(25.3%)	0.4%	(0.8%)	(1.0%)	5.9%	2.8%	0.9%
Salaries, Wages, and Benefits as a Percentage of Net Patient Revenue	97.2%	70.2%	55.6%	97.1%	44.2%	63.9%	71.2%

- Compared to Brooklyn hospitals with similar patient populations, SUNY has lower profitability
- Larger regional systems have healthier financial profiles than SUNY Downstate and similar Brooklyn facilities

Note: (1) Sourced from audited financials and includes DSH payments. SUNY Downstate's margin does not include state appropriations, but One Brooklyn Health's margin does. (2) SUNY Downstate income statement 2023 audited financials adjusted for Provider Relief Grant and other grants, NY state benefit appropriations, interest expense and professional liability appropriation. (3) NYC Health + Hospitals Kings County is included as it is not split from NYCHH financials

BHC and OBH FY22 data used; all else FY23. NYU and Northwell statistics from S&P; all else calculate from audited financials; financials are reported on the system level

Sources: Audited financial statements, S&P, Definitive Healthcare

Campus Finances

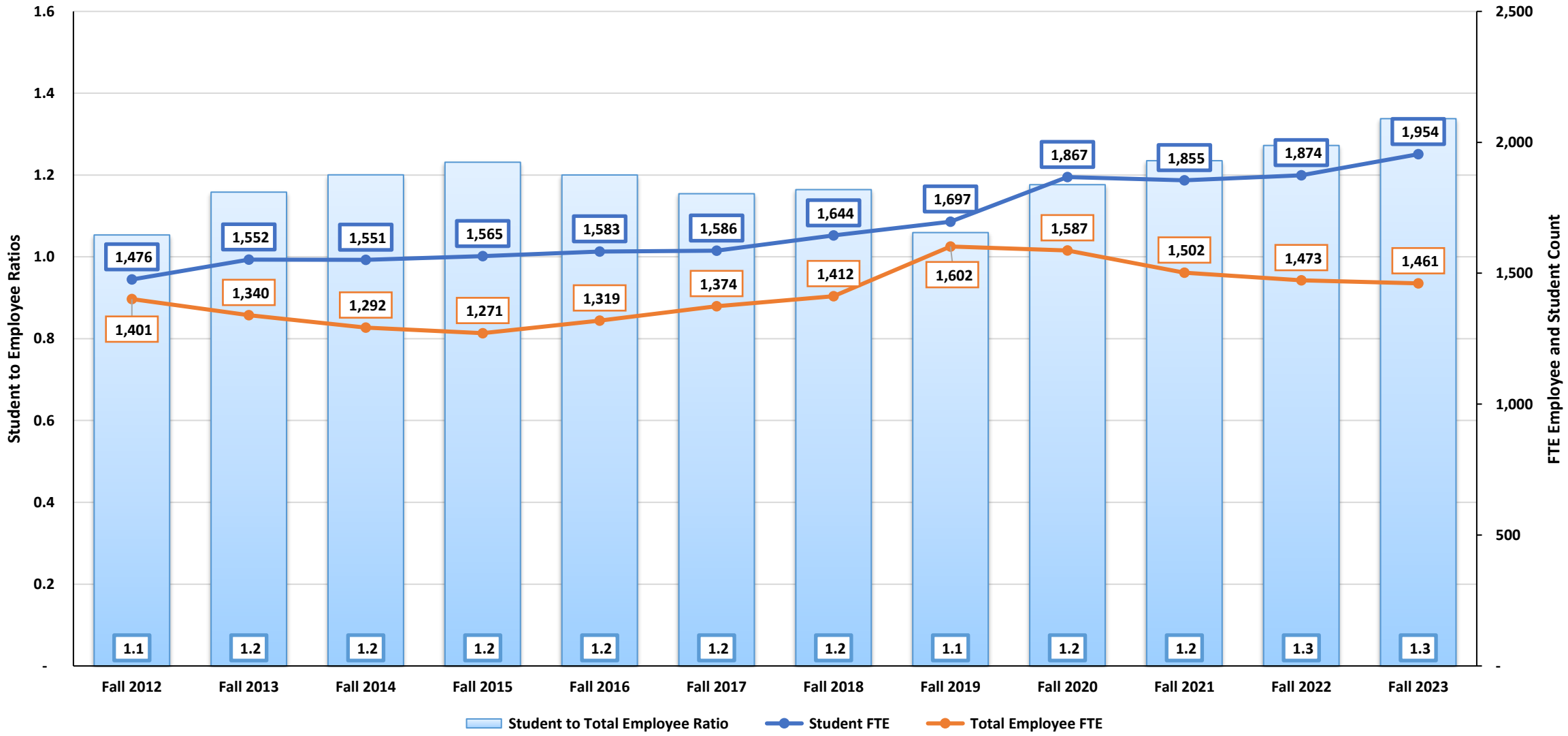
DOWNSTATE MEDICAL SCHOOL FINANCIAL POSITION, *FY2016 to FY2024, in millions of dollars*

Fiscal Year	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23	23-24
Beginning Cash Balance (July 1)	**$41.62**	**$50.67**	**$50.61**	**$68.72**	**$81.08**	**$39.19**	**$83.06**	**$58.64**	**$39.48**
Total Receipts	136.20	119.32	128.11	129.99	79.47	158.79	93.24	97.54	132.82
Total Disbursements	127.15	119.38	109.99	117.62	121.36	114.92	117.56	116.70	124.17
Surplus/Deficit	9.05	(0.06)	18.12	12.36	(41.89)	43.87	(24.32)	(19.16)	8.65
Ending Cash Balance (June 30)	**$50.67**	**$50.61**	**$68.72**	**$81.08**	**$39.19**	**$83.06**	**$58.75**	**$39.48**	**$48.13**

Source: SUNY System

**Disbursements include a temporary loan of $15M to the hospital in FY23, in addition to a $30.5M loan the previous year*

Campus Enrollment and Employment



Appendix 3-F Detailed Findings Efficiency of Operations and Quality of Healthcare Services Benchmarking

SUNY Downstate's Operational Performance Compared to SUNY Peers and Benchmarks

Metric	SUNY Downstate	SUNY Stony Brook	SUNY Upstate	**Median: Academics with Revenue <$1B**
Revenue	$0.5B	$2.1B	$1.9B	$0.7B
Discharges	8,569	37,712	31,488	18,212
Adjusted Discharges	13,937	63,144	56,116	26,477
FTEs	2,276	8,883	7,053	2,518
Revenue per FTE	$205,228	$238,511	$274,256	$300,447
Expense per FTE	$257,074	$259,133	$274,917	N/A

Sources: SUNY Audited Financials and Internal Data, Calendar Year 2023, Vizient ODB Benchmarking Data, 2024.

Advanced Metrics Used in Evaluating Operational Performance

Metric	Metric Purpose
Total FTEs per CMI-Weighted Adjusted Occupied Bed	Understanding the **labor intensity of a health system's staffing**. Hospitals with lower occupancy will see higher FTEs per adjusted occupied bed.
Total Expense per CMI-Weighted Adjusted Discharge	Sizing the **total expense base** of the health system, adjusting for intensity of care provided and for inpatient and outpatient services
Total AWI-Adjusted Labor Expense per CMI-Weighted Adjusted Discharge	Identifying the **labor expense base** of the health system, adjusting for intensity of care provided and for inpatient and outpatient services
Total Non-Labor Expense per CMI-Weighted Adjusted Discharge	Understanding the **non-labor expense base** of the health system, adjusting for intensity of care provided and for inpatient and outpatient services
Net Operating Revenue per CMI-Weighted Adjusted Discharge	Evaluating **revenue received by the health system**, adjusting for intensity of care provided and for inpatient and outpatient services

Metric or Adjustment	Definition
Adjusted Occupied Bed & Adjusted Discharge	Both metrics capture the total workload of hospital, accounting for outpatient and inpatient utilization, multiplying inpatient volume by an outpatient factor
AWI Adjustment	Adjusts labor expenses for Medicare's Area Wage Index for the local area
CMI Adjustment	Adjusts utilization costs for inpatient intensity; multiplies by the hospital's Case Mix Index

SUNY Downstate has Both Higher Revenue and Expenses than Similar-Sized AMCs, but Expense Multiples are Higher than Revenue

Metric	Median: Academics with Revenue <$1B	SUNY Downstate	Multiple of Median
Total FTEs per CMI-Weighted Adjusted Occupied Bed	2.7	6.5	**2.4x**
Total Expense per CMI-Weighted Adjusted Discharge	$10,239	$29,987	**2.9x**
Total AWI-Adjusted Labor Expense per CMI-Weighted Adjusted Discharge	$5,494	$15,947	**2.9x**
Total Non-Labor Expense per CMI-Weighted Adjusted Discharge	$4,992	$9,036	**1.8x**
Net Operating Revenue per CMI-Weighted Adjusted Discharge	$12,096	$23,939	**2.0x**

Sources: SUNY Downstate Audited Financials and Internal Cost Accounting Data, 2023; Vizient ODB Benchmarking Data, 2024. Sample size for each benchmark measure ranges between 14 and 15.

SUNY Downstate's Operational Performance Compared to SUNY Peers

Metric	SUNY Downstate	SUNY Stony Brook	SUNY Upstate
Total FTEs per CMI-Weighted Adjusted Occupied Bed	6.5	4.9	4.0
Total Expense per CMI-Weighted Adjusted Discharge	$29,987	$22,225	$18,779
Total AWI-Adjusted Labor Expense per CMI-Weighted Adjusted Discharge	$15,947	$10,538	$8,425
Total Non-Labor Expense per CMI-Weighted Adjusted Discharge	$9,036	$8,960	$10,744
Net Operating Revenue per CMI-Weighted Adjusted Discharge	$23,939	$20,484	$18,734

Sources: SUNY Audited Financials and Internal Data, Calendar Year 2023.

The Majority of Facilities Operating in Brooklyn Have Low Quality and Patient Satisfaction Scores Relative to Manhattan Facilities

	System	Hospital	Leapfrog Hospital Safety Grade	Medicare Overall Star Rating	HCAHPS Patient Survey Rating[1]	Health Equity Score[3]
Brooklyn	One Brooklyn Health	Brookdale Hospital Medical Center	D	1	1	A
	NYC Health and Hospitals	Kings County Hospital Center	C	1	2	A
	SUNY Downstate	University Hospital at Downstate	C	1	2	A
	Mount Sinai	Mount Sinai Brooklyn[2]	C	Data Not Available		
	Maimonides	Maimonides Medical Center	C	1	2	A
	Wyckoff Heights Medical Center	Wyckoff Heights Medical Center	C	1	2	A
	The Brooklyn Hospital Center	The Brooklyn Hospital Center	C	1	2	A
	NYC Health and Hospitals	NYC Health and Hospitals / Woodhull	C	2	2	A
	NewYork-Presbyterian	Brooklyn Methodist	A	Data Not Available		
Manhattan	NYU Langone	Tisch Medical Center	A	5	3	C
	NYC Health and Hospitals	Bellevue	C	2	2	A
	Mount Sinai	Mount Sinai Medical Center	B	3	3	A
	NewYork-Presbyterian	Weill Cornell Medical Center	A	5	3	N/A

Note: Detailed sources, definitions, and methodologies for the above scores are available in the appendix

Note: (1) HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems. This is a set of surveys by CMS that ask patients to report on their health care experiences. (2) Mount Sinai Brooklyn are not included in 2024 CMS Hospital Compare, so data is not available. Interfaith Medical Center is not included in Leapfrog Hospital Safety Grade Rating. (3) 2024-25 Lown Institute Hospitals Index for Social Responsibility; Sources: 2024 CMS Hospital Compare, 2024 Leapfrog Hospital Safety Grade Rating

Overall, Brooklyn Hospitals Have Poorer Clinical Quality Performance Than Their Manhattan-based Peers

CLINICAL QUALITY SCORES, *2022*

Weaker Performance — Stronger Performance

	System	Hospital	Patient Safety for Selected Procedures Composite	Mortality for Selected Conditions Composite	Patients Would Definitely Recommend This Hospital to Friends and Family	Hospital-wide 30-day unplanned readmission rate	Deaths - cardiac surgery - bypass operations only	Deaths - cardiac surgery - valve operations
Brooklyn	SUNY Downstate	University Hospital at Downstate	0.89	1.10	65%	15%	13%	13%
	One Brooklyn Health	Brookdale Hospital Medical Center	2.00	1.28	44%	16%	-	-
	NYC Health and Hospitals	Kings County Hospital Center	0.98	0.89	63%	15%	-	-
	Mount Sinai	Mount Sinai Brooklyn[2]	0.86	1.06	57%	15%	-	-
	Maimonides	Maimonides Medical Center	0.83	1.13	57%	17%	2%	4%
	Wyckoff Heights Medical Center	Wyckoff Heights Medical Center	1.31	0.95	53%	16%	-	-
	The Brooklyn Hospital Center	The Brooklyn Hospital Center	0.82	1.13	54%	15%	-	-
	NYC Health and Hospitals	NYC Health and Hospitals / Woodhull	1.64	1.02	55%	16%	-	-
	NewYork-Presbyterian	Brooklyn Methodist	0.65	0.96	-	-	4%	4%
Manhattan	NYU Langone	Tisch Medical Center	0.56	0.41	74%	13%	5%	5%
	NYC Health and Hospitals	Bellevue	1.03	1.02	63%	15%	8%	6%
	Mount Sinai	Mount Sinai Medical Center	0.83	0.98	69%	15%	3%	5%
	NewYork-Presbyterian	Weill Cornell Medical Center	0.64	0.86	73%	14%	2%	3%
		Key	**Lower is better**	**Lower is better**	**Higher is better**	**Lower is better**	**Lower is better.**	**Lower is better.**

Sources: New York State Department of Health.

SUNY Downstate Has Fairly Middle-of-the-Pack Performance on ED Timeliness Metrics

CLINICAL QUALITY SCORES, *2022*

Weaker Performance — Stronger Performance

	System	Hospital	Median time from ED arrival to ED departure for discharged ED patients (min)	Patient left ED without being seen	Admit decision time to ED departure time for admitted patients (min)
Brooklyn	SUNY Downstate	University Hospital at Downstate	183	1%	259
	One Brooklyn Health	Brookdale Hospital Medical Center	196	4%	392
	NYC Health and Hospitals	Kings County Hospital Center	274	8%	536
	Mount Sinai	Mount Sinai Brooklyn[2]	233	1%	201
	Maimonides	Maimonides Medical Center	224	1%	195
	Wyckoff Heights Medical Center	Wyckoff Heights Medical Center	230	2%	142
	The Brooklyn Hospital Center	The Brooklyn Hospital Center	196	3%	248
	NYC Health and Hospitals	NYC Health and Hospitals / Woodhull	210	6%	166
	NewYork-Presbyterian	Brooklyn Methodist	-	-	154
Manhattan	NYU Langone	Tisch Medical Center	206	1%	162
	NYC Health and Hospitals	Bellevue	201	1%	231
	Mount Sinai	Mount Sinai Medical Center	234	2%	366
	NewYork-Presbyterian	Weill Cornell Medical Center	238	2%	418
		Key	**Lower is better**	**Lower is better**	**Lower is better**

Sources: New York State Department of Health.

Appendix 3-H Detailed Findings Training Needs for Students and Employment Outcomes

Diverse Medical Education at SUNY Downstate

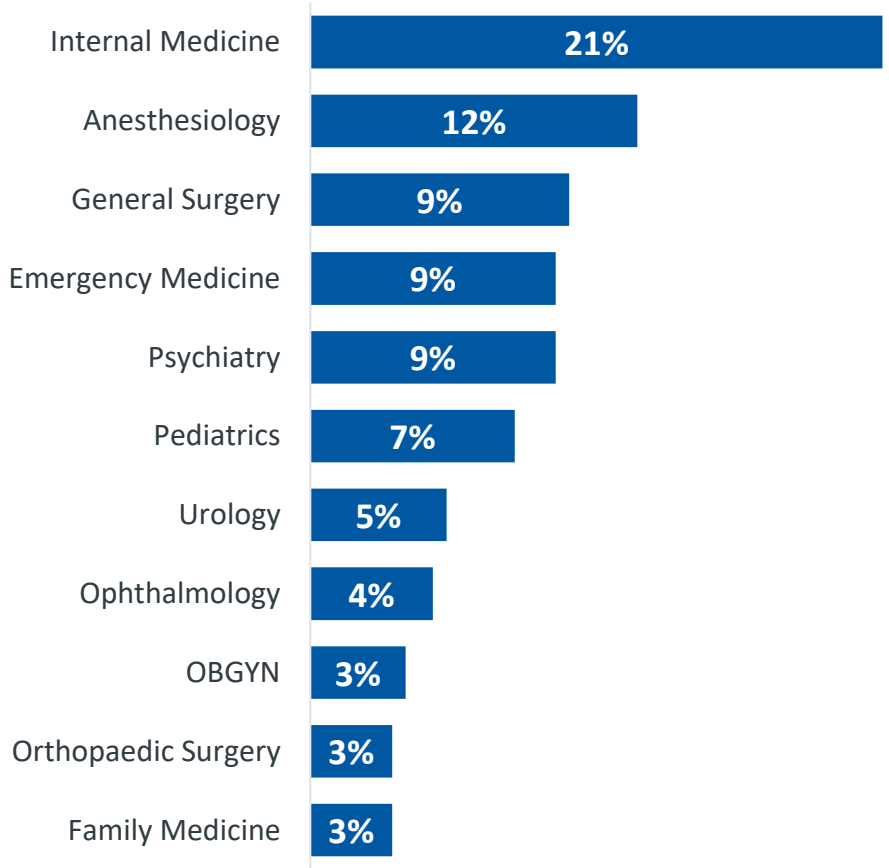
SUNY Downstate Medical School Profile	
Medical School Class Enrollment (2023)	**859**
% African American Students **(Downstate | National)**	*13% | 10%*
% Hispanic/Latino Students **(Downstate | National)**	*15% | 13%*
National percentile of African-American graduates	*93rd*
Match Rates (2024)	
% Staying in NY State	*74%*
% Staying in NYC	*51%*
% Matched to SUNY Downstate	*16%*

- By enrollment and graduates, SUNY Downstate is the largest medical school in NYC and in the top 3 in New York State
- Downstate had the most "underrepresented in medicine (URIM)" medical school graduates in New York State in the class of 2023
- SUNY Downstate has the 24th largest medical school in the nation out of 155 accredited US medical schools
- Ranked #6 by number of African-American faculty members among U.S. medical schools[1]
- Recipient of 2021 AΩA Award for Excellence in Inclusion, Diversity, and Equity in Medical Education and Patient Care[1]
- Though just 20% of U.S. nurses are minorities, 70% of SUNY Downstate's nursing students come from diverse populations

Note: (1) These statements are sourced from 2021; all other data points reflect 2023. (2) 2024 data has been requested from SUNY Downstate School of Medicine. More recent information to be forthcoming upon receipt. **Sources**: Internal SUNY Downstate Medical School data; SUNY Downstate website; AAMC 2024.

SUNY Downstate's Graduates Support Primary Care in New York, With Over 30% of Graduates Matching to IM, FM, or Pediatrics

DOWNSTATE GRADUATES RESIDENCY PLACEMENTS BY SPECIALTY, *2024*



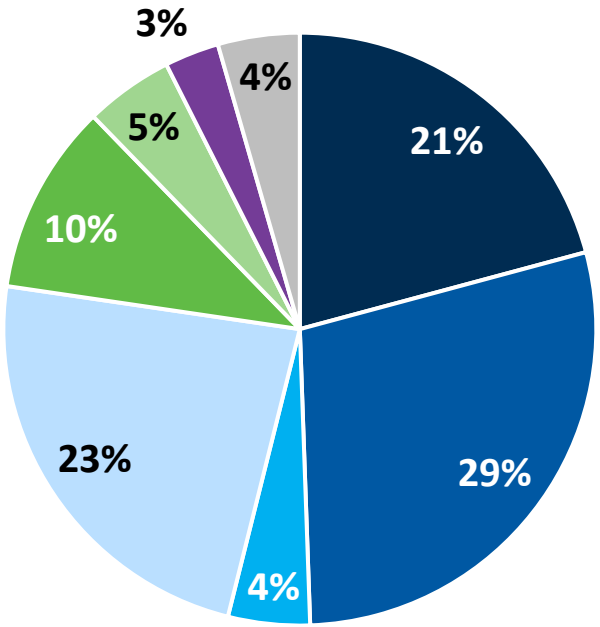
Source: Internal SUNY Downstate Medical School data; internal SUNY Downstate Medical School financials; SUNY Downstate website. Note: 2024 data has been requested from SUNY Downstate School of Medicine. More recent information to be forthcoming upon receipt.

SUNY Downstate's Footprint Only Supports ~One-Third of the School of Medicine's Clinical Placements

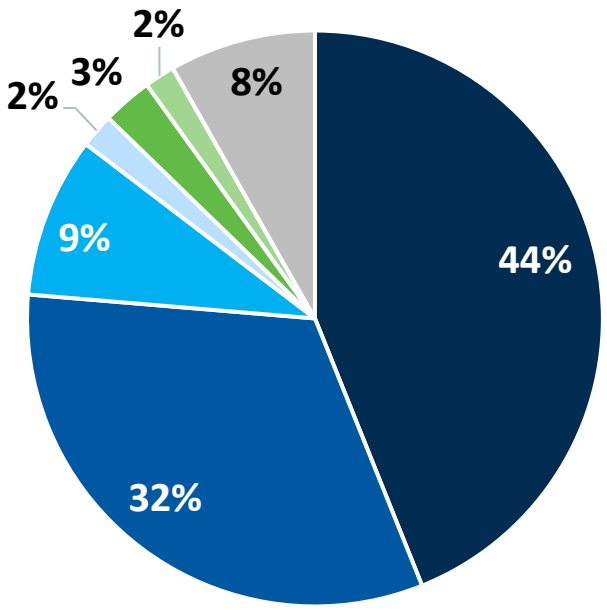
SUNY DOWNSTATE MEDICAL SCHOOL MISSION

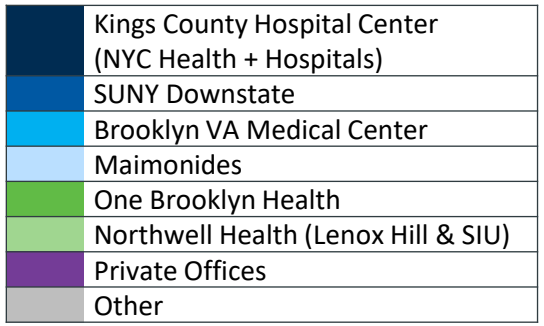
- Prepare the next generation of **socially conscious physicians**
- Conduct research to **reduce health care disparities**
- **Improve the health** of populations
- Enhance the **patient experience**
- Pursue **health equity**
- Strengthen our **community partnerships**

CLERKSHIPS



RESIDENCIES





Sources: Internal SUNY Downstate Medical School data; 2024-2025.

Appendix 3-I Detailed Findings
Other

Electronic Health Record System

Current Situation

- Downstate hospital currently on Altera (formerly Allscripts) for inpatient
- Downstate physician practices running on 9 different electronic medical record systems
- Multiple other disconnected or loosely connected related systems (revenue cycle, referrals, scheduling, etc.)

Goal

- Obtain a modern high quality electronic health system for both the hospital and clinical practices
- Ensure integration with high functioning related applications
- Improve patient care with comprehensive health records
- Improve the patient experience

Electronic Health Record System

Time is Short

- Altera contract expires at the end of 2026
- Downstate revenue cycle system, Eagle/Cerner revenue cycle contract sunsets December 2025, working on a 1-year extension
- Procurement process, including OSC approval, takes time
  - Estimating 8 months
- Implementation takes time
  - 18 months for typical purchase
  - 12 months for hosting by another entity

Procurement Options

- As a State entity, Downstate hospital must follow NYS procurement rules, options include:
  - RFP
  - OGS umbrella contract
  - RFI for hosting by another entity (i.e. Community Connect or something similar)
- Potentially, a non-state entity procures but uses a competitive process

DCAB Report
Appendix 3-G

Purpose & Methodology

Introduction

SUNY Downstate Medical Center's University Hospital of Brooklyn was constructed in 1966 and has had a number of departmentally-focused renovations over the years. The facility is published as approximately 693,000 gross square feet and is comprised of an 8-story wing with attached 3-story and single story sections. The Hospital has a full basement and sub-basement level housing primarily facility and clinical support service lines.

The Hospital is certified by the NYS Department of Health and is licensed for 342 beds; the majority of which are arranged currently as double occupancy room configurations. Most of the in-patient care suite layouts are original to the 1961 design and do not meet all current standards of care environments or required clearances. These regulatory deficiencies are identified in the following report, with preliminary recommendations to address them.

Purpose of Assessment

The Fiscal Year 2025 Enacted New York State Budget established the Downstate Community Advisory Board, charged to develop written recommendations that outline "a reasonable, scalable, and fiscally responsible plan for the health, viability, and sustainability of SUNY Downstate Hospital." By statute, the Advisory Board was tasked to consider eight factors, including the the "current state of the building infrastructure and capital needs."

The State University Construction Fund (SUCF) engaged QPK Design to perform a Building Assessment of UHB aimed at summarizing for the Advisory Board the current facility conditions; which would be used to help inform the Advisory Board's discussion and tasking.

Purpose & Methodology

The Assessment evaluated the current conditions of SUNY Downstate University Hospital (UHB)'s physical space and regulatory compliance, and outlined construction-associated cost models for various rehabilitation scenarios for the facility's revitalization. The objective of this assessment is to provide documentation which will be used as a summation of the facilities current inventory and condition, and to inform the Advisory Board of the current state of building infrastructure and capital needs.

Methodology

QPK Design (QPK) performed an Assessment of SUNY Downstate Medical Center's University Hospital of Brooklyn (UHB); to observe current conditions, document current program inventory, review regulatory compliance, and document deficiencies. The Assessment goal was to provide a summary of recommended renovations aimed at addressing observed deficiencies and supporting a revitalized compliant care facility.

In addition to the program inventory, regulatory, interior environment, façade/exterior, building structure, and site assessments performed by QPK Design, the Team included Consultants focused on MEP (Ramboll), Fire & Life Safety (Jensen Hughes), Accessibility (Jensen Hughes), AV/IT (Shen Milsom & Wilke), and Security (Shen Milsom & Wilke). Cost Modeling was performed by Consultant, Young & Associates, based on assessment and recommendations identified by the Team.

Mechanical Observations

Mechanical Project Scope:

- MEP Systems in the University Hospital mechanical equipment rooms.
- Performed over a 10-week period with follow up investigation as needed.
- Included mechanical rooms in the sub-basement, basement, 3rd floor and penthouse, as well as rooftop equipment, and the heating plant.
- Documented more than 400 individual pieces of equipment and collected more than 2,000 data points (model numbers, capacity, electric criteria, age, use/function, location, condition)

Mechanical Observations

Assessment Approach

- Visual Observations
- Equipment Age
- Typical Life Expectancy
- Facility Maintenance Knowledge
- Experience with Similar Equipment

Mechanical Observations

Visual Observations

Observations look for:

- Signs of equipment wear, deterioration, or imbalance
- Evidence of multiple repairs such as patched ductwork, insulation repairs, non-OEM parts
- Evidence of leakage of fluids and/or air from equipment
- Equipment not in service or excessive lockout tags
- Equipment & system labeling
- Posted operating instructions

Mechanical Observations

Equipment Life Expectancy

- ASHRAE Standards (average life)
- Manufacturer’s Recommendations
- Experience with Similar Equipment
- Life Extension Maintenance Practices

ASHRAE Equipment Life Expectancy chart

ASHRAE is the industry organization that sets the standards and guidelines for most all HVAC-R equipment. For additional info about ASHRAE the website is www.ashrae.org .

Equipment Item	Median Years
Air conditioners	
Window unit	10
Residential single or Split Package	15
Commercial through-the wall	15
Water-cooled package	15
Heat Pumps	
Residential air-to-air	15
Commercial air-to-air	15
Commercial water-to-air	19
Roof-top air conditioners	
Single-zone	15
Multi-zone	15
Boilers, hot water (steam)	
Steel water-tube	24 (30)
Steel fire-tube	25 (25)
Cast iron	35 (30)
Electric	15
Burners	21
Furnaces	
Gas- or oil-fired	18
Unit heaters	
Gas or electric	13
Hot water or steam	20
Radiant Heaters	
Electric	10
Hot water or steam	25

Equipment Item	Median Years
Air terminals	
Diffusers, grilles, and registers	27
Induction and fan coil units	20
VAV and double-duct boxes	20
Air washers	17
Ductwork	30
Dampers	20
Fans	
Centrifugal	25
Axial	20
Propeller	15
Ventilating roof-mounted	20
Coils	
DX, water, or steam	20
Electric	15
Heat Exchangers	
Shell-and-tube	24
Reciprocating compressors	20
Packaged chillers	
Reciprocating	20
Centrifugal	23
Absorption	23
Cooling towers	
Galvanized metal	20
Wood	20
Ceramic	34

Equipment Item	Median Years
Air-cooled condensers	20
Evaporative condensers	20
Insulation	
Molded	20
Blanket	24
Pumps	
Base-mounted	20
Pipe-mounted	10
Sump and well	10
Condensate 15	
Reciprocating engines	20
Steam turbines	30
Electric motors	18
Motor starters	17
Electric transformers	30
Controls	
Pneumatic	20
Electric	16
Electronic	15
Valve actuators	
Hydraulic	15
Pneumatic	20
Self-contained	10

Mechanical Observations

Maintenance Staff

- Facility identified all mechanical rooms in the buildings
- Facility's knowledge of the systems and equipment help identify key maintenance issues
- Interviews with individual maintenance supervisors provide insight into the condition of the existing equipment
- Specific equipment deficiencies identified by the maintenance staff
- Facility staff exhibited a level of expertise and experience needed to operate, maintain, and manage the equipment and systems

Mechanical Observations

Equipment Prioritization

1 – 5 years:

Poor Condition (older or distressed equipment)

6 - 10 years:

Fair Condition (signs of wear, but functional)

10 years:

Good Condition (newer equipment)

Mechanical Observations

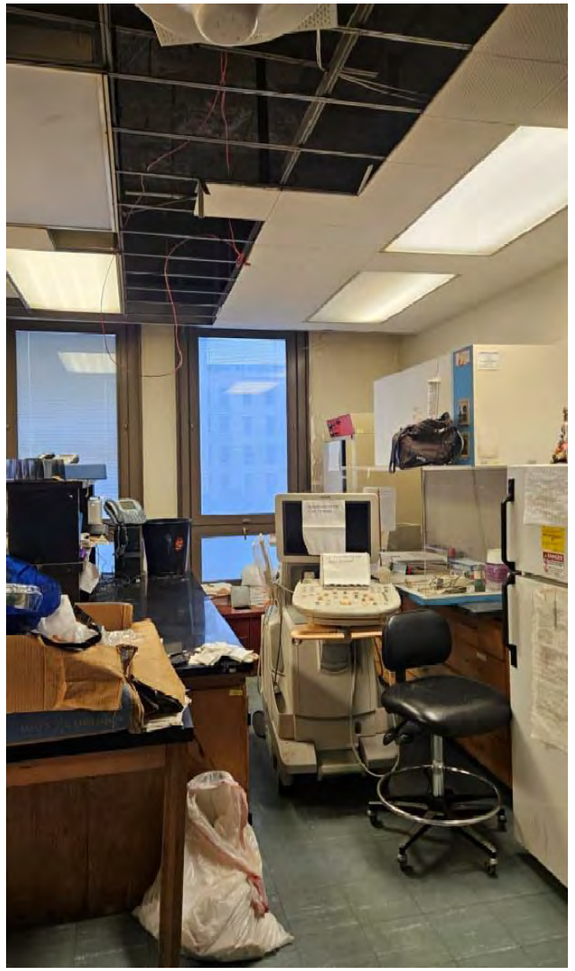
Equipment Assessment

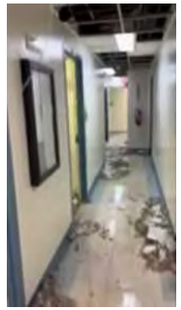
- Building includes a normal and expected combination of equipment ages
- Mechanical systems include reasonable and expected redundancy of equipment
- Insufficient electrical power in MER’s
- Extensive upgrades to large equipment in MER’s over the past 10 years (Electric Chillers, Cooling Towers, Boiler Room, Emerg. Generators, Fuel Tanks, Air Handlers)
- MER’s are easier locations for upgrades – not disruptive to patients/staff
- Upgrades only included equipment - not distribution systems connected to equipment

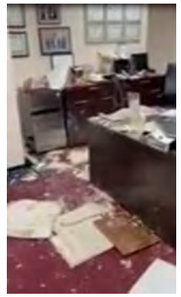
Mechanical Observations

Disruption / Failures

- Disruptive
- Costly Emergency Repairs
- Local Repairs do not Address Root Problems
- HazMat Concerns







Mechanical Observations

Distribution Systems Upgrades

- Distribution systems include heating piping, cooling piping, fire protection, city water, domestic hot water, waste piping, electrical power, ductwork, medical gases, communications
- Need to reduce emergency repairs from failures to systems
- Disruptive to patients/staff – phasing is critical
- Spaces closed during construction - swing space needed
- Construction workers in a hospital setting
- Cost Modeling: $250 Million for MEP systems

Note: *Projected costs in this analysis reflect the direct replacement of the systems only and do not account for associated complexities such as relocating occupants, operational shutdowns, potential revenue losses, constructing surge spaces, or the architectural work required to access the systems and restore affected areas. Additional costs could reach an additional 75-150% of the direct replacement costs.*

AV/IT/Security Observations

Audiovisual

- Goal to upgrade all AV systems to match current AV Facility Standards.
- Many of the current AV systems are very old.

IT

- The facility's IT infrastructure is well-established.
- Current physical connectivity is undergoing ongoing modification and expansion from multiple concurrent projects with differing levels of coordination.

Security

- The facility's security posture is well-established, supported by a range of reliable technologies.
- Current systems include video surveillance, access control, intrusion detection, and weapons detection.
- University Police oversees video surveillance across the facility, while the IT team monitors the IDFs and MDFs.

Fire and Life Safety

Observations / Deficiencies

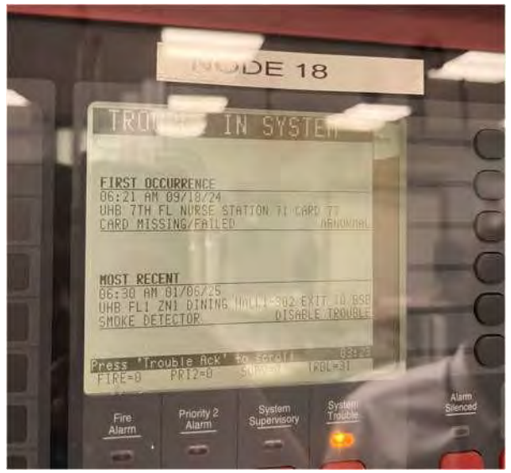
- Building is not fully sprinklered

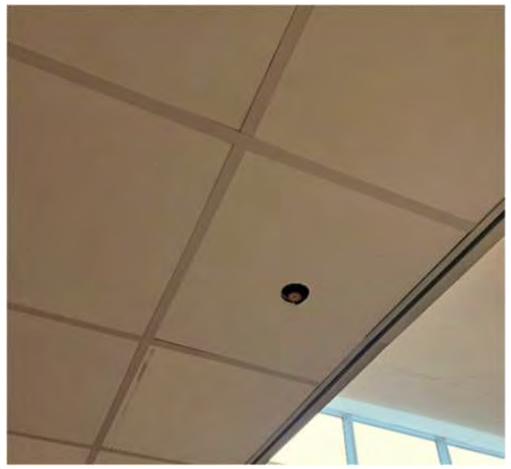
  (CMS deadline of 7/5/2028 for full sprinkler coverage of high-rise hospitals)
- Excessive fire pump corrosion observed
- Fire doors to Basic Science Building did not appear to fully self-close on multiple floors
- Possible inconsistent/missing suite designations observed in hospital areas
- Storage observed in decommissioned cold rooms without fire alarm or sprinkler coverage
- Door to required exit stair locked on 3rd floor

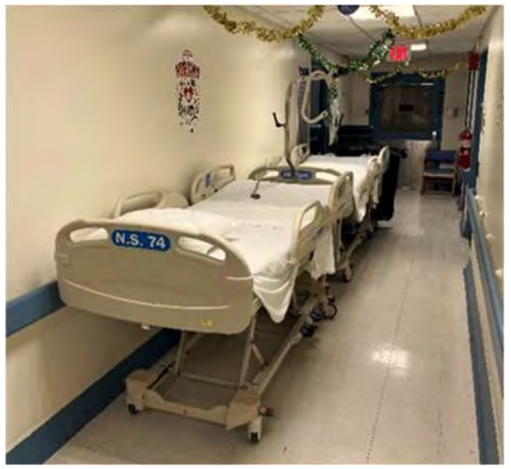
Fire and Life Safety

Observations / Deficiencies

- Numerous fire alarm trouble signals observed at fire alarm control panels
- Storage observed within 24 inches of unsprinklered ceilings
- Sprinklers observed to be misaligned from ceilings or missing cover plates or escutcheons
- Smoke barrier doors observed to be propped open
- Chute doors and stair doors occasionally have missing or painted fire-resistance rating labels
- Corridors obstructed by storage







Accessibility Observations

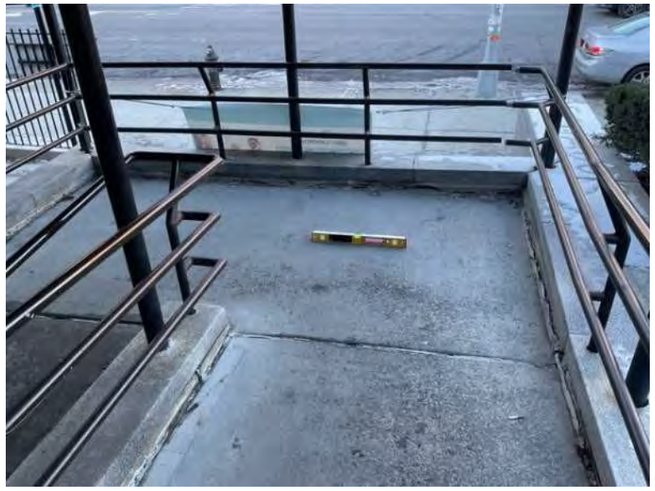
Observations / Deficiencies - Entrances

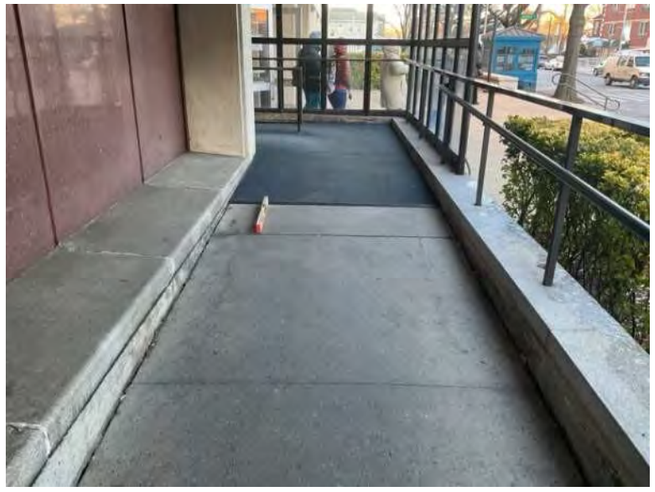
East Entrance Ramp

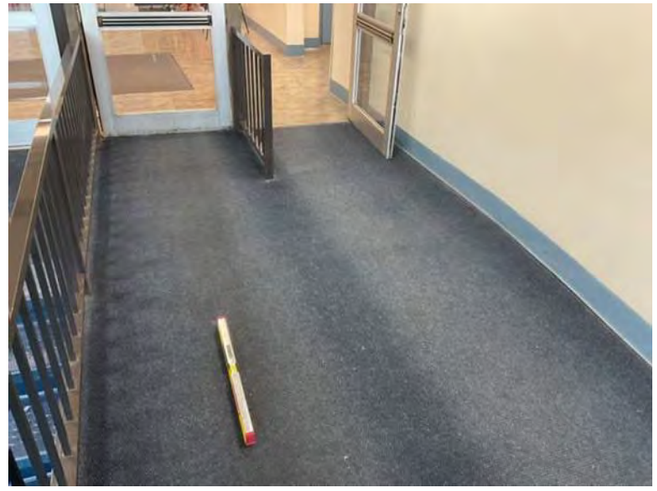
- Excessive cross slopes at landings
- Excessive cross slopes at ramp
- Pitted/cracked/irregular ramp and landing surfaces
- Deficient handrail extensions

South Entrance Inclined Walk

- Excessive slopes at walking surfaces
- Ramp without handrails and landings
- Deficient handrail extensions
- Unsecured carpets







Accessibility Observations

Observations / Deficiencies – Toilet & Bathing Rooms

- Obstructed toilet clear floor space
- Turning space not provided within toilet room
- Toilet not mounted within required ranges for height or relation to side wall
- Doors less than the minimum required 32” clear width
- Obstructed door maneuvering clearances
- Grab bars absent or not satisfying requirements
- Door hardware requiring tight grasping, pinching, or twisting of the wrist

Accessibility Observations

Observations / Deficiencies – Protruding Objects

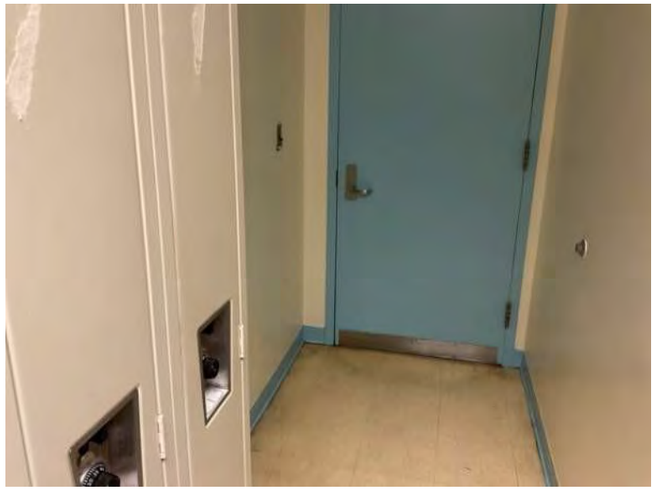
Objects protruding >4” into the circulation path with leading edges between 24” and 80” aff without a fixed cane detectable element beneath including some, though not all:

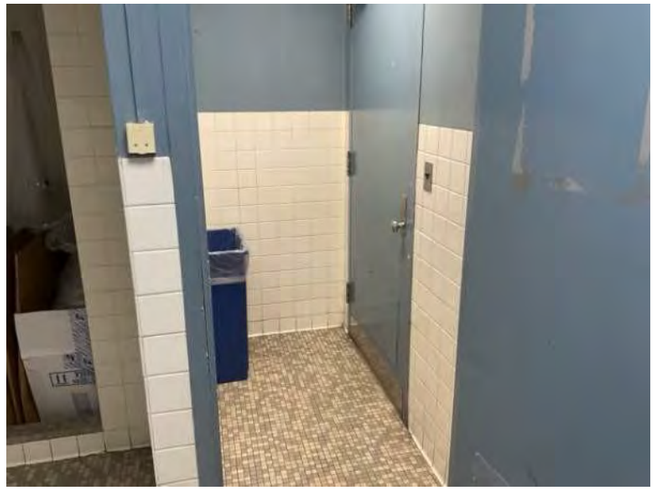
- Wayfinding signage
- Room ID placards
- A/V equipment
- Analog double sided wall clocks
- Fire extinguishers
- Horn/strobe devices
- Lighting fixtures

Accessibility Observations

Observations / Deficiencies – General

- Obstructed door maneuvering clearances
- Operable parts including doorknobs and storage elements that require tight grasping, pinching, or twisting of the wrist
- Operable parts >48” aff: Light switches, dispensers (hand sanitizer, paper towel, etc.), fire extinguishers,

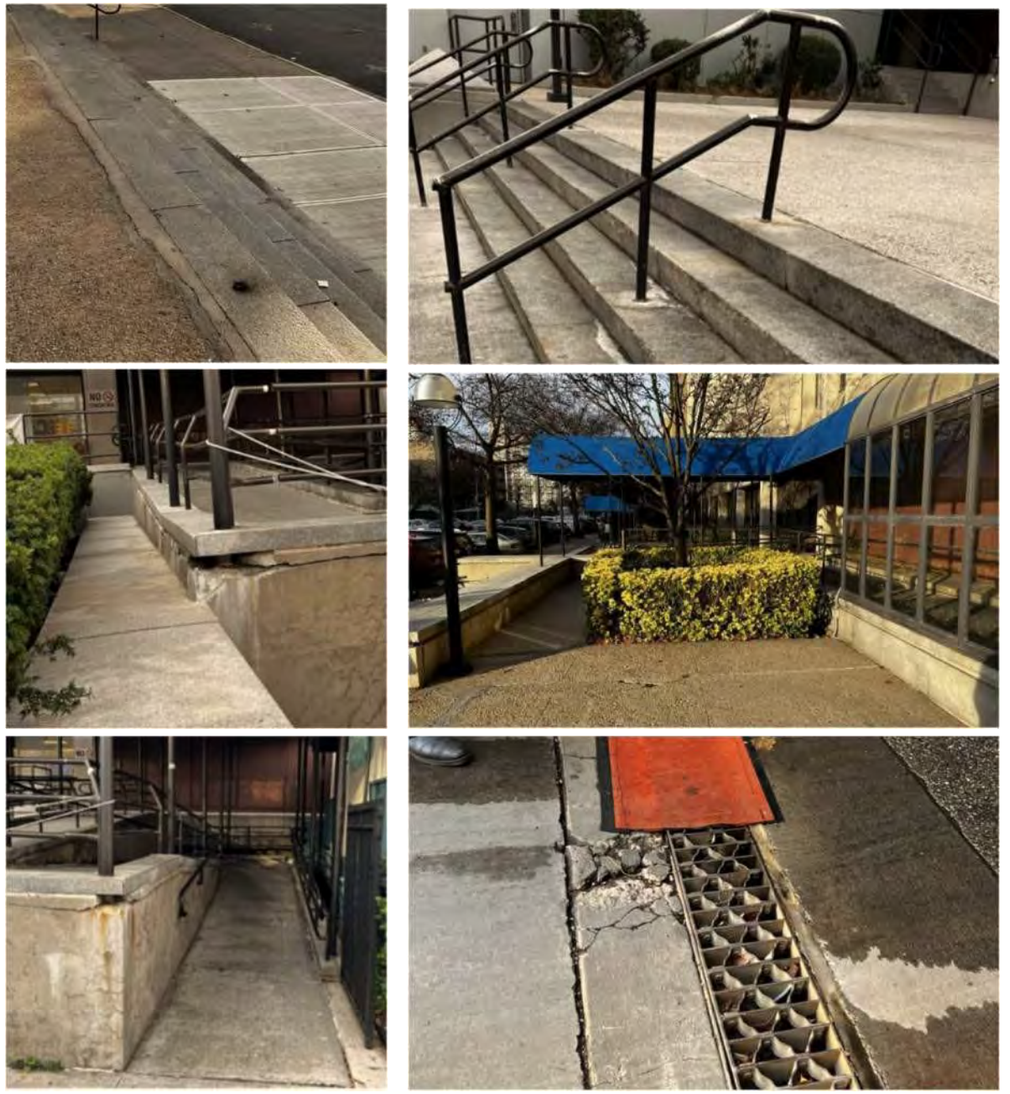




Architectural Observations

Observations / Deficiencies – Site

- Locations of spalled and failing concrete
- Rust jacking and failing ramp assembly
- Railings require replacement
- Pavers settled
- Failed concrete apron at trench drain
- Cracking in concrete pavement
- Deterioration at concrete joints



Architectural Observations

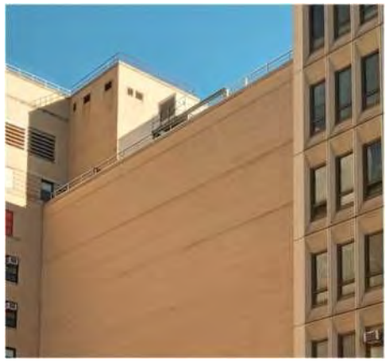
Observations / Deficiencies – Exterior Envelope / Facade

- Replace all aluminum windows to correct air and water infiltration and improve energy efficiency
- Repoint masonry (minor repairs)
- Many roof systems recently replaced (Roof Replacement and Upgrade program underway since 2018)
- Replace damaged metal panels at Emergency Room canopy and addition
- Insulate exterior wall with R-13.3

General: Condition of exterior envelope is in good condition.

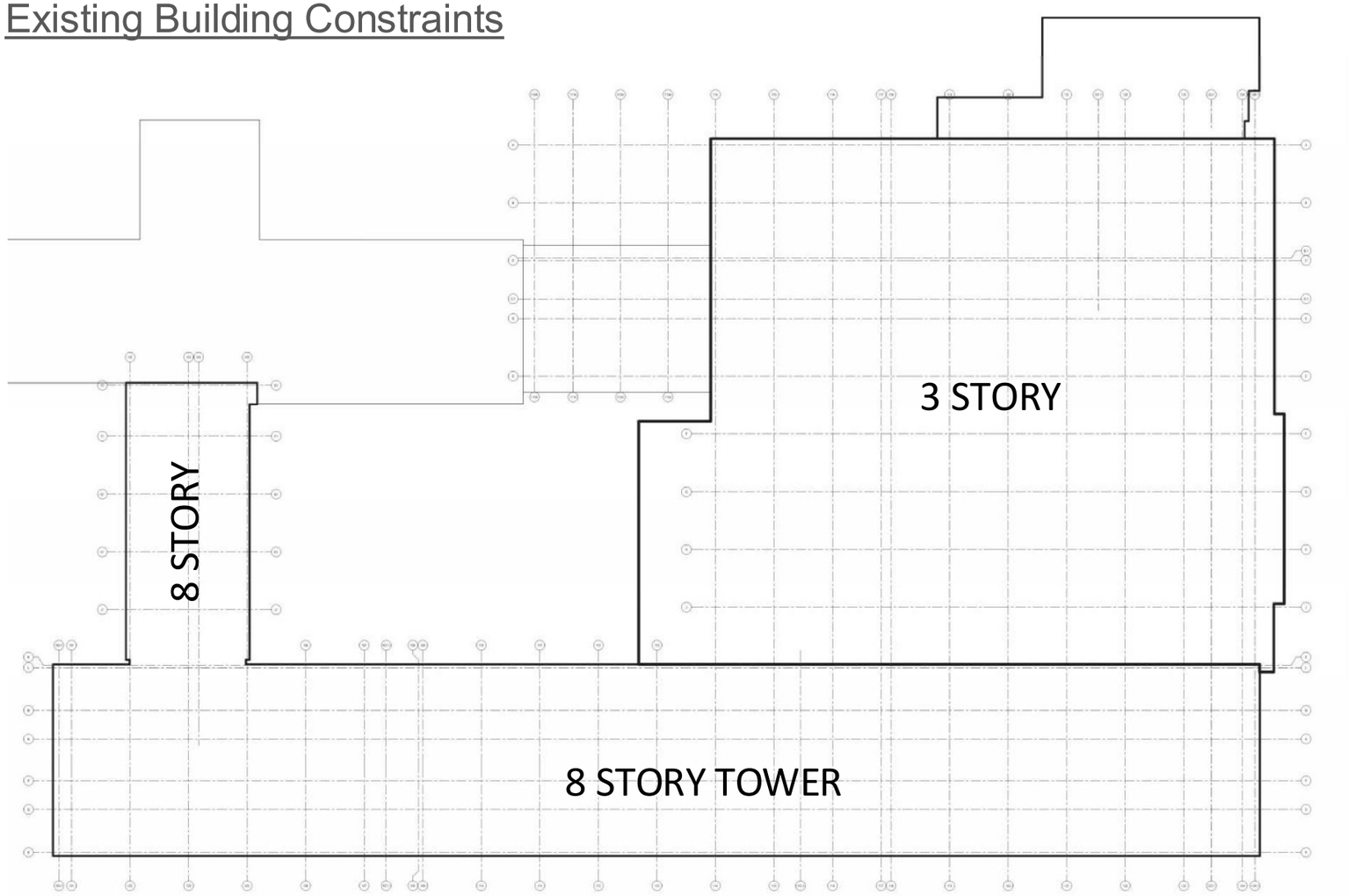
Precast panels and slate (original), EIFS, Insulated metal Panels, Multi-wythe brick

- Increase roof insulation to achieve current Energy Code compliance. Re-roof.



Architectural Observations

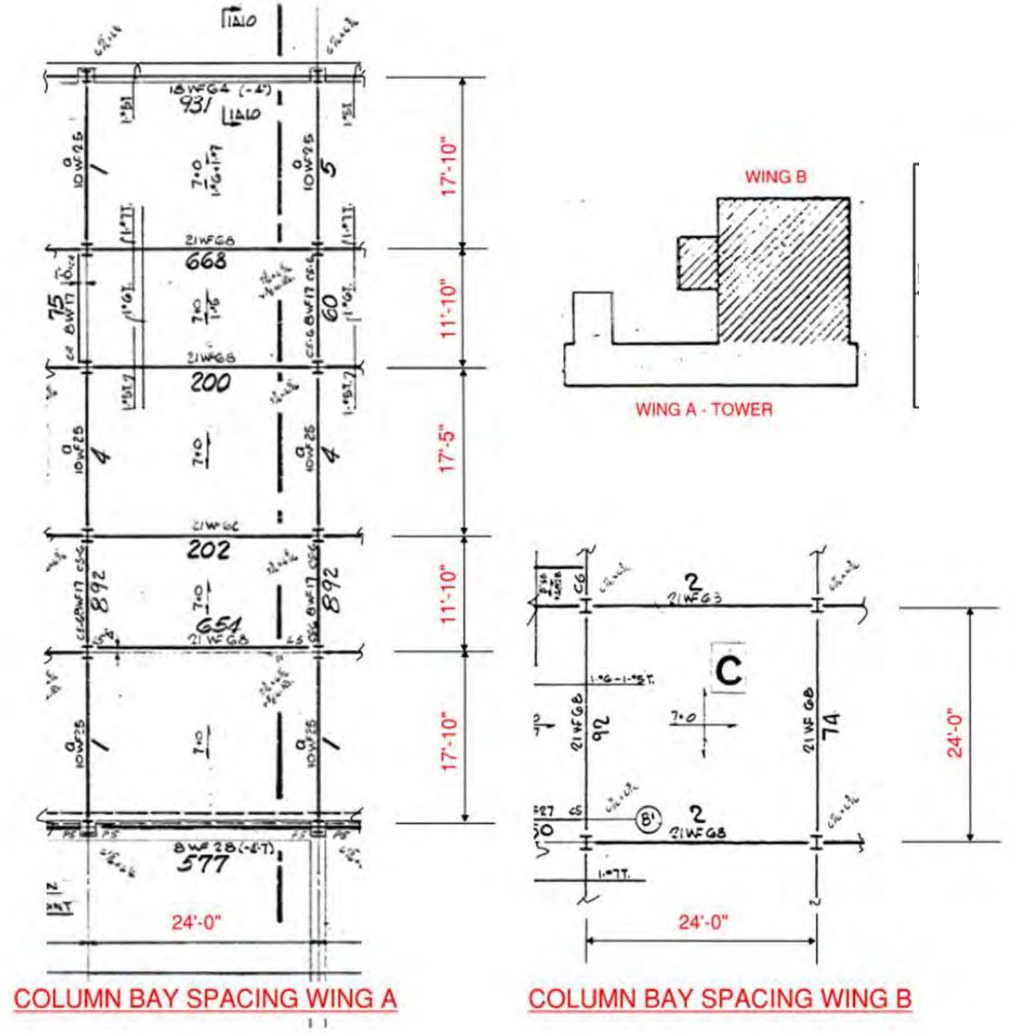
Existing Building Constraints

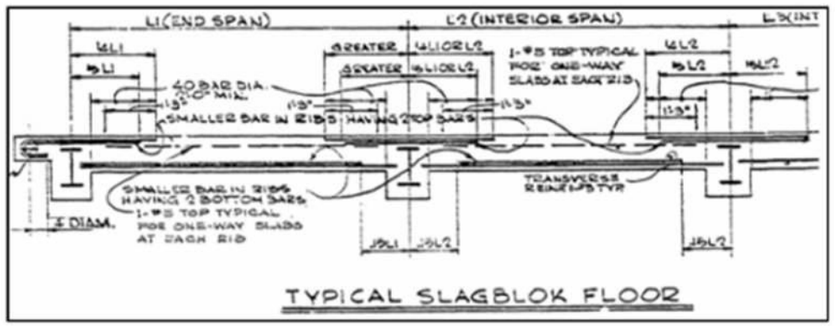


- Constructed 1966
- 8 Story, Attached 3 Story
- Area – approx. 700,000 GSF
- Column spacing –
  (varies) 24’ O.C., typ.
- Floor to Floor height – 12’ -0”
- Sub Basement & Basement:
  85,000 SF/ea
- Level 1 Floor Plate: 93,105 SF
- Level 2 Floor Plate: 94,550 SF
- Level 3 Floor Plate: 87,325 SF
- Level 4-8 Floor: 43,650 SF/ea
- Mechanical Penthouse: 20,000 SF

Architectural Observations

Structural Overview





- Structural steel frame with concrete slagblok floor (c. 1961)
- Column bay spacing as shown
- Precast and masonry exterior wall assembly
- Conventional concrete foundations and basement walls

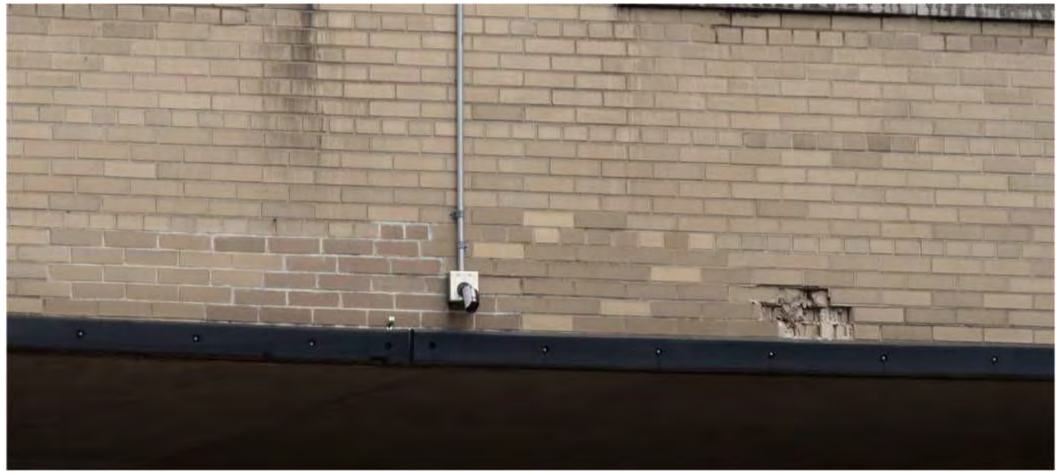
Architectural Observations

Structural Observations / Deficiencies

MISC. CONCRETE SPALL

PENTHOUSE STEEL CORROSION

SOUTH OVERHANG SOFFIT DEFORMATION



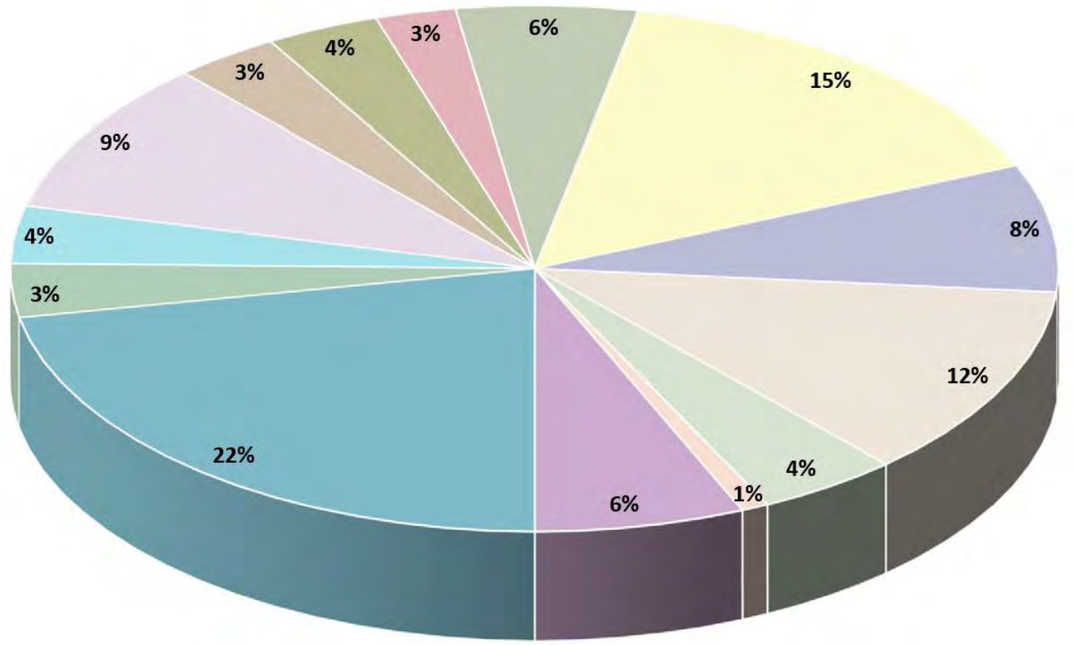
MASONRY DEFICIENCIES (EX. TUNNEL LINTEL)

Architectural Observations

Departmental Areas - Breakdown

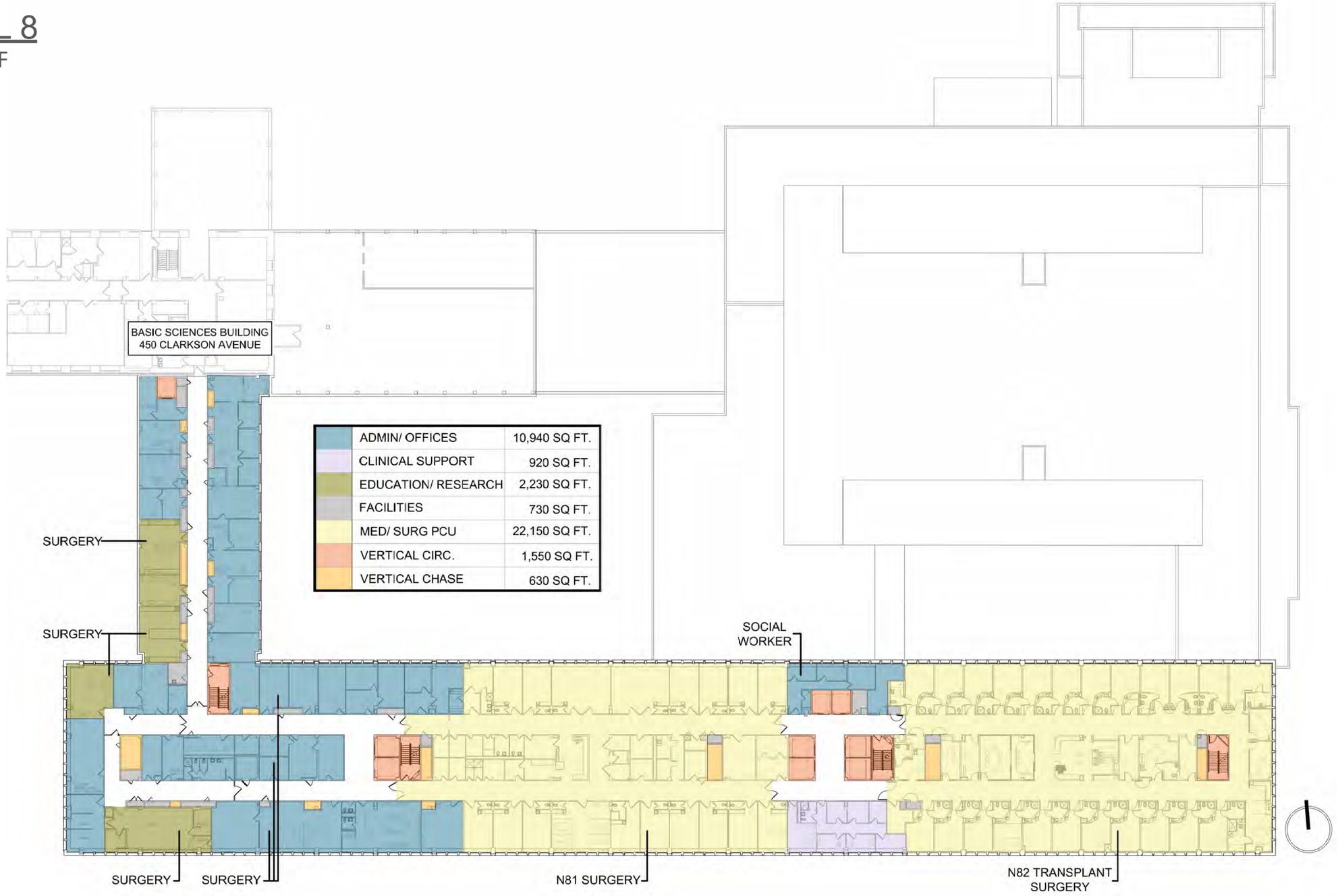
KEY FACILITY UNITS/ DEPARTMENTS	AREA	% AREA
ADMIN/OFFICES	100,000	22%
CCU	15,000	3%
CLINICAL LABS	16,100	4%
CLINICAL SUPPORT	43,100	9%
CUST SERVICES	14,800	3%
EDUCATION	15,900	4%
EMERGENCY	11,300	3%
IMAGING AND RADIOLOGY	25,400	6%
MED/SURG PCU	70,000	15%
OBSTETRICAL CARE UNIT	35,765	8%
OUTPATIENT	54,100	12%
PEDIATRICS	19,780	4%
REHAB ORTHO SPEECH THERAPY	3,800	1%
SURGICAL SERVICES	29,400	6%

**Gross building area is published as 693,000 SF and includes areas not reported above; Sub-basement, mechanical rooms, corridors, and vertical circulation, and area of exterior walls*



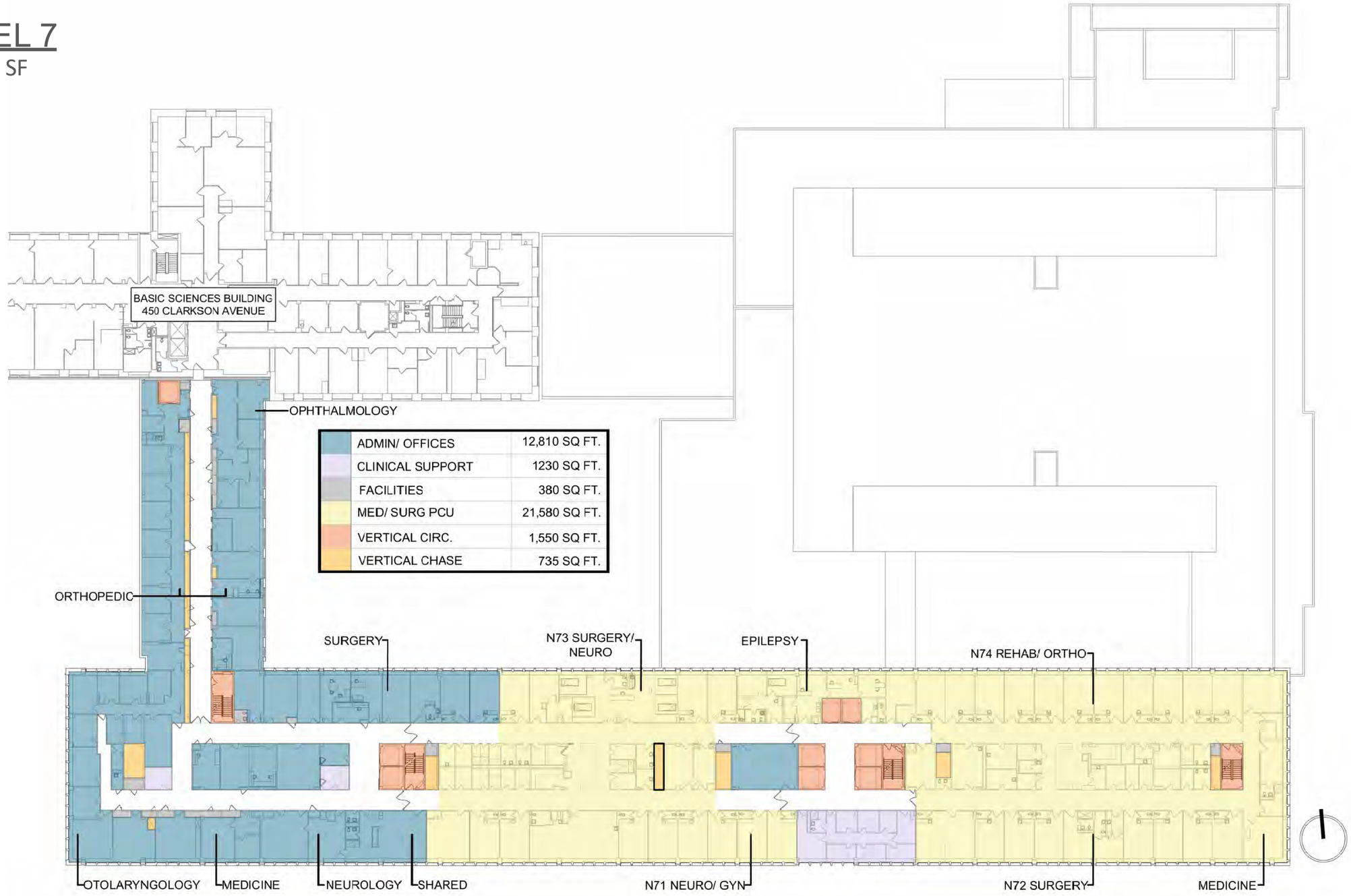
LEVEL 8

43,650 SF



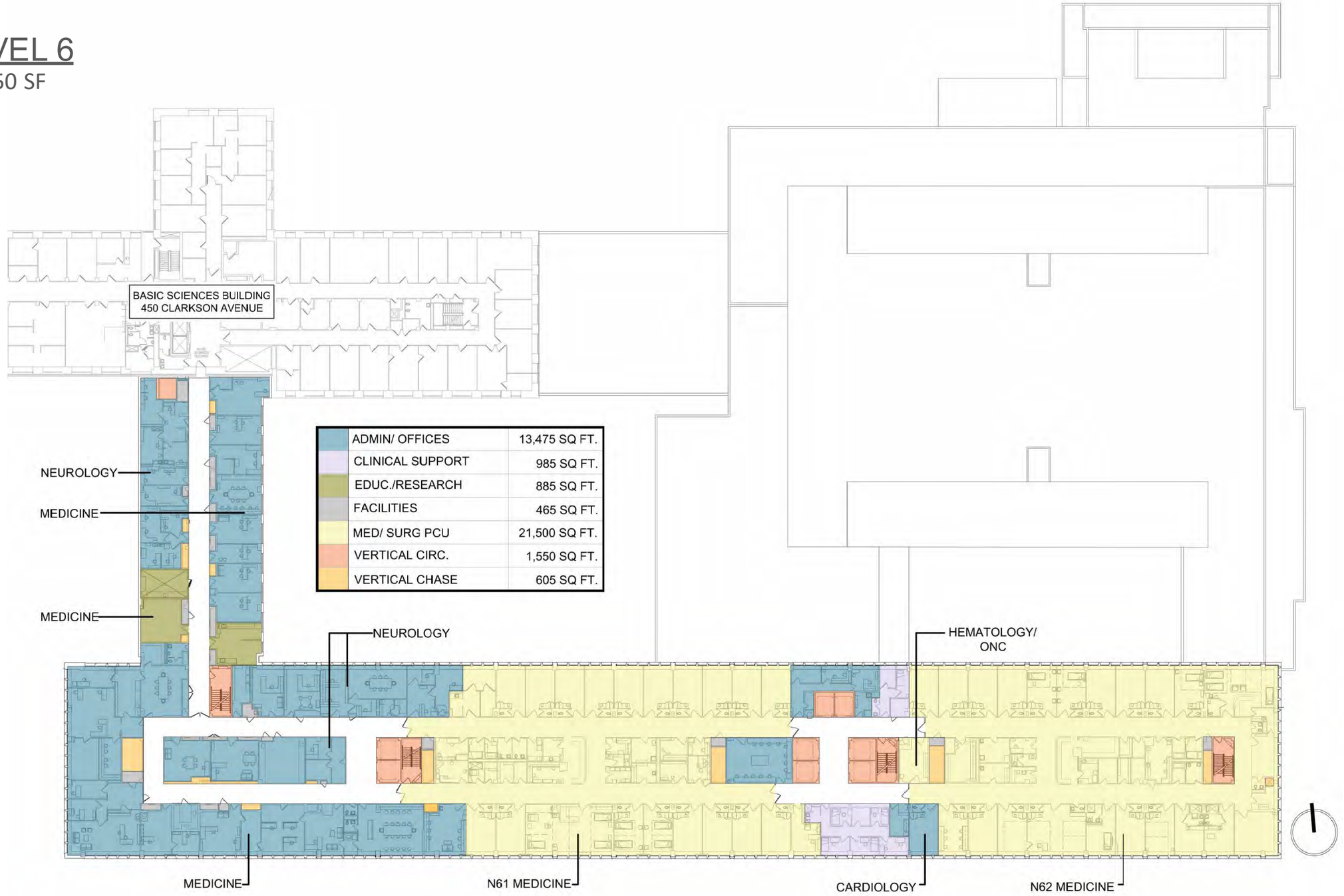
LEVEL 7

43,650 SF



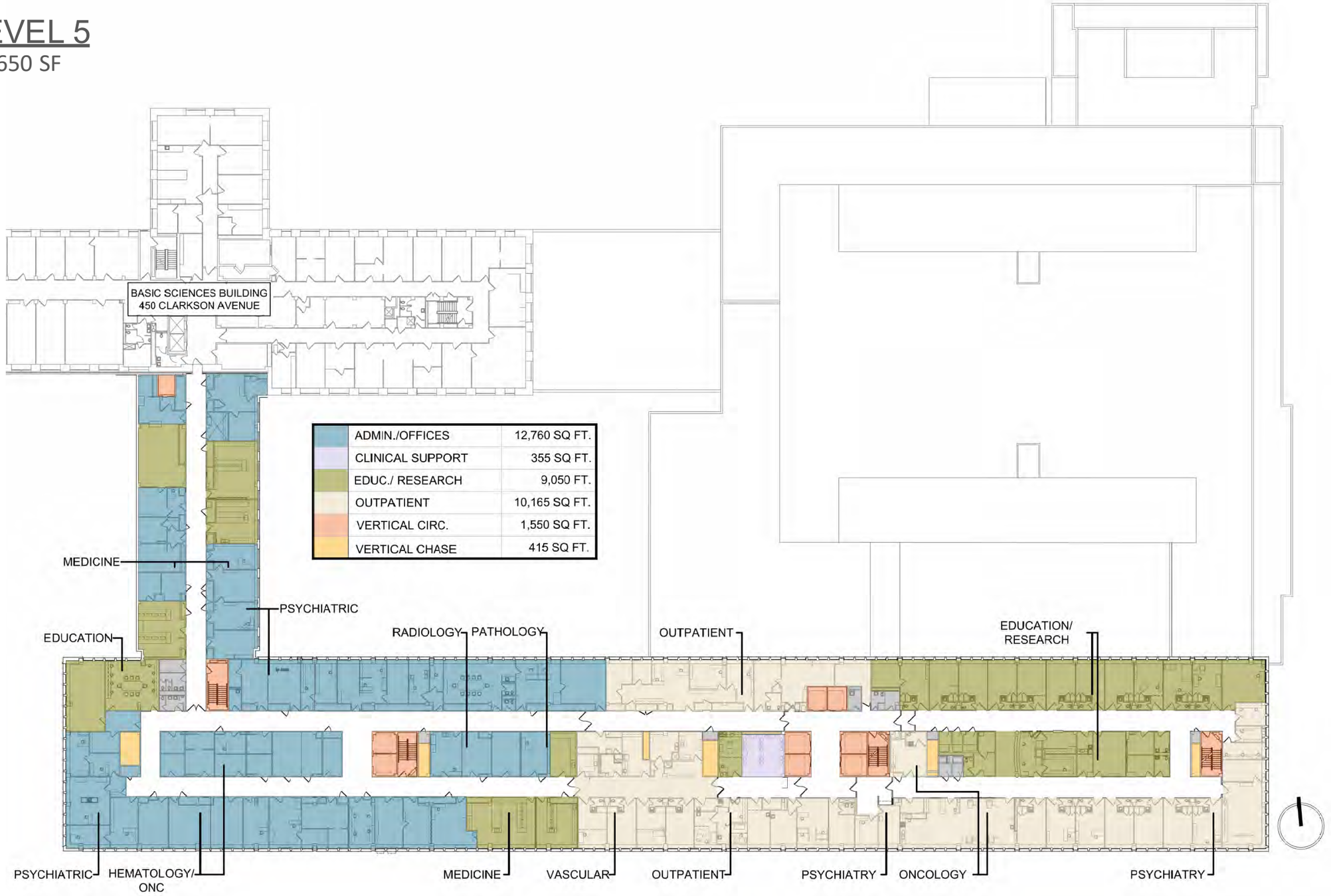
LEVEL 6

43,650 SF



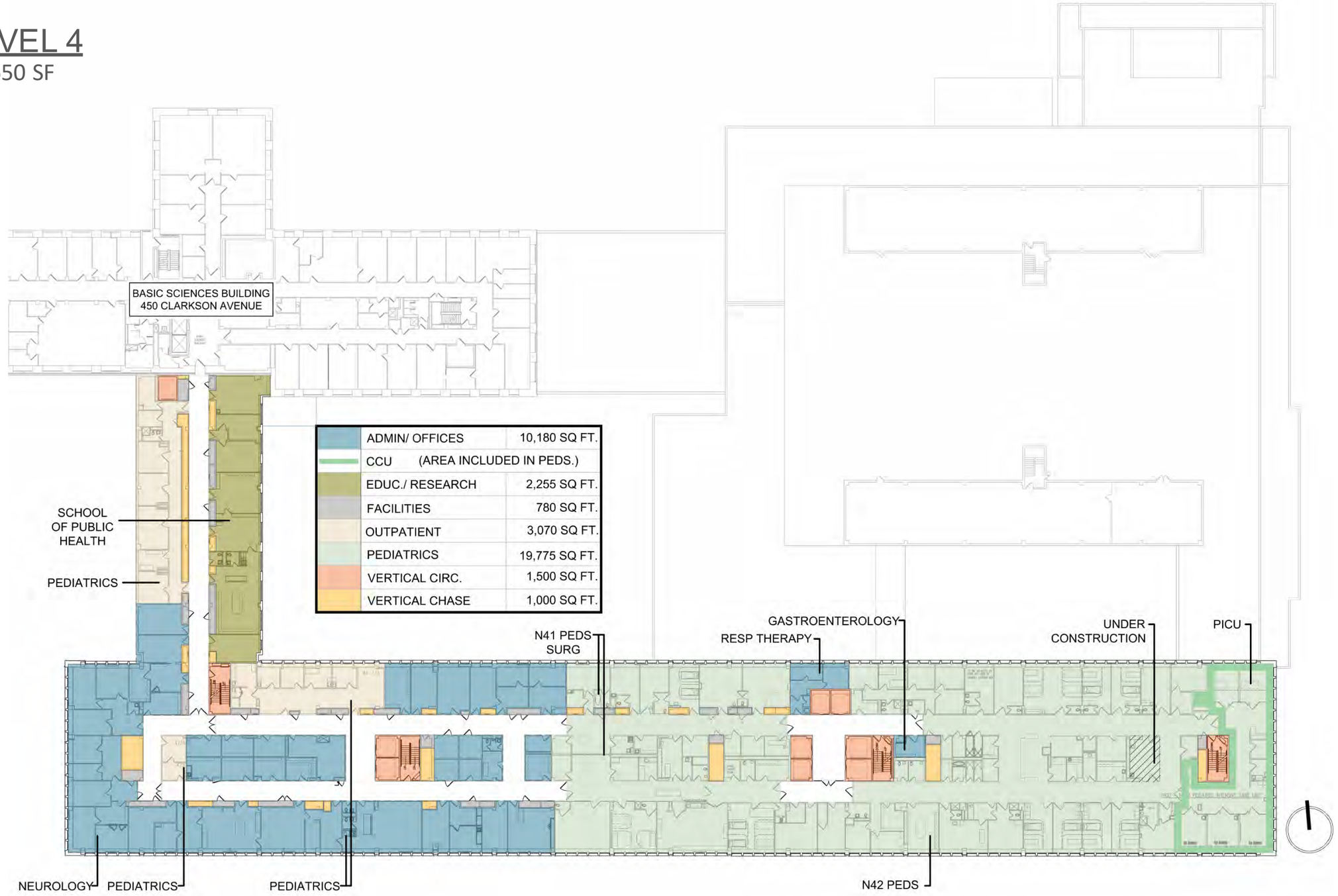
LEVEL 5

43,650 SF



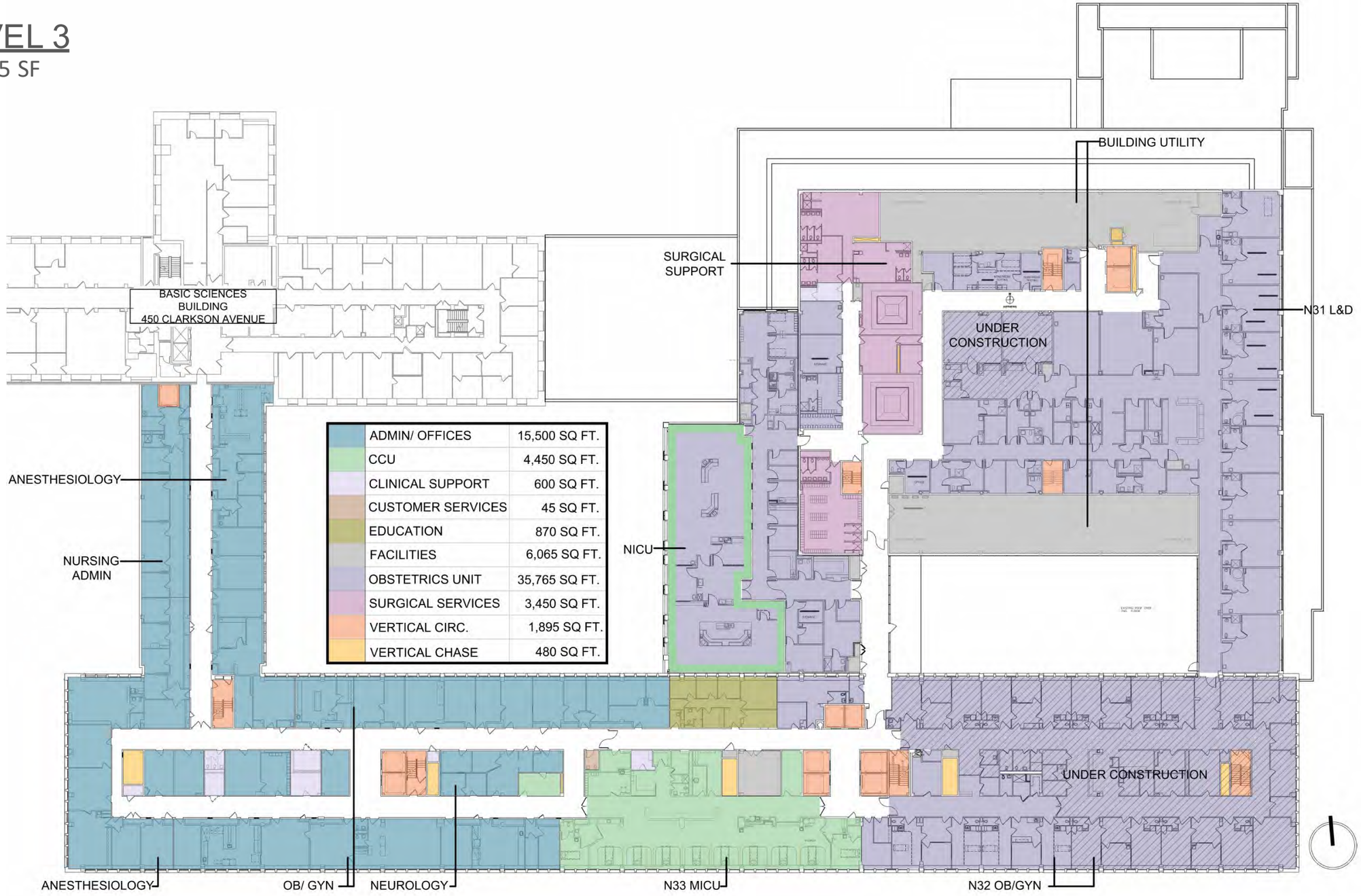
LEVEL 4

43,650 SF



LEVEL 3

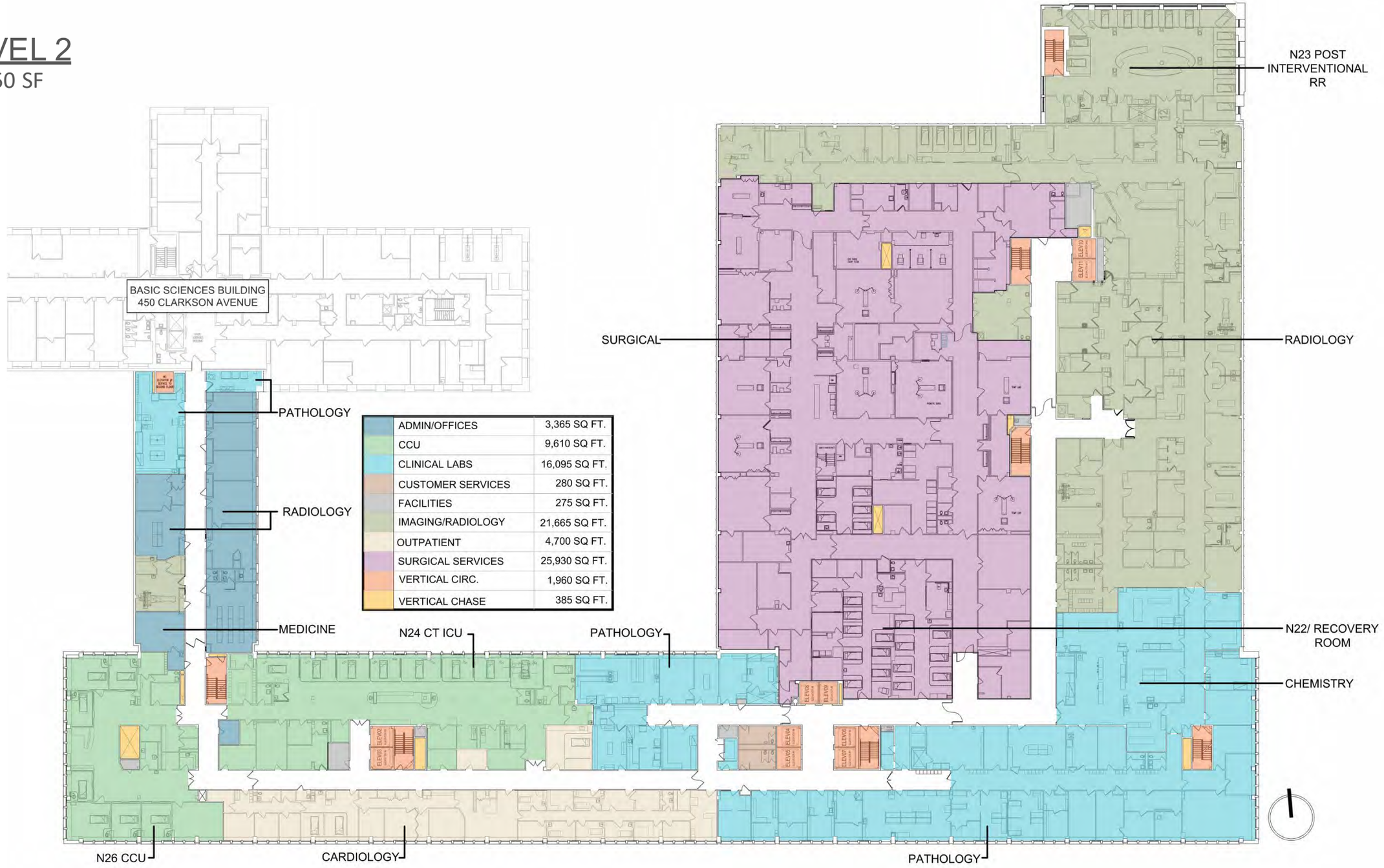
87,325 SF



ADMIN/ OFFICES	15,500 SQ FT.
CCU	4,450 SQ FT.
CLINICAL SUPPORT	600 SQ FT.
CUSTOMER SERVICES	45 SQ FT.
EDUCATION	870 SQ FT.
FACILITIES	6,065 SQ FT.
OBSTETRICS UNIT	35,765 SQ FT.
SURGICAL SERVICES	3,450 SQ FT.
VERTICAL CIRC.	1,895 SQ FT.
VERTICAL CHASE	480 SQ FT.

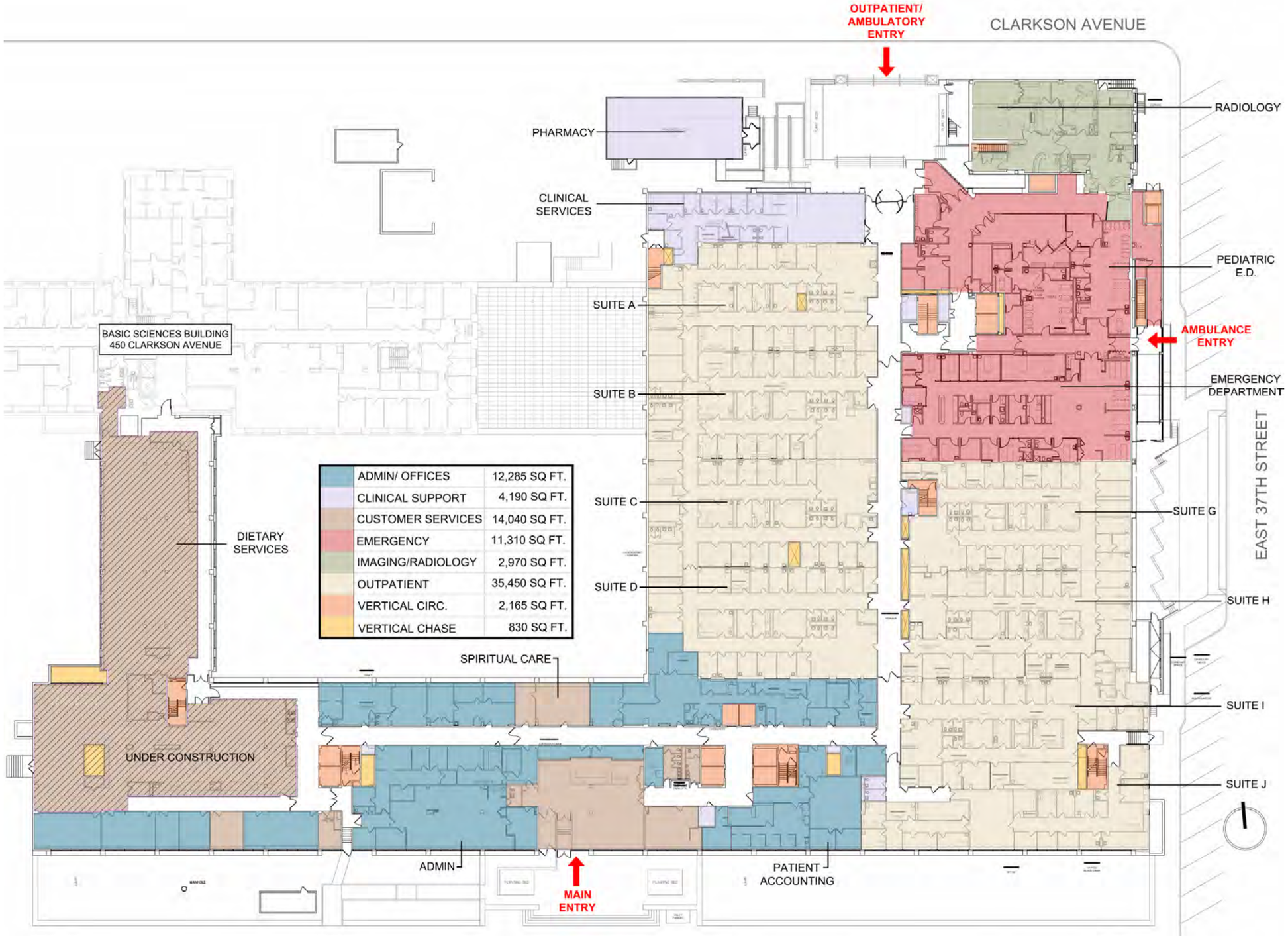
LEVEL 2

94,550 SF



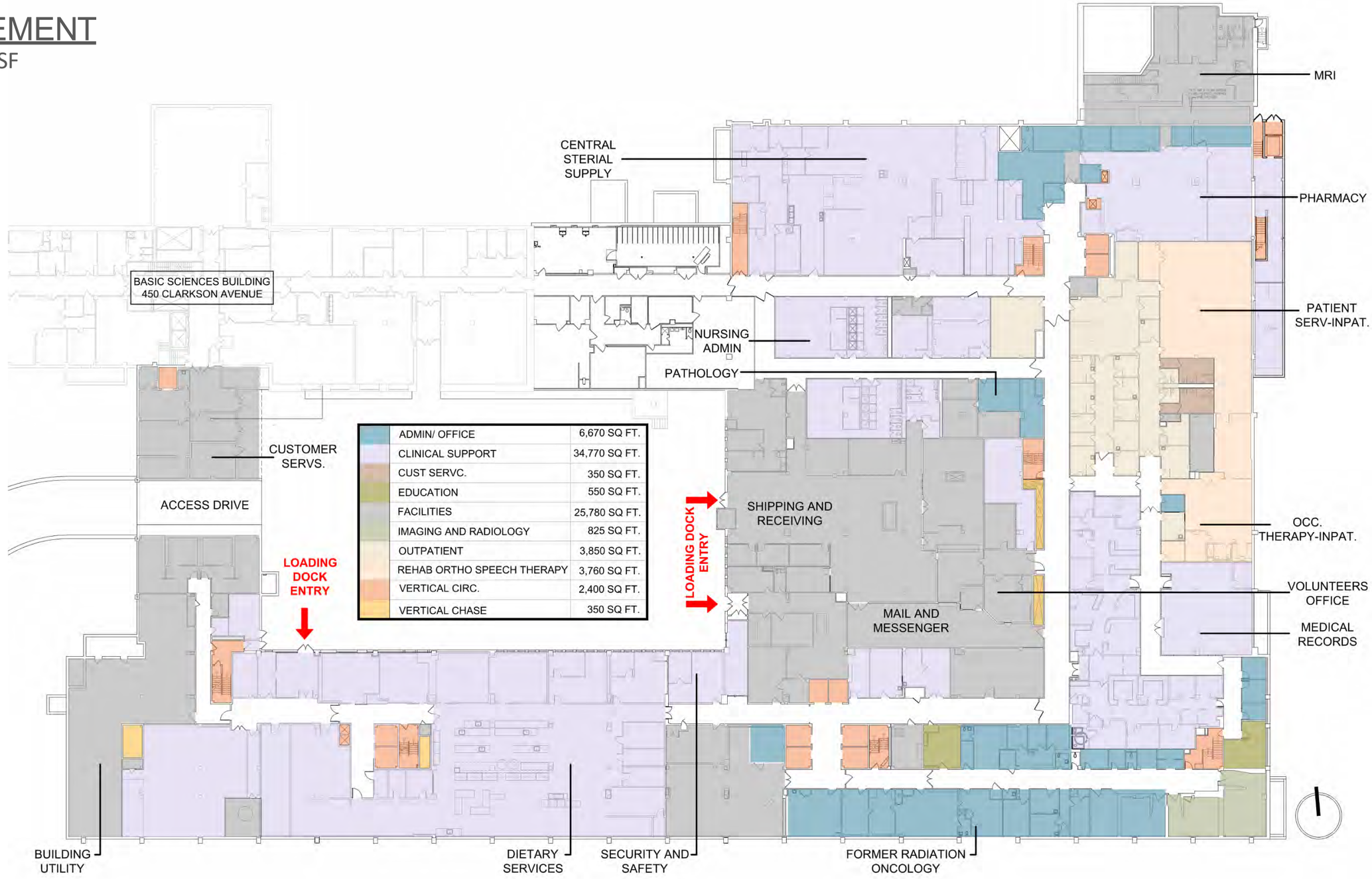
LEVEL 1

93,105 SF



BASEMENT

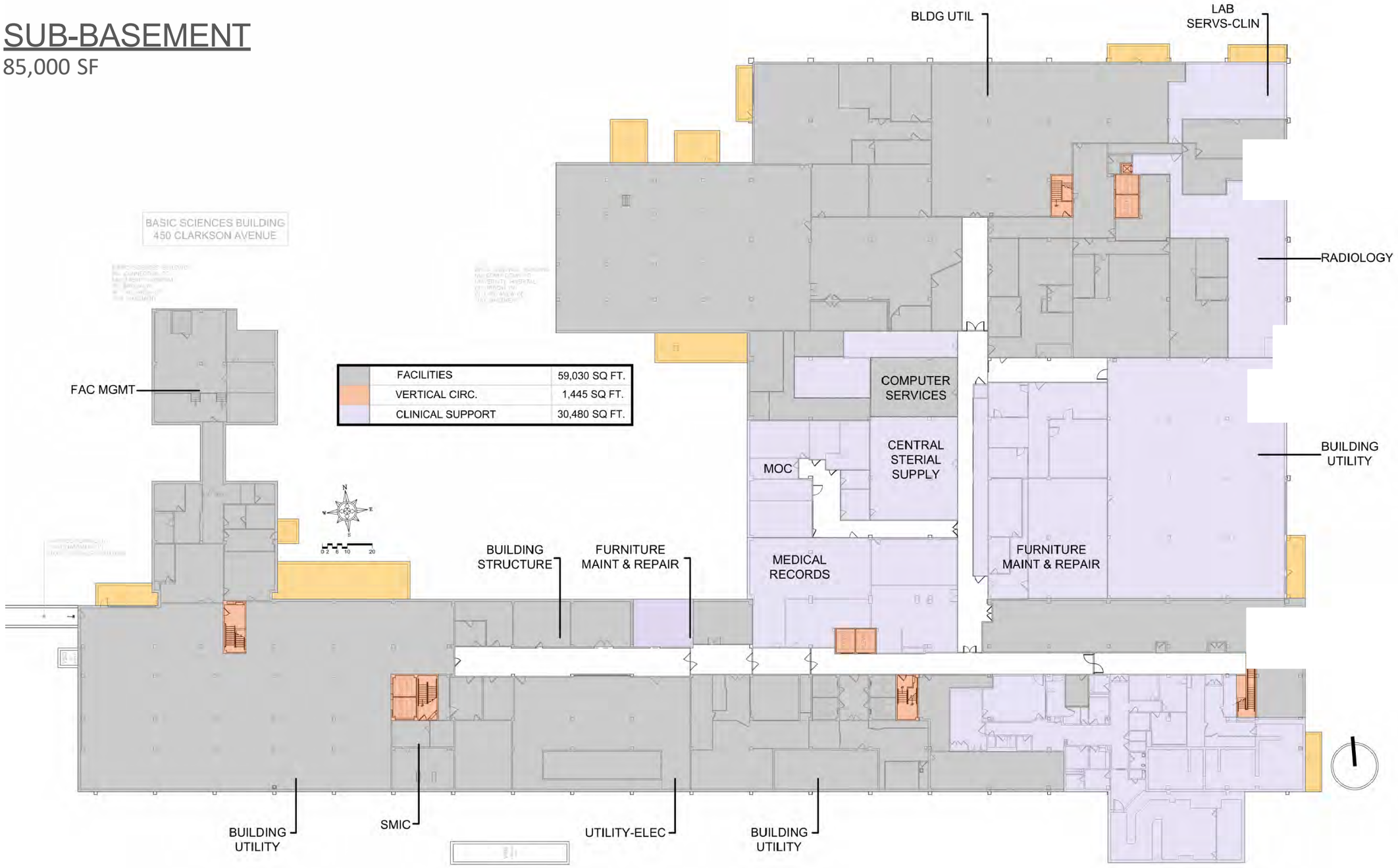
85,000 SF



ADMIN/ OFFICE	6,670 SQ FT.
CLINICAL SUPPORT	34,770 SQ FT.
CUST SERVC.	350 SQ FT.
EDUCATION	550 SQ FT.
FACILITIES	25,780 SQ FT.
IMAGING AND RADIOLOGY	825 SQ FT.
OUTPATIENT	3,850 SQ FT.
REHAB ORTHO SPEECH THERAPY	3,760 SQ FT.
VERTICAL CIRC.	2,400 SQ FT.
VERTICAL CHASE	350 SQ FT.

SUB-BASEMENT

85,000 SF



Renovation Recommendations

The following slides present an executive summary of initial observations for renovation by Care Unit and Department
Slides are organized by:

- Med/Surg
- Pediatric Care
- Critical Care Unit
- Obstetrical
- Surgical Suite
- Emergency Department
- Imaging & Radiology
- Outpatient
- Rehabilitation / Ortho / Therapy

This Hospital was designed in 1961 and construction completed in 1968. There have been many developments in regulations over the past 50-60 years both in General Building Codes, in Hospital/ Health Care Environment requirements, and in ADA/Accessibility.

Deficiencies observed and documented below reference current 2020 New York State Building Code, the 2018 FGI Guidelines for Construction and Design of Hospital Facilities (FGI), including 2012 NFPA 101 Life Safety Code and the 2010 ADA Standards for Accessible Design (ADA), and note the general condition of the space.

9 Patient Care Units have been assessed in depth and preliminarily cost modeled to achieve compliance.

MED/ SURG PATIENT CARE UNITS

UNITS SUMMARY

Level 8:

2 UNITS – 66 BEDS

- N81 Surgery
- N82 Transplant/Surgery

Level 7:

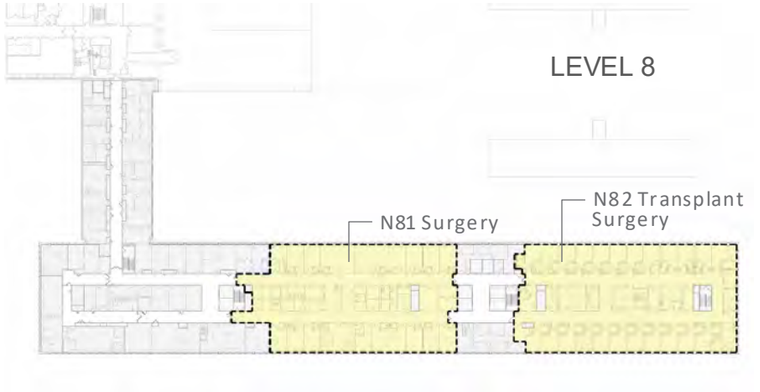
4 UNITS – 76 BEDS

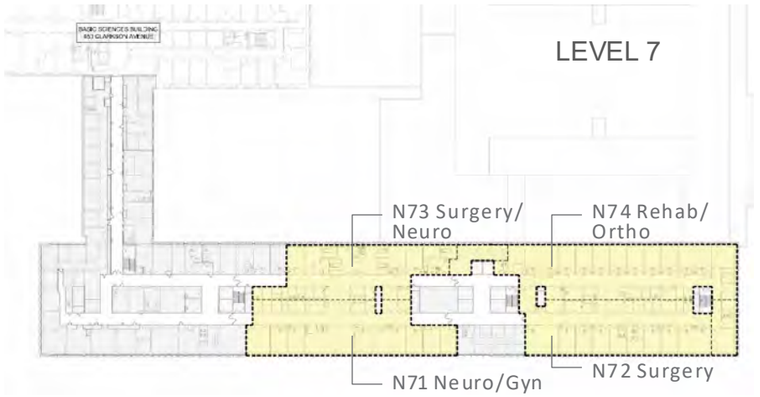
- N71 Neuro/Gyn
- N72 Surgery
- N73 Surgery/Neuro
- N74 Rehab/Ortho

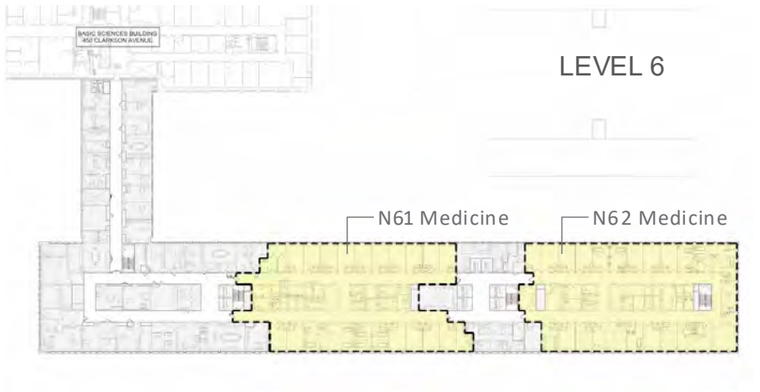
Level 6:

2 UNITS - 74 BEDS

- N61 Neuro/Gyn
- N62 Surgery





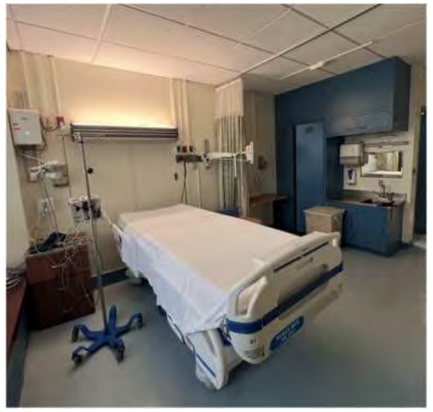


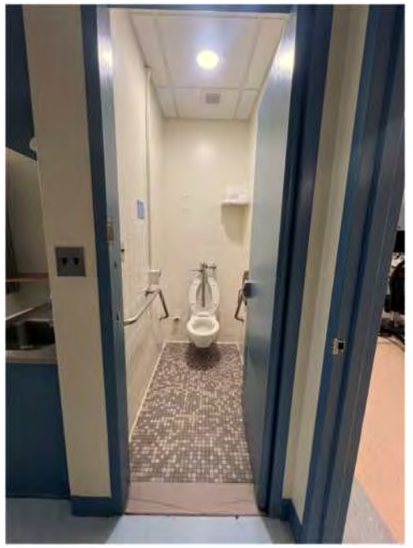
MED/ SURG PATIENT CARE UNITS

OBSERVATIONS / DEFICIENCIES

- One bed per room* not met; Double Occupancy, typical.
- Bed clearances (in Double Occupancy Patient Rooms) not met.
- Toilet Room with toilet, handwashing sink, bedpan rinsing device not present.
- 10% Accessible Toilet Rooms not present. Accessible bathing facilities not present.
- Patient/Family-Centered Care:
- No space for family/visitor seating within room.
- Patient/Family-Centered Care:
- No space for long-term patient seating within room.
- Patient privacy lacking.

Double occupancy allowed if AHJ permits.





MED/ SURG PATIENT CARE UNITS

Level 8	CARE UNIT forCOMPLIANCE Med/Surg	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Transplant Surgery	24 Beds (single)	11,500		
	OPTIMAL SF/BED	530-700sf	479		
	Surgical	42 Beds (double +)	10,650		
	OPTIMAL SF/BED	530-700sf	254		
	Current Med/Surg (Level 8) Totals	(66) **45-46**	**22,150**	$625	**$13,843,750**

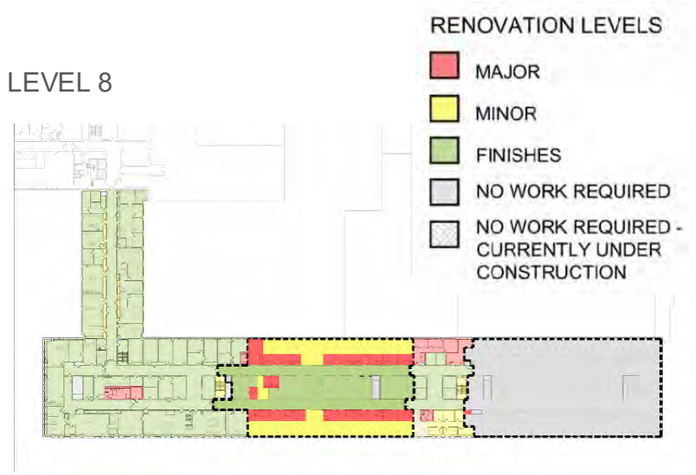
Level 7	CARE UNIT forCOMPLIANCE Med/Surg	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Med/Surg (4 Departments)	76 Beds	21,580		
	OPTIMAL SF/BED	530-700sf	284		
	Current Med/Surg (Level 7) Totals	(76) **45-46**	**21,580**	$795	**$17,156,100**

Level 6	CARE UNIT forCOMPLIANCE Med/Surg	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Medicine	37 Beds	10,600		
	OPTIMAL SF/BED	530-700sf	442		
	Medicine	37 Beds	10,900		
	OPTIMAL SF/BED	530-700sf	363		
	Current Med/Surg (Level 6) Totals	(74) **43-44**	**21,500**	$795	**$17,092,500**

OPTIMIZED SCENARIO		KEY Metric (average per floor)	low @530sf/bed	high @700sf/bed	$/SF	low	high
maintain SF	**Med/Surg Unit** (Standard Room) (w/ Toilet Room + shower)	**22,000 SF**	42	31	$880	$19,360,000	
maintain beds		**70 beds**	37,100	49,000	$880	$32,648,000	$43,120,000

OPTIMIZED SCENARIO		KEY Metric (average per floor)	low @650sf/bed	high @800sf/bed	$/SF	low	high
maintain SF	**Med/Surg Unit** (Universal Room) (w/ Toilet Room + shower)	**22,000 SF**	34	28	$1,100	$24,200,000	
maintain beds		**70 beds**	45,500	56,000	$1,100	$50,050,000	$61,600,000

LEVEL 8



LEVEL 7

LEVEL 6

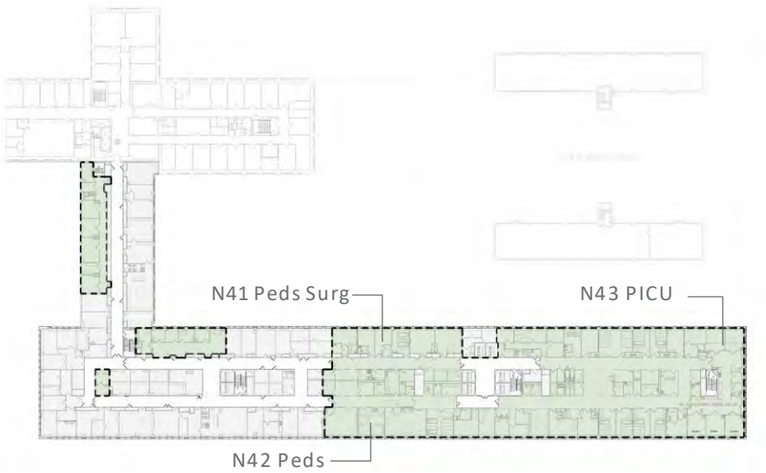
PEDIATRIC CARE UNITS

UNITS SUMMARY

Level 4:

- 22 Beds
- 5 Bed PICU

LEVEL 4

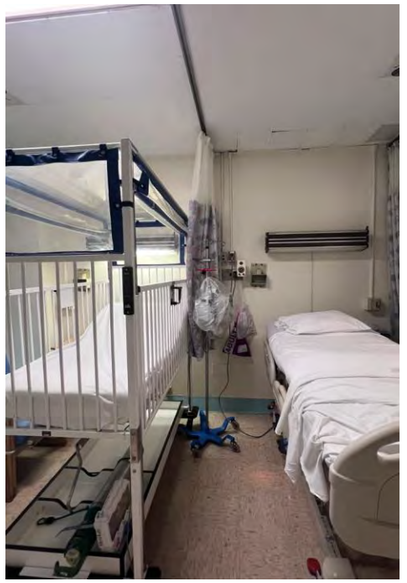


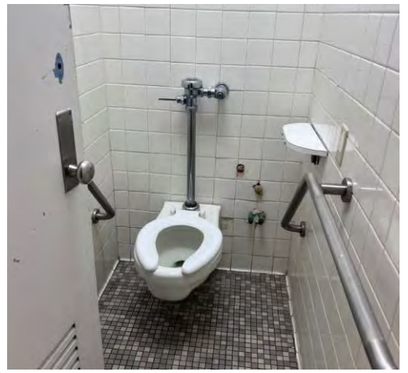
PEDIATRIC CARE UNITS

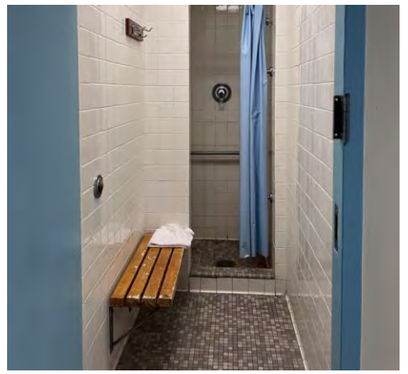
OBSERVATIONS / DEFICIENCIES

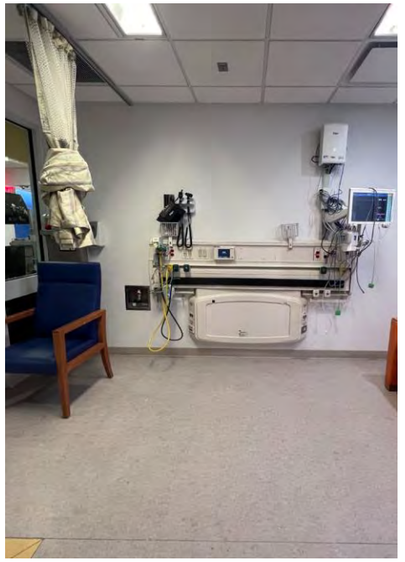
- Bay clearances in double rooms are not compliant.
- Double rooms do not have toilets or have toilets with no sinks in rooms. Most toilets are not accessible.
- Staff support areas are undersized and/or not accessible.
- Poor staff visibility of patient rooms, except in PICU.
- Minimal space for family visitation and overnight stays.

Double occupancy allowed if AHJ permits.







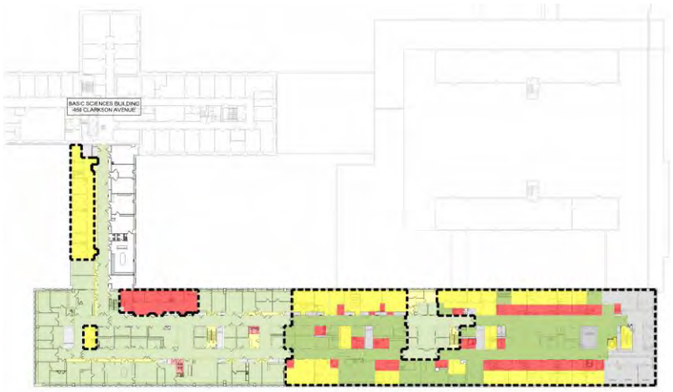


PEDIATRIC CARE UNITS

Level 4	CARE UNIT for COMPLIANCE Peds (Inpatient, PICU)	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Inpatient	(34 Beds) 20 observed	9,710		
	OPTIMAL SF/BED	550-750sf	286		
	PICU	5 Beds	2,700		
	OPTIMAL SF/BED	650-800 sf/bed	540		
	Pediatric Treatment Programs		7,365		
	Current Pediatric Unit (Level 4) Totals	(25) **16**	**19,775**	$810	**$16,017,750**

OPTIMIZED SCENARIO		**KEY Metric**	**low** @550sf/bed	**high** @750sf/bed	**$/SF**	**low**	**high**
maintain SF	**Pediatric Inpatient Unit** (Standard Room)	**9,710 SF**	18	13	$900	$8,739,000	
maintain beds		**20 beds**	11,000	15,000	$900	$9,900,000	$13,500,000
OPTIMIZED SCENARIO		**KEY Metric**	**low** @650sf/bed	**high** @800sf/bed	**$/SF**	**low**	**high**
maintain SF	**Pediatric Inpatient Unit** (Universal Room)	**9,710 SF**	15	12	$1,100	$10,681,000	
maintain beds		**20 beds**	11,000	16,000	$1,100	$12,100,000	$17,600,000
OPTIMIZED SCENARIO		**KEY Metric**	**low** @650sf/bed	**high** @800sf/bed	**$/SF**	**low**	**high**
maintain SF	**PICU**	**2,700**	4	3	$1,100	$2,970,000	
maintain beds		**5 Stations** (Private Rooms)	3,250	4,000	$1,100	$3,575,000	$4,400,000

LEVEL 4



RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

CRITICAL CARE UNITS

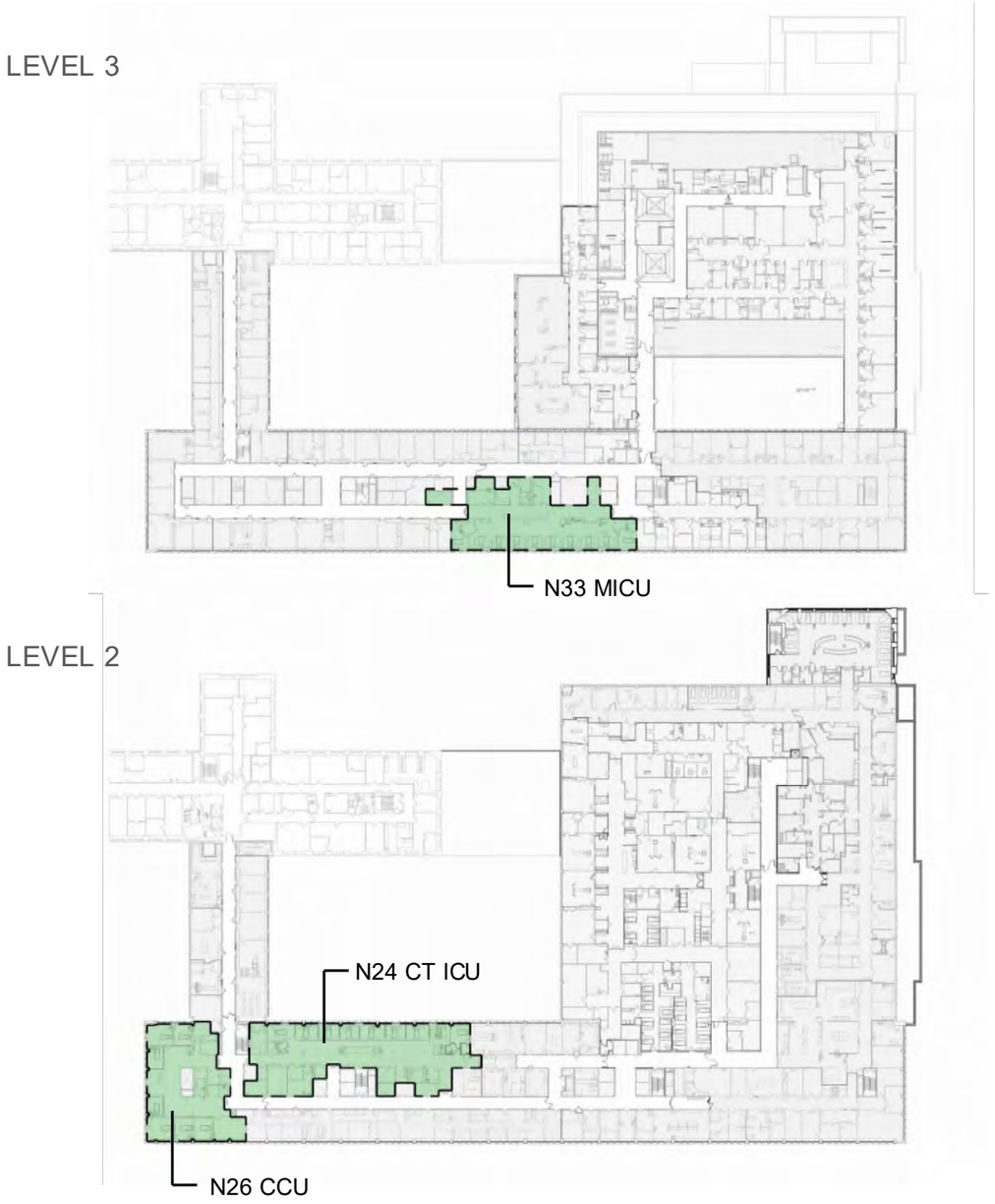
UNIT SUMMARY

Level 3: 1 UNIT - 10 BEDS

- MICU

Level 2: 2 UNITS – 16 BEDS

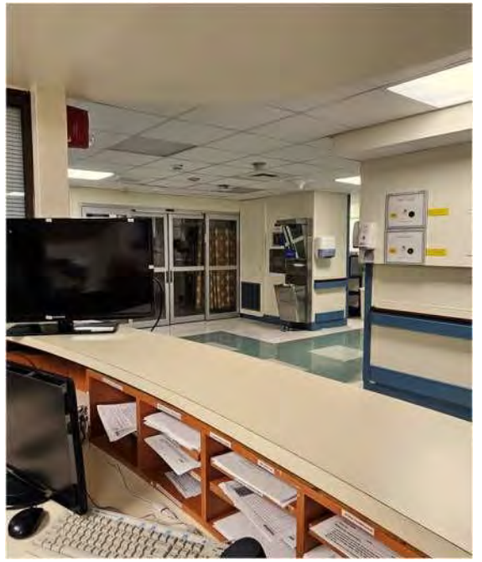
- CCU, former Cardiac CCU, inactive
- CT ICU, former Cardio Thoracic ICU



CRITICAL CARE UNITS

OBSERVATIONS / DEFICIENCIES

- Adjacency to Emergency, Respiratory Therapy, Labs, Radiology and Surgery could be improved
- Access control at entry inconsistent
- Limited visibility to each patient cubicle* from Nurse Station
- Supply & Equipment Storage limited
- Bed clearances inconsistent
- No direct access to Toilet or Waste Disposal Room
- Speech privacy only through curtains
- Patient personal storage / locker inconsistent
- Bedside area for families inconsistent
- No Consultation / Bereavement Room



* Cubicles allowed in renovation if AHJ permits.
Single-Patient Rooms are now required
w/ 200sf clear floor area.

CRITICAL CARE UNITS

Level 2 Level 3	CARE UNIT for COMPLIANCE Critical Care Unit	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	CCU (Level 2)	7 Beds	4,000		
	OPTIMAL SF/ BED	650-800 sf/bed	571		
	CT ICU (Level 2)	9 Beds	5,610		
	OPTIMAL SF/ BED	650 -800 sf/bed	623		
	MICU (Level 3)	10 Beds	4,450		
	OPTIMAL SF/ BED	650-800 sf/bed	445		
	Current CCU (Levels 2 & 3) Totals	(26) **18-22**	**14,060**	$1,100	**$15,466,000**

OPTIMIZED SCENARIO		KEY Metric	low @650sf/bed	high @800sf/bed		low	high
maintain SF	**Critical Care Unit** (combined)	**14,060 SF**	22	18	$1,100	$15,466,000	
		4,000	6	5			
		5,610	9	7			
		4,450	7	6			
maintain beds		**26 Beds**	16,900	20,800	$1,100	$18,590,000	$22,880,000

RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

LEVEL 3

LEVEL 2

OBSTETRICAL CARE UNITS

UNIT SUMMARY

Level 3: LABOR AND DELIVERY

- 9 Beds
- 1 Observation Room
- 6-7 Triage Beds
- 2 ORs (C-Section)
- 3 Recovery Bays

OB/GYN

- 22 Beds (Double Patient Rooms)

NICU

- 29 Stations

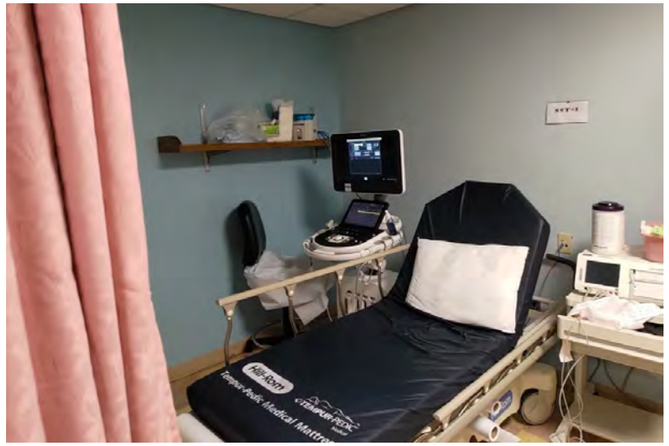
LEVEL 3

OBSTETRICAL CARE UNITS

OBSERVATIONS / DEFICIENCIES

- Bay clearances in Recovery areas are insufficient. Staff On-call and toilet facilities are undersized.
- Staff Locker Rooms and support spaces are undersized and/or not Accessible. Accessible Patient, Visitor, and Staff toilet rooms limited.
- Patient and staff circulation could be improved. Various patient support areas are underutilized. Storage within L&D units is limited.
- NICU not fully utilized and stations do not have proper clearance space. Finishes are dated and in fair to poor condition, especially at support areas.
  Postpartum/Inpatient Rooms under construction and unable to be observed.

* Cubicles allowed in renovation if AHJ permits. Single-Patient Rooms are now required w/ 200sf clear floor area.



OBSTETRICAL CARE UNITS

Level 3	CARE UNIT for COMPLIANCE Obstetrical Care Unit	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Labor Delivery Recovery (LDR)	9 (LDR)	15,560		
	OPTIMAL SF/ LDR Room	1,775-2,150sf	707		
	Cesarean OR &Recovery	2	2,500		
	Observation	1			
	L&D Triage	7			
	OBGYN		4,275		
	(11) Double Patient Rooms	22 beds (double)	9,530		
	OPTIMAL Patient Room (Singles)	270-300sf	225		
	NICU	29 (stations)	3,900		
	OPTIMAL Private NICU Room	650-800sf/room	134		
	Current OB/GYN Unit Totals	(22) **11**	**35,765**	$800	**$28,612,000**

OPTIMIZED SCENARIO		KEY Metric	low @1775sf/room	high @2150sf/room		low	high
maintain SF	**Obstetrical Care LDR**	**15,560**	9	7	$930	$14,470,800	
maintain beds		**9 Beds**	15,975	19,350	$930	$14,856,750	$17,995,500
maintain SF	**Obstetrical Care Inpatient**	**9,530**	18	14	$880	$8,386,400	
maintain beds		**22 Beds**	11,660	15,400	$880	$10,260,800	$13,552,000
OPTIMIZED SCENARIO		**KEY Metric**	**low** @2500sf/OR	**high** @3500sf/OR		**low**	**high**
maintain SF	**Surgical Suite** (Cesarean)	**2,500 SF**	1	1	$1,425	$3,562,500	
maintain rooms		**2 ORs (600 SF)**	5,000	7,000	$1,425	$7,125,000	$9,975,000
OPTIMIZED SCENARIO		**KEY Metric**	**low** @650sf/bed	**high** @800sf/bed		**low**	**high**
maintain SF	**NICU**	**3,900**	6	5	$1,100	$4,290,000	
maintain beds		**29 Stations** (Private Rooms)	18,850	23,200	$1,100	$20,735,000	$25,520,000

LEVEL 3

RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

SURGICAL SUITE

UNIT SUMMARY

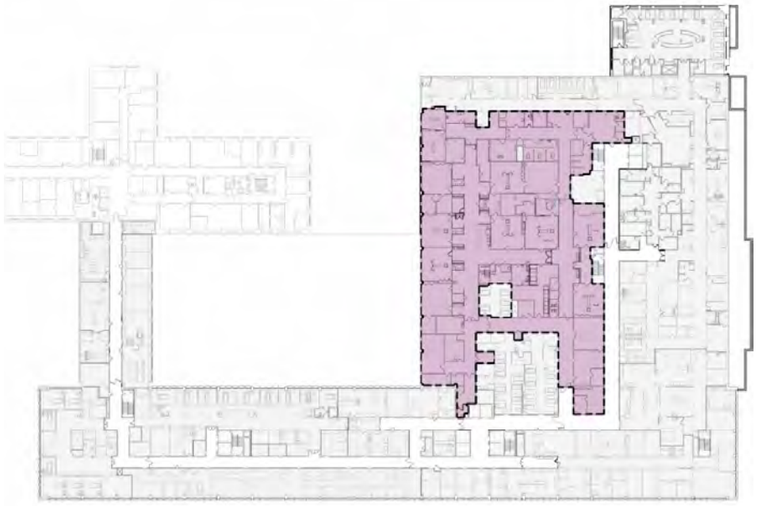
Level 3: Staff Support Spaces

Level 2: 12 ORs

- Procedure Room (2)
- General OR (9)
- Robotic Surgery (1)

LEVEL 3

LEVEL 2

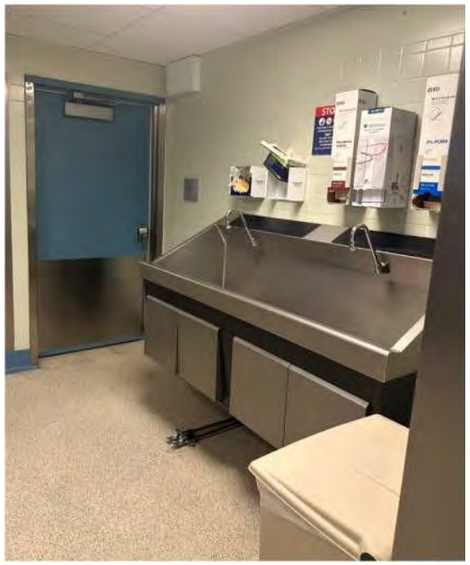


SURGICAL SUITE

OBSERVATIONS / DEFICIENCIES

- Clarity of Semi-Restricted Corridor could be improved
- Control point at unit entry could be improved
- Documentation and Work Areas are limited
- Operating Room sf close to minimum
- Med Gas / Power pedestal impedes flexibility and Anesthesia work area at patient head
- Storage limited
- Medical gases inconsistent
- Staff Locker Room / Change Room on 3rd floor w/ Dedicated Stair access
- Non-accessible Toilet Rooms



SURGICAL SERVICES / Surgical Suite – Level 2

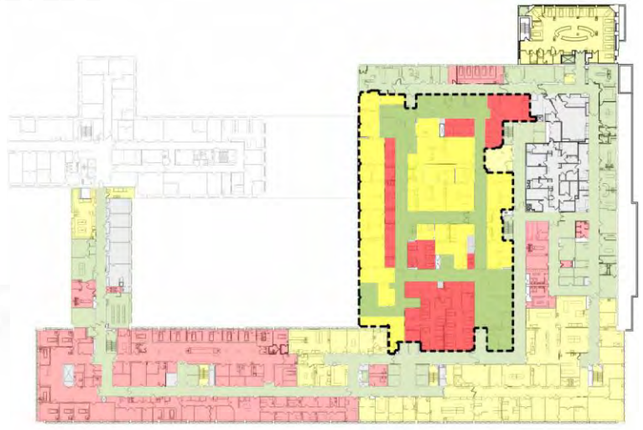
Level 2	CARE UNIT for COMPLIANCE Surgical Suite	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Procedure Room (Endo)	3 Rooms			
	OPTIMAL SF/ OR	250sf (160-180 min)	256-320		
	General Surgery	8 Rooms			
	OPTIMAL SF/ OR	660sf (400 min)	320-536		
	Robotic Surgery	1 Room (550sf)			
	OPTIMAL SF/ OR	700sf (600 min)	550		
	Current Surgical Suite Totals	**12**	**24,700**	$1,300	**$32,110,000**

OPTIMIZED SCENARIO		KEY Metric	low @2500sf /OR	high @3500sf /OR		low	high
maintain SF	**Surgical Suite** (General Surgery)	**24,700 SF**	10	7	$1,425	$35,197,500	
maintain rooms		**12 Room OR (660 SF*)**	30,000	42,000	$1,425	$42,750,000	$59,850,000

*SF will vary based on specialty

LEVEL 3

LEVEL 2



RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

SURGICAL SUITES / Pre- and Post-Op – Level 2

UNITS SUMMARY

Level 2:

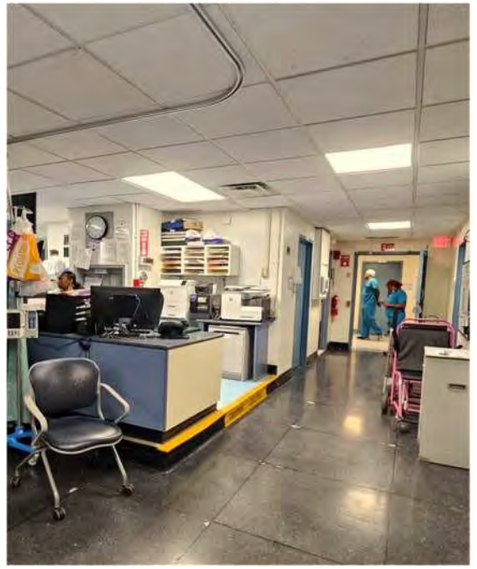
- 5 Beds Procedure Pre-/ Post
- 5 Beds Pre-Op
- 17 Beds Recovery

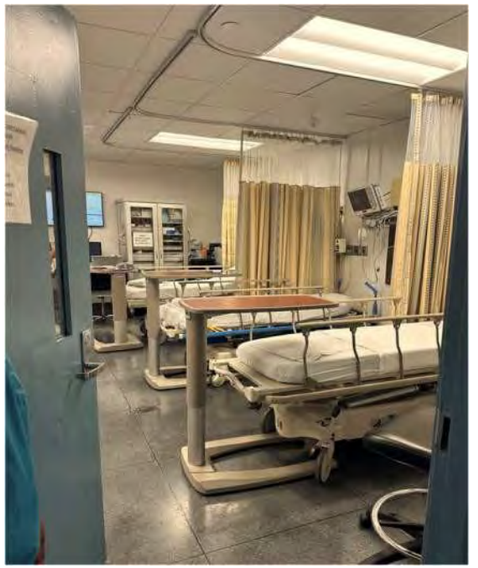
LEVEL 2

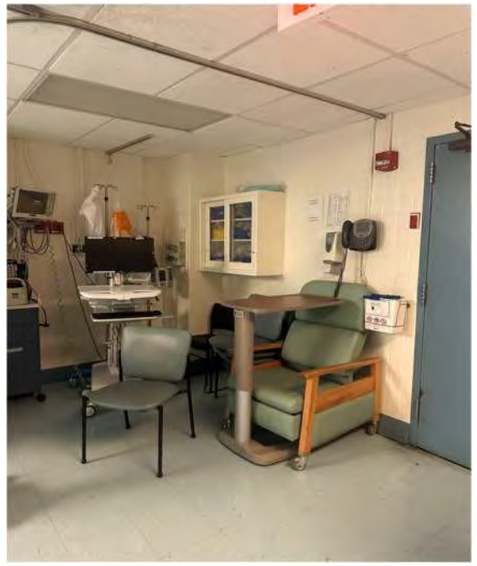
SURGICAL SUITE / Pre- and Post-Op – Level 2

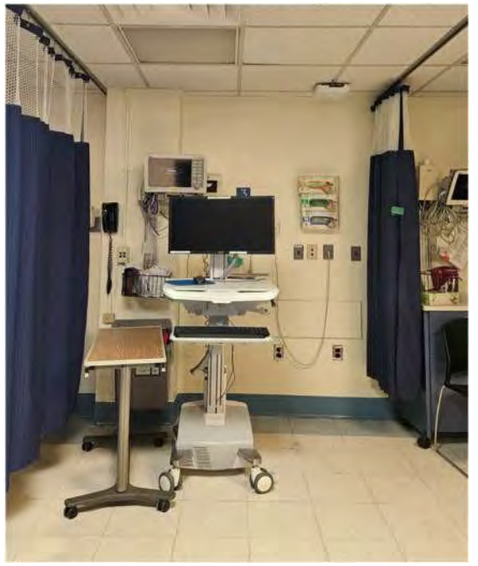
OBSERVATIONS / DEFICIENCIES

- Bed clearances not provided
- Support Spaces limited
- Limited visibility to each patient cubicle from Nurse Station
- Handwashing station counts don’t meet 1:4
- Pre-Op provides little support spaces
- No provision for Isolation
- 1 accessible Staff Toilet not provided
- 1:8 Patient Toilet not provided
- Ice making equipment (only 1 of the 3 areas)
- Bedside area for families inconsistent









SURGICAL SUITE / Pre- and Post-Op – Level 2

Level 2	CARE UNIT for COMPLIANCE Surgical Pre-/ Post	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Pre-Post (Procedure)	5 Beds	680		
	OPTIMAL SF/ BED	300-450sf/bed	136		
	Pre-Op	5 Beds	526		
	OPTIMAL SF/ BED	300-450sf/bed	105		
	Post-Op / Recovery	17 Beds	3,494		
	OPTIMAL SF/ BED	300-450sf/bed	206		
	Current Pre/Post Totals	(27) **10-16**	**4,700**	$980	**$4,606,000**

OPTIMIZED SCENARIO		KEY Metric	low @300sf / bed	high @450sf / bed		low	high
maintain SF	**Surgical Pre-/Post** (combined)	**4,700 SF**	16	10	$980	$4,606,000	
maintain beds		**27 Beds**	300	450	$980	$294,000	$441,000

LEVEL 2

RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

EMERGENCY DEPARTMENT

UNIT SUMMARY

Level 1: 38 STATIONS*

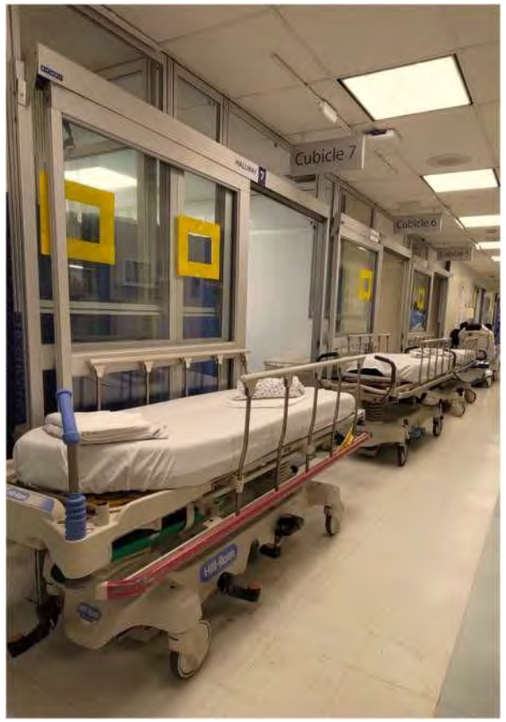
- Main E.D.
- Fast Track
- Pediatric E.D.
- Support Space

LEVEL 1

EMERGENCY DEPARTMENT

OBSERVATIONS / DEFICIENCIES

- Treatment bays and rooms are undersized at main ED, Peds ED, and fast track.
- Stretcher and direct-access storage space is undersized.
- Toilet rooms are undersized, and count is inadequate.
- Limited public drop-off area. ED entrance path could be improved (currently shared with outpatient access).
- Limited ambulance drop-off and maneuvering space
- Minimal accommodations for patients of size.
- No dedicated security space near entrance/ triage.
- Circulation among ED sections, and between imaging, could be improved.



EMERGENCY DEPARTMENT

Level 1	CARE UNIT forCOMPLIANCE Emergency Department	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	General Treatment	38 Stations	11,300		
	OPTIMAL SF/ Station	460-650sf	297		
	(19) Adult Stations				
	(11) Pediatric Stations				
	(8) Fast Track				
	Current Emergency Dept Totals	(38) **17-25**	**11,300**	$1,150	**$12,995,000**

OPTIMIZED SCENARIO		KEY Metric	low @460sf/bed	high @650sf/bed			
maintain SF	**Emergency Department**	**11,300 SF**	25	17	$1,150	$12,995,000	
maintain stns		**38 Stations**	17,480	24,700	$1,150	$20,102,000	$28,405,000

LEVEL 1

RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

IMAGING AND RADIOLOGY

UNIT SUMMARY

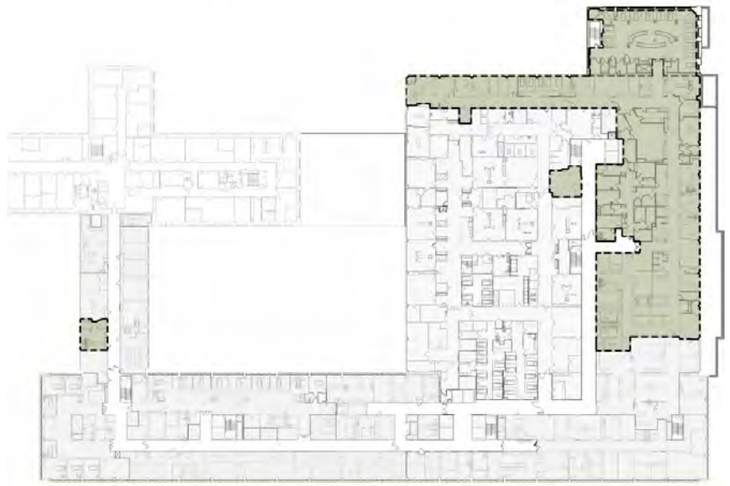
Level 2:

- Mammography, recently renovated
- Ultrasound
- Cath Lab
- CT
- BiPlane, recently renovated
- EP Lab
- X-Ray
- Fluoroscopy
- Nuclear Med

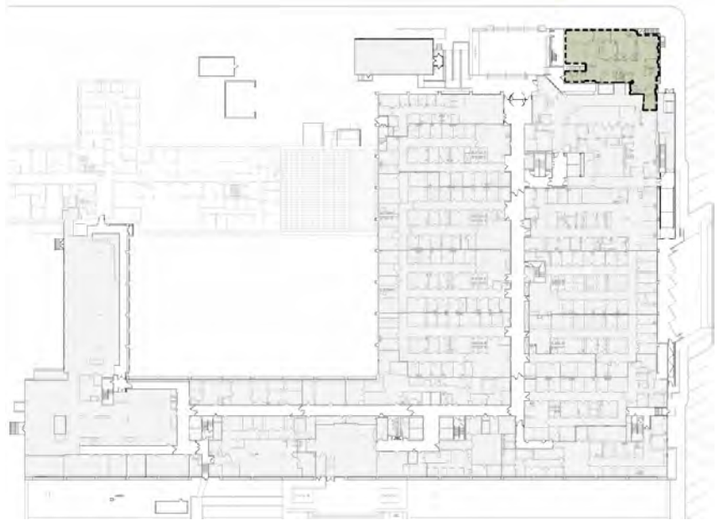
Level 1:

- CT
- MRI

LEVEL 2



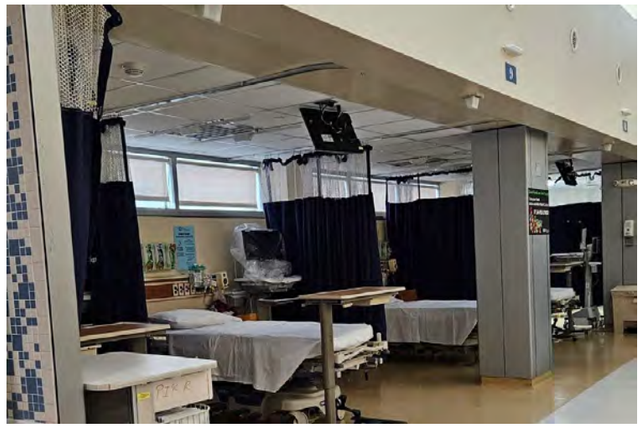
LEVEL 1



IMAGING AND RADIOLOGY

OBSERVATIONS / DEFICIENCIES

- Minimum FGI clearance at equipment inconsistent. Minimum clearance and bay sizes at PIRR limited.
- Accessibility issues observed at change rooms, locker rooms, some entries. Space and areas for staff and clinical support limited.



IMAGING AND RADIOLOGY

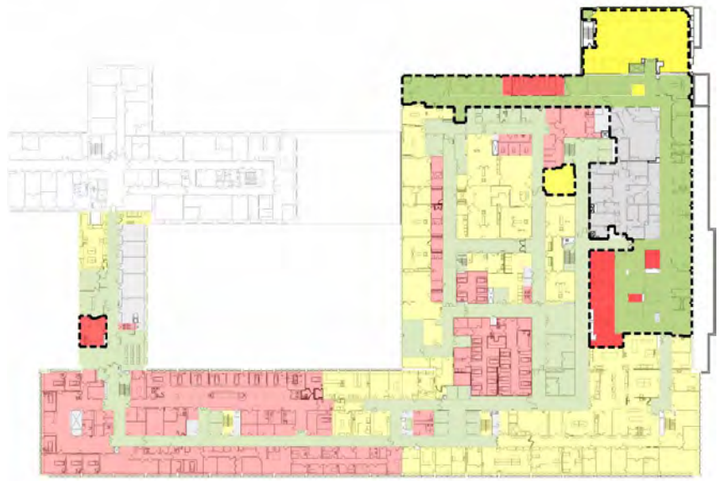
Level 1	CARE UNIT for COMPLIANCE Imaging / Radiology (Level 1)	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	MRI Suite (Level 1)	1 Room			
	OPTIMAL SF/ROOM				
	CT (Level 1)	1 Room			
	OPTIMAL SF/ROOM				
	Current Imaging (Level 1) Totals	**2**	**2,970**	$550	**$165,000**

OPTIMIZED SCENARIO		KEY Metric	low @1280sf /bed	high @1760sf /bed			
	Imaging / Radiology (blended)	2 Rooms	2,560	3,520			

Level 2	CARE UNIT for COMPLIANCE Imaging / Radiology (Level 2)	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Imaging / Radiology	16 Rooms	18,460		
	OPTIMAL SF/ROOM	1280-1760sf	1,154		
	(4) Mammography /Ultrasound				
	(2) Cath Lab				
	(2) CT / Pet CT				
	(1) BiPlane				
	(1) EP Lab				
	(3) X-Ray				
	(1) Fluroscopy				
	(2) Nuclear Med				
	Post Interventional Radiology Recovery	14 bays	3,970		
	OPTIMAL SF/ROOM	300-450sf/bay	284		
	Current Imaging (Level 2) Totals	**16**	**22,430**	$720	**$16,149,600**

OPTIMIZED SCENARIO		KEY Metric	low @1280sf /room	high @1760sf /room		low	high
maintain SF	**Imaging / Radiology** (blended) (Level 2)	**18,460 SF**	14	10	$880	$16,244,800	
maintain rooms		**16 Rooms**	20,480	28,160	$880	$18,022,400	$24,780,800
OPTIMIZED SCENARIO		**KEY Metric**	**low @300sf /room**	**high @450sf /room**		**low**	**high**
maintain SF	**Post Interventional Radiology Recovery (PIRR)**	**3,970 SF**	13	9	$980	$3,890,600	
maintain beds		**14 bays**	4,200	6,300	$980	$4,116,000	$6,174,000

LEVEL 2



LEVEL 1

OUTPATIENT UNIT

UNIT SUMMARY

Level 3:

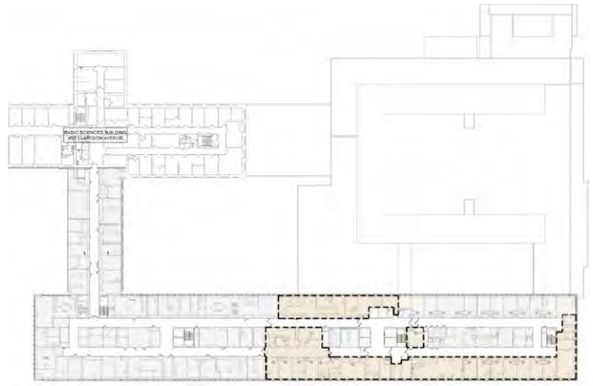
- MULTIPLE UNITS
- Psychiatry
- Vascular
- Miscellaneous Other Specialties

Level 1:

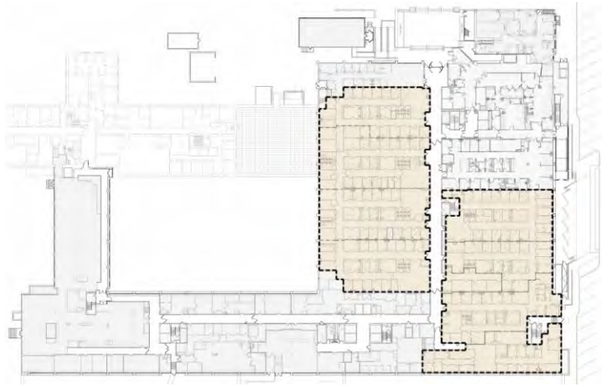
- 8 Units
- Suites A, B, C, D, G, H, I & J

Basement

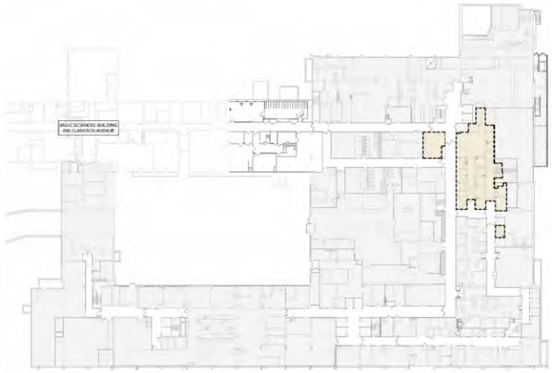
LEVEL 5



LEVEL 1



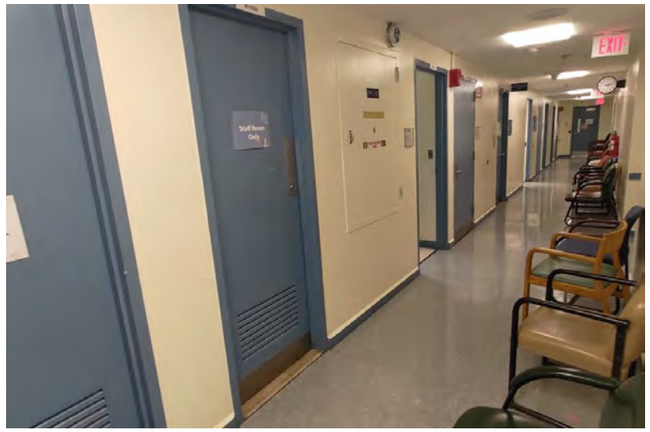
LEVEL 2



OUTPATIENT UNIT

OBSERVATIONS / DEFICIENCIES

- Inadequate and inefficient staff support spaces. Treatment areas underutilized in several suites. Toilet rooms undersized and not Accessible.
- Upper-level suites are located in spaces designed for other uses, which limits efficiency and proper patient & staff flow.
- Finishes in fair condition.

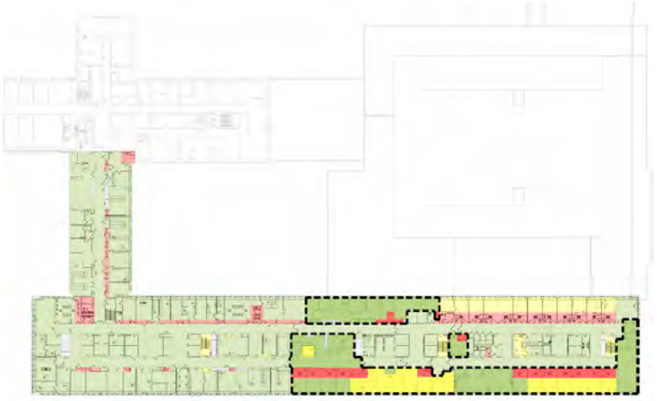


OUTPATIENT UNIT

Level 1 Level 5, B	CARE UNIT forCOMPLIANCE Outpatient Clinics	KEY Metric (current Exam Rooms)	SF (Suite)	$/SF	Reno COST
	Outpatient (Level 1)	**84**	35,450		
	OPTIMAL SF/ EXAM	500-725sf	422		
	Outpatient (Level 5)	**16**	10,165		
	OPTIMAL SF/ EXAM	500-725sf	635		
	Outpatient (Basement)	**10**	3,850		
	OPTIMAL SF/ EXAM	500-725sf	385		
	Current Outpatient Total	**110**	**49,465**	$660	**$32,646,900**

OPTIMIZED SCENARIO		KEY Metric	low @500sf /exam	high @725sf /exam	$/SF	low	high
maintain SF	**Outpatient**	**49,465 SF**	99	68	$700	$34,625,500	
maintain exams		**105 Exams**	52,500	76,125	$700	$36,750,000	$53,287,500

LEVEL 5



LEVEL 1

LEVEL 2

RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

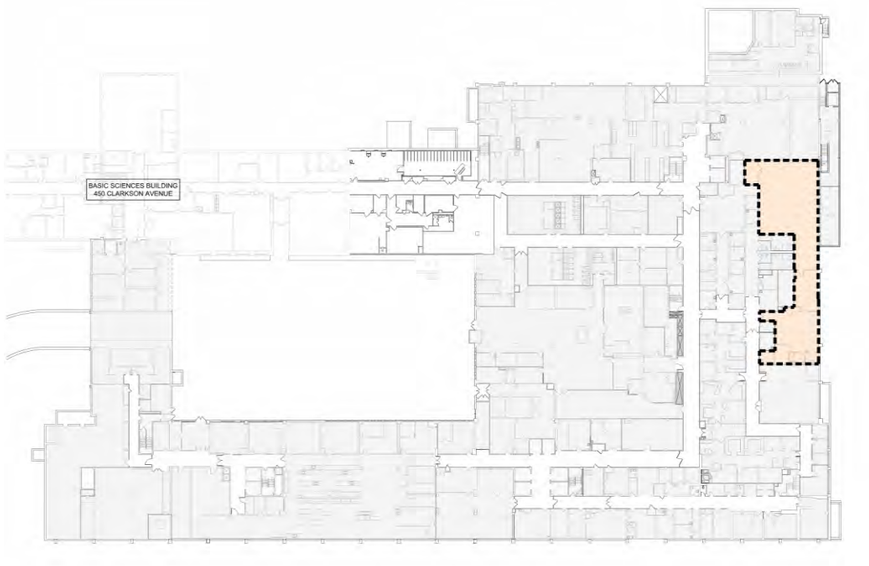
REHABILITATION/ ORTHOPEDICS/ SPEECH THERAPY

LEVEL 5

UNIT SUMMARY

Basement:

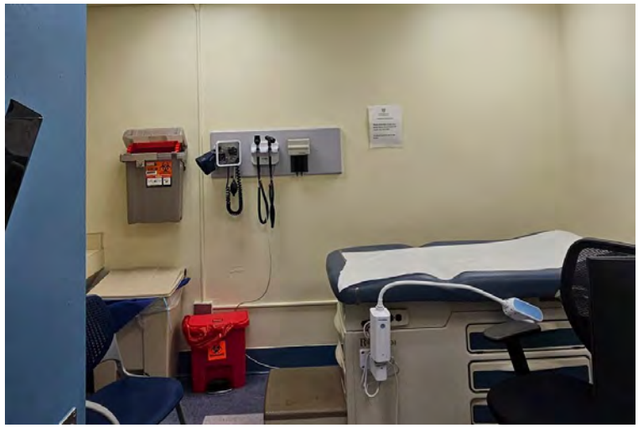
- Physical Therapy Gym
- Occupational Therapy Gym
- Treatment Offices



REHABILITATION/ ORTHOPEDICS/ SPEECH THERAPY

OBSERVATIONS / DEFICIENCIES

- Additional Accessible toilet rooms to be provided.
- Additional handwash stations to be provided.
- Patient Privacy could be improved in gym areas.
- Finishes in fair condition.



REHABILITATION/ ORTHOPEDICS/ SPEECH THERAPY

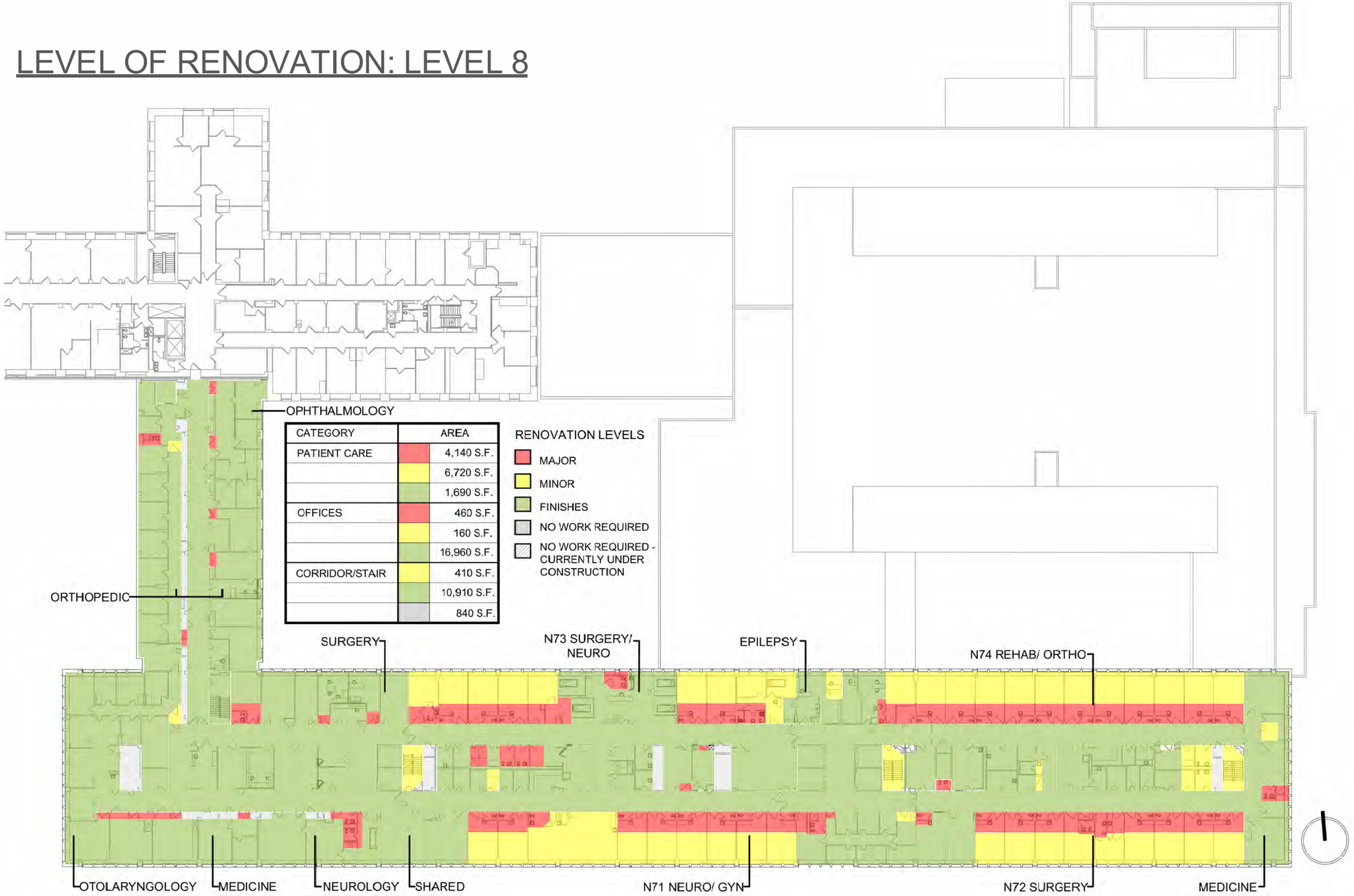
Basement Level	CARE UNIT forCOMPLIANCE Rehab / Ortho / Therapy	KEY Metric (current)	SF (Suite)	$/SF	Reno COST
	Rehab / Ortho / Therapy		3,800		
	Current Outpatient Total		**3,800**	$650	**$2,470,000**

BASEMENT

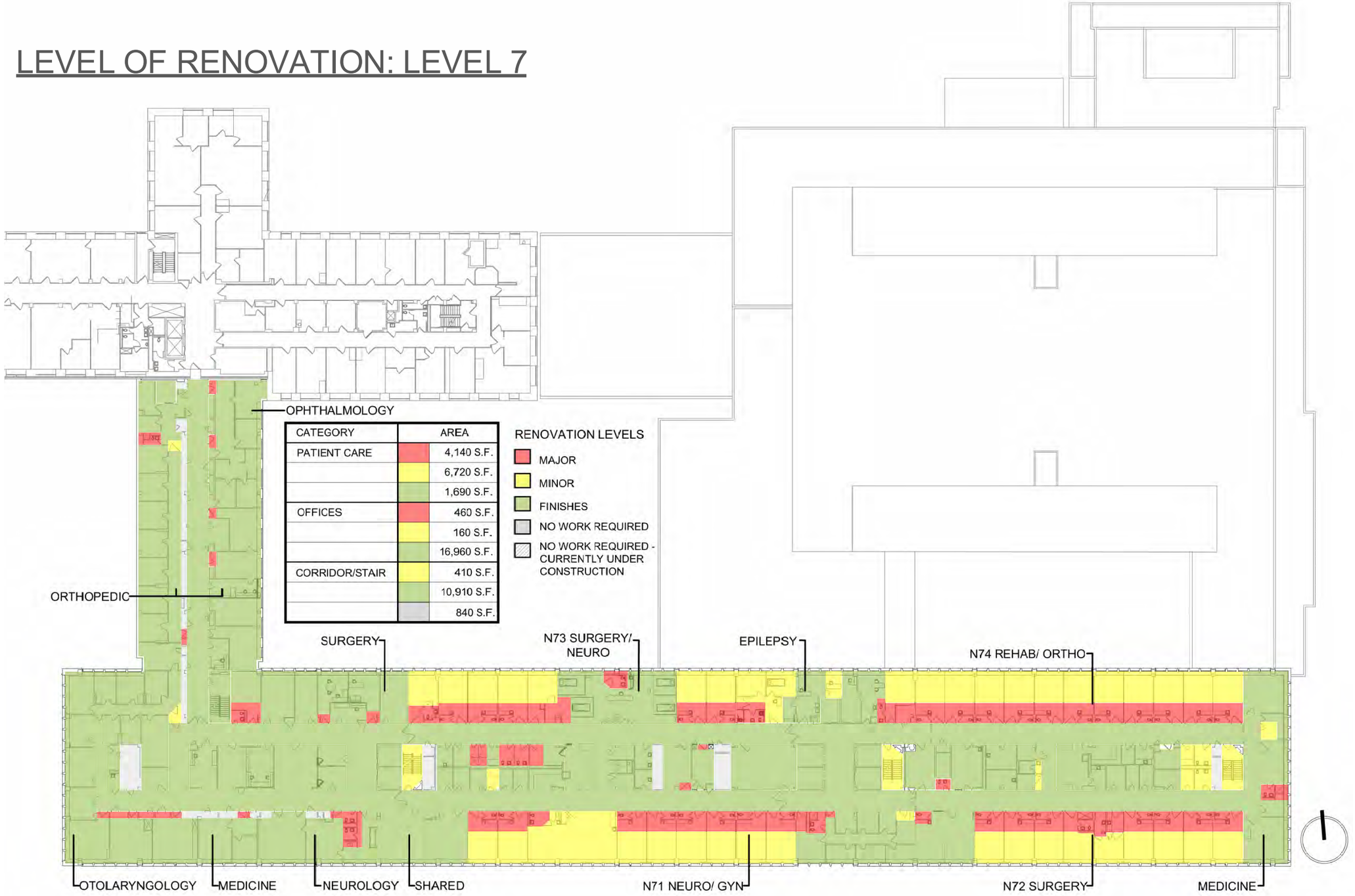
RENOVATION LEVELS

- MAJOR
- MINOR
- FINISHES
- NO WORK REQUIRED
- NO WORK REQUIRED - CURRENTLY UNDER CONSTRUCTION

LEVEL OF RENOVATION: LEVEL 8

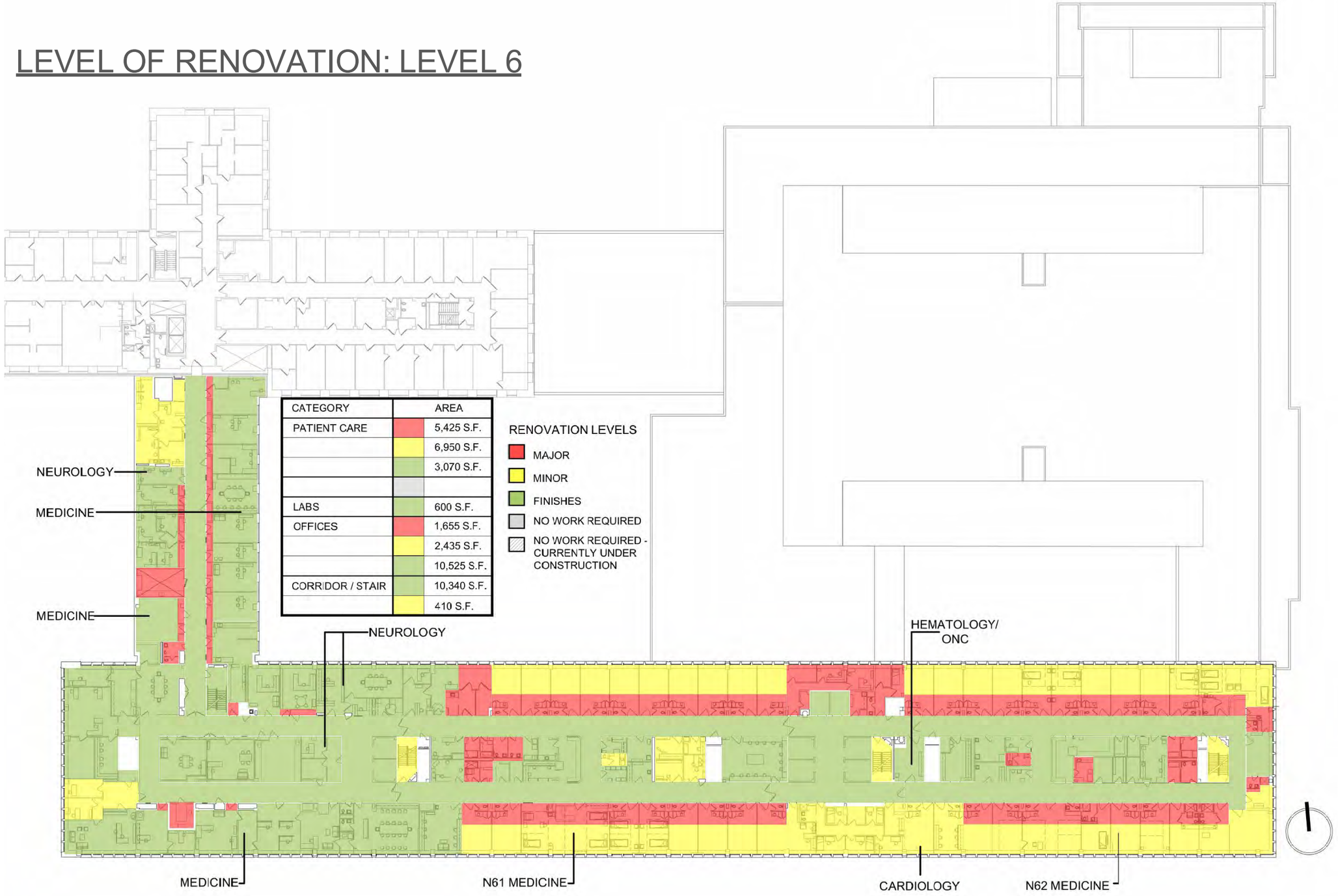


LEVEL OF RENOVATION: LEVEL 7

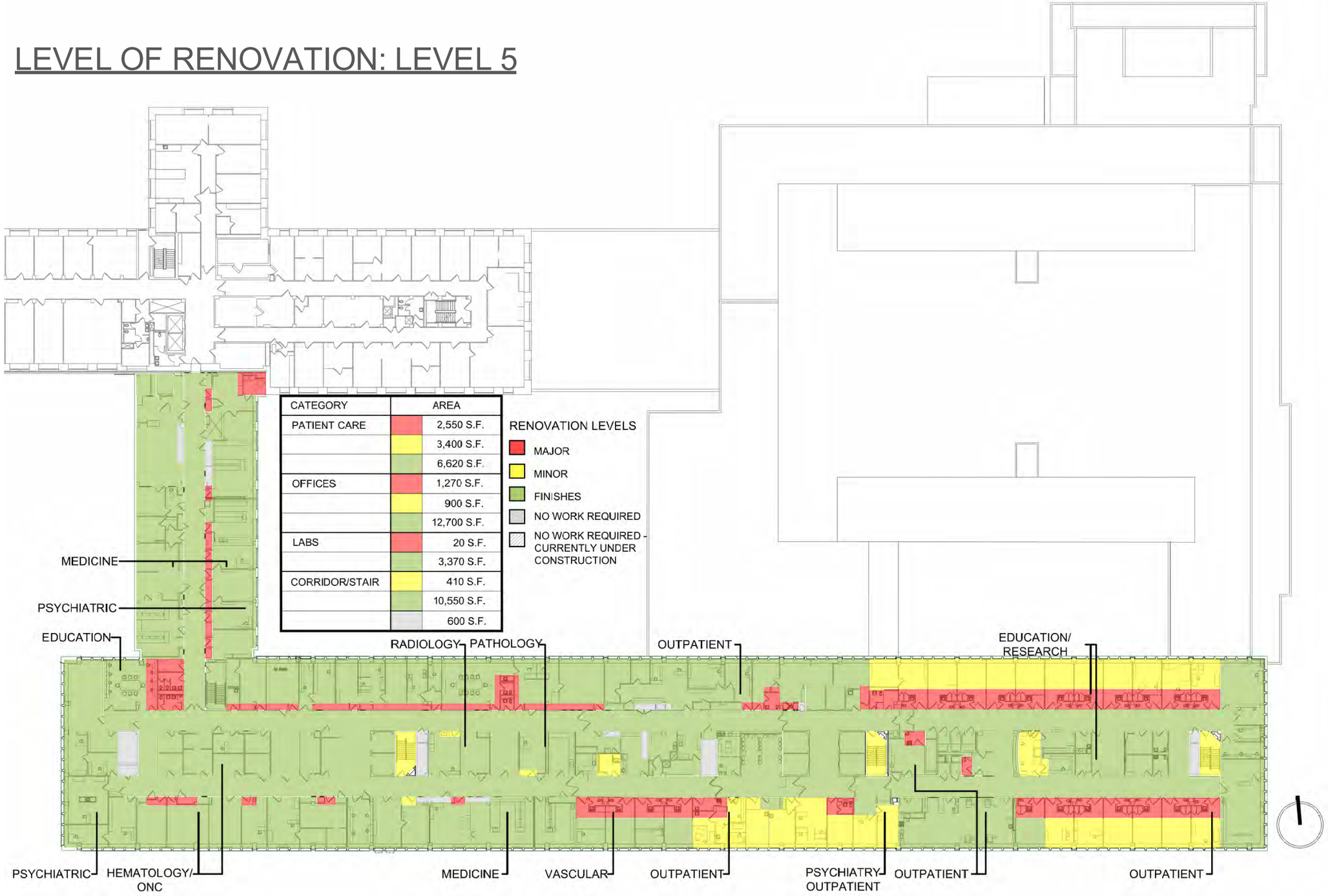


CATEGORY	AREA
PATIENT CARE	4,140 S.F.
	6,720 S.F.
	1,690 S.F.
OFFICES	460 S.F.
	160 S.F.
	16,960 S.F.
CORRIDOR/STAIR	410 S.F.
	10,910 S.F.
	840 S.F.

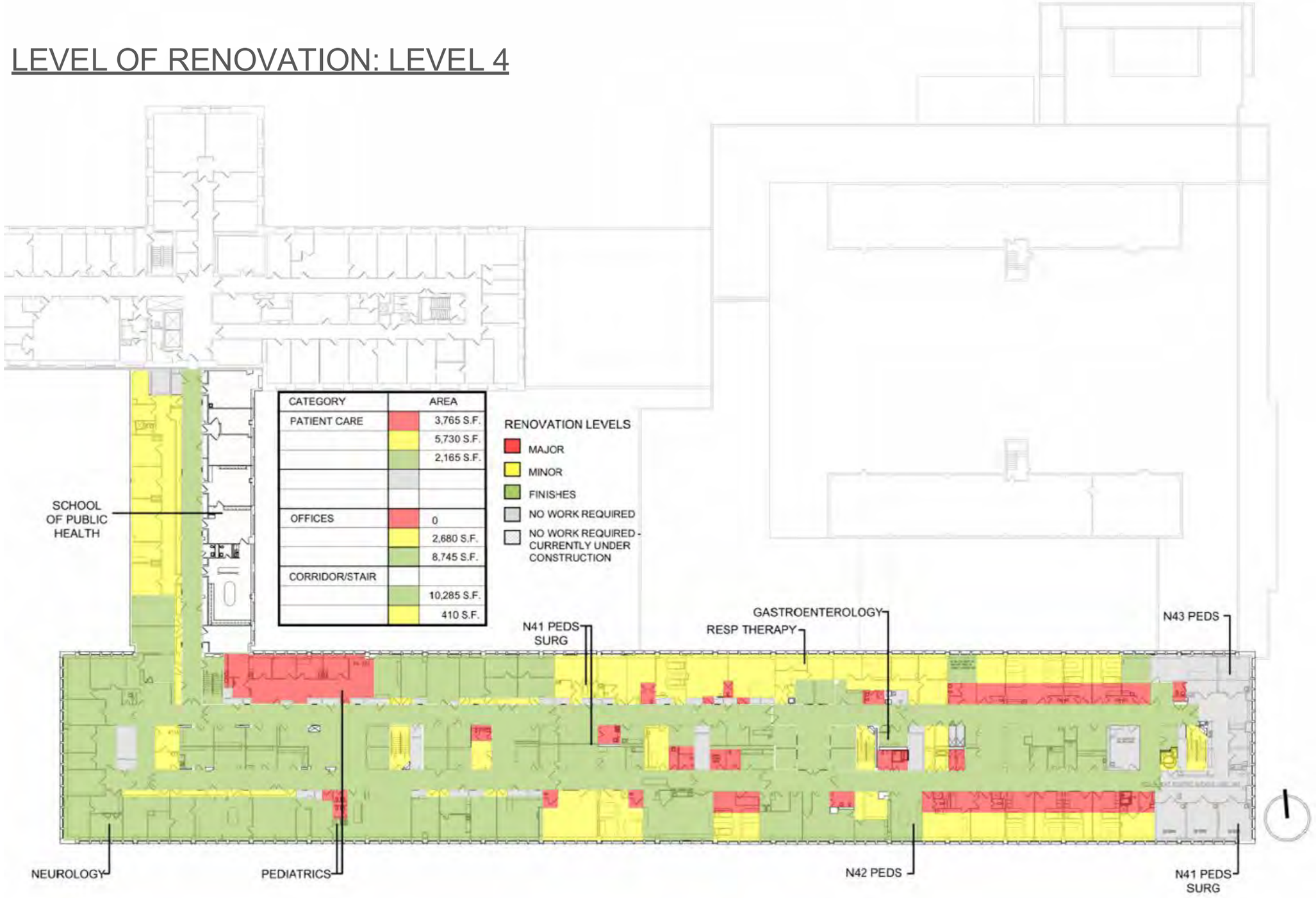
LEVEL OF RENOVATION: LEVEL 6



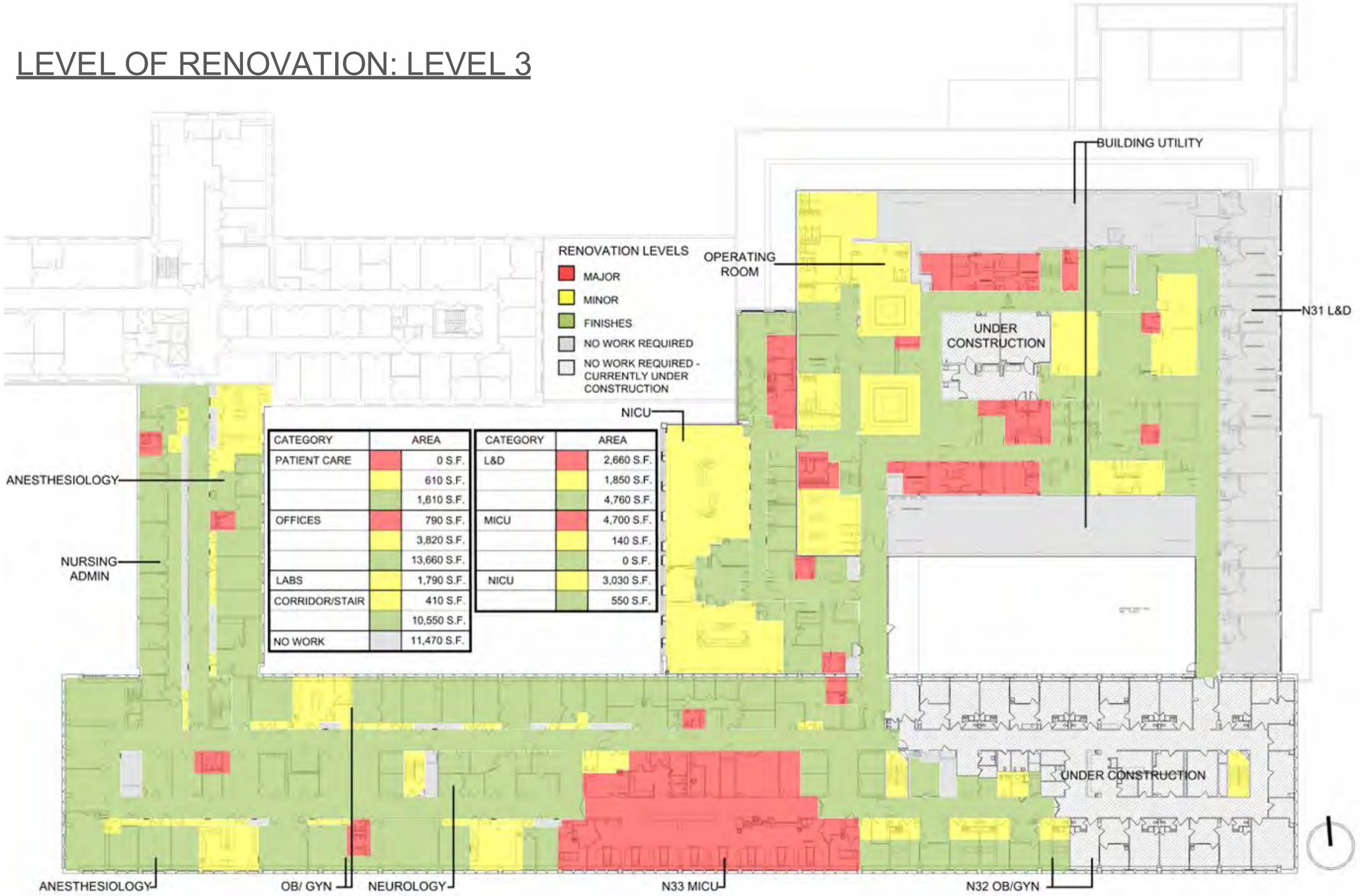
LEVEL OF RENOVATION: LEVEL 5



LEVEL OF RENOVATION: LEVEL 4



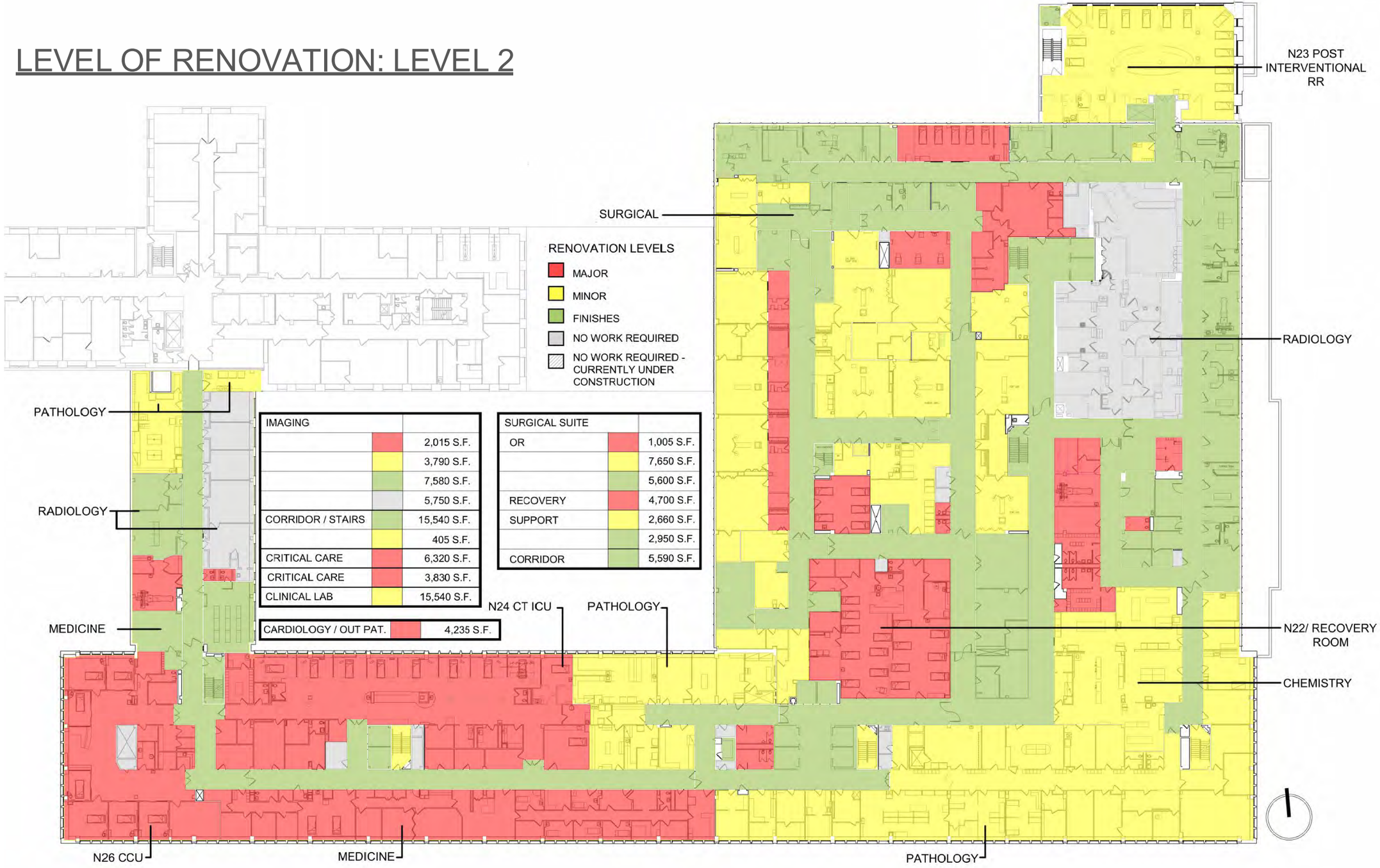
LEVEL OF RENOVATION: LEVEL 3



CATEGORY	AREA
PATIENT CARE	0 S.F.
	610 S.F.
	1,610 S.F.
OFFICES	790 S.F.
	3,820 S.F.
	13,660 S.F.
LABS	1,790 S.F.
CORRIDOR/STAIR	410 S.F.
	10,550 S.F.
NO WORK	11,470 S.F.

CATEGORY	AREA
L&D	2,660 S.F.
	1,850 S.F.
	4,760 S.F.
MICU	4,700 S.F.
	140 S.F.
	0 S.F.
NICU	3,030 S.F.
	550 S.F.

LEVEL OF RENOVATION: LEVEL 2

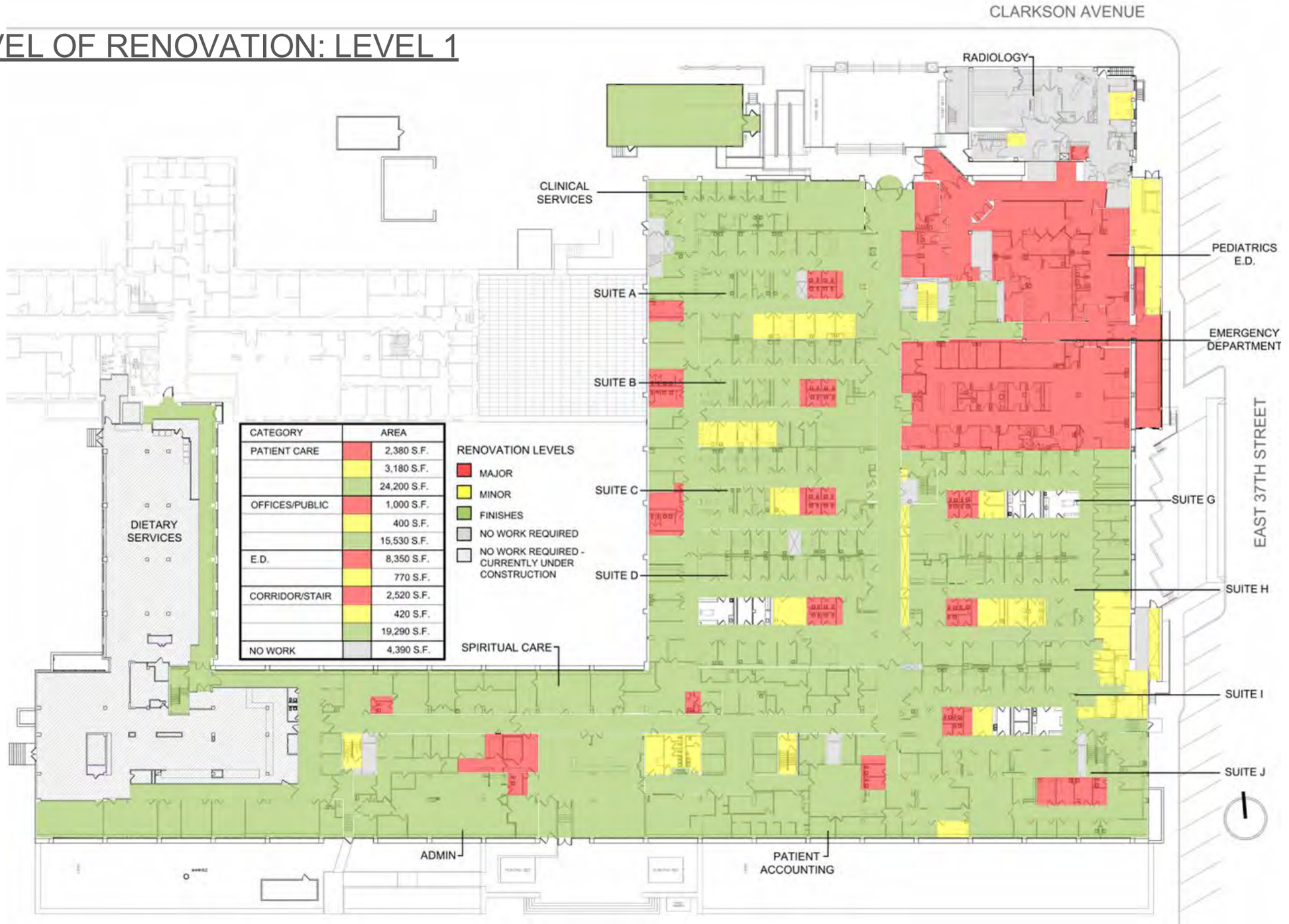


IMAGING		
		2,015 S.F.
		3,790 S.F.
		7,580 S.F.
		5,750 S.F.
CORRIDOR / STAIRS		15,540 S.F.
		405 S.F.
CRITICAL CARE		6,320 S.F.
CRITICAL CARE		3,830 S.F.
CLINICAL LAB		15,540 S.F.

SURGICAL SUITE		
OR		1,005 S.F.
		7,650 S.F.
		5,600 S.F.
RECOVERY		4,700 S.F.
SUPPORT		2,660 S.F.
		2,950 S.F.
CORRIDOR		5,590 S.F.

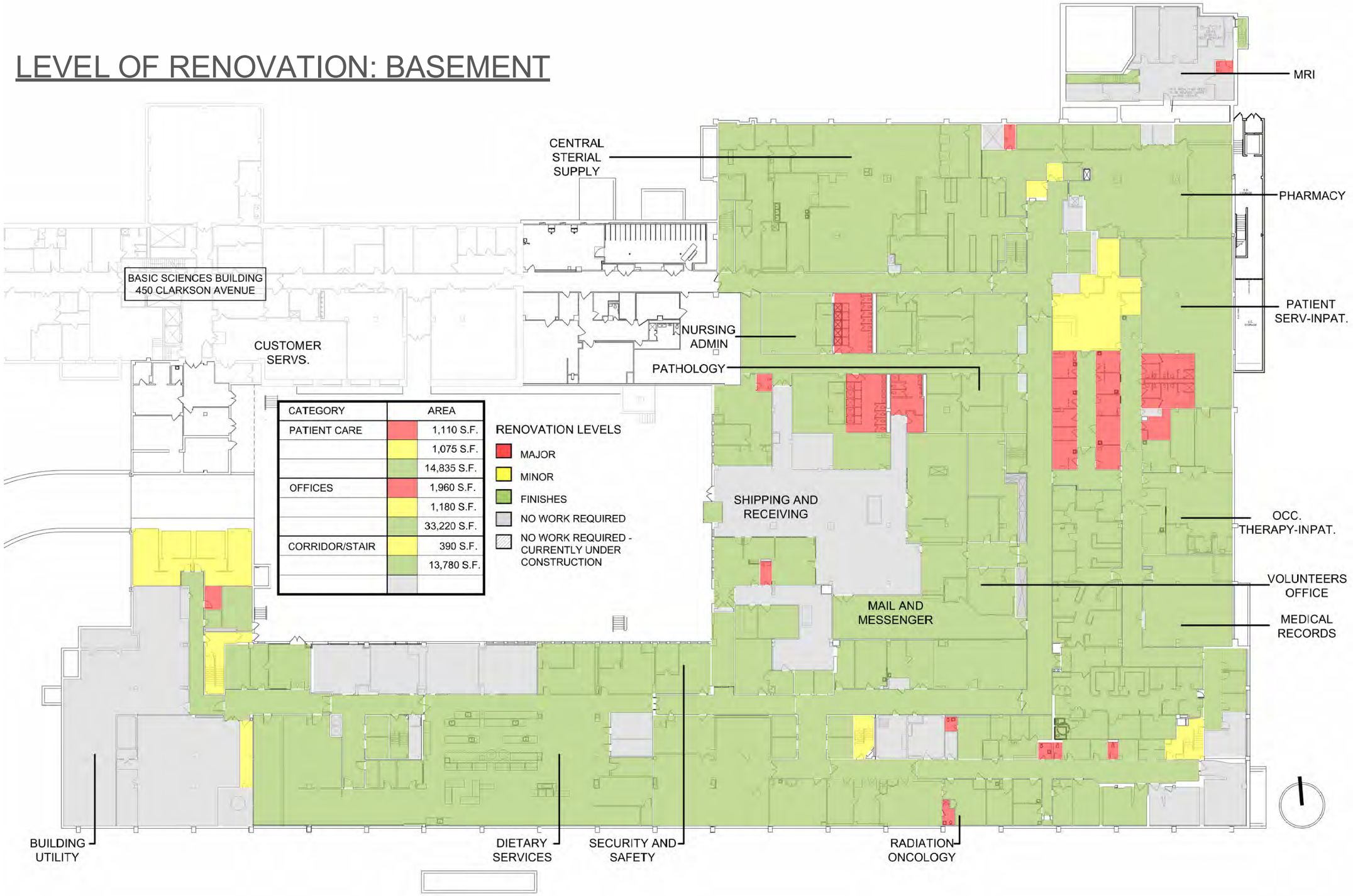
CARDIOLOGY / OUT PAT.		4,235 S.F.

LEVEL OF RENOVATION: LEVEL 1

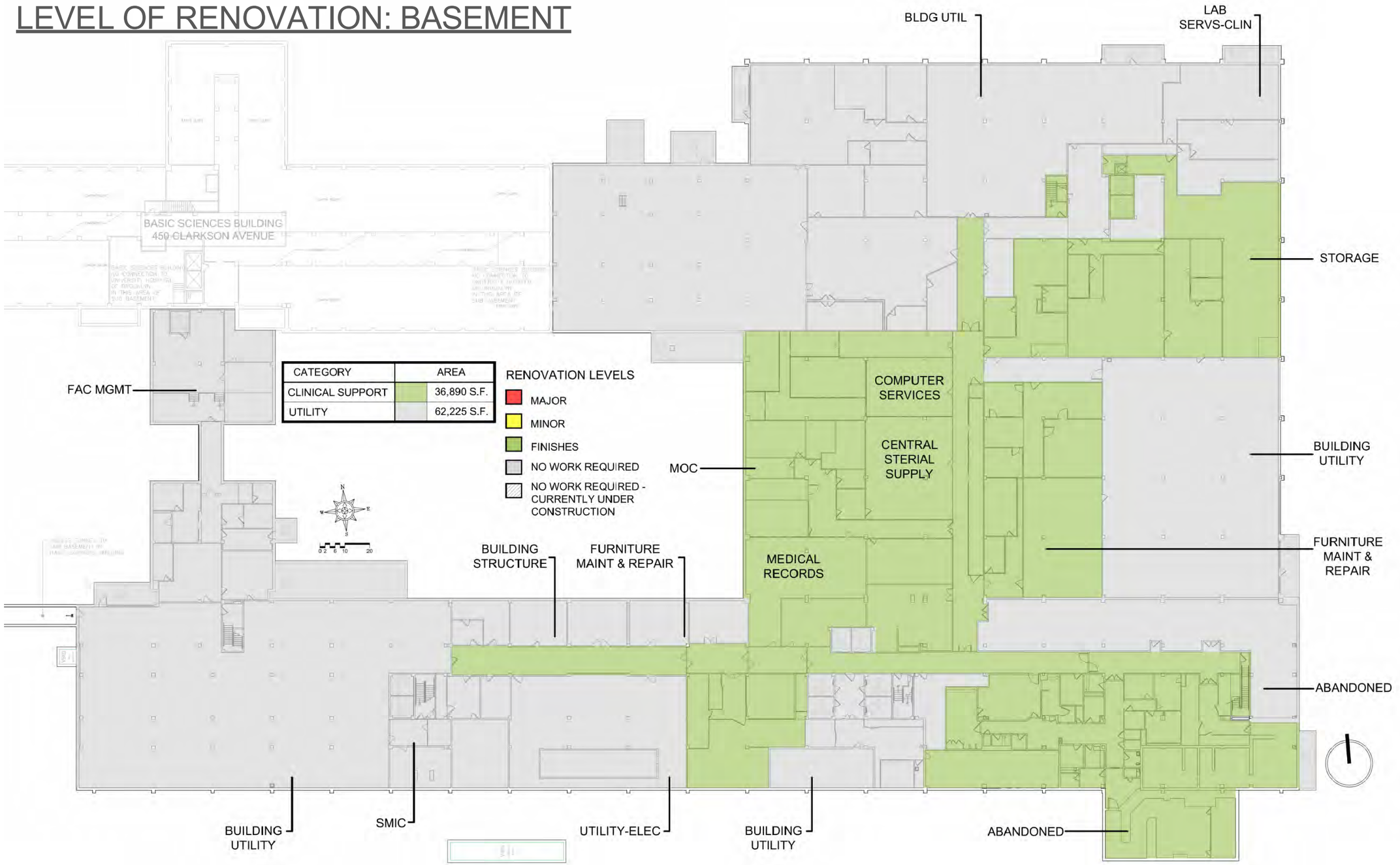


CATEGORY	AREA
PATIENT CARE	2,380 S.F.
	3,180 S.F.
	24,200 S.F.
OFFICES/PUBLIC	1,000 S.F.
	400 S.F.
	15,530 S.F.
E.D.	8,350 S.F.
	770 S.F.
CORRIDOR/STAIR	2,520 S.F.
	420 S.F.
	19,290 S.F.
NO WORK	4,390 S.F.

LEVEL OF RENOVATION: BASEMENT

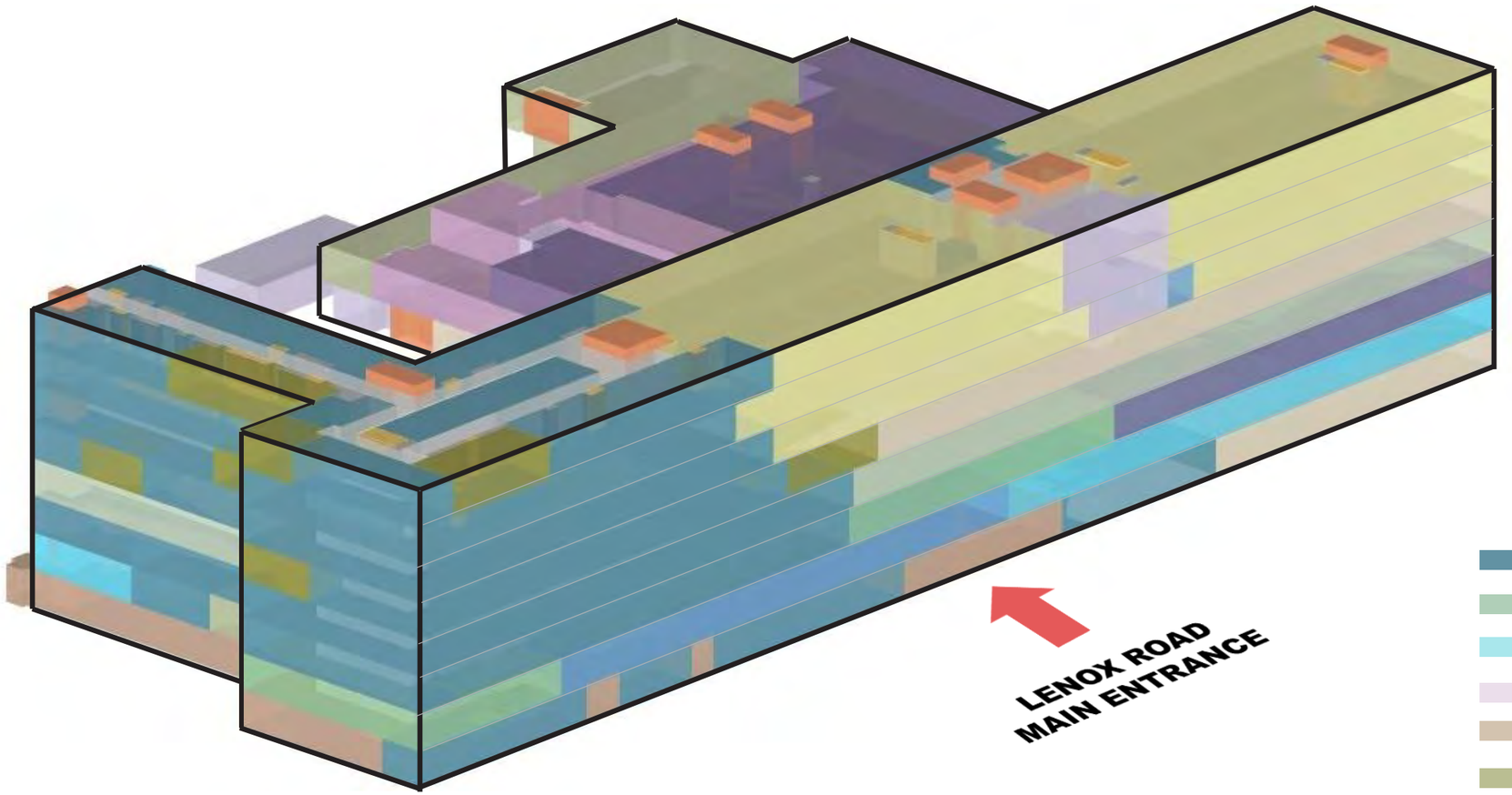


LEVEL OF RENOVATION: BASEMENT



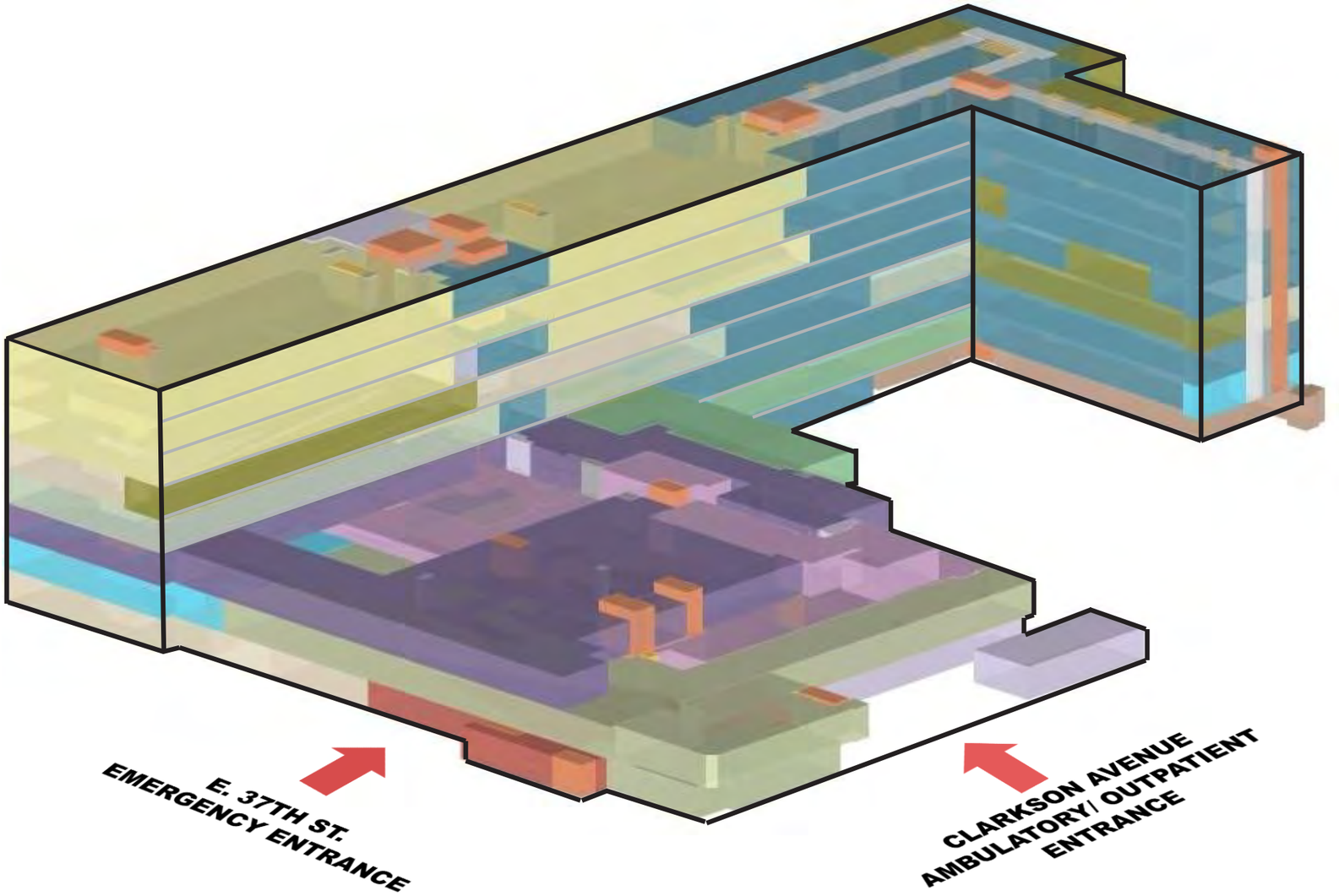
PRELIMINARY COST MODELING

Levels 4 through 8	$/SF	Reno COST	
Major (including MEP)	$880	**$146,944,725**	MED/SURG, PEDIATRICS, OUTPATIENT, OFFICES, CLINICAL SUPPORT, EDUCATION/RESEARCH
Minor (including MEP)	$795		
Finishes (including MEP)	$740		
Level 3	**$/SF**	**Reno COST**	
Major (including MEP)	$1,350	**$66,892,750**	OBSTETRICS, CRITICAL CARE, NICU, SURGICAL SUPPORT, OFFICES
Minor (including MEP)	$1,225		
Finishes (including MEP)	$1,150		
Level 2	**$/SF**	**Reno COST**	
Major (including MEP)	$1,425	**$113,329,125**	SURGICAL SERVICES, RADIOLOGY, CRITICAL CARE, CLINICAL LABS, CARDIOLOGY, OFFICES
Minor (including MEP)	$1,300		
Finishes (including MEP)	$1,225		
Level 1	**$/SF**	**Reno COST**	
Major (including MEP)	$1,075	**$70,807,150**	EMERGENCY, OUTPATIENT, ADMIN/OFFICES, IMAGING, CUSTOMER SERVICES, LOBBY
Minor (including MEP)	$930		
Finishes (including MEP)	$865		
Basement Level	**$/SF**	**Reno COST**	
Major (including MEP)	$860	**$49,209,835**	CENTRAL STERILE, KITCHEN, OUTPATIENT, CLINICAL SUPPORT, FACILITIES
Minor (including MEP)	$775		
Finishes (including MEP)	$720		
Interior Renovation Total		**$447,183,585**	LEVELS 1-8, BASEMENT, MEP
Exterior Upgrades Total		**$41,553,207**	SITE, ROOFS, BUILDING ENVELOPE
		$488,736,792	
Escalation (5% over 7 years)		$182,787,560	
		$671,524,352	
Phasing / Temp Relocations / Surge Planning - 25%		$167,881,088	
Preliminary Cost Model		**$839,405,440**	



- Admin/ Offices
- Critical Care Unit
- Clinical Labs
- Clinical Support
- Customer Services
- Education/ Research
- Emergency Unit
- Imagining and Radiology
- Med/ Surg
- Obstetrical Unit
- Outpatient
- Pediatrics
- Rehab/ Ortho/ Speech/ Therapy
- Surgical Services

23 JANUARY 2025



- Admin/ Offices
- Critical Care Unit
- Clinical Labs
- Clinical Support
- Customer Services
- Education/ Research
- Emergency Unit
- Imagining and Radiology
- Med/ Surg
- Obstetrical Unit
- Outpatient
- Pediatrics
- Rehab/ Ortho/ Speech/ Therapy
- Surgical Services

DCAB Report
Appendix 4-A

Scenario Modeling

Summary – Scenario Overview

	Scenario Description to Inform Modeling Inputs
Scenario 1a *Brooklyn for Downstate Option 2: Single Building for Hospital and Outpatient*	**Capital**: Unbound **Detail:** Demolish 3-story section of current hospital footprint and part of college, build new 16 story hospital. No investment in remaining current hospital.
Scenario 1b *Brooklyn for Downstate Option 5: Hospital + Outpatient Building*	**Capital**: Unbound **Detail:** Demolish 3-story section of current hospital footprint and build new 7-story outpatient building. Build new 14-story inpatient hospital on garage site. No investment in remaining current hospital.
Scenario 2a *Partially Renovate Hospital + Build Ambulatory + Rightsized ED*	**Capital**: Bound to $750M **Detail:** New ASC, ED right-size, 45 patient room renovation
Scenario 2b *Renovate Hospital + Build Ambulatory + Expand ED*	**Capital**: Unbound **Detail:** New ASC from 2a, ED expansion (42 treatment bays + 3 obs), renovate all Med/Surg Patient Rooms to single occupancy with private toilet room w/ shower and sink
Scenario 2c *Partially Renovate Hospital + Build Modified Ambulatory; Rightsized ED*	**Capital**: Bound to $750M[1] **Detail:** Modified 2a ASC (if necessary as needed to fit within budget) with infrastructure for future expansion, some hospital renovation (MEP and ED rightsizing, whatever number of patient rooms possible)
Scenario 3a *Ambulatory Center + New Inpatient Facility*	**Capital**: Unbound **Detail**: New advanced ASC, new 100-200 inpatient bed tower on garage site, limited current hospital rehab (MEP and ED minor renovation). Includes parking
Scenario 3b *Ambulatory Center*	**Capital**: Bound to $750M[1] **Detail:** Full investment in new advanced ASC only. No investment in current hospital
Scenario 4[2] *H+H Additional Collaboration*	**Capital**: Bound to $750M[1] **Detail:** Scenario 2 with phased collaboration with Kings County[2]

Notes: 1) With addition of $250 million in capital over five years, totaling $ 1 billion, and consideration of $125 million MEP project overlap. 2) Scenario 4 capital model matches Scenario 2 and therefore does not have a unique model depicted in *Appendix 4-A Scenarios Evaluated – Infrastructure*.

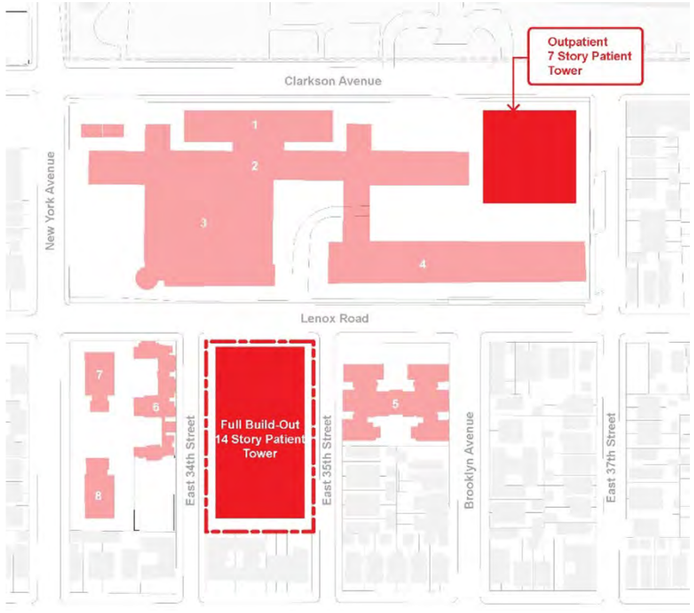
Summary – Scenario 1 (BFD)
Descriptions

Scenario 1a

Option 2 from Brooklyn for Downstate presentation to DCAB 5/7/2025.
Demolish 3-story section of current Hospital footprint and part of College, build new 16 story Hospital. No investment in remaining current Hospital. See Appendix 5 – Brooklyn for Downstate Presentation for more details.

Scenario 1b

Option 5 from Brooklyn for Downstate presentation to DCAB 5/7/2025.
Demolish 3-story section of current Hospital footprint and build new 7-story Outpatient building. Build new 14-story Inpatient Hospital on adjacent site. No investment in remaining current Hospital. See Appendix 5 – Brooklyn for Downstate Presentation for more details.



SCENARIO 1a, 1b SUMMARY

- To ensure consistency across all scenarios evaluated, DCAB infrastructure consultants applied the costing methodology used for all DCAB scenarios to Option 2 (Scenario 1a) and Option 5 (Scenario 1b) from the Brooklyn for Downstate (BFD) presentation delivered to DCAB on 5/7/2025. DCAB did not generate a massing diagram for this Scenario 1a or Scenario 1b.
  - To view BFD's original interpretation of Option 2 (Scenario 1a) and Option 5 (Scenario 1b) site plans, massing concepts, and cost estimates, see Appendix 5
- Cost estimate differences reflect varying assumptions for logistics/phasing, contractor requirements, construction manager fees, and contingency costs. Further variation resulted from differing escalation assumptions based on project timelines: BFD projected a 4-year construction period starting June 2028 and ending December 2032. DCAB modeling projected a 7-year construction period starting Fall 2031 and ending January 2039.
  - See the next slides for a line-by-line comparison of the cost estimate analyses

BFD 1a Estimate

$1,893,693,873
$852,780,397
$2,746,474,270

SCENARIO 1a COST MODELING

PRELIMINARY COST MODEL	$2,716,955,701
Total Anticipated SOFT COSTS	$869,425,824
TOTAL COST ESTIMATE	$3,586,381,525

BFD 1b Estimate

$1,652,958,441
$803,550,001
$2,456,508,442

SCENARIO 1b COST MODELING

PRELIMINARY COST MODEL	$2,846,997,790
Total Anticipated SOFT COSTS	$905,450,526
TOTAL COST ESTIMATE	$3,752,448,316

Total project duration for Scenario 1 models is +/- 12 years

SCENARIO 1a COST MODEL

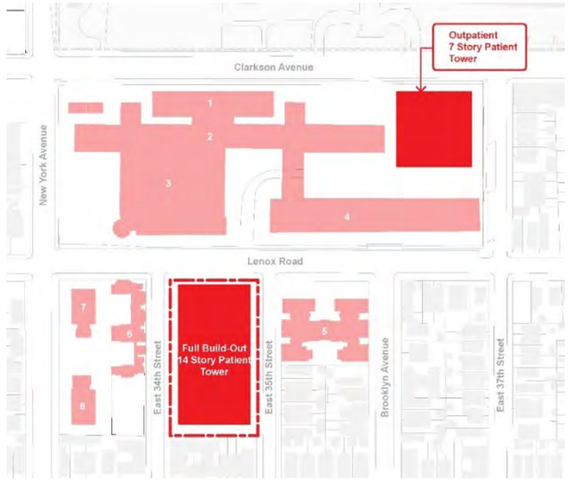
Brooklyn for Downstate, Option 2,
run against previous Cost Model calculation metrics/ factors

- Demolish 3-story section of current hospital footprint and part of college, build new 16 story hospital.
- No investment in remaining current hospital.

	B4D Cost Model	SCENARIO 1a Brooklyn for Downstate Option 2 - New Build Hospital Existing Hospital - No MEP Upgrades / No Renovations		
		New Hospital - 846,400 GSF		
		Site Prep / Demolition	$4,803,300	
		New Build Hospital	$1,244,208,000	
		Site / Utilities allowance	$10,000,000	
		Connector to Existing Hospital	$3,000,000	
		Renovated Existing Building at Connector	$700,000	
Line "A"	**$1,111,468,484**	**Subtotal**	**$1,262,711,300**	
	1.5% + 0.50%	Subcontractor Insurance / GL	included above	
		Logistics / Phasing	10%	$126,271,130
	4% + 9%	Contractor General Requirements / General Conditions	15%	$189,406,695
	3%	CM Fee	5%	$69,449,122
Line "H"	**$1,336,290,161**	**Hard Construction Cost value**	**$1,647,838,247**	
	15%	Contingency	20%	
	26.71% (61 month mid)	escalation (5%) construction midpoint (Apr 2035) 9.25 y	$739,549,805	
Line "L"	**$1,893,693,873**	**Hard Construction Cost + Contingencies**	**$2,716,955,701**	
	$1,893,693,873	**SCENARIO 1a PRELIMINARY COST MODEL**	**$2,716,955,701**	
SOFT COSTS	$126,960,000	Professional Fees + Reimb	$326,034,684	
		Commissioning (2%)	$54,339,114	
	$296,240,000	Equipment / FF&E (18%)	$489,052,026	
	$179,900,918	OCIP Costs		
	$249,679,479	Owner Contingency		
	$852,780,397	Total	$869,425,824	
Line "Q"	**$2,746,474,270**	**Project Total Hard + Soft Costs**	**$3,586,381,525**	

Total project duration for Scenario 1a model is +/- 12 years

SCENARIO 1b COST MODEL



Brooklyn for Downstate, Option 5,
run against previous Cost Model calculation metrics/ factors

- Demolish 3-story section of current build new 7-story outpatient building in its place.
- Build new 14-story inpatient hospital on current parking garage site.
- No investment in remaining current hospital.

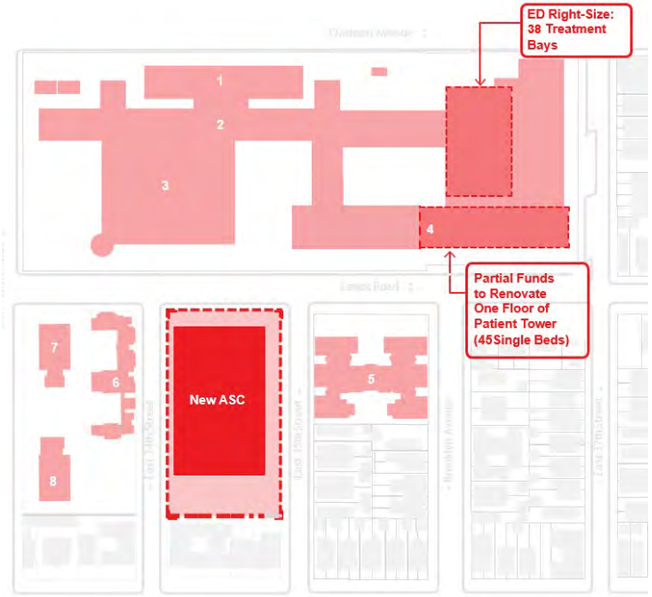
Total project duration for Scenario 1b model is +/- 12 years

	B4D Cost Model	SCENARIO 1b Brooklyn for Downstate Option 5 - New Build Outpatient Facility + New Hospital Existing Hospital - No MEP Upgrades / No Renovations		
		New D&T Center - 200,361 GSF		
		Site Prep /Demolition		$3,475,800
		New Build D&TC		$324,584,820
		Site / Utilities allowance		$10,000,000
Line "A"	**$284,268,338**	**Subtotal**		**$338,060,620**
		New Hospital - 646,039 GSF		
		New Build Hospital		$949,677,330
		Site / Utilities allowance		$12,250,000
Line "A"	**$734,113,508**	**Subtotal**		**$961,927,330**
		New Hospital and D&TC - combined		
	1.5% +0.50%	Subcontractor Insurance /GL		
		Logistics /Phasing	10%	$149,498,614
	4% +9%	Contractor General Requirements /General Conditions	15%	$194,998,193
	3%	CM Fee	5%	$82,224,238
Line "H"	**$1,224,374,473**	**Hard Construction Cost value**		**$1,726,708,995**
	15%	Contingency	20%	$345,341,799
	26.71% (61 monthmid)	escalation (5%) construction midpoint (Apr 2035) 9.25 yr		$774,946,997
Line "L"	**$1,652,958,441**	**Hard Construction Cost + Contingencies**		**$2,846,997,790**
	$1,652,958,441	**SCENARIO 1b PRELIMINARY COST MODEL**		**$2,846,997,790**
SOFT COSTS	$126,960,000	Professional Fees + Reimb		$336,050,968
		Commissioning (2%)		$56,939,956
	$296,240,000	Equipment / FF&E (18%)		$512,459,602
	$157,031,052	OCIP Costs		
	$223,318,949	Owner Contingency		
	$803,550,001	Total		$905,450,526
Line "Q"	**$2,456,508,442**	**Project Total Hard + Soft Costs**		**$3,752,448,316**

Summary - Scenario 2
Descriptions

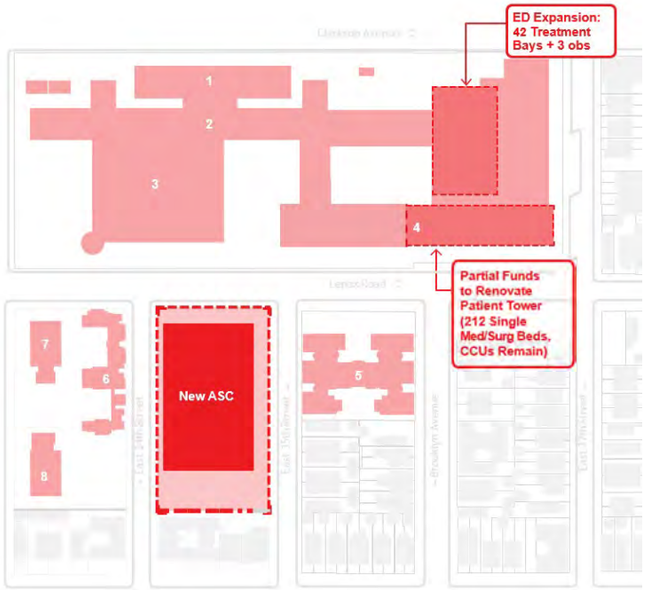
Scenario 2a

New Ambulatory Surgery Center focused on cardiology & oncology. Existing Hospital renovation: right-size the ED to maintain 38 stations, renovate one floor of Med/Surg Patient Rooms to single occupancy, and MEP upgrades throughout Hospital.



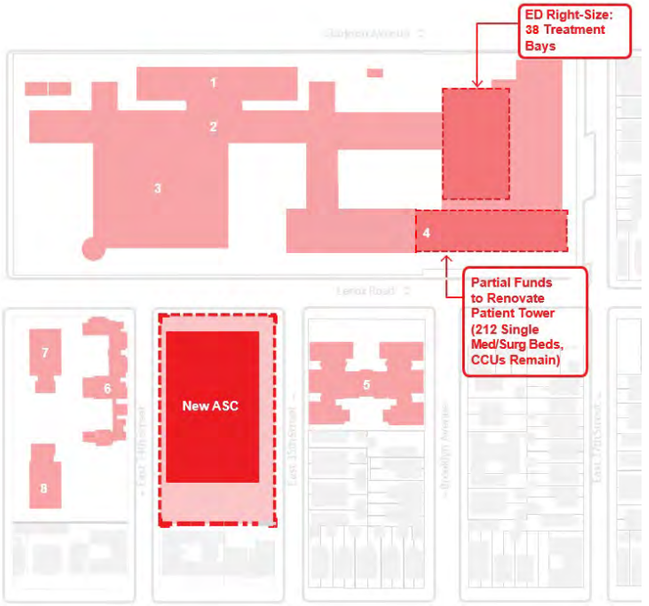
Scenario 2b – UNBOUND

New Ambulatory Surgery Center focused on cardiology & oncology. Existing Hospital renovation: expand the ED to 42 stations + 3 obs, renovate all Med/Surg Patient Rooms to single occupancy, and MEP upgrades throughout Hospital.



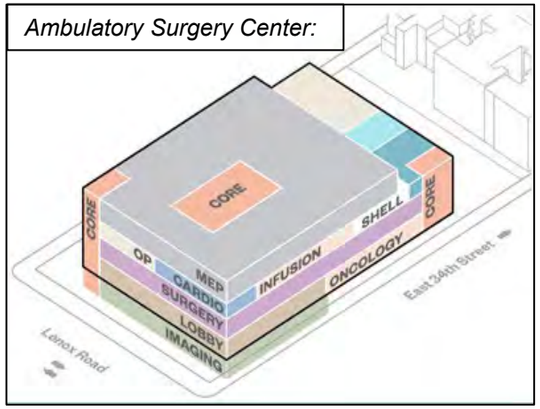
Scenario 2c – BOUND

New Ambulatory Surgery Center (reduced program/SF as needed to fit budget) with infrastructure to support future expansion. Existing Hospital renovation: right-size the ED to maintain 38 stations, renovate as many Med/Surg Patient Rooms to single occupancy as possible within budget, and MEP upgrades throughout Hospital.



SCENARIO 2a, 2b, 2c SUMMARY

Scenario 2a



Existing Hospital renovation: right-size the ED to maintain 38 stations, renovate one floor of Med/Surg Patient Rooms to single occupancy, and MEP upgrades throughout Hospital.

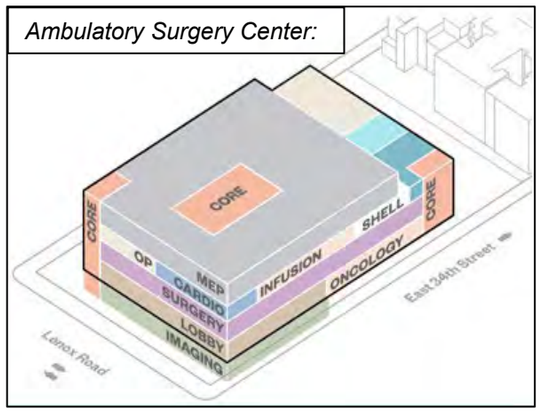
SCENARIO 2a COST MODELING

PRELIMINARY COST MODEL	$792,940,573	$870,150,362
minus $125M*	$667,940,573	$745,150,362
Total Anticipated SOFT COSTS	$277,500,000	

*Considers current MEP projects underway

TOTAL COST ESTIMATE	$945,440,573	$1,022,650,362

Scenario 2b



Existing Hospital renovation: expand the ED to 42 stations + 3 obs, renovate all Med/Surg Patient Rooms to single occupancy, and MEP upgrades throughout Hospital.

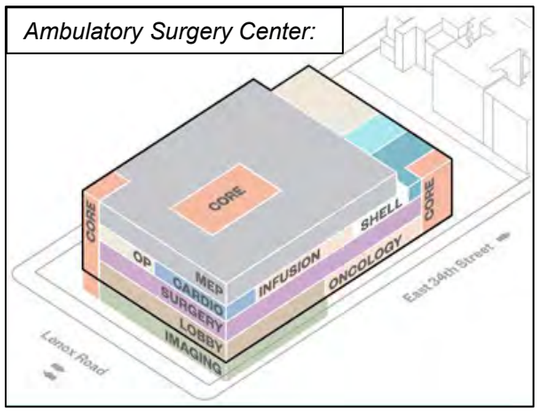
SCENARIO 2b COST MODELING

PRELIMINARY COST MODEL	$873,815,712	$946,050,476
minus $125M*	$748,815,712	$821,050,476
Total Anticipated SOFT COSTS	$277,500,000	

*Considers current MEP projects underway

TOTAL COST ESTIMATE	$1,026,315,712	$1,098,550,476

Scenario 2c



Existing Hospital renovation: right-size the ED to maintain 38 stations, renovate as many Med/Surg Patient Rooms to single occupancy as possible within budget (all rooms modeled), and MEP upgrades throughout Hospital.

SCENARIO 2c COST MODELING

PRELIMINARY COST MODEL	$875,063,440	$949,714,229
minus $125M*	$750,063,440	$824,714,229
Total Anticipated SOFT COSTS	$277,500,000	

*Considers current MEP projects underway

TOTAL COST ESTIMATE	$1,027,563,440	$1,102,214,229

After evaluation, DCAB requested that Scenario 2a, 2b, 2c be further studied as "Scenario 2," which included:

- The same new Ambulatory Surgery Center, with infrastructure to support future expansion
- Hospital renovation: 1) MEP upgrades throughout Hospital, 2) Modernize and expand ED to 42 stations + 3obs, 3) Renovate all patient beds to single occupancy (including med/surg and critical care units)

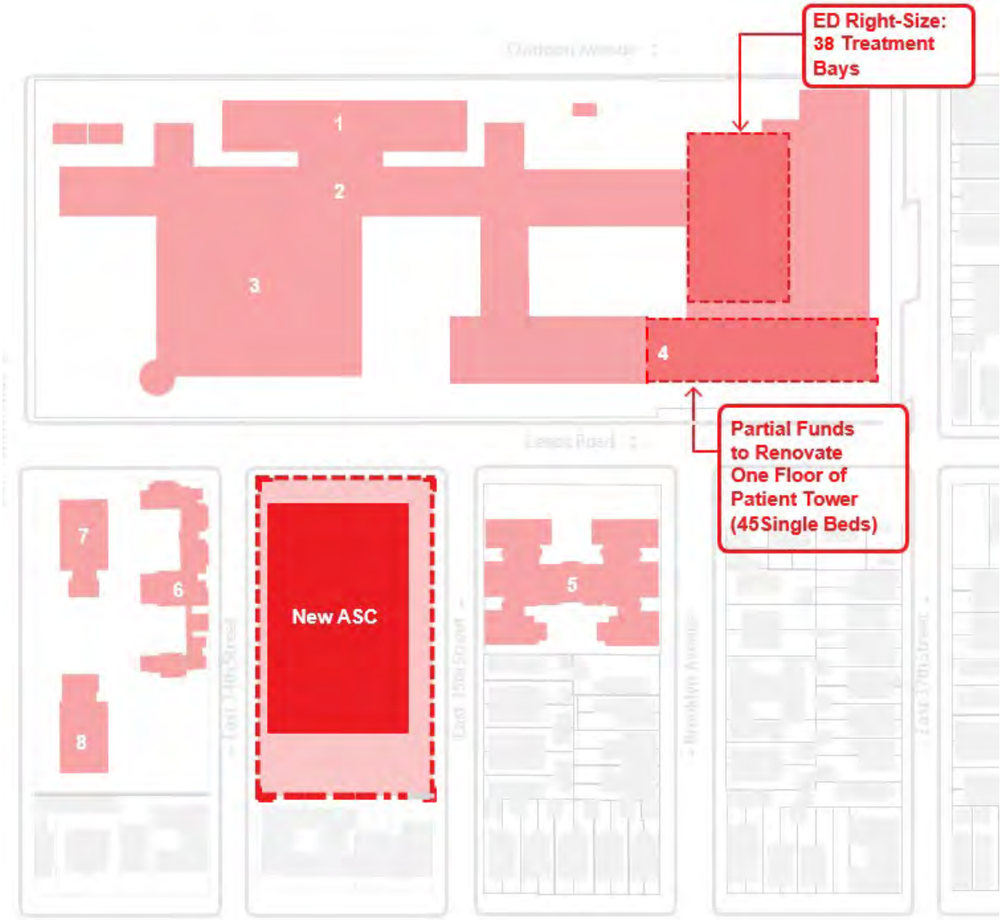
See "Appendix B – DCAB Recommendation Model" for more information

Total project duration for Scenario 2 models is +/- 7 years

SCENARIO 2a

Scenario 2a

- Construct new Ambulatory Surgery Center on current parking garage site. Includes imaging, procedure rooms, ambulatory surgery, and outpatient clinics
- Renovate 45 Med-Surg patient rooms in existing hospital to single bed occupancy.
- Right-size ED for current 38 key room count.
- Assume decanting of some outpatient clinics to support modernization, renovation, and expansion of the existing ED
- MEP upgrades throughout existing hospital



SCENARIO 2a KEY UNITS

KEY DRIVERS

Floors:

4

+1 Basement

Surgery

- ORs **5**
- Hybrid OR **1**
- Pre-Post **18**

Cardiology

- Cath Labs **2**
- IR **1**
- Procedure Rooms **3**

Oncology

Infusion

- Infusion Rooms **6**

Imaging

- Mammography **2**
- CT Sim **1**
- PET CT **1**

Treatment

- Linac **1**

Emergency

- Exams Rooms **36**
- Resuscitation Rooms **2**

***Renovated + Right-Sized**

Imaging

- CT **1**
- MRI **1**
- X-Ray **2**
- Ultrasound **2**
- PET CT **-**

Procedure Suite

- Procedure Rooms **2**

Outpatient

Faculty Exam

- Exam Rooms **24**

Inpatient

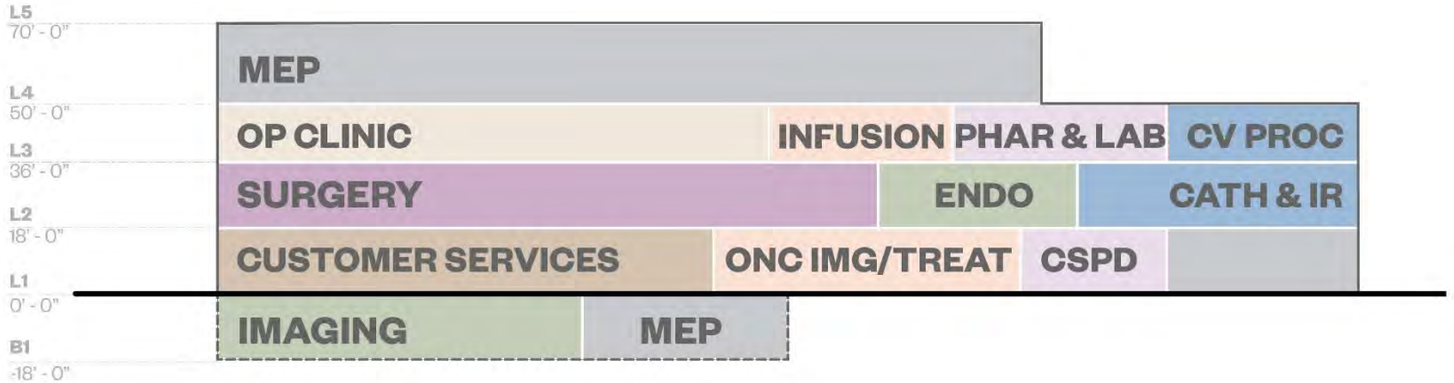
- Beds **45**

***45 Existing Patient Rooms Converted to Single Bedded Rooms**

SCENARIO 2a DIAGRAM

STACKING DIAGRAM

East 34th Street

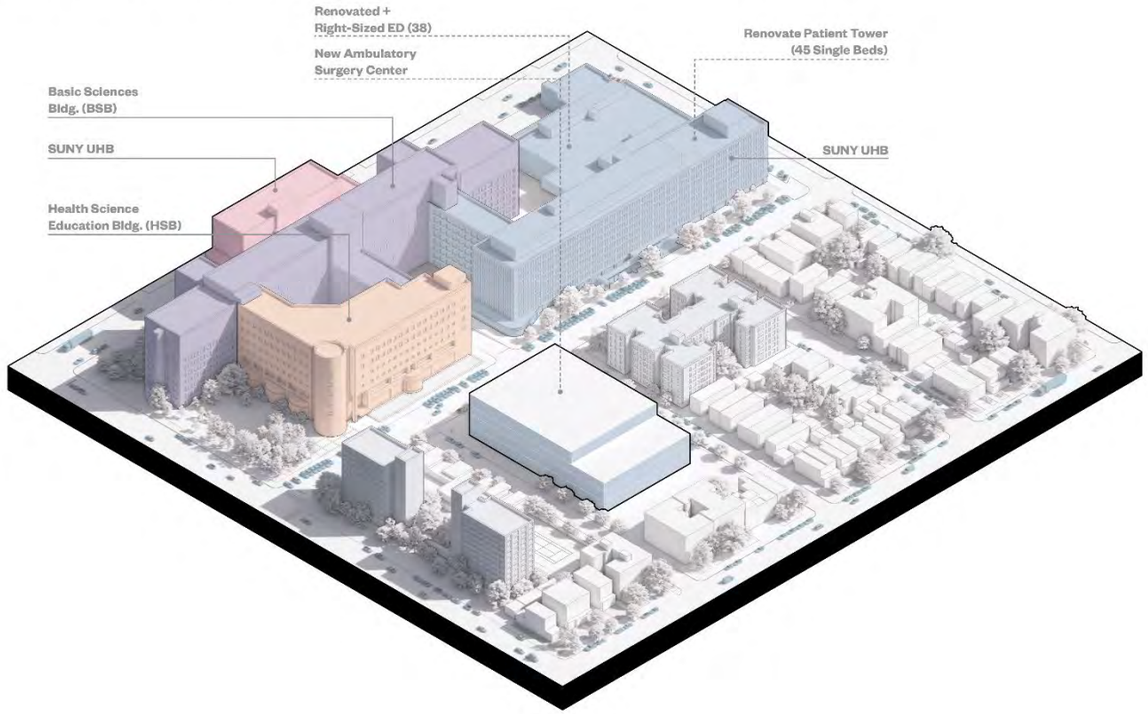


PROGRAM LEGEND

Outpatient:	18,060 sf	Oncology	16,360 sf	**Totals**	
Imaging + Radiology:	13,300 sf	Customer Services:	13,000 sf	DGSF:	110,780 sf
Surgery:	19,500 sf	Facilities	7,700 sf	Massing BGSF:	150,064 sf
Cardiology:	14,060 sf	Shell	4,600 sf		
Clinical Support	7,000 sf				
Admin:	1,800 sf				

SCENARIO 2a COST MODEL

ASC - CONTEXT



SCENARIO 2a Ambulatory Surgery Center - New Build Existing Hospital - Upgrades / Partial Renovation				
Lobby / Café Imaging Surgery / Procedure Oncology Cardiology Outpatient / Clinic Clinical Support Facilities Support Vertical Circulation	**New ASC**		low $2,000/SF	high $2,300/SF
	Building Gross SF	**150,064**	$300,128,000	$345,147,200
	Site, Utilities, Plantings	allowance	$15,000,000	$20,000,000
	escalation (5%) construction midpoint (Oct 2031) 5.75 yr		$102,053,905	$118,252,575
		New ASC Total	**$417,181,905**	**$483,399,775**
MEP Upgrade Emergency Department (right-sized) Patient Floors (reno)	**Existing Hospital Upgrades**			
	Site Improvements		**$1,000,000**	
	Upgrade MEP (Existing Hospital, balance of)		**$243,376,000**	
	Optimize Emergency Dept (Existing Hospital)		$1,150/SF (includes MEP)	
	38 Stations 460-650 SF/station	low 17,480 SF	high 24,700 SF	**$20,102,000**	**$28,405,000**
	Patient Floor Rehab (Existing Hospital) **Standard Single Rooms & Toilets**		$880/SF (includes MEP)	
	+/- 22,000 SF (one floor)	low 43 beds	high 46 beds	**$19,360,000**	
	escalation (5%) construction midpoint (Oct 2031) 5.75 yr		$91,920,668	$94,609,587
		Existing Hospital Renovation Total	**$375,758,668**	**$386,750,587**
		SCENARIO 2a PRELIMINARY COST MODEL	**$792,940,573**	**$870,150,362**
		minus $125M (Current MEP projects underway)	**$667,940,573**	**$745,150,362**

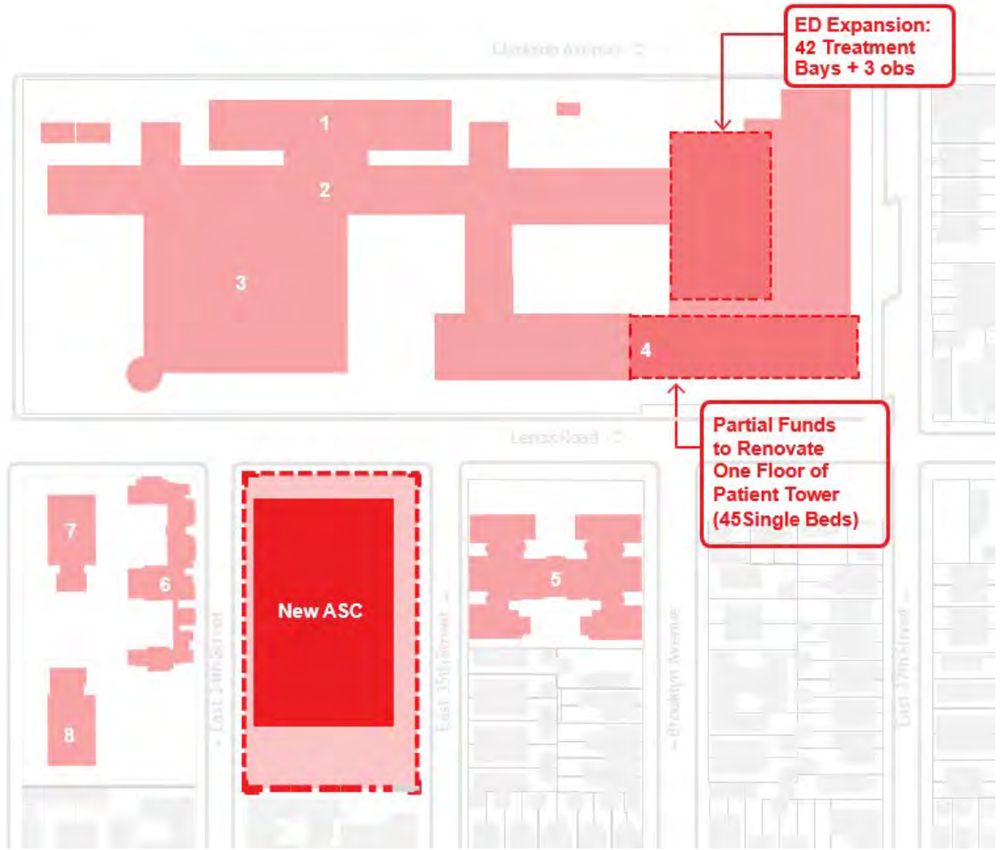
Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

Total project duration for Scenario 2a model is +/- 7 years

SCENARIO 2b

Scenario 2b

- Construct new Ambulatory Surgery Center on current parking garage site. Includes imaging, procedure rooms, ambulatory surgery, and outpatient clinics
- Renovate in-place all 152 Med-Surg patient rooms in existing hospital to single bed occupancy. 60 inpatient CCU to remain (CCU, PICU, NICU)
- ED expansion to 42 treatment bays and 3 observation bays.
- Assume decanting of some outpatient clinics to support modernization, renovation, and expansion of the existing ED
- MEP upgrades throughout existing hospital



SCENARIO 2b KEY UNITS

KEY DRIVERS

Floors:

4

+1 Basements

Surgery

• ORs	5
• Hybrid OR	1
• Pre-Post	18

Cardiology

• Cath Labs	2
• IR	1
• Procedure Rooms	3

Oncology

Infusion

• Infusion Rooms	6

Imaging

• Mammography	2
• CT Sim	1
• PET CT	1

Treatment

• Linac	1

Emergency

• Exams Bays	42
• Observation	3

***Renovated + Expanded**

Imaging

• CT	1
• MRI	1
• X-Ray	2
• Ultrasound	2
• PET CT	-

Procedure Suite

• Procedure Rooms	2

Outpatient

Faculty Exam

• Exam Rooms	24

Inpatient

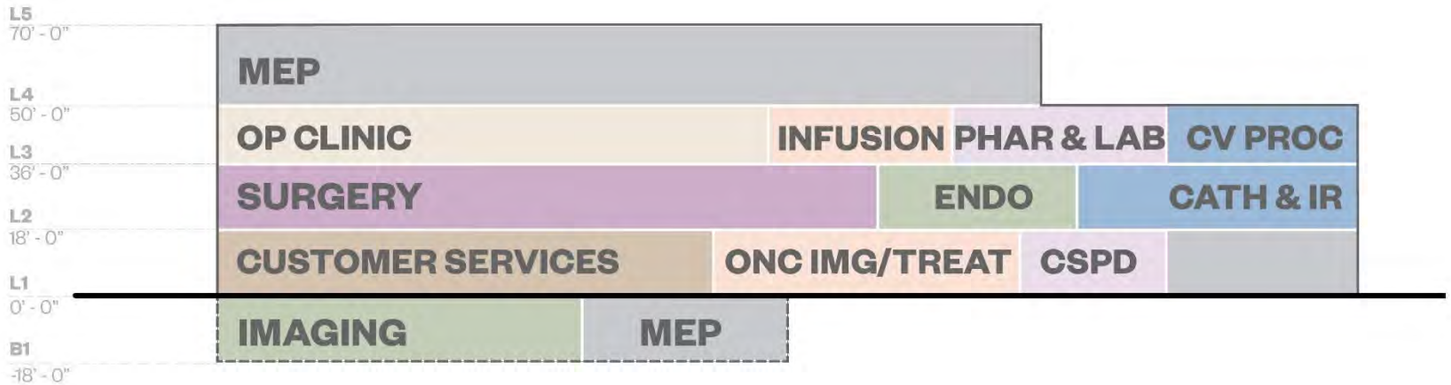
• Beds, Med-Surg	212

***All Existing Patient Rooms Converted to Single Bedded Rooms. ICUs Remain In-Place**

SCENARIO 2b DIAGRAM

STACKING DIAGRAM

East 34th Street



PROGRAM LEGEND

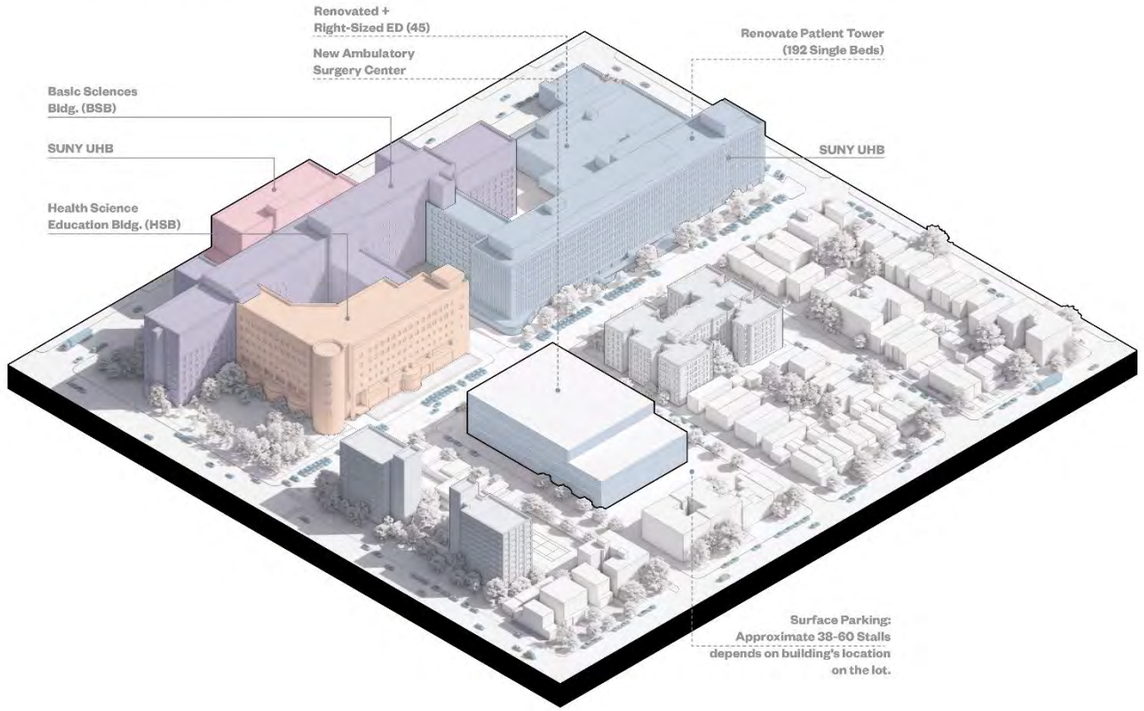
Outpatient:	18,060 sf	
Imaging + Radiology:	13,300 sf	
Surgery:	19,500 sf	
Cardiology:	14,060 sf	
Clinical Support	7,000 sf	
Admin:	1,800 sf	
Oncology	16,360 sf	
Customer Services:	13,000 sf	
Facilities	7,700 sf	
Shell	4,600 sf	

Totals

DGSF:	110,780 sf
Massing BGSF:	150,064 sf

SCENARIO 2b COST MODEL

ASC - CONTEXT



SCENARIO 2b - UNBOUND
Ambulatory Surgery Center - New Build
Existing Hospital - MEP Upgrades + 45 Station Right-Sized ED + Inpatient Reno to Single Rooms

						low $2,000/SF	high $2,300/SF
Lobby / Café Imaging Surgery / Procedure Oncology Cardiology Outpatient / Clinic Clinical Support Facilities Support	**New ASC**						
	Building Gross SF (maintained original Scenario 2SF)			**150,064**		$300,128,000	$345,147,200
	Site, Utilities, Plantings			allowance		$15,000,000	$20,000,000
	escalation (5%) construction midpoint (Oct 2031) 5.75 yr					$102,053,905	$118,252,575
				New ASC Total		**$417,181,905**	**$483,399,775**
MEP Upgrade Emergency Department (expansion) Patient Floors (Levels 3,4,6-8) (reno for Single occupancy)	**Existing Hospital Upgrades**						
	Site, Roofs, Building Envelope Upgrades					**$41,553,207**	
	Upgrade MEP (Existing Hospital, balance of)					**$214,815,700**	
	Optimize Emergency Dept (Existing Hospital)					$1,150/SF (includes MEP)	
	42+3 Stations 550-650 SF/station	(existing) 38 stations	low 24,750 SF	high 29,250 SF		**$28,462,500**	**$33,637,500**
	INPATIENT ROOMS Resulting bed count: **212** (existing 18) 3	**Patient Floor Rehab (Existing Hospital)** Standard Single Rooms & Toilets w/Showers				$880/SF (includes MEP)	
		Level 8 (Transplant MEP only)	(existing) 66 beds	reno 18 rooms/24ETR	new total **44 beds**	**$12,008,500**	
		Level 7 22,000 SF	(existing) 76 beds	reno 36 rooms	new total **42 beds**	**$19,360,000**	
		Level 6 22,000 SF	(existing) 74 beds	reno 38 rooms	new total **42 beds**	**$19,360,000**	
		Level 4 PEDS Beds - 9,710 SF	(existing) 22 beds	reno 12 rooms	new total **13 beds**	**$8,739,000**	
		Level 3 OBGYN Beds	under renovation		new total **11 beds**	MEP ONLY	
		Existing 5 PICU, 29 NICU, 26 CCU to remain				MEP ONLY	
		escalation (5%) construction midpoint (Oct 2031) 5.75 yr				$112,334,900	$113,176,794
				Existing Hospital Renovation Total		**$456,633,807**	**$462,650,701**
					SCENARIO 2b PRELIMINARY COST MODEL	**$873,815,712**	**$946,050,476**
					minus $125M (Current MEP projects underway)	**$748,815,712**	**$821,050,476**

Preliminary Cost Modeling note: Costs for different program needs averaged across all space use/departments

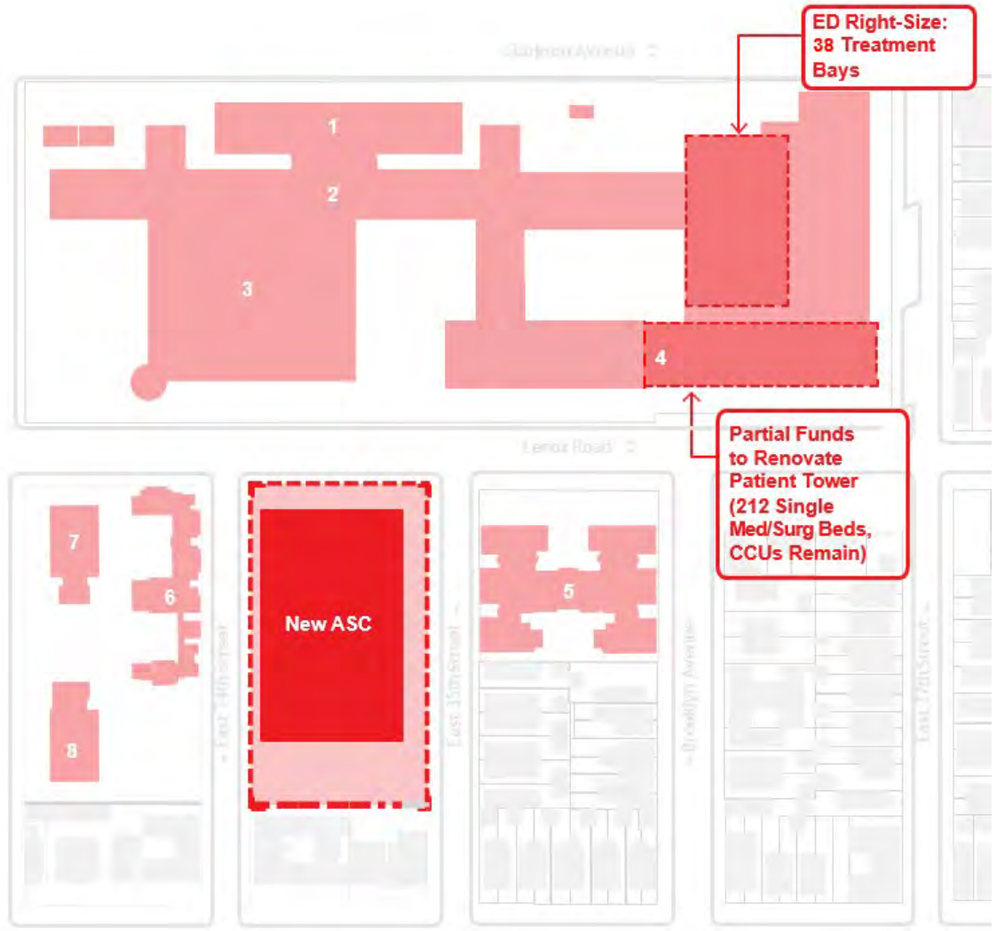
Total project duration for Scenario 2b model is +/- 7 years

SCENARIO 2c

Scenario 2c

- Construct new Ambulatory Surgery Center on current parking garage site with infrastructure to support future expansion. Includes imaging, procedure rooms, ambulatory surgery, and outpatient clinics

- Hospital renovation as budget permits: MEP upgrades, ED right-sizing, patient room upgrades



SCENARIO 2c KEY UNITS

KEY DRIVERS

Floors:

4

+1 Basement

Surgery

• ORs	5
• Hybrid OR	1
• Pre-Post	18

Cardiology

• Cath Labs	2
• IR	1
• Procedure Rooms	3

Oncology

Infusion

• Infusion Rooms	6

Imaging

• Mammography	2
• CT Sim	1
• PET CT	1

Treatment

• Linac1	1

Emergency

• Exams Rooms	36
• Resuscitation Rooms	2

**** Renovated + Right-Sized***

Imaging

• CT	1
• MRI	1
• X-Ray	2
• Ultrasound	2
• PET CT	-

Procedure Suite

• Procedure Rooms	2

Outpatient

Faculty Exam

• Exam Rooms	24

Inpatient

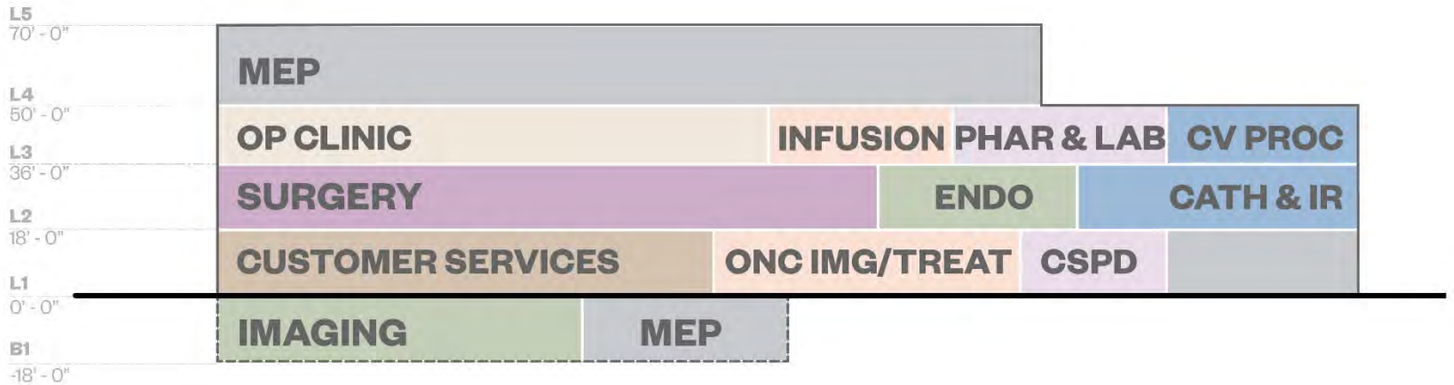
• Beds, Med-Surg	212

**** All Existing Patient Rooms Converted to Single Bedded Rooms. ICUs Remain In-Place***

SCENARIO 2c DIAGRAM

STACKING DIAGRAM

East 34th Street



PROGRAM LEGEND

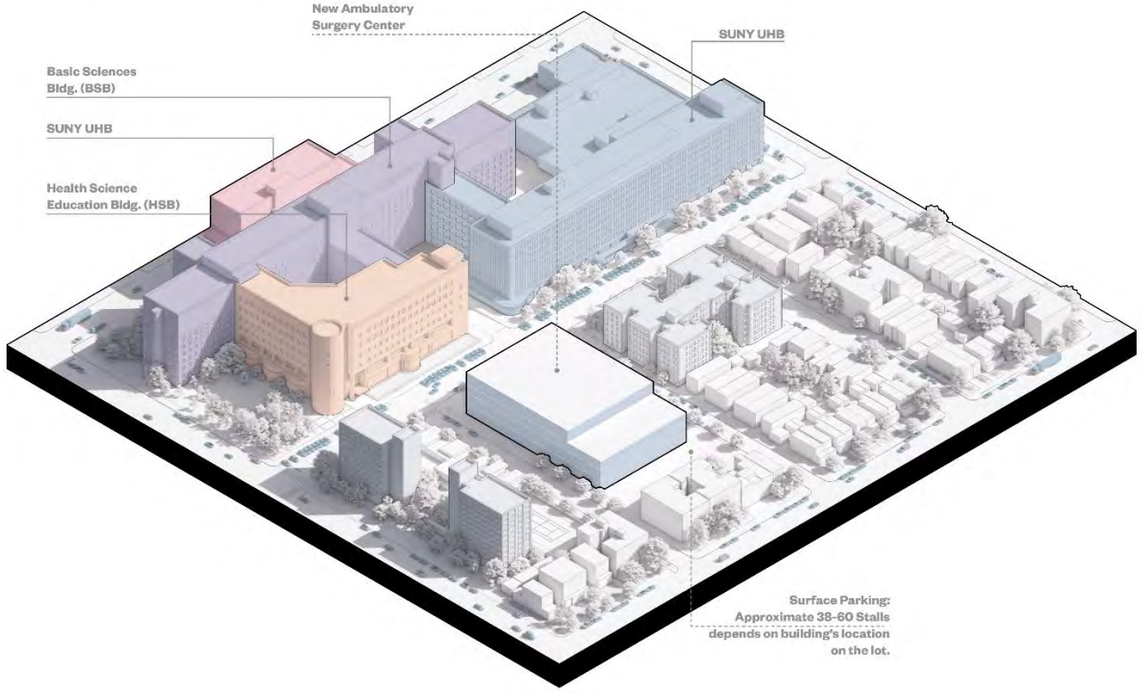
Outpatient:	18,060 sf	
Imaging + Radiology:	13,300 sf	
Surgery:	19,500 sf	
Cardiology:	14,060 sf	
Clinical Support	7,000 sf	
Admin:	1,800 sf	
Oncology	16,360 sf	
Customer Services:	13,000 sf	
Facilities	7,700 sf	
Shell	4,600 sf	

Totals

DGSF:	110,780 sf
Massing BGSF:	150,064 sf

SCENARIO 2c COST MODEL

ASC - CONTEXT



Total project duration for Scenario 2c model is +/- 7 years

SCENARIO 2c - $750M BOUND
Ambulatory Surgery Center - New Build
Existing Hospital - MEP Upgrades + 38 Station Right-Sized ED

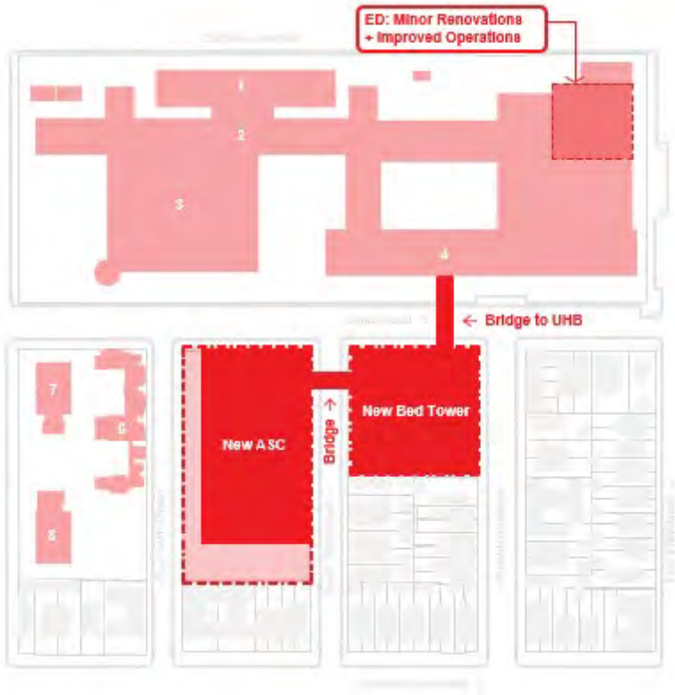
					low $2,000/SF	high $2,300/SF
Lobby / Café Imaging Surgery / Procedure Oncology Cardiology Outpatient / Clinic Clinical Support Facilities Support		**New ASC**				
		Building Gross SF	**150,064**		$300,128,000	$345,147,200
		Infrastructure upgrade			$6,000,000	$8,000,000
		Site, Utilities, Plantings	allowance		$15,000,000	$20,000,000
		escalation (5%) construction midpoint (Oct 2031) 5.75 yr			$103,996,999	$120,843,368
		New ASC Total			**$425,124,999**	**$493,990,568**
MEP Upgrade Emergency Department (right-sized) Patient Floors (Levels 3,4,6-8) (reno for Single occupancy)		**Existing Hospital Upgrades**				
		Site, Roofs, Building Envelope Upgrades			**$41,553,207**	
		Upgrade MEP (Existing Hospital, balance of)			**$214,815,700**	
		Optimize Emergency Dept (Existing Hospital)			$1,150/SF (includes MEP)	
		38 Stations 550-650 SF/station	(existing) 38 stations	low 20,900SF	high 24,700SF	**$24,035,000**	**$28,405,000**
	INPATIENT ROOMS Resulting bed count: **212** (existing 3	**Patient Floor Rehab (Existing Hospital)** Standard Single Rooms & Toilets w/Showers				$880/SF (includes MEP)
		Level 8 (w/Transplant MEP only)	(existing) 66 beds	reno 18 rooms/24ETR	new total **44 beds**	**$12,008,500**
		Level 7 22,000 SF	(existing) 76 beds	reno 36 rooms	new total **42 beds**	**$19,360,000**
		Level 6 22,000 SF	(existing) 74 beds	reno 38 rooms	new total **42 beds**	**$19,360,000**
		Level 4 PEDS Beds - 9,710 SF	(existing) 22 beds	reno 12 rooms	new total **13 beds**	**$8,739,000**
		Level 3 OBGYN Beds	under renovation		new total **11 beds**	**MEP ONLY**
		Existing 5 PICU, 29 NICU, 26 CCU to remain			maintain **60 beds**	MEP ONLY
		escalation (5%) construction midpoint (Oct 2031) 5.75 yr				$110,067,034	$111,482,254
		Existing Hospital Renovation Total				**$449,938,441**	**$455,723,661**
		SCENARIO 2c PRELIMINARY COST MODEL				**$875,063,440**	**$949,714,229**
		minus $125M (Current MEP projects underway) **TOTAL**				**$750,063,440**	**$824,714,229**
		omitting renovation of PEDS as future project - including escalation **TOTAL**				**$738,494,323**	**$813,145,112**
		omitting renovation of 1 MED/SURG floor and PEDS as future project - including escalation **TOTAL**				**$712,864,605**	**$787,515,394**

Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

Summary - Scenario 3
Descriptions

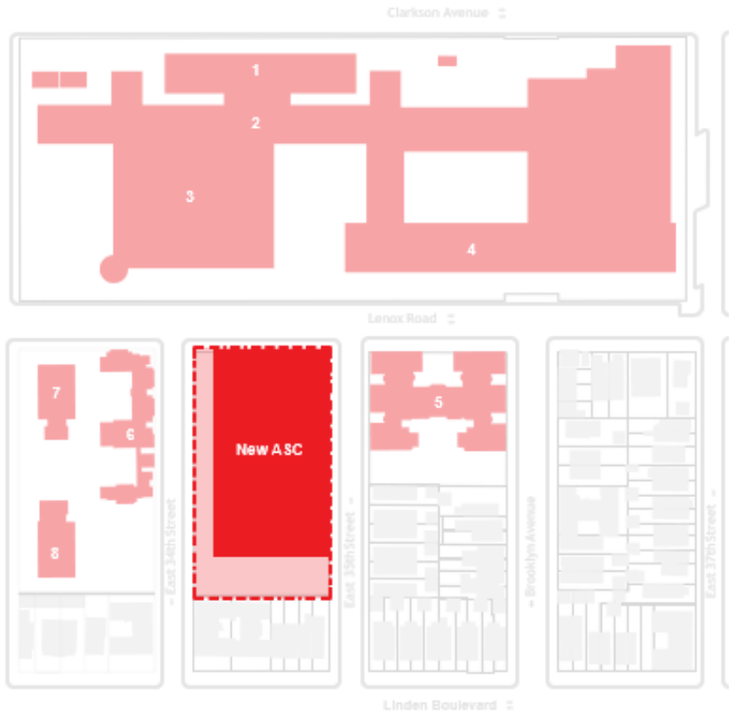
Scenario 3a – UNBOUND

New Advanced Diagnostic & Treatment Center, new 100-200 Inpatient Bed Tower. Includes parking. Limited renovations to existing Hospital; renovate and improve operations within existing Emergency Department, and MEP upgrades throughout existing Hospital.



Scenario 3b – BOUND

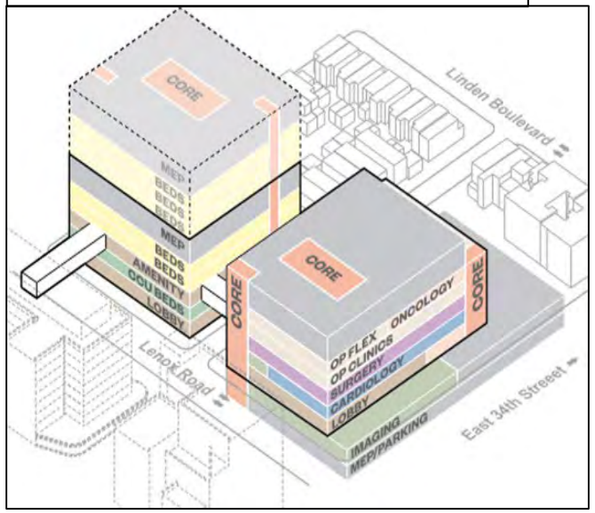
Full investment in new Advanced Diagnostic & Treatment Center. No investment in existing Hospital.



SCENARIO 3a, 3b SUMMARY

Scenario 3a

Diagnostic & Treatment Center & Bed Tower:



Existing Hospital renovation: renovate and downstate the ED from 38 to 21 stations and MEP upgrades throughout Hospital.

SCENARIO 3a COST MODELING

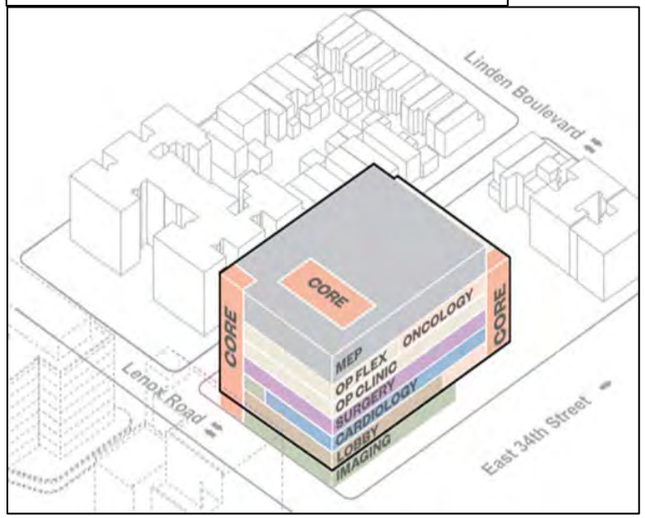
New D&TC + 100 Bed Tower + reno ED	$2,101,378,720	$2,341,872,377
minus $125M*	$1,976,378,720	$2,216,872,377
New D&TC + 100 Bed Tower w/ expansion capacity + reno ED	$2,116,158,720	$2,359,608,377
minus $125M*	$1,991,158,720	$2,234,608,377
New D&TC + 200 Bed Tower + reno ED	$2,499,638,418	$2,775,352,041
minus $125M*	$2,374,639,418	$2,650,352,041
Total Anticipated SOFT COSTS	$770,949,833	

*Considers current MEP projects underway

TOTAL COST ESTIMATE	$2,747,328,553	$3,421,301,874

Scenario 3b

Diagnostic & Treatment Center:



Existing Hospital renovation: none

SCENARIO 3b COST MODELING

PRELIMINARY COST MODEL	$661,641,889	$765,465,471
Total Anticipated SOFT COSTS	$277,500,000	

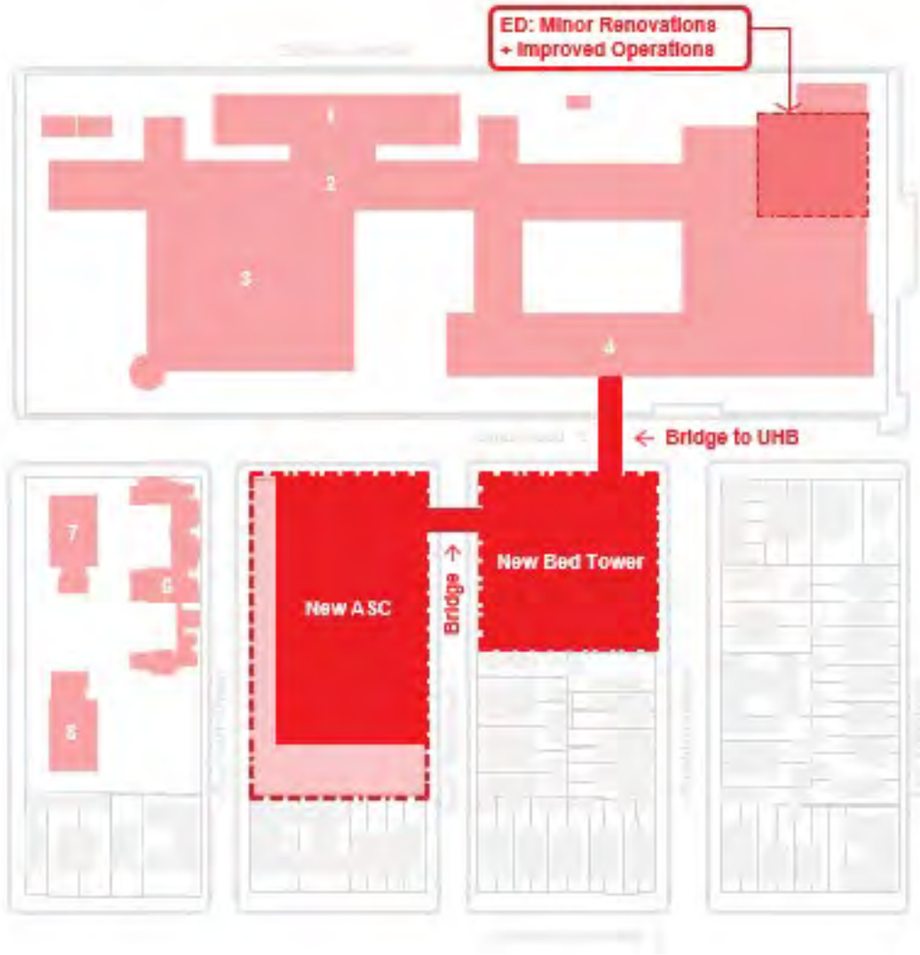
TOTAL COST ESTIMATE	$939,141,889	$1,042,965,471

Total project duration for Scenario 3 models is +/- 7-10 years

SCENARIO 3a

Scenario 3a

- Construct a new, larger-sized ambulatory, with parking and inpatient surgery facility on the current parking garage site.
- Build a new inpatient bed tower on the site of the current nursing dormitory. Consideration for 100 bed, 100 bed w/ expansion capabilities, and 200 bed options.
- Connect the new surgery facility and the new inpatient bed tower via a bridge.
- Provide an additional connection (bridge) between the new inpatient bed tower and the existing hospital building
- Retain the existing hospital building for Emergency Department (ED) and ancillary services. Improve operations for existing ED within existing footprint.
- MEP upgrades throughout existing hospital



SCENARIO 3a KEY UNITS

KEY DRIVERS

Ambulatory Care Center + Bed Tower

ASC

Floors:

6

+ 2 Basements

Surgery

- ORs 9
- Hybrid OR 1
- Pre-Post 30

Imaging

- CT 1
- MRI 1
- X-Ray 6
- Ultrasound 8
- PET CT 1

Procedure Suite

- Procedure Rooms 6

Cardiology

- Exam Rooms 10
- Procedure Rooms 4
- Cath Labs 2
- EP 1

Oncology

Clinic

- Exam Rooms 6

Infusion

- Infusion Rooms 12

Treatment

- Linac 1
- Brachytherapy 1

Outpatient

Women's Health

- Exam Rooms 10
- Procedure/Treatment 1
- Sonogram 1
- Mammography 2

Orthopedic

- Exam Rooms 16
- Cast Room 1
- X-Ray 1
- Procedure/Treatment 1

Endocrine

- Exam Rooms 8
- Procedure/Treatment 1

Faculty Exam

- Exam Rooms 16

Emergency

- Renovate + Improve ED Operations

Inpatient Beds

100 Beds

Floors:

6

+1B

- Adult 84
- Pediatric 16

200 Beds

Floors:

10

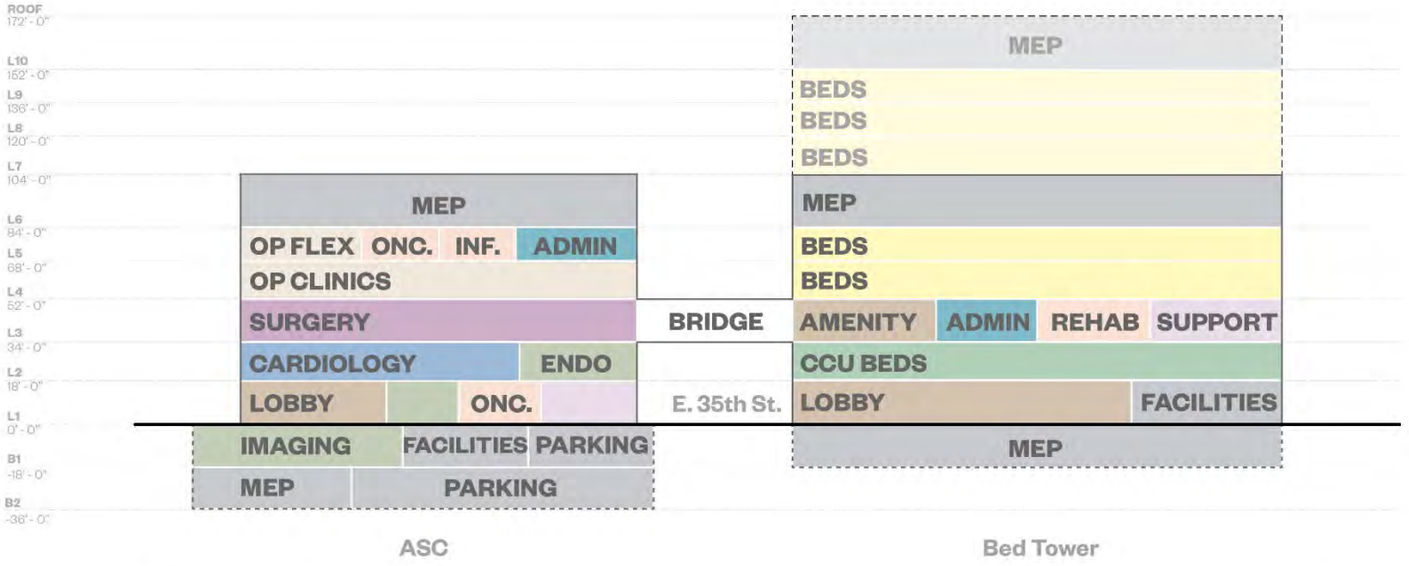
+1B

- Adult 184
- Pediatric 16

SCENARIO 3a DIAGRAM

STACKING DIAGRAM

200 Bed Tower Dashed In



PROGRAM LEGEND

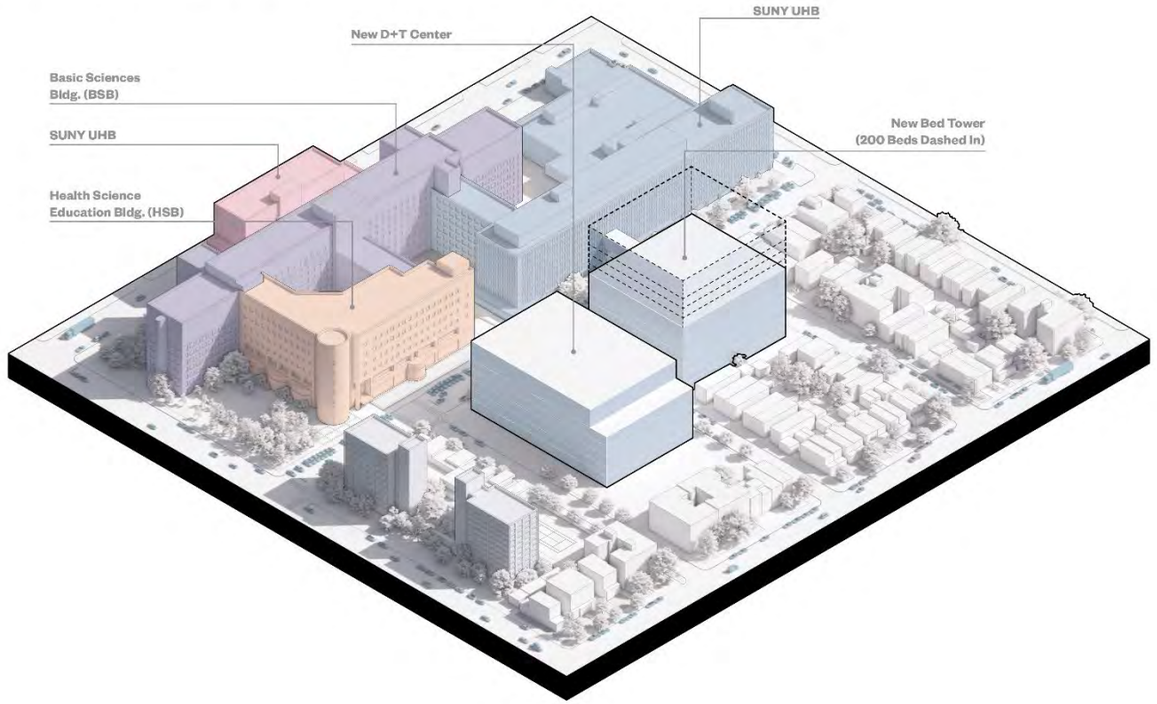
Outpatient:	47,560 sf		Clinical Support:	6,000 sf	
Imaging + Radiology:	38,000 sf		Admin:	5,000 sf	
Surgery:	35,060 sf		Customer Services:	25,392 sf	
Cardiology:	21,060 sf		Universal Beds (*100*):	85,176 sf	
Clinical Support:	6,860 sf		Universal Beds (*200*):	170,352 sf	
Oncology/Rad Onc:	19,000 sf		Facilities:	8,000 sf	
Admin/Office:	7,290 sf		Rehab:	6,000 sf	
Customer Services:	13,500 sf		Shell:	6,392 sf	
Facilities:	6,500 sf				
ASC			**Bed Tower**		

Totals

DGSF (ASC):	196,600 sf
Massing BGSF (ASC):	359,228 sf
*BGSF Includes Parking	
DGSF (*100 Beds*):	141,960 sf
Massing BGSF (*100 Beds*):	216,216 sf
DGSF (*200 Beds*):	227,136 sf
Massing BGSF (*200 Beds*):	360,360 sf

SCENARIO 3a COST MODEL

ASC + BED TOWER - CONTEXT



Total project duration for Scenario 3a model is +/- 12 years

SCENARIO 3a - UNBOUND
Diagnostic & Treatment Center - New Build w/ Bridge to New Patient Tower
Inpatient Tower - New Build w/ Bridge to Existing Hospital
Existing Hospital - Upgrades / Partial Renovation

Lobby / Café Imaging Surgery / Procedure Oncology Cardiovascular Outpatient / Clinic Clinical Support Facilities Support Admin. Vertical Circulation Bridge to New Patient Tower Parking	**New Diagnostic & Treatment Center**	**359,228 GSF**		low $2,000/SF	high $2,300/SF
	Building Gross SF	**359,228**		$718,456,000	$826,224,400
	Bridge / Connector to New Patient Tower			$4,480,000	$4,864,000
	Site, Utilities, Plantings	allowance		$15,000,000	$20,000,000
	escalation (5%) construction midpoint (Apr 2035) 9.25 yr			$352,733,408	$406,820,255
		New D&T Center Total		**$1,090,669,408**	**$1,257,908,655**
Lobby Acute Beds Universal Patient Rooms Amenity / Connection Facilities Support Vertical Circulation Bridge to Existing Hospital	**New Patient Tower - 100 beds**	**216,216 GSF**		low $1,800/SF	high $2,000/SF
		New 100 Bed Tower Total		**$606,406,846**	**$679,661,256**
	New Patient Tower - 100 beds w/ infrastructure upgrades for future expansion			low	high
		New 100+ Bed Tower Total		**$621,186,846**	**$697,397,256**
	New Patient Tower - 200 beds	**360,360 GSF**		low $1,800/SF	high $2,000/SF
		New 200 Bed Tower Total		**$1,004,667,544**	**$1,113,140,920**
MEP Upgrade Emergency Department (reno) Minor Renovations (bridge connection)	**Existing Hospital Upgrades**				
	Site Improvements			**$1,000,000**	
	Upgrade MEP (Existing Hospital, balance of)			**$256,785,000**	
	Renovate Emergency Dept (Existing Hospital)			$1300/SF (includes phasing premium)	
	11,300 SF	low 17 stations	high 25 stations	**$14,690,000**	
	Renovation at Connector (Existing Hospital)			**$1,072,000**	
	escalation (5%) construction midpoint (Apr 2035) 9.25 yr			$130,755,466	
				$404,302,466	

SCENARIO 3a PRELIMINARY COST MODEL	New D&TC + 100 Bed Tower + reno ED	**$2,101,378,720**	**$2,341,872,377**
	minus $125M Current MEP projects underway	**$1,976,378,720**	**$2,216,872,377**
	New D&TC + 100 Bed Tower w/ expansion capacity + reno ED	**$2,116,158,720**	**$2,359,608,377**
	minus $125M Current MEP projects underway	**$1,991,158,720**	**$2,234,608,377**
	New D&TC + 200 Bed Tower + reno ED	**$2,499,639,418**	**$2,775,352,041**
	minus $125M Current MEP projects underway	**$2,374,639,418**	**$2,650,352,041**

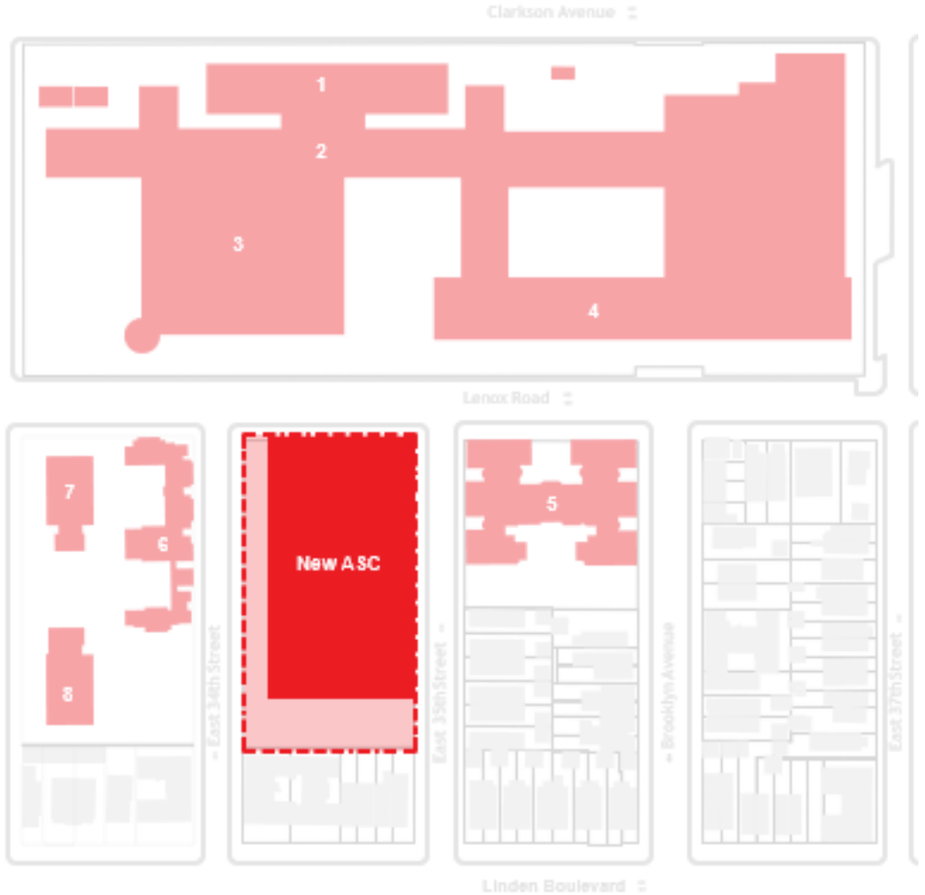
Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

SCENARIO 3b

Scenario 3b

- Construct a new, larger-sized ambulatory surgery facility on the existing parking garage site.

- No investment in current existing hospital.



SCENARIO 3b KEY UNITS

KEY DRIVERS

Ambulatory Care Center

ASC

Floors:

5

+1 Basement

Surgery

- ORs 9
- Hybrid OR 1
- Pre-Post 30

Imaging

- CT 1
- MRI 1
- X-Ray 6
- Ultrasound 8
- PET CT 1

Procedure Suite

- Procedure Rooms 6

Cardiology

- Exam Rooms 10
- Procedure Rooms 4
- Cath Labs 2
- EP 1

Oncology

Clinic

- Exam Rooms 6

Infusion

- Infusion Rooms 12

Treatment

- Linac 1
- Brachytherapy 1

Outpatient

Women's Health

- Exam Rooms 10
- Procedure/Treatment 1
- Sonogram 1
- Mammography 2

Orthopedic

- Exam Rooms 16
- Cast Room 1
- X-Ray 1
- Procedure/Treatment 1

Endocrine

- Exam Rooms 8
- Procedure/Treatment 1

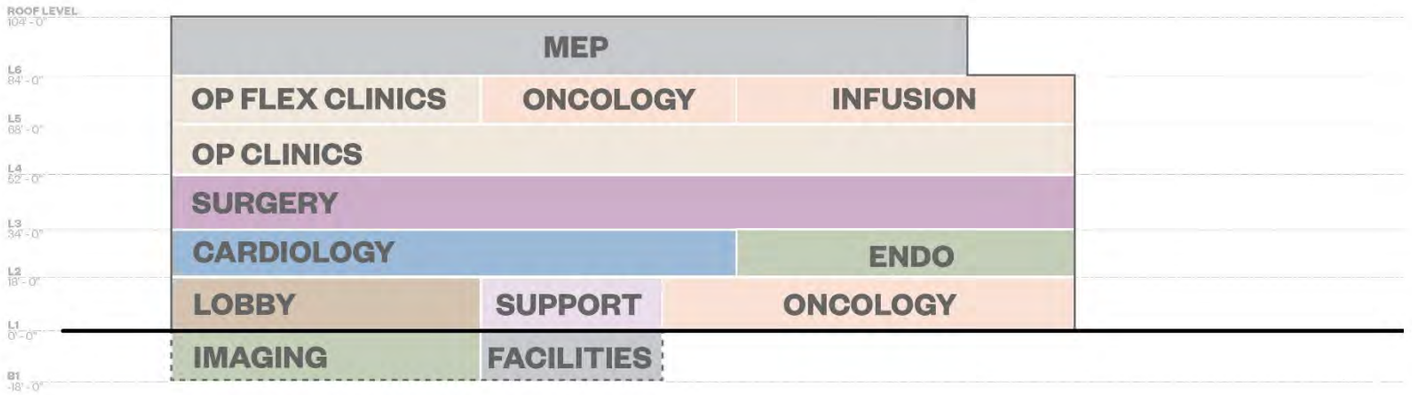
Faculty Exam

- Exam Rooms 16

SCENARIO 3b DIAGRAM

STACKING DIAGRAM

34th Street Elevation



PROGRAM LEGEND

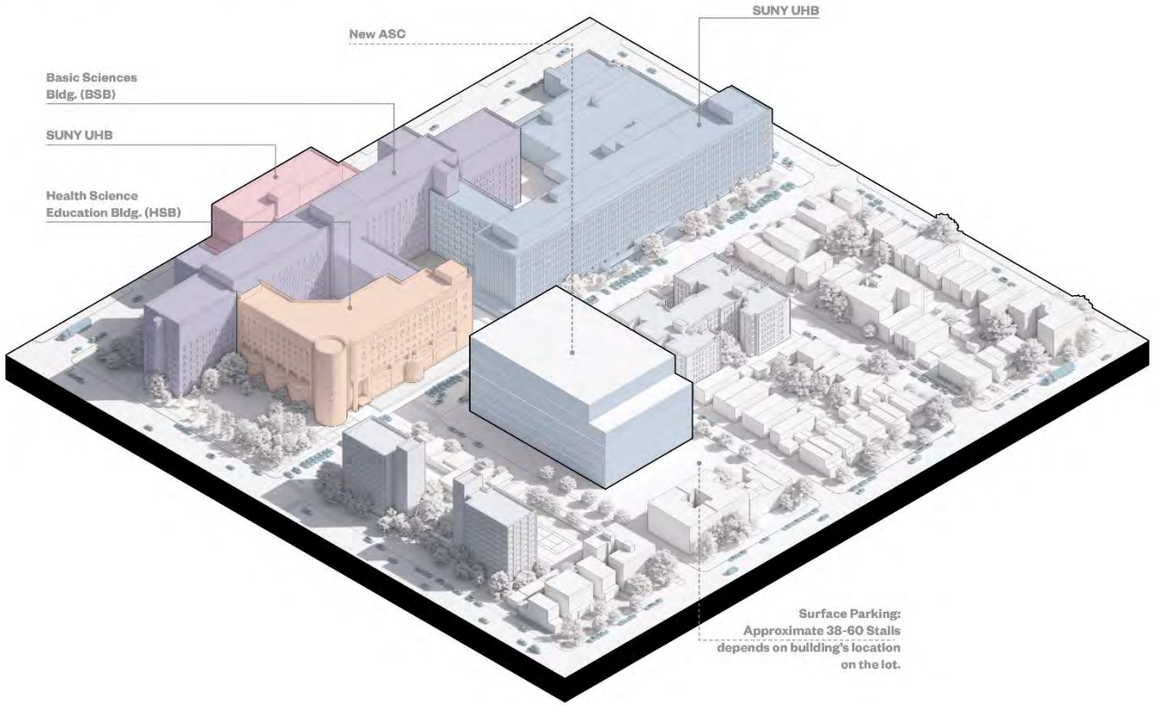
Outpatient:	47,560 sf
Imaging + Radiology:	38,000 sf
Surgery:	35,060 sf
Cardiology:	21,060 sf
Clinical Support:	6,860 sf
Oncology/Rad Onc:	19,000 sf
Admin/Office:	7,290 sf
Customer Services:	13,500 sf
Facilities:	6,500 sf

Totals

DGSF:	194,830 sf
Massing BGSF:	247,960 sf

SCENARIO 3b COST MODEL

ASC - CONTEXT



SCENARIO 3b - $750M BOUND
Diagnostic & Treatment Center - New Build
Existing Hospital - No MEP Upgrades / No Renovations

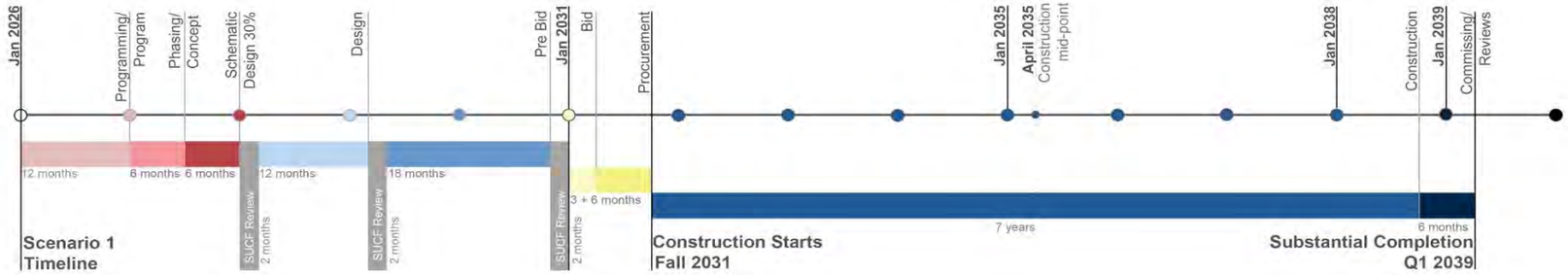
	New Diagnostic & Treatment Center		low $2,000/SF	high $2,300/SF
Lobby / Café Imaging Surgery / Procedure Oncology Cardiovascular Outpatient / Clinic Clinical Support Facilities Support Admin.	**Building Gross SF**	**247,960**	$495,920,000	$570,308,000
	Site, Utilities, Plantings	allowance	$10,000,000	$15,000,000
	escalation (5%) construction midpoint (July 2031) 5.5 yr		$155,721,889	$180,157,471
	New D&T Center Total		**$661,641,889**	**$765,465,471**
	SCENARIO 3b PRELIMINARY COST MODEL		**$661,641,889**	**$765,465,471**

Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

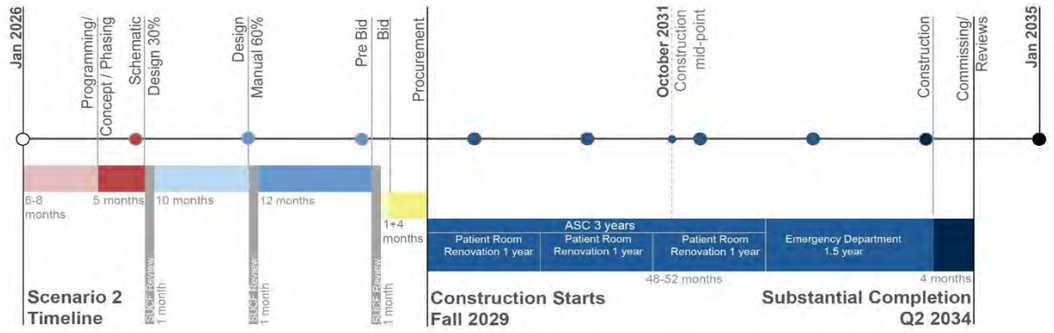
Total project duration for Scenario 3b model is +/- 7 years

Summary - Scenario Timeline Estimates

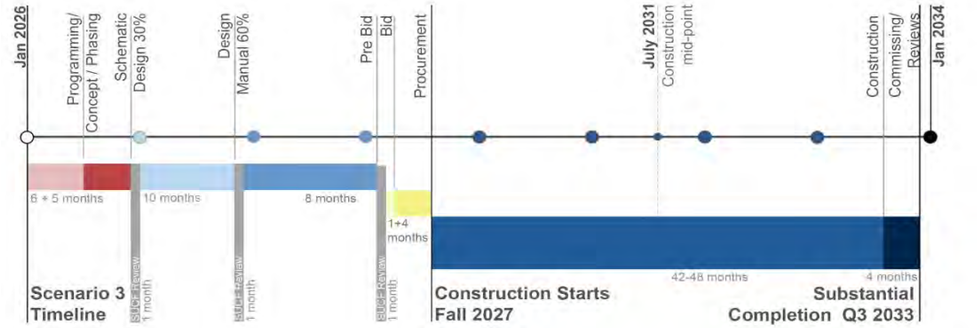
Scenario 1



Scenario 2



Scenario 3



ADDITIONAL INFORMATION
Hypothetical Modeling

Summary – Hypothetical Programs

Ambulatory Surgery Center (ASC)

Construct new ambulatory surgery center on current parking garage site.

(Key Planning Units derived from a previous ASC concept considered by SUNY Downstate in 2022)

New ACC COST MODELING

PRELIMINARY COST MODEL	$679,500,000	$784,862,500
Total Anticipated SOFT COSTS	$277,500,000	

TOTAL COST ESTIMATE	$957,000,000	$1,062,362,500

New 193-250 Bed Hospital

Construct new hospital on current parking garage site with connector bridge to King's County Hospital (option).

193 Bed Option, 250 Bed option.

(Key Planning Units derived from current SUNY Downstate Hospital program.)

New Hospital COST MODELING (193-250 bed)

PRELIMINARY COST MODEL	$2,170,384,440	$2,736,772,920
Total Anticipated SOFT COSTS	$779,349,582-$933,656,655	

TOTAL COST ESTIMATE	$2,949,734,410	$3,670,429,575

Initial Interpretation of BFD Hospital*

Option based on BFD Renderings.

Construct new hospital tower built over existing 3-story podium portion of existing hospital. Preliminary considerations incorporated to maintain hospital remains open and functional throughout construction.

(Key Planning Units derived from DCAB and projections, and ongoing discussions and planning sessions)

New Hospital (based on BFD Rendering) COST MODELING

PRELIMINARY COST MODEL	$2,653,081,332	$2,853,896,804
Total Anticipated SOFT COSTS	$1,049,507,393	

TOTAL COST ESTIMATE	$3,702,588,725	$3,903,404,197

*BFD was further modeled following receipt of more information from the group. See Scenario 1a and 1b for more information.

Hypothetical Bridge to Kings County Hospital was also modeled. See the following slides for more information

New ASC

- New ambulatory surgery center to be constructed on current parking garage site.

- Program based on modified previous ASC concept considered by SUNY Downstate in 2022

NEW ASC KEY UNITS

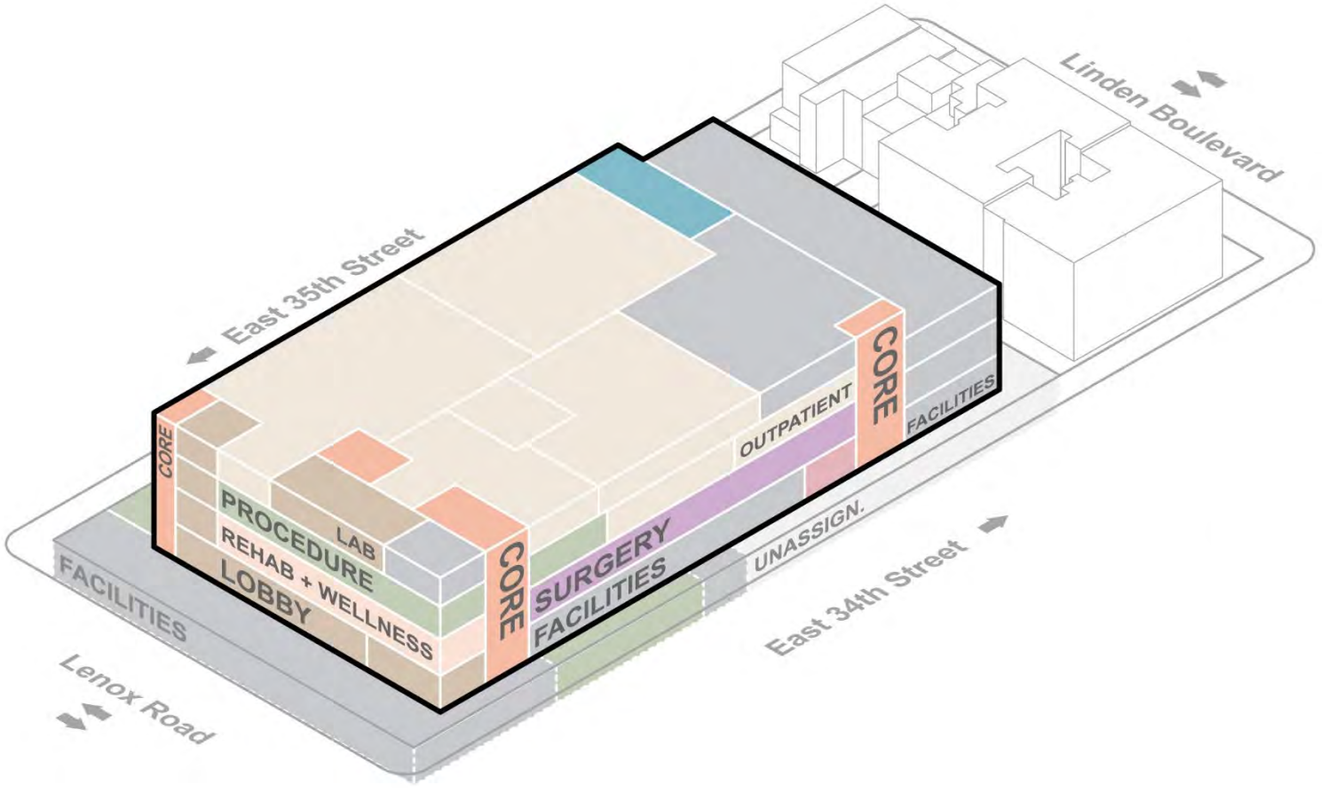
Hypothetical Ambulatory Care Center

Area	Key Room Type
Emergency Services	
Urgent Care	Exam/ Treatment Rooms
	Procedure Rooms
IMAGING AND RADIOLOGY	
Imaging	CT
	MRI
	X-ray
	Ultrasound
	PET CT
Procedure Suite	Procedure Rooms
DGSF Total	**33,100**
CARDIOLOGY	
Cardiovascular Suite	Cath Labs
	EP
DGSF Total	**9,000**
REHAB	
Rehabilitation and Wellness	Treatment Bay/Rooms
	Gym
DGSF Total	**3,500**
SURGICAL SERVICES	
Surgery	Operating Room
	Hybrid Operating Room
DGSF Total	**30,000**
OUTPATIENT	
Women's Health Institute	Exam Rooms
	Sonogram
	Procedure Room
	Mammography Room
Cancer Institute	Exam Rooms
Ortho + Sports Med Institute	Exam Rooms
	Cast Room
	X-Ray
	Procedure Room
CV Institute	Exam Rooms
	Procedure Rooms
Infusion Suite	Oncology Chairs
	Medical Chairs
Radiation Oncology	Linacc
	Brachytherapy
	CT-Sim
Wound Care	Hyperbaric Chambers
Endocrine & Metabolic Clinic	Exam Rooms
	Procedure Rooms
Faculty Flex	Exam Rooms
DGSF Total	**62,485**

Area	Key Room Type
CLINICAL SUPPORT	
Sterile Processing	
Phlebotomy / Lab	Chairs
Compounding Pharmacy	
DGSF Total	**6,400**
CUSTOMER SERVICES	
Lobby	
Café	
Registration	
Secondary Entrance	
DGSF Total	**12,700**
ADMIN / OFFICE	
Physician Flex/ Landing Space Clinics	
Physician Flex/ Landing Space Clinics/Canc	*er*
DGSF Total	**1,600**
FACILITIES	
Material Management	
Security	
Central Building Support Lockers	
Environmental Services	
DGSF Total	**6,000**

Total DGSF		**172,785**
Building Gross	**MEP/IT/FP/Cores/Shared Circulation/Shell**	**1.35**
Total BGSF		**233,260**

NEW ASC DIAGRAM



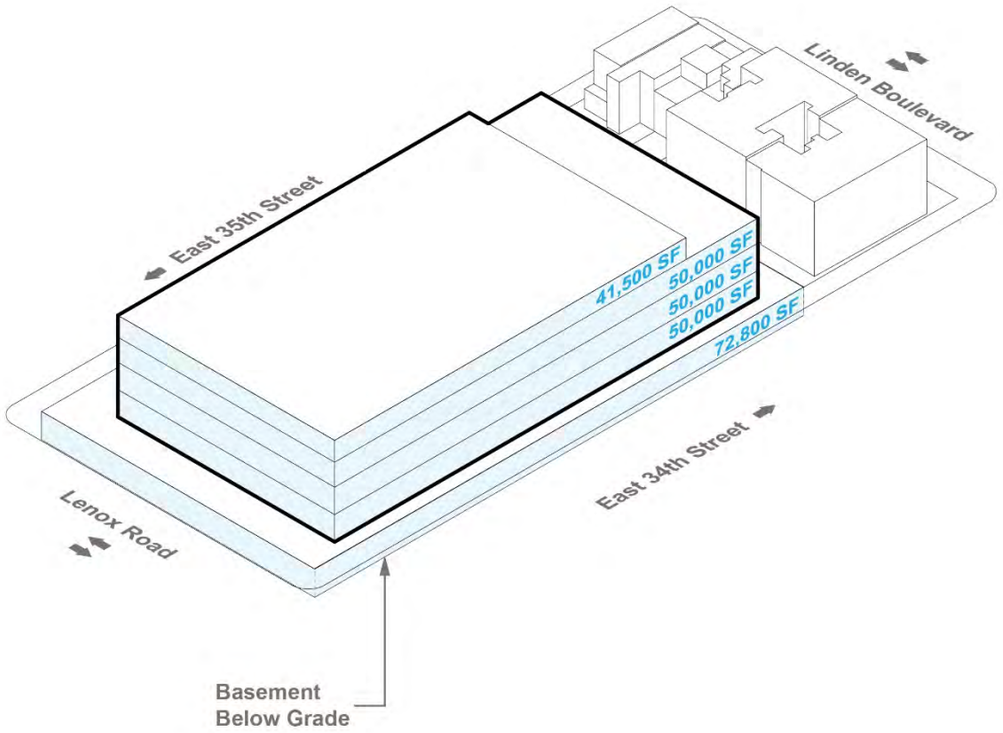
DGSF BREAKDOWN:

OUTPATIENT:	62,485 SF
IMAGING + RADIOLOGY:	33,100 SF
SURGERY:	30,000 SF
CARDIOLOGY:	9,000 SF
EMERGENCY SERVICES:	8,000 SF
CLINICAL SUPPORT:	6,400 SF
ADMIN:	1,600 SF
CUSTOMER SERVICES:	12,700 SF
REHAB + WELLNESS:	3,500 SF
FACILITIES:	6,000 SF
VERTICAL CIRCULATION	

TOTALS:

DSGF:	172,785 SF
BLDG. GROSS:	1.35
BGSF:	233,260 SF

NEW ASC COST MODEL

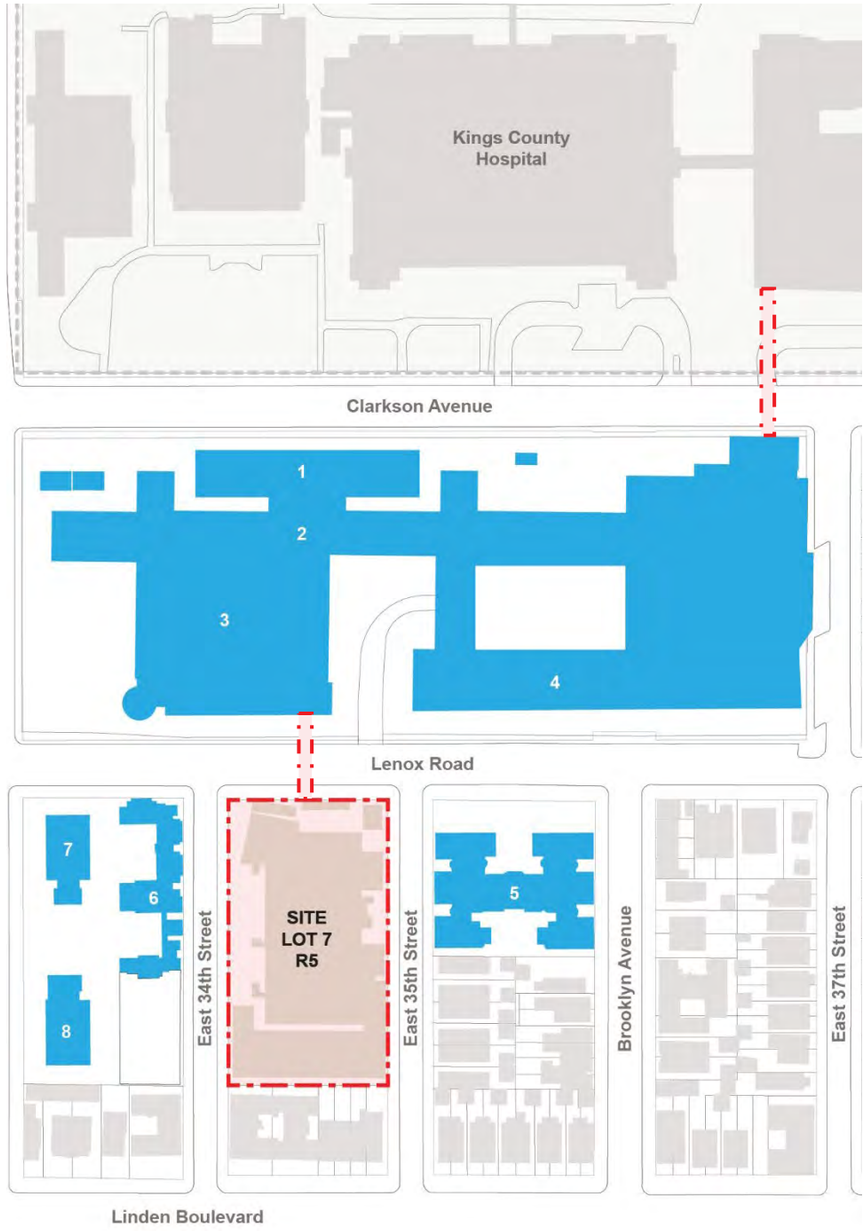


Ambulatory Care Center - New Build		Prelim BGSF	low $2,000/SF	high $2,300/SF
Outpatient Imaging + Radiology Surgery Cardiology Emergency Services Clinical Support Admin Customer Services Rehab + Wellness Facilities Support Vertical Circulation	**4 Story + Basement**	**264,300**	$528,600,000	$607,890,000
	Site, Utilities, Plantings	**allowance**	$15,000,000	$20,000,000
	escalation (5%) over 5 years		$135,900,000	$156,972,500
			$679,500,000	**$784,862,500**

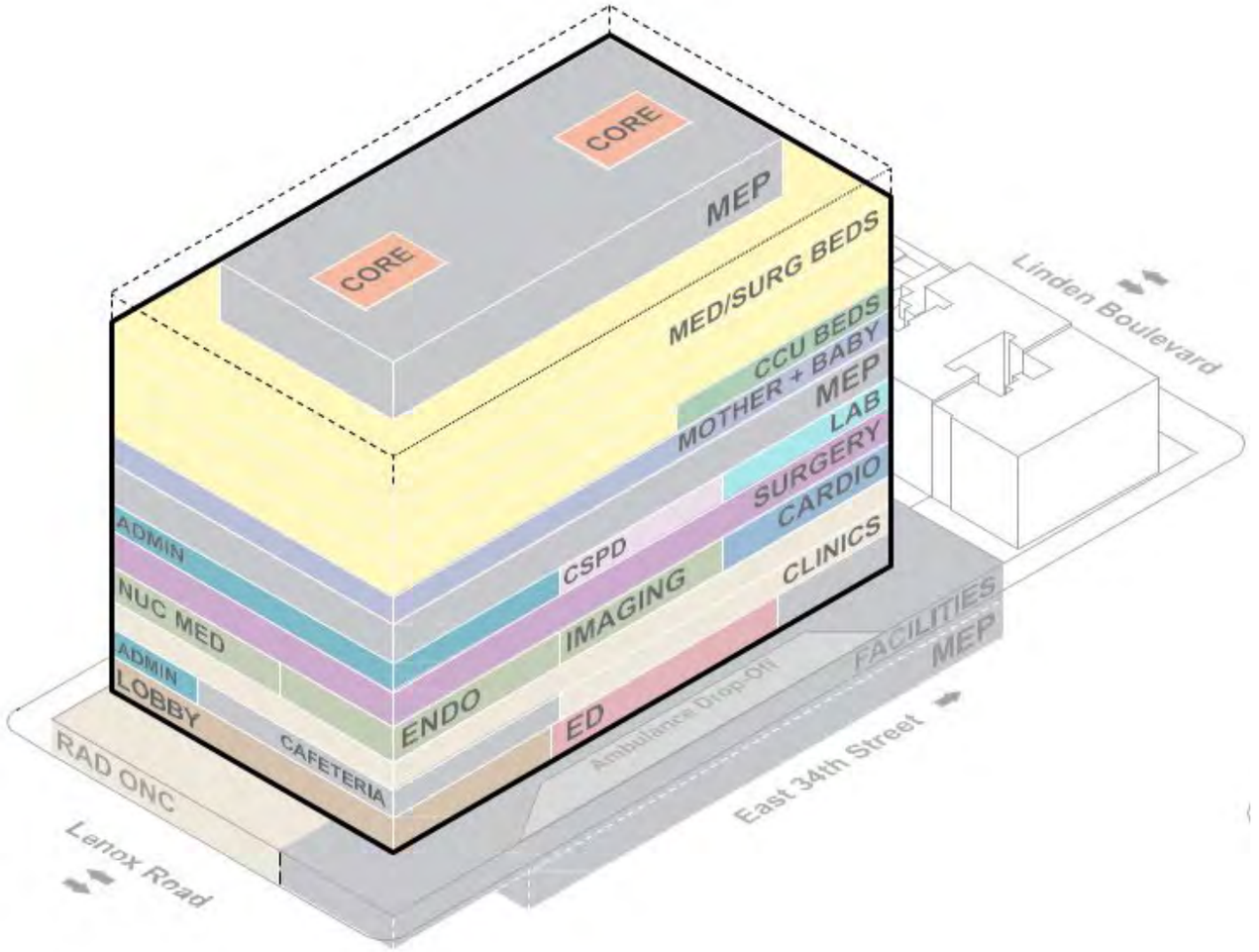
Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

New 193-250 Bed Hospital w/ Connecting Bridge

- Construct new hospital tower on current parking garage site.
- Programmed to align with optimized current hospital scenario of 193 beds, with infrastructure to support future vertical expansion for 250 beds.
- Consideration for connector bridge to Education Building and/or to King's County Hospital patient floor.



NEW 193-250 BED HOSPITAL w/ CONNECTING BRIDGE DIAGRAM



PROGRAM LEGEND

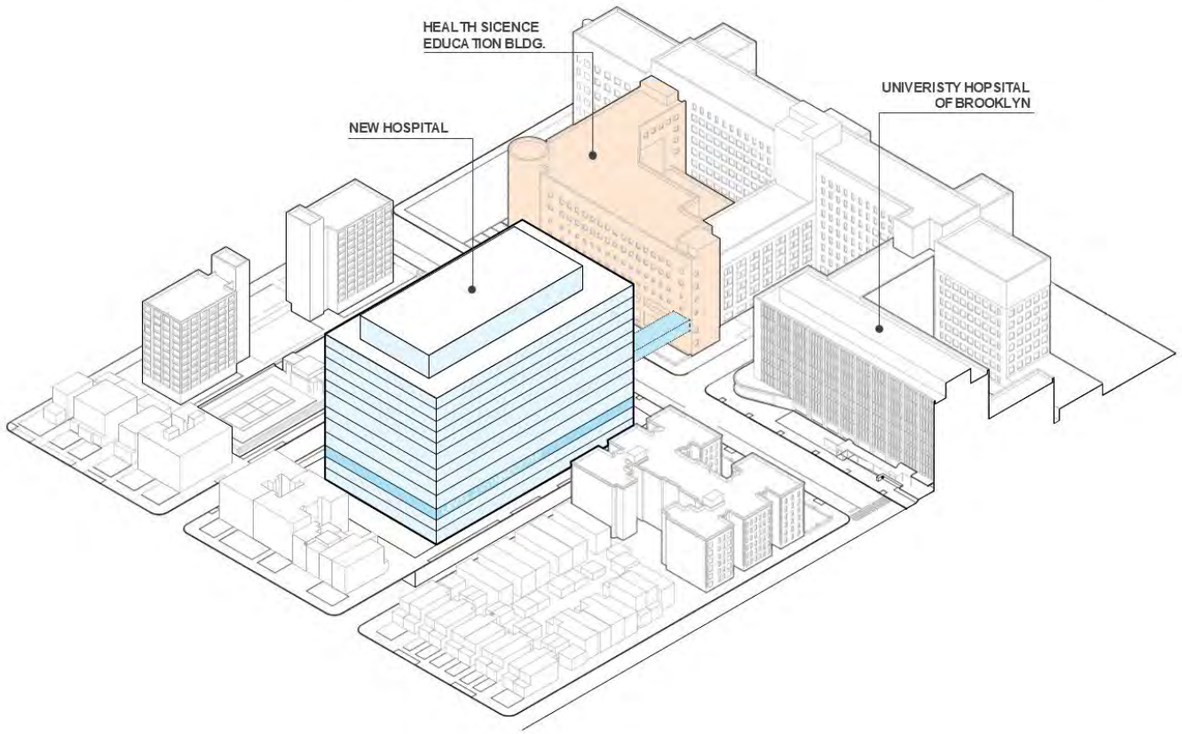
OUTPATIENT:	72,000SF
IMAGING + RADIOLOGY:	29,150SF
SURGERY:	35,000SF
CARDIOLOGY:	14,000SF
EMERGENCY SERVICES:	20,000SF
CLINICAL SUPPORT:	16,185SF
ADMIN:	15,400SF
CUSTOMER SERVICES:	12,460SF
REHAB + WELLNESS:	3,500SF
MED/SURG BEDS:	139,230SF
CCU BEDS:	24,570SF
FACILITIES:	57,250SF

TOTALS

DSGF:	507,040SF
MASSING BGSF:	734,940SF

NEW 193-250 BED HOSPITAL w/ CONNECTING BRIDGE
COST MODEL

NEW HOSPITAL



New Build Hospital		Prelim BGSF	low $2,200/SF	high $2,600/SF
Match "Optimized" current Hospital program	13 Story + (2) Basement	734,940	$1,616,868,000	$1,910,844,000
	Site, Utilities, Plantings	allowance	$15,000,000	$20,000,000
	escalation (5%) over 5 years @ midpoint		$538,516,440	$637,178,520
			$2,170,384,440	**$2,568,022,520**

New Build Hospital		Prelim BGSF	low $2,200/SF	high $2,600/SF
250 Bed	14 Story + (2) Basement	783,740	$1,724,228,000	$2,037,724,000
	Site, Utilities, Plantings	allowance	$15,000,000	$20,000,000
	escalation (5%) over 5 years		$573,945,240	$679,048,920
			$2,313,173,240	**$2,736,772,920**

New Bridge - Option 2		Prelim BGSF	low $3,400/SF	high $3,700/SF
Downstate Patient Tower to King's County Patient Tower DMC - Level 3	Single story, 256', 24' wide	6,100	$20,740,000	$22,570,000
			low $450/SF	high $600/SF
	Renovated "landing" areas	2,650	$1,192,500	$1,590,000
	escalation (5%) over 2 years		$5,176,070	$5,701,760
			$27,108,570	**$29,861,760**

Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

New Hospital based on Brooklyn for Downstate Renderings

- New hospital tower, based on interpretation of BFD rendering, to be constructed atop the existing three-story podium of the current hospital.
  - Construction must account for required phasing and downtime to ensure hospital remains open and functional throughout.

- Existing hospital bed tower to serve as interim swing space:
  - Supports relocation of clinical programs during construction over the operational hospital.

- Select soft programs (e.g., outpatient clinics, non-essential offices) assumed to be relocated off-site temporarily:

NEW HOSPITAL based on BFD KEY UNITS

KEY DRIVERS

Floors:
15
+ 2 Basements

Emergency
- Exams Rooms 32
- Resuscitation Rooms 2
- Trauma 4

** Right-Sized*

Urgent Care
- Exams Rooms 12
- Procedure/Treatment 1

** Located in Existing Hospital Building*

Surgery
- ORs 14
- Hybrid OR 1
- Endo 2
- Gen Procedure 4
- Pre/Post 50

Med-Surg Inpatient Beds
- Adult 187
- Pediatric 17

Critical Care Inpatient Beds
- Adult 30
- Pediatric 5

Mother + Baby
- LDRP 11
- NICU 29
- C-Section 2

250 Beds, Excluding NICU

Cardiology
- Cath Labs 2
- EP 1
- BiPlane 1

Imaging
- CT 2
- MRI 2
- X-Ray 6
- Ultrasound 8
- PET CT 1
- Mammography 2

Nuc Med
- Procedure Room 3

Oncology
- Linac 1
- Brachytherapy 1

Outpatient

Women's Health
- Exam Rooms 10
- Procedure/Treatment 1
- Sonogram 1
- Mammography 1

Orthopedic
- Exam Rooms 16
- Cast Room 1
- X-Ray 1
- Procedure/Treatment 1

Cardiovascular/Stroke
- Exam Rooms 16
- Procedure/Treatment 2

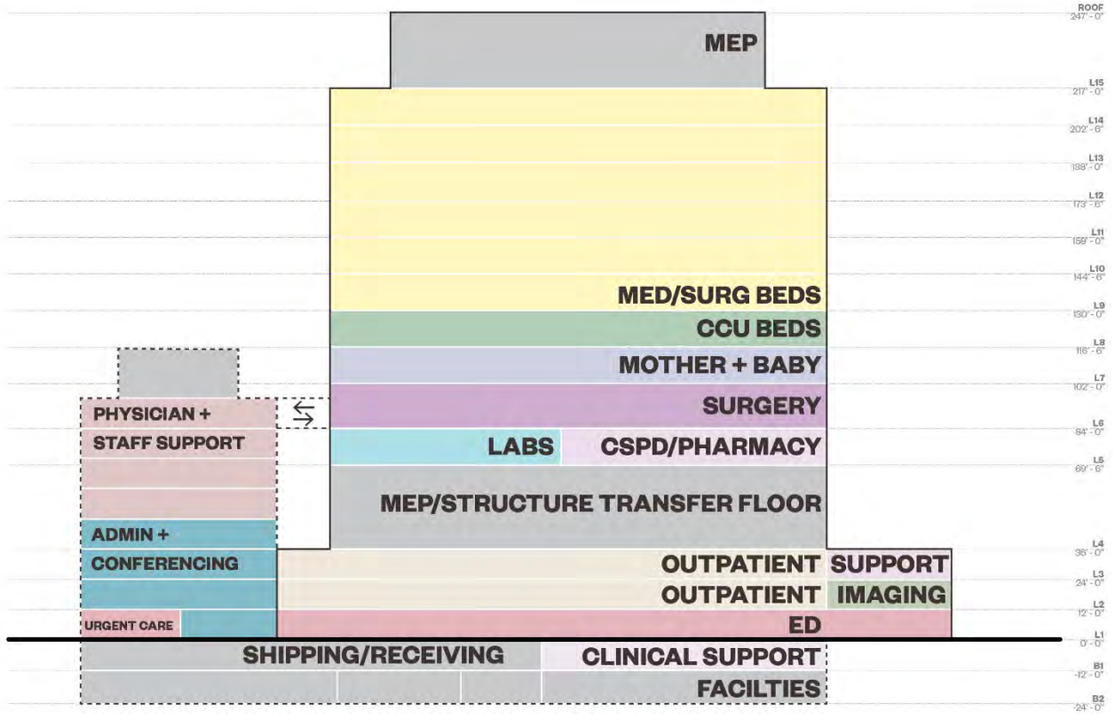
Endocrine
- Exam Rooms 8
- Procedure/Treatment 1

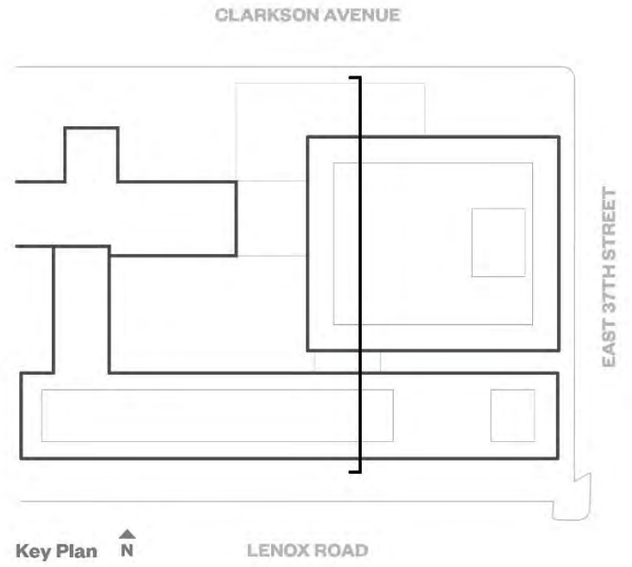
Faculty Exam
- Exam Rooms 16

NEW HOSPITAL based on BFD DIAGRAM

STACKING DIAGRAM

New + Existing Hospital





PROGRAM LEGEND

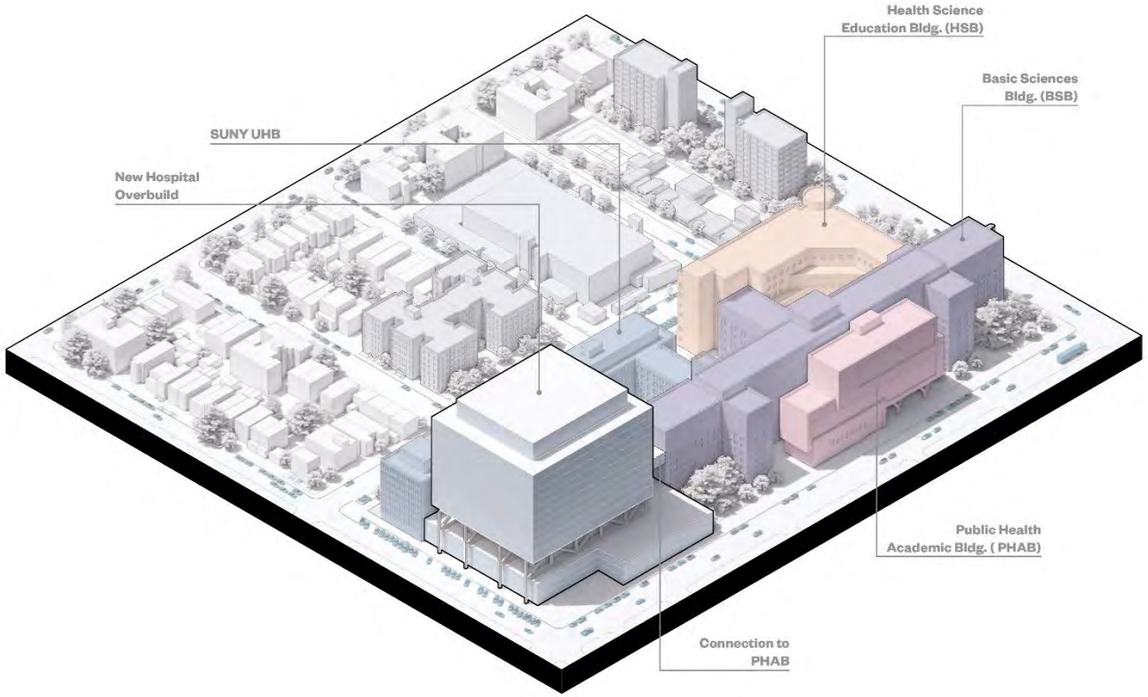
Outpatient:	77,550 sf	Clinical Support:	18,750 sf	Bldg. Support, Facilities:	71,500 sf
Imaging + Radiology:	28,850 sf	Labs:	17,500 sf	Phys + Staff Support	43,300 sf/floor
Surgery:	70,500 sf	Admin:	15,400 sf	*Not included in total SF numbers	
Cardiology:	14,000 sf	Customer Services:	15,900 sf		
Emergency Services:	30,400 sf	Med/Surg Beds:	185,640 sf		
Mother + Baby	44,765 sf	CCU Beds:	31,850 sf		

Totals

DGSF:	622,605 sf
Massing BGSF:	801,400 sf

NEW HOSPITAL based on BFD COST MODEL

NEW HOSPITAL - CONTEXT



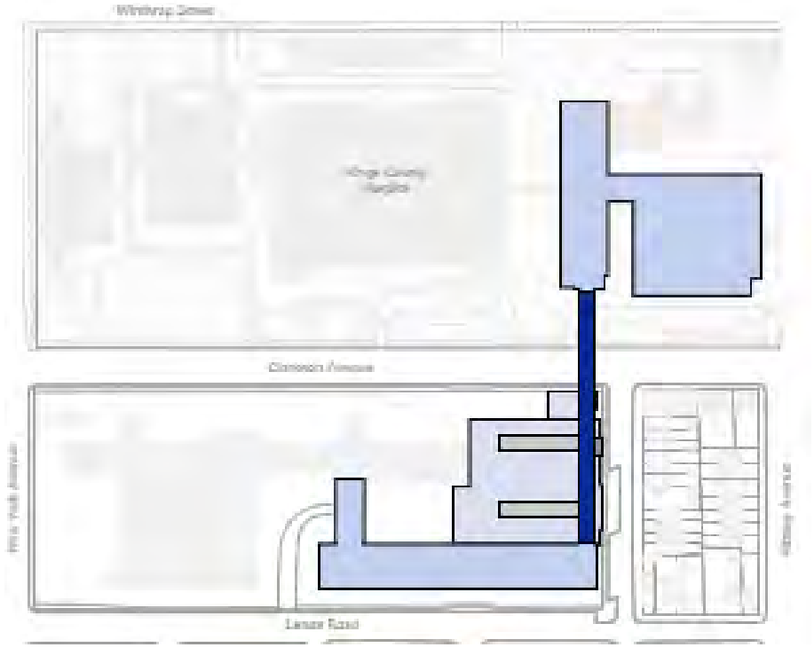
SCENARIO 1 - based on BFD Rendering
Hospital Tower - New Build w/ Connectors
Existing Hospital - Upgrades / Partial Renovation

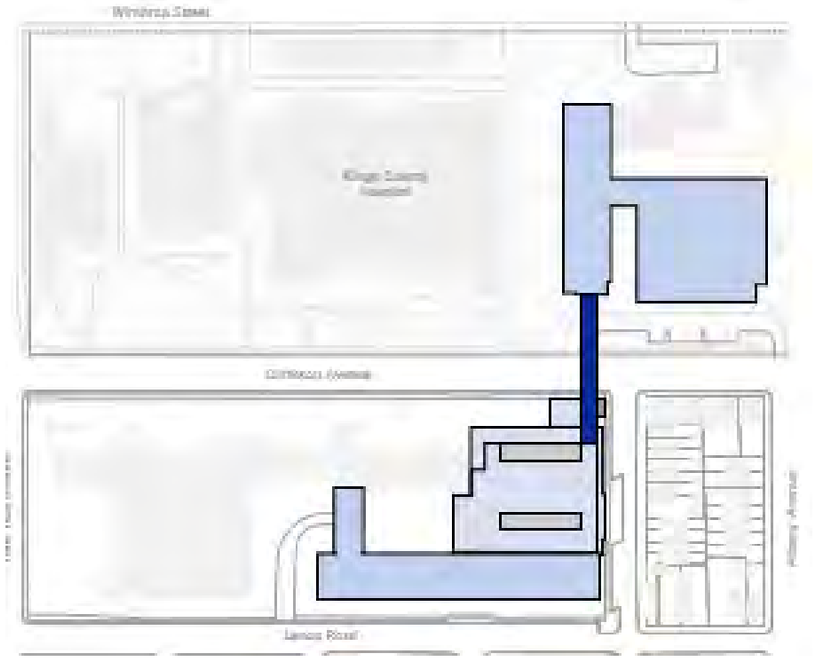
Lobby Critical Care Beds Universal Patient Rooms Mother + Baby Surgery Labs/Pharmacy Facilities Support Vertical Circulation Connector to Existing Hospital Connector to HSB Emergency Department (addition and renovation)	**New Hospital Tower - 250 beds**		
	Site Prep /Demolition	$5,158,115	
	Ancillary Structural	$109,050,000	
	Entry Addition	$6,816,600	
	Tower Addition	$1,228,500,000	
	Level 4 /Mechanical	$30,170,000	
	Connectors to Existing Hospital and HSB	$21,115,500	
	Renovated Existing Building at Connectors	$1,072,000	
	Penthouse	$22,203,200	
	Ambulatory /ED Addition	$127,886,000	
	escalation (5%) over 7-10 years	$580,437,309	$741,842,336
	New Hospital Tower Total	**$2,132,408,724**	**$2,293,813,751**
MEP Upgrade Imaging Oncology Cardiology Outpatient: Women's Health Orthopedic Cardiovascular/Stroke Endocrine Faculty Exam	**Existing Hospital Renovations**		
	Site Improvements	$1,000,000	
	Renovation of Existing Floors below Tower	$111,760,560	
	Renovation of Existing Patient Tower (Levels 1,2, 4-8)	$214,781,700	
	Renovation of Level 3 (Phasing: Interim L+D, NICU)	$40,727,925	
	Renovation of Level 3 (balance of floor)	$10,676,400	
	escalation (5%) over 7-10 years	$141,726,023	$181,136,468
	Existing Hospital Renovation Total	**$520,672,608**	**$560,083,053**
	SCENARIO 1 PRELIMINARY COST MODEL	**$2,653,081,332**	**$2,853,896,804**

Preliminary Cost Modeling note: Costs for different program needs averaged across all space use / departments

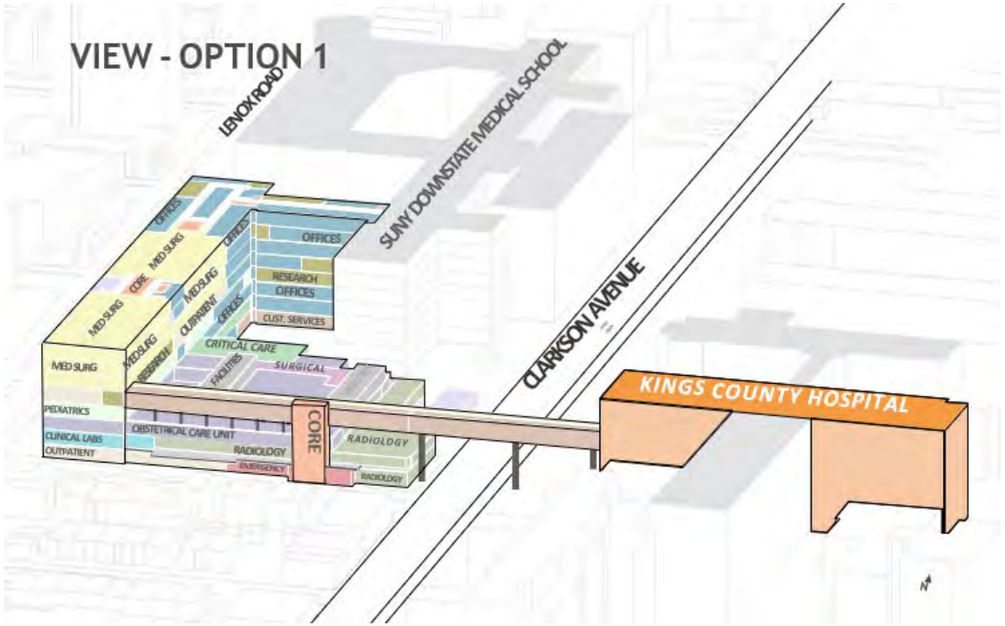
New Bridge to Kings County Hospital

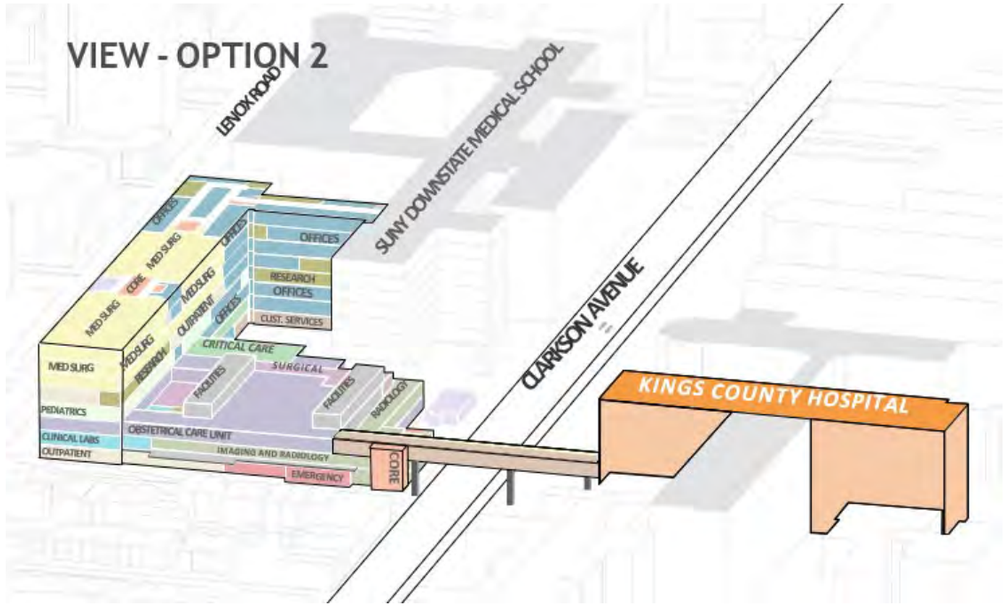
- Construct new bridge connect SUNY Downstate patient tower to Kings County Hospital
- Option 1 to connect Level 5 of SUNY Downstate patient tower to Kings County
- Option 2 to connect Level 3 of SUNY Downstate to Kings County



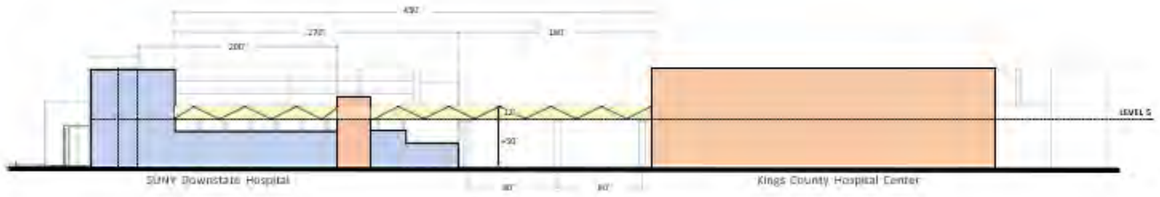


NEW BRIDGE TO KINGS COUNTY HOSPITAL DIAGRAM

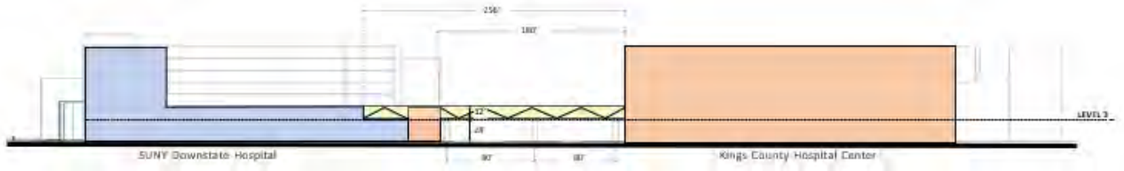




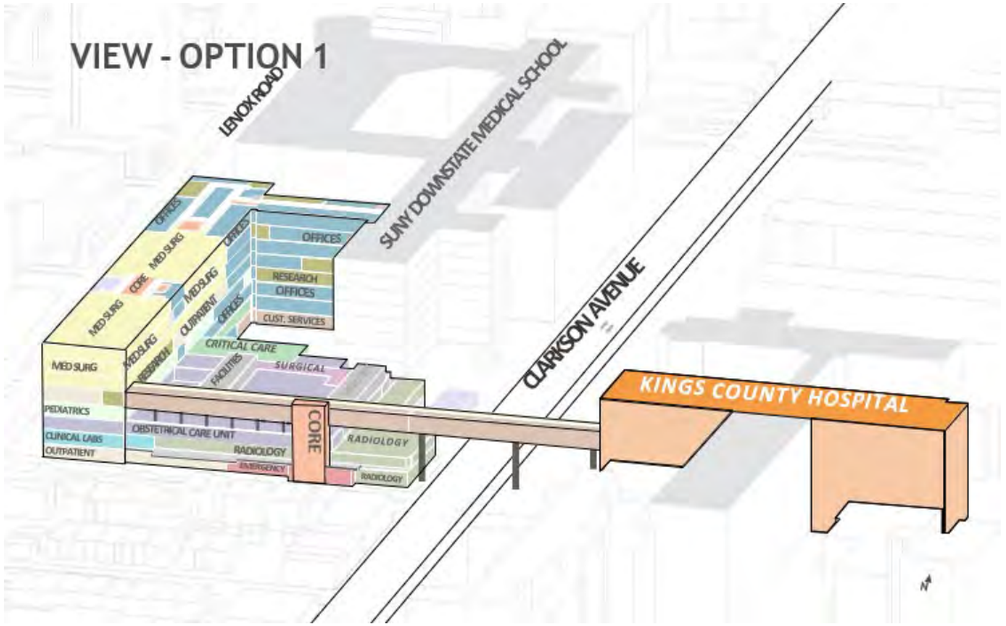
SECTION - OPTION 1



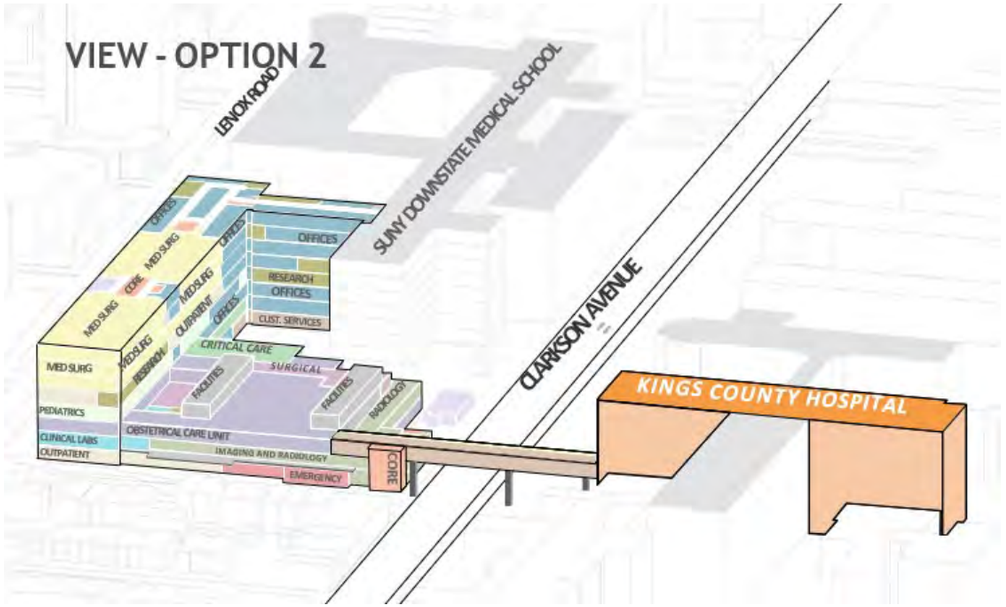
SECTION - OPTION 2



NEW BRIDGE TO KINGS COUNTY HOSPITAL COST MODEL



New Bridge - Option 1		Prelim BGSF	low $3,500/SF	high $3,800/SF
Downstate Patient Tower to King's County Patient Tower DMC - Level 5	Single story, 450'	10,800	$37,800,000	$41,040,000
			low $450/SF	high $600/SF
	Renovated "landing" areas	1,200	$540,000	$720,000
	escalation (5%) over 2 years		$9,048,240	$9,855,360
			$47,388,240	**$51,615,360**



New Bridge - Option 2		Prelim BGSF	low $3,400/SF	high $3,700/SF
Downstate Patient Tower to King's County Patient Tower DMC - Level 3	Single story, 256'	6,100	$20,740,000	$22,570,000
			low $450/SF	high $600/SF
	Renovated "landing" areas	2,650	$1,192,500	$1,590,000
	escalation (5%) over 2 years		$5,176,070	$5,701,760
			$27,108,570	**$29,861,760**

Appendix 4-B
Scenarios Evaluated Financial/Operating

Acknowledging the Challenges Shaping UHB's Future

Critical Access Point	UHB serves a vulnerable population, and service reductions could jeopardize both access to care and the economic stability of community
Impacts of State Ownership	UHB's public ownership drives higher labor costs, slower decision-making, and limited flexibility in pursuing partnerships and innovation
Lack of Scale	As a standalone hospital, UHB struggles to secure competitive payor rates and realize the cost efficiencies of larger systems
Academic Mission Tensions	Fulfillment of UHB's academic mission is at odds with service rationalization that is likely needed to enhance financial outlook
Stagnant Market Demographics	Demographic shifts in Brooklyn have not translated to a stronger payor mix within UHB's service area
Outdated Infrastructure	UHB's infrastructure does not meet modern care standards, making it harder to deliver high-quality, respectful care to underserved patients
Limited Funding Available	State funding is not unlimited – for UHB to receive additional funding beyond the $750M, the state will have to justify additional allocations

Scenario Considerations

Strategic Considerations

- **Regional Role:** Collaboration with other acute health care providers may offer lower-risk growth, though with shared control, increased complexity, and reduced returns
- **Historical Demand:** Decreasing inpatient & outpatient demand and increasing outmigration trends pose significant challenges
- **Financial Viability:** Breakeven hinges on contribution margin improvements and payer mix gains
- **Risk and Scale:** Smaller-scale or phased investments may offer more defensible returns

Operational Considerations

- **Physician Network**: Developing a community-based network of physicians who will refer patients will be critical to success
- **Technology Adoption:** Coordinating major technology upgrades (EHR, AI) with construction can maximize impact, but adds complexity and capital strain
- **Post-Acute Facilities:** Creating a network of post-acute facilities to facilitate transitions and discharge planning
- **Urban Planning Considerations:** Consider proximity to subway lines and other public transportation

Risks & Unknowns

- **Medicaid:** Steep cuts threaten Medicaid budget. If enacted, these cuts would pose severe risks
- **Site Neutrality:** Proposed changes could erode revenue from hospital-based outpatient care, undermining HOPD investment
- **Construction Risks:** Legacy infrastructure imposes cost, complexity, and potential physical constraints on any expansion effort
- **Data Integrity:** Data quality issues limit forecasting precision and raise execution risk
- **Regulatory & Licensing:** Success depends on CON approvals

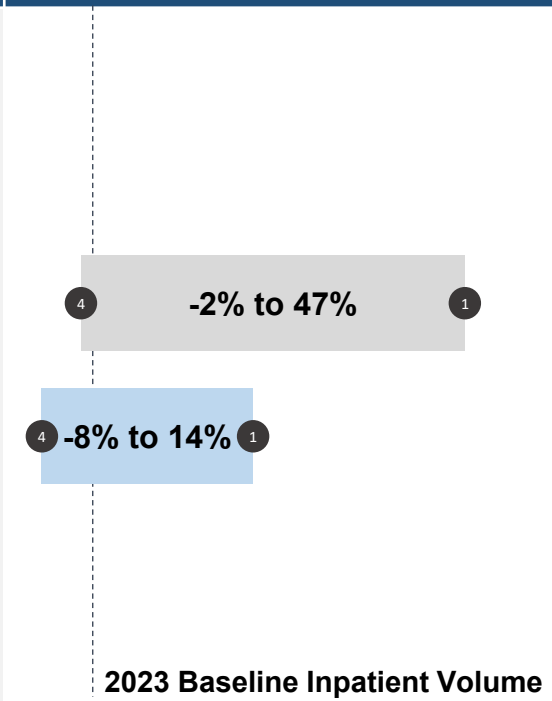
Opportunities

- **Stemming Outmigration:** Reversing outmigration could unlock significant volume by recapturing demand currently leaving UIHB's service area
- **Technology Adoption:** The facility investment provides a unique timing opportunity to invest in technology upgrades without further disrupting care
- **Site of Care Shift:** Shifting to lower cost of care settings mitigates the risk posed by potential site neutrality and Medicaid cuts

Two sets of assumptions showed (1) what must be true to achieve breakeven and (2) what outcomes are realistic

	"What Must be True to Breakeven" Assumptions	Market-Based Assumptions
Purpose	Understand conditions required to eliminate deficit and achieve breakeven	Estimate what market share, volume, and financial performance goals are within range based on market dynamics
Volume Assumptions	• Assumes new inpatient facilities will operate at 85% capacity • Outpatient growth is modeled at levels to support projected maximum utilization of facility scale	• Grounded in historical data on market share, regional demand, and hospital performance • **Upper Bound**: This limit caps market share growth by assuming UHB captures the same market share gain as the largest shift observed in the primary and secondary service area over the last 5 years. The bound is established by comparing this assumed market share gain against UHB's baseline volume and is represented as a % change. • **Lower Bound**: This establishes a minimum volume growth, assuming current market share and size trends continue for 5 years and then stabilize
Financial Assumptions	• Assumes a 12-20% increase in UHB commercial mix from its service area • Assumes commercial payers reimburse at 125% of Medicare rates • Projects a 10-47% decrease in both direct and indirect costs through efficiency gains • Modeled based on current contribution margins, improved by assumed efficiencies	• Uses UHB historical payer mix without assuming major shifts outside of previously observed shifts within market • Aligns UHB closer to current commercial payer benchmarks for reimbursement rates • Minor overhead efficiency savings assumed – relies on historical trends and cost allocation improvement • Contribution margins are modeled based on market norms

Key Assumptions: Inpatient Volume

Assumptions	Ranges Relative to 2023 Baseline (Across Scenarios)	Rationale & Supporting Data
UHB Inpatient Volume Growth		**Inpatient Market Trends: Key Insights** • **Stable Market Share:** Local hospital market shares have remained steady since 2019 • **Shrinking Market:** Inpatient care use by service area residents has declined 10% since 2019; patients leaving the service area for care increased 4.8pp, driven by increasing competition[1] • **UHB Trend:** Inpatient admissions at UHB fell 19% from 2019–2023, with a 0.7pp loss in market share[1] **Selected Upper Bound (+14% Volume):** Based on matching the largest recent share gain in the area (1.6pp by Kings County Hospital, 2019–2023)[1] **Selected Lower Bound (–8% Volume):** Assumes continued market decline with stable share **Implication: Aligning Size to Match Community Need** Building to realistic demand avoids overspending on space that may go unused – protecting care access and long-term sustainability to benefit the community

1. SPARCS Inpatient and Ambulatory Surgery Market Data 2019-2023

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Outpatient Volume Growth

Assumptions	Ranges Relative to 2023 Baseline (Across Scenarios)	Rationale & Supporting Data
UHB Outpatient Volume Growth	3 **39% to 176%** 1 3 **-8% to 39%** 1 **2023 Baseline Outpatient Volume**	**Outpatient Market Trends: Key Insights** • **Stable Market Share:** Outpatient market shares in the service area have shown little change since 2019 • **Shrinking Local Use:** Outpatient visits to local facilities fell 27% (2021–2024)[2]; ambulatory surgeries dropped 1.4% (2019–2023)[1] • **Rising Outmigration for Services:** More service area residents are going elsewhere for healthcare—local patients receiving care outside of the service area rose 10.6pp (2019–2023)[1] • **UHB Trend:** UHB outpatient visits declined 9%[3]; ambulatory surgery share fell 0.8pp (2019–2023)[1] **Selected Upper Bound (+39% Volume):** Assumes UHB matches largest recent share gain observed in the area (1pp increase by Maimonides, 2019–2023)[1] **Selected Lower Bound (–8% Volume):** Assumes continued market share erosion and flat market[4] **Implication: Aligning Ambulatory Capacity to Market Demand** Sizing outpatient investments to reflect true usage trends ensures resources are focused on delivering care and supporting long-term access and affordability

1. SPARCS Inpatient and Ambulatory Surgery Market Data 2019-2023; 2. SPARCS Inpatient and Outpatient Audit Reports 2021-2024; 3. SUNY Downstate Cost Accounting Files 2019 and 2023; 4. Sg2 Outpatient Market Estimates, 2024

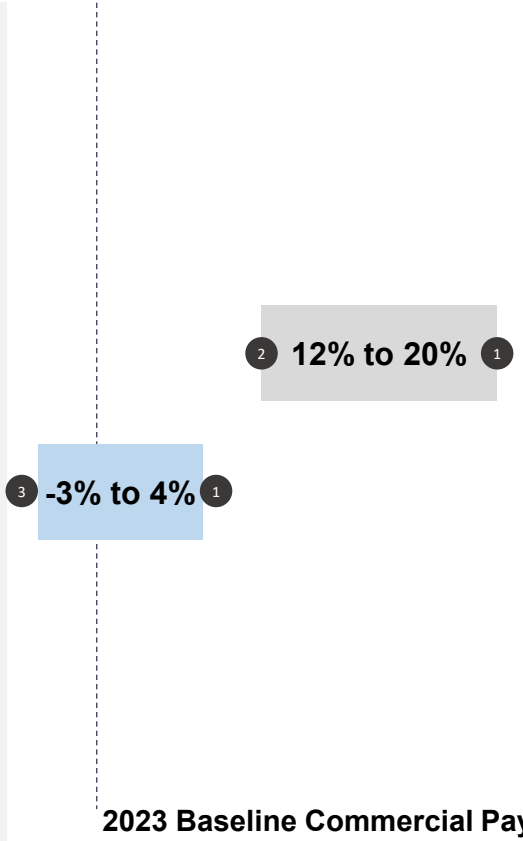
"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Commercial Payer Mix

Assumptions	Ranges Relative to 2023 Baseline (Across Scenarios)	Rationale & Supporting Data
UHB Commercial Payer Mix Increase Note: percentage point difference		**Commercial Payer Mix Trends: Key Insights** • **Limited Growth Potential:** The share of commercially insured patients in the area is small and largely stable • **Declining Commercial Volume:** Total commercial inpatient volume in the service area dropped 28% (2019–2023), as more patients sought care outside Brooklyn[1] • **Forecasted Decline:** Commercial payer mix in the area is projected to fall by 1pp through 2030[2] • **UHB Trend:** UHB commercial inpatient volume also declined 28%, with a minimal market share shift (–0.1pp)[1] **Selected Upper Bound (+4pp Mix Shift):** Based on the largest recent commercial share gain in the service area (4pp by Kings County Hospital, 2019–2023)[1] **Selected Lower Bound (-3pp Mix Shift):** Assumes continued commercial market volume decline with stable UHB market share **Implications: Grounding Expectations in Payer Trends** Commercial patients are a smaller—and shrinking—portion of the local market. Planning must reflect this reality to avoid overestimating revenue potential and ensure a sustainable path forward

1. SPARCS Inpatient and Ambulatory Surgery Market Data 2019-2023; 2. Sg2 Outpatient Market Estimates, 2024

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Commercial Reimbursement

Assumptions	Ranges Relative to Medicare Reimbursement (Across Scenarios)	Rationale & Supporting Data
Commercial Reimbursement % of Medicare	**125%** **125%**	**Both models assumed commercial reimbursement rates will be 125% of Medicare based on review of UHB's historical data and what is considered as standard based on market data** **Historical UHB rates show opportunity for improvement** • Historical UHB commercial rates are below 100% of Medicare reimbursement for inpatient services[1] **UHB Commercial Rates are far below NY State benchmark** • The benchmark for NY State is that commercial rates are at 200% of Medicare[2]

Medicare Reimbursement Rate

1. SUNY Downstate 2023 Cost Accounting Data; 2. Milliman 2024 Commercial Reimbursement Benchmarking

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumptions: Contribution Margin

Assumptions	Ranges Relative to 2023 Baseline (Across Scenarios)	Rationale & Supporting Data
Average Contribution Margin	**28% to 32%**	**SUNY Downstate provided data differ from market norms. According to internal cost accounting files:** • Medicaid is the most profitable line of business, where reimbursement typically only covers variable costs[1] • Note: Analysis excludes DSH payments **Comparable facilities to UHB show contribution margin as follows across lines of business:**[2] • Commercial: 45%-55% • Medicare: 35-40% • Medicaid: 0%-5%

2023 Baseline Contribution Margin

1. SUNY Downstate 2023 Cost Accounting Data; 2. Central Brooklyn Market Analysis

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Key Assumption: Overhead Cost Reduction

Assumptions	Ranges Relative to 2023 Baseline (Across Scenarios)	Rationale & Supporting Data
Overhead Cost Reduction	**10% to 47%** **5% to 10%** **2023 Baseline Costs**	• **"What Must be True to Breakeven" assumptions (10%–47% reduction) reflect the level of overhead savings needed for each scenario to break even financially** • **"Market-Based" assumptions (5%–10%) are more conservative and based on typical performance in similar hospitals** and the hospital's historical results • UHB internal data may overstate clinical overhead costs by including shared expenses—like university overhead—that do not directly support patient care. These areas may offer opportunities for savings[1]

1. SUNY Downstate 2023 Cost Accounting Data

"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

pp = percentage point change

DCAB scenario

Scenarios Assumptions

		Scenario									
		1		2		3a		3b		4	
Estimated Capital Cost		$2.847B		$874M - $950M		$2.1B - $2.9B		$661M - $765M		$874M - $950M	
		Market	Breakeven	Market	Breakeven	Market	Breakeven	Market	Breakeven	Market	Breakeven
Operating Income		($173M)	$-	($83M)	$-	($117M)	$-	($132M)	$-	($43M)	$-
Assumptions	Inpatient (IP) Volume Growth	14%	47%	4%	7%	4%	7%	-6%	7%	4%	-2%
	Outpatient (OP) Volume Growth	39%	176%	16%	56%	39%	133%	39%	104%	16%	40%
	Commercial Mix Shift	4%	20%	1%	12%	4%	20%	-3%	12%	1%	12%
	Commercial Reimb. % of Medicare	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%
	Contribution Margin	30%	N/A	30%	N/A	30%	N/A	30%	N/A	30%	N/A
	Overhead Cost Reduction	5%	34%	8%	20%	8%	46%	8%	29%	10%	10%

"What Must be True to Breakeven" Assumptions

Market-Based Assumptions

Methodology for market-based assumptions by scenario

Step 1. Upper and Lower bounds set by market analysis (see slides 3 - 10)

Step 2. High (“H”), medium (”M”), low (“L”) assumptions were set by scenario based on level of investment and area of focus

			Scenarios				
Assumption	**Lower Bound**	**Upper Bound**	**1**	**2**	**3a**	**3b**	**4**
Inpatient Volume Growth	-6%	14%	H	M	M	L	M
Outpatient Volume Growth	-8%	39%	H	M	H	H	M
Commercial Mix Shift	-3%	4%	H	M	H	L	M
Commercial Rate as % of Medicare	69%	125%	H	H	H	H	H
Average Contribution Margin	28%	32%	M	M	M	M	M
Reduced Overhead	5%	10%	L	M	M	M	H

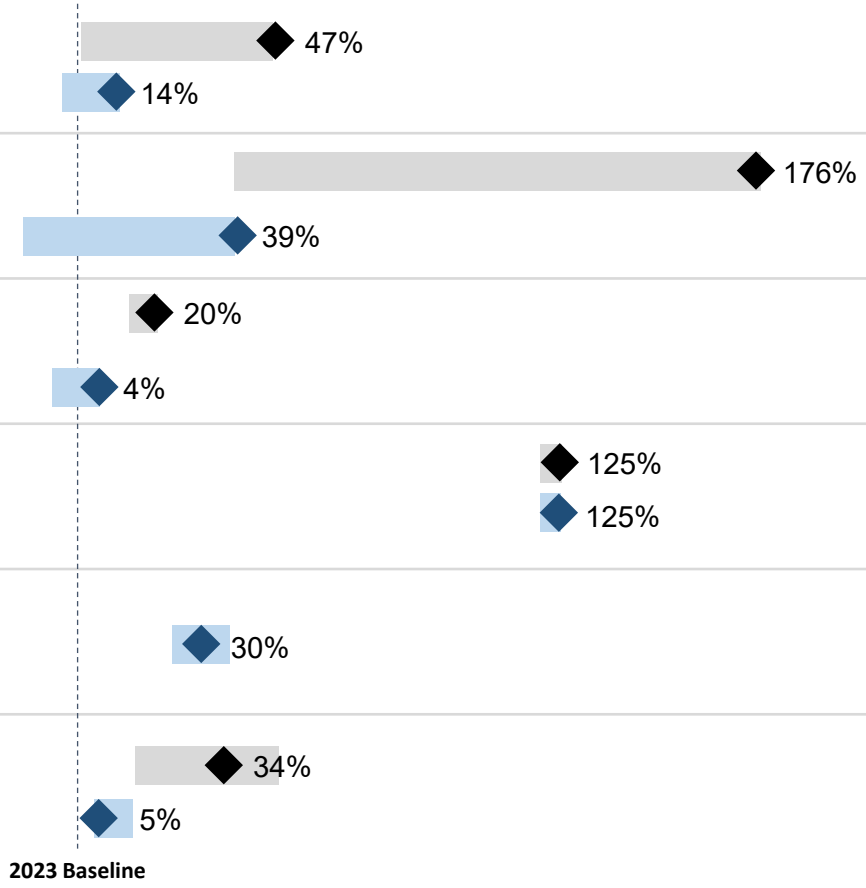
Step 3. “H” yielded upper bound, “L” yielded lower bound, and “M” yielded the midpoint between bounds

			Scenarios				
Assumption	**Lower Bound**	**Upper Bound**	**1**	**2**	**3b**	**3b**	**4**
Inpatient Volume Growth	-6%	14%	14%	4%	4%	-6%	4%
Outpatient Volume Growth	-8%	39%	39%	16%	39%	39%	16%
Commercial Mix Shift	-3%	4%	4%	1%	4%	-3%	1%
Commercial Rate as % of Medicare (adj.)	69%	125%	125%	125%	125%	125%	125%
Average Contribution Margin	28%	32%	30%	30%	30%	30%	30%
Reduced Overhead	5%	10%	5%	8%	8%	8%	10%

Assumptions | Scenario 1 (Brooklyn for Downstate)

Scenario 1 Description: 1a: Build a new 16-story inpatient hospital on the existing campus, including 2 floors for outpatient care. The current hospital building would not be renovated.1b: Build a new 14-story inpatient hospital on the existing garage site and a new 7-story outpatient center on part of the current hospital and campus footprint. No additional upgrades would be made to the existing hospital building.

Assumptions	Assumptions for Scenario 1b	Rationale Supporting Market-Based Assumptions
UHB Inpatient Volume Growth	47% 14%	• 14% inpatient growth is the upper bound and would match historical largest 5-year market share gain; selected due to scenario 1's significant upgrade to the inpatient facility
UHB Outpatient Volume Growth	176% 39%	• 39% outpatient growth is upper bound based on UHB match of largest 5-year competitor gain in ambulatory surgery market share, driven by large investment in new outpatient facility
UHB Commercial Payer Mix Increase	20% 4%	• 4% commercial payer mix increase is upper bound based on UHB matching largest 5-year commercial share gain by competitor, driven by significant investment in new facilities
Commercial Reimbursement % of Medicare	125% 125%	• Assumption that commercial reimbursement as a percentage of Medicare will improve to 125% to become closer to the NY market rates of 200%
Average Contribution Margin	30%	• 30% contribution margin is the midpoint between upper and lower bounds, accounting for increases in contribution margin based on improved cost allocation methods and efficiencies
Overhead Cost Reduction	34% 5%	• 5% overhead cost reduction is the lower bound of achievable cost reduction based on offsetting impact of maintaining a larger facility footprint



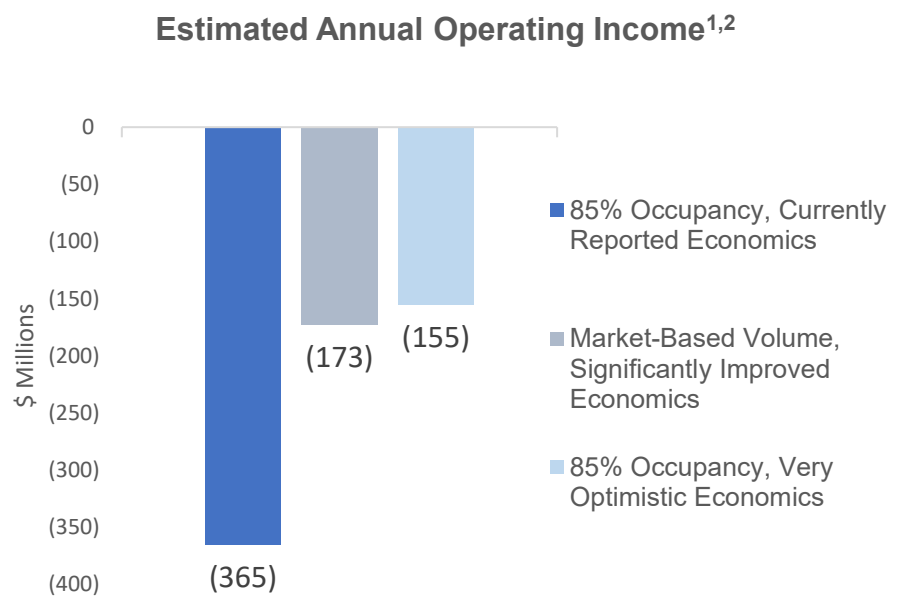
◆ "What Must be True to Breakeven" Scenario-specific Assumption
◆ Market-based Scenario-specific Assumption

"What Must be True to Breakeven" Assumption Range
Market-Based Assumption Range

Financial Implications | Scenario 1 (Brooklyn for Downstate)

Scenario 1 Description: 1a: Build a new 16-story inpatient hospital on the existing campus, including 2 floors for outpatient care. The current hospital building would not be renovated.1b: Build a new 14-story inpatient hospital on the existing garage site and a new 7-story outpatient center on part of the current hospital and campus footprint. No additional upgrades would be made to the existing hospital building.

Financial Implications



Key Takeaways

1. **Volume growth in Scenario 1 may not justify significant inpatient expansion**
   - **Decreased Hospital Occupancy:** Even with assumed upper bound 14% inpatient volume gain, occupancy would be 69% vs. 79% (current) due to new higher bed count
   - **Potential for Underused Facilities:** Despite expected outpatient market growth, new outpatient facilities may not be filled due to competition and increased numbers of patients seeking care outside UHB's service area
2. **Scenario 1 is estimated to worsen operating losses relative to baseline**
   - **UHB Financial Projection:** Market estimates still project substantial operating losses, driven by the potential difficulty of attracting the patient volume to fill a larger facility. Estimated annual operating loss range from $155M - $365M which would exceed current state operating losses of $95M annually

Implication: Aligning Expectations with Achievable Market Share Gain

Building a new larger hospital may not result in large enough gains in inpatient volume to justify the high capital expenditure

Concluded Range: ($365M) – ($155M)

{1} 2023 operating income deficit was ($95M)

(2) "Currently Reported Economics" is defined as the operating income estimated if current cost accounting reports were used (may over-allocate overhead expenses to UHB)

Assumptions | Scenario 2

Scenario 2 Description: Renovate all patient rooms to single occupancy, modernize the Emergency Department, and build a new 93k sqft Ambulatory Surgery Center (ASC) focused on cardiology and oncology services.

Assumptions	Assumptions for Scenario 2	Rationale Supporting Market-Based Assumptions
UHB Inpatient Volume Growth	7% 4%	• 4% inpatient growth is midpoint of upper and lower bounds of volume growth based on market and competitor performance in the service area, driven by renovation of all inpatient rooms to single occupancy
UHB Outpatient Volume Growth	56% 16%	• 16% outpatient growth is midpoint of upper and lower bounds of UHB improving volume based on market and competitor performance in service area, driven by investment in new Ambulatory Surgical Center
UHB Commercial Payer Mix Increase	12% 1%	• 1% commercial payer mix increase is the midpoint of upper and lower bounds based on market and competitor performance, driven by investment in renovated and new facilities
Commercial Reimbursement % of Medicare	125% 125%	• Assumption that commercial reimbursement as a percentage of Medicare will improve to 125% to become closer to the NY market rates of 200%
Average Contribution Margin	30%	• 30% contribution margin is the midpoint between upper and lower bounds, accounting for increases in contribution margin based on improved cost allocation methods and efficiencies
Overhead Cost Reduction	20% 8%	• 8% overhead cost reduction is the midpoint of achievable of cost reduction based on the balance of improved cost allocation and unit economics as well as the investment in facility improvements

2023 Baseline

*Scenario 2 includes addition of $250 million in capital over five years, totaling $1 billion, and consideration of $125 million MEP project overlap

◆ "What Must be True to Breakeven" Scenario-specific Assumption

◆ Market-based Scenario-specific Assumption

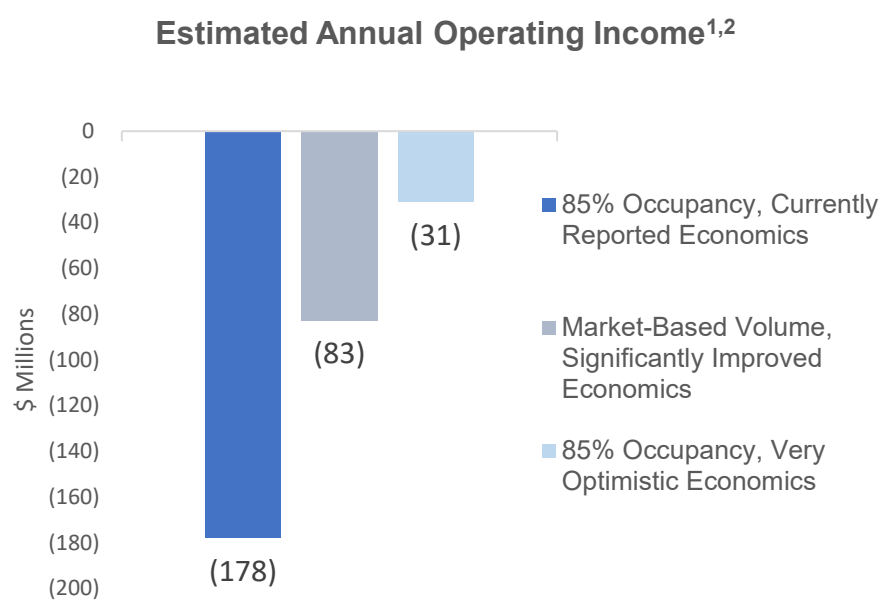
"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

Financial Implications | Scenario 2

Scenario 2 Description: Renovate all patient rooms to single occupancy, modernize the Emergency Department, and build a new 93k sqft Ambulatory Surgery Center (ASC) focused on cardiology and oncology services.

Financial Implications



Key Takeaways

1. **Scenario 2 right-sizes facility expansion based on attainable patient volume**
   - **Well-Utilized Outpatient Facility:** Projected outpatient volume growth of 16% would fill the proposed 93,000 sqft center, focused on high-need services like cardiology and oncology
   - **Increased Hospital Occupancy:** A modest 4% increase in inpatient demand driven by renovating the hospital would raise hospital occupancy from 79% to 82%—bringing it in line with industry standards and improving cost-effectiveness
2. **Scenario 2 is projected to reduce UHB's operating losses**
   - **UHB Financial Projection:** New volume may improve margins through better overhead allocation, a stable mix of commercial patients, cost reductions, and improved productivity. Models show UHB's operating margins could improve from ($95M)

Implication: Ambulatory Focus Sustainably Aligns UHB to Community Needs

The smaller financial outlay and ambulatory focus match UHB services with market demand and project stronger economics than current state. Further UHB operational improvements are required to achieve breakeven financials

Concluded Range: ($178M) – ($31M)

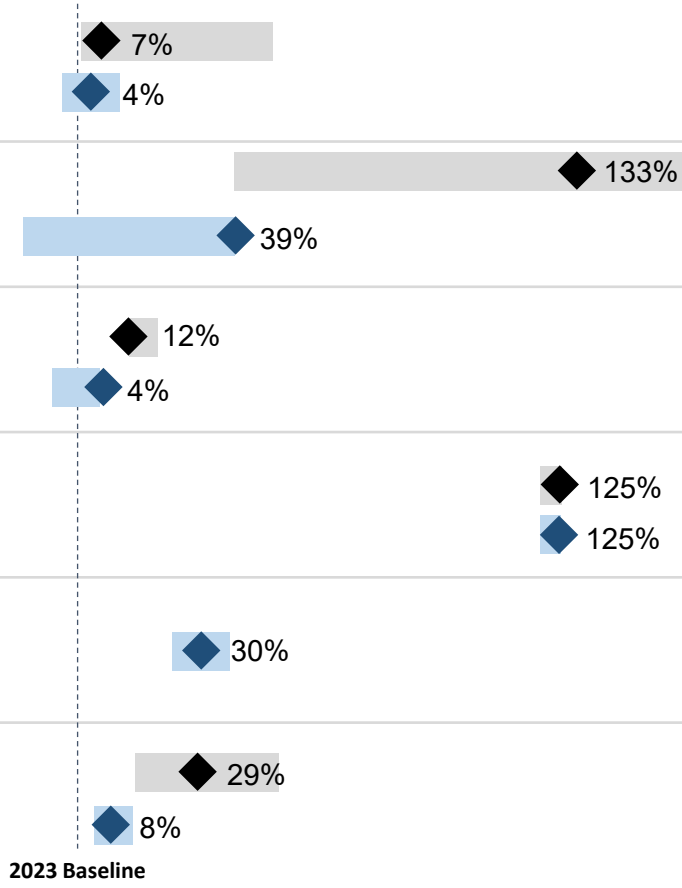
{1} 2023 operating income deficit was ($95M)

(2) "Currently Reported Economics" is defined as the operating income estimated if current cost accounting reports were used (may over-allocate overhead expenses to UHB)

Assumptions | Scenario 3a

Scenario 3a Description: Build a new 190k sqft Ambulatory Surgery Center (ASC) and a 100–200 bed inpatient tower on the garage site. Make limited improvements to existing hospital, including minor infrastructure and ED updates. Includes parking.

Assumptions	Assumptions for Scenario 3a	Rationale Supporting Market-Based Assumptions
UHB Inpatient Volume Growth	7% 4%	• 4% inpatient growth is midpoint of upper and lower bounds of volume growth based on market and competitor performance in the service area, driven by investment in new inpatient tower and offset by lack of investment in existing hospital
UHB Outpatient Volume Growth	133% 39%	• 39% outpatient growth is upper bound based on UHB match of largest 5-year competitor gain in ambulatory surgery market share, driven by large investment in new ambulatory surgery center
UHB Commercial Payer Mix Increase	12% 4%	• 4% commercial payer mix increase is upper bound based on UHB matching largest 5-year commercial share gain by competitor, driven by significant investment in new facilities
Commercial Reimbursement % of Medicare	125% 125%	• Assumption that commercial reimbursement as a percentage of Medicare will improve to 125% to become closer to the NY market rates of 200%
Average Contribution Margin	30%	• 30% contribution margin is the midpoint between upper and lower bounds, accounting for increases in contribution margin based on improved cost allocation methods and efficiencies
Overhead Cost Reduction	29% 8%	• 8% overhead cost reduction is the midpoint of achievable of cost reduction based on the balance of improved cost allocation and unit economics as well as the investment in facility improvements



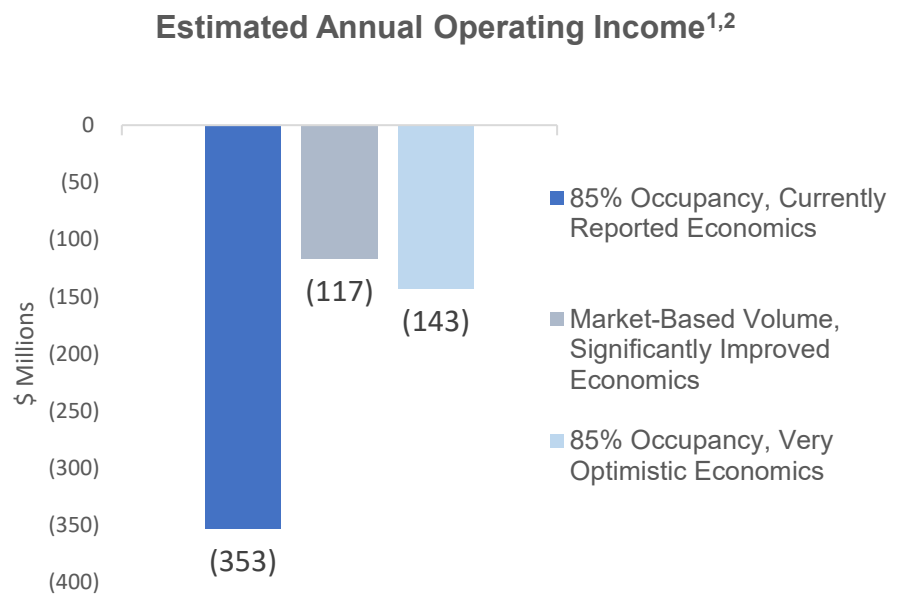
◆ "What Must be True to Breakeven" Scenario-specific Assumption
◆ Market-based Scenario-specific Assumption

"What Must be True to Breakeven" Assumption Range
Market-Based Assumption Range

Financial Implications | Scenario 3a

Scenario 3a Description: Build a new 190k sqft Ambulatory Surgery Center (ASC) and a 100–200 bed inpatient tower on the garage site. Make limited improvements to existing hospital, including minor infrastructure and ED updates. Includes parking.

Financial Implications



Key Takeaways

1. **Scenario 3a's large new facilities are likely to be under-utilized**
   - **Challenging Market Dynamics:** Despite a new inpatient tower, without updating the current hospital, it may be difficult to attract sufficient growth in patients to fill both the new and existing patient beds—especially with nearby hospitals offering fully modernized facilities and services
   - **Decreased Hospital Occupancy:** 4% estimated inpatient growth does not support the economics of 100 – 200 new beds while maintaining current inpatient footprint
2. **Scenario 3a is estimated to increase UHB's operating losses**
   - **UHB Financial Projection:** Operating losses are projected to rise to $117M–$353M per year, compared to $95M today.

Implication: Lack of Current Hospital Renovation in Scenario 3a Leaves Gaps
Lack of investment in modernizing the current space may translate to challenges attracting inpatient volume. This is projected to result in under-utilized space and increase UHB's financial losses

Concluded Range: ($353M) – ($117M)

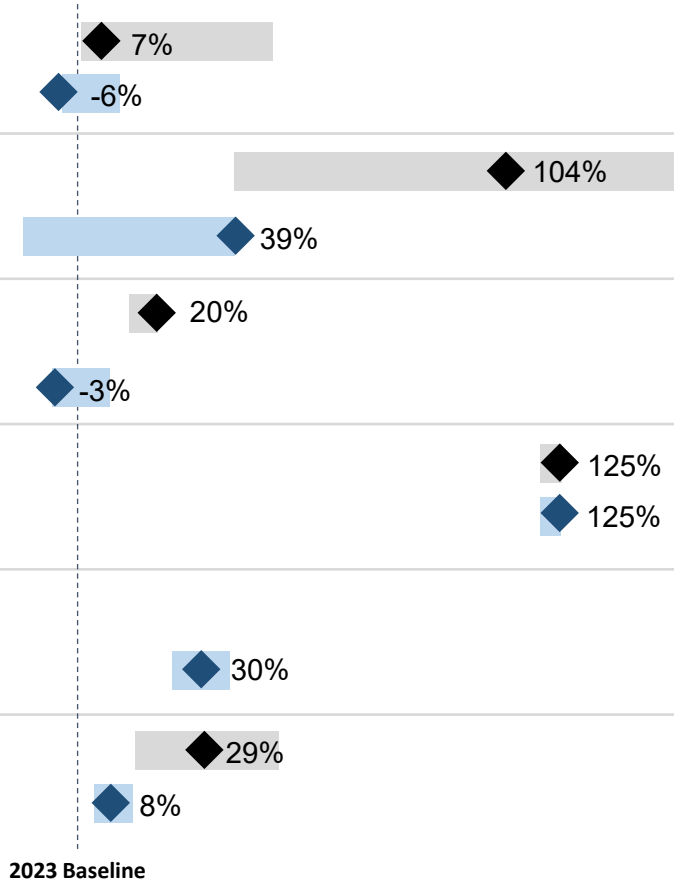
{1} 2023 operating income deficit was ($95M)

(2) "Currently Reported Economics" is defined as the operating income estimated if current cost accounting reports were used (may over-allocate overhead expenses to UHB)

Assumptions | Scenario 3b

Scenario 3b Description: Build a new 190k sqft Ambulatory Surgery Center (ASC). No further upgrades would be made to the existing hospital.

Assumptions	Assumptions for Scenario 3b	Rationale Supporting Market-Based Assumptions
UHB Inpatient Volume Growth	7% -6%	• 6% inpatient decline is low bound based on continued market volume trend, while not investing in the existing hospital leaves UHB market share unchanged
UHB Outpatient Volume Growth	104% 39%	• 39% outpatient growth is upper bound based on UHB match of largest 5-year competitor gain in ambulatory surgery market share, driven by large investment in new ambulatory surgery center
UHB Commercial Payer Mix Increase	20% -3%	• 3% commercial payer mix decrease is low bound based on UHB seeing continued out migration without hospital improvements
Commercial Reimbursement % of Medicare	125% 125%	• Assumption that commercial reimbursement as a percentage of Medicare will improve to 125% to become closer to the NY market rates of 200%
Average Contribution Margin	30%	• 30% contribution margin is the midpoint between upper and lower bounds, accounting for increases in contribution margin based on improved cost allocation methods and efficiencies
Overhead Cost Reduction	29% 8%	• 8% overhead cost reduction is the midpoint of achievable of cost reduction based on the balance of improved cost allocation and unit economics as well as the investment in facility improvements



◆ "What Must be True to Breakeven" Scenario-specific Assumption

◆ Market-based Scenario-specific Assumption

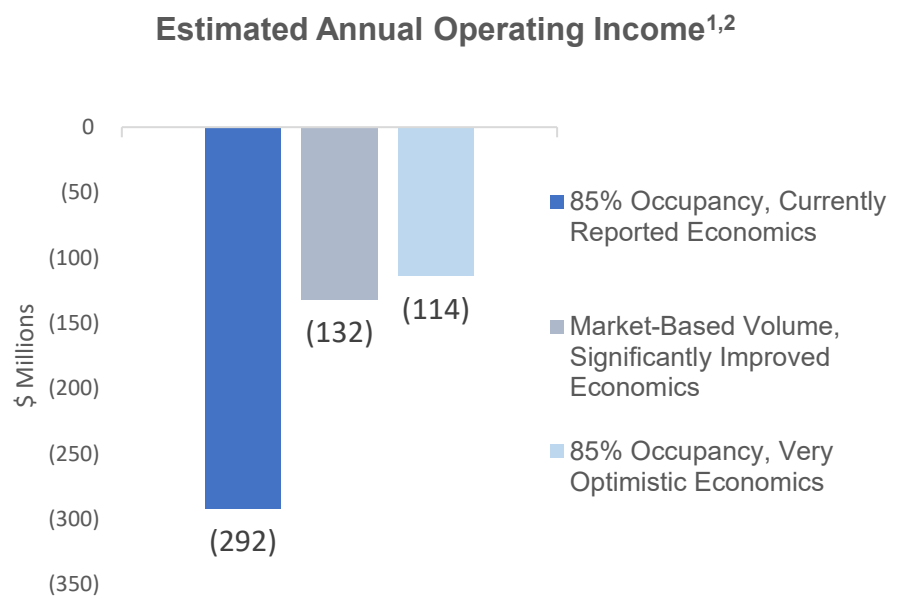
"What Must be True to Breakeven" Assumption Range

Market-Based Assumption Range

Financial Implications | Scenario 3b

Scenario 3b Description: Build a new 190k sqft Ambulatory Surgery Center (ASC). No further upgrades would be made to the existing hospital.

Financial Implications



Key Takeaways

1. **Scenario 3b's lack of inpatient focus risks care access**
   - **Risk of Declining Inpatient Facilities:** Without improvements to the current hospital, inpatient use is expected to decline, which could reduce access to essential care for the community
   - **Outpatient Facility May Be Too Large for Demand:** Even with a projected 39% growth in outpatient services, the new 190,000 sqft surgery center may be larger than needed, leading to underused space
2. **Scenario 3b is projected slowly increase operating losses**
   - **UHB Financial Projection:** Annual losses are projected between $114M and $292M—better than Scenario 3a but still above current $95M deficit.

Implication: Prioritizing Outpatient Growth Without Inpatient Support May Underserve Community Needs

While this plan better aligns with outpatient trends than Scenario 3a, it overlooks critical inpatient investments, which are vital for balanced, long-term community care and financial health

Concluded Range: ($292M) – ($114M)

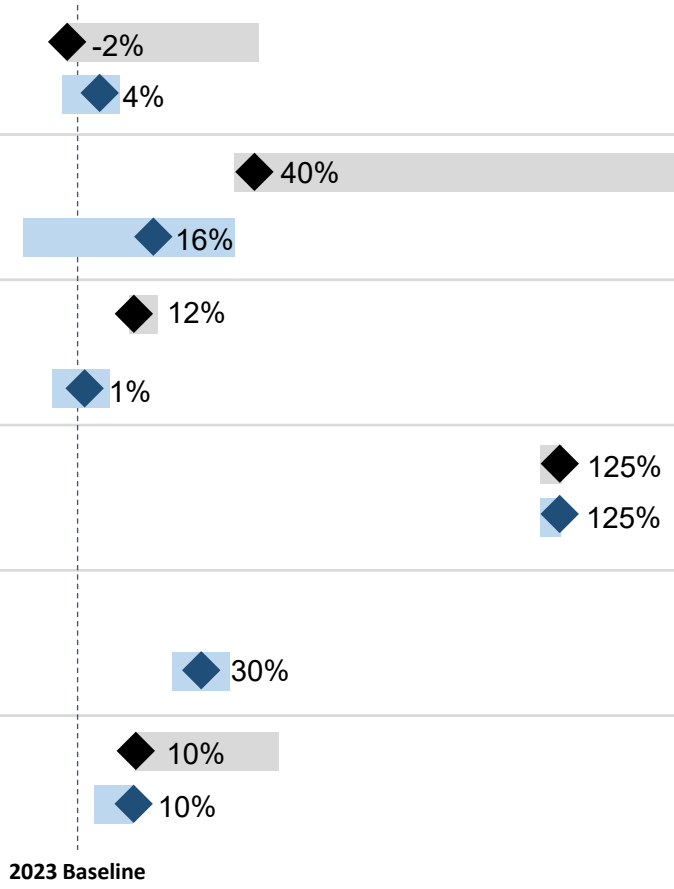
{1} 2023 operating income deficit was ($95M)

(2) "Currently Reported Economics" is defined as the operating income estimated if current cost accounting reports were used (may over-allocate overhead expenses to UHB)

Assumptions | Scenario 4

Scenario 4 Description: Renovate all patient rooms to single occupancy, modernize the Emergency Department, and build a new 93k sqft Ambulatory Surgery Center (ASC) focused on cardiology and oncology services. Collaborate with H&H to coordinate services

Assumptions	Assumptions for Scenario 4	Rationale Supporting Market-Based Assumptions
UHB Inpatient Volume Growth	-2% to 4%	• 4% inpatient growth is midpoint of upper and lower bounds of volume growth based on market and competitor performance in the service area, driven by renovation of all inpatient rooms to single occupancy
UHB Outpatient Volume Growth	40% to 16%	• 16% outpatient growth is midpoint of upper and lower bounds of UHB improving volume based on market and competitor performance in service area, driven by investment in new Ambulatory Surgical Center
UHB Commercial Payer Mix Increase	12% to 1%	• 1% commercial payer mix increase is the midpoint of upper and lower bounds based on market and competitor performance, driven by investment in renovated and new facilities
Commercial Reimbursement % of Medicare	125% to 125%	• Assumption that commercial reimbursement as a percentage of Medicare will improve to 125% to become closer to the NY market rates of 200%
Average Contribution Margin	30%	• 30% contribution margin is the midpoint between upper and lower bounds, accounting for increases in contribution margin based on improved cost allocation methods and efficiencies
Overhead Cost Reduction	10% to 10%	• 10% overhead cost reduction is the high end of achievable cost reduction based on the balance of improved cost allocation and unit economics as well as the investment in facility improvements and reduction of overhead expenses through collaboration with H&H



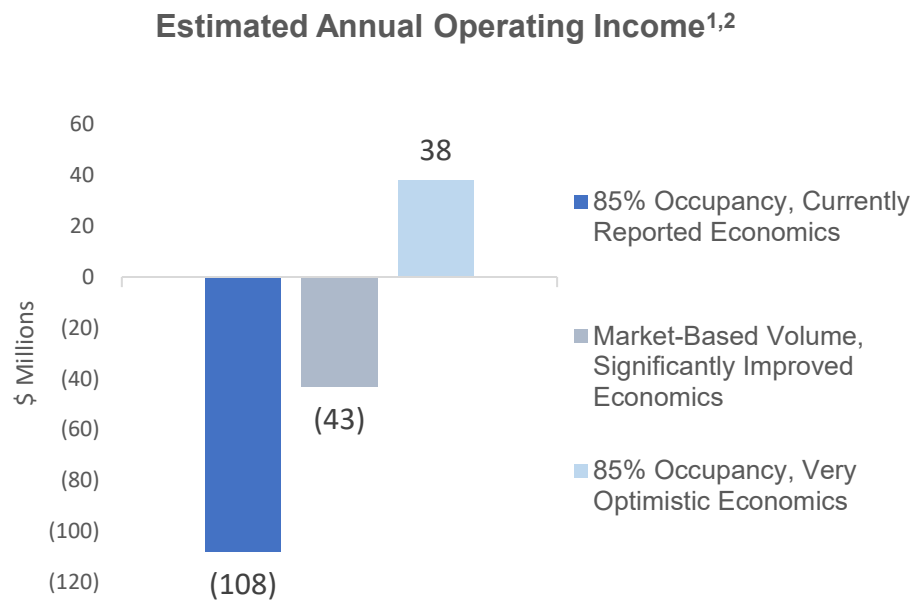
◆ "What Must be True to Breakeven" Scenario-specific Assumption
◆ Market-based Scenario-specific Assumption

"What Must be True to Breakeven" Assumption Range
Market-Based Assumption Range

Financial Implications | Scenario 4

Scenario 4 Description: Renovate all patient rooms to single occupancy, modernize the Emergency Department, and build a new 93k sqft Ambulatory Surgery Center (ASC) focused on cardiology and oncology services. Collaborate with H&H to coordinate services

Financial Implications



Key Takeaways

1. **Scenario 4 right-sizes facility expansion based on attainable patient volume while collaborating with H&H to deliver services in a coordinated manner**
   - **Well-Utilized Outpatient Facility:** Projected outpatient volume growth of 16% would fill the proposed 93,000 sqft center, focused on high-need services like cardiology and oncology
   - **Increased Hospital Occupancy:** A modest 4% increase in inpatient demand driven by renovating the hospital would raise hospital occupancy from 79% to 82%—bringing it in line with industry standards and improving cost-effectiveness
   - **Improved Service Mix:** Shifting of services with local partners will allow UHB to focus on more complex cases resulting in performing procedures that are reimbursed at higher rates
2. **Scenario 4 shows potential to improve current financial performance**
   - **UHB Financial Projection:** Annual operating income is projected between (108M) and $38M—which show operating margins could improve from ($95M) in the current state. Improvements could be driven by better overhead allocation, a stable mix of commercial patients, cost reductions, improved productivity, and a more advantageous case mix

Implication: The smaller financial outlay and ambulatory focus align with market demand and project stronger unit economics through phased sharing of services between UHB and H+H Kings County

Concluded Range: ($108M) – $38M

{1} 2023 operating income deficit was ($95M)

(2) "Currently Reported Economics" is defined as the operating income estimated if current cost accounting reports were used (may over-allocate overhead expenses to UHB)

Additional Information

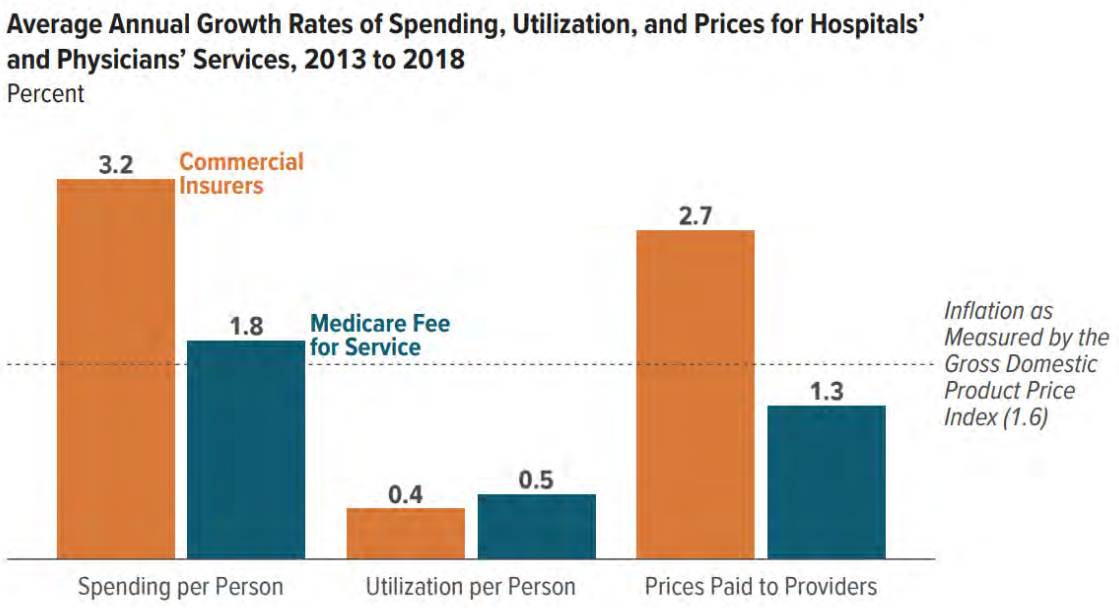
Change in Inpatient Service Area Market Share (% of Discharges), 2019-2023[1]

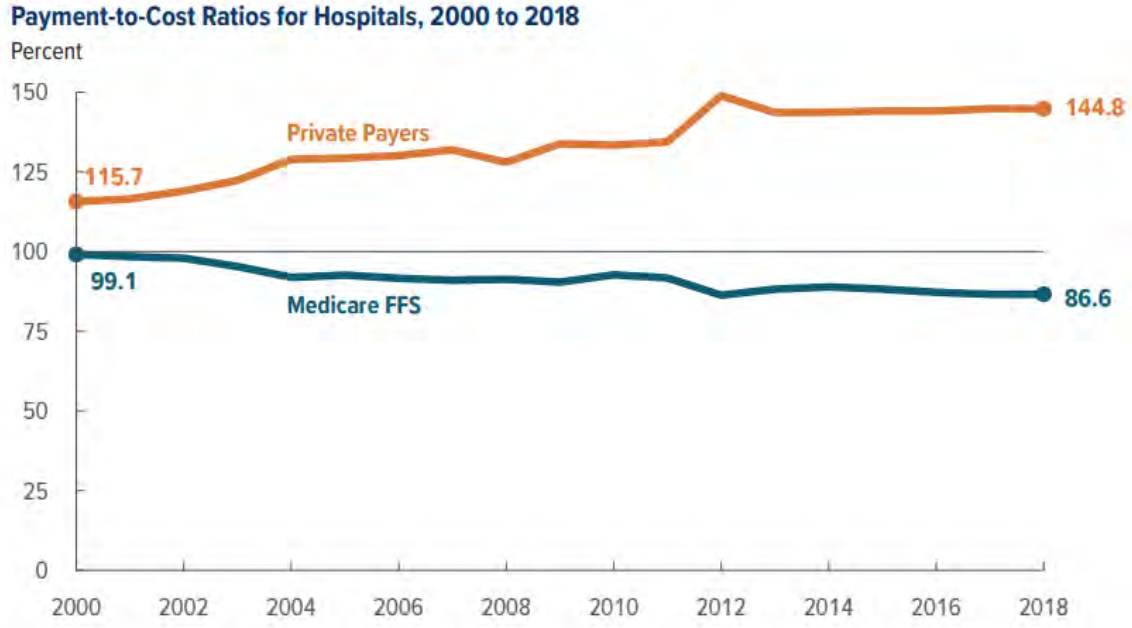
Facility ID	Facility	2019 Market Share (Service Area)	2023 Market Share (Service Area)	Gain/Loss in Market Share
001301	NYC Health + Hospitals/Kings County	13%	15%	1.55%
001324	Mount Sinai Brooklyn	5%	6%	1.11%
001304	NYU Langone Hospital - Brooklyn	2%	3%	1.10%
001318	Wyckoff Heights Medical Center	2%	3%	1.00%
001692	NYC Health + Hospitals/Woodhull	1%	2%	0.77%
001294	NYC Health + Hospitals/South Brooklyn Health, Ruth Bader Ginsburg / Coney Island Hospital	1%	1%	0.14%
010223	Calvary Hospital Brooklyn Campus	0%	0.07%	0.07%
001288	The Brooklyn Hospital Center	4%	4%	-0.23%
001309	Interfaith Medical Center	4%	4%	-0.27%
001305	Maimonides Medical Center	6%	5%	-0.51%
001293	Maimonides Midwood Community Hospital	2%	1%	-0.63%
001320	University Hospital SUNY Downstate	7%	6%	-0.71%
001306	NYP Brooklyn Methodist Hospital	11%	10%	-1.21%
001286	Brookdale Hospital Medical Center	12%	11%	-1.32%
001315	Kingsbrook Jewish Medical Center	6%	0.3%	-5.68%

1. 2019 SPARCS Inpatient Database, 2023 SPARCS Inpatient Database

Medicare Reimbursement Structure

According to the Congressional Budget Office, Medicare is currently reimbursing below costs and is causing NYS to cross subsidize the loss in order to maintain operations





Based on a CBO report issued Jan 26, 2022, Medicare reimbursement has fallen from 99.1% of costs to 86.6 % in 2018. Currently, it is estimated that the Medicare rate is now close to 80% of total costs[1]

1. Congressional Budget Office

Definitions Related to Operating Income Outcomes

Name	Definition
85% Occupancy, Currently Reported Economics	Operating income estimated if UHB was able to achieve 85% occupancy of the proposed capacity in a given scenario, and used current cost accounting files to project financials of additional volume that was captured
Market Based Volume, Significantly Improved Economics	Operating income estimated if UHB captured volume in line with expectations concluded via a market analysis using similar peers in the geographic area as a benchmark, but made significant improvement assumptions surrounding economic input factors such as direct cost reductions, increased reimbursement rates, etc.
85% Occupancy, Very Optimistic Economics	Operating income estimated if UHB was able to achieve 85% occupancy of the proposed capacity in a given scenario, but made very optimistic improvement assumptions surrounding economic input factors such as direct and indirect cost reductions, improved productivity, increased reimbursement rates, etc.

1. 2019 SPARCS Inpatient Database, 2023 SPARCS Inpatient Database