SBH Health System

SITE INFORMATION – HOSPITAL

Alternate contact: John DiGirolomo
Email address: jdigirolomo@sbhny.org

Type of Application: Establishment ☐ Construction ☒ Administrative ☐ Limited ☐

Total Project Cost: $27,145,141

Operator Information:
SBH Health System
4422 Third Avenue
Bronx, New York 10457

PFI#: 1176

Project Site Information:
SBH Health System
4422 Third Avenue
Bronx, New York 10457

PFI#: 1176

Site Proposal Summary (maximum of 1,000 characters):
SBH Health System (SBH), located at 4422 Third Avenue, Bronx (Bronx County), New York 10457, is seeking approval to increase the number of its inpatient psychiatric beds from 49 to 72, an increase of 23 beds, through the conversion of 12 inpatient chemical dependence - detoxification beds to 12 psychiatric beds and the certification of 11 new psychiatric beds. As part of this proposal, SBH will gut and renovate the Hospital's two (2) existing inpatient psychiatric units and renovate another floor in the Hospital to create a new inpatient psychiatric unit. At the end of the project, SBH will have three (3) 24-bed inpatient psychiatric units that meet up-to-date standards of care for inpatient psychiatric services and enhances patient and staff safety and comfort. SBH has been awarded Statewide Heath Care Facility Transformation Program III grant funds to assist with over 97% of the cost of the project.

Modify Name/Address: N/A

Beds:

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30	22	☐	☐	22
BONE MARROW TRANSPLANT	21		☐	☐	
BURNS CARE	09		☐	☐	
CHEMICAL DEPENDENCE-DETOX *	12	24	☐	X 12	12

CHEMICAL DEPENDENCE-REHAB *	13		☐	☐	
COMA RECOVERY	26		☐	☐	
CORONARY CARE	03		☐	☐	
INTENSIVE CARE	02	26	☐	☐	26
MATERNITY	05	16	☐	☐	16
MEDICAL/SURGICAL	01	254	☐	☐	254
NEONATAL CONTINUING CARE	27	5	☐	☐	5
NEONATAL INTENSIVE CARE	28		☐	☐	
NEONATAL INTERMEDIATE CARE	29	10	☐	☐	10
PEDIATRIC	04	16	☐	☐	16
PEDIATRIC ICU	10		☐	☐	
PHYSICAL MEDICINE & REHABILITATION	07		☐	☐	
PRISONER				☐	
PSYCHIATRIC**	08	49	X 23	☐	72
RESPIRATORY				☐	
SPECIAL USE				☐	
TRANSITIONAL CARE	33		☐	☐	
TRAUMATIC BRAIN INJURY	11		☐	☐	
	TOTAL	422	X 11	☐	433

Services: N/A

Remove Site: N/A

Executive Summary

SBH Health System (SBH), located at 4422 Third Avenue, Bronx (Bronx County), New York 10457, is submitting this Full Review Certificate of Need (C.O.N.) Application seeking approval to increase the number of its inpatient psychiatric beds from 49 to 72, an increase of 23 beds, through the conversion of 12 inpatient chemical dependence - detoxification beds to 12 psychiatric beds and the certification of 11 new psychiatric beds. As part of this proposal, SBH will gut and renovate the Hospital's two (2) existing inpatient psychiatric units and renovate another floor in the Hospital to create a new inpatient psychiatric unit. At the end of the project, SBH will have three (3) 24-bed inpatient psychiatric units that meet up-to-date standards of care for inpatient psychiatric services and enhance patient and staff safety and comfort. SBH has been awarded Statewide Heath Care Facility Transformation Program III grant funds to assist with over 97% of the cost of the project.

SBH is currently certified for a total of 422 inpatient beds, including 24 chemical dependence - detoxification beds and 49 inpatient psychiatric beds. The major driver for this request is to create a robust inpatient behavioral health platform by increasing the bed capacity of the inpatient adult psychiatric program by 23 beds, thereby expanding access to mental health care and ensuring appropriate levels of care in the mental health system in keeping with Governor Kathy Hochul's transformation plan for mental health services in New York State. Concurrent with this C.O.N. Application, SBH is submitting a Comprehensive PAR Application to increase the number of inpatient psychiatric beds to the New York State Office of Mental Health, a Limited Review Application to undertake renovations on the sixth floor of the Hospital for the relocation of a down-sized inpatient chemical dependency unit and a Certification Application with the New York State Office of Addiction Services and Supports to reduce the number of certified chemical dependency beds from 24 to 12.

New York State Department of Health
Certificate of Need Application

Schedule 1

Acknowledgement and Attestation

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

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

SIGNATURE:	DATE
PRINT OR TYPE NAME	TITLE
David Perlstein, MD	President & CEO

General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project.	YES ☒ NO ☐	Schedule 1 Attachment
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES ☐ NO ☒	

Contacts

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

Primary Contact			
NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY		
Frank Cicero, Consultant	Cicero Consulting Associates		
BUSINESS STREET ADDRESS			
925 Westchester Avenue, Suite 201			
CITY	STATE	ZIP	
White Plains	New York	10604	
TELEPHONE	E-MAIL ADDRESS		
(914) 682-8657	conadmin@cicreoassociates.com		

Alternate Contact			
NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY		
John DiGirolomo, Senior Vice President	SBH Health System		
BUSINESS STREET ADDRESS			
4422 Third Avenue			
CITY	STATE	ZIP	
Bronx	New York	10457	
TELEPHONE	E-MAIL ADDRESS		
(718) 960-9441	jdigirolomo@sbhny.org		

New York State Department of Health
Certificate of Need Application

Schedule 1

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

CHIEF EXECUTIVE			
NAME AND TITLE			
David Perlstein, MD, President & CEO			
BUSINESS STREET ADDRESS			
4422 Third Avenue			
CITY	STATE	ZIP	
Bronx	New York	10457	
TELEPHONE	E-MAIL ADDRESS		
(718) 960-3469	dperlstein@sbhny.org		

The applicant's lead attorney should be identified:

ATTORNEY			
NAME	FIRM	BUSINESS STREET ADDRESS	
Please contact the consultant			
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	

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

CONSUTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
Frank Cicero	Cicero Consulting Associates	925 Westchester Avenue, Suite 201	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
White Plains, New York 10604	(914) 682-8657	conadmin@ciceroassociates.com	

The applicant's lead accountant should be identified:

ACCOUNTANT			
NAME	FIRM	BUSINESS STREET ADDRESS	
Mary Grochowski, Executive Vice President & CFO	SBH Health System	4422 Third Avenue	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
Bronx, New York 10457	(718) 960-3839	mgrochowski@sbhny.org	

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER			
NAME	FIRM	BUSINESS STREET ADDRESS	
Paul Drago, AIA	NK Architects	233 Broadway, Suite 2150	
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS	
New York, New York 10279	(212) 982-7900	dragop@nkarchitects.com	

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

Other Facilities Owned or Controlled by the Applicant

Establishment (with or without Construction) Applications only **NOT APPLICABLE**

NYS Affiliated Facilities/Agencies

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

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

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

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

Out-of-State Affiliated Facilities/Agencies

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

Facility Type	Name	Address	State/Country	Services Provided

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

SCHEDULE 1 ATTACHMENT

Board Resolution

Project Narrative

A RESOLUTION TO BE ADOPTED BY
THE EXECUTIVE COMMITTEE OF THE BOARD OF TRUSTEES OF
ST. BARNABAS HOSPITAL

WHEREAS, the Executive Committee of the Board of Trustees of St. Barnabas Hospital (the "Hospital") deems it advisable and in the best interests of the Hospital to make improvements to the Ambulatory Care Building, renovations to the inpatient psychiatric units and to develop a new psychiatric unit, as well as to move the existing 24 bed detoxification unit from the 4th floor to the 6th floor and reduce the number of detoxifications beds from 24 to 12 (in order to accommodatc a new 24 bed psychiatric unit); and,

WHEREAS, the Hospital was awarded up to $38,980,021 pursuant to the New York State Statewide Health Care Facility Transformation Program III ("SHCFTP III") in connection with improvements to the Ambulatory Care Building, renovations of the current adult psychiatric units on Kane 2 and Kane 3 and the development of a new psychiatric unit on the 4th floor (collectively, the "SHCFTP III Projects"); and,

WHEREAS, in order to facilitate the development of the new psychiatric unit on the 4th floor, the detoxification unit will need to be moved to the 6th floor and be reduced from 24 beds to 12 beds, which is consistent with the average daily census of that unit (the "Detoxification Unit Project"); and,

WHEREAS, the Hospital may be required to file certificate of need applications with the New York State Public Health and Planning Council in order to complete the SHCFTP III Projects and the Detoxification Unit Project;

NOW, THEREFORE, BE IT RESOLVED, by the Executive Committee of the Board of Trustees of the Hospital, that:

1. The Hospital is authorized to file certificate of need applications required in connection with the SHCFTP III Projects and the Detoxification Unit Project and such applications may be approved and signed by the following individuals: Chairman of the Board, Vice Chairman of the Board and Treasurer; or any one of the following: President & Chief Executive Officer, Senior Executive Vice President & Chief Operating Officer and Executive Vice President & Chief Financial Officer.

2. This Resolution shall take effect immediately.

Date: March 26, 2025

E Sánchez

Elizabeth Sanchez, LCSW
Secretary

Project Narrative

Appendix A

Medical Director CV

SBH HEALTH SYSTEM

PROJECT NARRATIVE

St. Barnabas Hospital d/b/a SBH Health System (SBH), located at 4422 Third Avenue, Bronx (Bronx County), New York 10457, is submitting this Full Review Certificate of Need (C.O.N.) Application seeking approval to increase the number of its inpatient psychiatric beds from 49 to 72, an increase of 23 beds, through the conversion of 12 inpatient chemical dependence - detoxification beds to 12 psychiatric beds and the certification of 11 new psychiatric beds. As part of this proposal, SBH will gut and renovate the Hospital's two (2) existing inpatient psychiatric units and renovate another floor in the Hospital to create a new inpatient psychiatric unit. At the end of the project, SBH will have three (3) 24-bed inpatient psychiatric units that meet up-to-date standards of care for inpatient psychiatric services and enhance patient and staff safety and comfort. SBH has been awarded Statewide Heath Care Facility Transformation Program III (SHCFTP3) grant funds to assist with over 97% of the cost of the project.

SBH is currently certified for a total of 422 inpatient beds, including 24 chemical dependence - detoxification beds and 49 inpatient psychiatric beds. The major driver for this request is to create a robust inpatient behavioral health platform by increasing the bed capacity of the inpatient adult psychiatric program by 23 beds thereby expanding access to mental health care and ensuring appropriate levels of care in the mental health system in keeping with Governor Kathy Hochul's transformation plan for mental health services in New York State. Concurrent with this C.O.N. Application, SBH is submitting a Comprehensive PAR Application to increase the number of inpatient psychiatric beds to the New York State Office of Mental Health, a Limited Review Application to undertake renovations on the sixth floor of the Hospital for the relocation of a down-sized inpatient chemical dependency unit and a Certification Application with the New York State Office of Addiction Services and Supports to reduce the number of certified chemical dependency beds from 24 to 12 .

As reflected in the table below, this C.O.N Application will increase the number of certified psychiatric beds from 49 to 72; decrease the number of chemical dependency – detoxification beds from 24 to 12; and increase the total number of certified beds on the Operating Certificate from 422 to 433. The implementation of the proposed bed conversion will have no impact on meeting community need for inpatient chemical dependency detoxification services at SBH, which has been experiencing an average daily census of 10 since 2019. SBH has determined that the most effective way to meet community need for behavioral health services in the Bronx is to downsize the inpatient chemical dependency – detoxification unit and increase inpatient psychiatric bed capacity.

Table A. Current and Proposed Inpatient Bed Complement at SBH Health System

	Current Certified Beds	This Proposal	Proposed Certified Beds
AIDS	22		22
Chemical Dependency – Detoxification	24	-12	12
Intensive Care	26		26
Maternity Beds	16		16
Medical/Surgical	254		254
Neonatal Continuing Care Beds	5		5
Neonatal Intermediate Care Beds	10		10
Pediatric	16		16
Psychiatric	49	+23	72
TOTAL	**422**	**+11**	**433**

As part of this proposal, SBH will renovate an inpatient unit on the 4th floor, which currently houses SBH's inpatient chemical dependency unit, to create a new inpatient 24-bed psychiatric unit. In addition, SBH will renovate the existing inpatient psychiatric units located on the second and third floors of the Hospital.

The following sections demonstrate the case of need for this project and how SBH will ensure that all patients will continue to receive the high quality of care currently provided by SBH.

Public Need

The following factors were considered in the assessment of the need to increase the adult inpatient psychiatric bed capacity at SBH by 23 beds:

- The primary service area population demographics of SBH.
- The need for improved accessibility to behavioral health care for the residents of the service area.
- To support Governor Hochul's initative to increase inpatient psychiatric bed capacity to meet unmet need for inpatient care for adults.

SBH's mission is to provide high-quality, comprehensive, primary, specialty and preventive health and behavioral health services in an environment of care, respect, dignity and in a cost-effective manner that is responsive to the needs of the service community with continued emphasis on the underserved and those without access to care. As noted in the Introduction, the main rationale and need for this Application is to enhance access to inpatient psychiatric services for adults in SBH's service area.

Primary Service Area

SBH's primary service area includes the following Bronx ZIP Codes: 10453, 10456, 10457, 10458, 10459, 10460, 10462, 10467 and 10468. As shown in the table below, in general, the PSA population is comprised of a greater percentage of minorities than Bronx County, New York City and New York State as a whole and is poorer, compared to Bronx County, New York City and New York State. Moreover, 74.1% (or 508,162) of the PSA population was an adult over the age of 18. This is the age group that uses the services contemplated in this Application.

Demographic Profile	**PSA**	**Bronx County**	**New York City**	**New York State**
Population in 2023	685,779	1,419,250	8,516,202	19,872,319
% Male	47.3%	47.3%	48.0%	48.8%
% Age 65 and over	11.4%	13.9%	16.0%	17.4%
% Over age 18	74.1%	75.5%	79.6%	79.3%
% White, non-Hispanic	4.8%	8.8%	31.3%	53.4%
% Black, non-Hispanic	26.7%	29.1%	20.8%	13.6%
% Hispanic	61.7%	54.9%	28.4%	19.6%
% Asian	4.0%	4.0%	14.5%	8.8%
Social/Economic Characteristics	**PSA**	**Bronx County**	**New York City**	**New York State**
% Foreign-born	37.6%	34.2%	36.5%	23.3%
% Language other than English spoken at home	64.9%	57.1%	47.5%	30.6%
% Below Federal Poverty Level	30.3%	26.9%	17.4%	13.7%

Source: U.S. Census Bureau, 2019-2023 American Community Survey (ACS) 5-Year Estimates

The Adult Inpatient Mental Health System in the Bronx

The Bronx is an area of New York City in which SBH Health System is an essential provider of health and mental health services, including outpatient mental health treatment services to children,

adolescents and adults and inpatient mental health treatment services to adults. Outpatient programs are offered at various locations throughout the Bronx in two (2) centers and three (3) public schools. SBH is located in a mental health Health Professional Shortage Area (HPSA) (ME-Crotona ID: 7365719543), meaning there are not enough mental health professionals to meet the needs of the community. SBH is one (1) of six (6) hospitals in the Bronx that provide inpatient psychiatric care to adults. As indicated in the table below, these six (6) hospitals have the availability of a total of 420 adult beds or 3.92 per 10,000 adult population in Bronx County as of 2023 (1,071,534 adult residents per the 2023 ACS Survey). The Bronx County bed rate per 10,000 adult population is comparable to the Citywide rate of 3.74 (2,531 adult beds for 6,778,897 adult residents Citywide) and higher compared to the Statewide rate of 3.14 (4,941 adult beds for 15,758,748 adult residents Statewide). As noted below, however, utilization of this service in the Bronx outpaces all other boroughs; thus, based on the SHCFTP3 grant award, New York State has already determined the need for these beds.

Article 28 Hospitals in Bronx County with Adult Inpatient Psychiatric Beds

Hospital Name	Adult Psychiatric Beds as of 10/1/2024
BronxCare	79
Montefiore Medical Center	55
NYC H+H/Jacobi Medical Center	107
NYC H+H/Lincoln Medical & Mental Health Center	60
NYC H+H/North Central Bronx Hospital	70
SBH Health System	49
Total Bronx County Article 28 Adult Inpatient Psychiatric Beds	420

Source: New York State Office of Mental Health September 2024 Monthly Report, OMH Facility Performance Metrics and Community Service Investments

Utilization of Adult Inpatient Psychiatric Services in the Bronx

The New York State Office of Mental Health collects and reports county level data for inpatient use, providing data on inpatient census and population rates of utilization by region and county of residence for psychiatric inpatient settings, including General Hospitals, Private Hospitals, State Psychiatric Centers and Residential Treatment Facilities. The table below shows inpatient utilization trends for average daily census and bed use rate per 10,000 adult population for 2018 to 2022 (latest data available) for Stateside, New York City and each of the five (5) boroughs.

Average Daily Census and Population Rates for Article 28 Hospital Psychiatric Inpatient Services 2018-2022

	2018		2019		2020		2021		2022	
Region/County	ADC	Rate	ADC	Rate	ADC	Rate	ADC	Rate	ADC	Rate
Statewide	3,365.0	2.2	3,484.0	2.3	3,291.3	2.1	2,888.8	1.8	2,871.9	1.8
New York City	1,870.6	2.8	1,896.8	2.8	1,778.8	2.7	1,552.2	2.3	1,519.4	2.3
Bronx	400.3	3.7	430.9	4.0	403.3	3.8	343.0	3.2	352.5	3.4
Kings	557.6	2.8	588.2	2.9	554.8	2.8	428.6	2.1	43.1	2.2
New York	465.5	3.3	406.9	2.9	365.3	2.6	333.2	2.5	317.8	2.3
Queens	386.5	2.1	394.8	2.1	384.4	2.1	354.1	1.9	350.7	1.9
Richmond	69.7	1.9	76.0	2.1	71.0	1.9	63.3	1.6	62.3	1.6

Source: New York State Office of Mental Health County Planning Profiles

As indicated in the above table, the Bronx has the highest bed use rate compared to the other boroughs, Citywide and Statewide for the five-(5)-year period of 2018 through 2022. The Bronx bed use rate is significantly higher than the Statewide rate and Citywide rate for each year during the five-(5)-year period. In addition, when looking at the bed availability rate per 10,000 adult population of 3.9 for Bronx County and the 2022 bed utilization rate of 3.4 per 10,000 Bronx County adult population, the percentage occupancy of the 420 adult beds available in the Bronx in 2022 is 87.2%. Optimal utilization of inpatient psychiatric unit occupancy generally aims to strike a balance between patient needs, staff well-being and the potential for quality of care. Research suggests that occupancy rates should ideally be below 85%. Utilization rates greater than 80% create a more stressful work environment and utilization rates above 85% are associated with a deterioration in the quality of care.[1] SBH's proposal to add 23 psychiatric beds will provide additional adult psychiatric bed capacity in Bronx County that facilitates optimal utilization of the beds available in the Bronx and is responsive to Governor Hochul's transformation plan to enhance access to mental health services.

The table below shows the historical utilization of the SBH's inpatient adult psychiatric unit between 2020 and 2024.

	2020	2021	2022	2023	2024
Discharges	973	1,183	1,186	1,186	1,297
Patient Days	12,821	14,731	15,753	15,920	15,382
Occupancy %	71.7%	82.4%	88.1%	89.0%	86.0%

As indicated in the table above, the discharges from SBH's inpatient psychiatric inpatient beds have increased by 33% between 2020 and 2024 from 973 discharges in 2020 to 1,297 discharges in 2024. The occupancy of the beds has also increased and has consistently been over 85% since 2022, indicating that there is a need for additional inpatient psychiatric beds at SBH to bring the occupancy level down to the optimal utilization level of psychiatric inpatient units to balance patient needs, staff well-being and quality of care.

New York State's Prevention Agenda

SBH is committed to improving the health and well-being of the community. SBH actively assesses the community's health needs on an annual basis and recommends programs and/or services to meet those needs. SBH's action plan has been identified through its Community Advisory Board as it continues ongoing dialogue with patients, staff (including physicians, nurses and other personnel), volunteers, board members, local organizations, area business leaders, elected officials, not-for-profits and the New York City Department of Health and Mental Hygiene. These efforts have brought together a variety of health care providers and stakeholders to collaborate on the priority Prevention Agenda focus areas, as well as developing a Community Health Assessment. Based on the 2022 Community Health Assessment compiled by the Hospital in collaboration with other community partners, SBH selected the Prevention Agenda priority item to increase access to high-quality mental health services. This selected priority is fully compatible with SBH's community health initiatives and is and will be

[1] Jones, R. (2013) Optimum bed occupancy in psychiatric hospitals. Psychiatry On-line (http://www.priory.com/psychiatry/psychiatric_beds.htm)

supported by existing programs and staff, as well as the addition of new and modified programs, including SBH's plan to increase the adult inpatient psychiatric program capacity by 23 beds.

Program Management

SBH embraces a program of service to reach an underserved population and an operating philosophy that embodies the principle that comprehensive, coordinated, high-quality care is the right of every person, regardless of age, sex, sexual orientation, race, creed, religion, disability, source of payment or any other personal characteristic or qualification. Services provided through this project will be sensitive to the needs of the population and responsive to the desires of the Hospital's patients and their families.

The general operations of the inpatient psychiatric services at SBH will continue to adhere to the highest standards required under 14 New York Codes, Rules and Regulations (14 NYCRR) Part 580 regulating the operations of psychiatric inpatient units of general hospitals. SBH's standards of patient care emphasize accuracy and timeliness of diagnosis and referral to appropriate medical practitioners. All existing policies and procedures in place at SBH will continue to be incorporated into the operation of the inpatient psychiatric services, which will continue to be operated under the same high standards of care currently in practice at SBH.

A physician who is qualified for such duties by education and experience directs all administrative aspects of the inpatient psychiatric services at SBH and administers the Quality Assurance/Performance Improvement (QA/PI) Program associated with the inpatient psychiatric services. As Chair of the Department of Psychiatry, Lizica Troneci, M.D. (License No. 223741) has clinical oversight of SBH's inpatient and outpatient psychiatric programs. Please refer to **Appendix A** of this Project Narrative for Dr. Troneci's curriculum vitae.

SBH's existing QA/PI Program and operational protocols will be followed by the adult inpatient psychiatric program. The QA/PI Program ensures that patients receive the highest level of care and quality. There will be continuing education activities to provide staff with the opportunity to learn the newest technology, techniques and protocols in the provision of services in the child/adolescent unit.

To ensure that care is appropriate to an individual's needs, SBH will continue to use a comprehensive utilization review and monitoring program. The appropriate utilization of the adult inpatient psychiatric units will be monitored through the Hospital's QA/PI Program.

Lizica Troneci, MD

Chair Of Department of Psychiatry

Specialty
Psychiatry

Languages
English, Romanian

Locations
St. Barnabas Hospital

Education & Training

Montefiore Medical Center
Forensic Psychiatry, 2002 – 2003

Maimonides Medical Center
Psychiatry, 1998 – 2002

Carol Davila University of Medicine and Pharmacy, Bucharest, Romania
Class of 1994

Certifications & Licensure

Board Certification
American Board of Psychiatry and Neurology – Subcertification in Forensic Psychiatry

New York State Medical License
License#: 223741
Date of Licensure: January 2, 2002
Registered through Date: April 30, 2027

Working Capital Financing Plan

1. Working Capital Financing Plan and Pro Forma Balance Sheet:

This section should be completed in conjunction with Schedule 13. The general guidelines for working capital requirements are two months of first year expenses for changes of ownership and two months' of third year expenses for new establishments, construction projects or when the first year budget indicates a net operating loss. Any deviation from these guidelines must be supported by the monthly cash flow analysis. If working capital is required for the project, all sources of working capital must be indicated clearly. Borrowed funds are limited to 50% of total working capital requirements and cannot be a line of credit. Terms of the borrowing cannot be longer than 5 years or less than 1 year. If borrowed funds are a source of working capital, please summarize the terms below, and attach a letter of interest from the intended source of funds, to include an estimate of the principal, term, interest rate and payout period being considered. Also, describe and document the source(s) of working capital equity.

Titles of Attachments Related to Borrowed Funds	Filenames of Attachments
Example: *First borrowed fund source*	Example*: first_bor_fund.pdf*
Not Applicable	

In the section below, briefly describe and document the source(s) of working capital equity

Working capital will be funded through the current operations of SBH Health System. Please refer to the **Schedule 5 Attachment** for a Monthly Cash Flow Analysis showing sufficient cash throughout the first year of operations. Please also refer to the **Schedule 9 Attachment** for the 2023 Certified Financial Statement and the most recent 2024 Internal Financial Statement for SBH Health System.

2. Pro Forma Balance Sheet

This section should be completed for all new establishment and change in ownership applications. On a separate attachment identified below, provide a pro forma (opening day) balance sheet. If the operation and real estate are to be owned by separate entities, provide a pro forma balance sheet for each entity. Fully identify all assumptions used in preparation of the pro forma balance sheet. If the pro forma balance sheet(s) is submitted in conjunction with a change in ownership application, on a line-by-line basis, provide a comparison between the submitted pro forma balance sheet(s), the most recently available facility certified financial statements and the transfer agreement. Fully explain and document all assumptions.

Titles of Attachments Related to Pro Forma Balance Sheets	Filenames of Attachments
Example: *Attachment to operational balance sheet*	Example: *Operational_bal_sheet.pdf*
Not Applicable	

SCHEDULE 5 ATTACHMENT

Monthly Cash Flow Analysis

SBH Health System

MONTHLY CASH FLOW ANALYSIS - YEAR 1

Month	1	2	3	4	5	6	7	8				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Monthly Revenue	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]0
Monthly Expenses	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Remaining Cash	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

*Starting Cash reflects Cash and Cash Equivalents on the balance sheet of St. Barnabas Hospital d/b/a SBH Healllth Sytem as of December 31, 2024.

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: 5/5/2025	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Choose an item. If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: **Renovate existing Behavioral Health units and convert existing Detox unit to a Behavioral Health unit.**	
Site Location: **4422 Third Avenue, Bronx, New York, 10457**	

Brief description of current facility, including facility type: **The existing allocated space on the 2nd and 3rd floors of the Kane building is currently used as Behavioral Health units. The existing allocated space on the 4tht floor is a Detox unit.**	
Brief description of proposed facility: **The existing Behavioral Health units on the 2nd and 3rd floors of the Kane Building will be renovated to meet current guidelines. The existing detox unit on the 4th floor of the West Building will be converted to be a full inpatient Behavioral Health unit.**	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space: [redacted]	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: **Not Applicable**	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	No
Relationship of spaces conforming with Article 28 space and non-Article 28 space: **Not Applicable**	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. **Not Applicable**	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. [redacted]	Yes
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. **The project area is served by the following:**	

[redacted]

Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc.

[redacted]

Describe existing and or new work for fire detection, alarm, and communication systems:

[redacted]

If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. **Not in a flood zone.**

Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted.
N/A

Does the project comply with ADA? If no, list all areas of noncompliance.
Yes.

Other pertinent information:
Click here to enter text.

Project Work Area	**Response**
Type of Work	Renovation
Square footages of existing areas, existing floor and or existing building.	[redacted]
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	[redacted]
Does the work area exceed more than 50% of the smoke compartment, floor or building?	[redacted]
Sprinkler protection per NFPA 101 Life Safety Code	[redacted]
Construction Type per NFPA 101 Life Safety Code and NFPA 220	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Which edition of FGI is being used for this project?	[redacted]
Is the proposed work area located in a basement or underground building?	[redacted]
Is the proposed work area within a windowless space or building?	[redacted]
[redacted]	[redacted]
If a high-rise, does the building have a generator?	[redacted]
[redacted]	[redacted]

Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Click here to enter text.	[redacted]
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? The renovation of each floor will be done as a phase, resulting in three (3) phases, so that there is no disruption in the provision of care. Each phase will take 8 to 9 months.	[redacted]
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	[redacted]
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	[redacted]
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	[redacted]
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	[redacted]
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	[redacted]
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. The total number of inpatient psychiatric beds at the end of the project will be 72 beds, with 24 psychiatric beds on each unit. There will be 23 new psychiatric beds added to the existing 49 existing psychiatric beds.	[redacted]
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	[redacted]
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Type 1	[redacted]
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	[redacted]
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	[redacted]
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	[redacted]
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	[redacted]
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	[redacted]
Does the project involve a pool?	[redacted]

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

SCHEDULE 6 ATTACHMENT

Architect's Certification

Functional Space Program

Floor Plans

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS

(For projects not meeting the prerequisites for Self-Certification submission.)

Date: May 29, 2025
CON Number: TBD
Facility Name: St. Barnabas Hospital
Facility ID Number: 1176
Facility Address: 4422 Third Avenue, Bronx, New York 10457

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

To The New York State Department of Health:

I hereby certify that:

1. I have been retained by the aforementioned facility, to provide professional architectural/engineering services related to the design and preparation of construction documents, including drawings and specifications for the aforementioned project. During the course of construction, periodic site observation visits will be performed, and the necessary standard of care, noting progress, quality and ensuring conformance of the work with documents provided for all regulatory approvals associated with the aforementioned project.

2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed, in accordance with the functional program for the referenced construction project and in accordance with any project definitions, waivers or revisions approved or required by the New York State Department of Health.

3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations, and the applicable provisions of the State Hospital Code -- 10 NYCRR Part 711 (General Standards for Construction) and Parts (check all that apply):

   a. _X_ 712 (Standards of Construction for General Hospital Facilities)
   b. __ 713 (Standards of Construction for Nursing Home Facilities)
   c. __ 714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. __ 715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __ 716 (Standards of Construction for Rehabilitation Facilities)
   f. __ 717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:
   _____
   _____

4. I understand that as the design of this project progresses, if a component of this project is inconsistent with the State Hospital Code (10 NYCRR Parts 711, 712, 713, 714, 715, 716, or 717), I shall bring this to the attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department of Health prior to or upon submitting final drawings for compliance resolution.

5. I understand that upon completion of construction, the costs of any subsequent corrections necessary to achieve compliance with applicable requirements of 10 NYCRR Parts 711, 712, 713, 714, 715, 716 and 717, when the prior work was not completed properly as certified herein, may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative, full review, self-certification and reviews performed and completed by DASNY.

Project Name: St. Barnabas Hospital Kane Building Renovations

Location: (New York County)

Description: The existing psychiatric units on the 2nd and 3rd floors of the Kane Building will be renovated to meet the state guidelines. The existing 4th floor of the West Building will be converted from a detox facility to be a full inpatient psychiatric unit.

Architectural or Engineering Professional

Signature of Architect or Engineer

PAUL DRAGO

Name of Architect or Engineer (Print)

022980-1

Professional New York State License Number

NK Architects - 233 Broadway, Suite 2150, New York, NY 10279

Business Address

The undersigned applicant understands and agrees that, notwithstanding this architectural/engineering certification the Department of Health shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the Division to comply with the above- mentioned codes and regulations, whether or not physical plant construction or alterations have been completed.

Authorized Signature for Applicant

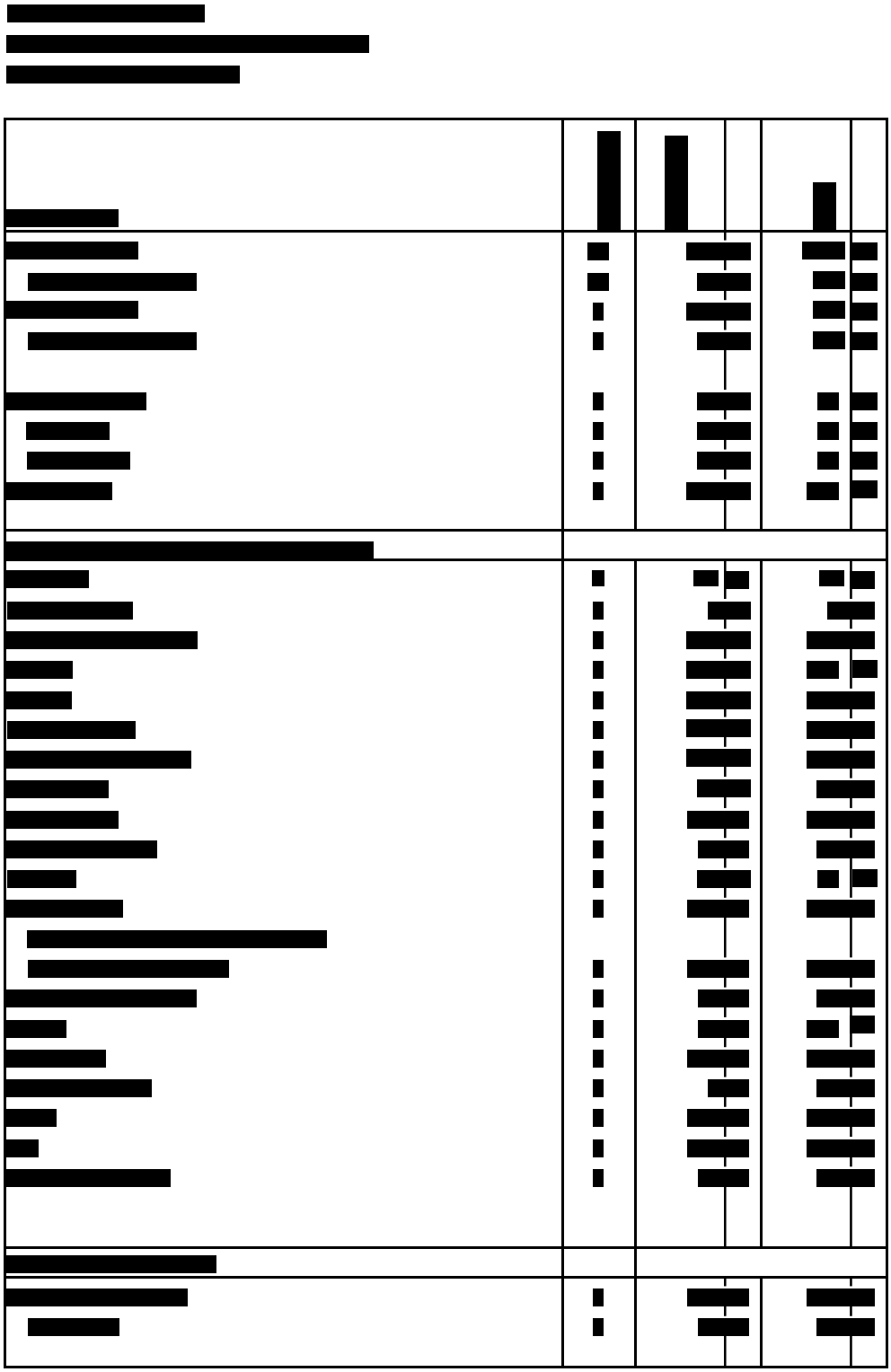
Date Name (Print) Title

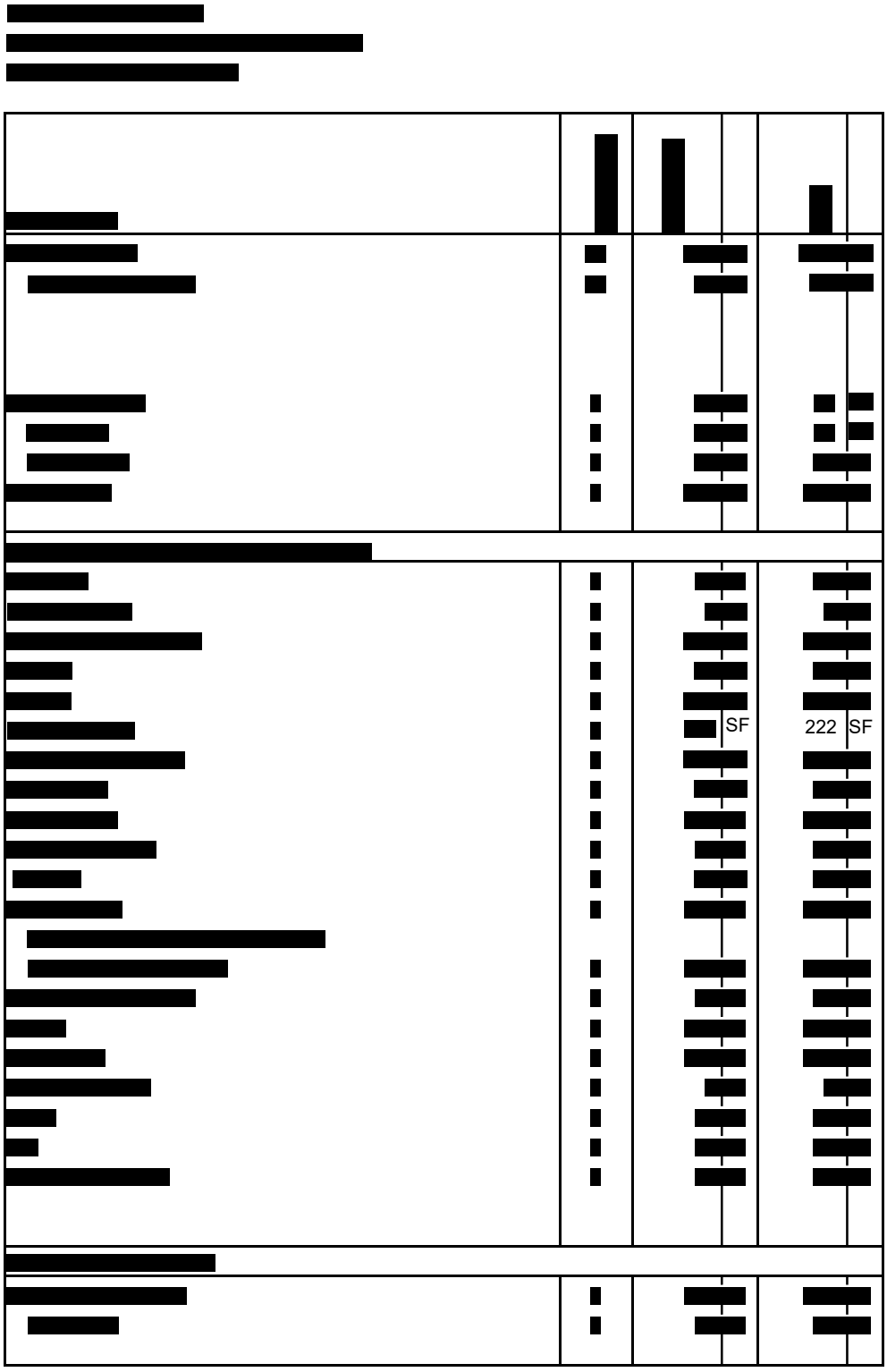
Notary signing required for the applicant

STATE OF NEW YORK)
) SS:
County of_____)

On the_____day of_____20__, before me personally appeared_____, to me known, who being by me duly sworn, did depose and say that he/she resides at_____, that he/she is the _____of the_____, the corporation described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the board of directors of said corporation.

(Notary) _____

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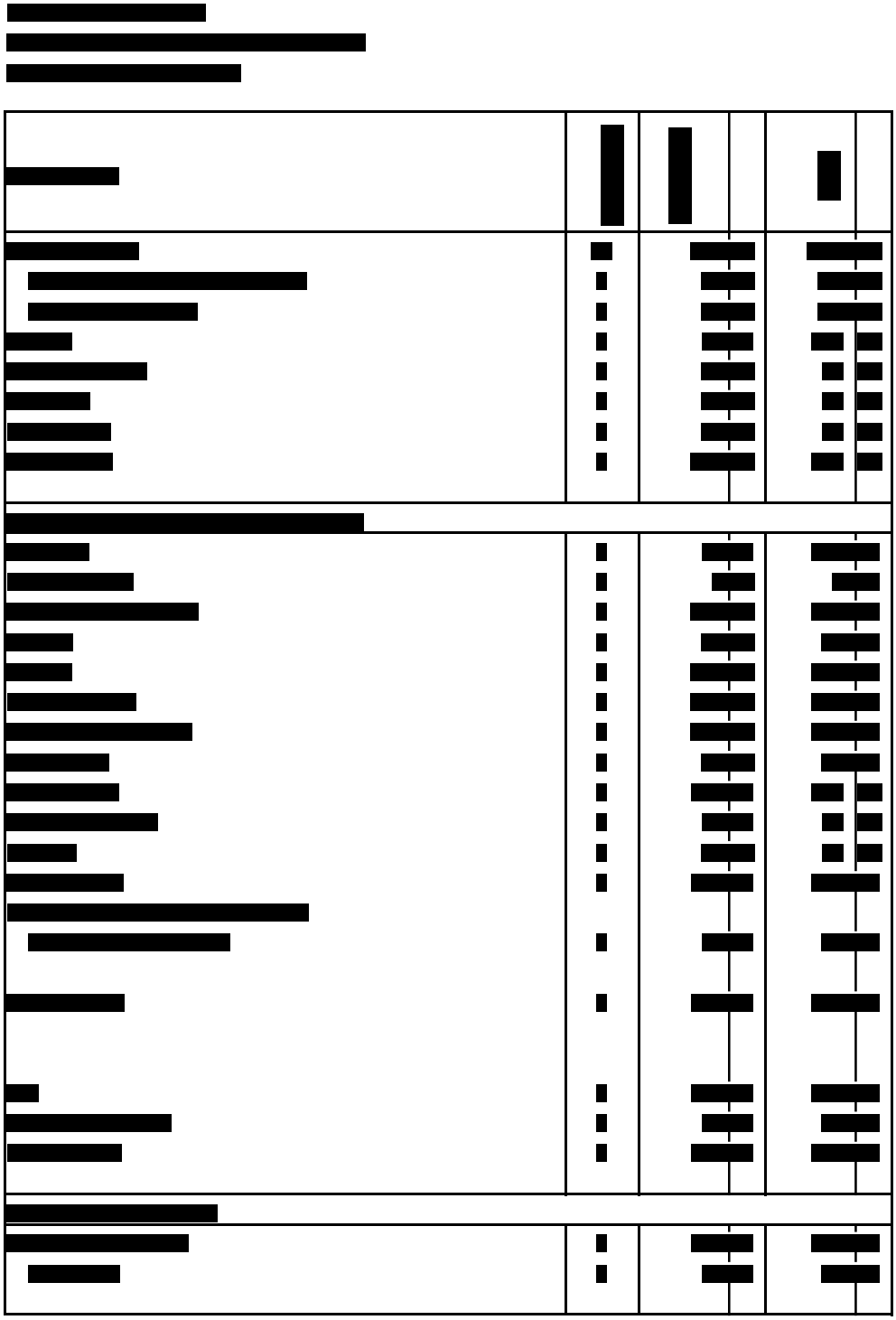

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

Environmental Assessment			
Part I.	The following questions help determine whether the project is "significant" from an environmental standpoint.	**Yes**	**No**
1.1	If this application involves establishment, will it involve more than a change of name or ownership only, or a transfer of stock or partnership or membership interests only, or the conversion of existing beds to the same or lesser number of a different level of care beds? **Not Applicable**	☐	☐
1.2	Does this plan involve construction and change land use or density?	☐	☒
1.3	Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved?	☐	☒
1.4	Does this plan involve construction and require work related to the disposition of asbestos?	☐	☒
Part II.	If any question in Part I is answered "yes" the project may be significant, and Part II must be completed. If all questions in Part II are answered "no" it is likely that the project is not significant	**Yes**	**No**
2.1	Does the project involve physical alteration of ten acres or more?	☐	☒
2.2	If an expansion of an existing facility, is the area physically altered by the facility expanding by more than 50% and is the total existing and proposed altered area ten acres or more?	☐	☒
2.3	Will the project involve use of ground or surface water or discharge of wastewater to ground or surface water in excess of 2,000,000 gallons per day?	☐	☒
2.4	If an expansion of an existing facility, will use of ground or surface water or discharge of wastewater by the facility increase by more than 50% and exceed 2,000,000 gallons per day?	☐	☒
2.5	Will the project involve parking for 1,000 vehicles or more?	☐	☒
2.6	If an expansion of an existing facility, will the project involve a 50% or greater increase in parking spaces and will total parking exceed 1000 vehicles?	☐	☒
2.7	In a city, town, or village of 150,000 population or fewer, will the project entail more than 100,000 square feet of gross floor area?	☐	☒
2.8	If an expansion of an existing facility in a city, town, or village of 150,000 population or fewer, will the project expand existing floor space by more than 50% so that gross floor area exceeds 100,000 square feet?	☐	☒
2.9	In a city, town or village of more than 150,000 population, will the project entail more than 240,000 square feet of gross floor area?	☐	☒
2.10	If an expansion of an existing facility in a city, town, or village of more than 150,000 population, will the project expand existing floor space by more than 50% so that gross floor area exceeds 240,000 square feet?	☐	☒
2.11	In a locality without any zoning regulation about height, will the project contain any structure exceeding 100 feet above the original ground area?	☐	☒
2.12	Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303?	☐	☒
2.13	Will the project significantly affect drainage flow on adjacent sites?	☐	☒

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☒
2.15	Will the project result in a major adverse effect on air quality?	☐	☒
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	☒
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	☒
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	☒
2.19	Will the project have any adverse impact on health or safety?	☐	☒
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	☒
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	☒
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	☒
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☒
Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☒	☐
	Agency Name:	New York City Department of Buildings – Bronx Borough Office	
	Contact Name:	Rodney Gittens, RA, Borough Commissioner	
	Address:	1775 Grand Concourse, 5th Floor	
	State and Zip Code:	Bronx, New York 10453	
	E-Mail Address:		
	Phone Number:	(718) 960-4700	
	Agency Name:	New York State Office of Mental Health	
	Contact Name:	Gina Bae, Director, Bureau of Inspection and Certification	
	Address:	44 Holland Avenue	
	State and Zip Code:	Albany, New York 12229	
	E-Mail Address:	Gina.Bae@omh.ny.gov	
	Phone Number:	(518) 474-5570	
	Agency Name:		
	Contact Name:		

	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.2	Has any other agency made an environmental review of this project? If so, give name, and submit the SEQRA Summary of Findings with the application in the space provided below.		**Yes** ☐	**No** ☒
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.3	Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.		**Yes** ☐	**No** ☒
Part IV.	**Storm and Flood Mitigation**			
	Definitions of FEMA Flood Zone Designations			
	Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.			
	Please use the FEMA Flood Designations scale below as a guide to answering all Part IV questions regardless of project location, flood and or evacuation zone.		**Yes**	**No**
4.1	Is the proposed site located in a flood plain? If Yes, indicate classification below and provide the Elevation Certificate (FEMA Flood Insurance).		☐	☒
	Moderate to Low Risk Area		**Yes**	**No**
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:			
	B and X	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.	☐	

	C and X	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.	☐	
	High Risk Areas		**Yes**	**No**
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
	A	Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones.	☐	
	AE	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30.	☐	
	A1-30	These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format).	☐	
	AH	Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	☐	
	AO	River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones.	☐	
	AR	Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations.	☐	
	A99	Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones.	☐	
	High Risk Coastal Area		**Yes**	**No**
	Zone	**Description**		
	In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
	Zone V	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones.	☐	☒
	VE, V1 - 30	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	☐	
	Undetermined Risk Area		**Yes**	**No**
	Zone	**Description**	☐	☒

	D	Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk.		
4.2	Are you in a designated evacuation zone?		☐	☒
	If Yes, the Elevation Certificate (FEMA Flood Insurance) shall be submitted with the application.			
	If yes which zone is the site located in?			
4.3	Does this project reflect the post Hurricane Lee, and or Irene, and Superstorm Sandy mitigation standards?		☐	☒
	If Yes, which floodplain?	100 Year	☐	
		500 Year	☐	

The Elevation Certificate provides a way for a community to document compliance with the community's floodplain management ordinance.

FEMA **Elevation Certificate** and Instructions

New York State Department of Health

Certificate of Need Application

Schedule 8A Summarized Project Cost and Construction Dates

This schedule is required for all Full or Administrative review applications except Establishment-Only applications.

1.) Project Cost Summary data:

	Total	Source
Project Description:		
Project Cost	$26,994,670	Schedule 8b, column C, line 8
Total Basic Cost of Construction	$26,994,670	Schedule 8B, column C, line 6
Total Cost of Moveable Equipment	$349,267	Schedule 8B, column C, line 5.1
Cost/Per Square Foot for New Construction	$0	Schedule 10
Cost/Per Square Foot for Renovation Construction	$575.94	Schedule10
Total Operating Cost	$27,489,274	Schedule 13C, column B
Amount Financed (as $)	$0	Schedule 9
Percentage Financed as % of Total Cost	0.00%	Schedule 9
Depreciation Life (in years)	10	Equipment
	25	Building Improvement/Other

2) Construction Dates

Anticipated Start Date	7/1/26	Schedule 8B
Anticipated Completion Date	9/30/28	

New York State Department of Health
Certificate of Need Application
Schedule 8B - Total Project Cost - For Projects without Subprojects.

This schedule is required for all Full or Administrative review applications except Establishment-Only applications.

Constants	Value	Comments
Design Contingency - New Construction	0.00%	Normally 10%
Construction Contingency - New Construction	0.00%	Normally 5%
Design Contingency - Renovation Work	10.00%	Normally 10%
Construction Contingency - Renovation Work	10.00%	Normally 10%
Anticipated Construction Start Date:	7/1/26	as mm/dd/yyyy
Anticipated Midpoint of Construction Date	8/16/27	as mm/dd/yyyy
Anticipated Completion of Construction Date	9/30/28	as mm/dd/yyyy
Year used to compute Current Dollars:	2025	

Subject of attachment	Attachment Number	Filename of attachment - PDF
For new construction and addition, at the schematic stage the design contingency will normally be 10% and the construction contingency will be 5%. If your percentages are otherwise, please explain in an attachment.		
For renovation, the design contingency will normally be 10% and the construction contingency will be 10%. If your percentages are otherwise, please explain in an attachment.		

New York State Department of Health
Certificate of Need Application

Item	A **Project Cost in Current Dollars**	B **Escalation amount to Mid-point of Construction**	C **Estimated Project Costs**
Source:	Schedule 10 Col. H	Computed by applicant	(A + B)
1.1 Land Acquisition	$0		$0
1.2 Building Acquisition	$0		$0
2.1 New Construction	$0	$0	$0
2.2 Renovation & Demolition	$18,343,173	$1,375,738	$19,718,911
2.3 Site Development	$0	$0	$0
2.4 Temporary Utilities	$0	$0	$0
2.5 Asbestos Abatement or Removal	$0	$0	$0
3.1 Design Contingency	$1,834,317	$137,574	$1,971,891
3.2 Construction Contingency	$1,834,317	$137,574	$1,971,891
4.1 Fixed Equipment (NIC)	$0	$0	$0
4.2 Planning Consultant Fees	$0	$0	$0
4.3 Architect/Engineering Fees	$1,553,695	$116,527	$1,670,222
4.4 Construction Manager Fees	$1,032,896	$77,467	$1,110,363
4.5 Other Fees (Consultant, etc.)	$95,000	$7,125	$102,125
Subtotal (Total 1.1 thru 4.5)	$24,693,398	$1,852,005	$26,545,403
5.1 Movable Equipment (from Sched 11)	$349,267	$0	$349,267
5.2 Telecommunications	$93,023	$6,977	$100,000
6. Total Basic Cost of Construction (total 1.1 thru 5.2)	$25,135,688	$1,858,982	$26,994,670
7.1 Financing Costs (Points etc)	$0		$0
7.2 Interim Interest Expense:: $ [ ] At [ ] % for [ ] months	$0		$0
8. Total Project Cost: w/o CON fees - Total 6 thru 7.2	$25,135,688	$1,858,982	$26,994,670
Application fees: 9.1 Application Fee. Articles 28, 36 and 40. See Web Site.	$2,000		$2,000
9.2 Additional Fee for projects with capital costs. Not applicable to "Establishment Only" projects. See Web Site for applicable fees. (Line 8, multiplied by the appropriate percentage.) Enter Multiplier ie: .25% = .0025 --> 0.0055	$138,246	$10,225	$148,471
10 Total Project Cost with fees	$25,275,934	$1,869,207	$27,145,141

Schedule 9 Proposed Plan for Project Financing:

I. Summary of Proposed Financial plan

Check all that apply and fill in corresponding amounts.

	Type	Amount
☐	A. Lease	
☒	B. Cash	$27,145,141
☐	C. Mortgage, Notes, or Bonds	
☐	D. Land	
☐	E. Other	
☒	F. Total Project Financing (Sum A to E) (equals line 10, Column C of Sch. 8b)	$27,145,141

If refinancing is used, please complete area below.

☐	Refinancing	$
☐	Total Mortgage/Notes/Bonds (Sum E + Refinancing)	$

II. Details

A. Leases

	N/A	Title of Attachment
1. List each lease with corresponding cost as if purchased each leased item. Breakdown each lease by total project cost and subproject costs, if applicable.	☒	
2. Attach a copy of the proposed lease(s).	☒	
3. Submit an affidavit indicating any business or family relationships between principals of the landlord and tenant.	☒	
4. If applicable, provide a copy of the lease assignment agreement and the Landlord's consent to the proposed lease assignment.	☒	
5. If applicable, identify separately the total square footage to be occupied by the Article 28 facility and the total square footage of the building.	☒	
6. Attach two letters from independent realtors verifying square footage rate.	☒	
7. For all capital leases as defined by FASB Statement No. 13, "Accounting for Leases", provide the net present value of the monthly, quarterly or annual lease payments.	☒	

B. Cash

Type	Amount
Accumulated Funds	$603,635
Sale of Existing Assets	
Gifts (fundraising program)	
Government Grants	$26,541,506
Other	
TOTAL CASH	$27,145,141

	N/A	Title of Attachment
1. Provide a breakdown of the sources of cash. See sample table above.	☐	See table above
2. Attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented to improve operations. In establishment applications for **Residential Health Care Facilities**, attach a copy of the latest certified financial statement and current internal financial reports to cover the balance of time to date for **the subject facility and all affiliated Residential Health Care Facilities**. If applicable, address the reason(s) for any operational losses, negative working capital and/or negative equity or net asset position and explain in detail the steps implemented (or to be implemented in the case of the subject facility) to improve operations.	☐	Schedule 9 Attachment
3. If amounts are listed in "Accumulated Funds" provide cross-reference to certified financial statement or Schedule 2b, if applicable.	☐	Cash and Cash Equivalents on the Balance Sheet
4. Attach a full and complete description of the assets to be sold, if applicable.	☒	
5. If amounts are listed in "Gifts (fundraising program)": • Provide a breakdown of total amount expected, amount already raised, and any terms and conditions affixed to pledges. • If a professional fundraiser has been engaged, submit fundraiser's contract and fundraising plan. • Provide a history of recent fund drives, including amount pledged and amount collected	☒	

	N/A	Title of Attachment
6. If amounts are listed in "Government Grants": • List the grant programs which are to provide the funds with corresponding amounts. Include the date the application was submitted. • Provide documentation of eligibility for the funds. • Attach the name and telephone number of the contact person at the awarding Agency(ies).	☐	Schedule 9 Attachment
7. If amounts are listed in "Other" attach a description of the source of financial support and documentation of its availability.	☒	
8. Current Department policy expects a minimum equity contribution of 10% of total project cost (Schedule 8b line 10)) for all Article 28 facilities with the exception of Residential Health Care Facilities that require 25% of total project cost (Schedule 8b, line 10). Public facilities require 0% equity.	☐	Equity Contribution Met
9. Provide an equity analysis for member equity to be provided. Indicate if a member is providing a disproportionate share of equity. If disproportioned equity shares are provided by any member, check this box ☐	☒	

C. Mortgage, Notes, or Bonds <u>Not Applicable</u>

	Total Project	Units
Interest		%
Term		Years
Payout Period		Years
Principal		$

	N/A	Title of Attachment
1. Attach a copy of a letter of interest from the intended source of permanent financing that indicates principal, interest, term, and payout period.	☒	
2. If New York State Dormitory Authority (DASNY) financing, then attach a copy of a letter from a mortgage banker.	☒	
3. Provide details of any DASNY bridge financing to HUD loan.	☒	
4. If the financing of this project becomes part of a larger overall financing, then a new business plan inclusive of a feasibility package for the overall financing will be required for DOH review prior to proceeding with the combined financing.	☒	

D. Land Not Applicable

Provide details for the land including but not limited to; appraised value, historical cost, and purchase price. See sample table below.

	Total Project
Appraised Value	$
Historical Cost	$
Purchase Price	$
Other	

	N/A	Title of Attachment
1. If amounts are listed in "Other", attach documentation and a description as applicable.	☒	
2. Attach a copy of the Appraisal. Supply the appraised date and the name of the appraiser.	☒	
3. Submit a copy of the proposed purchase/option agreement.	☒	
4. Provide an affidavit indicating any and all relationships between seller and the proposed operator/owner.	☒	

E. Other Not Applicable

Provide listing and breakdown of other financing mechanisms.

	Total Project
Notes	
Stock	
Other	

	N/A	Title of Attachment
Attach documentation and a description of the method of financing	☒	

F. Refinancing Not Applicable

	N/A	Title of Attachment
1. Provide a breakdown of the terms of the refinancing, including principal, interest rate, and term remaining.	☒	
2. Attach a description of the mortgage to be refinanced. Provide full details of the existing debt and refinancing plan inclusive of original and current amount, term, assumption date, and refinancing fees. The term of the debt to be refunded may not exceed the remaining average useful life of originally financed assets. If existing mortgage debt will not be refinanced, provide documentation of consent from existing lien holders of the proposed financing plan.	☒	

SCHEDULE 9 ATTACHMENT

Financial Narrative

2024 Internal Financial Statement

2023 Certified Financial Statement

Documentation of Heath Care Facility Transformation Program III Grant Award

FINANCIAL NARRATIVE

SBH Health System (SBH) proposes to increase the number of its inpatient psychiatric beds from 49 to 72, an increase of 23 beds, through the conversion of 12 inpatient chemical dependence - detoxification beds to 12 psychiatric beds and the certification of 11 new psychiatric beds. As part of this proposal, SBH will gut and renovate the Hospital's two (2) existing inpatient psychiatric units and renovate another floor in the Hospital to create a new inpatient psychiatric unit. At the end of the project, SBH will have three (3) 24-bed inpatient psychiatric units that meet up-to-date standards of care for inpatient psychiatric services and enhance patient and staff safety and comfort.

The Total Project Cost is estimated at 27,145,141 and is broken down as follows:

$	26,994,670	Total Basic Cost of Construction
$	2,000	CON Application Fee
$	148,271	CON Additional Processing Fee
$	27,145,141	TOTAL PROJECT COST

Project costs will be funded as follows:

$	26,541,506	Statewide Health Care Facility Transformation Program III (SHCFTP3) grant. Please refer to the **Schedule 9 Attachment** for documentation pertaining to the SHCFTP3 grant award.
$	603,635	Equity of SBH Health System. Please refer to the **Schedule 9 Attachment** for the 2024 Internal Financial Statement and the 2023 Certified Financial Statement of SBH. Please note the "Cash and Cash Equivalents" on the Balance Sheet for a specific cross-reference to the source of equity funds.
$	27,145,141	TOTAL

<u>Basis for Utilization, Revenues and Expenses</u>

The Current Year FTEs, expenses and revenues are based on actual 2024 FTEs, expenses, revenue and volume experienced by SBH in the operation of the inpatient psychiatric service. The projected utilization and staffing for this project are based upon the experience of SBH in providing inpatient psychiatric services at the Hospital. The incremental operating expenses and revenues for this project are based on the utilization projections for the inpatient psychiatric program that are part of this project, given the experience of the Hospital.

SBH HEALTH SYSTEM

Interim Financial Statements

December 31, 2024

SBH Health System
Financial Statements
December 31, 2024

Table of Contents

SBH Health System
Statement of Operations
December 31, 2024

	Year to Date			
	Actual	Budget	Budget Variance	Prior Year
Operating Revenue:				
Net Patient Care Revenue	[redacted]			
Directed Payment Template Revenue				
SBH Behavioral Health				
Physician Fee Revenue				
Miscellaneous Revenue				
FEMA COVID 19 Award				
Outpatient Pharmacy Revenue				
Grant Revenue				
1115 Waiver Revenue				
Donations				
Net Assets Released from Restrictions				
Total Operating Revenue				
Operating Expense:				
Professional Care of Patients - Nursing	[redacted]			
Professional Care of Patients - Other				
Dietary				
Household and Maintenance				
Administration and General				
Professional Liability Insurance				
Employee Health and Welfare				
Depreciation, Amortization and Rentals				
Interest				
SBH Behavioral Health				
Total Operating Expense				
Excess (Deficiency) of operating revenue over expense	[redacted]			
Non-Operating Revenue:				
Capital Grant Award	[redacted]			
Gain (Loss) on Sale / Disposal of Assets				
Investment and Trust Income				
Total Non-Operating Revenue				
Excess (Deficiency) of revenues over expenses	[redacted]			
Change in Net Unrealized Gain & Loses Pension	[redacted]			
Change in Net Unrealized Gain & Loses				
Change in Net Unrealized Gains and Losses				
Increase (Decrease) in Unrestricted Net Assets	[redacted]			

SBH Health System
Balance Sheet
December 31, 2024 and December 31, 2023

	2024	2023
ASSETS		
Current Assets:		
Cash and Cash Equivalents	[redacted]	
Current Portion of Assets Whose Use is Limited		
Total Patient Accounts Receivable		
Other Receivables		
Retroactive Receivables from Third Parties, net		
Prepaid Expenses and Supplies		
Total Current Assets	[redacted]	
Assets Whose Use is Limited:		
Under Financing Agreements	[redacted]	
Funds Held in Trust		
Board Designated Endowment Fund		
Prepaid pension benefits costs		
Total Assets Whose Use is Limited	[redacted]	
Property, Plant and Equipment:		
Land	[redacted]	
Buildings and Improvements		
Equipment		
Capitalized Interest		
Construction in Progress		
Total Cost	[redacted]	
Less: Accumulated Depreciation		
Net Property, Plant, and Equipment	[redacted]	
Total Due from Union Community Health Center	[redacted]	
Other Assets, net		
Total Assets	[redacted]	[redacted]
LIABILITIES AND NET ASSETS		
Current Liabilities:		
Total Accounts Payable	[redacted]	
Accrued Expenses		
Accrued Salaries and Related Expenses		
Current Portion of Long Term Debt		
Deferred Revenue		
Retroactive Payables to Third Parties		
Total Current Liabilities	[redacted]	
Long Term Liabilities:		
Mortgage/Loan Payable - net of Current Portion	[redacted]	
Retroactive Payables to Third Parties, net		
Accrued Postretirement Benefit Costs		
Accrued Pension Benefit Costs		
Estimated Professional Liability		
Financing Lease		
Other Operating Lease		
Total Liabilities	[redacted]	
Net Assets:		
Unrestricted	[redacted]	
Temporarily Restricted:		
Temporarily Restricted - Indigent Care		
Temporarily Restricted - Other Patient Care		
Permanently Restricted		
Total Net Assets	[redacted]	
Total Liabilities and Net Assets	[redacted]	

Consolidated Financial Statements and Supplementary Information

St. Barnabas Hospital
Years Ended December 31, 2023 and 2022
With Report of Independent Auditors

Ernst & Young LLP

St. Barnabas Hospital

Consolidated Financial Statements and
Supplementary Information

Years Ended December 31, 2023 and 2022

Contents

Ernst & Young LLP
One Manhattan West
New York, NY 10001-8604

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ey.com

Building a better working world

Report of Independent Auditors

The Board of Trustees
St. Barnabas Hospital

Opinion

[redacted]

Basis for Opinion

[redacted]

Responsibilities of Management for the Financial Statements

[redacted]

[redacted]

Auditor's Responsibilities for the Audit of the Financial Statements

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Building a better working world

Supplementary Information

[redacted].

Ernst & Young LLP

August 2, 2024

St. Barnabas Hospital

Consolidated Balance Sheets

	December 31	
	2023	2022
	(In Thousands)	
Assets		
Current assets:		
Cash and cash equivalents		
Current portion of assets limited as to use		
Patient accounts receivable, net		
Due from third-party payer reimbursement programs		
Other receivables		
Prepaid expenses and supplies		
Total current assets		
Assets limited as to use:		
Externally limited:		
Under malpractice funding requirements, net of current portion		
Under financing agreements, net of current portion		
Funds held in trust by others		
Internally limited, net of current portion		
Property, plant, and equipment, net		
Receivable from Union Community Health Center, Inc.		
Right-of-use assets		
Other assets		
Total assets	$	$
Liabilities and net assets		
Current liabilities:		
Accounts payable, accrued expenses, and other deferred liabilities		
Accrued salaries, wages, and related expenses		
Current portion of long-term debt		
Finance lease liability, current portion		
Operating lease liabilities, current portion		
Due to third-party payer reimbursement programs		
Total current liabilities		
Long-term debt, net of current portion		
Due to third-party payer reimbursement programs, net of current portion		
Estimated malpractice liability, net of current portion		
Accrued pension liability		
Finance lease liability, net of current portion		
Operating lease liabilities, net of current portion		
Other liabilities		
Total liabilities		
Net assets:		
Net assets without donor restrictions		
Net assets with donor restrictions		
Total net assets		
Total liabilities and net assets	$	$

See accompanying notes.

St. Barnabas Hospital

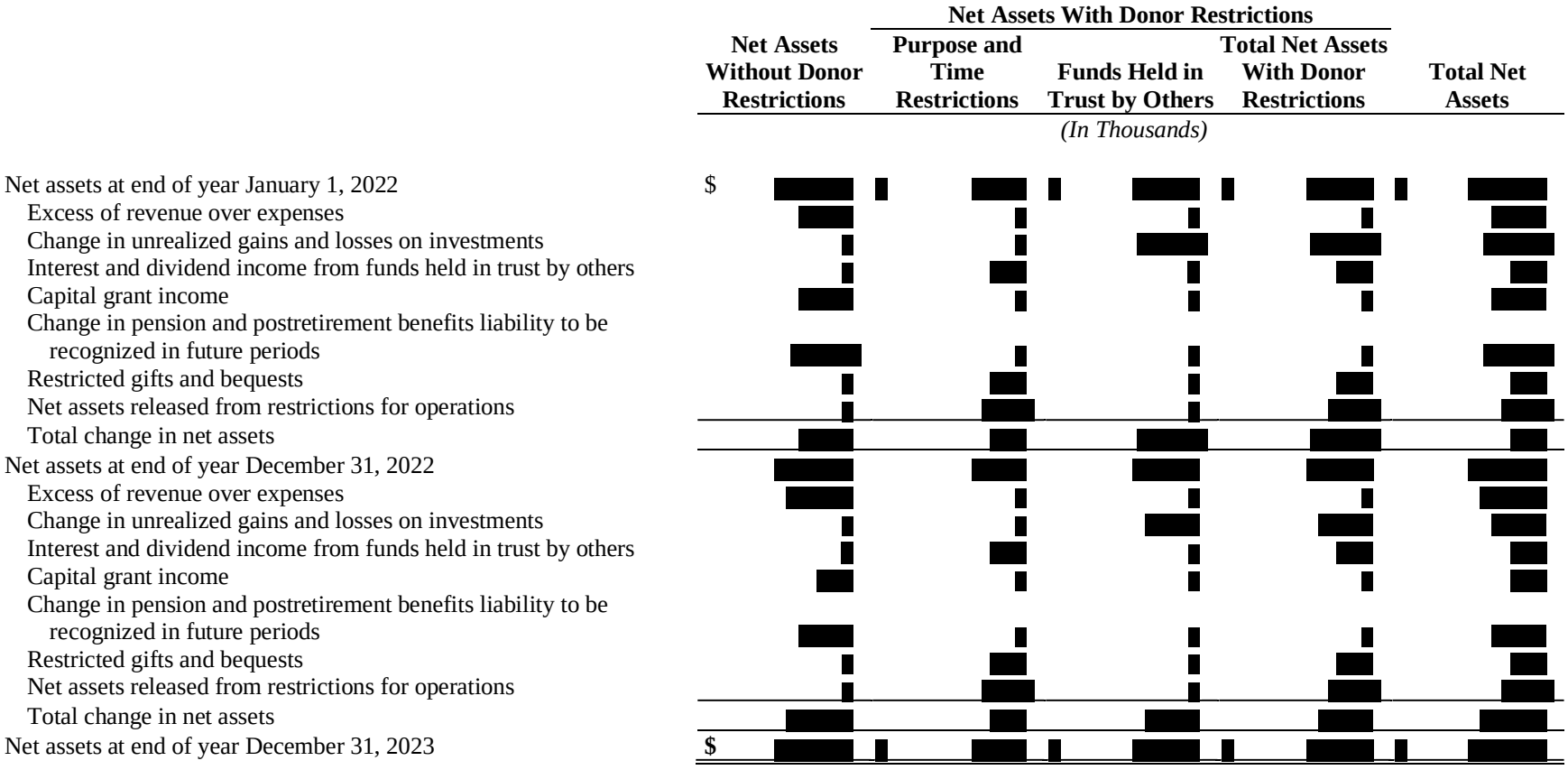
Consolidated Statements of Operations

	Year Ended December 31	
	2023	2022
	(In Thousands)	
Operating revenues		
Net patient service revenue	$	
SBH Behavioral Health operating revenue		
Other operating revenue		
Net assets released from restrictions used for operations		
Total operating revenues		
Operating expenses		
Professional care of patients		
Dietary services		
Household and maintenance		
Administration and general services		
Employee health and welfare		
Malpractice expense		
Interest		
Depreciation, amortization, and rentals		
SBH Behavioral Health operating expenses		
Total operating expenses		
Operating gain		
Investment income (loss), net		
Other (expense) income, net		
Net periodic pension and other postretirement cost other than service cost		
Excess of revenues over expenses		
Change in pension and postretirement benefits liability to be recognized in future periods		
Capital grant income		
Increase in net assets without donor restrictions	$	$

See accompanying notes.

St. Barnabas Hospital

Consolidated Statements of Changes in Net Assets



	Net Assets Without Donor Restrictions	Net Assets With Donor Restrictions: Purpose and Time Restrictions	Net Assets With Donor Restrictions: Funds Held in Trust by Others	Total Net Assets With Donor Restrictions	Total Net Assets
			(In Thousands)		
Net assets at end of year January 1, 2022	$				
Excess of revenue over expenses					
Change in unrealized gains and losses on investments					
Interest and dividend income from funds held in trust by others					
Capital grant income					
Change in pension and postretirement benefits liability to be recognized in future periods					
Restricted gifts and bequests					
Net assets released from restrictions for operations					
Total change in net assets					
Net assets at end of year December 31, 2022					
Excess of revenue over expenses					
Change in unrealized gains and losses on investments					
Interest and dividend income from funds held in trust by others					
Capital grant income					
Change in pension and postretirement benefits liability to be recognized in future periods					
Restricted gifts and bequests					
Net assets released from restrictions for operations					
Total change in net assets					
Net assets at end of year December 31, 2023	**$**				

See accompanying notes.

St. Barnabas Hospital

Consolidated Statements of Cash Flows

	Year Ended December 31	
	2023	2022
	(In Thousands)	
Operating activities		
Change in net assets	$	
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Change in pension and postretirement benefits liability to be recognized in future periods		
Depreciation and amortization		
Change in net unrealized and realized gains and losses on investments		
Gain on sale of property, plant & equipment		
Capital grant income		
Changes in operating assets and liabilities:		
Equity earnings in Healthfirst, LLC		
Patient accounts receivable, net		
Other assets and liabilities		
Prepaid expenses and supplies		
Change in right-of-use assets and lease liability		
Accounts payable, accrued expenses, salaries, and wages		
Accrued postretirement benefit cost		
Accrued pension liability		
Due to third-party payer reimbursement programs, net		
Change in receivable from UCHC		
Estimated malpractice liability		
Net cash provided by operating activities		
Investing activities		
Purchases of property, plant, and equipment		
Proceeds from sale of fixed asset		
Sales of assets limited as to use		
Purchases of assets limited as to use		
Distributions from Healthfirst, LLC		
Net cash (used in) provided by investing activities		
Financing activities		
(Repayment of) proceeds from NYC Provider Relief Loan		
Principal payments on long-term debt		
Principal payments on finance lease		
Proceeds from capital grant		
Net cash (used in) provided by financing activities		
Net increase in cash and cash equivalents		
Cash and cash equivalents		
Beginning of year		
End of year	$	
Reconciliation of cash, cash equivalents, and restricted cash to the balance sheets:		
Cash and cash equivalents	$	
Assets limited or restricted as to use: cash and cash equivalents		
Total cash, cash equivalents and restricted cash	$	
Supplemental disclosures of cash flow information		
Interest paid (includes capitalized interest aggregating $0 in 2023 and $231 in 2022)	$	
Purchases of property, plant and equipment included in accounts payable	$	
Asset acquired under finance lease	$	

See accompanying notes.

St. Barnabas Hospital

Notes to Consolidated Financial Statements

December 31, 2023

1. Organization

[redacted]

[redacted]

Liquidity and Operating Results

[redacted]

[redacted]

1. Organization (continued)

[redacted]

2. Summary of Significant Accounting Policies

Basis of Accounting

The accompanying consolidated financial statements are prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting standards.

Use of Estimates

[redacted]

Performance Indicator

[redacted]

2. Summary of Significant Accounting Policies (continued)

Cash and Cash Equivalents

[redacted]

Investments and Investment Income (Loss), Net

[redacted]

Assets Limited as to Use

[redacted]

[redacted]

2. Summary of Significant Accounting Policies (continued)

Property, Plant, and Equipment

[redacted]

Deferred Financing Costs

[redacted]

2. Summary of Significant Accounting Policies (continued)

Basis of Presentation

[redacted]

Donor Restricted Gifts

[redacted]

Inventories of Supplies

[redacted]

2. Summary of Significant Accounting Policies (continued)

The natural classification of operating expenses presented in the accompanying consolidated statements of operations for the years ended December 31, 2023 and 2022 are presented as follows:

	December 31, 2023						
	Professional Care of Patients	Dietary Services	Household and Maintenance	Administration and General Services	Employee Health and Welfare	Other	Total
Salaries and benefits	$ [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Supplies and purchased services	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Depreciation, amortization and rentals	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Insurance	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Interest	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Other operating expenses	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	$ [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

	December 31, 2022						
	Professional Care of Patients	Dietary Services	Household and Maintenance	Administration and General Services	Employee Health and Welfare	Other	Total
Salaries and benefits	$ [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]6
Supplies and purchased services	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Depreciation, amortization and rentals	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]55
Insurance	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Interest	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Other operating expenses	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total	$ [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Patient Accounts Receivable, Net and Net Patient Service Revenue

[redacted]

2. Summary of Significant Accounting Policies (continued)

[redacted]

2. Summary of Significant Accounting Policies (continued)

[redacted]

Net patient service revenue disaggregated by payer for the years ended December 31, 2023 and 2022, are as follows:

	2023	2022
	(In Thousands)	
Medicaid	$ [redacted]	[redacted]
Medicare	[redacted]	[redacted]
Medicaid managed care	[redacted]	[redacted]
Medicare managed care	[redacted]	[redacted]
Workers' comp and no fault	[redacted]	[redacted]
Self-pay	[redacted]	[redacted]
Commercial and HMO	[redacted]	[redacted]
	$ [redacted]	[redacted]

Deductibles, copayments and coinsurance under third-party payment programs which are the patient's responsibility are not included within the self-pay category above.

2. Summary of Significant Accounting Policies (continued)

Net patient service revenue disaggregated by lines of service for the years ended December 31, 2023 and 2022, are as follows:

	2023	2022
	(In Thousands)	
Inpatient services	$ [redacted]	[redacted]
Outpatient services, including emergency department	[redacted]	[redacted]
All other, including DPT revenue	[redacted]	[redacted]
	$ [redacted]	[redacted]

At December 31, 2023 and 2022, patient accounts receivable, net is comprised of the following components:

	2023	2022
	(In Thousands)	
Patient receivables	$ [redacted]	[redacted]
Contract assets	[redacted]	[redacted]
	$ [redacted]	[redacted]

Contract assets are related to in-house patients who were provided services during the reporting period but were not discharged as of the reporting date and for which the Hospital does not have the right to bill.

[redacted]

2. Summary of Significant Accounting Policies (continued)

[redacted]

Third-Party Payer Payment Programs

The Hospital has agreements with third-party payers that provide for payment for services rendered at amounts different from its established rates. A summary of the payment arrangements with major third-party payers follows:

Medicare Reimbursement: [redacted]

Non-Medicare Reimbursement: [redacted]

Other Third-Party Payers: [redacted]

2. Summary of Significant Accounting Policies (continued)

[redacted]

2. Summary of Significant Accounting Policies (continued)

The Hospital grants credit without collateral to its patients, most of whom are insured under third-party payer agreements. Significant concentrations of patient accounts receivable, net at December 31, 2023 and 2022, are as follows:

	December 31	
	2023	**2022**
Medicaid	**%**	%
Medicare		
Medicaid managed care		
Medicare managed care		
Workers' comp and no fault		
Commercial and HMO		
	100%	100%

Uncompensated Care and Community Benefit Expense

The Hospital, in keeping with its mission and philosophy to extend quality care and compassionate service, recognizes that some patients are unable to compensate the Hospital for their treatment either through third-party coverage or their own resources. The Hospital provides free care or sliding fee scales to patients financially unable to pay for services rendered. The Hospital does not pursue collection of amounts that qualify as charity care, and therefore they are not reported as revenue.

2. Summary of Significant Accounting Policies (continued)

Direct Payment Template Program

[redacted]

Tax Status

The Hospital is a not-for-profit corporation and is exempt from Federal income taxes under the provisions of Section 501(a) of the Internal Revenue Code (the Code) as an organization described in Section 501(c)(3). The Hospital is also exempt from New York State and local income taxes.

Recent Accounting Pronouncements

[redacted]

3. Capitated Arrangements

Healthfirst, Inc.

[redacted]

4. Assets Limited as to Use

The composition of assets limited as to use at December 31, 2023 and 2022, stated at fair value, is as follows:

	2023	2022
	(In Thousands)	
Cash and cash equivalents	$ [redacted]	
Mutual funds	[redacted]	
Funds held in trust by others	[redacted]	
Total assets limited as to use	$ [redacted]	
Under malpractice funding requirements	$ [redacted]	
Under financing agreements	[redacted]	
Funds held in trust by others	[redacted]	
Internally limited	[redacted]	
Total assets limited as to use	$ [redacted]	

Amounts included within the current portion of assets limited as to use on the accompanying consolidated balance sheets primarily relate to required malpractice settlements and debt service payments.

4. Assets Limited as to Use (continued)

Investment income (loss), net, including changes in net unrealized gains and losses on assets limited as to use included in the consolidated statements of operations for the years ended December 31, 2023 and 2022, consist of the following:

	2023	2022
	(In Thousands)	
Interest and dividend income	$	
Realized gains and losses on sales of securities		
Change in net unrealized gains and losses on investments		
Total investment income (loss), net	$	

5. Fair Value Measurements

For assets and liabilities required to be measured at fair value, the Organization measures fair value based on the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value measurements are applied based on the unit of account from the Organization's perspective. The unit of account determines what is being measured by reference to the level at which the asset or liability is aggregated (or disaggregated) for purposes of applying other accounting pronouncements. The Organization follows a valuation hierarchy that prioritizes observable and unobservable inputs used to measure fair value into three broad levels, which are described below:

Level 1: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets or liabilities.

Level 2: Observable inputs that are based on inputs not quoted in active markets, but corroborated by market data.

Level 3: Unobservable inputs are used when little or no market data is available.

A financial instrument's categorization within the valuation hierarchy is based upon the lowest level of input that is significant to the fair value measurement. In determining fair value, the Organization uses valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible and considers nonperformance risk in its assessment of fair value.

5. Fair Value Measurements (continued)

Financial assets carried at fair value as of December 31, 2023, are classified in the following table in one of the three categories described previously:

	Total	Level 1	Level 2	Level 3
		(In Thousands)		
Cash and cash equivalents	**$**			
Mutual funds				
Funds held in trust by others*				
	$			

Financial assets carried at fair value as of December 31, 2022, are classified in the following table in one of the three categories described previously:

	Total	Level 1	Level 2	Level 3
		(In Thousands)		
Cash and cash equivalents	$			
Mutual funds				
Funds held in trust by others*				
	$			

* Funds held in trust by others is primarily mutual funds.

The following is a description of the Organization's valuation methodologies for assets measured at fair value. Fair value for Level 1 is based upon quoted market prices. Fair value for Level 2 is based upon quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in markets that are not active and model-based valuation techniques for which all significant assumptions are observable in the market or can be corroborated by observable market data for substantially the full term of the assets.

6. Property, Plant, and Equipment

A summary of property, plant, and equipment at December 31, 2023 and 2022, is as follows:

	2023	2022
	(In Thousands)	
Land	$ [redacted]	[redacted]
Buildings and improvements	[redacted]	[redacted]
Major moveable equipment	[redacted]	[redacted]
Construction-in-progress	[redacted]	[redacted]
	[redacted]	[redacted]
Less accumulated depreciation and amortization	[redacted]	[redacted]
	$ [redacted]	[redacted]

[redacted]

6. Property, Plant, and Equipment (continued)

[redacted]

7. Long-Term Debt

A summary of long-term debt at December 31, 2023 and 2022 is as follows:

	2023	2022
	(In Thousands)	
[redacted]		

(a) [redacted]

7. Long-Term Debt (continued)

[redacted]

7. Long-Term Debt (continued)

[redacted]

7. Long-Term Debt (continued)

[redacted]

8. Net Assets With Donor Restrictions

[redacted]

8. Net Assets With Donor Restrictions (continued)

[redacted]

9. Medical Malpractice Claims

[redacted]

9. Medical Malpractice Claims (continued)

[redacted]

10. Pension and Other Postretirement Benefit Plans

[redacted]

10. Pension and Other Postretirement Benefit Plans (continued)

[redacted]

	2023		2022	
	Pension	Postretirement	Pension	Postretirement
	(In Thousands)			
Changes in benefit obligation				
Benefit obligation at January 1	$ [redacted]			
Service cost	[redacted]			
Interest cost	[redacted]			
Actuarial (loss) gain	[redacted]			
Benefit payments	[redacted]			
Benefit obligation at December 31	$ [redacted]			
Change in plan assets				
Fair value of plan assets at January 1	$ [redacted]			
Actual return (loss) on plan assets	[redacted]			
Employer contributions	[redacted]			
Benefit payments	[redacted]			)
Fair value of plan assets at December 31	$ [redacted]			
Reconciliation of funded status				
Unfunded status at December 31 – net amount recognized	$ [redacted]	$ [redacted]	$ [redacted]	$ [redacted]

The following table provides the components of the net periodic benefit cost (income) for the years ended December 31, 2023 and 2022:

	2023		2022	
	Pension	Postretirement	Pension	Postretirement
	(In Thousands)			
Service cost	$ [redacted]			
Interest cost on benefit obligation	[redacted]			
Expected return on plan assets	[redacted]			
Amortization of net actuarial gain (loss)	[redacted]			)
Net periodic benefit cost (income)	$ [redacted]	$ [redacted]	$ [redacted]	) $ [redacted]

[redacted]

[redacted]

Included [redacted]

	[redacted]		[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			
[redacted]	[redacted] [redacted]	[redacted] [redacted]	[redacted]	[redacted] [redacted]
	[redacted] [redacted]	[redacted] [redacted]	[redacted]	[redacted] [redacted]

[redacted]

	[redacted]		[redacted]	
	[redacted]	[redacted]	[redacted]	[redacted]
	[redacted]			
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

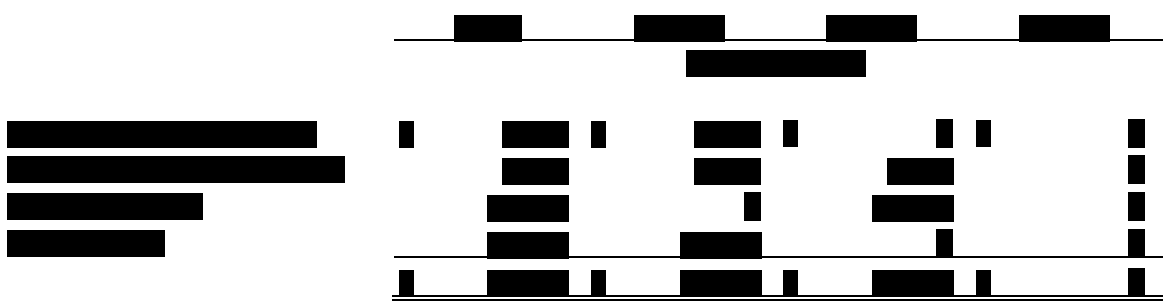
[redacted]

[redacted]

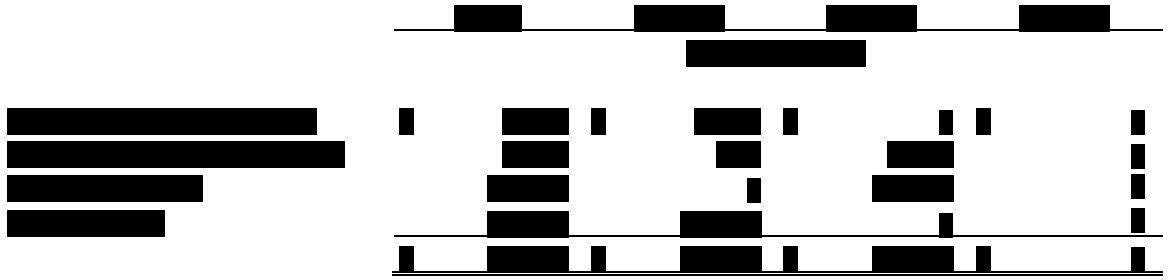
	[redacted]	
	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]

10. Pension and Other Postretirement Benefit Plans (continued)

[redacted]



[redacted]



[redacted]

Plan Investment Policy

[redacted]

10. Pension and Other Postretirement Benefit Plans (continued)

Target Asset Allocation

[redacted]

Pension Contributions and Benefit Payments

[redacted]

[redacted]:

	Expected Benefit Payments
	(In Thousands)
Year ending December 31:	
2024	$ [redacted]
2025	[redacted]
2026	[redacted]
2027	[redacted]
2028	[redacted]
2029–2033	[redacted]

10. Pension and Other Postretirement Benefit Plans (continued)

Multiemployer Defined Benefit Pension Plan

[redacted]

10. Pension and Other Postretirement Benefit Plans (continued)

[redacted]

Defined Contribution 403(b) Plan

[redacted]

11. Leases

[redacted]

11. Leases (continued)

The following schedule summarizes information related to the lease assets and liabilities at December 31, 2023 and 2022 (in thousands):

	Balance Sheet Classification	December 31 2023	2022
Assets:			
Operating leases	Right-of-use assets	$	
Finance leases	Property, plant and equipment, net		
Total lease assets		$	
Liabilities:			
Current:			
Operating leases	Operating lease liabilities, current portion	$	
Finance leases	Finance lease liabilities, current portion		
Noncurrent:			
Operating leases	Operating lease liabilities, net of current portion		
Finance leases	Finance lease liabilities, net of current portion		
Total lease liabilities		$	

The weighted-average lease terms and discount rates for operating and finance leases are presented in the following table:

	December 31 2023	2022
Weighted-average remaining lease term (years):		
Operating leases		
Finance leases		
Weighted-average discount rate:		
Operating leases		
Finance leases		

11. Leases (continued)

The following table presents certain information related to lease expense for finance and operating leases:

	Year Ended December 31	
	2023	2022
	(In Thousands)	
Finance lease expense:		
Amortization of right-of-use assets	$	
Interest on finance lease liabilities		
Operating lease cost		
Total lease expense	$	

The following table reconciles the undiscounted lease payments to the lease liabilities recorded on the accompanying consolidated balance sheets at December 31, 2023 (in thousands):

	Finance Leases	Operating Leases
2024	$	
2025		
2026		
2027		
2028		
Thereafter		
Total lease payments		
Less imputed interest		
Total lease obligations		
Less current portion		
Long-term portion	$	

12. Related-Party Transactions

12. Related-Party Transactions (continued)

[redacted]

re

[redacted]

13. Other Operating Revenue

Other operating revenue consists of the following for the years ended December 31, 2023 and 2022:

[redacted]

COVID-19 and CARES Act Funding

[redacted]

13. Other Operating Revenue (continued)

[redacted]

14. Subsequent Events

[redacted]

[redacted]

Supplementary Information

St. Barnabas Hospital

Consolidating Balance Sheet

As of December 31, 2023

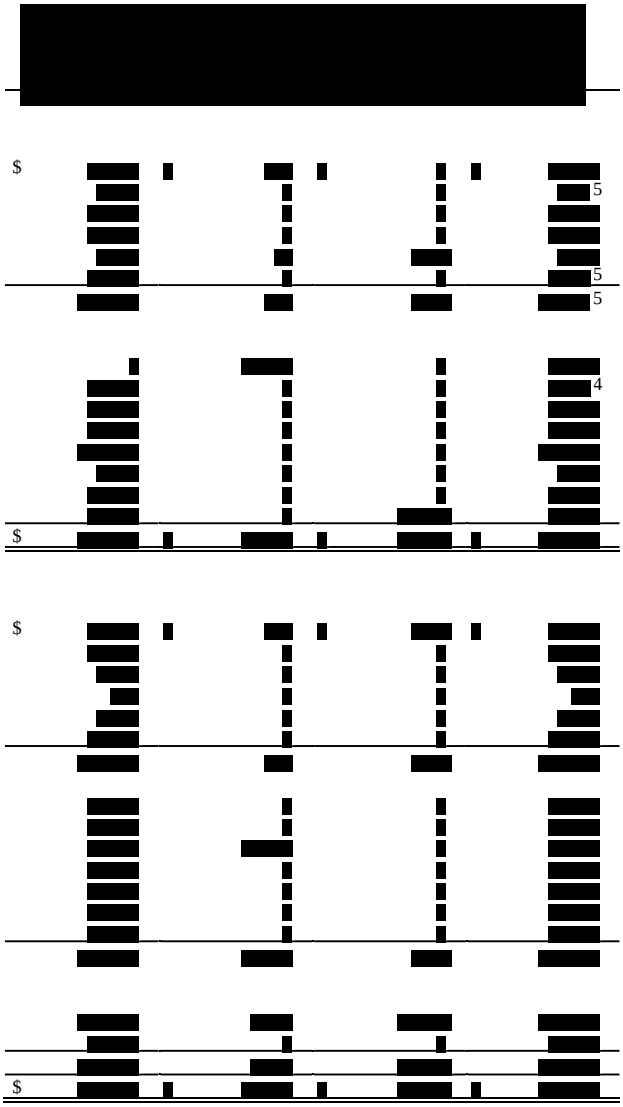
(In Thousands)

Assets	
Current assets:	
Cash and cash equivalents	$
Current portion of assets limited as to use	
Patient accounts receivable, net	
Due from third-party payer reimbursement programs	
Other receivables	9
Prepaid expenses and supplies	
Total current assets	
Assets limited as to use:	
Externally limited:	
Under malpractice funding requirements, net of current portion	
Under financing agreements, net of current portion	
Funds held in trust by others	
Internally limited, net of current portion	
Property, plant and equipment, net	
Receivable from Union Community Health Center, Inc.	
Right-of-use assets	
Other assets	
Total assets	$
Liabilities and net assets	
Current liabilities:	
Accounts payable, accrued expenses, and other deferred liabilities	$
Accrued salaries, wages, and related expenses	04
Current portion of long-term debt	
Finance lease liability, current portion	
Operating lease liabilities, current portion	
Due to third-party payer reimbursement programs	
Total current liabilities	
Long-term debt, net of current portion	
Due to third-party payer reimbursement programs, net of current portion	
Estimated malpractice liability, net of current portion	
Accrued pension liability	
Financing lease liability, net of current portion	
Operating lease liabilities, net of current portion	
Other liabilities	
Total liabilities	
Net assets:	
Net assets without donor restrictions	
Net assets with donor restrictions	
Total net assets	
Total liabilities and net assets	$

St. Barnabas Hospital

Consolidating Balance Sheet

As of December 31, 2022



Assets
Current assets:
Cash and cash equivalents $
Current portion of assets limited as to use 5
Patient accounts receivable, net
Due from third-party payer reimbursement programs
Other receivables
Prepaid expenses and supplies 5
Total current assets 5
Assets limited as to use:
Externally limited:
Under malpractice funding requirements, net of current portion
Under financing agreements, net of current portion 4
Funds held in trust by others
Internally limited, net of current portion
Property, plant and equipment, net
Receivable from Union Community Health Center, Inc.
Right-of-use assets
Other assets
Total assets $

Liabilities and net assets
Current liabilities:
Accounts payable, accrued expenses, and other deferred liabilities $
Accrued salaries, wages, and related expenses
Current portion of long-term debt
Finance lease liability, current portion
Operating lease liabilities, current portion
Due to third-party payer reimbursement programs
Total current liabilities

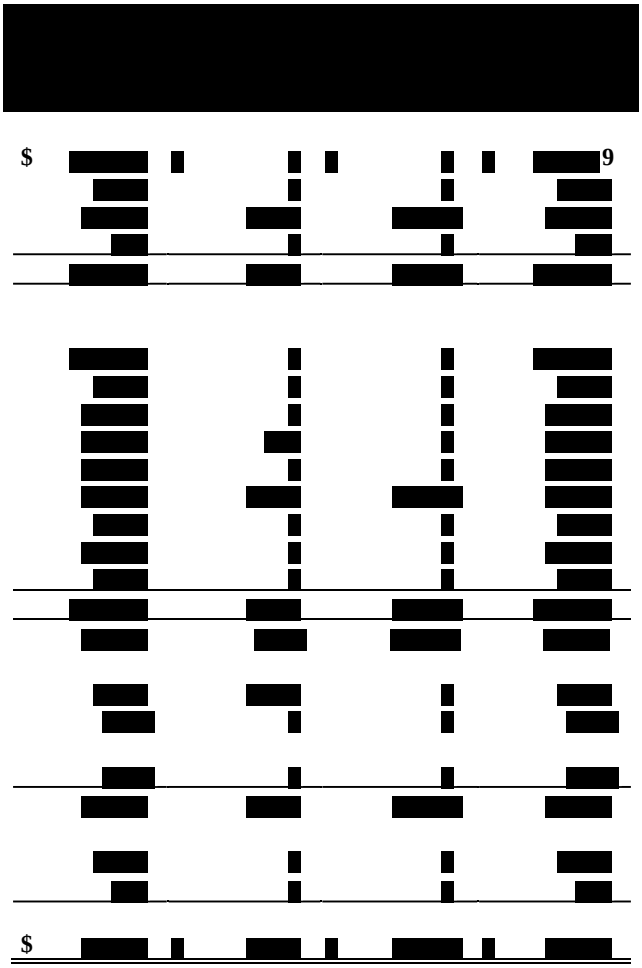
Long-term debt, net of current portion
Due to third-party payer reimbursement programs, net of current portion
Estimated malpractice liability, net of current portion
Accrued pension liability
Financing lease liability, net of current portion
Operating lease liabilities, net of current portion
Other liabilities
Total liabilities

Net assets:
Net assets without donor restrictions
Net assets with donor restrictions
Total net assets
Total liabilities and net assets $

St. Barnabas Hospital

Consolidating Statement of Operations

Year Ended December 31, 2023



Operating revenues
Net patient service revenue
SBH Behavioral Health operating revenue
Other operating revenue
Net assets released from restrictions used for operations
Total operating revenues

Operating expenses
Professional care of patients
Dietary services
Household and maintenance
Administration and general services
Employee health and welfare
Malpractice expense
Interest
Depreciation, amortization and rentals
SBH Behavioral Health operating expenses
Total operating expenses
Operating gain (loss)

Investment income, net
Other expense, net
Net periodic pension and other postretirement cost other than service cost
Excess (deficiency) excess of revenues over expenses
Change in pension and postretirement benefits liability to be recognized in future periods
Capital grant income
Increase (decrease) increase in net assets without donor restrictions

St. Barnabas Hospital

Consolidating Statement of Operations

Year Ended December 31, 2022

	[redacted]
Operating revenues	
Net patient service revenue	$
SBH Behavioral Health operating revenue	
Other operating revenue	
Net assets released from restrictions used for operations	
Total operating revenues	
Operating expenses	
Professional care of patients	
Dietary services	
Household and maintenance	
Administration and general services	
Employee health and welfare	
Malpractice expense	
Interest	
Depreciation, amortization and rentals	
SBH Behavioral Health operating expenses	
Total operating expenses	
Operating gain (loss)	3,650 9,891
Investment loss, net	
Other income, net	
Net periodic pension and other postretirement cost other than service cost	
Excess (deficiency) excess of revenues over expenses	
Change in pension and postretirement benefits liability to be recognized in future periods	
Capital grant income	
Increase (decrease) increase in net assets without donor restrictions	$

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NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

2/14/2023

VIA EMAIL

Dr. David Perlstein, MD MBA FAAP President & CEO
St. Barnabas Hospital
4422 Third Avenue
Bronx, NY 10457

Re: RFA# 18406, Statewide Health Care Facility Transformation Program III (SHCFTP III)

Dear Dr.David Perlstein, MD MBA FAAP:

We are pleased to inform you that, based on application number DOH01-SHCFT3-2021-00001 submitted under the above referenced RFA that was released in September 2021, you have been awarded a reimbursement grant in an amount up to $38,980,021.00.

Please note that this letter is not a final commitment to provide funds, but rather is evidence of the intention on the part of the Department of Health (DOH) to enter into a Master Grant Contract (MGC) with St. Barnabas Hospital subject to compliance with the conditions set forth in the RFA and the attached Addendum. The final amount to be awarded is subject to compliance with these conditions, and may be less than the grant amount set forth above. Master Grant Contracts are also contingent upon approval of the Attorney General and the Office of the State Comptroller.

Conditions to this award listed in the RFA and attached Addendum must be completed prior to the execution of your MGC with DOH and distribution of grant proceeds.

Should you have any questions concerning SHCFTP III or this Award Letter, please address your inquiry to Statewide3@health.ny.gov. In order to properly address your questions, please also include a contact person, contact e-mail, and contact phone number in the body of your e-mail.

Sincerely,

James V. McDonald, M.D., M.P.H.
Acting Commissioner
New York State Department of Health

cc: Reuben R. McDaniel, III, President and CEO, DASNY
Sara Richards, Director of Grant Administration, DASNY

Addendum

The following conditions must be satisfied with respect to each capital project to be funded with grant funds before the Master Grant Contract can be finalized and executed:

- Confirmation by DASNY Bond Counsel that the capital project is eligible to be funded through the State supported bond program. A DASNY representative will contact you if additional information regarding the capital project expenditures is required.
- Evidence of the completion of a review pursuant to the State Environmental Quality Review Act ("SEQRA"). A DASNY representative will contact you in order to determine the appropriate level of review to be conducted.
- Verification that all services provided in connection with the project are open to all regardless of religious affiliation and have no religious components. If this is required, DASNY will provide the form to the applicant.
- Completion of the Workplan and Capital Budget providing an outline/summary of the work associated with the Project(s), identifying the project(s) of objectives, metrics and milestones, and identification of project expenditures.
- Verification the awardee has secured site control of the properties to be used for this project(s).
- Provided a copy of the applicant's Operating Certificate to DOH.
- Provided current Workers' Compensation and Disability certificates of insurance to DOH.
- Confirmation of awardees current Charities Registration status to DOH.
- Vendor Responsibility/Grant Diligence Requirements:
  As a further condition to entering into a Master Grant Contract with the DOH:
  - Awardees must have completed a Vendor Responsibility Questionnaire (VRQ), either electronically or via paper form, within the past six months for which the contract will be finalized and executed.
  - Any requested Vendor Responsibility/Grant Diligence information must be provided to the satisfaction of DOH.
  - Identify any subcontractors that will receive over $100K in award funds and ensure they have obtained an OSC vendor ID and completed a Vendor Responsibility Questionnaire (VRQ).
  - DOH shall have determined that the awardee, and any contractor(s) and/or other vendor(s) providing any goods or services with respect to the Project, are (and will continue to be) responsible and ae able to meet the obligations under the MGC.
  - DOH, in consultation with DASNY or other parties as it shall determine to be necessary, shall, in its sole discretion, determine the truth and accuracy of all statements made in the Vendor Responsibility/Grant Diligence information and/or other documentation or information submitted in connection with any Project funded by the Grant.
  - DOH and/or DASNY, in their sole discretion, may request additional information or documentation, including in-person interviews of relevant individuals regarding any

aspect of the Project to be funded in whole or in part with Grant proceeds, and may audit any records of the Grantee related to the projects funded with the Grant.

- Verification that the awardee has initiated the request process for any necessary regulatory approvals and/or waivers such as DOH Certificate of Need (CON) approval, if required. In order to expedite the MGC execution process, CON and other DOH regulatory requirements should be considered as soon as possible.

If the above conditions are not satisfied within 60 days of the date of this notification, this award letter may expire. Upon written request from the applicant with an explanation acceptable to the Department of Health (DOH) as to why the required information was not provided to DOH and DASNY within the requisite timeframe, DOH may, in its sole discretion, grant an extension to allow more time to provide the information necessary to make a final determination of the grant award.

The following conditions must be satisfied with respect to each capital project <u>prior to the reimbursement with grant funds</u> under the terms of the Master Grant Contract:

- Submission of detailed project budgets for Bondability Review and Approval by Bond Counsel evidencing that bond proceeds will only be used for eligible costs.

- The primary source of funds for the SHCFTP III capital grant program will be bond proceeds, which by law may only be used for capital costs for federal income tax purposes and that comprise capital works or purposes under the State Finance Law. Therefore, Tax and bond counsel to the Dormitory Authority of the State of New York (DASNY) must confirm that the applicable grant expenditures identified in your application are costs that are eligible to be funded from proceeds of State-supported bonds as described in the Request for Applications Section III, B.

- The following costs are NOT capital costs and may not be funded with grant funds:
  - Internal labor costs (salaries, benefits, or other costs of an applicant's employees working on a project);
  - Costs of hand-held electronic devices or other equipment with a useful life of less than three years;
  - Ongoing maintenance fees; and
  - Other costs determined by DOH, DASNY and/or its bond counsel to be non-capital in nature.

- The budgets must separately identify all project costs, including those that are funded by independent sources and not grant funds. Professional estimates, quotes, bids, or other indicia from a design professional or equipment vendor setting forth the total Project cost must be provided.

- The budgets must identify all other funding sources and demonstrate to the satisfaction of DASNY and its bond and tax counsel that other available funds are both eligible and sufficient to pay such costs.

- If the Project includes IT or other technology equipment, the budget must clearly distinguish among the hardware, software development, software licenses, training, implementation, intellectual property costs and the amount and source of grant funds or other available funds to be spent on each component. Any project costs comprising ongoing maintenance fees also must be separately stated and funded with amounts other than bond proceeds. All components should be clearly identified and described. In addition, the amount of grant funds, if any, to be spent on each component must be stated, and the amounts of other available funds to be spent on such respective components must be clearly stated.

- If the Project includes the purchase of real property and if grant funds are to be used to acquire such real property, an appraisal meeting the Uniform Standards of Professional Appraisal Practice ("USPAP") standards for the real property to be acquired with grant funds must be provided, along with a completed Real Property and Fixed Asset Certification executed by the applicant. This form will be provided by DASNY to the applicable grantees.

- If the Project involves the renovation or improvement of a facility previously financed or refinanced with the proceeds of tax-exempt bonds, the applicant will have to complete and execute a Prior Bond Certification form. This form will be provided by DASNY to the applicable applicants.

- Public Authorities Control Board approval of the Project, as required and initiated by DOH and DASNY, is obtained.

- Confirmation of regulatory approvals and/or waivers such as DOH Certificate of Need (CON) required under the project(s) have been obtained.

- Confirmation that an MWBE Utilization Plan has been submitted and approved. Pursuant to the Request for Applications Section IV. I., the New York State Department of Health established a Minority and Women Owned Business participation goal of **30%** on any subcontracted labor or services, equipment, materials, or any combined purchase of the foregoing greater than $25,000 under a contract awarded from this solicitation. All grantees must submit an acceptable MWBE Utilization plan reflective of this goal. In addition, successful awardees are required to certify they have an acceptable Equal Employment Opportunity policy statement.

- Submission of required quarterly reports on the status of the Statewide Health Care Facility Transformation Program II project. Such reports shall be submitted no later than 30 days after the close of the quarter, and shall be consistent with the provisions of the terms of the State of New York Master Contract for Grants.

  The reports shall include:
  - Progress made toward Statewide Health Care Facility Transformation Program III objectives;
  - A status update on Project process and performance metrics and milestones;
  - Information on Project spending and budget; and
  - A summary of public engagement and public comments received.

- Confirmation that Financial Commitments in an amount sufficient to finance the full project cost less SHCFTP III grant proceeds are in place. Examples of acceptable commitments include:

  - Bank account and investment account statements;
  - Contractual agreements for the provision of such funds;
  - Board Resolution authorizing institutional funds to be utilized for purposes of the project;
  - Signed, notarized letter from a Senior Authorized Officer of the organization authorizing institutional funds to be utilized for purposes of the project;
  - Donor agreements and receipts;
  - Grant award letters with no outstanding contingencies, agreements and contracts;
  - Updated Letter of Interest including terms and conditions from a recognized lending institution, consistent with what was provided in your RFA submission;
  - Bond documents; or
  - Other documentation demonstrating, to the satisfaction of DOH and/or DASNY that sufficient funds for project completion have been secured and that the applicant is a going concern.

If the above conditions are not satisfied after the execution of the Master Grant Contract, delays in the commencement of your Project and receipt of state funds will occur.

Additional MGC Requirements of the Awardee:

- **Master Grant Contracts are also contingent upon approval of the Attorney General and the Office of the State Comptroller.**
- There are no advances allowed under this reimbursement grant award.
- State funding will only be provided to the awardee following the execution of the Master Grant Contract and submission of a reimbursement request acceptable to the DOH.
- If the Project is comprised of multiple and/or phased components, DOH may, after consultation with DASNY, enter into a MGC for those components of a Project that are Type II and may be properly segmented, including but not limited to planning, design or engineering costs, or for which a SEQRA review has been completed, so long as all other conditions of the Award Letter have been satisfied.
- DOH, DASNY, and other government agencies that may be involved in the grant process, and their bond counsel, are relying on the Grant Diligence information in order to determine whether or not to enter into a Master Grant Contract, including all required documentation provided in the course of reviews.
- DOH and /or DASNY, in their sole discretion, may request additional information or documentation, including in-person interviews of relevant individuals regarding any aspect of the Project to be funded in whole or in part with Grant proceeds, and may audit the records of the Grantee related to the projects funded with the Grant.
- The completed Grant Diligence information must be signed by one or more Authorized Officer(s) who possesses the requisite level of knowledge regarding the information provided and returned to the DOH.
- The Grantee acknowledges that there is a duty to notify DOH and DASNY of any changes to the statements made in the Grant Diligence information, as submitted to DOH and/or subsequently supplemented. The Grantee is hereby further advised that the submission of false information to the DOH could be a violation of Federal and State Penal Laws.
- The Grantee acknowledges that there is a duty to notify DOH and DASNY of any changes to the statements made in the Vendor Responsibility/ Grant Diligence information, as submitted to DOH and/or subsequently supplemented. The Grantee is hereby further advised that the submission of false information to the DOH could be a violation of Federal and State Penal Laws.
- Any request for modification or change to the awarded Project prior to finalization and execution of the Master Grant Contract must be identified in writing by the awardee to DOH within in 60 days of the receipt of this award letter.

New York State Department of Health
Certificate of Need Application
Schedule 10 - Space & Construction Cost Distribution

For all Full or Administrative review applications, except Establishment-Only applications. New Construction and Renovation must be entered on separate sheets (see instructions in line 43).

Indicate if this project is: New Construction [ ] **OR** Renovation: [X]

A			B	D	E	F	G	H	I
Location									
Sub project	Building	Floor	Functional Code	Description of Functional Code (enter Functional code in Column D, description appears here automatically)	Functional Gross SF	Construction Cost PER S.F. *Current* (un-escalated)	(F x G) Construction Cost TOTAL *Current* **sch.8B col.A** (un-escalated)	Alterations, Scope of work	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted] 4	[redacted]	[redacted]	
Totals for Whole Project:					[redacted]	[redacted]	[redacted]		**B**

Sch

If additional sheets are necessary, go to the toolbar, select "Edit", select "Move or copy sheet", make sure the "create a copy" box is checked, and select this document as the destination for the copy then select "OK". An additional worksheet will be added to this spreadsheet

	YES	NO	
1. If New Construction is Involved, is it "freestanding?	[ ]	[ ]	**N/A**

	Dense Urban	Other metropolitan or suburban	Rural
2. Check the box that best describes the location of the facilities affected by this project:	[X]	[ ]	[ ]

The section below must be filled out and signed by the applicant, applicant's representative, project architect, project engineer or project estimator.engineer,

SIGNATURE	DATE

PRINT NAME	TITLE
David Perlstein, MD	President and CEO

NAME OF FIRM
SBH Health System

STREET & NUMBER
4422 Third Avenue

CITY	STATE	ZIP	PHONE NUMBER
Bronx	New York	10457	(718) 960-3469

New York State Department of Health
Certificate of Need Application
Schedule 11 - Moveable Equipment
For Article 28, 36, and 40 Construction Projects Requiring Full or Administrative Review *

Table I: New Equipment Description

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Lease (L) or Purchase (P)	Date of the end of the lease period	Lease Amount or Purchase Price
--	--	Equipment and furniture for inpatient psychiatric units	---	P	---	[redacted]
		Please refer to the equipment list under the Schedule 11 Attachment				

Total lease and purchase costs: Subproject 1	
Total lease and purchase costs: Subproject 2	
Total lease and purchase costs: Subproject 3	
Total lease and purchase costs: Subproject 4	
Total lease and purchase costs: Subproject 5	
Total lease and purchase costs: Subproject 6	
Total lease and purchase costs: Subproject 7	
Total lease and purchase costs: Subproject 8	
Total lease and purchase costs: Whole Project:	[redacted]

Table 2 - Equipment being replaced:

List only equipment that is being replaced on a one for one basis. On the first line list the new equipment. On the second line list the equipment that is being replaced.

Sub project Number	Functional Code	Description of equipment, including model, manufacturer, and year of manufactor where applicable.	Number of units	Disposition	Estimated Current Value
		Not Applicable			

Total estimated value of equipment being replaced: Subproject 1	
Total estimated value of equipment being replaced: Subproject 2	
Total estimated value of equipment being replaced: Subproject 3	
Total estimated value of equipment being replaced: Subproject 4	
Total estimated value of equipment being replaced: Subproject 5	
Total estimated value of equipment being replaced: Subproject 6	
Total estimated value of equipment being replaced: Subproject 7	
Total estimated value of equipment being replaced: Subproject 8	
Total estimated value of equipment being replaced: Whole Project:	

SCHEDULE 11 ATTACHMENT

Equipment List

[redacted]

Quote

Date	04/28/2025
Quote #	QUO570736
Expires	05/28/2025
Project Name	2nd, 3rd & 4th Flrs.
Terms	Subject to Credit Approval
Estimated Ship Date	

Bill To

SBH Health System
4422 Third Ave
Attn: Accts Payable Braker Building 2nd Floor
Bronx NY 10457
United States

[redacted]

Ship To

SBH Health System
4422 Third Ave
Bronx NY 10457
United States

[redacted]

Line #	Item	Description	Image	Product Spec Sheet	Qty	Unit Price	Ext. Price
1	**PRD-RR06K**	**Kit, Prodigy/Arcadian, Removable Restraint Ring - Set of 6**		Product Spec	[redacted]	[redacted]	[redacted]
2	**PRD100-XXX**	**Prodigy, Bed, Platform Bed w/ Anchoring; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
3	**PRD130-XXX**	**Prodigy, Storage Bed; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
4	**PRD804-XXX**	**Prodigy, Wardrobe, Wardrobe Without Door; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
5	**MRB6-3680-C1NA-5**	**Comfort Shield Remedy - Sealed Seam Mattress, MRB6, 36" x 80" x 6"**		Product Spec	[redacted]	[redacted]	[redacted]

Line #	Item	Description	Image	Product Spec Sheet	Qty	Unit Price	Ext. Price
6	**MRB6-3075-C1NA-5**	**Comfort Shield Remedy - Sealed Seam Mattress, MRB6, 30" x 75" x 6"**		Product Spec	[redacted]	[redacted]	[redacted]
7	**VA620-XXX-W**	**Vesta, Lounge, Arm Chair, Ballasting; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
8	**G20-XXX000**	**Norix - Goby, Love Seats; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
9	**BE985-18-XXX-W**	**B-Side, Square, Ballasted 50 Lbs; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
10	**TA1800-MCXXXXX-XXX-11108W**	**Tabla, 18” Premium Round Table, Ballasting; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
11	**EV4242-MAXX-XXX-11XXX-W**	**Evvolve Table, 42" Square, Ballasting; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
12	**XB4200-MAXX-XXX-11XXX-W**	**X-Base Molded Table, 42" Round, Ballasted; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
13	**VA610-XXX-W**	**Vesta, Guest, Armless Chair, Ballasting; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
14	**VA600-XXX-W**	**Vesta, Guest, Arm Chair, Ballasting; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]
15	**AA1-1BXXX-1BXXX-3A**	**Affinity, Affinity Arm Chair Upholstered, Back Fabric Grade B, Seat Fabric Grade B; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes**		Product Spec	[redacted]	[redacted]	[redacted]

Line #	Item	Description	Image	Product Spec Sheet	Qty	Unit Price	Ext. Price
16	AA2-1B XXX-1B XXX-3	Affinity, Affinity Armless Chair Upholstered, Back Fabric Grade B, Seat Fabric Grade B; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes		Product Spec	[redacted]	[redacted]	[redacted]
17	MP3060 -TAXX- XXX-31 XX	Multipurpose, 30" x 60" Rectangle; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes		Product Spec	[redacted]	[redacted]	[redacted]
18	MP3600 -TAXX- XXX-30 XX	Multipurpose, 36" Round; Please select Fabrics and Finishes from www.norix.com/fabrics-finishes		Product Spec	[redacted]	[redacted]	[redacted]

Subtotal	[redacted]
Tax Total (%)	[redacted]
Shipping Charges	[redacted]
Total	[redacted]

Final pricing may be subject to change based on the selection of specific fabrics, finishes, or other customizations. Final pricing will be adjusted and confirmed upon final selections.

Shipping

Additional Services:

Important: Unless otherwise noted above, Freight shown above is Standard Dock to Dock Delivery via common carrier, using your personnel to unload the merchandise. You will be contacted 24 hours prior to delivery so you may make arrangements to unload the merchandise. If you require different delivery options, please complete and return the attached Delivery Change Form prior to placing your order.

This Quotation is valid for 30 days and subject to the Standard Terms and Conditions stated in the Norix Group Price List.

Thank you for allowing [redacted] the privilege of quoting your requirements.

If you'd like to place an order:

For orders over $10,000, please submit a PO to your [redacted] Customer Service Representative.

For orders under $10,000, please fill out the bottom portion of this quote and return all pages of the quote to your [redacted] Customer Service Representative.

Ship To: _____

Address: _____

_____

Contact: _____

Phone: _____

Billing Email: _____

Bill To (if different from above): _____

Address: _____

Accepted By: _____

P.O. Number: _____

Sales Tax Exempt? (please circle) Yes or No

Tax Exempt #: _____

Requested Delivery Date: _____

Contact: _____

Phone: _____

Schedule 13 A. Assurances from Article 28 Applicants

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

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

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

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

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

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

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

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

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

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

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

Date

Signature:

David Perlstein, M.D.
Name (Please Type)

President and CEO
Title (Please type)

New York State Department of Health
Certificate of Need Application

Schedule 13 B-1. Staffing

See "Schedu es Requ red for Each Type of CON" to determ ne when th s form s requ red. Use the "Other" categor es for prov ders, such as dent sts, that are not ment oned n the staff categor es. If a project nvo ves mu t p e s tes, p ease create a staff ng tab e for each s te.

[X] **Total Project** [ ] **Subproject number** [ ]

A		B	C	D
		Number of FTEs to the Nearest Tenth		
Staff ng Categor es		Current Year*	F rst Year Tota Budget	Th rd Year Tota Budget
1. Management & Superv s on		[redacted]	[redacted]	[redacted]
2. Techn c an & Spec a st				
3. Reg stered Nurses		[redacted]	[redacted]	[redacted]
4. L censed Pract ca Nurses		[redacted]	[redacted]	[redacted]
5. A des, Order es & Attendants		[redacted]	[redacted]	[redacted]
6. Phys c ans		[redacted]	[redacted]	[redacted]
7. PGY Phys c ans		[redacted]	[redacted]	[redacted]
8. Phys c ans Ass stants				
9. Nurse Pract t oners				
10. Nurse M dw fe				
11. Soc a Workers and Psycho og st**		[redacted]	[redacted]	[redacted]
12. Phys ca Therap sts and PT Ass stants				
13. Occupat ona Therap sts and OT Ass stants				
14. Speech Therap sts and Speech Ass stants				
15. Other Therap sts and Ass stants		[redacted]	[redacted]	[redacted]
16. Infect on Contro , Env ronment and Food Serv ce				
17. C er ca & Other Adm n strat ve		[redacted]	[redacted]	[redacted]
18. Other	Security Guards	[redacted]	[redacted]	[redacted]
19. Other				
20. Other				
21. Tota Number of Emp oyees		[redacted]	[redacted]	[redacted]

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

Describe how the number and mix of staff were determined:

Current Year staffing is based on actual staffing of the 49 inpatient psychiatric beds, which are located on two (2) inpatient units, at SBH Health System in 2024. Staffing in Year 1 and Year 3 reflects incremental staffing as a result of adding 23 inpatient psychiatric beds, creating three (3), 24-bed inpatient psychiatric units and is based on the experience of SBH Health System in providing inpatient psychiatric services.

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Schedule 13 B-2. Medical/Center Director and Transfer Agreements Not Applicable

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

.

Medical/Center Director	
Name of Medical/Center Director:	
License number of the Medical/Center Director	

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

Transfer & Affiliation Agreement	
Hospital(s) with which an affiliation agreement is being negotiated	
○ Distance in miles from the proposed facility to the Hospital affiliate.	
○ Distance in minutes of travel time from the proposed facility to the Hospital affiliate.	
○ Attach a copy of the letter(s) of intent or the affiliation agreement(s), if appropriate.	N/A ☐ Attachment Name:
Name of the **nearest** Hospital to the proposed facility	
○ Distance in miles from the proposed facility to the nearest hospital.	
○ Distance in minutes of travel time from the proposed facility to the nearest hospital.	

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Schedule 13B

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

Up oad a spreadsheet or chart as an attachment to th s Schedu e of a pract t oners, nc ud ng surgeons, dent sts, and pod atr sts who have expresse nterest n pract c ng at the Center. The chart must nc ude the nformat on shown n the temp ate be ow.

Additionally, up oad cop es of etters from each pract t oner show ng the number and types of procedures he/she expects to perform at the Center p

Not Applicable

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

Schedule 13 C. Annual Operating Costs

See "Schedu es Requ red for Each Type of CON" to determ ne when th s form s requ red. One schedu e must be comp eted for the tota project and one for each of the subprojects. Ind cate wh ch one s be ng reported by check ng the appropr ate box at the top of the schedu e.

Use the be ow tab es or up oad a spreadsheet as an attachment to th s Schedu e that matches the structure of the tab es (Attachment T t e:) to summar ze the f rst and th rd fu year's tota cost for the categor es, wh ch are affected by th s project. The f rst fu year s def ned as the f rst 12 months of fu operat on after project comp et on. Year 1 and 3 shou d represent projected tota budgeted costs expressed n current year do ars. Add t ona y, you must up oad the requ red attachments nd cated be ow.

Required Attachments

	Title of Attachment	Filename of Attachment
1. In an attachment, prov de the bas s for determ n ng budgeted expenses, nc ud ng deta s for how deprec at on and rent / ease expenses were ca cu ated.	Schedu e 13 Attachment	
2. In a sperate attachment, prov de the bas s for nterest cost. Separate y dent fy, w th support ng ca cu at ons, nterest attr buted to mortgages and work ng cap ta	N/A	

☒ Tota Project or ☐ Subproject Number

Table 13C - 1

	a	b	c
Categor es	Current Year	Year 1 Tota Budget	Year 3 Tota Budget
Start date of year n quest on:(m/d/yyyy)	1/1/24	10/1/28	10/1/30
1. Sa ar es and Wages	$	$	$
1a. FTEs			
2. Emp oyee Benef ts	$	$	$
3. Profess ona Fees	$	$	$
4. Med ca & Surg ca Supp es	$	$	$
5. Non med., non surg. Supp es	$	$	$
6. Ut t es			
7. Purchased Serv ces	$	$	$
8. Other D rect Expenses	$	$	$
9. Subtota (tota 1 8)	$	$	$
10. Interest (deta s requ red be ow)			
11. Deprec at on (deta s requ red be ow)		$	$
12. Rent / Lease (deta s requ red be ow)			
13. Tota Operat ng Costs	$	$	$

Note: The above reflects the operating costs of the inpatient psychiatric beds at SBH Health System.

Table 13C - 2

	a	b	c
Inpatient Categor es	Current Year	Year 1 Tota Budget	Year 3 Tota Budget
Start date of year n quest on:(m/d/yyyy)	1/1/24	10/1/28	10/1/30
1. Sa ar es and Wages	$	$	$
1a. FTEs			
2. Emp oyee Benef ts	$	$	$
3. Profess ona Fees	$	$	$
4. Med ca & Surg ca Supp es	$	$	$
5. Non-med., non-surg. Supp es	$	$	$
6. Ut t es			
7. Purchased Serv ces	$	$	$
8. Other D rect Expenses	$	$	$
9. Subtota (tota 1-8)	$	$	$
10. Interest (deta s requ red be ow)			
11. Deprec at on (deta s requ red be ow)		$	$
12. Rent / Lease (deta s requ red be ow)			
13. Tota Operat ng Costs	$	$	$

Table 13C - 3

	a	b	c
Outpatient Categor es	Current Year	Year 1 Tota Budget	Year 3 Tota Budget
Start date of year n quest on:(m/d/yyyy)	**Not Applicable**		
1. Sa ar es and Wages			
1a. FTEs			
2. Emp oyee Benef ts			
3. Profess ona Fees			
4. Med ca & Surg ca Supp es			
5. Non-med., non-surg. Supp es			
6. Ut t es			
7. Purchased Serv ces			
8. Other D rect Expenses			
9. Subtota (tota 1-8)			
10. Interest (deta s requ red be ow)			
11. Deprec at on (deta s requ red be ow)			
12. Rent / Lease (deta s requ red be ow)			
13. Tota Outpat ent Operat ng Costs			

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

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Schedule 13 D: Annual Operating Revenues

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

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

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

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

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

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

Required Attachments

	N/A	Title of Attachment	Filename of Attachment
1. Provide a cash flow analysis for the first year of operations after the changes proposed by the application, which identifies the amount of working capital, if any, needed to implement the project.	☐	Schedule 5 Attachment	
2. Provide the basis and supporting calculations for all utilization and revenues by payor.	☐	Utilization and revenues by payor are based on the experience of SBH Health System	
3. Provide the basis for charity care revenue assumptions used in Year 1 and 3 Budgets ((Table 13D-2B). *If less than 2%, provide a reason why a higher level of charity care cannot be achieved and remedies that will be implemented to increase charity care.*	☐	Charity care is based on the experience of SBH Health System	

New York State Department of Health **Schedul**
13D

Table 13D - 1

	a	b	c
Categories	Current Year	Year 1 Total Revenue Budget	Year 3 Total Revenue Budget
Start date of year in question:(m/d/yyyy)	1/1/24	10/1/28	10/1/30
1. Inpatient Services	$ [redacted]	$ [redacted]	$ [redacted]
2. Outpatient Services			
3. Ancillary Services			
4. Total Gross Patient Care Services Rendered	$ [redacted]	$ [redacted]	$ [redacted]
5. Deductions from Revenue			
6. Net Patient Care Services Revenue	$ [redacted]	$ [redacted]	$ [redacted]
7. Other Operating Revenue (Identify sources)			
8. Total Operating Revenue (Total 1-7)	$ [redacted]	$ [redacted]	$ [redacted]
9. Non-Operating Revenue			
10. Total Project Revenue	$ [redacted]	$ [redacted]	$ [redacted]

Note: The above reflects the revenue of the inpatient psychiatric beds at SBH Health System.

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

Patient Days [X] or Patient Discharges [ ]

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

Table 13D – 2B

Various outpatient services may be reimbursed as visits or procedures. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Visits (V) ☐ or Procedures (P) ☐

Outpatient Services Source of Revenue		Total Current Year			First Year Total Budget			Third Year Total Budget		
		(A) V/P	Net Revenue **(B)** Dollars ($)	$ per V/P **(B)/(A)**	**(C)** V/P	Net Revenue **(D)** Dollars ($)	$ per V/P **(D)/(C)**	**(E)** V/P	Net Revenue **(F)** Dollars ($)	$ per V/P **(F)/(E)**
Commercial	Fee for Service	**Not Applicable**								
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total										

Total of Inpatient and Outpatient Services		$ [redacted]			$ [redacted]			$ [redacted]		

SCHEDULE 13 ATTACHMENT

Calculation of Depreciation

SBH Health System

Calculation of Depreciation

Description	Amount	Depreciation Life	Depreciation Amount
Equipment	[redacted]	[redacted]	[redacted]
Building Improvement/Other	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]

Schedule 16 A. Hospital Program Information

All administrative aspects of the inpatient psychiatric services at SBH Health System (SBH) will be directed by an individual who is qualified for such duties by education and experience. The Quality Assurance (QA) Program for these services will be administered by the Medical Director, and will be consistent with, and an integral part of, SBH's existing QA Program. To ensure that care and services are appropriate to an individual's needs, SBH will continue to use a comprehensive utilization review and monitoring program for these services. The appropriate utilization of services will continue to be monitored through the QA Program, under the supervision of the Medical Director.

The inpatient psychiatric services at SBH will continue to utilize the same credentialing process for these services that is currently in place at SBH. Only those physicians who are qualified by virtue of their training and experience will be considered for staff privileges, and only those who demonstrate a high level of competence will be appointed to the staff of SBH. A similar process will be followed for nursing, technical and support staff members who seek employment.

In accordance with current policy at SBH, the ability to pay will not be a factor in the process of accepting patients. Every effort will be made to ensure that appropriate payment is made, but in no circumstance will a patient be refused treatment based on ability to pay. SBH currently has a sliding fee scale for its patients. All services will continue to be offered to those in need of care who satisfy admission requirements, regardless of age, sex, sexual orientation, race, creed, religion, disability, source of payment or any other personal characteristic.

Please refer to the Project Narrative under the Schedule 1 Attachment for additional information.

For Hospital-Based -Ambulatory Surgery Projects: **Not Applicable**
Please provide a list of ambulatory surgery categories you intend to provide.

List of Proposed Ambulatory Surgery Category

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

Number and Type of Operating Rooms:

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

Number and Type of Procedure Rooms:

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

Schedule 16 B. Community Need
See "Schedules Required for Each Type of CON" to determine when this form is required.

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

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

The primary service area for this project includes the following Bronx ZIP Codes: 10453, 10456, 10457, 10458, 10459, 10460, 10462, 10467 and 10468. SBH is located in a federally-designated mental health HPSA (ME-Crotona ID: 7365719543).

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

As shown in the table below, in general, the PSA population is comprised of a greater percentage of minorities than Bronx County, New York City and New York State as a whole and is poorer, compared to Bronx County, New York City and New York State. Moreover, 74.1% (or 508,162) of the PSA population was an adult over the age of 18. This is the age group that uses the services contemplated in this Application.

Demographic Profile	**PSA**	**Bronx County**	**New York City**	**New York State**
Population in 2023	685,779	1,419,250	8,516,202	19,872,319
% Male	47.3%	47.3%	48.0%	48.8%
% Age 65 and over	11.4%	13.9%	16.0%	17.4%
% Over age 18	74.1%	75.5%	79.6%	79.3%
% White, non-Hispanic	4.8%	8.8%	31.3%	53.4%
% Black, non-Hispanic	26.7%	29.1%	20.8%	13.6%
% Hispanic	61.7%	54.9%	28.4%	19.6%
% Asian	4.0%	4.0%	14.5%	8.8%
Social/Economic Characteristics	**PSA**	**Bronx County**	**New York City**	**New York State**
% Foreign-born	37.6%	34.2%	36.5%	23.3%
% Language other than English spoken at home	64.9%	57.1%	47.5%	30.6%
% Below Federal Poverty Level	30.3%	26.9%	17.4%	13.7%

Source: U.S. Census Bureau, 2019-2023 American Community Survey (ACS) 5-Year Estimates

Please refer to the Project Narrative under the Schedule 1 Attachment for additional information.

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

The Bronx is an area of New York City in which SBH Health System is an essential provider of health and mental health services, including outpatient mental health treatment services to children, adolescents and adults and inpatient mental health treatment services to adults. Outpatient programs are offered at various locations throughout the Bronx in two (2) centers and three (3) public schools. SBH is one (1) of six (6) hospitals in the Bronx that provide inpatient psychiatric care to adults. These six (6) hospitals have the availability of 420 adult beds or 3.92 per 10,000 adult population in Bronx County as of 2023 ((1,071,534 adult residents per the 2023 ACS Survey). The Bronx County bed rate per 10,000 adult population is comparable to the Citywide rate of 3.74 (2,531 adult beds for 6,778,897 adult residents Citywide) and higher compared to the Statewide rate of 3.14 (4,941 adult beds for 15,758,748 adult residents Statewide). As noted below, however, utilization of this service in the Bronx outpaces all other boroughs; thus, based on the SHCFTP3 grant award, New York State has already determined the need for these beds.

Utilization of Adult Inpatient Psychiatric Services in the Bronx

The New York State Office of Mental Health collects and reports county level data for inpatient use, providing data on inpatient census and population rates of utilization by region and county of residence for psychiatric inpatient settings, including General Hospitals, Private Hospitals, State Psychiatric Centers and Residential Treatment Facilities. The table below shows inpatient utilization trends for average daily census and bed use rate per 10,000 adult population for 2018 to 2022 (latest data available) for Stateside, New York City and each of the five (5) boroughs.

Average Daily Census and Population Rates for Article 28 Hospital Psychiatric Inpatient Services 2018-2022

	2018		2019		2020		2021		2022	
Region/County	ADC	Rate	ADC	Rate	ADC	Rate	ADC	Rate	ADC	Rate
Statewide	3,365.0	2.2	3,484.0	2.3	3,291.3	2.1	2,888.8	1.8	2,871.9	1.8
New York City	1,870.6	2.8	1,896.8	2.8	1,778.8	2.7	1,552.2	2.3	1,519.4	2.3
Bronx	400.3	3.7	430.9	4.0	403.3	3.8	343.0	3.2	352.5	3.4
Kings	557.6	2.8	588.2	2.9	554.8	2.8	428.6	2.1	43.1	2.2
New York	465.5	3.3	406.9	2.9	365.3	2.6	333.2	2.5	317.8	2.3
Queens	386.5	2.1	394.8	2.1	384.4	2.1	354.1	1.9	350.7	1.9
Richmond	69.7	1.9	76.0	2.1	71.0	1.9	63.3	1.6	62.3	1.6

Source: New York State Office of Mental Health County Planning Profiles

As indicated in the above table, the Bronx has the highest bed use rate compared to the other boroughs, Citywide and Statewide for the five-(5)-year period of 2018 through 2022. The Bronx bed use rate is significantly higher than the Statewide rate and Citywide rate for each year during the five-(5)-year period. In addition, when looking at the bed availability rate per 10,000 adult population of 3.9 for Bronx County and the 2022 bed utilization rate of 3.4 per 10,000 Bronx County adult population, the percentage occupancy of the 420 adult beds available in the Bronx in 2022 is 87.2%. Optimal utilization of inpatient psychiatric unit occupancy generally aims to strike a balance between patient needs, staff well-being and the potential for quality of care. Research suggests that occupancy rates should ideally be below 85%. Utilization rates greater than 80% create a more stressful work environment and utilization rates above 85% are associated with a deterioration in the quality of care.[1] SBH's proposal to add 23 psychiatric beds will provide additional adult psychiatric bed capacity in Bronx County that facilitates optimal

[1] Jones, R. (2013) Optimum bed occupancy in psychiatric hospitals. Psychiatry On-line (http://www.priory.com/psychiatry/psychiatric_beds.htm)

utilization of the beds available in the Bronx and is responsive to Governor Hochul's transformation plan to enhance access to mental health services.

Please refer to the Project Narrative provided under the Schedule 1 Attachment for additional information.

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

Historical utilization of SBH's inpatient psychiatric program has increased by 33% between 2020 and 2024 from 973 discharges in 2020 to 1,297 discharges in 2024. The occupancy of the beds has also increased and has consistently been over 85% since 2022, indicating that there is a need for additional inpatient psychiatric beds at SBH to bring the occupancy level down to the optimal utilization level of psychiatric inpatient units to balance patient needs, staff well-being and quality of care.

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

In accordance with current Hospital policy, SBH provides care to patients regardless of ability to pay. Financial Assistance is available to all qualified persons regardless of race, color, creed, sexual orientation, ethnic origin or other qualification. The Hospital's Financial Assistance policy and procedures are maintained and operated in compliance with the applicable State of New York Hospital Financial Assistance laws.

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

This proposal seeks to increase the number of inpatient adult psychiatric beds at SBH. As detailed above, SBH has experienced increased utilization (discharges) of its inpatient psychiatric beds since 2020 and occupancy of the beds has consistently been over 85% since 2022, indicating that there is a need for additional inpatient psychiatric beds at SBH to bring the occupancy level down to the optimal utilization level of the Hospital's psychiatric inpatient units to balance patient needs, staff well-being and quality of care.

Please refer to the Project Narrative under the Schedule 1 Attachment for additional information.

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

As outlined above, there is a need to increase the inpatient psychiatric bed capacity for adults in the Bronx to accommodate patient volume within hospital settings for inpatient psychiatric services. This proposal seeks to add 23 inpatient beds to SBH's adult bed complement to support the demand for inpatient psychiatric services for adults.

Non-Public Hospitals

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

   Key priority areas of the New York State Prevention Agenda 2025-2030, which is currently under development, will include: 1) Living in communities that foster and support optimal physical, mental, and social well-being (Social and Community Context); 2) Equitable access to healthy, and safe neighborhoods (Neighborhood and Build Environment); and 3) Access to timely, affordable, and high-quality health care services (Health Care Access and quality). SBH's proposal to increase the bed capacity of its inpatient adult psychiatry program by 23 beds advances the Prevention Agenda 2025 – 2030 overarching goals by enhancing access to timely, affordable and high-quality inpatient mental health services while supporting optimal physical, mental, and social well-being of the residents in the communities served by the Hospital. As a result of this project, SBH will facilitate equitable access to healthy, and safe neighborhoods in the Bronx.

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

   N/A – As described above, the project is advancing Prevention Agenda priorities.

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

   In keeping with promoting mental health, the SBH Health System has a comprehensive network of psychiatric clinical services located throughout the Hospital's service area. With a combined wealth of specialized centers and programs, the SBH network of behavioral health services is poised to provide patients with unparalleled psychiatric treatment to advance the field of mental health. To achieve this goal, SBH has developed the following plan of action:

   - Support collaboration among professionals working in the fields of mental, emotional and behavioral health.
   - Promote chronic disease prevention and recovery.
   - Address access to mental health services by preventing and reducing occurrence of mental, emotional and behavioral disorders among the residents of the Bronx.
   - Provide mental health counseling, support and family therapy services to the community.

   In addition to improving access to the treatment of mental health by providing timely mental health services, SBH has also demonstrated active engagement and leadership in broadening access to its community health outreach efforts which raise awareness, education, and screening related to risk factors of chronic disease, mental health issues and co-occurring substance use disorders.

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

   SBH's Community Service Plan (CSP) builds on the New York State Department of Health Prevention Agenda Priorities and the New York City Department of Health and Mental Hygiene's Take Care New York priorities. SBH engages a range of stakeholders of community providers and the public, with a particular focus on the medically underserved and minority residents, to better understand community needs, challenges and barriers to accessing care, and disparities in service provision and health outcomes to identify service gaps and Prevention Agenda Priority Areas for the CSP.

   SBH will continue to work with its local community partners and the New York City Department of Health and Mental Hygiene to advance the Prevention Agenda goals outlined in the CSP.

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

    SBH tracks metrics from the Prevention Agenda dashboard to track progress to advance local Prevention Agenda goals. A few pertinent metrics to track for this proposed project include:

    <u>Priority Area: Promote Mental Health and Prevent Substance Abuse</u>
    Focus Area: Prevent substance abuse and other mental emotional behavioral "MEB" Disorders.
    Goal: Prevent suicides.

    Metrics:
    - Number of persons screened for suicide risk.
    - Percentage of persons screened and assessed positive for suicide risk and were counseled about lethal means (same day as screening).
    - Number of suicide attempts by Bronx adults who attempted suicide one (1) or more times in the past year.
    - Age-adjusted suicide mortality rate.

    Area: Strengthen infrastructure across the continuum of care.
    Goal: Support collaboration among leaders, professionals, and community members working in mental, emotional and behavioral (MEB) health promotion, substance abuse, and other MEB disorders and chronic disease prevention, treatment, and recovery.

    Metrics:
    - Number of persons served by behavioral health programs.
    - Monitor behavioral health network performance, including number of persons seen, numbers of follow-up and referrals to community-based programs in the community.

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

    No.

ONLY for Hospital Applicants submitting Full Review CONs **Not Applicable**

Public Hospitals

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

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

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

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

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

C. Impact of CON Application on Hospital Operating Certificate

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

TABLE 16C-1 AUTHORIZED BEDS

Not Applicable – Please refer to the Sites Tab in NYSE-CON

LOCATION:

(Enter street address of facility)

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

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

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

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

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

TABLE 16C-2 LICENSED SERVICES FOR HOSPITAL CAMPUSES

Not Applicable – Please refer to the Sites Tab in NYSE-CON

LOCATION:

(Enter street address of facility)

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

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

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

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

[5] RADIOLOGY – THERAPEUTIC includes Linear Accelerators

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

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

Not Applicable

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

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

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

END STAGE RENAL DISEASE (ESRD) Not Applicable

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

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

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

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

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

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

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

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

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

Schedule 16 D. Hospital Outpatient Department - Utilization projections

a	b	d	f
CERTIFIABLE SERVICES	Current Year *Visits**	First Year *Visits**	Third Year *Visits**
MEDICAL SERVICES – PRIMARY CARE			
MEDICAL SERICES – OTHER MEDICAL SPECIALTIES			
AMBULATORY SURGERY			
SINGLE SPECIALTY -- GASTROENTEROLOGY			
SINGLE SPECIALTY – OPHTHALMOLOGY			
SINGLE SPECIALTY – ORTHOPEDICS			
SINGLE SPECIALTY – PAIN MANAGEMENT			
SINGLE SPECIALTY -- OTHER			
MULTI-SPECIALTY			
CARDIAC CATHETERIZATION			
ADULT DIAGNOSTIC			
ELECTROPHYSIOLOGY			
PEDIATRIC DIAGNOSTIC			
PEDIATRIC INTERVENTION ELECTIVE			
PERCUTANEOUS CORONARY INTERVENTION (PCI)			
CERTIFIED MENTAL HEALTH O/P			
CHEMICAL DEPENDENCE - REHAB			
CHEMICAL DEPENDENCE - WITHDRAWAL O/P			
CLINIC PART-TIME SERVICES			
CLINIC SCHOOL-BASED SERVICES			
CLINIC SCHOOL-BASED DENTAL PROGRAM			
COMPREHENSIVE EPILEPSY CENTER			
COMPREHENSIVE PSYCH EMERGENCY PROGRAM	**Not Applicable**		
DENTAL			
EMERGENCY DEPARTMENT			
HOME PERITONEAL DIALYSIS TRAINING & SUPPORT			
HOME HEMODIALYSIS TRAINING & SUPPORT			
INTEGRATED SERVICES – MENTAL HEALTH			
INTEGRATED SERVICES – SUBSTANCE USE DISORDER			
LITHOTRIPSY			
METHADONE MAINTENANCE O/P			
NURSING HOME HEMODIALYSIS			
RADIOLOGY-THERAPEUTIC			
RENAL DIALYSIS, CHRONIC			
OTHER SERVICES			
Total			

Note: In the case of an extension clinic, the service estimates in this table should apply to the site in question, not to the hospital or network as a whole.

*The 'Total' reported MUST be the SAME as those on Table 13D-4.

Schedule 16 E. Utilization/Discharge and Patient Days

Service (Beds) Classification	Current Year Start date: 1/1/2024		1st Year Start date: 10/1/2028		3rd Year Start date: 10/1/2030	
	Discharges	Patient Days	Discharges	Patient Days	Discharges	Patient Days
AIDS						
BONE MARROW TRANSPLANT						
BURNS CARE						
CHEMICAL DEPENDENCE - DETOX						
CHEMICAL DEPENDENCE - REHAB						
COMA RECOVERY						
CORONARY CARE						
INTENSIVE CARE						
MATERNITY						
MED/SURG						
NEONATAL CONTINUING CARE						
NEONATAL INTENSIVE CARE						
NEONATAL INTERMEDIATE CARE						
PEDIATRIC						
PEDIATRIC ICU						
PHYSICAL MEDICINE & REHABILITATION						
PRISONER						
PSYCHIATRIC	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
RESPIRATORY						
SPECIAL USE						
SWING BED PROGRAM						
TRANSITIONAL CARE						
TRAUMATIC BRAIN-INJURY						
OTHER (describe)						
TOTAL	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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

New York State Department of Health Schedule 20A
Certificate of Need Application

Office of Mental Health Program

This information is **required of Article 28 hospitals and diagnostic and treatment centers for projects that include mental health programs** subject to an operating certificate or prior approval by the Office of Mental Health under Article 31 of the Mental Hygiene Law (MHL). These projects include a new mental health program, or a new site, or modification to an existing program. Per MHL Article 31, prior consultation with the Local Government Unit and local Office of Mental Health Field Office is required before submission of the Article 28 application.

Section A - Attachments for New Program or New Satellite Location – Not Applicable

1. **Program and Service Area**
   a. Identify the type of mental health program to be provided.
   b. Define the geographic or political boundaries of the area to be served by the proposed program.
   c. Describe how the proposed program will function within the mental health system in the area to be served.

2. **Problems and Needs**
   a. Describe the target population for the program qualitatively and quantitatively. Describe problems of the target population and their families, and describe how the proposed program will address these problems.
   b. Describe how your organization currently serves the target population (if applicable).
   c. Provide any other information supporting need for the proposed program.

3. **Access**
   a. Describe how the program will serve the poor and the medically indigent.
   b. Describe the mechanisms by which the program will address the cultural and ethnic backgrounds in the treatment of the population in the service area.
   c. Describe the mechanisms for participation of consumer representation within the governing body (if applicable).
   d. Describe plans to enable persons with physical disabilities to access services, consistent with the characteristics of the population to be served.
   e. Indicate the transportation arrangements through which individuals will access the program.

4. **Continuity of Care**
   a. Describe a plan to ensure continuity of care within the mental health system and with other service systems. Identify specific providers to ensure linkages among programs.
   b. For outpatient programs, describe a plan by which patients in the program will be assisted during hours when the program is not in operation.

5. **Implementation**
   Describe start-up or phase-in activities necessary to implement the program. Include timeframes in your description.

6. **Functional Program**
   a. Mission - Provide an overview of the proposed program and describe the treatment philosophy.
   b. Organization - Describe the lines of authority from the governing body to the proposed program. Indicate the relationship of the program to other programs operated by your agency.
   c. Goals and Objectives - Describe the goals, objectives, and expected outcomes of the program. Indicate average length of stay.
   d. Admission - Describe admission criteria, policies, and procedures. Include inclusionary and exclusionary criteria, process, timeframes, record keeping, and procedures for notifying families and programs in which recipients are currently admitted.
   e. Discharge - Describe discharge criteria, policies, and procedures. Include process, timeframes, record keeping, and procedures for notifying families and programs to which recipients will be

referred for further services.

f. Services - Provide a detailed description of all services available to recipients admitted to the program. Specify how these services will be provided and the staff position responsible for providing the service. Identify the provider of any services to be delivered by other than the proposed program. For programs serving children, describe plans to coordinate with the family and the school.
g. Staffing - Provide a staffing plan for the program. Include descriptions of the qualifications and duties for each staff position.
h. Quality Assurance/Improvement - Describe your plans for utilization review, incident management, and internal monitoring.
i. Premises - Provide a description of the premises to be used by the program. Include appropriately labeled sketch drawings showing use and dimensions of rooms.
j. Waivers - Identity any waiver requests and provide justification for the request. Indicate the effect on your proposed program if the request is denied.

7. **Fiscal**
   a. Unless provided elsewhere in this application, submit a proposed budget for the first and second year of full operation of the mental health program.
   b. If Medicaid revenue is included, indicate the source and availability of the state share of Medicaid for projects other than Article 31 Clinics.

Section B - Attachments for Program Expansion at Existing Program or Site

1. Identify the program.

SBH Health System's inpatient psychiatry program.

2. Provide justification and data supporting the need for the expansion.

SBH Health System seeks approval to increase the number of its inpatient psychiatric beds from 49 to 72, an increase of 23 beds. The major driver for this request is to create a robust inpatient behavioral health platform by increasing the bed capacity of the inpatient adult psychiatric program by 23 beds, thereby expanding access to mental health care and ensuring appropriate levels of care in the mental health system in keeping with Governor Kathy Hochul's transformation plan for mental health services in New York State. SBH Health System has been awarded Statewide Health Care Facility Transformation III grant funds to assist with over 97% of the cost of this project. Concurrent with this C.O.N. Application, SBH is submitting a Comprehensive PAR Application to increase the number of inpatient psychiatric beds with the New York State Office of Mental Health. Please refer to the Project Narrative under the Schedule 1 Attachment for additional information.

3. Describe the impact of the expansion on services, staffing, caseload and space.

SBH Health System seeks to expand the inpatient psychiatric program by 23 beds for a total of 72 beds, thereby increasing the inpatient psychiatric services at the Hospital to provide additional adult psychiatric bed capacity in the Bronx to facilitate optimal utilization of the beds available to residents of the Bronx. This proposal is responsive to Governor Hochul's transformation plan to enhance access to mental health services. To achieve this expansion, SBH will renovate the Hospital's two (2) existing inpatient psychiatric units and renovate another floor in the Hospital to create a new inpatient psychiatric unit. At the end of the project, SBH will have three (3) 24-bed inpatient psychiatric units that meet up-to-date standards of care for inpatient psychiatric services and enhance patient and staff safety and comfort. Please refer to the Project Narrative under the Schedule 1 Attachment for additional information.

4. Provide a detailed description of services available to recipients as a result of the proposed

expansion. Specify how these services will be provided and the staff positions responsible for providing the service. Identify the provider of any services to be delivered by other than the provider of the licensed program. For programs expanding to serve children, describe plans to coordinate with the family and the school.

The proposed expansion will enhance access to inpatient mental health care and optimize utilization of the inpatient psychiatry units at SBH to balance patient needs and staff well-being. The expanded services, including the added staff positions and the services provided, will be modeled after the existing inpatient psychiatry program. The expanded program will follow existing policies, procedures and quality standards. Please refer to the Project Narrative under the Schedule 1 Attachment for additional information.

5. Indicate the fiscal impact of the expansion. Provide the incremental increases to expenses and revenues. If additional Medicaid is proposed to support the expansion, for projects other than Article 31 clinics, indicate the source and availability of the state share of Medicaid.

[redacted]

In all projects, identify the program affected.

1. **Reduce Existing Program Not Applicable**

   a. Indicate proposed effective date for reduction.
   b. Describe the reasons for the reduction and the impact (if any) on individuals currently receiving services.

2. **Closure of Program or Site Not Applicable**

   a. Indicate proposed effective date of closure.
   b. Describe the reasons for closing the program or site.
   c. Submit a transition plan showing that recipients will be linked to appropriate alternative programs, the alternative programs have agreed to accept the referrals, recipient transportation needs will be addressed, and follow-up will occur to confirm recipient linkage to programs.
   d. If the rationale for closure includes fiscal considerations, provide documentation to substantiate the lack of fiscal viability in the long-term.
   e. Submit a plan for safeguarding recipient records and financial accounts.
   f. Describe the process and timeframe for evaluation and placement of recipients and completion of other activities to conclude the affairs of the program.

3. **Change in Location Not Applicable**

   a. Indicate proposed effective date of relocation.
   b. Identify the new location.
   c. Describe the reasons for the relocation.

d. Describe how access and transportation needs will be addressed.
e. Provide a description of the premises to be used. Include appropriately labeled sketch drawings showing use and dimensions of rooms.
f. Provide a Certificate of Occupancy or equivalent from the local buildings jurisdiction prior to occupancy.
g. If program relocates to new county or borough, complete Section A (1-7).

4. **Change of Sponsor Not Applicable**
a. Identify new sponsor and current sponsor.
b. Describe the reasons for changing sponsorship of the program(s).
c. Include written concurrence from the current sponsor for transfer of the program(s). If current sponsor is a corporation include resolution from the Board of Directors.
d. Describe any changes to be made in operation of the program(s).
e. Describe the qualifications of the new sponsor for the operation of mental health programs.
f. Indicate any financial considerations involved in the change of sponsor.
g. Submit a transition plan, including timeframes, for the change of sponsor.

5. **Capital Project**
a. Describe the reasons for the project.

SBH Health System is seeking approval to increase the number of its inpatient psychiatric beds from 49 to 72, an increase of 23 beds. As part of this proposal, SBH will gut and renovate the Hospital's two (2) existing inpatient psychiatric units and renovate another floor in the Hospital to create a new inpatient psychiatric unit. At the end of the project, SBH will have three (3) 24-bed inpatient psychiatric units that meet up-to-date standards of care for inpatient psychiatric services, enhancing patient and staff safety and comfort. SBH has been awarded Statewide Heath Care Facility Transformation Program III (SHCFTP3) grant funds to assist with over 97% of the cost of the project.

6. **Change in Population Served Not Applicable**
b. Describe the population currently served in the program. Include quantitative and qualitative data.
c. Describe the population being added to or deleted from the program. Include quantitative and qualitative data.
d. Explain the reasons for the change in population.
e. If adding population, provide justification and data to support the need to serve this population.
f. Describe the impact of the addition or deletion on the existing program in terms of services, staffing, staff expertise, linkages, space, capacity or caseload, and fiscal (including the impact on the state share of Medicaid, for projects other than Article 31 Clinics).

7. **Other Projects Not Applicable**
a. Describe the project and the reasons for requesting approval. If an emergency situation, fully describe the nature of the emergency and the necessity for approval.
b. If a management contract or clinical services contract, provide:
I. Reasons for entering into the proposed contract
II. Copy of the proposed contract.
III. Background on the principals, officers, and directors of the organization.
IV. Information in sufficient detail to enable review of the project pursuant to Part 551.7(a)(15) of Title14 NYCRR.

New York State Department of Health Schedule 20B
Certificate of Need Application

Office of Alcoholism and Substance Abuse Services Program

Not Applicable

This information is required of Article 28 hospitals and diagnostic and treatment centers for projects that include Chemical Dependency (CD) programs subject to an operating certificate or prior approval by the Office of Alcoholism and Substance Abuse Services (OASAS) under Article 32 of the Mental Hygiene Law (MHL). These projects include a new Chemical Dependency (CD) program, or a new site, or a modification to an existing program. Per MHL Article 32, prior consultation with the Local Governmental Unit (LGU) and local OASAS Field Office is required before submission of the Article 28 application.

Section A – Attachments for New Service, New Additional Location or Capacity Increase of beds

1 Program and Service Area
- a) Identify the type CD treatment service to be provided.
- b) Provide a description of the area where the applicant plans to provide CD services.
- c) Describe how the proposed program will function within the network of CD provider in this area.

2 Need
- a) Provide an assessment of the need for the services requested.
- b) Describe how your organization currently serves the target population (if applicable).
- c) Provide any other information supporting need for the proposed program.

3 Functional Program
- a) Mission - Describe the applicant's approach/philosophy regarding the treatment of chemical dependence; include use of self-help services, medication, individual/group counseling and other treatment techniques.
- b) Organization – Describe the lines of authority from the governing body to the proposed program. Indicate the relationship of the program to other programs operated by your agency.
- c) Goals and Objectives - Provide a detailed list including, but not limited to: expected outcomes for patients, planned numbers and frequency of service delivery, planned length of stay and other proposed measures of success.
- d) Policies and Procedures – Submit detailed CD operational policies and procedures in accord with the proposed services to be provided. (not required when adding an additional location or a capacity increase of beds)
- e) Additional Locations – Indicate current annual number units of services at main location and projected annual number units of services at the additional location.
- f) Services – Describe the proposed operating schedule including days and hours.
- g) Staffing – Provide a staffing plan for the program. Include descriptions of qualifications and duties for each staff person.
- h) Premises – Provide a description of the premises to be used by the program. Include floor plan sketches drawn to scale.
- i) Provide a Certificate of Occupancy or equivalent from the local buildings jurisdiction.

4 Fiscal

a) Submit a proposed budget for pre-operational expenses and first year of full operation.

5 ~~Implementation~~

Describe start-up or phase-in activities necessary to implement the program. Include timeframes in your description.

Section B – Relocation an existing service.

1 Change in Location

a) Indicate the proposed effective date of relocation.
b) Identify the new location.
c) Describe the reasons for the relocation.
d) Describe how access and transportation needs will be addressed.
e) Provide a description of the premises to be used by the program. Include floor plan sketches drawn to scale.
f) Provide a Certificate of Occupancy or equivalent from the local buildings jurisdiction.
g) If the program relocates to a new county or borough, Complete Section A (1).

Section C – Change of Sponsor

1 Change in Sponsor

a) Identify the new sponsor and the current sponsor.
b) Describe the reasons for changing sponsorship of the program(s).
c) Include written concurrence from the current sponsor for transfer of the program(s). If current sponsor is a corporation, include a resolution from the Board of Directors.
d) Describe any changes to be made in the operation of the program(s).
e) Describe the qualifications of the new sponsor for the operation of CD programs.
f) Indicate any financial considerations involved in the change of sponsor.
g) Submit a transition plan, including timeframes, for the change of sponsor.